## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>1</td>
</tr>
<tr>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>Part 1. Scale and extent of the challenge</td>
<td>7</td>
</tr>
<tr>
<td>Part 2. Barriers to better services for frail older people</td>
<td>11</td>
</tr>
<tr>
<td>Part 3. Improving the systems and processes of care</td>
<td>17</td>
</tr>
<tr>
<td>Part 4. Improving the place of care</td>
<td>26</td>
</tr>
<tr>
<td>Part 5. Conclusion and actions</td>
<td>30</td>
</tr>
<tr>
<td>Notes</td>
<td>32</td>
</tr>
<tr>
<td>Contacts</td>
<td>37</td>
</tr>
</tbody>
</table>

The Deloitte Centre for Health Solutions provides insights and thought leadership based on the key trends, challenges and opportunities within the healthcare and life sciences industry. Working closely with other centres in the Deloitte network, including the US centre in Washington, our team of researchers develop ideas, innovations and insights that encourage collaboration across the health value chain, connecting the public and private sectors, health providers and purchasers, and consumers and suppliers.
Foreword

Welcome to the Deloitte UK Centre for Health Solutions report Better care for frail older people: Working differently to improve care. The report presents the Centre’s analysis of the challenges in caring more effectively for increasing numbers of frail older people.

In 1985, there were 690,000 people in the UK aged 85 and over, representing about one per cent of the population. By 2010 there were 1.4 million, or two per cent of the population aged 85 and over. By 2035, there will be 3.6 million in this group, or five per cent of the population. Greater longevity is a cause of celebration but it is also associated with multiple, physical and mental health conditions that place enormous strain on health and social care provision. The challenge is compounded by the need to deliver more care with fewer resources. The current model of care is at a tipping point, and may no longer be fit for purpose.

The report identifies the need to improve the capacity and capability of care providers and reduce the current tendency for frail older people to be ‘bounced’ back and forth from home to hospital to care home. The report focusses on the UK with an emphasis on England and is based on literature reviews, data analysis, interviews and Deloitte’s experience working with local health economies attempting to redesign services.

The report covers four key themes:

- the extent and impact of changing demographics
- the barriers to ensuring health and social care is fit for purpose
- new approaches and models of care
- the improvements needed in each place of care.

Deloitte believes the quality of care provided to frail older people should be a litmus test of the quality and effectiveness of health and social care services more generally. If we can get it right for the increasing numbers of our more vulnerable members of society, we have a better chance of developing a service that is fit for the 21st century.

We hope you find our analysis and research informative and insightful and welcome your feedback and comments.

Karen Taylor
Director, Centre for Health Solutions
Health and social care spend on people aged 65 and over, with at least one long term condition is increasing and is currently around £30 billion for those over 75.

80,000 sheltered housing spaces and 67,000 care home places will be needed in London by 2041.

960,000 people aged 65 or over act as unpaid carers and only 93,000 receive support services.

In Scotland implementing telehealth and telecare cost around £10 million providing gross benefits valued at £48 million.

The number of carers working more than 50 hours a week has doubled.

Health and social care spend on people aged 65 and over, with at least one long term condition is increasing and is currently around £30 billion (£15 billion for those over 75).

The NHS funding gap is predicted to grow to £30 billion by 2021.

Of the 1.56 million adult social care workers almost 40% do not have a relevant qualification.

In the next 20 years number of UK over 65s are projected to rise nearly 50%.

Population over 85: 1% in 1985, 2% in 2010, 5% in 2035.

Over 65s account for 2 million unplanned A&E admissions.

Over the past 5 years A&E attendances for over 80s have increased 65% and those conveyed by ambulance by 75%.

Over 414,000 people people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.

960,000 people aged 65 and over live in care homes, where average age is 85 and prevalence of dementia over 70%.
Executive summary

The National Health Service’s (NHS) greatest success has become its most daunting challenge. People are living longer but increasingly with one or more health conditions putting the current health and social care delivery model under unsustainable pressure as demand and costs escalate and quality is compromised.

Over the past 30 years life expectancy has risen by 10 per cent and the likelihood of death before the age of 65 has reduced by a third. Older people as a group provide an invaluable economic and social contribution to society in areas such as volunteering, childcare, care of other adults and charitable giving. However, health and social care spending on people aged 65 and over, with at least one long-term condition, is increasing and is currently at least £30 billion a year (£15 billion on those over 75).

The last two years have seen many high profile national reviews and reports that have highlighted serious concerns about the care provided to frail older people. The most defining of these is the Francis report into failings at the Mid Staffordshire NHS Foundation Trust, whose repercussions have reverberated across the health and social care system. The Government’s response, entitled Hard Truths: The Journey to Putting Patients First, accepts the majority of Francis’s 290 recommendations including agreeing that the link between culture and compassionate care for older patients is fundamental across all health and care settings. Indeed, there is a broad political and managerial consensus on many of the systemic changes that are needed, including integrating health and social care, and reform to the chronically underfunded social care system.

The barriers to better services for frail older people
Integration and reform of social care funding have been mooted by successive governments for over 30 years, with limited success. Many of the changes now being proposed require legislation, structural and organisational reform, with implementation likely to take between five and ten years and will require sustained and consistent leadership in order to succeed. In the meantime there are actions that can be taken to improve the efficiency and effectiveness of services.

A key barrier to integrating or improving services is the fact that funding streams for health and social care are separate. This presents a particular problem in financing the complex needs of frail older people since those needs increasingly span the boundary between the two systems.

Real-term funding for healthcare in England has been almost flat against a background of increasing demand for services of around four per cent per annum, driven largely by the ageing population. At the same time, intense pressure on social care budgets has resulted in a nine per cent decline in the number of older people receiving support between 2001-11 and 2012-13. This is putting further pressure on NHS services and is leading to funding gaps in both health and social care. These gaps mean that the desire of frail older people to remain in their own home is often undermined.

A further systemic barrier is the fragmented model of care delivery which remains focused on institutional, episodic care and siloed pathways into primary, hospital and social care. Efficient care is undermined further by the lack of shared access to patient information. This is exacerbated by the difficulty in accessing health and social care services out of hours. Consequently, increasing numbers of frail older people find themselves in hospital as the default position, with frequent emergency admissions to hospital and longer lengths of stay than medically indicated. Indeed, the majority of emergency bed days in the NHS are currently occupied by frail older people.

Older people’s complex requirements mean that they are likely to come into contact with the majority of staff groups and provider organisations across health and social care. Yet the staff who spend most time caring for frail older people receive the least training and remuneration. For example:

- low skilled homecare workers, care home staff and healthcare assistants provide the most contact hours, but have limited training or supervision and the lowest pay rates
- there is a mismatch between the training and location of healthcare staff and the needs of frail older people; with training and majority of care traditionally centered on single episodes of care in hospitals
- the role of the general practice is key to continuity and access but faces increasing capacity constraints and, despite limited training in the complexities of multiple conditions, the workload in caring for the over 75s is three times that of caring for the 45–64 age group and is very challenging.
Many health conditions experienced by older people have a causal link to, or are exacerbated by, housing conditions. Currently nearly half of all people aged 75 and over live alone. They are often socially isolated, which can cause chronic loneliness and lead to an increase in physical and mental illness.

Around one in three households where the oldest person is over 75 live in housing which has failed the official decent homes standard. A move from unsuitable housing into extra care housing can help maintain their independence for longer; however, availability of such housing is low. Frail older people with dementia (around one in six over 80 and one in three over 95) are more likely to need some form of residential care, but availability of suitable, affordable accommodation is often poor.

**Solutions to challenge the status quo**

Improving the experience and outcomes for frail older people requires improvements on three fronts: physical and mental healthcare, social care and place of care. Information is key to improving all three elements and enabling providers to plan and manage care more effectively. The primary care record, maintained by GPs, is a valuable source of information but, as noted, is currently difficult to access for other health and social care providers. Likewise, hospitals have detailed patient notes but these are still largely paper based and not linked to the primary care record. Action to link hospital and primary care data is underway, but plans to provide a fully integrated interoperable healthcare record is unlikely before 2018. Meanwhile, access to information is essential for frail older people given the multiple medical and social care interventions, including multiple medications.

Information is also important for commissioners who need a clear understanding of the health and social care needs and pattern of use of services so that interventions that will help keep people out of hospital, including at a point of crisis, are available when needed.

To shift the balance of care to the community, investment in primary and community healthcare services is needed. Deloitte’s work on ‘Any town’ for NHS England provides further suggestions on how commissioners might achieve improvements in outcomes and financial balance for their whole population, including specific initiatives targeting older people. This means redirecting some of the resources spent on caring for frail older people from the more expensive hospital settings to primary and community care. It also means investing in better quality homecare and extra care facilities.

Technology-enabled care such as telemedicine can play an important role in preventing or delaying the need for more expensive institutional care. However commissioners and providers need to co-operate to ensure that the incentives are aligned, including developing new reimbursement models. They also need to ensure that the technologies are understood by and valued by patients and are used to re-design services around the patient.

The Kings Fund and Nuffield Trust, among others, have published extensive research making the case for integration and for redirecting resources to provide better, more cost-effective care in the community and primary care (Part 3). While the research provides a compelling case for new models of care, the evidence base shows improvements in quality rather than reductions in costs. Consequently, adoption of these new models, albeit improving, is still low. The government’s Better Care Fund of £3.8 billion a year from 2015 is an important initiative which has the power to galvanise joint working but which will need to be implemented carefully if it is to realise its full potential.

Around one in three households where the oldest person is over 75 live in housing which has failed the official decent homes standard.
The NHS and social care need to start to work differently now, including accepting joint responsibility for organising services around the individual and adopting new contracting and funding models that support the provision of seven day services. Joint working requires strong and consistent leadership, clinical involvement and clear governance and finance arrangements. It also needs multi-disciplinary teams of appropriately trained staff to work in partnership with the voluntary and private sectors.

Steps that should be taken in the short term at the local health economy level include:

• adopting population health management, case finding and a register of frail older people
• implementing targeted prevention and early intervention strategies
• establishing a single point of access and appointing a care co-ordinator for everyone with a diagnosis of frailty
• providing annual frailty checks, and priority access, rapid assessment and diagnosis for everyone over 75
• involving people in their own care through personalised care planning and self-management support services.

