Nottingham and Nottinghamshire ICS

Frailty Clinical and Community Services Strategy

FINAL V2.0 March 2019

Contents

1. Executive Summary

The Integrated Care System (ICS) ambition across Nottinghamshire is to both increase the duration of people's lives and to improve the quality of those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The aim of the Clinical and Community Services Strategy (CCSS) is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view of beyond 5 years.

People who are experiencing "frailty" have decreased reserves and resistance to stressors. The prevalence of frailty increases with age. UK research suggests that about 14% of people aged over 60 may be frail and about 65% of those aged over 90 may be frail. Improving the care and support for older people with frailty is of particular importance, given that even small incidents can have significant impacts on their physical and psychological health.

All health and care partners strive to provide safe, high quality care for all people, but there are special challenges associated with caring for older people who are living with frailty. Older people are more likely to use health services and more likely to experience healthcare-associated harm. There are currently 1.1million people in Nottingham and Nottinghamshire ICS which is set to increase by 3% by 2024 and by 10% by 2039. The age profile of our populations in Mid and South Nottinghamshire are relative to that of the England average whilst Nottingham City population has a higher proportion of younger people due to having two universities. People are living longer and those reaching the age of 70+ is set to rise to 18% by 2039 (currently 13%).17% of the ICS population are over 65+ (20% of County residents and 11% of City residents). Between 2018 and 2026, the population of older people aged 85+ in Nottinghamshire is set to rise by 23% and the population of people aged 75-84 will rise by 35%. This is compared to an overall population increase of 4.5% generally in the same period.

In 2018/19, 2983 older adults were living in care homes funded by Nottinghamshire County Council and the Council funded care at home for 1802 older people. More older people than this will be funding their own care at home or in institutional care. We know from the 2011 Census that in Nottinghamshire, the majority of the 21,000 family carers who provide over 50 hours a week of care are aged 65+.

The frailty services review has been undertaken as part of the ICS Clinical and Community Services work stream. It has been supported by clinical and professional experts as well as other stakeholders in the development of place based service models for the future to support the long term needs of our existing frail citizens. We need to embed prevention of frailty prevalence in our population over the next 5-10 years by shifting our culture from one of illness, to one of healthier lifestyles and self-care.

The strategy identifies key themes and transformational opportunities, which include: prevention strategies to promote healthy ageing and independence and reduce avoidable admissions; the use of one frailty assessment tool across all sectors within the ICS; undertaking, sharing and implementing advance care plans for older people with moderate to severe frailty; urgent care response teams; system wide frailty MDT's; care confidence with care providers; Frailty Framework of Core Capabilities to be rolled out across the ICS and changing the culture across the ICS to make it that frailty is 'everyone's business', whilst at the same time we need staff to make the shift from asking "what is the matter with you?" to "what matters to you?". Older people have strengths and assets as well as individual preferences and rights to have choice and control in their life. By adopting the right approach, professionals will be working collaboratively and proactively with older people to find support and care solutions that enable each person to carry on living their life as independently and well as possible.

A transformation Bridge to the Future highlights current service offers across the ICS and identifies some potential long term steps that can be taken to achieve the identified opportunities with proposed timelines and the expected outcome for our citizens of Nottinghamshire.

The recommended next steps are vital in keeping the momentum of change in the future offer of improved prevention and better health for our citizens; providing the right tools for our population to support their wellbeing; providing strong communication links for our staff is vital to enable them to provide the best care for our citizens; the most appropriate models of care in acute settings, neighbourhood and home need to be provided equitably across the ICS and be provided using best evidence, in a flexible and patient centred way for them to fulfil their maximum potential throughout their lifetime.

2. Introduction

Background and Purpose	In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable. However, our health and care system faces change and this will impact on our services, for example, the growing prevalence of long-term health conditions places new strains on our system. There is inequality evident in both the location of challenges and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to enable citizens to stay active and fit. The ICS ambition across Nottinghamshire is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age. The requirement for a CCSS came from the recognition that to achieve this ambition the system has to change as a whole, rather than just in its individual acute, primary care, community and social care elements. It is recognised that only by working together to describe changes in how care is provided across the system, rather than through individual organisations, will we deliver the scale of change required
The ICS Clinical and Community Services Strategy	The aim of the CCSS is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention. This should be delivered closer to people's homes or in community locations where this enables better prevention, more supported self-care and earlier intervention to support citizens. The Strategy recognises that achieving this change is a long term programme that will be delivered over the next 5 years and beyond. This is also necessary to enable a necessary long term investment in the health and care buildings and infrastructure in the system. An overall CCSS whole life model framework has been developed to focus on the need to support people through their lives from living healthy, supporting people with illness and urgent and emergency care through to end of life care. Citizens can experience different parts of the system at different stages in their lives. With the development of the overall Strategy framework the next phase of work is to review the 20 areas of service across the ICS that collectively form approximately 80% of the volume of clinical work in the ICS. This will ensure that overall the Strategy is described as a coherent whole and generates a programme of change for the whole ICS. This review of Frailty services is one such review and is part of the first phase of work.
NHS Long Term Plan	The NHS LTP is clear that to meet the challenges that face the NHS it will increasingly need to be: more joined up and coordinated in its care; More proactive in the services it provides; More differentiated in its support offer to its individuals. The ICS has focused on describing 5 areas of focus for the delivery of the NHS LTP. These requirements are reflected in each of the service reviews that collectively will describe the CCSS **1. Prevention and the wider determinants of health -** More action on and improvements in the upstream prevention of avoidable illness and its exacerbations **2. Proactive care, self management and personalisation -** Improve support to people at risk of and living with single and multiple long term conditions and disabilities through greater proactive care, self-management and personalisation **3. Urgent and emergency care -** Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting **4. Mental health** - Re-shape and transform services and other interventions so they better respond to the mental health and care needs of our population **5. Value, resilience and sustainability -** Deliver increased value, resilience and sustainability across the system (including estates)

