NHS Employers
Culture Webinar
September 2023

Case Study: A Place to Meet the Needs of People Living with Frailty

Excellence • Compassion • Expertise

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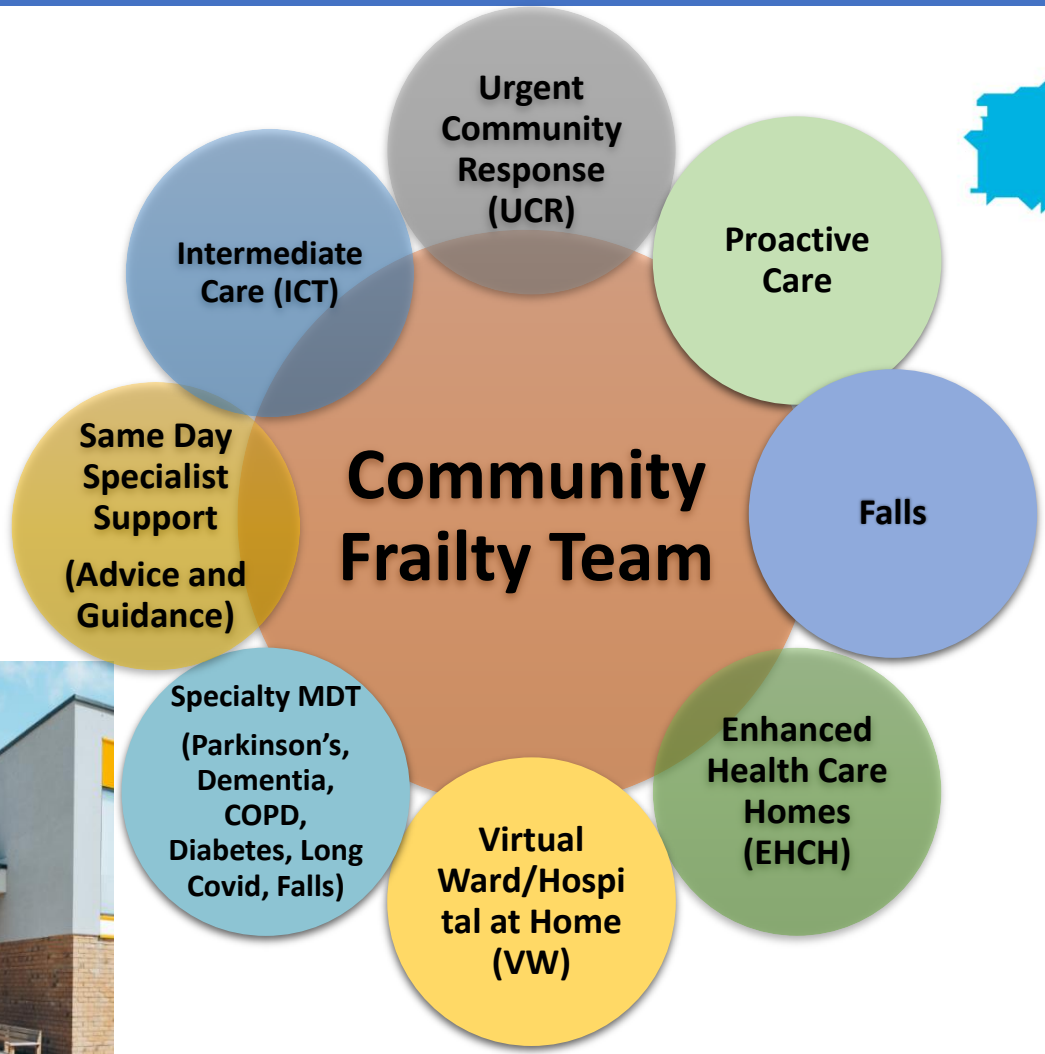
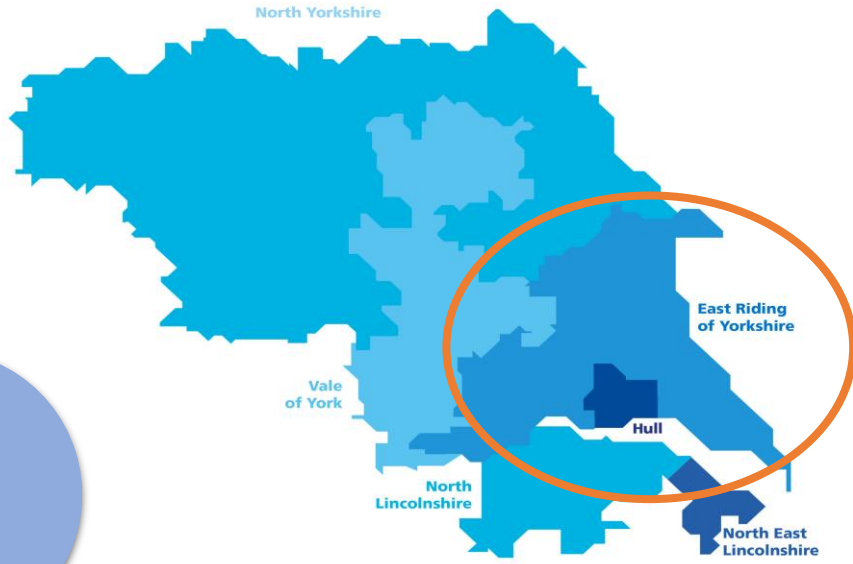
Hull and East Riding
Improving outcomes for People Living with Frailty

