



MAKING THE SHIFT IN FRAIL ELDERLY CARE

With caring for more frail elderly people out of hospital a key part of the QIPP programme and a cornerstone of many organisations' plans, a roundtable discussion looked at what will enable this shift to take place. Andy Cowper reports

The shift to caring for more frail elderly people out of hospital is a key part of the quality, innovation, productivity and prevention programme. Rob Webster, chief executive of Leeds Community Healthcare Trust, opened the roundtable discussion, suggesting that addressing this shift must be a system response.

He said: "Working from single organisational perspectives will fail. The challenge now is completely different from the mid-20th century, when the NHS was created to support and treat the sick and dying. Today, diseases that would have been fatal in 1948 are long-term conditions. And people expect to be cured, but their diseases can't be cured."

"Our major issues today are dementia, the frail elderly, chronic disease and multiple morbidity. We must think how we can support the frail elderly to live fully as healthily as possible – and when they need acute care, ensure it's good quality."

"Commissioners must focus

on chronic disease, health, wellbeing and things that drive these, like good parenting skills. We need a provider response built on the best evidence.

"The system response should build on the fantastic asset of list-based general practice, with health status records, incentivising GPs to risk-stratify patients and get the right response at the right level."

"We must raise the prestige of keeping patients well, via an integrated team across health and social care, affecting how people live in communities."

"In healthcare, we waste the assets of people every day. Online banking and supermarket self-checkouts successfully privatised our labour. We must support self-care, risk-stratify and plan care around patients, supported by brilliant IT and good acute care."

"The system puts up many barriers to this, including funding. Leadership in our current system only calls you to account for your own organisation. Financial systems

'Currently, pressure in the system is huge... Our job is to deliver better outcomes'

are based on the 1990s problem of waiting times: they reduced them but don't fix our problem today – successfully treating a much older population. Financial systems must change to address risk and integration, with approaches like 'prime vendor contracts'.

"We must always focus in social value: counting things like our impact on people's ability to hold a job or have a good family life, instead of outcomes."

Andrew Burnell, chief executive of City Healthcare Partnerships CIC, suggested: "Currently, pressure in the system is huge. Front-line colleagues say this isn't helped

by recent changes. Our job is to deliver better outcomes in trying times."

"Unfortunately, some centrally driven policy drives care into silos, misunderstanding that local politicians don't necessarily think the same as national ones. We try to drive integration; the national agenda drives other things. Health and wellbeing boards are having to come up to speed at 120 mph."

"Elements of finance and regulation must change. As a CIC provider, we're not regulated by Monitor, which is marvellous: we're regulated by patient care and outcome, and staff satisfaction."

"We take risk to improve patient care: that keeps us in business, employing 1,004 staff. We're already in provider plurality, but this year's winter pressures showed our future if we stay stuck in the current system. Our acute provider's applying to become an FT, and has to show Monitor what it is doing. In the reporting system, regulation and performance

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Clockwise, from top left: Chris Bull, Conor Burke, Andrew Burnell, Mark Newbold, Andy Cowper, Merav Dover, Emma Pearson, Rob Webster, Jonathon Fagge, Neil Griffiths, Chris Hopson

must be managed in a collective way to deliver new partnership approaches. What do current challenges around dementia and frail elderly mean for our acute provider's FT application?

"We need not to reinvent wheels. There are great ideas how to provide better services: just implement them. Where's the evidence being so risk-averse works? We won't meet the coming demand without taking risks.

"We must develop risk-sharing arrangements with our community: use relationships and community micro-cohesion to create a sustainable future. It's about using the resource of patients and the expert community."

Emma Pearson, chief executive, health and wellbeing, Capita, noted the need to move quickly. She said: "Cash is shrinking; massive changes are under way. We can't do this without underpinning shared data and knowledge, be it of patients or social care users.

"We lack a robust enough data system to give us a holistic picture, look across registered GP lists and develop holistically into social and preventative care. We must change provider incentives to look more at prevention. And we need to look at the 'Nudge' work: how to link it to public health and change behaviours to give people accountability for their lifestyle choices."

Foundation Trust Network chief executive Chris Hopson described the current situation as exciting and scary. He said:

"I'm a natural optimist but I'm fairly pessimistic about this. We've got 21st century health needs, which we're trying to meet with a mid-20th century NHS, stacked against integration. We've split social care from NHS care; we've atomised providers into ambulances, community, acute and mental health.