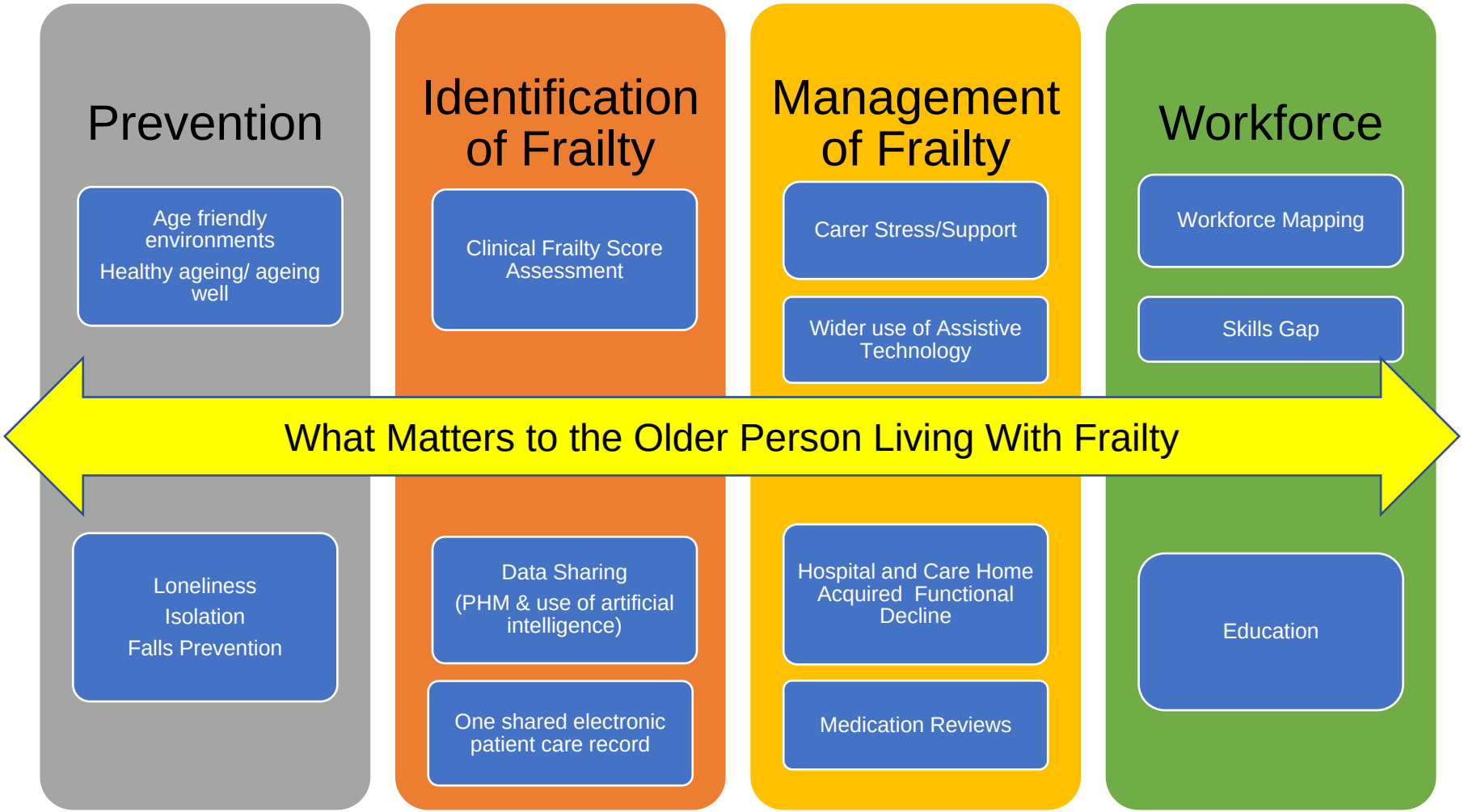
3. Approach and Scope

Approach	This strategy has been developed through an open and inclusive process which weaves together the expertise of clinicians and care experts with commissioners and citizens in determining the future shape of services across the system. There have been a variety of stakeholder and service user events to develop a clinical and community services model. An extensive system wide piece of work is taking place across a minimum of 20 services. The CCSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the prioritisation of five service reviews. These include; Cardiovascular Disease (CVD) to Stroke ; Respiratory – Asthma and COPD; Frailty; Children and Young People (CYP); Maternity and Neonates. This document discusses the approach, scope, the key issues and potential transformational opportunities within Frailty services across the ICS health, social care, public health and the voluntary sectors identified by reviewing the current service offer across the ICS. The service review was taken over approximately 14 weeks and there were three workshops held with stakeholders across the ICS. An Evidence Review document has also been developed which considered national and local best practice. This has been used to inform the development of the future vision and long term Transformation Proposal for Frailty services in the ICS.
Scope	The steering group agreed the following definition for frailty for the services review: *'Frailty is a medical syndrome resulting from the combination of the natural effects of ageing and the impact of multiple long-term conditions leading to a loss of function and reserves, leaving patients vulnerable to stressors and increases the risk of adverse health outcomes. It generally results in increased dependency and slow functional deterioration which may then require additional support.'* The scope of the service review included: - citizens identified with severe or moderate/mild frailty - citizens aged 65 and above - citizens at risk of developing frailty registered to a GP practice across the ICS – in the lowest economic quartile frailty starts earlier in the life course and progresses more rapidly, contributing to reduced life expectancy.
Engagement	The Frailty services review has been supported by an overarching Clinical Design Group of clinical professionals and social care representative in the ICS and a tailored frailty steering group comprising of stakeholders and clinical experts from across the ICS. They have provided expert advice, guided, confirmed and challenged assumptions throughout the period of review and connected to other workstreams. These two groups have formed part of the development process along with the ICS Clinical and Community Services Strategy Programme Board consisting of senior leaders in the ICS who oversee the work. Three workshops have been held which enabled a wide breadth of stakeholders (Clinicians, AHP, Nurses, Heads of Service, Social Care, Public Health, Commissioners, Academic Health Science Network and others) to be proactively involved in re-evaluating current service offers across the ICS in developing potential themes and agreeing transformational change for the future clinical services and community strategy. Citizen involvement has been co-ordinated though the Community Voluntary sector to gain views on 'What Matters to Older People' and focus groups helped to inform future service changes across the ICS.

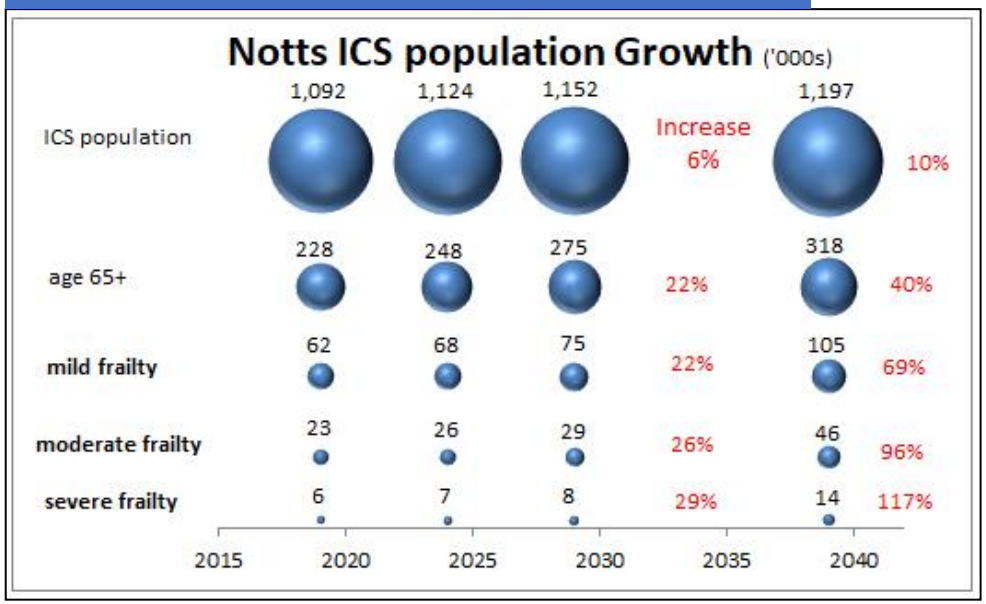
4. Content

Strategy Development	This Strategy Document consists of five key elements. These have been developed through a process of design and iteration at the three workshops and steering groups. The strategy has been developed with reference to the Evidence Review and the patient focus groups that have been held.
Priorities for Change	The work of the Steering Group and the first Workshop identified four key areas of focus that need to change in the ICS for Frailty care. These were based on a review of the current issues facing the ICS and the views of the Steering Group and workshop 1 attendees.
Proposed Future Care System	Following the evidence review at workshop 2 attendees started to develop the future Care System for Frailty to address the Priorities for Change. The future care system is described against two dimensions: • **Location** split between - Home (usual place of residence) – Acute Hospital with 24/7 medical presence – Neighbourhood representing all community/primary care and ambulatory care settings • **Urgency** split between - **Emergency/Crisis** requiring a service provided 24/7 to avoid crisis or risk to life – **Urgent** requiring a service 7/7 but not 24/7 to meet urgent care needs – **Scheduled** reflecting any arrangement where an appointment is agreed between a professional and a citizen The intention of the system model is to focus future care delivery closer to home and also with greater levels of scheduled care to best use the available resources and reduce demand on urgent and emergency care services. The new system to address the Priorities for Change is presented for each location and then summarised overall for the ICS.
Transformation Proposal	The Transformation proposal described the key initiatives or programmes that are required to deliver this new model. It shows: • **Priority** – What is the priority of the initiative in the view of the steering group and workshop attendees. • **Alignment** – At what level of the system should we aim to deliver each initiative. In most instances this is ICP level but there are some where the recommendation is for delivery to be at ICS level where the greater value is perceived to be in an overall approach. For some it is PCN level where differential delivery would be of benefit to meet the needs of very local populations. • **Enabling Requirements** – This indicates what is required from a range of enablers to support each Programme to deliver. This includes workforce, technology, estate or service configuration. There are also requirements of culture or finance and commissioning where a key change required is for the system to work together differently. • **Benefits and Costs** – Where available the key benefits of the initiative at system level are summarised.
Bridge to the Future	The ‘Bridge to the Future’ was generated at Workshop 3 and with the Steering Group. It summarises the current challenges for Frailty services within the ICS system now (Priorities for Change), where we would like to be and how we plan to get there. Progress with the ‘Bridge to the Future’ and the partnering Vision can be returned to with Stakeholders as the work develops to ensure it stays on track.

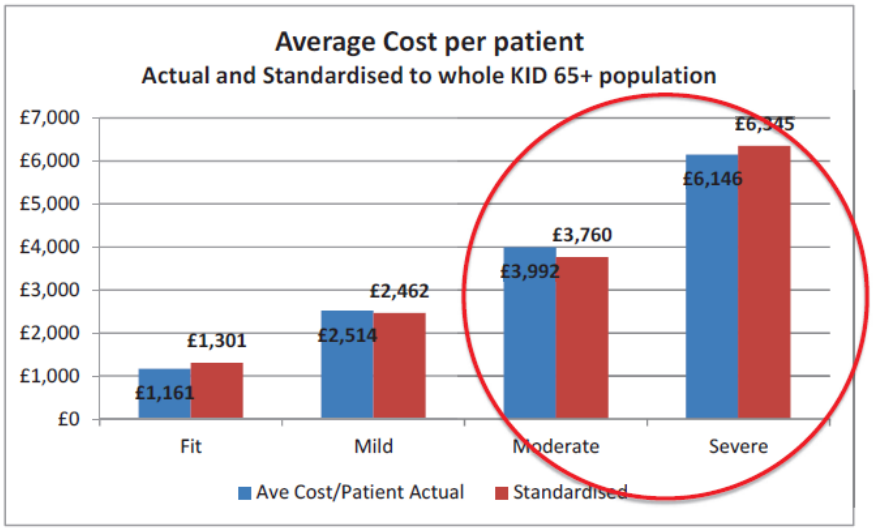
Frailty Key Themes



The graph below demonstrates that it is predicted that there will be an117% increase in the severely frail and a 96% increase in frail citizens in our ICS in the next 20 years.

