

Establishing and implementing best practice to reduce unplanned admissions in those aged 85 years and over through system change [Establishing System Change for Admissions of People 85+ (ESCAPE 85+)]: a mixed-methods case study approach

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Scientific summary

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Scientific summary

Background

The number of people aged 85 years and over in the UK is projected to more than double from the 2009 figure (1.4 million) by 2034, reaching 3.5 million. The proportion of unplanned admissions contributed to by this age group has risen in the last decade, and will continue to increase because of these demographic trends. Once admitted to hospital, older people have longer stays, are more prone to hospital-acquired complications, both physical and psychological, and may experience more difficulty returning home or to their usual place of residence due to disruption of previously established care packages. There is also evidence that, with appropriate case selection, clinical outcomes in community-based alternatives are as good as or better than in hospital, and that older people prefer to be treated at, or closer to, home. There are therefore strong arguments in favour of restricting emergency admission in this age group to cases where it is clinically necessary.

In England, between 2007/8 and 2009/10, the rate of unplanned hospital admissions of people aged 85 years and above rose from 48 to 52 per 100. There was substantial variation, with some areas showing a much faster rate of increase and others showing a decline. This suggests that lessons can be learned by comparing the approaches taken in health economies at both ends of distribution. Several policy analysts, including The King's Fund, have recognised the importance of tackling this issue from a systems perspective rather than through piecemeal initiatives, but it is less clear how this can be achieved in practice.

Aims

To identify system characteristics associated with higher and lower increases in unplanned admission rates in those aged 85 years and over; to develop recommendations based on best practice to inform providers and commissioners; and to investigate the challenges of starting to implement these recommendations.

Research questions

1. What system characteristics are associated with higher and lower than average changes in unplanned admission rates in those aged 85 years and over?
2. What are the antecedents, contextual factors and internal factors that influence these different characteristics of the management of care for those aged 85 years and over?
3. What are the lessons for commissioning, system configuration and system change to reduce unplanned hospital admissions for those aged 85 years and over more widely across the NHS?
4. What are the practical challenges faced by providers and commissioners in starting to implement system change to reduce unplanned admissions in those aged 85 years and over?

Methods

A mixed-methods, multiple case study approach was adopted. Six study sites were selected based on admission data for patients aged 85 years and over from English primary care trusts (PCTs): three where rates between 2007/8 and 2009/10 had increased most rapidly, and three where they had slowed down or declined. Each 'improving' or 'deteriorating' site comprised an acute hospital trust, its linked PCT/Clinical Commissioning Group (CCG), the provider of community health services, and adult social care. We considered only sites where there was a strong linkage between the PCT and an acute trust, as we wanted to explore areas where more than 80% of acute admissions for people aged 85 years and over from the selected PCT were admitted to one acute trust, so that there was at least a potential partnership between these organisations.

For each site, we obtained and examined enhanced Hospital Episode Statistics data and routinely available data, including the NHS Information Centre Indicator portal, NHS Better Care, Better Value Indicators and the general practitioner (GP) patient survey. These data were used to profile each site and to inform interviews with stakeholders. Where possible, interviews were conducted with representatives from health- and social care organisations (acute trust, PCT/CCG, provider of community health services, adult social care) at strategic and operational levels as well as with representatives of patient groups. A total of 142 respondents were interviewed, mostly individually but with some use of focus groups. Qualitative data were analysed using the framework approach, with themes taken from McKinsey's 7S model (Strategy, Structure, Systems, Style, Staff, Skills, Shared values).

A case report, summarising quantitative and qualitative findings, was produced for each site. Recommendations categorised by the 7S model were then derived from each site and collated. This model was chosen to capture the complex organisational structures, their elements and their inter-relationships. The initial list, together with a summary of the evidence base to support it, was sent to respondents and members of the steering group, who were asked to state their extent of agreement or disagreement. This exercise resulted in consolidation of some recommendations and others being dropped because of low levels of agreement.

