Wessex Community Frailty Audit
High Level Summary

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Wessex AHSN Community Frailty Audit 2019

• Following the publication of the National Institute for Health Research Dissemination Centre ‘Comprehensive Care: Older People living with Frailty in secondary care’ themed review, the Wessex Acute Frailty Audit was developed and run in 2018 to look at the standard of care provided for people living with frailty throughout our acute hospitals leading to the Wessex-wide service improvement projects that are now in progress.

• The Wessex Community Frailty audit was designed at Primary Care Network (PCN) level. It builds on the Wessex Acute Frailty audit and is part of a system wide approach across Wessex to improve the quality of care for those living with frailty.

• Improving care for people living with frailty or multiple long-term conditions is one of the 2019 NHS Long Term Plan (LTP) priorities.

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

• The audit pulls together initial NIHR research, the findings identified in the acute frailty audit and the national LTP priorities to help community frailty professionals identify areas of best practice and opportunity.
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 to 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 in some instances 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>Response</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>The process always takes place</td>
</tr>
<tr>
<td>Mostly</td>
<td>The process generally takes place</td>
</tr>
<tr>
<td>Occasionally</td>
<td>The process takes place ad hocly.</td>
</tr>
<tr>
<td>Don’t know</td>
<td>Not sure if the process takes place</td>
</tr>
<tr>
<td>N/A</td>
<td>PCN responded that the question was not applicable to them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Response</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>All staff have equitable access to training and attend</td>
</tr>
<tr>
<td>Most</td>
<td>The majority of staff have access to training and attend</td>
</tr>
<tr>
<td>Some</td>
<td>Inequitable access to training and attend</td>
</tr>
<tr>
<td>None</td>
<td>No training is available</td>
</tr>
<tr>
<td>Don’t know</td>
<td>Don’t know</td>
</tr>
</tbody>
</table>
High level Summary
High level Summary

- Baseline for opportunities for improvement, not mapped to PCN maturity
- 22 PCNs took part in the audit (32% response 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
Strategic Overview
How engaged is your local authority 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>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>
</tbody>
</table>

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.
1. Do you have a frailty lead for developing services within your PCN for people with living with frailty?

- Yes: 45.5%
- No: 50.0%
- Don't know: 4.5%

(n=22)
8. Have you considered the needs of people living with frailty and how it relates to your current frailty service provision?

- Yes: 81.8%
- No: 18.2%

(n=22)
1. Screening and sharing of frailty information
9. Within the primary care setting do you validate your local e-FI score with another frailty scoring tool?

- Yes: 45.5%
- No: 45.5%
- Don't know: 9.1%

(n=22)
10.1.a. Primary Care - If the service within your PCN identifies people living with frailty how often does this happen?

- Always: 36.4%
- Mostly: 31.8%
- Occasionally: 18.2%
- Don't know: 13.6%

(n=22)
10.1.b Primary Care - Is the identification of frailty information accessible to other organisations?

- **Always**: 31.8%
- **Mostly**: 27.3%
- **Occasionally**: 13.6%
- **Don't know**: 27.3%

(n=22)
10.1.c Primary Care - Do patients and carers have access to their information?

- **Always**: 27.3%
- **Occasionally**: 18.2%
- **No**: 9.1%
- **Don't know**: 22.7%
- **Mostly**: 22.7%

(n=22)
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.

We are looking at ways to collect this information through the PCN projects and “deep dives” through the Community Trusts and Local Authorities.

The key area of focus moving forward is to understand how information is shared across organisations.
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
2. Frailty knowledge, skills and training
11.1.a Primary Care - Have relevant staff within your PCN undertaken training on frailty?

- **All**: 31.8%
- **Some**: 27.3%
- **Most**: 18.2%
- **Don't know**: 13.6%
- **None**: 9.1%

(n=22)
12.1.a Primary Care - Have relevant staff undertaken anticipatory care plan training?

- Most: 27.3%
- Some: 31.8%
- All: 22.7%
- Don't know: 18.2%
14.1.a Primary Care - Have relevant staff received training in how to undertake capacity/best interest decisions?

- **Most**: 36.4%
- **Some**: 22.7%
- **27.3%**
- **13.6%**
- **Don't know**
15. Is there frailty awareness training provided to voluntary sector organisations within your PCN?

Yes: 9.1%

No: 27.3%

Don't know: 63.6%

(n=22)
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.

- We are looking at ways to collect this information through the PCN projects and “deep dives” through the Community Trusts and Local Authorities

- 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.
3. Current frailty pathway processes
16. Is there an integrated frailty care pathway within your PCN, that includes you and other local organisations?

- Don't know
- No
- Yes

- Total, Don't know, 1, 4%
- Total, Yes, 9, 41%
- Total, No, 12, 55%

(n=22)
17. Is the integrated frailty service pathway across the whole PCN or are there separate pathways?

- Don't know: 3, 14%
- Separate pathways: 18%
- Whole PCN: 36%
- No Response: 7, 32%
18.1.a. Specialist Frailty Practitioners - Do you have access to these services?

