Age UK | Age England Association

A Coordinated Response to Winter Pressures:

Working together to support older people through winter.

October 2023

Why focus on older people in winter?

Many of the pressures experienced by the health and care system each winter could be alleviated by coordinated action to anticipate the needs of older people. With better use of local data and a more collaborative approach, we could provide more appropriate support much sooner and avoid many disruptive and costly hospital admissions. Most importantly, it would improve the health and wellbeing of older people.

Winter is often a very challenging time for people in later life. A combination of cold weather, seasonal infections, and difficulties sustaining activity levels and social connection all increase the risk of an adverse health event which, for those living with pre-existing health conditions or frailty, all too often ends in hospital.

We know that older people in crisis account for a significant proportion of activity across urgent and emergency care.

In 2021/2022 there were 4.8 million emergency department (ED) attendances by older people. In the last representative year (2019/20) 855,115 emergency admissions were attributable to ambulatory care sensitive conditions (ACSC). This includes common infections like UTIs, and exacerbations of chronic conditions such as COPD. **Of 1.1 million adult ACSC admissions, 57% those were people aged over 65 (75% were amongst aged 50+)**.

People aged over 65 account for half of all patients arriving at ED by ambulance, are much more likely to be admitted and, experience longer waits as a result.[1] A significant proportion of this activity can be attributed to falls alone. In winter the likelihood of a fall and associated admission increases significantly for many older people. **In 2021/22 there were 223,101 falls related admissions in people over the age of 65, 146,934 of which were over the age of 80.**[2]

Once in hospital, older people are more likely to have longer stays and require additional support on discharge. Between 2020 and 2022, there was a 52% increase in the number of (typically older) people staying in hospital for 2 weeks or more[3], while those aged 65+ account for an estimated 85% of delayed discharges.[4] **Furthermore around 1 in 6 emergency admissions of people over the age of 75 occur within 30 days last being discharged from hospital.**[5]

Yet this is not inevitable.

Preventative approaches and early intervention measures can significantly reduce the risk of an older person's health deteriorating during the winter months. Greater investment in services delivering up-stream prevention all year round, will certainly reduce pressures on the urgent and emergency care system during the winter surge.

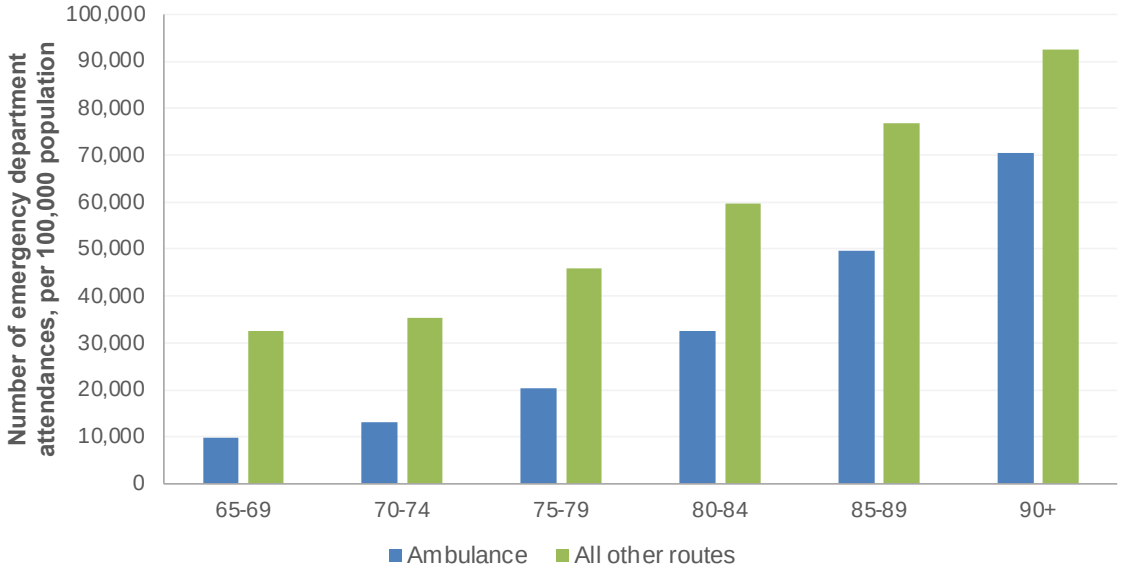
If an older person does become unwell, supporting them to receive treatment at home or in their community wherever possible, or enabling them to be discharged from hospital as soon as they are medically fit, will deliver a better outcome for the patient and allow the NHS to make best use of hospital resources.

Urgent and emergency care and older people

While people aged 65+ account for just over 21% of total emergency department attendances (NHS Digital 2022), ED attendance per head of the population increases significantly with age, with more than nine ED attendances for every 10 people aged 90+.

People aged over 65 account for almost half of ED attendances arriving by ambulance again with the proportion rising by age. 40% of patients arriving by ambulance will be admitted as an inpatient.

Emergency Department attendances, arrival by ambulance & all other routes, per 100,000 population, by age group, 2021/22, England.



Source: Age UK 2023: Analysis using: NHS Digital (2022). *Hospital Accident & Emergency Activity 2021-22.*

(Age UK, State of Health & Care, 2023)

The Winter Effect

There are a range of reasons why winter is a challenging time for many older people. The most common problems relate to the weather, increased loneliness and isolation, and greater risk of common seasonal infections. Taken together, many older people report a significant impact on their mood, physical function, and sense of wellbeing during the winter months.

Cold

Older age groups find it harder to regulate their body temperature, and chronic cold – defined as prolonged exposure to temperatures below 18°C (which can happen if a person is living in a cold home) – is associated with increased risk of cardiovascular events such as heart attacks and strokes, and exacerbations of respiratory disease and musculoskeletal conditions. It is also associated with poorer mobility and risk of falls.

Seasonal infection

Common respiratory diseases such as the Flu, Covid-19, and RSV are more prevalent in the winter months, as are other contagious illnesses like norovirus. Immune system function decreases with age meaning older people are more susceptible to the severe impacts of these viruses and make up large proportions of those who need hospital treatment and care.

Activity and social contact

Many older people also experience difficulties in maintaining their activity levels and social connection during the winter months.

Weather conditions, shorter days, and changes in people's health and wellbeing can make it harder for older people to sustain usual activities and routines. Reductions in activity are associated with physical deconditioning (including loss of muscle mass, strength and balance), while reduced social contact can cause low mood, challenges in managing everyday tasks, and increase the likelihood of health-risk behaviours.

