Submission to the Independent Expert Review on Delayed Discharges Working Group

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An Roinn Tithíochta, Pleanála, Pobail agus Rialtais Áitiúil
Department of Housing, Planning, Community and Local Government

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1. Introduction

Age Action welcomes this invitation to submit its views on Delayed Discharges to the Independent Expert Review Working Group. Age Action frequently receives calls on this issue to our Helpline from worried older people and their relatives.

2. Policy Context

Age Action is pleased to see the commitments made in the 2018 HSE Service Plan to improve the experience of older people needing admission to acute hospitals, notably:

- €18.25m for home support services to provide 754,000 hours to support 1,170 people to leave hospitals
- €1.4m for rehabilitation and step down beds in Limerick (four beds) and Cork (30 beds).
- €0.85m for complex case discharges from acute hospitals
- €0.65m for an additional six beds in the National Rehabilitation Hospital

However, we know that these measures in themselves are insufficient to solve the current crises in many of our acute settings. We are aware that the unmet need for Home Supports within the community plays a contributing factor to timely discharge of older patients.

We note also that delayed discharges is a key reform theme under the developing specialist hospital care networks element of the HSE 2018 Service Plan which aims to build capacity in hospitals to ensure "timely discharge as soon as acute care is completed" .[1]

Recent reports, in particular the Health Service Capacity Review and Sláintecare, both reference the inadequacies of Home Supports, the resulting unmet need of older people in the community and how this impacts negatively on the numbers awaiting discharge from acute settings.

[1] https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf

The most recent HSE quarterly performance states that 572 people were awaiting discharge from acute hospitals, 296 of whom were moving on to Long Term Nursing Care. Out of the total number awaiting discharge 58 per cent were aged over 65. [2]

Age Action is mindful that the Home Supports budget has been increased to €408 million in 2018. This additional €18.25 million is not enough to meet unmet need in the community which would enable older people to leave hospital to return home, where many of them want to and could be, with appropriate supports.[3]

Age Action also welcomes the recent publication by the Institute of Public Health in Ireland for the Department of Health Improving Home Care Services in Ireland: An Overview of the Findings of the Dept of Health's Public Consultation June 2018. This is a critical first step in the establishment of a statutory Home Care Scheme which will provide access to a sustainably funded and regulated model of home care with equitable, affordable access and high quality standards.

3. Current challenges contributing to delayed discharges

We set out below our understanding of current challenges which contribute to delayed discharges from acute hospitals.

i. Demographic challenges

Ireland's increasing life expectancy makes is creating challenges for the health service. People currently aged 65 can now expect to live into their 80s, with two-thirds of these years lived disability free.[4] However, as people live longer, their risk of disability also increases. It is estimated that 72.3 per cent of the population aged 85 and over will have a disability.[5] The number of people over the age of 65 is increasing by over 20,000 persons a year. In addition to this, the proportion of people over the age of 85 is projected to double in the next 20 years.[6]

[2] https://www.hse.ie/eng/services/publications/performancereports/january-to-march-quarterly-report.pdf

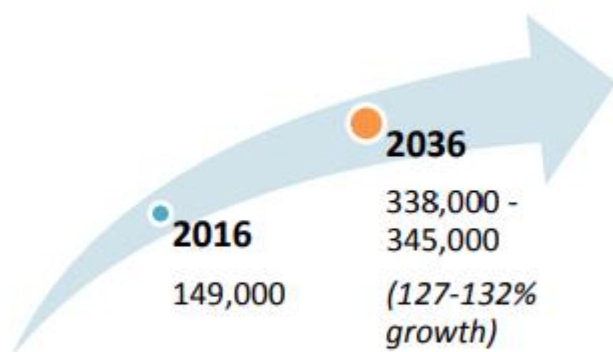
[3] https://www.hse.ie/eng/services/publications/serviceplans/national-service-plan-2018.pdf