Focus of today

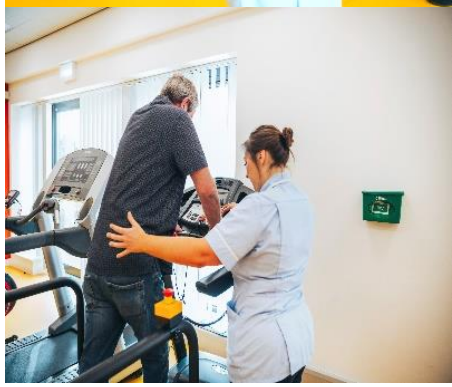
- Strategic aims
- System thinking
- Delivery
- Outcomes
- Culture
- Top Tips





System Thinking: Strategic Aims (2018 – current)

- Shifting the focus of delivery to **early help** and prevention (proactive)
- Deliver responsive (reactive) integrated **out of hospital** care
- **Respect patient choice** regarding preferred place of care
- **Reduce** demand for acute and social care services
- Address health and social care **inequalities**
- Strengthen **collaboration** and deliver an **integrated frailty system – not silos**
- Empower individuals and **communities** to engage
- **Continuously evaluate** and refine



NHS Humber and North Yorkshire Integrated Care Board (ICB)

NHS Hull University Teaching Hospitals NHS Trust

chp

citycare The Hull estates experts

HUMBERSIDE Fire & Rescue Service

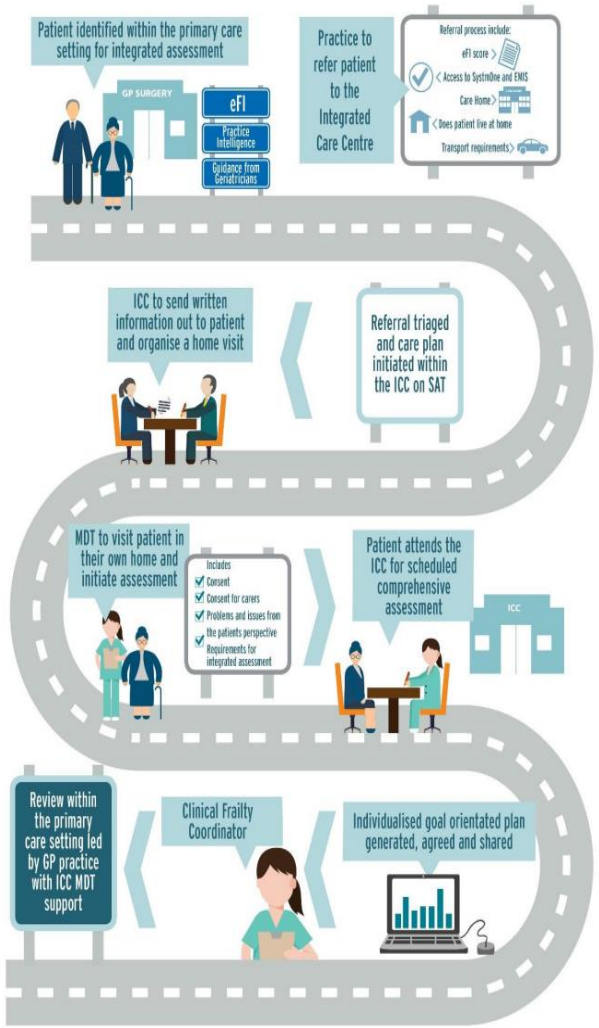
NHS Yorkshire Ambulance Service NHS Trust

NHS Humber Teaching NHS Foundation Trust

Hull City Council

EAST RIDING OF YORKSHIRE COUNCIL

PROACTIVE: Anticipatory Care (CGA)



- eFI and Practice Intelligence to case-find
  - Referral pathways expanded
  - Hospital frailty team
  - Mental health
  - Fire service
  - Social care
- Delivered by a specialist MDT
- Own home & care homes
- Frailty not age
  - Referred by eFI & Diagnosed with CSF
- Integrated record shared
- Patient-centred
- Advance Care Planning (ReSPECT)
- Can be delivered virtually also

HUB | Template Views | Pre-Assessment | Initial Assessment | Medical Assessment | Medication Rev...

Would you say your physical health is:	Poor
Has your health got worse in the last 6 months?	A lot worse
If your health has changed can you describe the change?	Having more difficulty breathing which is impacting daily living Pain in back, shoulders, neck. Burning sensation in head Pain in groins and upper thighs - less mobile
Did anything in particular happen to cause this change?	No
Are you worried about your health at the moment?	Yes
What worries you?	Difficulty breathing Pain - Kathleen states it can be that intense it makes her fall to her knees
Do you have problems with:	Seeing Hearing Breathing Chest Pain Pain Bowels / Waterworks
General Comments	Cataracts done 3-4 yrs ago - wears glasses Slight hearing impairment Has difficulty passing urine... will struggle to go all day therefore becomes swollen and uncomfortable
What would you say is your main health problem?	Breathing and pain- both affect functioning and mobility massively
Have you any other health problems?	Recent chest xray to exclude CA - all clear Angina

