

Consultation Document



Future Provision of Hospital Services for Older People

Consultation from 12th June 2014 until Friday 31st October 2014

EXECUTIVE SUMMARY

The Trust is committed to supporting older people to live as long as possible in their own homes, living independent lives and being able to choose how their needs are met.

We are now caring for more older people at home with the support of a range of community teams and services and making best use of the latest technology. We want to ensure that when older people do need hospital care, that they are able to quickly access care in a hospital environment that is high quality, delivered in an appropriate setting by a team of compassionate, respectful and expert health professionals with access to all the necessary diagnostics, specialist knowledge and treatment.

Currently, the Trust provides hospital care for older people at Craigavon Area Hospital, Daisy Hill Hospital, Lurgan Hospital and Loane House (South Tyrone Hospital). Patients admitted to Craigavon or Daisy Hill will have the support of teams of specialist staff; access to a range of diagnostic services; and have 24 hour pharmacy and laboratory support available. In Lurgan Hospital and Loane House, which are small stand-alone units, there is not the same immediate access to all of these services. This means that if a patient's condition deteriorates they have to be transferred from these hospitals, usually to Craigavon Area Hospital, for assessment, diagnostics and treatment which can be distressing and upsetting for older patients and their families. It is also becoming increasingly difficult to maintain the right level of medical cover at evenings and weekends at Lurgan and Loane House.

We want to ensure that we can deliver safe, high quality care for older people who need some continued care in a hospital setting after a period of acute illness and to ensure we are providing the same quality of care for our older population as we are to the rest of the population who need acute hospital care.

We are proposing to provide all inpatient Acute Hospital Care and Rehabilitation beds at Daisy Hill Hospital and Craigavon Area

Hospital, to ensure that patients have access to all the benefits and support which are only available from an acute hospital.

The Trust would propose should the changes we are recommending go ahead, that the **Lurgan and South Tyrone Hospital sites continue to provide a range of day assessment and rehabilitation services for older people and be considered for the future development of Community Treatment and Care Centres**. These centres would be a key enabler for the delivery of the health and social care service changes proposed under Transforming Your Care. The services and resources available within primary and community care have the potential to prevent the development of conditions which could later require hospitalisation. They can assist with the management of conditions, provide appropriate support to prevent hospitalisation and facilitate earlier discharge from hospital.

1.0 INTRODUCTION

The Trust wants to deliver a service model that will provide sustainable high quality care for frail older people. We want to support older people to live independently as long as possible in their own homes and communities and we want to ensure that when an older person needs hospital care that they are able to access the best hospital services which will provide the highest standard of care and be designed to meet their individual needs.

Older people should receive the same level of care and have the same timely access to hospital services as all our patients, regardless of age - this would include support from teams of specialist staff; access to a range of diagnostic and treatment services and the availability of 24 hour pharmacy and laboratory support.

This consultation paper explains the changes that we propose to seek to achieve this vision, including:

- Our current services in the hospital and community and how they are being used
- What issues and challenges we have with our current service model and why this has to change
- What the proposed future service model is
- What will be better after the change

The purpose of this consultation paper is to give you, the public and service users, the opportunity to:

- understand how we want to improve our services for older people, and
- make any comments or raise any questions that you might have about the proposed changes we outline below.

In Appendix 1 you will find a consultation questionnaire which has been developed to help you provide a response to the Trust on this document. The timeline for responses is 20 weeks commencing Thursday 12th June 2014 ending Friday 31st October 2014.

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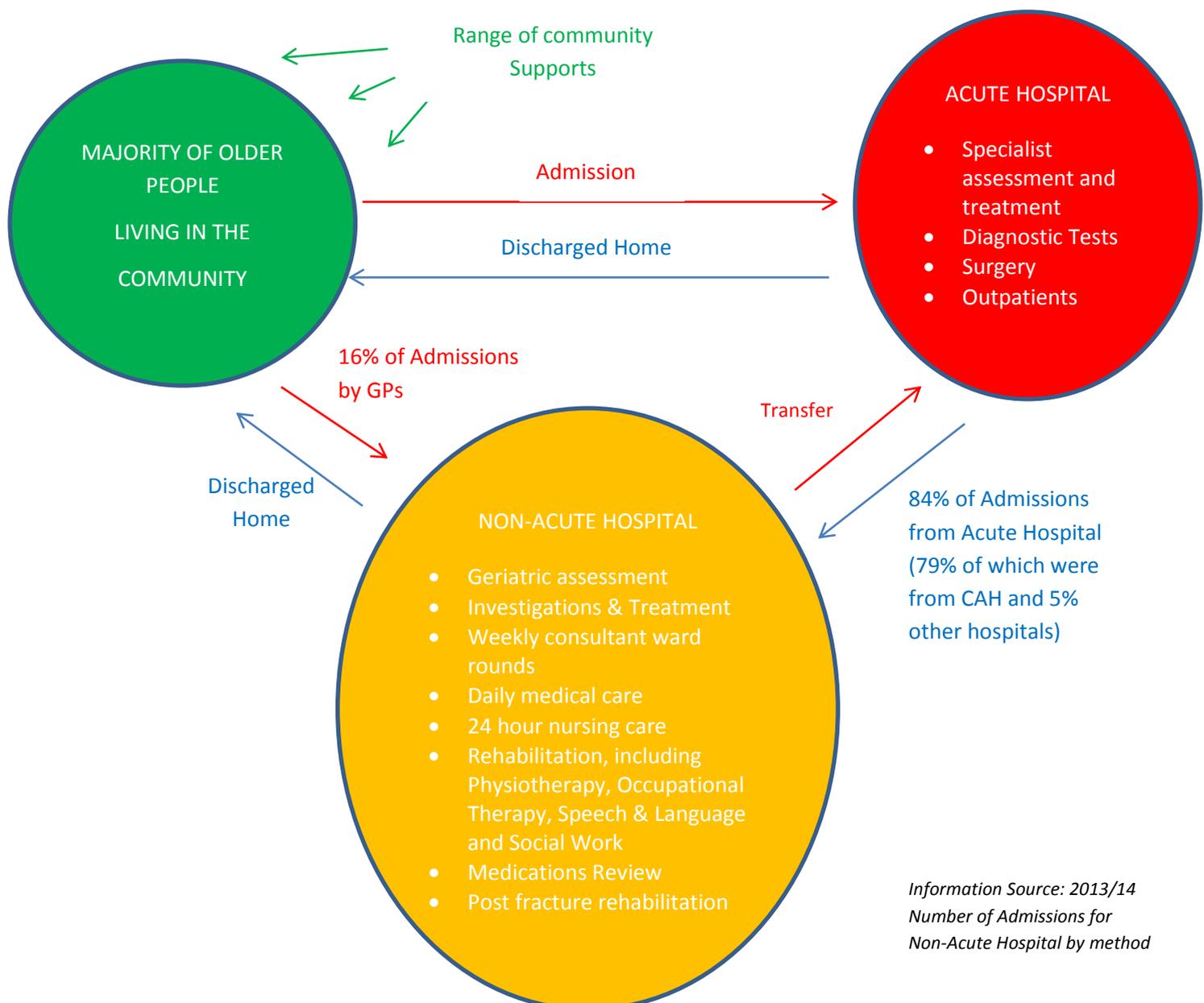
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Alternative Formats

