Shadow Oxfordshire Health and Wellbeing Board
26 July 2012
Themed discussion: frail older people

Introduction

1. Most of the spending of health and social care is focused on supporting frail older people often with several long term conditions such as heart problems, breathing difficulties, dementia or diabetes. Up to £500m is spent each year on this in Oxfordshire. Demands are likely to grow as the general population ages although these pressures can be reduced if people have healthier lifestyles (the **prevention agenda**) or there are **early interventions** as individuals become more frail which limit or delay the need for more intensive forms of care.

2. Supporting older people to live independently with dignity whilst reducing the need for care and support was identified as one of the priorities in the draft Health and Wellbeing Strategy. This priority has been supported strongly in the consultation. The strategy set out the challenges that we face in this area.

3. It is clear that we have not yet got all the right services in place, the right approach to commissioning those services or the right practices on the ground. This is despite the relatively high levels of spending in this area whether measured by the amount spent by adult social care or the number of community hospital beds.

4. These problems are most obviously reflected in the level of delayed transfers of care (where patients are delayed in one hospital setting due to the unavailability of the next proposed placement – whether elsewhere in the health system or at home with support from health and social care) This is a problem that has featured in Oxfordshire for many years. All partners are agreed that this problem is a reflection of wider system wide issues about how we support frail older people.

5. If we can tackle the broader system wide issues then we will reduce delays and also address the much more underlying issues which will become even more challenging if nothing happens as demographic pressures increase at a time of limited financial resources. This short paper provides more details about the analysis of the problems and then sets out what is happening in response. It is worth pointing out that a number of the issues set out in this paper are also reflected in the Government's White Paper "Caring for our future: reforming care and support" which was published on 11 July.

6. Our conclusion is that there has been considerable analysis of the issues which has helped improve understanding. Commissioners and providers now need to focus on implementing the changes that are required to improve personal experiences and to provide more timely and more effective services.

Analysis of the issues

7. Most (although not all) frail older people are over 85 years of age. There were **14,200** people in Oxfordshire **aged 85 or over** in **2008**. This is expected to increase to **37,600** by **2033** – an increase of **165%** (or over two and half times as many). The percentage increase in those aged over 90 is even greater.

8. **Levels of spending are relatively high**. Oxfordshire County Council spends **20%** more than comparable local authorities on adult social care for older people. The number of **community hospital beds** (which are almost entirely occupied by frail older people) is relatively high especially when compared with more urban areas.

9. Outcomes for older people in Oxfordshire are not as good as they should be. Life expectancy is high which one would expect with one of the most prosperous areas in the country (although there are significant differences within Oxfordshire which generally reflect the incidence of deprivation). However, the **number of older people who end up in care homes after being admitted to hospital** is about **twice** the national average. The **average length of stay in a care home in Oxfordshire** for those people who are known to social services is **nearly 3 years** (2.84) – possibly twice as long as in other areas. We suspect that those making their own arrangements are spending even longer in care homes when their care needs might be supported in the community.

10. The Institute of Public Care (based at Oxford Brookes University) carried out research with the County Council into the reasons why people were admitted into a care home. The five most important reasons were incontinence, falls, dementia, stroke and depression.

11. **Diagnosis of dementia is relatively low**. **Last year, only 38%** of people with dementia had a diagnosis compared with a national average of 42% and the performance in the **best performing area of 59%.** Early diagnosis of dementia means that the person and their family carer(s) are able to access services which help delay the onset of the dementia so that they are on average able to be supported at home for 18 months longer rather than being admitted into a care home.

12. Every survey of older people has confirmed that **older people want to be able to carry on living in the community for as long as possible**. We are not meeting their expectations. Consultation with older people always identifies that there is more that the NHS and local authorities (at all levels) can do to help support people living in the community with their personal and health care needs including addressing the issue of loneliness. If we can do more then this will improve outcomes for older people and will reduce some of the financial pressures because support in the community is normally much less expensive than bed based care - in a hospital or in a care home and whoever pays for it. We will need to work closely with the voluntary and community sectors to address this.

13. More recently, there are signs of increasing pressures within the system. The **numbers of referrals for ongoing care from the acute hospitals** has increased by **34%** over the last year. There is a lack of understanding as to why this is happening. The **number of placements from hospital into care homes** has increased by **28%** over the last year. This is despite the increase in the number of hours of home care (up from 74,000 hours a week in 2010 to 90,000 hours a week in 2011 – an increase of 21%). There have also been new community services developed such as Hospital at Home, the Crisis Response Service, the end of life care service (known as RISE), the Supported Discharge Service provided by the Oxford University Hospitals Trust and an expansion of the reablement service provided by Oxford Health Foundation Trust.

14. The increase in the number and diversity of services is creating some further issues as GPs struggle to work their way through the different services available.

