Dumfries and Galloway
IJB Clinical and Care Governance Committee

13th February 2020

This Report relates to
Item 9 on the Agenda

Frailty

Paper presented by Joan Pollard

For Noting

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List of Background Papers:	https://ihub.scot/improvement-programmes/living-well-in-communities/electronic-frailty-index-efi - eFrailty Index https://www.gov.uk/government/publications/physical-activity-guidelines-infographics - Physical Activity Guidelines 2019 http://www.managingmds.com/content/Clinical_Frailty_Scale.pdf - Rockwood Clinical Frailty Scale
Appendices:	Appendix 1: Membership Healthy Ageing Programme Board

1. Introduction

1.1 Clinical and Care Governance have requested an update upon activities to support individuals experiencing the effects of frailty

2. Recommendations

2.1 **The IJB Clinical and Care Governance Committee is asked to:**

- **Note the work around supporting people who are frail to look after and improve their own health and wellbeing and live in good health for longer and live, as far as reasonably practicable, independently and at home or in a homely setting in the community.**

3. Background and Main Report

3.1 Frailty is the manifestation of ageing whereby there is a loss of resilience that means that people don't bounce back quickly after a physical or mental illness, an accident or other stressful event. Frailty is associated with poor outcomes, including increased risk of anxiety and depression, disability, hospital admission, institutional care or death. The impact upon a person's quality of life is considerable. From a service perspective frailty results in an increased use of primary care and unplanned secondary care services. Elderly people who are frail are more likely to fall.

3.2 This is compounded by the fact that recent estimates by the National Records of Scotland predict that the number of people aged 75 years and over will increase by 79% in the next 25 years. Nationally it is currently estimated that just over 10% of the population are living with Frailty which for Dumfries and Galloway estimates out at circa 15,000 people

3.3 The Dumfries and Galloway Health and Social Care Partnership is currently involved in a wide range of initiatives within the Frailty agenda. These are most easily considered around the following:

- **Prevention**
- **Identification**
- **Reducing the impact**
- **Managing the care**

3.4 **Prevention**

It is known that one of the key areas determining an individual's decline into frailty is their sedentary behaviour. In adults over the age of 60years sedentary behaviour has been significantly associated with:

- Higher plasma glucose
- Higher BMI and waist: hip ratio
- Higher Cholesterol
- Reduced Muscle Strength
- Reduced bone density
- Frailty and falls

Intervening to reduce sedentary behaviour and increase physical activity is therefore key within the prevention agenda

In 2014, the Dumfries and Galloway Physical Activity Alliance (PAA) was established. The Alliance is a strategic partnership aiming to co-ordinate action to increase physical activity levels across our population. The PAA brings together over thirty partners from across physical activity priority settings including Health and Social Care, Transport and Environment, Education and Sport in order to provide leadership, advocacy, research and co-ordinated action.

This multi-agency group have been working to deliver against 22 key priority actions across the strategic partnership however key to the IJB are the following five areas:

- Long term conditions projects – this about investing and delivering enablement services and community physical activity/ strength and balance programmes to support people with long term conditions. Examples would include Cardio and Pulmonary rehabilitation, Tai Chi, Community Walking Groups etc
- Let's Motivate – continuing the operation of the Let's Motivate activity programme within Care Homes and Community Settings to improve physical activity levels on older and vulnerable adults.
- Exercise referral - to increase investment and promote exercise referral programmes including the development of technology to enable an equitable provision across the region
- Social Prescribing – to embed physical activity opportunities within models of social prescribing
- National Physical Activity Pathway - the aim is for the NHS National Physical Activity Pathway to be embedded by providers or primary and secondary care

The recommendations are in the processes of being updated and reviewed to reflect current priorities and revised physical activity guidelines https://www.gov.uk/government/publications/physical-activity-guidelines-infographics.

The partnership will be supported in taking this work forwards by Scottish Government and Health Scotland as we are an agreed Early Adopter region for a whole system working around Public Health Priority 6 (*A Scotland where we eat well, have a healthy weight and are physically active*). A series of local workshops will be delivered in early 2020 to map current systems and devise and inform action plans and approaches.

