Personalised Integrated Care in the UK : World Health Organisation
Global consultation for integrated care for older people

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Age UK
Love later life

The Problem

Overview

- 15.3 million people in the UK are aged 60 and above
- Number of people aged 60 or over is expected to pass the 20 million mark by 2030
- Increased prevalence of long term conditions is having a significant impact on health and social care[i]
- Most people in later life say that they want to live independently and healthily at home for as long as possible
- The UK currently spends too much on acute services at the point of crisis and not enough on preventative and community services

Care and support

- 1 in 8 older people do not receive the help they need[ii]
- Older people say it is difficult to find the support they need. They want to tell their story once and have help to navigate the disconnect between the current health and social care systems
- Older people want and deserve control over the services they need. They want services that are joined up, responsive, promote self-care and are holistic in their approach
- Too many older people with multiple long-term conditions are not getting the personalised, integrated care and support they need to live full lives at home and to sustain their independence for as long as possible
- Older people represent 60% of all hospital admissions, often in crisis because there isn't anywhere else to go
- The average length of stay for emergency admissions increases with age, from an average of 5.2 days for all admissions to 10.1 days for those aged 85+
- 38% of delayed transfers of care within participating organisations were on care of older people wards. This ranges from 8% to 68%

i) Age UK (2017) Later Life in the United Kingdom. Age UK
ii) Care Quality Commission (2017) The Health and State of Adult Social Care in England, Care Quality Commission

A possible solution

The Age UK Personalised Integrated Care programme brings together voluntary, health and care organisations in local areas across England to help older people who are living with long-term conditions and are at risk of recurring hospital admissions.
The programme combines medical and non-medical support that draws out the goals the older person identifies as most important to them. The starting point has been to flip the question from 'how to manage a health condition' to 'how to help older people live well'. In doing so, the various solutions to improve outcomes for older people, and for health and care systems, have been identified. These solutions shift away from the traditional 'deficit' and reactive-based models of care, and instead focus on prevention and harnessing existing assets (be they the assets that older people themselves possess, assets within the community or across local health and care partnerships).
The programme has adopted a phased approach. It has evolved iteratively over time, reflecting the need for flexibility to be built into the programme to respond to learning on the ground and to adapt to the changing context, both locally and nationally.

The timeline	
2011	Initial proof of concept study
2013 Phase 1	Pathfinder in Cornwall, UK
2015 Phase 2	Piloting the model with eight local health and care partnerships across England to test the model in different local contexts to learn key lessons about successfully delivering its core elements
2017 Phase 3	Rolling out a proven approach across five additional local health and care partnerships to see how it works in different local contexts

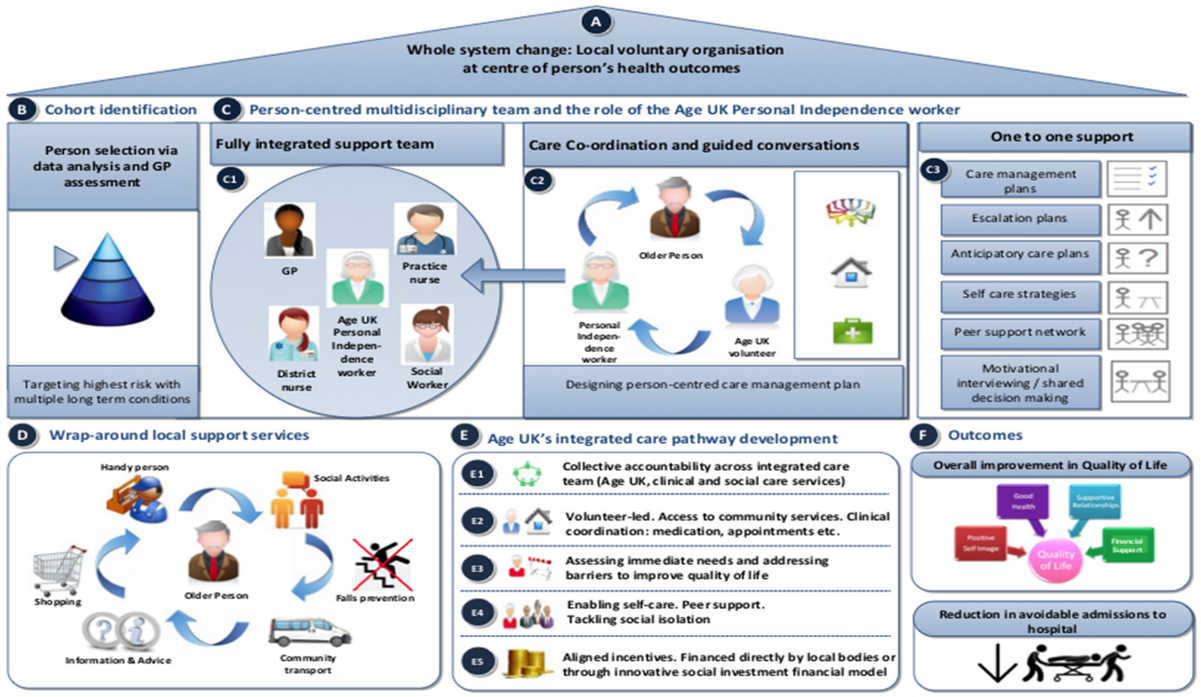
A whole-programme mixed-method approach to evaluating Phase 2 of the PICP has been embraced from the outset. This approach focuses on evaluating the programme against the Triple Aim outcomes of improved wellbeing, improved experience of care and reduced cost pressures on the local health and care economy, including evaluating:

- Changes in wellbeing scores, using the Short Warwick-Edinburgh Mental Well-being Scale
- Changes in hospital utilisation using a matched control group and conducted by the Nuffield Trust (UK)
- Qualitative evaluation of the impact of Phase 2 of the programme
- Ongoing formative evaluation drawing on performance data collected locally, national learning forums and health checks

Co-designing the programme locally: 5 work streams

Together, the co-design work streams have helped to ensure that the 'right' infrastructure and a collaborative culture are in place to support strategic and operational delivery and ultimately success.

"Co-design was done with all the partners sat around the table for a good length of time. We really got to the crux of what all the partners wanted to get out of the programme and the outcomes we wanted to see. And that helped to establish a shared vision. It meant we were able to agree the data sharing elements between the partners and build a strong performance management framework that captured the information we needed to track performance and outcomes so we could build a bigger picture of service. It was very much about having the right people around the table at the right time who would carry out the tasks too, as well as involvement at a strategic level. Our strong co-design meant that when we went to implementation we were all aware of what was happening and why, and it meant that we were able to deal with any issues very quickly." Professional stakeholder



The magical elements

The guided conversation and continuity of support	• Trusting relationships are built over several home visits enabling the older person to express their desires and emotions freely • Goes beyond "What do people need?' to understanding "What people can or could do with a little help" • Makes it possible for the Age UK PICs to understand and address and respond clients' reluctance to accept or seek help (from statutory organisations or elsewhere) and their motivations to make changes	Older people are equal partners in a discussion that that empowers them to identify their goals and preferences Care planning goes beyond a set of actions for health and care professionals to take, and instead focuses on how services and support can help ensure older people's goals and preferences are achieved

Multi-Disciplinary Team (MDT) working involving the Age UK personal Independence co-ordinator (PIC)	• Provides an effective mechanism to establish and maintain
	  • trusting relationships
	  • understanding of ways of working between various disciplines
	  • raise the profile of the value offered through the programme
	• Shifts the discussion and solutions away from a medical model
	• Facilitates timely access to care
	• Facilitates co-ordination of care
		Shared understanding of the contribution that different practitioners can make to improving the care and the health and wellbeing of older people
		Care and support for older clients recognises older people's holistic needs and is more co-ordinated

The PIC's knowledge of the local offer and follow-through support that extends beyond 'signposting'	• Tacit knowledge which extends beyond 'what's on paper or a directory' • Follow-through support helps to address the barriers to accessing care and support • For GPs and Health Care Professionals: follow-up support to chase other statutory services and make visible the community offer • For clients: support consists of 'doing' and enabling connections in a way that signposting alone does not achieve	Single and trusted point of contact to access a diverse range of support / co-ordtination of care and support driven by the older person's needs and preferences

Challenges

- The risk stratification criteria: Tension between the target cohort and wider local need
- Engaging General Practitioners (GPs)
- Tracking outcomes for the health system locally
- Recruiting volunteers, and having a timely pool of volunteers who match clients
- Addressing mismatches between existing community offers and clients' interests

Lessons learned

Case finding
A combination of proactive and reactive case finding involving clinical judgement has proved critical to creating sufficient demand for the programme and equality of access.
Cohort growth plans and creating demand need to acknowledge older peoples' choice and address the barriers they could face to joining the programme and uptake / retention rates.

