MEDWAY HEALTH AND WELLBEING BOARD

15 SEPTEMBER 2015

OUT OF HOSPITAL CARE/ SUPPORTING INDEPENDENT LIVING ENGAGEMENT EVENT

Report from: Dr Alison Barnett, Director of Public Health

Author: Karen Macarthur: Consultant in Public Health, Medway Council

Summary

The paper attached at Appendix 1 provides a short report of the Medway Health and Wellbeing Board Engagement Event on "Out of Hospital Care; Supporting Independent Living" which took place on the 16 June 2015 at the St Georges Centre, Chatham Maritime. It focuses on the workshop feedback at that event for the Board to discuss any further action needed in the identified areas.

1. Budget and Policy Framework

1.1 In 2015 the Medway Health and Wellbeing Board chose as one of its priorities to support the development of better out of hospital care and reducing inappropriate hospital admissions in Medway.

2. Background

2.1 Having identified the development of better out of hospital care and reducing inappropriate admissions as a priority, the Health and Wellbeing Board wanted to ensure stakeholders were engaged to build a common understanding of the issues across the whole system and what still needs to be addressed through better partnership working.

3. Advice and analysis

3.1 Emerging themes from the engagement event with respect to key changes that need to be made to pathways and services that support older people to stay living in the community and avoid unnecessary hospital admissions can be summarised as:

- Better identification of and support for carers including provision of respite care.

- Better information sharing across agencies and a single point of access for older people including development of a patient held record (frailty passport) to be consistent across agencies
- Increasing the uptake of the elderly annual review in primary care (to identify unmet need and promote prevention)
- Improving prevention as a key to systems transformation. Needs to include public health and practical prevention/early intervention such as promoting the Emergency Carer Card carried by carers. (This gives details of who else can provide emergency care if they are unavailable.)
- Ensuring a holistic approach, reviewing possibilities for more integrated working and ensuring mental health is appropriately integrated into all pathways.
- Implementation of seven day working in the health and social care system and the need to increase staffing levels (particularly GPs) to support this.

4. Financial implications

4.1 No financial implications arise specifically from this report.

5. Legal implications

5.1 There are no direct legal implications arising from this report.

.

6. Recommendations

6.1 The Health and Wellbeing Board is asked to consider this report and comment on any further action needed as a result of this engagement event on the emerging themes identified above and the information in Appendix 1.

.

Lead officer contact

Karen Macarthur, Consultant in Public Health, Medway Council
Tel no: 01634 332634
E-mail: karen.macarthur@medway.gov.uk

Background Papers

None

Appendices

Appendix 1: Medway Health and Wellbeing Board Engagement Event on “Out of Hospital Care; Supporting Independent Living” Report

.

Appendix 1

Medway Health & Wellbeing Board Engagement Event 16 June 2015
Out of Hospital Care; Supporting Independent Living Report

1. Introduction

This paper provides a short report of the Medway Health and Wellbeing Board Engagement Event on "Out of Hospital Care; Supporting Independent Living" which took place on the 16th June at the St Georges., Centre, Chatham Maritime

2. Purpose of event

In 2015 the Medway Health and Wellbeing Board chose as one of its priorities to support the development of better out of hospital care and reducing inappropriate hospital admissions.

As part of this commitment two events have been held to build a common understanding of the issues across the whole system and ensure wider stakeholder engagement. The event on the 16th June 2015 was particularly focused on looking at some of the wider areas that affect people's ability to live independently and avoid inappropriate admissions.

The event was attended by 33 stakeholders from a range of key organisations in Medway.

3. Programme for the day

The event comprised presentations from a range of partners to give a greater understanding of the issues involved and current developments and challenges in their areas. These were:

- Adult Social Care – Reablement, Personalisation Care and Support: *Ian Sutherland*
- The Frailty Project: Getting Care in the Right Place: *John Britt and Dr Sanjay Sunan*
- Housing Need and Issues in Medway: *Matt Gough*
- Carers: Experience and Issues: *Peter Turner*
- A Few Thoughts on Prevention…: *Dr Alison Barnett*

Following on from the presentations there were workshops which looked at whole system working with respect to improving pathways and services that support older people to stay living in the community, specifically focusing on what was currently working well, what was not currently working well and then identifying 3 key areas for change.

4. Workshop feedback

Feedback and key themes from the workshops are presented below under the relevant questions:

Q1. From your current experience what works well regarding pathways and services that support older people to stay living in the community and avoid unnecessary hospital admissions?

- There was thought to be a good understanding in Medway that ensuring good care in the right place is a complex multi-agency issue that no one organisation can tackle in isolation.

- There was general agreement on most of the tables that the current work to improve discharge processes was positive and that there was increasing embedding of the principle of admission avoidance and the availability of alternatives to admission. Specific areas around improving timely discharge that were felt to be positive were:

- Housing and housing adaptations, e.g. at discharge from hospital a patient's living environment is being increasingly considered and this is done in a timely way such that patients are discharged back to a safe living environment.
- Discharge from hospital to the care of community teams
- Increasing embedding of the principle of admission avoidance and the availability of alternatives to admission
- Integrated Discharge Team and the development of the Health and Social Care Navigators, which should enable better navigation of the system
- Frailty project which was having a positive impact on discharges < 24 hours & length of stay.

However while there was support for these developing initiatives, concern was expressed that they need to be embedded properly as in the past they had often been short lived.