This document can be made available on request in alternative formats e.g. easy-read, electronic version, Braille, computer disc, audiocassette, large font, DAISY, and in other languages to meet the needs of those are not fluent in English.

2.0 Current Service Model

The Trust's model of care recognises that there will be times when older people need help in order to help them maximise their independence and wellbeing. The majority of care for our older people is provided in the community through a range of services and should an older person's condition mean that they require an admission to hospital their needs may be met in non-acute hospitals (Loane House, South Tyrone Hospital and Lurgan Hospital) or in acute hospitals (Craigavon Area Hospital and Daisy Hill Hospital). The Trust's current service model is summarised in the below diagram.



Changing demands and choices by older people have led to many developments in community care services over recent years. Investment of over £5m over the past 5 years has enabled us to develop our specialist community teams for long-term conditions, improve our palliative/end of life care services, improve access to rapid assessment clinics, introduce new reablement services and support the use of new technologies.

Mr Saunders has chronic obstructive airways disease (COPD). He used to be in and out of hospital several times every winter with chest infections. He has now been provided with telemonitoring equipment by the specialist COPD team. He monitors his own temperature, pulse and oxygen levels on a daily basis in his own home, with the results being transmitted and made available on an electronic system accessed by the specialist team at their computer. Mr Saunders is now more aware of his own health and recognises early signs of a chest infection and the specialist COPD team have more timely access to information on his condition which has meant less reliance on hospital, GP and Out of Hours services. He has a better quality of life as he has more control over his condition.

We are now caring for more older people at home with a range of conditions that no longer need to be treated in a hospital setting. Some of our current community services and support include:

- *Rehabilitation services, such as reablement services, intermediate care teams, falls assessment and day hospitals*
- *Community teams for long-term conditions (respiratory, heart failure, diabetes)*
- *Community stroke team*
- *Memory service team*
- *Other teams such as continence, enteral feeding, parkinson's and tissue viability services*
- *Access to consultant led multi-disciplinary rapid access clinics and day hospital services for older people*
- *Enhanced use of technological supports at home, such as remote telehealth monitoring and telecare*

- *Working in partnership with a wide range of community and voluntary sector organisations who provide support to enhance care for people with long term conditions through ‘Challenging your condition’ and stroke-specific programmes; and who enhance independence at home and tackle issues associated with social isolation through schemes such as Care in the Home, Befriending, Good Morning Good Neighbour, etc.*
- *Working with our partners in primary care through the newly established Integrated Care Partnerships.*
- *Development of new day care models that will address specific needs of individuals with conditions such as dementia*

As a result of these developments, we have been able to reduce both the need for hospital admission, and the amount of time these patients have to stay in hospital.

Because we are able to support patients at home longer we are finding that older people who now require hospital-based care have more complex needs, often presenting with multiple health issues and needing access to more specialist advice and treatment.

Where an older person’s needs cannot be met in their home they will be admitted to hospital, this may be because they have had a stroke, hip fracture, heart condition or other medical or surgical need. The Trust is keen to help older people maintain their continued independence. As soon as they come into hospital, staff will work with the individual to start to plan for them going home or to Lurgan or South Tyrone Hospitals for a period of intensive rehabilitation first.

In 2013/14, 23% of our total hospital admissions were for patients aged over 75 years.

Of the Trust’s total hospital admissions, 98% were to our 2 main acute hospital sites (Craigavon Area Hospital and Daisy Hill Hospital) and 2% were to Lurgan Hospital and Loane House, South Tyrone Hospital.

