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advantAGE
MANAGING FRAILTY

Models of Care for Frailty – Report on Good Practices
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Work package: 7
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CONTENTS

BACKGROUND

ADVANTAGE JA WP 7 objectives for 2017 – 2018 are:

- To identify and share examples of good practice on models of person-centred care and support in different settings (primary health care, community care, social care and hospital care) in order to prevent or delay progression of frailty and enable people to live well with frailty.
- To analyse the impact of good practice models of care at an individual level and on health and social care systems including economic impact.
- To analyse the transferability for scaling-up of these models of care.

These objectives have been progressed through the following tasks:

7.1. Analyze established models of integrated care and support for long-term, chronic conditions in terms of their impact on the prevention or management of frailty. (Lead: MASSDF France).

7.2. Describe examples of person-centred coordinated care and support to prevent and tackle frailty in primary care settings. (Lead: HSE-NUIG, Ireland).

7.3. Describe how social care providers can implement enabling approaches at home or in care homes to delay progression of frailty and improve the quality of life and functional outcomes for older people and their caregivers. (Lead: THL, Finland).

7.4. Describe the experience and functional outcomes of comprehensive assessment and care in hospitals and at times of transition. (Lead: NHS Lanarkshire, UK).

7.5. Analyse case studies of comprehensive care models to assess outcomes, resource use and costs to inform the business case for investing in early interventions to prevent frailty and functional decline. (Lead: Kronikgune, Spain)

During the first year, partners produced a State of the Art Report (SoAR) on the evidence supporting frailty prevention and management activities, both at a personal and population level (Rodríguez-Laso A. et al., 2017). This was based on a review of the scientific literature published between 2002 and 2017, and a targted search of relevant grey literature.

The current evidence supports the case for a more holistic and integrated model of care for frailty, blending a chronic care approach (frailty viewed as a chronic syndrome) with education, enablement and rehabilitation to optimise function, particularly at times of a sudden deterioration in health, or when moving between home, hospital or care home (Hendry A. et al., 2018). In all care settings, these approaches should be supported by comprehensive assessment and multidimensional interventions tailored to modifiable physical, psychological, cognitive and social factors and appropriate to the goals and circumstances of the individual.

The SoAR recommends that effective models of care for frailty should incorporate the following components:

- a single entry point in the community – generally in Primary Care
- use of simple frailty specific screening tools in all care settings
- comprehensive assessment and individualised care plans – including for caregivers
- tailored interventions by an interdisciplinary team – both in hospitals and community
- case management and coordination of support across the continuum of providers
- effective management of transitions between care teams and settings
- shared electronic information tools and technology enabled care solutions
- clear policies and procedures for service eligibility and care processes.

In 2018, ADVANTAGE JA collected information from participating Member States (MS) and regions about their current approaches (strategies, policies, programmes, research and education) to address frailty. This complements the SoAR literature review and was designed to identify experience yet to be published. The consortium aims to analyse, discuss and use this information to build consensus for a common Frailty Prevention approach.

Work Package 7 partners have analysed the responses to survey questions on models of care submitted by the MS. This report outlines the collaborative process undertaken and highlights examples of good practice models of care that can be a source of inspiration for policy makers and wider stakeholders. These models of care may be spread or scaled as part of a comprehensive and integrated system to prevent and manage frailty.

Methods

WP7 leader, co-leader and Task leaders analysed free text responses to questions that sought to understand the models of care for frialty already implemented by participating Member States. They were asked to consider if the model of care described by the MS is in line with the recommendations of the SoAR, has been implemented at national or regional level, and if there is any supporting data on impact.

For consistency of assessment, WP7 task leaders were asked to review the responses by all MS to the survey questions that related to their tasks 7.2 – 7.5:

- Holistic social care, support and enablement
- Continuity and coordination in primary care
- Comprehensive assessment in hospitals
- Intermediate care and management of transitions

The specific survey questions for MS were:

- Please provide a brief description of holistic models of care for frailty being implemented in your country – indicating their status, target group, eligibility criteria, delivery settings, and any barriers or facilitators identified.
- Please describe how your country / region organises primary care services for frail older people – indicating the disciplines involved, actions to enable continuity and coordination of care and any relevant contractual levers, guidelines or standards that are applicable.
- Please describe how your hospitals a)provide care for frail older people specifically oriented to detect and prevent functional decline during admission and b) coordinate the care and support required for frail older people after discharge.
- Please describe briefly how social care services at home and in care homes support their staff to promote independence and wellbeing of frail persons and their caregivers – indicating the structures, processes and any relevant contractual levers, guidelines or standards that are applicable.
- Please provide a web link to your policy framework or guidance on "intermediate care" and/or "transitional care models" at the interface between hospital and community services (including primary care) – signposting to good practice examples of community alternatives to admission and supported hospital discharge where possible.
- Please describe briefly the impact of integrated models of care for frail adults in your country in terms of cost benefits, health outcomes or quality of life – indicating any lessons learned from evaluation of these models of care.

Table 1 lists the anchor statements agreed by the group to enable consistent assessment of the maturity of the models of care in the different care settings.

Table 1 Descriptors of level of implementation of the model of care

IMPLEMENTATION	**DESCRIPTION**
Sustainable	a NATIONAL strategy on ……. that has been EVALUATED or there is an agreed plan to SUSTAIN it
Advanced	There is a NATIONAL strategy on …….
Well developed	There is a WIDE ARRAY of programmes, guidelines or interventions to deliver ……..across most of the member state
Fair	There are SCATTERED programmes, guidelines or interventions by some providers in some areas for …….
Basic	There are NO specific programmes, guidelines or interventions to support…. …….

The information on MS considered to have an advanced stage of implementation was reviewed again through the lens of the EC definition and guidance on Best Practices:

a relevant policy or intervention implemented in a real life setting and which has been assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes. Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, intersectorality and participation of stakeholders.

Task leaders assessed the MS models of care examples against the following criteria:

- ✓ Model of Care is relevant for a frail population
- ✓ Model of Care does not breach ethical principles
- ✓ Model of Care promotes participation and empowerment
- ✓ Model of Care is consistent with the SoAR recommendations
- ✓ Model of Care design is well described – eg target/ pathway / stakeholders
- ✓ Model of Care is interdisciplinary, integrated and intersectoral
- ✓ Model of Care has been evaluated
- ✓ Model of Care is sustainable
- ✓ Model of Care is transferable to other systems

Results

Only three MS were considered to be at an advanced stage of implementing evidence based models of care for frailty across the continuum of care (Table 2). However in seven other MS, some elements were considered to be advanced. A further six MS had well developed models of care for frailty, albeit without a strategic national or regional approach.

Table 2 Implementation Status by Member States

Status of Examples	No of MS	Member State
Advanced In all 4 elements	**3**	Finland, France, UK
Advanced In 3 elements	**2**	Italy, Spain
Advanced In 1 element	**5**	Belgium, Ireland, Poland, Portugal, The Netherlands,
Well developed	**6**	Austria, Cyprus, Germany, Hungary, Malta, Slovenia
Basic / fair	**5**	Bulgaria, Croatia, Greece, Lithuania, Romania

The model of care was considered to be advanced in 23 examples from 10 MS.

Table 3 Advanced implementation by stage of pathway

Advanced examples	Total	MS
Holistic social care, support and enablement	**5**	Finland, France, Italy, Spain, UK
Continuity and coordination in primary care	**6**	Finland, France, Italy, Spain, The Netherlands, UK
Comprehensive assessment in hospitals	**7**	Belgium, Finland, France, Ireland, Poland, Spain, UK
Intermediate care / management of transitions of care	**5**	Finland, France, Italy, Portugal, UK

Limitations

There were limitations in the survey context and process affecting the responses and analysis:

- There was considerable variation in the level of detail reported by MS in the surveys and in the extent of stakeholder involvement in the process
- Awareness of models of care is likely to have been influenced by the specific expertise and sector perspective of MS beneficiaries completing the survey.
- The survey offers a snapshot in time and does not convey the emerging practice
- Assessing national implementation is difficult as many guidelines, strategies and programmes are implemented at a regional level, particularly when healthcare is devolved to regional administrations
- The system context, particularly access to universal health coverage, funding and development of the social sector, has a strong influence on holistic care, continuity and coordination
- MS with the most mature implementation of models of care for frailty across the whole pathway have had a greater emphasis on integrated health and social care and interdisciplinary primary care and community services.
- Societal and professional cultures are critical enablers for successful adoption of integrated care. Therefore examples need to be thoughtfully considered and adapted to suit another country context.

The purpose of this report is to provide insight and inspiration on the most comprehensive models of care for frailty that have been implemented by participating MS. The authors acknowledge that there are examples of innovation and emerging good practice in some care settings in many other MS.

The first three Case Studies describes three examples of comprehensive integrated models of care implemented at scale across the whole pathway.

A further three Case Studies highlight good practice models of continuity and coordination of primary care that have been implemented to an advanced level in some regions, and where the MS has shared some evidence about impact.

More information on impact and cost effectiveness of models of care is available in the WP7 analysis of information on outcomes, resource use and costs of care from the scientific literature on models of care for frailty.

