Integrated Care System
Nottingham & Nottinghamshire

Prevention workstream: structure, ambition and outcomes

A framework of action (January 2025)

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Our Frailty Programme

Ambition

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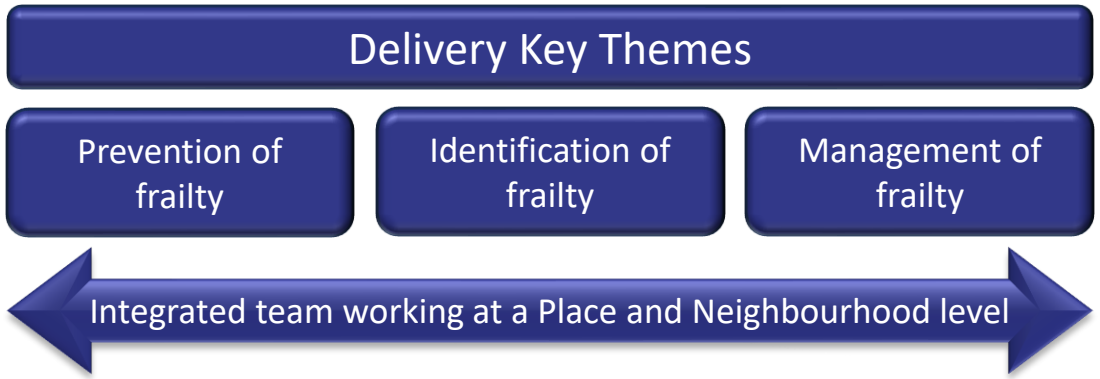
Maintaining independence by focusing on prevention for as long as possible in one's own home, increasing healthy life years, improving personalised care, achieving cost efficiencies and savings for the system.

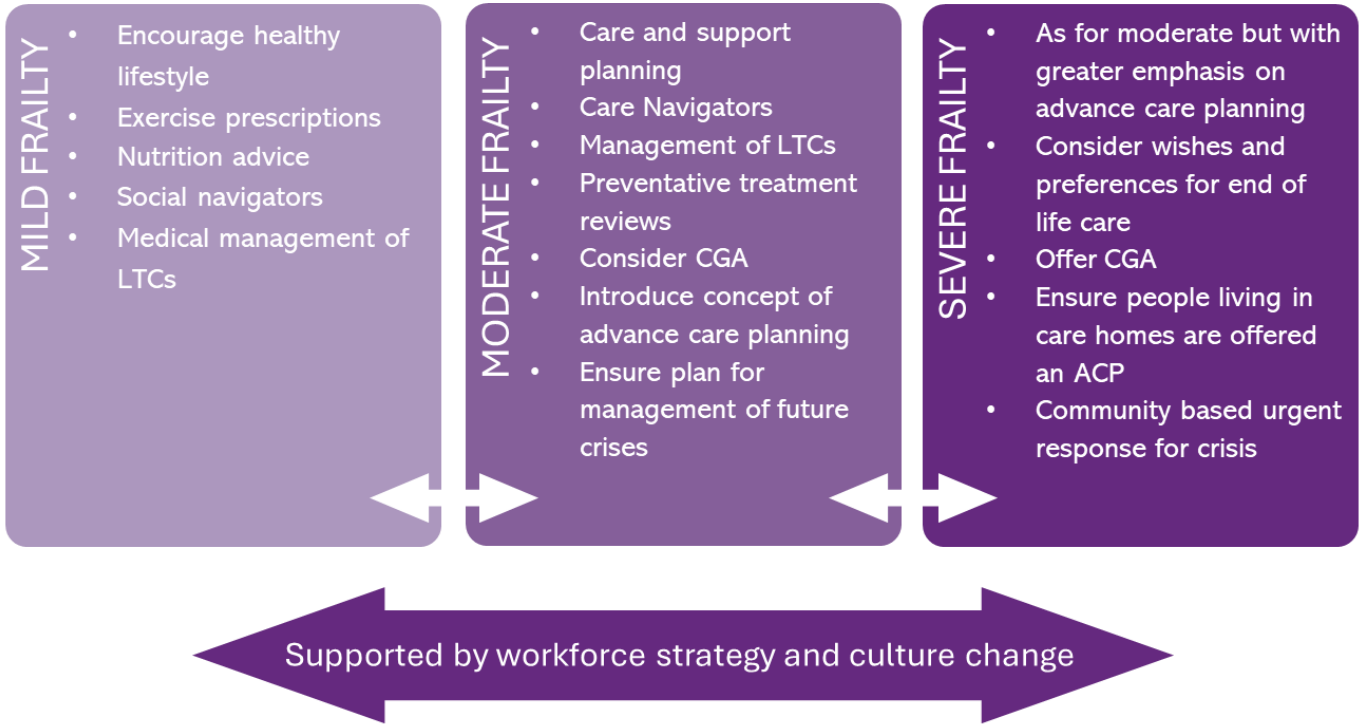
The goal is to reinforce the focus on personalised and proactive care that will enable us to deliver a fully integrated approach to Frailty and aims to:

- **Delay the onset of health deterioration where possible**
- **Maintain independent living**
- **Reduce avoidable exacerbations of ill health**
- **Reduce use of unplanned care**

This approach is consistent with:

- **ICB Frailty Strategy (2020)**
- **Our NHS Joint Forward Plan (2024)**
- **JHWB Strategies and**
- **System Integrated Care Strategy (2023/7)**





