

Making our health and care systems fit for an ageing population

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Published by
The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
www.kingsfund.org.uk

© The King's Fund 2014

First published 2014 by The King's Fund

Charity registration number: 1126980

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ISBN: 978 1 909029 27 9

A catalogue record for this publication is available from the British Library

Available from:
The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Edited by Kathryn O'Neill

Typeset by Grasshopper Design Company

Printed in the UK by The King's Fund

Contents

Acknowledgements	iv
About the authors	v
Key messages	vi
Introduction	1
1 Healthy active ageing and supporting independence	5
2 Helping people to live well with simple or stable long-term conditions	10
3 Helping people live with complex co-morbidities, including dementia and frailty	15
4 Rapid support close to home in times of crisis	22
5 Good acute hospital care when needed	27
6 Good discharge planning and post-discharge support	33
7 Good rehabilitation and re-ablement (outside acute hospitals) after acute illness or injury	38
8 High-quality, long-term nursing residential care for those who need it	42
9 Choice, control, care and support towards the end of life	48
10 Making it happen – integrated care to support older people and their families	54
References	59

Acknowledgements

The authors would like to thank Laura Bennett, James Thompson, David Buck and Duncan Hockey for their contributions to the paper, and are also grateful to those who took time to offer insightful comments on earlier drafts, notably colleagues leading services in Greater Manchester, Cornwall and Buckinghamshire and colleagues in The King's Fund – Chris Ham, Nicola Walsh and Candace Imison. Particular thanks go to our external reviewers, Professors John Young, Ian Philip and Jon Glasby, Dr Martin Bardsley and Dr David Paynton.

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Previously David was the government's National Clinical Director for Older People at the Department of Health, was seconded to the Civil Service from 2010 to 2013, and before that was a specialist clinical adviser in the Department of Health. He is a past secretary and current president-elect of the British Geriatrics Society and chair of the Royal College of Physicians Speciality Committee for Geriatric Medicine.

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Key messages

Improving services for older people requires us to consider each component of care, since many older people use multiple services, and the quality, capacity and responsiveness of any one component will affect others. The key components we have set out in this paper are:

- healthy, active ageing and supporting independence
- living well with simple or stable long-term conditions
- living well with complex co-morbidities, dementia and frailty
- rapid support close to home in times of crisis
- good acute hospital care 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 need it
- choice, control and support towards the end of life
- integration to provide person-centred co-ordinated care.

Within each component, we present evidence and guidance for how to provide high-quality care, with examples of local innovations. Key issues include the use of comprehensive geriatric assessment at the right time, and the effective provision of co-ordinated primary, community and social care services close to home.

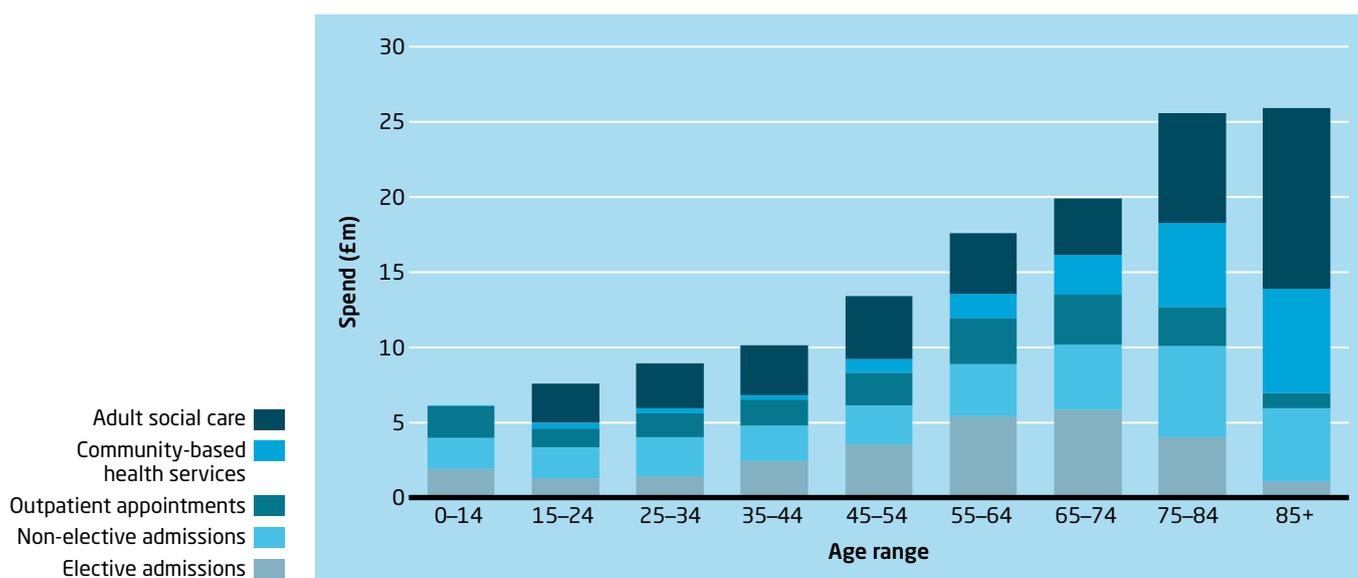
- Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time.
- Incremental, marginal change is not sufficient; change is needed at scale and at pace. This paper does not aim to address the barriers and opportunities that can respectively hinder or help bring about this service transformation, although those of course exist. Instead, it aims to give local service leaders in England and beyond a framework and tools to help them examine and improve the services they provide for older people.

Introduction

When the NHS was founded in 1948, 48 per cent of the population died before the age of 65; that figure has now fallen to 14 per cent ([Office for National Statistics 2011b](#)). Life expectancy at 65 is now 21 years for women and 19 years for men ([Office for National Statistics 2013c](#)), and the number of people over 85 has doubled in the past three decades ([Office for National Statistics 2013e](#)). By 2030, one in five people in England will be over 65 (House of Lords 2013).

This success story for society and for modern medicine has utterly transformed our health and care needs. Many people stay healthy, happy and independent well into old age, and there is mounting evidence that tomorrow's older people will be more active and independent than today's (Spijker and MacInnes 2013). However, as people age, they are progressively more likely to live with complex co-morbidities, disability and frailty. People over 65 account for 51 per cent of gross local authority spending on adult social care ([Health and Social Care Information Centre 2013c](#)) and two-thirds of the primary care prescribing budget, while 70 per cent of health and social care spend is on people with long-term conditions ([Department of Health 2013c](#)). The data from Torbay presented in Figure 1 emphasises how, across all services, activity and cost increase with age.

Figure 1 Annual cost* by age and service area for Torbay (population 145,000), 2010/11



*Costs of primary care and prescribing are not included
Source: Torbay Care Trust (reproduced with permission)

Health and care services have failed to keep up with this dramatic demographic shift. The NHS has designed hospital medical specialties around single organ diseases. Primary care consultations and payment systems do not lend themselves to treating patients with multiple and complex conditions (Beales and Tulloch 2013; Roland 2013). Common conditions of older age receive less investment, fewer system incentives, and lower-quality care than general medical conditions prevalent in mid-life (Steel *et al* 2008; [Melzer *et al* 2012](#)). There is substantial evidence of ageism and age discrimination in health and care services, ranging from patronising behaviour to worse access to treatment (Centre for Policy on Ageing 2009a, 2009b, 2009c). In addition, capacity in the community for the intermediate care and support services that help older people to remain well, manage crises, and recover from acute episodes is hugely variable and generally inadequate for demand ([NHS Benchmarking 2013](#)).

This paper is designed as a high-level resource and reference guide for local service leaders who want to improve care for older people. Within each component of care we describe the goal that the system should aim for and then present key evidence about what we know can work, selected examples of local good practice, pointers to major reviews and guidelines, and advice about where to start.

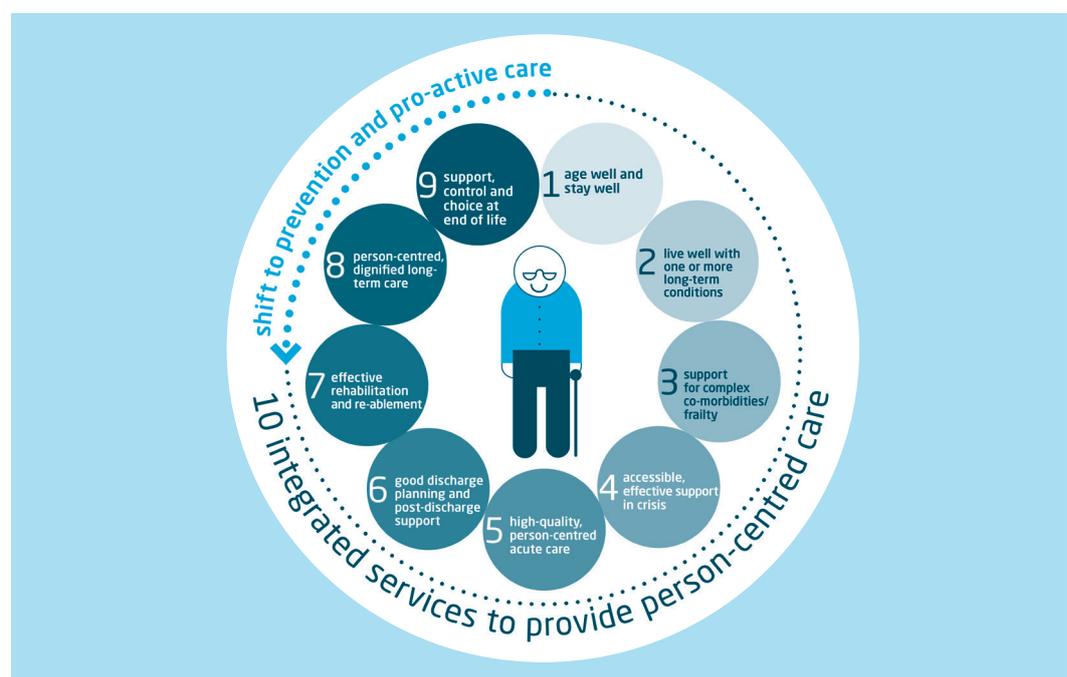
Although the paper refers to numerous systematic reviews, we did not use this methodology in writing the document, relying instead on the authors' own knowledge of the literature and other expertise on high-quality services. This was augmented by inputs from external reviewers, other experts within The King's Fund, and leaders in the health and care community, thus bringing together a wide range of resources and good practice. Where the evidence is sometimes incomplete or contradictory, we have stated this explicitly.

For each component of care, we have used the phrase 'what we know can work' because no service innovation or improvement initiative can simply be 'dropped in' and expected to deliver if the local systems, culture and leadership are not conducive to change.

The paper is structured around nine components, followed by a final, overarching component (integrated care centred around the individual's needs) that binds the others together. The components of care covered in the paper are set out in Figure 2 below, all contributing to an overall goal of high-quality, person-centred co-ordinated care for older people that focuses on maintaining health and independence.

By concentrating on components of care rather than over-specifying where care should be provided or who should provide it, we have aimed to focus on older people and their needs rather than service structures. There are multiple interdependencies and transitions between components and, in some cases, one team or organisation might provide several of them. For example, as our population ages, there is a considerable overlap between living with and dying from various conditions, and this is reflected in the concept of end-of-life care currently in use; this incorporates care for those who are nearing their final years, months and weeks of life – not just those who are in the final days of life (General Medical Council 2010).

Figure 2 Ten components of care for older people



When we consider what is required to improve quality of care for older people, we need to look beyond the narrow definition given by Lord Darzi in the NHS Next Stage Review – which centred on effectiveness, safety and experience ([Department of Health 2008](#)) – to encompass the broader domains of access, efficiency and equity, including freedom from (age-based) discrimination ([Institute of Medicine 2001](#)). For older people using multiple services, continuity and co-ordination are also key components of quality ([National Voices 2013](#)).

In addition, given current pressures on the NHS, we must strive wherever possible to ‘shift the curve’ from high-cost, reactive and bed-based care to care that is preventive, proactive and based closer to people’s homes, focusing as much on wellness as on responding to illness. When asked what they value in terms of wellbeing and quality of life, older people report that health and care services when they become ill or dependent are only part of the story. Many other things matter: the ability to remain at home in clean, warm, affordable accommodation; to remain socially engaged; to continue with activities that give their life meaning; to contribute to their family or community; to feel safe and to maintain independence, choice, control, personal appearance and dignity; to be free from discrimination; and to feel they are not a ‘burden’ to their own families and that they can continue their own role as caregivers (Tadd *et al* 2010; [Personal Social Services Research Unit 2010](#); [Nazroo and Matthews 2012](#)).

These priorities largely mirror those expressed by adults of all ages. We need to recognise that helping older people to achieve such goals should be a key mission of the health and care services we describe here and that such services are only one factor and do not sit in isolation. A range of other people and partners in local communities are important in helping older people to help themselves remain well and independent, as recognised by ‘asset-based’ approaches to wellbeing ([Glasgow Centre for Population Health 2011](#)). Even within health services, there is a growing focus in primary care on supported ‘self-management’ – enabling people and their families to reduce their risk of developing new long-term conditions or to live more comfortably with existing ones (Mathers *et al* 2011). We know that older people or those experiencing some of the conditions common to ageing are far less likely to receive such support (Steel *et al* 2008; [Melzer *et al* 2012](#)).

This paper can be used by local service leaders or practitioners who simply want to improve one or two components of care in a focused way. However, we hope that it will mainly be used by cross-agency, inter-professional groups wishing to improve quality and integration in services for older people across their local health economy. How can they do this effectively?

- By ‘walking the journey of care’ from prevention right through to the end of life.
- By agreeing an overarching vision and some key standards that all agencies can sign up to.
- By involving older people and their carers in service redesign from the outset and by looking at all the interfaces, transitions, duplications and interdependencies between the care components.
- By agreeing some outcome measures that define the performance of individual services but, more importantly, whole systems of care for older people.
- By building in outcomes that measure what older service users most value.
- By implementing best practice or ‘what good looks like’ in every component of care.

We have set this out in detail in the final and most important section of the paper, which discusses closer integration of care.

If we can get health and care systems and services right for our older population – those with the highest complexity, activity, spend, variability, and use of multiple services – we should help get it right for other service users. The twin challenges of demography and funding demand no less.

If this all seems aspirational or unattainable in the current climate, we should be encouraged by the fact that for every pair of good practice examples we have showcased from frontline services in the UK, we could have picked several more. Local service leaders are already innovating, implementing and transforming services for older people. What we need now is to disseminate their experiences and the lessons learnt so that those models can be adopted more widely, making the rest as good as the best. We hope this paper helps the cause.

1 Healthy active ageing and supporting independence

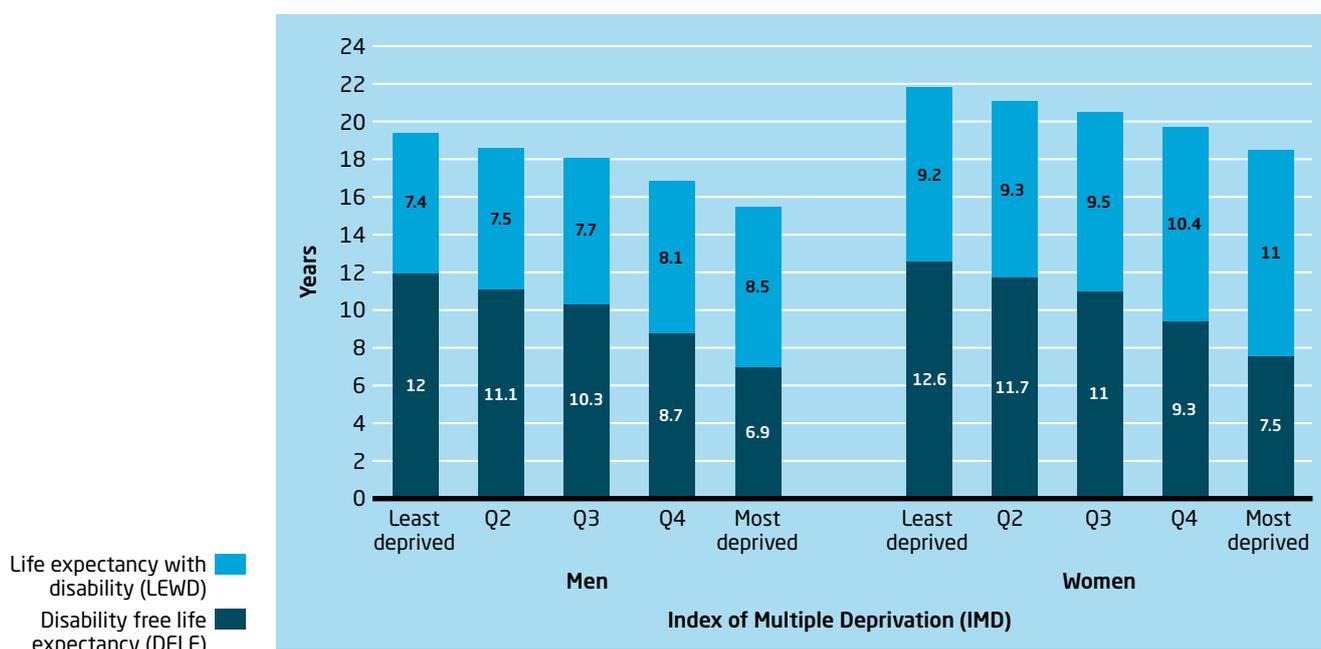
Goal

Older people should be able to enjoy long and healthy lives, feeling safe at home and connected to their community.

