

# The Failing Safety Net

September 2018



## Introduction

Not unreasonably, we expect the health and care system to be there to support us as we age, 'keeping an eye' and making sure we are safe and well. Those living alone at home, without family or friends to help, are arguably especially in need of this benign oversight. Unfortunately however, despite much well intentioned policy and the best efforts of many who work in health and care, this ideal remains a long way from the reality for many older people. Instead, from what Age UK sees and hears, significant and growing numbers of older people are living precariously, trying to traverse a complex health and care system while managing the day to day demands of living with ill health and disability.

The stories in this report show how easy it is for older people to 'fall off the health and care radar' or not get on it in the first place, so they only receive help at crisis point. It highlights the cliff edges and gaps between services for older people living in their own homes and the hard work and emotional energy it takes for loved ones to 'hold the ring' in a fragmented and under-resourced system, one which often seems to assume they are available to 'paper over the cracks'. It also reflects the sadness, stress and frustration experienced by committed health and care professionals who lack the time or support to do the job they want to do.

The bottom line is simply that far too many older people still do not receive the coordinated, wrap-around support at home that they need. And the problem is becoming more pressing by the day. Over 65s accounted for more than half the increase in emergency hospital admissions in the last two years<sup>1</sup>. According to NHS England, around a quarter of emergency admissions in 2016/17 could have been avoided had effective community care and case management been in place<sup>2</sup> and multiple experts agree<sup>3,4,5</sup>.

Our older population is growing rapidly, meaning there are increasing numbers of older people living with multiple long term conditions, frailty and significant care needs. Age UK estimates there are now more than 465,000 people aged over 65 living with three or more health conditions who are also in need of help with three or more activities of daily living (i.e. care needs), such as getting out of bed, going to the toilet or getting dressed<sup>6</sup>. Of these individuals, only about one in three receives care at home with the remainder relying on family - or managing without. Yet among those with family support, nearly two in three depend on a partner who is often an older person with their own increasing health needs<sup>7</sup>.

More broadly, of all those aged over 65 in the UK, nearly a third – more than 3.6 million people - live alone<sup>8</sup>, while around 1 in 10 (1.2 million people) are ageing without children<sup>9</sup>, and these numbers are expected to keep rising over the coming years.

Ever since the NHS first opened its doors in 1948 clinicians and policy makers have been talking about the need to expand services in the community, rebalance care away from hospitals and integrate support across health and social care to better support older people living with frailty at home. From the 1960s onwards concerns about fragmentation have been echoed by successive reviews and Government papers<sup>10</sup>. Most recently The NHS Forward View<sup>11</sup> rightly recognised that: "*The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need.....*"

It's time to move from rhetoric to reality and the NHS Long Term Plan now in development offers us an opportunity to do so but, for now, this report suggests, the safety net that should be there for older people is not always in place, and the consequences for those who fall between the cracks can be devastating. In particular, the prospects for older people who are on their own and in declining health at home are increasingly worrying. For these people the health and care safety net can be dangerously thin.

Three perspectives on 'holding the ring' in a fragmented and under resourced system:

### ***Karen's story - 'diary of a daughter'***

This is the diary of the daughter of an older woman aged 90, living at home with frailty, a necrotic pressure sore on her heel and considerable cognitive impairment, who is being cared for by this daughter (though she works part time) with support from domiciliary care. Her mum wants to stay living in her own home and she is committed to supporting this, so has moved in to help. This has been going on for about 18 months.

*"I get up about 7am and creep out of Mum's room so as not to wake her (I sleep on a put-you-up bed in her room in case she needs any help in the night). I carry out the usual domestic chores – there is always a lot of washing because my Mum is periodically incontinent. I wake Mum at approaching 9am and at about 9.30am the domiciliary carer arrives to help her with washing, breakfast and getting ready for the day. Today the carer arrives on time and it is one we know and Mum likes, so this is a bonus.*