BGS, Position statement on primary care for older people, 2018

Our Opportunity

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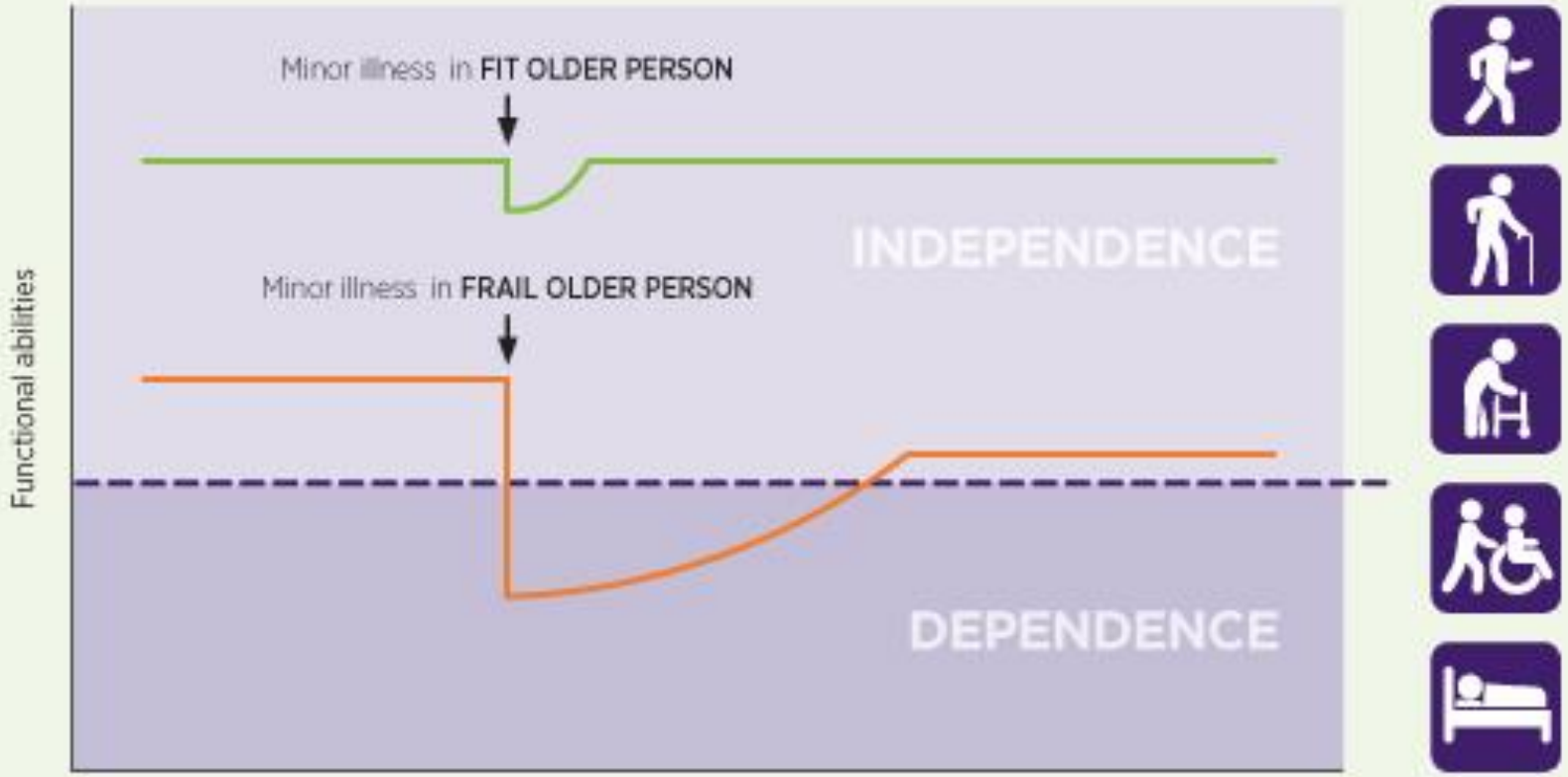
Frailty is a distinctive state related to the ageing process, but it is not an inevitable consequence of ageing



‘Rest is rust’

‘Prevention is better than cure’

‘Community rather than acute’

Purpose of this paper

Defining the prevention workstream

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- Prevention key deliverables
- Primary prevention activity
- Additional prevention focus activity at a Place Based Partnership level
- Making every contact count (MECC) and Building Blocks of Health
- Recognising the Community and Voluntary sector contribution to frailty prevention
- Delivery Metrics

Defining the prevention workstream

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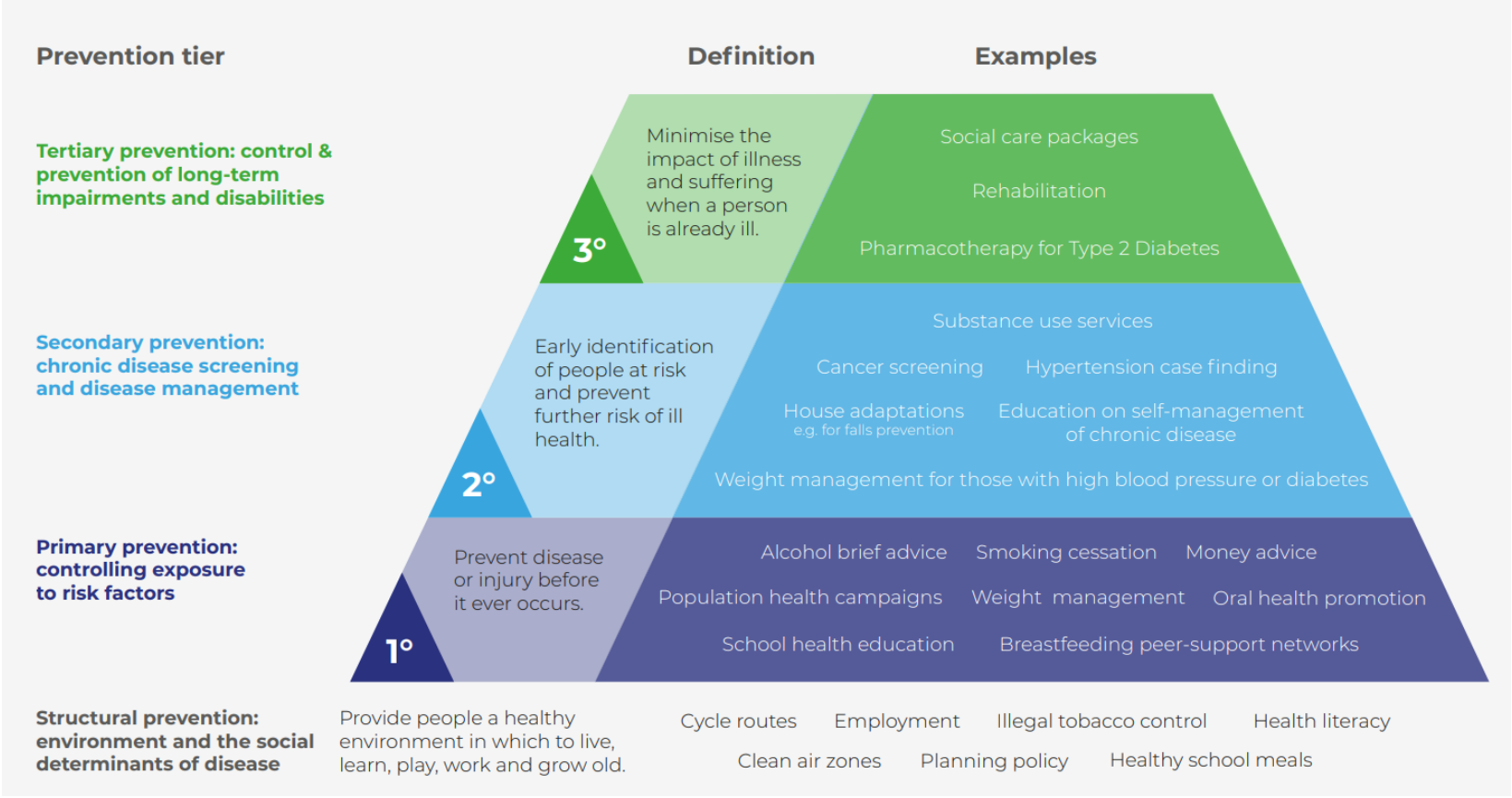
The main focus of this workstream is in preventing frailty and, as such, it is focused on structural and primary prevention. Where other types of prevention activity are mentioned, they will be identified.



