NHS
South Tees
Clinical Commissioning Group

Update for Governing Body

Improve - Integrated management and proactive care for the vulnerable and elderly

Overview

In the South Tees area, the number of people aged over 65 will increase by 20 per cent by 2021. Older people experience more ill health than other groups. This represents a challenge for the CCG but also an opportunity to improve the way we care for our elderly population.

At present, elderly and vulnerable people in our area are admitted to hospital more frequently than in other parts of the country and spend longer there than they need to because we don't have the right support available in the community.

For many people who are frail, elderly or have long-term conditions, a community or home-based service is more appropriate. Improving and enhancing the range and type of healthcare available close to home can help people to live independently for longer.

We believe that most people would prefer to receive care in their own homes or in the local community rather than in hospital. We need to develop health services which allow people to access care in an appropriate setting that is closer to home.

This view is endorsed by NHS England's national medical director, Sir Bruce Keogh, who has called for system-wide changes over the next three to five years so that care can be delivered in or as close to people's homes as possible.

According to NICE (National Institute for Clinical Excellence) guidance, stroke patients recover much better if they receive rehabilitation in their own home. For those who need rehabilitation in hospital, they should receive this in a specialist stroke unit. This does not happen in South Tees at the moment.

There is a need for the NHS and local councils to work together more closely to provide more responsive and personal services for the increasing number of older people who are living longer with health conditions.

The story so far

We have been working with local GPs, hospital clinicians, nurses, other health professionals and social care partners to consider how we can develop a more responsive and joined-up approach to caring for the growing population of older patients with long-term conditions and other care needs.

We have engaged in discussions with stakeholder, patients, carers and the general public to find out more about the type of services they need and how they should be organised in the future.

Views and comment received have helped us to refine our vision for services for the vulnerable, elderly and those with long-term conditions.

Our vision for services

Improved community support for elderly and vulnerable people including:

Better identification of those with health conditions by local GPs

Greater support from community matrons

More care delivered in patients' own homes, out-patient clinics and other community settings

Improved stroke services including:

Establishment of a community stroke team
More therapy in peoples' homes
Centralisation of stroke services in one location

A single point of contact for all health and social care needs leading to:

Rapid hospital discharges
Joined up health and social care provision delivered quickly when required
Same level of support provided to all, irrespective of where they live

Improved community services leading to:

More rapid hospital discharges
Better community rehabilitation
Better use of our existing community estate to enable more assessments, day treatments and out-patient services to be delivered closer to home

What happens next?

We are currently in the process of considering options for change with our GP practice members, partners and key stakeholders.

We will be putting forward proposals for service change as part of a formal consultation process which is due to start on 30 April 2014.

The consultation will include a number of public meetings as well as opportunities for local people to have their say through a range of other channels.

March 2014