Llywodraeth Cymru
Welsh Government

Integrated Information, Advice and Assistance (iIAA) for Adults with Complex Needs and Older People living with Frailty

National Integrated Care Guidance Framework

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'Assess, treat and back on your feet'

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Executive Summary

A focus on prevention and proactive care for adults with complex needs and older people living with frailty is now acknowledged across policy and national programmes as a key priority for delivery in pursuit of improved outcomes for this population, reduced inequalities and enhanced system resilience as outlined in *A Healthier Wales*.

This guidance is part of a toolkit for Regional Partnership Boards to support a coordinated approach to developing an Integrated Community Care System. This guidance focuses on the provision of Information, Advice and Assistance for this population group.

The provision of timely Information, Advice and Assistance (IAA) is a key component of enabling improved outcomes through preventative approaches, and as such is a duty placed on Local Authorities by the Social Services and Wellbeing (Wales) Act (2014) (SSWBA).

For adults with complex needs and older people living with frailty, their fluctuating needs will often require coordinated assessment, care, support and treatment by a range of health and social care professionals, reflecting each person's unique circumstances and presenting condition.

Part 9 of the SSWBA, and specifically the Duty to Cooperate, recognises that in supporting adults with complex needs, partnership working is essential in discharging LAs' IAA duties and ensuring that people's care and support needs are met.

In addition, the duty of quality requires quality-driven decision-making and planning to deliver better outcomes for all people who require health services. The duty came into force in 2023 under the Health and Social Care (Quality and Engagement) (Wales) Act 2020. Statutory guidance was published which describes best practice to assist NHS bodies in implementing the duty of quality. It sets out the 12 health and care quality standards which align with the duty.

This framework provides clarity on IAA arrangements for the statutory organisations which make up Regional Partnership Boards, specifically in relation to this population group and their unpaid carers. It reflects the need for an integrated response to the provision of assistance when they present with urgent and escalating needs or in crisis.

Drawing from peer reviewed evidence base and the *Integrated Quality Statement for Older People living with frailty* it outlines the key enablers and components that should be considered.

It is anticipated that this guidance will be valuable for Regional Partnership Boards to inform the design and implementation of best practice to optimise outcomes for adults living with complex needs, older people living with frailty and their unpaid carers.

The provision of IAA for adults living with complex needs is considered essential for the proactive management of their needs. Similarly, timely and effective IAA supports

seamless coordination of services to manage urgent needs and compliments Health Boards Single Point of Access objectives. This guidance should therefore be read in conjunction with Proactive Care Framework; SPOA Framework for Health Boards; Falls Response Framework

'Assess, Treat and Back on your Feet': A National Framework for Integrated Information, Advice and Assistance for Adults with Complex Needs / Older People living with Frailty in Wales

Themes	Requirements / Enablers
Context and Quality Statement	Older people and people living with frailty: integrated quality statement | GOV.WALES A Healthier Wales More than just words National Framework for Social Prescribing Social Services and Well-being (Wales) Act 2014 Primary Care Model for Wales Prevention Based Health and Care Framework Duty of Quality Statutory Guidance Proactive Care Framework National Single Point of Access (SPoA) Framework for Wales Enhanced Community Care Infographic Enhanced Community Care 'Virtual Wards' National Front Door Acute Frailty Service (AFS) for Acute Hospitals Framework for Wales Building Capacity through Community Care: Further, Faster, Together Six goals for urgent and emergency care: policy handbook for 2021 to 2026 | GOV.WALES National_Community_Nursing_Specification_v1_Jan_23.pdf 50 Day Challenge Booklet: PDF 2024 50 Day Integrated Care Winte

Overarching Core Principles re Integrated IAA	- Regional Principles - Operational Management Principles
Operating Standards for integrated IAA for Adults with Complex Needs	- Infrastructure - Assessment - Treat - Back on Feet

1.0 Introduction

This framework is aligned to *A Healthier Wales* and its vision for an Integrated Community Care System (ICCS) that enables citizen-focused 'place-based systems of care' that meet a defined population need, improving their wellbeing outcomes and reducing health inequalities.

The framework complements the Primary Care Model for Wales and associated responsibilities of Pan Cluster Planning Groups (PCPGs) and Regional Partnership Boards.

It provides planners, commissioners and operational leads within LAs and HBs with a definitive guide to the principles and standards which should be considered in the provision of efficient and effective Information, Advice and Assistance (IAA) specifically for adults living with complexity, comorbidity and / or frailty.

This framework does not undermine Local Authorities' existing arrangements to meet the IAA needs of their citizens [1]. It does recognise that meeting the complex and fluctuating needs of the population requires partner organisations to work together to achieve a coordinated and integrated approach to IAA. This is particularly important in meeting urgent and emerging escalated needs to ensure best outcomes are achieved for the person and sustainability of the system[2].

