

## From Frailty to Resilience

1 September 2017

 @WEAHSN # #FF2Resilience

### 1 Overview

#### About the West of England Academic Health Science Network

The West of England AHSN is delivering positive healthcare outcomes locally and nationally by driving the development and adoption of new innovations and making a meaningful contribution to the economy.

Established by NHS England in 2013, we are one of 15 AHSNs across England established to spread innovation at pace and scale.

As the only bodies that connect NHS and academic organisations, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

#### About the event

Following an expert reference group to scope the potential for the AHSN to support member organisations in their frailty work on 16 June 2017, this was the first meeting of the frailty community of practice.

### 2 Input from the room

14 attendees from 11 member organisations in the region including acute trusts, CCGs, community providers and mental health.

The group discussed:

- **Frailty scoring tools and comprehensive geriatric assessments (CGAs)** – what tools are validated for self-assessment? (Gloucester are using Rockwood for self-assessment) How do we combine tools? (South Gloucestershire combine Rockwood with timed get up and go test) Gloucestershire CCG has a SystemOne template for assessment and can share this. What pathways do people use for the next steps and escalation for different needs? The group agreed that whatever tool is used it is really a vehicle for discussion.

Tools mentioned:

- Edmonton frailty score <https://www.nscphealth.co.uk/edmontonscale-pdf>
- Rockwood <https://www.cgakit.com/fr-1-rockwood-clinical-frailty-scale>
- Prisma-7 <https://www.cgakit.com/fr-1-prisma-7>
- Timed Get up and Go [https://www.cdc.gov/steady/pdf/tug\\_test-a.pdf](https://www.cdc.gov/steady/pdf/tug_test-a.pdf)
- eFI [https://www.kingsfund.org.uk/sites/default/files/media/Healthy-Ageing-Collaborative-Electronic-Frailty-Index\\_2.pdf](https://www.kingsfund.org.uk/sites/default/files/media/Healthy-Ageing-Collaborative-Electronic-Frailty-Index_2.pdf) and <https://academic.oup.com/ageing/article/45/3/353/1739750/Development-and-validation-of-an-electronic>

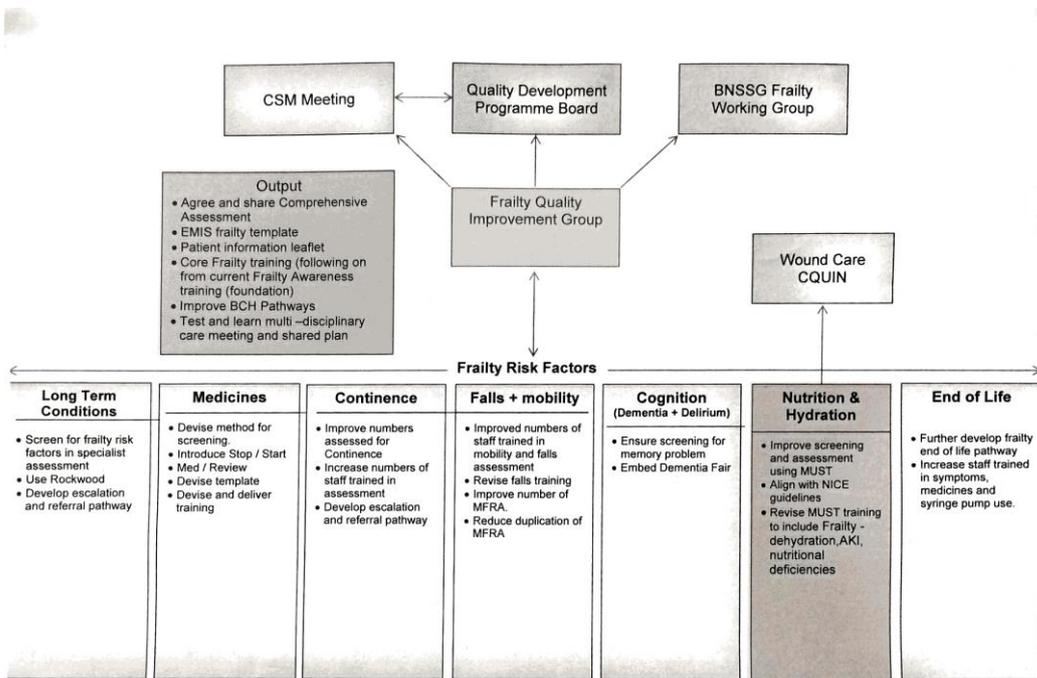
- **Frailty awareness** – how do we ensure that frailty is everyone’s business in the organisation? Do we need to rebrand the term “frailty” – would “resilience” or “living well” be better? What skills do people need – for example in one area all AHPs visiting patients are trained in B4 nursing skills so they can carry out nursing tasks at same time to avoid duplicate visits. Specialists need to know more about frailty, but the group discussed the value in everyone having a shared general level of knowledge and skills, and that developing a set of common principles could be a future task for this group. BCH to share their frailty awareness slides for clinicians.