There are also specific actions needed to make each place of care fit for purpose (Part 4), including:

• improving people’s living conditions through the provision of personal or capitated budgets which can then be used to fund repairs, adaptations and/or buy homecare or support a move to extra care housing
• inspecting, registering and accrediting nursing and care homes, to demonstrate their compliance with quality standards, including access to effective medical care
• implementing a hospital frailty pathway, based on the recommendations in the ‘Silver Book’ – an intercollegiate guide on providing quality care for frail older people with urgent and emergency care needs.

**Conclusion**

Caring for the increasing number of frail older people with multiple health conditions is extremely complex. It requires an urgent and radical shift in the current approach to care aimed at organising services around the patient and delivering the right services in the right place at the right time. The challenges of caring for an ageing population require health and social care commissioners and providers to work together, and with other partners in the private and voluntary sectors, to develop new care pathways (Figure 1). The focus should be on promoting home care, avoiding escalation of care needs and promoting a return to home care. In addition, commissioners need to use their contracting levers to require improvements in each place of care. Above all, while integration of commissioning and service provision may be desirable in the longer term, in the immediate term better care for frail older people requires all health and social care staff to be willing to work differently.
AVOIDING ESCALATION OF CARE

MANAGE RISK
- Identify and register all patients over 75 and stratify according to risk of hospitalisation
- Develop electronic alert system to flag risks with all local providers ideally via shared electronic patient records

PROMOTE SELF MANAGEMENT
- Support patients and carers to self-manage by providing guidance, education materials and advice service
- Use technology assisted support where indicated

EARLY INTERVENTION
- Commission prevention and early intervention strategies targeted at those with greatest need
- Provide all over 75s with annual health check
- Joint GP and consultant led service including consultant led community clinics and enhanced support to care homes

ADMIT ONLY WHEN NEEDED
- Implement a referral gateway to control referrals and appropriate hospital use
- Priority access to diagnostic tests for patients at risk

PROMOTING RETURN TO HOME CARE POST ESCALATION

PROVIDE HOSPITAL SERVICE VIA INTERMEDIATE & PRIMARY CARE
- Provide hospital input to primary care and care homes via technology e.g. telehealth
- Deliver hospital at home or other re-ablement service
- Upskill community and primary care workers

BETTER ENABLE PATIENTS TO RETURN HOME
- Develop frailty pathway protocols to support efficient transition from hospital into home/intermediate care
- Multi-disciplinary team (MDT) agree on medical needs, post discharge
- Agree discharge plan with patient and carer
- Assign dedicated social worker to each patient on risk register to advise on eligibility and provide social care packages

ENHANCE EFFICIENCY OF ACUTE TREATMENT
- Provide access to patient records from multiple settings via IT solutions
- Implement a hospital frailty pathway including geriatric assessment and medication review

PLAN FOR DISCHARGE ON ADMISSION
- Trigger frailty patient alert on admission including alerting MDT discharge team
- Engage social care and adopt co-ordinated discharge plan on admission

MULTIDISCIPLINARY TEAMS OF PRIMARY, COMMUNITY AND SOCIAL CARE STAFF WORKING TOGETHER ACROSS THE TRADITIONAL BOUNDARIES

Figure 1. An integrated model of care for frail older people
Part 1. Scale and extent of the challenge

There are currently 10.8 million people aged 65 or over in the UK and their number is projected to rise by nearly 50 per cent in the next 20 years. The population of over 75s increased from 4.4 million in 2001 to 4.9 million in 2010 and is projected to double in the next 30 years. The over 85s, currently some 1.4 million people are the fastest growing segment of the population. While this is undoubtedly a success story which should be celebrated; greater longevity has also brought an increase in multiple long-term conditions and frailty; along with a corresponding increase in dependence on health and social care services.

The scale of the challenge

Caring for people with at least one long-term condition accounts for 70 per cent of the NHS’s £110 billion budget and £10.9 billion of the £15.5 billion spent on social care. The General Lifestyle Survey estimates that 34 per cent of those with long term conditions are 65 or over and 17 per cent are over 75. This suggests that health and social care spend on those aged 65 and over is at least £30 billion (£15 billion for those over 75). Given that the prevalence of long-term conditions increases with age, along with the cost of health and social care spending, the overall costs are likely to be significantly higher.

The number of people with multiple long term conditions is expected to rise from 1.9m to 2.9 million by 2018, requiring about £5 billion additional NHS expenditure. Older people with long-term physical health conditions, commonly experience mental health problems such as depression and anxiety, with increasing age carrying an increased risk of dementia. Poor mental health often leads to a marked deterioration in quality of life and increased costs due to less effective self-care and other complications. Ageing increases most people’s dependency with social care crucial to older peoples’ welfare, especially the over 85s. From a lifetime perspective, some 80 per cent of older people will need social care in the later years of their lives.

Increasing age is directly correlated to:

- higher numbers of GP consultations, for example between 2000 and 2008 the average annual number of consultations per person in England increased from 4.2 to 5.5 but those aged 75 and over increased from 7.9 in 2000 to 12.3 in 2008
- greater chance of emergency admission to hospital, with more than 2 million unplanned admissions a year for people over 65, accounting for 68 per cent of hospital emergency bed days
- increased average length of stay in hospital from eight days for patients aged 65 to 74 years; 10 days for patients aged 75 to 84 years; and 12 days for patients aged 85 years or older
- increasing numbers and proportion of outpatient appointments, appointments for over 75s increased from 12.4 million (17 per cent) to 13.2 million (17.4 per cent) from 2011-12 to 2012-13.

Many older people live alone or with older and dependent partners in accommodation that is either remote or unsuitable for their needs. Currently, over two million people over the age of 75 live alone, with childless widows and those who have infrequent contact with their children or without adequate transportation, among the loneliest of older people. Social isolation is debilitating leading to loss of independence, and loneliness. Loneliness is linked to patterns of depression and increased suicide rates. Indeed, chronic loneliness is a public health issue, associated with: significantly greater risk of cardiovascular disease and stroke; a more rapid progression of Alzheimer’s disease; and suppression of the immune system. Chronic loneliness poses as large a risk factor for long term health as smoking, and increases likelihood of early admission to residential or nursing care.

Some 26 per cent of all older households live in non-decent housing with nearly one in three of the oldest households in England (where the oldest person is aged 75 or over) living in housing that is below the official decent homes standard. Furthermore, around 960,000 people aged 65 or over provide unpaid care for a partner, family or others but only 93,000 of these receive any carer-specific support services. Older carers in the UK provide up to £4 billion in unpaid volunteering and up to £50 billion in unpaid family care.
A definition of frailty
Defining someone as old is highly subjective. Organisations like the Office of Economic Cooperation and Development (OECD), classify people over 65 as old, however this definition is increasingly being challenged. As life expectancy, retirement age and quality of life for the over 65s have increased, many individuals over 65 do not consider themselves to be old. A UK survey found that 75 per cent of 65-69 year olds when asked to choose what stage of life they were currently said “later life or old age”, but 23 per cent said “middle adulthood”.

Frailty, in its simplest definition, is vulnerability to adverse outcomes. Older people with frailty can be readily identified and are often known to local professionals but, currently, frailty is not something that is formally diagnosed. People with frailty are likely to experience problems maintaining independent living, including a decreased ability to self-care. As the numbers and severity of frailty factors increase so does the risk of deterioration and chance of hospitalisation or institutionalisation (Figure 2). For the purpose of this report, the focus is on people aged 75 and over as the population most likely to exhibit frailty or move from low to high risk without health and social care intervention. However, if people meet the frailty definition, but are under 75, evidence of frailty outweighs age.

Figure 2. Frailty factors tipping an older person from low to high risk of needing enhanced levels of care

- Fall
- Bereavement
- Depression and/or loneliness
- One or more long term conditions
- Polypharmacy
- Breakdown in support network
- Change in carer
- Breakdown in the GP relationship
- Change in financial circumstances
- Nutritional factors such as obesity, diabetics who are not eating appropriately and malnutrition
- Inappropriate housing
- Homecare support or supported housing needed
- Increasing number of falls
- Bereavement – spouse or carer
- Acute illness or infection
- Long-term condition exacerbation
- Dementia/confusion
- Acute Depression/loneliness
- Incontinence treated/untreated
- Polypharmacy and poor medicines management
- Move from home care into assisted living or care home
- Increase in calls out of hours and on Bank holidays
- High number of falls and/or loss of mobility
- Very Acute illness and increase in numbers of serious infections
- Late stage dementia
- Accumulation of risk factors and deterioration of physical and/or mental health
- Extreme Polypharmacy
- Frequent hospital admission and/or need for institutionalisation
- Nursing home admission
Concerns about the current state of care for the frail older

Care for frail older people in the UK has been under intense scrutiny over the past few years with a plethora of high profile national reviews highlighting serious concerns about the care provided to this vulnerable group. These reviews also provide examples of good practice and over 400 recommendations for change. Reviews include:

• Fairer Care Funding – The Report of the Commission on Funding of Care and Support – the Dilnot Commission (July 2011)21

• The Francis Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (February 2013)22

• Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England (July 2013)23

• The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings, by Camilla Cavendish (June 2013)24

• A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture by Rt Hon Ann Clwyd MP and Professor Tricia Hart (September 2013)25

• Care Quality Commission on the State of Healthcare and Adult Social Care in England 2012-13 (November 2013).26

The quality of NHS care in England has been scrutinised more in the past year than in any year since 1948 leading to a widespread view that the NHS’s care for the frail older is in crisis with failing standards and poor health outcomes. At the same time the sheer scale of recommendations in the above reports makes it difficult for individual commissioners and providers to consider or demonstrate a comprehensive response.

The Governments response to the need to improve services

In England, the NHS reforms introduced in the Health and Social Care Act 2012 were a response to the need to change the way that the healthcare system commissions and delivers care. The reforms introduced major changes to the organisations, commissioning and provider structures and processes, and require care provision to be monitored at the local level using locally determined impact and outcome measures.27

The reforms are largely structural and organisational and on their own are unlikely to tackle the underlying challenges in caring for frail older people. Indeed, the conclusion from the Francis report was that action is needed across six core themes: culture, compassion, leadership, standards, information, and transparency.28 Few argue with this assessment and indeed, the Government’s initial response, Patients First and Foremost29, set out plans to prioritise high quality care, improve transparency and ensure that, where poor care is detected, there is clear action and clear accountability. In its final response, in November 2013, the Government responded in full to each of Francis’s 290 recommendations.30 While accepting the need to implement the majority of these recommendations, it is not clear how this will be monitored at the local level, nor has implementation been costed.

