South East London Integrated Care System

NHS South East London

SEL Ageing Well Framework

'Age without limits: you say, your way'

Final Draft Report
April 2025

Programme supported by:

HEALTH INTEGRATION PARTNERS

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NHS South East London

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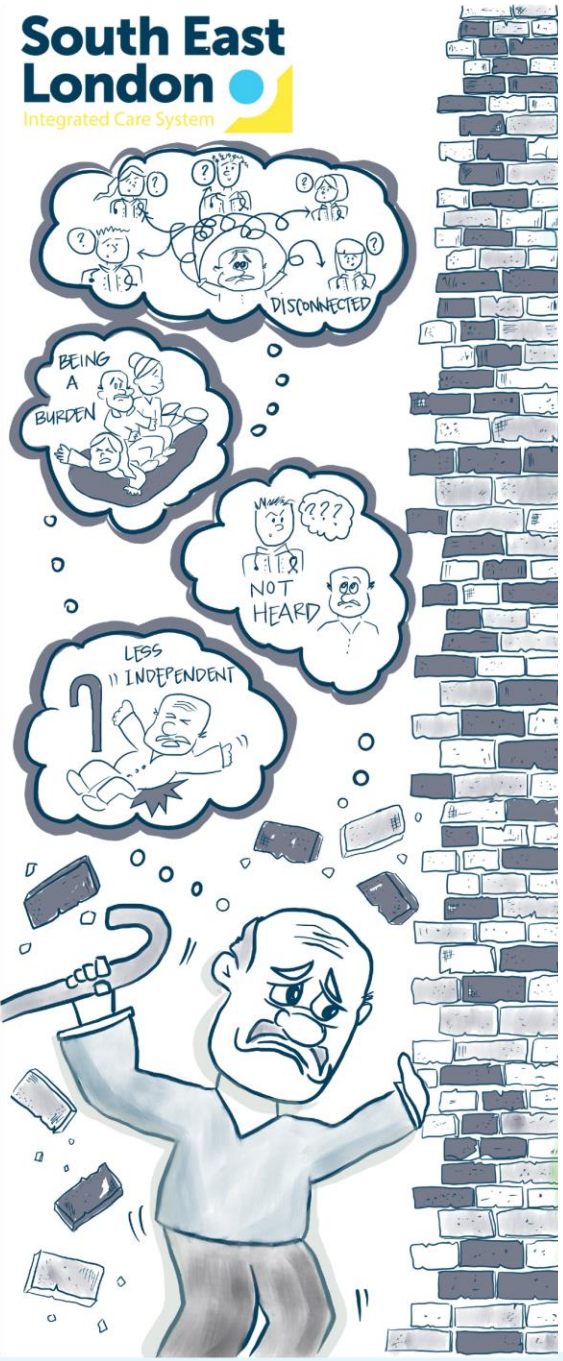


Executive summary

Introduction

- The SEL Ageing Well framework was developed between January and March 2025 driven by multiple stakeholders at Place and involving colleagues from across the whole SEL system. The framework builds on the good work already underway at Place, enabling Places to incorporate it as part of their local development. The framework will help us to share success between Places, develop parity and a consistent offer for SEL, recognising the need for local variation.
- Over 170 SEL colleagues and stakeholders have been involved in multiple working sessions to develop a shared vision and ambition for the framework with over 70 colleagues taking part in 3 face to face workshops to define the detail.
- The focus of the framework is initially on those aged 65+ including those at all stages of the frailty continuum (mild, moderate and severe). However, it is recognised that many of the elements included apply to younger cohorts showing earlier signs of ageing or frailty. The framework is not just health focused. It encompasses the wider factors and determinants pertinent to ageing well such as destigmatising ageing, building age friendly communities, the role of the carer and tackling social isolation. Definitions of ageing well and frailty were shaped as part of the work to achieve a focus on what would be important.
- The Ageing Well framework is aligned with and enabled by other emerging SEL strategies for example, Integrated neighbourhood Teams, Long Term Conditions and Urgent Community Response; recognising the interplay between these. The framework also aligns with key national directives such as the 2025/26 NHS Operating Guidance, 2025/26 Neighbourhood Health Guidelines and Lord Darzi's investigation in 2024.

Executive summary .. *continued*

Why we want to promote ageing well

- There are compelling reasons for promoting ageing well in SEL. More than 61% of non-elective beds are utilised by those age 65+ (equivalent to 1594 beds at a cost of over £250m in 2023/4).
- At least 12% of these admissions (154 per day) are due to ambulatory care sensitive conditions and therefore could be avoided with more effective management in the community.
- 50% of frail patients also stay in hospital for over 21 days, adding to the severity (and consequences) of hospital acquired disability.
- For those aged 65 and above admission costs and associated A&E attendance rates are higher in SEL compared to national benchmarks
- By 2028 the SEL over 65 population is expected to grow by 18%, adding to the above pressures. There is therefore a need to shift the focus to earlier identification and prevention – whilst equally supporting those at the other end of the frailty scale.
- The voices of residents also strongly point to the need for change. Over 100 residents were spoken to as part of the work. Their views, along with those captured from existing engagement work have helped inform priorities within the framework. For example, residents highlighted the need to feel more respected, trusted, listened to and believed.
- Residents need more help with the practicalities of life but want to remain independent and resilient despite vulnerabilities. They want purpose and connection and to be seen as 'whole' beings, equal to younger people. They also want to see more joined-up services that intervene with each other on their behalf.
- Unpaid carers want more flexible support and respite opportunities to help them to continue in their roles.
- A graphic has been produced that distills the views and aspirations of residents and is included in this report.

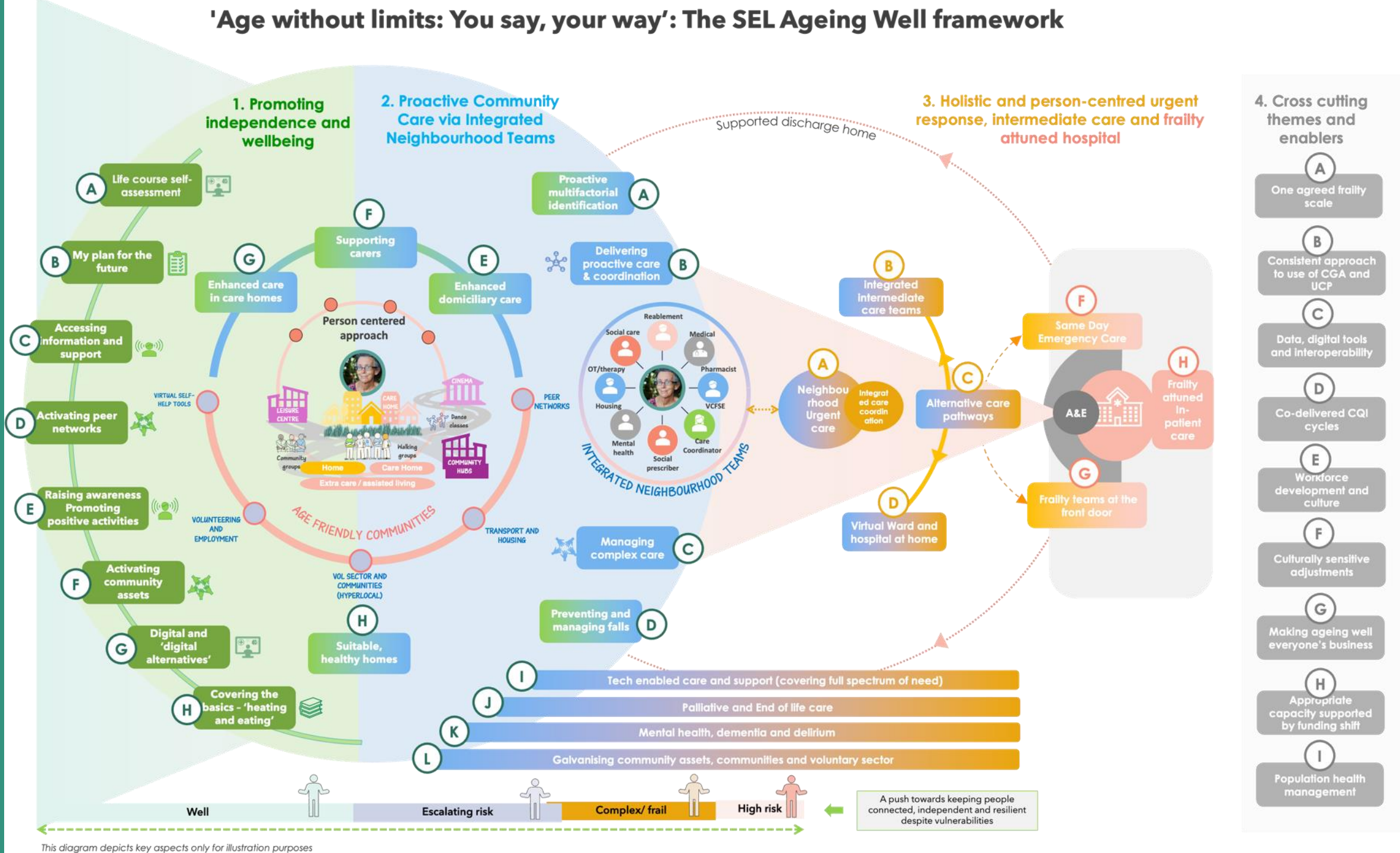
Executive summary .. *continued*

'Age without limits: You say, your way': The Ageing Well framework

- The framework comprises three interconnected zones, enabling people to move easily between zones based on where they are in their journey. The underlying principles and values relevant to all zones are also captured, such as the need for seamless navigation, a focus on active and engaged living and effective self-help.
- Zones are:
  - **Zone 1: Promoting independence and Wellbeing** – Supporting people to age well, maintain independence and social participation
  - **Zone 2: Proactive Community Care via Integrated Neighbourhood Teams** – Early identification of frailty and well-coordinated community-based care/response to exacerbation
  - **Zone 3: Holistic and person-centred Urgent Response, Intermediate Care and Frailty Attuned Hospital** – Neighbourhood based urgent response, step up/step down intermediate care, hospital front door and inpatient care
- Key principles and requirements for the care and support of people living with mental health problems, dementia and/or delirium are also captured for each zone. Palliative and end of life care and support needs are also summarised.
- A single overarching diagram that captures all the key elements of the framework per zone is provided. Each of these elements is then described in a zone summary, followed by more detailed description of each of the elements. These descriptions of each element include the factors and principles considered most important to SEL colleagues and reference some example initiatives already underway in SEL where good outcomes are being achieved.
- A range of enablers have been identified as critical to the development of the framework and a brief description of each is included. Key enablers include moving towards one agreed frailty score, a consistent approach to the use of tools such as Comprehensive Geriatric Assessment (CGA) and the Universal Care Plan (UCP), Workforce Development and Culture and Population Health Management (PHM).

The SEL Ageing Well Framework

'Age without limits: You say, your way': The SEL Ageing Well framework



This diagram depicts key aspects only for illustration purposes

Executive summary .. *continued*

How will we know we are making a difference?

- Outcomes that can be used to monitor and evaluate the success of the framework have been defined in areas such as quality of life, the effectiveness of support provided and whether we are reducing health inequalities for this population. Following review these outcomes have been further refined and prioritised. Potential key performance indicators for each outcome are suggested and an example system-level dashboard is outlined.

How will we implement the framework?

- Key success principles for implementing the framework are described, based on learning from elsewhere. The key to success during delivery is to emphasise a focus on people – for example, creating meaning, engaging and taking people on the journey, developing the right skills and motivations and providing strong leadership that inspires and establishes clear accountability.
- An overview implementation road map is provided summarising the key next steps at Place and SEL levels to deliver and embed the framework. As part of this it is proposed that Places assess themselves against the framework to help identify opportunities and priorities for delivery. These can then feed into (existing) local roadmaps for delivery.
- It is recommended that these roadmaps include definition of the ideal local care model and plans for local leadership, resources and project and change management methods. In parallel, demand and capacity modelling can take place to understand the impacts and shape the ‘left shift’ in resources required to invest in delivery. Implementation is likely to be phased and will need to be supported by a robust project delivery team and clarity on what support will be provided to Places.
- A QI methodology will be required that enables real-time learning and improvement and sharing of success between Places.

Executive summary .. *continued*

Next steps

Continued work is now required to support Places to adopt it as part of local design, planning and delivery. This includes:

- Broadening the engagement and socialisation of the model with stakeholders
- Individual Place led self-assessment against the framework, assess gap / opportunity for development
- Creation of Place roadmaps for implementation.

Appendices

- A set of appendices are provided which include a record of key outputs from workshops that have helped in shaping the framework and a summary of external cases studies and recognised best practices from elsewhere.

The picture on the right depicts the vision as defined during the resident and carer engagement sessions. Illustration done by an artist.

South East London Integrated Care System

NHS South East London

2. Introduction

HEALTH INTEGRATION PARTNERS

The work to deliver the SEL Ageing Well framework will require continued stakeholder engagement and understanding, enabling Places to utilise it as part of local design, planning and delivery

This report reflects the work that took place between January and March 2025, involving a wide range of stakeholders across SEL in developing the SEL Ageing Well framework. Continued work is required to refine the framework and support Places to adopt it as part of local design, planning and delivery. A great deal of work is already underway at Place to support residents with ageing well. This framework builds upon that work. It is not a mandated framework, but rather a capture of the most important elements and principles expressed by SEL colleagues alongside recognised best practices. It will hopefully enable achievement of local aims at an accelerated pace, sharing of 'what good looks like' between Places and greater parity of provision as part of a unified approach – recognising the need for local variation.

The framework will:

- Help **ensure parity** in the offer we provide to people
- Enable us to **maximise** our collective resources
- Enable us to **share best practice** and the good work already underway at a local level
- Provide a more s**treamlined experience** for people and staff.

Benefits of a shared SEL frailty framework:

- **Consistent approach**: e.g., assessment and care planning tools acknowledged by all partners
- **Collaboration and workforce:** real integration in place-based systems, with an upskilled, flexible workforce
- **People and processes:** Improved consistency of care, and increased focus on prevention and early identification of frailty
- **Measuring impact:** measuring consistent outcomes across the board and knowing what good looks like.

The development of the Ageing Well framework has been led and overseen by colleagues from across SEL

Colleagues from across the SEL system have participated in the development of the framework, including from the ICB, Local Authorities, Public Health, Primary Care, community-based care, VCFSE, acute care and mental health. Colleagues have taken part in **121's, extensive discussions, ongoing working sessions/forums and 3 key workshops each with around 50-70+ attendees** to help shape the recommendations. Four resident workshops were also held and several residents also joined in other forums and workshops:

121 sessions	**Place based meetings**	**3 Workshops**	**Meetings to align with INT/LTC developments**	**Resident and carer voice sessions**
Reference group meetings	**VCSE meetings**	**Housing and Social care meeting**	**4 deep dive meetings for core elements***	**Regular core Group meetings**

* care homes, domiciliary care, palliative and end of life care and mental health, dementia and delirium.

Engagement with multiple stakeholder groups from across the system to build the picture

A list of the names of key stakeholders who participated in this work can be found in the appendices.

