Staffordshire Frail Elderly Strategy (Approved: June 2015)

Prepared by Stoke on Trent CCG, North Staffordshire CCG & Cross Economy Transformation Team for Staffordshire's Health and Social Care Commissioners

The contributions to this strategy by Health and Social Care Commissioners are acknowledged

Frail Elderly Care – A Staffordshire Strategy

Introduction:

The Clinical Commissioning Groups (CCGs) and Local Authorities across Staffordshire (The Health Economy or HE) share a vision for the health and social care of the older population in general and those individuals within their communities who are frail and elderly. This vision respects the diversity of the populations the HE serves and allows for the differing operating conditions and challenges that the individual Commissioners face in securing sustainable and effective health and social care.

In arriving at the vision, the HE Commissioners have taken a collective view of what they consider the fundamentals of elderly care to be, and in determining a shared strategic approach they have taken into account:

- Wider Commissioner strategic intentions in their 5 year plans;
- The strategic imperatives of their Health and Wellbeing Boards;
- The priorities established through the Care Act and the Better Care Fund; and
- The recommendations of the KPMG "Final Report for Staffordshire LHE" (8 August 2014)

As a vision and shared strategy that brings together the core elements of the intentions of all the HE Commissioners it should be recognised that within this document it is not possible to:

- Reference all documents, research and literature that the individual CCGs and Commissioners have drawn on in arriving at their individual intentions;
- Differentiate within the strategy how individual CCGs and Commissioners subscribe to the vision, principles, objectives, desired outcomes and models of care other than to state that they do all subscribe;
- Interrogate local delivery proposals including the data, intelligence and financial assumptions on which those local delivery plans are based; and
- Detail the investment and decommissioning intentions of individual CCGs and Commissioners that may be necessary to realise the strategy at a local level.

Background and drivers for change:

The experience of Commissioners County wide supports national evidence that acutely ill older people are being poorly serviced by a lack of speedy access to appropriate assessment and treatment and a lack of generalist skills and expertise[1]. Commissioners have identified, confirmed by KPMG in the Staffordshire LHE Report, that current patterns of care for older people are unsustainable acknowledging primary and secondary care budgets are facing increasing pressures, there is an ageing population and the increasing complexity of patients requiring urgent care. The table below, drawn from ONS population data, provides a 3 - 4 year projection for the population aged 75 and over.

Year	75-79 Forecast	80-84 Forecast	85-89 Forecast	90+ Forecast	Total
2014/15	56100	39000	23500	13300	131900
2015/16	57000	40100	24300	14100	135500
2016/17	58400	41500	25200	14700	139800
2017/18	60800	43200	26000	15400	145400
% change by 17 / 18	8.38%	10.77%	10.64%	15.79%	10.23%

[1] Acute Medical Care of Elderly People, BGS (2011)

Consistently across Staffordshire, (in line with national benchmarks) older people, > 65, account for the majority of general hospital users (65%); frail older people in the acute care setting represent a low volume, high impact group; they have the longest length of stay, the highest rate of inpatient complications and subsequent re-admissions[2]. At any one time, patients in this group account for 70% of bed days. Commissioners are responding to the concept of frailty as a determinant in the management of older people and in particular, for many older people, a stay in hospital is disempowering: the environment itself, the noise, and the routines on the wards overwhelm and undermine them in ways that affect their ability to recover who they were and how they were living before they were admitted[3].

The table below illustrates A&E Attendance projections by age band (based on ONS population projections and modelled A&E attendance patterns).

Year	75-79 Forecast	80-84 Forecast	85-89 Forecast	90+ Forecast	Total
2014/15	25,453	24,096	19,598	13,383	82,530
2015/16	25,862	24,776	20,265	14,188	85,091
2016/17	26,497	25,640	21,016	14,792	87,945
2017/18	27,586	26,691	21,683	15,496	91,456
% change by 17 / 18	8.38%	10.77%	10.64%	15.79%	10.82%

The table below illustrates A&E Admission projections by age band (based on ONS population projections and modelled A&E admission patterns).