Inequity in offer between Hull and East Riding in own home

PROACTIVE - Core MDT composition – ONE TEAM

Multiple employing organisations

- Patients would not know

Operational manager

Parkinsons: similar to Core MDT

For remote CGAs

- Primary care dial in to MDT
- Social prescribers

Specialist MDTs link

- Chest
- Dementia
- Diabetes
- Falls

Proactive: System and Patient Outcomes

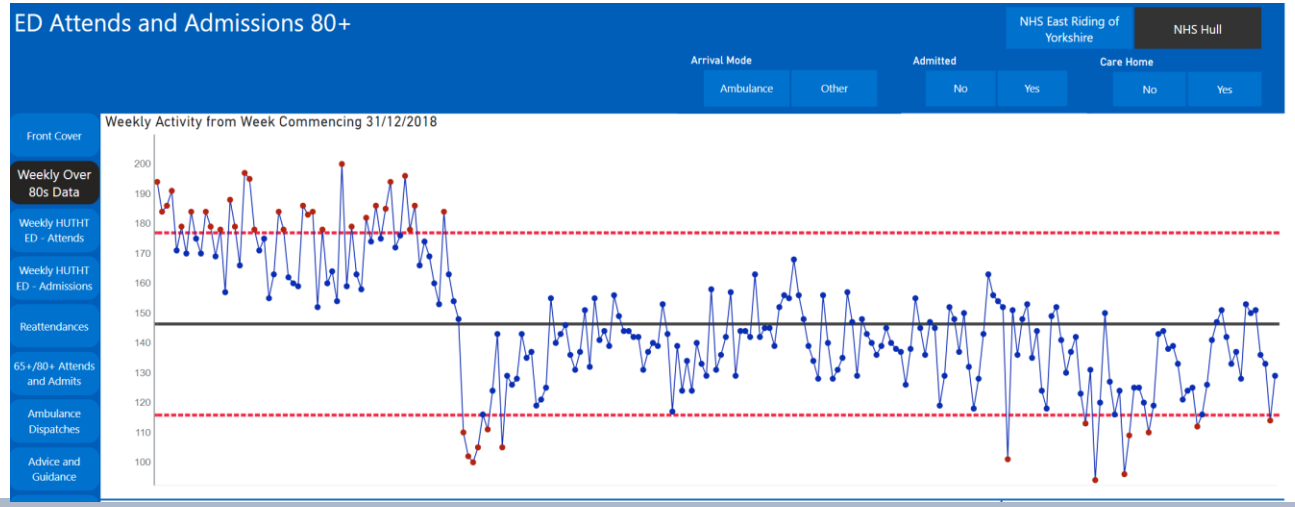
>10% reduction in GP appointments

>10% reduction in ED attendance and emergency admissions

>50% reduction in ED attends and admissions for Frequent flyers

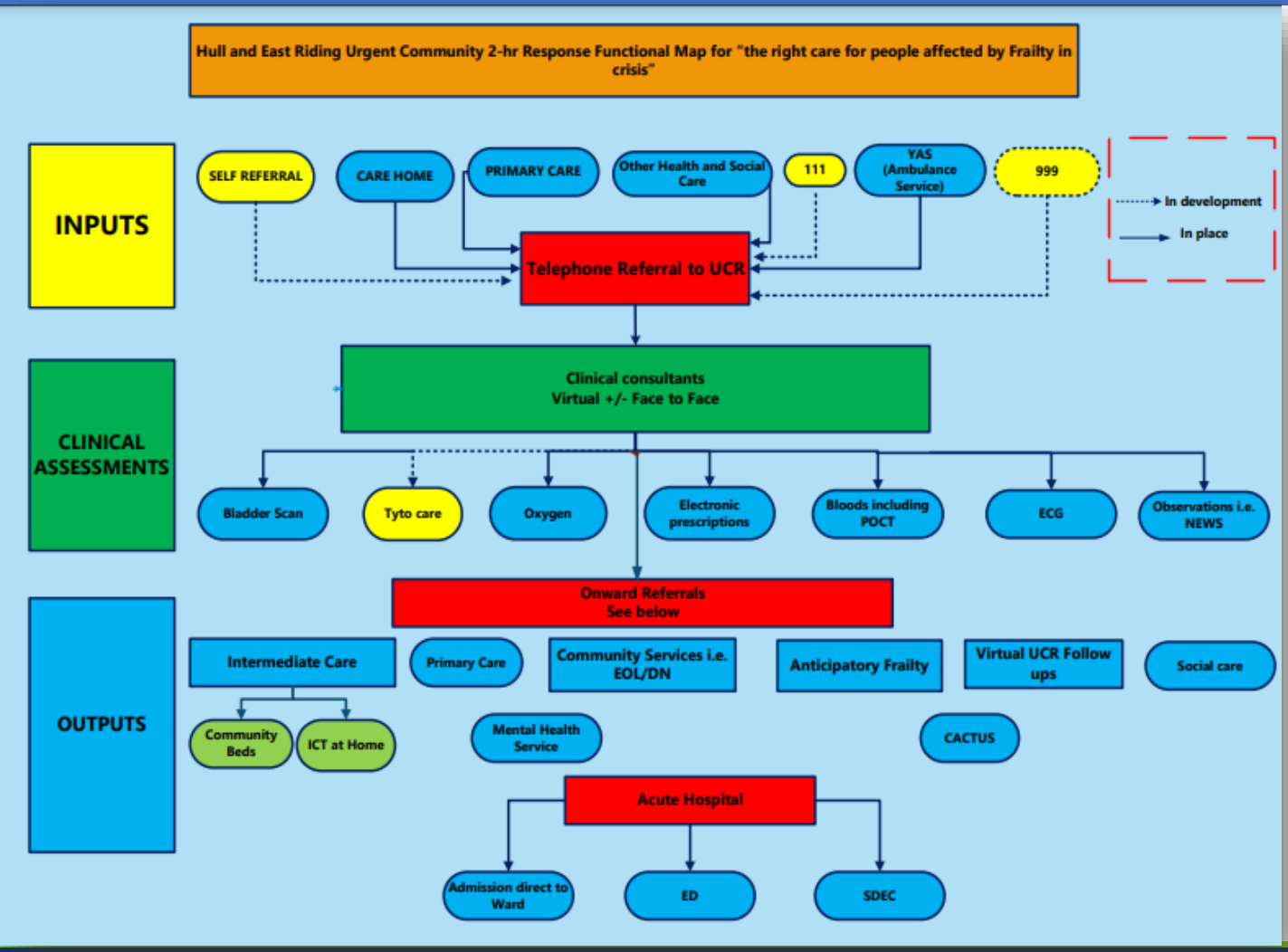
Average saving on drug costs: £100/patient/yr