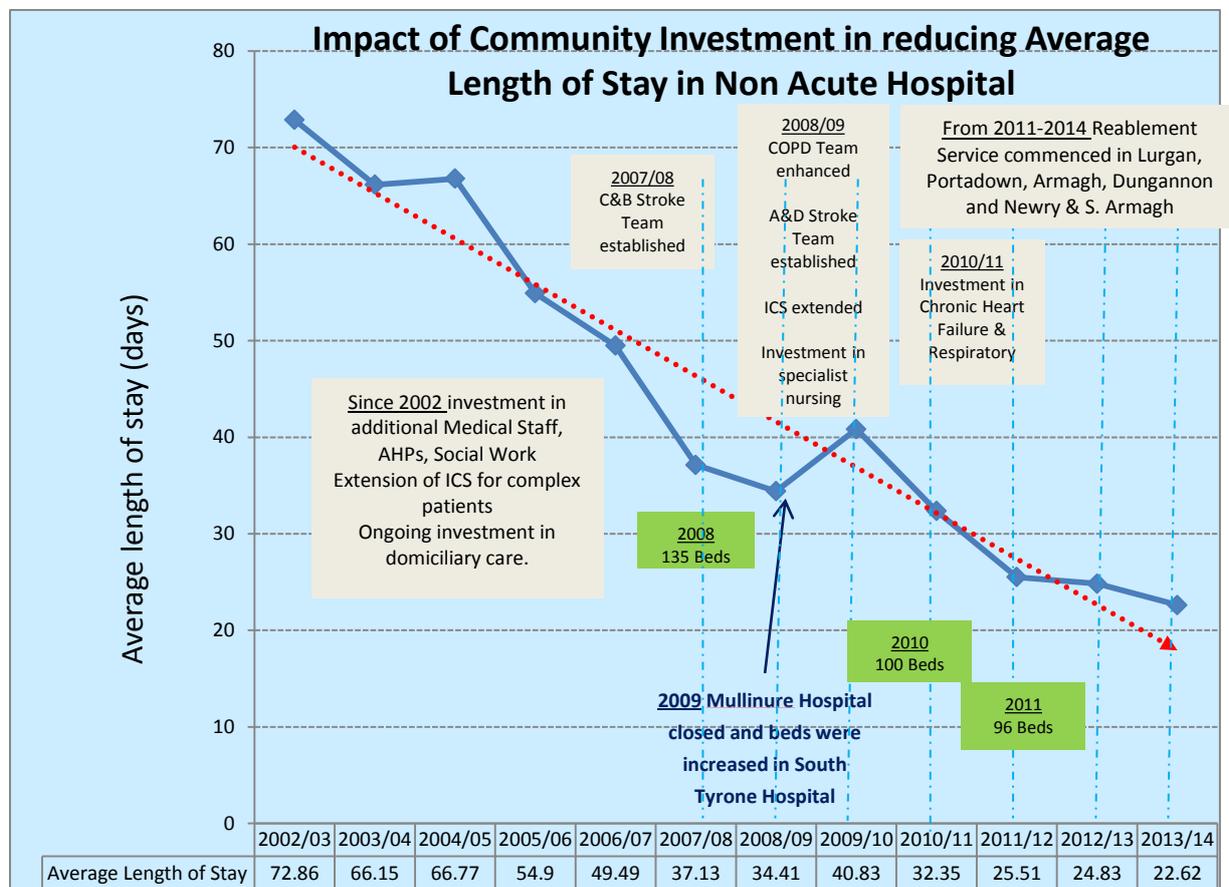
The care provided at Loane House, South Tyrone Hospital and Lurgan Hospital includes inpatient assessment and rehabilitation, sometimes referred to as 'non-acute' hospital beds. These hospital beds are necessary for patients who are either ready for discharge from an 'acute' hospital bed (with 79% being from Craigavon Area Hospital in 2013/14 and 5% being from other hospitals) or need to be admitted from the community (16% being directly referred by their GP in 2013/14) who are not medically fit and/or where their rehabilitation needs cannot be facilitated in either their home, a nursing or residential facility. These patients require on-going daily medical care from a consultant-led medical team, specialist assessment and intensive rehabilitation. This is seen as one of the key principles in shaping our proposals for future service delivery.

Patients who receive non-acute care in hospital include the frail elderly, those with multiple conditions and complex care needs. They may require a comprehensive geriatric assessment, investigations, treatment and rehabilitation as a result of an acute illness, injury or an exacerbation of a long-term condition and requires Consultant-led care.

Mr Jones, a 74 year old gentleman with diabetes was referred by his GP to a non-acute hospital. He complained of deteriorating mobility and loss of independence over a 6 week period. He was diagnosed with a nervous system abnormality and was treated with steroids. The gentleman required close medical monitoring due to risk of further deterioration with potential risk of breathing difficulties, infection and steroid induced unstable blood sugars. After 16 days in hospital where Mr Jones received rehabilitation, his condition improved and he was able to return home under the care of Intermediate Care Services for ongoing rehabilitation at home.

Patients with these needs living in the Newry & Mourne area are admitted to Daisy Hill Hospital and receive ongoing rehabilitation under the care of a Consultant in Level 6.

The following graph shows the reducing need for inpatient care for older people which has been enabled in part through the collective impact of the development of alternative community supports.



The average length of stay in our non-acute hospitals has reduced significantly, from 72.86 days in 2002/03 to 22.6 days in 2013/14, meaning that we now need fewer hospital beds for older people. This has led to a reduction in the need for beds from 135 beds in 2008/09 (36 beds Mullinure Hospital, 64 beds Lurgan Hospital and 35 beds South Tyrone Hospital) to 96 beds (51 beds Lurgan Hospital and 45 beds South Tyrone Hospital).

80 of these 96 beds are used for assessment and rehabilitation for older people. The remaining 16 beds are used for stroke rehabilitation and proposals for the future provision of these beds have been included in a separate consultation paper which looks specifically at the future model for acute and rehabilitation stroke services (see www.southerntrust.hscni.net/consultations).