[1] The Information & Advice Quality Framework for Wales (IAQF Wales) the-information-and-advice-quality-framework-for-wales.pdf

Better conversations SCW Information, advice and assistance under the… | Social Care Wales

[2] Duty of Cooperation

2.0 Adults with Complex Needs (including Frailty)

An Integrated Quality Statement (IQS) for Older People living with Frailty was developed by an Expert Reference Group of health and social care stakeholders and published in January 2024. The IQS outlines quality attributes of a frailty attuned system however it can equally be applied to adults living with complex needs and multi morbidity.

The IQS describes that 'what matters' to this population is to live as well and as independently as possible in their own home and community and, at the end of their life, to be supported to die in the place of their choice.

To achieve this outcome, the IQS advocates for a preventative and proactive approach to care and management. The importance of such an approach is set out in the **Building Capacity through Community Care Statement of Intent** (SOI) published by Welsh Government in June 2023 and also in the 50 Day Challenge Best Practice Guidance document (October, 2024).

In summary, the SOI describes the current health and social care system as being weighted towards reactive crisis management. This population often present to Local Authority social services departments and primary care with functional and / or cognitive decline which is often new and sudden.

Sudden and escalating needs for this population group are usually related to a physiological, social or psychological change such as infection, loss of a loved one or change of environment. Episodes like this are known to result in heightened stress and anxiety and often result in contact with urgent and emergency care providers such as Out of Hours GPs, 111, Welsh Ambulance NHS Trust (WAST) and Emergency Departments. It is generally acknowledged that around 20 – 30% of emergency department presentations and subsequent hospital admissions could have been prevented with early recognition and management of crisis and / or carer breakdown[3].

The reactive system, and in particular hospitalisation, can cause further deterioration and loss of independence resulting from things like exposure to hospital acquired infection, a loss of confidence, and loss of muscle mass (sometimes referred to as deconditioning).

This cohort often experience sudden episodes of decline and with fluctuating and escalating needs reflecting the complex combination of biopsychosocial factors. Earlier, preventative approaches including a coordinated approach to the provision of Information, Advice and Assistance help pre-empt and proactively manage these needs.

[3] NHS England » Delivery plan for recovering urgent and emergency care services – January 2023

3.0 Information Advice and Assistance

Local authorities have a duty to put in place a service that provides people (including carers) with the information, advice and assistance (IAA) that they need to take control over their day to day lives and achieve 'what matters' to them.

Health Boards have a duty to provide Local Authorities with information pertaining to care and support that they have available within that local authority's area.
There is also a duty to cooperate to meet population needs such as those for adults with complex needs.

Meeting the IAA needs of adults with complex needs and older adults living with frailty requires partners to work together to deliver an integrated IAA that can best respond to the complex needs of this cohort and achieve the best outcomes for the person.

An Integrated IAA Model (iIAA) can be described as *seamless integration of health, social care and wellbeing services to provide timely IAA for a defined population within a defined geographical footprint and which places the citizen at the centre and focuses on achieving 'what matters' to them.*

This framework recognises that each LA and its partners will need to design and deliver its iIAA in a way that reflects its population and unique context. However, to achieve a broad consistency of approach across Wales, each model must demonstrate alignment to the principles and standards set out below.

It also recognises that the nature of varying regional footprints requiring alignment of iIAA arrangements to other arrangements such as Health Board-led Single Points of Access providing clinical assessment for urgent care needs. We would expect Local Authorities to work with Health Boards at Regional level to achieve an integrated and coordinated system across health and social care.

Generally, IAA for this population group should provide a range of resources to support prevention, manage urgent and emerging needs and their long-term care needs (see Figure 1. below.

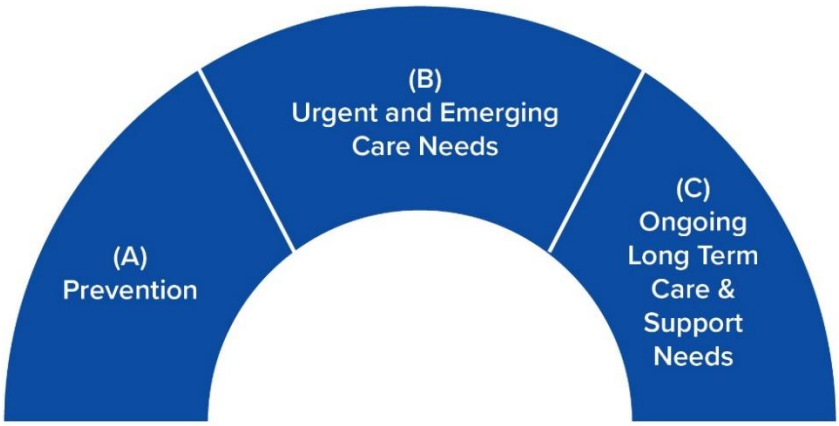

Figure 1.