The current situation

- Life-course strategies for public health and health inequalities have tended to focus on children and working-age adults rather than older people; in England, local health and wellbeing strategies have tended not to prioritise older people (Humphries and Galea 2013).
- There remain major inequalities in both absolute life expectancy and healthy life expectancy at 65, and in rates of premature mortality before 75 (Office for National Statistics 2011a) (see Figure 3).
- 11 per cent of people over 75 report feeling isolated, and 21 per cent feel lonely (Banks *et al* 2008).
- In England in 2012/13 there were 31,100 excess winter deaths – an increase of 29 per cent on the previous winter. Most excess deaths occurred in people aged 75 and over (Office for National Statistics 2013a).
- 34 per cent of people aged 65–74 are obese (Scarborough *et al* 2010), and only 8 per cent of women over 75 take the recommended levels of physical activity (NHS Information Centre 2009).
- Uptake of influenza and pneumococcal vaccinations is below the levels set by international targets and national guidance (Michel *et al* 2009; World Health Organization 2009; Public Health England 2013b).

Figure 3 Life expectancy with disability (LEWD) and disability free life expectancy (DFLE) for men and women at age 65, by Index of Multiple Deprivation (IMD) 2007 quintile, England, 2006-08



Source: Office for National Statistics 2011a

What we know can work

Life-course approaches to health and wellbeing that address the wider determinants of health

As the Marmot Review on health inequalities (2012) made clear, a person's health and wellbeing in later life are affected by determinants of health over the course of their life, such as education, poverty, housing and employment, as well as healthy lifestyles and health care. So interventions throughout the life course affect people in older age. And just as with health and wellbeing for younger age groups, all parts of the local system – from housing, the environment, social care, public health and health care – have a contribution to make. A recent paper from The King's Fund has highlighted the areas where local government can most effectively contribute to improving the health of their local populations (Buck and Gregory 2013). Some of the most important interventions for older people's health and wellbeing are described below.

Ensuring that we get housing right for older people

The right supply of housing in terms of location, affordability, size, tenure and facilities is a crucial factor in enabling people to remain in their own homes as they age (All Party Parliamentary Group on Housing and Care for Older People 2011). It is essential that new housing stock reflects the needs of the local ageing population, with sufficient extra care, sheltered and age-friendly housing available (Association of Directors of Adult Social Services/Housing Learning & Improvement Network 2012). Existing housing stock can also be adapted with aids and technology to assist older people with daily living and maximise their independence and safety. Adaptations and care packages can aid older people's recovery after a hospital stay and can help them to remain in their own homes at the end of life (National Housing Federation 2011, 2012). Providing adaptations to support an older person to remain at home for just one year can save £28,000 on long-term care costs (LaingBuisson 2008).

Preventing social isolation and promoting age-friendly communities

Loneliness, social isolation and social exclusion are important risk factors for ill health and mortality in older people (Stephoe *et al* 2012; World Health Organization 2002). Positive and supportive relationships with close family members contribute to older people's wellbeing, but those aged 75 and over are least likely to have these networks (Hoban *et al* 2013). Given the complex factors involved in isolation and loneliness, it is perhaps unsurprising that evidence about successful interventions is relatively limited, although group activities tend to have better outcomes than one-to-one interventions (Scottish Collaboration for Public Health Research and Policy 2010). Effective interventions to combat older people's isolation and exclusion often combine public services action with volunteering and greater involvement by families and communities (World Health Organization 2008); older people undertaking voluntary work is also associated with improved wellbeing and quality of life (Nazroo and Matthews 2012). The UK-wide Campaign to End Loneliness has a toolkit for health and wellbeing boards (www.campaigntoendloneliness.org), and the Local Government Association (LGA) has produced a wealth of material demonstrating what can be achieved at community level by promoting active ageing (Local Government Association 2012).

Cold weather planning

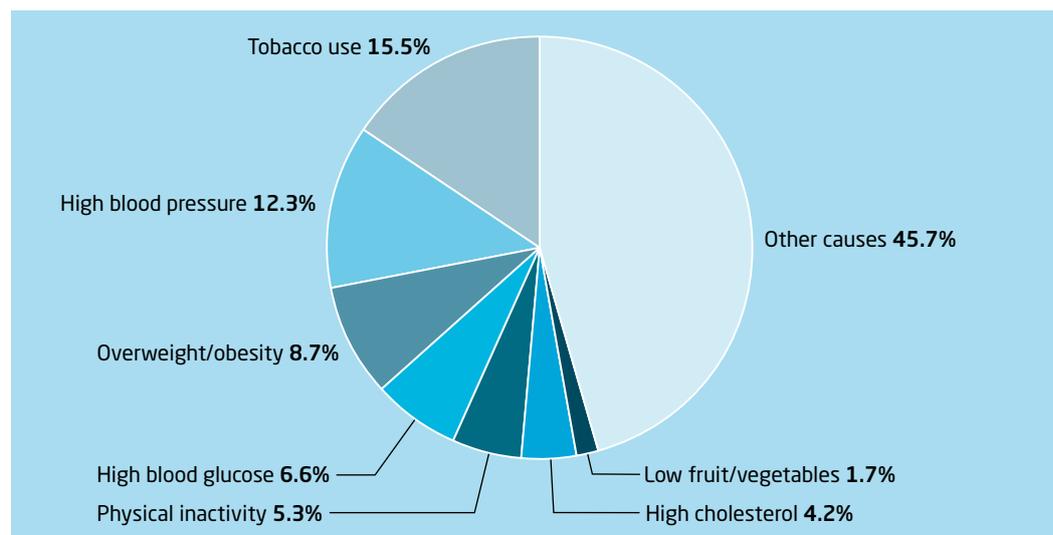
Countries that have invested in winter preparedness have all but abolished excess winter deaths (Department of Health 2010a; The Eurowinter Group 1997). Localities must develop and implement cold weather plans in line with Department of Health guidance (Department of Health 2011b). These should include actions to combat fuel poverty,

housing preparedness (including insulation), resource planning (for surges in health care demand), emergency and major incident responses, and systems for supporting the most vulnerable older people, including those who are housebound.

Promoting healthy lifestyles and wellness

The World Health Organization (WHO) estimates that more than half of the burden of disease among people over 60 is potentially avoidable through changes to lifestyle (see Figure 4, cited by Melzer 2013).

Figure 4 Burden of disease among people aged 60 and over



Source: World Health Organization 2011b

There is increasing evidence that adopting healthy lifestyles in old age can yield health benefits (Kenfield and Stampfer 2013), and maintaining behaviours such as regular exercise, not smoking, reducing alcohol consumption, healthy eating, and preventing obesity has a protective effect well into retirement (Rizzuto *et al* 2012). A 2012 [Cochrane Review of Physical Activity in Older People](#) has shown a wide range of benefits for balance, wellbeing, mobility, cognition and bone fragility from evidence-based tailored exercise interventions. There is particularly clear evidence regarding the benefits of exercise for older people (Sherrington *et al* 2008; de Vries *et al* 2012; Clegg *et al* 2013). Localities should ensure that all strategies and interventions to promote healthy lifestyles include and are accessible to older people.

Adequate treatment for ‘minor’ needs that limit independence

Many older people experience needs that tend to be characterised as ‘minor’, but which can significantly affect their independence, wellbeing and social engagement. These include mobility problems, foot health, chronic pain, visual and hearing impairment, incontinence, malnutrition and oral health. These conditions are also characterised by highly variable access and quality in terms of treatment (Collerton *et al* 2007; Craig and Mindell 2007; Department of Health 2009d; Royal College of Physicians 2010; Barrett *et al* 2011; Royal College of Nursing 2011; British Dental Association 2012; Leamon 2013; Collerton *et al* 2007). Local service leaders must not underestimate the importance of providing services to address these ‘minor’ needs, and should re-examine local provision, addressing any gaps. Low-level interventions such as help with household repairs, minor property adaptations, and other practical support such as befriending can help

to maintain independence (Allen and Glasby 2010). Proactive, early identification of such problems, using structured assessment tools coupled with tailored interventions, can have significant benefits for older people's wellbeing and independence (Melis *et al* 2008).

Vaccination

Influenza vaccinations for older people can save lives. However, in 2012, uptake of the vaccination in England was only 55 per cent among over-65s – well short of the WHO's 75 per cent target (National Institute for Health and Clinical Excellence 2008; World Health Organization 2009), prompting a national campaign to increase uptake (Public Health England 2013b). Pneumococcal immunisation is also important and is recommended for all those aged over 65, but latest data show that only 75 per cent of this age group had received it (Department of Health 2013a). Localities should ensure that vaccination uptake is in line with national and international guidance.

National screening programmes

A recent independent review has confirmed the effectiveness of the NHS breast screening programme (Independent Breast Screening Review 2012), while bowel screening reduces the chance of death by a quarter in those screened (Hewitson *et al* 2007). Action to increase uptake of national bowel and breast cancer screening programmes should therefore be a priority; more effort needs to be made to ensure that those people identified through screening as being at higher risk are invited for and take up further investigations. There is as yet no national screening programme for prostate cancer because the evidence of its potential benefits remains unclear, but there is a prostate cancer risk management programme based on prostate specific antigen (PSA) testing in men aged 50–69 (Public Health England 2013c). An abdominal aortic screening programme for men aged 65–74 is just beginning, and so uptake should be encouraged as the programme is rolled out across England.

Key reviews and guidance

Melzer D, Tavakoly B, Winder R, Richards S, Gericke C, Lang I (2012). *Health care quality for an active later life: improving quality of prevention and treatment through information: England 2005 to 2012*. A report from the Peninsula College of Medicine and Dentistry Ageing Research Group for Age UK. Exeter: PCMD, University of Exeter.

Scottish Collaboration for Public Health Research and Policy (2010). *Promoting health and wellbeing in later life: interventions in primary care and community settings*. Edinburgh: Scottish Collaboration for Public Health Research and Policy. Available at: www.scphrp.ac.uk/node/198 (accessed on 21 November 2013).

Department of Health Prevention Package (2009d). *Prevention package for older people resources*. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/dh_103146 (accessed on 28 November 13).

Local Government Association (2012). 'Ageing well legacy'. Programme website. Available at: www.local.gov.uk/ageing-well (accessed on 21 November 2013).

World Health Organization (2012). *Strategy and action plan for healthy ageing in Europe, 2012–2020*. Denmark: WHO Regional Office for Europe. Available at: www.euro.who.int/__data/assets/pdf_file/0008/175544/RC62wd10Rev1-Eng.pdf (accessed on 2 December 2013).

Allen K, Glasby J (2010). *'The billion dollar question': embedding prevention in older people's services – 10 'high impact' changes*. Discussion Paper. Birmingham: Health Services Management Centre, University of Birmingham.

Good practice examples

Newcastle West Clinical Commissioning Group Ageing Well Strategy

In conjunction with Newcastle Council, Newcastle West CCG has developed an ageing well strategy that goes beyond mid-life to the ‘mature life cycle’, which comprises ‘preparing for active old age’ (50 onwards), ‘active old age’, ‘vulnerable old age’ and ‘dependent old age’.

The strategy includes:

- health checks aimed at identifying risk factors such as obesity, physical inactivity and poor diet in those aged 40–74
- engaging older people as volunteers and health champions
- a focus on case-finding to identify older people who are vulnerable to deterioration or dependency so that they can receive proactive support
- a focus on supported self-management.

(Drinkwater *et al* 2012)

Age UK’s ‘Fit as a fiddle’ campaign

The ‘Fit as a fiddle’ campaign is a nationwide programme run by Age UK that supports healthy, active ageing by promoting physical activity, mental wellbeing and healthy eating, reflecting the ideas and needs of older people. It is delivered in partnership with regional and national organisations and encompasses a diverse range of initiatives – for instance, participation in activities, telephone peer support, chair-based exercise programmes, and social networks for older men experiencing social isolation.

The campaign’s activities appear to have had a positive impact on wellbeing, levels of happiness, physical activity and social engagement. An independent evaluation of the programme is now under way.

www.ageuk.org.uk/professional-resources-home/services-and-practice/fit-as-a-fiddle/

2 Helping people to live well with simple or stable long-term conditions

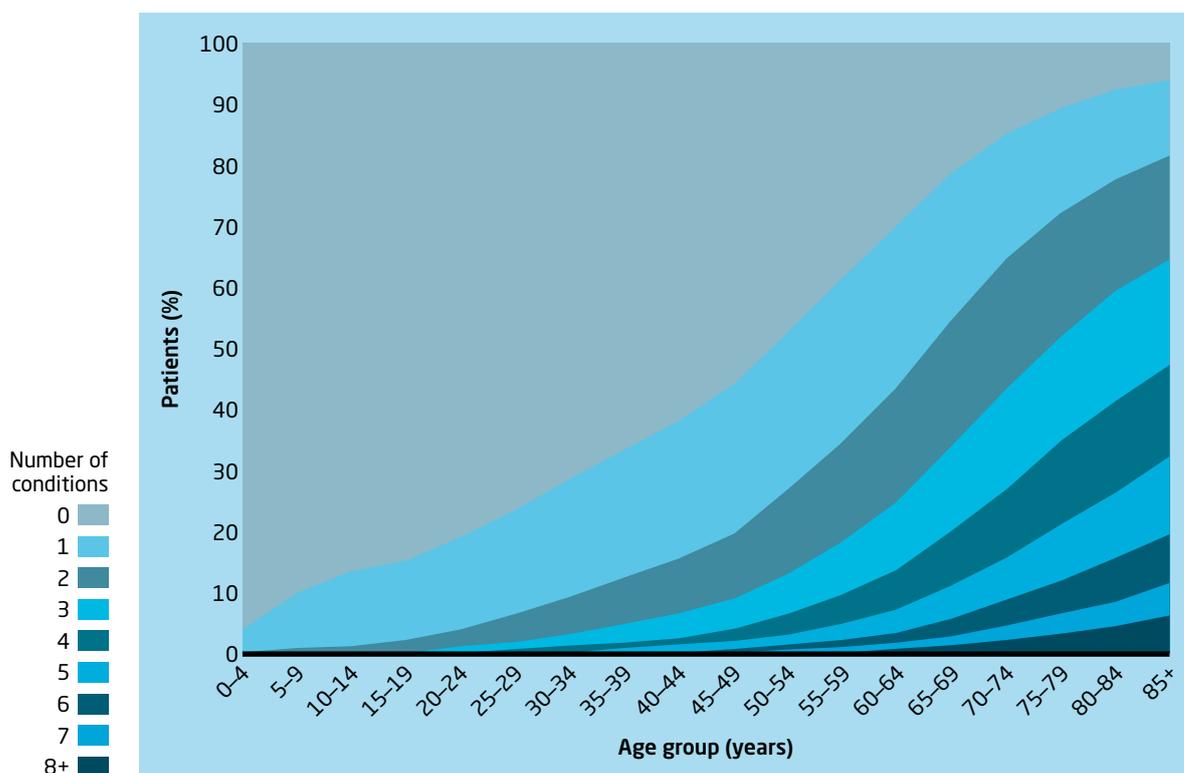
Goal

Older people with simple or stable long-term conditions should be enabled to live well, avoiding unnecessary complications and acute crises.

The current situation

- Most older people self-rate their health as 'good' or 'excellent', and most say they do not live with a long-term condition they consider to be 'life-limiting' ([Office for National Statistics 2013b](#)). However, most people over 65 do live with a long-term condition ([Banks *et al* 2008](#)), and most people over 75 live with two or more (see Figure 5) ([Barnett *et al* 2012](#); [Melzer *et al* 2012](#)).
- Older people receive poorer levels of care than younger people with the same conditions ([Centre for Policy on Ageing 2009a, 2009b, 2009c](#); [Melzer *et al* 2012](#)). For example, older people are far less likely to receive psychological therapies for mental illness and more likely to be prescribed drugs ([Cooper *et al* 2009](#)).
- General medical conditions are treated more effectively than common geriatric conditions; less than half of patients with poor vision, osteoporosis, urinary incontinence or arthritis are receiving basic quality care ([Steel *et al* 2008](#)).
- Despite a growing focus on supported self-management for people with long-term conditions ([Mathers *et al* 2011](#)), less than one in four people over 75 self-report receiving any support or advice in preventing further falls or progression of osteoarthritis or in managing their own diabetes ([Melzer *et al* 2012](#)).

Figure 5 Morbidity (number of chronic conditions) by age group



Source: Barnett *et al* 2012

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- UK health services perform badly compared with other countries in involving patients of all ages in supported self-care and shared decision-making (Health Foundation 2010); for example, older people report less education and support in self-management of diabetes (Melzer *et al* 2012).
- There are around 6 million people in the UK who are unpaid carers, largely for older people, and the number of adults caring for their parents is projected to increase by 50 per cent by 2032 (House of Lords 2013). Increasingly, these carers are older people themselves, often with their own health problems; many older couples provide partial care for each other rather than simply fitting the categories of ‘service user’ and ‘carer’ (Audit Commission 2004).