*I go to the pharmacy to pick up some of Mum's prescriptions – there is a queue as usual. Then I go to the GP (fortunately nearby) to pick up a Dangerous Drugs Act prescription for morphine patches (pain relief). I know all the reception staff there now. The good news is the prescription is there, the bad news is it needs printing off and then signing by a GP, so I hang around until the GP finds the time between seeing patients to do this. When I finally get it I go back to the pharmacy and wait in line again for my turn – to find the patches are not in stock and will need to be ordered. They will hopefully arrive tomorrow or the next day. I make a mental note to return to get them on my way home from work.*

*While I was at the GPs I asked about the home visit my Mum was supposed to be having a couple of weeks ago but which we've heard nothing more about. It turns out the GP we like and who knows Mum best isn't there this week. My mother isn't really mobile anymore and the pressure sore on her heel makes this worse, so she cannot get to the practice and nor is she really up to talking to the GP about her health over the phone, so that's my job too.*

*The District Nurse should have arrived by now to dress my Mum's pressure sore but hasn't showed up, so I call the office and they say the visit has been cancelled. This is strange as they come every other day. Soon afterwards a District Nurse appears, one we've never seen before. She is astonished to hear we were told her visit was cancelled. When I politely enquire about 'continuity of care' – we had the same District Nurse for the last three visits and it was helpful – she replies they are on a rota and usually people get promoted and then move elsewhere! The District Nurse says she thinks Mum could really do with a visit every day because of the seriousness of her pressure sore but doubts this will be possible because there aren't enough staff. She says she will report this at their team meeting.*

*30 mins later doorbell rings; it's the medical equipment company delivering some items ordered by a District Nurse – before talking to me. These turn out to be one product we already have and another that is an inferior version of something we were given some months ago. I put these upstairs with some other bits of kit we have been given that we haven't found helpful.*

*I have just enough time to phone to see if my Mum might get a chiropody visit soon – we have been waiting for quite a while; I get through to their office quickly, but am told there is a six month waiting list. The only other option will be to pay privately for a chiropodist, which costs £60 a go. As lunchtime is approaching I help Mum get something to eat. Then it's time for me to grab a sandwich and knock off some more chores before I go to work for the afternoon. It's been an unusually busy morning*

*juggling everything at home but not uniquely so. Eighteen months into this I have almost forgotten what it is like to have any real time to myself. I am committed to supporting my Mum for as long as she is alive, but there's no doubt it's a big effort and I have boundless admiration for those people who do this and more with less support than we get, and for years and years."*

### **Gary's story – overwhelmed with nowhere to turn**

*Gary's mum, Dorothy, was diagnosed with dementia in 2012 and died three years later. During the final years of her life, her condition deteriorated quickly and she became prone to mood swings and aggression. The carers that would come to look after her would often ask Gary to be there with them because they struggled with her difficult behaviour. Gary felt that "they weren't trained properly for dealing with her situation". Moreover, Gary and his Mum rarely saw the same carers twice in a row which was confusing and disturbing for her.*

*Gary eventually moved into his mother's house so he could care for her himself. Dorothy was incontinent and Gary describes how she would often "mess herself" and he would have to undress her and "hose her down". This was something Gary never expected he would have to do and didn't feel prepared or trained for. Dorothy had to be admitted to hospital several times because of UTIs.*

*During the last year of her life, Gary spent a lot of time and effort trying to get Dorothy into a care home. He felt the level of care she needed was more than he had the skills to give her. Eventually the council agreed that a care home would be the best place for Dorothy but it was too late - she died a few months later in hospital. Talking about the experience, Gary said: "I felt annoyed, angry, disappointed. At times it was very demoralising and exhausting. It will live with me forever".*

### **Joyce and David's story - what it takes to care for a loved one**

*Joyce is 73 and her husband, David, is turning 75. They have been married for over 50 years. Four years ago, David had a stroke followed by a massive brain haemorrhage. He had emergency brain surgery and was in a coma in hospital for a long time. For the last 18 months Joyce has been caring for David full-time; initially David received some domiciliary care help but it was so unreliable and lacking in continuity that Joyce asked them not to come any more.*

