Where would you like to be cared for?

South Lakes & Furness Patient Engagement Document

What is this engagement document about?

The health and care system in Morecambe Bay faces a number of challenges in delivering certain types of care. This document describes these challenges and describes the ways you can be involved to give us feedback on where you and your relatives would like to be cared for now and in the future.

The type of care we would particularly like your views on is “Step-Up” and “Step-Down” care within south Cumbria. This document explains what this means and also describes different models of this type of care to give you an idea of what is possible. Within Morecambe Bay, Step-Up and Step-Down care in south Cumbria is provided in ward facilities at three sites, Abbey View on the site of Furness General Hospital in Barrow, the Langdale units on the site of Westmorland General Hospital in Kendal and nine beds at Millom Hospital.

What is Step-Up and Step-Down Care?

Step-Up care provides nursing or therapy support for someone who is unable to safely remain in their own home without some care but where residential care or an acute hospital admission is not immediately necessary. Step-Up Care is only intended to be a short term solution until it’s safe to go home.

Patients are stepped-up from home because:

- They have an infection or have fallen and may need some extra nursing support because they’re unable to look after themselves, especially during the night. The rehabilitation ward will support them to regain their independence to return home.
- They need end-of-life care. The unit can look after them in the last days of life if someone is unable or chooses not to be cared for at home.

Step-Down care happens when someone has spent time in hospital and no longer needs the level of care given on a hospital ward but needs a higher level of support than can be given at home currently.

Patients are stepped-down from an acute hospital bed because:

- They may have been in hospital for surgery and need to rehabilitate before it’s safe for them to go home. The ward staff including nurses, physiotherapists, occupational therapists and social workers who will support them.

Abbey View, Langdale Units and Millom Hospital

In total there are 61 Step-Up and Step-Down beds open between the Langdale units at Westmorland General Hospital, Abbey View at Furness General and Millom Hospital serving a total population of 198,512 people in south Cumbria.

At Abbey View, most of the beds are used for people who need Step-Down care from Furness General, however sometimes people are ‘stepped-up’ from the Emergency Department.

The Langdale units see a majority of Step-Ups as the wards are on the same site as the Kendal Urgent Treatment Centre and from referrals by local GPs.

Similar to Langdales, Millom sees mostly Step-Ups with referrals from local GPs.

Why are we talking about Step-Up and Step-Down Care?

Older citizens are the highest users of health and social care. In Morecambe Bay, only 21% of the population are over 65 but account for 40% of emergency admissions and almost 70% of acute hospital bed days. Hospitals are under pressure from growing demand for their services and need to be able to use their resources to treat people who are acutely unwell.

In our Step-Up and Step-Down units the majority of admissions are older people. In a recent ward audit all patients were over 68 years of age with 63% of patients over 85 years of age. In the month-long audit the units cared for 28 people aged between 90 and 101.

Often it is these service users who are well enough to go home but are waiting for the social support they need to be able to live and manage at home safely sometimes leading to very long stays. During the ward audit, 33% of patients were waiting for care packages, care home beds or changes to be made to their house such as grab rails and ramps. Often this was only a few days but sometimes they stayed nearly a month longer beyond the date where it was medically safe for them to go home.

To address this issue, the NHS Long Term Plan[1] published in January 2019 makes a commitment to boosting out of hospital care including community-based crisis care and other services that will keep people in their homes and provide care closer to home.

Since 2014 we have been working together to deliver care closer to home in Morecambe Bay through the Better Care Together Strategy, including:

- Integrated Care Communities – these are based around your GP practices where health and social care staff are connecting with fire and police services, charities and other local groups to identify the people who are at highest risk of being admitted to hospital and supporting them at home.
- Integrated Rapid Response Service seeks to prevent hospital admission. Nurses, occupational therapists, physiotherapist and support staff work with other organisations such as social workers and domiciliary care providers to care for people in their own homes. The teams look after patients who may have developed an infection, an existing condition has got worse, or who may have fallen and need some extra care in order to stay at home and regain their independence. These teams also work together to provide support to people who have been in hospital enabling them to go home earlier.

To make sure we are using our resources effectively and delivering the best care for our patients Morecambe Bay Clinical Commissioning Group (CCG) requested an independent review of community beds in south Cumbria in 2017. This review included the Step-Up and Step-Down beds at Abbey View, Langdale and Millom. The findings from this review were:

- The Langdale units have a layout like an acute hospital ward and don't have facilities such as a kitchen or day room for Step-Up patients. These things create a homely feel and help people to make their own drinks and snacks,

meaning they keep moving about and caring for themselves as much as possible.

- 58% of patients no longer required their Step-Up or Step-Down bed and were in the wrong place due to waiting for a care home place or services not being available that would support the person at home.
- The units are not set up for people with mental health conditions like dementia or for people with little or no rehabilitation potential that need time to think or are waiting for adaptations to their home or a place in a care home.
- During the review, 2 of the 5 inpatients at Millom no longer required a bed. One of these patients needed specialist mental health support that the ward couldn't provide but stayed 97 days waiting for a specialist bed.

Patient Experience

Patients give positive feedback after being admitted to Abbey View, Langdales and Millom which we capture as part of the Friends and Family Test.
Over three months, 79% of people said they were extremely likely to recommend our service to friends and family if they needed similar care or treatment and provided the following feedback:

- "All staff are so friendly and caring".
- "Wonderful attention and loving kindness from everyone all the time".
- "Nursing staff are caring, extremely efficient and nothing is a trouble. Thank you all for kindness shown. The meals are excellent and the ward is pristine".