What we know can work

The fundamental principles of effective management of long-term conditions apply to people of all ages. They include population risk stratification, leading to personalised support that ranges from promoting health and wellness to supported self-care and shared care, through to specific disease management, care co-ordination approaches and case management as levels of risk and complexity increase (Roland and Abel 2012; Goodwin *et al* 2010).

Providing continuity and care co-ordination

In England, the new GP contract (which comes into force in October 2014) will ensure that all people over 75 with complex, multiple long-term conditions will be cared for by a named GP. Relational continuity of this sort can make an important contribution to providing more person-centred co-ordinated care (Roland 2013; Haggerty 2012) and is something that patients and their families have repeatedly identified as important to them (National Voices 2013; Ellins *et al* 2012; Mangin *et al* 2012).

Using population risk stratification

To help identify people at risk, NHS England incentivises annual health checks for all people aged 50–74. Despite Public Health England’s vigorous defence of this policy on the grounds that innovation cannot wait for research evidence (Goodyear-Smith 2013), there is only weak evidence that such checks are effective in reducing mortality (Krogstbøll *et al* 2012), although there is evidence that they can help encourage already healthy people to remain healthy (Iliffe 2013). Some service leaders are enthusiastic about proactive general population screening for those over 75 (Beales and Tulloch 2013), and there are credible peer-reviewed studies of such approaches in practice (Clark *et al* 2013; Health Foundation 2013c), although cost-effectiveness is uncertain. Targeted case-finding of at-risk groups within the older population is likely to be more effective in identifying unmet need. Using validated risk stratification tools with primary, secondary and social care data is one approach (Nuffield Trust 2011; Purdy 2010). However, these tools need to be linked to clear evidence-based strategies for tailored interventions designed for each at-risk group, including initial clinical assessment and screening to identify the specific unmet needs of those individuals.

Case management delivered through integrated locality-based teams

Case management has been defined as ‘a targeted, community-based and proactive approach to care that involves case-finding, assessment and care planning’ (Ross *et al* 2011). It works best as part of a wider programme to integrate care, including good access to primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation and re-ablement (Challis and Hughes no date; Ross *et al* 2011; Goodwin *et al* 2012).

Involving older people and their families in planning and co-ordinating their own care

A key aspect of good management of long-term conditions is ensuring that the services and support provided reflect the person's own circumstances and preferences (Coulter *et al* 2013). The 'house of care' model offers one approach for achieving this, where people with long-term conditions engage in collaborative care planning through pre-arranged appointments, co-producing a single holistic care plan with their care co-ordinator (Coulter *et al* 2013). This is particularly important for older people with multiple long-term conditions, since interventions and care planning approaches that focus on single chronic conditions can lead to chaotic overall care for these patients (Roland 2013; Haggerty 2012; Beales and Tulloch 2013; Barnett *et al* 2012).

Personal care budgets and direct payments

Local authorities, in conjunction with health partners, should ensure that older people and their carers are offered the choice of taking up personal care budgets and direct care payments, ensuring that there are sufficient safeguards to provide any vital care and support needs that are not covered. Most personal budget-holders report a positive impact on many aspects of their lives, including being supported with dignity and respect, staying independent, being in control of support, relationships with paid carers and family members, and improved physical health, personal safety and access to care (Hatton and Waters 2011). The impact of 'cash for care' on older people with complex needs is less clear than for younger people with disabilities or mental health problems (Glendinning *et al* 2008; Moran *et al* 2013), with the benefits potentially offset by anxiety and uncertainty among older people trying to navigate systems or co-ordinate their own care. However, it may be that the type of support needs to be tailored better to the needs of older people.

Telehealth

The evidence for telehealth services for people with long-term conditions is mixed, with the best evidence pointing to possible effectiveness of telecare services for older people with specific conditions such as cardiac failure, diabetes or chronic lung disease (Davies and Newman 2011); evidence suggests that telehealth can also play an important role in the delivery of care to remote and rural populations. It has been valued by staff and service users in some local examples of care co-ordination or virtual wards (Goodwin *et al* 2013), or in housing-based interventions to help keep older people living at home independently (National Housing Federation 2012), though it is hard to disentangle its effect from that of other service components. However, there is no strong evidence that telehealth reduces hospital admissions or costs (Scottish Collaboration for Public Health Research and Policy 2010). The Whole System Demonstrator (WSD) trial found ambiguous evidence in relation to hospital admission (Steventon *et al* 2012) and no real benefits in terms of cost-effectiveness (Henderson *et al* 2013) or quality of life (Cartwright *et al* 2013). In the UK, there is still doubt on both sides about how to improve joint working between the industry and health services (Barlow *et al* 2012).

Providing support and education for family and volunteer carers

The crucial role of carers in maintaining older people's independence and wellbeing was recognised in the Dilnot Review on care and support (Department of Health 2011c), and the National Strategy for Carers (Department of Health 2011d); WHO Europe, in its strategy for healthy ageing in Europe, identified 'public support for informal caregiving' as a key strategic priority (World Health Organization 2012). Local leaders in health

and social care, mental health, local government, and their voluntary sector partners should review the needs of carers for older people in terms of peer support, education, information and training, and respite, incorporating these into all health and wellbeing plans and mapping their own service provision against any national strategies to support carers.

Ensuring that older people receive the same care and support as younger people with the same condition

Age can be a legitimate factor in differentiating care and treatment – for example, when assessing the balance of risk and benefit in relation to the side effects of certain drugs. But from self-management support to psychological therapies, there is ample evidence that care and support for older people with long-term conditions is unjustifiably inequitable (Centre for Policy on Ageing 2009a, 2009b, 2009c). Localities should examine local performance with this in mind, to ensure that older people are not disadvantaged.

Improving care and treatment for the common conditions of ageing

In the first section we highlighted that access to care and treatment for many of the more minor conditions of ageing is variable and often poor. The same is true for a number of more serious long-term conditions that predominantly affect older people or are more common with ageing (Centre for Policy on Ageing 2009a, 2009b, 2009c; Steel *et al* 2008; Melzer *et al* 2012). These include osteoarthritis, cardiac failure, chronic airways disease, and non-insulin dependent diabetes. Despite clear guidelines from the National Institute for Health and Care Excellence (NICE) for these conditions, clinical audit data and other studies reveal significant care gaps (Steel *et al* 2008; Royal College of Physicians 2010, 2012c; Melzer *et al* 2012; Health and Social Care Information Centre 2013b). Localities must ensure that performance in these areas is assessed and managed.

Key reviews and guidance

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Good practice examples

Gloucestershire Heart Failure Service

Gloucestershire has a county-wide community specialist service for people with suspected or confirmed cardiac failure. If the diagnosis is confirmed, they are assessed jointly by a GP with a special interest in cardiac failure and by a specialist heart failure nurse, who agree a shared plan for treatment, management and self-care with the patient.

Nurse specialists also support older people with recent hospital admissions for cardiac failure to help them manage their transition back home and prevent readmissions. Patients and carers have access to specialist helpline reassurance and support. The service has successfully used telehealth to help patients monitor their vital signs, detect early deterioration, and help build their confidence in self-care.

(Moore 2008; see also Gloucestershire Care Services Heart Failure Service website: www.glos-care.nhs.uk/our-services/specialist-services/heart-failure-service)

Glasgow Fracture Liaison Service

Many older people who suffer fractures or osteoporosis have suffered previous 'herald fractures'. Their chances of going on to suffer further fractures or falls or develop worsening bone fragility could have been reduced by assessment, treatment and support after the first fracture.

The Greater Glasgow Fracture Liaison Service (FLS) offers assessment for all men and women over 50 with a new low trauma fracture, whether they have been admitted or presented as an outpatient. Patients are offered a one-stop clinic to assess fracture risk, carry out biochemical investigations and, where appropriate, bone density (DXA) scanning. Appropriate medical care is prescribed to reduce the risk of further fractures, and patients are referred to falls-prevention and exercise programmes that can reduce falls risk and increase bone density. Fracture liaison nurses offer ongoing support and advice, including support with medication, to ensure that treatment plans are sustained.

(Mitchell and Adekunle 2010)

3 Helping people live with complex co-morbidities, including dementia and frailty

Goal

Health and care services should support older people with complex multiple co-morbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications.

The current situation

- Frailty is common in people requiring care and support at home, those who are housebound, long-term care residents, recipients of home care, and among older people admitted to hospital ([British Geriatrics Society 2011](#); [Cornwell 2012](#)). It can also remain unrecognised until people present to services. With age, disability is also increasingly common (especially sensory impairment and mobility problems) ([Department for Work and Pensions 2013](#); [NHS Information Centre 2007](#)).
- Around 1 in 3 people over 65 and 1 in 2 over 80 fall each year; falls are the leading cause of ambulance call-outs to the homes of people over 65 ([Department of Health 2009d](#)).
- Dementia is progressively common in older age, affecting 1 in 6 people over 80 ([Alzheimer's Society 2007](#)). There is considerable underdiagnosis of dementia compared with expected rates ([NHS Atlas of Variation 2011](#)). Dementia often complicates multiple co-morbidities or frailty. It has been estimated to cost the public purse more than heart disease, stroke and cancer combined.
- Older people with complex needs greatly value continuity of care, with clinicians and carers who are familiar with their needs and who can help them to navigate multiple services ([Ellins *et al* 2012](#)).

What we know can work

Recognising the importance of frailty

Managing frailty is a key issue for modern health and social care services, yet it has been neglected in many local strategies for long-term conditions ([Clegg *et al* 2013](#)). Clinically, older people who are frail have poor functional reserve, so that even a relatively minor illness can present with sudden catastrophic functional decline – causing the person to fall, become immobile or rapidly confused, or to present non-specifically with failure to thrive ([Clegg *et al* 2013](#)). Identifying and supporting people who are frail therefore requires a focus of its own. A clinical description of frailty is provided in the box overleaf.

Frequent clinical presentations of frailty

Non-specific

Extreme fatigue, unexplained weight loss and frequent infections.

Falls

Balance and gait impairment are major features of frailty, and are important risk factors for falls. A so-called hot fall is related to a minor illness that reduces postural balance below a crucial threshold necessary to maintain gait integrity. Spontaneous falls occur in more severe frailty when vital postural systems (vision, balance and strength) are no longer consistent with safe navigation through undemanding environments. Spontaneous falls are typically repeated and are closely associated with the psychological reaction of fear of further falls that causes the patient to develop severely impaired mobility.

Delirium

Delirium (sometimes called acute confusion) is characterised by the rapid onset of fluctuating confusion and impaired awareness. Delirium is related to reduced integrity of brain function and is independently associated with adverse outcomes. Roughly 30% of elderly people admitted to hospital will develop delirium, and the point prevalence estimate for patients in long-term care is 15%.

Fluctuating disability

Fluctuating disability is day-to-day instability, resulting in patients with 'good', independent days and 'bad' days on which (professional) care is often needed.

Source: Clegg *et al* 2013

Using frailty risk assessment and case-finding

The Electronic Frailty Index (Trueland 2012), being piloted in English primary care data systems, will help to identify individuals who are frail. In its absence, older people who are identified through conventional risk-scoring tools or who come into contact with the system with problems indicating frailty should receive initial screening, combined with comprehensive geriatric assessment (Clegg *et al* 2013). Telephone (Gloth *et al* 1999) and face-to-face assessment tools (Rolfson *et al* 2006) are available. As with any case-finding system, it must be linked to assessment and support, including case management, care co-ordination, access to rapid support, rehabilitation, and support for carers. There are also some 'proxies' for frailty, such as being housebound, recurrent episodes of falls or reports from others of 'slowing up recently' – which might prompt staff to complete an initial assessment. For a very quick, pragmatic screening assessment, a timed 3-metre walk is a well-validated screening tool (Castell *et al* 2013); among those aged over 75, a walking speed of less than 0.8 m/s confers a 32 per cent chance of being frail.

Different degrees of frailty will require different supportive services and interventions, and it is useful to differentiate between them, as Rockwood *et al* did in the Clinical Frailty Scale 2009–10 version (*see* box below).

The Clinical Frailty Scale

1. **Very fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
2. **Well** – People who have no active disease symptoms but are less fit than Category 1. Often, they exercise or are very active occasionally, eg, seasonally.
3. **Managing well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.
4. **Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being ‘slowed up’ and/or being tired during the day.
5. **Mildly frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
6. **Moderately frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
7. **Severely frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
8. **Very severely frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
9. **Terminally ill** – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Where dementia is present, the degree of frailty usually corresponds to the degree of dementia:

- Mild dementia – includes forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.
- Moderate dementia – recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.
- Severe dementia – they cannot do personal care without help.

Source: Rockwood K *et al* (2005).

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Using proactive comprehensive geriatric assessment and follow-up for people identified as frail

Comprehensive geriatric assessment (CGA) is a 'multidisciplinary, diagnostic process to describe the medical, psychological and functional capabilities of a frail older person in order to keep a co-ordinated, integrated plan for long-term treatment and follow-up' (Stuck *et al* 2002). The main elements of CGA are shown in the box below.

Elements of comprehensive geriatric assessment

Medical assessment

- Problem list
- Co-morbid conditions and disease severity
- Medication review
- Nutritional status

Assessment of functioning

- Basic activities of daily living
- Instrumental activities of daily living
- Activity/exercise status
- Gait and balance

Psychological assessment

- Mental status (cognitive) testing
- Mood/depression testing

Social assessment

- Informal support needs and assets

Environmental assessment

- Care resource eligibility/financial assessment
- Home safety
- Transportation and telehealth

(Adapted from Ellis *et al* 2011)

CGA should play a role in the care of older people in a number of settings, described in other sections of this paper. Proactive community-based CGA, with at least six months of follow-up support for older people who are frail, can reduce hospital admissions, falls and moves into long-term care (Beswick *et al* 2008; Beswick *et al* 2010), and although the reported effects are relatively small (Iliffe 2013; [Scottish Collaboration for Public Health Research and Policy 2010](#)), it is a key component in some integrated services for older people in some localities ([Health Foundation 2013c](#); Clark *et al* 2013; Melis *et al* 2008; Beales and Tulloch 2013).

Promoting exercise for frail older people

Encouraging frail older people to take more exercise can improve outcomes and functional ability (de Vries *et al* 2012; Theou *et al* 2011; Clegg *et al* 2012; Sherrington *et al* 2008). Older people are more likely to participate if it is branded as activity rather than exercise, focused on wellbeing and independence rather than preventing falls or other adverse events, has professional support, and if there is an element of communal activity (Yardley *et al* 2007). Exercise programmes can be led by non-clinical professionals working in local government and the voluntary, leisure or housing sectors, following appropriate training, and so can be delivered relatively cheaply (Department of Health 2009a).

Falls prevention

Falls prevention has been identified as a key priority in WHO Europe's strategy for the ageing population (World Health Organization 2012). Falls are a leading cause of hospital admission among older people, often precipitate admission to long-term care, and can lead to debilitating injuries, loss of confidence and independence. Falls are increasingly common with age and frailty (National Institute for Health and Care Excellence 2013a; Cameron *et al* 2010). There is an extensive evidence base for interventions to prevent falls, focusing on identifying and addressing risk factors such as postural instability, muscle weakness, visual impairment, home hazards or 'culprit' drugs (National Institute for Health and Care Excellence 2013a; Cameron *et al* 2010).

Providing good care for people with dementia

Dementia is a particularly important issue, affecting 800,000 people in the UK already, with this figure projected to double over the next 20 years (House of Lords 2013). In England, there is now a National Dementia Strategy (Department of Health 2009c) backed by a number of incentives and outcome measures, and by the collaboration of more than 50 organisations in the Dementia Action Alliance. Local services leaders must have clear plans for diagnosis, care and support for people with dementia, and monitor progress against national guidelines. Key issues include:

- providing accurate early diagnosis, information and support for people with dementia and their carers when the condition begins to cause problems that are life-limiting (National Institute for Health and Clinical Excellence/Social Care Institute for Excellence 2006; Department of Health 2009c; Burns and Iliffe 2009; Alzheimer's Disease International 2011)
- ensuring that drives to increase diagnosis rates are combined with ensuring adequate capacity in support services, including specialist old age psychiatry services
- reducing antipsychotic prescribing (Department of Health 2009c)
- providing training and education to carers of people with dementia in how to support someone with that condition and how to navigate the care system (Alzheimer's Disease International 2011).

Reducing inappropriate polypharmacy

Older people with multiple conditions are likely to be on multiple medications: around 20 per cent of people over 70 are taking at least five medications and 16 per cent are taking 10 or more (Milton and Jackson 2007; Planton and Edlund 2010; NHS Scotland 2012; Duerden *et al* 2013). While some of this will be appropriate, concern has been expressed that older people are too often being 'medicalised' through diagnosis of

sub-clinical disease and over-treated with medication whose risks outweigh the benefits (Heath 2010). Not only does ageing lead to altered pharmacodynamics and kinetics, and increasing difficulties with concordance, but also to considerable drug–drug and drug–disease interaction (NHS Scotland 2012; Duerden *et al* 2013). For example, a range of medicines can precipitate acute delirium in frail older people (Young and Inouye 2008; National Institute for Health and Clinical Excellence 2010).

