Re-Imagining Community Services for Older People to Improve Quality Across the NHS

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The Big NHS Challenges

Increasing demand from an ageing and frail population
Example – the number of patients with dementia in Cambs is expected to double in the next fifteen years

General Practice and Acute Hospitals at capacity
Example – A and E waiting time targets missed at both acute trusts in Cambs for the last year with near 100% bed occupancy

Challenged funding
Example – Acute Trusts and CCG in Cambs all significantly overspent with a likely combined deficit for this financial year in excess of £100 million

Workforce poorly trained to deal with its major task – the multi-morbid elderly
Example – consultants trained in a single discipline, relatively few geriatricians / generalists / extensivists

All impact on quality
Background to Cambridgeshire and Peterborough

5 years ago Cambridgeshire CCG made a decision to tender all services for the elderly in the county with a view to bringing them under a single contract.

There was remarkable unanimity of support for this idea from commissioners and clinicians of all kinds.

In November 2014 contract awarded to a limited liability partnership of local NHS providers (Uniting care). The value of this contract was £725 million over five years.

The contract lasted between 1 April 2015 and December 2015 when the contract was cancelled by Uniting Care as it was felt to be financially unsustainable.

By April 2016 host organisations had to be found for all staff who had been employed by Uniting care.
Community Services in Cambridgeshire Now

As a result of the failure of Uniting Care, Cambridgeshire and Peterborough NHS trust (CPFT), the local mental health provider, took on community services in April 2016.

These included >100 inpatient rehabilitation beds, district nursing, physiotherapy, occupational therapy, dietetics, podiatry, minor injury units and SALT.

Specialist teams including diabetes, Parkinson’s, epilepsy, respiratory, cardiac, TB, MS, CFS and neurological rehabilitation.

In addition to the existing elderly mental health services

This comprises the best part of 2,000 staff and an annual budget of £70 million

We carry a caseload of c50,000 at any one time and receive 10,000 new referrals per month

In response the Trust created a directorate, the older people and adult community directorate comprised of the new services and older peoples mental health services.
Immediate change

14 neighbourhood teams were created which contained physical and mental health staff. Closer working was of obvious benefit – a third of older people receiving specialist mental healthcare were receiving input from a physical healthcare team at any one point in time.

Emergency response teams were formed. These included psychiatric teams for dementia and functional illness and also a physical healthcare emergency response, the JET team. This was modelled on the psychiatric home treatment teams.
What can physical healthcare learn from mental healthcare?

In 2007 psychiatric care in the county was facing similar challenges to the ones faced by the wider system now.

Major problems with beds being full and significant financial pressure.

The response was to create psychiatric crisis and home treatment teams.

Bed use fell - whole units were closed.
There are now only 249 psychiatric beds to serve a population of c1,000,000.
It is rare a bed is not available when needed.

This approach is cheaper, preferred by patients and offers clinical outcomes at least as good as the previous model.

It was achieved in the face of opposition from senior clinicians who predicted it could not be done and would be dangerous.
Can a home treatment approach work in physical healthcare?

When CPFT took over from Uniting Care a physical healthcare emergency response team was created, the Joint Emergency Response (JET) team, partly in the image of psychiatric crisis teams.

Initially the team was staffed by nurses offering a 4 hour response to a list of specific conditions.

Has grown to include therapy, nursing, paramedics and care with a broad remit to see any elderly person at risk of admission to acute hospital care (a similar remit to psychiatric crisis teams).

Further expansion is planned including addition of consultant geriatrician time.

As with setting up psychiatric crisis teams there has been opposition from clinicians on the grounds largely of safety and futility (‘It wont work’)

An 80 year old patient loses 1 year of muscle bulk for every day in the acute hospital – after ten days they come out as a 90 year old. We have taken up the mantra ‘at home is best’.
JET Outcomes

JET is now receiving 1,000 referrals per month

The average response time (call to JET practitioner arriving) is 158 minutes

The service has been repeatedly audited

The most recent audit suggests an admission avoidance rate of over 70% - i.e. 70% of patients seen would not only have gone to hospital but would have been admitted were it not for JET

This does avoid and not just delay admission – the audits have followed patients for 30 days after being seen by JET

Even based on the most parsimonious audit, the investment return is >1:1

High patient satisfaction lower cost and no suggestion of decreased quality
M Mirrors other international examples, for example Ireland
Last year

Ended with a caseload of 43,863
809,643 contacts
98% within 18 weeks

0 Never events
39 Sis
3 STL
14 avoidable PUs
Complaints 88
Compliments 4970
FFT 97%

One complaint for every 9,200 contacts, one SI for every 20,760 contacts, 50 compliments per complaint

In financial balance

Rated as Good by CQC
**Benefits of Integration**

Benefits of physical healthcare for mental health patients
Example - geriatricians coming in to the older peoples mental health wards has dramatically cut referrals to the acute hospitals

Benefits of mental healthcare to physical health
Example – dramatic benefits for IAPT dealing with anxiety in COPD, single unified team working with Parkinson’s disease patients

Benefits of culture
JET being based on psychiatric crisis teams

Benefits of holistic care
All services being under one provider solves the problem of our workforce being too specialised. Lots of specialised clinicians can work together to provide the complex care patients need.
Improving for the long term

Many further developments happening, including expanded cardiac and respiratory teams, case finding and case management and discharge to assess services addressing the problems of DTOC patients in the acute hospitals.

Close working with the STP and CCG

Many of the innovations here will help, but may not future proof us

Dementia is the biggest single challenge. It is growing and strongly predicts the need for institutional care. New treatments are both essential and tantalisingly close – many are at the stage of phase III trials.

Research is completely embedded in our service. Every patient is offered the chance to take part in research. We have a dedicated clinical research team and we are running 14 different studies involving c300 patients per year in dementia alone. We are extending this to other conditions.
Outcomes in dementia

100% completed to time and target

>1,300 patients recruited to dementia studies alone
Now expanded to include MH and community
Using Research to Drive QI
CPFT International

We have started to ‘export’ some of our ideas

Partners such as Qatar and China

Good for development on both sides and an external revenue stream
Case example

Lady with a long history of severe depression and diabetes with repeated presentations

Previously – when unwell, admitted to psychiatric hospital

Poor communication between physical and mental health

First change – treated at home rather than hospital

Second change – psychiatrists now working with diabetes team

Most recent episode, treated at home, drugs rationalised, mentally well, diabetes control much better, has dropped a dress size

‘You are a whole person, mind and body. Overall it is beyond words’.

A happy customer
Questions