Improving healthcare support in care homes

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NCD Older People
‘It's not how old we are but how we are old’
What we’re doing

- Promotion of electronic frailty index and additional information within summary care record
- Economic modelling of impact of frailty
- Care homes commissioning guidance
- NICE multi-morbidity clinical guideline
- Serious illness care programme
- Rightcare LTC Commissioning for Value
Projected UK age structure

ONS, 2015 (latest)

www.england.nhs.uk
Ageing population

- Older population expansion in England will accelerate next 20 years

- Over 65s will from 17% (2010) to 23% by 2035

- England in 2014: 9.5 million aged 65+; 471K aged 90+

- By 2035 there will be 14.5 million 65+ and 1.1 million 90+

- 15 million live with a long term condition (LTC)

- 58% people with a LTC are over 60 (14% under 40)
Ageing population-hospitals

- A&E attendances by people aged 60+ by two thirds 2007 to 2014
- 2010-15: 18% ↑ in emergency hospital older people admissions
- 62% bed days occupied by people aged +65 (NAO 2016)
- Bed occupancy >91% in Q4 2015-16 (CQC 2016)
- Care homes will remain important part of health infrastructure
Projected spend on health & elderly care as % of GDP

3 scenarios with & without assumptions about improvements in technology

Source: Ministry of Health and Social Affairs Sweden (2010)
Health and unpaid care

Over 65s report poorer health and provide a growing amount of unpaid care.

73% people >65 with disability receive care from a family member.

‘Verticalised’ families: more generations are alive simultaneously.

2007 to 2032 people >65 who require unpaid care is projected to have grown by >1 million.

For people >70 the primary challenge will be maintaining physical connectivity.
Health and unpaid care

- Over 65s report poorer health and provide a growing amount of unpaid care
- 73% people >65 with disability receive care from a family member
- ‘Verticalised’ families: more generations are alive simultaneously
- 2007 to 2032 people >65 who require unpaid care is projected to have grown by >1 million
- For people >70 the primary challenge will be maintaining physical connectivity
## Health and unpaid care

### Reported good health in the household population
- **Under 65:** 88% good, 12% not good
- **65 and over:** 50% good, 50% not good

The proportion of the household population aged 65+ with a long-term health problem or disability has increased; older people are remaining in households rather than moving to communal establishments.

### Activity limiting long-term health problem or disability in the household population
- **2011:**
  - Under 65: 11%
  - 65 and over: 52%
- **2001:**
  - Under 65: 12%
  - 65 and over: 50%

There has been a corresponding increase in the older population providing unpaid care.

### Hours of unpaid care provided per week: age 65+

<table>
<thead>
<tr>
<th>Year</th>
<th>1 - 19 hours</th>
<th>20 - 49 hours</th>
<th>50+ hours</th>
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<tbody>
<tr>
<td>2011</td>
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### Key Points
- Over 65s report poorer health and provide a growing amount of unpaid care.
- 73% people >65 with disability receive care from a family member.
- ‘Verticalised’ families: more generations are alive simultaneously.
- 2007 to 2032 people >65 who require unpaid care is projected to have grown by >1 million.
- For people >70 the primary challenge will be maintaining physical connectivity.
Hypotheses: evolution of healthy life expectancy

- **Expansion of morbidity/disability**
  - Year 2007
  - Year 2060

- **Dynamic equilibrium**
  - Year 2007
  - Year 2060

- **Compression of morbidity/disability**
  - Year 2007
  - Year 2060

- Increase in life expectancy

Legend:
- Yellow: years spent in good health
- Blue: years spent in bad health (with morbidity/disability)
Hypotheses: evolution of healthy life expectancy

Find → Recognise → Assess → Intervene → Long-term

Expansion of morbidity/disability

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Dynamic equilibrium

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Increase in life expectancy

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- **Dynamic equilibrium**
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Increase in life expectancy
### 5YFV: Older People

- **Focus on prevention**
- **Integration of care**
- **Stronger community services**
- **Lead role of GPs**

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www.england.nhs.uk
5YFV: Older People

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- Prevent *modifiable* aspects of unhealthy ageing & *unnecessary* hospital admission
- Enabling people *greater control* of their care: shared health & social care budgets
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- Support communities to choose *effective new care delivery options* which *integrate out of hospital care, primary care & other community based providers*
- Improve support to older people in care homes
GPFV: Older People

- Greater focus on prevention
- Better integrated
- Stronger community services
- Lead role of GPs

- Contractual measures: **improve hospital/GP interface**

- Support people living with long term conditions to self care: **early frailty**
  - Care planning
  - Local community pharmacy pathways to promote self care

- Voluntary sector organisation support to GP through **social prescribing**: call off services

- Develop digital interoperability to give **access to a shared primary care record**
  - Summary care records access in community pharmacies
  - Accelerated access to patient records across different services
  - Permit healthcare professionals in different settings to update & inform practices
## GPFV: Older People

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- Better integrated
- Stronger community services
- Lead role of GPs

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Frailty as a Long Term Condition

- A long term condition can be **diagnosed**, is **not curable** but can be **managed** and **persists**

- As resilience is lost, care and support planning assumes greater importance through to the end of life

