Staffordshire and Stoke-on-Trent Integrated Care System

Integrated Care Partnership Briefing

Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) Meeting

September 2024

This briefing aims to keep partners and members of the public informed of the discussions at the NHS Integrated Care Partnership (ICP) meeting.

ELF System Portfolio

Within the portfolio there are three programmes which make up E-L-F:

1. **E**nd of life
2. **L**ong term conditions
3. **F**railty – (We have identified four key areas in this programme: severe frailty, moderate frailty, mild frailty and prevention.)

Who's involved?

The ELF portfolio is supported by clinicians from both primary, community and secondary care along with our local authority partners and voluntary sector colleagues.

The programmes within the ELF portfolio have a co-dependency with each programme and other system portfolios, as many people who fall under one area (for example, frailty) will also come under other areas (for example, end of life or long-term conditions).

ELF system portfolio priorities

The key focus for the portfolio is to look at what service redesign opportunities there are, so we can identify some of the short-term changes that support our overall system recovery plan.

Progress made: Frailty

What we wanted	How we did it	What we achieved
Mild Frailty - A self-management signposting offer to slow progression among the 80,000 patients living with mild frailty in the community.	Test a digital offer that identifies mildly frail patients and offers an education intervention around modifiable risk factors for progression.	• My Health, My Way App*: A pilot across 10 practices and targeting circa 5,000 patients who are identified with Mild Frailty. • Potential Reach: 80,000 people.
Moderate Frailty - A more streamlined effective offer to moderately frail patients to slow down frailty progression and optimise existing service capacity.	Agreed common outcome framework across Staying Well Service in the South and Admission Avoidance Scheme in the North. Impact data commenced in March (six months on from baseline data being reported).	• Evaluation of Impact data to be undertaken during June – September to inform future service developments. • Developed Community of best practice across Staffordshire and Stoke-on-Trent. • Potential Reach: 30,000 people
Severe Frailty -To identify an evidence based best practice model and highlight the critical success factors for proactive community services for the 10,000 patients with severe frailty who are at increased risk of hospital admission.	Test of Change across five Community Matrons and six practices covering a practice population of circa 75,000 to conduct proactive Comprehensive Geriatric Assessment (CGA) assessment and support planning.	• 1,043 identified as severely frail using EFI and 151 identified to benefit from CGA approach • Test of Change Evaluation Complete/Economic Evaluation/Options Appraisal • Metrics for Falls prevention, Prevention – (Staffordshire Council), Mild, Moderate and Severe Frailty have been created. • Potential Reach: 10,000 people

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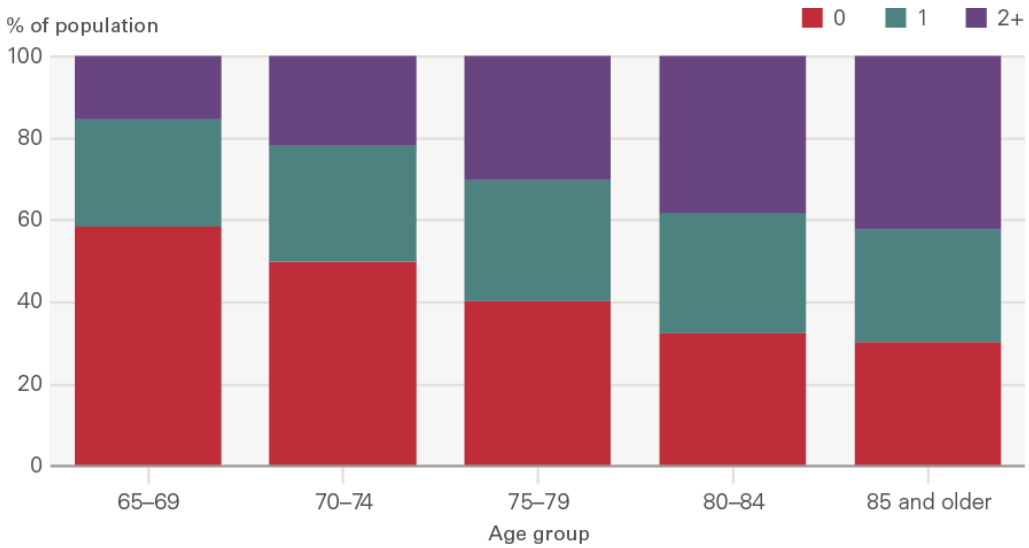
Falls - An enhanced falls prevention programme to reduce falls and subsequent serious injury, hospital attendances and admissions	Test of Change underway to evaluate feasibility and scalability of new interventions including digital offers, risk stratification, change in practice, standardisation of resources, training, review of community assets, partner workshops	• Identification of best practice model for falls and understanding of current gaps. • Full evaluation by December 2024 by Keele University.
Falls – Enhancing referral pathways between A&E and specialist falls service to optimise existing capacity	Strengthened relationships between community and acute services.	• Increase in referrals received into specialist falls services between Nov – March 24. This compares to a baseline of five for 22/23.

