# The vision for older people's health and well being in York 2010-2015

## 1 Introduction

1.1 The overarching vision for older people in York, to be achieved over the next five years, is one where **a higher proportion of older people remain within the community, having fewer hospital and care home admissions and are able to enjoy: greater independence; a wider choice of accommodation options; and greater social engagement.**

1.2 During the same time period, the deteriorating financial climate combined with the growth in the numbers of older people, will inevitably mean meeting greater demand with fewer resources.

1.3 This makes it essential to transform the services that health and social care fund, to reduce demand through successful and targeted health and social care interventions and to avoid duplication and waste.

1.4 If the vision is to be achieved then health commissioners and the local authority need to work ever more closely with each other and with voluntary organisations and other third sector bodies, in order to agree common targets for improving the health and well-being of local people and communities. This will require an improved understanding of need, and the ability to better define service requirements and use of resources.

**1.5 Five strategic outcomes have been developed through which the vision can be achieved. These are; that more older people will:**

- **Be demonstrably treated with dignity and respect.**
- **Have greater involvement in family and community life.**
- **Be able to achieve greater independence.**
- **Report that they are able to maintain good health.**
- **Remain within a home of their own.**

1.6 It is not intended that this statement covers every aspect of health and social care, neither should it replicate the range of statements and strategies that already exist. Instead, the intention is to define overarching outcomes which can be applied across health and social care provision and where those outcomes can only be achieved by health and social care working together.

1.7 For each of the outcomes there are a range of evidence based 'outputs' and processes described, by which the outcomes should be achieved. The outcomes are also accompanied by a set of principles which can be

applied not only to the outputs but to any health and social care activity.

1.8 Each of the outcomes are based either on existing policy goals within the local authority or the health community or on research / audit evidence of need, and where their achievement can be measured by a set of local indicators. The final section on implementation begins to explore some of these issues.

## 2 Principles

Below are outlined a set of principles designed to underpin the vision for older people in York. They are intended to be used by staff and managers in order to guide them in a range of situation regarding older people not just in delivering the specific outcomes linked to the vision statement. In this light all professionals are responsible for delivering all the outcomes, not just those that might be seen as belonging to one particular professional group.

2.1 Together we will ensure that our services are available to all irrespective of gender, race, disability, age, religion or sexual orientation and to pay particular attention to groups or sections of society where improvements in health and life expectancy and quality of life and sense of wellbeing are not keeping pace with the rest of the population.

2.2 Our services will reflect the needs and preferences of the people who use our services, of their families and their carers.

2.3 We are jointly committed to providing best value for taxpayers' money and the most effective and fair use of finite resources. We should always ask ourselves 'why shouldn't we work together' rather than 'should we do this together'.

2.4 We will give the people who use our services, their carers and the public the opportunity to influence and scrutinise our performance and priorities; and people, public and staff will be involved in relevant decisions.

2.5 We will expect all our staff, and staff in the services we commission, to deliver quality care and support. Wherever it makes sense we will deliver services through integrated teams, and support staff to work together to create simple access to the care and support our customers need.

2.6 We will work together to ensure that skill development and workforce planning promote quality and encourage integrated working between health and care services.

# Outcomes and outputs that flow from the vision

## 3 Outcome 1 – All older people are demonstrably treated with dignity and respect

3.1 Services should only be purchased from agencies and organisations that have a written and verifiable policy with regard to dignity[1].

3.2 People with dementia should receive help and support from staff knowledgeable about their condition whether in a social care or a health care setting[2].

3.3 Carers of older people, particularly where they are caring for someone with dementia, should be offered an agreed package of support. This should be flexible enough to cope with unexpected changes in circumstances, from the point of diagnosis onwards,[3] as well as information about the relevant condition.

3.4 There should be an improved inter-agency response to first contact. For example; whoever responds to the first contact with an older person, should be skilled enough to find out the whole story. Sufficient time should also be allowed for that person to tell their story in their way and at their pace, and appropriate arrangements should be in place to allow information to be shared between agencies.

3.5 In care settings where there is a key worker the older person should always be offered a choice of who that key worker is. The same should be true when any member of care staff is asked to carry out intimate personal care.

3.6 Where older people have a terminal condition it is important that they die in a place of their choosing and that services work together to help achieve this[4]. Where people indicate they wish to make 'living wills' staff should support and encourage this. Peoples wishes with regard to faith and beliefs should also be recorded and respected.

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[1] *Need to make sure this is included in the new home care contract and should be raised at the provider's forum.*
[2] *Development of the Dementia psychiatric liaison service. Shared pathway of care. Carers passport about that person.*
[3] *See York Strategy for Carers 2009-2011 and Dementia Review, Nov 2008.*
[4] *See End of Life Strategy (under development) and Recommendation 5, End of Life, Delivering Healthy Ambitions*

## 4 Outcome 2 – More older people have greater involvement in family and community life

4.1 All older people should have the opportunity, regardless of incapacity to engage in activities that they enjoy, whether living in their own homes in health care setting or in a care home[5]. Older peoples own contribution to the community through employment and work as volunteers should be recognised and encouraged.

