

Healthy Ageing Programme

Wessex AHSN Healthy Ageing Community Frailty Audit

1. Background

The NHS Long Term Plan 2019¹² outlines several important priorities and changes to the way the NHS should work to support individuals living with frailty. It also has a bearing on their carers to support them to age well and stay independent at home. People are now living far longer, but extra years of life are not always spent in good health. They are more likely to live with multiple long-term conditions, or live into old age with frailty or dementia, so that on average older men now spend 2.4 years and women spend three years with 'substantial' care needs, The Plan recognises that services are not consistently joined-up or responsive to their needs and describes the need to identify and provide proactive support and enhance rapid community response in times of crisis³.

The Wessex Academic Health Science Network (AHSN) Healthy Ageing community frailty audit (WCFA) aimed to provide a baseline for local primary care networks (PCNs) to identify areas of focus to support the delivery of frailty aspects of the Long Term plan to ensure that older people have equitable access to integrated services and provides a summary of where improvements can be made.

1.1 Context

The audit was developed by the (AHSN) Healthy Ageing Programme, building on the success of the Wessex acute frailty audit delivered in 2018, with 100% of Wessex trusts completing the audit and two Wessex wide service improvement project identified.

<https://wessexahsn.org.uk/projects/208/developing-an-acute-frailty-audit>

The NHS Long Term Plan 2019 recognises that services are not consistently joined-up or responsive to the needs of older people living with frailty. The overall aim is to support people to age well and to stay independent at home for longer and we wanted to test what this looked like in Wessex at Primary Care Network (PCN level). A decision to run the community-based audit at PCN level was made by the Wessex AHSN Community and Primary Care Expert Group as it was identified that PCNs are the vehicle for the delivery of the community frailty elements of the long-term plan of keeping patients at home, living independently for longer⁴

The WCFA was part of a Wessex wide approach [**Diagram 1**] to run one audit for the whole system to:

- Provide an overall picture of frailty provision at PCN level
- Support to the PCN network in providing a baseline for improvement in frailty services
- Identify areas for opportunity in supporting the delivery of national priorities of changing how the NHS works
- Support patients and their carers and, improving care for older people with frailty.

¹ <https://www.longtermplan.nhs.uk/>

² <https://www.ageuk.org.uk/our-impact/policy-research/frailty-in-older-people/frailty-and-the-nhs-long-term-plan/>

³ <https://www.longtermplan.nhs.uk/>

⁴ <https://www.longtermplan.nhs.uk/>

Diagram 1: Wessex wide audit approach



1.2 What were the aims of the audit?

Following on from the delivery of the Acute Frailty Audit in 2018;

- To deliver a complementary Community Frailty Audit (WCFA)
- To focus on the processes for identification of individuals living with frailty, and subsequent holistic assessment and care planning, training of staff, and communication with colleagues across the health and social care system at PCN Level
- To improve the standards of care for those at risk of or living with frailty
- To identify 1-2 service improvement projects at PCN level following the analysis of the audit
- To share findings and encourage national uptake of the audit.

1.3 High level findings from the audit

- 22 PCNs took part in the audit (32% rate/ 69 PCNs across Wessex).
 - The PCNs that took part covered all areas of the Wessex geographical area
 - Good uptake of the audit despite other competing priorities in responding to the Long-Term plan directives from NHS England including detailing plans for the delivery of Enhanced Health in Care Homes by Primary Care Networks (PCNs) which are included in the Network Contract Directed Enhanced Service (DES) for 2020/21. Complementary EHCH requirements for relevant providers of community physical and mental health services have been included in the NHS Standard Contract⁵
 - This supports the NHS Long Term Plan goal of "dissolving the historic divide" between primary care and community healthcare services and sets a minimum standard for NHS support to people living in care homes.

⁵ DES

- 68% of audits completed by PCN Clinical Directors. One PCN completed a return by PCN Clinical Director and a separate one by the PCN Manager lead.
- 45.5% of participating PCNs have a frailty lead for developing services for people living with frailty, which demonstrates that these PCNs have identified that frailty as an important area of focus.
- 80% have considered the needs of people living with frailty and how it relates to current frailty service provision; 4 organisations shared their plans with us which were reviewed by the Clinical Lead for the project.

2 Methods of delivering the audit

2.1 Project timeline

During April - August 2019, a sub working group from our Community and Primary Care Expert forum was convened to develop the audit questions using Delphi methodology. This method was used to establish clinical and strategic consensus on the audit questions. The group included representation from strategic, community frailty experts across Wessex and was chaired by Marianne Plater, Community Geriatrician from Southern Health NHS Foundation Trust. Three trainee consultant frailty practitioners from Health Education England were also included within the working group, with the ambition that they would run 3 PCN QI projects based on the outputs of the audit.

Table 1 illustrates the project timeline.

