

Frail Older People

Executive Summary

Frail older people are the most significant patient group in terms of complexity, growing demand and potential for improved care pathways. For the purposes of this JSNA chapter we have used the definition for frail older people to be “people over 75 with a significant level of physical or mental impairment which may interfere with the ability to undertake daily living and requires support from either formal or in-formal care services”. The majority of people aged 75 or over are not frail and are living independently. In addition, whilst not all frail older people are aged 75 or over, however, this age is used where other indicators of frailty are not available.

There are 20,562 residents in North Somerset aged 75 and above, of which 6,519 are aged 85 and older. The number of annual consultations and tests in primary care and prescriptions increases with age and increases rapidly for patients aged 80-89. The total cost of hospital care for people aged 75 and over in North Somerset was £31.6Million in 2011/12, of which 57% was spent on emergency admissions. 513 patients aged 75 and older in North Somerset are assessed to be at very high risk of hospital admission. The average cost of an emergency admission to hospital per patient in the very high risk group is £1,133. Patients with high and very high risk of unplanned hospital admission are most likely to have hypertension, cardiovascular disease, depression, chronic kidney disease and a range of respiratory conditions including COPD and asthma. Annually 1,518 patients are referred to the falls services after a fall, of which the majority (72.5%) are aged over 80.

2,600 referrals were received for social care for individuals aged 65 and above, with 45% being aged 85 and over. Of the 2,294 social services provided to people aged 65 and over, almost half of the services were provided in six wards, (three of the wards were in Weston-super-Mare).

The provision of nursing, residential and home care increases with age. The number receiving residential care aged 85 and older doubled compared to ages 75-84, yet there are half as many residents in North Somerset aged 85 and older. In recent years the ratio of residential care to nursing care has changed with an increase in residential care and decrease in nursing care. A large range of prevention, information, health and social care services are provided to frail older people in North Somerset.

The population aged 75 and over is predicted to increase to 37,000 in 2030; an increase of 68%. There is expected to be an increase of 88% by 2030 in the number of people living in care homes aged 75 and over. Some of the priorities

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for frail older people are communication, a focus on quality of life, addressing feelings of isolation, social relationships, self-determination, feeling safe and secure, and getting out and about.

National guidance and quality standards cover guidance on: falls, immobility, incontinence, dementia, confusion and end of life care.

Challenges for consideration

1. Promoting strong communities to support people.
2. Encouraging and developing positive attitudes to personal budgets among older people and their carers.
3. Continued promotion and development of early intervention, prevention and self-care.
4. Providing information, advice and support to frail old people who are “self-funders” of their own care.
5. Admit to hospital only those frail older people who have evidence of underlying life threatening illness or need for surgery.
6. Provide early access to an old age acute care specialist, ideally within the first 24 hours, who will undertake a Comprehensive Geriatric Assessment and provide a management plan.
7. Designing discharge services so that patients or their carers will not be asked to make decisions about people's long-term care needs while they are still in an acute phase
8. ‘Discharge to assess’ as soon as the acute episode is complete, in order to plan post acute care in the person’s own home.
9. Provide comprehensive assessment and reablement during post-acute care to determine and reduce long-term care needs.
10. Sharing of data to allow data linkage across local organisations.

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Why is this area important?

Clinical leaders across North Somerset, Bristol and South Gloucestershire are unanimous in regarding frail older people as the most significant patient group in terms of complexity, growing demand and potential for improved care pathways. Health and social care organisations in North Somerset are working on improving care for frail older people with organisations in Bristol and South Gloucestershire through the 'Healthy Futures' programme of work. Five priority areas are:

- high numbers of prescriptions/costs
- unplanned hospital admissions
- complex social care packages
- admissions to residential or nursing homes
- reablement and rehabilitation

There is evidence of increasing demand and need for social as well as health needs. Nationally there is a policy driver to keep people at home, to avoid admissions to hospital and reduce length of stay in hospital; this is particularly relevant for frail older people. Not everything can or should be done outside hospitals, but much can be. Currently services often fall short especially because of lack of co-ordination.

What are the needs of the population?

There is not a commonly agreed definition for frail older people. Eight indicators of frailty are: mobility, strength, endurance, nutrition, physical inactivity, balance, motor processing and cognition.¹ For the purposes of this JSNA chapter we have used the definition of "people over 75 with a significant level of physical or mental impairment which may interfere with the ability to undertake daily living and requires support from either formal or in-formal care services". The majority of people aged 75 or over are not frail and are living independently. In addition, whilst not all frail older people are aged 75 or over, this age is used where other indicators of frailty are not available.

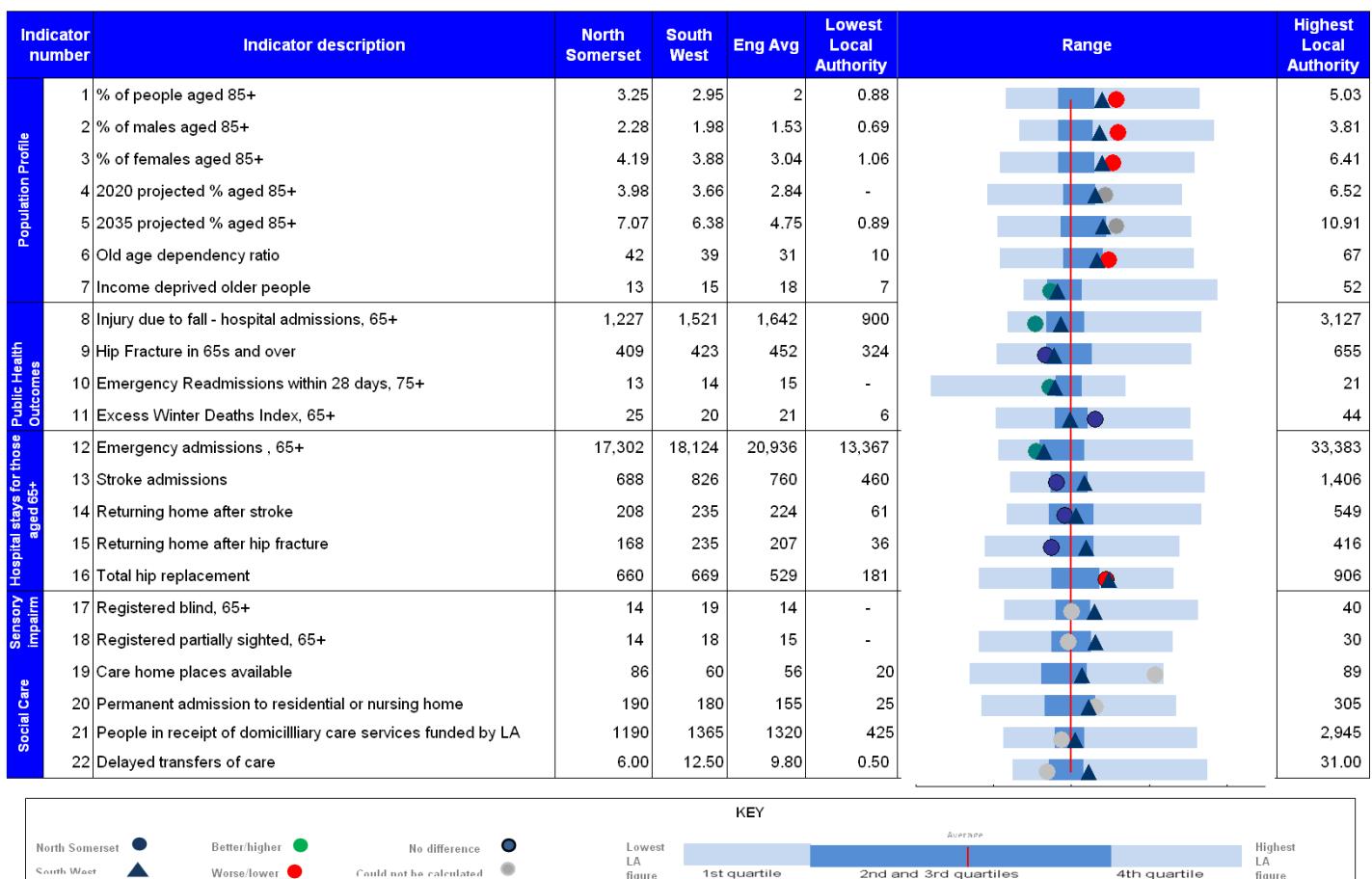
The Frail Older People Spine Chart summarises a range of indicators of health and well-being with a comparison to the England average. A description of each indicator is given on the next page. The profile shows that there are a significantly higher number of people aged 85 and over living in North Somerset compared to England. There is also a higher dependency ratio, with respect to the proportion of people of pensionable age to working age. However the income deprivation of older people is significantly lower than the England average. The health outcomes and hospital use shows that injuries due to falls leading to

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hospital admission, hip fractures, emergency readmissions and emergency admissions for the over 65s are all significantly lower than the England average. Although there is a higher than England excess winter death index for the over 65s, this is not statistically significant and the trend over time is of no change. There is a significantly higher rate of hip replacements in the over 65s. For the social care indicators it is not possible to calculate whether they are significantly different from England, however they are within the main range, with the exception of having a much higher availability of care home places. However this data is from 2009 and will be refreshed when more recent data is available.