Some national resources:

- National Frailty Meeting (28 September) – now sold out <https://eu.eventscloud.com/ehome/frailty2017/programme/>
- British Geriatrics Society <http://www.bgs.org.uk>
- NHS England – Older people living with frailty <https://www.england.nhs.uk/ourwork/ltc-op-eolc/older-people/frailty/>

- **Self-care and public engagement.** BCH shared that they were holding a patient focus group and could feed back at the next session on the outcome. Gloucestershire CCG are using PAM (patient activation measure) to understand where patients are on their health journey and how much they want to be engaged.
- **Structure of services** – there seem to be two models, either a specialist frailty team providing case management, or care managed by the patient’s GP practice (the “engine room” of care) with MDT (multi-disciplinary team) support. The group discussed who was involved in and MDT and how run, and Dr Kumar from North Somerset agreed to share their template and membership list of roles. The structure in North Somerset is integrated neighbourhood teams with risk-stratified locality MDTs.

Draft BCH structure shared by Sarah Whittle



- **Difficult conversations about ceiling of care/ treatment escalation plans (TEPs)**
  - St Peter’s Hospice provide local training and now in medical training for new doctors, so the gap is for those who completed training a while ago. “Squaring the curve of life” so people live well for more days towards the end of their life. Having a TEP is crucial, and it prompts you, however the group agreed it is the action taken that is most valuable.

# SIX TIPS

TO HELP YOU HAVE  
DIFFICULT CONVERSATIONS

@Haypsych  
www.halopsychology.com

**1 PREPARATION** is KEY.

- IT CAN BE HELPFUL TO JOT DOWN KEY POINTS IN PRIORITY ORDER IN ADVANCE.
- YOU’LL BE LESS LIKELY TO BE THROWN OFF COURSE.

THE TYPE OF SPACE YOU USE CAN HAVE AN IMPACT ON HOW THE CONVERSATION GOES. IDEAS:

- PRIVATE MEETING ROOM
- LOCAL COFFEE SHOP
- WALK AND TALK
- SIT IN LOCAL PARK

**2 PRACTICE** MAKES PERFECT

- HAVE A DRY-RUN WITH A TRUSTED COLLEAGUE OR YOUR COACH. THIS CAN HELP:
- REDUCE YOUR FEAR
- GIVE YOU FEEDBACK ON YOUR STYLE
- HONE YOUR MESSAGE

WHEN YOU’VE SAID YOUR INITIAL PIECE THEN STOP.

- ALLOW THE OTHER PERSON TO REFLECT AND TAKE IT IN.
- IF YOU FIND IT DIFFICULT, PUT A REMINDER TO YOURSELF, SUCH AS A POST-IT WITH THE WORD ‘QUIET!’

**3 SPECIFICS** ARE IMPORTANT

- HAVE ONE OR TWO DETAILED EXAMPLES TO ADD WEIGHT TO THE POINT YOU’RE MAKING.
- THESE SHOULD BE RECENT AND FIRST-HAND ACCOUNTS

HOW WOULD YOU FEEL TO HEAR THE FEEDBACK YOU HAVE TO GIVE? WHAT WOULD MAKE IT EASIER FOR YOU TO ACCEPT?

