Developing a Frailty Service in Lincolnshire West Clinical Commissioning Group

Dr Sunil Hindocha. Clinical Chief Officer, LWCCG.
Lincolnshire

• Total population of 730,000 people
• Over 2,000 sq miles
• 4 Clinical Commissioning Groups
• 1 Acute Trust
• 1 Mental Health Foundation Trust
• 1 Community Health Services Trust
• 1 County Council; 7 District Council
• Active Voluntary Sector
Area 449 sq. miles

37 Member Practices
101 GPs
4 localities

Registered population: 230,271

Annual Population Growth
Over 65 5.22%
Case for Change

- Frail older people comprise 3% of all emergency department attendees, but >75% will be admitted to an Acute Medical Unit.

- Frail older people have the longest length of stay, highest inpatient complications and subsequent readmissions.¹

- Utilisation review-257 reviews over 65’s- 54 % did not meet criteria for acute bed, 791 lost bed days

- 33% met criteria for home care.

¹Conroy et al, British Journal of Hospital Medicine, 2010.
What is frailty?

- Frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body’s physical and psychological reserves.

- Frailty varies in its severity.

- The degree of frailty of an individual is not static.

- Frailty is not an inevitable part of ageing; it is a long-term condition like diabetes or Alzheimer’s disease.
Why is frailty important?

• Older people living with frailty are at risk of dramatic deterioration in their physical and mental wellbeing after an apparently small event

• Frailty might not be apparent unless actively sought

• There is evidence that in individuals with frailty, a person-centred, goal-orientated comprehensive approach reduces poor outcomes and may reduce hospital admission
Integration Model for Frailty

Core Principles of an integrated approach
- Collaborate for mutual benefit to improve patient outcomes and experience
- Share relevant information, expertise and plans
- Avoid duplication wherever possible and trust each other's assessment
- Monitor the performance across the pathway
- Seek continuous improvement by working together to get the most out of the resources available and by finding better, more efficient ways of doing things
- Share the potential risks involved in service developments
- Promote the partnership approach at all levels in the organisation (e.g., through joint induction or training initiatives)

Outcomes
- People will feel supported and confident to remain in their own home or usual place of residence
- Patients receive appropriate assessment and personalised care
- Reduction in utilisation of hospital care
- There will be more rapid and timely responses to potential crisis situations
Strands of a Frailty Service

- Community based services:
  - Secondary Care clinician
  - Voluntary sector-Age UK, LACE, Hospice
  - Community services-Nursing, therapy, mental health
  - Primary Care
  - Dedicated Case Manager.
  - Simple assessment tool, universal
What Has Worked Well

- Integrated work – relationship management
- Holding regular MDT meetings – excellent engagement.
- Put people in a room together
- Having Project management
- Joint visits/Assessments
- Use of a case-finding tool- CSHA, E frailty
- Agreed shared assessment tools
- GP frailty specialists within community teams
Frailty Levels of Care

**Frailty Score 1 – 3**
Ranging from being very fit and active through to being treated for at least one condition which is well controlled

- General check-up and medication review
- Advise of the available “well-being” services in the locality and how these may be accessed (give as a handout)
- Reassessment
- Needs met and discharged
- Needs currently met and condition stable
- Needs increasing
- Appropriate Care Plan established including “Planning for the Future”

**Frailty Score 4 – 5**
Ranging from not dependent but may have disease symptoms through to requiring aids and equipment to help with activities of daily living (ADL)

- Complete an overview assessment
- Patient has care planned by key worker +/- MDT
- Care delivered by a generalist
- Advise and refer where necessary to “well being” services in the locality especially those which can offer further assessment and help, e.g. First Contact
- Reassessment
- Needs decreasing
- Needs currently met and condition stable
- Needs increasing
- Needs met and discharged
- Needs currently met and condition stable
- Needs increasing
- Appropriate Care Plan established including an Advance Care Plan

**Frailty Score 6 – 7**
Help is needed by the use of equipment and hands-on care from others through to being completely dependent on others for the activities of daily living

- Continuous MDT assessment
- Needs decreasing
- Needs currently met and condition stable. Care Package implemented in order that patients stay in usual place of residence
- Needs increasing
- Appropriate Care Plan established including review of the Advance Care Plan
- Activate Advance Care Plan
- Specialist referral and assessment, e.g. acute care, palliative care

Markers of Frailty
- Inability to perform one or more basic ADL in the three days prior to admission
- A Stroke in the past three months
- Depression
- Dementia
- A history of falls
- One or more unplanned admissions in the past three months
- Difficulty in walking
- Malnutrition
- Prolonged bed rest
- Incontinence

Version 02, November 2011
Challenges

- Workforce
- Achieving real cultural change
- GP engagement
- Information Sharing
- Gaining consistency – care planning
- Delivering impact at Scale
Current Frailty Service

- **Community based services:**
  - Self Care/community capacity
  - Preventative - Wellbeing Service
  - Neighbourhood teams
  - Care home Service
  - GpwSI
  - Primary Care Navigators – Age UK

- **Transitional Care Service**
  - Bed based to ‘Home First’ – major change project

- **Secondary Care**
  - Front door Frailty Service/ Assertive in-reach team
  - Integrated Discharge Hub
Impact
# Emergency admission numbers