3.5 **Identification**

The partnership is participating within Health Improvement Scotland's Living and Dying Well with Frailty Collaborative which aims to improve earlier identification, anticipatory care planning and shared decision making, and support a multidisciplinary/ multiagency approach so that people living with frailty get the support they need, at the right time, at the right place.

This programme works with GP clusters and their community teams and in our case the initial cluster is in Annandale and Eskdale around the Greencroft practices. During the collaborative the team will

- Use the eFrailty Index to identify people aged 65 and over living with frailty https://ihub.scot/improvement-programmes/living-well-in-

communities/electronic-frailty-index-efi

- Engage in anticipatory care planning conversations with these individuals and record the information in the Key Information Summary
- Work within a multi-disciplinary/ multi-agency team to consider the holistic needs of the person

The GP cluster in Annandale and Eskdale will test the methodology with a view to ultimately developing a roll out plan to spread these approaches across the region. The collaborative is in the very early phases and the team in is early development however they have already begun to identify individuals using the eFrailty tool and who do not yet have a KIS on the system. Anticipatory care planning conversations have begun with this first cohort of individuals.

In a parallel piece of work the Partnership has agreed to adopt the Rockwood Clinical Frailty Scale http://www.managingmds.com/content/Clinical_Frailty_Scale.pdf as one of our key assessment approaches. This scale is the underpinning rationale for the development of the eFrailty Index.

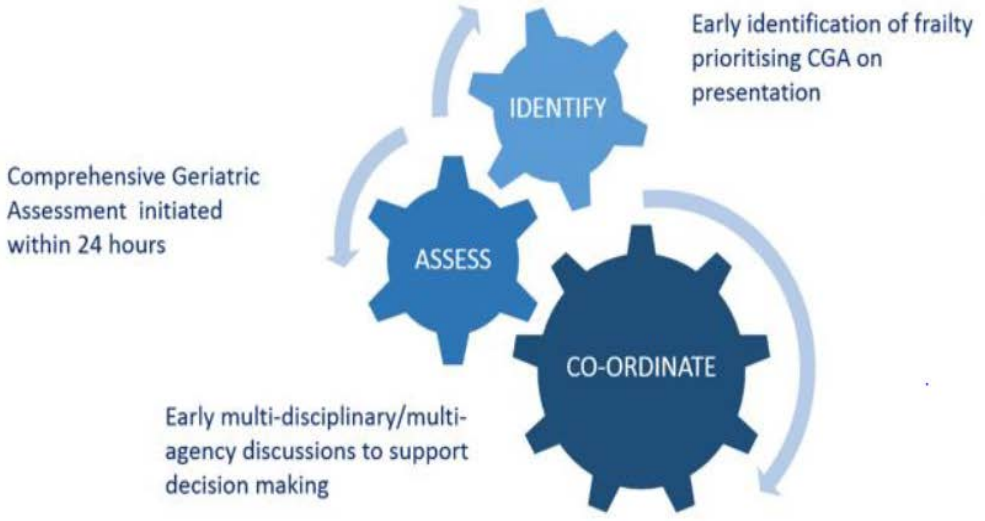
Despite its title the tool is stage related rather than age related and easily allows the individual (whether this be a member of the public or a member of staff) to easily identify the stage within the functional decline trajectory. This allows us collectively to more appropriately signpost the individual for support. Three multiagency meetings have taken place to explore the potential for the adoption of this approach and to begin to agree pathways which would follow this assessment. To date a draft outline has been developed and it is anticipated that this will be presented to Health and Social Care Senior Management Team for discussion over the next couple of months.