Meanwhile the Department has put in place:

• a tougher approach to the inspection and regulation of all health and social care providers, including general practice and private sector providers

• additional duties on providers and professionals to be open with patients in the event of a mistake

• a range of centrally determined initiatives to develop the capability of individual organisations and the system as a whole to improve quality and safety.31
In 2013 the Care Quality Commission appointed chief inspectors of hospitals, adult social care and primary care and consulted on a new system of ratings.32

In January 2014, NHS England issued practical guidance for commissioners, providers, nursing medical and allied health professional leaders on the provision of safe compassionate care for frail older people using an integrated care pathway. Many of the proposals resonate with the suggestions in this report.33

Part 2 of this report presents an analysis of the key barriers to improving services for the frail older. Part 3 identifies solutions to help improve the systems and processes of care. Part 4 identifies solutions specific to each location where care is delivered and part 5 presents conclusions and actions. End of life and palliative care issues will be covered in a separate report in due course.
Part 2. Barriers to better services for frail older people

For many years, successive governments have searched for solutions to improve health and social care services for growing numbers of older people. Numerous solutions have been piloted but, apart from a few localised examples, services remain fragmented. Arguably, the greatest barrier to improving services is the separate approaches to funding health and social care although other systemic barriers that have a particular impact on services for the frail older include:

- the lack of joined up, integrated services
- poor access to and transparency of information, including the lack of an interoperable patient record
- limited capacity and capability in caring for frail older people
- an inadequate emergency and hospital response
- low availability and affordability of suitable housing, homecare and residential care.

The separate approach to funding health and social care

Since 2010-11, real term funding for healthcare in England has been almost flat, in the face of increases in demand of around four to five per cent. The growing demand is largely due to: an ageing population, which is growing in size, and experiencing more chronic disease; and increases in the cost of providing health care, mainly workforce pay. If the NHS continues with the current model of care, there will be a funding gap of £30 billion from 2013-14 to 2020-21, in addition to the £20 billion of efficiency savings expected to be met by 2014-15. Meeting this budget shortfall in the absence of increased funding requires radical changes to types and location of services and ways of working.

Healthcare and social care funding, particularly for frail older people are interdependent. While they continue to be funded separately, the boundaries between the two funding streams are increasingly blurred. Pressures on local authority budgets means 87 per cent of local authorities are now restricting publicly funded care to those with substantial and/or critical needs.

In 2012-13, the total number of people receiving social care support fell to 1.3 million (nine per cent decline since 2011-12 and 25 per cent decline since 2007-08). Of these, 1.1 million people received community based services (down 10 per cent from 2011-12), 209,000 received residential care (down two per cent from 2011-12) and 87,000 received nursing care (which is less than one per cent change).

During the past decade numerous reports highlighted the inequities in the social care funding system but attempts at reform failed to materialise. In 2010 the coalition government established an independent commission to report on how to deliver fair, affordable and sustainable funding for care and support. The Dilnot report in July 2011 recommended a cap on the amount that any individual should pay towards their lifetime care costs and that eligibility criteria for services should be set nationally and improvements made to the deferred payment scheme.

The report was welcomed by most stakeholders, but key details are still being debated as part of Parliament’s scrutiny of the Care Bill. Meanwhile, the Shadow Labour Government is consulting on proposals to bring together the commissioning of health and social care in order to deliver whole person care. The House of Lords report Ready for Ageing? concluded that:

- the quality of healthcare for older people is not good enough
- social care and its funding are in crisis
- radical changes are needed to the way that health and social care is delivered
- that the split between healthcare and social care is unsustainable and will remain so unless the two are integrated.

During the past decade numerous reports highlighted the inequities in the social care funding system but attempts at reform failed to materialise.
The Health Select Committee report in February 2014 highlighted continuing concerns, that fragmented commissioning structures are significantly inhibiting the growth of truly integrated services and recommended that Health and Wellbeing Boards should develop their role to provide an integrated commissioning for health. Further, unless the current level of real terms funding for social care is ring-fenced, the system faces a serious risk to both the quality and availability of care services to vulnerable people in the years ahead.43

The failure to integrate health and social care
There are more than 175 different definitions of integration but few examples of effective integration operating at scale in England. Integration can be between health and social care (horizontal integration), or across primary, community and secondary care (vertical integration). Integration can also take place at a number of levels: team, service or organisation. It can apply to a small number of specialist services or the full range of health and social care services (Figure 3).

Figure 3. Types and levels of integrated care

<table>
<thead>
<tr>
<th>Types of integration</th>
<th>How this might look in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authority and NHS work together in informal relationship driven coordination</td>
<td>Reacting to opportunities to work together if they appear beneficial to all parties</td>
</tr>
<tr>
<td>Some formal commitment to joint working, coordination around some areas of strategy and/or commissioning depending on circumstances</td>
<td>Proactively seeking opportunities wherever they arise to work together utilising a ‘light touch’ Section 75 agreement</td>
</tr>
<tr>
<td>Health and local authority have some key joint appointments and the teams collaborate but are not integrated/combined</td>
<td>The main pillar of the approach is based around a Section 75 agreement to formalise future working arrangements/accountability/pooled budgets etc.</td>
</tr>
<tr>
<td>System wide commitment, shared vision and integration across most strategic and commissioning functions, senior joint appointments, formal high level backing but separate legal entities remain</td>
<td>This could mean acquisition/merger with Section 75 utilised to support the creation of a new organisation</td>
</tr>
<tr>
<td>Health and local authority care services have formed a single integrated legal entity or a combined service</td>
<td></td>
</tr>
</tbody>
</table>

Note Section 75 of the NHS Act 2006 provides the legislative framework for partnership working and allows the pooling of health and social care funds enabling NHS Bodies to exercise certain local authority functions and for local authorities to exercise various NHS functions.
Numerous reports, reviews and commissions have concluded that integration is the ultimate solution for improving care services, especially for frail older people. However other than a small number of successful examples, mostly involving the Care Trust model, this ambition has largely proved elusive.

In 2012 an independent evaluation of 16 integrated care pilots (including six case management sites) found that staff were more positive than patients who reported difficulties seeing a doctor or nurse of their choice and being less involved in decisions about their care. While there were reductions in elective admissions (down 4 per cent overall and 21 per cent in case management sites); outpatient visits (down 20 per cent or 22 per cent in case management sites); but an increase in emergency admissions (up two per cent or nine per cent in case management sites). There was no significant overall reduction in costs, though in case management sites there were an overall nine per cent reduction in hospital costs.

There is a large and growing body of research into the challenge of integration, led by the King’s Fund and Nuffield Trust. In 2013, the Chief Executive of the King’s Fund stated that, “Integration is a marathon not a sprint” and requires both a change in culture and the appropriate allocation of funding but is likely to take 5 to 10 years to achieve. Also, that structural integration on its own is insufficient and brings few benefits unless accompanied by:

- a willingness to challenge and overcome professional, cultural and behavioural barriers
- action to share information both within the NHS and between health and social care
- a willingness to provide financial support and flexibilities to encourage new models of care.

Northern Ireland has had an integrated health and social care service since 1973 (with a commissioner-provider separation). Scotland has had an integrated NHS structure since 2004, when unified health boards were created; however local authorities retain separate responsibility for social care and in 2009, Wales created unified local health boards, but local authorities retained responsibility for social care. While there is good evidence from these countries that integration reduces secondary care usage, there is limited evidence of whole system cost savings. The case for change is based on improving quality, patient and staff satisfaction with more radical redesign required to deliver financial benefits.

Inadequate information technology and the lack of an interoperable patient record

Another key barrier to providing integrated care is the lack of an interoperable patient record, especially for frail older people for whom the lack of access to information can have serious consequences. The premature wind down of the previous Government’s National Programme for Information Technology (NPfIT) left a legacy of low or non-existent interoperability between systems.

Although digital records are available in the majority of GP practices, NHS hospitals and other providers are at very different stages of digital maturity, with many relying mainly on paper-based records. Given the urgent need for access to shared data and information, NHS England has embarked on a series of initiatives, with expectations for:

- a patient data service (care.data) linking GP records to hospital records by end of June 2014
- a £500 million Safer Hospitals, Safer Wards technology fund
- integrated digital care records available at the point of care for all clinical and care professionals by 2018
- a paperless NHS by 2018

Many commentators believe expectations are too ambitious and unlikely to be achieved.
The capacity and capability of the health and social care workforce

The over 75s are often unable to access the levels of assistance and support needed to help them live safely. Caring for people with complex co-morbidities requires carers to understand how the different conditions inter-relate and how best to manage them. It is particularly important for GPs, hospital doctors and others who prescribe medication to understand the counter indications of different medication. Workforce pressures are evident across health and social care with challenges at most touch points. There is also an inverse relationship between the time people spend caring for the frail older and the amount of training and support they receive (Figure 4).

For many of the frail older, the largest proportion of care is provided by informal carers. Over the past decade the proportion of informal carers providing more than 50 hours a week has doubled but few have training or support. Estimates suggest that informal carers save the NHS and social care around £50 billion a year but increasing demand, is placing the informal carers under substantial pressure, often impacts on the carers own health.

Since 2011-12, the numbers of homecare hours purchased by councils have been falling. Seventy-three per cent of local authorities’ commission visits last only 15 minutes, indeed the proportion of such visits have increased by 15 per cent over the past five years. There is often a lack of autonomy about the type and timing of care, with concerns about inflexibility, a lack of privacy, and limited resources. Recruiting and retaining homecare workers is difficult with high turnover rates (24.8 per cent) due largely to poor pay and conditions. The training and education standards of homecare staff, like care home staff, are low (almost 40 per cent of the social care workforce do not have a relevant qualification with 28 per cent at entry level (or Level 1) and 14 per cent Level 2). There are no national funding streams for training of social care staff.

