

Older people's care

Understanding how integrated care systems are supporting older people

People in England can now expect to live for far longer than ever before, but extra years of life are not always spent in good health. Older people are now more likely to live with multiple and complex long-term conditions, or with frailty or dementia.

30% of people aged 65 and over, and 50% of those aged 80 and over, are likely to fall at least once a year.

One in seven people aged 85 or over permanently live in a care home. People resident in care homes account for 185,000 emergency admissions each year and 1.46

million emergency bed days, with 35-40% of emergency admissions potentially avoidable. Evidence suggests that many people living in care homes are not having their needs assessed and addressed as well as they could be, often resulting in unnecessary, unplanned and avoidable admissions to hospital.

The way we provide care and support for the most vulnerable groups of adults therefore needs to change – moving from providing care in hospitals when people are unwell, to supporting people to stay well and recover in their own homes, with the right support in place in their communities.

Helping people to stay out of hospital in South Yorkshire and Bassetlaw

Health and social care partners in Doncaster identified that their intermediate care services, including care for people with dementia, were too complicated, difficult to navigate and inefficient. They also found that 50% of people aged over 75 admitted to hospital could have been better supported at home.

Doncaster now has a single coordinated response to support an individual to stay at home. This includes increased capacity, an integrated care record and routing referrals for community support through a single point of access.

As a result of these changes the number of journeys by ambulances to emergency departments following a 999 call due to a fall, fell by 15% in 2017/18 for patients aged 65 and over. As at December 2018, this has reduced by a further 14%. In addition, the number of unplanned hospital admissions for people aged 65 and over for trauma and orthopaedics has also fallen by around 17% in the last two years. Fewer people are needing long-term care and more people are staying at home after receiving intermediate care in their communities.

Dorset's virtual ward supporting people with frailty

Hundreds of older people living with frailty are being monitored through a 'virtual ward' in Dorset, which is helping to keep them out of hospital. Doctors, nurses, social care staff, physiotherapists and others in West Dorset discuss patients who are put on a rolling 'virtual' list each week if thought to be at risk of hospital admission.



A person over 80 who spends more than 10 days in hospital will lose 10% of muscle mass - equivalent to 10 years of ageing.



As well as discussing patients' medical issues, they also bring in wider issues such as family problems, social care packages, equipment needed or lifestyle problems such as excessive drinking. Any problem set to impact on the health of the patient is then dealt with by the most appropriate member of the team, usually through a home visit.

Special health and social care coordinators, which straddle the NHS and social care teams, have information about all those aged over



On average older men now spend 2.4 years and women spend 3 years with substantial care needs.

75 registered with West Dorset GPs - if they go into hospital the coordinators will receive an alert and begin to plan for discharge. It often alleviates pressure on GPs who do not need to spend time calling social care

services or trying to organise other services in short appointments.

The approach is being rolled out across Dorset and other areas of the country are running similar schemes to identify older people and help support them better at home.

Camden's Rapid Response Team

Camden's Rapid Response Service is preventing unplanned avoidable admissions or readmission to hospital by providing care for people in their home, including in residential and nursing placements. The service supports those patients who have an urgent and immediate medical crisis that would be better treated at home, or in the community, without the need for hospital admission.

This has been particularly beneficial to older people, who are at an increased risk of hospital-acquired infections and falls due to an unfamiliar environment. The service offers short-term intensive support for up to 10 days, including nursing and therapeutic assessments and social care, enabling patients to safely regain independence as quickly as possible.

Referrals are received 24 hours a day, 7 days a week at a single point of access, from GPs, the London Ambulance Service and community

services. Once a referral is received, the service will complete a telephone triage and a healthcare professional will visit the patient at home, ideally within two hours.

The team is managed by a senior nurse and includes nurses, occupational therapists, physiotherapists, a pharmacist, a rehabilitation assistant and healthcare assistants. The service reports that over 80% of referrals have resulted in avoiding admission.

Surrey Heartlands' Care Home Advice Line

A Care Home Advice Line in Surrey is helping to reduce unnecessary hospital admissions for local care home residents. The service began as a pilot in North West Surrey where in 2017/18 care home residents accounted for over 1,660 admissions to St Peter's Hospital and nearly 2,500 A&E attendances. Over 52% of these hospital admissions took place out of hours and many were unnecessary and could have been avoided with the right medical advice.

Not only was this putting extra pressure on hospital services, but for many older people admission to hospital results in further deterioration of their wellbeing and independence. To address this, North West Surrey CCG worked with Care UK to set up a clinical advice line to support local nursing home staff out of hours and is available to both healthcare professionals and non-professional staff working in residential care homes.

The service has now been rolled out across central and west Surrey and is helping to reduce the number of care home residents being taken to A&E, as staff are now able to look after them more confidently with the right medical advice as well as helping to reduce pressure on emergency services.

Calls are answered by call handlers who determine if a resident really needs an ambulance. If not, a relevant clinician will be in touch who will give a detailed telephone review and advice. If required, they are also able to arrange a face-to-face visit by the out of hours GP.