South Lanarkshire University Health and Social Care Partnership

University Health & Social Care North Lanarkshire

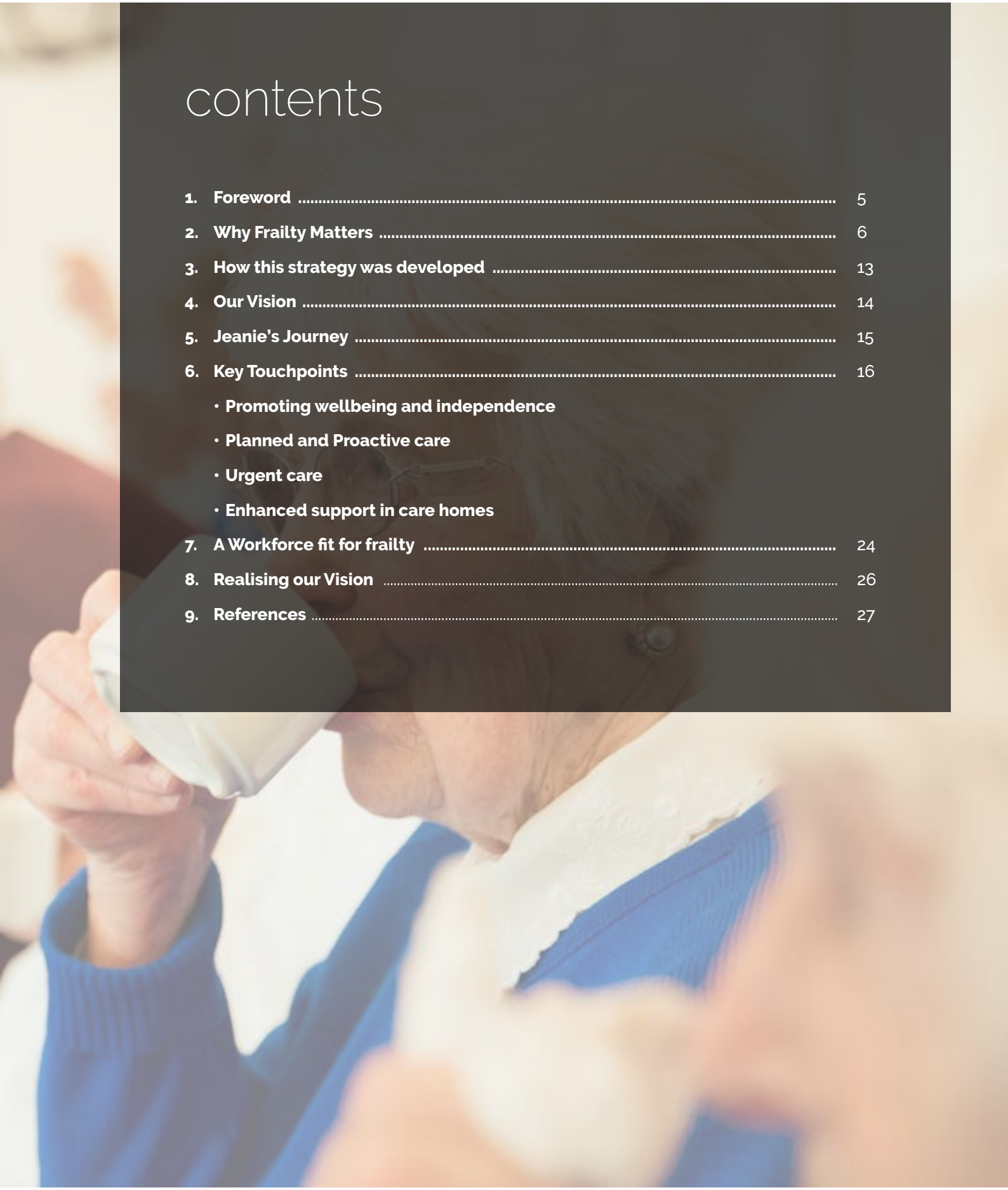
Strategy for Preventing and Managing Frailty: 2024 – 2029

Our Health Together

Living our Best Lives in Lanarkshire

NHS Lanarkshire

contents



1 Foreword

The demand for health and social care services in Lanarkshire is on the rise due to demographic shifts, medical advancements, and changes in care delivery methods. By 2045 the percentage of the population aged 65 years and over is expected to increase by over a third and evidence suggests that by 2030 the number of people aged 85 and older in Lanarkshire is set to increase by 24%.

However, we still see inequalities in life expectancy and years lived in good health across our communities. This is a gap we are working to close.

Engagement with our patients and service users tells us that many people fear old age as it is associated with disease and disability. While the occurrence of disease increases with age, the actual ageing process is not the main cause of diseases that result in frailty.

Some diseases can seem to be related to the ageing process, however many of the diseases associated with old age are preventable. The main reason disease happens more commonly as we age is that with each passing decade we are exposed to risk factors in our lifestyle and environment that cause disease.

However, these risks can be reduced at any age, no matter how old a person is. This means that frailty is not a certain part of ageing. Proactive prevention, early recognition and effective management requires us to have a consistent approach that we use to work in partnership with the people of Lanarkshire.

This strategy outlines our commitments to work together across health, public health, social care, housing, community and voluntary organisations, and with older people and those who are important to them, to help the people of Lanarkshire age well and live longer in good health.

We want people to remain healthy, active and connected with their communities. To support this, we will work together to deliver support and services that are inclusive, focus on the individual, and recognise and value the important role that families and carers play.

Together we will promote age friendly communities and design a health and care system that is well informed and focused on prevention and proactive management of frailty. This will, ultimately, play a key role in reducing inequalities and improving lives and population health for all.

This strategy for preventing and managing frailty supports our vision for Healthy Ageing and Living our Best Lives in Lanarkshire.

2 Why Frailty Matters

Improvements in healthcare and in tackling some social and economic factors contributing to health means people are living longer. This is good news. However, we don't just want to add years to our lives. We all want to enjoy good quality health and wellbeing in later life. In other words: Healthy Ageing.

The United Nations Decade of Healthy Ageing (2021-2030) aims to add life to years and create fairer, healthier and happier communities.[i] The priority goals are tackling ageism, creating age-friendly environments, creating integrated and responsive health and care systems and services, and ensuring access to long-term care for older people who need it These four goals resonate with our vision in Lanarkshire for **Healthy Ageing and Living our Best Lives**.

Many older people are currently living with multiple physical and mental health conditions. They are more likely to experience **frailty** – an age related condition in which multiple body systems gradually lose their in-built reserves, resulting in an increased risk of unpredictable deterioration from minor illness and events.[ii] Frailty affects around 12% of people aged over 65 years living in the community and over half of adults aged over 85 years or in a hospital or care home setting.[iii] Older people living with frailty often experience one or more of these five common syndromes:

- Falls (e.g. collapse, legs give way, found lying on the floor)
- mmobility (e.g. sudden change in mobility, 'gone off legs', stuck on toilet)
- Delirium (e.g. acute or worsening of pre-existing confusion or memory loss)
- Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- Medication-related harms

People with frailty are at increased risk of experiencing harm (including from healthcare interventions) and a disproportionate loss of functional ability from even minor illness. The consequences of escalating frailty are adverse outcomes such as disability and its consequences, frequent hospital admissions and increasing demand for long-term social care support.[vi v] Many people with frailty will have cognitive impairment or dementia and vice versa, increasing the complexity of their care and support needs.