Table 1: Wessex Community Frailty Audit Project Timeline

Timeline	Activity	Stakeholders
April 2019	Working group set up to design Community Frailty questions.	Representation from Consultant Geriatrician, GP Extensivist, Consultant Frailty Practitioners, Director of Transformation and the University of Southampton
May – August 2019	8 Plan Do Study Act Cycles to review and refine audit questions	Working group
Early September 2019	Engagement with STPs and CCGs – opening letter	PCN Clinical Directors, STP and CCG leads
Late September 2019	Electronic trial of audit questions with 1 PCN	Frailty Lead for 1 PCN
October 2019	Audit open for completion across Wessex PCNs (28 questions)	PCN Clinical Directors/ PCN Frailty Leads
November – December 2019	Analysis of Community Frailty audit	Centre for Implementation Science
February 2020	Healthy Ageing Community Frailty PCN workshop	Community Geriatricians, CCG leads, PCN Clinical Directors, PCN Frailty Leads and members of integrated teams

2.2 Audit development

The questions were developed to provide a snapshot view of processes and relationships linked to the themes of frailty screening and identification, management, and frailty awareness identified in the National Institute for Health Research (NIHR) Dissemination Centre themed review ‘Comprehensive Care; Older people living with frailty’⁶ which formed the basis of the Wessex Acute Frailty audit. The approach aimed to capture current practice rather than a comprehensive review.

⁶ <https://evidence.nihr.ac.uk/themedreview/comprehensive-care-older-people-with-frailty-in-hospital/>

The Community and Primary Care Expert Group reviewed and validated the audit questions and categorised them as follows⁷.

- High level organisational overview
- Screening and sharing of frailty information
- Frailty knowledge, skills and training
- Current frailty pathway processes
- Multi-disciplinary team interactions
- Service Improvement opportunities

PCNs were asked to provide responses, where possible, for

- Primary care
- Community –Physical Health Services,
- Community – Mental Health services; and
- Social Care

Between May and August 2019, the questions were rigorously reviewed for clarity and consistency using the Plan, Do, Study, Act Methodology (PDSA) methodology to finalise the questions.

During August and September 2019, the audit questions were trialled in using a spreadsheet template.

The final tool comprises of 28 high level questions.

It was agreed to use Online Surveys⁸ for the audit due to its ease of administration and data collection as well as use within academic research. The final questions used for the audit are detailed in **the Resource Section**.

In September 2019 the audit tool was tested with North Bournemouth PCN both in spreadsheet and electronic formats to enable the project team to identify any issues in interpreting the questions or collecting the data. There were no reported issues, and it was confirmed that the data collection process took no longer than 30 minutes to complete where data was readily available.

2.3 Stakeholder engagement

The programme lead promoted the benefit of completing the audit with CCG and PCNs leads through a formal letter of opportunity, detailing the opportunities the audit would provide in helping shape local frailty agendas. Letters were followed up with a telephone call to all CCG leads to encourage support for taking part in the project.

Feedback on the audit from stakeholders included the following:

“I think the survey is a great idea and hopefully will help to start standardising the provision of frailty services across Wessex.”

PCN Network Manager

⁸ <https://www.onlinesurveys.ac.uk/>

“An ideal way to link in with the work which is already going on in our system/acute sector, to get a baseline and build some relationships to drive collaboration and improvement.”

PCN Clinical Director

2.4 Data collection

During October 2019, the audit tool was sent to all Wessex PCN Clinical Directors to complete with their teams. (n=69). Guidance on completing the audit was provided, highlighting the need to complete with other members of the PCN.

The audit was initially open for a period of one month; at the end of October 2019, the audit window was extended by 2 weeks, with the Wessex AHSN Healthy Ageing programme capturing responses plus offered support to PCNs in collating the data.

The Healthy Ageing Programme reviewed the submissions and participating primary care networks were given the opportunity to validate their submissions. One PCN reviewed their submissions and made minor amendments. One PCN submitted two separate responses, one submission was submitted by the PCN Clinical Lead and the other by the Network Manager, this provided insight into the varying views of stakeholders within a PCN.

3. Data Analysis

In December 2019 and January 2020 initial analysis was undertaken by the Centre of Implementation Science at the University of Southampton to identify key themes arising from the audit. The data was presented in the format of a high-level summary pie chart and individual PCN responses.

This analysis was reviewed by the Healthy Ageing Community Frailty Audit working group.

The detailed analysis of the Wessex Community Frailty Audit is included in **the Resource section**.

Caveats and assumptions regarding the audit

- a. The data collected in the audit tool are based on a snapshot in time and it is acknowledged that PCNs may have subsequently improved on initial audit findings
- b. It is acknowledged that PCNs may not have identified frailty as a priority. The audit aims to help support organisations identify opportunities for quality improvement projects within the community setting
- c. The audit responses are also based on the auditor and view of staff in the PCN completing the audit
- d. Baseline for opportunities for improvement, not mapped to PCN maturity
- e. Small numbers may overinflate presented percentages
- f. Percentages presented have been rounded up.

