Classification: Official	Item No.

Meeting:	Health and Wellbeing Board
Meeting date:	28 March 2022
Title of report:	Frailty: burden of illness, inequalities, and transformation plans
Report by:	Samantha Merridale, Lindsey Darley, Steven Senior
Decision Type:	**No decision**
Ward(s) to which report relates	**All**

Executive Summary:

1. The purpose of this paper is to give the Bury Health and Wellbeing Board an overview of the current Frailty programme, and the rationale for taking forward this programme of work in Bury.

2. The Bury Frailty programme commenced in January 2022 following a process of self-assessment and a gap analysis across the whole system during 2021. The paper outlines emerging key themes and objectives for how we manage those who are deemed to be frail, with a focus on reducing health inequalities associated with frailty, prevention of deterioration of their condition, and maintaining their health and independence for as long as possible.

3. The paper describes the emerging areas of work, which specifically are focussing on:

    a. Older people's mental health – improving the management of people with cognitive impairment caused by either dementia or delirium;
    b. Establishing a virtual hospital for admission avoidance and early supported discharge;
    c. Establishing "Frailty hubs", managed by INTs/MDT across Bury;

d. Developing key competencies for upskilling our workforce, across the whole system, with consistent training material and methods;

e. Exploring new and innovative digital solutions aimed at keeping patients healthy, avoiding falls, and sharing care records across the wider system;

f. Pathways and pilots in the following areas:

    i. Developing a single assessment and scoring process for identification of frailty;

    ii. A programme to improve falls prevention and prevention of fractures;

    iii. Developing new pathways and provision for patients with respiratory conditions e.g. COPD / community acquired pneumonia / Long-COVID-19;

    iv. Early identification and management of patients with cardiovascular disease, including preventative initiatives with public health;

g. Anticipatory care

    i. Ageing Well;

    ii. Enhanced health at home;

    iii. Two-hour crisis response / Urgent Community Response;

h. Links to end-of-life programme

i. Establishing good networking and sharing of good practice with other localities in Greater Manchester (GM) and nationally.

4. The paper also describes the expected quality and population health outcomes which will be achieved by improving the way we deliver services for patients who are frail across the whole health and care system.

Recommendation(s)

That:

5. the HWBB note the commencement of this programme, and specifically the links with the Integrated Neighbourhood Team development plans.

Background

6. The British Geriatric Society describes frailty as "Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves."[1] There are multiple competing tools for measuring frailty and definitions vary. Although the BGS argues that frailty is different from long term conditions and multimorbidity, NHS England guidance on responding to frailty remains largely described in terms of existing public health and healthcare services

