Regional Southeast Frailty Event Report

Improving the care for people with Frailty - A multi-agency conversation

Introduction

This paper outlines progress and recommended actions following the series of Frailty regional launch pad events delivered with the support of NHS England**.** Given the significance of Frailty to the NHS the recommended actions coming out of the events, including pan STP collaboration across the pathway, could make a significant contribution to improving the quality of Frailty care and efficient use of resources across the South East.

Event description

Kent Surrey Sussex, Wessex and Oxford AHSNs worked in partnership with NHS England to deliver a regionally led whole system frailty event. The event supported a problem-solving approach to improving the health and well-being of older people living with frailty in line with the challenges of an ageing population. It addressed frailty by building connectivity to local teams and start developing networks to support STP frailty leads in improving the quality of life for people with frailty. A full agenda is outlined in Appendix 1.

Event aims and objectives

- Focus national strategic plans for older people living with or at risk of developing frailty onto the STPs in regional footprints
- Align strategic planning and prioritisation focused on healthy ageing through to acute frailty management, long term and end of life care for older people across the region
- Share good practice more assertively and capitalise on what is working well in their region, where and why
- Identify regional variation and where key elements of frailty care are either missing or could be assisted to develop
- Explore workforce issues for example the role of extensivism in primary care and understand how we can best connect the national programme and STPs around frailty and older people going forward

Audience analysis

The South-East Frailty event had 116 attendees registered including speakers and national programmes representatives. AHSN audience breakdown:

- Oxford 33
- Wessex 24
- Kent Surrey Sussex 58

Stakeholders Attending Overview and Numbers

NHS Bodies & NICE	12	Local authority	3	Commercial	2
CCGs	23	Academia	5	Fire and Rescue	4
AHSNs	7	STP	6	NHS Trusts	54

General outcomes

Overarching key themes emerging from the day were sharing data, workforce development and using workforce differently, changing culture within organisations, sharing best practice.

The afternoon tablework sessions connected stakeholders in the same STP footprint to share experiences, discuss actions required to improve frailty care and outcomes locally and identify what support is needed. Summary points below

STP area	**Action planned for next 12 months**	**Support needed from other organisations**
Berkshire ICS	Information sharing	National solution to data sharing
BOB	Join up with social care/3rd sector/SCAs	Social care and SCAs – to reduce conveyance
Frimley Health ICS	Digitally sharing information and proactive digital care planning	NHS Digital around IG & data sharing
Hampshire & Isle of Wight Table 1	Roll out fire services falls prevention course	National Fire Chief's Council – direction & action
Surrey Heartlands	STP to solve problem: discharge summaries sent out automatically without consent – why can't information come in as seamlessly?	Mandatory inclusion of ResPECT documentation in hospital discharge summary or at least that record exists
Hampshire and Isle of Wight (Table 2	Integrated management team in localities, single flat management structure, empowered and able to challenge	CCG support – robust relationship with CCG and providers – trust, open-ness
Kent and Medway	Get more information about GENIE – how to replicate it in Kent	More support from STP in sharing and support, good practice sharing (e.g. job descriptions)
Sussex & East Surrey Table 2	ResPECT & ACP information across the patch	NHS England – primary prevention
Sussex & East Surrey Table 4	Alignment between STPs regarding frailty agenda if frail what action should be taken what is the pathway?	Need regulators to sing from the same sheet – very conflicting messages

See appendix 2 for discussion points and outcomes.

NHS England's Support Offer

To support the challenges around the key emerging themes emerging from the regional Frailty Events and to continue improving the quality of life for people with frailty, NHS England has developed the following support offer:

1. Support effective population sub-segmentation by degree of need using the electronic frailty index to understand the current and expected future health and care needs of people with mild, moderate and severe frailty together with the opportunities available for ensuring adults continue to age well and remain fit.

2. Use this information to recurrently guide planning as well as sharing learning from current and future health and social care resource use associated with the various degrees of frailty in local older populations.

3. Support effective information governance among health and social care professionals using linked data to promote effective population health management and care for older people living with frailty.

4. Promote peer to peer networking and sharing of tools, best practice examples and resources through providing access to the Kahootz forum for frailty (joining details can be provided from england.clinicalpolicyunit@nhs.net

5. Support existing local work on agreed care standards and ambitions for frailty that support, develop, quality improve and embed best practice across a health and care system and are aligned to the development of national frailty care standards

6. Support effective care planning for older people living with frailty including developing simple but effective personalised care plans and ensuring that key information is shared between providers, systems, professionals across social care and health, and is accessible to patients and where appropriate their carers and those who matter most to them

7. Promote workforce development by developing and implementing the core capability framework for frailty. This will build from an ambition that every professional knows what to do next when presented with a person living with frailty and/or cognitive disorder.