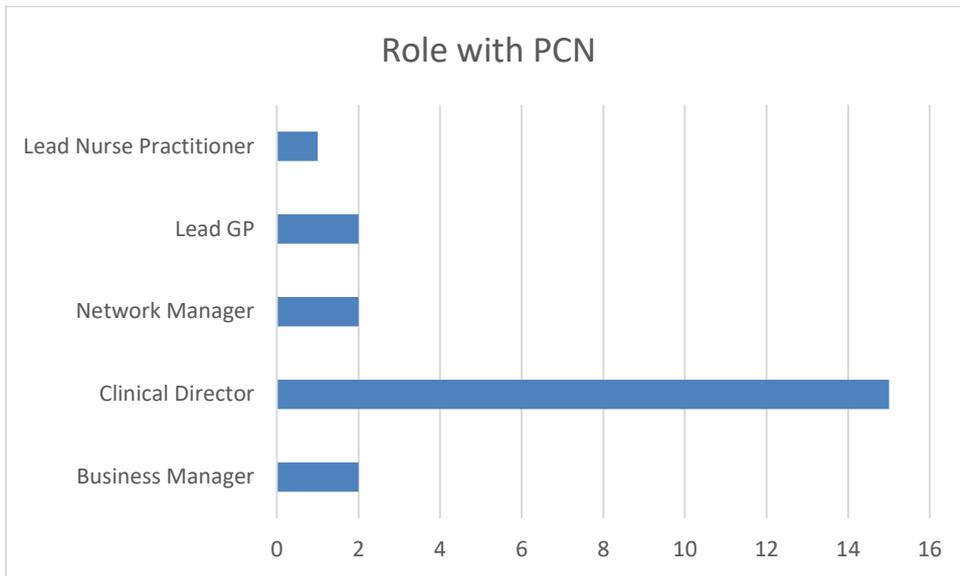
4. Results

The audit asked respondents to answer the same set of questions posed for Primary Care, Community Physical Health Services, Community – Mental Health services and Social Care. Following the audit, we recognised that PCNs only have access to Primary Care information.

Outputs of the question presented in this section relate to Primary care only and are presented in a tabular format, illustrating highlights such as access as validation of Electronic Frailty Index (e-FI)⁹¹⁰ scores with Rockwood Clinical Frailty Scoring¹¹; and opportunities for increasing specialist frailty provision. Where appropriate, PCN best practice examples have been provided and areas for service improvement identified.

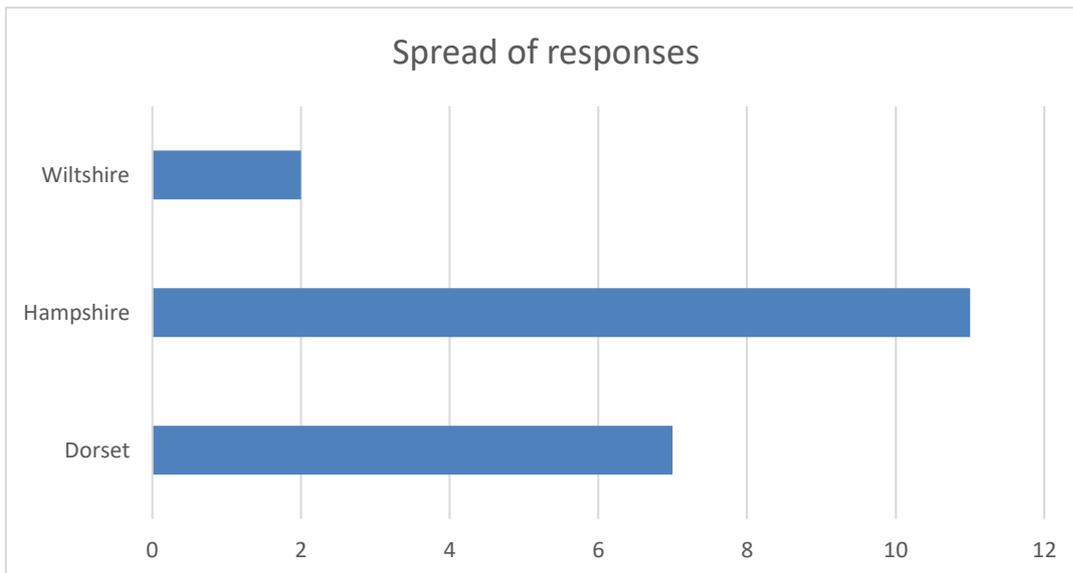
4.1 Analysis

a. Role within PCN



68% of the respondents were Clinical Directors of the PCN.

b. Geographical spread of uptake of audit



Two thirds (2 out of 3) of South Wiltshire PCNs (included in the Wessex AHSN geography) participated in the audit. Within Hampshire, 11 PCNs responded (out of 44 PCNs [25%]) and were predominately located

⁹ <https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/>

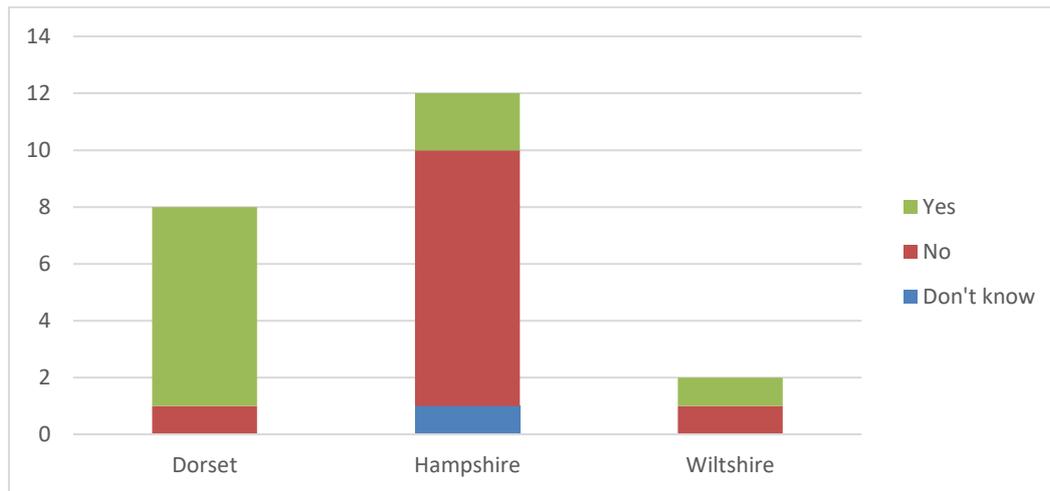
¹⁰ https://wessexahsn.org.uk/img/projects/Frailty%20Index%20for%20HCPs%20_%20V4-1580384125.pdf