Isolation

A lack of practical support or somewhere to turn for help in a crisis is associated with higher risk of an adverse health incident. Older people living alone are more likely to access urgent and emergency care services or have frequent contact with GP services. It is a strong predictor of being admitted to hospital (or readmitted within 30 days) or a care home. During the winter months, high levels of isolation coupled with increased health risks can amplify this effect.

Working in partnership to coordinate an effective response to winter pressures

We have an ageing population with increasingly complex needs, and demand for all forms of health and social care services is increasing. This is more acutely observed during the winter months, when the risk of adverse health incidents increases, and the capacity of services come under pressure. At the same time, when hospital flow slows, or urgent and emergency care are struggling, older people are often the ones impacted the most.

Improving access to high quality and timely treatment, care and support for people living with multiple, long-term conditions, complex health needs and/or frailty or disabilities is a key challenge for ICSs. Both the Fuller Stocktake Report and NHSE Recovering Access to General Practice plan acknowledge that a key driver in growth in demand is our ageing population and make the case for more proactive, preventative, and personalised care in response.

There is also a recognition from policy makers that the Voluntary, Community and Social Enterprise (VCSE) sector will be a critical partner in supporting transformation – moving Integrated Care Systems (ICSs) away from reactive treatment of illness towards population health approaches and models of care built around early intervention, and community-based support.

A recently published report by the NHS Confederation sets out clearly how areas that spend more on community care see a reduction in acute activity, including lower non-elective admission rates and ambulance conveyance rates. While the report in question focuses largely on clinical care in the community, this includes services such as podiatry and intermediate care, services that VCSE partners provide in whole or in part in many areas of the country.

Such a shift in priorities will take time and investment, and a degree of courage from health and care leaders. However, the development of ICSs means there is now a significant opportunity, and structures through which we can work differently at the level of system, place, and neighbourhood, both this winter and into the future.

In this guide we explore how ICSs and the VCSE can build on these opportunities and work together to increase their impact this winter.

The opportunity is twofold:

1. **Prevention and early intervention - reducing demand for urgent and emergency care**. There are significant – often untapped – opportunities to keep older people well and prevent unplanned admissions over winter. The first part of this document looks at the role of Population Health Management (PHM) in preventing admissions, and how the work of the VCSE delivers against ICS objectives in tacking health inequalities and delivery of preventative, personalised care closer to home. It sets out some examples of where data has been used to develop targeted interventions aimed at helping those older people at greatest risk of deteriorating health during the winter months.

2. **Effective discharge, sustaining people at home.** Recognising that some older people will experience both planned and unplanned hospital admissions this winter, we want their stay to be as short as possible (while also delivering the care that they need) and supported by an appropriate package to complete their recovery at home on discharge. That could mean hospital at home/virtual wards, reablement, community navigation or personal care, and often a combination of these services. Many VCSE organisations are already contracted to provide services to help people to recover following an admission, but the availability of these vital services is a postcode lottery and commissioners are not always aware of what the VCSE can do or are already doing. We've mapped some existing VCSE service models to the NHS priorities for this winter, to aid discussions around discharge and support following an admission.

In developing this guide we have drawn on the work of our nationwide network of Age UK partners to highlight what works, and as an illustration of what's possible for those working at ICS and Place looking to enhance collaboration with their local VCSE. For more information about the Age UK network contact healthinfluencing@ageuk.org.uk.

Quick guide: Supporting health and care systems deliver on winter plans

Ahead of winter, the NHS have published their plan 'Delivering operational resilience across the NHS this winter', setting out 10 evidence-based high-impact interventions (listed below). These priorities are focused on reducing waiting times for patients and crowding in ED, improving hospital flow and reducing length of stay.

Throughout this guide we will highlight practical examples of where they VCSE can - and many local Age UKs already do - make a valuable contribution to delivery of those plans and services. This includes virtual wards, same day emergency care, and work preventing admissions and readmissions.

Example of Service x NHSE High Impact Interventions	SDEC	Frailty	Inpatient flow and length of stay (acute)	Community bed productivity and flow	Care Transfer Hubs	Intermediate care demand and capacity	Virtual wards	Urgent Community Response	Single point of access	Acute Respiratory Infection Hubs
Home from Hospital/home and settled	x	x	x	x	x	x				
Admissions avoidance services – virtual wards				x	x		x		x	
Falls Prevention services		x						x		
Safe and Well Services		x								x
Meal delivery, nutrition and dietetics		x								
Patient Transport	x		x							
Hospital In-reach/Transfer of Care services			x		x	x				
Community Navigation	x	x	x		x		x	x		
Rehabilitation	x	x		x	x					
Community Response		x		x				x		

1. Understanding population risk

Population Health Management (PHM) has an important role to play in identifying older people at risk of an adverse health event through the winter months, supporting systems to put in place services and support to deliver the right help, to the right people, at the right time.

Using existing local data and intelligence to understand and predict need at ICS, Place and Neighbourhood level to design and target interventions, systems are able to make the best use of available resources, reduce variation in outcomes and tackle health inequalities – an important priority for both ICSs and the VCSE.

1.1 Population Health approaches to supporting older people in winter

PHM approaches have been used effectively to identify and target early intervention and prevention services towards older people who are most at risk of experiencing deteriorating health and avoidable urgent and emergency care use.

By stratifying local older populations according to both underlying risk factors – such as age, health condition and living with frailty – as well as socioeconomic, behavioural and environmental factors (particularly those associated with increased risk in winter such as cold homes or fuel poverty) - systems can identify individuals 'impactable' by packages of interventions and support, and work with partners to move preventative activity upstream.

