Deloitte.

Perspective 2

Summary from roundtable discussion on Better care for frail older people – April 2014

The Deloitte Centre for Health Solution's second roundtable discussion for policy makers, commissioners and providers of health and social care services explored how collaboration, integration and a better understanding of frailty might improve patient outcomes and deliver higher quality, more cost effective services for frail older people. The aim was to explore more widely the key challenges and solutions highlighted in our report *Better care for frail older people.*

The roundtable event in April 2014, chaired by Karen Taylor Director of the Centre for Health Solutions, explored:

- the extent and impact of the changing demographics
- the barriers to delivering a 'common sense' approach to care
- solutions in the form of new approaches and models of care
- scaling up the adoption of identified good practice.

Following a brief overview of the key findings in the Centre's report[1] the session started with a thought provoking introduction to the findings in a recent King's Fund Report: Making our health and care systems fit for an ageing population (March 2014).[2] This was followed by each participant identifying the key challenges that they felt needed addressing and an open discussion of these challenges and potential solutions.

Acknowledgement was given to the fact that increasing numbers of people, who are living longer, healthier lives, is undoubtedly a success story for society and for modern medicine. While this success has transformed society's health and care needs, the health and care systems and processes have been slow to respond. Moreover, as many people now stay

[1] Better care for frail older people: Working differently to improve care. Deloitte Centre for Health Solutions (March 2014). See also: http://www.deloitte.com/view/en_GB/uk/industries/life-sciences/better-care-for-frail-older-people/index.htm

[2] Making our health and care systems fit for an ageing population. King's Fund (March 2014). See also: http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

healthy, happy and independent well into old age, there is a need to look at ageing differently. Nevertheless, as people age they are progressively more likely to live with complex co-morbidities, disability and frailty. Indeed, the over 65s account for 51 per cent of gross local authority spend on adult social care, and two-thirds of the primary care prescribing budget. Furthermore, 70 per cent of health and social care spend is on people with long-term conditions with activity and cost increasing with age.

A key reason why health and social care services have failed to keep up with the changing requirements of older people is the fact that NHS hospital medical specialties and primary care consultations are still designed around single organ diseases, with payment systems that fail to support the needs of patients with multiple and complex conditions. Common conditions of older age are also likely to receive less investment, fewer incentives and lower-quality of care than the medical conditions that affect people in mid-life.

There is also substantial evidence of ageism and age discrimination in health and care services, ranging from patronising behaviour to poor access to treatment. Compounded by a lack of capacity in the community to deliver intermediate care and support services to help older people to remain well, manage crises, and recover from acute episodes. The capacity that exists is also hugely variable and generally an inadequate to meet to demand.

The King's Fund's 10 components of care for older people (9 components plus an overarching component -integrated care centred on the individual's needs) that binds the others together were considered a good place to start. The components are:

1. Age well and stay well
2. Live well with one or more long-term conditions
3. Support for complex co-morbidities
4. Access to effective support in crisis
5. High quality person-centred acute care
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement
8. Person centred dignified long-term care
9. Support, control and choice at end of life
10. Integrate services to provide person-centred care

It was felt that while these 10 steps reflect simple common sense, no one is getting all of them right.

The challenges that undermine the delivery of common sense care

The roundtable participants identified a number of challenges to better care for frail older people. The fact that care is still planned, funded and delivered in silos (primary, secondary, social etc.) remained an over- arching barrier to better care; and one that was particularly evident in the care of frail older people who bounce regularly between different places of care. Other more specific challenges included:

- **Denial or a lack of recognition of frailty as a condition across the health and care sector -** generally older people tend to be stoic and independent and consider their health as good, when actually, they would benefit from extra care or support services. Concerns about being a burden or fear of a diagnosis often causes delay in seeking advice or support, leading to exacerbations in the person's condition necessitating a crisis response when earlier intervention could have prevented this.

