Agenda Item CX/10/.
Devon Health and Wellbeing Board
11th September 2014

Frail Older People

Report of the Director of Public Health

Recommendation: It is recommended that the Devon Health and Wellbeing Board note the report and discuss in conjunction with the **Good Health and Wellbeing in Older Age** discussion paper and the **Public, service user and carer perspective** presentation by Healthwatch and the Joint Engagement Board

1. Background

1.1 What is frailty?

Frailty is not an inevitable consequence of ageing. Many people live to an advanced age while maintaining physical and cognitive function, functional independence and a full and active life, with ill health and disability compressed into a relatively short period before death.[1] However, in a proportion of people, the normal gradual age-related decline in multiple body systems is accelerated, resulting in limited functional reserve, so that even a relatively minor illness or event has a substantial impact on health.[2] This increased vulnerability is termed frailty.

1.2 How can frailty be identified?

There is no single characteristic that identifies frailty in older people. Although frailty increases with age, comorbidity and disability, it can be present in individuals without any of these three factors.[2]

Clinically, frailty can present with:[3]

- Non-specific symptoms (such as extreme fatigue, unexplained weight loss or frequent urinary infections)
- Falls
- Delirium
- Fluctuating disability

The Edmonton Frail Scale is a multidimensional assessment instrument and is a valid reliable and feasible method for identifying older people with frailty.[2] However, the diagnostic accuracy of this test has not been determined, which means that it is not known how many non-frail people may be incorrectly diagnosed as frail (false positives) or how many frail older people may be missed (false negatives).

The gold standard for the identification of frailty is the comprehensive geriatric assessment. This is a multidisciplinary assessment of an older person's medical, psychological and functional capability used to inform a coordinated and integrated plan for treatment and follow-up.[3] This method can be time and resource intensive.

1.3 Why is frailty important?

An increased risk of adverse health outcomes can be predicted by early identification of frailty, and adverse outcomes prevented by appropriate multidisciplinary interventions.

Frailty in older people negatively impacts on their quality of life and causes ill-health and premature mortality. Older people who are frail have an increased risk of falls, disability, long-term care and death.[2]

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[1] NICE Public Health Draft Guideline PHG64 (2014). *Dementia, disability and frailty in later life – mid-life approaches to prevention.*
[2] Clegg et al (2013). Frailty in elderly people. *Lancet*; 381:pp752-62.
[3] NHS England (2014). *Safe, compassionate care for frail older people using an integrated care pathway.*

There is also a significant cost associated with the frail older population. Over half of gross local authority spending on adult social care and two thirds of the primary care prescribing budget is spent on people over 65 years of age.[3]

Interventions to reduce the prevalence or severity of frailty can help to reduce morbidity, prevent avoidable admissions to hospital and long term care and their associated costs, and improve quality of life of older people.[1,3]

In addition, failure by health and care professionals to identify frailty in older people potentially exposes frail older people to interventions from which they might not benefit and may actually be harmed. Therefore, simply identifying older people who are frail can help prevent harm in this vulnerable group of adults.[4]

