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Provider Forum

17th October 2024

Working together
for a healthier future

Objectives of this Presentation

- Population Health perspective on frail patients
- Clinical perspective on how different ways of managing frail patients can lead to very different experiences
- Key objectives of our Integrated Care Board Work
- Idealised Wire diagram
- Overview of Workstreams
- The actual number of people living with frailty is likely to be higher and practices are working to improve the identification and diagnosis of frailty. However, identifying frailty should be done at all appropriate opportunities.
- Around 10% of people aged over 65 live with frailty. This figure rises to between 25% and 50% for those aged over 85.
- National data show that approximately 44% of people with severe frailty die within 3 years.
- WHHT audit of emergency admissions showed 25% were in last year of life, taking up 35% of occupied bed days

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Frailty

- There are approximately 90,000 people recorded as having frailty within HWE ICS.
- The majority of people are living with mild frailty (60%) and approximately 11% of people with frailty have severe frailty.
- The actual number of people living with frailty is likely to be higher and practices are working to improve the identification and diagnosis of frailty. However, identifying frailty should be done at all appropriate opportunities.
- Around 10% of people aged over 65 live with frailty. This figure rises to between 25% and 50% for those aged over 85.
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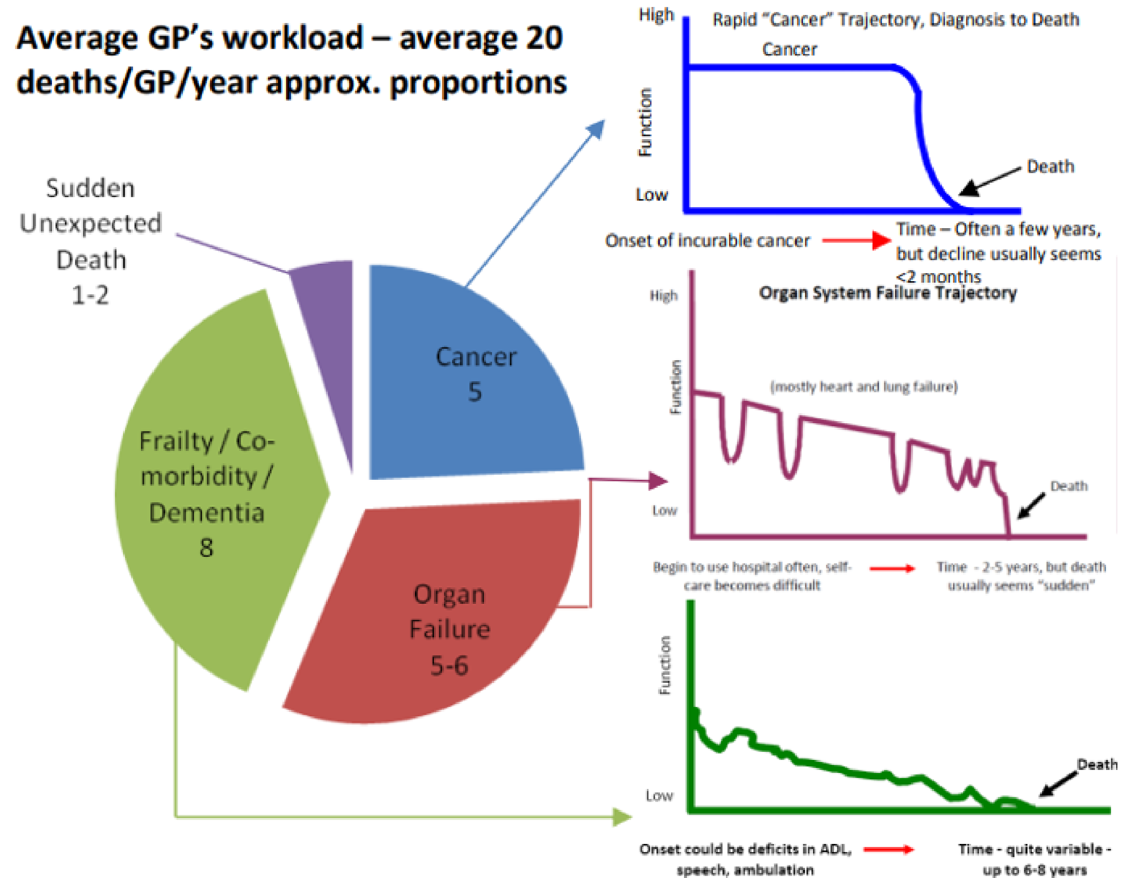

