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**COMMISSION**  
*on*  
**HOSPITAL CARE**  
*for*  
**FRAIL OLDER PEOPLE**



**MAIN REPORT**

**NOVEMBER 2014**

# COMMISSION *on* HOSPITAL CARE *for* FRAIL OLDER PEOPLE

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Here is a radical suggestion – make hospitals good places for old people. Few national providers would make such a blatantly ageist inference that its ‘core business’ was too tricky to manage, and propose to solve ‘the problem’ by ceasing to attempt to deal with it... The acute care of older people has progressed through being an inconvenience to being an anathema.

Professor Marion McMurdo, *BMJ* Letters

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## The commissioners

Full biographies of all the commissioners, plus complete background information, including the commission’s scoping report, can be found at [www.hsj.co.uk/frail-older-people](http://www.hsj.co.uk/frail-older-people)



**Chair** Dame Julie Moore is chief executive of University Hospitals Birmingham Foundation Trust



John Appleby has been chief economist at the King’s Fund since 1998. He is also a visiting professor at the Department of Economics at City University London



Julienne Meyer is professor of nursing care for older adults in the school of health sciences, City University London



John Myatt is the strategic development director for Serco’s healthcare business. He previously worked for the Cabinet



Professor David Oliver has been a practising hospital doctor for 25 years and a consultant, specialising in geriatric and general internal medicine, for 16 years



Jenny Ritchie-Campbell is Macmillan’s director of cancer services and innovation and joined the charity in 2010



Andy Cowper is secretary to the commission and comment editor of HSJ

### HOW THE COMMISSION WORKED

Commissioners studied the main reports on hospital care for frail older people from recent years, as well as all the material submitted to our original call for evidence.

To meet our aim of being a practically focused commission, we actively solicited reports of good practice from colleagues across the sector, with particular thanks to the British Geriatrics Society.

Feedback has suggested that our scoping report ([www.hsj.co.uk/5071053.article](http://www.hsj.co.uk/5071053.article)) was considered useful.

Our animation, Mrs Andrews’ Story ([www.hsj.co.uk/mrs-andrews](http://www.hsj.co.uk/mrs-andrews)), was nominated for an Independent Age Older People In the Media Award and a second film about how her care could have been better accompanies this report.

The commission sought out short case studies on good practice. These are available at [www.hsj.co.uk/frail-older-case-studies](http://www.hsj.co.uk/frail-older-case-studies).

# Key points

## Forget about government plans – hospital providers must and can get on with it now

**1** There is a myth that providing more and better care for frail older people in the community, increasing integration between health and social care services and pooling health and social care budgets will lead to significant, cashable financial savings in the acute hospital sector and across health economies. The commission found no evidence that these assumptions are true.

We should avoid wishful thinking that improving intermediate and community care (while perhaps the right things to do) will automatically mean we can disinvest significantly in hospitals.

Clearly, commissioners should invest in prevention and helping older people living with long term conditions to avoid crises, and in rapidly responsive services outside hospital (such as intermediate or social care). Just as clearly, there is too much variation between areas in rates of urgent admission and bed occupancy.

Yet even if we deliver more joined up care out of hospital, population ageing and the rising number of older people living with frailty, dementia and multiple long term conditions mean that even a levelling off of urgent activity over years, not months, will be a good result.

A body of evidence around the benefits of integrated care models exists, from several countries. However, these benefits take several years to achieve, and reductions in urgent activity are only one measure of success.<sup>1,2,3,4</sup>

A series of reviews by Cardiff and Bristol universities showed inconsistent evidence for a variety of interventions to prevent urgent admissions to hospital.<sup>5</sup> Research by Mason, Goddard and Wetherley found that not one of 38 integration schemes in eight countries, including 13 projects in England, secured a sustained, long term reduction in hospital admissions.<sup>6</sup> Nolte and Pitchforth's 2014 World Health Organisation paper on the evidence for integration found little or no evidence of cost-effectiveness, though some regarding better quality for patients.<sup>7</sup>

There are similar findings from the Nuffield Trust's *Evaluating Integrated & Community Based Care*, a Cochrane Review and the NHS Confederation's 2009 *Dealing With The Downturn*.<sup>8,9,10</sup> Further evidence supporting the commission's findings in these key points and in the main body of the report is published on the commission's website.

**2** The commonly made assertion that better community and social care will lead to less need for acute hospital beds is probably wrong. A short-term reduction in acute sector demand may follow as a consequence of community-based demand reduction initiatives, although this is unproven.

Improving community care may postpone the need for hospital care, but it will make frail older people neither invincible nor immortal: mostly, they will simply need the care later.

It will never prevent older people and their carers from needing or seeking urgent care in emergency departments or in hospitals.<sup>11,12</sup>

The majority of costs inevitably lie at the end of people's lives.<sup>13</sup> Around one in three people over 65 admitted acutely to hospital are in fact in their last year of life.<sup>14,15</sup>

Over time, spending in the acute sector will not reduce, and demand will continue to increase in line with our changing demographics.

England has fewer hospital beds than all but one OECD country per head of the population and has reduced its number of beds through a combination of reduced length of stay and, importantly, changes in policy over where to care for elderly and mentally infirm people over the past three decades.<sup>16</sup>

England has shut around 30 per cent of its hospital beds in the past 20 years, yet despite this, rates of urgent admission and readmission have continued to rise dramatically.<sup>17</sup> UK hospitals run very "hot" at around 95 per cent occupancy, even though optimal occupancy for good patient flow is between 85-90 per cent.<sup>18,19</sup>

**3** We need more realism in the debate about the quality and quantity of care that can be provided in an environment of funding that is declining relative to demand. The pursuit of current NHS funding policies looks likely to lead to a funding gap. No major political party's current health policy commitment will meet this funding gap.

NHS England's recent *Five Year Forward View* envisages an £8bn funding gap by 2020, assuming radical, rapid structural change in the provider sector worth £22bn of productivity gains over that period. This is a heroic assumption.

