Welcome
Shaping Sefton
Session 2: Frail Elderly

Welcome

Cllr Ian Moncur
Chair, Sefton Health and Wellbeing Board
Setting the Scene

Fiona Clark
NHS Southport and Formby CCG
NHS South Sefton CCG
Chief Officer
Vision

To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and wellbeing of our population.
Strategic Priorities

• Caring for our older and vulnerable residents
• Unplanned care
• Primary care
Transformational Programmes

Primary Care
We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

Community Care
We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

Intermediate Care
Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.
Transformational Programmes

**Unplanned Care**
We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

**Mental Health**
Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long term neurological condition within community based networks of care.
Components of Care

1. Age well and stay well
2. Live well with one or more long-term conditions
3. Support for complex co-morbidities/frailty
4. Accessible, effective support in crisis
5. High-quality, person-centred acute care
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and reablement
8. Person-centred, dignified long-term care
9. Support, control and choice at end of life

Integrated Locality Teams
Self Care
Virtual Ward Care Closer to Home
Self Care
Intermediate Care
Integrated Locality Teams
Intermediate Care
Integrated Locality Teams
Virtual Ward
Specialised services
Unplanned care

Shift to prevention and pro-active care
10 integrated services to provide person-centred care
Getting End-to-End Services Right for Older People with Frailty and Complex Needs

Prof David Oliver
Senior Visiting Fellow, The King’s Fund
President of the British Geriatrics Society

Mrs Andrews

Mrs Andrews' Story – what went wrong? - YouTube
Making health and care systems fit for our ageing population

How we might need to change?

Prof David Oliver

Consultant Geriatrics & Acute General Medicine, Royal Berks Hospital
BGS President
King’s Fund Senior Visiting Fellow
ECIST Clinical Advisor

Shaping Sefton Frail Older People Event June 2015
<table>
<thead>
<tr>
<th>Independence</th>
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<tbody>
<tr>
<td>• I am recognised for what I can do rather than making assumptions about what I cannot</td>
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<td>• I am supported to be independent</td>
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<td>• I can do activities that are important to me</td>
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<tr>
<td>• Where appropriate, my family are recognised as being key to my independence and quality of life</td>
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<tr>
<th>Community interactions</th>
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<tr>
<td>• I can maintain social contact as much as I want</td>
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<th>Decision making</th>
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<tr>
<td>• I can make my own decisions, with advice and support from family, friends or professionals if I want it</td>
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<table>
<thead>
<tr>
<th>Decision making</th>
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<tr>
<td>• I can build relationships with people who support me</td>
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<td>• 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</td>
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<td>• Taken together, my care and support help me live the life I want to the best of my ability</td>
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*Figure 1 ‘I’ Statements for Older People*
A health and social care summary (including symptoms, underlying diagnoses, medications and current social situation)

A Wellbeing maintenance plan which includes:
• What the individual’s goals are
• What the actions are that are going to be taken
• Who is responsible for doing what (including the patient, their carers, their relatives, the doctor and other health professionals )
• What the timescale is and how and when review will happen

An escalation plan which describes:
• What a patient and or their carer might need to look out for
• Who to call or what to do if there is a problem

An urgent care plan – which summarises what the individual wants to happen if a crisis occurs in either their own health (i.e. do they want to go to hospital, under what circumstances would they want to stay at home, whether there is a DNACPR order in place) or in the health of their carer. This carer’s emergency plan can sometimes be facilitated in advance by the Princess Royal Trust for Carers (www.carers.org) who will visit the patient and their carers to discuss contingency plans.

For some patients it will also be appropriate to have in place;

An advance care plan or end of life care plan – which could describe the patient’s wishes with respect to their preferred place of dying and whether they have ‘just in case’ medications in place.

