**Frailty Workshop 28th November 2024**

Executive Summary



This report summarises the outcomes of the Frailty Workshop held in November 2024. The workshop brought together partners from Primary Care, GHC, GCC, District and Borough Councils, GHNHSFT and VCSE to focus on the future of frailty services in Gloucestershire.

The feedback from the workshop captured several themes, including the need for an **integrated care approach** that uses **a proactive and systematic** method to **identify and manage frailty**. This approach would be delivered through a **person-centred approach**, with an emphasis on multi-disciplinary collaboration. To meet a person’s acute and chronic needs, it was highlighted that this approach require a range of **timely, responsive services** available 24/7 access to clinical and non-clinical care as well as **specialist support**.

Key preventative and proactive themes that emerged focused on **inclusive community engagement**, increasing public awareness, and promoting positive messaging about healthy ageing. There was also recognition that monitoring impact and **continuous improvement**, needed to be a key feature of future frailty provision supported by data-driven decision making. This approach would help support the ambition of addressing health inequalities and equalising resource allocation.

The information below details the responses to four key questions: what good frailty management looks like, current service availability, perceived gaps, and suggested solutions.

**Ideal Frailty Services**

*The workshop identified several characteristics of an ideal frailty service.*

1. **Multi-disciplinary Team (MDT) and Multi-agency Working**: Collaboration between healthcare providers, social care, housing, commissioned third sector services and community organisations is crucial.
2. **Proactive and Systematic Approach:** Implementing systematic use of tools such as Comprehensive Geriatric Assessments, proactive screening, and self-assessment tools.
3. **Holistic Assessment:** Incorporating wider determinants of health and focusing on what matters to the individual captured in a personalised care plan with a greater focus on a proactive rather than reactive approach.
4. **Continuity of Care:** Ensuring consistent care delivery across different settings and that care is coordinated.
5. **Good Communication:** Effective and timely information sharing between stakeholders, including digital care plans and shared electronic patient records. Integrated working that supports collaboration, building trusted relationships and a shared risk management approach.

**Perceived Gaps in Services**

*The workshop identified several gaps in frailty services.*

1. **Awareness of and access to services**: Variable awareness of available services and difficulties in reaching disengaged individuals.
2. **Integration and Collaboration**: Need for better integration between stakeholders such as primary care, social care, housing services, commissioned third sector services and VCSE organisations.
3. **Capacity and Coordination**: Insufficient rehabilitation services and capacity issues in Rapid Response teams.
4. **Timely access to Specialist Services and Support**: e.g. continence, rehabilitation, or dental care, which may result in deterioration and deconditioning.
5. **Technology and Tools**: Limited and variable use of AI tools or personalised proactive whiteboard for service demand analysis or risk stratification.
6. **Availability of 24hr responsive:** short term non-clinical, social support for crisis.

**Suggested Solutions**

*The following solutions were suggested as priorities for developing frailty services.*

1. Resource Allocation and Integration: **Improve coordination** among Integrated Neighbourhood Teams and **enhance integration** between different health delivery partners, social care, commissioned third sector services and community services.
2. **Data-Driven Decision Making**: Implement risk stratification and population health management tools.
3. **Community Engagement and Education**: Develop strategies that promote a strength-based approach through engagement, raising awareness. Equip staff with knowledge, skills, resources, and access to support to provide evidence-based care.
4. **Transport and Access**: Expand transport options and improve access to care services and community provision. Ensure services and available support reflects cultural variations and harnesses local provision.
5. **Long-term Strategic Planning and Capacity Building**: Develop a longer-term view of frailty services and **metrics and outcomes measures.**

Workshop attendees were split into geographically based groups (PCN’s) – Stroud, Cotswolds, Cheltenham, Gloucester, Forest of Dean and Tewkesbury. They were asked 4 questions:

1. Management of frailty: What does good look like?
2. Current service provision: What is currently available in your area to meet the needs of people living with frailty?
3. Gap analysis: What are the current gaps in services and support in your locality?
4. What solutions and ideas do you have to address these gaps?

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| **QUESTION 1: What does good look like?** |

The analysis of the workshop output regarding "what good looks like" for future frailty services reveals several common themes across different geographic groups. These themes have been ranked based on their frequency of mention and perceived importance.

