

Integrated Care System for Devon

HEALTHY AGEING COMMISSIONING HANDBOOK 2022

A toolkit to support local care partnerships in designing their own strategic plan for older people, focussing on population health, and adapted to local need.



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List of abbreviations:

Abbreviation	Meaning
A&E	Accident and Emergency
AC	Anticipatory care
ADLs	Activities of daily living
AHP	Allied health professional
ARP	Acute response practitioner
BI	Business intelligence
BIPAP	Bi-level positive airway pressure
CCG	Clinical commissioning groups
CFS	Clinical Frailty Scale
CGA	Comprehensive Geriatric Assessment
CI	Confidence interval
COPD	Chronic obstructive pulmonary disease
D2A	Discharge to assess
DES	Direct enhanced services
ECG	Electrocardiogram
eFI	Electronic Frailty Index
EHCH	Enhanced health in care homes
EIC	Enhanced intermediate care
FaME	Falls Management Exercise programme
FRAX	Fracture risk assessment tool
GP	General practitioner
GPwSI	General practitioner with specialist interest
GQOL	Global quality of life scale
HAND	Healthy Ageing North Devon
HCA	Healthcare assistant
IC	Intermediate care
iCOPE	Integrated Care for Older People
ICS	Integrated care system
IG	Information governance
IT	Information Technology
IV	Intravenous
LCP	Local care partnership
LOS	Length of stay
LPA	Lasting power of attorney
LTC	Long term conditions
MDT	Multi-disciplinary team
MFFD	Medically fit for discharge
MI	Myocardial infarction
NHSE	NHS England
OOH	Out of hours
OPIC	Older person's integrated care
P1-3	Pathway 1 to 3

PCN	Primary care network
PHM	Population Health Management
QOF	Quality outcomes framework
RCT	Randomised control trial
SCR	Summary care record or Shared Care Record
SDEC	Same day emergency care
SMR	Structured medication review
SPOA	Single point of assessment
SWASFT	Southwest Ambulance Service Foundation Trust
TEP	Treatment and escalation plan (type of advance care plan)
UCR	Urgent community response
VCSE	Voluntary, community and social enterprise
VTs	Vocational training scheme
VW	Virtual Ward
WEB	Woodbury, Exmouth, and Budleigh primary care network
WTE	Whole time equivalent

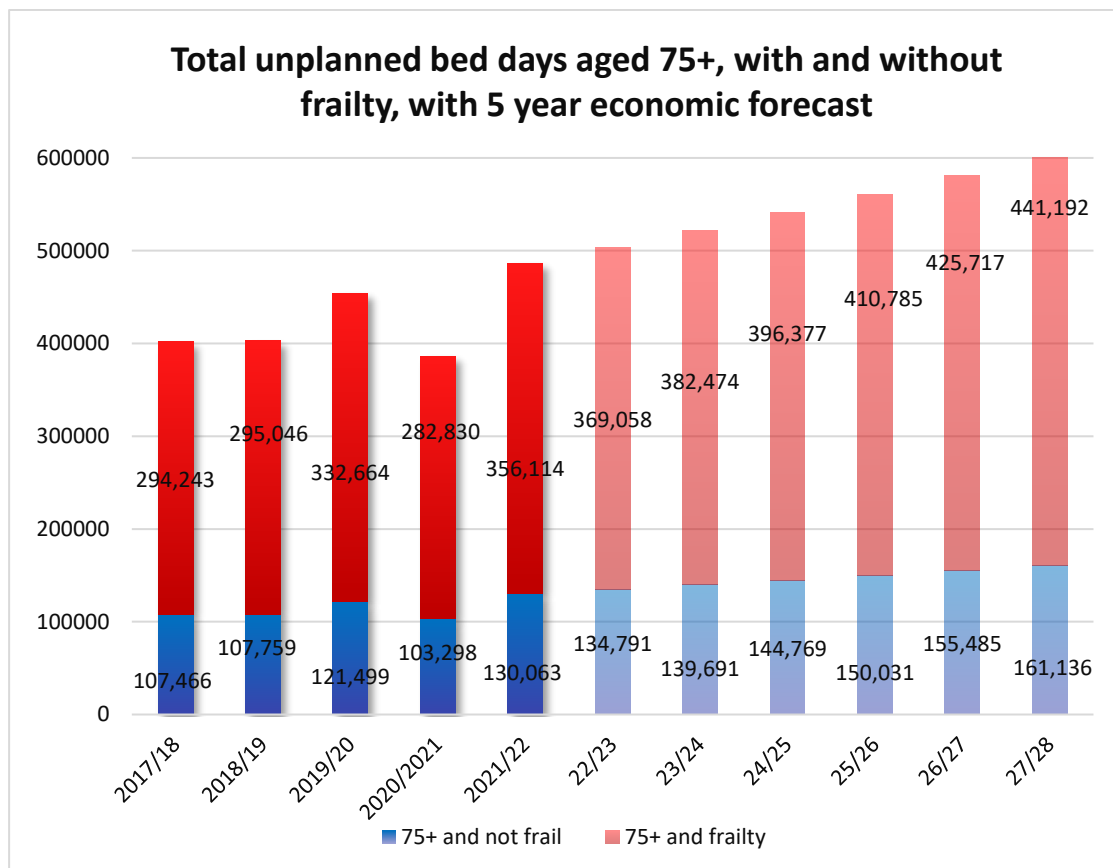
Executive Summary:

“The way we treat our children in the dawn of their lives and the way we treat our elderly in the twilight of their lives is the measure of the quality of a nation.”

Hubert H. Humphrey

It is also the measure of the quality of an integrated health and social care system. This document offers Local Care Partnerships (LCPs) a toolkit to commission integrated services for the proactive and urgent care of older people; focussing on population health and adapted to local need.

Why does this matter? Because older people, particularly those living with frailty (which is a **medical diagnosis** and used in this context, **NOT** as an adjective), multiple long-term conditions, and dementia, are at risk of adverse health outcomes. From a healthcare viewpoint, over half of hospital beds in Devon are occupied by older people (75+ years of age). As our population ages, healthcare utilisation increases, with rising total admissions (3.1%), unplanned bed days (3.6%), and total cost of care (3.4%), year-on-year. As the economic forecast shows, doing nothing is no longer an option.



The situation is made more challenging by external influences. The national service specifications, as they apply to older people, fall short of a comprehensive NHS “long term plan for older people.” This is compounded by ongoing funding insecurity, contrary to the ambitions set out in the NHS Long Term Plan. In Devon, we need a plan that supports healthy ageing, both now and in the future.

Population Health Management can offer a solution. Our older population can be identified and segmented by their physiological vulnerability to adverse health outcomes, based on the

medical diagnosis of frailty. They can be offered evidence-based interventions, personalised to the individual, who should be part of the ‘care & support team.’ There is a large and growing body of evidence for proactive, urgent, and integrated personal commissioning¹ interventions that support older people to live longer, better.

So, this is Devon’s Healthy Ageing Handbook 2022, a document that embraces population health and focuses on healthy ageing. It considers:

- The principles of population health
- Identification of older people at risk of adverse health outcomes
- Evidence-based interventions
- Personalised care based on a series of “I statements” (see Appendix 1)
- Continuity of care and how health and care services can be better integrated to support this through shared working and IT
- Evaluation
- Proactive and urgent care and the importance of a blended approach (with local case studies)
- Workforce planning: methods for gap analysing health and care services and workforce, and options for building capacity through collaboration, redesign, and skills mixing.

This toolkit is designed to provide each LCP with all the information that they need to make their own Healthy Ageing Strategic Plan. This will enable them to commission services for the proactive and urgent care of older people, which focus on population health, and are applicable to their locality. This plan will be quality assured by the OneDevon Integrated Care System and can be pulled “off the shelf” by LCPs at short notice, allowing them to capitalise on new opportunities as they become available to them.

We make no apologies for the length of this document; it must be understandable to clinical and non-clinical staff, providers, and commissioners and has gathered the experience of experts across Devon. It must also be capable of being referenced to and shared with patients, clients, and the public so that they may remain informed participants.

To improve readability, we have included the following:

- A separate **checklist** which LCPs can work through when building their strategic plan, with links to each section
- Structured individual sections, which include the following key points:
 - **By the end LCPs will...** A sentence or two explaining why this section is important to incorporate into their Healthy Ageing Strategic Plan
 - **Key points:** A summary of the section
 - **Likely target readership:** The professionals that this section is most likely to be relevant to.

This is a live and continually evolving document, which has been co-produced with stakeholders in health, social and the voluntary, community, and social enterprise (VCSE) sectors in our OneDevon system. We would like to thank them for their outstanding contributions, and we hope that this document proves a useful guide for LCPs as they develop their own Healthy Ageing Strategic Plan.

1. Introduction: Healthy ageing and the medical diagnosis of frailty – What’s the difference?

By the end of this section LCPs will... understand why frailty **REALLY** matters and the potential value of stratifying a population by their physiological reserve in their Healthy Ageing Strategic Plan.

Key points:

- **Healthy ageing** describes the natural ageing process, where a person’s health does not limit ability
- Some individuals show signs of “**accelerated ageing**”, which renders a person more vulnerable to environmental stressors and limits overall ability. The medical diagnosis that describes this is **frailty**
- **Frailty exists on a spectrum (mild, moderate, and severe)**. As frailty advances healthcare outcomes worsen, and health and care utilisation and costs increase
- **Frailty is modifiable. It can be prevented and improved upon with the right actions.**

Target readership: Health and care professionals; local leads and commissioners; regional leads and strategic commissioners, interested citizens

A longer life brings with it opportunities, not only for older people and their families, but also for society. Additional years provide the chance to pursue new activities such as further education, a new career, or a long-neglected passion. Older people also contribute in many ways to their families and communities. The role that they could play in our future society remains under-appreciated. Yet the extent of these opportunities and contributions depends heavily on their health and personal sense of wellbeing.²

As the human body ages, the body and body functions naturally decline. This is part of the natural ageing process and shouldn’t impact too much on health, as the human body has a lot of inbuilt reserve (often referred to as “intrinsic capacity”). However, whilst many older people enjoy a natural lifespan, where their health does not impact on their abilities until near the end of their lives, other individuals show signs of “accelerated ageing”, where they lose their inbuilt physiological reserve more rapidly.^{2,3}

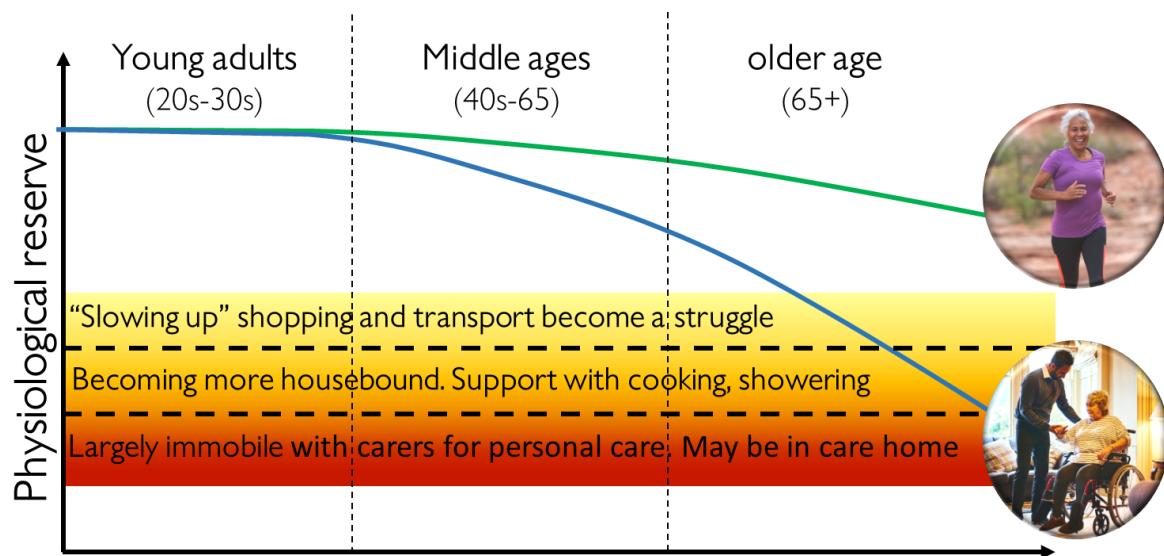


Figure 1: The varying health trajectories of the ageing process.³ Normal, healthy ageing should follow the green line. As health declines some people will become functionally limited by their health.

Although a proportion of the natural trajectory of ageing and loss of intrinsic capacity is genetic, the largest determinants of health trajectory have been described by Dahlgren and Whitehead's work.⁴ They include:

- Diet
- Physical activity
- Social isolation and poor mental health
- Socioeconomic status
- Environmental factors e.g., housing, smoking etc.^{2,4}

For some individuals, there may come a time where the body loses enough inbuilt reserve to the point where it starts to affect health and independence. There is a medical diagnosis that describes this: Frailty.⁵

Frailty exists on a spectrum.⁶ People with mild frailty begin to struggle with higher order activities of daily living, such as food shopping and transport. They may walk slower than a similar person who is fit and may show physical signs of being limited by their condition.

As frailty advances, household chores and bathing become more challenging, meaning that they may need support with this. Walking around the house becomes harder, walking aids may be needed, and many do not leave their home. At this stage a person is likely to have a diagnosis of moderate frailty.

Older people with severe frailty have very limited mobility; some may walk a couple of steps with assistance, many are wheelchair users or may even remain in their beds. They need a high level of hands-on support with personal care from friends, family, or professional carers. They may even need to move into supported living or care homes.

Why does this matter? Because the outcomes for frailty (especially if undiagnosed and untreated) are extremely poor, with one-year mortality for frailty rivalling that of some of the most serious types of cancer.⁷

Frailty status (=5764)	% Inpatient mortality	% readmitted <28 days
------------------------	-----------------------	-----------------------

Not frail (CFS 1-3; n=1471)	1.8	7.7
Mild frailty (CFS 4-5; n=1954)	3.7	13.9
Moderate frailty (CFS 6; n=1276)	6.4	15.4
Severe frailty (CFS 7-8; n=992)	17.6	12.1

Table 1: Inpatient mortality and 28-day readmission rate for patients diagnosed with frailty based on the Rockwood Clinical Frailty Score (CFS).^{6,9}

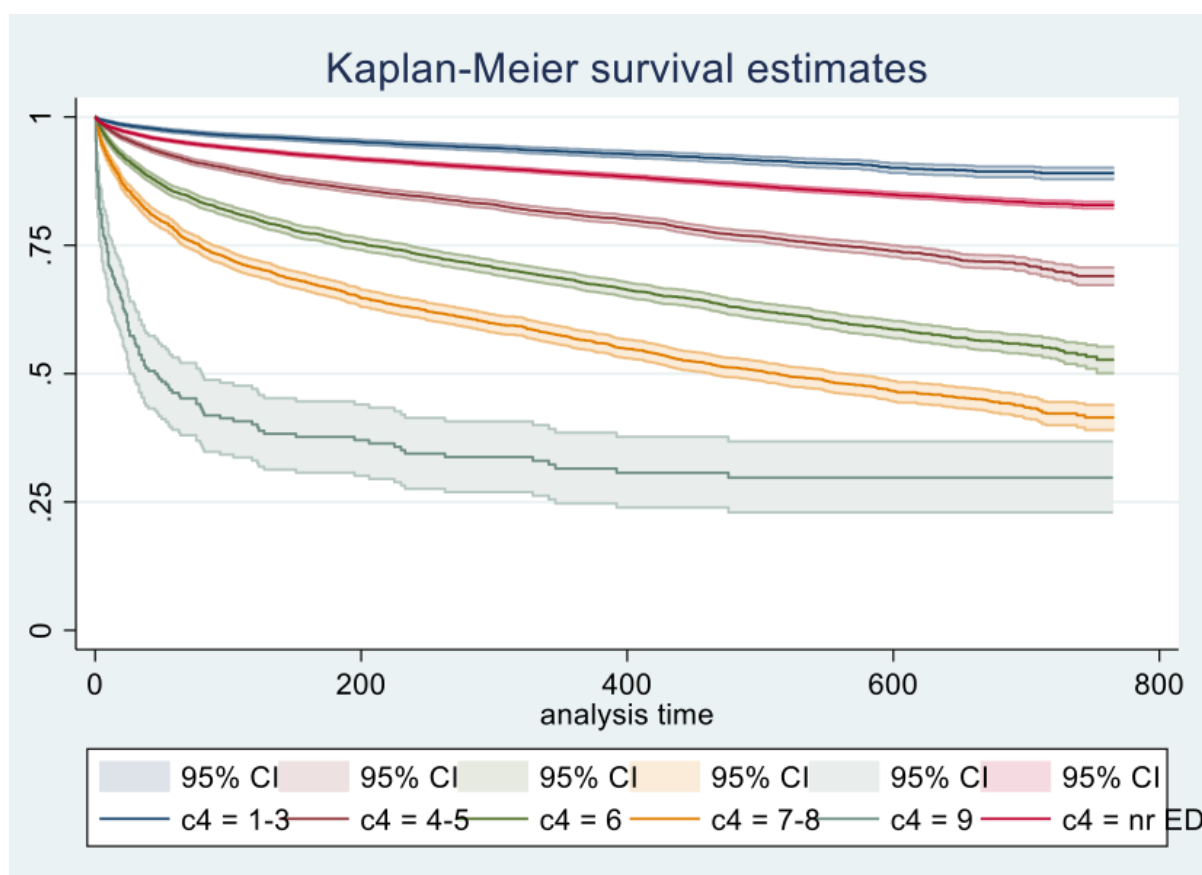


Figure 2: Survival curve for older people from the point at which they are admitted to Emergency Departments, by Rockwood Clinical Frailty Score.⁸

Frailty accounts for significant healthcare utilisation; 73% of all hospital admissions in the 75+ population have a diagnosis of frailty.⁹ Devonwide, between April 1st 2021-31st March 2022, frailty accounted for:

- 24% of all unplanned hospital admissions (n=35,996)
- 39% of all unplanned hospital bed days (n=256,114)
- 34% of the cost of unplanned hospital-based care (£115,694,429).