*Joyce has to do everything for David to make sure he is "clean and comfortable at all times". This involves regularly lifting him in and out of his bed or chair to wash him or take him to the toilet, throughout the day and night. David also has frequent seizures where Joyce has to call an ambulance. Sometimes he will have to go back to hospital and at other times Joyce is instructed on how to care for him at home.*

*Joyce is also responsible for giving David all of his medicines and making sure they always have enough to hand. That means frequent trips to the GP and pharmacist picking up prescriptions and time spent completing his medical records so they are all up to date.*

*But caring for David is not the only responsibility on Joyce's shoulders. "If David has to go out for a medical appointment it's a major issue. He can't travel in a car so we rely on wheelchair taxis. I spend ages ringing round companies to find one that can accommodate us as they are always busy. When I finally get the transport and the appointment, the event is a major problem in itself. If David needs to go to the toilet while we're out that's a major thing – I have a hoist to help me at home but they don't have those facilities when we're out."*

*Only after "fighting tooth and nail" for six months was Joyce able to get David into a day centre for two days a week. She spent a long time on the phone chasing people and explaining her and David's situation. Without this respite, Joyce says she just wouldn't be able to cope - and it's the only time David gets to go out of the house.*

*"It's a nightmare – it's a minefield. You are constantly on the go. There is something every day that you have to sort out. The hospital appointments, the prescriptions, organising transport to get him to a*

day centre for a couple of days a week. We have various people coming in to do his blood or his physio - every day there is something. It is very rare that we have a day where there is nothing extra going on.”

“Then there is all the running of the home – checking the bills are paid and the house is maintained. It isn’t just looking after David, it’s everything else. I’m 73 and luckily I am relatively fit for my age, but if I’m unwell I won’t be able to look after David properly.”

“I do it all out of devotion and love for my husband. I want to care for him for as long as I can but I don’t know how much longer I can do it. I’m frightened of him going into residential care permanently because it would break his heart and it would certainly break mine. I just couldn’t do it, I couldn’t do it. But I don’t know what I’m going to do, I just don’t know what I’m going to do.”

### **Rasila’s story – a lifetime providing care for her family**

Rasila is 67 and lives in London. Rasila has been a carer for her family for over 40 years - first for her parents and now for her younger sister who has advanced Alzheimer’s. Rasila had a high-flying career but felt she had to retire early to care for her family. Now, she says, she feels socially cut off. “I have no life of my own and have lost all of my friends. I haven’t had a holiday in 40 years. Everything has gone – I’m 24/7 just focussed on caring for my sister.”

When describing caring for her sister, Rasila explains “she has no mental capacity, and is totally mute, so all of her needs have to be met for every single thing because she doesn’t express herself”. Despite her sister’s obvious need for care Rasila has found dealing with the system to be “an enormous problem”. After their GP contacted the council about a care package, Rasila heard nothing for over six months.

Rasila’s role extends well beyond providing the actual care for her sister. She does everything for her sister, from arranging appointments, making phone calls, getting her medication and sorting out her correspondence. “Everything has to be done – it takes up a lot of time. Every day I lay awake at night and think, “What next, how am I going to cope? What more do they expect me to do?’ I have no one to turn to, no one to guide me.”

### **GPs: crucial but not always the service older people hope for or expect**

Past Age UK research asking older people what they most wanted from the health service produced two clear conclusions: keeping an eye on your health was seen as just as important part of the relationship with the NHS as providing treatment when you are actually unwell; and, unsurprisingly perhaps, the GP, in the broadest sense including the wider practice team, was the most natural place for them to turn to for help with any concerns<sup>12</sup>.

Yet the GP is notably absent from many of the stories we hear from older people – like Alan, who has not seen his GP for nearly a year despite having been in and out of hospital. For Alan, his GP unfortunately only appears as a ‘block’, with waits for home visits and for referrals preventing him from getting the care he needs in a timely way.

Even older people who have a strong relationship with a GP they trust can face practical barriers in getting the support they need. Waits for appointments and not being able to see the same GP have pushed patient satisfaction to an all-time low<sup>13</sup>. The average wait for an appointment is now nearly two weeks – up 30 per cent in a year<sup>14</sup>; and over 5 million people in England are unable to access a GP out-of-hours<sup>15</sup>. 27 per cent of older people who were unable to get an appointment report that they did not seek further help, despite having concerns about their health<sup>16</sup>.