The 3 face to face workshops were very well attended and represented all Places

The overall objective of the framework is to pull together our collective ambition for ageing well, building on the work already underway

A great deal of positive work on ageing well and frailty is under way at Place. The development of the framework is an opportunity to pull this together and build on it to define shared principles, key elements and best practices - towards providing consistent care that is equitable, safe and efficient. Objectives include:

- **Forming a co-developed vision with Place to generate local ownership**
- **Understanding current services, success stories and linking into other work at Place e.g. INTs, LTC, enhanced care in care homes**
- **Maximising the value of our collective learning and resources**
- **Encompassing wider factors and determinants e.g. housing, social isolation and building ageing attuned communities**
- **Inclusion of patient stories and involving residents in helping to shaping the framework**
- **Defining ageing well and frailty and addressing the needs of people across the frailty continuum**
- **Inclusion of the role of unpaid carers and family, acknowledging their important role**
- **Bringing together all partners across the system to improve service quality, optimise skills and manage pathways**

The work has taken place over three months, following a structured methodology

December	January	February	March	April
Mobilisation	**Establishing the baseline position and ambition**	**Developing the SEL Ageing Well framework**	**Testing and refinement of the framework**	**Finalising the framework**
• Confirm objectives, scope and outputs • Stakeholder mapping • Request for data and documents • Establishment of core design group • Initial comms, diarising and set up • Workshop dates to be confirmed • Project governance	Defining the 'as is' position and ambition at Place level via questionnaire template Data story board & patient stories Connecting with key stakeholders e.g., executives to create buy-in **Workshop 1** • Definitions of ageing well and frailty • Agree cohesive vision and ambition • Place level 'as is' positions	Place based focus group meetings –10 things Place's want from the framework Connect with resident groups to capture voice National & international best practice learnings **Workshop 2** • Defining the framework and key components • Presentation of the residents' voice	Sub-group meetings to define opportunities to generate ageing well services & communities 1:1's with wider system to fill in the gaps, refine & ratify outputs Governance forums e.g., Ageing Well groups/ UEC to broaden buy-in **Workshop 3** • Finalising the framework • Outcome measures • Developing a mantra • Defining next steps for implementation	• Development Roadmap including overall phasing and timeframes and at Place • Final 1:1 meetings as required • presentation at board meeting(s) • Final sign-off • Final
OUTPUTS 1. **Stakeholder map** 2. **Comms and diarised meetings** 3. **Agreed governance**	1. **Key opportunities around ageing well and frailty** 2. **Cohesive vision and ambition** 3. **Current work at Place** 4. **Definitions**	1. **Framework with unified language** 2. **Clear way forward for social construct elements** 3. **Residents' voice reflected in the framework**	1. **Final report including vision, SEL framework, outcomes, etc.** 2. **Roadmap leading into delivery**	1. **Finalised roadmap** 2. **Finalised report document complete and endorsed**

Definitions of ageing well and frailty were shaped early on to achieve consensus on the core drivers for the work and population in scope

- Around 70 colleagues and 100 residents were asked what 'ageing well' means to them and their views are reflected throughout
- It was agreed that mild, moderate and severe frailty are in scope and the priority focus in on people aged 65+
- However, it's recognised that frailty can occur much earlier (particularly in those prone to health inequalities e.g. lower socio-economic groups, significant mental health disorders) and therefore elements of the framework (such as early identification, prevention and positive ageing) increasingly apply to younger cohorts.

The appendices include a capture of what ageing well means to SEL colleagues and overall definitions for ageing well and frailty - drawn from these views and from recognised national bodies. Excerpts are as follows:

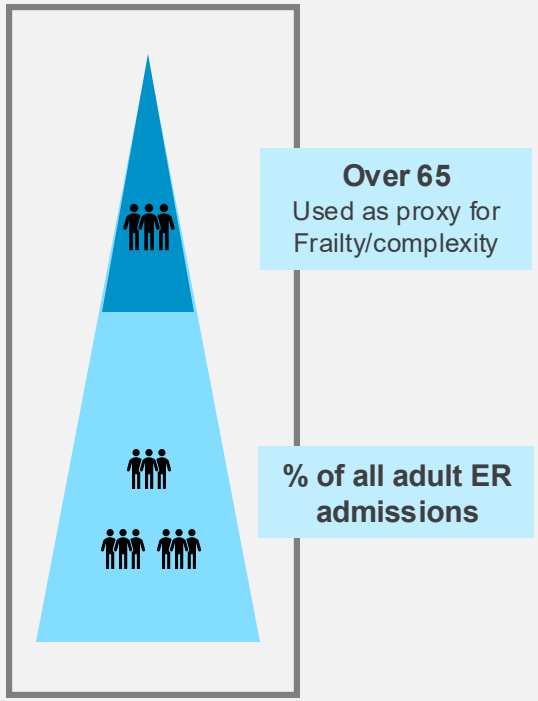
Ageing well *- The ability to maintain low risk of disease-related disability, high mental and physical function, and active engagement with life - including a positive attitude, sense of engagement, purpose and a desire to stay active and healthy in later life, including seeking help when needed and practicing self-care.*

Frailty *- a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves... a state of increased vulnerability resulting from aging-associated decline in reserve and function.*

Ageing well and frailty definitions

3.
Why we want to promote ageing well

Let us understand the scale posed by frailty across SEL: More than 61% of non elective beds are utilised by over 65 (over 65 used as a proxy in absence of frailty data)



Over 65
Used as proxy for Frailty/complexity

% of all adult ER admissions

	Number of admissions per day (2023/24) (Non elective only)	Number of beds utilised [1] (2023/24)	Total cost of admissions [2] (2023/24)
Over 65	154	1594	Over £250m
% of all adult ER admissions	39%	61%	54%

Length of stay of patients over 65 is longer largely due to higher complexity, social circumstances or process bottlenecks. Hence, the total bed days is disproportionately higher than total admissions

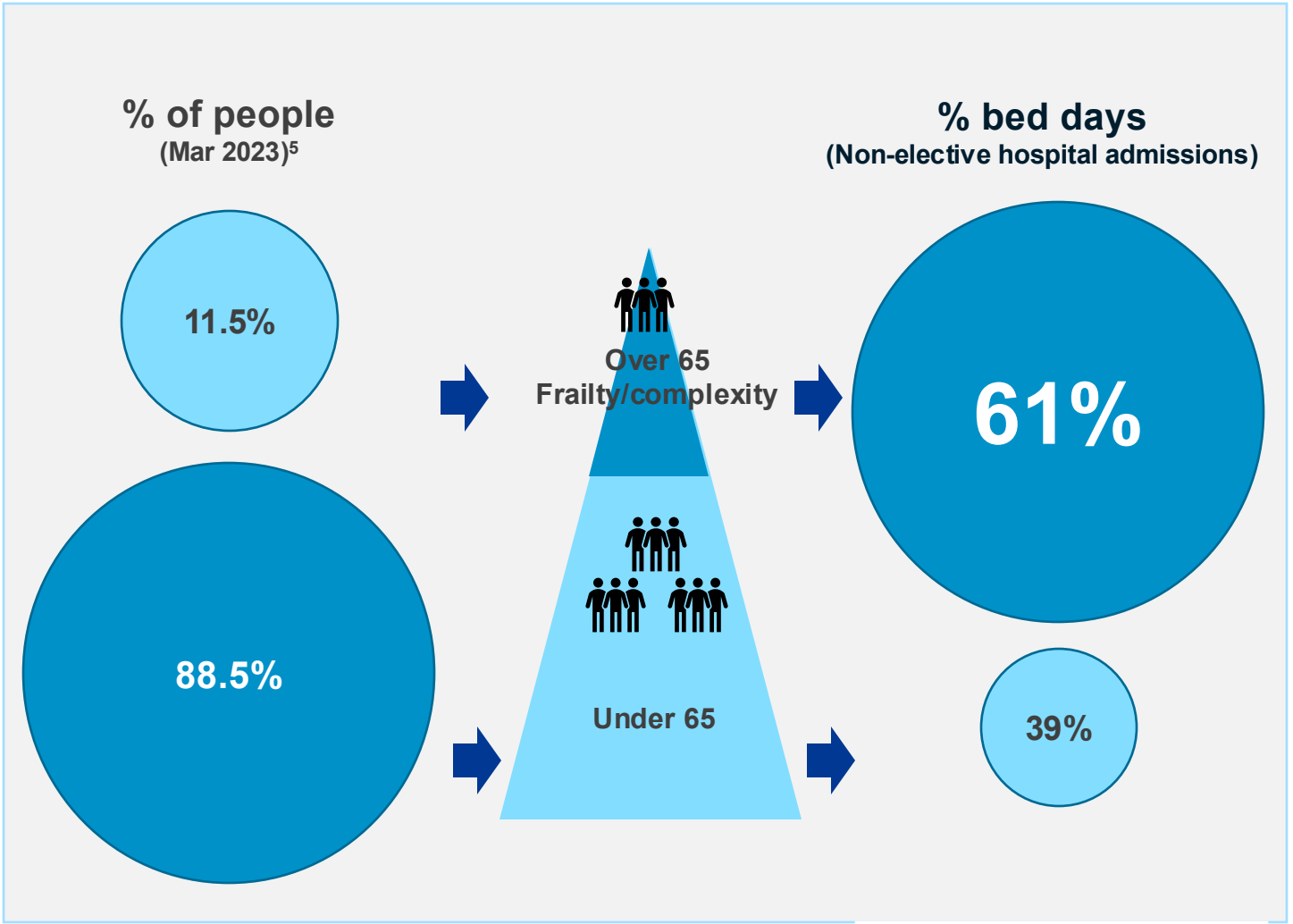
*Please note, data to be validated further
Data source: SUS aggregate download FY 2023/24
[1] Beds utilized calculation (bed-days / 365 and then adjusted for 95% occupancy – BOR)
[2] PBR cost used a proxy for total cost

With increased population growth and composition, the pressure and need for hospital beds will rise

Population growth

By 2028, the population aged 65 and over in SEL is projected to grow by 18%[3]

- **Bexley:** Population 244,247. Up to half of Bexley's population of over 65's are affected by frailty, rising to 65% in those over 90 years of age. There are estimated 23,500 people aged above 50 with frailty[4].
- **Bromley:** Population: second eldest population in London (17.7%), expected to grow to 67,000 over 65's by 2030[4].
- **Greenwich:** 289,100 residents within Greenwich. Number of residents aged over 65 has risen by 15.6% since 2011[4].
- **Lambeth:** 322,000 residents, 50% growth expected in the over 50s in the next 10 years[4].
- **Lewisham:** 200,600 population, 9.5% are aged 65 or over. Younger population, however, it is thought population growth won't be evenly spread across the ages, and there will be an increase in the older population[4].
- **Southwark:** 307,000 residents, comparatively younger population, population will continue to grow with over 17,000 additional people living in the borough by 2030[4].



*Please note, data to be validated further
[3] SEL ICS People strategy 2023/24- 2027/28
[4] South East London 2024/25 Joint Forward Plan
[5] Population and Person Insight data (PaPI)

There are a number of admissions that can be avoided through better proactive care in the community

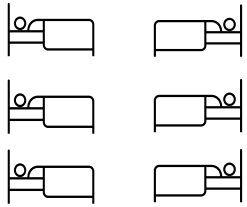
Number of admissions per day (Emergency only)

154

Ambulatory Care Sensitive Conditions (ACSC)

12%

1 ward in each Place



Falls	Sepsis	Pneumonia	UTI	COPD exacerbation
Congestive Heart Failure	Acute Renal failure	Cellulitis	Pneumonitis due to food and vomit	Fracture of neck of femur

Avoidable admissions

ACSC are conditions for which effective management and treatment within the community, should limit emergency admission to hospital.

A few examples include heart failure, COPD, influenza, pneumonia.

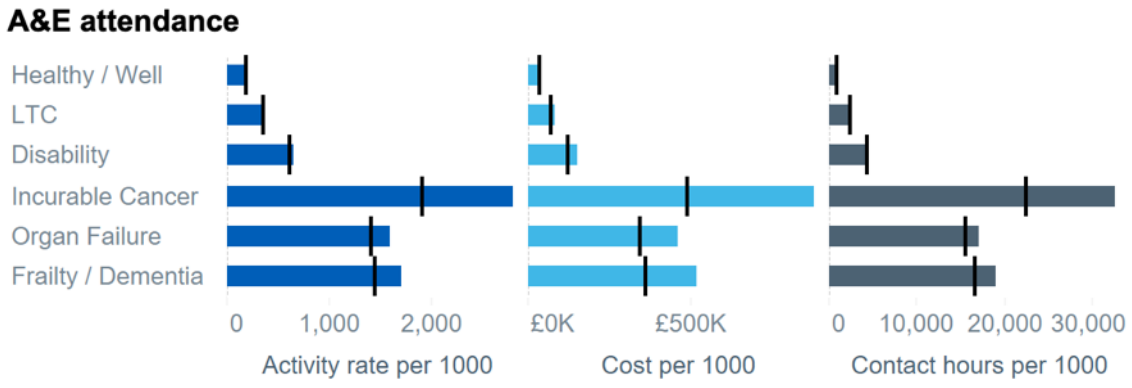
"In 2022/23, within 10 months, there were 1598 avoidable admissions to hospital relating to Ambulatory Care Sensitive Conditions, compared to 2205 in 2021/22. This suggested a 5% reduction target was on course to be met and exceeded.[5]"

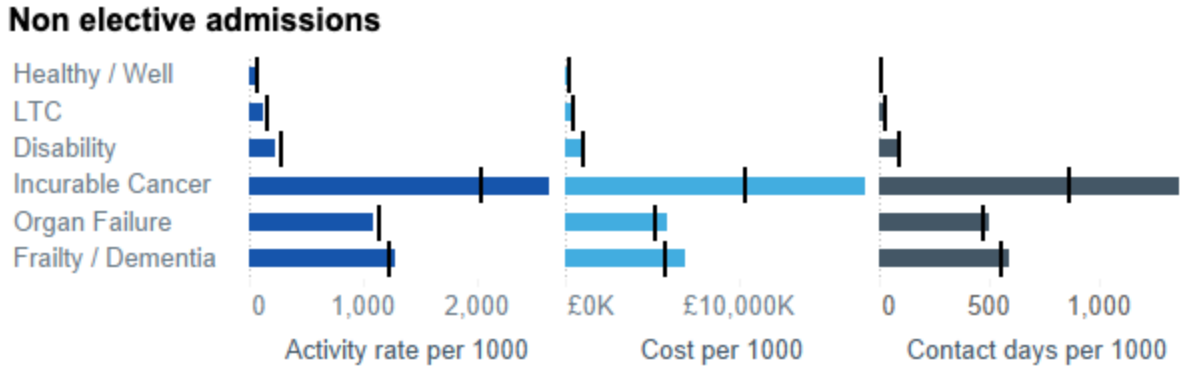
Utilisation of services for those that are frail/ dementia is substantial

For those aged 65 years and above, non-elective admission activity rates per 1000 are higher for SEL when benchmarked against national data[5]:

- SEL 245 per 1000
- England 238 per 1000

Non-elective admissions[5]: Cost per 1000 people in SEL is £1,223,000 which is £250,997 higher than the national benchmark





- For those with frailty/ dementia, in relation to A&E attendance, the activity rate, cost and contact hours are all above national benchmarks.
- The progression from LTC to frailty results in a substantial increase in activity and cost, hence prevention is critical.

We want to draw attention to hospital acquired disability (HAD)

50% of frailty patients stay in hospital for over 21 days[6]

The cumulative impact of extended or complicated hospitalisation among older patients typically results in patients experiencing a decrease in muscle mass and significant functional decline due to a complex process of physiological changes that can affect multiple systems

(Brown, Friedkin, & Inouye, 2004; Brown, Redden, Flood, & Allman, 2009; Chastin et al., 2019).

In a study of hospitalised community-dwelling older people at 6 months after discharge, 43% needed continuing help with medications, 24% were still unable to walk a quarter of a mile, and 45% were still unable to drive. The overall prevalence of HAD across studies has been estimated to be around 30%

National Institutes of Health (NIH)

Studies have observed that at least 30% of older patients hospitalised with an acute medical illness show a persistent decline in their ability to maintain Activities of Daily Living (ADLs)

(BMC Geriatrics)

So significant can the muscle loss be in bedridden seniors that while complete bed rest causes young adults to lose about 1% of muscle mass per day, the elderly may lose up to 5% per day

(Sarcopenia: Loss of Muscle Mass in Older Adults. Mary Ann E. Zagaria, 2010)

It has been estimated that 68 % of patients are discharged from post-acute medical settings below their pre-admission level of function.

(Gill, Gahbauer, Han, & Allore, 2009)

This means that post-hospitalisation, patients are not only recovering from their acute illness but also facing physiological stress and susceptibility to complications not directly related to the cause of their admission.