Defining someone as old is subjective and frailty is not something that is formally diagnosed, yet older people with frailty can be readily identified and are often known to local services. Indeed, most hospitals will readily acknowledge that they are seeing an increase in the number of frail, vulnerable and neglected older people. Despite this noticeable increase of frail older people in hospitals, frailty is still not considered appropriately in most care pathways. There was agreement that this is something that we urgently need to get right in acute care and also in earlier diagnosis in primary care.

- **Nursing homes are too often seen as the default position even though many older people would prefer to remain in their own homes or in suitable accommodation in their community -** nursing homes are too often seen as the default position, especially once someone who is deemed to be frail has been admitted to hospital. Yet for many people access to support in their own homes or availability of extra care housing would be the preferred solution. Providing suitable accommodation and addressing the health and social care needs of older people should be given much higher priority than hitherto. At the same time nursing homes, which will be the right place for many of our frailest older people, need to pass as fit for purpose.

- **A lack of focus in most places of care on dental and other day to day care needs** - good oral health is a significant contributor to general health, and poor oral health can have a measurable impact on people's ability to eat properly and obtain sufficient nutrition. It can also have an adverse effect on people's confidence and social interaction, leading to isolation and deterioration in physical and mental health. In many nursing homes, older people's oral health is often neglected and many find it difficult to access appropriate oral health and dental care. Simple dental questions should be included on care home admission surveys but are not. Older people, regardless of where they live, fear that the cost of dental work will be prohibitive. Indeed cost is seen as a significant barrier to better dental care. There was agreement that older people would benefit substantially from better access to good dental care as well as other services that the general public take for granted, such as ophthalmology, and that older people's needs in this respect should be evaluated regularly by carers.

- **Dementia is highly prevalent in frail older people, yet hospitals and care homes are ill equipped to deal with frailty and dementia -** dementia is a risk factor in relation to frailty and the risk of both increases with age. Around 80 per cent of residents in care homes have some form of dementia and many frail older people admitted to hospital have dementia, often undiagnosed. Indeed in many cases dementia is often undiagnosed until a crisis occurs and can undermine the chances of recovery or of the person being able to return to their own home. Dementia therefore presents a particular challenge and one that is increasing in prevalence. While there are numerous initiatives associated with the National Dementia Strategy and the Prime Ministers Dementia Challenge the general lack of diagnosis and confidence in understanding and treating dementia adversely affects the quality of care and outcomes for frail older people. Indeed, it was agreed that in general the care home sector, with the exception of some specialist dementia care homes, is particularly ill-equipped to deal effectively with dementia despite a large percentage of residents likely to have some form of the disease. And hospitals are more likely to focus on the admitting condition rather than acknowledging dementia as a comorbidity; leading to poorer outcomes. The increasing prevalence of frail older people and dementia suggests that all staff, in every care setting, need to be educated and trained in caring for people with dementia, including the inter-

relationship between frailty and dementia.

- **The role of the voluntary sector needs to be better understood and embraced as a resource for improving the care of frail older people** - a better understanding of the scale and capability of the voluntary sector is needed. Specifically those services that might provide help and support to frail older people. Voluntary organisations in the health and social care sector often find themselves competing for funding and the changes in the commissioning landscape mean that there is increasing uncertainty as to the sustainability of this funding. Yet many frail older people rely on the voluntary sector for support. While the demand for such support services is high, funding is increasingly constrained. There is a need for a better understanding of the role and importance of the voluntary sector and for a national concordat on working together to deliver more effective services for frail older people.

- **A lack of clarity over responsibility for disseminating best practice** – best practice continues to occur in pockets but it's unclear who should be responsible for disseminating this or how this should be done to best effect. Best practice usually involves taking risks, including bending the rules on funding in some way and, as a result, is incredibly difficult to implement in a single location (need to get a lot of different people with different agenda's on side) let alone across the country. In order to create an environment for sharing best practice, there is a need to get the funding models right and to create funding flows for extra care services. This will reduce the amount of wasted effort spent trying to create services that fall between funding streams.