8. Support effective local commissioning including through integrated health and social care systems, STPs and primary care networks and consider instruments such as CQUINs and a frailty currency to promote high quality care to support older people to stay healthy, independent and live safely in their home or community.

9. Develop and refine over time RightCare and Get It Right First Time (GIRFT) Frailty pathways and data packs.

Next steps

Kent Surrey Sussex, Oxford and Wessex AHSNs in partnership with NHS England are hosting a follow up webinar on **Tuesday 10 July 12.30-1.30pm** to feedback on the key emerging themes steps from the South East Regional Frailty Event, presentations from local providers

who have made changes following the event and outline next steps. The webinar aims to build on the actions and enthusiasm for change generated at the event and will be of interest to all regional stakeholders who are interested in working with STPs to improve the quality of life for people with frailty in their region. The webinar will include a question and answer session with National Leads. To register for the webinar please use the details below.

South East Regional Frailty Event Follow Up Webinar

Tuesday, July 10, 2018
12:30 pm | GMT Summer Time (London, GMT+01:00) | 1 hr
This is the event registration link below **Register**

Appendix 1– agenda

Time	Title	Speaker
09:30	**Registration and Networking**	
10:00	**Welcome and Introduction**	**Tracey Faraday-Drake** Programme Director, Kent Surrey Sussex ASHN
10:05	**Frailty: The National Perspective**	**Professor Martin Vernon** National Clinical Director Older People, NHS England
10:30	**Presenting the Regional Data Get it Right First Time & Right Care Information**	**Dr Adrian Hopper** Geriatric Medicine Lead, GIRFT **Dr Bruce Pollington** NHS Right Care Delivery Partner, NHS England
10:50	**Q&A Session**	**Facilitated by Dr David Hunt** Director Elderly Care, Western Sussex Hospitals NHS FT
11:05	**Refreshment break and Networking**	
11:20	**Introduction to Local Projects**	**Tracey Faraday-Drake** Programme Director, Kent Surrey Sussex AHSN
11:25	**Overview of Genie**	**Liz James** Senior Researcher, CLAHRC Wessex
11:40	**Technology and frailty, our experience in the Living Lab**	**Dr Anand Sundaralingam** Darzi Fellow, University of Brighton **Dr Theofanis Fotis** Principal Lecturer Nursing, Course Leader MSc Health - School of Health Sciences, University of Brighton
11:55	**Responding to Deteriorating Frailty – Consultant Practitioners in Frailty**	**Dr Abigail Barkham** Consultant Nurse for Frailty, Wessex AHSN
12:10	**Managing Frailty within Secondary Care**	**Dr Paul Wearing** Consultant Geriatrician, Royal Berkshire NHS FT
12:25	**Q&A Session**	**Facilitated by Dr David Hunt** Director Elderly Care, Western Sussex Hospitals NHS FT

12:45	Lunch and Networking	
13:30	**Introduction to Afternoon Session**	**Dr David Hunt** Director Elderly Care Western Sussex Hospitals NHS FT
13:40	**Facilitated Table Discussions**	
15:15	**Next Steps and Close**	**Professor Martin Vernon and Dr David Hunt**

Appendix 2 – Table discussion summaries

The afternoon tablework sessions were designed to help connect stakeholders in the same STP footprint to share experiences, discuss actions required to improve frailty care and outcomes locally and identify what support is needed.

STP Area: Berkshire ICS

<table>
<tr><td colspan="5">What actions can be planned for the next 12 months?</td></tr>
<tr><td colspan="5">• 8 High Impact Areas – final report : DTCCs (Master of Success)
• Connected care
• Information sharing
• CHASC sending information to and from ED</td></tr>
<tr><td colspan="5">What are the challenges to implementing these actions?</td></tr>
<tr><td colspan="5">• IT
• Resource – workforce and using workforce differently
• Cross organisational working
• Patients readmitted due to package of care not in place
• Availability of carers</td></tr>
<tr><td colspan="5">What support is needed from other organisations (national and local)?</td></tr>
<tr><td colspan="5">• National solution to data sharing
• Sharing best examples
• Utilise universities
• Money
• National Team/PHE guidance on self-management/prevention
• Appropriate housing – local solutions
• National support to work through contracting issues</td></tr>
<tr><td colspan="5">What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?</td></tr>
<tr><td colspan="2" rowspan="2"></td><td colspan="3">Phase of Care</td></tr>
<tr><td>Proactive</td><td>Routine</td><td>Responsive</td></tr>
<tr><td rowspan="2">Degree of Frailty</td><td>Mild</td><td>Rapid Access Clinic for Older People (RACOP) – MDT clinic

