Health & Wellbeing Partnership

FRAILTY STRATEGY for Gloucestershire

2022-2027

One Gloucestershire
Transforming Care, Transforming Communities

CONTENTS

EXECUTIVE SUMMARY

Gloucestershire Integrated Care System (ICS), working together with its partners, seeks to improve the health and wellbeing of Gloucestershire's residents. Through joint and collaborative effort, we can help people to remain as independent as possible, narrow any equality or inequities in the system and make the best use of resources.

The Frailty Strategy sets out a vision for the future and outlines a plan to achieve this. At its core is a transition from a reactive to a proactive model of support that is delivered in people's homes or community locations. It seeks to enable collaborative and integrated working to deliver positive outcomes. In simple terms we want to offer the right care, at the right time, in the right place, that improves the outcomes and resilience of people of all ages, right across Gloucestershire.

Reduced resistance to stressors and decreased reserves are features of "frailty". However it is not an inevitable part of ageing. With the right information, intervention and support to meet their physical, emotional and cognitive needs, people can live happy, healthy and fulfilling lives.

The Needs Assessment, Public Health Information, literature reviews, stakeholder and public engagement have increased the understanding of frailty in Gloucestershire and the current challenges and future needs. We know that some sections of the community are at greater risk of frailty, such as those living with a long-term condition, a Learning Disability, who are homeless or live with high levels of deprivation. One of the most significant frailty factors however is age.

Research suggests that 10% of people aged over 65 may have some degree of frailty, rising to between a quarter and half of those aged 85 years.[1]

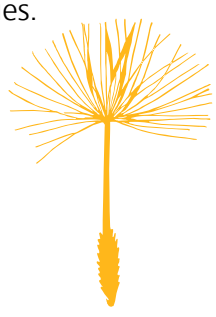
Gloucestershire has an ageing population with 21% aged 65+ years and this group is predicted to increase by 52% by 2043. The pandemic has also impacted on resilience, with individuals reporting increased levels of anxiety, loss of motivation, impacts on memory and loss of physical health.[2]

A frailty survey carried out in Gloucestershire in 2018/19 provided an insight into the views of the public. 81% of respondents thought that frailty could be prevented. They identified healthy diet and exercise as factors in keeping well. They also highlighted the need to raise awareness of frailty, the importance of information and knowing who to contact for advice.

Stakeholder workshops undertaken during the summer of 2021 brought together staff from across the statutory, voluntary and independent sectors. These events informed our understanding of frailty in Gloucestershire. They acknowledged challenges in the system and the impact of the pandemic. They also highlighted progress and developments, including the increased use of digital solutions, collaborative working and altered perspectives on community-based care.

This knowledge and understanding has informed the strategy and supported the development of four key priorities.

- Preventing frailty
- Identifying frailty
- Managing frailty
- Workforce



[1]Clegg A, Frailty in Older people Lancet 2013 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4098658/pdf/emss-59306.pdf

[2]Age UK https://www.ageuk.org.uk/latest-press/articles/2020/10/age-uk--research-into-the-effects-of-the-pandemic-on-the-older-populations-health/

The frailty strategy seeks to enable the delivery of a proactive community-based model of care that will increase resilience. It will prevent, halt, slow or reduce the impact of frailty, promoting healthy lifestyles that build resilience and help to anticipate and plan for change.

The strategy aims to ensure that regardless of where you live in Gloucestershire and regardless of your gender, socio economic status, ethnicity or age, you have access to information and support at or close to home that delivers positive outcomes for you, your family and carers. Our vision is for the people of Gloucestershire to live healthier, happier and longer lives.

OUR VISION

This strategy seeks to deliver the vision that:

The people of Gloucestershire live healthier, happier and longer lives.

Evidence gathered from the needs assessment, literature reviews and stakeholder engagement identified four key priorities:

- **Prevention of frailty**
- **Identification of frailty**
- **Management of frailty**
- **Workforce**

Promoting wellbeing and preventing ill health.

Develop workforce plans and initiatives to ensure staff are appropriately skilled and teams are fully staffed.

5

Transition to a proactive, holistic model of care that incorporates the components of emotional, physical and social care.

3

Management of frailty; supporting the development of a care pathway that focuses on care at home. Supported by a network of services that include same day emergency services, specialist support, primary care, therapy, reablement and social care.

4

Support statutory, independent and voluntary sector services to work collaboratively.

1

Identification of frailty.

Understanding of need and gaps to reduce inequalities and inequities.

2

Increased public understanding of frailty and how to build resilience.

Prevention of frailty

Build supportive neighbourhoods and communities. Work with transport and housing services to ensure safe housing that promotes independence and helps to reduce falls. Provide a range of wellbeing support to combat social isolation and loneliness. Run awareness raising campaigns and promote health to empower and inform.

Identification of frailty

Systematic screening and recording of frailty. Use of tools such as the Clinical Frailty Score, Comprehensive Geriatric Assessment and the Mental Health and Wellbeing assessment. Increased information sharing across systems.

Management of frailty

- Care and support at home providing alternatives to hospital admission: virtual wards, hospital at home, assistive technology, Same Day Emergency Care, (SDEC).
- Increased Multidisciplinary Team (MDT) working, Personalised care planning and coproduction.
- Medication optimisation.
- Falls prevention.
- Accessible information and resources. Reablement, rehabilitation and therapy. Adaptations and equipment.

Workforce

- Raising awareness, knowledge and understanding of frailty.
- Providing accessible information and resources.
- Recruiting and retaining staff.

Strategy development

The frailty strategy has been developed under the guidance of the Integrated Care System (ICS) Frailty and Dementia Clinical Programme Group (CPG). It has been informed by one to one, small group meetings and four larger stakeholder workshops held during the summer of 2021. At these events stakeholders from the statutory, third and voluntary sectors across the health and care landscape shared their experiences, ideas and views. This has provided a rich source of information that has been used to shape the development of the strategy, vision, principles and priorities. Views and feedback from experts by experience have been gathered from online surveys and informed by caseload reviews. Engagement with experts by experience, carers and wider stakeholders will be a key feature in the ongoing development, review and evaluation of the strategy.

The Vision

The vision for frailty is that the people of Gloucestershire live healthier, happier and longer lives. It reflects the principles set out in the NHS Long Term Plan[3], Ageing Well Programme and echoes the vision and ambitions detailed in the Gloucestershire Joint Health and Wellbeing Strategy[4].

The frailty strategy seeks to enable the development of a frailty pathway that will reduce variation, improve quality of care, support integrated working and deliver positive outcomes for the individual and their carers.

[3] The NHS Long Term Plan 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[4] Gloucestershire Joint Health and Wellbeing Strategy 2020-2030 https://www.gloucestershire.gov.uk/media/2106328/gc-c_2596-joint-health-and-wellbeing-strategy_dev12.pdf

AIMS AND PRINCIPLES

Aims

Over the next five years the strategy aims to:

- ➔ Improve the health and wellbeing of the people of Gloucestershire.
- ➔ Increase our understanding of inequity and inequalities and use this to improve access and support to all sectors of the community.
- ➔ Support a collaborative and integrated approach to managing frailty.
- ➔ Promote the delivery of personalised care.
- ➔ Raise awareness, knowledge and understanding of frailty.
- ➔ Build compassionate, supportive local communities and neighbourhoods.
- ➔ Provide a range of health and wellbeing support that meets individuals' physical, social and psychological needs.
- ➔ Provide care as close to home as possible.
- ➔ Proactively manage frailty, reducing the reliance and demand for urgent and emergency care services.
- ➔ Ensure there is a suitably skilled and competent workforce.

