Briefing paper

Our plans for Older people's services

April 2013

Northern Health and Social Care Trust

Contents

1. Introduction

This document sets out a vision of what we want life to be like for older people in the Northern Trust area. It sets out at a high level, what sort of services for older people will be needed and how these will be provided or developed.

In common with the rest of the United Kingdom, the Northern Trust area has an ageing population. Most older people do not need intensive support from health and social care but their quality of life can be improved by simple solutions provided by a variety of organisations. We celebrate that older people are living longer, positive and fulfilling lives and the contribution they make to economic and community life.

The partnership approach described in this document will ensure that we are well placed to work within the policy direction described in Transforming Your Care (TYC), namely the recognition of the value of local communities working together. TYC also recommended that there will be a reduction in statutory (Trust run) residential care homes for older people acknowledging that more older people will be supported to remain in their own homes and that the independent sector provide a wide range of accommodation based services widely across the area, including residential care. In keeping with 'Transforming Your Care', the Trust is consulting on its proposal for the future of statutory residential care for older people.

By working with partners from across the statutory, voluntary and community sectors, we will be able to deliver positive outcomes in a difficult economic climate.

This vision is based on what older people have told us is important to keep them well and independent, as well as understanding local needs and which services we need to develop. It sets out to communicate this to a wider audience.

2. Why do we need to change?

a. A growing and older population

People are living longer and we can all celebrate the added years of living that so many are enjoying. Information is now widely available that describes the changing profile of our local population, including the rising number of older people. If we are to address the priorities identified within Transforming Your Care (TYC) and achieve the best possible outcomes for individuals and our communities, it is clear that we need to change the way we provide services for older people. The time is right to shift care away from our acute hospitals toward care closer to home. We need to take action now to make sure that our acute hospitals at Antrim and Causeway can focus on the work that must take place in an acute setting and that those who do not need that level of care are cared for as close to home as possible.

We are concerned that some older people are admitted to long term residential and nursing care in the Trust area when, with appropriate services and support, they could remain at home. We need to continue to provide better services so that people can stay at home.

b. Choice and expectations

Over the last number of years we have asked older people and carers to tell us about the types of health and care services they would like to see provided in the future. The majority of people tell us that they want support so they can stay at home for as long as possible.

The Trust covers a large geographic area and if someone needs to attend a hospital they may have to travel a considerable distance. To minimise disruption to patients and their families it is important to be able to access as much care and treatment as possible, close to home, in facilities designed for that purpose.

3. What is our vision for the future?

In collaboration with Primary Care, local communities and councils, we aim to co-produce a model of service delivery for each local population and council area. The model will make sure that the services;

- meet the needs of each area and are responsive to the particular needs of local communities
- ensure that care and support can be triggered simply and in an integrated way
- ensure access to a rapid response service in the event of urgent need
- promote support for people with long term conditions so they have more control over their illness and have less admissions to hospital
- ensure people have the best opportunity to have their care and treatment completed at home or when necessary in a facility closer to home
- ensure people are able to access equipment locally and in a timely way
- ensure that where domiciliary support is required that this is available quickly and specifically focuses on reabling people to become as independent as possible
- ensure that people do not get admitted to long term residential and nursing care homes unless it is the only suitable option to meet their needs
- ensure that GPs, local councils, community and voluntary groups have every opportunity to assist in the development of service models

a. Integrated care and support

In order to change the way we develop services into the future, local health and social care professionals will be at the heart of decision making about community services. By integrating care planning across the hospital and community services we will make sure services are provided closer to home. Integrated care teams will work seamlessly to ensure that care needs are anticipated and met in a way that improves the patient experience and reduces the need for hospitalisation and institutional care.

A key part of this is the development of local fully integrated community teams that serve the populations they know well. This integrated local working is fundamental to securing the best value from the taxpayer's investment.

b. Helping people to stay at home

In an effort to break with traditional service model for home care we embarked on a journey in 2010 to re-design part of our home care service into a reablement home care service. The emphasis moved from providing a long-term service to one that focused on encouraging people to maintain their own independence and reduce dependence on long-term services. Results to date have shown that at least 20% of people (1 in every 5 people) who initially received domiciliary care, no longer needed it after a period of reablement. This means that we have been able to re-invest these resources in supporting more people at home.

