NHS
North West Surrey
Clinical Commissioning Group

Health and social care needs assessment

Frail older people in North West Surrey CCG

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2. Executive summary

2.1 Background and aim

The North West Surrey (NWS) population is growing and ageing. In the context of increasing costs, reducing budgets, and this growing elderly population, the NWS health and social care needs to change. In NWS Clinical Commissioning Group (CCG), a frailty pathway is therefore being developed. The aim of this needs assessment was to provide the evidence base for the development of the frailty pathway for frail elderly people in NWS.

2.2 Aim and methods

The needs assessment used a CCG agreed definition for frail elderly people which includes people aged 75 with diagnosed frailty symptoms, people living in nursing and residential care homes, people suffering from dementia, Parkinson's disease, MS and people in the last phase of life.

A range of (population) data sources were used to collate data on the needs of frail elderly people. Two mapping exercise were undertaken with input from social care, community services, GPs and CCG commissioners.

2.3 Main findings

National data on 'what frail elderly people want' showed that frail elderly people are interested in how to live their lives, not in health or social care services. They value their independence, and what matters to them is to maximise the activities they can still undertake.

The estimated current number of frail elderly people across NWS is 10,000 people; this will increase to 11,500 in 2018. This means that services for frail elderly people, if implemented fully, should have capacity for 10,000 people and that capacity should be increased in the next years.

The needs assessment described the specific needs of frail elderly, including factors impacting on their health and relevant conditions. One important factor of (mental) health is loneliness; it is estimated that up to half of people aged 85+ feel lonely regularly. In addition to long term conditions such as diabetes and cancer, neurological conditionals and mental health problems should be considered. Also it is important to take into sensory impairments into account; many elderly people in NWS are either (partially) deaf or blind which impacts on their ability to interact with services.

Mapping of current services showed that NWS is home to a wide range of services for frail elderly people, provided by the NHS, social care and the voluntary sector. The conclusion from the mapping exercise is that the landscape of NWS services in the community is currently too complex. It is not possible to fully oversee and understand who does what, and how services relate to each other. An important objective of the design of the frailty pathway must therefore be to reduce complexity in the community services. This is supported by the literature.

Last, the needs assessment showed there that a wide range of evidence and guidance relating to the development of better community services and integrated care is available. To date there is limited evidence that integrated care initiatives reduce costs; the focus should be at improving quality of care through implementing interventions that have shown to be effective elsewhere. It takes time to plan and implement large scale service change; any changes should be carefully defined and there should be a clear understanding of how the service change will lead to improved outcomes. Evaluation should be carefully planned and not start too early; new service models need time to embed before they can show results.

2.4 Recommendations

Based on the data collated in this needs assessment, the following recommendations were made:

Re the design of the frailty pathway:

- Plan the current frailty pathway to address the needs of frail elderly 10,000 people in NWS, and 11,500 in 2018.

- Ask frail elderly people in NWS what they want from health and social care, and how they experience current care and support. Involve them in the development of the frailty pathway.

- Use data included in this needs assessment on specific needs and risk factors of frail elderly people to make sure that services meet their needs.

- Involve front line staff (for instance community matrons) in the development of any new pathway; they know what NWS people need and they have direct insight into what works and what does not work.

- Following the design of the frailty pathway, widely advertise the availability of services and ensure there is one portal of services that patients and professionals (across health, social care and the voluntary sector) can access.

Re commissioning services in the pathway:

- Focus on reducing complexity of community services in NWS; identify which current services add value and decommission services that don't. Assess whether current services need more capacity to improve access to and effectiveness of these services.

- Assess the skill set and size of the existing NWS community workforce and consider training professionals in other professional's skills to create responsive, efficient community teams.

- Ensure that development of other CCG programmes, specifically the dementia programme, are closely linked.

- Use the King's Fund recommendations on NHS community services to develop NWS community services. Strive to make the community system simpler and avoid adding multiple initiatives to the already complex list of community services.

Re the use of evidence:

- Implement interventions for which there is evidence of effectiveness. In particular, consider implementing the seven evidence based interventions for supporting people living with frailty from David Oliver's report.

- Use the experience of previous integrated care initiatives in the design of integrated care for frail elderly people. In particular, carefully define what the programme should achieve, how and for whom, and ensure sufficient resources for implementation. Evaluation should be carefully planned and only start after the programme has had its start-up time and is truly running.

3. Background

The CCG NWS is responsible for planning and contracting healthcare for the 357,000 people living in its area. A number of developments in this population are taking place in parallel:

- The NWS population is growing, which mean that the CCG needs to plan for a higher demand on healthcare in the future.
- The NWS population is ageing; a higher proportion of the population will be older. As older people tend to require more healthcare than people of working age this will also increase the demand on healthcare. We know, for instance, that 80% of the emergency admissions who stay for more than two weeks in hospital are aged 65 and older (1). We also know that of those admitted to hospital for a condition that should normally be managed in primary care ('ambulatory care-sensitive conditions', *ACSC*s) over 30% were by people aged 75 and older (2).
- It has been suggested that in roughly half of all bed days (i.e. a day spent in hospital by one person) an alternative setting would have been more appropriate and potentially cheaper (1).
- As a result of complex interacting factors in society, including changes to the way we live, the design of our environment and progress in healthcare technology, more people now have chronic illnesses and will live longer with these illness than previous generations. It is estimated that 70% of the total health and care spend in England is currently spent on caring for people with long term conditions (3).
- The available NHS budget will not increase; a constant focus on cost reduction and efficiency is therefore required.
- The local government budgets have been reduced and will continue to be reduced: in the next 5 years Surrey County Council (SCC) will have to reduce spending by 200m over the next 5 years whilst demand for social services for older people is increasing (4).
- Funding from SCC and the CCG services will be pooled in the NWS Better Care Fund. The aim of this programme is to provide integrated health and social care in the community through joint commissioning of services for vulnerable people. The fund is required to include funding for protection of social services (i.e. to cushion the savings on social care) and for implementation of the Care Act 2015.

The above factors mean that the CCG needs to lead changes in the system – across the traditional boundaries of health care and social care - to better support our older residents. These changes are required not only to improve the health of older people, but also to make sure there remains enough budget to provide the required care and support for the general population. Every pound can only be spent once.

Second, we need to invest in the care and support of older people because we know that the current system does not serve them well: older people are at higher risk from adverse outcomes of being admitted to healthcare facilities such as medication errors and pressure ulcers (5) .

The changes to the system should meet the needs of the older population, as expressed by the older population. We know that the perceived needs of people (for instance the needs as perceived by their doctor) can differ substantially from the actual needs (6).

In April 2014, the CCG started the development of its 'frailty programme' to address these needs. The aim of this needs assessment is to support the development of this programme by providing evidence on needs, current service provision and best practice.

This needs assessment will focus primarily on frail older people aged 75 and older. A locally agreed definition of our frail 'cohort' of people will be used.

3.1 NHS NW Surrey CCG context

The purpose of the CCG is to enable the 357,000 people in NWS to enjoy the best possible health through planning and contracting of appropriate care and support from provider organisations[a].

The CCG has five strategic objectives and has recently developed a five year strategic commissioning plan (SCP). It includes six change programmes that will cover healthcare for all residents. One of these programmes is the frailty programme[b], which has the following aim:

"To support frail older people to live at home healthily, safely and happily for as long as possible"

The frailty programme is aligned closely to the strategic objectives of the CCG (Table 1).

Table 1: alignment of frailty programme with strategic objectives

CCG strategic objectives	How the frailty programme will contribute
1. To increase length of life and prevent people from dying prematurely	Healthy ageing and management of chronic illness will contribute to increasing the healthy life expectancy
2. To improve quality of life and promote independence	Healthy ageing, support close to home in crisis and good management of chronic illness and end of life will improve quality of life and independence.
3. Optimise the integration, quality and effectiveness of services	The frailty programme will be developed as an integrated range of services across health and social care
4. Help people recover from ill-health	Support close to home will ensure that frail people recover quickly and safely after illness.
5. Target spend for greatest gain and eliminate waste	The frailty programme will support a change from spending in acute care to integrated care in the community.

This needs assessment is written to support the development of the frailty programme, but three other SCP programmes are also highly relevant for implementation of the frailty programme:

- The Integrated Care programme: this programme aims to design coordinated out-of-hospital services for NWS patients, and particularly for vulnerable patients including frail elderly people. The (emerging) model of care will include NWS 'locality hubs' to provide services to this cohort of patients.
- The unplanned care programme: its aim is to provide unplanned care to people in hospital and to support people to access care in the community where possible
- The Targeted Communities programme: its aim is to prevent illness (primary prevention), reduce health inequalities and identify disease early (secondary prevention).

[a] Taken from the CCG website, http://www.nwsurreyccg.nhs.uk/what-we-do/pages/home.aspx
[b] From 1 August 2014, the frailty programme will be incorporated into a new programme called Integrated Care programme.

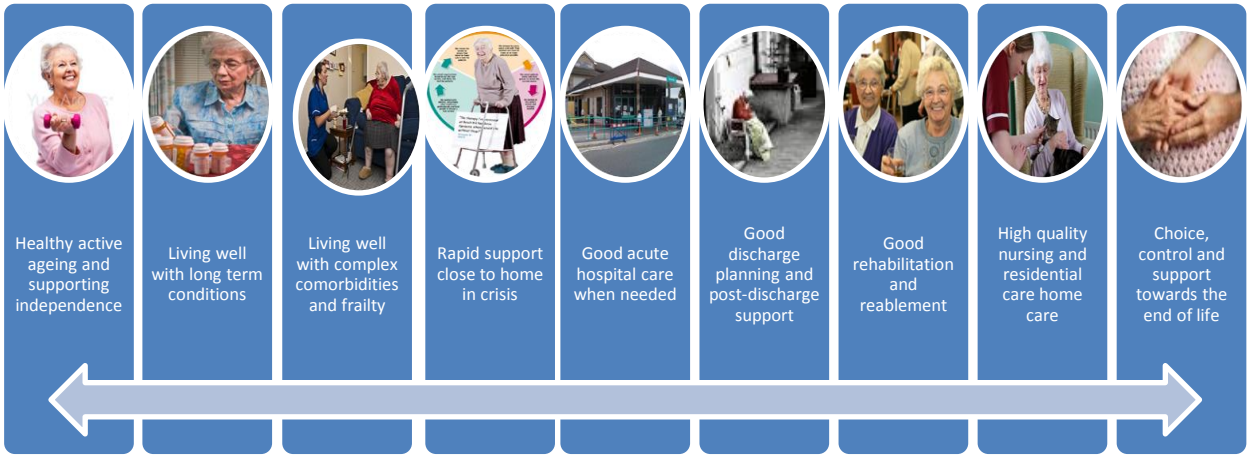
3.2 Policy context

3.2.1 National policy context

In the past years a large number of national policies, laws and strategies have been published regarding support and care for older people and redesign of the health social care system, including:

- Our Health, Our Care, Our Say (2006)
- The National Carers Strategy (2008) and "Recognised, Valued and supported: Next steps for the Carers Strategy" (Nov 2010), followed by 'NHS England's Commitment to Carers'(2014)
- The End of Life strategy (2008)
- The National Dementia Strategy (2009)
- Shaping the Future of Care Together (2009)
- Health and Social Care Act (2012)
- The Better Care Fund programme (2013), see under 3.2.2.

Recently, NHS England has published guidance about commissioning an integrated care pathway for frail, older people (5). The document recommends that an integrated care pathway for frail older people should cover nine areas of service provision:



The national NHS Outcomes Framework 2014 / 2015 (7) and the Public Health Outcomes Framework 2013 - 2016 (8) include outcomes that the NHS and Public Health organisations should improve for the population. The integrated care pathway described above is designed to meet the outcomes of the NHS Outcomes strategy.

A number of the outcomes in the Frameworks are specific to the health of older people and to management of long term conditions.

Table 2 shows the most relevant outcomes to be achieved for frail elderly people with their corresponding outcome indicator that organisations should use to measure progress against. Please note that some outcome indicators are shared across the NHS and Public Health (in *italic* in the table).

Table 2: relevant outcomes from the NHS and Public Health outcomes framework

Outcome from NHS Outcomes Framework 2014 / 2015	**Outcome from public Health Outcomes Framework 2013 - 2016**
Life expectancy at 75 (indicator 1B)	Health-related quality of life for older people (indicator 4.13)
Ensuring people feel supported to manage their condition (indicator 2.1)	
Reducing time spent in hospital by people with long-term conditions (indicator 2.3)	Objective 2: people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities. This includes indicators relating to smoking, alcohol, diet and self-reported wellbeing.
Enhancing quality of life for people with dementia (indicator 2.6)	Estimated diagnosis rate for people with dementia (indicator 4.16) Estimated diagnosis rate for people with dementia (indicator 4.16)
Emergency readmissions within 30 days of discharge from hospital (indicator 3B)	*Emergency readmissions within 30 days of discharge from hospital (indicator 4.11)*
Improving recovery from fragility fractures (indicator 3.5)	Hip fractures in people aged 65 and over (indicator 4.14)
Helping older people to recover their independence after illness or injury (indicator 3.6)	Injuries due to falls in people aged 65 (indicator 2.24)
Improving the experience of care for people at the end of their lives (indicator 4.6)	
Improving people's experience of integrated care (indicator 4.9)	
Reducing the incidence of avoidable harm (indicators 5.1 – 5.4)	
	Excess winter deaths (indicator 4.15)

In addition an Adult and Social Care Outcomes Framework 2014 / 2015 has been published (9). It has four overarching outcomes:

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

Last, a new Care Act was passed by Parliament 2014; the Act will come into effect in April 2015. This is the biggest change in care law in 60 years; the Act has replaced multiple outdated acts and for the first time in UK history there is now one Act about social care provision. The reforms on funding will take effect from April 2016 (10).

The Surrey County Council have published some clear documents and a video that explains about the Care Act and the implications for Surrey residents (11) (10).

Some of the key areas of change within the Act are:

- Councils will have a duty to promote people's wellbeing and to focus on prevention
- A new set of national eligibility criteria for care and support will be introduced (to reduce unfairness)
- New rights to support for carers; they will have the same right to support as the people they care for
- People will have a legal right to a personal budget and direct payment.
- The Act will require local authorities to provide clear advice and guidance for both carers and those with support needs, irrespective of whether the Council will pay for their care.

From April 2016 major funding reforms to the way that social care is funded will come into effect, including:

- A lifetime 'cap' of no more than £72,000 for individuals on reasonable care costs to meet their eligible needs. This cap will not include general living costs in residential care (this could be set at £12,000 per year)
- An increase in the capital threshold for people in residential care who still own their own home to £118,000 (including the value of the home and savings). The capital threshold for people not owing their own home will be £27,000 (12).

In Surrey, a number of the provisions of the Care Act are already in place. For instance, the Council provides carers' personal budget, people are supported to use personal budgets and deferred payments are already possible (i.e. paying for care after one' death by selling the person's house). However, details about certain regulations and implementation have not been published yet so the precise impacts of the new Act on Surrey residents are unclear yet. In particular it is foreseen that the combination of the new cap, the separation of the general living costs in residential care and the rise in the capital eligibility threshold for residential care will have a significant impact on the care market in Surrey.

3.2.2 Local policy context

The Surrey Joint Strategic Needs Assessment (JSNA) (13) makes the following recommendations for commissioning services for older people:

- Support older people in exercising choice and control through personalised care and self-directed support
- Specifically improve services for dementia
- Develop equality of access to health and social care services for older people
- Commission or support the development of preventative services, which will improve the quality of life of older people, maximize their independence and deliver value for money in adult social care and health services.

At a Surrey level there is a wide range of existing policies relevant to the health and wellbeing of older residents (Appendix A). What they have in common is their aim of respecting older people's choices, supporting them to stay in the usual place of residence for as long as possible (rather than in residential care) and to offer choice of services and support.

One major national policy development is the establishment of the Better Care Fund (BCF) which is a pooled fund between SCC and the six Surrey CCGs. Both the NHS and SCC will contribute existing funding to this pooled fund. The aim of the Fund is to transform local care and support by integrating health and social care services at a local level. The BCF will come into effect in 2015 - 2016[c]; many services for frail elderly patients will be jointly commissioned by the CCG and SCC. The (emerging) plans include a variety of improvement programmes such 'Mission 90' (aimed at NWS prevention) and an Integrated Frailty Pathway (mostly to be delivered through the locality hubs, see under 3.1).