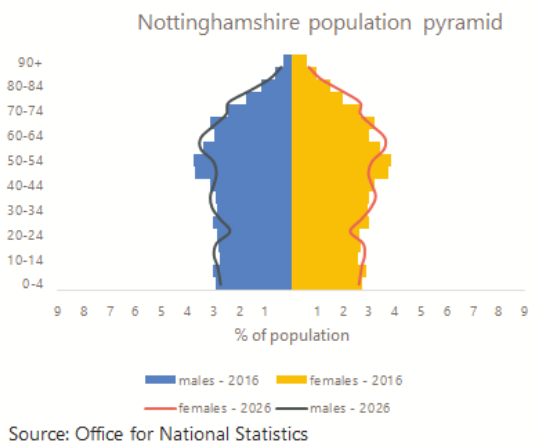


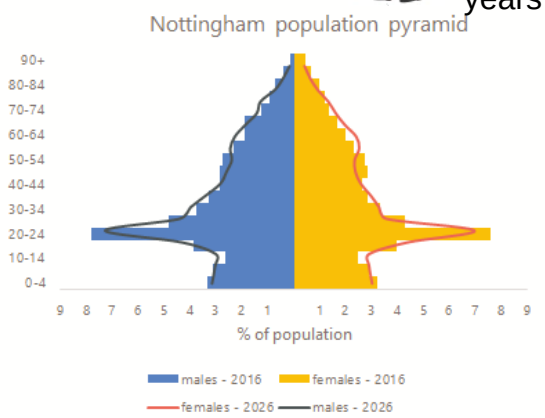
Frailty is expensive when severe



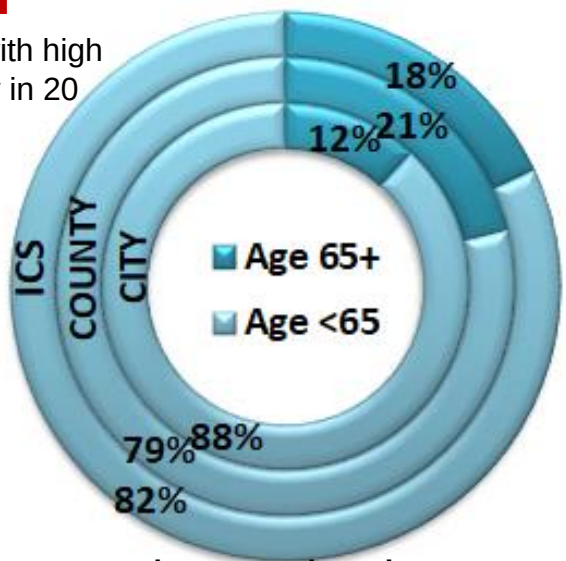
36%↑

65+ years with high dependency in 20 years





Source: Office for National Statistics



Flu Vaccination

5. Priorities for Change

40% of ambulance call-outs to homes for people aged 65+ are fall related

Severely frail have **4x** greater annual risk of dying, or admission to nursing home or hospital

9% enhanced summary care records for citizens living with frailty (moderate / severe)

LONELINESS

12% of older people feel trapped in their home

16% of older people have difficulty making doctor appointments

36% feel out of touch with the pace of modern life

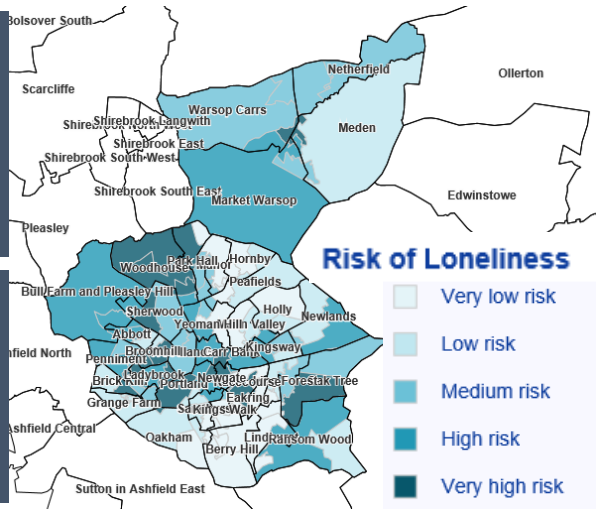
Every year

1 in 3 people over age 65 suffer a fall

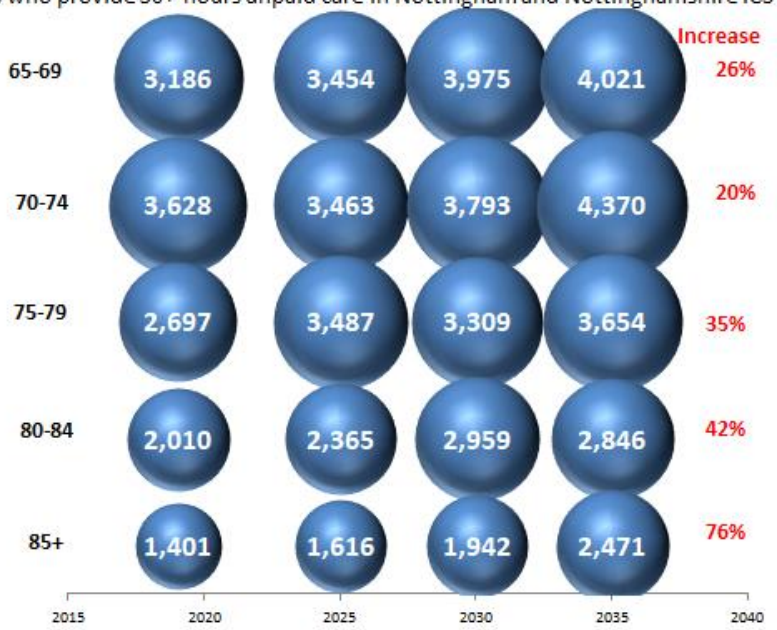
Carers are **2.5x** more likely to suffer psychological distress

Long-term loneliness is as damaging to health as 15 cigarettes a day

'high risk' of loneliness across large parts of Mansfield District



Carers who provide 50+ hours unpaid care in Nottingham and Nottinghamshire ICS



Sources: NHS Long Term Plan, Age UK, Institute of Public Care report.

5. Priorities for Change

The workshops identified 4 key themes and potential areas of change which include: prevention, identification of frailty, management of frailty and workforce (Slide10). While prevention is embedded through the overarching Clinical and Community Services Strategy, specific prevention focus within the new frailty services model has concentrated on the following areas:

Prevention	To prevent the onset of frailty it is important that we ensure the environment and places people live are age friendly and that people are enabled to age well, as well as being proactive to support people at higher risk or living with mild frailty. Early resolution and ageing well is key to managing longer term needs. This includes highlighting frailty or risk of frailty early on by providing information and advice on how people can be supported to stay living independently in their own home, having an active life with family and friends around, financial security, feeling safe at home and in the neighbourhood and understanding how to stay healthy and fit. Two primary risk factors that threaten ageing well are loneliness and falls. These need to be mitigated proactively by prevention strategies. **Loneliness and isolation** in older people is estimated to affect 10-20,000 older people in Nottinghamshire (2011). Both can increase the risk of developing mental health problems, Alzheimer's or dementia and also negatively impact on people's confidence and motivation. **Falls :** A third of people age 65 + fall at least once each year and 255,000 result in emergency admissions. By taking exercise reports indicate that 35% of citizens at risk of frailty do not become frail.
Identification of Frailty	Segmentation, identification and stratification of the frailty population will allow health and social care to focus their efforts together to support joint priorities, integrated and personalised care. While there is an existing electronic frailty index (EFI) nationally which is included in the GP contract and targets 65 years and above, it has been recognised locally that many more citizens are becoming frail earlier than this age. This is an automated system that pulls information from health record data and formulates a score to predict a level of frailty. While it is recognised that this is a way forward it is felt that this can not replace professional assessments. The information is not transferable across the system and is not updated at every contact with the citizen in health and social care settings. We need to have a standard clinical frailty scale implemented across the system allowing for improved live assessments, and scores, the use of the same language and read/write access scoring to be used across the ICS by all stakeholders with appropriate across system ICT. This would result in more appropriate and targeted interventions and allow us to track associated changes.
Management of Frailty	• The IPC estimated that between 2012 and 2020 the population aged 80 and over in Nottinghamshire would grow by 26% and the over 90's alone by 50%, this trend will now continue until 2030. In Nottinghamshire it is predicted that there will be an 85% increase in care home admissions by 2030 which is significantly higher than the average across England. It is widely recognised that the majority of older people with frailty in their home are cared for by informal carers. Carer stress has a significant impact on the wellness of the carer and there is great need to put into place better systems of support for them as well as the older person with frailty. We also know that an admission into hospital can lead to hospital acquired functional decline, (aged 80+ 10 days in hospital is the equivalent of 10 years of muscle wastage). • Technology can play a very significant part in supporting an older person to live independently and we are not maximising this potential at the moment. A Clinical Geriatric Assessment (CGA) remains the gold standard approach to improving a range of outcomes for older people in acute hospitals and it is recognised that there would be significant benefits if the use of CGA is broadened into community settings as it provides a 'holistic assessment' of those at risk or who are frail. • Early resolution services could offer an alternative to hospital admission by providing rapid assessment, home treatment and facilitate appropriate multi-agency support or signposting in the community. • In addition, there is a need to ensure that routine medication and falls reviews are undertaken with appropriate interventions planned with the citizen.

