Wessex Community Frailty Audit PCN Workshop: Welcome

Kathy Wallis
Associate Director, Healthy Ageing and Medicines Optimisation

13th February 2020
Housekeeping

@WessexAgeing
#WessexFrailtyFit
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>9.30</td>
<td>Welcome and setting the scene</td>
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<tr>
<td></td>
<td>The challenges and solutions to frailty identification and population health management</td>
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<td>Audit approach, findings, and emerging themes</td>
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<tr>
<td>11.30</td>
<td>‘What matters to you’: a PCN example</td>
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<tr>
<td>13.15</td>
<td>Workshop 1: what are PCNs doing well to support the frailty agenda?</td>
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<td>Workshop 2: what are the opportunities are there from across Wessex to support PCNs deliver the frailty agenda?</td>
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<td>Workshop 3: How can we foster joint working across services?</td>
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<td>Quality Improvement Projects: PCN, HEE, and Wessex AHSN</td>
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<td>Wessex AHSN Healthy Ageing and PCN Collaborative</td>
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<td>16.00</td>
<td>Close</td>
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</table>
Background

2 x Wessex-wide service improvement projects: training and awareness materials; screening and identification gold standards.

Local trust frailty improvement plans
Wessex wide approach

- Wessex Acute Frailty Audit
- Wessex Community Frailty Audit
- Local Improvement Plans and Wessex-wide Service Improvement
- Improve quality of care for people living with frailty across Wessex
- To provide a forum for PCN Clinical Directors, frailty leads, service managers and CCG and STP leads to review overarching themes from the Wessex Community frailty audit

- To identify opportunities improving the care of people living with frailty in the community across Wessex

- To promote open and transparent dialogue and networking, including sharing good practice, between the community frailty cohort

- To ensure that this work is locally recognised and is on the national radar in terms of influencing national policy streams concerning the management of frailty

- To agree next steps with the project – QI/PCN Collaborative approach
Wessex Community Frailty Audit PCN Workshop:

Marianne Plater
Consultant Community Geriatrician – Southern Health

13th February 2020
What is the definition of frailty?

- Multiple causes

  - Strength and endurance
  - Physiological function

  ——

  Vulnerability to dependency
  Death

Potentially reversible
Functional decline

- Independent
- Friends & Family
- Social Services
- GP
- Hospital

Function:
- Mild
- Moderate
- Severe

Acute decompensation
Intervention: A complex practice

- **Accurate assessment**: medical, physical /functional, psychological and social should (equally weighted)

- **Optimise**:
  1. Diagnose treat and prevent where possible
  2. Remove what is not helping e.g. deprescribing
  3. Understand the person to help them engage
  4. Consider their capacity to make risky decisions

- **Prognosis**: what next? How do we manage it?

- **Review/escalate**
Paradigm Shift in Clinical Practice

People living with

- Frailty
- Long term conditions
- Falls
- Mental Health Disorders
- Living in care homes

Complex practice by Doctors/Nurses/Therapists/Social Workers

Discreet services

- End of Life Care
- Palliative Care
- Anticipatory Care Planning
- Deprescribing
- Care Home residents
- District Nursing
- Frailty Services
- Rehabilitation
- Falls Service
- Acute Admissions
- Mental Health
- Specialist services
- Acute Geriatrics
- Community Geriatrics
- Voluntary services
- Fire Service
- Social services
Example 1: Falls – how can we shift our approach?

Alternative = Diagnose the iceberg

- Sarcopenia – Nutrition
- Depression / Malignancy / Dementia
- FOF / Anxiety

Bespoke Plan

Anxiety Mx, social engagement, SSRI, support with food

Review and Adapt

Same people – Paradigm shift in Practice – different outcome
Severe Dementia
COPD
Recent admission (fall / fractured wrist)

Recent GP visit due to infection of lungs
EOL plan not previously discussed

Confirm Diagnosis
Discuss possible treatment options
Collectively decide on ceiling of care

Benefits of admission were reduced due to her agitation and non-compliance

Treatment at home
IM Ceftriaxone
SC fluids
Chest physio
Support from ANP
Pressure relief equipment
JIC meds
HCSW

Patient survived this episode...

A few months later the GP took the same approach and the patient died peacefully at home

Increasing confidence / peer support
Barriers

• Time/continuity of clinician
• Headspace
• Skill and knowledge
• Lack of outcomes (knowledge data)
• Practitioner Confidence
• Leadership
  a) Understanding need to alter professional behaviour at scale
  b) System change – what is required?
  c) Chunking - to make it manageable

Maya Dirado  https://www.youtube.com/embed/iMA3tp0hCKM
Whole System Change:
manageable chunks to promote change in individual practice

Leadership (Q1, Q2, Q3) PCN / Voluntary sector / Local Authority
Mapped System (Q4)
Integrated Pathway (Q16, Q17)
Access to individual services required for complex practice (Q18)
Access to Crisis Management Services (Q19, Q20)
Screening and Sharing (Q9, Q10)
Training (Q11, Q12)
Training on skills required for complex practice (Q12 – Q14)
MDT – quality / efficacy (Q21 – Q24)
“It's impossible for certainty and curiosity to exist in the same moment. To discover new things, let go of the known and be open to every possibility.”
Developing the 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

Dr David Attwood
GP Partner and GPwSI Older People at Pathfields Medical Group
Clinical Lead for Integrated Care of Older People, Devon
Outcomes

• What is frailty
• Why does it matter?
• Population health management of frailty
• Low cost options for mass producing CGAs across providers
• How to go about doing it (IG, IT, info sharing etc)
What is frailty?

