TheAHSNNetwork

NHS Improvement

From Frailty to Resilience

Friday 3 November 2017

Sanger House, Gloucester CCG

@WEAHSN

1 Overview

About the West of England Academic Health Science Network

The West of England AHSN is delivering positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy.

Established by NHS England in 2013, we are one of 15 AHSNs across England established to spread innovation at pace and scale.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

About the event

The West of England Patient Safety Collaborative Board asked the Patient Safety Collaborative team to discuss and scope out the potential to incorporate a project on frailty into the Patient Safety Collaborative work plan for 2017/18.

A focus group was held on 16 March and the project lead attended the national AHSN sharing day on frailty. Discussions have taken place with individuals who have expressed an interest in working on improving safety for people with frailty.

Following an expert reference group meeting on 16 June the first frailty Community of Practice meeting was held on 1 September 2017 and saw 14 attendees from 11 member organisations including acute Trusts, CCGs, community providers and mental health Trusts.

The group agreed the Community of Practice would be called “From Frailty to Resilience” and agreed to share resources and experience via meetings every two to three months.

3 Input from the room

16 attendees in the room from 10 organisations with a topic focus of **multi-disciplinary teams**.

The group discussed the different models – some places have “community matrons” in others these are “clinical leads” or different names. The pros and cons of the role name were discussed.

North Somerset Community Partnership

Outcome measured: unmet needs identified
MDT membership includes:

- Consultant geriatrician
- Frailty practitioner – Making every contact count
- 2 community mental health nurses (were AWP but moved to NSCP)
- Pharmacist
- Community matrons – who hold a weekly meeting looking at case load
- And anyone involved with patient as requested e.g. falls
- Primary care GPs in cluster area are invited and they are keen to be involved
- Admin is part of the frailty team

Referral process: names screened against active caseload, 4-5 patients discussed per MDT, 15-20 minutes per patients
Frequency and duration: 75 mins, every 4 weeks
Frailty score used: Edmonton/ eFI
Documentation: electronic proforma on EMIS is updated live in the MDT.

Wiltshire Care and Health

11 community teams based around 40,000 practice population sized clusters
MDT membership includes:

- Community geriatrician is based in the acute trust with SLA to get involved for acute crises to prevent admission
- OT physio
- Core community nurses
- Adult social care
- Domiciliary care provider
- 2gether mental health trust
- Clinical leads (paramedic/ therapist by background)
- GP are invited but not interested in attending, although very welcome
- Continence and tissue viability specialist pulled in as needed

Referral process: Any specific patients can be brought
Patient-centred plans: Use a “risk and consequences” plan to enable patients with behaviour that might be too risky.
Agenda: The session includes a learning component.
Issues discussed include housing, family, social, not always medical needs plus long-term conditions with unmet needs. Learning difficulty patients the triggers some same, some difference.
Frequency and duration: practices hold GSF meetings, and the team input into those meetings.
Frailty score used: Rockwood at every contact and Community Geriatric Assessment where identified as needed.
Documentation: Mobile version of SystemOne although there are challenges when working remotely.

Gloucester

Practices moved into clusters about 12 months ago and realigned care teams to be coterminous. 2gether mental health and Gloucestershire Care Services are merging.
Patient-centred plans: use “this is me at my best” plans to know what is normal for the patient. Some places have “community connectors” for signposting/ social prescribing. Three

stakeholder events have been held involving (1) PPGs, (2) all community and voluntary sector partners for a community asset assessment, (3) You Said We Did.
Agenda: MDTs use a standardised framework.
MDT membership includes:

- Adult social care
- Practice staff

People not yet in the room "can't see the value yet."
Documentation; all record in their own notes, which creates a lot of work – no shared notes.
Frailty score used: Rockwood
Frequency: monthly
Referral process: by escalation from practice.
OPAL is the frailty front door at Gloucester/ Cheltenham hospitals, in place, but no formal link between community and acute frailty services.
Social prescribing is and has been in place for a long time in Gloucestershire. There has been delay involving them in the MDT process as the contract was out to tender and new locality based providers only started as 'Community Connectors' (new name for social prescribers – which has just changed again to Community Well-being) on 1st October.
MDT's membership is multi-agency and we have core members and extended members:
Core members: GCS – integrated community care services team members ; 2Gether trust – mental health service representatives; Community Well-being (will be core); Adult social care and GP practice staff.
Extended – invited dependent on referral, includes: SWAST; domiciliary carers; fire service etc.