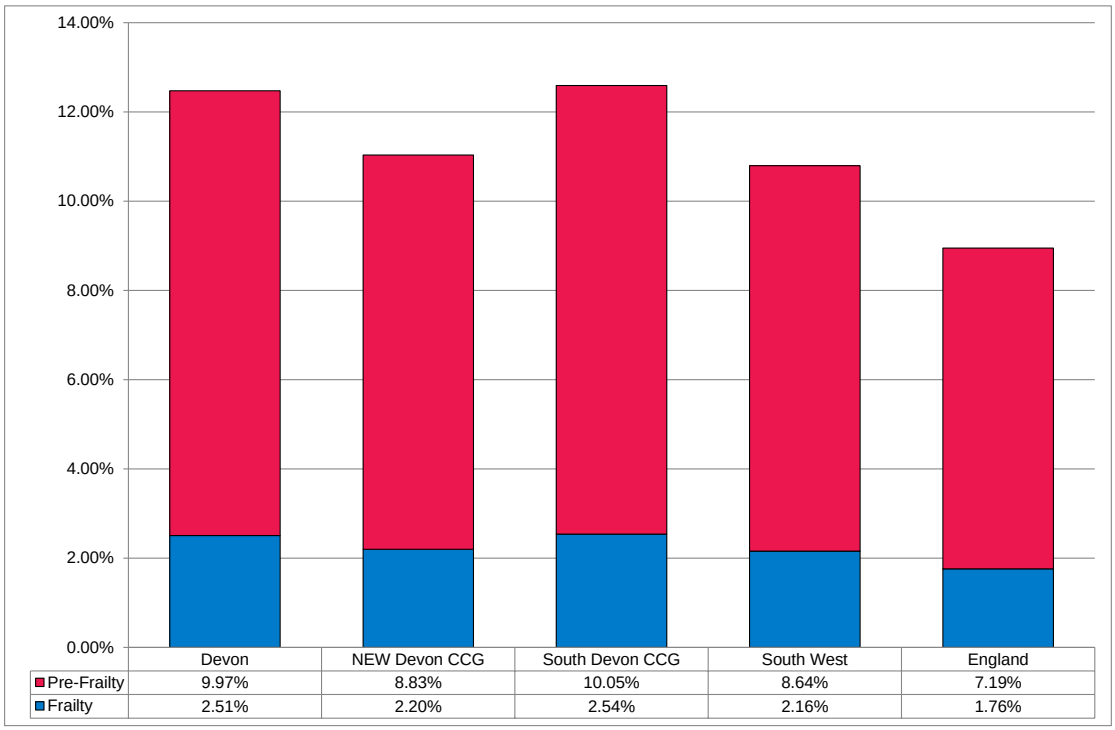
Conversely, it is possible for older people who are not frail to be refused treatment when decisions are based on age alone if it is assumed all older people are frail. Between 25 to 50% of over 85 year olds are frail. This means that up to 75% may not be frail.[4]

2. How many frail older people are there in Devon?

It is estimated that approximately 11% of over 65 year olds are frail, defined as having three or more symptoms from weight loss, self-reported exhaustion, low energy expenditure, slow gait speed and weak grip strength.[5] About 42% of over 65 year olds have one or two of these symptoms and are categorised as pre-frail.

This equates to 2.51% (19,001 people) of the Devon population who are frail and 9.97% (75,546 people) who are pre-frail (graph 1 and table 1).

Graph 1: Estimated percentage of total population who are frail or pre-frail and aged 65 and over



	Devon	NEW Devon CCG	South Devon CCG	South West	England
Pre-Frailty	9.97%	8.83%	10.05%	8.64%	7.19%
Frailty	2.51%	2.20%	2.54%	2.16%	1.76%

[4] Clegg et al (2013). Frailty in elderly people. *Lancet*; 381:pp752-62.
[5] Collard et al (2012). Prevalence of frailty in community-dwelling older persons: A systematic review. J Am Geriatr Soc; 60: pp1487-92.

Table 1: Older People Frail Estimates: Devon (Devon County Council), 2013

Age Group	Reported Frailty Rate	Reported Pre-Frailty Rate	Population	Estimated Frailty	Estimated Pre-Frailty
65 and over	-	41.6%	181,600	19,001	75,546
65 to 69	4.0%	-	56,422	2,257	-
70 to 74	7.0%	-	40,334	2,823	-
75 to 79	9.0%	-	32,639	2,938	-
80 to 84	15.7%	-	25,408	3,989	-
85 and over	26.1%	-	26,797	6,994	-

As these estimates focus on older people over 65 years of age with either frailty or pre-frailty, it is important to note that these are likely to be underestimates, as a proportion of the under 65 year old population will meet the criteria for frailty and pre-frailty.

Estimates frailty and pre-frailty in older people in Northern, Eastern and Western Devon Clinical Commissioning Group are displayed in table 2 and for South Devon and Torbay Clinical Commissioning Group in table 3.

Table 2: Older People Frail Estimates: Northern, Eastern and Western Devon Clinical Commissioning Group (part of Devon County Council and Plymouth City Council), 2013

