NEW MODELS OF CARE: CONSULTATION RESPONSE – Age UK North Staffordshire

Introduction

Age UK North Staffordshire welcomes:

● The opportunity for consultation and contributing constructive feedback on the proposals;

● The vision and ambition to locate more care in the community and home, reducing the volume of inappropriate admissions, and improving the speed and effectiveness of discharge from hospital;

● The goals of helping patients get better, faster and safer, and regain their independence;

● The recognition that lengthy stays in hospital can be counter-productive to the wellbeing and quality of life of patients;

● The recognition of the importance of working with patients and carers to design and deliver healthcare around their needs and wants.

Context

Age UK North Staffordshire (AUNS) and our predecessor organisation, Age Concern North Staffordshire, have been providing tailored services to people aged 50+ in Stoke on Trent and across North Staffordshire for over 20 years. Typically AUNS supports approx. 12,000 clients each year. We are a local independent registered charity currently providing:

- Community-based Health & Wellbeing services including Primary Care Support, befriending, falls prevention activity, exercise and walking groups, learning, memory and social activities;
- Services supporting Independence at Home: support on hospital discharge, recovery from illness or social care `step-down', help with housing options, home safety, help with removals, securing aids and adaptations, a shopping and cleaning service.
- Specialist Information & Advice Services through drop-in facilities, home-visiting and telephone;

The charity has a dedicated, experienced and well-qualified workforce equivalent to 55 full-time posts. Our contribution to this consultation draws from both our experience and expertise and that of the wider Age UK network.

While AUNS recognises the pressures on the local health economy arising from the growth of the older population, the rationalisation of social care, and the decline of family- and neighbour-based care capability, we share the view that this provides economy partners and stakeholders with both an opportunity and a requirement to re-design health care provision from approaches characterised by patient choice and self-management, with delivery based in the community and the home, enabled through improved provider integration.

We are concerned that, while service commissioners and statutory providers have been working on these proposals "for two years", engagement with a wider group of stakeholders appears to have come about after major conclusions have already been made. We are concerned that the proposals make little reference to the voluntary sector and its potential to work in partnership with statutory agencies and that the proposals make scant reference to preventative and early intervention measures. We would therefore welcome opportunities to work in partnership with commissioners in service redesign and believe that AUNS is uniquely placed in North Staffordshire's voluntary sector, drawing on the experiences of other local Age UKs and the resources of the national Age UK charity, in supporting the modernisation of these services.

STEP UP Proposal

We are conscious that people aged 65+ represent two-thirds of all hospital admissions and that on average the stays of people aged 75+ are around 2.5 times longer than those aged 15- 59. Emergency admissions account for over 35% of all admissions to hospital, but they take up over two-thirds of in-patient beds, as people admitted in an emergency tend to have a longer stay. Older people are more likely to have an emergency admission to hospital than any other group in the population.

However we are concerned that data on hospital admissions for older people can present only a partial picture, tending to emphasise the main or presenting condition as the key problem. In our experience this may be less significant to the older person than problems that have been building up before admission: social circumstances (such as living alone or having caring responsibilities) or general frailty. A hospital admission can occur when an older person has reached breaking point because of a combination of circumstances. It is at this point that fixing the main medical problem does not necessarily put the older person back in a position to cope. Addressing the problem therefore needs to take account of social rehabilitation and practical help. This can help to improve confidence, motivation and social engagement, working alongside clinical rehabilitation and personal care services.

Consequently we welcome measures aimed at preventing admission and/or reducing the risk of re-admission.

As an example, this charity is engaged with the Brinsley Avenue Medical Practice in an initiative that supports the Stoke-on-Trent Clinical Commissioning Group's Local Improvement Scheme 2014/15 V.8 to reduce overall avoidable non elective admissions to secondary care.

Our 1 day/week Age UK North Staffordshire Co-ordinator (AUKC) has visited all identified patients at home and carried out a patient needs and wants assessment, then actioning referrals, information or services as required.

From August to December 2014, 54 patients, - with an average age of 83.5 -, had been seen through a combination of 118 home visits and assessments, and 59 telephone contacts.

A Practice internal audit of the "At risk" register (the target group), comparing quarter 3, 2013-14 with quarter 3, 2014-15, has revealed that notified unplanned admissions had reduced by 12.5% - nearly 3 times the CCG rate.

This experience along with comparable work across the Age UK network in England is demonstrating that overall, the Primary Care Support services, working with patients, can identify and support a range of non-clinical needs that are having an impact on the use of clinical services across primary and secondary health care.

So, for instance a cost benefit analysis of Age UK Kensington & Chelsea, work with 79 patients during 2012-2013 and using data provided by the Kensington & Chelsea Public Health Intelligence Team, revealed that in the 6 months prior to Age UK involvement there were 33 Inpatient episodes at a cost of £60,225, and in the 6 months following there were just 6 episodes at a total cost of £10,950 (Guide to Developing Primary Care Navigator Services, Lorna Easterbrook, Age UK, 2014)

We would recommend therefore that roles such as these, which can be delivered by Voluntary Sector partners, are factored in to the mix of Step Up services and make-up of the ILCTs. In addition, we recommend that having non-medical 'navigator' and support workers embedded in GP practices will pay significant dividends in monitoring and working with vulnerable patients, providing support and intervention before a medical crisis takes place.