[4] https://health.gov.ie/wp-content/uploads/2018/01/Key-Trends.pdf

[5] http://www.cso.ie/en/media/csoie/newsevents/documents/census2016summaryresultspart2/Chapter_9 Health,_disability_and_caring.pdf

[6] https://health.gov.ie/wp-content/uploads/2018/01/Key-Trends.pdf

Figure 3. Population Growth Projections aged 80 years and over 2016-2036



Source: Oireachtas Library & Research Service | Spotlight Home Care for Older People – Seven Policy Challenges. 2018.

ii. Capacity challenges

Recent reports have indicated the impact that the growth in Ireland's ageing population will have on current and future capacity within the health system. Demand is predicted to increase for Home Care Packages by between 44 and 66 per cent and Home Help Hours by 38 to 54 per cent by 2030 respectively.[7] The Health Service Capacity Review report states that 120 per cent increase will be required in Home Support services if projected demand is to be met.[8]

These projections of Home Support future need illustrate the urgent need for the development of a sustainable, appropriately financed, statutory Home Supports scheme. Age Action is mindful that the findings from the above cited reports have serious implications for the planning of health and social care services for older people. The complexities of the challenges regarding workforce planning in the sector will also pose challenges as precarious work and low pay are endemic issues which need to be tackled.

[7] https://www.esri.ie/publications/projections-of-demand-for-healthcare-in-ireland-2015-2030-first-report-from-the-hippocrates-model/

[8] this report states that the required capacity will increase by 70 per cent requiring an additional 11,000 HCPs and an additional 7.2 Home Help Hours a year by 2031.

iii. Unmet need

Age Action is very concerned that the limited resources available in the Home Supports Scheme results in the prioritisation of Home Care Packages for those leaving acute hospitals over appropriate supports for older people in the community. Additional resources in the Scheme would mean that more people could continue to live at home - where many want to be - if supports were available to them. This would also see a reduction in the costs associated with long term residential care, acute hospital admissions and stays, as more older people would be cared for in the most appropriate location - namely the community.

Age Action welcomes the amalgamation of the Home Help and Home Care Packages into the Home Support Service for Older People. The alignment of Home Supports services into a single funding model is a positive development which should result in improvements in ease of access, assessment and availability for older people as the application process is now streamlined and simplified.

Unmet home supports need is associated with a variety of negative consequences that can affect the health and well-being of older people. These range from relatively minor consequences, such as feeling distressed because housework is not done, to major consequences, such as being unable to eat when hungry.[9] Through our direct work with older people in our Care and Repair Programme it is clear that older frail people can often sustain an independent lifestyle at home if they receive the appropriate practical, physical and psycho-social supports. Without these home care supports some older people have no option but to move to residential care settings, on discharge from hospital after an acute episode, which is often not their first choice.

The most recent HSE figures available show that there were 6,458 people waiting for new and additional Home Support services in May 2018.

The numbers without services waiting for Home Help were 2,539, with 2,303 waiting for Home Care Packages, compared to 2,456 and 2,218 respectively in May 2017.

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[9] Quail, J Wolfson, C and Lippman, A (2011) Unmet Need for Assistance to Perform Activities of Daily Living and Psychological Distress in Community-Dwelling Elderly Women. Canadian Journal on Aging 30 (4): 591– 602

Table 1 Unmet Home Supports Needs 2016 – 2018

Date	**Numbers without new and additional Home Help Hours**	**Numbers waiting for Home Care Packages**
December 2016	2,039	2,342
May 2017	2,456	2,218
May 2018	2,539	2,303

Source: HSE performance reports, various.

It is estimated that approximately 6.5 per cent of the population aged over 65 years receive home help in Ireland, which compares poorly with the OECD estimate of approximately 10.1 per cent of this age cohort needing the service. Both these estimated figures for people needing home supports far outstrip the HSE supplied figures giving the numbers waiting for new and additional services and for those without services.

