Cabinet – 15 September 2010

Frail Elderly Pathway

Portfolio: Councillor B. McCracken, Social Care & Health

Service: Vulnerable Adults Joint Commissioning Unit

Wards: All

Key decision: Yes

Forward plan: Yes

1. Summary of report

The aim of this pathway is to provide care in the person's own home to reduce the unnecessary use of acute hospital beds and care home placements, achieving as good or better outcomes in patients' health, well-being and quality of life. The pathway adopts the concept of a virtual ward whereby emergency, acute, primary care and community services, intermediate care, older people's mental health and social care services can work better together to deliver joined up care for frail elderly people with non specific, non life threatening conditions such as falls, immobility or confusion.

2. Recommendations

2.1 To continue to develop the frail elderly pathway in partnership with the NHS.

2.2 To establish a joint and multi-disciplinary hospital discharge team at The Manor Hospital.

3. Background information

Frailty is a subjective expression which is used to describe a distinct and ageing population usually over 75 years of age but not restricted to the over 75's. Frailty is described as *'not really a disease but a combination of the natural ageing process and a variety of medical problems'* (*Morley 2009*).

Government policy is to support older people in their own homes and to prevent avoidable emergency admissions to hospital and to care homes. Therefore intermediate care and re-ablement services are currently operating jointly between the Council and the NHS in Walsall, and have a successful record of supporting people to remain in their own homes. Current services include the Intermediate care at Home Service of In-House Homecare; the

PCT Intermediate Care Team; Rushall Mews Residential Care Home (Housing 21); and Richmond House Nursing Home.

There were a number of reasons why it became necessary to develop the Frail Elderly Pathway:

1. Increase in the elderly population

Over the next 10 years the elderly population in Walsall is expected to increase significantly, with the highest percentage increase of 40.38% in the 85+ age group. In Walsall the increase will be higher than the West Midlands average.

- Rising emergency admissions to the Walsall Hospitals Trust from this patient group and prolonged length of stay amongst frail elderly people is both operationally and economically unsustainable

- If no wider health economy approach other than hospitalisation is developed then the health economy of Walsall will not be equipped to cater for this vulnerable group of people.

- Approximately 10% of emergency elderly admissions are avoidable and a further 5% of patients who are admitted to hospital in Walsall often stay in longer than the national average which in turn makes them more prone to falls and infections whilst in hospital.

- A significant number of older people who are currently being admitted to hospital as an emergency, can be supported to stay in their own homes by establishing an integrated rapid response, assessment and support team. Some health and social care economies who have implemented integrated care have shown a reduction in hospital admissions (Sheppard 2009 and Croydon Hospital 2007)

- The forthcoming increase in the level of need for health and social care services from the predictable increase in the number of older people in the population has to be addressed without significant additional expenditure and there is a viewpoint that this planned reconfiguration will support this.

2. Improved benefits and outcomes for patients

- Develop an integrated health and social care pathway for older people currently being admitted to hospital as an emergency, who can be supported to remain in their own homes. This addresses the recommendations of the 2007 Darzi report which proposes that more integrated care should be provided at home which would prevent hospital admissions

- Older people with mental health conditions (e.g. dementia) and those with substance abuse can also benefit from this new service, with less risk of worsening confusion.

- Lower mortality rates and an enhanced quality of care as many of the complications such as healthcare-acquired infections, delirium, pressure sores, malnutrition, dehydration, side effects of medication which are prevalent in a hospital environment could be reduced and even prevented.

- Reduction of admission to nursing and residential home placement. Too often, hospital admission becomes a critical life event for older people, precipitating a medical, social, emotional and financial crisis which can subsequently lead to a transfer to institutional care.

- The pathway also addresses some of the standards set out by the NHS Institute for Innovation and Improvement 'Focus on: Frail Older People' 2006

- Improved experience for older people and their families and carers. Less risk of loss of dignity

3. An opportunity to review current intermediate care system and how it could be developed.

- To create a rapid response, assessment and support team comprising a mix of health and social care workers to provide the care and support needed to implement a care pathway that will in turn reduce emergency admissions to the acute hospital, and thus reduce expenditure within the hospital setting.

- To use the development of this care pathway as a demonstration of whole integrated systems working between the various parts of the NHS community, Social care services in Walsall and the wider Care Community.

- That health and social care workers in all settings will recognise that a reconfiguration of how they work will improve patient experience and provide improved value for money, and therefore they will be willing to change their work environment and professional practice.

