A Regional Approach to Frailty Community of Practice Meeting 6

7th February 2019

Lesley Bainbridge
Clinical Lead

Welcome and Introductions

Frailty ICARE: *what's the latest?*

1. **Evaluation:** ARC bid – still awaiting outcome, bridging the front line and academia - AHSN seeking funding for a PhD student and a Research Associate

2. **Workforce:** job descriptions for 3 cross organisational competency assessors at panel for 2nd time, further meeting with HENE planned for 18th Feb, current interest in testing competency framework
    - County Durham and Darlington; *Community Nursing*
    - Gateshead; *Community Nurse Practitioners, LA Prime Team*
    - Newcastle; *Older People's Medicine Wards*
    - Northumbria/Nth Tyneside; *Frailty Assessment Unit & IC MDT*
    - Sunderland; *to be confirmed*

Frailty ICARE: *what's the latest?*

3. **Digital:** job description for strategic clinical digital lead and support at panel for 2nd time, process to access funding still being finalised, ***Health Call*** - a collaboration of [6] Trusts, consolidating resources – people, prices, procurement, supported by the AHSN NENC, in simple terms works with a digital provider ***Inhealthcare*** to create information flow between systems, number of workstreams, those relevant to frailty
   - *NEWS and other clinical parameters, transferring care forms [care homes]*
   - *shingles*
   - *flu*
   - *virtual ward*
   - *nutrition and hydration*
   - *falls*
   - *wound care [link to React to Red?]*

All interfaces are open and published to allow for integration with any standards-based clinical system, device or application

inhealthcare
Digital Care Platform

Patient Information & systems

Spine
SUS
ERS
CP-IS
SCR
GP Connect

Department of Health

National

Scottish Care Information (SCI) Store

systmone
emis
ASCRIBE
DAWN CLINICAL SOFTWARE

Hospital

INRstar
systmone
emis health
VISION

GP



Care home

Tunstall



At home



On the move

Frailty ICARE: *what's the latest?*

4. Falls: North East Regional Falls Task Group – what is the link between local and regional falls work and Frailty ICARE outcomes and do we need to link the two? JS and LB to meet with them.

5. OP Mental Health: single group now [ICS mental health work stream and Care Closer to Home work stream], currently developing a 'sunshine or showers' tool for domiciliary care staff to be able to open a 'mood conversation' – housing CoPpers to test

Frailty ICARE: *what's the latest?*

6. Frailty ICARE Metric no 17:

In Hospital Delays Proportion of stranded patients in hospital: length of stay 7+ and 21+ days

CoP Question: why this and not DTOC?

Reply from Dawn Moody and Martin Vernon:

- been discussing both these measures in the context of the soon to be published RightCare Frailty Focus Packs
- originated from previous work with ECIST and NHSI hospitals programme looking at who was most likely to be at risk of LOS > 7 and 20
- modelled on age segmentation which is all we have data on for inpatients but aligned to work on Frailty trajectories done in Cambridge
- currently working with the LOS programme team to get Frailty more explicitly aligned, as a preface the Frailty at the Front Door guidance (developed by AFN and ECIST)

  https://improvement.nhs.uk/documents/579/identifying-and-managing-frailty-RIG.pdf
  https://improvement.nhs.uk/documents/2984/AEC_Same_day_acute_frailty_services_June2018.pdf
  https://i.emlfiles4.com/cmpdoc/9/7/2/8/1/1/files/46972_20180612-long-stay-reduction-letter-v1.0.pdf
- not a complete answer, more work to do - in particular keen for a ***frailty care bundle*** to be deployed to better map and support inpatient care to shorten unwarranted LOS

Frailty ICARE: *what's the latest?*

7. CoP Question: will there ever be an HRG for frailty?

Reply from Dawn Moody and Martin Vernon:

Nothing planned and the obvious challenge is finding a suitable code set in HES/SUS given there is not a designated frailty pathway for inpatients. However, good question CoPpers and will pick up a conversation on this within NHSE.

