

Frailty Model – Sustainable Care In The Community

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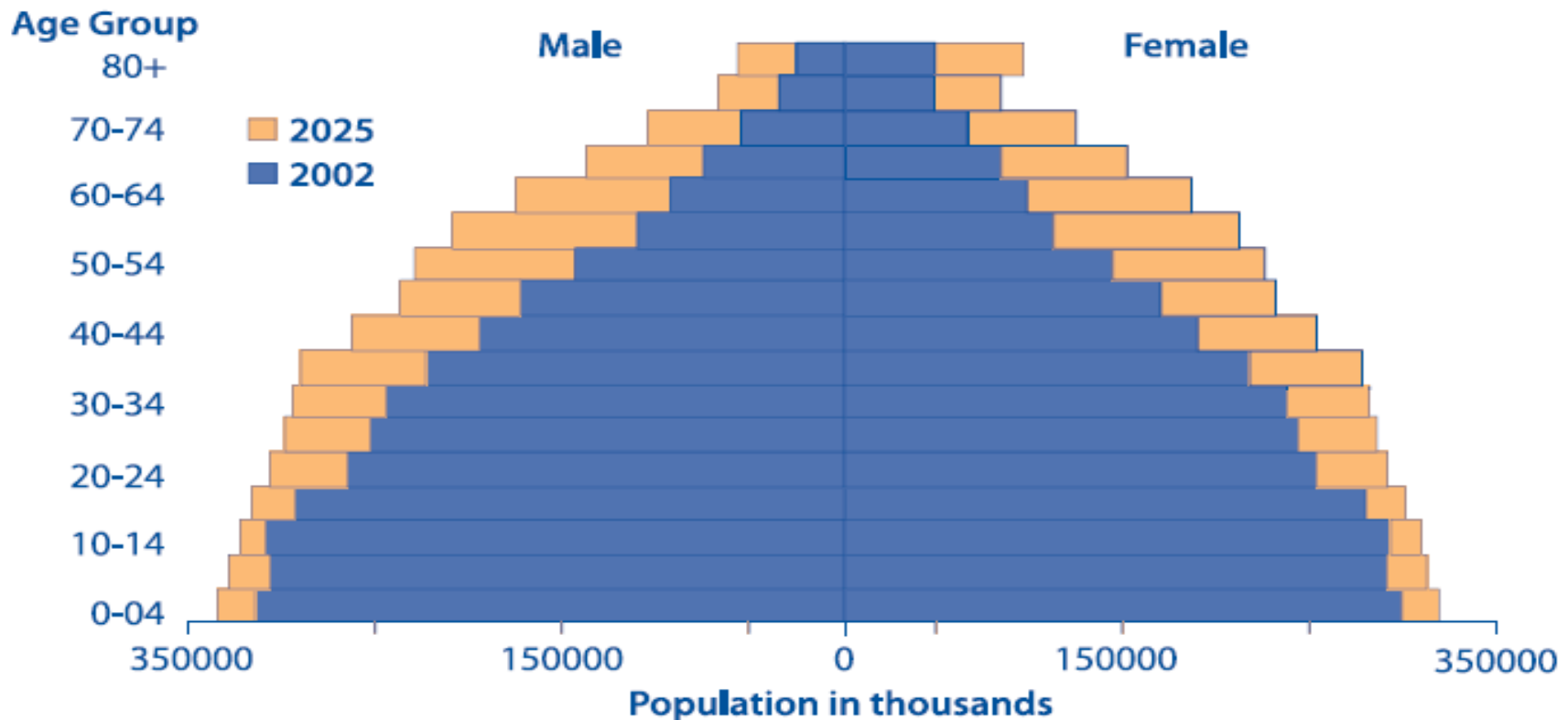
Chief of Staff, Community Services

Aneurin Bevan Health Board

CASE FOR CHANGE

- Demand will always beat supply
- Pressure on cost is remorseless
- NHS can not provide a comprehensive service on current assumptions after 2011
(Kings fund and the Institute of Fiscal Studies – IFS)

Figure 1. Global population pyramid in 2002 and 2025



Source: UN, 2001

Ref. WHO - Active Ageing 2002

- (a) Between 1970 and 2025, a growth in older persons of 223% - 694 million.
- (b) By 2025: 1.2 billion > 60 years.
- (c) By 2050: 2 billion; 80% living in developing countries.