**Common Themes and Rankings**

1. **Multi-disciplinary Team (MDT) and Multi-agency Working**

* Collaboration, trusted relationships, and shared risk taking between healthcare providers, social care, community organisations, and other partners.
* Key aspects include reducing silo working, partnership building, and improved involvement of key stakeholders such as geriatricians, pharmacists, frailty services, the person, and family.

2. **Proactive and Systematic Approach**

* A proactive approach to identifying, triaging, and managing frailty was a recurring theme.
* This includes proactive screening and risk stratification and systematic use of tools like Comprehensive Geriatric Assessments (CGA) and Clinical Frailty Scale (Rockwood) scores.

3. **Holistic Assessment**

* Emphasised as a critical component of good frailty services, incorporating wider determinants of health such as housing, social support, and community resources.
* Focus on personalised care plans designed in collaboration with people, family, and carers.

4. **Continuity of Care**

* Ensuring consistent care delivery across different settings and over time.
* Includes regular reviews of care plans and medication.

5. **Good Communication**

* Effective information sharing between stakeholders. Use of tools such as Personalised Proactive Whiteboard to support identification and co-ordinate management of care.
* Includes digital care plans, access to shared electronic patient records (e.g. Sunrise EPR), and clear communication pathways.

6. **Timely Support**

* The need for responsive services that have sufficient capacity and provide timely interventions to prevent crises.
* Includes proactive discharge planning from hospitals and timely access to community support.

7. **Addressing Health Inequalities**

* Focus on inclusivity by addressing barriers faced by marginalised communities.
* Suggestions include subsidised low-cost activities and digital inclusion initiatives.

8. **Public Engagement and Awareness**

* Recognised as vital for promoting understanding of frailty and promoting positive ageing well amongst the wider population.
* Health promotion campaigns, that are coproduced with the public.

9. **Specialist Advice and Support**

* Access to specialised services such as geriatricians, pharmacists, housing support, and frailty teams.
* Tools like Cinapsis for advice were also highlighted.

10. **Single Point of Access**

* Simplifying access to services through a central point was a common suggestion.

11. **Education and Capacity Building**

* Building capacity within Voluntary, Community, and Social Enterprise (VCSE) organisations.
* Staff education to improve knowledge and confidence.

12. **Measuring Impact**

* Importance of using an agreed set of metrics to systematically measure outcome, effectiveness, and impact of frailty interventions.

**Summary of Prioritisation**

*The most frequently mentioned themes. These are likely to be the highest priorities for stakeholders.*

* MDT/multi-agency working.
* Proactive/systematic approaches
* Holistic assessment
* Continuity of care
* Communication
* Timely social and clinical advice and support

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| **QUESTION 2: What is currently available in your area to meet the needs of people living with frailty?** |

An analysis of the local services for frailty across different areas in Gloucestershire reveals a range of offerings categorised into Promoting Independence, Proactive Care, Intermediate Care, and Frailty Attuned Care. The below is a summary of services available county-wide and some that are specific to certain localities:

1. **Promoting Independence and Community Events**

Available ‘county-wide’

* Social prescribers
* Strength and balance classes
* Food banks
* Exercise classes (including Tai Chi)
* Community hubs
* Information and awareness raising initiatives.
* Your Circle
* **Locality-Specific Services/support: Choose to Move, Seated exercise, Fit for Life, Cotswold Friends, The Royal British Legion, Fire Safety Checks, social activities (coffee mornings, luncheon clubs), Chatty cafes, Men in sheds, Health Champions, health and wellbeing information leaflet, locality-based education events.**
1. **Proactive Care**

Available ‘county-wide’

* Integrated Neighbourhood Teams (INTs)
* Risk stratification tools.
* Holistic Assessment
* Personalised care coordination
* Active Gloucestershire and the Live Longer Better campaign
* Personalised Proactive Whiteboard
* Virtual wards
* Mental Health Services
* **Locality-Specific Services and Initiatives: Digital HOPE, MYCaW, Geriatricians, Complex Care @ Home team, South Cotswold Frailty Service (SCFS), BRAVE AI for risk stratification, Digital remote health monitoring.**
1. **Intermediate Care**

