



CONFERENCE

“The commitment of European healthcare systems to prevent and manage the frailty challenge”

Integrated Care for Frailty

05-06 July 2018

Ancona, Loggia dei Mercanti

Prof Anne Hendry

NHS Lanarkshire, Scotland, UK

Senior Associate, International Foundation for Integrated Care

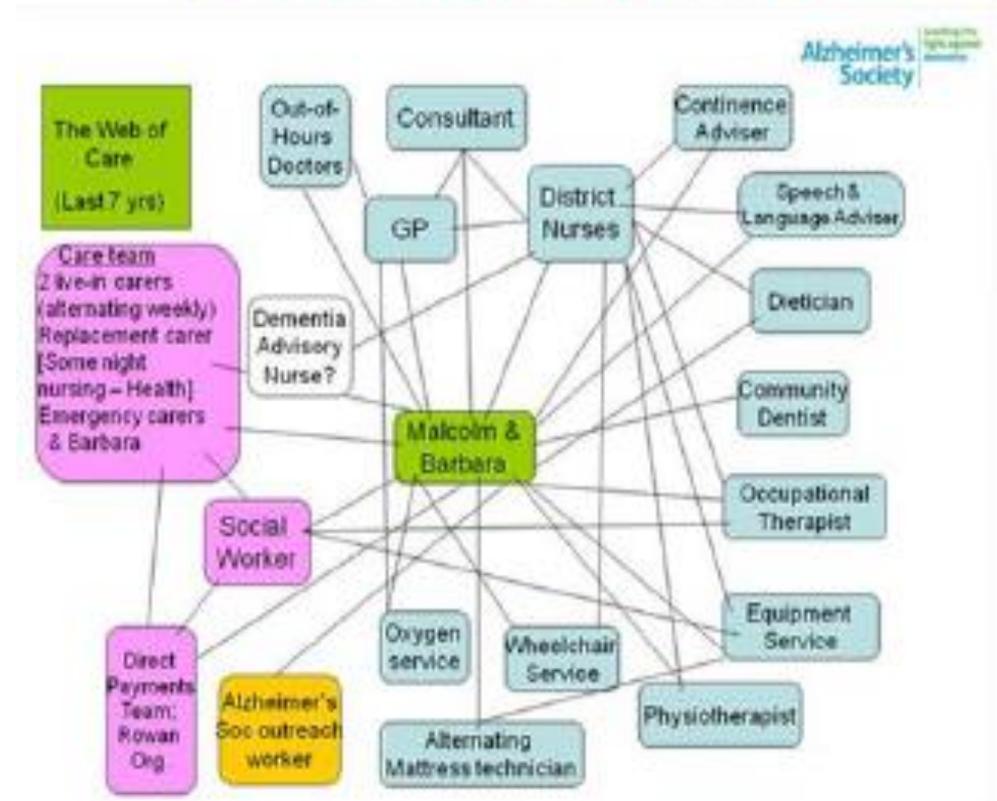


From Chronicity to Complexity

The complexity in the way care systems are designed leads to:

- lack of 'ownership' of the person's problem;
- lack of involvement of users and carers in their own care;
- poor communication between partners in care;
- duplication of tasks
- gaps in care;
- treating one condition without recognising others;
- poor outcomes to person, carer *and* the system

Alzheimer Web of Care



Frontier Economics (2012) Enablers and barriers to integrated care and implications for Monitor -

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Integrated Care: What Matters

“My care is planned with people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes” **National Voices**



- Coordination and continuity of care
- Trusted relationships
- Accessible information and advice
- Good communication with, and between, staff



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Current paradigm	Future paradigm
System geared towards acute or single condition	System designed around people with multiple conditions
Hospital centred	Embedded in communities and their assets
Doctor dependent	Multi-professional and team based care
Episodic care	Continual care and support when needed
Disjointed care	Well coordinated integrated health and social care
Reactive care	Preventive and anticipatory care
Patient as passive recipient	Informed empowered patients and clients
Self-care infrequent	Self management / self directed support enabled
Carers undervalued	Carers supported as equal partners
Low-tech	Technology enables greater choice and control



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World Report on Ageing and Health

