working together

Kirklees Frailty Strategy 2019 - 2022

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INTRODUCTION

PURPOSE

The purpose of this strategy is to outline how quality of life and outcomes for the Kirklees population will be improved by preventing Frailty and improving the identification and care of those who are frail. This will be achieved through taking a life course approach and focusing on primary and secondary prevention alongside maximising independence through early recognition and ongoing management. A collaborative and systemic approach will be taken, working across all health, social care, and voluntary and 3rd sector partners. To support our population, their families and carers a standardised approach to reduce variation, whilst providing personalised, person centred care will be developed. The key domains and principles describe the support available to help prevent frailty through enabling people to promote their own wellbeing that enables people to self-care effectively. Alongside this, the system will focus on prevention, promoting support and maintaining independence for the Kirklees frail population through developing high quality, personalised services that are flexible, responsive and enable frail people (of all age groups) choice and control over how their health needs, care and support are provided. This frailty strategy has been developed by a number of partners and is seen as the lever for transformational change.

WHAT DO WE MEAN BY FRAILTY?

Frailty is now widely recognised as a state of reduced resilience and increased vulnerability, which results in some people becoming more vulnerable to relatively minor changes in their circumstances which can lead to deterioration in their physical and mental health, wellbeing and/or ability to live independently.

DEFINITION OF FRAILTY:

- Related to but distinct from ageing, comorbidity and disability
- A state of reduced resilience and increased vulnerability
- A state which minor events can trigger disproportionate adverse outcomes in health, wellbeing and or functional ability

People living with frailty can be less able to adapt to stress factors such as acute illness, injury or changes in their environment, personal or social circumstances, and such changes are more likely to result in adverse health outcomes and loss of independence[1]. Frailty should be treated as a long term condition throughout adult life. This means starting with prevention and early identification of frailty and supporting people appropriately on the basis of their needs through to the end of their life.

WHY FOCUS ON FRAILTY?

Frailty is now nationally recognised as a long term condition which affects people's ability to recover when challenged by sudden, unexpected life changes. Frailty can lead to a rapid decline in health and well-being leading to crisis situations. For people at risk of developing frailty there are potentially preventable or modifiable risk factors or conditions. These include alcohol excess; cognitive impairment, falls, functional

[1] http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework

impairment, hearing problems, mood problems, nutritional compromise, physical inactivity, polypharmacy, smoking, vision problems, social isolation and loneliness. Promoting healthy ageing offers a chance to avoid or postpone the onset of frailty[2]. Through early identification of frailty and management, health, social care and third sector/voluntary professionals are able to improve their awareness of who is more at risk of developing frailty, effectively support people to maintain independence and self-care and achieve better holistic outcomes (as described through the seven Kirklees Outcomes detailed in the Health and Well Being Plan – see Appendix 1.)

HOW IS FRAILTY IDENTIFIED LOCALLY?

The Rockwood tool has been identified across West Yorkshire and Harrogate Health and Social Care Partnership as the initial assessment tool for frailty. However there is awareness that other tools are in existence locally and there may be a need for standardisation. For Kirklees Primary Care teams, a set of frailty assessment templates are available on the clinical systems to support the assessment and management of patients identified with moderate & severe frailty. Primary Care teams use the electronic Frailty Index (eFI) tool to firstly identify those patients 'at risk of frailty' followed by an assessment and identification of mild, moderate or severe frailty which is completed using the Rockwood Clinical Frailty Scale tool, supported by clinical judgement. Read-coding the level of frailty in the clinical record allows sharing of the frailty diagnosis via the Summary Care Record.

THE NATIONAL AND REGIONAL AGENDA

Frailty is part of the national agenda, with NHS England producing a range of resources[3] for commissioners and professionals around ageing well and supporting people living with frailty. The resources describe how population-level frailty identification and stratification can help plan for future health and social care demand, manage and best structure resources to optimise equity and outcomes whilst also targeting ways to help people age well. It is estimated that around 50% of people over the age of 65 are living with some degree of frailty and some people experience frailty earlier in life[4].

Frailty is also cited in the NHS Long Term Plan[5] which articulates that extending independence as we age requires a targeted and personalised approach, enabled by digital health records, population health management and shared health management tools. Promoting the prevention, early identification and self-care agendas enables people to look after their health and wellbeing, prevent, delay and minimise the severity and impact of frailty, and maximise outcomes. Hospitals will also reduce avoidable admissions through the establishment of acute frailty services, so that such patients can be

[2] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/preventing-frailty/
[3] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/
[4] http://www.firstresponsetraining.com/news/new-frailty-framework-launched-for-providing-care-and-support/
[5] https://www.longtermplan.nhs.uk/

assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in A&E and acute receiving units.

The West Yorkshire and Harrogate Health and Care Partnership have undertaken an information gathering exercise to understand the local frailty offer for patients across all 6 places. The Partnership adds value through comparing and contrasting, sharing best practice and bringing places together to share learning.

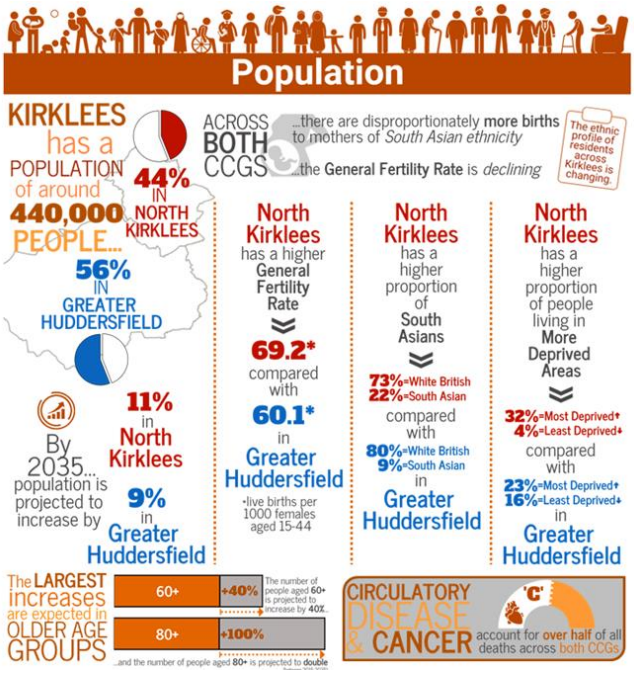
Health Education England and NHS England have also commissioned the development of a Frailty Core Capabilities Framework[6] to improve the effectiveness and capability of services for people living with frailty. One of the aims of this framework is to empower people living with frailty, as well as their family, friends and carers, to understand the condition, make the most of available support and to plan effectively for their own current and future care needs.

NHS RightCare has also developed an optimal frailty pathway (Appendix 2.) This strategy includes a number of references to the above national work and ensures the local work is in line with the national direction of travel for frailty.

