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Agenda Item: 12.

Integration Joint Board

Date of Meeting: 17 June 2026.

Subject: Clinical Services Review – Older Persons and Frailty Workstream.

1. Purpose

1.1. To provide members with an update on the work currently being done in relation to the Older Persons and Frailty Workstream.

2. Recommendations

The Integration Joint Board is invited to note:

2.1. The significant work undertaken to date in relation to Older Persons and Frailty, as detailed in Appendix 1 to this report.

2.2. That Orkney has recently been accepted onto Healthcare Improvement Scotland's Focus on Frailty Programme with clear national outcome milestones for 2027.

3. Background

3.1. The Chief Executive of NHS Orkney commissioned an external Clinical Services Review in early 2025. The review commenced in February 2025 and concluded in June 2025. The Board of NHS Orkney received a presentation on Clinical Services Review High-level Recommendations/Findings on 12 June 2025.

3.2. On 2 July 2025, the Integration Joint Board received a report on system pressures resulting in delayed transfers of care, where the Integration Joint Board approved the establishment of a Short Life Working Group to review discharge processes, delayed transfers of care and options for working differently/creating system capacity. It was also agreed that the Short Life Working Group should report back to the Integration Joint Board on the outcome of its deliberation no later than December 2025.

3.3. On 28 August 2025, the Board of NHS Orkney received the Clinical Services Review Implementation Plan which included the final Clinical Services Review as well as the Clinical Services Implementation Plan (Horizon 1). One of the recommendations from this was to develop an elderly care strategic plan setting out the development of a HUB approach.

3.4. Following a discussion between the Chief Officer and the Director of Nursing, Midwifery, Allied Health Professionals and Chief Officer Acute Services, it was agreed to merge the two working groups.

4. Older Persons and Frailty Workstreams

4.1. In January 2026, the Older Persons and Frailty workstreams were merged to better integrate acute, community and social care, recognising strong interdependencies across services.

4.2. The workstream, which meets every three weeks, provides a system-wide framework to reduce variation, strengthen multi-disciplinary team (MDT) working, improve coordination and support independence while reducing avoidable admissions and delayed transfers of care.

4.3. An Older Person and Frailty Workstream Deep Dive, attached as Appendix 1 to this report, was undertaken in Spring 2026.

5. Key Highlights

5.1. The key highlights of the deep dive are:

5.1.1. Extensive analytical activity is underway to understand system pressures, patient pathways, MDT coordination, delayed transfers of care and unscheduled admissions. This includes:

- Case study mapping of three patient journeys (frailty/falls, dementia and isles).
- MDT activity mapping to clarify current arrangements and improve organisation around the person.
- Guardianship and Power of Attorney deep dive to understand their role in delayed discharges.
- Admission and readmission deep dives for people aged 75+, including 30, 60, and 90 day reviews.

5.1.2. A GIRFE (Getting It Right For Everyone) toolkit pilot is underway, testing person-centred coordination tools (“My Plan” and “My Team”) across wards, one GP practice and the Link Practitioner Service. This focuses on reduced duplication, better coordination and improved patient experience. The pilot ran to the end of April 2026 with evaluation informing a phased rollout from May 2026.

5.1.3. An Intermediate Care Allied Health Professions Single Point of Contact pilot launched on 5 May 2026, with evaluation by the end of June 2026. The aim of this is to establish a clear, consistent referral route and Duty Huddle for community Allied Health Professions services. It is also hoped that it will reduce duplication and delays and improve clarity for referrers and patients.

5.1.4. A review of dementia service pathways and processes are underway which includes reviewing pre-diagnosis, diagnosis, post-diagnostic support, workforce capacity and awareness of dementia risk factors. An initial Dementia Workshop was held in April 2026 with a further session scheduled in June 2026 to map pathways. An updated formal Dementia Strategy will be produced, aligned with Public Health priorities, and presented to the Integration Joint Board.