Conventional care models	Older person centred and integrated care
Focuses on a health condition (or conditions)	Focuses on people and their goals
Goal is disease management or cure	Goal is maximizing intrinsic capacity
Older person regarded as a passive recipient of care	Older person is an active participant in care planning and self-management
Care is fragmented across conditions, health workers, settings and life course	Care is integrated across conditions, health workers, settings and life course
Links with health care and long-term care are limited or non-existent	Links with health care and long-term care exist and are strong
Ageing is considered to be a pathological state	Ageing is considered to be a normal and valued part of the life course



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ADVANTAGE JA Work Package 7 Models of Care



SoAR: Models of Care for Frailty

- a single entry point – generally in Primary Care
- simple frailty screening tools in all settings
- comprehensive assessment and individualised care plans – including for carers
- tailored interventions by interdisciplinary team – both at home and in hospital
- case management and coordination of care and support across providers
- effective management of transitions between teams and settings
- shared electronic information tools and technology enabled care
- clear policies and procedures for service eligibility and processes.

Hendry, A, et al. Integrated Care: A Collaborative ADVANTAGE for Frailty. *International Journal of Integrated Care*, 2018; 18(2): 1, 1–4.
DOI: <https://doi.org/10.5334/ijic.4156>

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ADVANTAGE JA Work Package 7 Models of Care

- To identify and share examples of good practice in different settings in order to prevent or delay progression of frailty and enable people to live well with frailty.
- To analyse the impact at an individual level and on health and social care systems including economic impact.
- To assess potential for scaling-up and knowledge transfer
- To inform the Frailty Prevention Road Map



Reshaping Care Programme

Preventative and anticipatory care

- Build social networks and opportunities for participation
- Early diagnosis of dementia
- Prevention of falls and fractures
- Information and support for self-management and self-directed support
- Prediction of risk of recurrent admissions
- Anticipatory care planning
- Suitable and varied housing and housing support
- Support for carers

Proactive care and Support at home

- Responsive, flexible, self-directed home care
- Integrated case/care management
- Carer support
- Rapid access to equipment
- Timely adaptations, including housing adaptations
- Telehealthcare

Effective care at times of transition

- Reablement and rehabilitation
- Specialist clinical advice for community teams
- NHS24, SAS and out-of-hours access ACPs
- Range of intermediate care alternatives to emergency admission
- Responsive and flexible palliative care
- Medicines management
- Access to range of housing options
- Support for carers

Hospital and care home(s)

- Urgent triage to identify frail older people
- Early assessment and rehab in the appropriate specialist unit
- Prevention and treatment of delirium
- Effective and timely discharge home or transfer to intermediate care
- Medicine reconciliation and reviews
- Specialist clinical support for care homes
- Carers as equal partners

Enablers

Outcomes-focused assessment

- Co-production
- Technology, eHealth and data-sharing
- Workforce development, skill mix and integrated working
- Organization development and improvement support
- Information and evaluation
- Commissioning and integration resource framework

