Ageing Well

Supporting Integrated Personalised Care for Older People

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NHS England and NHS Improvement

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**

What is policy seeking to achieve for older people?

Key outcomes:

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

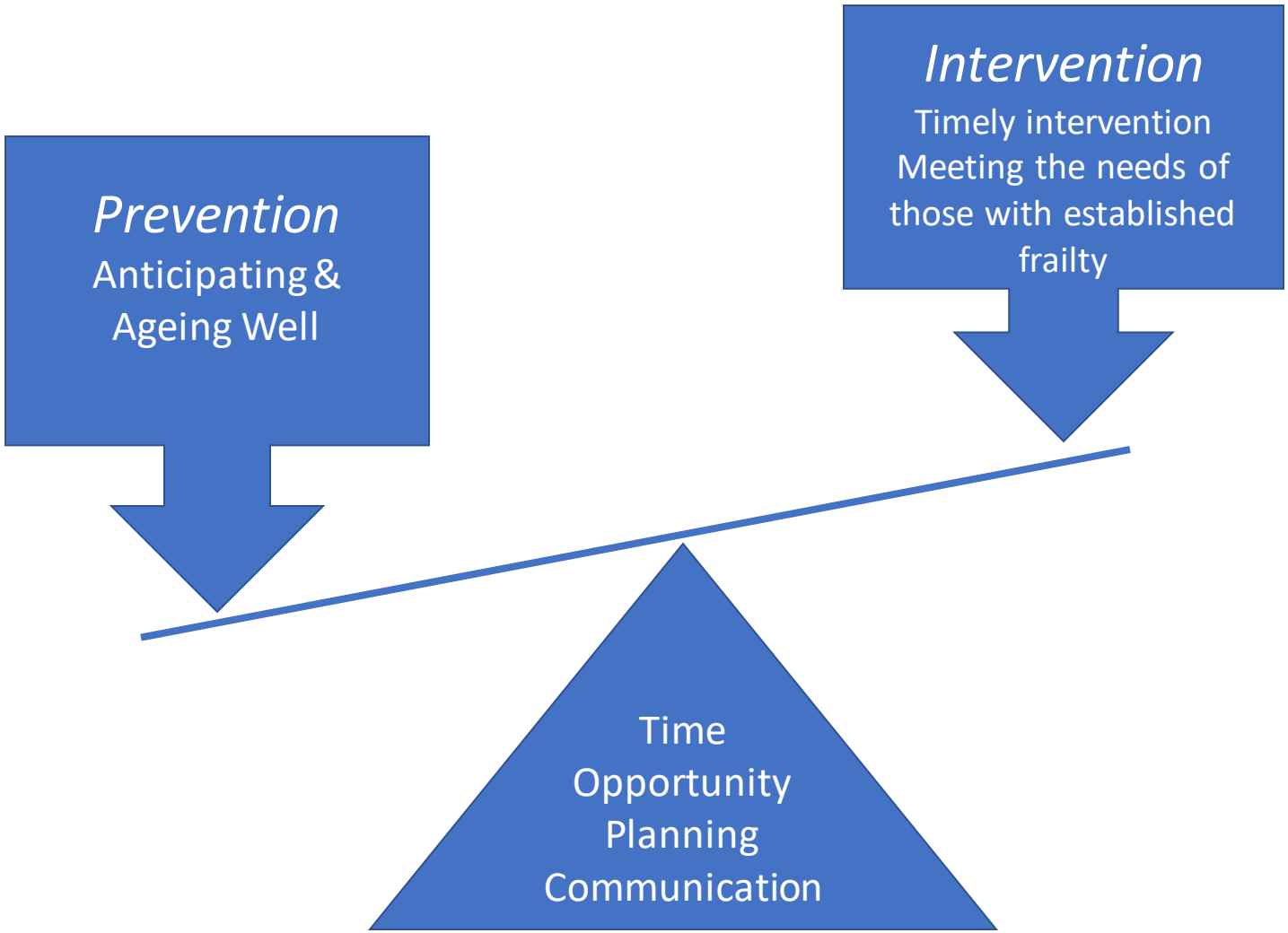
2) People get what they need, when they need it.

Why? Frailty is associated with distress

- Older adults (65+, Canada) with frailty living at home or institutionalised (*n* = 664)
- **48.2 per cent of the older adults living at home**-severe psychological distress symptoms
- **34.3 per cent of elderly adults living in institutions**
- Probability of reporting severe psychological distress associated with the respondents'
  - **Level of social support needed**
  - **Cognitive status**
  - **Functional status**
- No significant association between the respondents' level of their psychological distress and:
  - Age
  - Gender
  - Marital status
  - Education or income
- 77.9 per cent of respondents with severe distress were still severely distressed 12 months after first interview

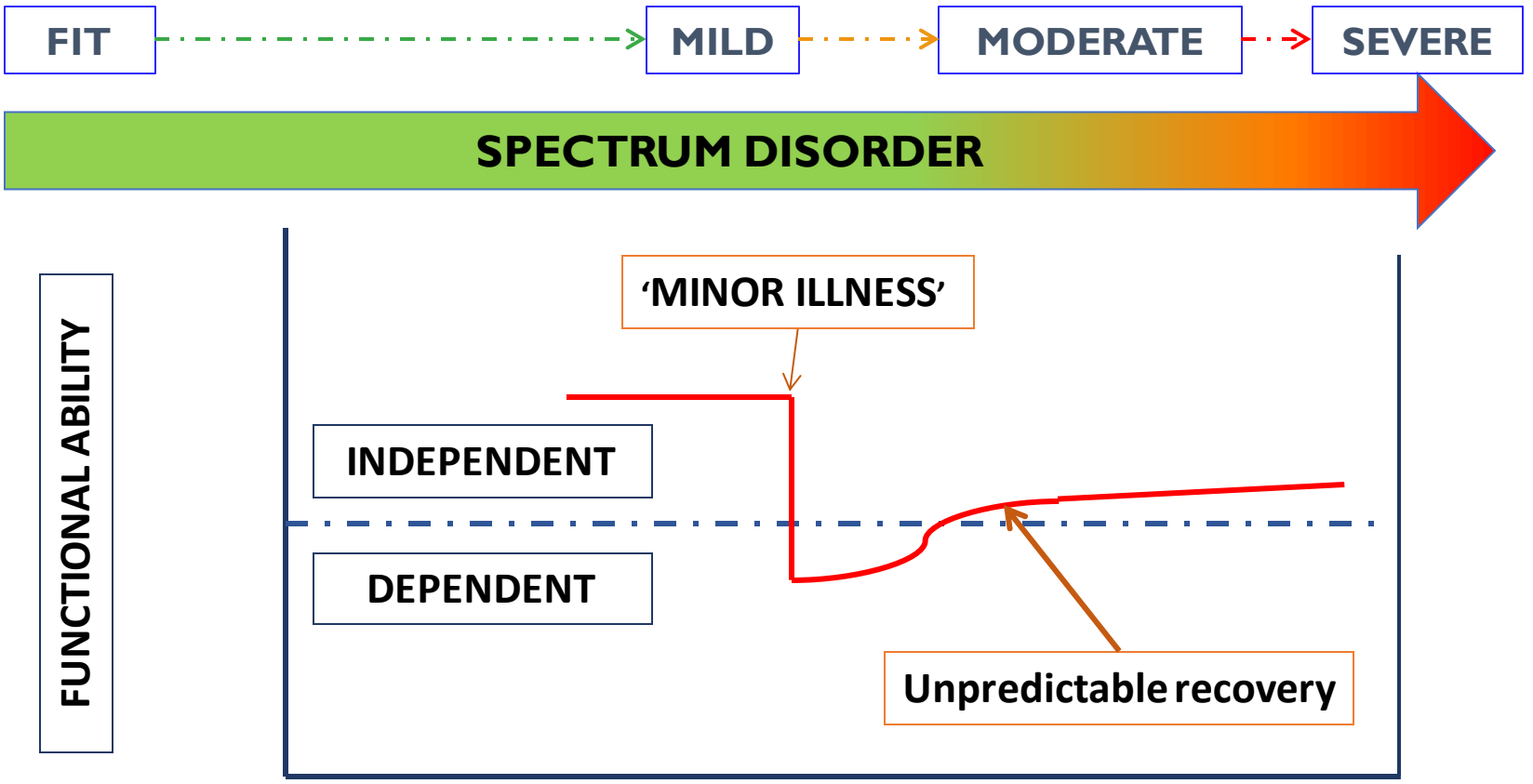
Predisposing and Facilitating Factors of Severe Psychological Distress among Frail Elderly Adults Michel Préville [a1], Réjean Hébert [a1], Gina Bravo [a1] and Richard Boyer [a2] https://doi.org/10.1017/S071498080000146X Published online: 31 March 2010

Using frailty identification to balance care



What does NHS England mean by frailty?