Despite the good experiences people have on the Step-Up/down units, many of these people no longer needed to be in hospital. On some of the units, there is lack of patient kitchen and day room facilities because the wards were originally set up as acute hospital wards and not rehabilitation wards. These are important features as doing normal day to day activities help people to retain their independence and strength. Up to 65 per cent of older patients' abilities to do normal activities reduce while they are in hospital. Many of these patients could prematurely end up in a care home because they are unable to take care of themselves safely at home. [2 & 3]

The best bed is often your own bed. For some people a stay in hospital longer than 10 days leads to 10 years of muscle ageing. If you are lying in bed for long periods of time and have reduced muscle strength it could increase your risk of falling or not being able to do the things that you enjoy.

Other UK Care Models

Other health care systems around the UK have looked at their Step-Up/down care and used some of the following methods to deliver care in their area.

Bhowmick Innovation Model - Wales

This model is used in Torfaen and Anglesey in Wales, known locally as Torfaen Advanced Clinical Assessment Team (ACAT) and Mon Enhanced Care (MEC) in Anglesey.

The teams in Wales introduced a model that:

- Created a 'hospital at home' where patients stay in their own homes and receive care like they would on a hospital ward. People are cared for at home by Nurses and Care of the Elderly Consultants who have rapid access to tests

like blood tests. Patients benefit from being in their own bed as it is more comfortable, pleasant and familiar for them.

- Provides extra support so that people are not admitted to hospital or so that their admission is as short as possible.
- Reduced premature admissions to care homes and improved health outcomes and greater independence for older people, meaning that they stay in their own home for longer.

Results from Torfaen and Anglesey

A review of both these services revealed that in the first year the ACAT team assessed 1,208 patients with an age range of 49 – 100 years. The number of hospital admissions prevented as a result of the new service was 975, which was approximately 80% of referrals.

Intermediate Care Allocation Team (ICAT) - Lancashire

ICAT is a service jointly paid for by Lancashire County Council and Morecambe Bay Clinical Commissioning Group.

The ICAT service is delivered by health and social care services working together with health staff to:

- Prevent hospital admission.
- Support early discharge from hospital
- Carry out assessments to promote independence and avoid long term care.

When people are due to leave hospital, doctors, nurses, physiotherapists and occupational therapists will assess what support the patient needs and refer them to ICAT to ensure the patient gets the right people to support their care. The support ICAT provides aims to speed up the recovery process and promote the individual's ongoing health, wellbeing and independence.

Hub Model – North Cumbria

North Cumbria has a population of 325,692. In 2017 they reduced the number of inpatient community beds down from 133 on eight sites to 104 on six sites. They also changed how they used the remaining beds, using some as day beds or to carry out pre-operation tests that require an overnight stay. They also developed Coordination Hubs in the community. These Hubs coordinate urgent requests for people who need support in their own home either to prevent an admission to hospital or giving care after leaving hospital. The Hubs have access to nurses, physiotherapists and occupational therapists with links to GPs in their area. Health staff are also trained to carry out social care assessments for the council meaning that requests for care packages can be made at the same time.

These are examples of how the Coordination Hub, Integrated Care Communities and Rapid Response work together to prevent admissions to hospital:

1. A person is unwell with reduced mobility and suspected urinary tract infection. During previous episodes they have been admitted to acute care for 8 -10 days. Occupational Therapist, Nursing and Social Care support is sent to their home for 48hrs of care to keep them at home safely and avoid hospital admission.
2. A person has reached the palliative stage of illness and wishes to die at home. The patient is feeling sick, restless and extra pain control is needed for

the patient along with care and support for the family. Call comes in to the Hub and care is provided from GP, community and health care teams at home.

3. A person falls while at home and their next door neighbour calls an ambulance. Paramedic attends, while the patient has no injuries and is just a bit shaken; the paramedic is concerned about leaving them at home. They contact Community Hub who send an Occupational Therapist to provide therapy support and link with family, neighbours and voluntary groups to provide support with shopping and other activities.

North West Sussex - Spot Purchased Beds

For patients being discharged from hospital who need more overnight care than can be given in their own home, some areas provide short term beds in care homes. These beds give the patient more time to rehabilitate in their community and for health and social care staff, time to assess the person's needs following an incident or illness which led to their admission to hospital.

Sessional Beds

Sessional beds involves using ward beds differently. A patient might have a bed for a couple of hours to receive treatments such as Intra Venous (IV) antibiotics, blood transfusions, chemotherapy or tests before an operation such as blood tests or electrocardiogram (ECG). Using beds in this way would reduce the amount of travelling the patient needs to do, reduce journey times and receive care locally.

Benefits

The benefit of these models is that care and support can be given either at home or closer to home meaning that visits and support from relatives and friends are easier and the person feels more connected as they are more familiar with the local surroundings. Being supported at home often leads to staying independent and doing the things that are important to you for longer and can be particularly helpful for someone with a diagnosis of dementia or Alzheimer's who might feel happier and more in control in a familiar place and maintaining their routines.

How can I get involved and share my views?

We want to know what you think; it could be that one of these models would work for us in Morecambe Bay; it might be a mixture of them all or even something completely different.

There are two ways to provide your ideas and feedback; by completing an online survey or you can request a paper copy by emailing: engagement.morecambebayccg@nhs.net

References

1 NHS Long Term Plan - https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf
2 Guide to reducing long hospital stays, NHS Improvement, June 2018 https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf, accessed on 2nd August 2019

3 Deconditioning awareness, British Geriatrics Society, https://www.bgs.org.uk/resources/deconditioning-awareness, accessed on 23rd July 2019