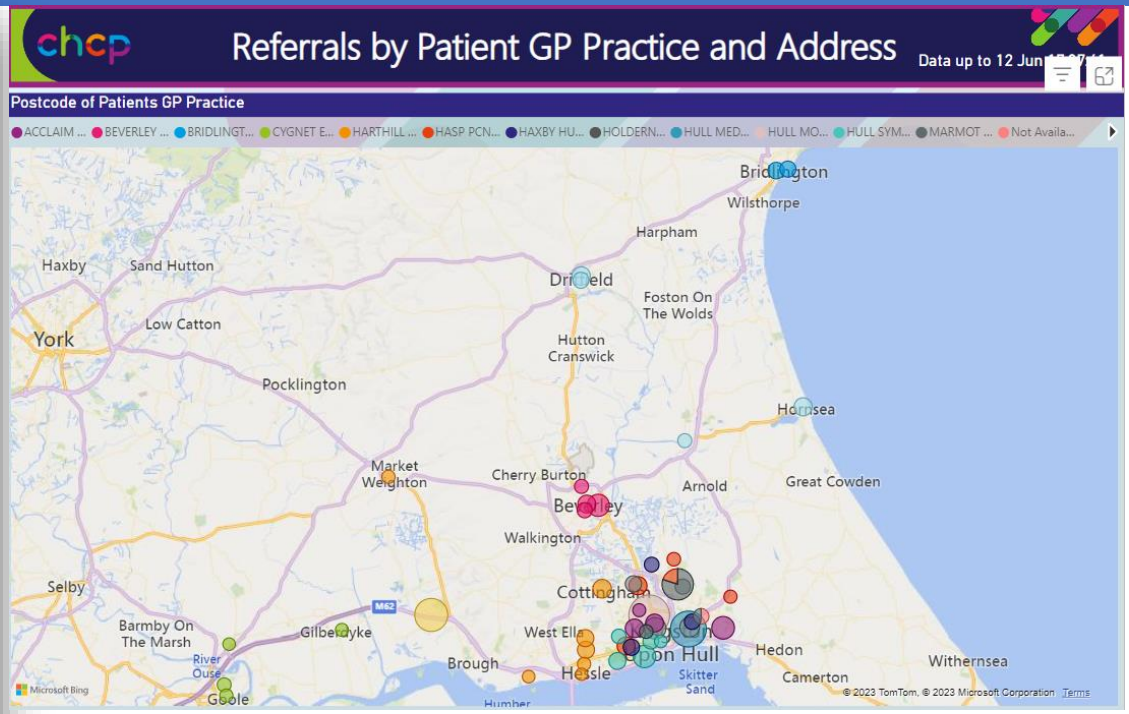
LTC + CFS 6-7	ED attends	ED admissions
COPD	-16%	-19%
Dementia	-15%	-28%
Palliative Care	-29%	-22%
Diabetes	-36%	-30%



- **Patient Reported Outcome Measures (PROMS): PACE study**
  - **NRCT published Jan 2023:** [A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty | BMC Geriatrics | Full Text (biomedcentral.com)]
- **Patients, their families and carers, say the care they've received has changed their lives**