Workforce	It has been recognised within the frailty service review that specialist levels of skills / competency are required as set out by the British Society of Geriatrics (BSG) for the workforce to serve the ICS population. Tier 1 – Those that require general awareness of frailty Tier 2 – Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making. Tier 3 – Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty. Joint workforce planning and training is required to allow us to provide sufficient service across the ICS at the appropriate skill level and also to raise awareness of frailty. Cultural change is necessary to make it that frailty is 'everyone's business' and include prevention knowledge and skills and to support staff to make the shift from asking "what is the matter with you?" to "what matters to you?", using strengths based approaches. By adopting the right approach, professionals will be working collaboratively and proactively with older people to find support and care solutions that enable each person to carry on living their life as independently and well as possible. Within workforces and voluntary sectors across the ICS the 'Make Every Contact Count' (MECC) principle needs to be adopted and embedded into all sectors.

6. Proposed Future Care System

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

Home	• Access to Assistive Technology (AT) to enable improved self-care, support carers , informal carers and families particularly in low socio -economic areas to carry on caring, reduce social isolation and raise alerts about any problems • Access to a tele care system particularly in rural and remote areas that will permit professional health and social care workers to support housebound older people remotely, so reducing travel costs and time • A frailty 'App' that can assess any early deterioration • BAME groups (translated literature will be required),oversized text etc. • Befriending services available to people who are housebound • High quality short term enablement and rehabilitation services to help people regain confidence and skills to live independently • High quality care provided in the home to meet daily living outcomes and support health maintenance • Access to health, social and voluntary support assessments at home, where this is the most appropriate venue. The presence of one or more frailty syndromes should trigger a more detailed comprehensive geriatric assessment. Health and social care assessment staff should be working in close partnership so that they can contribute to a joint assessment of older people, including mental health assessments • Voluntary sector support available in the home to support people to access new opportunities, advice and help • Home adaptation to remove falls, trips and hazards and adaptions to improve independence • An initial primary care response to an urgent request for help from an older person within 30 minutes • Mental health services should be commissioned such that they can contribute to specialist mental health assessments in older people within 30 minutes if appropriate. • A 24/7 single point of access (SPA) including a multidisciplinary response within 2 hours (14 hours overnight). This should be coupled to a live directory of service underpinned by consistent clinical content (NHS pathways). • People living in care homes should be able to access appropriate exercise and a range of activities to maintain and enhance their quality of life. • Accessible sources of information (i.e. digital, paper) about a wide variety of topics related to ageing well e.g. healthy eating, staying warm, benefits, carer support, aids and adaptations, fire safety, exercise, repairs, housing support. • Appropriate public information on emergency preparedness in appropriate formats for older adults and their carers. Reducing the intake of alcohol, being prepared for the winter, foot care, eye tests etc. • Access to support groups e.g. exercise classes, interest groups, befriending groups supported by community health champions. • Accessible sources of information about local social services. • Management of ‘home functional decline’ where support is required from an appropriately skilled workforce.

6. Proposed Future Care System

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Neighbourhood	• The local environment will be age-friendly so that older people can be active, socialise, and feel safe to get around • General practices should monitor hospitalisation and avoidable ED attendances and determine whether alternative care pathways might have been more appropriate e.g. falls emergency response vehicle • Clinicians referring to urgent care can use a simple referral system with an agreed policy provided by secondary care and social services • Older people being admitted to community hospitals, whether for 'step-up' or 'step-down' care, should be assessed and managed in the same way as people accessing urgent care in any other part of the health system • There will be local contact points where older people can receive tailored support and advice outside of the home • Mental and physical health and social care assessment staff should be co-located together so that they can cooperate and share information with each other easily. These integrated care teams will work around practice populations and provide proactive care to people with complex needs, to help manage their frailty and support independence • There will be a wide range of activities available in the local area to support older people to engage in physical activity (including evidence based strength and balanced exercise) and hobbies, meet other people for friendships and relationships and feel welcome in their community. e.g. Get Up & Go guides, Nott's Help Yourself • Accessible sources of information about local social services, falls services, healthy eating, staying warm, benefits and for carers of older people with frailty. • Appropriate community resources to support the management functional decline in the home • For severe frailty and managing this in the community, we need a culture of supportive, personalised and palliative care. As a system, there is a need to be able to have joined up personalised care with the aim of achieving outcomes which matter to our patients e.g. being looked after in their homes with palliative support for the end of their life due to frailty and old age. • That all workforce members focus on what the individual wants.
Acute Hospital	• Same day emergency care avoiding any admission if possible (a patient is seen, assessed and plan made without overnight stay in a hospital bed). Ambulatory emergency pathways with access to multidisciplinary teams should be available with a response time of less than four hours for older people who do not require admission but need on-going treatment (e.g. in a Clinical Decisions Unit). • Discharge to an older person's normal residence should be possible within 24 hours, seven days a week with any non-acute follow-up care organised quickly to enable the discharge. • Accessible sources of information available on discharge e.g. about carer support, falls services, healthy eating, staying warm, benefits, AT. • Interventions to prevent older people experiencing muscle wastage and losing confidence in hospital (hospital acquired decline). • Personalised care with personalised outcomes. • Clinical Geriatric Assessment (CGA) is initiated within 2 hours of being admitted to ED and 14 hours if an individual stays in over night in a hospital setting.

6. Proposed Future Care System

Home

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Planned/Scheduled

- Strength and balance training (low to moderate risk)
- Encourage a healthy lifestyle (use of Apps, literature, voluntary sector, health advisors, life coaches)
- Advance care plan in place
- CGA
- Access to transport
- Personalised budgets
- Carer support
- Community therapy (rehabilitation, reablement and recovery, a delivery of meals, home care, clinical/professional assessment etc.)
- High quality residential / nursing home care

Urgent – 24 hours

- Management of LTC
- LTC plan in place (individualised)
- Access to transport
- High quality residential / nursing home care
- Personalised budgets
- Carer support
- Urgent assessment at home

Emergency/Crisis – 4 hours

- Access & appropriate signposting to 999,111 or crisis support social and mental health support via call for care
- Access to urgent support
- Transport provision
- Carer support

KEY to information source: Steering Group/ Workshop s Evidence Document/ Guideline Patient Focus Groups

6. Proposed Future Care System

Neighbourhood

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Planned/Scheduled

- Group/one to one/volunteering activities health champions
- Befriending activities
- Intergenerational activities
- Multifactorial interventions for those at high risk of falls
- Fracture liaison services
- Strength and balance exercise groups in the community available in the local area for people at risk of falling, to improve their balance and mobility
- Nutritional advice
- Social prescribing
- CGA
- Transport provisions
- Carer support
- Annual review
- Preventative reviews
- Podiatrists
- Daily or session based booked respite services
- Accessible training opportunities F2F and web based to support carers
- Training to access digital services
- Access to preferential health advice for self if registered carer (i.e. GP home visits?)
- Social opportunities and networks

Urgent – 24 hours

- Care navigation
- Access for LTC escalation of concerns
- Advance care planning
- Access to a local hub for older people and carers
- CGA
- Transport provision
- High quality enablement support
- Integrated community multi-disciplinary team
- Carer support
- Annual health checks
- 6-9 month medication reviews

Emergency/Crisis – 4 hours

- Access to LTC crisis management support
- CGA
- Same day emergency care
- Carer support

KEY to information source: Steering Group/ Workshop s Evidence Document/ Guideline Patient Focus Groups

6. Proposed Future Care System

Acute Hospital

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

Planned/Scheduled

- Care and support planning
- End of life support
- CGA
- Appropriate follow-up
- Transport provision
- Carer support
- Signposting

Urgent – 24 hours

- Future crisis management plans
- Advance care planning
- End of life support
- CGA is initiated within 14 hours if an individual stays in over night in a hospital setting
- Good discharge planning
- Transport provision
- Carer support
- MDTs

Emergency/Crisis – 4 hours

- Emergency access for emergency assessment
- Inpatient MDT specialist support
- End of life support
- CGA initiated within 2 hours of being admitted to ED
- Good discharge planning
- Transport provision
- Carer support
- Call for care access

KEY to information source: Steering Group/ Workshop s Evidence Document/ Guideline Patient Focus Groups

6. Proposed Future Care System

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Frailty System

Level of Care	Availability	Acute Hospital	Neighbourhood	Home
4 hours or less	24/7	• Emergency access for emergency assessment • Inpatient MDT specialist support • End of life support • CGA • Good discharge planning • Transport provision • Carer support	• Access to LTC crisis management support • Comprehensive Geriatric support (CGA) • Same day emergency care • Carer support	• Access & appropriate signposting to 999,111 or crisis support social and mental health support for call for care • Access to urgent support • Transport provision • Carer support
24 hours/Walk up and wait	7 days	• Future crisis management plans • Advance care planning • End of life support • CGA • Good discharge planning • Transport provision • Carer support	• Care navigation • Access for LTC escalation of concerns • Advance care planning • Access to a local hub for older people and carers • CGA • Transport provision • High quality enablement support • Integrated community multi-disciplinary team • Carer support	• Management of LTC • LTC care plan in place • Access to transport • High quality residential / nursing home care • Personalised budgets • Carer support • Urgent assessment at home
Scheduled	Appt based	• Care and support planning • End of life support • CGA • Appropriate follow-up • Transport provision • Carer support	• Group /one-one/volunteering activities • Befriending activities • Intergenerational activities • Multifactorial interventions for those at high risk of falls • Fracture liaison services • Strength and balance exercise • Nutritional advice • Social prescribing • CGA • Transport provisions • Carer support • 6-9 month reviews • Preventative reviews	• Strength and balance training (low to moderate risk) • Encourage a healthy lifestyle (use of Apps, literature, voluntary sector, health advisors, life coaches) • Advance care plan in place • CGA • Access to transport • Personalised budgets • Carer support • Community therapy (reablement, delivery of meals, home care, clinical/professional assessment etc.) • High quality residential / nursing home care • Personalised budgets

Universal and targeted prevention strategies to enable healthy ageing, prevent falls and reduce loneliness and isolation

High Priority

The overarching future expectations will be to promote and encourage healthy ageing and disease prevention by providing the right tools, access to services and making them affordable using population health management methods. There requires a shift in the commissioning of services to promote, support, guide the maintenance of healthy lifestyles and encouraging self-care in the management of long term conditions that may contribute to a citizen's frailty.