***Mild Frailty – My Health My Way App**

- Pilot launched May 2024
- 10 participating GP surgeries
- Targeting 4,000 participants with mild frailty
- Variety of engagement approaches being trialed
- To date, 15% uptake and use of the app and this is likely to increase
- 80,000 population across Staffordshire and Stoke-on-Trent
- Healthy Ageing approach
- Proactive identification
- Upstream prevention
- Health education intervention
- Focused on modifiable risk factors
- Digital self-management

How health and social care needs are changing

The Health Foundation carried out some research to see if we are predicting the health and social care needs of our aging populations correctly. The colours in the chart below represent how many long-term conditions have been developed.



The table below shows the contrast to how social care needs have changed. The red bars show people who don't need support with activities of daily living. This remains stable until around the age of 85 when social care needs start to increase. The difference that we are starting to see is that when social care needs start to increase, they are much more complex than they used to be.

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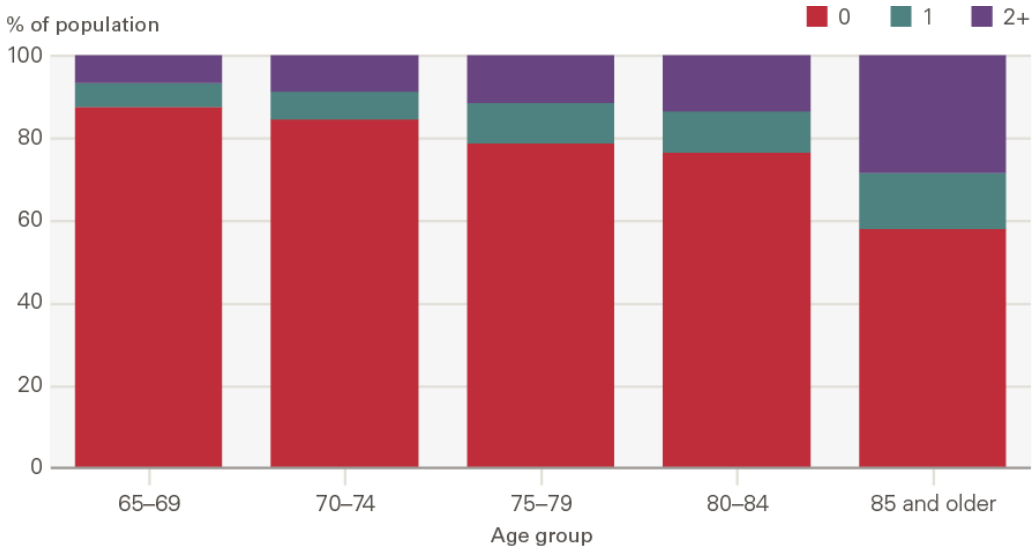


Our local geography

Looking at the next 10 years where are we likely to see these needs unfolding as the population changes in age in our area? The tables below show people who are going to have a medical complexity.

