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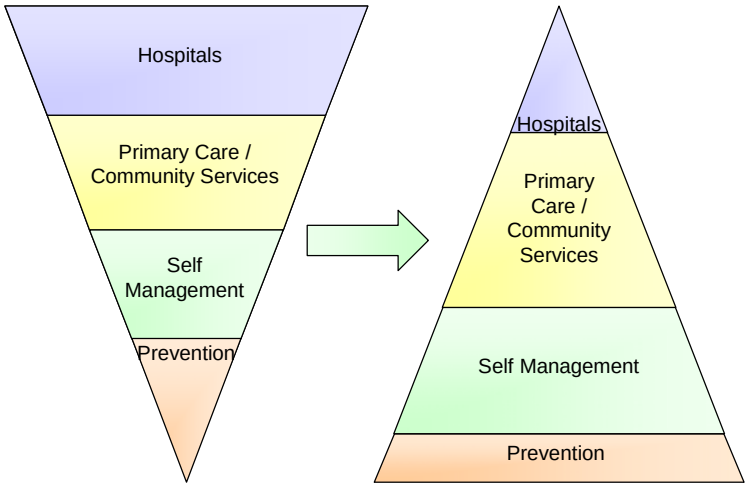
Template

This first page is intended to be a short Exec Summary of the Chapter and should be no more than 1-2 sides

Introduction

The Sunderland TPCT vision, is to change the shape of services away from an emphasis on treating ill health to one of helping individuals to live healthier lives, supported by an integrated tiered healthcare system as shown in the following diagram.



Move From

- Low emphasis on prevention
- Dependence on hospital care
- Variation in quality & provision
- Few services in community

Move To

- Healthier lifestyles, positive behaviours
- Increased self care & self management
- Services in the right place, from the right workforce, at the right time

The key elements of the Integrated Strategic Plan are:

- Stopping people getting ill (**prevention**);
- Actively identifying people with existing disease and those at risk of developing illness and establishing personalised treatment plans (**secondary prevention and long term conditions care**);
- When people do need treatment, providing high quality care in the right setting at the right time and so freeing up hospital space for our increasing elderly population (**care closer to home**).

This will be done by:

- **Improving health** - commissioning new services in tiered models of care with integrated pathways (moving in the future to greater joint/integrated commissioning of services);
- **Reforming services** – radical modernisation of pathways focused on safe, excellent quality services, eliminating waste and shifting care out of hospital, across a spectrum towards self care as appropriate (right services, right place, first time).

The areas in which major change is needed and the programmes of initiatives to be undertaken are:

Prevention	**Reducing CVD and cancer mortality**	• Obesity • Smoking • Alcohol
	Ensuring all children have the best start in life	• Child Health • Maternity
Long term conditions	**Identifying people with long term illnesses & risk factors then providing appropriate, high quality care and preventative treatment**	• CVD risk • Cancer
	Providing high quality intermediate and rehabilitative services	• Long term conditions & Rehabilitation
Safer, better quality services, delivered closer to home with no duplication or waste	**Streamlining high quality urgent care for adults and children**	• Sick & Injured children • Urgent care
	Providing more, high quality planned care closer to home	• Planned care
	Changing the way mental health services are provided	• Mental Health
	Providing those at the end of life with a good death	• End of Life Care

Key issues and gaps

- Locally it is estimated that the number of people aged 65 and over have problems with aspects of daily living, and this will rise by more than 25% in the next 15 years;
- The expected number of older people with dementia will increase by 40%;
- It was estimated that the number of people with functional dependencies will increase by 7.4% by 2025. In particular, those people with "severe functional dependencies" are most at risk of admission to hospital because of the nature of their conditions.
- 24% of the population in Sunderland have a limiting long-term illness. Higher than that of the region or national average;
- Falls are a major cause of ill health (morbidity) amongst older people, and the rate of falls in Sunderland is higher than that of Gateshead and South Tyneside, and higher still than the national average;
- The number of hospital admissions for people aged 65+ due to a fall have shown steady increase;
- The early mortality rate for all cancers per 100,000 of the population in Sunderland is significantly worse than in England and continues to show a rising trend. The percentage and number of people diagnosed with heart disease/stroke and COPD is also significantly worse than England;
- The percentage of people diagnosed with diabetes and the percentage of adults who smoke is also rising;
- There is a need to actively identify individuals with existing health issues and those who are at risk of developing serious illnesses, at the earliest opportunity in order to establish treatment plans before conditions escalate (45% of people with a long term condition are of working age);
- Local analysis showed, of those admitted to residential and nursing care from the advice & resolution panel between April – July 2011 33%, had come from a hospital setting. This could highlight pressure from hospital based professionals to admit individuals to residential care rather than return home;
- Analysis of the 728 admissions to permanent residential and nursing care in the 2 years prior to July 2011, highlighted that some 42% of clients had no services in place to help them remain in their own homes in the 2 months prior to going into care. This could also be seen as a contributory factor in admissions to hospital;
- Informal "carer fatigue" in supporting people in daily living as a result of long-standing and life-limiting conditions is a significant reason for public-sector care and support, particularly for those individuals with more significant dependencies. Without this informal care in place there is an increased risk of admission to hospital;
- Sunderland has higher number of emergency admissions and overnight occupied beds per 1,000 population and a longer length of stay for emergency impatient admissions than that of England;
- This may suggest there is a greater demand for emergency beds in Sunderland, inappropriate use of emergency beds, or that people are staying in those beds for longer periods of time - Sunderland has the highest mean length of stay and spend on admissions for traumatic brain injury nationally;
- In 2009/10, there were 854 delayed discharges from hospital (for people aged 18+). There is a need to promote seamless discharges from hospital to ensure that hospital space is available for those who are in most need of medical intervention;
- In 2010/11 there were 33,613 emergency admissions to Sunderland hospital, of those, 14,531 (43%) cases were readmitted within 30days. Those aged 75+, accounted for 28% of all emergency admissions and 20% of all readmissions. This data may suggest that for a large proportion of older people discharged from care, either there were no appropriate care

packages in place or that they were not proportionate to need;

- A joint audit of readmissions to the acute medical unit in March 2010, found that in 59% of cases the readmission was thought to have been avoidable:
- Unnecessary readmissions to hospital can have a far greater impact than for the individual themselves, but can ultimately result in a shortage of available beds preventing those who are in need of hospital treatment accessing this. Highlighting the need for greater focus and resources to prevent avoidable hospital admissions, by improving the support available to patients within the 30 days following discharge from hospital;
- 27% of older people discharged from hospital in 2009/10, were no longer at home, 3 months after discharge. To increase the numbers of people remaining at home after discharge from hospital, there is a need for increased high quality, intermediate and rehabilitative services, particularly for those with long term conditions;

Recommendations for Commissioning

Key objective's for health & social care providers in Sunderland is to change the shape of services from an emphasis on treating ill health to one of preventing ill health. Supported through the delivery of high quality intermediate and rehabilitation programmes delivered closer to home. A number of commissioning intentions have been recommended to support this;

Joint health & social care recommendations

- Implement a self care model for long term conditions, including self management and support;
- Commission new models and approaches to specialist rehabilitation which provides increased access from primary care;
- Develop and commission an integrated model of intermediate care services within each PCT locality, including care within individuals own homes and community based step up facilities;
- Improve discharge processes (including documentation) and opportunities for early supported discharge which focus on and integrate both health and social care needs;
- Introduce Telehealth technology for patients with long term conditions;

Health recommendations

- Health Care providers to review: Urgent Care Nursing Services, Rapid access community nursing teams, Role and effectiveness of Specialist Community Nursing and Community Matron;
- Implement the revised service specification of the district nursing service;
- Improve provision of heart failure services across primary community and secondary care;
- Review the COPD pathway and identify potential improvements to patient care;
- Implement single-site model for weekend TIA clinics;
- Develop a revised service model for the provision of diabetes services;
- Develop recommendations for future commissioning following the pilot of the community arrhythmia service;
- Implement an AQP procurement for community based INR services;
- Improve provision of AF services across primary, community and secondary care;
- Health care to introduce a proactive approach to early LTC management through closer alliance with leisure services and rehab programmes;
- Health care to introduce integrated working between specialist rehabiltation services and community services;
- Health care to introduce quality specifications for all rehabilitation services with an outcomes framework;
- Commission a home oxygen assessment service;
- Primary Care Mental Health Services - increase input into long-term conditions in terms of identification of mental health problems and treatment of them;

- Develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted;
- Develop a community based cellulitis and DVT model and service;
- Review impact of reablement on readmissions, focus on whether a step up approach would be implemented, so stepping up to a reablement facility;

Social Care recommendations

- Work more preventatively within local communities to identify people at risk of admission to care/hospital in order to reduce the number of people admitted to hospital;
- Increased focus on multiple admissions to hospital, to identify individuals that may be at risk of requiring care in the future;
- Intervene at the earliest opportunity in order to prevent admissions by delivering interventions which promote care within the home;
- Improved use and targeting of existing and new assistive technology as a preventative measure;
- Improved medicine management through increased advice and support;
- Evaluate the impact of 'Time to think beds' on avoiding readmissions and Maple lodge EMI assessment unit, in reducing mental health hospital admissions;
- Increased targeting of carers break opportunities, to reduce likelihood of carer fatigue;
- Utilising extra care accommodation where this is an appropriate resolution to permanent residential/nursing care;
- Improved collaboration with services such as memory protection service to support early identification of both individuals and carers;

1) Who's at risk and why?

70 of the cities 188 super output areas, are ranked amongst the 20% most deprived in England. While Sunderland continues to have worse health outcomes than the England position in terms of life expectancy, mortality rates and the prevalence of specific conditions. This relatively poor health profile of the population leads to a higher level of need for those with resulting daily living problems.

Avoiding emergency hospital admissions is a major concern for the National Health Service (NHS), not only because of the financial impact of this but also because of the disruption it causes to elective health care, particularly waiting lists. National research has highlighted that a number of factors are associated with increased rates of admission;
Age - Babies or very young children and older people are at higher risk
Social Deprivation - people who live in areas of socio-economic deprivation have higher rates of emergency admissions, in the UK, there are significantly correlations between the two (Majeed *et al* 2000)
Area of residence - Those who live in urban areas have higher rates of emergency hospital admission than
those in rural areas and those who live closer to A&E departments have higher
rates of admission (Purdy *et al* 2010a)
Ethnicity – Being from a minority ethnic group is associated with a higher risk of emergency admission

There are a number of reasons why people are admitted to hospital or other care/nursing environments and this will be dependent specifically on their individual vulnerability and circumstances, however broadly, this can be categorised into two key groups:
<u>Those at risk of being admitted to hospital</u>
Older population

- Sunderland is the largest city in the North East with a population of around 283,000, of which approximately 47,000 are aged over 65. People are now living longer and as a result there has been an increase in demand for services for elderly people through all the areas of service provision;
- Latest projections have predicted that over the next 20 years, there will be a continuing growth in the 65+ population by 50%. The oldest group, those who are aged 85 and over will increase substantially, from 5,200 to 12,800, 146%;
- This indicates that within the City there will a continuing ageing population, those who are now 'middle aged' will become the older population of the future;
- Locally it is estimated that 37% of people aged 65 and over have problems with aspects of daily living, and this will rise by more than 25% to over 22,400 in the next 15 years, simply because there will be more, older people in the City, living for longer;
- National research suggests those people who have 2+ types of problems in daily living and those without any carers' support are most likely to need some formal care and support in daily living, other risk factors for older people are: deprivation; lack of carers' support and housing;
- With age, frailty increases and this can mean that older people are more susceptible to accidents, which may result in broken bones and other injuries;
- Falls are a major cause of ill health (morbidity) amongst older people, and the rate of falls in Sunderland is higher than that of Gateshead and South Tyneside, and higher still than the national average.;
- There will be a 40% increase (to 4,200) in the expected number of older people with dementia in the city by 2025, which will have an impact for people and their carers.