CASE STUDIES

1 FINLAND

Context

The Constitution of Finland stipulates that society must guarantee adequate social, health and medical services for everyone and promote the health of the population. The Ministry of Social Affairs and Health oversees national policy and strategy on ageing, advises on relevant legislation, coordinates the development of quality recommendations, and delivery of a number of national and regional programmes and projects. These emphasis the principles of prevention, maintenance of functional capacity, independent living at home and active participation in society. An important goal is to add more healthy years without loss of functional capacity.

Aims

- Guarantee good health and wellbeing for older people
- Support health, functional capacity and independent living.
- High-quality, equitable, coordinated and cost-effective services based on the individual's needs
- Evidence for policy-makers and leaders to develop and evaluate these services

Implementation experience

A comprehensive programme of actions coordinated at national and regional levels:

- National legislation - National Elderly Care Act
- National Quality Recommendations that address the topis of function; counselling; workforce; age friendly services.
- National Government key programme: 'Improved home care for older persons and enhanced informal care in all age groups'' focuses on re-ablement to ensure as healthy and independent a life as possible.
- National Government key programme to improve home care for older people - focuses on re-ablement to ensure as healthy and independent a life as possible.
- KAAPO centres - a one-stop-shop approach to service guidance, allocation and client and service coordination.
- National Development Programme KASTE 2010–2015 for earlier intervention and enhanced staffing for home care
- Age Institute Foundation Programme to disseminate the Strength in Old Age model in municipalities to promote physical activity among people in later life.
- Primary care: integrated with formal and informal care networks, social supports and housing in all municipalities.
- Devolved decision making and resources to regions and municipalities

- Hospital programmes - CGA delivered by geriatric polyclinics, geriatric wards and in hip fracture rehabilitation pathways
- Regional rehabilitation and Intermediate care services that include a case/care manager or care coordinator, discharge team and liaison nurses and may include hospital at home, or home rehabilitation.

Weblinks to documents

- Act on Supporting the Functional Capacity of the Older Population and on Social and Health Care Services for Older Persons
- Ministry of Social Affairs and Health - Older people
- Health Promotion programme
- Improved homecare for older persons

Impact

The Elderly Care Act has been carefully monitored and evaluated by the National Institute for Welfare and Health - a specialist and research institution tasked with research and development on health services and other specialist tasks in the field - and by the National Supervisory Authority for Welfare and Health.

SOTKAnet national Indicator Bank provides indicators for monitoring and benchmarking of health and welfare, service needs, service structures and finances. For example, ''the status of the elderly services'' survey is sent to all social and health care organisations and municipalities. https://sotkanet.fi/sotkanet/en/index

The Report on Basic Public Services provides decision-makers at different levels of public administration with an overview of the current state of these services in Finland. The FinHealth population study, in 50 municipalities around Finland, includes a health examination and self-administered questionnaires. Some of those invited to participate are also selected to an interview on nutrition or physical activity and sleep measurements. Key risk factors for chronic diseases, including elevated blood pressure, total cholesterol and obesity, continue to be very common. While the quality of life of older people has improved, the previously observed positive development in functional capacity and work ability appears to have slowed down or stopped. https://thl.fi/fi/web/thlfi-en/research-and-expertwork/population-studies/national-finhealth-study

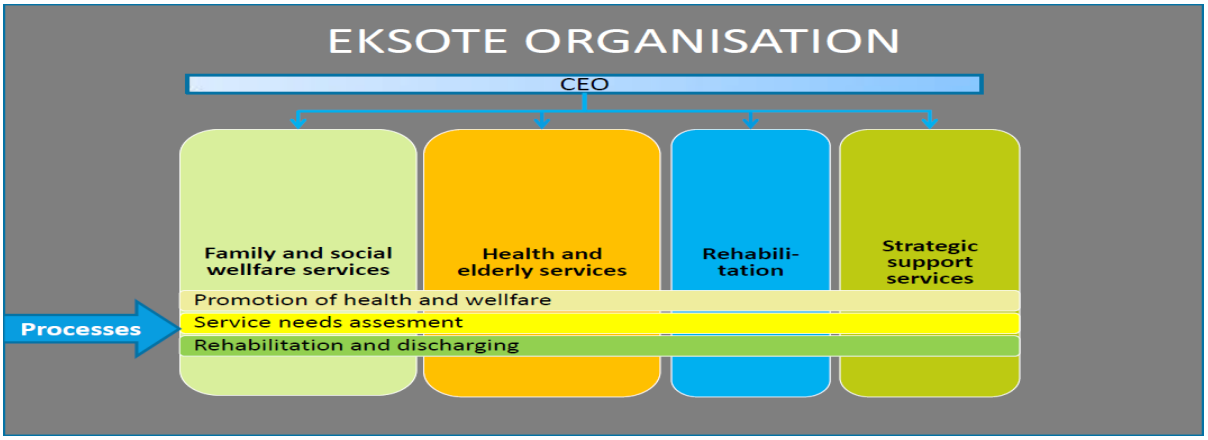
A clustered randomized controlled trial of a generic prototype of integrating the care of frail older adults in the community (PALKO) was shown to improve integration albeit had little impact on quality of life or functional outcomes (Hammar et al.,2007).

National Government key programme 'Improved home care for older persons and enhanced informal care in all age groups'' impacts will be assessed.

Regional example

Eksote Social and Health Care District of the South Karelia region has nine municipalities that share joint support services, and a single patient and customer information system. Figure 1 illustrates how the social and health care services are integrated with primary and secondary health care services, family and social welfare services, and community services that promote health, wellbeing and function for senior citizens.

Fig 1 Eksote Organisation structure http://www.eksote.fi/sites/eng/Sivut/default.aspx



The model offers early intervention and easy access to the following:

- Multidisciplinary needs assesment and rehabilitation at home
- Family care givers early support and coaching
- Early support for people with memory impairments
- Home visits that enhance well-being
- Low threshold receptions (Isoapu- service center)
- Single point of access
- Enhancing health in collaboration with organizations and volunteer workers
- Service guidance and internet advice, chat-services
- Centralised hospital discharge response – same day assessment and support
- Home care support for reablement
- Acute Home health care

Mobile outreach services support local wellbeing centers and low threshold service reception centers. Special workers, mobile teams, and a mobile laboratory and clinic provide nurse and oral health services to the more remote areas. The Iso Apu service centre model brings together Eksote district social services, advice and education for the elderly and the disabled under one roof. Providing multidisciplinary services under one roof enables the client to have a holistic assessment and range of interventions in a single visit. Rehabilitation and acute assessment skills have been strengthened in home care services and there are more personnel avalaible at evening and at weekends. A new cooperation model for Acute Home

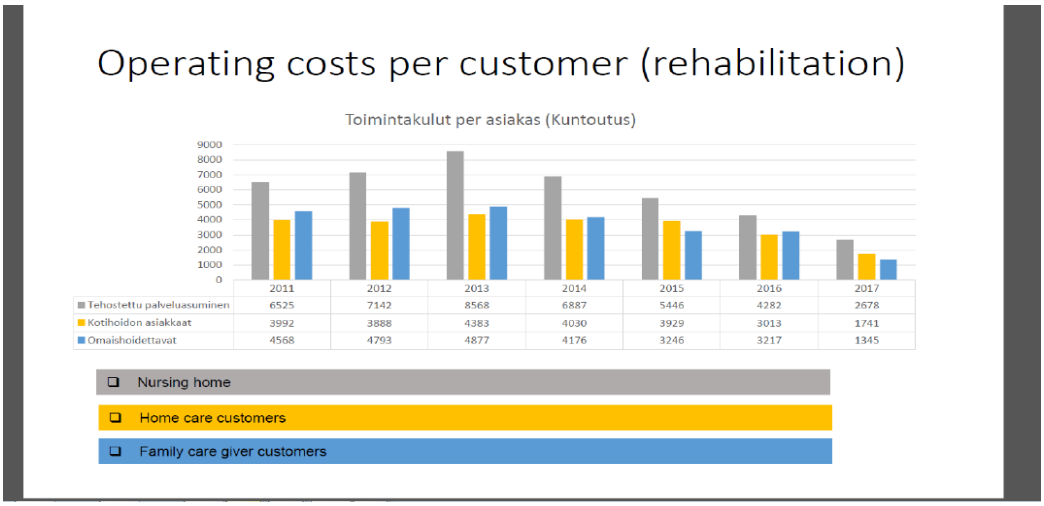
Health Care and Emergency Medical Service has been created.

The Eksote model identified value outcomes as:

- Reduced long term care in facilities and long term care
- Care delivered in remote versus acute settings
- New emergency models and surgical interventions avoided
- Effective home rehabilitation interventions
- Real world data analyses and clear view of the patient journey
- Measuring outcomes instead of volumes

The centralised discharge and home rehabilitation model have been associated with a 56% reduction in long term home care support, fewer new entrants to nursing home, reduced operating costs (Fig 2) with savings of 8000 Euro per person per annum compared to 2014.