THE LOCAL POPULATION

OVERVIEW

Around 440,000 people live in Kirklees (GP registrations January 2015) with roughly equal numbers of males and females. Kirklees has a varied population, many ethnicities are represented, speaking a range of languages and bringing a cultural diversity to the region. The population has increased by 8.4% since 2002, and is predicted to rise by a further 9.9% by 2030. Kirklees contains areas of high and low deprivation, with regions of highest deprivation found in some of the more densely populated urban areas to the north and east (including parts of Huddersfield, Dewsbury and Batley), and lower levels of deprivation found in the more sparsely populated rural areas to the south and west (including the Colne and Holme Valleys, Denby Dale and Kirkburton).



Population projections to 2030 from the Office for National Statistics (ONS) predict greater increases in the numbers of very young children and older adults (particularly those aged over 64), leading to a relatively smaller working age population supporting a larger dependent population. As the

[6] http://www.skillsforhealth.org.uk/services/item/607-frailty-core-capabilities-framework

number of people with multiple long-term health conditions increases with age, a projected ageing population is likely to lead to a greater demand on resources.

Information above taken from https://observatory.kirklees.gov.uk/jsna

WHAT DOES THIS MEAN IN RELATION TO FRAILTY?

People with frailty have a substantially increased risk of falls, disability, long-term care and early death. We also know that frailty is a graded abnormal health state which ranges from the majority who are mildly frail and need supported self-management, through to those who are moderately frail and would benefit from interventions such as case finding/case management, and those who have advanced frailty where anticipatory care planning and end-of-life care may be appropriate interventions[7].

Across Kirklees, a number of partners have recognised that there are an increasing number of older people attending emergency departments and accessing urgent health and social care services against a rising demand due to the projected growth in the number of people aged 85 over the next twenty years. There is a consensus that we need to change how we care for the needs of frail people, which will lead to improvements in quality, outcomes and efficiency, which also reflects the national guidance.

Fundamental changes in the way that the population is supported through earlier prevention methods and the way services are commissioned and provided are needed to support holistic approaches and the self-care agenda for people with frailty that is sustainable in the face of rising demand. Due to this, frailty is a priority area for integration between the two CCGs (Greater Huddersfield CCG and North Kirklees CCG) and the Council in Kirklees. To support this, the Kirklees Health and Wellbeing plan (2018 – 2023) brings together partners to focus on the people who live in Kirklees and how, working collectively, we can improve the health and wellbeing of the whole population. The aim is to overcome challenges of organisational and professional barriers to ensure people get access to the best quality support to start well, live well, and age well. The diagram in Appendix 3 (taken from the Health and Wellbeing Plan) describes the population characteristics of each of these groups and the focus in terms of supporting the population of Kirklees.

WHERE ARE WE NOW?

HIGH LEVEL SUMMARY

- A North Kirklees Frailty Strategy was developed in 2017 and set out the local vision, aims and principles. Due to the national focus and supporting published documents, plus the progress locally on frailty, the strategy has been reviewed and updated to develop this Kirklees wide frailty strategy.
- A number of key successes have been achieved over the recent years including:
  - ✓ Established acute frailty services within the two main hospitals of Kirklees. This also includes a direct admit scheme.
  - ✓ Collaborative falls prevention group developed focussing on assessment information and advice, education and training, awareness and activities
  - ✓ Joint work streams including Health, Social Care, 3rd sector and voluntary agencies developed to look at loneliness and social isolation across Kirklees

[7] https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

- ✓ North Kirklees Primary Care Quality Access Scheme in place delivering enhanced frailty requirements that are additional to the GP contract, with a focus on moderate frailty. This also includes having care companions in practices for frail patients, training taken place through Practice Protected Time and frailty templates available on the clinical system.
- ✓ Initiated a review of Intermediate Care and Re-enablement services. This includes a proposal around establishing a collaborative Kirklees Independent Living Team (KILT)
- ✓ Started to develop a personalisation programme including Making Every Contact Count, care planning and shared decision making.
- ✓ Raising awareness of frailty as a long term condition and recognising the impact on emotional health and wellbeing associated with LTCs.
- ✓ Development of an approach to end of life care with Kirkwood Hospice as the lead commissioner

FUTURE OPPORTUNITIES

Although a number of achievements have been made over the last few years in Kirklees, including closer and more joined up working between the two CCGs, the council, secondary care and community services, there are still challenges to overcome and further work to progress in order to promote prevention, early identification and self-care agendas and fully support the frail population of Kirklees.

CHALLENGES – HIGH LEVEL:

- ➢ There is an acknowledgment that a number of complex systems still exist within Kirklees where services are often fragmented.
- ➢ Our services use different IT systems making it difficult to share care plans or data, hampering integrated care, data and trend analysis and resource planning. There is also the challenge of the voluntary sectors involvement with this
- ➢ Some of our services are reactive to patients presenting in a crisis, often with a specific physical problem that has become urgent. Highlighting a need for further work to be done on the prevention and early intervention agenda
- ➢ Many of our services are designed to treat one condition at a time missing out on the benefits of using a holistic approach.
- ➢ Our local and national work has identified that some people are not comfortable with the phrasing or stigma associated with being labelled 'frail'
- ➢ There is still further work to be done locally to ensure frailty is recognised as a long-term condition (LTC) in Kirklees
- ➢ Variation exists locally and regionally including the age criteria for services
- ➢ Across all partners, workforce is a challenge reflecting the national challenge

OPPORTUNITIES/ASPIRATIONS – HIGH LEVEL:

- ➢ Engage with our local community (including hard to reach groups) and service users, their family and carers to co-produce services where appropriate or capture their experiences and needs and ensure these views are incorporated into future developments
- ➢ Engage with the public on starting and ageing well to support the primary prevention agenda
- ➢ Work with our local focus groups to help them better understand the term 'frailty' and help us identify the best way to communicate frailty with patients and the public through co-production

- Develop a communication plan aimed at all levels of health, social care and with the public. This includes what frailty is, how to prevent/minimise it, signs and symptoms and call to action to promote early diagnosis and intervention, the support available and promoting self-care
- Continue to join up health and social care commissioner and provider systems. Promote prevention, early diagnosis and intervention, self-care and treatment integration.
- Ensuring commissioned services recognise frailty and are evidence-based. Commissioning should take place collaboratively and ensure services are holistic, integrated and person-centred, which is inclusive of all key stakeholders, including frail patients. Commissioners should also ensure that service delivery is cost effective, safe, of a high quality and equitable in access and outcomes.
- Support people to feel empowered to take more ownership of their care
- Make better use of enablers, for example, self-care and technology through our personalisation and digital health agenda , third sector and voluntary agencies
- Enhanced health in care homes model
- Make changes to address emerging workforce challenges through transformation and recruitment opportunities to ensure we have the right professional with the right knowledge and skill set to meet the needs of our frail population. This could be through benchmarking against and embedding the core competencies, values and behaviours. The frailty framework could support this development.

Figure 1: Frailty Framework tiers:

Tier 1:	Those that require general awareness of frailty.
Tier 2:	Health and social care staff and others who regularly work with people living with frailty but who would seek support from others for complex management or decision-making.
Tier 3:	Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people living with frailty.

