Lincolnshire Older People's Five Year Strategy 2023 - 2028

Lincolnshire Older People's Five Year Strategy 2023 - 2028

Contents

Lincolnshire Older People's Five Year Strategy

Foreword

We are delighted to present our collective Lincolnshire Strategy for frail, older people. We have developed this strategy to address the needs of our aging population living with frailty.

Over one hundred thousand people over the age of 65 in Lincolnshire are living with frailty. This means they have reduced reserves and are more likely to be admitted to hospital if unwell or in crisis. One in four hospital inpatients has dementia, and 1 in 3 adults admitted acutely to hospital are in the last year of their life. Traditionally services and pathways have been separated, without coordination and medical care has been focussed on the management of patients with single conditions.

We believe that by integrating the different pathways across our county, we can offer increased support, preventative care and promote wellbeing.

Following a series of stakeholder workshops, together we have looked at our whole health and social care system to create this strategy to deliver the right care in the right place at the right time for frail, older people. We have based our strategy on the clinical evidence and National guidelines whilst using local intelligence on population data, geography and needs to personalise the care.

Our strategic ambition covers five areas: proactive care, enhanced community primary care, easier single point of access to services and an integrated clinical pathway delivered by an integrated collaborating workforce.

We would like to extend our thanks to our partners for their contributions to the Lincolnshire frailty strategy.

Dr Sadie Aubrey
Primary Care Clinical Lead for Frailty, General Practitioner, PCN Clinical Director and CEO Lincolnshire Primary Care Network Alliance

Dr Anne-Louise Schokker
System Clinical Lead for Frailty, Consultant Geriatrician and Medical Director Lincolnshire Community Health Services NHS Trust

Our ambition

Our ambition is to work together strategically to integrate our different services for older people to provide a single joined-up pathway of care that will:

- Proactively reduce health inequalities, promote healthy aging and keeping well.
- Support primary care to deliver personalised, patient centred care, closer to peoples' homes.
- Create a simple and effective support and referral process for when people need extra support or assessments, which are evidence based.
- Deliver seamless care across partners.
- Be delivered by an integrated team, including partners from health, social care, public health and the third sector, with a united purpose.

Introduction

Advances in health care in England have led to people living for longer than before. However, this is not always extra years in good health, and older people can develop multiple age-related, long-term conditions that can impact on their well-being and independence as they age.

Frailty is a long-term condition where a person has reduced overall resilience and physiological reserves. This means their bodies are less strong and minor illnesses, changes in medication, or stress can make them more unwell or fall. This can result in a rapid decline in function and health.

Frailty-related issues can include dementia and delirium, falls and reduced mobility, incontinence, osteoporosis and fragility fractures, polypharmacy (more than five medications), dependency on support for activities of daily living, and end of life care.

Nationally, around 5 – 10% of people attending Accident and Emergency Departments are older and living with frailty, leading to more than 4,000 admissions daily for falls, minor infections, medication side effects, and other conditions related to frailty.

When they are admitted to hospital, they are at risk of a longer length of stay and the associated risks of harm, including increasing immobility, declining function and reducing independence. Frailty is not an inevitable part of aging and can be identified early. Early identification enables proactive and anticipatory care to be provided, thereby minimising the risk of deterioration and associated loss of independence.

Proactive management of frailty by screening, comprehensive geriatric assessments, multidisciplinary interventions, and personalised care can reduce its progression, reduce hospital admissions by 20%, reduce falls by 10%, improve health, and subsequently reduce care needs. Currently, our services are not joined up, have overlapping purpose, different referral criteria and routes in, which leads to fragmentation of peoples' care and services that are complicated to navigate.

Frailty in Lincolnshire

Nationally around 10% of people over 65 and 25- 50% of those over 85, have a diagnosis of frailty. (Clegg et al 2013). In 2021, the over 85-year-olds represented 2.9% of the Lincolnshire population. By 2041 this is set to grow to 4.9%.