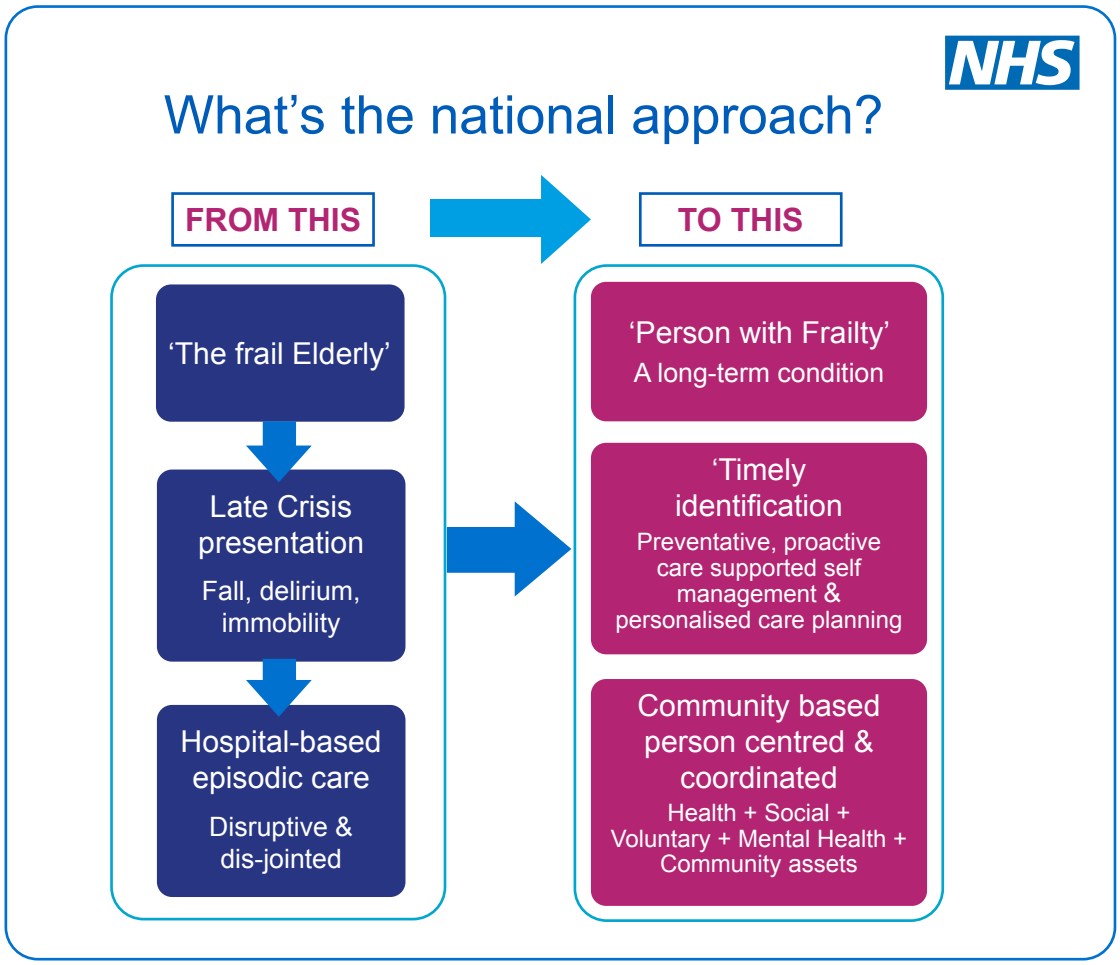
These aims will enable people to have a positive experience as they age. It will enable them to live as independently as possible, in a place of choice, connected to family, friends and community.

Principles

The principles that shape delivery of the strategy are:

- Population Health Management (PHM) approach to understand need, identify gaps, measure impact and outcomes.
- Health promotion, prevention and anticipatory approach to empower individuals to understand frailty. This will provide coping mechanisms and support to maintain independence and build resilience.
- Standardised screening, assessment, identification and recording of frailty.
- Care and support that is personalised, delivered in partnership with the individual and what matters to them.
- Collaborative working between the individual, carer and provider services.
- Information shared in an appropriate and timely way.
- Recognition and support to carers.
- Equitable access to services and inclusivity of all sections of the community.
- Embrace a positive view of ageing by promoting strategies and behaviour that promotes physical, social and psychological wellbeing.
- Enable the countywide workforce to have the right skills, knowledge and behaviours.
- A comprehensive system wide frailty pathway that is focused on 'home first'. Offering safe and effective alternatives to hospital admission as well as enabling timely supportive discharge.
- Utilise digital technology to enhance and support the delivery of care.
- Promote innovation and a process of continuous improvement to enhance outcomes, system flow, service redesign and redevelopment.

One of the key drivers within the strategy to improve health and wellbeing is to move from a reactive to proactive approach as outlined in fig 1. Proactive care means identifying individuals who will most benefit from services and support, stratifying risk (based on algorithms and assessment) then planning interventions with the individual that will reverse, reduce and slow the progression of frailty and help anticipate future needs.



(Fig 1)

SUMMARY OF STRATEGIC PRIORITIES

Based on the needs assessment and frailty workshops the following strategic priorities for 2022-2027 have been identified as:

- Prevention
- Identification
- Management
- Workforce

Prevention of frailty	
Theme	**Plans**
To raise the awareness and knowledge of frailty (education, information and resources). To increase the countywide knowledge of frailty prevention specifically relating to: • Falls • Delirium • Social isolation To support neighbourhoods, accessible transport and housing that fosters independence. To ensure individuals receive psychological and social support. To better understand the needs of ethnic minority groups. To increase understanding of need of specific groups: Homelessness, To increase the understanding of specific groups such as individuals who are homeless, have Learning Disability, younger frail people, those living with dementia or who have a Long Term Condition.	To improve the health and wellbeing of the people of Gloucestershire. Increase understanding of frailty across the county in order to: • Reduce the number of people who become frail. • Increase awareness in order that individuals are able to build resilience through interventions such as strength and balance. • To reduce social isolation and loneliness.To build compassionate, supportive local communities and neighbourhoods. To identify provision of accessible local support utilising community resources. To increase use of holistic assessment of need that identifies social, psychological and physical needs. To ensure diversity is reflected in strategic plans, priorities and service provision. To develop strategic plans and priorities that reflect and meet the needs of people of all ages.

Identification of frailty

Theme	Plans
To make every contact count to proactively identify and manage frailty. To have an agreed approach to: • Identifying frailty. • Diagnosing frailty. • Assessment of frailty. • Recording of frailty. To understand the range of frailty service provision across the county. To gather data and information, utilising the frailty dashboard and measuring impact and outcomes.	To increase the number of people identified as frail. Target interventions based on assessed need and local provision. Through identification and diagnosis, co-create personalised plans of care. To systematically use assessment and screening tools such as the Comprehensive Geriatric Assessment (CGA) and the Clinical Frailty Score (CFS) across the county.

Management of frailty

Theme	Plans
To promote integrated working, information sharing and digital connectivity. To deliver personalised care planning. To offer care at home or close to home as alternatives to hospital admission. To enable access to reablement, rehabilitation and therapy. To engage and provide support for carers. To provide access to information to support independent living and adoption of a healthy lifestyle. To promote a holistic approach to frailty that incorporates mental health, wellbeing, social, environmental and physical health needs. To support individuals to plan and prepare for changes and the future.	To support services to work in an integrated way, with service criteria and pathways that facilitate timely and Seamless transition between services and timely exchange of information. To promote the use of personalised care planning aimed at building resilience, increasing knowledge and understanding and support planning for the future. To reduce reliance and demand on urgent and emergency care services, offering alternatives to hospital-based care. To work to ensure individuals and their carer will get the right care, at the right time, in the right place. To empower and educate individuals in order that they can build resilience and manage their health and wellbeing. To ensure that social and environmental plans and priorities such as housing support individuals to live well and as independently as possible. To ensure that End of Life (EOL) treatment escalation plans are in place, shared and accessible.

Workforce	
Theme	**Plans**
To ensure workforce, consisting of both paid and unpaid individuals, is at a sufficient capacity and is equipped with the skills and knowledge to identify, prevent and manage frailty. To utilise and develop volunteer roles. To make education, information and resources accessible.	To ensure links to workforce recruitment, development and retention plans across ICS partners. To engage and work with voluntary sector organisations. To promote use of approaches such as Motivational Interviewing training to enable change behaviour and personalised goal setting.

BACKGROUND

The British Geriatric Society define frailty as:

Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves.[5]

The loss of these in-built reserves can result in a seemly small insult having a catastrophic impact and outcome for the individual, which can be physical or psychological in nature.

