Growing old together

Sharing new ways to support older people

A report by the independent Commission on
Improving Urgent Care for Older People

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Foreword

The challenges of managing urgent care demand in the face of continually overcrowded hospitals have dominated the thoughts of NHS leaders and clinicians alike for many years. The 'winter crisis' is a regular occurrence, despite an universal understanding that the solutions lie in the creation of more effective and accessible home and community care that focuses strongly on the maintenance of health and wellbeing.

Without this shift in emphasis, it is difficult to see the situation improving. Older people, who often have one or more chronic health conditions, are particularly poorly served by the present system, which was after all designed when the demographic was very different.

There is much excellent practice across the country, and there is no shortage of expertise on the particular needs of older people who require urgent care. This Commission has focused, rightly, on the practical and deliverable aspects: how can service provision be improved in local health systems, and how can we share and spread this innovation?

The need for change is clear, and the NHS Confederation's members are keen to adopt new approaches together with local partners. They have indeed urged the Commission to be radical in its output. The time is right too, as we move into an era when system will trump institution, and new organisations that cross current boundaries will come into being.

The Commission has benefited from considerable expertise within its ranks, and from visits to, and evidence from, a wide range of innovators across the service. We have seen how general practice can mobilise the local community to provide non-medical forms of support, and we have been impressed by the role that care coordinators and patient advocates can play as part of multidisciplinary teams that have the authority to organise and direct care provision for the individual.

Much of healthcare involves the management of risk, and we have been shown how much more effective this is when decisions about care are shared with the person and their families. Acting on the wishes of the individual is surely what the term 'patient centred' means, and embedding this into practice would be a truly radical change for service providers.

Older people frequently require the services of the acute sector, and we have seen exemplary practice in hospitals in which the need to work in partnership with other agencies, and to train staff on the particular needs of older people, are well understood.

No two people have the exact same needs. Throughout the course of this Commission, we heard that 'integrated care' means care that is coordinated around the specific needs of individuals, irrespective of the organisational structure, or structures, that deliver it. How many systems currently have care coordinators who can act as 'integrators' and make this happen?

I have been privileged to work with the Commission and see just how much transformational practice currently exists, but the challenge now is to ensure it happens at sufficient scale to ease the pressures right across the service. In our report, we suggest that regulators and system leaders must recognise the need to move away from the requirement for short-term performance improvement, which often leads to unsustainable 'quick fixes', so that leaders can lift their heads and come together in localities to plan for longer-term change.

Implementing systems of care delivery that are based on the principles in this report will require an appetite for radical change. What this report highlights is that radical change does not need to be complex; instead it should strip back complexities to result in a simpler, more straightforward way of organising care.

The rewards for this group in our society will be great, as the compelling account from Pippa Kelly illustrates so graphically. We hope our senior leaders will rise to this challenge and work with local partners to nurture those many individuals in the wider care system who are committed to making this change happen.

Mark Newbold
Chair, Commission on Improving Urgent Care for Older People

Pippa Kelly: a former carer's perspective

My parents became very ill in their final years and I am sorry beyond words that the NHS they loved failed them time and again, primarily because it placed processes before patients. I have numerous examples, but one stands out. It involves my father and contains all the ingredients of bad care: lack of compassion, communication and timely, appropriate intervention combined with a blind allegiance to procedure at that highest of all costs – an individual's welfare and health.

It happened a few years ago and is in stark contrast to the exemplary treatment my father-in-law, Maurice, recently received from the same NHS in the final week of his life. What is fascinating, and instructive, about these two cases, is that the positive elements that made Maurice's care so good were those that, in their negative form, made my father's so bad.

When my 88-year-old father was very frail, bedridden and being fed by a nasal gastric tube, he was taken to hospital with an infection. At about 3pm an A&E consultant prescribed antibiotics and said Dad should be driven home by ambulance "immediately, for palliative care".

This didn't happen. Instead, my father lay on a trolley for seven hours. Why? Because rules stated that only hospital ambulances could be used for discharging patients. Despite my repeatedly reminding nurses that my father was not being discharged because he was well, but because he was dying, they refused to arrange a frontline ambulance. They simply didn't seem to care. (A view that was reinforced when the hospital later acknowledged that, given the circumstances, Dad should have been allowed a frontline ambulance.)

When a hospital ambulance eventually became available, I drove ahead of it to Dad's flat. Within minutes, the phone rang: "Does Arthur Kelly have a DNR?" No hello, no introduction, just six heart-stopping words. It was the hospital driver informing me my father was too ill to be driven home by him and needed a frontline ambulance – the very means of transport he'd been persistently denied.

I somehow managed to convince a senior member of the hospital to allow my Dad to be driven home in the ambulance, accompanied by a nurse. It was near midnight by the time my semi-conscious father was placed in his own bed, but moments after the ambulance crew left I noticed that his nasal tube had become dislodged. I rushed downstairs only to be told that the nurse, though qualified to do so, wasn't authorised to reattach the tube. Dad would have to return to hospital and because the crew weren't allowed to take him in their ambulance, they explained, I would have to dial 999. The ambulance drove off leaving me incandescent with rage and fraught with something I can only call grief, mixed with utter disbelief.

In fact my father lived for another few months, but no thanks to his Kafkaesque experiences that day. And I am left wondering, as so often during my parents' ordeals at the hands of the very service designed to looked after them, what would have happened if I hadn't been there?

On a more positive note, when my 91-year-old father-in-law Maurice was admitted to hospital in his final week of life, his treatment was exemplary. After he suffered a bad fall, his GP called in the local rapid response unit who, according to my mother-in-law, were highly competent and caring. Within an hour, a physiotherapist appeared. Four days later, on a Sunday morning, two nurses arrived to get Maurice out of bed before deciding, later in the day (having taken telephone advice from a doctor), that he needed to go to hospital.

Once there, Maurice was seen by two doctors within an hour, then a consultant, and given a CT scan and a hip and chest x-ray – *on a Sunday*. During his stay, two things impressed us as a family: the nurses' compassionate professionalism and the can-do approach of everyone we encountered, from management to ancillary staff.

At the heart of these two cases – to quote the guiding principle of this report – was care focused on an individual's needs. In my father's case it was totally lacking. In Maurice's case it was delivered superbly.

Pippa Kelly is a former carer and an award-winning writer on elderly care and dementia. To find out more about her experiences, visit pippakelly.co.uk

Executive summary

The Commission on Improving Urgent Care for Older People was launched by the NHS Confederation in March 2015. It brings together experts from across the care system, who have a shared purpose of making care better for older people.

The background to the Commission is a concern that the care system is increasingly ill adapted to the needs of older people and particularly those with long-term conditions and/or frailty. This can lead to a lower quality of care for older people and also impact on the ability of the system to care for all patients. Issues include a lack of out-of-hospital services as an alternative to A&E, not enough focus on prevention and early intervention, delayed transfers of care, and the need to take a holistic view of people's health and wellbeing and provide solutions which meet their needs.

The aim of the Commission was to produce guidance for people involved in designing care for older people. As well as the experience of those involved with the Commission, it was informed by over 60 evidence submissions, a series of site visits to areas and organisations using innovative ways to deliver care, conversations with NHS Confederation members and patient and carer groups, and by a literature review, including other reports and guidance on older people's care.

The Commission recognises there are a number of fundamental elements that underpin good care for older people and ought to be borne in mind when any changes are being made. Most notable of these is that care driven by the individual should deliver a tailored, not a standard, response. The Commission also acknowledges the acute sector's role should be viewed as important and integral, at the right time.

What should excellent urgent care for older people look like?
The Commission has laid out a vision of what excellent urgent care should look like.

The members of the Commission examined many local health systems providing elements of excellent care. Though no one health economy claims to have

got all aspects in place, site visits showed some outstanding services often coupled with a desire to improve further.

Excellent care has many elements:
- It should respect the wishes and goals of the individual and their carer(s).

- It should support medical and non-medical care in the most appropriate setting.

- It should use the right resources – clinical or social – to support the delivery of care.

- It should prevent escalation to any inappropriate services.

- It should seek to use the right alternatives to resolve a crisis as early as possible, to avoid major disruption to a person's daily life.

- It should provide a clear plan to the individual of what the immediate and longer-term next steps are when acute care is required.

Definitions

Older people: According to Public Health England[1]: "There is no agreed definition of older or old people and people differ widely in what they consider to be old. Members of each age band are a very heterogeneous group and age is a very unreliable indicator of state of health or mental or physical capacity of any individual." However, for the purposes of this piece of work we have defined older people as those over the age of 65 years with one or more health needs.

Urgent care: For the purposes of this review, we have defined urgent care as including care to treat conditions that are not emergencies and do not pose an immediate threat to life, but do require treatment within 24 hours.

Key principles of the Commission

Commission members drew up eight key principles to be used as a touchstone in any redesign of services, to ensure older people's needs and wishes were being met.

1. **We must always start with care driven by the person's needs and personal goals**. The health and social care system needs to move to a model that primarily considers the needs and personal goals of the person, then considers what care is required and works collaboratively to provide it. The Commission believes this is a fundamental principle that should be at the centre of all approaches to redesign care.

   A cornerstone of this should be involving the person in decisions about their care, whenever possible. Individuals and their carers should be treated as equal partners in conversations about care, using appropriate means of communication. The term 'integrated care' is frequently used to describe the structure of service providers, but to be meaningful it should instead be used to describe the provision of care that is coordinated around the needs of the individual.

2. **A greater focus on proactive care**. The current system often focuses on providing care reactively. The Commission believes the mindset of the care system needs to change from reacting in a crisis, to proactively planning to avoid one and to react appropriately if someone deteriorates. This will help support hospital services to meet the needs of those who really need the unique skills, expertise and environment of the acute sector.

3. **Acknowledge current strains on the system and allow time to think**. Local leaders need the space to build relationships and sustainable solutions to the challenges they face. The current regulatory approach tends to assume that overwhelming urgent care pressures result from poor management and lack of effective planning, and reacts by requiring inappropriate actions that do not address the underlying causes. This pressure on institutional leaders to implement short-term fixes can result in actions that will not resolve the problem in a sustainable way. While it is important to deliver quality care today, the national bodies need to avoid taking actions against single institutions that hinder the development of collaborative working at local system level. It is this collaborative working that has the potential to bring about longer-term and transformative solutions.

4. **Care coordination and navigation – recognise the importance of having a single connection within a complex system**. The Commission views a care coordination function as a crucial part of providing people with truly integrated urgent care. A care coordination team plays a key part in overcoming any barriers to a person getting the health and social care support they need. In order to be effective, this team must be able to influence how local providers work together at an individual level.

5. **Encourage greater use of multidisciplinary and multi-agency teams**. These teams could operate in both the hospital and the community, bringing together staff from different backgrounds. Where appropriate, they should encourage and support self-management by working with people and carers. For frail patients, there is evidence that a comprehensive geriatric assessment – underpinned by a multidisciplinary approach – leads to better outcomes.

6. **Ensure workforce, training and core skills reflect modern-day requirements**. A system that is focused on treating people in the right place for their needs is likely to require a different workforce than that in place today. The Commission believes much of the planning for this workforce should be done locally, working within national guidelines. Some new roles may emerge and additional skills – such as using improvement methodologies – will be needed. The skills and knowledge to assist people living with dementia will be needed by many staff, not just clinicians.

