Hospice UK Conference
November 2023

Live Well-Die Well
Frailty Care Closer to Home

chcp
Excellence • Compassion • Expertise

Dr Dan Harman

Consultant Community Geriatrician, CHCP CIC
Strategic Clinical Lead, Humber (H & NY ICB)
Clinical Lead, System Wide Frailty Network, NHS Elect
Trustee, Dove House Hospice

NHS Elect

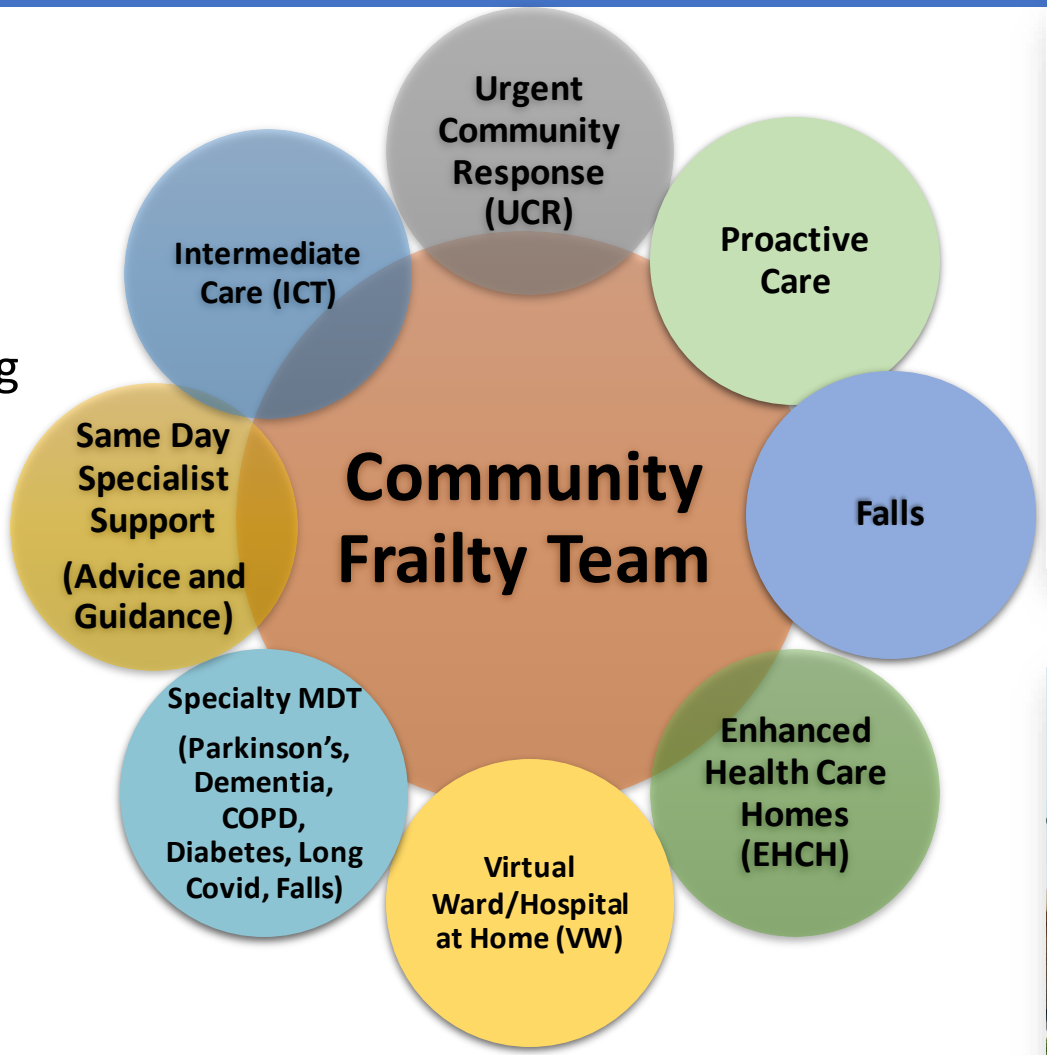
dovehouse hospice
caring for people with a life limiting illness

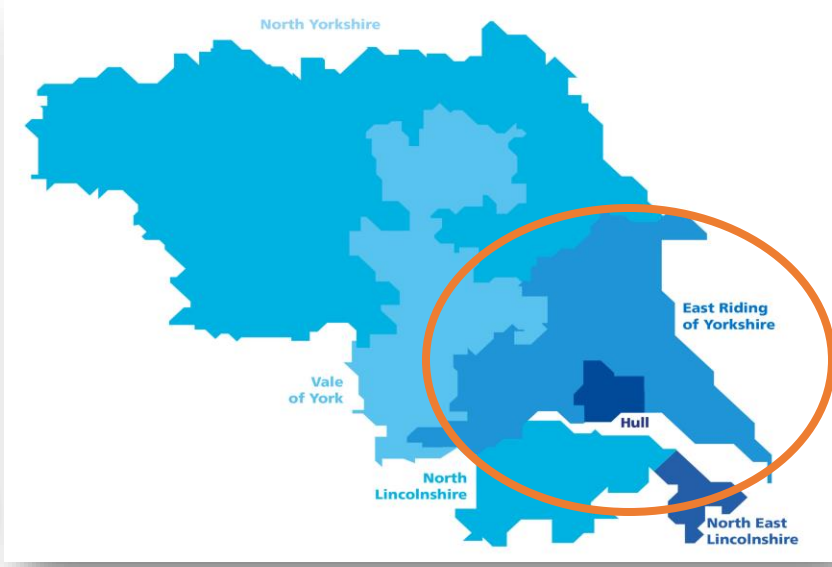
Hull and East Riding
Frailty Care Closer to Home

Focus of today

- Background
- Strategic aims
- Delivery &Outcomes
- Culture & System thinking
- Hospice role
- Top Tips

Right care in the right place at the right time for people living with frailty

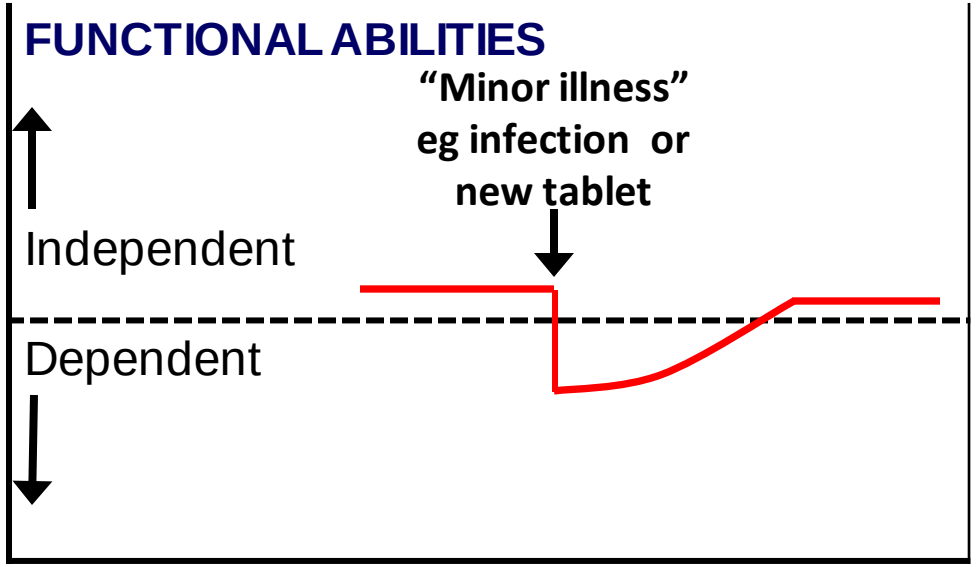




What is Frailty?