Whilst frailty is more common in older people with around 10 per cent of people aged over 65 years having frailty, rising to between a quarter and a half of those aged over 85,[6] frailty is still prevalent in younger people, as well as other sections of the population, such as people with learning disabilities. Less is known about frailty in these groups and sections of society.

Some of the frailty identification tools are not validated for use with these individuals. Identifying and determining the requirements of these groups needs further engagement and analysis in order that needs can be fully identified and incorporated into strategic plans and workstreams.

Engagement and discussions have highlighted the challenges around the use of frailty as a descriptor. Whilst the term frailty is generally understood by health and social care professionals, its use as a descriptor can be a barrier to the wider population. Many people do not perceive or wish to see themselves as frail, as it is associated with increased vulnerability and dependency. Consideration needs to be given to positive language and descriptors that foster independence; enabling, rehabilitative and preventative approaches. Engagement with the public and key stakeholders is key to finding the right language that embodies positivity and empowerment.

[5] https://www.bgs.org.uk/resources/introduction-to-frailty
[6] https://www.bgs.org.uk/resources/introduction-to-frailty

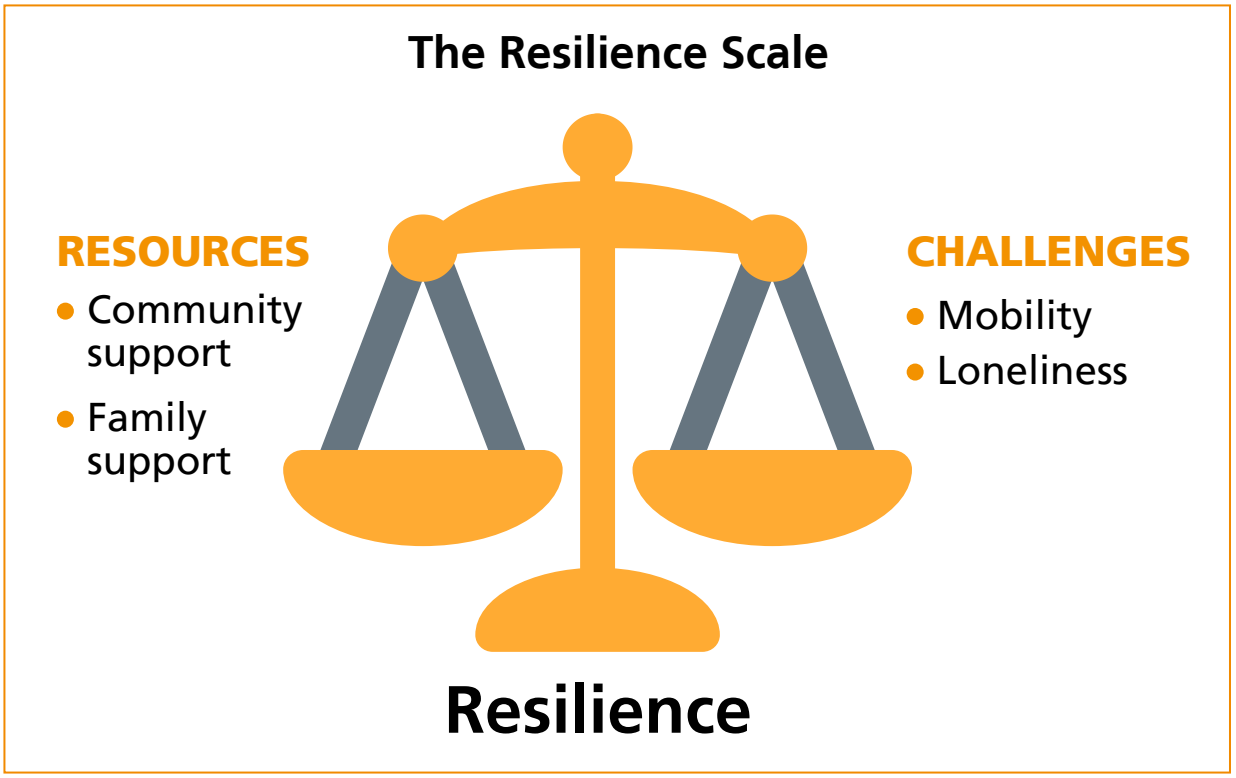
Case for change

Frailty is not an inevitable part of growing old or living with a long-term condition or disability. The countenance to frailty is resilience. This is an ability to adapt in the face of adversity, trauma, tragedy or threats. It can also be a response to stressors which can be physical, mental or social in nature. Active intervention can halt, slow or reverse the impact of frailty. Risks and harm can be mitigated, changes can be anticipated and the impact of stressors can be reduced.

There is significant evidence as to the benefits of this anticipatory care approach. It does however require a fundamental shift in behaviour and approach. It seeks to move away from a reactive model of care, where people are presenting in crisis, where the perceived 'safe' choice is hospital-based assessment and care.

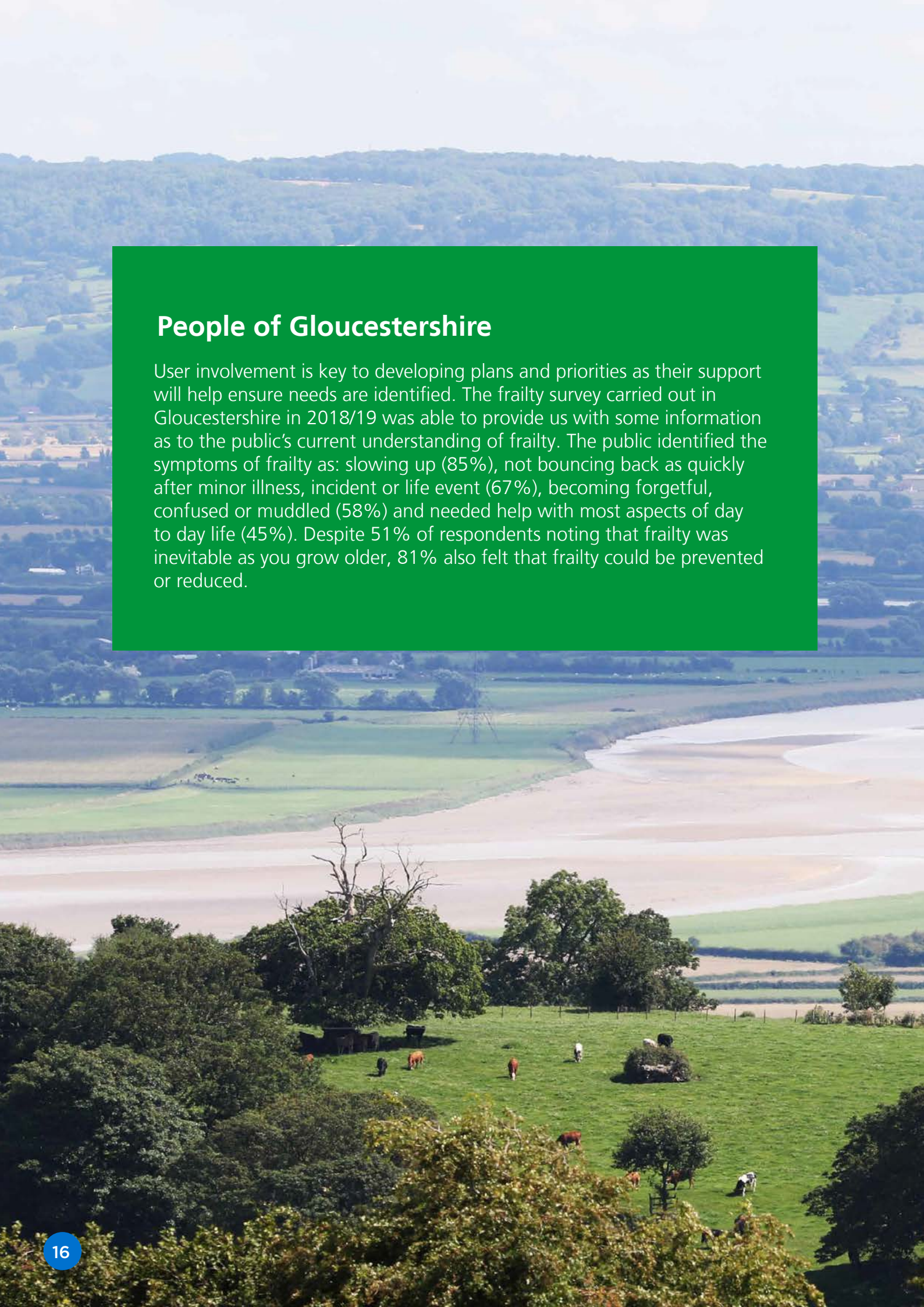
Anticipatory care makes a transition to a focus on "upstream" and the wider determinants of health. Screening helps early identification of need and personalised plans are co-created that seek to build resilience. Additionally there is a fundamental shift to community-based intervention and support.