7. **Leadership should encourage us to do things differently**. Leaders who support staff to innovate and make a difference are needed to drive through change. Enabling leadership will help staff produce their own solutions, tailored to the needs of the person, and it will avoid putting unnecessary hurdles in the way of staff who want to innovate. It is essential if multidisciplinary teams are to be sufficiently empowered to work effectively in the interests of patients. Leaders will increasingly need to work collaboratively and across organisational boundaries if they are to spread learning, so that good ideas can be adopted at pace and scale.

8. **Metrics must truly reflect the care experience for older people**. Much of the data captured by the NHS at the moment is not attuned to the experience of the person or what matters most to them. Metrics that measure the effectiveness of a whole system would facilitate the development of a strong collaborative approach across the system, by creating common purpose and accountability for delivery of agreed outcomes. There is already work going on to look at what metrics should be considered in urgent and emergency care. The Commission would like to see this give a more joined-up picture of how the care system is performing and responding to people's needs.

Introduction

The Commission on Improving Urgent Care for Older People was launched by the NHS Confederation in March 2015. It brings together experts from across the care system, who have a shared purpose of making care better for older people.

The background to the Commission is the concerns of those working within or accessing a system that is increasingly ill adapted to the needs of older people and particularly those with long-term conditions and/or frailty.

These problems include:

- Older people being directed towards A&E inappropriately, because of a lack of alternative out-of-hospital services that might better suit their needs.

- Problems with how people move through hospitals and out again to their own home or other place of care. This issue of 'flow' has been identified as crucial if hospitals are to provide excellent care to older people. People need to have swift access to expert opinion, diagnostic services and then treatment before being given what help they need to return home when clinically appropriate. When this does not happen, hospitals' ability to provide good quality care for everyone – not just older people – can be undermined.

- Enormous variation in what services are available in different parts of the country and in the chances of being admitted to hospital or receiving re-ablement services after a hospital admission.

- Difficulties in putting social care packages in place for older people who need support at home after an admission. This can mean people stuck in hospital long after they are medically fit to leave. Longer hospitals stays are associated with a loss of physical condition, especially muscle mass, and independence.

- A lack of focus on the preventative measures and early intervention that could stop deterioration in quality of life for some older people, and reduce pressure on the health system. This was evident in the decision to cut public health money available to councils in the 2015 autumn budget.

- A system that concentrates on the medical model and does not fully acknowledge the wider aspects of an individual's life that contribute towards health and wellbeing. Social isolation has been linked with a higher risk of death.[2] Increasing social connections among older people may have benefits for the NHS as well as individuals.

- The growing number of people living with dementia. Within ten years, more than 1 million people in the UK will have dementia.[3] This group may find hospital admissions disorientating, while staff and others who come into contact with them may not realise how dementia is affecting them in that environment. For example, they are more likely to have acute confusion as a result of dementia. They can also have a particularly poor experience of hospital care.

- Older people in housing that does not meet their needs as they age and particularly as their mobility decreases. If their housing requires adaptations to enable them to return home after a hospital stay, this can lead to delays in discharging them (an average of 27 days[4]). Age UK has been campaigning[5] for new homes to meet accessibility standards, a greater range of housing suitable for older people, and for older people who come into contact with the health service to be offered assessments of their housing.

A lot of what is said about healthcare for older people can sound very negative. We need to stop presenting older people as a problem for the system and using labels like 'social admission' or 'bed blocker', and talk in terms of helping people live in an environment that is most appropriate for their needs and wishes. And we need to remember that many older people remain in good health and retain their much-valued independence. There is much to be celebrated in people living longer: the NHS needs to play its part in ensuring that these extra years are as healthy as possible.

When older people do need hospital or other healthcare, they should be able to access it. The Equality Act 2010 made it clear that older people deserve the same access to the full facilities of acute and urgent care as younger people. However, urgent care services need to be age-differentiated and

age-attuned to the specific needs of older people living with frailty, age-related disability, multiple long-term conditions or dementia. The NHS should ensure that once a person's acute treatment episode is over, they are able to access timely and effective rehabilitation care and support outside hospital and avoid prolonged and often hazardous stays.

The solutions to many of these problems already exist in health services within the UK but few health economies have them all in place, let alone at the scale required to make a big difference. We are still too slow to adopt proven innovation across the whole service instead of re-imagining how we do things. Generally, getting this right is a win-win for people and services.

Most older people want to remain well; to access rapid support in crisis; to get back to their own home from hospital and regain their independence quickly; and to ensure that when they do need acute care, it is dignified and person centred. Most health and care systems would aspire to the same goals. Getting these things right could also help to unlock our health and care system at a time of funding and performance pressures.

Why another commission?

There have been several authoritative reports looking at different aspects of care of older people:

- The HSJ Commission on Hospital Care for Older People[6]

- The Royal College of Physicians' Future Hospital Commission[7]

- The King's Fund report, *Making our health and care systems fit for an ageing population*[8]

A full list of resources that managers and clinicians may find useful can be found at the end of this report (see page 41).

They have contributed much to the debate and the Commission was keen not to replicate their work, but build on their findings. The Commission has concentrated on what is known about good care for older people, what can be implemented in today's care system, and what has been done around the

country that has brought measurable improvement in older people's care. From this we have sought to draw out a set of principles that could help others starting to redesign services for the medium and long-term future. We have chosen not to focus on end-of-life care as a separate subject within the report; we are looking at the totality of urgent care for older people. Much of what we are suggesting would be of relevance to how people are cared for towards the end of their lives.

The Commission has brought together experts of different backgrounds and experience; asked for submissions of good practice from across the care system; and visited a number of areas that have reshaped their services for older people. A review of evidence and academic work was carried out to guide the work of the Commission. Findings have been shared with both users and providers of services, to ensure they are viewed as appropriate by users and their carers, and deliverable in local systems.

When the Commission was established it set itself the following questions:

- What does an optimum urgent care service for older people look like?

- Which services should change and how will they operate?

- What new skills would be required from our health and care workforce?

- What needs to happen to ensure the acute sector can provide safe and timely care to those who require it?

- What is needed from other providers in the local health economy – particularly primary, community and social care?

- What are the implications of service changes for acute hospitals and the wider local health and social care economy?

- Why has shift from acute to wider community care been slow and variable, and how can progress be facilitated in the future?

- What factors have inhibited local NHS leadership from effectively implementing new urgent and emergency care services for older people, and how can they be overcome?

The Commission has tried to address these issues through a set of principles, based on the range of evidence it has been presented with.

They are intended to support frontline clinical leadership and involvement in care planning and design; effective care coordination for the individual; and community engagement and support that helps maintain independence.

The Commission took as its starting point the premise that good care begins with keeping older people as healthy as possible, and in their own home or normal place of residence. For 400,000 people this will be a care home.[9] The need to engage with care home staff and to meet the health and wellbeing needs of this cohort of older people was frequently mentioned in meetings of the Commission.

The Commission was also aware of the range covered by the term 'older people'. Many older people, especially those in their 60s or early 70s, will be in good health, perhaps with minor health problems that are well controlled. Encouraging healthy living – exercise, diet, giving up smoking and not drinking too much alcohol – remains important for this group. Prevention and health promotion are not just applicable to younger people but can help older people maintain good health for longer. Intervention in the early stages of a condition can also prevent later problems and ensure that quality of life is maintained, as far as possible.

Some older people will already have one or more conditions that will bring them into regular contact with the health and care system, probably through their GP, community healthcare team or outpatients department at their local acute trust. In many cases, the aim will be to ensure that any deterioration in their condition is planned for and managed, without the need for an emergency hospital admission through A&E. Maintaining social contact in the face of worsening health and the restrictions it can bring will be important for this group. The health service can play a part in encouraging support groups and social events for patients.

Those with multiple conditions and those who are identified as frail are likely to have regular and multiple contacts with the NHS and social care and are most at risk of unplanned admissions. Hospital admission may mean that, when their care is transferred back to their home or into the community, they need an enhanced care package or to move into

Care homes – a key part of the system

NHS engagement with care homes has traditionally been patchy. With 400,000 people across the UK living in this sector, the vast majority of them older people and, by definition, in need of care, this patient group's impact on the NHS can be huge.[10]

Giving care home staff the confidence to look after older people with complex conditions can improve residents' health and quality of life and prevent unnecessary and potentially distressing admissions to hospital. East and North Hertfordshire CCG, together with partner organisations Hertfordshire County Council and the Hertfordshire Care Providers Association, are focusing on what they can do together to make a positive difference to the area's 3,000 care home residents and the staff who care for them.

Closer working between care homes and GP practices is now well established, with a GP practice linked to each care home, making regular 'ward round' visits. A rapid response service staffed by multidisciplinary clinicians will be deployed to assist residents at risk of hospital admission within an hour, and care home staff are being equipped with the skills they need to put in place preventative health and wellbeing measures. Among the steps taken through the care home improvement vanguard programme is the payment of a premium for complex residents if care homes are able to provide them with an enhanced level of care.

residential care. Arranging either of these can mean delays in transfer of care, and immobilisation can lead to further physical decline.

Improving care for this group may reduce pressure on the acute sector and offer the NHS some savings, although evidence is often unclear on this. More importantly, it is likely to lead to a better quality of life for people. However, there is also much to be gained by maintaining the health and independence of those earlier on this journey.

It will need all players in the care system to work together to ensure that people have a better experience. They may want care to be centred on the home, if appropriate. If they do need to go to hospital, they need a system that is attuned to their needs and designed around them. In particular, the system needs to recognise that a significant proportion of very old people will have dementia or other mental health conditions, and ensure their needs are catered for.

What we know about existing urgent care for older people

- There is enormous variation – more than nine-fold between CCGs for rates of emergency hospital admission in the over 75s.[11] Variation between admission rates from nursing and care homes is even more significant – nearly 93-fold even after excluding outliers. Varying access to alternative health services may be part of the explanation for that.

- For many over-75s with multiple conditions and frailty, a quick response at points of crisis in their health can make a significant difference. The *NHS Atlas of Variation* suggests medical assessment within two hours, together with treatment, supportive care and rehabilitation, is associated with lower mortality, greater independence and reduced need for long-term care.

- The way in which older people access care in an emergency and then 'flow' through the hospital system is extremely important both for their experience and for the smooth operation of the hospital. For example, through diagnostics, wards, treatment and the return home. Where one part of this slows down – such as transfer of care from the acute sector – it can affect the whole hospital and adversely impact on those seeking care.

- Once admitted to hospital, older people can face a delay before they are discharged or their care transferred, even when they are medically fit to return home or to step-down care. Delayed transfers of care have increased significantly over the last few years. Some of these are due to difficulties in arranging social care packages, but the availability of non-acute care provided by the NHS is also important.[12] There is also increasing concern that social care providers – both of residential and home-based care – may exit the market. Many are facing a rising number of pressures including staff retention, rising wages and costs within constrained budgets. All of this makes it more difficult for people to return home with a package of care.

- The chances of being discharged from hospital into re-ablement or rehabilitation services also varies widely for the over-65s according to where they live.

- Intermediate care can have positive outcomes for many older people, but increasing waiting times for access suggests that capacity is insufficient. The National Audit of Intermediate Care in 2014[13] found that only 10 per cent of those discharged from the care of a crisis response team then required hospital admission.

The unique collection of skills and resources available in hospitals play a vital part in older people's healthcare. Hospital care and admission should not be seen as a failure when it is the best – sometimes the only – way to meet the clinical needs of the patient. Some older people will have acute and immediate needs that can only be met currently within the acute sector. A hospital admission may also be the best way to get a patient stabilised, essential nursing care provided, multiple tests completed, a diagnosis confirmed and a treatment plan devised.

