Life Stages programme: Ageing Well

1. How can we build proactive, multi-disciplinary teams (MDTs) to support people with complex needs to keep well and to prevent progression from moderate to severe frailty for older people?

1.1 The majority of admissions into the acute sector are for an escalation of a long-term condition. People with long-term conditions account for 70% of all inpatient bed days.[(1)] 1 in 3 emergency admissions are now for people with 5 or more long term conditions, such as heart disease, stroke, type 2 diabetes and hip fracture. This is up from 1 in 10 a decade ago.[(2)]

1.2 For the older population – whether fit or mild, moderately or severely frail - being in hospital as a result of an escalation means significant risks in terms of infection, deconditioning and deterioration. The evidence on this is indisputable.[(2)]

1.3 In 2015/16 waits for further non-acute NHS care was the second largest causal factor of delays in discharge from hospital, and number of these delays are rising. The biggest cause of delay in discharge was waits for assessments, including Comprehensive Geriatric Assessments (CGA).[(3)] Discharge delays, weak handovers and waits for community services to start after discharge are causing patients to deteriorate unnecessarily and increases their risk of readmission.

The need for frailty MDTs as part of the integrated rehabilitation pathways

1.4 Building more frailty multi-disciplinary teams (MDTs) is essential if we are to address this. Frailty MTDs should be community-based.

1.5 The current picture or rehabilitation services is of piecemeal provision, often set up to resolve a problem within one part of the system without regard to the rest of the healthcare system and other rehabilitation services. As a result they are not properly linked up or standardised, good practice is rarely scaled up, and they are usually focused on single diseases. It is evident that there is both duplication and gaps that patients can fall through. The scale of this challenge cannot be adequately quantified, because data are not collected nationally to make this possible. This lack of data is part of the problem that needs to be addressed as a priority (see 1.18-1.21).

1.6 The development of Frailty MDTs must not add to this confused picture, or occur in isolation. Development of MDTs should rather form part of review of all rehabilitation pathways and population needs, and the redesigning of rehabilitation pathways within and between fully integrated health and social care sectors, physically co-located within community hubs where appropriate.

1.7 There is growing awareness of the benefits of organising more services to respond to symptoms, not specific conditions, and a holistic assessment of a patient's mental and physical rehabilitation needs that can take better account of multiple conditions. The CSP believes redesigning services around patient symptoms (such as breathlessness, pain, muscle weakness deconditioning, fatigue, depression and anxiety) would improve

outcomes for patients, respond to the issue of co-morbidities and the risk of developing co-morbidities, and makes best use of existing resources.

1.8 Community-based rehabilitation and frailty provision needs to be integrated into community hubs. They could be located with leisure services, with GP services, in local authority or other community venues. There should be a flexible approach to developing a model based on local circumstances and opportunities. They should share the following features:

- They need to be local (30-50k)
- Closely linked with social care and general practice, leisure and voluntary services
- Support integration in practice between health and social care
- Take a person-centred, holistic approach, building on shared decision-making and individually developed goals as part of a CGA or rehabilitation assessment, with a focus on self-management.
- Services within hubs should include frailty assessments and interventions, rehabilitation and pre rehabilitation for cardiovascular and respiratory diseases, cancer, joint replacements and other long-term conditions, fracture liaison clinics and falls prevention services.
- Staff in Community hubs should be deployed to work across acute and community sectors, to allow continuity of care through the patients journey from hospital to home, with a *'home first approach'*, understanding the risks of hospital deconditioning.
- MDTs in community hubs need to be able to access specialists for diagnostics in the acute sector and community based geriatricians
- Patients with long-term conditions and fluctuating rehab needs, need to be able to access services quickly and easily to prevent crises.

1.9 Frailty MDTs based within community hubs should provide CGAs, rather than these being carried out in hospital settings. Where rehabilitation support for people with complex conditions and frailty starts within the acute sector, to be most effective it should continue with no break as patients are discharged into the community. Currently this is best achieved through early supported discharge and a *'home first approach'* (discharge to assess), with staff in hospitals working with patients after discharge. In the future, rehabilitation teams this should include 'in-reach' into hospital.