Showcasing CoPper: Medicines

Steven Barrett
Lead Clinical Pharmacist
Northumbria Healthcare NHS FT

Showcasing CoPper: Frailty Implementation Pan South ICP

Jen Steele, Clinical Lead Care Closer to Home Network
Catherine Monaghan, Consultant Respiratory Physician

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Developing Integrated Health and Care

North East and North Cumbria

Working for people from North Yorkshire to the Scottish Borders

Join our journey...

Item 2 : Presentation of emerging ideas

South Integrated Care Partnership

Frailty Work Stream

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Frailty

- Safe, compassionate care for frail older people using an integrated care pathway (NHS England)
- NHS ten year plan
- ICARE framework

I-CARE : Preventing frailty and supporting people, families and communities living with frailty

INVOLVE

Engage and involve people, carer's and families to start the frailty conversation, enhance the voice of older people and tackle the frailty challenge together

MAKING IT HAPPEN

CONSIDER

High risk groups of people

- ✓ Over 85s
- ✓ Over 65s with multimorbidity or those who have experienced frailty syndrome
- ✓ Care home residents or housebound
- ✓ Taking 10 or more medications
- ✓ Known to community nurses or social care [inc. Continuing Health Care]
- ✓ Existing primary care registers
- ✓ Complex neurological problems
- ✓ Severe mental illness [older people]

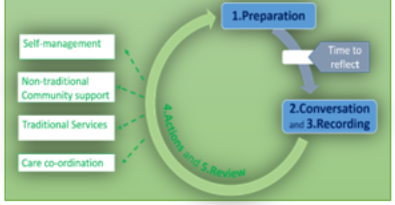
Using frailty tools such as the electronic Frailty Index

ASSESS

Verify frailty
(with tools such as PRISMA7 and TUGT, gait speed)

Classify severity
(with tools such as Clinical Frailty Scale or Edmonton Frailty Scale)

Use Care + Support Planning
(for ongoing needs-based, solution orientated conversations, that focus on 'what matters' to people and carers to support them to live and age well e.g. exercise, isolation)



RESPOND

Vulnerable (non-frail)

Encourage healthy ageing with signposting to keeping active, engaged and independent, including access to frailty friendly living and homes

Mild frailty

Encourage community connectivity through strengthening access and involvement of the Voluntary, Community and Social Enterprise sector

Offer self-management and shared decision making to develop a *self-management plan* to optimise LTCs including falls, immobility, incontinence and medication

Provide crisis response and recovery at or close to home including frailty-focused ambulance services with timely transfers of care from / to hospital involving carers and families.

Moderate frailty

Provide access to interagency teams for Comprehensive Geriatric Assessment and case management to develop an *emergency health care plan* to coordinate care and optimise end of life and dementia care

Provide timely access to experts offering frailty-based care in hospital with frailty assessment, diagnostics and pathways

Severe frailty

EVALUATE

- ➢ Excess Winter Deaths
- ➢ Reduced loneliness
- ➢ Carers /people with LTC can manage

- ➢ NHS Thermometer
- ➢ Dementia diagnosis
- ➢ Access to psychological therapies
- ➢ Medication reviews

- ➢ Dying in usual place of residence/place of choice
- ➢ Care home admissions
- ➢ Residence 91 days
- ➢ Hospital admissions in last 3/12
- ➢ Delayed transfers of care
- ➢ Population hospital bed following an emergency admission
- ➢ Carer's views on last 3/12 of life
- ➢ Emergency hospital readmissions /avoidable

Frailty

Overarching principles:

- Patients should be cared for as close to their own homes as possible
- Community teams should be adequately resourced to manage stable frail and frailty in crisis via integrated single point of access
- System approach linked to primary, social care and voluntary sector
- System approach to workforce development
- An acute admission should not be the default position
- Early Comprehensive Geriatric Assessment
- Active management following Advance Care Plans
- Pro-active population health approach to frailty, early detection and through reduction of loneliness and use of social prescribing
- Discharge to assess models including care providers

Frailty System Approach: Community Services

- Care as close to home to possible within teams who know their patients' needs
- Integrated Single Point of Access to services

This approach should provide;

- Keep people safe where they live
- Prevent avoidable admissions, minimise acute stay
- Optimise the quality of care,
- Discharge home, or as close to home as possible, when medically optimised.