- Partnership work with carers was thought to be improving and carer support at home was identified as positive by some.

- With respect to wider networks of social care and support, day centres, friendship groups, existing informal networks of family and friends and churches and other voluntary organisations all were thought to provide positive support.

Q2. From your current experience what doesn't work so well?

Discussions were wide-ranging across the tables. Key points raised were:

- Older people can be deteriorating in the community but often off the radar of health & care services. Carers also can be struggling to cope and remain without appropriate support in some cases. There is a need for better information as to why we aren't reaching some carers and their coping breaks down. Early assessment and planning in the community is important to stop avoidable crises occurring.

- Persistent issue of patients with length of stay >10 days. This was felt to be often due to problems with access to social care; the amount of paperwork which needs completing to apply for social support. This problem is most acute for patients with complex physical and mental health needs who are the most vulnerable to the complications of long hospital stays.

- Planning for discharge needs to be done with carers and patients and be carer/patient led. Practical appropriate support needs to be available on discharge including overnight when patient initially discharged from hospital

- Concern was raised about mental health patients and whether they were given parity of esteem when looking at this issue. Perhaps further work needs to be done to examine appropriate discharge planning in this area.

- The need for improvement in dementia services in order to avoid inappropriate admissions for dementia patients was raised. It was suggested that it would be useful to link Medway Community Healthcare Services with Older People's Psychiatric Service and there was also a need for a dementia crisis response service.

- Seven day working was seen as crucial to timely discharge planning and more generally as important in better systems working.

- Concerns raised regarding primary care were regarding:
    - Insufficient access to GPs which has a knock on effect on acute services
    - Problem of polypharmacy originating with GPs but not being dealt with by them
    - GPs not always delivering holistic care but lack of time and pressure on the primary care system understood to be an issue.

- More continuity of services was needed and current services still lacked good connectivity with and between each other.

- Change in perception and expectation was needed in the general population, people still felt their elderly relatives were “safe” in hospital.

- Need to recognise issues of sustainability and capacity in the voluntary and community sector.

- Some of the most challenging patients do not want to engage with health and care services- it is very difficult to help these people.

- For some supported housing, the needs of residents are inappropriately high for the level of support offered by the placement

Q3. From your experience of what doesn’t work so well, identify 3 key changes you would want to make and who needs to be involved in making those changes

Each table was asked to identify the 3 key changes that would be most effective in improving whole system working. Some tables identified more than three and for the sake of completeness these are included below. There were diverse opinions as to what these changes could be among the tables but

1. Reach unknown carers and support before crisis.

2. Recruitment of GPs.

3. Parity of esteem and more understanding of mental health as part of a holistic approach.

4. Better information sharing and systems. Data and intelligence should drive changes. Need to improve single point of access (2)

5. Need to think holistically even if a specialist, possibly need to incorporate this or develop it through CPD

6. More joined up services:
    - Co-ordinated by “someone”
    - Multi-disciplinary pathways
    - Community care navigator
    - Info sharing across agencies

7. Increase uptake of elderly annual review in primary care (which is a very good tool for identifying unmet need in the elderly and promoting prevention)

- Need systematic identification of non-attendees for the annual check
- Consider alternative provision of the annual check- possibly by phone or by someone other than a GP.

8. Patient held records - possibly a frailty passport
   - Would need to be consistent and accepted across agencies; standard format
   - Could build in components of the comprehensive geriatric assessment
   - Could include e.g. advance wishes

9. We need honesty about financial parameters we are working with and need to think about the system as a whole. Clarity about short term (next 5 years) objectives needed.

10. Improving prevention (radical upgrade) key to the systems transformation that is needed. Includes both PH and practical prevention/early intervention e.g. use of Emergency Carer Card carried by carer (which gives details of who else can provide emergency care by Emergency Services) could help prevent considerable waste and unnecessary service use.

11. Need to explore greater integration of health and social care and other services. Better Care Fund is thought to be important in developing this.

12. Improve flexible 7 day working to improve services for patients and carers.

13. Better respite opportunities for carers. Important in avoiding carer breakdown.

14. It may be useful to explore the possibilities for VCS/charity sectors to 'join-up' to realise economies of scale. (MVA)?
    – creation/maintenance of single list
    - support by offering mentoring
    - better recognition
    - help with comms/it (esp ' secure email')

15. Improve corporate/social responsibility = volunteering – encouraging staff to volunteer.

16. Continuity of information sharing – putting things in the 'right' order – one single point of access.

Conclusion and next steps

Overall, emerging themes from the engagement event with respect to key changes that need to be made to pathways and services that support older people to stay living in the community and avoid unnecessary hospital admissions can be summarised as:

- Better identification of and support for carers including provision of respite care.
- Better information sharing across agencies and a single point of access for older people including development of a patient held record (frailty passport) to be consistent across agencies
- Increasing the uptake of the elderly annual review in primary care (to identify unmet need and promote prevention)
- Improving prevention as a key to systems transformation. Needs to include public health and practical prevention/early intervention such as promoting the Emergency Carer Card carried by carers. (This gives details of who else can provide emergency care if they are unavailable.)

- Ensuring a holistic approach, reviewing possibilities for more integrated working and ensuring mental health is appropriately integrated into all pathways.
- Implementation of seven day working in the health and social care system and the need to increase staffing levels (particularly GPs) to support this.

The feedback from this event will be presented to the Health and Wellbeing Board and appropriate action will be considered.