The AHSN Network

NHS Improvement

From Frailty to Resilience

Friday 22 June 2018

@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 meeting

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. 16 attendees from 10 organisations attended on 3 November in Gloucester with a topic focus on MDTs.

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. Four meetings have been held so far.

There are currently 59 members of the frailty community of practice distribution list covering 24 organisations.

2 What is Frailty?

NHS England have defined frailty as a progressive, long term condition characterised by a loss of physical and/or cognitive resilience that means people living with frailty do not bounce back quickly after a an acute stressor event such as a physical illness, an accident or other stressful event.

Why Frailty is Important

The population of England is ageing. By 2040, nearly one in seven people are projected to be over 75. Whilst frailty is associated with age it is not the same: not all older people live with frailty and not all people living with frailty are old. Many of the factors that cause people

to age differently are amenable to population-level interventions based on lifestyle choices and exercise. Frailty (rather than age) is effective as a means of identifying people who may be at greater risk of future hospitalisation, care home admission or death. For example, people living with severe frailty have a four times greater one-year hazard ratio for these outcomes. This means population-level frailty identification can help anticipate future health and social care demand.

Accelerating population ageing coupled with existing health system pressures means it is important for local areas to take action to provide a more sustainable, whole-system approach to managing frailty that ensures that we have the rights types of services in the right quantities to meet demand. For example, the number of people aged 65 to 69 has grown by 34% in the last 10 years, with corresponding hospital admissions growing by 57%.

3 Input from the room

9 attendees were in the room each representing a different organisation locally, with the topic focus “what’s in your bag?”

Red bag scheme: https://www.england.nhs.uk/2018/06/red-bags-to-be-rolled-out-across-englands-care-homes-getting-patients-home-from-hospital-quicker/

Keep an eye on NHS England website for webinars to support red bag implementation e.g. 27 June https://www.events.england.nhs.uk/events/red-bag-implementation-support-31554

Red bag scheme

The Hospital Transfer Pathway, affectionately known as the 'red bag' scheme is designed to ensure that residents living in care homes receive safe, coordinated and efficient care should they need to go into hospital in an emergency. The simple initiative started three years ago in Sutton, South West London, and now all areas of the country are being urged to adopt the scheme.

So far the initiative in Sutton has resulted in:

Reduced hospital stays by three to four days

saving £167,000 a year

Stopped patients losing personal items such as dentures, glasses and hearing aids

worth £290,000 in a year

Improved communication between care home and hospital staff saving time, resources and duplication.

The scheme is just one NHS initiative taking place to make care more proactive in care homes; through the Enhanced Health in Care Homes Framework

Care homes using this model have seen bed days drop by *

4.5%

* Compared to an increase in areas without the scheme of 1.4 per cent.

To find out more visit www.england.nhs.uk/integratedcare

#futureNHS

RED FLAG

NHS
Gloucestershire
Clinical Commissioning Group

For dementia, those known to frailty services, Adult Social Care (ASC), Integrated Discharge Teams (ICT) and Complex Care at Home to initiate an multiprofessional MDT.

R resistive to help or services

E ever increasing contact with services without improved quality of life or resolution of persistent issues