Age 65+	2023	2033	%change 2023-33
Cannock Chase	20,636	25,387	23.0%
East Staffordshire	24,919	31,050	24.6%
Lichfield	26,201	29,663	13.2%
Newcastle-under-Lyme	28,033	32,488	15.9%
South Staffordshire	29,239	34,382	17.6%
Stafford	32,889	39,837	21.1%
Staffordshire Moorlands	25,889	29,881	15.4%
Tamworth	15,784	18,281	15.8%
Staffordshire	203,591	240,968	18.4%
Stoke-on-Trent	46,094	53,275	15.6%
England	11,041,499	13,408,469	21.4%

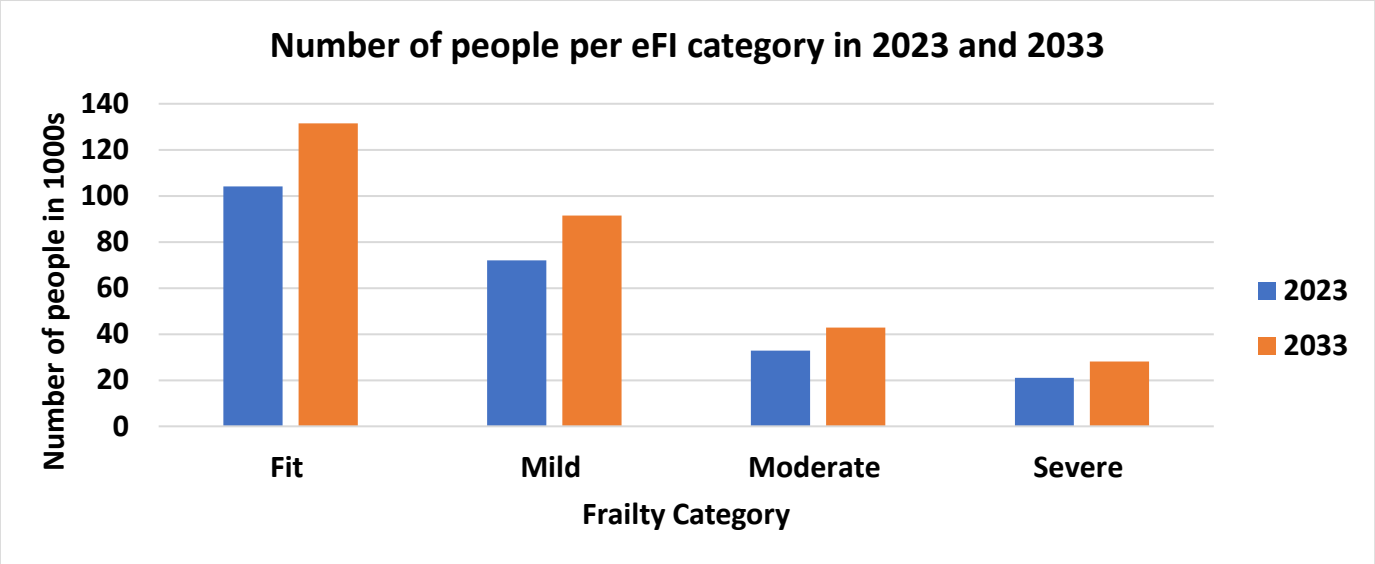
The areas circled in red will see bigger changes in their population aged 65 and over.

Age 85+	2023	2033	%change 2023-33
Cannock Chase	2,549	3,784	48.5%
East Staffordshire	3,210	4,786	49.1%
Lichfield	3,390	5,340	57.5%
Newcastle-under-Lyme	3,911	5,480	40.1%
South Staffordshire	3,846	5,590	45.3%
Stafford	4,268	6,547	53.4%
Staffordshire Moorlands	3,034	4,634	52.7%
Tamworth	1,623	2,623	61.6%
Staffordshire	25,832	38,784	50.1%
Stoke-on-Trent	5,187	7,026	35.4%
Staffordshire & Stoke-on-Trent	31,019	45,809	47.7%
England	1,511,088	2,122,470	40.5%

There is an uneven distribution of this age group (85 and over) across the region, which means both medical and social care complexity will be needed in different places at different times.