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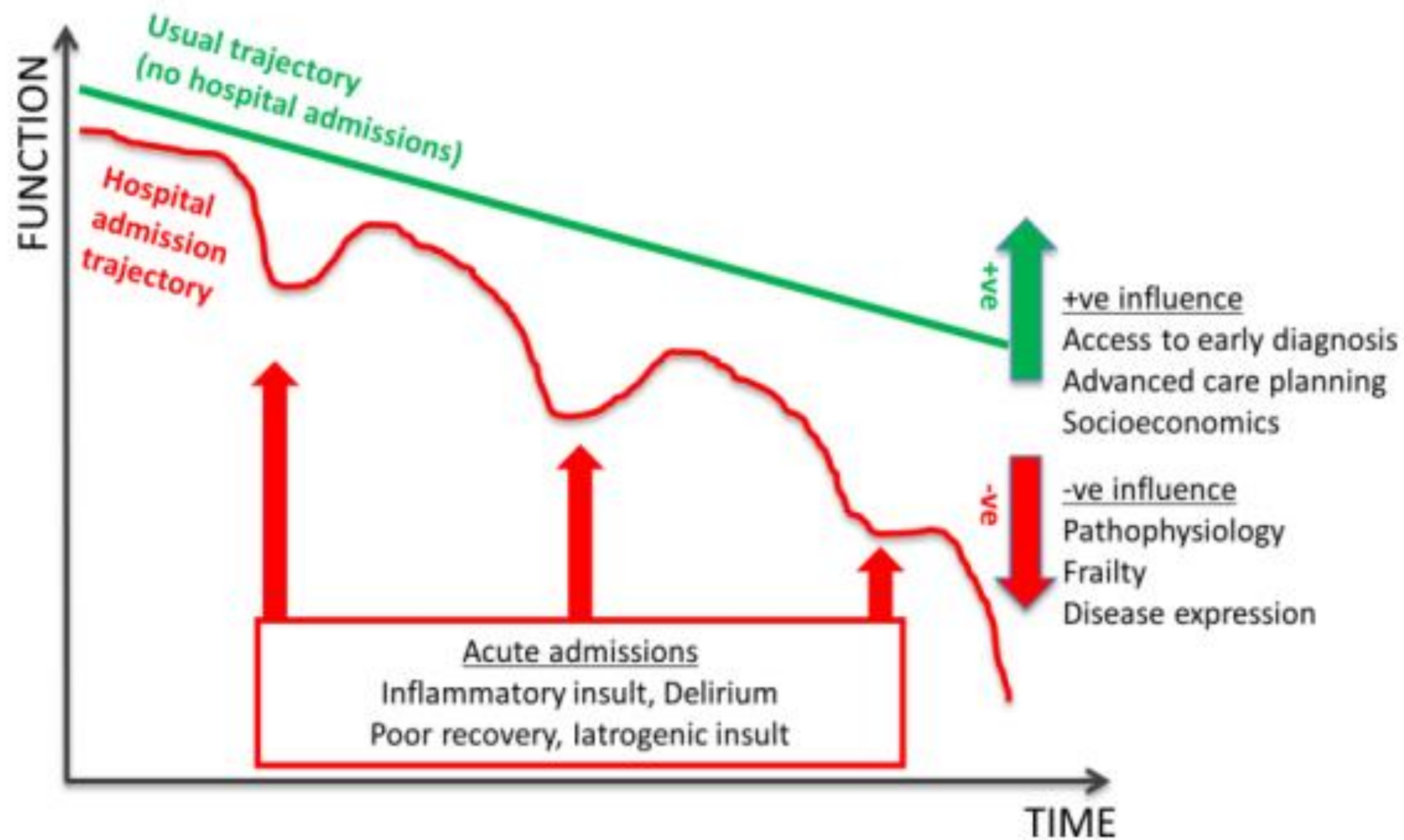
Impact of hospitalisation of frail patients



