south ayrshire
health & social care
partnership

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| **Meeting of South Ayrshire Health and Social Care Partnership**<br><br>**Held on:** | **Integration Joint Board**<br><br>**15th November 2023** |
| **Agenda Item:** | **13** |
| **Title:** | **Focus on Frailty and Ahead of the Curve update** |

**Summary:**

The purpose of this report is to update IJB members on key developments and issues related to the Focus on Frailty approach in South Ayrshire together with an update on progress on the Ahead of the Curve frailty programme.

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| **Author:** | **Phil White/Joanne Payne** |

**Recommendations:**

IJB members are asked to note the proposed South Ayrshire approach to Focus on Frailty and the update on progress re Ahead of the Curve.

**Route to meeting:**

| **Directions:** | | **Implications:** | |
|---|---|---|---|
| 1. No Directions Required | ☐ | 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

The purpose of this report is to update IJB members on key developments and issues related to the Focus on Frailty approach in South Ayrshire together with an update on progress on the Ahead of the Curve frailty programme.

## 2. RECOMMENDATION

**2.1 It is recommended that the IJB note the approach re frailty, and, in particular, Focus on Frailty programme in South Ayrshire and the update on progress re Ahead of the Curve.**

## 3. BACKGROUND INFORMATION

IJB members 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 at the November 2022 IJB.

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, the proposed approach agreed with Healthcare Improvement Scotland 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

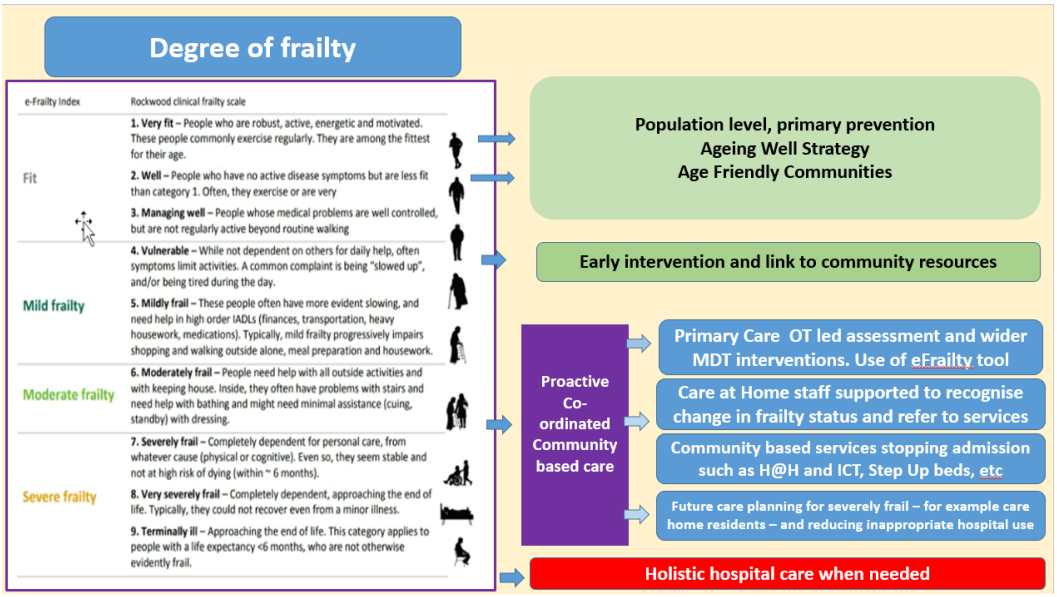
- Supporting people through hospital-based journeys and upon discharge
- Supporting Reablement and longer-term Community Rehabilitation interventions
- Supporting self-management
- Supporting informal carers throughout the whole process
- Particular support for frailty within Care Home sector
- Identification 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.

- The prevention component will be integral to our Ageing Well work not least the development of South Ayrshire an Age Friendly Community (and part of the UK Network of this WHO-led approach).

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 with strong support from QI expertise at local and national levels.

4.9 **Update on existing Ahead of the Curve work**

As has been mentioned earlier in the report, the Focus on Frailty programme will build on, and have as integral, the existing Ahead of the Curve work that the IJB has previously invested in. Progress on this work was tabled at an IJB in November 2022.

The following is a further update on progress and next steps for the work, especially as it is seen in the wider Focus on Frailty context.

IJB Members will know that there were two distinct components of the Ahead of the Curve work:

- Seeking to identify people at a very upstream stage through community-based contact and support
- Seeking to support people identified at a GP Practice level who may face imminent increase in their frailty status and MDT supports

The Occupational Therapy resource has been allocated to practices, according to data secured from Business Intelligence, on practices with the highest percentage of mild/moderate frailty within the population.