NHS NWS CCG and SCC have agreed to use their share of the BCF to support the following three key elements[d]:

- An Integrated Urgent Care Pathway: Focused on ensuring an effective and timely response when people need an urgent or emergency service, that flow through the whole system is optimised at all times, and that people are returned to their normal place of residence, with appropriate support where required, as quickly as effective care allows. We will streamline urgent and emergency services.

[c] A smaller 'pilot' BCF started in 2014-2015 nut this served mainly to develop the fund for 2015-2016.
[d] As submitted to NHS England in the CCGs' Strategic Commissioning Plan on 14 February 2014

- An integrated Frailty Pathway: Focused on ensuring older and more vulnerable people receive (i) proactive support to keep them independent and well in their own place of residence (ii) responsive care that delivers timely interventions when required to avoid the need for urgent or emergency care and (iii) support for people at end of life.
- Three integrated Locality Hubs: Focused on delivering equivalence in the out of hospital environment and ensuring both care practitioners and the public have as much confidence in out of hospital services as in hospital care. Over the next five years our ambition is to invert care provision so that significantly more of our resources are invested proportionately in the out of hospital environment instead of in hospital care.

3.3 Rationale for the needs assessment

'Commissioning' for NHS NWS CCG is the process of planning and purchasing of health care services (and increasingly also social care services through the BCF) to meet the health needs of the NWS population. It is often thought that this simply means 'paying for the right healthcare' but the process is more complex and – importantly – continuous.

Figure 1 shows this process, illustrated by the commissioning cycle. It shows that commissioning should start by planning services. Important questions to be answered are:

- What are the needs of the population?
- What services do we already have that meet those needs?
- Are the services sufficient and how many will we need in the future?
- Identify gaps in service provision and agree on priorities for service change.

Re the latter, it is important to consider the question 'what problem are we trying to solve'? Is it a problem of capacity of services, of a lack of the right services, or of a lack of coordination of existing services?

This needs assessment provides evidence and background to the planning phase of commissioning services for frail older people.

Only when there is broad agreement on the planning questions asked above, it is possible to move to the second phase of procurement. This phase is about the technical aspects of changing services, defining what is required and translating this into valid contracts, and procurement of the desired services. Providers should be heavily involved in this phase as they will have insight into the feasibility of implementation of certain models of care.

The third phases includes monitoring and evaluation of services; this should be a continuous process. The outcomes of monitoring will determine future planning of services: if a certain model of care does not meet the needs of the population, there will be a need to review services again. Hence commissioning is an ongoing process.

Figure 1: The commissioning cycle (Department of Health)

4. Aim and objectives

The aim of this needs assessment is to provide the evidence base for the development of the frailty pathway for frail older persons in North West Surrey.

4.1 Objectives

The needs assessment has the following objectives:
- To quantify the number of frail older persons in NW Surrey, now in and in the future
- To describe determinants of health of frail older persons
- To describe the current health and social support services to support the frail elderly in NW Surrey
- To identify gaps in service provision
- To provide an overview of current guidance documents and evidence of best practice.

5. Scope of the needs assessment

The scope of the population covered in this needs assessment was agreed in a joint health and social care workshop in April 2014:

- NWS residents aged 75 years and older AND 'frail' (see under 6.1 for definition) OR
- NWS residents with dementia OR dementia OR M. Parkinson OR in last phase of life
- NWS residents in nursing or residential care homes.

The scope of services described in this needs assessment is:
- NWS services (health, social care and voluntary sector) that support frail older persons to live at home independently.

6. Methods

6.1 Definitions

Frailty
There is no definitive definition of 'frailty' (5) but in this report frailty refers to a syndrome or combination of symptoms that put an older people at higher risk of poor health outcomes.

This has been summarised by NHS England (5) as:
"Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home".

Home
'Home' as used in the aim of the pathway refers to the usual place of residence of frail older people is defined as:
- The place where the frail elderly person resides independently i.e. home, in a residential care home, or in an assisted living facility.

6.2 Data sources

The data in this needs assessment were derived from a range of data sources including:

- The Office of National Statistics (ONS): population estimates
- Primary Care Support Services: NWS GP practice list size
- Poppi and Pansi population estimates (14) (15)
- The Surrey Joint Strategic Needs Assessment (JSNA) (13)
- Publications from The King's Fund
- Publications from The Nuffield Trust.

Please note: where possible we used NWS specific data relating to frail older people. Where these data were not available we provided data relating to a larger cohort of people (e.g. older people living in in NWS or in Surrey).

6.3 Mapping of services

Two mapping exercises were undertaken to better understand the current offer of health and social care services for frail elderly people[e].These meetings were attended by:

- Representatives of Surrey County Council (SCC), commissioners and providers of adult social care
- Representative of community services (Virgin Health)
- GPs (two in the first meeting, one in the second)
- CCG commissioning staff.

The following approach was used to map the services. We took the nine components of the NHS England's end to end pathway (see 3.2.1) as a starting point. For seven out of these nine components, participants identified relevant existing services from either health care, social care of the voluntary sector.

After this initial mapping, participants then commented on the following dimensions of quality[f]:

- The capacity of the services i.e. how many people can the service serve per year?
- The coverage of the services i.e. do they cover all residents of NWS?
- Effectiveness: do we know anything about the effectiveness of this service?
- Acceptability: is this service acceptable to people?
- Access: is this service accessible? Are some residents excluded from using this service, are there waiting lists?

The mapping exercise aimed to give an initial overview of the services, not to provide a complete assessment of the quality of services.

[e] The workshops took place on 17/03/14 and 30/04/14.
[f] Based on Maxwell's dimensions of quality. Oxford handbook of Public health practice, second edition, 2006 (page 431).

7. Needs

7.1 What do people want and need?

What matters to people (as opposed to healthcare professionals) should form the basis of any healthcare programme. It is therefore very important to engage elderly frail people living in NWS, especially those not in regular contact with their GP or other professionals, and to ask them what support they need. We don't know what NWs want yet, but national research gives some insight into what matters to frail older people:

"To me, a frail person is someone like a skeleton that can't move."

"A few years ago my wife got discharged from hospital. The report said 'a frail old lady of 88'. I said this is lies! She's got more willpower and determination in her body than anybody I ever knew!"

The above quotes were from participants in a recent study into the experience of 'frailty' (6). The study suggested that:

- There is huge difference between what healthcare professionals understand is 'frailty' and how older people see themselves. It also seemed that the participants recognised frailty in others, but found it very difficult to accept for themselves.
- Independence is very important to people. Frailty is seen as a process in which people gradually are capable of doing fewer tasks independently, which is difficult.

People held different views about support e.g. day care centres. For one of the interviewed elderly people, day care was very important:
"The biggest benefit of the day centre for her (frail elder lady interviewed) was that she could meet and talk to a range of people. This service had a significant impact on her happiness and confidence, and she explained that as a result her overall health and wellbeing had improved. Betty said that she now had the "confidence to try things, while still being realistic".

Another elderly lady however did not want to go to a day care centre: *"I think even with the organisations that do help the aged, they don't take into consideration, I don't think, the cultural differences. Not everybody goes to the same groups; not everybody wants to do the same thing."*

People had good and bad experiences from support organisations, and the level of support received: *"In Annie's opinion, some service providers would only help those who were very demanding. While she felt confident in this regard, her neighbour was less demanding and, as a result, only received minimal levels of support."*

What comes across from the Age UK research is that people value independence, and that what matters to them is to maximise the activities they can still undertake.

A recently undertaken review into whole person care also noted:

"People are interested in their lives rather than health and care services, and it can be easy for policy and policymakers to miss what matters most to ordinary people. Older people in particular emphasise the importance of their independence" (16).

A large proportion of frail older people will have one or multiple long term conditions. From research we know that people with long term conditions consistently say (17):

- They want to be involved in decisions about their care – they want to be listened to
- They want access to information to help them make those decisions
- They want support to understand their condition and confidence to manage their care
- They want joined up, seamless services

- They want proactive care
- They do not want to be in hospital unless it is absolutely necessary and then only as part of a planned approach
- They want to be treated as a whole person and for the NHS to act as one team.

These points were also reflected in local feedback in 2011 from Surrey residents affected by long term neurological conditions (Appendix B).

They said they wanted less:
- Residential care
- Standard, 9am to 5pm, Monday to Friday day care services
- Unplanned hospital care

And they felt they needed**:**
- Equitable and timely access to a wide range of local services
- Personal budgets and direct payments so people can exercise more choice and control over their support
- Opportunities for retraining, vocational rehabilitation, support for returning to work, employment, leisure pursuits and social participation
- Improved access to 24-hour specialist care and support for those with complex health and social care needs
- Flexible community services and support, and an increased range of service options to support people at home
- Support to navigate the complex health and social care systems and help people achieve their individual outcomes in life
- To maximise the use of Telecare, Telehealth and digital technology
- One stop shops and information and advice services
- Clear integrated pathways of care, including timely access to reablement and rehabilitation

Recommendation: ask frail elderly people in NWS what they want from health and social care, and how they experience current care and support. Involve them in the development of the frailty pathway.

Another way of understanding people's needs is to ask the staff who work with frail older people at their homes. In NWS a number of community matrons provide proactive, case management support at people's homes. They will have a holistic view on people's needs and the effectiveness of other services. The same will apply to e.g. district nurses and other staff who work with people in their own environments.

Recommendation: involve front line staff including community matrons and community nurses in development of any new pathway; they know what NWS people need and they have direct insight into what works and what does not work.

7.2 Demographics

7.2.1 Life expectancy at birth and age 65

Figure 2 shows the life expectancy at birth in NWS compared to England. The life expectancy at birth in NWS is currently 83.9 years for women (England 83.0 years) and 80.6 years for men (England 79.2 years)[g]. The healthy life expectancy i.e. the number of years expected to be lived in good health is higher for both women (68.9 years, 64.8 years England) and men (67.9 years, England 63.5 years) than England. In other words: children born in NWS are expected to live longer, and spend more years in good health, than children across England.

Figure 2: (healthy) life expectancy at birth in NWS and England

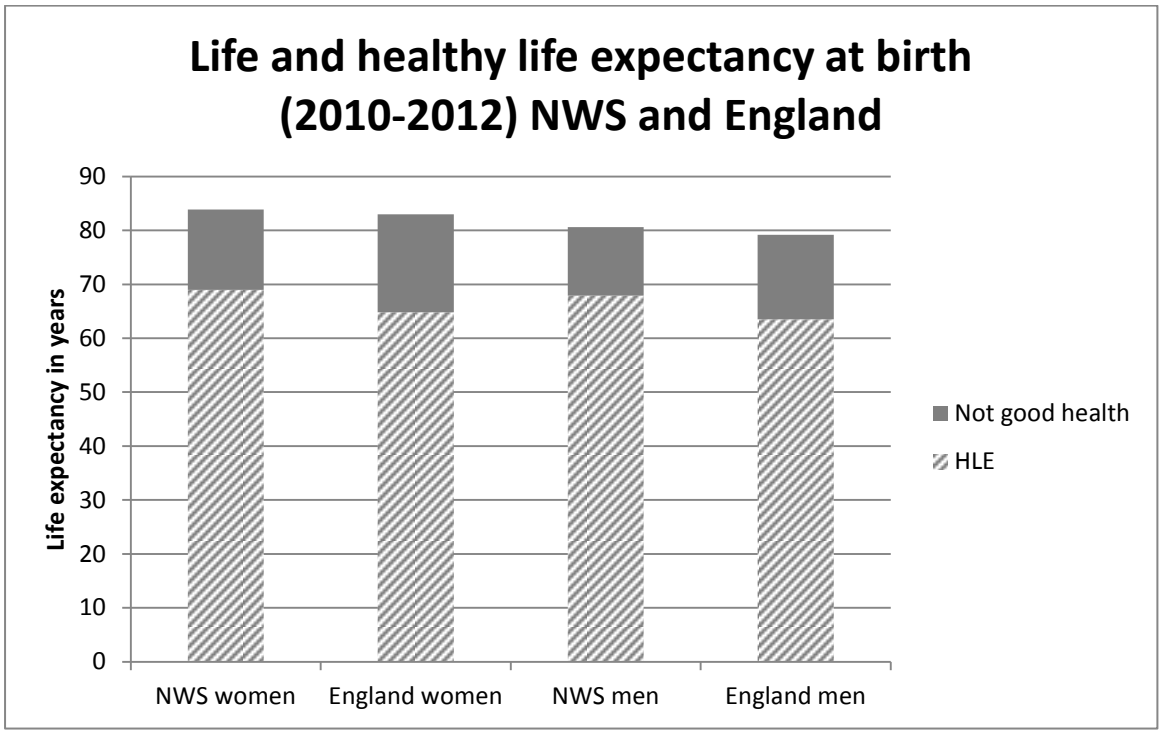


Figure 3 shows the life expectancy and the healthy life expectancy for people aged 65 in NWS compared to England. Clearly at this age a substantial proportion of life will be spent in 'less than good' health. People in NWS however have a higher healthy life expectancy than people in England. At the age of 65 they can still expect to spend over 50% of their remaining life in good health.

For women in NWS the life expectancy at 65 is 21.6 years (England 21.1 years), for NWS men it is 19.3 years (England 18.6 years). The healthy life expectancy for women at this age is 11.5 years (England 9.7 years) and 11.2 years for men (England 9.2 years).

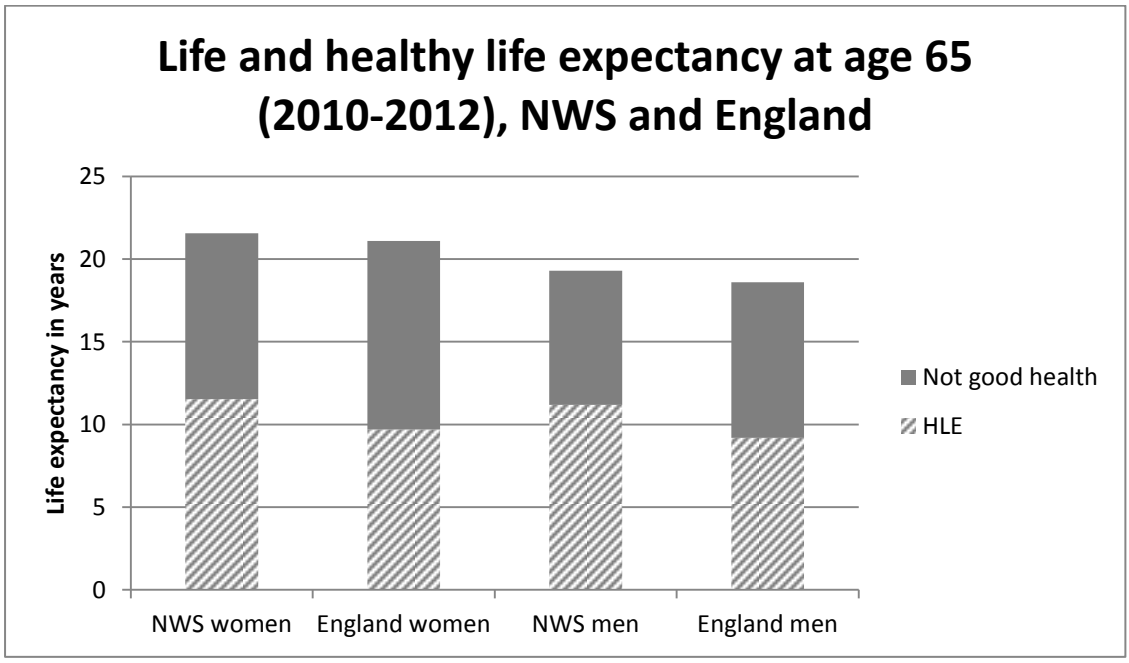
In summary, a NWS woman at 65 years old is expected to live until 86 years and 7 months[h]. Of those additional 21.6 years, 11.5 years will be in good health and 10.1 years in poor health.

A NWS man at 65 years old is expected to live until 84 years and 4 months. Of those additional 19.3 years, 11.2 years will be in good health and 8.1 years in poor health

[g] Life expectancy (2010_2012) is expressed as the expected life expectancy of a baby born between 2010 – 2012 assuming that the risk of dying for each age group will remain the same as in 2010-2012. http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/healthy-life-expectancy-at-birth-and-at-age-65--clinical-commissioning-groups--ccgs--2010-12/rpt-hle.html#tab-Methods

[h] Decimal of the years translated in 'years, months'.