Frailty in crisis; rapid support at home

- Single point of access with clinical triage
- Rapid Response services : within 2hours : ‘faster than an ambulance’ CGA within 4 hours
- Support from frailty coordinators
- Ambulatory pathways within each frailty unit
- Rapid access clinics with geriatricians
- Access to a community geriatrician to provide expert opinion and support
- Improved use of artificial intelligence

Community beds

- Accessed following assessment by frailty co-ordinators
- Step up, step across and step down
- Different medical models depending on locality

Community Hub

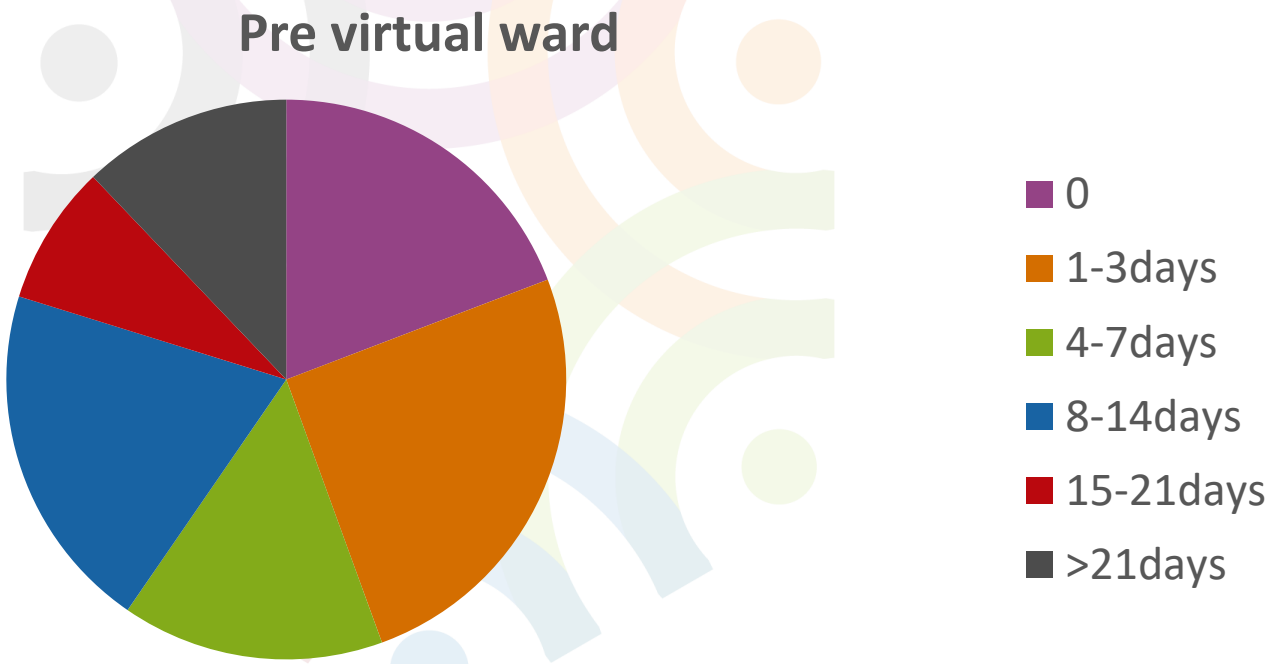
- Ambulatory pathways for frailty in crisis
- Step across beds
- Ability to provide other services to take pressure of the acute sites

