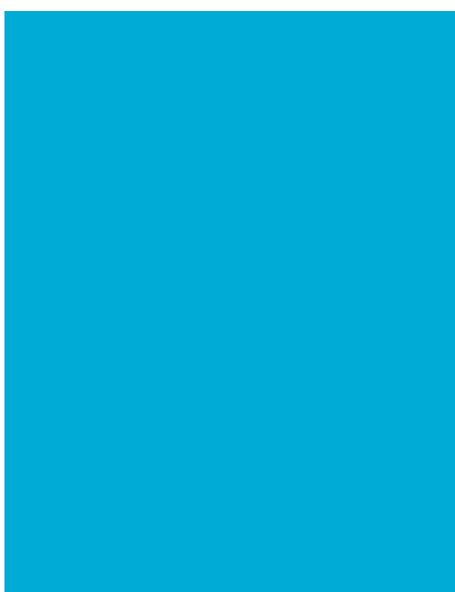


Safe, compassionate care for frail older people using an integrated care pathway:

Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders



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Contact details for further information: Carol Williams, Director of Nursing, Devon, Cornwall & Isles of Scilly Area Team, Peninsula House, Kingsmill Road, Tamar View Industrial Estate, Saltash, Cornwall PL12 6LE carol.williams19@nhs.net

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Safe, compassionate care for frail older people using an integrated care pathway:

Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders

“Care needs to be just as important as treatment. Older people should be properly valued and listened to, and treated with compassion, dignity and respect at all times. They need to be cared for by skilled staff who are engaged, understand the particular needs of older people and have time to care.”

‘Hard Truths, the Journey to Putting Patients First’,
Government response to the Francis Report, November 2013





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Forewords

David Oliver

Population ageing is a 'game changer' for health and social care services. While many people remain well, engaged and active well into later life, report high levels of happiness and continue to make a major contribution to local communities – as carers or volunteers, for instance – increasing age also brings an increasing chance of long-term medical conditions, frailty, dementia, disability, dependence or social isolation.

We can do much to prevent these problems or to help people live well with them, to retain their independence and keep out of hospital. But, in the end, we must also be realistic in acknowledging that older people often do need acute hospital admission, social care or rehabilitation after a spell of illness; that they will sometimes move into nursing or residential homes; and that support, choice and control towards the end of life are as important to them as they are to younger people with terminal illness.

Too often, long-term conditions strategies have tended to focus on single conditions, whereas most people over 75 have a number of conditions and want to be treated as an individual who needs coordinated, person-centred care rather than as a collection of diseases. Too often, these strategies ignore common conditions associated with ageing and, in particular, fail to mention the unique challenge of frailty. Older people who are frail often require a different level and type of support to those who are younger and fitter.

A second issue bedevilling our thinking has been the tendency to 'silo' pathways of care into 'acute', 'primary' or 'social', when in fact all elements of care and organisations providing them are interdependent. Older people and their families often fall through the gaps or suffer at transitions from poor communication and coordination and a system not designed around their needs.

Third, we have tended to make a false and unhelpful distinction between compassionate personal and nursing care and the more technical, medical model. In reality, if we assess frail older people well and treat underlying causes of deterioration, there is great potential to make them less dependent, less immobile, less fearful and less confused – and, in turn, less reliant on care. Conversely, we need to recognise that nurses and allied health professionals looking after older people require a body of skills and knowledge; and that some of the supports that older people require can be delivered within their community and by the voluntary sector.

To get all of this right, we need to look across the whole health and social care economy and ensure that the right skills and services are in the right place at the right time; that we genuinely involve older people and their carers in designing services; that all agencies sign up to a shared vision and collaborate effectively; and that we build in meaningful outcome measures.

This guide is a bold start in achieving that vision and I endorse it wholeheartedly.

Professor David Oliver
Consultant Geriatrician
President-elect British Geriatrics Society
King's Fund Senior Visiting Fellow
Visiting Professor, Medicine for Older People, City University, London

John Young

Getting services right for people living with frailty has become the 'must do' for health and social care communities. Not to do so exposes people to bump along between silos of well-meaning but poorly-organised care.

In this review we find a guide to building a more integrated approach. The key theme is compassionate care, underpinned by a strongly-articulated evidence base around effective assessment and management of predicaments related to frailty.

There are two building blocks. Firstly, what we already know works for older people in crisis but needs to be deployed more universally. Secondly, a newly-emerging preventative approach that offers the real possibility of living better with frailty and of a reduction in the unscheduled primary and secondary care contacts that characterise our current response.

So, what already works? Our starting position has to be an understanding of frailty as a distinctive state related to the ageing process, as multiple body systems gradually lose their in-built reserves. This means the person is vulnerable to sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication.

A person therefore typically presents in crisis with the 'classic' frailty syndromes of delirium, sudden immobility or a fall (and subsequent unsafe walking). There is strong evidence that medical assessment within two hours, followed by specific treatment, supportive care and rehabilitation, is associated with lower mortality, greater independence and reduced need for long-term care.

Much of this response is provided in hospitals by Geriatric Medicine, now the largest medical speciality in England. More recent research has demonstrated better outcomes from acute older care assessment units ('Frailty Units') at the front end of the hospital. Even more exciting has been steadily-accumulating confidence that more people presenting with a frailty syndrome crisis can be safely assessed and managed at home. This requires dedicated, well-led, multi-disciplinary community teams. Their development, with the right skills, integrated into primary and secondary care, is becoming the norm. This review explains how it can be achieved.

However, frailty doesn't spring up unannounced; it develops over five to 10 years. So could more be done before a health crisis? Older people with frailty can be readily identified and are usually known to local professionals. They usually have weak muscles and, often, conditions like arthritis, poor eyesight, deafness and memory problems. They typically walk slowly, get exhausted easily and struggle to get out of a chair or climb stairs.