The reablement service can help an older person to regain lost skills and rebuild their confidence so they can continue to live independently. To help people stay at home we will increase reablement services delivered in the persons own home.

Below is the example of an older man who benefitted from the trust's reablement service.

An 82 year old was discharged from hospital and the reablement team worked intensively with him in his own home. Staff worked to help him get washed and dressed and into his wheelchair each day. When he was ready, he worked with the physiotherapist to help get him back on his feet. The man can now walk on his own again using a walking stick to aid him. The encouragement and promotion of independence which is the ethos of the reablement service have supported him to regain essential life skills, and

eventually he was fully independent again and required no ongoing domiciliary support.

The man can now drive again and can take his wife out to the local shops. He knows that if it wasn't for the staff in the reablement team that he would not be as independent as he is today. He said;

"I am indebted to the staff from the reablement team who came to look after me and encouraged me to become more independent. They helped me wash and get dressed each day until I could manage to do this on my own."

c. Day care

Following a recent review, changes have been made within day care, to proactively address the increasing demand for specialised services in prevention and reablement. The day centres now focus on reablement with the provision of 4 new 16-week programmes. These programmes are designed to educate, support and improve the health and independence of service users and deliver measurable outcomes over clearly defined time periods. The programmes help people gain skills so they can remain in their own homes for longer and they provide an opportunity to help older people connect with local community and voluntary services. They also provide longer term support for those with progressive illnesses.

d. Providing accommodation with care and support

In most instances people, who need care and support, including older people, want to receive this in their own homes. During recent years access to a wider range of housing based schemes including sheltered housing has expanded.

The result of developing a wider range of services for older people over the last 3-5 years is that demand for bed based care continues to reduce. At the same time, the independent sector has been busy improving and developing new modern care homes and there are now more residential and nursing home care beds in the Trust area than we need. There is an average of over 200 available places at any one time in independent sector residential and nursing care. Alongside this, the independent sector is continuing to develop more nursing and residential homes.

There is a decreased demand for this type of long term service and a growing demand for home based care services. The changing profile of services is indicating that there is no longer the demand or need for statutory residential home provision and the Trust is consulting on

the future of its statutory residential homes for older people. This consultation paper is available on our Trust website and should be read in the context of this document. We value your input to this consultation process and would therefore welcome any comments you have to make.

However, for a small number of people, it is not possible to meet their requirements at home due to the complexity and range of needs that they have and they will have their needs met in a bed-based care facility such as a nursing or residential home.

e. Supported living

We will develop more supported living accommodation, working with the Housing Executive and Housing Associations in particular. Older people will have the choice of living within a more communal setting with flexibility about the amount of support or care they need and having the benefits of being a home owner or tenant. Supported living combines all the advantages of living in your own home with the benefits of access to on-site support and care teams. We are currently progressing with two such schemes: one in Ballycastle and one at Greenisland.

f. Working with community and voluntary organisations

We have been working with a number of community and voluntary sector organisations to enhance the range of support available for older people, both in their own homes and local communities. These services are provided on a one to one basis or through group support. They provide practical support and include things like:

- making sure older people's homes are safe and secure
- making regular contact for a friendly chat and perhaps a reminder about appointments or taking medicines
- helping with budgetary issues and applying for benefits
- providing opportunities for people to get together so they feel less isolated and by providing information on local activities or outings
- providing support for carers and relatives so they can have a much needed break

Using a community development approach, we will work closely with local Councils to seek out opportunities to get the best from all available resources through meaningful partnerships with local community and voluntary groups.

g. Assistive technology and equipment

A range of equipment aids can now be used to support people living at home. Many people are now familiar with 'care alarms', either worn by the individual or activated by a button somewhere in the person's home. They are used by thousands of people who are living alone. Care alarms were an innovation when they first appeared and they provide many older people and their families with peace of mind. Technology has come on leaps and bounds and other types of technical innovations can now also be put in place to support people in their own homes and to assist families, friends and home carers. These include devices such as falls detectors, low and high temperature sensors, movement sensors

and carer pager alerts.