“A STATE OF REDUCED PHYSIOLOGICAL RESERVE WHERE SEEMINGLY TRIVIAL STRESSORS TRIGGER A DRAMATIC DETERIORATION IN FUNCTION.”
What is frailty?
Frailty syndromes

- Recurrent falls
- New/worsening immobility
- New/worsening incontinence
- New/worsening confusion
- Susceptibility to side effects of multiple medications
Simplifying frailty diagnosis

- Do they exist in a state of reduced physiological reserve (strongly suggested by a frailty syndrome)?
- Where are they on the frailty spectrum?
Why is it important?

Two-thirds of hospital bed days are for patients over 65 with a quarter for patients over 80.
Frailty: why is it important?

• 12 million older people in UK
• We have 22.5% frailty prevalence
• Equates to 2.7 million older people with frailty
• Number of older people increasing
• Number of unplanned admissions rising by 3.2%/year

**BOTTOM LINE:** WE CAN’T AFFORD TO KEEP DOING MORE OF THE SAME
New tactics: population health management

**IDENTIFICATION**

- Severe frailty
- Moderate frailty
- Mild frailty
- Fit and well

**MANAGEMENT**

- Proactive AND urgent CGA
- Urgent CGAs require early in day response
- Minimise the time spent developing hospital associated morbidity
- Social prescriber referral?
- Physical exercise
- Public Health

**Proactive**

**Urgent**

**CGA**

**CGAs**

**require**

**early in day**

**response**

**Minimise**

**the time**

**spent**

**developing**

**hospital**

**associated**

**morbidity**

**Social prescriber**

**referral?**

**Physical exercise**

**Public Health**
Severe frailty (n=252)

Moderate frailty (n=403)

Mild frailty (n=369)

Fit and well (n=3528)
The Cost of the Real Population Pyramid in Pathfields Primary Care Network (32,000 patients)

Based on NHSE data broken down by frailty severity:
- Fit and well = £1,237/yr
- Mild frailty = £2,808/yr
- Moderate frailty = £4,461/yr
- Severe frailty = £6,955/yr
Living in Care home

Older people who leave their house

Older people who do not leave their house

Severe frailty

Moderate frailty

Mild frailty

Fit and well

(continues same length either side of diagram)
New tactics 1: Population health management

**IDENTIFICATION**
- Severe frailty
  - Living at home
  - Living in Care home
- Moderate frailty
  - Living at home
  - Living in Care home
- Mild frailty
  - Living at home
- Fit and well

**MANAGEMENT**
- Proactive AND urgent CGA
- Urgent CGAs require early in day response
- Minimise the time spent developing hospital associated morbidity
- Social prescriber referral?
- Physical exercise
- Public Health

(continues same length either side of diagram)
New tactics 2: Joining up work - the role of shared IT

Output:
Care and support plan shared with patient and out of hours providers (GP and ambulance)

QOF
Annual meds review
Hospital admission

CGA
Holistic Medical Review
• Review of LTC’s
• Medications review and de-prescribing
• Advanced care planning
• Patient goals

Assessment of function
• Mood and cognition
• Social situation
• Mobility and falls
• ADL’s
• Skin
• Hearing
• Vision
• Nutrition
• Continence

DN’s
Admission documents
Social care
Community providers
Engaging stakeholders ....

Consent for data sharing?
Principles of GDPR and information sharing
## Glossary of terms

<table>
<thead>
<tr>
<th>GDPR language</th>
<th>Lay person language</th>
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<tbody>
<tr>
<td>Data controller</td>
<td>Someone who has control of a patient’s data and determines how/who it will be shared with. Livewell, GP surgeries UHP etc all DC’s</td>
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<tr>
<td>Processing data</td>
<td>obtaining, recording, sharing, holding patient data</td>
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GDPR

• Much tighter list of conditions to satisfy for legally valid consent

• Article 9: processing of all patient data is strictly prohibited...
...unless it is for the provision of health and social care

section 9(2)(h)

“(h) processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services...”

GDPR
“Do not use consent as a condition for processing to meet GDPR/DPA requirements, unless in exceptional circumstances. The most appropriate basis for lawful processing that is available to publicly funded and/or statutory health and social care organisations in the delivery of their functions is Article 6(1)(e) and Article 9(2)(h) special category data.”
Translation

“Do not use consent as a condition for processing to meet GDPR/DPA requirements, unless in exceptional circumstances. The most appropriate basis for lawful processing that is available to publicly funded and/or statutory health and social care organisations in the delivery of their functions is Article 6(1)(e) and Article 9(2)(h) special category data....”
BUT…

• To comply with GDPR, if you are ever thinking about sharing information your need to do the following:
  – Only relevant data shared - Role Based Access
  – A Data Protection Impact Assessment (DPIA)
  – Patients still need to have the right to opt out
  – A Privacy Notice
  – Record of processing activities
What does a DPIA look like?

- 6-8 page document
- Basically a risk assessment
- Needs DPO sign off
The privacy notice

• Needs to be in a language understandable to patients

• Explains how their data is shared and with whom

• Offers them how to opt out and contact details

• Needs to be “easily available to the public”

  – On the website and on posters in waiting room (NHSE clarified this as a minimum requirement)
A note from Dr. Paul Cundy (BMA GP IT policy lead) on data protection officers (DPO)

• DPOs advise us data controllers on IG/GDPR

• Provide advice, when requested

• Needed whenever undertaking a DPIA

• Anyone can be a DPO… GDPR says they should have “the necessary level of expert knowledge……”

• DPOs are in advisory role only. You can go against the advice of your DPO but you’d better have a good reason!