At present, however, we do not formally 'diagnose' frailty or identify it with a specific 'code'. This makes systematic case-finding and proactive care difficult. Slow walking speed is a simple test that could help; taking more than five seconds to walk four metres is highly indicative of frailty.

The primary care electronic health record contains large amounts of data from which existing entries could be readily compiled into a 'Frailty Index' to identify older people who have frailty, and to grade the frailty state. This would allow structured self-management for people with mild/moderate frailty and case management for people with moderate/severe frailty. Health and social care communities need to embrace these exciting challenges.

John Young
Geriatrician and National Clinical Director for Frailty and Integration

Russell Emeny

Over the past few years, there has been a quiet revolution in our approach to the healthcare of frail, older people.

We can now describe what 'good' looks like. We know which interventions work and which are ineffective. 'Comprehensive geriatric assessment', 'frailty units', 'discharge to assess' and 'self-care' are becoming touchstones of good practice.

We know that inappropriate admissions and unnecessarily long periods in hospital can be very harmful and may mean that an older person deteriorates to a point where they will never be able to return to their home.

We also know that hospitals can be the right place for acutely-ill older people, as they provide the expertise and technology needed rapidly to fix complex medical problems and allow people to resume their lives.

This guide is a useful contribution to the movement to improve care across the NHS. It emphasises good practice along the whole pathway, both inside and out of hospitals, acknowledging that frail, older people deserve the best-possible, evidence-based healthcare that does no harm.

Russell Emeny
Director,
NHS Emergency Care Intensive Support Team
NHS IMAS

Liz Redfern

I am pleased to add my supportive comments and to encourage clinical professionals to use this guidance to improve the experience and outcomes for one of the most vulnerable groups of people we will have the privilege to care for. The real value in this guidance is that it brings together the importance of combining evidence-based, targeted interventions with compassionate care. Until we get both of these elements delivered in equal measure, on a consistent basis, we should not feel satisfied that we are meeting the needs of frail older people or of their carers and communities.

Liz Redfern, Deputy Chief Nursing Officer for
England, Director of Nursing NHS South



1 Introduction

We are an ageing society; many of us know or are caring for someone who is frail.

At a time in our lives when we and the people we love are most vulnerable, compassionate care is fundamental if we are to feel safe and supported. That means good communication, coordination of care, and skilled and evidence-based interventions.

In their daily working lives, most clinicians will spend more time providing care to people over the age of 75 years than to any other age group. Yet, we know that older people with frailty are at the greatest risk of a poor experience or of suffering actual harm as part of their 'care'.

The Government, in its response to the Francis Report and publication of 'Hard Truths' (Department of Health 2013), agrees that the link between culture and compassionate care for older patients is fundamental, across all health and care settings.

The frailty pathway and tools set out in this guidance have the potential to reduce harm and improve the experience of older people immeasurably. It is the opportunity for commissioners and for nursing, medical and allied health professional leaders to put end-to-end frailty pathways in place – and to make them stick.

This short guide and framework will help clinical commissioners and providers understand how the systematic implementation of an integrated pathway of care for frail older people cannot only improve patient experience, but deliver savings to health and social care systems. It offers practical guidance on tools to use in the clinical setting and incentives for making whole-system pathway changes.

Implementation of this pathway underpins all five domains of the NHS Outcomes Framework. It is designed to engage and capture the energies and commitment of medical, nursing and allied health professional leaders who have responsibility for meeting the domain requirements.

In short, this pathway, embedded across all care settings, has the power to transform the way vulnerable older people experience health and social care.



NHS England’s mission – high-quality care for all

The pyramid below shows how NHS England’s mission of ensuring high-quality care for all relates to its definition for quality, how it will measure success, and what care should look and feel like for patients.



What is frailty?

The clinical condition of ‘frailty’ is one of the most-challenging consequences of population ageing (Clegg *et al*, 2013). Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home. Between a quarter and half of people older than 85 are estimated to be frail, with overall prevalence in people aged 75 and over approximately 9% (Collard *et al*, 2012). People with frailty have a substantially increased risk of falls, disability, long-term care and death. We also know that frailty is a graded abnormal health state which ranges from the majority who are mildly frail and need supported self-management, through those who are moderately frail and would benefit from interventions such as case finding/case management, to those who have advanced frailty where anticipatory care planning and end-of-life care may be appropriate interventions. So frail people should not be perceived as a problem to the system but, rather, clinicians should support people with living with frailty to maintain their own health for as long as possible.





2 Reducing healthcare-related harm

There are times when a frail older person requires care in hospital and that is exactly the right place for them to be. However, we know that frail older people are at greater risk of experiencing significant harm if admitted to hospital as an emergency – particularly if they are delayed in an emergency department. A care pathway for frail older people reorganises services around the patient and provides care at all stages of the patient journey from healthy, active ageing through to end-of-life care.

When a frail older person requires admission to hospital, best practice models such as those employed by Sheffield Teaching Hospitals Trust should be adopted systematically (Health Foundation, 2013). This includes 'discharge to assess' where patients are discharged once they are medically fit and have an assessment with the appropriate members of the social care and community intermediate care teams in their own home.

If frail older people are supported in living independently and understanding their long-term conditions, and educated to manage them effectively, they are less likely to reach crisis, require urgent care support and experience harm.

This document summarises the evidence of the effects of an integrated pathway of care for older people and suggests how a pathway can be commissioned effectively using levers and incentives across providers.



The evidence

Levels of avoidable harm among older people are considerably higher than in younger age groups. Medication error is high due to the accumulation of multiple factors in prescribing and administration. These include:

- A higher likelihood of polypharmacy in the older population, who may be more susceptible to adverse effects.
- Missed medications in hospital and care home settings.
- Timing errors: for example, people with Parkinson's Disease not receiving medication at the correct time (Fialová & Onder, 2009).