A long-term condition characterised by lost biological reserves across multiple systems & vulnerability to decompensation after a stressor event



'You don't bounce back as quickly as you used to when something goes wrong'

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

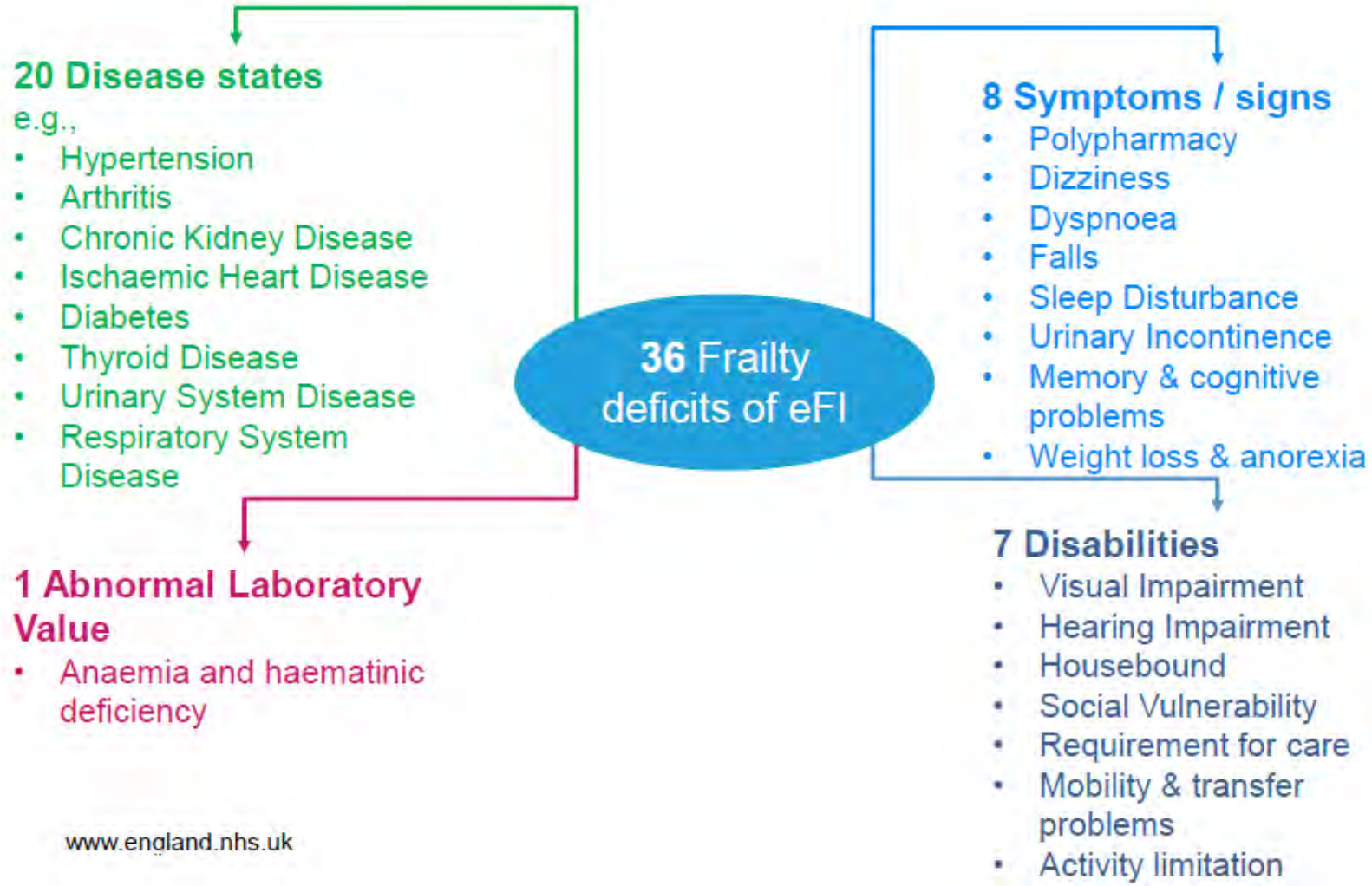
- **Elderly** =adjective: advanced age, old
- **Frail**=adjective: easily broken, not robust, weak
- **Frailty** = noun: the quality or state of being frail
- **Older**: adjective: comparator of old
- **Ageing**=verb: to grow old a normal phenomenon

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

People with frailty = people with specific needs + preferences 

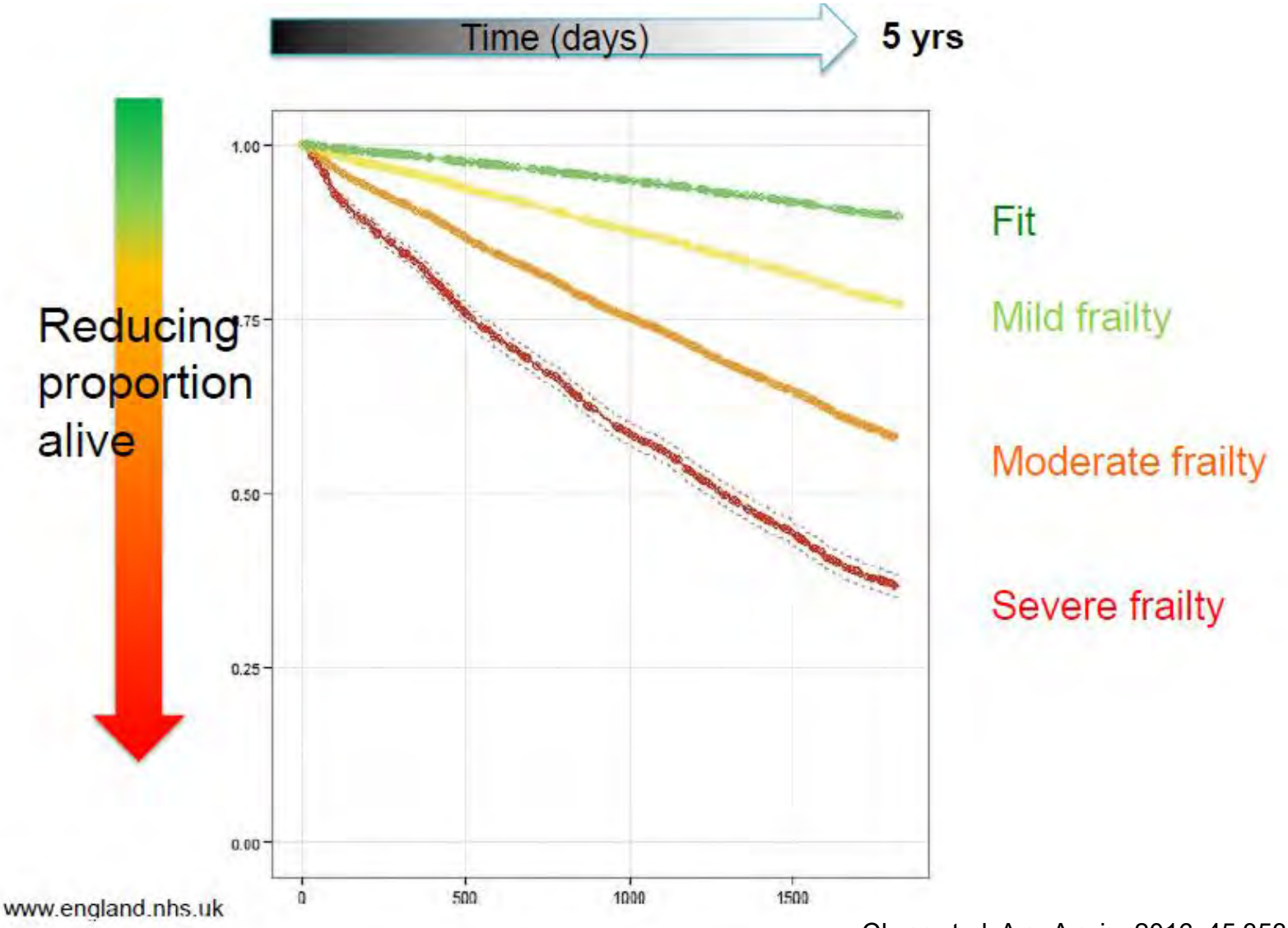
Ageing well = growing old positively: many can achieve this 