Programme Vision

Move from this:

... to this:

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Frailty transformation in HWE

- Strong focus on **IDENTIFICATION** of frail patients
- Rockwood
- End of Life – last year of life

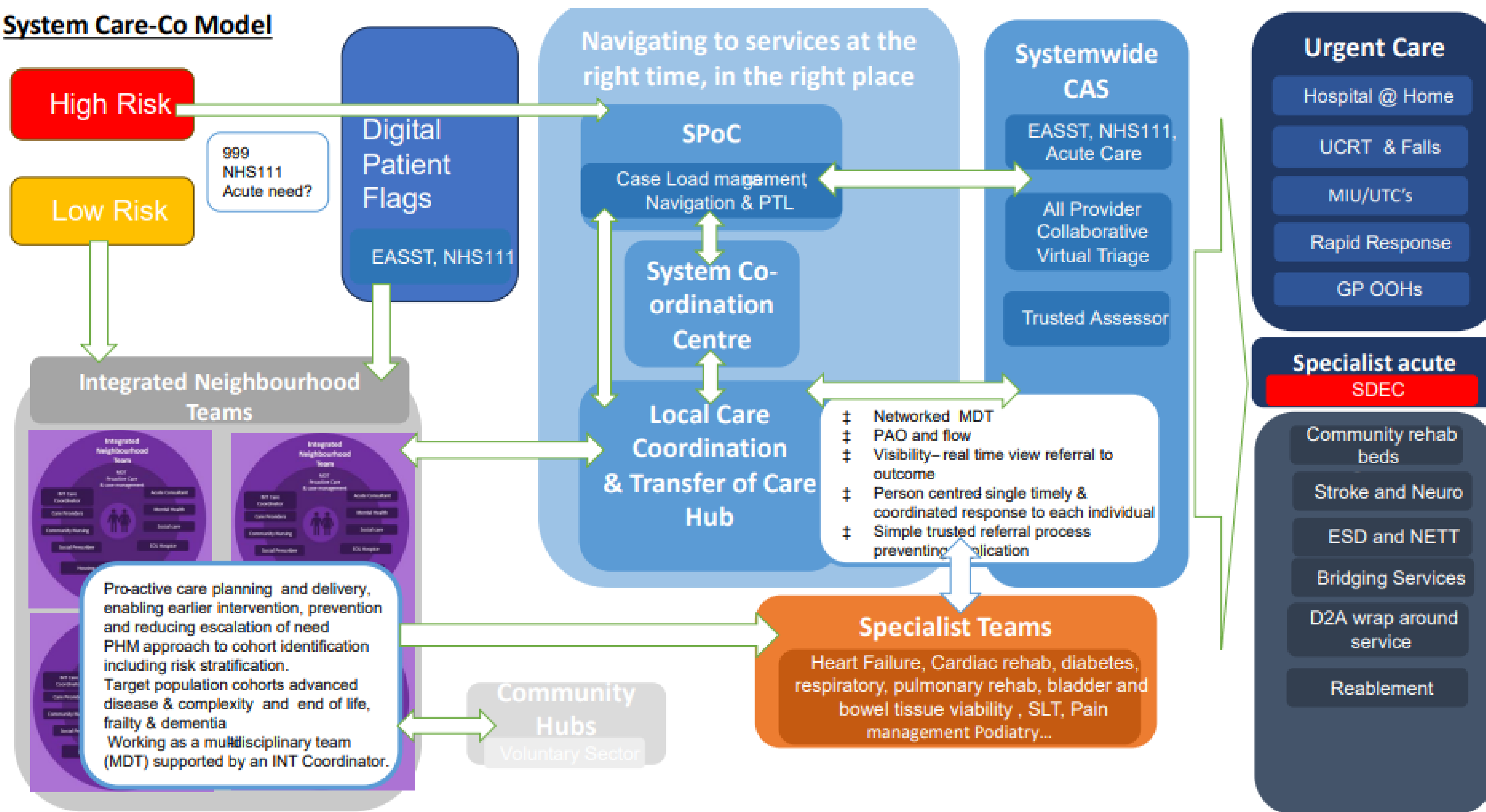
- **HOLISTIC**- not single condition
- Falls prevention
- Medication reviews and deprescribing