(English & Paddon-Jones, 2010; Hartley et al., 2019; Kortebein, 2009; Kosse, Dutmer, Dasenmbrock, Bauer, & Lamoth, 2013)

National Audit Office (NAO)

Today's analysis by the National Audit Office reveals that after spending ten days in hospital unnecessarily, a patient's health has deteriorated to such extent their life expectancy has been shortened by ten years - 18th March 2024

'It is often said that for every 10 days of bed rest in hospital, the equivalent of 10 years of muscle ageing occurs, in people over 80 years old- this may or may not be true to the word but certainly puts things in perspective'.
Dr Amit Arora, consultant geriatrician

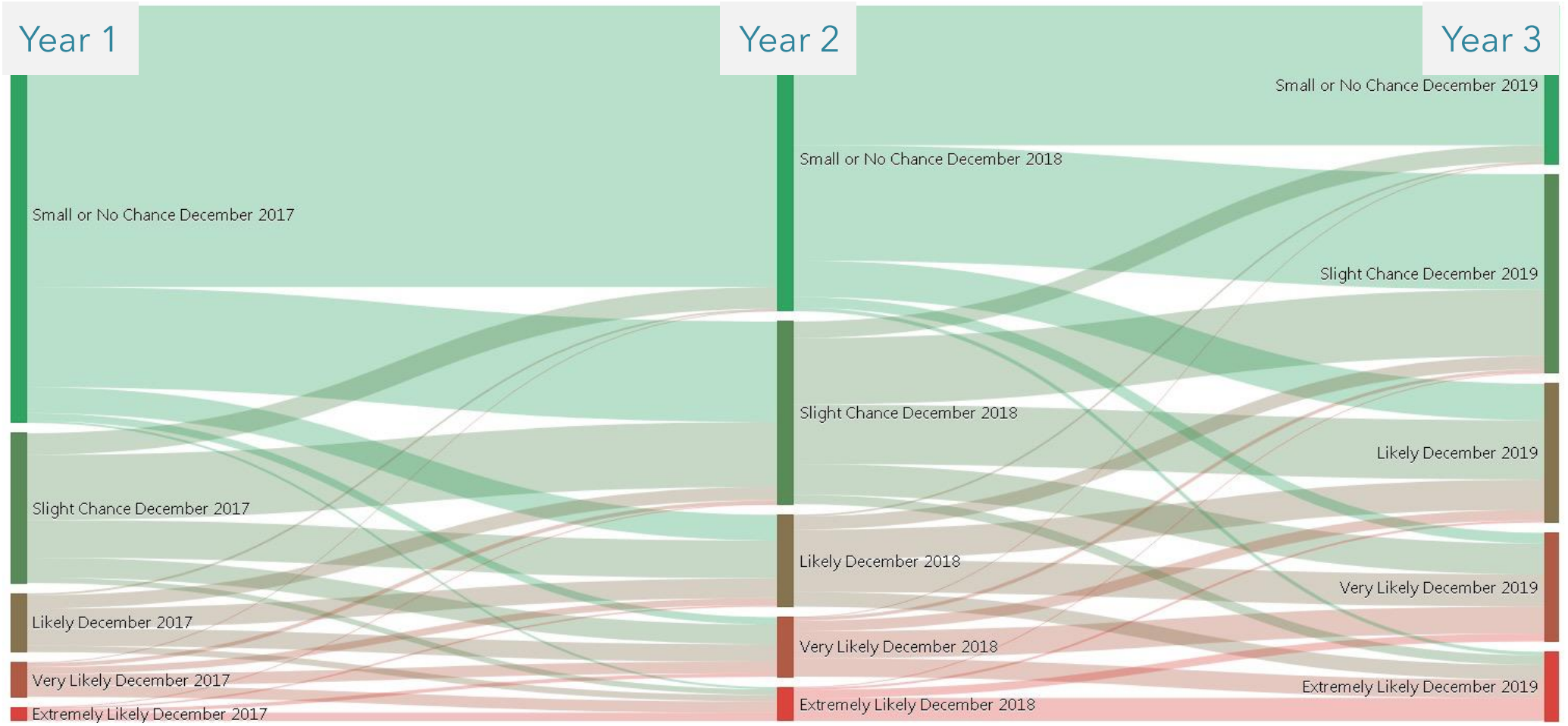
**Please note, data to be validated further. Data source: Frailty and multiple LTC SEL ICB presentation*

How risk/complexity changed over 3 years and why it is critical that we capture people at/before the point of rising risk (example taken from another ICS with pseudonymised data)

The chart shows how risks rose in people across a period of 3 years. Data is only for over 65 across one Place (2 boroughs).

It shows how those who had low risk (green) in Year 1, moved into higher risk segments (red) just within a period of 1 or 2 years.

Risk was measured using ACG algorithm from John Hopkins customised further to improve identification. Includes aspects such as frailty, LTC, H/O, Rx.



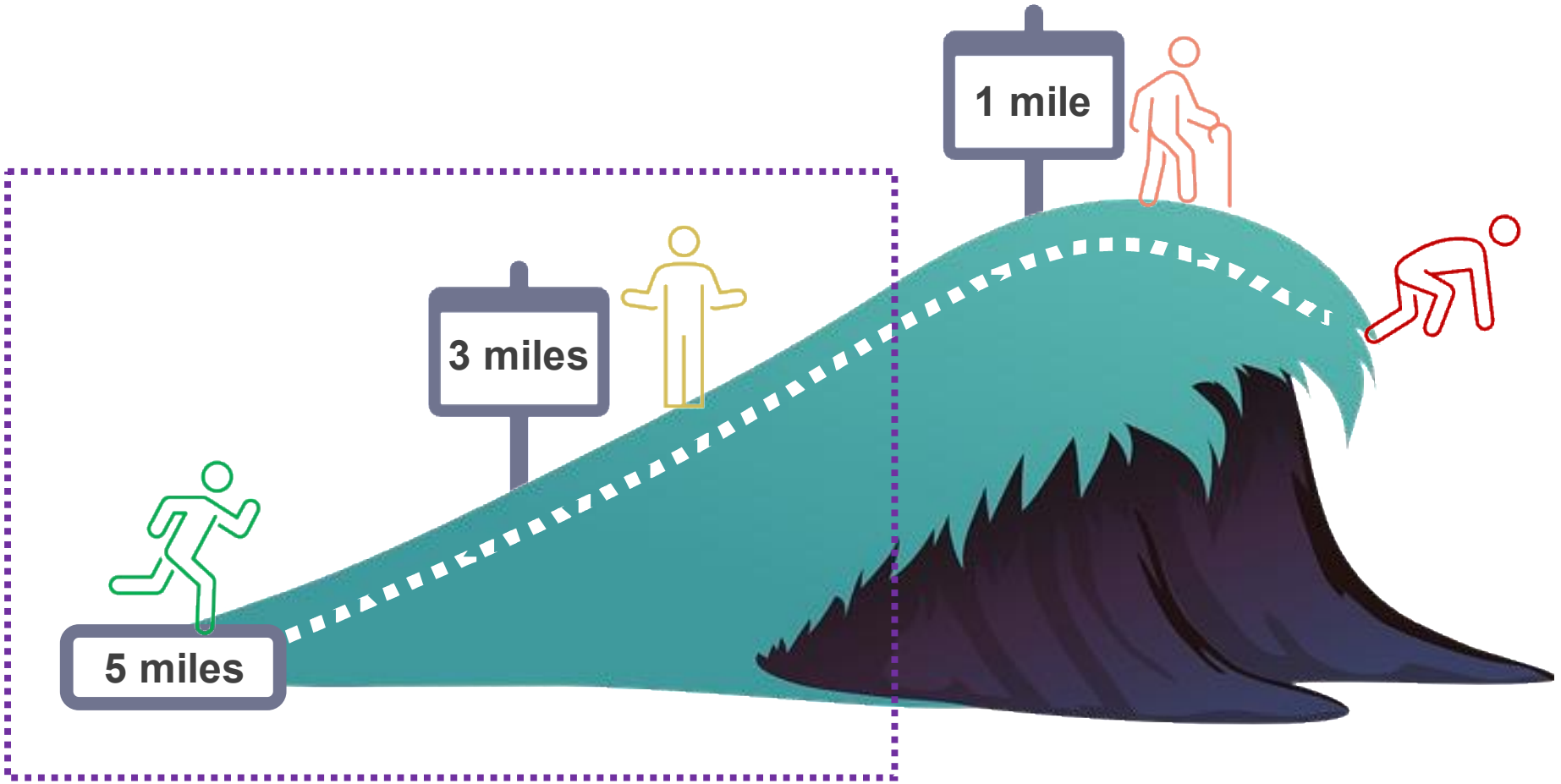
Year 1 profile of exactly the same population – two years ago

Year 2 profile of exactly the same population – one year ago

Year 3 profile of all over 65 who were admitted in hospital/attended A&E

There is a need to shift the focus towards early proactive prevention whilst equally supporting those at the other end of the scale

- Catching people at the '5-mile mark': there is a clear need to continue to shift focus towards early identification, proactive prevention and working with people holistically (health and social care).
- Equally, focusing on initiatives to support people when they are at the other end of the scale, looking at how we can proactively and reactively manage those living with frailty/ complexity.



The Ageing Well framework aligns with and helps meet the drivers and objectives of key national directives

Example national directives:		Examples of how the Ageing Well framework aligns
	British Geriatrics Society Blueprint for preventing managing frailty in older people (2023)	The framework delivers against the key BGS recommendations for the 'seven touchpoints' – from enabling independence and promoting wellbeing through to frailty-attuned hospital care
NHS	2025/26 NHS priorities and operational planning guidance	• Neighbourhood health services models to prevent admissions and improve access to care • Address inequalities and shift towards prevention
NHS England Neighbourhood Health Guidelines	Neighbourhood Health guidelines 2025/26	• Integrated working, reducing fragmentation, poor communication and siloed working. Increasing ability to self-care • Shifting focus from hospital to community and from treatment to prevention
	Fuller Stocktake Report 2022	• Providing more proactive, personalised care with support from a multi-disciplinary team • Helping people to stay well for longer and a focus on early identification and prevention • Streamlining access to care and advice
	Lord Darzi's independent investigation of the NHS in England (2024)	• Shifting spend from hospital to community • Listening and responding to the patient voice • Empowering patients • Multi-disciplinary teamwork and working.
	National Association of Primary Care: Creating Integrated Neighbourhood Teams. March 2025	• Engaging communities, citizens and patients • Start with staff and equip them to deal with the work • Simplify processes • Enlist hospital specialists

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4.
What do our SEL residents and carers say?

Quotes captured from primary research and a range of SEL reports providing residents' feedback

HEALTH INTEGRATION PARTNERS

A range of parallel activities took place involving residents to ensure their voice is reflected in the framework

1. Distilling themes from SEL and Place - based engagement work done so far

SEL has done significant work around engagement across all age groups and communities in the past few years. It was important that we capture and distill key themes that needed to be incorporated in the framework.

2. Connecting with residents to understand what ageing well means for them

- Blackfriars Settlement
- Bexleyheath in Bexley
- Orpington in Bromley
- Southwark Carers

Connected with residents across SEL to understand what 'ageing well' means to them, their experience and expectations. The engagement is still ongoing and will convert into a graphic. The key themes will be woven into the framework and will influence our priorities for delivery

3. Attendance in co-design workshops

Representatives attended both workshops (1 and 2) to support the co-design of framework

4. Continued engagement at Place

While the framework is being established, there will be continued hyper local engagement at Place to ensure the model of care is defined locally in line with the needs of the local population

Residents highlight the need to destigmatise ageing. They want to feel like they count and are respected and trusted. They place importance on purpose, connection, resilience and independence

1. **Remaining resilient despite physical vulnerabilities. Preventing deconditioning: physical, functional and cognitive**
   Missing out on physical, social and cognitive activities decreases confidence, increases fear and intrinsic capacity to protect myself. Optimising social, physical, functional and cognitive avoids deconditioning.

2. **Hopes and dreams for ageing well**
   Wanting to do things for myself, getting support adds to ageing well, having a sense of purpose, being able to use my previous skills to help others and laughter ☺

3. **Help with how to set yourself up for success to age well**
   Trusted, professional information and advice. **Having peace of mind.**
   Not having to burden friends and family.

4. **Loneliness and participation**
   Need for true human connection and bond between friends and family and opportunities to be part of other groups

LAUGHTER is essential for ageing well, and to share in the laughter with others, and seeing others enables me to focus less on pain and ailments

"Dreams? I don't really have any because I'm just trying to stay alive. I want to be there for my grandkids, but some days I'm just counting the days, and I need to make the most of every day. If I could, I would love to travel and fly, but I can't because I'm immobile."

"For me, ageing well means being able to feel INDEPENDENT. And have the ability to take care of yourself."

"Pensioners aren't necessarily the frail and retiring types of popular imagination. I don't think many people my age (early 60s) will be interested in playing Bingo in our retirement."

"On the whole as people get older, they would prefer not to be seen as a 'category' but simply as themselves ... among all sorts of other humans ... being as active, intelligent, engaged, healthy, friendly and involved as possible. Many frailties and disadvantages and problems are shared across age groups"

Includes excerpts from SEL resident engagement papers e.g., Age Friendly engagement insights – SEL Ageing Well Strategy 2025

Resident voice … continued

5

Reduce fears and increase safety
Need for more police, level pavements fewer blocked pavements due to roadworks, fear of electric bikes as a hazard, easier access to public toilets, more disability toilets.

6

Joined up care, coordination and accurate navigation, seamless continuity and effective coordination
Accurate, consistent signposting and need for more connection / **communication between services** and settings. Ensuring seamless continuity of care and through co-ordination.

7

Primary Care
Need to see the same GP for continuity
Telephone and video calls not being as good as face to face.
Difficulties in getting an appointment, especially online triage.
Having to give their same medical history repeatedly, and not all doctors read it before their appointments

8

Housing
Ability to adapt or change housing to meet changing needs as you age

"There should be a database enabling older people to swap homes to get what they want"

"I was falling but told I couldn't join strength and balance classes because I needed to see a cardiologist. 6 months later I'm still waiting"

"I would like to get advice but it's too hard to navigate"

"Virtual GP appointments only work if I have a Carer with me, otherwise I don't feel seen or heard, I prefer face to face"

"I wanted to join the gym but couldn't get past the questions, form filling and documents required at reception"

"I would like to get advice but it's too hard to navigate"

"We're going to hand over our lives, probably to a white person or a South Asian person but there's no trust between us and those communities"

"When I phoned up on the day, the appointments have already gone. I can't tell you the last time I've actually seen my doctor face to face because I can't get an Appointment."

Resident voice … continued

9

Caring role

Access to more flexible, ad hoc support (including respite) instead of an 'all or nothing' arrangement.

Unpaid carers able to get a GP appointment quicker and at a time they need it. Pre-emptive planning for carer crisis – leading to peace of mind and the right action.

Advocacy and earlier respite for carers.

10

Respect and feeling heard

Considering the person's whole life not just seeing a health problem.

Feeling that you must lie and exaggerate to be seen.

Feeling judged and dismissed as a patient or carer.

"Someone to talk to mum about how to live better in her own home – keeping warm, paying bills, buying a hearing aid, checking for risk of financial abuse."

"Contacted NHS for an eye appointment, chased up for weeks without action....admin was not listening, when final action was taken, I was told that I should have come sooner, leaving me feeling that I can't win, when I tried everything in my power to be seen."

"I get exemplary support from my local GP and the Guys and St Thomas' NHS Trust…"

"I felt like I was dismissed and spoken down to as well. They were still offering me what I said I don't need so I thought it was more or less a box ticking exercise."

"There's also the systemic issue of structural racism. I'm very, very aware of it. I know that doctors are under pressure. I believe that the wider system does, either actively, sometimes disadvantage us or through negligence as Black people."

"Work needs to be done to close the wealth gap, as poorer residents have less positive experiences with ageing."

"You can tell the difference between a doctor who tells you what to do and the one that converses with you right? Someone who takes the time to explain things to you, who listens to you, you know, and takes into consideration your views."

"But being aware of the community that you serve. What does that community that you're serving look like? So then be more educated about them… about foods, about culture, about all those things, because you can then better support. Because when somebody is coming to you, you can show that understanding."

Feedback from unpaid carers highlights practical changes that would make a real difference to their quality of life

"Carers' organisations and carers carry no weight, they should be respected, they should mean something"

"No communication between organisations whatsoever – each has its own agenda and won't intervene with the other"

"I can't get my Mum to activities in the community if there is no reliable transport"

"What if the person I care for won't accept help from anyone else? I need an advocate to help free me up from the trap"

"I would have peace of mind as a carer if a plan was in place for what should happen if I am taken ill or go into hospital."