Some Facts

- Nearly 33% of inpatients could safely be cared for in another setting than in an acute hospital [Kings fund audit 1992; DOH 2000]
- 29% of patients in acute hospital beds are medically stable [43% in elderly wards] [Barbara Vaughan; Gill Withers 2002]
- In Wales, higher proportion of chronic long term conditions (23%) compared to England (18%); Northern Ireland (20%)
- Audit of 5 GP Practices in Swansea revealed 3% of population with 2 comorbidities + emergency admission accounted for 59% of hospital admissions [Ref = WAG 2007 – Designed to improve health ...chronic conditions Wales]
- **Conclusion:** A focused integrated approach of Health and Social Care, Housing and Transport is recommended

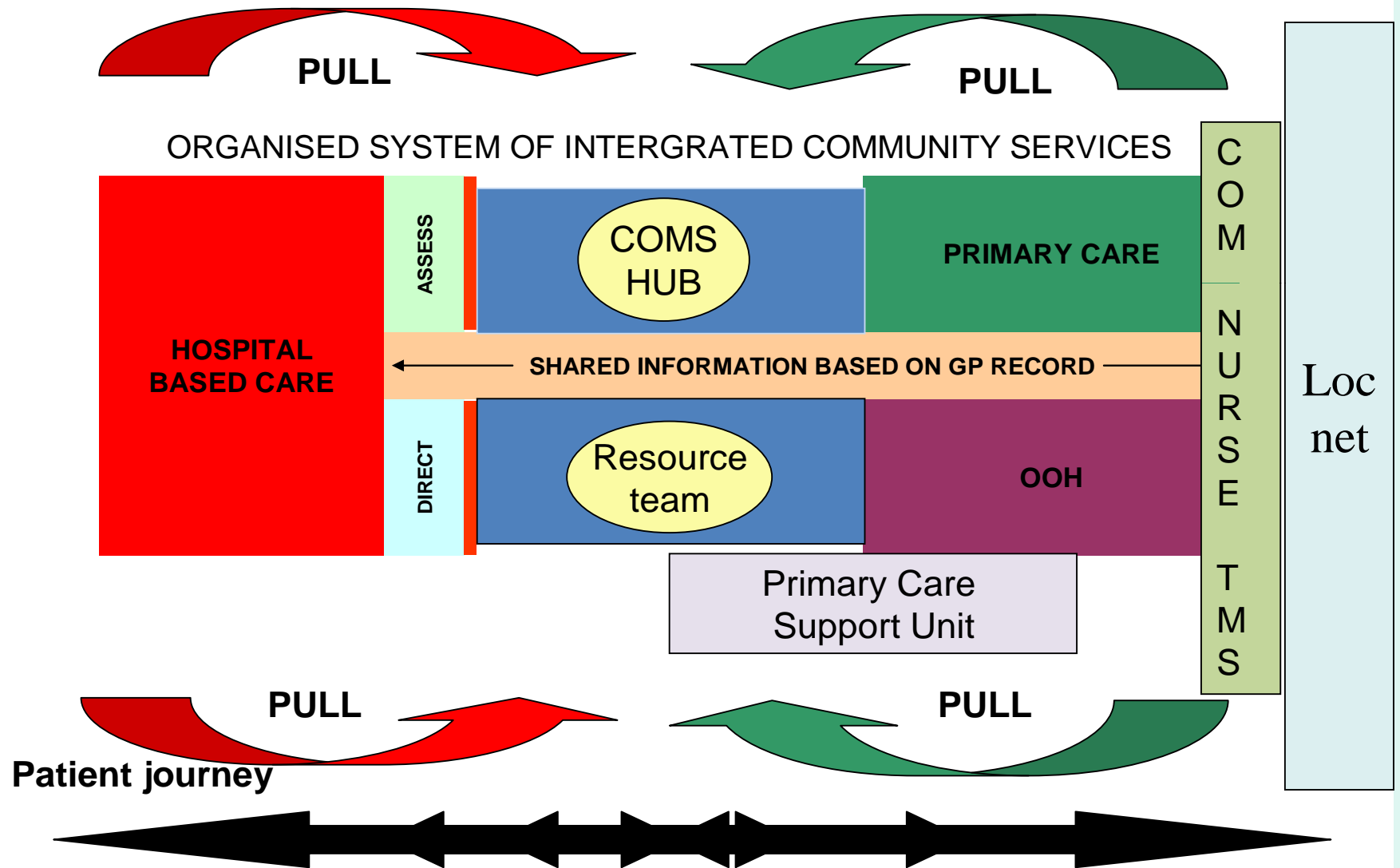
WHO has identified that chronic conditions will be the leading cause of disability and death by 2020

Targets

Reduce number of emergency bed days by 5%

- Analysis of NHS use indicates that effective chronic disease management presents significant scope to reduce avoidable hospital admissions
- For patients with more than one condition the costs are six times higher than people with only one

Future System of Care "Seamless Pull System with Integrated Access to Information"