The services being developed will mean that people can receive intensive support and treatment at home, assisted by new technology and equipment, which will allow them to recover after a crisis or illness and remain independent for as long as possible.

We plan to ensure more people get the opportunity to use technology to assist their independence at home and we will extend the use of assistive technology.

Charlie O'Kane from Magherafelt uses the Telemonitoring service due to heart and chest problems. He can monitor his vital signs using the new technology every day. This information is monitored centrally and if readings show signs of deterioration to an unacceptable level, Charlie's nurse is alerted. Speaking about the service Charlie said;

"Being able to check my own blood pressure has given me back my independence by allowing me to manage my own condition as I dont have to keep going back and forwards to my GP. Since I started monitoring myself I have not needed to go into hospital for staff there to monitor my vital signs. It has also made me more aware of the difference between a normal reading and one which is too high".

"Knowing that my nurse is monitoring my condition on a daily basis now gives me peace of mind and makes me feel more in control of my health. It reassures me to know that I can contact my nurse about my condition without having to leave the house and if necessary my nurse will come out to my house to see me".

"Using the equipment is easy and I don't think anyone would find it hard to use as there is no technical knowledge required to use the equipment".

h. Provision of equipment to help people remain independent

Equipment services are now very responsive to need but we recognise that some relatives and carers prefer to collect equipment themselves. To facilitate this we are opening our facilities for collection of prescribed smaller items of equipment. We are exploring ways to develop this further through the introduction of a retail model where people will receive an equipment prescription and collect the items from local suppliers even nearer to home, improving timely access and providing further choice.

i. Palliative and end of life care services

The Regional Palliative and End of Life Care Strategy calls for less people to die in hospital and we will work in an integrated way to maintain care at the end of life close to home. We plan to network services around GP practices. Community nurses and GPs will act as keyworkers to co-ordinate care for those people on patient care registers.

j. Long term conditions

People with long term conditions historically receive a lot of care from acute hospitals. We will develop better ways to keep these people at home through working with GPs to create new long term conditions care pathways. These pathways will identify those at risk of admission to hospital so that we can provide them with the support, information and education to better manage their own conditions.

k. Intermediate care

Our Intermediate Care Service promotes faster recovery from illness at home, supports earlier discharge from hospital, avoids the need for long-term care and helps maintain independence. A stay in hospital because of illness is a significant event in anyone's life but for older people it can be life changing. When a stay in hospital is necessary it is important to get people back

home as soon as possible in order to minimise disruption to patients and their families. Once medically fit patients no longer need to stay in an acute hospital environment but some older people need additional support, rehabilitation and confidence building for no more than a few weeks.

Most people will return directly home with the support of the Integrated Rehabilitation and Stroke Services Team who provide a time limited period of on-going assessment and treatment. In recent years there has been additional investment in these teams to support people who have had illnesses such as strokes so they can continue their rehabilitation at home. People who have had fractures are cared for at home after their surgery by these teams or in a nursing or residential home. We call this 'intermediate care'.

l. Community hospitals beds

We acknowledge that community hospitals can make a vital contribution to the future of health care in the Northern area, when they are operated efficiently and effectively.

A community hospital bed is for a person who is medically stable and has a specific nursing, medical or therapeutic need. This is usually in the form of rehabilitation, helping many people to return home or avoid them being admitted to an acute hospital. End of life care is also provided in these settings, providing pain and symptom control and supporting other end of life care needs and preferences.

We believe these local community hospitals can make a real contribution to the health and wellbeing of local people. The development of community hospitals relies on strong local partnerships and community support. Community hospitals allow Antrim and Causeway hospitals to focus on patients who require specialist secondary care and ease the pressure on beds, clinics and emergency services. It is recognised that some people treated in acute hospital beds can be cared for equally well in a small hospital nearer their homes.

