

ADASS Eastern region

Investing in prevention for older people at the health and social care interface

September 2011

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Report

1 Introduction

This paper is based on a presentation delivered to the Eastern Region group of the Association of Directors of Adult Social Care (ADASS) in August 2011 by Prof. Andrew Kerslake of the Institute of Public Care (IPC). The brief was to look at key issues around the health and social care interface and how a financial model could be developed that would stimulate improved performance. The paper is designed to support and encourage a new approach to commissioning and configuring an integrated approach to service provision that straddles health and care. It comprises five sections:

- Assessing the impact of changing demand.
- How might we begin to think about reducing demand for health and care services?
- Does prevention work at the health and social care interface?
- Developing an investment based approach to reducing demand.
- An example of an investment based model.

2 Changing demand

Like all parts of England, the Eastern region is about to experience considerable demographic change. Over the next twenty years the population aged 80 and over is estimated to grow by 100% from just under 300,000 to around 580,00¹. At the same time there is also likely to be a rise in the number of people with a moderate to severe learning disability from around 22,000 to 26,000². However, not all of that increase will translate into demand for state funded social care. The relationship of demographics to demand is complex, particularly with regard to older people. For example, some of the variables that will influence future demand include:

¹ POPPI

² *ibid*

Wealth: In twenty years time nearly 80% of the population aged 65 and over are likely to be owner occupiers³. Occupational pensions have become an increasingly significant source of income with one-fifth of average gross incomes for single pensioners and over one-quarter of average gross incomes for pensioner couples coming from this source⁴. Take up of learning disability provision will also be influenced in older age by the capacity of people to inherit wealth from their parents. Finally, demand for state funded social care provision will be influenced by the government's response to the Dilnot commission.

Consumer expectations: If the potential benefits of services are poorly understood, hard to access, perform poorly or are seen as highly pressurised, this will influence demand. For example a number of reports regarding continence and older people hypothesise why more people don't come forward for treatment. Part of the explanation is about aging and expectations. If you believe your condition is simply down to being old (and hence irreversible) you are less likely to present for treatment even though you may have a condition that is perfectly treatable. Is the desire of many older peoples to remain in their traditional family home a reluctance to accept aging, familiarity, a desire to maintain their equity or a lack of alternatives or a combination of all four.

Interconnectivity: Health and care services not only respond to demand but also influence it. For example, poor performance in relationship to stroke recovery by the health service increases the demand for social care, whilst equally the quality of home care may well influence demand for community health services. For both health and care services demand is affected by the housing in which older people live. Poor quality housing can drive increased demand in respect of COPD, housing with trip hazards can increase the potentiality of falls and fractures amongst older people. New accessible housing into which health and care services can be easily delivered reduces the need for acute provision in both health and care services.

Health improvements: It is reasonably well chronicled that improvements in health have been a major influence on increased longevity. However, whilst new treatments may diminish demand for services by improving wellbeing (such as drugs that better help people manage dementia), other health interventions may increase demand through diminishing mortality but not morbidity, eg, survival from stroke may be greater given an increase in the use of thrombolysis but may increase the number of people with a disability.

³ Ibid

⁴ Pension Trends: Chapter 11: Pensioner income and expenditure, ONS, Sept 2010

Social care interventions: Availability and access to services influences demand. If services are not advertised or are hard to access, then demand will appear to go down. However if a particular intervention is encouraged at the expense of another then demand may appear to increase. For example, the use of state funded residential care has not increased in line with population growth. This reason may be based on a series of interconnecting factors such as the availability of a wider range of alternatives or local authorities encouraging people to take up other interventions or more effective gate keeping of access to an expensive resource. If home care staff tell people that getting home care is becoming increasingly difficult and perform their tasks 'at a gallop', people may be disinclined to ask for more support and may also cling onto their existing care hours even when they might not need so much help.

