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:

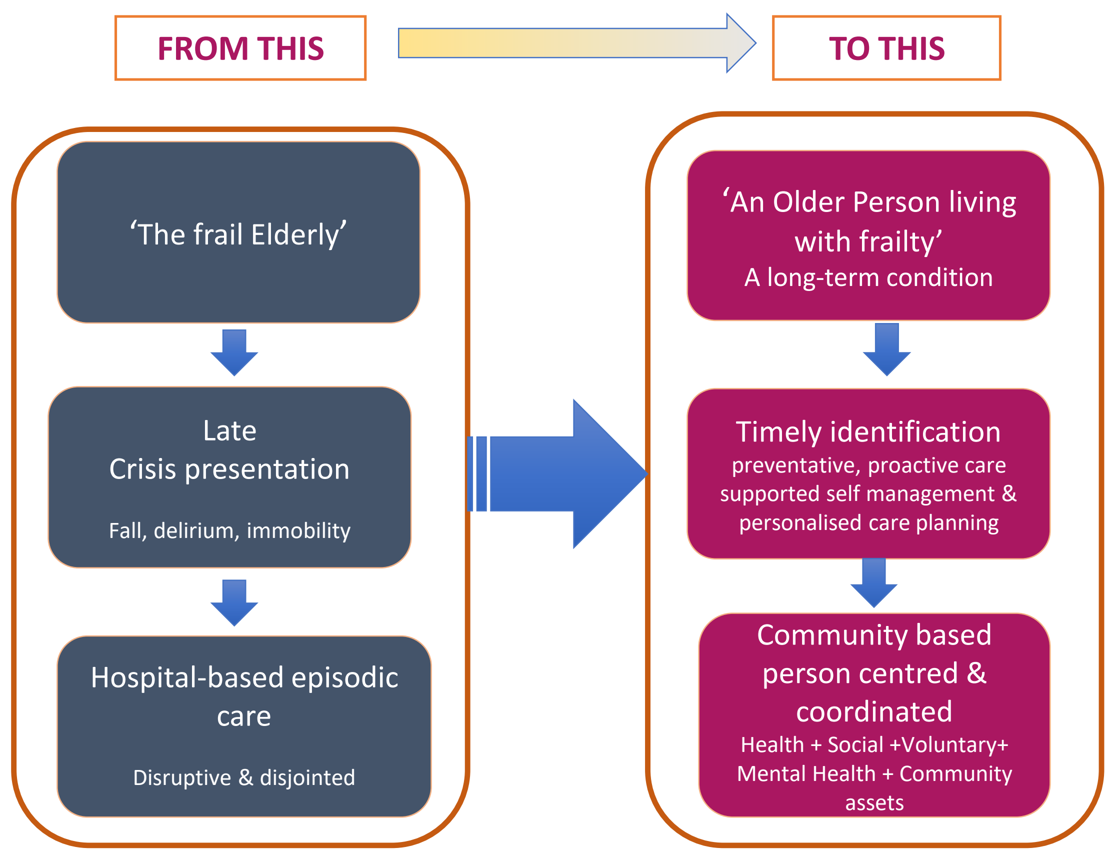
1) Care that makes sense to people (and their carers and families)

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**

What's the national approach?



