NHS RightCare

RightCare Scenario:
The variation between standard and optimal pathways

Janet's story:
Frailty

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The story of Janet's experience of a frailty care pathway, and how it could be so much better

In this scenario – using a fictional person, Janet – we examine a frailty care pathway, comparing a sub-optimal experience against an ideal, optimal pathway. For each stage we have considered the impact on the person, their family's experience, and also the costs associated with care.

This document was updated in June 2019 to align with new guidance and reference costs, and is intended to help local health systems understand the implications – both in terms of quality of life and costs – of shifting the care pathway for older people living with frailty from a reactive approach (primarily based on an acute response) to a proactive approach, e.g., providing an integrated primary care and community-based response, with support from the voluntary sector.

It shows how RightCare can support systems to improve the value and outcomes of the care pathway.

Two summary slide packs are also available from the RightCare website.

RightCare has also produced a Frailty Toolkit that has been developed to support systems in understanding the priorities in frailty care. It contains the latest guidance and a self-assessment questionnaire to support frailty system analysis.

Look out for the green boxes in this scenario to see where it links with the RightCare Frailty Toolkit. You can access the Toolkit from the RightCare website.

Introduction

According to the electronic Frailty Index it is estimated that about half of people over the age of 65 are living with some degree of frailty - 35% mild, 12% moderate and 3% severe. People living with frailty sometimes find themselves in receipt of poor-quality care and experience repeated avoidable admissions to hospitals, prolonged lengths of stay and delayed discharges – resulting in worse health and wellbeing outcomes, and higher costs to health and care services.

Frailty is a progressive long-term health condition related to, but not primarily caused by, ageing and is usually characterised by a complex mix of physical health, mental health and increasing social care needs. However, it is important to know that not all older people are living with frailty, and not all people with frailty are old. NHS England estimates that 1 in 5 people aged 90 and over remain fit, while over 1 in 4 aged 65 to 69 exhibit a degree of frailty. In populations with high levels of deprivation, frailty may start much earlier in life.

Frailty is a condition where the body's in-built reserves are reduced, meaning people are vulnerable to sudden changes in their health and wellbeing triggered by events in their life or health, such as a bereavement, an infection, injury, planned surgical

treatment or a change in medication. Whilst there is evidence that frailty may be modifiable in the earlier stages, in the current health and care system a person living with frailty will typically present in crisis with non-specific manifestations of frailty (often referred to as the 'frailty syndromes') such as delirium, sudden immobility or a fall, incontinence or side effects of medication.

However, while frailty syndromes may present suddenly to health and care professionals, the underlying frailty condition develops slowly and may be unrecognised in the early stages. Frailty is therefore, a progressive long-term condition that usually develops over several years, which suggests that more could be done before a health or care crisis occurs. As with any other long-term condition, when people living with frailty are supported to live well, independently and to manage their long-term conditions, they are less likely to reach an unanticipated crisis, require urgent care or experience poor outcomes.

Greater awareness and knowledge of frailty has enabled the NHS in England to start systematically identifying people living with severe and, where possible, moderate frailty using a population-based approach. To support this, NHS England has published guidance ('Supporting routine frailty identification and frailty through the GP Contract 2017/2018') which was updated in April 2019. This is helping to increase knowledge of frailty prevalence and demographics and provides new opportunities for frailty interventions based on a personalised care approach.

NHS Long Term Plan

This RightCare scenario supports the delivery of the NHS Long Term Plan for older people living with frailty. The Plan sets out an evidence-based framework of care for older people with frailty to be delivered through the national Ageing Well programme which commenced in 2019. This focuses on delivering integrated personalised care in communities and addresses the needs of older people with three inter-related service models centred on clearly identifiable patient cohorts:

1. Community multidisciplinary teams: target the moderate frailty population, people whose annual risk of urgent care utilisation, death and care home admission is up to three times that of an older person of the same age who is fit. This group is considered to be the most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation;

2. Urgent Community Response: timely crisis response and community recovery for older people who are at risk of unwarranted stays in hospital and whose needs can be met more effectively in a community setting; and

3. Enhanced health in care homes: for which there is not a consistent health care support offer across England, despite care home beds outnumbering NHS hospital beds by 3:1 and being an increasingly important place for end of life care.

The Ageing Well programme and framework aim to support commissioners and providers of acute and community health services, social care and the voluntary sector to work together, turning what is currently urgent care into planned care for key groups of vulnerable older people.

Introducing Janet

Janet is an 84-year-old retired teacher living with her 85-year-old husband Arthur in the family home they bought when they had their first child.

Since retiring 20 years ago, Janet had been active, going to the local market on Saturdays and playing bowls with her husband and friends every Sunday.