It is widely acknowledged that General Practice is struggling. The GP workforce is shrinking; between 2015 and 2018, the numbers of GPs fell by 5 per cent, whereas those of hospital doctors have grown by almost 10 per cent since 2013<sup>17</sup>. At the same time GP workload has

increased very significantly - by 16 per cent between 2007 and 2014 alone<sup>18</sup>. Two in five GPs intend to quit direct patient care in the next five years<sup>19</sup>; and the numbers of GPs taking early retirement have risen threefold in the last ten years<sup>20</sup>, so the state of the GP workforce is a source of real concern.

The outcome for many older people, however, is that over-worked, time-poor GPs are no longer always able to look after them if they have complex needs in the way they and their families might expect and that GPs themselves would often wish.

### ***Alan's story – endless wait for a wheelchair without which he cannot go out***

*Alan lives alone in a sheltered housing estate. He is very hard of hearing, obese, and has lymphedema and Parkinson's. Alan used to enjoy getting out and being independent but just before Christmas last year he had a fall and broke his hip and knee. Since he was discharged from hospital back home seven months ago Alan has not left his flat and has barely moved from his chair, where he sits in the day and sleeps at night. Alan says he hasn't seen his GP for over a year - and certainly not since he was discharged from hospital. A district nurse has been to visit him once.*

*As a result of his fall, as well as his other conditions, Alan finds moving around painful and is unsteady on his feet. He worries he will fall again. Because of this he only moves to use the commode, which is just a few feet away. Alan has to urinate often because of his conditions. Rather than continually get up for the commode, he urinates in bottles that he places next to his chair. The commode and the urine bottles are only emptied when a carer visits him in the evening to microwave him a meal for dinner.*

*Alan's main goal is to get outside and "breathe some fresh air" but to do that he will need a wheelchair. His flat is tight for space, so the wheelchair will need to be small enough to navigate his flat but large enough for Alan to be able to use comfortably. A request was made to the council on Alan's behalf by his local Age UK. Four weeks later, nothing had happened. Out of frustration, Alan was about to spend the last of his savings on buying a scooter, but the one he was offered would have been far too small for him to use.*

*When the local Age UK chased the council about a wheelchair for Alan they found the delay was because the GP had not completed the referral form. To do this, the GP needed to take some measurements and they hadn't yet visited Alan at home. After chasing the council again, the local Age UK learned that someone had been sent on behalf of the GP to take the measurements and the referral had finally been made. The standard wait for a wheelchair at this stage is three months, but Alan has been warned it will be even longer than this as he requires a home visit, rather than a phone call, to fully assess his needs.*

## **The consequences for older people when home care and community health services are dangerously overstretched**

District nurses, allied health professionals such as physiotherapists and occupational therapists, and paid care workers, are on the frontline in the community; going into older people's homes and playing a crucial role in helping them to stay safe, well and independent. Without them, many older people might not get the pain relief or drugs they need, their pressure sores and ulcers could become dangerously infected and their struggles to keep themselves fed and clean would simply go unaddressed or unnoticed.

But unfortunately there are not enough staff to do all the work that is required. It's not easy to know the precise number of nursing staff working in the community as many are employed by non-NHS providers, but just looking at district nurses we can see that this workforce has declined by almost half since 2010<sup>21</sup>; and the staff who remain are incredibly stretched<sup>22</sup>. Because district nurses are often under such pressure they may feel pressured to do no more than they

absolutely have to, and as quickly as they can. One risk is that they may be too busy to notice if an older person is becoming seriously unwell, with lack of continuity in staffing compounding this problem. Another risk is that these professionals under acute pressure retreat back to being exclusively task focused, because this is one of few ways available to them of managing an intolerable workload.

The traditional idea that a community nurse or paid care worker coming to visit an older person means that someone is able to look out for them is just not the reality any more for many; for example, a visit from a paid care worker can be for as little as 15 minutes. This leaves no time to spot if the older person has any other needs, let alone build a relationship.

