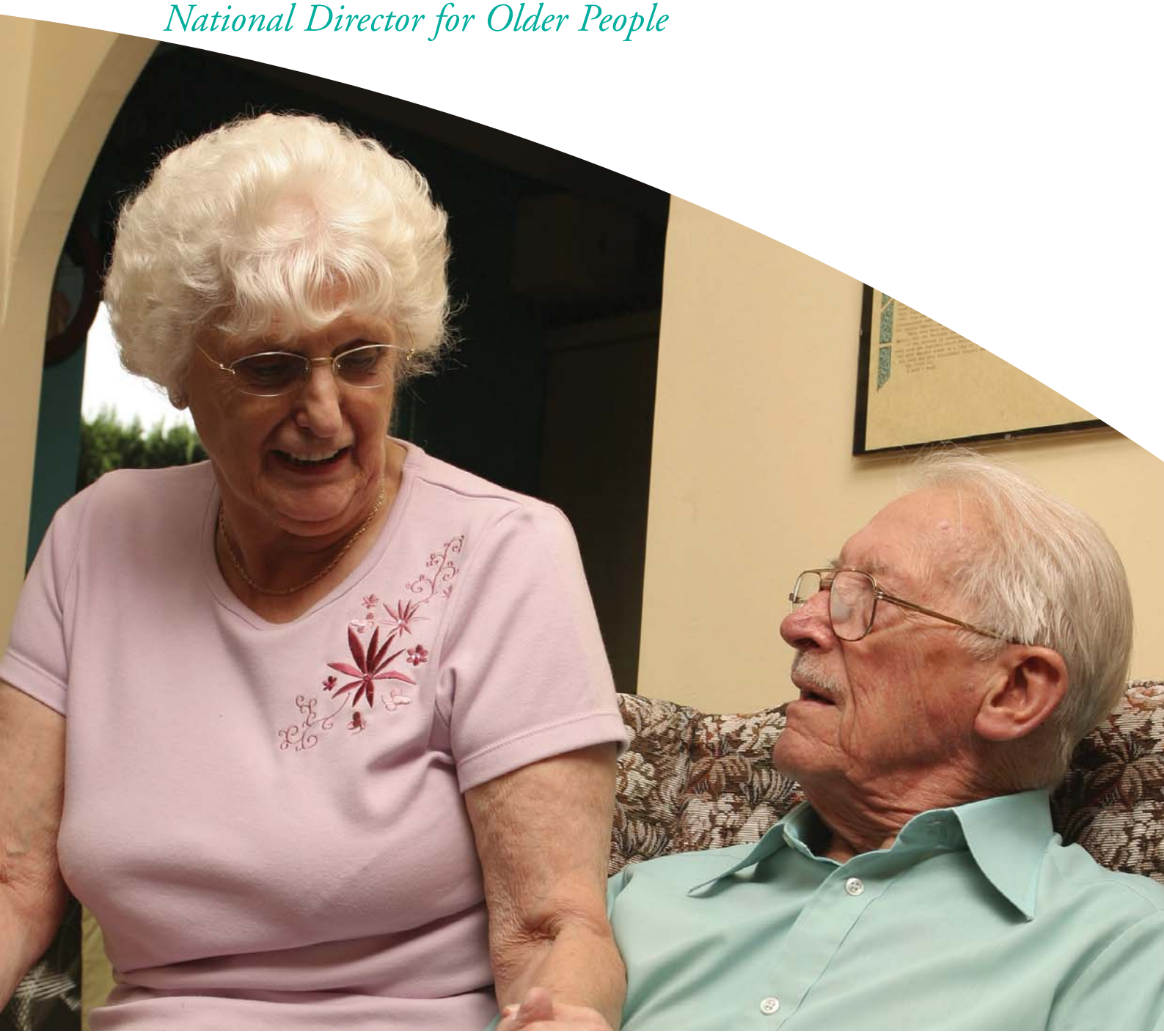
DH Department of Health

A Recipe for Care – Not a Single Ingredient

Clinical case for change: Report by Professor Ian Philp, National Director for Older People



NHS

A Recipe for Care – Not a Single Ingredient

Reconfiguring our specialist services to bring care closer to home will make a big difference to the lives of older people and their families, according to Professor Ian Philp, National Director for Older People.

The Challenge

Change is central to the NHS's history and longevity. Where and how the NHS provides services needs to change constantly because the nature of the people we serve changes continually.

By 2025, the number of people in the UK aged over 85 will have increased by two-thirds. Why is that important? Because it is older people who are the main users of health and social care services.