Longwood Publishing Corp. *Healthcare Quarterly* Vol.19 No.2 2016

‘Bottom Up’ Change and Innovation

£ 300 million Change Fund 2011-15

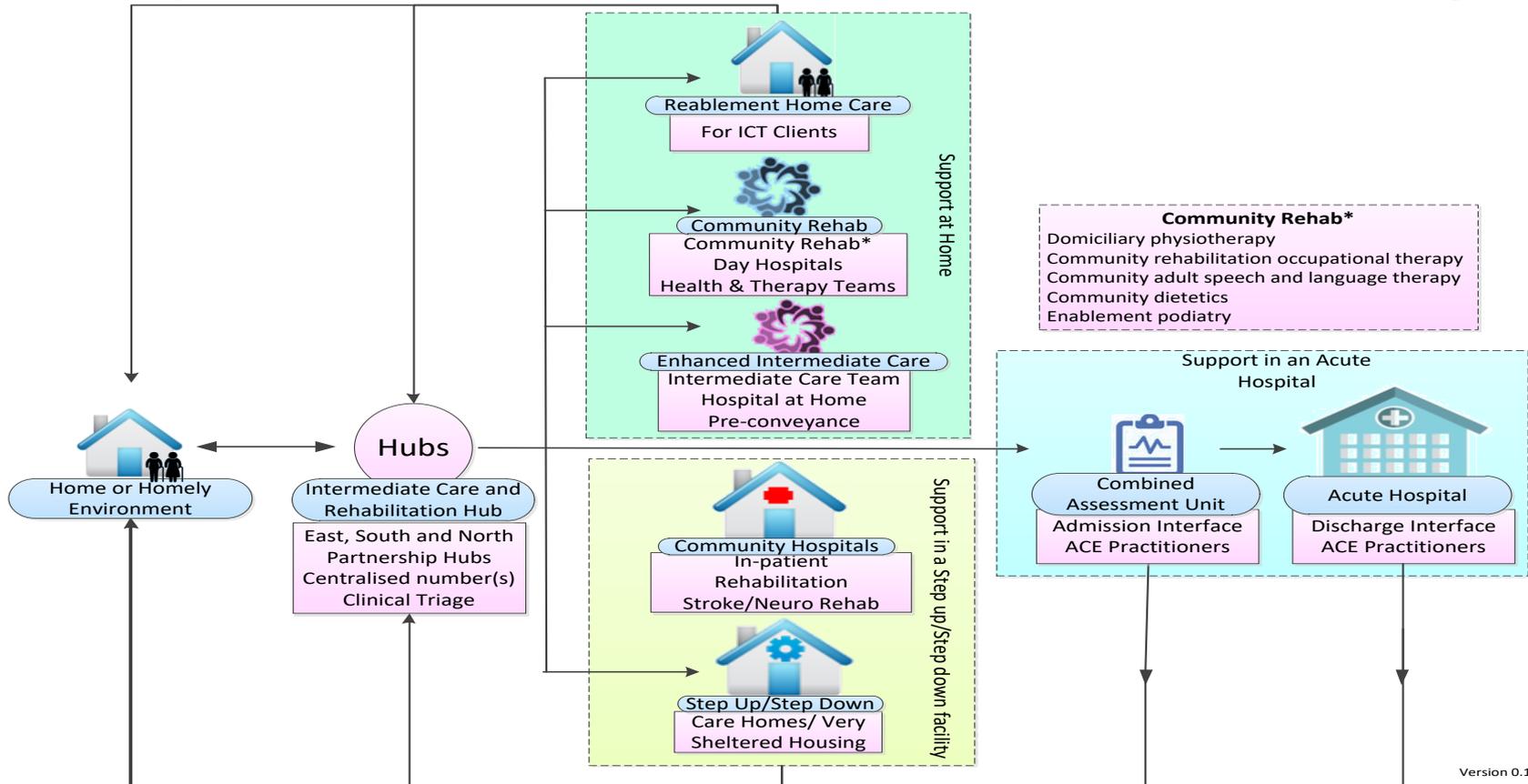
20% of funds to be invested in direct or indirect support for carers