Clinicians need to prescribe with full consideration of interactions between drugs, ageing and disease, and the older person's ability to adhere to medication regimes, as well as prioritising the person's own goals for treatment (Duerden *et al* 2013). This can be aided by structured decision tools such as Beers Criteria (Manyemba and Jackson 2012), STOPP (Screening Tool of Older Person's Prescription) or START (Screening Tool to Alert the Doctor to Right Treatment) (Duerden *et al* 2013; NHS Grampian 2012), and by regular proactive review and adjustment of medication. Although the current GP contract does include an incentive to review all patients on four or more medications, there is little evidence that this improves safety and quality of prescribing for older people with complex needs. Systematic collection of data on polypharmacy and structured review of goals and benefits of all medications should be built into primary care prescribing systems, and every contact with secondary care used as an opportunity to rationalise medications.

Key reviews and guidance

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Good practice examples

Guideposts

Guideposts is a charity that offers support to a range of groups, including older people with complex needs and their carers. For older people with complex needs and frailty, they offer a range of practical support and advice to help them retain their independence and control and to live at home for as long as possible. Support provided includes:

- light housework
- blitz cleaning
- laundry, washing and ironing
- preparation of light meals
- shopping for everyday needs or special occasions
- pension or prescription collection
- assistance to attend appointments
- friendship and companionship
- personal care
- day and night sitting (night sitting available by request).

The charity also offers carer support groups, carers' newsletters, drop-in centres and coffee shops for carers, training for carers, and emergency cards for carers so that in crisis other agencies and professionals have a better understanding of the needs of their loved ones. It provides local postcode-based information on support services through information prescriptions and a 24/7 helpline to support people with dementia and their carers.

(www.guidepoststrust.org.uk)

Gnosall GP surgery services for older people, Staffordshire

Within the Gnosall group practice, all listed patients over 75 are sent an annual 'birthday card' from the practice, inviting them to complete a detailed annual health review (including any role they play as a carer). The practice uses 'elder care facilitators', employed by the voluntary sector and often with long experience in care and support services. They follow up initial screening with a role as an 'intelligent companion' and system navigator, also collecting data and offering pre- and post-diagnostic support, drawing up care plans and helping older people to enact them, and offering early crisis support.

The practice also employs recently retired GPs and old age psychiatrists to carry out comprehensive assessment of higher-risk individuals and help draw up advance care plans. These focus on proactive and anticipatory care, including medicines review, falls prevention, support for carers, social identity, and support with accommodation. Older people or their carers are supplied with handheld applications to help co-ordinate their care, control their own records, and trigger appropriate urgent support when required.

Delivering this model has reduced length of stay in acute hospitals for over-75s, especially those at high risk, and has released savings in acute hospital activity. It is also very well received by older people and their carers.

(Clark *et al* 2013)

4 Rapid support close to home in times of crisis

Goal

When the health or independence of older people rapidly deteriorates, they should have rapid access to urgent care, including effective alternatives to hospital.

The current situation

- Older people who are frail, cognitively impaired or disabled can become rapidly immobile or confused, suffer falls, or go very quickly from coping to not coping in the face of even minor acute illness or a worsening of an existing condition (Clegg *et al* 2013). Older people who are not frail can also suffer rapid deteriorations in health (Ellins *et al* 2012).
- Older people are more likely to call an ambulance from home, more likely to be taken to hospital, and then more likely to be admitted than younger people (British Geriatrics Society 2012b). People under 65 use an average of 0.2 emergency bed days per year, while people over 85 use an average of 5 bed days (Imison *et al* 2012).
- Case analyses and narrative data from older people and their carers suggest that a lack of alternative services is behind many of these episodes (Haggerty 2012; Mytton *et al* 2012; Primary Care Foundation 2009).

What we know can work

Promoting continuity of primary care

Approximately 95 per cent of urgent care in England is delivered in primary care (British Geriatrics Society 2012b). Continuity of primary care may reduce the chance of acute hospital admission among older people (Health Foundation 2011a; Goodwin *et al* 2013). But a recent major review of prevention of unplanned admissions (Purdy *et al* 2012) found the evidence to be inconsistent. On the other hand, older people and their families place great premium on continuity of care, familiar clinicians, and co-ordinated care, while discontinuous, disjointed care can compromise quality and reduce satisfaction (National Voices 2013; Roland 2013; Ellins *et al* 2012; Haggerty 2012; Health Foundation 2011a; Ross *et al* 2011). As discussed in the previous section, the new GP contract in England attempts to address this by providing named clinicians for older people with complex needs.

Providing urgent access to primary care

Timely access to primary care, within and outside of usual surgery hours, is important (Primary Care Foundation 2009). Older people and their carers have expressed dissatisfaction over access to out-of-hours provision (The Patients Association 2013) and rapid general practice responses (Age UK 2012a, 2012b). Local service leaders should review the effectiveness and consistency of local provision for urgent primary care and carry out regular reviews of admissions for, and accident and emergency (A&E) attendances by, frail older people so that lessons from preventable admissions can inform service redesign. Out-of-hours care works best with case-finding and risk stratification to identify those older people most at risk of deterioration, and with sufficient capacity in home support services. Accessible, single shared records may improve the quality of out-of-hours decision-making. The current service model must be transformed to meet the needs of older people with complex needs who can deteriorate rapidly at any time, in or out of hours, and require effective and speedy support from practitioners who understand their individual circumstances and conditions.

Providing urgent, co-ordinated social care

Social work expertise and social care capacity are important elements in multidisciplinary initiatives such as rapid response, crisis response teams, and care-at-home services. As with primary care, appropriate social care services should be available out of hours, and should enable swift assessment of an individual's care and support needs with the aim of stabilising the situation and assembling a care plan that avoids clinically unnecessary admission to hospital or to long-term residential care. The recommended 'Silver Book' standard is that a 24/7 single point of access (SPA), including a multidisciplinary response within 2 hours (14 hours overnight), should be commissioned. Discharge to an older person's normal residence should be possible within 24 hours, 7 days a week – unless continued hospital treatment is necessary. Social care services that need to be in place include social work assessment, home care, equipment and telecare ([British Geriatrics Society 2012b](#)). The new Better Care Fund in England requires local authorities and clinical commissioning groups (CCGs) to provide seven-day services to support hospital discharge and prevent unnecessary hospital admissions ([NHS England and Local Government Association 2013b](#)).

Ensuring that ambulance services implement shared care strategies with other services

Ambulance crews can play an important role in allowing older people to remain at home if this role is recognised and supported as part of a wider integrated care pathway. Education for advanced paramedics, enabling them to provide initial management and stabilisation for a variety of conditions, can have an impact on hospital admission, length of stay, and patient satisfaction (Mason *et al* 2007). Shared care protocols with local acute providers and community services can drastically reduce the number of ambulance journeys to hospital for older people who have fallen or become acutely unwell (Logan *et al* 2010; [NHS Confederation 2010](#)). Localities should develop shared care protocols with ambulance organisations that can enable older people to remain at home. Ambulance organisations should examine their own governance to mitigate a defensive approach and ensure that paramedics are trained and supported in efforts to help older people remain at home.

Using admission-prevention Hospital at Home services

These involve a team of health and social care professionals that provide treatment at home for people who would otherwise be admitted to an acute hospital ward. Evidence has shown higher patient and carer satisfaction, reduced mortality and reduced readmission rates for at-home services ([Shepperd *et al* 2008](#); [Caplan *et al* 2012](#)). Local service leaders should consider developing Hospital at Home services for older people with long-term or complex needs (including dementia) and for those with conditions such as pneumonia, cellulitis and chronic obstructive pulmonary disease (COPD).

Using virtual or community wards

The components of virtual wards vary, but the principle is to provide an integrated health and social care team with services for people at high risk of hospital admission. There is anecdotal evidence from Croydon and other sites ([Rankin 2010](#); [Chenore *et al* 2013](#); [Bardsley *et al* 2013](#)) of high patient satisfaction, with patients less likely to call 999; in many localities that have implemented virtual ward models, primary care providers and commissioners have been impressed with results and have continued funding the schemes (personal communication, Worcestershire). However, recent evaluations of virtual wards in four parts of England have shown no reductions in cost or hospital bed

utilisation (Lewis *et al* 2013), though there were some reductions in elective activity. If virtual or community wards are developed locally, it should be because they are meeting patients' needs and provide a mechanism for care closer to home for those at highest risk, rather than because they will deliver savings (Lewis *et al* 2013). Any savings released by reductions in hospital admissions may only be medium term; and a reduction in hospital admissions may not in itself generate overall cost savings unless there is some closure of capacity in acute or other care provision. A bed not filled by a virtual ward patient will probably be filled by someone else (NHS Confederation and Royal College of General Practitioners 2013; NHS Confederation 2009; Lewis *et al* 2013). Similar considerations apply to Hospital at Home models.

Providing telecare for older people at risk

There are a range of technologies available to support older people in their homes such as falls alarms and devices to monitor vital signs or movement beyond safe areas. A number of case studies have shown local benefits (Personal Social Services Research Unit 2010; Steventon and Bardsley 2011; National Housing Federation 2012). Telecare has also been shown to provide reassurance to carers and relatives that could, in turn, have potential to reduce demands on health and social care (Steventon and Bardsley 2011). But, overall, the evidence is equivocal (Davies and Newman 2011), and the use of these technologies is most likely to be effective in the context of integrated locality-based services designed to support older people rather than their use in isolation. Local service leaders should therefore consider the use of telecare solutions for older people at risk of hospitalisation or moving to long-term care as part of wider integrated care strategies, but should not assume that these can be effective without access to a range of other services.

Discharge-to-assess models

When older people present to emergency and urgent care centres, it is important to be able to identify those people who can be discharged straight back home with appropriate support and complete their ongoing assessment in their own home. This approach employs the principles of 'discharge to assess' and 'decide to admit'. The acute team ensures that the person's needs are assessed, and any acute illness stabilised and treated; but instead of also determining the person's ongoing care and support needs, they refer straight back out to a 'wraparound' community team who can complete assessments and organise support from the person's own home. A number of individual studies have shown the benefits of early senior review linked to these models in terms of reduced admission rates, reduced bed occupancy, and higher rates of discharge home within 24 hours of presentation (Health Foundation 2013a, 2013c; Fox *et al* 2013). Effective discharge-to-assess models require timely expert assessment on initial acute presentation to hospital and adequate capacity for providing ongoing assessment and support at home.

Providing rapid access ambulatory care clinics

Delivering better anticipatory care for people with long-term conditions involves providing rapid access to specialist advice from hospital clinicians and the use of 'chair-based' ambulatory care clinics (Tian *et al* 2012; R Rosen, personal communication 2014; Staples 2012; Purdy *et al* 2012). For older people with complex needs and deterioration in health or function, the use of rapid access assessment clinics – either on the acute hospital site or in the community – can also help to prevent hospital admission or attendance and support people to remain at home (de Silva 2013). An analysis of 1,880 older patients seen in such a clinic showed that 59 per cent were discharged home, 29 per cent were referred on for intermediate care, and only 15 per cent were referred to the local acute hospital (Koduah *et al* 2013). Local service leaders should review current outpatient provision

and create additional capacity in rapid assessment clinics for older people (with access to a range of diagnostic and multidisciplinary skills) and in ambulatory care clinics. Local primary care, social care and accident and emergency (A&E) staff need to be made aware of these clinics and offer a functioning single point of access and advice.

Using community and interface geriatrics

There has been growing interest in the UK in the role of community geriatricians and ‘interface’ geriatricians, who focus on patients coming through the front door of the acute hospital but with links into the community. Roles vary but include providing support to long-term care residents and integrated locality teams, and providing community-based rapid access clinics for older people. The creation of these roles provides an example of delivering more responsive speciality support closer to patients’ homes. For instance, creating interface geriatricians in Leeds and Leicester has delivered early gains in terms of reducing admissions and increasing same-day discharges (Fox *et al* 2013).

Key reviews and guidance

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Good practice examples

Nottinghamshire Ambulance Trust

Nottinghamshire Ambulance Trust worked with partners in local primary and social care, community health organisations, and the local acute provider to create a pathway for referral from 999 paramedics called to the homes of people over 65 who had fallen; they were to be referred to a community falls assessment and treatment team rather than be taken to hospital. This was backed by training for paramedics and the development of clear protocols.

In a randomised controlled trial with nearly 1,500 patients in each group, those referred to the community falls team experienced a 55 per cent reduction in falls in the following year, a 60 per cent reduction in ambulance call-outs for falls, and measureable improvements in physical function.

(Logan *et al* 2010)

Sandwell Integrated Care Services Team (ICARES)

The Sandwell Integrated Care Services Team (ICARES) offers one single point of access, seven days a week, for primary, hospital, mental health or social care professionals or concerned older people or carers. The team incorporates a range of disciplines, including nurse specialists in case management/disease management and nurse practitioners skilled in Hospital at Home interventions, therapists, rehabilitation assistants, social workers, care assistants and night sitters. It also has easy access to local GPs and to voluntary sector organisations.

On receipt of a referral, they assess urgency of need and guarantee to begin assessment and support in the person's own home within three hours of referral (for urgent cases) and within two days (for subacute cases). They are then able to arrange 'wraparound' services as required to help the person remain at home, unless hospital admission is necessary. The service also supports care home residents in crisis in the same way.

Source: [The King's Fund 2013](#)

5 Good acute hospital care when needed

Goal

Acute hospital care must meet the needs of older patients with complex co-morbidities, frailty and dementia. Services should provide adequate access to specialist input, minimise harms and ward moves, and provide care that is compassionate and person-centred.

The current situation

- A total of 43 per cent per cent of people admitted to hospital non-electively are over 65, accounting for 53 per cent of all bed days ([Health and Social Care Information Centre 2013a](#)); people over 65 also account for 80 per cent of hospital admissions that involve stays of more than 2 weeks ([Poteliakhoff and Thompson 2011](#)). There is a more than threefold variation between areas in rates of emergency admission and occupied bed days for people aged over 65 ([Imison *et al* 2012](#); [NHS Atlas of Variation 2011](#)).
- In a typical 500-bed district general hospital, there will be around 200 patients over the age of 65 with mental health problems (100 with dementia, 90 with depression and 60 with delirium) ([Royal College of Psychiatrists 2005](#)). Patients with dementia stay in hospital for seven days longer than others ([Alzheimer's Society 2009](#)).
- Older people are more likely to stay a long time in hospital, to be moved while there, to experience delayed discharge, and to be readmitted within a month as an emergency (McMurdo and Witham 2013; [British Geriatrics Society 2012a](#); [Cornwell 2012](#)).
- Successive audits have shown consistent failures to provide even basic assessments or treatment plans for some of the common harms of hospitalisation such as falls, acquired infections, pressure sores, delirium, immobility and malnutrition ([Royal College of Psychiatrists 2013](#); [Royal College of Physicians 2010, 2011, 2012d](#); [Healthcare Quality Improvement Partnership 2012](#); [Royal College of Nursing 2011](#); [Power *et al* 2012](#)).
- Numerous reports have documented failings in older people's experience of care in hospital ([House of Lords and House of Commons 2007](#); [Ombudsman 2011](#); [Care Quality Commission 2013](#); [The Patients Association, no date](#); [NHS Confederation *et al* 2013](#)).
- There is considerable evidence of ageism and age discrimination in secondary care, ranging from patronising attitudes or language, to older people being denied treatment on the grounds of age alone, to common conditions of ageing being neglected in service planning, priorities and training of staff ([Centre for Policy on Ageing 2009a, 2009b, 2009c](#)).

What we know can work

Using comprehensive geriatric assessment

Hospitals are often faced with significant numbers of admissions from older people who present 'non-specifically' with problems such as falls, immobility, confusion, or a general failure to thrive or manage at home. These people should not be dismissed with labels such as 'social admission', 'acopic' or 'off legs' ([Oliver 2008](#); [Kee and Rippingale 2009](#)). There is significant evidence that comprehensive, interdisciplinary assessment of older people presenting to hospital delivers long-term benefits in terms of their surviving hospital admission and being able to remain in their own homes with less cognitive decline ([Ellis *et al* 2011](#)). Comprehensive geriatric assessment should be provided as soon

as possible after admission by a skilled, senior member of a multidisciplinary team, and used to identify reversible medical problems, target rehabilitation goals, and plan all the components of discharge and post-discharge support needs.

Focusing on older patients with frailty

All acute hospitals should compare their own standards of assessment and treatment for frail older people against those set out in the Silver Book guidelines on emergency care for older people ([British Geriatrics Society 2012b](#)), co-written by a number of colleges and specialist societies. Systems should be in place for identifying older people who are frail and providing targeted evidence-based care for issues such as continence, falls, immobility, discharge planning and community support, and end-of-life care planning. This should be backed up by education and training for staff in all clinical areas around frailty, ensuring adequate establishment of clinicians with specialist training in the care of older people, and participating in regular relevant clinical audits. A new checklist is now being trialled, 'Frailsafe', which aims to identify frail older patients soon after admission and target interventions to improve quality and minimise harm ([British Geriatrics Society 2013c](#)).

