

## **Development of an Action Plan to reduce the impact of Frailty in the Southern AIPB area**

### **1. Introduction**

This paper seeks to summarise the planning process which Southern Test AIPB members undertook, and outlines the development of the draft AIPB Frailty Plan. This Plan provides the Shadow AIPB with an opportunity to consider taking it forward as the initial step in the development of the Shadow's AIPB Area Health and Well-Being Plan and in line with the strategic direction and the Health Minister's priorities.

In the Minister's statement (July 2024) he gave a commitment to addressing health inequalities and that it must be at the heart of health reform and a priority across all parts of Government. It has been evidenced that populations experiencing inequalities are more likely to experience premature frailty and those with the greatest need often also have the greatest difficulty in accessing and receiving appropriate care and support. This draft AIPB Frailty Plan is the first step in identifying those with frailty putting in place measures to slow its onset or progression, and potential reversal of symptoms enabling people to live independently for longer and help to reduce demand for emergency care and long-term support.

### **2. Background**

Each AIPB is a planning body for its geographical area with responsibility for exercising the following functions:

- identifying the health and social care needs of their local population (supported by a population needs assessment);
- agreeing on the priorities from the identified need, aligned under a Strategic Outcomes Framework;
- developing a plan to meet those needs; and
- developing and providing recommendations on the distribution of available resources to meet those needs.

The Test AIPB provided a mechanism to bring together a wide range of partners working locally in partnership beyond the HSC, to identify local needs, agree priorities and identify what cross-sector collective action should be taken to effect change with a focus on prevention, early intervention and community health and wellbeing. The Test activities in the Southern Area were aimed at enabling the ICS programme team to further refine the design of AIPBs, understand the needs of the organisations and sectors involved, as well as supporting the establishment of strong foundations for integrated working and provide an environment to test key aspects of the model in practice.

The Southern Test AIPB has been operational since April 2023 to assess the ability to deliver on the aforementioned functions, with an initial timescale to cease the operation of the Test AIPB in December 2023. However, a decision was made by the Test AIPB members, and approved by the ICS NI Steering Board, to continue the work and momentum of the Test until the establishment of Shadow AIPBs. This period of extension of the Test has enabled members to review the feedback of evaluation report and provided an opportunity for all partners to influence the further development of the plan.

### **3. Planning Process**

The Test AIPB members worked through a planning process which included:

- Analysis of Population Health Data for Southern population (*June 2023*)
- Workshops which identified local priority issues, initially agreed as Children & Young People, Mental Health and Frailty. (*June 2023*)
- Input from Strategic Partners in the PHA, SPPG and Trust to help understand the current evidence base, baseline services or interventions and the key challenges for each of these areas (*August and September 2023*)

To support AIPB members' work through the planning process, an informal working group was established by the SPPG and PHA partners to progress actions which had been agreed at AIPB Board meetings. This group met weekly; whilst membership changed over the planning period as the AIPB became more specific about their priorities, core membership included representatives from SPPG, PHA, DOH and Trust. Its purpose was to collate information from a range of sources, primarily from colleagues who were working in commissioning or providing Trust services or programmes in the areas of Children & Young People, Mental Health and Frailty. Online presentations from these individuals were prepared and they attended AIPB Board meetings to assist in discussion.

### **4. Focus on Frailty**

Test AIPB members considered the 3 identified priorities above and acknowledging that this was a test environment with limited timelines it was agreed that the AIPB would focus on one key priority area – Frailty. This included getting a deeper understanding of the problems and gaps around frailty in the Southern area, as well as seeking expert advice and recommendations around potential actions for improvement. The 2023 British Geriatric Society (BGS) Report [Joining the dots: A blueprint for preventing and managing frailty in older people | British Geriatrics Society \(bgs.org.uk\)](#), which was shared with the AIPB, states that “Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged over 65 years have frailty, rising to between a

quarter and a half of those aged over 85.” It also states “that frailty is not an inevitable part of ageing, and putting in place measures to slow its onset or progression should be a priority” and “that prevention and reversal of frailty enables people to live independently for longer and helps to reduce demand for emergency care and long-term support”