Year	75-79 Forecast	80-84 Forecast	85-89 Forecast	90+ Forecast	Total
2014/15	15,162	16,151	14,349	10,317	55,979
2015/16	15,405	16,607	14,838	10,938	57,788
2016/17	15,783	17,187	15,387	11,403	59,760
2017/18	16,432	17,891	15,876	11,946	62,145
% change by 17 / 18	8.38%	10.77%	10.64%	15.79%	11.01%

Frailty:

While commissioners agree that frailty is a state of vulnerability resulting from the cumulative decline in physiological systems which occurs progressively over a lifetime there is currently no County wide shared definition of frailty and no single frailty index is applied. However, in the work to date the following characteristics are referenced by Commissioners as factors:

i. Usually, but not exclusively, Commissioners reference frailty linked to older age;
ii. Commissioners generally agree the person will have two or more long term conditions;
iii. It is consistent that Commissioners mean the person has no functional reserve (ie: no physical capacity to endure a further incidence of ill health);
iv. Polypharmacy is commonly associated with frailty by Commissioners;

[2] Age and Ageing, BGS (2011)
[3] Kings Fund – Continuity of Care for Older Hospital Patients March 2012

v. Commissioners expect frail persons will either have higher levels of social care input to support them in their own home or be resident in a Care Home (Residential or Nursing);
vi. It is anticipated by Commissioners that frail persons are likely to have or be at great risk of developing dementia; and
vii. All Commissioners assume that once frail patients decompensate if they develop a further complication/illness they decompensate further very quickly.

National evidence suggests that up to one quarter of hospital beds are occupied by people with dementia[4]. Across the County, those patients with dementia, or who display symptoms or behaviours associated with dementia, stay in hospital longer (often with multiple transfers of their care) than other people for the same procedures.

In recent years practice across the County, by all Commissioners, has been reactive to system pressures which has led to "silo" interventions and fragmented pathways from crisis responses to need through to meeting long term health and social care needs in primary care and eventually end of life and palliative care needs. All Commissioners identify, at a local level, the vital importance of commissioning integrated services that allows for the management of people before their needs escalate, to respond to their needs in an anticipated and planned way, reducing the need for expensive crisis responses and unscheduled care. In addition, Commissioners recognise there is a disconnect between the delivery of health and social care services and wider well-being support with inconsistent and sometimes limited community and volunteer involvement and the use of community social capital or community assets with varied and inconsistent approaches to the involvement of carers. Custom and practice has become to respond to the needs of frail older people and patients in a reactive way through structured services and programmes where these exist with an emphasis on managing people through the system rather than being person centred wrapping responsive services around individuals in anticipation of their needs.

Consistently in their local plans and statements of intent, Commissioners focus on areas where they identify the need for change:

- ✓ improvement in the model of care and the management of patients;
- ✓ improving the patient / user experience;
- ✓ reducing transfers of care within and between organisations and where possible eliminating the need for transfers of care completely;
- ✓ more and better joint and integrated working between health, social care and mental health services;
- ✓ better and timely information sharing between those involved in a person's care including the sharing of information with people themselves and importantly their carers;
- ✓ planned and "in time" care co-ordination with simplification of what are often complex and involved patient management processes;
- ✓ establish the utilisation of Technology Enhanced Care Services (TECS) to support people in their self-management and to support clinicians / professionals in securing health and social care outcomes; and
- ✓ access to intermediate community-based services as an alternative to acute hospital attendances and acute hospital admission.

[4] Commission on Improving Dignity in Care for Older People (2011)

Vision:

> *That the people of Staffordshire have access to and benefit from a coherent integrated model of care that is consistently available across the County while being locally responsive to the needs of communities and individuals.*

The HE are determined that in pursuit of the vision and the coherent model of care there will be latitude for innovation at a local level where this builds the local capacity to deliver services effectively within financial and other resource constraints.
The vision reinforces the HE common goals of securing true integration in the delivery of all care including social care and mental health, promoting independence, preventing avoidable admissions, supporting individuals to manage crises in their health and wellbeing, securing the right care in the right place for the individual at the appropriate level of care while enabling people to live well, live independently and live confidently.