Available ‘county-wide’

* Community Therapists (Physiotherapists, Occupational Therapists)
* District Nurses
* Falls services
* Continence services
* Cinapsis
* Virtual wards
* Home first
* Integrated care teams – Physiotherapy, Occupational Therapists
* Falls service
* Pulmonary Rehabilitation
* Podiatry
* Continence
* Carers Hub
* **Locality-Specific Services: Same Day Emergency Care (SDEC), Community Hospitals, Home First Reablement, bed-based care, Rapid Response Teams.**
1. **Frailty-Attuned Hospital Care**

Available ‘county-wide’

* Frailty teams/wards in hospitals
* Age UK
* Personalised Care and Support Plans
* Wellbeing budgets
* Integrated flow hub
* Frailty wards/Care Of The Elderly
* Same Day Emergency Care (SDEC)
* **Locality-Specific Services: Impact hub, Integrated flow hubs, dedicated Frailty champion roles.**

**Summary of responses:** It was highlighted that some services appear to be available only in specific localities:

Dementia support services Memory Lane Singers, Dementia cafes), Hoarding support (Happy Homes), Rethink and Art Shape (mental health and art therapy), Befriending services, Housing support (lifelines and minor repairs), frailty teams, Impact Hubs.

It is important to note that that this feedback and observations was from the workshop attendees. There may be additional countywide and local services available that those attending were not aware and therefore did not mention.

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| **QUESTION 3: What are the current gaps in services and support in your locality?** |

Summary of the key gaps in frailty services across different localities as perceived by the attendees. The gaps are organised into four main categories: Independence and wellbeing, Proactive Care, Intermediate Care, and Frailty Attuned Care.

1. **Independence and wellbeing**

**Knowledge, Awareness and Access**

* Lack of awareness about available services (Public and Professionals)
* Limited awareness of existing frailty services among people and healthcare professionals
* Limited access to social prescribing and underutilised community services and assets
* Difficulty reaching those not already engaged with services.
* Confusion about funding options (self-funding vs. ASC funded)
* Limited activities specifically for men

**Information and Communication**

* Lack of real-time, accurate, and consistent information about services
* Need for a comprehensive, up-to-date directory of resources, with consistent information about available/capacity services.
* Challenges in sharing information across multiple directories

**Affordability and Inclusivity**

* Cost of services, such as exercise classes, can be a barrier.
* Need for better cultural understanding and inclusivity in service offerings.
* Limited activities specifically for men and need for greater number of culturally sensitive services.
* Funding sustainability, overreliance on short-term VCSE funding and individual efforts
* Digital divide, with many older adults lacking technological skills or access to devices.
* Variable access to social prescribing (focus depend on PCN priorities and may not always be frailty based)

**Transport and Environment**

* Lack of affordable, accessible, and reliable transport options
* Age-friendly communities’ approach, with improved accessibility that reflects population diversity and is culturally sensitive.
1. **Proactive Care**

**Integration and Collaboration**

* Lack of a single point of access or colocation of services
* Need for better integration between primary care, social care, and housing.
* Limited collaborative MDT working

**Technology and Tools**

* Improvements in use of risk stratification tools like Brave AI and Personalised Proactive Whiteboard
* Limited use of AI tools to analyse service demand.

**Workforce and Training**

* Gaps in falls prevention training across various professionals
* Need for expanded roles of pharmacy teams in supporting proactive care.
* Variations in coding and outcome measures
1. **Intermediate care**

**Capacity, Crisis Support and Coordination**

* Limited access to 24/7 urgent short-term response to prevent hospital admissions.
* Capacity and availability of rehabilitation services, Rapid Response, and Integrated Care Teams
* Knowledge, awareness and understanding of each sector's role.
* Delayed therapy reviews resulting in patient deconditioning and readmission risks.
* Multiple ‘single point’ of access for community services
* Need for improved integration and collaboration between primary care, social care, and housing services.
* Limited access to crisis supports to prevent hospital admissions.

**Communication and Information Sharing**

* Challenges in sharing information across multiple directories and systems
* Inconsistent use of tools like ReSPECT plans for advance care planning
* Mixed messages when people are passed between services.