Frail Older People Spine Chart North Somerset

The profile below shows how the health of older people living in North Somerset compares with England and the South West. Within the diagram North Somerset is represented by the circle and the South West by the triangle. The graph represents the range in scores across all local authorities in England, see key at the bottom for more explanation.



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Indicator notes for Frail Older People Spine Chart

- (1) % of the population who are aged 85 and over, ONS 2010
- (2) % of the male population who are aged 85 and over, ONS 2010
- (3) % of the female population who are aged 85 and over, ONS 2010
- (4) 2020 projected % aged 85+, 2010 ONS SNPP
- (5) 2035 projected % aged 85+, 2010 ONS SNPP
- (6) The old age dependency ratio is the number of people of state pension age and over as a percentage of the working age population, ONS 2010
- (7) Income Deprivation Affecting Older People Index, IMD 2010
- (8) Rate of emergency hospital admissions for falls, in persons aged 65 and over, per 100,000 2010/11
- (9) Rate of emergency hospital admissions for hip fractures, in persons aged 65 and over, per 100,000, 2010/11
- (10) Indirectly standardised percentage of emergency admission to any hospital in England occurring within 28 days of the last, previous discharge from hospital after admission in 75s and over, 2009/10.
- (11) Excess Winter Deaths Index (EWD Index) in Over 65's is the excess winter deaths as a ratio of the expected deaths based on the non-winter death rate for all persons over 65 years, 2007-10, WMPHO Excess Winter Deaths
- (12) Directly standardised rate all hospital admissions (emergency) per 100 000, 65+, 2008/09, HesOnline
- (13) Directly standardised rate all hospital admissions for stroke ICD10 I61-I69 per 100 000, 65+, 2008/09, HesOnline
- (14) Directly standardised rate for stroke (I61-I64) who return to their usual place of residence on discharge per 100 000, 65+, 2008/09, HesOnline
- (15) Directly standardised rate of patients admitted for hip fracture who return to their usual place of residence on discharge per 100 000, 65+ 2008/09, HesOnline
- (16) Directly standardised rate hospital episodes of patients with hip replacement operation, per 100 000, 65+, 2008/09, HesOnline
- (17) People 65+ registered with councils as blind per 1000 population, March 2011, NHS Information Centre for health and social care
- (18) People 65+ registered with councils as partially sighted per 1000 population, NHS Information Centre for health and social care
- (19) Care home places available per 100,000 population, 2009, CQC South Region.
- (20) Older people admitted to supported permanent residential and nursing care during the year per 100,000 population aged 65+, 2010/11, National Adult Social Care Intelligence Service.
- (21) People funded by the LA to receive a domiciliary care services at some point during the year are 100,000 population aged 65+, 2010/11, National Adult Social Care Intelligence Service
- (22) The ratio of delayed transfers of care (all ages) per month per 100,000 population, 2011/12, National Adult Social Care Intelligence Service.

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Population

The population resident in North Somerset are slightly older than the profile for England (see Table 1). There are 20,562 residents in North Somerset aged 75 and above, of which 6,519 are aged 85 and older.

Table 1 The number of residents in North Somerset aged 65 and above by age group (2011)

	England		North Somerset	
	Number	%	Number	%
65-74	4,552,283	9%	22,071	11%
75-84	2,928,118	6%	14,043	7%
85-94	1,090,033	2%	5,952	3%
95+	90,095	<1%	567	<1%
All ages	53,012,456	100%	202,566	100%

Source: 2011 census

NHS care

25 of 26 practices in North Somerset use the Primary Care Data Reporting Tool (PCDR) with a registered population of 208,037 patients. PCDR includes data from primary care systems and secondary care to calculate patients' likelihood of requiring unplanned hospital care. This is calculated using the Kings Fund Combined Predictive Model. The number and percentage of patients at the four levels of risk of hospital admission are shown in Table 2¹. 0.4% of patients are in the very high risk group and 2.3% in the high risk group.

¹ Data downloaded from PCDR on 18/5/2012

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Table 2 Number of patients at levels of risk of unplanned admission to hospital (n=208,037)

Risk of hospital admission	Number (%) of patients	
Very high risk	936	(0.4%)
High risk	4,745	(2.3%)
Moderate risk	33,932	(16.3%)
Low risk	168,036	(80.8%)

513 of the patients in North Somerset at *very high risk* of hospital admission are aged 75 and over (see Table 3); this is 55% of all patients at very high risk. Nearly two thirds of patients aged 75 and over at very high risk are female. Table 4 shows the figures for patients at high risk of admission. Of the 4,745 at *high risk* of admission, 55% are aged 75 and over.

Table 3 Number (%) of patients aged 75 and over at levels of *very high risk* of admission to hospital by age and gender (n=208,037)

Age range	Females	Males	All
75 to 79	61	49	110
80 to 84	78	66	144
85 to 89	89	34	123
90+	92	44	136
Total ≥ 75	320 (62.4%)	193 (37.6%)	513 (100%)

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Table 4 Number of patients aged 75 and over at levels of *high risk* of admission to hospital by age and gender (n=208,037)

Age range	Females	Males	All
75 to 79	303	260	563
80 to 84	446	312	758
85 to 89	395	233	628
90+	474	172	646
Total >75	1,618 (62.4%)	977 (37.6%)	2,595 (100%)

The number of long-term conditions registered for patients at very high risk and high risk is shown in Table 5. This includes patients of all ages; patients may have more than one long-term condition; and the long-term condition may not be the reason they are at very high risk but is likely to contribute to their risk score. Table 5 shows that patients with high and very high risk of unplanned hospital admission are most likely to have hypertension, cardiovascular disease, depression, chronic kidney disease and a range of respiratory conditions including COPD and asthma.

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Table 5 Number (%) of patients of all ages at high risk and very high risk of admission to hospital by long-term conditions

Long-term condition		Very high risk (%)	High risk (%)
Hypertension	506	(18.6)	2,402 (21.7)
Cardiovascular disease	480	(17.7)	1,745 (15.8)
Depression	385	(14.2)	1,511 (13.7)
Chronic Kidney Disease	258	(9.5)	1,151 (10.4)
Asthma	253	(9.3)	1,041 (9.4)
COPD	216	(8.0)	757 (6.8)
Diabetes	196	(7.2)	834 (7.5)
Thyroid	118	(4.3)	491 (4.4)
Cancer	95	(3.5)	460 (4.2)
Dementia	90	(3.3)	241 (2.2)
Mental Health	57	(2.1)	207 (1.9)
Epilepsy	54	(2.0)	183 (1.7)
Learning Disabilities	8	(0.3)	40 (0.4)
Total of all long-term conditions	2,716		11,063

The annual number and cost of emergency admissions to hospital for patients by risk group is shown in Table 6. The average cost per patient in the very high risk group was £1,133, which was almost 2.5 times more than the cost of those in the high risk group.