In Lincolnshire, over 101,370 people, who are over the age of 65, meet the Electronic Frailty Index (a tool utilised in General Practice to identify people at risk of frailty) criteria for mild, moderate or severe frailty (August 2023). This represents 12.5% of our population, and 53.5% of people over 65 years old. Many of these people are yet to have a formal diagnosis based upon assessment and as such are not receiving an optimal care, designed to keep them well for longer and prevent them becoming progressively more frail.

As people progress from mild to moderate, and then moderate to severely frail, their contact with the health and care service increases by approximately 35% for each progression, with an associated 78% spend increase for moderately frail people and 87% spend increase for severely frail people.

11% of the frail population are either resident in care homes (5,906) or housebound (5,257). Nearly half of the frail population live in rural areas, with a further 10% living in coastal areas. Frail people living in coastal areas are on average more multi-morbid, are 25% more likely to be admitted, and when admitted likely to spend longer in hospital.

19% of people with frailty aged over 65 live in areas associated with household poverty, and only 3% are identified as claiming benefits (note - benefits data is not complete). 22.5% of people with frailty aged over 65 have a history of falls, 26.9 % are on a waiting list, and 73.3% are not presently coded as having a ReSPECT plan in place.

What do we want to do differently across Lincolnshire?

We presently spend over £284 million from the health and social care budget on treating frail individuals (around £110 million on mildly frail, £87 million on moderately frail, and £84 million on severely frail). This increasing demand and its associated impact on financial expenditure represents a real opportunity to do something different, use our money more wisely, and impact positively upon outcomes and experience for our older population.

Frailty in Lincolnshire	Mild frailty	Moderate frailty	Severe frailty
Over 65s with frailty	**60,748**	**26,814**	13,808
Average age	76	79	83
Average number of Long-Term Conditions	2.9	4.6	6.5
Total contacts with health & care system Per Person Per Year (PPPY)	52	70	97
Primary care encounters	46.6	59.9	76.5
Acute elective encounters	3.2	4.3	4.8
A&E attendances	0.4	0.7	1.3
Emergency admissions	0.1	0.3	0.7
Community encounters	1.3	3.8	11.7
Mental health encounters	0.3	0.7	1.1
Unplanned bed days (PPPY)	2.5	4.9	7.5
Spend per person per year	**£1,817**	**£3,249**	**£6,084**

Partner agencies from across the health, social care, public health and the third sector in Lincolnshire have come together, with patients, their families, and members of the public, to co-produce our strategy based on local experience and best practice from elsewhere.

Our ambition is to work together strategically to integrate our different services for older people to provide a joined-up service that will:

- Support people over 65s to remain independent for longer, so they spend less time attending health and social care appointments and more time doing things that are important to them.
- Keep people with frailty well at home, for as long as possible, improving health outcomes and quality of life.
- Ensure when patients experience a frailty crisis they have timely access to high quality urgent services, where possible based in the community, avoiding unnecessary admissions to hospital.

- Ensure patients don’t experience unnecessary treatments and interventions including diagnostics and do not take medications that don’t enhance their health and / or quality of life.
- Ensure when a patient with frailty needs to be admitted to hospital, they receive rapid access to evidence-based pathways of care, delivered by staff who have access to information about their care to date, and are discharged within 24 hours of being ‘discharge-ready’ back into the care of the community team.
- Create an integrated pathway for frailty, with different services working together to deliver joined-up and seamless services for older people.
- Provide an enhanced package of support to patients living within care homes, coordinated by local Primary Care Networks, delivered by a multi-disciplinary team of professionals.
- Provide our staff with the skills, tools, and knowledge they need to provide high quality and compassionate care.
- Address health inequalities by developing a targeted approach to service delivery, with a view to delivering equitable access, experience and quality care for all older people with frailty, which will evolve over time based upon review of data / intelligence and our learning.

Our delivery model will focus on five key areas:

Proactive Care - Health Promotion, Self Care and Ageing Well

Prevention (Healthy Ageing), Personalised Care, Advice and Guidance

Primary Care

Anticipatory/Pro-active Care Framework.

Case finding using the Electronic Frailty Score (eFI) and the Clinical Frailty Score (CFS).

Care coordination and management.

Comprehensive Geriatric Assessments (CGA).