HE Commissioners are determined to realise a vibrant participation of the third sector and community and voluntary organisations and importantly to recognise and nurture the valuable contribution made by family and carers.

The Fundamentals of Elderly Care:

Before stating the Commissioner shared fundamentals of elderly care, this strategy builds on an underpinning set of principles integral to all HE Commissioners – the HE are committed to the NHS England mission of high quality care for all; that Commissioners are striving for parity for mental health; and that the Commissioners respond to and seek to promulgate the best practice guidance from the Royal College of Physicians, the British Geriatrics Society and Kings Fund.

Fundamental 1: Elderly Care should be a whole system approach where all elements of the system link by design and work together to proactively support the patient anticipating, planning and delivering for their needs;

Fundamental 2: There should be timely, proportionate and appropriate communication between all those involved in a person's care and support that always engages the person and their carer(s) where the ability to provide for excellence in a person's care is enabled by access to information;

Fundamental 3: That irrespective of where people present in the system, they have access to an appropriate and rigorous assessment of their needs, that this assessment is trusted and informs the diagnosis of their health, social care and wider well-being needs and that they are able to access treatment and care services in the setting appropriate to their assessed needs promptly without unnecessary transfers of their care and without unnecessary admission to hospital;

Fundamental 4: That the quality of care received and the experience of individuals should not be adversely affected by where they normally reside, the time their care is needed, the place where their care is delivered, or by the person or organisation delivering their care;

Fundamental 5; There is a requirement for case finding and case management that navigates people through to the services they need that leads to achievement of

outcomes, these outcomes being determined by screening and assessment processes that inform the care plan and the actions taken to deliver care;

Fundamental 6: An emphasis on prevention and support for living well, including after episodes of illness or where an individual's well-being has been compromised, is essential and at all times individuals should be supported to achieve optimal recovery, their best level of reablement, rehabilitation, and confidence; and

Fundamental 7: Preserving dignity, respect and privacy for all must be at the heart of our model of care and by design we should eliminate health inequalities.

While not a fundamental, the HE believe that under this strategy they should centralise where possible and localise where necessary – this reflects wider ambitions to commission care and other services that reflect the specific needs of local populations and that routine health and social care should take place in the home or as close to home as possible recognising that where necessary care will be delivered in acute and community hospitals and other centres.

Our objectives:

Through consistent commissioning across the County, and where appropriate the wider operating footprints of the individual CCGs, the CCGs and their associate commissioners will:

- ✓ Focus on prevention and have as a priority supporting older people to live well where there are accessible opportunities for the health and wellbeing of older people to be sustained;
- ✓ Drive a culture change that delivers individual independence where people (and the important people in their lives and their living arrangements) are able, confident and empowered to participate in their self-care, where they are able to make informed decisions on their care and the first response to their needs;
- ✓ Focus on design and delivery of services that support and add value to patient care from General Practice and Primary Care that utilises community and acute provision effectively under an integrated continuum of care;
- ✓ Secure better anticipatory and preventative care that focusses on the needs of the individual where the person is involved in the assessment of their need and the putting in place of a care plan;
- ✓ Develop innovative and robust approaches to risk stratification and case finding that leads to the effective objective based case management of people and health and social care case management with purpose;
- ✓ Build the capacity of local practitioners at all levels so that they respond confidently and appropriately to the needs of local people on a day to day basis and at times of crisis or uncertainty;
- ✓ Ensure that information, necessary so that practitioners can deliver integrated services to people and patients, is available and accessible at any and all times that interventions or actions with individuals are being planned, reviewed or delivered;
- ✓ Drive for single trusted assessments of an individual's needs that inform a single care plan which patients and their carers have ownership of and to which the individual can allow access to practitioners involved in their care and wellbeing;