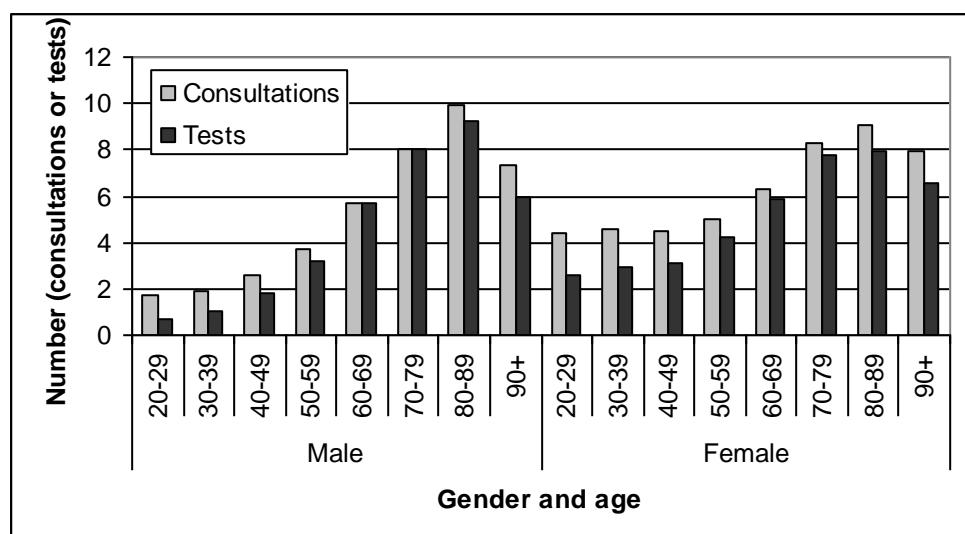
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Table 6 Annual number and cost of emergency admissions to hospital for patients (all ages) by risk group (1 April 2011- 31 March 2012)

Risk of hospital admission	Number Patients	Number of Hospital Events	of Cost (£Millions)	Average Cost per Patient (£)
Very High Risk	937	665	1.1	1,134
High Risk	4,750	1,364	2.2	470
Moderate Risk	33,952	3,867	6.5	191
Low Risk	168,398	5,448	7.8	46
Total:	208,037	11,344	17.6	84

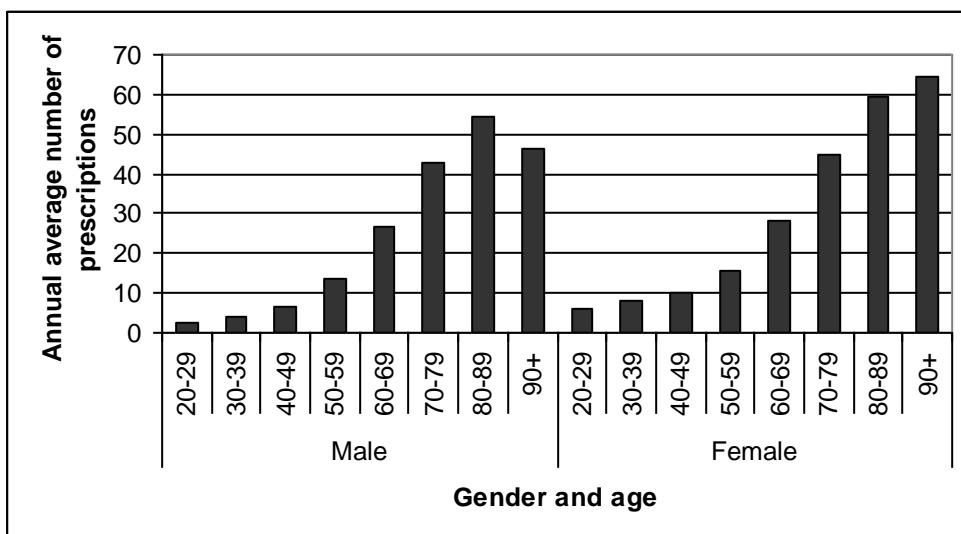
From national data we know that the number of annual consultations in primary care, test and number of prescriptions increases with age. Analysis of primary care data from 86,100 individuals in 174 English practices was undertaken by the University of York (see Graphs 1 and 2). At most ages women have higher rates of resource use but resource use increased more rapidly with age for men and was higher for men aged 80-89.

Graph 1 Average number of primary care consultations and tests per individual in 2007/8 from national research



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Graph 2 Average number of prescriptions per individual in 2007/8 from national research



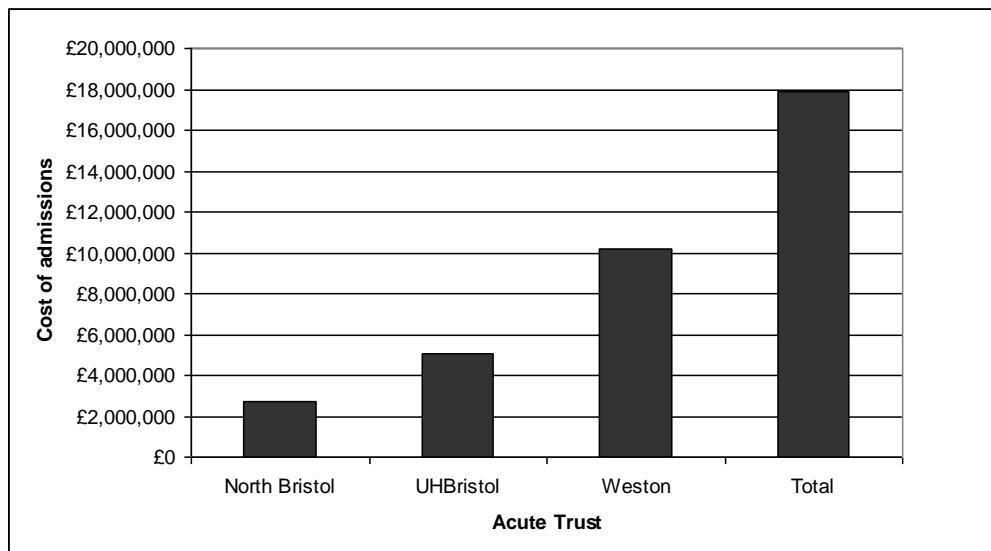
Hospital activity and cost data for patients aged 75 and over in North Somerset in 2011/12 for treatment at Weston Area Health NHS Trust, University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust shows that the majority of emergency admissions are to Weston Area Health Trust. In North Somerset the total cost of hospital care for people aged 75 and over was £31.6 Million in 2011/12, of which 57% was spent on emergency admissions (see Graph 3 and Table 7). There has been an increase over the last ten years in the number of elective and emergency admissions for patients aged 75 and over (see Graph 4). During the last ten years there have been many changes in the acute services provided locally and national initiatives (e.g. closure of A&E at Southmead, opening of Independent Treatment Centres, 18 weeks from referral to treatment) which may have impacted on the changes over time.

Table 7 Annual hospital activity and cost for patients in North Somerset aged 75 and over (2011/12)

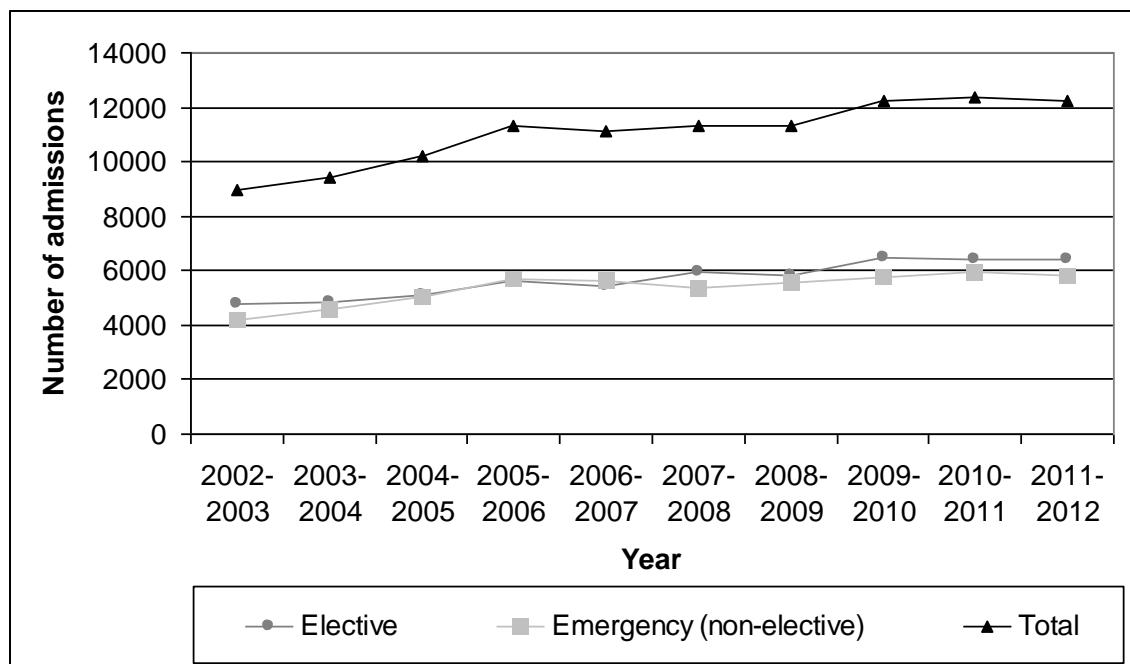
	Activity	Cost
Elective	6,312	£8.1M
Emergency	5,761	£18M
Outpatients	43,860	£5.5M

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Graph 3 Total cost of emergency admissions for over 75 year olds in North Somerset by Acute Trust (2011/12)



Graph 4 Trend in annual number of elective and emergency admissions in North Somerset (2002/3 to 2011/12)



The average length of stay in hospital increases directly with age: nationally it is 8 days for patients aged 65–74 years²; 10 days for patients aged 75–84 years;

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and 12 days for patients aged 85 years or older. More than a quarter of patients older than 85 years admitted as emergencies stay for more than two weeks, and about 10 per cent stay for more than a month.