As the proportion of older people in society increases, hospitalisation rates Devon-wide have also increased:

- Total hospital admissions people aged 75+: 3.1% rise year-on-year
- Total unplanned bed days people aged 75+: 3.6% rise year-on-year
- Total cost of care people aged 75+: 3.4% rise year-on-year.

This is based on a modelled analysis of yearly hospitalisation data from 2017-2022 (see Appendix 2 for methodology employed). If no action is taken, the economic forecast looks bleak (Graphs 3-5).

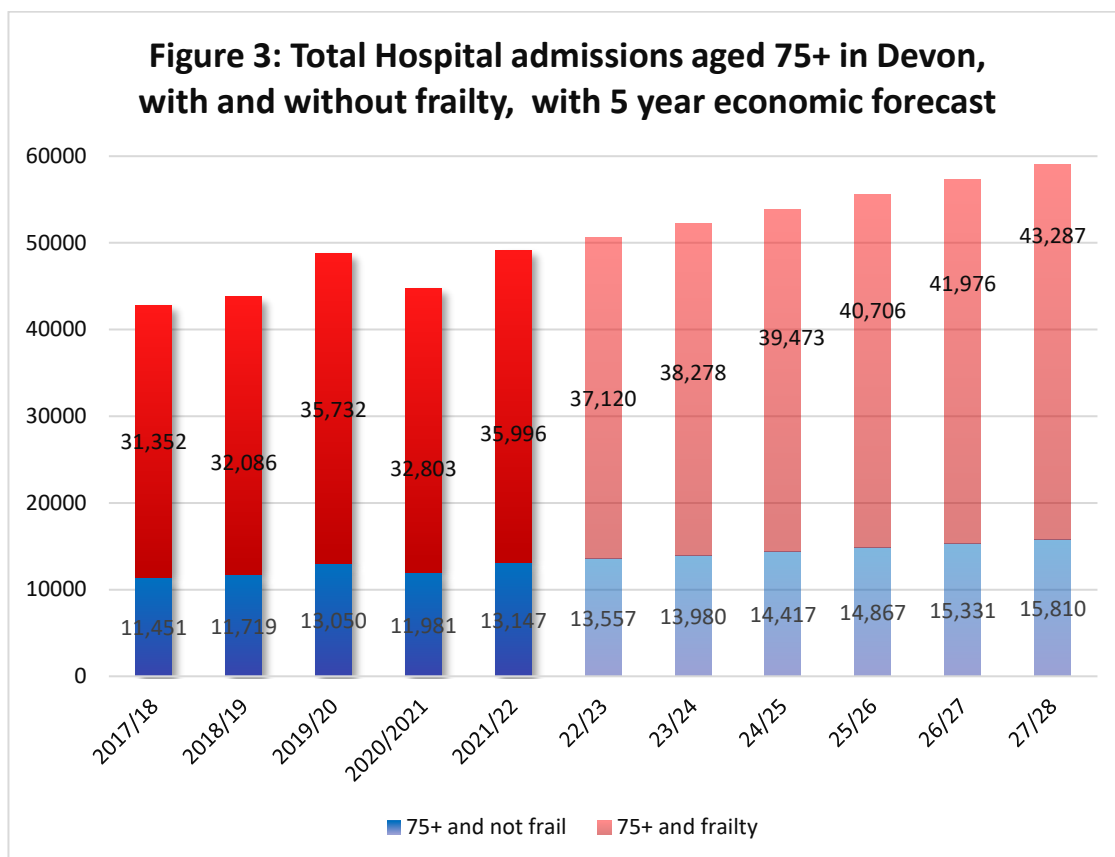


Figure 4: Total unplanned bed days aged 75+ in Devon, with and without frailty, with 5 year economic forecast

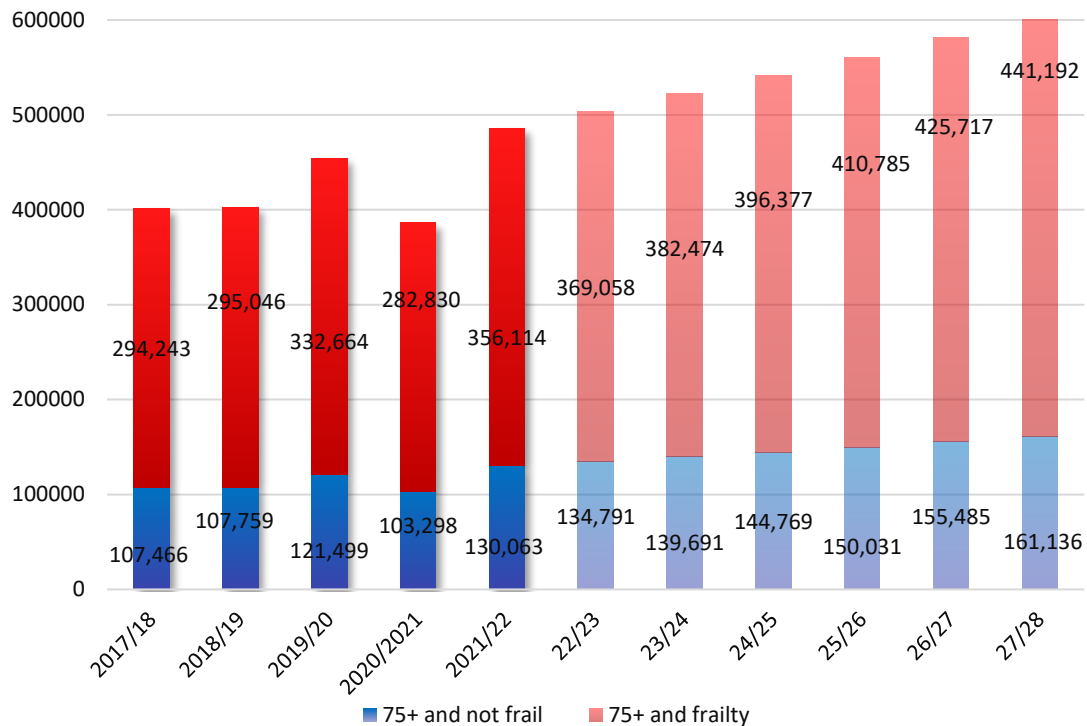
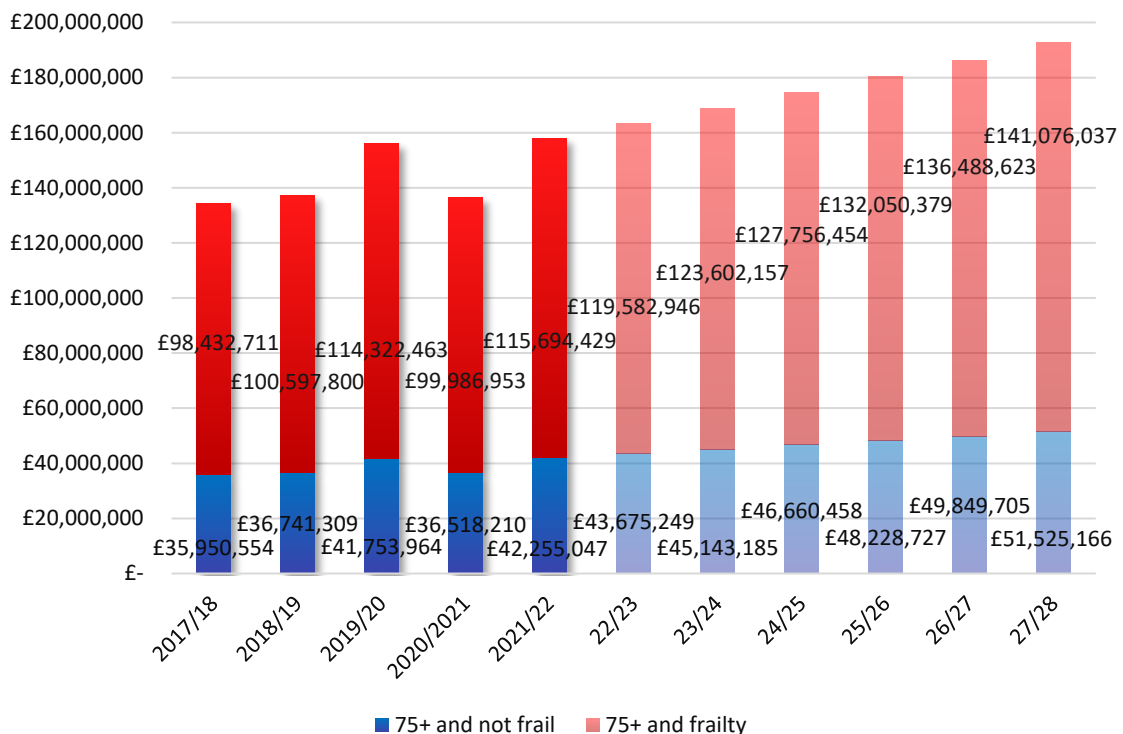


Figure 5: Total cost of care aged 75+ in Devon, with and without frailty, with 5 year economic forecast



The data is stark. It highlights the need to address frailty at population level, without delay. We need to change the way we work. This requires a whole systems solution, owned by and adapted to the needs of each of the LCPs in Devon.

Herein lies a beautiful truth: **Ageing cannot be prevented, but frailty is dynamic and modifiable.** There are interventions that have been proven to recover the trajectory of the ageing process (described in Figure 1), thereby improving health and allowing older people to live longer, better.

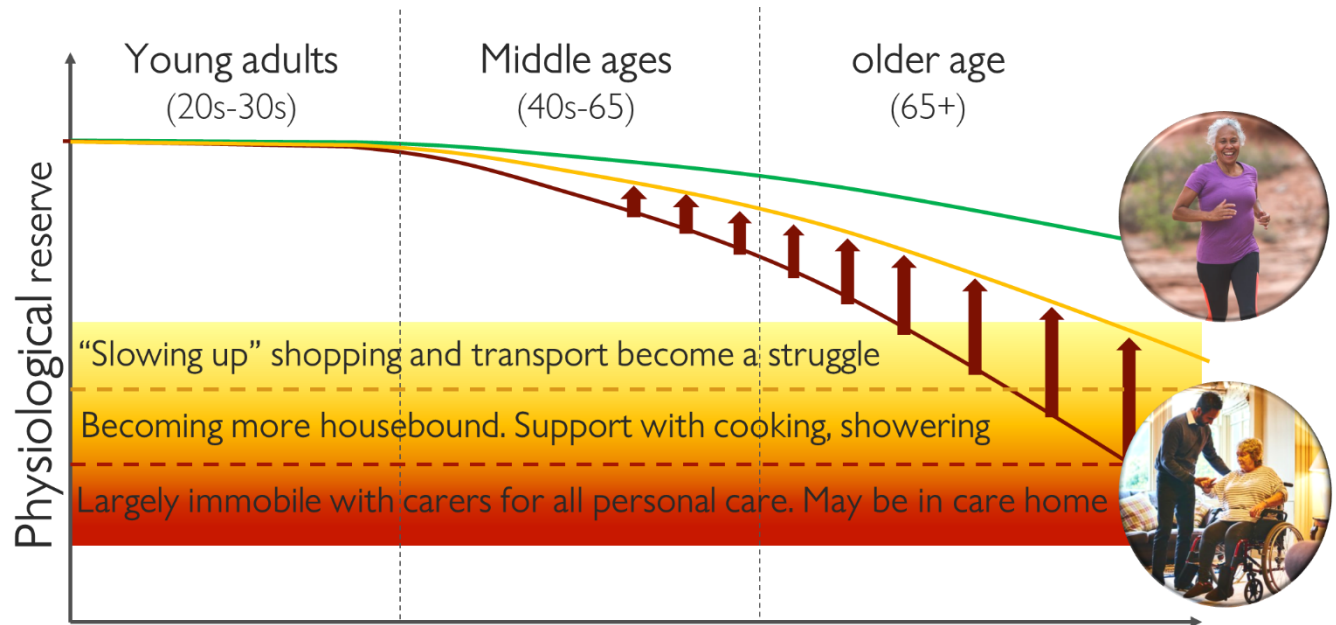


Figure 6: Ageing cannot be prevented, but frailty can be improved upon with the right evidence-based interventions.

In the next section we will appraise the evidence through the lens of Population Health Management and explore how this might be personalised to the individual.

2. Population Health Management of older people with frailty: Identification, segmentation, and evidence-based interventions

By the end of this section LCPs will... understand population health management and evidence-base for older people and use this as the outline of their Healthy Ageing Strategic Plan.

Key points:

- **Population health management** of older people involves three steps:
 1. Identify a group of individuals who may have undiagnosed frailty
 2. Segment the population based on frailty severity
 3. Offer evidence-based interventions for each segment, personalised to the individual.
- **Identification and segmentation:** There are many tools available to identify and segment the population. An in-depth critical appraisal for health and social care professionals is outlined in this section.
- **Evidence-based interventions:** There are a range of interventions that promote healthy ageing through prevention and modification of frailty.
 - **Frailty prevention:** Primary care, social prescribers, and the voluntary, community, and social enterprise (VCSE) sector all have key roles to play in preventing, reducing, or halting frailty and promoting healthy ageing.
 - **Older people with significant frailty:** A key intervention is a comprehensive geriatric assessment (CGA) with evidence for increased survival, health, independence, and a reduction in healthcare utilisation. CGA cycles should be embedded in all services that interact with older people and should follow three “I Steps”:
 - **I**nformation gathering stage
 - **I**ntervention stage
 - **I**nformation sharing. Care and support plans should be offered to the patient and (with consent) shared with health and social care providers in the locality

Target readership: This varies throughout the document (see each section).

2.1 An overview of Population Health Management

Target readership: Health and care professionals; local leads and commissioners; regional leads and strategic commissioners; interested citizens.

The previous section discussed the natural ageing process; how some individuals seem to “age faster”. It introduced the medical diagnosis of frailty; a state of reduced physiological reserve (or intrinsic capacity). Outcomes for older people with frailty are stark. Healthcare utilisation is high and increasing, and the presence of frailty influences the management of all other long-term conditions, as well as their wider health and social care needs. However, the trajectory of “accelerated ageing” that results in the spectrum of frailty (mild, moderate, severe) is potentially modifiable. Slowing these trajectories will allow older people in Devon to live longer and better.

Population Health Management (PHM) is a concept that has emerged over the recent years and is useful for improving the ageing trajectory and defining how systems can work better. PHM involves:

1. Identifying a population group at risk of adverse health outcomes
2. Segmenting that population
3. Offering evidence-based interventions to each population segment, personalised to the individual (based on the “I” statements outlined in appendix 1)

An example of Population Health Management is West Devon’s Integrated Care for Older People (iCOPE – see case study), detailed in the “plan on a page” below. Frailty identification for iCOPE is discussed in the next section and a more detailed analysis of interventions is in the case studies section, later in the document (Section 5).

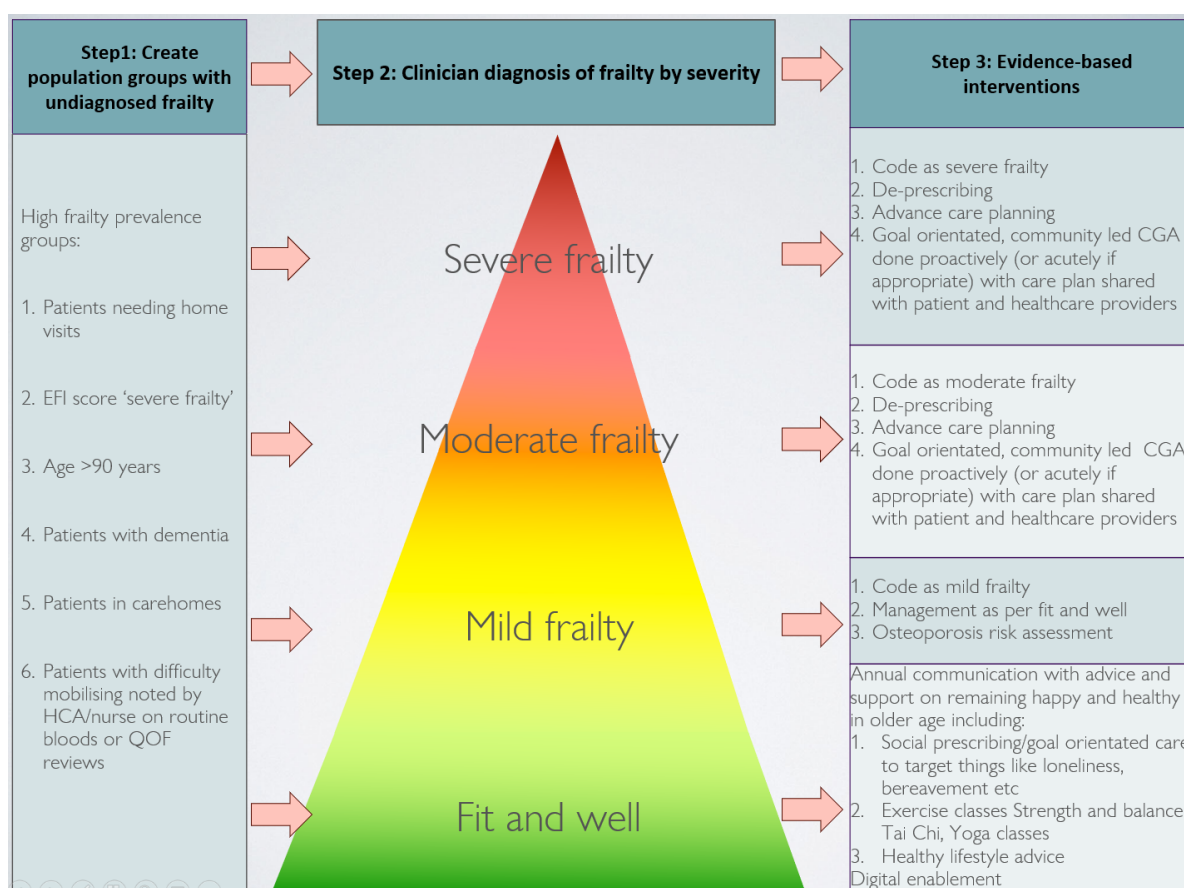


Figure 7: iCOPE “plan on a page” Population Health Management plan to support the healthy ageing of older people.