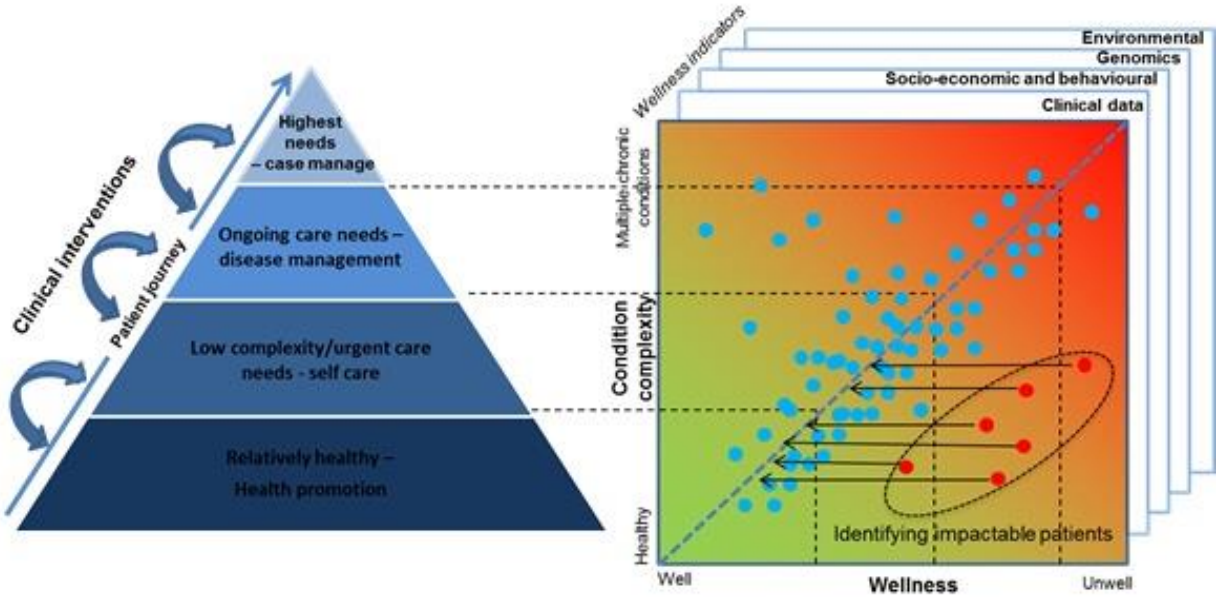


Figure 3 - Fell G. (2017)[6]

Case study: Bedford Borough Council Public Health – Winter Warmth

Each place board within the ICS was allocated a sum of money to initiate a PHM project for winter 2022/23.

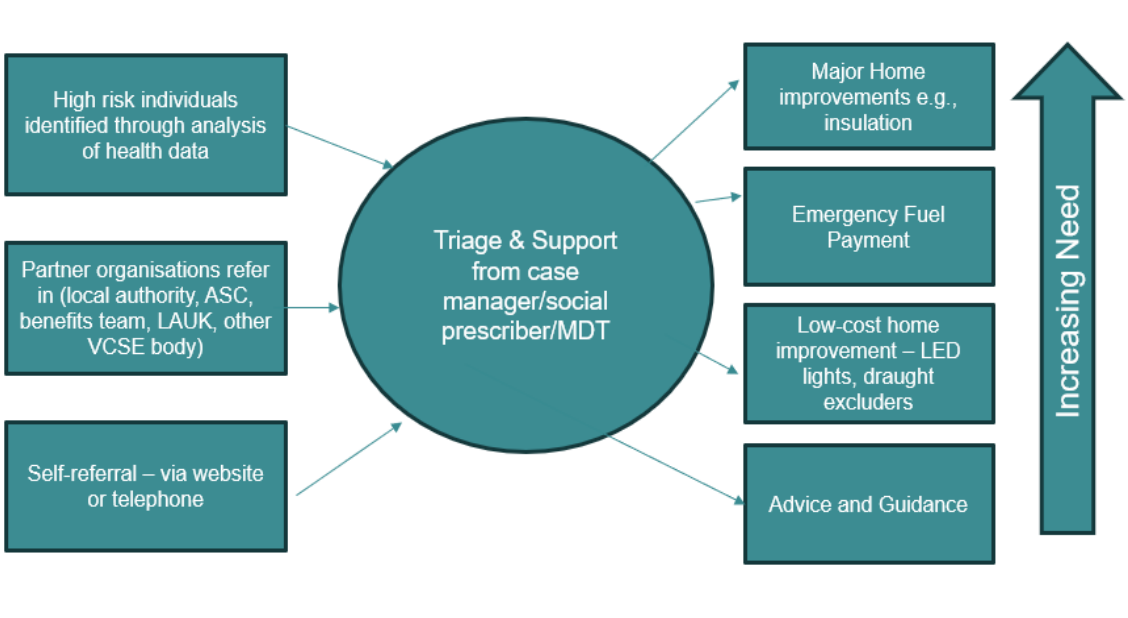
The project set out to address a key local health and wellbeing priority involving wider determinants of health and health inequalities, using existing data in an innovative way and requiring a collaborative approach with partner organisations. Analysis of data by lower super output area showed that 1 in 5 households in 2019 were living in fuel poverty, many of which were concentrated in urban areas, and that number was expected to double this year as a result of rising energy costs. The local authority also knew that there were around 100 excess winter deaths before covid.

A steering group was established with the local authority, provider collaborative, ICS and VCSE representative body. Scoping was undertaken to understand any existing programmes and new initiatives.

The system's commissioning support unit Arden and GEM the conducted an analysis of health and public health data to identify an initial cohort of 1,157 'high risk' individuals with underlying health conditions that might also be impacted by cold and damp homes.

Those individuals were initially contacted by letter, with the process of stratification happening during follow up communications. Referrals were also taken from partners, and people who were aware of the programme through media communications and felt they might meet the criteria for intervention were invited to make contact.

The model below was developed:



With thanks to Bedford Borough Council Public Health Team

Case Study: Anticipatory Care in Leeds – Using data to identify Frailty

In Leeds local teams adopted a proactive population health management approach to select a sub-cohort of people living with frailty who were predicted to be most at risk of a deterioration in health and could therefore benefit most from proactive interventions. They used their knowledge of local needs to test and build on the initial insights from the data.

Dementia, mobility and nutrition issues were all additional factors which compounded this risk which the teams looked to address through new anticipatory care models. They introduced a proactive assessment and triage service for these patients and then a range of personalised interventions including referrals to group 'live well' consultations, individual medical consultations in clinic and home visits led by an occupational therapist.

NHSE Integrated Care in Action

1.2 Identifying risk factors in winter

Older people who are at risk of an adverse health event would benefit from interventions to address these risk factors throughout the year. However, for the reasons set out in this guide, some health conditions, environmental issues such as unsuitable housing or economic factors such as low income, can be exacerbated during the winter months. We have identified the most relevant predictors to consider. **For more information about the underlying drivers of hospital admissions download our evidence summary slide pack.**

Systems adopting a PHM approach may want to do any or all of the following:

1) Take a broad approach to understanding risk and identifying need across their older population based on common predictors;
2) Use defined combinations of variables reflecting what they know about local patterns of service utilisation;
3) Look to target older people living in communities known to be underserved/hardly reached, and where particularly stark health inequalities are identified.