"When carers are coping they should still be allowed some respite; a chance to recharge the batteries. It will mean they can go on caring for longer – it's an investment"

"Staff need time to have proper conversations with carers who often know the answers more than anyone"

"Mum is not considered bad enough to get help, so I do everything! But something more flexible is needed; even if the voluntary sector helped me out half a day a week. But the current approach is more 'all or nothing"

"As a carer it should be easier for me to get a GP appointment. I should be a priority to enable me to keep on caring"

"My mother needs help with paying bills, making appointments, getting groceries online, sorting glasses and hearing aids, online banking, using parking apps, dealing with chatbots and having her questions answered."

An artist attended the sessions that we held with residents to understand what ageing well means to them – and their voices have been captured in a graphic

Four workshop sessions were held with residents and unpaid carers to understand what ageing well means to them and to capture their experience and expectations of services. The workshop sessions were as follows:

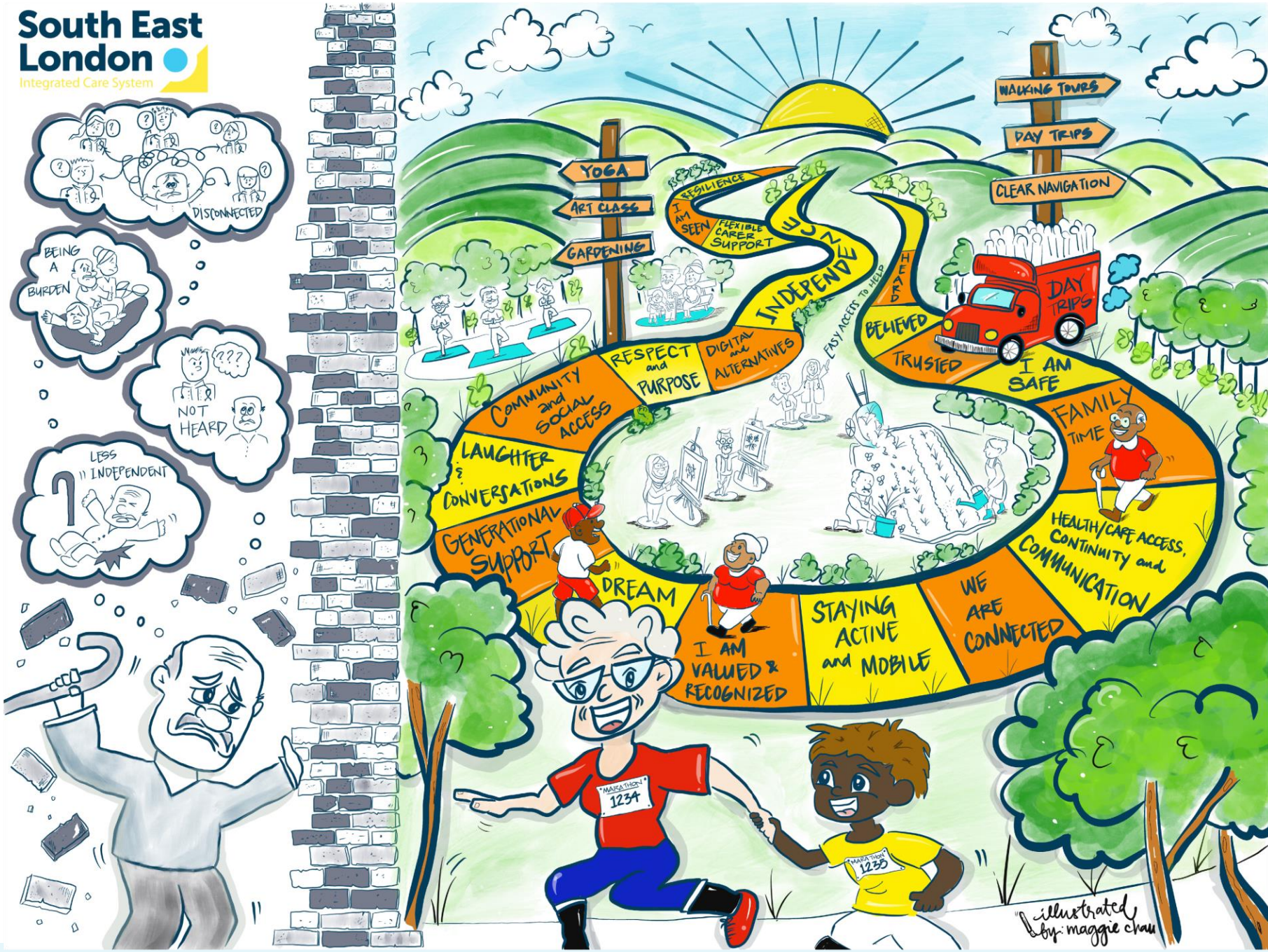
Borough	Resident/Carer organisation	Date of engagement
Southwark	Southwark Carers Cafe	21 February 2025
Southwark/Lambeth	Blackfriars Settlement	11 March 2025
Bromley	Orpington Methodist Church Art Class Group	13 March 2025
Bexley	Bexleyheath Geddes Place Church	10 March 2025

The key themes from the sessions have been woven into the framework to help inform the priorities for delivery. In addition, an artist has produced a graphic depicting the voice of residents and unpaid carers, which can be found on the following slide.

Resident voice

The left-hand side of the graphic captures some of the main challenges residents face when dealing with services.

The right-hand side of the diagram portrays the aspirations, hopes and dreams that residents have including what they like to do and how they would like to feel.



5.
‘Age without limits: You say, your way’
The SEL Ageing Well framework

150+ clinicians and professionals have been engaged and involved in developing the framework, at SEL and local levels - identifying key values and principles that underpin the framework, below

1. Early identification
Understanding who our older and frail population are and identifying them sooner

2. Seamless navigation
Visibility and clarity about what sits where across settings, enabling easier signposting, self-navigation (by problem) and movement between zones and real connection and dialogue between professionals

3. Hyperlocal VCFSE involvement
Stronger connection, Increased visibility, bigger role in healthcare, trust and financial security for VCFSE, especially grass roots offers

4. Improved Accessibility
Removing barriers to accessing amenities and services such as need for form filling, providing documents and overcoming travel, digital and language barriers. Providing alternatives to digital

5. Social Well-being
Fostering environments where people build and sustain lasting friendships and social connections to prevent the loneliness spiral

6. Personalised Care
What it means to the individual e.g., listening, understanding, believing, trusting and respecting. Seeing an active, whole life, not a health problem. Making nuanced decisions based on *'what matters to me'* and accepted shared risk with residents and families.

7. Active & Engaged Living
Focus on exercise, cognitive stimulation, nutrition, hydration, & self-care - enabling purposeful living that creates resilience, connection and independence

8. Positive Ageing
De-stigmatising ageing and promoting positive representations of older people as having a purposeful life to live and a strong contribution to make. Making amenities and services more age and culturally friendly.

9. 'Heating and eating'
Ensuring the basics are supported to set yourself up to age well such as heating, eating, paying bills, getting appointments, using on-line services

10. Equity
Independence and wellbeing of people is of equal importance regardless of setting. Care homes and home care are not separate ecosystems and require an integrated offer that enables equitable access.

11. Wider factors
Addressing the wider things that foster ageing well – e.g., feeling safe on the streets, level pavements, access to shops and public toilets, bus drivers being mindful of older people stepping onto buses

12. Activating self-help
Facilitating communities to help themselves e.g., via peer and expert support groups, volunteering, linking people up with people, allowing people to swap their homes

The Ageing Well framework comprises three inter-connected zones. People move easily in and between zones based on where they are on their journey

The emphasis of the framework is on early proactive prevention but also includes 'what good looks like' for those further along the frailty continuum.

1

Promoting independence and wellbeing- thriving at home

Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

2

Proactive community care via integrated neighbourhood teams

Early identification of frailty and rising risk, working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

3

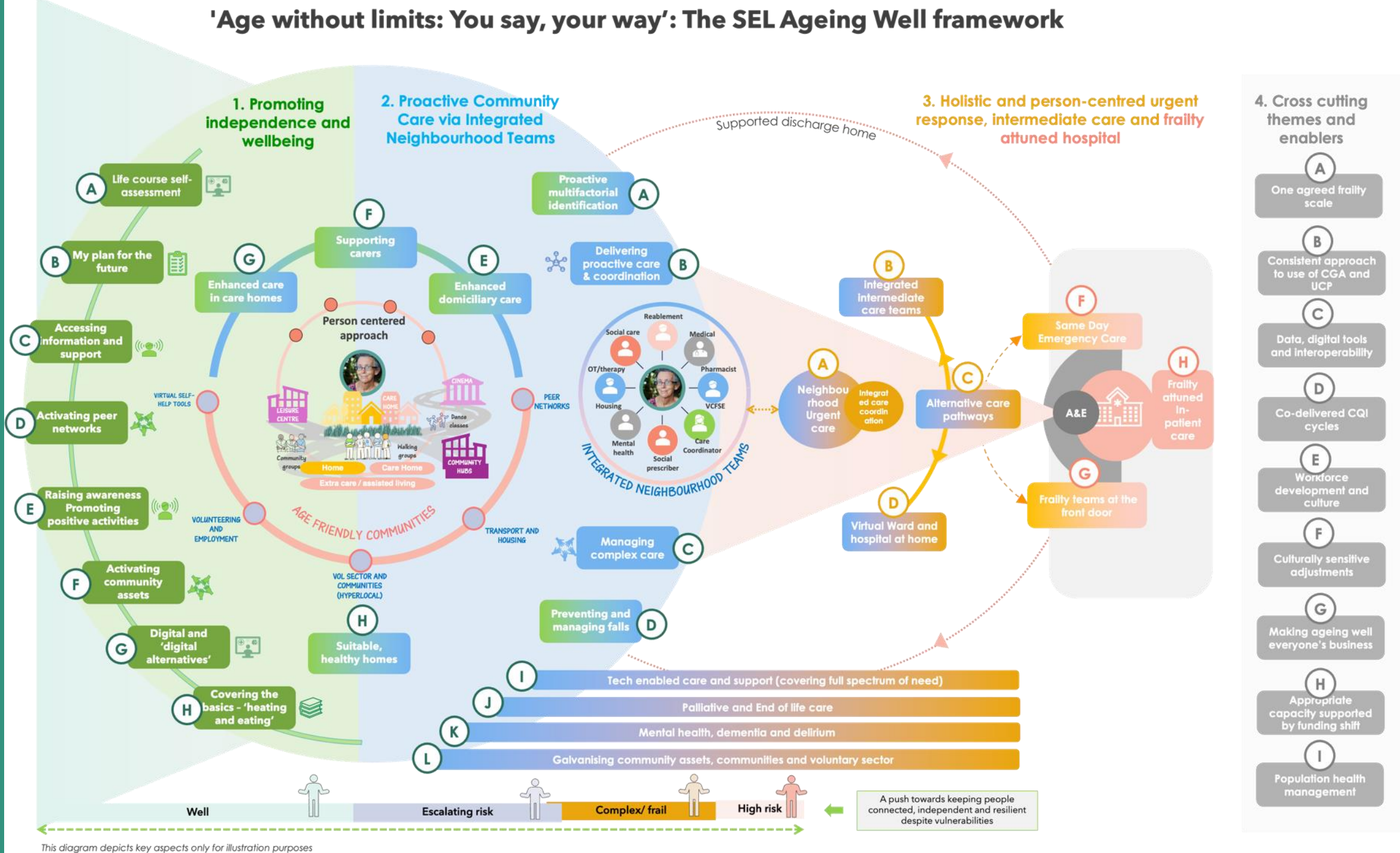
Holistic and person-centred urgent response, intermediate care and frailty attuned hospital

Working closely with zones 2 and 4 to provide holistic and person-centred urgent / timely step-up and step-down community care that helps to avoid unnecessary hospital attendance, admission or readmission and enables timely discharge.

Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and hospital discharge for those who are admitted.

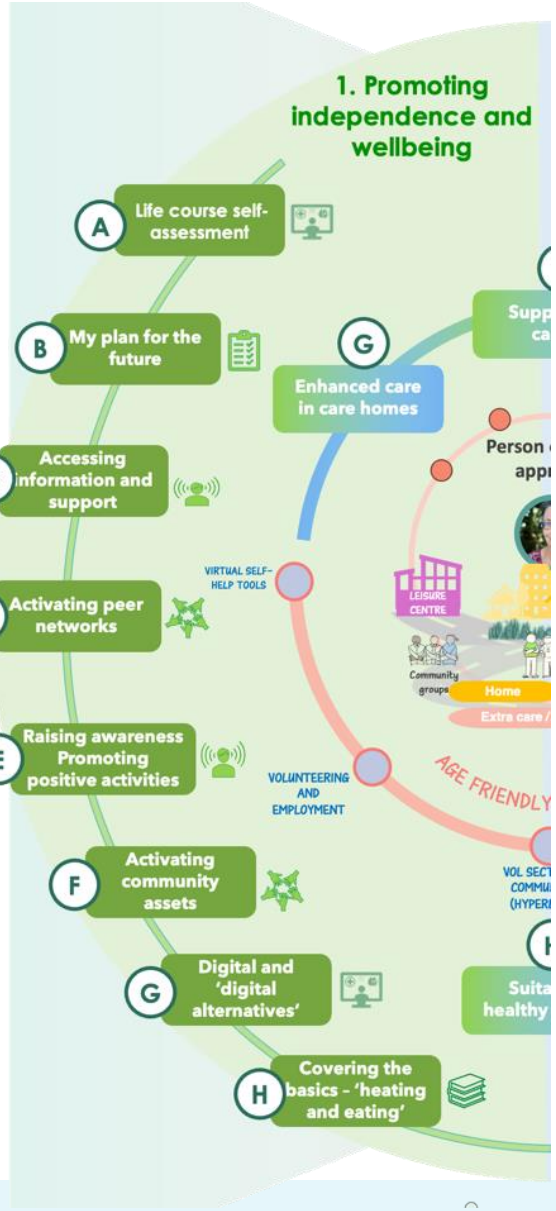
The SEL Ageing Well Framework

'Age without limits: You say, your way': The SEL Ageing Well framework



This diagram depicts key aspects only for illustration purposes

Zone 1: Promoting independence and wellbeing - thriving at home



Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

This zone comprises of the following elements:

- Life course self-assessment, empowering people to self-identify goals and take holistic actions based on 'ageing well milestones' This feeds into 'My Plan for the Future' OR "Planning ahead for what matters to me?"
- 'My Plan for the Future', a self-led holistic tool and plan reflecting personal goals and informed by the ageing well milestones including actions I will take to maintain my health and wellbeing, e.g. adopting a healthy lifestyle and preparing for the future. Includes support and resources I will access, e.g. a community exercise programme or other support through voluntary, community, faith and social enterprise (VCFSE) such as managing money. Plan includes end of life. Can be generated digitally and produced with support from a community champion.
- An easily accessible one stop shop ('access hub') that provides and signposts people to information and knowledge about ageing well and helps them to access local services, support and VCFSE sector offers. Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers.
- Building and delivering local community peer support groups and networks that for example, provide opportunities for older people to contribute, share and learn new skills leading to improved social connections and reduced isolation, and that contribute to building age friendly environments. Inter-generational working e.g. bringing students into care homes/older people into schools and utilising industry e.g. professionals being role models or peer mentors to others.

Zone 1: Promoting independence and wellbeing - thriving at home

Zone 1: Working in partnership to create local age-friendly, compassionate and responsive communities that encourage and support people to age well, through supporting their health and wellbeing, independence and social participation. Improving the building blocks of ageing well such as safety, access and housing.

- Raising awareness of the factors that prevent, slow, and reverse frailty and enable ageing well such as exercise, hydration and nutrition (insights from blue zones). Raising awareness of, normalising and breaking down taboos associated with ageing and dying. Promoting a positive approach and positive representations of older people. Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones as well as other non-digital media
- Incentivising and activating community assets to provide easy, affordable or free (off-peak) access to local activities, events and facilities (including gyms, cinema, yoga classes, leisure centres, education courses). Asset based community development in which communities do it for themselves. Systems taking an active role in local leadership to influence community developments according to local need.
- Improving the accessibility, knowledge and use of digital tools by residents. Supporting access equity where digital access is not achievable for individuals.
- Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness such as a secure home, heating, cleaning, having access to food and that food is being eaten
- Addressing other wider factors that support independence such as ensuring decent housing, well-lit streets, level pavements and easy to read signage.

