Lincolnshire West Clinical Commissioning Group

Lincolnshire West CCG:

An Integrated Frailty Pathway

Context

Lincolnshire West Clinical Commissioning Group (CCG) commissions a wide range of health services for a local population of nearly 225,000 people, over a significant geographical area. Their aim is to improve the quality and delivery of health services for their patients.

One of the ways in which they intend to achieve this aim is by working with their partners to deliver high-quality and coordinated, integrated healthcare.

Like many areas across the UK, Lincolnshire West has an increasing older population – one in twelve are over 75 years of age. An integrated healthcare system will help to ensure these people can remain healthy and safe at home, and offer a rapid community response, that provides older people with a viable alternative to hospital admission.

Analysis

In 2010, when the CCG started to address this issue, analysis of elderly wards in Lincoln County Hospital found that 20 per cent of people over 75 years old could have been treated more effectively in a community setting, or may have avoided admission had more robust preventative measures been in place.

This was backed up by anecdotal evidence, as patients told their primary care doctors that they struggled to access social care in a timely fashion, and ended up in hospital as a result.

This not only presented significant issues in terms of patient experience and safety, but also had a financial impact on the health economy, as secondary care providers allocated resources to patients who could have avoided admissions through effective community healthcare. For instance, it can cost up to £3,000 to fix an older person's hip, because a relatively inexpensive grab rail has not been installed in their home.

Resourcing and project management

This project did not require financial investment – the issue was not with needing extra resource, but with managing the existing resource more efficiently. Equally, it was believed that putting in a pathway that allowed for early interventions for frail older people would achieve significant savings.

The project was led by Carol Cottingham, the CCG's Head of Delivery for Urgent Care and Long Term Conditions, with external support bringing additional service redesign experience.

Solution

It was vital that interventions, to move patients both in and out of hospital happened at the earliest possible time. Therefore, the CCG began work on a project to produce a frailty pathway to integrate services with the following intended outcomes:

- people can be maintained well and safely in their own homes
- people can be supported to remain safely at home in times of crisis
- people admitted to hospital return home safely and in a timely manner

The project team initially worked with a range of clinicians, patients and carers to agree an effective end-to-end pathway to identify and manage frailty. This comprised a number of service changes and developments along the pathway from prevention through to end-of-life care. These included:

- Development of the range and access to third sector services
- Creation of a community geriatrician post
- Establishment of integrated community response teams
- A project to work with local care homes which provided additional training and enhanced GP involvement.

GP Practices were supported to use the Canadian Frailty Scoring tool to identify at risk patients. This tool allows clinicians to rate patients aged over 75 in terms of their frailty. A score of one to three indicated that they were able bodied, four to five showed a potential risk of admission, while six to seven showed a need for admissions.

Of most interest to the project were those people scoring between four and five, as they could end up being admitted to hospital unnecessarily, without an integrated pathway.

They embedded the scoring system in primary care – as this is the most frequent first point of contact – and then used by the wider community team to ensure appropriate care planning, provide proactive support and reduce crises.

Partner and patient engagement

The CCG realised immediately that, by its very nature, an integrated pathway required all partners to be involved. Using existing relationships, a steering group was set up, with representation from secondary care clinicians, ambulance services, mental health providers, community nurses and social care services.

Crucially, training was needed for frontline staff, for three purposes: to explain the scoring system and resulting pathway; to teach staff how to track patients through the entire health system; and to engage their hearts and minds to ensure buy in to the pathway with an evidence-based case for change.

At the start of the project, patients were also asked for their thoughts on the current system, and taken through the proposed model. In order to ensure that the scoring made sense, a pilot group of patients were asked to score themselves using the same criteria – it transpired that these scores were remarkably similar to those scores given by clinicians.

Outcomes

Since the pathway, and its associated measures, was introduced in 2011/12, almost three quarters of patients over the age of 75 have a registered frailty score – meaning that they are now in a position to receive the most appropriate care pathway from all local health providers.

These patients are more likely to be cared for at home by the clinician best placed to help them, and patients and carers are more likely to have access to appropriate information, advice and support.

As a consequence, there has been a three per cent reduction in unscheduled hospital admissions for over 75s since 2010, and a 36% reduction in excess bed days over the same period.

These figures were achieved at a time when the number of unscheduled admissions and excess bed days were increasing nationally. The figures indicate that the objectives that the project set out with were being met.

Dr Sunil Hindocha, Chief Clinical Officer at Lincolnshire West CCG, gave this advice to any other CCGs that were considering moving towards a similar integrated system for identifying and managing frailty: “Get out and do it. The outcomes will be good for patients, for the CCG, and for the health economy as a whole.”

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