NHS RightCare Frailty Pathway
An optimal frailty system

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- **Adrian Hopper** – Consultant Physician & Frailty Pathway GiRFT Lead
- **Alex Thompson** – Pathways Topic Lead

31 August 2018
# NHS RightCare Frailty Pathway

An optimal frailty system

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<th>Title</th>
<th>Presenter</th>
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<td>1</td>
<td>RightCare pathways explained</td>
<td>Alex Thompson</td>
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<td>Ageing Well - Quality Healthcare in Later Life</td>
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<td>Alex Thompson</td>
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What is a RightCare pathway?

A high-level overarching national case for system change

Practice examples that show the potential in population health approaches

Priorities for improvement and key high impact interventions along a pathway

Underpinning guidance, evidence and implementation resources to help make change on the ground
How are Pathways created?

1. **Topic Selection**
2. **Scoping**
3. **Engage**
4. **Construct**
5. **Publish & Promote**
6. **Evaluate**
7. **Refresh**

**Pathway Development Operational Guide**

Author: Alex Thompson - NHS RightCare Pathways Topic Lead
Date: 13 April 2017

**NHS RightCare Frailty Pathway**

- **Priorities**
  - Prevention, support, medication, and information to early
    - Early intervention
  - Support those with mild frailty, those requiring support
  - Assess those with moderate frailty
  - Support those with severe frailty

- **Tasks and Benefits**
  - Early identification
  - Early intervention
  - Support those with mild frailty
  - Support those with moderate frailty
  - Support those with severe frailty
## The NHS RightCare Frailty Pathway

### Priorities

<table>
<thead>
<tr>
<th>Population segmentation, identification and stratification of frailty</th>
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<tbody>
<tr>
<td>• System-wide recognition of the signs of frailty</td>
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<td>• Know what to do when signs of frailty are found</td>
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<tr>
<td>• Standardised way of stratifying frailty status</td>
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<tr>
<td>• Identify frailty &amp; frailty status</td>
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<table>
<thead>
<tr>
<th>Supporting people with mild frailty and encouraging people to ‘age well’</th>
<th>Support people with moderate frailty</th>
<th>Reduce hospital length of stay</th>
<th>Support people with severe frailty</th>
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<tbody>
<tr>
<td>• Define the local healthy lifestyle offer</td>
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<td>• Education &amp; understanding of frailty</td>
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<td>• Supported self-care</td>
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<tr>
<td>• Nutrition</td>
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<tr>
<td>• Mild frailty: acknowledge, understand and address the condition</td>
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<td>• Multidisciplinary assessment of risk stratified patients</td>
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<tr>
<td>• Home and/or community based rehabilitation</td>
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<tr>
<td>• Recognition of deterioration</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• Crisis response</td>
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<tr>
<td>• First 24 hours</td>
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<td></td>
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<tr>
<td>• Effective rehabilitation</td>
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<td></td>
<td></td>
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<tr>
<td>• Transfers of care to new care setting</td>
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<tr>
<td>• Co-ordination of care through sharing information</td>
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<tr>
<td>• Training &amp; capabilities of social care staff</td>
<td></td>
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<td></td>
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<tr>
<td>• Management of urgent care situations</td>
<td></td>
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<tr>
<td>• Enhance healthcare in care homes</td>
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<td></td>
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<tr>
<td>• End of life care</td>
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### Falls and Fragility Fractures

### Delirium, Dementia and Cognitive Disorder

| • Early identification of delirium |
| • Education of population, patients, families & carers |

### Personalised care

| • Advance care planning |
| • Shared Decision Making |

### The case for change

### Self assessment check-list
Ageing Well
Quality Healthcare in Later Life

The National Frailty Challenge

Martin Vernon
What do we mean by frailty?

“A long-term condition characterised by lost biological reserves across multiple systems & vulnerability to decompensation after a stressor event”

SPECTRUM DISORDER

FIT ➔ MILD ➔ MODERATE ➔ SEVERE

FUNCTIONAL ABILITY

INDEPENDENT ➔ ‘MINOR ILLNESS’ ➔ DEPENDENT

Unpredictable recovery
Three priorities for frailty

• Change in approach to health & social care for older people

• Preventing poor outcomes through active ageing

• Quality improvement in acute & community services
Why? - we don't all age in the same way

Also, consider inequalities carefully:

Lowest economic quartile frailty commences earlier in the life course and progresses more rapidly, contributing to reduced life expectancy.
Costs distribute differently as frailty progresses

Percent total spend by category within eFI band
Patients 65+ KID Jan - Oct 2017 activity data

<table>
<thead>
<tr>
<th>Category</th>
<th>Fit</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>GP Prescription</td>
<td>13.8%</td>
<td>15.2%</td>
<td>11.1%</td>
<td>8.4%</td>
</tr>
<tr>
<td>GP</td>
<td>13.0%</td>
<td>9.6%</td>
<td>8.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td>MH Inpatient</td>
<td>3.5%</td>
<td>3.6%</td>
<td>1.6%</td>
<td>1.8%</td>
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<tr>
<td>MH Community Care</td>
<td>2.4%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>10.5%</td>
</tr>
<tr>
<td>Community Care</td>
<td>4.5%</td>
<td>5.2%</td>
<td>7.7%</td>
<td></td>
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<tr>
<td>Acute cost/patient</td>
<td>50.0%</td>
<td>45.8%</td>
<td>46.1%</td>
<td>47.7%</td>
</tr>
<tr>
<td>Social Care Ave/Patient</td>
<td>12.7%</td>
<td>18.5%</td>
<td>23.2%</td>
<td>24.2%</td>
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</tbody>
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Integrated Care for Older People (ICOP)

Current position

Ageing population
2040 nearly one in seven will be over 75.