"We've got the money wrong, focused on individual institutions: our incentives are about individual institutions. We've got performance management wrong: it's about the individual, not the whole

system. Our leadership model's wrong: it's about individual institutions. Our culture and values are wrong: we don't value innovators. Our IT and data approach is wrong. The whole model is wrong.

"Changing this is a 10-year process, already happening in places due to leaders like Rob [Webster] and Mark [Newbold], who see their job being to lead things as a single integrated system, despite all incentives pointing the wrong way. They're taking risks and putting their personal futures on the line."

Norwich CCG chief executive Jonathon Fagge felt optimistic. He said: "The vision for integrated care close to home works: integrated care needs either a clear national vision or genuine local freedom. We can enable commissioner and provider teams to design something that works for their population, but habits of central command and control seem to pop back up when problems appear in A&E, and the centre says 'do this to fix it'. That goes against local innovators and moves them backwards, though it may lift the worst performers up from the floor.

"Innovation's vital, but also expensive and disruptive: it has a failure rate and it's hard. Our clinicians can design the system, but someone must make it happen. Manager-bashing is unhelpful: we need good managers to do the detail-work."

"We clearly need finance system changes to address the acute sector's likely response to potential loss of income. I don't quite accept that payment by

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results drives activity: we know our acute provider has a PFI cost-base and runs very full. If we cut its activity its income falls but not its costs. As its commissioner, we must be sympathetic. If we go from cost-and-volume base to block contracts, we'll be certain costs are locked-in, but I'm not sure savings come from activity: that's the risk.

"We could risk-share with providers: that raises Monitor's attitude to risk. If I ask my acute provider to take risk, what is Monitor's view? Torbay is facing this difficulty."

Mark Newbold, chief executive of Heart of Birmingham FT, suggested "the NHS had never felt this uncertain since I started". He said: "We ought to have a system changed to local leadership, but it seems that nothing has changed, judging by the central response to the urgent care problems. I can see the new world in which we feel we should be operating, but it still feels like the old world.

"We need system targets, not individual ones. Right now, it's very hard being heavily regulated as an individual acute provider. System levers and incentives all

ROUNDTABLE PARTICIPANTS

Chris Bull former chief executive, Herefordshire Council and PCT, adviser to Public Health England, and chair, Winterborne View improvement board

Conor Burke accountable officer, Barking and Dagenham and Havering and Redbridge CCGs

Andrew Burnell chief executive, City Healthcare Partnerships CIC

Merav Dover chief officer, Southwark and Lambeth Integrated Care

Jonathon Fagge chief executive, Norwich CCG

Neil Griffiths health market sector director, Capita

Chris Hopson chief executive, Foundation Trust Network

Dr Mark Newbold chief executive, Heart of Birmingham Foundation Trust

Emma Pearson chief executive, health and wellbeing, Capita

Rob Webster chief executive, Leeds Community Trust

work based on individual organisation targets: tariff, etc. Norman Lamb's integration pilots may unpick details.

"Do we have a common understanding of what shared care out-of-hours means: not geographically, but who leads on the long-term conditions care? Lead providers might be acute, community, third sector or private, but we must understand the model of care."

Chris Bull, adviser to Public Health England and chair of the Winterborne View improvement board, noted: "Having worked around care integration for a long time, we rarely describe the problem we're trying to solve. Much of our challenge today is how to care for and support a growing older population."

"It's not about organisational structures and processes: they make it easy to get caught in a debate about integration – which is the process you do to achieve something, not a thing in and of itself."

"Understanding our challenge means a better chance to bring together local council and community leaders. Most people have experience of struggles to support an older relative getting sub-optimal care. Start by defining our problem, then ask 'what can we do together to try to resolve it?'"

"It needs health and wellbeing board leadership, and also what I call permission. Incentives, especially in the NHS, often act counter to trying to find sensible local solutions."

"We discuss health and social care as if they're the same, and heavy users of social care are often heavy users of health. There may be benefits of rationalisation of duplication and cross-boundary skills, but most social care is procured by citizens themselves. So we need to think through what part individuals and families play, and how personal health budgets fit in."

"Who's in control? Do we have a system which delivers what it delivers? Or empowered users who can choose and whose choices and risks we support?"

"There's an issue on public health and early intervention: how we respond differently to people in crisis; and design and deliver long-term conditions support. We must also think through upstream interventions, so that at a point of crisis, an acute bed isn't the only alternative. We know district

'Much of our challenge today is how to care for and support a growing older population'

general hospitals are pretty full of older people in acute beds for sensible reasons individually – but how many of those admissions could have been avoided by effective early intervention?

