Unplanned admissions of older people: exploring the issues

Executive Summary

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Published March 2011

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Background

National strategies, local initiatives, cross-agency agreements, various targets and financial incentives have all been deployed in an effort to reverse the growth in emergency bed days (EBDs). Within this rapidly changing context there was another effort underway: the *Improving the Future for Older People* (IFOP) programme of the Innovation Forum. A group of nine English councils created their own network in 2003, with the primary aim of reducing use of emergency bed days. Specifically, they agreed to work in partnership with health and third sector organisations to achieve the 'headline target' of a 20% reduction in EBDs for people aged 75 and over, over a three-year period from 2004 to 2007.

Aims

We examined how these nine councils and their partners approached this challenge of reducing EBDs for older people, the interventions they adopted, the opportunities and difficulties encountered, and the consequences for patients. In particular, we were interested in whether governance through such a partnership (i.e., networks) achieved change in EBD numbers or were centrally articulated incentives or targets stronger influences? The overarching study aim, therefore, was to examine the impact of different governance models as local health and social care economies sought to reduce utilisation of unplanned inpatient bed days by older people.

Six objectives specified the activities necessary to achieve this aim:

- Explore the changes in emergency bed days within each of the nine participating sites before and after the IFOP project.

- Identify the characteristics and mechanisms of governance arrangements that are seemingly effective in reducing utilisation of unplanned bed days by older people while ensuring quality and equity.

- Identify, measure and profile local initiatives to reduce unplanned hospital stays by older people.

- Examine roles played by non-NHS agencies in achieving NHS targets in relation to hospital bed use.

- Explore professionals' experiences of different governance models.

- Compare and contrast the user/patient experience within three key conditions: falls, chronic obstructive pulmonary disease (COPD) and stroke.

Methods

A multi-method approach was used, grounded within the framework of 'realistic evaluation'. There were two main phases: exploratory and explanatory. In the first we worked with all nine sites, relying particularly on documentary analysis and structured questionnaires. For the explanatory phase we selected three of these sites to test and understand the initial descriptive outputs. We relied particularly on semi-structured interviews with key informants, non-participant observation and individual patient journeys through the health and social care system.

Results

We described the key characteristics of participating councils and PCTs, their performance on relevant indicators (such as delayed discharge, intensive home care, contract types, direct payments, supply of hospital beds and per capita expenditure). Most network arrangements were directed social partnerships – a type of enacted social partnerships differentiated by the level of involvement of government, which establishes or sponsors such networks to achieve specific policy goals. Sites were either moving or aspiring to move towards an increasingly 'joined-up' approach to commissioning.

Governance structures in the IFOP networks were essentially similar in a number of respects. The main decision-making body was a steering group of senior managers. Statutory bodies were much more strongly represented than other organisations, or users. IFOP networks operated in environments where other networks with closely-related remits were also operating. All the IFOP networks inherited and re-badged some of their projects for reducing unplanned bed-day use by older people from their member-organisations or from earlier networks, and so were constrained to some degree by existing managerial hierarchies. Each network had some structures for involving users, but these were somewhat marginal to the networks. Every network felt the need, above all, to respond to a complex of policy mandates that bore more heavily upon their health than upon their local government member-organisations.

Where there were differences in governance structures, two main models were identified. One was a 'joined-at-the-top' model, where the member organisations' senior managers met to coordinate projects which remained owned, managed and implemented by those organisations severally and independently. This was a network of hierarchies. The other was a horizontal 'network-of-networks' model, where the IFOP network substantially relied on other external networks to implement its decisions and for critical inputs (such as user views) to those decisions. Both were clearly quasi-networks. Despite the emphasis given in policy documents and IFOP objectives, quasi-market models of governance were not found.

The majority of the service models and initiatives that sites introduced to address IFOP targets seemed to have multiple aims. These included: preventing acute events and patients needing an emergency attendance at

a hospital; diverting emergency attendees to services that provided community-based care; facilitating the timely hospital discharge of those patients that did need urgent care in a hospital bed.

Most IFOP projects were funded and managed by PCTs and/or local authorities. Acute trusts were seldom perceived to take the lead in reducing acute bed day use by older people. Senior managers also indicated that relationships with the acute sector could be difficult. Acute trusts also tended to make up a small proportion of the membership of such groups. Given the pivotal position of acute hospitals in effecting change in terms of care pathways, this must be a concern. A lack of commissioning expertise and capacity within PCTs were the barriers most frequently identified as key barriers to 'shifting the money' from the acute sector to community health and social care. The underdevelopment of joint commissioning posed a barrier to more integrated working.