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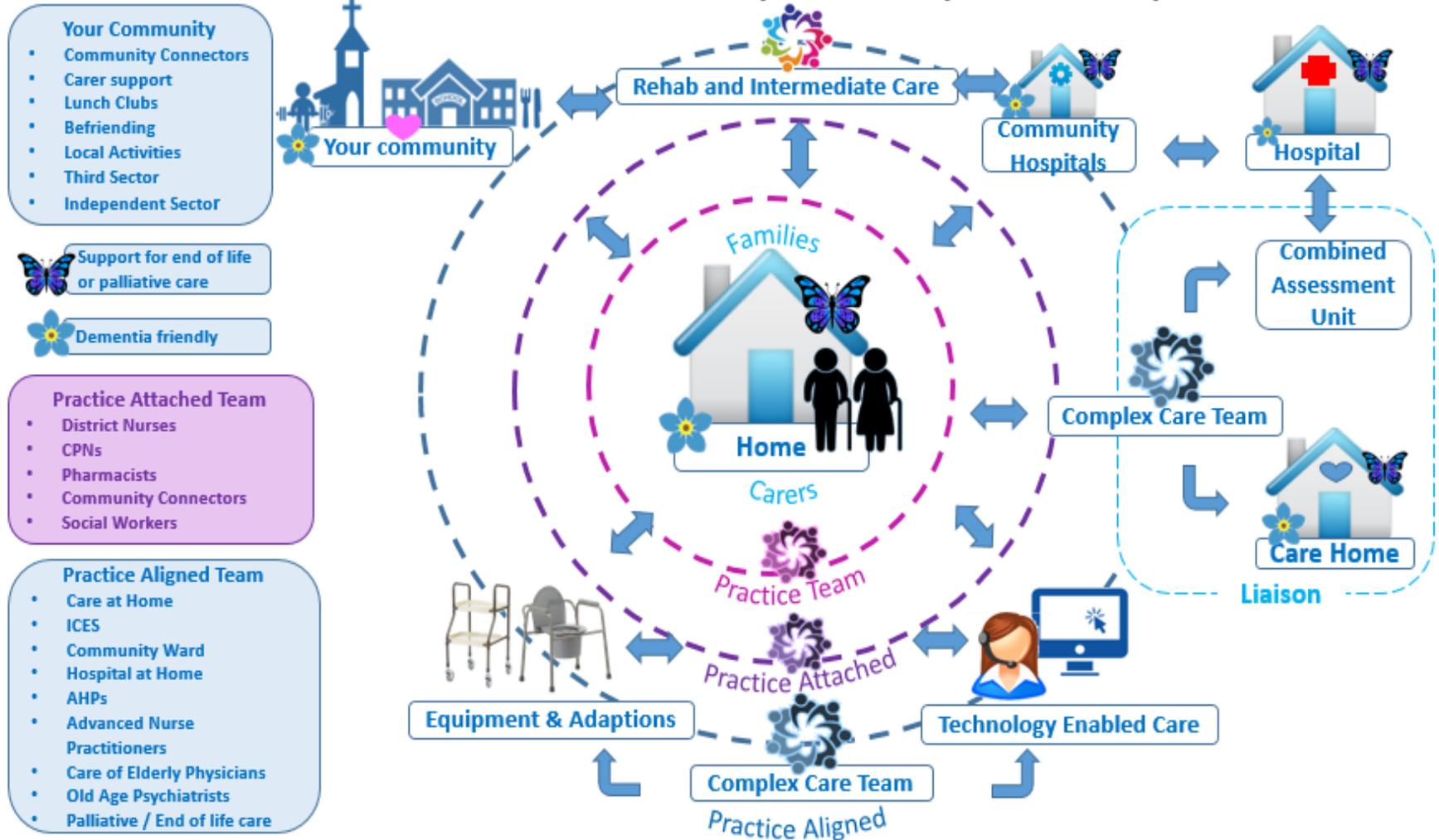
Pathway of Care

Pan-Ayrshire Tec-Enabled Model for Intermediate Care and Rehabilitation



From Pathways to Integrated Systems

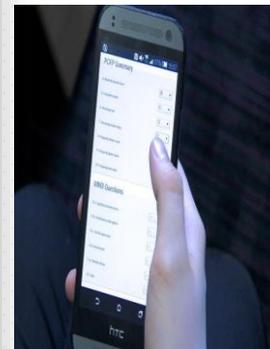
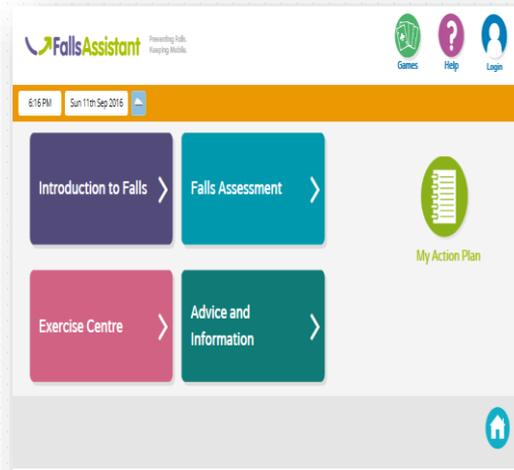
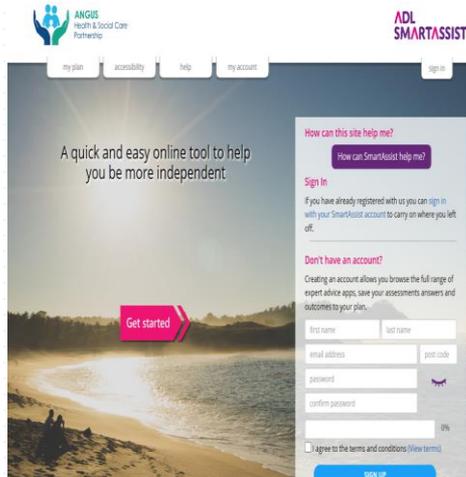
New Models of Care for Older People and People with Complex Care Needs



