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Southampton locality-based model of care for elderly people: ensuring continuity of care

This Future Hospital Programme case study from Dr Catherine Akerman at University Hospitals Southampton NHS Trust (UHS) describes how a new model of care for attending to elderly inpatients can reduce admission time, provide stronger continuity of care for the patient and improve communication.

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Integrated care

Key recommendations

- Appointing consultants to locality-based working (in which each consultant is assigned a locality based on a cluster of GP services and assumes responsibility for patients admitted or readmitted from that locality) can improve continuity of care for patients.

- Assigning responsibility to a defined cohort of patients allows consultants to develop an understanding of each patient's individual circumstances.

- Defining localities by groupings of GP practices can enhance communication and information sharing between consultants, GPs and community services.

Local context

UHS serves a population of around 269,422, of whom 16,835 are over 75 (6.2%), from the city of Southampton plus 347,268 from west Hampshire, with 380,229 over the age of 75 (11%). From April 2014 to March 2015 the service had approximately 4,637 admissions, with a median length of stay of 8-10 days. While yearly admissions vary between 250 and 500 across the localities the majority of these localities register an admission rate of around 400 per year.

We recognised a need to enhance health care for older, frail patients in the population. Our core aims for the project were to:

- reduce length of stay
- establish continuity of care for patients
- improve the communication processes between the hospital and community services.

Our solution

The Southampton Locality-based Model of Care was first piloted in 2010. This new model saw consultants appointed to manage a locality, as opposed to the pre-established ward-based model. In the last 6 months we have started formal anticipatory care plans for NH residents on discharge from UHS. This is electronic and shared with the GP and ambulance service. Older people's practitioners (OPPs) have started to visit care homes after discharge to aid our relationships with these homes and to ensure a successful discharge.

This means that a consultant will attend to patients that only come in from their (the consultant's) locality; a locality being a grouping of GP surgeries within a close geographical location.

To achieve this new way of working an agreement was initially sought straight from the chief executive who supported the new model. Meetings were then held with our two local community trusts who agreed to help support the model and early supported discharge where appropriate. A pilot was organised, with a project manager and two consultants. This had full support from our care group manager.

I manage the New Forest locality. This means that should a patient be admitted from one of the GP surgeries under the New Forest area they will be assigned under my care. Patients are automatically allocated to the right locality team through our doctors' 'worklist' IT system. I will place them on my 'worklist', through which we can order tests or look at the patient's past medical history, and manage their case alongside an OPP. If the patient is readmitted they will fall under my care again, which

ensures the best possible continuity of care for the patient. I am able to build up knowledge of those patients that are readmitted and have a greater focus on their individual circumstances.

The service is currently in place for patients aged over 80; however younger patients can be referred if they require geriatrician input. Patients who require admission are referred to the acute medical unit (AMU) through AMU consultants or on-call medical specialist registrars (SpR). The patient will then be automatically moved to the appropriate consultant, according to their GP surgery and the locality it falls under, on the day of admission.

> *'The service has achieved its aim to improve continuity of inpatient care and has resulted in enhanced communications between the hospital, the patient's relatives and community services.'*
> Dr Catherine Akerman, University Hospitals Southampton NHS Trust

Staffing

For each locality there is: one clinical lead, 12 locality consultants and OPPS. OPPS are mostly senior nurses, although there are a few who have therapy backgrounds. The role of the case managers is to coordinate the patient pathway, liaise with the multidisciplinary team (MDT) and community care teams, help to expedite investigations, and communicate with families. Communication with the community has involved direct links with the integrated community teams, the community matrons as well as GPs. This has usually been by phone or email, but also involves face-to-face visits with the community teams.

Challenges

Unfortunately the CCG were not in favour and tried to stop the pilot. The CCG wanted more front door working. However, we had been trying this method for 12 months and were finding no changes or improvements. Through agreement and support from our chief executive we were able to override the CCG and pilot the model and then gain evidence to the CCG that this was a better model of care.

The change from ward-based to locality-based services means we no longer work with one nursing team on one ward. We have an initiative called 'ward rounds to inspire' which sets out agreed 'rules' for ward rounds. These include speaking to the nurse in charge of each ward visited to obtain any nursing information or concerns and the handover plan from the ward round at the end. Nursing communication is audited. This was met with some nursing resistance; previously a ward team worked closely together with the same doctors and nurses. However, each team of doctors still had a large number of patients on outlying wards. Although close working with one team of nurses has been lost to some extent, we are working towards having patients moved to one specific ward per consultant. Each consultant has a ward that a patient should be ideally moved to, once there has been a decision to admit. With bed pressures this hasn't been achieved yet and is work in progress.

A further challenge is that there is still a lack of community support. Furthermore, recruitment of geriatricians to the community posts to support this model has been difficult. Instead we are working on the hospital consultants having community sessions in their locality. Newer consultants have community sessions in their jobplan, but this isn't the case for consultants appointed previously who have committed to other clinical sessions already in their jobplans. There is still more work to be done to improve community links.

Outcomes

Patients are reassured; they know that if they are re-admitted, they will be looked after by the same consultant who knows them and their social situation well.

Integrated care

An evaluation of the effectiveness of the service found that the average length of stay fell from 16.2 days in 2008 to 11.5 days in 2010. In a control team, which was still ward-based, the average length of stay fell from 15.4 days in 2008 to just 14.8 days in 2010. When you compare these two results it is clear that the locality-based model resulted in a greater reduction in the average length of stay.

The service has achieved its aim to improve continuity of inpatient care and has resulted in enhanced communications between the hospital, the patient's relatives and community services. Although our community links are still in development we have been able to ensure, through our case managers, that there is good communication with our community teams to support discharge. There are electronic records in the community with the Hampshire Health record, but there is still work to be done to add our information from UHS onto this.

As always, services change along with staff and it can be a challenge knowing the correct person to speak to in the community. For some community teams – there are robust virtual ward rounds, which we try and attend. Additionally GPs recognise the elderly care consultant responsible for their area and are therefore able to easily identify/communicate with one geriatrician for their patients.

What's next?

Further development of our community links is a priority step for the future of this service. Our next plan is to have virtual wards through a confidential 'Skype-type' system called 'polycom videos' which has just been bought by the Trust.

We aim to appoint more community geriatricians. We have appointed one recently, but sadly we have had one retire.

The team

Drs Mark Baxter, Jonathan Sparkes and Gayle Strike were involved in the initial pilot, along with Vanessa Arnell-Cullen (manager) and Sarah Needle (project manager).

Drs James Adams, Gayle Strike, Erisa Ito, Dan Baylis, Harnish Patel, Ibrahim Bodagh, Debika Hall, Anushka Singh, Sarah Gilson and Catherine Akerman have continued the locality model.

Our older persons' practitioners are Joy Saxby, Zoe Barber, Emma Bradley, Jemma Harris, Leanne Gordon, Lucy Lewis, Faye Osment, Merly Sebastian, Nerissa Thompson and Michelle Neville.David Griffiths is our care group manager.

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