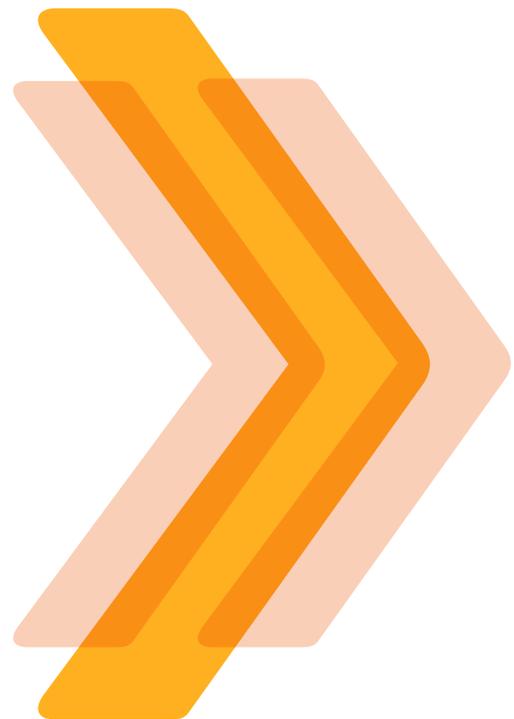


# Leeds interface geriatrician service



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# Specialists in out-of-hospital settings

As part of the drive to keep patients out of hospital and better integrate services across settings, consultants are starting to develop new models of care that link secondary, primary, community and social care professionals.

This case study is one of six, which form part of a project undertaken by The King's Fund to investigate the different ways in which consultants are working beyond their traditional boundaries. The King's Fund's staff reviewed relevant documentation and interviewed staff to help identify the key characteristics of this new way of working, explore the challenges in establishing services of this type and understand what benefit they could bring for patients and the NHS.

The other five case studies are:

- Portsmouth and South East Hampshire diabetes service
- Whittington respiratory service
- Imperial child health general practice hubs
- Sunderland dermatology and minor surgery service
- Haywood rheumatology centre.

Further details on the other study sites can be found at: [www.kingsfund.org.uk/specialistcasesstudies](http://www.kingsfund.org.uk/specialistcasesstudies)

For an overview of the project, including key strategies for out-of-hospital working, the challenges to developing these services and the benefits for patients and the NHS please go to: [www.kingsfund.org.uk/specialists](http://www.kingsfund.org.uk/specialists)

# Background

Over the past 30 years, life expectancy at birth has grown by 8 years for men and 6 years for women, and the number of people living beyond 85 has more than doubled ([Office for National Statistics 2013a](#), [2013b](#)). As people age, they increasingly live with multiple co-morbidities, disability and frailty. Consequently, their care requires a multidisciplinary approach that accounts for both their social support and complex health care needs. Co-ordinating services to support older patients to continue to live at home is a key goal of effective geriatric care ([Oliver et al 2014](#)).

# Overview

The geriatrics team at Leeds Teaching Hospitals NHS Trust works with Leeds Community Healthcare NHS Trust to provide a number of services beyond their core acute work. These aim to keep patients out of hospital and involve geriatricians working across secondary, primary and community care settings. The service has four main areas.

- **Multidisciplinary team-working in the community.** Leeds has been divided into 12 neighbourhoods, each of which has an integrated health and social care team. The core team comprises social workers, district nurses and community matrons, with strong links to other community services such as general practice. They each serve a population of approximately 70,000 people aged over 65 across the three CCGs in Leeds. Interface geriatricians from Leeds Teaching Hospital support the integrated health and social care teams by attending multidisciplinary team meetings and providing home visits. They began supporting some of the teams in 2012, and by April 2013, all 12 teams had geriatrician support. The specialist input into the integrated care teams is funded via a direct agreement between the three Leeds CCGs and Leeds Teaching Hospital, which pays for 12 programmed activities of the geriatric team's time.
- **Primary Care Access Line (PCAL).** This nurse-led telephone service runs from 7am to 10pm, seven days a week, allowing GPs and other community staff to get patients directly admitted to specialty beds, preventing them from having to present at A&E. Helpline staff can offer alternatives to admission such as intermediate care beds or review at the hospital outpatient clinic. Interface geriatricians are also available via the phone line to provide specialist advice. This part of the service is not directly funded by the CCG, and the cost is absorbed by Leeds Teaching Hospital.