Acute Frailty Units/ pathways

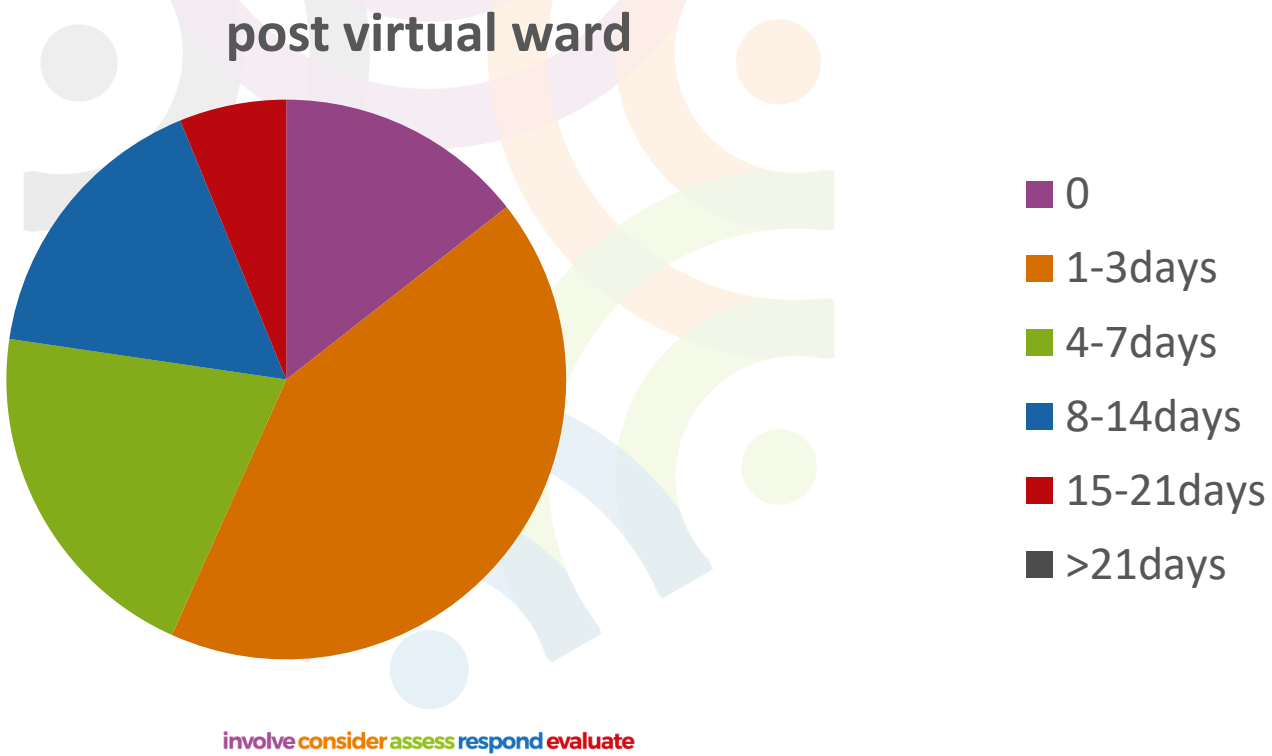
Frailty Assessment and Acute Frailty Unit at each hospital site. This is the agreed option

- Front of house model established at each acute site
- Expert decision makers 8am-8pm seven days a week: assessment within 30 minutes
- Therapy support seven days per week
- Multidisciplinary approach, including TEWV
- Frailty coordinators act as link to:
    - Community
    - Front of house
    - In-reach into back of house

Frailty coordinator data



Frailty coordinator data



Frailty coordinator data

- Introduction of virtual frailty ward October 2018
- 351 patients on caseload in three months
- 11% increase in patients discharged in <3 days
- 16% increase in patients discharged within 7 days
- 9% reduction in frail patients becoming super-stranded

Collaborative next steps

- The approach to frailty requires a whole system approach
- The principles of the model are being shared across both acute and community providers and commissioners
- Re-design will realise benefits across the system
- Commissioning intentions will be aligned to this work so future commissioning reflects the agreed approach

Priority areas

National data shows that if in the North East we;

- Lowered our emergency admission rates for 65-79 year olds to the national average we would reduce admissions by 8.8%
- Lowered our rate of permanent admission to care homes to national average these admissions would reduce by 27.1%

So providing care to keep frail patients safely managed in the community will support these reductions

Support and Decision Making.....