Fig 2 Changes in operating costs 2011- 2017



"We have developed home rehabilitation in Eksote since 2010. At the beginning we didn´t have much staff to work on the field and that´s why we started to support home care workers to sustain customers functional ability. This is very important also today though we have much more resources and our interventions provided by rehabilitation professionals are very intensive. Strategically the main point has been brave change from institution based models to home based models. We have moved our nurses duties to physio and occupational therapists duties. We have integrated our processes and put the effort to early intervention stage. We have decided to work multidisciplinary in all our processes. Now we want to discharge very rapidly and straight to home if possible and support them. We want to develop wide customer management solutions in the future to improve our processes." Lehmus R, 2018

2 FRANCE

Context

In France, frailty is a pillar of the 2015 French law for adapting society to people at risk of loss of autonomy. There are three major national programmes that together support system wide action:

- "Pour bien vieillir" (for ageing well) – community prevention and health promotion
- PAERPA (pathway for people at risk of losing their autonomy) – primary care based
- National guideline ''Preventing the iatrogenic dependency related to hospitalisation'' inspired by the Canadian programme ''Specialized approach to senior care"

Each regional pension fund CARSAT network is implementing a prevention program designed to prevent frailty in senior citizens. The main topics cover physical activity, balance and nutrition, cognitive activity, sleep, social network, isolation. "Frailty observatories" gather administrative data from pension funds and medical insurance databases in order to identify more vulnerable geographical areas and individual persons at risk. Identified risks are economic frailty (minimum old age pension), social frailty (isolated people), difficulties to access rights, healthcare and prevention system (no general practitioner, long-standing diseases, no seeking care).

Individuals at risk are offered a comprehensive assessment and an assistance plan. The FRAGIRE grid, a multidimensional tool that assesses depression and suicidal risk, mobility, accommodation, caregivers, cognitive abilities,isolation, leisure and activities, is being tested to standardise practices in identifying and measuring frailty.

The PAERPA programme (pathway for people at risk of losing their autonomy) is a national government initiative to address the challenges of integrating the care of community-dwelling older adults. This targets elderly people at risk of disability or loss of autonomy (frail people or people having chronic diseases), with specific actions for people aged 75+. Criteria for inclusion are based on the following risk factors: an emergency hospitalisation in the last six months, polypharmacy with ten drugs, multimorbidity and three drugs, reduced mobility and a history of a severe fall, cognitive, mood or behavioral disorders, socioeconomic issues, or difficult access to care. The programme is supported by national practice guidance.

Aims

- Optimise elderly care pathways in order to meet the needs of older people living at home and maintain their autonomy
- Consolidate home care to enable people to continue living in their own homes
- Improve the coordination of care delivered by health and social care providers, focused on the primary care team
- Preventing iatrogenic dependency related to hospitalisation

Implementation experience

- PAERPA pilot involving nine Regional Health Agencies from 2014
- A National practical guideline provides support to social care professionals for identifying, preventing and managing the risk of autonomy loss/frailty.
- Training for healthcare professionals on polypharmacy and better use of medications, personalised care plans, identifying risk factors, falls, malnutrition etc
- Tools to support decision making and action: templates, a Territorial Support Platform information system with secure messaging, a personalised care plan in the shared electronic medical record.
- Training on using the new model and tools, improving practices and collaboration.
- New remuneration system triggered by care plans by multidisciplinary team
- National guidelines preventing iatrogenic dependency related to hospitalisation - focus on the immobilization syndrome, acute confusion, undernutrition, falls, new urinary incontinence, adverse drug reactions, and hip fracture management
- National guidelines on preventing rehospitalisation by early screening and assessment of people at risk and continuity of care for complex cases (planned home visits by GP or ambulatory nurse, advance practice nurse, geriatric mobile team, case manager, healthcare network, social workers).
- PRADO program operated by health insurance pension securing hospital discharge, report and hospital discharge letter to GP, and messaging between professionals
- Hospital units for aftercare and rehabilitation and home-based hospitalization (available throughout the national territory). Temporary places in nursing homes.
- Guidance and tools for enhancing cooperation between hospitals and nursing homes
- A new national model and funding system successfully introduced at scale across France as regional health agencies expand the new organizational models and tools on a large scale. Phase 2 extension began in 2016 - currently half a million people aged ≥75 years involved.
- National Hospital guideline, based on the Canadian program "Specialized approach to senior care" and the AINEES tool. Actions include:

➢ systematic preventive interventions for all patients aged 70 or older and / or frail, designed to promote functional independence

➢ specific interventions for prevention and early treatment for patients at increased risk of functional decline (deterioration of an item of the AINEES tool at entry or during hospital stay), with a multi-professional team including a physiotherapist or occupational therapist

➢ specialized assessment and treatment interventions in cases of immobilization syndrome, undernutrition or severe falls, with a geriatric team.

Weblinks to documents

http://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/documents-de-travail/serie-etudes-et-recherche/article/evaluation-qualitative-paerpa-rapport-final

https://www.has-sante.fr/portail/jcms/c_1602735/fr/comment-reduire-les-rehospitalisations-evitables-des-personnes-agees

https://www.has-sante.fr/portail/jcms/c_2801190/fr/prevenir-la-dependance-iatrogene-liee-a-l-hospitalisation-chez-les-personnes-agees

http://circulaires.legifrance.gouv.fr/pdf/2018/01/cir_42901.pdf.

https://www.has-sante.fr/portail/jcms/c_2801173/fr/orthogeriatrie-et-fracture-de-la-hanche

https://www.santemontreal.qc.ca/fileadmin/fichiers/actualites/2016/sept/COMTL_AAPA.pdf

http://www.irdes.fr/recherche/questions-d-economie-de-la-sante/235-evaluation-d-impact-de-l-experimentation-parcours-sante-des-aines-paerpa.pdf

www.pourbienvieillir.fr/espace-professionnels

https://www.carsat-lr.fr/partenaires/irv/regional-institute-ageing.html

http://www.pole-gerontologie.fr/fr-cohorte-fragire.html.

Impact

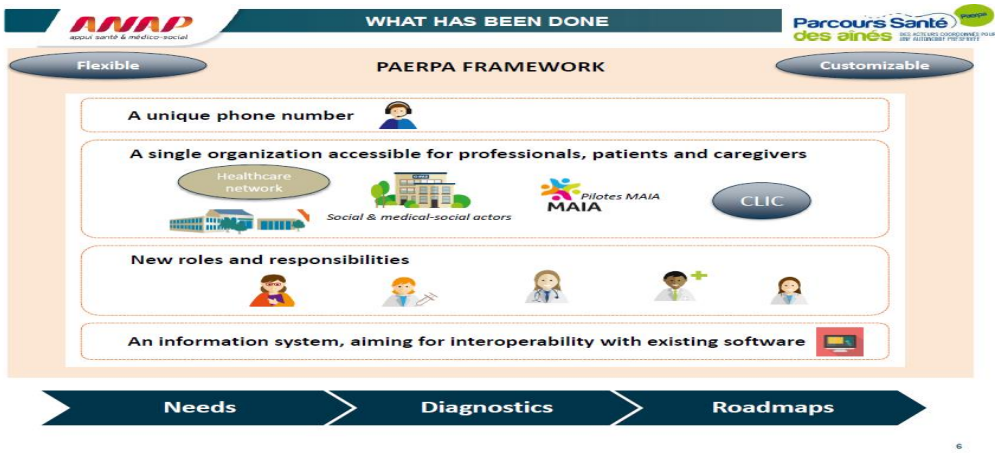
In the baseline study, the rate of hospital readmissions was more than 40% among people aged 85 years, and around 20% of these were attributed to problems with medicines. It was estimated that a reduced length of hospital stay, in line with the best performing areas, could reduce national costs by 2 billion euros. However the intermediate evaluation (2017), comparing the 2015 and 2016 data for PAERPA territories and controls, shows no effects on hospitalisation but reductions in medication use and costs. Time from launch to full implementation was eighteen months on average. Triangulating qualitative analyses with system deployment data suggests that the difference in "maturity" between the territories can be a determining factor in the impact.

The analyses also show that the structure of healthcare provision in the territories is a determinant of hospital use, which has been little modified by the Paerpa experiment. However the programme does seem to perform well in certain fields, for example to reduce the risks of iatrogenic medication. The lack of significant overall effect of PAERPA on the early data appears to mask significant effects in some territories. Analysis of the 2017 data will make it possible to measure whether these effects are further strengthening and if similar effects are emerging in new territories. The final evaluation at the end of 2018 will include an economic evaluation, a process evaluation, and evaluation of quality of care and patient satisfaction.

Regional Example

The PAERPA program (figure three) in nine regions is built around five key actions :

Figure 3 PAERPA Framework



1. **Consolidating home care** to enable people to continue to live in their homes. Multiprofessional team work in primary care and **personalized health care plans**.

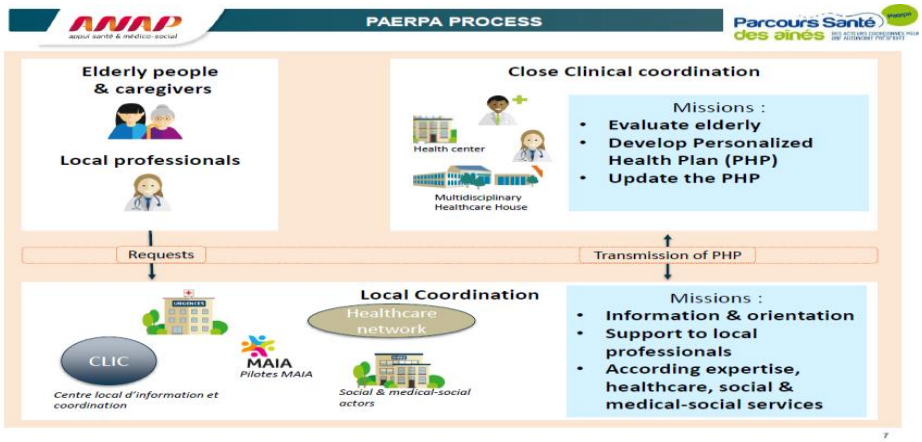
2. **Improving coordination** by a **territorial support platform (TSP)** that offers a single entry for both professionals and users, in order to inform and refer to local health and social services, support access to rights, care and other assistance (figure 4). Coordination connects different medical, home care, nursing and social services of the territory and a phone number is available for elderly people and their caregivers.