MDT working and case review
The extent to which Age UK PICs have become embedded within MDTs has varied across and within sites and has been driven and hindered by common factors across all Phase 2 sites.
Case review by an MDT has not taken place for all clients due to relatively low-level and short-term goals and needs identified by some clients and the criteria for MDT meetings.

Personalised shared care planning and a single care plan
In practice and reflecting the timescales of Phase 2 of the programme, the focus has been on facilitating and enabling personalised care and support planning, rather than the output of a single 'shared care plan' that is shared between and reviewed by multiple professionals.

Programme and team management
Strategic management of the programme locally requires knowledge, multiple skills and expertise from the Voluntary and Community Sector and the Health and care system.
An operational Age UK team leader to performance-manage and support the Age UK team and volunteers has also proved essential.
The role of the Age UK PICs is a challenging one and requires multiple competencies.

Active local performance management to maximise success

- At a local level, additional support, resource and time is likely to be needed to maximise the benefits of the data captured through the programme's output and performance framework.
- The national monthly learning forum, a community of practice for those involved in the programme, and health checks at key stages have proved effective in facilitating the exchange of knowledge and taking stock of performance to support continuous improvement.

Programme level performance management and evaluation

- Defining, cleaning and processing the outcome, activity and cost data generated is complex and resource intensive but essential to create a robust picture of programme level performance.
- Embed formative and summative evaluation from the outset, combining qualitative and quantitative approaches to understand whether and how the programme is on track to identify lessons learned to support continuous improvement along the way, and to understand the impact of the programme – going beyond what works, and exploring what works for whom and in what circumstances.
- One year's operation is insufficient to 'stabilise' delivery of the model. Evaluation of impact after 12 months is therefore likely to capture only the impact of implementation – longitudinal evaluation is essential.

Improving older people's wellbeing

Changes in the Short Warwick-Edinburgh Mental Well Being Scale (SWEMWBS) and qualitative research findings highlight that the programme has had a significant positive impact on the wellbeing of older people.

SWEMWBS Value		
n = 932	Guided conversion	Goal achieved
Mean	21.66	23.91
Standard Error	0.14	0.15
Median	21.54	24.11
Mode	19.25	26.02
Standard Deviation	4.34	4.51
Range	28	25.49
Minimum	7	9.51
Maximum	35	35.00
Confidence Interval (99.90%)	+/- 0.47	+/-0.49

- There has been a significant increase in mental wellbeing of 2.24 points as measured by SWEMWBS across the programme sample (n=932) who received the guided conversation and the following intervention (t (931) = 21.21262, p = 0.001)
- Preliminary analysis using imputed SWEMWBS values indicate that not only does the intervention improve mental wellbeing but that it continues to improve following the end of the intervention, up until 2 months after the intervention has finished. This was an improvement of 3.40 points on the SWEMWBS scale.

Wellbeing has been improved by:

- Helping older people to become aware of their own needs and fostering agency – empowering clients to make purposeful choices and to be in control
- Enabling independence and wellbeing through practical support
- Reducing isolation and raising ambition by motivating clients to re-engage with interests and become more socially connected
- Providing an 'extra arm' of support for older people

"It was a lifeline when I really needed it. I didn't have to make a doctor or a nurse's appointment to ask 'How do I go on about this or that?', which I don't like doing. I had someone who I could talk to, and that helped me feel like what I need or what I was worrying about isn't a problem. That makes me feel better and more in control. Whatever you want to know or ask is at the end of that lifeline, even if it doesn't involve Age UK, they point you in the right direction." **Client**

"My wife's health is getting worse. She falls a lot and can't get out. I was finding it hard to lift her and help her; I have back problems. And it was getting me down, I was getting really depressed. At first, I thought the help offered by Age UK was for my wife, but [the PIC] was there to help me, too. He made me feel comfortable getting help. He has been excellent, helped with lots of things. He also introduced me to Veterans in Communities (VIC). I can't get there that often, as I worry about leaving my wife, but I keep in touch with VIC gives me something else to think about, something else to do, and that helps me to feel better." **Husband of client**

