GUIDANCE, DOCUMENT

Older people and people living with frailty: integrated quality statement

What we are doing to improve care for older people and people living with frailty.

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Our aim is for Wales to be a place where older people can live a long, healthy, and happy life. We will ensure we take into account 'what matters' to older people in our decision making in improving care.

Introduction

Focussed on older people and people living with frailty, this Integrated Quality Statement (IQS) will set the direction for whole system service transformation enabling a more integrated role for the Third Sector and greater citizen involvement.

Development of the IQS focused on quality-of-life outcomes and is based on the principles of population health management. The IQS sets out those high-level quality attributes that are considered essential to enable an ‘outstanding place-based system of integrated health and social care’ for older people living with frailty and will compliment work that is progressing within National Programmes of work.

The IQS will underpin the development of a commissioning framework and service specification which will provide a detailed outline of those components associated with an ‘outstanding place-based system of care’ for this population.

A national leadership team will be established that will be responsible for the development, design and implementation of this framework. The leadership team will work alongside a network of ‘experts’ in consisting of clinicians, professionals and managers from the NHS, Local Authorities (not limited to social care) and the Third Sector. It will develop national resources that lead to more consistent, and higher quality, delivery of care for older people and those living with frailty.

The development of the framework will include a suite of outcome indicators and

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improvement measures across each component part of this population group and system of care. Improvements in the outcomes for this population and the quality of care for older people and those living with frailty will be monitored through this mechanism. This will ensure we are doing the right things and know if we are doing the right things well.

Population and condition context

Older people, many of whom will be living with frailty, use the NHS and social care services more than any other population group. The proportion of people aged 75 or older in Wales is projected to increase from 9.9% of the population in 2021 to 13.8% in 2041, increasing from around 307,000 people to around 455,000 people. Two thirds of adults over the age of 65 years are expected to be living with multiple health conditions by 2035. Increased life expectancy means that people spend longer living with multiple conditions, with little change in healthy life expectancy.

Our aim is that Wales is a place where older people and those living with frailty can live a long, healthy, and happy life. They can remain active, independent, and connected in their own homes and communities, continuing to enjoy the things that matter to them. At the end of their life, they die according to their wishes in a place they choose. These are the quality-of-life outcomes forming the foundation stone of this Integrated Quality Statement (IQS).

As we age, we want to have control of our life, for our choices to be respected and to be listened to even if not everyone agrees with them. The opportunity to build meaningful relationships through continuity of care is important, and co-ordinated care is a key to integrated care. Continuity and co-ordination become increasingly important as care and support needs become more complex. It is imperative that we take a whole system focus on older people and those living with frailty.

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Over time, our health and social care system has increasingly struggled to adapt to the multiple and interacting health (physical and mental) and social circumstances of our growing older population. However, it is not age per se that underpins this challenge, rather it is the increasing prevalence of frailty associated with this population.

Frailty is a long-term condition. It describes a state of health whereby body systems gradually lose their biological, physical, and mental resilience. It is commonly associated with the ageing process and therefore mostly experienced by older people, although not all older people are living with frailty. However, as the population continues to age, the number of people living with frailty or who are at risk of developing frailty will increase.

In simple terms, frailty affects the person's ability to cope with even minor illness, infection, or stressful life events such as a change in living circumstances, or bereavement (particularly of a spouse or partner). When this happens, they may appear differently to the way they would normally and may become confused (or more confused than usual), unstable on their feet (and at high risk of falling) and unable to do tasks they could do previously. For a person living with frailty, unfortunately this can mean that they 'bounce back' more slowly, and for some, they are less likely to 'bounce back' to the level of independence they enjoyed previously. Early intervention and rehabilitation can be an effective intervention to maximise their recovery in these situations.

There are important and often unrecognised things to note about frailty when considering the quality of health and social care required to ensure we achieve 'what matters' to this population:

- Frailty is not an inevitable consequence of ageing and is a long-term condition.
- Frailty is not as well recognised and acknowledged by society as are other better-known long-term conditions such as Type 2 diabetes.
- The incidence and prevalence of frailty increase with age and can be

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impacted by other factors such as social deprivation and living circumstances e.g., housing, income and physical factors such as decline in nutritional status.

