south ayrshire
health & social care
partnership

Meeting of South Ayrshire Health and Social Care Partnership **Held on**	**Integration Joint Board** **16th November 2022**
Agenda Item:	**6**
Title:	**Occupational Therapy Early Intervention Frailty Service – Staying Ahead of the Curve**

Summary:
The purpose of this report is to update IJB Members on the development work regarding the Occupational Therapy led early intervention frailty work.

Author:	**Joanne Payne (Service Lead Occupational Therapist)**

Recommendations:

IJB Members are asked to note the progress made in relation to this early intervention frailty work and request an update report in 6 months with a view to consolidating existing work and potentially rolling out to all GP Practices and localities.

Route to meeting:

Update report for the IJB.

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	☐

OT-LED EARLY INTERVENTION FRAILTY SERVICE – STAYING AHEAD OF THE CURVE

1. PURPOSE OF REPORT

1.1 The purpose of this report is to update IJB Members on the development work regarding the Occupational Therapy led Early Intervention Frailty Service (Staying Ahead of the Curve) and to make recommendations on the further development of this service.

2. RECOMMENDATION

2.1 The author requests that consideration be given to additional funding for the Early Frailty work whilst the board is identifying future priorities for investment. This would enable the work to extend to further practices.

3. BACKGROUND INFORMATION

3.1 Frailty is the manifestation of aging that is associated with poor outcomes, including increased risk of disability (both physical and mental health), hospital admission, institutional care or death. The impact upon an individual's quality of life is considerable. Frailty is not a disease, but rather a set of areas that decline, relating to the aging process. The kind of issues that can occur are: - reduced mobility and falls, reduced appetite, reduced muscle strength, mental health decline. These symptoms can lead to a greater risk of needing significant health and care supports and can lead to increased acute hospital admission and further decline

3.2 Due to the demographics in South Ayrshire, there are likely to be a significant numbers of people living with Frailty. Without interventions along this journey their frailty is liable to progress to the point where they need increasing amounts of services, including home care services and secondary care services.

3.3 A helpful way to look at the frailty journey is the Life Curve (Fig 1). This lays out a frailty journey in relation to the ability to carry out activities of daily living. Alongside the trajectory for people with no interventions – which leads to higher dependency and use of services, there is a better trajectory where there are interventions in place to mitigate and arrest the development of frailty

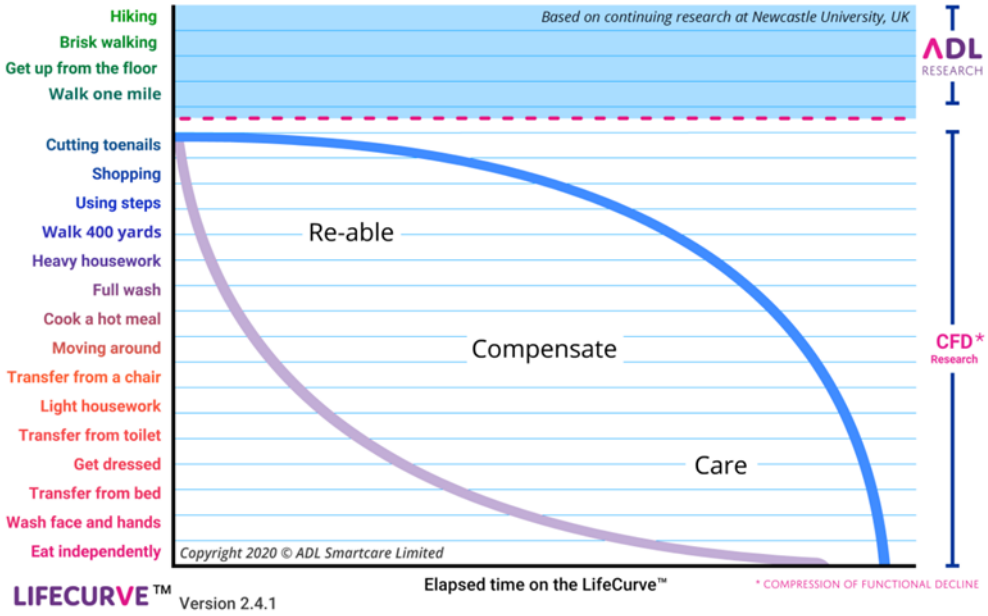


Fig 1.