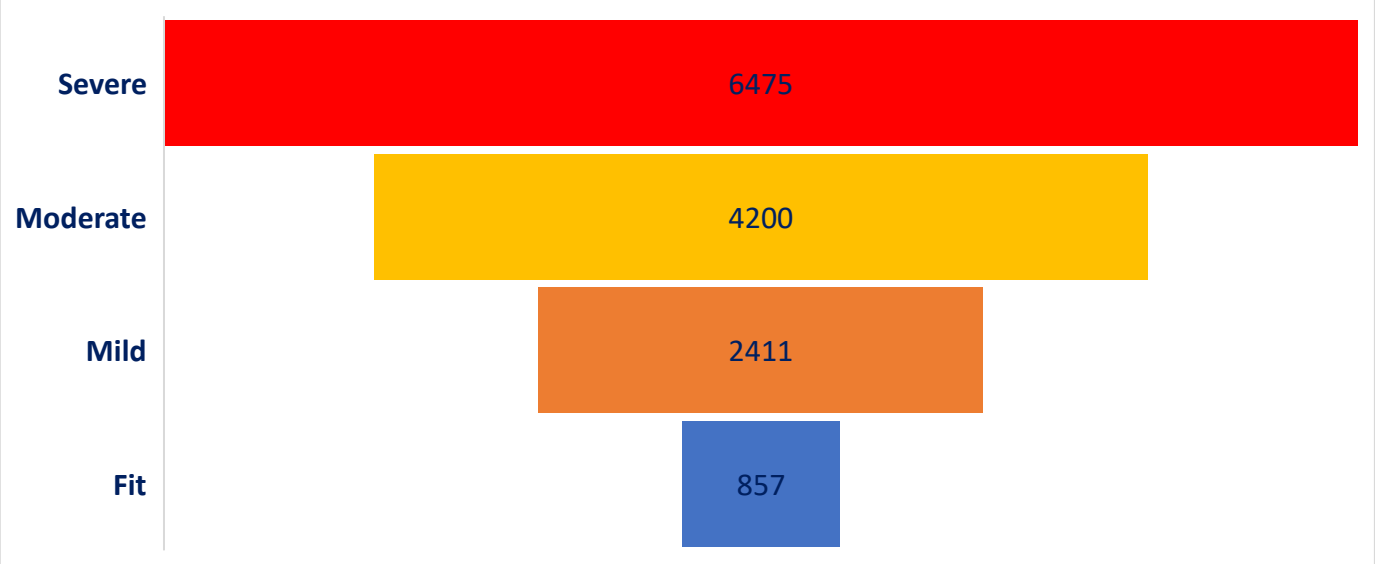
What does frailty mean?

Frailty and ageing are not the same thing. Frailty is when multiple body systems gradually lose their in-built reserves, which leaves an individual more vulnerable to infections, falls and ultimately can be a precursor to death. The blue bars in the chart below show current numbers and the orange bars show projections for the next 10 years. What we are seeing is that we will universally have increases in all the categories of frailty, but the biggest increases are going to happen in old people who are fit or have mild frailty.