However, some older people end up in A&E or a hospital bed because there are inadequate services elsewhere in the system, or because it is the 'always open' option. Health and social care services outside hospitals will need strengthening and investment to meet the needs of the growing older population – and to offer more viable alternatives to hospital admission. Where older people require services that are only available in hospital, admissions can sometimes be avoided by good organisation – allowing the patient to attend for the day and organising the tests around them. There are examples where this has worked well in the NHS, such as at Sheffield Teaching Hospitals Trust (see page 35).

When the Commission argues for better support outside hospital, it is arguing for the unique collection of services and skills found in the modern acute hospital to be used only for those who can most benefit from them. Increasingly, that requires an out-of-hospital service that supports people to remain in their own homes and communities where possible. Some of this support will address their non-healthcare needs.

"Health and social care services outside hospitals will need strengthening and investment to meet the needs of the growing older population – and to offer more viable alternatives to hospital admission."

The case for change

When the NHS was founded in 1948, 48 per cent of people died before they reached 65. Life expectancy was 71 for women and 65 for men. Services were designed around the needs of younger people, often with single diseases or short-lived episodes of illness – very different from today's NHS. In 2016, only 12 per cent of people die before 65. The fastest growing age group is the 'oldest old' – those over 85. At 65, a man can expect to live on average for 18 years and a woman for 20 years. By 2030, we will see an increase of 51 per cent in the population over 65 and 101 per cent in over 85s. Men at 65 will live until 88 on average, with women until 91.[14]

Figure 1: Morbidity (number of chronic conditions) by age group
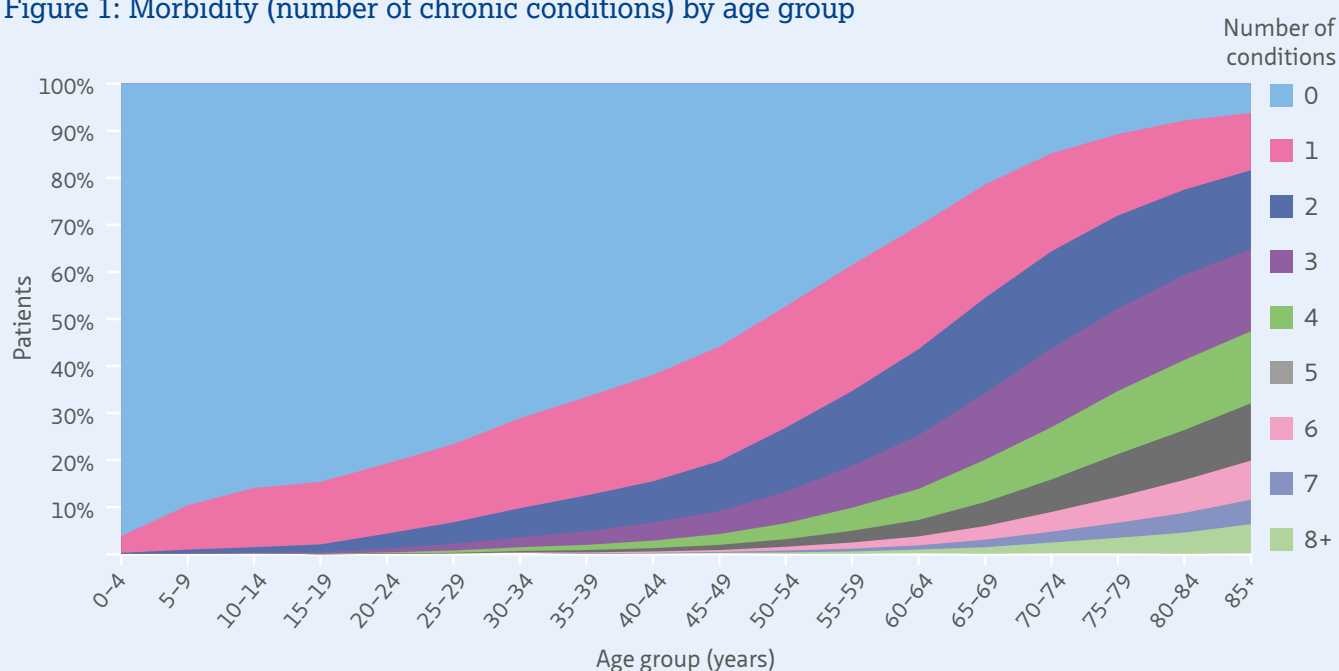
Source: Epidemiology of multimorbidity and implications for healthcare, research, and medical education: a cross-sectional study[15]

The facts

- Older people are high users of hospital services, accounting for 54 per cent of bed days and 40 per cent of day cases in England.[16]

- 1.5 million people in the UK are over 85.[17] This group needs a high level of health and social care input and is expected to nearly double by 2032. If they are admitted to hospital, this is more than twice as likely to be an emergency admission than for a younger person.[18] Their average length of stay after an emergency hospital admission is nearly twice the average of all ages, at 10.9 days.[19]

- By 2020, 7 million people in England aged over 60 are likely to have two or more long-term conditions.[20]

- Health and care expenditure for over-75s is many times higher than that for younger people – up to 13 times higher, according to some calculations.[21]

- In 2012/13, there were 2,211,228 emergency admissions to English hospitals of people over 60. The cost was £3.4 billion.[22]

- In 2013/14, there were nearly 3.7 million attendances at English A&Es by people over 65. Nearly 10 per cent of these involved those aged 90 or older.[23]

Health of the ageing population – upsides and downsides

The demographic shift represents a victory for public health, preventative and curative medicine, with death rates from big killers such as heart disease, stroke, respiratory disease and infection all falling dramatically over the previous century. But it does represent a game changer for our health services, including hospital care.

It would be wrong to characterise older age as a time of uniform poor health, dependency, vulnerability and isolation. In reality, well into older age, people rate their own happiness and wellbeing quite highly and most say they do not live with a life-limiting long-term condition. Many older people continue to contribute actively as unpaid carers (1.5 million of whom are themselves over 65); grandparents, volunteers or in paid employment. People can expect, on average, around a decade of healthy life expectancy at 65. Recent data suggests that, if anything, people are staying healthier for longer, though regional inequalities in healthy and absolute life expectancy persist. The people presenting

Figure 2: The average number of years that people live free of disability at age 65 in England, 2005–07 to 2009–11

Source: Office for National Statistics (2014)

frequently to acute care services could give us a very skewed view of older people as being in generally poor health and of high dependence.

Despite these gains in life expectancy, wellbeing, and the prevention and treatment of disease, older age does bring a variety of health problems.

a. Long-term medical conditions (LTCs)

Many documents and strategies about long-term conditions tend to discuss single conditions and often ones prevalent in mid-life as well as older age, such as diabetes or chronic obstructive airways disease. But many long-term conditions affect people in older age predominantly. These include incontinence, osteoporosis, Parkinson's disease and heart failure. With increasing age, people tend to live with multiple long-term conditions – for instance, those over 75 live with three on average. Multiple long-term conditions lead to multiple medications (polypharmacy), recognised as a frequent cause or complication of admission to hospital. Yet we have designed much of our primary and acute care system and evidence-based guidelines around single conditions in otherwise fitter and younger people. For people with multiple LTCs, or 'multi-morbidity', we need a very different style of medicine geared up around individuals' needs and not a medical model or disease-focused approach.

It is older people with multiple (often life-limiting) long-term conditions who account for an increasing proportion of acute care activity and A&E attendance.

b. Dementia

Dementia is increasingly prevalent with age, and it is estimated the number living with dementia in the UK is currently 850,000 – it will rise to over 1 million by 2025.[24] By the time we are over 80, around one in five women and one in six men live with dementia. This is increasingly reflected in the acute system. Around one in four beds in hospitals in England is occupied by someone with dementia, and on average they stay seven days longer than other patients. Around 40 per cent of all acutely admitted patients over 75 have dementia. The last few years have seen a major push to improve care for those affected by
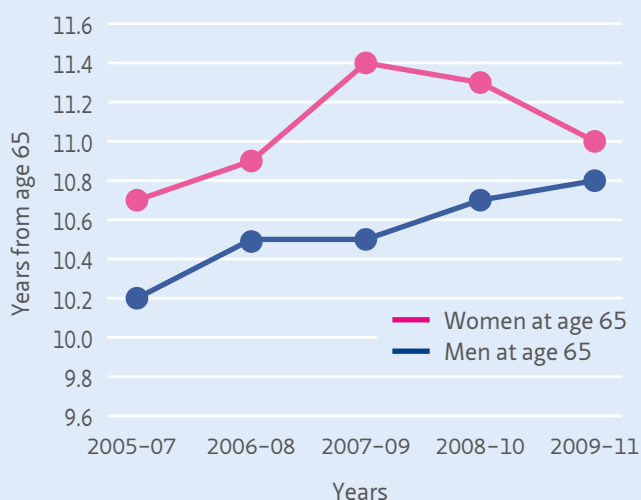
dementia, including the National Dementia Strategy, the Alzheimer's Society's *Fix dementia care*, the NHS Confederation's own *Acute awareness* report and Royal College of Psychiatrists' audit of dementia care in general hospitals. This has been further strengthened by initiatives such as the Dementia Action Alliance, dementia CQUIN, the Prime Minister's Dementia Challenge, and John's Campaign to ensure carers can remain in hospital with their loved ones. Yet still many complaints, incidents and harms of hospitalisation, as well as delayed transfers of care and recurrent readmissions, concern people living with dementia alongside their acute medical problems.

Figure 3: Distribution of long-term conditions by age of A&E attendee 2012/13, Focus on A&E attendances, QualityWatch
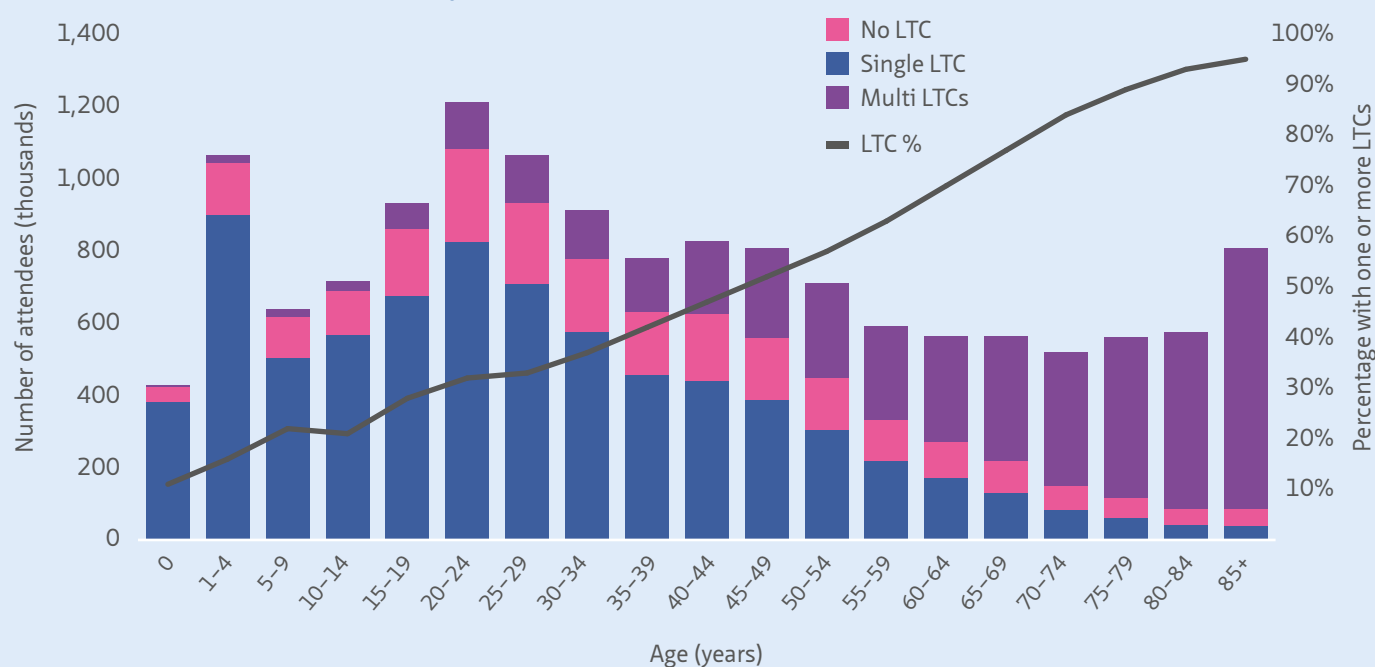
Source: Nuffield Trust and Health Foundation (2014)