3.4 The investment from the partnership has allowed the Occupational Therapy service to lead on a new proactive and timeous model. This work aims to intervene with individuals' earlier in their frailty journey with the aim of maintaining individuals' independence for longer, and this report outlines the progress to date.

3.5 The funding from the partnership, has allowed the establishment of two teams carrying out preventative interventions with those experiencing frailty. Both teams come under the umbrella of 'Staying Ahead of the Curve', in reference to the Life Curve work and the positive trajectory of the Curve.

3.6 Band 4 Assistant Practitioner staff are developing extensive networks within their localities, by talking to and attending community groups, shops and other community resources. They are profiling the importance of early interventions, in the maintenance of independence long term and encouraging individuals to self-refer in to the service, to have conversations. They are also taking referrals from toe cutting services. Difficulty cutting your toe nails independently is the first step on the Life Curve and is a pivotal time to see individuals are advice on the maintenance of independence.

3.7 The second part of the team consists of Qualified Occupational Therapy staff who are linked to Primary Care Practices. This team are engaging with the teams that sit around the practice, advocating the benefits of having conversations with individuals at an early stage of Frailty. This team are taking

referrals from the practice team. We are also negotiating with Business intelligence to proactively identify individuals who are at risk of Frailty using the Electronic Frailty index (App 1 for details). All of this work aims to empower individuals to manage their own health and wellbeing, to delay the onset of more complex frailty issues.

4. REPORT

4.1 Service Infrastructure

4.1.1 Primary Care

We have recruited to 6 Occupational Therapy posts. Each Occupational Therapist will cover two practices, presently we have capacity to cover a further 4 practices in South Ayrshire, potentially covering 12 out of 18 practices

These practices have been choses on the basis of data secured from Business Intelligence on the percentage of frailty within the population of the practice.

The service is now established in the following GP surgeries:

- Troon & Villages locality (1/2): Templehill
- Ayr & Prestwick (3/10): Tams Brig, Fullarton Practice, Cathcart Street
- Girvan & Maybole (4/6): Dr McCulloch and Partners, Riverside Medical Practice, Dr McMasters and Partners, Ailsa Craig Practice, Maybole Medical Practice, Dailly Medical Practice
  Please note the numbers in brackets denotes how many of the practices within each cluster we have a presence in.

4.1.2 Referrals

In the period up from 01.03.2022 to 14.10.2022 (33 weeks), the service has received **180** referrals. Of these referrals, 146 (81%) have been accepted. 19% were declined as they were already open to or better placed in another Occupational Therapy service. For more detail on referrals please refer to App

The spread of these by month in Fig 2. shows the rate of growth of the service through its set-up phase:

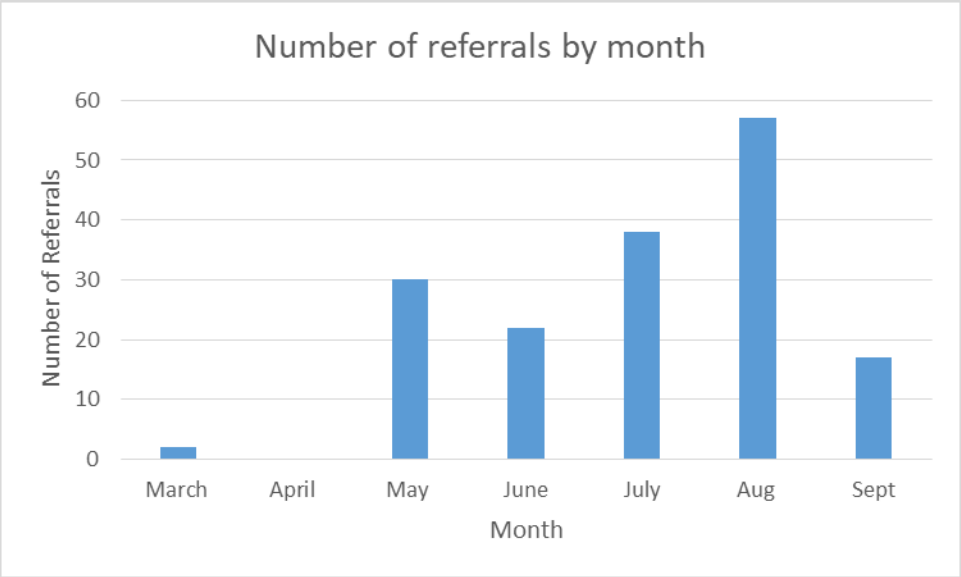


Figure 2. The number of referrals per month.