Defining the prevention workstream

Structural prevention

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In parts of Nottingham and Nottinghamshire, people are experiencing illness and frailty earlier than they should and ultimately having their lives cut shorter than their peers. Almost every aspect of our lives impacts our health including jobs and homes, access to education and public transport and whether we experience poverty or discrimination.

Maintaining good physical and mental health as you grow older requires strong foundations. Research suggests a significant proportion (43%1) of the variation in frailty status can be explained by not having the right building blocks in place on which to build a healthy future. For instance, living in cold, damp homes can result in respiratory problems and other health issues that can limit mobility and increase the risk of frailty. A smaller network of family and friends can also result in spending less time outdoors or being isolated and ultimately putting people at greater risk of a range of health issues.

Together we have the levers to influence local policy and help secure the building blocks of good health. However, our desire as a system to develop healthy housing, employment, or community plans isn't only driven by the stories of frailty and is part of the everyday work of our public health teams in Local Authority. **No additional action is required specific to frailty.**

Note: The above views the building blocks of health in relation to healthy ageing. However, the story of the building blocks of health can also be told when considering the more immediate impacts they have on those already living with frailty and the need to limit it's impact (secondary prevention) or on those who suffer more severe frailty (tertiary prevention). It is important other workstreams consider which of the building blocks of health have the greatest impact on their cohort of patients and can be acted on quickly to prevent people's health from worsening.

1. Tan V, Chen C, Merchant RA (2022) Association of social determinants of health with frailty, cognitive impairment, and self-rated health among older adults. PLoS ONE 17(11): e0277290. https://doi.org/10.1371/journal.pone.0277290

Defining the prevention workstream

Primary prevention (Rationale)

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- Tobacco use is a major cause of preventable death and is associated with various negative health outcomes. Smoking has been found to be a predictor of future and worsening frailty status in community-dwelling populations[2,3].
- Living with being overweight or with obesity has a number of negative health implications. Obesity is associated with increased comorbid diseases and poor physical function, social health, and quality of life in older adults. Obesity has been linked with frailty in older men and women with increases in the risk for functional disability in older persons due to carrying excess weight, along with age-related decreases in muscle mass and strength[4,5].
- Higher levels of physical activity are beneficial to physical function, muscle strength, and cognitive function. Synthesis of data from cohort studies suggests physical activity has a protective effect, decreasing the odds of frailty[6].
- Influenza is associated with a substantial health burden, especially in high-risk people such as older adults, frail individuals and those with underlying chronic diseases. Vaccination is the most effective method for prevention and control of influenza.

2. Kojima G, Iliffe S, Walters K. Smoking as a predictor of frailty: a systematic review. BMC Geriatr. 2015 Oct 22;15:131. doi: 10.1186/s12877-015-0134-9. PMID: 26489757; PMCID: PMC4618730.
3. Gotaro Kojima, Steve Iliffe, Stephen Jivraj, Ann Liljas, Kate Walters, Does current smoking predict future frailty? The English longitudinal study of ageing, Age and Ageing, Volume 47, Issue 1, January 2018, Pages 126–131, https://doi.org/10.1093/ageing/afx136
4. Jayanama, K., Theou, O., Godin, J. et al. Relationship of body mass index with frailty and all-cause mortality among middle-aged and older adults. BMC Med 20, 404 (2022). https://doi.org/10.1186/s12916-022-02596-7
5. Villareal DT, Banks M, Sinacore DR, Siener C, Klein S. Effect of Weight Loss and Exercise on Frailty in Obese Older Adults. Arch Intern Med. 2006;166(8):860–866. doi:10.1001/archinte.166.8.860
6. Zhao W, Hu P, Sun W, Wu W, Zhang J, Deng H, Huang J, Ukawa S, Lu J, Tamakoshi A, Liu X. Effect of physical activity on the risk of frailty: A systematic review and meta-analysis. PLoS One. 2022 Dec 1;17(12):e0278226. doi: 10.1371/journal.pone.0278226. PMID: 36454790; PMCID: PMC9714708.

Supporting Prevention Key Deliverables

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1. Primary prevention activities though Local Authority commissioned services
2. Adding value to prevention through targeted work in Place Based Partnerships.
    - Including: smoking cessation, eating well, falls prevention and targeted work on immunisation and vaccinations
3. Supporting the roll out of making every contact count (MECC) and use of Building Blocks of Health

Supporting Prevention Key Deliverables

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1. Primary prevention (Activity)

Nottingham City Council and Nottinghamshire County Council both commission Integrated Wellbeing Services; Thriving Nottingham and Your Health Notts respectively. These services provide a single point of access to a range of health and wellbeing services including:

- **Smoking cessation**: a comprehensive supported online and/or in-person offer. Additional funding has recently been allocated by DHSC and is being used to strengthen links with primary care and secondary care; develop new harm reduction pathways for heavy smokers and those with serious mental illness; communication campaigns; and, in Nottingham City, exploration of new delivery models through third parties (e.g. Pharmacies, Vape shops etc).