Table 2 shows the decrease in home help hours and clients since 2008. The 2018 allocation of Home Supports services, shown in table 3, will not bring the number of recipients back to the 2008 level, which given the exponential growth in the population cohort in question, is a cause for concern.

Table 2 Home Help Hours and Clients 2008 - 2017

	2008	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
No of Hours millions	12.63	11.89	11.68	11.09	9.88	9.74	10.3	10.44	10.6	10.5
No of clients	55,366	53,791	54,000	51,000	45,705	46,454	47,061	47,915	47,000	46,254

Source: HSE Annual Reports and Financial Statements 2008-2015; HSE Annual Service Plan 2017.

Table 3. Activity Levels Home Care vs Residential Care 2018

Service / Scheme	***No. of people***	***Proportion of over 65s (approx.)***
Nursing Home Support Scheme	23,334	4%
Home Help and Home Care Packages (10.57m Home Help Hours, 20,175 Home Care Packages and 235 Intensive Home Care Packages total of 360,000 Home Support Hours)	50,500	8%

Source: Oireachtas Library & Research Service | Spotlight Home Care for Older People – Seven Policy Challenges. 2018.

The above graphics clearly show that the current level of supply does not meet the present and emerging Home Support needs of older people. The average value of a Home Care Package is approximately €8,580 per annum (€165 for approximately 6.5 hours per week), while the annual cost year of providing care for an older person in a private nursing home within the NHSS is €49,932[10].

It is clear that a sustainable, statutory Home Care Scheme, underpinned with robust eligibility legislation and quality standards, is the best and most effective use of resources.

Age Action is very mindful of the long-term commitment to implement Sláintecare which commits to delivering affordable, integrated, GP and primary and social care services to all. This report estimates that to begin to meet unmet need in home care provision for older people the cost will be between €120 million and €205 million over the first five years of Sláintecare. This is based on calculating unmet need at the more realistically estimated levels of 26% and 50% respectively.

iv. Delays in the roll out of the Single Assessment Tool

International best practice advocates standardised comprehensive care needs assessment to appropriately identify older persons' care needs. The implementation

[10] http://health.gov.ie/wp-content/uploads/2015/07/Review-of-Nursing-Homes-Support-Scheme.pdf

of an electronic standardised care needs assessment is critical for the future planning of services for older people at a network, regional and national level.

The roll out of the SAT project will lead to the implementing of a national clinical information system, accessible in 'real time' which facilitates information sharing in a consistent and transferable way between health and social service agencies.

Age Action understands that there are some technical delays in the building of the IT-enabled standardised assessment (interrail assessment system) to support service access based on identified need. We ask that all required support and resourcing is provided to expedite this critical element of service improvement.

v. Underdeveloped inter sectoral linkages

Linkage between hospitals and community health services varies across the country. The problems of integration between acute and community settings can mean delays in timely discharge. This can result in people being discharged from hospital without adequate supports in place for them in the community, which in turn can lead to readmission.

Delays in getting adaptations and specialised equipment for people moving out of hospital mean that they may have to stay in hospital longer or move to a nursing home until their home has been adapted to suit their requirements. Older people often have to wait months to have their homes assessed for adaptation by an occupational therapist. The availability of housing adaptation supports can vary according to geographical area. Many older people are forced to pay privately to ensure they can live safely in their own homes. Changes are needed in the operation of home adaptation schemes to enable them to deliver adaptations quickly and in a proactive manner before the older person is in crisis.

4. Alternative models of intervention and best practice

The below alternative models of intervention and best practice can enhance outcomes for older patients awaiting discharge from hospitals and will reduce the numbers receiving care in the most expensive setting within the health system.

i. Home Care Packages

Home Care packages provide appropriate care meeting the personal needs of older people who are ready to leave hospital and also of those living in the community who wish to remain at home. However demand outstrips supply and funding is insufficient.