2.2 Identification and segmentation of older people with frailty: Analysis of available tools for the community

Target readership: Health and care professionals; local leads and commissioners; interested citizens.

The first step in any Population Health Management strategy is identifying frailty. Whilst any healthcare provider organisation can do this, primary care seems a particularly intuitive place to focus efforts. GPs have excellent longitudinal and clinical knowledge of their patients and see them when they are at their usual baseline. We will consider two different tools: The Pathfields Tool and the Electronic Frailty Index (eFI).^{10, 11}

The Pathfields Tool:

Practices in Western have chosen to use the Pathfields Tool to case-find frailty in their practice population.¹⁰ Built using primary care IT (EMIS and SystmOne), it creates a list of patients who are at high risk of having undiagnosed frailty (outlined in Step 1 of Figure 7 above). When saving the patient record of one of these patients, a clinician receives the following popup, inviting them to diagnose frailty by severity:

The screenshot displays the 'The Pathfields Tool' interface. At the top, it asks 'Does this person have reduced physiological reserve?'. Below this, there are four categories of frailty, each with a description and a corresponding icon:

- Not Frail:** Physiologically robust and functionally independent. Icon: A person walking.
- Mild Frailty:** Mildly reduced physiological reserve. Slowing up e.g. taking a long time to walk into your consultation room. Struggling with higher order activities eg transport. Icon: A person walking with a cane.
- Moderate Frailty:** Reduced physiological reserve with significant impact on function. Can do some personal care but help needed with bathing, cooking etc. Patient generally housebound. Icon: A person sitting in a chair.
- Severe Frailty:** Reduced physiological reserve with severe impact on function. Dependent on carers. Patient housebound or in care home. Icon: A person in a bed.

On the right side, there are four buttons labeled 'Click if not Frail', 'Click if Mild Frailty', 'Click if Moderate Frailty', and 'Click if Severe Frailty'. To the right of these buttons, there is a logo for 'Target Health Solutions' and 'Pathfields MEDICAL GROUP', and a logo for 'Sentinel Health & Wellbeing'. At the bottom of the form, there are buttons for 'Information', 'Print', 'Suspend', 'Ok', 'Cancel', and 'Show Incomplete Fields'.

Figure 8: Screenshot of Pathfields Tool in primary care IT (in this case SystmOne). A modified version of this is available for use in practices that use EMIS, the other primary care IT system used.

The tool invites the clinician to make a frailty assessment and diagnosis using the Rockwood clinical frailty scale, supplemented by the clinician's longitudinal and clinical knowledge of the patient.⁶ Once the patient is diagnosed, the software goes dormant for a year, allowing

systematic and opportunistic case-finding of frailty and the creation of a dynamic frailty register.

The Pathfields Tool was shown to have superior diagnostic accuracy compared with the current method advocated by NHS England (using the Electronic Frailty Index); 76% vs 47%.^{11,12} It has also been demonstrated to have a much lower false negative rate; for every five patients diagnosed with frailty using the Pathfields Tool, eFI would detect two patients and be falsely negative in the other three. The Pathfields Tool also identifies patients with mild frailty, allowing early intervention.^{9,10}

Feedback from GPs using the system was that it was time neutral and more accurate. Whilst the Pathfields Tool can be used on both primary care IT systems in Devon (EMIS and SystmOne), it is important to note that at this time of writing, a clinical safety case report has not been completed, meaning that practices that choose to use this tool do so at their own risk.

The Electronic Frailty Index (eFI):

The eFI is also integrated within SystmOne and EMIS. It analyses the patient record looking for 36 conditions based on 2000 read codes. Each condition counts as 1/36 points. The conditions are summed, then decimalised. Patients with an eFI score of 0.24-0.36 returns a score of “eFI moderate frailty” and a score of >0.36 scores “eFI severe frailty”.¹¹

Current practice is a two-step approach of 1) running a search of patients with eFI scores 0.24 or more and then 2) applying clinical judgement to determine if the patient has a diagnosis of frailty.

Clinician feedback reports that using eFI is time consuming, as it requires a GP to look at each patient’s records, to inform clinical judgement of the diagnosis. It has a high false negative and false positive rate.¹⁰

Ultimately it is down to LCPs to decide how they identify frailty in their area. Practices may choose to use the Pathfields Tool, continue using eFI, or may decide to build their own software that fires a prompt to offer a Rockwood Score upon saving the patient record.

2.3 Overview of evidence-based management of older people with frailty:

Target readership: Health and care professionals; local leads and commissioners; interested citizens.

Once the older population has been segmented by frailty severity in a locality, it falls to Local Care Partnerships (LCPs) to consider the planning and delivery of evidence-based services in their area. The document below *Living well in communities with frailty: evidence for what works* produced by Healthcare Improvement Scotland, encompasses a series of visuals looking at key interventions, strength of evidence, links to the evidence, and cost.¹³



lwic-frailty_evidenc
e-for-what-works_ju

A table of these and other evidence-based interventions is summarised below:

Frailty status	Evidence-based intervention
Not frail - mild frailty	• Behavioural change techniques • Lifestyle intervention • Good long term conditions management • Exercise interventions and physical activity
Mild frailty	• Nutritional interventions • Osteoporosis risk assessment*
Moderate frailty	• Nutrition interventions • Immunisation (COVID, influenza, pneumococcal vaccination) • Comprehensive Geriatric Assessment (CGA) with primary care and MDT, supported by community geriatrics, encompassing: ○ Patient goals ○ Long term conditions review ○ Polypharmacy review ○ Advance Care Planning ○ MDT assessment of function • Hospital-at-home • Reablement
Severe frailty	• Immunisation (COVID, influenza, pneumococcal vaccination) • Comprehensive Geriatric Assessment (CGA) with primary care and MDT, supported by community geriatrics, encompassing: ○ Patient goals ○ Long term conditions review ○ Polypharmacy review ○ Advance Care Planning ○ MDT assessment of function • Hospital-at-home • Bed-based intermediate care

Table 2: Evidence based interventions by tier of frailty

*Whilst there is little evidence to support a systematic osteoporosis risk assessment in mild frailty, this approach feels intuitive, as many patients with mild frailty could end up having falls in the future. It takes around a year for bone sparing agents to work so starting them early could reduce traumatic fractures and frailty progression at population level.

2.4 Interventions that promote healthy ageing and prevent frailty:

Low levels of physical activity, poor nutrition, social isolation, and poor mental health are strongly linked with the development of frailty.^{2,3,4} LCPs will therefore need to focus on prevention of frailty as part of their healthy ageing strategic plan. Personalised care and support planning using behavioural change techniques for older people have shown promise in a systematic review.¹⁴ Significant improvements in quality of life were noted when conversations took place concerning what mattered most to that person and their health and

wellbeing aspirations. Following this, support was built up around their strengths, their own networks, and resources (assets) available to them in the local community.

This is an area where social prescribers excel. They are trained in motivational interviewing and its application to personalised care and support planning as per the “I” statements in Appendix 1. They also have excellent local knowledge of VCSE providers in the community and how this might be harnessed to support the individual.

In addition, many older people can directly access VCSE organisations, offering them a source of social support, which may contribute to better health, wellbeing, and care outcomes.

To support healthy ageing through better personalised care and support, LCPs should engage with local VCSE and social prescribing organisations as part of developing their Healthy Ageing Strategic Plan. Examples of how this has been done successfully can be found in the case studies in Section 5.

2.5 The Comprehensive Geriatric Assessment (CGA): An overview

Target readership: Health and care professionals and local clinical leads; interested citizens.

A CGA, is a lifelong, cyclical assessment process for older people with moderate to severe frailty and aims to support older people in achieving their goals. Key components outlined below:

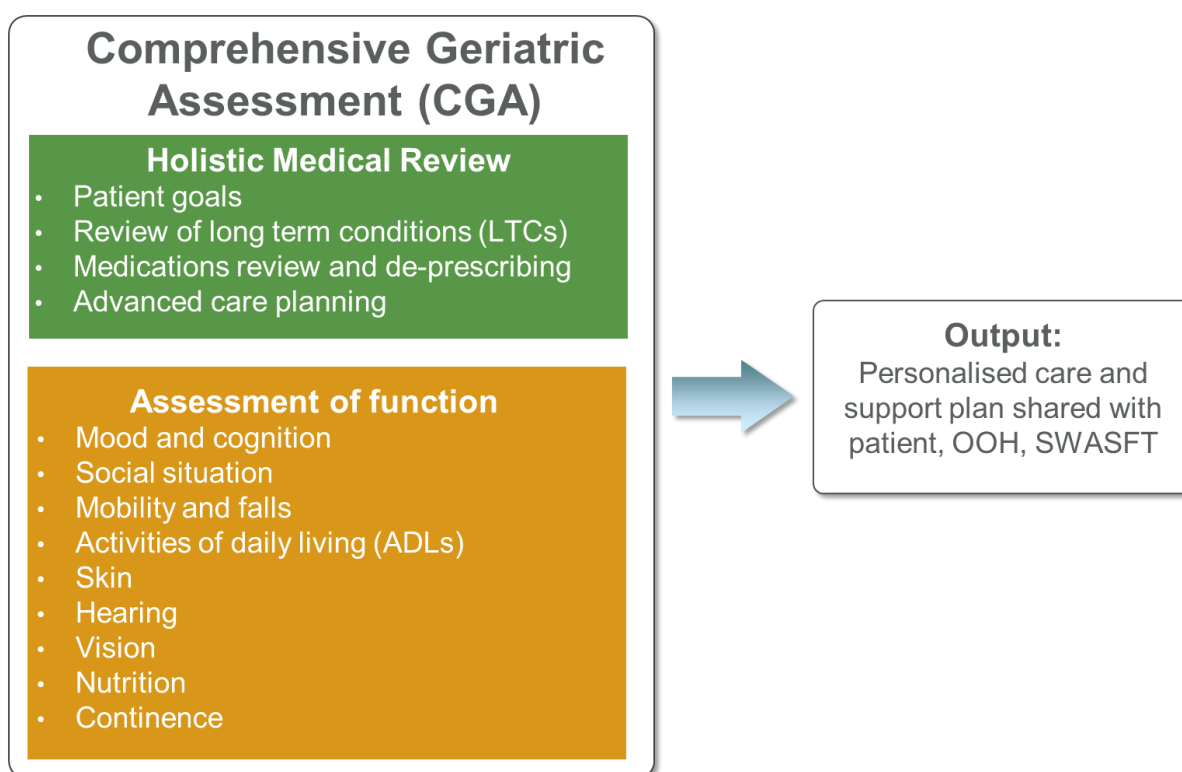


Figure 9: Key components in a Comprehensive Geriatric Assessment.

The CGA can be divided into the holistic medical review, which encompasses advance care planning conversations, medications and long-term conditions optimisation, and an MDT assessment of function. The composition of health and social care professionals in an MDT

needs to be adapted to the needs of the patient – To quote one geriatrician: “Not every older adult needs to see the whites of my eyes!”.

The assessment process needs time so that interventions and response can be monitored. As a result, the CGA process takes place asynchronously, with relevant professionals assessing different domains at different time, with central coordination from an MDT coordinator.

The output is a personalised care and support document, which should be shared with the patient and across all providers in the locality. This should be written in a manner the patient/family can understand and include the following:

1. Contact details (including emergency contact details)
2. GP surgery (and contact details) and other services involved
3. Past Medical History
4. Allergies
5. Drug History
6. Patient aspirations or goals
7. Functional status (“My situation”), once optimised, at the end of the CGA assessment process. This should be written against the key domains outlined in the functional assessment section in Figure 9.
8. Advance Care Planning preferences, which (if appropriate at the time) should include resuscitation status, hospitalisation preferences, emergency contacts including lasting power of attorney (LPA), preferences surrounding place of death, services currently involved, and anticipatory prescribing. As part of this process, patients should be offered a Treatment and Escalation Plan (TEP).

Guidance on personalised care and support planning can be found in Appendix 1.

A CGA cycle has three discrete “I” stages:

1. **Information gathering stage:** information is collected under each of the domain titles (see Figure 9), allowing problems to be viewed in their entirety. All domains are inextricably intertwined. The information gathering stage ends with the formulation of a problem list. Special note should be made of unpaid carers and their wellbeing, as they are an essential part of an older person's support network
2. **Intervention stage:** Once the problem list has been formulated, activities and interventions are planned against these areas. The aim is to optimise social support, physiology, wellbeing, and independence, so that an older person can achieve their goals.
3. **Information sharing stage:** this occurs at the end of a CGA cycle when an older person has achieved their goals or is on track to do so. A personalised care and support plan is generated (see above for format) and this is shared with the individual and organisations across the locality.

In 1-2 years time, or if the patient deteriorates, the CGA cycle re-commences.

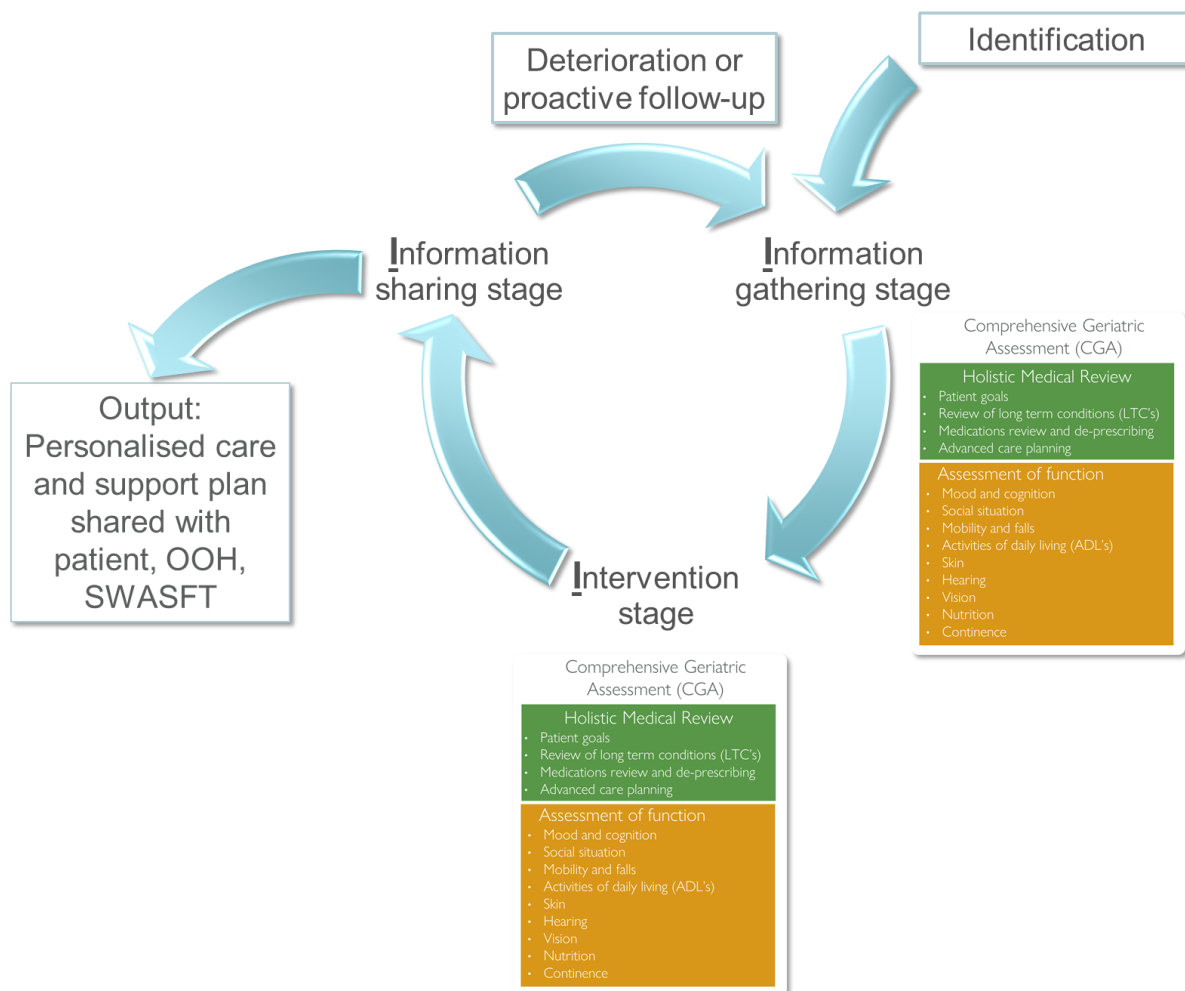


Figure 10: A CGA cycle with its three discrete stages

2.6 Comprehensive Geriatric Assessment: Evidence of effect

Target readership: health and care professionals and local clinical leads; interested citizens.

