West Wales Care Partnership
Partneriaeth Gofal Gorllewin Cymru

Integrated Care Fund 2018/19
Project Brief

Project Title	Frailty Nurse Practitioner - Pembrokeshire Older Peoples Service
Is this a new project or continuation?	An extension of the existing 'Community Services for Frail Older Adults' to a more collaborative, integrated and multi-disciplinary service for frail older people living in Pembrokeshire
What alternative delivery concept is being tested?	Through ICF, Pembrokeshire is employing a Project Manager to develop integrated community resource teams (CRT's) to care for people closer to home, prevent admission and facilitate early discharge from hospital. An Intermediate Care Strategy is being developed to achieve this service realignment and The Frailty Service will play a vital role in this new, alternative provision.
In which financial year will the project complete testing of concept?	2019/2020
Which ICF theme does it align with?	Older people with complex needs and long term conditions, including dementia
Regional Project Lead/Link Representative	
Local Authority Project Lead/Leads and/or Link Representative/ Representatives	Jason Bennett
HDUHB Project Lead/ Link Representative	Sonia Hay Ceri Griffths
Third Sector Project Lead/ Link Representative	

1. **Background/Rationale:** *(No more than 300 words, including how your proposal (1)* ***tests alternative delivery concepts*** *(2) l****inks with local strategies and plans such as Transforming Clinical Services; Integrated Medium Term Plan; Well Being Plans etc.*** *(3)* ***contributes to regional priorities*** *and (4)* ***supports delivery of objectives within the West Wales Area Plan.****)*

It is well documented that West Wales has a higher proportion of older people than the welsh average with Hywel Dda serving a growing and aging population that is projected to continue to increase significantly over the next 20 years. This is particularly challenging in the over 85 years of age population group, with some predictions suggesting this increase may be by as much as 129% in Pembrokeshire alone by 2035.

With 21% of the current Hywel Dda population over 65yrs of age and accounting for 55% of all emergency admissions and 57% of bed days, alongside projections of national figures suggesting around 10% of people over 65 have frailty and that one in four people 85 years and over are living with frailty or complex needs, there is clearly a need for coordinated, integrated and patient centred services to support the growing social and health care needs of these people within their local communities.

The Pembrokeshire Older Peoples Service will build on the success of the 2017/2018 Community Frailty Service in Pembrokeshire and improve collaborative and integrated working across all health and social care services as well as 3rd Sector agencies and services.

The service will be closely aligned with:

- Local strategies and development programmes, specifically working closely with health and social care services in the adoption and implementation of the Hywel Dda Frailty Strategy Programme; with Primary Care and 3rd Sector in the identification, assessment and support of patients requiring assistance to remain independent and able to live well within their communities with care services delivered closer to home; as well as also working closely with local communities and community hospitals to address concerns highlighted in the recent Community Health Council report on Social Isolation and Boredom in Community Hospitals.

- Regional priorities including working closely with health, social and voluntary sectors to support the implementation of Strategic Objective 8: Frailty and Dementia at both a local and regional level as part of the Hywel Dda Annual Plan – 2018/19.

- Identified actions and needs as West Wales Population Assessment needs including; supporting and enabling the maintenance of independence and well-being in collaboration with primary care, social services, local authority and voluntary agencies under the Social Service Well Being Act (2014) and Living Well services. This will include working closely with primary care to develop frailty risk stratification registers and supporting initiation and delivery of pre frail education sessions.

- Supporting people to be cared for within their own homes and communities

- Provision of rapid access and services to enable patients to stay at home with emergency support

2. **Purpose: What will you do and how will you do it?** *The proposal should support at least one of the aims identified within the Welsh Government* Guidance *for use of the ICF. Please outline how your service would meet a particular Aim (or Aims).*

ICF Aim	Description of how your proposal will meet the Aim(s)
ICF General Principles: 18 – i. Focus resources and increase capacity of care coordination or rapid response schemes (such as community resource teams) and the pace at which they are developed, to better meet demand and improve equity of access to services	• Through ICF, Pembrokeshire is employing a Project Manager to develop integrated community resource teams to care for people closer to home, prevent admission and facilitate early discharge from hospital. An Intermediate Care Strategy is being developed to achieve this service realignment and Pembrokeshire People Older Service will play a vital role in this new, alternative provision. • Our frailty nurse practitioners will work closely with MDT's in primary care, social services and 3rd sector agencies to proactively identify people at risk of becoming frail.
ICF General Principles: 18 - iii. Establish preventative intervention to help avoid unnecessary hospital admissions or inappropriate admission to residential care as well as preventing delayed discharges from hospital	• We will provide early and proactive identification of patients with frailty enables holistic integrated assessments aimed at identifying potential problems and creating an active management plans that is shared with all stakeholders for the key aims of: (1) Reducing emergency and acute hospital admissions (2) Reducing length of stays for patients over 65yrs who are admitted to hospital (3) Contribute to a reduction in the number of patients requiring admission to social care or Reablement placements

ICF Aim	Description of how your proposal will meet the Aim(s)
ICF General Principles: 18 - vi. Promote and maximise independent living opportunities, including ensuring increased provision of timely home adaptations	• We will ensure the provision of frailty services in local communities by way of domiciliary visits and community clinics using local 3rd sector agencies to support patients with identified needs to remain independent and within their own homes where possible, keeping the person at the centre of all assessments. • The service will provide comprehensive geriatric assessments within a multi-disciplinary and integrated team to support patients to remain well and as independent as possible within their own communities. This involves close working with Community Resource Teams consisting of primary care, community and social care services to provide joined up integrated working.