Frailty was identified as an appropriate area for focus due to a number of factors;

- It was recognised that there is a growing population of people with frailty.
- The current model of care for people with frailty is reactive and can be disjointed and is linked with increased hospitalisation, delayed discharge and readmission to hospital and increased demand for long term care.
- There are systematic ways to identify people over 65 years old with mild, moderate and severe frailty.
- There is a strong evidence base for interventions which can prevent or reverse components of frailty.
- Supporting older people is already a key priority for AIPB members, but a more joined up approach is needed to get the most benefit from the expertise and resources of partners across health and social care, local council, and the voluntary and community sectors.
- That interventions can both improve quality of life and reduce costs and pressures across the system.
- Members also discussed the importance of understanding what people with Frailty want and the evidence base to support it. In regard to the statutory duty of Personal and Public Involvement (PPI), it was noted that at a regional level the Frailty Network had worked with Age NI to produce a document “*Rethinking Frailty – what do older people want*” in 2018/2019. This project engaged with over 700 older people regionally. The key messages were that older people want to hold onto independence and to get support when they need it in a timely fashion. The Southern Trust had also run a pilot frailty assessment project in 2018/19 in which all the patients of one GP practice who were over 75 (203) were invited to attend a frailty assessment clinic. Almost one third accepted the invitation. After assessment, those who needed it were provided with information, signposting and/or referral to a wide range of services such as those aimed at reducing social isolation, better access to transport, or continence advice. In response to a questionnaire on their experience, 100% of a sample of attendees reported finding the clinic of benefit and all would recommend it to others. It was noted that at the outset the service had been called a frailty assessment service, but after attendee

feedback this was changed to Aging Well, and as a result a higher proportion of those invited attended in person.

## **5. Frailty Proposals for Consideration**

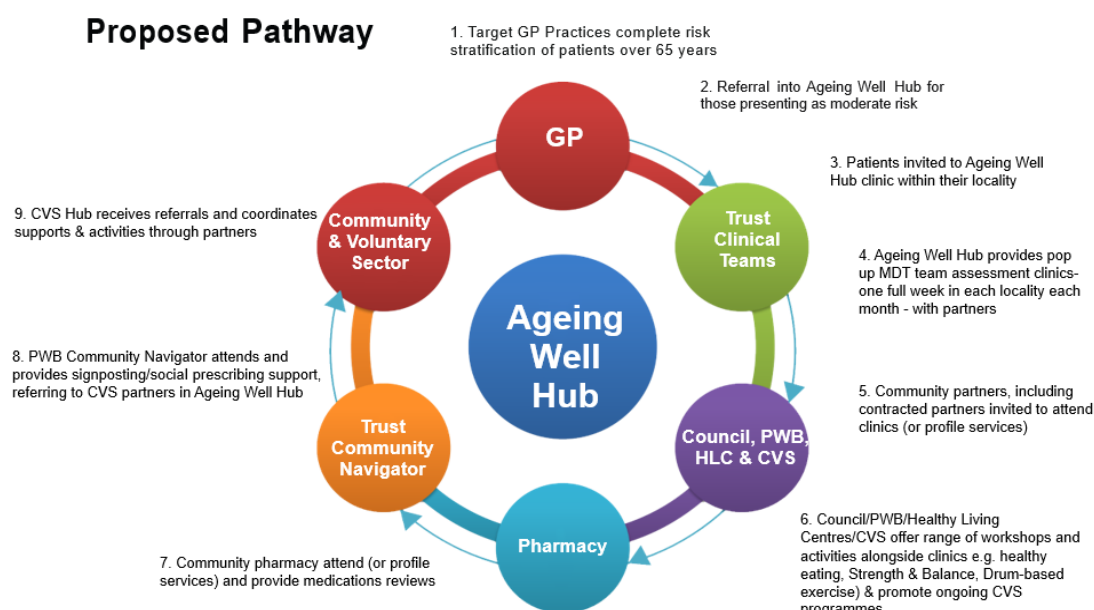
SPPG and PHA partners to the Test AIPB were asked to support the development of the frailty plan by bringing forward proposals for AIPB members' consideration. This was taken forward by;