If we don't change the way we support older people as they age, we can anticipate a dramatic increase in frailty-related disability and dependency, escalation of health and social care costs and of the human and economic costs of unpaid caregiving, and a negative impact on survival and quality of life.[vi] However, frailty is not an inevitable consequence of ageing. It is potentially reversible, especially in the early stages.

Frailty has a range from mild to severe and its consequences can be avoided, delayed or reduced if frailty is prevented and managed well at key touchpoints across the health and social care system.[vii] Creating age friendly environments and communities where people age well, and designing a health and care system where frailty is prevented, delayed, and managed effectively are sound investments in human and economic terms.[viii] In a 'frailty informed' system, older people and all who support them will understand the impact that even a minor illness may have on functional ability and cognition. Through shared decision making, they will thoughtfully consider the balance of risk and benefit from each intervention, including a decision to admit to hospital.

Profile of Ageing in Lanarkshire

Both North Lanarkshire and South Lanarkshire Health and Social Care Partnerships (HSCPs) have seen significant increases in the population aged over 65 years with a much higher growth in those over 85 years as illustrated in Figures 1 and 2.

Figure 1

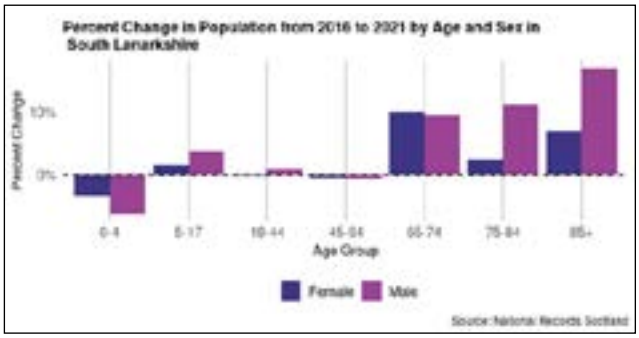
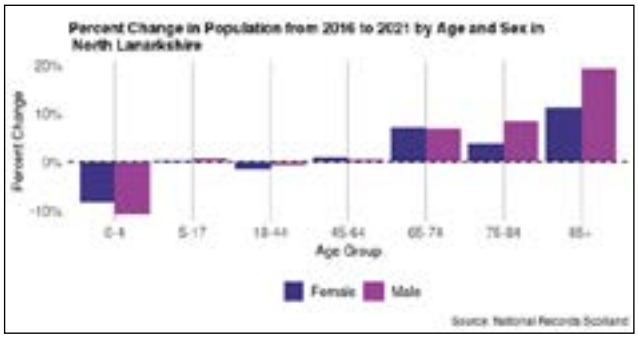


Figure 2



As they age, people are more likely to have a long term condition (LTC), as shown in figures 3-6.

Figure 3 **South Lanarkshire**

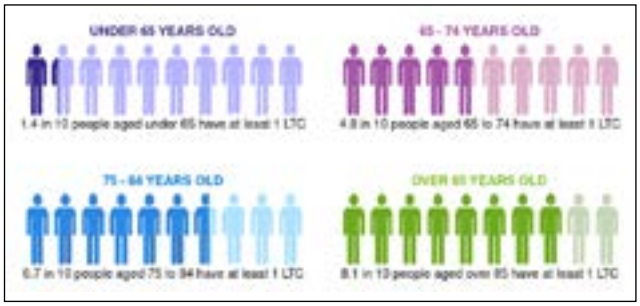


Figure 4 **North Lanarkshire**

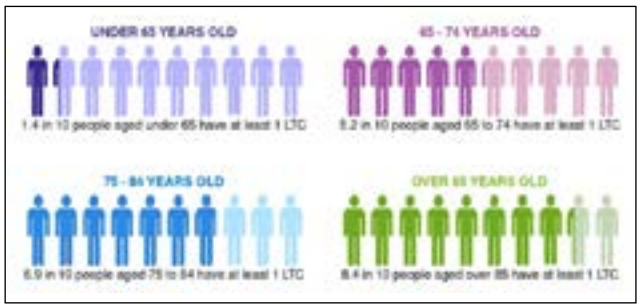


Figure 5

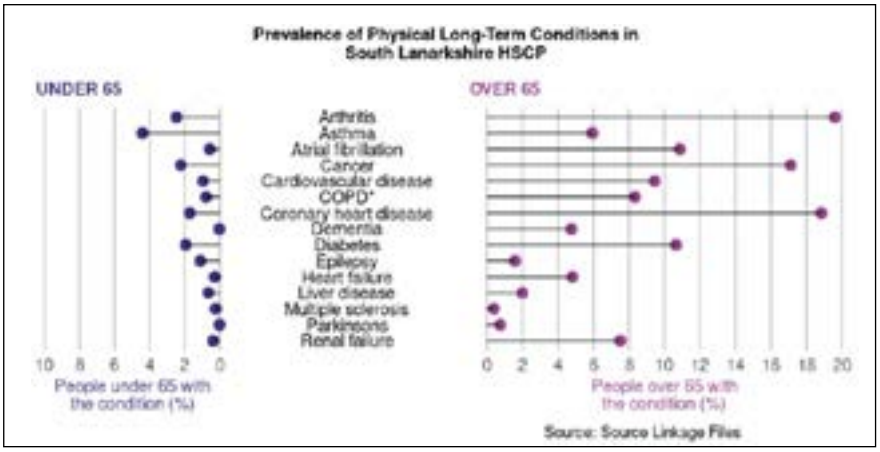
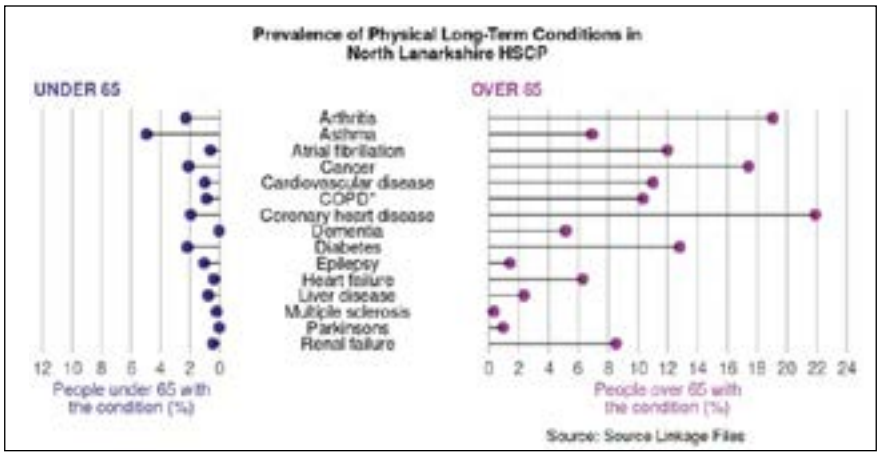


Figure 6



Compared to younger adults, older people with LTCs are more likely to have multiple LTCs (MLTCs), known as multi-morbidity (figures 7 and 8).