3.0 WHY IS THERE A NEED FOR CHANGE?

More people than ever before are likely to survive to old age. To meet the needs of older people our services have been evolving which means we are able to care for more people than ever before at home and in future less people will need to be admitted to hospital or will be able to stay at home longer before needing hospitalisation. Inevitably, there will be times when older people will need to come into hospital for their care and we know that we are caring for increasing numbers of frail older people, many with more than one condition, in our assessment and rehabilitation hospital beds. **We need to ensure our future inpatient services for older people are safe and provide high quality, compassionate care.** The main reasons why we believe we need to change the way we deliver this care now is set out below:

3.1 Demographics

Across the Southern Trust area there is an expected increase of 33% of people over the age of 65 between 2011 and 2021, this will include an increase of 3,521 people over the age of 85 in the next 10 years (*Information Source: NINNIS Population Projections by LGD 2008-2023*). With an increasing ageing population, more people are living longer fuller lives and are able to maintain their independence while other people will have more complex needs requiring medical care. Considering that as people age they are more likely to experience disability or illness there will continue to be increased demands placed on health and social care services.

The average age of our patients at Lurgan and South Tyrone Hospitals is 82 years. 35% of our patients are over 85 years of age.

3.2 Increasing complexity of patient need

Illness in older people tends to be non-specific which means that older people do not usually present with typical symptoms as would be found in a younger person. They may present with falls, delirium or incontinence as the result of serious underlying conditions such as heart

failure or infection. It is vitally important that these patients have access to skilled medical assessment, diagnosis and treatment.

We know that our patient's needs on admission to hospital are becoming increasingly complex, requiring more access to specialist teams and services at our acute hospitals and that the current service model could be improved. Currently, patients may be transferred from Loane House, South Tyrone Hospital and Lurgan Hospital to other acute hospitals for a range of reasons. For example, this may be as a result of patients becoming medically unstable and the need to access acute services before continuing with rehabilitation (20% of patients in both 2012/13 and 2013/14).

The Trust recognises that there will always be frail older patients who need consultant-led medical care in a hospital, but for whom a busy general medical acute ward is not the most appropriate setting to meet their care needs. At the same time, the Trust is keen to ensure that dedicated hospital care for these patients avoids potentially avoidable moves across sites and provides for timely access to diagnostics, specialist medical and professional staff.

3.3 Providing the highest standards of evidence-based care

The Trust is committed to providing the highest standards of evidence-based care that patients, clients, their carers and wider family can expect to receive:

- All older people should expect the same opportunity of access to assessment, care and treatment as other users of health and social care.
- Treatment and care should be delivered in the most appropriate setting.
- Older people and carers of older people should have timely access to flexible and responsive services, in order to meet their individual needs.

- Older people should be offered a period of reablement to regain their optimum level of independence and confidence before any assessment is made for longer term supports.

The Royal College of Physicians 'Future Hospital Commission: Caring for Medical Patients' (September 2013) indicated that fragmented, disjointed care, with multiple ward moves, inconsistent teams and numerous clinical handovers has many disadvantages for all patients, but is particularly high risk for frail older people and older persons with memory problems. It can lead to delirium, an increased risk of clinical incidents such as falls and hospital acquired infection, reduced independence and quality of life, and reduced patient satisfaction, increased risk of complaints, communications breakdowns and operational inefficiency.

Physicians report that a lack of continuity of care is their principal concern and that when patients do leave hospital they may be more dependent on long term care in the community than they were before their admission to hospital. It is further acknowledged that signs of deterioration may be subtle in older people and access to the full range of resources could help prevent an emergency situation.

The Trust want to establish a model of care which will ensure older people receive the highest quality medical care in hospital when they need it. Research and evidence support the need to: -

- **Make best use of specialist medical/professional resources to improve outcomes for the patient**

During an older person's time in hospital, geriatric medical assessment and daily medical cover is necessary to effectively assess the needs of the individual, offer timely diagnosis and treatment and ensure discharge when the patient is medically fit to be discharged with appropriate community support where and when needed.

It is becoming increasingly difficult to maintain the level of medical cover necessary at Lurgan and South Tyrone Hospitals. This is partially due to

a difficulty in attracting and recruiting Specialist Doctor Grade staff in stand-alone/off site units. There are currently insufficient numbers of trained Doctors in the Northern Ireland system which means that the Trust is trying to draw this type of doctor from a small pool. It is widely recognised that it can be difficult for medical staff to maintain their full range of clinical skills if working in a stand-alone unit and this can create issues for the medical supervision of junior staff.

The Trust currently has different arrangements in place for out of hours medical cover at Lurgan and South Tyrone Hospitals and recognise the need to move towards 24/7 medical cover as patients become more complex.

The Kings Fund 'Older People and Emergency Bed Use: Exploring Variation' (August 2012) acknowledges that patients' length of stay can be further shortened by frequent medical review/ward rounds; specialist input and/or training in particular areas such as geriatrics, stroke, heart failure and dementia. Timely access to therapist input is also a key factor in supporting improved outcomes.

The Trust recognises that by integrating the pathway between primary, community and secondary care it will support greater utilisation of staff with specialist knowledge and skills to care for frail older people, including more regular review by senior clinicians and more regular therapist input to meet the clinical needs of the patient.

- **Improve access to appropriate diagnostic and related medical services without the need for potentially avoidable moves across sites for frail older people**

The Royal College of Physicians 'Future Hospital Commission: Caring for Medical Patients' (September 2013) emphasises the importance of access to the technology and diagnostic services provided by the hospital. They advise that physicians crossing from the inpatient to community arena may be based on the site of the hospital, and a close link between these teams and acute inpatient services, with possible rotation of all staff between roles, ensures a shared understanding of where patients can receive the maximum value from their health service.

When a patient requires an MRI scan they are transferred by ambulance to Craigavon Area Hospital and should they require an x-ray or CT scan, they will be transferred by ambulance either to Craigavon Area Hospital (mainly patients at Lurgan Hospital) or between Loane House and the main building at South Tyrone Hospital (for South Tyrone Hospital patients). The table below demonstrates the number of these transfers from non-acute hospitals to Craigavon Area Hospital for diagnostic appointments over recent years.