Predictors for admissions – identifying those at risk	
Clinical Risk Factors	• Malnutrition & Dehydration • Cardiovascular disease • Respiratory illnesses • Leg Ulcers • Cancer • Functional Decline • Dementia • Musculoskeletal conditions (arthritis, osteoporosis) • Polypharmacy • Poor mental health • Frailty (mild, moderate and severe) • Diabetes • Visual impairment • Diagnosis with a terminal condition
Social and-economic Risk Factors	• Fuel Poverty • Low income • Damp/ mouldy, poorly insulated homes • Living Alone • Loneliness • Bereavement • Caring • Social Isolation • Poor transport links • Digital exclusion • Other environmental factors in home (loose rugs, poor lighting)
Other Predictors	• Increasing age • Previous Hospitalisation • History of Falls

Age UK HI 2023 – Predictors for admissions

1.3 Joining up data and insight

Case finding for patients at risk of readmission to hospital is not a new concept, but we have better resources at our disposal in 2023, including structures bringing together health, care, and VCSE that ought to allow systems to leverage data more effectively.

The data that can help to identify individuals who could benefit from interventions may be held by several different organisations, including Primary Care Networks/ Neighbourhood Teams, providers and hospital trusts, NHS 111, emergency services, and community-based clinicians such as district nurses. At the same time, socio-economic and environmental data and insight is often held by local authorities and their public health teams and local VCSE organisations. Some ICSs are working with external providers to support their analytics and undertake predictive modelling, bringing together health and social care data (although the latter can be more limited).

The Electronic Frailty Index (eFI) is a particularly important tool in identifying older people at risk during winter. The tool, using patient records and embedded in GP practice IT systems, is able to risk-

stratify the local 65+ population to help identify those likely to be living with mild, moderate or severe frailty.

The VCSE sector also has an essential role to play in identifying individuals that need help and support, particularly if we are to reach people before they hit crisis point. VCSE and community groups often have a sophisticated real time understanding of people who may be at risk; and become aware of emerging challenges within their communities before those impacted present to statutory services.

It is vital that ICSs, place boards, and neighbourhood teams work with and through their existing services and networks and incorporate local knowledge alongside their data analysis.

As ICSs establish and improve their data analysis capacity, bringing together the data and insight held by partners across the system will be key. Hugely valuable information and insight often sits outside formal NHS or local government structures. The local VCSE, faith and community groups, housing associations and others will have critical insight into the needs and challenges of a local population, as well as assets and expertise to help deliver solutions.

1.4 Tackling health inequalities

Systems that analyse and use data to design services around the needs of their populations, will better understand where there are gaps in services, inequalities in access, and the overall impact of the wider determinants of health on their communities.

Using PHM to support older people at risk of an avoidable admission to stay safe and well at home this winter will not only help address immediate system pressures as we set out earlier, but could also help systems achieve their objectives in tackling health inequalities.

There is significant variation in people's experience of ageing – as evidenced by the wide disparity in healthy life expectancy across communities – with most of that variation determined by the circumstances in which they live their lives.

Ageing is both biological and psychosocial process. The impact of biological ageing – the process of acquiring health conditions and functional disabilities as a person gets older – often brings with it a range of other changes which may have an impact on life circumstances, mental wellbeing and health behaviours. Common examples include exiting the labour market, bereavement, or caring responsibilities that impact on a person's sense of purpose and identity, their daily routines, and social connections. Many health challenges associated with older age are driven by the intersection between, and compound risk of, these biological and psychosocial factors combined. There is wide variation in the experiences of biological and psychosocial ageing between individuals and across communities at any given chronological age.

Life expectancy follows the social gradient, and many older people in deprived areas, or living in poverty, may develop significant needs at a younger age. People ageing in the least advantaged circumstances are more likely to experience age-related disability and poor health at a younger chronological age, live with poorer health throughout their later years, and have lower life expectancy than people with greater advantage. **For instance, those living in the most disadvantaged circumstances experience multimorbidity 10 to 15 years earlier that those in the most affluent areas.**[7]

But every ICS, Place and Neighbourhood will recognise the challenge of meeting the needs of an ageing population that is not necessarily ageing well. So, while the precise nature of the support that communities need will vary, every ICS should be working at Place and Neighbourhood to design and commission data driven, proactive and preventative services to meet the needs of older people. In doing so they will ensure they are also beginning to tackle health inequalities and should eventually see a reduction in unplanned acute activity.

It is important for individual systems to understand the experiences of ageing within their local population and develop services that reflect the overall context of the communities they serve.

For this reason, we recommend systems consider all those aged 50+ within their ageing strategy and when identifying cohorts and designing interventions targeting their older population.

Understanding inequalities in later life

There are groups of older people, typically those living in the least advantaged parts of the country or in minority communities, who are less well served in terms of access to and experience of health and care services. They are also more likely to report poor health and wellbeing outcomes. Typically older people in the least economically advantaged groups, those already living in poor health, informal carers and those who experience additional barriers to access – including digital exclusion and English as a second language – report poorer experiences. It is also important to recognise the intersection of age with experiences of lifelong discrimination based on – for example – race, sex, sexuality or gender identity. Ageing may intensify existing or introduce news challenges.

Analysis of the GP Patient Survey found:

- 48.3% of people aged 65+ felt supported to manage their long-term condition/s in the most deprived areas in 2022, compared to 59.8% in the least deprived areas;
- 60% of informal carers reported a health condition or disability compared to 50% of non-carers.

NHS Data showed that here were also around twice as many attendances to ED departments in England for the 10% cent of the population living in the most deprived areas (3 million), compared with the least deprived 10% (1.5 million). Difficulties accessing primary and community care together with poor housing and overall living conditions contributes to inequalities in physical and mental health.[8]

People living with the most significant levels of frailty, disability or those living with dementia – typically those in the oldest age groups (80+) – can also experience some of the most significant challenges access suitable care and have some of the poorest experiences. For example, older people living with frailty, those living with dementia and older people admitted in an emergency report poorer experiences of acute care in the NHS inpatient survey. Older people also experience some of the longest waiting times in ED.

A key challenge for systems is ensuring that they are able to break down data by suitable age bands and undertake an intersectional analysis to identify those older people at greatest risk of poor access, experience or outcomes from services.