STRATEGIC AIMS, OBJECTIVES AND OUTCOMES

The key aim is that the population of Kirklees receives a more personalised approach tailored to support their needs. The focus will be on prevention and early identification. This approach will embed shared decision making in our working practice which is fundamental to changing the relationship with patients and ensuring they feel more empowered to take control of their care. This will also include outcome-focused care planning with a strengths-based approach. This will ensure that the frail population of Kirklees are supported to live as independently as possible for as long as possible in their chosen place of residence. This will be underpinned by the ethos of providing the right care in the right place at the right time, first time; with a focus on quality, patient outcomes and effective use of financial resources. Care and support will be designed in a co-ordinated way that will support patients to be successful in achieving the outcomes that matter most to them.

KIRKLEES FRAILTY VISION:

Our frail population will be enabled to self-care (optimising their health and wellbeing,) identified early and supported to live as safely and independently, for as long as possible, through an integrated proactive approach to frailty across the health and social care system.

Domain 1: Prevention

- Taking a life course approach focusing on starting well, living well and ageing well
- Effectively communicate messages about healthy living according to the abilities and needs of individuals
- Facilitate access to sources of health promotion information and support
- Encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. Making Every Contact

Domain 2: Healthy and safe Environment

- No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality.
- Kirklees population to have access to a safe, warm, affordable home in a decent physical environment within a supportive community.
- Holistic assessments will aim to examine a person's physical and mental health status and functional as well as social and environmental issues.

Domain 3: Supportive Networks

- People living with frailty and their family, friends and carers are able to make the most of the support on offer and can plan effectively for their own current and future care.
- The needs of carers will be identified and supported.
- Local frail people can control and manage life challenges by engaging with a supportive network of health, social care and voluntary services.

Domain 4: Seamless, integrated system

- People experience seamless health and social care appropriate to their needs that it is affordable and sustainable.
- Frail people are able to navigate around an integrated service delivery across the voluntary, primary, community, and social care sectors.
- Care is led by a fully integrated commissioning process which includes, workforce planning and community capacity training, with the avoidance of duplication of assessment

Domain 5: High Quality, Person Centred and Personalised Care

- Workforce has the correct capability and competencies to deliver quality services.
- NHS England Personalised Care Operating Model (Appendix 5) will be embedded.
- Shared Decision Making to hear the voice of the patient and ensure they are actively involved and engaged in their care.
- Evidence based commissioning intentions that will drive primary and secondary prevention, early assessment and pro-active management.

DELIVERING THE STRATEGY

For the purpose of the strategy, the principles and outcomes have been split into 5 key domains. These are:

1. Prevention
2. Healthy and Safe Environment
3. Supportive Networks
4. Seamless Integrated System
5. High Quality, Person Centred and Personalised Care

DOMAIN 1: PREVENTION

The number of people with diseases will double over the next 20 years and the number of people with more than one long-term condition is growing rapidly. The number of people with health and social care needs will also continue to increase unless we enable them to live and age well. Healthy behaviours, including not smoking, avoiding harmful alcohol consumption, good nutrition, physical activity and safe sex have a positive effect on people's health and promoting that of future generations, contributing to them having the best start in life. Health inequalities have a significant impact on people's long-term health and wellbeing. Deprivation (including financial, food, housing, and fuel poverty) amplifies the effects of unhealthy behaviours and negatively impacts on people's life chances (including their likelihood of smoking, quality of education and employment) and their health and wellbeing. Unhealthy behaviours in youth and early adulthood significantly determine a person's health in later life so prevention and early intervention throughout the life course is vital. [8]

There is a need to address all types of prevention: primary prevention by promoting health and wellbeing and preventing ill health; secondary prevention through early detection and intervention of ill health thereby reducing its severity and impact, halting or slowing its progress, and where possible promoting recovery and preventing/delaying relapse; and tertiary prevention where the impacts of ill health are minimised and quality of life and wellbeing are promoted.

An integrated holistic approach rather than a disease centred approach is needed to address frailty prevention properly and effectively. A comprehensive frailty prevention approach should encompass

- Starting well - giving children the best start in life and promote intergenerational health and wellbeing;
- Healthy ageing - including integrated health and wellbeing approaches that support health promoting lifestyles and behaviours, for example, personal resilience, health weight, physical activity, nutrition, smoking cessation, substance misuse recovery and sexual health;
- Reducing health inequalities - including those associated with poverty, housing, education and employment;
- Living and ageing well approaches with embedded education and enabling ethos - including , healthy, safe and enabling environments, self-care, falls prevention, medication reviews, vaccinations programmes, promoting nutrition and hydration, home exercise programmes, support to regain skills such as cooking or dressing, and approaches that build social networks and reduce isolation, depression and anxiety (Hendry A et al, 2018.);
- A personalised approach that includes the identification of people's health and well-being, individual circumstances and priorities and values, resilience, capacity and assets. Support and resources should be tailored (as appropriate) to promote health, wellbeing, personal capacity, resilience and individual and community assets.

By strengthening and better coordinating the local prevention approaches at all levels it will deliver improved outcomes for the local population. This has highlighted a need for greater focus locally around primary prevention through promoting physical activity, nutrition, social participation ensuring people have adequate, warm and safe accommodation and reducing health inequalities. Early identification within secondary prevention will reduce the need for more intensive health and social care, and tertiary prevention will be enabled by comprehensive geriatric assessments, routine annual health check-ups, and supporting patients to have the ability to self-care. To further support people to achieve their goals, an outcome based approach should be utilised. Using this approach we are clear that the starting point of any planning process should be a clear statement of what conditions of wellbeing are desired (the outcome). Starting with outcomes enables us to step back from the things we are already doing or commissioning and explore what needs to be done, by whom and with whom to achieve improved outcomes

[8] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report-2018.pdf

for the citizens and places of Kirklees and the people who use our services. If we achieve the seven outcomes for Kirklees (see appendix 1) we will know that people are ageing well.[9]

[9] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report-2018.pdf

Domain 1: Prevention

Principles:

- Preventing and reducing the risk of frailty
- Reducing the severity and impacts of frailty
- Living well with frailty, promoting independence and community skills
- Physical and mental health and wellbeing

How will the Domain be embedded locally?

- Starting well programme
- Health Weight Declaration and associated work-streams
- Integrated Wellness Model and associated resources including Integrated Wellness Service, Community Plus, Social Prescribing
- Falls service and falls prevention work-stream
- Promoting physical activity, nutrition and social participation
- Medicines optimisation
- Self-care initiatives and resources
- Education and awareness locally to ensure the population of Kirklees:
    - Understand the importance of exercise, physical activity, diet and hydration for preventing and reducing the risk of frailty
    - Are aware that factors such as smoking, obesity and inactivity increase the risk of frailty
    - be aware of and be able to access services such as health checks, free eye and hearing tests and home safety checks
- Act on day-to-day interactions with people to encourage changes in behaviour that will have a positive impact on the health and wellbeing of individuals, communities and populations, i.e. Making Every Contact Count
- Effectively communicate messages about healthy living according to the abilities and needs of individuals
- Facilitate access to sources of health promotion information and support
- Understand approaches to prevent or reduce the risk of frailty syndromes
- Understand the importance of early recognition and timely management of frailty syndromes
- Developing capabilities in prevention, risk reduction, and a range of specific actions to support living well with frailty and maintaining independence to enable people and practitioners to deliver timely, high quality interventions that will in turn improve the outcomes and quality of life for people living with the condition.