People with problems in daily living

- It was estimated in 2010, that 26,130 people aged 20-64 were known to have functional dependencies. This is set to increase by 7.4% in 2025. This will be highly influenced by the number of people aged 50-64 years in the City;

- People who have significant functional dependencies are those who are most at risk of admission to hospital and predictions are that this figure will rise slightly by 2020;
- In particular, those people with "severe functional dependencies" are most at risk of admission to hospital because of the nature of their conditions. Those people with "significant" & "severe" dependencies are those most likely to need public-sector care and support;

People with long term conditions

- The 2011 Health Profile for Sunderland identified that life expectancy in the City, is significantly worse than the National average;
- Within Sunderland itself there are wide variations in life expectancy, with local analysis identifying eight neighbourhoods that have significantly poorer life expectancy, than the average, including: City Centre, Hendon, Hetton, Southwick, Thorney Close and thornhill;
- Life expectancy in Sunderland for females is 81 and for males 76, this is slightly lower than that of England as a whole at 82 and 78 respectively;
- 24% of the population have a limiting long-term illness. This compares to 23% of the population across the North East and 18% across England;
- 11% of the population suffer from chronic pain with a resulting debilitating impact on function, relationships and ability to cope and subsequent demand on services;
- 8% of the population claim disability living allowance, higher than the England rate of 5%;
- There are a wide range of diseases that lead to premature mortality in Sunderland, when comparing this to life expectancy in England, three groups of diseases have the biggest impact: cancers, circulatory diseases and respiratory diseases;

Carers are the providers of the majority of care to people with long-term illnesses and disabilities in Sunderland. The cost of replacing this care is estimated at £706.9 million p.a. (Circle at University of Leeds/Carers UK). Stressed and ill carers are often unable to maintain their caring responsibilities and this can significantly heighten the risk of admission to hospital for the people they care for.

<u>Post Discharge Care</u>

Residential Care/Nursing

- Local analysis showed, of those admitted to residential and nursing care from the advice & resolution panel between April – July 2011 33%, had come from a hospital setting. This could highlight pressure from hospital based professionals to admit individuals to residential care rather than return home.
- Of all new admissions to residential care in Sunderland, in the 2 years prior to July 2011, 77% of people had an informal carer. Some 26% had the informal carer living at the same address, whilst 51% had their informal carer living at a different address.
- This could highlight the pressures on carer's and their lack of ability to cope with the amount of caring and the time associated with this. This pressure/anxiety may be increased further, during a break from their caring responsibilities for example due to a stay in hospital, if carers feel they can no longer continue in this role, or feel that they are unable to cope in situations where health has deteriorated further;
- The risk of admission to residential care/nursing is even greater amongst those individuals with no informal carer. Given, that after a stay in hospital, due to an accident or operation, they may be unable to care for themselves independently and require support with a number of essential daily living tasks;
- Research carried out around Prevention of Admission to Residential and Nursing Care in Sunderland found that a stay in hospital may make people feel more dependent and require additional needs to what they had previously. Families may feel care is the only option if they are unable to cope;

Readmissions

- For those individuals who have been released from hospital, a significant proportion will need some help in daily living, for a time limited period or longer term;
- In cases, where care packages upon release are not appropriate or, do not meet the needs of the individual, there is a significant risk of readmission;
- This can also be the case, for individuals who lack the support of an informal carer, to assist them with various forms of daily living;
- For individuals, who have been in hospital for extensive period's of time, where there has been a delay in implementing care packages which would result in discharge, there is a high risk that they will find it particularly difficult to adjust and cope outside of this setting.

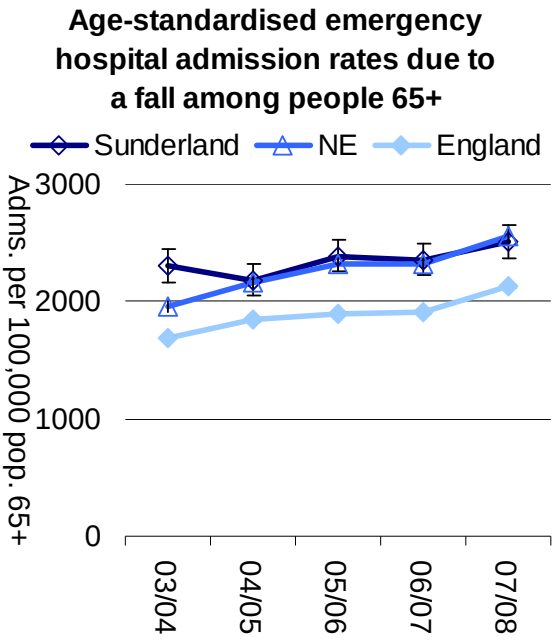
2) The level of need in the population

Those at risk of being admitted to hospital

Older People

- The 2010 MORI Survey found that 47% of people aged 65+ in Sunderland, say they have a long term disability illness or health condition that restricts their daily activities. With help most often needed in relation to housework, shopping or mobility outdoors;
- Older people with 2 or more types of significant problems, in daily living, are particularly at risk of admission to care/hospital;
- Local caseload analysis, of those 65+ accessing care services at home, has shown that at 31st March 2011, 8% were classified as needing critical support, and a further 4% substantial support. As highlighted in the risk section, given the specific needs of these individuals they are particularly vulnerable to residential care admission;
- Comparisons with, 2010 data, has indicated that the percentage of adults rated as 'critical' has increased from 5% to 8%. Increases were also observed amongst those rated as requiring substantial (2% to 4%) and moderate (27% to 39%) support

The chart below, highlights the hospital admission rates for people aged 65+ due to a fall. This shows how the number of admissions have increased by 18% between 2004/05 and 2008/09. The rate of falls per 100,000 of the population is also considerably higher than the national average.



- Local analysis has estimated that there were 3,110 people aged 65+ years with dementia in Sunderland in 2009 with 2,210 people having severe or very severe dementia;

- Analysis from the NHS has indicated that the percentage and number diagnosed with dementia in Sunderland has shown a rising trend;
- Alzheimer's disease (the most common disorder), affects 62% of those with dementia, with vascular dementia accounting for 17%;
- Many of the carers of people aged 65+ with dementia are of similar ages because most are spouses, who generally experience greater stress than other carers.
- The Adults in Need Census 2010 in Sunderland City Council conducted by social care professionals of a representative sample of people with dementia/cognitive impairment supported by the Council found customer's had at least one other condition in 75% of cases, with orthopaedic conditions, strokes, and heart and circulatory disorder being the most common, often influencing daily living needs;
- Many of those with severe dementia, especially those over 85+, have a combination of mental and physical problems in daily living. For example, the proportion of customers aged 65+ with severe dementia who needed physical help with daily living activities was estimated to be 60% of the total;
- Action on dementia a voluntary organisation within the City who work with dementia sufferers and their families, including helping people through their treatment journey in hospital, reducing hospital stays (reduces time in hospital) and also help support carers, helping prevent people from readmission to hospital, highlighted a number of needs for people diagnosed with dementia and their carers:
    - Appropriate assessments for dementia, easier access to appropriate aids and adaptations in the home could help reduce the pressure on carers as well as prevent strain on carer services and hospital admissions;
    - For those who are not able to access current services post hospital discharge, there will be a need for further help in the future;
    - Require a joint needs assessment for individuals with dementia – looking at their physical wellbeing and mental health as well as that of their carers;
    - Need clear pathways between GPs and specialist services in hospital;
    - Importance of listening to what people need and want as well as their carers needs – invest to prevent
    - Personalisation, allowing people to choose their own care package, would be beneficial to both individuals and their carers, allowing more control over their care;
    - Requirement for additional assisted housing schemes for dementia sufferers;

People with problems in daily living

- People who experience problems with daily living, can be at particular risk of admission to hospital, additional factors that may impact on this include;
    - no carer support - 8% of people aged 55+ surveyed in relation to their housing needs and aspirations said they don't get help from anyone even though they need it. These tended to be single people living alone;
    - unsuitable housing - 20% of respondents, felt that their home was not suitable for their needs. For over, half of those, this was due to mobility issues making it difficult for them to move around their home People under the age of 65yrs with dysfunctional problems have very limited housing options eg neurological conditions or traumatic brain injury increasing length of stay in hospital;
    - life changing events, such as hospital stays;
    - Other life circumstances;
- Informal "carer fatigue" in supporting people in daily living as a result of long-standing and life-limiting conditions is a significant reason for public-sector care and support, particularly for those individuals with more significant dependencies;
- Qualitative research about the underlying reasons why people were admitted to residential/nursing care, has highlighted, that in a significant number of cases reviewed, this was due to a late involvement with adult social care which often led to "carer breakdown" or "fatigue", particularly at a time of crisis. In cases where carer relationships breakdown, there

is a risk that without the appropriate care in place, to meet the needs of those individuals, there is an increased risk that they may be admitted to hospital.