Zone 1: Promoting independence and wellbeing - thriving at home

A. Life course self-assessment	• The aim is to focus on prevention by doing the right thing at the right time. This can be enabled through supporting people to self-identify suitable goals and actions based on 'ageing well milestones'. The milestones create a shift in perception, empower people and strengthen understanding of actions that should be taken to 'age well'. This may include information such as "at age 75 focus on this type of exercise, diet and lifestyle to keep your bones healthy and reduce risk of falls". • Milestones will also flag national screening programmes such as the bowel cancer screening kit offered every 2 years for 50–74-year-olds and highlight local resources, e.g. how to access community exercise programmes. It can include continence care information for those over 50. • Milestones can also help educate younger people (e.g., men in their 40s and 50s to take earlier action to prevent issues as they age. • The milestones provide a guide to the production of 'my plan for the future'. This should not be a one-off assessment and can form part of the person's universal care plan (UCP).
B. My plan for the future	• A personalised plan, which is self-generated or co-produced with a 'wellness coach' or similar, that captures the person's self-identified goals and actions **they** will take to maintain wellbeing and stay healthy. • The life course self-assessment (above) will help inform and feed into the plan. • The plan will also encourage people to think through what matters most to them, and plan what they want to happen in future, for example if they become unwell – and prompt earlier action, e.g. around producing a lasting power of attorney (LPA) or deciding arrangements for care they may need, including what to do should a crisis be looming or occur, and preferences or arrangements for end of life. • Approach to recognise that changes with ageing can be stressful (e.g. retirement) and therefore be done with empathy.

Zone 1: Promoting independence and wellbeing - thriving at home

C. Accessing local information and support	• An easily accessible (to residents, carers and staff) one stop shop ('access hub') that provides and proactively signposts people to information and knowledge about holistic ageing well and helps them to understand and access local services, support and VCFSE offers. • Could be virtual/digital or walk-in, providing an alternative for those unable to access digital offers. The hub can be co-located with existing community services at Place, with a focus on local health promotion. Hub may also be able to aid professionals with navigation of local resources to support residents. • Public health involvement to promote prevention, working in partnership with residents and resident-facing professionals. • Sharing of information on different partner initiatives, across partners e.g. visibility between health and social care about ambitions, innovations and developments (e.g. falls prevention). A resource that enables staff to understand what is provided in the community and how it helps to get home from hospital earlier with better support or avoid unnecessarily going into hospital. • Sharing self-help information about falls, continence care, mental health and education around diet, hydration and exercise will have a significant impact on quality of life for residents. Practical advice e.g. how to get a hearing check, manage gas and electric, pay bills, get an optician appointment. • Information is sensitive to cultural and generational challenges. • Information be provided to the 'access hub' through people e.g. champions and networks. • Include simplifying existing websites, making them more accessible.

Zone 1: Promoting independence and wellbeing - thriving at home

D. Activating peer networks and intergenerational relationships	• Building local community peer support groups, improving social connections and reducing isolation (therefore improving mental health and reducing depression and anxiety) within the local community. • Utilisation of community champions and creating community networks which are of high value, providing support and resilience. • Creating intergenerational connections to reduce societal ageism barriers e.g. older people mentoring in schools, students volunteering via local VCSFE organisations. • Interventions and activities should be personally relevant (e.g. acceptable in different cultures).
E. Raising awareness and promoting positive activities	• Raising awareness, changing perceptions and activating people to prevent frailty as well as identifying signs of frailty at the earliest opportunity, hence implementing actions to reduce progression. • Early discussions and awareness of palliative care/death literacy. Promoting episodic symptoms support e.g. palliative care. • Raising awareness of the factors that prevent, slow, and reverse frailty (insights from blue zones). • Putting out key messages such as ‘come to us early to prevent illness’ or ‘do this for yourself to take charge of your health’ – or messaging to activate neighbours to look out for older people in their neighbourhood. • Delivery of the above via hyperlocal social media/marketing, NHS App, smartphones and other non-digital alternative media. • Changing the images and photos we use to portray older people, to more positive, breaking down stereotypes.

Zone 1: Promoting independence and wellbeing - thriving at home

F. Activating community assets

- Setting up and running social and exercise classes, including strength and balance training, tai chi, yoga, pilates, walking, circuit training, dance, spin, cheerleading, choir and swimming.
- Easy, affordable/free access to local activities such as leisure centres/cinema/ gyms to improve connections.
- Musical and dance activities from their era, keeping sighted different older people will have grown up in different years and cultures.
- 'Expert patients' teaching e.g. exercise groups, how to use gym equipment or other new skills such as DIY, gardening co-ops (e.g. building gardens in care homes or GP surgeries), men in sheds to maximise peer-peer influence and mentorship.
- Expert patients may also encompass specific co-morbidity and mental health peer support and identifying champions in key areas e.g. falls, hydration, continence, loneliness, hearing loss, etc. As well as death and technology literacy.
- Activating people to contribute to their communities by recognising their contributions and maximising volunteering opportunities and skills.
- Providing recognition, accreditation and awards for both those who lead and those who participate in exercise groups. e.g. NHS 'couch to 5k'.
- Local and community gyms and swimming pools promoting classes
- Corporate social responsibility: connecting with local corporate companies who can support people to age well e.g. local theatre, professionals providing peer mentorship, tapping into philanthropic opportunities.
- Having accessible transport links (volunteering opportunities around this).
- Community assets need to be dementia-friendly and mental health trained
- Consider adopting interventions such the 'paperweight armband'- an easy tool to help identify older people who are at risk of malnutrition, developed by Age UK Salford. Since the introduction of the paperweight armband, Age UK Salford has reported a reduction in hospital admissions, a 50% increase in reporting of underweight BMI in primary care after 1 year and a more appropriate prescribing of oral nutritional supplements).

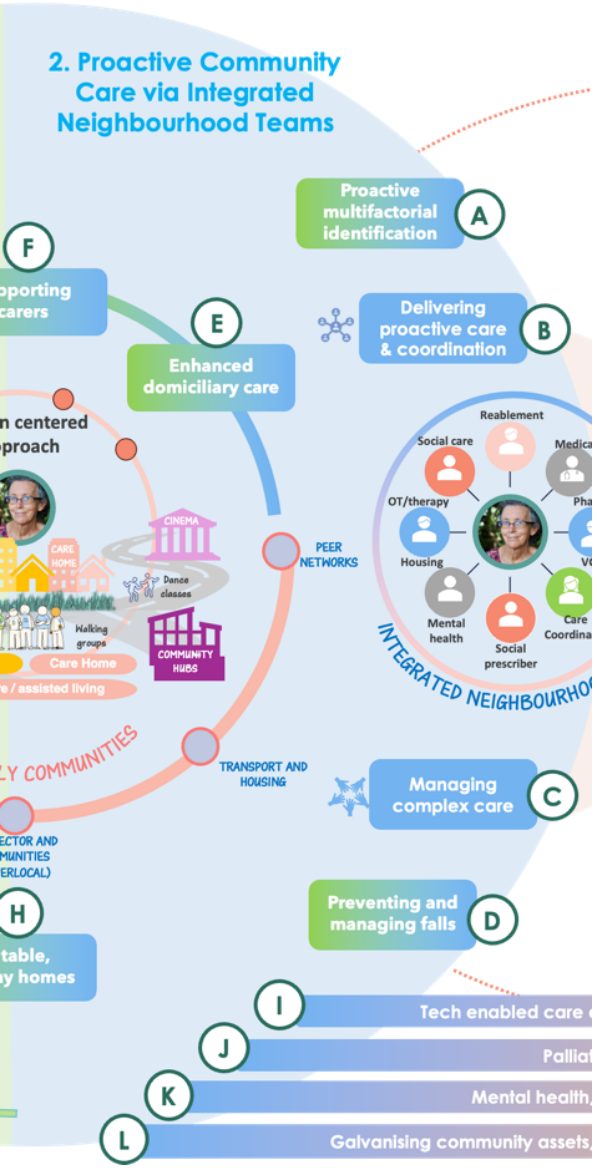
Zone 1: Promoting independence and wellbeing - thriving at home

G. Tapping into the digital world	• Improving accessibility, knowledge and use of digital tools by residents within the local community. This may be achieved through implementing digital 'drop-in' sessions within local libraries or community centres for instance, or that may be supported by local university student volunteers/peer mentors. • Supported by key FAQ leaflets. • Age friendly support available within libraries. • Providing alternatives to digital (e.g. appointment cards, paper diaries) for people with dementia/others who would benefit e.g. dementia, digital poverty, language barriers / others.
H. Covering the basics – 'heating and eating'	• Ensuring that the basic, minimum things are more easily accessible and in place to support wellbeing, prevent illness and assist recovery from illness • Examples include a secure home with working locks, minimising drafts, heating, cleaning, having access to suitable food and checking that suitable food is being eaten and managing money. • Whilst services exist that focus on these 'basics' for people with an identified need, the numbers of people living without them are significant and it is incumbent on all to be alert, identify gaps and problems and help address them, which may include being proactive and notifying VCFSE organisations that can support. • Consider an 'older person's' review in their home, "I want... I need.... I can... I can't..." • Consider what population health management (PHM) data we need and what we want to capture to address the 'basics.'

Zone 1: Promoting independence and wellbeing - thriving at home

Wider determinants	• Identifying changes that are required within the wider infrastructure to create an age friendly community (in reference to WHO age-friendly cities framework). • Addressing issues such as pavements, street lighting, access to clean and usable public toilets, access to outdoor seating, support with employment and better transport links. • Uptake of benefits, managing rising cost of living, financial advice and employment support. • Recognising and meeting people's spiritual beliefs, personal values and needs. • Ageing well cafes and death cafes. • Where people are in receipt of extra care, ensuring this is integrated with the wider social/community offer so it supports people to get out and join in rather than become isolated at home.

Zone 2: Proactive community care via integrated neighbourhood teams



Zone 2: Early identification of frailty and working with people, their carers and networks to provide well-coordinated, community-based care that maintains resilience, delays and responds to exacerbation.

Proactive community care focuses on delivering an integrated and coordinated primary and community care-based offer, which is holistic and personalised for people with frailty and/or at rising risk, enabling a good quality of life. Through understanding *who and what matters*, it prioritises what is important to the individual. Key components include:

- Proactive multifactorial identification of people living with frailty and/or at rising risk via consistent means
- A dedicated care team of multi-agency professionals formed within the neighbourhood, including specialists who provide a personalised and holistic approach, with multi-disciplinary team (MDT) interventions and support which includes facilitation of interventions beyond only health and social care.
- Robust, flexible support for unpaid carers, ensuring a carer's assessment is completed, regular reviews occur and signposting to appropriate resources takes place.
- Increased focus on hydration, nutrition, eyesight, hearing to tackle the modifiable risk factors for frailty and falls.
- Multifactorial assessment of frailty including falls and its prevention and continence promotion amongst others using a comprehensive geriatric assessment (CGA) framework for those with moderate/severe frailty.
- Managing people with frailty and escalating complexity via a named care coordinator i.e., someone to holds the case to enable pulling together and coordination of support.
- Enhanced and more integrated domiciliary care which is flexible, high quality and personalised, via well trained and supported staff.
- Defining elements that will improve the way ageing and frailty are managed in care homes, e.g. ensuring all residents have a CGA and proactive planning ahead including end of life.
- Easier access to responsive advice and guidance, with reduced bureaucracy.
- Developing and integrating the use of telecare and telehealth to enable people to stay at home where possible.
- Structured face to face medication reviews resulting in better patient understanding of medications and shared decision-making based on patient-oriented goals
- Increasing the role of VCFE organisations, including more formal, longer-term funding.

Zone 2: Proactive community care via integrated neighbourhood teams

A. Proactive multi-factorial identification	• Proactive multifactorial identification of frailty and its severity (mild, moderate, severe) with a uniform tool across health and social care, e.g. using the clinical frailty scale (CFS) to enable standardisation and one common language. • Using collective local intelligence (wider proactive community flag) to supplement the data e.g. from GP practices in which all system staff (regardless of host organisation) are trained to **help** identify frailty (with a united system language of what we mean by frailty) and connect with others to enable residents earlier access to CGA and help. Making all system interactions count to enabling holistic whole person approach, whether resident accesses help via their GP, secondary care, community pharmacists, social care, district nursing, carers, VCFSE, learning disabilities services, homeless and refugee services, housing, domiciliary care and pharmacy. All partners working together to deliver as an MDT. • No wrong door to an organisation approach. Move organisational navigation from the user to the access point. • Community information hub or 'access hub' to also report and raise concerns about vulnerable people. • Consider an in-reach team with an ageing well skill set (geriatrician, nurse, AHP), working with GPs, allocating whole day going into e.g., sheltered accommodation, Latino centre to test different 'out of the box' ways of finding and responding to people (see Lambeth approach) • Ensuring people with severe mental illness (SMI) and/or dual diagnosis, are not excluded. • Looking at the value of shared records, collected by all, to create a single, shared frailty register. • Use of data and/or artificial intelligence (AI) to identify people with frailty or at a rising risk.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination	• A dedicated care team of multi-agency professionals formed within the neighbourhood, including primary care, allied health professionals (AHPs), including speech and language therapists (SALT), physiotherapists, occupational therapists (OT), substance use, mental health, housing, community nursing and secondary care specialists. Consider establishing a specific frailty neighbourhood team as part of integrated neighbourhood teams (INT) that visits, conducts CGA/tests, plans, delivers and follows up care. • Frailty neighbourhood team to include CGA & frailty skilled workers working within their scope of practice with support, admiral nurses, social prescriber, pharmacist, council access (social care and housing) as well as geriatrician input feasible to context. • Focus on individual's holistic needs and preferences, established through 'talking to the person', carers and family on 'what matters to them', enabling nuanced decision-making, as well as and providing a personalised and holistic approach, with MDT interventions. • Consistent minimum core actions to be carried out at mild/moderate/severe stages of frailty. • Building a strong social prescribing resource/team who build relationships with individuals. • Seeing people who are teetering before they reach crisis point and galvanising holistic (not just health) interventions straight away before exacerbation occurs. • Above arrangements to include making reasonable adjustments for people with mental health needs and dementia or other characteristics that mean care or care pathways need nuance to facilitate equity.

Zone 2: Proactive community care via integrated neighbourhood teams

B. Delivering proactive care and coordination .. Cont'd	• Close liaison and optimal use of VCFSE organisations, including hyper local offers. • Definition of a strategy for medicines management and de-prescribing including proactive identification of most vulnerable patients with medication issues, structured face to face medication reviews based on shared decision-making and what matter to the person • Access to pharmacists for a second opinion (including via MDTs with social prescribers for non-drug options), • Clear links to community pharmacy to enable bi-directionally MDT working between primary care, frailty teams and community pharmacist to better identify non-concordance, better access to help, information and health education • Provision of help especially post-discharge (e.g., through the New Medicines Services and Discharge Medicines Service), information and education so that patients better understand their medications – and clear ownership of these elements so professionals know 'who does what'. • Existing examples that incorporate some of these aspects are the integrated clinical pharmacy services – GSTT Integrated Local Service Pharmacy team, Lewisham Integrated Medicines Optimisation Service (LIMOS), Bromley Integrated Medicines Optimisation Service (BIMOS).
C. Managing complex care	• Cohort may include homeless, asylum seekers and prisoners, as well as more obvious groups e.g. severe mental health disorders, care homes. • Manage people with frailty and escalating complexity via complex care coordination. • Bring specialist and acute input into the community MDT e.g. SALT, substance use, secondary care experts. • Strong role for social prescribing and use of VCSFE sector. • Explicit medicines management strategy for complex patients with MDTs including prescribers (e.g., GPs), pharmacists and specialists to make balanced decisions about polypharmacy and de-prescribing for complex patients. Guide by patient-oriented goals, so that complex decisions about stopping/starting medications are supported and made and in a timely way – and complex patients are supported with proactive help and advice to optimise concordance (e.g., via referral to community pharmacy to engage with and support complex patients).