Frailty is loss of physiological (or inner) reserve

Frailty presenting in crisis as sudden loss of mobility/independence



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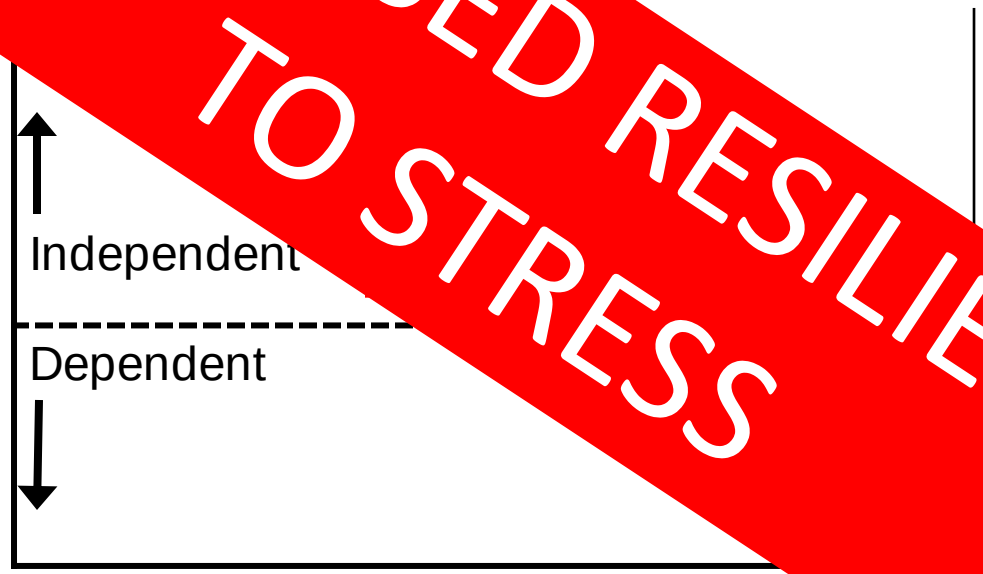


DECREASED RESILIENCE TO STRESS

Frailty Care Needs to Change – Personal Experience

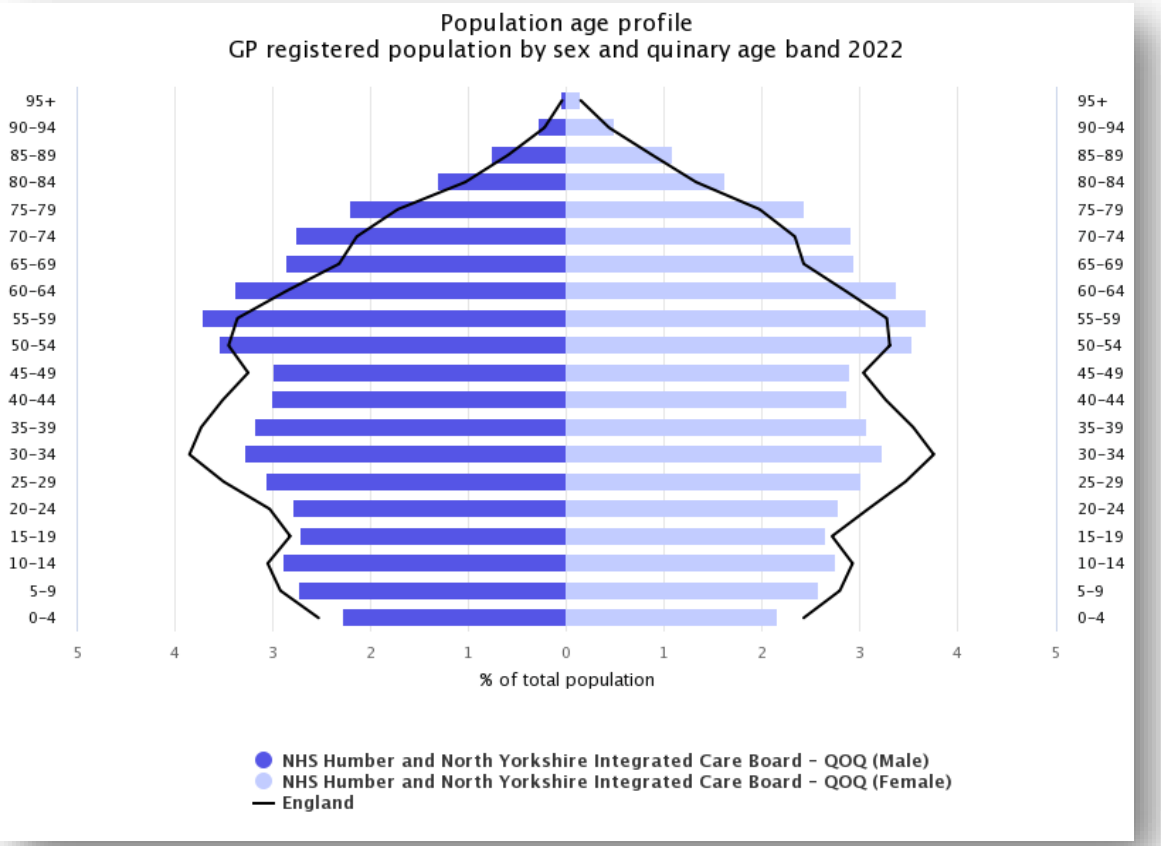
TODAY

'The Frail Elderly'
(i.e. a label)

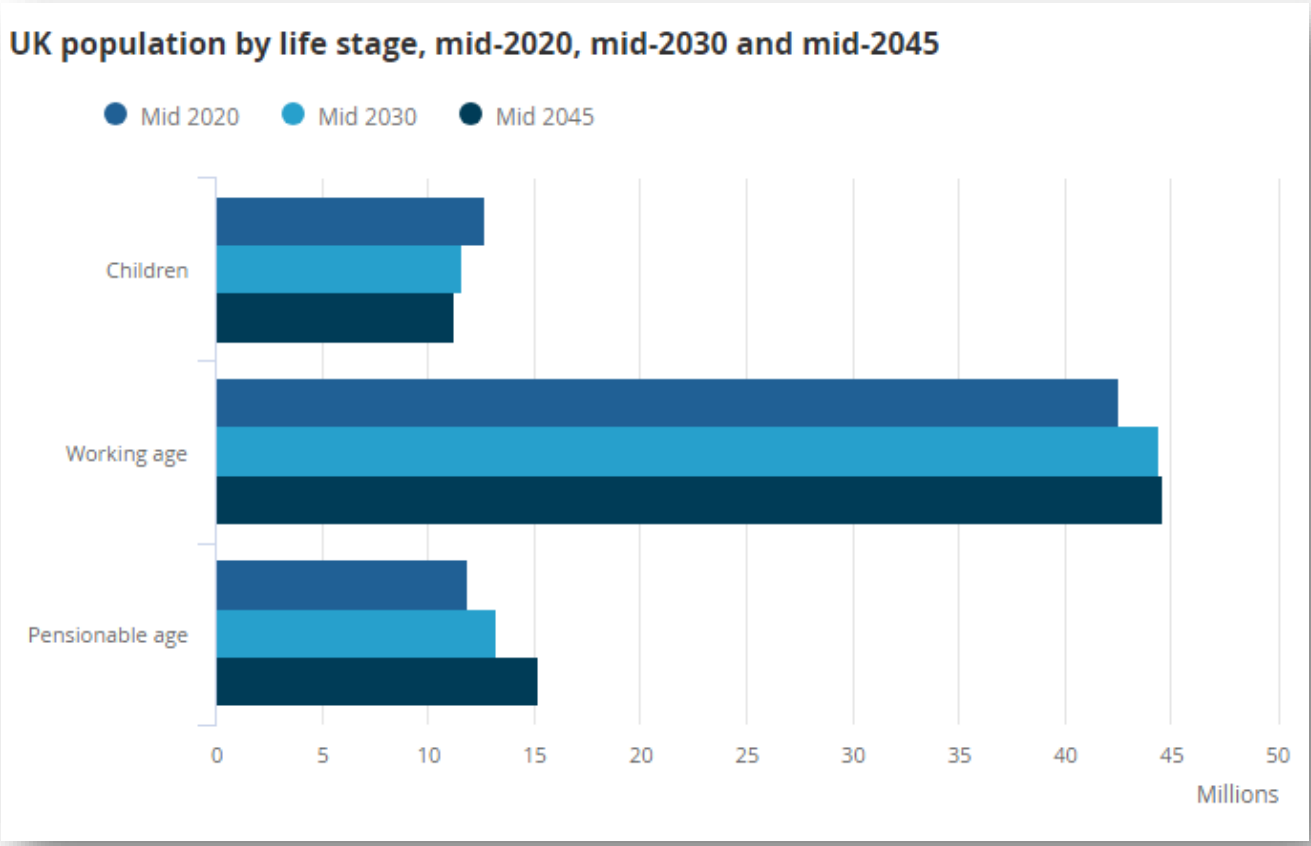
Presentation late & in crisis
(e.g. delirium, falls, immobility)