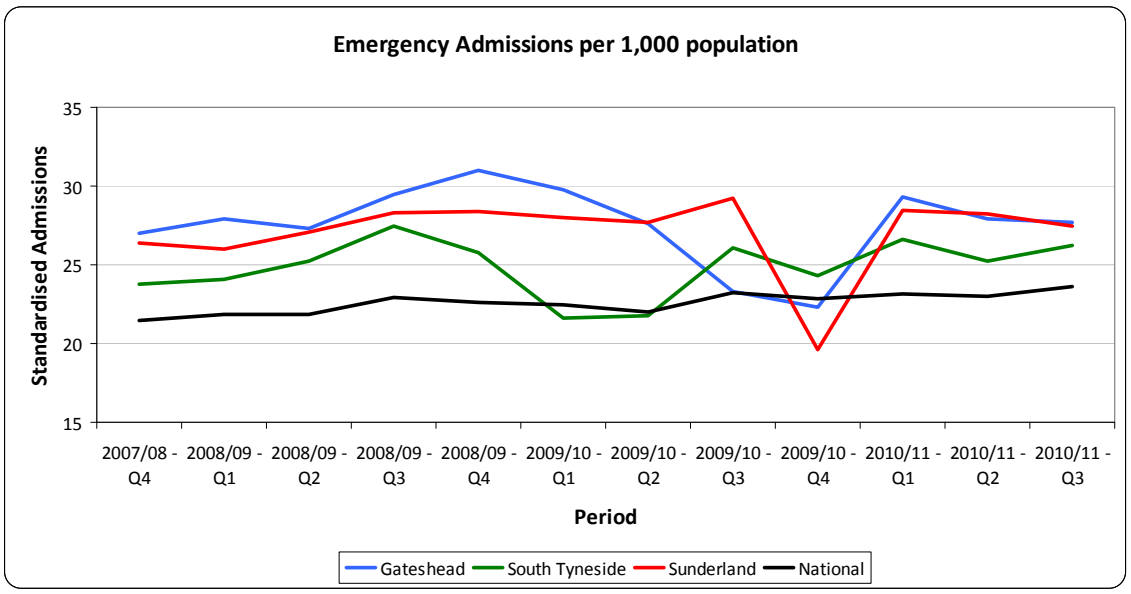
People with long term conditions

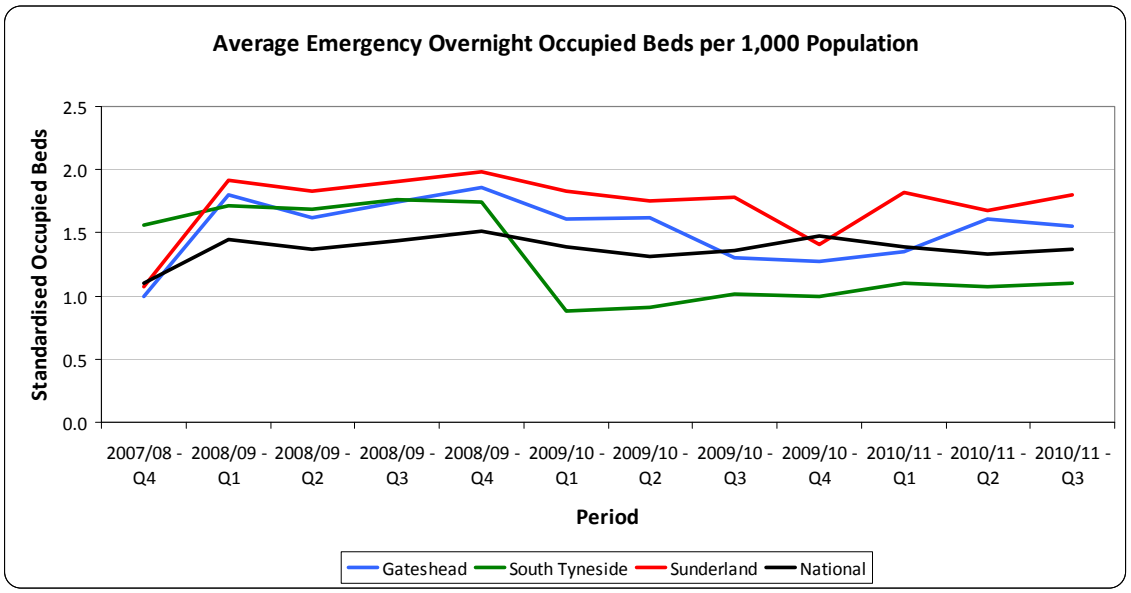
- When the life expectancy gap between Sunderland and England is considered two of these diseases, cancers and circulatory diseases, dominate the analysis, together with respiratory diseases;
- The early mortality rate for all cancers per 100,000 of the population in Sunderland is significantly worse than in England and continues to show a rising trend. The percentage and number of people diagnosed with heart disease/stroke and COPD is also significantly worse than England;
- These are all chronic diseases and so will impact not only of length of life but also the quality of life experienced by the population;
- Tobacco, alcohol and obesity are the biggest modifiable risk factors for these diseases:
    - The prevalence of smoking in Sunderland is higher than that of the national average (25% compared with 21%), and continues to rise, with rates of smoking related deaths also higher;
    - 28.5% of adults in Sunderland drink above the recommended weekly safe limits, with 6.8% drinking at harmful levels. As a result Sunderland has much higher levels of alcohol related diseases than the national average Including traumatic and recurring traumatic brain injuries;
    - 18.2% of adults in Sunderland are considered to be obese. The percentage of adults diagnosed with diabetes, also continues to show a rising trend, with a rate worse than that of England;
- There is a need to actively identify individuals with existing health issues and those who are at risk of developing serious illnesses, at the earliest opportunity in order to establish treatment plans before conditions escalate;
- It should be noted that there are areas in which Sunderland displays more positive outcomes, with the percentage of eligible women, screened for breast cancer and cervical cancer, significantly better than England as a whole;

11% of the population of Sunderland are carers and 3% of the population cares for over 50 hours per week (Census 2001). Recent research by circle at the University of Leeds suggests there is likely to have been a 5% increase in the number of carers in Sunderland since 2001. Regional statistics (Circle, see above) show that 82% of carers in the NE are aged 16 – 64 (80% England). Working age carers in the NE are less likely to be in employment or have formal educational qualifications. Any carer providing high levels of care is twice as likely as non-carers to become permanently sick or disabled themselves. Carers of all ages are at risk of damage to their own mental and physical health, unemployment, poverty and loss of family and social life, all of which have a significant effect on the carer's resilience and that of their family.

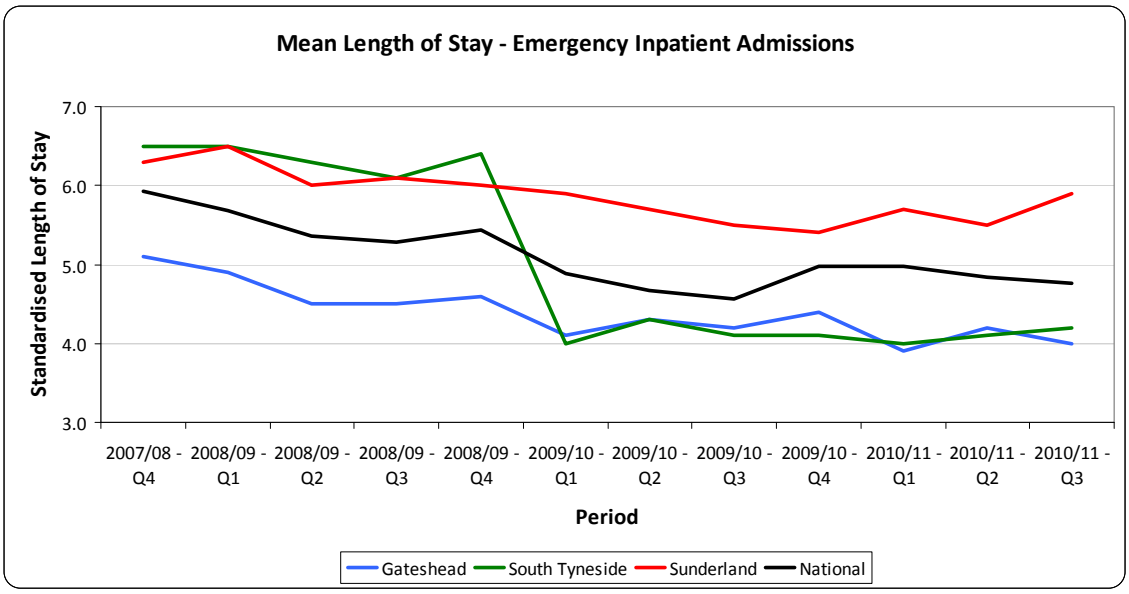
Emergency Beds

- In the first three quarters of 2010/11, Sunderland had a higher number of emergency admissions and overnight occupied beds per 1,000 population than the national average, despite a significant decrease between quarter 3 and 4 of 2009/10 specifically Sunderland has the highest admission and LOS for people with Traumatic brain injury, nationally (Rehab strategy SoTW);



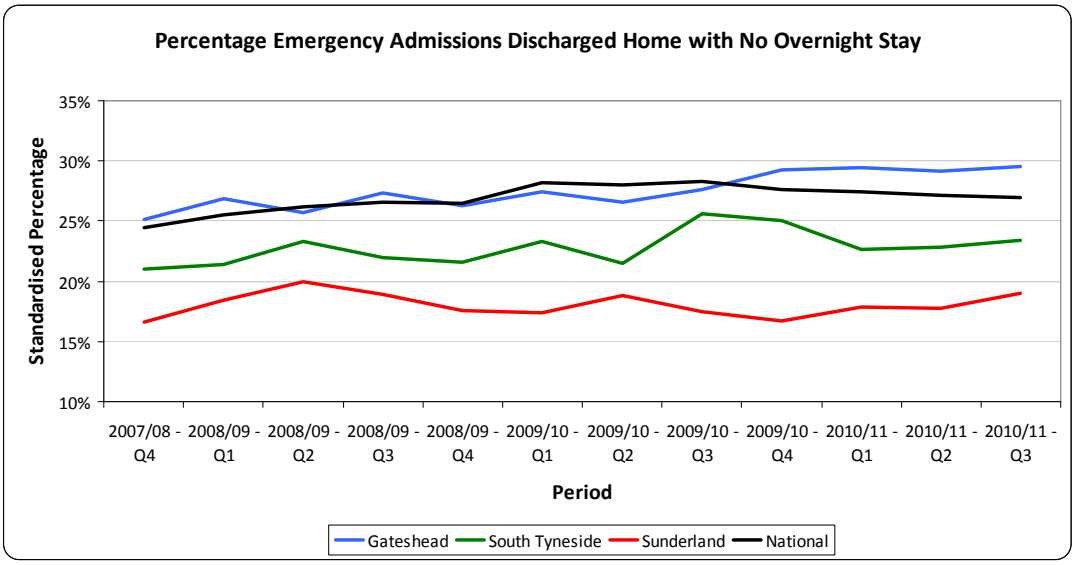


The mean length of stay of emergency impatient admissions in Sunderland has been longer than that of England for the last three years. At quarter 4 of 2010/11 it was 5.9 days compared with 4.8 nationally;



This may suggest there is a greater demand for emergency beds in Sunderland, inappropriate use of emergency beds, or that people are staying in those beds for longer periods of time;

Sunderland also had a consistently lower percentage of patients discharged home with no overnight stay than England as a whole;