Figure 7

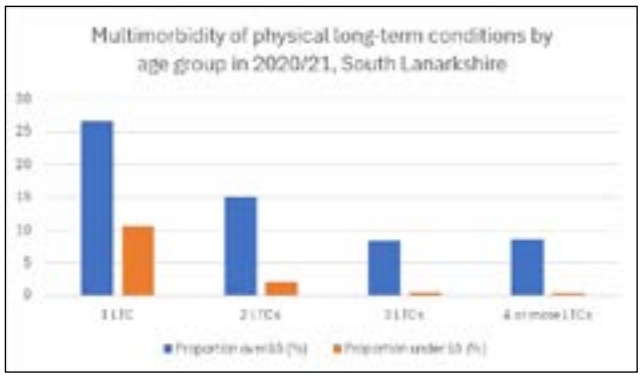
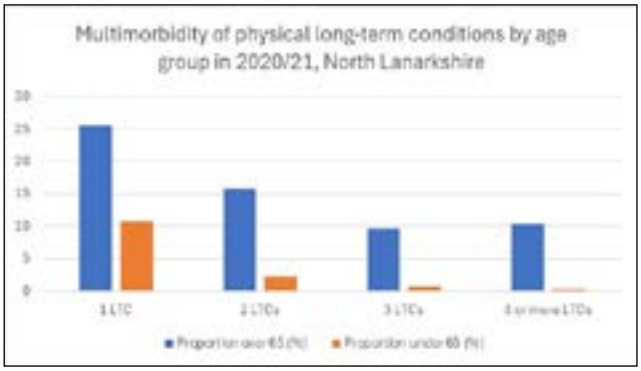


Figure 8



Having MLTCs increases the level of clinical complexity, particularly if the conditions are associated with a degree of frailty. Therefore, older people are more likely to experience health crises that result in attendance at A&E (figures 9 and 10) or emergency admission to hospital.

Figure 9

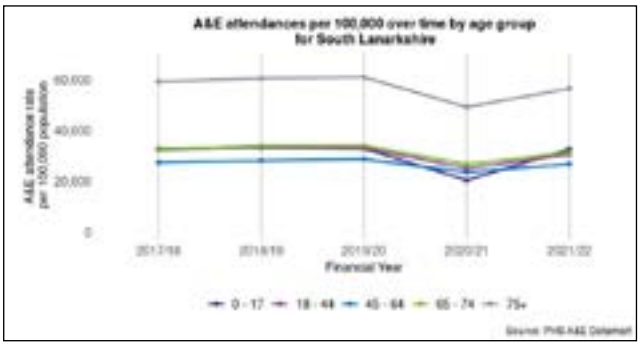
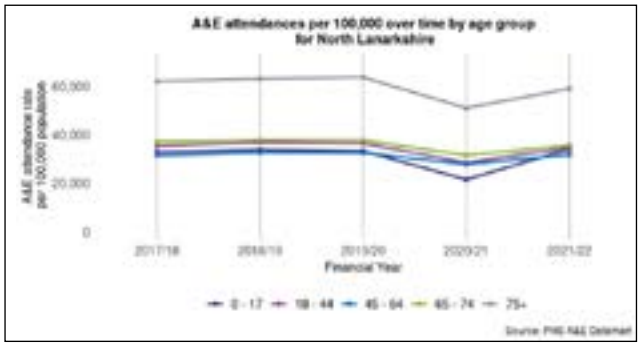


Figure 10



Compared to younger adults, when older people are admitted to hospital, their hospital stay is often longer (figures 11 and 12), associated with a delay in discharge (figures 13 and 14) and a higher risk of readmission (figures 15 and 16).

Figure 11

Figure 12

Figure 13

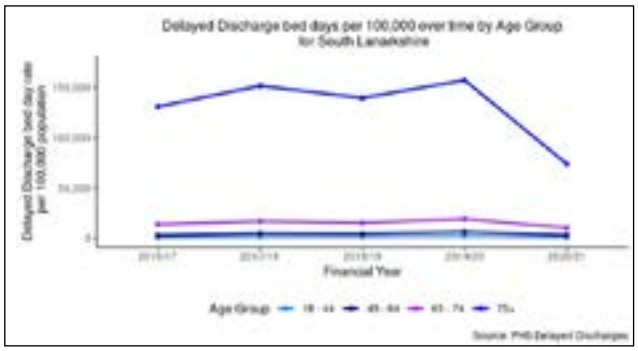


Figure 14

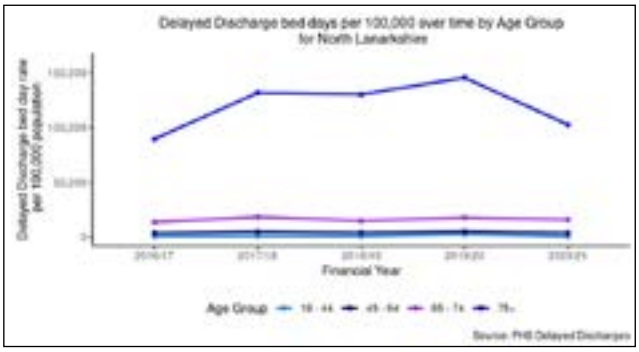


Figure 15

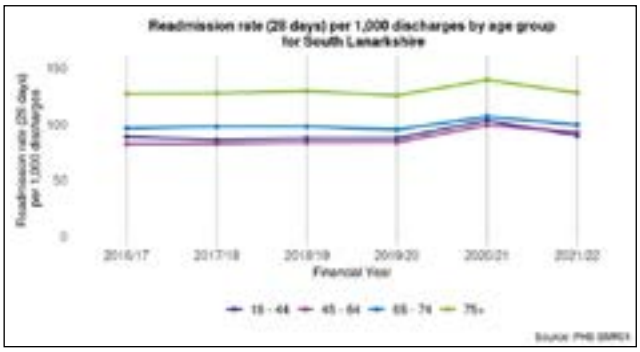
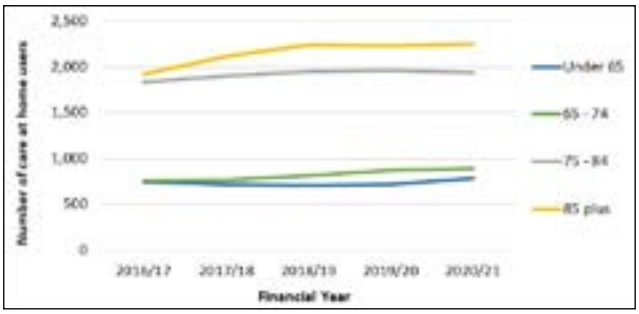


Figure 16

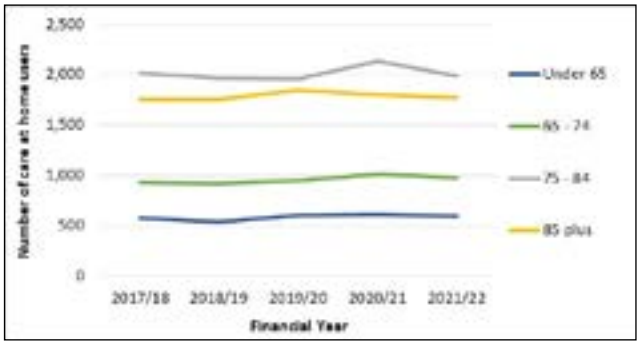
Older people are more likely to require regular support from unpaid carers and formal social care support at home (figures 17 and 18).