Electronic identification of frailty-the eFI



Clegg et al: Age Ageing2016: 45:353-360

Population segmentation using the eFI



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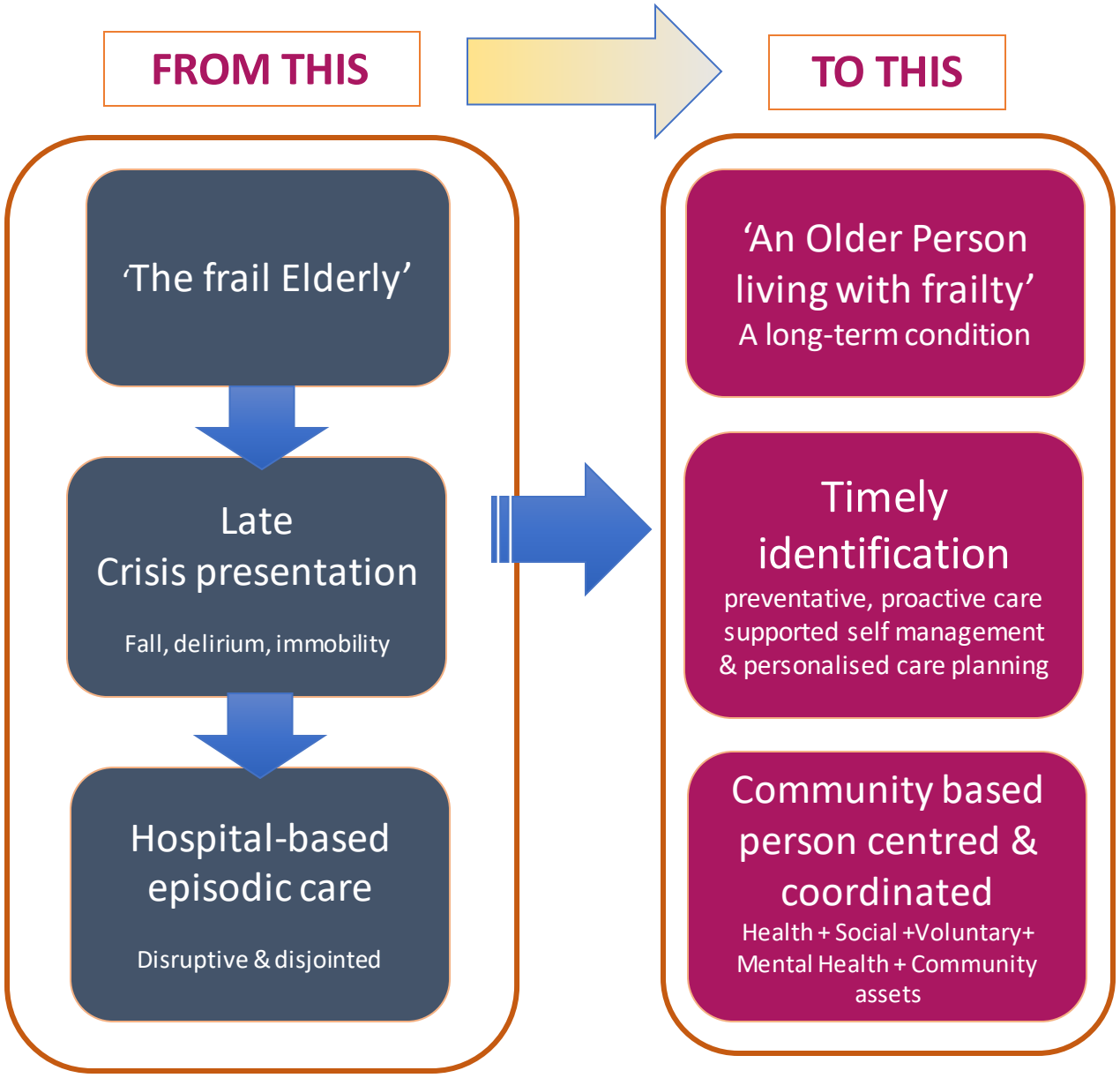
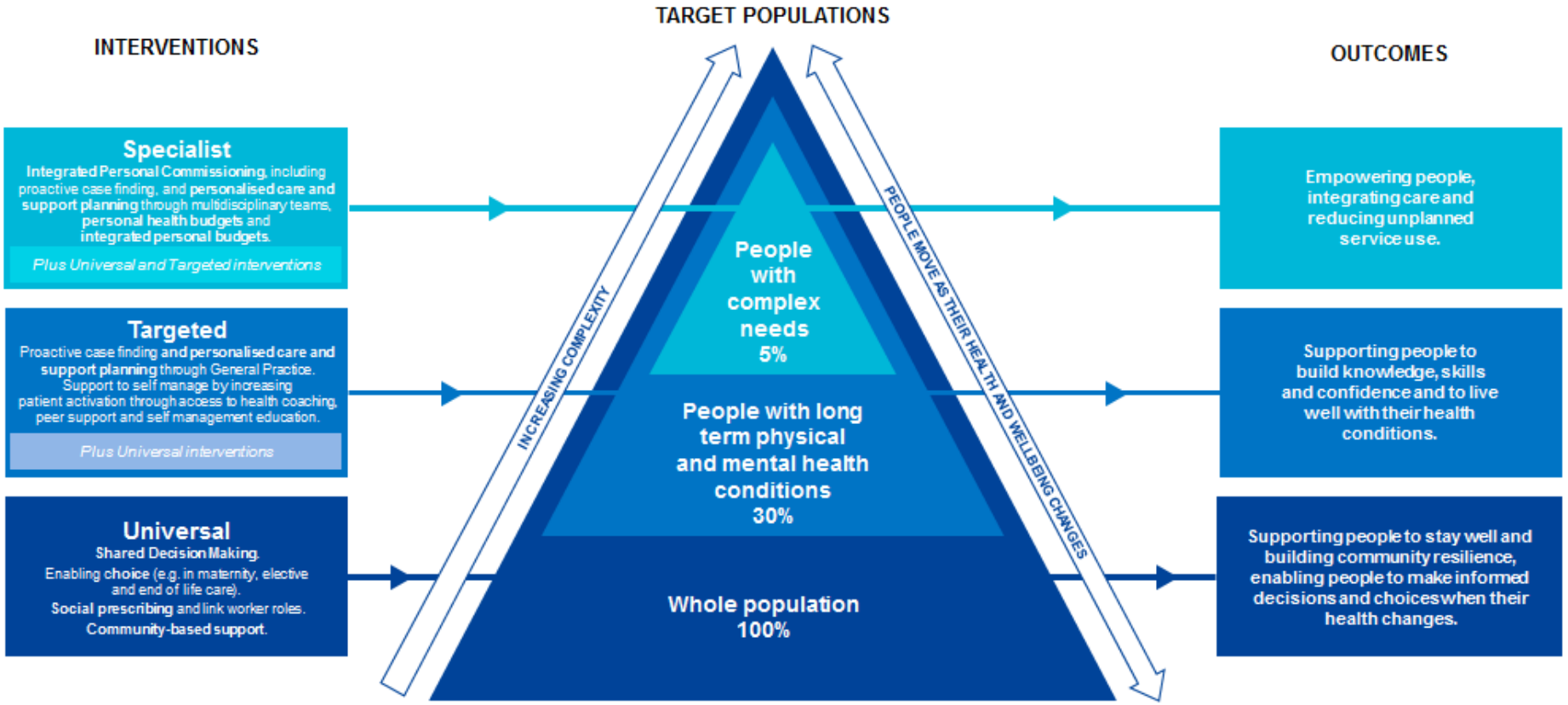
What's the national approach?