Figure 2 Common Elements of an Individualised Care and Support Plan
To Discuss
(you can all have all slides & my email/twitter)

I: The success story of population ageing
II: What this means for population health
   • Good and bad news
III: What this means for health services
   • “older people R Us”
IV: How our systems/services need to change

I might play an animated patient story
I’ll signpost key resources along the way

TheKing’sFund
Ideas that change health care
I: Population Ageing

A success story, not a catastrophe
A success for society, preventative and curative medicine

Source: ONS, 2011
From “rectangularisation” to “elongation” of survival curve.

Distribution of death England 1841 - 2006

1947 NHS Founded, 48% died before 65. In 2015 its c 14%
By 2030 men aged 65 will live on average to 88 and women to 91

By 2030 51% more over 65, 101% more over 85

Ageing, carers & care-workers

- Already around 6 million people in the UK are **carers for an older relative**
- By 2022, the supply of carers will be outstripped by demand
- *House of Lords “Ready for Ageing” report 2013*
- 1.4 M carers are over 65 often with own health issues
- <5% receive **statutory social care support**
- Demographic transition & dependency ratio has major implications for **workforce to support our older citizens** (e.g. currently in general practice & community nursing)
- And **retirement age** of health and social care staff
Social care/LA funding/provision crisis

- 28% cuts in support grants to LG (also affects voluntary/housing/transport)
- Social Care not ring-fenced
- *Cuts in Public Health Budget*
- Better Care Fund, not new money & big expectations!
- Of 10 M over 65s c 480k receive social services
- 380,000 in care homes
- Dilnot recommendations on LTC care funding?
- c 800,000 England with “substantial” needs unmet
- Further £4.3bn shortfall by 2020
Continuing healthcare assessment

- In Trusts / LHBs where continuing healthcare (CHC) assessments occur, 100% report that they take place on inpatient wards.
- 60% are able to deliver CHC assessments in a patient's own home, and 50% in intermediate care bed based units.
- CHC assessments are carried out by a separate team of CHC nurse assessors in 39% of Trusts / LHBs, integrated discharge teams in 34% of Trusts / LHBs and by hospital discharge teams in 18% of Trusts / LHBs.
- The average length of time for a CHC assessment is 11.9 days. The lowest reported time was 2 days, and the longest length of time for a CHC assessment to take place was 43 days.

NHS Benchmarking
Acute Care Report 2015

However much we invest in prevention & wellbeing, people will get ill. & Even if more older people stay well for longer, there will be more older people to compensate.
Language and perceptions

- “Grey Tsunami”
- “Time Bomb”
- “Burden”
- Older people invisible
- Or “elite” (sky-diving grannies)
- Portrayal as dependent, vulnerable, isolated, ill
- Labelled “bed blocker” “social admission” etc
- Ageist values
- Age discrimination (e.g. CPA report 2009)
- Even in health professionals
- Values/priorities
In fact, most older people in decent nick and contributing still (UK cohort studies/census)

- 70% M & 60% of F > 75 self report health as “good” or “very good”
- 2/3 over 75 say they don’t live with life-limiting LTC
- Most over 75 remain in own homes with no statutory social support
- 70-80 year olds self report highest levels of satisfaction with life
- Taking into account unpaid caring, granparenting, volunteering, spending, paid employment, over 65s make net contribution to economy (Sternberg Report)
Figure 3  Life expectancy with disability (LEWD) and disability free life expectancy (DFLE) for men and women at age 65, by Index of Multiple Deprivation (IMD) 2007 quintile, England, 2006-08

Source: Office for National Statistics 2011a
Figure 4  Burden of disease among people aged 60 and over

Tobacco use 15.5%
High blood pressure 12.3%
Overweight/obesity 8.7%
High blood glucose 6.6%
Physical inactivity 5.3%
Low fruit/vegetables 1.7%
High cholesterol 4.2%
Other causes 45.7%

Source: World Health Organization 2011b
HEALTH CARE QUALITY FOR AN ACTIVE LATER LIFE

Improving quality of prevention and treatment through information: England 2005 to 2012
Multimorbidity in Scotland
(Scottish School of Primary Care Barnett et al Lancet May 2012)
e.g. Only 18% with COPD just have COPD
Problematic Polypharmacy.
(10% over 75s on 10 + meds).