Meta-analysis demonstrated that CGAs performed during an acute hospital admission increased the likelihood of patients being alive and in their own homes 12 months later.¹⁵ A randomised control trial (RCT) comparing admissions avoidance home-based-CGAs (whilst under Acute Hospital-at-home care) with routine hospital admission demonstrated that older people were less likely to be living in long-term residential care at 6 months with the home-based-CGA intervention. It was also more cost effective.^{16,17}

There is a growing body of evidence for CGA in the community. A recent study performed in 1604 individuals in a primary care setting in Sweden showed a 17% relative risk reduction in unplanned hospital admissions and healthcare costs for those who had undergone a CGA, compared to those who had not.¹⁸ There is emerging data in Devon of a survival advantage from CGA and a reduction in unplanned admissions.

It seems clear that CGAs improve healthcare outcomes, quality of care, and health utilisation. LCPs should ensure that services working closely with older people should include CGA completion as part of their outcome improvement strategies.

3. Infrastructure needed to maximise high quality CGA output:

By the end of this section LCPs will be able to...

- Understand the importance of setting minimum standards for CGAs
- Explain which partner organisations will be responsible for delivering CGAs in proactive and acute settings in their Healthy Ageing Strategic Plan
- Explain how informational and relational continuity will be harnessed to enable seamless CGA delivery across partner organisations in their Healthy Ageing Strategic Plan
- Consider how the health and social care workforce may be upskilled and expanded in their Healthy Ageing Strategic Plan

Key points:

- **Minimum standards for CGAs:** All CGAs should follow three “I” Steps **AND** be delivered by an MDT
- **Proactive CGA delivery:** done in partnership by primary care and community services as part of EHCH and Anticipatory Care specification^{19,20}
- **Acute CGA delivery:** done in partnership by urgent crisis response, Virtual Wards, discharge to assess, and same day emergency care. An Urgent Visiting Service is vital for an early-in-day clinical evaluation.
- **Continuity** is essential to support this style of working and CGA delivery and there are two types:
 - **Informational continuity:** shared or highly interoperative IT. An options appraisal of current IT systems is needed, employing platforms which offer the best ability to:
 - Share information to enable CGA and MDT working.
 - Support service evaluation and a live-feed linked dataset to identify older people in crisis. This requires read code alignment
 - **Relational continuity:** LCPs should consider who will sit on an MDT, which provider organisation that health or social care professional will come from, and links between provider organisations to develop a “Team of multidisciplinary teams.”
- **Current and future workforce development:** LCPs should consider the best way to upskill their workforce and train a future workforce. Examples are included in this section.

Target readership: health and care professionals; local leads and commissioners; regional leads and strategic commissioners; interested citizens.

3.1 Improving CGA quality: Setting minimum standards for CGA

All LCPs should aim to have CGA embedded in all services that are heavily involved with older people. Examples include intermediate care, Virtual Wards, primary care, community services, and secondary care. CGAs will be delivered proactively in the case of primary care and community services, or more reactively in the case of intermediate care, Virtual Wards, and secondary care.

Minimum standards are needed for a CGA to be truly called a CGA. Firstly, it needs to be conducted by a multidisciplinary team (MDT). Secondly the CGA process should follow three “I” stages:

- **I**nformation gathering stage
- **I**ntervention stage
- **I**nformation sharing. Care and support plans should be offered to the patient, they should contain the information outlined in the previous section (as appropriate), and (with consent) shared with healthcare providers in the locality

If either these three steps are not taking place, or if an MDT review is not undertaken, then a CGA is not being delivered.

3.2 Settings for CGA delivery: Proactive CGAs

It is useful to consider the national and local specifications in Appendix 3 and 4, where there are contractual requirements regarding the delivery of CGAs.

All patients in care homes require a CGA and care and support plan as part of the Enhanced Health in Care Homes service specification.¹⁹ This needs to be jointly delivered between primary care networks (PCNs) and community service providers.

Older people with moderate-severe frailty who live in their own homes would also benefit equally from a CGA. LCPs should consider how they may extend this offering, under the anticipatory care national service specification.²⁰ Ideas for how to do this can be found in the case studies section.

3.3 Settings for CGA delivery: Urgent CGAs

This area is more complex, because an older person with frailty presenting in crisis needs a **same day CGA commenced and a plan to stabilise the situation by 5pm that day, or they may end up having an avoidable hospital admission**. Key milestones of this journey are outlined in the diagram below.

It is important to note that virtually all older people with frailty and in crisis will be too unwell to attend their GP surgery. This means that the first step in the journey is a morning home visit and clinical evaluation, to determine the cause of the crisis. This cannot wait until lunchtime, as by then half the day has been lost. All LCPs must have a morning home visiting service embedded within their urgent response services, unless serving a widespread rural population where it may not be feasible to implement one. Piloting of urgent visiting services have suggested a higher probability of a same day discharge.²¹ This is discussed further in the case studies section (South locality).

Following evaluation, there will be four outcomes:

- **Crisis support not needed:** Manage in primary care
- **Crisis support needed:** Can be managed in the community with support from Urgent Crisis Response (UCR) or Virtual Wards (VW)
- **Diagnostic exclusion cohort:** Crisis present, but same day emergency care (SDEC) is needed to access secondary care diagnostics and expertise, prior to onward management in UCR and VW. Prompt conveyance is needed to enable this to happen (see Section 6.8 for further information)
- **Needs hospital:** Life threatening or serious medical condition present, requiring inpatient treatment. Once the person is medically stable for discharge, they can be transferred to a “discharge to assess” (D2A) service.

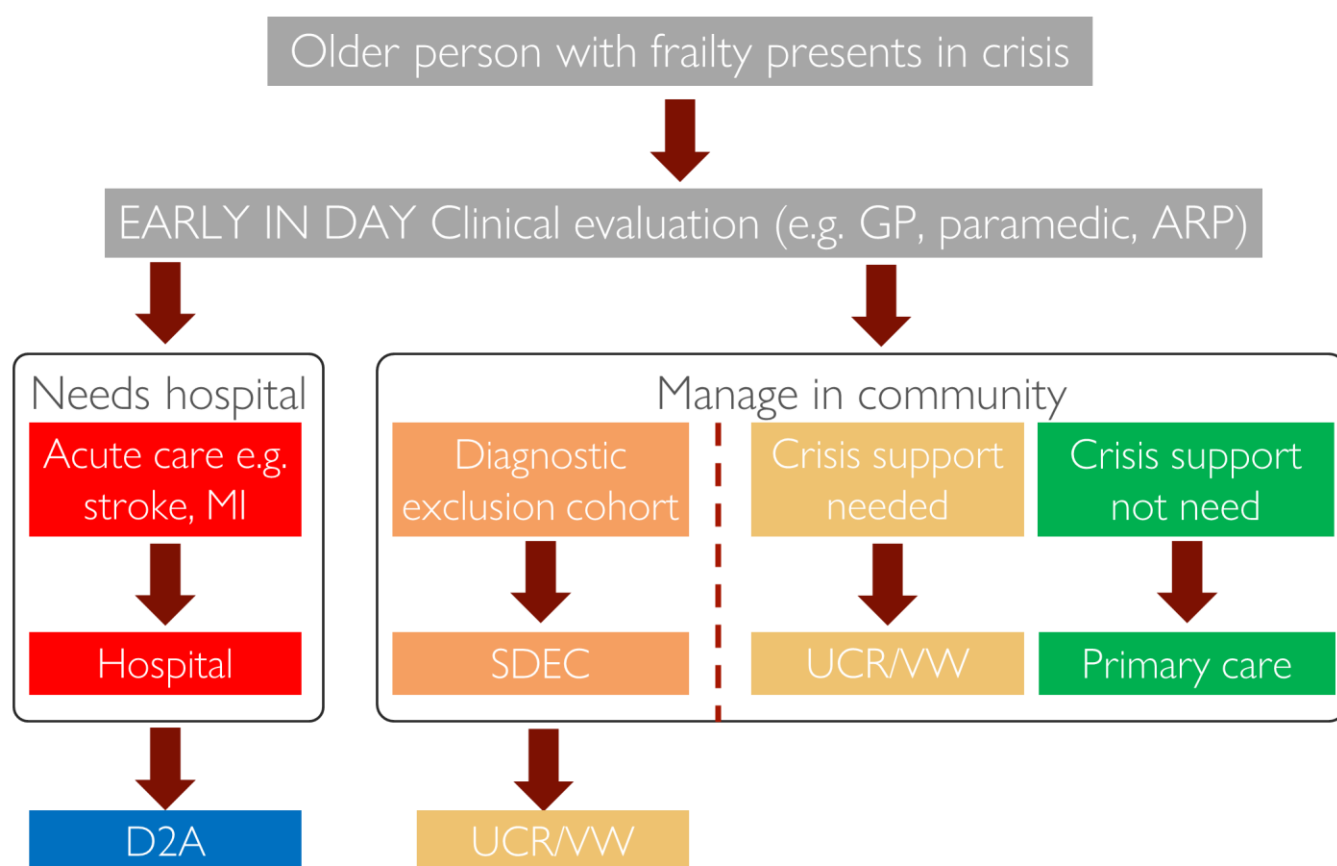


Figure 12: Key milestones needed to evaluate and stabilise and older person in crisis.

Abbreviations: ARP – acute response practitioner; UCR - urgent community response; VW – Virtual Wards; SDEC – same day emergency care; MI – myocardial infarction or “heart attack”; D2A – discharge to assess.

In terms of CGA delivery, if crisis support is not needed, the patient will enter a proactive CGA cycle as per section 3.2. If crisis support is needed UCR could deliver the CGA, liaising with healthcare professionals at VW/SDEC, as indicated. If a hospital admission is required, the acute CGA is commenced as an inpatient and further cycles undertaken by the D2A team, as required, during the recovery phase.

The exact governance for coordinating this process can be decided at locality level. The most important outcome is the increased quality and quantity of CGAs.

National standards exist for UCR and VW.^{22, 23} These will not be elaborated on now, other than to say that LCPs working within these areas will need to comply with the national standards (see Appendix 3 for details).

The activities of SDEC for frailty have been partially defined by national guidance, but their primary purpose has not.²⁴ The authors and contributors of this document are clear that the purpose of SDEC for frailty is to:

- Avoid the need to admit a patient by excluding serious medical diagnoses
- Start the CGA process and ensure that it is handed over to an appropriate service to complete if this is required.

A case study on SDEC can be found in Section 5.

To summarise, in a crisis situation, a CGA needs to take place acutely. This requires the following services in each locality:

- Urgent Visiting Service (UVS)
- UCR
- Virtual Wards
- SDEC
- D2A
- Social care

All services will need to be closely integrated with each other, as well as with other healthcare providers, such as the ambulance service, primary care, social care, and hospitals.

3.4 Delivering CGA across provider organisations: Infrastructure needed for continuity of care

In both proactive and urgent settings, one service working alone can seldom deliver a full CGA cycle. For example, an acute trust can start the CGA cycle, but it needs completing in the community by another provider once the patient has fully recovered. Care must be seamless as the patient moves between providers, akin to the Buurtzorg model of care.²⁵ There are two types of continuity, **informational continuity**, and **relational continuity**. These are discussed below.

3.4.1 Informational continuity:

Shared/highly interoperable IT is an essential ingredient of the CGA process, increasing quality and output. LCPs should undertake an options appraisal of current IT systems, selecting those which offer the highest ability to share information, to enable CGA and MDT working.

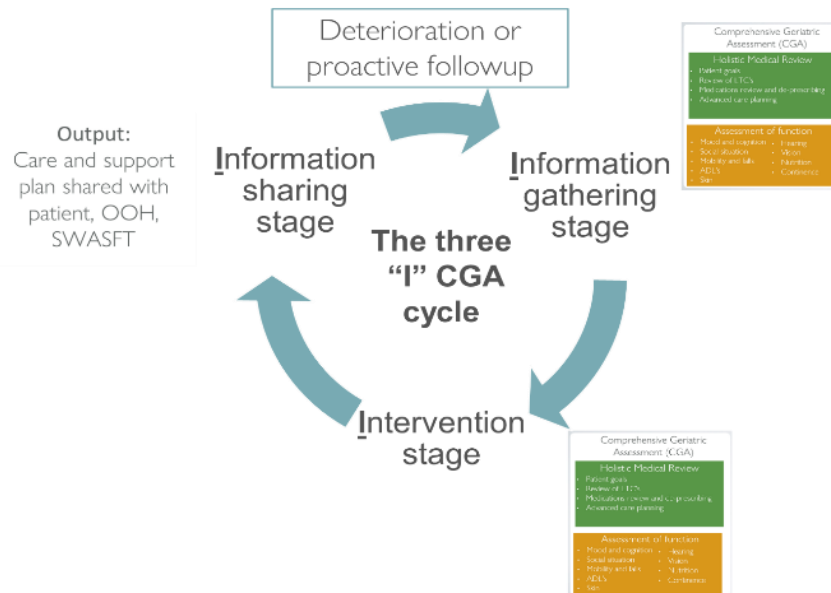
In addition, LCPs will need to ensure they have the appropriate information governance processes in place for safe information sharing across providers for the purposes of direct care and risk stratification.

The advantages for the CGA process are outlined below:

Shared IT as an enabler in the information sharing stage: If a patient slips into crisis, the full picture is instantly available to all teams involved. Having the care and support plan shared with all providers will speed up the 2nd CGA cycle when the time comes.

Shared IT as an enabler in the information gathering stage: Gathering information from the patients and family takes 1-2 hours.

Shared IT allows parts of the CGA process completed by teams in other providers to be brought together and synthesised into a new CGA cycle, increasing quality and quantity of CGAs.



Shared IT as an enabler in the intervention stage: Information from different health and care organisations is available to the MDT allowing triangulation of information and better decisions to be made.

Having a combined patient record, shared by health and care professionals from different organisations, offers additional advantages: A single record and single assessment document can be created and professionals from different organisations can send information to each other by task. This makes efficient coordination of activity possible.

Lastly, some IT platforms can be customised to allow IT-assisted prompting and decision-support to ensure that all domains of the CGA are completed to a consistent standard.

Figure 11: The value of shared or highly interoperable IT in enabling a 3 "I" CGA cycle.

There are two other key areas where IT is essential:

- **Service evaluation**
- **Development of a "live-feed" linked dataset to identify patients that slip into crisis:** When older people with frailty go into crisis, a crescendo of patient contacts

are created across the system. However, some parts of the system may be blind to this, e.g., Primary care may not know about a crisis and cannot mobilise the required infrastructure if an older person has multiple ambulance and out-of-hour GP contacts.

This is covered further in Section 6, under the IT gap analysis. For now, it's important to understand that both processes are driven by read codes and uniformity of read coding is needed Devonwide.

3.4.2 Relational continuity:

Having the same healthcare professionals on an MDT enables trusted relationships to form, which drive tighter integration between services. LCPs should consider who will sit on an MDT, which provider organisation each healthcare professional will come from, and work to build links between provider organisations, ultimately developing a “team of multidisciplinary teams.”

3.5 Current and future health care workforce development:

There is a workload-workforce-skills mismatch in the UK. Currently the only medical professionals that have received formal training in leading and coordinating CGA are geriatricians and a handful of consultant practitioners from non-medical positions. They predominantly work in acute trusts. The Primary Care Network DES for enhanced health in care homes and community services two-hour urgent community response standards requires a cadre of community-based professionals to deliver CGAs.^{19, 22} However, this workforce has received little training or development to date.

In Devon, there is a growing need to upskill the existing workforce and train a large cadre of advanced practitioners (nurses, paramedics, and AHPs) who specialise in frailty, can coordinate CGA cycles, and can undertake clinical evaluations.

The best people to provide this training are community geriatricians, GPwSI older people, and the small number of existing consultant practitioners. Each PCN and MDT should have access to a link specialist from this above list. In addition to providing direct care, they will have dedicated sessional time spent in the community, upskilling the existing workforce and training the future workforce, particularly in the advance clinical practitioner role.

Work on this has been undertaken between primary care and community geriatricians in the Western locality, looking at offering two sessions of geriatrician time per 30,000 PCN list size, in addition to current community geriatrics workload. In Western, this would require a minimum of six whole time equivalent geriatricians, or similarly qualified healthcare professionals. In addition to upskilling the workforce, 6 WTE geriatricians could train in two years:

- 9 Advanced clinical practitioners
- 12 non-medical prescribers
- 6 GPwSI older people.

They would also be able to:

- Support GP VTS training
- Support 2 Geriatric Medicine specialty registrars
- Support undergraduate and foundation year medical training.

Growing and upskilling Devon's workforce will futureproof it, as our population continues to age.

3.6 Current and future social care workforce development:

Ensuring that the right social care is available, at the right time and in the right place, is the cornerstone of management of older people, families, and communities. The social care workforce is central to delivering that care, but also achieves wider outcomes, such as improved population health, wellbeing, and prosperity. All LCPs must strive to provide outstanding levels of social care.