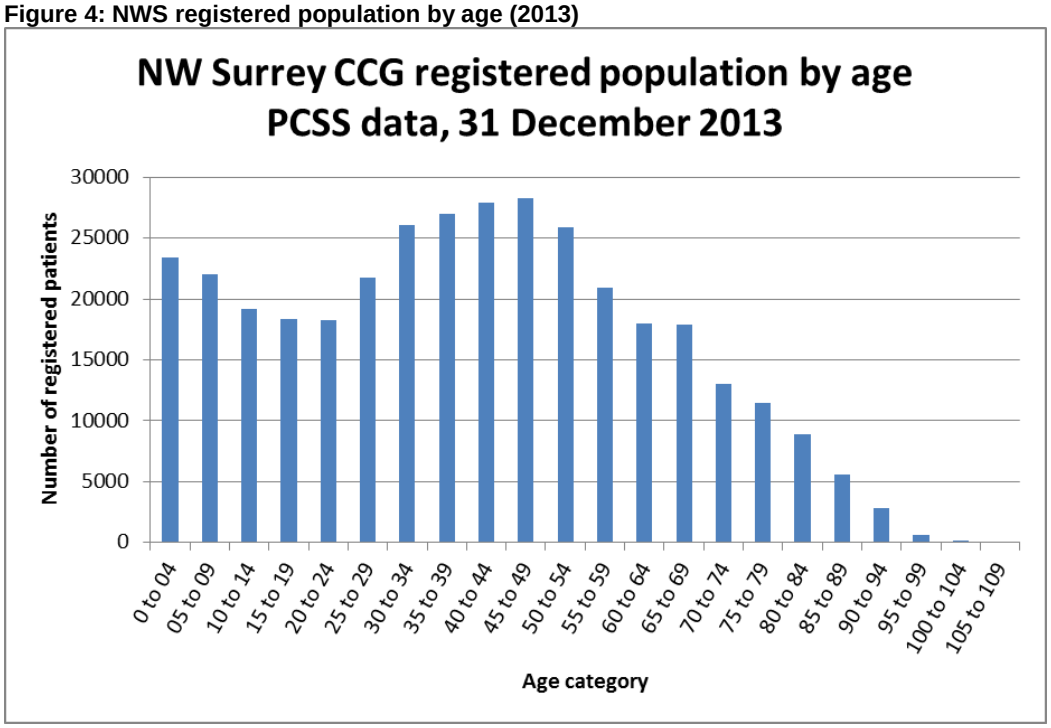
Figure 3: healthy) life expectancy at age 65 in NWS and England



7.2.2 Size of the population aged 75+

By 2013 the total number of people registered with NWS GPs was 357,435. Figure 4 shows the breakdown by age of all registered patients.

Figure 4: NWS registered population by age (2013)



Of all registered patients, just over 29,000 people were aged 75 and older (8.2% of the total population, Table 3). It is of note that although in the total population there are roughly as many women as men, this is different in the population aged 75 and older. In this age group the number of female residents is more than 40% higher than the number of male residents.

Table 3: NWS GP total list size and breakdown by older age (December 2013)

	Number of male patients 2013	Number of female patients 2013	Total list size 2013	% of total list size 2013
Total list size (all ages)	177,755	179,680	357,435	100.0%
Population 75 - 79	5,244	6,185	11,429	3.2%
population 80 - 84	3,776	5,093	8,869	2.5%
Population 85 +	3,168	5,894	9,062	2.5%
Total Population 75 +	**12,188**	**17,172**	**29,360**	**8.2%**

ONS population projections for Surrey[i] were used to give projections of population growth in NWS in the next five years. Table 4 shows that the NWS population overall (all ages) will grow by 5.3%. The population aged 75 and older will grow 11.5% with the greatest increase in people aged 85% (increase of 20.9%). In 2018, almost 33,000 people will be aged 75 and older; compared to 2013 this age group in the population will then comprise 8.7% of the total population compared to 8.2% in 2013.

Table 4: NWS GP total list size 2013 – 2018 and breakdown by older age

	Total 2013 list size	% population change Surrey	Total 2018 list size	% of total list size 2018
total list size (all ages)	**357,435**	**5.3%**	**376,379**	100.0%
Population 75 - 79	11,429	**6.2%**	12,138	3.2%
Population 80 - 84	8,869	**8.2%**	9,596	2.5%
Population 85 +	9,062	**20.9%**	10,956	2.9%
Total Population 75 +	29,360	**11.5%**	32,736	8.7%

Note: the CCG is also responsible for commissioning healthcare for people living in the NWS area who are not registered with a GP. The size if this population is unknown; the registered population is therefore assumed to be the CCG population.

7.2.3 Number of frail older people in NWS

There is not one recognised definition of frailty (18), but NHS England describes it as follows (5):

"Frailty develops as a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home".

One (widely quoted) systematic review aimed to provide data on the prevalence of frailty among people living in the community aged 65 and older (18). Based on four studies (three of whom used the Fried Frailty Index, which requires the presence of at least three symptoms of weight loss, exhaustion, weakness, slowness and low physical activity, to diagnose frailty), the prevalence by age for people living in the community was estimated.

[i] From ONS 2011 population projections http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/stb-2011-based-snpp.html

Table 5 shows the prevalence of 'diagnosed frailty' by age group. The table clearly shows that the chance of being frail increases with age.

Table 5: prevalence of frailty, Collard et al (18).

Age group	Prevalence
Population 75 -79	10%
Population 80 -84	15.70%
Population 85+	26.10%

When applied to the NWS population, an estimated 4,900 people aged 75+ living in the community in NWS (i.e. not in a nursing or residential care home) are estimated to be frail (Table 6). This number is expected to grow to 5,600 people in 2018.

Table 6: prevalence of frailty in NWS population aged 75+

Age group	Prevalence of frail older people	Total 2013 list size	Number of frail older people 2013
Population 75 - 79	10%	11,429	1,143
Population 80 - 84	15.70%	8,869	1,392
Population 85 +	26.10%	9,062	2,365
Total	NA	**29,360**	**4,901**

7.2.4 Estimated size of the NWS 'frail cohort'

After extensive consultation with the CCG's GPs it was decided that any frailty services (or 'the frailty pathway') should apply to a number of specific patients groups *in addition to older people classified as frail*. These patient groups were:

- People living in nursing homes and residential care homes in NWS
- People with dementia
- People diagnosed with Parkinson's disease
- People diagnosed with Multiple Sclerosis (MS)
- People in the last 12 months of life ('end of life').

Table 7 shows the estimated number of people belonging to these patient groups. In total almost 17,000 people in NWS are estimated to be in one of the above groups. These groups, however, will overlap; some frail people will live in nursing homes, some will have been diagnosed with dementia.

To account for this overlap, the estimated size of the frail elderly population is estimated to be **10,000 people in NWS** in 2013. This is expected to increase to 11,500 in 2018[j].

It should be noted that the majority of these people will be aged 75 and older, but some people will be younger and suffer from a specific disease or be in the last 12 months of their lives.

Table 7: population sizes of selected conditions

Condition	Number of people in NWS, 2013	Data source	Comment
Frailty	4,901	Collard et al, ONS estimate	Aged 75+
People living in nursing / residential care homes	2,700	CCG data	Capacity
Dementia	4,500	Poppi data	>65, of which half undiagnosed
Parkinson's disease	676	Neuronavigator website	All ages
Multiple Sclerosis	564	Neuronavigator website	All ages
End of Life	3,500	CCG expert data	Estimated 1% of population
Total	**16,841**		
Total adjusted for overlap	**10,000**		

Recommendation: plan the current frailty pathway to address the needs of frail elderly 10,000 people in NWS, and 11,500 in 2018.

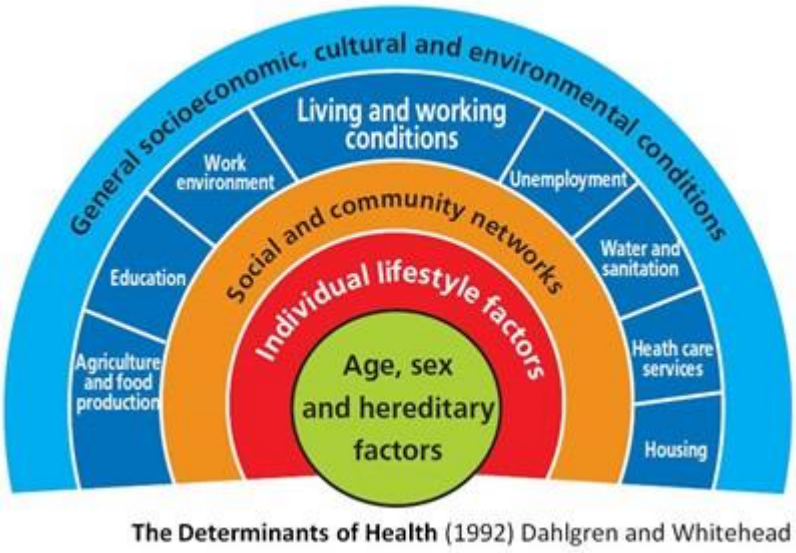
[j] Applying the expected growth rate for the +75 population of 11.5% (see Table 4)

7.3 Older people's determinants of health

The section below describes factors that impact on the health of older people, including frail older people in NWS.

Health is influenced by many factors as illustrated in Figure 5. At the heart of the model are factors that are largely out of our control: our age, our sex and our genes. The subsequent layers show all the different levels of factors that impact on health. Social factors such as education levels and employment status for instance are strongly related to health outcomes (19). They also impact on people's community networks and these in turn impact on lifestyle. For instance we know that more highly educated people are much less likely to smoke than lower educated people (13).

Figure 5: determinants of health model.



The Determinants of Health (1992) Dahlgren and Whitehead

Below follows a description of a selection of factors relevant for the health of (frail) older people, whereby the model will be followed inside out i.e. from age / sex / hereditary factors to wider socio economic factors.

7.3.1 Age / sex / hereditary factors

<u>Age</u>
The prevalence of diagnosed frailty increases with age and is estimated to be 26% in people aged 85+ (18). Increasing age is often linked to decreasing wellbeing and increasing levels of frailty, but it is important to note that people age differently and that there is huge variation in fitness and wellbeing across the ages (18). How healthy people are at a certain age depends on multiple factors including the early life factors such as the education level of their parents and their early development as a child (19), and their choices and opportunities during their lives.

<u>Sex</u>
The prevalence of frailty in community based studies was almost twice as high in women as in men (18). The mean age of people included in these studies was 75 years.

<u>Ethnicity</u>
Ethnicity of people is important for several reasons:

- Disease may present differently in different ethnic groups

- People may perceive complaints and illness differently in different ethnic groups
- Cultural aspects should be included in planning of interventions.

People in Surrey including NWS are overwhelmingly white: over 97% of the NWS population aged 75+ is white (REF Poppi, Table 8[k]). The largest group of people with non-white ethnicity aged 75+ live in Woking and have an Asian / Asian British ethnicity but they only constitute 1.7%.

It should be noted however that the younger age groups are more ethnically diverse and that services should take this into account for planning of future healthcare delivery to this age group when they are older. For instance, in the age group 25 to 34 in Woking, 20% of the people are from non-white ethnicity (15).

Table 8: Ethnicity of NWS residents aged 75+

Ethnicity	Number of people	% of people 75+
White	26,919	97.7%
Mixed ethnicity	80	0.3%
Asian / Asian British	365	1.3%
Black or Black British	81	0.3%
Chinese or Other Ethnic Group	101	0.4%
Total NWS aged 75+	**27,546**	**100.0%**

Older people with learning disabilities

The life expectancy of people with learning disabilities, although still significantly lower than the general population, has increased substantially over the past decades (20). A small group of older people aged in NWS have learning disabilities. It is estimated that in 2014 there were 589 people with learning disabilities, including people with moderate and severe learning disabilities and Down's Syndrome. This number will increase to approximately 640 people in 2014 ((14) Table 9). Older people with learning disabilities share certain needs with the normal older population, but they are at greater risk for e.g. dementia and psychiatric disorders than the general population. They are also at higher risk of poverty and social isolation (20).

The British Institute of Learning Disabilities (BILD) provides resources for professionals planning health and social care for this group of people; a special website is dedicated to older people with learning disabilities[l]. It is of note that because people with learning disabilities now become older than ever before, services may not have experience with planning and providing the care for this age group. This may include staff in residential homes for people with learning disability; it is important that staff are trained adequately to care for people in this 'new age range'.

Table 9: estimated numbers of people with learning disabilities (POPPI data, 2009)

Borough	People predicted to have a learning disability, by age group	2014	2018
Elmbridge (counted half)	Age 75-84	76	79
	Age 85+	39	44
Runnymede	Age 75-84	100	106
	Age 85+	44	54
Spelthorne	Age 75-84	124	128
	Age 85+	49	61

[k] Poppi data, based on ONS 2009 population estimates per Borough; numbers were derived by adding total numbers from Woking, Runnymede and Spelthorne and half of the Elmbridge population 75+

[l] BILS ageing well website: http://www.bild.org.uk/information/ageingwell/

Woking	Age 75-84	108	110
	Age 85+	49	58
Total people aged 75+		**589**	**640**

7.3.2 Individual lifestyle factors

The importance of individual life style factors on health later in life is clear; risk factors such as smoking and alcohol use impact on health. Data on risk factors in people living in NWS (but not specifically older people) can be found in the JSNA (13).

Below are a number of points regarding risk factors in elderly people:

- People over the age of 60 smoke less than the general population and are more likely to quit smoking through the stop smoking services (21)
- The prevalence of obesity increases with age for both men and women. In 2011, 75% of men aged 75+ were overweight or obese and 70% of women aged 75+ were overweight or obese. In the age group 25-34 the prevalence was 55% for men and 45% for women (22)
- The proportion of people meeting the recommended levels of physical activity drops by age. Of men aged 75+ less than 10% met the recommended levels, for women this was 5% (23). Evidence shows that physical activity is very important for the fitness, strength and wellbeing of older people (24)
- Hazardous alcohol use generally reduces with age (21). The all-age prevalence of hazardous drinking in Surrey is 25% which is the second highest prevalence in England (25). In the absence of specific data on alcohol use in older people in NWS it can be assumed that a relatively high proportion of older people will drink high levels of alcohol.

7.3.3 Social and community networks

<u>Loneliness</u>

Loneliness is an important issue for elderly people's wellbeing; a recent Age UK report estimated that nearly half of the people aged 85+ experience being lonely most or some of the time (26).. If this estimate applies to NWS (local data are not available) it would mean that 4,500 NWS residents over the age of 85 experience loneliness. The definition of loneliness used was "the subjective feeling of not having the desired quantity and quality of relationships". It is of note that people find it difficult to discuss loneliness: eighty per cent of people aged 85+ have not told their own children they feel lonely (26).

Loneliness is correlated to lower sense of satisfaction with life and with worse health outcomes (26):

- 1 in 10 people who visit their GP do so primarily because they are lonely
- lonely people are estimated to be twice as likely to develop Alzheimer's as those who are not lonely
- Those who suffer from loneliness have a 64% greater risk of developing clinical dementia
- Lonely people suffer disproportionately with mental health issues, cognitive decline, hypertension and are more likely to be admitted for residential or nursing care
- Loneliness has also been linked to emergency hospitalisation and re-hospitalisation within the year.

An illustration of loneliness amongst elderly people came from the Age UK qualitative study in which all participants commented on how much they had enjoyed the company of the researchers (6).