Diagnostic Imaging Examination	Number of Examinations requiring a transfer to CAH		
	2011/12	2012/13	2013/14
CT	224	166	182
Fluoroscopy	6	2	2
MRI	38	51	55
Non-Obstetric Ultrasound	182	176	159
Radio Nuclide	14	6	9
X-ray	3	6	8
TOTAL	478	401	415

4.0 WHAT IS OUR PROPOSED FUTURE SERVICE MODEL?

4.1 The Trust's Vision

The Trust wants to achieve the best possible outcomes for older people who need hospital care by providing them with appropriate access to all related specialist acute services, to develop a hospital model of care that takes account of all health care needs of frail, older patients and build a service model in the long term.

While specialist assessment and intensive rehabilitation beds are a valuable part of the whole system of care for older people within the Southern Trust area, it is recognised that there is a need to consider a more systematic and integrated approach to future service development.

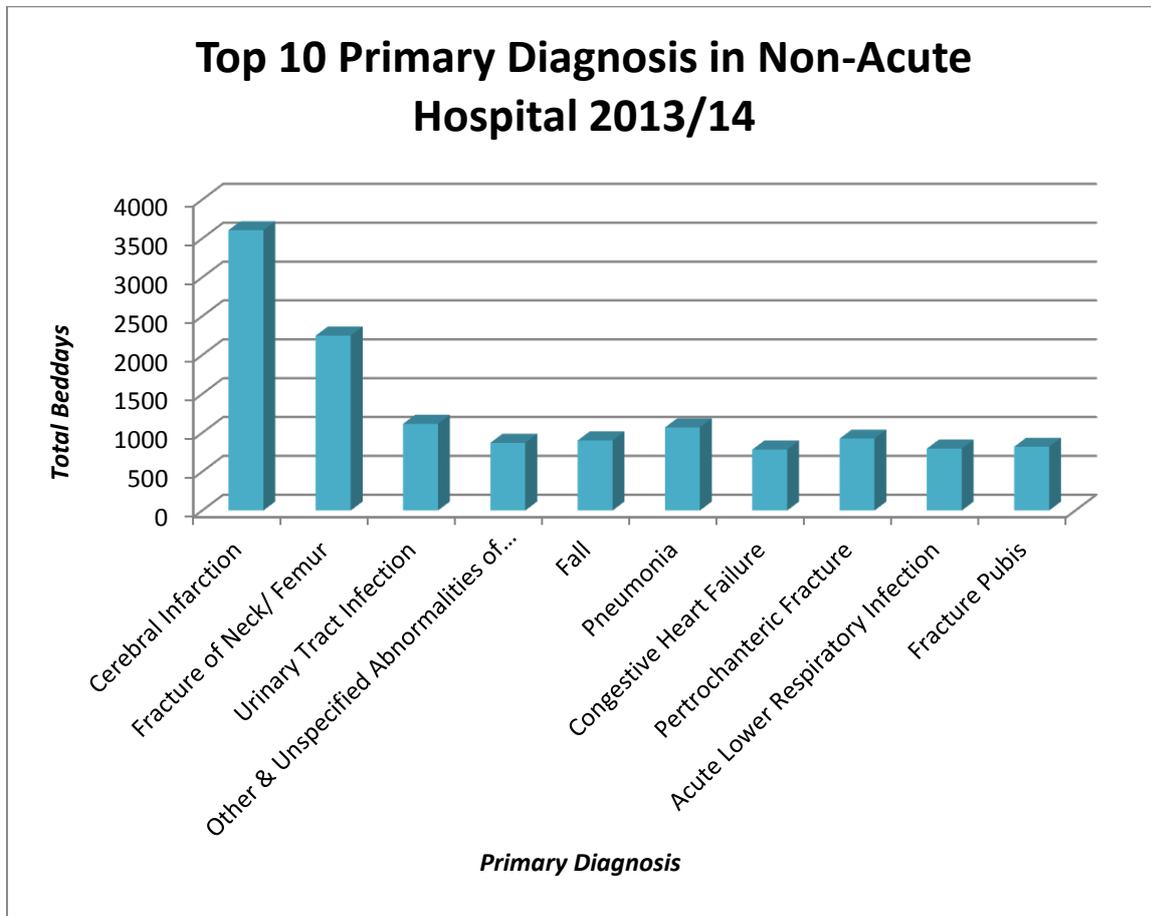
The Trust's vision is to:

- Continue to develop community services in line with evidence of best practice to enable more frail older people to be safely cared for at or closer to home.
- Improve the way we respond to the needs of older people ensuring they can access the right services at the right time in the right place.
- Ensure that when hospital care is needed beyond the acute stage that this is provided safely, in the best environment with easy access to a range of professional staff and services.

4.2 Proposals for service change

Recent investment in our community services has resulted in less reliance on hospital beds and we know we can make further improvements to our length of stay to get patients home safely even sooner.

The top 10 primary diagnosis of patients admitted to our non-acute hospitals in 2013/14 is shown in the graph below: -



Benchmarking undertaken across Trusts, based on inpatient settings at 40 peer hospitals across the UK, identified opportunities for the Trust to further reduce its average length of inpatient stay from 23 days to an average of 16 days. Considering these findings alongside our knowledge of our top primary diagnosis we can achieve these reductions by: -

- Improving communication and coordination of care across teams based in the hospital and in the community**, including reduced duplication in assessment processes and better use of technology to share information. For example, on admission to hospital, information will now be received from the key community services that the patient is known to in order to help better coordinate both the person's treatment and discharge plans.