Polypharmacy and medicines optimisation
Making it safe and sound

Authors
Martin Duerden
Tony Avery
Rupert Payne

Source: Guthrie and Makubate (2012)
Figure 4: The consensus estimates of the population prevalence of late onset dementia in men and women aged 65+, UK, 2007.
Figure 7: Prevalence of mobility problems* in men and women aged 65 +, England 2005.
Appendix one: Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up" and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care without prompting.

In severe dementia, they cannot do personal care without help.
Figure 1: Vulnerability of frail elderly people to a sudden change in functional status after a minor illness.
Frailty Syndromes (how people with frailty present to services).
*Clegg, Lancet. BGS “Fit for Frailty”*

- “Non-specific”
  - E.g. fatigue, weight loss, recurrent infection
- Falls/Collapse
- Immobility/worsening mobility
- Delirium (“acute confusion”)
- Incontinence (new or worsening)
- Fluctuating disability
- Increased susceptibility to medication side effects
  - E.g. Hypotension, Delirium
III: What this in turn means for 21st century services

“Older People R US”
Long-term conditions and Health Service Use (England 2005)

People with limiting LTCs are the most intensive users of the most expensive services.

- **Number of people**: 0% (No LTC), 20% (Non-limiting LTC), 80% (Limiting LTC)
- **GP consultations**: 50% (No LTC), 40% (Non-limiting LTC), 10% (Limiting LTC)
- **Practice Nurse appointments**: 30% (No LTC), 35% (Non-limiting LTC), 35% (Limiting LTC)
- **Outpatient and A&E attendances**: 40% (No LTC), 50% (Non-limiting LTC), 10% (Limiting LTC)
- **Inpatient bed days**: 60% (No LTC), 30% (Non-limiting LTC), 10% (Limiting LTC)

Care Home Case Mix BGS

- 16% die within 6 months and 25% within 12
- Median survival 16 months
- 67% immobile or need help with mobility
- 78% dementia or other mental impairment
- c. 20% Stroke
- 10% end stage cardiac/respiratory disease
- 8-12% documented depression
- 30-65% incontinent of urine/faeces or both
- Average resident falls 2-6 times a year
- Median medications per resident 9 (Barber N CHUMS study) (high prescribing, admin, follow-up error)
Acute admissions from care homes
(Quality Watch 2015)
Median age of intermediate care patient = 82 (NHS Benchmarking)
NHS Benchmarking National Intermediate Care Audit 2014 – one of many graphs c 50% of beds and places we need currently

Figure 6.5.2: Average waiting time referral to assessment

- Home based IC
- Bed based IC
- Re-ablement

Average wait (days)

2013
2014
Older people and the integration and care co-ordination agenda

- Older people
- Especially with complex needs/frailty
- Most likely to use multiple services
- See multiple professionals
- And suffer at hand offs between agencies
- And from disjointed, poorly co-ordinated care
- e.g. Birmingham “Care Transitions” project
- Or Age UK/RVS work on re-admissions
- Or CQC “falling through the cracks” report
Care transitions NIHR report
University of Birmingham

Understanding and improving transitions of older people: a user and carer centred approach

- Poor communication between services
- Lack of adequate assessment and planning prior to transition
- Inadequate notice of/preparation for transition between services
- Inadequate consultation and involvement
- Over-reliance on informal support
- Inattention to the special needs of particularly vulnerable groups
- An increased risk of premature transition and/or transition to inappropriate care settings due to service pressures and inter-agency tensions.