¹¹ https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf

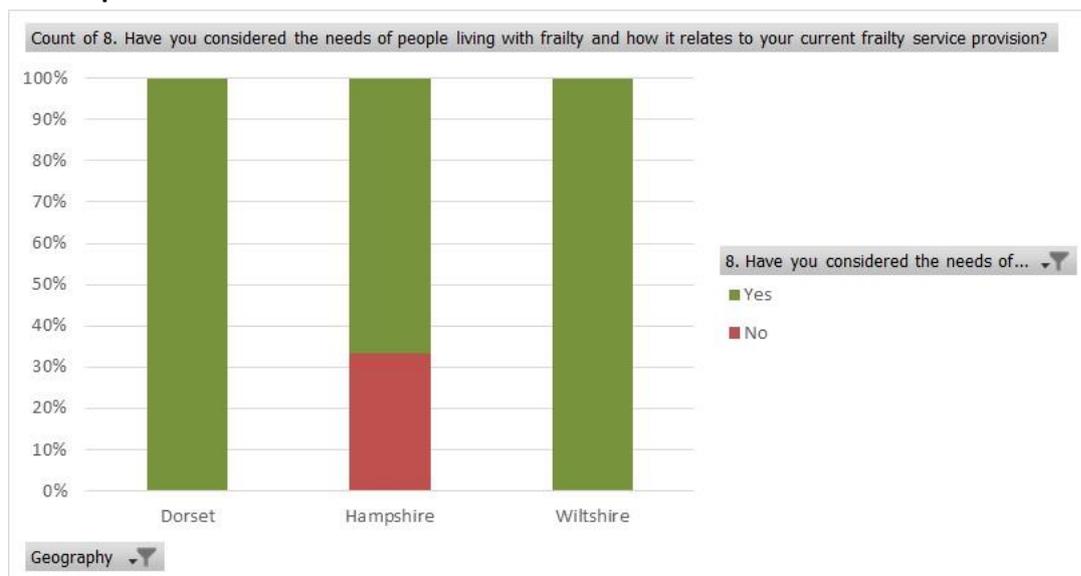
within South East Hampshire and North Hampshire. Within Dorset, 7 out of the 18 PCNs responded to the audit (39%).

c. Do you have a frailty lead for developing services within your PCN for people with living with frailty? (split by geography)

45.5% of PCNs reported having a frailty lead for developing services for people living with frailty, which demonstrates that these PCNs have identified frailty as an important area of focus but that it is also recognised PCNs may have a different clinical focus such as mental health and long term conditions, dependent on their local population needs.



d. Have you considered the needs of people living with frailty and how it relates to your current frailty service provision?



80% of PCNs reported having considered the needs of people living with frailty and how this relates to their current service provision, with 4 PCNs in Hampshire identifying that this work needs to be considered to

understand further opportunities for development and integration of key frailty services and provision including the inclusion of acute and community geriatricians in MDT discussions where appropriate.

e. How engaged is your local authority with your PCN?

This question explored how PCNs are aligned with local authority to deliver the Long-Term plan¹². Collaboration with local authorities is critical, building on effective joint working with partners. Nine PCNs cited that they were engaged with their local authority and 11 PCNs were either not engaged or had variable levels of interaction. The examples below encapsulate examples of good engagement approaches and relationships.

“A partnership and steering group were formed in July 2019. This brings together the local authority, district authority, clinical commissioning groups, the Primary Care Network and other services.”

“Actively decompensating individuals can receive urgent reablement care packages to address their social needs whilst our frailty team support their clinical needs; the two services work seamlessly together to provide support.”

f. How are voluntary services engaged with your PCN? ¹³

Voluntary services are able to facilitate community engagement to ensure that delivered services are personalised and can provide mechanisms for outreach; they are able to support PCNs in identifying and getting to know local groups and communities that have poorer health and/or access to services and can support in mapping the strengths and resources in the local community; how to work with the community sector to establish or develop referral schemes. 12 PCNs are actively engaged, with 3 PCNs not clear on

¹² <https://www.local.gov.uk/sites/default/files/documents/Briefing%20-%20LGA%20Primary%20Care%20Network%20Development%20FINAL%20WEB.pdf>

¹³ https://www.nationalvoices.org.uk/sites/default/files/public/publications/primary_care_networks_briefing_for_vcse_26_02.pdf

whether there are relationships to be built upon. This indicates that more focus on engaging with the voluntary sector is needed to support the delivery of the long-term plan.

Level of engagement	Number of PCNs (n=22)
Engaged	12
Not engaged	3
Variable engagement	3
No response	1
Don't know	3

“We have a strong network of private and charitable organisations that complement the statutory services. Our local population benefits from a befriending service, advice for pensions and benefits and access to community transport groups. Our care navigators and social prescribers are well placed to support service users to access these services and provide additional support.”

g. Screening and sharing of frailty information – Primary Care

Capturing of frailty information at a primary care level is important¹⁴, to ensure that patients receive the right level of care in the right setting to meet their need.