Hospital-based: episodic, disruptive & disjointed

Frailty Care Needs to Change – Data



Source: www.fingertips.phe.org.uk



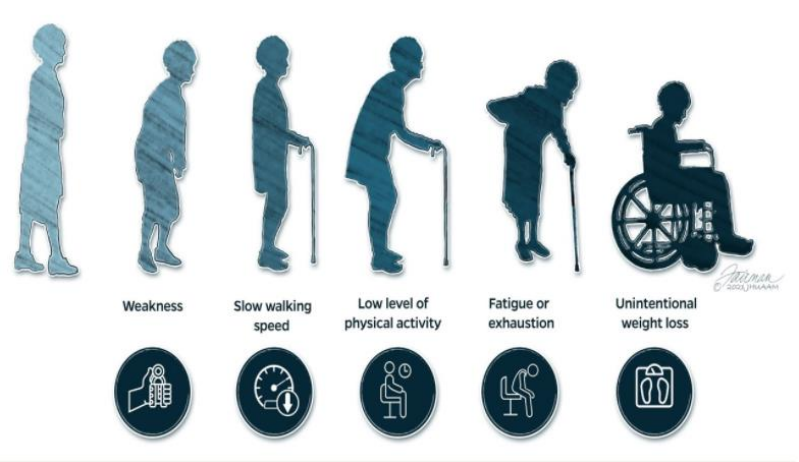
Source: www.ons.gov.uk

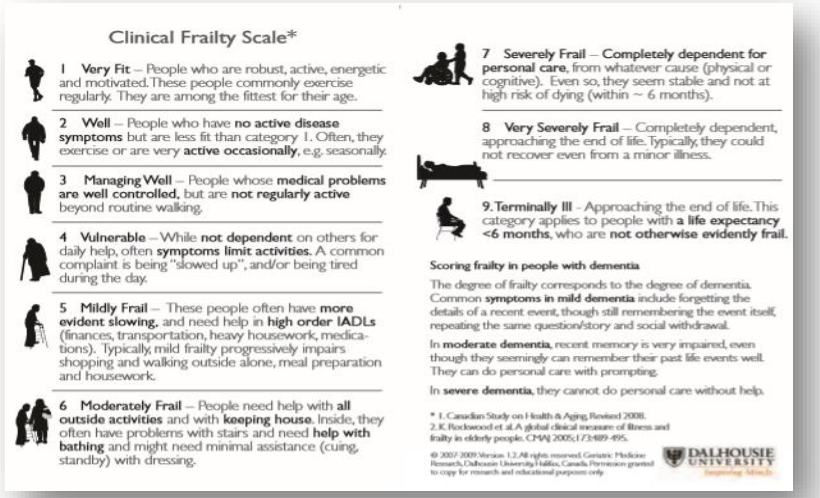
Frailty costs UK healthcare systems £5.8billion/year
47% of inpatients 65+years are frail (source: Clegg et al, Lancet 2013)
3.2 % moderately-severely frail: 36% of bed days

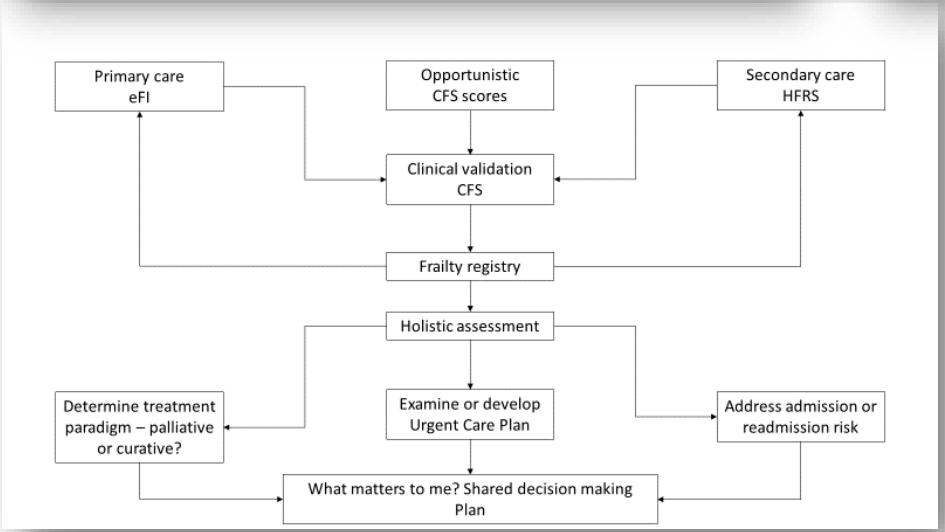
Impact on services
Who will care for us?

How to Identify Frailty ?