National Institute for Health Research
Service Delivery and Organisation Programme

Jo Eills¹, Jon Glasby¹, Denise Tanner², Shirley McIver¹, Deborah Davidson¹, Rosemary Littlechild², Iain Snelling¹, Robin Miller¹, Kelly Hall¹, Katie Spence¹ and the Care Transitions Project coresearchers.³

¹Health Services Management Centre, University of Birmingham
²Institute of Applied Social Studies, University of Birmingham
³Solihull, Leicester, Gloucestershire, Manchester

The King's Fund
NHS Constitution Tech Handbook

2013/14 Planned CCG Commissioned Expenditure

- Primary Care Provision c £9 bn
- Adult Social Care c £10bn
- Acute £34.5bn (53%)
- Community £6.5bn (10%)
- Mental Health £6.6bn (10%)
- Prescribing £9bn (14%)
- Continuing Care £3.7bn (6%)

Other CCG £4.2bn (7%)

Figure 7 - 2013/14 planned CCG commissioned expenditure
Over 65s in hospital (England)

Total emergency occupied bed days by age band
1999/00 to 2009/10

The King’s Fund
Ideas that change health care
Impact of long stays

- Evidence points to older people typically having longer stays in hospital. The following charts show the impact of long stays in hospitals.
- Spells with a length of stay of more than 21 days account for 5% of total spells, yet account for 41% of total occupied bed days, indicating the resource being utilised by the “long-stayers”.
Modern Hospital Case mix

Interaction of Aging, Environment and Disease

- Dementia 1 in 4 beds
- Delirium 1 in 4 over 65s
- Falls = 35% safety incidents
- Falls a major reason for admission
- Median Barthel in over 65 Acutes = 12
- Incontinence c 1 in 4 over 65
- Nutrition
- Immobility
- Hip Fracture is good example (med age 84)
Following the money? Acute Care (but similar patterns across services) *NHS Constitution*

**Chart showing indexed costs for each 5 year age bracket as a proportion of cost for those aged 85+ - General & Acute**

*Figure 13 - Chart showing indexed costs for each 5 year age bracket as a proportion of cost for those aged 85+ (General and Acute)*
QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

The Silver Book

Dementia

Commitment to the care of people with dementia in hospital settings
Figure 1: The vicious circle, Audit Commission (1997, 2000)

- Admissions to hospital are increasing
- Pressures on hospital beds are increasing
- People are being discharged sooner
- There is less money available for preventative services
- There is increasing use of expensive residential and nursing home care
- There are insufficient rehabilitation services
Fig 1 Emergency admissions to NHS hospitals in England, 2000-2011.
EMERGENCY READMISSIONS: ENGLAND 1999-00 to 2009-10

Year
Number readmissions
Age 0-15
Age 16-74
Age 75+
Age 16+
All ages

Fastest Rise is in Over 75s
Mudge et al. 2011 function in acutely admitted older patients.

Figure 1. Percentage of study participants (n = 615) requiring human assistance in each activity of daily living, at baseline, hospital admission, and hospital discharge.
Delayed Transfers. Thompson J, Kings Fund 2014

Figure 31: Delayed transfers: Average number of patients delayed per day each month

Data source: Acute and non-acute delayed transfers of care, patient snapshot, 2014/15 www.england
King’s Fund Older People and Emergency Bed Use 2012: c3 fold variation in admission rates & bed days in over 65 (needs-adjusted)

Figure 2: Needs-weighted emergency bed days per person over 65, per annum, national distribution

Figure 4: Factors driving rate of use of hospital emergency beds for people over 65

- System relationships factors
  - Governance models
  - Commissioner behaviour/relationships
  - Provider behaviour/relationships
  - Staff beliefs and values
  - Leadership

- Patient factors (demand side)
  - Age
  - Socioeconomic status
  - Sex
  - Health needs
  - Beliefs and values

- Hospital factors (supply side)
  - Access (rurality)
  - Internal processes: admission, treatment and discharge

- Community factors
  - Primary care supply and capacity
  - Community care supply and capacity
  - Local authority care supply and capacity
“Our hospitals are struggling to cope with the challenges of an ageing population and rising emergency admissions”

- “A third fewer general and acute hospital beds than 25 years ago but last decade has seen 37% increase in emergency admissions with biggest increase in over 75s”

- “2/3 of patients admitted to hospital are over 65 and many have dementia, frailty or complex needs....buildings, services and staff are not equipped to deal with them”
IV: How our services need to change & improve

Much good practice to celebrate but need “the rest as good as the best”
Mrs Andrews’ Story
(Which I wrote for HSJ Commission on Frail Older People
HSJ Nov 2014/March 2015)

› Please watch actively
› https://www.youtube.com/watch?v=Fj_9HG_TWE
M
› And reflect at each stage, what could/should have happened differently
› This shows essentially caring people trying to do the right thing
› But the system letting her down
› There is a “what should happened instead” on youtube ....