3. **Outcomes:** *Please list which of the outcomes from the regional outcomes framework attached will your proposal contribute towards and how it will do so (minimum of 1, maximum of 3.)*

Regional Outcome(s)	Description of how your proposal will meet the Outcomes(s)

Theme 2: Promoting independence – “step up my care”; preventing admissions to hospital & discharge at front door	The Frailty Nurse Practitioners will: • Work with primary care to develop frailty registers and proactive identification of patients who would benefit from early intervention including the over 75 trigger review • Support the delivery of care closer to home by providing frailty services within local communities, including comprehensive geriatric assessments (CGA) and management plans designed to prevent admissions and keep people independent • Improve the provision and accessibility for people to attend frailty clinics closer to home, eg, GP surgeries, community centres, patients own homes including residential and nursing homes • Provide responsive care to patients requiring the skills and expertise of the frailty nurse practitioners to maintain their independence, well-being and quality of life, keeping patients well and reducing the need for acute emergency admissions • Work closely with social services colleagues to identify patients who are at risk of deterioration and provide early integrated comprehensive geriatric assessments to ensure management and treatment plans are in line with patients’ needs and requirements • Work closely with acute care, primary care and social services to roll out delirium screening to patients within the community at risk of admission due to unrecognised delirium • Provide CGA based assessments which are central to the effective management of frailty and frailty nurse practitioners will be developed to be able to provide detailed and high quality assessment of patients with frailty, reducing pressures on GP’s and acute physicians by early identification and proactive management

Theme 3: Promoting independence – efficient discharge from hospital & continue to care for me	The Frailty Nurse Practitioners will: • Work closely with acute services to reduce length of admissions by provision of a discharge follow up service • Work closely with acute services including care of the elderly consultant in the provision of rapid access frailty services to prevent admissions and maintain people at home. The frailty nurse will support the clinic based within the acute general hospital on a daily basis, providing initial assessments, treatment and management plans as well as provide a follow up discharge service to patients who do not require emergency admission

4. **Implementation Timescales –** *please indicate the following:*

When will project development commence?	On-going
When will initial expenditure commence?	1st April, 2018
When will staff recruitment commence (if required)?	Staff in post
When will project delivery commence?	1st April, 2018
Expected date of completion of project concept testing.	31st March 2020
Expected date of project review/embedding learning into mainstream practice or termination.	31st March 2020

5. **Amount Requested** (*include detailed breakdown of costs and if revenue or capital*)

Revenue

1.00 WTE Band 7 Nurse = £50,724 P/A

Revenue SUB TOTAL = £50,724 P/A

6. **Proposed Performance Indicators:** *(What will it enable you to achieve in addition to what you are doing now. i.e. how many additional participants/outcomes? Please refer to ICF 17/18 C)*

Performance Indicators	
How much will you do? (Quantity)	**How well will you do it? (Quality)**
• *Increase the number of community MDT's* • *Increase the provision of domiciliary visits to patients within their own homes, care home and nursing homes* • *Work closely with care homes to provide frailty services and assessment* • *Support the development of a rapid access frailty clinic within the acute hospital to actively prevent avoidable admissions*	• *Measurable outcomes will be collected including patient and user experiences and feedback* • *We will demonstrate a reduction in hospital admissions and length of stay* • *We will improve the care and experiences of patients being seen within the frailty service*
How will people be better off as a result? (Quality and Quantity of effect)	
• *We will support people to remain independent and well for longer* • *We will support people to remain at home or within their place of choice* • *We will work to prevent patients being admitted hospital unnecessarily* • *We will work to maximise patients' quality of life* • *We will give people the opportunity to discuss advance care plans, giving them control and decisions of their future health needs*	

7. **Sustainability:** *After testing and review, how will successful concepts be incorporated into either mainstream delivery, IMTP, TCS, Area Plan or Well-Being developments and what is the exit strategy? (no more than 100 words*)

This service development is integral to Hywel Dda Strategic Objectives and will be incorporated into existing service and funding in 2019/2020.

9. **What are the implications if this business case isn't supported?**

Staff member has been recruited to a permanent contract.

Without investment into frailty services the demands on health and social care services will continue to poses challenges and difficulties to providing good quality and effective care to patients. Increases in avoidable admissions and prolonged length of stay will continue to have a negative and damaging impact of the ability of core services to manage this cohort of patients. This in turn would also result in a missed opportunity for the Pembrokeshire Older Persons Service to achieve full alignment and integration with the county Intermediate Care Strategy currently in development.

10. **Please provide supporting evidence of engagement with key stakeholders, in the development *or* delivery of the project, particularly 3rd sector and community partners when alternative delivery concepts are being tested.**

The initial implementation of the service was well supported and continues to be well supported by all key stakeholders including health, social, 3rd sector agencies and regular representation at the Pembrokeshire Older Person's Strategy Partnership Group. It is anticipated that ongoing support will continue in the format of regular steering group meetings and involvement with all key changes to the service.

11. **Please ensure a completed 12 month budget profile is attached.**