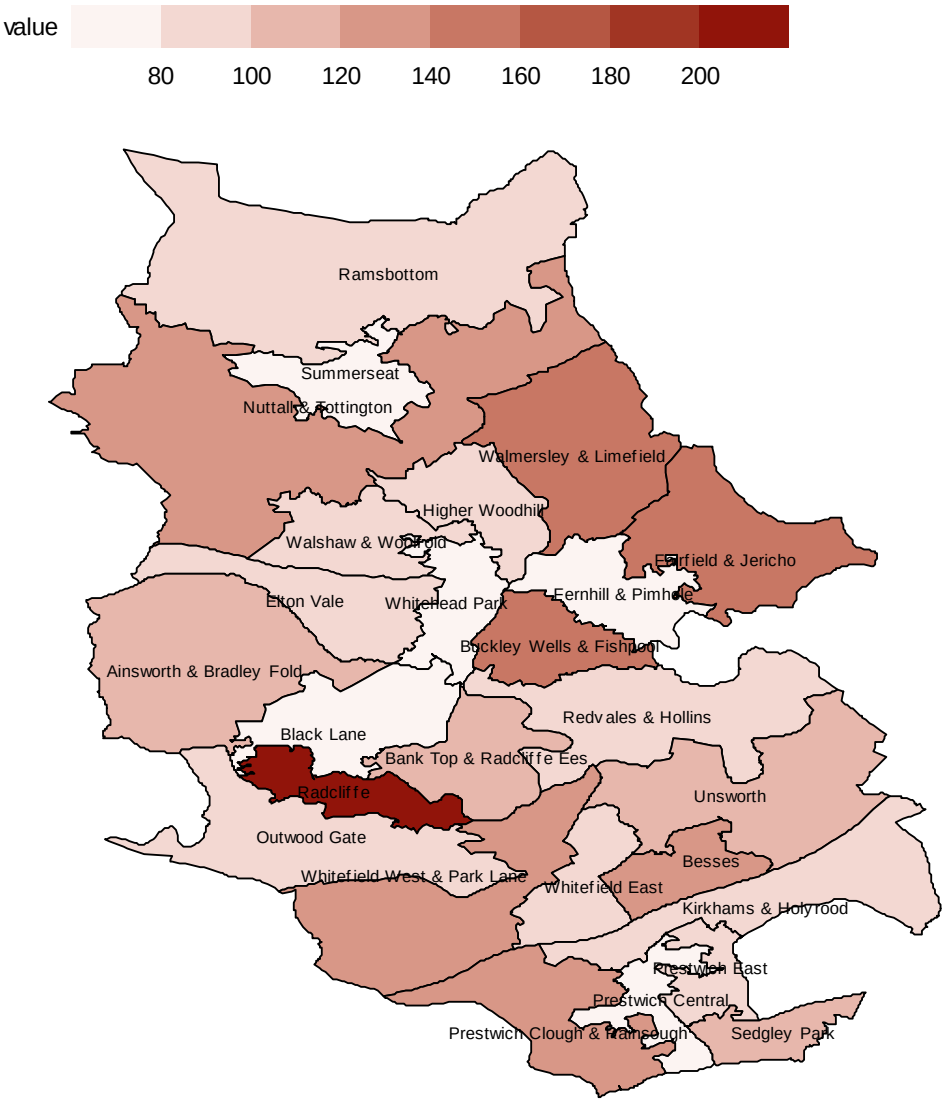
7. NHS England guidance[2] refers to mild, moderate, and severe frailty. It claims that around 12% of people aged 65 and over are living with moderate frailty and 3% with severe frailty. Local data on frailty is not available, but Bury's numbers are likely to be worse: life expectancy at 65 is worse than the English average for men and women, and indicators for some age-related conditions linked to frailty are worse than average when compared to similar areas.[3]

8. The lack of local data on frailty means that we cannot measure inequalities in frailty or related conditions directly. However, national data on a range of age-related conditions show inequalities by both deprivation, ethnicity, and gender. Local data exists on some aspects of frailty, such as emergency hospital admissions for hip fractures in older people highlights patterns of inequality within Bury (see figure below). These data highlight that although some neighbourhoods have particular challenges, there are inequalities in this aspect of frailty within all neighbourhoods.

[1] https://www.bgs.org.uk/resources/introduction-to-frailty
[2] https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2019/07/frailty-toolkit-june-2019-v1.pdf
[3] Emergency admissions for COPD and dementia and % reporting two or more long-term conditions at least one of which is musculoskeletal.

Emergency hospital admissions for hip fracture in persons 65 years and over, standardised admission ratio

Bury MSOAs. Data from 2015/16 - 19/20



Standardised admission ratios represent the number of admissions relative to what would be expected if the local rate was the same as the national average, adjusting for different demographics. Areas with values higher than 100 are above the national average. MSOAs - middle-super output areas - are small geographic areas used by the Office for National Statistics and others.

9. The concept of intervention decay which has been discussed at previous meetings is harder to apply to a broader issue like frailty. The lack of good data measuring frailty directly and the many different types of illness linked to frailty make applying this approach more difficult. A frailty performance and data subgroup exists which is responsible for defining and developing better local measures. This is likely to depend on access to patient-level data, such as GP records.

10. This does not mean that frailty cannot be prevented. NHS England guidance suggests for healthy older people and those with mild frailty, a focus on physical activity, healthy weight, nutrition, and hydration, is recommended. This is part of our core public health offer.