The combination of the pandemic and its impact on physical and psychological health, along with growth year on year of the number of older people in Gloucestershire, have the potential to significantly increase demands. Many services are already struggling to remain responsive. A case for change is to ensure that Gloucestershire's strategic approach will manage demand, ensuring that systems and services are working effectively together to deliver positive outcomes for the individual and their carer, whilst making the most effective use of resources.



The above figure shows the resilience scale.

Our aim is for the scales between Resources and Challenges to be equally balanced.
In the example presented in the above figure, the individual has mobility issues and lives alone. These are their challenges. The available resources of community support and family support balance out these challenges and enable the individual to have resilience.



People of Gloucestershire

User involvement is key to developing plans and priorities as their support will help ensure needs are identified. The frailty survey carried out in Gloucestershire in 2018/19 was able to provide us with some information as to the public's current understanding of frailty. The public identified the symptoms of frailty as: slowing up (85%), not bouncing back as quickly after minor illness, incident or life event (67%), becoming forgetful, confused or muddled (58%) and needed help with most aspects of day to day life (45%). Despite 51% of respondents noting that frailty was inevitable as you grow older, 81% also felt that frailty could be prevented or reduced.

As part of the 2018/19 frailty survey people were asked who they would contact if they or a family member had symptoms of frailty. The majority (79%) said their GP, followed by family and friends (56%) and practice nurse (42%)

Who would you contact initially if you or a family member had symptoms of frailty?			
			Response Percent
1	I wouldn't want to trouble anyone		6.06%
2	Your GP		78.79%
3	Practice Nurse at Doctors Surgery		42.42%
4	Local community group or voluntary organisation e.g. Age UK		24.24%
5	Search the internet for advice e.g. Your Circle		15.15%
6	Family or friends		57.58%
7	Social Prescribers / Wellbeing Coordinators / Community Wellbeing Agents		18.18%
8	Local County Council/Social Services		21.21%

Whist the survey results suggested that GP surgery was the most likely point of contact for people looking for help or advice on frailty, the survey respondents also highlighted the need for good quality information that was easy to access. Further and on-going engagement with people with lived experience, their carers and the general public will be part of the on-going development and review of the strategy.

Population Health Management

Population Health Management (PHM) is an approach that aims to improve the physical and mental health outcomes and wellbeing whilst reducing inequalities across a defined population. It includes actions to reduce the occurrence of ill health and reflects the wider determents of health such as social or economic factors, health behaviours and physical environment.

Utilisation of a PHM approach aims to improve health through data driven planning and the delivery of care to achieve maximum impact. Whilst frailty exists across the whole of the county, there are local variations and inequalities. The use of PHM enables the sub division and risk stratification of a given population. This helps ensure that interventions or services to prevent frailty and improve the health and care of those people living with frailty are targeted appropriately. PHM can also help support a common and shared understanding which can help communities identify how they can best work together to meet these needs.

Equality

Inequality can be due to a number of factors. These include health behaviours such as smoking, diet and alcohol, as well as psychosocial factors, isolation, social support, social networks and self-esteem/self-worth. There are also wider determinates of health such as income and debt, employment, education and skills and environmental factors such as housing, air quality and pollution. Understanding and identifying these factors will help ensure these are addressed in the strategic plans, priorities and workstreams.

Carers

Carers play a vital role in reducing risks, building resilience, maintaining independence and providing companionship and care. They need to be engaged, involved and listened to. Whilst often a rewarding role, it can also go unacknowledged and can impact on the carers' own physical and emotional health and wellbeing. Caring responsibilities can have an economic impact, with many reducing work commitments in order to fulfil their caring role. For some this results in financial hardship. The frailty strategy and supporting workstreams acknowledge the significant contribution carers make and seeks to make provision for them.

Care Homes

Many of the individuals who live in a residential, nursing or specialist residential care setting have complex care needs and are frail. Engagement with these individuals and the staff that support them, is vital to understand their needs and how best to meet them. These can then be translated into strategic plans, priorities and workstreams.

THE PICTURE IN GLOUCESTERSHIRE

Frailty in Gloucestershire – *"there's a lot of it about"*

Information based on Electronic Frailty Index (EFI) data indicates that in Gloucestershire there are approximately 90,000 people classified as living with mild, moderate or severe frailty. Age standardisation rates by localities demonstrate that across Gloucestershire between 104 – 157 per thousand of the population have some degree of frailty. (Fig 2) This locality data illustrates the spread of frailty and is informing our understanding of frailty.

Frailty Rates by Locality

Locality	Cohort_Size	Frailty Population	Prevalence_1k	Standardised Rate_1k
Gloucester City	190,501	26,578	139.52	157.04
The Forest of Dean	66,726	10,302	154.39	138.79
Tewkesbury Newent and Staunton	46,598	6,699	143.76	132.87
North Cotswolds	34,582	4,910	141.98	119.5
Cheltenham	176,420	19,660	111.44	118.07
South Cotswolds	65,448	7,424	113.43	104.73
Stroud and Berkeley Vale	130,281	14,576	111.88	104.3

(Fig 2)

There is a wide range of statutory service provision in Gloucestershire. Alongside this is a wealth of independent sector organisations. These provide a variety of services such as volunteer driving, lunch clubs, Men's Sheds, Faith Groups and befriending services. A baseline assessment of services currently underway will help enhance our understanding of the local landscape, inequalities and factors that impact on resilience.

The stakeholder engagement events that took place in summer 2021 demonstrated a commitment to working together. The workshops captured passion, ideas and learning and showcased some of the innovative person-centred developments in the county.

Summary and themes from workshops are noted in Appendix A. The workshops also highlighted some of the variations and challenges, which are outlined below:

- Some services operate in specific geographical areas.
- There is not a standardised approach in the use of assessment and screening tools, such as the Comprehensive Geriatric Assessment (CGA), Clinical Frailty Score (CFS), PiNCH ME and SQUiD (Single Question in Delirium).
- There is variation in the recording and coding of frailty.
- There are workforce vacancies across the system.
- Access to training can vary in services and sectors.

Along with the county variations, the needs assessment also identified some of the key challenges. These included:

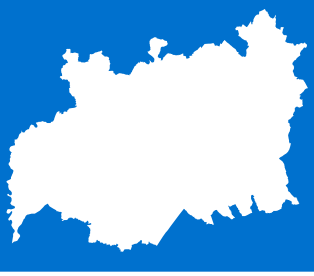
- Impact of the pandemic on people physically, mentally and socially; e.g. deconditioning, loneliness, isolation.
- Increasing number of people aged 65+, resulting in increased disease prevalence in Falls, Delirium, Long Term Conditions, Dementia etc.
- Increasing complexity of care needs.
- Inequity and inequalities across the county in some areas and for some sections of the population.
- Increased volume and workload for carers.
- Workforce impacted by vacancies, high staff turnover, needing to release staff for training and development, contractual arrangements and Brexit.
- Issues with system capacity in health and social care are resulting in people experiencing delays, experiencing longer length of hospital stays and not being able to access the right care, at the right time, in the right place.
- Digital connectivity: Systems and processes mean information is not shared in a timely way.

These challenges are set against the context of a protracted pandemic, with services seeking to restore, recover and meet the demands of winter pressures and business as usual. No one service or organisation can resolve these challenges. Collaborative working and agreeing priorities and plans will help ensure that collectively we can begin to address these and work to reduce variations.