Specialist elderly care units and wards

There is good evidence that specialist acute geriatric wards deliver higher-quality care with shorter lengths of stay and lower costs ([Baztan *et al* 2009](#); [González-Montalvo *et al* 2010](#); [Ellis *et al* 2011](#)). Comprehensive geriatric assessment is most effective on consultant-led speciality wards with a resident multidisciplinary team ([Ellis *et al* 2011](#)). Specialist stroke units have consistently been shown to save lives and improve outcomes ([Chan *et al* 2013](#)). While the precise service model will vary, all acute hospitals should consider creating acute medical units or spaces within them designed for the short-term assessment and stabilisation of frail older people, with a view to expediting discharge ([British Geriatrics Society 2012b](#)). Since it opened in 2010, a 48-hour turnaround acute frailty unit in Poole Hospital has been shown to increase 0–2 day discharge from 20 per cent to 36 per cent, delivering a 22 per cent reduction in monthly occupied bed days ([Richards *et al* 2013](#)). Service leaders should consider whether they have enough speciality beds to look after all frail older medical patients with complex needs, and enough consultant geriatricians, relevantly trained nurses and allied health professionals to deliver specialist care and assessment for them.

Liaison and in-reach services for frail older people under other medical and surgical specialities

Given the case-mix of modern hospitals, it is likely that even with a large speciality inpatient bed base for geriatric patients, there will still be numbers of older people throughout general hospitals. Proactive specialist 'in-reach' older persons' assessment and liaison (OPAL) teams can be used to offer expert advice, follow-up and care co-ordination for older people throughout the hospital. OPAL models at St Thomas' ([Harari *et al* 2007](#)) and Charing Cross hospitals ([Nair *et al* 2008](#); [National Hip Fracture Database 2013](#); [Langhorne *et al* 1993](#)) have contributed to improvements in clinical effectiveness and efficiency. Proactive input from geriatricians working with multidisciplinary teams in the care of older patients with hip fracture has been shown to deliver a range of benefits ([National Institute for Health and Clinical Excellence 2011b](#); [National Hip Fracture Database 2013](#)). Most patients with hip fracture are over 80 and many are frail, with complex needs. Proactive geriatric liaison with older people undergoing surgery (POPS) models can also improve outcomes, reduce complications and shorten length of stay ([Harari *et al* 2007](#); [Dhesi and Griffiths 2012](#)).

Maximising continuity of care

The Future Hospital Commission established by the Royal College of Physicians (RCP) recognised, in its recommendations, the importance of care continuity and of named, accountable clinicians who can co-ordinate care (Royal College of Physicians 2013). Co-ordinating the contribution of different professionals requires team leadership, clarity about what each individual and professional brings, about who is accountable for what, and about what delegation means, as well as regular team meetings and good record-keeping (Cornwell 2012). The Future Hospital Commission also recommended that generalism be revived in hospital medicine to ensure continuity of care for patients with multiple conditions, and encouraged more widespread training in geriatric medicine (Royal College of Physicians 2013). Senior, consistent supervision can also improve continuity and reduce length of stay. On adult general medical wards with a large proportion of older patients, twice daily consultant ward rounds were shown to halve length of stay when compared to twice weekly (Ahmad *et al* 2011). Minimising ward moves is an important part of providing continuity. 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 for older people.

Improving safety and preventing avoidable deaths

Hospitals must make safer care for older people a key priority, and safety strategies must cover the prevention and treatment of falls, pressure sores, hospital acquired infection, medication errors and deep vein thrombosis (Health Foundation 2013b; Oliver 2012). The Keogh Review found that many patients who suffer critical deteriorations while in hospital had physiological signs that were not recognised or acted on soon enough (Keogh 2013). Strategies to reduce avoidable unexpected mortality should therefore ensure that adequate priority is given to older people with complex needs, including physiological warning scores, critical care outreach, regular senior review, and adequate access to high-dependency beds. Older people must not be denied treatment such as emergency surgery, stroke thrombolysis or coronary revascularisation on the grounds of age alone. Falls – as the commonest safety incident in adults – merit especial focus, accounting for around 30 per cent of all incidents, with nearly 270,000 falls per year in English hospitals, and with the highest incidence in the over-80s. They are a marker for how well we manage older people in hospital and can lead to serious injury, death, and prolonged hospital stay (Healey and Scobie 2007; Oliver *et al* 2010). Implementing best practice has the potential to reduce the rate of falls by around 20 per cent (Healey and Scobie 2007; National Institute for Health and Care Excellence 2013a; Cameron *et al* 2012).

Minimising harms of hospitalisation

Hospitals must have regard for some of the other potentially preventable harms of hospitalisation for older people that are not traditionally considered as safety issues, such as malnutrition, delirium and immobility as a result of bed rest. All patients should be screened on admission for risk of malnutrition (National Institute for Health and Clinical Excellence 2012). This should be linked to regular monitoring of food intake and weight, and provision of additional nutritional assessment and intervention when needed.

Hospitals should systematically identify those at high risk of delirium and act to ensure adequate hydration and good bowel management, as well as avoiding unnecessary medication, controlling pain, and ensuring that hearing and eyesight are optimised. Delirium should be diagnosed using a validated screening tool (Inouye 2003); where diagnosed, action should be taken to find and treat underlying medical causes and to mitigate effects through things like adequate lighting and providing familiar staff.

Bed rest in older people in hospital can lead to a range of harms (Knight *et al* 2009a, 2009b; Nigam *et al* 2009). Even in healthy older adults, 10 days of bed rest can lead to a 14 per cent reduction in leg and hip muscle strength and a 12 per cent reduction in aerobic capacity: the equivalent of 10 years of life (Kortebein *et al* 2008). Hospitals should ensure that all ward staff encourage older people to stand and mobilise as early and as often as possible. Levels of mobility should be regularly documented from admission to discharge, with targeted input provided to older people at risk of immobility seven days a week (Academy of Medical Royal Colleges 2013).

Improving care for inpatients with dementia and mental health problems

Given the large numbers of older people in hospital with dementia, delirium, depression, anxiety or other chronic mental health problems (Royal College of Psychiatrists 2005) and the national drive in England to improve the care of people with dementia (Department of Health 2009c), hospitals should develop a strategy for the care of older inpatients with dementia and other mental health problems. This should include:

- identifying people with dementia, delirium and mental health problems
- efforts to make care more person-centred
- involving carers more systematically
- education and training for staff
- making physical environments on elderly care wards more ‘dementia-friendly’
- developing pathways for common issues such as antipsychotic prescribing and behavioural and psychological symptoms
- safe discharge from hospital and developing formal links with local community mental health services for older people
- considering creating specialist inpatient dementia liaison teams (Royal College of Psychiatrists 2012; NHS Confederation 2012). In some acute trusts, these teams have delivered a range of benefits in terms of length of stay, quality of care, and response times to referral (Tadros 2011; Holmes 2010)
- participation in national dementia audits and monitoring their own performance through these, and against contract incentives such as the dementia Commissioning for Quality and Innovation (CQUIN) payment.

Focusing on dignified person-centred care

There is a complex interplay of issues that results in the delivery of care for older people that is undignified and uncompassionate, ranging from the practical (lack of staff, lack of appropriate training, pressure on beds, competing priorities) to the cultural (lack of organisational support and leadership, lack of engagement from medical teams) (Tadd *et al* 2011; Department of Health 2013d; NHS Confederation *et al* 2013; Cornwell 2012). Hospitals should put in place an organisation-wide programme of quality improvement around person-centred dignified care for all inpatients, including the most frail and vulnerable. Elements of such a programme should include:

- a clear leadership focus ‘from board to ward’ on issues around dignity in care, with time spent at board level on patient experience issues
- developing a culture and systems that invite feedback and information from patients and their carers, and use this information to improve care

- full involvement of older people and carers in service design
- education and training to equip the workforce to meet the needs of the ageing population, including training for care assistants
- matching nursing staffing levels with age and dependency of ward patients
- open engagement with regulation and inspection and full participation in audit.

Key reviews and guidance

British Geriatrics Society (2012b). *Quality care for older people with urgent & emergency care needs 'Silver Book'*. London: British Geriatrics Society. Available at: www.bgs.org.uk/index.php?option=com_content&view=category&layout=blog&id=207&Itemid=888 (accessed on 4 December 2013).

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Good practice examples

Transforming care in England for older people with hip fractures

The average age of people admitted to hospital with a hip fracture is 84. Most of these older people are frail, have fallen, have bone fragility, have multiple co-morbidities, and many have dementia or delirium; the hip fracture is often the culmination of these problems, compounded in many cases by acute illness. Even with prompt evidence-based treatment, excess mortality at 12 months is still more than 20 per cent, and many of those who survive never return to their former levels of independence.

continued opposite

Transforming care in England for older people with hip fractures *continued*

It used to be commonplace for older people with broken hips to receive little systematic input from doctors trained in geriatrics or general medicine to help deal with their co-morbidities. It was also common for their surgery to be repeatedly delayed, leaving patients starved or immobile, or be carried out late at night by junior operating teams.

In 2007, the British Orthopaedic Association (BOA) and British Geriatrics Society (BGS) co-wrote 'The Blue Book' setting out standards for management of patients with hip fracture, supported by guidelines from the National Institute for Health and Clinical Excellence (NICE) in 2011b. In 2008, the BOA and BGS set up the National Hip Fracture Database – the largest in the world, with all acute providers participating. In 2009 this was linked to a national 'best practice tariff' for people with hip fracture. Standards included pre- and post-operative assessment by geriatricians, senior operating teams on dedicated day-time trauma lists, early post-operative mobilisation, early ward transfer and adequate analgesia, and a maximum 36-hour wait for surgery without justifiable medical reasons for cancellation. All data is transparent and allows comparison in real time with other providers. In the 5 years to 2013, 30-day mortality has fallen from 10 per cent to 6 per cent, median time to theatre has fallen dramatically, overall length of hospital stay has reduced, and more patients are leaving hospital with adequate falls and bone health assessment and preventive intervention.

(National Hip Fracture Database 2013)

University Hospitals Birmingham Dignity for Older Patients Project

Delivering dignity in care for older people at University Hospitals Birmingham has focused on:

- seeing the person: getting to know them, using the 'All About Me' document and an activities programme
- supporting carers: ensuring that they feel welcome on the wards and that their contribution is valued. They can stay overnight in hospital on a fold-down bed, particularly if their relative is distressed or dying
- welcoming volunteers to work alongside staff (including an activities co-ordinator) to provide a social setting at mealtimes and using familiar objects such as china cups and saucers to encourage frail older people to socialise and eat and drink more as they have 'another cup of tea and a slice of cake'.

They have appointed 506 dignity champions, who are staff from a range of backgrounds all based throughout the clinical areas where older people are cared for. They promote dignity in care, share good practice resources with staff, challenge undignified care, advocate for patients and families and help raise awareness and knowledge among their colleagues. The team review the care on the wards using 'dignity rounds' and direct observations of care, supporting their champions by providing:

- dignity workshops
- dignity launch (an annual marketplace event in the hospital atrium)
- a birthday event to celebrate good practice
- a dignity conference.

6 Good discharge planning and post-discharge support

Goal

Discharge planning needs to start at first contact with hospital and be standardised and embedded in practice, with older people and their carers fully and promptly involved in their own discharge plans and goals. The NHS and social care should work together to ensure that patients can leave hospital once their clinical treatment is complete, with good post-discharge support in the community to reduce the likelihood of further emergency readmissions.

The current situation

- A total of 80 per cent of those who stay in hospital longer than 14 days are over 65 ([Poteliakhoff and Thompson 2011](#)).
- It has been estimated that a third of older patients initially admitted to hospital as a medical emergency no longer have a need to be in a hospital bed ([NHS Confederation 2013](#)).
- Older people are more likely to be admitted with existing health or social services needs or require step-down health or social care services on discharge; they are also more likely to experience delayed transfers of care ([Katikireddi and Cloud 2008](#)).
- In recent years, the number of delayed transfers of care has remained broadly stable, with wide variation. Patients waiting for non-acute NHS care are the main reason for delays ([NHS England 2013](#)).
- The 2012 inpatient survey ([NHS Surveys 2012](#)) reported that 33 per cent of patients said they had no information about danger signs to watch out for after discharge, and 24 per cent had no information on whom to contact if they experienced any problems.
- Older people frequently report uncertainty, lack of confidence and lack of support on discharge from hospital ([Age UK 2012a](#)). More than one in three older people report feeling lonely and isolated on returning home ([Royal Voluntary Service 2013](#)).
- Poor quality discharge can lead to unnecessary readmission ([Conroy *et al* 2013](#)). Older people with complex needs, including long-term conditions and frailty, are at particularly high risk of readmission. Median rates of emergency readmission within 28 days are rising and stand at 14 per cent for people over 75, with major variation between acute hospitals ([Health and Social Care Information Centre 2012](#)).
- In a joint Department of Health/Foundation Trust Network study, around one in four readmissions were found to be a result of hospital care or poor hospital discharge planning, with most being due to relapses of long-term conditions ([Foundation Trust Network 2012](#)).

What we know can work

Early senior assessment, assertive discharge planning, and a clear focus on patient flow

Hospitals should provide senior decision-makers near the front door of the hospital seven days a week, with full access to diagnostic facilities, other key multidisciplinary team members, and clear links to step-down services. The focus should be on discharging patients who do not need to be admitted so that they can be assessed in the community; for those who do need to be admitted, the focus should be on anticipated discharge

dates, clear clinical criteria for discharge, and admission into the right ward setting, under the right team, first time (Royal College of Physicians 2012a; Emergency Care Intensive Support Team 2011; British Geriatrics Society 2012b). This approach can deliver significant reductions in admissions, and increase the percentage of patients discharged within 48 hours (Health Foundation 2013b; Fox *et al* 2013).

A concerted focus on discharge planning throughout hospital stay, and the ability to discharge seven days a week

For all older patients in all clinical areas, discharge planning should be embedded in daily patient review, with a constant focus on whether the person still needs an acute hospital bed, and if not, what they require in order to go home safely and promptly (Emergency Care Intensive Support Team 2011; Health Foundation 2011b). The Department of Health's 'Ready to go?' guidance (2010b) sets out 10 principles for discharge planning (*see* box below).

The 10 steps for effective discharge planning

1. Start planning for discharge or transfer before or on admission.
2. Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient and carer in your decision.
3. Develop a clinical management plan for every patient within 24 hours of admission.
4. Co-ordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.
5. Set an expected date of discharge or transfer within 24–48 hours of admission, and discuss with the patient and carer.
6. Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.
7. Involve patients and carers so that they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.
8. Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.
9. Use a discharge checklist 24–48 hours prior to transfer.
10. Make decisions to discharge and transfer patients each day.

In England, there is now a major policy push on seven-day service provision, with more consultant presence and availability of other key staff such as allied health professionals at weekends (Department of Health 2013b). A report by the Academy of Medical Royal Colleges on seven-day service provision made specific recommendations on increasing rates of discharge at weekends (Academy of Medical Royal Colleges 2012). Currently, weekend discharge rates for acute older patients are much lower than for weekdays – partly due to lack of access to community services, but also due to lack of senior review, access to investigations, and insufficient implementation of criterion-led discharge that can be triggered without medical review.

Involving older people and their carers in discharge plans

Discharge planning that involves people and their carers reduces the chance of readmission (Bauer *et al* 2009). However, poor experiences for older people and their families of discharge from hospital have been cited in numerous reports (Francis 2013; Royal College

of Physicians 2012b; National Voices 2013; Ombudsman 2011; Ellins *et al* 2012; Which? 2011; Alzheimer's Society 2009; Royal College of Psychiatrists 2013; Cornwell *et al* 2012). Hospitals should ensure: that older people and their carers are involved from the outset in identifying goals and concerns for their discharge from hospital; that their expectations are managed; and that they have adequate notice of and involvement in their own discharge plan. Having a single named individual clinician or care co-ordinator can help, as long as the patient or their carer knows how to contact them; there is also written information such as the Alzheimer's Society's 'This is me' booklet for inpatients with dementia, which aims to ensure that personal information is shared with professionals.

Ensuring integrated information systems and structured multi-professional communication

Local service leaders should develop improved protocols for information-sharing and integrated information systems, especially around care transitions such as hospital admission and discharge. Specified discharge worker roles, multi-professional care co-ordination teams, and information technology systems promote better service satisfaction and subjective quality of life for older people when compared with standard hospital discharge (Cornwell *et al* 2012; Health Foundation 2011b).

Strengthening post-discharge assessment and support

Comprehensive geriatric assessment (CGA) of older people post-discharge, and tailored interventions following CGA, can both reduce the risk of nursing home admission and hospital readmission (Beswick *et al* 2008). Transitional care programmes that provide additional support to people in the immediate post-discharge period can improve care for older people (Dedhia *et al* 2009; Naylor *et al* 2004). Local service leaders should consider developing capacity in post-acute Hospital at Home schemes for targeted patients, though it should not be assumed that such teams will deliver cost savings.

Early supported discharge teams – providing rehabilitation, equipment, personal care, medical review or nursing interventions, and tailored to the individual's needs for a time-limited period – have been shown to be effective in reducing readmissions and improving outcomes in stroke (Shepperd *et al* 2010). Leaders of local stroke services should ensure that such teams are embedded in stroke services and have sufficient capacity to take all suitable patients. The voluntary sector can play a key role. Organisations such as the Royal Voluntary Service (RVS), the British Red Cross and Age UK offer 'home from hospital' services. A recent study by RVS in Leicester demonstrated a halving of readmission rates, and enhanced confidence and satisfaction in recently discharged people over 75 who received support from volunteers (Royal Voluntary Service 2013). Other case studies have shown that home improvement and handypersons agencies and charities providing adaptations have also helped to reduce readmissions and improve post-discharge support (National Housing Federation 2012).