Falls MDT clinic</td><td>Making every contact count

Care planning in primary care</td><td></td></tr>
<tr><td>Moderate</td><td>Rapid Access Clinic for Older People (RACOP) – MDT clinic

Frailty screening / identification

Falls MDT clinic</td><td>Frailty screening / identification and care planning

Interface Geriatrics, including CGA

Frailty Friendly Front Door (FFFD)</td><td>Frailty team, including presence at front door (Emergency Department / Elderly Care Physician of the Day)

Daily MDT board rounds</td></tr>
</table>

		Falls and Frailty Response Service (FFR) Rapid Response and Treatment (RRAT) for Care Homes Care Home Support Team	Hip fracture unit, including early supportive discharge Dementia friendly elderly care wards	Enhanced Recovery programme Integrated Discharge Service (RBFT and BHFT combined with social services)
	Severe	Falls and Frailty Response Service (FFR) Rapid Response and Treatment (RRAT) for Care Homes	Frailty screening / identification Frailty Friendly Front Door (FFFD) Interface Geriatrics, including CGA Hip fracture unit, including early supportive discharge	Daily MDT board rounds Enhanced Recovery programme Integrated Discharge Service (RBFT and BHFT combined with social services)

STP area: BOB

What actions can be planned for the next 12 months?

- Reconfiguration
- Telephone follow up from acute
- Join up with social care/3rd sector/SCAs
- Reduce conveyance work with SCAs
- Communication with public/providers (change risk profile)
- What interventions are indicated based on frailty score
- Community therapy increase resource/responsiveness
- High frequency users

What are the challenges to implementing these actions?

- Cash and allocation of resources
- Responsiveness within 4 hours
- Using EFI to determine resource
- How do we determine where to concentrate resource/activity/geographical area
- Cultural shift re organisations accepting greater risk

What support is needed from other organisations (national and local)?

- Social care
- SCAs – to reduce conveyance
- Shape atlas PHE
- Develop patient passports
- IT sharing

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	Primary Care District nursing/therapy Pharmacy Church Third sector Age UK +++ Exs on referral	Carer support & respite	Carer support & respite
	Moderate	EFI – primary care Care frailty CHSS Proactive care planning Age UK Falls services Respiratory service/PR	Hospital@home PCEVS – early visiting services ANP outreach Memory clinic Mental health	Memory clinic Mental health
	Severe	Emergency department Acute palliative care team		EMU AAAR RACH

STP area: Frimley Health ICS

What actions can be planned for the next 12 months?

- Ensuring our response to Frailty is consistent across the Frimley ICS in reducing variation
- Sharing best practice
- Digitally sharing information and proactive digital care planning
- Linking into the fire service in terms of prevention
- Headspace for leaders and staff to work proactively whilst continuing to manage cases

What are the challenges to implementing these actions?

- Organisational barriers
- Local & national priorities
- Funding streams
- Resource rethinking the way we utilise resource
- Information governance
- Capacity to work proactively –
    - How to get the balance between fire fighting/preventative
    - Double running costs and capacity

What support is needed from other organisations (national and local)?

- Sharing best practice
- NHS Digital around IG & data sharing

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	Social prescribing Social isolation through local authorities	Making every contact count	
	Moderate	Case finding (EFI) Integrated virtual "CGA" frailty MDT	ICTs – Integrated Core Teams Integrated Frailty In-Reach for care homes	Frailty team – Hospital based integrated frailty liaison service – front door including ICT members and in-reach GPs Integrated hubs and MDTs
	Severe	Case find (EFI)	ICTs	

STP Area: Hampshire & Isle of Wight Table 1

What actions can be planned for the next 12 months?

Through Frailty Delivery Group continue to work on:

- Frailty awareness momentum
- Roll out fire services falls prevention course
- Evaluation of red bag
- Skills for life/frailty education
- Develop admissions avoidance
- Identify people at risk of loneliness and social isolation in Wessex
- Embed frailty pathway
- GENIE implementation
- Roll out frailty framework

What are the challenges to implementing these actions?