3. **Securing hospital discharge to home-** anticipation and preparation of hospital discharge, identification of people at risk of losing autonomy, transition to temporary accommodation, mobilization of health and/or social home care, GP informed, support by TSP.

4. **Preventive actions to avoid unnecessary hospitalizations**: good practices to identify at risk patients, health educational sessions (e.g. drugs management and falls prevention), access to geriatric expertise, geriatrician's phone number.

5. **Better use of medications**. Review of medical prescriptions and drug reconciliations by GP and the dispensary pharmacist.

Figure 4 PAERPA Coordination



3 UK

Context

In the UK, healthcare policy, funding and delivery are fully devolved to each of the four nations. Factors related to ageing and frailty are well recognised across UK governments. In all regions models of care are currently changing to improve outcomes and support for older people and adults with multimorbidty and complex care needs. Across all UK regions there is a shift towards holistic and person centred integrated care and support that has a focus on active and healthy ageing and managing the growing number of older people living with frailty. The new care models promote prevention, early intervention, self-management, enablement, rehabilitation, care and support planning, and care coordination as well as managing transitions between care settings and palliative and end of life care. These approaches are complemented by specific interventions such as use of risk prediction tools or the electronic frailty index to identify high risk patients in primary care to target CGA and interventions for preventing and managing falls, dementia, delirium and polypharmacy.

Aims

There are regional variations in the maturity and detail of the organisational and contractual frameworks for these new models of care but the shared vision and principles are:
person centred care and support, integrated around the individual, to improve health and wellbeing, increase the quality of care, improve value and reduce health inequalities.
The models of care span the continuum of identification, prevention, early intervention, technology enabled self-management, rehabilitation and enablement, care planning, care coordination, transitions between care settings, CGA in acute care and palliative and end of life care.

Implementation experience

The regional experience in Scotland is used to illustrate the UK experience. However most of the elements of the model of care also apply to the other UK nations. Scotland has had a specific cross government policy focus on transforming outcomes of care and support for older people that laid the foundations for legislation to integrate health and social care (Hendry A. 2016). Implementation experience in Scotland spans seven years to date (Hendry A 2017; Hendry A et al., 2017).

A key success factor has been weaving together a number of interdependent programmes for collective impact. The key milestones are described below:

- 2011 - report of cross party review for public sector reform recommeded a focus on prevention, integration and inequalities
- Guiding coalition of senior leaders from health, social care, housing, Third sector and independent sectors, and senior leaders across government from all parties

- A burning platform from raised awareness of data to model the demographic change, the anticipated demand, and unsustainable nature of current care models.
- Public engagement and dialogue on a future vision: older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting.
- National strategy on Reshaping Care of Older People 2011-2021
- Ringfenced innovation funding to test new models
- National improvement team to support spread and scale of interventions
- Improvement network to share good practice, tackle variation and track progress
- Core set of improvement measures across the pathway
- National stretch target to reduce bed days in hospital as a result of emergency
- National quality standards for older people and programmes of improvement and scrutiny of care delivery in hospitals, care homes and care at home
- Active and healthy ageing action plan to promote community capacity building
- National risk prediction tool to target people for new models of care
- Programme to scale anticipatory care planning and sharing of electonic key information summary about treatment ceilings and preferred place of care
- National programmes on dementia, falls prevention, Think frailty in hospital
- National hip fracture audit programme
- National frameworks for intermediate care, dementia strategy and palliative and end of life care
- Person centred care improvement programme and coproduction network
- National guidance on management of polypharmacy
- National Technology Enabled Care programme and investment
- 2014- new legislation to establish integrated health and social care organisations with joint strategic commissioning and a single budget
- 2018- new GP contract attuned to complexity, frailty and multimorbidity

Weblinks to documents

England

New Care Models; Overview by King's Fund Multispecialty providers GP contract and frailty
https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

Northen Ireland

Health and Wellbeing 2026- Delivering together

Wales

http://gov.wales/topics/health/nhswales/plans/care/?lang=en

Scotland

Reshaping Care for Older People: A Programme for Change 2011-2021

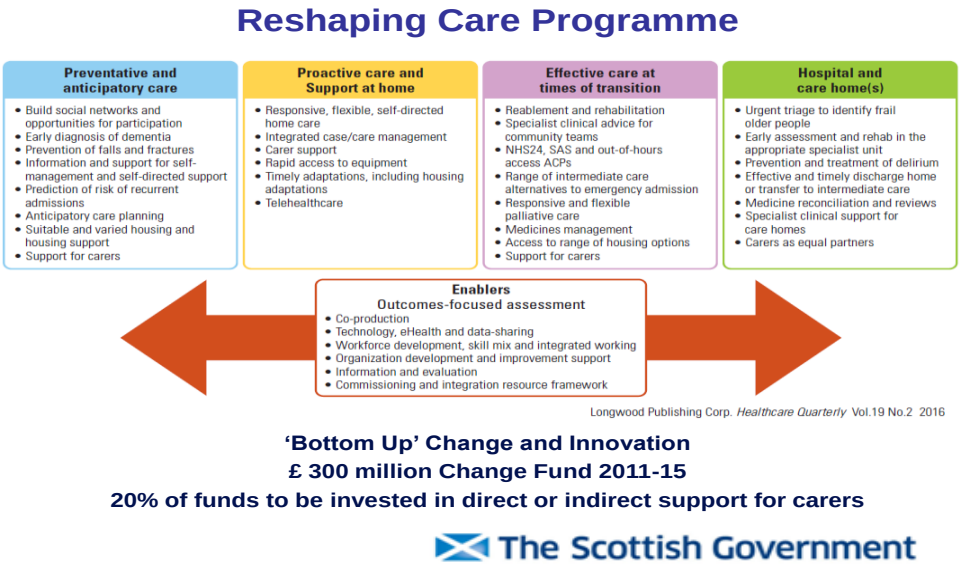
Regional Example: Scotland

Reshaping Care for Older People: A Programme for Change 2011 – 2021 introduced an integrated model of care to deliver an ambitious shift towards more care at home and in community settings supported by greater investment in preventative support and use of technology to empower greater choice and control. The programme sought to transform the philosophy of care from reactive services provided to older people towards preventative, anticipatory and coordinated care and support at home delivered with older people and their caregivers.

For four years from April 2011, a £300-million Change Fund (around 1% of the healthcare and social care budget for older people) was ring-fenced for the purpose of Reshaping Care. All 31 local partnerships of health, social care, housing, voluntary sector and independent sector partners worked together to use this funding to enhance the well-being and independence of older people and their carers; prevent, reduce or delay dependency; improve experience and personal outcomes; and increase the resilience of the system. The sentinel measure was the rate of bed days associated with emergency admission to hospital. Partnerships were expected to develop strategic commissioning plans using an integrated health and social care budget to sustain their new models of care beyond the conclusion of their Change Fund in 2015.

A Joint Improvement Team led a cross-sector improvement network to enable local systems to test new approaches, spread good practice, tackle variation and track progress on a core set of improvement measures. The 31 partnerships in Scotland implemented a bundle of interventions across the Reshaping Care pathway (figure 5). These include preventative and anticipatory care, coordinated care and support at home, intermediate care to improve outcomes at times of transition, and improved quality of care in hospitals and care homes.

Figure 5 Reshaping Care for Older People national pathway



Examples of the pathway elements include:

- Building community capacity for preventative supports that enable older people and their carers to remain active, independent and connected with social networks
- Applying a national risk prediction tool to target high resource users
- Scaling up person centred anticipatory care planning and sharing
- Polypharmacy reviews
- Community rehabilitation and reablement
- Falls prevention programme
- Proactive, coordinated care management for people with complex support needs
- Frailty pathways for community CGA
- Hospital at Home and intermediate care services to manage transitions
- Think Frailty screening in hospitals and pull to CGA
- Technology solutions for assisted living
- Preparation to introduce a new GP contract focused on multimorbidity and frailty

Impact

The programme concluded in March 2015. Results have been tracked beyond the end of the programme to assess the degree of sustainable change. Outcomes achieved were:

- 39% of the Change Fund was invested in support for carers
- 17% reduction in people conveyed to hospital after a fall
- 83% of older people receiving support at home benefit from telecare.
- Bed days in hospital for people aged 75+ following an emergency admission reduced by 10% from 2009/10 to 2015/16.
- Each day in 2016/17, people aged 65+ used around 1533 fewer emergency hospital beds than 'expected' had the 2008/09 rate at continued in line with population ageing
- In 2017, there were around 7,213 fewer older people in care homes than projected based on the 2009 rate and demographic trends.
- Estimated institutional costs avoided (based on daily rate for care home and emergency hospital beds) was approximately £480 million in 2016/17 (around £1.3 million per day).