The evidence that two thirds of the funding gap can be met by further gains in productivity and prevention is lacking. The source of funding for these provider efficiency reforms is unclear: if they do not succeed, negative implications for the quality of care would follow.

The impact of increasing demand owing to demographic change; funding restraint enacted through tariff deflators; and the Better Care Fund has been to squeeze acute hospitals from all sides.

A failure to adequately address this issue with increases in funding over the forthcoming planning period will directly and negatively affect the quality of care that is provided by hospitals to older people living with frailty.

Evidence for these key points is available at [www.hsj.co.uk/frail-older-evidence](http://www.hsj.co.uk/frail-older-evidence)



**We need to ensure that older patients with frailty are not punished for the system's inability to provide what they need**



**4 Hospitals should not be used to provide care that should more appropriately be provided elsewhere. Commissioners must improve community care to meet future demand, but the required investment must be based on evidence.**

No patient should need to be admitted to hospital due to a lack of home help, adaptations, and other straightforward and obvious requirements. Ensuring adequate community provision is in place is a commissioner responsibility, which will become more important as a consequence of demographic change.

We should never blame frail older patients for presenting inappropriately to hospital where we have designed a health system inappropriate to their health and care needs. Many older people default to emergency departments because of a lack of rapidly responsive primary or community alternatives.

Most admissions in people over 75 have bypassed GPs or out-of-hours services. Older people are more likely to call an ambulance, more likely to be conveyed to hospital, and once there, more likely to be admitted.<sup>20,21</sup>

Two rounds of the National Intermediate Care Audit<sup>22</sup> have shown that we only have around half the “step up” and “step down” beds and places we require to ensure that no older person is in a hospital bed whose needs could be met elsewhere; also, that response times and capacity in intermediate care services are very variable.

Delayed transfers of care from hospital for both health and social care reasons are still a major problem in NHS hospitals.<sup>23</sup>

Increasing community and social care resources may enhance the care that older people receive at home and bridge gaps in current services. It is well known that the quality of those services is little measured and little understood. It is unclear whether increasing investments on out of hospital health and social care will wholly or partly just satisfy demand for services in the community that are presently unmet.

Some policy advocates suggest that increasing levels of community care for older people with frailty is better and cheaper than increasing the quantity of beds in acute hospitals. International evidence suggests that achieving this properly takes a minimum of four years and requires significant investment, as has been found in the US by the Veterans Administration, Intermountain and Kaiser Permanente.

**5 While acute hospital admission is often the right thing to do for frail older people, being in hospital also creates risks for older people.**

Hospitals need to gear up to provide the very best care for frail older people, who are now their most frequent users, involving geriatricians from the start of the admission together with the other appropriate specialists.<sup>24,25,26,27</sup>

Hospitals can fix this issue, but the right leadership is too often lacking. Too many leaders are not copying others' good practice.

Leaders feel they are distracted by regulatory interference in measuring the wrong areas, and by tariff incentivising inappropriate things.

The commission aims to give practical support to improve hospital care for older patients with frailty who need acute care (fractured hips, acute stroke and other such conditions). Providing care for older patients with frailty and multiple health problems is often more complex due to their comorbidities and age related issues.

We need to ensure that older patients with frailty are not punished for the system's inability to provide what they need. The commission believes that frail older people in hospitals should expect to receive best in class care wherever they are. It is within the grasp of the staff and management of acute hospitals to start improving the healthcare that they provide to these people today, within their current resources.

A good starting point would be for hospitals to understand whether they provide a good service now. The commission is providing a set of resources to health service professionals to help.

The commission's final report in March 2015 will target messages for political leaders and members of the public. ●

**Key points references. Full references are available at [www.hsj.co.uk/frail-older-references](http://www.hsj.co.uk/frail-older-references)**

**1** Ham et al 2011

**2** Goodwin N et al 2012

**3**) NHS Confederation 2009

**4** NHS Confederation and Royal College of GPs 2013

**5** Purdy et al 2012

**6** York University 2014 [www.york.ac.uk/news-and-events/news/2014/research/che-research/](http://www.york.ac.uk/news-and-events/news/2014/research/che-research/))

**7** Nolte and Pitchforth, 2014 World Health Organisation paper [www.euro.who.int/\\_data/assets/pdf\\_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf](http://www.euro.who.int/_data/assets/pdf_file/0019/251434/What-is-the-evidence-on-the-economic-impacts-of-integrated-care.pdf)

**8** Evaluating Integrated & Community Based Care, Nuffield Trust [www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation\\_summary\\_final.pdf](http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf)

**9** Cochrane Review [www.hsj.co.uk/resource-centre/best-practice/care-pathway-resources/why-early-discharge-in-stroke-care-can-be-vital-for-recovery/5038502.article](http://www.hsj.co.uk/resource-centre/best-practice/care-pathway-resources/why-early-discharge-in-stroke-care-can-be-vital-for-recovery/5038502.article)

**10** Dealing With The

Downturn, NHS

Confederation 2009 [www.nhsconfed.org/Publications/reports/Pages/Dealing-with-the-downturn.aspx](http://www.nhsconfed.org/Publications/reports/Pages/Dealing-with-the-downturn.aspx)

**11** Making Health and Care Services Fit for an Ageing Population, Oliver et al, King's Fund 2014

**12** Safe Compassionate Care for Older People, NHS England 2014.

**13** Appleby 2013; chart 3.6 page 78 of <http://cdn.budgetresponsibility.org.uk/41298-OBR-accessible.pdf>

**14** RCGP and RCN 2012

**15** Nuffield Trust 2010

**16** Appleby 2013

**17** RCP London 2013, Hospitals on the Edge

**18** ECIST 2011

**19** Health Foundation Unblocking The Hospital in Gridlock 2013

**20** Silver Book 2012

**21** Poteliakhof et al 2011

**22** NHS Benchmarking 2013

**23** NHS England 2013

**24** Bridges et al 2009

**25** Oliver et al, King's Fund 2014

**26** Oliver, Clinical Medicine

**27** NHS Confederation and Age UK 2013





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**There is always a well-known  
solution to every human problem –  
neat, plausible and wrong**

HL Mencken,  
humourist and essayist,  
*The Divine Afflatus* (1917)

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# Our findings

The standards of hospital care for frail older people affects us all – current and future patients and their relatives and friends, clinical and managerial colleagues, and citizens and taxpayers



**There is a mindset among some hospital colleagues that frail elderly patients are ‘not our core business’**



Further evidence supporting these findings is available at [www.hsj.co.uk/frail-older-evidence](http://www.hsj.co.uk/frail-older-evidence)

## **JULIE MOORE** **THE IMPORTANCE OF CLINICIANS DESIGNING THEIR OWN DATA MEASURES**

Clinicians are rational and intelligent beings with a scientific background.