REACTIVE / CRISIS
2hr Urgent Community Response (UCR) and frailty virtual ward





Currently
8am-8pm 7 days

REACTIVE: UCR and Virtual Ward – MDT Composition

Multiple employing organisations

- Patients would not know

Operational manager

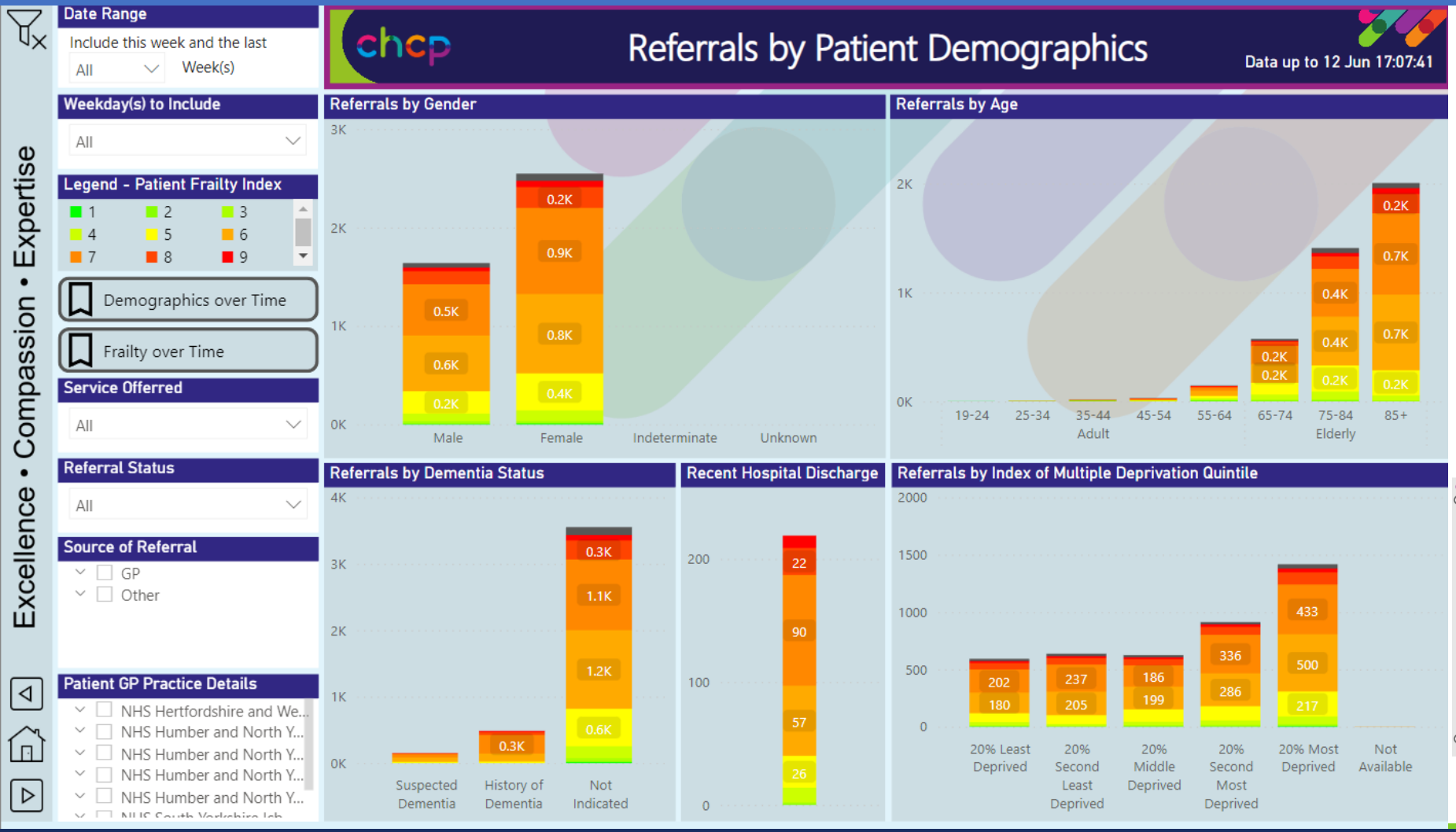
Gaps

- Mental health
- Social services
- VSO

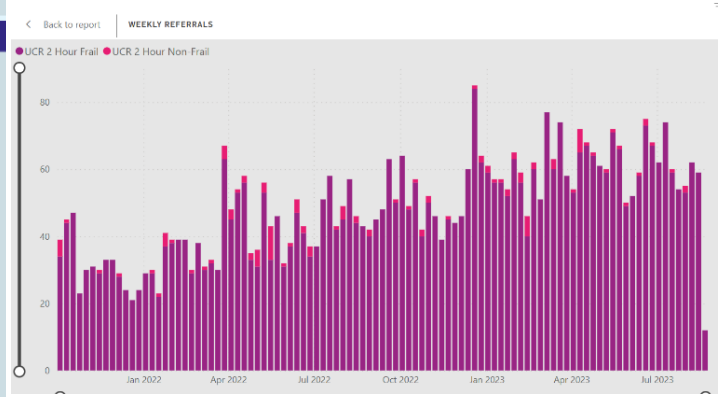
- Rely on existing urgent pathways

- Demonstrates interdependencies between health and social care

UCR: Core Frailty Work!