- **Geriatrician input in A&E.** A geriatrician attends A&E five afternoons a week between 2pm and 5pm. Working with the early discharge assessment team, they provide comprehensive geriatric assessment of patients within an hour of them presenting at A&E. They work closely with A&E consultants and staff, supporting and educating them when required. Leeds Teaching Hospital also absorbs the funding cost of this service.
- **Intermediate care.** Geriatric consultants work with intermediate care teams to care for patients in intermediate care beds, which in Leeds are located in care homes. It provides a link between the acute services and the community service, with the aims of facilitating discharges, preventing unnecessary admissions and providing thorough holistic care plans for older people.

The service aims to reduce unnecessary admissions and emergency attendances and to ensure care is provided in the most appropriate environment for each patient.

# Referral pathway

Frail older patients at risk of becoming unstable and patients with complex needs are referred to multidisciplinary team meetings by members of the integrated health and social care teams, or are identified using a risk stratification tool. This includes the 2 per cent of patients at high risk of admission who have been identified by GPs as part of the requirements for NHS England's unplanned admissions enhanced service.

Discussion at multidisciplinary team meetings may result in: a home visit by a specialist or by other members of the integrated health and social care team, a review in clinic or an admission to an intermediate care bed. The patient's progress is monitored in weekly case management meetings.

GPs and other community staff can directly admit patients to the acute trust or seek specialist advice via the Patient Care Access Line. Patients presenting in A&E are assessed by interface geriatricians and either admitted to hospital or discharged home.

# Innovative features

The geriatric team at Leeds Teaching Hospital has looked across all stages of the older patient's pathway and has developed services that address issues experienced at each stage.

- They work to **avoid unnecessary hospital admissions** by triaging and assessing patients in A&E.
- The Patient Care Access Line addresses delays that GPs and community staff experience in **getting patients admitted to hospital beds** and it avoids unnecessary attendances in A&E by providing direct access to admission. It spares frail older patients from enduring long waiting times and being moved around the hospital and enables prompt initiation of treatment.
- Geriatric input into MDT meetings allows patients to be **managed proactively**, with early intervention that helps them stay at home and prevents acute admissions.

# Impact

- It is difficult to isolate the impact on **hospital admissions** of the interface geriatrician, as opposed to the integrated health and social care team as a whole. However, since the introduction of the multidisciplinary teams, the rate of growth in emergency admissions for older people in Leeds has started to decline. Until the end of 2012, emergency admissions for patients aged 65 and over were typically increasing by 5.9 per cent a year. During 2013, this rate of growth fell to 1.7 per cent (**Doherty 2013**).
- Interviewees from the integrated care teams reported that **patients appreciated** the input of the interface geriatrician and that care is now more streamlined around their social and medical needs. Patients are no longer obliged to repeat their story to others in the integrated care team and they see members of staff who are well informed about them. However, no patient survey data was available to confirm this.
- During the first year of geriatrician support to **the Patient Care Access Line**, the geriatrician provided advice on 209 older patients. An analysis of these calls found that 26 per cent of potential admissions were avoided following discussion with an adviser (**British Geriatrics Society 2013**).
- There is some evidence that **geriatrician input into A&E** has decreased hospital admissions without harming health outcomes. During their first year in operation, geriatricians provided comprehensive geriatric assessment of 590 patients, 60 per cent of whom were discharged from the emergency department. This compares favourably to a usual discharge rate of between 20 and 33 per cent for patients aged 75 and over who present at A&E (**British Geriatric Society 2013**). The increased rate of discharge has not resulted in worse health outcomes: readmission rates for patients discharged from A&E was no different from readmission rates for patients discharged from the hospital's medical wards for older people (**British Geriatric Society 2013**).