- Funding
- Geographical boundaries & multiple CCGs
- Buy-in and organisational barriers
- CCG engagement
- Time
- IT interface & shared systems
- Resources/recruitment & retention
- Current contractual requirements
- Engagement with primary care

What support is needed from other organisations (national and local)?

- Sharing & learning from pilots (Best Practice)
- Flexibility from CCGs on current contracts to try integrated working
- True integration
- Quality metrics as well as cost metrics – quality for patient
- Integrated budgets
- Health & Well Being Boards
- Buy-in/pledge from all providers
- National Fire Chief's Council – direction & action

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	Frailty awareness campaign Proactive care team GENIE Fire Service falls course Patient Activation Measures Safe & Well	Day Centres GP Practice Nurse Voluntary Sector OP follow ups Pharmacy	Fire Service SCAs Self management ICY (Community Nurse Therapist) Falls clinics/rapid assessment clinics
	Moderate	Specialist Nurses GENIE Palliative Care (EOLC planning)	CGA/Care Planning GP weekly check up (LTCs) GFI identification Meds reviews	Acute admission FIT – frailty intervention teams Hospital@Home ERSH/CRT – intermediate care OPMH
	Severe	Palliative Care (active)	Special care Package of care Community care team	Nursing home placement Acute frailty team

STP Area: Hampshire & Isle of Wight – Table 2

What actions can be planned for the next 12 months?

- Workforce – HEE & STP training team need short & long term plan
- Integrated management team in localities, single flat management structure, empowered and able to challenge
- Training capability
- Drive change based on optimum outcomes across localities and all agencies
- Medicines optimisation – use of community pharmacy, PINCER, polypharmacy management
- Address self-management, pre-retirement and ageing well
- Digital technology – digital strategy, single data sharing agreement
- CCG – single locality plan within each locality to simply provision offer

What are the challenges to implementing these actions?

- Shared access to patient information
- Need for standardisation of concepts, local interpretation/needs
- Move to needs focus not age focus
- Complex multi layered provision
- Workforce & skills/capabilities
- Time & head space to lead change
- Understanding of frailty
- Clinical managers and local leadership
- Changing culture within organisations

What support is needed from other organisations (national and local)?

- National CQUIN for frailty to drive wider changes across service delivery
- National frailty competencies, apprenticeships
- Royal Colleges for each discipline to align with workforce planning
- CCG support – robust relationship with CCG and providers – trust, open-ness
- Clinical assessment time – CGA (workforce, capability)
- GP contract

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	31/3/18 CFI Measuring vs action/implementation Care Homes	ICTs AS/CRT Care plans MDTs Frailty Consultant Practitioner Community Navigators	Increase intensity offers Polypharmacy de prescribing and meds reconciliation
	Moderate	Integrated team ? rotational posts	Comprehensive patient pathway – multiple diagnosis based pathway dovetailed into frailty pathway	Integrated team ? rotational posts
	Severe			What services are available Competency/workforce Care plan? Seamless transition between services Acuity (MFFD) vs delirium, mobility, social care

STP area: Surrey Heartlands

What actions can be planned for the next 12 months?

- Sort out IT so that patient journey is accompanied by information
- Consent – share how some areas have sorted
- Flag up patients known to other services in ED
- Look at how fire and rescue can feed into systems – lots of intelligence
- Mandatory inclusion of ResPECT documentation in hospital discharge summary or at least that record exists

What are the challenges to implementing these actions?

- GPs have concerns about data sharing
- Discontinuing care

What support is needed from other organisations (national and local)?

- STP consent to share with opt out
- STP to solve problem: discharge summaries sent out automatically without consent – why can't information come in as seamlessly?
- ResPECT available electronically

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

No information provided

STP Area: Sussex & East Surrey – Table 2

What actions can be planned for the next 12 months?

- ResPECT & ACP information across the patch
- Coordinated care home rounds and relationships
- Support informatics in working towards integrated systems
- Training plays
- Role out Red bag scheme and message in a bottle
- Care Navigators, GENIE
- Integrated MM team
- ID frailty earlier via GP contract?

What are the challenges to implementing these actions?

- Finance
- Workforce and knowing which people to contact
- IT
- Culture
- Silos
- Time
- Not knowing what services are out there

What support is needed from other organisations (national and local)?

- NHS England – primary prevention
- NHS England – ACP
- NHS England – IT
- NHS England – POA & wills
- Mapping of all services

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	Vulnerable patient scheme Volunteers MMT Navigators & link workforce	Volunteers (3rd sector)	Acute medical - Trust
	Moderate	Community acute frailty Fire services/first responders Care home nurses		Health and social connect Community hospital/rehab Facilitated early discharge teams
	Severe	Palliative		Acute Medical Trust

STP Area: Sussex and East Surrey – Table 4

What actions can be planned for the next 12 months?

