



Services for Older People

A whole systems approach to structuring services for older people that allows partner agencies to fundamentally align services around now ahead of further political reform.

The coming storm

It is increasingly obvious that the UK can no longer afford to run services for older people separately in the NHS and local government and with separate care models.

The UK economy is emerging from the deepest recession in peacetime years, the size of the public service economy is arguably unsustainable and the demographic clock is ticking. Typically with current patterns of care, each local health and social care community will need an additional hospital ward for older people every 4 years. Public service budgets face their most difficult squeeze for a generation. The circle cannot be squared with today's thinking.

Over a decade of unparalleled growth and investment in public services has failed to address the fault line established in 1948 between health and social care. Arguably the growth has helped both the NHS and local government to put off the fateful day when the inevitable question about their continuing separation has to be addressed seriously. In the meantime each has grown with its own language and culture, to the point where health and social care staff now commonly use the same words to mean different things, adding to the confusion. It's not their fault. Get them in the same room and they want the same things for their clients and patients. The confusion is a function of the system.

The classic political response will be to reorganise and/or reassign responsibilities between health and social care after the general election. Experience tends to suggest the realignment will also happen during a period when SHAs and PCTs are sent into a tailspin of organisational change within the NHS. What's new? Corporate memory and knowledge will be lost yet again in expensive restructuring.

Meanwhile local authorities will press on with personalisation, and more and more citizens and their carers will exercise freedom of choice to secure their own care packages. In a recent workshop we ran for practitioners in health and social care, however, a simple show of hands amongst NHS staff demonstrated less than 10% of them knew what their Social Care colleagues meant by "personalisation". One of the most fundamental policy levers for change in social care was a mystery to their NHS colleagues on the front line. It wasn't that they didn't want to know-the fact they were in the same room for a half-day showed great local insight to the need to work closer together-they just said it was hard enough keeping up with the changing policy agenda in the NHS! Ironically, while policy has Local Authorities driving more actively the Total Place agenda, on the ground the systems fault-line between health and social care is at risk of getting even wider.



Faced with this scenario the temptation may be to sit tight and wait until the general election plays out and the new political architecture and solutions for the NHS and local government are actually in place. Regardless of the speed with which bills are passed in the new Parliament, we all know it will take at least two or three years before the new arrangements start to settle. Meanwhile the economic storm in public services is crashing all around and by the time the new arrangements settle the economic hole will be deeper simply because the NHS/local government fault line in health and social care is still intact.

The truth is that NHS and local government leaders all know they can't wait that long. The challenge is to find alternative ways of working together within existing legislative frameworks.

Towards a solution

We would like to suggest a potential solution. It is not built just on theory, but on our experience of working with health and social care economies over the last two years looking at some of their "wicked problems", and also at some great examples of breakthrough thinking in local situations. Among many others, we have seen excellent examples of joint work in Virtual Wards, Intermediate Care, Active Case Management, Health Improvement Teams, Transforming Community Services and radical approaches to the delivery of General Practice in primary care. We have worked with commissioners and providers in both the NHS and in Local Authorities. We genuinely believe this is something NHS and local government leaders can do today to start building tomorrow.

The first step is to look for the things that won't change; the irreducible constants in the equation.

Starting with individual people, we have a hierarchy of family, neighbourhoods, communities, and places (villages/towns/cities). These social structures are relatively stable, albeit the experience of individuals will vary. In health care we have a relatively stable infrastructure of GP practices, which of course are small to medium size businesses in their own right, around which community health and some social services tend to cluster.

The instability in the system comes in the shape of the ever-changing landscape of public service organisations. Over the past 35 years we have had, in the NHS alone, structures involving:

- Regional health authorities/Area Health Authorities/Health Districts/Sectors and Units of management
- Regional health authorities/District Health Authorities/ units of management
- Regional Health Authorities/District Health Authorities/NHS Trusts/GP fundholders
- Regional offices/District Health Authorities/Primary Care Groups/NHS Trusts
- Strategic Health Authorities (28)/Primary Care Trusts/NHS Trusts
- Strategic Health Authorities (10)/Primary Care Trusts/Foundation Trusts/NHS Trusts/practice based commissioners

Is it any wonder the complex and messy problems don't get resolved when the landscape changes so often?