# Barriers and enablers to service development

## Local context

- Interviewees cited a **high level of clinical leadership** as a key enabler for this service model's development. Leading it is a senior, experienced and well-recognised geriatrician who was committed and highly motivated to change the way services were provided locally. She is involved in work across the city as the clinical sponsor for integration in Leeds and is respected and trusted by social care and community health colleagues.
- The service was established within an **environment receptive to change**. Hospital geriatricians had been working with primary and community care staff in a less formal way for more than a decade, supporting intermediate care teams, sometimes visiting patients at home and providing supervision to community matrons. There was also a drive across the city to integrate health and social care services. In 2010, the Leeds transformation board was formed, a city-wide agreement between health and social care partners with the aim of delivering innovative solutions for health and social care problems in a constrained financial environment. Leeds is also an integration pioneer site.
- Leeds Teaching Hospital benefits from having the **capacity in its geriatric workforce** to enable consultants to undertake out-of-hospital roles in addition to their acute work. In some areas recruitment to consultant posts in geriatric medicine may be difficult, but Leeds has been able to recruit additional staff to test the effectiveness of community work and has subsequently made substantive appointments. The Royal College of Physicians estimates that the number of geriatricians will have to increase at a rate 2.5 per cent higher than that seen in their 2012 census in order for geriatricians to have the capacity to fulfil a broader role across primary, secondary and community care (**Federation of the Royal Colleges of Physicians of the UK 2014**).

## Service design

- Geriatricians who take on the interface role in the community also work in the acute trust. Having the same individuals **working across secondary and community settings** was seen as key to the success of the service. This enables geriatricians to access notes and investigations in the hospital, provide advice to the multidisciplinary team about hospital services and develop continuing relationships with patients that span organisational boundaries. Interviewees reported that geriatrician input into the multidisciplinary team meetings had led to better interdisciplinary relations, prompt referrals and greater awareness of services available among primary and community care staff.
- Specialists take on an **educational role**, when working in A&E and with the integrated care teams, that develops skills in these teams to treat more patients themselves when the geriatrician is not present. Multidisciplinary meetings have a strong educational component: specialists have ongoing supervisory relationships with members of the integrated health and social care team and provide regular clinical skill updates. While working in the emergency department, geriatricians provide informal training to other A&E staff during assessments.
- Interviewees reported some challenges in ensuring that **multidisciplinary team meetings** were effective. As these meetings become more popular, they are harder to manage, with more people around the table providing update reports. There is a danger that the focus is lost with too many attendees, which must be balanced against the benefits of additional input from a range of clinicians and health and social care professionals. The integrated health and social care teams also aim to improve primary care input into the meetings, as GPs do not currently attend.
- The integrated health and social care teams use a **risk prediction tool** to identify patients at high risk of hospital admission to discuss at the multidisciplinary meetings. However, there have been some problems with the accuracy of this tool, as it is not always clear why patients have been identified as at risk. Sifting through patient notes to assess who is truly at risk is time-consuming.

## Funding arrangements

- The commissioner is working to define a service specification to include the multiple parts of this service and to agree a **consolidated funding approach**. This has been a challenge: the service is complex, with many components that have evolved differently. As a result, each component has separate funding arrangements, including non-recurrent funding for some parts and others which are currently unfunded. The commissioner aims to implement a new funding arrangement in which Leeds CCGs make a single payment to Leeds Community Healthcare NHS Trust. It would act as a lead provider and subcontract geriatric sessions from the acute trust.
- Because of active case-finding, the integrated health and social care teams uncover previously unmet demand in the community, and savings from reduced hospital admissions are likely to take some time to be realised. This means that **financial benefits** may not be seen in the short term. The fact that the CCG in Leeds was able to recognise the importance of the service's impact on quality of care and to support this despite the lack of proven financial benefits was an important enabler to getting this service funded.

## System-wide

- **Community geriatric training** is at present only a small component of the medical curriculum. The service lead recognises the need to embed out-of-hospital working into geriatrician training programmes and is working with the British Geriatrics Society to raise awareness of this via a special interest group on community geriatrics.
- National **data-sharing issues** affect this service. Currently, there is no single portal whereby health and social care information can be accessed and the integrated health and social care teams are not currently able to share data between social care and health professionals. GPs, acute trust and social care workers use three different IT systems to record their data, while district nurses use written notes that are held by the patient. Leeds is working towards a shared care record to combat this, and has used its 'pioneer' status to ask for central clarification regarding information governance barriers and issues.

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