- **Information** that enables healthy ageing (community inclusion, housing and wider determinants of health for those who are fit and well requiring no statutory provision but the occasional intervention from primary care ***(Prevention).***
- **Advice** that enables access (sign-posting) to self-care interventions to manage less complex needs ***(Prevention)***
- **Assistance**** This area of provision is most likely to require an integrated approach to meeting presenting needs and is the main interface with Health Board SPOA provision. Assistance here responds to:
    - Expected decline related to known complexities which are generally progressive in nature **(long-term care and support needs)**
    - Sudden decline / escalated needs **(urgent or emerging needs)** associated with the fluctuating nature of their condition, injury or illness, and the provision of immediate review, appropriate response and 'wrap around' care & support and treatment that enables the person to get 'back on their feet', including enhanced community care services.

3.1 Principles of an Integrated IAA

Regional Partnership Board Leadership:

- Local Authorities and Health Board leaders think, act, behave and making decisions as one, aligning relevant assets and resources to better support people This includes iIAA as integral part of enhancing the person's experience of navigating the system.
- Local Authorities and Health Board leaders enable their organisations to align their resources to functionally integrate their iIAA model within their system i.e facilitating a single coordinated approach at a Regional level, but delivered at Pan Cluster / Local Authority level
- Local Authorities and Health Board leaders develop their iIAA in a manner that ensures equity and optimal outcomes for the population and value and sustainability for the System.
- Local Authorities and Health Board leaders implement effective governance to ensure the iIAA delivers safe, effective and efficient outcomes for the System, its organisations and the population.
- Local Authorities and Health Board leaders develop a joint approach to iIAA data and other data sources, to inform joint needs assessment, planning, commissioning and demand / capacity management that ensures sufficient workforce capacity and capability
- Local Authorities and Health Board leaders promote the iIAA widely to ensure public awareness
- Staff will have the right level and balance of skills, as well as having access to professional specialist expertise

Integrated Service Leadership and Management:

- Focus on *what matters* to an individual, which should be co-produced
- Trusted, meaningful relationships are developed and fostered between professionals, the person, their informal carers and their family
- Adopts a *tell us once* approach and make every contact count
- Eliminate waste and duplication of effort
- Are compassionate leaders, building trust and reducing conflict to ensure collective accountability for the iIAA service
- Resources, including staffing and budgets are managed through effective governance processes
- Adopt a balanced approach to risk and timely decision making
- Enable routine consideration of Technology Enabled Care and its benefits (Video Conferencing, Telecare, Telehealth etc)
- Ensure holistic assessment and routine consideration of people's cognitive needs alongside responding to physical health needs and impairment
- Enable a 'Warm hand on - Warm hand off' approach, minimizing delays and administration associated with inter-service referral and criteria, and ensuring everyone is informed
- Adopt a proactive approach to care management and review
- Ensure access to specialist services who have a duty to operate within this model
- Ensure continuity of care, optimising care management resource and processes
- Clear clinical governance arrangements in place to ensure safe practice and continuity of care
- Offer interventions that are proportionate to the needs to the person delivered by the most appropriate care professional/provider
- Enable a 'one person up the garden path' approach, supporting staff to develop additional skills and safely blur professional boundaries to optimise capacity and the experience of the person

3.2 Operating Standards of an integrated IAA

Section A: Prevention

Definition

Provides general information and advice to support ongoing wellbeing and prevent urgent and emerging need

Responsible Organisation

Local Authority

Hours of Operation

Usually 0900 – 1700 Monday to Friday but determined by the responsible organisation.

Partners / Stakeholders

- Health Board (Part 2 Duty to provide information re services to LA)
- Social Prescribers
- Community Groups
- Public Health
- Primary Care Contractors
- Pan Cluster Planning Groups
- Third Sector Providers
- Local Authority Depts
- WAST / 111 (e.g Press 0, Press 1 etc.) / Health Board SPOA

Outcome Measures

Wellbeing Outcomes (via Regional Integrated Fund reporting)

Section B: Urgent and Emerging Care Needs

Definition:

Well planned, integrated, responsive, co-ordinated community care services in a defined 'neighbourhood' such as Local Authority footprint that is wholly aligned to Health Board SPOA.