Figure 4: Prevalence of dementia among males and females in England, 2014
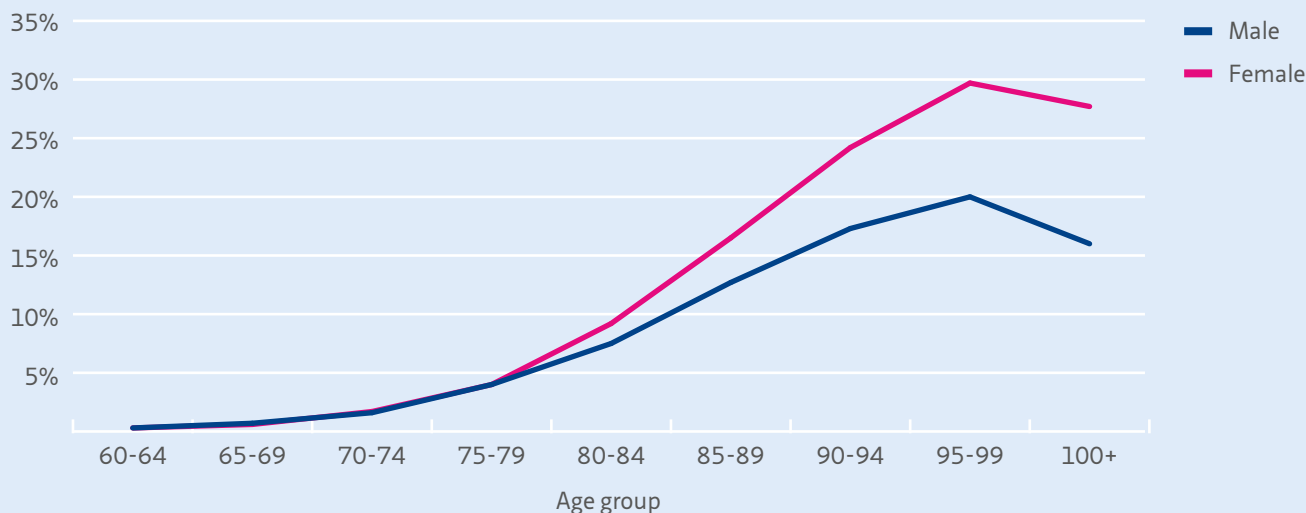
Source: Age UK and University of Exeter Medical School (2015)

c. Age-related disability

While most people retain independence well into older age, the older we are the more likely we are to become dependent for help in one or more common activities of daily living such as walking, washing, dressing or toileting.

Such disability is inevitably more common in people living with frailty, dementia or multiple LTCs and it has significant implications for how we organise acute services. In the face of acute illness or injury, older people already dependent will continue to need help. The disability may be compounded by visual or hearing impairment: 40 per cent of over 65s have significant hearing loss and 90 per cent of those registered partially sighted are over 75. Crucially, older people often lose functional independence during acute illness or during hospital admission, making adequate rehabilitation and re-ablement crucial aspects of good acute care for older people. Even ten days of bed rest can lead to a 14 per cent loss in muscle strength and a 10 per cent loss of aerobic fitness in someone over 80.

Figure 5: Percentage of study participants (n=615) requiring human assistance in each activity of daily living, at baseline, hospital admission, and hospital discharge
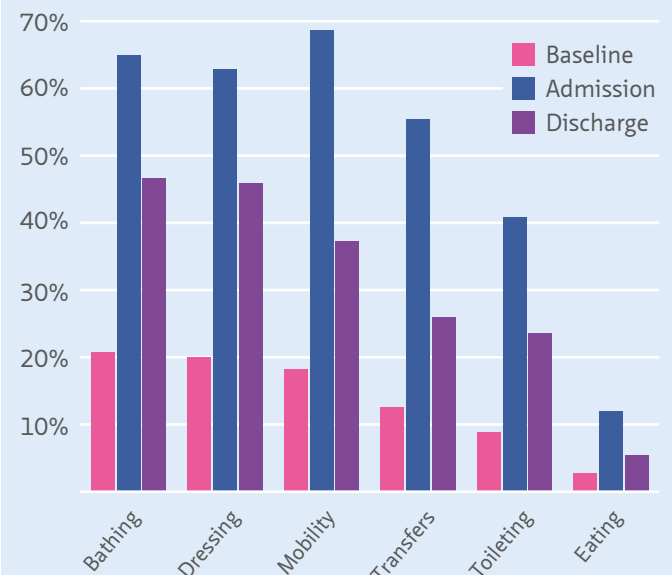
Source: University of Queensland School of Medicine and Royal Brisbane and Women's Hospital (2010)

Figure 6: Number of difficulties with activities of daily living by age, England 2012/13
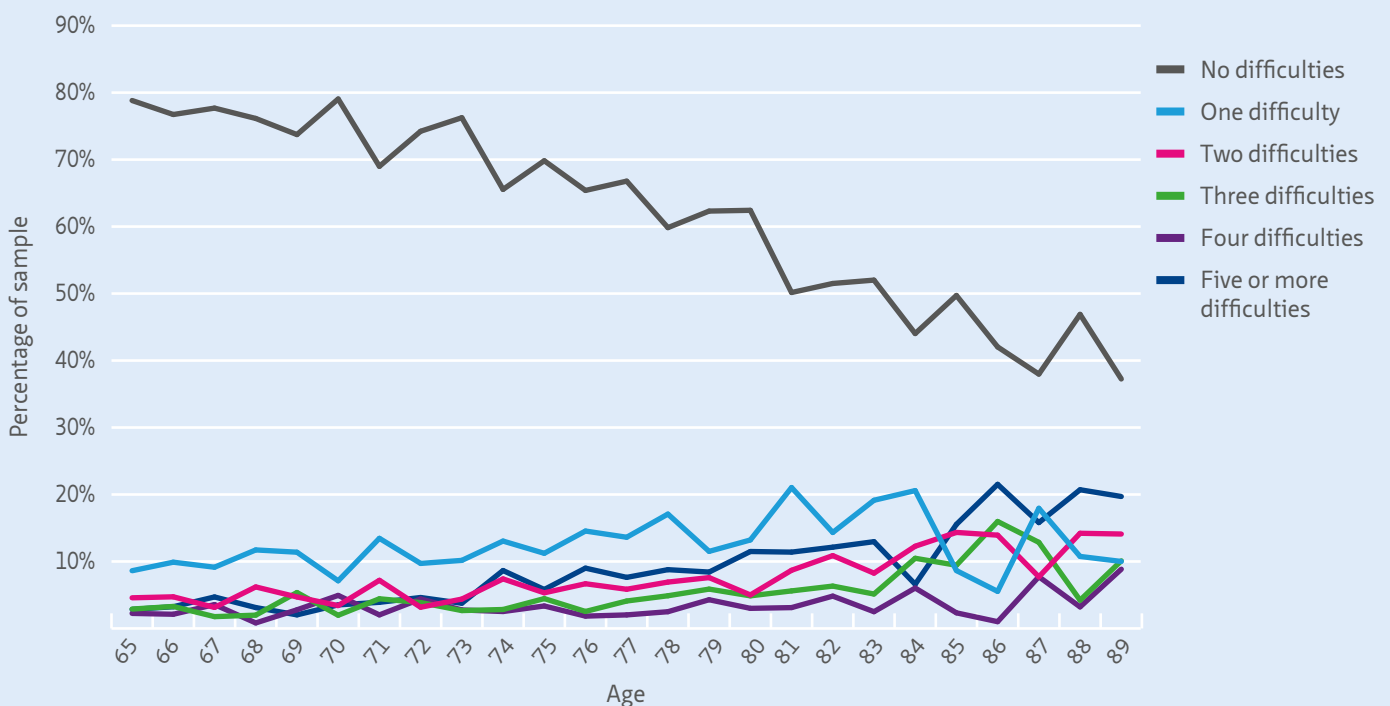
Source: English Longitudinal Study of Ageing (2014)

d. Frailty

To understand how we need to change urgent care services to meet the needs of our ageing population, it's crucial to understand frailty. NHS England estimates that around 7 per cent of people over 65 live with severe frailty. And it is frail older people who are most likely to use acute and urgent care services, and to be those very people who end up staying in hospital longer and suffering from harms of hospitalisation. Frailty is highly predictive of hospital admission, of death and of requiring nursing home care. It is crucial that we begin to see frailty as a long-term condition in its own right. In essence, people who are frail are those who have muscle weakness, fatigue easily, have slow walking speed, weight loss and who often have very little in reserve. These syndromes account for a large proportion of modern urgent care activity, with a minor illness often being the trigger. Frail older people are especially prone to complications of hospitalisation.

Crucially, they may present to acute care systems 'atypically'. It is also predominantly people with frailty who are care home residents and who require intermediate care services, social care support and end-of-life care.

Frailty syndromes (how people with frailty present to services)[25]

- Falls/collapse

- Immobility/worsening mobility

- Delirium ("acute confusion")

- Incontinence (new or worsening)

- Increased susceptibility to medication side effects, such as hypotension, delirium

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It is not just about healthcare

- 3.5 million people over 65 live alone already and this number is expected to rise.[26] 2 million people over 75 live alone.

- By 2018, it is estimated that there will be 7 million older people who can't walk up a flight of stairs without resting.[27]

- Falls, often in the home, are the single largest cause of emergency hospital admissions for older people[28], and impact on long-term outcomes. A falls prevention strategy could reduce the number of falls by 15-30 per cent.

- Cold homes lead to more hospital admissions and additional GP consultations. Age UK has calculated this costs £1.36 billion a year.[29]

- Many older people in Britain will struggle with the activities of everyday living but may have only informal support from friends and family, or no support at all. Others will have to pay for this support. The numbers receiving publicly-funded care has significantly reduced from 1.2 million in 2004/05 to under 900,000 in 2012/13.[30]

What does improving care for older people mean?

Improving care for older people means designing health and care services so that they are shaped and designed around the needs of the person. This will require the involvement of older people and their carers at all stages.

This can lead to better outcomes for individuals and will benefit the wider urgent and emergency care system, which is currently under severe pressure.

Older people receiving care are often depicted negatively or derogatively by the media and others as 'bed blockers', when in fact it is the system that is engineered badly and fails to meet their needs appropriately.

The Commission is clear that older people are not the problem. They are more likely to have complex health needs than the rest of the population and if we can get it right for them we can improve the system for everyone.

"Improving care for older people means designing health and care services so that they are shaped and designed around the needs of the person. This will require the involvement of older people and often their carers at all stages."