Comprehensive Personalised Care Model

All age, whole population approach to Personalised Care

NHS England



Personalised Care Operating Model

NHS England

WHOLE POPULATION
when someone's health status changes

30% OF POPULATION
People with long term physical and mental health conditions

Cohorts proactively identified on basis of local priorities and needs

Shared Decision Making

People are supported to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on their personal preferences and, where relevant, utilising legal rights to choice (All tiers)

Personalised Care and Support Planning

People have a proactive, personalised conversation which focuses on what matters to them, delivered through a six-stage process and paying attention to their clinical needs as well as their wider health and wellbeing.

Review

A key aspect of the personalised care and support planning cycle. Check what is working and not working and adjust the plan (And budget where applicable)

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLER

FINANCE ENABLER

WORKFORCE ENABLER

COMMISSIONING AND PAYMENT ENABLER

Optimal Medical Pathway

Social Prescribing and Community-Based Support

Enables professionals to refer people to a 'link worker' to connect them into community-based support, building on what matters to the person and making the most of community and informal support (All tiers)

Supported Self Management

Support people to develop the knowledge skills and confidence (patient activation) to manage their health and wellbeing through interventions such as health coaching, peer support and self-management education (Targeted and Specialist)

Personal Budget

An amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. May lead to integrated personal budgets for those with both health and social care needs (Initially Specialist)

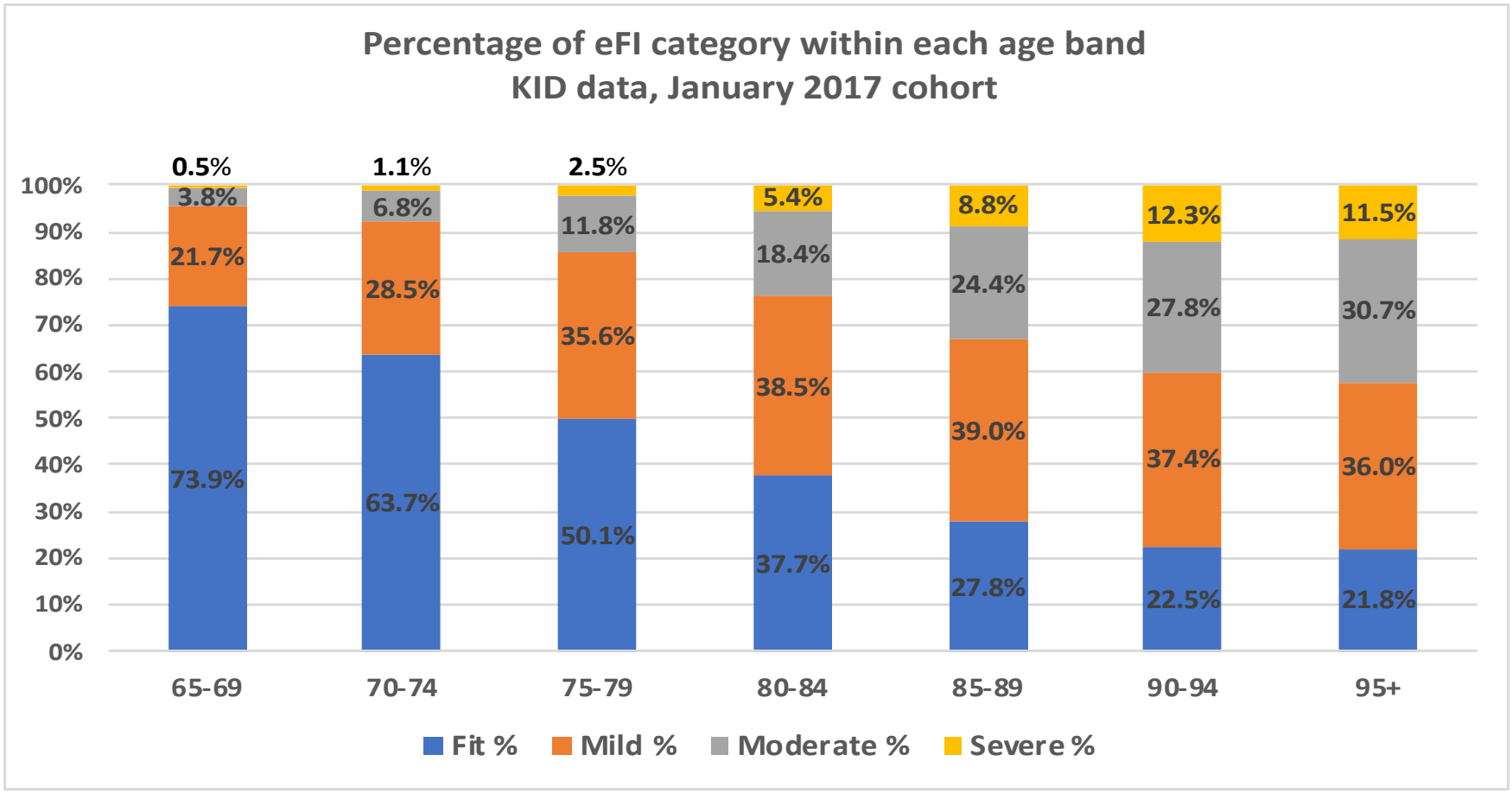
Rationale: Population ageing

- **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*

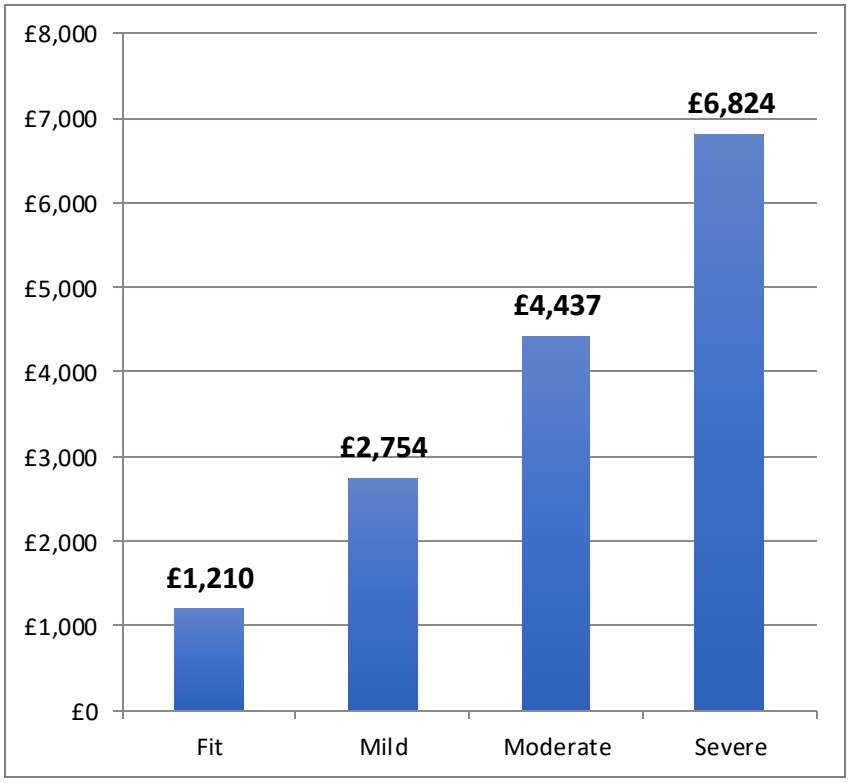
Rationale: we don't all age in the same way