• Liability for breaches lies with the data controller, not the DPO
The future: IG framework for an integrated local health and care record?
## Appendix H – Supporting Tools and Templates (Information Governance Framework v0.10)

Please find below links to national and statutory guidance, tools and templates (both national and local examples) which are presented in the table below. These are aligned to the content of the framework. This is not an exhaustive list however, it is provided as a resource to support LHCRs meet these requirements.

### How to use
The table should be read across from left to right (items within the same row relate to the same requirement).

<table>
<thead>
<tr>
<th><strong>Section 2.1 Secondary Use Data Governance Tool (SUDOT)</strong></th>
<th><strong>Requirement</strong></th>
<th><strong>National / Statutory Guidance</strong></th>
<th><strong>Other Tools</strong></th>
<th><strong>Local Examples</strong></th>
</tr>
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<tbody>
<tr>
<td>The SUDOT is being developed by NHS England to implement robust governance processes to support the use of data for secondary purposes</td>
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### Section 4.1 The importance of Good Information Governance Practice for LHCRs

<table>
<thead>
<tr>
<th><strong>Requirement</strong></th>
<th><strong>National / Statutory Guidance</strong></th>
<th><strong>Other Tools</strong></th>
<th><strong>Local Examples</strong></th>
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<tbody>
<tr>
<td>Key requirements for Data Protection Officer responsibilities</td>
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<tr>
<td>4. Skills for Care - <a href="https://www.skillsforcare.org.uk/AboutUs/TrainingMessage/TrainingForTheData-Protection-Officer-and-Associate-Careworker">https://www.skillsforcare.org.uk/AboutUs/TrainingMessage/TrainingForTheData-Protection-Officer-and-Associate-Careworker</a></td>
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**Other Tools**


**Local Examples**

1. [One London South East London LHCG, The DPO Role Definition Summary](https://www.lhcr.org.uk/)
   - SEL DPO role
   - 2.0 April 2019 (See p 14)

- [Survey ISA](https://www.isa.org.uk/)
Engaging stakeholders ....

Consent for data sharing?

- Sharing is caring
- Implied consent? explicit consent?
- We have a lawful basis for processing...
- ...subject to certain conditions
Is there an IT system that is versatile enough to do this?
Proactive Review:

Please complete the following:

1. Patient Goals
2. LTC and deprescribing
3. ACP conversation
4. Functional Assessment
5. Consent for record sharing
6. Sharing the ACP

Important readcodes (tick a)
- Not for resuscitation
- Not for future hospital admissions (unless for comfort)
- Dementia advance care plan
- LPA for property and affairs
- Lasting power of attorney personal welfare

Other outcomes (Ongoing Episode)

Confirmation!

Admin have been sent a task to notify OOH, ambulance providers and send patient the care plan.

DON'T FORGET TO PREVIEW THE CARE PLAN AND SAVE IT TO RECORDS (otherwise they have nothing to send!)
More readcodes (evaluation)

Task sent to admin

Ambulance service notified of patient on EOL care register (XaZm)

Subject of comprehensive geriatric assessment plan (XaZi)

No problems linked to this section

Sharing ACP decisions with out of hours service (XaXz)

OOH providers (GP and ambulance teams) made aware of advanced care planning conversations.

Advance care plan sent to patient

No interventions recorded

Hey guys,
A few things to do:

1. Please attach the care plan saved in notes and send the following email to swasnt.clinical-alerts@nhs.net:

   Dear colleagues in Ambulance Services,
   This [insert patient's full name] [insert patient's full address] has an advanced care plan and TEP in place which can be found with the patient. Please find the care plan attached. Sadly we are not able to attach the TEP as it is with the patient but the decisions are captured in the care plan. Please read this before considering further treatment and admission and please do take both into hospital if the patient is going.
   
   Yours sincerely,
   The Pathfields Medical Group Care Home Team

2. Send the same care plan to the patient, ideally via email. Please include the message below as a cover letter for the care plan:

   Dear patient and carers,
This patient has had a Comprehensive Geriatric Assessment. They will almost certainly have a Care and Support Plan and a TEP.

If you are contemplating a hospital admission they must go in with this for continuity of care.

View now and print?

Special Notes:
Known to LTC Matrons 434332

09:30
24/10/2019
Horizon scanning for a versatile IT solution
Question 1:

Single point of information recording/access:
Put your hand down if your IT system *can’t* do the following:

• One point of access to PMHx, DHx, allergies and all clinic letters
• Record a patient encounter
• Prescribe medication
• Request tests eg pathology and radiology
Question 2:

Efficiency and speed:

Put your hand down if doing things on your IT system takes longer than doing it by hand.
Question 3:

Safety:

Put your hand down if your IT doesn’t warn you about contraindications, drug-drug interactions, and pre-existing allergies as you are about to prescribe.
Question 4:

Managing workflow/audit trails:

Put your hand down if your IT does not allow you to:

- Communicate with teams in other buildings/providers
- Assign workflow (good audit trail of communication)
Audit/QI work:

Put your hand down if your IT does not allow you to:

- Do population/hospital based reporting
Customisability:

Put your hand down if you can’t adapt your IT to augment your intelligence and bend it to your will.
Question 7:

Miscellaneous:

Put your hand down if your IT can't do the following:

1. Manage your rota
2. Book your follow up appointments
3. Process your tests and letters that you send/receive
4. Communicate with other provider organisations
Question 8:

Is your IT...