Janet's journey

Janet's journey started when she began to find everyday tasks more difficult and her walking was becoming slower. She had already had one fall but had not requested or received any support to prevent further falls.

On a Friday evening, while using the bathroom, Janet felt dizzy and fell. Arthur, Janet's husband, came to help her but couldn't manage to get her back on her feet, and Janet said her right hip hurt. He called 999 and when the paramedics arrived, they advised the couple that Janet would need to go to A&E, even though she wasn't keen and preferred to stay at home.

At 6.30pm that Friday evening, Janet was in the hospital's emergency department. Around 8pm, the on-call A&E consultant arranged for her to get a hip X-ray, which didn't show any fracture. However, her blood and urine tests suggested she was mildly dehydrated and might have a urinary tract infection.

Janet spent nearly four hours in the emergency department, then moved on to the acute medical unit where she was put on a drip and given antibiotics to treat her infection along with her usual medications.

On Saturday morning, Janet was seen by the on-call doctor for a medical review but before anyone had a chance to fully assess her mobility, needs and preferences, she was moved to the first available bed on a general medical ward. She spent the rest of the weekend worrying and waiting for further updates on what might happen to her. There was no routine physiotherapy or occupational therapy over the weekend, so she couldn't be referred to the home rehabilitation team until Monday. Arthur had been able to visit but there had been very little information over the weekend as to

what would happen with Janet, which left them both feeling vulnerable and not having any control of their situation.

By Monday morning, Janet had been either on a trolley or in bed with the cot sides up for three days and nights, because she was deemed to be at high risk of falls, and a catheter had been inserted to monitor fluid output.

By then, her muscles had started to get weaker, particularly in her legs. She was seen that morning by the physiotherapist who got her out of bed with the aid of a walking frame.

On Monday morning the ward doctors and occupational therapists decided to gather more information on Janet's medical history, usual abilities and needs. They asked for her GP records to be emailed in securely via NHSmail and talked to Arthur who told them that Janet had been getting more unsteady recently and that he often had to help her climb the stairs. She had suffered another fall and he also explained her memory wasn't as good as it used to be.

The ward team discovered that her blood pressure was dropping very low when she stood up; indicating that she had 'postural hypotension' which often leads to falls and faints in older people. They decided to stop a couple of her heart medications to see if it could help solve this problem.

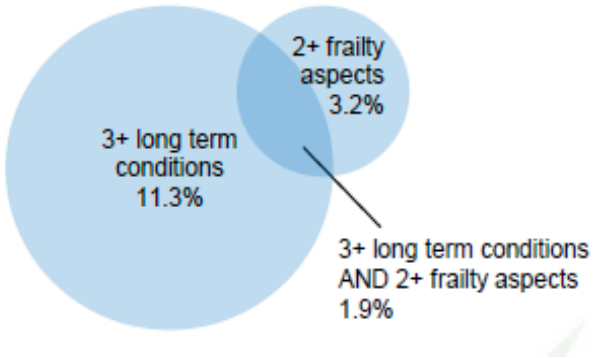
Then Janet's bed on the acute medical ward was needed for an acutely ill patient, so she was moved to an available bed on a surgical ward.

Data analysis on frailty

Historically, there has not been routine data relating to the identificiation of individuals living with frailty. In the absence of such data, analysis has often used proxies such as 'patients with three or more long term conditions'. In the 2018 GP Patient Survey a new question was included, relating to three aspects of frailty:

Q32 Have you experienced any of the following over the last 12 months?

- 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 the above



Analysis of the survey responses reveals that the group of patients flagged as 'living with frailty' by this question (where two or more aspects apply) differs from the group of patients flagged as having 'three or more long term conditions'.