What should excellent urgent care for older people look like?

The Commission was very keen to provide a vision of what excellent urgent care should look like.

The commissioners heard about many areas that provide elements of excellent care, though no one health economy claims to have got all aspects in place.

- It should respect the wishes and goals of the individual and their carer(s).

- It should support medical and non-medical care in the most appropriate setting.

- It should use the right resources – clinical or social – to support the delivery of care.

- It should prevent escalation to any inappropriate services.

- It should seek to use the right alternatives to resolve a crisis as early as possible to avoid major disruption to a person's daily life.

- It should provide a clear plan for the individual of what the immediate and longer-term next steps are when acute care is required.

While many areas may have not achieved the full spectrum, this list provides a reference point of how the system could work to the greater benefit of people.

Putting the person at the heart of care

It is very easy to talk about older people as if they were homogenous. In reality, they will be as varied as any other group in society and will have their own preferences around care and desire for dignity. Designing efficient systems that recognise this will be a challenge for health and social care systems, but is vital if care is to be truly personalised. How each health or social care staff member – often working under tremendous pressure – treats the people they care for will have an impact on the person's overall experience of care in the system. And what is commonplace for staff can often be alien and bewildering for the person and their carers who do not experience it daily.

One way to raise awareness of this is through the Whose Shoes project. Gill Phillips, who had 30 years' experience of social care through working in local government, developed Whose Shoes to provide a reality check for professionals and encourage people to look at issues in health and social care from different perspectives. It allows participants to 'walk in other people's shoes' through a wide range of scenarios and topics. In particular, healthcare professionals and managers can put themselves in the shoes of patients and carers who are having to navigate what can be a complex system and access it at the right point. For example, A&E can be a bewildering experience for older people and their families, trying to understand what is happening to them and why. The regulations around payment for continuing healthcare needs is another example of a complex problem that many struggle to understand whether they – or those they care for – are eligible.

Whose Shoes also fits in with the personalisation agenda, encouraging everyone to recognise that the person is an individual. This can be particularly important for those living with dementia. Reminders of the life they have lived and their interests and preferences can be a powerful tool in improving empathy among those who care for them.

"A&E can be a bewildering experience for older people and their families, trying to understand what is happening to them and why."

Key principles

The members of the Commission spent much time drawing on their personal experiences and professional expertise, and discussing the lessons learned from site visits. They talked about what principles were important in the design of care for older people before deciding on these principles, which are numbered in order of importance. Members felt that any redesign of existing systems should use them as a touchstone to ensure that older people's needs and wishes were being met by the health and social care system.

① We must always start with care driven by the person's needs and personal goals

Putting the person's needs at the front of care planning was seen as the way to create a sustainable model of care that could rise above any structural changes over the next ten years. The Commission saw this as a fundamental principle that should be at the centre of all attempts to redesign care.

Older people will experience care as a whole, rather than seeing it as fitting within a health or social care silo, or being provided by different organisations. The health and social care system needs to start using language that reflects the patient's perspective. It requires a move to a model that considers the needs and personal goals of the person in the first place, then looks at what care is required and works collaboratively to provide it.

Because the needs of older people are often more complex, a new model needs to be built around them. This should not be constrained by organisational or sectoral boundaries: form needs to follow function. Older people and, where appropriate, their carers and legal guardians, need to be involved in the design of services at all points.

The term 'integrated care' is frequently used to describe the structure of service providers, but to be meaningful it should instead be used to describe the provision of care that is coordinated around the needs of the individual.

A cornerstone of this should be involving the person in decisions about their care, whenever possible. Individuals and their carers should be treated as equal partners in conversations about care, using appropriate means of communication. Individual care planning should contain escalation plans outlining what should happen if the older person's health deteriorates.

A willingness to discuss the risks of different options for care should be part of this.

Not all people want the same things. A new model needs to focus on flexibility and creativity, allowing professionals greater freedoms to implement decisions made in conjunction with the person and their carer, based on their needs rather than protocols.

There has already been good work done on this, such as by National Voices on person-centred care coordination, the NIHR Care Transitions project, HealthWatch's *Safely home* and the Royal Voluntary Service's *Going home alone*.

Giving people greater control over their health and wellbeing can have significant benefits for both the NHS and the individuals involved. People need to have the opportunity to co-create healthcare and support plans that allow them to manage their day-to-day living.

Some people will make choices that health and social care professionals feel are better for the individual, but which current systems don't allow to work in practice. This is clearly outlined by Pippa Kelly's story at the beginning of this report (see page 5). Professionals need to be more confident in supporting decisions that allow people to live according to their wishes, while explaining and mitigating any risks. An example of this might be supporting an older person to return home after a hospital admission through assessment of their ability to cope in their home environment and providing necessary equipment. Anecdotally, those assessed at home require less support than those assessed in hospital.

Professionals will recognise that these decisions often involve a trade-off between optimal medical care and the wishes of the individual. Breaking down barriers to allow an honest conversation and questioning about different options for care is important. Professionals will need support and training to develop confidence to make decisions that support people in living as they wish: they also need to know their decisions will be backed by their line managers, senior managers and boards.

② A greater focus on proactive care

As part of this shift towards joint responsibility, members of the Commission felt the mindset of the care system needed to change from reacting in a crisis to proactively planning to avoid one and to react appropriately if someone needs care. Many patient groups, charities and professional leaders are already saying this is the right way to go, for example, the BGS' *Fit for frailty*, the NHS England *Safe compassionate care and frailty* toolkit, as well as some of the other publications already mentioned or listed at the end of this report (see page 40).

A focus on wellbeing and, often, community support can help avoid an older person being admitted to hospital and preserve their independence in day-to-day living. There is a lot the NHS can learn from the fire service and the change it has made from focusing on saving lives in an emergency to helping prevent the emergency in the first place.

Slips, trips and falls are a frequent reason for a hospital admission among older people. Preventing accidental falls can reduce pressure on urgent care services as well as avoiding the loss of independence that frequently follows them in older people.

However, all of this will require action across a number of areas including environmental and health issues. It will require assessment of the risks of falling as well as looking into why an older person has fallen, and will link into areas such as providing appropriate housing for older people and providing adaptations when a need is identified, rather than after an incident has occurred.

Reducing the numbers of these avoidable injuries needs greater public education on making homes safer, and greater investment in a national strategy for falls and preventative care for older people.

There needs to be greater emphasis on assessments in the home, out-of-hours support from community and voluntary services to avoid unnecessary admission, and provision of the most appropriate care to enable older people to continue living in their home environment.

Westminster Falls Service

The Westminster Falls Service is a multidisciplinary team offering falls risk assessment and targeted intervention for people referred following a fall, or who are at risk of falling. The falls pathway enables the person to reach the recommended 50+ hours of strength and balance required to prevent falls in the long term. People who are assessed as high risk of a fall are reviewed by telephone. People followed up a year post-discharge reported a 60 per cent reduction of falls, 55 per cent fewer fractures, 92 per cent fewer A&E admissions, and an 80 per cent reduction in GP appointments compared to the year prior to intervention.[31]

Risk stratification can be helpful in identifying and targeting people who are at risk of developing an increased need for services. This has been used in some health economies such as Slough to identify the frailest individuals and seek to reduce emergency attendances and admissions. However, stratification is only useful if resources are available to provide effective care to prevent this happening.

The National Audit of Intermediate Care in both 2014 and 2015[32] showed the value of rapidly supportive community response teams in keeping people out of hospital.

Similarly, when in hospital there are a number of initiatives proven to help ensure an older person gets the responsive urgent care they need. For example, having a senior clinician at the 'front door' of the

hospital to provide an initial assessment of a person's care needs, and some elements of a comprehensive geriatric assessment (CGA)[33], means people can be admitted or enabled to return home as appropriate. A CGA is a diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances.

This can be done in an acute medical unit and means a person can be discharged without going to a ward if they do not require acute care. Similarly, if an older person is an inpatient, regular daily reviews by a consultant, a clear care plan, early access to multidisciplinary assessments, and discharge planning from the moment they are admitted will reduce the length of stay.

These are practical steps that, if spread throughout the health system, could make a real positive difference to both the individual receiving care and the acute system.

One of the challenges of change is that the whole NHS system is overstretched at the moment, facing the pressure of maintaining high-quality care while also coping with difficult financial conditions that are also affecting social care and the voluntary sectors. Transforming care while also coping with the day job of keeping services running will put considerable demands on many NHS organisations and individuals.

While financial resources for the NHS may have increased, and the recent spending review has indicated that there will be some front-weighting to help the NHS make changes, money remains tight. In part, this is because of increasing demand for NHS services, but budget cuts in social care have also contributed to the pressures that are causing many NHS providers to go into financial deficit. The NHS culture and funding systems are not helpful to achieving the aims of more coordinated and collaborative working and long-term sustainability. The approach to performance management is a flawed one, which assumes poor management

and lack of effective planning are to blame when organisations are overwhelmed by urgent care pressures, and reacts with the enforced requirement of inappropriate actions that are short-term focused and which do not address the longer-term challenges.

Local leaders need to be given the space to build relationships and devise sustainable solutions. Requiring them to produce quick fixes to meet short-term imperatives is likely to fail to meet the needs of people accessing the service, and it frustrates and alienates staff.

Oxford Terrace and Rawling Road Medical Group, Gateshead

Around 2,500 people registered with the practice were identified as being at higher risk of hospital admission. The practice was aware that it needed to take a different approach with this group and has introduced a number of initiatives, such as establishing practice health champions to offer community support and social interaction with other people, including many who are older. Activities can be purely social, such as tea dances, but can also have an educational element such as talks on fire safety.

Primary care coordinators also work with individual people and their carers, guiding them to sources of help and support. They will proactively contact vulnerable patients who have had a hospital admission. Another strand of the work has included employing an occupational therapist who visits patients in their own homes as well as supporting other staff.

③ Acknowledge current strains on the system and allow time to think

No one working in the care system at the moment can fail to be aware of the severe pressure on all parts of it. Whether it is care homes struggling to recruit the right staff to cope with the increasing dependency of some residents, or A&E departments under pressure on the four-hour target, services are facing challenges to provide high-quality care in a financially strained system.

Within the NHS, the centrally-driven performance culture puts pressure on single institutions to resolve performance shortfalls quickly, and this can lead to an inappropriate short-term response that stifles the sort of coordinated and partnership working that is necessary if services are to transform for the better. This ultimately disempowers the individual receiving care.

The system tends to assume poor management is to blame for a lack of effective planning and then reacts with inappropriate actions that do not address the longer-term problems. Many national bodies speak of greater freedoms to devise local solutions but it is important this is backed up by the actions of regulators and regional teams.

To overcome some of the current issues, the Commission believes it is important for local leaders to be given the space to build relationships, and consider and devise new and sustainable solutions. This will require a different approach to performance management, in which the need for a new approach to solving the problems is recognised, acknowledged and supported.

There are some positive signs of a greater realisation of the need and barriers to change. The Five Year Forward View sets out a vision of an NHS that operates quite differently. The vanguard projects are already starting to put this into practice, developing closer links between different parts of the system, including health, social and voluntary sectors, and putting the person at the centre. However, widespread transformation will need both funding – a need which was only partially recognised in the autumn statement – and space to develop these new models and ways of working. One of the major challenges for the immediate term will be delivering change at the necessary pace and scale, and there are many barriers to that.

"The Five Year Forward View sets out a vision of an NHS that operates quite differently. The vanguard projects are already starting to put this into practice, developing closer links between different parts of the system, including health, social and voluntary sectors, and putting the person at the centre."