We think the long-term solution to the older people services fault-line lies in starting with the individual as a citizen.

If we think about the individual – and their family and informal carers- and the "significant events" they experience in terms of health and social care we believe a relatively simple model can be built to describe a conceptual health and care pathway for older people that captures the key points where professional intervention, from either health or social care, may be required.

What do we mean by "significant event"? It is the time when a change occurs, a new creation, transformation or inspiration, leading to a new state of being or a new identity. Think of the conversion of dough to bread, or crude oil to fuel. In terms of social care, think of the conversion from 'unsafe to safe' or from 'disabled to independent'. In terms of health care, think of the conversion from 'undiagnosed to diagnosed illness', or from 'diseased to healed'.

The Health and Care Pathway

We suggest there are six high-level generic significant events on the health and care pathway for older people, around which services can be organised from all agencies. We have assigned a pathway stage to each of these, starting with the equilibrium of stable or improving health:

- Stage 0 = Equilibrium (stable or improving health) in the normal place of residence. For older people the normal place of residence may be
 - At home (own or family)
 - In sheltered/supported/extra care housing
 - Care Home (either Residential or Nursing Home)
- Stage 1 = Presentation & assessment.
- Stage 2 = Diagnosis (Health)/ Needs identification (Social Care)
- Stage 3 = Treatment (Health)/ Care planning and delivery(Social Care)
- Stage 4 = Return to equilibrium through rehabilitation or reablement (note that equilibrium after stage 4 may be at a different level to that which led to presentation)
- Stage 5 = Palliate (end of life care)

The stages are not necessarily sequential. For example effective intervention at stage 4 should ideally lead to a resumption of stage 0 equilibrium. Good re-ablement, Intermediate Care and rehabilitation services aim to achieve precisely this. In cases of end of life care, stage 1 presentation might lead directly to stage 5 - palliation. Indeed in cases of end of life care intervention at stages 3 and 4 might well be completely inappropriate for the individual and their family where the odds of a successful outcome are highly unlikely. Just think how many unnecessarily distressing deaths could be avoided in ambulances and A&E departments if we could get this stage of end of life care right.

Where stage 4 interventions have been either ineffective or absent following treatment or care delivery, repeat presentation at stage 1 is not uncommon in the elderly, leading to repeat diagnoses/needs identification and treatments/care planning and delivery at stages 2 and 3. The revolving door syndrome in health and social care can often be tracked back to inadequate intervention at stage 4. Effective case management in the community & primary care setting, across



stages 0-3 for people with long term conditions and increasing frailty is an emerging and increasingly beneficial response for such cases.

Note that the stages are structured around the experience of the individual older person and not around the experience of the professional or provider of care.

Complexity is added by the fact that each of these stages can be delivered in a wide variety of different settings, as outlined in the table below:

Significant events	Equilibrium - normal place of residence	Presentation & assessment of condition	Diagnosis/Needs identification	Treatment/ Care Planning	Return to Equilibrium [Rehab & reablement]	Palliate
Stage	0	1	2	3	4	5
Home						
Supported housing						
Care Home						
Primary Care setting						
Intermediate Care setting						
Hospital - ambulatory Care						
Hospital - in-patient care						

The ideal of course is to keep people at stage 0 in a way that both enhances their quality of life, but also proves to be less resource consuming¹.