Outcomes:

- Population of Kirklees will start well, live well and age well
- People in Kirklees live independently and have control over their lives
- People in Kirklees are more active, healthy population
- Fewer people in Kirklees will become frail or experience the acuity of Frailty worsening

Measures

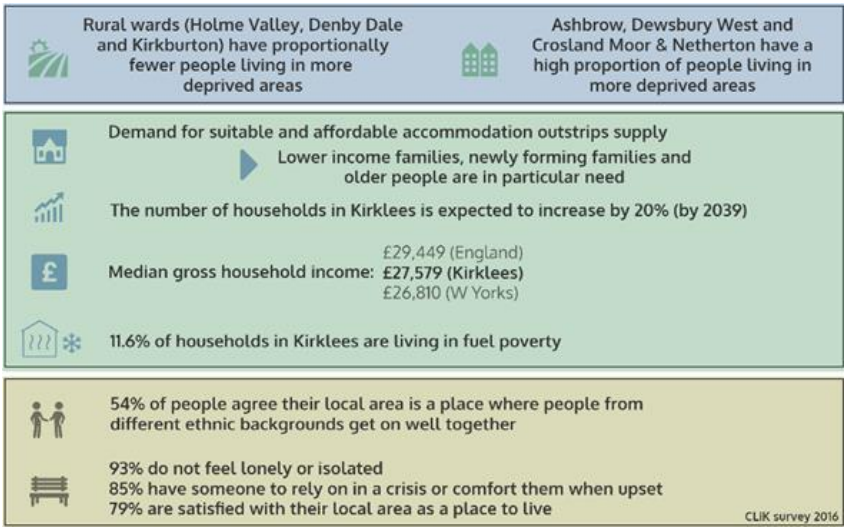
- Breast-feeding rates
- Smoking rates
- Levels of physical activity
- Levels of wellbeing
- A&E presentations for dehydration and malnourishment
- Population with one or more long-term condition
- Home suitable for personal needs
- Living in poverty
- Reduction in the number of people who are identified as frail
- Reduction in the number of falls
- Reduction in the acuity of people identified as being frail

DOMAIN 2: HEALTHY AND SAFE ENVIRONMENT

Creating a physical environment in which people can live healthier lives with a greater sense of wellbeing is hugely important in reducing health inequalities. Living close to areas of green space including parks, woodland and other open spaces can improve health, regardless of social class. The more deprived the neighbourhood, the more likely it is to have social and environmental characteristics presenting risks to health.

Decent, affordable and appropriate housing is increasingly needed to meet the current and longer term needs of the population. In Kirklees 1 in 6 (16%) homes were in poor condition and often occupied by people who were most vulnerable (elderly, economically inactive, socially isolated) and who were unable to bring their homes up to a decent standard and maintain that standard. Overall, 1 in 6 (16%) householders felt their house was not suitable for their needs; older people were more likely to feel it was too large and families with children were more likely to feel it was too small.

In areas of Kirklees where high deprivation levels existed there were corresponding high levels of non-decent, poor quality housing, especially in the private rented and owner-occupied sector within central Huddersfield and Dewsbury.[10]



There are however a range of local assets in Kirklees that make a huge contribution to families and communities by supporting people to improve their outcomes, their wellbeing and their health. It is vital to build on the assets of individuals and communities, including those in later life. These contributions can only be ensured if we foster people's health and participation as they age, through environments which promote accessibility, equity, safety, security and support age friendly environments. The Ageing Well in Kirklees [11]report further defines these assets and provides detail and guidance on actions that can be taken.

[10] https://observatory.kirklees.gov.uk/jsna/housing

[11] https://www.kirklees.gov.uk/beta/delivering-services/pdf/public-health-report-2018.pdf

Domain 2: Healthy and Safe Environment

Principles:

- Living well with frailty, promoting independence and community skills
- Voluntary, community, social enterprise and housing sectors as key partners and enablers

How will the Domain be embedded locally?

- Community services will support patients to stay at home safe and well (this includes the development of the Kirklees Independent Living Team model)
- Regularly re-assess needs within the living environment to ensure frail people remain as independent and safe as possible and the chance of re-admission to hospital is kept to a minimum
- Promote a 'home first' philosophy to support as many frail people to stay in their own home environment
- Provide intense health and social care within the community in times of crisis and choose to admit only those frail people who have evidence of underlying life-threatening illness or need for surgery
- Discharge to assess as soon as the acute episode is complete in order to plan post-acute care in the person's normal place of residence
- Provide rapid access to equipment; support services and a flexible bed base
- Maximise potential of Mobile Response through increased use of Care Phones
- Community providers work re digital technology
- Domiciliary Care provision
- Falls service and falls prevention work-stream
- Links with loneliness
- Good neighbour scheme

Outcomes:

People in Kirklees who are frail will have improved health and wellbeing though:

- Being able to maintain their independence and enjoy the best possible quality of life where ever they live
- Professionals competently providing advice, guidance and signposting on changing or adapting physical and social environments to ensure physical safety, comfort and emotional security
- Professionals and patients awareness of how living with frailty affects and is affected by many different aspects of a person's life (including the person's physical health, immobility, mental health, loneliness, cognitive function and their social and home environment) and is actively supported to self-care and signposted to supports as appropriate
- Living in enabling and supportive environments where they feel valued and understood.

Measures

Increase in the number of people that are:

- Supported with digital/assistive technology
- Having appropriate equipment/home adaptations
- Have accessed social prescribing or signposted onto relevant services

DOMAIN 3: SUPPORTIVE NETWORKS

Effective and sensitive communication that takes account of individual characteristics, needs and circumstances is required to develop supportive, caring relationships with people living with frailty. It is also needed to build and support the networks of care that enable people living with frailty to maintain their independence and enjoy the best possible quality of life, whatever the extent of their frailty and the circumstances of their life. Domain 3 will therefore focus on supportive networks.

Families and carers provide the key foundation for this care for many people who are living with frailty. However, due to the complex and multidimensional nature of frailty, people living with the condition also often benefit from the involvement of a wide range of other people and organisations. In order to achieve the best outcomes, these individuals and organisations must work in close partnership with individuals living with frailty, their families, carers, and of course with each other.

An individual's health, emotional wellbeing and quality of life are highly dependent upon wider social and economic circumstances. Factors such as isolation and housing may have pervasive effects that reduce an individual's ability to manage their own health and respond to illness.

In Kirklees, a higher proportion of people report being lonely all or most of the time in North Kirklees (8%) compared to Greater Huddersfield (6%). Loneliness is highly related to deprivation, with the proportion reporting being lonely all or most of the time around ten times higher in the most deprived groups compared to the least deprived groups (11% vs 1% NK | 10% vs 1% GH). Around one in ten people report they do not have someone they can rely on in a crisis (9% NK | 8% GH). This value is lower for those over the aged 65+ (5% in both CCGs).