The overarching future expectations will be to that the localities that the ICP serves become Age Friendly Environments/Places in line with the WHO framework that foster healthy and active ageing and help people remain independent for as long as possible. The wellbeing services operating across the life course that provided targeted primary prevention services to support people with single and multiple behaviour risk factors including mental wellbeing, physical activity including strength and balance exercise, diet, smoking and alcohol use. These will have a community focus to support the Age Friendly agenda and be prioritised in communities where risk of frailty is higher and support in place through social prescribing and Connect to motivate and support people to achieve ageing well goals and accessing well-being services where appropriate.

The main prevention strategies that need to be written and agreed across the ICS are:

a) Age friendly environments - Ensuring design, infrastructure and facilities in local environments/places consider the needs of people as they get older to enable independence. Early access to information around minor adaptations, smaller aids and equipment is key to managing the person's risk within their environment in relation to their functional ability. This early intervention and resolution will enable stakeholders to better manage frailty and falls risk which would be provided proportionate to identified needs.
b) Healthy ageing /ageing well – Commissioning public health services that enable communities and individuals to prevent risk factors for frailty through targeted prevention (e.g. alcohol, smoking, physical inactivity, poor diet/obesity)
c) A strategy to reduce loneliness and isolation.
d) A strategy to prevent falls and manage fragility in the community through providing structured evidence based exercise, developing the falls prevention skills of the workforce and reduce hazards, slips and trips in the home.

These approaches have been recommended because of the weight of evidence to show that having an impact in these areas will have a significant impact to reduce and delay older people declining from a position of being fit and healthy to becoming frail. If people are already frail due to health conditions, they are more likely to become more severely frail quickly if they are lonely or/and if they experience one or more falls. Further work is needed to reach an agreed position for each strategy as this will require more focused discussion with our cross-sector multi-agency group.

Alignment: Development of an Age Friendly Environments will require incorporation and alignment of this framework across Healthy and Sustainable Places work streams, in Health and Wellbeing Board Strategies and the ICS place based approaches. This will require ICS engagement with local authority function outside of the ICS. The development of prevention services across the ICS will require alignment of commissioning intentions and current services across Public Health, Social Care and the NHS across local authority functions wider than social care and alignment with NHS structures. Future models of care for frailty services will be driven by population health management and it will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCNs) within the ICS to provide flexible services that will meet the prevention agenda in relation to the key areas of focus identified within the frailty service review.

Benefits: Ageing well starts from early years and is a life course journey, where flexible approaches need to be provide ongoing support in maintaining a healthy lifestyle amongst our citizens. Modelling work suggests that as well as significant health benefits that interventions in all of the four areas identified could provide a positive return in investment, e.g. reduction in emergency admissions, delays in transfer and discharges, reduced falls through falls assessments and interventions, reduction in pharmacy costs and improved outcomes for patients when regular 6-9 month medication reviews are undertaken, improved enablement through the use of assistive technology and improved use of neighbourhood and voluntary services to support patients and carers. Falls prevention exercise has been found to be cost effective (PHE, 2018).

7. Transformation Proposal

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Roll out of a clinical frailty scale across the ICS **High Priority**	People living with severe frailty have over four times greater annual risk of dying, hospitalisation or nursing home admission. Those living with moderate frailty are three times more at risk and those with mild frailty have nearly twice the annual risk of dying, hospitalisation or nursing home admission. By identifying a patients frailty action can be taken to reduce risks. The Acute Frailty Network found that 20% of those aged 75+ experience 80% of the harms. While it recognised that the electronic frailty index (EFI) has been introduced under the new GP contract to predict all those 65+ years for frailty is a positive way forward in acknowledging frailty across health and social care. In addition it will help identify and map populations at risk and those living with health and social care models and it will allow for targeted interventions for those at risk of frailty or those that are living with mild, moderate or severe frailty. The frailty service review recommends the Clinical Frailty Scale (CFS) should be used across the system as it will allow for improved personalised care offers that will impact in a positive way to patient and carer quality outcomes and reduce admissions into hospital settings. **Alignment**: The roll out of the Clinical Frailty Scale would require the ICS to lead on the implementation across the system as it will require the support of an integrated approach using the expertise of the ICS IT services for inter-connectivity across the system. **Benefits**: One tool used by all that come into contact with the citizen, it can be updated as a live system, improved assessment, identification and improved targeted interventions. The tool is quick to use and simple to training is required.
Undertaking, sharing and implementing advance care plans for older people with moderate to severe frailty across the ICS **High Priority**	Advanced care planning is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future and if they wish to set on record their choices about care treatment and future decision making while they are able to do so. While there has been significant progress locally with advance care plans (ACP) within cancer services, the frailty services steering group felt that there were still considerable inequalities in how and when these discussions and plans take place with patients identified as frail and in particular those identified with moderate to severe frailty. There does not appear to be a clear method/process of sharing information across the system, which can lead to the citizen and their family not being aware of the agreed plans or them having to repeat these plans which can be distressing to the citizen and their family. There appears to be a mixture of paper and IT ways of recording ACP. The service review recommends ACP should be one single care record and increased planning should take place within the home or neighbourhood settings. There needs to be increased education on how to approach ACP with citizens and their families earlier e.g. a diagnosis of dementia may have been made, but the patient still has a level of capacity to express their wishes for their future health and support. **Alignment**: The introduction of ACP across the system would require the ICS to lead on the implementation as it will require the support of an integrated approach using the expertise of the ICS IT services for inter-connectivity across the system and existing work streams. **Benefits:** That the ACP will be accessible at every contact and inform discussions at important stages of peoples lives, e.g. during admission to hospital if their condition deteriorates, with their GP or when admitted to a care home.

MDT's to work more effectively with integrated community multi-disciplinary teams

High Priority

There is a pressing need to change how we care for older people with urgent care needs, to improve quality outcomes and efficiency. Implementation of improved care for older people requires a whole system approach. NICE recommends that there should be a named care co-ordinator for older people with social care needs and multiple long term conditions.

The frailty service review recommends the establishment of proactive community multidisciplinary team assessment processes for people identified as living with moderate frailty. Community multidisciplinary teams target the moderate frailty population, people whose annual risk of urgent care utilisation, death and care home admission is up to three times that of an older person of the same age who is fit. MDT core teams should include social care, mental health, housing and should be able to call on support from voluntary sector organisations for low level interventions (e.g. financial advice, social contact, appropriate housing). Currently there is a Housing with Care Strategy that social care are working on with District Councils to improve the range of options available to older people.

The frailty service review has indicated that there needs to be a consistent approach in providing Same Day Emergency Care (SDEC) for acute frailty for patients who would otherwise be admitted to hospital. The NHS Long Term Plan (LTP) recommends that this should be available for at least 70 hours per week. It is felt locally that this should be offered 24 hours, seven days per week. The implementation of undertaking a clinical frailty assessment within the first 30 minutes to meet the LTP recommendations needs to be rolled out more comprehensively across the ICS. Health urgent care services should be working closely with other partners (e.g. Social Care, District Councils) to achieve the best service for citizens who have urgent needs.

For people with complex health, social care and housing needs who are not in a crisis situation, our existing integrated care teams provide an ideal foundation upon which to build a truly integrated, personalised and holistic service that can respond appropriately to enable people to stay living independently at home for as long as possible and avoid hospital admission. Co-location of these teams is the optimal arrangement to encourage effective working but other models are available if this is not possible

Alignment : This will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCNs) within the ICS to provide MDT requirements and services that will maximise the urgent care and scheduled care response across the ICS which will allow a degree of flexibility to meet the needs of their local population.

Benefits :
This group is considered to be the most amenable to targeted proactive interventions in being able to reduce frailty progression and unwarranted secondary care utilisation.

Improved citizen and carer satisfaction, reduction in emergency admissions to hospital and care homes, greater success in supporting older people to achieve their health and social care outcomes, decreased length of stay in hospital and less delayed transfers of care.