National data identifying the scale of these issues is difficult to find, with a paucity of information specific to the older age group. However, we know that medication error is the second most common underlying cause of patient safety incidents, accounting for 11% of the 1.2 million incidents recorded via the National Learning and Reporting Service in 2011 (NRLS, 2011); omission and incorrect dosage or strength are the top two categories of error.

Falls are another key area of concern for older people. While the causes of falls are complex, frail older people are particularly vulnerable because of medical conditions such as delirium, cardiac issues, problems with poor eyesight or problems with strength and mobility (Patient Safety First, 2009). This complex interplay of individual and environmental factors can be seen in figures showing that the proportion of falls in care among patients over 70 is 2.77%, compared with 1.26% in patients aged 70 or younger (NHS Safety Thermometer, 2013).

Pressure ulcers show a similar pattern to falls, with 6.24% of patients over 70 recorded in the NHS Safety Thermometer (2013) as having a pressure ulcer, compared with 3.41% in all other age groups. Prevalence is noticeably higher in community settings such as nursing homes and patients' own homes, where they may be under the care of a district nursing team. NICE guidelines make a range of recommendations for the prevention of pressure ulcers (NICE CG7, 2003), but also state that there is a poor evidence-base for prevention; this is ripe for new research.

It is also now established that frail older people can suffer harm from receiving care in an acute setting when this is not absolutely necessary. There is a four-fold variation between organisations in admission rates for people aged 65 and over. There is a combined effect of long-term demographic trends, a failure to embed best practice systematically in caring for frail older patients and small stimuli, which has created a vulnerable, fragile system of care with the potential to cause harm (Emeny, 2013).

The length of time spent in the emergency department (ED) can also result in harm, with complex older patients more likely to be at risk; a study by Richardson found a 43% increase in mortality at 10 days after admission through an overcrowded ED (Richardson, 2006). Length of stay in an ED is predictive of inpatient length of stay (Liew *et al*, 2003). A stay of 4-8 hours increases inpatient length of stay by 1.3 days, while a stay of more than 12 hours increases length of stay by 2.35 days. Patients treated in an overcrowded ED also often have treatments delayed (Pines *et al*, 2005). For patients who are seen and discharged from an ED, the longer they have waited to be seen, the higher the chance that they will die during the following 7 days (Guttmann *et al*, 2011).

A disparity in outcomes for older patients can also be seen in the 28-day readmission rate, with standardised rates of 10.1% in the 16-74 age group, compared with 15.3% for the over-75s. The vast majority of older patients are discharged back to 'usual place of residence', but there is evidence to suggest that discharge to alternative destinations, such as care homes, is linked to extrinsic factors such as deprivation (Connolly & O'Reilly, 2009) rather than to need.

Delirium characterised by the recent onset of fluctuating inattention and confusion is common in frail older people in hospital and in the care home setting. It contributes to substantial morbidity and mortality, causes considerable distress to patients and families, and it adds an estimated additional £1,275 per patient to the costs of an episode of care (US Department of Health and Human Services, 2004).





3 Care with compassion

There is a wealth of patient experience information available to commissioners, but it is difficult to analyse in terms of frail older patients alone. Much of the qualitative feedback relating to older patients comes from informal carers, and it is fair to say that feedback is very mixed. Themes within both are common, with care and compassion often cited by patients and carers alike. Another theme on the negative side is that key information is not being passed between care organisations, with patients having to provide information again and again (Patient Opinion, November 2013). This will have a particular impact on patients with cognitive dysfunction.

The cost of care

Financially, there is a growing body of evidence which points to the need to have an integrated care pathway in place to prevent harm and additional costs to the system. Currently costs can be quantified in terms of harm related to pressure sores, urinary catheterisation, urinary-tract infection and falls that lead to increased morbidity, suffering, extended length of stay and increased risk of not returning to usual place of residence, with the subsequent cost of care home placements. In an average district general hospital with 500 beds, we would expect £230,000 per year to be spent on the harm caused through care processes (Plowman *et al*, 1999; Cheema, 2013).





4 Case finding and assessment

The essential elements of an end-to-end pathway of care for frail older people are described in the box below. Frailty is a complex and fluctuating syndrome. Patients will enter the pathway at different levels, or may require identification in primary care in order to access appropriate services along the pathway. However, identification of frail people and the level of frailty can be a challenge. While many experienced clinicians can instinctively recognise a frail person, there is a need to support identification using case-finding tools and techniques. There are many screening tools available to identify frail people and organisations will wish to choose their own based on reliability/validity, clinical opinion and ease of use. However, some examples are set out on the following pages.

Healthy active ageing and supporting independence
Living well with simple or stable long-term conditions
Living well with complex comorbidities, dementia and frailty
Rapid support close to home in crisis
Good acute hospital care when (and only when) needed
Good discharge planning and post-discharge support
Good rehabilitation and re-ablement after acute illness or injury
High-quality nursing and residential care for those who truly need it
Choice, control and support towards the end of life

(King's Fund, 2013)



Identification of people living with frailty

Commissioner and provider organisations need to decide which case finding and identification tools they will use, but it is important to have a consistent approach across all organisations involved in the care pathway. We have given examples of some tools currently in use on the next pages of this document. The gait speed test (Studenski *et al*, 2011) is a valid predictor, and can be used to support carers, relatives and volunteers in identifying frail people to health and social care services. The Edmonton Scale (Hilmer *et al*, 2009) can be used in primary and community care. An electronic frailty index (EFI) (Trueland, 2013) is under development by Dr Andrew Clegg and colleagues at Leeds University; it uses indicators of frailty coded on general practice systems to identify frail people for further screening and assessment.

Gait speed test

Average gait speed of longer than 5 seconds to walk 4 metres is an indication of frailty. The test can be performed with any patient able to walk 4 metres using the guidelines below.