Reducing delayed transfers of care

There are numerous reasons why patients experience delayed transfer of care from acute hospital to community health or social care services, including waits for assessment or care provision. Some localities in England have succeeded in significantly reducing delayed transfers (Ham 2012; Thistlethwaite 2011; Health Foundation 2013a, 2013c), and from 2015/16, the Better Care Fund requires local authorities and NHS partners to demonstrate that seven-day services are in place to support daily discharge of patients and to prevent unnecessary admissions at weekends (NHS England and Local Government Association 2013a). The evidence from these studies suggests some key actions that can reduce delayed transfers of care for older people, as follows.

- Begin discharge planning early, so that staff are already referring for community services well in advance of discharge.
- Put in place an agreed discharge process that sets out timescales and protocols for assessment and decision-making (including risk assessment) and how different professionals and agencies will work together to achieve timely discharge.
- Ensure that patients already receiving community services are discharged as soon as it is safe to do so, with re-starts of care and minimal cancellation of services.
- Promote a ‘discharge to assess’ model so that older people’s care needs can be assessed in their own homes.
- Ensure that older people do not become dependent or disabled in hospital by providing high-quality care and rehabilitation.
- Enable ‘in-reach’ services from social care and community services.
- Support extra capacity in integrated locality teams to ensure that patients are discharged to alternative sources of support.
- Use pooled health and social care budgets or transfer of funds from NHS to social care to reduce delays.

Key reviews and guidance

Department of Health (2010b). *Ready to go? Planning the discharge and the transfer of patients from hospital and intermediate care*. London: Department of Health. Available at: www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/EastMidlands/PandEI/Ready_to_Go_-_Hospital_Discharge_Planning.pdf (accessed on 5 December 2013).

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Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, Richards S, Martin F, Harris R (2009). ‘Hospital at home early discharge (Review)’. *The Cochrane Library*, issue 1.

Cornwell J, Levenson R, Sonola L, Poteliakhoff E (2012). *Continuity of care for older hospital patients: a call for action*. London: The King’s Fund. Available at: www.kingsfund.org.uk/publications/continuity-care-older-hospital-patients (accessed on 21 January 2014).

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Health Foundation (2011b). *Getting out of hospital? The evidence for shifting acute inpatient and day case services from hospitals into the community*. London: the Health Foundation. Available at: www.health.org.uk/public/cms/75/76/313/2539/Getting%20out%20of%20hospital%20summary.pdf?realName=nx9Vzs.pdf (accessed on 5 December 2013).

Foundation Trust Network (2012). *Briefing on the readmission policy 2012/13 with additional information on the reviews*.

Good practice examples

Sheffield patient flow

Lean improvement methodology (originally used by Toyota for car manufacturing) is used in Sheffield Teaching Hospitals to improve the flow of older patients, and reduce mortality and overall bed occupancy. Initial analysis showed that 80 per cent of people staying more than 2 weeks were over 80, accounting for nearly half the bed days in adult medicine; in addition, around 1 in 3 patients over 65 occupying a bed no longer needed to be in hospital.

Consultants changed their work practices so that they could be on the front door of the hospital up to 12 hours a day, 7 days a week, to enable increased real-time senior review. Availability of doctors was matched to patient flows and arrival times. They adopted the principle of 'discharge to assess' (from the front door of the hospital) and 'decide to admit' (under the right speciality team, first time) alongside a clear focus on discharge planning and minimising internal delays.

Within 6 months, admission rates for patients over 65 had fallen, and bed occupancy had reduced by 60 beds; in-hospital mortality fell by 15 per cent, and readmission rates did not rise. In future, the team aims to provide real-time clinic assessment so that GPs can refer older patients in crisis for a 'one-stop' assessment.

(Health Foundation 2013b)

Interface geriatricians and 'discharge to assess' in Leeds

Leeds Teaching Hospitals has a 60-bed acute assessment unit for older people, which provides comprehensive geriatric assessment (CGA) to facilitate discharge to community services for ongoing support or assessment, or commence appropriate treatment or discharge planning early in admission. From 2010–11, it achieved a four-day reduction in length of stay for acutely admitted geriatric medicine patients. In 2012, three consultant interface geriatricians were appointed. They link closely with the Early Discharge Assessment Team and can offer a range of interventions, including direct communication with primary care, direct referral to specialist clinics or community rehabilitation teams, altered medication, organising investigation, and rapid access to social care assessment and support. They focus on patients who have been readmitted within seven days of discharge or who are unlikely to need medical admission but have complex needs due to cognitive impairment, physical disability or ongoing medical issues.

Within the first year, they had assessed 590 patients, 60 per cent of whom were discharged from A&E (more than double the discharge rate in the previous year for comparable patients); they had also provided clinical advice to 209 patients (using conference calls between a GP and nurse), reducing admission rates by 26 per cent in the group of patients focused on.

<http://britishgeriatricsociety.wordpress.com/category/interface-geriatrics/>

7 Good rehabilitation and re-ablement (outside acute hospitals) after acute illness or injury

Goal

Older people should receive adequate rehabilitation and re-ablement when needed, to prevent permanent disability, greater reliance on care and support, avoidable admissions to hospital, delayed discharge from hospital, and to provide adequate periods of assessment and recovery before any decision is made to move into long-term care. Acute hospitals must play their part in ensuring adequate inpatient rehabilitation, but most rehabilitation services could be provided outside hospital settings.

The current situation

- Most people over 65 presenting acutely to hospital have impairment in one or more activities of daily living (Hubbard *et al* 2004), and many have not returned to baseline levels of mobility or functional independence on discharge from hospital (Mudge *et al* 2011).
- The median age of people using intermediate care or re-ablement services is 83 (NHS Benchmarking 2013).
- Access to rehabilitation and re-ablement outside acute hospitals varies significantly (NHS Benchmarking 2013).
- The National Intermediate Care Audit for England (NHS Benchmarking 2013) concluded that there are only around half the beds and places needed to ensure that no older person is in a hospital bed if it can be avoided.
- A lack of capacity in post-acute rehabilitation is most probably a key factor behind the high numbers of older people who go straight from a hospital stay into long-term care (Horne 1998; Department of Health 2009e).

What we know can work

Rehabilitation and re-ablement are two services on a continuum of intermediate care. Rehabilitation is primarily a health model that includes physical therapy and occupational therapy to prevent admission to acute care or facilitate a stepped pathway out of hospital. Re-ablement is primarily a social care model that focuses on promoting and optimising independent functioning rather than resolving health issues (Social Care Institute for Excellence 2013). Despite these formal definitions, the terms are often used interchangeably, and many localities provide a number of differently named services providing elements of both.

The majority of rehabilitation and re-ablement services are step-down services following a hospital stay, but they can also be step-up services, aiming to provide the necessary support to prevent any further deterioration that could lead to a hospital stay (Allen and Glasby 2010). Local service leaders should ensure that there is enough capacity and responsiveness to meet the needs of every older person who might benefit from these services. They should adhere to the standards of evidence-based practice set out in the Department of Health's Halfway Home document (Department of Health 2009b) and use the methodology set out in the National Intermediate Care Audit (NHS Benchmarking 2013) for categorising services and describing responsiveness, outcomes (including patient reported outcomes), admission criteria and length of stay, and matching need to demand.

Shared and comprehensive assessment of needs and personalised plans

The goals of each individual may include mobility, self-care, continence, and activities of daily living such as food preparation, as well as resumption of hobbies and social activities such as visiting friends or walking to the shops. This requires local health, housing and social care services to work together (Social Care Institute for Excellence 2013; Pitts *et al* 2011; Allen and Glasby 2010). 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 decisions made. Shared information and protocols, as well as co-located or integrated health and social care teams, can ensure that the work of multiple professionals and agencies is streamlined and co-ordinated (Allen and Glasby 2010). Those teams who refer people to rehabilitation and re-ablement services also need to be involved, since they need a clear understanding of the services available to be able to refer effectively (Allen and Glasby 2010; Barton *et al* 2006).

Implementing evidence-based best practice

Evidence-based best practice should be implemented where possible. The National Institute for Health and Care Excellence (NICE) has produced guidelines for rehabilitation in specific clinical areas, such as stroke and cardiac rehabilitation (National Institute for Health and Care Excellence 2013b, 2013c). No single leading delivery model exists for re-ablement services. However, the Social Care Institute for Excellence (2013) guide, *Maximising the potential of reablement*, summarises the evidence and outlines key considerations for commissioners and service providers, while the *Care Services Efficiency Delivery Re-ablement Toolkit* (Department of Health 2011a) provides a standard framework for establishing or reviewing a re-ablement service.

Commissioning for outcomes

Rehabilitation and re-ablement services are time-limited, often to periods of six to twelve weeks. However, given the crucial importance of personalising support to a person's own goals, contracting and commissioning these services is most effectively done not on the basis of time periods and tasks, but on the outcomes desired for that person. This approach will support achievement of indicators in the Adult and Social Care Outcomes Framework, which were developed based on what matters to people, and include 'delaying and reducing the need for care and support'. Rehabilitation and re-ablement services should be flexible, ensuring that people move on as soon as they are ready to and allowing people to receive services for longer than six weeks if necessary (Rabiee *et al* 2009). Lump sum payments can give providers the increased flexibility needed to adjust support according to people's changing needs (Social Care Institute for Excellence 2013).

Providing home-based rehabilitation and re-ablement

Home-based rehabilitation is less expensive than rehabilitation in day hospital settings (Forster *et al* 2008), and home care re-ablement has been shown to reduce the need for long-term care (Department of Health 2009b). Older people report greater satisfaction with intermediate care provided outside of hospitals, and carers benefit from a re-ablement approach to ongoing care outside of hospital (Wilson *et al* 2008; Glendinning *et al* 2011; Arksey *et al* 2013). The workforce required for home-based rehabilitation and re-ablement services should have an appropriate mix of skills that may include nurses, therapists, social workers and community psychiatric nurses, and be led by a senior clinician (Department of Health 2009b; Barton *et al* 2006). Voluntary sector organisations can also provide rehabilitation and re-ablement support. Housing services can play a vital role in ensuring that an older person's home is fit to provide a safe environment and to maximise independence (Wood and Salter 2012).

Providing community hospital-based rehabilitation and re-ablement

Community hospitals rather than acute hospitals have been found to be a more effective setting for the rehabilitation of older people following an acute illness (Young *et al* 2007). Commissioners should ensure that there are enough beds and places for those requiring ongoing rehabilitation, including those needed to prevent people being admitted to acute hospitals. Commissioners should compare their provision and activity with localities with a similar demographic profile.

Using alternative providers of rehabilitation and re-ablement

Other alternatives to acute hospitals for rehabilitation and re-ablement of older people include spot purchasing nursing home beds or wings of nursing homes, or new forms of sheltered or retirement housing often known as ‘extra care housing’ (Housing Learning & Improvement Network 2008). There is little evidence on the effectiveness of this form of provision for rehabilitation and re-ablement, despite it being common practice. A Cochrane review of nurse-led rehabilitation in bed-based care settings, including care homes, indicated that results were mixed, with comparable levels of wellbeing and lower readmission rates but a tendency to higher mortality and much longer overall stay than was the case with usual care (Griffiths *et al* 2007).

Providing workforce training in re-ablement

An effective re-ablement service requires specific training and skills distinct from broader home care services. The workforce should be trained to focus on actively supporting older people to do things for themselves, and recognising that support needs will change as the person’s abilities and independence are restored (Social Care Institute for Excellence 2013; Pitts *et al* 2011).

Successful ending of and transition from rehabilitation and re-ablement

If, at the end of the period of rehabilitation and re-ablement, a person is assessed as having ongoing needs for support, it is important that care is planned to provide those services and maintain the progress made. In practice, this can often be most effectively achieved through joint working between the rehabilitation and re-ablement teams and the ongoing care providers in the time leading up to, during and after transition, and specifying this responsibility in contracts (Social Care Institute for Excellence 2013). Where an older person does not meet council eligibility criteria for ongoing care, the re-ablement team ought to support and signpost the person and their carers to any voluntary sector programmes such as befriending services that might be of use.

Key reviews and guidance

Department of Health (2009b). *Intermediate care – halfway home. Updated guidance for the NHS and local authorities*. London: Department of Health.

NHS Benchmarking (2013). *National audit of intermediate care report 2013*. Manchester: NHS Benchmarking Network. Available at: www.nhsbenchmarking.nhs.uk/National-Audit-of-Intermediate-Care/year-two.php (accessed on 18 November 2013).

Social Care Institute for Excellence (2013). *Maximising the potential of reablement*. London: Social Care Institute for Excellence. Available at: www.scie.org.uk/publications/guides/guide49/files/guide49.pdf (accessed on 5 December 2013).

Department of Health (2011a). *Care services efficiency delivery homecare re-ablement toolkit*. London: Department of Health. Available at: <http://webarhive.nationalarchives.gov.uk/20120907090129/http://www.csed.dh.gov.uk/homeCareReablement/Toolkit/> (accessed on 5 December 2013).

Griffiths PD, Edwards ME, Forbes A, Harris RG, Ritchie G (2007). 'Effectiveness of intermediate care in nursing-led in-patient units' (Summary). *Cochrane Database of Systematic Reviews*, issue 2, article CD002214.

Forster A, Young J, Lambley R, Langhorne P (2008). 'Medical day hospital care for the elderly versus alternative forms of care (Review)'. *The Cochrane Collaboration*. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001730.pub2/pdf/standard> (accessed on 5 December 2013).

Good practice examples

Birmingham Cross-City Clinical Commissioning Group and Birmingham Community Healthcare NHS Trust

Birmingham Community Healthcare NHS Trust runs two community health unit wards on acute sites within the Heart of England Foundation Trust. Each provides a period of intensive multidisciplinary assessment, and support with decision-making, for vulnerable and frail older adults facing significant changes to their care and accommodation. Being outside an acute care environment enables these individuals to regain their independence while identifying the areas where they require support.

Joint health and social care funding is used to support patients in the units. After initial assessment and identification of need for long-term services, people are moved out of the wards and into a local authority-funded phase of care and onto long-term services as soon as possible. Joint funding enables a more seamless transition and avoids delays to care transfers. The community units have enabled more older people to return to their own homes, and reduced delayed transfers and excess bed days in the acute trust.

(NHS Benchmarking 2013)

Leicestershire Home Care Re-ablement Services

In 2007, the Department of Health Care Services Efficiency Delivery programme published a retrospective evaluation of Leicestershire Home Care Re-ablement Services. These services put in a time-limited package of re-ablement for older people in receipt of new social care packages – generally on discharge from hospital – compared to 'control' recipients of care who did not receive re-ablement.

At first review, 58 per cent of the intervention group and only 5 per cent of the control group were able to have their care packages discontinued; 17 per cent of the re-ablement group had their package maintained at current level, compared with 71 per cent of the control group. There was an overall average reduction of 28 per cent of home care hours required by those in the intervention group.

(Department of Health 2011a)

8 High-quality, long-term nursing and residential care for those who need it

Goal

Though some people make a positive choice to enter long-term care, older people should only generally move into nursing and residential care when treatment, rehabilitation and other alternatives have been exhausted. Residents should consistently receive high-quality care that is person-centred and dignified, and have the same access to all necessary health care as older people living in other settings.

The current situation

- Four per cent of people over 65 are permanent residents in care homes in England, rising to more than 20 per cent of those over 85 ([British Geriatrics Society 2011](#)). There are an estimated 390,000 people over 65 in care homes in England ([British Geriatrics Society 2013a](#)) – four times as many as in hospital beds at any given time.
- There is wide variation in rates of long-term care placement between localities, and a sixfold difference in the chances of someone over 65 going straight from an acute hospital bed to long-term care ([NHS Atlas of Variation 2011](#); [Audit Commission 2011](#)).
- Care home residents are among the sickest patients and tend to have the most complex needs ([British Geriatrics Society 2011](#)). Levels of dependency are rising, so that the population in ‘residential’ homes now resembles that only found in nursing homes a few years ago (Bebbington *et al* 2000).
- Despite these complex and high levels of need, people living in nursing and residential homes face wide variation in their access to all necessary health services. Surveys across the UK have found that:
 - 68 per cent of care home residents do not get a regular planned medical review by their GP
 - 44 per cent were not getting a regular planned review of their medication
 - 41 per cent could not access specialist dementia services ([British Geriatrics Society 2012a](#)).
- Too often, residents end up being admitted to hospital as unplanned emergencies, some of which are avoidable ([British Geriatrics Society 2011](#)). Around a quarter of all patients admitted to NHS hospitals with hip fracture are from nursing and residential homes (Sahota and Currie 2008).
- An estimated 50 per cent of residents admitted to hospital who died could have been cared for in their care home with better proactive management ([National Audit Office 2008](#)).
- Only 1 per cent of total UK consultant geriatrician time is contractually allocated to care homes ([British Geriatrics Society 2011](#)).
- The Care Quality Commission’s dignity and nutrition inspections use the same assessment domains across care homes and hospital settings, and its 2012 data reveals poorer care in care homes compared with hospitals on every domain except safe access to medicines ([Care Quality Commission 2013](#)).