4. Closure of Canterbury Ward

Canterbury Ward at the Manor Hospital which was opened temporarily was due to be closed in May 2010 as it was scheduled for demolition. This lead to a reduction of 20 beds in the hospital's bed compliment. A further possible reduction of 10 beds is predicted if the pathway is adopted, this will further assist the hospital in meeting its anticipated occupancy rate.

5. Feedback from 2009 winter pressures

- Throughout the winter of 2009 staff across the health and social care economy worked in a more integrated way in order to meet the demands on health and social care. Feedback was very positive and staff reported that they worked well together and were more productive.

- A report into winter pressures of 2009 throughout the West Midlands showed that although the number of GP emergency admissions to hospital were lower in Walsall, those patients that did present to A+E in Walsall were more likely to be admitted (Wyatt 2009).

4. Current Position

The current system of admitting patients (within the over 75 year group) to hospital is not only costly but has a high mortality rate and blocks beds within the system unnecessarily

The number of non elective hospital admissions for patients over 75 years for Walsall residents during 2008-09 amounted to 7,407 of which 87% or 6,453 were admitted to the Walsall Hospitals NHS Trust (Manor Hospital). The costs for non elective emergency admissions amount to £21.9m of which £19.25m related to expenditure at the Manor Hospital (Appendix A). The mortality rate for those patients admitted as non elective emergency cases was 13.6%. The average bed days, was 9 days for patients who fell within this group.

Due to the increase in number of people who could fall ill within the 75 years or older group over the next 10 years, it is estimated that the costs of hospitalisation for non elective emergency cases would increase by £5.25m. The current system is therefore not sustainable from both a financial and bed occupancy aspect

The alternative is to put in place a service that will be for people primarily over the age of 75 years (with some exceptions) who are registered with GP's in Walsall, or resident in Walsall Borough. The target group being people who are currently being admitted to the Manor Hospital on an emergency basis with conditions that experience elsewhere shows would be better supported in their own homes.

This will be brought about by bringing together health and social care workers who are currently operating separately and in a variety of settings so that they can provide an integrated rapid response, assessment and support service, thereby introducing a single and integrated assessment and case management system, under an integrated management structure. There will for instance be the creation of a joint and multi-disciplinary hospital discharge team at The Manor brought about by bringing together staff employed by the hospital, the Council or the PCT that are currently working separately.

The model is based on the total number of over 75's who were admitted to the Manor on a non elective emergency basis for 2008-09 was 6,453 of these 877 died in hospital, leaving 5,576. From these a selection of 4,261 (66% of total non elective emergency admissions) patient's diagnosis were scrutinised by clinicians with a view to determining whether they needed to be admitted, or alternately, where there had been a need to admit, whether an earlier discharge would have been in the patient's best interest.

The selection of 4,261 was made up of the following specialties:

General Medicine	2,629
Geriatric Medicine	1,147
Rehabilitation	485

The results of the clinical review determined that 982 admissions would not have been admitted had there been an alternate service (Remain at Home) and a further 299 admissions could have been discharged earlier from the Manor provided that there was a service to look after them either at home or in the community (Admitted but discharged after 48 hours).

The criteria for admission to the pathway will be people primarily those over the age of 75 years (with some exceptions) who present with 2 or more of the following in the absence of a life-threatening condition:

- Showing a deterioration in cognition / increase in confusion
- Showing a deterioration in mobility and / or an increase in unexplained falls
- Showing a deterioration in continence
- Increased generalised weakness
- Had a recent incident that has significantly increased dependence and risk

The first phase of the pathway was implemented from April 2010 with two case management co-ordinators based at the Manor Hospital identifying patients brought to A&E or the Medical Assessment Unit who can go home. They are redirected to existing intermediate care services at Rushall Mews (Housing 21); Richmond House Nursing Home; or to the Council Home Care Service for them to go back to their own homes.

In the first quarter there were 208 referrals to the pathway, with over 170 people receiving intermediate care service. The next phase starts from October 2010 with the addition of a Rapid Assessment and Treatment Team. Work will continue to re-model existing intermediate care services that are currently commissioned via the Joint Commissioning Unit from the PCT provider side, and from in-house Council provider services.

5. Resource considerations

5.1 **Financial**: The development of this care pathway is part of a broader strategic approach to the management of unscheduled care services that incorporates a series of other care pathways (e.g. stroke, Chronic Obstructive Pulmonary Disease etc) and relates to other programmes of work such as management of long term conditions, assistive technology and tele-health care.