SoAR: Identifying Frailty

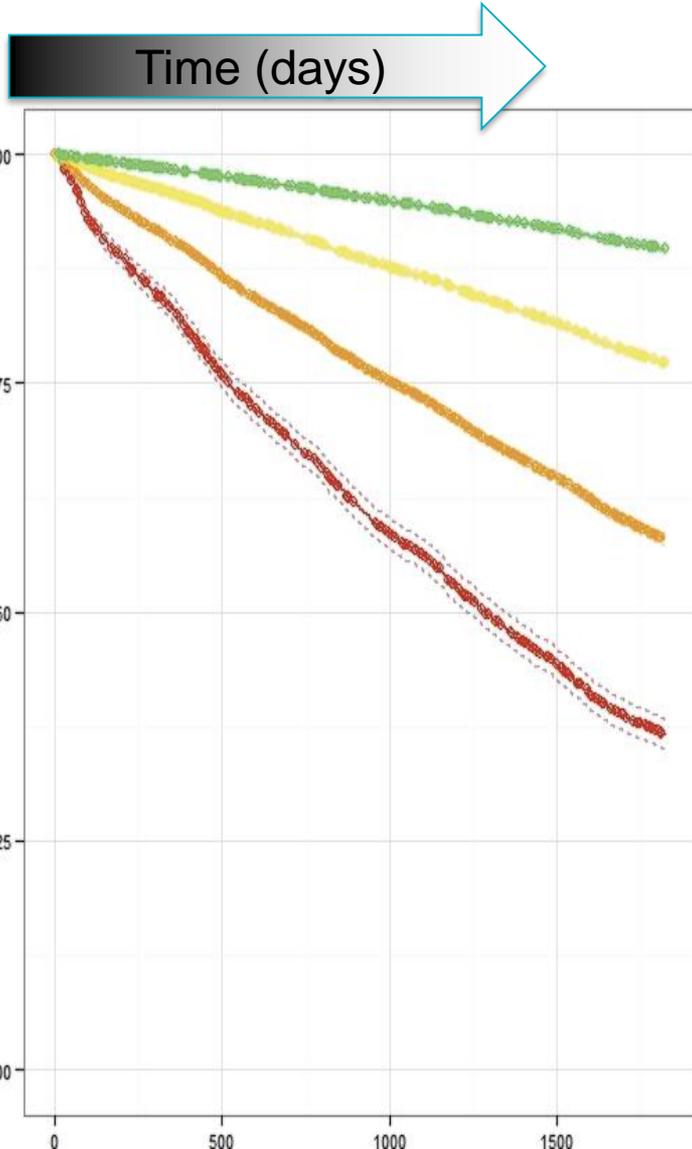
Opportunistic screening for over 70s using tools that are:

- Quick to administer (taking no more than 10 minutes to complete).
- Do not require special equipment.
- Have been validated and are meant for screening



- 1 Very FR** - 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 artistic 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 are 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 III** - 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 with prompting. In **severe dementia**, they cannot do personal care without help.