- ✓ Provide for co-ordination of services and support patient and person navigation through to services that meet their needs so that care is delivered in the right place, at the right time, by the person best able to meet their needs;
- ✓ Ensure that older people who present to services (in primary care, community or acute settings) have speedy access to comprehensive geriatric assessment as an integral part of a whole assessment of their needs;
- ✓ Provide for the prompt assessment of the needs of frail older people who present in acute settings so that patients can step down or step across to appropriate services as an alternative to admission or, if admission is necessary, patients are managed effectively under an informed care plan, improving health outcomes, supporting independence and minimising length of stay;
- ✓ Improve medicines management for older people at home, in homes, in community services, under intermediate care or in acute settings so that unnecessary or inappropriate prescribing is avoided;
- ✓ By design, integrate mental health care into all services and facilities so that the needs of individuals, and in particular frail older people, with dementia and other age related conditions are accounted for and met;
- ✓ Provide pathways of care that are simple and unambiguous and provide clarity that individuals will receive appropriate, proportionate and responsive services that ensure safe care in the most appropriate setting without unnecessary delays, transfers of care or unnecessary admission to hospital;
- ✓ Ensure that older people and in particular frail older people stay in an acute hospital only when they are acutely ill and require treatment or interventions or a level of specialist care or rehabilitation that can only be provided in the acute setting;
- ✓ Ensure that older people and in particular frail older people stay in a rehabilitation, recovery or reablement setting only when they continue to benefit and require treatment or interventions or a level of specialist care or therapy that can only be provided in these settings;
- ✓ Ensure that older people who reside in homes benefit from health and social care equality and incentivise homes to follow pathways of care and to participate in meeting the needs of individuals at home, or in the most appropriate setting without unnecessary delays, transfers of care or unnecessary admission to hospital; and
- ✓ Encourage and enable use of Technology Enhanced Care Services through wider adoption of assistive technology, telecare and telehealth.

The Continuum of Care:

The HE are committed to ensuring a continuum of care that focusses on the needs of individuals and takes account of the circumstances of the individual and their degree of vulnerability so that the best care is provided at the right time, in the right place by those best equipped to meet the person's needs where the intent is to respond to the acuity of the person supporting their independence and optimal recovery.

Under the prevention and self-care elements of this strategy there will be specific cross over to the local Long Term Conditions work stream, the staying healthy and active work stream and the urgent care work stream of the HE. There will be a local emphasis on engaging, mobilising and working in partnership with the 3rd Sector and Local Authorities (including but not limited to the Better Care Fund) to develop local models of support that allow older people, particularly those with high

support needs, live well and to live confidently in later life. Evidence shows these models are greatly valued by communities and achieve significant outcomes for individuals particularly when they link to other services.

The continuum of care assumes a vital role for carers so there will be a cross over with local carer strategies where the emphasis will be on supporting carers to keep well themselves.

The HE will promote interactions between clinicians and practitioners along the continuum of care as a vehicle for continuous improvement, personal and organisational development and to encourage better networking, care planning and exchange of information leading to an improved patient experience and better patient outcomes.
The important place of information across the continuum is recognised and the HE will continue to search for the effective sharing of records, real time communication between primary, secondary, community and mental health including with equal standing local authority services (particularly social care) and the 3rd Sector.

As individuals move through the continuum of care access to specialist and consultant medical input, senior clinical input, and specialist service practitioners needs to be assured.

The Continuum of Care												
Prevention	Empowering Self-Care and Education	Support at Home	Enhanced Services at Home	Managed crisis and planned responses to need	Step Up	Acute services including admission where necessary	Manage Discharge effectively avoiding readmissions	Step Down	Enhanced Services at Home	Support at Home	Empowering Self-Care and Education	Community and Voluntary Sector support
An integrated delivery system involving public health, community and voluntary sector, primary care, community service, acute and secondary care services and the patient .												