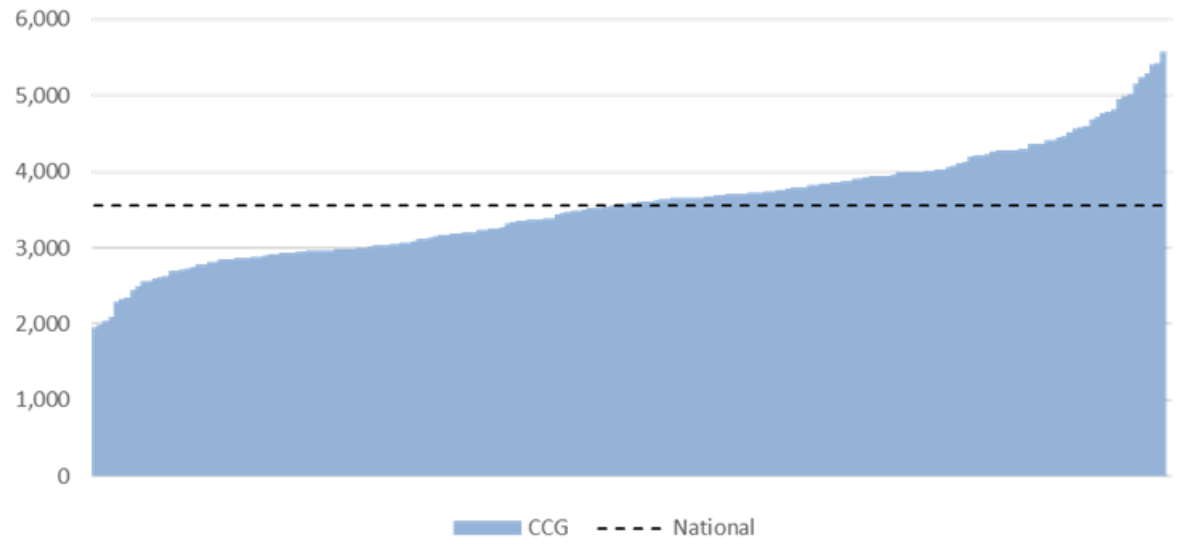
Changes made to the General Medical Services (GMS) contract in 2017/18 introduced routine frailty assessment for all patients aged 65 or older, and the submission of associated data. These changes represent an important addition to national data flows for frailty.

Quality assurance shows likely differences in how frailty assessments, data collection and data submission have been implemented across the country. As the data flow 'beds in' over time and focus on the identification of individuals living with frailty increases, it is expected that the coverage, quality and completeness of data will improve.

The scale of the issues raised in this scenario

We know that there is a strong correlation between frailty, impaired mobility and falls[1]. Therefore, to understand the potential scale of frailty issues across England a good measure is shown in the chart below.

Figure 1: Injuries due to falls – Emergency admissions for people aged 75+ per 100,000 age-sex weighted population (2017/18



Source: National Commissioning Data Repository (NCDR) – Hospital Admissions Databases, SUS+ SEM (Secondary Uses Services Plus, Standard Extract Mart)

In England the rate of emergency admissions for people aged 75 or older due to injuries from falls was 3,550 per 100,000 population in 2017/18. Across all 195 CCGs this equates to more than 163,000 serious falls for this age group, and these are just the ones that we know about – this scale is significant.

[1] …significant correlations between avoidance of activities on the one hand, and physical performance, muscle strength, forward endpoint excursion of the centre of gravity, and previous falls on the other hand. Logistic regression analysis revealed that fear of falling and avoidance of activities in daily life were predictive of falls within a 1-year follow-up, (Fear-related avoidance of activities, falls and physical frailty. A prospective community-based cohort study KIM DELBAERE , GEERT CROMBEZ , GUY VANDERSTRAETEN , TINE WILLEMS , DIRK CAMBIER 2004)
Nowak and Hubbard, 2009. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2746842/ Also references that people living with frailty are 3.6x as likely to fall as non frail adults

Back to the story…

On Wednesday, five days after her admission, Janet was able to stand with assistance and walk short distances. The physiotherapists came to see her and made a plan to refer her for ongoing rehabilitation in the local community hospital, as the next step on her journey to getting back home. The referral involved filling out and securely emailing several forms to their referral 'hub' but there were no beds available in the community hospital, so she had to stay in the acute hospital.

By the following Monday – day 10 of her admission – the surgical ward needed more beds so she was moved to a 'winter escalation' ward. After all these moves, Janet had become increasingly confused and agitated. She sustained another fall, and was found lying on the floor by the nurses. She sprained her wrist which made it difficult to hold her walking frame, and now required two nurses to move her out of bed.

Janet spent more and more time in bed with the cot sides up to protect her from another fall. By day 12 of her admission, the community hospital phoned back saying that she had 'no potential for rehabilitation' and should have a care package instead. She was therefore referred to social services with the aim of sending her home on Friday, over two weeks after her admission to hospital.

However, the care package could not be put in place until the following Tuesday when she went home to receive a three-times-a-day care package. She still hadn't received a formal diagnosis for the underlying causes of her progressive memory issues and falls, or a plan made to further investigate these issues in the community.

Three weeks after leaving the hospital, Janet suffered another serious fall and had another stay in hospital; similar in many ways to her first acute experience.