Towards the beginning of the project we identified an implementation site to address research question 4. This included the appointment and part-time funding of an implementation fellow from within the organisation to act as a conduit between the research team and the implementation site. Their role was to examine how best our recommendations could be used to support system change within one health economy.

Results

Summary of quantitative findings

Between 2007/8 and 2009/10, average admission rates for people aged 85 years and over rose by 5.5% annually in deteriorating sites and fell by 1% annually in improving sites. The most important differences were the much lower proportion of zero-day admissions (where admission and discharge were on the same day) in improving sites, and lower overall readmission rates, suggesting that improving sites had been able to provide alternatives for these patients. Another reason for differences in performance was changes in admission rates for acute ambulatory care sensitive conditions, which rose sharply in deteriorating sites and declined in improving sites. This could reflect lower provision of community and GP services in these locations, as supported by evidence from the GP survey that access to GP services, including out-of-hours services, was poorer. Furthermore, problems with GP access are associated with increased use of emergency departments, which could itself increase admission rates, particularly for less than 1 day. The suggestion that both primary and secondary care services are under more strain in deteriorating sites is also supported by our finding that during the period under examination, the population aged 85 years and over in deteriorating sites rose by 3.4%, compared with 1.3% in improving sites.

Qualitative findings: deteriorating sites

Although all six sites provided information about what worked well and less well, the three deteriorating sites revealed a picture of uncertain and complex health system change, where service leaders did not always display a shared vision, clear understanding or foresight about how different system elements should interact with each other. Across these sites a number of common features emerged.

First, all three revealed no evidence of overall 'system strategy'. Although individual system components might have quite developed strategies for aspects of unplanned care, such as the emergency department, there was little appreciation of how the components of the wider health system should fit and work together.

Second, strategies tended to be dominated by acute care provision and system changes to support the reconfiguration of acute care, to the detriment of policies to expand or improve primary and community care.

Third, strategies were driven by prevailing national targets, which also reinforced the importance of acute care and had the potential to fragment community care. This was exemplified by the preoccupation with delayed hospital discharge over and above preventing hospital attendance.

Fourth, where improvement projects were identified, these tended to be highly reactive and short-lived, with little follow-through, strategic alignment or consideration of the resource implications.

Fifth, there was widespread underinvestment and lack of planning for primary care. GP practices were generally seen to be managing chronic care and experiencing difficulties with demand for emergency care.

Sixth, there was little evidence of integration between acute, primary and community services. Each was characterised by distinct governance and funding arrangements, divergent cultures and values, and different ways of working.

Seventh, there was little understanding of or planning for whole-pathway care; that is, understanding the complex journeys that patients travel through the health- and social care systems. As above, there was often emphasis on key care stages, such as admission and discharge, but not on the wider constellation of agencies involved.

Eighth, there was excessive demand on limited services, especially community-based services. This meant many specialist community teams were routinely overstretched and struggled to provide comprehensive packages of care.

Qualitative findings: improving sites

The three improving sites provided a picture of health systems which, in contrast with the deteriorating sites, involved greater stability and continuity among a range of well-co-ordinated health- and social care service providers. In comparison with the deteriorating sites, a number of features emerged.

First, all three exhibited a shared and comprehensive strategy for managing unplanned care, including specific policies and procedures for older patient groups. These were linked to a range of interventions to better manage patient care in the community, which included rapid-access services, intermediate care services, out-of-hours care and support from voluntary sectors. Significantly, these strategies and policies were shared across the wider health- and social care setting, suggesting an underlying basis of collaboration and co-ordination between care providers.

Second, each site was characterised by stable and clear strategic leadership, whether through individual change agents or through co-ordinated agencies, that provided continuity of purpose, fostered collaborative working and maintained commitment to improvement. Significantly, there was less evidence of knee-jerk change or projects not being brought to completion.

Third, improvement projects were generally well resourced, often through cofunding or matched funding arrangements between local agencies and national bodies. Moreover, change projects were usually given time to develop and embed into practice rather than being subject to changing fashions or emerging policies.