The outcomes under this strategy:

The outcomes are based on securing improvements in the commissioning of health care of elderly people generally and specifically for those with complex requirements. In delivering these outcomes the CCGs will:

- ✓ Establish and embed relationships between the CCGs and their associated commissioners in health, social care and third sector services for frail older populations;
- ✓ Ensure consistency of services across the County, demand equality of access for all communities, and coherent local delivery of the continuum of care; and
- ✓ Ensure joint working including shared commissioning.

The CCGs agree that effective care for frail people with complex needs demands integrated and coordinated patient-centred journeys which; building on the core care provided by General Practice and Primary Care; recognise and respond to the scope and complexity of need, are proactive whenever possible, are promptly reactive whenever necessary, maximise continuity of care and minimise sudden or unplanned transitions of care, particularly towards the end of life.

Strategy into deliverables / what success will look like:

- ✓ Non-elective admissions of people identified as frail older people not to exceed XXXX in a stated year; or
- ✓ Non-elective admissions of people identified as frail older people to be in line with Better Care Fund plans;

- ✓ Number of GP led intermediate care based episodes of care for frail older people not to be less than XXXXX; or
- ✓ Number of GP led intermediate care based episodes of care for frail older people to increase by Y%;
- ✓ 100% of frail older people under an integrated single care plan will benefit from care navigation and care co-ordination;
- ✓ Number of integrated single care plans that have an active and sustained contribution from a community and voluntary sector organisation not be less than XXXX or Y% of all plans;
- ✓ Number of referrals to acute settings of frail older people from homes not to exceed XXXXX; or
- ✓ Number of referrals to acute settings of frail older people from homes to reduce by Y%;
- ✓ XX% of Older people and / or their carers are able to discuss how their care is organised and the actions they are taking or their contribution under the integrated single care plan;
- ✓ XX% of older people and / or their carers are able to name the key clinician involved in their care and where applicable how to contact their care co-ordinator or navigator;
- ✓ XX% of GPs confirm there is an accessible comprehensive geriatric assessment process which informs health and social care planning and supports excellence in the delivery of care;
- ✓ 100% of all single integrated care plans include an assessment of the mental health needs of patients and state the actions under the care plan and anticipate the outcomes to be delivered by the care provided;
- ✓ Care is co-ordinated through a single care plan that anticipates patient need and eliminates the necessity for patient transfers throughout the episode of care;
- ✓ There are no incidents of breakdowns in communication between clinicians and practitioners involved in care such that patients and / or carers report that on all occasions care has been discussed or required there has been access to the current and up to date version of their single integrated care plan;
- ✓ 100% of patient or service user and their families and carers report they have been engaged (appropriately and consistently) in the setting and agreement of their care plan, this will include offering patients the opportunity to be involved in advance care planning supported by skilled practitioners;
- ✓ XX% of patients or users under the service confirm that, where they can make a judgement, they received care that met their needs, delivered at their home when it was appropriate to do so and that patients stepped up into other services as their needs required it;
- ✓ XX% of patients beginning inpatient stays, in any setting, have their discharge organised within YY hours of admission (engaging General Practice and the wider Primary Care team) so that patients can step down at the first opportunity delivering the shortest length of stay needed by the individual patient and in line with their individual needs;
- ✓ Discharge planning and the continuation of care post discharge will ensure that patients achieve their expected health outcomes such that any re-admission to a bed based service is a cause for concern and a driver for continuous improvement so all re-admissions within 14 days will be subject to a root cause analysis (RCA);
- ✓ Timely and informed diagnosis and assessment (starting within 1 hour of attendance) allows and enables utilisation of local services directly from emergency portals;
- ✓ Following any episode of care, through any combination of services, XX% of beneficiaries and / or their carers report they have achieved an acceptable return to wellbeing;
- ✓ Following any episode of care, through any combination of services, XX% of care practitioners suggest that beneficiaries have achieved an acceptable return to their normal state or have secured optimal recovery;
- ✓ End of Life care will be anticipated and planned for, such that 100% of patients receive high quality co-ordinated end of life care;
- ✓ XX% of patients will be supported to die in their place of choice; and

- ✓ Patients, their families and carers assess the services they receive as excellent and would recommend them to others needing or requiring care.