The King’s Fund
Ideas that change health care
Quality in services for older people. 
*Much good practice to celebrate but must do better*

- Outcomes
- Evidence-based processes to deliver them
- Safety & avoiding harms
- Experience/person-centredness

**Efficiency**
- *Unwarranted variation*
- *Wrong person in wrong setting at wrong time*
- *Hand offs, delays, poor co-ordination, duplication*

- Non-discriminatory
- Joined-up/co-ordinated
Making our health and care systems fit for an ageing population
Shift to prevention and pro-active care

1. Age well and stay well
2. Live well with one or more long-term conditions
3. Support for complex co-morbidities/frailty
4. Accessible, effective support in crisis
5. High-quality, person-centred acute care
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement
8. Person-centred, dignified long-term care
9. Support, control and choice at end of life

10 Integrated services to provide person-centred care

The King's Fund
Ideas that change healthcare
Lessons from experience: making integrated care happen at scale and pace

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

Thank you

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Frail Older People in South Sefton

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Associate Medical Director, Liverpool Community Health NHS Trust
Research Fellow in Frail Elderly, International Consortium for Health Outcomes Measurement
Honorary Clinical Lecturer, Institute for Ageing & Chronic Disease, University of Liverpool
Health Foundation / Institute for Healthcare Improvement QI Fellow 2011-12
Shifting the curve to the left

- Risk stratification / Screening
- Set up appropriate interventions
- Work in collaboration with all providers
- Quality improvement / PDSA / Innovation / Research
- Scale up
South Sefton over the last 3 years

- Community Intermediate Care MDT
- Proactive virtual MDT ward
- Urgent care MDT
- Rapid access MDT ambulatory clinic
- Proactive care homes management
Challenges

• Live shared relevant outcome measures
• Creating a work environment that supports and encourages frontline providers of care/interventions
• Social care services
• Age friendly environment and policies
• Primary and community care funding
• Secondary care presence outside the hospital
The cup is half full

- South Sefton CCG
- Sefton Council
- Voluntary services
- Aintree University Hospitals NHS FT
- Liverpool Community Health NHS Trust
- A can do attitude
- Willingness to learn
- Pragmatic optimism
South Sefton on a Journey

- Reactive (urgent)
- Proactive (prevention, slowing things down, good death)

- MDT approach supported by telehealth
- Social Services/Voluntary Sector

- More generic therapists, nurses, HCAs, doctors skilled up to the top of their licence with specialist support
- Seamless care as experienced by the older person and their carers/family
Thank you for your attention

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Frail and Elderly Services in Southport and Formby

Dr. S. Fraser Gordon. BSc. MBChB. MRCP. PhD
Consultant Physician- General and Elderly Medicine
What is frailty?

- Not a disease
- Decreased physiological reserve
  - Decline across multiple physiological systems
  - Decreased resistance to stressors
- The ‘Precarious House Syndrome’
Frailty Services: Past

No Integrated care

Systems become saturated

Hard working but ultimately inefficient and will fail
Frailty Services: Present

FESSU

CERT / IMC

Subacute frailty clinic

Community Pharmacy

Specialist Geriatricians
Frailty Services: Present

Phase 1 A: FESSU

- 28 bedded unit
- Consultant led
- Formal CGA / Anticipatory care plans
- Daily Therapy review
- Dedicated discharge coordinator
- Dedicated elderly care pharmacist
Frailty Services: Present

Phase 1 A: CERT Team

MDT team
Hospital avoidance
Facilitate early discharge
Intermediate care
Extensive MDT input
Frailty Services: Present