4.2 Good up to date information about the range of services and opportunities should be available to all older people. There should be an offer of support available to those who need it, so that they can take up community provision rather than people simply being signposted to alternative services.

4.3 The local authority and health agencies need to work together to understand where there are risks and barriers to older people participating in community life, eg, snow clearance, access to transport, presence of banks and post offices, etc. Leisure services should ensure that there is proportionality in the activities they offer to ensure they are relevant to and accessible by older people.

4.4 Funding partners need to explore investing in a programme of community leadership. Local existing leaders of voluntary effort should be encouraged and resourced to identify and deliver greater community support for older people[6].

4.5 The impact of living alone in older life, whether as a result of divorce, death, separation , or never having been in a partnership will need to be a consideration in reaching and finding people and in offering support.

4.6 All policies of the local authority and health commissioners should recognise that by 2030 25% of the population of the City will be aged over 65. This should be reflected in the type of services and facilities that are available.

[5] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009*

[6] *See The Westfield Project led by economic development*

## 5 Outcome 3 – More older people are able to maximise their independence

5.1 Older people should always be consulted about any service to be provided and their wishes and views ascertained. Where desired, the option of a personal social care budget should be offered that is sufficient to meet peoples assessed needs. There should be encouragement for older people to self manage health conditions, rather than allowing a potential crisis to occur[7].

5.2 There should be a greater emphasis on collecting the views of service users, carers and those who do not use health or care services but could benefit for doing so. For example, there should be a range of ways to collect feedback, including internet based forums for service users and carers to express consumer views about the care and health services that they receive. Such collections should avoid duplication across agencies and wherever possible should be combined.

5.3 There should be an increased use of technology focussed on alleviating specific risks to service users. The range of technological services available should be explained to service users and carers. Use of technology should be planned and of demonstrable benefit, and should include opportunities for short term usage designed to improve independence and self care[8].

5.4 Older people should be encouraged and enabled to self manage their health conditions.

5.5 Health and care assessments should have an emphasis on what people can do as well as what they cannot and should record activities that people used to participate in and why they no longer do so[9]. There should be a statement about the degree of independence and choice the older person would like to achieve.

5.6 Longer term and intensive care and support should be planned and provided only after looking at rehabilitation and 'reablement' opportunities, which are intended to help people regain skills and confidence to care for themselves. This will include technology based supports. All of which could increase independence and reduce reliance on care services.

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[7] *Recommendation 1 & 9, Long term conditions, Delivering Healthy Ambitions*
[8] *Electronic Home Care Monitoring, Blue Print for Adult Social Care Sept 2009*
[9] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009*

## 6 Outcome 4 - More older people report that they are able to maintain good health

6.1 Health and care services should proactively identify those at risk of hospital admissions and then act to reduce the risks. Alternatives to hospital admission should be available for those who can be cared for outside an acute hospital setting. This will include good care at home as well as care in community based units. These options should be available to avoid admission and to speed up discharge

6.2 Planning for discharges from hospital needs to improve. An older person should only be discharged from hospital when it is both timely and safe for this to occur. Greater attention should be paid to older people's confidence to manage on their own as well as their physical capabilities.

6.3 Where an older person has suffered a stroke then there should be improved restoration of functionality and a diminution in the number of older people who have further strokes or TIAs. The levels of permanent impairment to individuals should be reduced[10].

6.4 Where older people have had a fall that has required a health service intervention, then they should receive a targeted falls prevention service. This is particularly appropriate for older people who have had a fall in a care homes[11].

6.5 There should be a targeted increase in the detection of continence problem in older people with an equivalent diminution in the proportion of older people with a continence problem who are catheterised or use pads to 'manage' the problem[12].

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[10] *York hospital under achieved in terms of its 2008/09 meeting of the stroke standard with only 28% of stroke patients in 2008-09 spending time on a specialist stroke unit. Nationally a third of all patients admitted to hospital for a stroke have previously had an earlier stroke or a TIA. 11% go on to a care home 2% within two weeks.*

[11] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009 and York Health Group Commissioning Intentions 2009/2010 – 2010/2011. Nationally. 80% of hip fractures are to women. Average age is 83. The 2007 RCP Audit showed that 22% of all hip fractures occur in care homes. 27% of older people who have had a hip fracture go on to have a continence problem brought about from their hospital admission although in 60% of those cases no referral is made to a continence service. 11%of patients have an unplanned re-admission to hospital within 12 weeks of their fall. There is a strong connection between the falls and depression, with a 30% increased risk of hip fracture for older women if they are suffering from depression.*

[12] *People with continence problems often suffer for years before they reveal their problem. Just over half of hospital sites and only a third of mental health sites offer structured training in continence care. Documentation of continence assessment and management has been described nationally as "wholly inadequate". 90% of PCTs have a written policy saying continence products (pads) are supplied on the basis of clinical need*

6.6 There is a need for improved services focusing on depression in older people particularly where the person has experienced the bereavement of a long term life partner[13].

6.7 All older people should have access to regular dental care regardless of where they live and their ability to access a dental surgery unaided[14].