The electronic frailty index (e-FI) is a risk stratification tool and needs to be supplemented with a further frailty screening tool to optimise identification of screening of different levels of frailty.¹⁵

The audit asked respondents whether:

- The local e-FI score is validated alongside another screening tool
- The information is accessible to other organisations
- Patients and carers have access to their information.

Highlights	Opportunities
45.5% (10) PCN primary care services validate their e-FI score with another frailty scoring tool.	3 PCN primary care services did not know how often they screen for frailty
9 out of the 10 PCN Primary Care Services use Rockwood Clinical Frailty Score to validate their e-FI score	6 PCNs primary care services do not know if they share their primary care frailty identification information is accessible to other organisations
Within primary care 15 of the PCNs stated that a e-FI frailty score is obtained always or most of the times.	14 PCNs primary care services provide access to frailty information to patients and carers
One PCN uses Edmonton, Frailty Syndromes and an other locally developed frailty tool to validate the e-FI score	

¹⁴ <https://ihub.scot/improvement-programmes/living-well-in-communities/electronic-frailty-index-efi/>

¹⁵ <https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/>

The above table illustrates that 15 PCNs (68% of participating PCNs) obtain an e-FI score always or most of the time, with 10 PCN validating their e-FI score, 9 of which use the Rockwood Clinical Frailty Score. There were also examples given of innovative approaches to screening, comprehensive geriatric assessment¹⁶ (CGA) and sharing the information across the system:

“We undertake monthly risk profiling via our Integrated Care Hub (Community services). We look for patients with a rising eFI. These patients are reviewed and shared with primary care partners. Patients with unmet needs are discussed at our MDT. Primary care considers frailty coding if appropriate. We also undertake monthly searches to identify newly coded patients with moderate frailty; patient names are given to frailty teams for consideration of CGA (limited by capacity and enhanced frailty specifically targeting moderate frailty) and Community services will flag patients with frailty on discharge to primary care.”

This demonstrates an awareness of the e-FI tool being a population stratification tool and the need to validate other frailty scoring tools. 6 PCNs did not know if their primary care frailty identification information is accessible to other organisations.

Another PCN, demonstrated a simple, but impactful innovative approach¹⁷:

“We send out birthday cards at 75yrs which incorporate questions which enable us to do an Edmonton score.”

Points for consideration:

- Additional support that may be needed for the other PCNs in developing a standard screening approach includes the promotion of:
 - Validating local information with a recognised frailty tool
 - Ensuring that an e-FI score is obtained for all patients
 - Clarification with wider partners on how frailty information is shared across and between organisations, linking in with the wider sustainability transformation partnerships (STPs) to develop solutions
 - Consistency of access to frailty information for patients and carers across the PCN network.

h. Frailty knowledge, skills and training (Primary Care)

Questions 11 to 14 focus on frailty related knowledge, skills, and training. To, “deliver high quality care and services effective and efficiently to older people, health care professionals need to understand the best principles of care for the older population to detect frailty and provide treatment and interventions”¹⁸. The questions asked within the audit, for relevant PCN staff related to:

- Frailty awareness
- Developing and discussing anticipatory care plans with people living with frailty (including the development of end of life planning¹⁹ and wellness plans)
- Anticipatory care planning²⁰

¹⁶ A Comprehensive Geriatric Assessment (CGA) is a process of care comprising a number of steps. Initially, a multidimensional holistic assessment of an older person considers health and wellbeing and leads to the formulation of a plan to address issues which are of concern to the older person (and their family and carers when relevant). (BGS 2019)

¹⁷ <https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/efs.pdf>

¹⁸ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6385767/>

¹⁹ <https://www.nhs.uk/conditions/end-of-life-care/>

²⁰ <https://www.nhsinform.scot/care-support-and-rights/palliative-care/planning-for-the-future/make-an-anticipatory-care-plan>

- Health behaviour change approach training e.g. Making every contact count (MECC)²¹, health coaching²², motivational interviewing²³ and communication approaches
- Capacity/best interest decisions²⁴.

Highlights	Opportunities
50% of primary care (all/most) staff within the PCN have received relevant frailty training	9.1% of PCNs provide frailty awareness training to the voluntary sector (63.6% responded they did not know)
50% of relevant staff within primary care have undertaken anticipatory care training (All/most categories)	27.3 % of relevant staff have received best interest training (All)

11 PCNs (50%) have received relevant frailty training²⁵ within primary care, with only 27.3% of staff having received best interest training, highlighting that there is a further need for PCNs to access frailty training for their teams. Only 9.1% of PCNs have provided frailty awareness training to the voluntary sector, so this is an area for service improvement. However, the voluntary sector could obtain access to locally and nationally developed materials from

- British Geriatrics Society <https://www.bgs.org.uk/policy-and-media/new-%E2%80%98one-stop-shop%E2%80%99-for-frailty>
- <https://www.frailtytoolkit.org/frailty360-intro/>
- Wessex AHSN <https://wessexahsn.org.uk/projects/315/wessex-acute-frailty-education-and-awareness>

Points for consideration:

The table above highlights the additional focus that may be needed in supporting PCNs accessing:

- Frailty awareness training, with particular focus on providing training to the voluntary sector
- Anticipatory care planning training
- Best Interest training.

i. Current frailty processes

The Long-Term Plan describes the importance of integrated care services to bring together health and social care organisations to ensure patients are at the heart of the pathway²⁶ Questions, 16 -20 looked to identify integration and accessibility issues to key frailty related services from a primary care perspective.