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**

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

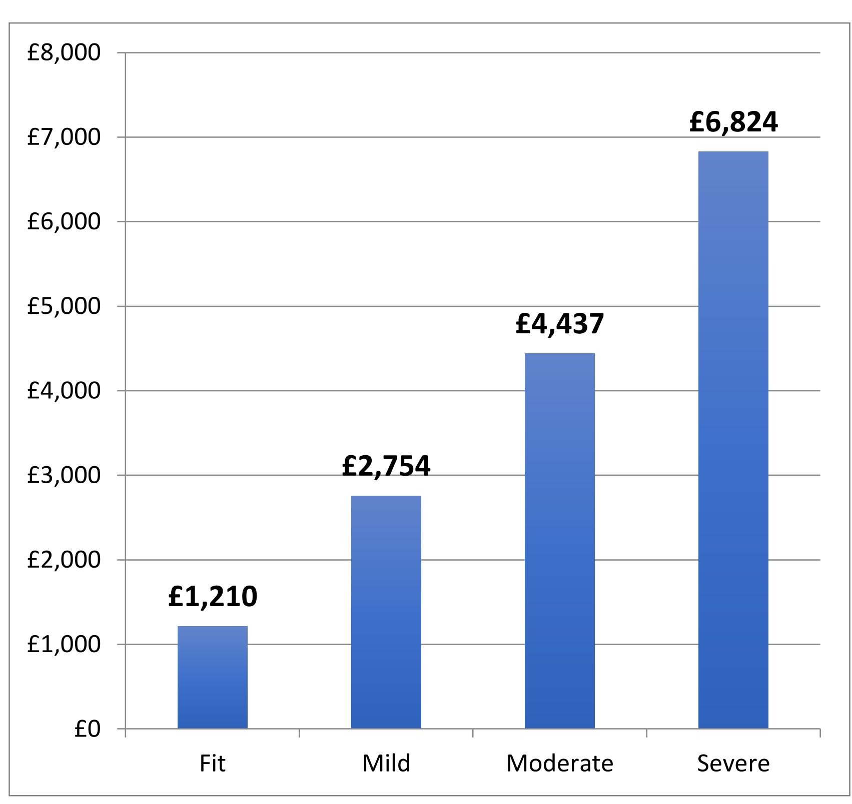
Percentage of eFI category within each age band
KID data, January 2017 cohort

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

- 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

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

Frailty group	Social Care	Acute	Primary Care	Mental Health	(unlabelled)
Fit	13%	52%	24%	6%	4%
Mild	19%	45%	26%	5%	5%
Moderate	24%	45%	20%	4%	7%
Severe	26%	46%	15%	3%	10%

Percentage of annual cost (0%–100%)

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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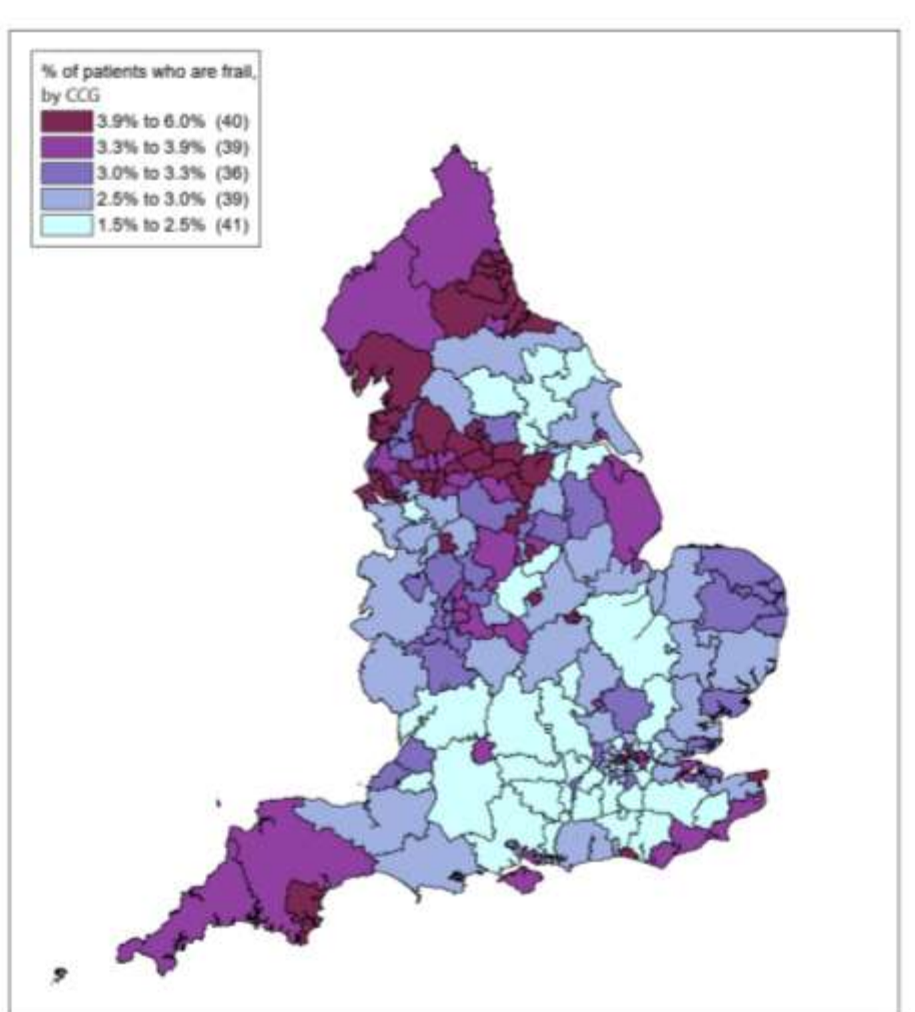
Prevalence of frailty-GPPS: inequalities