- Tools can help
  - Electronic Frailty Index (eFI)
  - Hospital Frailty Risk Score (HFRS)
- Clinical assessment
  - Frailty Syndromes
  - Phenotype
  - Rockwood Clinical Frailty Scale
- **Assess, use, record, share**







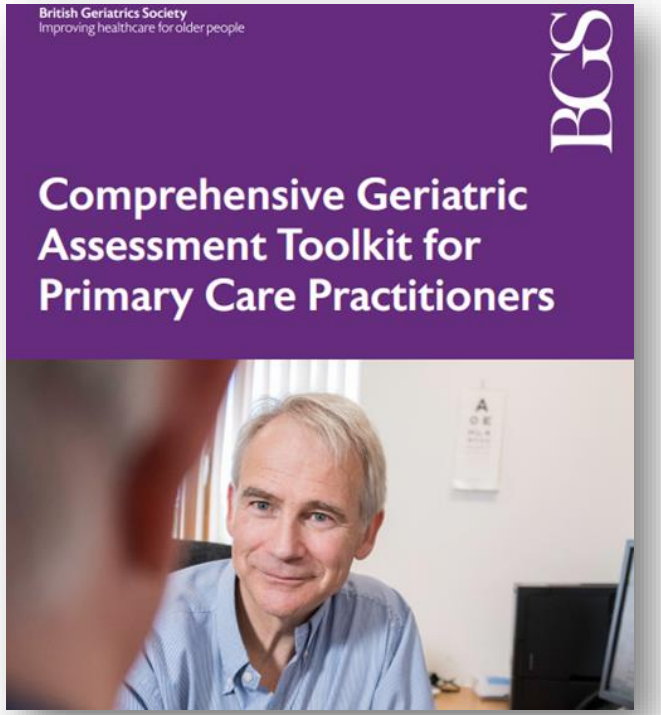
Source: S.Conroy & NHS Elect, 2023

Comprehensive Geriatric Assessment

- Multidimensional, multidisciplinary holistic assessment of an older person
- Incorporates a specific set of clinical competencies that can reduce adverse outcomes
- Leads to the formulation of a plan
  - Address issues of concern to the older person (and their family and carers)
- In hospital
  - Effective in reducing mortality and improving independence (still living at home)
- In community settings
  - Reduce hospital admissions
  - Reduce the risk of readmission in those recently discharged
  - Improve emotional and physical wellbeing

- GOLD STANDARD for frailty care

- For some can reverse frailty



The Change

TOMORROW

"An older person living with frailty"
(i.e. a long-term condition)

Timely identification for preventative, proactive care by supported self-management & personalised care planning

Community-based: person-centred & co-ordinated
(Health + Social + Voluntary + Mental Health)

System Thinking: Strategic Aims (2018 – current)

- Shifting the focus of delivery to **early help** and prevention (proactive)
- Deliver responsive (reactive) integrated **out of hospital** care
- **Respect patient choice** regarding preferred place of care
- **Reduce** demand for acute and social care services
- Address health and social care **inequalities**
- Strengthen **collaboration** and deliver an **integrated frailty system – not silos**
- Empower individuals and **communities** to engage
- **Continuously evaluate** and refine

NHS Humber and North Yorkshire Integrated Care Board (ICB)

NHS Hull University Teaching Hospitals NHS Trust

chp

citycare The Hull estates experts

HUMBERSIDE Fire & Rescue Service

NHS Yorkshire Ambulance Service NHS Trust

NHS Humber Teaching NHS Foundation Trust

Hull City Council

EAST RIDING OF YORKSHIRE COUNCIL

PROACTIVE Care Model
Comprehensive Geriatric Assessment (CGA)

Case Identification

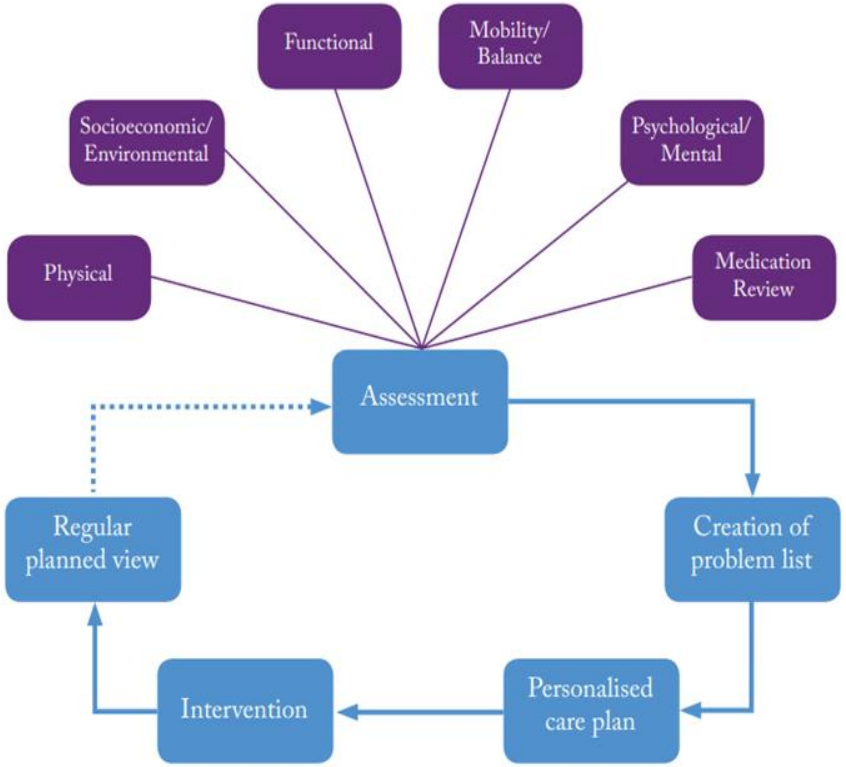
Holistic Assessment, MDT and Interventions

Personalised Care and Support Planning

- eFI +
- Case finding across health and social care
- Own home and care homes
- Frailty not age

- Specialist MDT
- Comprehensive Geriatric Assessment
- Includes Structured Medication Review

- Patient concerns inventory
- Advance Care Planning
- Coordination
- Record Sharing



PROACTIVE - Core MDT composition – ONE TEAM

Multiple employing organisations

- Patients would not know

Operational manager

Parkinsons: similar to Core MDT

Specialist MDTs

- Chest
- Dementia
- Diabetes
- Falls

For remote CGAs

- Primary care dial in to MDT
- Social prescribers

- Own home & care homes
- Frailty not age
  Referred eFI Diagnosed CSF
- Patient Concerns Inventory
- Integrated record shared
- Advance Care Planning (ReSPECT)
- Delivered virtually also

Community CGA: System Outcomes

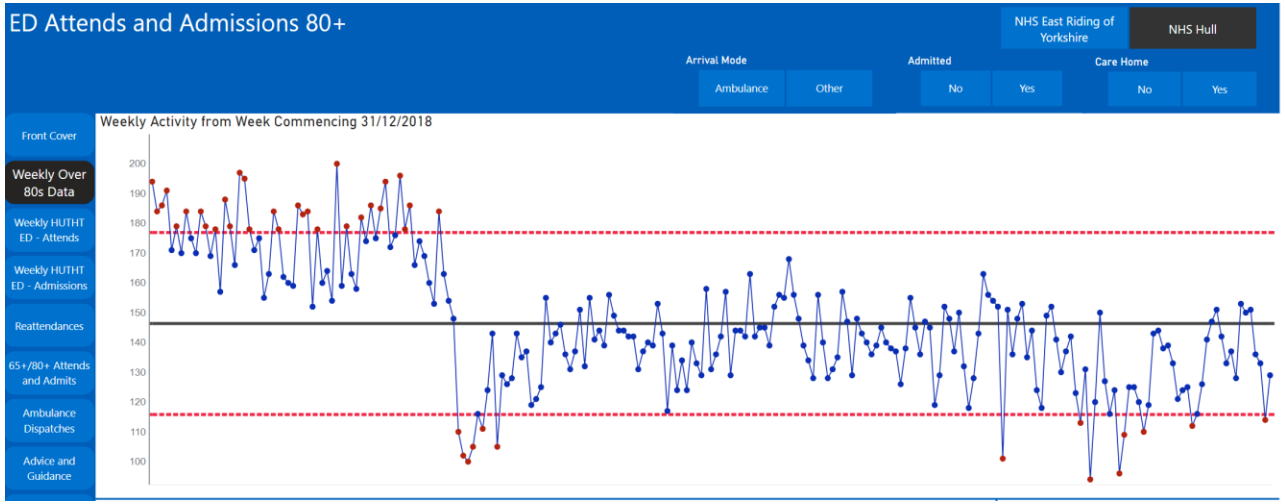
>10% reduction in GP appointments

>10% reduction in ED attendance and emergency admissions

>50% reduction in ED attends and admissions for Frequent flyers

Average saving on drug costs: £100/patient/yr

LTC + CFS 6-7	ED attends	ED admissions
COPD	-16%	-19%
Dementia	-15%	-28%
Palliative Care	-29%	-22%
Diabetes	-36%	-30%