In addition, high staff turnover means an older person is unlikely to see the same nurse or paid care worker each time. If they have no real knowledge of the person they are caring for it is much harder for these professionals to know if their health is deteriorating. Like Jean, Sarah's mum, whose care worker didn't spot she had delirium.

When paid care workers and community nurses have to rush around with too much to do they risk becoming burned-out and disconnected from the people they are supposed to care for; in these circumstances it is not surprising if some older people 'fall through the cracks'.

### ***Ralph's story – no one triggered the alarm or got him the help he needed***

*Ralph and Joan were happily married. They had no brothers or sisters and had never had children. Joan was close to her two cousins but they, and their families, lived far away and so mainly talked on the phone.*

*Ralph had diabetes and had been born with a deformed arm that he couldn't use and Joan had lived with arthritis for a long time. Despite this, both had fulfilling careers and lived well – Joan would drive and Ralph would navigate. She would do the cooking and cleaning and help Ralph by cutting up his food for him. He was in charge of their finances.*

*Over time, Joan's arthritis worsened and she struggled to move about. She also became increasingly deaf and started to lose her sight. One day she had a fall and broke her hip. Because of Ralph's arm, he was unable to help her and had to call an ambulance. After her operation, the hospital would not discharge Joan back home as it lacked the adaptations that would enable her to get around in a wheelchair. She was admitted to a care home. Although she was well cared for it took Ralph an hour on the bus to visit her.*

*Without Joan's help with day-to-day activities, Ralph's health started to decline. With only the use of one arm, Ralph struggled to keep himself fed and clean and the house in order. During one visit to the care home, Ralph was hit by a bus and badly injured his leg. When he was discharged from hospital he was visited by district nurses who reviewed his wounds and changed his dressings.*

*Although he was being visited regularly by district nurses, the wounds on his legs still hadn't healed. The nurses also hadn't recognised the extra difficulties Ralph would likely be facing as a man living alone with only the use of one arm, such as not being able to prepare or eat food or keep himself clean. A few months later, Ralph developed a prostate problem and was fitted with a catheter that he had to change himself. Again, he found this difficult because of his arm and this would often lead to accidents, but he still got no extra support.*

*One day, when the son of one of Joan's cousins phoned Ralph to check on him, he was completely incoherent. They called an ambulance and the crew found Ralph semi-conscious. He was rushed to hospital but died shortly after from septicaemia, or blood poisoning. Joan died nine months later.*

*Michael, another member of Joan's cousin's family, said they had felt powerless to help Ralph because they lived so far away and because he would decline any help they offered. But he says he wishes that the healthcare professionals they had come into contact with had done more: "His diabetes required on-going self-administered medication but, after his accident, there were additional*

*problems with leg sores that wouldn't heal, plus having to self-catheterise because of his prostate problem. You would think that a district nurse should have appreciated he needed more help and done something about it. The GP didn't do anything either. Ralph didn't get any special assistance because of his disability - probably because they didn't realise how much he had relied on Joan, but that just isn't right."*

*"And then after their enforced separation, surely there should have been a review of his situation that revealed he was clearly lonely, disabled, suffering from several different ailments and finding it difficult to cope with daily living. I cannot get over how poor, inconsistent and dysfunctional Ralph's care was after Joan had to go into a care home."*

### **George's story – in the absence of anyone 'holding the ring', poor communication means he endured great pain and waited to get the medication he needed**

*George lives alone and has no family or friends nearby. He is living with dementia and a number of other health conditions and he also struggles with gout. Because of his dementia, he often forgets to take his medicines as he should. One day, the gout in George's knee got so bad he couldn't walk and he called for an ambulance to take him to A&E.*

*The hospital discharged him with two additional medicines to help get control of his episode of gout. He was also appropriately given a home care package because he was assessed as needing help to take his medicines. However, because George's medicines had not been dispensed into blister packs the paid carers who came along refused to give them to him – even though this is not a legal requirement. Therefore George went without his medication.*