When a performance measure makes sense and is based on clinical evidence, then they are generally really keen to make sure the care of their patients meets that standard. Problems arise when clinicians are asked to deliver standards that have no proven clinical benefit.

Asking clinicians to develop quality

standards based on sound clinical evidence that will have a positive outcome for patients is a great way to ensure compliance with those standards and to drive up quality.

These standards have to be open to questioning by a jury of peers and the results subject to similar scrutiny.

*Dame Julie Moore is chief executive of University Hospitals Birmingham Foundation Trust and commission chair.*

There have been a number of welcome initiatives and reports aimed at addressing the problems in hospital care for older people. Both Francis inquiries made it clear that many of the scandals in Mid Staffordshire Foundation Trust surrounded the care of older people.<sup>1</sup>

In his first inquiry report, Sir Robert Francis wrote:

*Many of the cases in which patients and their families have reported concerns have involved elderly patients. The multiple needs of such patients in terms of diagnosis, management, communication and nursing care are in many ways distinct from those of younger patients... Older patients will often present with a complex of medical and care problems requiring a skilled and all embracing multidisciplinary team approach. Active management with the assistance of specialist advice will often be needed.*

*The trust had a service for the care of the elderly but there has been little evidence of its contribution in many of the cases of concern reported to the inquiry.*

The range of issues raised by Francis around the care of older inpatients mirrored those identified by the 2007 all parliamentary committee into the human rights of older people in healthcare; the Patients Association CARE campaign; the 2011 Ombudsman's report *Care And Compassion* on care of older people; the Age UK/NHS Confederation 2012 Delivering

Dignity commission; and the national bereavement survey on experiences of end of life care.<sup>2</sup>

The 2012 RCN report on safe staffing in older people's wards also highlighted the systematic under-provision of nurses in clinical areas where the most vulnerable and dependent older people often receive care.

As the King's Fund's *Call to Action on the Care of Frail Older People with Complex Needs* noted, there had been 27 reports and guidelines on dignity in care for older people in hospital over the previous decade.<sup>3</sup> There should be simply no need to keep describing this set of problems. There should, instead, be a relentless focus on solutions.

Colleagues with whom commission members have spoken report a mindset among some hospital colleagues that frail elderly patients are "not our core business". This cultural attitude seems to be strongly associated with a compounding element of care pathway fracture for frail older people in acute settings. These kinds of pathway problems leave this patient group being particularly vulnerable to getting stuck in the system or receiving a poor service.

The facts are stark: there is a more than threefold variation between areas in rates of emergency admission and occupied bed days for people aged over 65.<sup>4,5</sup> Eighty per cent of those who stay in hospital longer than 14 days are over 65.<sup>6</sup>

The oldest old (aged 85-plus) accounted for 585,057 of the 12.2 million (4.8 per cent) first attendance to English emergency departments in 2008-09, and 62 per cent were admitted to hospital.<sup>7</sup>

The NHS Confederation estimated in 2013 that one third of older patients initially admitted to hospital as a medical emergency no longer need a hospital bed. A joint Department of Health/Foundation Trust Network study in 2012 found that one in four hospital readmissions were as a result of hospital care or poor hospital discharge planning, with most being due to relapses of long term conditions.

### **Building on existing good work**

The commission was clear from the start that it neither wanted nor needed to replicate the excellent previous reports in this area by organisations such as the King's Fund, Age UK,

## JULIE MOORE

### HOW BIRMINGHAM USES REAL TIME INDICATORS TO BOOST CARE

Many potential harms can happen to a patient on admission to hospital. It is vital that a patient's risk of coming to any harm is assessed as quickly as possible in the admission, to enable strategies to reduce risk to be put into place. These risks include risk of falling; developing pressure sores; developing DVT; and not being appropriately nourished.

The earlier this assessment takes place, the earlier the measures to reduce risk can be put in place. At University Hospitals Birmingham Foundation Trust, for example, we have seen a reduction of 40 per cent in harm from inpatient falls by making sure all patients are assessed within six hours of admission (including patients admitted at night; for most patients the time taken is much shorter).

You can only measure speed and timeliness of assessment, and measure these in real time, using electronic patient management systems. Retrospective audit shows you where things went wrong, but it is less helpful in putting it right. Staff need real time feedback on their performance to enable them to sort any issues.

At Birmingham, we have developed a suite of 13 indicators around care and assessment that have led to significant reductions in incidents of harm. These are measured on a daily basis, and fed back to the clinical teams on a daily basis.

We have seen great sharing of good practice across the organisation among wards and departments as a result of this.

British Geriatrics Society, the Royal College of Physicians' Future Hospitals Commission, the Commission On Dignity In Care, the Academy of Royal Medical Colleges and others.

All of these reports informed our discussions to great effect, and we recommend them strongly. We wanted to take a practical approach, highlighting what could be done with immediate effect to make care better.

Likewise, the commission was conscious of some negative portrayals of NHS staff in certain previous reports, and wanted to highlight and celebrate existing good practice, which tends to be locally rooted, rather than based in imposed, one size fits all solutions.