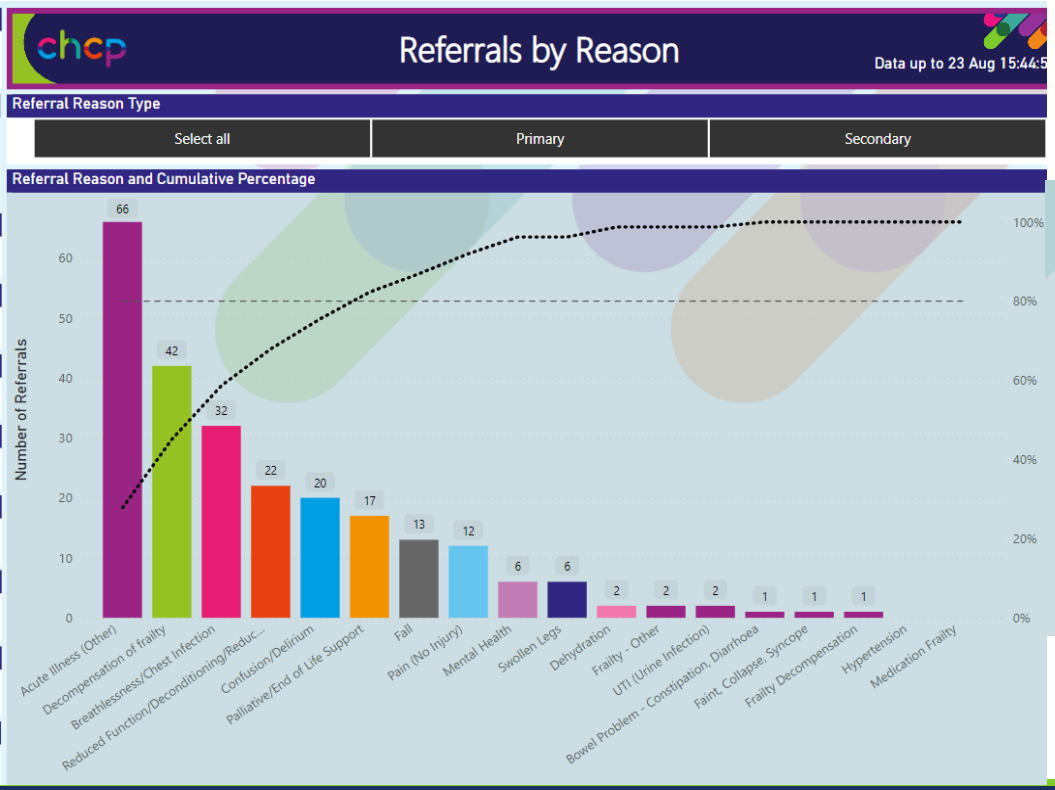


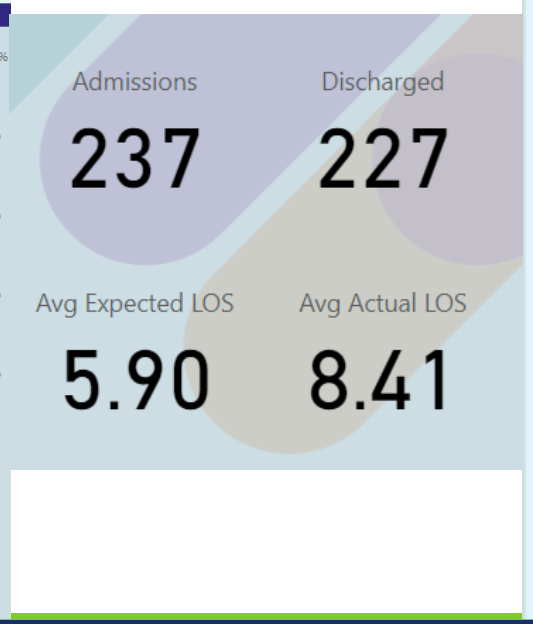
- Main referral source: Paramedics
- Only 17% conveyance
- Proactive and reactive pathways aligned

