south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership **Held on:**	**Strategic Planning Advisory Group** **26th September 2023**
Agenda Item:	**8**
Title:	**Focus on Frailty**

Summary:

The purpose of this report is to update SPAG members on key developments and issues related to the Focus on Frailty approach in South Ayrshire.

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Recommendations:

SPAG members are asked to note the proposed South Ayrshire approach to Focus on Frailty.

Route to meeting:

Directions:		**Implications:**	
1. No Directions Required	X	Financial	☐
2. Directions to NHS Ayrshire & Arran	☐	HR	☐
3. Directions to South Ayrshire Council	☐	Legal	☐
4. Directions to both SAC & NHS	☐	Equalities	☐
		Sustainability	☐
		Policy	☐
		ICT	☐

LOCALITY PLANNING AND REPRESENTATION ON FOCUS ON FRAILTY

1. PURPOSE OF REPORT

1.1 The purpose of this report is to update SPAG members on key developments and issues related to frailty and in particular, the Focus on Frailty programme in South Ayrshire.

2. RECOMMENDATION

2.1 It is recommended that the SPAG note the approach re frailty and Focus on Frailty programme in South Ayrshire.

3. BACKGROUND INFORMATION

SPAG members will have been previously briefed about a range of HSCP work focusing on supporting frailty including the Ahead of the Curve programme in Primary Care and wider Communities.

Working together with colleagues from UHA an application was submitted for participation in a national HIS programme called Focus on Frailty. This was successfully considered, and we now form part of a network of 6 partnerships working with national colleagues in HIS/improvement Hub to develop further pioneering work on frailty.

4. REPORT

4.1 Essentially, the proposed approach submitted to the Focus on Frailty programme was:

Building on previous experience linked to frailty as party of the (Pre-Covid) Frailty Collaborative, our further investment in upstream frailty supports within primary care, our collective work with acute colleagues and nascent work on an 'Ageing Well' Strategy (under Community Planning) we would wish to develop a whole system approach to addressing Frailty. Our community-based approach is branded 'Ahead of the Curve' and the learning from this programme will be instructive re our whole approach.

This will include:

- Very upstream population health approaches based within localities and with support from wider Community Planning Partners
- Intervention and supports at early (mild)stages of frailty with particular reference to the Life Curve
- GP Practice based interventions using the eFrailty tool and OT-led supports for people moving into significant levels of frailty
- Community based supports for those with significant frailty that might mitigate a potential hospital admission
- Support through hospital-based journeys and upon discharge

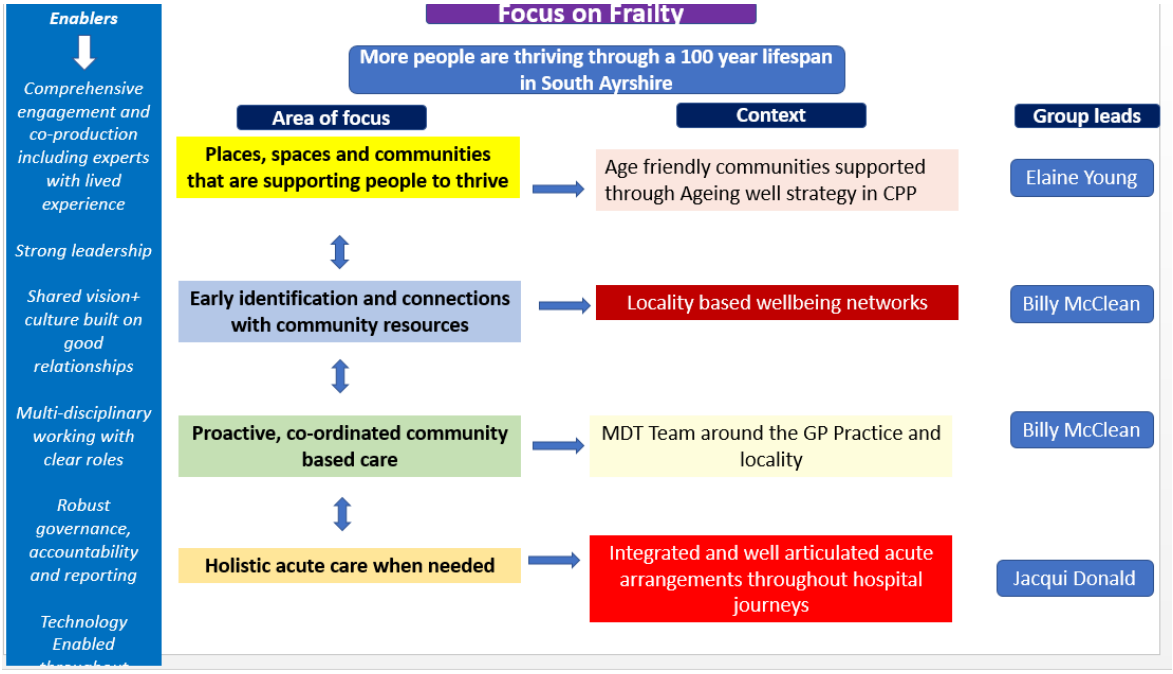
- Support Reablement and longer-term Community Rehabilitation interventions
- Supportive self-management
- Support for informal carers throughout the whole process
- Particular support for frailty within Care Home sector
- Identification of where technology enabled care approaches can add value
- Links to the opportunities linked to our new Micro-enterprise approaches