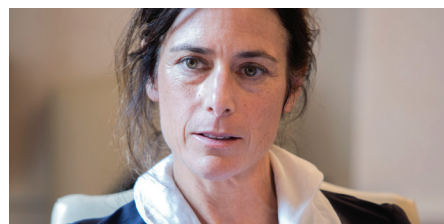
"From the council/local authority viewpoint, unless we approach this in a totally new way, costs will become unaffordable. So we either plough in more money, which can only be at NHS expense, or we think through joint responses to make better care for old people in non-institutional settings sustainable in the long run."

Neil Griffiths, health market sector director of Capita Group, suggested "an encouraging number of CCGs have started looking at the system in a different way". He said: "One challenge is integrated care: ideally across community, social and secondary care, creating a whole-system in one go, if possible."

"The single-organisational principle Rob [Webster] mentioned doesn't seem to work due to the restrictions it imposes on people's care. Part of the yet-to-do heavy lifting is that community care is stuck between GPs and secondary care, being too pulled about to let them show system leadership."

"Cambridgeshire's approach of pathways as organising principles looks interesting. There the challenge is to integrate between pathways, with the ultimate prize being integrating pathways around the individual patient. That's really hard but involves prime contractors or individuals taking on a system leadership role to build systems around that."

"Concerns are about CCGs' capacity to do this in the face of various pressures, and the lack of suitable IT and data. The historical information needed to actually define a cost-base doesn't exist. Can we operate the system to collect that information to enhance the service as we go, incrementally



developing data to the point of having the information needed to set a capitated budget?

"More can be done on prevention: things like social investment bonds, which will pay out to investors in five or 10 years' time. We need bold steps. The prevention problem is always the time-lag to payback."

"We must engage patients and ask them what they want from a system designed around them. Having done some of that work, patients' logic and common sense are great. They don't make crazy demands."

Merav Dover, chief officer of Southwark and Lambeth Integrated Care, said: "We can transform this system at scale and pace. We have the financial support of Guys and Tommy's charity funding us while we take risks. All organisations are pooling resources, giving us more risk-taking freedoms."

"Our communities have people dying too young and living too many years in pain and unhappiness. Our professionals are increasingly unhappy with the service they can provide. And money's running out. Nationally and locally, we have extraordinary clinicians, professionals, managers and people in our communities: together we will deliver. We now understand our costs better than ever. Neil's right: an acutuary would say 'you're kidding', but it's good enough: let's go for it."

"We need better proactive identification of those at highest risk of getting ill. Then we must act, coordinate and be terrier-like in making sure that appropriate care is developed and delivered – nearly always in the patient's home. It's about getting the right workers doing the right thing to and with the right person in the right place

at the right time."

"Our five provider organisations and two commissioners have to join up services – and remember that five wrongs don't make a right. It's about reliable, proactive, preventative and coordinated care."

"We must resource our communities' assets, developing and building on them, helping them support one another. It's not just about one clinical silo: it's about fantastic volunteer schemes, like going into elderly people's homes to take them out for a group walk around the park and then back into their own home. For older people, feeling safe and supported to take part and leave their home can help them feel less lonely. Getting older people feeling safe to go for regular walks would reduce falls more than a falls clinic. Using volunteers, making healthcare 'open source'."

"There's a huge behaviour change programme to help communities understand their health is partly their responsibility: they can't smoke and drink and not go out and exercise, and then assume treatment will fix them. We need behaviour change to support system change."

Conor Burke, accountable officer for Barking and Dagenham and Havering and Redbridge CCGs, agreed.

He said: "Defining the problem requires intelligence and data. Improving care for frail older people is a macro-level problem, but a lead provider needs micro-level data on what it looks like over a number of years, without which it's difficult to negotiate and specify your offering. We also need a better narrative to bind us into a joint solution, and I think we should move from



'Moving care out of hospitals means motivating front-line colleagues to behave and work differently'

saying 'integrated' to 'person-centred'.

"Politics hasn't been mentioned. There are issues around risk-taking post-Mid Staffs. It's also two years to the general election, which means we've effectively got a year, with local elections in London next year. The latest reorganisation stopped us developing risk-sharing contracts and sharing data. We need to recognise political reality, and plan for what can work beyond the next election.

"I started in the NHS as an occupational therapist 25 years ago doing Hospital At Home. We're still talking about it now, using new names. Others are doing it: the US has good examples.