Primary care IT (EMIS, S1 etc)?
The story so far

- GDPR
- Population health management
- Buttressing a CGA onto current systems to save cost
- Emergency horizon scan
- What next
Creating and living the dream

• Identify a dynamic PCN and community provider to pilot this with
• Find a computer wizzard and manager to provide operational support
• Step 2: sort out the GDPR:
  – Privacy policies etc
• Step 3: fuse MDT from community provider with MDT in PCN and give them 6 months of headspace.
  Mission:
  1. Develop a single shared assessment document between PCN and MDT on a shared IT solution
  2. Deliver a shared CGA using an MDT approach
  3. Share the care and support plan with out of hour providers
Two final messages
A housebound 84 year old female with parkinsons, DLB and poor sleep is recently started on amitriptyline. She is a frequent faller.

She suffers a fall and 999’d into hospital with knee pain. Xray excludes knee injury. Started on cocodamol by ED and discharged to IC. Confused in aftermath (bloods/MSU/CT head NAD). On day of discharge the physio says “she remains a high falls risk but there is little that can be done.”

Medications: madopar TDS, quinine, aspirin 75mg, atorvastatin 20mg ON, ramipril 10mg OD, amlodipine 5mg OD, oxybutynin 5mg BD, amitriptyline 20mg ON, quetiapine 50mg

• Discuss the case and conduct a medications review
• What key components of the CGA are missing here?
• How can we ensure that all components of the CGA are done using a systematic technique in teams?
CGA checklist for MDT

- Comprehensive Geriatric Assessment (CGA)
  - Holistic Medical Review
    - Review of LTC’s
    - Medications review and de-prescribing
    - Advanced care planning
  - Assessment of function
    - Mood and cognition
    - Social situation
    - Mobility and falls
    - ADL’s
    - Skin
  - Consent for data sharing

- Output:
  - Care and support plan shared with patient, OOH, SWASFT

- 8 hours of career changing CPD points for operational leads
Message 2: For the commissioners

Ref: Final report on cost-effectiveness of models of care for Frailty, AdvantAGE, Managing frailty, Nov 2018

• Local leadership and partnership working are key to successful development. Give the team headspace, IT and management support and they will totally nail this!

• Only long term studies with integrated, cross-provider, person-centred care and a comprehensive analysis, achieved a positive outcome.

• In one example the positive outcomes appeared only after three years of implementation, with a reduction in functional decline and reduction in hospitalisation, all without any significant increase in cost for implementation.
Summary

It’s all about Population Health

Goal is happy healthy independent in dwelling of own choice NOT reduction in LOS

Components of CGA’s are already happening. Take advantage of this!

You have a lawful basis for sharing information under article 6 and 9 of GDPR as long as you hit the minimum criteria

Find an adaptable, versatile IT solution that can be shared across PCN and community providers

Checklist, headspace, bottom up, time and faith!
Questions?
Wessex AHSN Healthy Ageing Programme –

Emerging themes from the
Community Frailty Audit 2019

Cheryl Davies
Programme Manager Healthy Ageing Wessex AHSN

13th February 2020
National Context and Drivers: Why focus on frailty in the community?

• One audit for the whole system – acute + community = total picture

• The NHS Long Term Plan outlines several important changes to the way the NHS should work to support patients and their carers.

• Improving care for older people living with frailty or multiple long-term conditions is one of its priorities

• The plan recognises that services are not consistently joined-up or responsive to the needs of older people living with frailty with an overall aim to support people to age well and to stay independent at home for longer.

• We wanted to test what this looks like in Wessex... at Primary Care Network level (PCN)

• PCNs are the vehicle for the delivery of the frailty elements long term plan, keeping patients at home and independent for longer = good place to start and create a baseline
Wessex AHSN Community Frailty Audit 2019

• The Wessex Community Frailty audit was run during October 2019 and looked at the following themes at PCN level for Primary care, Community – Physical, Community – Mental Health and Social Care

  1. Screening and sharing of frailty information
  2. Frailty knowledge, skills and training
  3. Current frailty pathway processes
  4. Multi-disciplinary team interactions
  5. Service Improvement opportunities

• The results of the audit will be used to identify topics/areas/themes for Wessex wide and local service improvement projects support improvements in quality of care and experience for people living with frailty within the community.

• The audit has been developed by the Wessex Academic Health Science Network (AHSN) Healthy Ageing Programme and in collaboration with our Community and Primary Care Expert group which included representation from strategic and community frailty experts across Wessex.
Wessex AHSN Community Frailty Audit 2019 Caveats

• Data collected represents a snapshot in time and reflects the present baseline across the participating Primary Care Networks
• Small numbers may overinflate presented percentages
• Percentages have been rounded
• 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
<table>
<thead>
<tr>
<th>Timeline</th>
<th>Activity</th>
<th>Stakeholders</th>
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<tbody>
<tr>
<td>April 2019</td>
<td>Working group set up to design Community Frailty questions.</td>
<td>Representation from Consultant Geriatrician, GP Extensivist, Consultant Frailty Practitioners, Director of Transformation and the University of Southampton</td>
</tr>
<tr>
<td>May – August 2019</td>
<td>8 Plan Do Study Act Cycles to review and refine audit questions</td>
<td>Working group</td>
</tr>
<tr>
<td>Early September 2019</td>
<td>Engagement with STPs and CCGs – opening letter</td>
<td>STP and CCG leads</td>
</tr>
<tr>
<td>Late September 2019</td>
<td>Electronic trial of audit questions with 1 PCN</td>
<td>Frailty Lead for 1 PCN</td>
</tr>
<tr>
<td>October 2019</td>
<td>Audit open for completion across Wessex PCNs (28 questions)</td>
<td>PCN Clinical Directors/ PCN Frailty Leads</td>
</tr>
<tr>
<td>November – December 2019</td>
<td>Analysis of Wessex AHSN Healthy Ageing Community Frailty audit</td>
<td>Centre for Implementation Science</td>
</tr>
<tr>
<td>February 2020</td>
<td>Wessex AHSN Healthy Ageing Community Frailty PCN workshop</td>
<td>Community Geriatricians, CCG leads, PCN Clinical Directors, PCN Frailty Leads and members of integrated teams</td>
</tr>
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Focus of the community audit questions