“Integration of the community and primary care teams has been a revelation as all the pieces of the jigsaw have fitted together re proactive and reactive care of frail pts. Also ensuring there is equal service across the PCN was vital. Communication and job satisfaction amongst the teams has improved as they are all supporting each other and are aware of what their roles are within the team but also flexible.”

²¹ <https://stpsupport.nice.org.uk/mecc/index.html>

²² <https://www.england.nhs.uk/personalisedcare/supported-self-management/approaches/>

²³ <https://www.rcn.org.uk/clinical-topics/supporting-behaviour-change/motivational-interviewing>

²⁴ <https://www.scie.org.uk/mca/practice/best-interests>

²⁵ Relevant frailty training in this context relates to appropriate training for staff group

²⁶ <https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/nhs-organisations-focus-on-population-health/>

“Our team is going live this month to provide an equal service across the network whereas prior there had been huge differences in the level of the service. Our primary care frailty teams (ANP, Senior nurses, HCAs, admin) are working closely with the local community CRT and community matrons to provide proactive care (care plans, identifying area of need etc) as well as reactive care increased input of care at home if deterioration or acute problem to prevent hospital admission where possible etc.”

Highlights	Opportunities
40.9 (9) % of PCNs have a integrated care pathway with 14% of PCNs stating they have separate pathways	36 % (8) have access to a Specialist Frailty Practitioner
45.5% (10) of PCNs have access to Community Frailty Team services and 50% (11) to a Community Geriatrician	50% (11) of PCNs have access to Community Geriatrician services
54.5% (12 PCNs) have access to continence services	36 % (8) have access to social care services
54.5% (12)of PCNs have access to same day emergency care services living at home	36% (8) of PCNs have access to GP practice pharmacist review services
63.6% (14) have access to step up beds (with the majority of PCNs being able to access)	41% (9) have access to patient support and information services

Only 40.9% of PCNs have an integrated pathway and not all have access to Community Frailty teams and community geriatricians. 14% of PCNs have separate pathways illustrating a level of inequity within care provision.

Only 36% of PCNs have access to a specialist frailty practitioner, with 45.5% of responding PCNs not having access to same day emergency care services at home.

Points for consideration:

The table and Appendix highlight the huge variability and issues across PCNs in the services that can be accessed. Focus on improving access, capacity and coverage in the following areas is paramount in developing integrated services:

- Accessing social care
- Pharmacist reviews
- Patient support and information services.

10 Multi-disciplinary team interactions – Primary Care

It is estimated that 12% of people aged 65 or over are living with moderate frailty. Key aims for this group are to provide integrated multidisciplinary teams (MDT) to support people in rehabilitation and reablement and prevent further progression of their frailty.²⁷²⁸

Questions 21-25 posed in the audit identified the frequency of the MDTs, key stakeholders and whether information was shared with the wider system.

Highlights	Opportunities
95.5% of PCNs have an opportunity to discuss people living with frailty within an MDT meeting	59.1% of MDTs take place on a monthly basis (36.4% weekly)
18 PCNs record the actions of the MDT in the patients notes 15 PCNs sharing information with other health and social care organisations	Examples of wider MDT attendees –Acute Geriatrician Consultant, MDT facilitators, Care Navigators and Palliative Care – attendees not consistent across every PCN
59% share the MDT outcomes and actions with the patients/carers	

From the audit it was evident that:

- The majority of PCNs carry out an MDT and record the actions within the patients notes
- Not all PCNs share primary care information with other health and social care organisations
- 59.1% of MDTs take place on a monthly basis, with one PCN responding, “I would prefer we held weekly MDT meetings rather than monthly meetings to ensure we are responsive to our patients’ needs.”

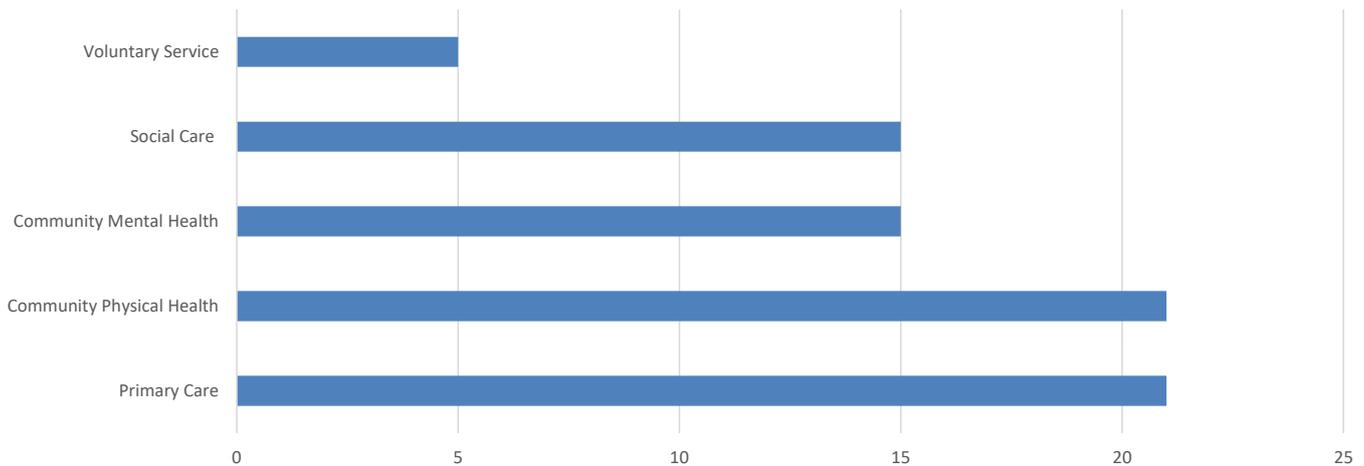
The graph below also illustrates the variability of health and social care representatives attending the MDT across Wessex. All PCNs have a primary care and community physical health representative, but only 5 PCNs reported having a representative from the voluntary service.