## Table 1: Emergency Admissions - LWCCG

<table>
<thead>
<tr>
<th>Age Band</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>15/16 F/O</th>
</tr>
</thead>
<tbody>
<tr>
<td>65 - 69</td>
<td>1,357</td>
<td>1,428</td>
<td>1,459</td>
<td>1,511</td>
<td>1,629</td>
<td>1,456</td>
<td>1,526</td>
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<tr>
<td>70 - 74</td>
<td>1,539</td>
<td>1,676</td>
<td>1,644</td>
<td>1,564</td>
<td>1,578</td>
<td>1,550</td>
<td>1,603</td>
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<tr>
<td>75 - 79</td>
<td>1,725</td>
<td>1,850</td>
<td>1,781</td>
<td>1,795</td>
<td>1,625</td>
<td>1,754</td>
<td>1,673</td>
</tr>
<tr>
<td>80 - 84</td>
<td>1,875</td>
<td>1,992</td>
<td>1,985</td>
<td>1,977</td>
<td>1,914</td>
<td>1,810</td>
<td>1,757</td>
</tr>
<tr>
<td>85 +</td>
<td>2,559</td>
<td>2,803</td>
<td>2,927</td>
<td>3,148</td>
<td>2,796</td>
<td>2,764</td>
<td>2,710</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,055</strong></td>
<td><strong>9,749</strong></td>
<td><strong>9,796</strong></td>
<td><strong>9,995</strong></td>
<td><strong>9,542</strong></td>
<td><strong>9,334</strong></td>
<td><strong>9,269</strong></td>
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</table>
### Emergency Admissions for All Conditions Aged 75+ (Apr-Dec)

<table>
<thead>
<tr>
<th>Organisation</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boston</td>
<td>2,132</td>
<td>1,987</td>
<td>-145</td>
<td>-6.80%</td>
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<tr>
<td>East Lindsey</td>
<td>2,246</td>
<td>2,326</td>
<td>80</td>
<td>3.56%</td>
</tr>
<tr>
<td>Skegness &amp; Coast</td>
<td>2,381</td>
<td>2,460</td>
<td>99</td>
<td>4.19%</td>
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<tr>
<td>LECCG</td>
<td>6,739</td>
<td>6,773</td>
<td>34</td>
<td>0.50%</td>
</tr>
<tr>
<td>Gainsborough</td>
<td>930</td>
<td>986</td>
<td>56</td>
<td>6.02%</td>
</tr>
<tr>
<td>Lincoln City South</td>
<td>1,089</td>
<td>1,057</td>
<td>-32</td>
<td>-2.94%</td>
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<tr>
<td>North Lincoln</td>
<td>1,411</td>
<td>1,316</td>
<td>-95</td>
<td>-6.73%</td>
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<tr>
<td>South of Lincoln</td>
<td>1,219</td>
<td>1,196</td>
<td>-23</td>
<td>-1.89%</td>
</tr>
<tr>
<td>LWCCG</td>
<td>4,649</td>
<td>4,555</td>
<td>-94</td>
<td>-2.02%</td>
</tr>
<tr>
<td>South Holland</td>
<td>2,156</td>
<td>2,140</td>
<td>-16</td>
<td>-0.74%</td>
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<tr>
<td>Welland</td>
<td>1,903</td>
<td>1,985</td>
<td>82</td>
<td>4.31%</td>
</tr>
<tr>
<td>SLCCG</td>
<td>4,059</td>
<td>4,125</td>
<td>66</td>
<td>1.63%</td>
</tr>
<tr>
<td>SWLCCG</td>
<td>2,836</td>
<td>2,988</td>
<td>152</td>
<td>5.36%</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>18,283</td>
<td>18,441</td>
<td>158</td>
<td>0.86%</td>
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</tbody>
</table>
Enhancing quality of life for people with long term conditions

<table>
<thead>
<tr>
<th>Name</th>
<th>Period</th>
<th>Value</th>
<th>Mean</th>
<th>Chart</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency admissions for acute Ambulatory Care Sensitive Conditions (Directly Standardised Rate per 100,000 population)</td>
<td>Jun 1516</td>
<td>76.2</td>
<td>99.4</td>
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<tr>
<td>Emergency admissions for chronic Ambulatory Care Sensitive Conditions (Directly Standardised Rate per 100,000 population)</td>
<td>Jun 1516</td>
<td>44.1</td>
<td>62.4</td>
<td></td>
<td></td>
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<tr>
<td>Emergency admissions for patients age 65 and over with Dementia (Directly Standardised Rate per 100,000 population)</td>
<td>Jun 1516</td>
<td>29.8</td>
<td>55.5</td>
<td></td>
<td></td>
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<tr>
<td>Emergency admissions for asthma, diabetes and epilepsy in under 19 year olds (Directly Standardised Rate per 100,000 population)</td>
<td>Jun 1516</td>
<td>3.49</td>
<td>5.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes admissions (Directly Standardised Rate per 100,000 population)</td>
<td>Jun 1516</td>
<td>4.13</td>
<td>5.14</td>
<td></td>
<td></td>
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<tr>
<td>Admissions for patients age 65 and over for or with a fall (Directly Standardised Rate per 100,000 population)</td>
<td>Jun 1516</td>
<td>32.4</td>
<td>39.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
THANK YOU