4.1.3 Patient Characteristics

Average age: 78.8 years (range from 51 – 94)
Gender split: 70% female, 30% male
Average Rockwood Frailty Score: 4.8
(Note – Rockwood Frailty tool is a commonly utilised means of quantifying a person's level of frailty).

4.1.4 Interventions

Each individual referred into the early frailty service, receives an assessment based on the iHub Scotland Frailty Assessment, to capture core clinical information that impacts on frailty, including mobility, medication, nutrition and swallowing.

After this assessment is carried out, 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 (eg 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, hand rails 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

4.1.5 Outcomes

Although it is very early, the team have begun to identify impact data. Throughout the service, we have consistently been using the Indicator of Relative Need 2 (IoRN2).

Indicator of Relative Need 2 (IoRN2)

61 IoRN2 were completed pre-intervention, and 45 have been completed post-discharge. The spread of these is shown in Fig 3. below, which shows a shift to the left for the post intervention scores, indicating an improvement.

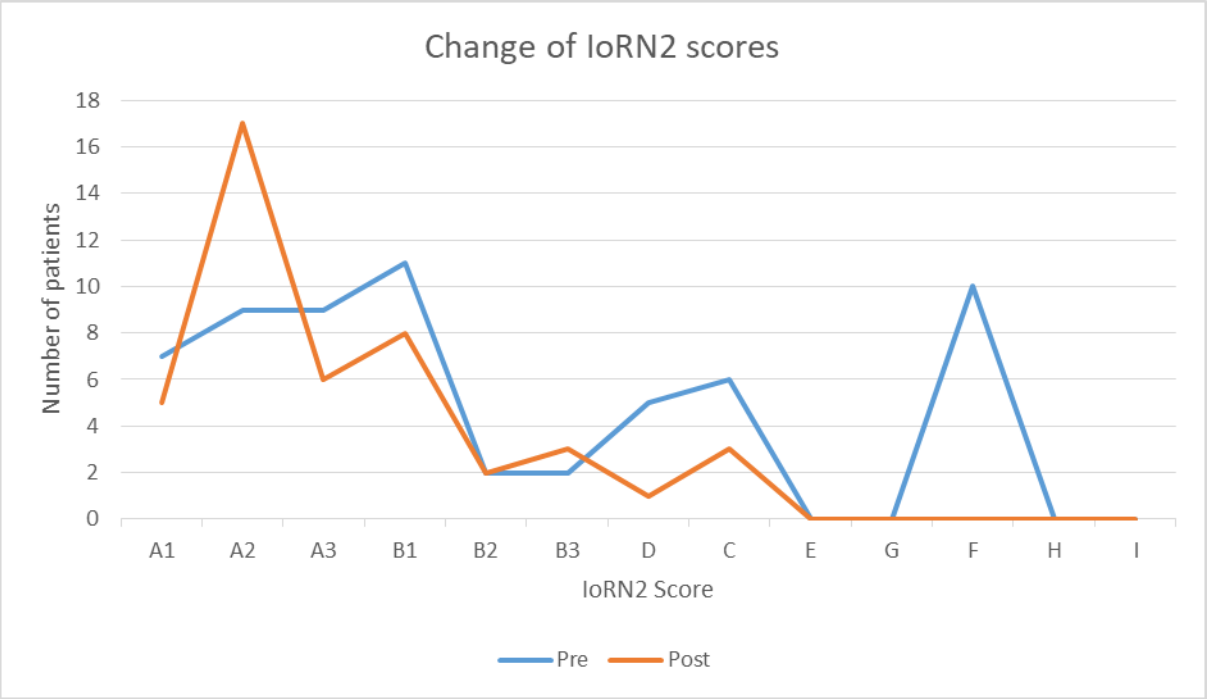


Figure 3. Change in IoRN2 scores

In terms of outcome measure we have also used:-

Falls Efficacy Scale (FES)

Canadian Occupational Performance Measure (COPM)

EQ-5D-5L

See Appendix 2 for more details

Patient experience

Recognising the value of patient experience in both evaluating the service and informing future service developments, we have created a proforma for colleagues to complete over the phone with a selection of patients each month.