However, social care is in crisis and urgent action is needed.²⁶ Five key actions for LCPs are outlined below:

1. **Reward:** Devon is completing the Fair Cost of Care exercise, a comparative investigation into the pay and conditions of the Independent Sector workforce.²⁷ It should be completed later this year. Other rewards include better working hours, more flexible working, consideration of study leave for training, improved annual leave processes, discounts, and other benefits.
2. **Recognition:** Feeling valued and receiving recognition leads to a social care workforce that are more motivated to deliver the best outcomes for those in their care. This will improve recruitment and retention. Examples of this might include:
 - a. **Healthy Ageing Strategic Plans** designed by LCPs to include VCSE and social care providers, along with these facilitating the market, from the outset.
 - b. **Better engagement with healthcare:** Examples might include closer links with GP surgeries (hotlines, alignment of providers to PCNs) to enable trusted relationships to form, where care workers feel part of the decision-making process. Better engagement is listed in the *High Impact Change model* and improves health and wellbeing outcomes.²⁸
3. **Skills and career pathway development:** Training carers will allow skills mixing between health and social care, which can improve capacity, capability, and patient care. Examples might include recording vital signs, weights for heart failure monitoring, wound care, use of equipment (so that double-handed packages of care can be reviewed and stepped down), recognition of some of the more subtle signs of older people who are in crisis (e.g., hypoactive delirium), enabling early intervention. Training and career progression also improve recruitment and retention
4. **Innovation:** LCPs should consider prototype hubs for how they might pilot better collaborative working.
5. **Digital and technology:** Upskilling in enabling technology e.g., remote vital sign recording, and use of video/photo apps will allow carers to act as the eyes and ears of health and care professionals in community services and primary care.

Case studies on the above are discussed in Section 5. LCPs can see how to gap analyse their social care workforce in Section 6.3.

4. How to evaluate a Population Health Management plan for older people

By the end of this section LCPs will be able to...

- Explain in their Healthy Ageing Strategic Plans, which outcome measures they will use for evaluation, explain how a linked dataset will enable this and discuss plans for operationalising a linked dataset.

Key points:

Each population segment needs to be evaluated in five key areas:

- Patient/client/carer satisfaction
- Staff satisfaction
- Population health
- Healthcare utilisation
- Carbon footprint.

All matter equally.

LCPs may want to create a linked dataset to support these outcomes.

Target audience: health and care professionals; local leads and commissioners; regional leads and strategic commissioners; interested citizens.

There are lots of ways to evaluate a service. It is vital to set aims as this will dictate the outcome and process measures used. If we take the frailty spectrum as a construct, it soon becomes apparent that outcomes for older people with mild frailty are very different to those for older people with severe frailty. The outcome measures therefore also need to be adapted accordingly.

Aims can be grouped under five headings:

- Patient satisfaction
- Staff satisfaction
- Population health
- Health and care utilisation
- Carbon footprint

In the future we will consult on a 6th aim, reduction in health inequalities and how this might be measured. **All outcomes matter equally.**

Process measures can also be used in evaluation, as they demonstrate quality of care. Two examples are CGA and personalised care and support planning; both interventions have the dual advantage of improving quality of care and offering better outcomes.

An example evaluation matrix, with a non-exhaustive list of outcome measures, are shown below. The carbon footprint calculator can be accessed via this link: <https://shcpathways.org/full-calculator/>.

Population tier	Six aims being measured	Activity to deliver outcome	Evaluation
Not frail	Patient satisfaction	Annual communication and appropriate signposting	Global quality of life (GQOL) scale before and after annual communication
	Staff satisfaction	NA	
	Population health	Attainment of good population health metrics	QOF Number of patients not frail and mild frailty provided with an annual communication
	Health and care utilisation	NA	Number of 65+ year olds seeing a social prescriber
	Address healthcare inequalities	Identification of people in fuel poverty	
	Carbon footprint	NA	
Mild frailty	Patient satisfaction	Annual communication and appropriate signposting	GQOL scale before and after annual communication
	Staff satisfaction	NA	
	Population health	Number of patients with mild frailty who have been screened for osteoporosis Offer referral to social prescriber Offer referral to falls/exercise class	Denominator: Patients with mild frailty Numerators: Annual communication Offer of a referral to social prescriber Offer of a referral to falls/exercise class FRAX score within last 1-2 years Number on osteoporosis register (and number on medications for osteoporosis, if indicated)
	Health and care utilisation	Hip fracture prevalence Fragility fractures prevalence	Linked dataset with Derriford hospital, comparing hip fracture prevalence before and after and with current national average
	Address healthcare inequalities	Identification of people in fuel poverty	
	Carbon footprint	Carbon footprint of hip fractures	Enter hip fracture data into carbon calculator
Moderate and severe frailty	Patient satisfaction	Delivery of a goal orientated CGA	Patient and family feedback Random case analysis of CGAs looking at how many patients achieved their goals Number of patients with personalised care and support plans
	Staff satisfaction		Semi-structured interviews of staff delivering CGAs? Staff written feedback
	Population health	Delivery of a goal orientated CGA	Denominator: patients with mod-severe frailty and those in care homes Numerator: Number of CGAs Number of SMRs Prevalence of key high-risk medication in older people Number of patients with personalised care and support plans shared with locality (OOH GP, SCR etc) Advance Care Planning: Number of patients with a resus decision Advance Care Planning: Number of patients with a hospital admission decision documented
	Health and care utilisation		Hospitalisation data: admissions, LOS, unplanned bed days, cost of care
	Address healthcare inequalities		
	Carbon footprint	Carbon footprint calculator	Number of journeys by ambulance Number of A&E attendances Number of unplanned bed days

Table 3: Sample evaluation matrix for a Population Health Management strategy.

LCPs should consider developing a linked dataset, where they synchronise their frailty register with healthcare metrics such as ambulance, A&E, and admissions data. As well as

supporting evaluation, it also identifies patients in crisis, who might benefit from an urgent CGA.

5. Case studies of Population Health Management of older people in Devon:

By the end of this section LCPs will be able to...

- Understand the value of a blended approach to proactive and urgent care and ensure that the right balance of both is in their Healthy Ageing Strategic Plans.

Key points:

- Each locality has a good example of how they have improved the care of older people
- Two localities adopted a proactive approach. The data shows that by improving health they have reduced admissions
- Two localities adopted an urgent care approach. The data shows that they didn't reduce admissions but did reduce length of stay.
- Each locality needs a blended approach of proactive and urgent care to enable healthy ageing and reduce healthcare utilisation.

Target readership: health and care professionals; local leads and commissioners; interested citizens.

In the previous section we discussed some of the components of a high-quality health and care service, which enables healthy ageing. In this section we will look at how these components have been combined into models of care, with case studies from each locality.

Case study 1: Innovation in social care. Improving capacity, capability, and workforce across Devon.

In addition to completing the Fair Cost of Care exercise, there are numerous other developments in social care which are outlined below.²⁷

The Coastal Community Health and Social Care Team: Optimal care using a single-handed care approach:

The Coastal Community Health and Social Care Team identified that many adults who had two carers attending in a visit ("double-handed" care), could transition to one carer attending ("single-handed" care) with the right equipment and safe moving and handling practices.

Employing a person-centred, strengths-based approach the team reviewed the care and support for adults receiving double handed care and did the following:

- **Joint holistic assessments with health and social care:** working together with occupational therapists and their local social care hub (Care Direct Plus), they carried out holistic moving and handling assessments

- **Training and skills-mixing:** Elizabeth Martin (Occupational Therapist and local training provider) worked collaboratively to develop training in single-handed care approaches, which was piloted with a small number of care providers.

The outcomes from the pilot were:

- **Improved client satisfaction** because of the independence gained through this strengths-based, person-centred approach to care and support planning.
- **Improved carer satisfaction:** Through the delivery of training which has received positive feedback
- **Improved care and support capacity:** By providing care and support that is proportionate to client needs.

As a result, the Coastal team have set up a moving and handling forum for local care providers, with advice and information from Occupational Therapists. Devon County Council is currently exploring wider delivery of training in single-handed care approaches.

Addressing the “2-4” gap:

Currently domiciliary care agencies have shift patterns of 0700-1400 and 1600-2200. Domiciliary care providers feel that this work pattern makes the job less flexible and reduces recruitment and retention. Meanwhile, community services are also struggling with maintaining an adequate workforce to meet their workloads. There are opportunities for community services to enter into arrangements with domiciliary care (and potentially staff in care homes), subcontracting certain clinical activities to them, and upskilling through training. For social care, this would address the “2-4 gap”, offering more flexibility for carers and making the job more attractive. For community services, this would help to address workforce shortfall. Areas ripe for skills mixing might include:

- **Wound care and medications administration:** Around 30% of a district nurses (DN) work might involve visits for minor pressures sores, giving insulin, wound care and simple first aid. Upskilling carers to perform these activities and using digital technologies (such as the Healthy IO app for wound care) would improve DN capacity
- **Reablement and home exercise:** Therapists could reduce their visits by upskilling carers to undertake home exercises with clients. Use of video technology could also improve capacity
- **Recognition of sick patients:** Care workers could be upskilled in the taking of vital signs and recognition of when an older adult is unwell, through the use training programmes such as RESTORE2. This could be further supported with remote monitoring technology, allowing a prompt response if a patient becomes unwell.
- **Improved links between community services, primary care, and domiciliary care:** The Enhanced Health in Care Homes (EHCH) service specification has enabled better links with PCNs and trusted relationships have flourished, improving patient care. It seems logical that this care model could be extended to domiciliary care, with direct lines to GPs and duty community services, alongside better integrated digital technology.

This is an area that is ripe for development and exploratory scoping pilots are currently underway.

Innovation: “Live Lab” pilot in Exmouth/WEB health and care system:

A “Live Lab” was created in September 2022, to better understand how the health and social care workforce can work more collaboratively. In the medium term it hopes to do the following:

- **Employers panel** working collaboratively with social care employers, exploring ways of making the social care workforce feel more valued through recognition and reward (including pay)
- **Advocating for care workers** LiveLab have created a care workers forum, which is the public voice of the care worker and a source of wellbeing and support
- **Test bed** for joint working, skills-mixing between health and social care and development of digital technology

Case study 2: Proactive care in North Devon: Fuel poverty, Older Person's Integrated Care (OPIC) teams, Healthy Ageing in Northern Devon (HAND), Reconditioning Initiative and more.

North Devon has taken a proactive, upstream, and collaborative approach to improving care for older people. Key areas include:

Fuel poverty programme:

Fuel poverty is linked to adverse health outcomes such as respiratory and cardiovascular disease. Many patients from a socially deprived background will also have co-existing frailty. A linked dataset was created that allowed people at risk of fuel poverty to be targeted for a home energy assessment by a private provider. The results showed estimated savings of £821 per client. Further details are below:



NPCCB report - Fuel Poverty Programme.

Proactive care for people living in care homes and those who are housebound with frailty:

Older Person's Integrated Care (OPIC) teams deliver holistic, proactive care, with personalised care and support planning for people living in care homes and those who are housebound. Key features include:

- Long term condition management
- MDT input
- An Urgent Visiting Service (UVS)
- Links to other professionals such as the community therapies team who also run strength and balance classes.

Healthy Ageing in Northern Devon (HAND):

The HAND group is comprised of older people, healthcare professionals, and VCSE sector who co-design a joined-up offer of care and support to older people in Northern Devon. The aims are to delay frailty and to support older people to remain active and independent with a good quality of life. HAND has recently procured funding to run the evidence-based FaME strength and balance programme. HAND has also funded nine community activity projects for older people. Through collaborative work with the VCSE, HAND has improved wellbeing by addressing social isolation for a number of older people. These are factors that may lead to a reduction in the use of stretched NHS care services. Please click [here](#) for evaluation and video reports of the community activity projects:



Reconditioning Initiative: This project aimed at increasing activity in residents in care homes by improving physical activity (reconditioning). Care homes received visits from an Activity Facilitator, who engaged with residents, family and staff, providing education, signposting and personalised exercise programmes. Care homes could also apply for funding to purchase equipment and to access programmes that increase physical of residents in care homes (further details in link above).

Settle and Support at Home volunteer service: A Settle and Support volunteer in One Northern Devon helps with settling into home after discharge; putting the heating on, making a cup of tea, and doing the first shop, to make sure there is food at home. They can also organise for a one-off prescription collection. Volunteers can do up to three visits or phone calls and they also make sure that people who have been recently discharged are connected to other VCSE organisations in the community.

Evidence from similar pilots showed that older people recently discharged from hospital felt more confident and happier, with improved levels of social contact and better health. This translated into a 6% absolute reduction in 30-day readmission.²⁹

Case study 3: South Devon: Enhanced Intermediate Care (EIC) and Urgent Visiting Service (UVS). An example of urgent care for older people.

Enhanced Intermediate Care:

Torbay and South Devon NHS Foundation Trust, an Integrated Care Organisation (ICO), re-designed its Intermediate Care (IC) services to manage more complex, older patients in the community, also striving to facilitate earlier hospital discharge and reduce admissions from the community. The “Enhanced” IC service (EIC) employed GPs, pharmacists, and the voluntary sector to work with social and community services (the traditional model), in locality ‘hubs’. It was assumed that the EIC would deliver a more strengths-based, person-centred, coordinated care (PCCC) offering, which would be delivered ‘closer to home’, whilst also reducing system demand and costs.³⁰

Another key advantage of EIC was the referral process. A single point of contact existed, which health and care professionals and patients could access

Enhancing IC through greater acute, primary care, and voluntary sector integration can lead to more complex, older patients being managed in the community, with modest impacts on service efficiency, system activity, and notional costs.³⁰

Urgent Visiting Service (UVS):

In March 2017, South Devon piloted a UVS in the Newton Abbot locality.²¹ Patients who were housebound with significant frailty, and were calling in crisis for a home visit, were referred by their GP surgeries to a locality wide UVS if they had the following presentations:

- Shortness of breath
- Abdo pain
- New/worsening falls/mobility issues
- New/worsening incontinence
- New/worsening confusion
- Clinician judgement of the need for an urgent visit.

During this four-day pilot, 118 requests for a home visit were triaged by GPs in the locality, of which 14 had the presentations above and were referred to the Urgent Visiting Service. Following their UVS review, four were transferred to hospital (conveyance rate across locality 3.04%). All patients who would have been admitted were captured by the UVS.

The mean arrival time in secondary care was 12:44, instead of late afternoon, meaning that patients had a higher probability of same day discharge. If an admission was needed, their earlier arrival meant that they had to wait less time for definitive treatment (e.g., for sepsis).²¹

Further information can be found below:



ambulatory care for
frailty (2).pdf

Case study 4: Proactive care in West Devon: Integrated Care for older people (iCOPE).

The iCOPE model of care in Western takes a Population Health Management approach, focussing on proactive care. It outlines how to identify, segment, and manage each population segment, based on current evidence. The “plan on a page” can be found in Section 2, Figure 7.

Frailty case-finding was systematised using the Pathfields tool and a dynamic frailty register created in each practice. PCNs sent a birthday card to all 65+ year olds who were not frail or who had mild frailty. The card used motivational interviewing by performing the following activity:

1. Rate overall quality of life using the Global Quality of Life Scale
2. Reflect on why they gave themselves this score
3. What would it take to improve a score by 10, 20, even 50 points? What key personal goals may act as this measure?
4. Support needs

Following this activity, the card signposts to social prescribers, local voluntary sector groups, as well as other lifestyle interventions (physical activity, diet, remaining socially connected etc.). The card was co-designed with older people.

Patients with mild frailty were offered a bone health assessment and were started on bone sparing agents if they had osteoporosis.

When managing patients with moderate-severe frailty, PCNs and community services pooled their staff to offer Ageing Well MDTs which offered proactive three-step CGAs to older people with moderate-severe frailty, in their own homes. This complemented the current work offering CGA to older people in care homes (as part of the primary care enhanced health in

care homes contract¹⁹) and ensured that this entire population segment could be offered equity of care.

The locality is now evaluating how CGA output might be increased in urgent care settings, such as intermediate care. The service specification can be found below:



iCOPE Service
Specification (1).pdf

Case study 5: East Devon: Same Day Emergency Care (SDEC) and falls prevention with the VCSE

Same Day Emergency Care (SDEC) with Virtual Wards:

East locality provides a highly evolved same day emergency care strategy at the Royal Devon University Healthcare NHS Foundation Trust (RDUH), with a Virtual Ward aligned to it.

A key feature of SDEC is excluding the need to admit and maintaining the expectation that patients will be discharged home that day. As a result, patients are managed in chairs. There are SDEC pathways for a variety of presentations, such as syncope, SVT, chest pain, heart failure, COPD, palliative care emergencies, and frailty.

Patients are referred to a single point of contact, which is staffed by a band 7 nurse. The nurse takes the referral and refers into the appropriate pathway and service.

SDEC is kept separate from ambulatory care, which is used to follow-up patients seen by SDEC. Patients who need further monitoring are discharged home, but remain part of a “Virtual Ward”, with appropriate staffing available to provide home visits and deliver inpatient-equivalent care. For example, they have the capacity to give IV antibiotics and provide wearable remote monitoring. Patients are then followed up in ambulatory care, as required.

This process makes it much easier to discharge than admit patients. Since inception, there have been no serious incidents. Patient surveys demonstrate high levels of satisfaction.

Falls prevention with the VCSE:

The Eastern locality has a high population of residents aged 65+ compared to the national average of 18.5%³¹. They analysed the number of emergency admissions for falls within these age groups for the locality. Approximately 95% of all hip fractures were caused by falls.³² Therefore, they also included emergency admissions due to hip fractures.

The results are below:

	Population age 65+	Age group	Emergency admission due to falls*	Emergency admission due to hip fracture*
Exeter	21,303 (16%)	65-79	928	265
		80+	4305	1460
East Devon	45,104 (30.5%)	65-79	597	207
		80+	4105	1352
Mid Devon	19,760 (23.7%)	65-79	582	200
		80+	4632	1240

Table 4: Population demographics and emergency admissions due to falls.