Figure 17 **Rate per 1,000 population of South Lanarkshire care at home users by age group and financial year**



Data Source: SWiSplus, South Lanarkshire council

Figure 18 **Rate per 1,000 population of North Lanarkshire care at home users by age group and financial year**

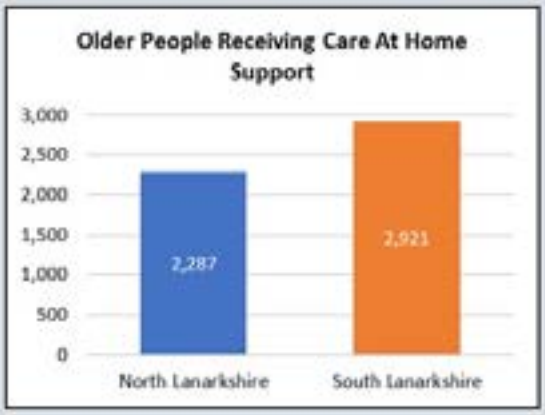


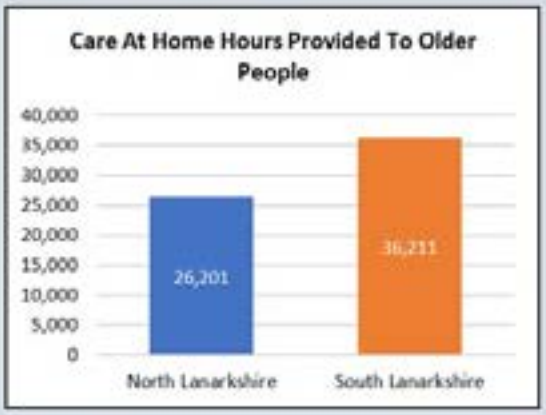
Data Source: SWiSplus, North Lanarkshire council

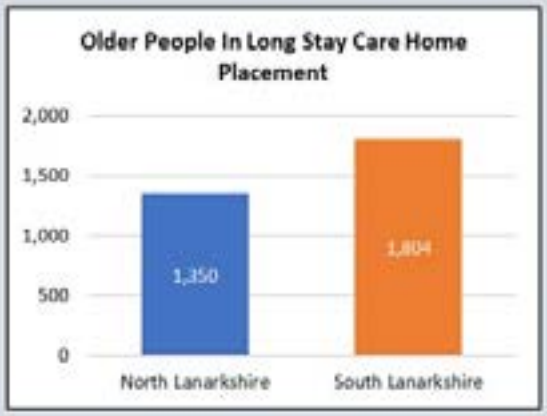
However, many older people themselves contribute support and care as unpaid carers or as volunteers.

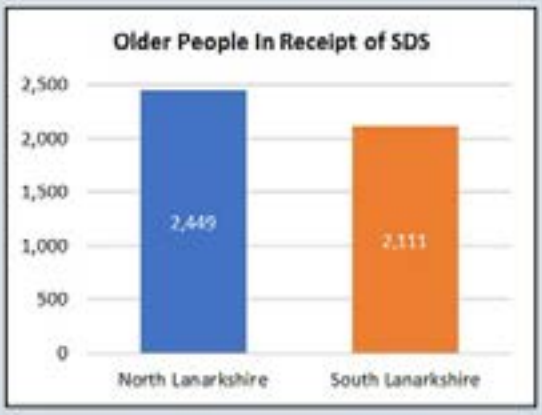
Older people are also the main users of primary care, community services, rehabilitation, residential care and palliative and end of life care services. Figure 19 presents a snapshot of supports and services used by older people in Lanarkshire at November 2023.

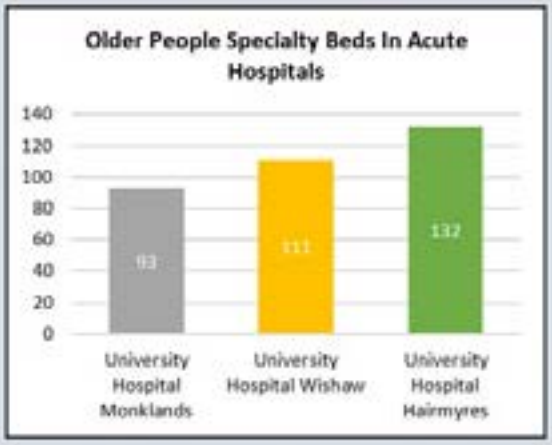
The profile of services used by older people (aged 65+) in Lanarkshire as at November 2023











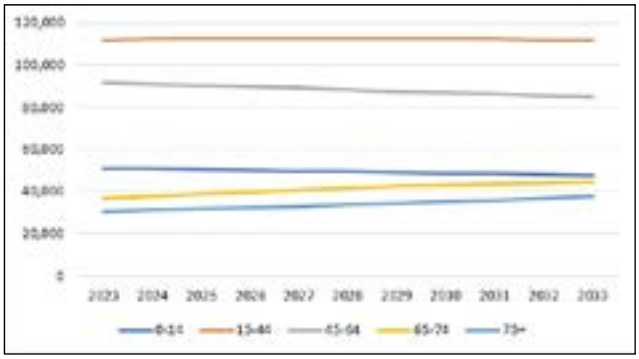
Older People Hospital At Home Capacity	90

=Legacy contracted beds

Projected Future Demand for Services

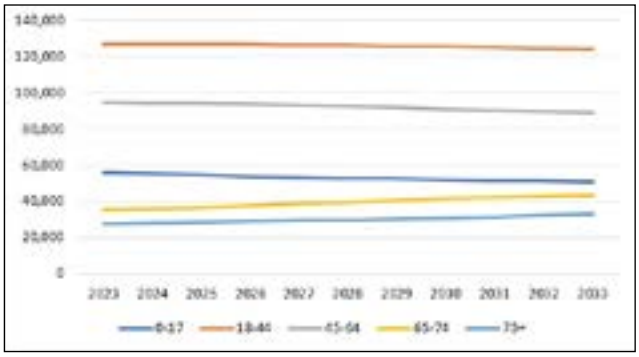
The population aged over 75 in South Lanarkshire is expected to increase by 24% in the next decade, with North Lanarkshire over 75's expected to increase by 20%, as illustrated in figures 20 and 21.

Figure 20 **South Lanarkshire projected population by age band**



Data Source: National Records of Scotland population projections

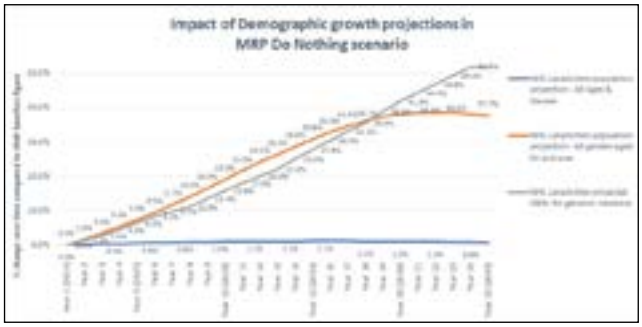
Figure 21 **North Lanarkshire projected population by age band**



Data Source: National Records of Scotland population projections

Data analysed for the University Hospital Monkland rebuild programme (MRP) projects a significant growth in demand for local hospital services over this period. The highest projected growth is for the geriatric medicine specialty, with a steady growth in the oldest old increasing the demand for inpatient beds year on year (figure 22).

Figure 22 **Impact of Demographic Growth Projection in Monkland Rebuild Programme 'Do Nothing' Scenario**



This trend would be mirrored at the other Lanarkshire acute hospitals. Without a shift in the way we plan and deliver care for the growing number of older people with MLTCs and frailty, the projected increased requirement for acute care will be matched by an increase in need for care at home as well as primary care, community services, rehabilitation, residential care and palliative and end of life care. This comes at a time when we are facing many challenges in recruiting and retaining our workforce.

Older people are the main users of both emergency and planned care, meaning work in these areas must consider the specific needs of older people with frailty. We will ensure this strategy informs and supports the work of these groups and emerging plans for people living with long term conditions, cancer, dementia, falls, and palliative and end of life care, and builds on the commitments of the Strategic Plans for the North and South Lanarkshire HSCPs.