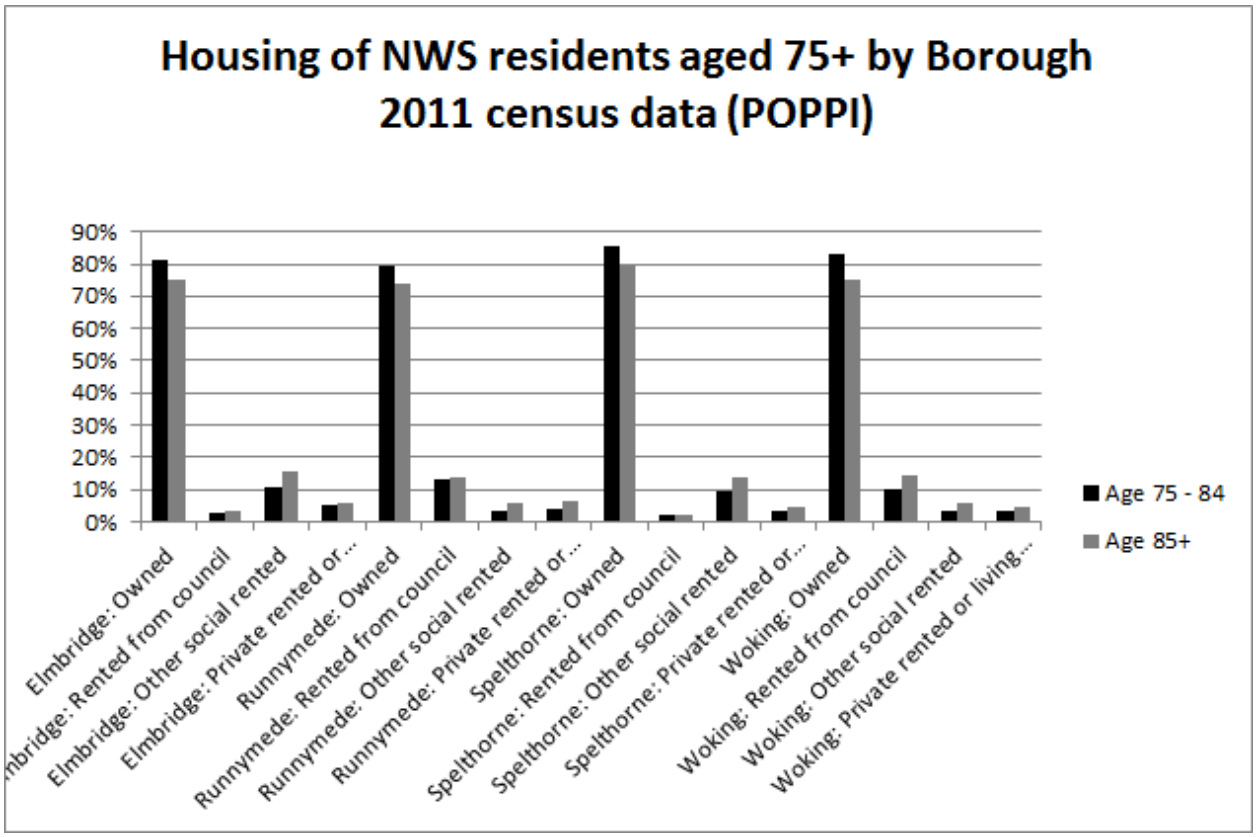
7.3.4 Living and working conditions

Housing

In Surrey, roughly one third of all men over the age of 75 live alone, but more than half (61%) of women in this age group live alone (Poppi data (14)).

The overall majority of elderly people in North West Surrey live in houses they own (Figure 6). Data based on the 2011 census show that in the age group 75 – 84, between 79% and 86% of residents live in their own house. In the age group 85+ this proportion drops to between 74% and 79%. In Runnymede and Woking, more people live in houses rented from the Council than rented from another social landlord (e.g. housing association), in Elmbridge and Spelthorne more people rent form other social landlords than from the Council.

Figure 6: Housing data by Borough



The POPPI website (data on older people[m]) also includes data on the number of people living in care homes; these data however were based on the 2001 census results. These old data have therefore not been included in this needs assessment. New data based on the 2011 census are expected in 2014.

Based on capacity, it is estimated that in North West Surrey, 2700 people live in nursing or residential care homes (Table 7).

[m] Projecting Older People Population Information System

7.3.5 General socioeconomic factors

Many socioeconomic factors impact on health of elderly people. Income, housing and the availability of services for the elderly are dependent on e.g. pension systems, and the general economic state of the country. The level of deprivation of a person has a great impact on many risk factors and the prevalence of disease (19) and has therefore been included here.

Levels of deprivation

Generally, the North West Surrey population is wealthy and healthy. There are however differences in deprivation between the NWS Boroughs.

The IDAOPI (Income Deprivation Affecting Older People Index) is a measure of the proportion of older people (adults aged 60+) who live in poverty in a specified area. The 2010 results showed that in the NWS people roughly one on ten people aged 60 or above live in poverty (Table 10). In comparison, in some London Boroughs up to half of the people aged 60 years and older live in poverty (Tower Hamlets 52%, Newham 45%) (27).

Table 10: IDAOPI scores per local authority

Local authority area	% of people 60+ living in poverty
Elmbridge	9.4
Runnymede	10.9
Spelthorne	10.0
Woking	10.8

Frailty in older adults (as diagnosed with the Frailty Index score) is associated with individual and neighbourhood deprivation; poor older people living in deprived areas are most vulnerable (28).

One other factor in this category is legislation, most notably the implementation of the new Care Act (see 3.2.1). New funding arrangements will impact on people's financial situation, and if 'integrated health and social care services' that were previously provided free of charge by the NHS will require self-funding under the new Act, this may impact on uptake of services.

7.4 Health conditions in older people.

A comprehensive overview of health conditions in older people can be found in the report 'Healthcare quality for an active later life' (21).

Below follows a snap shot of local and national data, relevant for the development of services for frail elderly in NWS.

7.4.1 Long term conditions

The importance of long term conditions (LTCs) for the sustainability of the NHS has been well established. For instance, people with long term conditions account for (17):

- 50% of all GP appointments
- 64% of outpatient appointments
- 70% of all inpatient bed day
- In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs.

In the national age group of 70-79, it estimated that 50% of people have one or two LTCs, and in addition more than 10% have three LTCs (17).

In the national age group of 80+, these proportions have increased to 55% of people having one or two LTC and 15% having three LTCs. In other words: in the age group, a large majority of 70% of the people have at least one LTC (17).

7.4.2 Neurological conditions: MS and Parkinson's disease

There is a wide range of neurological conditions that affect elderly people. People with Multiple Sclerosis (MS) and people with Parkinson's disease have been included in NWS frailty cohort (see 7.2.4); these two conditions have therefore been included.

Multiple Sclerosis

The prevalence of MS is between 100 and 120 per 100,000 people (29). In 2013, there were 564 people diagnosed with MS in NWS [n]. This number includes people of all ages as age specific data were not available.

MS is a neurological chronic condition with an unpredictable natural course. Disease modifying drugs are now available but people generally become more and more disabled during their lifetime. This can have a great impact on their (mental) health, work, relationships and wellbeing in general (30). Care for people with MS requires a multidisciplinary approach in NWS, led by specialist nurses.

NICE guidance on MS (29) includes a list of priorities for implementation to improve the care for people with MS:

- Every patient needs specialist neurological services
- A person suspected of having MS should have access to urgent diagnosis
- Commissioners should ensure that MS services work seamlessly from the person's perspective
- Services should be responsive to the varying needs and expectations of people with MS
- Sensitive but thorough assessment: professionals working with persons with MS should carefully explore 'hidden' problems associated with the disease such as depression and bladder control
- Self-referral after discharge from specialist services; every person with MS should know where to go for information or support after discharge from specialist neurological services.

The MS Trust has developed an MS pathway for commissioners based on NICE guidance. This pathway can be used to develop good quality care and support for people suffering from MS (30).

Parkinson's disease

Parkinson's disease is a progressive neurodegenerative condition which can cause severe disability and reduced quality of life. Many patients develop psychiatric problems such as dementia (31) in addition to the movement disorders that are typical of the disease.

The prevalence of Parkinson 's disease is comparable with the prevalence of MS: 100 – 180 people per 100,000 have the disease. In 2013, there were 676 people diagnosed with Parkinson's disease in NWS [o]. As with MS this number includes people of all ages as age specific data were not available.

NICE's key priorities for implementation are:

[n] Data from www.neuronavigator.com
[o] Data from www.neuronavigator.com

- Diagnosis and expert review: patients suspected of Parkinson's Disease should have access to rapid diagnosis by a specialist
- People with Parkinson's disease should have regular access to specialist nursing care
- People with Parkinson's disease should have access to physiotherapy
- People with Parkinson's disease should have access to occupational therapy
- People with Parkinson's disease should have access to speech and language therapy
- Palliative care requirements should be required during all phases of the disease and patients and their carers should have the opportunity to discuss their wishes with professionals.

Parkinson's UK, a research Charity, has published a guide for commissioners on the value of Parkinson's specialist nurses (32). Based on a number of case studies they have calculated that a single Parkinson's nurse could save over £43,000 pounds per year in consultant appointments, £80,000 in avoided admissions and £147,000 per year in prevented bed days. This is in addition to greatly improving the quality of care for patients.

The PCT Surrey developed a draft Long Term Neurological Conditions strategy 2011-2015 which includes useful feedback from Surrey patients and their carers about what kind of care they want and need. A summary has been included in Appendix B.

7.4.3 Sensory impairments

In developing healthcare for the elderly we increasingly rely on self-care which may include written information, telecare and phone contact with health care professionals. It is important that people can receive the information provided, and for that we should take sensory impairments into account. Below is a snapshot of information about sensory impairments (based on JSNA data (13). The range of disabilities that may be barriers to accessing healthcare is much larger and includes for instance (functional) illiteracy. It has been estimated that 5% of English adults have literacy levels below those expected of an 11 year old (33). This is often overseen and will impact on the ability of people to e.g. understand medication prescriptions.

Hearing impairments

It is estimated that one in seven Britons have hearing problems ranging from being 'hard of hearing' to deaf. Based on this is it estimated that over 24,000 people aged 65+ in NWS had moderate to severe hearing impairments in 2010 (Table 11). This equates to just under half of the NWS population aged 65 and older (just over 60,000 people in 2013, PCSS data, see 6.2).

Table 11: estimated number of people with hearing needs in NWS Boroughs in 2010 (13)

Local Authority area	**Number of people 65+ with moderate or severe hearing impairments**
Elmbridge (population counted half)	4,845
Runnymede	6,098
Spelthorne	7,202
Woking	6,167
Total NWS	**24,312**

Visual impairments

One in five people aged 75 and older in the UK have some degree of sight impairment; for people over the age of 90 this applies to more than one in three people. It is estimated that in 2010 in NWS there were almost 5,000 people aged 65+ with moderate or serious visual impairments (Table 12)

Table 12: estimated number of people with visual impairments in NWS Boroughs in 2010 (13)

Local Authority area	Number of people 65+ with moderate or serious visual impairments
Elmbridge (population counted half)	965
Runnymede	1,237
Spelthorne	1,469
Woking	1,261
Total NWS	**4,932**

Deafblindness

Deafblindness is called 'dual sensory loss'; it refers to people who have both sensory and hearing impairments. It is estimated that in 2010 there were approximately 1,300 deafblind people in NWS.

Table 13: estimated number of deafblind people in NWS Boroughs in 2010 (13)

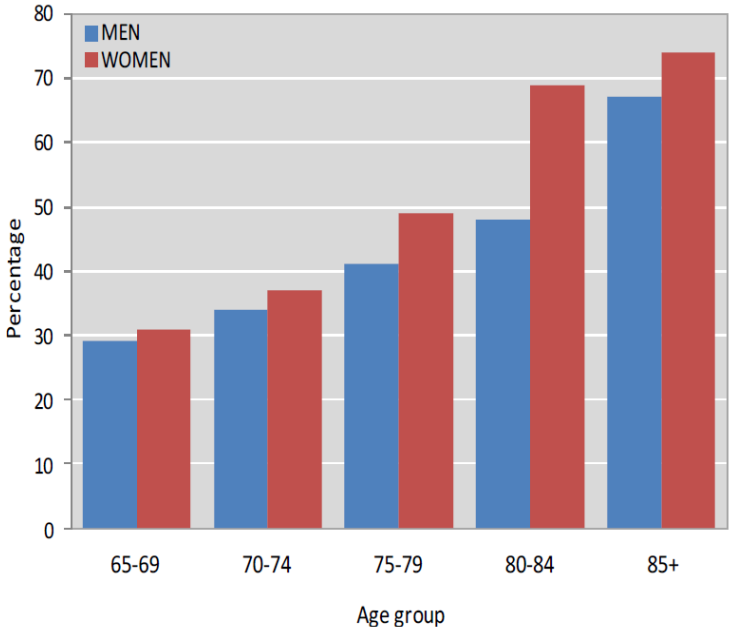
Local Authority area	Number of people 70+ predicted to be deafblind
Elmbridge (population counted half)	278
Runnymede	310
Spelthorne	395
Woking	296
Total NWS	**1,279**

7.4.4 Mobility problems and falls

Mobility problems

For elderly people, being able to walk moderate distances (e.g. a quarter of a mile) greatly enhances independence. National data from 2005 showed that women consistently have more mobility problems than men (Figure 7); this is linked to the higher prevalence of osteoporosis in women. The prevalence of mobility problems increased with age for women and men. There was a stark increase in the number of women with mobility problems from the age group 75-79 (48%) to age group 80-85 (68%) (21).

Figure 7: Prevalence of mobility problems (not being able to walk ¼ mile) people aged 65+, England 2005 (21)



Falls

The prevalence of older people falling is very high. Each year, 30% of people over 65 and 50% of people over 80 years fall (13). One year after a fall, one in five older people are either in hospital, full time care or have died. Falls have been recorded as contributing factors in 40% of admissions to nursing home (13).

In Surrey, PCT data from 2010 / 2011 show that treatment of hip fractures also cost the NHS more than treatment of heart failure and diabetes combined (13).

7.4.5 Mental health in elderly people

Among older people living in the community, mixed anxiety and depression is the most common mental disorder, followed by anxiety and depressive episodes separately (21). The estimated prevalence of these illnesses in people aged 75 and over was 6.3% for men and 12.2% for women (data from 2007); the proportion of younger people with these conditions was higher (17.7% for the age group 16-64) (34). Other data suggest that the prevalence of e.g. depression in older people is higher and that in the age group of 65+, one in five people are affected by depression and two in five living in care homes, and that many of these people will not be receiving mental health services (35).

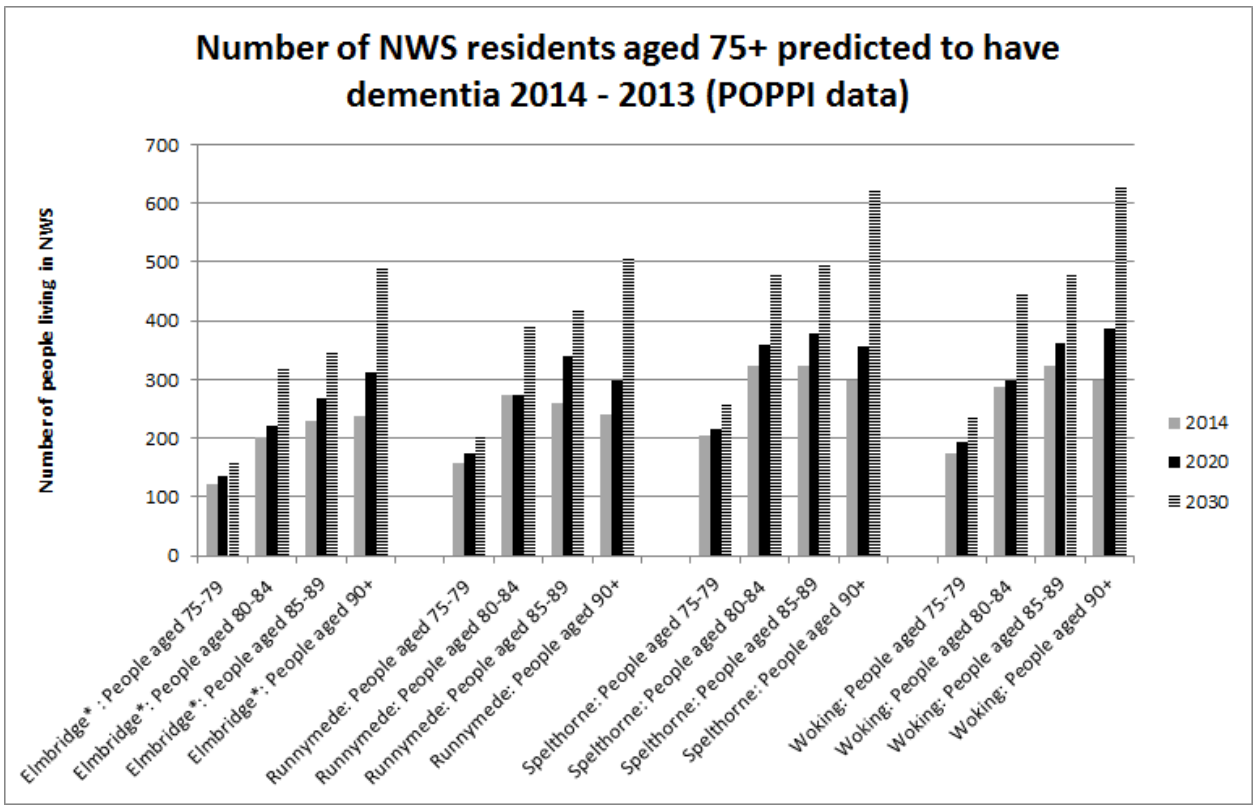
Dementia

The prevalence of dementia increases starkly with age. Figure 8 shows the number of people aged 75+ predicted to have dementia in NWS residents, in 2014 and in the future. At present it is estimated that 3,960 people living in the 3,5 NWS Boroughs have dementia, and this is predicted to increase to 4,580 in 2020 and 6,460 in 2013. Based on the 2013 total population of 29,360 people aged 75+ in NWS this would mean that one in seven or eight of people in this age group suffer from dementia, but many will never be diagnosed. Under diagnosis of dementia is a national problem that is addressed through a national dementia strategy (36).