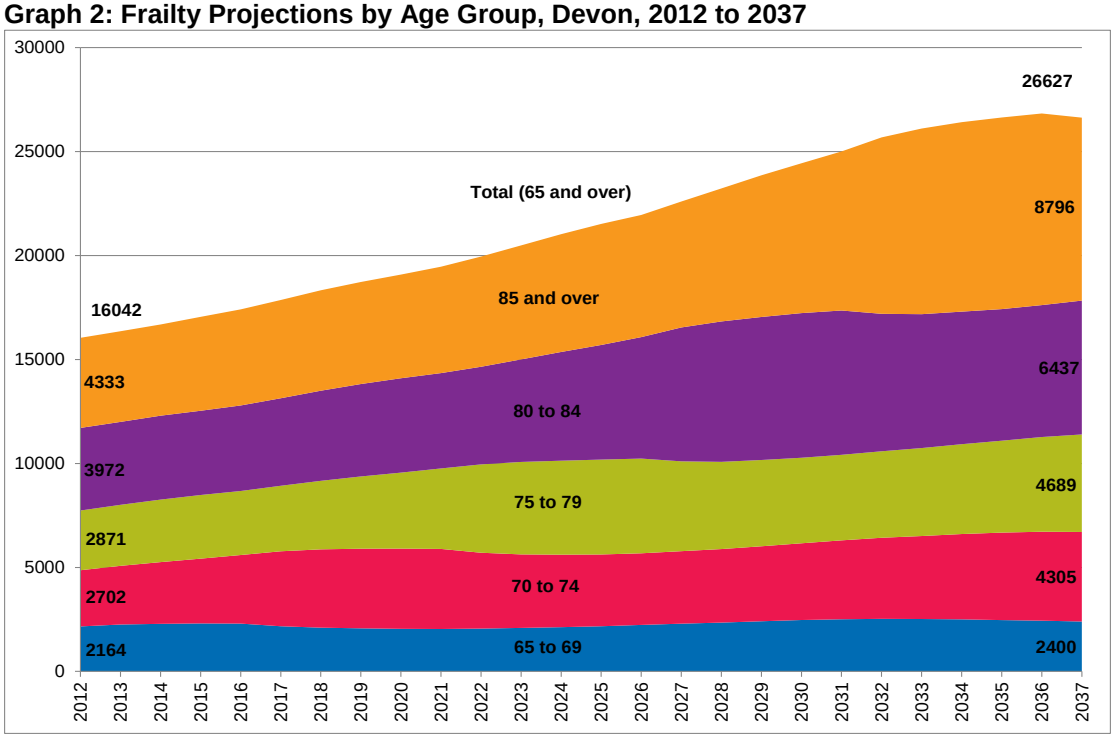
Age Group (years)	Reported Frailty Rate	Reported Pre-Frailty Rate	Population	Estimated Frailty	Estimated Pre-Frailty
65 and over	-	41.6%	190,811	19,741	79,377
65 to 69	4.0%	-	59,505	2,380	-
70 to 74	7.0%	-	42,775	2,994	-
75 to 79	9.0%	-	34,832	3,135	-
80 to 84	15.7%	-	26,767	4,202	-
85 and over	26.1%	-	26,932	7,029	-

Table 3: Older People Frail Estimates: South Devon and Torbay Clinical Commissioning Group (part of Devon County Council and Torbay Council), 2013

Age Group (years)	Reported Frailty Rate	Reported Pre-Frailty Rate	Population	Estimated Frailty	Estimated Pre-Frailty
65 and over	-	41.6%	69,783	7,337	29,030
65 to 69	4.0%	-	21,676	867	-
70 to 74	7.0%	-	15,447	1,081	-
75 to 79	9.0%	-	12,472	1,122	-
80 to 84	15.7%	-	9,646	1,514	-
85 and over	26.1%	-	10,542	2,751	-