The nine councils that established the IFOP programme agreed that achievement of the headline target would be assessed across the programme *as a whole*, rather than at the level of the individual network. The 20% reduction in EBDs between 2004 and 2007 was collectively achieved. But there was variation between sites. In comparing the performance of networks, we included this headline target, along with three further outcomes: decreases in emergency admissions, decreases in delayed discharges, and whether those adopted projects were sustained beyond the end of IFOP programme.

We also examined patient journeys. Adherence to IFOP goals would have been expected to generate care processes that delivered: patient-centred care; timely access to appropriate preventative, assessment and treatment services with the goal of reducing avoidable acute bed use; ready access to community and institutional services for supplying rehabilitation and long-term care; and integrated working between all relevant service providers and adequate continuity of care. Evidence generated by our study of patient journeys offered examples of 'good practice' conforming with this vision, but also demonstrated many ways in which practice fell short of expectations These included sub-optimal use of services for preventing crises and acute events, a narrow range of services used in a crisis, distrust of nursing staff, concerns about poor communication between professionals, delays in discharge and carer burden.

Conclusions

When juxtaposing these outcomes alongside the differentiated governance models, we found no simple association between the model of governance adopted within the study sites and the outcomes achieved. Strong governance conditions within networks did not necessarily predict successful achievement of the outcomes. The results generated by the patient journey study identified that the strategic goals of the IFOP were not always translated into operational practice. From the theoretical arguments and from the empirical data collected, analysed and brought together, we can only offer an equivocal response to this question, although one that is in the

spirit of realist evaluation. A number of mechanisms need to be brought together to achieve change and there is not just one governance structure that can be relied upon to produce the stated outcomes. Central targets and incentives are necessary to focus action, networks are essential to negotiate cross-cutting problems, whilst the mechanisms put in place to meet any targets (which are the local interventions) need to move away from the usual scatter-gun approach of large numbers of 'boutique' pilot projects to focus on a smaller number of services that can be mainstreamed.

This study offers a framework for analysing some of the potential impacts of the changes proposed in the recent NHS White Paper. The proposed changes are likely to erect some barriers to the horizontal coordination of services through provider networks, particularly the sheer extent of reorganisation and the risk that the continuing shift towards market-like structures will lead to further service fragmentation. Balancing these, the development of local authorities' 'place shaping' roles may constitute a potential facilitator for network development and a focus on whole system reform.

The study's findings reinforce messages surrounding the delivery of high quality care that have been emphasised in previous research and policy papers. Single-point-of-access telephone numbers should be encouraged; and efforts are needed to increase the uptake of community care and treatment alternatives, and that are available 'out of hours'. Patients and carers should be involved in decision-making in regard to their hospital care, particularly in discharge planning. Co-location of staff of different agencies and the development of cross-organisational networks at a practitioner level, would help practitioners to share learning and foster trust between agencies. The proposed creation of GP-led commissioning through consortia creates opportunities to strengthen links at practitioner level between primary, social and domiciliary care, with contract monitoring brought closer to the patient level. For improvements to occur, local networks will have to recruit the new consortia as active network members; representatives of these networks might also be involved in the management of the consortia.

Rather than demonstrating a direct causal relationship between outcomes and individual modes of governance, the project suggested the relevance of interdependencies between modes of governance and contextual factors to secure the results observed. A direction for future research would be to explore the possibility that different configurations of governance models and other conditions may produce desired outcomes, rather than seeking the optimal fit between outcomes and causal factors. Researchers, commissioners and the policy community could usefully explore the implications of adopting this perspective, based on an understanding of complexity theory and associated methodologies.

One mechanism that we have identified to combat the threat of increasing service fragmentation is the fostering of trust through strong horizontal networks. As the policy agenda moves to give further emphasis to personalisation, the use of networks in successfully implementing policy

goals will become essential. Through categorisation of published governance models we were able to draw some inferences around those structures necessary (though not always sufficient) for networks to achieve their objectives. These included: the necessity of a network-based implementation group; that localities should set up single networks to focus on specific discrete changes, rather than developing a number of competing networks with a similar remit; and that there should be a 'joined-at-the-top' model of governance.

Addendum

This document is an output from a research project that was commissioned by the Service Delivery and Organisation (SDO) programme whilst it was managed by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) at the London School of Hygiene & Tropical Medicine. The NIHR SDO programme is now managed by the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton.

Although NETSCC, SDO has managed the project and conducted the editorial review of this document, we had no involvement in the commissioning, and therefore may not be able to comment on the background of this document. Should you have any queries please contact sdo@southampton.ac.uk.