28 questions include the following themes:

1. Screening and sharing of frailty information
2. Frailty knowledge, skills and training
3. Current frailty pathway processes
4. Multi-disciplinary team interactions
5. Service Improvement opportunities
High level Summary

• Baseline for opportunities for improvement, not mapped to PCN maturity
• 22 PCNs took part in the audit (32% rate/ 69 PCNs across Wessex)
• Good uptake of the audit despite other competing priorities
• 70% of audits completed by PCN Clinical Director
• 45.5% of PCNs have a frailty lead for developing services for people living with frailty
• 81.8% have considered the needs of people living with frailty and how it relates to current frailty service provision
How engaged is your local authority with your PCN?

<table>
<thead>
<tr>
<th>Level of engagement</th>
<th>Number of PCNs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged</td>
<td>9</td>
</tr>
<tr>
<td>Not engaged</td>
<td>9</td>
</tr>
<tr>
<td>Variable engagement</td>
<td>2</td>
</tr>
<tr>
<td>In development</td>
<td>1</td>
</tr>
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Actively decompensating people can receive urgent reablement care packages to address their social needs whilst our Frailty support team support their clinical needs – the two services work seamlessly to provide support.

A partnership and steering group was formed in July 2019 and will be meeting in November 2019. This brings together the local authority, District Authority, Clinical Commissioning Group, Primary Care Network and other services.
How are voluntary services engaged with your PCN?

<table>
<thead>
<tr>
<th>Level of engagement</th>
<th>Number of PCNs (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaged</td>
<td>12</td>
</tr>
<tr>
<td>Not engaged</td>
<td>3</td>
</tr>
<tr>
<td>Variable engagement</td>
<td>3</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
</tr>
</tbody>
</table>

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

Limited links with third sector; accessed on an ad hoc basis related to patient need rather than frailty need.
Screening and sharing of frailty information

• The audit asked respondents to answer the same set of questions posed for Primary Care for the following services:
  
  • Community – Physical Health
  • Community – Mental Health &
  • Social Care

• Following the audit, we recognise that PCNs will not have access to this level of detail.

• The key area of focus moving forward is to understand how information is shared across organisations.
## Emerging themes (1)

### 1. Screening and sharing of frailty information – Primary Care

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

Recognising frailty at an early stage is essential to provide appropriate care for the patient and can help prevent hospital admissions. Questions on the management of frailty were added to the CICT module this year.

50% of Community Integrated Care Teams screen for frailty regularly when a person is referred. Where screening for frailty takes place, the most commonly used tool is the Rockwood Clinical Frailty Scale used by 82% of teams. 18% of teams screen for frailty using a locally agreed frailty tool.

Do you use the electronic frailty index (eFI) obtainable via primary care health records to obtain registers of people identified as frail?

- 25%
- 75%

Does the CICT routinely screen for frailty when a person is referred to the CICT?

- 50%
- 50%
10. Innovative ways of screening for frailty*

- Baseline screening for frailty undertaken to ensure original cohort identified (at start of Frailty core contract)
- Monthly risk profiling via Integrated Care Hub (community services) - looking for patients with rising EFI (a surrogate marker for deteriorating frailty or newly developing frailty) - these patients are reviewed and shared with primary care. Patients with unmet needs are discussed at MDT. Primary care to consider frailty coding if appropriate. Monthly searches to identify newly coded patients with moderate frailty - names given to frailty teams for consideration of CGA (limited by capacity and enhanced frailty specifically targeting moderate frailty) Community services will flag patients with frailty on discharge to primary care.

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

- Our ICPCS 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. Social care workers are present at our monthly VW 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.

* further examples available on request
Frailty Knowledge, Skills and Training

• The audit asked respondents to answer the same set of questions posed for Primary Care for the following services:
  • Community – Physical Health
  • Community – Mental Health &
  • Social Care

• Following the audit, we recognise that PCNs will not have access to this level of detail.

• 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.
## Emerging themes (2)

### 2. Frailty knowledge, skills and training (Primary Care)

<table>
<thead>
<tr>
<th>Highlights</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>50% of primary care (all/most) staff within the PCN have received relevant frailty training</td>
<td>9.1% of PCNs provide frailty awareness training to the voluntary sector (63.6% responded they did not know)</td>
</tr>
<tr>
<td>50% of relevant staff within primary care have undertaken anticipatory care training (All/most categories)</td>
<td>27.3 % of relevant staff have received best interest training (All)</td>
</tr>
</tbody>
</table>
Emerging themes (3)

