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?

**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
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
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

- **Fit**
  - Social Care: 4%
  - Acute: 52%
  - Primary Care: 24%
  - Mental Health: 6%

- **Mild**
  - Social Care: 5%
  - Acute: 45%
  - Primary Care: 26%
  - Mental Health: 5%

- **Moderate**
  - Social Care: 7%
  - Acute: 45%
  - Primary Care: 20%
  - Mental Health: 4%

- **Severe**
  - Social Care: 10%
  - Acute: 46%
  - Primary Care: 15%
  - Mental Health: 3%
## 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>
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<tr>
<td>65+ without frailty assessment</td>
<td>7,468,288</td>
<td>74.4% 65+</td>
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<tr>
<td>Total moderately frail</td>
<td>630,921</td>
<td>6.3% 65+</td>
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<tr>
<td>Total severely frail</td>
<td>320,262</td>
<td>3.2%</td>
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<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>
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<tr>
<td>Moderate or severe frailty w/falls clinic</td>
<td>25,570</td>
<td>2.9% (moderate/severe frailty)</td>
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<tr>
<td>Moderate or severe frailty w/consent to SCR</td>
<td>140,501</td>
<td>14.8% (moderate/severe frailty)</td>
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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

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

[Bar chart showing the percentage of patients with moderate or severe frailty diagnosis by STP area, with West Yorkshire having the highest percent and North London having the lowest.]
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 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

National average (all ages 16+)

16-34: 1.8%
35-54: 2.9%
55-74: 3.3%
75+: 7.6%

...more likely to live in deprived areas

% of frail patients by deprivation

National average (all areas)

Most deprived areas: 4.6%
Moderately deprived areas: 2.9%
Least deprived areas: 2.1%
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’
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

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

Ageing Well Programme Implementation

- % coverage from present position
- Implementation Years
- 2 hour/2 day standards

Programme team planning:
- National spread
- Transition to BAU

Legend:
- EHCH
- UCR: Crisis+Reablement
- UCR: Home + Beds
- Community MDTs
### Programme alignment with new system architecture

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Purpose</th>
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| 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**

**Urgent response & reablemen**

**Programme team & national support**
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

NHS England and NHS Improvement