Age Action understands the rationale behind the decision to prioritise funding for Home Care Packages applications from acute services to facilitate quicker bed turnaround. However we continue to be seriously concerned for service users in the community who are unable to access timely supports. This inequitable situation continues to have a very negative impact on older people in the community waiting for home supports. We therefore support the specific asks of the Irish Association of Social Workers submission on delayed discharges concerning the :

- Reversal of the Home Care Assistant role from Community Intervention Teams
- Resourcing of primary care services to facilitate reviews of Home Care Packages post discharge from hospital

ii. *Practical partnerships - Bon Secours Hospital Cork and Age Action Cork*

Age Action has a successful history of responding quickly to the needs of older people. We operate a national programme called Care and Repair which carries out minor repairs and DIY for older people in their homes free of charge.[11] To meet the needs of local older people who are ready for discharge from hospital, Age Action Cork has joined with the Bons Secours Hospital Cork, beginning in August 2018, to run a pilot to facilitate older people to return home from hospital. The pilot is funded by the Bons Secours Hospital and aims to improve the homes of older people to meet their needs on discharge. This is an example of innovation and partnership between acute and voluntary sectors. Please see Annex 1 for further details.

ii. *Reablement - supporting older people to maintain independence and well-being*

There are positive indicators that identifying older people at risk of becoming frail and providing them with reablement, or restorative care programmes, results in

[11] https://www.ageaction.ie/how-we-can-help/care-and-repair

improvements in health-related quality of life and well-being and reduced home care costs.[12] In many countries policymakers are actively promoting reablement as an effective means of supporting older people to be independent. For example, in Denmark, municipalities are required by law to assess if a person in need of home care services could benefit from a reablement programme. Reablement helps older people regain confidence and skills needed to live independent and fulfilling lives reducing the need for home support services. Tailored, intensive programmes, usually with support from an occupational therapist, are provided to people in their own homes for between three to 12 weeks with relevant equipment and technology provided on discharge from hospital.

Reablement is at yet undeveloped in the Irish context, although a HSE report produced by Mazars highlighted that comparable reablement programmes in England were cost-effective and reduced the need for homecare.[13] An award winning[14] HSE reablement pilot conducted in North Dublin in 2014 found that 24 per cent of participants needed no further home care supports after the intervention, while 61 per cent needed reduced home help or home care packages.[15] Despite the positive indications from this pilot, and international research, reablement is not widely accessible in Ireland, although savings to both long term care and residential care budgets and better outcomes or participants are evidenced.

Age Action strongl urges Government to build upon the learning from the 2014 HSE pilot and ensure that reablement forms an integral element of the forthcoming statutory Home Care Scheme.

iii. Improved model of care centred on Comprehensive Community Based Services

We note the model of care that is described in the Health Services Capacity Review (page 99)[16] and acknowledge the cross-system reconfiguration it requires. We

[12] http://www.ifa-copenhagen-summit.com/wp-content/uploads/2016/04/Copenhagen-Summit-Final-Report.pdf
[13] http://www.hse.ie/eng/services/publications/olderpeople/Activity-Resource-Review-Home-Care-Services-May-2016.pdf
[14] Irish Health Care Awards hosted by the Irish Medical Times
[15] Rooney, Barbara (2016) Reablement – HSE Dublin North Central. Presentation.
[16] https://health.gov.ie/wp-content/uploads/2018/02/71580-DoH-Dublin-Report-v6.pdf

believe the benefits it illustrates show its potential efficacy: more appropriate care closer to home, better experience for patients, reduction in ambulance call outs, reduction in Emergency Departments attendances and admissions and reductions in delayed discharges. The concepts and scenarios evinced in this model clearly show the cross-system change needed to secure a reduction in delayed discharges from acute hospitals.

The Interdisciplinary models of care, cited in the Irish Association of Social Workers Submission, such as the HomeFirst team in St James, the GEMs service in St Lukes Kilkenny and the FITT in Beaumont Hospital as examples of best practice in the care of frail older persons.[17]

iv. Prioritised resourcing of NGO led preventative older persons services

Services which contribute an important preventative role in supporting the well being and health status of older people are often provided by NGOs and voluntary organisations in an innovative and flexible way, answering need where it arises. These organisations provide services such as day centres, meals on wheels, respite services, befriending services, Care and Repair Services et al. These services must be financially resourced to enable them to provide the required essential services on a national basis.