“We as a PCN would like to mould the MDT meeting process to better suit the geographic footprint of the PCN and to include PCN allied employees such as the Social Prescriber, Pharmacist, Physicians Associate etc. More time needs to be allocated in relation to PCN size. If we are to persist by utilizing remote login then we must ensure that the technology and set up of the meeting works well. Good meetings are ones where we can see and hear each other adequately which currently is not happening.”

²⁷ <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf>

²⁸ <https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf>

Who attends the MDT discussion (face to face or virtually)



“Social care workers are present at our monthly meetings, but we cannot access any of their records and otherwise there is little communication- this is a source of great frustration. Am aware that we need to work more closely with our teams and the social care service and planning to develop this.”

“We have a dedicated proactive care lead who works up cases to be discussed in our weekly Anticipatory Intervention Meeting, which is multidisciplinary and includes input from a geriatrician.”

Points for consideration:

- Ensuring virtual working and technology is enhanced to deliver exemplar MDTs
- Is MDT information shared with other health and social care organisations?
- Both the patient, their family/carers are included in MDT discussions
- Standardisation of who attends MDT sessions, including identifying key representatives from health, social care and voluntary care.

11. Feedback to the Wessex System

Each participating PCN received a copy of their data alongside a summary of the overall findings and a summary copy was made available to all PCNs in the Wessex AHSN network.

Following the audit, a workshop was held and led by the Wessex AHSN Healthy Ageing Programme on 13 February 2020 to present the key findings. The workshop provided an opportunity for the data from the audit

- To be shared with frailty experts and key decision makers from across Wessex
- To demonstrate the added depth and value the local audit provided
- To enable local organisational planning and the identification of service improvement projects to be identified to improve the quality of care of patients living with frailty within the community.

The AHSN welcomed Dr David Atwood²⁹ as their keynote speaker sharing his approach in “developing a case for population health management for older people: how joined up working can deliver the triple win of improved care, reduced demand and cost savings.”

Over 40 colleagues were in attendance, including NHS Benchmarking, frailty clinicians and senior executives from participant organisations and system leaders. Post event, NHS Benchmarking³⁰ included some key questions from the Wessex Community Frailty Audit into the national Community Services annual return demonstrating the portability of translating the audit questions nationally.

The workshop focused on addressing the following three questions, using the audit responses as a basis of discussion. Each group was facilitated by one of the project team.

- **What are PCNs doing well to support the frailty agenda?**
- **From the audit data, what are the opportunities across Wessex to support PCNs to deliver the frailty agenda?**
- **How can we foster joint working between acute, social care, community, and voluntary services and PCNs?**

During the event, it was evident that the following aspects needed to be considered as a system to ensure the frailty aspects of the NHS Long Term plan are implemented. To summarise there is a need, to:

- Develop professional networks to ensure that the patients’ needs are at the centre of service development
- Develop a forum to hear and consider patients and carers voices
- Frameworks for delivering MDT meetings, enabling attendance from colleagues across the system and organisational boundaries
- Communication between acute, primary and community teams is a confounding factor in delivering patient-centred care, shared information is key in expediting the care of individuals living with frailty, but sharing records and information across multi-professional organisations remains a logistical challenge to be resolved collaboratively
- A clear desire to simplify the process, removing of traditional barriers to ensure a responsive and joined up response should be built upon.

Output and resources from the event can be found at <https://wessexahsn.org.uk/projects/317/wessex-community-frailty-audit>

A 6-month review event had been planned for September 2020 to review resultant projects from the audit, but due to the onset of Covid-19 this has been put on hold.

12. Lessons learnt from the Community Frailty Audit

- a. PCNs are at varying stages of readiness and engagement in delivering the NHS Long Term Plan. ***Progress has been made since the onset of the Covid-19 pandemic to expedite virtual delivery of integrated services but these need to be aligned to longer term organisational strategies. PCNs still remain at different levels of maturity***
- b. The audit was run at the same time PCNs were being asked to submit plans to CCGs as part of the Long-Term Plan mandate which resulted in an overburdening of requests. ***In collaboration with CCGs, when re-running the audit, clarity from CCG leads will be sought in understanding wider***

²⁹ (GP Partner and GP with Special Interest in Older People at Pathfields Medical Group/Clinical Lead for Integrated Care of Older People, Devon and Honorary Secretary for the British Geriatrics Society

³⁰ <https://www.nhsbenchmarking.nhs.uk/projects/community-service>

system pressures and to link in with existing communication streams to elevate administrative burden