Visiting CoPper

Community Nursing, the National Picture and the NHS Long Term Plan

Emma Self
Community Nursing Lead NHS England

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Integrating Care for Older People

- Programme overview and next steps
- January 2019 emma.self@nhs.net @emmaself7

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The Long-Term Plan – overview and summary

- The Long-Term Plan was published on 7 January 2019 and set out a ten year vision for what the NHS should look like over the next decade

- It sets out five major practical changes to the NHS service model to be brought about over the next five years:
  1. Boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services
  2. Redesign and reduce pressure on emergency hospital services
  3. People will get more control over their own health, and more personalised care when they need it
  4. Digitally-enabled primary and outpatient care will go mainstream across the NHS
  5. Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere

The Long-Term Plan – overview and summary

- The Plan also outlines a series of delivery priorities for the future including:

- Offering targeted support to people for both their physical and mental health needs, including musculoskeletal conditions, cardiovascular disease, dementia, multi-morbidity and frailty.
- Driving further improvements in care quality and outcomes in specific clinical areas (e.g. reducing maternal deaths)
- Taking more NHS action on prevention and health inequalities including smoking, alcohol and obesity
- The development of infrastructure that can enable system changes to take place including digital, workforce development and financial investment

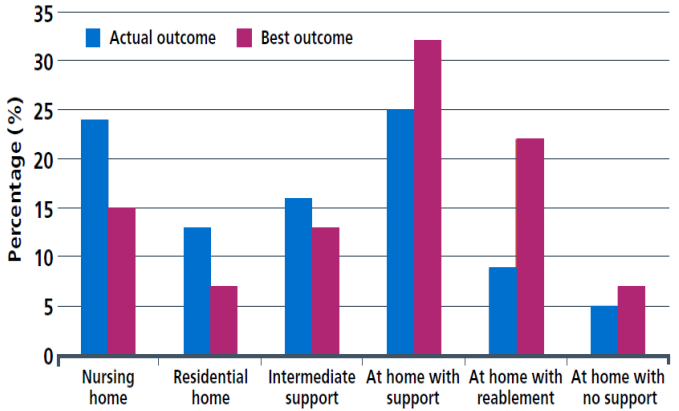
The proposals for supporting integrated care for an ageing population are featured in the first chapter of the Long-Term Plan alongside the development of Primary Care Networks (PCNs) and community teams

Background to the programme – system challenges and opportunities

- Supporting people to age well is of key importance:
- People in England now live for far longer, but extra years of life are not always spent in good health
- Older people are more likely to live with multiple long-term conditions (multimorbidity) and complexity, or live with frailty or dementia

- The way we provide care and support for the most vulnerable groups of adults, needs to change:
- Currently older people with varying degrees of frailty don't always get the care they need in the right setting and at the right time and hospital interventions for some people with frailty are limited in efficacy
- National audit data (NAIC 2017) suggests that intermediate care capacity needs to increase and improve in its responsiveness
- Enhanced health support to care homes is not consistently offered or guaranteed across the country

Figure 5: Differences in where people are discharged compared to where would be best for them.



Source: Newton Europe.