- 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

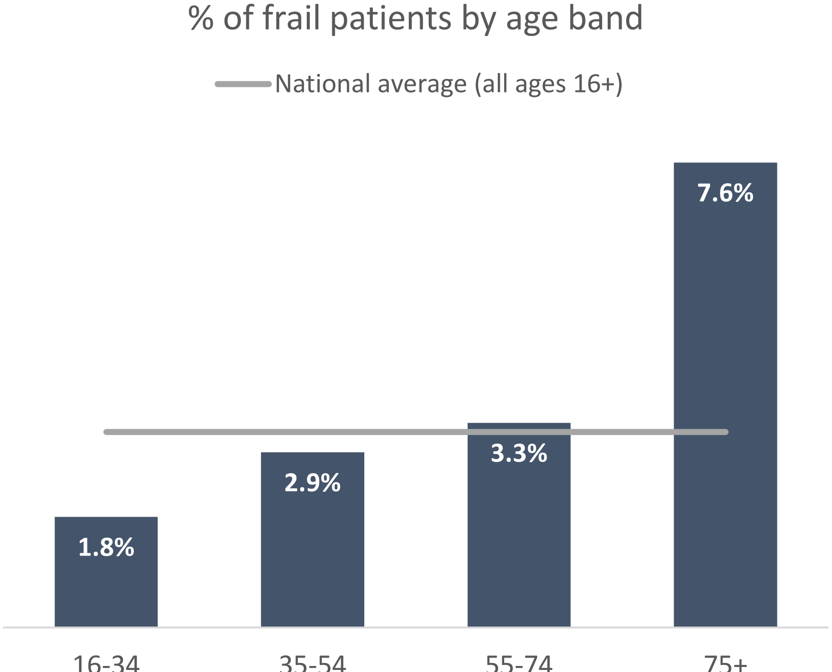
*based on GP-registered population

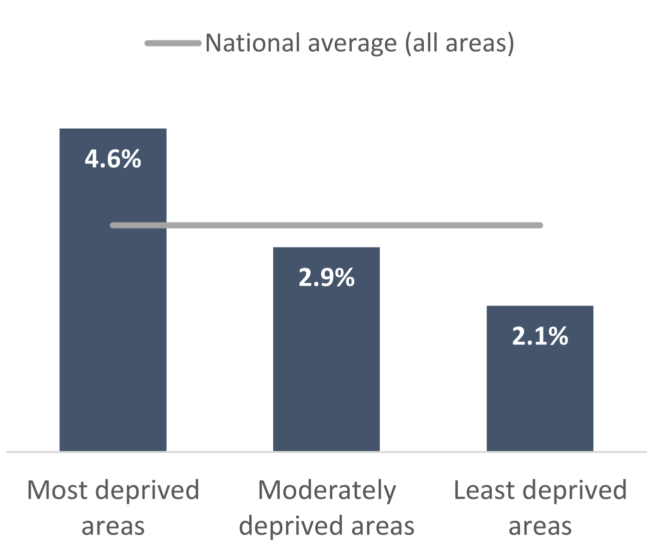


Characteristics of population with frailty

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