**Specialist Services**

* Long waiting times for some specialist services, i.e. continence, dental or memory assessment
* Variations in access to community geriatrician support
1. **Frailty attuned care**

**Screening and Access**

* Inconsistent access to vision screening for frail adults on wards
* Challenges accessing care and equipment, particularly outside of normal hours.

**Coordination and Communication**

* Mixed messages when people are passed between services.
* Need for simplified pathways and processes to ensure people and carers can navigate the system.

**Admission and Discharge Planning**

* Need for better pre-admission and discharge communication.
* Lack of follow-through across the system, such as ASC discharging people in hospital without continuity planning

**Local Provision**

* Limited diagnostic outreach to rural areas
* Insufficient local services making access difficult for some populations.

**Summary of responses:** These gaps highlight the need for improved coordination, communication, and integration of services across the health and social care system to better support individuals with frailty. Addressing accessibility could be achieved by providing services (where possible) locally. Affordability was a factor, as well as having a single point of access/contact. A recurring gap was noted as crisis support, in and out of hours that could meet an individual's health and social care needs in a timely way helping to avoid crisis or to offer alternative to hospital admission.

In addition, workshop participants noted that frailty care needs to be evidence based, with a clear set of metrics and data to evidence impact, delivered by staff who have access to specific education, training and specialist services.

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| **QUESTION 4: What solutions and ideas do you have to address these gaps?** |

Based on the responses from the workshop attendees, the following priorities for developing frailty services across the county and in specific areas are detailed:

**Countywide Priorities**

1. **Resource Allocation and Integration**

* Improve coordination among Integrated Neighbourhood Teams (INTs)
* Enhance integration between health, social care, community services and other partners.
* Focus on better use of existing resources.
* **Summary: promote the development of INT’s and integrated Multi Agency/ Multi-Disciplinary working**

2. **Data-Driven Decision Making**

* Implement agreed risk stratification and population health management approaches
* Address health inequalities using deprivation and other data
* Ensure consistent data usage across services
* **Summary: utilise a population health management approach and a systematic risk stratification process to 1) identify people living with frailty, 2) identify those who are at risk of poor outcomes, 3) identify health inequalities**

3. **Community Engagement and Education**

* Develop strategies for raising awareness, motivating people, promoting self-care, and providing information that help the public understand, manage and maintain good health and wellbeing
* Promote wellbeing and frailty education in schools and communities
* Improve communication across systems
* **Summary: Raise awareness of frailty, provide accessible information to promote self-identification of frailty. Utilise a targeted approach to key cohorts of people to help them manage and maintain good health and wellbeing.**

4. **Transportation and Access**

* Expand transport options (carpools, ambulance services)
* Improve access to care and community services and provision
* **Summary: Provide a range of accessible affordable transport options**

5. **Long- term Strategic Planning and Capacity Building**

* Develop a longer-term strategic view of frailty services
* Measure outcomes and economic impact of preventive measures
* Align strategies with Integrated Care System (ICS) expectations
* Clarify leadership roles in frailty care
* Redefine frailty to anticipate needs over time
* **Summary of responses: Ensure a strategic approach achieved through long term planning and capacity building, that anticipates future needs. Use an evidence and best practice-based approach, that measures impact and effectiveness.**

Area-Specific Priorities

1. **VCSE Support**

Strengthen collaboration with voluntary, community, and social enterprise organisations

1. **Physical Activities**

Promote and facilitate physical activities for individuals living with frailty

1. **Emergency and Respite Care**

Establish emergency/respite beds in community hospitals and other settings

1. **Medication Management**

 Explore options for reviewing and optimising medication regimens

1. **Vision Screening**

Address gaps in vision screening services

1. **Care Access**

Improve access to care services

1. **Inter-Service Communication**

Improve the communication between services in order to reduce duplication and enhance care provision and decision making.

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| **Next Steps-** Workshop outputs will be used to: |

1. To support the development of the Gloucestershire Frailty Business Case.
2. To inform the development of the Frailty and Dementia Clinical Programme Group work plan for 2025/26.
3. To inform the development of a best practice frailty model for Gloucestershire.
4. Feedback will shape and inform work plan priorities of the Ageing Well programme.