

Enhancing Care for Frail Older Adults: The Impact of the Frailty Network in Lanarkshire

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Background –

The number of people aged 65 and over is expected to grow by a third by 2045 (National Records of Scotland, 2023). Lanarkshire has taken a whole system approach to frailty to help manage this increase in the aging population. From speaking to a range of stakeholders including service users, it was recognised that to improve a person's experience through our healthcare systems, we must look at their whole journey, both in the community and in acute sites. Therefore NHS Lanarkshire has created a Frailty Strategy, 2023-2028, which focuses on proactive, preventive measure and aims to promote independence so older people can live at home well for as long as possible. This is hoped to allow people to receive appropriate services they require at an appropriate time and follows the **right care, right place, right time ethos** and the GIRFE approach.

The Frailty Network was established in November 2023 to help support this whole system approach to frailty and lead on the implementation of the Frailty Strategy. It is led by a team of frailty practitioners and involves a wider network of people across both acute and community settings. The Frailty Network encompasses the Frailty Strategy ethos of proactive management and was created to discover and encourage positive change within our process' and pathways.

Aim –

The creation of the Frailty Network aims to enhance care for frail individuals within Lanarkshire through integrated multidisciplinary collaboration across acute and community settings. The Frailty Network is focused on creating proactive, personalised, person centric improvements that will help individuals receive the care they require by supporting a whole system approach to frailty.