Zone 2: Proactive community care via integrated neighbourhood teams

D. Preventing and managing falls	• Falls management model as part of proactive community care. Timely multifactorial assessment for falls addressing additional factors such as eyesight and hearing, for those that are complex and predisposed to falling. • Preventative measures such as activity, strength and balance exercises are highlighted in Zone 1 (Component F).
E. Supporting carers	• Unpaid carer's assessment completed and reviewed regularly. • Earlier, more flexible and episodic, ad hoc support (including respite) for carers (instead of an 'all or nothing' offer). • Unpaid carers able to get a GP appointment at a time they need it, recognising the importance of their role. • Signposting to appropriate services including financial advice and support groups within the community e.g. carers café. • Pre-emptive planning for carer crisis e.g. contingencies if the carer becomes unwell, leading to peace of mind and the right actions taken. • Carer identity card indicating where to find an 'emergency pack' so that urgent and emergency services know where to find everything in the event of a carer crisis. • Providing training for carers to increase their skill and resilience to managing older people with frailty.

Zone 2: Proactive community care via integrated neighbourhood teams

F. Enhanced domiciliary care

- For stable people at home, care which is flexible, high quality and focused on how to support people to achieve their full potential supported by a personalised care plan that is regularly reviewed.
- Redesign recognising the holistic opportunity to keep people at home for longer, prevent escalation and delay admission to a care home. Redesign aligned to the CQC framework.
- Moving from a 'task and time' approach to outcomes; optimising the person, increasing self-sufficiency and encouraging/supporting social engagement and participation.
- Establishing stronger partnership working between domiciliary care providers, informal carers and the health and care system so that issues are identified and acted upon earlier.
- Domiciliary care staff upskilled and supported in proactively identifying signs of deterioration early on and able to make direct referral to the resident's nominated coordinator and be involved in MDT meetings. Uniformity in training needs across the borough, to reduce the variation in care delivered by domiciliary care providers including in skills related to frailty to enable earlier escalation of concerns.
- Provision of coaches to support workers through oversight, giving advice, coaching and training e.g. in practical ways to optimise the person, identifying and managing concerns such as frailty, delirium and behavioural and psychological symptoms of dementia (BPSD).
- Training can be also attended by other formal/informal carers to create local support networks within communities to become the 'eyes and ears' of domiciliary care.
- Option for people to select their preferred wellbeing worker using summary info about their profile (experience, style of working).
- Health visitor role coordinated with domiciliary care to provide enhanced support.
- Ensuring clear expectations are set between wellbeing worker and client at outset e.g. 'I will use my mobile phone as part of my job whilst I am with you'.
- Paying workers the London living wage.

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing)

- Care homes are not a separate ecosystem and residents are to receive equivalent care and support as those in other settings, recognising they are of equal importance and that the model may need nuance to enable equity of access. For example, ensure use of the life course self-assessment in care homes (see Zone 1), and use of CGA, UCP and ACP.
- Care home settings are often poorly understood by health teams. There is a need to shift to a positive approach, listening and championing care home staff and asking them what they most need. Consider a care home champion post per Place.
- Training and support to maintain competency are key, so that care home staff feel confident (recognising they sometimes do tasks infrequently so get out of practise e.g. using a syringe driver). Healthcare should play an active role in supporting health-related training, e.g. in falls prevention, wound care etc.
- Provision of training around early recognition of deterioration with supportive tools (e.g. RESTORE2) and 4AT (screening tool used to assess delirium and cognitive impairment).
- Consider establishing a care home support team (CHS) and/or primary care, to provide a transparent, uniform offer into care homes, supporting e.g. bedside training, clinical supervision (around topics such as falls prevention/management, tissue viability, polypharmacy reduction, nutrition and hydration) to build trust and dissipate fear (see Penninsula Practice, Greenwich as an example). This support to be provided to care home health care assistants (HCAs), not just registered staff.
- Consider a specific care home mental health/dementia team as part of the above provision, to provide training and support to e.g. mental health, dementia, delirium and BPSD.
- Consider a geriatrician in-reach model reaching into care homes to support MDTs, training and to visit specific residents to prevent admission (Whipps Cross Hospital model).

Zone 2: Proactive community care via integrated neighbourhood teams

G. Enhanced care in care homes (including sheltered supported housing and extra care housing) Cont'd	• Regular feedback to relatives regarding the resident's progress and proactively addressing any relative's concerns. • Care homes direct referral pathway to same day emergency care (SDEC). London Ambulance Service (LAS) transfer to SDEC, SDEC provide treatment and LAS return to care home). • Specifically ensure an Alzheimer's support worker supports transitions into care homes to settle the person and resolve issues. • Include care homes within a telecare and telehealth strategy, e.g. providing the opportunity for wearables to be utilised where this shows evidence-base to support its utility. • Involvement of activity coordinators within care homes to keep residents engaged with social activities and group activities and to promote self-help and independence and include accessing the community where possible. • Include a spell in care homes as part of student training, e.g. to enable deeper understanding of frailty. • Align with the national framework for enhanced health in care homes (EHCH).
H. Suitable homes	• Develop processes to swap social homes with others to get a home that meets changing needs and preferences as you grow older (e.g. moving from a high rise flat to a ground floor flat with a balcony if you develop knee problems and have a dream of having a place to sit outside). • Prioritising housing adaptations and changes for people with specific needs via making a link between health, social and housing services - working together to respond to people's changing needs in a coordinated way. • Influencing the design of new build housing and estate infrastructure so that it is suitable for older people's future needs.

Zone 2: Proactive community care via integrated neighbourhood teams

I. Technology enabled care and support (TECS)	• Consider development of an integrated telecare and telehealth strategy and approach that optimises the ability to keep people living with frailty safe and independent at home (aligned to virtual ward offer). • As part of strategy scan the market to identify new products to innovate the offer, move from analogue to digital and upgrade the user experience. • Examples of TECS include community alarms and detectors, door alarms, home activity detectors (e.g. falls), TECS supporting daily activities of living such as picture clocks with visual, audible clues, and wearables (e.g. blood pressure monitors), low tech items like walking sticks also included. • Consider same day TECS delivery to expedite timely discharge of people with frailty from hospital. • Consider VCSFE ability to directly source smaller items themselves to increase speed of response and source at cheaper prices. • Monitor clinical and cost effectiveness outcomes, satisfaction levels and benefits gained as part of rigorous evaluation process.

Zone 2: Proactive community care via integrated neighbourhood teams

J. Palliative and end of life care (PEoLC)

- The narrative should be focussed on what is right for the individual and include shared decision making, not on what is best for the system.
- Recognising 'ordinary dying' – palliative and end of life care should be everyone's business, not just that is the palliative care specialists.
- Build PEoLC skills within the neighbourhood teams to reduce over-dependence on specialists. Recognise the need for a personal navigator role at the end of life.
- Recognising that domiciliary care and district nursing play a vital role at the end of life, alongside GPs and community services.
- Social care plays a huge role in the holistic care for a person – palliative care is not just about medical care needs.
- Palliative care does not just happen at the end of life – it can be episodic and last a number of years.
- Creating a culture where people are more comfortable to talk about death and see it as part of the continuum of care, 'planning for the end'.
- Recognising that advanced care planning (ACP) is not a one-off conversation, rather should be ongoing and it is not the responsibility of a single role – it is everyone's responsibility.
- Embedding early advanced care planning as a standard, before a crisis happens, 'planning for the future is key', particularly for people living with dementia.
- Having difficult conversations regarding PEoLC earlier to enable care, and death, to happen in the person's place of preference, with family members/friends present.
- Outcome measures should be focussed on quality of advance care planning rather than preferred place of death, as well as learnings from national audit of care at the end of life (NACEL), and the emphasis on staff and bereaved carer feedback.
- Timely support to carers is key and gaps in bereavement services need to be filled and offers made more transparent (e.g., in a brochure). (Greenwich public health team undertaking pilot bereavement project).

Zone 2: Proactive community care via integrated neighbourhood teams

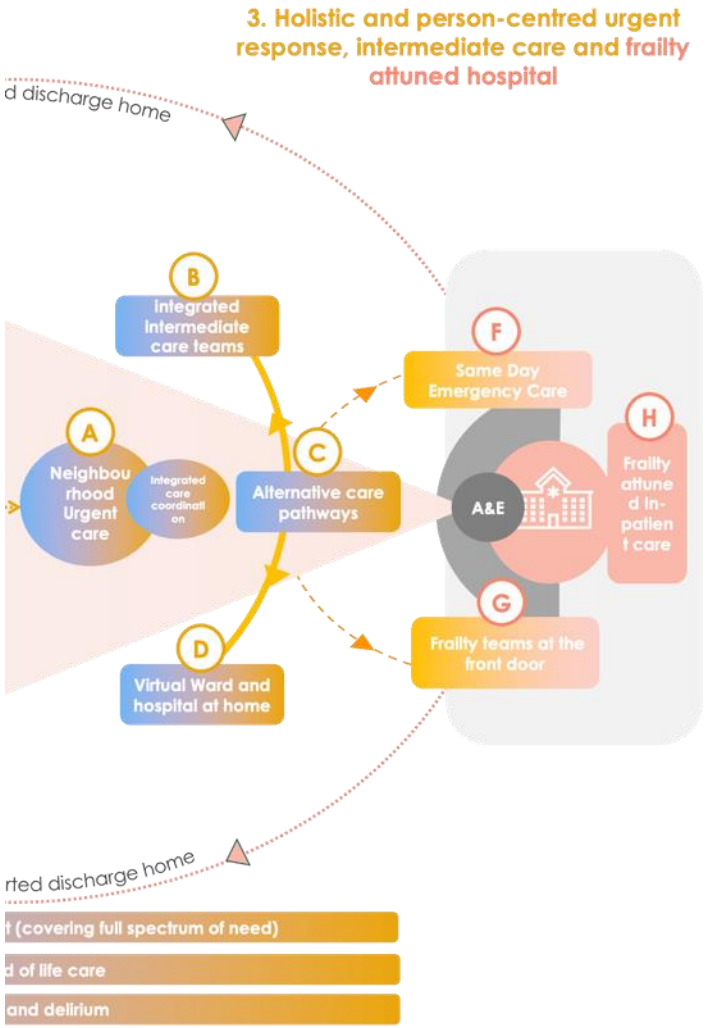
K. Mental health, dementia and delirium	• Please see the next slide that summarises some of the important elements across all zones regarding Mental Health/Dementia & delirium within the framework.
L. Galvanising community assets, communities and voluntary sector	• A key feature of the framework involves increasing partnership working between voluntary, community, faith and social enterprise (VCFSE) sector organisations and the wider system to improve health and care outcomes • Specifically, there is an opportunity to increase the role of voluntary sector organisations who often know residents better than other agencies, are more skilled in supporting their needs and can do so more effectively and efficiently than statutory services • To do this best, voluntary sector organisations need to be 'around the table' from the kick-off, involved in designing solutions and services and require more formalised roles supported by secure, longer-term funding. They also need to be part of the ongoing review and refinement of services • Places are at different points in this journey; effective starting points include helping to build a local collaborative of organisations supported by some practical governance (such as collaborative meeting points, clear leadership, etc.). Identifying a specific aim in terms of shifting budgets to the voluntary sector is also recommended • It is also important to ensure strong participation from hyper-local organisations, helping to build real local knowledge, goodwill and cooperation with residents and resident groups at neighbourhood level • The extent to which the above represents a change in culture and way of thinking is not to be underestimated, so continual challenge to change the status quo is to be encouraged.

Mental Health/Dementia & delirium within the framework

ZONE 1	ZONE 2	ZONE 3
• Knowing exactly who our population with mental health problems and dementia are • Equally promoting independence and wellbeing for people living with mental health problems and dementia ensuring parity of provision for these groups and reducing stigma. • Early identification: spotting and responding proactively to early signs of deterioration. • Supporting people to engage with their health, e.g. to address excessive drinking and resultant low mood. • Early support and advocacy to good decision-making about what to do e.g. post diagnosis • Supporting people to build resilience post-diagnosis • Understanding and acting upon carer risk	• Clear support post-diagnosis (instead of being sent all over the place) • Dementia care home team providing advice, training and coaching to staff e.g. managing BPSD, monitoring hydration, etc. • Upskill domiciliary care workers to reduce avoidable escalation and admission with earlier detection and action to deterioration and delirium. • Strong connections with social care link workers • Pre-planned crisis escalation support (including e.g. giving carers urine pots so testing can be expedited quicker). • Carers as full partners in decision making and effective carer support and respite • Managing behavioural issues associated with dementia (across zones). Understanding people's unmet needs and what they are trying to communicate via their behaviours to keep people in the least intensive setting. • Access to substance use specialists e.g. to take part in MDT discussions • Making reasonable adjustments e.g. providing paper appointment cards, using paper diaries (instead of automation).	• Timely step-up/step-down to intermediate care • Provision of specialist input e.g. speech, language, nutrition. • Integrated, wrap around offer (housing, homecare, domiciliary care). • Speedy return to normal place of residence • Skilled management of emergency presentations to avoid admission. • Timely identification and assessment of dementia/delirium in hospital (4AT). • Strong focus on nutrition, hydration and constipation checks at all stages of the journey. • Minimal ward moves and improving the patient experience • Nuanced decision-making based on what and who matters to the person. • Optimising the discharge process for people with mental health problems and dementia, so they experience parity. • Being more empathetic and proactive when appointments are missed, e.g. following up, taking time to explain and re-setting appointments. • Consider Admiral nurse as part of team to provide support to and help to navigate/coordinate and signpost care for people living with dementia (including support to carers).

Skills and knowledge to respond to mental health issues, dementia and delirium and the interplay between them.
Cohesion and effective communication between teams.
Data and digital interoperability.
Dementia-attuned environments.

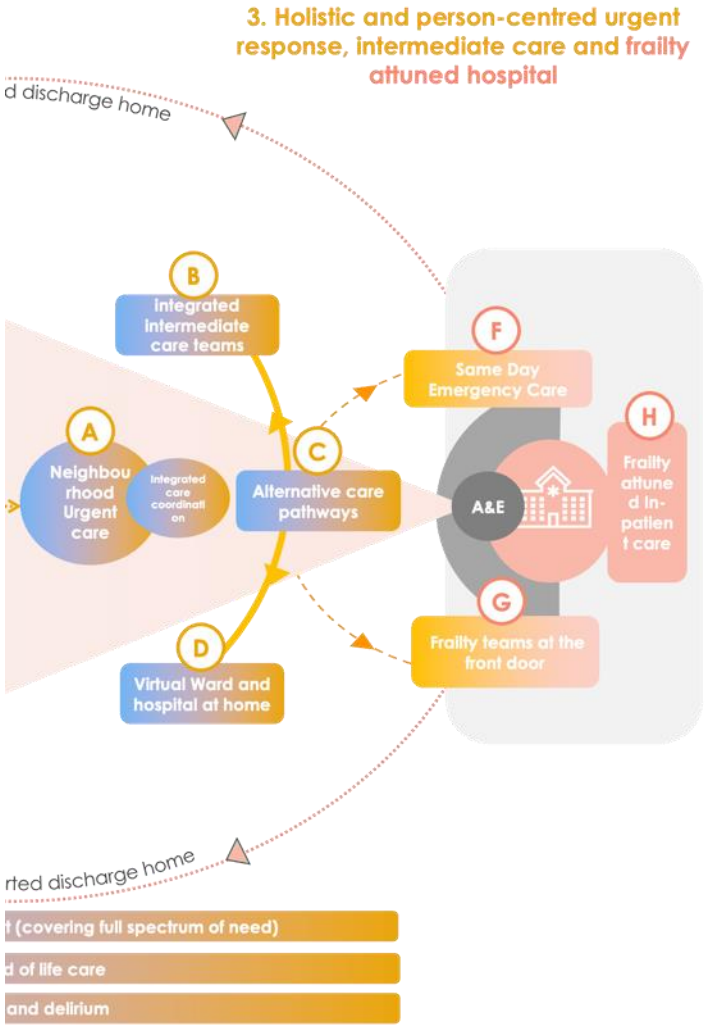
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Neighbourhood-based urgent community care preventing escalation for those at home
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Step-up intermediate care and/or hospital@home helping to avoid unnecessary hospital attendance or admission.
- Step-down intermediate care and/or hospital@home for those at the hospital front door or who have been admitted, enabling timely discharge and avoidance of readmission.
- Strong focus on step-up provision to ensure fewer people are unnecessarily admitted to hospital in the first place.
- Simplified and coherent community escalation attuned to the holistic needs of older people and those living with frailty to keep people at home for as long as possible. Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Provision of timely, strengths-based and coordinated intermediate care (recovery, reablement and rehabilitation) based on people's goals and focused on wellbeing and independence, for those who need a continued period of managed care in the community or following presentation at or admittance to hospital.