NHS England analysis- KID 2017-18

Rationale: frailty care already attracts substantial costs

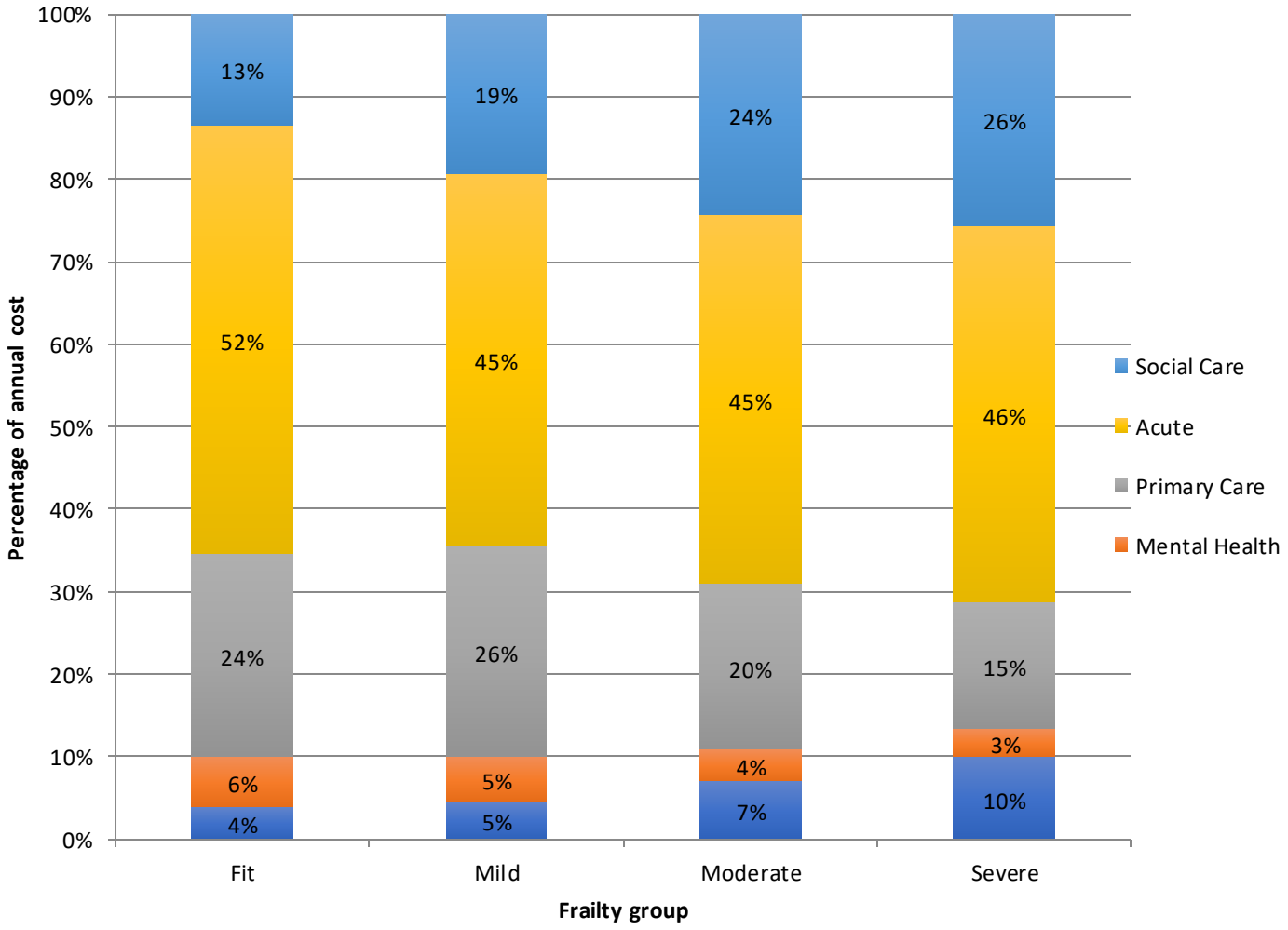
- Estimated annual care cost for people aged ≥ 65 with severe frailty in England is **£2.0 billion**
- Estimated annual care cost for all people aged ≥ 65 in England with all degrees of frailty is **£15.3 billion**
- Estimated gross annual saving across NHS & social care in England if frailty degree was one category lower for 10% of people in each category is **£605.3 million**.



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



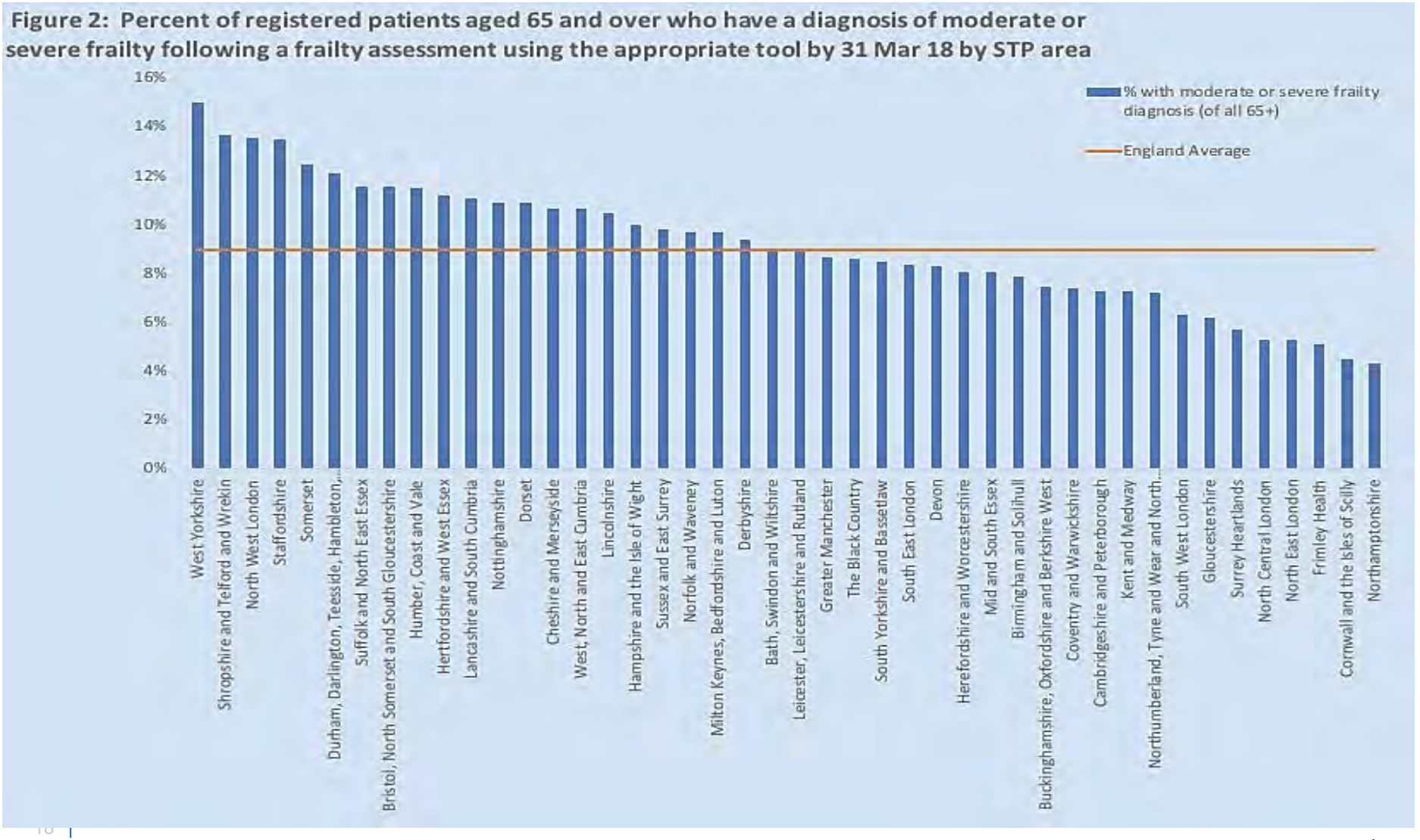
NHS England analysis- KID 2017-18

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

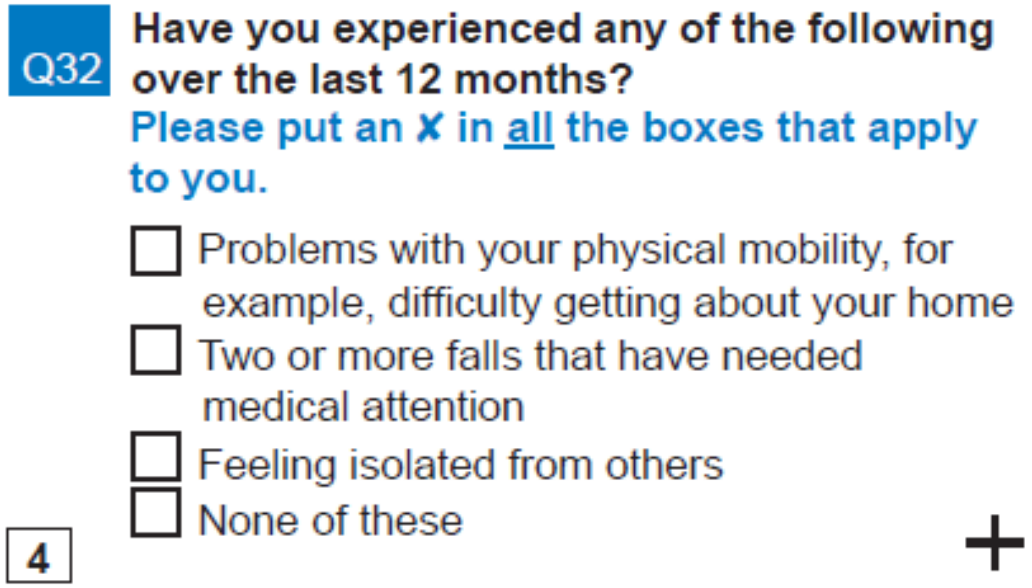
GMS (2018) frailty identification by STP



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.