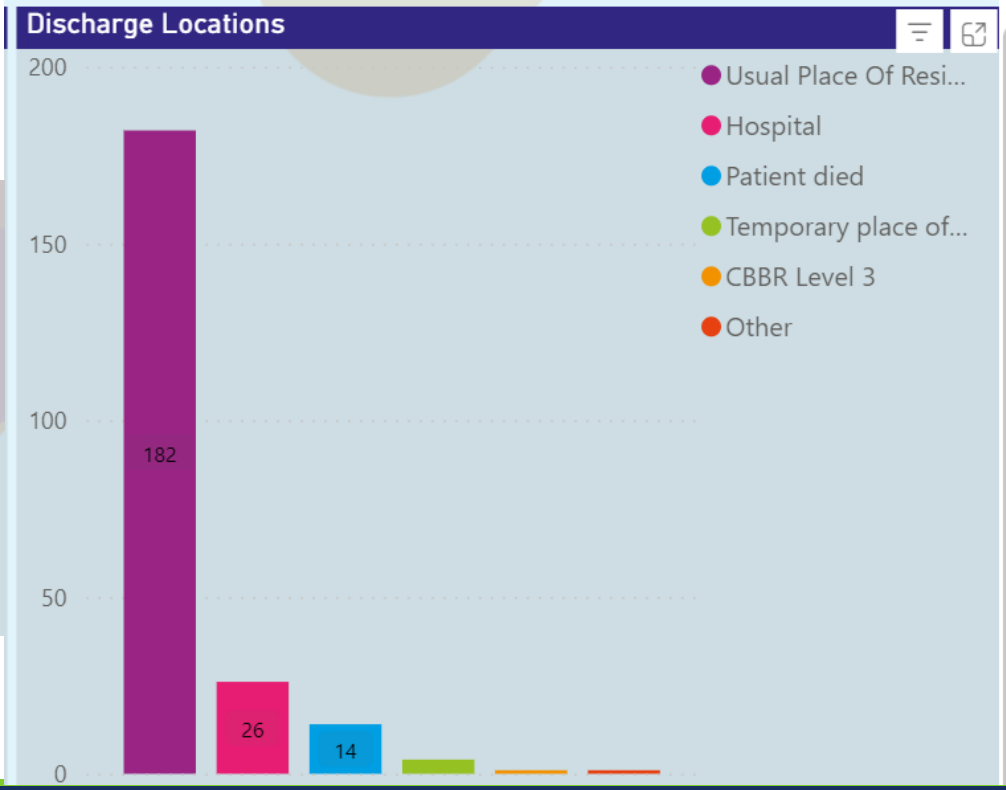


Frailty Virtual Ward Outcomes

Linking reactive and proactive
Requires integrated workforce





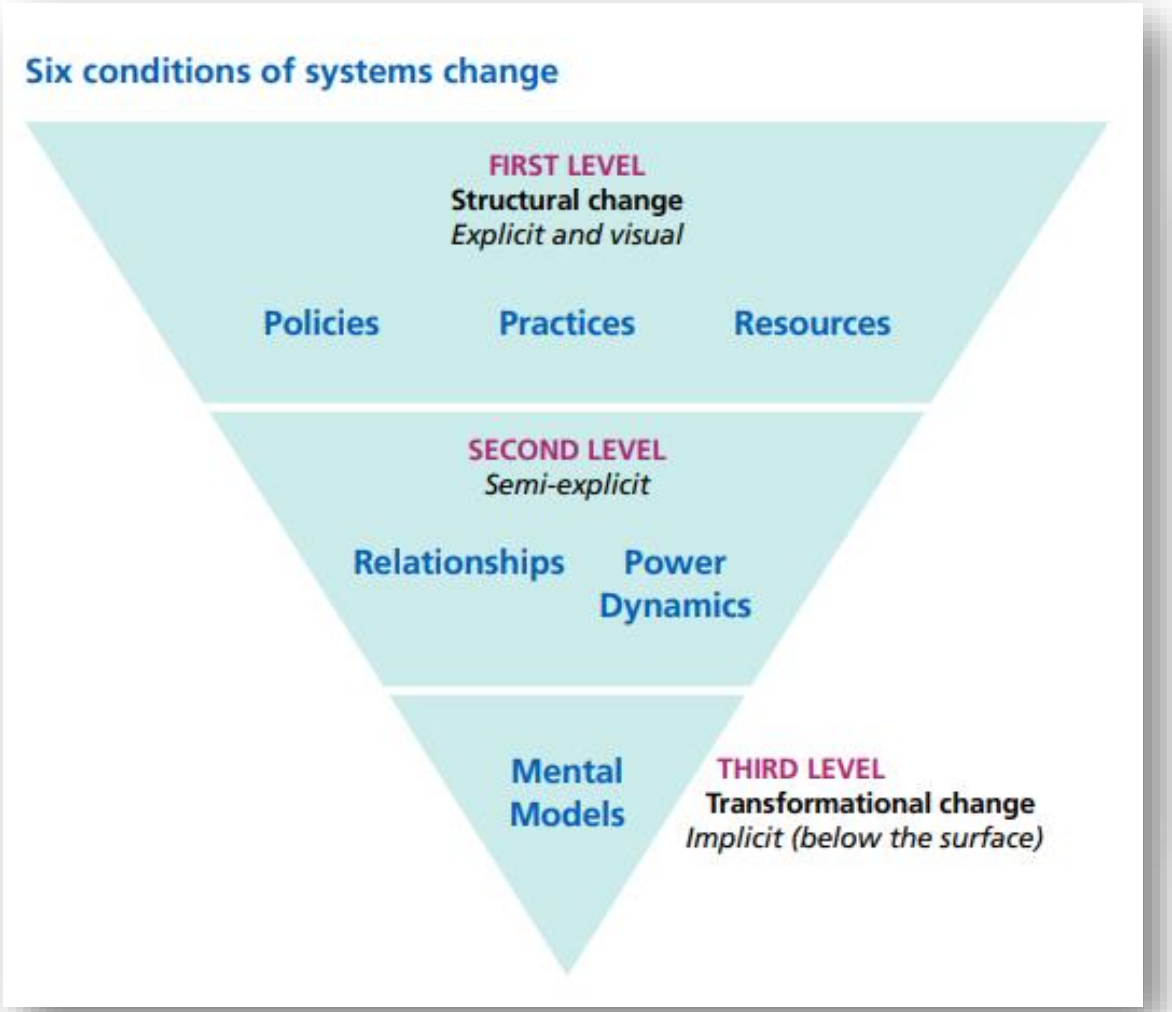


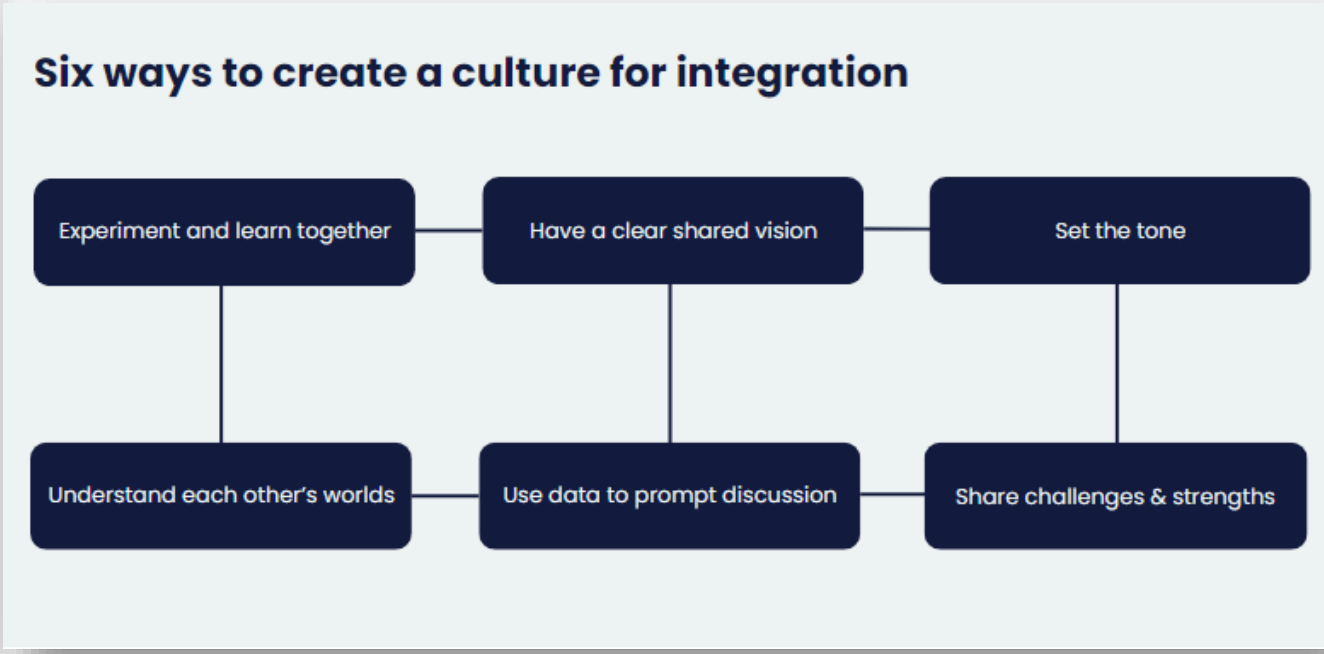
The Ageing Well Agenda- What have we achieved?

