Ageing Well

Integrating Care for Older People

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NHS England and NHS Improvement

What is policy seeking to achieve for older people?

Key outcomes:

1) Care that makes sense to people (and their carers and families)

2) People get what they need, when they need it.

Three national priorities for older people

1. **Change in approach to health & social care nationally**
2. **Preventing poor outcomes through active ageing**
3. **Quality improvement in existing acute & community services**

Using frailty identification to balance care

Intervention
Timely intervention
Meeting the needs of those with established frailty

Prevention
Anticipating & Ageing Well

Time
Opportunity
Planning
Communication

Words matter: *be careful using the F-word*

- **Elderly** =adjective: advanced age, old
- **Frail**=adjective: easily broken, not robust, weak
- **Frailty** = noun: the quality or state of being frail
- **Older**: adjective: comparator of old
- **Ageing**=verb: to grow old a normal phenomenon

The frail elderly = not robust & old: **'an inevitable end state for everyone'**

People with frailty = people with specific needs + preferences

Ageing well = growing old positively: many can achieve this

What’s the national approach?

FROM THIS	TO THIS
‘The frail Elderly’	‘An Older Person living with frailty’ A long-term condition
Late Crisis presentation Fall, delirium, immobility	Timely identification preventative, proactive care supported self management & personalised care planning
Hospital-based episodic care Disruptive & disjointed	Community based person centred & coordinated Health + Social +Voluntary+ Mental Health + Community assets

Frailty is being used here as a paradigm

Rationale: Population ageing

- **Number of people aged 65 &over will increase by 19·4%**: from 10·4M to 12·4M
- **Number with disability will increase by 25·0%:** from 2·25M to 2·81M
- **Life expectancy with disability** will **increase more in relative terms**

Frailty in this context is an expression of 'problematic' ageing

Forecasted trends in disability and life expectancy in England and Wales up to 2025: a modelling study: *Guzman-Castillo et al, Lancet Public Health 2017*

Rationale: we don't all age in the same way

Percentage of eFI category within each age band
KID data, January 2017 cohort

Age band	Fit %	Mild %	Moderate %	Severe %
65-69	73.9%	21.7%	3.8%	0.5%
70-74	63.7%	28.5%	6.8%	1.1%
75-79	50.1%	35.6%	11.8%	2.5%
80-84	37.7%	38.5%	18.4%	5.4%
85-89	27.8%	39.0%	24.4%	8.8%
90-94	22.5%	37.4%	27.8%	12.3%
95+	21.8%	36.0%	30.7%	11.5%

NHS England analysis- KID 2017-18

Rationale: frailty care already attracts substantial costs

Frailty level	Cost
Fit	£1,210
Mild	£2,754
Moderate	£4,437
Severe	£6,824

NHS England analysis- KID 2017-18

Rationale: distributive spend can be improved upon

Proportion of total costs by care type for each frailty category, KID population aged ≥65, Jan – Dec 2017 full year cohort

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Percentage of annual cost

Fit: 13%, 52%, 24%, 6%, 4%
Mild: 19%, 45%, 26%, 5%, 5%
Moderate: 24%, 45%, 20%, 4%, 7%
Severe: 26%, 46%, 15%, 3%, 10%

Social Care
Acute
Primary Care
Mental Health

Fit
Mild
Moderate
Severe

Frailty group

NHS England analysis- KID 2017-18

Finding frailty: GP Contract 2017/18 Data [Q4]

Definition	Cumulative 2017-18 total	Cumulative 2017-18 %
Count 65+ with frailty assessment	**2,574,063**	**25.6% 65+**
65+ without frailty assessment	7,468,288	74.4% 65+
Total moderately frail	**630,921**	**6.3% 65+**
Total severely frail	**320,262**	**3.2%.**
Total moderate and severely frail	**951,183**	**9.47% 65+**
Severe frailty w/medication review	210,687	65.8% (severe frail
Moderate or severe frailty w/fall	102,378	10.7% (moderate/severe frailty
Moderate or severe frailty w/falls clinic	25,570	2.9% (moderate/severe frailty)
Moderate or severe frailty w/consent to SCR	140,501	14.8% (moderate/severe frailty)

NHS England data

GMS (2018) frailty identification by STP

Figure 2: Percent of registered patients aged 65 and over who have a diagnosis of moderate or severe frailty following a frailty assessment using the appropriate tool by 31 Mar 18 by STP area