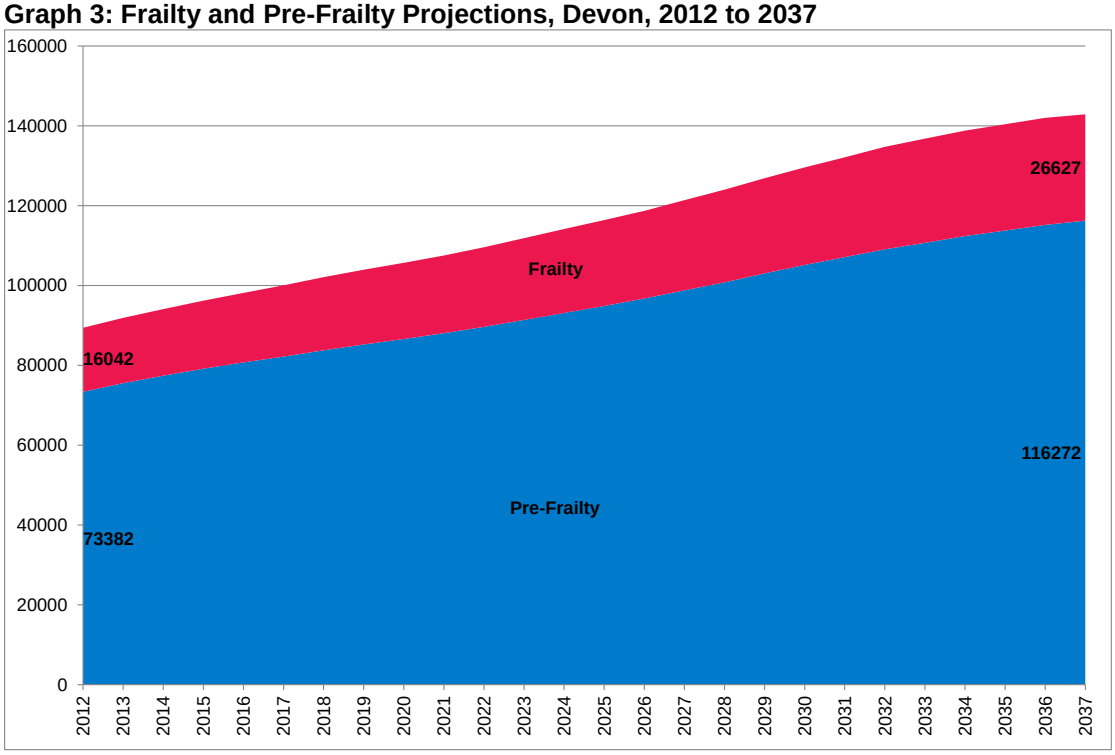
The number of older people who are frail is predicted to rise over the next 25 years (graph 2).

Graph 2: Frailty Projections by Age Group, Devon, 2012 to 2037



It is predicted that by 2037 there will be 26,627 older people who are frail and 116,272 who are pre-frail (graph 3).

Graph 3: Frailty and Pre-Frailty Projections, Devon, 2012 to 2037



3. What can we do about frailty?

In January 2014, NHS England published *Safe, compassionate care for frail older people using an integrated care pathway.*[6] Their pathway contains nine stages, each containing evidence-based examples (taken from the Silver Book[7] and the King's Fund's *Making our health and care systems fit for an ageing population*[8]):

1. Healthy active ageing and supporting independence
2. Living well with simple or stable long-term conditions
3. Living well with complex comorbidities, dementia and frailty
4. Rapid support close to home in a crisis
5. Good acute hospital care when (and only when) needed
6. Good discharge planning and post-discharge support
7. Good rehabilitation and re-ablement after acute illness or injury
8. High quality nursing and residential care for those who truly need it
9. Choice, control and support towards the end-of-life

3.1. Healthy active ageing and supporting independence

Aim: Older people should be able to enjoy long and healthy lives, feeling safe at home and connected to their community.

Healthy ageing is associated with **being physically active, not smoking, eating healthily, maintaining a healthy weight and drinking alcohol sensibly**. Therefore, changing these common behavioural risk factors during adult life, not only reduces the risk of non-communicable disease (such as heart disease or stroke), but also helps prevent dementia, disability and frailty.

The National Institute for Clinical Excellence (NICE) have recently published draft guidance on **mid-life approaches** to the prevention of dementia, disability and frailty.[9] The guidance emphasises changes to these behavioural risk factors during adult life will reduce the risk of dementia, disability and frailty in later life. The **NHS Health Check programme** provides one mechanism to do this. Individual behaviour change approaches such as this are likely to be more cost effective and less likely to widen health inequalities when combined with **population-based approaches**.

Uptake of the **breast, bowel and abdominal aortic screening programmes** should be encouraged to ensure the cost-effectiveness of the programmes.

Psychosocial risk factors such as **social isolation**, loneliness and social exclusion are associated with cognitive decline and dementia. They reduce resilience to disease onset and progression, increasing morbidity and mortality. Interventions to improve social connectedness reduce GP attendances, hospital admissions and long-term care requirement. Evidence of effective interventions is limited, but group-based interventions, older people undertaking volunteering, or those that combine public services action with volunteering and greater involvement of families and communities are more likely to be effective. Low level interventions, such as household repairs and other practical support can also help to maintain independence.

Winter planning, including influenza and pneumococcal immunisation, actions to combat fuel poverty and improve housing preparedness (insulation), and capacity planning, helps prevent excess winter deaths.