- **Weight management**: a collection of weight management programmes co-designed with and delivered to Children and Young People and their families, teenagers or adults. In addition, a programme of engagement events related to nutrition education including in schools, also exist.

- **Physical activity**: both service provide physical activity opportunities either delivered directly or via community organisations. This offer also includes chair based or functional exercise sessions for older adults.

- **Other**: Both Health and Wellbeing services provide a holistic assessment of those they come into contact with providing coaching where appropriate and brief advice and/or signposting for alcohol, mental health and gambling (City).

- These services are not designed specifically to prevent frailty. However, Nottingham City and Nottinghamshire County Public Health teams utilise KPIs within their contracts to ensure that services target those living in communities suffering greater levels of deprivation.

Supporting Prevention Key Deliverables

1. Primary prevention (Activity) cont.

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- Work already occurs with ‘place’, secondary care providers, social care, and community and voluntary sector organisations to ensure smooth and efficient referral pathways. Collaboration between primary prevention services and place will continue but with no additional NHS resource available to further leverage place, there are no additional actions specific to frailty.

- Nottingham City Council and Nottinghamshire County Council both commission NHS Health Checks for those aged 40 years and older using their contracts to prioritise ‘at risk’ populations. These contracts continue to be reviewed regularly in terms of effectiveness and best value. Furthermore, this is considered alongside Place Based Partnership work on other Long-Term Conditions (e.g. Heart Health in Nottingham City).

- The statutory assurance role at local level for health protection sits with local government through the Directors of Public Health and exercised through the Nottingham and Nottinghamshire joint Health Protection Board. Updates on screening, immunisation and vaccination (including seasonal flu) is provided by NHS colleagues. Working groups are identified to progress local activity to enhance the equity of access and uptake of various programmes with funding from the Public Health Grants and ICB Healthcare Inequalities and Innovation Fund. This activity may be considered primary or secondary prevention for a range of health conditions not just frailty with programmes of work monitored by the Health Protection Board – unless new resources become available, there are no additional actions specific to a frailty workplan.

Supporting Prevention Key Deliverables

2. Adding value to prevention through targeted work in Place Based Partnerships.

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Includes: smoking cessation, eating well, falls prevention and targeted work on immunisation and vaccinations.

All 4 Place Based Partnerships have agreed Place delivery plans which focus on addressing population health need at a Place and neighbourhood level

These plans also contribute to supporting prevention, identification and management of frailty

- The development of integrated neighbourhood working across all 4 Places with targeted community interventions
- Focus on improving immunisation rates, related to flu, pneumonia, covid by sign posting to services, targeted promotion, some targeted neighbourhood clinics and working with NUH on opportunistic flu clinics
- Supporting the uptake of health checks through community case finding and signposting

Primary, secondary and tertiary prevention activity at PBP:

- Enhancing Tobacco Control approaches at a neighbourhood level
- Interventions to support healthy eating and moving more
- Promoting uptake of immunisations and vaccinations
- Tackling social isolation and loneliness

Enabling actions:

- Integrated Neighbourhood Working
- Embedding Making Every Contact Count approach
- Maximising the Building Blocks of Health
- Training programmes e.g. End of Life, Care Homes
- Health Inequalities, Innovation and Investment Fund

Supporting Prevention Key Deliverables

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3. Making Every Contact Count

- Identifying opportunities to maximise making every contact count and maximising use of the Building Blocks of Health across our work
- Working with Public Health colleagues across City and County Public Health to add value to current work and identify areas for focused work
- Identify appropriate metrics that would help understand the impact of MECC and use of the Building Blocks of Health.

Outcomes

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Many of the outcomes and outputs related to prevention activity are monitored elsewhere in the system and therefore Place Based Partnerships should continue to maintain a watching brief and, where appropriate, use innovation funding to add value to existing pathways and services.

- **Smoking**: The Nottingham and Nottinghamshire Smoking & Tobacco Control Alliance monitors annual updates on the smoking prevalence in Nottingham City and Nottinghamshire's districts. Nottingham City Council and Nottinghamshire County Council Public Health teams monitor the number of four week quits achieved by their respective integrated wellbeing services.
- **Eating & Moving for Good Health**: Data on the proportion of children and adults living with being overweight or obese is monitored as part of by local authority's public health team and by the health and wellbeing boards. As with smoking, the number of participants taking part in weight management programmes and achieving significant weight-loss is monitored by the public health teams.
- **Vaccination uptake**: The Nottingham and Nottinghamshire Health Protection Board monitor and interrogate data on vaccination uptake with NHS partners.
- **Making every contact count**: led by Nottinghamshire County Council to implement the MECC plan, monitor impact and interrogate data.

Prevention Workstream

Governance

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- There is currently no frailty specific programme of primary prevention work. Services commissioned by public health work closely with Place Based Partnerships and primary care to maximise their impact. These services leverage existing resources and without additional funding there are limited opportunities to add value.
- Public Health leads in Nottingham City Council and Nottinghamshire County Council provide Clinical Leadership. There are Senior Responsible Officers working across Public Health initiatives has currently been identified.
- Given the monitoring of performance and outcomes by commissioners and existing groups and boards, it is proposed that no additional oversight is required in relation to frailty. Existing relationships between Public Health teams and Place Based Partnerships will continue to ensure opportunities to build on existing prevention activity is identified.
- Outcomes and outputs of interest have been identified and will be reviewed annually by prevention leads and place-based partnerships to consider if any further action can be supported.