1.5 What is the role of the VCSE?

The VCSE has an important role to play in PHM.

The VCSE hold valuable data and insight into their communities. This may include information and data about who accesses their information and advice or support services, providing important context into the wider determinants of health and wellbeing that NHS or statutory bodies lack.

Working at a granular level within their communities or patient populations, they may also bring unique insight into the underlying challenges and broader drivers of poor health impacting on individuals, groups or key geographical areas; as well as key service gaps and areas of unmet need, common problems in existing patient pathways or barriers patient groups have accessing or engaging in care.

VCSE organisations frequently work as part of larger national collaborative networks or organisations to access additional data analysis, research or maintain bodies of expertise of particular concern to their communities. This includes bespoke quantitative and qualitative research, secondary analysis of national data collections as well as academic partnerships and service innovation. This research, service development and insight is generally specifically commissioned to fill existing gaps in services and provide support for the individuals and communities they work with.

The VCSE are able to reach individuals and communities who are otherwise disengaged with statutory services. Whether through existing services and support, volunteers or targeted outreach programmes, local VCSE organisation are often able to deliver support in locations, at times and in ways that build trusted connections with people who may be either unable or unwilling to access existing statutory services on a routine basis. This trusted connection means VCSE organisations can work 'upstream' with individuals and communities most at risk of an adverse health event.

Using their insight into and experience of working with key communities, the VCSE are well placed to support the design and delivery of services and support. Many VCSE organisations already deliver tailored support to older people who are vulnerable to unplanned hospital admission and can support their communities with greater levels of personalisation and holistic support, as well as being able to design programmes and interventions which are reactive and responsive to the needs of their local populations.

2. Delivering interventions

VCSE organisations like Age UK already do a lot of work that helps to keep older people supported, engaged with their communities, and crucially out of hospital throughout the year. This could be as simple as a fitness class or walking groups to keep older people active and mobile, a lunch club, or meal delivery service. In many cases, local VCSE organisations will already have a range of existing assets, services and support that could be scaled up in the winter months. These organisations can also identify groups of people or individuals who may need extra support as we head into winter.

2.1 Support to stay safe and well at home in winter

Amongst older people living with frailty, multiple or complex health needs, 'small' events, or a series of them – often ones related to their living conditions or life circumstances – can quickly escalate or accumulate into an acute medical crisis.

This means tackling social isolation, providing information and advice on access to benefits, respite and support for unpaid carers, or help with everyday tasks such as shopping for and preparing food and drink are as important as clinical care in supporting older people to stay safe and well at home.

In winter 2022/23, many Voluntary sector and faith groups hosted warm spaces to help people who might be struggling to heat their home. Warm spaces schemes had the added benefit of bringing people together who might otherwise have been socially isolated.

The Age UK annual 'Spread the Warmth' campaign delivers essential information and advice, bespoke winter support services including vaccination uptake, warm spaces and emergency food, medication or heating. Our Winter Wellbeing Hub brings together a wide variety of resources for professionals and older people. More information and resources are also available by contacting: healthinfluencing@ageuk.org.uk

The table below sets out some examples of the services and support that can address common winter health issues and prevent or delay the onset or exacerbation of common conditions that may result in an unplanned admission to hospital. **For more information about the underlying drivers of hospital admissions download our** evidence slide summary pack.

Winter health Issues	Service Type
Cold related exacerbations of health problems – CVD, frailty, respiratory	Support to access relevant benefits and energy programmes Community hubs and warm spaces Emergency support – e.g. additional heating supplies/ meter keys/ 'hot boxes' Warm Homes schemes
Increased risk of falls	Support to remain physically active through winter Targeted falls prevention Home safety checks and/or minor adaptations
Increased risk of social isolation and loneliness	Befriending and community support to remain socially connected Group Activites
Risk of seasonal and common infections – flu, covid, UTIs	Support to access vaccinations and essential healthcare services, including medications and pharmacy Services to prevent malnutrition and dehydration

Winter health issues and services to prevent or delay the progress of health conditions

Case study: Winter wellbeing service - Age UK Blackburn with Darwen

Throughout winter 2023 Age UK Blackburn with Darwen offered an enhanced winter wellbeing and support service. The service distributed winter wellbeing packs, including advice on how to stay safe and well in winter, information about benefit maximisation and cost-of-living support, as well as details of services and support available through the charity. Additional support was targeted at older people who had recently been discharged from hospital or at high risk of an admission (for example those with recent history of falls). People identified at risk were offered a full holistic assessment and tailored support package.

The impact for older people

Mrs I is 65 and living alone in a one bedroom rented flat above a shop. She lives with a number of both mental and physical health conditions, including arthritis, bladder issues and a genetic disorder. She was already rarely leaving her flat due to her mental health conditions when last December she fell on the stairs, severely injuring her shoulder. After the fall she was in pain and struggling to mobilise while on a waiting list for surgery. Mrs I was also struggling to pay her energy bills and was trying to keep warm at home by spending most time in bed, which was further impacting her mood. She had received a letter indicating she was ineligible for the Warm Homes Discount as her landlord had not supplied an EPC certificate for the property.

Through the winter support service Mrs I received a winter wellbeing pack and was offered a further assessment. The team were able to provide her with a suitable electric blanket straight away, this meant she could stay warm in her living room during the day which helped her mood. It also reduced her energy bills. The team then contacted the landlord to arrange an EPC to ensure Mrs I could access the Warm Homes Discount and conducted a benefit check to increase her income. The team referred Mrs I to other services to work with her to build her confidence and attend regular groups to reduce isolation and improve her mental wellbeing.

Case study: Crisis prevention and early intervention – Age UK Birmingham and Sandwell

Over the course of winter 2023 Age UK Birmingham and Sandwell offered emergency support to older people in or at risk of crisis. Support included emergency food parcels, emergency gas or electricity meter top up, heating at home (for example electric blankets and battery-operated heaters) as well as transport assistance. The service provided immediate support to older people referred or identified within its services, aiming to prevent or deescalate a crisis. The team are then able to continue working with individuals to address their underlying challenges.

As part of this work, they also prepared an asset register of organisations across Birmingham and Sandwell, who were providing winter solutions such as warm spaces, social meeting clubs, free or subsidised hot meals, food banks and hardship grants.