There are many fine examples of services in England that are addressing such issues and making a difference. These include University Hospitals Birmingham Foundation Trust's ongoing dignity programme; the use of mealtime volunteers to improve nutrition at University Hospitals Southampton Foundation Trust; the national drive by the Royal College of Nursing to improve the care and environment for older people with dementia; the work of the National Hip Fracture Database movement; and the Royal Voluntary Service scheme to support older people on discharge from hospital and prevent readmission. There is much good practice out there: we just need to make the rest as good as the best, and do so quickly.

Notable good practice examples have been set out elsewhere: as at the King's Fund Innovations in Services for Older People event this year; in the King's Fund report *Making Health And Care Systems Fit For An Ageing Population*; in NHS England's 2014 *Safe Compassionate Care*; in the National Audit of Intermediate Care or the Gold Standards Framework programme on improving end of life care and advance care planning in acute hospitals.

Part of this commission's work has been to highlight a number of such good practice examples. We would welcome more from people leading local services. These good practice case studies can be accessed on the commission's website ([www.hsj.co.uk/frail-older-case-studies](http://www.hsj.co.uk/frail-older-case-studies)).

Many factors contribute to good acute care for frail older people. The most common ones

we encountered were obvious: a commitment to high quality standards for this patient group and intolerance of failure on the part of all clinical and non-clinical colleagues across a provider system. Particular factors included discharge planning, dignity champions, nutrition, nursing, mental health and physiotherapy, as evidence submitted to the commission confirmed.

The commission recognises that older people are calling for more relational care. They want to be recognised by those treating them as individuals; to be involved in decision making; and to feel that staff care for and are emotionally connected to them. Beyond this key element of patient experience, there are other equally important aspects of quality:<sup>8</sup>

- outcomes (and the application of evidence based interventions known to deliver them);
- safety and preventing avoidable harms;
- fairness and equity (free of discrimination based on age or other factors such as dementia or poor mental health);
- continuity and care coordination (in other words "integrated care");
- responsiveness and person-centredness;
- efficiency.

The commission agreed that trying to form a list of all the component categories would probably add little of practical use and value. It concluded that local providers should establish where their service gaps and weaknesses are. As a result, its scoping report centred on a framework of questions for teams and organisations to ask themselves, to identify potential gaps in their current practices ([www.hsj.co.uk/older-people-checklist](http://www.hsj.co.uk/older-people-checklist)).

The commission also developed a new checklist of self-assessment prompts for

### DEVELOPING A SUPPORTIVE CULTURE

The National Institute for Health Research's service and delivery organisation suggests these prerequisites for creating a supportive culture:

- A shared vision and goal
- Leadership from the top
- Fostering positive relationships
- Enabling and involving staff at all levels

of the organisation, especially clinical staff

- Investing sufficient time, resources and education in staff development

- Empowering people, especially those closest to the delivery of care

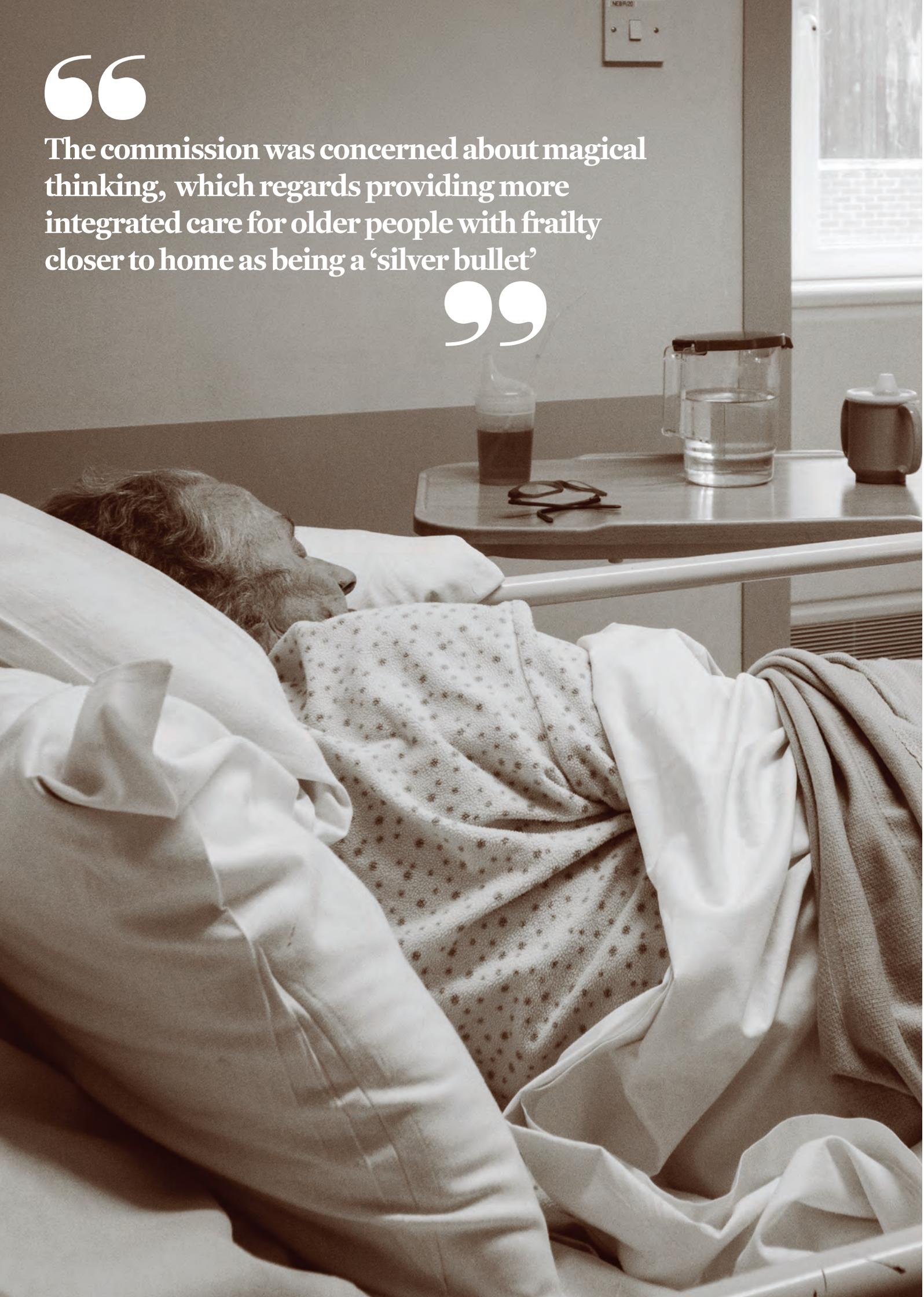
- A focus on the patient experience

[www.nihr.ac.uk](http://www.nihr.ac.uk)