PUT YOURSELF IN THEIR SHOES

“Seek to understand in order to be understood”  
-STEPHEN COVEY

**4 ENVIRONMENT** IS IMPORTANT

**5 SILENCE** IS GOLDEN

**6 THEIR SHOES**

Five-year Kaplan–Meier survival curve for the outcome of mortality for categories of fit, mild frailty, moderate frailty and severe frailty (internal validation cohort)

<https://academic.oup.com/ageing/article/45/3/353/1739750/Development-and-validation-of-an-electronic>

Resources:

- TEP video from Devon in community <https://youtu.be/QAJtWiw3NHo>
- TEP video from Devon – COPD in ED <https://youtu.be/Ym7BbikKbWU>
- Wiltshire CCG guide <http://www.wiltshireccg.nhs.uk/wp-content/uploads/2015/08/TEP->

[Education-July-2015-presentation.pdf](#)

See also the Last 1000 days <http://www.last1000days.com> and video from Molly Case <https://youtu.be/HynytVepxZc>

- **Outreach** – how do we reach those in care homes, “housebound” (there was discussion of the use of this term), and supported housing. Sirona and Gloucestershire Care Services have been working with HCAs (healthcare assistants) in these settings in local clusters with other partners.

Case study: Dr Martin Vernon, Manchester <http://www.bgs.org.uk/ch-support-manchester/resources/casestudies/casestudysmanchester>

- **What interventions is there evidence for the biggest impact?** Medicines review by a community pharmacist can identify issues and stop drugs causing side effects, however stopping disease-specific medication does need GP or community geriatrician input. Gloucestershire CCG shared their de-prescribing guidance.

Gloucestershire CCG guidance: <https://g-care.glos.nhs.uk/pathway/104/resource/8>

- **How do we measure our impact?** The group discussed measures including: was CGA completed? How many unmet needs identified? What actions were taken? Dr Kumar agreed to share the measures they used in North Somerset.

### 3 Outcomes and next steps

The group agreed on the name “From Frailty to Resilience” #FF2F as their group name and hashtag to tag conversations on social media, and to share the resources discussed in the session.

**Next meeting: Friday 3 November, 1:30pm – 4pm**, venue North Bristol Intermediate Care Centre (TBC) Topic focus: MDTs

**Thank you to everyone involved in the session!**

## Appendix 1. QI projects shared via survey monkey

Please continue to add your projects at: <https://www.surveymonkey.co.uk/r/frailtyQI>

**Improving frailty pathway** – Larger project to refocus activity to the front door, and identify frail patients as they arrive. In development/ scoping. Top tips: Exec buy in – now suddenly urgent following an NHSI visit. Areas we would like help and support from members of the community: Screening – any successes? Jarrod Richards, Consultant Geriatrician – NBT, jarrod.richards@nbt.nhs.uk

**Improving the frailty pathway:** reintroducing the amber care bundle, reduction in fall QIP – staff understanding of QI methodology, change management and culture change. In development/ scoping. We are getting medical input into the projects. Areas we would like help and support from members of the community: in the frailty pathway would need collaborative work with community partners. Suzanne Luxton, matron stroke and elderly care – Weston general hospital, sluxton@nhs.net

**Working better together – Managing frailty in the community:** developing Multi-agency MDT meetings to enable health (physical & mental) and social care, community and voluntary services work better together in coordinating care and supporting people with frailty and their carers. – Gloucestershire has an above average aging population presenting with moderate to high frailty condition. Many of these people are being managed predominantly and sometimes inappropriately by medical interventions. Data analysis and local intelligence supports the notion that over emphasis of a medical model of care results in a high frequency and duration of hospital admissions as well as overloading GP and community services. We have identified a number of compounding problems: GP surgeries in some areas are struggling with practice resilience; there is poor communication between services resulting in poor care coordination and duplication; there is a lack of awareness and integration of community resources and assets; there is not a uniform or joined up system wide personalised care approach resulting in duplication and poor awareness of what really matters to a service user and their carers. Objectives are to reduce emergency attendance and hospital admissions; develop a care co-ordination process; develop a system wide personalised care approach; promote health and wellbeing self-care; integrate local area health, social and community services.

Early progress/ testing. 16 Cluster groups involving health and social care providers have formed in Gloucestershire serving an identified local population. Each cluster team has made a commitment to identify and develop different ways of working together to address key problems for populations.