Therefore, simply extrapolating population increases is unlikely to provide an accurate forecast of the demand. What is clear is that notwithstanding alternative interventions, changing expectations and better health treatments being available, the restrictions on public funding combined with the very large increases in population within the region will almost inevitably put pressure on all services, and particularly on those that are universally available. Consequently there is a need to explore how demand might be changed, diverted or managed better and more cheaply but in particular, how demand at the health and care interface can be reduced – which is the subject of the rest of this paper.

3 Reducing demand

There has been much confusion in recent years about the activities needed to reduce demand, partly driven by loose terminology, eg, early intervention, prevention, and low level provision, have been used as if they mean the same thing. The consequence of this has been a lack of clarity over what exactly any particular intervention is supposed to achieve. For example; is non-intensive service provision by the voluntary sector also supposed to be preventative, does early intervention actually move people onto an accelerating pathway of care / support rather than increase peoples independence, how can services for carers caring for more than 50 hours a week be described as low level provision.

Underpinning this lack of clarity has been the lack of a relationship between funding and outcomes. There are three particular issues. Because funding may be distributed by a wide variety of organisations or departments individual sums may look small but the total expenditure may be large. Equally, if there are many funders there is little co-ordination between them and a lack of an agreed focus on the results to be achieved. Finally, the basis on which money changes hands can be on widely varying terms and conditions, from gifts to loans, to grants to contracts.

Much of what has been described as prevention has also either not used the evidence available to design preventative approaches or has not delivered replicable results. For example the Department of Health's three year Partnerships for Older People Programme, whilst initially reporting success⁵ has subsequently been shown not to have delivered the health benefits it was strongly suggested could be achieved⁶.

Finally, there has often been an assumption in public care that prevention is an 'add on' or an 'additional service'. Consequently, developing preventative services can often be seen to increase costs rather than diminish them and that they run alongside the interventions they are supposed to replace. As a result preventative interventions constantly get developed as pilots or experiments rather than as main stream provision.

The contention of this paper is that if demand is to be reduced it is has to be through interventions integrated at the point of delivery, be targeted and evidence based, tackle performance where that is an issue and change the basis on which the funding of prevention is made.

4 Focussing Prevention

In 2008 /09 the IPC together with Oxfordshire County Council engaged in a programme of background research exploring how preventative provision could best be targeted. The research involved a quantitative analysis of files and a set of interviews of those admitted to care homes. In total there were 115 cases reviewed by a file audit and 21 interviews conducted with older people who had been admitted to a care home. Some of this work has since been replicated with other authorities with similar results.

Table 1. Characteristics and conditions commonly found amongst older people admitted to care homes

Predominant characteristics of the population prior to care home entry	Personal Conditions	Exacerbating factors to the personal conditions
Over 85	Falls	Had one fall already requiring a health care intervention.

⁵ National Evaluation of Partnerships for Older People Projects Final Report, PSSRU, 2009

⁶ An evaluation of the impact of community-based interventions on hospital use: A case study of eight Partnership for Older People Projects (POPP), Adam Steventon, Martin Bardsley, John Billings, Theo Georghiou and Geraint Lewis, Nuffield Trust, 2011.

Predominant characteristics of the population prior to care home entry	Personal Conditions	Exacerbating factors to the personal conditions
Female	Has dementia. May / may not involve care from another person	Carer elderly. Carer with own health problems.
Limited social engagement	Stroke	Had one stroke or TIA. Limited rehabilitative input. Motivated to make full recovery.
Lives alone	Incontinence	Continence problem undetected. Continence problem managed rather than treated.

Key characteristics identified amongst care home populations were the proportion of older women (71%), who live alone (64%), aged 85 and over (58%), with difficulty in walking (56%), urinary incontinence (45%), bowel incontinence (34%), dementia (40%), experiencing a fall in the last 12 months (41%) and admitted from hospital (61%).