- **PLAN** with the patient not to the patient
- Use **DIGITAL ACPs**, holistic, person-centred, honest, proactive
- All stages of the pathway

- Utilise **ALTERNATIVES** to conveyance and admission:
    - prevention of admission
    - rapid response
    - Virtual Hospital
    - Acute frailty/ SDEC services

- **CONSIDER** harm in an acute setting
- **CONSIDER** the potential risk of decompensation, delirium, and other types of harm to frail patients
- **CONSIDER** wishes of patients' care preferences when they are end of life
- **REFLECT FRAILTY/ EOL STATUS**
- use the GIRFT acute frailty pathway

- **PRIORITISE DISCHARGE** FROM DAY ONE



System Care-Co Model
High Risk
Low Risk
999
NHS111
Acute need?
Digital Patient Flags
EASST, NHS111
Integrated Neighbourhood Teams
Pro-active care planning and delivery, enabling earlier intervention, prevention and reducing escalation of need
PHM approach to cohort identification including risk stratification.
Target population cohorts advanced disease & complexity and end of life, frailty & dementia
Working as a multidisciplinary team (MDT) supported by an INT Coordinator.
Community Hubs
Voluntary Sector
Navigating to services at the right time, in the right place
SPoC
Case Load management, Navigation & PTL
System Co-ordination Centre
Local Care Coordination & Transfer of Care Hub
Networked MDT
PAO and flow
Visibility– real time view referral to outcome
Person centred single timely & coordinated response to each individual
Simple trusted referral process preventing duplication
Systemwide CAS
EASST, NHS111, Acute Care
All Provider Collaborative Virtual Triage
Trusted Assessor
Specialist Teams
Heart Failure, Cardiac rehab, diabetes, respiratory, pulmonary rehab, bladder and bowel tissue viability , SLT, Pain management Podiatry...
Urgent Care
Hospital @ Home
UCRT & Falls
MIU/UTC's
Rapid Response
GP OOHs
Specialist acute
SDEC
Community rehab beds
Stroke and Neuro
ESD and NETT
Bridging Services
D2A wrap around service
Reablement

Urgent and Emergency Care (UEC) Frailty and End of Life (EoL) and Care Closer to Home (CCTH) Workstreams

Aim to reduce frailty non-elective admissions by 25%		
UEC priorities - managed at UEC Programme Board, reported at UEC Board 1. Demand management innovation:111/CAS/UCCH (A2S and CB4C) new model 2. SDEC for acute frailty 3. UTC and MIU system review	**Frailty and EoL priorities - managed at Frailty/EoL Board*, reported at UEC Board** 1. Digital Advanced Care Plan implementation 2. Deprescribing including reduction in anticholinergic medicines 3. Falls prevention - mapping pathways e.g. long lie and overall review of commissioned services	**Care Closer To Home (Community Services Review) priorities - managed by CCTH Steering Group, reported at UEC Board** 1. At scale implementation of Integrated Neighbourhood Teams within PCNs 2. UEC pathways - UCR and VW/H@H 3. Care Coordination Centres 4. Intermediate Care - early supported discharge, D2A, reablement focus

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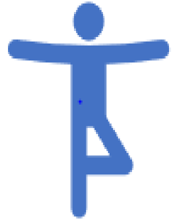
Elevator Pitch



Falls prevention
Risk identification and sign posting. Pathways e.g. long lie, anticoagulation, early intervention and falls cars, STACK removal and commissioned services

Deprescribing including reduction in anticholinergic medicines

Digital Advance Care Plan implementation

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