"Thank you so much for your help you have given me. It was all done and so well done I a few weeks makes life in my new home so much better. You were so kind and very approachable!! You waved your magic wand and it all happened! Thank you"

"improved my confidence…. very pleasant and felt listened to. Also was given great advice and information…. took on board the difficulties I was experiencing and offered lots of advice, information, would not hesitate to recommend your service to friends and family."

"easy to speak to and very helpful… alarm fitted so feels better if anything happens in the home."

"Put at ease straight away, comfortable with her… Appreciated tips on how to get off floor safely."

"Makes life easier… rails on bed, Turning in bed and Raised Toilet Seat is particularly useful overnight…. My confidence has improved! The girls were very easy to talk to, very thorough, provided good advice and all sorts of little tips. I didn't really want to ask for help but was glad I did… very quick response just when I needed it, more information and reassurance that I expected. I'm amazed at how much information I got. I really appreciated it all, particularly the leaflets about out in the garden."

4.2 Band 4 Assistant Practitioner role

4.2.1 Recruitment

We have recruited 5 band 4 assistant practitioners, with one advert out at the moment to backfill a post. Each of the assistant practitioners are attached to a locality.

Girvan and Maybole	- I WTE
Ayr	- 2 WTE (+ 1 WTE after recruitment)
Prestwick	- 1 WTE
Troon	- 1 WTE

4.2.2 Referrals

Since June 2022, 35 self-referrals have been received, see Fig 4 below for referral sources.

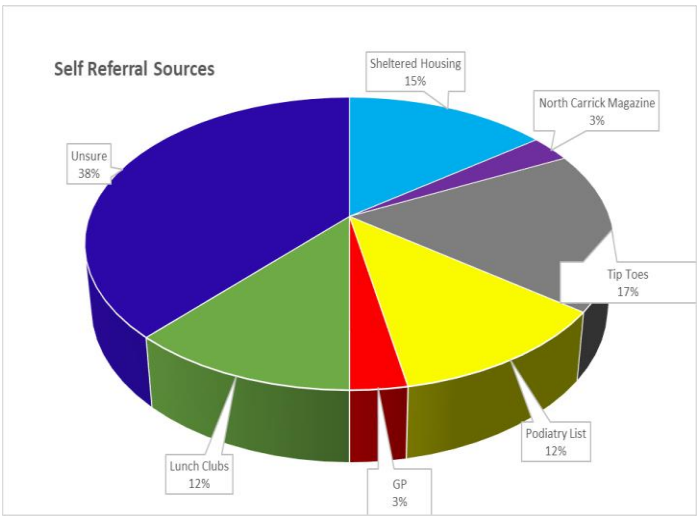


Fig 4

4.2.3 Interventions

When an individual is referred into the service, one of the assistant practitioners will visit and carry out a wellbeing review. This conversation aims to:-

- ❖ Help individuals to identify what is important to them and help them to achieve their goals
- ❖ Equip individuals with the information/ support they need to live their healthiest most independent life
- ❖ Targeting those who are just on the cusp of their frailty journey, as we want to help individuals patients who are maybe “just managing” to managing well
- ❖ Keeping patients living as independent for as long as possible

From this conversation a plan is co-created and some of the interventions have been:-

- Confidence building
- Support to access community resources
- Falls prevention advice
- Home safety advice
- Group fall prevention talks at lunch clubs/sheltered housing