- **Improved integration of day hospitals with community services, such as stroke and intermediate care services, to support rehabilitation.** These will continue to be locally provided at Armagh, Dungannon and Lurgan.
- **Full roll out of reablement services to support people to regain skills and confidence to live independently.** This service was established in Lurgan and Portadown in 2011/12 and has now been rolled out into 5 of the Trust's 7 locality areas.

- **Implementation of a rapid response 'Hospital at Home' model during 2014/15.** This multi-disciplinary team, which will be consultant led, will be able to respond to urgent requests from a GP to assess and treat an older person in their own home (including nursing homes) where it is safe to do so, therefore preventing potentially avoidable attendances at GP Out of Hours, Emergency Departments and hospital admission.

Mrs Connolly, an 86 year old lady had bowel surgery in Craigavon Area Hospital. Following her surgery she was transferred to a non-acute hospital bed as she required IV fluids with daily medical monitoring of blood tests due to risk of developing serious complications such as kidney or heart failure. After a 20 day stay Mrs Connolly was able to return home. In the future, Mrs Connolly will be able to have this treatment in the community through access to a rapid response 'hospital at home' service.

- **Development of a fracture rehabilitation pathway to enable patients to remain under consultant care via a virtual ward following discharge from hospital.** This will enable patients to receive care at home or in a nursing or residential home rather than in hospital. Patients will be

In 2013/14, there were 1,397 Finished Consultant Episodes in our non-acute hospitals, accounting for a total of 30,981 bed days.

Those with a 'fracture' primary diagnoses accounted for 21% of these bed days.

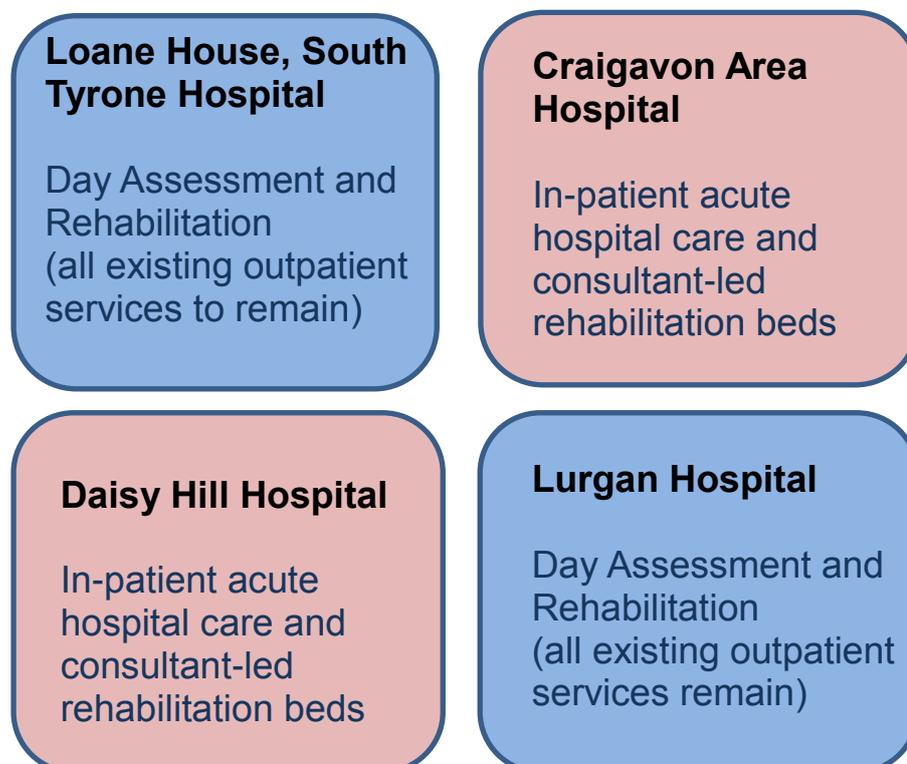
following discharge from hospital. This will enable patients to receive care at home or in a nursing or residential home rather than in hospital. Patients will be

provided with appropriate equipment and space for their rehabilitation needs to be met through input from appropriate clinical staff.

Whilst the Trust will continue to need additional resources to help us manage demographic pressures we are confident that we will be able to reduce our length of stay by better managing growing acute demands through improved ways of working and the development of community services.

Based on the modelling analysis completed and agreed with the Southern Local Commissioning Group, the proposed reduction in length of stay would mean that the Trust could reduce from 80 assessment and rehabilitation beds for older people (excluding 16 stroke beds) to a future bed profile requirement of up to 62 beds. This takes account of the fact that our population of older people has and will continue to grow both in absolute numbers as well as in the level of need for health and social care support.

We are proposing to consult on the location of all in-patient services on two sites, at Craigavon Area Hospital and Daisy Hill Hospital and to continue to provide local access to a range of essential support services such as day assessment and rehabilitation services and rapid access clinics for older people at Loane House and Lurgan Hospital:



This would mean the centralisation of up to 62 beds at Craigavon Area Hospital to meet the needs of the populations of Armagh and Dungannon and Craigavon and Banbridge. Due to the importance of geographical coverage and accessibility to inpatient rehabilitation services it was agreed that there should be continuity of inpatient assessment and rehabilitation beds at Level 6 in Daisy Hill Hospital to provide adequate coverage to the southern part of the Trust area.

Further detail on the appraisal process can be accessed on request to:

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4.2 What will be better after the change?

The Trust's proposed changes aim to deliver the following benefits to you: -

- **Improvements in the range and level of community supports available to people in their home, enhancing patient choice and helping them maintain their independence.** This will include a new consultant-led 'hospital at home' service; maximising use of our day hospitals; development of a fracture rehabilitation pathway and plans for the future development of Community Treatment and Care Centres in Lurgan and Dungannon.