STEP DOWN Proposal

The Discharge Pathway described for this stage raises a number of issues.

1) With regard to the simple/timely discharge of a patient not requiring further assessment, we would recommend that s/he is provided with some monitoring follow-up from the GP Practice to ensure that the home environment and the patient situation is optimised to mitigate risks of deterioration and re-admission.

2) Overall the **'Discharge to assess'** approach is welcome, but a number of measures would be needed to ensure that patient safety is safeguarded at the initial return-to-home stage. We presume that this would be part of the Hospital Integrated Discharge Team's role. Clearly of paramount importance will be the initial assessment process with the patient about whether a return to the home is feasible/appropriate, and whether the home setting is suitable to receive the patient from Day 1.

Age UK experience, and our own local Hospital Discharge services provided at The Royal Stoke Hospital for many years, consistently show that avoidance of an emergency re-admission is improved by:

▪ 'Low-level', practical support in the first few days after returning home when patients may face a lack of mobility, restricting access to local services and other support. This can include escorting the patient home and helping them to settle back at home, making sure that there is adequate food and heating, that they know what to do in an emergency or if they are worried, and helping to deal with correspondence; returning to the hospital later to collect a TTA (To Take Away) form;

▪ Befriending and emotional support to counter vulnerability caused by depression, insecurity and loneliness

▪ Advocacy support in dealing with issues with health and social care services, ranging from someone to help navigate the health and social care systems through to someone who could support them in making complaints or resolving any other issues.

3) Consequently we welcome the proposition of a Single Organisation (Royal Stoke Hospital) being responsible overall for the patient's clinical care, discharge and the initial at-home/community hospital recovery phase. In our view it will be beneficial for the patient to have a named person as a main point of contact and assessment, to work closely with the ILCTs in building the mix of community wrap around services to meet the patient's ongoing needs, wishes, and help design her/his own care management arrangements. However, we believe that it is essential that the Trust is increasingly exposed to, aware of and works with voluntary sector partners in achieving these aims as there is otherwise a danger of a continuing over-emphasis on medical solutions to non-medical issues and needs.

We anticipate that much of the wrap-around services required, at least the non-clinical, are likely to be accessed locally to the patient's home. Consequently part of the effectiveness of this role will necessarily rest in the quality of the knowledge of, and relationship with suitable local service providers, facilities, resources, etc.

Given the current funding climate, particularly in relation to the Voluntary Sector, we do have some concerns about whether there will be sufficient provision or capacity available in the local community to fully meet the range of likely wrap-around needs.

From our experience, for rehabilitation and recovery to be at its most effective, it needs to be characterised by a person-centred approach which maximises patient choice and independence and which addresses the individual's physical, emotional and psychological needs. Respect and Empowerment need to be at the core of this approach. For there to be meaningful choice, the patient needs informed awareness and understanding of options and their implications, with support for the consideration process. There needs to be honesty and transparency, with the wellbeing of the patient uppermost. Providing sufficient time, information, support and guidance to the patient are key, free of pressure to move patients through the process.

4) Recent informal consultation undertaken by this charity with a dozen patients at visiting times on Chatterley Ward, Haywood Hospital, revealed:

- Low levels of understanding of benefit entitlement: 25% who were not in receipt of Attendance Allowance (AA) were entitled to it; and in addition 2 relatives felt that the parent not hospitalised would also qualify for AA. For those patients seen by a Social Worker, s/he will ask about AA followed by referrals to AUNS as appropriate. However completing the form ready for discharge could help speed it up, through accelerating the process of getting people money that they are entitled to. It may also alleviate some of their anxieties about returning home should the patient be self-funding;

- A lack of appropriate advice, guidance and support to patients, carers and relatives about housing choices linked to the patient's illness/condition;
- That rather than just handing patients and relatives an information leaflet, direct proactive on-ward engagement by this charity's staff with them was appreciated as help and reassurance; and could be effective in helping facilitate the Step Down process as well as post-discharge recovery.

While we recognise the primary value of in-situ assessment, the findings from this Hayward exercise do suggest that there is some scope for advancing discussion with patients about post-discharge arrangements and wishes while patients are still hospitalised.

5) From the information on the proposals to-date, it remains unclear:-

a) how the transition from the Discharge-Recovery phase back to the care and responsibility of the GP will operate;

b) the rationale for retaining Bradwell for community hospital bed provision; and the selection of Longton and Cheadle for decommissioning and "other uses";

c) how data management and systems integration will be achieved to enable all stakeholders in the patient journey to have access to key patient information.

Conclusion

1) Overall in this charity's view, the proposal advances the establishment of cost-effective, community-based services, which can both prevent the need for hospital admission and safely reduce length of stay for older people. This should also improve the patient experience.

2) Clearly there are various critical dependencies for the success of the proposed approach which require further development and resolution (egs 5. a, b and c above);

3) The local Voluntary Sector can , and this charity in particular does offer a range of services which support older people's independence and enhance their quality of life, including:

   • identifying older people in the community who may be at risk
   • supporting older people who are in A&E
   • providing 'home from hospital' services that support and help older people to regain independence.

4) This charity would welcome the opportunity to continue contributing to the ongoing development and refinement of this important new approach.

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