Tackling health inequalities associated with frailty

11. Primary prevention of frailty is largely common to prevention of other aspects of illness. This is addressed in wider public health work to promote good health in adulthood. The focus of the frailty programme therefore is on early identification and effective management of frailty. Within this there needs to be a focus on minimising inequalities in identification and management of frailty. The aims for the Bury Frailty programme are:

    - Reduce health inequalities by ensuring equitable access to early intervention and effective frailty pathways in all parts of the borough;

    - Using a "making every contact count" approach – improving access to self-care advice, preventative and health promotion services following a care intervention; and

    - Take a particular focus on improving outcomes for those patients deemed to be frail suffering long term respiratory and cardiovascular disease.

12. The programme will build on the principles in the GM Population Health Framework.

13. It has been recognised that the development plans for the Bury Integrated Neighbourhood Teams (INTs) are closely linked to the emerging frailty programme of work. Among the priorities described for the INT plans are specifically:

    - Recognise that tackling health needs and reducing health inequalities requires a collaborative, systematic approach;
    - Focus resources at a Bury-wide and Neighbourhood level on reducing inequalities in access and outcome using evidenced based interventions

14. Two of our neighbourhoods (Prestwich and North) have listed frailty specifically as an area of focus for the coming year, with strong links across all neighbourhoods supporting the PCN DES for anticipatory care.

Why do we need to focus on the management of frailty in Bury?

15. A stocktake in 2021 identified that, across the whole system, there were several professional groups who were attempting to progress initiatives around managing frailty, for example the acute frailty network, the community frailty network, integrated neighbourhood teams, primary care initiatives, work being led by Bury Council and work taking place in the independent sector.

16. Due to COVID-19 the GM frailty programme had paused which had created a gap in the sharing of information and good practice regionally, resulting in some silo working. It was apparent in Bury that the management of frailty was a priority across several our transformational programmes, particularly Urgent Care and end-of-life care. The GM Frailty programme was re-established early in 2021.

17. System wide stakeholder engagement, including with neighbourhoods, determined that we need to baseline what our current programmes are, our approach to managing frailty, and the gaps in our service provision. It was acknowledged that there are some examples of good practice – but that all parts of the system are not particularly connected, and that we often have inconsistencies in approach and a lack of "joined up" planning. There was a lot of enthusiasm to formulate a Bury Frailty Strategy.

18. To identify service gaps and areas of good practice, we performed a self-assessment benchmarking exercise in the summer of 2021.

19. A self-assessment tool was created, using measures from Right Care and the GM Frailty Standards. Due to the large number of stakeholders, we organised a series of meetings with different parts of the system, namely:

    - Acute
    - Primary Care
    - Mental Health
    - Community
    - BARDOC (out of hours)
    - Care home sector
    - NWAS

20. In each meeting, we worked through the self-assessment tool, and noted the responses and comments at each stage. The meetings were very well received, and show cased the effective work already taking place across Bury. However, there is still a large amount of work required to strengthen, develop and align services across the Bury footprint, to improve the way that we manage patients who are frail, and improve patient experience and outcomes when living with frailty.

21. We also worked extensively with the GM Frailty programme team, the Ageing Well Programme, Health Innovation Manchester and experts from surrounding localities, e.g. Tameside and Glossop, to get a systematic view of what a "best practice" frailty strategy for Bury would look like.

22. We have also aligned our discussions with the Ageing Well Programme, led by Deb Yates at Bury Council, as there are overlapping priorities and opportunities for developing or improving provision and pathways of care.

Key findings from the self-assessment:

- We do not have a single, joined up borough wide strategy for Frailty in Bury which meets GM and national guidance;
- We have multiple "networks" but no single approach;
- We do not have consistency in the way that data is shared across the system – e.g. community teams, INTs who cannot access the electronic frailty index (EFI) as this is primary care;
- Different key performance indicators and outcome measures are in place in different parts of the system particularly in care homes;
- We need to develop the concept of "Making Every Contact Count" across all parts of the system;
- Social prescribing is not routinely used in care home settings, and there is no standardization of approach across the 5 INTs;
- A standard validated tool – Clinical Frailty Score – has recently commenced, but needs embedding in community, and there is no standardised information or data available to share from acute to community / primary care. This needs development. Discharge data back to care homes needs urgent improvement;
- We need to take a multi-disciplinary team (MDT) approach to Comprehensive Geriatric Assessments in all settings, to ensure consistency;
- There is no single care plan which is visible across the whole system. Often, numerous care plans are put in place;
- We are not using our 2-hour crisis response (Rapid Response) team effectively enough to manage patients with frailty particularly in care homes;
- No real awareness of the Enhanced Health in Care Homes Framework in the care home setting, although this was about to be commenced by primary care networks (PCNs) pre-COVID but paused. There could be an opportunity to provide in-reach geriatric care into care homes;
- The Directory of Services is not always as up to date as it could be and care homes have no access to it;
- Lack of understanding about the current falls team in Bury, and what the BEATS team can offer;