5. Conclusion

It is clear from the type and frequency of queries to the Age Action Helpline that an emergency stay in hospital is often the first time that an older person, and their family, begins to consider long term residential care.

Age Action frequently deals with queries from stressed family members describing the pressure they come under from hospitals when their relative is ready for discharge. This pressure often comes at a time when they are dealing with new and

[17] https://www.iasw.ie/Submissions-and-Representations

complicated legal and financial information and are required to make quick decisions on important matters.

Carol's story

Carol is an only child, her mother (86) is in hospital, Carol is trying to find a nursing home bed for her mother, near her husband who is still alive. The hospital is putting pressure on her to find a home for her mother even if it is a long way from where her husband lives. She has a transitional funding for the Fair Deal. The hospital is threatening to start charging her mother for the hospital bed.

A prioritisation of funding for health and social care services delivered in the community is a critical variable which must be prioritised to begin to address the systemic challenges which lead to delayed discharges. This investment in community services is long overdue and is required imm

Home Support services in the community and relevant primary care services such as the Community Intervention Teams (and other allied health staff) must be adequately resourced. This will enable them to deliver responsive tailored care to older people to help avoid and reduce hospital admissions.

ANNEX 1

Care & Repair Hospital Discharge Service Cork

The Problem

Older people are often discharged from hospital with reduced mobility levels following accidents or illnesses. Often they need adaptations in their homes to accommodate for this. Examples include moving bed downstairs, handrails installed, etc.

Often the hospitals are not in a position to discharge people into a home they deem to be unsafe. The patient often stays in hospital longer than is necessary or eventually moves to a nursing home.

In some instances the living conditions may not have been good before admission to hospital. Issues such as dangerous electrics, trip hazards, poorly functioning heating systems, drafts, etc. can exist.

The Solution

The Care & Repair team works with health professionals, clients and their family/friends to provide an increased level of support for those being discharged from hospital. A series of tasks are agreed on a case by case basis that would enable a client to move home. For example it could be to install handrails, replace a toilet seat, move bed downstairs, and remove trip hazards.

The Care & Repair "hospital discharge team" has a checklist and meets with a health professional to agree a course of action. The checklist provides a template for the C&R team to examine a person's home and make recommendations both on items that can be completed by volunteers and also on things that would require professional tradesmen such as electrics, plumbing etc. It also allows the health professionals to provide their input into the plan of action. Increased support can be provided by the Care & Repair team in the weeks following discharge to assist with things like shopping, bins etc.

Issues to Consider

- The service will involve cooperation between health professionals, clients, families and the Care & Repair team so that all parties achieve satisfactory results that ultimately benefit the client/patient.
- The client must give written permission both for an examination of the house and for any work to be done, and must note any valuables that are in the home. Arrangements for accessing the home must be agreed.
- A nominated health professional will be the point of contact for the Care & Repair team for each client
- Clients and health professionals would need to understand the limits of what can be provided by the service, and that any materials would need to be paid for
- As a volunteer endeavour, recommendations on things like electrics etc. are made in good faith and do not guarantee the safety of appliances/wiring etc.
- Time scales: Where possible the C&R hospital discharge service should be part of a planned discharge of a patient from hospital. Where it is known several weeks in advance that a patient will be ready for discharge, the C&R team should be contacted at the earliest opportunity so that work can be completed on-time.
- For the initial pilot, clients with relatively straightforward requirements should be chosen for the service. This will enable all parties to test the proposed systems and make any required changes before taking on more challenging work/clients.
- The geographic area that will be covered by the service is Cork City and suburbs including the outer “ring” of Ballincollig, Passage West and Glanmire.

The terms of reference are currently being finalised by a pilot Steering Committee.