The impact for older people

Mrs M is 72 years old and has a heart implant device monitored by her local hospital. Mrs M had a pre-payment meter for both gas and electricity. She contacted the team on a Friday afternoon in distress when she only had £7 left until her next benefit payment in 5 days' time. The team were able to dispatch a volunteer to provide a top-up for her energy meter and a food delivery the same day.

Case study: Enhanced befriending - Age UK Lincoln and South Lincolnshire

During winter 2023 Age UK Lincoln offered additional befriending contacts and home visits by staff and volunteers targeting older people with identified needs who were either geographically isolated, housebound or experiencing social isolation. By conducting home visits the team were able to offer both companionship and a holistic assessment, including support to access benefits and referral to routine services. The Charity supports a large rural area where services can be difficult to reach for many older people, particularly those who are not online.

The impact for older people

Mr M has hearing issues and memory problems making it difficult to deal with many issues over the phone. He was struggling to access Pension Credit and, as a result, would not have received any additional cost-of-living payments. The team were able to visit Mr M at home and complete the relevant applications online with him and liaise over the phone with the different agencies.

2.2 Proactive support for people with more complex needs

For older people at the highest risk of an unplanned admission or adverse health event in winter, multi-disciplinary packages of support, tackling their health, care environmental and social needs are beneficial.

These case studies set out a range of ways Age UKs have worked in collaboration with their health and care systems to better meet the needs of older people identified to be at risk of an avoidable acute health crisis.

Case study: Home Wellbeing Service – Age UK West Sussex, Brighton & Hove

Age UK West Sussex, Brighton and Hove were commissioned to work with a cohort of patients identified as living with complex physical and mental health issues with the aim of reducing pressure on NHS Services.

Within 24 hours of receiving a referral a brief telephone needs assessment was carried out with the individual referred and visit arranged within the next 7 days. The team then carry out a holistic 'Home Welfare Assessment', and discuss with the client the services on offer to support them to live independently in their home. With the client's permission referrals would then be made into our existing Age UK services for immediate practical interventions and where appropriate external agencies offering specialist care and advice. The most common referral was to 'Help at Home' service who help with household tasks such as cleaning. There are also high numbers referred into telephone befriending service, information and advice services (often with a view to accessing unclaimed benefit entitlements).

Other services provided included frozen meals, gardeners, handy people, volunteer home visitors and for those in Brighton and Hove with more complex and urgent needs were referred into Age UK crisis service. Age UK also worked in partnership with the Fire Service, Occupational Therapy, Carelink, Careline and the Council's Adult Social Care Team, and also referred on to the Stroke Association and Parkinsons society where appropriate.

The impact for older people

Mrs A is 76 years old and living alone. She was referred into the Home Wellbeing Service (HWS) by the fracture clinic, after her dog pulled her over and fractured her wrist. Mrs A was finding it difficult to cook meals and do her laundry. She is also agoraphobic and experiences high levels of anxiety. The HWS assigned a Home Help to assist with food preparation, laundry and also importantly, dog walking.

Due to Mrs A's high levels of anxiety, she didn't feel able to use a taxi or the hospital transport, so the HWS provided transport so she was able to attend her follow up appointments at the fracture clinic. Mrs PM said the HWS staff were her 'guardian angels' at a time when she needed them most. Her six weeks in the service is now over but she is continuing with her Home Help, as a paid for service as she has found it so helpful and has built a great deal of trust in them.

Case Study – Blackburn with Darwen - targeting non elective attendance and admissions

Age UK Blackburn with Darwen have been working with their ICS Population Health Management team and other partners to develop and pilot an improvement approach to reducing non-elective attendance/admission to acute care.

The work is part of a broader 'priority ward' programme which has identified wards within the ICS footprint which have higher than expected non-elective admissions, even when taking into account factors such as deprivation levels.

The pilot is focussed on one particular ward in the Borough which, for over 65's has the highest levels of non-elective admissions and the longest lengths of stay.

A project group is established including partners from Population Health, Public Health, Adult Social care, and primary care along with Age UK.

This group has looked at the clinical data related to conditions causing most admissions and with the longest lengths of stay and will be triangulating this with other clinical data including clinical frailty scores; other health and care related data including access to support via the integrated neighbourhood teams and adult social care support; and selected wider determinants data including housing tenure.

Alongside looking at the data, engagement activity is being planned within the identified ward to gather insight and co-produce a different approach to supporting people in the target cohort. Working with primary care to use risk stratification partners will work together to have strength-based discussions and proactively develop care and support offers.

The intended outcome from the work is to develop pathways of support within the community that enable people to better manage their health conditions and to access relevant support and services to prevent a deterioration in health and to manage their needs within their own homes.

The longer-term aim is to develop an approach which can be replicated across the borough to manage frailty and reduce the risk of increasing numbers of people experiencing more severe levels of frailty.

National policy – NHS England Proactive care

Since the 2019 NHS Long Term Plan, there has been an aspiration to roll out a formal model of "proactive care" (previously called "anticipatory care"). This approach would see local NHS services identify, assess, plan and coordinate care for core cohorts of patients. Older people with frailty are the group most likely to benefit and would be prioritised.

Some areas of the country have already embarked on similar programmes, but it is anticipated that the formal NHS England framework for proactive care will be published during the Autumn/Winter 2023 for roll-out in 2023/24, The VCSE sector will be a key stakeholder in making this approach work.

2.3 Crisis response - early intervention, preventing admissions

Even where proactive support is in place, there will be occasions when an older person experiences a rapid deterioration in their health.

However, timely intervention at crisis point can delay the escalation of need, and the voluntary sector have a vital role to play in delivering short term support with the basics of everyday life – from checking that essential supplies are available and can be stored safely, to ensuring that furniture is arranged safely.

VCSE partners provide valuable support for people who experience a crisis, whether they have fallen ill, suffered a bereavement or loss, are experiencing a domestic emergency or have been discharged from a planned or unplanned stay in hospital. Crisis care delivered at home can stop or delay the deterioration in an older person's health and allow time for other services to address unmet needs to be arranged, but these services also make it much easier for those who do need in-patient care to be discharged safely, with a reduced risk of readmission.

Some VCSE partners are also able to provide telecare monitoring and respond to non-injury falls, an important priority for all systems this winter and key to reducing pressure on other emergency services, and consequential, disruptive admissions. One such service is illustrated below.