Community CGA: Patient Reported Outcome Measures

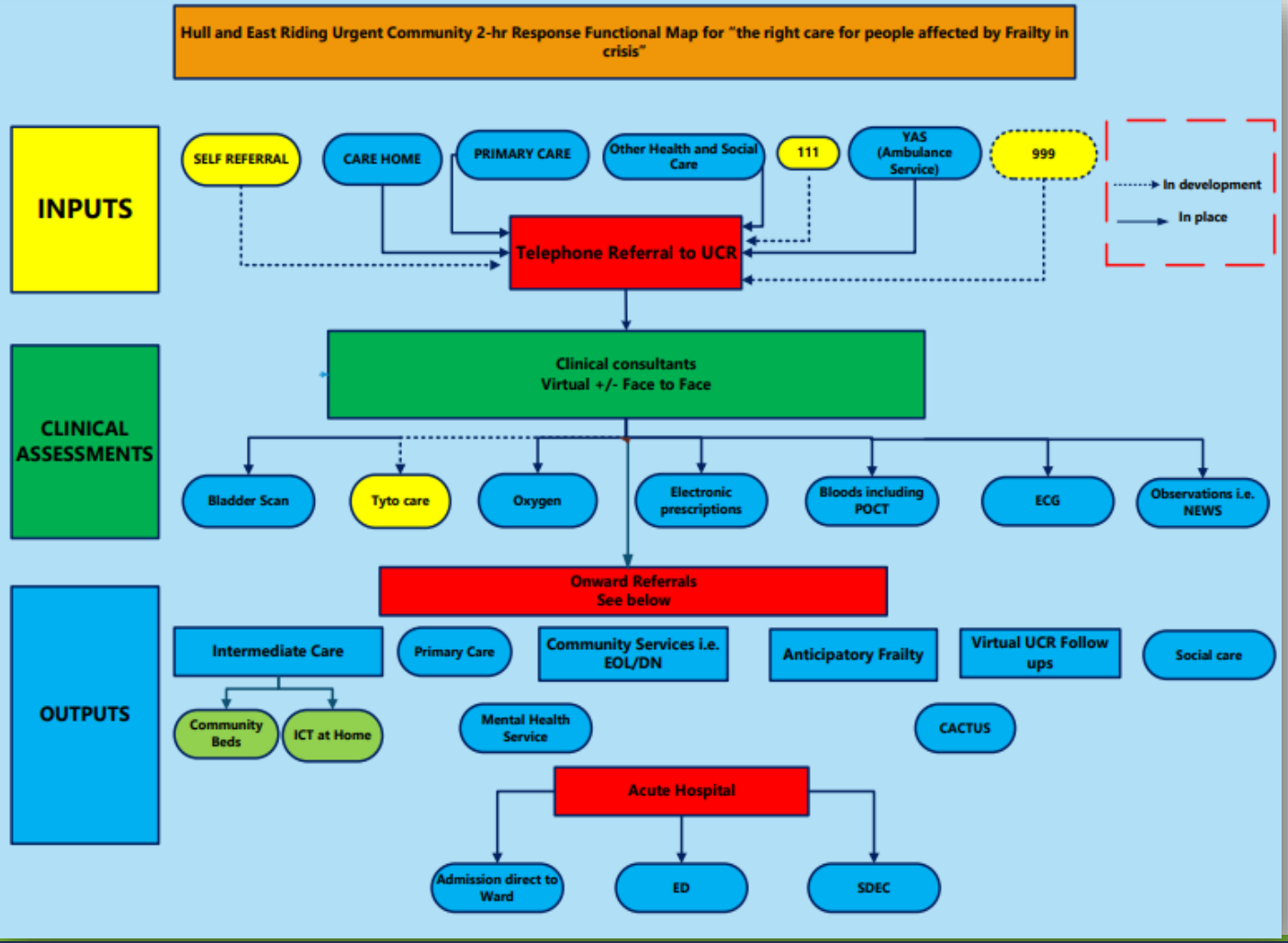
- **A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty (F.Murtagh *et al*, BMC Geriatrics 2023)**
  - Wellbeing and quality of life sustained improvement at 10-14weeks
    - P<0.001 intervention v control group in total IPOS score
    - Psychological improvement > physical wellbeing
- **Experiences of a Novel Integrated Service for Older Adults at Risk of Frailty: A Qualitative Study (F.Murtagh *et al*, Sage 2023)**

I was able to discuss my concerns and how I was feeling. I felt heard. I also feel like most of my health concerns were addressed….

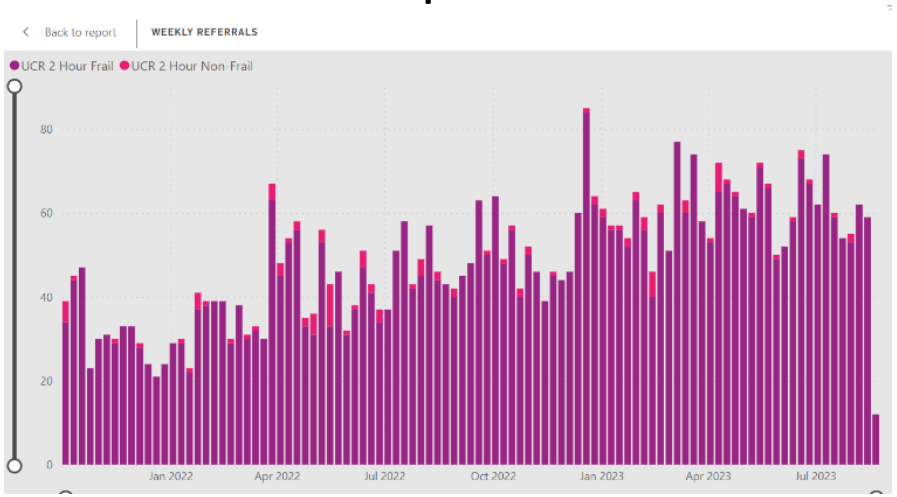
The overall experience was fantastic. They even sorted transportation and provided a meal

Areas to improve:
- Advance care planning
- Integration with other services
- Follow up

REACTIVE / CRISIS
2hr Urgent Community Response (UCR) and Frailty Virtual Ward



- Main referral source: Paramedics
- Only 17% conveyance
- Proactive and reactive pathways aligned
- Highest proportion of activity in 20% most deprived areas