It is estimated that at present only half of all people with dementia have been diagnosed in NWS (personal communication dementia commissioner). This means that many people with (early symptoms) of dementia will not receive appropriate levels of care and support.

Figure 8 shows that the number of people with dementia is roughly the same across the 3,5 Boroughs.

Figure 8: NWS residents predicted to have dementia (*Elmbridge population counted half)



Recommendation: when designing services for frail older people, ensure that development of other CCG programmes, specifically the dementia programme, are closely linked.

Recommendation: when designing services for frail elderly people, use data included in this needs assessment on their specific needs and risk factors.

8. Current service provision for frail older people

In NWS a broad range of services are available to support and care for frail older people. Figure 9 shows the mix of different services identified in the mapping exercise. These services were offered by:

- The local authorities' social services (in green)
- Healthcare services including NHS and Virgin health services (in blue)
- The voluntary services (orange).

The detailed list of services summarised in this 'soup of services' is included in Appendix C. What is clear from the summary picture is that this is a complex system that is difficult to oversee for any organisation.

This is in line with a recent King's Fund report about community services which said that community services are complex and 'system' is difficult to navigate even for professionals (37): "This has mainly been the result of services being created for a particular purpose or client group without a clear plan for how they relate to the wider system".

Figure 9: current services for frail elderly people in NWS,

The mapping exercise resulted in two groups of services: 'core' services for frail older people i.e. services that relate to health and wellbeing of older people in general. In addition we mapped the services that related more specifically to seven of the separate components.

We learned that it is mostly not possible to map social care and NHS services along outcomes of the end to end pathway, as social care services don't use medical needs as a starting point and

most components of the pathway (e.g. living with long term conditions) are designed around medical need. Social care allocation is based on social needs irrespective of medical need[p].

Core social services included 10 different services and provisions, including sheltered housing, day centres, meals on wheels, wellbeing centres, reablement and packages of care.

Core health services included 12 different services including GPs, community pharmacists, practice nurses, community nurses and district nurses.

Core services from the voluntary sector include voluntary transport, Age UK, bereavement care and carer support services.

Services were mapped against the components of the 'end to end pathway' from NHS England (see 3.2.1) to understand how services related to the outcomes specified in the pathway. The provision of good hospital care was not included. Table 14 shows the number of services, in addition to the core services, mapped against each outcome. Please note that some services, such as the dementia navigators from social care, related to multiple outcomes and have thus been included twice in this table (the full results of the mapping exercise can be found in Appendix C).

Table 14: summary of mapping of services

Component of end to end pathway	Number of different social care services (SCC and Districts / Boroughs)	Number of different health services	Number of different services from voluntary sector
Healthy active ageing and supporting independence	2	0	3
Living well with long term conditions	2	6	4
Living well with complex co-morbidities and frailty	2	2	1
Rapid support close to home in crisis	3 (of which one combined with healthcare)	5	1
Good discharge planning and post-discharge support	2	4	0
Good rehabilitation and reablement	1 (combined with healthcare)	6	0
Choice, control and support towards the end of life	0	5	1

The mapping exercise gave initial insight into capacity and coverage of the services. For instance, we know that 3.5 WTE of dementia navigators are available in NWS and that they work across all three localities in NWS. We also know that across NWS there are specialist nurses available for e.g. heart failure and diabetes but that their capacity is limited, and that the participants of the mapping exercise perceived a shortage of district nurses in NWS[q].

[p] Social care is also means tested as opposed to care provided by the NHS; in Surrey a large majority of people self-fund their social care.

[q] Note: the Royal College of Nursing warned in June 2014 that in the past 10 years in England there has been a 47% reduction in the number of qualified district nurses (http://www.rcn.org.uk/newsevents/press_releases/uk/district_nurses_face_extinction_in_2025)

8.1 Example of community support: the community matrons

One of the many community based services in NWS is the 'virtual ward' or workforce of community matrons. They are experienced nurses who visit frail older people in their homes for a duration of maximum 3 months, with the aim to improve their function and wellbeing and prevent hospital admission. On a recent shadowing visit with one of the matrons, the following activities were observed during a visit to a new patient:

- Comprehensive assessment of daily needs including home adaptations
- Checked use of walking aids
- Medication review. Called pharmacy and GP as medication did not correspond with hospital discharge list
- Checked all available meds in house, also from partner; neither took medication correctly
- Administered a memory test, scored poorly
- Discussion of needs, got permission for referral to mental health matron
- Left materials of local voluntary sector organisations
- Discussion with social care in weekly MDT meeting
- Enter data in ambulance system
- Matron will follow up next week with patient.

Evaluation data on the virtual ward is limited but does show that the number of people being admitted was reduced after being visited by the community matrons. More robust evaluation of data will be required but there are indications that the service that the community matrons provide is very valuable and meets many of the requirements for 'integrated care provision.'

9. Gap analysis of frailty services in NWS

In a gap analysis the following would be compared:
- The need of the population i.e. the needs of the estimated 10,000 frail elderly people in NWS
- Current service provision.

Based on the mapping exercise it is not possible to identify current gaps, as we are not clear enough on the objectives, the capacity and coverage of services. If we knew whom they target and how, we would know if (part of the) cohort of 10,000 people were being served or not.

Anecdotally, staff involved in the mapping exercise seemed to feel there was a shortage of rapid response service in the community. The mapping exercise also showed a lack of services that can address multiple problems (social and health) quickly, 24 hours per day (Appendix C). In the (relative) absence of such services it is understandable that patients and carers call an ambulance if they can't manage at home.

The mapping exercise showed that the landscape of social services is currently too complex. It is not possible to fully oversee and understand who does what, and how services relate to each other. It also showed that there is overlap in service provision by the different sectors, i.e. that services are offered by both social care, the NHS and the voluntary sector. This applied to at least the following services:
- Reablement services
- Services for carers
- Occupational therapists
- Dementia care.

As it is unclear which residents these services target, where, with what objective and at what cost, it is likely that there is duplication and reduced (cost) effectiveness of service provision. An important objective of the design of the frailty pathway must therefore be to reduce complexity in the community services.

The gap analysis approach should be taken forward in the commissioning process of services for frail elderly. This approach could be:

1) Develop a shared vision across health, social care (and where possible the voluntary sector) of what care for frail elderly should look like
2) Review services to understand whether they meet the needs of the population and are part of a coherent system of care and support in NWS
3) If not, decommission services to release funding
4) If services have the potential to meet the needs and do fit into a coherent system, decide whether current services need more capacity and increase funding
5) Decide whether, once current services have enough capacity, additional services are required and procure these.

Recommendation: In the development of the frailty pathway, focus on reducing complexity of the community services; identify which current services add value and decommission services that don't. Assess whether current services may need more capacity to improve access to and effectiveness of these services.

One of the lessons learned from the mapping exercise is that health and social care providers are not aware of the availability of services for frail elderly people (Appendix G). This means that even if services could meet the needs of the population, they may not be utilised sufficiently as people cannot be referred in.

Recommendation: following the design of the frailty pathway, widely advertise the availability of services and ensure there is one portal of services that patients and professionals (across health, social care and the voluntary sector) can access.

10. Guidance and evidence on service redesign for frail elderly

NWS services will need to change to meet the needs of the frail elderly population, but the question is how. In this chapter, relevant guidance including evidence on what works has been summarised.

10.1 Guidance on the development of community services

The King's Fund has published a useful report on reforming NHS community services (37) . Community services form a large part of NHS activity yet in many areas it is not clear what services are being provided to whom. This also followed from the NWS mapping exercise (see chapter 8).

In the context of shifting care from the acute sector to the community, it is essential that community services work effectively. The King's Fund argues that as a result of frequent reorganisations, community services have become too complex and fragmented and are therefore not capable of serving the needs of the population. The (sometimes poorly thought through) reorganisations led to implementation of multiple programmes implemented for different patient groups without clarity about how the services related to the wider health economy.

The King's Fund set up a working group of community providers to make recommendations on improving community services. They describe a number of steps that should be taken to transform community services (37):

- "A key first step is to remove the complexity that has resulted from different policy initiatives over the years. A simple pattern of services should be developed, based around primary care and natural geographies and with a multidisciplinary team. These teams need to work in new

ways with specialist services – both community and hospital based, to offer patients a much more complete and less fragmented service.

- New models need to include both mental health and social care, including the management of the health and social care budget for the care of their patients.
- These services need to be capable of a very rapid response and to work with hospitals to speed up discharge. Access to community or nursing home beds for short stays can make an important difference.
- Significant numbers of patients occupying hospital beds could be cared for in other settings but only if suitable services are available and can be accessed easily.
- New ways to contract and pay for these services are needed. This will also require changes in primary care and hospital contractual arrangements and in the infrastructure to support the model.
- Community services also need to reach out into communities more effectively. The opportunity to harness the power of the wider community to support people in their own homes, combat social isolation and improve prevention is not being fully exploited".

Recommendation: use the King's Fund recommendations on NHS community services to develop NWS community services. Strive to make the community system simpler and avoid adding multiple initiatives to the already complex list of community services.

10.1.1 Case study community MDT team

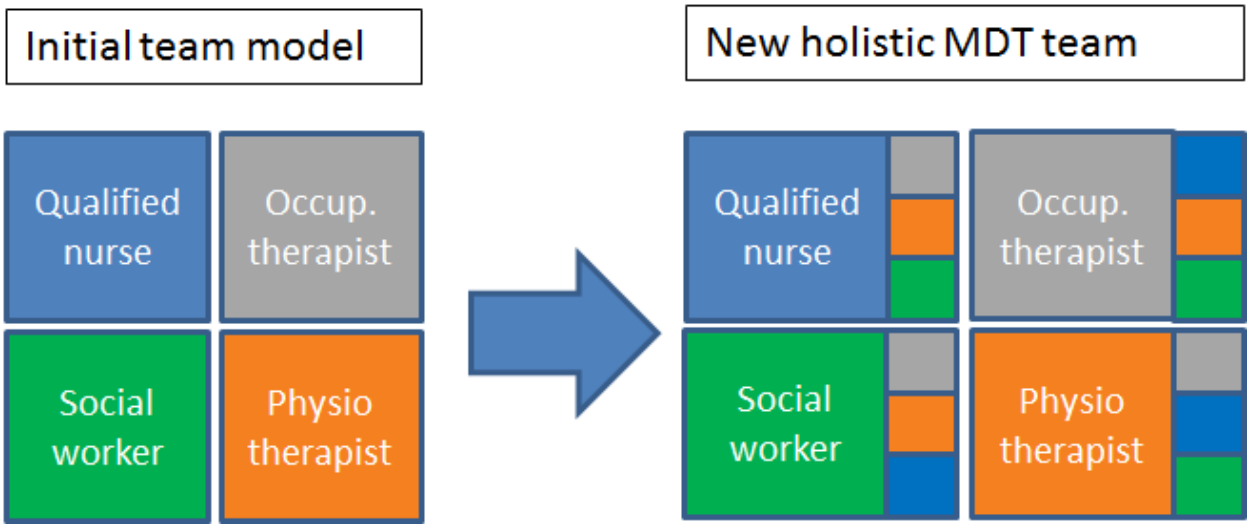
In many policy recommendations, multidisciplinary community teams are mentioned. One interesting case study comes from Nottingham where a social enterprise (The Nottingham CityCare Partnership) delivers community healthcare.

The pilot has been described in the Health Service Journal (38). In 2009 the organisation set up a pilot to change an existing intermediate care team into a new crisis response team. The new team soon found that the needs of the elderly people they cared for were very broad and required different skills sets, but not at the level of a fully trained professional nurse or occupational therapist. They designed the 'holistic practitioner role'.

In this model (see Figure 10) four group of professionals (qualified nurses, social workers, occupational therapists and physiotherapists) are being trained in each other's disciplines up to the level of a general assistant practitioner. "In practice it means, for example, a nurse can undertake a full nursing assessment during a visit and, while there, sort out basic occupational therapy issues such as equipment to get in and out of bed or to cook safely in the kitchen. Similarly, a physiotherapist could teach an exercise programme and do a basic tissue viability assessment at the same time."

Initially these changes were difficult for staff, but then their confidence increased. The team have reported greater job satisfaction. One nurse commented: "'You should have asked me that on Monday when I was mainly being a nurse. Today I have spent the morning being a social worker and the afternoon as a physiotherapist." She says she never wants to go back to her previous way of working − she now has more freedom to help, which was why she became a nurse in the first place' ".

Figure 10: Nottingham CityCare model for multidisciplinary working (38)



The potential benefits of using this approach in community care for elderly frail people in NWS could be:

- Reduced number of different people visiting the homes of frail elderly people
- Fewer handover moments (i.e. risks of errors reduced)
- Better coordination
- Improved quality of care
- Greater job satisfaction of staff.

Recommendation: assess the skill set and size of the existing NWS community workforce and consider training professionals in other professional's skills to create responsive, efficient community teams.

10.2 Evidence for effective frailty pathways

The NHS England Integrated pathway for frail elderly (see 3.2.1) was supported by a 2014 report written by David Oliver for the King's Fund; this included an overview of evidence on 'what can work' in providing care and support for elderly people (39).

By 'what can work' the authors means interventions that have shown to be effective and for which there is evidence of effectiveness in the literature. Rather than saying that these interventions *will* work, the author emphasises that "no service innovation or improvement initiative can simply be 'dropped in' and expected to deliver if the local systems, culture and leadership are not conducive to change."

The evidence overview is comprehensive and includes evidence for interventions to provide ten key components[r] of care for elderly people:

- healthy, active ageing and supporting independence
- living well with simple or stable long-term conditions
- living well with complex co-morbidities, dementia and frailty
- rapid support close to home in times of crisis
- good acute hospital care when needed
- good discharge planning and post-discharge support
- good rehabilitation and re-ablement after acute illness or injury
- high-quality nursing and residential care for those who need it
- choice, control and support towards the end of life
- integration to provide person-centred co-ordinated care.

Note: the report also includes case studies and lists of further reading including key publications and guidance.

For this needs assessment the evidence on 'helping people live with complex co-morbidities, including dementia and frailty' is most relevant. It should be noted however that a proactive programme to prevent frailty and care for 'pre-frail people' should focus on implementing interventions to meet all components of care for elderly, of which frail elderly are a subgroup.

Table 7 includes seven evidence based interventions to support people to live with complex co-morbidities including dementia and frailty. The report includes guidance on each component.

Table 15: Summary of evidence from David Oliver report, 2014 (39)

Component of care	Example of what can work
Helping people live with complex co-morbidities, including dementia and frailty	Recognising the importance of frailty
	Using frailty risk assessment and case-finding[s]
	Using proactive comprehensive geriatric assessment and follow-up for people identified as frail
	Promoting exercise for frail older people
	Falls prevention
	Providing good care for people with dementia
	Reducing inappropriate polypharmacy

[r] These components largely overlap with the pathway components in the NHS England pathway
[s] See Appendix E for more information about the new DES including its risk assessment and how it relates to identifying frail elderly people

Recommendation: in the design of the frailty pathway, implement interventions for which there is evidence of effectiveness. In particular, consider implementing the seven evidence based interventions for supporting people living with frailty from David Oliver's report.

10.3 Age UK guidance on developing care for frail elderly

The Age UK qualitative research report (see 7.1) (6) makes a number of recommendations for policy makers including CCG. They believe there are three core objectives to support frail elderly people:

Maximising capacity and capability: services should focus on supporting frail elderly maximise what they can do. Below is a summary of recommendations relevant to CCGs:

- "Every opportunity must be taken to identify people that are living with or are at risk of frailty.
- Community services should become multi-purpose. For example, GP practices could be linked to money guidance agencies or befriending and falls prevention services.
- Housing, including home adaptations, must be routinely incorporated into individual and local service planning. Leaving someone to wait for seven months, for a stair lift for example (…) is unfair on individuals and often a false economy.
- Reducing loneliness must be included as an objective in all joint health and wellbeing strategies"

Personalising care goals: the research showed that the goals of frail elderly people are often different from the goals of their service providers. This is not right; what matters is what matters to people. A summary of recommendations relevant to CCGs is:

- "Older people living with frailty and their carers should be encouraged and supported to discuss what is most important to them and this should inform any care or support package.
- All local services, particularly NHS and social care services, must invest in spreading approaches that embed shared decision-making.
- Older people living with frailty and their carers should have ownership of care plans; usable information to help them manage their health and wellbeing, including access to supported self-management; and a clear point of contact when changes in their health or social circumstances occur.
- As we age, we should all be encouraged to establish our wishes and preferences in advance of a crisis.
- The quality of local services must be judged on their ability to support people to continue meeting life goals, regardless of their age.