Delayed transfer from hospital

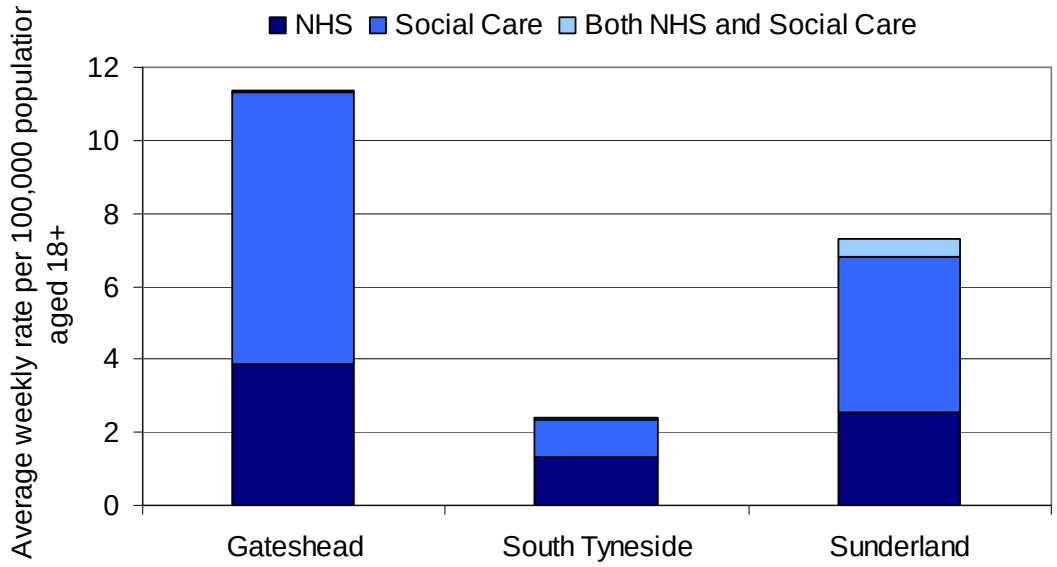
- In 2009/10, there were 854 delayed discharges from hospital (for people aged 18+);
- Of those, the cause of delay was attributed to Social Care in 58% of cases (495);
- The number of cases where the delay was due to the NHS, was significantly lower at, 35%. Both agencies were sighted as the cause of delay for 7% of people.

The chart below, demonstrates the average weekly rate of delayed transfers of care from all NHS hospitals, acute and non-acute, per 100,000 population aged 18 years and over.

- The average weekly rate of delayed discharges, showed steady increases between 05/06 and 08/09 (2.6 to 8.2), but a slight decrease was observed in 2009/10;

- The chart highlights that in Sunderland the average weekly rate of delayed transfers of care (per 100,000 of the 18+ population) was 7.3;
- When breaking down this figure by individual agencies, the average weekly rate of delay due to Social Care was 4.2;

Average weekly rate of delayed discharges by cause of delay, 2009/10



- Promoting seamless discharges from hospital will help to ensure that hospital space is available for those who are in most need of medical intervention;

Post discharge care

Residential Care/Nursing

- The most common factor in informal carers feeling that they are no longer able to cope physically and/or emotionally is "carer fatigue" and this is often a key reason for admission to residential/nursing care;
- Research conducted around the Prevention of Admission to Residential and Nursing Care in Sunderland, suggested that for those cases where informal carers where in place, whilst carers were aware of the help, support and services available through Adult Services, advice and information about this is not always available and/or offered. Information may have only been obtained following an episode of crisis such as admission to hospital, i.e., through necessity rather than prevention. If services were intervene earlier offering support, respite etc to carers, this may help to reduce the number of carers who reach 'crisis point';
- Providing and facilitating carers breaks, may also help to support continuing informal caring relationships in the longer term;
- Analysis of the 728 admissions to permanent residential and nursing care in the 2 years prior to July 2011, highlighted that some 42% of clients had no services in place to help them remain in their own homes in the 2 months prior to going into care. This could also be seen as a contributory factor in admissions to hospital. For example an individual who experiences problems moving around within their home and does not have aids/equipment or support to improve mobility may be at higher risk of a fall resulting in injury, than those with care packages in place;
- A further 10% had only started to receive services to help them to live in their own homes in

the 2 months before being admitted into residential/nursing care. The remaining 48% of people did have services in place that had been in place for at least 2 months or more before going into care.

- This suggests that prior to going into residential and nursing care a large proportion of people (42%) do not seem to be receiving any support or services to help them to live independently in their own homes, highlighting a lack of monitoring and early intervention. Furthermore 10% of people had only started to receive any services to help them live independently in their own homes in the 2 months prior to being admitted into care, this further highlights a lack of early intervention.
- The rate of older people aged 65+ supported to live at home in Sunderland is significantly better than that of England and within the City there are a number of schemes/initiatives in place which aim to prevent people from entering residential Care;
    - Extra Care – Within Sunderland, there has been the development of 3 'extra care' facilities. This type of accommodation, offers a new way of supporting people to live independently for as long as possible, combining the security and privacy of a 'home of your own', with access to 24-hour care/support services if required. A fourth scheme is currently being built.
    - Tele-Care - The service provides a range of equipment installed in an individuals home that can be attached to an alarm system which, when activated sends an alarm to a control room; which will then respond to the alarm call. This scheme currently supports over 22,000 vulnerable people to maintain their independence and remain in their own home.

Readmissions

- In 2010/11 there were 33,613 emergency admissions to Sunderland hospital, of those, 14,531 (43%) cases were readmitted within 30days;
- Those aged 75+, accounted for 28% of all emergency admissions and 20% of all readmissions;
- 32% of people aged 75+ admitted in 2010/11 were readmitted within 30 days;
- This data may suggest that for a large proportion of older people discharged from care, either there were no appropriate care packages in place or that they were not proportionate to need;
- Those individuals who are readmitted to hospital, because there were no, or inadequate care arrangements, may be at a greater risk of being placed in more permanent residential care, particularly if the type of care needed falls outside of that which, would be delivered within a hospital setting;
- Unnecessary readmissions to hospital can have a far greater impact than for the individual themselves, but can ultimately result in a shortage of available beds preventing those who are in need of hospital treatment accessing this;
- This highlights the need for greater focus and resources to prevent avoidable hospital admissions, by improving the support available to patients within the 30 days following discharge from hospital;

The percentage of preventable hospital admissions in general (whether first or recurrent), has been estimated to be nationally between 10% - 25%. Some of these readmissions are planned and may be part of the natural course of treatment for specific conditions; but, for many others, hospital readmission is an indicator of poor care or discharge planning and inadequate or fragile support in the community. Increasingly readmission is seen a monitoring tool for quality and a missed opportunity to better coordinate services better hospital and home.

City Hospitals has historically had higher than average readmission rates compared to other acute Trusts across England. These rates continue to rise despite investment in a number of complementary initiatives and new services designed to prevent admissions for high risk patient

groups, including enhanced OOH services, intermediate care services and rehabilitation / convalescence schemes. Preventing avoidable readmissions has been a Trust and PCT priority for some time. In March 2010 a joint audit of readmissions to the acute medical unit was undertaken by City Hospitals Sunderland and Sunderland PCT. In total 90 patients were included in the audit. The aims of the audit were:

- to assess whether the readmission was linked to the previous admission
- to ascertain if the readmission could have been avoided in any way
- what could have been done to prevent the readmission
- to explore areas where discharge planning and communication could be improved, i.e. referrals and restarts between health care teams

Main findings of the audit were:

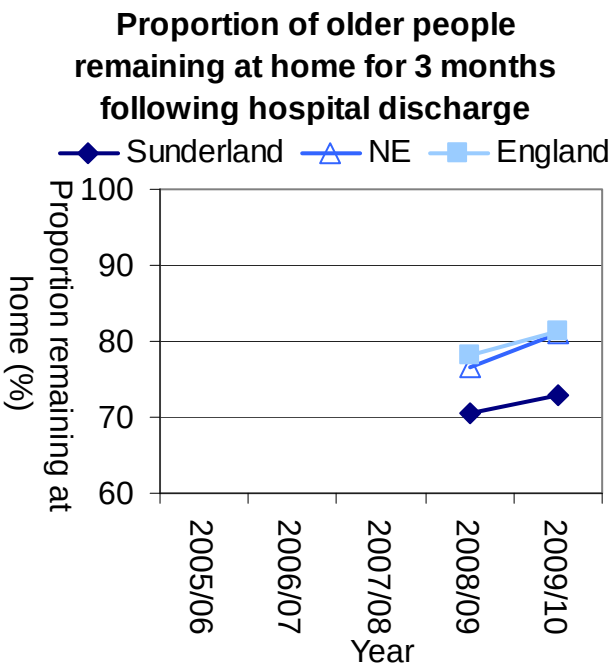
- 73% came via A/E and 14% by G.P, three quarters of patients came from their own homes
- The mean interval between initial admission and readmission was 10.7 days
- 46% of patients had follow-up and 89% had a discharge plan but the plan was not implemented in 33% of cases
- In 84% of cases the reason for readmission was medical , medical + social (7%) and social 3%
- In 77% of cases the readmission was linked to the initial admission
- Overall, in 59% of cases the readmission was thought to have been avoidable

As a result of the audit a number of recommendations were made including:

- Improve the timeliness of care packages so that no patients remain in acute beds waiting for a care package
- New DH guidelines 2010 recommend inclusion of all adults of all ages to Intermediate Care (Halfway Home)
- Multi Disciplinary team based in A&E that will, facilitate safe timely discharge , prevent admission, provide appropriate equipment to keep the patient at home, meet short term social care needs in the patients own home, facilitate admission to Intermediate Care when appropriate
- Improved education for all staff and patient about what services are available to patients on discharge
- No patients are admitted into hospital if an urgent OPD appointment could have resolved the problem

Achieving independence for older people through rehabilitation/intermediate care

- 72.9% of older people discharged from hospital to their home in 2009/10, were still at home 3 months after discharge;
- The information therefore suggests that 27% of people discharged, do not remain at home, in the first three months. This figure has slightly improved in comparison to 08/09, and is also marginally higher than the proportion regionally or nationally;
- Again this may be attributed to a lack of post discharge care, in order to support recovery;
- To increase the numbers of people remaining at home after discharge from hospital, there is a need for increased high quality, intermediate and rehabilitative services, particularly for those with long term conditions;
- The roll out of services of this type will support individuals to regain their health and independence, whilst reducing dependency on social care services following discharge;
- When care needs are reduced, the implementation of lower intensity interventions such as community equipment, adaptations and telecare services, will help individuals to maintain their health and independence in the longer term;



It is predicted that around 14% of the population of Sunderland population, have a long term condition. Which would potentially need or benefit from the traditional approach of rehabilitation services, based on the assumption that promoting independence, mobility, and living in ones own home is the ultimate goal. People with such conditions generally have increasing rehabilitative needs in order to achieve this as they get older.