Holistic Assessment.

Personalised care and Support.

Pro-active Medicines Management.

Single Point of Access

Navigation and signposting.

Digital information sharing.

Senior clinical decision making.

Integrated Services

Bringing pathways together

Reduce duplication

Pro-active step-up care rather than crisis management

Community hubs of care closer to peoples' homes

Timely and proactive communication with primary and community care teams at discharge to support transition home

Integrated Workforce

A team of teams, with reduced duplication, shared purpose and an upskilled, specialist workforce

Achieving our ambition

Primary Care and Pro-active Care

Primary care is the corner stone of identification of frailty, supporting older people to age well and ensuring personalisation of care.

We aim to support all older people to remain well longer by providing them with access to a call centre or a face-to-face meeting with a person who will direct them to a variety of service offers, close to their home, designed to address issues impacting them personally such as diet, exercise, smoking, bereavement, and loneliness. Advice on how to access health services, particularly those focused upon disease prevention such as vaccinations, routine health checks and screening, will also be provided.

Care for people identified as being frail will be delivered by the community multidisciplinary team using evidence-based tools and assessments including the Comprehensive Geriatric Assessment.

All partners will work together to deliver multidisciplinary care, with additional support where our population heath needs and inequalities indicate it is required such as in care homes, in some geographical locations and for specific population segments.

People with frailty will have access to a staff member skilled in care coordination who manages their personalised plan. This plan proactively describes their care, and details their advance care planning.

People living in care homes will receive an enhanced package of care, including review of their medications, described within their Personalised Care Plan, delivered by a multidisciplinary team, in collaboration with the care home team.

How will people experiencing frailty be identified?

We have developed an integrated care pathway to ensure all patients with frailty are proactively identified and have access to appropriate care. Patients will be identified from General Practice held records, using the Electronic Frailty Index, and validated using the Clinical Frailty Score. Where more detailed assessment is required a Comprehensive Geriatric Assessment will be conducted. This can be undertaken by one of a variety of team members from across primary, community or hospital care, who has skills and experience in managing frailty and is best placed to work with the individual patient. Outputs will be recorded on a shared clinical record accessed by all professionals involved in their care.

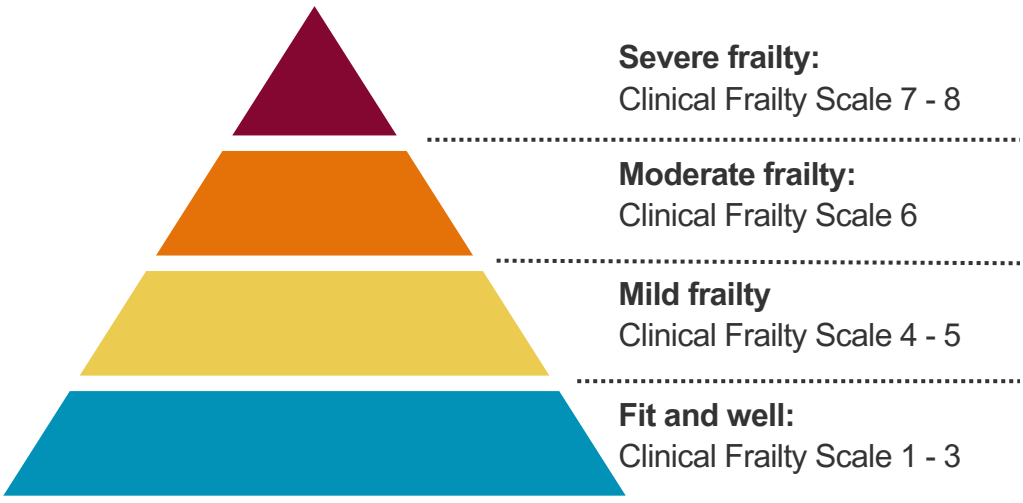
Pathway for Primary Care Network-based proactive care

Step 1. Use the eFI as Population Health Management approach to identify frailty

Step 2. Clinically validate frailty using the Clinical Frailty Scale

1	Very fit
2	Fit
3	Managing well
4	Vulnerable
5	Living with mild frailty
6	Living with moderate frailty
7	Living with severe frailty
8	Living with very severe frailty
9	Terminally ill