- Reduced duplication
- **Integrated** care records
- Adopted **Home First** principles - moved specialist provision **closer to home**
- Reduced emergency **attends and admissions**
- Increased utilisation of **step-up** community bed capacity
- Created new pathway for **paramedic support** at the scene
- **Reduced costs** of medication
- Shared learning and **understanding** of different roles and responsibilities
- Created a **can-do** culture
- Feeling of belonging – **a shared identity** / hub of excellence / pride
- **Co-location** has nurtured the ICC vision and kept it person centred
- **Supported** carers
- **Made frailty everyone's business**
- **Shared** the journey and the data

Winter doesn’t just have to be about beds

How this is Possible: Culture for Integration





System Frailty Principles – Place Based Solutions

1) Use population-based frailty identification
2) Deliver integrated proactive and reactive care closer to home
3) Address health and care inequalities (inc. Care Homes)
4) Involve Patient and Public partners
5) Embrace digital technology
6) Deliver frailty attuned hospital care
7) Coordinate compassionate end of life care
8) Enable independence and promote wellbeing
9) Develop system oversight and communication with stakeholders
10) Dedicate time for clinical and strategic leadership
11) Embed and enable a Quality Improvement approach
12) Promote a Measurement for Improvement mindset
13) Make 'frailty' everyone's business through education and training
14) Develop the frailty workforce that can deliver

Example: THE WORKFORCE

- **Takes time**
- Shared goals: right care in right place at right time
- See and solve
  - Based on personalised care
- Upskill others – Frailty everyone's business
  - social care, care homes, paramedics
- Specialist skill development
  - Portfolios / rotational / job shares
- Across organisational boundaries
- Future clinical workforce
  - GPVTS, ANP, PA
- Recruit "right" people – ran gaps
- Learn from each other and each others organisations
- Use MS teams:
  - For communication each day
  - Sharing learning
- Retention high: feel valued, empowered, work makes a difference

Challenges: THE WORKFORCE

- An integrated workforce plan
  - Systems thinking
- Workforce blended roles
  - Competency framework
  - ACP (pharmacy / physio)
  - How to upskill in existing teams (not bleed system)
- Frailty training
- Short term funding doesn't always help recruitment
  - "go at risk" : take a 1-2 year fixed term post
  - Is it a risk worth taking?
- Secondments becoming permanent

Critical Success Factors – Top Tips

- **Dedicated Clinical Leadership**
- **Engaged senior leadership / executives** with shared purpose
- **Relationships** & **Trust**
  - **Integrate records**
  - **Access**
- Ensure **public engagement**
- Stop thinking organisations and **think people – 1 Team (systems thinking)**
- **Be Strategic**: Create a **shared purpose** and aims
- **Be brave**, be involved, be confident
- Start with **small steps** build on success
  - PDSA but avoid pilotitis
- One version of the **truth**: Data is key
- Embrace **Digital solutions**
- If estate is a challenge **– virtual CGA**
- Support
  - System Wide Frailty Network (NHS Elect)
  - NHSE Community of Practice

Shared Learning

Further information:

- The Concept:
  - A place to meet the needs of people living with frailty | NHS Employers
  - The Jean Bishop Integrated Care Centre – YouTube
  - NHS England — North East and Yorkshire » Centre's integrated services transform care for frail and elderly residents
  - BBC One - Panorama, The NHS Crisis: Can It Be Fixed?
  - BGS Joining the Dots - A blueprint for preventing and managing frailty in older people.pdf
- Patient Experience:
  - The Jean Bishop Integrated Care Centre, Hull - Ray's story – YouTube
  - A non-randomised controlled study to assess the effectiveness of a new proactive multidisciplinary care intervention for older people living with frailty | BMC Geriatrics | Full Text (biomedcentral.com)
  - Experiences of a Novel Integrated Service for Older Adults at Risk of Frailty: A Qualitative Study - Imogen Wilson, Blessing O Ukoha-kalu, Mabel Okoeki, Joseph Clark, Jason W Boland, Sophie Pask, Ugochinyere Nwulu, Helene Elliott-Button, Anna Folwell, Miriam J Johnson, Daniel Harman, Fliss EM Murtagh, 2023 (sagepub.com)
- Yorkshire & Humber AHSN:
  - Understanding-our-response-to-COVID-19-report-singles.pdf (humbercoastandvale.org.uk)
- NHS ELECT:
  - Case Studies — SWF Network

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