*Directly standardised rate – per 100,000

These findings led to the decision to focus on falls prevention. Using a Population Health Management (PHM) approach, a steering group was formed, linking NHS Devon with other statutory and voluntary sector organisations. This group then planned spending on a falls prevention program, with the following outcomes:

- **Employment of a Falls Prevention Clinical Practitioner:** To deliver falls prevention training to care homes, care agencies, the emergency services and the voluntary sector. They also work with occupational therapists and falls champions to deliver the service.
- **Steady on Your Feet Devon:** This is a Devon-wide on-line resource, with an accompanying App to follow. It offers advice on preventing the most common causes of falls, also offering a self-assessment tool for falls risk. It directs individuals to relevant resources and organisations, is free to use, does not require a log in, and is available to everyone ([Welcome to Steady on Your Feet Devon](#))
- **Strength and Balance Classes (using FaME):**³³ In conjunction with the VCSE and local leisure facilities, a program of strength and balance classes is being rolled out in Eastern Devon, with plans to expand throughout the region.

Individuals can be referred by healthcare professionals or can self-refer to the program. There are six weekly free sessions, which can be extended by another eighteen weeks at reduced cost, to encourage participants to continue. Instructors are currently being trained to run these sessions which are due to start in November 2022.

The classes are being carried out in conjunction with Exeter University, who are supporting evaluation of the program.

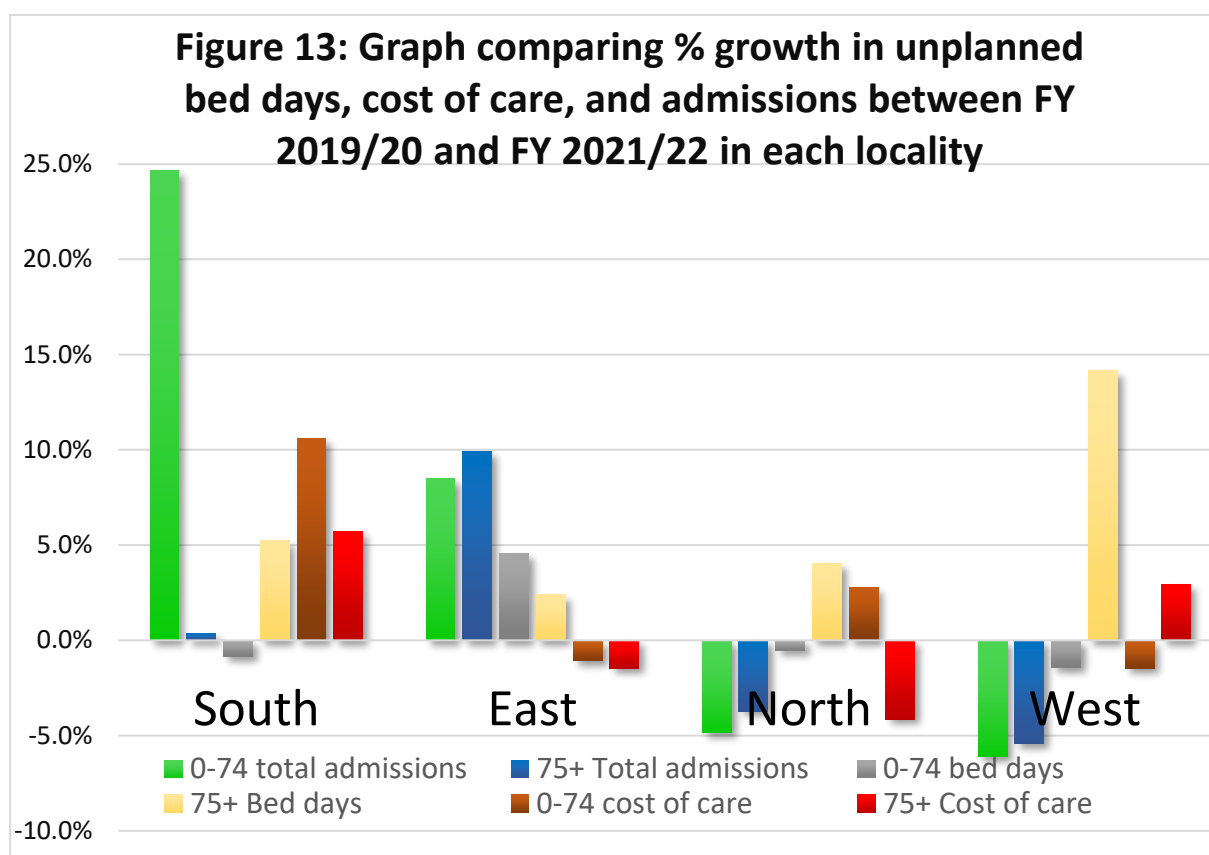
5.1 Are these different approaches affecting healthcare utilisation?

Target readership: health and care professionals; local leads and commissioners; regional leaders and commissioners

Two localities, North and West, have predominantly followed a proactive and preventative approach, aiming to keep people well and reducing predisposing risk factors for slipping into crisis. East and South focussed on urgent care, particularly same day ambulatory care and intermediate care capability. This distinction is important when considering healthcare utilisation:

- An effective proactive approach should result in less people becoming unwell. There should be a reduction in total unplanned admissions
- An effective urgent care approach will not halt admissions. However, if working well, should result in fewer hospital bed days.
- The total cost of care is based on the cost per bed day. These costs will be best reduced by the employment of a combination of both approaches.

The graph below compares growth in admissions, unplanned bed days, and cost of care in patients aged 0-74 and 75+ (where frailty prevalence is at 73%), across the four localities in Devon (financial years 2019/20-2021/22):⁷



The results are clearly contrasted. The proactive approaches followed in the North and West localities have resulted in a reduction in total admissions across all age ranges. This may be because interventions in both localities have been targeting people in the 65-75 age range, as well as 75+. The Northern locality has seen the largest reduction in cost of care for people aged 75 or older (4.1%), probably due to the reduction in admissions and only a modest rise in unplanned bed days in this cohort. Whilst Western saw the largest reduction in hospital admissions (0-75, 6.1%; 75+ 5.4%), the patients that were admitted had a higher number of unplanned bed days and savings were not realised. This suggests that Western may benefit from expanding its same day emergency care and admission avoidance capabilities.

In the South and East regions, who pursued an urgent care approach, South saw the largest rise in cost. This is due to surge in admissions in the 0-74-year age group (25%) and an increase in the number of unplanned bed days for 75+ year olds. East locality saw a similar rise in admissions (0-74, 6%; 75+, 10%), but has a highly evolved ambulatory care service closely integrated Virtual Ward and intermediate care, leading to fewer unplanned bed days. Of all localities, they achieved the largest proportional reduction in cost of care, when factoring in the number of admissions, as the admissions were able to be discharged home sooner.

In conclusion, the evidence suggests that a proactive approach reduces total unplanned admissions, whilst an urgent care approach reduces unplanned bed days. Combining both approaches in each locality will have the greatest synergistic benefit. Each local care partnership (LCP) will need to conduct an analysis of services and workforce to address the gaps in their services.

6. Next steps for Devon and Local Care Partnerships: Building your Population Health Management plan for older people

By the end of this section LCPs will be able to...

- Use the healthy ageing commissioning checklist (see embedded document below) to support the design of their healthy ageing strategic plan
- Perform a gap analysis of workforce, systems and processes in health, social care, social prescribing and VCSE partner organisations, using the methodology outlined below
- Outline plans to overcome these issues in their Healthy Ageing Strategic Plans
- Demonstrate how their plan is aligned to local national commissioning priorities.

Key points:

There is suggested methodology for performing a gap analysis in the following areas:

- Upskilling and training the workforce
- Information governance
- IT capabilities
- Social care
- Intermediate care
- Virtual Wards
- Proactive care of older people in their own homes (Anticipatory Care)
- Urgent visiting service
- Same day emergency care
- Suggested “how to” guides are under the relevant headings in section 6
- Consider how existing services might be better integrated as part of the gap analysis
- Devon ICS can offer support and guidance.

Target readership: local leads and commissioners.

We are hopeful that LCPs will use this information and build their own Healthy Ageing Strategic Plan, based on their demographics, assets, and gaps. The aim is healthy ageing and population health, **NOT** reduction in health and care demand (which is an outcome measure, rather than an aim). A checklist of things to include in the strategic plan can be found below:



Ageing Well
implementation plan

Each Healthy Ageing Strategic Plan should contain enough detail that it can be understood and visualised by patients and health and social care professionals working within it. For

every part of this checklist, each LCP will need to undertake a gap analysis of their workforce, systems and processes in health and social care partners organisations and add this into their plan. The checklist of gaps to address includes:

- Upskilling and training the workforce
- Information governance
- IT capabilities
- Social prescribing and VCSE
- Social care
- Intermediate care and community services
- Virtual Wards
- Proactive care of older people in their own homes (Anticipatory Care)
- Urgent Visiting Service
- Same day emergency care.

Whilst performing these gap analyses, LCPs should simultaneously identify ways to redesign workforce models, with blended roles, skills, and considered opportunities for collaboration between health, social care, and voluntary and community service partners. Ideas and examples of this are detailed in Section 5.

6.1 A note on the methodology of gap analysis for workforce

Assessment of the best methods for gap analysis of workforce was undertaken with local subject matter experts from health and social care, who regularly work in this area. In all cases, options appraisals for different methodology were considered and tested. The most robust methodology has been chosen and is outlined in this document.

Devon ICS is extremely grateful to colleagues (see acknowledgements) for their help and support with this, as it was a significant undertaking. LCPs are welcome to consider alternative methodologies for performing a gap analysis in health, social care, and VCSE workforce, but if they choose to do this, please speak to the Ageing Well team in Devon ICS to discuss the methodology first.

6.2 Gap analysis for workforce skills:

Section 3.5 discussed the subject of upskilling the workforce to improve CGA quality. LCPs may choose to commission a community geriatrics service where, as well as offering direct care, community geriatricians (or appropriately qualified staff) might be employed to upskill the current workforce and train new health and social care professionals. Please see section 3.5 for further details.

Gap analysis revealed that Western locality (total population 368,172; age 65+ 76,050; 75+ 36,173) would need a minimum of 6 WTE geriatricians (2 currently employed, 4 needed) to fulfil this commitment. For reference (and to support modelling in the other localities), the population of the other localities are detailed below:

- **Eastern locality:** total 422,655; age 65+ 99,610; 75+ 49,952
- **Northern locality:** total 178,736; age 65+ 47,066; 75+ 22,539
- **South Devon and Torbay:** total 300,352; age 65+ 80,260; 75+ 39,222.

6.3 Gap analysis for Information governance, Information technology, read codes standardisation, and other remote monitoring:

6.3.1 Information governance (IG):

Localities will need to consider the IG arrangements required to enable staff across multiple healthcare organisations in their locality to share information for the purpose of direct care. The NHS England Information Governance Framework for Integrated Health and Care provides good guidance on these issues.³⁴

Data protection officers from all provider organisations involved in the care of older people will be required to draft IG documents; including data protection impact assessments, data sharing agreements, and privacy posters (to be displayed on websites and in waiting rooms). Organisations will need to ensure that staff are appropriately IG trained and update their Record of Processing Activities (ROPA) and other documentation, as appropriate.

6.3.2 Information Technology (IT):

IT solutions should look to use applicable national standards (directory currently in public beta test at <https://data.standards.nhs.uk>), which will continue to develop as the national data and interoperability strategy emerges.³⁵

IT decisions should ideally be based on an options appraisal of IT systems that maximise CGA quality, quantity, and information sharing, through efficiencies in each of the three stages of a CGA cycle (see Sections 2.5, 3.1, and 3.4). Some questions to consider include:

- Will the IT enable a 3 “I” CGA cycle (see Figure 11) to take place? How will it speed up/improve data quality in the information gathering, intervention, and information sharing stages?
- Will the IT generate a care and support plan?
- Which IT systems are interoperable with it?
- Can searches be run that enable targeted high value interventions to be performed? (An example might be a search of all patients with frailty in hospital who are on high-risk medications)
- How customisable is the IT? Can it be adapted to local need? Can it be used for IT-assisted decision support? An example might be firing a “red alert” on all patients with significant frailty, when a high-risk drug is about to be prescribed, or prompting for a certain clinical activity
- Scalability: if software is designed in one system, how easy is it to scale it to the same system in another organisation, or another IT system?
- Will the IT system support service evaluation and a live-feed, linked dataset?
- How will LCPs ensure that their chosen IT and providers use the standardised read codes (see next section)?

6.3.3 Read code standardisation:

Read code standardisation is needed across Devon, as this will allow data to be collected for service evaluation and the development of a live-feed linked dataset. The latter is particularly interesting; older people in crisis often present to multiple different healthcare providers in a

short time frame. Having a linked dataset will allow the system to identify older people in crisis and target them for appropriate care. SNOMED read codes are used on all major IT systems in primary and secondary care (e.g., EMIS, SystmOne, Cerner, EPIC, Nervecentre, and other major vendors).

We suggest that all providers use the read codes below for identification, management, and Advance Care Planning of older people with frailty. LCPs may want to choose additional read codes, to support other clinical activities in their area. Read codes in red should have their significance rules changed, so that they appear as problems in the GP record and are shared on the summary care record (SCR). Read codes in purple should be shared on the SCR as a minimum:

Service outcomes	Read code to use (SNOMED read code)
Frailty identification and diagnosis assessment	• Patients identified as fit and well (i.e., not frail): Read code "Frailty assessment" (1086611000000106) AND "Unsuitable for frailty assessment" (1086631000000103) in SystmOne "[RFC] well person" (Concept ID 90761000006102; Description ID 90761000006118) in EMIS • Patients identified with Mild Frailty: Read code "Frailty assessment" (1086611000000106) AND "Mild frailty" (925791000000100) OR "CSHA (Canadian Study of Health and Aging) Clinical Frailty Scale level 5 - mildly frail" (1129371000000104) • Patients identified with Moderate Frailty: Read code "Frailty assessment" (1086611000000106) AND "Moderate frailty" (925831000000107) OR "CSHA (Canadian Study of Health and Aging) Clinical Frailty Scale level 6 - moderately frail" (1129381000000102) • Patients identified with Severe Frailty: Read code "Frailty assessment" (1086611000000106) AND "Severe frailty" (925861000000102) OR "CSHA (Canadian Study of Health and Aging) Clinical Frailty Scale level 7 - severely frail" (1129391000000100) • Patients (with frailty) who live at home and are not housebound: Read code "able to mobilise outside" (301563003) AND read code "lives in own home" (160943002) • Patients (with frailty) who live at home and are housebound: Read code "housebound" (160689007) AND read code "lives in own home" (160943002) • Patients (with frailty) who live in a care home: Read code "lives in care home" (248171000000108)
Management of patients with moderate or severe frailty	• Patients who have received a structured medication review: Read code "structured medication review" (1239511000000100) • Patients who had a CGA: Read code "subject of Comprehensive Geriatric Assessment plan" (836131000000104) • Patients with an advance care plan: Read code "treatment and escalation plan". (735324008) • Patients with a resuscitation decision documented: Read code "not for resuscitation" (304253006). Read code "For resuscitation" (304252001). • Patients with a hospital admission decision documented: Read code: For future hospital admissions on TEP "listed for admission to hospital" (183767005). Read code: Not for future hospital admissions on TEP: "patient refuses hospital admission" or "hospital admission declined" (183960004). • Number CGAs shared with patient OOH GP and Paramedics Read code "sharing Advance Care Planning decisions with out of hours service" (922301000000104)

Table 5: Minimum standardised set of read codes to be used Devonwide by all healthcare providers who support older people.

In addition to IT, health and care providers will need to consider a gap analysis of remote monitoring technology, which will be particularly useful for Virtual Wards. Examples include wearables that can monitor vital signs and detect deteriorating patients, movement and falls sensors, and medication-taking prompting technology.

6.4 Analysis of voluntary, community, and social enterprise (VCSE) sector:

Prevention of frailty/frailty progression is important and LCPs should analyse the social prescribing and VCSE landscape, ensuring there is enough capacity in the system.

Section 2.4 discussed the importance of prevention of frailty/frailty progression and LCPs should analyse and engage the social prescribing and VCSE landscape, ensuring that there is enough capacity in the system, both within the primary care setting, and the community offer through VCSE partners. LCP Healthy Ageing Strategic Plans must have a strong emphasis on promotion of healthy ageing, with personalised care and support based on the “I” statements in Appendix 1.

The VCSE are an integral partner. It comprises:

- Approximately 7,000 organisations
- Twice as many registered charities compared to the national average
- An employer of almost 5% of Devon’s working population
- A base for an estimated 59,000 volunteers, who contribute 115,000 hours each week, equating to an annual value of £74 million.

The social prescription offer in Devon is comprehensive. Each of our 31 PCN’s has access to at least one Social Prescriber, with 60% employed through a commissioning arrangement with a local VCSE organisation. For frailty to have an emphasis, it is vital that this offer is understood, as well as the referral pathways for people who are “prescribed” in the community. This is much better understood at the locality level, through LCP’s.

It is also vital that the role of unpaid carers is understood, in terms of their contribution to the wider care system. Any future commissioning direction must take this into account, by working closely with the VCSE organisations who support unpaid carers on a daily basis. This will enable them to better understand what carers need to give care effectively. Importantly, it is VCSE organisations who support them when they need to be cared for.

As an ICS, co-production and co-design of services, and shared thinking on policy development with the VCSE is vital. They have a wealth of expertise and experience and have credible links into the community that have been built up over many years. Joint thinking and planning will result in services that people want to use and that they feel they have an influence over.

