



Perspective 3

Summary from July 2014 roundtable discussion in Newcastle: **Better care for frail older people: working differently to improve care**

The Deloitte Centre for Health Solution's third roundtable discussion on better care for frail older people brought together policy makers, academics, commissioners and providers of health and social care service from across Newcastle and Gateshead in the North East of England to discuss the challenges in caring for an older population from a whole health economy perspective. It considered how to harness the different parts of the system to become more than the sum of the parts. While a key objective was to explore the key challenges and solutions highlighted in the Deloitte report ***Better care for frail older people***, the fact that all participants were key stakeholders in the North East health economy provided an opportunity to consider more integrated and cross sector, local solutions.

The roundtable event in July 2014 was chaired by Karen Taylor, Director of the Centre for Health Solutions, and hosted by the Deloitte UK Newcastle office. It explored how best to:

- deliver the right care in the right place at the right time
- view ageing as a triumph and acknowledge the contribution that older people make to society
- provide better care in each place of care that frail older people access
- scale up the adoption of identified good practice.

Following a brief overview of the key findings in the Centre's report the session started with insights on some of the challenges facing frail older people in the North East, as seen through the lens of Age UK; and a thought provoking introduction from Newcastle University Institute of Ageing and Health, to the idea of ageing being a triumph of humanity, which should be

celebrated by empowering older people to live life more fully. Each participant was then invited to identify the key challenges that they felt needed addressing which was followed by an open discussion of these challenges and a focus on potential solutions.

The scale and extent of the challenge

Acknowledgement was given to the successful achievement of society that has enabled increasing numbers of people to live longer, healthier lives and the recognition that while many more people are living into their 80s and 90s they are not all the same but have widely different needs. This is largely because chronological age is not the best measure of need – indeed there are numerous examples of 50 years olds needing significant health and social care support and a 90 year old who is in training to run the Great North Run. While ageing is inevitable, it is also malleable.

The *Newcastle 85 Plus* study suggests that there is actually a misperception of how bad things are, it tracked down people who were still alive post 85 and found that 77 per cent believed that their health was “good” or better and identified that few of them were actually in care homes. Given that many people now stay healthy, happy and independent well into old age, there is a need for society to look at ageing differently.

Nevertheless, as people age they are progressively more likely to develop 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.

More specifically in the North East, a small percentage of patients requiring hospital beds and other residential accommodation are using 50 per cent of the budget. This has contributed to the development of a negative perception of ageing, fuelled by the general media which consistently portrays the needs of older people as “a burden”, or “a time bomb” and fails to recognise or highlight the significant value they bring, and will continue to bring through, for example, volunteering and lending support to families, communities and society in general.

Indeed there is substantial evidence of ageism and age discrimination in health and social care, 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 widely variable and often inadequate to meet the demand.

A key reason why health and social care services have failed to keep up with the changing and multiple 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 totality of 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.

The specific challenges to better care for frail older people

Loneliness was identified as a challenge that has become increasingly difficult to tackle.

With people living longer but with life limiting conditions, compounded by a loss of independence and a diminishing circle of family and friends, loneliness is becoming a significant public health issue. While chronic loneliness can affect people of all ages it poses a particular threat to the very old, quickening the rate at which their faculties decline and cutting their lives shorter. Research studies have shown that chronic loneliness is associated with significantly greater risk of cardiovascular disease and stroke; it contributes to a more rapid progression of Alzheimer's disease and suppresses the immune system. Loneliness also

reduces life-span, with researchers finding that chronic loneliness poses as large a risk factor for long term health as smoking 15 cigarettes a day. It also increases the likelihood of early admission to residential or nursing care.

While tackling social isolation is undoubtedly challenging, in most instances the answer is not some innovative costly solution. Indeed, harnessing the social capital in voluntary and charitable organisations is likely to prove much more effective in supporting older people to live well in their communities than is currently the case. There is also a compelling argument for everyone to stop and think and do something, no matter how small, to help alleviate the chronic loneliness and support needs of frail older people and other vulnerable members of our society, including those in our own families.