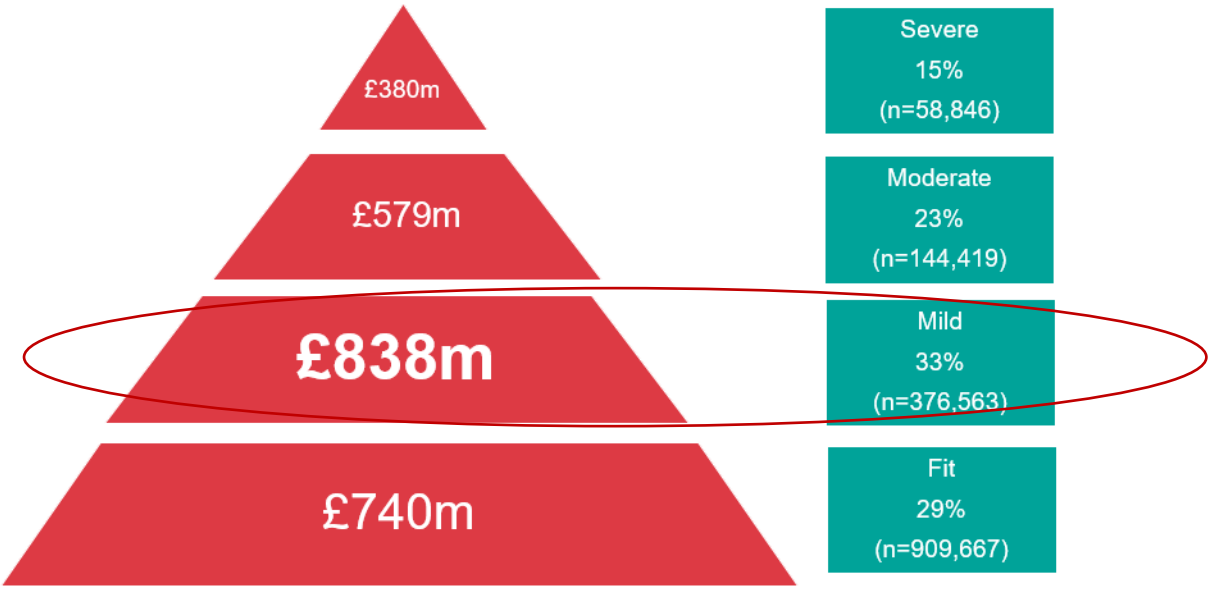


Cost of Frailty

The chart below shows the cost per person to primary care and secondary care services only. This does not include the cost to the community services or the costs to the individual.



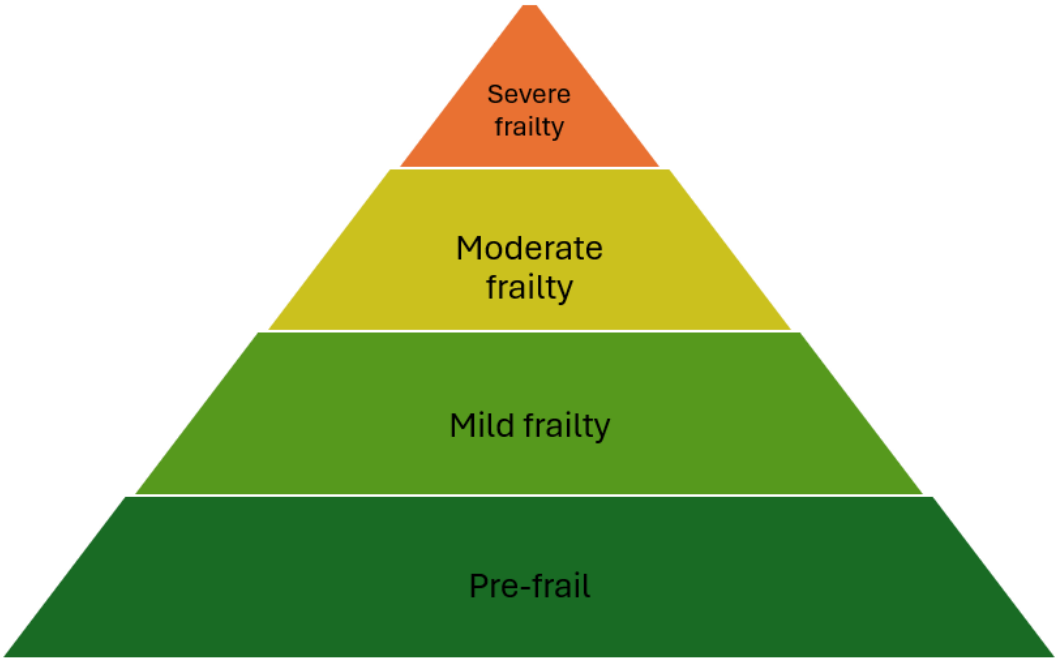
Although the cost per person from mild frailty is small, the overall cost to the system is much bigger because of the large number of people with mild frailty (see the amount circled in red).



The chart above shows each band of frailty and the overall cost to the system.