Four weeks after Janet returned home (from her second hospital admission), her memory was getting worse. Arthur was more and more anxious, worried and exhausted, and as a result Janet was admitted for respite to a local care home. As she was now living with severe frailty and required daily personal care, Janet stayed in the care home for just over a month. Arthur was left on his own in their family home, visiting Janet as often as he was able. The care home support came to an end when Janet (who was now deteriorating quickly) had another serious fall. She was again taken to hospital and after one week of hospital care Janet was admitted to intensive care with severe hospital acquired pneumonia where she died 10 days later.

Arthur was lonely and isolated at home and his eyesight was getting worse. A few months later, he was unable to reapply for a driving licence due to his poor vision and had to sell his car. His social interaction with the world became less and less frequent, as he feared leaving the house and had less reason to do so without Janet.

Areas for GPs and commissioners to consider

The role of CCGs is to understand the reasons why people develop frailty and to use that knowledge to commission care and support differently in the future. The following statements and questions are some action areas that can lead to improvement within frailty systems:

- Promoting frailty as a long-term condition which must be systematically identified, in order for proactive, timely and targeted interventions to be planned and delivered.
- Taking a system-wide approach to population segmentation and risk stratification for older people identified as living with frailty.
- Planning care models to support people living with mild and moderate frailty to age well.
- Planning care models to support people living with moderate and severe frailty to live in their communities.
- Identifying and reporting on measurable positive and negative frailty-associated outcomes.
- Ensuring communication about frailty and cognitive status occurs across health and social care sectors, and between primary, secondary and community health sectors.
- System wide training and competence according to the Frailty Core Capabilities Framework to support people living with frailty.
- Self-assessment of the frailty system as mentioned in the RightCare Frailty Toolkit.
- Supporting people with mild and moderate frailty to age well, including the establishment of proactive and recurrent community multidisciplinary team assessment processes for people identified living with moderate frailty.
- Personalised care – how are people living with mild, moderate or severe frailty and those at risk of frailty supported to have choice and control over how their care is planned and delivered, based on what matters to them?
- What actions are undertaken to ensure people living with mild, moderate and severe frailty and those at risk of frailty have a good experience of care?

The RightCare Frailty Toolkit includes a self-assessment that is designed to help local areas, including sustainability and transformation partnerships (STPs), integrated care systems (ICSs) and primary care networks (PCNs), gain enhanced understanding of their frailty system.

What could have happened differently? Janet's optimal care pathway

Please read the green boxes throughout the optimal care pathway to see which section of the RightCare Frailty Toolkit contains the relevant support and information.

Janet's journey starts four years earlier

This is the story of Janet, an 80-year-old retired teacher who was living with her 81-year-old husband Arthur in the family home they had bought when they had their first child back in the 1950s. Since retiring 16 years ago, Janet had been quite active, going to the local market on Saturdays and playing bowls with her husband and friends every Sunday.

On a Friday afternoon, Janet and Arthur received a visit from the local fire and rescue service. This was part of the firefighters' programme of 'Safe and Well' visits in the area and had been booked by Janet's pharmacist during a routine medication review.

For an example of where safe and well visits are being provided please see Hampshire Fire and Rescue Service. They provide free safety assessments for vulnerable people in their community and provide referrals to other services for their professional assessment if required.

The firefighters checked appliances and potential risks of fire. They also took this opportunity to check how Janet and Arthur were coping in the house and whether they had any particular needs. Arthur told them that Janet had started finding everyday tasks longer to do and was finding it harder to move around the house, let alone walk to the local shop.

The firefighters took this opportunity to assess Janet's walking speed through a gait speed test. The results showed that her walking speed was slower than normal (more than five seconds to cover four metres), and that she may be displaying early signs of frailty.

The firefighters provided Janet and Arthur with two guides, 'A practical guide to healthy ageing' and 'A practical guide to healthy caring', which contained hints and

tips on how to stay physically and mentally well and independent. They also referred her to a local social prescribing link worker who developed a simple plan with Janet and Arthur following a series of conversations to help understand what was important to them. This included putting Janet and Arthur in touch with a local charity to enrol in exercise classes, which could help them both to remain mobile and reduce the risk of falls. Janet and Arthur started a regular exercise class that improved their fitness and gave them an opportunity to meet new people and socialise. Using the information, her engagement with other people, and continuing her regular visits to her exercise classes, Janet was able to maintain her wellbeing and independence.

The charity operating the exercise group had ensured that all their group leaders had tier 1 training based on the Skills for Health Frailty Core Capabilities Framework. As the instructor had worked with Janet for a while they were able to notice a deterioration in how much Janet could do, perhaps indicating a change in Janet's frailty status. The exercise instructor suggested to Janet and Arthur that a discussion with their GP would be a good step, to ensure Janet was getting all the help she needed.