16%
14%
12%
10%
8%
6%
4%
2%
0%

% with moderate or severe frailty diagnosis (of all 65+)
England Average

West Yorkshire
Shropshire and Telford and Wrekin
North West London
Staffordshire
Somerset
Durham, Darlington, Teesside, Hambleton,...
Suffolk and North East Essex
Bristol, North Somerset and South Gloucestershire
Humber, Coast and Vale
Hertfordshire and West Essex
Lancashire and South Cumbria
Nottinghamshire
Dorset
Cheshire and Merseyside
West, North and East Cumbria
Lincolnshire
Hampshire and the Isle of Wight
Sussex and East Surrey
Norfolk and Waveney
Milton Keynes, Bedfordshire and Luton
Derbyshire
Bath, Swindon and Wiltshire
Leicester, Leicestershire and Rutland
Greater Manchester
The Black Country
South Yorkshire and Bassetlaw
South East London
Devon
Herefordshire and Worcestershire
Mid and South Essex
Birmingham and Solihull
Buckinghamshire, Oxfordshire and Berkshire West
Coventry and Warwickshire
Cambridgeshire and Peterborough
Kent and Medway
Northumberland, Tyne and Wear and North...
South West London
Gloucestershire
Surrey Heartlands
North Central London
North East London
Frimley Health
Cornwall and the Isles of Scilly
Northamptonshire

Fusion48 analysis

A different lens: Frailty and the GP Patients Survey

2018 GP Patients Survey (GPPS) included a frailty-specific question for the first time, formulated with input from NHSE's National Clinical Director for Older People:

Q32 Have you experienced any of the following over the last 12 months?

Please put an ✘ in all the boxes that apply to you.

- ☐ Problems with your physical mobility, for example, difficulty getting about your home
- ☐ Two or more falls that have needed medical attention
- ☐ Feeling isolated from others
- ☐ None of these

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Prevalence of frailty-GPPS: inequalities

- **Darker/pinker areas** on map are CCGs with **higher proportion of frail patients**
- CCGs with **more frail patients** seem to be concentrated in the **north of the country, and in urban areas in the Midlands**