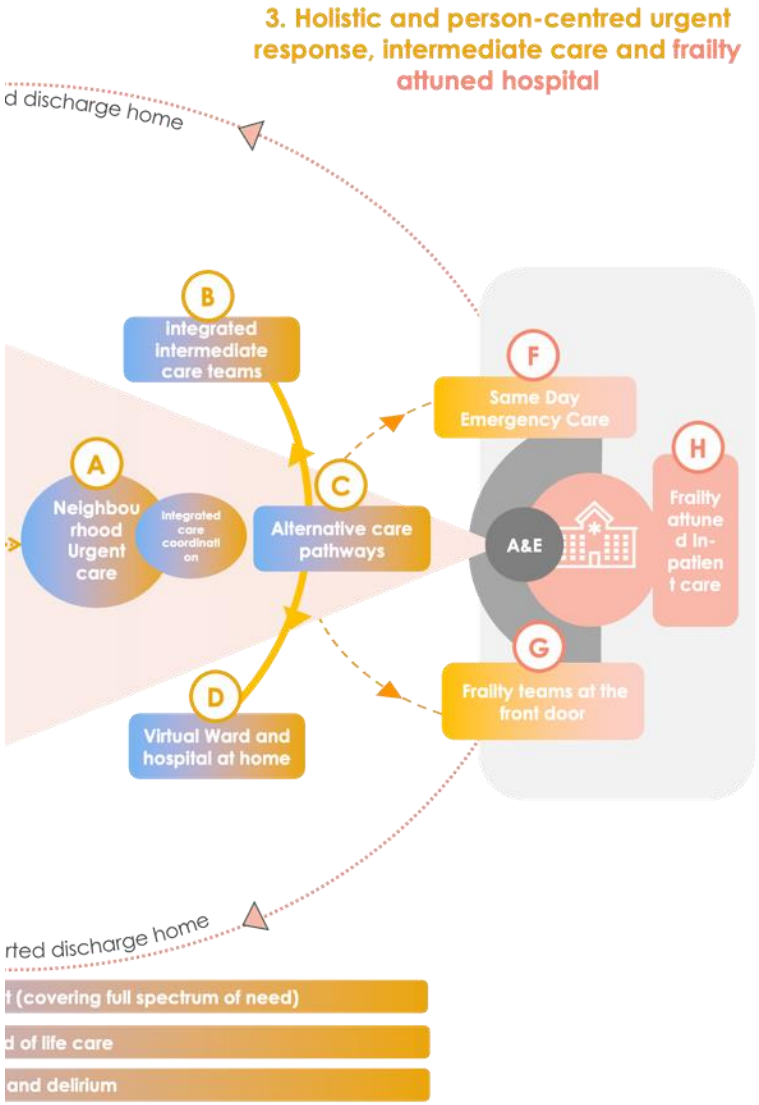
Zone 3: Holistic and person-centred urgent response, intermediate care and frailty attuned hospital



Zone 3 - working closely with zone 2 to provide:

- Intermediate care needs identified in the community or hospital front door escalated into a single point of access for advice or acceptance for rapid therapeutic transfer of care, including real time review of any existing package of care in place.
- Timely delivery of intermediate care and support without delay that would otherwise lead to deterioration at home or deconditioning in hospital, e.g. therapy starts immediately post discharge to avoid person becoming bed bound and to optimise independent living.
- Includes advice and support to help people manage life events such as bereavement, organising care requirements and planning lasting power of attorney.
- Ability to make direct referral to a virtual ward to prevent admission or expedite earlier discharge from hospital.
- Inclusive of direct access to medical support (including via advice and guidance) and a solid out of hours provision.
- The ability to align mental health resources to the more urgent mental health and dementia cases to ensure parity of care for people with mental health problems and dementia. For example, admiral nurse involvement to expedite swifter hospital discharge and provision of a short period of specialised support at home to enable earlier discharge for people with delirium.

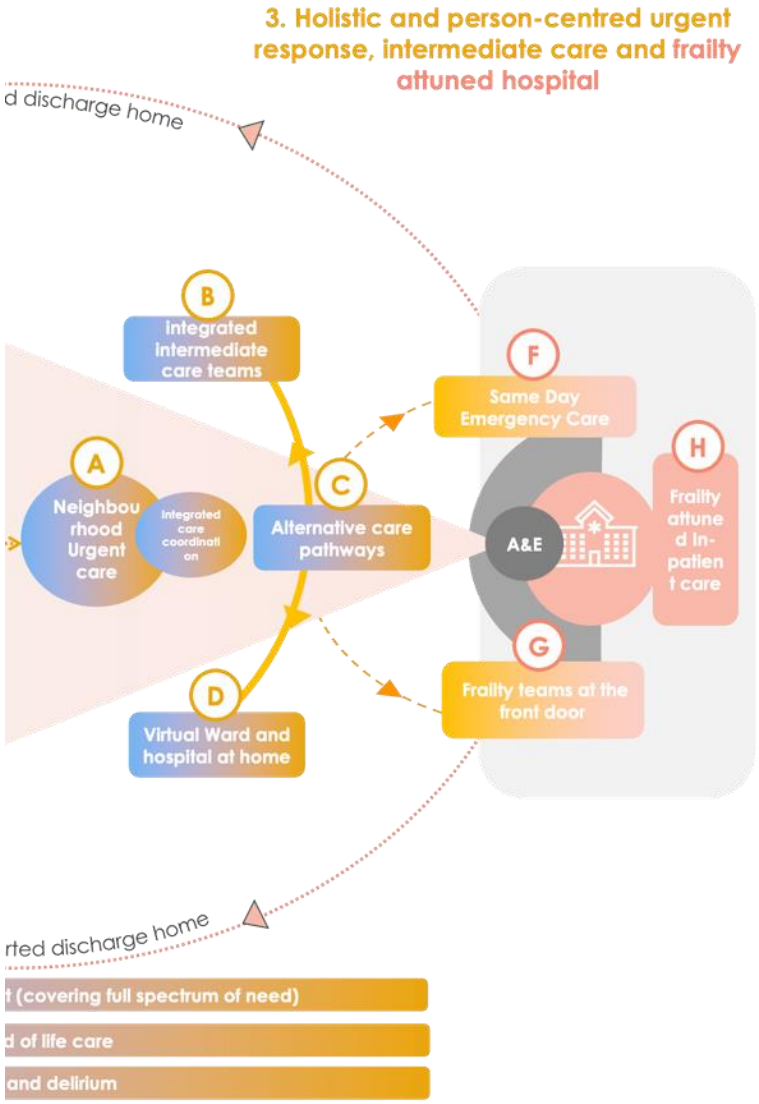
Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams.

- Frailty team at the front door to proactively identify frail people, carry out holistic assessment and care planning and where possible transfer directly back to community-based care before the person becomes ‘medicalised’.
- Establishing realistic independence and activities of daily living (ADL) baseline and making nuanced decisions based on this and 'what and who matters to the person'.
- SDEC - assessment and care by specialist clinicians on the day of arrival to hospital as an alternative to admission, ensuring those that would not benefit from hospital admission are discharged back into the community.
- Acute frailty unit - a multidisciplinary assessment unit, to address the urgent medical needs for those that are frail and require a short stay (less than 3 days) in hospital.
- Fracture liaison service - identification of people who have suffered a fragility fracture, providing a bone health assessment to identify future falls risks and to reduce the risk of future fractures.
- An inpatient older people’s ward for those who require a longer inpatient stay due to medical reasons – including a focus on reablement, mobility, exercise and cognitive stimulation to reduce deconditioning during their stay.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**



Front door frailty team focused on identification of frailty and same day delivery of coordinated care so that people can be discharged back into the community or undertake a short stay in a frailty unit, avoiding admission where possible. Frailty-attuned hospital care and timely hospital discharge for those who are admitted. Flexible boundaries and closer working between acute teams and integrated neighbourhood teams (cont'd)

- Transfer of care hub providing coordinated discharge back to the community, including taking actions from day of admission (as part of discharge planning) to expedite timely discharge without delay.
- Frailty and dementia/delirium skilled and attuned staff in all key hospital roles, so that for example, decision-making about care is more nuanced and driven by *what and who matters* to the person.
- Defined standards for frailty-attuned care for people in other settings such as surgery, oncology and other non-geriatrician led inpatient services.
- Consider use of summary acute medicine indicator table (SAMIT 75+) offering national comparative data for frailty at site level. Metrics cover demand, flow and outcome for both the admission and recovery phases of frailty care.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

A. Neighbourhood urgent care with integrated care coordination

- Neighbourhood-based urgent care encapsulates a range of functionalities including urgent community response (UCR) and is directly connected with neighbourhoods (these are being developed and will be further refined).
- Integrated care coordination (hub) that provides a single point for remote assessment via MDT resulting in (1) advice, (2) direct booking or referral or (3) case holding – where appropriate.
- Seamless flow and pathways between services and in-reach into neighbourhoods as a shared resource.
- Core MDT: An MDT approach consisting of paramedics, nurses, OT, dietician, social care professionals, advanced care practitioners and managers.
- Connected teams: Direct interface with health and social care provision such as GP, 111, pharmacy, INT, Virtual ward, LA front door, Housing,
- System collaboration: Access to other professionals including UEC, GP, hospital, mental health, housing, urgent response mental health placement etc
- System integration/technology: ensuring visibility of patients, access to shared records, data transfer between MDT and use of tele-monitoring/tele-care
- Care navigator/ co-ordinator with clear ownership of cases. Strong key relationships and conversations-with clear communication lines
- Holistic approach with focus on prevention, e.g. ensuring that lower-level or emerging social needs are not missed

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

B. Integrated intermediate care teams	• MDT working to deliver a timely step-up and step-down service focused on recovery, wellbeing and independence • MDT comprising of medical, therapy, mental health, nursing, VCSFE, pharmacy, reablement, night carers, handyman service. • Access to extended MDT and/or advice including housing, geriatricians, cardiologists, etc. • Coordinated, proactive support, putting everything in place, working closely with a carer or family where present • Real time review and adjustment of support and ability to increase or decrease care to optimise outcomes • Access to existing CGA or ability to carry out a CGA, aligned to an urgent care plan • Specific liaison role with care homes to ensure proportional access and utilisation of service by care homes • Utilisation of service by specialist palliative care, hospice and end of life care teams • Timely access to equipment to ensure care and support commence rapidly.
C. Urgent community response and alternative care pathways	• Consistent UCR offer across SEL aligned to national standards and population health. Seamless flow/pathways into/in-between ACP :virtual wards, frailty units, SDEC • Intermediate care needs identified in the community, at the hospital front door or at discharge from hospital are escalated into the single point of access for advice, guidance or referral for a rapid, therapeutic transfer of care, including real time review of existing packages of care • Specifically for frailty, which is delivered at a place level, and may differ operationally between places based on local requirements. • Anyone can access and be signposted, including professionals working in zones 1 and 2, care homes, palliative care, etc. • Timely, direct access to reablement and rehabilitation via one and done process (no hand-offs). • A senior experienced clinician and social care led service, with authority and decision-making capabilities. • Rotation of staff within the system for care alignment and development. • Standardisation and simplification of proforma.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

D. Virtual ward and hospital at home	• Direct referral pathway from intermediate care teams, urgent community response teams, front door frailty teams, SDEC, discharge teams and transfer of care hub (TOCH) to virtual ward. • Virtual ward teams specifically skilled in frailty care and falls management.
F. Same day emergency care (SDEC)	• An MDT led frailty SDEC approach (geriatrician, advanced frailty practitioner, case manager, pharmacist). • Conduct investigations and delivery of short-term treatment e.g. iron infusion. • Assessment of acute issues referred from LAS, community teams, outpatients, care and nursing homes and front door frailty team • Direct link to virtual ward.
G. Frailty Teams at the Front Door	• Proactive screening and identification of frailty in ED through seeing all people age 65+ • Automatic CGA for CFS frailty score 6 and above and for those living in care homes. • An MDT approach: geriatrician, advanced frailty practitioner, physician associate, frailty pharmacist, frailty dedicated physiotherapist, social worker, community advanced nurse practitioner (ANP) and mental health representation. • Assessment and planning, including redirecting people back home, referral to community-based care, falls clinic, intermediate care, fast-tracking to the acute frailty unit or admission. • Providing advice to the ED team. • Geriatrician-led frailty advice line for GPs, community health services and ambulance service. • Good links to community teams, virtual ward, equipment services and voluntary sector (e.g. for meals, shopping, etc.).

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

H. Frailty Attuned In-patient Care	• An acute MDT bed base utilised to address urgent medical needs for those that require assessment and/or a short stay (less than 3 days) in hospital. • Utilised by the frailty at front door team. • Direct and easy referral to intermediate (step down) care. • A dedicated environment providing patient-centred care (and continuity) via a frailty and dementia/delirium trained MDT (including a frailty consultant and access to mental health specialist) that focuses on the patient, carer(s) and families. • Routine screening for delirium (4AT). • Timely access to CGA e.g. to identify/avoid people being constipated, dehydrated, becoming delirious, resulting in falls. • Increased VCSFE involvement, expediting early action to support timely discharge such as making home ready for person to go home. • Focus on food and feeding and hydration. • A focus on reablement, mobility, exercise, continence care and cognitive stimulation on the ward to reduce deconditioning and hospital acquired disability (HAD), helping to minimise the need for packages of care once discharged. • Dementia support worker present with time to have the conversations and help plan and put support in place. • Focus on early discharge recognising every day in hospital has detrimental outcomes and leads to loss of independence.

Zone 3: Holistic and person-centred urgent community response, reablement and rehabilitation and **frailty attuned hospital**

Supported Discharge Home

- Frailty attuned, therapeutic transfer of care processes, interfaces, proforma, assessment, out of area arrangements, etc.
- Link to discharge coordination.
- Direct interface with specialist older people's ward, care and nursing homes and intermediate care
- Live view of capacity for frailty-related services.
- Personal health budget in hub to enable discharging the person sooner/on time e.g. via provision of food, towels, and other items required, that were unforeseen or not addressed as part of a discharge plan
- Ability to refer directly e.g. to handyman services e.g. to fit key safe, repair locks or windows, fix the heating
- VCSFE support to unpaid carers/families at point of discharge to navigate the system and achieve a coordinated, timely and worry-free discharge.
- Full sharing and use of CGA and other information with care or nursing homes at point of transfer, recognising that going into a home is a major life event and that a 'discharge letter' is not sufficient to expedite this or achieve a person-centred, therapeutic transfer of care.

(this element does not appear as a numbered item in the overarching framework)

A range of enablers have been identified as critical to the delivery of the framework

The cross-cutting themes and enablers that will support the ageing well/frailty framework include the following:

- One agreed **frailty scale** to be used across the ICS.
- Consistent approach to use of **Clinical Geriatric Assessment** (CGA) and Universal Care Plan (UCP) - develop a technological solution to pull information from clinical systems such as EMIS in primary care into the UCP.
- **Digital tools** and data sharing - enabling digital solutions for patients and obtaining digital equality. Having required data sharing agreements in place to support collaboration
- **Continuous quality improvement cycles** – Formal QI methodology in place co-developed, owned and actioned across partners.
- **Workforce development and culture** – Achieving a universal minimum skill and competency level for ageing well and frailty (ideally including dementia and delirium) across all roles. Supporting the wellbeing of staff to prevent burnout and increase job satisfaction and staff retention. Developing 'employer of choice' status and attracting the best people with a passion for supporting older people to SEL. Achieving a shift in culture so that e.g., older people are respected, trusted and believed as equal citizens living full and well-rounded lives and with hopes and dreams. Supporting a cultural shift to increase pre-emptive thinking and genuine shared responsibility for prevention e.g., through talking to one another and triggering timely action in response to concerns or yellow/red flags, regardless of role. Co-location of teams to support building of strong, authentic teams and relationships
- **Culturally sensitive adjustments** – understanding the barriers to accessing services and wider amenities in the community, which could be real or perceived. Adjusting practices, processes, pathways, measures etc. in response to older peoples' experiences to create inclusion, encourage self-care and meet their needs. Health inequalities – look at how to tackle inequalities not only in access to services but also regarding preferences and limitations due to race, gender, etc.
- **Making ageing well everyone's business.** Ensuring that ageing well/frailty is "everyone's business" including raising awareness and upskilling the workforce to understand ageing well and recognise frailty and early signs of deterioration. Making it "every professional's responsibility" to input into the UCP. Supporting the upskilling and raised awareness of staff in care homes and domiciliary care
- Having a clear and overt strategy in place for **delivering the funding shift** needed to fulfil the ambitions of the framework, supported by a demand and capacity model that sits alongside the framework, pinpointing the capacity needed in each area to successfully deliver the required care and support
- **Population health management** (PHM) - using PHM capabilities such as predictive risk analytics to identify cohorts and further predict the risk of deterioration. Using alerts e.g., to indicate where patient reviews have been missed or need to be undertaken. Access to granular detail, e.g., to enable identification of people with frailty and at risk of deterioration.