Care homes employ predominantly low-skilled social care staff caring for over 400,000 older people, a fifth over the age of 85. Given the increasing frailty and life limiting conditions of residents, the low level of skills and training fails to equip them to handle the increasingly complex healthcare requirements. Access to GP surgeries and outpatient clinics can be difficult leading to overuse of A&E and emergency admissions. Fifty-seven per cent of older people in care homes have inadequate access to the NHS services they require.

The number of people working in adult social care in England in 2010 was estimated at 1.56 million and projected to grow by between 24 per cent and 82 per cent between 2010 and 2025. The mismatch between supply and demand by 2025 is estimated at around 1 million (a shortfall of 35 per cent).
Specialist geriatricians and other specialist medical staff, highly trained but too few for the increasing demand and largely hospital based.

Most GPs are generalist with limited training in complex needs of frail older people but significant experience caring for them.

The Cavendish Review highlighted challenges in recruiting, retaining, educating and training unregistered healthcare assistants and support workers. Although they provide the bulk of hands-on care in hospitals, nursing homes, care homes, and people’s homes, the review concluded that “the system is disconnected, with the NHS operating in silos and social care a distant land occupied by a different tribe”.66

Community care comprises weekly or, in some cases, daily visits with payments made predominantly through block contracts with few incentives to support reductions in acute admissions and length of stay. District nurse numbers fell by 38 per cent between 2001 and 2011. By 2016, the UK is likely to have 47,500 fewer nurses than it needs.67 Furthermore, the nursing education system is largely hospital based and is not configured to meet the current policy of shifting care to the community.

Deloitte’s 2012 report, Primary Care Today and Tomorrow, highlighted the significant capacity constraints facing general practice and that the ageing population was placing increasing demands on an already stretched workforce leading to problems in recruitment and retention.68 NHS England has recently issued a call to action with respect to improving primary care.69 Currently the GP workload in caring for those aged 75 and over is around three times that of caring for the 45–64 age groups. The recent proposal that a named GP will take on accountability for each patient over the age of 75 will increase this workload still further.70

Most nurses receive very limited training in the complex nursing needs of frail older patients. Nurses initially work in hospitals before moving to the community, with many attracted by fixed hours rather than the shift work associated with hospitals.68

Figure 4. The time spent caring for frail older people is inversely correlated to the amount of formal training received

The people with the greatest expertise in caring for frail older people spend proportionately less time with an individual patient which more often than not is in the hospital setting.

The AMOUNT OF FORMAL TRAINING RECEIVED is inversely correlated to the TIME SPENT CARING FOR THE FRAIL OLDER PEOPLE.

- **Informal Carers**
  - Social care provided to those meeting eligibility criteria
  - Contact following referral by GP to provide specific aspect of care
- **Social Care**
- **Community Nurses etc.**
- **GPs, Practice Nurses**
- **Hospital Staff**
- **Specialists**
- **Inpatient Staff**
  - Inpatients in hospital for specific treatment
  - Diagnosed with infection or specific illness, e.g. dementia
  - Requires special management or care

**Visits and length of stay increasing with age**

**First point of contact managing generalist needs with increasing numbers of consultations**

**Provide regular weekly visits to perform specific tasks like pressure ulcer or diabetes management etc**

**Provide regular hands on care, largely unsupervised, in peoples homes or in care homes with limited qualifications or training**

**Day to day care provided by informal carers, mostly family members/friends etc. With limited if any training. For the very frail this can mean 24/7 care**
The need for a better urgent and emergency response and changes to inpatient and outpatient care for the frail older
The physical and mental health problems of frail older people often require an urgent and emergency response with increased risk of deterioration and poor outcomes. While an ambulance response is often within minutes of receiving a call, for most other services response times can take hours or days. Ambulance staff and out of hours services face particular challenges when responding to calls from older people who live alone or care for their equally frail partner, or whose assessment is compounded by poly-pharmacy and a lack of information. This makes decisions as to whether they can be managed at home, difficult, and increases the likelihood of transfer to hospital.

Over the last few years, A&E has experienced a challenging combination of inadequate staff resources, leading to reliance on high numbers of locum staff, and increases in the numbers and acuity of frail older patients. In the past five years while the number of people over 80 has increased by eight per cent, A&E attendances have increased by 65 per cent and those conveyed by ambulance by 75 per cent. In last 12 months, attendances by over 65s increased by 8 per cent.

Access to specialist geriatric assessments can help improve the outcomes for patients in hospital, including preventing admissions, yet geriatricians lack the capacity to meet the needs of the increasing numbers of frail older people. Health Education England, in its first national workforce plan, identified plans to grow the geriatric medicine workforce by 65 per cent from 2014 to 2020.

Outpatient services are often the first point of contact to secondary care. Delivery of outpatient services is complex, often requiring the co-ordinated delivery of parallel and or sequential steps by a range of staff. The basic model for delivering outpatient services has remained relatively unchanged but changes in demography, science and technology, mean that this approach is becoming increasingly unsustainable. Commissioners and providers are beginning to review the value of the model, especially for frail older patients who can have multiple out-patient appointments yet for whom the stress of travelling to and from the hospital, finding a car park, and waiting for their appointment can often exacerbate their condition. Yet, outpatient attendances for the over 75s increased from 12.4 million (17 per cent) to 13.2 million (17.4 per cent) from 2011-12 to 2012-13.

The lack of suitable housing and other accommodation
Many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, housing conditions. The housing-health link becomes more important with age, as people become more prone to trips and falls and more susceptible to cold or damp-related health conditions, while poor thermal standards are a quantifiable contributor to excess winter deaths. This issue is covered in more detail in Part 4.

Availability and affordability of nursing homes and residential care
During the 1990s demand for care home places dropped as local authorities applied increasingly strict eligibility criteria and many small scale private sector homes exited the market. Capacity has started to grow in recent years, driven by demographics and the difficulties keeping older people with high care needs out of non-residential settings. Capacity and demand in the care home sector is expected to continue to grow in response to the increase in the numbers of very frail people and people with dementia.

There are some 3,800 nursing homes and 10,500 residential homes for people over 65 in the UK caring for around 431,500 people in residential care, approximately 414,000 of whom are aged over 65. The bulk of this capacity (79 per cent) is operated by private (for-profit) providers with the voluntary sector (not-for-profit) providers accounting for 13.7 per cent. In 2012, the average annual fee for a nursing home in the UK was £38,376 and for a residential home £27,872. The annualised value of the UK market is £15.2 billion, the largest single segment of the independent health and care services sector.

At September 2013, local authorities remained the largest single source of funding for older and physically disabled people in residential settings with local authorities financially supporting 49 per cent of all residents. The NHS supported 6.7 per cent and 44.2 per cent was funded by self-payers who arrange their own accommodation, with the aid of their families. Over a quarter of local authority funded residents receive third party top-ups from families and friends, which enable them to choose a care home which is more expensive than the councils are usually prepared to pay for. By far the biggest issue facing the independent care home sector has been local authorities implementing zero or sub-inflation up-ratings in baseline fee levels during the three years 2010/11 to 2012/13. As a result, the market has become increasingly polarised between affluent areas with high levels of self-pay, where fee levels have risen with inflation, and less affluent areas highly dependent on state-pay.
Part 3. Improving the systems and processes of care

If it is accepted that integration of services will take between five and ten years, there will be a need for sustained and consistent political leadership to make this change happen. In the meantime there are a number of immediate targeted changes to the systems and processes of care that can have a more immediate impact on quality of care for the frail older. This part of the report focusses on examples of good practice, already being implemented in parts of the UK and other countries, providing suggestions for improving systems and processes of care in the short to medium term. While there is a need for some investment, all require providers and other staff to work differently in caring for the frail older (Figure 5).

Figure 5. Staff need to work differently in caring for frail older people

Frail older people require access to a proactive and integrated care system that will deliver a step change in the management of their health, from early identification through to treatment and supported self-management. Health and social care needs to improve communication and co-ordination of services, with all touch points in the system having access to robust, reliable and up to date information on a patient’s health and social care needs. Underpinned by regular case review, including input from specialist geriatricians.

• Limited proactive care
• Multiple access points
• A level of inappropriate admissions and delayed transfers of care
• System difficult to navigate between health and social care
• Care only provided in response to crisis or cry for help
• Fragmented commissioning
• Poor access to information and data

• Prevention and early identification of those at risk and population health management
• Single access point, care co-ordinator (named GP)
• Priority access, rapid assessment and early diagnosis
• Supported discharge, self-management, follow-up and support
• New integrated commissioning models
• Access to single patient record

Prevention and early identification of those at risk – population health management
Unplanned admissions cost the NHS an estimated £11 billion a year so reducing them will not only lead to improvements in individual patients’ health status and generate net savings for the health service. Over recent years a range of predictive models have been used to identify people at high risk of admission or readmission to hospital (Figure 6). The increasing ability to link large data sets at an individual level whilst protecting the confidentiality of patient, as envisaged by the new care.data scheme, means that the sensitivity of these types of models and their applications is likely to grow. For example, the Nuffield Trust have built a model based on linked GP, hospital and social care information that predict which individuals are at risk of starting intensive social care in the next 12 months. 81
Figure 6. Use of predictive modelling to identify patients at risk of admission/readmission

<table>
<thead>
<tr>
<th>Model</th>
<th>Description and availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARR++ Patients at Risk of Readmission</td>
<td>The PARR uses Hospital Secondary User Services (SUS) datasets and case finding algorithms use prior hospital discharge data to identify patients at high risk of hospitalisation in the 12 months following the identification. The tool provides a PARR score from 0-100. Free to NHS.</td>
</tr>
<tr>
<td>PARR-30 – predictions of admission to hospital within the next 30 days for patients who are currently in hospital</td>
<td></td>
</tr>
<tr>
<td>Combined Predictive Model (CPM)</td>
<td>The CPM integrates accident and emergency and GP data sources to predict risk of emergency admission to hospital across an entire population. It builds on the PARR models. Is tailored to the customer, and relies on the quality of GP data. Cost around £150,000 per commissioner to develop.</td>
</tr>
<tr>
<td>Uses GP and hospital data to make predictions of unplanned hospital admission for everyone</td>
<td></td>
</tr>
<tr>
<td>The Scottish SPARRA Scottish Patients at Risk of Readmission and Admission model</td>
<td>Central compilation of recent hospital data with messages sent to GP practices and each health board identifies people who have entered a cycle of repeat admissions to hospital in the previous 3 years and predicts their risk of future hospitalisation.</td>
</tr>
</tbody>
</table>

