Ageing Well

Integrating Care for Older People

Martin Vernon
National Clinical Director Older People

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

**Prevention**
Anticipating & Ageing Well

**Intervention**
Timely intervention
Meeting the needs of those with established frailty

**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

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The frail elderly = not robust & old: ‘an inevitable end state for everyone’  

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People with frailty = people with specific needs + preferences

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Ageing well = growing old positively: many can achieve this
What’s the national approach?

FROM THIS

‘The frail Elderly’

Late
Crisis presentation
Fall, delirium, immobility

Hospital-based episodic care
Disruptive & disjointed

TO THIS

‘An Older Person living with frailty’
A long-term condition

Timely identification
preventative, proactive care supported self management & personalised care planning

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*

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

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

<table>
<thead>
<tr>
<th>Age Band</th>
<th>0.5%</th>
<th>1.1%</th>
<th>2.5%</th>
<th>5.4%</th>
<th>8.8%</th>
<th>12.3%</th>
<th>11.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>3.8%</td>
<td>6.8%</td>
<td>11.8%</td>
<td>18.4%</td>
<td>24.4%</td>
<td>27.8%</td>
<td>30.7%</td>
</tr>
<tr>
<td>70-74</td>
<td>21.7%</td>
<td>28.5%</td>
<td>35.6%</td>
<td>38.5%</td>
<td>39.0%</td>
<td>37.4%</td>
<td>36.0%</td>
</tr>
<tr>
<td>75-79</td>
<td>73.9%</td>
<td>63.7%</td>
<td>50.1%</td>
<td>37.7%</td>
<td>27.8%</td>
<td>22.5%</td>
<td>21.8%</td>
</tr>
<tr>
<td>80-84</td>
<td>0.5%</td>
<td>1.1%</td>
<td>2.5%</td>
<td>5.4%</td>
<td>8.8%</td>
<td>12.3%</td>
<td>11.5%</td>
</tr>
<tr>
<td>85-89</td>
<td>6.8%</td>
<td>11.8%</td>
<td>18.4%</td>
<td>24.4%</td>
<td>27.8%</td>
<td>30.7%</td>
<td>36.0%</td>
</tr>
<tr>
<td>90-94</td>
<td>3.8%</td>
<td>6.8%</td>
<td>11.8%</td>
<td>18.4%</td>
<td>24.4%</td>
<td>27.8%</td>
<td>30.7%</td>
</tr>
<tr>
<td>95+</td>
<td>73.9%</td>
<td>63.7%</td>
<td>50.1%</td>
<td>37.7%</td>
<td>27.8%</td>
<td>22.5%</td>
<td>21.8%</td>
</tr>
</tbody>
</table>

Fit % | Mild % | Moderate % | Severe %

NHS England analysis - KID 2017-18
Rationale: frailty care already attracts substantial costs

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

Fit: 13% Social Care, 52% Acute, 24% Primary Care, 6% Mental Health
Mild: 19% Social Care, 45% Acute, 26% Primary Care, 5% Mental Health
Moderate: 24% Social Care, 45% Acute, 20% Primary Care, 4% Mental Health
Severe: 26% Social Care, 46% Acute, 15% Primary Care, 3% Mental Health

NHS England analysis - KID 2017-18
## Finding frailty: GP Contract 2017/18 Data [Q4]

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

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
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 X 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
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
Characteristics of population with frailty

...much older than average (but a lot of ‘frail’ younger people too)

% of frail patients by age band

<table>
<thead>
<tr>
<th>Age Band</th>
<th>National Average</th>
<th>Frail Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-34</td>
<td>1.8%</td>
<td>1.8%</td>
</tr>
<tr>
<td>35-54</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>55-74</td>
<td>3.3%</td>
<td>3.3%</td>
</tr>
<tr>
<td>75+</td>
<td>7.6%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

...more likely to live in deprived areas

% of frail patients by deprivation

<table>
<thead>
<tr>
<th>Deprivation Level</th>
<th>National Average</th>
<th>Frail Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived areas</td>
<td>4.6%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Moderately deprived areas</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Least deprived areas</td>
<td>2.1%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>
A tactical approach to managing complex needs nationally

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

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| 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
Ensure key resources are adequately configured

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

- 4% of Consultant workforce are Geriatricians
- 64% of Trusts have a frailty unit
- 93% of frailty units use CGA
- 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
- Nurse and HCA staff per designated care of older people bed: 1.3 WTE
- 20% of total pay costs are spent on bank & agency across the pathway

- 86% of delayed transfers of care were attributable to people age 65 and over in 2017/18
- 3.8% of occupied bed days are delayed transfers of care
- 61% of patients included in the service user audit have had a hospital admission in the last 12 months

NHS Benchmarking 2018
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 (A-C) and one control site (D).
## Improving community services (positive deviance)

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home based intermediate care</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 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 |

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**
Improving community services (positive deviance)

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed based intermediate care services</td>
<td></td>
</tr>
<tr>
<td>Exploitation of alternative funding streams</td>
<td>• Finance – cost per service user</td>
</tr>
<tr>
<td>Good communication and links with other providers</td>
<td>• No metric</td>
</tr>
<tr>
<td>Simple commissioning structure</td>
<td>• No metric</td>
</tr>
<tr>
<td>Opportunities to feedback to management</td>
<td>• No metric</td>
</tr>
<tr>
<td>Proactive recruitment and putting in processes to</td>
<td>• Development of trans-disciplinary roles for staff</td>
</tr>
<tr>
<td>try and retain staff</td>
<td>• Use of the workforce flexibly</td>
</tr>
<tr>
<td></td>
<td>• Vacancy rates</td>
</tr>
<tr>
<td>Involvement of family in care planning</td>
<td>• 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</td>
</tr>
<tr>
<td>More internal training and awareness programmes</td>
<td>• Will the service take service users with cognitive impairment</td>
</tr>
<tr>
<td>for cognitive impairment</td>
<td>• Screening for cognitive impairment</td>
</tr>
<tr>
<td>Carrying out home visits either prior to or shortly</td>
<td>Included in NAIC 2019 dataset</td>
</tr>
<tr>
<td>after discharge</td>
<td></td>
</tr>
</tbody>
</table>

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)

NHS Benchmarking 2019
Spreading best practice across the country

Developing Communities of Practice for the Ageing Well Programme

📅 25 September 2019 10:00am – 4:00pm
📍 The Kia, Oval, London, The Kia, Oval, London, SE11 5SS, United Kingdom

Tickets

All booking fees included.

Developing Communities of Practice for the Ageing Well Programme

🔍 SELECT OPTIONS

💰 FREE

🔍 BOOK NOW
## Ageing Well summary plan on a page

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

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim People Plan published</td>
<td>3 June 2019</td>
</tr>
<tr>
<td><strong>Long Term Plan Implementation Framework published</strong></td>
<td>27 June 2019</td>
</tr>
<tr>
<td>Main technical and supporting guidance issued</td>
<td>July 2019</td>
</tr>
<tr>
<td><strong>Initial system planning submission</strong></td>
<td>27 September 2019</td>
</tr>
<tr>
<td><strong>System plans agreed with system leads and regional teams</strong></td>
<td>15 November 2019</td>
</tr>
<tr>
<td>Operational and technical guidance issued</td>
<td>December 2019</td>
</tr>
<tr>
<td>Publication of the national implementation programme for the Long Term Plan</td>
<td>December 2019</td>
</tr>
<tr>
<td>Operational planning</td>
<td>Jan – March 2020</td>
</tr>
</tbody>
</table>
Thank You!

Contact us

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Thank You!

NHS England and NHS Improvement