- Working with the Regional Frailty Network to identify evidence-based interventions for frailty
- Engaging with SPPG Primary Care, Hospital Care & Community Care Directorates, PHA and Trust colleagues to collate existing plans and priorities to address frailty by identifying a "long list" of frailty focussed interventions and plans which may have benefit.
- It was noted that in parallel with the work of the AIPB 'Test', the Cooperation & Working Together (CAWT) partnership were preparing a suite of proposals to bid for Peace Plus funding under Theme 4.1 Healthy & Inclusive Communities – Collaborative Health & Social Care: Ensuring equal access to health care and fostering resilience of health systems, including primary care and promoting the transition from institutional to family and community-based care. One cross border submission was to raise awareness of frailty through developing/delivering a promotional campaign to address people with 'mild' frailty through the establishment of cross border infrastructure to provide early frailty interventions. This will assist individuals to find and engage with suitable programmes and services within their communities. The outcome of this submission will not be known until Autumn 2024.
- In light of this proposal, it was agreed not to include interventions for people with mild frailty in this Test AIPB action plan but progress of the CAWT proposal should be considered by the AIPB in further development of the plan.
- Applying planning criteria which shortlisted out interventions considered "business as usual" for the HSC alone or could be delivered by single organisation activities or more appropriately lead by Community Planning Partnerships. This included older people's health improvement activities, public health information, medication reviews in Care Homes, and provision of domiciliary care support services.
- Submitting to the Test AIPB a range of shortlisted proposals, the foundation of which was population-based risk-stratification of people 65 years old and older at risk of frailty, using an electronic frailty index score (eFI) derived from routine primary care record data. This was one of the recommendations in the BGS report

and also aligned with the primary care Quality and Outcomes (QoF) framework in operation in England, described in more detail in page 6. The eFI is a risk stratification tool which automatically calculates a score to identify whether a person is likely to be fit or potentially living with mild, moderate or severe frailty. The eFI is not intended to be used as a diagnostic tool; individuals deemed to be at risk of frailty based on their score require further confirmatory testing. This can then be used to offer multidisciplinary assessment to confirm the diagnosis of frailty, signpost, advise and/or offer services. Other shortlisted proposals included staff education on frailty, and a range of evidence-based interventions in Secondary and Community Care. (See Annex A)

- Identifying potential localities across the Southern area to implement or test the concept of the proposal. Evidence suggests that where practices have a larger proportion of patients in the oldest age groups, or living in areas with high levels of deprivation, they are more likely to identify a greater proportion of people living with moderate to severe frailty. Initial localities and potential GP practices which could be approached had been identified considering a combination of population deprivation and high ED usage. However, it was acknowledged that this ideal scenario, in which all the selected practices would have the capacity to agree to be part of a pilot, was unlikely, given known pressures on primary care in the area which have led to practice closures. Securing General Practice involvement to test the model might have to take a more pragmatic approach.
- Exploring the option of establishing a pilot 'Ageing Well' Hub to which individuals identified by their General Practice as being in the moderately frail category using the eFI could be referred for:
  - i. Confirmation of the diagnosis and, as appropriate
  - ii. Provision of advice on self-management
  - iii. Signposting to local services such as those aimed at reducing social isolation
  - iv. Multidisciplinary assessment
  - v. Specific interventions such as continence services, strength & balance classes or medication review
- The Hub model was envisaged as bringing together HSC staff already working in this field, but not currently organised as a co-ordinated team, to work closely with Community & Voluntary (C&V) and council partners, all of whom would receive additional training on the management of Frailty. The service could be provided as a mobile 'pop-up' service in targeted localities and would not have a single fixed location.