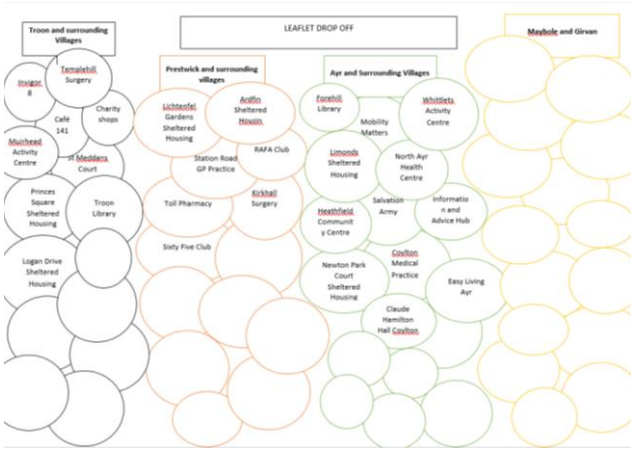
4.2.4 Patient Story

- Individual recently lost husband and was struggling to leave her home without support
- Occupational Therapy Assistant Practitioner (OTAP) starting going out short walks and building the distance up each week. The OTAP suggest a local lunch club, which the patient agreed to and had a lovely time and is still currently in attendance making new friends

4.2.5 Communication

One of the priorities within this role has been the development of a communication plan..

Figure 2. below illustrates the extensive efforts from the Occupational Therapy Assistant Practitioners (OTAPs) to distribute leaflets, attend community groups and grow networks within our local community to enable those who could benefit from the service to find out about it and self-refer themselves.

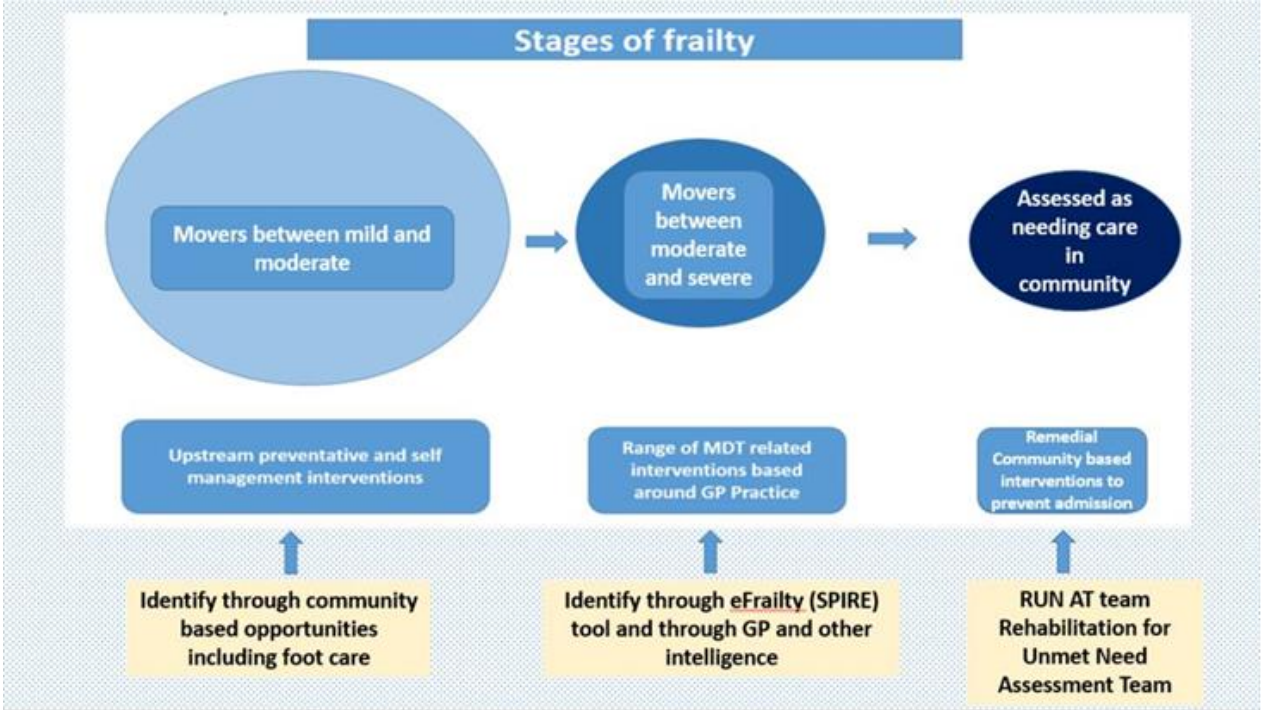


4.3 Monitoring/Evaluation

As the service develops, we are aware of the need to gather further feedback from our stakeholders, including primary care staff (GPs and practice managers), as well as other local healthcare professionals and the community groups with whom we have been linking in with. Over the next 6 months we will also continue to gather data on the impact of the service. Hopefully we will be able to present this data at a future IJB meeting.