The overall assumption is that the care pathway will be developed out of a reconfiguration of services that is possible within the existing resources, so that the reduction in emergency admissions to the Manor Hospital will result in cash savings for the health and social care system as a whole.

The example of this for Walsall Council is that the in-house council home care service needs to transfer some long term homecare cases across to independent home care agencies so as to create more capacity for intermediate care cases. This transfer will provide for a more effective use of in-house home care and thus reduce the number of care home placements or long term home care cases.

There are some additional costs for NHS Walsall to establish a Rapid Assessment and Treatment Team and commission clinical cover for people in their own homes who would have been admitted to hospital.

The development of the revised model is build into the forecasted budget targets for 2010/11 and will be monitored and controlled via the council and partners.

5.2 **Legal**: There are no direct legal issues. Whilst the pathway requires a greater degree of co-ordination between the Council and the NHS, each retains their separate legal responsibilities.

5.3 **Staffing**: The pathway will require a number of clinical and non clinical personnel to ensure effective implementation. It will consist of multi-disciplinary teams which will include staff from primary, social care, secondary care and community sector, with single line management arrangements and shared accommodation.

The service will be based on the redesign of current services any many of the posts will be funded from existing posts. The example of this for Walsall Council is that Social Workers currently based at the Manor Hospital will become part of a joint and multi-disciplinary hospital discharge team that will be able to work more cost effectively and generate some staffing savings for re-investment to other parts of the pathway.

6. Citizen impact

These arrangements mean that the health and social care system of services in Walsall will be better able to support older people in their own homes, with fewer inappropriate admissions to hospital or care homes.

7. Community safety

There are no direct community safety implications arising from this initiative.

8. Environmental impact

There are no environmental issues

9. Performance and risk management issues

9.1 **Risk**: This development requires a greater degree of co-ordination and joint working between the Council and the NHS. This in turn creates additional interdependencies for both organisations. However, the potential benefits in terms of developing a health and social care system that is capable of containing additional demand generated from a higher number of older people in the population outweigh the risks to each agency.

Risks identified in the Business Plan for the Frail Elderly Pathway include:

- That Health Clinicians will not be willing to accept responsibility for the medical cover of people at home with conditions that mean they are currently admitted as an emergency to hospital. This has been addressed by The Manor Hospital, which has agreed a rota arrangement with physicians.

- That hospital based professionals will fail to recognise that some older people who are brought to the hospital can be taken home again and supported by the new service. A hospital and community joint training programme is being implemented to mitigate this.

- That there may be insufficient home care capacity to provide the workforce necessary to support a higher number of people being cared for in their own homes. The Joint Commissioning Unit is working with homecare agencies in the Borough to prepare them for the development of the frail elderly pathway.

- That insufficient consultation with older people and their families over the changes that are to be made will result in them continuing to expect to enter hospital instead of being supported in their own homes. A robust joint communication and engagement strategy will be implemented at a point when the frail elderly pathway has demonstrated its effectiveness, so that individuals can be reassured that it is a better response to need than a hospital or care home admission.

- That patients remain on the pathway for longer than necessary. Patients will have a predicted date of discharge agreed on there first MDT assessment, this date will be monitored and proactive discharge planning adopted.

- That staff in existing services may not want to adopt new working practises. A service transformation process will support staff with concerns about new ways of working.

9.2 **Performance management**: In order to monitor the benefits of the service some of these Key Performance indicators will be used:

- Rapid assessment response times
- Admission rates of over 75's to hospital
- Reduction in readmission rates for over 75yrs to hospital
- Reduction in length of stay for patients over 75yrs.
- Reduction in long term nursing and residential placements of the over 75's
- Improved patient satisfaction surveys.

10. Equality implications

The Frail Elderly Pathway is being developed with the same level of equality assurance as current services.

11.0 Consultation

Consultation with staff and staff representatives regarding changes to working practice (e.g. extended hours working) is underway, and timed to be completed ready for the second phase of implementation of the pathway.

Consultation with individuals and patient groups has been conducted via My NHS Parliament and other groups such as the older people forums and the Older People Partnership Board. The response to the consultation has been very favourable.

Background papers

None

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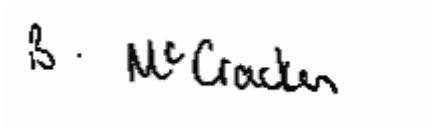

Councillor Barbara McCracken
Portfolio holder

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