Around nine in ten people are socially connected (defined as having someone to rely on in a crisis or having someone to provide comfort when upset). Social connectedness is slightly higher for Greater Huddersfield (86% NK | 88% GH) and significantly higher for older adults across both CCGs (91% for ages 65+ | 86% for ages 18-64).*Taken from Kirklees Observatory*[12]

[12] http://observatory.kirklees.gov.uk/jsna/CCG

Domain 3: Supportive Networks

Principles:

- Families and carers, or representative of the individual as partners in care

How will the Domain be embedded locally?

Support Programmes and Services

- Offer referral to patient support programmes (Expert Patient (now within the Wellness model), DESMOND, Advocacy)
- Sign-post to appropriate services and resources e.g. social prescribing
- Work with the voluntary sector as partners in both the development and delivery of frailty (and associated services that promote health and wellbeing that contribute to the agenda) services and pathways and build on the key role they play in currently delivering services tackling loneliness and isolation
- Ensure all people identified with moderate/severe/very severe (palliative) frailty are assigned a case manager/Care Companion
- Build on the Kirklees Directory of Services and make widely accessible
- Work with voluntary sector

Family and Carers:

- Family, carers and social networks will be involved in planning and providing care
- Value and acknowledge the experience and expertise of people, their families, their carers and support networks, enabling choice and independence as far as is practical
- Patients, family and carers will be supported to access and use information and local support networks
- Ensure patients identified as being palliative or at the end of life, and their carers, feel supported both during end of life care and after the person has died
- Care navigation

Social Isolation and Loneliness:

- Social isolation and loneliness strategy group developed across Kirklees with representation from key stakeholders – currently developing an action plan

Workforce:

- Embed the Frailty Core Capability Framework locally which will support the workforce to have the correct skills in supporting people living with frailty
- Mechanism will be established to ensure professionals are aware of social networks or groups which provide leadership within the community to support people living with frailty and how they can get involved

Outcomes:

People in Kirklees who are frail will have improved health and wellbeing through:

- Increased professionals and patients understanding of the associated impact of social isolation and the importance of social networks and communities for people living with frailty and their carers, and improved signposting where appropriate and support for patient choice
- Increased awareness and understanding (public and professional) of the importance of home and a 'caring network' (family, friends and others around an individual) in enabling people with frailty to live well
- Support for patients to maintain and develop new social connections, have opportunities to learn new skills and being able to contribute back to the community
- Patient's access a wide range of networks, feeling able to accept offers of help and recognising when and how to ask for help when needed.

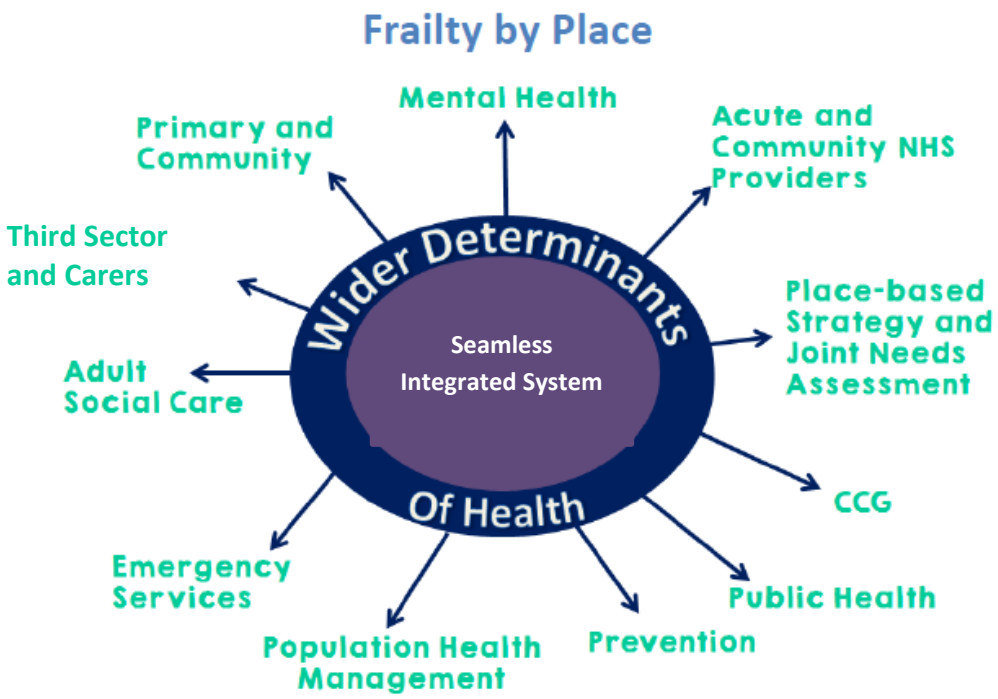
Measures

Increase in the number of people who are;

- Socially connected/regularly engaging in social activity
- Carers and family aware of what help, advice, information is available
- Voluntary sector staff and volunteers understand frailty and are aware of information and services available for people who are frail and their families.

DOMAIN 4: SEAMLESS INTEGRATED SYSTEM

As outlined previously, there is an acknowledgment that a number of complex systems still exist within Kirklees where services are often fragmented. Domain 1 will therefore focus around the Kirklees system and how commissioners and providers work closely together to ensure services are joined up and avoid fragmentation. This will build on the concept around shared MDT discussions between different organisations and services to take a collaborative approach. This will be strengthened through the integration agenda between the two CCGs and Kirklees Council whereby services will be commissioned jointly in the future where appropriate. There are many different services and organisations involved in frailty and this can make it confusing for patients and professionals to navigate the system. Therefore we all need to work together to ensure the best possible outcomes for patients. Through this approach, clinical variation will be significantly reduced for frail patients through effective monitoring, planning and continuous service improvement to deliver streamlined care



Domain 4: Seamless, Integrated System

Principles:

- Collaborative and integrated working
- Leadership in transforming services
- Research and evidence-based practice
- Reduced duplication and variation across the system
- Effective use of resource
- Communication

How will the Domain be embedded locally?

Integration

- Due to the interdependencies and joint working of the projects across Health and Social Care, frailty is one of the focus areas for integration between the two CCGs and the Council
- Undertake reviews of current service provision and the development of new models jointly between Health and Social Care
- Ensure care is co-ordinated and system wide
- Develop a process to integrate systems allowing the sharing of care planning information, where the person has consented

Shared Vision

- A shared vision, aim and objectives will be owned by all key Stakeholders
- Hold a local summit with all Stakeholders to agree the vision, strategy, definition of frailty, gap analysis and key actions and milestones
- Providers will be supported and encouraged to work together in a holistic way putting the patient at the heart of decision making

Assessment Tools and Templates

- System-wide recognition of the signs of frailty
- Standardised way of identifying frailty and stratifying frailty status (assessment tools and templates)

Communication and Engagement

- A communication and engagement plan will be developed to ensure all key Stakeholders remain up to date with progress of each project. This will include regular reports through formal governance structures
- Raise awareness of frailty and the risk factors associated across the Kirklees health and social care system
- Regular communication channels with all stakeholders
- Ensure appropriate training of "all things frailty" is available for all staff across all sectors. This includes frailty recognition, assessment tools, Delirium and Advance Care Planning

Best Practice:

- Ensure an evidence-based consistent approach to assessing frailty

Workforce:

- Embed the Frailty Core Capability Framework locally

Outcomes:

People in Kirklees who are frail will have a better experience of care and improved health and wellbeing through:

- The integration of the frailty programme across health and social care
- Engaged stakeholders working together towards a common goal with a single approach to frailty and joined up services.
- Highly skilled and educated workforce with the correct competencies to meet the needs of the population (in line with the Core Capability Framework)
- A single approach to frailty assessments and reduced duplication and variation
- Stakeholders aware of progress with local projects
- The local recognition of frailty as a LTC (long-term condition).
- People in Kirklees with signs of frailty will have improved health and wellbeing outcomes through system wide recognition of the signs of frailty and what to do when signs of frailty are found as a result of earlier identification and help.