Managing risk: risk management in frail elderly people must be undertaken in partnership with frail elderly and their carers and should take their wellbeing and quality of life into account.

This is a summary of recommendations relevant to CCGs :

- "Care planning for older people must incorporate risk as something which is managed rather than simply avoided.

- The *Silver Book*[t] includes good practice for when older people are admitted to hospital in an emergency and should be widely implemented. However, this must also include effective out of hours services and comprehensive support for carers.

- People expected to need a move to a care home should be assessed by an older people's specialist so that a strategy to avoid admission, wherever possible, can be developed.

- Public health initiatives and messaging must do more to highlight frailty as something that you can change or reduce the risk of, irrespective of age"

10.4 Evidence on integrated care

There is a wide literature base on 'integrated care'. Integrated care can mean different things to different people, in different countries and across different healthcare system. Below follows a brief summary of relevant evidence on integrated care, where relevant for the development of the frailty pathway.

The premise of integrating care for frail elderly in NWS is that this group of people have a wide range of needs including (mental) health and social needs. Not one silo of services or organisations can address these needs. Hence more integration of services to support frail elderly people in NWS is required.

10.4.1 Nuffield Trust 2013

The evidence on the effectiveness of integrated care is limited. The Nuffield Trust has evaluated a range of community based integrated care programmes in over 30 sites across England (40). Their conclusion is that to date none of these interventions have shown to be effective in reducing emergency hospital admissions; they acknowledge this is a disappointing finding.

Based on their research, the Nuffield Trust make a number of recommendations for implementing integrated care interventions (40):

- Recognise that planning and implementing large scale service changes take time.

Many US models of integrated care have taken years or decades with stable leadership to develop. The authors make the important point that developing the interventions and good evaluation takes time; sponsors of projects should understand that within two years of running and interventions they will not see an impact on service use.

- Define the interventions clearly and what it is meant to achieve and how, and implement it well.

The research showed that it was often difficult to evaluate the impact of an intervention because it was not clear what the interventions was compared with 'usual care'. This can be improved by utilising good project management.

[t] The Silver Book is a set of quality standards for emergency care for elderly people, available from http://www.bgs.org.uk/index.php/bgscampaigns-715/silverbook

- Be explicit about desired outcomes and use interim markers of success

Is it clear and logical how and why an interventions would lead to desired outcomes, e.g. reduced hospital admissions? Is it possible to identify intermediate markers of success? A number of the studies included in the report found that although emergency admissions had not been reduced following an intervention, outpatient attendance or elective care had been reduced.

- Generalisability and context are important

Consider if a 'proven effective' method of integrating care works in the CCG's context. A main issue is whether the right target population is included in the intervention; if people are included who are low risk, the intervention may not work as the effect is 'diluted' (41).

- Size and time matter

If you want to show a statistically significant result of an intervention you need a large number of people to be included in the intervention. This is often difficult and there is a risk of then including people that are at lower risk of the outcome (see above). A useful alternative is to collect qualitative data i.e. to ask frail elderly people, their carers and staff whether the intervention is helping them or not.

- Hospital use and costs are not the only impact measures

Following from the comments above, consider in honesty what the interventions is supposed to achieve. If this is improvement of quality of care for elderly, then hospital use should not be used as a primary outcome indicator.

- Pay attention to implementation

The Nuffield Trust believes that one of the reasons why the interventions did not show effectiveness was that programmes had not been implemented fully. If a programme has only been implemented for e.g. 30% it is unlikely to show effectiveness.

- Carefully consider the best method for evaluation

The Nuffield Trust found that interventions often took time to develop. If evaluation started too early, there were risks of finding that the intervention did not work, whereas in fact it had been 'too early to say'. The recommendation is therefore give the intervention time to develop, during which there can be some light monitoring of processes, and evaluate after the embedding time.

- Work with what you have: organisation and structural change may not deliver outcomes.

Structural change (changing organisations) may take up a lot of time and may not improve care for patients. It is important to be clear about what changes should happen on the ground and to plan for these changes.

10.4.2 Evidence review integrated care

Public Health Ealing has undertaken an evidence review on integrated care to Ealing CCG in developing integrated care. It looked at the evidence for effectiveness of integrated care programmes on quality of care, mortality of patients, hospital use and cost savings.

The summary of the review has been included in Appendix E.

Some of the main findings were:

- "The evidence base for integrated care approaches is stronger for individual long-term conditions, such as heart failure and COPD, than for frail older people or older people with multiple long term conditions" (i.e. based on the evidence integrated care approaches are more effective for people with single long term conditions than for frail older people or people with multiple long-term conditions).
- "There is very little evidence reported on overall cost savings as a result of integrated care approaches".

Recommendations from the evidence review were:

- Integrated care initiatives should adopt a multi-disciplinary approach and include a self-care component where possible.
- Improving care quality must be the central aim for local integrated care initiatives.
- A small number of shared care-quality outcome measures should be agreed (…). These measures could include self-reported wellbeing measures, measures of satisfaction with care, measures of function (such as mobility), and clinical measures such as blood pressure control.
- Cost savings cannot be expected as a result of integrated care initiatives.
- Local integration initiatives must include a **prospective** evaluation, with agreed aims and objectives and regular reporting against these objectives. Evaluation reports should be available to the public.

Recommendation: use the experience of previous integrated care initiatives in the design of integrated care for frail elderly people. In particular, carefully define what the programme should achieve, how and for whom, and ensure sufficient resources for implementation. Evaluation should be carefully planned and only start after the programme has had its start-up time and is truly running.

11. Main findings

The aim of this needs assessment was to provide the evidence base for the development of the frailty pathway for frail elderly people in NWS. The needs assessment used a CCG agreed definition for frail elderly people which includes people aged 75 with diagnosed frailty symptoms, people living in nursing and residential care homes, people suffering from dementia, Parkinson's disease, MS and people in the last phase of life.

Care and support for frail elderly is at the core of national and local policy. A well designed frailty programme, if implemented successfully, will contribute to all five strategic objectives of the Getting it right is important first and foremost for frail elderly people and their carers in NWS, but also for the CCG NWS.

The needs assessment's findings fit into the planning phase of the commissioning cycle which should drive commissioning at the CCG. An important part of this phase is to ask patients what kind of services they want and need. Elderly NWS residents have not been asked that question yet. In the absence of local data we should use national data derived from interviews with frail elderly people. What the data show is that there is a big difference between how professionals understand frailty and how people understand frailty; many people identified as 'frail' don't see themselves like that at all. Also, people highly value their independence and want to do as much as they can with their current functionality. People are interested in how to live their lives, not in health or social care services. Services should be built around supporting people to live their lives.

For planning of health and support services we need to understand how many people would require those services. In this needs assessment this cohort of people has been defined. The number of people currently in the frail elderly cohort across NWS is 10,000 people; this will increase to 11,500 in 2018. This means that services for frail elderly people, if implemented fully, should have capacity for 10,000 people and that capacity should be increased in the next years.

After estimating the size of the cohort that services need to cater for it is important to understand the specific characteristics of frail elderly people. This needs assessment therefore includes chapters on determinants of health (i.e. factors that impact on the health) of frail older people and a number of important diseases relevant to the people in the cohort. One important factor of (mental) health is loneliness; it is estimated that up to half of people aged 85+ feel lonely regularly. Another important factor is deprivation. Generally people in NWS are affluent, but it estimated that 10% of people aged 65 in NWS live in poverty. Planning for services should take note of more deprived areas and ensure sufficient support is available there.

Mapping of current services against the NHS England pathway for frail elderly people showed that NWS is home to a wide range of services for frail elderly people, provided by the NHS, social care and the voluntary sector. The mapping exercise showed overlap and potential duplication; for instance, there were multiple providers of occupational therapy, reablement and carers' services. It also showed that it is difficult to map social care and healthcare services against the same outcomes. Social care services are offered on the basis of social needs irrespective of whether someone is frail; we therefore found it more useful to distinguish between a wide range of 'core' social services available, and a smaller number of services that specifically address outcomes included in the pathway.

The mapping exercise showed that the landscape of services in the community is currently too complex. It is not possible to fully oversee and understand who does what, and how services relate to each other. As it is unclear which residents these services target, where, with what objective and at what cost, it is likely that there is duplication and reduced (cost) effectiveness of service provision. An important objective of the design of the frailty pathway must therefore be to reduce complexity in the community services.

Last, the needs assessment assessed current guidance and evidence about the development of a frailty pathway. There is a lot of evidence and guidance relating to the development of better community services, specific frailty services and 'how (not) to' set up integrated care locally. The CCG should use the available guidance to develop an evidence based frailty pathway. This will ensure frail elderly people in NWS can stay at home healthy, safely and happily for as long as possible.

12. Recommendations

Based on the data collated in this needs assessment, the following recommendations were made:

Re the design of the frailty pathway:

- Plan the current frailty pathway to address the needs of frail elderly 10,000 people in NWS, and 11,500 in 2018.

- Ask frail elderly people in NWS what they want from health and social care, and how they experience current care and support. Involve them in the development of the frailty pathway.

- Use data included in this needs assessment on specific needs and risk factors of frail elderly people to make sure that services meet their needs.

- Involve front line staff including community matrons and community nurses in development of any new pathway; they know what NWS people need and they have direct insight into what works and what does not work.

- Following the design of the frailty pathway, widely advertise the availability of services and ensure there is one portal of services that patients and professionals (across health, social care and the voluntary sector) can access.

Re commissioning services in the pathway:

- Focus on reducing complexity of community services in NWS; identify which current services add value and decommission services that don't. Assess whether current services need more capacity to improve access to and effectiveness of these services.

- Assess the skill set and size of the existing NWS community workforce and consider training professionals in other professional's skills to create responsive, efficient community teams.

- Ensure that development of other CCG programmes, specifically the dementia programme, are closely linked.

- Use the King's Fund recommendations on NHS community services to develop NWS community services. Strive to make the community system simpler and avoid adding multiple initiatives to the already complex list of community services.

Re the use of evidence:

- Implement interventions for which there is evidence of effectiveness. In particular, consider implementing the seven evidence based interventions for supporting people living with frailty from David Oliver's report.

- Use the experience of previous integrated care initiatives in the design of integrated care for frail elderly people. In particular, carefully define what the programme should achieve, how and for whom, and ensure sufficient resources for implementation. Evaluation should be carefully planned and only start after the programme has had its start-up time and is truly running.

13. References

1. **The King's Fund.** Data briefing. Emergency bed use: what the numbers tell us. *http://www.kingsfund.org.uk/sites/files/kf/data-briefing-emergency-bed-use-what-the-numbers-tell-us-emmi-poteliakhoff-james-thompson-kings-fund-december-2011.pdf (accessd on 19/05/2014).* [Online] 2011.
2. **The King's Fund.** Data Briefing, Emergency hospital admissions for ambulatory care-sensitive conditions: identifying the potential for reductions. *available from http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf (accessed on 19/05/2014).* [Online] 2012.
3. **Department of Health.** *Long Term Conditions Compendium of Information: Third Edition.* 2012.
4. **Surrey County Council.** *Medium term financial plan 2014-2019. Available from http://www.surreycc.gov.uk/view?a=812301 (accessed on 31 July 2014).*
5. **NHS England.** *Safe, compassionate care for frail older people using an integrated care pathway:ractical guidance for commissioners, providers and nursing, medical and allied health professional leaders, available from http://www.england.nhs.uk/ (accessed on 07/05/2014).*
6. **Ipsos Mori for Age UK.** *Understanding the lives of older people living with frailty. Available from http://www.ipsos-mori.com/researchpublications/publications/1660/Understanding-the-lives-of-older-people-living-with-frailty.aspx (accessed on 19 May 2014).* 2014.
7. **Department of Health.** *NHS outcome indicators 2014/2015 at a glance. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256457/At_a_glance_NHS_OF.pdf (accessed 21 July 2014).* 2014.
8. **Department of Health.** *Public Health Outcomes Framework 2013 - 2016. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263659/2901502_PHOF_Improving_Outcomes_PT1B_v1_1.pdf (accessed on 21 July 2014).*
9. **Department of Health..** *Adult Social Care Outcomes Framework. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263783/adult_social_care_framework.pdf (accessed 21 July 2014).*
10. **Surrey County Council.** *The Care Act Briefing June 2014. Available from http://www.surreycc.gov.uk/__data/assets/pdf_file/0011/854327/Care-Act-Briefing-June-2014.pdf (accessed on 22 July 2014).*
11. **Surrey County Council.** The Care Act. *http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/adult-social-care-strategies-policies-and-performance/the-care-act (accessed on 22 July 2014).* [Online]
12. **Surrey County Council.** Care Act funding reforms easy read,April 2014, available from http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/adult-social-care-strategies-policies-and-performance/the-care-act. (accessed 22 July 2014). [Online]
13. **Surrey County Council Public Health.** Joint Strategic Needs Assessment (JSNA). *http://www.surreyi.gov.uk/grouppage.aspx?groupid=36&cookieCheck=true (accessed on 07/05/2014).* [Online]
14. **Institute of Public Care.** POPPI - Projecting older people population information system. Available from http://www.poppi.org.uk/ (accessed on 30 July 2014). [Online]
15. **Institute of Public Care.** PANSI - projecting Adults Needs and Service Information. Avaialbel from http://www.pansi.org.uk/index.php?pageNo=355 (accessed on 30 July 2014). [Online]
16. **Independent Commission on Whole Person Care for the Labour Party.** *One person, one team, one system. Report of the Independent Commission on Whole Person Care. Available from http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf (accessed on 9 June 2014).* 2014.
17. **Department of Health.** *Long term conditions compendium of information, third edition. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf (accessed on 23 July 2014).*
18. **Collard RM, Boter H et al.** Prevalence of frailty in community-dwelling older persons: a systematic review. *J Am Geriatr Soc.* 2012, Vols. 60:1487-1492.