3) Current services in relation to need

Sunderland City Council has many services in place to prevent and minimise the risks of admission to hospital, with services focused around helping people to remain within their own homes:

Home Care
A number of people who are recovering from illness, or have functional dependencies may need help with daily functions, such as getting out of bed, dressing or personal hygiene. The council provides care package's to suit the individual's needs and help them live comfortably in their own home. In 2010/11, 3,358 people received home care provision from SCC.

Sunderland Tele-care
Sunderland Tele-care supports over 22,000 vulnerable people living at home and carers throughout the city by providing services such as property exit sensors, fall detectors, bed sensors, key safes and many more. This provides security and reassurance, to help people remain independent in their own homes for longer.

Community Equipment Service (Council & South of Tyne and Wear PCT funded)
The service supplies and installs equipment and minor adaptations within the home to assist residents of Sunderland live in their homes for longer. The aim is to prevent accidents/falls which may lead to hospital/residential care admissions, therefore promoting personal independence, safety and mobility in the home. The type of equipment provided includes beds, internal grab rails, hoists, riser/recliner chairs as well as sensory equipment such as hearing loop systems, tele-flashers and smoke alarms. In 2010/11, 15, 146 residents received aids from the Community Equipment store, often meaning that ongoing support was not required, minimising the costs of implementing more expensive care packages.

Short Break services
Short breaks, short-term care, or respite services can be arranged for a short period of time for a number of reasons, for example if a person is recovering from an illness and may need an interim placement between hospital and home, to allow carers a break from their responsibilities, or to allow practitioners time to complete assessments on a person. In 2010/11, 1,286 people utilised respite/short term care services from SCC (excluding 100% health funded cases). For some individuals this may have helped to prevent longer term admissions to hospital.

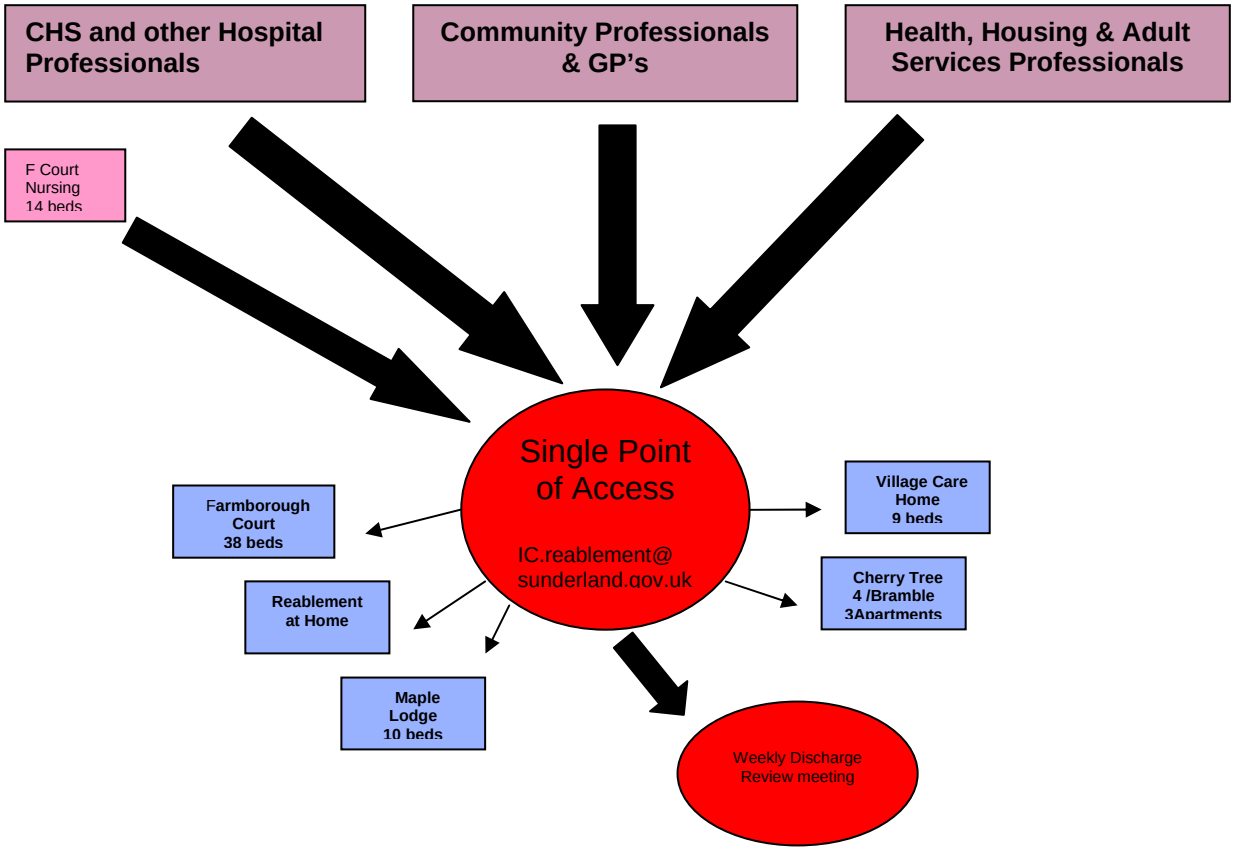
Direct Payments
To help people in Sunderland the freedom to live at home for longer, the Direct Payments service allows you the flexibility to chose and purchase the service you require, promoting financial independence and allowing more choice and control over how the council assist with social care needs.
The services available for purchase include arranging your own home support, day services, short breaks or equipment loans. The proportion of people receiving Direct Payments and other direct financial support increased from 5.8% in 2008/09 to 31.8% of people with an ongoing care plan in 2010/11.

Intermediate Care Service
This service is designed to maximise the well-being and independence of the people of Sunderland who may need a period of care, for example if recovering from an illness or to avoid an admission to hospital and remain living in their own home wherever possible. The Intermediate Care Service includes a 24 hour Rapid Response Team, a Rehabilitation Service, Dementia Care & Rehabilitation Service and the Enablement & Convalescence service.
In 2010/11, 633 people in Sunderland received an intermediate care service from SCC (both residential and outreach provided by Farmborough).

Farmborough Court provides a base for a range of intermediate care services for older people who need convalescence or a rehabilitative stay. There are 4 distinct units within the building that provide up to 54 places for older people, some of whom may also have mental health and physical needs, including dementia. Intermediate Care is the term used to describe a range of services provided in the community to help older people to:

- Recover from illness and trauma
- Have a timely hospital discharge
- Remain independent and living at home wherever possible

A first stage single point of access into the social care aspects of Intermediate Care has been developed. This brings together staff form key services into one place of referral, based currently in City Hospitals Sunderland (see model below).



Reablement - The Reablement at Home Service provides vulnerable older people & their carers with high quality personal care, assistance, rehabilitation and basic health support; following an assessment of need by Care Managers; helping them to live as independently as possible at home through:

- Supporting people who are discharged home from hospital
- Supporting people at home to prevent unnecessary admissions into hospital or long-term care
- A period of assessment of people's needs

In 2010/11, 333 people in Sunderland received a reablement package at home from SCC.

New Dawn – Hetton

This is a befriending visiting service, which helps to avoid people being admitted to hospital as they can receive help and support at home.

Social Work Teams - Initial Advice & Assessment Teams/Complex Teams, five geographically operational teams of Social Work and Care Managers who provide assessment functionality for customers within the community and who are in hospital and residential based services. Complex services; include specialist teams of Social Work and Care Managers whose customers present with a Learning Disability, Mental Health, Drug & Alcohol or Physical Disability and who require complex care planning. The hospital Social Work Team consists of Social Workers and Care Managers who are sited on CHS site and whose primary function is to support hospital discharge both from within CHS and out of City Hospitals.

Galleries Day Unit - A 5 day service providing group and one to one rehabilitation sessions as

well as nursing services such as ambulatory BP clinics. Again, an open access referral but the majority is from GPs and community teams. Maximising independence through the promotion of health and wellbeing.

HELP Team [Healthy Exercise & Lifestyle Programme - The aim of the HELP Team is to address inequalities in health care, disease management and treatment, enhancing quality of life. The Sunderland Exercise on Referral scheme offers patients the opportunity to participate in activity programme giving them the support they need to make long term lifestyle changes which improve their health. They provide a range of rehabilitation and exercise programmes including those linked to the obesity, CHD and cardiopulmonary care pathways.

Falls nurse/specialist co-ordinator - Coordinates the falls pathway across Sunderland, works to reduce the risk of falls to prevent the number of people falling and to reduce the number of serious injuries sustained by those who have fallen.

Community Matrons - Provide care to patients with very complex needs who are high intensity users of a range of services. Due to the nature of their individual conditions several consultants/teams/services can be involved in the patient's care and the CM acts as the key worker to ensure care plans are active and realistic changing as the chronic disease progresses and needs alter.

Urgent Care Team - Provides care to patients with acute illness, injury or exacerbation of a long term condition and delivers initial assessment, diagnosis and patient management making a differential diagnosis. The team cares for all patients throughout Sunderland including those who live in care homes as well as their own homes. This team works more to prevent admissions than facilitate discharges.

District Nursing Services - Provides care to housebound patents. Patients can be housebound due to a short term illness/episode or can be housebound due to a complex illness or disease.

Home Improvement Agency (Including handyperson services) - The Home Improvement Agency aims to enable those in need of support to maintain their independence in their chosen home for the foreseeable future. This will be achieved by supporting people throughout the repair, adaptation or improvement process, so that individuals are able to remain in their own home, in a warm safe and secure environment. The service provides:-

- Disabled Facilities Grants (DFG's) and adaptations
- Housing Assistance (practical and financial advice)
- Handypersons and Minor Alterations Service
- Energy Efficiency Advice and Signposting

General Advice and Signposting in relation to practical tasks that support people to live independently.

Extra Care - enables people to live in their own homes independently with access to tailored care and support to meet the needs of the individual, and gives access to other social health and well being opportunities. It gives older people their own self contained home, with legal rights to occupy. Most schemes offer a choice of tenure which provides housing solutions for people with different kinds of incomes. The schemes developed in Sunderland offer rented; part rent and part buy or outright sale options. The ability to have care available over a 24 hour period, based upon assessed individual need promotes independent living.

Palliative Care Team - Provide a specialist social work service to patients diagnosed with a terminal illness and work with our health colleagues to provide an integrated and responsive service at an extremely sensitive time.

Day services - In Sunderland there are a range of facilities offering day opportunities and day care for people over the age of 65. Some of these facilities are provided by local organisations charitable and voluntary agencies or community groups. Some are provided in partnership with Sunderland City Council. Some day opportunities can be accessed directly within the community or by contacting agencies such as Age Concern. Sunderland City Council helps to locate day opportunities through signposting. Day Services fall into three broad categories:-

- Day Opportunities
- Day Care
- Luncheon Clubs

Rapid response and Early supported discharge – Provides rapid assessment and intervention for patients attending A&E, AMU, the Walk in Centre and ward C36 at City Hospitals Sunderland, who are deemed medically fit and not requiring admission. It provides assessment and intervention to support discharge within City Hospitals Sunderland to patients who do not require acute medical care but may have short term care or therapy needs to enable them to return home.