Falls in frail older people

The North Somerset Community Partnership falls service received 1518 referrals for patients who have fallen in 2011/13. Of these the majority (72.5%) were for patients aged over 80 (see Table 8).

Table 8 Number of referrals to the Falls Service in 2011/12 by Age

Age	Number of referrals	Percentage
Under 60	64	4.2%
60-69	104	6.8%
70-79	250	16.5%
80+	1100	72.5%

Social care services

Social Services collect data about the annual number of referrals, assessments and packages of care. The packages of care data provide information about social care provided: community based services (home care, day care, meals on wheels, short breaks, professional support, direct payments, equipment or other); residential care; nursing care. The data presented here is for 2011/12.

During 2011/12, 2600 referrals were received for social care for individuals aged 65 and above, with 45% being for those aged 85 and over (Table 9). 1,812 assessments were made and 2,294 services were provided. There will be many more individuals who have a need for care who pay for private provision of care or receive informal care.

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Table 9 Number of Social Care referrals, assessment and services provided in 2011/12 in North Somerset by age

Age	Referrals	Assessments	Services provided¹
65 to 74	465	340	405
75 to 84	958	670	745
85 plus	1177	802	1144
Total	2600	1812	2294

¹ More than one service may be provided per person

Of the 2,294 social services provided in 2011/12 to people aged 65 and over, almost half of the services (997) were provided in six wards (see Table 10).

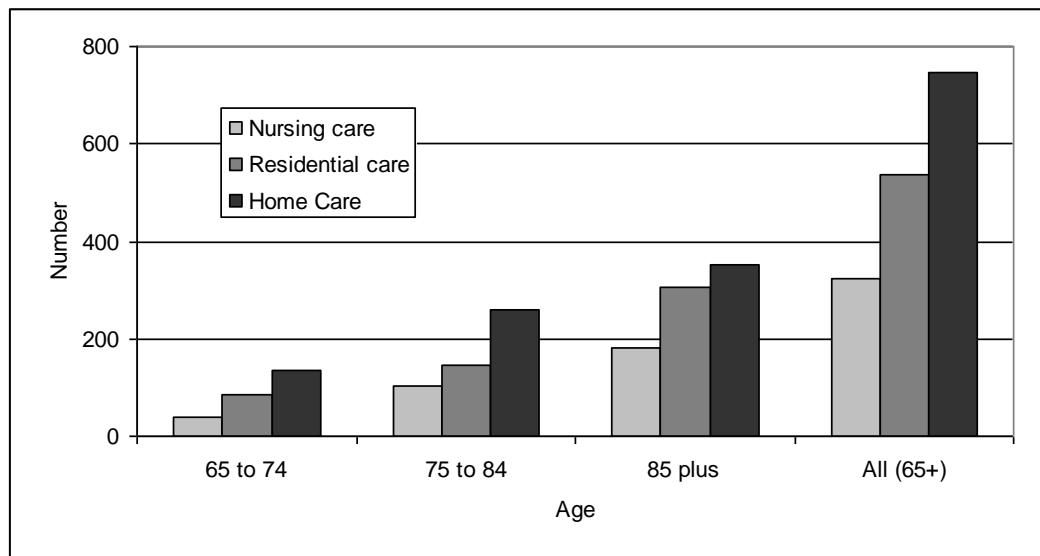
Table 10 Provision of Social Care in six wards

Ward	Number of services provided
Weston-super-Mare West	283
Weston-super-Mare Clarence and Uphill	243
Weston-super-Mare Central	158
Portishead East	106
Banwell and Winscombe	105
Clevedon Walton	102

The provision of nursing, residential and home care increases with age (see Graph 5). The number receiving residential care at ages 85+ doubled compared to 75-84, yet there are half as many residents aged 85+. In recent years the ratio of residential care to nursing care has changed with an increase in residential care and decrease in nursing care. This change is in part due to work by staff to ensure that individuals are in the correct type of care home for their needs and work with health colleagues to provide some care in residential care.

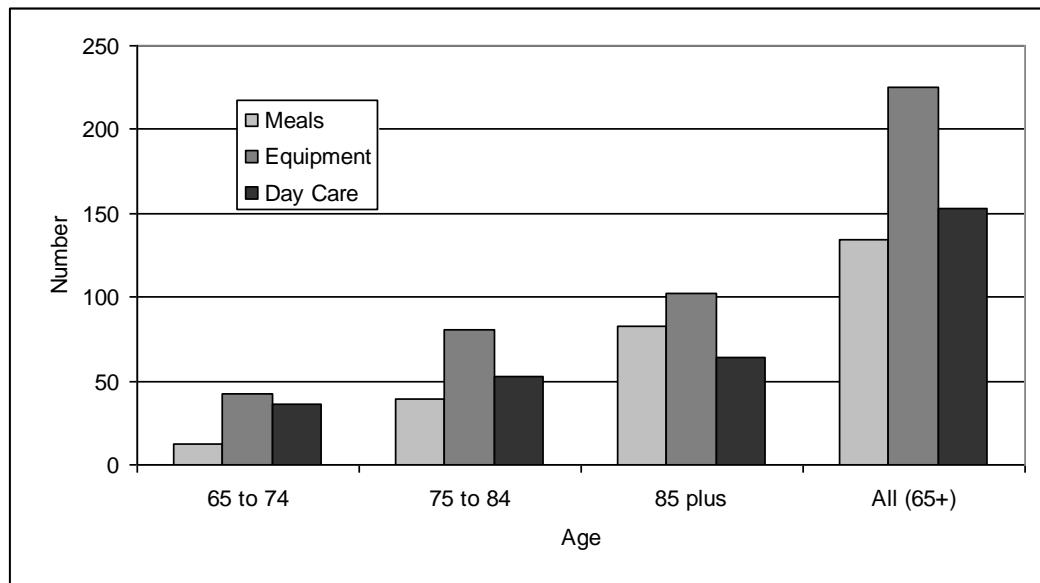
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Graph 5 Nursing, Residential and Home Care by age and Year (2011-12)



The provision of meals, equipment and day care all increase with age (Graph 6). Between 2010/11 and 2011/12 there was an increase in the provision of equipment through the introduction of Telecare.

Graph 6



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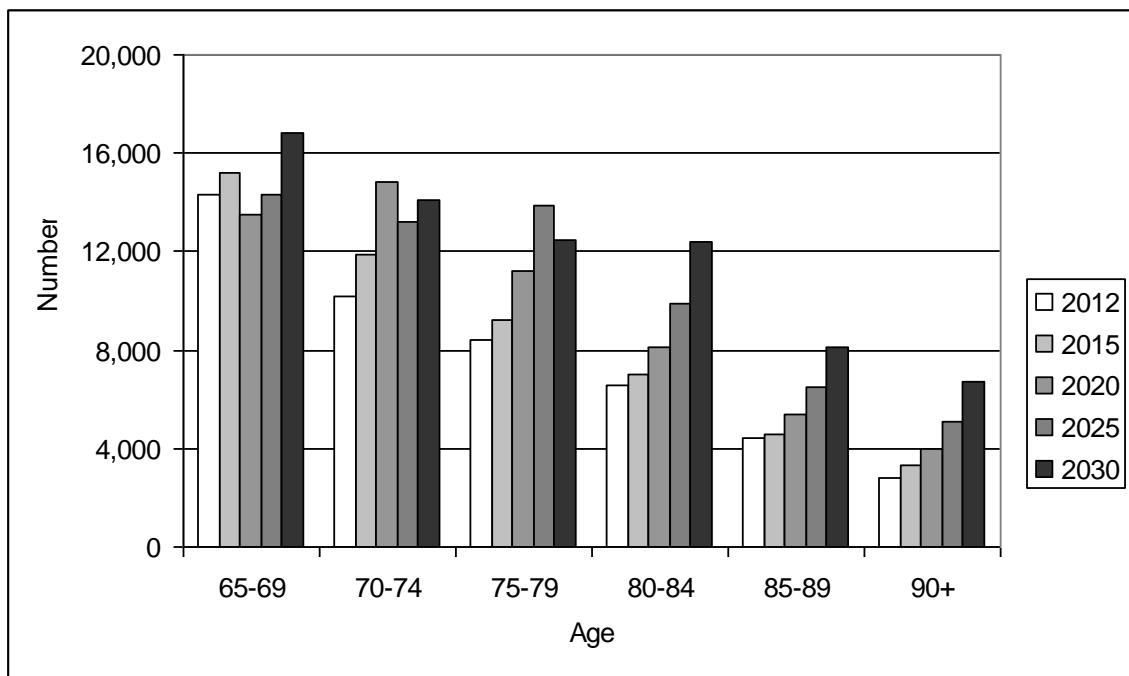
Projections of future social and health care use

The Projecting Older People Population Information (POPPI) system provides the projections for North Somerset using Office for National Statistics data for the years 2012, 2015, 2020, 2025 and 2030. The population aged 75 and over is predicted to increase from 22,000 in 2012 to 37,000 in 2030; an increase of 68% (see Graph 6).