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The commission was concerned about magical thinking, which regards providing more integrated care for older people with frailty closer to home as being a ‘silver bullet’

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## JOHN MYATT

### OVERCOMING BARRIERS TO CHANGING HOW PEOPLE WORK

As anyone will tell you, changing the way people go about their work is hard. There are many management texts on the correct way to go about change management, and plenty of examples of spectacular failure when people get it wrong. Rather than rehearsing these well-trodden points, I am instead going to pick out one theme: individuality.

It is easy to assume that making a service better, streamlining it and reducing failure points might make things better for staff. It is less chaotic, after all.

This might be true for some (or even many), but certainly not all.

I remember a point early in my career when I spent time talking to staff following the successful implementation of an IT system. The situation for customers and the organisation had improved markedly: few disagreed with that.

However, I was struck by how the new situation was received by some of the most capable staff. I recall clearly a wistful hankering for the days when things went spectacularly wrong, where all hands went to the pump, and the power that came from knowing that “I, and only I, can fix the mess in which we find ourselves”.

Removing the chaos had taken away the part of the job they enjoyed the most – where they felt at their most useful. It struck me that these capable staff would soon be moving on to pastures new.

But it also struck me that had the implementation gone poorly, had issues arisen along the way, that it would have been this same group who would have shown the flaws in the new thinking.

I recall another situation when I spoke to a member of a professional group in receipt of a new service. Extensive consultation with members of the profession had been undertaken to design the new service, but the individual was not happy. When I mentioned the scale of the consultation that had been undertaken, the person responded: “Well, no-one asked me.” I feel it is a telling remark.

I am not saying that the satisfaction of each member of staff should take precedence over replacing chaos with order in a public service. Instead, my point is that most public services rely on people: motivated, capable people, and those people are individuals with free minds who won't necessarily conform to a set of standards, or fit into the behaviours of a cohort, however much we might want them to.

Engaging at the individual level takes a long time. It might seem that it cannot be done; but sometimes slowing down allows us to speed up in the long run. Especially in healthcare, where individual interactions are so important.

*John Myatt is the strategic development director for Serco's healthcare business and a commissioner.*

professional groups, which can be found on the inside back cover of this report.

#### Workforce and skill mix

Workforce and skill mix issues are glaring. A recent British Geriatrics Society survey showed that only half of UK medical schools have structured content on geriatric medicine despite older people living with frailty, dementia or complex comorbidities accounting for so much of activity in hospital, primary and community care services.<sup>9</sup>

The General Medical Council has now recognised the importance of early postgraduate exposure to training in geriatric medicine.<sup>10</sup> Even though we are fortunate in the UK to have a long tradition of geriatrics and geriatricians, and geriatric medicine is the largest general internal medical speciality, geriatricians can never look after everyone in hospital. Older people are admitted to all clinical areas and so all doctors need to acquire the right skills and values.

The Royal College of Physicians in its 2013 Future Hospitals Commission and workforce reports, and the 2014 Greenaway Shape Of Medical Training review<sup>11</sup> recognised that in an era of increasing sub-specialisation, we need more “expert generalists” to look after typical acute inpatients who now generally have multiple long term conditions and not just single diseases.

The Future Hospitals Commission and Academy of Medical Royal Colleges (2014) have also recognised the value of single, named “whole stay” clinicians. *Cancer Services Coming Of Age*<sup>12</sup> confirmed that skill mix and workforce are significant ongoing issues for providing appropriate care for older patients.

At present, what the commission heard

would suggest that the only widespread generalists in the acute sector are intensivists and geriatricians.

#### Local systems

Improving acute care for frail older people will also mean that changing roles will be needed from staff in ambulance services and district nursing, as well as improved connections with the nursing and residential care home sectors. Re-examining what care is provided by whom and where across our local health and care systems will show us what successful changes in these areas need to look like.

The hokey-cokey approach to implementing the better care fund has not been helpful to planning services with greater clarity. Nor are the causes of the problems nationally identical.

The commission discussed whether there might be a need to agree national standards for using the better care fund, such as maximum time before social worker assessment. Using a targets approach often achieves results, but also risks causing unintended consequences and disempowering local autonomy, as NHS England's *Five Year Forward View* (2014) has acknowledged.

The funding issue is ever present in an NHS apparently expected to meet rising demand without appropriate real-terms increases. Costs are rising year on year for residential and nursing care providers, and for those who pay their fees.

Problems often arise in hospital care for frail older people due to care pathways getting blocked and a lack of services to pick up emerging demand. This is caused by a lack of funding, inadequate strategic planning, and the absence of meaningful pooled budgets and genuine partnership working.

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## JENNY RITCHIE-CAMPBELL HOW TO DEVELOP AND SUSTAIN PARTNERSHIP WORKING

It is clear there are a range of inequalities in cancer care facing older people. These inequalities often manifest as challenges in three areas: insufficient support and enthusiasm for older people to self manage their care results in a loss of control; information that is appropriate for them is difficult to access and navigate results in a loss of choice; and the combination of a health and social care system that encourages paternalism and a deferential attitude to care from many older patients results in a loss of voice.

This escalates levels of care that might otherwise be avoidable or manageable. It's also unacceptable for this loss to remain unchallenged. We believe that these needs must be better understood and addressed.