3 How this Strategy was developed

This strategy has been developed by an interdisciplinary and cross sector group chaired by the Nurse Director, Health and Social Care North Lanarkshire. Membership included:

- HSCPs: Heads of Health, medical, nursing and AHP representation
- Acute: Clinical Leads COTE, Hospital at Home, operational and nursing leads;
- Corporate: Public Health, Health Improvement, planning leads, staff-side, EDI lead
- Third sector representatives including older people and carer advocacy
- Community representatives
- Local Authority representatives

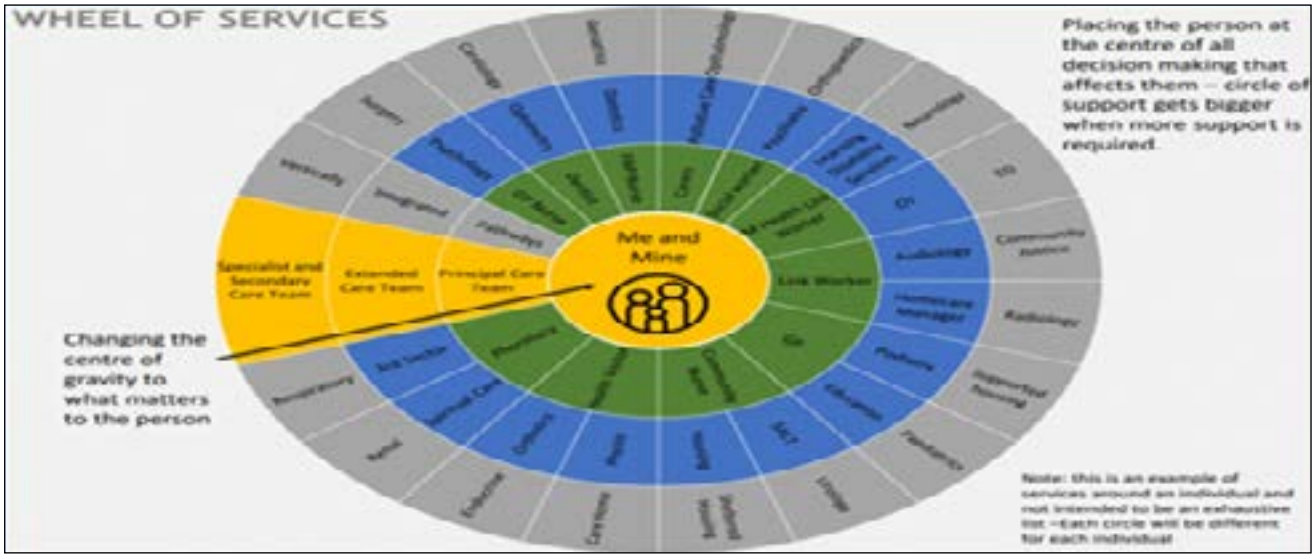
Members of the strategy group engaged with their respective networks and formed five short life working groups to explore what changes are required at different parts of the system to improve how we work together to prevent and manage frailty. The five working groups sense- checked and further developed their proposals through six whole system stakeholder events hosted between August 2022 and March 2023. Detailed work on acute services was developed further through Operation Flow task and finish group five.

In developing their new Strategic Plans, both North and South Lanarkshire HSCPs involved local communities, older people and carer representatives. We have drawn heavily on this lived experience and on recent engagement by North Lanarkshire's Getting It Right for Everyone (GIRFE) Pathfinder for older people and frailty. GIRFE places the person at the centre of all decisions that affect them to achieve their best outcomes, through a joined-up, coherent and consistent multi-agency approach (Figure 23). [ix]

This strategy embraces the **GIRFE five key principles:**

1. Focused on individual care needs
2. Based on an understanding of the physical and mental well-being of individuals in their current situation
3. Based on early intervention
4. Requires joined-up working/information sharing
5. Based on a human rights approach

Figure 23



4 Our Vision

Every older person in Lanarkshire with, or at risk of, frailty is supported to be healthier, to remain independent for longer and to live their best lives. All partners work together, and with older people, unpaid carers, families and communities, to prevent, detect and delay escalation of frailty through proactive, personalised, coordinated support at home, or closer to home, and age attuned integrated acute and community services.

Ways of Working

Promoting Health and Wellbeing

- We will work with Public Health and community partners to build social capital, community assets and create inclusive, compassionate, age and dementia-friendly communities
- We will deliver wide and inclusive public messaging on healthy ageing and wellbeing in later life
- We will ensure systematic identification of frailty in all care settings to allow early intervention through a proactive, anticipatory and enabling approach, avoiding crisis wherever possible
- We will enhance digital inclusion with community partners and use technology to support older people to remain well and independent in the place they call home for as long as possible and to mitigate deterioration and complications

Tackling Inequalities

- We will ensure non-discrimination on the basis of gender, age, ethnicity, sexuality, physical function, cognitive ability, social or economic circumstances or place of residence - so all people experiencing frailty access the right care, at the right time, in the right place
- We will co-design services with older people, families and carers for inclusion and equity and to recognise and mitigate health inequalities across communities and all life stages
- We will involve carers as equal partners and offer information and support to support carers to remain well and reduce carer strain
- We will build confidence and capability for comprehensive person centred assessment relevant to their role for all disciplines and in all care settings

Delivering Sustainable Healthcare

- We will scale up proactive future care planning and support for people with frailty in each locality, working together to plan and coordinate care, support wellbeing and optimise independence
- We will deliver high-quality emergency care attuned to the needs of older people with frailty with a specific focus on the first 72 hours through pathways that fully integrate urgent community response, short term hospital level care at home, and acute assessment in hospital
- Urgent community response in all localities will be well aligned with goal oriented reablement, intermediate care and rehabilitation that enable people to regain their independence
- All hospitals teams will plan for discharge from admission, take actions to reduce deconditioning, identify and manage delirium and work with community partners to reduce length of stay and improve transitions of care
- Outpatient and ambulatory care models will be accessible for older people and offer same day, 'one stop' and virtual options for pre-assessment, assessment and follow up consultations that value patient, carer and staff time and reduce carbon footprint
- We will enhance healthcare support for residents in Lanarkshire care homes

5 Jeanie's Journey

The strategy considers what we need to do at specific system Touchpoints to improve outcomes for people such as Jeanie, for her family and for the health and care system.

Jeanie is 81 years old, a widow who lives alone and is independent but uses a stick to walk outside. She has high blood pressure, hypothyroidism, pernicious anaemia, osteoarthritis and cataracts in both eyes and takes eight different medicines. She attends the practice nurse every three months for blood pressure checks. Jeanie used to play bowls regularly and get the bus to the shops with her friends but recently stopped doing these activities as her eyesight is failing. She missed her optician appointments during the pandemic. She feels less steady on her feet and is afraid she may fall. Now she generally only goes out with her family in their car.

One afternoon she went out to the shops alone to buy a birthday gift for her daughter. Unfortunately, she tripped over a paving slab and fell. She was shaken but thankfully was not badly hurt. A passing driver took her home. Jeanie called her GP surgery and was given an appointment for a check-up with the nurse who referred her to a local exercise class. However, Jeanie didn't want to go along on her own. She still felt stiff and sore from her fall. She began to spend more time in bed and couldn't be bothered cooking. As the weeks went by Jeanie became more anxious and depressed, felt weaker and struggled to get up and down the stairs at home.