Lifestyle changes and social prescribing can help to delay age related issues such as dementia and the loss of independence

Research suggests that if 1 in 10 people adopted a healthier lifestyle, 2000 people per year would not develop dementia. With social prescribing the focus of Age UK's approach to people recently diagnosed with dementia. In North Tyneside an approach to integrate the voluntary sector with multi-disciplinary teams, based on best practice example from Cornwall, involving proactive case finding and management, is having a measurable impact.

Integration of services and partnering with volunteers and the voluntary sector while challenging has the potential to be a real game changer.

There was broad agreement of the need to connect funders and providers of health and social care services and to give more recognition to the wealth of 'non-formal' community care that's available, for example volunteers and the voluntary sector. There was also a view that the people who are more likely to notice a change in circumstances or deterioration in an older person's health are those who have more frequent contact, such as the local pharmacy or grocery store.

Overlaps and gaps in service provision and a lack of a single point of contact for patients undermined by a lack of system leadership

Currently, individual provider organisations tend to focus on a "set menu of options", while failing to see the system from the patient's perspective. This was contrasted to the improvements seen in stroke services where the whole system reorganisation has achieved impressive outcomes by closing many of the gaps. Indeed, most people do not understand or care about artificial organisational boundaries but want a single point of contact and a personalised solution. This was something that needed to be tackled urgently, requiring all stakeholders to subjugate their vested interests and move away from the current system of silo based, fragmented care.

There was agreement that the last 10 years has led to degradation in the relationship between GPs and hospital consultants which to a degree has been precipitated by "Choose and book" as this gets in the way of personal relationships and trust. There were also concerns that the relationship between GP and Community staff has also deteriorated as they no longer have the proximity of relationship and hence the benefits of proximity have been lost.

Indeed, healthcare struggles because business gets done through relationships and change gets in the way of productive relationships. Stability of leadership and consistency of purpose is very important – yet the circumstances fight against us. What is needed is to bring people together at the coal face to develop trust. Clinical leadership and clinicians in leadership roles is one solution but this has been talked about for some time with limited success due largely to cultural barriers.

The lack of an interoperable, shared patient record is a significant barrier to better care

One consultant in old age psychiatry described the benefits that can be realised by having a locally developed integrated patient record between primary and secondary care which had been in place prior to the introduction of the National Connecting for Health scheme. This has transformed the ability of the hospital to treat patients using linked information from the GP, physiotherapist etc. While these links are undoubtedly better there are still gaps particularly with social care. The failure of the national scheme, however, has caused problems and significant delays for other providers in the locality. All agreed the need for hard data and access to research. Data sharing is still a challenge when a service doesn't know what the person/people providing the other elements of care have done. There was strong support for the idea that the benefits of data sharing should trump the Information Governance rules.

Patient and carer access to records is a challenge that needs to be addressed. With a strongly supported view that people with digital familiarity could take more of a role and own their own records. The difficulty of that is there is no one to hold the ring. Most patients think that the whole NHS is already sharing, which they have no problem with, but cannot bear the idea of sharing their data with business. Concerns were also expressed that questions and decisions over information sharing get kicked up the hierarchy to the next level above and rarely provide an answer something that it was hoped the government might finally do something about.

A lack of clarity over responsibility for disseminating best practice and continued resistance to adoption

Regular changes in organisational structures and management hierarchies have destabilised the system and led to a lack of corporate memory and leadership. The constant morphing of organisational boundaries takes time and money and breaks relationships. However one area of constancy is at GP and Consultant level, many of whom may have been in post for 10, 20 or even 30 years. The constant changes also lead to real difficulties developing and sustaining trusted relationships between management and health and social care professionals.