4 Care coordination and navigation – recognise the importance of having a single connection within a complex system

Navigating the health and social care system is a challenge even for those who know it well. For many older people and their carers, it can be a challenge too far.

One of the key recommendations of the Commission is the development of a care coordination function to give people a single point of contact with the health and, ideally, the social care system to ensure the right decisions are made to suit their needs. Care coordination has a crucial role in integrating and influencing the care pathway in the best interests of the individual. It can recognise the holistic needs of the person. For example, by 'prescribing' social interaction through a support group or social activities, as well as supporting them through the health and social care system.

Care coordination should be given the recognition it deserves in order to redress the balance in the relationship between the person receiving care and those delivering it. High-level support is vital if care coordination is to be a driver towards a more coordinated approach that transcends organisational boundaries. It should not be seen as a purely administrative function, but should be influential in the way care is delivered, and should be able to identify and remedy barriers to providing the care that the patient wants. For example, care coordination teams should be able to get involved if transfer of care is being delayed, and attempt to resolve any issues.

Many older people may only need a care coordinator sporadically, at times when they come into greater contact with the NHS such as deterioration in their condition or a hospital admission. Involvement will need to be flexible enough to be intensified and relaxed according to their needs.

It is likely that a team of care coordinators would fulfil this function for an older patient, rather than one person. Shared information within this group of staff is therefore vital so that an individual's case can be seamlessly picked up by any team member. The care coordinator is, in effect, the integrator of care for the individual.

Age UK Pathfinders project

Care coordination and navigation does not have to be an NHS function. In Cornwall, Age UK staff members or trained volunteers fulfil a coordination role for older people identified as being at risk of hospital admission. As well as working with NHS staff on a care plan designed to keep people out of hospital, they look at the individual's social needs, and the goals that the person identifies as most important for them.

This wraparound care will then involve aspects such as social activities, benefits advice and home help. Typically this phase will last three months, with the older person then being encouraged to take the lead around their own care. They can remain in touch with their care coordinator. A shared care plan is regularly reviewed by a multidisciplinary team based in primary care. This project has run since 2012 and was adopted as one of the government's integrated care pioneers. The scheme has been developed over the last few years and now operates in nine sites with 4,000 people in total. Early evaluation shows a significant increase in wellbeing, a 31 per cent reduction in all hospital admissions and a 26 per cent reduction in non-elective hospital admissions.[34]

⑤ Encourage greater use of multidisciplinary and multi-agency teams

Older people's care could be enhanced by greater use of multidisciplinary teams in both hospitals and the community, bringing together staff from different backgrounds to contribute to decisions and break down barriers. There can be benefits for staff around upskilling by working in this way.

The view of the Commission is that these teams should be set up within identifiable community locations in order to encourage consistency across all parts of the system, and allowing smoother transfers of care between secondary care and home. The Commission does not intend to be prescriptive about the size or geography of such teams, or where the team is located, as local systems are best placed to determine this themselves.

When the Commission sought the views of a group of care service users, they suggested that the local GP surgery would be an effective base, as these are readily accessible and could offer a one-stop facility. However, the area covered would need to be big enough to support a team where individual members had specialist skills, while being small enough to enable staff to function as a team. In some areas, this might point towards a team covering 30,000 to 50,000 people, although this may depend on the number of older people in the area with high levels of need. The exact make-up of a multidisciplinary team should also be determined locally, but it is important that the views of general practice, social care, community pharmacy and mental health should be represented. As well as medical, nursing and allied health professions, they could benefit from access to medicines management expertise and palliative specialists.

These teams should be accessible to patients at all times, but with an emphasis on supporting self-management and self-care where appropriate, using technology as an enabler and proactively maintaining health. Some people's ability to self-care will be affected if they have high levels of cognitive impairment, and they will require more input. Individual care planning would be key and the team would also support people after discharge from hospital. There should be a route into medical or more advanced nursing care, when necessary, with close links to GPs and other members of the primary and community care teams in the area served by the team. The potential benefits include consistency across all parts of the system, smoother transfers of care between secondary care and home, and encouraging a more effective way of coordinating the sharing of information with different agencies. These teams will need an understanding of the wider system they are working within, given the role they are likely to play in step-down care and the diverse needs of patients – not all of which will be medical. Crucially, they must be able to influence providers and direct services so that they are coordinated and provide for the needs of each individual.

One of the ways that multidisciplinary teams can make a difference is through the development of a CGA. There is a body of evidence that frail patients benefit from a CGA[35] when they present to hospital with acute problems.

An effective CGA will result in a holistic plan for treatment, rehabilitation, support and long-term follow up. It is associated with people being more likely to be alive and in their own home a year later (meta-analysis of 22 trials, covering 10,000 patients[36]). Multidisciplinary CGAs have helped to transform stroke and hip fracture care in many areas, and the multidisciplinary team approach is vital to ensure patients move smoothly through hospitals and that they can return home or move onto a lower level of care as soon as possible. The National Intermediate Care Audit in 2014 and 2015 showed that multidisciplinary teams were linked to better outcomes and a better chance of keeping patients at home.[37] Within hospitals, offering rapid access one-stop clinics bringing together diagnostics, therapeutic services and medical and nursing expertise can avoid some admissions – although many acutely unwell older people will still need admission.

6 Ensure workforce, training and core skills reflect modern-day requirements

The Commission envisages a system that is much more focused on treating people in the right place to meet their needs, rather than resorting to hospital admission as the default option. This will require new skills from the workforce and its leaders. The changing demographics of the country have not yet been fully reflected in current planning.

Members of the Commission believe much of this workforce planning would be better done locally but working within a national set of principles. Local education and training boards, CCGs and care providers in each area are best placed to establish the right numbers of staff groups and the core common skills needed. The needs of the independent care sector – a big employer of nurses and healthcare assistants – should also be considered in workforce planning to ensure that the right staff are available to deliver care across the health and social care system.

These skills are likely to be different from those needed in the past. The requirement for closer working across teams, organisations and sectors such as local authorities and the voluntary sector, and the increased numbers of older people needing care, will require highly developed skills around planning and coordinating care.

Some new roles could emerge, for example more generic support workers, carrying out both health and social care tasks, or the growth of community geriatricians bringing expertise into the community that used to be only available through the acute sector. The new nursing associate role may also be important in providing aspects of care. But such planning should not just be about the doctors and nurses model – important though they are in older people's care – it should also include allied health professions and social care. Allied health professionals have a critical role to play in new models of care and are important in re-ablement and supporting older people to return home.

Local systems will need to equip their workforce to plan and deliver care across large teams and organisations, with an emphasis on self-governing teams. Education will be needed around the roles and functions of all parts of the system if care is to be planned effectively. Skills that underpin good planning and delivery, such as project management or capacity and flow management, are sometimes assumed to be in place without any training. More needs to be done to ensure staff have access to training to enhance the skills they already bring to the role. Other skills that need to be taught are those associated with working in an empowered and self-governing team.

Some of the most successful systems we saw had used improvement methodologies to analyse where the problems in their urgent care system lay, introduce a different approach, and measure the difference this made. In some cases, these methodologies were used by staff at all levels, who were motivated and encouraged to drive improvements: this was particularly impressive. Data was often used to drive this change, rather than passive monitoring of the system.

NHS systems should reflect on where these skills are available in their workforce and whether key staff involved in older people's care need training in them.

"More needs to be done to ensure staff have access to training to enhance the skills they already bring to the role. Other skills that need to be taught are those associated with working in an empowered and self-governing team."

Skills for multidisciplinary and multi-agency team members

- Working as members of empowered and self-determined teams.

- Understanding the specific needs of older people.

- Care coordinating and working across organisational boundaries.

- Advocacy and care coordination in complex systems.

Skills for the broader healthcare workforce

Many of the healthcare staff with whom older people come into contact won't be specialists in their care, but their interactions with them will still be important. This can be as true of a receptionist or porter trying to deal with a person who is distressed, as it is of a consultant or nurse. All people who come into contact with older people in care settings need access to training to help them understand their care needs and sensitivities. Communication skills are an important part of this.

Skills for staff working with people with dementia

People with dementia, in particular, will benefit if those around them have an understanding of their condition and its impact on behaviour and emotional state, especially when they are outside their normal environment. Some hospitals have given hundreds of staff – including many non-clinical staff who come into contact with patients – basic training in dementia awareness. One in six people over 80 have dementia, according to the Alzheimer's Society[38], and one in four acute hospital beds will be occupied by someone with dementia. If those caring for them, whether they are healthcare professionals or the porter or cleaner, don't understand the impact of dementia on them or are not equipped with the skills to help them, the individual's experience of care will not be as good as it could be.

NELFT and LAS

Older people who have a fall at home are often taken straight to the A&E department of a local hospital. This may start a cascade of care that ends in them being admitted and sometimes remaining in hospital for some time. A new initiative in east London, involving the North East London Foundation Trust and the London Ambulance Service NHS Trust, is changing that. Older people who fall, but don't appear to have a fractured neck of femur, are assessed at home by a nurse and a paramedic. This comprehensive assessment can last two hours and means, if appropriate, they can then be cared for at home. The team carries some simple equipment that can assist in this, such as walking frames, and can also arrange for the delivery of more complex equipment, a community nursing team to come in or a social care package to be started. The scheme has successfully avoided admissions – around 70 per cent of those seen in the first third of 2015/16 were kept at home. Of those remaining at home, only a small proportion have subsequently needed hospital admission within the next 48 hours – this was normally triggered by abnormal blood tests. This suggests the right people are being kept at home.

"All people who come into contact with older people in care settings need access to training to help them understand their care needs and sensitivities."

(7) Leadership should encourage us to do things differently

Many of the services we saw on site visits had been improved by heroic leaders going above and beyond to improve care. This often involved navigating the complexities of the system and bringing people together to look at how the system could be changed for the better.

This can be made more effective when those individuals are supported and enabled by senior managers and leaders. Leadership is not just about those at the top of single organisations. There is increasing recognition of the need for collaborative leadership and leadership at different levels between organisations. Examples include the Advancing Quality Alliance's (AQuA) Integrated Care Discovering Communities.[39]

We saw great examples of leaders quietly encouraging and supporting frontline staff to make changes that might have been seen as too risky in other systems, but were achievable with proper safeguards. Leaders can use relationships to create a system that enables staff to do the right thing for the people they care for. They can encourage an environment where staff and the people they care for have meaningful conversations about the option of taking on more responsibility for their own health. This enabling leadership style avoids putting unnecessary hurdles in the way of staff who want to innovate, and is essential if enabled multidisciplinary teams are to work effectively for the people in their care.

This needs to happen across the system and, crucially, one of the most important characteristics of leaders is likely to be the ability to work and influence outside their own organisation, linked to a willingness to share learning more widely. Many great NHS initiatives never get beyond the pilot stage. It will take ambition and bravery to do things at scale.

Sheffield Teaching Hospitals NHS Foundation Trust

One of the common themes running through our site visits was the enthusiasm of frontline staff to identify and bring about improvements in patient care or experience. Very often it was the experience of one particular patient that prompted them to make changes that then impacted on a whole group of patients.

In many cases, staff at all different levels had been trained to use an improvement methodology and were able to use this to guide small changes and then refine these to make further improvements. The support of senior managers in their organisations was an important factor in their success. Working in a culture that encouraged staff engagement, involvement and innovation was key.

In Sheffield, for example, teams caring for older people realised that the traditional method of assessing medically fit patients for discharge home could often lead to longer-than-necessary lengths of stay in hospital, and also a higher level of home support, than was actually required.

