The HSJ/Serco Commission on Hospital Care for Frail Older People report – the time to act is now

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The Health Service Journal’s (HSJ) Commission on Hospital Care for Frail Older People is striving to transform health and social care for our older population. It published a ‘Main Report’ in November 2014¹ and a final report is due in March 2015 which will target messages at the public and political leaders. At the release of a scoping report² in May 2014 the commission made the provocative statement that:

Although health policy and political consensus has apparently united under the banner of ‘integration’, the health and social care system for frail older people shows significant signs of disintegration. It remains to be seen whether the commitment to deliver the significant organisational and relational changes - let alone the shift in funding - needed to bring about genuine integration will prove possible and durable in reality.

In producing their report, the commission studied reports on hospital care for frail older people from recent years, as well as all the material submitted following their call for evidence. Furthermore, they actively solicited reports of good practice from colleagues and organisations across the sector. The commission reviewed their findings and made five key
points for improving hospital care for frail older people. In doing so it was unequivocal: ‘Forget about government plans – hospital providers must and can get on with it now.’ This article provides an overview of the main report and, while based on acute hospital care, many issues will resonate with older adult mental health wards and services.

The commission’s findings

Numerous initiatives and reports have aimed to address the problems of hospital care for older people. The King’s Fund identified 27 reports and guidelines on dignity in care for older people in hospital over the last decade. The commission bluntly observed there was ‘…simply no need to keep describing this set of problems’ and that there should now be ‘a relentless focus on solutions’. It wanted to take a practical approach, ‘highlighting what could be done with immediate effect to make care better.’ It acknowledged the negative portrayal of NHS staff in previous reports and counteracted this by highlighting and celebrating existing good practice by describing specific programmes and approaches used by various organisations across the country.

Not our core business?

A cultural mindset among some hospital colleagues, that frail elderly patients are ‘not our core business’, was identified. Along with a lack of proper care pathways, this left these patients vulnerable to either getting stuck in the system or receiving poor care. Some ‘stark’ facts were evidenced including that 80% of those who stay in hospital longer than 14 days are over 65 and that the NHS Confederation estimated that, in 2013, one third of older patients initially admitted to hospital as a medical emergency did not need to stay in hospital.

The commission was concerned about the prevalence of magical thinking in current policy and politics which regarded providing more integrated care for frail older people closer to home as being ‘a silver bullet’ to ‘slay the demon of poor care’. This was described as a ‘Messiah concept’ and much ‘caution, pragmatism and realism’ was urged, given the poor track record of previous NHS ‘Messiah concepts’ such as ‘lean’ thinking, community matrons and the case management pyramid. It was highlighted that local providers should identify where the weaknesses and gaps in services are, rather than forming a list of all the components needed for good quality care. In its scoping report, the commission suggested a framework of questions for teams and organisations to help them identify their potential gaps ([www.hsj.co.uk/older-people-checklist](http://www.hsj.co.uk/older-people-checklist)). The commission also produced a helpful checklist of self-assessment prompts for professional groups.

Improving the hospital stay

The need for more ‘expert generalists’ to look after acute in patients who have multiple long-term conditions and not single diseases was recognised, as was the value of having single, named ‘whole stay’ clinicians. The perils of prolonged hospital stays were noted for frail older people: prolonging a stay even by one day could be detrimental. Ten days of bed rest for someone over 75 lead to a 10% loss of aerobic capacity and 14% loss of muscle strength – equivalent to 10 years of life. Every ward move on average added two days to the length of stay.

When frail older people need an acute bed the report suggested the environment must be ‘age-proof’ and fit for purpose for them, including those with dementia. Importantly it recognised that older people were ‘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.

The report’s five key points

The opening statement for this part of the report pulls no punches: ‘Forget about government plans – hospital providers must and can get on with it now.’

1. The commission found no evidence in the assumption that providing more and better care for frail older people in the community, and by integrating health and social care budgets, will lead to any significant financial savings in the acute hospital sector. It suggested local commissioners should invest in setting up rapid response services to help and prevent older people with long-term conditions avoid crises. However even after setting up such services it will take years, not months, to see levelling off of urgent activity due to increasing numbers of older people living with frailty, dementia and multiple comorbidities.

2. The commonly made assertion that better social and community care will lead to less need for acute beds ‘is probably wrong’. Improving community and social care may postpone acute hospital admissions, but it will ‘never’ prevent older people or their carers seeking urgent care. England has fewer hospital beds than most Organisation for Economic Co-operation and Development (OECD) countries. It has shut around 30% of its hospital beds in the last 20 years although rates of admission and readmission have risen dramatically and UK hospitals operate very ‘hot’ at around 95% occupancy even though optimal occupancy for good patient flow is between 85 and 90%.

3. The current NHS funding policies will most likely lead to a funding gap, and no major political party’s health policy commitment will meet it. NHS England’s Five Year Forward View (2014) envisaged an £8billion funding gap by 2020. This was by making a ‘heroic’ assumption of £22billion of gains in productivity being achieved by radical and rapid structural changes in the provider sector. There was no evidence that further gains in productivity and prevention would significantly close this estimated gap. Neither was there clarity on the funding for reforms, which, if unsuccessful, will have a negative effect on the quality of care.

4. No patient should be admitted to hospital due to lack of home help, adaptations or other requirements which can be met at home. Hospitals should not be used to provide such care. Many older people attend emergency departments due to lack of rapid response services. They should not be ‘blamed’ for presenting inappropriately to hospital ‘where we have designed a health system inappropriate to their health and care needs’. There is a paucity of ‘step up’ and ‘step down’ beds, required to ensure that these patients do not end up using a hospital bed instead. It remained unclear whether increasing investments on out of hospital health and social care will satisfy demand for services in the community that are presently unmet.

5. Hospitals need to provide the very best care for frail older people, who are now their most frequent users. The report advocates involving geriatricians from the start of an admission, working together with other specialists Leaders felt they were distracted by regulatory interference in measuring the wrong areas, and tariffs incentivising
inappropriate things (albeit the report does not say what such ‘things’ are). The report says: it is ‘within the grasp of the staff and management of acute hospitals to start improving the healthcare they provide…today, within their current resources’.

Conclusions

The report was candid – too much care for frail older people is not as good as it can, and should, be. It concluded that ‘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 been oversold’. A one-off effort at improving the care in hospital and beyond for frail older people will only result in short term gains in cost and care; in the medium to long-term it will most likely increase the demand for care. Improved community care will provide a temporary reduction in acute hospital demand but this will rise again for patients who will be older and frailer. The report notes that improving the whole hospital journey for frail older people is needed. Our healthcare system can achieve this if we are determined, open and honest about this challenge, but it will need dedicated involvement from all staff groups. It will need persistent effort and development of a culture based on performance measurement focused on patient needs and outcomes. The report believes these ‘are things we can do’ and for the sake of improved care for frail older people, ‘we must get on and do them’.

This is an excellent report and is highly recommended. It eschews the normal more staid report format. The presentation is engaging and interactive and can only be described as funky! It is provocative, clear and straight to the point – it wants to be an immediate catalyst for change in this area. The outlook, that enough is enough so lets start solving problems, is refreshing as is their view that we do not need more reports telling us the same old thing. We can only hope that hospitals and trusts can proactively use this report and break out of stuck mentalities and approaches and develop pathways in hospital to provide better care for frail older people.

References

1. HSJ/Serco, Commission on Hospital Care for Frail Older People – Main Report (2014)
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2. HSJ commission scoping report: Pave the way for better elderly care (2014)
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