There are 2,966 people living in care homes aged 75 and over, and this is expected to increase to 5,564 in 2030; an increase of 88%. Graph 8 shows that there are currently 11,119 people aged 75 and over living alone in North Somerset and this is predicted to rise to 19,411 by 2030; an increase of 75%. There are currently 5081 people aged 75 and over who are living alone and have a limiting long term illness and this is predicted to increase to 9,324 by 2030; an increase of 84%.

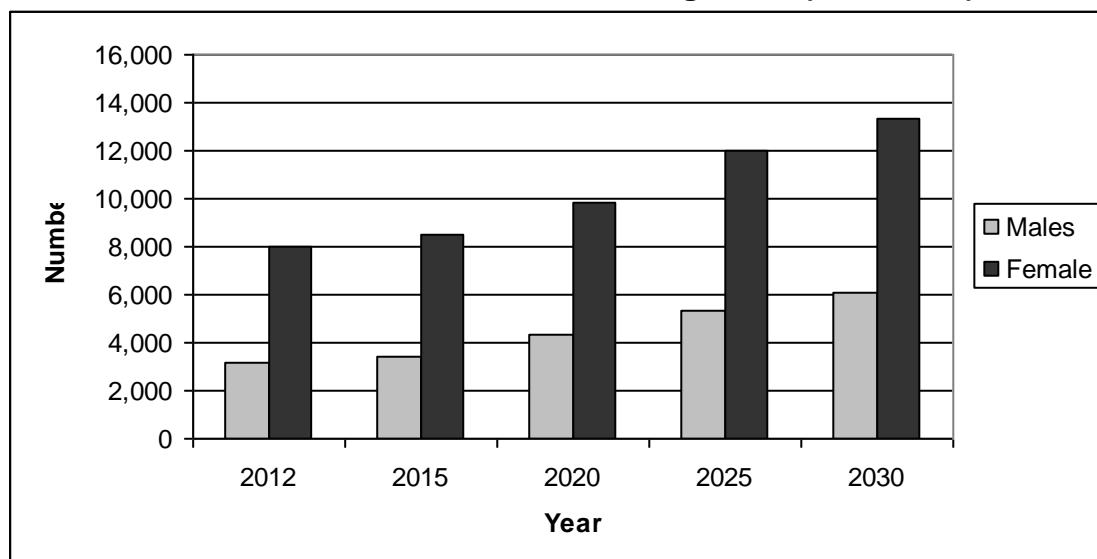
There are currently approximately 817 people aged 75 and over admitted to hospital as a result of a fall. This is predicted to increase to 1,461 in 2030; an increase of 83%.

Graph 7 Projecting Older People Population Information: number of people aged 65 and over in North Somerset by age group (2012-2030)



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Graph 8 Projecting Older People Population Information: people aged 75 and over in North Somerset living alone (2012-2030)



Additional information on projections for people aged 65 and over is available from POPPI on:

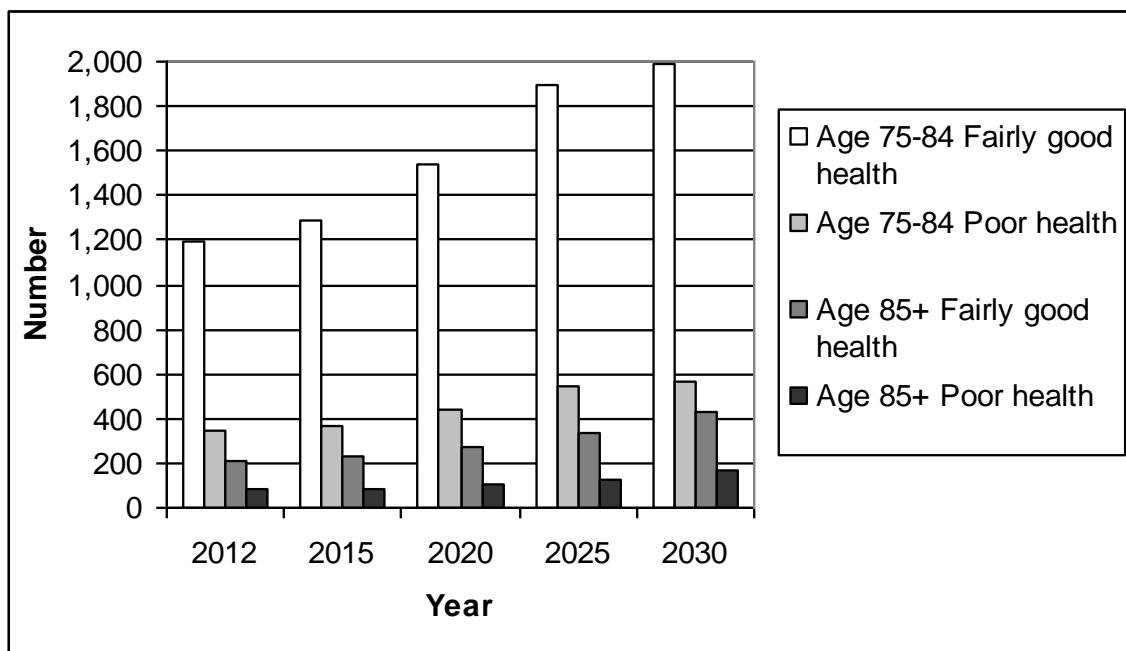
- Support arrangements: provision of unpaid care, domestic tasks and self care
- Health: disease groups e.g. limiting long term illness, depression, dementia, heart attack, stroke, bronchitis/emphysema, falls, falls with hospital admission, continence, visual impairment, hearing impairment, mobility, obesity, diabetes
- Multiple characteristics: tenure/illness; ethnicity/illness; general health/unpaid care; unpaid care/age/hours; illness; living alone.

Carers

The Projecting Older People Population Information (POPPI) system projects that the number of older people in North Somerset providing unpaid care by age and health status (see Graph 9). The term "unpaid care" covers any unpaid help, looking after or supporting family members, friends, neighbours or others because of long-term physical or mental ill-health or disability or problems related to old age. In 2012 it was estimated that there were 424 people aged 75 and over in poor health who were providing unpaid care in North Somerset and 1408 people providing unpaid care who are in fairly good health.

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Graph 9 People aged 65 and over by general health and provision of unpaid care and age, projected to 2030



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Current service provision

A large range of prevention, information, health and social care services are provided to frail older people in North Somerset. Descriptions of the important components of the pathway are shown in Table 11. Table 12 outlines the services provided to this group.

Table 11 Components of Frail Older People Pathway in North Somerset

Information for Older people	<ul style="list-style-type: none"> • Well Aware (BNSSG) • Alzheimer's Society (Dementia) • Age UK • Carers Support Centre • Community Connect • Care Connect/SPA • Community Development Workers • Care Navigators • GP's • Health Care Staff • Social Care Staff • Somerset Racial Equality Council • North Somerset Council • Citizen's Advice Bureau • Vision North Somerset
Prevention	<ul style="list-style-type: none"> • Stroke Cafes • Home from Hospital Partnership • Enablement • Community Falls Service and clinics • Community Development Workers • Care Navigators • Pulmonary Rehabilitation Programme • Home Oxygen Service • Self-care
Admission avoidance	<ul style="list-style-type: none"> • Community Teams including Community Wards and Community Rapid Response • Social Care assessment and services • GWAS referrals • Safe Haven Beds with Nursing Homes and Community Hospital • Social Care-Home Care packages • Carers overnight sitting service.