4.4 Future direction

This Frailty work is part of the Ayrshire wide Frailty work. Pathways are being established between services across the spectrum of Frailty. See below diagram for community base Frailty Services



The author has meetings arranged in the upcoming month to establish a pathway from the Acute site alongside the Frailty Nurse Consultant and Advanced Care of the Elderly practitioners. Hopefully this will go some way to ensure the service is as integrated as it can be.

The Frailty work as well as having local attention, is also garnering National attention. The service have met with staff from HIS to feedback on the Frailty work, and the team have been asked to do a workshop at a National Frailty meeting. The work has been aligned with the iHub team.

In addition to this Templehill Surgery has been selected to be part of a Royal College of Occupational Therapy, research project to more formally evaluate the work.

5. STRATEGIC CONTEXT

This piece of work closely aligns with the SAHSCP Strategic objectives:-

We focus on prevention and tackling health inequalities
We nurture and are part of the communities that care for each other
We work together to give you the right care in the right place
We help build communities where people are safe
We are ambitious and effective partnership
We make a positive impact beyond the services we deliver
We are transparent and listen to you

6. IMPLICATIONS

6.1 Financial Implications

6.1.1

6.2 Human Resource Implications

6.2.1 N/A

6.3 Legal Implications

6.3.1 N/A

6.4 Equalities implications

6.4.1 No issues

6.5 Sustainability implications

6.5.1 No issues.

6.6 Clinical/professional assessment

6.6.1 No issues

7. CONSULTATION AND PARTNERSHIP WORKING

7.1 Through the development work in the last 9 months, the team have built relationships within locality, contributed to locality planning meetings and networking events. We have strong relationships with Primary Care, VASA and SAHSCP, and continue to reach out to departments and organisations that could be of benefit to patients accessing the Staying Ahead of the Curve service.

7.2 To further enhance integrated working across the partnership, we have requested read only access to social care's records system (Care First) and the mental health record system (Care Partner) would greatly enhance the service. This is being agreed with the respective teams, as part of developing further relationships within the partnership.

8. RISK ASSESSMENT

8.1. A service-level risk assessment has been completed and will be maintained in line with SAHSCP organisational arrangements.

REPORT AUTHOR AND PERSON TO CONTACT

Name: Joanne Payne
Phone number: 01292 665699
Email address: joanne.payne@aapct.scot.nhs.uk