Hospital liaison discharge team - This team is based at City Hospitals Sunderland. The main aim of the team is ensure that hospital staff, carers and relatives are supported in planning the discharge of patients with complex health and/or social needs whilst ensuring that those patients with simple needs are discharged in a timely way to facilitate patient flow. They link in with fellow health and social care teams to discuss issues and identify solutions to facilitate discharge from the acute hospital setting. The team liaise with intermediate care colleagues to ensure that existing services are appropriately utilized. The team identify potential delayed discharges on a daily basis and liaise with the link social worker to move plans forward.

Age UK Hospital Discharge Team - Provide a free service for people over 60, who are being discharged from hospital living in the Sunderland area who do not have a formal care package to support their arrival home and start the reablement process. Through the service we are quickly able to assess if further interventions are needed and make a referral to prevent unnecessary re-admissions to Hospital

Age UK also provide low level support in the first week post discharge in order to prevent readmissions

The Sunderland Carers' Centre provide a range of support to Carers, including information, advice and support at meetings (advocacy). This is supported by a number of other local groups such as, Action on Dementia Sunderland, MS Society, Parkinson's Society.

4) Projected service use and outcomes in 3-5 years and 5-10 years

Over the next 20years the over 65 population in Sunderland is set to increase from 47,000, with sustained year on year growth to 70,500 by 2033 – an increase of 50%. The largest increase within this age group will be those aged 85+ and generally those with the greatest care needs, with an expected increase of 146% from 5,200 to 12,800. The 65-84 population will also increase significantly over this period, however, this will show a steadier incline from 41,700 to 57,700, 38.4%. Modelling of extra care places has indicated the need for the provision of up to 1350+ units of extra care accommodation by 2015 to meet the demand and prevent unnecessary admissions into residential and nursing care;

The numbers of people who are obese and who suffer the effects of excess drinking are also

predicted to rise. These increases will have significant implications for health services, particularly as older people use services more often, have more complex needs and stay longer in hospital. Modelling shows that, in ten years, if nothing is done differently, there will be a need for around 200 additional hospital beds in Sunderland at a cost of over £20m.

The Kings Fund paper 'Avoiding hospital admissions' documents a number of ways to identify patients who may be at high risk of future emergency admission. They include the following;
Threshold modelling - which is rules based, and identifies those at high risk who meet a set of identifying patients with repeated emergency admissions as a marker of high risk of future admissions.
Predictive modelling - in which data are entered into a statistical model in order to calculate the risk of future admission. Predictive modelling is thought to be the best available technique (The King's Fund 2005).
Testing the various models results in varying degrees of accuracy in predicting future admission. Those models that include data from primary care records perform around 10 per cent better than those that rely on secondary care data alone. In order to improve the performance of predictive models, detailed data on individual patients need to be available.

A hospital activity model was developed by NHS South of Tyne and Wear in 2007 to identify the financial and capacity consequences for the following ten years. The model uses a number of methods and data, including population forecasts to establish the likely impact on future activity of a range of factors, including predicted changes in disease prevalence (in particular obesity, dementia, diabetes and alcohol harm) and expected clinical and technological changes. These impacts were built into the baseline model which shows likely future activity if no significant changes are made.

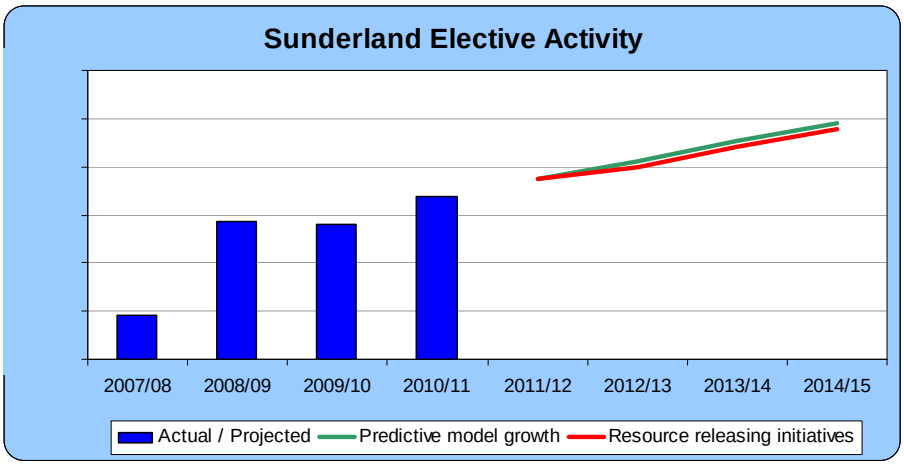
The very strong message from the initial iterations of the model was that if NHS South of Tyne and Wear does not take effective action, the increasing elderly population with their high use of health services, coupled with the inevitable developments in clinical practice, technology and patient expectations would result in less than ten years, in hospital capacity shortages and a financial cost which the PCTs could not meet. This model shows that for Sunderland TPCT, if there are not change's in the way in services are provided, the following growth in hospital activity levels will be expected over the next four years.

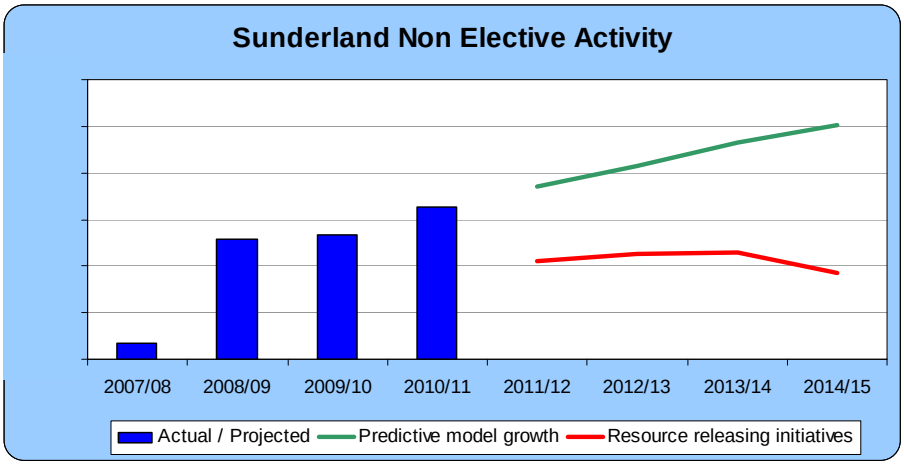
	2011/12	**2012/13**	**2013/14**	**2014/15**
Elective Hospital Spells	1.43%	1.49%	1.65%	1.48%
Non Elective Hospital Spells	1.24%	1.32%	1.43%	1.14%
First outpatient attendances	1.50%	1.53%	1.82%	1.69%

Similar increases in accident and emergency (A&E) activity are expected, change's in how these services are provided are not made.

However, there are a range of plans in place to reduce hospital activity (inpatient, outpatient and A&E) through redesign of services, better care of people with long term conditions and more streamlining of urgent care services.

The green lines on the following graphs show the forecast growth in activity, while the red lines show how the plans for activity reductions mitigate this growth. The numbers shown by the red line are those in activity trajectories, submitted to the Strategic Health Authority and Department of Health.


Sunderland Elective Activity
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
Actual / Projected
Predictive model growth
Resource releasing initiatives


Sunderland Non Elective Activity
2007/08
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2010/11
2011/12
2012/13
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2014/15
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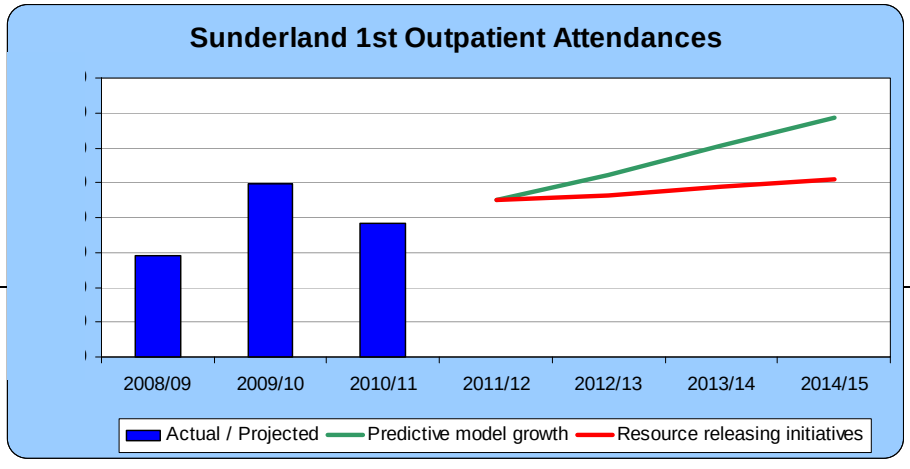
Sunderland 1st Outpatient Attendances
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
Actual / Projected
Predictive model growth
Resource releasing initiatives

The reduction of 225 elective hospital spells and 3,540 outpatient attendances over 4 years will be achieved by moving services out of hospital into primary or community care and will require an increase of around 7,530 primary / community contacts.

The reduction of 3,199 non elective spells over the same time period will be achieved through better care of people with long term conditions outside hospital and the streamlining of urgent care services. These changes will require an increase of around 12,800 primary care contacts and / or community contacts.

The Rehabilitation strategy (sotw), documents a number of conditions or health traits that is anticipated will also make demands on or benefit from rehabilitation services in the future if a more proactive approach is taken. This inclusive approach for predicting need for a spectrum of rehabilitation services include the following long term conditions; Cancer survivors, chronic pain COPD, Chronic heart disease, Stroke, Rheumatoid arthritis and Neurological conditions as well as Falls. The Sunderland prediction using this approach to the strategy would be 29.5% of the population accessing services.

The key message from the strategy is that it will be important to mainstream access to a wider spectrum of rehabilitation services, to stratify the risk factors and target resources proactively to slow down the progress and impact of the life limiting condition and/or to maximise the individuals capacity to adapt and live independently for as long as possible. The menu of prehab/rehabilitation options should be delivered by a wider range of specialists at a time when the changes could be easier to realise, before people become disabled. There are workforce issues to address to achieve the synergy, capacity and outcomes required across a wider range of professional groups/agencies.

The move to a more preventative strategy and shaping of services which: stop people from becoming ill, identifies people with disease and those at risk of developing illness and implementing treatment at the earliest opportunity and providing high quality care in the right setting at the right time, may help to improve health and minimise, avoidable admissions, readmissions and residential care placements.

There is also National evidence (The Kings Fund Avoiding hospital admissions) which suggests that there are a number of avoidable admissions;
Ambulatory or primary care sensitive conditions (ACSCs) are those for which hospital admission could be prevented by interventions in primary care (Bindman *et al* 1995; Purdy *et al* 2010c).
Some admissions (eg, those for dementia) may not be perceived to be avoidable, as the disease course is not significantly modifiable. However, the availability of more suitable alternatives to an acute hospital admission – for example, respite care or home care – can result in admission avoidance in the acute situation.