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	<ul style="list-style-type: none"> • GP beds at Clevedon Community Hospital • Respiratory Hot clinics –WHAT/NBT/UBHT • Community IV Service • Out of Hours Nursing Service • Out of Hours GP service • GP in Urgent Care • Hospital from Home • Home Oxygen Service • Minor Injuring Unit at Clevedon Hospital • Heart Failure Service • IV Service
Identification and Case Finding	<ul style="list-style-type: none"> • Community Teams • Local Authority and 3rd Sector Community Connect • Risk stratification • 40-70- Vascular health check. Over 70s health check • LTC health checks (supported by Dementia, Diabetes, LD, COPD, CHD and Carer registers) • GP support • Community In Reach Service • Primary Care Liason Service
Comprehensive geriatric Assessment/Assessment	<ul style="list-style-type: none"> • Comprehensive Geriatric Assessment is not provided comprehensively at local acute Trusts • Community Teams Assessment including Falls and Nutrition • Adult social care assessment • Carers assessment reablement • Falls assessment and clinics • Memory nurses • Multidisciplinary team assessment for Community Ward patients.
Trajectory(care) Planning EOL Advanced Planning	<ul style="list-style-type: none"> • EOL service and advance care plans • Personalisation • Personal budgets • Care planning • Continuing Health Care planning (PCT) • Care planning of all patients with a long term condition
Care Co-ordination/Transitions of care	<ul style="list-style-type: none"> • Active case management by Community Ward • Case management by social care teams • Mental Health Primary Care Liaison Workers • Carers Link Workers

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Sharing information about individual older people	<ul style="list-style-type: none"> Information sharing between primary care and other health and social care providers Information sharing between North Somerset Community Partnership and North Somerset Council teams and primary care Information sharing between North Somerset Community Partnership and Avon Wiltshire Partnership teams. Information sharing between voluntary sector and North Somerset Council and North Somerset Community Partnership. Information sharing between North Somerset Council and Avon Wiltshire Partnership.
In Patient Care	<ul style="list-style-type: none"> Community In-reach Team AWP psychiatric liaison Clevedon Community Hospital Weston Area Hospital NHS Trust North Bristol NHS Trust University Hospitals Bristol NHS Foundation Trust
Discharge	<ul style="list-style-type: none"> Reablement Hospital from home Assess and Hospital support team. Community Teams Community In Reach Team Reablement through START Social care assessment and services

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Support at Home	<ul style="list-style-type: none"> • Community Teams • Specialist Community Services for example Tissue Viability Service • Personal budgets provided by North Somerset Council • Social care packages commissioned through North Somerset Council • Home care commissioned by North Somerset Council on behalf of NHS North Somerset • Meals on wheels • Carers' groups • Macmillan nurses • Marie Curie services • Stroke cafes • Community equipment • Out of hours nursing Service • Wheelchair service • Continuing Health Care Home • GPs • Practice Nurses • Voluntary Sector Groups • North Somerset Council Services
End of Life	<ul style="list-style-type: none"> • Fast track pathway • Integrated Health and Social Care EOL Pathway • Marie Curie Care Coordination scheme • Advanced Care Plans • Community Nursing Teams • Weston Hospice Care • St Peters Hospice Care • Out of Hours Nursing Service • Community night sitting service

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Table 12 Services provided for frail older people in North Somerset

Intermediate Care	<ul style="list-style-type: none"> • Planning integrated health system with LA, acute trust and community provider • Enablement programme • Reablement through START and independent home care providers
Carers	<ul style="list-style-type: none"> • Personal budgets <p>The contract for carers services in North Somerset is currently being tendered.</p> <p>The following services are currently provided by Crossroads;</p> <ul style="list-style-type: none"> • Carers assessments, including access to a break away from the caring role • Carers support groups • Provision of information and advice • Providing the voice of carers in North Somerset, providing views and feedback • Emergency cover for carers
Nursing and Care Homes	<ul style="list-style-type: none"> • Nursing Homes • Residential Homes • North Somerset Council Brokerage Team • Safehaven Beds • Nursing Home LES
Community Beds	<ul style="list-style-type: none"> • 7 Safe Haven Beds in nursing homes • 2 Safe Haven beds in Clevedon Community Hospital • 3 GP led beds at Clevedon Community Hospital • Enablement Contract within Nursing Homes • CHC placements
Medicines Management	<ul style="list-style-type: none"> • Work with care homes and nursing homes on pain control, anti-psychotics and general medicines governance
Telehealth and Telecare	<ul style="list-style-type: none"> • A variety of schemes are provided • Local Authority telecare service • Licensed Assessors from within the Home Care Sector • Home telehealth monitoring: pilot led by NSom CIC, with O2 (from June 2012) • Telehealth being explored
Patient experience and public Involvement	<ul style="list-style-type: none"> • Full PPI work plan • Joint Early Intervention and Prevention Strategy • Community Patches development workers • The Care Forum • LINk/ HealthWatch • Joint Carers Commissioning Strategy

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	<ul style="list-style-type: none"> • Older People's Planning Group • Carers Advisory Network • Primary Care PPI team • Condition specific support groups/networks: e.g. British Lung Foundation Breathe Easy
Long Term Conditions	<ul style="list-style-type: none"> • Community based heart failure service • Secondary care respiratory hot clinics. • Pulmonary rehabilitation programme • Disabled Adults Resource and Rehabilitation Team • Multiple Sclerosis specialist nurse • Community Teams • Personal budgets and social care packages
Falls	<ul style="list-style-type: none"> • Fall service and clinics within Community Teams • Rapid response
Dementia	<ul style="list-style-type: none"> • AWP North Somerset Memory Assessment Service • Alzheimer's Society Services – Dementia Support Worker service, Memory Cafes', Singing For The Brain, Carers training Programme (CrISP), Telephone Keep in Touch Service, Volunteer Befriending, Carers Support Groups, a number of self-sustaining peer support groups and the Forget Me Not service – bookable slots in GP practices for people to discuss memory concerns • Memory Matters – open information sessions for people with dementia, their family and & carers provided through a partnership of AWP, Alzheimer's Society and Rethink Mental Illness. • Brunelcare – Memory Café, coffee mornings, lunch clubs • Rethink Mental Illness Floating Support Service
New ways of working	<ul style="list-style-type: none"> • Development of Phase: 2 of an evaluation study with regards to an Integrated Care Organisation across Health- Acute and Community and Social Care
Other	<ul style="list-style-type: none"> • Partnership with local GPs • Extensive joint working with Local Authority • Extensive joint working with voluntary sector • Significant (multi £m) investment in recent years • Effective working relationships with all stakeholders

Care Management for Frail Older People

Care management's primary function is to assess people's social care needs and ensure, where a person is eligible that the appropriate services are provided.

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Local authority care managers and care co-ordinators work in teams with occupational therapists and work closely with colleagues from the NHS. Within North Somerset care managers are usually social workers. Care managers and care co-ordinators, working from the perspective of promoting choice and control and a personalised approach, carry out a range of tasks such as:-

- Providing information and advice, or signposting people on to appropriate organisations to provide specific advice.
- Arranging support plans and personal budgets, including direct payments.
- Arranging for assistive technology
- Putting in place services to support carers
- Supporting the person to use their personal budget for support and assistance at home
- Arranging care home placements when the person can no longer be supported at home.

Care co-ordinators are officers who have knowledge and experience in assessing and arranging all of the services above where needs are more straightforward and less complex. Care Managers have the necessary skills and knowledge to recognise and appropriately respond to frail older people who suffer with levels of confusion or lack mental capacity to make key decisions about their lives. Care managers and social workers also have a key role to play where there are safeguarding concerns for older people – see separate section on Safeguarding.

Discharge services to support frail older people

Adult social care is committed to facilitating safe discharge from both acute and community hospitals. The service works with patients with lower level needs to ensure they receive appropriate services by signposting them to support services (Home from Hospital). For those patients who prefer to organise their own care, we refer to and provide the services of Care Navigators. Care Navigators are able to explain services that are available in the community and assist with negotiating with service providers. Patients who have more complex care needs are assessed by adult social care for reablement or enablement. These are services that provide active care in the persons own home or in a care home, respectively. The aim of the service is to promote recovery and reskill people to become confident and independent in carrying out activities of daily living. The Care assistants with professional input from occupational therapists and physiotherapists work with people for up to 6 weeks to become as independent as possible following a stay in hospital. Once reablement/enablement is complete the team will then work with the person and their carers/family to put in place any

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ongoing services needed such as personal budgets, home care and on occasion are care home placement.