…more likely to live in deprived areas

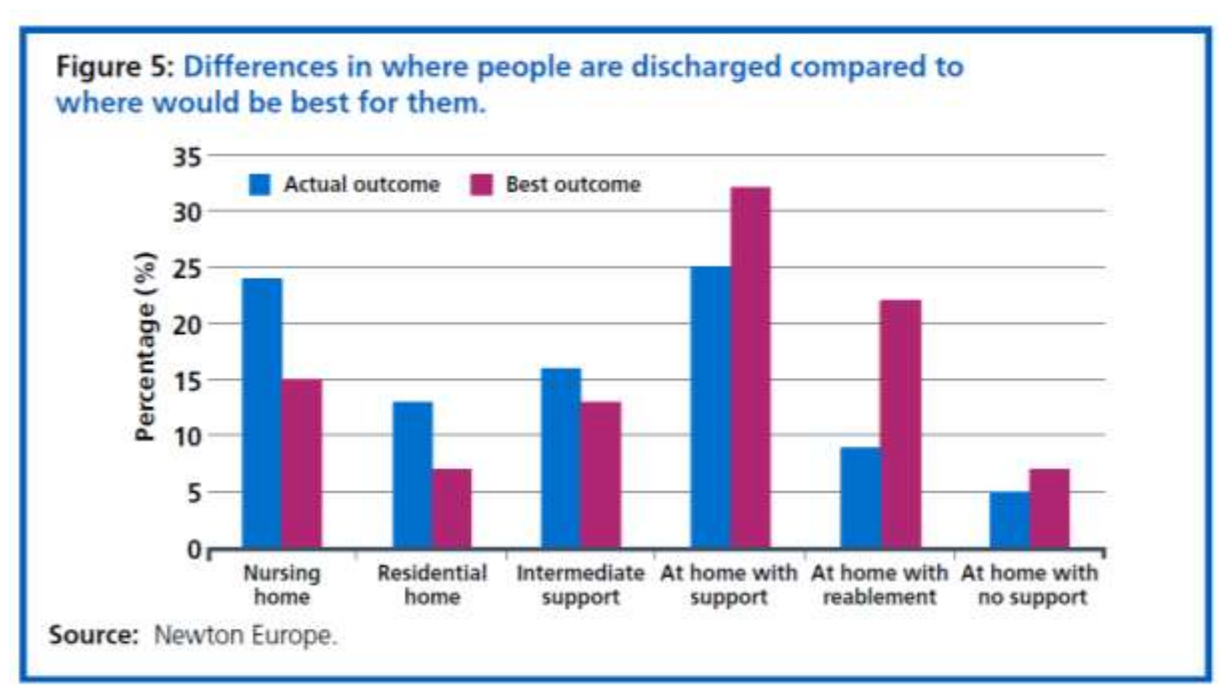




System challenges & opportunities

- 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



- 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.