Frailty at the Front Door Collaborative

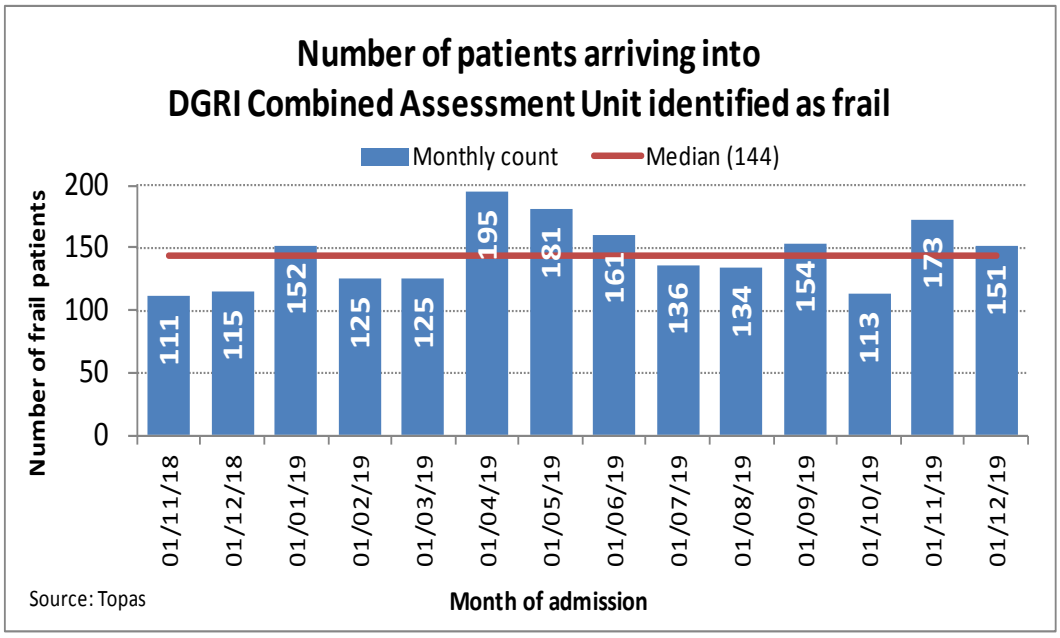
The Frailty at the Front Door Collaborative is part of Health Improvement Scotland's Acute Care portfolio aimed at improving the process of identifying and co-ordinating the care to improve the outcomes for people who are living with frailty that present to unscheduled care. NHS Dumfries and Galloway participated in this collaborative between December 2017 and May 2019.

Growing numbers of older people are being admitted to hospital in an emergency and some of those admitted will deteriorate further or experience a delay in returning home due to being frail. The Frailty at the Front Door Collaborative had the following aims:

- Identification of frailty at the point the person presented to the acute services using a validated screening tool
- Delivering rapid assessment of frailty using comprehensive geriatric assessment (CGA)
- Co-ordinating the needs of people living with frailty using structured, focused frailty huddles to determine the most appropriate pathway of care.