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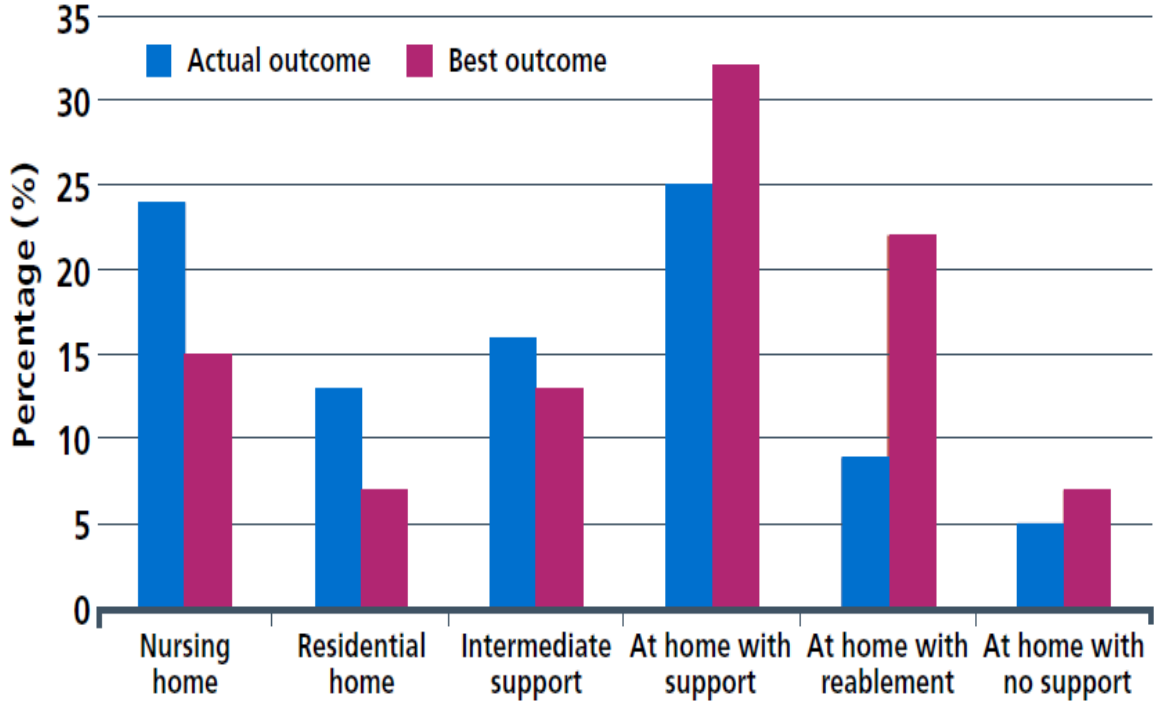
Figure 5: Differences in where people are discharged compared to where would be best for them.



Source: Newton Europe.

Background to the programme – integrated care proposals

- As part of the development of the Long-Term Plan, proposals for supporting integrated care for an ageing population were created. They recommended:

- Bringing together GPs and their teams, as well as hospitals, community teams, social care and the voluntary sector to play a joint role in helping older people to stay well and better manage their own conditions and live independently at home for longer
- The use of a population health approach to identify and support patients older people at risk of adverse health outcomes and provide them with proactive personalised care
- Investing in developing/enhancing rapid community response teams, working between GP surgeries and hospitals, to prevent unnecessary emergency hospital admissions and speed up discharges
- The guaranteed provision of enhanced NHS care for people living in care homes

Long-Term Plan commitments on integrated care

- The Long-Term Plan sets out new investment and national commitments on integrated care:
- Funding: £4.5 billion of new investment will fund expanded community multidisciplinary teams aligned with new primary care networks based around neighbouring GP practices
- Commitments/targets:
- Within the next five years all parts of the country:

  *"Will be expected to have improved the responsiveness of community health crisis response services to **deliver the services within two hours of referral** in line with NICE guideline NG74, where clinically judged to be appropriate"*

  *"**Should be delivering reablement care within two days of referral** to those patients who are judged to need it"*