19. **Marmot, RA.** *The Marmot review, 2010, Fair society healthy lives. Available from http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review (accessed on 27 July 2014).*
20. **British Institute for Learning Disabilities.** *Factsheet: older people with a learning disability, 2012. Available from http://www.bild.org.uk/information/ageingwell/ (accesed on 22 July 2014).*
21. **PCMD Ageing Research Goup / Age UK.** *Health care quality for an active later life. Available from http://www.exeter.ac.uk/media/universityofexeter/medicalschool/pdfs/Health_Care_Quality_for_an_Active_Later_Life_2012.pdf (accessed 22 July 2014).*
22. **National Obesity Observatory .** *Data factsheet adult weight, February 2013. Available from http://www.noo.org.uk/uploads/doc/vid_17925_AdultWeightFactsheetFeb2013.pdf (accessed 30 July 2014).*
23. **The NHS Information Centre.** *Health Survey for England 2008 volume 1, physical activity and fitness. Available from http://www.hscic.gov.uk/catalogue/PUB00430/heal-surv-phys-acti-fitn-eng-2008-rep-v2.pdf (accessed 30 July 2014).*
24. **Chief medical officers of the four home countries.** *Start active, stay active. A report on physical activity for health. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216370/dh_128210.pdf (accessed on 29 July 2014).*
25. **Surrey County Council.** Joint accomodation strategy for people with care and support needs. *http://www.surreycc.gov.uk/__data/assets/pdf_file/0006/177234/Joint-Accommodation-Strategy-for-People-with-Care-and-Support-Needs-April-2010-2014.pdf (accessed 07/05/2014).* [Online]
26. **Centre Forum / Age UK.** *Ageing alone: loneliness and the oldest old. Available from: http://www.centreforum.org/index.php/mainpublications/612-ageing-alone (accessed on 9 June 2014).* 2014.
27. **Public Health England.** *Older people deprivation, available from http://www.apho.org.uk/resource/item.aspx?RID=97318 (accessed on 6 June 2014).*
28. **Lang, I, Hubbard R et al.** English Longitudinal Study of Ageing. Neighborhood deprivation, individual socioeconomic status, and frailty in older adults. Available from http://www.elsa-project.ac.uk/publicationDetails/id/5850 (accessed 4 June 2014). 2009.
29. **National Institute for Health and Care Excellence (NICE).** *Clinical guideline 8. Multiple sclerosis: Management of multiple sclerosis in primary and secondary care. Available from: http://www.nice.org.uk/guidance/CG8/chapter/Key-priorities-for-implementation (accessed on 31 July 2014).* 2003.
30. **Multiple Sclerosis Trust.** *Multple Sclerosis information for health and care professionals. 2011. Available from http://www.mstrust.org.uk/downloads/ms-info-health-professionals.pdf (accessed on 31 July 2014).*
31. **National Institute for Health and Care Excellence (NICE).** *Clinical guideline 35: Parkinson's disease: Diagnosis and management in primary and secondary care. Available from http://www.nice.org.uk/guidance/cg35/chapter/introduction (accessed on 04 August 2014).* 2006.
32. **Parkinson's UK.** *Parkinson's nurses – affordable, local,accessible and expert care. A guide for commissioners in England. Available from http://www.parkinsons.org.uk/sites/default/files/publications/download/english/englandnursereport.pdf (accessed on 4 August 2014).* 2011.
33. **National Literacy Trust.** Adult literacy, available from http://www.literacytrust.org.uk/adult_literacy (accesed on 24 July 2014). [Online]
34. **The NHS Information Centre for health and social care.** *Adult psychiatric morbidity in England, 2007; results of a household survey. Available from http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf (accessed 29 July 2014).*
35. **Mental Health Foundation.** *The fundamental facts, the latest facts and figures on mental health. 2007.Available from (acessed on 30 July 2014).*
36. **Department of Health.** *Living well with dementia: a national dementia strategy. 2009. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168220/dh_094051.pdf (accessed on 30 July 2014).*

37. **King's Fund.** *Community services, how they can transform care. Available from http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/community-services-nigel-edwards-feb14.pdf.* 2014.
38. **Upton S, Creswell, A.** A multitalented approach to delivering community care. Available from: http://www.hsj.co.uk/home/commissioning/a-multitalented-approach-to-delivering-community-care/5067234.article (accessed 31 July 2014). *HSJ.* 5 February 2014.
39. **The King's Fund.** *Making our health and care systems fit for an ageing population, 2014. Available from http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population (accessed on 31 July 2014).*
40. **The Nuffield Trust.** *Evaluating integrated and community-based care, how do we know what works? 2013. Available from http://www.nuffieldtrust.org.uk/publications/evaluating-integrated-and-community-based-care-how-do-we-know-what-works (accessed on 4 August 2014).*
41. **Edmons J, et al.** Specialist geriatric medical assessment for patients discharged from hospital acute assessment units: randomised controlled trial. 2013, Vol. BMJ 2013;347.
42. **Surrey Health and Wellbeing Board.** Health and Wellbeing Strategy. *http://www.healthysurrey.org.uk/health-and-wellbeing-board/health-and-wellbeing-board-str/ (accessed on 07/05/2014).* [Online]
43. **Surrey County Council Adult Social Care.** Adult Social Care Commissioning Strategy for Older people in Surrey. *https://www.surreycc.gov.uk/__data/assets/pdf_file/0009/272268/OP-Commissioning-Strategy-Final-20120221.pdf (accessed on 07/05/2014).* [Online]
44. **Surrey Health and Wellbeing Board.** *Surrey Health and Wellbeing Strategy: older adults action plan 2014 - 2016 , available from http://mycouncil.surreycc.gov.uk/documents/s12949/Older%20Adults-Final%20Report.pdf (accessed on 16 May 2014).*
45. **Surrey County Council.** Dementia and older people's mental health commissioning strategy. *http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/adult-social-care-strategies-policies-and-performance/dementia-and-older-peoples-mental-health-joint-commissioning-strategy (accessed on 07/05/2014).* [Online]
46. **Surrey County Council.** Commissioning strategy for people with long term neurological conditions. *http://www.surreycc.gov.uk/social-care-and-health/adult-social-care/adult-social-care-strategies-policies-and-performance/joint-commissioning-strategy-for-adults-with-long-term-neurological-conditions (accessed on 07/05/2014).* [Online]
47. **Surrey County Council.** Surrey carers strategy. *http://www.surreycc.gov.uk/social-care-and-health/information-for-carers/surrey-carers-charter-and-strategy (accessed on 07/05/2014).* [Online]
48. **NHS Surrey and Surrey County Council.** *Draft Joint Commissioning Strategy for Adults with Long Term Neurological Conditions in Surrey 2011 - 2015. Available through Julie Gardner, CCG NWS.*
49. **NHS England.** Avoiding unplanned admissions enhanced service: proactive case finding and care review for vulnerable people. Guidance and audit requirements. . *http://www.nhsemployers.org/~/media/Employers/Publications/Avoiding%20unplanned%20admissions%20guidance%202014-15.pdf (accessed 22 July 2014).* [Online] 2014.
50. **Office for National Statistics (ONS).** *Healthy Life Expectancy at Birth and at Age 65: Clinical Commissioning Groups (2010-12). Available through: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-353264 (accessed on 19 May 2014).* 2014.

Appendix A Relevant Surrey policies

Name policy	Scope	Years covered	Authors
Surrey Joint Health and Wellbeing Strategy (42)	Health and wellbeing of all residents including older residents in Surrey	2014 -	Surrey Health and Wellbeing Board
Adult Social Care Commissioning Strategy for Older People in Surrey (43)	Surrey County Council's approach to meeting the social care needs of older people	2011 - 2020	SCC
Surrey Health and Wellbeing Strategy: Older Adults Action Plan 2014-2016 (44)	Joint action plan to deliver actions from Health and Wellbeing Strategy	2014 - 2016	Surrey Health and Wellbeing Board
Joint Accommodation Strategy for people with care and support needs (25)	Mapping of housing and care needs in all districts / boroughs and action plans; housing for older adults is priority for all districts / boroughs	2010 - 2014	SCC and 11 District and Borough councils
Dementia and Older People's Mental Health Joint Commissioning Strategy (45)	Dementia and mental health services for older people, based on national strategy 'Living well with dementia' (2009)	2010 - 2015	SCC and NHS Surrey
Joint Commissioning Strategy for Adults with Long Term Neurological Conditions in Surrey (46)	Long term neurological conditions including MS and Parkinson's disease	2011 - 2015	SCC and NHS Surrey
Surrey Carers strategy (47)	Strategy to support carers in their carers' duties but also support carers' health and ambitions (includes action plan)	2012 – 2015	SCC

Appendix B Summary points from Surrey LTNC Strategy 2011-2015

Below is a summary of relevant points of a draft Surrey wide strategy for Long Term Neurological Conditions, including MS and Parkinson's disease. The full report is available from the CCG NWS (48).

"What have people told us they want?

Various co-design, stakeholder engagement and focus group events, and consultations with the Users and Carers Reference Group, identified a range of areas where people have concerns and where improvements need to happen:

- An accurate diagnosis, timely assessments and ongoing reviews of conditions and individual needs is important to help people plan for their future
- More choice and control over care, treatment and support
- Support to stay at home and to remain as well, healthy and as independent as possible
- Clear information about their condition and about the support and services available to them, in a format that suits them
- Everyone involved in the care of people with LTNCs should have a good understanding of their needs and be appropriately trained
- Smoother, more coordinated pathways of care, with improved communication between service teams A key worker/care navigator role is seen as important
- More care at home and/or closer to home to reduce the need for hospital visits
- Equitable access to a full range of services. These services include intensive rehabilitation and reablement, speech and language therapy, physiotherapy, pain and spasticity management, specialist services, psychological and family support and equipment.
- Proactive services with easy, fast access to increased support if required
- Everyone who wanted to should have access to specialist nurses/ practitioners
- Improved end of life care and support so that people can die in dignity and without pain, in the place of their choice and are cared for by staff with appropriate knowledge and skills
- Improved access to cognitive therapy for those with other neurological conditions e.g. brain tumours.
- Support to get back to work or seek employment, learn new skills or retrain
- Telecare and telehealth support to help people with LTNCs manage their own conditions.
- Carers should be able to talk to the right person with the right expertise about their needs, and access support whenever they need a break from their caring role."

What service changes are needed?

In summary:

WE NEED LESS:

- Residential care
- Standard, 9am to 5pm, Monday to Friday day care services
- Unplanned hospital care

WE NEED:

- Equitable and timely access to a wide range of local services
- Personal budgets and direct payments so people can exercise more choice and control over their support
- Opportunities for retraining, vocational rehabilitation, support for returning to work, employment, leisure pursuits and social participation
- Improved access to 24-hour specialist care and support for those with complex health and social care needs
- Flexible community services and support, and an increased range of service options to support people at home
- Support to navigate the complex health and social care systems and help people achieve their individual outcomes in life
- To maximise the use of Telecare, Telehealth and digital technology
- One stop shops and information and advice services
- Clear integrated pathways of care, including timely access to reablement and rehabilitation

Appendix C Mapping results

CORE FRAILTY SERVICES							
Service	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
SOCIAL CARE							
Social Care Practitioners (SCC)	Undertake assessments for older people and develop care plans.	Currently able to manage demand	Across NWS	✓	✓	✓	Free
Wellbeing Centres (SCC)	Local hubs of information and support services relating to memory loss, dementia and associated problems. Carers may find the Wellbeing Centre support and services very helpful in their caring role.	Unlimited	One in each NWS Borough	Effective for those accessing but more work required to raise profile		Open to anyone, whatever their situation and whether they are concerned about themselves or others. Transport provided by District & Boroughs	Local prices vary
Extra Care (Sheltered Housing)	Extra Care Housing is housing designed with the needs of frailer older people in mind and with varying levels of care and support available on site. People who live in Extra Care Housing have their own self-contained homes, their own front doors and a legal right to occupy the property. It comes in many built forms, including blocks of flats, bungalow estates and retirement villages	200 approx flat in NWS	Across NWS	Open to non-residents during the day as a day centre	✓		Rent or purchase of property and contribution to care
Day Centres/ Leisure Centres/ Community Centres (District & Borough	Centres aim to promote an active and full life offering a range of leisure activities, services and facilities to suit individual tastes and needs.	Currently able to manage demand	Across NWS	✓	Not acceptable to all Referrals currently by community matrons and	Transport provided	Dependent on centre and activity

Councils)					social services		
Meals on Wheels (District & Borough Councils)	Meals on Wheels deliver hot or frozen ready-made meals either on a permanent or short term basis. The service encourages people to remain independent, continue to live in their own home and to assist carer's in their caring role. It also ensures that people are being encouraged to eat nutritious meals and are prompted to drink as well as having someone check that they are well.	Currently able to manage demand	Across NWS	✓	✓		Cost incurred
Reablement (SCC)	Homecare provided by local authority for up to 6 weeks with the aim of enabling independence.		Across NWS	✓	✓	✓	
Befriending Services (District & Borough Councils)	Befriending services provide one to one support by trained volunteers. Befrienders provide emotional support at times of change or difficulty.	Limited	Dependent on volunteers	✓	✓	Dependent on volunteers	Free
In-touch (SCC)	Provided by the Locality Team for those on the caseload with stable needs to prevent crisis by contacting individuals 3-4 times a year	2,500	Across NWS				
Assessment Support	Support for individuals during the assessment process						
Social funded packages of care							

Service	Description	Annual capacity	Coverage across NWS	Effectiveness	Accept-ability	Access	Cost to person
HEALTH CARE							
GPs	Provide primary care to registered patients	Unlimited	Across NWS	✓	✓	✓	Free
Community and primary care Pharmacists	Deliver medications, fill dosette boxes	Limited	Across NWS	✓	✓	✓	Free
Domiciliary care	Homecare that helps people cope with disability or illness, and allows them to maintain independence	Unlimited	Service providers across NWS	✓	✓	✓	Subject to individual assessment by Surrey County Council and eligibility for support
Dieticians	Community support with nutrition	Limited	X2 across NWS				

Opticians	Providing domiciliary optical services						
Dentists	Providing domiciliary dental services						
Podiatry	Providing domiciliary podiatry services						
Audiology	Providing domiciliary audio services						
Community matrons			Across NWS	✓	✓	✓	Free
Practice nurses		Currently able to manage demand	Across NWS	✓	✓	✓	Free
Carers Breaks	Early intervention flexible break/respite service for carers, registered with GP practice, who are providing unpaid care	Yearly allocations to GP practices; in 14/15 there were 724 allocations of £500 each for NWS carers.	Across NWS	✓	✓	Carers eligible for Carer Break only once	Free
District nurses		Lack of capacity within NWS	Across NWS	✓	✓	✓	Free

Service	Description	Annual capacity	Coverage across NWS	Effectiveness	Accept-ability	Access	Cost to person
VOLUNTARY SECTOR							
Citizens Advice Bureau	We help people resolve their legal, money and other problems by providing free, independent and confidential advice	Currently able to manage demand	Across NWS	✓	✓	Dependent on local CAB	Free
Samaritans	Mental health support, Depression/ isolation focus.	Unlimited	Across NWS	✓	✓		Free
Voluntary Transport	Community Transport is for people who cannot use conventional public transport services. This could be because they do not have access to these services or because they are unable to use it because of sensory and/or mobility problems. There are a variety of community transport schemes in	Limited	Dependent on volunteers	✓	✓	Require notice	Cost to cover fuel

	Surrey. Local transport solutions are designed around users' needs resulting in innovative and flexible schemes.						
Red Cross	The British Red Cross provides support at home, transport and mobility aids to help people when they face a crisis in their daily lives						
Age UK	Age UK help people to make the most of later life by inspiring, supporting and enabling in a number of ways including training and remaining independent	Limited	Across NWS	✓	✓		Cost to person dependent on service provided
Victim Support	Free confidential help to victims, witnesses and other affected parties of crime. Lines are open Monday to Friday, 8am-8pm, and Saturday 9am-5pm	Unlimited	Across NWS	✓	✓	✓	Free
Cruse Bereavement Care	Offers support following bereavement		Across NWS				Free
Carer support (Action for Carers)	Provides free advice and is led by carers. The main aim is to raise awareness of carers' needs and concerns, empowering and enabling carers to have their views heard and taken account of both in Surrey and nationally. This is achieved through the 'Giving Carers a Voice' service		Across NWS				
Surrey Care Association	Provides information about independent care providers In Surrey		Surrey Wide				

Healthy active ageing & supporting independence								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
Social	Dementia Navigators	Help people with the dementia live independently in their own homes by visiting individuals, their carers and families to act as a guide and help them navigate the system to get help or access local services.	3.5 WTE across NWS (x7 DNs in total)	Across NWS				Free
	Surrey Fire & Rescue (SCC)	As well as providing a response service to the people of Surrey, we focus our efforts on education - raising awareness amongst the most vulnerable people in order to reduce suffering caused by fires, road traffic collisions and other emergencies.		Across NWS				
Health								
Voluntary sector	Drop By	Interactive online community to keep over 60's in touch	Unlimited	Across NWS		Limited and dependent on skills of user and access to computer	Requires Internet access	Free
	Admiral Nurses (Friends of the Elderly)	Admiral Nurses are mental health nurses specialising in dementia. Admiral Nurses work with family carers and people with dementia, in the community and other settings. Working collaboratively with other professionals, Admiral Nurses seek to improve the quality of life for people with dementia and their carer's. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships						
	Alzheimer's Society	Alzheimer's Society provide local information and services to people affected by dementia in their communities. Our local services include day care and home care for people with dementia, as well as support and befriending services to help partners and families cope with the demands of caring.	Limited	Across NWS	✓	✓	✓	