Frailty prevalence increasing
A person with mild frailty has twice the mortality risk of a fit older person at the same age.

Opportunities for prevention
There are currently 4000 hospital admissions a day for people with frailty.

Intermediate care gap
National audit data (NAIC 2017) suggests intermediate care capacity needs to double.

An NHS priority
The priority for the NHS to help older people stay healthy and independent with work already underway through Vanguards and NMCs.

10 year vision

The NHS has an opportunity to be world leading in our approach to population ageing & care for older people with frailty.

This can be achieved by implementing at scale support for people in community settings.

Currently older people with frailty often don’t get the care they need in the right setting and at the right time.

Hospital interventions for some older people are limited in efficacy.

Working with social care we will take a new approach to providing targeted population based care focused on the needs of older people vulnerable to the effects of frailty to stay healthy live independently and live safely at home or in their community.

We will continue to support older people with advancing frailty in their communities to the end of their life.

Proposed service model

Ageing Well Service
Multidisciplinary teams (MDT) focused on meeting the needs and improving care for 1.2m patients living with moderate frailty with the aim of preventing frailty progression.

Urgent Community Response and Recovery Service
Achieving a 2 day referral to commencement of care and 2 hr crisis response in the first 5 years. This service builds from the existing intermediate care model by increasing capacity and responsiveness.

Enhanced health in Care Homes (EHCH)
Reaching all people living in care homes and building on national adoption of models of best practice with the aims of delivering personalised care.

These linked models need to be delivered within primary care networks.

Implementation will be developed from existing and best practice in an adoption and improvement approach.
Population segmentation, risk stratification and linked service interventions based on what people need

**Structural dependencies**
- Integrated working across organisations & systems
- Primary Care Networks
- Commissioning and regulation
- Population health management
- Local health and care record

**Target populations**
- End of life care
- Severe Frailty
- Moderate Frailty
- Mild Frailty
- Whole population

**Interventions**
- Enhanced Health in Care Homes
- Urgent Community Response and Recovery
- Ageing Well
- Primary Prevention

**Outcomes**
- Deploying more shared decision
- Enabling more people to die in a place of their choice
- Reducing avoidable admissions to hospital
- Reducing unwarranted use of hospital bed days
- More people and carers reporting improved experiences of care
- Supporting people to maintain or improve their frailty status
- Supporting more people to access Personal Health Budgets
- More people reporting improved continuity and experience of care
- More people supported to self-manage their condition resulting in fewer unwarranted ED attendances and GP appointments

Want to know and share more? england.clinicalpolicy@nhs.net
Frailty – the GiRFT perspective
Adrian Hopper
• GIRFT is delivering 35 workstreams, occurring concurrently at different stages.
• Core focus is on peer to peer engagement within specialties, but to maximise improvement opportunities we also need to focus on patient pathways and services that cross specialty boundaries.
• GIRFT is therefore delivering a number of cross cutting projects:
  - Litigation
  - Procurement & Technology
  - Patient Safety
  - Patient Safety
  - Medicines Optimisation
  - Frailty
  - Coding
  - Critical & Intensive Care
  - ED & Acute Admissions
  - Brain conditions
  - Outpatients
  - Diagnostic services
  - Anaesthetics Perioperative
  - Pathology services

• And GIRFT Clinical Leads are coming together to work in clinical service lines when beneficial for exploiting opportunities or joining up services across specialty boundaries:
GiRFT Regional Hubs support trusts in delivering the Clinical Leads’ recommendations by:

- Helping them to assess and overcome the local and national barriers to delivery.
- Working closely with NHSI regions to ensure prioritisation of GiRFT delivery takes account of the wider context within each trust and is joined up with local and regional improvement initiatives.
- Joining up with NHSE/RightCare to ensure integrated support for STP level improvements.
- Producing good practice manuals of case studies and best practice guidance that trusts can use to implement change locally.
- Supporting mentoring networks across trusts.

Each hub will have two clinical ambassadors: regionally recognised leaders of improvement programmes.
According to HES data, across the South 17.9% of patients 75 and over admitted in an emergency had length of stay zero in 2016/17.

Source: Hospital Episode Statistics (HES) 2016/17
According to HES data, across the South among patients 75 and over, those admitted for 21 days or more consumed 53% of the total bed days in 2016/17.
According to HES data, across the region 47% of patients 75 and over admitted as an emergency who stay in hospital 21 or more days are discharged to a care home.

**Source:** Hospital Episode Statistics (HES) 2016/17
Response to severe frailty – emergency admission from care homes

- 400,000 residents
- 0.7 admission/resident/yr
- Mean LOS 7 days (with variation)

Interventions – out of hospital support
- Advance care planning
- End of Life Care
Thank you

Round up and Questions