One way to achieve this is through long term, sustainable partnerships between care providers and voluntary sector organisations representing the needs of our older population. These charities have invested in continual understanding of what older patients and carers want across the entire pathway. This enables us to challenge effectively, convene different providers, and connect with the right partners to provide the right support for older people.

At Macmillan Cancer Support, for example, we have seen progress in the support and care of older people through the availability of a peer advocate. This is where a trained, independent advocate supports

people who have difficulty representing their interests, and has proven to be an effective way of supporting people accessing the care services they need and can help build confidence to confront a diagnosis or treatment.

We have developed this via a partnership with the Older People's Advocacy Alliance, a national infrastructure organisation which promotes and develops independent advocacy with older people in the UK. Our partnership is now running across 10 sites, and we have recruited more than 300 peer advocates and 150 local cancer champions.

We have seen and been able to demonstrate how this kind of support complements the work of health and social care professionals involved in the care of older people affected by cancer. We also recognise that there are significant unmet needs for unpaid carers and we believe that this type of peer advocacy is beginning to bridge some of these gaps.

As a result, we have received significant interest from CCGs and social care, as well as primary care, in the benefits of maintaining choice, voice and control for older people. With an ageing society, the value of partnering and sharing expertise has never been more important.

*Jenny Ritchie-Campbell is Macmillan's director of cancer services and innovation.*

**Video**  
Watch Mrs Andrews' story at  
[www.hsj.co.uk/mrs-andrews](http://www.hsj.co.uk/mrs-andrews)

### Magical thinking and Messiah concepts

The commission was concerned about the prevalence of magical thinking<sup>13</sup> in current policy and politics, which regards providing more integrated care for older people with frailty closer to home as being a "silver bullet" to slay the demon of poor care.

We described this as a Messiah concept. The commission concluded that the track record of success for previous Messiah concepts in the NHS (lean, Toyota, community matrons, the case management pyramid) should urge us towards caution, pragmatism and realism.

### Patient experience

In hospital, older people's feedback tends less to focus on the quality of clinical care; they expect this to be in place. Instead, they highlight the importance of relationships and approaches to care. They want staff to: "See who I am!"; "Involve me!"; and "Connect with me!"<sup>14</sup> These relational aspects are also important to relatives who visit and staff who work in hospitals,<sup>15</sup> as well as being key to good leadership to support transformational change.

These more relational aspects of care need to be emphasised in acute hospitals, to ensure parity of esteem between clinical and relational care. It could also help to counterbalance the damage of a tick-box culture which focuses too

## RESPONSE: RCP LONDON FUTURE HOSPITAL IDENTIFYING KEY CHALLENGES

Many older patients have multiple, complex conditions and are not well managed by current NHS systems of care.

Care that is fragmented, with multiple ward moves, changing clinical teams and repeated handover, puts this patient group at particularly high risk. This includes an increased risk of adverse clinical incidents, communication breakdown, reduced quality of care, efficiency and patient satisfaction.

The Royal College of Physicians London's 2013 *Future Hospital* report identified key areas for improving the care of frail older patients:

- Increased collaborative working by geriatricians and their teams with primary care services to identify frail older patients in the community early when they have an acute illness or exacerbation of a long term condition – in order to manage the illness at home.
- Identifying those patients who present to hospital as an emergency but who do not require admission. Arrangements in which geriatric multidisciplinary teams work in ambulatory emergency care, enable early

expert assessment and same day treatment in hospital without admission. The potential benefits of avoiding admission in older patients with frailty and dementia are considerable. These patients are at risk of prolonged hospitalisation in an unfamiliar environment, causing distress, fracturing community support and undermining their independence.

● Organising services so that frail older patients who require admission receive a comprehensive geriatric assessment early in their admission pathway – ideally in a dedicated frailty assessment unit. CGA leads to better outcomes for this vulnerable patient group including reduced readmissions, reduced long term care, greater patient satisfaction and lower costs.

The frail older patient presenting with an acute illness is now "core business" for almost all NHS healthcare practitioners. Clinical staff should have sufficient training to be able to recognise and respond to the needs of frail older patients to ensure that their care is safe, coordinated, effective and efficient.

*Dr Mark Temple is an RCP Future Hospital Fellow.*

## RESPONSE: BRITISH GERIATRICS SOCIETY AGE SHOULD NEVER BE A BARRIER TO CARE

The British Geriatrics Society welcomes the findings of the report, and hopes the key principles will be taken on board by national policy makers, as well as the organisations responsible for commissioning and providing care for older people living with frailty.

Age should never be a barrier to receiving the best care, in an appropriate environment, delivered by skilled, trained professionals.

Lessons should be learnt from the exemplars of good care, while acknowledging that a one-size-fits-all model will never be successful within the NHS because of local variances in community and social care provision.

Comprehensive geriatric assessment (CGA) is the multidimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a co-ordinated and integrated plan for treatment and long term follow-up.

A patient who receives CGA during an illness is 30 per cent more likely to be alive and living in their own

home at six months than a person receiving standard care. The BGS believes that all older people living with frailty are entitled to receive CGA regardless of the environment in which they receive their care, and has recently published Fit for Frailty guidelines in conjunction with Age UK and the RCGP.

Frailsafe ([www.frailsafe.org.uk](http://www.frailsafe.org.uk)), a BGS project in conjunction with the Health Foundation and other partners, is designed to improve the safety of care that older people receive on admission to the acute hospital environment.

An entire systems change is needed, with the older person rooted firmly at the centre, and their care designed around their needs. Traditional barriers affecting transition between services and environments need to be destroyed. Investment, both financial and motivational, is needed in all arenas where care is received and delivered for this vulnerable cohort, and it needs to happen sooner rather than later.