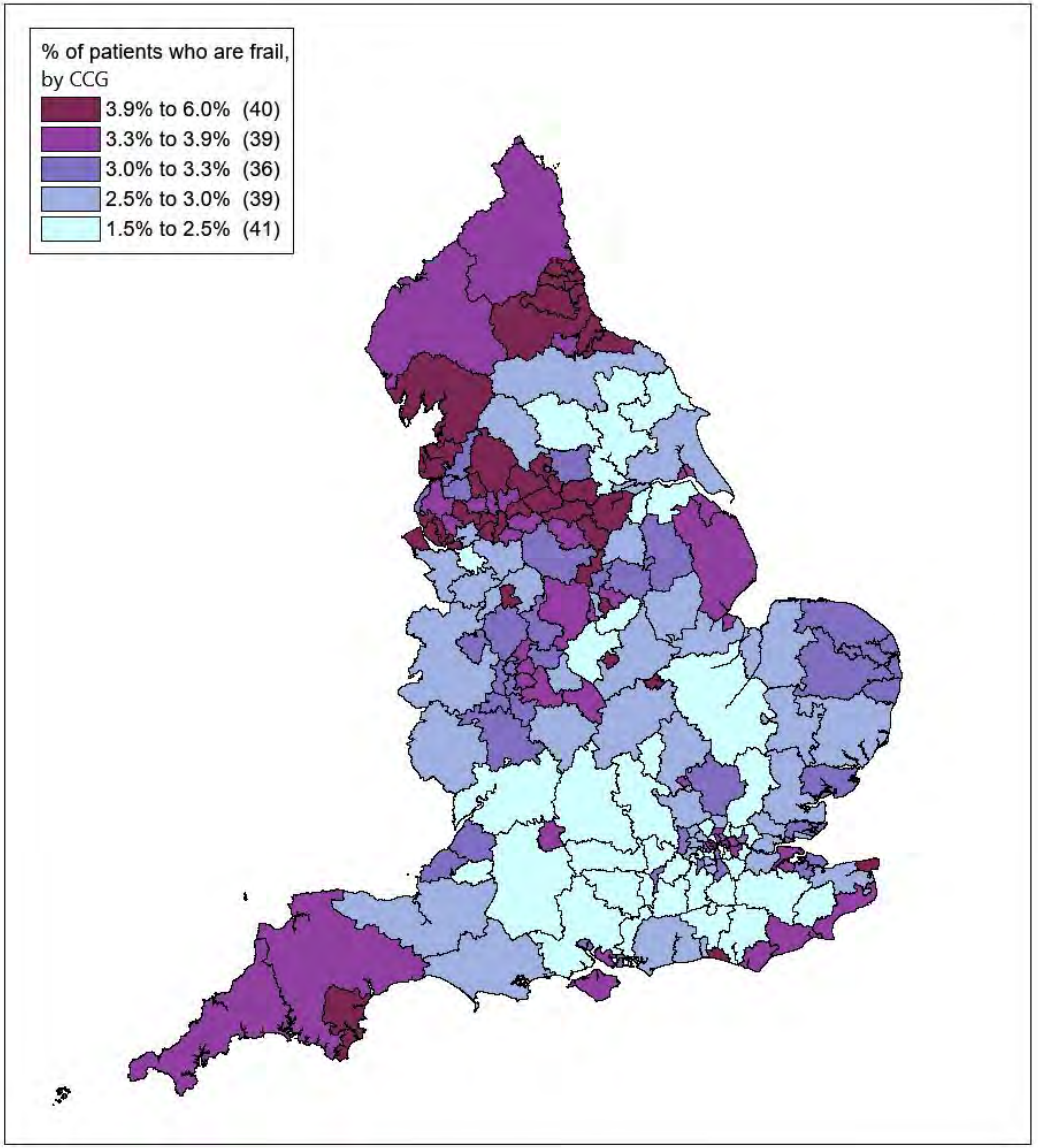
- ☐ Problems with your physical mobility, for example, difficulty getting about your home
- ☐ Two or more falls that have needed medical attention
- ☐ Feeling isolated from others
- ☐ None of these

4

Prevalence of frailty-GPPS: inequalities

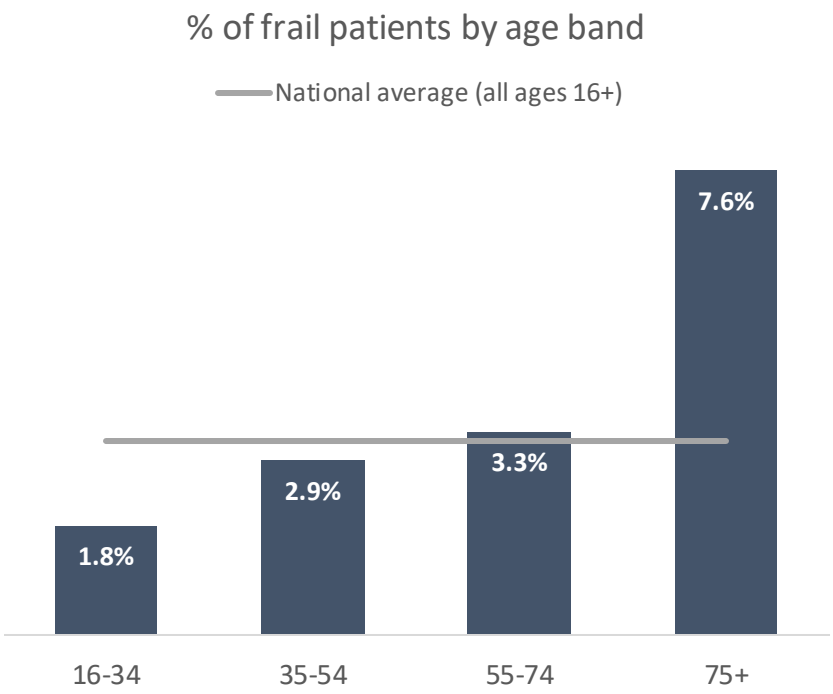
- **Darker/pinker areas** on map are CCGs with **higher proportion of frail patients**
- CCGs with **more frail patients** seem to be concentrated in the **north of the country, and in urban areas in the Midlands**