1.10 Community rehabilitation services need to play a larger role in prehabilitation with patients prior to surgery or medical intervention. This is an area of service where there is a growing evidence-based to show positive impact on outcomes and reducing complications. For example: for elective upper abdominal surgery[4] and non-small cell lung cancer.[5] Where prehabilitation does exist it is usually organised within hospital settings run by acute trusts, but could be provided within the community as part of an integrated service.

1.11 While rehabilitation pathway development is becoming a priority for NHS England and other national stakeholders, this is uncoordinated. For example, NICE have various rehabilitation pathways, NHS England programmes such as Rightcare and Getting it Right First Time and departments like the Pricing Unit all consider rehab. What is missing is a single approach to bringing the various critical parts of the system that is necessary for successful design and delivery of rehabilitation together.

1.12 There needs to be national system leadership to align the different activities and agencies in this space. As such, rehabilitation needs to be a cross cutting theme for the Long Term

Plan and the CSPs suggests that a task and finish group of national stakeholders to identify and exploit commonalities between different rehabilitation pathways, and forward the policy and service developments within the plan.

Reforms to commissioning of community rehabilitation services

1.13 In spite of extensive evidence of benefit and value, rehabilitation services are inconsistently commissioned. The fragmented, poorly integrated nature of provision described above is both cause and effect of poor commissioning, combined with cuts to funding for community services, a lack of clarity within payment and commissioning systems, and problems with lack of awareness of commissioners in some areas.

1.14 Community-based rehabilitation services have experienced disinvestment, when the direction of health policy and population need should dictate an increase. Half of all community providers report that they are managing real term cuts in their budgets in 2017/18.[(6)] As a result of this taking place over many years community services apply stringent inclusion and exclusion criteria in an attempt to manage demand. This creates a barrier to effective handover from acute settings.

1.15 Reversing this will require important reforms to commissioning and payment practices and systems. Currently rehabilitation activity is not specified within units of provision in enough detail, and the Commissioning Guidance for Rehabilitation published in 2016 did not address this. Where definitions of rehabilitation within tariffs are too vague, rehabilitation is assumed to be included within funding of episodes of care, when the reality of acute rehab provision is limited and nowhere near meets patient need. The new best value tariffs for COPD and for hip fracture both illustrate this. National prices for rehabilitation post discharge only apply when a single provider provides both acute and community services. Where this is not the case there can be reluctance by the CCGs to commission community services, because they perceive that they have already paid the full rehabilitation tariff to the acute sector, even though no community service being provided.

1.16 As NHS payment and commissioning systems are developed they need to be able to properly identify the activities and staffing required to meet rehabilitation needs in the population – addressing the lack of clarity about what rehabilitation activity is included within payment for episodes of care and who pays for community–based rehabilitation activity. Opportunities to enhance currency approaches to community services should continue to be explored as a way to address this. The community healthcare funding currency models programme led by the NHS England Pricing Team needs to address this, and taken forward through the NHS Long Term Plan, including across the clinical priorities identified.

1.17 There is significant variability in how well community rehabilitation is understood by CCGs and the value of it to population health and reducing demand on the system. So as well as reforming payment and commissioning systems there is an urgent need for training and support for commissioners and providers so that rehabilitation needs within the population are better understood and reflected in commissioning decisions.

Reforms to address the data deficit

1.18 Related to the lack of any standardisation in provision and its fragmented nature, is the lack of visibility of the community sector in general and community rehabilitation services in particular. This is caused by a lack of data on patients' needs, patient outcomes and impact of rehabilitation services on other services. This presents significant challenges preventing commissioners from seeing where the gaps are, and where rehabilitation outcomes need to be improved.

1.19 Lack of rehabilitation data leads to commissioning gaps within the community sector as a whole. In the acute sector rehabilitation data is often not recorded separately from operations or other medical intervention. The data deficit makes it difficult to commission services and this has contributed to the overall disinvestment in the community sector.

1.20 To address this, implementation of the Community Services Data Set needs to ensure that there is standardised data collected on rehabilitation across sectors and pathways. The Data Set needs to be expanded and/or complemented with mandated data collection on community providers' activity. The data need to be both recorded and available, inclusive of all rehabilitation activity, across acute, primary care and community.