Older people spent around 3.2 million more days at home in 2016/17 than predicted based on the previous balance of care and the impact of ageing. The gains in reshaping care have continued beyond the conclusion of the Change Fund in March 2015.

''The co-productive partnership approach enabled a 'whole systems approach' to developing tests of change. This meant we were able to work on developing new models and pathways of care for people that were a combination of partnership working involving health, social care, communities, Independent and Third sectors. This approach takes an investment of time and resource but the results of this work have been hugely positive and have provided a solid platform upon which integrated/partnership approaches to the planning and delivery of services can grow.'' Dumfries and Galloway Partnership

4 ITALY

Context

Local Health Authorities (ASL, Aziende Sanitarie Locali) are responsible for providing health care services to frail older people, mainly through Local Health Districts and General Pratictioners (GPs). Social care is provided by the Municipalities and includes home help, hygiene and personal care, home keeping, and support to mobility. Each region is moving towards strategies for codesign of the care process together with the person and his/her family, and encouraging the person to play an active role in his/her illness. There is an Agreement between national and regional governments that regions must develop advanced models for the management of chronic diseases, and care and rehabilitation of frail and dependent people.

Aims

The model of care for frail and dependent people is mainly characterised by

- patient's single access to the social and health services network,
- assessment of the individual's health and social needs
- identification of the most adequate diagnostic-therapeutic pathways,
- taking into account the social and environmental conditions of the patient.

Implementation Experience

The new models of care operate at different levels in the system.

"*Punto Unico di Accesso*" across Italy are single access points (PUA) for citizens to access health and social care services from one office and have an assessment that leads to an Individualised Care Plan (PAI). PUA improve access, continuity and coordination for all older adults, a large proportion of which are likely to be frail. Case managers coordinate the care of frail older adults working with GP "Continuity of Care" Doctors in primary care. PUAs can also be accessed by a range of professionals to support discharge.

***Unità Valutativa Integrata*"** PUAs may refer to Integrated Evaluation Units (UVI) for further assessment by a multidisciplinary team that carries out multidimensional evaluation, usually in primary care settings, with validated tools. If requested the UVI can be carried out in hospital settings. The policy ambition is to perform all assessments in a computerized format and using standardised tools at regional level, to identify the user's needs and inform the individualized care plan (PAI) which will then be carried out in the community. UVI identify the formal contact person for the patient's care pathway (i.e. the "case manager"), and the informal contact person (the caregiver), monitor the intervention and adapt it, if necessary. The target population for UVI's work are the persons in a complex social and health need, with particular reference to frail people.

"Personalized Care Plan (PAI)" This sets out the objectives and expected results in terms of maintaining or improving the health status of the person, and identifies the level of complexity, the duration of the intervention, the social and health services that must be provided, consistently with the resources available. The priority areas are: continuity of care for the frail patient in the hospital discharge process and handover to community and vice versa; the dissemination of standardised procedures; and dissemination and use of multidimensional assessment tools for the definition of the health care needs and care needs of frail people.

''Case della Salute'' "Community Health Homes" are multi-functional facilities able to provide a complete range of primary care services and to guarantee continuity of care and prevention activities, through a multidisciplinary team of professionals. They carry out primary, secondary and tertiary prevention, home care and promotion of citizen participation in health. They are integrated within the GPs network, but can also manage people whose GP is not based in the "Casa della Salute".

"***l'Assistenza Domiciliare Programmata", ADP*** involves weekly, fortnightly, or monthly visits by the district nurse of GP at the home of the patient for: monitoring of health status; control of hygiene and environmental conditions; training of the patient and family members; advice regarding nutrition; collaboration with social services staff for the needs of the patients and family; "individual programmes" for prevention or rehabilitation purposes.

"Supported discharge" for frail patients can involve discharge to a residential facility coordinated by the PUA. The facilities must guarantee different levels of care (medical, nursing, physiotherapy, specialist, etc.) including telemedicine activities. Access is provided directly by the hospital units, residential facilities or patient's home, by request of the GP or hospital doctors. The patient's stay is around 30 days, extendable to 60 days in exceptional cases. The presence of a nursing coordinator guarantees integration between units the hospital and community services. Two different models have been adopted:

- The Integrated Intermediate Structure (IIS), a model of hospital requalification with the functional integration of services and the coordination of secondary prevention
- The Community Hospital, focused on primary care and coordinated by the Local Heath Districts.

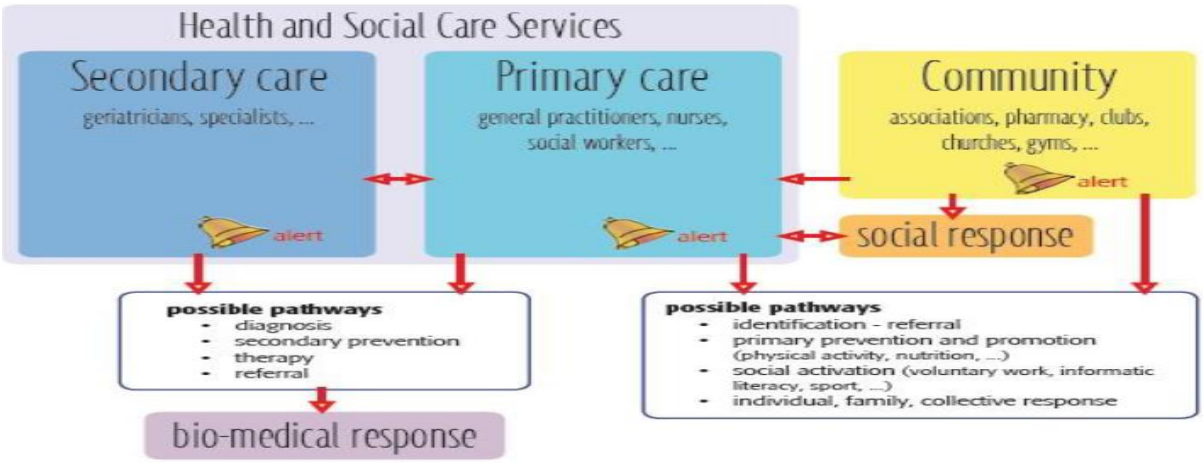
"The Silver Code'' Innovative transition of care project funded by the Ministry of Health based on a prognostic index using administrative data (i.e. age, gender, marital status, recent hospital and day-hospital [DH] admissions, and number of taken drugs) which identifies older patients at increased risk for 1-year mortality and likely to benefit from admission to geriatrics instead of internal medicine wards. Its implementation has been successful in several Italian Hospital including the Ospedale Gemelli in Rome.

The Sunfrail model

Some regions in Italy developed the Sunfrail model (figure 6) as part of the European refrerence sites network project coordinated by Emilia-Romagna Region and funded by the 3rd health programme (www.sunfrail.eu.) The coneptual model foresees a "multiple entry door system", where professionals and trained carers in different sectors may identify frailty and its risks through a nine questions tool that considers the biomedical and socio-economical dimensions of frailty. This activates an initial "alert" for prevention, professional/specialist and diagnostic actions, supported by plans to:

- apply a predictive model to identify patients at high risk of hospitalization and frailty;
- provide information about high-risk patients to the general practitioners (GPs) and nurses in the Case della Salute (Community Health Care homes -CHC);
- provide additional information useful for the identification of patients who may benefit for case management or disease management purposes and interventions
- identify preventive pathways for frailty conditions considered preventable, by linking available health, social and community resources
- assess the quality of the health care provided through monitoring of professionals and patients experiences regarding services
- improve capacity for early identification, prevention and management of frailty through a multi-professional educational model

Figure 6 Sunfrail conceptual model



Weblinks to documents

http://www.regione.lombardia.it/wps/portal/istituzionale/HP/DettaglioRedazionale/servizi-e-informazioni/Enti-e-Operatori/sistema-welfare/attuazione-della-riforma-sociosanitaria-lombarda/riordino-rete-offerta/dgr2017-6551-riordino-rete-offerta1

https://www.personaedanno.it/dA/c3519a6e57/allegato/AA_012736_resource1_orig.pdf
http://www.regioni.it/download/news/537527/
http://www.agenas.it/images/agenas/monitor/quaderno/pdf/12_PRESA_IN_CARICO_DEGLI_ANZIANI.pdf

http://www.euro.who.int/__data/assets/pdf_file/0010/373555/RHN-regions-web.pdf?ua=1
https://bmjopen.bmj.com/content/bmjopen/4/9/e005223.full.pdf

https://www.researchgate.net/publication/303371639_The_implementation_of_a_Community_Health_Centre-based_primary_care_model_in_Italy_The_experience_of_the_Case_della_Salute_in_the_Emilia-Romagna_Region

Impact

Evaluation of models of care in Italy has used record linkage of administrative data from different information flows including hospital discharge and emergency services. AGENAS - a national not for profit public body for health service research, monitoring, evaluation, training and innovation support - evaluated the effectiveness and equity of community models of care for people with complex social and health needs in Lombardy, Tuscany and Veneto. The study concluded that the most appropriate way to respond to chronicity, disability and frailty is the creation of a "system" able to ensure timely and effective solutions to complex, multiple and changing health and social care needs. This care model should be stable yet flexible, acting as a bridge between the hospital and the community which promotes social and health integration.

Regional example: Marche Region

The region has a higher than national average population aged over 65 years (24%). The new models of care improved access and productivity of care between 2015 and 2017 at minimal cost (revenue increase= 1%).