A high-level outline of the proposed pathway is shown below. **More detailed work on the model could be taken forward with partners in the target locality/localities if this option were to be agreed by the Test AIPB.**



- At the test AIPB Board meeting in May 2024 concerns were raised at the potential numbers of individuals who might need referral to the hub in a short time period if this model was proven to be feasible and rolled out across the area. Members wished to explore whether a less resource-intensive model, focusing on informing individuals of their potential risk and signposting to self-management resources might be an alternative option. In addition, they wished to extend the options to strengthen primary prevention messaging in general to those in a younger age group (e.g. 55-64-year olds) and specifically to carers within this group. The AIPB Working Group members discussed this at length and acknowledged the importance and long-term benefits in targeting this younger age group. In exploring options to systematically risk-stratify those in the 55-64 age group it was noted that the eFI could not be used as it is not validated for use in the under 65s. Further work is needed to explore the most appropriate methods to reach this younger cohort and to engage fully with partners to address issues of primary prevention. As this could not be completed within the timescale for the Test AIPB, the Working Group proposed that the initial focus of the draft Test AIPB Frailty Plan would be on those aged 65 years and older risk-stratified as moderately frail, and in doing so their carers who may be within the younger age group of 55-64 years would also be identified. The AIPB Working Group also proposed that work to explore ways in which partnership working as part of the AIPB process could strengthen existing primary prevention programmes targeting the younger age group should be considered by the AIPB in future development of the plan.

- Given the uncertainty in terms of potentially generating large demand for a service which was just being established, further information was obtained on the potential number of referrals that might be generated from use of the eFI. In one local GP practice which has 1,630 patients aged 65 and over living in their own homes, eFI stratification resulted in the following distribution.

<b>e-Frailty Score</b>	<b>Number</b>	<b>Percentage</b>
Fit	726	44.5%
Mild	616	37.8%
Moderate	238	14.6%
Severe	50	3.1%

It should be noted that this distribution of frailty scores is in keeping with prevalence rates reported from English GP practices which use the eFI tool as part of their GP contract arrangements introduced in 2017/18 to routinely identify patients who are 65 and over who have frailty.

Even if all individuals living in the Trust area and risk stratified as being in the moderately frail category were to be invited to attend an Ageing Well assessment, it is unlikely that all will take up the offer. The 2018 Southern Trust pilot of over 75 year olds had an uptake rate of around 30%. For planning purposes, if it is assumed that between 30-50% of those categorised by eFI as moderately frail chose to attend, based on the 2024 mid-year population estimate this would amount to a range of 2,855 to 4,760 individuals attending such a service in a first round of invitations, which could be phased in over time depending on resourcing and selection of priority areas to be targeted.

Evidence indicates it is the “moderately frail” who are most likely to benefit from confirmation that they do have frailty, and from interventions to prevent or reverse it. However, even within that description varying levels of need will require a different response. Some of this moderately frail group will have long-term conditions and will already be known to services. Others will be unaware that they are at risk or that they could change their likely trajectory towards severe frailty if they can be helped to take a proactive approach.

Once people at risk of moderate Frailty have been identified using the eFI, a more in-depth assessment, using the Clinical Frailty Scale, could be used to confirm the diagnosis. The assessment would consider social factors, long term condition management, self-management/education, enablement and rehabilitation to

optimise function. This provides significant opportunities for input from all sectors to provide advice and support on issues such as:

- Sight and hearing checks
- General ageing well advice – Take 5
- Identify and address isolation, loneliness, bereavement, housing, benefits / financial wellbeing
- Discuss individuals interests and priorities
- Agree self-management goals and actions
- Exercise, self-management and advice e.g. signpost to local leisure services / community services
- Identify informal carers – consider carers assessment and referral as appropriate
- Postural hypotension assessment
- Offer health improvement /protection advice e.g. vaccinations, screening, healthy eating, stop smoking, etc.
- Home accident prevention / safety / assess for risk of falls
- Polypharmacy review
- Consider mild cognitive impairment/ dementia screening, mental health needs
- Review long term conditions as appropriate
- Discussions on what is important to the individual, care planning

The ideal model will enable access to a varied range of services and interventions tailored to the individual's needs.