Percentage (%)

3
2.5
2
1.5
1
0.5
0

2010-11 2011-12 2012-13 2013-14 2014-15 2015-16 2016-17 2017-18 2018-19

Awaiting care package in own home — Others

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

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

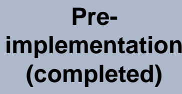
Enhanced Health in Care Homes (EHCH)

- 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

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 2019/20 to 2023/24



Pre-implementation (completed)

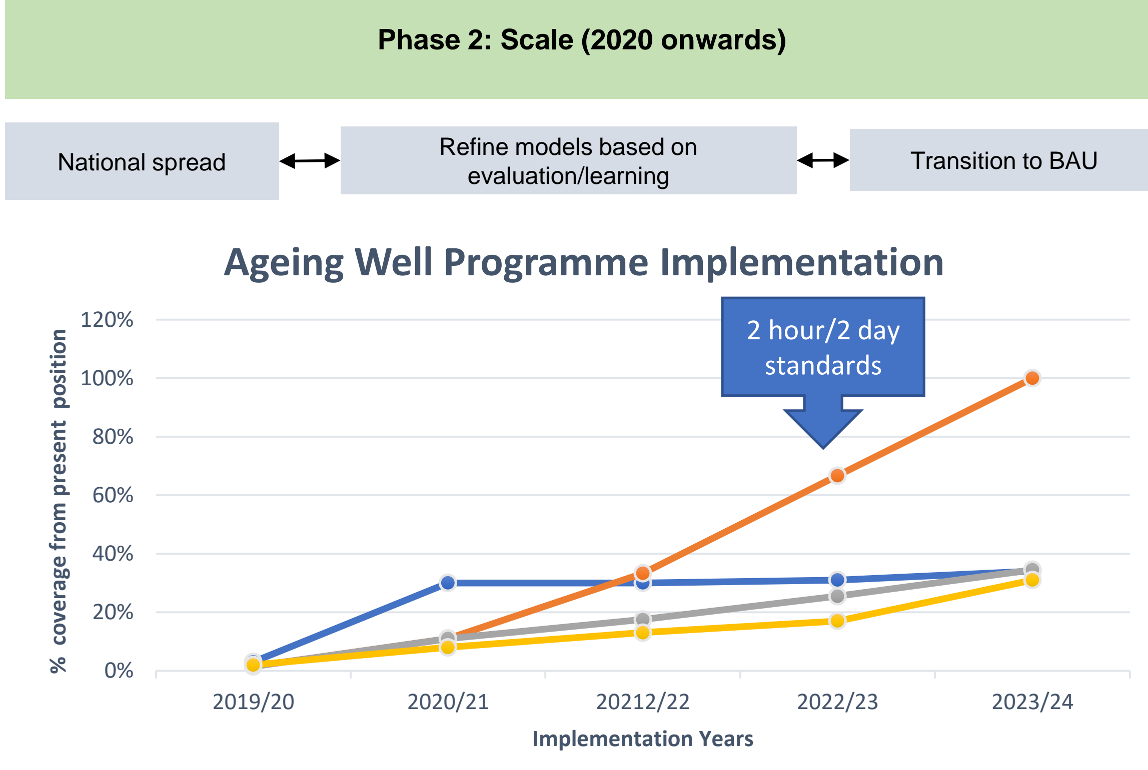
- Codification of models and mapping good practice
- Develop of funding allocations & site selection strategy
- Develop data & analytics plans and an evaluation strategy
- Programme team planning

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

Ageing Well & EHCH (Neighbourhood, Place)

Urgent response & reablement (Neighbourhood, Place, System)

Programme team & national support (System, Region)

What should systems build into in their 5-year plans?

1. **Benchmarking** of Ageing Well services

2. Supporting complete and quality data submission to the **Community Services Dataset** (CSDS)

3. Planning for appropriate **activity changes**

4. **Workforce growth and development plans**, including working with local voluntary sector

5. Development of local Ageing Well **service specifications**

6. Planning to achieve required **metric reporting**

7. Cross sector and organisation **information/data sharing agreements**

8. A cross sector **engagement strategy**

9. Plan to identify and address issues which prevent cross-organisational and integrated team working

Next steps for Ageing Well

January 2019

NHS Long Term Plan

GP Contractual Framework

Spring 2019
Publication of local plans for 2019/20

Autumn 2019
Publication of local five-year plans