1. Accompany the patient to the designated area, which should be well-lit, unobstructed, and contain clearly indicated markings at 0 and 4 metres.
2. Position the patient with his/her feet behind and just touching the 0-metre start line.
3. Instruct the patient to "Walk at your comfortable pace" until a few steps past the 4-metre mark (the patient should not start to slow down before the 4-metre mark).
4. Begin each trial on the word "Go".
5. Start the timer with the first footfall after the 0-metre line.
6. Stop the timer with the first footfall after the 4-metre line.
7. Repeat three times, allowing sufficient time for recuperation between trials.

The Edmonton Frail Scale

Frailty domain	Item	0 points	1 point	2 points
Cognition	Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of 'ten after eleven'.	No errors	Minor spacing errors	Other errors
General health status	In the past year, how many times have you been admitted to a hospital?	0	1-2	≥2
	In general, how would you describe your health?	Excellent/very good/good	Fair	Poor
Functional independence	With how many of the following activities do you require help: meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications?	0-1	2-4	5-8
Social support	When you need help, can you count on someone who is willing and able to meet your needs?	Always	Sometimes	Never
Medication use	Do you use five or more different prescription medications on a regular basis?	No	Yes	
	At times, do you forget to take your prescription medications?	No	Yes	
Nutrition	Have you recently lost weight such that your clothing has become looser?	No	Yes	
Mood	Do you often feel sad or depressed?	No	Yes	
Continence	Do you have a problem with losing control of urine when you don't want to?	No	Yes	
Functional performance	I would like you to sit in this chair with your back and arms resting. Then when I say 'Go', please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3m away), return to the chair and sit down.	0-10 seconds	11-20 seconds	>20 seconds, patient unwilling or requires assistance
Total	Final score is the sum of column totals			/17

Scoring the Reported Edmonton Frail Scale (/17):

Not frail 0-5

Apparently vulnerable 6-7

Mild frailty 8-9

Moderate frailty 10-11

Severe frailty 12-17

Frail people at different stages of the pathway will require a range of interventions that are clinically effective and appropriate for their level of frailty. These interventions may well involve voluntary and community sector groups, in addition to clinical assessment and support, particularly at the early stages of frailty when the focus should be on maintaining independence and optimising function and health.

Comprehensive geriatric assessment

Many frail older people, once identified, will require comprehensive geriatric assessment (CGA) (British Geriatrics Society, 2010). This is defined as a 'multi-dimensional interdisciplinary diagnostic process focused on determining a frail older person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long-term follow-up'. CGA has a very strong evidence base for effectiveness and has been shown to increase patients' likelihood of being alive and in their own homes after an emergency admission to hospital. This is associated with a potential cost reduction compared with general medical care (Ellis *et al*, 2011). In terms of Numbers Needed to Treat (NNT), to avoid one long-term care placement, for CGA the number is 20. This is compared with NNT of 120 people who take an aspirin each day to prevent stroke.' The domains of a CGA are set out on page 17.

Medical	Mental health	Functional capacity	Social circumstances	Environment
Comorbid conditions	Cognition	ADLs	Informal support	Home comfort/facilities
Disease severity	Mood/anxiety	Gait/balance	Social network/activities	Personal safety
Medication review	Fears	Activity/exercise status	Eligibility for care resources	Use or potential use of telehealth/telecare
Nutritional status				Transport facilities
Problem list				Accessibility of local resources

Organisations may wish to develop their own assessment templates and documentation; however, the domains described above must be included as a minimum in an effective CGA. In addition, a multi-disciplinary team should deliver the CGA. This must include as a minimum:

- A competent specialist physician in medical care of older people.
- A coordinating specialist nurse with experience.
- A senior social worker or a specialist nurse who is also a care manager with direct access to care services.
- Dedicated appropriate therapists.
- The older person and their family, carers or friends (BGS, 2010).

Interventions

Examples of interventions which should be in place at each stage of the pathway are described below. These are drawn from the Silver Book (2012) and from recent work carried out by the King's Fund on integrated care pathways for frail older people (Oliver *et al*, 2013). These can be used by clinical commissioning groups (CCGs) in developing commissioning intentions and in commissioning services along the whole pathway, and by providers in ensuring that their services are fit for purpose.

Healthy active ageing and supporting independence:

- Influenza and pneumococcal pneumonia vaccination.
- Adequate treatment for 'minor conditions' which may limit independence.
- Support to maintain healthy lifestyle – regular exercise, not smoking, reducing alcohol consumption, healthy eating and preventing obesity.

Living well with simple or stable long-term conditions:

- Personalised care planning and shared decision-making is a universal offer for all those aged 75 and over with one or more long-term condition.
- Treatment and management of long-term conditions in older people is optimised and there is no discrimination on the basis of age alone.
- The use of assistive technology is part of the menu of options in place for patients to effectively self-manage their long-term condition.

Living well with complex comorbidities, dementia and frailty:

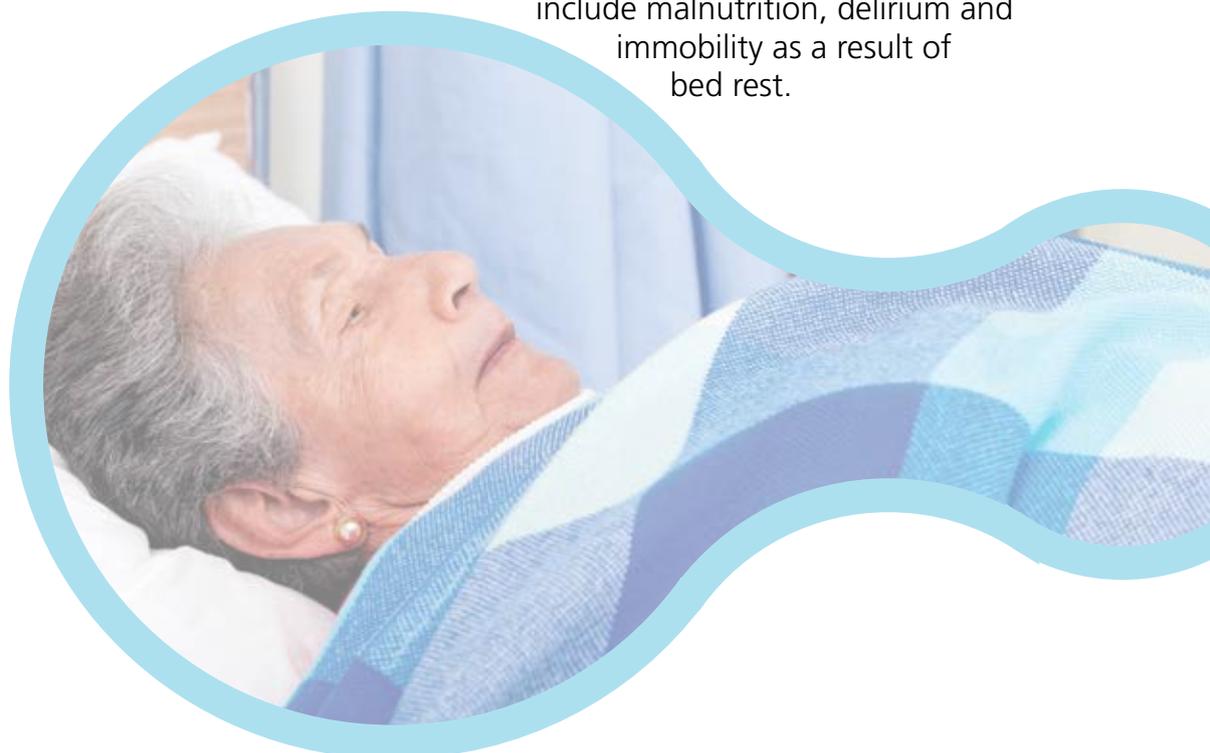
- Systematic, targeted case-finding. This includes using risk stratification, electronic case-finding tools and screening within primary and community settings.
- Proactive comprehensive geriatric assessment (CGA) and follow-up.
- An identified keyworker who acts as a case manager and coordinator of care across the system.
- General practices monitor hospitalisation and avoidable ED attendances regularly and determine whether alternative care pathways might have been more appropriate.
- Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role.
- Opportunities to participate in exercise are available to frail older people.
- Frail older people have access to services to prevent falls.
- A comprehensive service for those with dementia must be available and accessible.
- Services are available to reduce polypharmacy in frail older people.

Rapid support close to home in crisis:

- Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics.
- A comprehensive geriatric assessment initiated rapidly, within four hours of referral, 8am to 8pm, seven days a week.
- Ambulatory emergency pathways with access to multi-disciplinary teams should be available with a response time of less than four hours for older people who do not require admission but need ongoing treatment.
- Mental health services should contribute with specialist mental health assessments if appropriate.
- An interface or community geriatrician service is available to provide expert clinical opinion, clinical support and supervision to community teams and domiciliary care when needed to housebound patients.
- Rapid access ambulatory clinics available in acute and community hospital settings for the provision of rapid access to specialist advice from the multi-disciplinary team.
- A personalised care plan including emergency contingency plan, advanced care plan and the facility to allow a natural death order (if clinically appropriate) is in place and can be accessed by the patient and all services involved in their care and support.
- There are shared care protocols with ambulance organisations that can enable older people to remain at home.

Good acute hospital care when (and only when) needed:

- A simple referral system with a single point of access for frail older people.
- Expert decision makers are available at the front door of the acute hospital from 8am to 8pm, seven days a week. Specialist assessment should be available within 12 hours of admission, seven days a week.
- An identified Frailty Unit/Service should be available with staff trained how to look after frail focusing on rapid assessment, treatment and rapid discharge.
- The presence of one or more frailty syndromes should trigger a comprehensive geriatric assessment.
- Sufficient specialty and community hospital beds to look after all frail older patients with complex needs and enough relevantly trained staff to deliver high-quality care and assessment for them.
- Hospitals should have operational plans to reduce the number of ward moves, especially out of hours with accompanying plans to mitigate their adverse effects on continuity of care, reduction in harm and improved patient experience for frail older people.
- Adequate education and training for staff in all clinical areas focusing on care and compassion for frail older people
- Strategies to reduce avoidable unexpected mortality should be in place including physiological warning scores, critical care outreach, regular senior review and adequate access to high dependency beds.
- Older people must not be denied potential life-saving treatment such as emergency surgery, stroke thrombolysis or coronary revascularisation on the grounds of age alone.
- Hospitals incorporate organisational learning from safety incidents and near misses into operational policies, education and training and should encourage a culture of open reporting of safety incidents affecting older patients.
- Hospitals make safer care for older people a key priority, and safety strategies must include specific attention to the prevention and treatment of falls, pressure sores, hospital-acquired infection, medication errors and deep vein thrombosis, based on national guidance. However, hospitals must also have regard for some of the other potentially preventable harms of hospitalisation for older people. These include malnutrition, delirium and immobility as a result of bed rest.



Good discharge planning and post-discharge support:

- Patient, carers and families are involved in decision making from admission.
- Discharge to an older person's normal residence should be possible within 24 hours, seven days a week – unless continued hospital treatment is necessary.
- Older people should only be discharged from hospital with adequate support and with respect for their preferences.
- Older people being admitted following an urgent care episode should have an expected discharge date set within two hours.
- There is a hospital based multi-disciplinary team located at the front door of the hospital integrated with the community team focused on the facilitation of discharge.
- Care packages to support discharge should be available within 24 hours of referral to Adult Care and Support.
- Adequate and timely information must be shared between services whenever there is a transfer of care between individuals or services.
- When preparing for discharge, older people and carers should be offered details of local voluntary sector organisations, other sources of information, practical and emotional support including information on accessing financial support and re-ablement services.
- Voluntary sector services should be available to provide a 'welcome home' service for frail older people who live alone 7 days a week.