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[6] NHS England (2014). *Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders.*
[7] http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
[8] The King's Fund (2014). *Making our health systems fit for an ageing population*
[9] NICE Public Health Draft Guidance (PHG64) *Dementia, disability and frailty in later life – mid-life approaches to prevention*

Ensuring **appropriate housing** in terms of location, affordability, size, tenure and facilities is crucial for making sure older people can remain in their own homes. New housing stock must reflect the needs of the local ageing population and existing housing should be adapted to maximise the independence and safety of older people.

Locally:

- *33,153 people in Devon were offered a health check in 2013-14. This represents 13.54% of the eligible population (244,934), which is below the South West (16.17%), comparator group (18.79%) and England (18.45%) rates.*[10]
- *14,142 people in Devon received a health check in the first three quarters of 2013-14. This represents 5.77% of the eligible population (244,934), which is below the South West (7.35%), comparator group (8.43%) and England (9.03%) rates.*[11]
- *Uptake of influenza immunisation in over 65 year olds, and in particular in at-risk under 65 year olds, is low compared with child immunisation uptake rates. A programme of work is underway to increase uptake rates in these groups.*[12]
- *Just under 1 in 10 people in Devon live in fuel poverty (9.73%), which is above the South West average (9.39%), but below the local authority comparator group (10.05%) and England (10.90%) rates. Within Devon the highest levels of fuel poverty were seen in Exeter (10.88%) and the lowest were seen in Mid Devon (8.87%).*[13]
- *Self-reported wellbeing (low happiness score) - Within Devon, 9.2% of the population had a low happiness score (ranked 0-4 on a scale of 10) on the index compared with 10.4% for the South West, 9.4% in the local authority comparator group and 10.4% in England overall.*[14]
- *Social contentedness - 40.6% of social care users surveyed in Devon in 2012-13 reported being satisfied with their social situation, this is slightly below the South West, local authority comparator group and England rates at 44.8%, 45.2% and 43.2% respectively.*[15]

3.2. Living well with simple or stable long-term conditions

Aim: Older people with simple or stable long-term conditions should be enabled to live well, avoiding unnecessary complications and acute crises. Older people should receive the same care and support as younger people with the same long-term condition.

The principles of effective management of long-term conditions apply equally to people of all ages. Decisions should not be based on age alone.[16] Nationally, there is substantial evidence that care and support for older people is unjustifiably inequitable.

Population risk stratification through targeted case finding of at-risk groups within the older population may be effective in identifying unmet need, but only if these are combined with evidence-based, tailored interventions for each group.

Decision making should be shared with older people and **personalised care plans** developed. This is repeatedly identified by patients and their families as important.

Self-management[17] support is a portfolio of techniques and tools to help patients choose healthy behaviours, combined with a fundamental transformation of the patient-caregiver

[10] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon_PHOF_Jun14_2.22_Offered_NHS_Health_Check.pdf
[11] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon_PHOF_Jun14_2.22_Received_NHS_Health_Check.pdf
[12] http://www.devonhealthandwellbeing.org.uk/aphr/2013-14/
[13] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon_PHOF_Jun14_1.17_Fuel_Poverty.pdf
[14] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon_PHOF_Jun14_2.23_Wellbeing_Low_Happiness_Score.pdf
[15] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon_PHOF_Jun14_1.18_Social_Contentedness.pdf
[16] *The Equality Act 2010*

relationship into a collaborative partnership.[18] As such, patients should be offered the opportunity to co-create a **personalised self-management plan** (tailored to their condition), which could include:[19]

- Patient and carer education programmes
- Medicines management advice and support
- Advice and support about diet and exercise
- Use of telecare and telehealth to aid self-monitoring
- Psychological interventions (e.g. coaching)
- Pain management
- Patient access to their own records

Self-management can be supported through appropriate **assistive technologies.**[20] This ranges from memory aids to telecare[21] and telehealth[22]. Evidence on the benefits of telecare is equivocal, but it is most likely to be effective if used as part of, rather than instead of, integrated locality-based services to support older people. Telehealth may possibly benefit older people with single specific long-term conditions, such as heart failure, diabetes or stroke, or for remote and rural populations, but the evidence is mixed for people with multiple long-term conditions and there is no definitive evidence that it will reduce hospital admissions or costs.