Delivering our commissioning responsibility:

The CCGs believe that under this strategy they should centralise where possible and localise where necessary – this reflects wider ambitions to commission care and other services that reflect the specific needs of local populations and that routine health and social care should take place in the home or as close to home as possible. The prior commissioning and procurement of individual CCGs needs to be taken into account as does the necessity for local decommissioning and the implications this might have for the continuity of services and the CCGs while all experiencing resource constraints are not in the same financial position.

The table below details the CCGs and by association the HE commissioners common or shared ***critical service components*** that impact on delivery and determine the degree of success. These ***critical service components*** reflect the key elements drawn from Annex 1 which develops the Frail Elderly Solution Design Overview (originally Appendix 3 in the KPMG Final Report to the Staffordshire LHE, page 44). In considering the KPMG Solution Design, the HE determined that additional columns were necessary to incorporate existing and planned actions not identified by KPMG at the time of their study and as a basis for bringing together the disparate intentions of the Commissioners under consistently applied headings. The HE has reviewed the actions and intentions listed in each column and identified where there is the greatest potential for co-ordination in addressing the ***critical service components*** across the HE.

Critical Service Components – For shared pan Staffordshire development
Achieving personal responsibility (patient education and empowerment and carer resilience)
Single assessment (trusted assessment)
Intermediate care
Step up and step down practice
Frail elderly assessment activity (including comprehensive geriatric care assessment)
Parity for mental health and approach to dementia
Access to diagnostics including access to specialist interpretation and advice
Care facilitation, co-ordination and navigation
Making effective use of Technology Enabled Care (TECS)
Information management

Sustaining a Cross Economy Strategy:

Arrangements need to be agreed to ensure that the dialogue on effective commissioning is sustained and evolves as the landscape of health and social care commissioning continues to change. The impetus gained from the KPMG review and the importance of the Better Care Fund have served to highlight how Commissioners can inadvertently duplicate effort in pursuit of similar commissioning objectives.

A lesson learnt in arriving at this strategy is that initiatives to address the ***critical service components*** must start with a mapping of existing intellectual capital and identify where work has already started to identify the stage of development. From this a ***Lead Developer*** should be identified to organise and lead task and finish activity with the objective of arriving, at pace, with recommendations to the HE.

All recommendations should be underpinned with an appropriate level of service design and indicative specifications from which pan Staffordshire and where appropriate localised commissioning decisions can made. Lead Commissioner and other arrangements should respond to the recommendations.

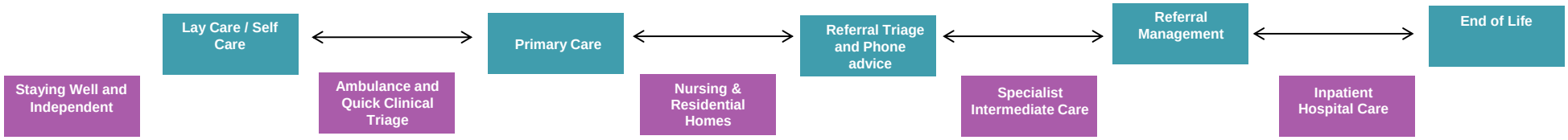
Throughout, there should be proportionate commissioner participation in support of the ***Lead Developer*** where the HE commits its intellectual property and knowledge to ensure that the best solutions possible are proposed. This should ensure first a robust and inclusive development process and second deliver ownership of the outcome at an individual commissioner level.

Oversight arrangements will be necessary, these should however be aligned with or take account of:

- Priorities established by Health and Wellbeing Boards;
- The integrated work stream arrangements of the HE Commissioners (driven by Better Care Fund);
- Existing Cross Economy Strategic Leadership arrangements - such as Accountable Officer and COO forums and CELG (it is recognised these arrangements are being reviewed);
- Clinical Senate, Clinical Forums and Clinical Network arrangements (eg Star Chamber established in Northern Staffordshire) as proportionate clinical representation in the oversight arrangements will be required; and
- Economic imperatives driving the necessity for system wide QIPP and efficiency gains.