The service is now established in the following 10 GP surgeries:

- Troon & Villages locality (1/2): Templehill
- Ayr & Prestwick (6/10): Tams Brig, Fullarton Practice, Cathcart Street, Dalblair, Alloway Place, Bankfield
- Girvan & Maybole (4/6): Dr McCulloch and Partners, Riverside Medical Practice, Dr McMasters and Partners, Ailsa Craig Practice, Maybole Medical Practice.

Evidence suggests (BGS, 2023) that Leadership is pivotal when establishing Frailty services. At the present time the service is led by an occupational therapy team lead (Band 7), this is funded from the core Occupational Therapy service.

In addition, the partnership funded workforce, is 2 (WTE) Band 6, and 3 band 5 staff (2.8 WTE). One member of band 5 staff has secured a promoted post and will leave the service after the Festive period. In terms of workforce, there are challenges associated with recruiting and retaining band 5 staff.

In the period from 01.04.2022 to 01.10.2023, the service has completed **330** frailty assessments at the request of GPs and their practice team.

The Electronic Frailty index has been successfully used to proactively identify patients who were not otherwise in touch in with primary care services. (Background on the EFi can be accessed via the 2019 iHub report). A pilot of the EFi was carried out at the beginning of the year, where a manual report was generated and highlighted individuals who's EFi score changed 2, 3, or 4 points in the last 3., 6, or 12 months. From this first pilot 105 individuals were identified, with 45 being screened out as inappropriate as they were in care homes, or currently open to another Community Rehab Service. Of the 60 individuals left, opt in letters were sent offering our service. From the 60 individuals 34 took up the offer of input. The work will continue to grow as capacity allows.

At a population level, the assistant practitioner staff have engaged widely with their localities. A large part of their work has been to give talks to groups in local churches, lunch clubs, community centres and sheltered housing units, among many other partners.

These talks have reached over 500 local people with simple aging well messages, and details about the self-referral pathway into the service.

To date the service has completed **172** well-being reviews from individual self-referrals.

There is a real appetite from localities for groups, therefore, to progress this work, each of the assistant practitioners have now been allocated portfolios across: Functional MOTs, Falls Prevention, Wellness Recovery Action Planning, Mental Health and Dementia. An application has been made to the SAHSP's Innovation Fund for training to support this work.

Both components of the Ahead of the Curve work have conversations with individuals based on the Frailty indicators. This is very much embedded in 'what matters to the individual.' From this a bespoke plan is co-created with individuals.

To date the most common interventions are documented below:

- Falls prevention education (using Positive Steps booklets and Super 6 exercises)
- Referrals to Invigor8 (falls prevention classes)
- Signposting to local social opportunities
- Signposting to local transport solutions (e.g., MyBus scheme)
- Prescribing of equipment to enable safe completion of activities of daily living such as toileting, showering, bathing, and managing kitchen tasks
- Ordering of grab rails, handrails, and bannisters to ensure safe movement in and out and within the house
- Self-management support to manage low level pain, fatigue, anxiety and low mood
- Coaching approaches to problem solve challenges linked to daily activities
- Advise re techniques and gadgets to manage key tasks when hand mobility/pain/tremor are limiting
- Support to re-engage with hobbies and activities to alleviate boredom and maximise wellbeing
- Signposting and support to recognise family members as carers when appropriate
- Onward referrals to other professionals are detailed in Fig 1