Validation of eFI



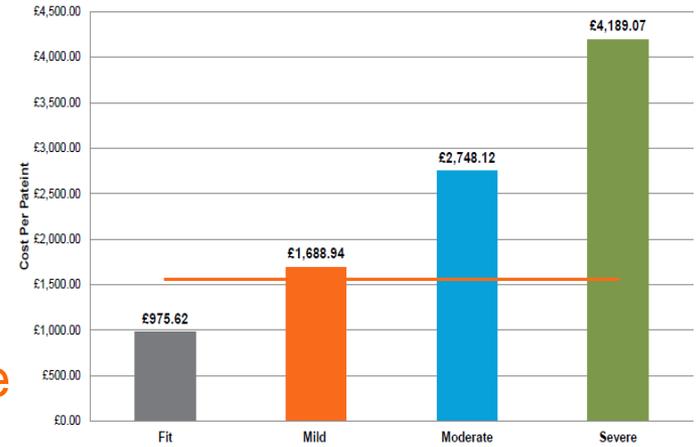
Fit

Mild frailty

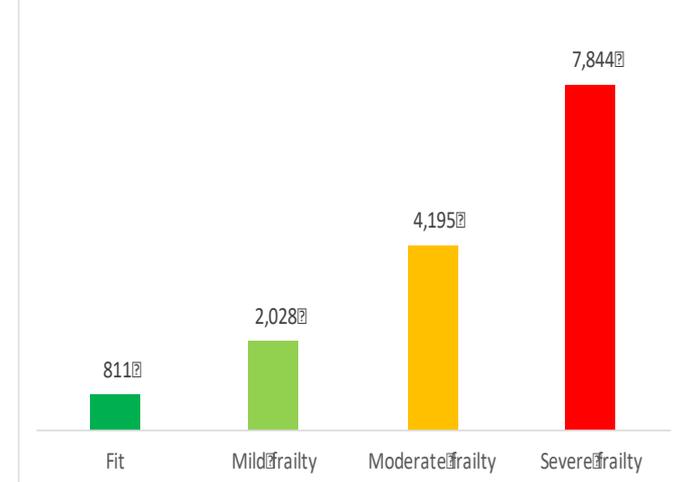
Moderate frailty

Severe frailty

NHS Spend as Captured in KID - Average Cost Per Patient by Frailty Category, Patients 65 years and older
Source: KID, 2016-17 data



Emergency Bed Days per 1,000 person year



e Frailty Index in a Report on Complex Patients

Lyall Cameron NHS Ayrshire and Arran

KIS? (All values) ACP? (All values) Polypharmacy Review? (All values) Care Home? (All values) Usual GP (All values)