Integrated IAA model enables:

- Proactive management of a defined 'complex' caseload and their Future Care Plans
- Facilitates simultaneous senior multi professional assessment of presenting need and subsequent decision-making regarding care and treatment planning and deployment.
- Ensures the right interventions by the right professionals at the right time to reduce risk of further deterioration and acuity thereby promoting recovery and reduced need for long term care. Interventions could include:
    - Self-care advice and assistance (includes equipment and adaptations)
    - Urgent care 'eyes on' response including falls response,
    - Rapid access to diagnostics within 60 minutes
    - Urgent care provision (reablement, Enhanced Community Care, therapy led programmes, assistive technology)

Responsible Organisation

Local Authority and Health Board are jointly responsible for implementing iIAA (Parts 2, 3, 4 and 9 of Social Services and Wellbeing (Wales) Act apply in relation to meeting the needs of adults with complex needs / frailty)

Operational Standards iIAA 'Assess, Treat, Back on your Feet'

The infrastructure:

- Operational 7 / 7 per week between 0700 – 2200 hrs
- Supported by business and administrative infrastructure
- Open, easy access through an integrated 'hub' (through colocation / open Teams Channel)
- Has access to appropriate range of digital systems to access care records (on a proportionate basis)
- Receives referrals from:
    - People known to the 'complex caseload' at times of concern
    - IAA (prevention section) for people not known to the caseload however presenting with sudden unexpected decline or emerging urgent needs / carer breakdown
    - Community health and care professionals including care providers, care homes and WAST

- Hospital Discharge Teams and / or provides in-reach to the discharge hubs
- Alarm Receiving Centres (Falls Response)
- Health Board SPOA
- Clinical Support Hubs '111' and GPOOHs

'Assess'

- Facilitates simultaneous senior multi professional assessment and decision making re care, support and treatment and adopting Trusted Assessor model where appropriate.
- As a minimum multi professional team should include: Social Worker, Physiotherapist, Occupational Therapist, Community Nurse, Advanced Clinical Practitioner. The team would also benefit from:
  - Wider Allied Health Professionals eg SALT / Dietetics / Podiatrist and Healthcare Science Professionals
  - Pharmacist
  - Approved Mental Health Professionals (AMHPs) / Mental Health Crisis Team
  - Medical Assessment
- Alignment to TEC Alarm Receiving Centres
- Facilitates rapid access to 'eyes on' assessment where required within a 1 – 2 hour period (including falls and TEC alerts for breached vital sign / care parameters)
- Rapid access to diagnostics within 60 minutes (including Frailty Assessment Units and SDEC / SDUCs)
- Access to national palliative care (111 Press 0), Verification of Expected Death and After Death / Bereavement pathways

'Treat' (When the person has acute medical needs that are intense and fluctuating)

- Access to national falls response, respiratory and catheter pathways
- Rapid access to Level 4 Enhanced Community Care within 2 hours and clinically led care provision until person's needs become sub-acute usually a minimum of 48 hours however can be longer.
  - Clinical interventions in the persons own home e.g. Intra Venous medication, sub cutaneous / intravenous hydration, pain relief
  - Needs to include wrap around nursing care including vital sign observation and personal care
- Facilitates scheduled appointments or assessments including acute medical hospital admission

'Back on your Feet'

- Access to 'step up' or 'step down' Level 3 Multi Professional 'wrap around' care within 48 hours e.g. reablement (at home or in bedded facility), therapy led programmes for a period of up to 6 weeks.

- Future Care Planning (FCP) and / or review of the FCP

Section C. Ongoing Long-term Care and Support

Definition

Provision of ongoing long-term care and support following formal assessment of eligibility for care and support including: Domiciliary Care, Residential Care, Nursing Care, EMI services

Responsible Organisation(s)
Local Authority and Health Board

Hours of Operation
Monday to Friday 0900 – 1700hrs

Appendix

Draft Outcomes and Process Measures for Urgent and Emerging Needs

At time of publication definitive outcomes and process measures are being considered nationally by Integrated Community Care System Leadership Group. The following have been proposed and are included for your information.

Population Outcome

- 60% will stay in or go back to their community from all interventions including step up / step down beds. They may not require ongoing long term care and support needs however may include monitoring on district nurse caseload.
- 10% may require admission to hospital
- 30% will have ongoing long term care and support needs (e.g. social care, Funded Nursing Care / Continuing Health Care at home or in residential / nursing placement).

System Outcome Measures

- Count of people receiving long term care and support
- Count of people waiting for long term care are support
- Number of emergency admissions > 75s
- Count of people admitted to hospital as emergency with LOS > 21 days

Service Improvement Measures

- Count of referrals to ECC
- Count of referrals to Reablement
- District Nursing capacity (7/7) (visits and people seen)