Although not evident from the file audit, the impression gained from the number of people living alone was that social isolation and depression were underlying conditions influencing progression along the pathway to care. Also inappropriate or inaccessible housing, although not recorded systematically enough to be quantified, also looked to be an influence in the decision to enter a care home. Overall there was a history of health and social characteristics of the population constantly intertwining, illustrating that to be successful any intervention aimed at preventing care home admission needs to combine health and care components.

In many cases deteriorating health and well-being had begun with a stroke or bereavement of a partner. In those cases, where the older person did not have a dementia, falls and incontinence or urinary tract infections were recurring themes. Initially stroke looked to be less common from the file audit although the interviews revealed this as an unrecorded factor which had often occurred earlier along some people's care pathway.

In terms of preventative service provision, 84% of those admitted were already known to social care and receiving a service. However, 50% were

not getting an intensive care package. These trends were confirmed by the interviews. There was a surprisingly limited take-up of intermediate care and telecare recorded. Although the falls service was mentioned by a few interviewees, there was no mention of the continence service.

A high proportion of admissions were from hospital. This may reflect the greater frailty of people going into care homes, or may reflect discharge practices, or some other factor in operation. For example, 73% of people living alone were admitted from hospital compared with 46% of those living with others.

In the two areas from which the samples were drawn (one urban and one very rural) there were variations in practice suggesting both differences in the application of eligibility criteria, the services available and differences in the economic wealth of the populations.

In addition to conducting the audits and interviews the most significant characteristics surrounding admissions to care were subject to a literature review. These reviews looked at three things: Was there potential to lessen the impact of these characteristics through improved practice, was there evidence of a link between the characteristics identified in the research and care home / repeat hospital, admissions, and were there proven approaches that could lessen the likelihood of these outcomes? Since the initial project the literature reviews have been updated and can be summarised as follows:

5 Providing the evidence for change

Continence⁷

The great majority of continence services are poorly integrated across acute, medical, surgical, primary, care home and community settings. “Although 55-80% of services report themselves as integrated across healthcare settings, only four services across the country fulfill all of the requirements set out in the DH guide “Good Practice in Continence Services”.

There has been a gradual upward trend in the documentation of the likely cause or type of urinary tract infection. However, a third of people still have no diagnosis written down.

The majority of policies regarding the provision of containment products, eg, pads, include a statement that provision is according to clinical need. However, 66% of primary care sites impose a limit on provision of 4 or less pads per day.

⁷ Taken from Royal College of Physicians Report on Continence Care 2010

Quality of care (assessment, diagnosis and treatment) is worse in older people, but people of all ages, and vulnerable groups in particular (frail older people, younger people with learning disability) continue to suffer unnecessarily and often in silence, with a 'life sentence' of bladder and/or bowel incontinence.

Stroke⁸

In England, fewer than 40% of trusts are achieving the minimum standard on stroke care. Even the best region is only just over half and the worst, East of England, only 29% of trusts achieved the required standard.

The national standard is to admit all patients to stroke units. However, "Almost half of hospitals report the need to admit patients to non-specialist beds. On the day of the (RCP) audit 36% of patients who were in one of these beds had been there for more than 24 hours".

More than 1 in 10 units that provide stroke care for patients beyond 72 hours exclude patients on the basis of 'no rehabilitation potential'. "It is impossible to judge whether a patient has 'rehabilitation potential' at such an early stage and policies to exclude stroke patients from a stroke unit are indefensible".

Less than a third of hyperacute units have specialist stroke ward rounds 7 days a week.

Only a third of stroke units meet all five of the basic criteria used in the SUTC (Stroke Unit Trialists' Collaboration) key characteristics to define quality. "All services should be striving for excellence. Few can be said to have achieved it."

Dementia⁹

Over a third of people with dementia who go into hospital from their own homes are discharged to a care home setting.

Just 19% of hospitals had a system to ensure ward staff were aware that a person had dementia and how it affected them. Although it was policy in 96% of the hospitals that all patients with dementia have an assessment made of their nutritional status, the audit found that this did not happen for 30% of the patients. 69% of hospitals were not able to identify people with dementia within reported information on in-hospital falls and their causes.