7. Transformation Proposal

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Improve support to reduce carer stress across the ICS **High Priority**	**What needs to improve to support carers more effectively:** • Early identification to enable proactive support and training to support them in the longer-term as their needs and those of the person they care for change. • Carers need to be aware of possible future needs of the person they care for but in an appropriate and timely manner with real, practical solutions available to help them manage this. • Carers should be respected for their knowledge as an 'expert'. • Carers personal budgets need to be outcomes-based to ensure that provision meets an identified need. This is likely to be a one-off cost with ongoing provision commissioned in the service user name however, some ongoing support for carers may be required in exceptional circumstances. • Short breaks provision needs to be utilised to maximise the outcome for the carer and service user with innovative mechanisms available to achieve this. • A whole family, whole-systems approach to assessments will ensure that support is available to maximise outcomes for the whole family unit. • These actions will need to be implemented across the ICS to ensure a consistent approach to enabling carers to maintain their caring role. **Benefits:** • Plan for possible crisis points and assist carers to have relevant skills and support networks in place to prevent carer breakdown. • Enable the carer to continue in their caring role for as long as possible thereby reducing the likelihood of the service user entering long term care prematurely. • Enable service users to live at home for as long as possible. • Provide greater choice and control for service users and carers about how they receive their support.
Maximise the use of assistive technology to design and maximise interventions to support healthy ageing **High**	Assistive technology is changing everything and it is helping older people to remain independent. There is a requirement for the ICS to consider how the future of technology can be adapted to aid all of our citizens but in particular older adults. There have been some significant technological advances with new mobile devices, wearable gadgets and security technologies being released to help everyone's age to help older citizens stay independent in their own home. Some examples include: stair lifts, voice recognition software, robot dogs & cats to allow people to pet and interact with an animal without hygiene and contamination worries, a seal robot designed to help those with anxiety and dementia among other health concerns, click and key finder and virtual services (counselling, pharmacy, GP) and monitoring systems for families to keep a check on an older person at home. **Alignment**: At an ICS level there is a requirement that all services are: - Interconnected and one patient held record can be shared and updated by a professional at every contact with a older person. - Sharing of information across organisational boundaries by helping systems to talk to each other and allowing viewing of live datasets. - Need for proactive interventions to prevent escalation of needs, triggered by predictive analytics and automated workflows. - Using information intelligently across systems to commission services more accurately when and where they are needed, enabling population health management. **Benefits:** • Increased choice, safety, independence and sense of control. • Improved quality of life. • Maintenance of ability to remain at home. • Reduced burden placed on carers. • Improved support for people with long-term health conditions.

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Training and Care confidence in Care Providers is developed across the ICS **High Priority**	Estimates of the total number of people living in care homes nationally range from 250,000 to 480,000 and the number is growing year on year. Enhanced Health in Care Homes (EHCH) Vanguards have demonstrated improved quality in care, provisions of the right care and access to the right healthcare of a citizens choosing and the best use of resources. Currently in the ICS there is not a consistent health care support offer and this is mirrored nationally, despite care home beds outnumbering NHS hospital beds by 3:1 and being an increasingly important place for end of life care. The frailty review recommends a consistent introduction of EHCH across the ICS and also that all Care Providers are supported to complete the Digital Toolkit so that they can receive health information via NHSMail. **Alignment:** This will be the responsibility of the Integrated Care Partnerships (ICP) and Primary Care Networks (PCN's) within the ICS to provide and meet the EHCH requirements across the ICS which will allow a degree of flexibility to meet the needs of their local population. **Benefits:** High quality care; reduced pressure on GP's and acute services (29% reduction in ED attendances and 23% emergency admissions); enables the development of different relationships between health, social care and commissioners; influences a culture of improved core capabilities framework to support people living with frailty; sustainability.
Having the right skill mix with the right training and development to provide the individual person centred care across the ICS **High Priority**	NHSE recognise that frailty remains a new area for much of the workforce and work is needed to position frailty as a long term condition and underpin it by upskilling the workforce. The Frailty Framework of Core Capabilities (2018) by Skills for Health has identified the skills and knowledge and behaviours required to deliver high quality, holistic, compassionate care and support. It provides a single, consistent and comprehensive framework to develop staff of all disciplines. Using the RightCare assessment tool across the ICS it has identified the following: • Workforce mapping across the system has not taken place with a particular focus on frailty services. • There is no coordinated and collaborative programme of work underway to address skill gaps across the system. • Frailty workforce development plans are not linked to education and skills for dementia or other key skills frameworks. • Home care and home based support. The recommendations of the frailty service review is that the Frailty Framework of Core Capabilities is rolled out across the ICS and that frailty becomes 'everyone's business'. **Alignment:** The introduction of The Frailty Framework of Core Capabilities and relevant training would require the ICS to lead on the implementation as it will require the support of National and Local workforce strategies, funding and adopting an integrated and sustainable long term approach. **Benefits:** Enables all staff groups to gain a level of knowledge and skills to work effectively with older people with a particular emphasis on health complexity, person centred care, dementia, end of life and frailty frameworks.

7. Transformation Proposal

	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits	Costs
Encourage healthy ageing and disease prevention. Key areas of focus include strategies on: loneliness, isolation, falls , exercise. Some examples include: - healthier lifestyle programmes, smoking cessation, maintain healthy weight - local policy changes - awareness campaigns - appropriate information - improve physical health, - promote behaviour change - physical activity opportunities - Signposting / navigation - provide training to make it everyone's business	High	ICS PHM SC An Integrated approach	Review of skill mix and integrated workforce planning Upskilling the wider NHS workforce to support the roll out	- Integrated IT system - Better profiling of patients using technology - Making available more portable technologies - Expand home assistive technology	Age friendly environments across the ICS Asset mapping Review housing stock Co-location of services	To make frailty 'everyone's business' and shift cultural perception Integrated social care, health and PHM Model Shared and integrated use of workforce across system where appropriate Developing trust programme across different neighbourhoods and roles Shift away from a medical model Shared decision making Think about dying well as living well culture	Alignment of strategies across the ICS Alignment of commissioning intentions Shift in funding Funding to match need (additional needed)	5% at risk of frailty, with exercise 35% reduction of them becoming frail, saving NHS £900k pa nationally. Decade of loneliness costs £1.7K-£6K Signpost/navigation £2-£3 ROI per £1 invested Befriending cost effective mixed results. Bereaved widows £24 ROI per £1, Community café £8 ROI per £1. Intergenerational 'Good Gyms' £4.56 ROI per £1 - Preventing falls team every £1 spent £5 saved across health and social care.	
Roll out the clinical frailty scale across the whole system: - Allow for improved personalised care - To improve quality outcomes & reduce admissions into hospital settings	High	ICS	Training Programme for all staff	Inter-connectivity across the system Broadband in rural areas	N/A		Adoption of the same assessment tools across the ICS	20% of age 75+ experience 80% of the harms.	
Undertaking, sharing and implementing advance care plans for older people with severe frailty: -Agreed information sharing across the ICS - Earlier and increased planning at home	High	ICS	Training Programme for all staff	Connectivity to have Visibility / access to see and update ACP	N/A		Training budgets needs to be considered	Reduce patient distress, avoid duplication.	
- MDT's to work more effectively with integrated community multi-disciplinary teams - Consistency in the offer of SDEC across the ICS - Consistency of offer for urgent / crisis care - Co-location of integrated teams Introduce care co-ordinator roles for older people with social care needs and multiple long term conditions - Community multi-disciplinary teams to be established across the ICS to target moderate frailty population	High	ICP	Competency based training and joint roles	Connectivity to have Visibility / access to IT Systems	Community Hubs Co-located integrated Carer supportive environments across the ICS		Joint commissioning required for an integrated offer	- Community MDT team target moderate frailty population that are 3x more likely to be hospitalised, die or admitted to a care home. - Most amenable group to targeted interventions to reduce frailty progression	

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7. Transformation Proposal

	Priority (High/ Med/ Low)	Alignment (ICS/ ICP/ PCN)	Workforce	Technology	Estate/ Configuration	Culture	Finance/ Commissioning	Benefits	Costs
Carer Stress – To support carers more effectively - Early identification - Proactive support - Outcome based carer budgets - Short break provision - Whole family approach is adopted across ICS	High	ICP	Training and joint roles Use of Voluntary sector roles	Connected IT system Use of AT	Carer supportive environments across the ICS	To make frailty 'everyone's business' and shift cultural perception Integrated social care, health and PHM Model Shared and integrated use of workforce across system where appropriate Developing trust programme across different neighbourhoods and roles Shift away from a medical model Shared decision making Think about dying well as living well culture	Minimal investment required	Home adaptations can reduce care giving hours by up to 60%. Carers are **2.5x** more likely to experience psychological distress	
Care confidence with care providers - Consistent introduction of Enhanced Health in Care Homes across the ICS - All care homes are supported to complete the Digital Toolkit	High	ICP	Training Programme for Care Home staff	Telemedicine advice links NHS IT links	'Extracare' type development		Consider use of the private sector	Care home vanguard in Rushcliffe had 23% fewer emergency admissions and 29% fewer A&E attendances	
Having the right skill mix with the right training and development to provide the individual person centred care across the ICS: - Workforce mapping across the ICS - Development of a collaborative programme of work to address skill gaps across the ICS - Roll out the Frailty Framework of Core Capabilities across the ICS - Development of an education and skills programme for frailty to include dementia	High	ICP	Review of skill mix to based on population need Identify key roles Develop 3 tier competency frameworks Consider retention on staff	Integrated IT system E-learning Virtual learning	Access to community beds		Training budgets needs to be considered when commissioning services	Signpost/navigation £2-£3 ROI per £1 invested This will deliver the preventative advice, reduce falls etc.	