Older people should be offered the choice of **personalised care budgets and direct payments**, but safeguards need to be in place to ensure that vital care and support needs not covered are provided. Most personal budget holders report a positive impact on many aspects of their lives, but in older people these benefits are more uncertain and may be offset by increased anxiety and uncertainty.

Locally:

- *In Devon between January and September 2013, 68.1% of people with a long-term condition in the GP survey, felt they had enough support to manage their own condition. This is significantly higher than the national (64.0%), South West (66.1%) and local authority comparator group (64.7%).*[23]

3.3. Living well with complex comorbidities, dementia and frailty

Aim: Health and care services should support older people with complex multiple comorbidities to remain as well and independent as possible and to avoid deterioration and complications.

Care focused on individual long-term conditions can be chaotic, inefficient and ineffective (e.g. polypharmacy). Coordination of care around all of the needs of a frail older person could be facilitated by improving relational continuity of care with an identified keyworker who acts as a case manager and coordinator of care across the system; e.g. the new GP contract in England will ensure all people over 75 years of age with complex multiple co-morbidities have a **named GP**.[24] Multi-component approaches to improve coordination of care are more likely to be effective than single component approaches. **Community-based multi-professional**

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[17] Self-management can be defined as a subset of self-care, it is about individuals making the most of their lives by coping with difficulties. It includes managing or minimising the way the condition limits the individual as well as what they can do to feel happy and fulfilled despite their condition

[18] de Sliva D (2011). *Helping People Help Themselves.* London: The Health Foundation.

[19] The King's Fund (2012). From Vision to Action: Making patient-centred care a reality. London: The King's Fund

[20] Assistive technology is an umbrella term for any device or system that allows an individual to perform a task they would otherwise be unable to do or that increases the ease and safety with which the task can be performed

[21] Telecare can be defined as the use of electronic sensors and aids that aim to make the home environment safer, enabling people to live at home, independently, for longer. Sensors automatically raise alarms through call centres, wardens or friends and family

[22] Telehealth is the use of electronic sensors or equipment to monitor people's health in their own homes (e.g. blood pressure, weight, oxygen levels). Information can be monitored by clinicians without the individual leaving their home

[23] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Manage-Own-Condition.pdf

[24] DoH (2014). *Transforming Primary Care. Safe, proactive, personalised care for those who need it most*

teams based around general practices and comprehensive geriatric assessments to develop **coordinated, integrated plans for long-term treatment and follow-up** are key components.[25]

Outcomes are improved in frail older people who are encouraged to be more active, therefore opportunities to participate in exercise should be provided. Older people are more likely to participate if delivered as communal activity to improve wellbeing with professional support.

Falls prevention services and comprehensive services to ensure both the **early diagnosis and adequate care and support of dementia** are vital.

There is an extensive evidence base on effective interventions to reduce falls and the National Institute for Clinical Excellence (NICE) have published the NICE Clinical Guideline (CG161) *Falls: assessment and prevention of falls in older people*. The key issues set out in the NICE Commissioning Guide (CMG48) *Support for Commissioning Dementia Care*, NICE Clinical Guideline (CG42) *Dementia: Supporting people with dementia and their carers in health and social care* and the government's *Living well with dementia: a national dementia strategy* (2009) include accurate early diagnosis, information and support, corresponding capacity in support services to match the improved diagnosis, reduced antipsychotic prescribing and training for carers.

Carers of frail older people should be offered an independent assessment of their needs and signposted to interventions to support them in their caring role.

Locally:

- *There were 3,259 admissions due to falls in 2012-13 in Devon for people aged 65 and over. The age standardised rate per 100,000 was 1672.8 in Devon, which is below the South West (1875.6), local authority comparator group (1809.9) and England (2011.0) rates. The rate is Devon is the second lowest in the South West.*[26]
- *The diagnosis of dementia in Devon needs to be improved. In 2012-13, 5,483 people in Devon were on a GP register for dementia, compared with an expected prevalence of 13,093, this is a diagnosis rate of 41.9%. This is the third lowest ratio in the South West, and is below the South West (46.5%) and England (48.1%) rates.*[27]
- *The carer reported quality of life in Devon is in line with both the South West and national average.*[28]

3.4. Rapid support close to home in a crisis

Aim: Frail older people can become rapidly immobile or confused, fall or go from coping to not coping when they experience even a minor illness or event. When their health or independence rapidly deteriorates, they should have rapid access to urgent care, including effective alternatives to hospital.