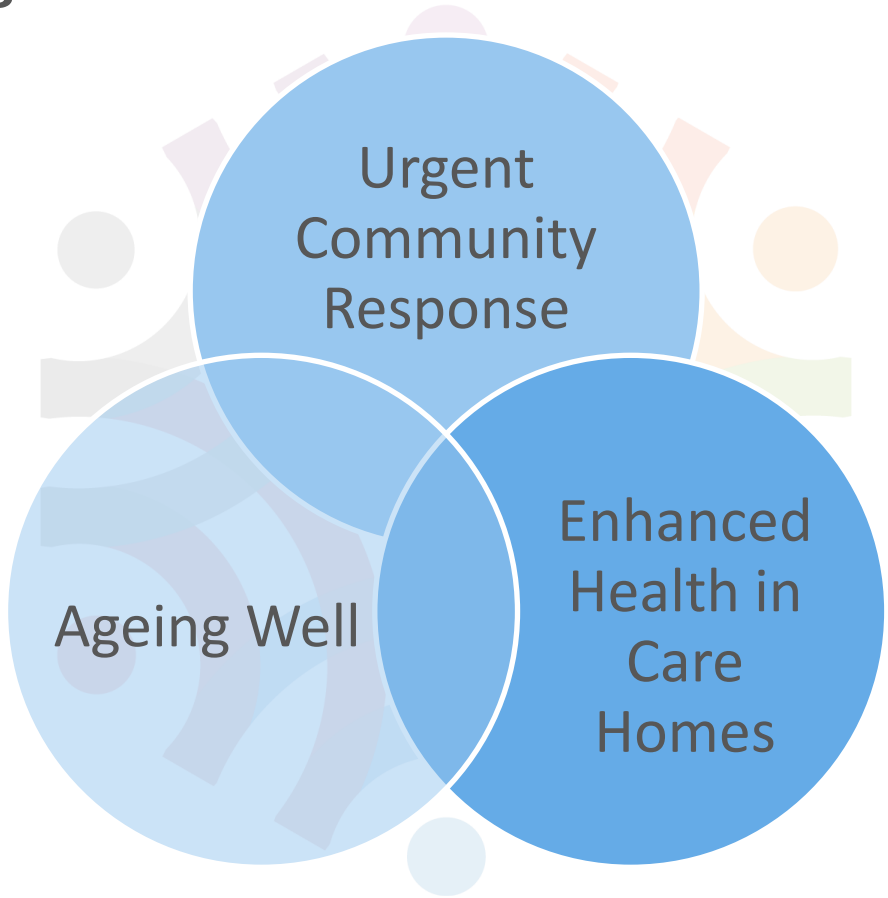
- *"Primary care networks will from 2020/21 **assess their local population by risk of unwarranted health outcomes** and, working with local community services, make support available to people where it is most needed"*
-
- *"Will upgrade NHS support to all care home residents who would benefit by 2023/24, with the EHCH [Enhanced Health in Care Homes] model rolled out across the whole country"*
- *"Care home residents will get regular clinical pharmacist-led medicine reviews where needed"*

Additional actions as part of the urgent and emergency care

- Integrated Urgent Care
- To support patients to "*navigate the optimal service 'channel', a single multidisciplinary Clinical Assessment Service (CAS) will be embedded within integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20.*"
- CAS will provide specialist advice, treatment and referral from a wide array of healthcare professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care providers
- By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

- Integrated working with care homes
- Care home staff will have access to NHSmail, enabling them to communicate effectively and securely with NHS teams involved in the care of their patients.

Models for integrated care



Ageing Well model

I

Ageing Well

- A preventative care programme that aims to support early identification of people living with moderate frailty, where possible improve this and/or prevent the progression of this condition
- The programme will be delivered through Primary Care Networks and multi-disciplinary teams, and use the Electronic Frailty Index and clinical judgement to identify older people living with moderate frailty and their carers who are at risk of adverse health outcomes and provide them with tailored care
- **Intended key outcome**: supporting people to stay well and at home for as long as possible.

Case study

Cambridgeshire Community Services NHS Trust has used a model to identify 800 people who have high health needs, based around the frailty registers of GPs. These people are now proactively supported by multi-disciplinary teams. As a result, acute hospital usage, by these people, has fallen more than the target of 15%.

Urgent Community Response model

II

Urgent Community Response

- A programme that aims to increase the capacity and responsiveness of community services
- The programme will involve the early identification of people in need of urgent care input and provision of timely, well-coordinated recovery and rehabilitation services within new 2 hour/2 day delivery standards
- This includes responding to and meeting the needs of people at the end of their life
- The programme will also entail joint working between health, social care, local government and VCSE providers and commissioners and aim to prevent unneccesary hospital admissions and support early community discharge
- **Intended key outcome**: moving from providing care in hospitals to supporting people to stay well and recover in their own homes.

Case study

Integrating care between health and social care partners in Doncaster has reduced the number of unplanned hospital admissions, for people aged 65 and over, for trauma and orthopaedics by around 17% in the last two years.