1.21 Development of frailty MDTs and community rehabilitation within integrated community hubs will rely on ensuring digital infrastructure integration. Community frailty and rehabilitation MDTs must have access to the data from acute and primary care services to enable them, and the other services, to offer the best level of care to patients. They should be digitally-abled and make best use of approaching telemedicine innovations – e.g. falls prevention monitoring devices, self-management technology or remote monitoring, with access to appropriate mobile devices with solutions to widespread issue of connectivity and barriers to personal use of technology.

Workforce

1.22 To develop frailty MDTs and community rehabilitation services, there needs to be an expansion of the rehabilitation workforce. Critical in this is an expansion of physiotherapy numbers.

> The UK has a lower number of physiotherapists than most other European countries per head of population. Denmark has 3 times the number of physiotherapists per head of population than the UK. Older people in Denmark living with frailty, regardless of their diagnosis, will generally only need to spend 2 days in hospital and then discharged with a care package and a rehab plan. Anyone applying for social care will be offered rehab first to see if they can postpone needing the extra help. In most parts of Denmark fewer than 2% of the 85's and over live in institutional care, compared to an average of 15-20% in the UK.
> Eurostat: Statistics Explained. Practising physiotherapists, 2010 and 2015
> Eurostat: Statistics Explained. Very elderly population aged 85 years and over living in an institutional household, by NUTS level 2 region, 2011 (% share of very elderly population)

1.23 The registered physiotherapy workforce is now going through a period of much needed expansion, and the cap on supply created by insufficient commissioning and insufficient funding for HEIs through the bursary system has been lifted. This expansion needs to be utilised in the development of frailty and community rehabilitation MDTs, and first contact physiotherapists (FCPs) in primary care.

1.24 Because of the fragmented nature of provision, models of integration so far have not focused sufficiently on sharing teams and skill operationally across boundaries in a 'place-based' approach. On a recent service visit to an acute hospital, vCSP staff were told by CSP members a need for in-service training had been identified by the community rehabilitation team as a requirement for it to improve its referral practice. However, CSP members within the acute trust were not allowed to provide this training because the community rehabilitation team was funded by a neighbouring CCG. Through member engagement, the CSP believes this is a common situation.

1.25 There is also an important leadership role to be played by physiotherapists and other AHPs to develop services and support integration, though posts such as Community Matrons and non-medical clinical leads. These roles are traditionally filled by nurses, but given the importance of physical activity within rehabilitation, arguably advanced practice

physiotherapists in some situations will better meet the needs of the service. All job roles like these need to be updated so that they are explicitly based on capabilities to meet need (such as the advanced clinical practice capability standard) and not by profession.

1.26 Traditionally, most advanced practice roles for non-medical staff have been concentrated in acute care, and in particular the orthopaedic and rheumatism departments in hospitals. This has perpetuated a professional culture – found across all health professions - that tends to view community-based roles as lower in status than those based within a hospital setting. This needs to change if we want the system to be better at reducing demand on the acute sector and elective care.

1.27 Physiotherapy and AHP support worker roles are increasingly taking on greater degrees of responsibility for hands on patient care and exercise classes and potential from this needs to be fully utilised. These higher level support worker roles need to be invested in, recognised and standardised in line with the Nurse Associate role, with the necessary input from all the relevant professional bodies and the Professional Standards Authority.

2. What would good crisis care that helps prevent unnecessary hospital admissions for older people living with various degrees of frailty look like?

2.1 The model of rapid response teams is now well-established and are proven to be successful in reducing unnecessary hospital admissions for older people with various degrees of frailty. These need to be made standard.

2.2 What has been missing from this model is sufficient capacity within community rehabilitation teams to prevent people from reaching that point of crisis.

3. What would the right measures to put in place to know that we are improving patient outcomes for older people with various degrees of frailty?

Outcome measures for older people with various degrees of frailty

3.1 There needs to be enforced mandating of Community Service Data Set, with expansion or supplimentation of dataset to include providers' activity in addition to patient-level metrics.

3.2 All health and social care professionals need to be working to the goal of supporting patients to become and remain mobile. Evidence shows that early mobilisation in older patients in hospitals reduces the length of stay by reducing deconditioning.[7] The physiotherapy workforce has an important part to play in sharing expertise to build confidence and awareness of their colleagues.

