May 2000

Shaping the future NHS: Long term planning for hospitals and related services

Response to the Consultation Document on the findings of the National Beds Inquiry from the Joseph Rowntree Foundation

1. *How can we best contain inappropriate emergency hospital admission rates, particularly for older people?*

The Consultation Document points out that 60% of all ordinary (overnight) admissions are now emergencies. What is not known is what proportion of these are `inappropriate' - or how that term is defined. It may also be the case that an admission which is deemed to be `inappropriate' by medical or nursing staff is felt to be appropriate and necessary by anxious patients and their carers, because other services are not available. We are not aware of any studies of the circumstances of people admitted to hospital. But a report commissioned by the Anchor Housing Trust provided evidence that some acute short-term crises, such as illness, resulting in older people moving to residential care cold be avoided by increasing levels of appropriately targeted community based support. (Anchor Trust, *what older people want: a manifesto on long-term care for independence and security in later life,*1996). it is therefore likely that some older people are admitted to hospital because the situation at home has deteriorated, relatively quickly, to the point beyond which they can be maintained at home. A more effective capacity for picking up on short-term crises could prevent this situation occurring.

One way of identifying people likely to have crises is through risk assessment. Going through a process, for example, using the Minimum Data Set/Resident Assessment Instrument or the Home Care version for people living at home can identify those people whose medical, mental or social conditions may indicate an increased risk of emergency hospital admission. By identifying the risk and putting in place preventative measures, many of which are low cost, the rate of such hospital admissions may be reduced.

2. *What scope is there to use alternatives to emergency admissions while securing as good outcomes as hospital-based care? What are the obstacles to such a move?*

A focus on preventing a situation arising where emergency admissions are necessary (eg preventing fractures following falls; better monitoring of people at risk) is a more plausible strategy than diverting emergency admissions elsewhere. The Foundation has not itself done any work on possible ways of diverting people from emergency admissions. We do know of some schemes, but these are no doubt familiar to the Department of Health. For example, the `Whole system' approach in North West Surrey where the Bournewood Community Health Trust is seeking to deliver significant improvements in the care of older people. This

apparently includes a Rapid Response Integrated Care Service which provides GPs with flexible options for avoiding hospital admission and enables quick discharge from A & E departments. This is partly based on domiciliary support but also on care in community hospitals. There are also services such as the South and East Belfast Trust's Intensive Home Care scheme, which is able to successfully offer an alternative to hospital for frail, functionally dependent individuals on the threshold of nursing home/long term continuing care. But we do not know if the scheme responds to emergency situations.

3. *In elective care, what scope is there for the further transfer of in-patient cases to day cases or ambulatory care? What are the obstacles to this?*

The JRF has no information on this.

4. *What measures would most improve the ability of the NHS to respond to peaks and troughs in demand over the year?*

The JRF has no information on this.

5, *Is there further scope to reduce the average length of hospital stay by improving the organisation of care, the impact of new diagnostics, therapies and anaesthetics, pre-assessment, the use of care pathways or other changes?*

Work that the Foundation has funded suggests that better provision of care in the community can lead to the successful discharge of older people from hospital. The Darlington project - one of 28 pilot projects funded by the then DHSS under its Care in the Community Initiative in the late 1980s - was evaluated with funding from the Foundation. This project introduced the concept of the generic *home care assistant* whose role was to provide all the personal care and domestic help that an older person needed, in a flexible and responsive way. The home care assistants were managed by a care manager who had responsibility for an average of 15-18 clients (and around 18 part-time home care assistants). The results of the work are discussed in David Challis et al, *Care management and health care for older people*, Arena 1995. The team found that vulnerable elderly people who had been in acute and long-stay wards in hospital were enabled to return home and be supported there. Overall greater benefits were obtained by the older people and their carers for the same or a slightly lower cost.