Source: Nuffield Trust

A number of other screening tools have been developed for use in community settings or to delay entry into a care home. There are also specialty specific models including: LACE developed in Canada – which stands for: length of stay (L); acuity of the admission (A); co-morbidity of the patient (C); and emergency department use (E). CHADS2 – identifying patients at risk of decline due to congestive heart failure (C); hypertension (H); age ≥ 75 years (A); diabetes mellitus (D); and prior stroke or transient ischaemic attack/TIA (S).82

General practice, with its registered list of patients, has untapped potential to develop a more proactive approach to improving population health83 and has a key role to play in identifying people living with frailty. There are a number of tools, such as the Edmonton Scale, which can be used to identify frailty with consistency of approach important. Sustained progress depends on partnerships between practices, local communities, clinical commissioning groups, local authorities, academic groups and community and acute providers; and requires good-quality data and risk stratification tools to support this task.84

Single point of access for care
Across the UK, NHS commissioners are adopting single point of access schemes. These schemes use clinical triage to evaluate need and dedicated teams of health and social care staff; to provide GPs and other healthcare professionals with an efficient way of referring patients to the right services. They also support patients to get the support they need, including post-acute care and re-ablement, rapid response nursing and hospital at home services.

While these may be appropriate organisational responses to manage demand there is a need to ensure that the impact on patients is monitored and concerns responded to. Many examples are emerging including:

- Oxford Health NHS Foundation Trust’s Single Point of Access service to the Trust’s community health services
- In east Sussex, Hermes provides a clinician to clinician telephone triage service for GPs and healthcare professionals, staffed by a call centre team managing all unscheduled care and cover for 750,000 patients. The service helps GPs and others transfer patients to community services, manage the referral process including transport, and liaise with referring GPs to agree the appropriate urgent care pathway.
**General Practice acting as care navigator**

Since 2004, GPs have been incentivised to become more specialist, which is contrary to the primary care needs of people with complex co-morbidities. The King’s Fund inquiry into general practice concluded that the majority of GPs should remain generalists, but should also extend their role and act as care navigators, working alongside specialists, to provide more care in the community.

The last two years has seen a move to larger practices to enable GPs to focus on particular cohorts of patients, particularly frail older people and to play a central role in coordinating their care. This helps minimise disruption and avoids expensive duplication of investigations. The role requires effective communication, robust clinical support, and information systems between providers. It also requires GPs to be less gate-keeper and more care navigator.

In adopting the care navigator role, GPs need to work with nurse practitioners, practice nurses, community matrons and district nurses and engage with social care and therapy staff. The new commissioning regime provides an opportunity to modernise the primary care model with opportunities through the new £50 million Challenge Fund to identify innovative ways of providing primary care services.

**Primary care, priority access, rapid assessment and early diagnosis**

The adoption of innovative tools, such as telephone triage systems, can enable GPs to spend longer with those patients who need to be seen, cover more clinical territory and make a greater impact over a shorter time. Case examples and independent reviews of patient access scheme show increased patient satisfaction.

A review of some 13,000 GPs found continuity was important rising from 20 per cent with children to 60 per cent for patients over 70. The review also suggested that access and continuity are interdependent. In recognition of the value of the GP/patient relationship, the Department has agreed with the British Medical Association that from 2015 a named GP will be accountable for every patient over the age of 75. In return GPs will have reduced requirements to demonstrate achievements under the Quality and Outcomes Framework payment system and funding to help avoid patients being admitted to hospital inappropriately.

Increasingly, Complex Care Practices (CCP) are being established in areas with high numbers of frail older. These employ a multidisciplinary team who care for a registered list of 500 or so patients per GP, depending on complexity of care needs. Teams of health and social care professionals are then incentivised to keep the patients as well as possible in their own homes (using a capitated budget to fund care across the community and acute sector). The CCP also supports patients in care and nursing homes. Several GP services are looking at innovative ways to manage home and nursing home residents. For example: Ealing Clinical Commissioning Group (CCG) is funding a GP service providing care to nursing home residents 12 hours a day, for 365 days a year.

**Involving people in their own care – self management and advocacy services**

Policy direction is towards involving patients and their carers more in managing and making decisions about care and treatment. Work on behalf of the National Collaboration for Integrated Care and Support, co-developed by National Voices, identified a narrative for person-centred co-ordinated care as:

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Many frail older people and their carers need access to support and ideally a case manager. Independent patient advocates also have an important role to play, but are rare. Often it is left to the patient’s family to act as advocates. Advocacy services can be a relatively inexpensive way of improving care, for example the Older People’s Advocacy Alliance.

MySupportBroker is a social enterprise, peer to peer network model, that uses a proprietary online care and support planning and brokerage portal to matches customers to brokers and link them to agencies through online care and support plans. Around 25 per cent of clients are over 80 years of age. A key outcome is that 97 per cent of clients have taken up self-directed personal budgets and report reduced social isolation and increased community engagement. There is a measurable reduction in council costs for care and support planning and reduced administration and care costs. The unit cost for care and support planning and brokerage is less than half of the council average of £800.
New integrated commissioning models

The problem created by disparate approaches to funding has led to the development of a number of new approaches to commissioning (Figures 7 and 8).

Figure 7. Commissioning using accountable care provider or prime contractor model

Overview
- A single accountable provider given the whole budget for a cohort of patients. The commissioner contracts with the lead provider who is responsible for the services and outcomes achieved across the pathway – subcontracting elements of the services to other providers as required
- Whole pathway commissioning can occur at a condition level, programme budget or specialty level
- There are a number of ways to assign accountability for example through network, alliance contracting or lead provider
- Define the cohort of patients covered within the service
- Service may be jointly commissioned to better enable integration.

Detail

Commissioner
- Single or joint commissioners
- The commissioner(s) contracts with a single prime provider for the whole frail older people’s pathway with a set budget for delivery of services
- The pathway is commissioned with a focus on agreed outcomes rather than how the service is delivered
- The single provider has lead responsibility for delivery on those outcomes.

Prime contractor
- The prime contractor may deliver a substantial part of the care pathway themselves, for example a community provider delivering community beds and community services, or may be a joint venture set up for the purpose
- The prime provider receives the whole budget and delivers their element of the service and subcontracts for other services with incentives to focus on lower cost interventions at an earlier stage in the patient pathway.

Specialist services
- Where the prime provider uses the services of a hospital these are paid for at the tariff rate but the cost is within the managed budget again creating incentives to minimise delayed discharges.

Benefits and key considerations
- Minimises risk to the commissioner as the prime provider has responsibility for the full budget and has incentives to intervene earlier to reduce costs
- Focuses on the whole patient pathway and incentivises treatment in lowest cost, most appropriate setting, focussed on patient need. Decision making for patient sits with the organisation providing the care
- Enables continuous improvement in quality of services as the prime contractor manages the pathway for the agreed period of the budget before retendering
- Simplifies commissioning and reduces commissioning costs as single contract to manage with a focus on achieving agreed outcomes
- Encourages innovation by providers to find alternative ways to care for patients within the given budget.

- Determining most appropriate prime provider to deliver the benefits and incentivise behaviours
- More complex model where social care is included needs consideration on how to manage the health and social care funds
- Model owned by the commissioner with an outcome based service specification and clear objectives at the go to market stage
- Managing and enabling patient choice needs to be considered and referrals to providers other than the prime contractor must be facilitated.
Furthermore, the Year of Care Funding Programme for long term conditions advocates a more integrated approach to funding, based on three main principles:

- systematic risk profiling of the population
- integrated locality care teams including social care, community services, allied health professionals and general practice
- maximising the number of patients who can self-manage through systematic transfer of knowledge and care planning.  

Figure 8. Commissioning using capitation based funding or pooled funding approach

**Capitation based – Overview**

- Commissioners pay a prospective fixed fee to the provider for healthcare needed by each patient within specified time period, covering the whole population within a defined group
- The commissioner pays the provider per patient regardless of the level of activity for that patient
- The desired outcomes for the service are identified from the service specification
- The commissioner may choose an integrated provider which includes representation across primary and secondary care, and potentially social care to ensure the primary contractor will take responsibility for a budget based on the capitation model.

**Capitation based – Benefits**

- Incentivises providers to provide lowest cost treatment to the patient as they are paid per person and not by the nature, type or number of treatments
- Can incentivise an increased focus on preventative care as it may be more cost effective to prevent a person becoming acutely ill than to treat them once they are ill, may also incentivise integrated care to increase efficiency
- Capitation payment does not define the method of treatment and therefore may encourage innovation or flexibility in the nature of treatments provided.

**Key considerations**

- May increase the risk faced by providers as financial risk sits with the provider, and a larger population or cohort of patients can help to mitigate this risk
- Providers have financial incentive to use lower cost treatments and therefore outcomes need to be clearly defined to ensure quality of care is not impacted. Providers may have an incentive to restrict access to treatments particularly if they are high cost
- Commissioners need to ensure there are a clear set of outcome measures and may wish to include an additional fee to ensure the focus on outcome is maintained
- Requires more complex information both on services but also on the population and would benefit from risk stratification to maximise the benefits for the population and focus resources on the right patients. Providers may avoid highest risk or cost patients, if the capitation payment is insufficient.

**Pooled funding – Overview**

- Commissioners of health and social care can pool their funds into and single funding budget. Some or all budgets are pooled and then managed by a single organisation, pooled funds lose their identity as ‘health’ or ‘social care’
- This usually takes the form of a section 75 arrangement where the commissioner enters into a formal partnership agreement covering some or all of the services
- Under a section 75 agreement budgets do not need to be pooled but can be delegated or transferred and so technically remain separate thus maintaining the social care Sovereignty Guarantee or funds can be pooled fully.

**Pooled funding – Benefits**

- Pooling funds removes some of the barriers to health and social care working in an integrated way. It enables integration of services as there is no distinction in the source of funds but instead a focus on the appropriate treatment for the patient whether health or social care need
- A pooled budget may make it easier to manage resources and realise savings across all budgets through integration
- May enable better information sharing across organisation.

