Ageing Well

Supporting Integrated Personalised Care for Older People

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NHS England and NHS Improvement

MAY 2019
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

**Prevention**
Anticipating & Ageing Well

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

**Time**
**Opportunity**
**Planning**
**Communication**
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

- **FIT**
- **MILD**
- **MODERATE**
- **SEVERE**

**SPECTRUM DISORDER**

- **INDEPENDENT**
- **DEPENDENT**

- **‘MINOR ILLNESS’**

Unpredictable recovery

‘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

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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

20 Disease states
- Hypertension
- Arthritis
- Chronic Kidney Disease
- Ischaemic Heart Disease
- Diabetes
- Thyroid Disease
- Urinary System Disease
- Respiratory System Disease

8 Symptoms / signs
- Polypharmacy
- Dizziness
- Dyspnoea
- Falls
- Sleep Disturbance
- Urinary Incontinence
- Memory & cognitive problems
- Weight loss & anorexia

36 Frailty deficits of eFI

1 Abnormal Laboratory Value
- Anaemia and haematinic deficiency

7 Disabilities
- Visual Impairment
- Hearing Impairment
- Housebound
- Social Vulnerability
- Requirement for care
- Mobility & transfer problems
- Activity limitation

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Population segmentation using the eFI

Reducing proportion alive

Time (days) 5 yrs

Fit
Mild frailty
Moderate frailty
Severe frailty

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
Comprehensive Personalised Care Model
All age, whole population approach to Personalised Care

Specialist
Integrated Personal Commissioning, including proactive case finding and personalised care and support planning through multidisciplinary teams, personal health budgets and integrated personal budgets.

Targeted
Proactive case finding and personalised care and support planning through General Practice. Support to self manage by increasing patient activation through access to health coaching, peer support and self management education.

Universal
Shared Decision Making.
Enabling choice (e.g. in maternity, elective and end of life care).
Social prescribing and link worker roles.
Community-based support.

Target Populations

People with complex needs
5%

People with long term physical and mental health conditions
30%

Whole population
100%

Outcomes

Empowering people, integrating care and reducing unplanned service use.

Supporting people to build knowledge, skills and confidence and to live well with their health conditions.

Supporting people to stay well and building community resilience, enabling people to make informed decisions and choices when their health changes.

Increasing Complexity

People move as their health and wellbeing changes.
Personalised Care Operating Model

WHALE 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)

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)

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)

Optimal Medical Pathway

LEADERSHIP, CO-PRODUCTION AND CHANGE ENABLERS

WORKFORCE ENABLERS

FINANCE ENABLERS

COMMISSIONING AND PAYMENT ENABLERS
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>Fit %</th>
<th>Mild %</th>
<th>Moderate %</th>
<th>Severe %</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>73.9%</td>
<td>3.8%</td>
<td>21.7%</td>
<td>0.5%</td>
</tr>
<tr>
<td>70-74</td>
<td>63.7%</td>
<td>6.8%</td>
<td>28.5%</td>
<td>1.1%</td>
</tr>
<tr>
<td>75-79</td>
<td>50.1%</td>
<td>11.8%</td>
<td>35.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>80-84</td>
<td>37.7%</td>
<td>5.4%</td>
<td>38.5%</td>
<td>5.4%</td>
</tr>
<tr>
<td>85-89</td>
<td>27.8%</td>
<td>8.8%</td>
<td>39.0%</td>
<td>8.8%</td>
</tr>
<tr>
<td>90-94</td>
<td>22.5%</td>
<td>12.3%</td>
<td>37.4%</td>
<td>12.3%</td>
</tr>
<tr>
<td>95+</td>
<td>21.8%</td>
<td>11.5%</td>
<td>36.0%</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

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**.
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

Frailty group

- Fit
  - Social Care: 13%
  - Acute: 52%
  - Primary Care: 24%
  - Mental Health: 6%

- Mild
  - Social Care: 19%
  - Acute: 45%
  - Primary Care: 26%
  - Mental Health: 5%

- Moderate
  - Social Care: 24%
  - Acute: 45%
  - Primary Care: 20%
  - Mental Health: 4%

- Severe
  - Social Care: 26%
  - Acute: 46%
  - Primary Care: 15%
  - Mental Health: 3%
<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

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

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*based on GP-registered population*
Characteristics of people 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%
Last time you had a general practice appointment, how good was the healthcare professional at...

- **...giving you enough time?**
  - Frail patients: 79.2%
  - All patients: 86.9%

- **...listening to you?**
  - Frail patients: 81.6%
  - All patients: 89.0%

- **...treating you with care and concern?**
  - Frail patients: 80.6%
  - All patients: 87.4%
During the GP appointment—meeting needs

During your last general practice appointment, were you involved as much as you wanted to be in decisions about your care and treatment?*

- Frail patients (% answering ‘yes, definitely’): 48.1%
- All patients (% answering ‘yes, definitely’): 60.9%

During your last general practice appointment, did you have confidence and trust in the healthcare professional you saw or spoke to?*

- Frail patients (% answering ‘yes, definitely’): 58.7%
- All patients (% answering ‘yes, definitely’): 69.2%

Thinking about the reason for your last general practice appointment, were your needs met?*

- Frail patients (% answering ‘yes, definitely’): 48.9%
- All patients (% answering ‘yes, definitely’): 63.7%

*(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
- 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 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)**
- Refine models based on evaluation/learning

**Ageing Well Programme Implementation**
- National spread
- Transition to BAU

Graph showing % coverage from present position over Implementation Years 2019/20 to 2023/24 for different categories:
- EHCH
- UCR: Crisis+Reablement
- UCR: Home + Beds
- Community MDTs

2 hour/2 day standards
## Programme alignment with new system architecture

<table>
<thead>
<tr>
<th>Level</th>
<th>Pop. Size</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neighbourhood</td>
<td>~50k</td>
<td>• Strengthen primary care&lt;br&gt;• Network practices and other out of hospital services&lt;br&gt;• Proactive &amp; integrated models for defined population</td>
</tr>
<tr>
<td>Place</td>
<td>~250-500k</td>
<td>• Typically borough/council level&lt;br&gt;• Integrate hospital, council &amp; primary care teams/services&lt;br&gt;• Develop new provider models for ‘anticipatory’ care</td>
</tr>
<tr>
<td>System</td>
<td>1+m</td>
<td>• System strategy &amp; planning&lt;br&gt;• Develop accountability arrangements across system&lt;br&gt;• Implement strategic change and transformation at scale&lt;br&gt;• Manage performance and £</td>
</tr>
<tr>
<td>Region</td>
<td>5-10m</td>
<td>• Agree system ‘mandate’&lt;br&gt;• Hold systems to account&lt;br&gt;• System development&lt;br&gt;• Intervention and improvement</td>
</tr>
</tbody>
</table>
Next steps for Ageing Well

- **May 2019**: Establish Programme Implementation Guidance
- **Summer 2019**: Develop Programme with regions
- **Autumn 2019**: Publication of local five-year plans
- **April 2020**: Full Programme Launch
Questions