System outcomes are:

More care at home and closer to home

- The percentage of people >=65 receiving home care increased by about 1%.
- The number who received more intensive multidisciplinary Integrated home care (Assistenza Domiciliare Integrata-ADI), increased from 7,277 to 12,404.
- The number of people admitted to Intermediate care or Community hospitals increased from 64 in 2015 to 1,477 in the first semester of 2017.

More appropriate care

- Although the number of attendances at A&E increased by 7.4% the number of non critical (white code- no real danger) attendances decreased by 1.5%.
- The number of people who accessed residential settings dedicated to special needs, including safe homes for older people (Residenze protette anziani) and intermediate care residencies, increased from 9,909 to 13,258.

More out patient and ambulatory care

- Waiting list for a specialistic visit decreased by about 3.5%
- The volume of specialist visits in the same period increased by 286%.
- Waiting lists for specilistic diagnostic tools and examinations slightly increased but the volume of examinations performed has increased by 347%

Source: "Sistema di valutazione della performance dei sistemi sanitari regionali" - Laboratorio di Management e Sanità Istituto S. Anna di Pisa – 2017

5 SPAIN

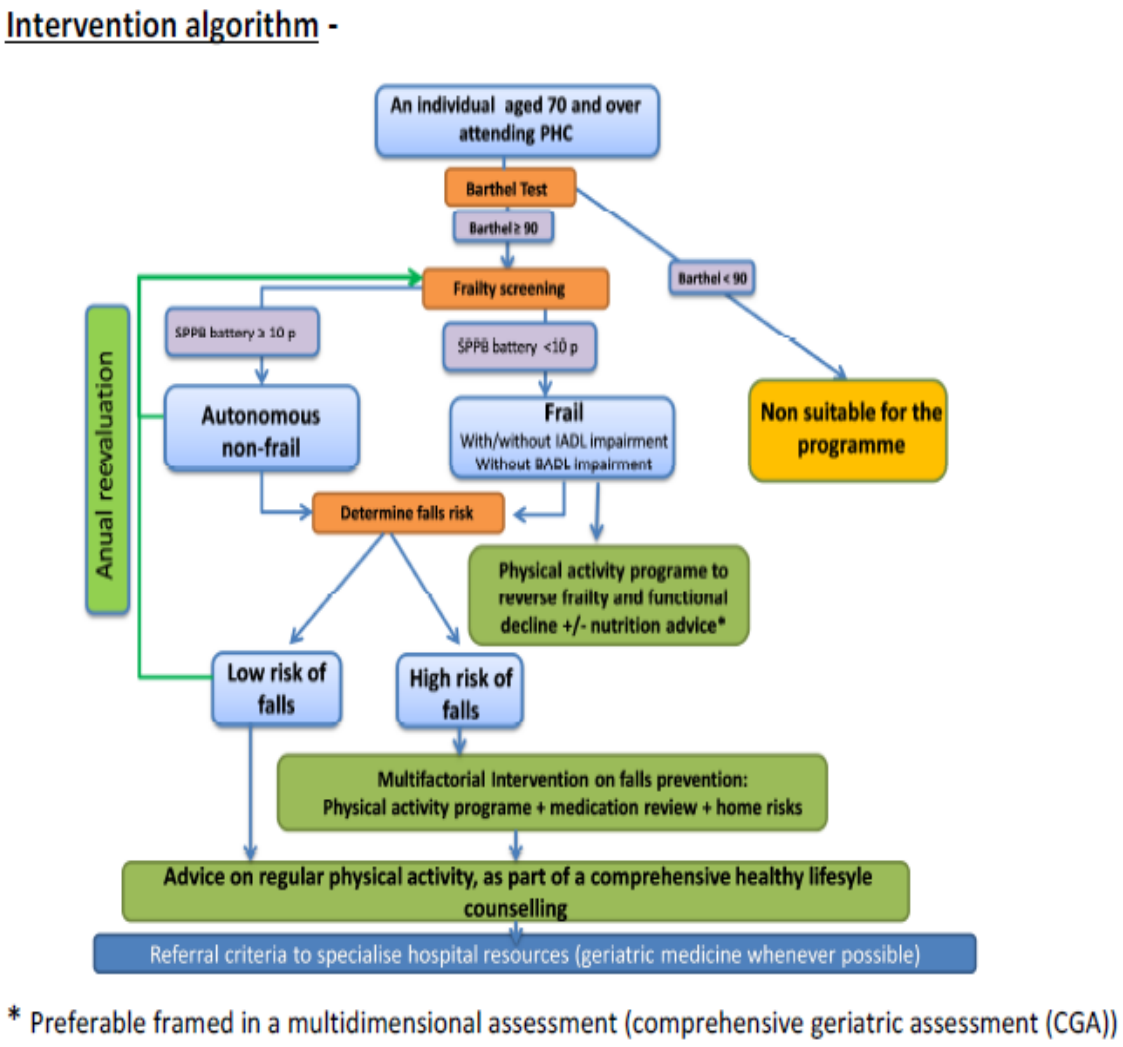
Context

Spain has a well developed model of care for chronic disease with good continuity and coordination in primary care. The NHS in Spain developed a consensus document on frailty and falls prevention among the elderly as part of their Prevention and Health Promotion Strategy 2014 to 2020. The national process was spearheaded by the *Spanish Ministry of Health* and consensus was reached with regional ministries of health and professional organisations on a pathway algorithm, illustrated in Figure seven.

Aim

Early detection of risk factors for frailty by primary health care centres among the population aged 70+ followed by a multidisciplinary intervention based on physical activity and healthy ageing, prevention of disease and maintaining function.

Fig 7 Falls and Frailty algorithm



* Preferable framed in a multidimensional assessment (comprehensive geriatric assessment (CGA))

Implementation experience

Regions adopt similar approaches in applying the algorithm for falls and frailty.

Robust patients are offered health promoting interventions aligned with the Spanish NHS consensus document about life style counselling in primary care. Patients at high risk of falls are offered a multifactorial intervention on physical activity and falls prevention. A follow-up visit is scheduled 6 months later. Referral for specialist evaluation (preferably to a geriatrics department when this resource is available) is considered in specific situations.

The Comprehensive Geriatric Assessment (CGA) process is led by GPs and nurses in the community who visit people over 70 years and develop a personalised care plan that promotes physical activity and healthy ageing, prevention of disease and maintaining independence. Assessments are repeated every 1-3 years.

Liaison nurses are common in most regions. They aim to improve the continuity of care and use an app in the electronic health record (EHR). The Continuity of Care report is available electronically for hospitals, primary care centres and nursing homes in Madrid and Valencia. Geriatric outpatient services collaborate in coordination of care after discharge.

A range of programmes and resources such as screening and assessment tools, advice on multiprofessional team-working, training courses, educational manuals for professionals and lay carers, and care protocols for nursing homes, support all stakeholders to be alert to the needs of older people when they are planning and offering services.

Some specific regional variations are described below:

Madrid

Madrid has a framework document for the development of continuity of care in the region: Service 420 (Standardized Portfolio of Services). Continuity of care is based on:

- Director of care continuity in each hospital who works in collaboration with the primary care and hospital boards through the “Primary care-Specialized care Care Commission”. These commissions design and implementcare processes.
- “Care Coordination Commission” of professionals from primary care and hospitals.
- Consulting specialist in a hospital service who receives referrals from general practitioners, facilitates and coordinates care.
- Liaison nurse who belongs to the hospital service and coordinates continuity of care of people with chronic care needs working with community services.

In Madrid, every public hospital has at least one geriatrician. Protocols are being developed in all facilities to perform a CGA of frail patients: a) before elective surgery; b) in emergency care; c) when required in admissions under other specialities or d) at discharge. In each centre with geriatrics departments, admission criteria include “frail patient”.

Valencia

Primary care teams composed by physicians, nurses, social workers and case manager nurses undertake comprehensive care of frail patients in their daily practice, but not following a specific programme of multidimensional assessment. The approach is geared to complex chronic patients.

The Basque Country

"Organizaciones Sanitarias Integradas" (OSIs) integrate primary care and hospital structures for a defined geography and population. The Basque Council of Health and Social Care is also driving change through territorial health and social care commissions to improve equity of access, develop a system to share social and health information and tools for CGA across sectors, and creation of teams of primary social and health care between OSIs and city councils, training of professionals and carers and the development of rehabilitative and orto-geriatric care in the community. There is also a focus on research, innovation and transfer of knowledge in the social and health care space.

The KAIA process ('Joint Evaluation Primary/Hospital Care of Multimorbidity in Different OSIs with an Assessment of Frailty'), was developed by primary and specialised professionals of two geographical areas and three general hospitals in 2012. The HARP tool (Hospital Admission Risk Profile, Sager MA 1996) is used alongside tools to assess social and family support, carer's burden and dependency for basic activities of everyday living. Information is evaluated at regualar intervals in small groups with primary care and hospital professionals.

"Plan Atención al Mayor"- 'Plan of Assistance to the Old One', is due to be implemented soon. The plan aims to provide an integrated, continuous, individualized high quality primary care for people aged 70+ years. The intervention involves a state-of-the-art multidimensional evaluation of function, cognition, clinical condition, social support (specifically assessment of the carer) and end-of-life care needs. These are the components of the CGA adapted to the everyday conditions of primary care. Individuals will be classified as a healthy old person, person with chronic disease, frail person, or a dependent individual at the end of his/her life.