Case study: Crisis response service – Age UK West Sussex, Brighton and Hove

The Age UK Brighton and Hove 'crisis response service' provides short term emergency support for people finding it difficult to cope due to illness, an accident or emergency. The service offers practical help, including shopping, collecting prescriptions, meal preparation, support with essential household tasks and personal care. It can also offer wellbeing 'comfort' calls after an emergency or bereavement. Older people can self-referred, or be referred into the service by a friend, relative or healthcare professional. The service provides essential support to enable older people to stay at home who might otherwise find themselves on the accessing urgent or emergency care.

Case study: A&E support team – Age UK Hillingdon

Age UK Hillingdon operate an ED service which deploys staff in the emergency department at Hillingdon Hospital to support older people during their time in the department. This can include practical and emotional support, providing reassurance and companionship, liaising with clinical staff, supporting nutrition and hydration and supporting practical arrangements as required. They are also able to offer information and advice and signposting.

National policy – Urgent and Emergency Care (UEC) Recovery and Urgent Community Response (UCR)

The UEC Recovery Plan launched in January 2023, set out how the NHS should respond to pressures across urgent and emergency care. This was initially in response to challenges exacerbated by the

pandemic and a sequence of challenging winters. For the longer-term, it starts to set out new ways of working to better respond to public needs and make efficient use of hospital services in particular.

The main drivers for this work are to reduce the delays in both walk-in ED and ambulance handovers. However, underpinning this work should be reductions in attendances in the first place and more rapid discharge once someone is fit to go home.

The VCSE can play an important role in both these goals.

Urgent Community Response (UCR) was initially set out in the NHS Long Term Plan and has been operating since 2020. UCR services seek to intervene early, primarily to avoid the need to transfer people to hospital. This could be for someone who has had a deterioration of their health condition or minor fall, for example. It commits to a 2-hour attendance by the appropriate team from referral into the service.

In the first-year evaluation, published in September 2023, partnerships with the voluntary sector were identified as a key factor across sites successful delivering UCR. In particular, they played an important role in providing follow-up support and in engaging patients/family for feedback.

2.4 Virtual Wards or Hospital at Home

The hospital at home model is well-established in international practice. The aim is to provide services and support akin to a hospital ward but in a patient's own home. Underpinning this are a mixture of home visits by staff, including the equivalent of a regular ward round; monitoring and remote testing equipment; and protocols for escalation and carer support. Hospital at home is distinct from traditional admissions-avoidance approaches – it is a de facto admission for a specific purpose, simply delivered in your home, enabling people to stay somewhere they are comfortable and familiar. The NHS in England typically refers to this approach as "Virtual Wards".

VCSE support can be an important aspect of providing the sort of 'wrap around' support needed to ensure an older person, their family or carer is supported and feels confident to manage at home during and after the 'admission'. This could include making sure that an older person's home is equipped to support them during the period of virtual monitoring (for example moving furniture, stocking the fridge, undertaking household tasks) and that other non-clinical needs are met – it can also provide much needed respite for unpaid carers.

Case study: Lincoln & South Lincolnshire Age HART service

Lincoln & South Lincolnshire Age UK's Hospital Avoidance Response Team (HART) is a holistic preventative service, working in partnership with Lincolnshire Community Health Services NHS Trust to avoid unnecessary hospital admissions, reduce ED attendances and prevent protracted hospital stays and other delayed transfers of care. The service provides short term care and support at home to older people either post-discharge or where hospital admission is deemed inappropriate or avoidable – often working to support local Urgent Community Response teams. The service can either bridge a gap until longer-term arrangements are established, or step in when short term support may be able to help someone sustain or regain their independence. The service can also

respond to non-injury falls. The service can also identify and signpost individuals to access support that would be of benefit, including their wellbeing service and access to advocacy.

The impact for older people

Mrs M is 92 years old and was referred to the HART by the Urgent Community Response team following a fall at home which had resulted in fractures to her wrist and finger. Mrs M had lived fully independently at home in a rural location, but following the fall required support with her personal care and household tasks while she recovered. The fall had also impacted Mrs M's confidence. She had been issued with equipment by UCR and referred to reablement services. The HART team were asked to provide short term support to bridge the gap until the reablement service had capacity to take over.

The HART responders visited Mrs M to talk about what help and support she needed to help regain the levels of independence she was accustomed to, and feel confident in managing her daily routines and activities. The team worked with Mrs M to put in place a personalised plan, supporting her to manage tasks such as washing and dressing, as well as meal preparation and help at home. To help Mrs M feel more confident about managing alone at home, the team also added themselves as an emergency contact to her 'lifeline' so they would be able to respond 24/7 in the event of her experiencing any distress.

In the week following her fall, Mrs M developed additional difficulties mobilising and needed extra assistance with transfers. She was also in significant pain. The team supported her to access her GP who reviewed her prescription, reducing the pain and swelling she was experiencing and improving her mobility once more.

In the visits that followed, Mrs M built up a strong rapport with the team responders, having a significant impact on her mood and confidence, that in turn was supporting her recovery. As Mrs M's confidence increased and mobility improved, she was able to manage her usual daily routines more regularly. On some occasions Mrs M was able to manage by herself and let the team know a particular visit was no longer required. Mrs M continued to make good progress and, following a positive review with her clinician assuring her the fractures were healing well, she felt able to reduce and, ultimately, stop receiving our support.

Over the course of the two-month period, the team made regular contact with the reablement service. Unfortunately, the reablement service lacked the capacity for our team to transfer Mrs M's case during that time. The team also liaised with adult social care on Mrs M's behalf, however by the end of the support Mrs M felt able to manage without on-going support.

National policy – NHS Virtual wards

NHS England has been encouraging the roll-out of virtual wards during 2022/23 and achieved treating 100,000 patients in that year. It is targeting 40-50 virtual wards per 100,000 population and is aiming for 10,000 virtual wards beds in anticipation of Winter 2023. In its guide to ICS leaders, NHS England stipulated that VCSE sector organisations should be involved in the design of virtual wards and foresees a role for the sector in supporting services and ongoing leadership.

2.5 Effective Discharge – supporting recovery and preventing readmissions

Supporting discharge and getting the right support in place following an admission to hospital is essential in enabling older people to return home when they are ready to leave hospital. It will also help in preventing their being readmitted within 30 days. Even for individuals who do not have significant on-going care needs, practical and emotional support in the days and weeks post-discharge can be essential in enabling them to manage at home during their recovery. A contributing factor in readmission amongst older people is often whether they live alone and, as a result, are less likely to have informal support in place.