Co-production and the active involvement and participation from the public and all sections of society is central to frailty planning, priorities, management and measuring impact. On-going engagement is required to ensure any plans, priorities and workstreams reflect local need and deliver on desired outcomes. This will form part of the overall strategic work plan.

LOCAL CONTEXT

Across Gloucestershire there are people who are at risk or who have frailty. Two main factors will impact on frailty in Gloucestershire over the next **2-5 years.**



1

An **older population** - The number of people in Gloucestershire aged **65+** is forecast to rise faster than nationally in the next **25 years**, rising from **135,000** to **205,900** people between 2018 and 2043. This is equivalent to an average increase of **2,800 people** per year.[7]

2

Pandemic impact - Changes implemented as part of the response to the global pandemic have impacted in a number of ways. Social isolation and shielding have led to physical deconditioning. These physiological changes, following a period of inactivity, may impact on the body in several ways including loss of muscle mass and muscle strength. These physical changes are linked to an increased risk of falls, functional decline, reduced inability to undertake usual activities of daily living and reduced mobility. Alongside the physical impact there has been a psychological effect, which includes loss of support networks, increased levels of anxiety and depression, insomnia and loneliness. These have all impacted on mental health and wellbeing.

Facts and Figures

In Gloucestershire **21.3%** of the GP registered population are **65** and over.

Based on the eFI data for the population aged 65 and over **41.7%** are living with some level of frailty. This can be broken down to **27.8%** with mild frailty, **11.1%** with moderate frailty and **2.8%** with severe frailty.

82% of people thought that frailty could be prevented or improved.[8]

[7] Inform Gloucestershire 2020 https://inform.gloucestershire.gov.uk/media/2099482/op_prevalance_of_need_2020_final.pdf

[8] Gloucestershire Frailty Survey 2018/19

ENABLERS

There is a range of enabling workstreams that will help and support the delivery of the strategy and improvements in care. These include:

Digital

In the last few years our use of digital technology in the form of Telehealth, virtual wards and remote consultations have significantly changed the way care is delivered. Despite these digital advances the current health and social care digital architecture means that many IT systems are not connected. Information does not flow through the system. As a result, there is duplication of effort and staff don't have access to all relevant information to support assessment and planning for patients and families. This often results in repeated questioning and information gathering. A key enabler in the delivery of the strategy is to maximise the use of digital developments to enable timely access to information, as well as continuing to transform the way care is delivered.

Recording & data collection

Systematic recording of frailty will help identify need at a micro and macro level. It will enable the incidence and levels of frailty across the county to be identified. It will provide a benchmark to measure impact, outcomes and performance along with informing service development and prioritisation of investment.

Screening and Assessment tools

There is a variety of tools to support identification, assessment, planning and delivery of care. These include: Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), the Comprehensive Geriatric Assessment (CGA) and the Clinical Frailty score. To be effective they need to be part of the frailty pathway, used consistently by staff who are trained and skilled in their use. The consistent use of these tools can have many benefits, providing a common language and understanding of need between services. It can also inform decision making and help ensure resources or interventions are targeting appropriately.

Education and Resources

Training and education aims to ensure that staff have the right skills and competencies. Within the county is a wealth of expertise and experience along with a wide range of educational resources. The development of an Education and Training Strategy will bring these resources and information together in a structured way. Access to good quality information will support the general public and staff. This needs to be provided in a variety of ways to ensure accessibility by all sectors of the community.

Personalisation

Individuals having choice and control has been a central tenant of legislation, policy and guidance for several years. The personalised care agenda, What Matters to Me and Me at my Best progress this approach further. This partnership approach where interventions and resilience plans are coproduced will help ensure care is tailored to individual need and help transform the relationships between professionals and the individual from fixer to facilitator.

Experts by experience

The voice, views and involvement of people with lived experience is vital. Whilst staff are powerful advocates for the people they support, it is vital that the voice of the public is heard directly. There are some key questions that only experts by experience can answer, such as:

- What do you need to live happier, healthier and longer lives?
- How best we can reduce inequalities?
- Did the intervention provided make a difference?

Continuous engagement and public involvement will help shape continuous improvement, define priorities and inform services in the future.

High Impact Change Model

The High Impact Change Model was developed by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), national partners. Updated in 2020 it supports the ambitions in the NHS Long Term Plan. The model offers a practical approach to managing patient flow and hospital discharge. The model identifies system changes that include a workstream which will focus on:

- Early discharge.
- Monitoring patient flow.
- Discharge teams.
- Home first and discharge to assess.
- Seven day a week services.
- Trusted assessors.
- Enhanced health in care homes.

Interdependencies

Frailty is complex, it is not an illness but the combination of a range of factors which may include the natural process of ageing or the impact of a long-term condition or disability. It encompasses the domains of physical, psychological and social health. As a result, it creates interdependences across a range of statutory, third sector and health and social care services who need to work collaboratively if they are to meet the holistic needs of the individual and their carer. The construction of a frailty pathway that spans across all organisations and systems will map these interdependencies, identify gaps and support the development of integrated, seamless and co-ordinated care pathways.

Strategy context and implementation workstreams

The Frailty Strategy is integral to two wider programmes, Gloucestershire County Council (GCC) Transformational Programme for Adult Social Care and the ICS Ageing Well Programme. GCC, through the Adult Single Programme, has transformed the way in which it works. Reflecting the requirements of the Care Act, it seeks to:

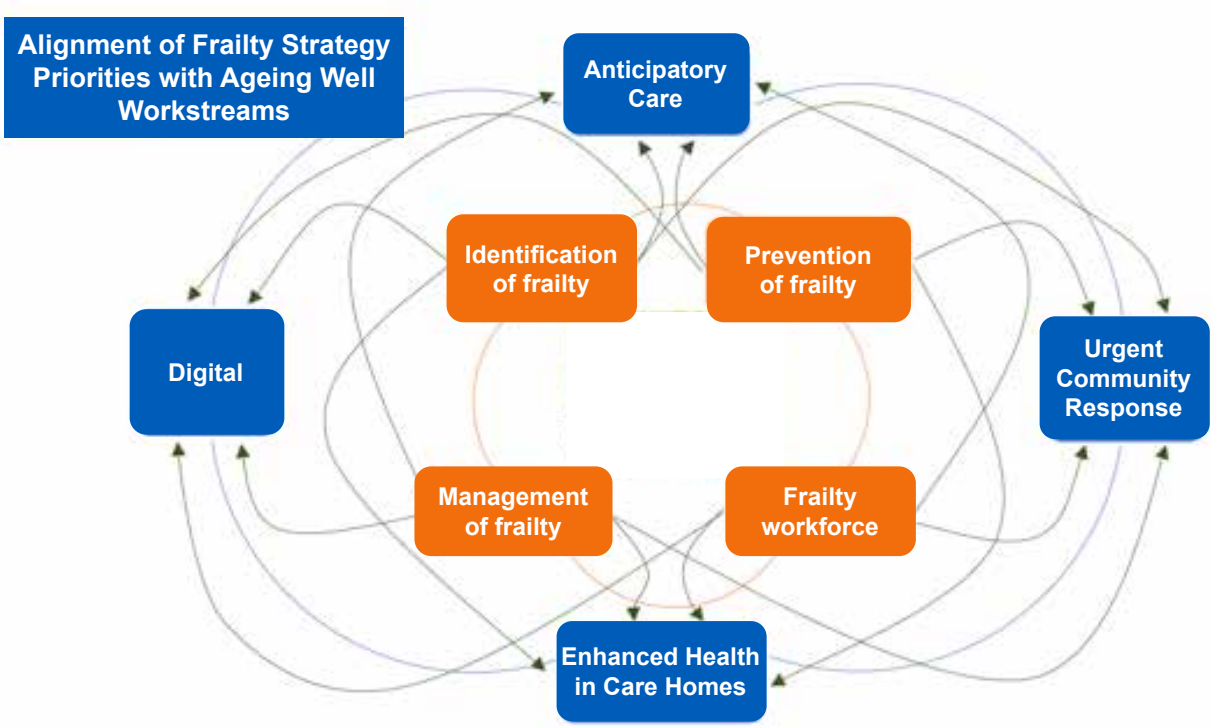
- Support early intervention and prevention and work collaboratively across the Adult Social Care System and with partners.
- Improve the impact of short-term help to make sure people regain their confidence and independence whenever possible.
- Explore the potential of technology to support carers and improve the quality of care that people receive.
- Work with independent care providers to address capacity gaps and over provision to improve the terms and conditions of care sector staff.
- Respond to further guidance or legislation.