- **Improved ease of access to hospital services for older people requiring an inpatient stay** which will include diagnostics, acute geriatric services and a range of specialist services, including psychiatry of old age.
- **Improved access to consultant and senior medical staff in hours and out of hours which has been proven to improve patient outcomes.** This will support more timely discharge once a patient is medically fit with appropriate community support where and when needed.
- **New purpose-built accommodation for the provision of assessment and rehabilitation beds** on the Craigavon Area Hospital site which will meet new standards and provide environments necessary to support the care expected by patients, carers and their families.
- **Less transfers between hospital sites for older people requiring diagnostic tests or further investigations,** particularly if an older person becomes medically unwell and requires access to acute care services.
- **Improved working arrangements between acute and rehabilitation services through the centralisation of beds.** This will improve staff cover arrangements and provide opportunities for enhanced learning and understanding. It will also provide for better utilisation of medical staff and opportunities to enhance medical skills and supervision arrangements for junior staff.
- **Less professional time spent travelling across sites,** allowing more time to be spent on patient care.

4.3 Potential Implementation & Timescales

Following consultation, should a decision be made to re-provide inpatient assessment and rehabilitation beds from the Lurgan and South Tyrone Hospital sites, there would be a need to secure capital funding to provide for new build accommodation at Craigavon Area Hospital. The Trust would commence plans to implement the necessary changes in a phased way from 2015/16.

4.4 Proposals for Alternative Use or Disposal of Assets

The Trust's strategic direction is to provide more locally accessible support to help older people maintain their independence in their own home.

As the Trust continues to develop modern, locally sustainable primary and community care services that are responsive to local community needs, the Lurgan and South Tyrone Hospital sites will remain a key resource for the local population and we must develop these sites to best meet their changing needs. **It would therefore be proposed that the Lurgan and South Tyrone Hospital sites be considered for the future development of Community Treatment & Care Centres (CTCCs).**

The proposed service model for the CTCCs will be based on the hub and spoke approach outlined within Transforming Your Care, with hubs providing core services for local GP Practices and health centres (the spokes). The hubs will encompass those services which do not require a hospital bed but which are too complex or specialised to be provided in a spoke. These new centres will be critical in supporting the development of integrated primary and community care services that are closely linked to secondary care provision to provide better outcomes for the patient.

These centres would be a key enabler for the delivery of the health and social care service changes proposed under Transforming Your Care. The services and resources available within primary and community

care have the potential to prevent the development of conditions which could later require hospitalisation. They can assist with the management of conditions, provide appropriate support to prevent hospitalisation and facilitate earlier discharge from hospital.

4.5 Management of Change

In order to manage and mitigate any potential differential impact on existing staff the Trust will adopt a project management approach. As part of this approach a project management group will include a human resources and trade union representative(s) so as to ensure robust, fair and agreed human resources processes are in place to manage any future staff changes. The Trust's Management of Change Framework is the main vehicle for effecting change within the Trust.

4.6 Equality Impact Assessment

An Equality Impact Assessment (EQIA) has been prepared by the Southern Health and Social Care Trust (SHSCT) to assess the impact of this proposal. This document can be accessed from the Trust's website www.southerntrust.hscni.net/consultations.

Appendix 1

Your chance to have your say – Consultation Questions

The Trust wishes to consult as widely as possible on the proposal. Please use this consultation questionnaire to register your comments by 31st October 2014.

Section 1.0 of this document provides additional information on the Trust's communication, consultation and engagement processes and how you can be involved.

Question 1

Do you agree with the Trust's proposals to further enhance community-based services for older people?

Yes

No

Please give reasons for your response below:

The Commissioner believes that community based services can make a significant contribution to older people having appropriate choice over their care needs. The expansion of these services is welcome if they provide more choice, and convenient access to health and social care services for older people. The commitment to develop more Community Treatment and Care Centres (CTCC's) at the Lurgan and South Tyrone Hospital sites is welcome as long as it forms part of a varied mix of treatment and care available in the area, that is accessible to all. CTCC's will be more effective as a supplement to, not a replacement for, non acute hospital services. The plans to provide a 'one stop shop' for local health and social care services, including GP care, community health and social care services, diagnostic services, treatment for minor ailments, rehabilitation services and local services has the potential to increase usage of services and provide more options for older people in what treatment and care they have available. This potential will not be realised if it is made harder for older people to access other services.

This is consistent with the first principle of Transforming Your Care, that the individual “must be at the centre of the health and social care system” and any model be “built around what will produce the best outcomes for individual users, carers and families.”¹ The Commissioner feels that if community based services are to be enhanced, then every opportunity must be taken to ensure that older people are properly aware of the range of services that are available and how to access them.

The Commissioner recognises that the average length of patient stays for older people has been reduced by the investment made in alternative community and home based supports.

Despite this, there will still be a need for non acute hospital facilities, and it is crucial this future need is accurately considered. Hospital beds and facilities are necessary whenever patients are recovering from discharge from an acute bed, or where their fitness or rehabilitation needs cannot be facilitated in their home or a residential facility. It is not always possible for complex co-morbidities and frailty to be treated at home or in the community.

Given that patients who receive non acute care include the frail elderly, and those with multiple conditions and complex care needs, due attention must be paid to planning appropriately for the complex future health needs in line with future population trends.

The expectation of the Southern Local Commissioning Group as stated in their Population Plan is that hospital services must be maintained at the “highest quality levels possible and in line with regionally specified criteria and standards” and that there must be “safe, effective acute care provided locally where possible and centralised where necessary.”² This is an essential principle that must be adhered to in providing hospital services across the Southern Trust. Projections show a growing incidence rate of chronic conditions such as hypertension, diabetes, asthma and obesity.³ Some of these conditions will require non acute care. Adequate planning and provision must be undertaken.