What we know can work

Preventing avoidable admissions to long-term care

Local service leaders should ensure that all older people for whom long-term care is being considered have a comprehensive assessment of need, adequate treatment of medical problems precipitating the decision to move, adequate rehabilitation and, wherever possible, are not moved into long-term care directly from an acute hospital setting. Alternatives such as enhanced support at home, a move to age-friendly housing, carer support or end-of-life care at home should all be fully considered. Older people and their carers should be fully involved in decisions about future location of care.

Localities with relatively high rates of care home placement, even when adjusted for the numbers of 'self-funding' residents, should analyse the probable causes for this. One issue may be availability – areas with higher numbers of care home places may experience a lower threshold for admission. Other factors include:

- capacity in age-friendly housing (including sheltered accommodation and extra care housing)
- availability of aids, telecare adaptations, and care and repair services ([Housing Learning & Improvement Network 2008](#); [National Housing Federation 2012](#))
- availability of and charging for home care services ([Windle *et al* 2010](#))
- availability of both step-up and step-down intermediate care and re-ablement services ([NHS Benchmarking 2013](#); [Audit Commission 2011](#); [Social Care Institute for Excellence 2013](#))
- investment in good discharge planning and post-discharge support
- systematic use of comprehensive geriatric assessment, either in people's own homes or in hospital ([Beswick *et al* 2008](#); [Beswick *et al* 2010](#); [Ellis *et al* 2011](#))
- availability of specialist support for people with dementia ([Alzheimer's Disease International 2011](#)) or for end-of-life care at home ([Gold Standards Framework website](#)).

We also know that common precipitants of moves to care homes include recurrent falls, incontinence and behavioural symptoms of dementia ([Centre for Policy on Ageing and Bupa 2012](#); [Department of Health 2009e](#)); that adequate investigation and treatment for these conditions therefore has the potential to prevent admissions.

Active commissioning of health and mental health care for care home residents

GP collaboration with care homes can be poor, and access to other services such as community geriatricians can be very variable ([British Geriatrics Society 2011](#)). There is no single model of care that guarantees provision of high-quality health care in care home settings, nor is there one ideal contractual arrangement, since the care home market is so diverse. Whatever the model in use locally, service leaders need to work in consultation with care home providers to ensure that health care for care home residents is an actively commissioned service, with clear service specifications linked to quality standards that are detailed in contracts. In most cases, this will involve providing residents with enhanced, proactive primary care services that in turn provide access to the full range of necessary multidisciplinary and specialist services, including geriatricians, old age psychiatrists, therapists, allied health professionals, community pharmacists, and palliative care clinicians ([British Geriatrics Society 2013b, 2012a](#); [College of Occupational Therapists 2013](#)). These professionals all already provide health care in care homes, but they do so in an ad hoc, siloed way rather than as integrated multidisciplinary teams ([Gage *et al* 2012](#)).

The British Geriatrics Society has published important guidance for the commissioning of high-quality care in care homes (*see* box). NICE has also published a quality standard for the provision of mental health care to care home residents (NICE 2014). Key facets of care home medicine include falls prevention, identification and management of incontinence, proactive medication review and adjustment, reduction of psychotropic drugs, and a better focus on end-of-life care. These are summarised in a recent paper by Burns and Nair (2014), alongside descriptions of potential models of delivery.

British Geriatrics Society: Commissioning guidance for high-quality health care for older care home residents

This new guide:

- outlines what the priority services should be for older care home residents
- explains what the outcomes should be for residents themselves, for the local NHS, and for local care homes as a result of having these services in place
- describes what activities will enable these outcomes to be achieved
- suggests how services can be monitored and evaluated to see if they are having a positive impact.

Key aspects of health care that need to be addressed for residents include:

- health promotion and chronic disease management
- falls management
- continence
- nutrition
- rehabilitation
- psychological wellbeing
- pain management
- medicines management and prescribing
- dementia care
- emergency and crisis management.

The guidance is available at: www.bgs.org.uk/campaigns/2013commissioning/Commissioning_2013.pdf

(British Geriatrics Society 2013a)

Information-sharing

When a new resident moves in to a care home, there needs to be a prompt transfer of clinical information to the care home to enable health care staff to build on the wealth of assessment that will have been conducted prior to this. This is particularly important for continuity of care where a change of GP and/or other health care professional occurs as a result of the move. Community nurses working as case managers could supplement general medical services in this regard, and serve as a clinical and communication bridge to specialists and other community health services such as pharmacy (for medication reviews) and mental health teams.

Conducting holistic assessments

There is evidence that comprehensive, multidisciplinary assessment can improve care for residents in care homes, just as for older people admitted to hospital. In Sandwell, in the West Midlands, a one-year pilot achieved positive results by introducing detailed multidisciplinary reviews for care home residents by a geriatrician, nurse specialist and pharmacist. One care home experienced a 16 per cent reduction in hospital admissions and a 43 per cent reduction in occupied bed days; in another, the decrease was 29 per cent and 71 per cent respectively (British Geriatrics Society 2013a). Assessment should be seen as a continuous and regular process, not a one-off event at admission.

Providing support and training for care home staff

There is a dearth of national data about the size and structure of the care home workforce. In particular, there is scant large-scale evidence about the education and training received by care workers and care assistants, who make up the majority of the workforce. Care homes experience high staff turnover, with 42 per cent of staff leaving within 12 months of joining (Centre for Policy on Ageing and Bupa 2012). Training and education in issues such as dementia and end-of-life care are important; evidence increasingly suggests that training is most effective when registered and non-registered workers learn together on-site as part of an overall quality improvement initiative, 'in order to make learning a force for change rather than a means of qualification' (Owen *et al* 2006).

Using evidence-based frameworks for assessment of quality of life and improvement of relationship-centred care

The quality of life offered to residents in care homes has improved markedly when compared with the meagre 'last refuge' before death that Peter Townsend found in his 1962 study (Townsend 1962). The best care homes focus on creating positive communities and delivering care that provides the environments, activities and relationships that together provide a good quality of life for residents (Owen *et al* 2006).

A range of frameworks for considering care home quality are available, the most comprehensive of which cover not just structures and clinical outcomes but also the relational aspects of caring and the issues that are important to residents and their families. One example is the CARE profiles (combined assessment of residential environment), which attempt to reflect the experiences of residents, their families and care home workers in one framework, based on Nolan's six senses (security, continuity, belonging, purpose, fulfilment and significance) (Nolan *et al* 2006). Quality frameworks need to be broad enough to allow for individual variation; no two residents will have precisely the same definition of quality of life. But recognising this, evidence-based frameworks provide an important structure for assessing and improving quality of both life and care.

Key reviews and guidance

British Geriatrics Society (2011). *Quest for quality – British Geriatrics Society joint working party inquiry into the quality of healthcare support for older people in care homes: a call for leadership, partnership and quality improvement*. London: British Geriatrics Society. Available at: www.bgs.org.uk/campaigns/carehomes/quest_quality_care_homes.pdf (accessed on 20 January 2014).

British Geriatrics Society (2012a). *Failing the frail: a chaotic approach to commissioning healthcare services for care homes. Analysis of data collected by CQC about PCT support for the healthcare of older people living within nursing and residential care homes*. British Geriatrics Society. Available at: www.bgs.org.uk/index.php/mnupressreleases/1907-cqc-report-too-many-failing-hospitals (accessed on 20 January 2014).

British Geriatrics Society (2013b). *Commissioning guidance for high quality health care for older care home residents*. Available at: www.bgs.org.uk/index.php/resources-6/bgscampaigns/commissioning2013/2581-commissioning2013-requisite (accessed on 5 December 2013).

Health Foundation (2013b). *The improving prescribing for the elderly (ImPE) project: Funded by the NIHR CLAHRC for North West London*. Available at: http://patientsafety.health.org.uk/sites/default/files/resources/the_improving_prescribing_for_the_elderly_project.pdf (accessed on 5 December 2013).

College of Occupational Therapists (2013). *Living well through activity in care homes: the toolkit*. London: College of Occupational Therapists Limited. Available at: www.cot.co.uk/living-well-care-homes (accessed on 5 December 2013).

National Institute for Health and Care Excellence (2014). *Mental wellbeing of older people in care homes*. NICE quality standard 50. Manchester: National Institute for Health and Care Excellence. Available at: <http://guidance.nice.org.uk/QS50> (accessed on 23 January 2014).

Owen T, and National Care Homes Research and Development Forum (eds) (2006). *My home life: quality of life in care homes*. London: Help the Aged. Available at: www.scie.org.uk/publications/guides/guide15/files/myhomelife.pdf (accessed on 5 December 2013).

Audit Commission (2011). *Joining up health and social care: improving value for money across the interface*. London: Audit Commission. Available at: <http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/Downloads/vfmhscinterface.pdf> (accessed on 5 December 2013).

Burns E, Nair S (2014). 'New horizons in care home medicine'. *Age and Ageing*, vol 43, no 1, pp 2–7.

Good practice examples

My Home Life

The *My Home Life* programme is a collaborative initiative to promote quality of life in care homes for older people. It is led by City University in partnership with Age UK and has the support of the Relatives and Residents Association and all the national care home provider representative organisations across the United Kingdom.

It began as a small project to synthesise the evidence base for best practice and is now seen as a social movement for change and quality improvement. It seeks to do this by celebrating and spreading good practice and enhancing relationships between residents, relatives and staff and enabling better partnership working between care homes and their local community and the wider health and social care system. The programme has spread across national borders with *My Home Life* initiatives in England, Wales, Scotland and Northern Ireland.

The programme has disseminated a range of evidence-based resources to 18,000 care homes, provided leadership support for more than 500 care home managers and engaged in community development work in 25 local authorities (eg, *My Home Life Essex*). The *My Home Life* vision includes eight themes – maintaining identity; creating community; sharing decision-making; managing transitions; improving health and health care; supporting good end-of-life care; keeping the workforce fit for purpose; and promoting a positive culture – and is underpinned by relationship-centred care. It has influenced national and local policy and created a community of practice and engagement through social media and volunteering.

(www.myhomelife.org.uk)

Preventing acute admissions from care homes

Ashford and St Peter's Hospitals NHS Foundation Trust, concerned about high rates of acute admissions from nursing homes, collected data on more than 2,000 local nursing home residents admitted to the trust over a three-year period, and identified 82 residents with 4 or more admissions. They set up a trial project to reduce the rate of acute admissions, first focusing on the 3 local care homes with the highest rates of multiple admissions, then extending it to 12 care homes.

Consultant geriatricians visited each home and discussed with staff how admissions might be prevented. This led to the establishment of medical advisory meetings at which GPs, geriatricians and care home managers discussed the residents' needs on a monthly basis. Specialist medical advice over the telephone was made available to nursing homes and short-term capacity was created to provide intravenous antibiotics and fluids to residents who needed them. Joint protocols were established to shorten length of stay if residents were admitted to hospital.

The initial trial halved the rate of admissions from the three homes, resulting in ongoing funding for the project. Results remained impressive when it was rolled out to 12 care homes, with a 35 per cent reduction in admissions and potential savings of £370,000.

([Lisk et al 2013](#))

9 Choice, control, care and support towards the end of life

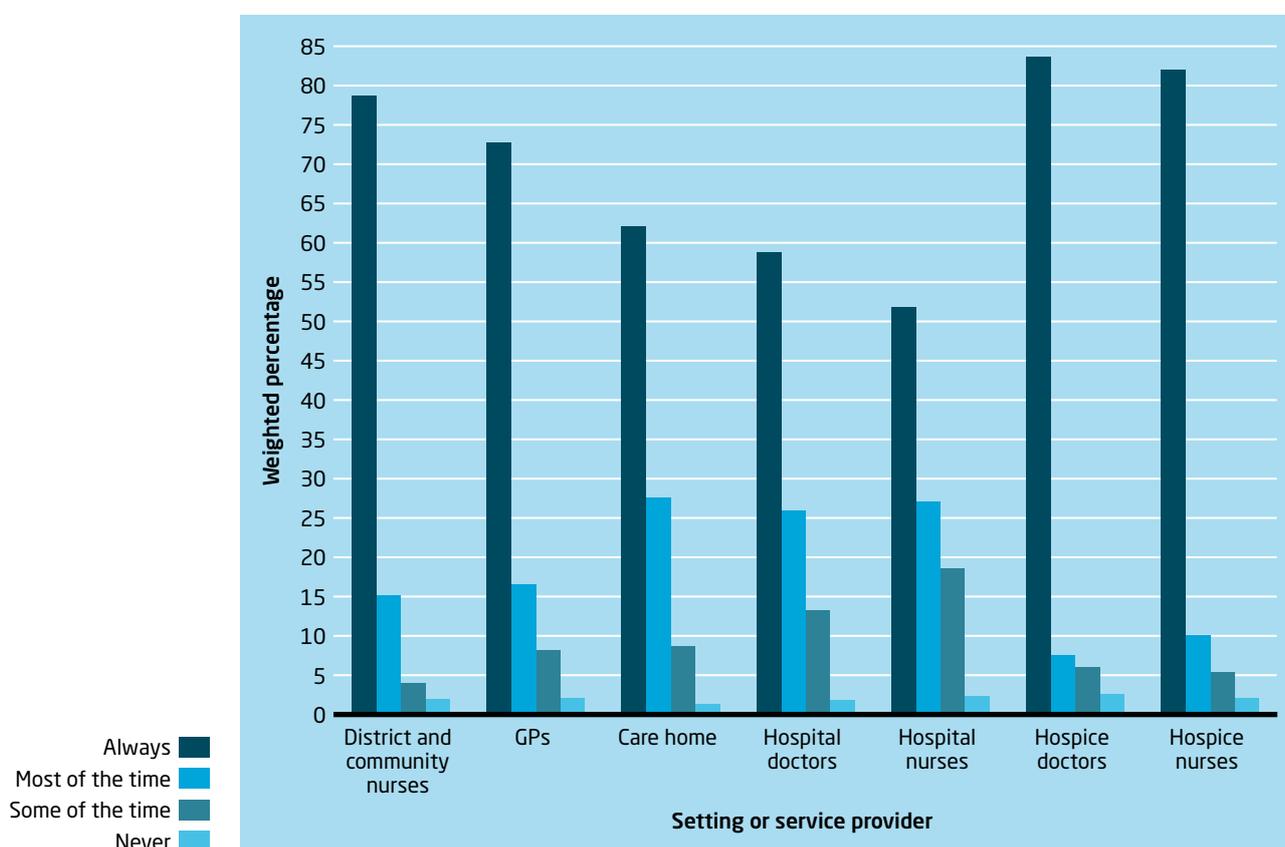
Goal

Older people who are nearing the end of life should receive timely help if they want or need it, to discuss and plan for the end of life. End-of-life care services should provide high-quality care, support, choice and control, and should avoid ‘over-medicalising’ what is a natural phase of the ageing life course.

Current situation

- Overall, older people receive poorer-quality care towards the end of life than younger people. They are:
 - less likely to be involved in discussions about their options
 - less likely to die where they choose
 - less likely to receive specialist care or access hospice beds (Seymour *et al* 2005; Gott and Ingleton 2011).
- According to the World Health Organization, ‘... older people suffer unnecessarily, owing to widespread underassessment and under-treatment of their problems and lack of access to palliative care’ (World Health Organization 2011a).
- The second National Bereavement Survey (Office for National Statistics 2013d) found that care was rated most highly by respondents whose loved ones died of cancer in their own homes. Being shown dignity and respect was rated highest in hospices and lowest in hospitals (*see* Figure 8).

Figure 8 How often the patient was treated with dignity and respect in the last three months: by setting or service provider, England, 2012



Source: National Bereavement Survey (VOICES) – Office for National Statistics 2013d

- The chances of someone over 65 being able to die in their own home vary widely ([NHS Atlas of Variation 2011](#)), but hospital is by far the least preferred place of death ([Office for National Statistics 2013d](#)). Public Health England has published *End of Life Care Profiles* ([Public Health England 2013a](#)) for localities, which show the wide variation in capacity and place of provision.
- In a National Audit Office (NAO) study, at least 40 per cent of people who died in hospital did not have medical needs that required them to be treated in hospital, and nearly a quarter of them had been in hospital for over a month ([National Audit Office 2008](#)).
- Older people with frailty or dementia experience particularly poor end-of-life care, including being less likely to have advance care planning or to be involved in discussions about their care ([Office for National Statistics 2013d](#); [Alzheimer's Society 2008](#)).
- Access to specialist palliative care remains variable, within hospitals and particularly in community settings. Around 20 per cent fewer older people receive specialist palliative care compared with younger age groups, and it has been posited that age discrimination may be part of the explanation for this (National Council for Hospice and Specialist Palliative Care Services 2004).

What we know can work

The King's Fund has previously stressed that end-of-life care is one of the key areas that commissioners must focus on ([Naylor *et al* 2013](#); [Addicott and Hiley 2011](#)). There are a number of important frameworks and guidance documents for local service leaders wanting to improve the quality of their end-of-life care services. The Royal College of General Practitioners (RCGP) has published guidance for commissioning in end-of-life care ([Thomas and Paynton 2013](#)), and the National Institute for Health and Clinical Excellence quality standard set out the desired quality and outcome goals ([National Institute for Health and Clinical Excellence 2011a](#)).

Local service leaders should review their own services against these quality standards. They should ensure that all services supporting people at the end of life adhere to these standards, and that staff have the skills and capacity to deliver against them, so that older people (including those with dementia and frailty) receive the same standard of care as younger people. Some of the most important opportunities for improving end-of-life care for older people are set out below.