The Sheffield team decided to turn things on their head and, instead of determining fitness to return home by assessing patients in the artificial surrounds of the hospital environment, they trialled assessing patients in the more familiar surroundings of their own home.

In the beginning, with the support of senior clinicians and managers, a single patient was assessed in their own home. The assessment showed that the person was able to remain living independently at home and also needed a lower care package than expected. The concept of discharge to assess (D2A) was born. The new way of working has been gradually rolled out and more than 7,000 patients have been assessed on discharge using the new active recovery service over the last year. Patient satisfaction has been high and results show people have been discharged home when medically fit in an average of 1.1 days, compared with 5.5 days three years ago – a saving of more than 30,000 bed days and higher quality of patient experience.

8 Metrics must truly reflect the care experience for older people

The NHS collects a lot of data, though it is arguable that not all of it is the right data. Data needed to assess performance against relatively crude targets such as waiting times may not reflect the experience of the person or what they would identify as important to them.

The Commission would like to see a new set of metrics developed that measure what matters to people and their carers, across the whole system, rather than looking at just one organisation or department within it.

A balanced scorecard reflecting waiting times, patient experience, staff satisfaction, and outcomes would give a much broader picture of how services and care systems are performing and responding to people's needs.

Metrics that measure the effectiveness of a whole system would also facilitate the development of a strong collaborative approach across the system, by creating common purpose and accountability for delivery of agreed outcomes.

NHS England is working with staff and service users on what metrics should be considered as part of its urgent and emergency care review. We hope the focus on metrics that give a more rounded and measured value of the care delivered to the person will continue throughout their journey, from a GP or hospital, right through to the care home.

"The Commission would like to see a new set of metrics developed that measure what matters to people and their carers, across the whole system, rather than looking at just one organisation or department within it."

Improving urgent care for older people – the fundamental elements

The Commission recognises there are a number of fundamental elements that underpin good care for older people and ought to be borne in mind when any changes are being made.

Care driven by the individual should deliver a tailored, not a standard, response

The organisation of urgent care services for older people must be based on the needs and personal goals of the individual if they are to work effectively. Empowering the person receiving care will require a change in the relationship between the individual and professional, and a willingness on the part of organisations to be driven by the decisions that are taken. An essential element of this is a full understanding of the goals and ambitions of the individual, which allows good decision-making. It will also require processes to enable this to happen, particularly in periods of transition.

Multidisciplinary teams should be seen as key to care planning, organisation and delivery

Service provision should be based on a multidisciplinary and multi-agency team approach, situated mainly within the community, accessible at all times, and enabled and empowered to take decisions at local level and flex the approach in accordance with individual need.

Training and skills development should be fit for current and future needs

We must think beyond the traditional skills in the planning and delivery of care, given the needs for greater working across teams, organisations and sectors, and larger numbers of older people requiring care. Working in empowered teams, leading and overseeing such teams, understanding the specific needs of older people and acting as an advocate are all skills that need to be taught, developed and supported. This should happen from initial professional training right through an individual's career.

The acute sector's role should be viewed as important and integral, at the right time

The NHS needs the acute sector to be available for the patients who need it, when they need it. It is usually the only setting that can meet all the needs of acutely unwell older people, many of whom will require admission.

Nothing in this report should be read as downplaying the importance of the acute sector for the people who need it, or the priority given to ensuring that people get the best treatment while they are in an acute hospital. Ensuring people are diagnosed, treated and care is transferred in a timely manner is also crucial for the sustainability of hospitals.

The best acute centres use an approach based on engaged staff, strong links with the wider local care system, proven improvement methodologies, partnership working, and training for staff on the particular needs of older people in order to provide the most appropriate care.

The acute sector has a vital role to play in sharing its skills and knowledge – and potentially personnel – with other parts of the system.

A longer-term view must be taken into account

The current pressures on all parts of the system must be acknowledged and measures taken to ensure that leaders are encouraged and supported to focus on generating longer-term, sustainable improvement through collaboration with other agencies.

We must measure what matters to people

A new set of metrics should be implemented to reflect the experience of individuals and show how the whole system is working for them.

What the evidence tells us

As part of its work, the Commission commissioned a literature review on what is known to work in improving older people's urgent care. The full document[40] accompanies this report and is available at **www.nhsconfed.org/commission** – here are some key points.

- There is no explicit consensus on what the term 'urgent care' means.

- There is limited evidence relating specifically to urgent care for older people.

- There is a lack of an evidence base to improve learning and share best practice.

- What work has been done focuses on admissions avoidance and discharge with little focus on prevention.

- There is awareness of the challenge of getting the right skill mix to deliver older people's care well and to build the right multidisciplinary team.

- There is limited acknowledgement of the role that community services and social care play in effective urgent care.

- It is important to raise awareness among professionals of the particular challenges around meeting the needs of older people.

- Professionals need to be responsive to the needs of older people with multiple conditions and/or complex social situations, and the benefits of multi-agency and inter-professional responses.

Making it happen – putting the recommendations into practice and what next for the Commission

This report is not the end for the Commission. Its aim of providing practical help for its membership and partners right across the care system will be carried forward in a number of ways.

Building up online resources on the NHS Confederation website
- Continually updated case study library containing Commission submissions and best practice examples.

- Multimedia content, including interviews with healthcare leaders and professionals, and older people and carers.

- Updates on relevant news.

Peer-to-peer learning/training resources
- Webinars focused on national and international case studies.

- A range of site visits across the UK, bringing people together from across the system.

Stakeholder engagement
- Including with government, parliamentarians and national stakeholders to help influence policy in the interests of older people, NHS leaders and staff.

Events
- National and local events, including a strong focus on the Commission's work during the NHS Confederation annual conference in June 2016.

Site visits and case studies

As part of this project, the Commission visited a range of urgent care systems spanning acute and primary care, voluntary sector and local government partners and commissioners.

These site visits formed part of the Commission's work to develop evidence-based solutions to the challenges of caring for older people.

"The service costs are shared between LAS and the community treatment team. It is typically seeing more than 100 people a month, with 70 per cent of those seen in the first third of 2015/16 being kept at home."

North East London Foundation Trust and London Ambulance Service NHS Trust

Older people who fall at home frequently end up in A&E departments and may be admitted. In some cases this is unnecessary, but alternative services are not available or can't be mobilised quickly.

In one part of London, community nurses from North East London Foundation Trust (NELFT) and paramedics from London Ambulance Service (LAS) are providing a home-based emergency assessment and treatment service for people who fall, avoiding the need for many of them to go to A&E. This is linked into community teams and also social care, allowing care packages to be increased in the aftermath of a fall. It also works with a telecare provider whose staff may be alerted if a patient falls.

The mobile team covering Barking, Dagenham, Havering and Redbridge operates from 7am to 7pm seven days a week. This has been identified as the key time for falls, with a peak in the morning. LAS control room staff identify appropriate cases for them to attend. In addition, the team can select other suitable cases by looking at all the calls in the area. It has recently introduced a laptop in the car to enable this to be done while mobile.

A patient who meets the criteria for the scheme will be visited by the 'k466' rapid response vehicle, staffed by a paramedic and a nurse. They will carry out a comprehensive assessment, lasting up to two hours.

The team has immediate access to some simple equipment to enable patients to remain at home. This includes commodes and walking frames, as well as replacement parts for walking sticks and frames. In one case, the team dismantled a bed and set it up downstairs, which meant the patient could remain at home safely.

The service costs are shared between LAS and the community treatment team. It is typically seeing more than 100 people a month, with 70 per cent of those seen in the first third of 2015/16 being kept at home. Overall, it has saved around £108,000 through avoiding ambulance trips, A&E assessments and admission.

Only around 5 per cent of people seen and kept at home have been admitted to hospital within the following 48 hours. This has mainly been because of abnormal blood results. There is also some evidence that a high proportion of patients who are taken to A&E after being seen by the team are then admitted to hospital, suggesting they are taking the right decisions about people.

The service is likely to work best in an urban area, where travel times between calls are low. The skillset of staff is important – former A&E nurses, for example, will be used to dealing with and closing wounds that other staff might want to refer into hospital.

Key elements for success
- Buy-in from staff has been important. This has included ideas from the staff on the ground, but also includes telephone support from senior doctors where necessary.

- Joint working between LAS and the community team has grown with the scheme but is constantly reinforced through visits to the LAS control centre by team members. Greater knowledge of the services among call handlers has boosted referrals and LAS ambulance crews have confidence in the team's judgements.

- Technology has helped the service to be more efficient and effective. This has included using Skype-style technology to discuss difficult cases in real time and an electronic directory of local services (including non-public telephone numbers), as well as the British National Formulary, a pharmaceutical reference book.

Lessons learned
- The criteria for the service has changed since it started – most importantly, it has moved from over 75s to over 60s. This increased referrals and gave a critical mass for the service. However, it stopped seeing all fallers, as those with hip pain would need hospital assessment for fracture.

- Good working relations with social service teams are important where people need social care support to remain at home. Generally it is easier and quicker to get an existing care package increased than a new one started.

“Buy-in from staff has been important. This has included ideas from the staff on the ground, but also includes telephone support from senior doctors where necessary.”

South Western Ambulance Service Foundation Trust

For many older people whose health suddenly deteriorates, the ambulance service or NHS 111 will be their point of entry to the health service. Getting the right response from this initial contact can determine their path through the NHS.

South Western Ambulance Service provides emergency, NHS 111, a single-point-of-access team (SPOA) and GP out-of-hours across much of its geographical area. It has two regional hubs, which house staff providing all these services who can coordinate responses and share expertise. A pool of GPs and nurses work across all services and move between teams. This can improve continuity of care.

The SPOA will problem solve and find the right service for a person, including checking what beds are available across the system. The team will also speak to healthcare professionals. Having this system enables gaps in provision to be identified and then fed back to commissioners. Running the GP out-of-hours service too gives an additional option when dealing with callers, and being co-located means the GP can have input into 999 and NHS 111 calls as well, when appropriate.

There are also links into intermediate and community care, including a rapid response team run by Care UK. This has enabled the trust to limit the number of people taken to A&E.

Key elements for success

- Barriers between the services have been broken down. In the case of the hubs, almost literally. This means a caller can be passed between services seamlessly, without having to wait for a callback or for formal handoff.

- There are good relationships with both commissioners and providers. The ambulance service has been able to showcase its work, which is inspiring other parts of the health and social care economy to respond.

- Information flow enables, for example, ambulance crews to have up-to-date information about the person they are seeing and to add to patient records.

- The trust has invested in staff training to enable them to work in these new ways. This has included work with a local university around nurse practitioners, pathway training for call advisers and new training modules.

Lessons learned

- Recruitment can still be a challenge. Paramedics, in particular, are in short supply nationally. Other parts of the care system locally can have problems attracting staff and this may impact on their ability to respond to patient needs. Social care may face problems with the national living wage. Budget pressures may also have an impact.

- It can be difficult to get all parts of the system engaged around the clock. In an ideal world, people could be provided with social care and mental health support quickly, whatever the time of day. In practice, there can still be difficulties arranging this in a timely manner.

Sheffield Teaching Hospitals NHS Foundation Trust

Five years ago Sheffield Teaching Hospitals, like many hospitals, had a problem. Older people, admitted as an emergency, were spending a considerable length of time waiting to be discharged once they were medically fit to leave hospital.

After spending time listening to people and examining the traditional ways of working, the Sheffield team, which comprised a multidisciplinary group of clinicians and non-clinicians, realised they could make a significant change to the length of stay for older people while also improving their experience and care.