Council occupational therapy services for frail older people

Occupational therapy aims to promote and restore independence, health and well-being to frail older people. They achieve this by working in partnership with frail older people and, where relevant their carers to ensure the person can remain living in their own home by maximising their abilities to carry out day-to-day activities such as self care and domestic tasks. Occupational Therapists form part of the multi-disciplinary approach, working with social work, care co-ordinators and NHS colleagues to build on people's abilities to manage everyday tasks. Occupational therapists can:-

- Advise on new techniques to manage activities such as, safely getting in and out of a chair or on and off the toilet
- Prescribe methods for professional and informal carers carrying out moving and handling techniques such as assisting someone in and out of bed.
- Arrange the loan of equipment to help with day-to-day living
- Prescribe Assistive Technology such as 'Telecare' equipment to reduce the day to day risks and hazards that frail older person's encounter e.g. falls, injury, isolation.
- Prescribe adaptations e.g. level access shower or a stair-lift to enable the person to continue living in their home
- Prescription of minor adaptations to an individual's home, such as, the installation of grab and stair rails
- Advise on eligibility for a Disabled Facilities Grant, for major adaptations, and making recommendations to the Housing Renewal Team where appropriate.

In North Somerset 60% of Service Users of Occupational Therapy Services are over the age of 75. (Figures from July 2012).

Safeguarding

50% (163) of the safeguarding referrals for the year 2011/12 were for people aged 75 and over. When anyone contacts North Somerset Council with a concern in relation to a vulnerable adult this is followed up in accordance with the North Somerset No Secrets Policy (2008). Safeguarding work places an emphasis on working in partnership with other agencies; this includes key health agencies and the police. There is ongoing work to raise awareness of safeguarding and steps are taken to prevent abuse from occurring. Examples of

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this include links with groups within the local community who have a focus on supporting elderly people.

Advice

Age UK Somerset with the support of volunteers run 'Big Advice Days' where a wealth of information is available and advice given to ensure people access the help that is available. In addition, their community development workers and community agents work with older people in their community to reduce social isolation, provide older people with a voice to comment on current services and new developments and create sustainable social opportunities, including learning new skills. The advocacy service is delivered by trained volunteers who encourage and help people access the benefits available to them. A volunteer befriending scheme has been set up for isolated older people.

Health Community Teams

A Community Team is a group of community based multi disciplinary health professionals some of whom have extended clinical assessment, examination and prescribing skills. The team provides both planned and unplanned care services to the patients on the caseload, of which planned care forms the largest part. Support is provided to patients when receiving routine treatment or during an acute phase of an existing long term condition or of a new condition such as a fall. The multi disciplinary team provides patients on the community ward with individual case management, with a key worker to ensure a co-ordinated care approach is achieved. The focus of the team is to avoid hospital admissions and facilitate early discharge for appropriate patients.

The Community Teams manage cohorts of patients classified into 4 distinct groups:

- 1) Patients who have a high acuity and dependency and need admittance to the Community Wards.
- 2) Patients who have a high acuity and dependency and need a short term intervention from Community Rapid Response
- 3) Step Down (Medium acuity and dependency) – the patients in this group will already be on the team caseload, either within planned care or the community ward and will require a length of stay longer than 14 days.
- 4) Planned and Routine Community Care (Low acuity and dependency) – this patient group will make up the majority of the Community Team caseload.

The Community Teams have been set up around a cluster of GP practices, and each team works with approximately of 30,000 GP residents' population. Within the Community teams the role of the ward will include extended operational

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hours from 7.00 – 22.00, regular (at least weekly) multidisciplinary board round as would be seen on a hospital ward and capacity for up to 3 visits per day to a patient. Caring for patients in their usual place of residence, which includes the patient's own home as well as both nursing and residential homes is a key factor for both patients and carers.

Community Rapid Response will provide support to all the Community Teams by offering a flexible workforce to provide additional capacity and skills when required. In addition this support service will be responsible for the additional functionalities within the team:

- 1) The Intravenous (IV) service – Community Rapid Response will manage and ensure business continuity for the IV service.
- 2) Support and business continuity for the Out of Hours Nursing
- 3) Central point of contact for the Great Western Ambulance Service NHS Trust referrals (subject to the induction of 111 and any other in year developments).
- 4) Fallers' response service, having the capacity and flexibility to respond within 1 hour to any faller that is referred to the team.
- 5) Carers Response Service – this is a service that is referred from Care Link if a carer is admitted to hospital.
- 6) Safehaven bed coordination – the expectation is that Community Rapid Response will provide a single gateway to access to the 7 Community Beds (2 x Clevedon Court, 1 x Cleeve Court, 4 x Albert House with the possibility of an additional 2 beds in Clevedon Community Hospital). The team will provide daily bed status updates to the Community Teams and Commissioning Teams including patient length of stay and reason for admission.

Each multi disciplinary community team is staffed to reflect the needs of the population including clinical lead, team coordinator, Occupational Therapists, Physiotherapists, Community Nurses, Assistant Practitioners, Generic Support Workers and Team Clerks.

Expected Outcomes including improving prevention

- Patients being able to remain in their homes and communities and maximise independence.
- Reduction in unplanned admissions and attendances to hospital
- Reduced length of stay of hospital admissions.
- Improved health and wellbeing for the local population.
- Improved End of Life Care in partnership with the end of life care service
- To reduce Length of Stay in hospital for patients.

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Public Health

The following public health services are provided to frail older people:

As part of the national seasonal flu vaccination programme GP practices in North Somerset offer all patients over 65 years old a flu and pneumococcal vaccination between the flu season (usually October to January). The flu vaccination of staff working in care homes is also promoted to help protect vulnerable older people living in these care homes.

Patients invited for their annual flu jab are also informed of the help available to warm their homes and reduce fuel bills. Up until the end of March 2013 the Governments' Warm Front insulation and heating programme will provide grants for those in receipt of certain benefits. Free loft and cavity wall insulation schemes will be replaced by a new Government initiative to access loans for heating and insulation through the Green Deal.

Malnutrition usually refers to under nutrition (a shortage of calories), with this comes a lack of essential protein, vitamins and minerals which has adverse effects on the body and its functions. Malnutrition has wide-ranging repercussions including poor quality of life in later years; impaired immunity which can lead to infection, pressure sores and poor wound healing; slower recovery from surgery or injury; poor respiratory muscle function and cough leading to an increase in chest infections; low mood and self neglect; reduced mobilisation and falls because of poor bone health; and difficulty keeping warm. A partnership work programme to raise awareness of and prevent malnutrition and dehydration in older people (particularly in residential and nursing homes) is being developed locally. This includes work to:

- Revise residential and domiciliary care provider contracts to include malnutrition awareness and prevention
- Extend current training provision for these providers to include malnutrition awareness and prevention
- Investigate the need for healthy cooking training for catering staff in residential homes and develop a solution if necessary
- Audit and promote proper use of oral nutritional supplements in primary care.

North Somerset Care & Repair provide a home safety check through their Handyman Service and can remedy simple home defects or hazards.

Health Trainers offer support on a wide range of health issues including smoking.

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Age UK Somerset deliver an Ageing Well exercise programme open to all over 50 but targeted at frail older people. This community based exercise programme ranges from seated exercise in care settings to tai chi and exercise to music in community halls. The Community Falls service works with frail elderly at high risk of a fall. In addition, falls 'clinics' are run regularly at surgeries and care settings for anyone who is concerned about falling.

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What do people think?

In preparing this section it has not been possible to make direct contact with, or find engagement / consultation undertaken directly with, frail older people as defined in this chapter. Due to their circumstances many frail older people either live in residential care or at home and in both cases do not find it easy to participate in traditional consultation or engagement exercises. In consultation and engagement terms frail older people would be traditionally regarded as a "hard-to-reach" group whose actual voice or views are seldom heard either in general or even older people specific engagement or consultation exercises.

The council and the CCG when it comes in to operation from April 2013 have made it very clear they wish to move towards a "co-production" model of service design and delivery. This will involve service users and carers taking part at a much earlier stage as "equals" in service design. It will be important therefore to address in particular all "hard-to-reach" groups including frail older people to ensure their voice and views are heard and responded to.