REACTIVE: UCR and Virtual Ward – MDT Composition

Multiple employing organisations

- Patients would not know

Operational manager

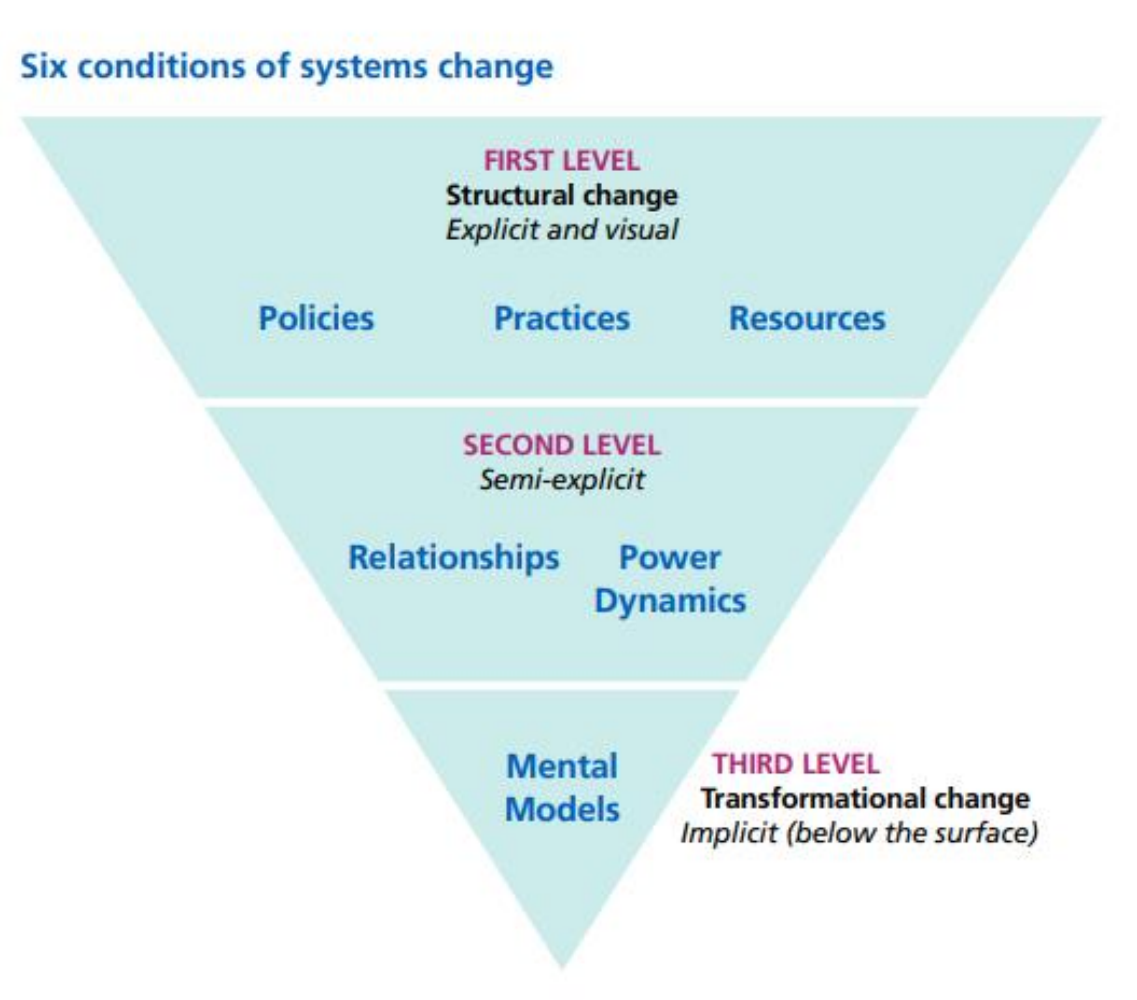
Gaps

- Mental health
- Social services
- VSO

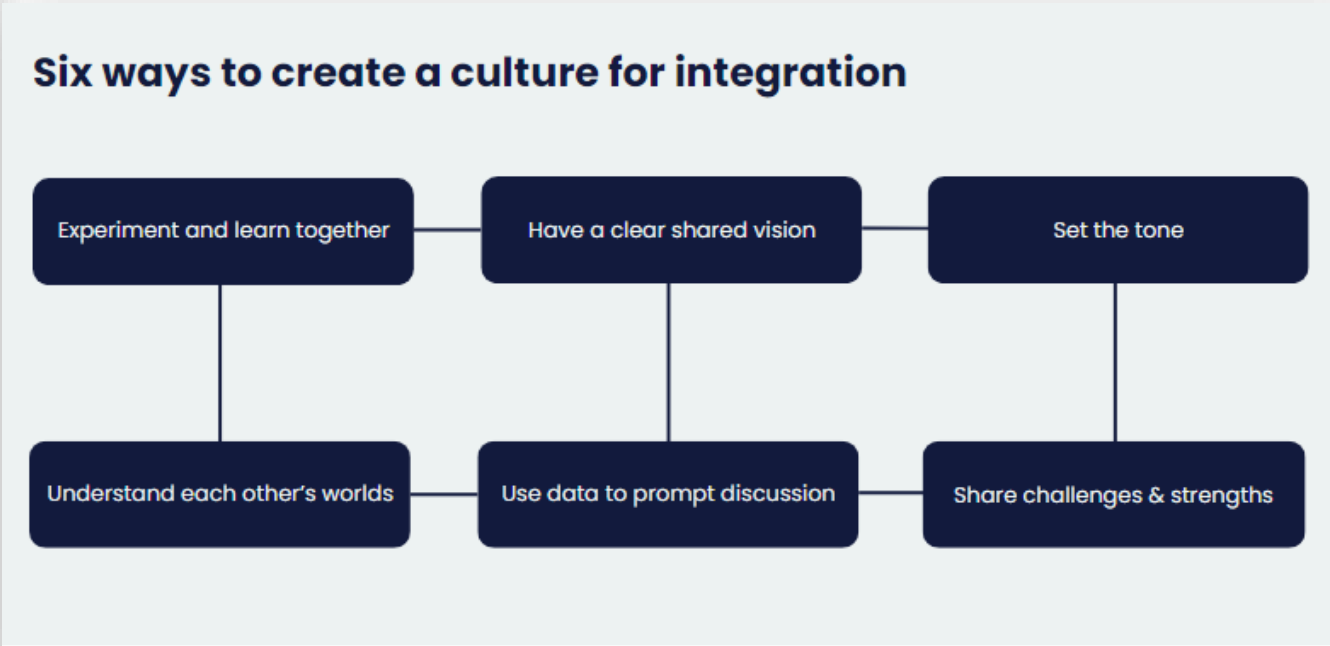
- Rely on existing urgent pathways

- Demonstrates interdependencies between health and social care

How this is Possible: Culture for Integration



Source: S.Conroy & NHS Elect, 2023



Source: NHS Employers, 2023

System Frailty Principles – Place Based Solutions

1) Use population-based frailty identification
2) Deliver integrated proactive and reactive care closer to home
3) Address health and care inequalities (inc. Care Homes)
4) Involve Patient and Public partners
5) Embrace digital technology
6) Deliver frailty attuned hospital care
7) Coordinate compassionate end of life care
8) Enable independence and promote wellbeing
9) Develop system oversight and communication with stakeholders
10) Dedicate time for clinical and strategic leadership
11) Embed and enable a Quality Improvement approach
12) Promote a Measurement for Improvement mindset
13) Make 'frailty' everyone's business through education and training
14) Develop the frailty workforce that can deliver