*based on GP-registered population

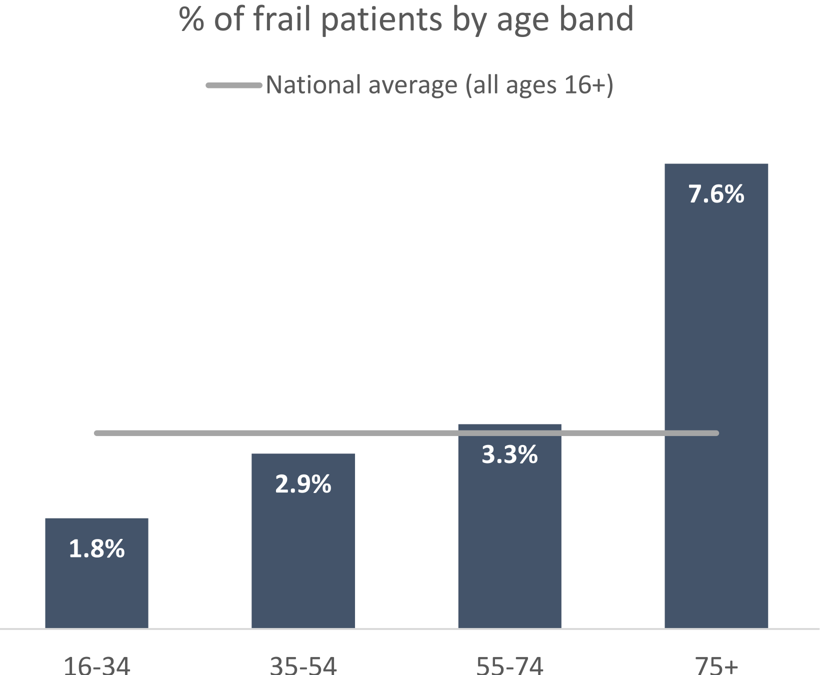
% of patients who are frail, by CCG

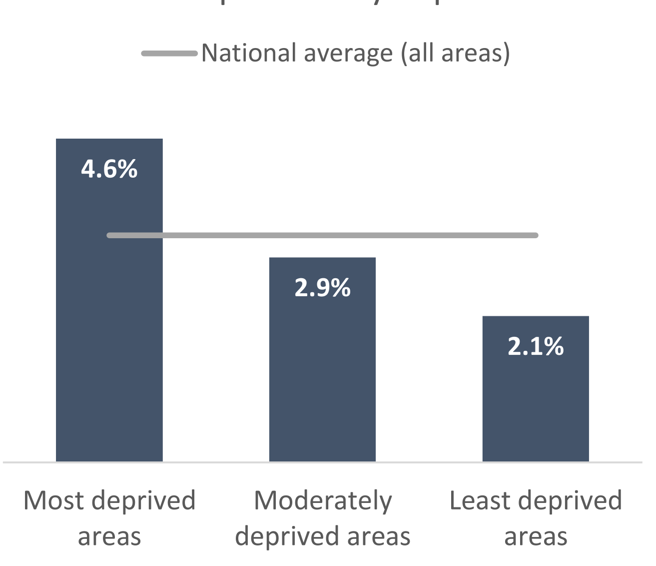
3.9% to 6.0% (40)
3.3% to 3.9% (39)
3.0% to 3.3% (36)
2.5% to 3.0% (39)
1.5% to 2.5% (41)

Characteristics of population with frailty

…much older than average (but a lot of 'frail' younger people too)

…more likely to live in deprived areas





A tactical approach to managing complex needs nationally NHS

2017-18: introduction of the GMS frailty requirements

- Routine identification of severe (and moderate) frailty
- Annual medication review and falls risk identification
- Sharing frailty information via the Summary Care Record

2019: NHS Long Term Plan

- Ageing well community MDTs for 1.2m people with moderate frailty
- Guaranteed offer of enhanced health in care homes
- Urgent community response
  - Crisis response delivered in 2 hours
  - Reablement delivered in 2 days

Ageing Well-new model for people with complex needs

- Funding for delivering the three models agreed through the LTP process – includes central funding agreed specifically to support delivery of the 2 hour / 2 day standards by 2023/24

Urgent Community Response

- Deliver clearly defined crisis response services within two hours of referral across the country – within five years to avoid unnecessary hospital admission and support same day emergency care
- Deliver clearly defined reablement care within two days of referral to all those judged to need it across the country – within five years to reduce unnecessary hospital stays

Enhanced Health in Care Homes (EHCH)

- Upgrade NHS support to all care home residents who would benefit by 2023/24, with the EHCH model rolled out across the country across the next decade as staffing and funding grows

Anticipatory Care (Community Multidisciplinary Teams)

- From 2020/21 have primary care networks assessing local populations at risk and working with local community services to support people where it is needed most through targeted support
- Support the expansion of the existing community dataset
- Support the commitment to greater recognition and support for carers

Programme alignment with new system architecture

Level	Pop. Size	Purpose
Neighbourhood	~50k	• Strengthen primary care • Network practices and other out of hospital services • Proactive & integrated models for defined population
Place	~250-500k	• Typically borough/council level • Integrate hospital, council & primary care teams/services • Develop new provider models for 'anticipatory' care
System	1+m	• System strategy & planning • Develop accountability arrangements across system • Implement strategic change and transformation at scale • Manage performance and £
Region	5-10m	• Agree system 'mandate' • Hold systems to account • System development • Intervention and improvement

Community Teams

EHCH

Urgent Community Response

Programme team & national support

Ensure key resources are invested optimally

NHS RightCare: Frailty Toolkit

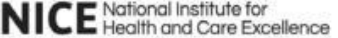
Optimising a frailty system

Increasing numbers of people are at risk of developing frailty. People living with frailty are experiencing unwarranted variation in their care.

This toolkit will provide you with expert practical advice and guidance on how to commission and provide the best system wide care for people living with frailty.

June 2019
Gateway ref: 000513

Informed by relevant NICE recommendations



Ensure key resources are adequately configured

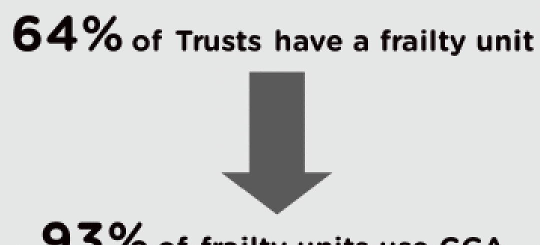
Managing Frailty and Delayed Transfers of Care in the Acute Setting 2018 Findings

4%

Percentage of Consultant workforce are Geriatricians

44%

Fewer hours of geriatric team availability in A&E at weekend



Senior medical cover to frailty units per day:

12 hrs Mon-Fri
7 hrs Sat-Sun

1.3 WTE

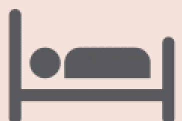
Nurse and HCA staff per designated care of older people bed