The content of this chapter therefore is reliant on information gained from those directly working with frail older people, and research. In terms of research a article "A Better Life - What Older People with High Support Needs Want and Value" by Jeanne Katz, Caroline Holland and Sheila Peace Faculty of Health & Social Care Published November 2011 highlighted the following-

Why do we know so little?

- * People with different priorities; an invisible grouping
- * Communication: dementia, dual sensory problems
- * Focus on health and social care needs, not quality of life
- * Diversity of communication issues — language and cultural barriers not adequately addressed
- * Older people with high support needs often isolated and not enabled to engage collectively

What is valued by this group?

- * Social: Relationships: maintaining and making new friendships; interacting in different ways, especially mental stimulation to maintain cultural activities; opportunities to contribute through diverse roles

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- * Psychological: Self-determination, deciding which decisions to make themselves and which to devolve; desire for continuity or support to adjust to change
- * Physical: Living in a safe, secure environment, even if this means compromise.
- * Getting out and about; contact with nature and the outdoors

What helps or hinders

The following helps frail older people:

- * Continuity of Care and Support: Friendly carers who provide appropriate and respectful support; clear communication.
- * Dedicated Time: Clearly defined quantity and quality time so that biography acknowledged and needs met.

The following hinders frail older people:

- * Inadequate information about available services or financial support.
- * Urgent needs not addressed such as equipment which could transform their lives: mobility, visual or hearing aids, or access to internet or loops.

In terms of locally, Age UK Somerset, who support the Senior Community Link engagement mechanism with older people, identified: isolation; accessible and affordable transport; confidence; and finances as the major issues frail older people are concerned about. In terms of Adult Social Services and Housing feedback forms overall older people are satisfied with social care services provided. 95.6% of older people (aged 75 plus) answered that they were very satisfied or quite satisfied with their experience of social care, compared with 94.7% of younger adults. Generally older people are pleased with the help and support of staff and the eventual service provision. They state that services are good and occasionally comment that the service has helped to improve their quality of life. Generally people are satisfied with the information provided, but a minority comment that they are concerned that their involvement with their key worker is to cease and occasionally seem unaware that they can contact via Care Connect should their needs change. This may suggest a wider opinion. A few people commented that their homes were unsuitable for adaptations, or that adaptations could not be carried out as originally planned.

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Vision North Somerset work with people with a visual impairment. Figures from the Royal National Institute Of Blind People 1 in 12 people over the age of 60 will experience significant sight loss. This increases to 1 in 6 for people over 85. The effect of sight loss has a considerable impact for frail older people particularly when linked with conditions such as heart problems, dementia, hearing loss and other issues which are prevalent amongst older people. Vision North Somerset records indicate that 1,264 of their service users are aged 75 and 326 of these are aged 85 or older. Of the 1,264 service users 507 have significant health issues including diabetes, arthritis, heart conditions, dementias, 36 consider themselves to have mental health issues, anxiety or depression. In addition 261 people have severe hearing loss and a further 179 have a moderate hearing loss.

Vision North Somerset staff have observed the following issues raised by frail older people:

- * Fear of being forced to go into residential care
- * A wish to remain independent
- * To be specifically treated for their condition or illness rather than just being told it's a symptom of old age
- * They appreciate the initial assessment and being given information or signposting to enable them to maintain choice and control
- * They particularly appreciate referrals being made to other agencies such as OT's, housing etc. on their behalf
- * Practical assistance in terms of aids and equipment
- * Opportunities to choose whether to participate in social activities - this can relieve depression and improve wellbeing
- * Some want to be left alone, some want to be looked after

In terms of the services that Vision North Somerset provide, the following are of particular importance to frail older people.

- * Initial assessment to provide information, options, signposting and referral to other agencies
- * Risk management advice - lighting, marking up cookers, daily living skills etc., all designed to maintain independence, avoid trips and falls etc.

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- * Low vision is the single greatest input for this group (magnifiers, CCTV's etc.)
- * Help to access benefits such as Attendance Allowance
- * Social opportunities
- * Being able to take medication safely

What works

Guidance from the National Institute of Health and Clinical Excellence

The National Institute of Health and Clinical Excellence (NICE) has produced guidance and quality standards which are relevant to the care of frail older people including: instability (guidance on falls)³; immobility (rehabilitation and post-acute care)⁴; incontinence⁵; dementia⁶ and confusion (delirium)⁷. In addition, there is a national strategy for end of life care.⁸

- The major risk factors for falling are diverse, and many of them can be changed: balance impairment, muscle weakness, excessive or suboptimal medication use and environmental hazards. The National Institute of Health and Clinical Excellence clinical guideline of good practice to assess and prevent falls.³

The National Institute of Health and Clinical Excellence are preparing guidance on:

- Delaying the onset of disability, frailty and dementia in later life
- Falls in older people (update)
- Older people with multiple morbidities: discharge planning and post discharge care

These will inform future preventative work when they are published in 2013/14.

Literature review

A comprehensive literature review of evidence-based best practices to manage frail older people was undertaken by GPs in Clevedon on 2011. The conclusions from the review were:

- There is robust evidence to recommend Comprehensive Geriatric assessment (CGA) in hospital as it reduces institutional admission, the risk of falls and improves physical function but effects are generally small. Comprehensive geriatric assessment is defined as a "multidimensional interdisciplinary diagnostic process focused on determining a frail elderly

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person's medical, psychological and functional capability in order to develop a coordinated and integrated plan for treatment and long term follow up"

- Vitamin D supplementation reduces falls in elderly women but not fall related fractures.
- Withdrawal of psychotropic medication reduced falls in the short term.
- Telecare may provide cost savings in terms of reduced hospital admission, home check visits and sleepover nights.
- Vision screening and nutritional screening appear to have little or no beneficial effect.

Challenges for Consideration

The JSNA chapter on older people⁹ includes a number of challenges which are relevant for the work with frail older people, which include:

- To enable independent living reducing reliance upon residential care through the joint reablement programme with social care and health partners including acute trusts and the development of early intervention and prevention approaches.
- To address the needs of the growing numbers of older people with dementia and continue to support people to self care and thereby manage their own long-term condition.
- To build-on the development of and improvements with the provision of information and advice to older people.
- To identify means of developing the range of housing, care and support options available to enable older people to live independently in the community
- To meet the aims of the local carers strategy that include ensuring that carers are identified as early as possible in order to provide them with information and advice, and to provide carers assessments.

Based on the assessment of data, evidence, current practice and community perspectives, challenges for frail older people in North Somerset are:

- Promoting strong communities to support people.
- Continued promotion and development of early intervention, prevention and self-care.

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- Encouraging and developing positive attitudes to personal budgets among older people and their carers.
- Providing information, advice and support to frail old people who are “self-funders” of their own care; taking account of the budget challenge faced by both NHS and local authorities and taking account of the high number of care home beds in the authority. There is the potential to encourage dependency and be over-reliant on social care and health services. There is also the challenge of the increased number of older people the high numbers of beds attract. There is a need therefore to increase and widen choice of provision including extra care services and domiciliary services.
- Admit to hospital only those frail older people who have evidence of underlying life threatening illness or need for surgery. They should be admitted, as an emergency, to an acute bed.
- Provide early access to an old age acute care specialist, ideally within the first 24 hours, who will undertake a Comprehensive Geriatric Assessment and provide a management plan.
- Designing discharge services so that patients, or their carers, will not be asked to make decisions about people's long-term care needs while they are still in an acute phase, as they will have access to enablement/reablement services.
- ‘Discharge to assess’ as soon as the acute episode is complete, in order to plan post acute care in the person’s own home.
- Provide comprehensive assessment and reablement during post-acute care to determine and reduce long-term care needs.

Preparing services for future challenges

Commissioners will be better informed about how services are used by frail older people and therefore better able to commission and integrate services if data is appropriately shared between different organisations allowing for data linkage. The early work across BNSSG on Connecting for Care supports this approach. This data linkage should take place at the individual level with a common identifier such as the NHS number. Such information could usefully include:

- Demographics: age, gender, postcode (for Ward & IMD score), GP practice, place of residence (home, residential/nursing home)

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- Primary care: Long-term conditions; number of prescriptions; high or very high risk of hospital admission assessed on risk stratification
- Unplanned Hospital Admissions: where admitted from; primary diagnosis for admission; primary procedure; length of stay; cost of admission; place of discharge.
- Social care: Reason for referral. Provision of packages of care.
- Community healthcare: admission to community ward; reason for admission.
- Avon Gloucester and Wiltshire Mental Health Partnership: dementia outpatients and home visits.
- GP Out of Hours: calls and home visits
- Ambulance: emergency ambulance transfers to hospital.

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