- **Variation of standards undermines the value that could be obtained from services** - the King's Fund and other national reviews and reports constantly highlight the wide variations in performance and the huge variation of care standards between hospitals/ care providers. For example, there is a more than threefold variation between areas in rates of: emergency admission and occupied bed days for people aged over 65; the number of delayed transfers of care, largely due to patients waiting for non-acute NHS care; and in the rates of emergency readmissions of older people within 28 days. There is also wide variation in rates of long-term care placement between localities, and a six-fold difference in the chances of someone over 65 going straight from an acute hospital bed to long-term care. These variations need to be tackled as a matter of urgency, by reducing the variation and emulating the better performers, so that the overall standards and cost-effectiveness of the care provided is improved.

Potential solutions to help deliver better care for frail older people

Following discussion on the challenges, the focus turned to the types of solutions that could and should be mainstreamed. These included:

- **A gradual introduction to extra care services** – a gradual but early adoption of extra care services by older people will provide some of the much needed support services and also help promote earlier diagnosis of problems and early intervention to prevent escalation. This would reduce the burden on acute care by intervening before a 'crisis' and help preserve people's independence. Extra care housing can also promote a sense of community where everyone is in a similar position and

available to provide support to each other. However, older people are generally quite frightened of moving out of their home and in denial about their health and care needs and, as a result, currently take a more reactive approach, which ultimately can be more costly. Ninety-nine per cent of people, when asked, say they do not want to go to a care home. Given the negative media publicity about the sector, the lack of transparency and visibility about the care home experience, this is not surprising. And indeed it is often the family who decide the time has come, rather than the overt wishes of the frail older person. Better care planning, robust reliable information on the quality of experience and type of care available, as well as more options in terms of the types of supported accommodation available, would help improve this situation. Choice, in terms of types of care and accommodation is just as important, if not more important, than choice in healthcare for frail older people.

.

- **Improve education, training and supervision at all levels of care provision including the public** - caring for the complex needs of older people should be embedded in doctors and nurses and other allied health professional's formal training. Indeed there is a need for all staff to understand the way care is delivered outside of the hospital and how far this meets people's needs and whether there is more that hospitals could do to support care in the community. Likewise community and primary care staff need a better understanding of what happens to their patients when they are in hospital and the challenges faced by hospitals due to poor diagnosis and slow intervention in the community. They also need to develop an awareness and understanding of how they could work better with hospitals. The participants were particularly struck by Figure 4 in the Centre's report which illustrates how the time spent caring for frail older people is inversely correlated to the amount of formal training received and suggested the need for this pyramid to be turned into more of a square, or certainly for informal carers, social care providers and community staff, to receive much more education and training. In addition there was strong support for supervision and mentoring of non-qualified staff to ensure minimum standards are being upheld.

- **The adoption of technology enabled care services was seen as a potential game changer provided better evidence of impact and cost-benefits were available** – there was recognition that technology such as telehealth and mobile health applications (mHealth) could vastly improve efficiency of care workers, free up more time for face-to-face care, and educate and empower patients. However there was also recognition that there is little evidence on cost-effectiveness. Indeed clinicians appeared reluctant to adopt technology due to fear of the change it would bring to their relationship with patients. Doctors can usually see the benefits to them of adopting technology, particularly in relation to improving access to information, sharing patient records etc but were less enthusiastic about reducing the face-to-face link with their patients or of shifting the balance of power. Even though most would recognise the importance of technology in supporting self-management, they are also wary of recommending particular mHealth apps due to concerns over security of information and confusion over regulatory requirements.

- **Collaboration with and support for the role that private providers play in social care** – there was recognition of the important role that the private sector has played in the provision of social care and that the private sector remains well placed to continue to provide good social care, partly as customers have choice, and they therefore have to entice the consumer to use their services. A lot of time has been spent understanding the needs of older people and shaping/ creating services around this need and there are lots of examples of good practice. The issue of

turnover and pay is recognised and support for a solution to be found to zero contract hours and 15 minute visits, but in many other respects, the private sector is vital to this aspect of care.