20%

Percentage of total pay costs are spent on bank & agency across the pathway

86%

Percentage of delayed transfers of care were attributable to people age 65 and over in 2017/18



3.8%

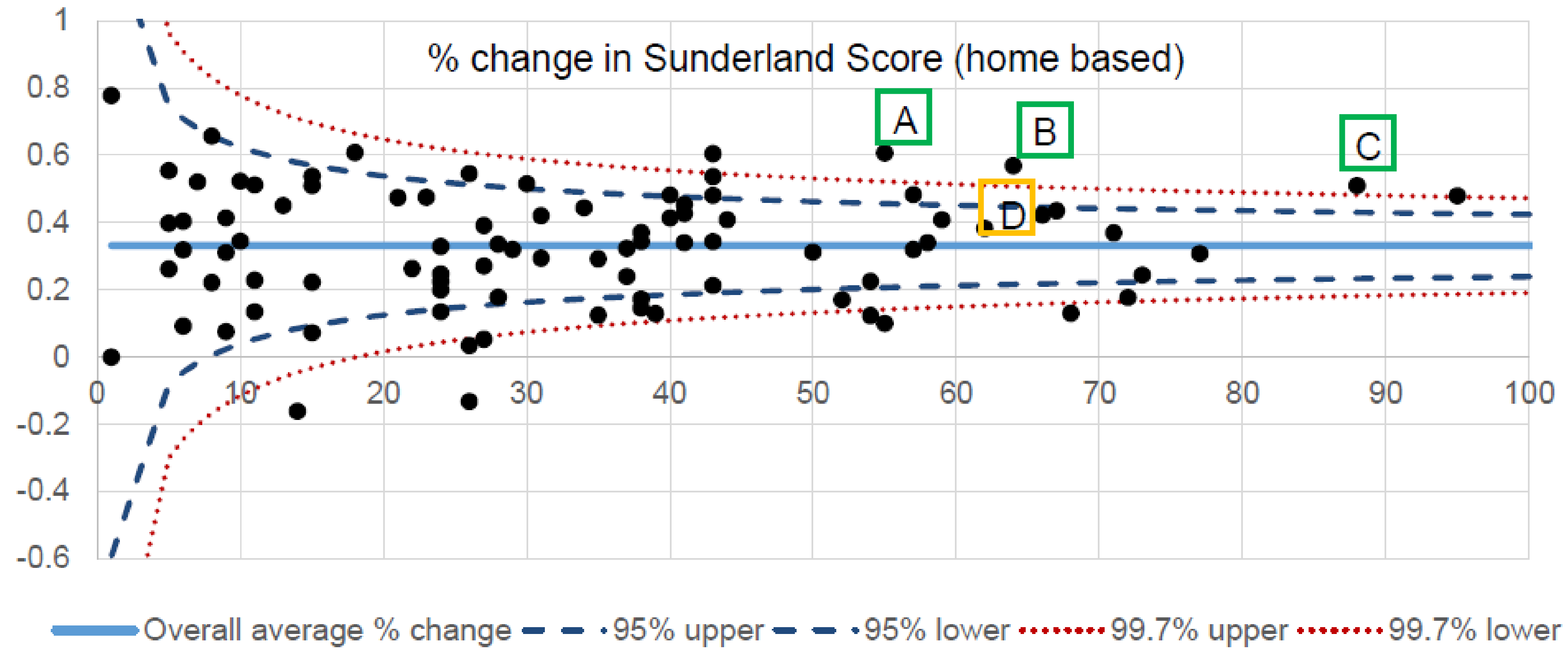
Percentage of occupied bed days are delayed transfers of care

61%

Percentage of patients included in the service user audit have had a hospital admission in the last 12 months

NHS Benchmarking 2018

Improving community services (positive deviance)



Funnel plot shows which **home based** intermediate care services were identified (NAIC 2015 data) as positively deviant. A control site with an above average percentage change in Sunderland Score (functional outcome measure) was chosen. The control site had a similar sample size to the three chosen positively deviant sites. three positively deviant sites (A-C) and one control site (D).