*Within a few weeks, George went back to A&E because his knee was causing him so much pain. He was discharged but, again, his medicines weren't in blister packs and so his paid carers again refused to administer them. After just two days, George went back to A&E for the third time because the pain in his knee was becoming unbearable.*

*George's pain remained uncontrolled for a further five days because his carers continued to refuse to administer anything outside of a blister pack. In the end, George's GP had to change his prescription from tablets to a pain relief patch and request that a district nurse go in to administer it in order for George to get the pain relief he desperately needed.*

### **Sarah and Jean's story – paid care staff fail to spot a developing health problem**

*Sarah's mum, Jean, is living with vascular dementia and Alzheimer's. Jean used to live alone and have a carer come in every day to get her up, washed and dress, give her breakfast and her medicines. Sarah would go to her Mum's after she finished work. More often than not she would find that Jean had refused to let the carers wash her.*

*One day Jean had a fall and broke her hip and a wrist. After a month in hospital she was discharged back to her own home. About a year later she got pneumonia and became delirious. Although Jean's carers arrived as usual to get her up in the morning, they did not notice how unwell she was. It was someone from the 'meals on wheels' service who came in later who called Sarah up to let her know that her mum didn't seem herself.*

*Jean was very unwell and Sarah and her family were worried she might die. After Jean was finally discharged from hospital, Sarah moved her mum in to live with her. She says she is "in no doubt that if she went back home [after being discharged from hospital] she wouldn't be with us now".*



## A spell in hospital is often the first time it is realised that an older person is struggling and needs more help

In our society today there are millions of older people living alone, many in declining physical and mental health. Some, without family or friends to advocate for them, can be invisible to 'the system' until they come into contact with a hospital or the ambulance service – say after a fall. However, this doesn't necessarily mean they have all been coping well or that some wouldn't have benefited from some extra help, earlier on.

Going into hospital is often the trigger for an older person to begin to get more care at home. This may genuinely be required for the first time as a result of a crisis like a nasty fall or serious infection. But for some we know that the need will have been there for much longer without any health or care professionals knowing or responding.

Even when there is no dispute that an older person in hospital needs more support at home once they are discharged, either temporarily to help them get back on their feet or into the longer term, they may not get it very quickly. Despite an enormous effort by hospitals and local authorities to improve the situation, waiting for care to be put in place was still the biggest cause of delays to people coming out of hospital in England last year<sup>23</sup>; delays attributable to social care alone cost the NHS an eye-watering £500 a minute<sup>24</sup>.

The numbers of older people 'stranded' in hospital have gradually reduced in the last year or two but, at the same time, there has been a rise in the numbers who are discharged but who then have to be rapidly readmitted, suggesting that in some cases older people may be being sent home too soon or without the right support in place<sup>25</sup>.

### **Kates' story – 'off the radar' until crisis hit**

*Kate is in her seventies. She was admitted to hospital after she fell on the pavement in her local town. When she arrived at the hospital staff found she was dehydrated, malnourished, weak and confused. Until her fall, Kate had been looking after herself - she had no carers and would go to church every day on the bus.*

*Kate told staff at the hospital that she has no family and that her only contact was a friend at church. Staff at the hospital wanted to be able to discharge her home and got in touch with a local Age UK. When staff went to her house they found it to be tidy and clean but sparse and in some disrepair - it was obvious that Kate hadn't really used her heating or hot water for years.*

*They also noticed a lot of unopened mail and it appeared that Kate had not been managing her correspondence or financial affairs. When they spoke to Kate about this she struggled to remember things and became easily confused. Many of her bills were unpaid while the account with her electricity provider was thousands of pounds in credit.*

*A few hours after the Age UK staff had helped Kate to get back home, she could not remember having ever been to hospital. Paid carers visited Kate for a few weeks after she was discharged but it was decided by her local authority that she did not qualify for any further support. This was because she was considered to be capable of managing her own personal care, even though she was still visibly malnourished and there were concerns that she would forget to take her medicines correctly.*

*Although Kate had been living in the same flat for over ten years, she had never registered with a local GP. With the support of Age UK, Kate's friend from church has helped her to register with her GP and she has now been referred to a memory clinic and given new glasses. There are still concerns Kate is not eating enough and the local Age UK is trying to get Kate referred to the community mental health team for further support.*



## Repairing the broken safety net

How 'typical' the stories in this report are is hard to judge, but from what older people and their families tell Age UK it is clear that the health and care safety net for unwell older people living with frailty at home is not nearly as strong as it should be, exposing those living alone without support from family and friends to particular risk.