Lead Developers should carry responsibility for reporting to all HE Commissioners (through the COO forums and cross economy arrangements) and should expect to support individual Commissioners through their individual decision making and governance processes.

Observation: At a high level, the table below describes the KPMG frail elderly solution



Setting, Responsibilities and Actions								
1. Risk Stratification 2. Influenza and pneumococcal vaccinations 3. Support to maintain healthy lifestyle 4. Social opportunities (physical and virtual) 5. Engaged communities 6. Core Public Health offer supporting lifestyle and behavior change 7. Effective self-care of LTC and other conditions 8. Effective carer support and information 9. Mental wellbeing services 10. Social care support. 11. Universal community support and wellbeing. 12. Information advice and guidance	**CCG and LAs** 1. Identification of named individuals. 2. 'Key worker' approach. 3. Integrated service offer between social care, health, voluntary/ third sector, mental health. 4. Individual care and contingency plans, accessible by social, mental, health services. 5. Aspire to use integrated information systems. 6. Supportive pharmacy services. e.g medicine reviews . 7. Use of technologies to support self-care and reduce dependency. 8. Peer support networks providing choice and range of access to individuals 9. Targeted behavioral lifestyle management programmes with focus on physical activity. 10. Psychological therapies to support patients with emotional wellbeing of disease management 11. Patient education and training programmes to empower patient's self-care	**Ambulance** 1. Identification of patients on risk register; provision of support or redirection. 2. Emergency care plans **Phone** 1. Quick access to clinical triage systems, run by clinicians. 2. Diversion of key individuals into right setting of care.	**GP Practices**: 1. Risk Stratification to identify named individuals 2. Accountable GPs for all named patients 3. Care plan development, execution. 4. Holistic assessments. 5. Integration of social, community and tertiary care into primary setting 6. GP access to specialist support to manage patients. Eg Education, MDTs, Clinical case reviews, outreach, telephone/email advice. 7. Upskilled GPs/PNs to manage more patients within primary care. 8. Delivery of evidence based care processes / clinical checks to ensure optimal management of patients with LTCs **Other GP services** 1. GPs at the front entrance of A&E. 2. GP phone triage. 3. GP home-calls. 4. GP nursing home visits. 5. Consistency of information and care provided between in hours and out of hours GP Services	**Specialist care:** 1. Timely Assessments 2. Prompt transfer of comprehensive clinical information to the care home / GP. 3. Adequate clinical training for care home staff. 4. Reviews which are timely and assertive.	**Phone** 1. Referral management services and advice for GPs, potentially run by specialists. 2. Send some patients to intermediate care, others to hospital; support GPs in managing remaining patients.	**Specialist Hub** 1. Specialised ambulatory services with multi-disciplinary team (social workers, geriatricians, therapists, etc.) 2. Community beds with right-level of step-up/down services. 3. Effective use of Telehealth services. 4. Supported with right level of diagnostics, and expanded working hours. 5. Re-ablement services to ensure patients gain maximum control and independence. 6. Crisis response to prevent hospital admission 7. Provision of both home based and bed based Intermediate care, with balance towards domiciliary provision and reablement.	**Phone** 1. Specialist-supported referral managemen t services. 2. Coordinates admissions into inpatient care. 3. Supports discharge back into the community.	**Specialist inpatient care** 1. Inpatient care for acutely ill patients. 2. Management to patients' care plans. 3. Coordination with community and social care to avoid delays in discharge. 4. Coordination with mental health beds.	**Palliative Care** 1. Structured approach in care homes such as Gold Standards Framework with advanced care plans, advance decisions and adequate choice, control and support towards the end of life. 2. Equitable access to specialist palliative care services

	. 12. Supporting anticipatory planning to scenario plan events and responses 13. Ongoing support and liaison services and crisis support 14. Default choice of control, offering DPs, PBs and PHBs. 15. Commission in partnership for shared outcomes.								