Providing workforce training and support

Staff across a range of health and care settings who are caring for people in their last year of life need specialist training and support. The National Gold Standards Framework Centre (GSF) in End of Life Care provides comprehensive training programmes for staff combined with strategic support and tools that aim to ensure that end-of-life care services provide 'the right care, for the right person in the right place at the right time, every time' (see the [Gold Standards Framework website](#)). Following successful implementation of the GSF training programme, accreditation is a rigorous process of quality assurance that includes key outcome measures, comparative audits, a portfolio of evidence, and independent visit or interview. Skills for Care also offers national end-of-life care qualifications in social care ([Skills for Care 2013](#)).

Identifying people in the last year of life

Where possible, people in their last year of life need to be identified in advance in order to discuss and plan care, including issues such as under what circumstances their treatment should stop. There is evidence that early involvement in end-of-life care

planning increases satisfaction and can increase the likelihood of someone being able to die at home (Howie and Peppercorn 2013; Gomes *et al* 2013). The national ‘find your 1 per cent’ campaign is supporting GPs to identify those patients who they suspect may die within a year; evidence suggests that there is considerable scope to increase the proportion of patients identified as such who could then receive advance care planning (Denning *et al* 2012). A 2009 primary care audit showed that only 25 per cent of people who died were included on the palliative care register; but those on the register received better co-ordinated care (Thomas *et al* 2011).

Ensuring effective assessment and advance care planning

Unlike a patient receiving a terminal diagnosis – for instance, where a person presents late with metastatic cancer – for many older people nearing the end of life, there is no sentinel event that presents an opportunity for a clinician to ‘break bad news’. Talking about dying is difficult; a survey of GPs in 2012 revealed that 35 per cent had never initiated a conversation about end-of-life care with one of their patients (Royal College of General Practitioners and Royal College of Nursing 2012). However, as soon as a clinician suspects that a patient may be approaching the end of life, they must initiate conversations to help explore the person’s understanding of their condition and to assess their physical, mental, social and spiritual needs, with referral to community palliative care teams or other relevant health and social care professionals as needed (Mullick *et al* 2013). Advance care planning is also important to guide future treatment decisions following any later loss of decision-making capacity. The Mental Capacity Act 2005 enables people to appoint a family member, carer or professional as a welfare attorney to make decisions on their behalf should the need arise.

There is a growing body of research and guidance, nationally and internationally, in best use of advance care planning for people nearing the end of life (Thomas and Lobo 2011; International Society of Advance Care Planning & End of Life Care 2011). Advance care planning helps to meet patient preferences (Abel *et al* 2013) and must be handled sensitively; a major international study found that just under three-quarters of people want to be fully informed if they have less than a year to live (Harding *et al* 2013). It is important that care planning is not seen as a one-off event; communication with patients and their families should be a continuous process.

Strengthening co-ordination and discharge planning

Patients in their last year of life are admitted to hospital an average of 3.5 times (Lyons and Verne 2011). A multidisciplinary model of care with good communication between primary and secondary care and with the voluntary sector is essential in end-of-life care to avoid unnecessary admissions and manage discharge from hospital effectively. A stronger focus on integrated cross-boundary care is developing, with examples such as the GSF Cross Boundary Care programme to improve co-ordination across different providers. Community and primary care services that are accessible 24/7 are an essential element. Initiatives in IT systems, most notably the Electronic Palliative Care Coordination System (EPaCCS) tool, are helping to support better care planning and co-ordination between health and social care (www.nhs.uk/improvement-programmes/long-term-conditions/epaccs.aspx).

Ensuring adequate provision of specialist palliative care services

The UK has well-developed and world-leading specialist palliative care services; traditionally these have focused on supporting cancer patients, but there is now increasing extension for frail elderly non-cancer patients. However, there is widespread variation in access to specialist palliative care services (National Council for Hospice and Specialist Palliative Care Services 2012), defined as the ‘active, total care of patients with progressive,

advanced disease and their families ... provided by a multi-professional team who have undergone recognised specialist palliative care training' (Tebbit 1999). Access to specialist palliative care is worse for older people (Centre for Policy on Ageing 2009c; Office for National Statistics 2013d). Localities should make use of the commissioning guidance for specialist palliative care from the Association for Palliative Medicine of Great Britain and Ireland (2012) to assess local need and ensure that sufficient capacity is provided.

Supporting care home residents to die in the care home rather than in hospital

Many older people living in care homes who are very near the end of life are taken to hospital to die when they could, with the right support, remain in the care home. Local service leaders should invest in implementing structured approaches in care homes such as the Gold Standards Framework, with advance care plans, advance decisions and adequate palliative care support for care homes. Doing so can significantly improve the quality of care (British Geriatrics Society 2011). In south-east London care homes, for example, the percentage of residents able to die within the care home increased from 56 per cent in 2007–8 to 78 per cent in 2011–12 through the application of these principles (Gold Standards Frameworks Centre (2012) St Christopher's Regional Centre).

Providing home-based services

Home care includes care that is provided by primary care, domiciliary care teams, home health care providers, and focused home nursing services. These teams and agencies need training in end-of-life care, especially for elderly people and those with dementia. Home nursing services can provide comprehensive end-of-life care services, including discharge support, urgent care, social care and emotional support. A recent evaluation of the Marie Curie Nursing Service found that it was effective in supporting more people to die at home, with less use of hospital services (Chitnis *et al* 2012).

Improving end-of-life care for people with dementia

The particularly poor end-of-life care experienced by people with dementia can be the result of either too much intervention (such as tube feeding and the use of restraints) or too little (inadequate pain control, malnutrition and dehydration, and inadequate emotional and social support) (Hughes *et al* 2007). Reasons for this include the difficulty of identifying when people with dementia enter the end-of-life phase, and difficulties in communication, which make it difficult to accurately assess and treat pain, and to ascertain the patient's wishes and preferences.

Too often, localities develop strategies for the care of people with dementia in isolation from strategies for end-of-life care (National Council for Palliative Care 2009). A co-ordinated approach to end-of-life care for people with dementia should include the following elements.

- Advance care planning conversations happening with people with early stage dementia so that their preferences can be expressed before their condition deteriorates (Shega *et al* 2003).
- Staff caring for people with dementia should be trained in end-of-life care competencies, and vice versa.
- Care co-ordinators for people with dementia such as Admiral Nurses and GPs should be fully involved in co-ordinating the person's end-of-life care.
- Multidisciplinary guidelines specific to people with dementia should be applied, as they have been shown to result in a decrease in antibiotic prescribing and an increase in the use of pain relief in the last two weeks of life (Lloyd-Williams and Payne 2003).

Improving end-of-life care in hospitals

More than half of all hospital complaints relate to end-of-life care; more than half the population die in hospital (Office for National Statistics 2013d); and at any one time, about 30 per cent of hospital patients are considered to be in their final year of life (National Audit Office 2008). So improving hospital care for older people is one of the most urgent requirements through reducing length of stay and rapid discharge, and improving the quality of inpatient care for those dying on hospital wards. Several improvement programmes focus on this area, including the NHS Transform programme, GSF Acute and Community Hospitals programmes and other such initiatives encouraged by incentivised CQUIN schemes.

Management of the dying phase and the crucial importance of involving patients and families

Although a consensus statement in support of the Liverpool Care Pathway was published by 20 organisations representing patients and professionals in September 2012 (Liverpool Care Pathway Consensus Statement 2012), the recent independent review of the Liverpool Care Pathway, *More care, less pathway* (2013), concluded that it was at times applied poorly and that it should therefore be replaced by personalised care plans backed up by condition-specific guidance. The review stressed that the principles of good palliative care on which the Liverpool Care Pathway is based must be upheld, including regular assessment and management of symptoms, comfort measures, and provision of psychological, social and spiritual support. Paramount in this is the full involvement of patients and their families, regular communication, plus allocation of a nominated senior responsible clinician.

Key reviews and guidance

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Good practice examples

Deciding right

'Deciding right' is an English north-east regional initiative to help people and professionals work in partnership to make care decisions in advance. The key strands are:

- 'choice and capacity' – supporting individuals to make and document advance decisions about future treatment in case of subsequent loss of capacity or to help make decisions in their best interests in conjunction with their families or registered deputies
- 'agreement' – to ensure that the decisions are genuinely shared and made in partnership
- 'right documentation' – to ensure that standardised documents are used across all services in line with legal guidance to ensure that decisions are in the best interests of the individual and not the organisation
- 'education' – the right for everyone to have the resources to understand and use the initiative

'Deciding right' identifies the triggers for making decisions in advance, complying with national legislation and guidelines and putting shared decisions based on individual needs and wishes at the core.

(www.cenne.org.uk/end-of-life-care---the-clinical-network/decidingright)

Marie Curie Nursing Services

The Nuffield Trust recently conducted an evaluation of Marie Curie Nursing Services. The researchers found that comparing terminally ill people receiving Marie Curie Nursing Services with matched controls, 76 per cent were able to die in their own home and only 7.7 per cent in hospital, whereas in the 'usual care' group, 34 per cent died at home and 42 per cent in hospital. Only 11 per cent of those receiving Marie Curie support (compared with 35 per cent of the control group) underwent emergency admission to hospital towards the end of life, and 7 per cent (compared with 28 per cent) attended A&E. Many of the individuals concerned were over 70 and many had non-cancer diagnoses.

(Chitnis *et al* 2012)

10 Making it happen – integrated care to support older people and their families

In any one local area, individual professionals, teams and organisations working in each of the nine components we have covered in this paper could all find ways to improve the quality and continuity of their individual practice and services for older people. But to deliver the radical transformation that quality and financial pressures demand, we need to go much further. Our current fragmented services are not meeting the needs of older people, who are the group most likely to suffer problems with co-ordination of care and transitions between services (Ellins *et al* 2012; Haggerty 2012). We need to drive whole-system changes in the services we provide for older people so that we consistently provide care that is co-ordinated around people's needs and goals, delivering the right care at the right time, and in the right place (National Voices 2013). This requires teams in physical and mental health, social care, public health and the wider public, private and voluntary sectors to work together. Integrated care is therefore the final and overarching component of this paper.

The balance of evidence is clear that integration can improve people's experience and outcomes of care, and deliver greater efficiencies (Curry and Ham 2010; Ham *et al* 2011; Goodwin *et al* 2013; NHS Future Forum 2011; NHS Confederation and Royal College of General Practitioners 2013). It is important to recognise that achieving improvements for older people will also positively affect care for the rest of the population. More effective urgent care and post-acute rehabilitation and re-ablement services are important for people of all ages, while reducing inappropriate care and shortening acute lengths of stay for older people could release resources to meet other needs.

There is no one model for providing integrated care for older people – the right approach will vary according to the local context (Ham and Walsh 2013). But it is likely to involve action at multiple levels. At the local system level, it will require leaders to set shared strategies and enable resources to be pooled across organisations. Innovations in commissioning and organisational forms such as family care networks may aid this (Addicott and Ham 2014). At the clinical or care team level, it will require shared information and new ways of working such as single assessment processes and shared care plans.

From 2015/16, a Better Care Fund worth £3.8 billion will be allocated to localities in England to help drive local integration of services and to improve outcomes for people with health and care needs. Whether through the Better Care Fund or not, there is much that local leaders can do to provide better integrated services for older people. The King's Fund has published a framework for local leaders wanting to develop integrated care at scale and pace, with 16 key steps, summarised in the box overleaf (Ham and Walsh 2013).

Lessons from experience: making integrated care happen at scale and pace

1. Find common cause with partners and be prepared to share sovereignty.
2. Develop a shared narrative to explain why integrated care matters.
3. Develop a persuasive vision to describe what integrated care will achieve.
4. Establish shared leadership.
5. Create time and space to develop understanding and new ways of working.
6. Identify services and user groups where potential benefits from integrated care are greatest.
7. Build integrated care from the bottom up as well as the top down.
8. Pool resources to enable commissioners and integrated teams to use resources flexibly.
9. Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector.
10. Recognise that there is no 'best way' of integrating care.
11. Support and empower users to take more control over their health and wellbeing.
12. Share information about users with the support of appropriate information governance.
13. Use the workforce effectively and be open to innovations in skill-mix and staff substitution.
14. Set specific objectives, and measure and evaluate progress towards them.
15. Be realistic about the costs of integrated care.
16. Act on all these lessons together as part of a coherent strategy.

Bearing these overarching lessons in mind, we encourage local service leaders to use the nine components of care we have set out in this paper to 'walk' the journey for older people, from healthy active ageing right through to end-of-life care – all the time recognising that there are multiple dependencies between the various components. In doing so, it should be possible to:

- agree some key performance standards that all organisations can aspire to achieve in the care of older people
- map out which elements of good practice are already provided, whether they are sufficient to meet the needs of all older people who would benefit from them, and where the gaps are
- identify early priorities for change (such as minimising multiple repeated assessments or improving capacity in intermediate care) and quick wins
- ensure that the work is informed by meaningful input from older people and their carers about what matters most to them in service redesign, and that progress and performance is measured against this, using systematically collected feedback from older people and their carers on their experience of care.

Remember that there is no reason why one provider or integrated care team cannot deliver several of the components (eg, rapid support, re-ablement, 'discharge to assess', and early supported discharge).

In order to deliver these changes it will be important to ensure the right workforce with the right skills in the right part of the system to help deliver more co-ordinated care closer to home and to care for an increasingly older group of service users with complex needs. It may also require creative ways of working, more use of the voluntary sector, and staff who are able to work flexibly to fulfil a number of roles. This has been acknowledged by the Royal College of Physicians in its Future Hospital workforce document ([Royal College of Physicians 2013](#)) and in three recent reports from The King's Fund ([Cornwell 2012](#); [Imison and Bohmer 2013](#); [Edwards 2014](#)).

We want to end with an example of a locality that is putting these processes into practice. There are many localities throughout the NHS in England and beyond that are at various stages of this work, and we hope to build on this momentum through this paper and the work we are doing to create a community of shared practice. South Warwickshire offers one recent example, which was the subject of a 2013 Health Foundation report and won a 2012 *Health Service Journal* Integrated Care Award ([Philp 2012](#)). No locality, not even South Warwickshire, would claim that they have got it right with every part of the care pathway for older people. But their experience shows what can be done, along with early gains in services for older people (*see box below*).

What has been achieved in South Warwickshire around services for older people has also been achieved in several other parts of the UK and beyond ([The King's Fund Integrated Care Map](#)). The twin challenges of ageing demography and financial pressures on services mean that we must spread these approaches more widely. Failure to act now will continue to leave older people becoming avoidably ill or dependent, or struggling to navigate complex and frustrating systems. There is plenty we can do to improve services for older people, and service leaders and policy-makers are more focused on this goal now than they have been at any time since the NHS was founded. It is time to move away from short-term pilots and projects that are not sustained and embed these approaches in the way we work.

South Warwickshire project on improving care pathways for older people

South Warwickshire NHS Foundation Trust provides acute hospital services to South Warwickshire and community health services across the whole of Warwickshire.

The trust has worked with partners from primary care, social care and Age UK Warwickshire to develop integrated services for older people. This has been established through early intervention to promote independence in old age and includes GP identification of at-risk older people followed by telephone assessment by trained Age UK assessors. The trust has also worked to provide a better response to a frailty crisis by improving pre-admission to hospital assessment, providing specialist acute care, and promoting recovery before placement.

Facing the problem of rising acute admissions among older people, an acute hospital becoming 'blocked' with older patients who were 'long-stayers' or became 'delayed transfers of care', the trust worked with local primary care teams, social services and the voluntary sector (Age UK) to change pathways, ultimately aiming to deliver more care closer to home. This was coupled with the acute hospital clinicians changing the

continued overleaf

South Warwickshire project on improving care pathways for older people continued

way they worked. The trust is 'vertically integrated' so also runs community health services – which gave it the ability to create some additional capacity in community rehabilitation and rapid response teams while the new pathway was embedded.

Key principles were:

- **'get in early'**, using Age UK staff and community nursing teams to carry out structured comprehensive geriatric assessment for older people living at home, thus identifying problems sooner to prevent crises
- **'discharge to assess'**, ensuring that older people were seen seven days a week by senior clinical multidisciplinary teams and, when they did not need admission, to be discharged for ongoing assessment and treatment in their own homes)
- **'decide to admit'**, so that when older people did require hospital admission they were admitted straight to specialist consultant-led elderly care wards. This was coupled with a sustained focus on senior front door assessment, frequent ward rounds, proactive discharge planning, and the ability to take an additional 50 patients each week out of A&E or the acute medical unit and back to their own homes for assessment.

Within 18 months of the project starting up, emergency admission rates in people over 65 had levelled off – this against a background of previously rising admissions and ongoing increased acute activity for older people in the region; in addition, average length of stay had reduced and mortality rates had fallen. By 2013, there had been a reduction in length of acute stay of around one day compared with 2011, a sustained increase of around 25 per cent in the proportion of zero day admissions, a sustained decrease in the proportion of patients staying longer than 14 days, and an increase in the proportion of patients discharged home before lunch.

The trust, along with local partners, has embedded the new model of working and is now expanding the focus to other parts of the care pathway for older people to generate similar 'win/win' gains for older people and for the local health and care system.

(Health Foundation 2013c)

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