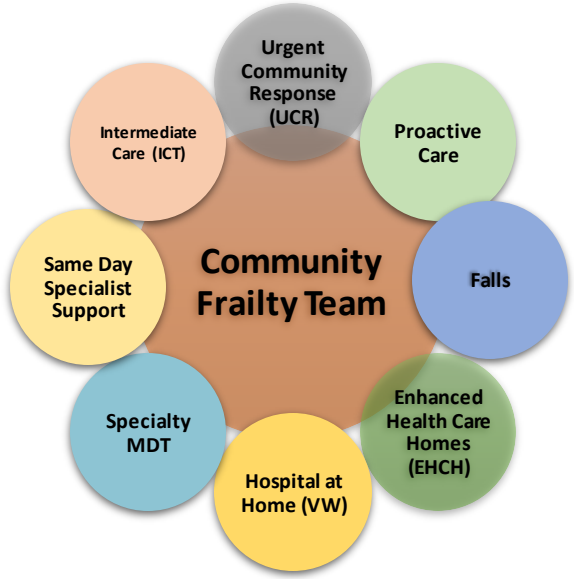
Example: Develop the Frailty WORKFORCE That Can Deliver

- **Takes time**
- Shared goals: right care in right place at right time
- See and solve: Based on personalised care
- Upskill others – Frailty everyone's business
  - social care, care homes, paramedics
- Specialist skill development
  - Portfolios / rotational / job shares
- Across organisational boundaries
- Future clinical workforce: GPVTS, ANP, PA
- Recruit "right" people – ran gaps
- Learn from each other and each other's organisations
- Use MS teams:
  - For communication each day
  - Sharing learning
- An integrated workforce plan required
- Retention high: feel valued, empowered, work makes a difference

Jean Bishop ICC Workforce

The Frailty Agenda- What have we achieved?

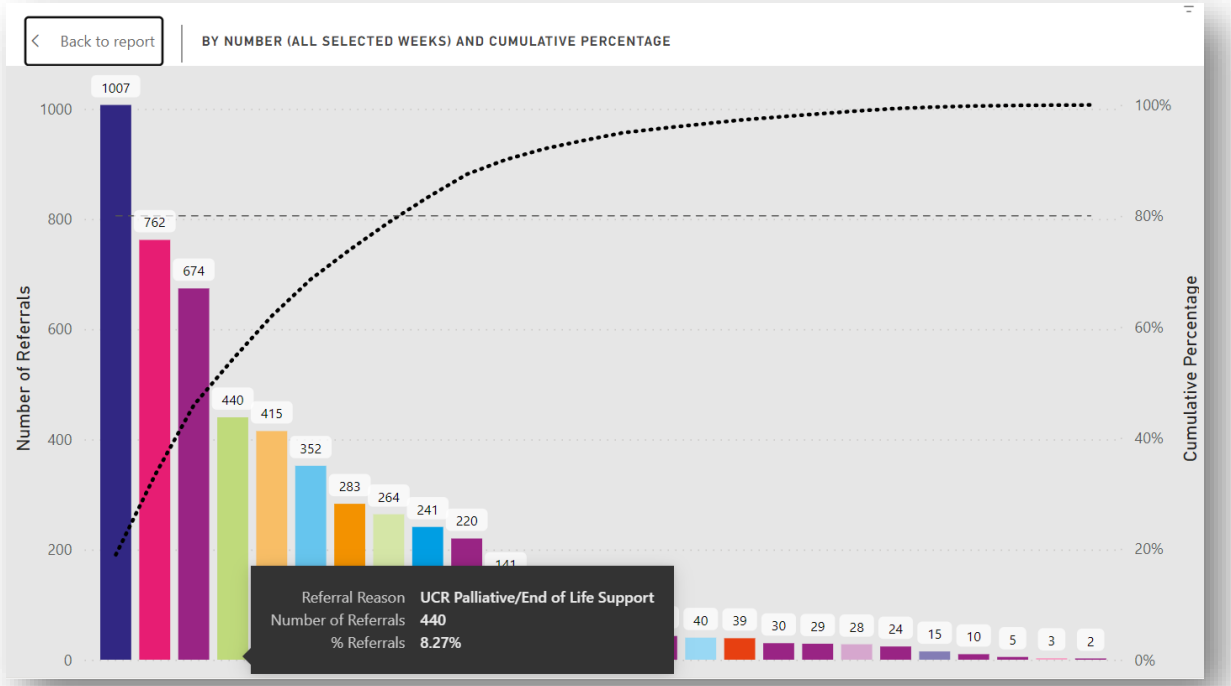
- Reduced duplication
- **Integrated** care records
- Adopted **Home First** principles - moved specialist provision **closer to home**
- Facilitated **living well and dying well**
- Reduced emergency **attends and admissions**
- Increased utilisation of **step-up** community bed capacity
- Created new pathway for **paramedic support** at the scene
- **Reduced costs** of medication
- Shared learning and **understanding** of different roles and responsibilities
- Created a **can-do** culture
- Feeling of belonging – **a shared identity** / hub of excellence / pride
- **Co-location** has nurtured the ICC vision and kept it person centred
- **Supported** carers
- **Made frailty everyone's business**
- **Shared** the journey and the data



Critical Success Factors – Top Tips

- **Dedicated Clinical Leadership**
- **Engaged senior leadership / executives** with shared purpose
- **Relationships** & **Trust**
  - Integrate records
  - Access
  - Colocation helps
- Ensure **public engagement**
- Stop thinking organisations and **think people – 1 Team (systems thinking)**
- **Be Strategic**: Create a **shared purpose** and aims
- **Be brave**, be involved, be confident
- Start with **small steps** build on success
  - PDSA but avoid pilotitis
- One version of the **truth**: Data is key
- Embrace **Digital solutions**
- If estate is a challenge **– virtual CGA**
- Support
  - System Wide Frailty Network (NHS Elect)
  - NHSE Community of Practice