Targeted frailty prevention work in Place Based Partnerships (PBP)

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- South Nottinghamshire PBP
- Nottingham City PBP
- Mid Nottinghamshire PBP
- Bassetlaw PBP

South Nottinghamshire
Place-Based Partnership

Our local population

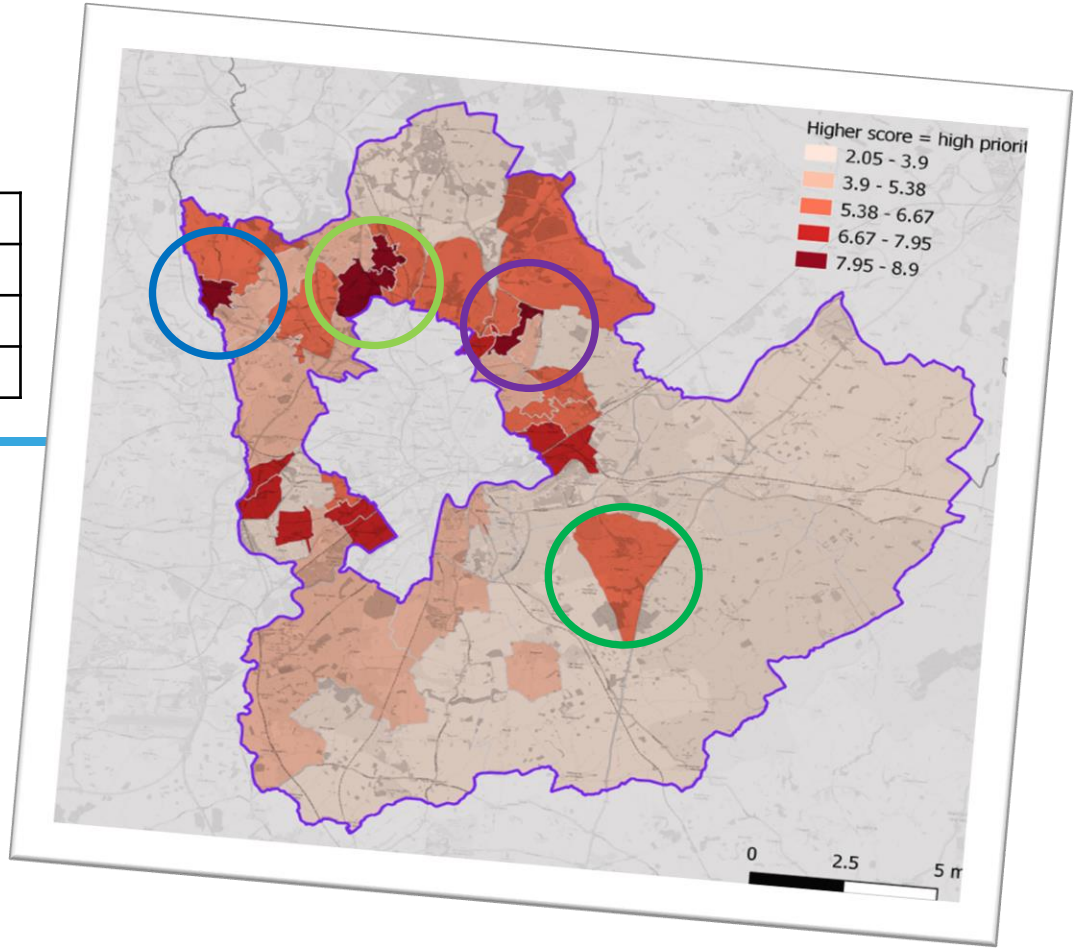
- South Nottinghamshire covers some of the wealthiest areas in the East Midlands, but with several pockets of significant deprivation.
- On average people in Rushcliffe, Broxtowe and Gedling respectively have the highest levels of education and highest median salaries in Nottinghamshire. Rushcliffe is the least deprived population in Nottinghamshire and one of the least deprived in the UK.
- While generally, health outcomes are better or equal to the UK average, the area has an ageing population (see table), and one where older people are living with one or more long term conditions. The proportion of people aged 65 and over with 4 or more diseases is set to almost double by 2035.

Percentage of the population	Over 65	Over 85
Broxtowe	21.1%	2.8%
Gedling	21.1%	2.6%
Rushcliffe	21.2%	3.1%
Ashfield *(Hucknall population included within South Notts)*	19.4%	2.2%
Nottinghamshire	20.9%	2.6%
East Midlands	19.5%	2.5%
England	18.4%	2.5%
Expected increase in population of Notts from 2021 to 2026	11%	12%

South Nottinghamshire
Place-Based Partnership

Our local population

	Eastwood
	Hucknall
	Arnold
	Cotgrave



- There are pockets of significant deprivation where there is an urgent need to tackle health inequalities including mental health, alcohol and smoking, some cancers and respiratory diseases. These are reflected in the heatmap which shows the priority areas based on the combined indicators identified within the Joint Health and Wellbeing Strategy.
- In each of our four districts the areas identified with the highest level of health inequalities are Eastwood Town, Hucknall Town, Arnold Town and Cotgrave.

Income deprivation	Healthy weight (children)	Preventable deaths	Ethnicity	Children in poverty	Smoking
High in **Eastwood** (24%), **Arnold** (18%) and **Hucknall** (16%) (national average 12%)	Childhood overweight up to 27.9% in reception (**Cotgrave**) and up to 42% in Y6 (**Eastwood**)	In **Arnold** & **Eastwood**, deaths under 75 years are ⅓ to ½ higher than nationally. Many are preventable	All areas have a lower proportion of non-White British ethnicity (4-8%) than the national average (~20%)	⅓ of children in poverty in **Hucknall**, just under ¼ in **Eastwood** and **Arnold**	High primarily in working ages in **Eastwood** and **Arnold** but may be under recorded in 30-44 year olds in **Cotgrave**

South Nottinghamshire
Place-Based Partnership

FRAILTY PREVENTION WORK

FRAGILITY FRACTURES

01 Promoting primary and secondary prevention of fragility fractures

02 People with 3 or more risk factors for falls have a FRAX completed and associated interventions in 4 priority neighbourhoods

03 People not on treatment for fragility fracture to be reviewed and treatment started (where appropriate)

04 Continue roll out of technology enabled care

INTEGRATED NEIGHBOURHOOD WORKING

01 Increase referral uptake and completion to services which support risk reduction including smoking, weight management, alcohol reduction and healthy lifestyles

02 Increase referrals/signposting to services and organisations which tackle loneliness, poor housing and benefits

Nottingham City

Life Expectancy and Healthy Life Expectancy

Men in Nottingham City die on average 5 years earlier than men in Nottinghamshire County (2022 ONS data), whilst women die on average 2.1 years earlier.