⁸ Based on National Sentinel Stroke Organisational Audit, Royal College of Physicians, 2010 and Supporting Life After Stroke – A review of Services for people who have had a stroke and their carers, Care Quality Commission, 2011

⁹ Based on; Counting the cost: Caring for people with dementia on hospital wards, Alzheimers Society 2009, Improving services and support for people with dementia, National Audit Office, 2007 and National Audit of Dementia (Care in General Hospitals), Royal College of Psychiatrists, December 2010

77% of hospital staff said that antipsychotic drugs were used always or sometimes to treat people with dementia in hospital, although in a quarter of cases they estimated this was not necessary.

47% of carers said that being in hospital had a significant negative effect on the general physical health of the person with dementia, which wasn't a direct result of the medical condition.

77% of hospitals do not have a training strategy identifying key skills for working with people with dementia. Only 31% of GPs believe they have sufficient training to diagnose and manage dementia, a decrease since the Forget Me Not report eight years ago.

Falls¹⁰

Injurious falls are the leading cause of accident-related mortality in older people. The most common serious consequence of falling is hip fracture. This occurs in approximately 76,000 people per year in the UK. Half of all older people suffering a hip fracture never return to their previous level of independence. About 10% die within a month and approximately 20% enter a care home. Patients with first fractures are not flagged up for secondary prevention.

Only around half of A&E and MIU routinely screen people who have had a fall for risk of future falls. Less than half of falls admissions are screened for osteoporosis risk. Only 52% of fallers who attend ED or MIU are screened for future risk of falling and a mere 15% for osteoporosis. This has not improved significantly since 2008.

Despite 94% of sites stating they use a tool or proforma that includes standardised gait, balance and mobility assessment only 34% of non hip fracture patients and 72% of hip fracture patients receive an assessment. 86% of services report that they provide supervised strength and balance exercise training yet only 19% of non-hip fracture patients had participated in any form of exercise for falls prevention within 12 weeks of the fracture. Many of the exercise programmes being provided are not evidence based.

Care home residents are a high-risk population for falls fractures, but often have less access to preventative services than community-dwelling older people. In the clinical audit, care homes were the usual place of residence in 10% of non-hip fractures and 22% of hip fractures. Although they only make up 4.5% of the population.

It would appear clear from the above data that reducing demand is not going to take place unless performance in these key characteristics is radically improved. This is particularly true given that the standards to be

¹⁰ Based on Falling Standards, Broken Promises, Report of the national audit of falls and bone health in older people 2010, Royal College of Physicians 2011

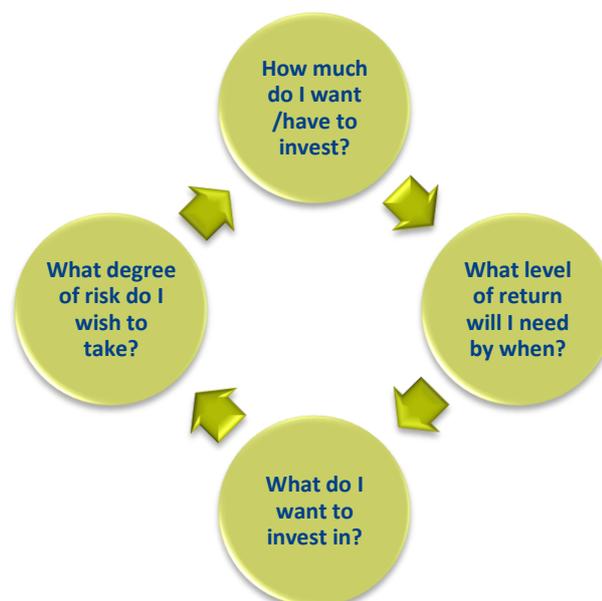
achieved are not particularly rigorous¹¹, that there is sometimes a discrepancy between health service reporting as compared to the service actually received and that many older people endure more than one of these conditions. However, given the level of investment in health and care services over the last ten years the question remains as to whether improvement within the current performance and funding framework is likely to occur. The remainder of this paper looks at whether an alternative approach to funding might not deliver better results.