There should be a **single point of access to community services**. A **comprehensive geriatric assessment** should take place within four hours of referral, 8am to 8pm, seven days a week. This will require **rapid access ambulatory clinics** available in acute and community hospital settings for specialist advice from the multidisciplinary team, including mental health and community geriatrician support, and ambulatory emergency care pathways. This could be facilitated by personalised care plans, including an emergency contingency plan and advanced care plan, as well as shared care protocols with ambulance organisations to enable older people to remain at home.

[25] The King's Fund (2012). From Vision to Action: Making patient-centred care a reality. London: The King's Fund
[26] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Injuries-Due-to-Falls.pdf
[27] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Dementia-Diagnosis-Rate.pdf
[28] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Carer-Quality-of-Life.pdf

Locally:

- *In the period from October 2012 to September 2013 the rate of avoidable emergency admission per 100,000 population was 1787.8 in Devon, which was in line with the South West rate (1786.6), but significantly below the England rate (1976.3).*[29]

3.5. Good acute hospital care when (and only when) needed

Aim: Acute hospital care must meet the needs of frail older people. Hospitals should ensure they provide access to specialist input, minimise ward moves, minimise preventable harm (including malnutrition, delirium and immobility as a result of bed rest) and provide compassionate and person-centred care.

One way of delivering this would be **an identified frailty unit or service** with staff trained how to look after frailty, focusing on rapid comprehensive geriatric assessment, treatment and rapid discharge.

All hospitals should compare their own standards of assessment and treatment of frail older people against those set out in the Silver Book guidelines on emergency care for older people. NICE have published guidance on Delirium: Diagnosis, prevention and management (NICE Clinical Guideline (CG103)).

Robert Francis's report into the failings at the Mid Staffordshire Foundation Trust recommends the need to develop the right culture of care within the NHS through better leadership, training, information and transparency. In their response the government reinforces the link between culture and compassionate care for older people. Part of this response involved reforming the law relating to care and support for adults. The Department of Health's *The Care Act 2014* sets out the responsibility of local authorities to promote wellbeing when carrying out any of their care and support functions. It recognises that in doing so, local authorities will need to move towards a model centred on meeting needs through preventing or delaying care and support needs, rather than simply the provision of services.

Locally:

- *There were three cases of MRSA Bacteraemia in 2013-14 in Devon, Plymouth and Torbay. The incidence rate per 100,000 in Devon (0.3) was below the South West (0.8) and England (0.8) rates.*[30]
- *There were 302 cases of Clostridium Difficile in 2013-14 in Devon, Plymouth and Torbay. The incidence rate per 100,000 in Devon (26.4) was broadly in line with the South West (26.6), and England (25.0) rates.*[23]
- *Overall, the percentage of patients in the 2012 Devon hospital bed occupancy in Devon acuity audit who were "fit to leave" was 30.5%. This is a reduction of 1.6% since 2011, where 32.1 % of patients in a comparable setting were classed as "fit to leave" and a reduction of 8.1% since 2010, where 38.6% of patients in a comparable setting were classed as "fit to leave".*[31]

3.6. Good discharge planning and post-discharge support

Aim: Discharge planning should start on admission to hospital and involve older people and their carers or families in decision making. The NHS and social care must work together to ensure patients can leave hospital once their clinical treatment is complete, with good post-discharge support in the community to prevent readmission.

Communication between services and coordination of care is essential whenever there is a transfer of care. This can be achieved by a **hospital-based multidisciplinary team integrated with the community team**, focused on the facilitation of discharge and the

[29] Devon Better Care Fund Outcomes Report – 4th August 2014
[30] NHS Outcomes Framework CCG assigned cases
[31] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/10/Acuity-Audit-2012-FINAL.pdf

provision of Care Packages to support discharge within 24 hours of referral to Adult Care and Support.

Locally:

- *In Devon in 2010-11, 10.29% of patients discharged after an emergency admission were readmitted within 30 days. This is significantly below the South West (10.93%), local authority comparator group (10.95%) and England (11.78%) rates.*[32]

3.7. Good rehabilitation and re-ablement after acute illness or injury

Aim: Frail older people should receive adequate rehabilitation and re-ablement when needed to prevent permanent disability, greater reliance on care and support, avoidable admissions to hospital, delayed discharge from hospital.