*Zoe Wyrko is director of workforce planning at the British Geriatrics Society.*



**The commission's report must be candid about its conclusion that too much care for frail older people is not as good as it can and should be**



much on measurement and not enough on "meaning".<sup>16</sup>

Improving care for frail older people cannot be confined to the process around hospital contexts. We need to look across the whole journey of care for frail older people. The private (for profit and not-for-profit) and voluntary sectors are significant players in health and social care settings: the care home sector has three and a half times more beds than the NHS, and is caring for some of the most frail and vulnerable citizens in our society today. The British Geriatrics Society, in its papers *A Quest For Quality* (2011), *Failing The Frail* (2012) and *Care Home Commissioning Guidance* (2013), highlights the importance of better partnership working with the care home sector – without this, health related models of care are unlikely to succeed.

### Known gaps

There are significant care gaps and variation in the quality of primary care support for people who are frail or have multiple age related long term conditions.<sup>17</sup> Health and wellbeing strategies are often insufficiently focused on the mature life course, even though at 65 people can already expect to live another two decades on average, with these projections moving to another 23 years for men and 26 for women by 2030.<sup>18</sup>

Sources such as the National Audit of Intermediate Care (2014) show we have nowhere near enough places and beds in both step up (admission prevention) "discharge to assess" or "step down" post-discharge intermediate care, re-ablement and hospital at home/virtual ward services.

There are also major unwarranted geographical variations in rates of admission or bed occupancy to hospital and in care home placement direct from hospital beds. Some systems perform better than others.

Too many older people are, through no fault of their own, remaining in high-cost acute beds which are not always well suited to their needs because of a lack of capacity, workforce and skills in other, more appropriate care settings. When older people with frailty have a genuine need to be in hospital, we need to make this environment age-proof and fit for purpose, reflecting the needs of those older people who are there and including those with dementia. This will require meaningful changes in the distribution of funding through the system (and disinvestment is always hard). It will also require provider sectors learning from good practice from one another, and co-creating new ways of working. Co-creation requires reflective space, and time to be creative.

Funding pressures are also, in the commission's view, a root cause of the lack of reflective space and creative relentless cost-cutting, and the potential for innovative solutions is being stymied or wasted. If all attention is focused on the 'slash and burn' of cost improvement programmes, providers may be failing to see that they could provide care in

work differently and have better outcomes. The rising tide of demand is squeezing everything, including fees for independent care, in individuals' homes and in care homes. The independent sector's inability to absorb more cost savings now appears to be having a direct impact on other health and social care providers in the public sector.

The commission's report must be candid about its conclusion that too much care for frail older people is not as good as it can and should be. Alongside this clear message, we hope that this message will give providers throughout the system the resolve, supported by some practical signposts and tools, to make the changes.

### The hospital role

We need to make an impact at the point of acute admission for frail older people, by ensuring that care is as expert, focused and streamlined as possible. We know that prolonging a hospital stay by even one day can have detrimental effects on an older person's health and fitness. Ten days of bed rest for someone over 75 leads to 10 per cent loss of aerobic capacity and 14 per cent loss of muscle strength – equivalent to 10 years of life.<sup>19</sup> On average, every ward move adds two days to length of stay.<sup>20</sup>

The way we organise hospitals could have negative impacts on the health of an older person. The self-assessment tools provided by the commission aim to help leaders at all levels of organisations, from board to ward, to ensure they are providing the most appropriate care aimed at providing expert intervention in a timely fashion.

We cannot settle for simply accepting that poor quality care for older people with frailty may be cheaper to provide. We must improve care in hospitals because even if we improve community and intermediate care, and all the transitions into and out of the acute setting,

## RESPONSE: AGE UK IDENTIFYING KEY CHALLENGES

*"A few years ago my wife got discharged from hospital. The report said 'a frail old lady of 88'. I said 'this is lies!'"*

The word "frailty" is on the whole rejected by older people, and while some may recognise features of "frailty" in their health, it is more likely to alienate them than prompt them to seek help.

Many older people admitted to hospital often have no choice but to engage with the concept, "frail elderly" being typically used as a shorthand for many of the oldest old with multiple health needs. Unfortunately, this does not usually bring with it a sense of urgency to their care or trigger additional support. We are often made to believe that they should not be in hospital at all.

Age UK receives letters from older people who have fallen in hospital; become malnourished; been moved multiple times with no one taking responsibility for their care. Nobody should be discharged anxious, depressed and weak, with no progress on the issue for which they were admitted and no plan for ongoing care.

We are led to believe that the only solution is to prevent older people coming in to hospital, but that

## RESPONSE: THE KING'S FUND THREE AREAS FOR IMPROVING HOSPITAL CARE

### Involving patients and their families and carers

NHS leaders continue to espouse the critical importance of patient and family involvement across the health system, but the reality of many people's experiences remains far from this ideal, and this is certainly true for frail older people in hospitals and their families.

Whether through coordinating consultant ward rounds and visiting hours so that family members get to speak to the clinicians managing their loved one's care, or inviting patients and families to offer information about their personal history, values, needs and preferences in "all about me" forms, there are a wealth of good ideas and ways to get much better at involving people during their stay in hospital.

Leaders of organisations need to embed the importance of involvement in their values and strategy, and support staff to make this a priority.

### Specialist care

There is clear evidence that proactive input from specialist geriatricians working with multidisciplinary teams can improve outcomes for frail older people in hospital. But most hospitals will not be able to provide specialist units for all the older people in their care.

Specialist "in-reach" teams can be used to give people specialist assessment, and offer expert advice and follow-up. Such teams at St Thomas' and Charing Cross hospitals for example have been shown to improve clinical effectiveness and efficiency.

### Minimising ward moves

Too many frail older people are moved between multiple different wards during their hospital stay, undermining continuity of care, and increasing risks in terms of delirium and infection.

Hospitals should have operational plans to reduce the number of ward moves, especially out of hours, with accompanying plans to mitigate their adverse effects for older people.

*Catherine Foot is assistant director of policy at the King's Fund.*

is not the answer. The community can be the best place to support many older people, but admission to hospital is not always a failure.

Not getting the most from an admission, and certainly making someone worse, is definitely a failure.

How do we go about addressing these issues? We need professionals to recognise that older people with frailty are core business for the NHS. This means education that provides a grounding in older people's care and wards designed and run to meet their needs.