6.5 Gap analysis of social care:

Sections 3 and 5 have discussed the challenges in social care and solutions such as the “Homecare Cost of Care Toolkit.”²⁷ They also detail a package of opportunities to improve this sector.

LCPs will need to undertake a gap analysis of their social care workforce. There are challenges here; notably, that due to an extreme deficit in domiciliary care, many patients are currently placed temporarily in care homes or in supported living. Furthermore, deficits in UCR and same day emergency care will result in more people being admitted and

deconditioning, resulting in an increased need for care. For these reasons it is tricky to gap analyse the care home and supported living sector, until domiciliary care gaps are addressed.

There are two options to gap analyse the workforce. The first is looking at local intelligence in the Skills for Care³⁶ website (link: <https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/Workforce-intelligence/publications/local-information/My-local-area.aspx>).

This estimates workforce gaps by vacancy rates (% number of vacancies as a proportion of total filled posts). The limitation with this methodology is that it is not a true workforce gap analysis based on patient demand.

Another option that focusses more on patient demand is to approach leads in social care at locality level and ask for a search of the following:

- Current adult social care funded packages of care, broken down by whether they are single-handed or double-handed and the number of sessions of care per day
- Number of clients in brokerage (assessed as eligible for care but awaiting a package of care)
- Number of clients who have NOT yet been assessed and are on the waiting list to be assessed/reassessed by adult social care under the Care Act (the vast majority will need care).

With this information, you can calculate number of carers needed by modelling the data from current funded packages of care to clients who are awaiting care. This is outlined in the steps below.

Step 1: Calculation of current domiciliary care capacity:

After obtaining the above dataset, create an excel spreadsheet (downloadable excel sheet included at end of this gap analysis, with formulas), working out the percentage proportion of patients by their care needs and the number of visits needed per patient. A worked example (based on fictitious data) is shown below:

	Total by caseload	Proportion of caseload	Total by visits/day
Total packages of care	925		2519
Total single-handed packages of care	783	0.85	1543
1-7 visits/ week (once a day)	359	0.39	359
8-14 visits a week (twice a day)	198	0.21	396
15-21 visits a week (3 times a day)	128	0.14	384
22-28 visits a week (4 times a day)	88	0.10	352
29 visits a week (5 times a day)	8	0.01	40
38 visits a week (6 times a day)	2	0.00	12
Double-handed care packages	142	0.15	976
1-7 visits a week (once a day)	14	0.02	28

8 – 14 visits a week (twice a day)	22	0.02	88
15 – 21 visits a week (3 times a day)	26	0.03	156
22 – 28 visits a week (4 times a day)	57	0.06	456
29 – 35 visits a week (5 times a day)	14	0.02	140
36+ visits a week (6 times a day)	9	0.01	108

Table 6: Example data; analysing the number of patients on the adult social care caseload, the proportion in receipt of certain packages of care, and the total visits for this caseload.

To use this example, if there are 57 patients in need of a double-handed care, four times a day, then that would mean:

- **Percentage of total with double-handed care four times a day:** $57/925 = 0.06$ or 6%
- **Total visits for patients with double-handed care four times a day:** $(4 \times 2) \times 57 = 456$

Once you have the total number of visits per day, work out the total number of whole-time equivalent carers needed. The calculation for this is as below, assuming that:

- One visit takes 45 minutes (**NOTE:** figure based on working in an urban area. Rurality may change this calculation)
- A WTE carer works 36 hours/wk. (6x6 hour shifts).

Total visits/week = total visits per day $\times 7 = 2,519 \times 7 = 17,633$ visits/wk.

Assuming each visit is 45 mins, number of hours for all visits a week = 13,225 hrs/wk.

Number of WTE carers (hours for all visits a week /36) = 367

Number of WTE carers, with addition of seven weeks leave per year. = Number of WTE carers + (7/52 weeks of year $\times$ Number of WTE carers) = 417

Step 2: Model the social care workforce gap:

Next, tabulate your patients who are waiting for care; either where they are in brokerage or on the waiting list for a social worker to see and perform an assessment or reassessment under the Care Act. A sample table (based on fictitious data) is shown below:

Breakdown	Total patients
Total patients waiting for care	580
Brokerage total	172
UCR	40
Community	68
D2A	59
Health	5
On waiting list for Care Act assessment/reassessment	408

Table 7: Patients on waiting list for a Care Act assessment/reassessment or have been assessed and are in brokerage awaiting a package of care. Total patients are a sum of the two groups.

Once LCPs have this information, it is possible to model the data for patients in brokerage and patients waiting to be assessed under the Care Act, assuming that all will all end up with packages of care (which nearly all will) and based on the proportions of allocated care packages in Table 6. The modelled data is shown below:

Modelled breakdown of total	Modelled caseload	Modelled % of caseload	Modelled visits per day
Modelled total	580		1579
Total single-handed packages of care	491	84.6%	968
1-7 visits/ week (once a day)	225	38.8%	225
8-14 visits a week (twice a day)	124	21.4%	248
15-21 visits a week (three times a day)	80	13.8%	241
22-28 visits a week (four times a day)	55	9.5%	221
29-35 visits a week (five times a week)	5	0.9%	25
36+ visits a week (six times a week)	1	0.2%	8
Double handed care packages	89	15.4%	612
1-7 visits a week (once a day)	9	1.5%	18
8 – 14 visits a week (twice a day)	14	2.4%	55
15 – 21 visits a week (three times a day)	16	2.8%	98
22 – 28 visits a week (four times a day)	36	6.2%	286
29 – 35 visits a week (five times a day)	9	1.5%	88
36+ visits a week (six times a day)	6	1.0%	68

Table 8: Modelled data of domiciliary care visits from the 580 patients on the social care waiting list.

Using the same calculations as Step 1 (for workforce analysis and planning), it is possible to estimate the workforce needs. Using the example above, an extra 261 (an extra 63%) WTE domiciliary carers are needed to create a fully functioning domiciliary care workforce in this imaginary locality.

Using this formula the current estimated domiciliary care WTE workforce in Devon is 1225 . The additional estimated domiciliary care WTE workforce needed in Devon stands at 776

A sample spreadsheet to use with formulas is as below:



Domiciliary care gap
analysis V2.xlsx

This gap analysis has deliberately stopped short of calculating funding needs because it is recognised that social care is underfunded. Once the Homecare Cost of Care²⁷ funding exercise is completed it will be possible to give adequate financial projections.

6.6 Combined gap analysis of intermediate care (discharge-to-assess (D2A) and Urgent Crisis Response (UCR):

This is complex, as many patients and staff are “in the wrong place”; support workers in intermediate care are plugging social care gaps, patients are discharged to care homes because of a deficit in domiciliary care, and COVID outbreaks in care homes have created additional pressures for placements and workforce respectively. There may be wider shortages in community services which also need consideration in this gap analysis. LCPs may choose to include this.

Within these constraints, various methods were considered and attempted, including quantification of the number of patient contacts of a random sample of patients, as well as some demand-capacity modelling. However, these analyses were flawed, as they failed to consider administrative and non-clinical staff, or length of time of contact. For example, a district nurse doing compression bandaging, which can take around 45 minutes, would have counted as one patient contact, as would an HCA recording a blood pressure, which would take 5 minutes. On balance, providers and commissioners felt that the methodology outlined below was the most robust way to perform a gap analysis of intermediate care.

Step 1: Calculate the “mean discharge gap”.

To gap analyse this workforce, we suggest using the Devonwide discharge data for medically fit, Pathway 1-3 discharges. Each LCP can randomly generate 6-12 dates during the last 6-9 months for Pathway 1-3 discharges, detect the number of patients in hospital who are medically fit for discharge, the number of patients that were discharged, and the number that could not be discharged, and then calculate “the discharge gap.” Then take the average of all dates to calculate the “mean discharge gap” (mean number of patients who were medically fit but couldn’t be discharged, per day). An example is outlined below by each locality for six random dates from December 2021- May 2022:

	06/12/21	17/01/22	21/02/22	21/03/22	11/04/22	23/05/22	Average
Devonwide							
Total pts MFFD P1-3	293	302	308	242	304	246	283
Total pts MFFD P1-3 for discharge today	34	35	26	26	29	38	31
Discharge gap	259	267	282	216	275	208	251
% Discharged same day	12%	12%	8%	11%	10%	15%	11%
North*							
Total pts MFFD P1-3	39	43	51	31	50	34	41
Total pts MFFD P1-3 for discharge today	0	0	5	0	0	0	1
Discharge gap	39	43	46	31	50	34	41

% Discharged same day	0%	0%	10%	0%	0%	0%	2%
East							
Total pts MFFD P1-3	95	109	91	65	97	96	92
Total pts MFFD P1-3 for discharge today	21	16	12	8	10	22	15
Discharge gap	74	93	79	57	87	74	77
% Discharged same day	22%	15%	13%	12%	10%	23%	16%
South							
Total pts MFFD P1-3	41	52	60	41	55	46	49
Total pts MFFD P1-3 for discharge today	4	11	6	8	7	5	7
Discharge gap	37	41	54	33	48	41	42
% Discharged same day	10%	21%	10%	20%	13%	11%	14%
West							
Total pts MFFD P1-3	118	98	106	105	102	70	100
Total pts MFFD P1-3 for discharge today	9	8	3	10	12	11	9
Discharge gap	109	90	103	95	90	59	91
% Discharged same day	8%	8%	3%	10%	12%	16%	9%

Table 9: Calculation of the discharge gap and mean discharge gap by locality. *There are anomalies in North locality's data meaning that these results are inaccurate and should not be used to base a decision on.

Step 2: Calculate the percentage increase in intermediate care caseload (D2A and UCR) if the “discharge gap” were absorbed

Once the mean discharge gap is calculated, then the intermediate care workforce can be modelled, to provide for this larger population. A worked through example comes from Livewell, who provide community services for Western locality, where the mean discharge gap is 91 patients/days.

Breakdown of caseload	Number of patients
UCR average caseload /wk.	110
UCR total/yr.	5957
D2A average caseload /wk.	406
D2A total/yr.	21755
Intermediate care (D2A+UCR) Avg. caseload /wk.	516
Intermediate care (D2A+UCR) Total/yr.	27712
% Increase in intermediate care caseload	18%

Table 10: Current caseloads in UCR and D2A and percent increase in Intermediate care caseload (D2A+UCR) to absorb the extra patients awaiting discharge onto the current caseload.

If the weekly UCR and D2A caseload are added together, there are 516 patients/week in intermediate care (= D2A+UCR). To absorb the other 91 patients awaiting discharges, the intermediate care workforce would need to increase by $91/516 = 18\%$.

Step 3: Calculate workforce expansion needed in intermediate care (D2A+UCR)

Work out the WTE workforce increase in intermediate care, by analysing it against the Agenda for Change (AfC) staff bands. Then increase each AfC staff band by the same percentage as the % increase in workload.

Once done, it should be straightforward to work out how staff might be re-used, more efficiently used, and finally, what additional funding might be needed to do this. Funding should ideally be used to frontload services, i.e., UCR and the future Virtual Wards (or hospital-at-home) workstreams, to support with avoidable admissions, as older people are at risk of adverse health outcomes from hospitalisation.^{8,9}

Some LCPs may judge that they have shortages in wider community services and may choose to conduct further gap analyses in this area, or to extend the intermediate care gap analysis to the whole of community services.

6.7 Gap analysis for Urgent Visiting Service (UVS):

All LCPs, particularly those with a large urban population, should consider a UVS for older people with the following presentations:

1. Shortness of breath
2. Abdominal pain
3. Acute frailty syndromes (new/worsening falls, confusion, immobility, incontinence, or acute functional decline)
4. Clinician judgement of the need for an early-in-day visit.

A UVS is essential; when older people slip into crisis, they will require a medical evaluation to determine the cause of the crisis and an MDT with social care provision to stabilise the situation. It takes time to coordinate this, and sometimes the medical evaluation requires Same Day Emergency Care (SDEC) in an acute hospital to exclude certain diagnoses. This service should be fully integrated, both with enhanced PCNs and UCR/VW. A UVS should be regarded as a core aspect to a locality's UCR offering.

6.8 Gap analysis of Same Day Emergency Care (SDEC) for frailty:

There is a strong interdependency between SDEC capability and UCR/VW. Hospitals should consider many different areas, including staffing requirements, referral pathways, discharge and follow-up arrangements, diagnostics, and pharmacy. A SDEC standard operating procedure from RDUH can be found below.



Same Day
Emergency Care SOP.

LCPs should consider transport to hospital as part of their SDEC gap analysis. Transport should aim to be at the patient's household within 30 minutes of calling. Generally speaking, a non-paramedic crew will be suitable for nearly all patients that are referred to the UVS. Non-paramedic crews can do the following:

- Pick up patients from the floor including those with fractures e.g., fractured neck of femur
- Record vital signs
- Administer oxygen if there is a hypoxia that needs treating
- Give Entonox
- Perform basic life support
- Call a trained crew if the patient is severely unwell.

Non- paramedic crews should not be employed in the following situations:

- Severe pain requiring morphine
- Chest pain felt to be a myocardial infarction
- Palpitations requiring an ECG
- Life-threatening emergencies requiring life-saving intervention, medication, or an emergency hospital admission
- Suspected cervical spinal injuries.

6.9 Gap analysis for enhancing Virtual Wards (VW) capabilities for older people with frailty:

Virtual Wards (VWs) offer a genuine alternative to a hospital admission and are cost effective, at £2458 less per patient.^{16,17} Patient satisfaction is also higher. LCPs will have submitted their Virtual Ward plans to NHSE, based on the funding allocations for Devon.

The current national funding allocation limits the full scope of virtual wards. However, once current VWs are embedded within the system, LCPs could contemplate how they might develop them further, by having 10-15 “enhanced” VW beds for medically unwell older people with frailty per 100,000 population. These patients will require daily ward rounds with input by a medical professional or advanced clinical practitioner. Examples of conditions that could be managed include:

1. Acute kidney injury, without uraemia, hyperkalaemia, or volume overload
2. Decompensating heart failure, without significant pulmonary oedema
3. COPD, without the need for BiPAP or ventilation
4. Infection, without significant haemodynamic collapse, requiring IV antibiotics

There will be other examples. In all cases, shared decision-making, based on patient preference and clinical safety is essential.

When considering staffing, there needs to be clear leadership by a senior clinician with sufficient clinical time allocated; to take responsibility for assessing and responding to the evolving clinical picture. This is due to the uncertain and variable nature of acute medical crises in patients with moderate or severe frailty. These problems do not fit into a predictable care pathway, in the way that other diagnoses in non-frail patients do.

Consultant physician input to a VW service will require a sustainable model, which provides resilient staffing and necessarily interacts with other hospital delivered services. Thus, a gap analysis must be undertaken in the context of these services.

6.10 Gap analysis for proactive care for older people:

Once LCPs have drawn up their Population Health Management (PHM) plan for older people, they can gap analyse organisations that will be involved in proactive care (e.g., primary care, community services, and voluntary and community sector organisations).

This gap analysis will largely focus on services for older people in their own homes and should complement proactive care for older people in care homes, which is covered separately under the Enhanced Health in Care Homes (EHCH).

7. Next steps following the development of Population Health Management and gap analyses:

Target readership: local leads and commissioners; regional commissioners; interested citizens

By completion of section 6, LCPs should have achieved the following:

- Developed a Population Health Management plan for older people using the key ingredients and recommendations outlined in the Summary of Recommendations section and marked them against the Healthy Ageing Checklist, embedded in Section 6
- The plan will have been jointly created with health, social, and VCSE partners
- Compared it with local and national commissioning priorities to ensure alignment
- Performed a gap analysis of current services, including how existing services might be re-configured to meet the needs of older people.

Whilst on this journey LCPs will have simultaneously identified ways to redesign workforce models, roles and skills, and will have considered opportunities for collaboration between health, social care, and VCSE partners.

Once the plan, opportunities for collaboration, gap analysis, and Fair Cost of Care²⁷ exercise are complete, LCPs will be able to estimate their funding shortfall. LCPs can submit their plan, the checklist, and other associated documents to Devon ICS for quality assurance and alignment with local and national specifications. This proactive approach will really put LCPs and Devon ICS on the “front foot” when new opportunities arise for health and social care.

Devon ICS will offer LCPs as much support as needed on this journey.

7.1 The role of Joint-Commissioning at LCP-level, to support a Healthy Ageing Strategic Plan

To support their strategic plan, each LCP may be considering setting up a jointly commissioned “Healthy-Ageing Board”, with commissioners and providers from all services involved in older people. It will be down to each LCP to decide on their organisational governance, terms of reference, representation, and other associated activities.

8. Conclusions and implications of LCP-based joint commissioning for Devon Integrated Care System.

Target readership: local leads and commissioners; regional commissioners; interested citizens

“The way we treat our elderly in the twilight of their lives is the measure of the quality of an integrated care system.”

Adaptation of a quote by Hubert H. Humphrey

This document has offered Local Care Partnerships (LCPs) a toolkit to commission integrated services for the proactive and urgent care of older people; focussing on population health and adapted to local need.

A key feature has been the concept of joint commissioning for healthy ageing at LCP level; with a shared vision of what good preventative, proactive and urgent care looks like, involving leaders from across health care, social care, and VCSE.

In Devon ICS, we will be doing the same. In the coming weeks and months, we will be having our first jointly commissioned board meeting for healthy ageing, where we will be bringing together senior leaders with expertise in health care, social care, VCSE, workforce, finance, digital, and urgent care. We will be discussing our aims, terms of references, and how we can ensure strategic alignment of all the different threads that make up a healthy ageing strategic plan.