Phase 1 A: Subacute Frailty Clinic

- Rapid access daily clinic
- Home assessment by CERT team
- Consultant led CGA
- Clinic slots for telephone and email advice for GP’s
- Extensive MDT input / Voluntary Sector
- Gold standard care / admission avoidance
Frailty Services: Present

Phase 1 A: Medicines management

- Dedicated care home Pharmacist
- Medication reviews
- Identification of high risk medications
- Liaise with primary and secondary care
- Gold standard care / admission avoidance
Frailty Services: Future

FESSU
CERT
Primary Care
Voluntary Sector
Frailty Clinic
Community Geriatrician

Social services
Community MDT
Anticipatory care
Information sharing
EDUCATION
Frailty Services: Future

Phase 1 B: Primary care

- Identify frailty
- Frailty register
- Early frailty intervention
- All over 75's on 5 or more medications for specialist medicine review
- Education and GPs
- Gold standard care
Frailty Services: Future

Phase 1 B: Education

- Vital integral part of service
- Cross boundary education programme
- Support development of GPs and MDT
- Support development of all primary and secondary care frailty team members
- Gold standard care
Frailty Services: ? Future

Telemedicine for care homes linking with geriatricians, GP’s and A+E

Locality MDT- GPs and Community Geriatrician
Frailty Services: Our Vision

- Education
- CERT
- Frailty Clinic
- Primary care
- Secondary care
- Social services
- FESSU
Any questions?
Sefton VCF Sector and Frail Elderly

Nigel Bellamy Deputy Chief Executive Sefton CVS
Some of the Sectors local networks

- Health and Social Care Forum
- Every Child Matters Forum
- Advocacy Information and Advice Forum
- Mental Health Service Users Forum
- Ability Network
- Equal Voice (BME) Network
- Embrace (LGB) Network
- Faith Network
- Intrust (Trans gender) Network
- Sefton Environmental Network
- Sefton Women's Network
Sefton Voluntary, Community and Faith Sector

- 1300 mainly home-grown organisations many work on a locality basis
- Quarter specialise in working with Older People –
- Around 14000 Volunteers 32% of 65–74 year olds, 20 % 75+ volunteer
- 90% self-funding + volunteer led
What VCF organisations currently do in Sefton

- University of the 3rd Age
- Volunteering opportunities
- Health trainers
- Home repairs
- Chair based exercise
- Tea Dances
- Social groups
- Condition specific support
What VCF organisation do currently in Sefton

- Social activities in the community and in care homes
- Practical Help – Gardening, DIY, Shopping
- Self care management programmes
- Health Trainers
- Luncheon clubs
- Advocacy, Advice and Information
- Volunteering Opportunities
- Mental Health and Well-Being
- Condition Specific Support
- Re-ablement
What VCF organisation do currently in Sefton

- Complementary therapies
- Sessions in nursing homes
- Befriending
- Family support
- Listening ear
- Advocacy, Advice and Guidance
- Practical help
- Pet care
New Realities

“A ‘CAN-DO’ COLLABORATIVE Agreement between Sefton MBC and VCF Sector”

Principles:
Common Purpose
Solution focussed
Mutual respect
Risk Aware
What we have in development

- VCF Direct  www.vcfdirect.org.uk
- Falls prevention
- Dementia Friends and Dementia Friendly
- Carers Strategy
- Mental Health Forum
- SPOC
- And more....
What we’d like to do

- Peer to peer support
- Integration– BCF
- Self care
- Meaningful daytime activity
- Pre retirement
- Co–production/shared decision making
- And more....
More people will know how to plan and prepare for a better later life – and more will do so.

More organisations will know what works to support individuals and society to enjoy better later lives – and more of them will act on this evidence.