4 of the clusters have identified frailty as a key issue within their population and committed to a pilot test and learn multi-agency MDT method of working.

MDT framework and evaluation process has been developed – 3 of the clusters are testing this (1 has started already; 2 start a schedule of meetings at the end of August)

2 of the clusters are also currently engaged in running a series of public and stakeholder engagement events with a local community focus.

Top tips: We are using imeet/Skype to support the process and help support members time management. Planning, coordination and communication is key. Making a time commitment to ensure effective collaborative working and genuine coproduction has been key and requires careful management. Areas we would like help and support from members of the community: Sharing of knowledge and understanding of resources, methodologies and models that have been used or tested.

Julie Mackie, Service Development Manager – Gloucestershire Care Services NHS Trust, julie.mackie@glos-care.nhs.uk

**South Cotswold Community Frailty Service:** Improving the quality of life for adults living with frailty. Early progress/ testing – The NHS Gloucestershire Clinical Commissioning Group (GCCG), Gloucestershire County Council (GCC), South Cotswolds Primary Care Locality, and a wide range of other partners across both the statutory and voluntary sector have agreed to work together on an innovative Community Frailty Service in the South Cotswolds in Gloucestershire to support people

to understand and manage their health and wellbeing due to the high level of individuals with living with frailty in the area. Service commenced 6 months ago. University of Gloucestershire have been selected to independently evaluate the service following a procurement process. The project is part of the Gloucestershire STP. This is an innovative and exciting initiative as the service is hosted by a GP practice on behalf of the locality.

Top tips: – use of patient held orange folder to ensure all partner organisations are informed: includes service leaflet and business card, personalised care plan 'Me at my best', Advanced Care plan and guidance, Health Coaching

- Cluster based working: developed inter-practice agreement between 8 surgeries including information governance agreement

- Proactive case finding: using the Electronic Frailty Index

- Patient Activation Measure (PAM) use: key to health coaching and personalised care planning.

Areas we would like help and support from members of the community: – Care planning: to ensure that a person centred approach is adopted

- In process of developing a countywide Clinical Programme Group for Frailty: community support will be beneficial to develop the pathway

Jane Haros, Lead Clinical Commissioner – NHS Gloucestershire Clinical Commissioning Group, j.haros@nhs.net

**Community Frailty Nurse** to deliver rolling programme of education to community teams so they are better skilled at delivering evidence based frailty interventions and support a CGA approach – New focus in GP contract supports identification and management of frail patients in the community. The project is addressing the skills and ability of community teams to support GPs to undertake this.

In place locally. In discussion with provider to finalise job plan.

Top tips: We were hoping to be able to recruit a geriatrician to work alongside the nurse to undertake education sessions to GPs but the lack of Geriatricians nationally has meant we were not able to recruit.

We are investigating how to recruit / develop GPwER Older People to increase the pool of skilled practitioners in this area. Areas we would like help and support from members of the community: Management of frailty in the community an interest, monitoring and KPIs

Katia Montella, Project Officer – NHS BaNES CCG, katia.montella@nhs.net

**Moving complex frail assessments into ED.** Frailty recognition tool development in ED –

Tomorrows work today in CGA – bringing it earlier into the admission process, reducing admissions and LOS, improving frailty quality metrics

In development/ scoping. This is something of an incremental change, with an AMU team already in place attached to a frailty unit, and therapy input already present in ED. However – other business as usual issues have been a risk thus far.

Top tips: Don't firm up a timeline with an otherwise fragile system.

Jarrold Richards, Consultant Geriatrician – NBT, jarrod.richards@nbt.nhs.uk

**BCH Quality Improvement Group for Frailty.** Improved staff competence for frailty risk factors. Improved Screening, Assessment and appropriate referral for frailty risk factors.

Early progress/ testing. This group brings together a variety of workstreams already in place or being developed that fit with Frailty.

Top tips: Staff confidence to put frailty knowledge into practice is a key factor.

Areas we would like help and support from members of the community: We would like to explore coping mechanisms and a tool that may help us measure what enables a person with a high frailty score to live well.

Sarah Whittle, Clinical Lead Nurse Community Nursing – Bristol Community Health, sarah.whittle2@nhs.net