Older People's Care in Numbers

People over 65 make up around 16% of the population but this group:

1. In 2003/04 accounted for 43% (£16.47bn) of the NHS' total budget.
2. Occupy 65% of acute hospital beds.
3. In 2005/06 accounted for 63% (5.02 million) of all finished consultant episodes in acute hospitals.
4. In 2004/05 accounted for 58% (£6.38 bn net) of social services' budgets.
5. In 2004/05 received 71% (1.23 million people) of social care packages.

Older people are three times more likely than younger people to be admitted to hospital following attendance at an emergency department. Once there older people are also more likely to stay and suffer life-threatening infections, falls and delirium.

Key Elements of Older People's Care

1. Early intervention and assessment of old age conditions.
2. Long-term conditions management in the community integrated with social care and specialist services.
3. Early supported discharge whenever possible delivering care closer to home.
4. General acute hospital care whenever you need it combined with quick access to new specialist centres.
5. Partnership built around the needs and wishes of older people and their families.

Older patients often have multiple health problems, are taking a variety of medication and often present to the health service with non-specific problems like falls and confusion.

Our existing services were not designed with older people's needs in mind.

To add to this challenge we also expect advances in medical science and technology to mean we can do more for older people. Expectations regarding choice and control

over services will also rise as the baby boomer generation moves into old age.

To meet all these challenges we need to innovate and use evidence to underpin what works and expose what doesn't.

In this report we identify how we can successfully reconfigure services for older people. The end result will be reduced need for acute hospital care and increased investment in preventive services and community-based health and care services. The five key elements for bringing about these changes are: early intervention, long-term conditions management, early supported discharge, acute hospital care whenever needed, and partnership.

Early Intervention

When eighty-five year-old John Marrin fell for the first time the NHS did what it does best – it reacted swiftly. An ambulance took him to hospital and surgeons fixed his broken hip.

But when John fell a second time the local ambulance service didn't just react, it intervened. Ten days after the fall, which had left John bruised, he was visited in his Sunderland home by Phil Kyle, the Falls Lead at the North East Ambulance Service (NEAS).

John's second fall had triggered a computer alert at NEAS headquarters and Phil wanted to offer John more help.

Within 24 hours of filling out a short questionnaire, John was receiving physiotherapy treatment at Galleries Day Unit, Washington, twice a week and he now goes to "movement" classes once a week with "two lovely nurses."

"I'm really enjoying it and it's been a great benefit," John said. "I was falling because I was getting a bit stiff and this really helps to get the hip moving." Phil's assessment was that John would continue to fall as long as he spent his days in his room watching television.

Making straightforward arrangements for John to get physiotherapy and attend day

Early Intervention and Assessment Benefits

Falls and Fractures –
If every Strategic Health Authority (SHA) in England invested £2m in falls and bone health early intervention services they could each save £5m (net £3m) in one year in reduced NHS costs by preventing 400 hip factures.

Nationally, this would translate to the service saving 800 lives and maintaining the independence of hundreds of older people. At least 2000 more would be able to walk unaided; 2400 would be able to dress themselves; 3600 could continue shopping and it would mean sleeping through the night for a further 1400 without pain.

care has improved his quality of life and is likely to save the NHS thousands of pounds in the long term.

Phil Kyle's approach began when he realised the ambulance service was ideally placed to identify people prone to falling. He issued every ambulance officer in the North East with a recognised falls assessment form and 18 months later the number of falls in the North East had dropped by 23%.

That's close to 4,000 fewer fall victims a year. With each ambulance journey costing £166 that could mean a saving of £664,000 a year for the NEAS alone. Savings that could be used to help treat other people.

But the real beauty of Phil's scheme is that it has helped to trigger a cultural change throughout the region. Community nurses, care workers and wardens are all encouraged to take the initiative and suggest older people who need assessing to reduce the chances of them falling.

Once referred patients can access handyman services to secure carpets, move furniture or install handrails. If their falls are being caused by faints, poor eyesight or brittle bones the person will be referred to consultants for tilt testing, eye tests or a Dexa bone density scan.

Partnership is also leading to more appropriate use of emergency services. If an older person falls now in the North East but doesn't hurt themselves NEAS liaises with social service departments in the region to send "lifting teams".

The ambulance service is also using computer programmes to identify "fall hotspots" which are often uneven pavements or ungritted paths in winter in areas with high concentrations of older people. When the alert appears the local council is asked to act.

I see early intervention and assessment like this being applied to a range of conditions such as dementia, continence, vision, hearing, food care and oral health problems.

Long-Term Conditions Management

Anticipating and co-ordinating care needs is the key to better management of millions of older people who suffer from chronic conditions like heart disease, diabetes or asthma.

The traditional approach has been to let them get on with it until they have a crisis. Wait for them to turn up in our surgeries and emergency departments.