- **Improving quality of care and patient outcomes though investment in re-ablement services.** Around 70 per cent of older people come out of hospital with decreased mobility as a result of a combination of time spent being bed-bound and a lack of access to rehabilitation and re-ablement services. Access to step down facilities and a focus on rehabilitation services in the community is critically important in order to preserve independence and reduce the chance of re-admission. Commissioners' failure to invest in such services is a false economy as without such support, the overall physical and mental health of older people will deteriorate and the risk of institutionalised care increase.

Examples of good practice

During the discussion a number of specific examples of good practice were highlighted which participants thought should be adopted more widely. In particular:

- **Birmingham** – is continuing to develop a cross-city wide approach to the provision of integrated health and social care. The focus is primarily on integrating services in order to move services out of hospital into the community, particularly for patients with long term conditions. There is a shared vision across most of the key stakeholders across the local health economy, based on extensive consultation, including clinicians, providers, the local authority, councillors, MPs, patient groups, the third sector, local communities and the wider public. The next phase in the process is to identify specific options for re-configuration and provision of services throughout the whole health economy, and what this means for providers, commissioners and patients. Ultimately the aim is to tackle the predicted financial deficit while improving access to the right care in the right place at the right time.

- **Hampshire –**for a number of years good community care services have been available to all regardless of ability to pay, as a result of agreements reached between local councils and health care commissioners who put agreements in place to support the funding of access to care in relevant cases a number of years ago. Indeed, as part of nine year housing strategy, Hampshire closed 'old school' residential care homes and replaced them with new state of the art extra care housing. Hampshire's motivation for this initiative came from the need to use the small amount of funding received from government efficiently and recognition that they have a large elderly population and a deficit of appropriate affordable housing. Another success was the re-tendering of meals-on-wheels with the winning company providing high quality food and, where required, a companion to encourage older people to eat better. They have also appointed local care navigators which involves recruiting and training non-clinical personnel in understanding the range of services (public, private, voluntary/ charity) available in the community and recommending these to patients. Hampshire has, to date, been able to overcome the problem of siloed funding of health and social care budgets by putting in place binding, joint funding agreements and securing funds from the local authority and healthcare commissioners to support frail older people more effectively through joint working. The changing NHS landscape and new payment by results regime presents a risk to the improvements that have been seen to date.

- **Around 10 per cent of hospitals have implemented a geriatrician of the day and rapid discharge pathways for older people.** In line with the 'Silver Book' – a best practice guide for hospitals, the introduction of an acute geriatrician within the medical triage team has helped provide early decision making, based on a frailty score. Other initiatives include an ambulatory care pathway, segregating vulnerable people from the main AE population to provide a less noisy and threatening environment. This also provides direct admission to older people wards which have 24/7 consultant cover and the implementation of discharge plans from the outset.

This roundtable discussion agreed that there was no one size fits all solution but that the time has come to look at solutions to disrupt the status quo and that a focus on the issues and suggestions covered by the roundtable would be a good place to start.

Contacts

Karen Taylor
Director, Deloitte Centre for Health Solutions
Tel: +44 (0)20 7007 3680
Email: kartaylor@deloitte.co.uk

Further information

Given the wide ranging nature of the discussion and the interest shown by a wide variety of people and organisations it was agreed that the Centre would host a roundtable discussion on better services for frail older people in the North East to consider how a whole health economy is responding to the challenges identified with a particular focus on integration joint working and funding. A write up of this discussion will be available on our website in due course. You can also find on there a summary of our first roundtable which explored how to deliver improvements in each place of care that frail older people may find themselves.

www.deloitte.co.uk/centreforhealthsolutions.

If you would like to discuss the ideas and suggestions in this document or the Better care for frail older people report please feel free to get in touch.

Deloitte Centre
for Health Solutions