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8. Workstream Requests

Workforce	The following are key areas that need to be considered to enhance the future health and social care within frailty services: • Workforce mapping across the system is undertaken taken within the ICS with a particular focus on frailty services . • A coordinated and collaborative programme of work is undertaken to address skill gaps across the system . • Frailty workforce development plans are linked to education and skills for dementia or other key skills frameworks across the ICS . • That the Frailty Framework of Core Capabilities is rolled out across the ICS • Personalised approaches and strengths-based thinking is rolled out across the ICS
Technology	The following are key enablers to ensure the sustainability of the proposed transformational opportunities and will aid all themes identified, particularly in prevention, identification and management of frailty across the ICS: • Electronic shared care health records • Maximise accessibility / connectivity • Carers status record • To roll out a clinical frailty scale across all services/sectors • Visibility and access to have the ability to update assessments and Advance Care Plans • Telemedicine advice links and access to tele care • Investment in assistive technology, automated workflows, citizen access to digital information, data analytics • Virtual location access to equipment
Estate	It is recognised that the acute services are fixed points and that ED services will continue to be provided at the two acute trusts, below highlights some areas where there may be additional estates required or integration of services using existing estates across the ICS: • Some urgent care could be provided in the home or as part of the Primary Care Networks, but relies on appropriate levels of staff. • Community Hubs will need to consider how to embed prevention, improved assessment and the management of frailty within the ICP's. This could include care co-ordination, MDT support, citizen reviews, crisis/urgent support, housing, finance, social care, healthy living community support. • Provision of one single point of access across the ICS 24/7. • Extra care type developments across the ICS. • Identification of an increased level of Enhanced Health Care Homes. • Opportunities for health and social care staff to work together in the same building within their geographical patch.
Culture	To drive a culture change we need a paradigm shift in how we think, how we provide and where we deliver care to our ageing populations. Frailty needs to become 'everyone's business' and recognised as a long term condition with integrated health, social, public health and voluntary sector models of care/support to be inclusive, equitable and sustainable across the ICS to meet our population needs. In addition, we need to be able to work in partnership with older people and their carers, seeing them as experts in their own lived experience and asking them "what matters to you ?" so we can find solutions together. Shared and integrated use of workforce across organisations will enable the sharing of resources as there are limited staff groups and expertise, particularly with the introduction of MDT's and care coordinators. Organisational trust and changes in how future services are commissioned will provide the greatest influence on the future of integrated service provision and how best evidence can influence the future frailty service offer across the ICS.

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9. Frailty Services Vision

Frailty Vision: The Nottinghamshire ICS will support all ages and older people to enjoy physical and mental health and wellbeing to their full potential. It will promote and pursue equality, independence, participation, care, self-fulfilment and dignity of older people at all times.

From Now Through to …	2021/22 Phase 1	2022-2025 Phase 2	2025+ Phase 3	To…
- Negative perceptions amongst older people, and the rest of society, on ageing and health status have a significant impact on frailty and healthy ageing. - Loneliness and isolation affects 10 -20,000 older people in Nottinghamshire (2011) - High admission rates due to falls 65+ (City) & 85+ (County)	**Prevention** That the following strategies will have been developed & aligned: • Age friendly Environment • Healthy Ageing / Ageing well • Loneliness & isolation • Falls • Education and training to make frailty everyone business • Upskill wider NHS workforce • Increase health checks to prevent frailty through self awareness	Development of strategy work streams & care outcome metrics - Improved falls prevention service across the ICS - Co-location of services - Expand home assistive technology and adaptations	- An integrated social care, mental & physical health & PHM model - Alignment of commissioning intentions and pooled budgets - Improved care outcomes	- The ICS has created environments and opportunities that enable people to be and do what they value throughout their lives.
- GPs are able to systematically identify people likely to be at risk of frailty using Electronic Frailty Index (eFI) - Different organisations use a different frailty assessments - There is duplication in assessment due to a lack of trust across the system - Assessment scores are not transferred across organisations - Unable to quantify frail service users easily	**Identification of frailty** - A system wide clinical frailty scale is rolled out across all sectors - A training programme has been developed to support the roll out - Interoperability of IT systems across the ICS - Intelligent use of data that promotes prevention within community, primary and secondary care.	- Use collective data sets to risk stratify the ICS population to inform future models of health and social care and tailor interventions - Review progress and the appropriateness of screening/identification to minimise any possible unintentional harm e.g. false negatives, stigma.	Using a combination of data sets targeted interventions will focus on early prevention and identification of those at risk of developing frailty	All citizens at risk or living with frailty are identified across the ICS and appropriate person centred plans are in place to best support the individual to fulfil their potential Future models of care for frailty services will be driven by population health management using informed datasets
- Services are provided in silos within and across organisations - Inequalities in how and when ACP take place with patients identify with frailty and how they are recorded - Carers are 2.5 times more likely to experience psychological distress - Acquired functional decline is common within hospital and home settings - There is not a consistent support offer in care homes despite 3 x as many beds as in acute settings - There is a need to continue to reduce adverse events through medication reviews	**Management of frailty** - Frailty MDTs have been developed to support person centred decision making and care embed advanced care plans - Consistency of offer of same day emergency care - Develop a strategy to roll out the benefits of enhanced health in care home vanguards - Support care homes to complete the Digital tool kit - Early identification of carers and personalised support plans - Build on current offer of medication reviews (currently GP based)	ACP are all put onto a shared IT system and are developed in a timely manner Roll out of enhanced health care in care homes across the ICS Outcome based carer budgets Proactive support models are in place for carers	The ICS will lead the way in providing an integrated frailty care focusing on what matters to the older person living with frailty	A whole system approach to assessments to ensure that support is available to maximise outcomes for the whole family unit
- There are persistent shortages across key staff groups with frailty knowledge - There remains uncertainty on the future status of EU nationals working in health and social care - Social care ad residential care vacancies turnover in Nottingham is 30% (in line with England)	**Workforce** - Review of skill mix based on population need - Feed into the ICS response to the NHS LTP - Identify key/new roles - Roll out 3 tier competency frameworks for all staff groups	Agree central investment in education and training places for roles to support integrated frailty services Support new ways of working and roll out new roles	A flexible workforce that is not constrained by organisational or professional boundaries, by linking with education providers and reviewing the approach to training our future workforce focusing on the skills that we need.	An Integrated multidisciplinary workforce to ensure that the right mix of services is available in the right place at the right time according to need.

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10. Conclusions and Next Steps

Conclusions	The review of Frailty services as part of the development of a Clinical Services and Community Services Strategy for Nottingham and Nottinghamshire has been undertaken using a co-design model where key stakeholders and voluntary sectors have collaboratively worked together to shape a vision for a future care system for Frailty in Nottingham and Nottinghamshire. The four key themes for improvement identified were: prevention (age friendly environments, healthy ageing and ageing well, loneliness, isolation and falls prevention); identification of frailty (clinical frailty score assessments and data sharing and electronic care record; management of frailty (carer stress, the use of technology, hospital and care home acquired decline and medication reviews); and workforce (workforce mapping, skills gap development and education). The review describes a future care system in different care settings and with care provided at different levels of urgency and envisages 8 high priority programmes to transform care • **High** - Universal and targeted prevention strategies to enable healthy ageing, prevent falls and reduce loneliness and isolation • **High** - Roll out of a clinical frailty scale across the whole system across the ICS • **High** - Undertaking, sharing and implementing advance care plans for older people with severe frailty across the ICS • **High** - MDT's to work more effectively with integrated community multi-disciplinary teams • **High** – Improve support to reduce carer stress across the ICS • **High** - Maximise the use of assistive technology to design and maximise interventions to support healthy ageing • **High** - Training and Care confidence in Care Providers is developed across the ICS • **High** - Having the right skill mix with the right training and development to provide the individual person centred care across the ICS To achieve these there are a range of enabling requirements for the ICS across workforce, estate, technology, culture and financial systems. Collectively these initiatives can transform frailty services in Nottingham and Nottinghamshire by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate with a long term view. The overarching future expectations will be to that the ICS moves towards providing Age Friendly Environments/Places that foster healthy and active ageing and help people remain independent for as long as possible
Next Steps	This strategy sets the future direction of development of Frailty Care in the ICS and it is proposed it will shape future work of the ICS in a number of ways: • The identified priorities and programmes should be used to inform commissioning, ICS, ICP and PCN activity. • The enabling activities require development and inclusion in the relevant ICS workstreams to inform their work programmes and areas of focus. • The aggregate impact of the collective suite of service reviews should be used to shape focus of future service provision in acute and community settings in the ICS.