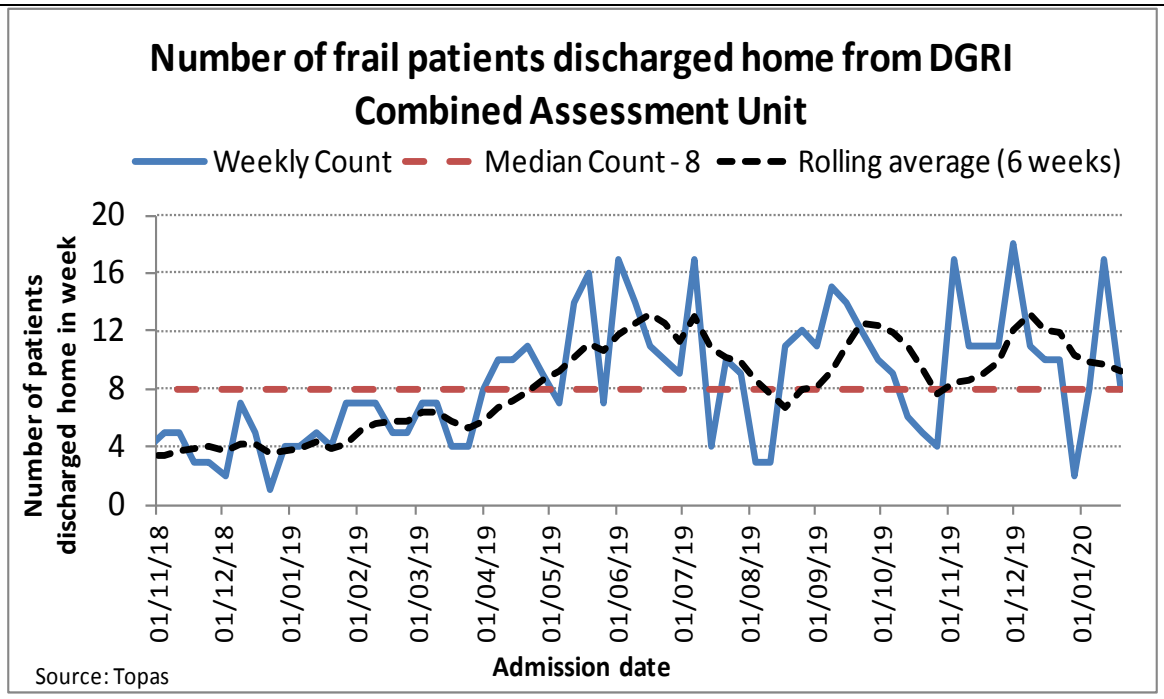


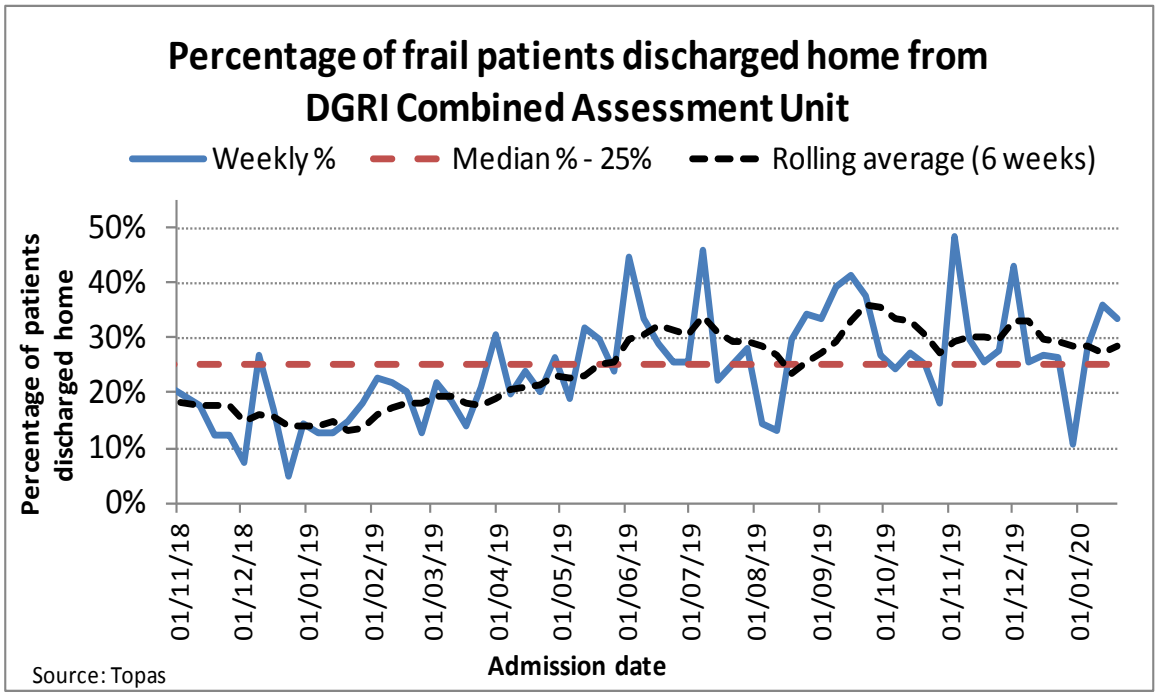
A multidisciplinary team is now established working within the Combined Assessment Unit (CAU) which includes Frailty Nurse, AHPs (Occupational Therapy and Physiotherapy) and the wider ward team. A screening tool has been adopted with current completion rate around 98%.



An average of 144 people (living with frailty) per month arriving into our CAU were identified as frail. The numbers identified as frail in November 2019 and December 2019 were 56% and 31% higher than the respective months a year earlier. Note these large increases could reflect more comprehensive identification of frailty rather than simply an increase in the number of frail patients being admitted.

This increased identification of people has resulted in different conversations taking place with the individuals themselves and with their carers and the health and social care team supporting them resulting in a change in pathways.