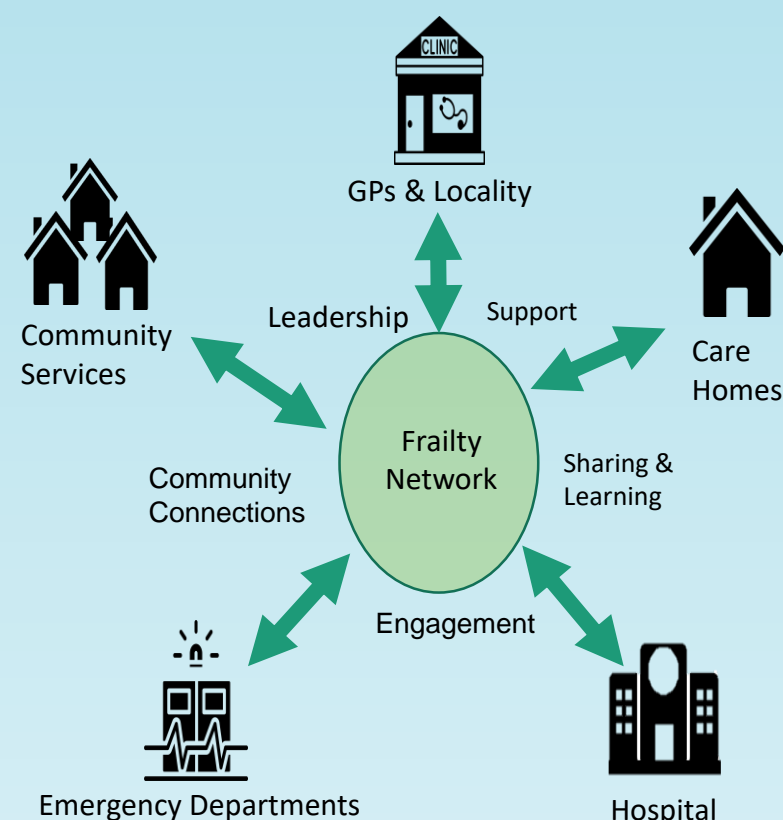


Table 1: Function of the Frailty Network

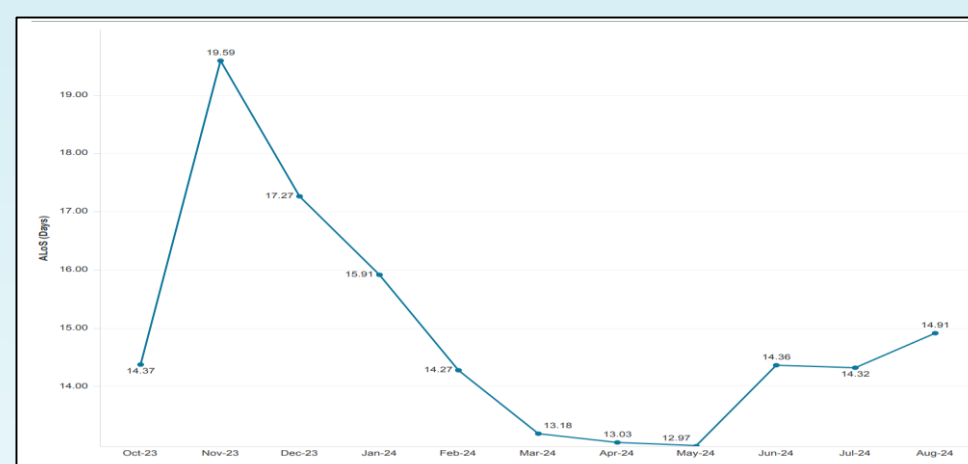


Table 4: LOS in MOA wards Nov 2023 – August 2024

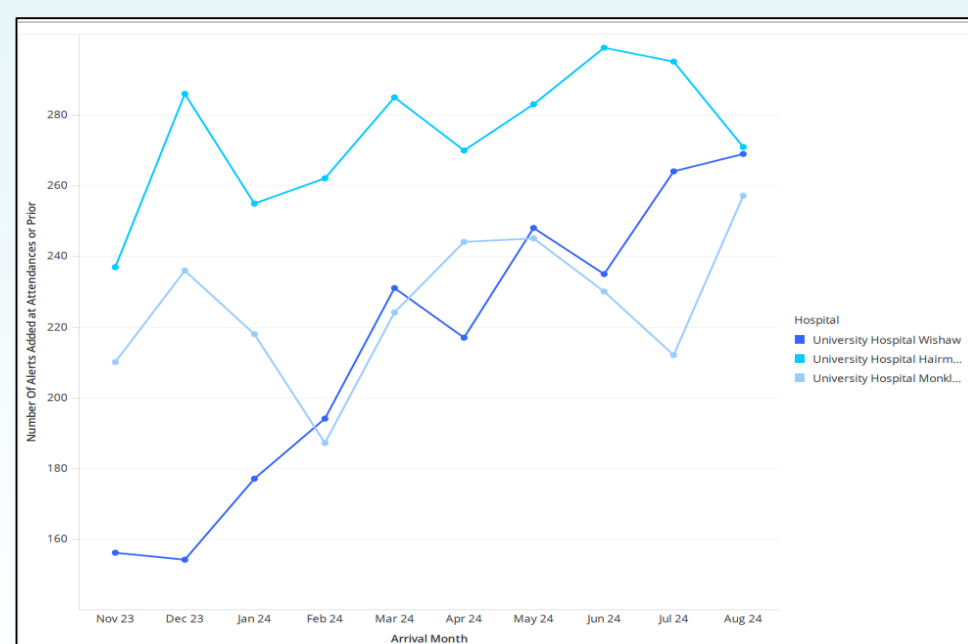


Table 5: Frailty Identification Alerts Nov 2023 – August 2024

Stakeholder Group	Stakeholder Segments	Communication/ Notification Methods
H&SCP	Localities	Face to Face, meetings and emails
	Care Homes	Meeting attendance and emails
	GIRFE	Meetings
	District Nurses	Face to Face, meetings and emails
	Community Rehab Teams	Face to Face, meetings and emails
	GPs	Face to Face, meetings and emails
	Social Work	Face to Face, meetings and emails
NHS Lanarkshire Board	NHSL Flow	Meetings
	Transformation and Reform	Meetings and Planning
Interface	Frailty Network	Monthly Meetings
	Consultant Connect	Promotion
	Hospital @ Home	Support
	Flow Navigation Plus	integration and Support
Acute Sites	ED Teams	Face to Face, meetings, emails
	MOA Teams	Face to Face, meetings, emails
	AHP Teams	Face to Face, meetings, emails
	Pharmacy	Face to Face and emails
	Hospital Managers	Face to Face and emails
Off-site Beds	Off-site bed areas	Face to face, audits, meetings
Third Sector & community teams	Voluntary Action S & N Lanarkshire	Face to Face and emails
	Hospice Services	Face to Face and emails
	Alzheimer's Scotland	Face to Face and emails
Digital Technology	Assistive Technology Team	Face to Face and emails
	Wearable Technology	Emails, Teams
Local Universities	University of the West of Scotland	Face to Face and emails
	Strathclyde University	Face to Face, meetings, emails