NHS Benchmarking 2019

Improving community services (positive deviance)

Hypotheses	Metric
Home based intermediate care	
The value of multi disciplinary team working	• The development of generic roles • The transference of discipline specific skills to other disciplines • The number of disciplines seeing the patient
Feeling valued	• PREM summary score – the overall median summary score for the service
Feeling "protected"	• Decommissioning of intermediate care services • Extent of cost improvement schemes within intermediate care
Positive workforce indicators	• Low staff turnover/high staff retention rates • Low vacancy rates • Multi-disciplinary team meetings held regularly
Having clear structures in place	• Single point of entry into the service • Agreed referral routes/criteria • Provision of individualised packages of care which are goal centred • Care plans in place and reviewed • Flexible use of workforce

Home based intermediate care

Metrics tested at service level with NAIC 2018 data

The two metrics showing a significant positive association with outcomes for patients were:

- **A review of the care plan by the multidisciplinary team (MDT); and**
- **The number of disciplines who saw the patient**

NHS Benchmarking 2019

Improving community services (positive deviance)

Hypotheses	Metric
Bed based intermediate care services	
Exploitation of alternative funding streams	• Finance – cost per service user
Good communication and links with other providers in the ecosystem	• No metric
Simple commissioning structure	• No metric
Opportunities to feedback to management	• No metric
Proactive recruitment and putting in processes to try and retain staff	• Development of trans-disciplinary roles for staff • Use of the workforce flexibly • Vacancy rates
Involvement of family in care planning	• My family or carer was also involved in these decisions (about my care) as much as I wanted them to be – question taken from the PREM
More internal training and awareness programmes for cognitive impairment	• Will the service take service users with cognitive impairment • Screening for cognitive impairment
Carrying out home visits either prior to or shortly after discharge	Included in NAIC 2019 dataset

Bed based intermediate care

Metrics tested at service level with NAIC 2018 data

The four metrics demonstrated a significant positive relationship with outcomes:

- **Number of disciplines who saw the patient**
-
- **PREM summary score (consolidated score which sums all components of the PREM questions)**
- **Screening service users for cognitive impairment**
- **Review of the care plan by the multidisciplinary team (MDT)**

Spreading best practice across the country

Ageing Well summary plan on a page

	UCR		EHCH			Anticipatory Care	
Area	19/20	20-23	19/20	20/21	23/24	19/20	20/24
Accelerator sites		7 sites	None	None	None	None	7 sites
Rest of England	Support joint workforce planning link to EHCH	2hr crisis/ 2 day reablement 23/24 All UCR achieve by 2028/29	Support joint workforce planning Refresh of the EHCH Framework	Achieve roll out of elements in clinical elements 1-4 and 6 by end of 20/21	Achieve roll out of elements in clinical elements 1-4 and 6 by end of 20/21	Joint workforce planning link to EHCH and UCR % increase	% increase
Evaluation	CSDS to collate via additional collection	TBC CSDS v1.5	Baseline TBC	QI	TBC	TBC with PCNS	TBC with PCNS
Enabler activities	Pilot Clinical Assessment Services (CAS) will act as the single point of access	Clinical Assessment Services (CAS) will act as the single point of access by 2023	NHS Mail roll out	PCN Contract specification will roll out of a proportion of some of the elements 1-4 Community Services contract to be developed	PCN Contract specification will support roll out of a proportion of some of the elements 1-4		PCN contract supports Community Services contract to be developed
Community of practice	For all elements						

What should be built into local 5 year plans?

1. Strong, effective leadership
2. A realistic, simple plan that makes sense to everyone
3. Effective, sustained engagement and communication
4. Empowered people and supported services
5. Sustainable relationships across services and sectors
6. Sustained focus on service quality improvement
7. Building capacity through skills, capabilities and local assets
8. Measurable benefits to people and communities

Key planning milestones

- **27 September 2019:** Systems to share a draft of their plans, including detail on clinical priorities and trajectories. Regions, working with central teams, will use this information to build a national picture against our overall outcome goals, feeding back where adjustments are needed.
- **By 15 November 2019:** System plans should be agreed with system leads and regional teams, in consultation with National Programme Directors. Packages of future support from central teams to support delivery will also be agreed.
- By the end of **March 2020**: Provider and CCG plans for 2020/21, which are fully aligned with the system-level plans, to be submitted, along with agreed contracts between providers and commissioners. A further submission to demonstrate that plans and contracts are aligned between commissioners and providers will also be required.

Milestone	Date
Interim People Plan published	3 June 2019
Long Term Plan Implementation Framework published	**27 June 2019**
Main technical and supporting guidance issued	July 2019
Initial system planning submission	**27 September 2019**
System plans agreed with system leads and regional teams	**15 November 2019**
Operational and technical guidance issued	December 2019
Publication of the national implementation programme for the Long Term Plan	December 2019
Operational planning	Jan – March 2020

Thank You!

Contact us

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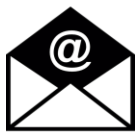

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Thank You!