The new Intermediate Care and Rehabilitation service (ICAR) will be an integral part of the intermediate care pathway for Sunderland residents. A key objective of this new service is to shift the focus of intermediate care beds in the city to a ‘step up’ preventative model, decreasing the number of ‘step down’ beds required both in Houghton PCC and other intermediate care facilities over time.

The ICAR service will operate from a 24 bedded inpatient unit within Houghton PCC. The service will bring together both medical and nursing care with one unit adopting a rehabilitative and reablement ethos to service delivery. The service aims to meet the needs of individuals who require a higher degree of care and support than can be provided in a home setting, even with new technology and enhanced care support, and for whom care in an acute hospital bed would be default outcome, however these individuals do not require the care of an acute physician.

The service will support individuals to maximise their potential and remain as independent as possible, and reduce hospital readmissions and admissions to long term care, by providing opportunities and actively encouraging reablement and rehabilitation whilst undertaking health and social care assessments and providing nursing and / or medical care.

The service will not however work in isolation, and will have wider inter-disciplinary input from a range services who will provide in-reach into the unit. These include: community therapy, medicines management, specialist nurses, community matrons, case/.care managers, key workers social work and specialist mental health support. Carers will also be actively involved in the planning and delivery of integrated care for the users of the services.

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Collaborative working with other providers across the whole system will also be required, such as North East Ambulance Service, Housing services and the voluntary and community sector.

In line with this the number of carers in Sunderland is also predicted to increase and many will be carrying a greater burden of care as people with long-term illness and disability are supported at home for longer and the prevalence of certain illnesses e.g. dementia, increases. Unless carers are well supported they will be unable to assist in the delivery of care at home or becoming more economically active and resilient.

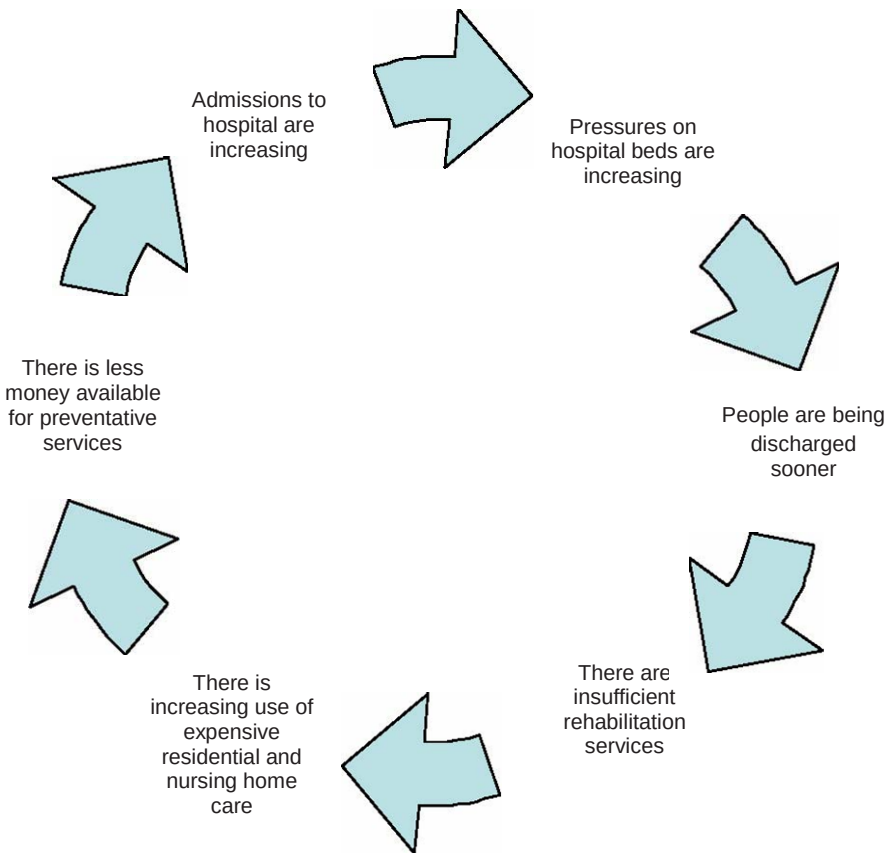
5) Evidence of what works

A key aim of health and social care services is to help older people with care and support needs to continue to live a chosen lifestyle and to have as good a life as possible. This might involve:

- Preventing the person from becoming ill or frail in the first place (Primary prevention)
- Helping someone manage a condition as well as possible (Secondary prevention)
- Preventing a deterioration in an existing condition (Tertiary prevention)
- Providing active support to help someone regain as much autonomy and independence as possible (Rehabilitation)

The University of Birmingham Health Services Management Centre in its paper 'The billion dollar question': embedding prevention in older peoples services, documents the increasing pressures health and social care services have fund themselves under due to a series of demographic, social and technological changes. The audit commission (1997, 2000) has described the pressures in the system in terms of a vicious circle (see below figure 1).

Figure 1: The vicious circle, Audit Commission (1997, 2000)



As admissions rise, it is argued, lengths of stay decline, opportunities for rehabilitation are reduced, there is an increased use of expensive care home places, and less money for rehabilitation/preventative services – thereby leading to more hospital admissions. In order to break this cycle, there is a need to invest more in both prevention and rehabilitation, to help older people to stay healthier, more independent and socially included for longer and to recover as fully as possible when they do require hospital treatment.

In response to this 10 potentially high impact changes are proposed to embed prevention into older peoples services, which are also applicable to people with problems in daily living and those living with long term conditions;

- Promoting healthy lifestyles (primary prevention)
- Vaccination (primary intervention)
- Screening (primary/secondary/tertiary prevention)
- Falls prevention (primary/secondary/tertiary prevention)
- Housing adaptations and practical support (primary/secondary/tertiary prevention)
- Telecare and technology (secondary/tertiary prevention)
- Intermediate care (secondary/tertiary prevention)
- Re-ablement (secondary/tertiary prevention)
- Partnership working (may have longer term impacts, currently unknown)
- Personalisation (may have longer-term impacts, currently unknown)

In December 2010 The Kings Fund published a paper which considered the research evidence for a range of interventions to avoid emergency or unplanned hospital admissions. This review

identified interventions where there is evidence of an impact on hospital admissions, those where there is evidence that the intervention has no beneficial effect and a range of interventions where more evidence needs to be built in order to determine whether they have the potential to significantly reduce admissions;

Interventions where there is evidence of positive effect

Reducing admissions

Continuity of care with a GP
Hospital at home as an alternative to admission
Assertive case management in mental health
Self-management
Early senior review in A&E
Multidisciplinary interventions and telemonitoring in heart failure
Integration of primary and secondary care
Role of specialist nurses in neuro conditions.
Chronic Pain management programmes with behavioural therapy

Reducing re-admissions

Structured discharge planning
Personalised health care programmes

Interventions with evidence of little or no beneficial effect

Pharmacist home-based medication review
Intermediate care
Community-based case management (generic conditions)
Early discharge to hospital at home on readmissions
Nurse-led interventions pre- and post-discharge for patients with chronic obstructive pulmonary disease (COPD)

Interventions for which further evidence is needed

Increasing GP practice size
Changing out-of-hours primary care arrangements
Chronic care management in primary care
Telemedicine
Cost-effectiveness of GPs in A&E
Access to social care in A&E
Hospital-based case management
Rehabilitation programmes and outcomes delivered
Rapid response teams

It is important to remember that the purpose of this review was to examine only the impact of these interventions on hospital admissions; a number of these interventions are intended to have wider beneficial effects, such as reducing length of stay or improving patient experience of care, and may be successful in achieving these.

Conclusion and recommendations

The main conclusion drawn from the research was that there was insufficient evidence to support the effectiveness of many of the interventions currently being implemented to reduce avoidable hospital admissions. A number of recommendations were made as a result of this:

Hospital providers and commissioners should:

- be clear about which admissions they consider to be avoidable, what proportion of these admissions are avoidable, and how these admissions should be coded and measured
- implement evidence-based interventions as follows:
  -multidisciplinary interventions and telemonitoring for patients with heart failure, and assertive case management for patients with mental health problems
  -hospital at home
  -closer integration of primary and secondary care
  -conduct early senior review in A&E, and implement structured discharge planning (providers only)

- continue to implement acute assessment units, but consider the overall impact on number of admissions
- aim to increase self-management among people with long-term conditions where evidence of benefit.

In addition, commissioners should:

- disinvest in programmes where there is robust evidence that they have little or no effect
- evaluate all new interventions, as even those that have proved beneficial in other settings may not be transferable to the local population.

Primary care providers should:

- aim to increase continuity of care with a GP
- consider the impact of local, out-of-hours primary care arrangements on avoidable admissions
- consider closer integration of primary and social care, evaluating the outcomes of new interventions
- consider closer integration of primary and secondary care, evaluating outcomes of new interventions.

There is strong evidence from the Department of Health's National QIPP LTC Workstream regarding three key drivers for LTC care – these are risk profiling, integrated neighbourhood care teams, and self management/shared decision making.

The Combined Predictive Risk Model (CPM) identifies patients who are at risk of a future hospital admission. Health services can then proactively manage these at risk patients in order to reduce their risk. This model uses 'health resource' data such as medicines, diagnoses, outpatient appointments, A&E attendances, admissions, consultation rates, to assign every GP patient a risk score – their risk of future admission to hospital.

Patients are then categorised as Very high risk; High risk; Medium risk; Low risk – each category indicating different priorities for management

Since March 2011 CPM information has been available to every GP in NHS SoTW with lists of every patient in each category. Best practice states that GPs should pro-actively manage and prioritise patients in Very high and High risk Categories – working with patients, carers, specialists, community matrons, adult care, and voluntary sector services as needed to improve integrated care and self care.

6) User Views

The key focus of the Intermediate Care at Home service was provide support for people to recover/maintain their ability to undertaken tasks associated with daily living. An internal commissioned review of this service and associated outcomes was conducted in 2010. Analysis

below is based on the re-ablement clients only (158);

- The vast majority of respondents (83%) to the customer feedback survey felt that the quality of the service they had received was 'good' or 'excellent' and 100% state that they would use the service again if they needed it;
- It was reported by reablement staff that not all individuals referred to the service were suitable for reablement;
- In some cases there seems to be an extended customer journey to reach the service, e.g. a hospital physiotherapist will identify someone, this will be passed to nurse who will then pass on to the social worker who will then pass on to ICAH staff who will then need to engage therapy staff.