Table 2 – Engagement Table & Method of Communication

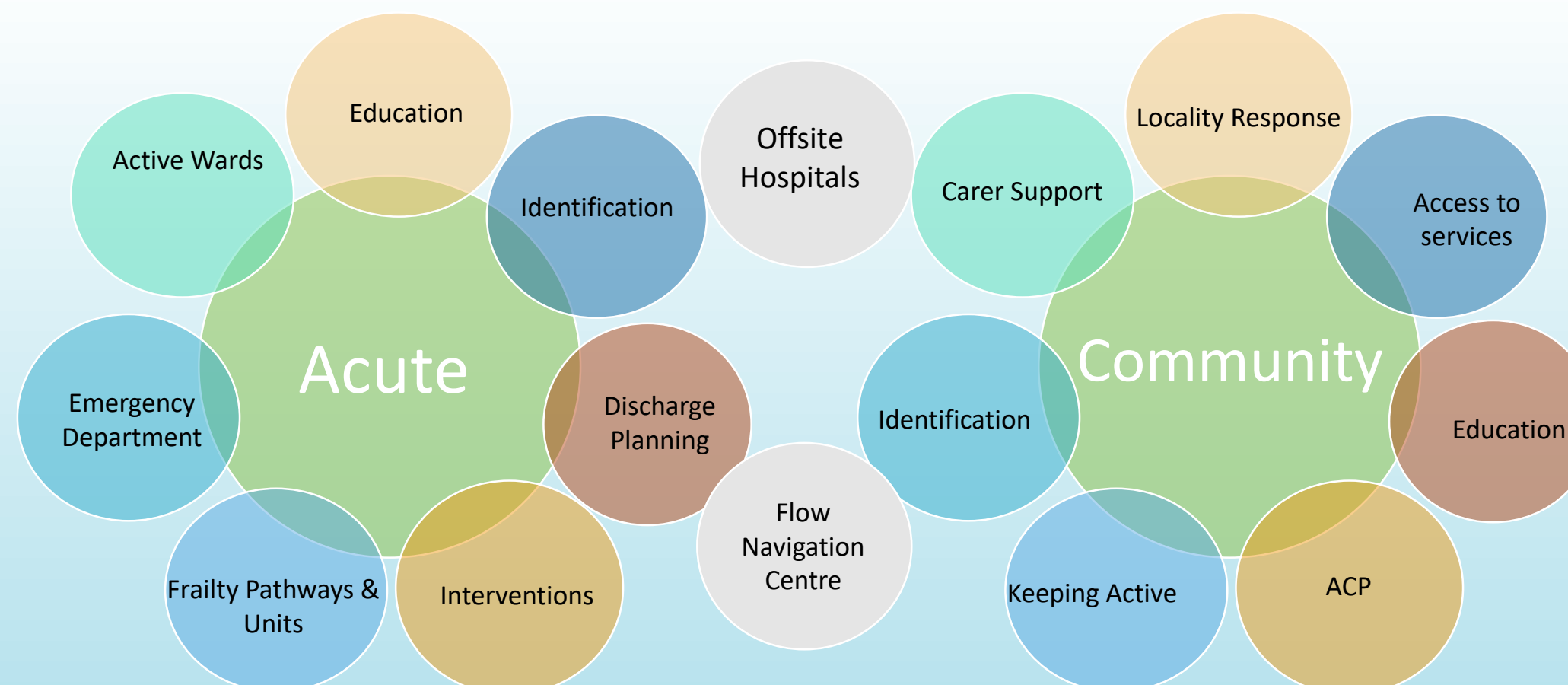


Table 3 - Current Priorities and ongoing work in Lanarkshire

Method –

The Frailty Network is a change idea employed within Lanarkshire to assist in the improvement of the frailty pathways and support a whole system approach. To achieve its aims, the Frailty Network is attempting to create the conditions for change through supportive leadership, innovation and collaboration (Table 1). The first phase of the Frailty Network was ensuring strong communication and engagement with multiple stakeholders from all settings including acute, community and third sector (Table 2). This allowed an understanding on the current pathways and process' and discovering the services that already available for the frail people of Lanarkshire. This step allowed the Frailty Network to focus on ways to enhance the care for frail people focusing on some main aspects within our systems which we prioritised through understanding our systems and engaging with teams. Table 3 shows the current areas being prioritised across the system. As the Frailty Network is a large ongoing piece of work, many aims are over the long term and short term measurements will not show the overall impact of the Frailty Network. However, some of the measurements we are looking at include identification of frailty, length of stay within our medicine for the older adult wards and flow throughout our offsite hospitals (Table 4 & 5).

Results and Conclusion –

The implementation of the Frailty Network has resulted in a collaborative monthly meeting that consists of a wide variety of the MDT from both acute and community areas. It has generated rich discussions and allowed us to agree on common measures which will be available via a frailty data dashboard. The collaboration between acute and community teams, combined with proactive interventions and the use of digital technology, has started the journey to a more sustainable future. Continued focus on integrated leadership and shared goals will further refine and sustain these improvements. Further research is required to assess long-term impact. Ongoing engagement with wider teams is still required to ensure continuous communication and whole system improvements.