Fourth, these sites typically provided integrated community health- (and, in some cases, social) care provision through a single or main NHS organisation. This could either be a typical community health-care provider or a unified community and acute provider. Significantly, the integration of community care within one provider not only enabled efficiency savings but, more importantly, enhanced integration between specialist teams or care providers. It also meant that the introduction of service

innovations could be more easily aligned with and integrated into existing services, rather than being seen as operating in competition.

Fifth, there was also closer alignment of out-of-hours GP services with either community or acute NHS providers. As above, this facilitated closer integration of primary, acute and community services, especially for information sharing, continuity of care and joined-up working more generally.

Sixth, these services also seemed to make more explicit and strategic use of voluntary care agencies. These often provided service in more responsive and dynamic ways that eluded traditional health-care providers.

Implementation

Engagement with the implementation site is ongoing. Recommendations were presented to several forums, including CCG boards and GP forums, in 2013 but as yet with no tangible impact. Recommendations are contributing to an urgent care transformation workstream across the health economy of the implementation site. As part of this process, a survey is under way seeking response to the recommendations from a wide range of stakeholders. This process illustrates the importance of aligning proposals for system change to sites' needs and strategies, and of understanding when, how and to whom they should be directed to achieve the greatest impact.

Conclusions and recommendations

Both quantitative and qualitative data supported the conclusion that rising admission rates for older people were seen in places where several parts of the system were under strain. Pressure points in the system that contributed to this outcome included worse access to GPs both in and out of hours, excessive demand on emergency departments and lack of provision of intermediate care. Places which had stemmed the rising tide of admissions had done so through strong, stable leadership, a shared vision and strategy, and common values across the system. The following is a summary of our main recommendations.

Strategy

1. Aim to maximise integration between care providers: community and acute care trusts and health and social care.
2. Work at relationships with the local authority and acknowledge that it is a political organisation.
3. Focus on reconfiguring according to the needs of the whole system, not isolated pockets.
4. Avoid transient pilots with no follow-through and multiple initiatives which are inadequately promoted/marketed.

Structure

1. Consider how palliative care teams are integrated as part of the overall system of care.
2. Integrate social work and nursing teams that cross the boundary between community and hospital.
3. Integrate clinical information systems for primary care, walk-in centres, urgent care centres, ambulatory care and social care.
4. Understand and address the impact that early-discharge policies can have on admissions unless additional and compensatory changes are made to the system to accommodate these patients.

Systems

1. Review skill mix in emergency departments and acute assessment units; consider specialist geriatric teams/frailty units (24/7), GPs, community matrons, occupational therapists and social workers.
2. Assess the need for geriatrician input to intermediate care.
3. Provide a specialist community-based 24/7 response service for people with urgent mental health needs.
4. Be flexible about community nurses supporting residents of nursing homes and assure quality of care where homes provide intermediate care.

Shared values

1. Develop and communicate a shared vision of high-quality care for older people, accommodating medical, functional and managerial perspectives.
2. Break down role boundaries wherever they get in the way of effective care.
3. Enable professionals across the system to better understand each other's roles, priorities and ways of working, including recognising that a key role for managers is to manage uncertainty; consider rotating staff through services to enhance this knowledge transfer.
4. Focus on the needs of the patient, building relationships and supporting staff through redesign.

Skills, staff and style

1. Ensure all relevant disciplines are given the opportunity to contribute their skills to multidisciplinary teams and look to role extension as an alternative to increasing the teams' complexity.
2. Invest effort in developing skills of key groups, for example staff in care homes.
3. Acknowledge that leadership by committed and charismatic individuals makes a difference, especially when working across organisations; take advantage of these people but build in succession planning.
4. Recognise the importance of clinical leadership: clinician managers can offer particular perspectives.

Recommendations for research

Research on individual components of care for older people needs to take account of impact on the system as a whole. Areas where more evidence is needed include the impact of improving access and continuity in primary care, the optimal capacity for intermediate care and how the frail elderly can best be managed in emergency departments.

Study registration

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