All people 70+ years old in a clinically stable situation registered in the primary care centre will be visited by the general practitioner and/or the nurse. This assessment will produce a care plan oriented to the promotion of healthy ageing, the prevention of diseases and keeping functionality. This activity will be registered in the electronic health record and will be evaluated through defined indicators. Assessments will be performed every 1 to 3 years unless specific interventions require a shorter period or relevant clinical, social or familiar changes are experienced.

Web links to documents

https://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/Estrategia/docs/FrailtyandfallsElderly.pdf

Impact - No national or regional evaluations have been provided

Regional Example: Andalusía

Health care is provided through the Andalusian Public Healthcare System, a wide network based on accessible, high-quality, patient-centred care. Two levels of care are primary health care, the backbone of the system, and specialised care of varying complexity. The overarching goals are stated in the Andalusian Health Plan as well as the program-contract between the regional health authority and health services providers, managers and professionals, at all levels of care, sharing common objectives. Several transversal plans have been designed to tackle the most relevant health-related issues.

The health examination in people over 65 years aims to facilitate early detection of frailty through tests, questionnaires and performance validity in order to implement care plans, health promotion and prevention measures that improve health and quality of life, promote independence and reverse or delay the onset of frailty. The program operates in all Primary Care Centers throughout the region through the coordinated work of family doctors, nurses, social worlers and other professionals working in the public health care system. The over 65 population enrolled has increased to 839,948 by 2015. The program is being updated in line with current scientific evidence and with other public services. All information is stored in the corporate EHR, accessible by healthcare professionals and citizens as well.

The Plan on Comprehensive Health Care for Patients with Chronic Diseases and the Andalusian Comprehensive Care Strategy. A common corporate electronic health record and information system (Diraya) within the Andalusian Healthcare Service facilitates sharing of health information throughout the system. People with frailty and dependency can access the system also through community social services. The portfolio of social services and benefits was recently updated for approval by the new Law of Social Services of Andalusia.

Although full integration between healthcare, public and private social services does not always happen, coordination of services is encouraged. The Integrated Healthcare Process for People with Multimorbidity is designed for patients with more than one severe chronic disease or clinical or social factors. A team perform a CGA and develop a care plan which is stored in the corporate EHR. Some people will have a case manager (liaison nurse) and patients discharged from hospitals may be selected for telephone follow up by the Salud Responde service (telehealth). Although there is no full sharing of medical and social records, some initiaties are facilitating this linkage, connecting services such as medical appointments through the Andalusian Telecare Service or the health record for dependent patients.

6 The Netherlands

Context

Municipalities are responsible for the implementation of the elderly health care policy. Various health insurance companies have a module for frail older people. The sector organisation for Social Work in The Netherlands is active in every municipality for older people with help and support. The National Care for the Elderly Programme (NPO) brought together regional and national organisations in a programme to improve care for elderly people with complex care needs April 2008 to 2016.

Aim

Coherent provision of care that is better suited to the individual needs of the elderly

Implementation experience

The programme funded regional networks where all involved in (health)care for the elderly were welcome to participate - for example, general practitioners, care and nursing homes, hospitals, home care services, health insurance companies, pharmacies and municipalities, but also the elderly themselves. Programme budget was used to fund projects aimed to organise prevention, diagnosis, treatment or care in a different manner, looking beyond the boundaries of existing legislation and types of funding. Older people were involved both regionally and nationally in the discussions about new subjects and projects. Many older people benefited from improved quality, a greater degree of independence, greater retention of function, less reliance on care services and a reduced risk of care and treatments that are unnecessarily burdensome. Some of these models still exist, while others have stopped or continue to exist in a slimmed-down form.

The NPO facilitated Ageing Better - an umbrella stakeholders organisation which represent several regional and national organisations in the Netherlands working on a broad range of key issues such as primary care, long-term care, local care services and social services, housing for elderly, health inequalities and welfare.

Transmural care bridge is a bridge between professionals in hospitals and professionals in primary care to increase the retention of function and independence of older people after they have been discharged from hospital. It consists of three parts:

- Hospital geriatric team carries out an assessment and draws up a care treatment plan.
- The district nurse visits the patient in the hospital and discusses the care treatment plan.
- Within two days after discharge, the district nurse visits the patient at home, followed by a number of follow up home visits that focus on medication safety, medical aids, social cards and informal care support

Weblinks to documents

http://www.beteroud.nl/ouderen/zorg-transmurale-zorgbrug.html
https://academic.oup.com/ageing/article/45/5/585/1712099
https://www.beteroud.nl/dutch-national-care-programme-for-the-elderly.html

Cost-Effectiveness of a Chronic Care Model for Frail Older Adults in Primary Care: Economic Evaluation Alongside a Stepped-Wedge Cluster-Randomized Trial.

http://www.commonwealthfund.org/~/media/files/publications/case-study/2015/may/1818_gray_home_care_nursing_teams_buurtzorg_model_case_study.pdf

Impact

In 2016, Hoogendijk analysed three different integrated models studies in the NPO:

- The Frail Older Adults: Care in Transition (ACT) trial in 35 primary care practices where 'frailer' adults aged ≥65 years were randomised to receive in-home comprehensive assessment and interdisciplinary case management versus usual care. No significant effect was found on quality of life, psychological health, function, hospitalisation, or costs at 24 months. Study limitations were the screening approach, emphasis on medical interventions and suboptimal fidelity.

- In the Prevention of Care cluster randomised trial in 12 practices, adults ≥70 years with frailty (Groningen Frailty Indicator –GFI- score ≥ 5) received comprehensive assessment and interdisciplinary care based on tailored treatment plans and regular evaluation and follow-up over 24 months. Mixed method analyses showed no significant differences compared to control group with regard to disability (primary outcome) or secondary outcomes (depressive symptoms, social support interactions, fear of falling, and social participation). Sample sizes were small and the study may have targeted a cohort that was too frail to impact on study end points.

- Utrecht primary care PROactive Frailty intervention Trial (U-PROFIT) was a cluster randomised trial over 12 months in 3092 community-dwelling people ≥ 60 years from 39 primary care practices. The multi-component intervention (in-home CGA by a practice nurse, tailored care plans, and coordinated interdisciplinary interventions) was associated with small effects on ADL / IADL and dependency but no effects on health-related quality of life, hospitalisations, mortality or satisfaction with care.

Looman et al., (2016) reported on a study of the Walcheren Integrated Care Model (WICM). Patients aged ≥75 years with GFI ≥4, and their caregivers, received needs assessment, multidisciplinary care plan and consultations, case management, integrated information system, psychosocial interventions, education, training, and counselling. The study had a small effect on health, quality of life, health care use and satisfaction with care after three months. However, in an economic evaluation over 12 months, WICM was not cost-effective

as costs per quality-adjusted life year were high. The short duration (12 to 24 months) did not enable long-term and durable effects; the inclusion criteria may not have been specific enough; outcomes measures may not have been sensitive enough; non-medical solutions like social care and community support may not have been well developed; and the absence of impact may reflect pre-existing strong primary care in the Netherlands. Overall the Dutch studies suggest that more research is needed to determine which older population would benefit most from such interventions in primary care.

Case example

Buurtzorg Nederland is a not for profit home-care organisation in which around 70% of employees are registered nurses. The Buurtzorg model is of a skilled, generalist registered nursing team (maximum of 12 nurses) based in a neighbourhood of up to 15,000 residents to provide nursing and supportive home care services to around 50-60 people at any one time. The flat organisational structure promotes greater autonomy for nurses in responding to the needs of individuals. The organisation has rapidly expanded and by 2014 employed 8,000 nurses in 700 teams caring for 65,000 patients (Gray et al., 2015).

The model covers:

- Holistic assessment of needs and care planning
- Mapping and involving networks of informal care
- Identifying and coordinating care provided by other formal carers
- Care delivery and support for the client in his/her social environment
- Promoting self-care and independence.

Outcomes - 24/7 access; holistic care from one nurse and a local network of support; professional satisfaction from continuity, autonomous practice and more patient / client facing time; reduced administrative overheads, promotion of self-care, independence and disease prevention; reduction in home care but when nursing home, physician, and hospital costs are added, *total* per-patient costs are average for other models in the Netherlands.

Challenges - Managing governance and aligning with established external regulatory and supervisory system. Ensuring effective interface with primary care staff.

Cross case comparison

Table 4 shows the extent to which the components of the models of care in the six Member States align with the State of the Art Report (SoAR) recommendations for models of care to prevent and manage frailty.