Step 3. Segmenting cohorts



Step 4. Evidence-based interventions based on degree of frailty

Comprehensive Geriatric Assessment and Personalisation

 **Medical**	Includes review of all long-term and acute medical conditions as well as stopping unnecessary medications. This also involves planning for the future and having honest conversations about what matters most to the individual and developing anticipatory care plans.
 **Functional**	This normally requires a therapist to assess the person's mobility and ability to look after themselves, for example, assessment of gait, balance and mobility, washing and dressing.
 **Psychological**	This involves assessment of memory to pick up on symptoms of dementia or delirium. It also involves assessment of mood, as anxiety and depression are common in older people.
 **Social**	Assessment of formal care needs, informal care arrangements, social networks and other supportive mechanisms is a critical part of CGA.
 **Environmental**	Assessment of home environment, often led by an Occupational Therapist. There could be adjustments and equipment needed to help and support the person at home. There could also be hazards that need to be addressed in order to maintain their independence at home.
People supporting these domains	• Primary care clinicians • Geriatricians • Mental health team • Physiotherapists • Social workers • Occupational Therapists • Pharmacists • Speech and Language Therapists Dieticians • Volunteers • Patients and family members • Other appropriately trained and experienced professionals

Single Point of Access

People living with frailty who are becoming more unwell or dependent will benefit from a coordinated specialist review and assessment. Evidence shows they will be more likely to be at home and not be admitted to hospital or a care home after six months of having one.

Assessment will be accessed through a single access point, which will be available 24/7, for all care/provider teams to contact. The team will ensure the referring clinician is not required to make multiple calls to gain support for a frail patient. They will adopt a flexible and solution focused ethos aiming to take responsibility for addressing a wide variety of presenting needs associated with frailty, as the result of a single call. The Single Point of Access will be clinically navigated and will have access to shared records, detailing care to date. They will be responsible for coordinating the next steps for the individual through the integrated services and as appropriate providing feedback to the referring clinician. They will also offer clinician-to-clinician conversations with a view to providing advice and guidance where required.

Integrated Services

This will bring together the different services that have developed over time and deliver them in an effective, responsive joined up way.

Our ambition includes:

- Community hubs of assessment, investigations, and treatments closer to peoples' homes from our local community hospitals.

- Same day emergency care units for older people at community hospitals and co-located with our A&Es.
- Frailty virtual wards for hospital at home care for those in need.
- Short stay assessment units for those needing hospital assessment.
- Supported step down from hospital and reablement within 24 hours of becoming ready for discharge.
- Personalised end of life care in the persons' preferred place of care.

These services will be offered seven days a week and use technology to virtually triage, monitor and support people at home.

For patients temporarily cared for away from their homes e.g., in an acute or community hospital, we will ensure they have access to high quality, timely and efficient care. We will undertake work in partnership with our patients and their families to continuously improve both their experience and outcomes. Early and proactive coordination with community and primary care teams will be undertaken to ensure appropriate and personalised care is in place as soon as they arrive back to their own home.

Integrated Workforce

Lincolnshire is a large county, resulted in extended travel times for community-based staff, impacting upon their ability to offer timely, care closer to the patient's home.

By creating shared purpose and functions between teams who provide services to people with frailty we will make the working day more efficient for staff, allowing us to use our resources most effectively.

We will create a single team with a shared vision and values, who can work flexibly across the patient pathway, respond effectively to fluctuations in demand and offer continuity of care to patients and their families.

We will create a Multidisciplinary Workforce Development Programme which will support the delivery of specialist care, underpinned by shared professional standards.

We will develop attractive career pathways which enhance progression and support the recruitment and retention of staff, thereby developing resilient and sustainable frailty services.

Shared pathways of care, crossing organisational boundaries, for common conditions relating to frailty such as delirium, dementia will be implemented supported by multi-agency training and resources, including digital solutions to support shared record keeping and to enhance patient care.