5.1.5. Care at Home and Care Home services are a key strategic priority within the workstream and represent the most resource-intensive area of delivery. A Project Initiation Document (PID) has been developed and was approved by the Council's Corporate Leadership Team on 23 April 2026. This PID aims to look at workforce and models of care.

5.1.6. As mentioned above, progress on the recommendations in relation to Frailty have been incorporated to support a more integrated system-wide approach. The key areas of focus include the use of the Clinical Frailty Scale (CFS) and eFrailty index, clear protocols linked to frailty scores and improved MDT working and care planning. Orkney has recently been accepted onto the Healthcare Improvement Scotland Focus on Frailty Programme with clear national outcome milestones for 2027.

5.1.7. In December 2025, Professor Stephen Friend held a session in Orkney on the use of dynamic frailty assessment tools which enable daily frailty monitoring and support earlier intervention as well as to allow more proactive care. The workstream is exploring expansion of telehealth, remote monitoring, apps and wearable technology to support independence.

6. Contribution to quality

Please indicate which of the Orkney Community Plan 2025 to 2030 values are supported in this report adding Yes or No to the relevant area(s):

Resilience: To support and promote our strong communities.	Yes.
Enterprise: To tackle crosscutting issues such as digital connectivity, transport, housing and fuel poverty.	Yes.
Equality: To encourage services to provide equal opportunities for everyone.	Yes.
Fairness: To make sure socio-economic and social factors are balanced.	Yes.
Innovation: To overcome issues more effectively through partnership working.	Yes.

Leadership: To involve partners such as community councils, community groups, voluntary groups and individuals in the process.	Yes.
Sustainability: To make sure economic and environmental factors are balanced.	Yes.

7. Resource and financial implications

7.1. There are no immediate financial implications directly arising as a result of this report, nevertheless, it is anticipated that improvements in service delivery will better ensure that people will more consistently receive the help they need when they need it. This is likely to improve their outcomes and reduce the costs of crisis and acute care.

7.2. While there are no immediate workforce implications, progressing the actions within the Older Persons and Frailty Workstream will improve MDT working and collaboration which will benefit the services.

8. Risk, equality and climate change implications

8.1. There are no risk, equality or climate change implications directly arising as a result of this report.

9. Direction required

Please indicate if this report requires a direction to be passed to:

NHS Orkney.	No.
Orkney Islands Council.	No.

10. Escalation required

Please indicate if this report requires escalated to:

NHS Orkney.	No.
Orkney Islands Council.	No.

11. Authors and contact information

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12. Supporting documents

12.1. Appendix 1: Older Persons and Frailty Workstream Deep Dive.

Appendix 1

Transformational Priorities Programme

Older Persons and Frailty Workstream Deep Dive

Executive Leads:
Stephen Brown, IJB Chief Officer
Sam Thomas, Executive Director of Nursing, Midwifery, AHPs, and Chief Officer Acute

Drafted by:

Harmony Bourn, Project Manager

1. Introduction / Background

The Older Persons and Frailty Workstream is one of four workstreams established as part of the Transformational Priorities Programme, following the Clinical Services Review (CSR). Its purpose is to provide a coordinated approach to improving care for older people and reducing variation across services.

Following a programme-wide prioritisation exercise, it was recognised that frailty-related activity spanned both the Acute / Front Door and Older Persons workstreams. As a result, these elements were brought together into a single Older Persons and Frailty Workstream, reflecting the interdependencies between frailty assessment, pathways, multidisciplinary team (MDT) working, wider service redesign, and supporting a more coordinated system-wide approach.

This paper provides a deep-dive overview of the Older Persons and Frailty Workstream, setting out each sub-project and sub-activity, along with associated deliverables, milestones, outputs, and outcomes.

2. Workstream Overview, Scope and Governance

The Older Persons and Frailty Workstream aims to deliver measurable improvements in outcomes and experience for older people in Orkney, particularly those living with frailty, dementia, and complex needs. This will be achieved through earlier identification of frailty, improved coordination of care and multidisciplinary working, and proactive support to help people maintain independence, avoid unnecessary hospital admissions, reduce delayed discharges, and experience smoother transitions across services.