**Key considerations**

- Clarity over who is responsible for the pooled fund, responsibility for managing the budget needs to be clearly defined with agreements in place for risk around any overspends or under spends
- Need to determine if funds are pooled at a commissioner level only or if these would then be delegated to a single provider or prime contractor to enable integrated working at the provision level as well as the purchasing level.
The aim is to have a national Long Term Condition (LTC) ‘Year of Care’ payment model, facilitating the delivery of integrated health and social care based on need rather than disease. The programme completed its first trial year testing implementation of the model in March 2013, and on the back of this testing a national pricing model is planned for development. Figure 9 details some evidenced based case examples.

### Figure 9. Case examples of integrated/accountable care development in the UK

<table>
<thead>
<tr>
<th>Name</th>
<th>Overview of the model</th>
<th>Characteristics of health economy</th>
<th>Key initiatives and outcomes where known</th>
</tr>
</thead>
</table>
| North West London | • Specific care pathways were created covering frail older people and diabetic patients providing access to better, more integrated care outside of hospital, reducing unnecessary hospital admissions  
• Formed a multidisciplinary group (MDGs) of clinicians and social workers, includes patients and voluntary sector  
• Aims to reduce overall costs by 24% over a 5 year – Integrated Care Pathway tool used to risk stratify patients | • Similar sized population served (500,000 people) 6.7% over 75 – 28% of healthcare spend  
• Frailty and older people focus | • They created a patient registry, segmented the patient population according to risk, and developed best practice clinical protocols and care package  
• Focus on falls, medicine management, dementia, diabetes.  
• Modelling suggests costs could be reduced by 24% over 5 years; emergency admissions by 30% and nursing home admissions by 10%  
• Review by Nuffield Trust found to early to judge but staff and patients report improved access and more efficient use of time |
| South West Essex | • Integrated approach to planning and co-ordination of care with a shift in focus from acute to community care  
• Overall anticipated savings of £3.7m over 4 years due to joint commissioning with the County Council | • 408,000 population 7.6% over 75. The 85-plus age group is experiencing the greatest growth proportionally  
• Risk stratification delivering clinical prompts to GPs  
• Care co-ordination to prevent crisis moments | • Symphony Alert registry of patients  
• Single point of access, Frailty assessment unit and co-ordinated discharge plan  
• Targets include anticipated savings of £3.7 million, reducing emergency admissions by 15-30% and readmission within 48 hours by 80% |
| South East Essex | • South East Essex PCT has commissioned an integrated service for Elderly and Chronic Obstructive Pulmonary Disorder patients focussed on improved access to appropriate care and self management  
• Savings anticipated to be £7m across planned and unplanned care | • 339,000 population 9.7% over 75  
• In South East Essex 37% of people are registered as having at least one Long Term Condition  
• Population over 65 is growing between 29 and 44% | • Single understood process for assessment, not usually conducted in the acute setting  
• Saving £11.5 million; reduction in emergency admissions 15-30% and readmission within 48 hours by 80% |
| Torbay | • Integrated care for region split into five health and social care teams covering localities of 25,000 – 40,000 aligned to general practices. Teams have a single manager and point of contact, and use unified assessment process. Shared health and social care electronic record. The programme developed a story about ‘Mrs Smith’, a typical older lady requiring a range of services which had a big impact | • 140,000 population ,high proportion of population ages over 75 (12.4%)  
• Single acute site | • Increased spend on intermediate care in the community to keep people at home  
• Reduction in the average number of occupied beds from 750 in 1998/9 to 528 in 2009/10  
• Lowered the number of emergency bed days by 753 (per 1,000 population aged 65 and over) |
| Sheffield Teaching Hospitals Trust | • Integration of community health services with the acute provider for frail older people, including nursing, health visiting and physiotherapy services and a focus on self care including systematisation of care planning and increased use of Assistive Technology | • Population 560,000, 7.6% over 75  
• Significant issues with length of stay and evidence that 49% of patients aged over 75 years could have been provided with alternative care out of hospital | • Community-led discharge process co-ordinated by a named individual  
• Anticipated outcomes – 5% reduction in length of stay; 5% reduction in readmissions (within 28 days) and 12% reduction in A&E attendance |
| Hampshire | • Frail and elderly pathway with single point of access for community and social services; patient expert programme to increase prevention; early and integrated discharge planning that reduces hospital attendances and increases care at home | • 1,314,000 population 9.3% over 75  
• Current provision for Frail elderly is inconsistent across the County with a lack of coordination between practitioners | • Disinvestment from inappropriate unscheduled services (focus on people with mental health problems, including dementia)  
• Doing nothing creates a forecast real terms net cost pressure of £47.6m over 2009/10-2014/15, while implementing the strategy produces a cumulative real terms net saving of £1m |
The government has acknowledged that social care remains a priority, and in addition to the extra £1 billion being provided in 2013-14 and 2014-15, and a new pooled budget of £3.8 billion, known as the Better Care Fund from 2015. However, it is not new money as £1.9 billion will come from CCG allocations (equivalent to around £10 million for an average CCG) in addition to the NHS money already transferred to social care. Of the total, £1 billion will be paid depending on local performance including how well integration is safeguarded.98

For most CCGs finding money for the Better Care Fund will involve redeploying funds from existing NHS services. Departmental guidance is clear that the Better Care Fund should entail a substantial shift of activity and resource from hospitals to the community and that ‘hospital emergency activity will have to reduce by 15 per cent’. At the same time the government is supporting 14 new integration pioneer pilots, varying in approach, but most emphasising preventative care, particularly for the frail older. Several seek to create either a single access point for patients, or a multi-agency response unit to deal with emergencies.99

To help CCGs respond effectively to the above commissioning challenges, Deloitte were commissioned by NHS England to provide research evidence and case examples to help deliver better care within the available financial resources. ‘Anytown’, is a modelling guide to help commissioners with their mandatory five year plans and shows how a typical urban, suburban and rural CCG could achieve improvements in outcomes and financial balance over the strategic planning period up to 2018-19. It provides a wide body of research evidence, case examples and financial modelling many of which are relevant to improving services for frail older people in recognition of the importance of delivering better care to this vulnerable group.100
To start a new section, hold down the apple+shift keys and click to release this object and type the section title in the box below.

Improving interoperability of information and technology is key to improving services, including integration

The intention that providers of primary and secondary care will be able to share patient records by 2015 is of particular relevance to the frailolder. Without robust information treatment is likely to be sub-optimal. A number of local health economies have tackled this (Case example 1), others have yet to develop interoperable systems. In the absence of an electronic record most local health economies provide paper-based records of community visits and treatment. However, this record is largely left in the person’s home and rarely accessed by other health care providers. Some health economies are equipping their community teams with tablets and secure access to patient records, which is improving productivity and effectiveness of community nursing. Others have developed local health and social care partnerships and collaborations including a shared record.101

Information prescriptions

Given the complexity of many frail older people’s conditions, patient and carers are often confused and concerned about how to best manage the condition. Traditionally, patients receive leaflets but these tend to be condition specific, can be confusing, and sometimes contradictory. They can also quickly become out of date. In recognition of this some organisations are developing electronic information prescriptions, such as the Guideposts Information Prescription for Dementia, which provides a comprehensive guide to a range of support, care and advice services for people with dementia, linked to a 24-hour national dementia helpline.102

Use of technology assisted care: Telehealth and telecare

Deloitte’s report, Telecare and telehealth – a game changer for health and social care, provided a synopsis of the available evidence on the costs and benefits of telehealth and concluded that technology assisted care provided an equitable way of enabling more people to live independently for longer, while supporting health and social care providers to work differently. The government has continued to stress the need to make progress by 2017 towards its ambition that three million people with long-term conditions will benefit from telehealth and telecare.103

Case example 1

Integrated care record across the Salford health economy

The Salford health economy has integrated primary, community and acute care through a real time shared patient record. Patient data is uploaded to a central database every night, allowing clinicians in A&E to access a patient’s primary care record, while GPs are able to access records of patient use of acute services. While this faced initial technical and political challenges – with access to the data taking two years to negotiate – it has paid dividends in improvements in the quality of patient care. In addition, through the North West eHealth informatics spin-off company, the use of anonymised data has enabled the injection of £30m into the local health economy, including a world-leading clinical trial of respiratory medication using real-time data (the Salford Lung Study). There have also been benefits in savings of GP time through greater efficiency and reduced duplication of effort.

Given the complexity of many frail older people’s conditions, patient and carers are often confused and concerned about how to best manage the condition.
The technology underpinning telehealth has changed significantly in the past two years. There is also much more experience in implementing the technology, with providers seeing telehealth as part of an overall system change. Telehealth can be used to reduce or facilitate early discharge from hospital (Case example 2). While adoption in England remains low, it is being deployed at scale in Scotland (Case example 3).

**New legislation, inspections and standards to improve care**

In response to a growing clamour of criticism of its performance, in April 2013 the CQC launched its refreshed strategy for 2013-2018 Raising standards, putting people first and in June 2013, launched a consultation on changes to the way the CQC regulates, inspects and monitors care. The CQC are also following the example of Ofsted and rating the outcomes of its inspections.

Other key changes that should improve the standards of services for the frail older include:

- a new quality mark scheme by the Royal College of Psychiatrists, designed to establish how ‘elder-friendly’ a ward is
- a House of Lords amendment to the Care Bill, to provide more protection to self-funders
- a campaign to end 15-minute homecare visits and zero-hour contracts for care staff, which means 220,000 care workers receive less than the minimum wage.

**A national approach to delivering more care closer to home**

In Scotland, a national approach to supported living has helped deliver compelling results (Case example 4).
Part 4. Improving the place of care

The suitability of accommodation for older people is critical to their care. There is significant housing poverty among older homeowners, especially in the private sector, with an estimated 3.2 million older householders living in non-decent private sector homes. Given that many ill-health conditions have a causal link to, or are exacerbated by, particular housing conditions and that with age, people become more prone to trips and falls and susceptible to cold or damp-related health conditions, the housing-health link becomes increasingly important.