Following the recommendation of the exercise group leader Janet – now aged 85 – decided to visit her GP with her husband. Although she was well, she had been feeling weaker and had found it more difficult to cope at home.

In the meantime, Janet's GP practice has been using the electronic frailty index (eFI) to systematically identify people at risk of living with moderate or severe frailty. As a result, when Janet attended for her appointment, the practice nurse started to discuss this with her. Janet was receptive to this conversation as the fitness instructor had already raised this issue and because Janet had a good relationship with the practice nurse, who she had known for years.

After an initial assessment Janet was informed that she was showing signs of living with moderate frailty. Though she was a little bit anxious when the word 'frailty' was mentioned, she soon understood that recognising that she might be living with some

Frailty Toolkit key areas of focus: Standardised way of stratifying risk

Frailty Toolkit key areas of focus: System-wide recognition of the signs of frailty and frailty education and understanding

degree of frailty would help her to know what she could do and get the support she needed to maintain her independence.

At this point the GP also informed Janet about the enhanced summary care record, and asked Janet if she would consent to this being used for her. Activation of the enhanced summary care record allows access across the system which supports improved care coordination and its request is now a requirement of the GP contract (see below). Because Janet was living with moderate frailty the GP referred her to the local Ageing Well multidisciplinary team (MDT) for further assessment and intervention.

GP Contract requirements:

1. **Identify potential frailty**
2. **Apply clinical judgement**
3. **Take action – for patients identified as living with severe frailty**

NHS England's 'Ageing Well' programme sets out to deliver the NHS Long Term Plan's evidence-based framework of care for older people. One of its interventions is to:

Promote a **multidisciplinary team approach** where doctors, nurses and other allied health professionals work together in an integrated way to provide tailored support that helps people live well and independently at home for longer.

Over the following two months, the MDT – as part of the primary care network local integrated care service – met to discuss Janet's needs and carried out a falls risk assessment in Janet's home. Janet and Arthur were fully involved in all discussions, which also included an informed medication review by the local pharmacist that targeted falls risk reduction, reducing polypharmacy and limiting any potential side effects. Janet was also referred to the local memory service, where she was diagnosed with early-stage Alzheimer's disease. All her results were quickly sent back to her GP electronically.

Frailty Toolkit key area of focus: MDT team assessment of risk stratified patients

When Janet returned to see her GP with Arthur, they discussed together the implications of her diagnosis, including her moderate frailty and early-stage Alzheimer's disease, and proceeded to agree together a personalised care and support plan for frailty and dementia, in line with best practice NHS guidance. This would identify her support needs, reflect her goals and aspirations and outline actions, including what to do in case of acute events such as a serious fall. Janet's personalised care and support plan included a routine of falls prevention exercises and advice (e.g. having properly fitting slippers) that were supported by a physiotherapist (an example of supported self-

Frailty Toolkit key area of focus: Personalised care and support planning

management). This was as well as regular attendance at a memory café run by the local charity to support Janet's health and well-being, along with helping Janet and Arthur to maintain social contact and encourage peer support. She also received a planned visit from social services to fix handrails in her bathroom.

In the meantime, routine integrated MDT assessments continued to support Janet's ongoing needs and to maintain the understanding of her frailty status. Over the next three months Janet was supported by a charity-funded care coordinator to make sure she knew about the services available to her. Also, Janet and Arthur's family were now more aware of what they could do and, amongst other things, supported them with regular meals out and taking them to the supermarket.

On a Wednesday evening almost 12 months after Janet's GP confirmed she was living with signs of moderate frailty, Janet fell in the kitchen. Although Arthur didn't think she was seriously hurt he contacted NHS 111 for advice. Because Janet was at a high risk of injury the 111 call centre organised for a community paramedic to see Janet. The paramedic assessed Janet and ascertained that Janet had no serious injuries or any need for acute admission. The paramedic then contacted the Integrated Urgent Care Clinical Assessment Service (IUC-CAS) located in the 111 call centre to inform them of the outcome and that Janet would need community follow-up and support. The IUC-CAS had access to Janet's personalised care plan and was aware of all the services already involved in Janet's care. Importantly, the IUC-CAS team were aware of the decisions she had made earlier with her GP about her preferences for care in the event that she fell. They could also see that she had already received full assessment and interventions to reduce, as much as possible, the risk of falling and injury.