App. 1

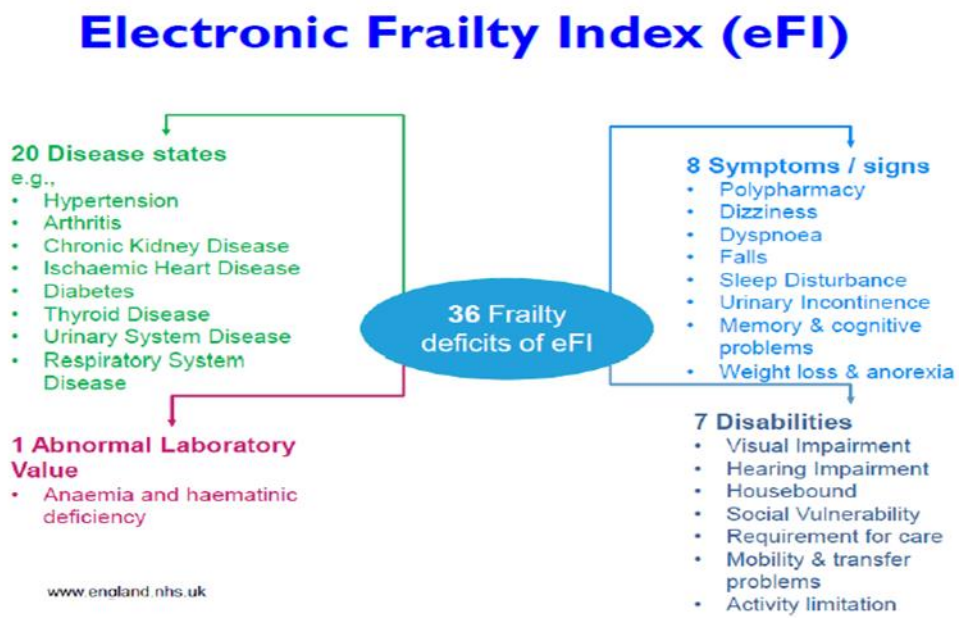
Electronic Frailty Index

Identifying people with frailty who could benefit from preventative interventions to enable them to live well for longer in their communities.

The electronic frailty index (eFI) is a tool that can be used to identify people as they progress through different levels of frailty, and is based upon a person's needs, rather than their service use.

The eFI uses a cumulative deficit model to identify and score frailty based on routine interactions with their GP. As individuals interact with GPs, their GP records accumulate a list of read codes and community prescriptions. The eFI uses a subset of these read codes to interpret any number of up to 36 potential deficits. The number of deficits that an individual is considered to have is then divided by the total (36) to produce a score. This score determines whether a person is considered fit, mildly frail, moderately frail, or severely frail and nearing the end of their life. This can be calculated for an individual or for a whole GP practice population over 65 years of age.

Using eFI to identify people with lower levels of frailty, before they have significant unplanned service use, means these individuals can be targeted with appropriate preventative interventions



App 2

Falls Efficacy Scale (FES)

We had a small data set where the Falls Efficacy Scale was used. It is worth noting that while this was a designated outcome measure, it was only completed for 5/45 patients, because the remainder did not identify a fear of falling so it was not appropriate.

	Number of completions	Score
Pre-intervention (baseline)	5	27.6
Post-intervention	5	16
	Average change	11.6

Canadian Occupational Performance Measure (COPM)

Furthermore, the Canadian Occupational Performance Measure was used for 5/45 patients, when it was deemed appropriate. The pre and post scores indicate a positive impact in terms of patient's self-reported performance and satisfaction with the specific occupations that relate to their goals (these included showering, gardening cooking).

	Number of completions	Performance Score	Satisfaction score
Pre-intervention (baseline)	5	4/10	5/10
Post-intervention	5	7.4/10	8.2/10
	Average change	3.4	3.2

In August, recognising the limited proportion of patients for whom these measures were suitable, we reviewed other measures, and agreed on a service wide use of EQ-5D for patients seeing either an OT or OTAP. Additionally, those patients seeing an OT would be asked the questions from the SMAS.

There are several patients for whom outcome questionnaires were not completed on discharge, due to specific circumstances (patients having died, or not being able to be contacted or declining).

EQ-5D-5L

At the point of writing this report (October 2022), 10 patients had completed an EQ-5D upon discharge. The five questions cover the domains of mobility, self-care, usual activities, pain and mood, and it is scored from 1 – 25.

	Number completed	Score (average)
Pre-intervention	38	13

Post-intervention	11	10
	Average change	-3

For the purposing of benchmarking, there does not seem to be other data sets to compare our data, but we are continuing to look into this.

SMAS

At the point of writing this report (October 2022), 4 patients had completed an SMAS upon discharge. The Self-Management Ability Scale was chosen as self-reported 10-item questionnaire that includes OT related questions around joy, routine and daily life, questions around information and social support as well which relate to health literacy (a key focus of many of our interventions at this early frailty stage), and two questions which focus on future plans which feels very relevant again at this early stage.

	Number completed	Score (average)
Pre-intervention	11	37/60
Post-intervention	4	47.75/60
	Average change	+10.75/60 (18% increase)

"improved my confidence…. very pleasant and felt listened to. Also was given great advice and information…. took on board the difficulties I was experiencing and offered lots of advice, information, would not hesitate to recommend your service to friends and family."