D drug/medication change or non-compliance with medication

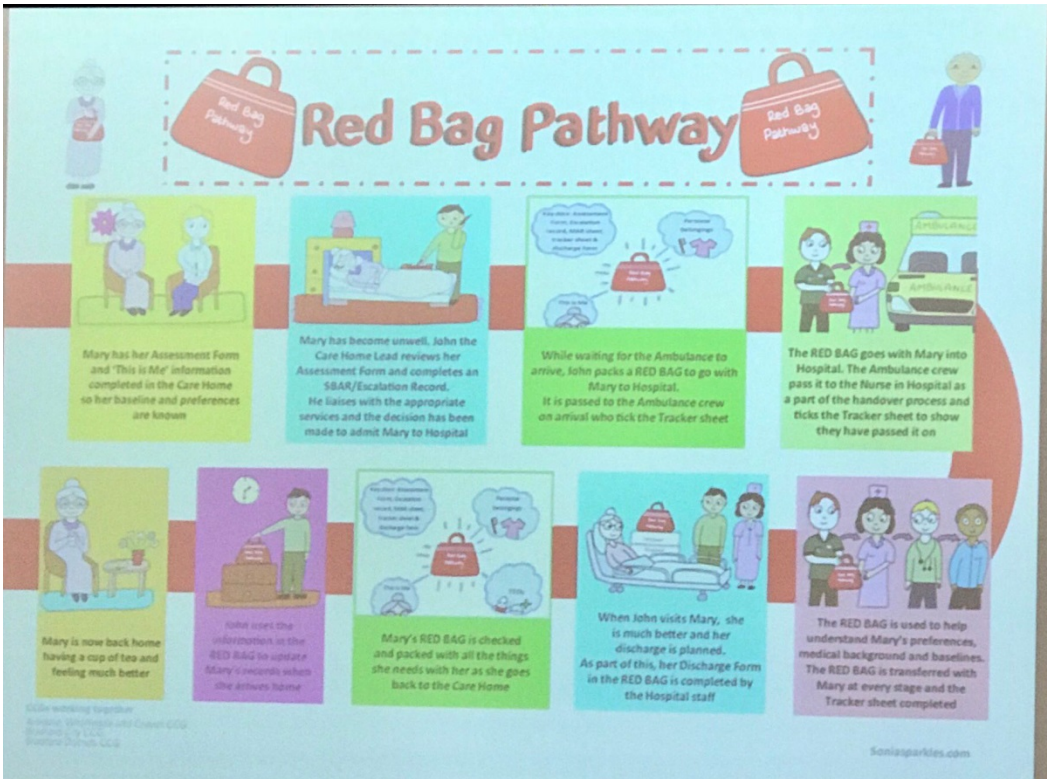
F frailty score high (6-7) or increasing falls

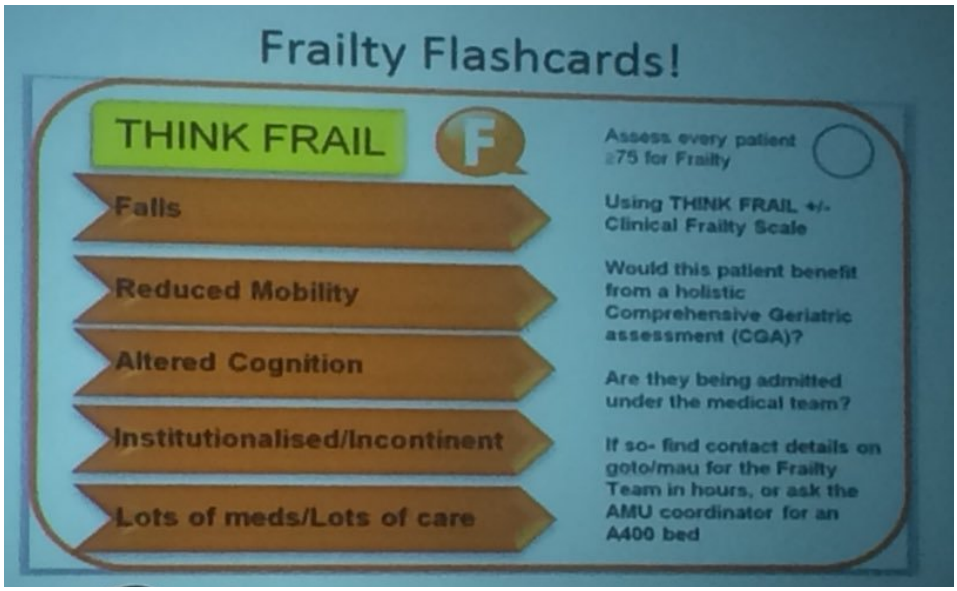
L lives alone, or couple supporting each