Jeanie's daughter visited one weekend and found her mum to be muddled, unable to get out of bed, and had been incontinent. She called 111 and Jeanie was referred to hospital. Doctors in A&E diagnosed a chest infection and delirium as a complication of her immobility. Jeanie was admitted to hospital after some hours waiting for a bed. The only bed available was in a surgical ward.

Jeanie improved after a few days of antibiotics and fluids and was given a walking aid and helped to mobilise again. She wanted to return home but her daughter was worried that the same issues may recur. She had caring responsibilities for her own grandchildren and asked if it would be better to think about Jeanie moving into a care home. Jeanie's return home was deferred until a full assessment could be carried out. Unfortunately, while undergoing rehabilitation and assessment in the ward, Jeanie fell and sustained a hip fracture. Progress after surgery was slow, complicated by recurrent urine infections and another episode of delirium. The whole team were unsure if Jeanie would be able to return home now.

- What could help Jeanie stay well and remain independent for longer?
- How might proactive care and early intervention delay her health decline?
- What could support her care at home / timely return home in a crisis?
- What enhanced support will she need if she moves to a care home?
- How can we build a workforce that is fit for frailty?
- How can we create the conditions for more collaborative working together?

6 Key Touchpoints

Promoting wellbeing and independence

Ageing well enables older people to achieve the things they value, fosters social participation, helps to prevent isolation and has much broader benefit for our society and local communities.[x] Those with the least resources or who live in the poorest areas are most at risk of poor health.[xi] Poor health in later life can also take a heavy toll on unpaid carers and families. Achieving good health outcomes requires much more than just good healthcare. Affordable transport, easily accessible streets, buildings and green spaces, supportive age friendly communities, social connections and opportunities to participate are all crucial to wellbeing in later life.

Modifiable risk factors for frailty are also risk factors for dementia so a preventative approach will impact on both conditions.[xii] Loneliness and social isolation are associated with higher mortality, increased risk of heart disease, stroke, high blood pressure, depression and suicidal thoughts, and contribute to frailty and dementia risk as much as physical inactivity.[xiii] Regular exercise, particularly strength and balance training, reduces falls and slows progression of frailty.[xiv] People with communication, cognitive, sensory or physical impairments may need tailored support to take part in physical activity and to access other key interventions such as immunisations. Inadequate nutrition is an important modifiable risk factor for frailty and falls and is highly influenced by poverty, food insecurity and social networks.[xv]

What we are doing now:

- Locality Planning Groups for Frail Elderly and LTC (FELT)
- Comprehensive immunisation programmes that target older people
- Community Solutions programme in North Lanarkshire
- Training in community led support and asset based community development
- Third sector and community partners support our workforce to co-produce care and support with a more holistic, person centred and inequalities focus
- Social prescribing support, GP link workers and development of community assets and third sector capacity and resources for health and wellbeing
- Carer Support Link Workers based within Acute Hospitals offer staff training in holistic needs assessments for patients and their carers
- Investment in technology enabled care with initiatives such as Making Life Easier app and website in North Lanarkshire, and the Locator tool in South Lanarkshire
- Blantyre Life campus for technology enabled housing with care services
- Use of telecare and assistive technologies across both HSCPs
- Exercise prescriptions for leisure services and NatureScot: Our Natural Health Service
- Working with library services on information and support for self-management
- Implementing Lanarkshire's strategy to prevent falls and fractures
- Collaboration with Scottish Fire and Rescue service on home safety visits
- South Lanarkshire Council has committed to being an Age Friendly Council

What we will do more of:

- Support staff to have strength based, good conversations on What Matters to You with information, advice and resources for healthy ageing and self-management
- Improve staff awareness and confidence to refer/ signpost to community, CVS partners and NHS services such as smoking cessation and exercise programmes
- Use information from all partners to ensure preventative supports and services reach older people who are at greatest risk of frailty, addressing current inequity of access
- Develop a Lanarkshire-wide cross sector "good practice" and information sharing forum on healthy ageing and preventing frailty involving voluntary sector, primary care, community and acute staff
- Ensure the appropriate CVS organisations and statutory staff are linked into Locality Planning Groups for Frail Elderly and LTC (FELT)
- Link people at risk of frailty and people living with frailty more quickly into community supports which will benefit their mental and physical wellbeing, reduce social isolation and enable them to develop wider social networks
- Increase investment in Social Prescribing with longer term financial support to CVS partners so that initiatives can be scaled up and embedded in communities
- Provide more information, advice, education and support for unpaid carers to stay well and continue in their role
- Build on established community and intergenerational assets and networks
- Promote use of Making Life Easier (MLE) and other digital tools, addressing inclusion
- Support early self-identification of frailty through public health promotion campaigns including intergenerational work with schools and nurseries

What this would mean for Jeanie:

When Jeanie sees the practice nurse for her blood pressure check they talk about what matters to Jeanie and what she can do to stay well. They discuss her family support and social networks and why Jeanie has stopped seeing friends and going to the bowls. The nurse wonders if Jeanie's cataract has deteriorated and recommends she makes an appointment with her optician. They agree that getting back to bowling would allow her to keep fit and catch up with old friends but Jeanie says she won't go along on her own.

The nurse refers Jeanie to a Link worker who calls and arranges to meet with her and her daughter at home. The Link worker identifies a local walking group and a volunteer befriender who will support Jeanie to rebuild her confidence going out walking and travelling by bus to the bowling club.

Jeanie's optician diagnoses macular degeneration and refers her for urgent outpatient treatment to prevent this worsening. Jeanie's local library provides information and resources on keeping active at home and how to reduce her risk of falling.

Planned and Proactive Care

The identification of frailty is everyone's business. Earlier and targeted intervention requires a simple, easily reproducible, validated tool that the public and non-specialist workforce can use. The Rockwood Clinical Frailty Score[xvi] is proving useful in a pilot with district nurses but other tools may be more suitable for lay workforce and the public. Older people living with frailty can be identified routinely in primary care using the electronic Frailty Index.[xvii]

Many professionals, services, community partners, family and unpaid carers will contribute to an individual's care and support, often with little or no communication between them. People with significant or escalating frailty should be offered a comprehensive multi-disciplinary assessment and personalised interventions co-ordinated by a local multidisciplinary team (MDT) of healthcare, social care and community or voluntary service partners working together. The older person and their unpaid carer or family should be involved in developing a personalised care plan based on their goals and preferences. 'Polypharmacy', the prescribing of multiple medicines, increases the likelihood of experiencing harmful side effects. People with frailty require medications to be tailored to their individual needs rather than strictly following guidance designed for single diseases.

Structured medication reviews[xviii] allow patients to make informed decisions and prioritise medicines for continuation or discontinuation, in order to maximise benefit and minimise harm. Emerging evidence shows that this proactive approach can improve care continuity and co-ordination, reduce medicine related harm and costs, and reduce emergency attendances.