*based on GP-registered population

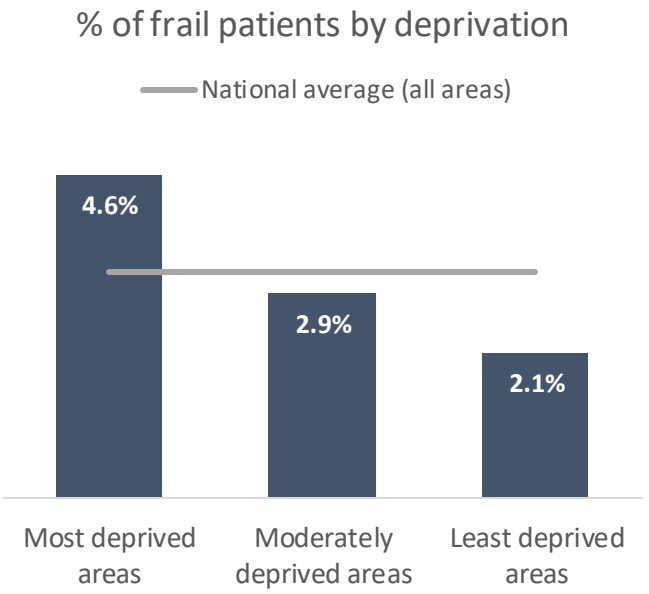


Characteristics of people with frailty

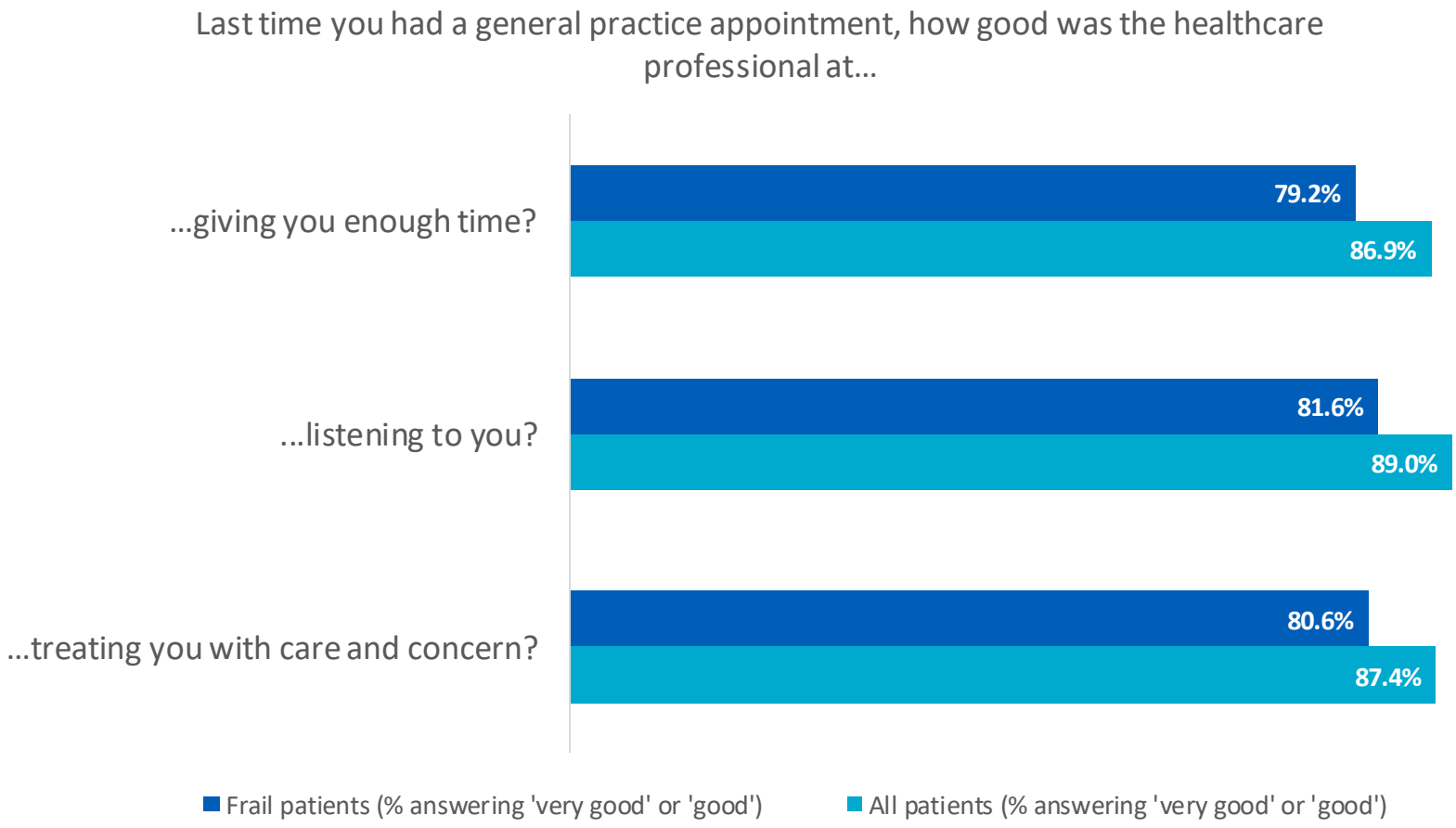
…much older than average (but a lot of 'frail' younger people too)



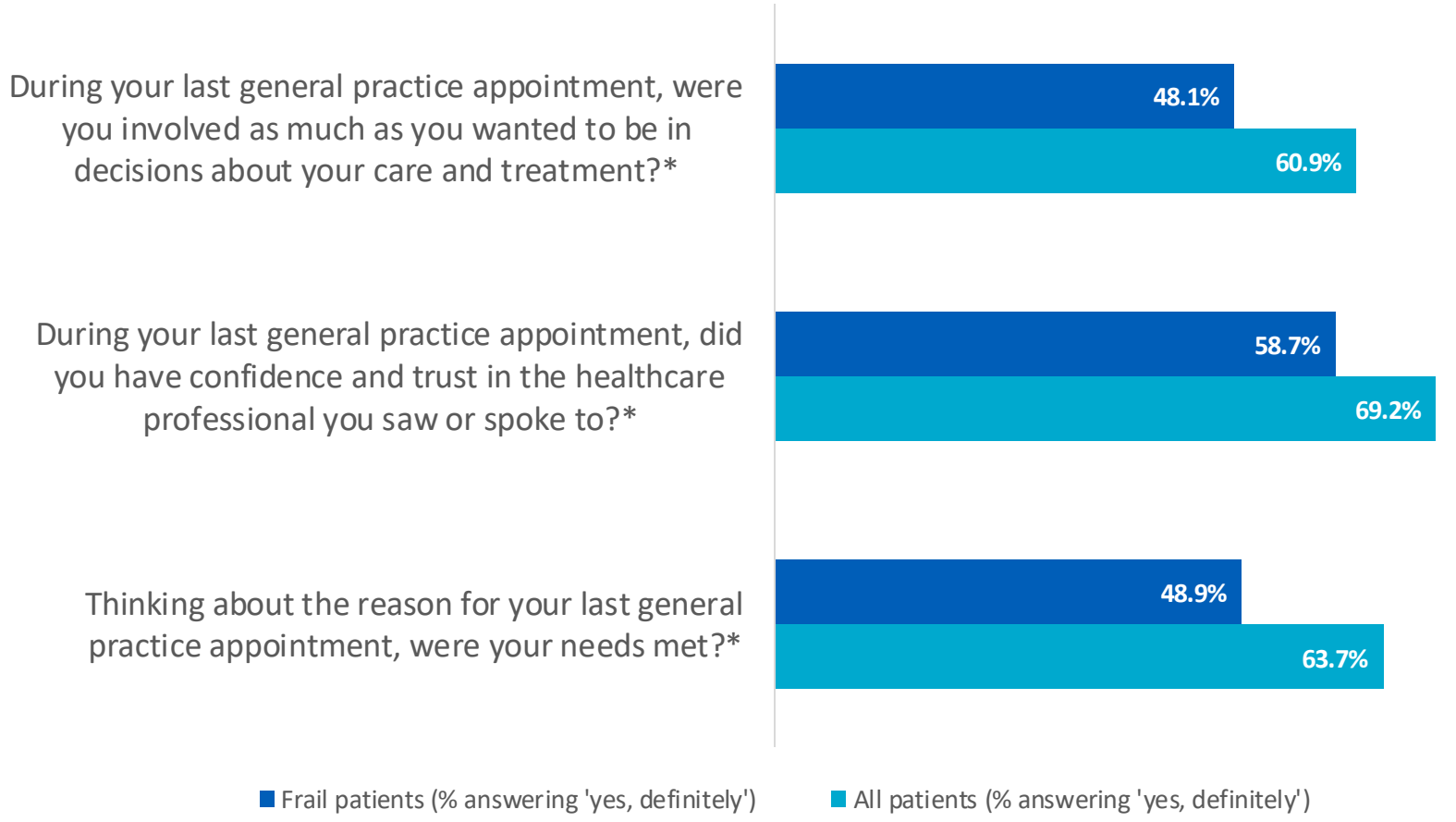
…more likely to live in deprived areas



During the GP appointment-time to listen



During the GP appointment-meeting needs

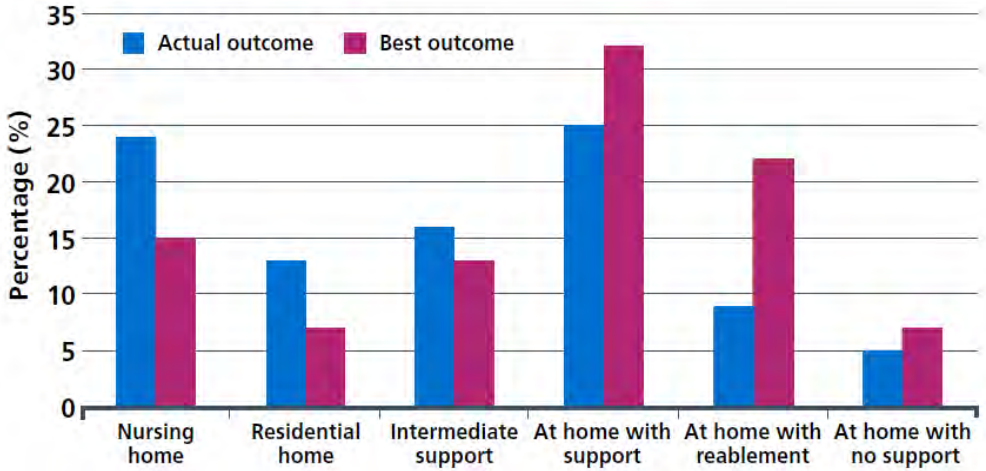


*(excluding don't knows)

System challenges & opportunities

- People with varying degrees of frailty don't always get the care they need in the right setting and at the right time
- Hospital interventions for some people with frailty are limited in efficacy

Figure 5: Differences in where people are discharged compared to where would be best for them.