Best practice continues to occur in pockets but it's unclear who should be responsible for disseminating this or how this can be encouraged at scale. There was strong support for stopping re-inventing the wheel and a plea for capturing corporate memory more effectively. The observation was made that hospital consultants were often in post for 20-30 years, likewise GPs, but chief executives and other senior managers, executives, and policy makers changed regularly, bringing with them what were seen as uninformed or unnecessary policy changes, often led from the centre in London, with no understanding of local communities like the North East.

Introducing new practice usually involves taking risks, including bending the rules on funding in some way. As a result, it is incredibly difficult to implement even in a single location (without getting a lot of different people with different agendas on side) but examples of initiatives that truly benefitted patients were now emerging. There was some concern that the Better Care Fund may have missed an opportunity to truly transform service delivery.

There was recognition of the resistance to ideas or practices that had "not been invented here" and the prevailing attitude and a cultural belief that the local needs and places of care are so different that you "cannot compare". Whilst there are improvements there is still resistance and a sense that "data doesn't apply to me". Resistance to learning from abroad is fading but the question was asked as to why everyone has to go to the same place to see for themselves rather than accepting the feedback from others and even then most people still come back and say that it cannot be done here.

A mismatch between service provision and service needs

Given the political mantra of providing more care closer to home and that care in the community is perceived as more cost effective for frail older people than hospital care; changing the physical estate is a much needed but incredibly difficult challenge. There is general acceptance of the need to consolidate and remove resources tied up in some community hospitals to enable more care to be delivered in people's homes. And to develop the primary care estate so it can deliver the wider agenda of care now expected.

At the same time a number of the acute hospitals are facing major financial challenges. In order to change the configuration of services need to prove that it will work from an outcomes and financial angle requiring a proof of concept to be undertaken and obtain buy in of all stakeholders. On the one hand there is a need for community assessment hubs for elderly; on the other have £2 million of void cost in community estate which they want to release and spend. This is proving challenging, especially around engaging with the public – all they see is the loss of a building.

Potential solutions to help deliver better care for frail older people

While integration was seen as the main answer more energy needs to be spent on implementation rather than on definitions

There was agreement that the best return on investment would come from vertical integration between acute, community and primary care. Lessons could be learned by examining what used to be possible 15 years ago when there was a focus on Multi-Disciplinary Teams around Learning Disabilities and Mental Health. The time has come to get smart about working together. Not engaging with integration is not an option any longer.

Essential to this agenda is the need to create trusted relationships and also need to get IT to talk to share data and details. However, rather than getting hung up on pooling or sharing the suggestion was to focus upon the person and fill the social gap. Sometimes the answer is not money but putting a hand out to the person. Examples are emerging of primary care multi-disciplinary teams that include hospital and community staff working together for the benefit of patients.

The role of the voluntary sector could be better understood and harnessed as a resource for improving the care of frail older people

There was recognition of the need for a better understanding of the scale and capability of the voluntary sector. Specifically those services that might provide help and support to frail older people given that many frail older people rely on the voluntary sector for support. However, the voluntary 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 funding. Voluntary community often not seen as equal partners and to an extent, voluntary sector is not great at working together, nevertheless there is great work being done which could and should be built on.

One suggestion was the need for a national concordat on working together to deliver more effective services for frail older people. For example, Age UK is working with the local authority and acute trust to map the 27 services that touch older people. They have gathered over 200 narratives to work out how it looked from a service user perspective. The aim is to improve understanding of demand and capacity with a view to having joint design event to manage conditions upstream before conditions become acute. While it is challenging to get the energy and identify catalysts to change, to do things differently needs people to think differently.

Primary care could and should have a more significant role in the care of frail older people

One suggestion was to develop primary care at scale; rather than having hundreds of individual practices and that in this way could achieve mass engagement. Government want more responsibility on GPs but do not follow this up with funding. Primary care are ideally placed to support frail older people to live independently for longer, they have likely known their patients for many years, understand their circumstances, know their families and can recognise when a person's condition is deteriorating. But many of the changes to primary care over the last decade have undermined this to some extent. There is a need for more investment in primary care and in return for primary care to take explicit responsibilities for the health and well-being of all their frailer older patients.