Good rehabilitation and re-ablement after acute illness or injury:

- Adequate and flexible provision of step-up and step-down home-based and bed-based rehabilitation and re-ablement services with enough capacity and responsiveness to meet the needs of everyone who might benefit.
- Shared assessment frameworks across health and social care should lead to a personalised care plan for each individual, where the individual and their carers are key participants in any decision made.
- Contracting and commissioning of services is done not on the basis of time periods and tasks, but on the outcomes desired for the person.
- Workforce required for home-based rehabilitation and re-ablement services should include an appropriate skill mix including nurses, therapists, social workers and community psychiatric nurses, voluntary and community groups, led by a senior clinician.

High-quality nursing and residential care for those who truly need it:

- All older people for whom long-term care is being considered have a comprehensive assessment of need, adequate treatment of medical problems which are precipitating decisions to move, adequate rehabilitation and wherever possible, are not 'placed' directly from acute hospital settings.
- Alternatives should all be fully considered. Telecare/AT options considered and optimised before move to care home.
- Assessments should not be a cause of delay in hospital.
- When a person is admitted to a care home, primary-care services should provide comprehensive geriatric assessment, personalised care planning in partnership with the person and planning for the future. Commissioners need to commission adequate primary care services to ensure this can happen effectively.
- Healthcare for care home residents is an actively commissioned service, with clear service specifications linked to quality standards detailed in contracts. The goal should be to provide high-quality, multi-disciplinary and multi-agency healthcare support for older people in long-term care.
- Adequate clinical training for care home staff; both registered and non-registered workers learning together on-site as part of an overall quality improvement programme.
- When a new resident moves into a care home, there needs to be a prompt transfer of clinical information to the care home.
- Comprehensive geriatric assessment should be carried out on admission and a personalised care plan put in place aimed at prevention of admission, optimising management of long-term conditions and ensuring the wishes of the resident are at the forefront of any decision made.

Choice, control and support towards the end of life:

- Structured approaches in care homes such as the Gold Standards Framework, with advance care plans, advance decisions and adequate choice, control and support towards the end of life.
- Tools are used systematically to identify frail older people at the end of their life.
- Advance care planning is not seen as a one-off event; communication with patients and families is a continuous process and should be made available to patients with and without mental capacity, fully involving carers/relatives in best interest decisions.
- Equitable access to specialist palliative care services for frail older people.
- Commissioners should use the BGS Commissioning Guidance: 'High Quality Health Care for Older Care Home Residents' (BGS, 2013) to specify the clinical and service priorities for meeting care home residents' needs.



5 Levers and incentives

Major drivers and incentives are being put in place to bring frailty management centre-stage in the two-year and five-year planning cycles for the NHS. Working with local authorities and under the auspices of Health and Wellbeing Boards, commissioners are well placed to focus use of the Better Care Fund on transforming the care of older people, reducing duplication, driving healthcare closer to home, and focusing on primary and secondary prevention as set out in the NHS England Planning Guidance 'everyone counts planning for patients 2014/15 to 2018/19'.

Aligning incentives and contracting requirements across a whole-system frailty pathway, including primary as well as acute, community and mental health providers, will help drive the required system changes.

Primary care

Changes to the GP contract in 2014/15 mean there will be an enhanced service for avoiding unplanned admissions that require case management of vulnerable patients; personalised care planning; and a named accountable GP and care coordinator.

Primary care commissioners should ensure that the needs of frail older people are at the heart of their commissioning. Older people with frailty are most in need of medical continuity and will have significant medical requirements. Primary care commissioners should show that they understand and resource these issues, including ensuring GPs provide adequate medical support to care home residents.



CQUINs for providers

Setting a range of CQUINs with providers at critical points of the frailty pathway will help resource and embed service redesign. It is strongly suggested that CQUINs should be developed that encompass:

- Establishment of case-finding in primary care and a register of frail older people.
- Systematic screening for frailty in people over the age of 75 in primary care, at hospital admission and in the community setting.
- Comprehensive geriatric assessment using shared templates across all providers.
- Personalised care planning, shared across all organisations.
- Development of seven-day services to support frail older people close to home.
- The training of the voluntary sector in simple frailty screening, and the establishment of referral pathways, by community services.
- Same-day discharge of frail older people using discharge to assess methodology.

CQUINs relating to frailty should be based on recognised evidence. NICE Quality standards for dementia, hip fracture, mental wellbeing of older people in care homes and stroke can be found at: <http://www.nice.org.uk/guidance/qualitystandards/QualityStandardsLibrary.jsp>

Developing the workforce

Health Education England is responsible for delivering a better health and healthcare workforce nationally and locally, and is responsible for the education, training and personal development of staff, including recruiting for values. Caring for frail older people and those with dementia is one of its key strategic priorities in the context of the population's age profile and the future projections for care provision that this brings.

Commissioners and providers working through their LETBs have the opportunity to commission the delivery of education to improve the skills and pre- and post-graduate education of all health and healthcare workers who care and provide treatment for people with frailty, from prevention through to end-of-life care.

National Community Nursing Strategy Programme

In order to rise to the challenge of delivering complex care close to home, to improve outcomes for people with long-term conditions, and to manage increasing growth in the older population, the role of community and practice nurses moves centre stage.

A national Community Nursing Strategy is currently under development, led by Jane Cummings, Chief Nursing Officer for NHS England. This will provide an important underpinning framework for commissioning organisations to work with providers in configuring an effective and adequately skilled and resourced community and practice nurse workforce.



6 Measuring outcomes

Measurement is critical to the effective evaluation of any commissioning intervention; it is crucial that good measures are identified and reviewed from the beginning of the commissioning process. This is not only important in the context of final evaluation, but also in identifying areas for improvement and evidencing whether a change or intervention is a success.