Frailty Toolkit key area of focus: Coordination of care through sharing information

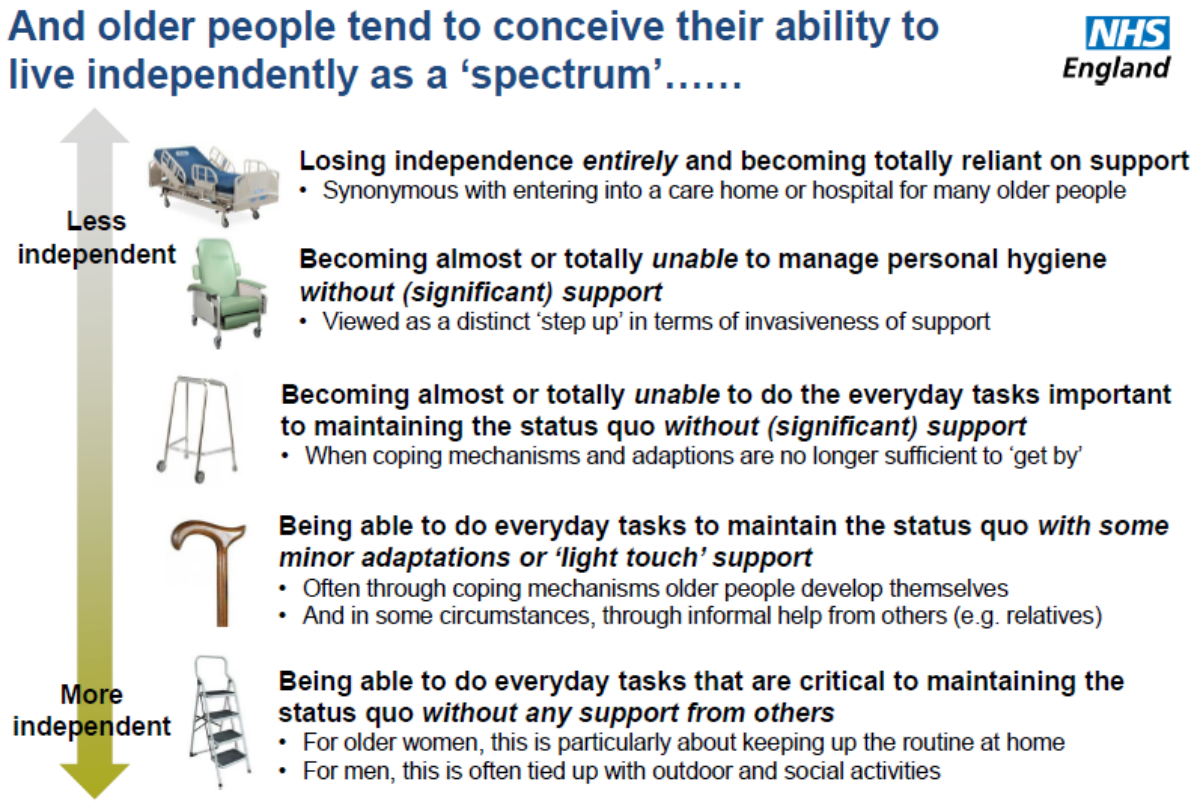
The IUC-CAS team coordinator contacted the local Urgent Community Response (UCR) service who were able to organise regular support visits for Janet and Arthur to arrive at their home within two hours of the referral and to continue for the next few days. The coordinator also sent a secure referral via NHSmail to Janet's local Ageing Well MDT to organise a further multidisciplinary assessment as soon as possible.

The following morning the multidisciplinary key worker contacted Janet and Arthur to advise them what would happen next and organised a visit to reassess Janet on behalf of the MDT. In discussion with Janet and Arthur the MDT decided to refer Janet to the local community geriatrician's rapid access clinic for a comprehensive geriatric assessment (CGA).

The assessment showed that Janet's blood pressure was dropping very low when she stood up, indicating that she had postural hypotension which often leads to falls and faints in older people. Some changes were made to her medication and all her results were recorded in the MDT integrated care service notes.

A few days later, Janet and Arthur reviewed and updated the personalised care and support plan with her MDT key worker. After undertaking a clinical frailty score they

advised that Janet's frailty was at risk of increasing from moderate to severe and that a few more steps would need to be taken to minimise her risk of falling. The key worker provided Arthur with advice and information on how to cope at home with a view to alleviating his concerns and agreed to visit regularly to coordinate Janet's care.



Source: BritainThinks. Frailty: Language and Perceptions: A report prepared by BritainThinks on behalf of Age UK and the British Geriatrics Society June 2015.

The following year, shortly after her 88th birthday, Janet fell in the night whilst getting out of bed to go to the bathroom. Arthur came to help but couldn't manage to get her back on her feet. As she was getting a lot of pain from her right hip he dialled 999 to call an ambulance. Due to shared protocols with primary care and community services the ambulance trust was able to access Janet's personalised care and support plan. This meant that the trust was aware of Janet's needs and which services were involved in her care. They sent a paramedic to assess her injuries and they were concerned that Janet may have broken her hip. Janet and Arthur were advised that it would be best to be checked at the hospital. Janet was helped to ensure she had adequate clothing and personal items to take with her and transported in an ambulance with her husband.