Complex Patients for Practice - 80

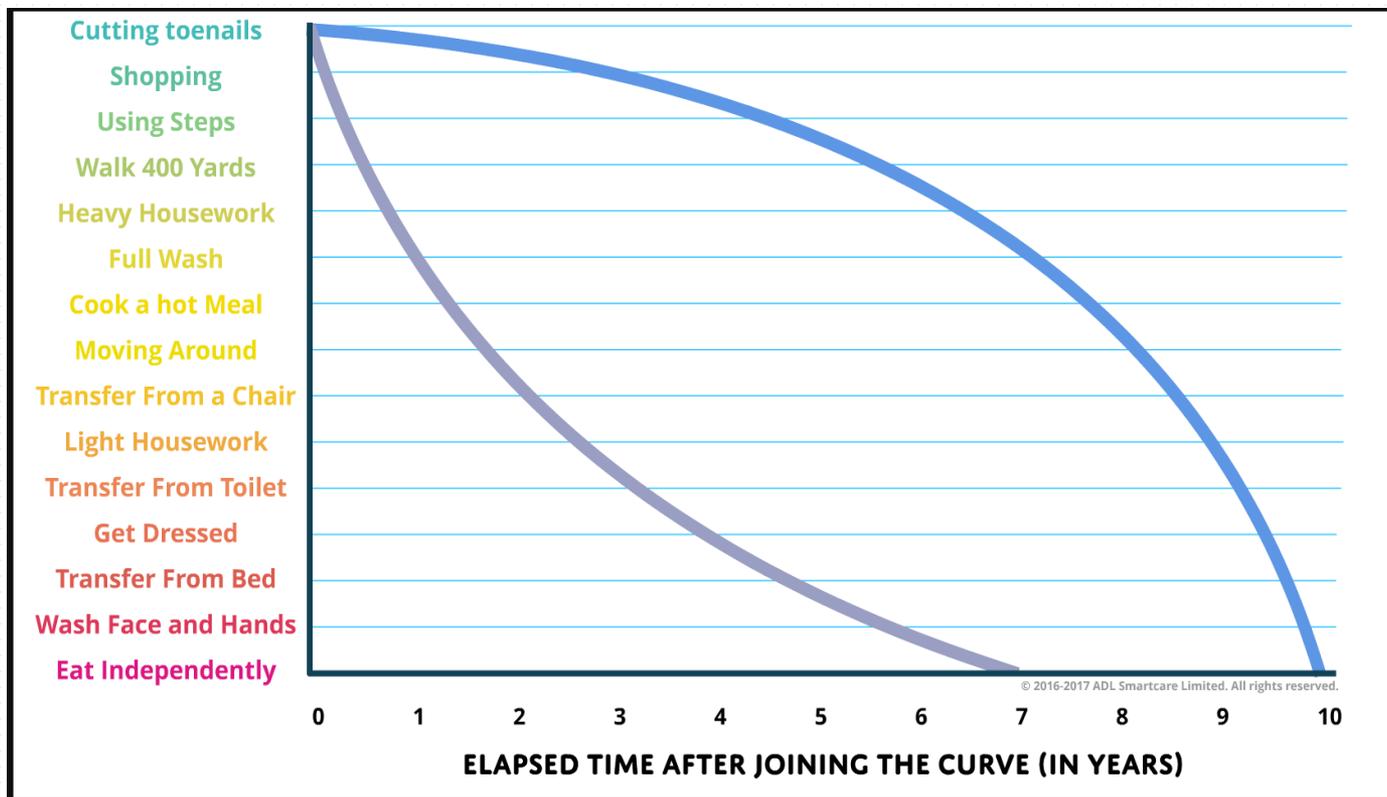
Filters Applied - None

CHI	Age	Gender	Repeat Meds	High Risk Rx	Multi-morbidity	Frailty Score	Care Home	Poly-pharmacy Review	ACP	KIS	A&E	Emer Adm	Bed Days	OOH Home Visits	OOH PCTC	OOH Advice	Usual GP Code
2	75	Female	13	6	5	30.6%		02/02/16		31/12/15	7	7	37	5		3	A
0	82	Female	24	5	8	41.7%		07/01/15			4	4	19	1	1	2	A
0	80	Male	18	6	4	38.9%					6	4	25			4	A
2	86	Male	10	1	1	50.0%					1	1	105	4		2	A
0	86	Male	17	6	9	61.1%		24/02/16	24/02/16	24/02/16	4	4	27			2	A
2	90	Male	12	7	4	36.1%		05/02/15			5	1	8	1	1	1	A
0	61	Female	10	3	3	19.4%	Yes	01/12/16			4	4	129	5		3	A
1	52	Male	18		2	22.2%				28/10/16	8	10	67	8	1	2	A
1	81	Female	10	6	5	38.9%					4	5	7			2	A
2	88	Male	11	4	5	38.9%	Yes	16/12/15	06/11/15	04/04/14		1	7				A
2	82	Female	12	6	4	55.6%					4	2	5	4		3	A
2	83	Female	17	10	7	50.0%		01/03/16	01/03/16		4	4	5	1			A
2	77	Female	14	7	3	27.8%	Yes	01/12/16			1	1	53			1	A
3	40	Male	13		5	25.0%	Yes	19/01/16	06/11/15	22/10/13	1	6	50			1	A
0	82	Male	15	7	8	38.9%	Yes	13/01/16	06/11/15	22/11/16	1	1	3				A
2	87	Female	12	7	6	38.9%	Yes							3		1	A
2	74	Male	12	11	4	30.6%					5	6	169				A
2	72	Male	17	1	4	36.1%					2	3	68			1	A
1	75	Female	20	8	6	55.6%					1	2	7				A
1	74	Male	15	10	4	38.9%					3	4	6			2	A
1	87	Male	15	4	4	41.7%	Yes	13/10/16	19/02/16	01/04/14				1		1	A
2	68	Female	27	12	4	44.4%				12/10/15	1	1	25				A
2	70	Female	17	7	2	38.9%		24/02/16		24/02/16	2	4	25			2	A

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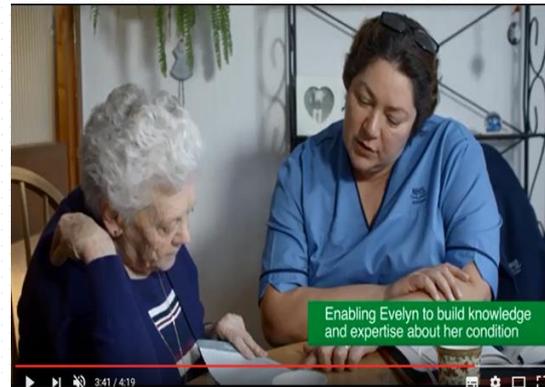
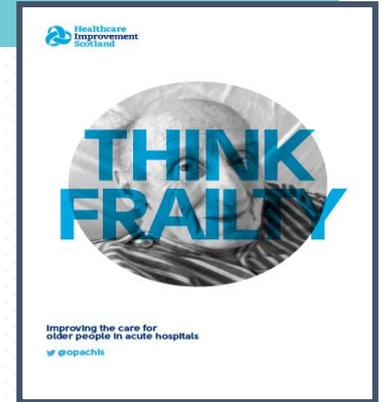