It will mean getting much better at managing flows through hospital, so that multiple needs and conditions can be assessed early and onward care and discharge planned around this assessment. These plans must be patient-centred, asking the question "what can we do for you?" not "how closely can we match your needs to the hospital?"

Finally, we need a change in the perception of frailty. Not as a sign that there is nothing left to do or that this is a person who cannot cope at home but as a meaningful trigger for coordinated and compassionate care.

"Frailty" must never be a passport to a second-tier health service.

*Caroline Abrahams is charity director of Age UK.*

Full references are available at [www.hsj.co.uk/frail-older-main-report](http://www.hsj.co.uk/frail-older-main-report)

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**Improving the entry to, journey through and exit from hospital care for frail older people is something that our health and care system can do, if we determine that it will. It needs candour about the challenge, buy-in from all staff groups, persistent effort and developing a performance measurement culture focused on patient needs and outcomes**



## PROFESSOR JULIENNE MEYER LESSONS FROM THE CARE HOME SECTOR

The national media depict care homes negatively. This influences not only how the public view them, but also how those working with them engage, including hospital staff.

At the root of this is fear. Fear of our own frailty, end of life and dementia. Our pride in the NHS also means that we may tend to look down on those who work in social care; in particular, those working in the private sector. Older people used to be cared for in the NHS, where staff had more education and training and support to deliver care, potentially at a higher standard.

We should not blame our colleagues for problems in the system which are beyond their control. Negative thinking undermines all that we do. We need to focus much more on being appreciative of each other. Why do we always look at problems, when actually we could reinforce good practice more by starting with “What is working well now?” and “What more needs to be done to make it even better?”

Language is important: we need to challenge each other when negative and blaming language is used within our own service and across services. Those working in hospitals need to better understand the context of care homes and appreciate more what is being achieved and what life is like for those working at the coal face in care homes.<sup>21</sup>

There is much to be learnt from care homes: the sector where you will see the true integration of health and social care, and a balance between quality of life and quality of care. Care homes are also about the living and the dying, and because they are run as small, medium and large businesses also have to focus on quality of management to survive.

Eighty per cent of their residents have some form of cognitive impairment, so they are also

good places to learn more about how to care for people with dementia.

Those working in the NHS need to understand the context of private care services (both at home and in care homes), value and respect them more, and work in better partnership with them.

There are some good examples of this in practice. Independent evaluators<sup>22</sup> have shown that the support networks put in place for care home managers through My Home Life Essex resulted in better commissioning and an increase in managers’ ability to motivate staff to provide relationship-centred care to residents.

The positive changes in the relationship between Essex County Council and the county’s care home sector were driven by the council’s corporate ownership of the new approach, investment in the care sector, a focus on quality improvement rather than monitoring compliance, effective leadership and a support network for managers.

My Home Life ([www.myhomelife.org.uk](http://www.myhomelife.org.uk)) provides an evidence-based vision for best practice in care homes<sup>23</sup> that has spread across national borders, helped unify the sector and raise its profile. This vision has at its heart the importance of relationships and draws on research in long term care<sup>24</sup> that highlights the importance of and offers practical ways of helping not only older people, but also, relatives and staff feel a sense of security, belonging, continuity, purpose achievement and significance in their day to day lives.

There is some evidence that its messages cut across settings and those looking after frail older people could learn a lot from this successful initiative that promotes positive risk. *Julienne Meyer is professor of nursing care for older adults, City University London.*

experience shows that the best we will achieve is a temporary dip in demand.

To cope with rising demand, hospitals have become more streamlined and more efficient in dealing with acute patients. For example, some providers have installed scanners actually in the accident and emergency department so that acute patients are scanned immediately and not sent to the main department.

Forty-eight hours has become a long time in hospital care. In that time it is possible to have complex blood and imaging diagnostic tests undertaken, treatment commenced and the patient discharged, sometimes even after undergoing surgery.

### Conclusions

*“It is curious that people should think a report self-executive. When the report is finished, the work begins”*

**Florence Nightingale, letter to Mary Elizabeth Herbert (1863)**

Providing better care for frail older people closer to home is an answer, and is probably the right thing to do – but it is not a permanent solution to demand rising. It is not the answer, as it has often been over sold.

The likely consequence of a one-off effort to improve care for frail older people in hospital and beyond is a temporary and short term dip in cost and a temporary improvement in care standards; in the medium-to-longer term, it is likely to fuel demand for care. Old age and infirmity do not just go away, except in death (which is inevitable, but may not be the finest basis for health policy in this area).

We can change our systems to provide care closer to home and maintain people in their own homes for as long as possible – all that will be great. But at some point, most people will develop an acute illness (and with increasing comorbidities, an acute flare-up of some of these is increasingly likely as time goes on), and then require admission to hospital.

Increasing and better care in the community may provide a temporary reduction in acute hospital demand, but at some point this will arise again for patients who will by then be that much older and frailer.

The NHS can have huge, merited confidence in its ability to deliver – despite frequent managerial and structural reorganisations. Long waits for care have mostly been consigned to history (save in mental health); stroke care has been massively improved by changing – and yes, closing – services.

Improving the entry to, journey through and exit from hospital care for frail older people is something that our health and care system can do, if we determine that it will. It needs candour about the challenge, buy-in from all staff groups, persistent effort and developing a performance measurement culture focused on patient needs and outcomes

These are things that we can do. For the sake of improved care for frail older people, we must get on and do them – if we care, in both the literal and metaphorical sense, for frail older people in our society. To borrow NHS England chief executive Simon Stevens’ memorable phrase, we need to “think like a patient; act like a taxpayer”. ●

# Challenges for improving hospital care for frail older people

Many groups of people can be demanding on the part of older people with frailty. Reflecting on individual and team practices and roles can help professionals to be sure they are delivering the care to patients they would expect and want for their loved ones.

Asking questions and sharing information and knowledge are important ways to assess ourselves. Here are some specific questions and actions for different groups – professionals and the public – to help improve frail older people’s hospital care journeys.



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