We will work in partnership with local providers of health education to promote Lincolnshire as an attractive place to work and to ensure innovation, research and evidence-based practice are embedded within our delivery models.

What will be different for our patients and their families?

- All older people will be able to able to access a wide variety of personalised services and advice, designed to support them to age well, via a single number.
- Our services will support patients, carers and families to self-care, with a view to staying well.
- Care between primary, community and hospital care will feel seamless, supported by a staff member skilled in care coordination who will be able to provide timely advice, information and access to care from the right professional.
- Patients and their families will be proactively involved in co-creating care plans to ensure their wishes, fears and preferences, particularly as they draw near to the end of their life, are understood by the whole frailty team and where possible enacted.
- Shared records will prevent patients and their families having to tell their story on repeated occasions, to multiple professionals.
- Where possible care will be delivered in the patient's own home, with attendance at the Accident and Emergency Department and unplanned admission to hospital only happening where it is clinically necessary and in accordance with the patient and/or their family's/carers wishes.
- We will provide regular opportunities for feedback and engagement to ensure our services continue to evolve and improve and are co-designed with patients and their families at the centre.

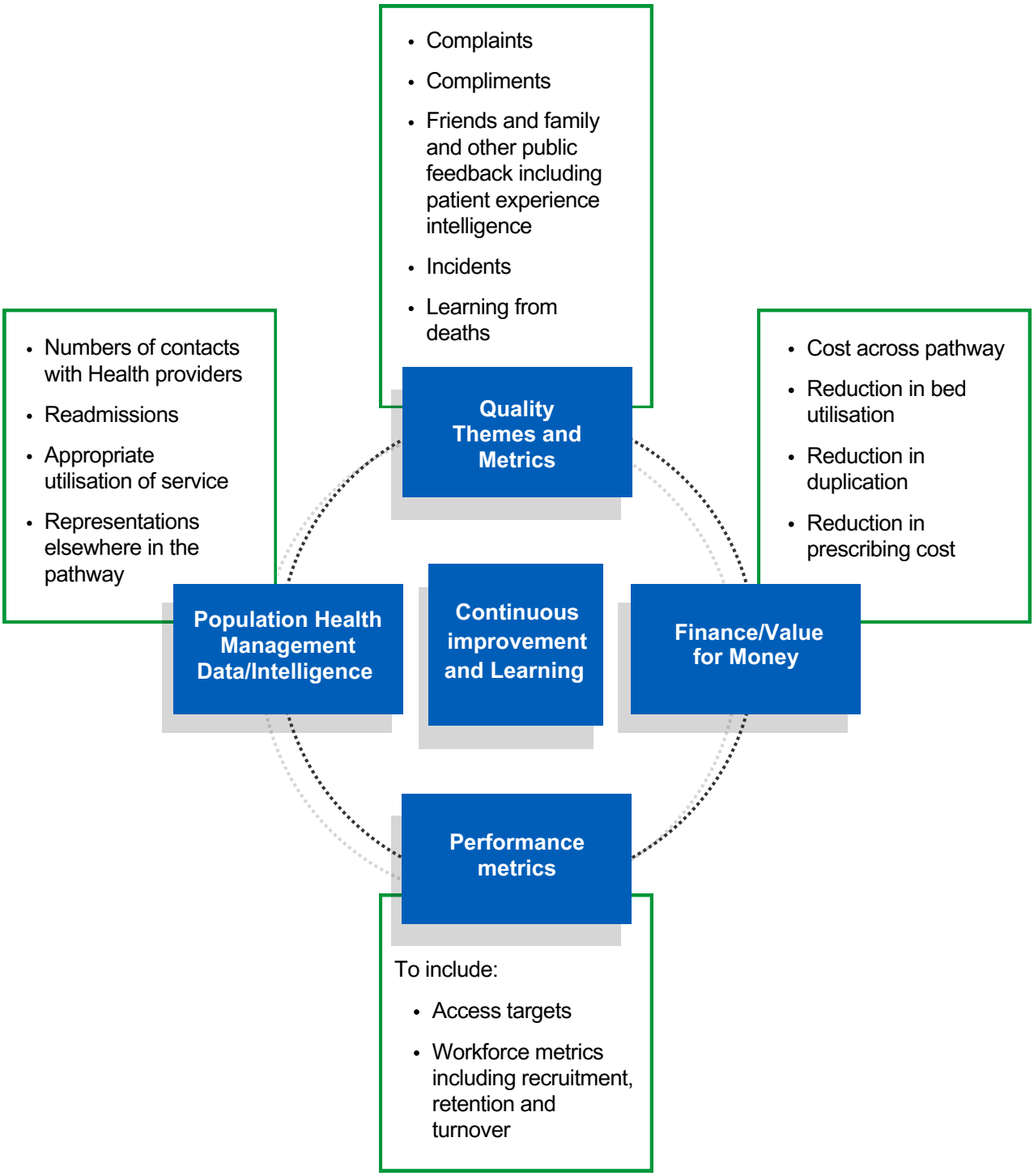
How will we know we have made a difference?