There is a comprehensive weight of research showing that individuals who are over 85 suffer more from medical problems resulting from frailty. In terms of future planning, these future projections must be as much a part of planning as current reductions in average patient stays. Could demand for non acute hospitals increase again in the future and does this need to be incorporated into future planning? Analysis of future population trends in the Southern Trust area shows that from 2013 to 2023, the total population of over 65’s will increase by 25%. As the Southern Trust have pointed out, the increase in numbers in older people in the Southern Trust area is larger than the increase in number in Northern Ireland as a whole. Breaking these trends into age bands, we can see that the growth in some older age groups is even higher – there are projected to be 39% more over 85’s in 2023, with 27.5% more 80-84’s.⁴

1.Transforming Your Care: A Review of Health and Social Care in Northern Ireland.

2.Southern Local Commissioning Group Locality – Population Plan, ‘Changing for A Better Future’.

3.Southern Local Commissioning Group Locality – Population Plan, ‘Changing for A Better Future’.

4.Ninnis Statistics, <http://www.ninis2.nisra.gov.uk/public/pivotgrid.aspx?dataSetVars=ds-4678-lh-37-yn-2008-2023-sk-74-sn-Population-yearfilter-->

Question 2

Do you agree that the current non-acute hospital model has to change?

Yes

No

Please give reasons for your response below:

The Commissioner recognises the proposed enhancements to non acute care that will result from movement of non acute hospital beds. Patients admitted to the facilities at Craigavon or Daisy Hill sites will have access to specialist staff, a range of diagnostic services and 24 hour pharmacy and laboratory support, giving them more options for treatment and care depending on the progression of their condition.

While facilities will improve, these changes will have other effects on older people, with resulting changes to bed availability, location and travel. The proposed reductions in lengths of stay and the concurrent reductions in beds must be carefully considered, and it is very important that these plans take account of future population projections, and mitigate against any adverse impact on older people.⁵

Question 3

Do you agree with the proposed relocation of non-acute hospital beds from Loane House, South Tyrone Hospital and Lurgan Hospital to a new build development on the Craigavon Area Hospital site?

Yes

No

Please give reasons for your response below:

In the process of centralisation at Craigavon Area Hospital, 62 beds will be located on that site, with residual capacity at Daisy Hill Hospital. The reduction of permanent beds could impact upon older people at times of high demand for non acute beds, and must be considered before this process is advanced.

There is also the question of the extra distance older people may need to travel within the Southern Trust area. This is of particular concern to people who may have previously used Loane House, and the enhanced distance they will be required to travel if a situation occurred where they needed non acute care. Loane House is around 19 miles from Craigavon Area Hospital, and around 31 miles from Daisy Hill Hospital, where there will be continuity of inpatient assessment and rehabilitation beds at Level 6. This may not just impact on the person receiving a non acute bed (many may have been transferred from an acute facility) but also on family or friends who wish to visit them.

While reducing the number of sites with non acute beds will increase many people's distance from a non acute facility, it will especially affect those for whom Loane House was the nearest facility. Older people make up a very high proportion of the people using non acute facilities at Loane House. It is said that with the location of other resources in the facilities where the non acute beds are closing, like day assessment and rehabilitation in Loane House and Lurgan Hospital, that older people "will still be able to access the vast majority of their care from their local community."⁶ The Commissioner hopes that this will in fact be the case and seeks assurance that there will be proper planning of future facilities that are based on likely future need for treatment and care. It is a principle of TYC that "services should be planned on the basis of the needs of a defined population or health and social care economy." The distance people have to travel should be taken into account. The Commissioner hopes that these measures will reflect the objectives outlined by the Southern Trust to "ensure patient/client quality and safety is maintained and patient/client experience and satisfaction is enhanced."⁷

It is also important that the 'shift left' from environments like non acute hospital care to the home and community settings is accompanied by other initiatives, like improved medicines management to reduce unnecessary admissions to hospital, telemonitoring services and the development of rapid ambulatory services linked with community based services.

Please include any other comments you wish to make on the proposals outlined within this document.

The Commissioner believes that care and treatment must be centered on the individual. Individuals must have choices and be able to receive care or treatment most appropriate to their individual needs. The Commissioner welcomes the fact that these proposals are based on the framework that "everyone has the right to equal care, and it is our vision that whenever anyone needs health or social care, they will be treated in the right place, by the most appropriate person and in a timely and compassionate way."⁸ The commitments by the Southern Trust are that all older people "should expect the same opportunity of access to assessment, care and treatment as other users of health and social care." Treatment and care "should be delivered in the most appropriate setting." Older people and their carers "should have timely access to flexible and responsive services, in order to meet their individual needs." These are all very important commitments that the Commissioner expects must be honoured.⁹

That future policy is based on rigorous study and planning for future need is of the utmost importance. The Commissioner believes that planning for the future must be based closely around projected need, and such projections must be accurate and comprehensive. The relative elective admission rates to hospitals in the Southern Trust area has risen above the Northern Ireland rate. The numbers of individuals with long term conditions is expected to rise by 30% between 2007 and 2020¹⁰ and in light of the different treatments they will need, this must be factored into future planning. The Commissioner notes that these proposals were influenced by a modelling analysis completed and by the Southern Local Commissioning Group.¹¹

8. Southern Health and Social Care Trust, Presentation, 'The Trust Vision for Services'.

9. Southern Health and Social Care Trust, 'Consultation Document: Future Provision of Hospital Services for Older People'.

10. Southern Local Commissioning Group Locality – Population Plan, 'Changing for A Better Future'.

11. Southern Health and Social Care Trust, 'Changing for a Better Future, Our Vision – A Summary of Consultation Proposals'.