To change this we have to help older people manage their own conditions by providing individual nursing care and advice and give them services in their community that maintain their independence.

The Changing Face of Older People's Care

1950s – Development of specialist care for older people to treat disease and provide rehabilitation, reducing the need for long-term institutionalised care.

1970s – Increasing access to acute hospitals for older people but gradual withdrawal of specialist care in the community.

2006 – Age no longer a barrier to NHS treatment and the development of intermediate care services which bridge the gap between hospital and home.

After evaluating disease management projects in England and around the world we know the most successful approach for older people is where community nurses have quick access to specialist services.

Evaluation of case management projects found they faltered because partnership between nurses and other parts of the NHS was poor. Nurses had limited success accessing services to prevent hospital admission. This doesn't mean case management doesn't work. It means the service can't run in isolation. New pathways need to be developed to capitalise on the early identification of problems. For instance, acute hospitals could run emergency geriatric consultant clinics for community nurses to refer to. This would ensure patients they are concerned about are seen in 24 hours, not 24 days.

Early Supported Discharge

As well as reducing the need for hospital admission it is also important to support early discharge from hospital.

Ellen McKivett was ninety-three when she was taken to hospital for the first time in her life.

Consultants at Darent Valley Hospital's accident and emergency department

quickly diagnosed a serious infection in her hand which needed to be treated on a ward with a course of intravenous antibiotics.

But instead of being admitted to one of Darent Valley's 460 beds, a member of Dartford, Gravesham and Swanley Primary Care Trust's rapid response team approached Ellen in A&E and offered her a choice of care.

She could be treated at Darent Valley or be transferred to Livingstone Hospital Rehabilitation Unit, a 38-bed former community hospital run by a consultant nurse and overseen by a GP specialising in geriatric medicine.

"I'd never been to hospital before and the Livingstone just struck me as a calmer, friendlier place. It was also more convenient for my daughter to come and see me," Ellen explained.

On average, patients, mostly elderly, stay at Livingstone Hospital for about 15 days. When Ellen was fit enough to leave she was given a package of health and social care help in her warden-assisted home specifically designed and delivered by the hospital's multi-disciplinary community team which includes physiotherapists, pharmacists, social workers, nurses and GPs.

I've been to see Livingstone Hospital myself and it epitomises the future of care for older people. Not only are older patients getting better care, closer to home but emergency admissions to Darent Valley's acute beds are down and the number of delayed discharges at Darent have dropped from 54 a week – the equivalent of two wards – to four or five a week. That's reducing the PCT's costs and allowing it to spend money on better care for other patients.

Best Practice for Older People

- The Partnership for Older People Projects show that when the NHS, local government and independent sectors work together older people's health, independence and well-being can be improved.
- More personalised care and better co-ordination of services can be achieved if a person either holds their own record of needs, circumstances and priorities or if the NHS and social services share the information electronically.
- Early intervention in dementia care has been shown to help sufferers and their families enjoy a higher quality of life and reduce the need for admission to care homes.
- People with poor mobility, confusion or who suffer falls should be assessed during emergencies and referred to an old age specialist so they can receive care that meets their needs in the community.
- Transferring patients with conditions like broken hips, joint replacement, pneumonia and stroke to the community for rehabilitation can considerably shorten lengths of stay in hospital.
- Providing intermediate care facilities alongside direct involvement with emergency departments and medical admission units can lead to the early discharge of older patients into community facilities.
- Community Hospitals can act as a hub for local health and social care services for older people providing a centre of excellence in integrated care.

And outcomes at Livingstone have also improved. Previously, when it was used solely for GP referrals, it wasn't uncommon for patients to spend six months to a year in the 38 beds available for respite care and deaths in the hospital were frequent because there was no co-ordinated attempt to rehabilitate patients and return them to their homes or family.

Now, though, Livingstone is relieving pressure on Darent Valley hospital and actively helping older people to return home. The hospital also continues to take direct GP referrals, works to rehabilitate people and acts as an intermediate care facility for medical and surgical patients from other acute hospitals.

Livingstone represents one aspect of the future of older people's care in England. It is a story of team work, co-operation, choices, early intervention, prevention and making better use of the buildings we already have.

Livingstone Hospital is a Victorian building that started life as a maternity hospital, went on to become a small surgical unit and then a GP referral hospital. It has always had a place in the community but what it has been used for has changed markedly over the years.

Benefits of New Older People's Services

1. **Convenience** – Care closer to home and a hospital in your home.
2. **Quality** – Quicker access to specialist care.
3. **Effectiveness** – Co-ordinated health and social care.
4. **Efficiency** – Better management of long-term conditions.
5. **Value for Money** – Fewer emergency admissions, shorter stays in hospital and quicker rehabilitation in the community.