Smoothing the process of treatment and discharge for those receiving Same Day Emergency Care is equally essential. In upcoming guidance on the acute frailty service in hospital, the VCSE sector will be recommended for onward referral where, for example, someone arriving in ED is able to go home the same day.

While there remain a variety of challenges across the discharge pathways, there remains significant potential to deliver improvements by working in partnership with VCSE.

The majority of older people will be discharged through pathway 0 with no *additional new* needs or pathway 1 requiring some additional support at home. However, even amongst those discharge on pathway 0 many will need support to return home and manage during their recovery. This could include support with shopping and essential household tasks, it is also an opportunity to identify underlying challenges which may benefit from referral to other support services such as befriending.

Case Study: Home and Settle – Age UK Wakefield

Age UK Wakefield provides combined patient transport and 'home and settled' services. The services is able to provide suitable patient transport to bring people home on discharge from a hospital ward or directly from ED. The service ensures that someone is safe, secure and comfortable at home, helping people to settle back in with a hot drink or meal. It can deal with immediate problems and unexpected emergencies (such as faulty locks or heating system problems) as well as making sure someone has access to essentials. The team can check whether further support is required and connect people with other suitable services.

Case study: Discharge and post-discharge support – Age UK Norwich

Age UK Norwich discharge service starts work with older patients on the ward. The hospital-based staff can work with patients to reduce the impact of deconditioning during their hospital stay, and make sure they have the right information, advice and support in place to safely and successfully return home when they are medically fit for discharge. A multi-disciplinary team can continue to provide support for individuals living with complex needs and/or in circumstances that mean they may need regular practical and emotional support to manage as independently as possible at home, or reduce the risk of preventable decline, crisis or re-admission.

Case study: Facilitating the discharge processes – Age UK Isle of Wight

Age UK Isle of Wight's hospital service works in the community unit and day hub to support patients' recovery by encouraging them to take part in daily activities, helping improve or sustain their physical and cognitive condition. The team also provide care navigation services on the ward where they have the time to sit and talk to patients about what they may need to get home safely, and supporting them to navigate to get the support they need. Age UK Isle of Wight is also able to provide on-going support to sustain people at home.

National policy – Hospital discharge and community support/Discharge to assess

Discharge guidance is based on a 'discharge to assess' model. Meaning individuals should be discharged when clinically ready with appropriate support to continue their recovery at home (their usual place of residence) wherever possible. A longer-term assessment of their needs should take place at home, taking into account their home and usual environment.

This had been supported by time-limited funding to pay for the services needed in the community, ending each year at the end of March. In the 2023/24 NHS planning guidance, ongoing funding was included in ICS system allocations to continue to pay for these activities. The budget for the Better Care Fund was also increased, allowing spending transfers between the NHS and local authorities.

2.6 Rehabilitation & Reablement

Timely and appropriate rehabilitation to restore physical function and reablement to recover and regain independence are crucial not only to ensure that hospital inpatients are fit for discharge, but to prevent readmissions. Better outcomes would be possible for older people if they could all access high-quality, person- centred, rehabilitation and reablement support.

But there is significant national variation in the availability of rehabilitation and reablement services. This is not only in terms of those people that are offered reablement at discharge but also in the numbers of older people still at home 91 days after reablement. It may be that some of the emergency admissions for ambulatory care sensitive conditions are also partly explained by the availability and quality of rehabilitation and reablement services.

The VCSE can and do design and deliver a myriad of services that sit alongside formal clinical and personal care both in the community, within hospital settings and following an emergency or planned acute stay. ICSs that effectively bring together community partners to design interventions with a focus on prevention and addressing the wider determinants of health, and more effective crisis and discharge care will see the benefits this winter, and beyond.

Case study: Health Coaching – Age UK Norwich

Age UK Norwich's Health Coaching service delivers both rehabilitation support for recovery following an adverse health event such as a stroke or heart attack, and helps people who are identified as at risk of deterioration to improve their health and wellbeing and get more out of life.

In collaboration with One Norwich Practices, the service provides personalised Health Coaching to help people to recover from illness or injury, to help with weight management or general physical and mental health. The programme works with people who have risk factors such as high blood pressure, asthma/COPD, diabetes or mobility issues. It offers free, one-to-one personalised weekly coaching for six months, followed by a six-month self-care phase where participants are supported to access a wide range of clubs and activities.

The personalised sessions are balanced to the patient's ability, interests or recovery goals (i.e. strength & balance, mobility & flexibility, heart and lungs health).

The impact for older people

Mr C is 87. He has had two strokes, a double heart bypass and lives with type 2 diabetes. He is partially sighted, and his eyesight has deteriorated further his since second stroke.

Mr C was referred by his GP to the Age UK Norwich Health Coaching programme and was assessed. He said he had lost his confidence with balance, and uses his walker to move around the house, but had stopped going outside completely. He wanted to regain confidence to walk outside and go swimming. Mr C and his wife had noticed a change in his posture, no longer lopsided on his affected side and is standing straighter.

Over the 12 weeks of 1-1 coaching his mobility improved and no longer uses his walker to move around his house. Mr C has more energy to exercise and has returned to his aquafit class. He has experienced no falls and is now sleeping much better.

National Policy – NHS Intermediate Care, reablement and rehabilitation

NHS England recently published its *Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge*. The framework includes best practice for commissioning and providing services for the period directly after leaving hospital on discharge to assess Pathways 1 and 2 (see discharge guidance above) and is time-limited (typically no longer than 6 weeks).

It includes a number of recommendations targeted to this winter and for the longer term. These include undertaking workforce analyses and planning; establishing or enhancing transfer of care hubs; and standardising assessments. The VCSE sector is very visible as a partner within the framework and there is an emphasis on the contribution of unregistered staff and the non-clinical workforce.

Alongside this was also published *A new community rehabilitation and reablement model*. This again outlines best practice for step-down care but also links into the transition into longer-term support where it is needed. It also provides more detail on standards for assessment in the community and integrated practice for delivery of services. Again, there is an expectation that the unregistered workforce will make a central contribution in delivering this model, particularly the VCSE sector and carers.

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This document has been developed as part of a joint programme of work established by Age UK and the Age England Association (the membership body for all local Age UKs operating in England) in early 2023. The "AEA-AUK NHS Development Programme" facilitates the national charity working in partnership with local, independent Age UKs to gain a richer understanding of health and care systems, investigate the opportunities to support local systems via collaborative working and help bolster the capacity of local Age UKs to deliver great services which help meet the health and care needs of local older populations.

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