Having this structure and expertise will enable us to offer a clearer vision and better support to LCPs, avoiding duplication and inefficiency.

We hope that this document, and our emerging governance structure, will offer LCPs all the support that they need, to commission their own Healthy Ageing Strategic Plans.

Thanks for reading.

References:

1. *Evaluation of the Integrated Personal Commissioning (IPC) Programme*. Final evaluation report. SQW. Dec 2019
2. *Decade of healthy Ageing*. Baseline report, WHO 2020
3. Living, Longer, Better campaign. <https://www.livelongerbetter.uk/>. Founded by Sir Muir Gray
4. Dahlgren G, Whitehead M. *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Sweden: Institute for Futures Studies, 1991.
5. *Fit For Frailty Part 1*, British Geriatrics Society, 2017
6. Rockwood K, Song X, MacKnight C, et al.; *A global clinical measure of fitness and frailty in elderly people*. *Cmaj* 2005;173(5):489-95. doi: 10.1503/cmaj.050051.
7. *Cancer statistics for the UK*, Cancer research. <https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk>
8. *Frailty and COVID-19: why, what, how, where, and when?* Specialised Clinical Frailty Network 2020 <https://www.scfn.org.uk/clinical-frailty-scale>
9. Wallis, S., et al *Association of the Clinical Frailty Scale with hospital Outcomes*. *QJM: An international journal of Medicine* 2015. 108(12): pp 9430949 <https://doi.org/10.1093/qjmed/hcv066>
10. Attwood D, Boorer J, Ellis W, et al.; *The Pathfields Tool: a frailty case-finding tool using primary care IT—implications for Population Health Management*. *Age and Ageing* 2020;49(6):1087-1092. doi: 10.1093/ageing/afaa119
11. Clegg A, Bates C, Young J, et al.; *Development and validation of an electronic frailty index using routine primary care electronic health record data*. *Age and Ageing* 2016;45(3):353-360. doi: 10.1093/ageing/afw039.
12. *Routine Identification of Frailty – Requirements of the new GP contract 2017/2018*. Northeast and North Cumbria Academic Health Science Network 2017
13. *Living well in communities with frailty. Evidence for what works*. Healthcare Improvement Scotland ihub. 2018
14. Ahmed, S. et al *Behaviour change techniques in personalised care planning for older people: a systematic review* *British Journal of General Practice* 2021; 71 (703): e121- e127. DOI: <https://doi.org/10.3399/bjgp20X714017>
15. Ellis G, Gardner M, Tsiachristas A, et al.; *Comprehensive Geriatric Assessment for older adults admitted to hospital*. *Cochrane Database Syst Rev* 2017;9(9):Cd006211. doi: 10.1002/14651858.CD006211.pub3.
16. Shepperd S, Butler C, Craddock-Bamford A, et al.; *Is Comprehensive Geriatric Assessment Admission Avoidance Hospital-at-home an Alternative to Hospital Admission for Older Persons? : A Randomized Trial*. *Ann Intern Med* 2021;174(7):889-898. doi: 10.7326/m20-5688
17. Singh, S. et al. *Is Comprehensive Geriatric Assessment hospital-at-home a cost-effective alternative to hospital admission for older people?* *Age and Ageing*, 2022 51(1), pp1-11 <https://doi.org/10.1093/ageing/afab220>
18. Nord M, Lyth J, Alwin J, et al.; *Costs and effects of Comprehensive Geriatric Assessment in primary care for older adults with high risk for hospitalisation*. *BMC Geriatrics* 2021;21(1):263. doi: 10.1186/s12877-021-02166-1.
19. *The Framework for Enhanced Health in Care Homes Version 2*. March 2020. NHS England and NHS Improvement
20. *Network Contract Direct Enhanced Service- contract specification 2022/23 – primary care network requirements and entitlements*. NHS England 2022
21. Attwood, D. et al *There and back again: the development of an ambulatory care pathway for older people living with frailty that begins and ends in the patient's own*

- home: results of a four day pilot.* Age and Ageing 2019 volume 48, issue supplement_1 ppi1-i15 <https://doi.org/10.1093/ageing/afy211.09>
22. *Community Health Services two-hour urgent community response standard.* NHS England, 14th March 2022
 23. *Enablers for success: Virtual Wards including hospital-at-home.* NHS England 25th April 2022
 24. *Same-day acute frailty services.* NHS England, the Ambulatory Emergency Care Network, and the Acute Frailty Network. May 2019
 25. *Buurtzorg: revolutionising home care in the Netherlands.* Centre for Public Impact, BGC Foundation. November 2018
 26. *Who Cares? The need for real reform for social care in England.* The British Medical Association. June 2022
 27. *Homecare cost of care Toolkit.* Local Government Association 2021
<https://www.local.gov.uk/our-support/sector-support-offer/care-and-health-improvement/commissioning-and-market-shaping/cost-of-care-toolkit/homecare-cost-of-care-toolkit-information-and-user-guide>
 28. *High Impact Change Model* Local Government Association. July 2020
 29. *Home from Hospital Service,* Royal Voluntary Service.
<https://www.royalvoluntaryservice.org.uk/about-us/commissioned-services/supporting-your-recovery/home-from-hospital-service/>
 30. Elston J, et al. *Impact of 'Enhanced' Intermediate Care Integrating Acute, Primary and Community Care and the Voluntary Sector in Torbay and South Devon, UK.* International Journal of Integrated Care, 2022; 22(1): 14, 1–17. DOI: <https://doi.org/10.5334/ijic.5665>
 31. *Population estimates for the UK, England, Wales, Scotland, and Northern Ireland: Mid 2020.* Office of National Statistics, June 2021.
 32. Vieira, E.R, et al *Prevention of falls in older people living in the community.* BMJ, 2016 28(353)i1419 doi: 10.1136/bmj.i1419.
 33. *Evidence based OTAGO and FaME Delivery: Implementation guidance for commissioners, public health officers and leisure service managers.* Later life Training July 2017.
 34. *Information Governance Framework for Integrated Health and Care: Shared Care Records.* NHS England September 2021
 35. *NHS Standards Directory:* NHSE (link: <https://data.standards.nhs.uk/>)
 36. *Skills for Care* www.skillsforcare.org.uk
 37. *Think Local. Act Personal. How to do personalised care and support.* Coalition for Collaborative Care. 2014. [TLAP-Making-it-Real-report.pdf](https://www.thinklocalactpersonal.org.uk/TLAP-Making-it-Real-report.pdf) (thinklocalactpersonal.org.uk).
 38. *2022/23 priorities and operational planning guidance Version 3.* NHS England 22nd February 2022

Appendix 1: “I” statements:

Target readership: Healthcare, social care, and VCSE professionals; local leads and commissioners; regional commissioners; interested citizens.

The following are a series of “I” statements from the Coalition for Collaborative Care, that describe what good, citizen-focused, personalised care and support look like; from the point of view of our patients themselves (link: [TLAP-Making-it-Real-report.pdf](https://thinklocalactpersonal.org.uk/TLAP-Making-it-Real-report.pdf) (thinklocalactpersonal.org.uk).³⁷

Living the life I want, keeping safe and well:

- I can live the life I want and do the things that are important to me as independently as possible.
- I am treated with respect and dignity.
- I feel safe and am supported to understand and manage any risks.
- I am supported to manage my health in a way that makes sense to me.
- I have people in my life who care about me – family, friends and people in my community.
- I am valued for the contribution that I make to my community.
- I have a place I can call home, not just a ‘bed’ or somewhere that provides me with care.
- I live in a home which is accessible and designed so that I can be as independent as possible.

Having the information I need, when I need it:

- I can get information and advice that helps me think about and plan my life.
- I can get information and advice about my health and how I can be as well as possible – physically, mentally and emotionally.
- I can get information and advice that is accurate, up to date and provided in a way that I can understand.
- I know about the activities, social groups, leisure and learning opportunities in my community, as well as health and care services.
- I know what my rights are and can get information and advice on all the options for my health, care and housing.
- I know how to access my health and care records and decide which personal information can be shared with other people, including my family, care staff, school or college.

Keeping family, friends, and connections:

- I have people who support me, such as family, friends and people in my community.
- I can meet people who share my interests and have the opportunity to join and participate in a range of groups.
- I feel welcome and safe in my local community and can join in community life and activities that are important to me.
- I have opportunities to learn, volunteer and work and can do things that match my interests, skills and abilities.
- I can keep in touch and meet up with people who are important to me, including family, friends and people who share my interests, identity and culture.

- I have a co-produced personal plan that sets out how I can be as active and involved in my community as possible.

My support, my own way:

- I have care and support that enables me to live as I want to, seeing me as a unique person with skills, strengths and personal goals.
- I am in control of planning my care and support. If I need help with this, people who know and care about me are involved.
- I know how much money is available to meet my care and support needs. I can decide how it's used – whether it's my own money, a health or social care personal budget, or a budget managed on my behalf.
- I have care and support that is coordinated and everyone works well together and with me.
- I can choose who supports me, and how, when and where my care and support is provided.
- I can get skilled advice and support to understand how my care and support budgets work and enable me to make the best use of the money available.
- I can get skilled advice and support to recruit and manage my personal assistants, whether I employ them or an organisation does.

Staying in control:

- I am supported to plan ahead for important changes in life that I can anticipate.
- When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place before change happens.
- If I move from my home to another place, the people who are important to me are respected, listened to, supported and involved in decisions.
- If my medication has to change, I know why and am involved in the decision.
- I can plan ahead and stay in control in emergencies. I know who to contact and how to contact them and people follow my advance wishes and decisions as much as possible.
- I know what to do and who I can contact when I realise that things might be at risk of going wrong or my health condition may be worsening.

The people who support me:

- I am supported by people who see me as a unique person with strengths, abilities and aspirations.
- I am supported by people who listen carefully so they know what matters to me and how to support me to live the life I want.
- I am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health.
- I have considerate support delivered by competent people.

Appendix 2: Urgent care modelling

Target readership: Healthcare professionals; local leads and commissioners.

Calculation of hospitalisation data on frailty:

Frailty prevalence data in patients aged 75+ years from Cambridge University Hospital (CUH) was overlayed on top of unplanned admissions data supplied by the Devon Integrated Care System (ICS) Business Intelligence (BI) from Financial Year (FY) 2017/18-21/22.⁷

CUH data on frailty prevalence and outcomes in patients aged 75+ is found in table 11 below:⁷

	n	% Total	LOS	% Readmitted within a month	% Mortality in hospital
Not frail	1474	26%	6.0	7.7	1.8
Mild	1954	34%	8.9	13.9	3.7
Moderate	1276	22%	12.2	15.4	6.4
Severe	992	17%	12.4	12.1	17.6
Palliative	68	1%	9.6	13.2	30.9
Total Frailty	4222	73%			

Table 11: Frailty prevalence at Cambridge University Hospital in 75+ year olds⁹

Admissions data with CUH frailty modelling data from FY 17/18-21/22 is shown in the table overleaf. This meant that, Devonwide, Frailty accounted for:

- **Total unplanned admissions:** 35,996
- **Total unplanned bed days:** 356,114
- **Total unplanned cost of care:** £115,694,429

However, this number is likely an under-estimate as this data is based on the 75+ population. A significant proportion of patients aged 65+ in hospital, and a handful of patients younger than 65, will also have co-existing frailty.

	2017/18	2018/19	2019/20	2020/2021	2021/22
Patients admitted					
0-74	64791	64829	69615	59638	70486
75+ and total patients admitted:	28935	29229	31987	29610	32779
• 75+ and not frail	7741	7819	8557	7921	8769
• 75+ mild frailty	9809	9909	10844	10038	11112
• 75+ moderate frailty	6405	6471	7081	6555	7256
• 75+ severe frailty	4980	5030	5505	5096	5641
• 75+ palliative	341	345	377	349	387
• 75+ frailty (total)	21194	21410	23430	21689	24010
Total admissions					
0-74	88893	88849	96827	83812	100500
75+ Total admissions:	42803	43805	48782	44784	49143
• 75+ and not frail	11451	11719	13050	11981	13147
• 75+ mild frailty	14510	14850	16537	15182	16660
• 75+ moderate frailty	9475	9697	10799	9914	10879
• 75+ severe frailty	7367	7539	8396	7707	8458
• 75+ palliative	505	517	575	528	580
• 75+ frailty (total)	31352	32086	35732	32803	35996
Total unplanned bed days					
0-74	380227	394694	422038	357864	424324
75+ Bed days	401709	402805	454163	386128	486177
• 75+ and not frail	107466	107759	121499	103298	130063
• 75+ mild frailty	136180	136551	153962	130898	164814
• 75+ moderate frailty	88928	89171	100540	85479	107627
• 75+ severe frailty	69135	69324	78163	66454	83672
• 75+ palliative	4739	4752	5358	4555	5736
• 75+ frailty (total)	294243	295046	332664	282830	356114
Total Cost of care					
0-74	£162,598,392	£167,652,600	£181,912,402	£158,235,937	£184,132,261
75+ Cost of care	£134,383,265	£137,339,109	£156,076,427	£136,505,162	£157,949,476
• 75+ and not frail	£35,950,554	£36,741,309	£41,753,964	£36,518,210	£42,255,047
• 75+ mild frailty	£45,556,020	£46,558,053	£52,910,017	£46,275,345	£53,544,982
• 75+ moderate frailty	£29,748,967	£30,403,314	£34,551,270	£30,218,700	£34,965,915
• 75+ severe frailty	£23,127,724	£23,636,432	£26,861,175	£23,492,908	£27,183,532
• 75+ palliative	£1,585,368	£1,620,239	£1,841,290	£1,610,401	£1,863,387
• 75+ frailty (total)	£98,432,711	£100,597,800	£114,322,463	£99,986,953	£115,694,429

Table 12: Unplanned admissions data, Devonwide, with CUH data based on frailty prevalence overlaid to model frailty prevalence

Appendix 3: Alignment with national commissioning priorities:

Target readership: Local leads and commissioners.

Rather than discuss the different national service specifications, this appendix will assume that the reader has the necessary knowledge and offers references to guidance, if needed. National specifications are outlined in the table below and has been divided up by provider and whether proactive or urgent care is being delivered:

Healthcare provider	Population segment	Aligned national service specifications
Primary Care Networks (PCNs)	Proactive Care: - Older people with frailty in care homes - To be confirmed but could be proactive care of older people with frailty in own homes	Proactive Care: - Enhanced health in Care Homes (EHCH national service specifications)¹⁹ - Anticipatory Care (AC) National Service Specification²⁰
	Urgent Care: Same day access	Urgent care: Same day access as part of the PCN Direct Enhanced Service (DES) contract²⁰
Community Services	Proactive Care: Same as PCNs above	Proactive care: Same as PCNs above
	Urgent Care: Admission avoidance of older people with frailty: - Urgent Crisis Response (UCR) - Hospital-at-home (best thought of as medical and nursing input for medically unwell patients in UCR)	Urgent Care: Admission avoidance of older people with frailty: - Community Health Services two-hour urgent community response standard²² - Virtual Wards national specification²³
	Urgent Care: Discharge Support for older people with frailty: Discharge to assess	Urgent Care: Discharge Support for older people with frailty: No national guidance
Acute Trusts	Proactive care: Improve elective waits e.g., for older people with frailty and needing joint replacements	Proactive care: 2022/23 Priorities and operational planning guidance³⁸
	Urgent Care: Admission avoidance: Expand same day emergency care (SDEC) capability	Urgent Care: 2022/23 Priorities and operational planning guidance³⁸

Table 14: Matrix of service provider, population segment and aligned national service specifications

Appendix 4: Local commissioning priorities:

Target readership: Local leads and commissioners.

There are three key local documents with commissioning priorities outlined below:

Commissioning document	Priority areas
Devon ICS 2022/23 operational planning priorities document (based on the national 2022/23 priorities and operational planning guidance).³⁹  2022-23 Narrative Submission Template	Key priorities 2022/3: - Invest in our workforce - Respond to COVID ever more effectively - Deliver significantly more elective care - Improve responsiveness of urgent and emergency care and build community care capacity - Improve timely access to primary care - Grow and improve mental health services and services for people with LD/autistic people - Continue to develop PHM, prevent ill-health, and address healthcare inequalities - Exploit the potential of digital technologies to transform the delivery of care and patient outcomes - Make the most effective use of our resources - Establish ICBs and collaborative system working
Primary care Integration Baseline Review:  3. Primary Care Integration Feedback	Key recommendations: - Develop workforce strategy - Design evidenced based frailty Mx and intervention framework - Support with service identification and mapping – consider digital solution - Multiple non-recurrent funding sources – nebulous pot needed - PCN Anticipatory care lead – ? change to ageing well lead - Estates and accommodation – not sure I can help much here... - Sharing best practice - High flow analysis - Support with evaluation and review - Support with IG
Integrated Care Delivery Framework  Integrated Care Delivery Framework	Key areas: - Agree a common purpose and shared strategy for integration including setting clear goals and outcomes - Risk stratification- identify population group most likely to benefit from integrated care - Easy access to information – SPOA - Multidisciplinary team – invest in development and training of MDTs - Personalised care approach - UCR - Operational framework- create an operational framework that is right for the local area, and which aligns to service delivery and consider evaluation - Community capacity- Build capacity for integrated community-based health social care (UCR, D2A, VW) - Collaborative culture - Workforce planning
Community First Strategy:  Community First Strategy v3.8 MASTER	The vision: to create the conditions to empower people to take a greater role in their own health and care and deliver services which use our workforce most effectively to deliver outstanding care

Table 15: Key local priorities and documents.