These charts are indicating that twice as many people who live with frailty have been being discharged back home since June 2019 as compared to the period Nov18 – Feb 19.

A model is being tested for a week commencing 27th January whereby a medicine for the elderly consultant will in-reach into Combined Assessment Unit. This will further support the completion of the CGA and frailty huddles to determine the best pathway for care.

Connections across the wider health and social care landscape are good with a Frailty Interest Group established and meeting quarterly and a plan to make the whole system frailty pathway visible.

Risks to success have been identified as follows:

- Staffing capacity – the model is dependent upon single handed roles (medicine for the elderly consultant and frailty nurse, who is also in fixed term contract)
- Access to alternatives to admission to support transfer or discharge
- Bed pressures in CAU sometimes mean that people are admitted before assessment is complete

3.6 **Reducing the Impact**

Research into ageing has identified that with a rehabilitative and reablement approach there is potential to reduce the impact of frailty upon an individual and enable them to live more independently. All AHP led rehabilitation approaches have this focus at their core. However it has been identified that the key point in determining the descent into frailty is an inability to walk 400 yards.

As already outlined in the section around prevention returning the person to increased activity is key to increasing their independence and overall quality of life but also to reducing their dependence upon services for support. The partnership has therefore recently taken the decision to increase resources within the Short Term Assessment and Reablement Service (STARS). STARS operate on a seven day per week basis, providing an intensive period of rehabilitation and enablement (for up to 6 weeks) to any adult experiencing difficulties maintaining independent living and socialisation at home.

The service operates a model which is underpinned by the principles of rehabilitation and enablement and through the use of timely and focused intensive interventions the person will be supported to:

- Maximise quality of their life, choice, control and independence
- Identify and proactively participate in their goals, activities and aspirations to achieve outcomes that matters to them.
- Facilitate engagement with, and confidence in, using assistive and inclusive technology to support re-activation of physical activity and self-efficacy in ability to manage or accommodate long term health or well-being needs.
- Minimise formal support needs including recognising and supporting the value and well-being of unpaid Carers.
- Acknowledge and work appropriately across medical and social models of care and support to ensure the person is safe and empowered which included non residential care and support

It is proposed that all requests for new or increased care/support, including rapid response, are initially accessed via STARS, thus ensuring equity of access across the region.

STARS are also currently working in partnership with Scottish Ambulance Services to support the roll out of the pathway for assessment and support for those people who have fallen at home but do not need to be conveyed to hospital. At the moment this pathway operates only in Nithsdale but it is anticipated that roll out will commence in February 2020.

3.7 **Managing the Care**

A Healthy Ageing Programme Board has been established with wide representation from key stakeholders across the partnership (membership in Appendix 1)

This programme board provides strategic leadership to champion and support a collaborative, co-productive and inclusive approach to developing a strategy to support healthy ageing

The Programme Board oversees a range of subgroups focussing upon the following areas:

- Care at home
- Care Homes
- Housing with Care and Support
- Day Services, and
- Intermediate Clinical Care

The sub groups are currently exploring best practice to begin to define the models for the future. Further information can be made available as this becomes more developed.

In a parallel piece of work is planned to establish a task force within the Sustainability and Modernisation programme around the development of Home Teams, a new way of working together to support individuals in communities. Close links will be established as this task for develops

4. Conclusions

4.1 There are a wide range of initiatives currently underway to support and improve the outcomes for people living with frailty within Dumfries and Galloway.

5. Resource Implications

5.1 No implications for resources

6. Impact on Integration Joint Board Outcomes, Priorities and Policy

6.1 Links to National Health and Wellbeing outcomes 1 & 2

7. Legal and Risk Implications

7.1 None

8. Consultation

8.1 Consultation is not necessary

9. Equality and Human Rights Impact Assessment

9.1 Not required

10. Glossary

10.1 All acronyms must be set out in full the first time they appear in a paper with the acronym following in brackets.

EQIA	**Equalities Impact Assessment**
IJB	**Integration Joint Board**
CAU	**Combined Assessment Unit**
STARS	**Short Term Assessment and Reablement Service**
CGA	**Comprehensive Geriatric Assessment**
AHPs	**Allied Health Professionals**
PAA	**Physical Activity Alliance**