The workstream provides an overarching, system-wide framework to coordinate a range of interrelated improvement activity. Its scope will continue to evolve as additional frailty-related activity from the Acute / Front Door is incorporated.

Governance arrangements are in place to support coordinated delivery. An Older Persons Working Group meets on a three-weekly basis with progress monitored through checkpoint reporting and escalated to the Improving Together Programme Board through a monthly highlight report. Executive Leads and the Project Manager meet in advance to provide oversight and support delivery.

The Working Group co-developed a set of deliverables and milestones, with a Delivery Lead identified for each, as outlined in Appendix 1. Delivery is progressed through several work strands with the Working Group providing overarching coordination and oversight. The agreed work strands are:

1. Analytical reviews
2. Getting It Right For Everyone (GIRFE) Team Around the Person
3. Intermediate Care Allied Health Professions (AHP) Single Point of Referral (SPoR)
4. Dementia services review
5. Care at Home and Care Home Services
6. Frailty development areas
7. Telehealth expansion

3. Work strands Overview

3.1 Analytical Reviews

A programme of time-limited analytical activity is underway to build a shared understanding of current pathways, decision-making, system pressures, and to inform where earlier intervention, improved coordination, or service redesign could improve outcomes and flow.

Case study mapping exercise

Three patient journeys – one involving frailty and falls, one involving dementia, and one from the isles – are being mapped to identify system challenges, duplication, and missed opportunities for earlier intervention or prevention.

Three patients have been identified and information requests issued. Given the resource-intensive nature of data collation, particularly where paper records are involved, cases are being progressed sequentially to support focused review. Information will be consolidated into chronological timelines and reviewed by the Working Group, with learning captured through case studies. Information collation for one patient is nearing completion, with triangulation into a journey map underway. Collation for the remaining two cases will continue once the first dataset is complete.

Milestone: Completion of one case study mapping, with learning identified and case studies produced by end June 2026.

Output: Evidence-based case studies that articulate system constraints and opportunities.

Outcome: A robust evidence base to agree and prioritise improvement actions that improve system flow, multidisciplinary working, and service experience for older people.

Multidisciplinary (MDT) Team activity mapping

MDT activity mapping is being undertaken to clarify existing MDT arrangements, including purpose, frequency, membership, and administrative support, in response to identified coordination challenges. An MDT mapping template has been developed to support consistent data collection and identification of opportunities to better organise MDTs around the person, aligned with GIRFE.

Milestone: Completion of MDT activity mapping by end May 2026.

Output: Completed MDT mapping dataset and standardised template capturing current MDT arrangements.

Outcome: A shared understanding of current MDT arrangements and coordination challenges, providing a clear evidence base to improve MDT organisation and strengthen multidisciplinary working.

Guardianship deep-dive

Analysis is underway to assess the extent to which delayed discharges are linked to the absence of Power of Attorney (PoA) or guardianship arrangements. Findings will inform opportunities to strengthen capacity assessment processes and earlier intervention, including consideration of extended sign-off assessments and targeted public awareness to support earlier planning.

Admission deep-dives

An admission deep-dive for patients aged 75 and over, alongside a 30-60-90-day admission review, will examine reasons for presentation, admission, and readmission across defined time horizons. This analysis will identify demand patterns, early readmission trends, medium-term deterioration or system gaps, and opportunities for admission avoidance and earlier preventative intervention.

Support has been offered by the Scottish Government Rapid Improvement Team to assist with these analytical reviews. Milestones will be confirmed once scope and support arrangements are agreed.

Outputs (across above reviews): A suite of evidence-based analytical outputs covering delayed discharge drivers linked to absent POA or governance arrangements, admission and readmission trends, and wider system pressures.

Outcomes (across above reviews): A clear evidence base to inform improvements to capacity assessment and earlier POA planning, and to prioritise high-impact improvement actions that improve system flow, outcomes, multidisciplinary working, and service experience for older people.