- c. CCGs were still in the early stages of working with PCNs to identify the themes that they wished to work on, not all PCNs are focusing on frailty as a theme which created challenges in collecting audit information as well as missed opportunities. ***When re-running the audit, collaboration with CCG leads will ensure that PCNs working on the frailty agenda are included in the audit***
- d. There are a lot of complexities in how different services are delivered, interact and integrate within the community setting. Delivering the audit at PCN level seemed to be the best fit in terms of strategic vision and understanding the scope of delivering the Long-Term Plan. Running the audit, it became apparent that within a PCN setting, not one stakeholder group could respond to all the posed questions, so a more collaborative approach is needed. ***Development of a framework to guide colleagues in completing the audit will ensure consistency of approach***
- e. Engagement across local CCGs and PCNs was challenging due to the changing health landscape. ***If the audit was to be re-run, we would undertake a more detailed stakeholder mapping exercise and adapt our approach with engaging with connectors at all levels within the system MDT colleagues/and PCNs to improve the uptake of the audit***
- f. Due to the onset of Covid-19 the trainee frailty consultant QI projects did not progress as hoped as colleagues were redeployed to support the pandemic. The trainees have moved onto new rotational posts. ***The planned QI projects need to be reviewed to understand whether there the projects can be resurrected within the planned localities***
- g. Post Covid-19, there are new emerging post Covid frailty questions that need to be captured. ***The audit will need to include questions relating to the impact of increased use of technology/remote working/blended care approaches on delivery of frailty services as a result of Covid-19.***

13. Recommendations and next steps:

1. Improvement areas/projects

- i. Development of an MDT best practice standard approach for use across Wessex
- ii. Identification of exemplar PCNs delivering integrated care across all settings
- iii. The key area of focus moving forward is to ensure that all community colleagues undertake frailty awareness training and utilise the education materials developed as part of the Wessex Acute Frailty Audit.

2. Modification of the audit questions and approach

- i. Review of audit questions to identify questions to be removed/modified.
Whilst the final analysis utilised all of the data collected, some questions did not provide any added value to the baseline questions.

3. Plans to rerun/progress

- i. Support from Trust Executives, STPs, and Health Education England will be sought to deliver these objectives as and when required by the working groups
- ii. Undertake a frailty services review as appropriate in 2022.

14. What did the Wessex Community Frailty Audit add to local and national knowledge?

- Provided an evidence base to the complexities of community frailty care and provision
- Provided a context for PCN readiness to deliver the frailty aspects of the long-term plan

- Provided insight into how different geographies in Wessex are delivering/planning to deliver frailty-related care, highlighting examples of best practice
- Provided reassurance that MDTs are carried out, but they are delivered differently across Wessex
- Provided an opportunity for system leaders and PCN leads to discuss emerging variability across key frailty development areas
- We assumed that PCNs would have access to information relating to social care, community health and mental health service provision; the audit provided evidence that this was not the case. This will help inform future audit approaches.

15. Acknowledgements

The Healthy Ageing Programme would like to acknowledge the support, drive and enthusiasm by the core working group in developing this innovative audit:

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<https://wessexahsn.org.uk/programmes/35/healthy-ageing>

Version Control

Version	Date	Author	Comment
V0.1	23/7/2020	Cheryl Davies	
V0.2	31/7/2020	Marianne Plater	Review and feedback
V0.3	7/8/2020	Euan Sadler Kathy Wallis Kathleen McCulloch	Review and feedback Proof read

Appendix A

Consultant Community Geriatricians	Falls service	Social care	Continence Service	Community Frailty Teams	GP Pharmacist
We have a named geriatrician but not easily accessible or visible	Slow response times	Response times tend to be slow and referral processes can be tortuous but our H&SC coordinator is skilled at navigating this route.	Very limited capacity	Rehabilitation capacity an issue	GP Pharmacist is to support all patient groups not just frailty – they are overwhelmed
Limited capacity and access	Limited capacity		Unacceptable waits	Funding streams target mild frailty	Does not cover whole PCN
Under review	Overwhelmed		Not frailty specific	Does not cover whole PCN	
	Unacceptable waits				

Resources:

Wessex Community Frailty Letter



wCFA letter kw
v0.2.docx

Wessex Community Frailty Audit Questions

<https://wessexahsn.org.uk/img/projects/Wessex%20Community%20Frailty%20Audit%20Questions.pdf>

Wessex Community Frailty Audit Summary Output

<https://wessexahsn.org.uk/img/projects/Wessex%20AHSN%20Healthy%20Ageing%20Community%20Frailty%20Data%20High%20Level%20Feb%202020.pdf>

Wessex Community Frailty Event Resources

<https://wessexahsn.org.uk/img/projects/WAHSN%20Healthy%20Ageing%20Community%20Frailty%20PCN%20Audit%20Event%2013.02.20%20Complete%20Set.pdf>

<https://wessexahsn.org.uk/videos/show/355>

Wessex Community Frailty Fishbone diagram – barriers to integration

<https://wessexahsn.org.uk/img/projects/Wessex%20Community%20Frailty%20Audit%20Fishbone%20Diagram.pdf>

Wessex Community Frailty Workshop theme summary

<https://wessexahsn.org.uk/img/projects/PCN%20themes%20from%20event.docx>

Wessex Community Frailty QI projects

<https://wessexahsn.org.uk/img/projects/Vale%20PCN%20poster%20for%20AHSN.pdf>