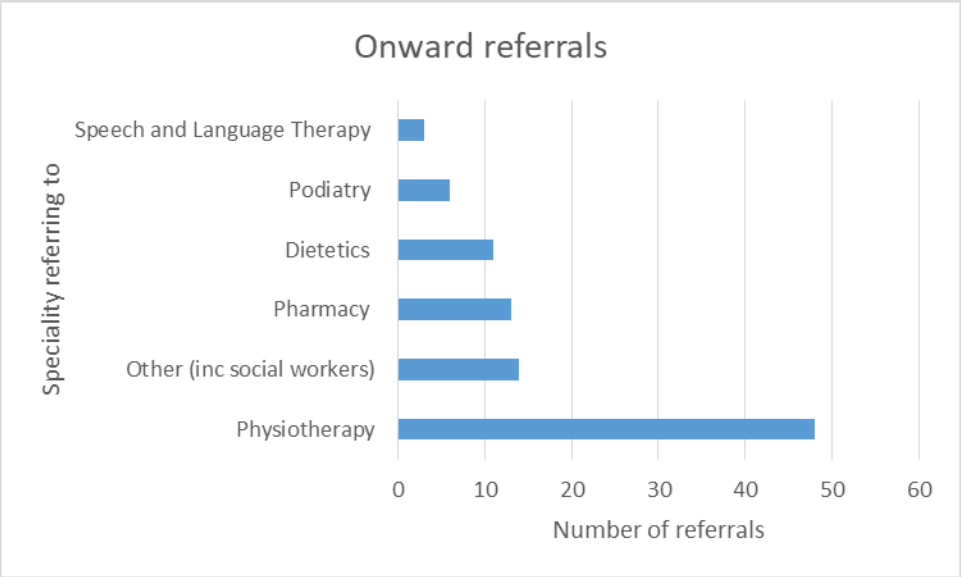



Fig 1. Onward referrals made to other healthcare professionals.

In summary, from 502 reviews, there were 95 onward referrals, 79 of which were too other AHPs. The most common onward referral was for physiotherapy.

**OUTCOME MEASURES**

NHS Ayrshire & Arran

## Service outcomes

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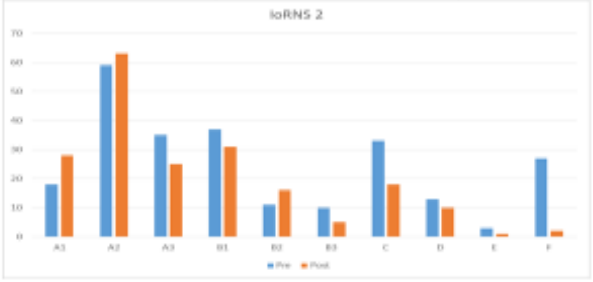
| | Scale & detail | Pre-intervention | Post-intervention | Change |
|---|---|---|---|---|
| **Rockwood Clinical Frailty Scale (CFS)** | 1 – 9<br>*Higher number indicates greater frailty* | 4.5 (n=262)<br>*'Vulnerable' to 'Mildly Frail'* | 4.3 (n=262) | 4.5% |
| **EQ-5D** | 1 – 25<br>*Higher number indicated greater degree of problems with aspect of ADLs* | Qualified staff 12.8 (n=121)<br>Assistant Prac. 11.1 (n=105) | 10.4 (n= 121)<br>7.8 (n=105) | 21%<br>30% |
| **Self-Management Ability Scale (SMAS)** | 1- 60<br>*Higher number indicates greater self-management knowledge, confidence and skills* | 39.4 (n=36) | 45.6 (n=36) | 16% |
| **Indicator of Relative Need 2 (IoRN2)** | A – G<br>*Non-numerical scale, earlier alphabetical letters indicate greater independence with ADLs.* |  | | |



Date of data extraction: 10.07.2023

**Lessons Learned**

- The local work on Frailty in South Ayrshire, is sector leading. The work has been profiled at the NES conference, and nationally at the Royal College of Occupational Therapy conference.

- The work locally was also part of a national review that was carried out by the Royal College of Occupational Therapy. Primary care evaluation - RCOT

- Outcome data is demonstrating a 21% to 30% self-reported improvement in ability to function (EQ 5D). This would suggest that the earlier that we intervene with individuals the more impact on function is demonstrated.

- Patient stories demonstrate value to the work.

- 25% of individuals are being referred onto other AHP services.

- There is an appetite from individuals at a community level, for both group and individual interventions.

**Future Direction**

There is the need to consolidate the existing programme, building from the learning from the initial phase with a few to delivering the service across all localities and with a link to all GP Practices.

The following actions will support this longer-term aim:

- Potential future workforce will be discussed in the context of the Budget Review process for the Partnership.
- Over the next 6 months, a scoping exercise will be carried out to establish the potential role of having an extended MDT (25% of referrals are forwarded onto another AHP services). This will investigate how an MDT frailty clinic could be piloted in one locality.
- Short-term funding will be explored to provide wider training, pilot Falls education, Wellness Recovery Action Planning and Stress management groups.
- The piloting of Functional MOT drop-in sessions, across stakeholders including Ayr United football club, supermarkets etc.
- Continuing to build on the work already done on the Electronic Frailty Index with Practices and Primary Care Analyst.
- Commencing a test of change in Dr McCulloch Practice in Girvan. The team will test an Occupational Therapy Frailty Clinic, in which GPs can appoint individuals directly on EMIS PCS, and those individuals will be seen within the practice.

## 4. 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

## 5. 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

## 6. CONSULTATION AND PARTNERSHIP WORKING

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

## 7. RISK ASSESSMENT

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Date 31/10/23