## **6. Development of the Draft Frailty Action Plan**

### Long Term Goal

The NHS in England is reported to be the first health system in the world to systematically identify people, aged 65 and over, who are living with risk of moderate and severe frailty using a population-based stratification approach. This is done using the electronic Frailty Index (eFI) as referenced in Page 4. Changes to the GP contract in 2017/18 in England introduced routine frailty identification using the eFI for patients who are 65 and over. This process aimed to identify those most at risk of adverse events including hospitalisation, nursing home admission and death. In addition to identifying patients at potential risk of both moderate and severe frailty, it includes a number of key interventions to be carried out within each Practice. These are, for patients identified as living with severe frailty (around 3% of over 65s), to undertake an annual medicines review, a falls risk assessment if clinically appropriate, and promotion of the enriched Summary Care Record (SCR). For patients identified as living with moderate frailty (estimated at around 12% of over 65s), Practices to consider undertaking a medicines review, a falls risk assessment, and promotion of the enriched SCR.

Within Hull and East Riding further focus on frailty initiated the development of a re-designed community frailty pathway led by local geriatricians and primary care staff who brought together a range of specialists and the voluntary sector, to work as a single system supporting vulnerable patients. It saw a reduction of up to 50% in emergency and GP attendance of patients with moderate and severe frailty; 63% of patients that were referred to the service by ambulance staff remained at home, who would otherwise have been conveyed to hospital; cost savings of around £100 per patient through pharmacy reviews of medication.

As set out in the BGS website, there has been development of an Integrated Dataset in Kent based upon GP eFI scores. This sets out trends in frailty severity as it rises with age, and links frailty categories to NHS service costs. The estimated average annual NHS cost of caring for severely frail patients aged over 65 to the NHS was estimated at £4,189, while the average cost for patients considered to have moderate frailty was £2,748 (2016/17 prices) [Bash Current and future cost of frailty.pdf \(bgs.org.uk\)](#).

The AIPB working group felt strongly that a systematic approach to frailty would be best achieved by implementing a QoF in NI similar to that in England. However, it is recognised that General Practice in NI is very vulnerable, and in this context the existing NI QoF for other conditions has been suspended for 2024/25. Even if a frailty-targeted QoF were to be agreed in principle, it may not be possible to implement this in the short to medium term. Given the pressures on General Practice, an alternative model that required less practice professional input, was considered as an option within this action plan.

### Short - Medium Term Goals for the Test AIPB

Early identification, coupled with targeted support can help older people living with frailty to stay well and live independently for as long as possible. Whilst most GP practices in NI have access to eFI software, its use is not part of the GP contract here and it is therefore not routinely applied. If NI was in a position to adopt the same approach as England across the region, this would deliver initial interventions within primary care and underpin a systematic approach to frailty by AIPB partners, enabling provision of targeted interventions that can prevent, reverse and slow down the progression of frailty.

On considering the Test Evaluation Report, AIPB members agreed that resources within the community & voluntary sector and council partners could play a significant role in prevention, early intervention and community health and wellbeing of people aged 65 years and over identified with moderate frailty. These could address short-medium term goals.