To prevent inappropriate placements, there should be adequate periods of assessment and recovery before any decision is made to move into long-term care. **Contracting and commissioning services on the basis of outcomes** rather than time periods and tasks would facilitate this.

Although there must be adequate inpatient rehabilitation, the majority of rehabilitation services could be provided in the community. **Shared assessment frameworks** across health and social care would lead to a personalised care plan for each individual and improve continuity of care.

Locally:

- *In 2010 Devon implemented a countywide in-house social care re-ablement service for older people. The service works with people who would normally receive long term personal care to get back on their feet as quickly as possible and help them to stay independent for longer. In 2012-13, re-ablement services were effective for 87% of older people who received the service in Devon, compared with 81% in the South West and 81% nationally.*[33]
- *In 2012-13 1.7% of older people discharged from hospital in Devon were offered re-ablement services, compared with 3.1% in the South West and 3.3% nationally.*[34]

3.8. High quality nursing and residential care for those who truly need it

Aim: Frail older people should only move into long-term care when treatment, rehabilitation and other alternatives have all been exhausted.

If all older people for whom long-term care is being considered had **a comprehensive geriatric assessment of need**, adequate treatment of medical problems which are precipitating decisions to move, adequate rehabilitation and wherever possible, were not admitted directly from acute hospital settings, avoidable long-term care admissions would be prevented.

Frail older people living in long-term care should consistently receive high quality care that is person-centred and dignified. **Care home staff, both registered and non-registered, should receive training** together on site.

Frail older people living in long-term care should have access to the same high-quality, multi-disciplinary and multi-agency health care as those not living in long-term care. This could be achieved by making **healthcare for those living in long-term care an actively**

[32] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Readmissions-to-Hospital-Within-30-Days.pdf
[33] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Reablement-Services-Effectiveness.pdf
[34] http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/06/Devon-HWB-Outcomes-Report-June-2014-Reablement-Services-Coverage.pdf

commissioned service with clear service specifications, including, for example, a comprehensive geriatric assessment on admission and a personalised care plan, linked to quality standards detailed in contracts.

NICE has published guidance on managing medicines in care homes (NICE Guideline (SC1)).

Locally:

- *There were 625.0 permanent admissions to care homes per 100,000 persons aged 65 and over in Devon in 2012-13. This is below the South West (680.8), local authority comparator group (685.9), and England (697.2) rates.*[35]

3.9. Choice, control and support towards the end-of-life

Aim: End-of-life care services should provide high-quality care, support, choice and control, and should avoid 'over medicalising' what is a natural phase of the ageing life course.

The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs and preferences and deliver care to meet these needs. This can be facilitated by using a structured approach such as The National Gold Standards Framework Centre in End-of-Life Care, ensuring **advanced care planning** with older people as they approach the end of their life.[36]

Locally:

- *In 2012, 20.0% of deaths in Devon occur in a person's own home compared with 20.3% nationally. In a 2002 survey the proportion of people who stated they would prefer to die at home was 56%.*[37]

4. Summary

The guidance set out in NHS England's *Safe, compassionate care for frail older people using an integrated care pathway* aims to transform the way frail older people experience health and social care. The recommendations contained within the document can be condensed into the following 4 principles:

1. Prevention is key
    - Primary prevention (reducing the incidence of disease and health problems within the population)
    - Secondary prevention (systematically detecting the early stages of disease and intervening before full symptoms develop)
    - Tertiary prevention (reducing the impact of disease and promoting quality of life)
2. Care decisions should be based on functionality, not age alone
3. Promotion of integrated care
    - Shared decision making with older people
    - Person-centred care, not disease specific care (comprehensive geriatric assessment and personalised care plan)
    - Continuity of care (relational continuity)
    - Coordination of care (improved communication between and links across services)
4. Improvements to the quality of care
    - Responsiveness
    - Safety
    - Compassionate services

[35] Devon Better Care Fund Outcomes Report – 4th August 2014
[36] http://www.goldstandardsframework.org.uk/
[37] 2012 End-of-Life profiles

5. Equality and Legal Considerations
This report has no specific equality or legal implications that are not already covered by or subsumed within the detailed policies or actions referred to therein'.

6. Public Health Impact
The Devon Health and Wellbeing Board will be central to overseeing the commissioning of services which address public health and other relevant health and wellbeing outcomes

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DEVON COUNTY COUNCIL

Electoral Divisions: All

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Background Papers
Nil