- Alignment between STPs regarding frailty agenda if frail what action should be taken what is the pathway?
- Need equal buy-in to the process e.g. DNR instructions
- Fire and other services supporting those who are isolated
- Workforce reviews
- How do we share learning?
- Optimise process to get geriatrician to individual on need fasters
- Involving partners – blue light services
- E Sussex going through recruitment for frailty specialists
- Make sure all partners are engaged and enabled with tools
- Need to get better at care at home medicine – standardise best initiatives
- ASHN Living Well for Longer programme education model for new workforce, technology, communities of practice
- Integration of IT right info at the right place
- STP website

What are the challenges to implementing these actions?

- Getting people to work together – no initiative to work together
- Workforce – difficult conditions, medical and nursing recruitment is difficult
- Need to shift specialists to help with workforce attractions
- STP has many different workforces need to work ground up and identify where to start
- Guidance from other sectors to support others
- Need to choose what to address and agree on this. Strong characters bad and take over discussions
- Evidence and data difficult to pull together
- Be brave to try something new
- People keep moving jobs, relationships and agendas change
- Lots of different practice – what is really best?
- Referral pathway in all directions, information is siloed, what are people offering?

What support is needed from other organisations (national and local)?

- More money – pump priming
- Need regulators to sing from the same sheet – very conflicting messages
- How can you support individuals to identify a wider chain of events?
- A&E sharing for data signed up records
- Help with IT – needs systems to talk to each other
- National Fire Chief's Council – direction and action
- Guidance on GPDR – what does it really mean?
- Signposting needs to be easier
- Shared outcomes and measurable -set out what good looks like
- Data protection protecting patient – vs sensible approach, educate patients
- No code for frailty on hospital systems – can identify but not capture

Kent Surrey Sussex Academic Health Science Network | Oxford Academic Health Science Network | Wessex Academic Health Science Network | NHS England

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?				
		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	Brighton has team which provides voluntary care to those that are frail Rapid access clinic Fire crews pick up info from visits – safeguarding and referral pathways (sometimes too much effort to do)	GPS "should" do routine 65+ frailty Safe & well – visits from fire service. How do we know what to ask? A&E, Dieticians education, Making every contact count	Most things are responsive not preventative – social services, health
	Moderate	Services to allow core GMS group to provide frailty screening assessments Those with multiple co-morbidities = good community nursing can identify Well being hubs	A&E, Dieticians education, Making every contact count See the whole patient Fire crew = dementia friends	
	Severe	Palliative care – active	A&E, Dieticians education, making every contact count All care plans stored with IBIS Care for Carers services – adult care services being hit = won't be commissioned in the same way	24hour EOLC phone line – including clinicians – system1 based (only 50% of practices have system1 so other 50% don't have as much data stored. If in nursing home or severe frailty added to frailty register and then a form of virtual ward – primary care, voluntary and others – still work in progress – hard to link with other areas

STP Area Kent & Medway

- Get more information about GENIE – how to replicate it in Kent
- Improve communication and raise awareness of services available to GPs
- Front door frailty geriatrician (A&E)
- Multi disciplinary working – identify patients, MDT approach to each case
- Care navigators to follow up recommendations following contact with hospital

What are the challenges to implementing these actions?

- Scarce resources of Geriatrician Consultants
- Engagement of MDT team/cultural changes/information governance
- Shared care report
- Measuring improvements – how and what to measure?

What support is needed from other organisations (national and local)?

- Meds optimisation programme (NHSE) ensure that it is included in the programme
- More support from STP in sharing and support, good practice sharing (e.g. job descriptions)
- NHSE to communicate and share goals and outcomes and key performance indicators

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?

		Phase of Care		
		Proactive	Routine	Responsive
Degree of Frailty	Mild	Encourage self-care (Patient Activation Measures) Refer to community services Technology to engage people and improve comms	Frailty screening Secondary point of access “picking up” on issues such as social isolation and falls and deconditioning	Prevent further deconditioning on hospital admission
	Moderate	Refer to community services Technology to improve comms	Frailty screening Secondary point of access “picking up” on issues such as social isolation and falls and deconditioning	Prevent further deconditioning on hospital admission
	Severe	Care Home medication review End of life project – up to date records and advance care plans, person management in own home Technology to improve comms	Liaison service of Geriatrician services during hospital stay	