To a great extent we know what needs to change to restore the broken safety net for older people living at home; there are lots of examples of good practice which need scaling up so many more older people can benefit. These come into a number of different categories, including 'hospital at home teams' that bring acute care into older people's homes; care navigators to be single liaison points and to help older people assemble the different types of care they require, on their own terms; multi-disciplinary teams comprising clinicians, care staff and allied health professionals such as physiotherapists, that work proactively in the community to help older people who could benefit from ongoing, joined up support; and strategies to ensure that the contributions of voluntary organisations, including local Age UKs, are fully part of the mix of what's on offer to older people living at home.

Some great examples of where this is working well and having a positive impact on the lives of older people are included below.

The NHS is putting together a Long Term Plan and this is potentially the vehicle for putting measures like these into effect across the country. Certainly, if this can be achieved it ought to mean that older people who are living at home receive more appropriate help earlier on, with their loved ones bearing less of the responsibility than they do now to make things happen for them – with obvious consequences for those with no one to help them. And when older people are in need of hospital care, getting access to swift effective treatment and ensuring they are discharged home quickly as possible, with support firmly in place, should increase the chances of them making a full recovery.

The missing link in this vision is, of course, the contribution of social care. It is impossible to conceive of an approach like this working unless social care plays an equal part, alongside the NHS, because so many older people who live at home and who are unwell have care as well as health needs. If this is to happen, social care will need a sustained injection of additional funding, to the tune of several billion pounds extra each year. There are three big opportunities coming up soon for Government to direct this expenditure: the autumn Budget; the local government spending settlement in December; and the Spending Review some time in 2019. One of these opportunities needs to be taken and the sooner the better.

If social care does not get the extra funding it needs the numbers of older people living with unmet care needs will continue to rise – it already stands at 1.4 million in England - and there will be no foundation on which to build an effective, integrated service across health and care for older people living at home. This in turn would be likely to mean that high and rising numbers of older people continue to be admitted to hospital when it could have been avoided, where some become 'stranded' beyond the time at which they are medically fit to leave. Such a situation would cause problems right across the hospital sector and frustrate efforts to improve the NHS more generally, as well as undermining the health and wellbeing of many thousands of older people who just want to get home safely. The stakes really couldn't be any higher.

In addition, the national failure in effective health and care workforce planning must be swiftly reversed: it is nothing short of a disaster that the GP and District Nurse workforces, to name just two, are in such obvious decline, given the extent to which they are core to supporting a rapidly ageing population. We need a genuinely joined up approach across health and care to creating the sustainable, appropriately skilled workforce that is required.

### **Fred's story - virtual wards**

*Fred is 81 years old and lives alone. He was diagnosed with chronic obstructive pulmonary disease (COPD) some time ago and has a number of other conditions, including diabetes and arthritis, and he has previously had a stroke. For two years Fred has been struggling with his COPD, which has been getting worse. After a number of visits to hospital he had a series of follow up appointments which were either cancelled or could not happen because he had been readmitted to hospital so missed them.*

*Fred was regularly feeling breathless and started getting anxiety attacks. He lost his confidence and was calling the emergency services because the only place he felt safe was in a hospital. He attended hospital frequently and was regularly admitted. He was prescribed multiple courses of antibiotics and steroids that made very little difference to his breathlessness but added to his overall health risk, especially as he has diabetes and is not very mobile.*

*Fred was finally referred to a 'virtual ward' after it was noticed how many times he had been in and out of the hospital. He was quickly given an appointment with a community COPD clinic. They identified that he did not have COPD after all but another respiratory condition. He is now on the correct medication and a year after his appointment at the COPD clinic has not been back to hospital.*