More specific outcome focused feedback from the customer feedback survey highlights that from starting the service until now:

- 71% felt that their health condition is better managed than it was.
- 46% feel more physically active than they did.
- 56% feel more mentally active than they did.
- 64% find it easier to undertake routine daily activities in their own home.
- 82% feel more confident to live in their own home than they did.
- 46% feel that they now need less support than they did previously.
- 57% felt that they had achieved what they wanted to from the service (and a further 32% partially).

In terms of respondent's ability to carry out a variety of activities:

- 35% felt their ability to walk indoors/outdoors had improved.
- 56% felt that their ability to get in/out of bed had improved.
- 44% felt that their ability to get on/off a chair had improved.
- 46% felt that their ability use the bath/shower had improved.
- 41% felt that their ability to get washed and dressed had improved.
- 22% felt that their ability to cook a meal had improved.

The analysis/consultation highlighted a number of positives from the Intermediate Care Scheme, not just in terms of evidential customer outcomes, short-term satisfaction and longer-term reablement outcomes, but also in terms of service delivery and cost-effectiveness outcomes, with scheme demonstrating strong cost-benefit outcomes.

During 2009/10, a number of focus groups and 1-1 interviews took place with the public and carers working with Age Concern (now Age UK), Sunderland Carers Centre, Farmbrough Court, Sycamore Care Centre and City Hospitals Sunderland.

Due to the breadth of services that come under the heading of Intermediate Care, and its links with hospital discharge and wider community health and social care services, this led to a very varied content of discussion in the PPI work above and subsequently very diverse comments and views. However, key themes emerging can be summarised as:

- The need for person-centred care, focused on individual needs and promoting choice and control
- A social disability model which promotes independence and enablement not compensation
- Carers as partners in care, whose views, needs and expertise should be recognised and acted upon
- The need for good discharge planning and coordinated transfer of care
- Care at home if possible, but availability of alternatives to hospital if recuperation and rehabilitation is required

In September 2010, a 'Positive Ageing' conference was held by the TPCT, in conjunction with

HHAS and Age UK. During the conference, more that 60 members of the public, users and carers participated in workshops on 'Staying Healthy for the Future', which included a question on support after illness. The comments most relevant to Intermediate Care, Reablement and Rehabilitation are provided below.

What have been your good experiences? Any ideas/thoughts on what else would have made a positive contribution after a period of ill health?

- *Quick access to health services*
- *Immediate post-op care*
- *24/7 Team*
- *Social services*
- *Equipment provided*
- *Good hospital after care*
- *Follow up rehabilitation*
- *GP to contact patient post discharge/ill health*
- *Phasing into normal routine*
- *More information should be given*
- *More respite facilities*
- *Longer hospital stay to recover or more access to intermediate care i.e. Farmbrough Court*
- *Single rooms in hospital*
- *Individualised care*
- *Care based on needs rather than statistics*
- *Blocks of intermediate care provided after which nothing else provided – individual goes back to where they started (very negative experience)*

7) Equality Impact Assessments

Local feedback from the International Community Organisation of Sunderland (ICOS), highlighted the barriers faced in accessing health, particularly in relation to GP services which are not always accessible to migrant communities. ICOS is currently undertaking ongoing work with GPs to improve this. Walk-in centres also work differently in Poland to Sunderland and there is a need to make information on how they work and how to access them available, to improve access and take up of services. This may ultimately help to prevent the number of people attending or being admitted to hospital, through earlier access to medical advice and services within the community.

8) Unmet needs and service gaps

- Falls are a major cause of ill health (morbidity) amongst older people, and the rate of falls in Sunderland is higher than that of Gateshead and South Tyneside, and higher still than the national average;
- The number of hospital admissions for people aged 65+ due to a fall have shown steady increase;
- There is a need to actively identify individuals with existing health issues and those who are at risk of developing serious illnesses, at the earliest opportunity in order to establish treatment plans before conditions escalate;
- Local analysis showed, of those admitted to residential and nursing care from the advice & resolution panel between April – July 2011 33%, had come from a hospital setting. This could highlight pressure from hospital based professionals to admit individuals to residential care rather than return home;

- Analysis of the 728 admissions to permanent residential and nursing care in the 2 years prior to July 2011, highlighted that some 42% of clients had no services in place to help them remain in their own homes in the 2 months prior to going into care. This could also be seen as a contributory factor in admissions to hospital;
- Informal "carer fatigue" in supporting people in daily living as a result of long-standing and life-limiting conditions is a significant reason for public-sector care and support, particularly for those individuals with more significant dependencies. Without this informal care n place there is an increased risk of admission to hospital;
- Sunderland has higher number of emergency admissions and overnight occupied beds per 1,000 population and a longer length of stay for emergency impatient admissions than that of England;
- This may suggest there is a greater demand for emergency beds in Sunderland, inappropriate use of emergency beds, or that people are staying in those beds for longer periods of time e.g. for traumatic brain Injury;
- In 2009/10, there were 854 delayed discharges from hospital (for people aged 18+). There is a need to promote seamless discharges from hospital to ensure that hospital space is available for those who are in most need of medical intervention;
- In 2010/11 there were 33,613 emergency admissions to Sunderland hospital, of those, 14,531 (43%) cases were readmitted within 30days. Those aged 75+, accounted for 28% of all emergency admissions and 20% of all readmissions. This data may suggest that for a large proportion of older people discharged from care, either there were no appropriate care packages in place or that they were not proportionate to need;
- A joint audit of readmissions to the acute medical unit in March 2010, found that in 59% of cases the readmission was thought to have been avoidable:
- Unnecessary readmissions to hospital can have a far greater impact than for the individual themselves, but can ultimately result in a shortage of available beds preventing those who are in need of hospital treatment accessing this. Highlighting the need for greater focus and resources to prevent avoidable hospital admissions, by improving the support available to patients within the 30 days following discharge from hospital;
- 27% of older people discharged from hospital in 2009/10, were no longer at home, 3 months after discharge. To increase the numbers of people remaining at home after discharge from hospital, there is a need for increased high quality, intermediate and rehabilitative services, particularly for those with long term conditions;

Substantial need remains to identify carers so that they are aware of the services offered, to protect carers' own health (mental and physical), to lessen the burden of care and ensure that they can maintain a life outside of their caring responsibilities. It is essential that all services are sensitive to the needs of carers.

There is a need for a more systematic approach to improving the quality of life and well-being of carers, building on practice already in place through the Wellness Service, Carers Breaks and Opportunities Fund etc.

9) Recommendations for Commissioning

Joint health & social care recommendations

- Health & Social care providers to implement self care model for long term conditions, including reviewing current provision of self management education and support, improving access to a menu of options, systematic delivery within pathways, and

workforce development to increase capacity and capability;

- Health & Social care providers to consider the findings of the review and Commission new models and approaches to specialist rehabilitation which provides increased access from primary care, a menu based approach to service delivery and ensure synergies and joint working between specialist professionals - key focus areas include cardiac, COPD, falls, stroke and Neuro;

- Health & Social care providers to develop and commission an integrated model of intermediate care services (including rehabilitation and reablement) for individuals with long term conditions and frail elderly within each PCT locality, including care within individuals own homes and community based step up facilities;

- Health & Social Care providers to improve discharge processes (including documentation) and opportunities for early supported discharge which focus on and integrate both health and social care needs;

- Introduce Telehealth technology for patients with long term conditions under a joint initiative across NHS SoTW with Local Authority colleagues in each locality;

Health recommendations

- Health Care providers to review Urgent Care Nursing Services across Sunderland to understand the impact to develop a future state;

- Health Care providers to review the existing rapid access community nursing teams and consider opportunities for improved access and clarity of role (linked to intermediate care, see above);

- Health Care providers to review provision role and effectiveness of Specialist Community Nursing and Community Matron to develop appropriate models of case management that support proactive and anticipatory primary care;

- Health Care providers to implement the revised service specification of the district nursing service and consider future commissioning intentions;

- Health care to introduce a proactive approach to early LTC management through closer alliance with leisure services and rehab programmes;

- Health Care providers to improve provision of heart failure services across primary community and secondary care;

- Health Care providers to review the COPD pathway and identify improvements that could be made to improve patient care;

- Health Care providers to implement single-site model for weekend TIA clinics;

- Health Care providers to develop a revised service model for the provision of diabetes services across primary community and acute;

- Health Care providers to develop recommendations for future commissioning following the pilot of the community arrhythmia service;

- Health Care providers to implement an AQP procurement for community based INR services;

- Health Care providers to improve provision of AF services across primary, community and secondary care;

- Health Care providers to commission a home oxygen assessment service;

- Primary Care Mental Health Services - increase input into long-term conditions in terms of identification of mental health problems and treating them – through other specialist staff already dealing with LTC;

- Health care to introduce integrated working between specialist rehabiltation services and community services;

- Health Care providers to develop safe and appropriate pathways for patients with ambulatory care conditions to enable assessment and treatment in hospital without the need to be admitted;

- Health Care providers to develop a community based cellulitis model and service;

- Health Care providers to develop a community based DVT model and service;

- Health care to introduce quality specifications for all rehabilitation services with an outcomes framework;

- Review impact of reablement on readmissions, focus on whether a step up approach would be implemented, so stepping up to a reablement facility Eg Houghton le Spring PCC and rehab beds;

Social Care recommendations

- In order to reduce the number of people admitted to hospital there is a need to work more preventatively within local communities to identify people at risk of admission to care/hospital by strengthening the social work presence across the five geographical areas;

- Increased focus on identifying multiple admissions to hospital, in order to recognise at the earliest opportunity those individuals that may be at risk of requiring care in the future;

- There is a need for social care providers to intervene at the earliest opportunity in order to prevent admissions by delivering interventions which promote care within the home;

- Improved use of existing and new assistive technology as a preventative measure, through appropriate targeting;

- Improved medicine management for both individuals and their carers through increased advice and support;

- There is a need for providers to evaluate the impact of 'Time to think beds' on avoiding readmissions through the provision of high quality reablement interventions and Maple lodge EMI assessment unit, in reducing mental health hospital admissions through the use of a 'step up' model;

- Ensure services are available to support carers through the provision of advice, information and education and training. Alongside this there is a need for more targeting

of carers break opportunities, to reduce likelihood of carer fatigue in situations where this is a significant risk;

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- Utilising extra care accommodation where this is an appropriate resolution to permanent residential/nursing care and explore improved options for adults of a younger age with significant functional problems;
- Improved collaboration with services such as memory protection service to support early identification of both individuals and carers;

10) Recommendations for needs assessment work

Further analysis of international migrants to the City, to establish their health needs and how they access health services within the community.

Health Needs Assessment for Nursing Home Residents, to:

- Provide information on current health and well-being needs of nursing home residents in Sunderland
- Provide information on current healthcare utilisation of this population
- Inform the Sunderland PCT/CCG and LA Commissioners and others involved with the care of nursing home residents about where services need to be focused to achieve quality care that is equitable to other older people living in South Tyneside

The above will help to target services to these groups of individuals

Key contacts

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