AWP

Documentation: Rio
Frailty score used: Rockwood

Sirona Care & Health

4 community matrons with 8 MDTs. Each sector works separately. The specialist teams work across house bound and care homes with an 18-24 week input, with revaluation after 6 months. PAM (patient activation measure) in place.

SWAST

Frailty score used: Rockwood

Measurement

The group discussed shared measures and output measures. For example:

- Unmet need identified
- Linking to adult social care measures
- Assessment after 6 month and change in frailty score (achieving no change in frailty score after 6 months would demonstrate that support is having an impact as usually frailty score would be expected to deteriorate after 6 months).
- Looking at measures based on functional profile rather than age profile.
- Rate of reduction in NOF, admission from care homes, length of stay or readmission rate.
- GP confidence (measured by survey), e.g. how confident are you to manage your own patient caseload/ do you feel supported?

Bath (RUH)

Frailty flying squad in ED. Membership includes: consultant geriatrician, specialist nurse practitioner, therapist, CGA at acute stage with aim to turnaround patients so they are supported to return to their own home rather than being admitted. 20% go home at this stage. Those who are admitted are triaged to short-stay ward or older people's ward if non-specific presentation. The team follow up the next day.
When measuring the impact the readmission rate for patients seen by the frailty flying squad is lower than the general readmission rate for patients over 85 in the hospital.
The next step is how community services link in with the acute frailty team.
Community matrons are set up in clusters in B&NES.
Documentation: presently paper-based 2 page CGA.

Bristol Community Health

MDTs are based in GP practice. There is no designated frailty lead but they link into the consultant geriatrician service at Southmead.
Focus of the frailty support has been on upskilling everyone to the same level of knowledge and skills.
Frailty score: Rockwood.

3 Outcomes and next steps

Actions

- **Jane Haros** to share Rockwood/ eFI mapping once completed.
- **Gloucester** to share their standard MDT framework with the group.
- **Gloucester/ Wiltshire** to share examples or templates for "This is me at my best" and "Risks and consequences" patient-centred care plans.
- **All** to check they can access the LifeQI discussion forum.
- Reminder to **all** to share quality improvement projects in their organisation via the survey https://www.surveymonkey.co.uk/r/frailtyQI

Resources shared

- Frailty video from Hein https://vimeo.com/241487852
- CGA toolkit plus: https://www.cgakit.com/
- Contact from Kate Cheema: company have developed an approach to analysis using open source prescribing and primary care data, looking to identify a case study around their approach applied to frailty and variation at practice level. More info here: https://traynedinsight.com if interested please contact Nathalie (nathalie.delaney@weahsn.net)
- https://www.scie.org.uk/future-of-care/asset-based-places/
- ECIP series https://improvement.nhs.uk/resources/safer-faster-better-webinar-series/
- NHS England https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/webinar-recordings/
- Wessex AHSN dementia friendly surgeries report https://www.slideshare.net/WessexAHSN/dementia-friendly-surgeries-summary-report?from_action=save
- Group sessions over telehealth http://www.nymblscience.com/

Next meeting focussing on workforce, training, and culture change

Friday 23 February 2018, 1:30pm – 4pm
Venue: Room 1, Frailty Service, North Somerset Community Partnership, 2a Townshend Road, Worle, BS22 7GF (Free parking available)

Thank you to everyone involved in the session and to Gloucester for hosting us – please do share details of the discussion forum with colleagues and encourage them to join the mailing list!