Common assessment framework

3.3 Service level outcome measures should be developed to complement patient-level outcome measures, with data collected from existing and new primary, secondary and community datasets. Everyone who is frail or pre-frail, including those identified through the Electronic Frailty Risk Indicator, should be provided with Comprehensive Geriatric Assessment (CGA).

3.4 Everyone who is diagnosed with a long-term condition, or has had medical treatment where there it is known that rehabilitation improves outcomes, should be provided with a common rehabilitation assessment. Mental and physical rehabilitation needs should have parity of esteem and included in all assessments.

3.5 The purpose of the assessments is to stratify patients in terms of their needs and their frailty risk and match them up with the appropriate care and rehabilitation offer – which will

normally be services provided as part of an integrated community hub model, or for support in self-care from voluntary sector, primary care and leisure services.

3.6 CGAs and rehabilitation assessments for specific conditions are usually carried out within the acute sector. This is a cause of unnecessary delays in discharge, with all the negative impact on the patient described above. The assessments are best carried out primarily by MDT frailty teams and community rehabilitation teams within the community.

3.7 Currently there are multiple assessment frameworks to assess need for people who are frail and/or have long-term conditions. The NCD's task and finish group proposed above should look at what steps are necessary to move to a common assessment framework across a range of long-term conditions, that can be used by all health and care staff across all sectors.

3.8 All common assessment frameworks agreed nationally should be mandated and embedded within the electronic health record systems across all sectors.

3.9 Rehabilitation stratification tools must be developed, tested and mandated for use to support the reduction in disability and cost effective use of resources. For example, the use of the Keele STarT Back Screening Tool - a simple prognostic questionnaire that helps clinicians identify modifiable risk factors (biomedical, psychological and social) for back pain disability. Evaluation of this tool has shown when patients are then stratified into low, medium or high-risk categories, each with a matched treatment package, related disability is reduced and cost effectiveness is improved.

4. What more could be done to encourage and enable patients with long term health issues to play a fuller role in managing their health?

4.1 Physical activity declines with age, and by the age of 75 years only one in ten men and one in 20 women are active enough for good health.[8] Doing more to support physical activity is key to supporting people to manage their health as they get older. Individuals who regularly engaged in exercise activities are less likely to develop frailty for a period of 5 years compared with those who were sedentary and are far less likely to transition from moderate to severe frailty.[9] Group exercise programmes are effective for reducing or postponing frailty.[10]

4.2 Recent research by the Richmond Group of charities into co-morbidities has shown that mobility is the main factor for people with a range of long term conditions in determining their quality of life and in health inequality and the primary indicator of whether an individual will develop another long term conditions.[11] Supporting patients to remain or return to mobility through physical activity is a central purpose of rehabilitation services across pathways.

4.3 The evidence review carried out for the UK Chief Medical Officers' update of physical activity guidelines showed that for those in transition to frailty or following discharge from hospital or at the onset of a disease of its diagnosis, the risk of falls was reduced by activities to help maintain strength and balance.[12] This work also showed better health outcomes for very frail older adults undertaking supervised structured exercise that incorporate progressive resistance training, balance training and some aerobic endurance work.

4.4 Community rehabilitation MDTs need to have the capacity to be more responsive to what patients need to self-manage long-term conditions. This includes allowing patients to self-refer themselves back into rehabilitation programmes if needed, or to access the team for advice and support. For example, if patients with chronic obstructive pulmonary disease could access advice and support from physiotherapists on chest clearance and be prescribed antibiotics when becoming increasingly short of breath or expectorating more

than usual, more COPD exacerbations could be managed at home and avoid requiring a blue light to hospital.

4.5 The deployment of physiotherapists as first contact practitioners (FCPs) provides additional expertise to the GP team in providing first line advice and support for patients with long term conditions or identified in the electronic frailty index, and linking them to the appropriate community rehabilitation hub services and social prescribing initiatives.

4.6 For people with low needs who need support to self-manage, exercise professionals in leisure services and local voluntary groups have an important role to play in providing exercise and lifestyle support. It is important that GP teams and community rehabilitation services have effective links and referral routes to and from these.

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