Key metrics

- **Improved patient and family experience.**
- **Improved workforce stability including:**
  - o Improved staff experience.
  - o Reduction in turnover and vacancies.
  - o Increased number of staff accessing the frailty specific mandatory training.
- **Reduced number of patients with frailty progressing from mild to moderate and moderate to severe.**
- **Increased number of patients with frailty accessing proactive care including:**
  - o Increased referrals to social prescribing.
  - o Increased rates of identification of frailty patients.
  - o Increased number of patients who access a holistic multi-disciplinary assessment.
  - o Increased number of Personalised Care and Support plans.
  - o Increased proportion of patients who have current ReSPECT form in place.
  - o Increasing numbers of patients accessing community based, frailty specific services.
- **Reduction in non-elective care including**
  - o Reduced attendances at the Accident and Emergency Department and reduced number of bed days sent in an acute hospital for people living with frailty.
  - o Reduced number of unnecessary procedures and interventions including diagnostic tests and procedures.
  - o Reduced amount of inappropriate prescribing and associated expenditure.

Measurement of impact

In combination with performance metrics, quality metrics and themes, financial performance and population health management intelligence will be utilised to calculate the overall impact of the changes to the frailty pathway. An approach of continuous improvement and learning will be utilised to support delivery of improvement, based upon data and intelligence collated in a dashboard.



How will we deliver the five year strategy?

- Capitalise upon our strong models of clinical and medical leadership which exist across the Lincolnshire system.
- Create governance and accountability frameworks which support change at pace and pro-active management of risk.
- Develop a detailed implementation plan which specifies responsibilities for delivering milestones within agreed timescales.
- Develop a dashboard which supports measurement of impact, delivery of agreed Key Performance Indicators.
- Design and implement a communication and engagement strategy to ensure changes are communicated and staff, patient and public voices are captured and utilised to support ongoing improvement and change.
- Adopt a culture of learning and continuous improvement.

Acknowledgements

This document was co-created with the support of people and organisations from across Lincolnshire. We therefore would like to express our thanks to:

- Patients, carers, and families who shared their experiences and insights with us
- The Lincolnshire PCNs and Primary Care Practices
- The Neighbourhood Leads
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Lincolnshire County Council
- NHS Lincolnshire Integrated Care Board
- Age UK
- NHS England GIRFT (Getting It Right First Time) Team

References

British Geriatrics Society (2017) **Fit for Frailty, Part 1**

British Geriatrics Society (2023) **Joining the Dots: A Blueprint for Preventing and Managing frailty in older people**

Conroy, S. (2021) **Quality Care for Older People with Urgent Care Needs – Silver Book II** British Geriatrics Society

Guildford and Waverley Health and Care Alliance (2022) **Ageing Well in Guildford and Waverley – Frailty Strategy 2022 - 2026**

Office for Health Improvement and Disparities (2022) **Healthy Ageing: Applying All Our Health**

Photographic credits:

Photographs: Pages 1, 5, 6, 8, 10, 13, 16, 18 and 20.
Photographer: **Elliot Manches**
Images courtesy of the **Centre for Ageing Better**

Lincolnshire Older People's Five Year Strategy 2023 - 2028