The role of the voluntary sector in integrating health for older people with frailty

Caroline Abrahams, Charity Director, Age UK
Clinical features of frailty

- Living with frailty typically means a person is at a higher risk of a sudden deterioration in their physical and mental health.
- Frailty is distinct from living with one or more long-term condition and/or disability.
- Older people living with frailty can be low users of health services until a relatively minor event precedes a major change in their level of need.
What matters to older people?

Older people describe frailty and wellbeing in terms of **everyday tasks** and **how it feels** if these task start to become difficult.

- **Domestic activities**
  - Cleaning, washing and ironing
  - Shopping and preparing meals

- **Outdoor activities**
  - Gardening
  - Walking / walking the dog

- **Social activities**
  - Going out with friends / family to restaurants, cafes, pubs, organised events, shops

“**It’s very annoying. I can’t do things I used to do - I used to do all of my windows and my nets.**”

Female, 71, South (7 on Rockwood Scale)

“**My house always used to be so spotless. I do feel useless sometimes that I can’t keep it like I used to.**”

Female, 85, North (7 on Rockwood Scale)

“**It’s disheartening really, because your brain tells you can walk but then your body can’t do it.**”

Male, 83, South (6 on Rockwood Scale)

“**My friend and I go out to the shops for a look around and a cup of tea and a piece of cake. It’s the highlight of my week.**”

Female, 83, North (7 on Rockwood Scale)
Ruth

- Recently lost husband and experienced a bad fall.
- Digestive problem causing her to lose weight
- Frequent contact with GP and very low mood and anxiety
- Age UK volunteer worked with her to build confidence, helping Ruth to start leaving house
- Referred for balance and stability class
- Worked with GP to arrange suitable meals
- Now fully engaged with social activities
- “Given me things to look forward to”
Personalised services and support working together around individual needs

- Healthcare
- Financial security
- Social care
- Housing
- Community
- Social networks

Individual older person
What is unique about Age UK’s integrated care programme?

• **Helping the person – not the condition** - person-centred care integrating across multiple long term conditions as well as ancillary preventative services that make a huge difference.

• **A seamless way of connecting health and care services** – creating new care pathways that are clinically endorsed, that work for older people and ‘bridges the gap’.

• **Major step change in the approach** – putting the local Age UK at the centre of older people’s health outcomes – requires a ‘whole system change’.
Home of care

Whole system change: Local voluntary organisation at centre of person's health outcomes

B. Cohort identification
Person selection via data analysis and GP assessment
Targeting highest risk with multiple long-term conditions

C. Person-centred multi-disciplinary team and the role of the Age UK Personal Independence worker

Fully integrated support team

Core Co-ordination and guided conversations

Designing person-centred care management plan

One to one support

- Care management plans
- Escalation plans
- Anticipatory care plans
- Self care strategies
- Peer support network
- Motivational interviewing: shared decision making

D. Wrap-around local support services

E. Age UK’s integrated care pathway development

F. Outcomes

Overall improvement in quality of life

- Reducing avoidable admissions to hospital

- Aligning incentives: Financed directly by local bodies or through innovative social investment financial model

- Enabling self-care. Peer support. Tackling social isolation

- Assessing immediate needs and addressing barriers to improve quality of life


- Collective accountability across integrated care team (Age UK, clinical and social care services)
Person and system benefit

Improves Wellbeing for older people:
• Person centred smart goals
• Inter-dependency within the community
• Emotional wellbeing
• Physical wellbeing
• Loneliness

Reduces Hospital Admissions:
• (Delivers Cashable Savings)
• Reducing cost across the whole health and care system
• Performance Management Framework
• Financial Model

Supports Transformational Change to the Whole System:
• Multi disciplinary team working
• Shared single care plan
Cornwall Results

- 31% reduction in all hospital admissions
- 8% reduction in social care costs
- 26% reduction in non-elective hospital admissions
- 20% average improvement in wellbeing
- 20% of people supported go on to become volunteers themselves
New lease of life

‘I have been encouraged to look at patients where I thought their dependency levels would only increase and see that with a relatively small level of intervention, they can be encouraged back to a much lower level of dependency.’

Dr Tamsin Anderson, Newquay GP

‘I can’t get out and it’s wonderful that you come and take us out, it’s a new lease on life.’

Val, an older person on the Programme
Interest from across the UK

- Cornwall – scale up to 1000 older people & changing practice across the county
- Portsmouth – also an Integrated Personal Commissioning demonstrator site
- Age UK – Evidence base
  - Nuffield Evaluation requires 4,000 older people to receive the services and support

Sites in progress:
- North Tyneside
- Blackburn with Darwen
- East Lancashire
- Sheffield
- Guildford and Waverley
- Ashford and Canterbury
- Redbridge Barking and Havering
Summary

• Health and care services rarely equipped to meet the experience of living with frailty

• Voluntary sector focuses approach on what’s relevant to people’s lives

• Better placed to facilitate links between multiple local services, particularly non-NHS services.

• Provides trusting relationship for “guided conversation”, seeking out what’s most important to people.