6 Developing an investment based approach to reducing demand

Making judgements about investments is not just the provenance of merchant bankers. Whether buying a house, developing a pension plan or simply opening a savings account we all make decisions about investments as Figure 2 illustrates:

Figure 1. Making personal investments

This kind of thinking can be easily translated into a strategic approach for considering the best options for investing in prevention. It combines two decision making processes: What is the area that is best to invest in and having chosen the target area what should the investment portfolio look like.



¹¹ For example the basic criteria used to measure stroke unit quality is taken from the Stroke Unit Trialists' Collaboration. The standards are; a consultant physician with responsibility for stroke; formal links with patient and carer organisations; multidisciplinary meetings at least weekly to plan patient care; provision of information to patients about stroke; continuing education programmes for staff.

Figure 2. Choosing the investment target area

Choosing where best to target interventions is not an easy decision. In the current financial climate the temptation is always to go for the biggest saving. Yet if the evidence base for delivering change is thin and it requires a big shift in professional culture it may not be easy to achieve. Equally, an intervention may be financially advantageous and be amenable to change but if it does not appeal to the consumer it may not work, eg, hip protectors save people from fractures, but if they are unsightly or uncomfortable to wear they are unlikely to be used and hence will not be an effective intervention.

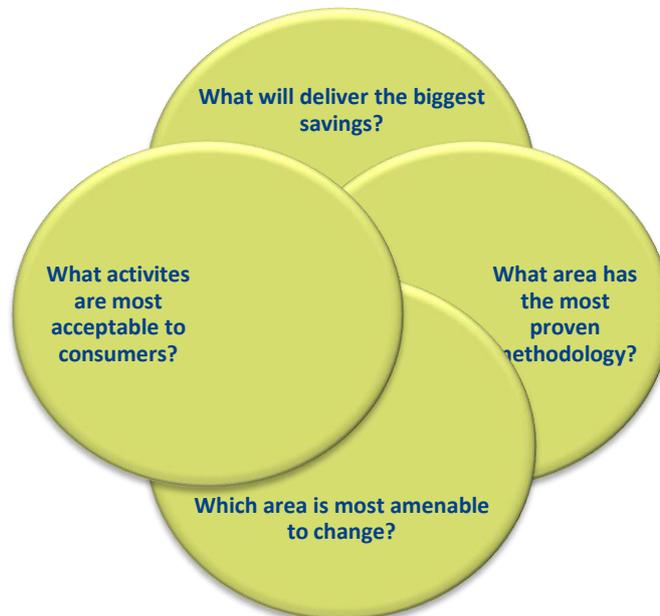


Figure 3. The investment decision making cycle



An investment approach starts from asking what is it that needs to, or can, be achieved and what is the evidence base that suggests this is possible for that collective group. Then the decision as to what to spend is made on the basis of how much money is needed, to achieve what result, over what time period. Finally this is followed by a decision as to whether this is the most cost effective approach. (high expenditure for a given period may be quite appropriate if it removes the need for longer term expenditure).

7 Applying the framework: falls

As identified above falls have serious implications for health services, care services and for those individuals who suffer a fall. The number of admissions to hospital for falls has increased by 36% over the five years between 2003- 4 and 2008- 9 despite a considerable growth in health service investment and with a national emphasis on falls prevention. It is estimated that 4.6 million hospital bed days were used in 2006/7 in England for fractures in over 60 year olds and frailty related falls in over 75 year olds¹².

Resources

In terms of investment, funding is spread over a wide variety of sources for example:

- Social care.
- Health (ambulance service, acute and PCT).
- Other local authority sectors (building adaptations, drop curbs etc).
- Voluntary sector.
- Personal expenditure.