Where Might the Hospice be able to Help?
Palliative Care Needs

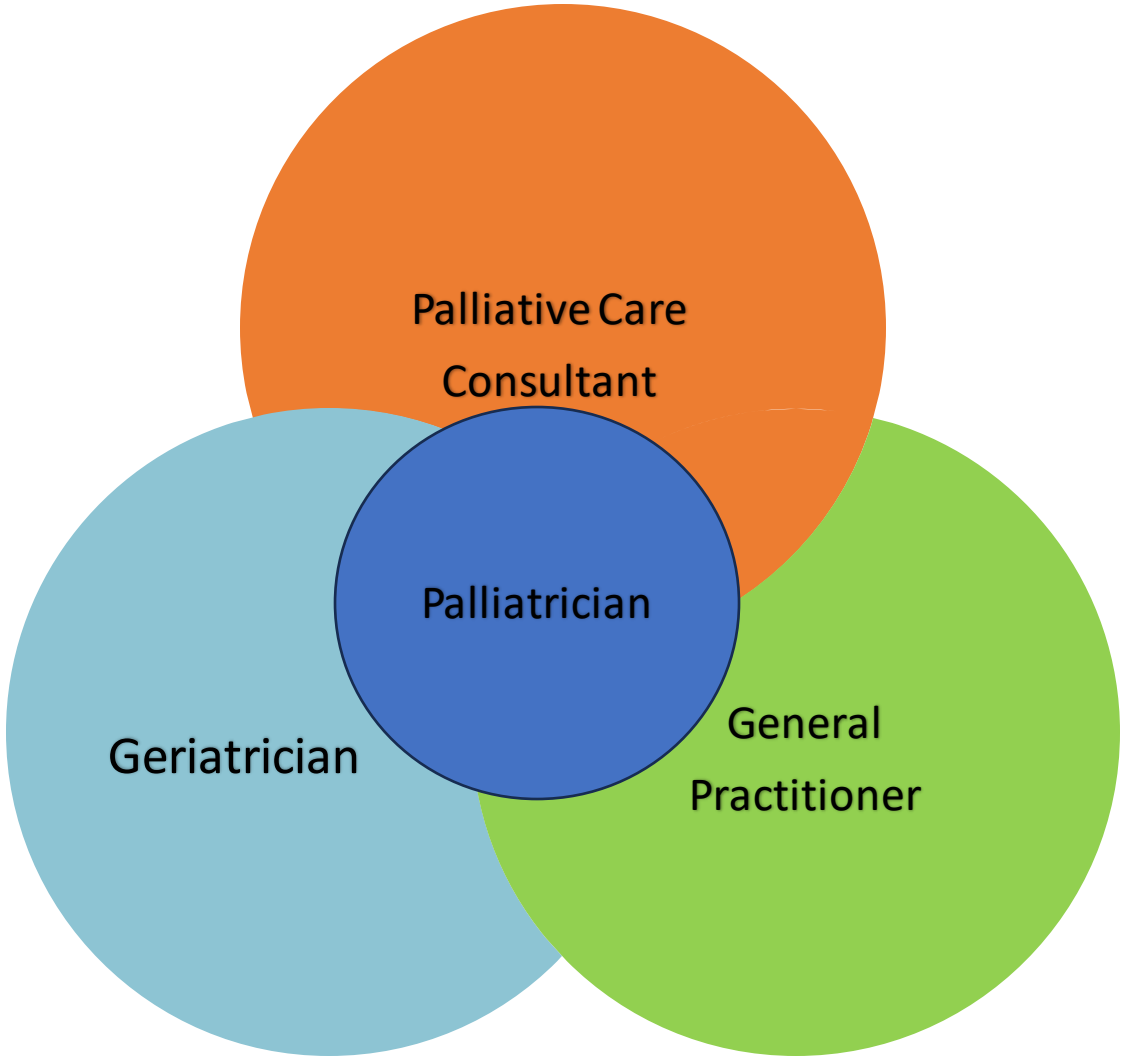


Hull and East Riding UCR, Oct 2023

Hull and East Riding VW, Oct 2023

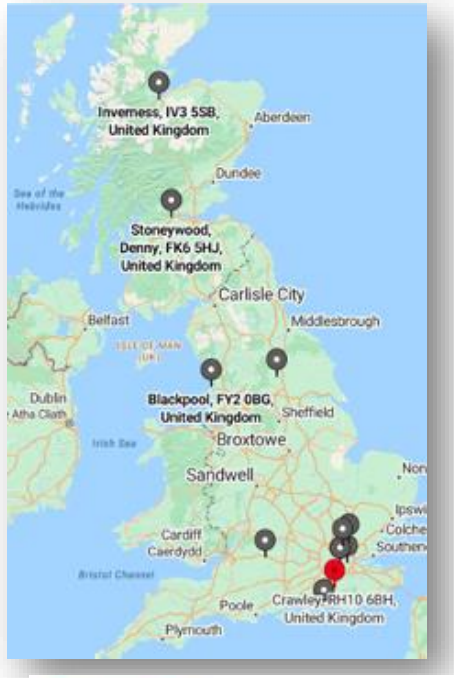
Clear need for further integration
Back to systems thinking!

A Shared Skill Set



Hospice UK: Extending Frailty Care Programme (April 22-April 25)

- Aims to improve quality of life for older people with advancing frailty who have palliative care needs, and who also experience lack of care coordination due to fragmented community services
- Bring together UK opinion and research leaders in frailty and palliative care to determine high impact opportunities for improvement
- Emerging evidence-based frailty care models will be planned, tested using a Quality Improvement approach, and evaluated
- 11 sites:
  - St Catherines, Crawley: Outreach, Education
  - Strathcarron: Care for people in prisons
  - Highlands: Helpline and education in care homes
  - St Clare's, East Sussex: Domiciliary care – new frailty care lead role
  - Trinity, Blackpool: Community Pathway – Partnership
  - Isabel, WGC: Compassionate communities
  - ellinor, Gravesend: Care home rehabilitation
  - St Michaels, Harrogate: Pathway streamlining/care co-ordination
  - St Christopher's, London: Care Home, education and family support
  - Prospect House, Swindon: Virtual Ward support, Education
  - St Barnabas, Worthing: Patient journey and equity of access
- Using QI methodology
- Peer support (ECHO Network)



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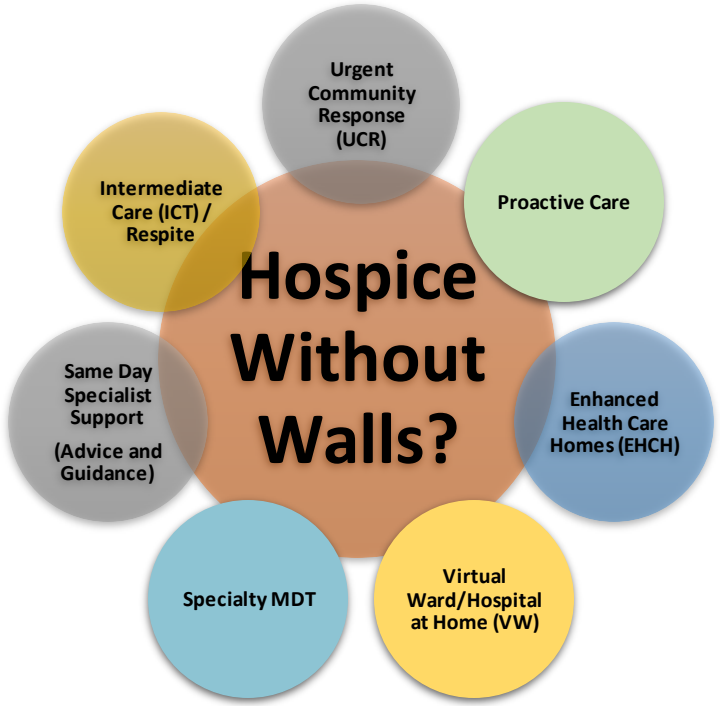

- Hospice has a role to play in all!
- Would urge you to get involved
- Don't start from scratch
- Consider:
  - Access (pathways) & Outreach
  - Inpatient admissions based on frailty
  - Sharing information

A word on Care Homes

- Oldest old
- Multi-morbidity
- Polypharmacy
- Physical and cognitive frailty
- Issues of capacity
- End of life

Legend!

Care Home Residents: Require CGA approach

CGA is a lens through which to identify and unpick frailty syndromes

Problem lists can be fun!

Shared Learning

Further information:

- The Concept:
  - A place to meet the needs of people living with frailty | NHS Employers
  - The Jean Bishop Integrated Care Centre – YouTube
  - NHS England — North East and Yorkshire » Centre's integrated services transform care for frail and elderly residents
  - BBC One - Panorama, The NHS Crisis: Can It Be Fixed?
  - BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf
- Patient Experience:
  - The Jean Bishop Integrated Care Centre, Hull - Ray's story – YouTube
  - A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty | BMC Geriatrics | Full Text (biomedcentral.com)
  - Experiences of a Novel Integrated Service for Older Adults at Risk of Frailty: A Qualitative Study - Imogen Wilson, Blessing O Ukoha-kalu, Mabel Okoeki, Joseph Clark, Jason W Boland, Sophie Pask, Ugochinyere Nwulu, Helene Elliott-Button, Anna Folwell, Miriam J Johnson, Daniel Harman, Fliss EM Murtagh, 2023 (sagepub.com)
- NHS ELECT: Case Studies — SWF Network

Contacts:

- daniel.harman2@nhs.net anna.folwell1@nhs.net

Jean Bishop BEM (1922-2021)
Final thoughts and Q&A

With special thanks to:

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  - Professor Johnson
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