- Frailty is progressive and develops over time, sometimes many years. Like other long-term conditions such as diabetes, with awareness and optimal management, frailty can be prevented, its onset delayed and its progression slowed down, and sometimes it can be reversed to some degree.
- Frailty is a better predictor of health than age alone. Age is just a number and tells us very little about the individual's health and their ability to achieve 'what matters' to them. For example, an 85-year-old may be fit, well and independent while a 65-year-old may be severely frail and requiring formal care and support to achieve a level of independence.
- As levels of frailty increase, health and care needs also increase as the condition progresses. Frailty is also strongly associated with dementia risk and should be considered a target for dementia prevention strategies.
- Best practice for the care of those living with frailty depends on early recognition of changes in social, psychological, and clinical needs that have resulted in a change in physical ability or mental capacity such as a new confusion, a fall, or reduced ability to do things they are usually able to do or an increased risk of malnutrition. When this happens, the right anticipatory care and early support can avoid the situation deteriorating into crisis, supported by the effective use of 'intermediate models of care', including reablement.
- The current health and social care system tends to be weighted towards reactive crisis management. As a result, those living with frailty are more likely to be admitted to hospital, often for avoidable reasons. This approach, and in particular hospitalisation, can cause a deterioration in frailty and loss of independence resulting from things like exposure to hospital acquired infection, a loss of confidence, and loss of muscle mass (sometimes referred to as deconditioning).
- Many adults living with frailty depend on informal and unpaid care and support provided to them by family, their neighbours and wider community.

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Managing the fluctuating needs of the condition can be challenging and stressful, particularly when attempting to navigate a complex health and care system for timely advice and assistance.

- Whilst ‘frailty’ is a health condition well recognised and commonly used by health and care professionals, it is also a word associated with deficit and stigma by some, particularly older people themselves, and therefore rejected. Older people are more likely to use much simpler language, describing themselves for example as, ‘not being able to do the things I used to do’ or, ‘not be as strong as I used to be’. We need to be mindful about how the words ‘frail’ or ‘frailty’ are used. We should therefore refer to individuals as ‘living with frailty’, just as we would refer to an individual living with Type 2 diabetes.

Achieving our aim and quality-of-life outcomes for this population demands a fundamental shift towards a population health management and ‘place based’ approach. This will include creating and capitalising on opportunities to align with existing ageing well strategies and National Programmes, and activity to shift the balance from acute hospital environments and build greater capacity for community focused care. Community focused care will be integrated and co-ordinated providing proactive, urgent and crisis care management in the community 24/7. This will involve the systematic and proactive identification and management of frailty as a long-term condition to prevent, delay, reverse or slow down its progression. It will also require a focus on relational, co-ordinated and anticipatory care.

Importantly, achieving our aspiration requires commissioners, providers and professionals across the whole system to ensure that ‘what matters’ to older people and people living with frailty is central to decision making. It will also require improved societal awareness of frailty as a long-term condition and its effective management.

Quality attributes for older people and people

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living with frailty

The National Leadership Team, Providers, Commissioners, and Organisations will:

Equitable

1. Engage and involve those with lived experience of frailty (older people, carers and communities) as equal partners and agree common outcomes for the population that reflects 'what matters' to them and which all stakeholders together will be expected to collectively improve.

2. Provide support to create and embed quality metrics based on the lived experience of people and their carers who are living with frailty, dementia and sensory or communication needs, to improve the quality and equity of services.

3. Improve population and professional knowledge about the condition of frailty and empower people, their families, and carers to self-manage and navigate their care needs, and enable the health and care professional to prevent frailty and facilitate its proactive identification and management.

4. Co-design, with a wide range of stakeholders (eg TEC, housing, leisure), the system and standards associated with an 'outstanding place based (integrated) system of care' and associated care pathways for older people who are at risk of developing frailty or are living with frailty.

5. Ensure that the system, in its design, uses language and descriptors which are consistent and easily understood by the public, commissioners, providers and organisations.

6. Develop a system-wide outcome framework for a population health

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approach to the prevention and management of frailty and reducing health and wellbeing inequalities for this population group. This will include a focus on dementia, falls prevention, mouth health and malnutrition, Technology Enabled Care (TEC), housing, community and third sector partners to create inclusive, compassionate, age and dementia friendly communities.