3. Current frailty pathway processes: *

* Option for PCNs to bypass question where appropriate

<table>
<thead>
<tr>
<th>Highlights</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.9% of PCNs have an integrated care pathway with 14% of PCNs stating they have separate pathways</td>
<td>36% have access to a Specialist Frailty Practitioner</td>
</tr>
<tr>
<td>45.5% of PCNs have access to Community Frailty Team services and 50% to a community Geriatrician</td>
<td>50% of PCNs have access to Community Geriatrician services</td>
</tr>
<tr>
<td>12 PCNs have access to continence services</td>
<td>36% have access to social care services</td>
</tr>
<tr>
<td>54.5% of PCNs have access to same day emergency care services living at home</td>
<td>36% of PCNs have access to GP practice pharmacist review services*</td>
</tr>
<tr>
<td>63.6% have access to step up beds (with the majority of PCNs being able to access)</td>
<td>41% have access to patient support and information services</td>
</tr>
</tbody>
</table>
### Issues identified accessing services

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

Limited capacity and access refers to the limited availability of resources and access to services for patients with frailty. The response times are slow, and the referral processes can be complex. The Community Frailty Teams are overwhelmed due to the significant demand for services. The GP Pharmacist is responsible for supporting all patient groups, not just those who are frail, indicating an additional strain on their capacity. The funding streams are targeted at mild frailty and do not cover the entire Primary Care Network (PCN).
Emerging themes (4)

4. Multi-disciplinary team interactions – Primary Care

<table>
<thead>
<tr>
<th>Highlights</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.5% of PCNs have an opportunity to discuss people living with frailty within an MDT meeting</td>
<td>59.1% of MDTs take place on a monthly basis (36.4% weekly)</td>
</tr>
<tr>
<td>18 PCNs record the actions of the MDT in the patients notes</td>
<td>Examples of wider MDT attendees – Acute Geriatrician Consultant, MDT facilitators, Care Navigators and Palliative Care – attendees not consistent across every PCN</td>
</tr>
<tr>
<td>15 PCNs sharing information with other health and social care organisations</td>
<td></td>
</tr>
<tr>
<td>59% share the MDT outcomes and actions with the patients/carers</td>
<td></td>
</tr>
</tbody>
</table>
Emerging themes (4)

4. Multi-disciplinary team interactions (continued)

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

- Voluntary Service
- Social Care
- Community Mental Health
- Community Physical Health
- Primary Care
Examples of good practice and innovation of sharing information

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

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.

Our ICPCS 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.
## PCN Service Improvement Opportunities

### Development of professional networks
- Interfacing with Social Care
- Voluntary sector involvement - Consistency/ availability/ accessibility
- Frailty specific services / geriatrician support - what’s their role
- Crisis intervention - non GP led

### Multidisciplinary Teams
- Better resourced - time to attend, frequency
- Mix of professionals
- Logistical issues - remote attendance robust technology

### Communication
- Shared records
- Telephone access
- Formal and informal

### Process
- Removal of referral barriers eg age, caseload
- Ownership of the situation
- Responsive
- Lack of understanding between organisations
- Duplication due to unclear roles, boundaries and poor communication
Feedback from participant PCNs

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

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

PCN Network Manager
Questions?
Refreshments and Networking
What matters to you?

An example of population health management, social prescribing and proactive integrated care in practice”

https://www.youtube.com/watch?v=kzajE_cgus4&feature=youtu.be
Lunch and Networking
Workshop 1:
What are PCNs doing well to support the frailty agenda?
Workshop 2:

From the audit data, what are opportunities are there across Wessex to support PCNs to deliver the frailty agenda?
Workshop 3:

How can we foster joint working between acute, social care, community and voluntary services and PCNs?
James Lee
Consultant Practitioner Development Programme
Health Education England
and
Salisbury NHS Foundation Trust
Quality Improvement projects: Collaboration between local PCNs, Health Education England and the Wessex AHSN.

Background:

- Currently working clinically with Salisbury Medical Practice Older Persons Team.
- Previously worked in Salisbury Hospital (Front Door Frailty) and South Wiltshire Community (Neurology).
- Training and Experience with QI through HEE QI fellowship projects and Consultant practitioner development programme.
Sarum PCN’s: South, West, North.
Initial ideas and aspirations:
A project aimed at addressing some of the key findings of the community frailty audit.
A project across all three Sarum PCN’s.
A project focused at the interface between Primary care, Community Services and the Acute Trust.
However:
All three PCN’s at different stages of development of different Frailty services. Not all have ‘frailty lead’.
How much experience do the PCN’s have with QI?
Are the three PCN’s able and willing to work together?
What will the audit tell us about our local needs?
Discussions with teams before the audit:

**Primary care older persons teams:** “We could work so much more with OPAL (SFT Front door Frailty service).”

**OPAL:** “We could work so much more with the community and Primary Care older persons services.”

But what did they mean by this?
Knowing when they have a mutual patient.
Sharing knowledge about home circumstances – avoiding duplication.
Communication around discharge planning.
Shared risk assessment = shared risk = earlier discharge?
Joint working = inreach and outreach, rotational posts.
Wanting to spend clinical time with each other.
What does the audit tell us about the Sarum PCN’s?

- Not all the PCN’s have older persons/frailty practitioners.
- Not all practices within individual PCN’s are equally engaged with Older Persons Teams or voluntary sector organisations.
- PCN CD’s and older persons teams often don’t know what other services (e.g. community teams, mental health, social care) do for people with frailty.
- No integrated pathways yet.
- Conversations between services are happening but some in silos.
- Some training in place.
- MDT’s are well established but may be sub-optimal.
- Some access to Geriatricians but varied.
Sarum West “Time for Care Programme”
Dr Fiona Dawe, Dr Gareth Dawe, members of the Older Persons team.
Sarum West “Time for Care Programme”
Initial driver diagram:
Aims, primary drivers and secondary drivers:

To reduce the negative consequences of frailty in 95% of patients >75 years old by 2023.
OR
To improve the outcomes and experiences of elderly patients >75 years old who are living with frailty.