NOTE: In further developing and implementing the proposals set out above as part of our focus, each partner organisation within the ICS will continue to ensure that they comply with their statutory duties and system/organisational governance processes, particularly (but not limited to) those relating to patient and public involvement; equality and inequality analysis

11. List of Abbreviations

1°, 2° Care	Primary, Secondary Care	ICP	Integrated Care Partnership
A&E	Accident and Emergency	ICS	Integrated Care System
ACP	Advanced Care Plan	ICT	Information Technology
ANP	Advanced Nurse Practitioner	LTC	Long Term Conditions
App	Application	LTP	Long Term Plan
AT	Assisitive Technology	MDT	Multi-Disciplinary Team
BAME	Black, Asian and Minority Ethnic	MECC	Make Every Contact Count
BSG	British Society of Geriatrics	NHS	National Health Service
CCSS	Clinical and Community Services Strategy	NICE	National Institute for Health and Care Excellence
CFS	Clinical Frailty Scale	PCN	Primary Care Network
CGA	Clinical Geriatric Assessment	PH	Public Health
ED	Emergency Department	PHE	Public Health England
EFI	Electronic Frailty Index	PHM	Population Health Management
ENCH	Enhanced Health in Care Homes	ROI	Return on Investment
EoL	End of Life	SC	Social Care
GP	General Practitioner	SPA	Single Point of Access

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12. Data Sources

Data Sources	NHS Long Term Plan ICP Report – Institute of Public Care National Office of Statistics Local Data from NUH, SFHFT, Social Care, CCGs, GPRCC Public Health England Fingertips Michael Vernon presentation Office of National Statistics Age UK

GLOSSARY

CGA	**Comprehensive Geriatric Assessment**	CGA is a process used by healthcare professionals to assess the status of people who are frail and older in order to optimize their subsequent management.
eFI	**Electronic Frailty Score**	eFI is a estimated score of frailty calculates this from consideration of 36 deficits which are derived from Read Codes. Severe frailty is estimated when a patient has a score of 0.36, moderate when score is 0.25-0.36.
CSF	**Clinical Frailty Score**	Clinical Frailty Score (Rockwood) is a quick visual way of assessing the frailty of a patient.

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13. Appendix 1 – Activity Data

Using Age 85+ as a proxy for frailty (likely to underestimate frailty in our system)

	Inpatient 85+ 2018-19			
Emergency	NUH City	NUH QMC	SFH Kings Mil	Other
Activity	1,866	10,307	6,009	915
Bed Days	12,946	56,498	35,125	10,006
Cost	£6,849,585	£34,611,787	£20,269,445	£2,831,263
Elective	NUH City	NUH QMC	SFH Kings Mil	Other
Activity	2,513	2,742	2,459	3,577
Bed Days	1,704	693	986	11,152
Cost	£3,187,199	£2,159,300	£2,074,308	£3,616,786
Daycase	NUH City	NUH QMC	SFH Kings Mil	Other
Activity	1,953	2,535	2,200	2,852
Cost	£1,173,351	£1,459,225	£1,282,274	£1,672,099

	% Inpatient 85+ 2018-19			
Emergency	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	9%	14%	14%	10%
Bed Days	16%	29%	32%	12%
Cost	12%	23%	22%	17%
Elective	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	3%	7%	6%	5%
Bed Days	8%	4%	14%	11%
Cost	4%	4%	5%	5%
Daycase	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	3%	8%	6%	5%
Cost	3%	6%	6%	4%

	Outpatient 85+ 2018-19			
	NUH City	NUH QMC	SFH Kings Mil	Other
Activity	16,429	25,013	16,784	24,622
Cost	£1,597,880	£1,565,865	£1,319,379	£1,495,602

	Outpatient 85+ 2018-19			
	NUH City	NUH QMC	SFH Kings Mill	Other
Activity	5%	6%	5%	6%
Cost	5%	6%	5%	5%

All Types	A&E 2018-19		
85+	NUH QMC	SFH Kings Mill	Other
Activity	11171	7337	1828
Cost	£2,028,257	£1,258,386	£181,151

	A&E 2018-19		
85+	NUH QMC	SFH Kings M	Other
Activity	6%	8%	2%
Cost	9%	10%	2%

2% of Nottingham and Nottinghamshire Citizens are age 85+. However this age group account for around 30% of bed days at QMC and Kings Mill hospitals and 22-23% of their inpatient emergency costs and 9-10% of the A&E activity costs.

There are national survey's looking at the prevalence of frailty in hospitals. Some studies have used 85+, which has limitations. Others have suggest 15-33% of patients depending on tool used.

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13. Appendix 2 – Activity Data

				actual frailty assessment		eFI score (to predict frailty)			
ICP	Total Population	Population Under 65	Population 65+	Latest frailty Read code severe	Latest frailty Read code moderate	"Severely Frail"	"Moderate Frailty"	"Mild Frailty"	"Fit"
Mid Nottinghamshire	333,075	266,392	66,683	3,894	5,834	6,303	12,087	21,760	26,533
Nottingham City	379,749	337,285	42,464	2,402	4,296	4,591	8,372	13,474	16,027
South Nottinghamshire	377,409	298,136	79,273	5,001	7,868	6,733	13,018	24,786	34,736
ICS	**1,090,233**	**901,813**	**188,420**	**11,297**	**17,998**	**17,627**	**33,477**	**60,020**	**77,296**

Latest frailty read code 'severe' is where a professional has assessed the patient and identified them as severely frail. eFI scores of severely frail is computer generated and suggests that there is a greater likelihood of a citizen be scored as frail. The data that is be collated is beginning provided a better idea of the size of our frail population.

County Care Package Category	Latest frailty Read code severe	Latest frailty Read code moderate	eFI Severe Frailty	eFI Moderate Frailty	eFI Mild Frailty	eFI Fit
Adults Assistive Technology	520	385	798	402	141	27
Adults Care Home (Older Persons)	809	463	1023	456	164	27
Adults Care Home (Under 65)	<6	<6	6	14	8	<6
Adults Day Services	106	86	149	111	73	22
Adults Deaf & Visual Impairment Service	<6	6	8	<6	<6	<6
Adults Direct Payments	397	284	568	261	107	20
Adults Extra Care	<6	<6	<6	<6	<6	<6
Adults Home Support	652	380	997	400	144	34
Adults NHS Continuing care	57	48	68	74	38	15
Adults Reablement	31	30	68	41	11	6
Adults Transport	12	12	15	14	10	<6
Not Ranked	40	19	52	25	10	<6
Total	**2624**	**1713**	**3752**	**1798**	**706**	**151**

Long Term Community:

Ageing Well (65+)- Average of Weekly cost **£213**

Living Well (18-64)- Average of Weekly cost **£310**

Long Term Resi/nursing:

Ageing Well (65+)- Average of Weekly cost **£627**

Living Well (18-64) - Average of Weekly cost **£1,432**

These figures represent the average weekly cost of a social care package (County patients) for those patients currently in our system **who are eligible for social care, irrespective of their health condition.**

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13. Appendix 3 – Activity Data

Table 2: Predicted growth in the older people population in Nottinghamshire

Age group	Predicted growth to 2020	Predicted growth to 2030
80 +	↑ 26%	↑ 50%
90 +	↑ 50%	↑83%

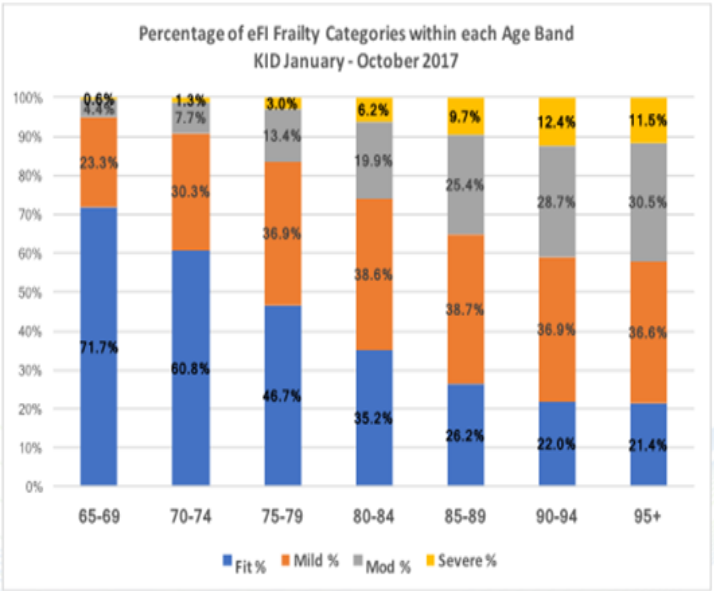
Source: Predicting Older People's Population Information (POPPI)

Table 3: Predicted growth in care home admission in Nottinghamshire with or without nursing

	Projected growth to 2025	Projected growth to 2030	Projected growth to 2035
Nottinghamshire	↑ 30%	↑ 54%	↑ 85%
East Midlands	↑ 29%	↑ 53%	↑ 84%
England	↑ 27%	↑ 48%	↑ 78%

Source: Predicting Older People's Population Information (POPPI)
Numbers calculated by applying percentages of people living in care homes/nursing homes in 2011 to projected population figures

There is predicted 83% growth in those 90+ to 2030 and 85% growth in care home admissions to 2035.



We don't all age the same way, not all citizens 85+ are frail, but likewise 0.5% of 65-69 year olds are severely frail.

Health Checks are a good opportunity to increase awareness of how to age well, more can be done to increase take up in our ICS.

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