Outcome measures are of key importance, but process and balancing measures should not be excluded. These can be very useful in determining effective change and action in the short term, especially where an intervention is particularly complex or where outcome measures can take a long time to determine.

It is recommended that measures to evaluate the implementation of any frail older people's pathways are based on the following categories:

- **Patient experience:** where patients themselves have provided feedback on the quality or effectiveness of the service they have received.
- **Harm reduction:** where outcome measures indicate whether harm to frail older patients has occurred.
- **Quality of life:** whether or not frail older patients are able to maintain reasonable quality of life after contact with health services.
- **Systems supporting older people:** where measures relate to the systems that treat frail older patients, and whether these support improvements in care.
- **Financial:** where indicators show any savings released as a result of changes to the pathway.



Category	Measure
Patient experience	Support to self-manage long-term conditions (LTCs)
Patient experience	GP listening with care and concern
Harm reduction	Pressure ulcer incidence
Harm reduction	Harm from medication errors
Quality of life	Discharge rates to usual place of residence
Quality of life	Proportion of patients with fragility fractures recovering to their previous levels of mobility/walking ability at 120 days
Systems supporting older people	Emergency readmissions: 30 and 90 day
Systems supporting older people	Length of stay: key LTCs, without dementia
SUS	Cost of emergency readmissions in over 65s
SUS	Cost of excess bed days

The table above gives some suggested measures which are already recorded within the health system. There is a need to develop a balanced scorecard of outcome measures relating to frail older people and their care. In order to evaluate the impact of an integrated, 'end-to-end' pathway, this should include those from the NHS Outcomes Framework, the Social Care Outcomes Framework and the Public Health Outcomes Framework. Future work on developing a specific set of quality measures with financial modelling is planned for later in 2014.



7 Examples of good practice

In July 2013 NHS England, along with partners, launched a national Call to Action setting out the challenges and opportunities faced by health and care systems across the country. The need to find ways of raising the quality of care while managing a funding gap of £30 million requires radical action to find innovative and creative ways of shifting activity and resource from the hospital sector to the community. The evidence is strong that by implementing an end-to-end frailty pathway across whole health and care systems, as described in this guide, such a shift is possible.

Pioneer site case studies

Fourteen pioneer sites have recently been announced by the Government to transform the way health and care is being delivered to patients by bringing services closer together than ever before.

The fourteen sites are pioneering new ways of delivering coordinated care. The aim is to make health and social care services work together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

It is intended that learning from this process will be shared nationally, with the aim of making integrated care and support the norm and to end disjointed care.

A number of the sites have a focus on improving integrated care for older people. These are detailed on the following pages.



Cheshire

Connecting Care across Cheshire will join up local health and social care services around the needs of local people and remove organisational boundaries that can get in the way of good care. Local people will only have to tell their story once – rather than facing repetition, duplication and confusion. The programme will tackle issues at an earlier stage before they escalate to more costly crisis services and there will be a particular focus on older people with long-term conditions and families with complex needs.

CONTACT:

laurence.ainsworth@cheshirewestandchester.gov.uk

Cornwall and Isles of Scilly

Fifteen organisations from across health and social care, including local councils, charities, GPs, social workers and community service will come together to transform the way health, social care and the voluntary and community sector work together.

NHS Kernow (Cornwall and Isles of Scilly Clinical Commissioning Group) is planning to commission an 'end-to-end' integrated frailty pathway from April 2014. In order to achieve this, commissioning intentions have been signalled clearly to providers. Having gained pioneer status, it is hoped that some of the proposed flexibilities in contracting will enable this to happen at scale and pace. The following preparatory steps have been taken:

- A cross-organisational frailty pathway steering group has been established with effective clinical leadership and programme management support.
- A definition of frailty and a high-level frailty model and pathway have been agreed.
- Principles for thresholds for access to services are being considered and interventions across the elements of the pathway have been identified.
- Providers are mapping current services to the pathway in order to identify duplication and potential gaps.

- Approaches to case-finding of frail older people have been identified and now need to be piloted in practice.
- High-level cross-organisational standards have been developed across the pathway and will inform commissioning intentions and be played into contracts.
- Plans have been made for the frailty cohort to be mapped, based on an assumptive model against age cohorts from 75 years upwards at practice level, costs and activity across acute/community hospital.
- A standardised CGA template and personalised care plan is under development for use across all organisations as a shared assessment. An electronic portal is being developed to facilitate information-sharing.

CONTACT:

zoe.howard@kernowccg.nhs.uk

Greenwich

Teams of nurses, social workers, occupational therapists and physiotherapists work together to provide a multi-disciplinary response to emergencies arising within the community which require a response within 24 hours. The team responds to emergencies to which they are alerted within the community at care homes, A&E and through GP surgeries, and handle those which could be dealt with through treatment at home or through short-term residential care.

Over a two-and-a-half-year period, over 2,000 patient admissions were avoided due to immediate intervention from the Joint Emergency Team (JET). There were no delayed discharges for patients over 65 and over £1m has been saved from the social care budget.

CONTACT:

andrew.stern@royalgreenwich.gov.uk

Islington

Islington Clinical Commissioning Group and Islington Council are working together to ensure

local patients benefit from better health outcomes. They are working with people to develop individual care plans, looking at their goals and wishes around care and incorporating this into how they receive care. They have already established an integrated care organisation at Whittingdon Health, better aligning acute and community provision.

Patients will benefit from having a single point of contact rather than dealing with different contacts, providing different services. Patients will feel better supported and listened to.

CONTACT:
kathleen.kelly@nelcsu.nhs.uk

Leeds

Leeds is aiming to go 'further and faster' to ensure that adults and children in Leeds experience high-quality and seamless care. Twelve health and social care teams now work in Leeds to coordinate the care for older people and those with long-term conditions.