Enable patients to live safely in their place of choice
Multi-disciplinary teams
Improved access to carers
Excellent data sharing between organisations
Standardised data input and summarising
Reliable access to step up / step down beds
Improved communication with hospital
Good transport links
Community engagement
Engagement with voluntary sector

Change Ideas:
GROUPED CHANGE IDEAS

Change Idea groups:
- Prescribing (and de-prescribing)
- Shared standardised documentation
- Interservice working
- Skills and training for team (Workforce)
- Social care
- Carers
- Knowledge and resources.
Next steps:
Define aim, measures and interventions (change ideas).
Which change idea start with high impact, easy to implement?
Run PDSA cycles.
Service user input.
Quality Improvement in the Frailty Support Team (Totton and Waterside)

Emma Matthews
Consultant Practitioner Trainee (Older People and Frailty Pathway)
Health Education England
Frailty Support Team – 3 Teams
Lymington, Avon Valley, and Totton and Waterside

Frailty Ambulance Practitioners
Ambulance Technician’s x 7

Clinical Leads
Consultant Practitioners x 3
Frailty GPs x 2
Advanced Clinical Practitioner x 1

Frailty Practitioners
RMN x 1
RGN’s x 7
OT’s x 2
Physio x 2
Paramedic x 1

Additional Staff
Associate Practitioner x 2
Healthcare support workers x 4
Clinical Team Lead x 1
Administrator’s x 2
Surgeries Covered:
- Wistaria & Milford
- Chawton House
- Barton & Webb-Peploe
- The Arnewood
- New Milton
- Twin Oaks
- Brockenhurst & Sway
- Lyndhurst
- Cornerways
- Ringwood
- Fordingbridge
- Waterside & Blackfield
- Waterfront & Solent
- Forestside
- Forest Gate
- Testvale
- Totton
Team Purpose

- Rapid assessment of patients
- Reduction in the number of repeat calls
- Support nursing and residential homes
- Working across boundaries, people and systems
- To support primary care within localities as a safe alternative to admission
SOAR Analysis

**Strengths**
- Safe
- Patient Satisfaction
- Relationships with GP, Reablement, relatives
- SOS Pathway to LNFH

**Opportunities**
- Influence SHFT
- DN therapist/CMHT
- SDEC
- Silverline
- GP relationships
- Hampshire CCG

**Aspirations**
- Be the best
- Reduce admissions to acute hospital
- Improve communication
- Improve IT safety

**Resources/Results**
- Meet with GPs/DNs/UHS
- IT Access
- DNAR/AAND Training
- Team – new members, training, embed
What can we say about the people admitted to Same Day Emergency Care (SDEC - UHS)

- Reviewed ED presentations where member of the multidisciplinary team would review (Geriatrician lead – Medical for older people)
- Results – 17 older people reviewed with Consultant Practitioner
- 4 needed hospital due - hip fractures, IV supplements or antibiotics
- 13 could have been supported by FST
- Observations – once in system increased referrals to ‘specialist’, extra tests done, increased time taken, risk adverse
- Once they arrive at hospital they get ‘sucked in’
Frailty Support Team – Reporting from Tableau

- Referrals received & discharged over 12 months (Feb 19 – Jan 20)

Frailty Support Reporting - Totton & Waterside, Reactive Referrals

<table>
<thead>
<tr>
<th>Referrals Received</th>
<th>Feb 19</th>
<th>Mar 19</th>
<th>Apr 19</th>
<th>May 19</th>
<th>Jun 19</th>
<th>Jul 19</th>
<th>Aug 19</th>
<th>Sep 19</th>
<th>Oct 19</th>
<th>Nov 19</th>
<th>Dec 19</th>
<th>Jan 20</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted referral</td>
<td>30</td>
<td>26</td>
<td>23</td>
<td>35</td>
<td>24</td>
<td>43</td>
<td>28</td>
<td>28</td>
<td>31</td>
<td>37</td>
<td>24</td>
<td>40</td>
<td>259</td>
</tr>
<tr>
<td>Inappropriate referral</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>No Service Capacity</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>13</td>
<td>14</td>
<td>16</td>
<td>11</td>
<td>14</td>
<td>28</td>
<td>14</td>
<td>132</td>
</tr>
<tr>
<td>Grand Total</td>
<td>34</td>
<td>41</td>
<td>33</td>
<td>42</td>
<td>38</td>
<td>59</td>
<td>43</td>
<td>45</td>
<td>45</td>
<td>52</td>
<td>57</td>
<td>54</td>
<td>543</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals Discharged</th>
<th>Avg. Caseload length (weeks)</th>
<th>0.9</th>
<th>0.9</th>
<th>1.0</th>
<th>1.1</th>
<th>0.9</th>
<th>0.7</th>
<th>0.6</th>
<th>0.5</th>
<th>0.5</th>
<th>0.5</th>
<th>0.7</th>
<th>0.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Total appointments</td>
<td>7.0</td>
<td>6.1</td>
<td>6.7</td>
<td>6.9</td>
<td>5.0</td>
<td>5.8</td>
<td>5.7</td>
<td>5.5</td>
<td>4.7</td>
<td>4.9</td>
<td>5.6</td>
<td>6.5</td>
<td></td>
</tr>
<tr>
<td>Number of Discharges</td>
<td>39</td>
<td>29</td>
<td>38</td>
<td>40</td>
<td>41</td>
<td>53</td>
<td>48</td>
<td>46</td>
<td>41</td>
<td>52</td>
<td>58</td>
<td>50</td>
<td></td>
</tr>
</tbody>
</table>