Frailty Toolkit key area of focus: Coordination of care through sharing information

On arrival at the urgent treatment centre (UTC), Janet was identified from her electronic care records as someone living with moderate frailty (and at risk of increasing to severe frailty). An urgent X-ray of her hips and pelvis was arranged and she then waited for the results so that once a fracture was excluded she could be helped back into her own clothes. The doctors were able to review her personalised care and support plan and carry out an assessment to see if there had been any important new changes to her condition. Due to the complexity of her needs and the potential seriousness of her injuries, they decided that further investigation was needed and arranged her admission to the acute medical unit under the embedded acute frailty team for further assessment. A multidisciplinary team with expertise in assessment of older people, led by an advanced frailty clinical practitioner and supported by a consultant geriatrician, started a comprehensive assessment of Janet's condition. Janet's stay on the unit was clearly focused from the outset on rapid targeted assessment and future care planning to support discharge at the earliest opportunity.

Frailty Toolkit key area of focus: Effective rehabilitation

Although she was now on a bed, Janet was still in her own clothes and comforted by the presence of Arthur who was allowed to stay on the ward. She was given intravenous fluids and antibiotics as she was found to be mildly dehydrated and to have a urinary tract infection. Having excluded a hip fracture she was supported to get out of bed and move around as much as possible, with an expected discharge before the end of the weekend. By that point the team had already alerted the GP surgery and community Ageing Well MDT of Janet's admission to, and expected discharge from, hospital and recorded the information in her shared care record.

Frailty Toolkit system improvement priority: Reducing hospital length of stay

The next morning the specialist team completed Janet's CGA. Although Janet showed deterioration in her functional ability, in particular her mobility, her medical condition was now stable, so the team discussed plans for discharge the following day with Janet and Arthur.

Because of her increased needs, but also because Janet could still transfer and mobilise with the help of one person and a walking frame, plans were made for her to have home-based rehabilitation and recovery care. This was based on goals set jointly with Janet and Arthur. Together the specialist team reviewed and updated Janet's personalised care and support plan that had been instigated by the Ageing Well MDT to take account of her changed medical, functional and environmental support needs, and provide enablement and independence. A referral to the reablement team was made with an expected start date of within two days in line with the Ageing Well programme access to reablement care standard. This would allow a discharge date home to be agreed with Janet and Arthur. This package comprised three visits a day from a reablement worker to help Janet get washed, dressed and with mealtimes.

Frailty Toolkit key area of focus: Effective rehabilitation

The specialist team confirmed Janet's care plans to her local GP and that Janet would be going home with support from the community rehabilitation and recovery service. The specialist team also arranged for her key worker from the Ageing Well MDT to visit her at home shortly afterwards to check how the couple were coping at home. A key component of the acute frailty unit discharge arrangement was to agree and confirm the appointments. These steps reassured the couple and provided confidence that they would be supported with adequate community care on return home.

After 10 days of home-based rehabilitation and recovery care Janet reached her goal of being able to independently transfer and walk around her house with a walking frame. After this, Janet received regular contact calls from the community Ageing Well MDT key worker and physiotherapist to support her further recovery. On completion of reablement her continued package of care continued with a social care support worker visiting twice daily. Janet and Arthur chose to arrange this through a personal health budget (PHB), to give them more choice and control over the service provided by the support workers. The money was managed for Janet and Arthur by a third party to give them additional peace of mind. Family also supported Janet and Arthur, with regular visits and giving them lifts to the supermarket and to see friends.

The prompt provision of short-term rehabilitation services, including delivery of reablement, within two days of referral together with support from the community Ageing Well MDT social care services helped to keep Janet's condition stable, while supporting her recovery. She was able to continue to live in her own home and lead a fulfilled life with support from her family.

Janet died peacefully at home, aged 89, surrounded by Arthur and her family, just as she wanted and was stated in her care plan.

The 'bills' and how they compare

What are the financial costs to the healthcare system of Janet's care? The following tables give a high-level pathway description of the two stories above.