The NHS and local authority have opened a new joint recovery centre offering rehabilitative care – to prevent hospital admission, facilitate earlier discharge and promote independence. In its first month of operation, it saw a 50% reduction in length of stay at hospital. Patients will also benefit from an innovative approach which will enable people to access their information online.

CONTACT:
stuart.robinson@leeds.gov.uk

Kent

In Kent, the focus will be around creating an integrated health and social care system which aims to help people live as independent a life as possible, based on their needs and circumstances. By bringing together CCGs, Kent County Council, District Councils, acute services and the voluntary sector, the aim will be to move to care provision that will promote greater independence for patients, while reducing care home admissions. In addition, a new workforce with the skills to deliver

integrated care will be recruited.

Patients will have access to 24/7 community-based care, ensuring they are looked after well but do not need to go to hospital where this is appropriate. A patient-held care record will ensure the patient is in control of the information they have so that they are able to manage their condition in the best way possible. Patients will also have greater flexibility and freedom to source the services they need through a fully integrated personal budget covering health and social care services.

CONTACT:
jo.toscano@kent.gov.uk

North West London

The care of North West London's two million residents is set to improve with a new drive to integrate health and social care across the eight London boroughs. Local people will be supported by GPs who will work with community practitioners, to help residents remain independent. People will be given a single point of contact who will work with them to plan all aspects of their care taking into account all physical, mental and social care needs.

Prevention and early intervention will be central – by bringing together health and social care far more residents will be cared for at or closer to home, reducing the number of unplanned emergency admissions to hospitals. The outcomes for patients and their experiences of care are also expected to increase. Financial savings are also expected, with the money saved from keeping people out of hospital when admission is unnecessary being ploughed back into community and social care services.

CONTACT:
sg@londoncommunications.co.uk

South Devon and Torbay

South Devon and Torbay already has well-coordinated or integrated health and social care but as a pioneer site now plans to offer people

joined-up care across the whole spectrum of services, by including mental health and GP services. They are looking at ways to move towards seven-day services so that care on a Sunday is as good as care on a Monday – and patients are always in the place that's best for them.

Having integrated health and social care teams has meant patients having faster access to services; previously, getting in touch with a social worker, district nurse, physiotherapist and occupational therapist required multiple phone calls, but now all of these services can be accessed through a single call. In addition, patients needing physiotherapy only need to wait 48 hours for an appointment – an improvement from an eight-week waiting time.

CONTACT:
sallie.ecroyd@nhs.net

Southend

Southend's health and social care partners will be making practical, ground-level changes that will have a real impact on the lives of local people.

They will improve the way that services are commissioned and contracted to achieve better value for money for local people with a specific focus on support for frail older people and those with long-term conditions. They will also look to reduce the demand for urgent care in hospitals so that resources can be used much more effectively. Wherever possible they will reduce reliance on institutional care by helping people maintain their much-valued independence.

By 2016 they will have better integrated services, which local people will find simpler to access, and systems that share information and knowledge between partners far more effectively. There will be a renewed focus on preventing conditions before they become more acute and fostering a local atmosphere of individual responsibility, where people are able to take more control of their health and wellbeing.

CONTACT:
hayleypearson@southend.gov.uk

South Tyneside

People in South Tyneside are going to have the opportunity to benefit from a range of support to help them look after themselves more effectively, live more independently and make changes in their lives earlier.

In future GPs and care staff, for example, will have different conversations with their patients and clients, starting with how they can help the person to help themselves and then providing a different range of options including increased family and carer support, voluntary sector support and technical support to help that person self-manage their care.

There will be changes in the way partners organise, develop and support their own workforces to make it possible to deliver these improvements and a greater role for voluntary sector networks.

CONTACT:
samantha.start@southtyneside.gov.uk

Waltham Forest, East London and City

The Waltham Forest, East London and City (WELC) Integrated Care Programme is about putting the patient in control of their health and wellbeing. The vision is for people to live well for longer leading more socially active independent lives, reducing admissions to hospital, and enabling access to treatment more quickly.

Older people across Newham, Tower Hamlets and Waltham Forest will be given a single point of contact that will be responsible for coordinating their entire healthcare needs. This will mean residents will no longer face the frustration and difficulty of having to explain their health issues repeatedly to different services.

CONTACT:
savaia.stevenson@nelcsu.nhs.uk

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Authors

Helen Lyndon RN MSc, Nurse Consultant Older People and Long Term Conditions – Kernow Clinical Commissioning Group, Peninsula Community Health Services

Kate Cheema MSc, Head of Service Commissioning, Quality Observatory

Carol Williams RN, MSc, Director of Nursing, NHS England Devon Cornwall and Isles of Scilly Area Team

Thanks and Acknowledgements to the Frailty Steering Group

Marie Batey, Head of Acute Services and Older People, Nursing Directorate of NHS England

Clare Chivers, Deputy Director of Education and Quality, Health Education South West

Sarah Elliott, Director of Nursing, NHS England Wessex Area Team

Russell Emeny, Director, NHS Emergency Care Intensive Support Team NHS IMAS

Karen Grimshaw, Nurse Consultant Older People, Plymouth Hospitals NHS Trust and Nurse Executive, Governing body of South Devon and Torbay CCG

Dr Anthony Hemsley, Consultant Geriatrician, Royal Devon and Exeter NHS Foundation Trust

Dr Dafydd Jones, Western Locality GP Clinical Lead for Frailty, New Devon CCG

Sam Lee, Patient Safety Lead, NHS England Wessex Area Team

Sharon Matson, Western Locality Head of Commissioning, New Devon CCG

Philippa Potter, Assistant Director of Nursing, NHS England South

Dr Phil Taylor, Axminster Medical Practice and Eastern Locality Frailty Clinical Lead, New Devon CCG

Professor John Young, National Clinical Director for Integration and Frailty