Improve education, training and awareness of the different levels of care

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 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 a general consensus that technology, such as telehealth and mobile health applications (mHealth), could 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. Doctors can usually see the benefits to them of adopting technology, particularly in relation to improving access to information, sharing patient records etc. They 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. One example of a technological innovation that was paying dividends was the introduction of electronic standard discharge summaries.

Improving quality of care and patient outcomes through investment in re-ablement service, education and training

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 was seen as 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.

Attention was drawn to the Office of the Government Chief Scientist and their work on mental capital and well-being (2008). This identified the five daily portions for mental wellbeing; among which are: Stay Connected and Keep learning. But the challenge was how people keep learn in an age of austerity. The University of the Third Age was highlighted as one of the ways to achieve this however it is perceived as very middle class and is only now examining the barriers to social inclusion. One of the barriers, however, is finding a venue, obtaining affordable accommodation at a time when Local Authorities are putting up estate costs. There is a clear opportunity to signpost to other areas. Investment in education opportunities could pay dividends in reducing use of health and social care services.

Supporting older people to act as role models and ambassadors and giving older people a voice

Older people could themselves be supported to act as role models or ambassadors and help other older people navigate the complex health and social care sector. They might also be encouraged to befriend the young to help bridge the generation gaps and tackle ageism from the bottom up. In future, the catalyst for adopting new models of care is likely to be the 'voice' of the empowered and knowledgeable older person within an environment that encourages this voice. This involves addressing how society views older people and creating a vision of life beyond adulthood by adding the concept of a rewarding and fulfilling "elderhood" into our current lexicon. Overall the need is for policy makers, commissioners and providers to walk in the shoes of frail older people and deliver services accordingly.

There was strong support for the suggestion that services would improve if health and social care managers and professionals would "Walk in the shoes of the patient". Providers across the health economy needed to work together and to gain central support to locally led initiatives.

Patient stories are a powerful and impactful way of encouraging change

Acknowledgement was given to the idea that while clinical solutions may be needed the softer solutions are often overlooked yet could in the long run be much more cost-effective. Social prescribing was seen as a solution. Various examples of individual patient stories were shared, including the bereaved older widower who subsequently lost his dog to cancer and whose health then deteriorated rapidly. This went unnoticed by statutory services but was noticed by the local pharmacist who contacted Age UK who were able to link him to a dog walking service which gave him a reason for living for the remaining time he had left

A further patient story which resonated with everyone and illustrated how little things could make a real difference but also how far there was still to go to deliver a joined up service. The story concerned an elderly lady with dementia for whom, and following diagnosis, numerous challenges were encountered. These included:

- the lack of a care navigator and not knowing who to speak to or who might be in a position to provide an explanation of the whole patient journey
- getting multiple appointments, some on the same day but in different places with different organisations
- appointment letters usually very vague and not saying what or why or how it all fits together
- difficulty physically accessing care or knowing what care is available and that if a person doesn't know what to ask for doesn't get it – don't ask don't get
- transport not available at time of appointment, for example sent an appointment for a Sunday but no patient transport at weekend or night and transport has to be sanctioned by GP for each individual service and not by patient need with a time lag in system and usually by letter with no live or online access
- no cross referencing between services for example new pills prescribed but no consideration given to persons ability to remember to take them or explanation or understanding of side effects.
- Linkage between services: undertaking minor surgery procedures without arrangements for follow on home care services that are delivered by other agencies.

This roundtable discussion concluded on an acknowledgement that there was no one size fits all solution but that the time was ripe to look at solutions that disrupt the status quo. The fact

that the participants were from all the different parts of the local health economy was seen as conveying a huge advantage in being able to implementing the changes and solutions discussed. Indeed participants agreed that they would explore the idea of establishing a regular forum to help drive the agenda forward.

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Further information

Summaries of all our roundtable discussions are available on our website 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.

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