4.2 The work will be embedded within and integral to other linked programmes such the new Teams Around the Locality, wider Whole System Intervention work with acute colleagues and with particular linked services and approaches such as Discharge Without Delay, ACE Practitioners, Hospital at Home, Reablement, AHP supports including Community Rehabilitation Team, Run At Team, TEC team, reformed Social Work supports and third sector/carers service initiatives.

4.3 The work will build upon a number of existing interventions and programmes, but seek to build a more whole-system, coherent, articulated and integrated approach that recognises the range of supports needed throughout a whole person's journey. This will be congruent with:

- The NHS Ayrshire and Arran Caring for Ayrshire vision
- The South Ayrshire HSCP Strategic Plan
- The South Ayrshire HSCP Older People's Service Plan including the move towards locality working
- The potential Community Planning based Ageing well Strategic thinking and emerging strategic approach

4.4 A diagram setting out the proposed approach is set out below:



4.5 Essentially the following will be the focus of the programme in South Ayrshire

- Our priority will be to build a better articulated and integrated approach to addressing frailty from population and public health approaches, very early community approaches, early identification within GP Practices together with person centred planning, downstream supports for those with more challenging frailty, supports in times of crisis, support at hospital front door, through hospital journeys and upon discharge.

- We will continue to build upon the existing use of the eFrailty tool, within GP Practices and roll out to more Practices in time.

- We will make frailty integral to our new Locality Teams.

- We will want to ensure frailty is embraced within a greater context through Community Planning based approaches and within new locality working and integrated within the nascent Ageing Well Strategy.

- We will establish greater partnership approaches that will include HSCP, Acute, Primary Care, Community Teams, Third Sector, Carers Services, Independent Sector, wider CPP partners and local citizens.

- We will seek to build whole system knowledge and skills through a three-tier approach to workforce development.

- We will build upon the locality engagement work linked to frailty ensuring that lived experience informs all planning for example, our Journey Mapping work.

4.6 We will seek to establish clear and visible leadership re our frailty work including from management as well clinical and care leaders. We will want to establish a culture where frailty is 'owned' by a range of players within community and hospital-based contexts. We will ensure our approach is mindful of the needs of a diverse local population and subject our planning to Equality Impact Assessments.

4.7 The programme sponsors are the HSCP Head of Service and the new UHA Manager and the clinical lead is the Consultant Geriatrician leading on Hospital at Home with clinical support from a variety of MDT leads but including HSCP CD and Stakeholder GPs.

4.8 The programme will be rooted in a Quality Improvement approach.

4.9 There is a Programme oversight group meeting every 2 weeks (chaired by HOS) that ensures the different component parts of the programme can report on progress and ensure the work is strongly based on QI principles.

Each component part has aim statements, driver diagrams and key measurable outputs that it is seeking to develop although the more upstream focused work is strongly linked to our Ageing Well work programme. The work also forms a key part of our Team Around the Practice working reported elsewhere in SPAG.

This has involved strong community engagement, initially in Troon.

5. STRATEGIC CONTEXT

The Frailty work seeks to address the following strategic priorities:

- We focus on prevention & tackling inequality.
- We work together to give you the right care in the right place.
- We are an ambitious & effective Partnership.

6. IMPLICATIONS

6.1 Financial Implications
6.1.1 No implications

6.2 Human Resource Implications
6.2.1 No implications

6.3 Legal Implications
6.3.1 No implications

6.4 Equalities implications
6.4.1 No implications

6.5 Sustainability implications
6.5.1 No implications

6.6 Clinical/professional assessment
6.6.1 No assessment needed

7. CONSULTATION AND PARTNERSHIP WORKING

The work has been developed through a partnership approach with HSCP and Acute NHS colleagues.

8. RISK ASSESSMENT

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