The broader conversation around an ageing society will have evolved – so that, as a country, England becomes more ready to celebrate longer later life and to see the benefits arising from greater numbers of older people.
Contact:

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General Practice: Focus on Frailty

Dr Niall Leonard
GP and Clinical Vice Chair
NHS Southport and Formby CCG
The Background in Southport and Formby

- Population
- Workload
- Unplanned care
- Care Homes
- Hospital Services
- Community Services
- Workforce
- Estate
- Funding
- 3rd Sector
Fit for the Future

- Redefine purpose of General Practice
- Strategic thinking at practice level
- Radical approach to workforce
- Education and skills gap
- Estate-bigger/more flexible
- Self care/health promotion/3rd sector
- Community services
- Appropriate Hospital services
What are we doing?

- Local Quality Contract for GPs
- Enhanced Out of Hours services for Frail Elderly
- Network of GPs with Special Interests (GPSIs) at Locality level
Local Quality Contract

- Identify Frail adults
- Comprehensive assessment
- Simple interventions
- Educational programme
- Practice organisational development
- Continue to develop over 3-4 years
- Realistic about rate of impact
Enhanced Out of Hours Service

- 111/999/OOH/AED
- Identify and support most at risk of being admitted as an emergency
- Self funding on 2-3 prevented admissions a week
- Care Homes/Own homes
Network GPSIs

- Alternative to hospital referral
- Working with Hospital Service
- Linked to localities and Community teams
- Intermediate Care beds
Challenges

- Money
- Differences across the borough
- Shift to long-term thinking about local need
- Hearts and minds
Tina Wilkins

Sefton Council

Adult Social Care

www.sefton.gov.uk
Total Net Expenditure Per 100,000 £000s

- 2008/09: £37,000
- 2009/10: £39,000
- 2010/11: £39,000
- 2011/12: £40,000
- 2012/13: £41,000
- 2013/14: £41,000
Projected Budget Increase to Cope with Just New Admissions as result of population change 65+
Gender (Over 65) | Population Change & Projection | Fuel Poverty | Pension Credits
---|---|---|---
58% | Up by 12% since 2002 | More than 2,500 over 60’s living in fuel poverty | One in four over 65 year olds in receipt of pension credits
42% | Up a further 46% by 2037 |

Living Alone | Day Care | Residential Care | Joint Replacement
---|---|---|---
31% | £128,345 | By 2030 two in three care home residents will be over 85 | 23% increase in Hip Replacements & 13% increase in knee replacements between 2007/08 and 2011/12
More than 18,000 Over 65 Single Occupant Households | In 2012/13 there were 665 over 65’s accessing day care at an average unit cost of £193 |
<table>
<thead>
<tr>
<th>Elective Hospital Admissions</th>
<th>Non Elective Hospital Admissions</th>
<th>Depression</th>
<th>Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>15% of elective admissions were for joint replacements</td>
<td>In 2013/14, Non Elective admissions cost £35.5m</td>
<td>Two out of three over 65’s suffering depression are female</td>
<td>49% predicted increase in sufferers between 2015 and 2030</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart Attack / COPD</th>
<th>Diabetes</th>
<th>Adult Safeguarding</th>
<th>Reablement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sefton COPD mortality amongst over 65’s 225 per 100,000 compared to 202 nationally</td>
<td>57%</td>
<td>480</td>
<td>91% of over 65’s receiving services at home 90+ days after hospital discharge</td>
</tr>
<tr>
<td>Of diabetes sufferers in Sefton are over 65</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Challenging Times!

Council Budget Cuts

Working Towards Integration
So How Have We Begun To Move Forward?

Reality Check

I'M WAITING FOR A GOVERNMENT BAILOUT...

Actions?
Sefton Needs to Work Together to be Resilient and have Resilient Communities
Good Health and Wellbeing needs to become the norm
Thank You
Response and Reflections
Prof. David Oliver

Facilitated Session
Lunch
12.30pm – 1.30pm
What can we do as a society when deterioration starts?

What can we do before medicalisation?

Mr Asan Akpan

Facilitated discussion
Thinking Outside the Box

Prof. David Oliver

Facilitated discussion
Summary

Action and Next Steps

Fiona Clark
Thank you

Contact:

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