The Ageing Well Programme is the delivery mechanism for realising the objectives of the NHS Long Term Plan. The Ageing Well Programme seeks to:

- Support people to stay well and independent at home for as long as possible, wherever they call home.
- Prevent unnecessary admissions to hospitals and residential care and accelerate the treatment of people's urgent care needs.
- Ensure people can return home safely and timely after being in hospital with assessment and on-going care and support in the community.

Ageing Well key workstreams:

1) Anticipatory Care aims to proactively manage health and care intervention at individual and population level. It adopts a population health management approach identifying cohorts of people through risk stratification.
2) Urgent Community Response aims to avoid unnecessary hospital admission and support discharge by ensuring that everyone who requires a two-hour crisis response receives one, regardless of where they live. It also aims to provide reablement care for people who need it within a maximum of two days.
3) Enhanced Health in Care Homes aims to ensure that people living in care homes receive the same level of care and support as those living in their own homes. This is done by providing proactive and preventative care centred on the needs of individual residents, their families and care home staff.
4) Digital aims to ensure community health services, as part of local systems, provide a comprehensive digitally enabled service that aspires to the highest standards of excellence and professionalism. It will be available to all based on clinical need and will deliver the best value for public money. It includes data, IT and technology.



(Fig 3)

Figure 3 outlines the independencies and connections with the Ageing Well Programme and the frailty strategy.

FRAILTY WORKSTREAMS

There are key themes that emerge in the Transformation Programme and the Ageing Well Programme. These include early and proactive intervention, care at home, reducing crisis, increasing independence and resilience.

Frailty Workstreams

The function of any strategy is to describe the vision, aims and objectives will be realised. The frailty strategic priorities are be underpinned by five workstreams. Whilst there are interdependencies between the workstreams, as well as the wider Ageing Well and Transformation Programme, each will have its own scope of work, action plans, milestones and measurable targets. The workstreams are structured around the frailty well pathway of:

- Preventing Well.
- Diagnosing Well.
- Supporting Well.
- Living Well.
- Dying Well.

The model is adapted from the Dementia Well Pathway[9] It aims to provide a simple but comprehensive structure on which to outline the way forward. The ICS Frailty and Dementia Clinical Programme Group will play a key role in providing strong leadership, collaborative working, aligning workstreams and monitoring strategic progress. The overall governance structure is outlined on page 35.

[9] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Preventing

- I understand my medication.
- I don't feel so isolated or lonely.
- I know where to go to get help.

Strategic Aim #1: Preventing Well

Prevention is key to improving the quality of life. This aim is to reduce the number of people who become frail and to halt, slow or reduce the impact of frailty through early identification and the development of plans and interventions. These will build resilience, anticipate changes and identify and mitigate risks.

The outcomes of this strategic aim are to:

- Reduce the number of people who become frail.
- Halt, slow or reduce the impact of frailty.
- Gain a deeper understanding and overview of frailty in the county.
- Raise awareness and increase understanding of frailty by promoting and encouraging healthy lifestyles and behaviours across all ages and sections of society.
- Develop/provide proactive health and care interventions aimed at reducing risks and building resilience.
- Develop a range of services and interventions that support care at home and ageing well.

We will do this through health education, risk stratification and anticipatory care interventions. We will undertake a baseline assessment of frailty services. We will gain involvement and feedback from experts by experience and their carers. We will support the delivery and development of anticipatory care services that reduce frailty risks and build resilience through education and health promotion.

Mr Osmanski

Mr Osmanski is 80. He has recently had a fall. He mentions this to the pharmacist when he pops in to collect his routine prescription. The pharmacist takes some time and talks to Mr Osmanski about the fall. She makes some suggestions as to steps he might take to reduce the risk of further falls. She records her conversation and actions on a shared care record. When Mr Osmanski visits the practice nurse for routine health screening and blood test she is able to check with him what steps he has taken and whether he needs further information, support or referral.

Diagnosing

- **I have regular check-ups and understand why they are important to detect problems or issues early.**
- **I have information and support that reduces my risk of frailty and helped me to build my resilience.**

Strategic Aim #2: Diagnosing Well

Diagnosing well will identify those at risk or those who are frail. The aim is to work with individuals and their families to plan a programme of care that increases resilience whilst reducing frailty progression. It will help to avoid unnecessary harm whilst empowering the individual to make informed choices enable them to plan for expected and emergency situations.

The outcomes of the strategic aims are to:

- Increase the number of people who are screened and assessed for frailty.
- Increase the number of people who have personalised plans aimed at increasing resilience, reducing risks and anticipating changes.
- Identify the levels of frailty within the population across the county to a level of Integrated Locality Partnership (ILP), Primary Care network (PCN) and neighbourhood detection. We will utilise this information to increase understanding of need and demand whilst informing capacity planning and supporting the measuring of impact of interventions.
- Increasing individuals' understanding of how to build resilience.

We will do this by consistently and systematically identifying frailty and sharing this information across systems and services. We will develop shared care plans and actions to build resilience. We will use a Population Health Management approach to understand frailty at local and countywide level. We will help individuals build resilience and reduce the impact of frailty by providing accessible information

Mrs Smith

Mrs Smith is 78 and her husband has noticed that she is more muddled than usual. He mentions this to one of the care staff who visit daily. The staff are aware of the risk of delirium and gather more information from Mr and Mrs Smith. Based on this they make contact with the primary care team. Prompt intervention and two nights of overnight care mean Mr Smith is supported and able to care for his wife at home. The cause of the delirium is identified and a plan of action put in place involving Mr and Mrs Smith and the care staff to avoid recurrence. A flag relating to delirium risk is placed on Mrs Smith's notes to alert any agency or service involved in her care.

Supporting

- **I receive care that is coordinated, teams share information and know about my preference and choices.**
- **I have a personalised plan of care that also recognises the role and needs of my carer.**
- **I have the treatment and support I need at or as close to home as possible.**
- **My home is adapted to meet my needs.**

Strategic Aim #3: Supporting Well

This strategic aim will ensure that people who are at risk or have frailty are enabled to live as well as possible. It will ensure that emotional, social and psychological needs are met in a timely and coordinated way. It will ensure that individuals get the right care, provided at the right time, in the right place with support equitably available across the county but reflective of local diversity, provision and need. It will ensure that care is delivered as close to home as possible.

The outcomes of this strategic aim are to:

- Increase the number of people reporting positive outcomes from interventions and support.
- Improve equity of access to support and services across the county.
- Ensure the timely provision of support and the seamless transition between services.
- Understand the needs of younger people and other groups at risk of frailty and ensure these are identified and met.
- Reduce reliance and demand on urgent and emergency care services.
- Increase the range of anticipatory care responsive same day or community-based services.
- Improve communication and reduce duplication through information sharing.
- Increase the use of digital and assistive technology to support people to live well.
- Increase public awareness of frailty and understanding of how to build resilience.
- To engage, empower and support carers.
- To support medication optimisation.
- Ensure workforce has the right skills and competencies.

We will do this through co-production with the individual and what matters to them and their family. The skills and contribution of carer will be integral to the support system. The frailty pathway will be focused on 'home first' with services at or close to home, that will proactively meet the physical, psychological and social need. Stakeholders will work together to agree an integrated model of care that is responsive, impactful and maximises the resources in local communities.

Ms Jones

Ms Jones is 77, lives alone following the death of her partner 11 months ago and has become more anxious and socially isolated. Ms Jones is helped to explore and understand her feelings and to develop a plan of action that will help alleviate these anxieties. She is introduced to a local photography group. Through the group she starts to reconnect with her local community, makes new friends and builds confidence. Ms Jones reports that her confidence has improved along with her sense of wellbeing.