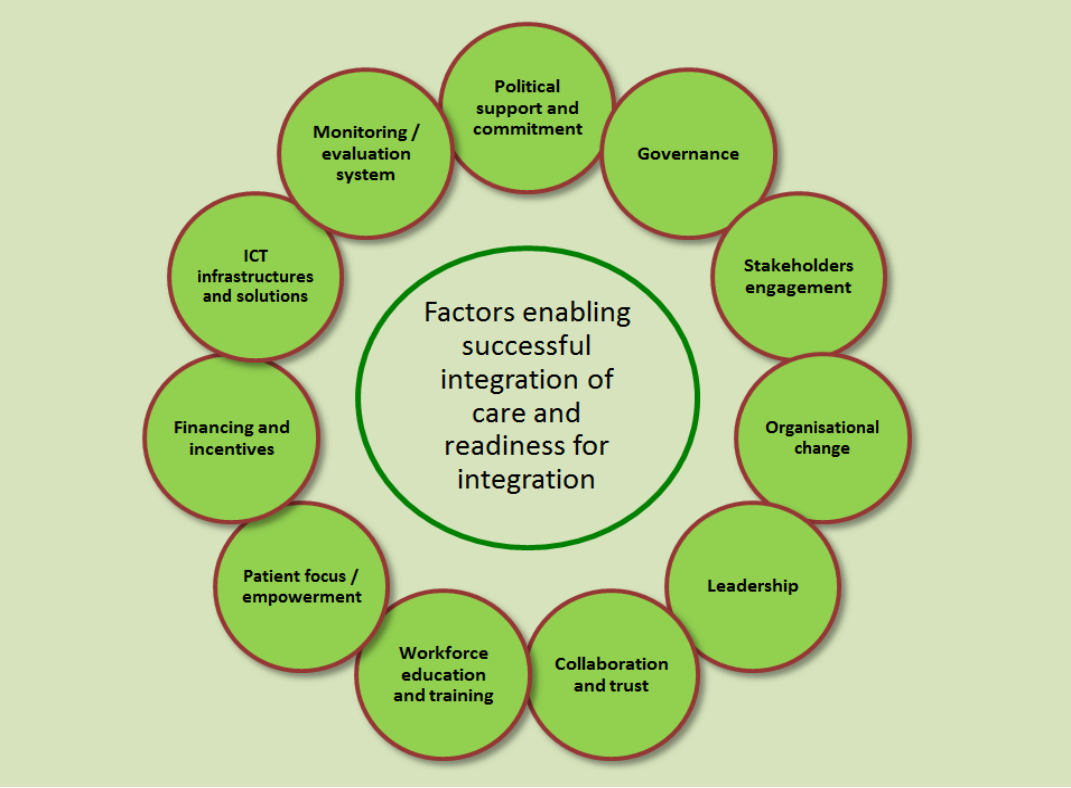
Member State case study	Finland	France	UK	Italy	Spain	The Netherlands
SoAR recommendation						
a single entry point in the community – generally in Primary Care	+++	+++	+++	+++	+++	+++
use of simple frailty specific screening tools in all care settings	+	++	++	+	++	++
comprehensive assessment and individualised care plans – including for caregivers	+++	+++	+++	++	++	+++
tailored interventions by an interdisciplinary team – both in hospitals and community	+++	+++	+++	++	+++	++
case management and coordination of support across the continuum of providers	+++	+++	+++	+++	+++	++
effective management of transitions between care teams and settings	+++	+++	+++	+++	++	++
shared electronic information tools and technology enabled care solutions	+++	+++	+++	++	+++	++
clear policies and procedures for service eligibility and care processes.	+++	+++	+++	+++	+++	+++

Lessons for Member States

This WP7 report describes 'what' models of care and approaches have been implemented to prevent and manage frailty. However to realise the anticipated benefits, the models of care must be adapted to fit with the organisational and cultural context of the specific regions or MSs. Therefore there are many levers, barriers and enablers that need to be considered to understand 'how' to successfully contextualise, adapt and transfer the mode of care. This is of course not specific to frailty but an issue for implementing any complex intervention such as integrated care for chronic disease. The particular challenge for frailty is the need for integrated care across both health and social sectors.

The Expert Group on Health Systems Performance Assessment identified factors which influence readiness to scale up integrated care (European Commission, 2017). Assessment of each of the factors in Figure 8 is a critical step to understand readiness to adopt, scale up or transfer good practice models of care for frailty.

Figure 8 Factors enabling successful implementation of integrated care



These factors can be considered to highlight the learning from implementing the good practice models of care for frailty.

Political support and commitment
Secure cross government support for active and healthy ageing and an age friendly society. National strategies and legislation should focus on enabling active participation in society, maximising functional capacity and maintaining independent living at home.

Governance
Consistent quality standards, recommendations and guidelines are needed to implement policy and translate knowledge into practice.

Stakeholder engagement
Work at all levels of the organisation and wider system – involving teams from population health planning, service commissioning, finance, professional practice, older people and their carers, advocates. Botton up local and regional plans with buy in from all partners appears to be more successful than a top down central approach

Organisational change
Population health expertise and capability to stratify risk factors for frailty to target interventions effectively. Project management skills to implement complex system change over time, recognising there is not a 'silver bullet' or 'quick win'

Leadership
Communicate the shared purpose and mobilise persuasive local change agents to lead new approaches at point of care

Collaboration and trust
The challenge of building common ground between different professional groups should not be underestimated. Develop national and local support for implementation and learning networks to help spread innovation, encourage adoption of new practices and support multiprofessional working and trusting relationships

Workforce education and training
Education and training of all health and social care staff should develop their ability to identify and manage frailty and support older people to be independent, have good nutrition, stay active and promote psychosocial wellbeing.

Patient focus / empowerment
Participation of older adults in the design of services is important and adds value, and could be replicated elsewhere at minimal cost. Focusing on what matters to older people and their carers improves outcomes, reduces unwanted interventions and overall demand.

Financing and incentives
Agree strategic plans and commission use of a joint health and social care budget, at least for long term care. Dedicated pump priming funding is needed as a catalyst and incentive for change. Resist competing demand for resources and diverting attention to shorter term pressures. Seek to secure sustainable long-term funding.

ICT infrastructure and solutions
A unified clinical and care record and / or data sharing across providers is a powerful enabler but new systems take time to adopt. All of the examples had well developed health

IT systems but data sharing across the full multiprofessional team and between primary care and hospital sectors was not always in place.

Monitoring / evaluation system

Long term studies and follow up data are required to evaluate implementation as it takes many years to fully deploy complex system change. It is difficult to attribute impact in multiple complex interventions across settings.

Table 5 illustrates our analysis of the presence of these enabling factors in each of the case studies.

Table 5

	Finland	France	UK	Italy	Spain	The Netherlands
Political support	√	√	√		√	√
Governance	√	√	√	√	√	√
Engagement	√	√	√	√	√	√
Organisational Change	√	√	√		√	
Leadership	√	√	√	√	√	√
Collaboration	√	√	√	√	√	√
Workforce education	√	√	√	√	√	√
Patient empowerment	√	√	√	√	√	√
Finance and incentives	√	√	√			
ICT	√	√	√		√	√
Monitoring	√	√	√	√		√

Assessing Readiness for Implementing Integrated Care

The SCIROCCO Maturity Model and its online self-assessment tool, co-funded by the Health Programme of the EU, has been designed to facilitate wide engagement and reflection on system readiness for implementing integrated care. The aim is to support stakeholders to plan for successful implementation and scaling-up of new models of integrated care.

The domains of the SCIROCCO Maturity Model are:

- Breadth of Ambition
- Capacity Building
- Citizen Empowerment
- Evaluation Methods
- Funding
- eHealth Services
- Innovation Management
- Population Approach
- Readiness to Change
- Removal of Inhibitors
- Standardisation & Simplification
- Structure & Governance

These domains align fairly well to the levers and enablers identified in the 2017 report by the Expert Group on Health Systems Performance Assessment.

The SCIROCCO interactive on line resource (figure 9) is available in English, Italian, Spanish and Czech and is supported by illustrative guidance and user tools.

Currently, over 40 European and international regions have used the tool to better understand how they can accelerate their progress in implementing and scaling-up integrated care.

The self assessment tool may be useful for MS as they prepare to build readiness for implementing effective integrated models of care for frailty.

Figure 9 SCIROCCO Self Assessment Domains

CONCLUSIONS

In summary, integrated models of care to prevent and manage frailty are considered to be at an advanced stage of development in six Member States participating in Advantage JA. The six examples featured in this report share several common success factors:

- Strong political support
- Legislative frameworks
- Financial incentives
- Leadership and support to change the professional culture
- Screening and risk prediction tools to select frail older people for interventions
- Person centred and holistic approaches

All examples applied both a person centred and population based approach. Although all have their starting point in primary care, managing established complex frailty and multimorbidity requires a comprehensive multidisciplinary approach that is well integrated with hospital services. More research is needed to determine which older people would benefit most from more intensive interventions in primary care.

Technology solutions may help identify individual risk of frailty, enhance communication and continuity of care and improve the coordination of care transitions between different professionals and levels of care. Work Package 6 has gathered more information on examples of ICT for preventing and managing frailty.

The case studies in this report can be used as a source of inspiration for policy makers, managers, professionals and wider stakeholders. The models of care implemented have an empirical evidence base and may be spread, scaled up and transferred to other regions and MSs as part of a comprehensive and integrated system to prevent and manage frailty. However, understanding and adapting to the policy, professional and system context is paramount for successful translation.

The examples provide real world learning that adds further weight to the SoAR recommendations on the effective models of care for frailty:

- a single entry point in the community – generally in Primary Care
- use of simple frailty specific screening tools in all care settings
- comprehensive assessment and individualised care plans – including for caregivers
- tailored interventions by an interdisciplinary team – both in hospitals and community
- case management and coordination of support across the continuum of providers
- effective management of transitions between care teams and settings
- shared electronic information tools and technology enabled care solutions
- clear policies and procedures for service eligibility and care processes.

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