In terms of the benefit of improved performance then some of the basic costs have been identified by the Royal College of Physicians Audit¹³ easily identified For example:

- A fully integrated, evidence based falls and bone health service, would lead to a reduction of 4,500 hip fractures in the UK per year, with a net saving of £34 million.
- Based on 2009/10 costs each hip fracture averted will avoid on average:

¹² Falling Standards, Broken Promises, Report of the national audit of falls and bone health in older people 2010, Royal College of Physicians 2011

¹³ Op cit

- £10,170 payment by results (PbR) tariff costs, and reduce NHS community service costs by £1,600 per community hospital admission.
- Save £400 per referral to intermediate care
- Save £3,879 in local authority social care costs over 2 years.

Outcomes / Evidence: Who to target?

Currently a falls policy might cover all aspects of why older people fall. A falls investment strategy needs to identify the priorities that will deliver the best return over the shortest period of time for the lowest possible price. Such a consideration might cover questions such as

- What are the substantive topics or conditions which research suggests needs targeting?
- What interventions work best, for whom over what time period?
- What is the validity or strength of those estimates?

Research can be helpful in defining who might most benefit / be easily identified as the primary beneficiaries of targeting. Therefore in respect of falls the focus might be on older people who:

- Present for medical attention because of a fall.
- Report recurrent falls in the past year.
- Demonstrate abnormalities of gait and/or balance.

It might also be important to take into account based on likely risk factors:

- High osteoporosis risk.
- People living in care homes.
- Urinary incontinence.
- Home hazards.
- People who are highly medicated.

Finally, the evidence suggests that understanding an individual's attitude can also be a useful diagnostic tool, given that fear of falling is a significant predictor of those who are most likely to have a fall in the future. It should also be considered in terms of determining well being on hospital discharge and the need for further intervention and help to determine which interventions are chosen.

Outcomes / Evidence: What interventions?

The need for an evidence based approach has been underlined by the Royal College of Physicians. who in their report¹⁴ state that “Despite clear guidance from the DH about what exercise programmes are supported by evidence, a number of sites claiming to have evidence-based programmes are, in fact, providing exercise that may not prevent falls... It is worrying that there is a lack of awareness about what constitutes evidence-based exercise and what does not”.

The evidence suggests that individualised multifactoral interventions are the most likely to succeed and should cover:

- Strength and balance training.
- Home hazard assessment and intervention.
- Vision assessment and referral.
- Medication review with modification/withdrawal.

Together with:

- Programmes of over 12 weeks duration.
- Before and after testing.
- Combined calcium and vitamin D supplement.

Return

- Take the identified target population describe what is done now for this group at what net costs over a given time period for a given number of people.
- Using the same target population and the preferred interventions identify the net costs (including start up costs) of any alternative approach over a given time period for a given number of people?
- Identify the anticipated annual return on investment.

Risk

Here you are trying to consider what is the likelihood of the benefits that have been indentified, occurring and over what time period. Therefore the starting point is a consideration of what factors are most likely to diminish the return on investment. These might include:

- Poor evidence base.
- Professional resistance.
- Consumer resistance.
- Organisational change.

¹⁴ Falling standards, broken promises Report of the national audit of falls and bone health in older people, Royal College of Physicians, 2010

It is also important to consider

- What reliance is there on other variables that could help or hinder delivery?
- If it does reduce expenditure will that show in the areas where there is a need to spend money in order to save? If not, how might a funding 'pot' be established?

The investment based model as outlined has a number of aspirations:

- To switch the focus from measuring processes or outputs to whether results for a population have been achieved.
- A results driven approach is far more likely to drive a reconfiguration of the work force. From separate disciplines and services where no one individual is responsible for the overall result to service integration at the point of delivery, where people are not just responsible for their little bit of the intervention but collectively responsible for achieving the overall outcomes.
- It should also drive a much stronger focus on the relationship between funding, evidence and the results to be achieved. A service led culture often means once developed a service remains in existence regardless of whether it is the best approach or the cheapest approach - it simply becomes *the* approach.