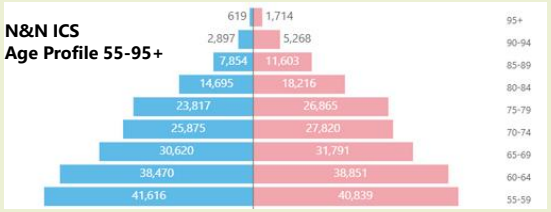
Healthy life expectancy shows the years a person can expect to live in good health (rather than with a disability or in poor health). In Nottingham City men and women can expect to enjoy 57.4 and 57.1 healthy years respectively. People in Nottingham City have the lowest average healthy life expectancy from birth. This data indicates people in Nottingham City experience frailty at an earlier age than other areas. For this reason, the City PBP uses 55 rather than 65 as the age to identify frailty in our population.

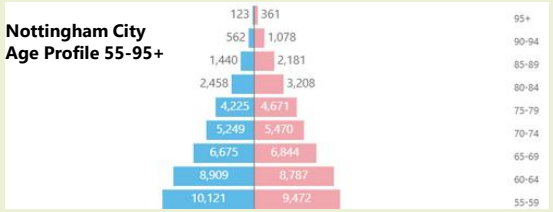
Nottingham PBP has a programme to improve outcomes and experiences of people experiencing severe multiple disadvantage (SMD). Nottingham has the 8th highest prevalence of SMD in England - currently it is estimated that over 5,000 of the City's citizens experience SMD. No official sources of data exist for life expectancy specifically in relation to people facing SMD, but it is almost certainly significantly lower than the national and Nottingham city average.

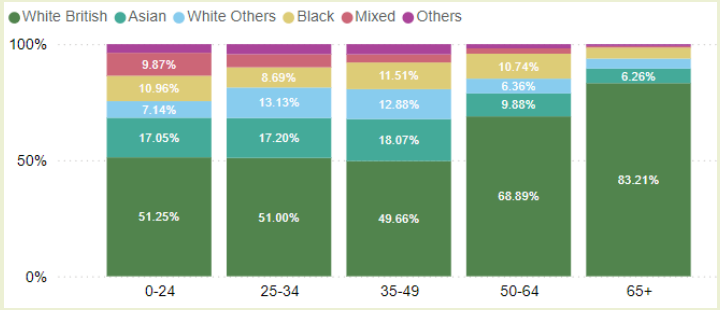
At the end of 2018, out of the 3480 Beneficiaries of the SMD programme, the average age of death was 45. This population cohort experiences frailty at a younger age than the wider Nottingham City population. Indeed in 2018, the proportion of Beneficiaries with a disability or long-term limiting condition (where data is known) was 42%.

Age Profile

Nottingham City has a younger age profile than the England average and N&N ICB. City has 5,745 85+ which is only 1.43% of its population; this is in comparison to South Notts who have 11,959 85+ representing 3% of their total population. Over 65s make up 11% of the City population but 18% of the total ICS. A higher proportion of lower cost housing, greater public transport options, presence of two universities, better access to jobs and cultural activities and amenities all make Nottingham City more attractive to a younger demographic. Nottingham City also has a lower life expectancy compared to the rest of the County.







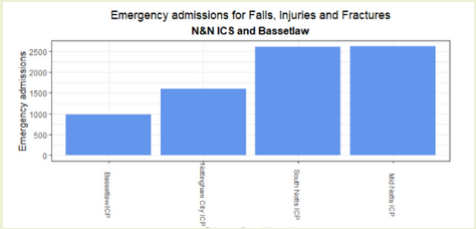
Nottingham has an ethnically diverse population, with 43% from Ethnic Minority groups. The graph to the left demonstrates that diversity differs by age group. The over 65 population are 83.2% White British. As the population ages, Nottingham City will need to prepare for an increasingly diverse older generation

.

Medical Factors

Conditions such as diabetes, cardiovascular disease, chronic obstructive pulmonary disease (COPD), and rheumatoid arthritis can accelerate the aging process. As of December 2024, Nottingham City has 24, 215 patients with 3 or more long term conditions (LTCs).

During 2023/24 there were 3857 NEL admissions for circulatory reasons and a further 5893 for respiratory conditions. Analysis on NEL admissions by the SAIU indicates that when standardised for deprivation all PCN have less NEL admissions than expected apart from Bulwell Top Valley.



As seen in the graph to the left, due to the younger population, Nottingham City has lower numbers of admissions compared to South Notts and Mid Notts for flu and falls (SAIU Aging Well Data Pack, 2021).

Logic regression analysis identifies that people identified as being in IMD quintile 1 are 2.5 times more likely to have a flu and pneumonia admission than someone in quintile 5.

Lifestyle Factors impacting on Frailty

Smoking: Smoking remains a significant public health concern in Nottingham City, with prevalence rates exceeding national average. ONS data indicates that 18.2% of over 18s smoke compared to the England average of 11.6%. 13% of Nottingham's over 65s are smokers compared to 12% of the N&N ICS.

Alcohol: Nottingham City has significantly more alcohol related admissions in the 65+ population compared to Nottinghamshire and the England average. In 2022/23 (OHID) there were 1235 admissions: the highest number in the East Midlands.

Physical Activity: Sport England Active Lives survey in 2022/23 identified that Nottingham has lower rates of physical activity compared with other areas. 56% of over 75s in Nottingham are classed as 'inactive' and 37% of them do no activity at all.

Socio-economic Factors impacting on Frailty

Deprivation: The SAIU Aging Well PHM Deep Dive (2021) identifies that 40% of Nottingham City's over 65 population are in the two most deprived deciles (1&2). There is also variation within PCNs - in Aspire more than 60% of of over 65s are in decile 1 and 2. Poverty, limited access to healthy foods and poor housing are all factors that can accelerate frailty. Healthy life expectancy is lower for Primary Care Networks with higher levels of deprivation.

Nottingham City Place: Frailty Prevention

Nottingham City Place-Based Partnership

Seasonal Vaccinations

PCN Activity: 7 City PCNs are undertaking additional activities this autumn/winter to increase uptake of seasonal vaccinations. Examples include using Care Coordinators and Social Prescribers to proactively contact patients, localised social media campaigns and offering vaccinations out of hours or in community hubs. The 7 PCNs have received £2.5k each to support this additional activity.
NUH opportunistic Flu offer: vaccines will be offered again to all unvaccinated adults attending outpatients from January 2025. In 2023/24 1000 vaccines were delivered by NUH.
Community Hubs: 3 PCNs are offering vaccines in community settings. Utilising the new provision within the PCN DES they will offer community based vaccination sessions in locations such as The Chase in St Anns. EMAS are supporting vaccinations in NCE PCN.