- **Don't know**: 3 (14%)
- **No**: 9 (41%)
- **Not applicable**: 1 (4%)
- **Yes**: 8 (36%)
- **No Response**: 2 (9%)

(n=22)
18.2.a. Community Geriatrician - Do you have access to these services?

- **Not applicable**
- **Yes**
- **No Response**

- Total, No Response, 9 (41%)
- Total, Yes, 11 (50%)

(n=22)
18.3.a. Social Care - Do you have access to these services?

- Don't know
- No
- Not applicable
- Yes
- No Response

- Total, Don't know, 1, 4%
- Total, Yes, 8, 36%
- Total, No Response, 9, 41%
- 14%
- 5%
18.4.a. Community Frailty Teams - Do you have access to these services?

- **Yes**: 10, 45%
- **No**: 9, 41%
- **Not applicable**: 5%
- **No response**: 9%

(n=22)
18.5.a. GP practice pharmacist (medication review) - Do you have access to these services?

- No
- Not applicable
- Yes
- No Response

- Total, No Response, 9, 41%
- Total, Yes, 8, 36%

(n=22)
18.6.a. Patient support and information - Do you have access to these services?

- Don't know
- No
- Not applicable
- Yes
- No Response

Total, Don't know, 1, 4%
Total, No Response, 9, 41%
Total, Yes, 9, 41%
18.7.a. Falls Service - Do you have access to these services?

- Not applicable: 4%
- Yes: 55%
- No Response: 41%

Total, Yes: 12, 55%
Total, No Response: 9, 41%
Total, Not applicable: 1, 4%

(n=22)
18.8.a. Continence Service - Do you have access to these services?

- Not applicable
- Yes
- No Response

- Total, No Response, 9, 41%
- Total, Yes, 12, 55%

(n=22)
19.1.a. Do you have access to same day emergency care services for frailty patients living at home?

- Yes: 54.5%
- No: 45.5%

(n=22)
19.2.a Do you have access to same day emergency care services within the hospital setting?

Yes: 40.9%
No: 31.8%
Don't know: 27.3%
20. Do you have access to step up beds?

- Yes: 63.6%
- No: 36.4%

(n=22)
20.a. If yes, does the whole of the PCN or some of the practices have access to step up beds?

- Some practices
- Whole of the PCN
- No Response

- Total, No Response, 8, 36%
- 9%
- 55%

(n=22)
## 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></td>
<td>Unacceptable waits</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
4. Multi-disciplinary team interactions
21. Within a primary care setting is there an opportunity for people living with frailty to be discussed within an MDT meeting?

- Yes: 95.5% (n=22)
- No: 4.5%
21.a. If MDT meetings are held, how frequently do they take place?

- Monthly: 59%
- Weekly: 36%
- No Response: 1%, 5%

(n=22)
21. b If MDT meetings are held please identify who attends (either face to face or virtually) the MDT discussion?
22. Are actions recorded within the patient's record following the MDT meeting?

- Don't know
- Not Standard Practice
- Standard Practice
- No Response

- Total, Don't know, 1, 4%
- Total, No Response, 1, 5%

82%
24. Are these actions and outcomes from the MDT meeting shared with other health and social care organisations?

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't know</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>68%</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>No</td>
<td>9%</td>
<td></td>
</tr>
</tbody>
</table>

Total, Yes = 15, 68%
Total, Don't know = 4, 18%
Total, No Response = 1, 5%

(n=22)
24.b. Are these actions and outcomes from the MDT meeting shared with the patient and/or carers?

- Don't know: 5, 23%
- No: 3, 14%
- Yes: 1, 4%
- No Response: 1, 4%

Total: 11
5. Service Improvement Opportunities
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.
## Community Frailty Service Improvement Opportunities

<table>
<thead>
<tr>
<th>Development of professional networks</th>
<th>Interfacing with Social Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Voluntary sector involvement - Consistency/ availability/ accessibility</td>
</tr>
<tr>
<td></td>
<td>Frailty specific services / geriatrician support - what’s their role</td>
</tr>
<tr>
<td></td>
<td>Crisis intervention - non GP led</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Multidisciplinary Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better resourced - time to attend, frequency</td>
</tr>
<tr>
<td>Mix of professionals</td>
</tr>
<tr>
<td>Logistical issues - remote attendance robust technology</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shared records</td>
</tr>
<tr>
<td>Telephone access</td>
</tr>
<tr>
<td>Formal and informal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of referral barriers eg age, caseload</td>
</tr>
<tr>
<td>Ownership of the situation</td>
</tr>
<tr>
<td>Responsive</td>
</tr>
<tr>
<td>Lack of understanding between organisations</td>
</tr>
<tr>
<td>Duplication due to unclear roles, boundaries and poor communication</td>
</tr>
</tbody>
</table>
Useful references

**NHS Long Term Plan 2019**


**National Institute Health Research 2018**


**British Geriatrics Society**

https://www.bgs.org.uk/topics/integrated-care
https://www.bgs.org.uk/resources/integrated-care-for-older-people-with-frailty-0