### **Alison's story - hospital at home**

*Alison is 89 and lives at home, supported by her son Chris. She had a fall in winter 2017 which caused a brain injury and subsequent dementia and led her to be in hospital for five months. Then, after she was discharged home with a care package she experienced recurrent chest and pressure sore infections, and UTIs. These resulted in her being in and out of hospital for short spells through the summer and early autumn.*

*Each time Alison went into hospital she lost some mobility and became quite confused and distressed - a downward spiral in her mental and physical health was apparently underway. Then in October when Alison developed yet another infection the decision was taken to refer her to the local multidisciplinary 'hospital at home team', rather than admitting her to hospital. Clinically led, this team comprises doctors, nurses, paid care workers and physiotherapists, among others. They visited Alison within hours of getting the referral, decided on a treatment regime, which included intravenous antibiotics, and took responsibility for administering them to Alison while she remained at home. They also reviewed her general situation, decided that her care package needed to be increased, liaised with local commissioners to organise it, and also provided Alison with some ongoing physiotherapy to help her mobility.*

*Six months later Alison remains at home; she has not had to go back into hospital again. Her son Chris says, "This team was a real Rolls-Royce operation. They gripped Mum's case and got more organised in a few days than anyone else has done over many months. And it worked; my Mum's condition has stabilised – she was so much better off staying at home. I felt supported too and it was such a relief not to be trying to deal with it all on my own."*

### **Michael's story - care navigators**

*Michael is 74 and lives with his wife, Elaine, who is 68. Michael was in the Army for 12 years. He suffered a serious brain injury in 2004 which has affected his speech, memory and mobility and makes it hard for him to interact with people - Elaine says "his emotional side has gone". Michael also has cancer, diabetes and a number of other serious health issues.*

*When Michael first came home from hospital they were assigned a 'care manager'. Elaine says he was "wonderful" and that for four years she knew who to speak to if she had any concerns or needed anything sorted. "You can see how special [the care manager] was because Michael can remember his name so clearly, even after all these years".*

Now that they no longer have a care manager, Elaine can never get hold of the right person to help her and she feels completely isolated. "Your confidence is at an all-time low when you're thrown into a traumatic situation. You need somebody to hold your hand."

### **Pat's story - the role of the voluntary and community sector**

Pat is 66 and lives with her husband and son. She has a number of health conditions, including fibromyalgia and arthritis, which cause her considerable pain and severely limit her mobility. Pat can't manage the stairs in her home so she can't reach her bedroom or bathroom. She was sleeping on a camping bed in the lounge, washing herself in a bowl and using a commode in the hallway. Pat is also incontinent, struggles with depression and anxiety, and suffers from severe panic attacks.

Pat's son helps care for her around his full-time job. Although she is hugely grateful for her son's help, Pat feels deeply embarrassed by her situation and sees herself as a burden. Even with her son's support, Pat still felt trapped and isolated - she hadn't left the house for some time and had lost touch with her friends.

Pat finally decided to try and get herself some help and applied for Attendance Allowance, but was told that she didn't qualify for support. She was crushed. Then, after seeing an advert in the paper, Pat reached out to her local Age UK. First, the Age UK staff wrote to the Department of Work and Pensions and asked them to reconsider Pat's Attendance Allowance application. Her case was reviewed and it was agreed that she was eligible for the benefit after all, and at the higher rate. Pat's son was also granted Carers Allowance.

Subsequently, the local Age UK was also able to put Pat in touch with a community transport scheme, so she is now able to get to church three times a week and has reconnected with friends. They also referred Pat to the Community Continence Team, which she never knew existed but which has given her lots of useful advice and are providing her with incontinence pads for free. The council is also due to come and fit grab rails, a stair lift and make adjustments to Pat's bathroom so she can use it again.

Pat said, "I know my health problems are never going away, but I feel so much better as I feel less of a burden on my family, I have a hope that my home will be improved for me, I have the money and the means to get out of my home independently and feel like I have friends and a purpose again at my church."

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