Inver in Larne, Robinson Memorial in Ballymoney and Dalriada in Ballycastle (alongside other community hospitals to be developed), will continue to be a significant component of the new architecture for the Trust. They will enable GPs to extend their practice in primary care and incorporate a range of community beds that integrate with rehabilitation and social care services.

We will work with GPs, local and regional Commissioners and other stakeholders in determining the future development of further community hospitals, giving consideration to how they will fit within regional plans for health and care centres and plans to deliver more services in community settings.

m. Making it easier to get in touch

People have told us how difficult it is to talk to the right person in the Trust. We plan to develop a contact centre that will provide one point of contact for people who need to contact us about their health and social care. The contact centre will also be able to deal with straight forward queries, direct people to other appropriate services or identify the right professional staff that need to get involved.

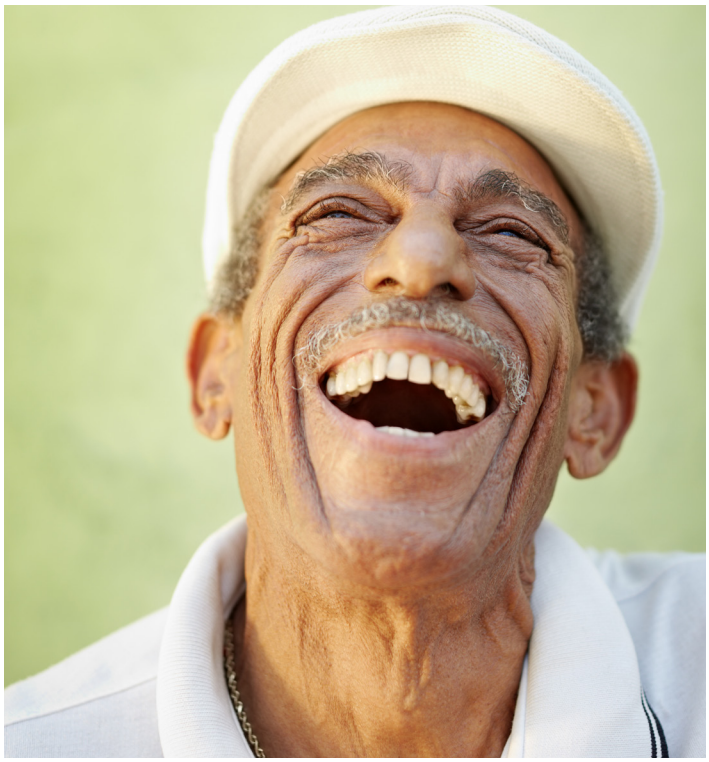
n. Effective governance

Good governance is achieved through developing services that are safe and effective and by creating a culture and willingness to learn and improve. We will continue to engage effectively, both within the organisation and with external stakeholders, as well as listening to and acting on user experience.

We will work 'hand in glove' with GP colleagues to manage and develop our services and to ensure the quality of our shared services.

Practical approaches to better governance will include the development of an electronic system

for domiciliary care. This system is designed to add protection to lone workers in the community and to highlight service failures when visits do not take place during scheduled times, allowing a timely response to unmet need. This approach will be piloted in the coming months. We will also continue to make sure that people who have their care provided by the independent sector will have it monitored and reviewed by Trust staff.



4. Improved outcomes for users

We envisage that the transformation of older people's services will result in the following benefits for service users.

- More older people will be supported to live independently and in their own homes for as long as possible
- Alternative care and support pathways will be developed, with a new emphasis on promotion of healthy ageing and support for carers
- Improved levels of user engagement and improved satisfaction through more personalised care
- Improved access and information for all service users through the introduction of the contact centre and directory of services
- Increased access to assistive technology and widening the access of this technology to service users
- Maximisation of resources through efficiency and better value for money.

Northern Health
and Social Care Trust