Frailty Support Reporting - Totton & Waterside, Reactive Referrals

<table>
<thead>
<tr>
<th>Referrals Received over the last 12 months (excluding current month)</th>
<th>Feb 19</th>
<th>Apr 19</th>
<th>Jun 19</th>
<th>Aug 19</th>
<th>Oct 19</th>
<th>Dec 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average</td>
<td>55</td>
<td>53</td>
<td>54</td>
<td>56</td>
<td>55</td>
<td>53</td>
</tr>
<tr>
<td>SPC Control Limits</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
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</tr>
</tbody>
</table>

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<td>55</td>
<td>53</td>
<td>54</td>
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<td>53</td>
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<tr>
<td>SPC Control Limits</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
<td>45</td>
</tr>
</tbody>
</table>
Problem statement

Some older unwell people are still not being seen by the frailty support team

They are sicker for longer, recover slowly, and need more care

Leading to worsening quality of life or even death
Process map of Frailty Support Team FST
(Totton and Waterside)

Older Person unwell at home/carer or relative in crisis/Concerned

- South Central Ambulance Service (SCAS) 1st responder
- Intermediate Care Services (District nurses or therapists)
- Reablement (Social Services)
- Carers (Social Services)

GP/SCAS

Frailty Support Team

Integrated Care Team Caseload

Social Services

Bickley Green (Social Services Step up)

Forest Court (Social Services Step up)

Salisbury

UHS

RBH

LNFH

Fordingbridge (health step down)

Patient journey
**Exploratory Idea**
Review case studies to learn if our service involvement would have made a difference

<table>
<thead>
<tr>
<th>Plan</th>
<th>Do</th>
<th>Study</th>
<th>Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review GP admissions to hospital data</td>
<td>Review GPs highest attenders to hospital in last year (x2 GP practices within Hythe and Totton)</td>
<td>Define admission Why did they attend Who could have been supported by FST</td>
<td>So now we think we need to explore from the UHS lens</td>
</tr>
<tr>
<td>Review UHS admissions</td>
<td>Review Emergency Department presentations who were seen by same day emergency care (SDEC – Geriatrician lead – medicine for older people)</td>
<td>Who attended Who needed hospital admission Who could have been supported by FST before they presented</td>
<td>From both sources of data What could we do differently?</td>
</tr>
</tbody>
</table>
What can we say about the 18 people who were frequently ‘admitted’ to Southampton hospital last year from GP/SCAS?

18 Cases reviewed by Consultant, Consultant Practitioner Trainee, and Frailty Practitioner.

Admissions ranged from 5-9 per person.

Some of these were outpatient appointments, some ED attendances, some were admissions.

1 had no data regarding intervention or outcome.

3 would have benefitted from Comprehensive Geriatric Assessment and if referred to frailty team would have been referred on for this.

6 would have benefitted from anticipatory care planning – and would have received this if they’d been referred to the frailty team.

6 were diagnosed with cancer – and would not have benefitted from referral to frailty team.
### Intervention PDSAs – What could we do differently?

#### A few possibilities – test ONE at a time

<table>
<thead>
<tr>
<th>Increase anticipatory care plans – (aim for 20% rise)</th>
<th>Attend GP Virtual ward MDTs – aim for 1 referral a month from one GP who is not currently referring (increase if frailty support team capacity allows)</th>
<th>Smooth pathways with other HCPs within SHFT to integrate better – attend monthly meetings</th>
<th>Seek service user feedback to Co-create next QI</th>
<th>Risk stratification to ID ‘rapid risers’</th>
<th>Integrated community working via the community hub for our high risk/high need group</th>
</tr>
</thead>
</table>
Thank You
Any Questions
What next – what would help you deliver this exciting agenda?

As an AHSN we will be facilitating and supporting:

a. 3 x Health Education England Trainee Consultant Frailty Practitioners in collaboration with the Healthy Ageing programme will be working with 6 PCNs to deliver QI projects

As a Healthy Ageing Programme we can:

a. Offer QI guidance/support for 2 further PCNs or an offer to work with local CCGs?

b. Provide a network of support to deliver rapid quality improvement projects to transform frailty provision within the community at pace

c. To help you identify evidence best practice and to provide a platform for learning and sharing across Wessex

d. Signpost you to local and other PCNs nationally, who are developing similar approaches to you so learning can be shared nationally and locally?

What would help you?
Workshop Objectives

- To provide a forum for PCN Clinical Directors, frailty leads, service managers and CCG and STP leads to review overarching themes from the Wessex Community frailty audit

- To identify opportunities improving the care of people living with frailty in the community across Wessex

- To promote open and transparent dialogue and networking, including sharing good practice, between the community frailty cohort

- To ensure that this work is locally recognised and is on the national radar in terms of influencing national policy streams concerning the management of frailty

- To agree next steps with the project – QI/PCN Collaborative approach
Thank you...

Contact us to join our mailing list for newsletters or to join our community of practice

healthyageing@wessexahsn.net

@Wessexageing

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

Limited spaces left.. Thinking Differently, Ageing Well Conference
12th March 2020, Novotel, Southampton

https://www.eventbrite.co.uk/e/thinking-differently-ageing-well-frailty-conference-2020-tickets-85485466331

#WessexFrailtyFit