Resources in both health and social care are increasingly being targeted at stage 0, but not necessarily in a co-ordinated way between local government and the NHS. This is not just a matter of partnership between health and social care, but also brings into play local authority functions in areas like housing, leisure and education for older people, as well as agencies such as housing associations and the police. And of course there are the often underutilised resources of the

¹ The 29 local authority led Partnerships for Older People projects (POPPs) pilot schemes for example, showed that in projects concentrating on secondary and tertiary prevention, for every extra pound spent, there will be at least the return of that one pound in emergency bed-days. The headlines estimate saving is £1.40, with the range between £1 and £1.90. **Windle et al, The National Evaluation of POPPs, PSSRU, University of Kent 2010.**



voluntary and faith sectors – especially when considering that underlying the ‘tipping point’ for many older people leaving ‘stage 0 - equilibrium’ is the issue of social exclusion and isolation.

Each of the agencies knows the prevention agenda to be best from their own perspective in terms of quality of life and resource utilisation, and each will doubtless sign up to Local Area Agreements to improve partnership working without any difficulty. What is often lacking is a conceptual delivery framework to help make the partnership working tangible.

Many local health and social care systems currently ‘default to acute hospitals’ at stage 1. This is not always the best option for older people and their families – nor the best use of the system’s resources. This need not be the case but does require a well thought through, resilient and connected set of services aligned and built around everyday primary care and community services – supporting people at stage 0. A key challenge for GP Practice Based Commissioners and community health service leaders is to think through how they can design and develop their services to meet the challenge of resetting this acute default.

Our whole system model can allow the various agencies to identify the resources and services they dedicate to each of the pathway stages and settings, and build on that to provide a co-ordinated set of services designed around the individual older person. Within each stage there will be complex process and systems issues to be resolved, all of which is possible using whole systems lean techniques.

Leadership of the system

Issues will emerge around leadership of the system at each pathway stage and how resources are both invested and saved. A problem about whole systems is that the benefits do not necessarily accrue to the party making the investment, and therefore strong governance in partnership arrangements need to be agreed at the outset if this model is to be utilised in multiagency working, particularly around financial flows.

Adopting this pathway approach doesn't need to wait for political solutions. It can be done within existing legislation and organisational frameworks. Where local partners want to retain control over their own resources and delivery mechanisms, they can agree governance arrangements to allow them to work on the pathway in partnership. Where local partnerships are more advanced and they want to pool their commissioning resources they have ready mechanisms in section 75 arrangements for resource pooling between the NHS and local government. Where they want to integrate the delivery vehicle the Care Trust governance arrangement is available. We don't need to wait for political solutions at a national level.

Command and control models of leadership will simply not be appropriate to lead the system. Collaborative and distributed leadership approaches will be necessary, requiring significant levels of emotional and social intelligence from leaders in each agency. But that’s a whole subject in its own right, and not for this paper.



Benefits

Field testing in health and social care communities has identified a number of potential benefits. The pathway;

- enables managers and professionals to use a common language and high-level conceptual structure
- structures professional responses around person-centred needs
- enables professionals to think differently about where they deliver their interventions
- focuses and coordinates Partnership services around Stage 0 to optimise independence and well-being
- helps plan capacity and capability to optimise Stage 0 equilibrium
- helps locate and understand the contributions and aims of each service on the pathway (e.g. Long Terms Conditions Case Management is primarily designed to sustain Stage 0 equilibrium for those at greatest risk of constant Stage 1 presentations and crisis interventions)
- Helps audit the extent to which services fulfil the right pathway stages.
- Identifies capacity gaps and bottle-necks on the pathway
- Assists in reviewing capacity and capability along the whole pathway
- Assists in review responsiveness to patient/client need along the whole pathway

Conclusion

The challenge for older people services into the future is both complex and messy. The answer is not in a slash and burn approach to budgets in individual organisations or in returning to the "one size fits all" cheap and cheerful approach to health and social care provision. The health and care pathway presents a relatively simple conceptual framework to allow partner agencies to work together with the service recipient genuinely at the centre.

Let's not leave it to our children to sort this lot out. It does not require organisational change; it just requires a change in organisational thinking.

Let's be kind to our children-after all they will choose our care homes!

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