3.2 GIRFE Team Around the Person Pilot

The GIRFE Team Around the Person toolkit was co-developed through national pathfinder areas, including Orkney Health and Social Care Partnership. Older people and frailty were a defined GIRFE pathfinder theme, with local engagement identifying priorities such as a

single care coordinator, better-connected support, reduced repetition, and access to services closer to home, including through virtual appointments. These priorities informed the development of the toolkit.

A pilot is underway to test the toolkit across the inpatient wards, one GP practice, and the Link Practitioner Service. The *My Plan* and *My Team* documents have been refined, alongside a patient leaflet and PREM-based evaluation tools. These are being tested with a small cohort of older people to inform further refinement ahead of wider rollout. The pilot runs until the end of May, with evaluation sessions planned in June to capture feedback and learning.

Following evaluation, the Older Persons Working Group will consider scaling up a phased rollout to other services, including opportunities to reduce duplicative documentation where appropriate.

Milestone: Completion of pilot and review of evaluation by end June 2026.

Output: GIRFE toolkit developed and tested with a pilot cohort, with evaluation findings informing refinement of the toolkit and approach.

Outcome: A refined GIRFE toolkit with clear recommendations for phased rollout and scope across services, strengthening person-centred, coordinated care and reducing duplication.

3.3 Intermediate Care AHP Single Point of Referral Pilot

A key recommendation from the CSR was to establish a Single Point of Referral (SPoR) for Intermediate Care AHP services to address unclear referral pathways, duplication, and inefficiencies arising from referrals entering services through multiple routes. The SPoR and duty model being established aim to improve coordination, efficiency, and patient experience.

Referral and triage documentation has been developed. Phase 1 pilot testing was soft launched on 5 May 2026, with positive feedback received on the referral and triage form and early patient interactions. Further work is required to streamline processes and address interoperability issues. Phase 2 planning is underway through a Short Life Working Group, with testing to resume once these processes have been refined and interoperability issues addressed. Work to enable GP direct referral has paused due to eHealth capacity constraints and will be revisited once internal processes are sufficiently established.

Milestone: Phase 1 pilot soft launched on 5 May 2026, with Phase 2 testing planned to begin before the end of June.

Output: A tested Single Point of Contact model, including agreed referral and triage processes, Duty Huddle arrangements, and supporting training.

Outcome: Improved coordination and oversight of community-based AHP referrals, reducing duplication and delays, clarifying referral pathways for referrers, and a more efficient, person-centred approach that improves patient experience and supports system flow.

3.4 Dementia services review

A review of dementia service pathways and processes is underway to assess effectiveness and identify opportunities for improvement and service redesign. Agreed areas of focus include pre-diagnosis and future arrangements for the GP with a Specialist Interest in Dementia role, expansion of the Admiral Nursing Service, redesign of post-diagnostic support, and increasing awareness of dementia risk factors.

A dementia development session has been held to map existing pathways, with a focus on pre-diagnosis and referral into dementia services. A second session is scheduled in June 2026 to consider acute and inpatient pathways. Findings from both sessions will inform service changes and improvements. Public Health has agreed to support increased awareness of dementia risk factors, aligned with a current focus on brain health, and the dementia strategy will be updated and formalised.

Milestone: Completion of development sessions, with agreed actionable plans for improvements and redesign by end July 2026.

Output: A mapped and evaluated overview of current dementia service pathways, and identified improvement priorities, informed by development sessions, and an updated dementia strategy.

Outcome: A clear agreed direction for dementia service improvement and redesign, enabling more coordinated pathways, strengthened post-diagnostic support, increased awareness of dementia risk factors, and a formalised dementia strategy that improves experience and outcomes for people living with dementia and their carers.

3.5 Care at Home and Care Home services

Care at Home and Care Home services are a key strategic priority within the workstream and represent a significant area of delivery. Work is underway to scope future service and workforce models across community and social care to ensure they are sustainable, flexible, and aligned to current and future needs.