"Moving care out of hospitals means motivating front-line colleagues to behave and work differently, regardless of system disincentives. The front line will still be around after the next election. CCGs offer a chance to broaden this agenda to GPs, which we've never really done before. I have 190 practices, with 550 GPs: how can I get them over the next five to 10 years to really move this forward as local leaders?"

Mr Webster agreed that since "GPs stay in an area, they have to lead this consistently. Scale is an issue: most people go to their GP six times a year. GPs are part of the solution, but they're part

of the problem too".

Ms Pearson added: "It feels as if we went backwards on GPs. Twenty years ago, they were out in the community more, picking up on problems as a family doctor. Now there are huge constraints on access and being able to refer into systems."

Ms Dover suggested separating what only GPs can do from what other staff can do. She said: "Who can step in and do early risk-assessment? Who's first to notice when an older person starts deteriorating? Probably a family member, faith leader, neighbour or the person running the corner shop. How can they alert us?"

Mr Fagge observed that, when changing its offer and business model, "the private sector borrows to invest. NHS financial flexibility is very limited. Without a consistent cross-system financial approach, there are disincentives to doing the right thing."

Mr Hopson reflected that despite financial incentives, "people are making this work, saying privately: 'We'll ignore system constraints and see how much we can get away without falling foul of financial accountability'. This is about disruptive innovation."

Dr Newbold agreed, suggesting the "practical step to instead use system-wide goals to set the beginnings of common purpose".

Mr Bull called this "making a reality of local leadership, more in terms of the system than the individual NHS organisations. If we build local political leadership committed to this change, that's potentially powerful."

Mr Webster commissioned King's Fund research on what works in moving care out of acute settings: it "found evidence you can reduce acute numbers, using a set of common goals, preventing acute admissions through carer respite and actively pulling patients out of hospital with discharge support. This means identifying and fixing the bits of your local system that don't work."

Mr Griffiths felt the NHS should run awards for plagiarism. He said: "We could copy local authorities, who have done a lot of work on customer experience and journeys, and on productivity drivers."

Mr Burnell noted: "You don't engage young carers of frail older people by offering them toast and tea, but you might by

social media networks." He added: "As a non-NHS provider, I need competition to exist, but cooperation is the only way we'll fix problems in frail elderly care locally. Some local authorities want to keep provision very local: whether your face fits can matter as much as other aspects."

On system complexity, Mr Bull emphasised: "We must start with a strategic needs assessment for each area and know what's currently provided. If all local organisations described their current local needs together, many solutions would stare us in the face."

"My local community and mental health trusts did a great deal with their local acute, which was struggling with discharge, saying: 'Let us in around the



wards and let us select who we pull out, and give us the tariff price for the last two or three days of a five-day stay.' Win-win: the acute got freed-up beds, community and mental health trusts got investment, and patients got home. It involved addressing some acute clinicians' risk-aversion."

Ms Dover added: "We need chasers and integrators, having created so complex – and not necessarily reliable – a system."

Mr Webster stressed: "If we don't get the acute stuff sorted, other efforts will all be wasted. There's not been a political narrative about integrating care since Ara Darzi left the DH."

Mr Hopson suggested that while that's true, "red, yellow and blue are all groping for it. The politics is important."

Mr Fagge stressed the importance of scale and pace: "Incremental approaches take a long timescale. Pace requires a strong national narrative."

"Or a strong system

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narrative," replied Ms Dover.

Dr Newbold added: "The problem's not about acute providers; it's that we need a new model of care. Regarding a narrative, we all – including the public – need a story of where we're trying to reach."

While Ms Dover felt it would be good to have that, she added: "We can get a long way with system narrative and leadership from the people round this table. If we have a common case for change, that's a narrative. Then, if we mobilise resources accordingly and identify our



first steps, that's likely to work."

Mr Bull emphasised: "There remains a national role to give people freedom to exercise local leadership, enabling them to do things that fit in a locality, rather than be constrained by tonal expectations of how care is organised."

Mr Webster added: "The narrative mustn't pit us against each other 'acute bad, community good', which you can get, especially with local politicians."

Mr Hopson suggested this "shows a need to get local leaders to form a federation".

He said: "Currently, leaders can get away with not doing that, hence fragmentation between acutes, CCGs, local authorities, community, mental health and ambulance trusts. Until the system says 'that's unacceptable', we won't improve frail elderly care at scale and pace. We need sticks and carrots to ensure fragmented, silo-ed care isn't acceptable." ●