What we are doing now:

- Enhanced primary care teams have additional roles including Occupational Therapist, Physiotherapist, Pharmacist and GP link workers in line with the Primary Care Improvement plans. This provides a foundation for a proactive MDT approach
- Coatbridge locality Frailty MDT pilot in selected GP practices to identify escalating frailty. Selected patients are offered a face to face 'What Matters to Me' conversation with a trained professional from a local advocacy organisation. This conversation is an opportunity for a shared decision-making approach to future care planning, assessment of frailty and carer's assessment. The advocacy worker discusses the assessments with the locality virtual MDT who formalise a diagnosis of frailty, allocate a key worker, organise a medication review and additional interventions tailored to the person's priorities and values. Piloting a similar virtual MDT in seven care homes
- Introduced Future Care Plans for people with MLTCs and in care homes
- Testing care co-ordination for people with complex needs in two localities
- Targeting earlier evidence based interventions for people at risk of falls and fracture
- Testing use of participatory design to develop a relational and proactive technology enabled approach for people who have presented with falls or syncope

What will we do more of:

- Identify and target individuals who do not engage with Primary Care services who may be on the cusp of decline and are likely to benefit from proactive care
- Support individuals to stay well in their own homes by addressing income maximisation, food and fuel poverty, as well as physical and nutritional needs
- Include frailty screening within the pre-assessment process prior to elective surgery and consider implications for treatment escalation plans and discharge planning
- Design a referral pathway and process for holistic assessment, early intervention and person centred goal setting for individuals considered to have mild frailty
- Consider using the skills and experience of voluntary sector partners for initial holistic assessments and care coordination for mild frailty, with clear criteria for escalation
- Adapt the community frailty MDT and care co-ordination model to all localities, recognising the exact model may differ between localities
- Further develop the Locality Response model as a virtual MDT to coordinate care for those with the most complex needs, supported by a Single point of access / hub(s) as community front door(s) in the demonstrator localities
- Test the advanced practitioner for frailty role in localities
- Wrap care and support around the person, involving those who are important to them in the caring circle
- Improve the recording and sharing of assessments and care plans with all partners

What this would mean for Jeanie:

After her fall, Jeanie's practice nurse discusses her changed condition at the locality frailty MDT. The pharmacist reviews her medicines and suggests reducing the dose of one of her blood pressure medicines and changing her painkiller to reduce the risk of falling. Jeanie is seen by the falls team physiotherapist who gives her some exercises she can do at home to improve her strength and balance. The occupational therapist visits Jeanie at home to provide advice on how to adapt to her failing vision. She requests a grab rail for the front and back steps. The telecare service make contact and Jeanie takes up the community alarm service. This provides her daughter with much needed reassurance.

The link worker provides information about Making Life Easier and how Jeanie can access dial-a-bus to attend her planned ophthalmic appointments. The GP has a conversation with Jeanie about her wishes for her future care and completes a Key Information Summary which is available for Out of Hours services and acute care staff to view in a crisis.

Jeanie asks her daughter to be her welfare power of attorney and makes the application.

Urgent Care

A journey through acute hospital care can be complex and potentially harmful for people living with frailty. Multiple ward moves increase the risk of delirium and deconditioning and reduce the likelihood of returning home. Comprehensive Geriatric Assessment (CGA) by a team skilled in managing frailty and practising Realistic Medicine is highly cost-effective.[xix] CGA arranges relevant diagnostics, delivers timely tailored interventions, proactive discharge planning and access to transitional care, reablement and intermediate care services at home or in a step down bed.[xx] Hospital at Home offers short term hospital-level care at home for selected patients with acute conditions that would normally require an acute hospital admission.[xxi] Outcomes are at least equivalent to those of inpatient care.[xxii] [xxiii]

We aim to ensure that every older person living with frailty in Lanarkshire is able to avoid emergency hospital admission, if safe and appropriate, and return home without delay. This requires the right care and support to be available to manage the acute crisis along with reablement and rehabilitation to avoid cyclical decline. Acute services have a duty to foster stronger multi-disciplinary links with community and primary care teams and to provide the required specialist advice and support to avoid crisis admissions. Local demographic and geographic factors need to be considered when designing urgent care services so they are equitable but flexible to the needs of different communities. A 'one model fits all' approach will not suit a diverse area like Lanarkshire. Effective interface working requires better communication, embracing novel technology to raise awareness of the capability of community services, community and third sector supports. We look to Lanarkshire's digital health and care strategy to improve the sharing of information so that everyone involved in an individual's care can access and record the relevant results, medication changes, functional abilities and wishes for future care including treatment escalation planning.

What we are doing now:

- Hospital at Home (H@H) services operates across the majority of Lanarkshire
- Reinstating the urgent locality response model in East Kilbride and testing a model for rapid triage and urgent MDT response to crisis in Wishaw locality
- Enhancing capacity for community nursing and health care support workers
- Established Home First team in South Lanarkshire and Home Assessment Team in North Lanarkshire to facilitate timely and successful discharges
- Reviewing reablement and community rehabilitation capacity
- Introduced a technology enabled intermediate care housing development at Blantyre
- Introduced a Flow Navigation Centre for urgent referrals to acute care
- Consultant Connect building great relationships between hospital / community staff
- Enabled access to Key Information Summaries for ED and Out of Hours staff
- Expanded the Acute Care for the Elderly practitioner posts in the three acute hospitals
- Roll out of Planned Date of Discharge for the Discharge without Delay programme

What will we do more of:

- Include a baseline Rockwood Clinical Frailty Score with the Key Information Summary on a sharable Electronic Health Record to support decision-making by paramedics and Out of Hours' services and introduce the tool in ED
- Further develop 'call before convey' and community falls response pathways and protocols with the Scottish Ambulance Service, telecare providers and Care Homes
- Scale up the Consultant Connect for specialist telephone advice, triage and rapid access to outpatien
- At clinic appointments or Hospital at Home alternative pathways
- Ensure early identification of frailty in the ED to trigger early comprehensive front door assessment by staff with expertise in frailty
- Assess older people in an acute frailty unit or frailty–friendly environment, with rapid 'pull' pathways to the right specialty bed, H@H or locality MDT support
- Right size capacity required to manage older people with frailty in an acute Frailty Unit or ward staffed by teams trained in Comprehensive Geriatric Assessment
- Make transferring older people with frailty to a ward that is not attuned to meet their specialised needs a 'never event' because of the associated potential harms
- Develop transitional care follow up processes that include anticipatory care planning and treatment escalation plans for people at high risk of decline and readmissions
- Learn from the two locality urgent response models and scale up the approach, introducing single points of access to urgent care in each locality
- Consolidate and enhance community reablement, intermediate care and rehabilitation capacity to support recovery of independence at home
- Review the capacity, function and staffing associated with community beds across Lanarkshire to improve their contribution to specialist led step up and step down intermediate care, interim care and hospital based complex clinical care

What this would mean for Jeanie:

Jeanie's Key Information Summary flags she has frailty and wishes care at home. The flow navigation centre directs the call to ED as H@H does not yet accept new referrals at weekends. ED staff complete a frailty score and Jeanie is fast tracked to the acute frailty team. They commence treatment and start to mobilise her immediately, moving her to a ward designed to meet her needs to manage her delirium and chest infection. A frailty icon on the hospital electronic patient record flags her as high risk for boarding. The ward MDT links with H@H and Home First on Monday and plans discharge for when intravenous antibiotics switch to tablets. The MDT involve Jeanie and her daughter in her discharge planning so they are confident the support and equipment will be in place. Jeanie returns home and is monitored by the H@H team for a week. Her daughter stays with Jeanie for a few days to help her settle back home.

The reablement team supports Jeanie to regain her independence over the next month and the locality MDT co-ordinates her care and support. Jeanie reconnects with her friends.

Enhanced Support in Care Homes

The Scottish Government Healthcare framework for adults living in care homes[xxiv] outlines six key elements to enhance clinical and care support. This is done through a strong partnership approach that recognises the knowledge and experience of care home staff and wraps care around the resident. The enhanced approach is illustrated in Figure 24, reproduced from the.