Living

- **I have access to information and support, that helps me live independently and keep me well.**
- **I am supported to be part of my local. community and contact with people that matter to me.**

Strategic Aim #4: Living Well

The aim is for people to have a positive sense of wellbeing, feel fulfilled and engaged in the community in which they live. Having an understanding of the factors that contribute to wellbeing and overall health will enable people to live well for longer. This can be achieved by enabling access to information and developing a network of support for the individual to ensure their physical, social and psychological needs are met.

The outcomes of this strategic aim are to:

- Individuals and their carer get the right care, at the right time, in the right place.
- Ensure that personalised care focuses on what is important to the individual.
- Increase proactive identification of risks and plans to reduce these whilst building resilience.
- Reduce loneliness and social isolation through meaningful social engagement and role/ place within the community.
- Enable access to housing and improved environmental factors that support people to live as independently at home for as long as possible.
- Enable access to information on benefits and financial support that enables individuals to live well.
- Increase range and access to information, resources and support to enable individuals to live well and build resilience.

We will do this through the provision of a range of information and a network of support that meets the individuals' social, physical and psychological needs. Services will be delivered in a planned and coordinated way.

Mr Patel

Mr Patel is 65 and planning to retire. He has non-insulin dependent diabetes and some visual impairment. Being independent and being an active member of the community is very important to him. He joins a pre-retirement course that gives him lots of information and resources. This helps him understand what aids and adaptations may help him at home to live more independently. He identifies some volunteering roles that will utilise his knowledge and expertise. He enrols on an online course on living with and looking after yourself with diabetes. Mr Patel reports feeling positive about the future and is glad that he can use the skills he has gained during his working life to help others.

Dying

- **I am prepared for the future; I know what to do if my heath changes.**
- **I have made my wishes known, so that I can have a good death, in a place of my choosing and that my wishes are respected.**

Strategic Aim #5: Dying

The aim is for palliative and end of life needs to be identified as earlier as possible. The individual and their carers are made aware and are prepared for death. Plans are in place that detail preferences and choices along with treatment escalation plans and anticipatory prescribing. Care is supported by open and honest conversations that enable the individual to live well and have a good death, in their place of choice. The outcomes of this strategic aim are to:

- Increase the identification in the number of people who are nearing end of life, helping to ensure their choices and wishes are recorded, regularly reviewed and shared with those that need to know so their preferences can be met.
- Increase the number of people who are cared for and die in place of choice.
- Increase the information and support for carers pre and post bereavement.

We will do this by supporting the Palliative and End of life Strategy and workstreams to ensure these reflect the needs of people who are frail.

Vision – Providing care close to home that is proactive, preventive, personalised, enabling and equitable

The vision for frailty that was adopted and endorsed by participants at the frailty workshops and the ICS Frailty and Dementia Clinical Programme Group was:

> *"The people of Gloucestershire living healthier, happier and longer lives."*

Encapsulated in this vision is a model of care that is focused on prevention and building resilience. It delivers care that is personalised, with services provided close to home that meet the physical, social and psychological needs of the individual.

When required, access to specialist support is provided in a timely way and transition and transfers between services happens in a seamless way, including the exchange of relevant information. Plans are in place to reflect changing need and these include treatment escalation plans where preferences and wishes are recorded. These ensure the intervention is in the best interests of the individual and reflect the preferences of the individual and deliver positive outcomes. Care is provided by a workforce (both paid and unpaid) who have access to training, resources and support with the right tools, skills and competence requisite to their role.

Within Gloucestershire the aim is to have a proactive and preventative approach. This will be one that helps individuals understand what is needed to build resilience that will support their health and wellbeing.

This proactive model of care will consist of screening individuals to identify their risk of frailty through the use of tools such as the Comprehensive Geriatric Assessment (CGA) and Clinical Frailty Scale (CFS). This information would be used to co-produce a personalised care plan that would seek to build resilience, maintain good health and help the individual understand warning signs or triggers that may indicate changes in health that may alter or increase frailty risks.

Improving access to care is vital to the delivery of positive outcomes and address inequalities. This will include access to specialist intervention and may be delivered in the community or in a hospital setting. It is vital that individuals can move in and out of these services in a timely way. This helps ensure that these services remain responsive and that the resource and skills of the staff are utilised appropriately.

Service design needs to reflect cultural, socioeconomic factors and local demographics, utilising the wealth of experience in statutory, independent and third sectors organisations. It needs to be sustainable and coproduced with experts by experience and their carers.

NATIONAL CONTEXT AND DRIVERS

White Paper "Integration and Innovation: working together to improve health and social care for all (February 2021)

The proposals within this legislation are recommendations built within the NHS Long Term Plan. The legislation is guided by 3 main principles.

1) To increase integration within the NHS in England and between the NHS, local government and other health system partners.
2) To reduce bureaucracy and remove barriers to integrated working that benefits service users.
3) To improve accountability and enhance public confidence.

NHS Long Term Plan 2019

This outlines how people who have frailty or who are at risk will be offered targeted support for both their physical and mental health needs. The Ageing Well programme is one of the vehicles to support these ambitions/targets.

Shifting the Centre of Gravity – Making placed based, person-centred health care a reality Local Government Association (November 2018)

Dementia Challenge

In 2015, the Dementia 2020 Challenge was launched. It aimed to make England, by 2020, the best country in the world for dementia care, support, research and awareness. The Challenge identified 18 key commitments under four themes: Dementia Awareness; Health and Care Delivery; Risk Reduction; and Research and Funding. There were a number of commitments made to support dementia. These included increasing the rates of dementia diagnosis, creating dementia friendly communities, raising awareness of dementia, risk reduction strategies and increased dementia research. (February 2015)

Five Years Forward View 2014

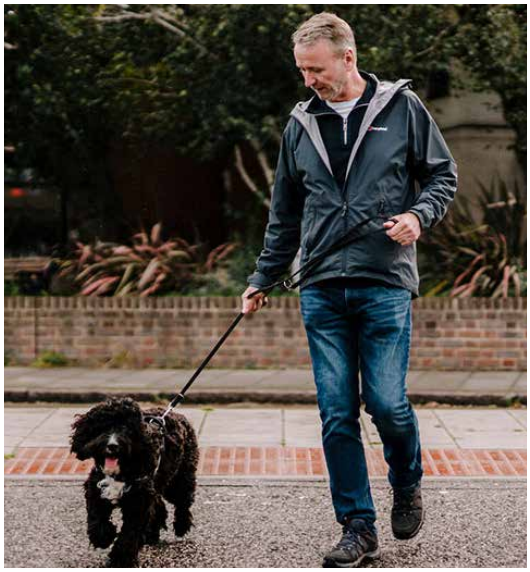
This sets out a shared strategic vision for the future of the NHS. It plans to address inequalities and gaps in services and it proposes a remodelling of services. Amongst these are urgent and emergency care, mental health, primary and acute care services. (October 2014)

NICE guidance quality standards, statements and supporting reports

Much of the National Institute of Excellence's (NICE) guidance includes reference to frailty for example, dementia disability and frailty in later life, (NG 16, October 2015) Multimorbidity clinical assessment and management (NG56 September 2016), Multimorbidity and polypharmacy.

The Care Act 2014

This brought together a range of legislation, reports and reviews with the aim of consolidating and modernising the framework of adult social care in England. The Act placed the individual in the centre of care, giving them new rights, along with recognising the key role and needs of carers, whilst placing a focus on prevention and promoting wellbeing.



Measures and Indicators

Measuring outcomes is key to assessing the impact of the strategy. Each of the individual workstreams will develop a set of outcomes measures. These will help determine if the intended benefits have been delivered. The overarching indicators that will demonstrate success are:

- Earlier identification of people who are frail.
- Self-reported outcomes that demonstrate improvements in quality of life for the individual and their carer.
- Recording of frailty score.
- Increasing the number of people with personalised plans of care.
- Reducing the demand on urgent and emergency care and preventing unnecessary hospital admissions.
- Increasing the frailty provision in the community.
- Increasing provision of services and opportunities to build resilience.
- Enabling a workforce that has access to a range of frailty education, training and development.
- Increasing awareness of frailty.