It was agreed that scoping of existing community focused proposals is therefore an important step of the draft Frailty Action Plan in line with the ICS Strategic Outcomes Framework which aims to;

- *Improve health and wellbeing of older people*
- *Reduce pressure on secondary care services*
- *Make better use of existing resources and services*
- *Aim to reduce health inequalities*

AIPB members discussed the use of eFI in GP practices to risk-stratify patients with moderate frailty (though not at this stage requiring them to provide assessments or intervention, in order to minimise the workload on practices). They also discussed the results of a pilot project undertaken by a NI GP to offer multi-disciplinary assessment within their Practice to individuals identified as having frailty, which had been presented to the Test AIPB members. This pilot was carried out in a practice with a list size of 1,735 patients 65 years and over using the eFI tool. The results identified 11% patients as having severe and 19% a moderate frailty score. The findings reported patients with a range of issues including Atrial Fibrillation, Postural Hypotension, Essential Hypertension, Falls, Continence Issues, Hearing Loss, Depression, Memory Loss and Social Isolation. The outcomes of patient review included new diagnoses, referral to strength and balance classes for falls prevention, rationalisation of medication, referral to Audiology, Optician, Dentist, Care of the Elderly, Dementia Clinic, Continence Services and Social Prescribing.

Given the current vulnerabilities and pressures in the area it was felt that there was unlikely to be the capacity in GP to fully implement this approach of both risk-stratification and reviewing patients within their local GP practice. Nevertheless, actively seeking practices willing to participate in the concept or practices managed by the Trust could be explored.

Test AIPB members also considered identifying individuals with frailty by application of method which would not involve GPs. This would involve use of the Rockwood Frailty Scale screening tool when people over 65 are attending healthcare settings for other reasons. This tool was used by the Southern Trust in 2018 in a Health and Well-Being Screening Pilot for Over 75 Year Olds and referenced in Page 3.

Test AIPB members agreed that the draft Frailty Plan would focus on the following Key Areas and Actions within 1-4 with further exploration on Key Area 5 "MDT Assessment in Ageing Well Hub" to be considered by the AIPB.

1. To identify a locality/s to test the concept
2. To identify target group/s within the local population
3. To agree an approach to identify people with moderate frailty within the identified locality
4. Development of Ageing Well Hub - Self-management and sign posting to local or online resources
5. MDT Assessment in Ageing Well Hub - Identification of individuals who would benefit from an assessment by multi- disciplinary team.

	Key Area	Actions
1	Identify Locality	<p>(i) Based on GP Practices which are currently managed by SHSCT. These currently include Kilkeel Medical Practice and Mullaghbawn Surgery both in the Newry &amp; Mourne area.</p> <p>(ii) As in 1(i), with an extension to GP Practices with capacity and willingness to scope their patient lists using eFI in Craigavon/Portadown and Armagh/Dungannon areas.</p> <p>Localities with stronger community and voluntary infrastructure could offer the best opportunity to prove the concept in the first instance.</p>
2	Identify Target Group/s	<p>(i) 65 years and over age group, to include those who are carers</p> <p>(ii) Carers in 55-64 age group</p>
3	Approach to identify people with Moderate Frailty *	<p>(i) Application of eFI in the two Trust-run GP practices in the Newry and Mourne area (where the Trust can request this is carried out).</p> <p>(ii) As in 3(i) an invitation to other practices in Craigavon and Armagh/Dungannon, seeking two which may be willing to participate in the concept.</p> <p>(iii) Trust-identified individuals found by application of the Rockwood Frailty Scale Screening Tool (by trained staff) when people 65 and over are attending healthcare settings for other reasons.</p> <p>(iii) Identification of carers via Trust-held data and/or Council Carers' card scheme</p>
4	Development of Ageing Well Hub - Self-management and sign posting to local or online resources	<p>(i) Scoping of existing community and voluntary sector infrastructure and resource within identified localities to develop a directory of services that patients identified as frailty or being at risk of frailty can be sign-posted to and supported to self-manage.</p> <p>(ii) Mapping financial investments from all partners that support ageing well in identified localities.</p>

*\* In all options identifiable patient data cannot be shared outside their GP practice without their consent. Options could include supporting practices to write to patients directly offering them signposting, and/or an opportunity for MDT assessment. The details would require further discussion with GP representatives.*

## **7. Conclusion / Recommendations**

Test AIPB members are asked to consider the contents of this paper and the actions with regards to the proposed plan, including; identifying a locality / localities for initial implementation, the target groups, the process of identification of people with frailty and the initial stages in development of the Ageing Well Hub for self-management and sign-posting to services. It is recognised that further work will be required to agree measurable outcomes before a service could commence to determine the success of the plan and potential roll-out to other localities.