6.8 Where older people have difficulty in cutting, or are unable to cut, their toenails, access to an appropriate service that can help with this should be made.[15]

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*yet 73% limit the number of pads to four a day. The average age of those known to the PCT with a continence problem was 80.*

[13] *The majority of older persons who commit suicide are widowed although only a small proportion of the oldest old have experienced the recent loss of a partner. However in absolute terms the oldest old men experience the highest increase in suicide risk immediately after the loss of a spouse.*
*A comprehensive Dutch study in 2008 showed there was a link between a history of depression and Alzheimer's. Amongst those who have experienced the death of a spouse in old age 30-60% meet major depression criteria at one month, 24-30% at two months and 25% at three months. The most effective interventions at alleviating social isolation are group activities at a social and educational level. Individual interventions are less effective but work best where the giver of support is matched in terms of age and interests with those of the recipient.*

[14] *Older people suffer a wide number of likely additional dental problems yet conversely are less likely to receive treatment. For example; The Adult Dental Health Survey 2008 for Portsmouth reviewed dental care of older people in care homes. Found that 465 had no teeth 73% had dentures, 24% suffered oral pain, 29% not seen a dentists in ten years, 25% felt they needed dental treatment tomorrow.The additional problems include those that stem from the type of medication being taken impacting on the capacity to swallow and the likelihood of introducing dental decay, through a diminution in effective soft tissue holding teeth in place and softer diets, which require minimal chewing and thereby reduces stimulation of muscle tone and the condition of the oral tissues. As a consequence, sugar is retained in the mouth for a longer period of time which promotes dental caries.*

[15] *Help the Aged reported in 2005 that over two thirds of older people have foot problems and there is some evidence that the proportion may be higher as many people are too embarrassed to seek help. The longer term impact of denying treatment to those considered to have a low risk is yet to be established although Malkin et al suggested that 25% of people needing foot care are not receiving it.*

## 7 Outcome 5– More older people remain within a home of their own.

7.1 There should be a continued development of a programme of extra care housing particularly providing a stimulus to the independent sector to develop provision for older owner occupiers. There is a need to develop ECH on a community basis rather than a just a housing basis, ie that people can receive the range of extra care services within particular given neighbourhoods[16].

7.2 There needs to be much greater clarity about who the Local Authority would fund in residential care and why[17].

7.3 Older people need to be assured that when it comes to hospital discharge they will have the opportunity to fully explore the choices and the implications of those choices that are available to them.

7.4 Where aids and adaptations do not exacerbate people's dependency then there should be a greater funding emphasis on providing property adaptations. Funding partners should also be aware of the costs and benefits of the adaptation programme and the impact of delays in delivering adaptations[18].

7.5 Over and above access to health and care provision older people's confidence to remain in the community is based on their ability to maintain their property, play a part in their neighbourhoods and to feel safe. The local authority will work with a range of agencies across the City to ensure that these ambitions can be achieved and that older peoples feelings of safety and security are regularly monitored.

[16] *This is similar to the Dutch model of integrated neighbourhoods called 'Woonzorgzones'. These are now being planned in about 30 neighbourhoods and villages all over the Netherlands. The woonzorgzones are geographical areas that offer round-the-clock care and a certain percentage of adapted housing within 200 m walking distance of integrated service.*

[17] *The EPH review should respond to this (likely that care home provision will be seen as for those needing high physical care needs and dementia where people are at risk).*

[18] *See Priorities and Gaps Older Peoples Services to Promote Health and Well- Being Feb 2009*

## 8 Aspects of implementation

8.1 There should be improved measurement of service success by outcomes rather than outputs. In achieving this the test should be who can provide the best outcome at the best possible price rather than professional groups being allowed to 'colonise' areas of service provision, ie, we are the only group who can deal with dementia, continence stroke etc[19].

8.2 There should be a greater capacity to monitor and measure why hospital admissions and care home admissions occur and those results fed back into the commissioning process. From this there will be an increased capacity to target key populations most at risk.

8.3 In order to consolidate skills and knowledge, reduce costs and give service users a more consistent experience, consideration should be given to the balance of services necessary to achieve the outcomes required within the funding available.[20]

8.4 There should be less repeat assessments by different professional groups and organisations and greater service user satisfaction with the assessment process. Where assessments are completed by 'front door' services they should be accompanied by good risk analysis.

8.5 There should be a greater transferability of skills across health and social care.

8.6 There should be an assumption that the delivery of a paid for care and health service should be a last resort. Therefore, health and care should look to provide greater support to family, friends and communities to support older people rather than fund a paid service. Consequently, there should be a shift in expenditure away from funding whole services to one of investment, wherever possible in supporting and extending an existing activity. A greater test of investment should be applied, ie, if this amount of money is spent what is the desired return from that expenditure and is this cost effective.

8.7 Where consultation exercises are undertaken the norm should be that they are jointly undertaken between health services and the local authority unless there is a good reason for not doing so.

[19] *Recommendation 2, Planned Care Delivering Healthy Ambitions.*
[20] *Improving Clarity and Efficiency of the End to End Customer Process, Blue Print for Adult Social Care Sept 2009.*