Unfortunately one of the key components that made this scheme successful - the pivotal role of the *care manager* - was lost when this pilot project was taken over by mainstream services. There are other schemes currently being developed, such as the Augmented Care at Home developments in Ayrshire and the pilots under the Public Service Productivity Panel, which are aiming to provide holistic and flexible care to older people in the community. But the main

focus of these schemes is to maintain people at home and prevent inappropriate admissions to residential and nursing homes.

In relation to another client group - young people who use assisted ventilation - the evidence suggests that to reduce their hospital stay requires a focus on care provision, not on new therapies and diagnostics. A study by Jane Noyes, *Voices and choices: young people who use assisted ventilation*, Stationery Office 1999 (and JRF Findings 969 September 1999) found that young people had spent prolonged periods of time in hospital when they no longer had a medical need or wanted to be there. The young people and their parents found the system of discharging young people from hospital was disorganised and inefficient. Care packages, when they were set up, varied widely and were not based on individual need.

6. *Are there good reasons for the large variations between Health Authorities in the patterns of service delivery?*

The JRF has no information on this.

7. *Do areas with higher and lower levels of bed availability deliver significantly different outcomes?*

The JRF has no information on this.

8. *What proportion of patients currently treated in acute hospital beds can and should be safely and cost-effectively managed and rehabilitated in other settings? What are the obstacles?*

The JRF has no information on this.

9. *Do the three scenarios identified for the future development of services for older people cover the main service options? Are these scenarios equally relevant to other patient groups?*

A fourth possible scenario would be an extension of the `care closer to home' option. The implication of this situation is considered to be an active policy to build up *intermediate care* services. It may simply be a matter of terminology, but at alternative approach would be to focus all attention on improving the care provided *in the community*. It is clear that almost everyone would prefer to be at home rather than hospital - provided appropriate support and care is available. `Intermediate' care, in terms of provision on the boundary between the community and the hospital might not be needed if we seriously invested in preventive work and the provision of services to people living in their own homes.

The need to focus on improving services to people in the community, to prevent admissions to

hospital and speed discharge, applies to all patient groups.

10. *What balance of hospital and other services would be most effective and cost-effective in achieving the Government's service objectives for older people?*

The Foundation is not in a position to know what the most effective and cost-effective balance between hospital and other services would be. What is very clear to us both from our research and our experience as a care provider is that the provision of domiciliary care and of residential and nursing homes is considerably underfunded at present. More investment in services outside hospital - for example, adequate funding to the private and independent sector to enable them to invest in residential and nursing home provision for people with dementia - would facilitate the earlier discharge from hospital for this group of older people. Properly resourced, many nursing homes would be able to provide the *intermediate care* envisaged in the consultation paper. But there is currently a shortage of beds in nursing homes in some areas so expecting current provision to meet these additional demands would not be realistic.

11. *What steps should the NHS and partner agencies take in the short, medium and longer term to bring about the scenarios?*

12. *Are the service assumptions used to illustrate each future scenario realistic? Do the resulting projections capture the most probably service futures?*

a. The measures that need to be taken include action by the Government to significantly increase the funds available for care provision, particularly of domiciliary care. The JRF's *Inquiry into Meeting the Costs of Continuing Care* (Joseph Rowntree Foundation 1996) proposed that more funds should be raised - through a new compulsory social insurance scheme - which was clearly linked to an entitlement to an agreed minimum level of good quality care. The significance of these recommendations were that the Inquiry concluded that there needed to be a **new contract** between the state and the individual, with the state committing itself to providing good quality care in exchange for more money being taken, over their lifetime, from individuals. The alternative is to fund increased services from general taxation, as proposed by the Royal Commission. The JTF Inquiry felt that a new contract would be more likely to deliver this extra funding over the medium to long term.

b. The current arrangement where health care is free at the point of delivery and social care is means-tested is a major disincentive for people needing care who have a choice as to where they receive it. In a situation of scare funds it also means that service providers seek to shunt costs elsewhere, rather than concentrating on providing a good, patient-oriented, service themselves.