Early supported discharge reduces pressure on acute hospital beds, reduces the risk to the older person of acquiring infections and other complications like bedsores and helps older people regain their confidence more quickly.

Evaluation of new intermediate care services shows that they reduce length of stay, have higher patient satisfaction ratings, at least as good clinical outcomes as acute hospitals and are no more expensive than traditional services.

They also reduce the need for long-term residential care services by providing time and space for older people to recover their health and independence before any decision is taken about their future care.

Acute Hospital Care When Needed

Photo courtesy of Nottingham City PCT

In previous papers George Alberti, the National Director of Urgent and Emergency Care and Roger Boyle, the National Director of Heart Disease and Stroke, have outlined their case for increased clinical specialisation in their areas and the changing roles of acute hospitals.

If Ellen McKivett had suffered a stroke or heart attack she would have received higher quality care at a specialist stroke centre or a hospital specialising in primary angioplasty for heart attack victims than in a district general hospital. Specialist centres will undoubtedly save lives and older people are much happier when they know they are being treated by experienced clinicians.

Decisions to admit older people to hospital need to be based on an assessment of each individual's needs, priorities and the patient's capacity to benefit from treatment, not age.

Travelling isn't a barrier to this approach. Older people are unlikely to refuse a short-term specialist treatment if they know everything will be done to return them home or to a facility close to their home.

They will not linger in hospital beds. Our investment in services for supporting early supported discharge and new incentives for hospitals to reduce length of stay mean that older people will only be in acute hospitals for a short period, when they require high intensity treatment.

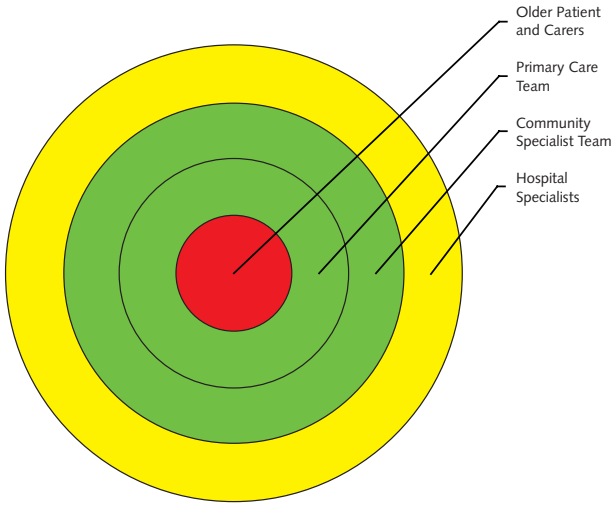
The other model of specialisation that works with older patients is multi-disciplinary teams across all the settings of care, together with colleagues in social and primary healthcare. These teams need to bridge hospital and community settings by working together to ensure the patient is paramount, not the system.

The Partnership Model

Early intervention and assessment for old age conditions, long-term conditions and care co-ordination in the community, early supported discharge from hospital, acute hospital care whenever you need it and assessment in the community prior to residential placement are all part of the recipe for the new and improved services we need for older people in the 21st Century.

Critical to this mixture of ingredients is partnership between the individual and agencies involved in the older person's care.

For older people the first ring of support is their family. In many cases the carer is the spouse who may be old themselves and have their own care needs. Our first responsibility is to recognise, value and support the role of carers.



Primary healthcare and local government services provide the next ring of support to ensure that common problems associated with ageing are identified early.

What we need to build is a second ring of community specialist health and care services supporting primary care teams aimed at reducing the need for acute hospital and long-term residential care services.

Finally the patient is surrounded by a ring of hospital based services for which there will always be access based on need.

Conclusion

New services for older people are helping them to maintain their independence and avoid unnecessary hospital admission. At the same time, continued investment in community services is providing care closer to home, including specialist older people's mental health, falls and bone health, multi-disciplinary assessment and intermediate care services involving partnerships between the NHS, social care and independent sector providers.Significant progress is already being made. For example, the period between January and November 2006 saw a 20% reduction in the numbers waiting for a Dexa bone density scan.

Older people are likely to be the main beneficiaries of reforms that strengthen the ability of GPs, Primary Care Trusts and Local Authority Councils to jointly design and buy new services.

As choice in social care is increasingly driven by direct payments to people to allow them to buy their own services, NHS commissioners will need to match these developments by providing a range of options to patients.

In the future, the NHS should design services for older people to ensure that the right care is delivered in the right place by teams with the skills to meet the health and care needs of people with age-related problems.

However, our health and care services are rising to the challenge and the case for new services is being proved every day in the NHS. It is already delivering better clinical outcomes, better patient experiences and better value for money.

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