The teams caring for older people were challenged by the traditional method of assessing medically fit patients for discharge home, which could often lead to longer lengths of stay in hospital than necessary and also a predicted higher level of home support than was actually required.

The Sheffield team, with involvement from service users, decided to turn things on their head and instead of determining fitness to return home by assessing patients in the artificial surrounds of the hospital environment, they trialled assessing patients in the more familiar surroundings of their own home. The aim is to assess the patient at home within a day of the decision that they are medically fit to discharge.

As the starting point for change, a single medically fit patient was taken home and assessed in their own home by a physiotherapist. The patient's bed was kept available in case their care needs could not be met at home in real time. The patient in fact proved to be very confident in their own home and the visit ended up with the patient making the physiotherapist a cup of tea.

This patient and many more showed that assessment in familiar surroundings proved a useful way of judging how they would cope on discharge. In general, it showed people needed a lower level of support at home than staff would have expected from seeing them in hospital. The process was iteratively refined and expanded, and discharge to assess (D2A) has now been rolled out further in the trust. Readmission rates have not been affected and the number of patient falls has reduced in the group

of patients who were assessed at home, because patients are less likely to fall in their own home. Shorter stays mean they are also less likely to get hospital-acquired infection.

Patient satisfaction has been high and, in the past year in Sheffield, more than 7,000 older patients have been discharged home in an average of 1.1 days compared with 5.5 days three years ago – a saving of over 30,000 bed days and a higher quality of patient experience.

Key elements for success
- Enthusiasm of key members of staff.

- The gathering of data and examination of process. Data together with patient stories are most powerful.

- Change that is best owned by staff working together with their patients, supported by senior managers and clinicians.

- PDSA (Plan-Do-Study-Act) cycles used repeatedly to change and refine systems.

- Sheffield Teaching Hospitals is vertically integrated, and is co-terminous with both the city council and the city's single CCG.

- A can-do attitude allowed changes to be made to long-existing pathways and ways of working, without needless obstacles being put in the way. Staff were supported by managers and senior clinicians.

Lessons learned
- The changes have been a continuous process, with ongoing refinements rather than a one-off 'big bang'. Several years into the project, there are still weekly improvement meetings where problems are discussed and changes proposed.

- Relatives and carers can sometimes be concerned about early discharge and need reassurance that the person is both fit to be discharged and that any care package will be in place.

- There are complex staff management implications of some of these changes, such as nurses and consultant geriatricians all changing their job plans on one day. This worked because they had all been involved in the PDSA testing cycle and could see the benefits for patients.

Royal Berkshire Hospital NHS Foundation Trust

Ensuring older patients are seen by a senior doctor and discharged or care is transferred as soon as possible are two elements of a comprehensive approach to improving patient flow at Royal Berkshire Hospital.

Older people coming in through A&E will be met by geriatricians and will have access to an acute frail unit from 8am to 8pm seven days a week. A number of specialists will proactively visit the patient without waiting for a referral from other clinicians. Occupational therapists are available until 9pm and a multidisciplinary meeting each day will run through every patient. An afternoon huddle will also discuss patients who might be candidates for discharge from the acute sector that day.

This 'assessment at the front door' aims to ensure patients who can safely return home do so and that others will be seen, assessed and treated swiftly, reducing length of stay. The geriatrician on duty ensures that those that are acutely ill are seen quickly and a 12-hour limit on this is written into job plans.

A rapid assessment service sees GP referrals and GPs can ring up consultants to discuss cases, which can avoid some admissions. There are strong links into the community, with outreach to care homes and home visits for GPs.

This model of working has evolved over time. Change has been incremental, is often revisited and revised, and is very much led by staff working with older patients.

The trust has also trained 1,000 staff a year in caring for patients with mental health issues. These have included porters and security staff, and the trust has seen a fall in safety incidents. Money from the Prime Minister's dementia fund has been used to redesign wards and an older people's mental health team is based at the site but employed by the mental health trust.

If people are admitted, the aim is to get them home swiftly and appropriately. This means identifying patients who can be discharged early each day and putting plans in place, with an early afternoon meeting to update. A special team identifies people who have become stuck in the system and tries to overcome obstacles. For example, obstacles to rapid discharge of medically fit people.

The trust works in a complex health and social care economy with five separate social care systems, a number of small CCGs and also community and mental health providers. Engagement with all of these has been challenging and means different approaches sometimes need to be used for people from different areas, such as around intermediate care.

Key points
- This is a trust working in a complex local health economy with five local authorities (each with their own social care system) and a number of CCGs. Finding solutions has been complicated by this as the level of services varies between different areas.

- The approach has extended beyond A&E doctors to include, for example, oncologists and respiratory medicine specialists who will be expected to come to the patient and offer their input. But it has remained staff led and the impetus to change has come from staff saying that the systems were unsustainable and needed to change.

Lessons learned
- Change has been incremental rather than big bang. Small changes have been tried and refined, although there was no specific formal change methodology adopted.

- The trust does not have an acute frailty unit but it ensures that patients who are frail get the same package of care they would in a unit. It has not felt the need to rebadge.

- The solution for all of the problems is not in the hospital's gift. It has focused on the elements it can influence, such as patient flow, but support from partners is crucial to make progress on other parts. Small problems can have big consequences. For example, it can take up to two days to get 'nomad' packs of medicines from high street pharmacies for patients who are discharged from the acute sector.

Oxford Terrace and Rawling Road Medical Group, Gateshead

The traditional model of short appointments with GPs can make it difficult to meet the increasingly complex needs of many patients, especially when these needs are wider than simply clinical ones.

The Oxford Terrace and Rawling Road Medical Group in Gateshead has introduced a range of initiatives to help people, especially those with complex needs and/or dementia. While these have been in response to people's needs, they are also helping lessen pressure on the acute system by reducing avoidable admissions.

The initiatives

- Primary care navigators provide support for frail and older patients with other care needs. They work with both patients and carers (including care homes), to guide them to sources of help and support. Working within the complex care team, they deal with patient queries, prescription and home visits queries, and contact vulnerable patients or those who have been recently discharged from hospital. They work as healthcare assistants every second week, which helps them to identify patients and carers who may benefit from the service. The service has led to a significant increase in the number of patients being screened for dementia, given a dementia assessment, and has reportedly led to a reduction in avoidable admissions.

- A practice-based occupational therapist has been recruited, using readmissions funding from NHS England. The occupational therapist works with the complex care needs team, providing advice about referral criteria and taking the leading role in providing the care for some patients.

- Practice health champions are volunteers who offer a form of community support and social interaction to other patients, especially those who are older. They have organised activities ranging from tea dances to a talk from the fire brigade about home safety. A long-term conditions forum has been set up to provide feedback for the practice.

- Specialist older persons' care nurses are co-located in the practice but funded by the local acute trust. They are linked to four care homes but their role involves other local residential and nursing homes.

Key points

- The whole system needs to be working at the same level, with organisations willing to support each other. For example, the practice supported local pharmacies around electronic prescribing.

- A good relationship with the CCG is crucial. The CCG has worked with the practice and other organisations to encourage them to apply for transformation funding, and there has been a high level of engagement. But, in turn, the practice has ensured that it is measuring the impact of changes.

- The right culture and ethos is absolutely key, with the practice being encouraged to experiment and take risks. Staff within the practice can suggest how care could be improved.

- Robust governance and decision-making underpins innovation, for example with clinical supervision.

Lessons learned

- Initiatives led organically from one another and were often driven by the desire to remove waste from GP and nurse time to create more capacity.

- Sometimes the evidence to support change is not yet available but the patient need can provide a starting point. Waiting for evidence could delay making changes that respond to need.

- Look outside the regular avenues for resources and funding. Newcastle University funded a tea dance in return for the opportunity to carry out research on patient feedback.

- Community resilience and self-care is important. The practice champions show what people can achieve for themselves. Patient-run support groups build up relationships and an ethos of self-help that could reduce demand for GP services.

Age UK in Cornwall – The Pathfinders project

This integrated care project started in Cornwall, bringing together members of a multidisciplinary team including an Age UK staff member or trained volunteer who acts as coordinator. Working with patients, they draw up a care plan aimed at keeping the person healthy and out of hospital. This can include medical elements such as falls prevention, but also attention to the social needs of the patient. The scheme has been developed over the last few years and now operates in nine sites with 4,000 people participating in total. Evaluation shows a significant increase in wellbeing, a 31 per cent reduction in all hospital admissions and a 26 per cent reduction in non-elective hospital admissions.

Age UK contributed a small amount of money, which acted as a catalyst. Setting up the schemes involved gathering data and presenting it to all the organisations involved. It was important that organisations all felt they gained from the schemes. However, the coordinator role was crucial, acting as a mixture of advocate and navigator.

"The scheme has been developed over the last few years and now operates in nine sites with 4,000 people participating in total. Evaluation shows a significant increase in wellbeing, a 31 per cent reduction in all hospital admissions and a 26 per cent reduction in non-elective hospital admissions."

East and North Herts CCG

People living in care homes are likely to be heavy users of emergency and urgent care. Care home residents are generally older and live with more health complaints and conditions than the general population. Historically, NHS engagement with care homes has been patchy at best, and residents can find it difficult to access the same range of expert treatment that most of us take for granted. Frailty, medication errors and a lack of confidence about dealing with specific conditions are all contributing factors that result in care home residents being heavy users of emergency and urgent care.

In 2013/14 in the East and North Hertfordshire CCG area, there were 1,744 admissions to hospitals from care homes with 454 of these resulting in a stay of less than 24 hours. Care home residents over 65 were three times more likely to go to hospital than those who lived at home.

However, the key role that confident, well-trained and expertly supported care home staff can play in providing high-quality care to frail older people is increasingly being recognised. East and North Herts CCG is working closely with partner organisations Hertfordshire County Council and the Hertfordshire Care Providers Association to offer more effective early intervention and support to the people living in the 92 care homes in its area. Staff champions in a number of homes have already received up to 18 days training in one of six specialist areas, including:

- dementia
- nutrition
- engagement and wellbeing
- falls and fragility
- wound management
- health, including end-of-life, continence, neurological and respiratory conditions.

Care homes can be eligible for a £70-a-week patient premium if they care for people with more complex needs who meet strict criteria, as long as those homes can meet the required staff training standards. This money can be used to buy resources to further support service users, towards the cost of additional staff training, or to pay enhancements to improve staff retention.

In addition, the vanguard project promotes good health by:

- supporting all homes with multidisciplinary teams of health experts, including dieticians, geriatricians, pharmacists, mental health professionals, doctors and nurses

- providing a rapid response team of clinicians to assist residents in failing health within 60 minutes of a call

- giving GPs mobile access to comprehensive information about each patient during their visits.

GP practices in East and North Hertfordshire are also aligned with particular care homes, promoting better relationships between GPs, care practitioners, patients and family carers.

A history of successful partnership working and funding (including some Better Care Fund money) has enabled this partnership approach to healthcare delivery to be developed. The CCG is also a vanguard site, although much of the ongoing improvement work started before this was set up. Being part of the vanguard scheme means that East and North Hertfordshire is benefiting from national support and investment, as well as learning from other schemes further afield, such as the area of telehealth.

Although it is early days for the project, there are already some emerging signs that the new approach is benefiting care home residents, aiding recruitment in the care sector and leading to less demand on the rest of the NHS.

"There are already some tentative signs that the new approach is benefiting care home residents, aiding recruitment in the care sector and leading to less demand on the rest of the NHS."

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Further reading

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Acknowledgements

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