- Dementia diagnosis is generally good, but we need to separate dementia from delirium. We need an agreed standardized, single assessment tool for identifying patients with cognitive impairment in both acute and community settings;
- No formalized standardised system for Advanced Care Planning for patients at end-of-life, and advance care plans should be visible across the whole system; and
- We need to undertake more education and awareness around system wide recognition of the signs of, and managing patients with frailty, and needs embedding into competency frameworks.

Emerging Key themes

23. Below is a summary of the 8 key themes that emerged from the feedback obtained, which has formed the basis of our Frailty Programme:

Bury Frailty transformation programme

24. In November 2021 the Bury Transformation Board agreed to establish a formal programme of work around frailty. This has emerged into a complex programme of work consisting of several areas of priority, namely:

- Older people's mental health – improving the management of people with cognitive impairment caused by either dementia or delirium;
- Establishing a virtual hospital for admission avoidance and early supported discharge;
- Establishing "frailty hubs", managed by INTs/MDT across Bury, commencing with south Bury (Prestwich/Whitefield)
- Developing key competencies for upskilling our workforce, across the whole system, with consistent training material and methods;
- Exploring new and innovative digital solutions aimed at keeping patients healthy, avoiding falls, and sharing care records across the wider system;
- Pathways and pilots in the following areas. (Note that this is a new programme of work and the anticipated timelines for these pathways are not yet established). Commencing in Q1 2022/23:
    - Developing a single assessment and scoring process for identification of frailty
    - A programme to improve falls prevention and prevention of fractures
    - Developing new pathways and provision for patients with respiratory conditions e.g. COPD / community acquired pneumonia / Long COVID
    - Early identification and management of patients with cardiovascular disease, including preventative initiatives with public health
- Anticipatory care
    - Ageing Well
    - Enhanced health at home
    - 2 hour crisis response / Urgent Community Response
- Links to End Of Life programme
- Establishing good networking and sharing of good practice with other localities in GM and nationally.

25. Much of this work will lend itself to co-production and the newly established Bury Frailty Steering Group will be responsible for leading this work through specialty subgroups.

26. The work has commenced in early Spring 2022 and will be widely rolled out during 2022/23.

Quality Drivers

- Improve population segmentation, identification and stratification of frailty;
- Improve support for patients with mild, moderate and severe frailty and encouraging patients to age well;
- Reduction in hospital length of stay;
- Reduction in falls and fragility fractures;
- Improve management of patients with delirium, dementia and cognitive disorders;
- Improve personalised care;
- Improve experience of care; and
- Improve workforce experience.

Expected Quality Outcomes

- Improved clinical outcomes achieved by easier access to early interventions for the management of frailty within the Borough, with care closer to home;
- Access to defined clinical pathways for patients with escalation of chronic disease (e.g. COPD, CVD, mental health);
- Improved clinical outcomes through early supported discharge to patient's usual place of residence (Virtual Hospital);
- Delivery of coordinated MDT approach to prevent hospital admissions and through step-up Virtual Hospital model;
- Promoting the use of innovative digital solutions (e.g. Safe Steps, shared care plan, single assessment for cognitive impairment) as part of early identification and primary prevention / anticipatory care; and
- Improving medicines optimisation for patients with frailty.

27. A whole system Frailty Steering Group has been established, with a consultant clinical lead and professional leads from all parts of the system. The group meets monthly. Subgroups have been established to take forward specific pieces of work.

28. The Frailty Steering Group sends regular reports to the Bury Transformation Board, and the ICB, as well as the Clinical Reference Group and the GM Frailty Care Group.

Samantha Merridale
Programme Lead – Frailty
17th March 2022
Samantha.merridale@nhs.net