"It was [the PIC's] enthusiasm that made me think about what I used to do and what I have actually let go of. I had been sitting there, not really feeling sorry for myself but definitely feeling down. Then suddenly she comes along and says, 'You can still do this, what's the problem?' I think a lot of it is motivation – we lose the motivation at some point and get stuck in a rut. But she sowed a seed of thought in my mind that I could do something if I tried. She has inspired me to go back and take up some of the hobbies I had abandoned. I've taken up sewing again, which I really enjoy." **Client**

Improving experience of care and it's delivery

The PICP has improved experience of care and its delivery by

- Improving care coordination and timely access to support.
- Supporting person-centred care planning – facilitating a more holistic person-centred approach to care planning by enhancing healthcare professionals' knowledge of their patients and helping to shift the conversation from a medical model to more holistic care planning for older people.
- In some instances, the service has also supported more opportunistic and responsive care - a result of the Age UK PICs' capacity to maintain regular contact with patients who might otherwise be 'off the radar' of GPs or other health and care professionals for a period of time.

"[The PICs] have helped to reframe the discussions in the MDT meetings, it makes the discussions more holistic. We start to think outside of the box about the things we can do to improve people's overall health and wellbeing and not just the conditions they are suffering from. In many cases [the PICs] have been able uncover social issues and the underlying presentations of these patients that weren't obvious to us beforehand. The PICs would come back to the MDT meeting and mention it and that would help us to look at how we would care for that individual, informed by that softer knowledge." **Professional stakeholder Clinical Stakeholder**

"It has helped to join things up – it's the most holistic facility we have. The Age UK PICs can do three to six sessions; social services do a different job. Age UK is the most holistic and joined up, which is really useful." **Clinical Stakeholder**

"No-one was aware of the situation; we were quite isolated, we felt like we were being missed by services, and didn't know what help we could get. The language barrier was an issue, we couldn't get across what help we wanted and we felt like people couldn't relate to us or understand. [The PIC] spoke to us in own language – she asked the questions nobody else asked and helped us access the support we needed." **Client**

"It would be a regressive step if [the PIC] wasn't available. We've seen some progress: we feel there is an improvement in the care of our patients, we feel that we know them better for it. And I think our patients feel special because they know there is a service there for them, and they know we are trying to help, even with the non-medical issues." **Clinical Stakeholder**

Reducing the cost pressures on the health and care system

Reducing hospital admissions
Reflecting the challenges in accessing local healthcare data which have created a dependency on the Nuffield evaluation, stakeholders from the majority of sites were uncertain about the impact of the service on acute care.

The results from the two local Age UKs that have been able to access data are promising. However, one site acknowledged the challenges of attributing change to the PIC, given the recent wider system changes, including the introduction of locality-based interdisciplinary teams.

"We have tracked patients pre and post intervention and we have seen a statistical change in the number of hospital attendances: unplanned hospital admissions and A&E attendances have both decreased by 16%." Commissioner stakeholder (Ashford and Canterbury)

Stakeholders from across all sites have also noted that the instability of medical conditions and overall health, new diagnoses, and changes in circumstances (such as the loss of a partner) have, in some instances, resulted in clients experiencing hospital admissions.

Freeing up GPs and practice staff to focus on primary tasks
The findings from the qualitative research suggest that the programme has had a positive impact on the workload of GP practice staff by supporting those older people who would otherwise have sought help from their GP or other healthcare professionals for underlying non-medical needs.

Supporting right care, right place, right time
There was a strong consensus across most sites that the programme has been effective in answering previously unmet need by filling a gap in existing statutory services and, for some clients, gaps in their wider support networks. In addition, the findings from the qualitative research highlight that the programme has also uncovered and responded to unidentified need. While in some instances, this will lead to increased use of resources in primary, community and social care, it has supported right care, right place, right time.

"From a primary care perspective, we've seen better outcomes for those patients, our high-intensity users. We've observed reductions in telephone appointments, we've seen a reduction in actual GP appointments and the need for home visits as a result of Age UK. I think a lot of that is down to the fact that they've got that PIC that they can contact." **Clinical Stakeholder**

"We have some evidence that the model has saved the GPs time. This is very much linked to Age UK, because the team and volunteers are able to respond to the non-medical needs of patients, so those patients are less inclined to contact the GP because they are lonely." **Commissioner stakeholder**

"I would recommend other practices to get involved because it reduces your workload. Taking the time to engage with Age UK frees up some of your other time to deal with the more complex cases. It benefits your patients, because you have got somebody else out there identifying needs where people may not be asking for it, so it's a win-win." **Clinical Stakeholder**