7. Agree, develop and embed population outcome indicators and system / service level performance improvement measures.

8. Work with digital colleagues to develop and put in place a 'value-based frailty dashboard' to monitor how the actions implemented by providers, commissioners and organisations improve the quality of health and social care for this population.

9. Use data to demonstrate to services and their teams how their actions are improving the quality of health and social care. This data will be used nationally to monitor organisational accountability to deliver and consistency in the quality of care for older people at risk of or living with frailty is achieved across Wales.

10. Engage with representative groups of the population to identify the challenges they face in accessing care currently and use this information to adapt and improve access.

Safe

11. Ensure a system wide focus (across all service areas including housing, leisure, TEC, third sector and others) on improving the effectiveness of care of people living with frailty and improve their health outcomes.

12. Undertake workforce planning and demand and capacity modelling to ensure availability of adequate numbers of specialist and generalist professionals from the full range of professions across health and social care

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with the right skills to manage care needs of older people and people living with frailty in all areas of care need.

13. Develop national tools that support the screening, identification, and proactive and urgent care management of older people across the system and care pathways.

14. Improve education about frailty and its best practice and ensure it becomes core component of all professional and clinical education frameworks. This will build the capacity required across all disciplines and service areas to ensure quality improvement and integrated practice is core.

Effective

15. Ensure that Frailty is routinely identified in a consistent, systematic, and standardised way. Population segmentation and risk stratification of frailty is enabled across the adult population and provides a framework to support commissioning, service and workforce planning at local level.

16. Embed the integrated standards of care for older people and people living with frailty developed by the National Leadership Team and 'network of experts' across preventative, proactive, urgent and long-term pathways of care in partnership with the Third and Digital (Technology Enabled Care – TEC) Sectors.

17. Enable greater person-centred care across primary, community (health and social care) and specialist care through implementation of an electronic care record.

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Efficient

18. Enable Comprehensive Geriatric Assessment and planning by the multi professional team responsible for improving outcomes for people living with frailty across primary, community (health and social care) and acute care through development and implementation of a multi professional care record.

19. Provide a framework for delivery and accountability at service and organisational level consisting of population outcome indicators and system / service level performance improvement measures.

Person-centred

20. Work with people living with frailty, their families, and carers to better understand the lived experience and develop an underpinning language and culture that makes 'frailty' easier to understand and live with.

21. Ensure strong leadership across the system that promotes a shared vision for healthy ageing, preventing, and managing frailty which ensures assessment and care planning is based on ‘what matters’ to the individual and protects their wellbeing and independence.

22. Define and develop an ‘Anticipatory Care Plan’ template for use by people living with frailty, their families and carers to enable us to support them to achieve ‘what matters’ and quality of later life and at the end of life.

23. Ensure that multi-disciplinary professionals routinely and regularly review individuals’ ‘Anticipatory Care Plans’ and ‘care and support plans’ and are supported to achieve the outcomes that matter to them.

24. Ensure that ‘Anticipatory Care Plans’ and ‘care and support plans’ include

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information that support people to better understand and manage their condition while providing them with the means to escalate concern of condition decline at the earliest opportunity.

25. Ensure information, advice and assistance (IAA) is available 24 /7 to support people living with frailty and their families / carers to help address the emotional, social and psychological impact of living with frailty. As according to Welsh language policy and legislation to ensure that all reasonable steps are taken to provide bilingual IAA.

26. Ensure peer support opportunities are available in their own communities to provide a support network for people, their families and carers who are living with frailty.

Timely

27. Provide people living with frailty and their families and carers are provided with a 24/7 single point of contact (SPOC) that ensures timely access to health and social care information, advice, and assistance to meet their proactive (including self-management), urgent and long-term care needs (includes social, psychological as well as physical / medical needs).

28. Provide a 24/7 Single Point of Contact and provide facilities for Technology Enabled Care (TEC) Alarm Response for Telecare and Telehealth monitoring and rapid response to presenting need.

29. Develop All Wales guidance for the provision of rapid response to crisis that meets NICE standards and outlines levels of competencies required to meet presenting social, psychological, and medical needs of older people and people living with frailty.

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