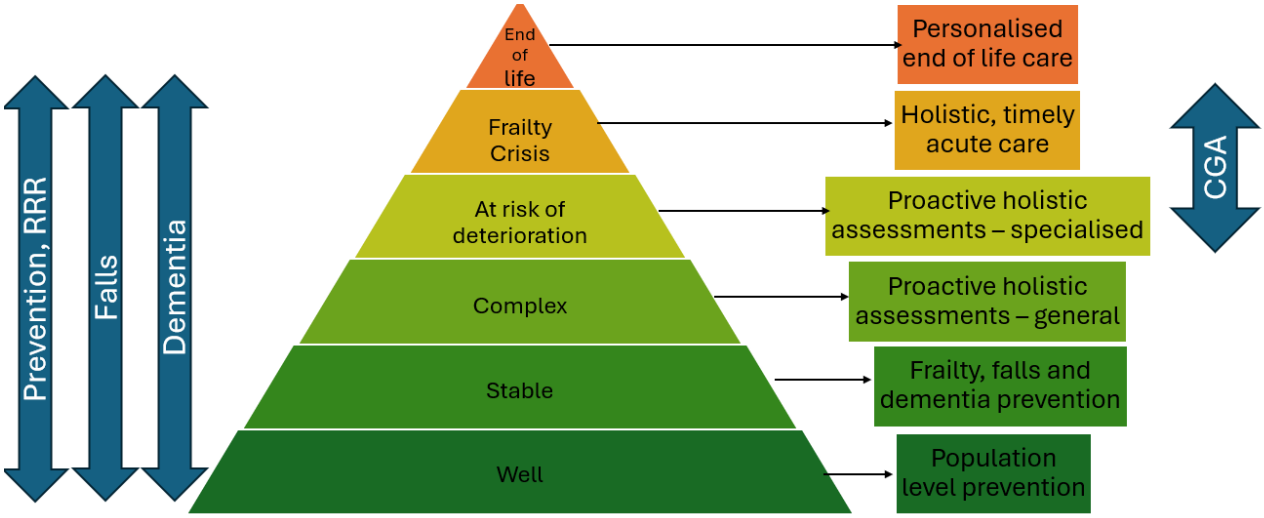
Population segmentation

We try to identify people who would most benefit from certain interventions and our frailty tools will categorise people into these sort of categories:



Level of need

Prevention remains important through all stages of frailty:



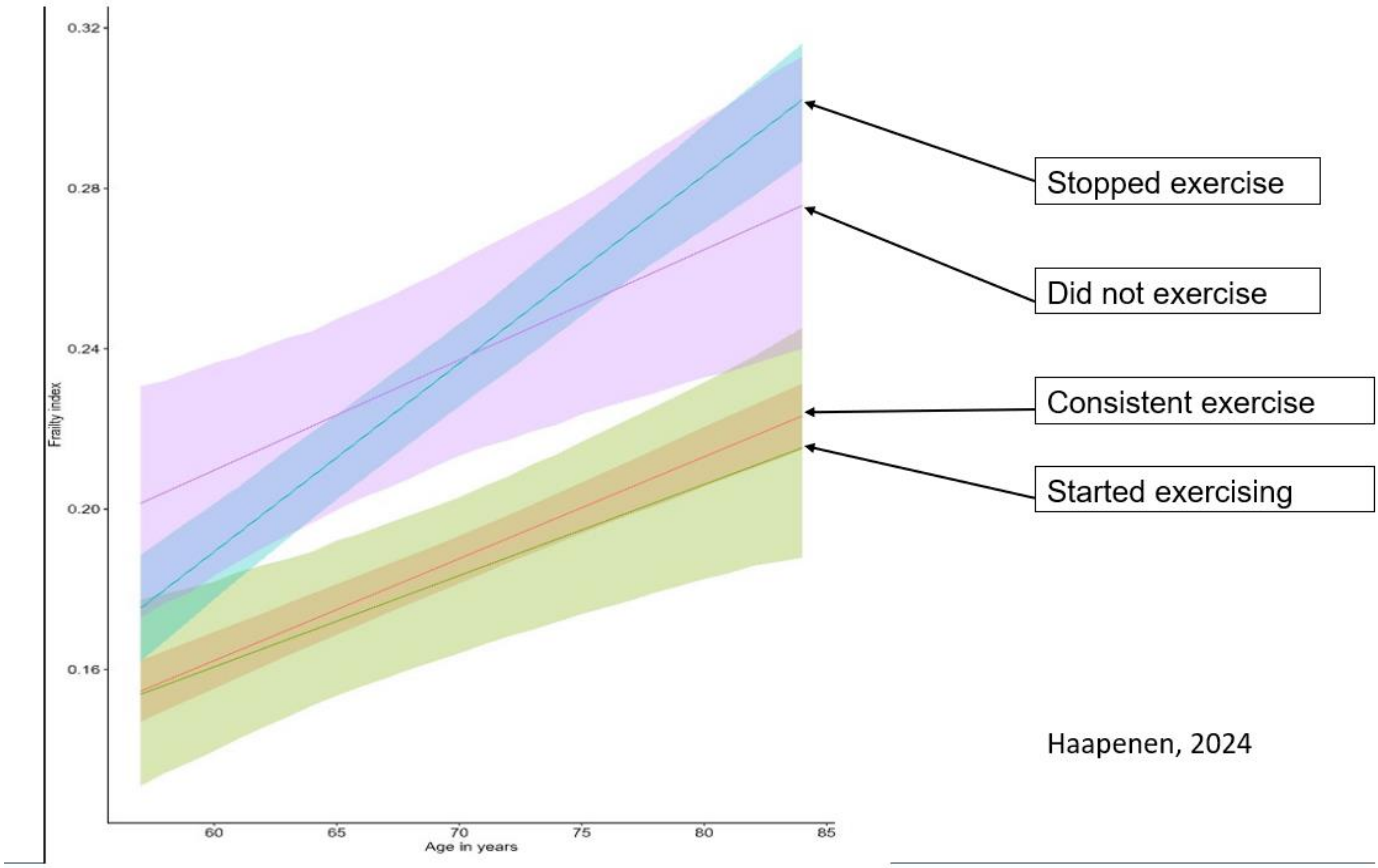
Quality of life vs quantity of life

The data below shows life expectancy in our area. If you were 65 years old in 2020-2022, you could expect to live in Staffordshire as a man for another 18 years and in Stoke-on-Trent for another 17. If we extend life without making that life healthy, what we are in effect doing is committing individuals to years of living with a disability or years of living in poor health.

	Sex	Time period	England	Staffordshire	Stoke-on-Trent
Life expectancy at 65	Male	2020 - 22	18.4	18.4	17
Life expectancy at 65	Female	2020 - 22	20.9	21	19.2
Time spent living with a disability	Male	2018 - 20	8.6	8.5	9.9
Time spent living with a disability	Female	2018 - 20	11	12	12.2
Time spent living in poor health	Male	2018 – 20	7.9	6.8	9.9
Time spent living in poor health	Female	2018 – 20	9.6	10	12

Prevention
It is never too early or too late to start prevention which is shown in the chart below.

Each of the coloured bars show a different type of exercise behaviour from average age of 50 onwards.



Evidence base for reducing admissions

1) Increased access to primary care:
- GPs, pharmacy, dental, podiatry optometry
- Case management
- Acute care at home / virtual wards

2) Increased access to community care:
- Community nursing
- Social care
- Support to stay independent.

3) Holistic assessments:
- Comprehensive geriatric assessments
- Multi-disciplinary care planning, intervention and system coordination

Feedback

The partnership split into groups to discuss and capture feedback on the following topics of discussion:

1. How do we shift the focus from acute care or extension of life more towards prevention and improving the quality of life?
2. How do we together achieve integrated community based holistic care and support for frail older people who are at high risk of admission into hospital?
3. What are the actions you and your organisation can take away from this conversation?

The following points were fed back to the group:

- Prevention: one size doesn't fit all and a lot of messages that are often given out in campaigns aren't designed to reach the right people, there needs to be a much more individualised approach. Could we utilise local radio, voluntary sector, people embedded in the community to help deliver the key messages.
- Multidisciplinary approach that we have in the Staying Well service was clearly a well evidenced model and having that multidisciplinary team wrapped around people made a difference to not only them, but also their carers.
- Housing and housing support is very important within this agenda.
- What is getting in the way of us taking this forward?
- Better communication and using the data effectively so that we can make the most impact and really understand our communities and population as well as the individual.
- Partnership working: what can we do better? Can we get a better understanding of the opportunities and what can we do differently.
- Looking closely at our local offer as well as the wider offer.
- Need to be more proactive rather than reactive – we need to see the right people at the right time.
- Improve integrated working, what can we learn from other successful integrated partnership working.
- We need to invest time in evaluating evidence to show the impact that can be made.
- Loneliness is a key factor.
- What are the barriers to exercise? Why do people not want to exercise, what is stopping them or why do they feel uncomfortable?
- Self-care: exercise massively impacts physical and mental health
- What are the intervention triggers? At what point do we need to intervene? E.g retirement, bereavement, divorce?
- How can we let the target population know what sort of exercise classes there are locally that are suitable for their age group, e.g water classes?
- Tenancy support – working with estate agents to look at housing issues.
- Prevention needs to be more than just a tick box exercise.

Date and time of next meeting: Monday 2 December 2024, 3.00pm – 5.00 pm, via MS Teams.