South East London Integrated Care System

NHS South East London

6.
How will we know if we are making a difference

Outcomes and measures

HEALTH INTEGRATION PARTNERS

Introduction

- The following slides outline a list of outcomes developed through engagement with stakeholders across all Places in SEL, encompassing a wide range of professions (e.g., clinical, social, managerial) and care settings (voluntary sector, local authorities) as well as residents.
- Please note that this list of outcomes is still "in development." Other outcome frameworks, such as those for LTC and neighbourhoods, have already been or are currently being developed. It is essential that we align these outcomes, and as such, the list will evolve alongside the development of other programs.
- The goal is to establish a unified set of outcomes across SEL that reflects progress and achievements at three levels: neighbourhood, Place, and South-East London. To ensure practicality and relevance, it is crucial to limit the number of indicators that effectively demonstrate overall impact in line with the aspirations of the ageing well framework.
- To keep it practical and meaningful, it is important that there is a finite number of indicators that can show the overall impact in line with the aspirations of the ageing well framework.
- The indicators should be SMART and, ideally, based on established data points that can be centrally extracted to support an automated dashboard across the system. This dashboard will be designed to filter by location, population segment, and severity of frailty (mild, moderate, severe). Developing this automated (or semi-automated) dashboard is a key part of the roadmap ahead and will require a task and finish group, including data experts, clinical/professional leads, and executive oversight.
- Considerations for dashboard development includes: (1) availability of and access to viable data points (such as in GP records, HES and LA datasets), (2) creation of repository of joined-up datasets, (3) assessment of data quality, (4) defining key algorithms and definitions, and (5) the development of the dashboard, which will involve testing, refining, and implementing through a quality improvement (QI) process.

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
1	**Improvement in quality of life**	• Are we genuinely supporting in people to age well and thrive? • Are we making a difference to the quality-of-life outcomes of people (residents, patients and carers)?	**At system level:** • Priority: Healthy life span as a marker of ageing well * • Priority: Quality of life of people who use services (ASCOF) • Carer reported quality of life (ASCOF) • Mortality rate of >65 population * **At an individual / cohort level:** • EQ-5D patient reported outcomes-based quality of life score • Set of outcomes defined in INT at the time of care planning and then assessed at defined intervals 1. Achievement of goals defined at the time of care planning 2. Improvement in ADL from baseline (if relevant) 3. Reduction in reported loneliness (if relevant) 4. Improvement on overall mental wellbeing 5. Improvement in clinical outcomes (exact indicator will depend upon the clinical condition of the patient) • Self reported outcomes: Use of simple wellness star. Use of digital / telehealth to monitor wellness scores where possible

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
2	**Supporting people to age well**	• Are we able to reduce risk for individuals and stop or slow their progression into higher frailty zones for e.g. mild to moderate and moderate to severe / reduce manifestations of growing frailty	• Priority: Reduction in number of admissions due to ACSC / avoidable admissions *(avoidable admissions codes to be confirmed locally and monitored against baseline or as a rate of population)* • Priority: Reduction in people with 10+ medications (poly-pharmacy) *(https://www.who.int/docs/default-source/patient-safety/who-uhc-sds-2019-11-eng.pdf)* • Priority: Reduction in people with self reported isolation (ASCOF) • Reduction in number of admissions due to falls *(measure against baseline or as a rate of population)* • Reduction in number of people requiring domiciliary care (new) • Reduction in people who are house-bound *
3	**System sustainability (value-based care)**	• Are we reducing demand from resource intensive areas such as hospital and long-term residential care and shifting focus of care into community	• Priority: Reduction in ED presentations for over 65 or those who are mild/mod/severe frail • Priority: Reduction in % of patients over 65 with a Length Of Stay of 21+ Days • Priority: Reduction in admissions into residential care (nursing and residential care homes) • Priority: Reduction in number emergency admissions to hospital and beddays (measure against baseline and as a rate of population) • Increased SDEC utilisation and reduction in ED utilisation for people with moderate to severe frailty with UCP in place • Reduction in care home conveyances to ED • Reduction in LAS conveyances to hospital

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
4	**Improved resident / carer experience**	• Are the experience of our residents, patients and carers positive. Do they feel supported, seen, heard and respected in their interactions with health and care services. Do they have a positive experience of ageing.	**At system level:** • Priority: Proportion of people who use services who report having control over their daily life (ASCOF measure) • Priority: Social Isolation: Percentage of adult carers who have as much social contact as they would like (ASCOF) • Social Isolation: Percentage of adults who feel lonely often or always **At an individual / cohort level:** • To be delivered at service level such as people supported by Integrated neighbourhood teams • Qualitative survey (person feedback): List of 5 questions - could include aspects like 'ability to self manage', 'improved connectivity' and 'feeling trusted, heard and respected' • Real life stories through deep dive semi-structured interviews (for learning and CQI)

5	**Improved access to community assets**	• Are residents provided with opportunities to access support in the community to support them in ageing well.	• Priority: Proportion of people accessing the green and blue zone such as:
			  • Access into neighbourhood services (e.g. INT), community activities
			  • Access to community-based support and amenities (e.g. exercise classes)

6	**Reduced health inequalities**	• Are the outcomes the same in all resident/population groups ie gender, ethnicity, sexual orientation, deprivation level (IMD), mental health, LD and other exclusion groups such as homeless • Is access to community-based support and neighbourhood equitable	In addition to dissecting the data, survey and interviews above to identify any signs of inequality, the following additional objective measures to be considered: • Priority: Rate of NEL admissions in respective population cohorts • Priority: Access into neighbourhood services (e.g. INT), community activities and amenities (e.g. exercise classes) • Access to suitable housing • Rate of multi-morbidity (4 and more LTC) in respective population cohorts

* Indicators that will show impact in the longer term

How we will know if we are making a difference
Outcomes that will be used to monitor and evaluate

The following table outlines the key outcomes that were jointly developed with input from stakeholders. The outcomes aligns with the aim to improve outcomes and experience for people with a more sustainable health and care economy. The indicators will be refined further as part of implementation.

	Outcomes	What do we aim to understand from the indicators	Potential Indicators Long list at this stage - to be refined further
7	**Identification of people with escalating frailty**	Are we identifying people with escalating frailty or complexities before it is late	• Priority: Proportion of people with Moderate frailty who are identified and supported by INT • Dementia diagnosis rate for 65+ years old * • Proportion of people that have been enrolled in neighbourhood care that have been flagged by population health algorithms (future) • Consider: Increased coding of frailty status of population
8	**Positive dying**	Are the patient's wishes being included in their ACP, including their preferred place of death. Are we recognising 'ordinary dying'	• Priority: PPoC and PPOD from UCP correlated against actual place of care and death • Number of 'Plan for the future' achieved (tbc - % of total population over 65)
9	**Other**		• Priority: Proportion of UCP and CGA completed for people with frailty (mild, moderate and severe) • Number of SMR / polypharmacy reviews

* Indicators that will show impact in the longer term

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7.
How we implement the framework

HEALTH INTEGRATION PARTNERS

A recommended first principle is that the biggest proportion of effort in implementing the Ageing Well framework should be on people

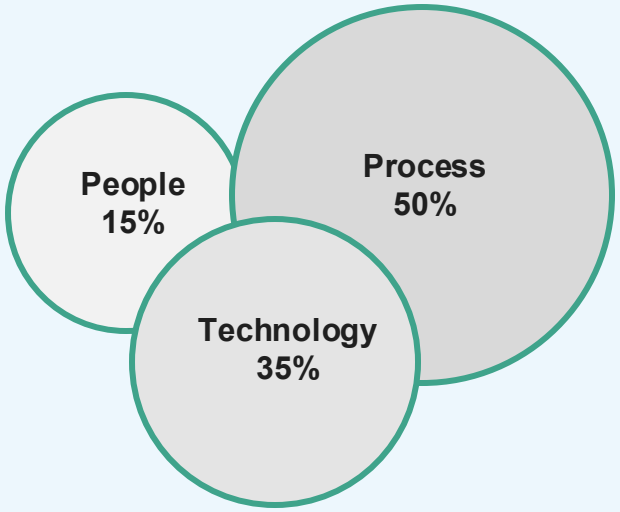
Nearly two thirds of healthcare change projects fail and less than 5% deliver what they are supposed to[1]

Common pitfalls include insufficient focus on:

- → Creating meaning and purpose
- → Engaging and taking people/partners on the journey
- → Having the right team, skills and knowledge for the job
- → Visible leadership championing the work
- → Tapping into values, feelings and attitudes
- → Creating trust, ownership and accountability
- → Tracking, reporting and promoting success
- → Project methods that drive delivery at scale and pace

Most healthcare transformations **under invest in the human dimension**

Proportion of effort showing less focus on people led change



Change dominated by process and technology only achieves around a 10% level of adoption [2]

1. *NCBI 2022*
2. *Ian Gotts. Common Approach, Uncommon Results 2007*

This recommended first principle then translates into some further recommendations for how SEL should approach implementation of the framework

Engagement	• Developing a strong 'brand' identity for the framework that conveys not just the 'tasks' bit also the 'spirit and emotion' behind the ambition and embedding this in each Place • Developing a robust approach to engagement at SEL and Place level including executive and front-line buy-in across all partners e.g., health providers, social care, Local Authority, Public Health, VCFSE, private providers e.g., domiciliary care and care homes • Patient, carer and family education, engagement and co-production.
Leadership, resources and skills	• Clarifying programme leadership and project management resources at SEL and Place levels (identifying inspirational leaders) • Putting the resources in place required to deliver the framework • Establishing a multi-professional training and job shadowing/rotational roles skills transfer framework for ageing well and frailty.
Delivery and change management	• Having clarity on what the ICB is doing and what Place is doing and ensuring the ICB provides the required practical support needed to Place (e.g., identifying and agreeing the deliverables that can be done 'once for SEL' that support standardisation, efficiency and avoidance of duplication such as the Life course self-assessment, My Plan for the Future, CGA, UCP, frailty identification/scoring tool and the enablers) • Developing a new, proactive and dynamic approach to change e.g., via establishment of a community of practice and champions to inspire and drive developments, capture and assimilate feedback etc. • Sharing good practice examples across SEL enabled by a single, easy to use communication channel.
Measurement and funding	• Developing clear success measures and minimum standards to be achieved by services and the implementation programme/project itself (and securing a signed agreement to these across providers) • Establishing a holistic, longer-term plan for funding versus a short-term or piecemeal approach • Planning the investment into ageing well and frailty jointly and openly with wider partners, around an approach emphasising people.

Implementation planning – key elements

Change initiation planning at Place

- Review of framework against current Place plans and initiatives underway
- Understanding of gaps and opportunities and what to prioritise from the framework
- Identifying the key interventions to be developed building from what is already underway
- Defining the *how* – including resources, change management approach, requirements for support from SEL
- Production of practical delivery plan of action including stages, phasing, QI cycles, etc.

SEL parallel review

- Parallel review of Place plans and understanding of what can be done at SEL level/practical support Places need from SEL
- SEL level planning (aligned to Place plans) and mobilisation of SEL-level resources to deliver
- Alignment and coordination of plans with wider SEL strategies and initiatives (INTs, LTCs etc.)
- Plans to include SEL level comms and engagement e.g., resident education, launch of brand, etc.
- Plans include laying foundations for investment shift e.g., to upstream prevention, longer term VCSFE funding, etc.

Engagement and mobilisation at Place (building on existing work underway)

- Identifying Place lead(s) who will drive delivery (overall leads and lead clinicians, professionals, etc.)
- Engaging and onboarding of partners/individual stakeholders at Place who will participate in and help lead design and delivery
- Set up of collaboration and sharing across Places e.g., community of practice, shared communication channel, best practice library, change management approaches, etc.
- Establishing/activating resident engagement and co-production approach
- Mobilising the Place-level resources and project to deliver, including comms, engagement, launch of the brand etc.

Implementation planning – key elements

Demand and capacity modelling

- Scoping and mobilising the D&C modelling – SEL and Place levels
- Marrying the modelling to Place plans e.g. Place assumptions, timings, phasing, etc.
- Gaining collaboration with wider partners e.g., agreeing principles/actions for resourcing, investment, investment shift, etc
- Building the SEL and Place level D7C model
- Gaining buy-in to the model across all stakeholders

Creating a dashboard

- Creating a SEL dashboard of outcome measures and KPIs
- Populating the dashboard with baseline assumptions (SEL and Place level)
- Quarterly reporting of progress and achievement of outcomes as change is delivered.

Enablers

- Scoping and detailed specification of enablers required to enable the framework
- Developing a specific plan for delivery of enablers to meet the requirements of the framework
- Aligning the specification and plan with existing work already underway on enablers and adjusting any existing specification and plans as required to ensure delivery meets Place requirements
- Mobilising delivery of enablers, prioritised against plans.

Roadmap for implementation

Stage 1: Establishing the vision and the framework to deliver it

SEL Ageing well framework

- Bringing system stakeholders together
- Resident voice
- Framework for ageing well

Demand and capacity modelling

- System baseline for frailty demand and capacity
- Utilisation hot spots and projections
- Overall shift in demand and capacity with new framework

Defining outcomes

- Key outcomes and indicators to know what we are making a difference
- Define system dashboard for frailty
- Establish data points and beta test live dashboard

Stage 2: Embedding the framework (SEL–Place-Neighbourhoods) Change initiation planning

1. Self assessment @ Place

- Map services against framework
- Map performance: What is working well & not
- Define - stay as is, scale, enhance

2. Analysis of opportunities

- Identify areas of improvement against framework
- Scope of development – SEL vs Place
- Impact (£, outcomes)

3. Priorities for delivery

- Prioritise based on potential impact, deliverability and strategic alignment
- Roadmap for implementation

6. Change management, OD and enablers

- Identify change leaders
- Engage, inspire, empower frontline
- Requirements; Digital/OD/training
- Change management

5. Demand and capacity

- Impact on baseline demand and capacity
- Identify shift in resources (Left shift)
- Upfront investment or business case (if req'd)

4. Operating model

- Engage – frontline / clinical / professional
- Define operational model
- Define who/what/how
- Trajectory of implementation

Key tenets of delivery

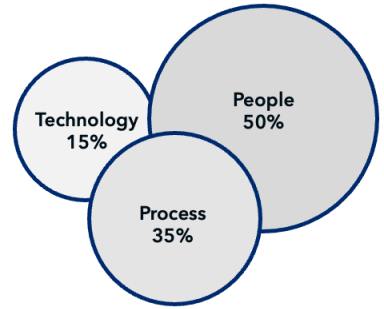
Regular touchpoints

System-wide cross learning workshops

System governance, oversight and review

Stage 3: Phased QI led implementation

Achieving the right focus for change



Phased implementation

- Robust program delivery team (representing system partners)
- Oversight and governance
- Clarity on SEL-level support to Places
- QI methodology and system-wide learn and share events
- Communication plan

- Continued QI cycle
- Test and titrate
- At scale delivery

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8.
Appendices
(circulated as a separate document)

HEALTH INTEGRATION PARTNERS

Appendices - contents

1. Project Plan
2. Summary of baseline positions at Place
3. Outputs from workshops
    a) Ambition and vision
    b) What must change?
    c) What else must change?
    d) Ageing well and frailty definitions
4. Governance
5. What ageing well and frailty mean in SEL
6. Mantra
7. Case Studies
8. List of stakeholders who participated in developing the framework

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Programme supported by:

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