Living well with long term conditions								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
Social	Dementia Navigators	Help people with the dementia live independently in their own homes by visiting individuals, their carers and families to act as a guide and help them navigate the system to get help or access local services.	3.5 WTE across NWS (x7 DNs in total)	Across NWS				Free
Health	Respiratory care team (Virgin Care)	The respiratory care service provides specialist support, advice and care for patients with respiratory problems. The team works in partnership with local respiratory physicians, GPs, social services and acute hospitals to provide integrated care.	Limited	Across NWS	✓	✓	✓	Free
	Specialist nurses (Virgin Care)	e.g. MS, Parkinsons, heart failure, diabetes	Limited	Across NWS	✓	✓	✓	Free
	Diabetes nurses in primary care	Warwick trained practice nurses providing support and management of diabetes in primary care.						
	Telehealth	Telehealth refers to the delivery of health related services and information via telecommunication technology. In NWS Telehealth is currently provided for the management of Chronic Obstructive Pulmonary Disease (COPD) and heart failure.	Approx 140 patients (funding until 2016 only)	Across NWS	✓	✓ Patients must meet selection criteria- not appropriate for all patients	✓	Free
	Virtual ward	Integrated case management pathway for people identified at high risk of admission to hospital through the use of the risk profiling tool set up in GP practices and local	Currently able to manage demand	Across NWS	✓	✓	✓	Free

		intelligence enhancing their ability to self-care and ultimately ensuring that patients and carers get the care they need mainly within a community setting.						
	Continuing Healthcare	A package of care that is arranged and funded solely by the NHS for individuals who are not in hospital but have complex on-going healthcare needs.						
Voluntary Sector	The Stroke Association	Providing services across the country to help those affected by stroke.		Country-wide	The Stroke Association		Country-wide	The Stroke Association
	The Hubs (Surrey Disabled Peoples Partnership)	Provide advice and support for people with any kind of disability which things like benefits and returning to work	Unlimited	Locality based- Staines, Woking & Runnymede	Not used as much by older people	Low (used more by younger people)	Dependent on locality hub- located in towns	Free
	Alzheimer's Society	Alzheimer's Society provide local information and services to people affected by dementia in their communities. Our local services include day care and home care for people with dementia, as well as support and befriending services to help partners and families cope with the demands of caring.	Limited	Across NWS	✓	✓	✓	
	Admiral Nurses (Friends of the Elderly)	Admiral Nurses are mental health nurses specialising in dementia. Admiral Nurses work with family carers and people with dementia, in the community and other settings. Working collaboratively with other professionals, Admiral Nurses seek to improve the quality of life for people with dementia and their carer's. They use a range of interventions that help people live positively with the condition and develop skills to improve communication and maintain relationships						

Living well with complex co morbidity and frailty								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
Social	Telecare	Telecare is the name given to the range of sensors which link with the traditional community or lifeline alarms. The sensors are designed to assist people of all ages to live more independently by monitoring their safety around the home and alerting a 24 hour care center should a potential emergency occur.	Unlimited	Across NWS			✓	12 weeks trial-free Dependent on equipment costs vary from around £4-5 per week
	Crossroads	Crossroads Care Surrey is a charity that provides much needed respite breaks to support carers.	Limited		✓	✓		Cost to carer
Health	Telehealth	Telehealth refers to the delivery of health related services and information via telecommunication technology. In NWS Telehealth is currently provided for the management of Chronic Obstructive Pulmonary Disease (COPD) and heart failure.	Approx 140 patients (funding until 2016 only)	Across NWS	✓	✓	Telehealth refers to the delivery of health related services and information via telecommunication technology. In NWS Telehealth is currently provided for the management of Chronic Obstructive Pulmonary Disease (COPD) and heart failure.	Approx 140 patients (funding until 2016 only)
	Annual health checks by GP/PN							
Voluntary Sector	Surrey Association for Visual Impairment (SAVI)	Helping people with vision impairment and dual sensory loss, includes assessment, reablement, support planning and provision of on-going support		Surrey Wide				

Rapid support close to home in crisis								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effective-ness**	**Accept-ability**	**Access**	**Cost to person**
Social	Reablement (SCC)	This service is also able to provide rapid support		Across NWS	✓	✓	✓	
	Carewatch rapid response	Response time of 2-4 hours						
H&S	Twilight night service			Across NWS				
Health	Dementia respite care	Short term support services for people with dementia, their family and carers at a time of crisis. The service is 24/7 with a 2 hour response time. The service enables people to remain in their own homes by providing the appropriate support to see them through a crisis period, including, where necessary, night sitting.	Currently able to manage demand	Across NWS	✓	✓		
	Paramedics/ consultant paramedics	Emergency service	Unlimited	Across NWS	✓	✓	✓	Free
	Marie Curie			Across NWS				
	Hospice Helplines	24/7 hour helplines provided by Woking & Sam Beare Hospice and Princess Alice Hospice						Free
	CPNs	Can call a patient back on the same day						Free
Voluntary sector	Carers Support- Sitting services							

Good discharge planning and post discharge support								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
Social	DFG							
	Equipment provision							
Health	Step down beds			Brockhurst Care Home				
	ICT	Located in St Peter's to support early discharge						
	Medihome	Provide IV antibiotics in patient's own home						
	Respiratory Care Team	SLA with St Peters to support discharge						

Good rehabilitation and reablement								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
H&S	Occupational Therapists							
Health	Community Rehab beds		Waiting list for beds	Walton and Woking				
	Falls Team							
	Early discharge team							
	Speech and language Therapy	Offers treatment advice and support, may loan communication aids.						
	Pulmonary rehab		Waiting lists					
	Community physio therapists							

High quality nursing and residential care, home care								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Acceptability**	**Access**	**Cost to person**
Social								
Health								

Choice, control and support towards the end of life								
Sector	**Service**	**Description**	**Annual capacity**	**Coverage across NWS**	**Effectiveness**	**Accept-ability**	**Access**	**Cost to person**
Social								
Health	District nurses	Providing support at end of life	Lack of capacity within NWS	Across NWS	✓	✓	✓	Free
	Hospital		Unlimited	Across NWS	✓	Depends on patient's wishes	✓	Free
	EOLC Co-ordinated Service	Integrated service provided at end of life to support people to receive care in their preferred place.		Across NWS				Free
	Begitta Trust							Free
	Marie Curie			Across NWS				Free
Voluntary Sector	Woking & Sam Beare Hospice			Across NWS	✓	✓	✓	Free

Appendix D Known unmet needs of older residents in Surrey

The JSNA contains information on unmet needs for older people living across Surrey, based on research and feedback from Surrey residents. Below is a summary of these needs (16):

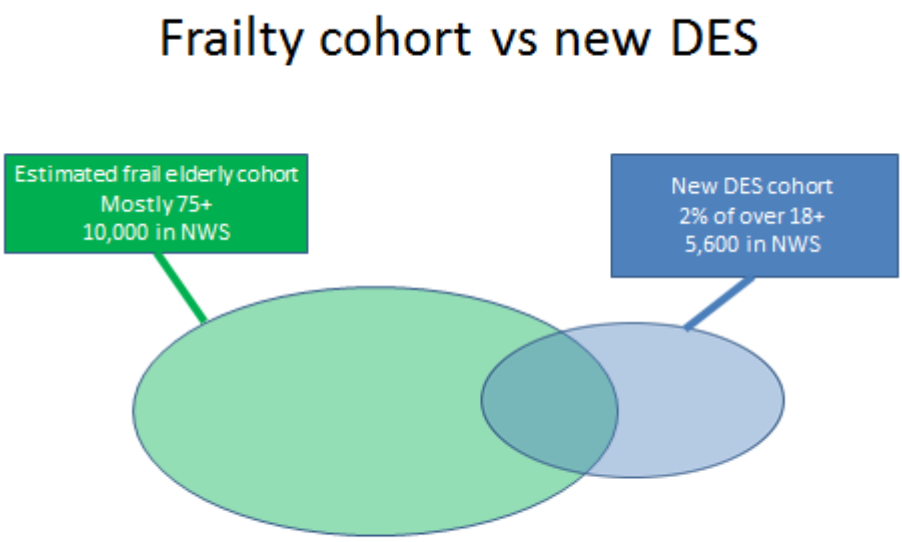
- Older people should be supported so that they are not affected by loneliness and isolation.
- Through forum meetings, older people and carers in Surrey have stated that there should be continuity of care whenever someone changes accommodation or moves into residential care. This involves continuously meeting needs and personal outcomes with appropriate care and support.
- Telecare is currently under-utilised, partly because Adult Social Care staff have not yet fully embraced the concept, in terms of assistive technology being a positive option for people, and partly because of the general public not being aware of the benefits.
- Access to telehealth services in Surrey is currently limited and inconsistent, with little variety in equipment.
- Meals on Wheels services are not offered in every borough and district and are inconsistent.
- Transport and therefore access to local community activities is not consistently offered across the county
- Respite services are difficult to access and not meeting the needs of carers
- There are no established older people services in Surrey that currently provide care and support for people with learning disabilities over 65 years of age. Traditionally as individuals with learning disabilities get older they have remained in specialist learning disability services regardless of whether their needs have changed.
- Older people who currently receive home based care services want reassurances that care providers arrive on time and stay for the time agreed.

Appendix E Avoiding unplanned admissions DES

From April 1, 2014 a new directed enhanced service (DES) has taken effect for GP practices. This enhanced service aims to improve the care for vulnerable patients to prevent them from being (re) admitted to hospital. This is highly relevant for frail older people as they are likely to be part of the target group of the DES. Please note that the cohort of frail older people will *not* be equivalent to the cohort identified for care through the DES; the DES is designed for people of all ages including children at high risk of admission (Figure 11). This group will also include e.g. working age people with severe mental health or social needs which will require a different approach from frail elderly people.

The DES will therefore identify only a proportion of the NWS frail elderly; the risk assessment tool could be used to identify the wider cohort that requires integrated care.

Figure 11 frailty and DES cohort



Below follows a summary of points about the DES that re relevant for this needs assessment; these are based on NHS England guidance (49).

The ES requires practices to:

- Identify patients at high risk of admission to hospital with use of a risk stratification tool
- Manage these patients appropriately by ensuing that personalised care plans are in place and providing same day telephone access for patients, and for health and social care professionals involved in care
- This will apply to a minimum of 2% of patients per practice aged 18 (estimated at 5,600 in NWS in 2013[21]) plus any children with complex health and care needs.
- All patients thus identified as high risk will be assigned a named accountable GP and where relevant a care coordinator; the GP will have the overall responsibility of coordinating the patient's care and providing information to the patients and their carers.

[21] PCSS practice registration data December 2013.

- These patients will each have a personalised care plan.

The risk stratification tool should:
- Give equal consideration to both physical and mental health conditions

Regarding case management, the practice should:
- Ensure that 2% of patients are on the high risk register at all times; there will need to be a regular review of new patients on the list and patients who can be removed from the list because they have either moved, passed away or are no longer considered at highest risk.
- Ensure all patients on the list have a personalised care plan within one month of being added to the high risk register.
- The practice will undertake monthly reviews of all patients on the register

Regarding improving the hospital discharge process, the practice
- Will ensure that when a patient on their register is discharged from the hospital, they have been contacted by either practice or community service staff as soon as possible but within three days of the discharge notification being received.

Re internal practice reviews, the practice should:
- Regularly review emergency admissions and A&E attendances of patients from their care and nursing home
- Undertake monthly review of all patients on their high risk register.

Payment of the ES will be subject to meeting the different requirements of the ES and will be a maximum of £2.87 per registered patient.

For a practice with a list size of 2,000 patients, this means:
- The practice will be required to implement the ES interventions for at least 40 patients
- For this, the practice will be paid £5,740 annually; this equates to £143,50 per patient on the register.

Appendix F Rapid evidence review Integrated Care

Rapid evidence review: Examining the effectiveness of selected patient-level integrated care interventions.

Dr Will Maimaris, SPR in Public Health, Ealing Council April 2014

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Summary[22]

Background

In order to both improve the quality of care for people with long-term conditions and reduce demand on primary and secondary care, an integrated approach to health and social care has received broad support at both national and local levels.

At the local level in Ealing, The Better Care fund and Whole Systems Integrated Care are important new initiatives involving an integrated approach to health and social care.

Although integrated care can be defined in many ways, all involve providers and commissioners of care working together to improve outcomes for users of the health and social care system.

The evidence base for integrated care is still emerging. However, there is already some evidence from previous reviews that integrated care initiatives can improve care quality and reduce demand on health services (LGA[23], Nuffield Trust[24], King's Fund[3]). As yet, there is no evidence that integrated care approaches will result in overall cost savings for health and social care systems.

Integrated care approaches should combine whole-system level (**macro**) changes with interventions at the patient-group (**meso**) and patient (**micro**) level. (King's Fund[25])

Aims and methods

To inform local work on integrated care, this rapid review aims to gives an overview of the evidence from systematic reviews for the effectiveness of the following approaches to integration at the patient (**micro**) or patient group level (**meso**).

- Multi-disciplinary disease management programmes
- Case management
- Care planning and enhanced discharged planning
- Self-care and self-management

These integrated approaches are considered in the following groups:

1. Frail older people or older people with multiple long-term conditions
2. People (of any age) with the following long-term conditions,
    - Dementia
    - COPD
    - Heart failure

This review does not look at systems-level approaches to integration, such as culture change initiatives, or structural or financial changes to organisations.

[22] Full report available through Ealing CCG or director of Quality and Innovation, NWS CCG
[23] Local Government Association, Integrated Care Evidence Review – November 2013
[24] Evaluating integrated and community-based care: How do we know what works? Nuffield Trust. 2013
[25] Clinical and service integration: The route to improved outcomes. The King's Fund 2010.

Main findings

The evidence base for integrated care approaches is stronger for individual long-term conditions, such as heart failure and COPD, than for frail older people or older people with multiple long term conditions.

Integrated care approaches reported in the literature are highly varied and success of these approaches is likely to depend on the context and setting which they are delivered. In spite of this, the following general evidence statements apply.

There is strong or moderate evidence that **multi-disciplinary disease management programmes** can improve care quality outcomes and reduce acute healthcare use in both COPD and heart failure. There is weak evidence that these programmes can improve care and reduce acute healthcare use in older people with multiple long-term conditions or frail older people.

There is moderate evidence that **self-care programmes** can improve care quality and reduce acute healthcare use in COPD. There is weak evidence that self-care programmes can improve care in heart failure and in older people with multiple long-term conditions or frail older people.

There is moderate evidence that **enhanced discharge planning** can improve care quality and reduce acute healthcare use in heart failure.

There is moderate evidence that **case management** approaches can reduce acute healthcare use in heart failure. There is weak or equivocal evidence that case management approaches can improve care quality or reduce acute healthcare use in older people with multiple long-term conditions or frail older people or people with dementia.

There is very little evidence reported on overall cost savings as a result of integrated care approaches.

Recommendations for local integrated care initiatives

Integrated care initiatives should adopt a multi-disciplinary approach and include a self-care component where possible.

Improving care quality must be the central aim for local integrated care initiatives.

A small number of shared care-quality outcome measures should be agreed by Ealing CCG, Ealing Council, local providers of health and social care and most importantly by local service users. These measures could include self-reported wellbeing measures, measures of satisfaction with care, measures of function (such as mobility), and clinical measures such as blood pressure control.

Cost savings cannot be expected as a result of integrated care initiatives.

Local integration initiatives must include a **prospective** evaluation, with agreed aims and objectives and regular reporting against these objectives. Evaluation reports should be available to the public.

Appendix G Limitations and lessons learned

As with all needs assessments, this needs assessment has its limitations. The needs information included was based on perceived relevance for the development of the pathway; it was not a systematic description of all factors relevant to the health of frail elderly people. An extensive bibliography has been included which should assist commissioners in finding additional information.

The mapping exercise was successful in that it brought together professionals from social care, community services, GPs and commissioners. They learned about the range of services available by doing the mapping; it was clear that they had not heard of many services before. There was therefore a learning component of participating in the mapping exercise, which made clear that information about available services needs to be improved.

A clear limitation of the mapping exercise was that the results were dependent on the knowledge of those participating and on their subjective judgement on the quality of the services. The gaps in the result tables (Appendix C) also show that a lot of information was not available. To get a more complete overview of services, and potentially more detail on what they deliver, multiple events with a wider range of stakeholder engagement will be required. The 3.5 Boroughs and Districts should be represented as they will be able to give an overview of the local voluntary sector organisations; large voluntary organisations should also be invited.

That said, we should acknowledge that in Surrey approximately 80% of social care is self-funded and there will be many private care providers, some of which Surrey County Council will be not be aware of. It will therefore not be possible to give a truly comprehensive list of all services for frail elderly people.

It should also be noted that mapping of services can only ever give a (subjective) *indication* of the quality of services and cannot replace systematic evaluation. Robust evaluation is a key element of the commissioning cycle and of any service improvement and should be built into service development from the start.

On a practical level, the learning from the two mapping events was that planning and running these meetings takes a lot of time and requires a lot of detailed work. Setting up bigger events to undertake mapping of services systematically with more stakeholders will require dedicated resource.

Last, this needs assessment included evidence on ‘what works’ in service design relevant to the frail elderly population. For this we mainly made use of published reports by leading think tanks such as The King’s Fund and The Nuffield Trust and charities. Undertaking a full systematic review of the literature was out of scope of this needs assessment.