Governance

A governance structure will support the development and implementation of the strategy. It will monitor if the strategic aims have been achieved and evaluate if it has been delivered in line with the strategic principles. The governance structure is outlined below.

ACKNOWLEDGMENTS

Many thanks to everyone who has contributed to the development of this strategy, either through the provision of data, insight, views or experience. This strategy aims to capture this knowledge and develop it into a shared vision with priorities, aims and a road map that ultimately seek to improve the lives of the people of Gloucestershire.

APPENDIX A

Key findings from the frailty workshops – key themes

Frailty workshops

In summer 2021 a set of four stakeholder workshops were held. These sessions provided valuable insight into the challenges and demands facing services across the county. It identified the need to join up systems, share information in a timely way and enable consistent reporting and recording of frailty.

Workshop participants highlighted that many services were struggling to remain responsive and meet demand. There are gaps and delays in systems, which meant people were sometimes cared for in the wrong setting and this can have a negative impact on the individual.

A resounding message from the workshop is that significant and sustained inroads into managing/ supporting people with frailty can be made through a collaborative and integrated approach. The ICS is ideally placed to support this ambition.

Some of the issues identified during the workshop and through individual and group meetings have included:

a. Inequity and inequalities in access to frailty support /service provision.

b. A shared IT system is needed to help information exchange, reduce duplication and assist decision making.

c. Gaining a clear overview of the challenge of frailty is difficult due to code variations and processes for data collection.

d. The impact of the pandemic has led to deconditioning and poorer disease management.

e. Hospital admission is seen as safe option and default position. We need to reduce reliance on this and increase community resources, change behaviour and attitudes.

f. Importance of trusted relationships in driving forward developments and enabling shared decision making and shared risk taking.

g. Concerns for patient welfare and the risk of further deconditioning due to extended hospital stays whilst waiting for discharge.

h. Current service demands coupled with the need to implement recovery plans and respond to 'winter pressures'.

GLOSSARY

Association of Directors of Adult Social Services (ADASS)	A charity and membership organisation which aims to be a leading voice of adult social care, working in partnership with people to help transform their experience of care and support.
British Geriatrics Society (BGS)	The professional body of specialists in the healthcare of older people in the UK.
Clinical Frailty Score (CFS)	Clinical Frailty Score is a judgement-based frailty tool that evaluates specific domains including comorbidity, function and cognition to generate a frailty score ranging from 1 (very fit) to 9 (terminally ill).
Clinical Programme Group (CPG)	Clinical Programme Groups are a partnership group of individuals who meet on a bi-monthly basis to provide oversight of their particular clinical programme area. For example, the Frailty and Dementia CPG in Gloucestershire oversees the implementation of the Frailty and Dementia strategies in Gloucestershire. CPGs are made up of service leads, experts by lived experience and senior stakeholders.
Comprehensive Geriatric Assessment (CGA)	Comprehensive Geriatric Assessment is a process used by healthcare practitioners to assess the status of people who are frail and older in order to optimise their subsequent management.
Delirium	A serious disturbance in mental abilities that results in confused thinking and reduced awareness of the environment. Also known as sudden confusion.
Dementia	Term used to describe a group of symptoms affecting memory, thinking and social abilities severely enough to interfere with your daily life. It isn't a specific disease, but several diseases can cause dementia.
Electronic Frailty Index (eFI)	Electronic Frailty Index – the eFI is based on 36 physical, mental and social deficits, the presence/ absence of each of these are combined to provide an overall score. The score is then used to classify the population into fit, mild, moderate or severe frailty levels.
End of Life (EOL)	End of life care includes physical, emotional, social and spiritual support for patients and their families. The goal of end of life care is to control pain and other symptoms so the patient can be as comfortable as possible. End of life care may include palliative care, supportive care, and hospice care.

Frailty	A person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury.
Gloucestershire Health and Care NHS Foundation Trust (GHC	An NHS Foundation Trust which provides physical health, mental health and learning disability services throughout Gloucestershire.
Gloucestershire Joint Health and Wellbeing Strategy	A strategy that aims to improve the health and wellbeing of people in Gloucestershire. It articulates Gloucestershire's Health and Wellbeing Board's response to the Prevention System Peer Challenge and sets out a clear vision and priorities.
Home First	The 'Home First' model aims to stop patients being stranded on hospital wards. Planning for the future and long term decisions are taken following recovery and an assessment at home rather than in hospital.
Integrated Care Board (ICB)	A new organisation responsible for providing oversight of the implementation of an Integrated Care System across Gloucestershire.
Integrated Care System (ICS)	New partnerships between the organisations that meet health and care needs across an area, to co-ordinate services and to plan in a way that improves population health and reduces inequalities between different groups.
Integrated Locality Partnerships (ILP)	Partnerships made up of senior leaders of health and social care providers and local government. They work with each other to bring services together and plan how they are delivered to their local populations.
Local Authority (LA)	Local government is responsible for a range of public services for people and businesses in defined areas. These include services such as social care, schools and housing. There are three tiers of local government in Gloucestershire and responsibility for services is divided between the county council, six district councils and 264 parish and town councils.
Local Government Association (LGA)	The national membership body for local authorities.
Long Term Conditions (LTC)	A long-term condition is an illness that cannot be cured but can usually be controlled with medicines or other treatments.
Me at My Best	A Care Plan that aims to support people with a long-term condition, including living with frailty and dementia. It is a record of what is usual for an individual and how they live at home with their health condition.
MYCaW (Measure Yourself Concerns and Wellbeing)	An individualised outcome measure used for evaluating holistic and person-centred approaches to supporting people. It is a short, validated tool that can be routinely incorporated into a consultation to see where a person most wants support or used in an organisation to improve workplace wellbeing.

NHS Long Term Plan (LTP)	The Long Term Plan sets out action to ensure patients get the care they need fast and to relieve pressure on A&Es. It sets out key ambitions for the NHS over the next 10 years (2019-2029).
Pain, Infection, Constipation, dehydration, Medication, Environment (PiNCH ME)	PiNCH ME is a tool used to help assess the potential cause of delirium.
Plan-Do-Study-Act (PDSA)	A scientific method used to test a change, by planning it, trying it, observing the results and acting on what is learned.
Population Health Management (PHM)	The process of improving clinical health outcomes for a defined group of individuals (for the purposes of this Strategy individuals with Frailty) through improved care co-ordination with partners and patient engagement.
Primary Care Network (PCN)	Groups of GP practices that work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices which are known as PCNs. They build on existing primary care services to enable greater provision of personalised and integrated health and social care for people within their local communities.
Recommended Summary Plan for Emergency Care and Treatment (ReSPECT)	ReSPECT is a national patient held document, completed following an Advance Care Planning conversation between a patient and a healthcare professional. ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices.
Rockwood Clinical Frailty Score	Rockwood is the Clinical Frailty Scale (CFS) being used by the NHS to help decide which people are most likely to recover, ranking frailty from one to nine.
Same Day Emergency Care (SDEC).	Same day emergency care is the provision of same day emergency care for patients being considered for emergency admission.
Single Question in Delirium (SQiD)	SQiD is a single question used to identify delirium. This is a simple prompt question which asks "Is the patient more confused than before?'
South Cotswolds Frailty Service	South Cotswolds Frailty Service is an anticipatory care community service embedded in and delivered by the South Cotswolds PCN.
Telehealth	Providing health care at a distance rather than face-to-face.
What Matters to Me	Everyone will have their own 'What Matters to Me' orange folder, which is owned by the individual and contains their personalised care and support plans, which are co-produced by staff and the individual. By holding the folder themselves, the individual will be able to share their information with other health and social care professionals and voluntary community sector colleagues during routine assessments or an emergency situation, in which guidance in the folder will provide instructions on what actions should be taken.

Review and monitoring

The strategy will be reviewed and reported on a regular basis by the Frailty and Dementia Clinical Programme Group. The overall strategy will be formally reviewed in 2026.

For more information on the Frailty Strategy for Gloucestershire please contact **glccg.ageingwell@nhs.net.**