What is happening in response?

15. There is **collective recognition** that this can not continue and things need to change (for all the reasons set out above). This is reflected in the **Appropriate Care for Everyone (ACE) Programme** led by Dr Stephen Richards, Vice Chairman of this Board which brings together health and social care commissioners and clinicians from the County Council and the Clinical Commissioning Group and the key providers namely Oxford University Hospitals Trust, Oxford Health Foundation Trust and the operational side of adult social care. In addition, the **providers** are working together on issues which are within their direct control. This is led personally by the Chief Executives of those organisations.

16. Some progress has been made on providing support to frail older people to live in their communities. In 2009, there were only 20 **extra care housing** units in Oxfordshire. This had increased to 276 last year and will increase to 407 by next March. Plans are well advanced to increase the number still further to 930 by March 2015. This reflects close working between the District/City Councils (who are responsible for housing and planning) and the County Council (responsible for social care). However, there is more work to be done: planned provision is still too patchy; there are few developments for those who want to continue to own their own properties; there are other areas of housing need for older people which need to be considered. Further work is underway to consider these issues.

17. **Reablement and rehabilitation** are essential if frail older people are to be given a chance to “get back on their feet” (literally as well as metaphorically) when they become unwell or have a fall. Reablement services were introduced relatively early in Oxfordshire but the services provided have not been operating at the level of capacity required or been as effective as they might be. Oxford Health Foundation Trust (who

provide these services) are committed to increasing significantly the number of people supported by the reablement service and improving the number of people who do not need ongoing care after their period of reablement has been completed. Additional funding is going into this service using the additional funding provided by the Department of Health to the Clinical Commissioning Group for this purpose.

18. The PCT and the County Council have worked closely together to improve the services available to **carers**. This is recognised by the Oxfordshire Carers Forum. Resources for carers have been protected by both organisations. However, it is likely that further improvements can be made which will provide further support to the invaluable work provided by carers.

19. Older people (and their relatives) need much better **information and advice** so that they can make decisions about how they live their lives to reduce the chance of them needing care. This is a clear gap at the moment which is in the process of being addressed. In particular it is important that those who fund their own care (and may not receive any advice from social care) have the right information and advice before they decide what to do.

20. Both health and social care leaders recognise that there are improvements that need to be made in the way that professionals (whether hospital consultants, nurses, therapists, GPs or social workers) support frail older people in hospital, at risk of admission or when they are discharged home. This means improving **assessment** arrangements and **discharge planning**. There is strong support to the principle that we should "**discharge to assess**" rather than assess people in a hospital environment. (The hospital environment is the wrong place to make an assessment of people's long term care needs). We have not yet delivered on this aspiration. Work is currently underway to move to this as the overriding principle in the autumn. Professionals will be supported to change the way that they carry out their duties.

21. To help guide GPs (and other health and social care professionals) through the services available a **single point of access** to community services is being developed which will speed up discharge, help avoid admissions to hospital, simplify pathways and improve patients' experience of care. This has been rolled out within Oxford Health's community health services and will be extended to adult social care by the end of this year. This is part of the work to deliver integrated community services.

22. It is also important to review the **efficiency and effectiveness** of all the **community services** commissioned by health and social care. Immediate work (which will be concluded over the summer) will focus on **community personal care services** notably the Crisis Response service and the Supported Discharge Service and their links with the Reablement Service and mainstream home care services. Issues already identified

which need to be addressed include developing a Rapid Response service (which supports people when they are discharged home to be assessed), to improve night care and to ensure that services do not duplicate other services or make recruitment of care workers more difficult.

23. This review needs to be extended more widely to review all relevant health and social care services. It will be guided by the development of a **joint health and social care Older People's commissioning strategy**. This will build on the existing overarching strategy, Ageing Successfully, and the work that adult social care has done recently on its commissioning intentions for older people. The strategy will come forward for agreement by this Board next March.

24. There is widespread support for the idea that **health and social care must work more closely together** so that that the patient/service user experiences no gaps. At the operational level this is reflected in the integrated community service teams (which underpin the single point of access – see paragraph 21 above) as well as the joint work on discharge and assessment arrangements and changing the way that professionals work (paragraph 20). It is reflected on the commissioning side from the joint strategy which builds on established good practice in Oxfordshire for other groups. This needs to be supported by developing a **genuine pooled budget for older people** which incorporates all appropriate budgets for older people and enables resources to be moved around in reflection of changing needs and an understanding of which services most effectively and efficiently meet those needs. The intention is to introduce major changes from 1 April 2013.

Conclusion

25. A great deal of time has been devoted to analysing these complex problems. Work must now focus on delivering the changes suggested by the analysis to build on work that has already been done. Health and Wellbeing Board will be able to monitor the results through performance reports that come to future meetings.

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