Source: Newton Europe.

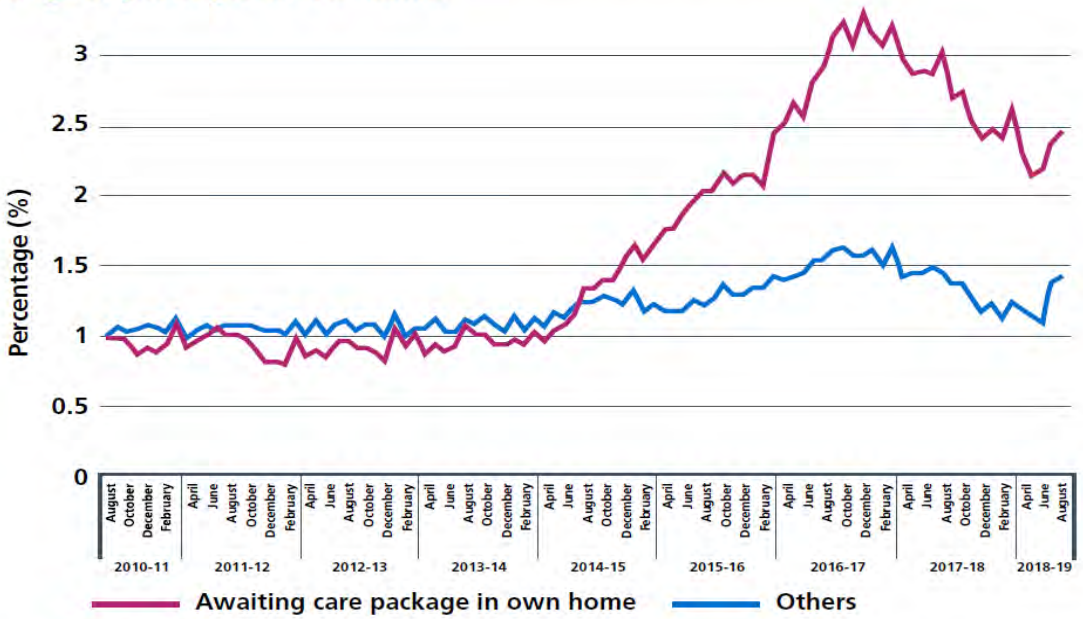
- National audit data (NAIC 2017) suggests **intermediate care capacity needs to increase & improve responsiveness**
- **Enhanced health support to care homes** is not consistently offered across the country

Social Care

- **Wellbeing of older people and pressures on the NHS linked to how well social care functions**
- When agreeing the NHS' funding settlement government committed to ensure that adult social care funding is such that it does not impose any additional pressure on the NHS over the coming five years

'That is basis on which the demand, activity and funding in the Long Term Plan have been assessed'

Figure 9: Growth in Delayed Transfers of Care from hospital due to waiting for packages in the home.



Source: NHS England. Delayed Transfers of Care: Monthly Situation Reports.

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

Community 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

Delivering on the LTP commitments to 2023/24

Pre-implementation (completed)

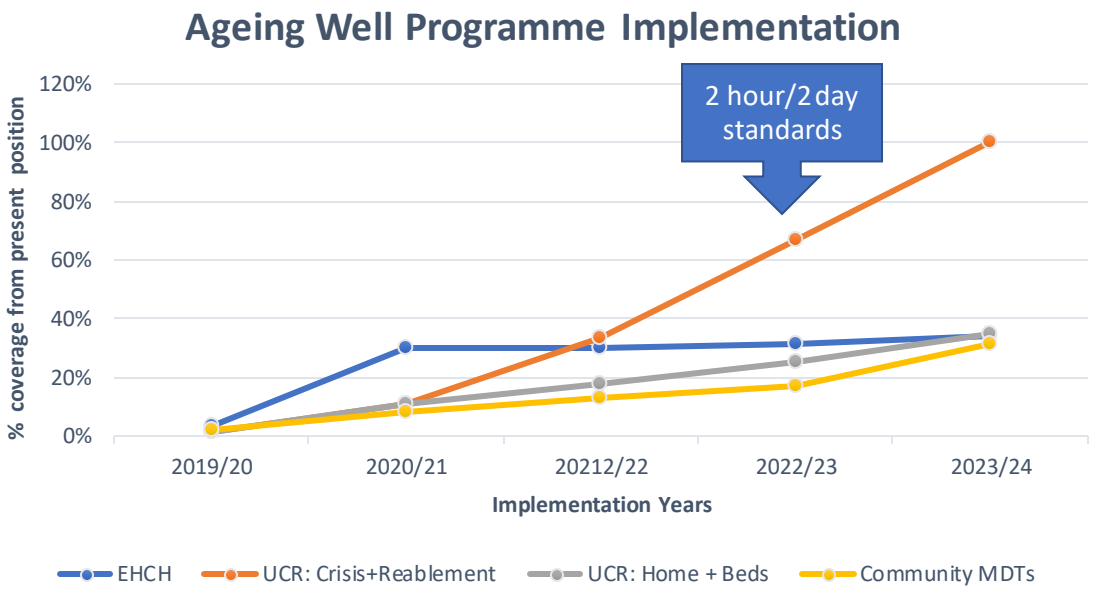
- Codification of models and mapping good practice
- Develop of funding allocations & site selection strategy
- Develop data & analytics plans and an evaluation strategy
- Programme team planning

Phase 1: Launch accelerator sites (2019/20)

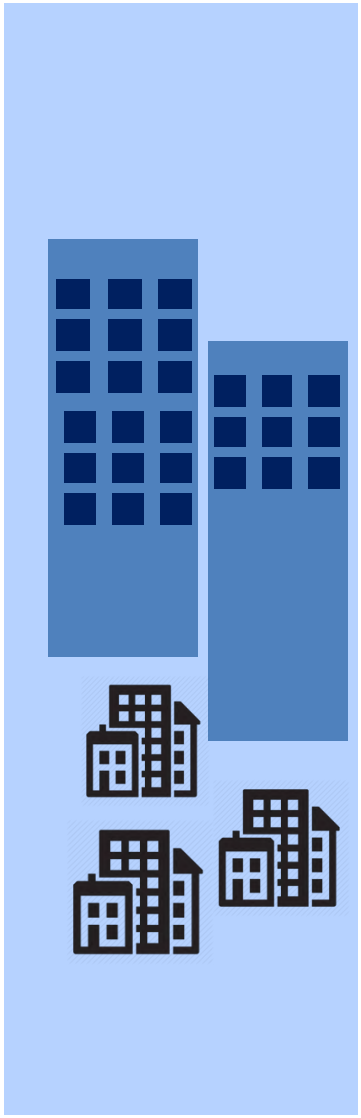
- Site support materials published (care elements & case studies)
- Community of practice established
- Accelerator sites refine & test models
- Local & national evaluation arrangements established
- Process learning shared between sites & nationally
- Baselining exercise conducted
- Interim data collection options established
- National and regional programme team recruited

Phase 2: Scale (2020 onwards)

National spread ↔ Refine models based on evaluation/learning ↔ Transition to BAU



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

Next steps for Ageing Well

Questions