c. Evidence suggests that the objectives for Care in the Community outlined in the 1989 `Caring for People' White Paper and the 1990 NHS and Community Care Act have not be achieved. The way in which the purchaser-provider split has developed in practice has resulted in inflexible, task-oriented services which do not involve service users in decisions. There needs to be a return to the provision of services which are flexible and person-centred, not provider led. The Darlington project provided one model which could usefully be reintroduced. Increased funds would also mean that services could be provided to older people with a need for low intensity services rather than being targetted solely at those with very high support needs.

d. In the context of flexible, person-centred services, there is a need to return to the original idea of the generic home care assistant - who meets the needs of individuals rather than simply carrying out specific tasks. The Australian Community Aged Care Packages have pursued the Darlington model and these arrangements are working well.

e. We need better financial support for residential and nursing homes.

The Government's recent announcement that 'bed blocking' could be relieved by transferring older people to private and voluntary residential and nursing homes for rehabilitation and recuperation could not happen without additional resources. At present time there is a shortfall of up to £100 per week between the fee offered by statutory services and the actual costs of the placement in care and nursing homes. The costs of good rehabilitation would have to exceed the normal care home fees for such a programme to succeed. But this would be a good investment. There are well established models, notably the Outlands project in Devon, that have shown that properly funded rehabilitation can drastically reduce not only the numbers of elderly people in acute hospital settings but also the numbers of people transferred permanently to long-stay residential or nursing care.

f. We need to look again at the process of assessment which needs to encompass health and housing dimensions to be truly multi-disciplinary.

13. *What are likely to be the key workforce implications of the scenarios? In particular, what scope is there fore using new types of worker, in what key staff groups might there be barriers or shortages and how might these best be tackled?*

There is an acute shortage of nurses working in the residential and nursing home sector. In the community, many nursing tasks, such as taking blood pressure, dressing open wounds, stoma care and tube feeding, are now being carried out by care workers who have no nursing training. At present there are serious concerns that some of those carrying out these `nursing' tasks are not properly trained or supervision. The Foundation has developed the JRF

Certificate in Care which attempts to fill some of these gaps

The JRF Certificate in Care sets out to give care workers critical enabling knowledge, based on sound academic principles, to fill the skill mix gap. Whilst not attempting another layer of nurse education it does enable workers and their supervisors to take on extra roles. The course covers essential areas of social policy, psychology of caring and human development alongside options of: caring for older people, people with learning disabilities, healthcare and home care. The approach works not only for residential and nursing settings but also for community based care; caring for other vulnerable groups such as those with mental health problems; and young people in institutional settings such as boarding schools.

The JRF Certificate has been accredited by four English Universities and has attracted students from all sectors of the care industry - statutory, voluntary and private. In 2001 it is expected that the course will gain even wider national coverage when it is offered by the National Extension College.

There are indications from a number of studies and from the Foundation's own experience that some of the shortages of care assistants that are developing are due to problems of morale. One of the negative consequences of the current model of service provision which is based on short task-related visits is that the work becomes very unrewarding and unsatisfying for care workers and their managers. This problem could be addressed by the `job enrichment' which would flow from a return to the Darlington model.

14. *What are the other issues that will need to be addressed to achieve the changes envisaged in the scenarios?*

The key issue is the better funding of care services in the community.

15. *Given the uncertain future, how do we ensure that the NHS retains as much flexibility as possible?*

Community-based services have to be well organised and well resourced.

16. *What should be the priorities for further research on the optimal balance of care for all population groups?*

Studies which could demonstrate effectiveness and cost-effectiveness of services require careful quantitative work over a period of time. Adequate samples and a longitudinal approach lead to expensive pieces of research - generally beyond the resources of the Joseph Rowntree Foundation. These kinds of studies should be a priority for the Department.