Both health and social care sectors need to understand the impact that poor standards and quality of older people’s housing and accommodation can have on care outcomes. A better supply of suitable alternatives could allow individuals to retain their independence for longer, and help improve health outcomes but there is currently insufficient supply of appropriate housing.

The place of care includes the individual’s home, supported living/retirement housing, care home or nursing home, specialist nursing home, and hospital. With increasing frailty there is an increasing tendency to bounce between these different places of care in a non-linear manner (Figure 10). A key concern is the effectiveness of the transition or hand over between places of care and that the environment and standards of care in each location is suitable for each person’s needs. At each touch point, interventions are needed to avoid or delay the need for residential care. For example, housing related care and support services can make a significant financial contribution to health and social care economies by offsetting health and social care expenditure.

Figure 10. Bed bouncing between different parts of the health and social care system

Older people often bounce between places of care in a non-linear manner, for example following a fall at home and admission to hospital, may recuperate in a nursing home before returning home. With increasing frailty, hospital admissions increase as does the need for more supported living, and ultimately a care home. At each touch point there will be engagement with different types of health and social care staff.
Case example 5
Overview of the economic benefits of supported home care provided by the British Red Cross (BRC)

An economic evaluation of six case studies found a range of positive impacts. Estimates of savings per user ranged from £168 to £704. The benefits accrued to both health and social care commissioners with savings due to reduced demand for secondary, residential and domiciliary care. By extrapolating the findings the BRC is estimated to cost health and social care commissioners approximately £5.4m but reduce spending on alternative services by £13.4m; saving healthcare £3.2m, and social care £4.8m.

Initial benefits relating to the prevention of admissions to hospital or reduced length of stay, were enhanced further by reduced readmission rates. Service users also reported high levels of satisfaction with over 70 per cent rating them as ‘excellent’. Most users highlighted that they felt treated with dignity and respect, as well as helping them maintain or regain their independence.

Evaluation by Deloitte Economic Consulting

#### Table: Savings across BRC schemes

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Type</th>
<th>Savings to health care commissioner</th>
<th>Social care savings</th>
<th>Savings per service user</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camden</td>
<td>Community</td>
<td>£76,502</td>
<td>£707</td>
<td>£246</td>
</tr>
<tr>
<td>Herefordshire</td>
<td>Community</td>
<td>£0</td>
<td>£218,118</td>
<td>£347</td>
</tr>
<tr>
<td>Bristol(1)</td>
<td>A&amp;E Discharge</td>
<td>£46,442</td>
<td>£0</td>
<td>£168</td>
</tr>
<tr>
<td>Blackpool</td>
<td>A&amp;E Discharge</td>
<td>£191,407</td>
<td>£0</td>
<td>£264</td>
</tr>
<tr>
<td>Torfaen</td>
<td>Community</td>
<td>£140,869</td>
<td>£0</td>
<td>£704</td>
</tr>
<tr>
<td>Nottingham</td>
<td>Community</td>
<td>£315,897</td>
<td>£56,493</td>
<td>£633</td>
</tr>
</tbody>
</table>

(1) Prospective evaluation

#### Breakdown of returns in health and social care

![Graph showing breakdown of returns in health and social care]

- Savings to healthcare: 39.7%, 24.5%, 75.0%, 74.9%, 90.0%, 279.6%
- Savings to social care: 131%, 1%, 0%, 0%, 0%, 0%

Better care for frail older people Working differently to improve care
Case example 6

Evermore and the Green House Project – shared living with demonstrable qualitative and quantitative benefits

The Evermore concept in the UK is modelled on the United States (US) Green House Project established over 10 years ago (now in 32 states with 144 homes open and 120 homes in development). An evaluation of the Green House Project in the US compared nine Green House units housing 97 residents to four Traditional units housing 158 residents using data collected between June 2004 and September 2009. This evaluation found that Green House residents had: an improved quality of life and emotional well-being; were able to maintain self-care abilities longer; had fewer experiences of depression or being bedfast; and improved family and staff satisfaction. The evaluations also found: four-fold increase in ongoing personal development.

Evermore aims to adopt the Green House principles and provide a community for older people, generally over 80, who can no longer cope with living alone. It works by supporting groups of around 12 older people to live within each household. People either own or rent their purpose-built apartment which opens onto a shared living space and communal kitchen. The aim is to provide a sense of security and companionship but also independence, with an emphasis on shared meals aimed at tackling the risk of malnutrition and dehydration suffered by many older people. Multi-skilled staff (known as Mulineddors) provide hospitality services and domestic support based on individual needs and preferences. These staff will receive relevant education and training through the Evermore Academy, and participate in ongoing personal development.

In 2013, the Department announced a £240 million Care and Support Specialised Housing Fund and the Greater London Authority, a £60 million fund to support developments in the capital, in recognition of the pressing needs of older people in the city whose number is predicted to increase at double the rate of the general population in coming years. Estimates suggest that some 80,000 sheltered housing spaces and 67,000 care home places will be needed by 2041. However, these initiatives are likely to fall short of demand.122

Extra care housing

Extra care housing is distinct from residential care and while ‘specialist’, it is closer to ordinary housing. A move from less suitable housing into extra care housing can maintain older peoples independence for longer and can often release capital though downsizing, to support care needs. Research by the International Longevity Centre suggests extra care schemes can improve their health and wellbeing outcomes by up to 15 years.123 While there are additional costs, the combination of age-friendly design, 24-hour support and opportunities for social contact, mean extra care housing can be a cost effective alternative to a care home (Case example 6).

Continuing care retirement communities

The concept of continuing care retirement communities range from assisted living schemes through to retirement villages. Currently there are around 35,000 assisted living and extra care units in England with the substantial majority being social rented schemes operated by registered providers. Privately funded lease purchase schemes account for around 5,000 extra care units. Of the 384 older residential studies, only 26 per cent were located outside of Southern England and then closely matched pockets of affluence in the West Midlands and North West. Indeed, the South East and London offer the strongest fee profiles for nursing homes at average rates of £961 and £906 per week respectively. The average rates for the South West and East of England are £796 and £777 a week.124

Residential care

In care homes, the average resident is 85 years old and often very frail and suffering with dementia. The prevalence of dementia in care settings is around 70 per cent.126 The definitions of residential and nursing care are becoming blurred. People who would have been in hospital or a nursing home 10 years ago are increasingly cared for in residential homes. Estimates suggest the number of older people in care homes need to rise by 29 per cent, to keep pace with demographic changes.127

Provision of effective medical care in care homes

Notwithstanding the funding challenges, an important consideration for care homes is the need to provide for the challenging health care needs of their residents. However, a report by the British Geriatrics Society (BGS) in 2011 found that healthcare for care home residents remained a ‘Cinderella’ service in the NHS and that traditional general practice in many areas does not appear fulfill this void. Part of the problem is the variety of healthcare arrangements for care home services. Some contract directly with local GP practices, some receive care through Local Enhanced Services (LESs), and other rely on standard contracts. The result is a patchy quality of service, leading to avoidable hospital admissions and poor continuity of care for patients.128
In some cases commissioners’ contract for GPs to provide dedicated teams to care homes. GPs running these services can opt out of the normal GP contract and spend more time concentrating on the specific needs of older patients. If these early adopters can prove that the model works, it could fundamentally change how general practice cares for the very frail older. Recent projects include Sheffield CCG (case example 7).

**Improving care of frail older people in hospitals**

Given the increasing numbers of frail older people attending A&E departments who require admission (Part 2), hospitals have been reviewing how to improve their services many adopting ideas and recommendations from the Silver Book, a Best Practice Guide for hospitals. Examples of new ways of working include:

- the introduction of an acute physician within the medical triage unit, providing early senior decision making and introducing an ambulatory care area where patients on ambulatory pathways are treated in chairs, freeing up emergency medical beds for those patients that really need it

- redesign of the patient pathway for care of the older, providing a ‘frailty score’ within a short time of arrival and those deemed to have complex frailty needs being treated by the acute care of the elderly team

- hospitals segregating their vulnerable and older patients from the main A&E population, providing a less noisy and threatening environment

- direct admission to care of the older wards, 24/7 consultant cover and geriatrician of the day

- adopting quality indicators (such as reducing falls and pressure sores, improving weight management and nutrition and medicines management) and treating the whole patient not just the condition

- introducing new staffing models for A&E departments. These include initial triage by senior clinicians, a geriatrician of the day, new nurse practitioner roles, emergency nurse consultants, rotation of middle grade doctors into A&E and Older Care Assessment units.

---

**Case example 7**

**Model of care home primary care services in Sheffield**

Commissioners in Sheffield used a Local Enhanced Service to encourage residents in each local care home to register with a paired GP practice. Named GPs held weekly surgeries in the care homes, providing proactive care such as annual reviews, monthly analysis of emergency admissions and medication reviews twice a year. In the first year of pilots involving 500 patients, emergency hospital admissions fell 9 per cent, saving £145,000. The scheme has since been expanded to cover all 85 care and nursing homes in Sheffield.

A number of hospitals are also adopting their own vertically integrated solutions. Including funding the installation of telehealth in care homes and extending the use of hospital at home and early supported discharge services. Furthermore, in the absence of capacity in the community, hospitals are opening up step down facilities and providing virtual wards and hospital at home rehabilitation and reablement services.

---

**A number of hospitals are also adopting their own vertically integrated solutions.**
Part 5. Conclusion and actions

The number of frail older people is rising faster than funding and health and social care providers and commissioners need to transform the way they deliver services. This report provides a synthesis of the information and evidence on the challenges in caring for the frail older and suggestions and examples of good practice. Deloitte’s work on ‘Any town’ for NHS England provides further suggestions on how CCGs might achieve improvements in outcomes and financial balance for their whole population, including specific initiatives targeting the older people. This report, underpinned by the examples in ‘Any town’ provides a basis for commissioners and providers to evaluate and improve the current state of the care of their population. Ensuring effective use of the £3.8 billion, Better Care Fund, from 2015, will also be essential for the future success of integrated care.