This programme of work will support the development of more coordinated, nursing-enabling models of care, strengthening capacity across the system and supporting improved flow for older people.

Milestone: Delivery of redesigned Care at Home and Care Home workforce model, including transition to nursing home registrations and full implementation across services by August 2028.

Output: A redesigned Care at Home and Care Home service model, including approved workforce models, nursing home registrations, and implemented rota and staffing arrangements across services.

Outcome: A sustainable, nursing-enabled care home and community care model that improves acute hospital flow, reduces delayed discharges, supports timely discharge planning, and strengthens workforce resilience and responsiveness.

3.6 Frailty development areas

Frailty recommendations arising from the CSR, originally planned through the Acute / Front Door workstream, are now being incorporated into the Older Persons and Frailty Workstream to support a more integrated, system-wide approach.

NHS Orkney has been accepted onto the Healthcare Improvement Scotland (HIS) Focus on Frailty Programme, providing a structured national improvement framework. A weekly Working Group has been established to progress this work with support from HIS. Key areas of focus include the introduction of Clinical Frailty Scale (CFS) scoring, supported by use of the eFrailty Index; development of clear protocols linked to frailty scores, including referral triggers and integration of advanced care planning; establishment of dedicated frailty assessment and triage processes; strengthened MDT working; expansion of responsive community services, including virtual ward monitoring for high-risk patients; and improved communication and handover across services.

Additionally, a frailty process-mapping exercise has been scheduled for July 2026 to identify system gaps, disconnections, and opportunities for improvement. This will inform prioritisation and phasing of subsequent improvements.

Milestone: Completion of frailty process-mapping workshop and agreement of prioritised improvement actions and phasing by end July 2026.

Programme outcome-based milestones (HIS Focus on Frailty):

- By March 2027, at least 10% of people aged 65 and over will have a recorded Rockwood Clinical Frailty Scale assessment within the relevant clinical system, with improved information-sharing to reduce duplication and support joined-up working.
- By March 2027, 70% of people with a CFS score of 5 or above will have evidence of proactive, community-based support within the previous 12 months, supporting earlier intervention, reduced deterioration, and improved outcomes for older people across Orkney.

3.7 Telehealth expansion

A key opportunity identified through the CSR is the expansion of telehealth, self-monitoring, and app-based support to help people maintain independence and live at home for longer.

In December 2025, engagement with Professor Stephen Friend explored the use of dynamic frailty assessment tools, including apps and wearable technologies, which enable daily frailty monitoring and support earlier intervention and more proactive care.

Further opportunities are being explored through a potential partnership with BT and Feebris to develop virtual care solutions for people living with frailty. As frailty pathway mapping progresses, these opportunities will be assessed to identify where digital solutions can most effectively support local improvement activity and emerging frailty pathways.

Milestone: Review of telehealth opportunities by end June 2026.

Output: An assessment of telehealth and virtual care opportunities for frailty including dynamic frailty assessment tools and remote monitoring solutions, with recommended priority use cases aligned to local frailty pathways.

Outcome: A clear basis for optimising digital solutions where they add most value, supporting earlier intervention, proactive management of frailty, and helping people maintain independence and live at home for longer.

4.0 Summary

The Older Persons and Frailty Workstream represents a large, system-wide programme of improvement. Good progress has been made across all work strands, with strong governance foundations now in place. Key analytical reviews, pathway mapping, and pilot activity are underway and approaching completion, providing a growing evidence base to inform targeted improvement actions and service redesign.

Delivery is supported through clear governance arrangements, defined milestones, and alignment with national programmes, including the HIS Focus on Frailty Programme and support from the Scottish Government Rapid Improvement Team.

Given the scale and interdependency of the workstream mean, delivery will continue until 2028, particularly in high-impact areas such as Care at Home and Care Home services and frailty development. Continued dedicated project management and coordination are essential to maintain momentum, manage dependencies across strands, and ensure emerging learning is translated into sustainable improvements that improve flow, reduce delayed discharges, and deliver better experience and outcomes for older people in Orkney.