A assessment of mental capacity required

G gaps in Activities of Daily Living (ADL) impacting on health & wellbeing

for further information please contact helen.vaughan1@nhs.net


Red Bag Pathway
Mary has her Assessment Form and 'This is Me' information completed in the Care Home so her baseline and preferences are known
Mary has become unwell, John the Care Home Lead reviews her Assessment Form and completes an SBAR/Escalation Record. He liaises with the appropriate services and the decision has been made to admit Mary to Hospital
While waiting for the Ambulance to arrive, John packs a RED BAG to go with Mary to Hospital. It is passed to the Ambulance crew on arrival who tick the Tracker sheet
The RED BAG goes with Mary into Hospital. The Ambulance crew pass it to the Nurse in Hospital as a part of the handover process and ticks the Tracker sheet to show they have passed it on
Mary is now back home having a cup of tea and feeling much better
Mary's RED BAG is checked and packed with all the things she needs with her as she goes back to the Care Home
When John visits Mary, she is much better and her discharge is planned. As part of this, her Discharge Form in the RED BAG is completed by the Hospital staff
The RED BAG is used to help understand Mary's preferences, medical background and baselines. The RED BAG is transferred with Mary at every stage and the Tracker sheet completed


Frailty Flashcards!
THINK FRAIL
F
Falls
Reduced Mobility
Altered Cognition
Institutionalised/Incontinent
Lots of meds/Lots of care
Assess every patient ≥75 for Frailty
Using THINK FRAIL +/- Clinical Frailty Scale
Would this patient benefit from a holistic Comprehensive Geriatric assessment (CGA)?
Are they being admitted under the medical team?
If so- find contact details on goto/mau for the Frailty Team in hours, or ask the AMU coordinator for an A400 bed

Who has what where?

- **Somerset** have started the red bag project for complex care patients in the community, identified from looking at people who have regular admissions to hospital. Symphony project are working with 15 care homes in Somerset to develop.
- **RUH** have a frailty "big room" as part of their flow project and are happy for people to visit to see this in action. They have heard red bags are coming through via a Vanguard project (5 in nursing homes, five in residential homes).
- **Gloucestershire** have an orange folder for people with complex needs including those living independently in their own home. Helen shared the contents with attendees.
- **Swindon** have piloted in one care home and one nursing home with four bags.
- **BNSSG** have just started with 3 homes in North Somerset, 4 in Bristol.
- **Wiltshire** are not using at present.
- **Weston** have secured funding to open a front door frailty unit and hope to launch the service and the unit at the end of August 2018. It is a purpose-build unit in between the ED and MAU. They have added Clinical Frailty Score (Rockwood) into their hospital computer system. They intend to launch frailty hot clinics where patients can be reviewed by MDT. They are working with community teams and creating an electronic CGA template that will be stored on EMIS. They have launched the red bag scheme for patients from care homes, and are developing a frailty folder. Their focus is on education for delirium and have added the 4AT screen onto the combined common clerking booklet. This promotes a "carer's card" initiative including reduced parking and reduced cost of meals for carers who are able to continue to help care for their loved one whilst in hospital. Rachael is working with Dr Alison Rich in palliative care to offer advanced care planning to all patients living with frailty by offering discussion of the 'treatment escalation plan' she created and the new ReSPECT form. Information will be communicated with GPs and community teams to ensure we aim to meet the wishes of patients.
- **AWP** have been awarded CCG funding for the community part of the delirium pathway and their proposed model to spot purchase community delirium beds for patients who have unresolved delirium, reducing their length of hospital stay.

What are the barriers and issues?

- Concerns over the cost of the bag (ranging from £15 — £60 each) and not all are being returned after admission.
- Staff (particularly ambulance) are not always sure where bags are kept. Message in a bottle is used to help ambulance staff know where to find.
- High turnover in nursing home staff: often new entrants to the care sector who then leave, rather than staff moving around the providers. High turnover in managers of homes too.
- Access to systems – ambulance service do not have access to electronic records systems to enable them to see the CGA. Some teams have used electronic but had to go back to paper.
- Keeping up-to-date – although printed material easiest to transfer and access, there are issues with information being out of date as soon as it is printed, and duplication.