Table 1 - Suboptimal care pathway

Year 1 (Janet is 80)	• No community engagement or education provided
Year 2	• No support received, and Janet's deterioration goes unnoticed
Year 3	• Janet still receives no support and her deterioration continues to go unnoticed
Year 4 (Janet is 84)	• Janet has her first fall and spends 18 days in acute setting • No diagnosis given for memory issues or falls, and no plans to investigate these further • Janet receives three-times-a-day care package at home for three weeks • Janet has her second fall and spends another 18 days in acute setting • Janet spends just over a month in a care home • Janet deteriorates and spends 10 days in intensive care • Janet dies in hospital aged 84

Table 2 – Optimal care pathway

Year 1 (Janet is 80)	• Early community engagement and education provided • Charity support and advice, including exercise classes
Year 2	• Self-management
Year 3	• Self-management
Year 4	• Self-management
Year 5 (Janet is 85)	• First appointment with GP • Janet is assessed as living with moderate frailty • Appropriate e-care and support put in place • Janet is referred to her local Ageing Well MDT
Year 6	• Janet has her first fall – no serious injuries and no acute hospital admission required
Year 7	• Self-management
Year 8 (Janet is 88)	• Janet has her second fall and spends four days in acute setting • Janet receives community-based reablement • Janet receives twice-a-day care
Year 9	• Janet continues to receive twice-a-day care • Janet dies peacefully at home at the age of 89 – surrounded by Arthur and her family as she wanted, and as stated in her personalised care plan

In the suboptimal care pathway Janet received no support during the early years of her frailty symptoms. No health costs arise at that point, but strategically, these years were the most important to Janet's long-term health. If preventative care had begun to impact here, the later complications might have been delayed and been more manageable, as indicated in her optimal care pathway.

Not only is Janet's (and her husband's) health and quality of life significantly better in the optimal care pathway, but the costs to the healthcare system are estimated to be almost 30% lower - even though Janet lives for an additional four years. The impact is significant on outcomes, quality and finance.

The tables below (2a and 2b) summarise the estimated financial costs for the two pathways by cost category and by provider.

Table 2a

Analysis by cost category	Suboptimal £	Optimal £
Community care	1,470	13,809
Immediate care	3,321	0
Prevention and public health	0	1,425
Primary care management	0	4,885
Urgent and emergency care	1,497	831
Non-elective admissions	24,075	1,460
Total	**30,363**	**22,410**

Table 2b

Analysis by provider	Suboptimal £	Optimal £
Acute trust	24,816	1,460
Urgent treatment centre	0	74
Ambulance service	756	757
Primary/community	1,470	18,694
Care home	3,321	0
Third sector/other	0	1,425
Total	**30,363**	**22,410**

The costs shown above are indicative costs to the healthcare system. Where available, reference costs have been used, particularly to estimate the cost of emergency care and non-elective admissions.

These estimates do not necessarily reflect the cost to the commissioner as this will vary depending on local contractual arrangements and the types of services already being commissioned. The actual cost to local systems of providing the types of services indicated in the scenarios may also vary depending on what other services are already in place.

The estimates are based on two hypothetical pathways for a fictional patient. They may not reflect the actual cost of healthcare for any individual patient. There may also be other costs incurred by such a patient, but which are not noted in either pathways, and these have been excluded from the estimates above.

We have not tried to separate out what might in some cases be a cost of social care as this might vary depending on an individual patient's circumstances.

Each system should consider the impacts of pathway changes, taking into account local circumstances and evidence, including the make-up of the local population and the services already in place.

Think change, Think RightCare

RightCare is a national programme within NHS England and NHS Improvement, which now has a regional arm to drive maximum impact nearer the point of delivery. Each region has a full RightCare team consisting of Delivery Partners, analysts and project management all available for system support.

The RightCare teams work locally with systems to present a diagnosis of data and evidence across that population. RightCare Delivery Partners and their teams work collaboratively with systems to look at the evidence to identify opportunities and priorities. The Delivery Partners are senior, change leaders who can influence systems to deliver effective and efficient returns for their population.

As most health conditions are linked to demographic factors such as deprivation and age, RightCare produces other resources such as data packs, which compare systems to their closest demographically similar geographies. This is to provide realistic fair and meaningful comparisons, considering the need for healthcare of different populations. Deprived populations will have much higher rates of admissions and worse health outcomes for conditions such as respiratory disease, cardiovascular disease, cancer or diabetes.

The data and evidence produced by RightCare provide systems with a set of resources to concentrate their improvement efforts where there is greatest opportunity to address variation and improve population health.

RightCare is a proven approach that delivers better outcomes and frees up funds for further innovation – please see the graphic on the next page. For more details about our programme and to explore our latest publications please visit www.england.nhs.uk/rightcare.

You can also contact the RightCare team via email at rightcare@nhs.net.

For a comprehensive list of guidance and best practice please see the RightCare Frailty Toolkit.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 2233 or email england.contactus@nhs.net.