University of Newcastle Life Curve



SoAR WP6: Managing Frailty

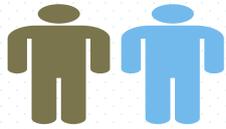
- ✓ Comprehensive Geriatric Assessment*
- ✓ Care planning and tailored interventions
- ✓ Telehealth and telecare solutions
- ✓ Falls prevention interventions
- ✓ Tools to manage inappropriate prescribing and polypharmacy



7 STEPS TO APPROPRIATE POLYPHARMACY



- Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, Conroy S P, Kircher T, Somme D, Saltvedt I, Wald H, O'Neill D, Robinson D, Shepperd S. *Comprehensive geriatric assessment for older adults admitted to hospital.* *Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No.: CD006211.*



39%

CHANGE FUND
SPEND 2014/15
SUPPORTED
CARERS



2.8
Million

MORE DAYS
IN OWN HOME
THAN 'EXPECTED'

17%
FEWER



OLDER PEOPLE
CONVEYED
to HOSPITAL
after a fall
(non-injured)

10%
REDUCTION

IN RATE OF 75+
EMERGENCY BEDDAYS
OVER 5 YEARS

1600
PER DAY



FEWER PEOPLE
AGED 65+ IN HOSPITAL BEDS
THAN 'EXPECTED'



IN RECEIPT OF
FORMAL CARE AT
HOME
HAVE TELECARE

6000
PER DAY



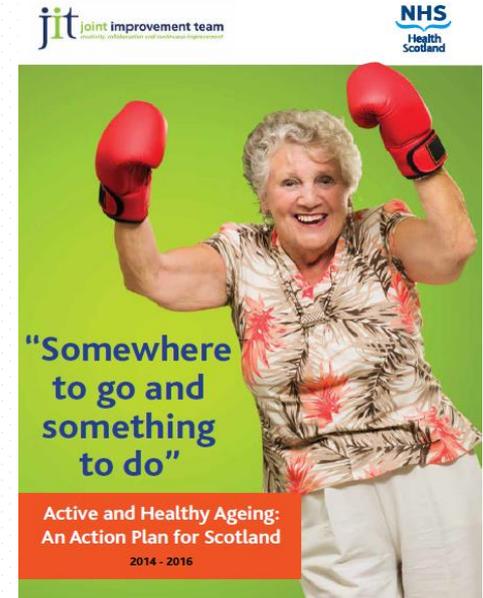
FEWER PEOPLE
IN CARE HOMES
THAN 'EXPECTED'

19%
FEWER

PEOPLE DELAYED
IN HOSPITAL
OVER 2 WEEKS

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Imagine a world in which everyone can live a long and healthy life.....



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Face up to Frailty

Health and Social Care Integration

Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

www.scotland.gov.uk/HSCI
Follow us on twitter @scotgovHSC

The Scottish Government
Riaghaidh na h-Èide

There's no ward like home

'Frailty Five - Must Dos for Me'

- Anticipatory Care Plan
- Polypharmacy Review
- Falls Risk assessment + TEC
- Carer support & emergency plan
- Case / care manager

Integrated Care Matters

➤ **Webinar Series and Topic Resources**

➤ www.integratedcarefoundation.org/scotland



➤ **Special Interest Groups (SIGs)** hosted on IFIC website:

- Polypharmacy and Adherence
- Intermediate Care
- Palliative & End of Life Care
- Frailty



➤ Sign up at: <https://integratedcarefoundation.org/ific-membersnetwork/groups/>

➤ **Contact**

Marie Curran IFICscotland@integratedcarefoundation.org



THANKS FOR YOUR ATTENTION

anne.hendry@lanarkshire.scot.nhs.uk