Measures

- Evidence the impact of joint projects and commissioning across health and social care. This should be achieved through effective measure of the 3 domains of quality (user experience, patient outcomes and safety of care)


working together

DOMAIN 5: HIGH QUALITY, PERSON CENTRED AND PERSONALISED CARE

Some of the challenges identified locally include some of our services being reactive to patients presenting in a crisis, often with a specific physical problem that has become urgent. Also many of our services are designed to treat one condition at a time missing out on the benefits of using a holistic approach.

Domain 2 will therefore involve a number of projects to ensure patients receive the best personalised services in accordance with their needs, in a timely manner, using a shared decision making approach and embedding holistic assessments (see appendix 4). This will be underpinned with the ethos of providing the right care in the right place at the right time, first time; with a focus on quality, spend and patient outcomes.

The 3 elements of quality (clinical) are identified and measured through:

- Patient experience
- Clinical effectiveness
- Patient safety

The delivery of high quality services therefore requires the above 3 elements to be measured throughout the patient journey which allows providers and commissioners to identify what works well and which areas require improvement. This will contribute towards a seamless pathway and wrap around care for patients. Evidence based pathways are also key. There have been a number of national documents and guidance published around Frailty and the Kirklees system needs to review these and ensure they are implemented and embedded locally.

Other quality aspects and measures are required to address the environment, loneliness and isolation, physical conditioning, strength and balance and all that contribute to promoting health and wellbeing. These factors reduce the risks associated with the impact of frailty.

Taking a person-centred approach to care, which recognises values and builds upon this individuality, is essential in helping to achieve the best outcomes for people living with frailty. NHS England has a strong focus on person centred and personalised care with the role out of the personalised care operating model (see appendix 5). This model will be embedded across the system.

In order to provide a high quality, personalised approach to frail patients, firstly they need to be identified in order to be managed and supported appropriately. Frailty is relatively easy to recognise when severe, but identifying it in people with less advanced frailty can be challenging. It's important that people who are defined by the electronic Frailty Index (eFI) as fit, mildly or moderately frail are supported to manage their health and wellbeing as they age, while those identified as living with severe frailty are properly supported according to their needs.[13]

[13] https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/

Domain 5: High Quality, Person Centred and Personalised Care

Principles:

- System wide understanding of frailty
- Proactive support and prevention
- Physical and mental health and wellbeing
- Care and support planning
- Frailty identification and assessment
- Person-centred approach
- Voice of the individual first

How will the Domain be embedded locally?

Person Centred:

- Understanding individuals ability to self-care and their protected factors in relation to the risk of development of frailty
- Individuals are supported to engage fully or a representative of the individual are supported through decision making in their best interests

Patients at the heart of decision making:

- NHS England Personalised Care Operating Model will be embedded (see appendix 5)
- Shared Decision Making
- Making Every Contact Count
- Promote self-management through long term condition reviews
- Promote healthy lifestyles through NHS Health Checks
- Offer support for individualised goals (health trainers, PALS)
- Ensure people are informed as early as possible about the approach to end of life to enable informed decision making about their preferences

Education:

- Patient education to support improved self-management skills to help people with frailty to improve their wellbeing
- Ensure appropriate training of "all things frailty" is available for all staff across all sectors. This includes frailty recognition, assessment tools, Delirium, Advance Care Planning and supporting professionals to develop their skills in order to sensitively discuss end of life needs

Early frailty identification and assessment:

- Use the electronic frailty index tool to identify those at risk of frailty and understand our frail population
- Develop a process for stakeholders to inform general practice of those at risk of frailty
- Promote consistent use of frailty assessment tool (Rockwood) to confirm frailty across all sectors
- Promote prevention and support services for those identified with mild frailty
- Offer a full comprehensive frailty assessment for those identified with moderate and severe frailty
- Support those assessed as severely frail or palliative to access end of life care that is timely and compassionate
- Support Primary Care with frailty aspects within the GP contract, changes to QOF codes and local quality improvement schemes (see appendix 6)

Best Practice:

- Ensure commissioned services are in line with best practice, including NICE guidelines and nationally published documentation

Service Outcomes and KPIs

- Align service outcomes and robustly monitor for effectiveness, quality and patient experience

Care Plans:

- Outcome-focused care planning undertaken with a strengths-based approach. Agree to use a range of care planning tools to support the varying needs of our population
- Use the approved NHSE audit tool as a framework to ensure care plans are personalised
- Where appropriate use the Patient Activation Measure as a marker of a person understands of their condition and how to manage it.
- People with severe frailty who are approaching the end of life should be offered the opportunity to agree an **End of Life Plan** which articulates their wishes and preferences around future care (EPaCCS)

Workforce:

- Services delivered by qualified and well trained staff.
- Embed the Frailty Core Capability Framework locally

Outcomes:

People in Kirklees who are frail will have improved health and wellbeing through:

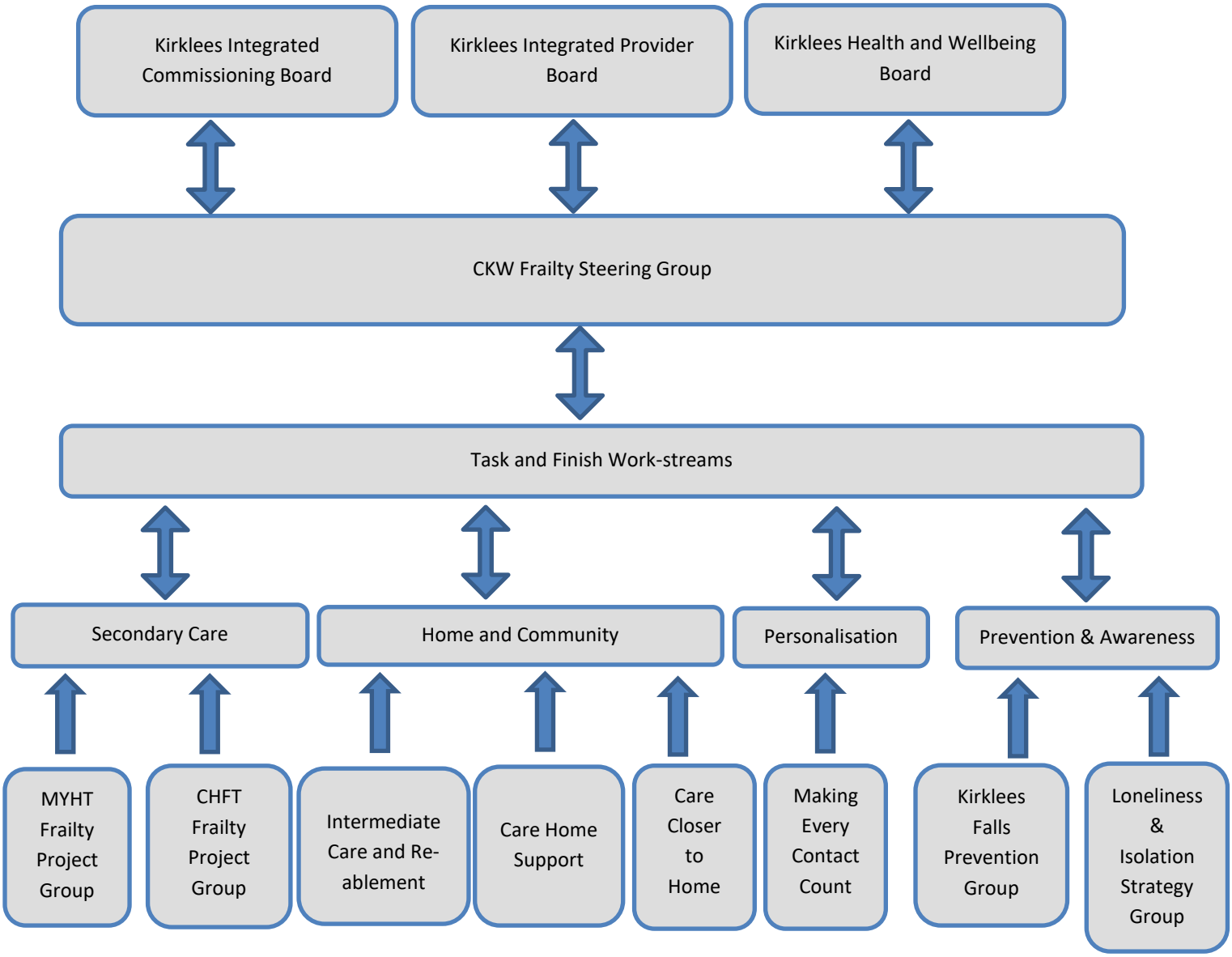
- Personal choice and control over the decisions that affect them
- Early identification, risk stratification, management and support

- Increased shared decision making and patient understanding around frailty and keeping well through self-care
- Access to personalised care and selection of outcomes that matter to them the most (refer to I-Statements)
- Maximised independence

Measures:

- Increase (against estimated prevalence) in the number of people that are identified as mild, moderate and severely frail (identification of the previously unidentified)
- Increase in the proportion who are identified earlier (i.e. mild)
- Increase in the number and proportion of people who feel more confident and able to manage their own health and care
- Frailty services meeting their set KPIs

GOVERNANCE ARRANGEMENTS



APPENDICES

APPENDIX 1: SEVEN KIRKLEES OUTCOMES

APPENDIX 2: THE NHS RIGHTCARE PATHWAY

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The NHS RightCare Frailty Pathway

NHS RightCare

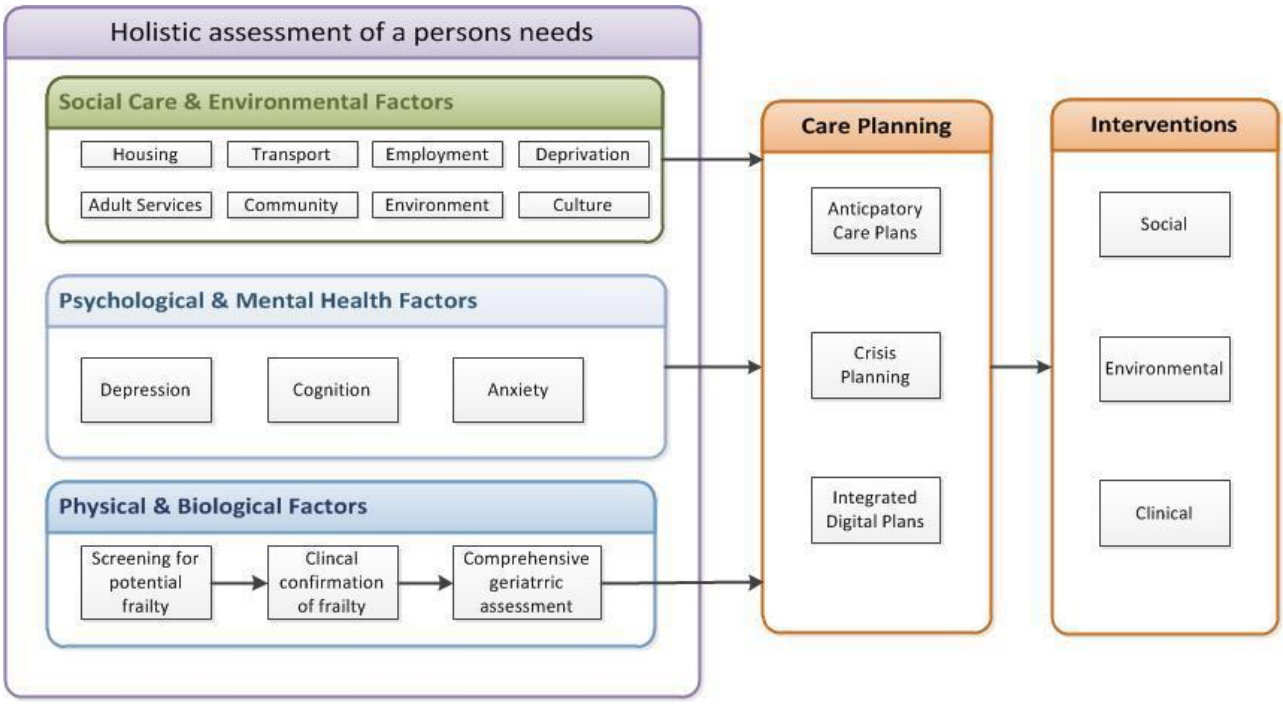
Priorities			
Population segmentation, identification and stratification of frailty			
• System-wide recognition of the signs of frailty • Know what to do when signs of frailty are found		• Standardised way of stratifying frailty status • Identify frailty & frailty status	
Supporting people with mild frailty and encouraging people to 'age well'	**Support people with moderate frailty**	**Reduce hospital length of stay**	**Support people with severe frailty**
• Define the local healthy lifestyle offer • Education & understanding of frailty • Supported self-care • Nutrition • Mild frailty: acknowledge, understand and address the condition	• Multidisciplinary assessment of risk stratified patients • Home and/or community based rehabilitation • Recognition of deterioration	• Crisis response • First 24 hours • Effective rehabilitation • Transfers of care to new care setting • Co-ordination of care through sharing information	• Training & capabilities of social care staff • Management of urgent care situations • Enhance healthcare in care homes • End of life care
Falls and Fragility Fractures			
Delirium, Dementia and Cognitive Disorder			
• Early identification of delirium		• Education of population, patients, families & carers	
Personalised care			
• Advance care planning		• Shared Decision Making	
The case for change		**Self assessment check-list**	