Further discussion by AIPB members will be required in terms of identifying gaps in service provision and resources required if the implementation of the MDT assessment within the Ageing Well Hub is agreed.

## **8. Next Steps**

### **8.1 Presentation of Frailty Action Plan to Shadow AIPB**

Following induction of Shadow AIPB members, the Frailty Action Plan will be presented to Shadow AIPB members for consideration as the initial step in developing an Area Health and Well-Being Plan. Delivery of the plan will be in line with agreed Governance and Accountability Arrangements as set out in the Departments ICS NI Operating Procedures which is currently in draft and awaiting approval by the ICS Steering Board.

## SPPG, PHA, Trust Proposals for AIPB Frailty Plan

**1. Locality Based Frailty Teams** – engage all partners through **education initiatives and use of screening tools etc.** This team will work closely with **Primary Care colleagues, to identify people at risk of frailty and signpost to services available at local leisure centres, community centres etc.**

**2. Implementation of Regional Pathway for Falls in Care Homes** - Reduction in NIAS call outs and a reduction on number of care home residents requiring attendance at ED as homes are more equipped to assess and manage fall. Pilot studies indicate approx. 30% reduction

**3. Identification of Frailty at clinical contacts using Clinical Frailty Scale** (Rockwood) Will help identify those with complex needs who are at greatest risk of adverse outcomes – helping to avoid additional hospital acquired complications (e.g. delirium, deconditioning, falls) which are known to increase LOS and dependency at discharge.

**4. Frailty Education – Fundamentals of Frailty** - All staff across all settings who interact with older adults will have received appropriate training / education on the recognition and appropriate interventions / treatment pathways associated with Frailty.

**5. Identification of Frailty and stratification** the 65+ population at general practice level through the implementation of the electronic frailty index (eFI).

**6. Frailty at the Front Door** - Acute care at the front door - Emergency medicine specialists and geriatricians worked together to develop shared competencies in frailty and emergency care to enable early holistic assessment of older people in urgent care in order to alter their care trajectories and to improve experience and outcomes.

## 7. Inpatients – Pathways for Prevention, Identification & Management of Delirium & Deconditioning

**8. Improved awareness of the risk of malnutrition** in older adults through a targeted approach to good nutrition across inpatient and day settings.

**9. Pharmacy review for persons on 5+ medications** – practice based pharmacists / MOOP team. By ensuring CGA completed, this will lead to required medicine reviews (link across to Frailty at Front Door proposal, Delirium, Care Home Falls, eFI proposals)

**10. An oral care training programme of care home staff to be delivered by appropriately trained dental nurses.** The training will allow care home staff to brush residents' teeth twice per day using high strength fluoride toothpaste (toothpaste provide as part of scheme)

**11. Opioid / gabapentinoid reduction** - initiatives for patients on medication to treat chronic pain (exclude non-cancer/palliative). Aim to reduce inappropriate over reliance on opioids in those with chronic pain.

**12. Delirium Identification and support** - Propose to provide effective preventative detection and at risk monitoring, improved management, effective co-ordinated transition and discharge support across hospitals, community or Care Home settings to include post discharge communication and support.

## 13. Expansion of Acute Care at Home Service

**14. Falls prevention** - a comprehensive multi- agency approach to deliver an intervention at scale across the SHSCT locality which would comprise evidence-based falls prevention programmes, strength and balance training and home safety/ accident prevention measures and education and awareness raising.