- Information governance issue if bags are lost – also consider what to put in as will be accessible.
- Communications, communications, communications — getting the message out to receiving hospitals is crucial, including internally for ward—ward moves.
- Well-defined SOPs are crucial to success.
- Process for reviewing and keeping updated.

What goes in a red bag / orange folder?

- TEP/ Summary Care Plan (purple edge).
- Change of clothes #endPJparalysis
- My goals plan
- Me at my best (available as SystemOne and EMIS templates via Helen Ballinger)
- DNAR note – yellow sticker on front, blue edged in folder
- Personalised sticker on front with key contact information including email address for team. (Gloucestershire)
- Red bag checklist (used in Taunton).
- Baseline observations (Weston)

4 Resources shared

Please register for follow-up webinar to regional event on **Tuesday 17 July** 12 noon – 1pm https://www.eventbrite.co.uk/e/south-west-regional-frailty-event-follow-up-webinar-tickets-46838103027

Vee suggested participants join the CHAIN network, details how to register at https://www.chain-network.org.uk which has a frailty sub-group.

Nic Aplin sent on the contact details of Fusion48 who had carried out analysis of the GP contract data. http://fusion48.net/frailtyhttp://fusion48.net/frailty/frailty-contract-analysis/frailty-care-heatmaps

Where area is above the median this is highlighted in green (see next page)

5 Outcomes and next steps

- **Nathalie** to share output report from ReSPECT event and details to register for next event in October.

Next meeting focussing on "DNACPR" to be co-located with ReSPECT event.

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

CCG area	Registered list population aged 65 and over	% of total population aged 65 or other	Number of GP practices included in frailty contract	% of patients aged 65 years or over who have	% of patients aged 65 years or over with a	Estimated diagnosis rate (% of expected prevalence	Ratio of moderate to	Ratio of moderate and	% of patients with a diagnosis of severe frailty	% of patients aged 65 years or over with a	Referrals to falls clinic as a % of patients with a	% of patients with a diagnosis of moderate or
NHS North Somerset CCG	50,388	23%	18	63%	13%	79%	1.6	3.1	77%	12%	11%	5%
NHS Bristol CCG	66,261	12%	46	64%	12%	73%	0.8	2.5	76%	17%	7%	14%
NHS South Gloucestershire CCG	48,711	18%	24	31%	10%	61%	1.5	2.5	80%	15%	13%	11%
NHS Gloucestershire CCG	131,385	21%	77	21%	6%	38%	2.1	1.5	69%	16%	13%	35%
NHS Bath and North East Somerset CCG	38,631	19%	25	59%	13%	80%	3.0	3.2	80%	11%	31%	20%
NHS Wiltshire CCG	100,951	22%	45	11%	8%	49%	2.5	1.9	76%	16%	8%	16%
NHS Swindon CCG	36,080	15%	24	11%	8%	48%	3.3	2.0	68%	12%	16%	7%
STP Area												
Bristol, North Somerset and South Gloucestershire	165,360	16%	88	54%	12%	71%	1.2	2.7	77%	15%	9%	10%
Gloucestershire	131,385	21%	77	21%	6%	38%	2.1	1.5	69%	16%	13%	35%
Bath, Swindon and Wiltshire	175,662	19%	94	22%	9%	56%	2.8	2.2	76%	14%	15%	16%
England	**10,046,668**	**17%**	**7008**	**26%**	**9%**	**58%**	**2.0**	**2.2**	**66%**	**11%**	**25%**	**15%**
All CCGs												
Highest	206,226	30%	105	82%	23%	145%	4.5	5.6	89%	24%	229%	58%
Upper quartile	56,507	21%	42	31%	12%	76%	2.6	2.8	72%	13%	37%	18%
Median	**40,297**	**18%**	**31**	**23%**	**9%**	**54%**	**1.9**	**2.0**	**65%**	**10%**	**22%**	**13%**
Lower quartile	30,186	15%	21	16%	7%	49%	1.5	1.5	57%	8%	15%	9%
Lowest	8,647	5%	5	4%	2%	10%	0.3	0.4	34%	1%	3%	0%