Figure 24 **Scottish Government, My Health, My Care My Home framework**

What we are doing now:

- Established a Care Home Assurance Team
- Expanded the number of Care Home Liaison nurses across Lanarkshire
- Appointed a Practice development educator for care homes
- Delivered an initial six month education programme for care home staff
- Piloted and developed a model for Frailty MDT meetings in care homes
- Increased the uptake of anticipatory care planning
- Piloted the use of the ReSPECT document
- Introduced care home pharmacist sessions to review and optimise polypharmacy
- Reduced the use of medicines associated with falls and harm and related costs
- Aligned many of our care homes with GP practices using a local enhanced service (LES)
- Testing extended hours for Hospital at Home support for care homes
- Scoping an alternative pathway for radiology and specific flow navigation response

What will we do more of:

- Rebrand the Care Home Assurance Team to a Care Home Support Team reflecting a shift from inspection to a model of assurance based on appreciative inquiry and a focus on clinical support by care home liaison nurses
- Improve collaborative working by ensuring care homes are fully involved in co-design of improvement projects
- Improve access for residents by using technology and remote consultations
- Review the LES contract arrangements, listening to concerns of GPs and care homes and promote GP uptake of LES for care homes without this service to improve resident access to primary care
- Recruit dedicated care home pharmacists to ensure a realistic medicine approach for all new residents in care homes
- Continue to roll out the Care Home MDT model - set to expand to 24 care homes
- MDT to review clinical portal referrals for assessment and treatments of residents to ensure they are still appropriate

- Promote use of SBAR to communicate in acute and emergency situations
- Explore professional to professional lines of communication
- Extend availability of Hospital at Home hours support to residents in care homes
- Explore mechanisms for care homes to stock certain drugs
- Use a standard transfer document to improve communication at care transitions
- Promote the adoption of Enriching and Improving Experience framework and Scotland's Bereavement Charter within care homes

What this would mean for Jeanie:

Over time, following a series of further health problems, Jeanie and her family come to a shared decision with the locality MDT to move to a care home. A comprehensive clinical transfer document gives the care home the information they need to care for Jeanie.

Jeanie's social worker reviews her progress in the care home, within 4-6 weeks, involving staff and family. Care Home staff work with Jeanie and her family to develop a personal care plan that includes future care planning and ReSPECT document. The Care Home liaison team provide support and training to the Care Home staff as required. The GP aligned to the Care Home undertakes a full medical assessment and review of her medication within 4 weeks of admission. and polypharmacy.

Staff help Jeanie use video-consultation for her healthcare appointments to reduce travel and future health crises are managed in the care home by the locality MDT with advice and support from Hospital at Home if required.

7 A Workforce Fit for Frailty

Older people are already the main users of healthcare and social care and support. That means the majority of the health and care workforce will care primarily for older people. All workers, in the context of their own role and work remit, have a unique and essential role in responding to people who are affected by frailty. This doesn't mean that everyone needs to be an expert in frailty. A wide range of expertise and skills are required to support people in different settings. The inclusion of guidance and competencies in preventing, identifying and managing frailty within educational curricula and quality standards is critical to help skill up the wider workforce. Developing an integrated workforce fit for frailty is a vital step for realising our vision and to deliver the best possible health and social care for older people. The Skills for Health Frailty Core Capabilities Framework[xxv] provides a single, consistent and comprehensive framework on which to base workforce development. The framework builds on, and cross-references, other core skills frameworks for dementia, end of life care and person-centred approaches. Fifteen core capabilities are defined for **three tiers of stakeholders**:

- **Tier 1** Those who require general awareness of frailty
- **Tier 2** Health, social care and others who regularly work with people living with frailty
- **Tier 3** Health, social care and other professionals who provide expert care and lead services for people living with frailty.

Figure 25 illustrates our proposed four tier approach that includes a Tier 0, building greater public awareness of frailty, how to prevent frailty, and how to access support to live our best lives.

Figure 25

The group has reviewed the range of educational resources on frailty available to people working at these different tiers and in all care settings. These include outputs from a local Frailty Matters project that involved citizen co-coaches to strengthen the leadership role of community nurses in managing frailty within interdisciplinary teams.[xxvi]

What will we do more of:

- Raise public awareness of healthy ageing and what people and communities can do to promote wellbeing in later life and prevent frailty
- Support citizens and staff to identify early signs of frailty using validated tools
- Support community and voluntary sector staff to carry out an initial assessment of people who present with early signs of frailty, with clear criteria for escalation
- Scale up training in community led support, asset based community development approaches and enabling self-directed support
- Develop an education and training plan to enhance knowledge and skills on frailty in all staff who regularly provide care and support for older people
- Improve confidence and capability of staff in using and demonstrating assistive technologies and digital solutions to enable people to have greater choice and control in their care and support
- Develop advanced practice skills in frailty for a greater number of staff and disciplines who work in community settings
- Identify opportunities for shadowing and rotational posts to promote system wide understanding and capability to prevent, detect and manage frailty
- Support staff to work differently in new roles / in new ways with more autonomy
- Build greater readiness for relational working and collaborative practice

What this would mean for Jeanie:

Jeanie had heard about healthy ageing and preventing frailty in a talk at her local church and had picked up some information from her local library. Her family had noticed information on line about staying active and Making Life Easier.

Jeanie's GP practice team and the staff in the local pharmacy have had training in identifying the early signs of frailty and know where to signpost Jeanie. The locality MDT have had training in good conversations and in using the Clinical Frailty Score to identify the suspected level of frailty. Each locality has a sufficient number of staff from different disciplines who are trained in comprehensive holistic assessment of frailty and coordination of care. Each locality has a sufficient number of staff who have advanced practice skills in case management of people with complex needs associated with frailty.

Everyone pulls together to support Jeanie achieve what matters to her with the people who are important to her and to live her best life.

8 Realising our Vision

To successfully prevent and manage frailty, reverse cyclical decline, and reduce crisis admissions, we need to scale up proactive, person centred and integrated care and support and effectively manage transitions when the individual or carer's condition or circumstances change. This requires a collaborative approach where all of our workforce have a better understanding of each other's roles and where they can add value, minimising repetition and waste. Building relationships and trust within MDTs and at the interface between teams and care settings is critical for successful continuity and coordination. Excellent communication and information sharing is an important enabler of informational continuity and we look to the digital health and care strategy for the required infrastructure and resources.

Geriatric medicine is the largest clinical specialty in NHS Lanarkshire with over 514 acute and community hospital beds, 90 hospital at home beds and a range of outpatient clinics across many sites. It is recognised as a progressive service in Scotland but specialist resources are not equitably distributed and some communities are relatively underserved. The specialty recognises the need to become even more community facing and to explore new roles and novel technologies to extend its reach. To realise our vision and transform care for people living with frailty will require collaboration, innovation and improvement across disciplines, in all care settings and on a multi-sector basis across Lanarkshire.

We will take forward three strategic actions to enable this transformation:

1. Establish a Lanarkshire-wide **Frailty network** supported by a clinical lead, nurse/ AHP consultant and dedicated QI capacity. The multidisciplinary, cross sector network will seek ways to include the voice of lived experience of frailty so staff from all disciplines and partners can learn from experts by experience, share good practice and exchange learning with colleagues across Scotland and beyond.
2. Develop a **Quality Assurance Framework and Quality dashboard** of key indicators to track system performance, using mixed methods to analyse what matters to people, professionals and the health and care system. This will help identify and challenge unwarranted variance in practice, lever professional curiosity and pride to ensure the highest quality of care in all settings, and enable the best outcomes for people, professionals and the system.
3. Collaborate with NHS national boards and local universities to create a virtual **'Living Lab'** to foster innovation, action research and evaluation of our collective efforts to promote healthy ageing and prevent and manage frailty.

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