APPENDIX 3: POPULATION CHARACTERISTICS AND OUR FOCUS

Population characteristics		Our focus	What we know about this group
Living well	Majority of the population who are largely healthy (both mentally and physically), manage their own health and wellbeing and have little requirement for contact with formal or statutory services. A proportion of this population are subject to risk factors related to behaviours (smoking, alcohol consumption, diet and exercise) or social factors (employment, housing, social isolation).	Keeping people well, physically and emotionally through the creation of healthy places which promote healthy behaviours and of resilient, connected and vibrant communities Reducing risk factors associated to healthy behaviours or social factors, often linked to inequalities	There are 91,000 adults living in Kirklees who are in the segment most poorly motivated to look after their health
Independent	A significant proportion of our population are living with conditions or social factors impacting their health and wellbeing, who are largely managing independently or with informal support Within this cohort, people will be accessing GP support or outpatient appointments specific to their needs	Enable this population group to manage their own health and wellbeing through access to information, advice, support and digital opportunities Ensure holistic support for physical and mental health and wellbeing needs	84% people over 50 has a long-term condition (67% people under 50). Half of these people are managing alone
Complex	A small proportion of our population are living with multiple long-term conditions, significant disabilities and complex needs, some may be at the end of their life The needs of this group are often significant and debilitating, preventing work or regular opportunities for engagement with the wider community. Cost of provision of support to this group is very high.	Create a new offer for people with complex needs which will: • Focus on strengths and assets in planning support • Reduce duplication between services and number of times a person has to tell their story • Focused on planned and preventative interventions rather than a reactive need for unplanned acute and urgent services	Approximately 30,000 people over 65 are living with three or more long-term conditions
Acute or urgent	At any time, some proportion of our whole population will have acute or urgent needs which need swift and/or specialist interventions	Ensure that where people require urgent, acute or specialist care, this will be the right intervention provided in the right setting in a timely way	On an average day (taken on 03/10/17) there are 437 A&E attendances and 8,744 routine and urgent GP appointments across Kirklees

Taken from the Health and Wellbeing Plan

APPENDIX 4: HOLISTIC ASSESSMENTS OF A PERSON'S NEEDS



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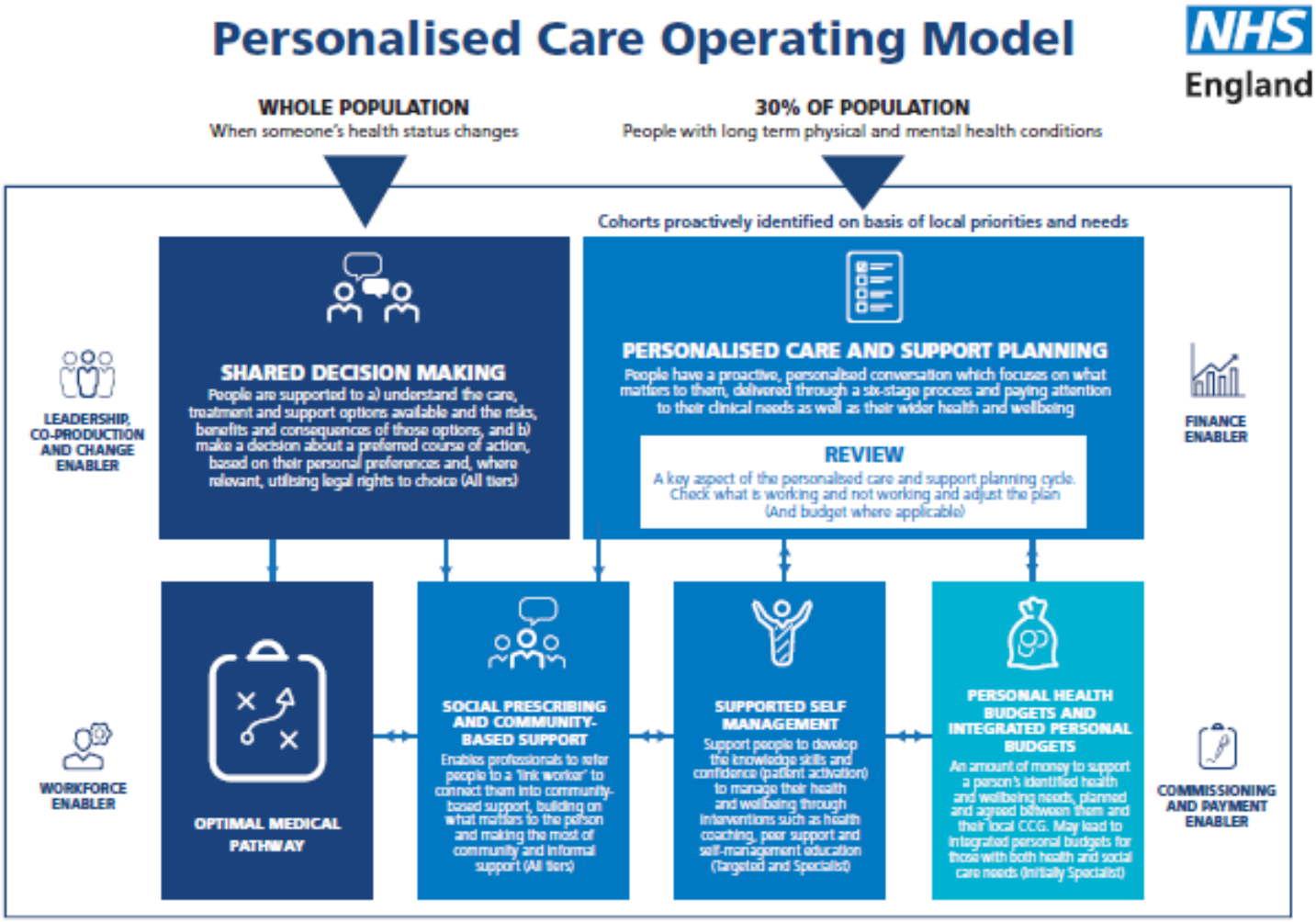
APPENDIX 5: PERSONALISED CARE OPERATING MODEL



APPENDIX 6: PRIMARY CARE AND FRAILTY

The Primary Care contract requirement on frailty is to proactively identify older people (aged 65 and older) who are living with severe or moderate frailty using an evidenced based tool. People identified will be offered a small number of key evidence-based interventions which include annual medication review (severely frail only), falls risk identification and promoting the use of the additional information in the Summary Care Record.

In addition, in North Kirklees, as part of the Quality Access Scheme (1st April 2018 – 31st March 2020) practices are being asked to provide a holistic comprehensive frailty review for those patients identified as being moderate and severely frail and to identify and assign a Care Companion to support this patient cohort. Clinical templates are available to guide clinicians through the frailty review.

FRAILTY CLINICAL READ-CODES

Frailty diagnosis	SYSTMONE	EMIS
MILD	XabdY	2Jd0.
MODERATE	Xabdb	2Jd1.
SEVERE	Xabdd	2Jd2.

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