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Enhanced Health in Care Homes model

III

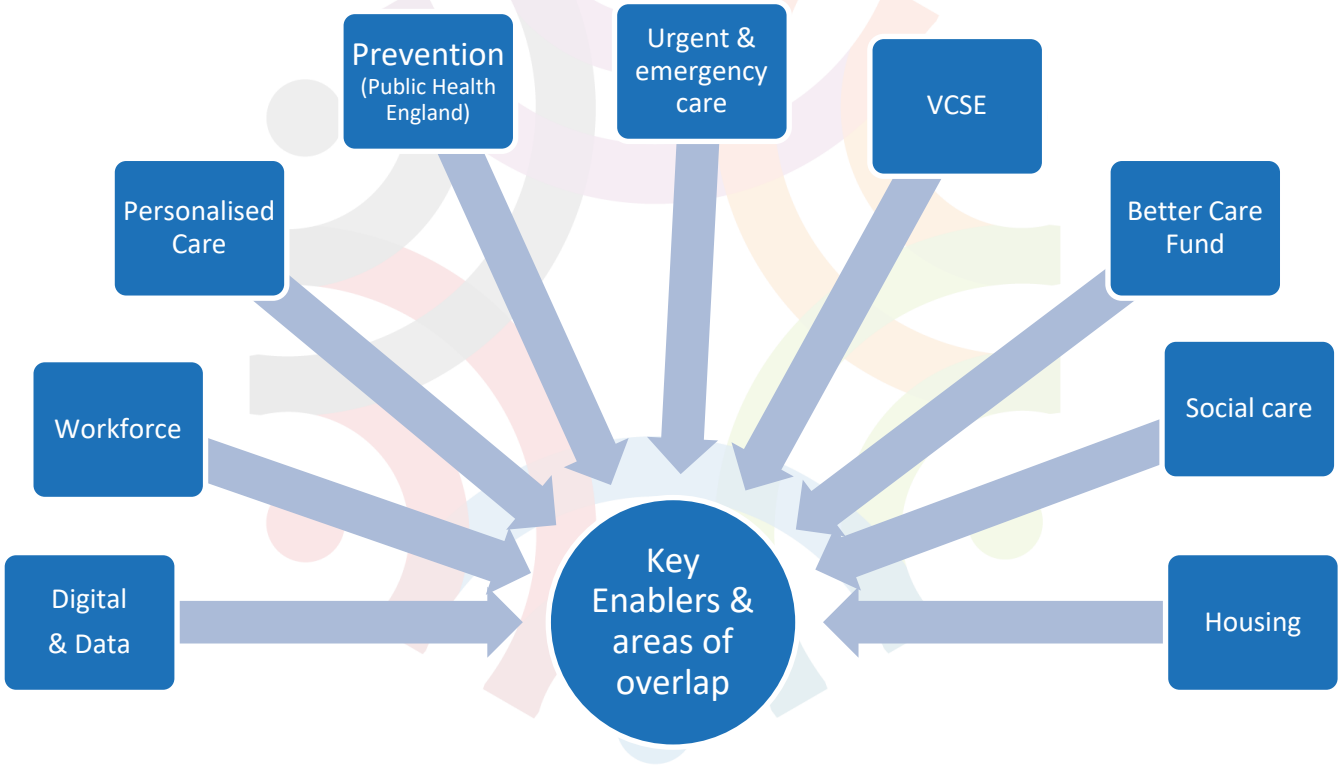
Enhanced Health in Care Homes

- A programme that will roll out the successful Care Home Vanguards 'Enhanced Health in Care Homes' model nationally to help address variability in access to health care and ensure that all care homes residents receive holistic/integrated care
- The programme will involve the delivery of enhanced primary care/specialist support in care homes, regular multi-disciplinary team resident reviews, aligned with rehabilitation services where these are provided, and support timely access to out of hours support and end of life care
- **Intended key outcome**: improving the provision of care across all care homes.

Case study

Analysis of the Wakefield Enhanced Health in Care Homes programme has shown a 27% reduction in ambulance calls from care homes for falls, and a 28% reduction in hospital bed days.

Key Enablers of integrated care



Next steps

- Following the publication of the Long-Term Plan, from January to April 2019 an interim programme team is:
- Developing a strategy for the workstream
- Developing the models
- Developing an implementation plan
- Engaging with internal and external stakeholders to support the development of the proposal
- Work to align with BCF policy and planning for 19/20 and longer term wider BCF review

Any Other Business

CCH

- Locality CoPpers:
  - steering groups
  - mapping
  - action plans
- Supporting CoPpers:
  - sub-groups to be established; mental health, digital, workforce