Figure 11 outlines what a new integrated care pathway could look like. In addition, some of the key levers that are needed in the short term include commissioners:

- introducing joint personal budgets for the health and social care needs of people suffering with frailty, assessed on the basis of need at 75 (or on diagnose of frailty) and reviewed annually
- adopting new funding models to provide the right care in the right settings at the right time, including moving from volume to outcome, value-based payment models, for example accountable provider or prime contractor model, capitation based funding or pooled funding models
- developing incentives to encourage providers to adopt technology to support their delivery of care and improve the interface between providers and patients, particularly between hospitals and care homes and general practices and people’s homes.

Meanwhile health and social care providers:

- should review their workforce capacity and capability and where services are provided. Meaning geriatricians coming out of the hospital setting to deliver assessment and intervention in the community and GPs, with a training in frailty management, providing appropriate care
- should ensure their staff receive relevant training on the impact of ageing on health and are certified as to their level of competence in managing conditions associated with ageing, in accordance with standards developed by Skills for Care and Health Education England
- need to see access to effective healthcare in care homes as a human right and should agree with commissioners arrangements for funding multi-disciplinary teams to help identify and tackle avoidable deterioration in patients’ conditions and reduce the need for emergency and planned hospital care.

There is a need for more primary, community and district nurse and other allied health professionals input to the case management of frail older people. Currently, there is no readily available supply large enough to meet this need suggesting that in 2014-15 all staff will need to be more agile, accessing data and information on the move, enabling them to spend more time with patients and less time travelling or in the office. This culture change will need to be well considered, planned and implemented; using mobile technology as an enabler.

General practice has a key role in dealing with frail older patients with complex needs who are adrift in the community and increasingly wash up on the shore of the hospital. This ‘care gap’ needs to be addressed by challenging the medical profession to think and act differently. Evercare, community matrons, virtual wards are all models aimed at bringing care to people with complex needs in the community. The medical input for this group, however, has not been clearly defined, supported or delivered. Commissioners need to ensure that specific service specifications are agreed with providers to meet the physical health, mental health and social care needs of frail older people cared for in their own homes or in residential settings.
Integrated care pathway for frail older people

### Identification and risk stratification
- Identify and register all patients over 75 and stratify according to risk of hospitalisation using markers of escalation, such as diabetes, COPD, falls, dementia.
- Develop electronic alert system to flag risks with all local providers ideally via shared electronic patient record.
- Commission prevention and early intervention strategies targeted at those with greatest need and provide all over 75s with a joint health and social care budget, based on identified needs.

### Crisis Prevention
- Provide all over 75s with annual health check.
- Develop prevention and early intervention strategies, clinical protocols and care packages for each risk group.
- Appoint a care navigator for all over 75s including a named GP for high risk patients.
- Support patients and carers to self-manage by providing guidance, education materials and advice service.
- Use technology assisted support where indicated.

### Preadmission
- Implement a referral gateway to control referrals and appropriate hospital use.
- Provide patients with single point of access to a rapid response service.
- Ensure clinical protocols and care pathways adhered to at each patient contact point.
- Priority access to diagnostic tests for patients at risk.

### Acute treatment
- Provide access to patient records from multiple settings via IT solution.
- Frailty patient alert triggered on admission including alerting MDT discharge team.
- Frailty (older peoples) assessment.
- Unit with geriatric input on decision to admit.
- Named clinician for each episode of care including daily assessment and medication review.

### Discharge
- Establish in-hospital MDT, including social care and adopt co-ordinated discharge plan on admission.
- Patients and carers agree co-ordinated discharge plan, including indicative length of stay.
- Hospital input to intermediate, social and community care services including using telehealth.
- Provide hospital at home service or access to reablement service to facilitate early discharge.

### Intermediate care
- Establish multi-disciplinary intermediate care teams.
- Develop frailty pathway protocols to support efficient transition from intermediate care to home.

### Social care
- Assign dedicated social worker to each patient on risk register.
- Ensure providers have appropriately educated, trained, and remunerated domiciliary and care home staff and establish register.
- Input to multi-disciplinary team on eligibility and availability of social care packages.
- Co-provide home from hospital reablement services to help people return home or to care home.
- Incentivise use of telehealth and telecare.

### Primary and Community care
- Joint GP and consultant led service including consultant led community clinics and enhanced support to care homes.
- Community MDT responsible for urgent assessment, intervention and reablement.
- Up-skill community matrons and others to deliver care normally provided in hospital; Eg oxygen service, warfarin etc.
- Appropriate use of assistive technologies.

---

**Figure 11. Redesigning pathways for frail older people**

Vision

To improve outcomes by creating access to better, more integrated care outside of hospital; reducing unnecessary hospital admissions and enable effective working of professionals across provider boundaries.

The pathways covered would include falls management, dementia, medicine management, end of life care, early supported discharge and a rapid response service.

Outcomes

Modelling suggests that the overall cost of caring for frail older people could be reduced by 20-30 per cent over 5 years; emergency admissions might be decreased by 15-30 per cent and nursing home admissions by 10-20 per cent; and readmission rates within 48 hours by 50-80 per cent.

Commissioners need to move from volume to outcome, value-based payment models, for example accountable provider or prime contractor model, capitation based funding or pooled funding models.

---

**A multi-disciplinary team should operate across the whole pathway**
Notes

3. Ibid.
10. Primary care today and tomorrow. Improving general practice by working differently, Deloitte Centre for Health Solutions. See also: http://www.deloitte.co.uk/centreforhealthsolutions
12. Ibid.
18. OECD Factbook, Office of Health Economics, 2011-2012. See also: http://www.oecd-ilibrary.org/sites/factbook-2011-12-en/02/01/04/index.html?contentType=&itemId=/content/chapter/factbook-2011-12-en#containerItemid=/content/serial/18147364?accessItemids=6&mimeType=text/h
23. Review into the Quality of Care and Treatment Provided by 14 Hospital Trusts in England, led by Professor Sir Bruce Keogh, the NHS Medical Director in NHS England, September 2013. See also: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf


43. Public expenditure on health and social care, Health Select Committee, February 2014. See also: http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/793/79303.htm

44. Integrating health and social care in Torbay: Improving care for Mrs Smith, The King’s Fund, 31 March 2011. See also: http://www.kingsfund.org.uk/publication/integrating_health_1.html


47. Integrated care for patients and populations: Improving outcomes by working together, King’s Fund and Nuffield Trust Commission on integrated care, January 2012. See also: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/integrated_care_for_patients_and_populations_-_improving_outcomes_by_working_together_jan12_0.pdf


49. Ibid


60. End 15 minute care visits, Leonard Cheshire, October 2013. See also: https://www.google.co.uk/#q=Leonard+Cheshire+end+15+minute+care+visits


64. Ibid.


69. Primary Care today and tomorrow; Improving general practice by working differently, Deloitte Centre for Health Solutions, May 2012. See also: http://www.deloitte.co.uk/centreforhealthsolutions

70. Call to action, NHS England, July 2013. See also: http://www.england.nhs.uk/ourwork/com-dev/igg-cta/


73. Ibid.


76. Deloitte analysis of Health and Social Care Information Centre data on outpatient appointments. Sourced on 14 February 2014. See also: http://www.deloitte.co.uk/centreforhealthsolutions


108. A new quality mark scheme designed to establish how “elder-friendly” a ward is, Royal College of Psychiatrists, September 2013. See also: http://www.rcpsych.ac.uk/workingscience/qualityimprovement/qualityimprovementaccreditation/elder-friendlyqualitymark/overviewofthequalitymark.aspx


114. Homes for older Londoners: Building healthy homes for a comfortable and independent retirement, London Assembly Housing Committee, November 2013. See also: http://www.london.gov.uk/sites/default/files/Final%20draft%20report%2026%20November%20%28Recovered%29_0.pdf

115. The economic impact of care in the home services, Deloitte Economic Consulting and British Red Cross, November 2012. See also: http://www.redcross.org.uk/About-us/-/media/BritishRedCross/Documents/What%20we%20do/UK%20services/Final%20report%20to%20BRC_with_marque_NO_APDI%20(1).pdf

116. Literature Review of the Evidence Base for a Hospice at Home Service, Centre for Health Services Studies University of Kent, August 2008. See also:http://kar.kent.ac.uk/24789/1/hospice_at_home_literature_review.pdf


118. Elderly demand better homes, BD online, 2013: Housing and Improving Learning Network http://www.bdonline.co.uk/otherreportsandguidance/Housing/elder-friendlyqualitymark/overviewofthequalitymark.aspx

119. The National Evaluation of Partnerships for Older People Projects, PSSRU. See also: http://www.pssru.ac.uk/pdf/rs053.pdf


122. Establishing the extra in extra care housing. Perspectives from three Extra Care Housing Providers, ILC-UK, Kneale D, September 2011. See also: http://www.ilcuk.org.uk/index.php/publications/publication_details/establishing_the_extra_in_extra_care_perspectives_from_three_extra_care_hou


126. A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II, Matthews et al, July 2013. See also: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961570-6/fulltext


Contacts

Author
Karen Taylor
Research Director
Deloitte UK Centre for Health Solutions
Tel: +44 (0) 20 7007 3680
Email: kartaylor@deloitte.co.uk

Contacts
Rebecca George
Lead Partner Public Sector Health
Tel: +44 (0) 20 7303 6549
Email: regeorge@deloitte.co.uk

Simon Hammett
Lead Partner EMEA Healthcare and Life Sciences
Tel: +44 (0)20 7303 6402
Email: sarasiegel@deloitte.co.uk

Sara Siegel
Partner Strategy and Consulting
Tel: +44 (0) 20 7007 7908
Email: sarasiegel@deloitte.co.uk

Neil Hudson
Lead Partner UK Healthcare and Life sciences
Tel: +44 (0) 20 7007 7472
Email: nahudson@deloitte.co.uk

David L Jones
Partner Corporate Finance Advisory
Tel: +44 (0) 20 7007 2259
Email: davidljones@deloitte.co.uk

Kathy Colgan
Partner UK Healthcare
Tel +44 (0) 28 9053 1200
Email: kcolgan@deloitte.co.uk

Contributors
Hilary Jones, Shobhna Misha, Hannah Harris and Oliver Whight

Contact information
To learn more about the Deloitte UK Centre for Health Solutions, its projects and events, please visit:
www.deloitte.co.uk/centreforhealthsolutions

Deloitte Centre for Health Solutions
Stonecutter Court
1 Stonecutter Street 01/09
London EC4A 4TR