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**CARE & SUPPORT PLANNING**

**RESILIENCE**

**PREVENTION**

**END OF LIFE**

**INCREASING FRAILTY**
Frailty as a Long Term Condition

- A long term condition can be *diagnosed*, is *not curable* but *can be managed* and *persists*

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Potential Frailty Interventions

Symptom relief
Setting patient-centered goals
Family and caregiver support

Exercise interventions

Comprehensive geriatric assessment and treatment
Geriatric evaluation and management (GEM)

GEM and Adult Care for Elders units,
programs for acute care for the elderly

Hospice care, maintain comfort and dignity

Increasingly frail
Potential Frailty Interventions

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Care homes?
Ageing population-care homes

- One in six people aged +85 live permanently in a care home: 4% aged +65
- Care homes beds outnumber hospital beds by 3:1: key system asset
- Care homes play a vital role in:
  - Permanent care
  - Facilitated hospital discharge
  - Rehab and recovery
  - Respite care
  - End of life care
- Key role in hospital admissions avoidance & early supported discharge
Commissioning Guidance

- Structured care homes support: ↑ from estimated 40% coverage

- Coordinated action across all elements of EHCH model: consistency

- Targeted at CCGs, providers, local authorities

- MCP, PACs where whole population model of care in place

- A dedicated system of care comprising:
  - Medical
  - Nursing
  - Allied health professional
  - Integrated with specialists:
    - Geriatricians
    - Mental health
    - Palliative care
Collaboration towards End of Life

Find ➔ Recognise ➔ Assess ➔ Intervene ➔ Long-term

Frailty Care

Specialist palliative care

Last year of life  Months  Weeks  Days  Death  Bereavement

Increasing complexity

End of life care

Bereavement care

*SPC Commissioning Guidance December 2012
Structured Care Homes Support

Key attributes

- **Proactive** optimised resident-centred LTC assessment, management
- **Proactive** resident centred care planning
- **Coordinated:** all system parts work together and talk to each other
- **Capability for 24/7 response** to unplanned changes in resident condition
Key Elements

- **Primary care**
  - Alignment to General Practice and proactivity
  - Medication review
  - Hydration and nutrition
  - Urgent care

- **Multi-disciplinary team support**
  - Expert advice & care for those with complex needs
  - Care navigation (people and professionals)

- **Reablement & rehabilitation**

- **End of life care**
  - Advance care planning
  - Palliative care skills and knowledge
  - Dementia care

- **Joined up commissioning & collaboration: health & social care**

- **Workforce & skills development**

- **Data and technology**
  - EPaCCS
  - Telemedicine
Onwards and upwards
Dawn Moody

Associate NCD Older People
West Midlands GP Access Fund Project:
Frailty Work Stream

Improving care for care home residents as part of an integrated approach to frailty in primary care
People with frailty, whatever their place of residence, have most to gain from integrated and person-centred care.
Making our health and care systems fit for an ageing population

The Kings Fund, 2014
‘Fit for Frailty’
The British Geriatric Society, 2014/2015

- Advice and guidance on the recognition and management of frailty in community and outpatient settings

- Advice and guidance on the development, commissioning and management of services for people living with frailty in community settings
‘Fit for Frailty’ – Implementation

**Clinical Development**

**Identifying frailty**

Older people should be assessed for frailty during all encounters with health and social care personnel.

Identifying frailty at practice level using existing health record data is an emerging possibility.

**Managing frailty**

Ensure access to CGA, coordinated care planning and holistic multi-disciplinary interventions.

Integrated care pathways; appropriate alternatives to hospital admission; avoid delayed transfers of care.
‘Fit for Frailty’ – Implementation

**Systems Management**

**Managing services**
- Develop **training and education** packages for local needs, to enable multi-professional and cross-organisational delivery of care for frailty
- **Evaluation** must be an integral part of service design and delivery

**Developing and commissioning services**
- Develop ‘**whole system**’ frameworks using new structures and flexible workforce development to overcome traditional boundaries in care
- Establish **integrated contractual frameworks** and collaborative commissioning to support / reinforce provider innovation
GP Access Frailty Work stream

Key Objectives

• Developing a workforce that is ‘Fit for Frailty’

• Improving access to Comprehensive Geriatric Assessment in the community

• Reducing inequality of care through integrated service design
Frailty Awareness Sessions

110 participants
48 different organisations
Included care home staff

Day-long events
3x2 hr sessions
Shrewsbury & Telford

99% rated events as good or excellent
New Academic Course Developed

School of Medicine
Diploma in Medical Science

To find out more visit: www.keele.ac.uk/pgcourses/ or email: nz.parks@keele.ac.uk
New ‘Frailty GP’ roles created

- Employed by Shropdoc
- 2 days per week
- Attracted experienced GPs
- Masters level training
- Clinical service delivery
- Clinical leadership roles
- Training colleagues in primary care and care homes
- Huge potential future asset to Local Health Economy
Offer CGA in community settings

Initially in care homes

Challenges

Opportunities

Role of technology

Assessing Frailty: Comprehensive Geriatric Assessment

Comprehensive Geriatric Assessment (CGA) is recognised as the gold standard for the care of people with moderate to severe frailty. There is evidence that CGA carried out in the community reduces the risk of admission both to hospital and to nursing homes for older people with frailty.
Next steps

Systems Management

Managing services

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Thank You

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