It is self evident that delivering the kind of change an investment based model implies is far from easy, in part because there is no simple interdisciplinary organisational framework within which such change can be managed and delivered. However when the demographic change is married with the performance issue in the key areas, financially and morally there seems little alternative.

8 Summary

Although, as this paper points out, predicting the exact volume of future demand for any given service is complex and subject to a wide number of influences, the sheer size in the growth of the older peoples population in the Eastern region is likely to considerably increase demand for health services and to a lesser, but still highly significant extent, for social care services. Therefore, the primary goal of any prevention strategy has to be the reduction of future demand. The most significant factor in achieving that goal is compressing the period of morbidity or ill health prior to death given that it gives rise to considerable health and social care expenditure.

However, achieving that goal cannot be laid solely at the door of the NHS. Improved health is conditional upon a lessening of the social factors that

give rise to, or exacerbate some health conditions, and for social care, through reablement programmes to reduce the future need for health services. Although not discussed here health and social care also relies on there being a good stock of housing suitable for older people (predominantly in the private sector given the level of home ownership amongst older people). Good housing can reduce falls through having fewer home hazards, can diminish health conditions through improved ventilation and heating and can help make the delivery of health and care services into the home easier through good design.

Finally, communities have to work for older people. What was apparent from the Oxfordshire work and from earlier IPC studies is that some people remain in the community despite having health conditions and care needs in excess of those of people in hospital and residential care. The reason often lies at the door of an individual's motivation and will, which in turn is about having a strong desire to remain in the community. This may come about through friends, neighbours and relatives, through an active and involved social life or through having well supported carers. It also comes from neighbourhoods 'working for people' through factors such as; safety and community policing, access to community facilities, good street architecture, etc.

However, these are contextual factors and are unlikely, on their own, to succeed in reducing demand unless performance in the key areas that drive repeat hospital admissions and care home admissions are improved. As the Royal College of Physicians reports reveal the performance in strokes, falls, dementia and continence is simply not good enough. Equally, given the level of past investment, it seems clear that doing more of the same is unlikely to be successful, hence the need for a model based on social investment.

It is suggested below that there are four interlinked ways forward for health and social care partners. To deliver them requires impetus from the new local Health and Wellbeing Boards. They could benefit from the analytical input of public health not only through the JSNA identifying target populations but also in terms of developing outcome based measures of performance. But above all else delivering change at an interagency level requires considerable leadership from strategic commissioners and the development of the health and social care market to provide more innovative solutions.

- To have a clear framework within which different preventative interventions can begin to be identified and separated. This not only means health and social care but should also include defining the benefits that housing can deliver and how these can be achieved. It might focus on a revised approach to the voluntary sector which puts delivering independence and well being at the top of its funding criteria

thereby avoiding unwittingly putting people on the first step of a pathway of dependency.

- Given the demographic growth in the numbers of older people and the potential impact this may have on the four conditions there is a clear need to target interventions and to measure success. Equitable resource allocation is of little benefit if nobody gets better. Therefore, there is a need to focus on what evidence based interventions are; measurable, achievable and deliverable.
- There needs to be a local commissioning framework that is interdisciplinary, interagency and interdepartmental. In particular, it should focus not on the managerial integration of services but integration at the point of delivery, or at least having one lead professional responsible for ensuring that the necessary interventions occur and whose personal performance is judged on the achievement of outcomes.
- Achieving beneficial outcomes is not just the provenance of the individual. Strategic commissioners have to begin to assess the value of prevention by its cost against the outcomes it achieves. For too long proxy indicators of the volumes of service have been used to measure success. As the stroke audit shows the existence of a stroke unit is not proof that good stroke care is available or that people get better. When two thirds of units fail to meet even the most basic minimum standard, high quality rehabilitation can hardly be likely to be occurring. The ultimate goal of any investment strategy has to be in the results it delivers not in a process that might appear nice but actually makes a loss.

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