Increasing Referrals into Smoking Cessation

In 2023/24 Clifton and Meadows PCN undertook a project to increase the accuracy of patients' smoking status and offer cessation support to smokers. This project is now being rolled out to all City PCNs. Practices send out in batches, 4 simple questions to patients via a text message. If the patient identifies as a smoker they receive a link to Thriving Nottingham's smoking cessation service (encouraging citizens to refer in for support). In Clifton and Meadows the number of coded smokers dropped by around 100 (1%) and there were 90 referrals made to the smoking cessation service between Oct 22-Feb 23, of those referred 27 Citizens quit (resulting in a 30% quit rate). Increases in referrals and changes in smoking status will be monitored.

Bestwood and Sherwood Proactive Care Pilot

During 2023/24 Bestwood and Sherwood was one of the proactive care pilot sites. They developed a model to identify patients that at risk of health decline and accessing unplanned and emergency care. Once patients were identified they were offered a range of interventions including falls prevention, pharmacological review, social care review, social prescribing, and befriending referrals.

During the next five months the clinical leads of the pilot intend to support, engage with primary care teams across Nottingham City, to share the key learnings and recommendations from the pilot. Specifically the benefits in implementing the eCGA and CFS into business-as-usual when managing frailty.

Mid-Nottinghamshire Place-Based Partnership

Ageing Well is a Mid Notts Priority because…

In Mid Notts we have **71,774 residents** over the age of 65 which is around **20% of the population** and is growing rapidly as a proportion.[1] [2]

Up to **60% of our older people have an eFi calculation of mild to severe** which is higher when compared to most other Nottinghamshire Places, especially when looking at severely frail. We know that older people who are severely frail are 13.8 times more likely to have a hospital admission and those who live alone are 8.8 times more likely. [2][3]

In Mid Notts around **11,500 of our older people live alone** and are at higher risk of loneliness and isolation; **this is the highest percentage in Nottinghamshire at around 17%.** [4]

Older people are particularly at **risk of loneliness** and isolation in Nottinghamshire which is shown to be damaging to shorten life and increase disability. [5]

Mid Notts female and males are below the England average for life expectancy. [6]

Integrated Care System

ICS Frailty Transformation Programme three priorities

Frailty Prevention	Early Identification	Ongoing Management

It is a strategic priority – to support delivery of the Integrated Care System Frailty Transformation Programme and within our local Mid Notts Place Based Partnership Plan 2024/25 we have developed the following aims for Ageing Well along with priority projects.

MNPBP Place Plan Ageing Well Objective: Support **older people** maintain their independence using data to assign risk levels and mutli- professional **personalised care** approaches, which also **increase community connections** and relationships.

MN HIIIF Programme Objectives:

1. Maintain people living independently in their communities.
2. Decrease the pressure on social care and health services by being proactive.
3. Enabling the population access to support services.
4. Reduce the rate of falls.
5. The INT approach will strengthen the wider integrated teams to help to improve the life expectancy of our population

Priority MNPBP Frailty Projects 2024/25

Best Years Hub (12-month Pilot in Newark and Sherwood)	Embedding Prevention as part of Integrated Neighbourhood Working (Living and Ageing Well)	Enhanced Support to Care Homes
Support population to age well with increased community connections and increased use of community assets and services. Development of Best Years Hubs to improve social isolation, health management, digital inclusion and advanced care planning.	Increase use of Clinical Frailty Score (eFi) in general practice and across Place partners to help determine level of frailty. Delivering co-designed interventions to help people age well through proactive case finding of 20% most deprived.	Support Primary Care Networks to enhance support to Care Homes, with an additional focus on falls prevention and admission avoidance.

Documents referenced are in notes section below. Please click embedded link (on picture above) to view Mid Notts PBP Plan refresh2024/25.

Mid-Nottinghamshire Place-Based Partnership

Positive outcomes from Ageing Well/Frailty Projects, so far…

Since work began on Enhanced Support to Care Homes we have seen an increase in:

- Number of people in a care home identified with a care home code.
- Number of people in a care home on the End of Life register from a low of 46.1%.
- Number of people in a care home with a completed ReSPECT form a low of 70.3%.
- number of people in a care home with a preferred place of death recorded from a low of 30.3%.

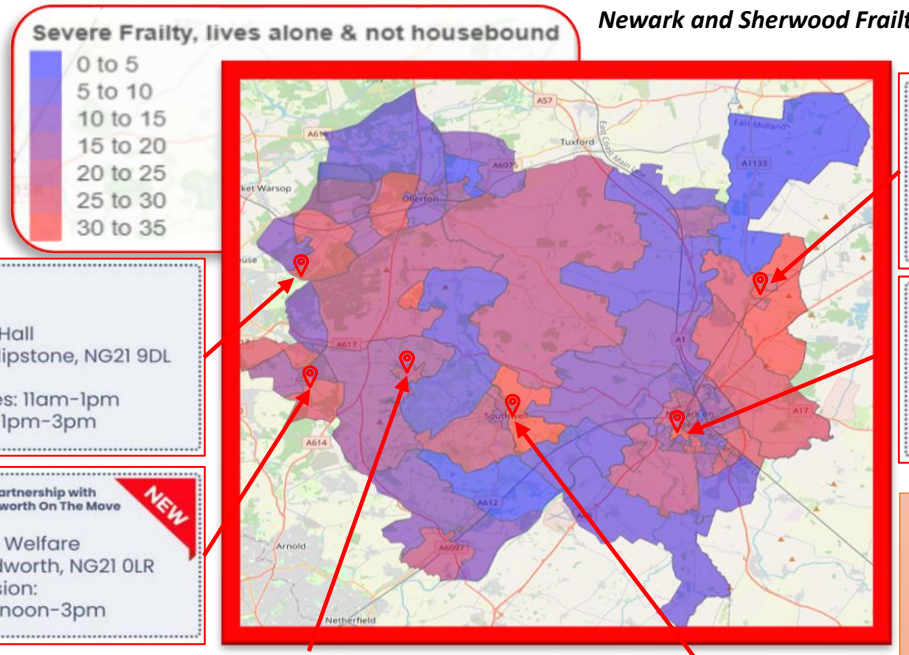
Since the start of our work Embedding Prevention as part of Integrated Neighbourhood Working, we have seen an increase in:

- Proactive case finding and early identification for those aged over 65 years, living in IMD decile 1 and 2 with severe/moderate frailty and loneliness.
- Referrals to Social Prescribing Link Workers for moderate to severe patients by eFI.
- The Clinical Frailty Score (CFS) recorded for patients living in a care home in the last 12 months

Data taken from Mid Notts Frailty Dashboard

Roll out of Best Years Hubs in Newark and Sherwood, 2024

Newark and Sherwood Frailty Heatmap created by SAIU Team



Clipstone
Clipston Village Hall
90 Church Rd, Clipstone, NG21 9DL
Every Thursday
Group & activities: 11am-1pm
Drop in support: 1pm-3pm

Blidworth In partnership with Blidworth On The Move — NEW
Blidworth Miner's Welfare
Mansfield Rd, Blidworth, NG21 0LR
Introductory session:
Wed 11th Dec | 12 noon-3pm

Farnsfield In partnership with Farnsfield Friendship Group — NEW
Farnsfield Cricket Club
48 Station Ln, Farnsfield, NG22 8LB
Introductory session:
Fri 24th Jan | 2pm-4pm

Southwell
Our Lady of Victories Church Hall
Halam Rd, Southwell, NG25 0AD
Every Tuesday
Group & activities: 1:30pm-3:30pm
Drop in support: 3:30pm-4:30pm

Collingham
William Bailey House,
Windsor Cl, Collingham, NG23 7PS
Every Wednesday
Drop in support: 12:30pm-1:30pm
Group & activities: 1:30pm-3:30pm

Hawtonville
Cleveland Sq Community Centre
Hawtonville, Newark, NG24 4HL
Every Wednesday
Group & activities: 10:30am-12:30pm
Drop in support: 12:30pm-3pm

Mike James, the man who named Best Years: "These are the Best Years of our life if we have the right support"

More information and outcomes from the Best Years frailty project can be found here.

Microsoft Edge PDF Document

Similar frailty projects are being planned and delivered across the Mansfield and Ashfield places in 2025 (dependent on future HIIIF funding).

Why Ageing Well?

Bassetlaw has one of the highest proportion of elderly and growth rates across Notts. The Office of National Statistics population projections indicate a 23.32% increase in the population aged over 65 years by 2032.

Bassetlaw is predominantly rural; due to limited access and availability of services in rural areas, elderly people can experience deficits in nutrition, transportation, income and housing. The main drivers of inequalities in rural elderly population includes social exclusion and isolation, access to and awareness of health and other community services, financial difficulties including fuel poverty and housing issues, a lack of transport and distance from services, low levels of physical activity, and mobility or existing poor health as the healthiest populations are those of working age moving out of rural areas.

Focus cohort: Frailty

Primary Definition:

- Those patients diagnosed with moderate or severe frailty **and**
- Living in a LSOA of highest quintile of Deprivation **and**
- Living in a LSOA of fuel poverty **and**
- Diagnosed with Social Isolation and/or Loneliness and/or Living alone

Loneliness and social isolation

Health risks	Increased risk of cardiovascular disease, dementia, stroke, depression, anxiety, and premature death
Other effects	Increases use of healthcare, and can harm societal health

Prevention | Equity | Integration

Bassetlaw PBP Frailty interventions

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Bassetlaw Place-Based Partnership

Bassetlaw Food Insecurity Network (BFIN);
made up of a variety of organisations, as well as local groups and people, that are all passionate about **tackling food insecurity** within Bassetlaw

MECC & Behaviour Science Nudge Training; Smoking cessation, weight management, housing, benefits, vaccs & imms, screening, etc

Energy, fuel and keeping warm advice & support.

Multiple groups and organisations; prehab, rehab, LTC management, exercise on referral, Expert Patient Programme

Bassetlaw social prescribing model: Hospital in reach, community support, High Intensity User, Hospital discharge.

Befriending & support for social isolation.

Targeted Vaccinations via PCNs

Rural transport to secondary primary & community care services

Bassetlaw Warm Spaces

Tobacco control charter

Get Out Get Active

Get out Get active

https://publuu.com/flip-book/42500/551862

Winter-Wellness-booklet-21-1-Feb-2021.pdf

Prevention

Equity

Integration

Community and Voluntary Sector

Recognising and valuing the contribution to frailty prevention

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- Review with VCSE partners in February

Milestone Plan to March 31st 2025

Supporting frailty prevention

Integrated Care System
Nottingham & Nottinghamshire

Milestone	Completion date	Owner	RAG	Explanation
Frailty Prevention Framework	31.01.25	FC/DJ/LR		To agree a frailty prevention framework of actions
VCSE discussion on frailty prevention	28.02.24	FC/HL/AB		As an action from the November Board mtg
Confirm metrics and contribution to frailty programme	31.01.25	FC/CC		Frailty prevention outcomes defines and focuses on added value
Deliver PBP frailty plans which includes prevention milestones	31.03.25	PBPs		As part of PBP Place Delivery Plans (includes refresh from 1.4.25)
Share quarterly updates on progress against PBP Frailty Plans	31.03.25	PBPs		Frailty dashboard at Place established
Share learning and case studies	ongoing	PBPs/VCSE		Use of NHS futures platform
Implement PBP INW models	31.03.25	PBPs		As part of PBP Place Delivery Plans (includes refresh from 1.2.25)

The focus of prevention will support delivery of current ICS agreed metrics:

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- Reduction in smoking prevalence in adults (aged 18+) to 5% or less by 2035 across Nottinghamshire and Nottingham City *(Indication of progress reviewed through annual national smoking profile and number of people quitting smoking via smoking cessation contracts)*
- Increase in Flu, Covid, RSV, Pneumonia/Shingles vaccine uptake from 23/24 for each eligible group and 100% offer
- Increase referrals/signposting to services and organisations which tackle loneliness, poor housing and benefits. *(use of social prescribing link worker referral measure from GPRCC, case studies and patient stories)*
- Making every contact count and the building blocks of health (*to be informed by the MECC delivery framework*)