THE EVIDENCE-BASE FOR INTERMEDIATE CARE

	<u>RCTs</u>	
• HOSPITAL-AT-HOME	22	✓
• DAY HOSPITAL	12	Expensive
• NURSE-LED UNITS	10	Very expensive
• COM. REHAB.TEAMS	2	✓
• CARE HOME REHAB.	1	Shifts costs to social care
• COMMUNITY HOSPITAL	1	✓

- Message:** (a) Target people with greatest clinical need (Frailty)
- (b) Integrate I.C with Mainstream Services

Clinical Futures: Gwent

Non-acute beds and places required by LHB		2014-15 with new MoC							
		Newport	Caerphilly	Torfaen	Blaenau Gwent	Monmouth	Powys	Other	All Gwent
Intermediate	<i>medical</i>	117	121	96	82	77	1	7	501
Care and/or	<i>surgical</i>	2	1	2	1	2	1	0	8
Non-acute	<i>total</i>	119	122	98	83	79	1	7	509
Provided as	<i>NHS etc beds</i>	38	39	31	26	25	0	2	162
	<i>places at-home</i>	81	83	67	57	54	1	5	347
	<i>total places</i>	119	122	98	83	79	1	7	509

Frailty Programme Board

- Membership

- Chair – Alison Ward, CEO, Torfaen LA
- LA reps (social care)
- LHB reps
- Trust Corporate and Divisional reps
- Voluntary sector
- GP
- Ambulance

- Work Streams

- Independent Living and Reablement
- Urgent Response and Intervention
- Capacity and Financial Modelling

Frailty Syndrome

- Frailty = (Dependency x vulnerability x co-morbidity)
+
(Environmental x social factors)

What is it?

Physical characteristics Multidimensional

- Weakness
 - Slowness
 - Poor endurance
 - Weight loss
 - Physical inactivity
- Socio-demographic
 - Biomedical
 - Functional
 - Effective and cognitive components

Table 1: Health Variables and Cut-points for the Frailty Index

List of 40 Variables included in the frailty index	Cut Point
Help Bathing	Yes = 1, No = 0
Help Dressing	Yes = 1, No = 0
Help getting In/out of Chair	Yes = 1, No = 0
Help Walking around house	Yes = 1, No = 0
Help Eating	Yes = 1, No = 0
Help Grooming	Yes = 1, No = 0
Help Using Toilet	Yes = 1, No = 0
Help up/down Stairs	Yes = 1, No = 0
Help lifting 10 lbs	Yes = 1, No = 0
Help Shopping	Yes = 1, No = 0
Help with Housework	Yes = 1, No = 0
Help with meal Preparations	Yes = 1, No = 0
Help taking Medication	Yes = 1, No = 0
Help with Finances	Yes = 1, No = 0
Lost more than 10 lbs In last year	Yes = 1, No = 0
Self Rating of Health	Poor = 1, Fair = 0.75, Good = 0.5, V. Good = 0.25, Excellent = 0
How Health has changed in last year	Worse = 1, Better/Same = 0
Stayed in Bed at least half the day due to health (In last month)	Yes = 1, No = 0
Cut down on Usual Activity (In last month)	Yes = 1, No = 0
Walk outside	<3 days = 1, ≤ 3 days = 0
Feel Everything is an Effort	Most of time = 1, Some time = 0.5, Rarely = 0
Feel Depressed	Most of time = 1, Some time = 0.5, Rarely = 0
Feel Happy	Most of time = 0, Some time = 0.5, Rarely = 1
Feel Lonely	Most of time = 1, Some time = 0.5, Rarely = 0
Have Trouble getting going	Most of time = 1, Some time = 0.5, Rarely = 0
High blood pressure	Yes = 1, Suspect = 0.5, No = 0
Heart attack	Yes = 1, Suspect = 0.5, No = 0
CHF	Yes = 1, Suspect = 0.5, No = 0
Stroke	Yes = 1, Suspect = 0.5, No = 0
Cancer	Yes = 1, Suspect = 0.5, No = 0
Diabetes	Yes = 1, Suspect = 0.5, No = 0
Arthritis	Yes = 1, Suspect = 0.5, No = 0
Chronic Lung Disease	Yes = 1, Suspect = 0.5, No = 0
MMSE	<10 = 1, 11-17 = 0.75, 18-20 = 0.5, 20-24 = 0.25, >24 = 0
Peak Flow	See Table 2
Shoulder Strength	See Table 2
BMI	See Table 2
Grip Strength	See Table 2
Usual Pace	See Table 2
Rapid Pace	See Table 2

The list of health deficit variables included in the FI and how they were coded as deficits.

Prevalence of Frailty

3 or more of the outcome

Age	65-69	70-74	75-79	80-84	85+	
%Frailty	18.3	21.7	32.1	32.5	48.8	
Estimated numbers of frail elderly people by Local Authority						Estimated Total
Blaenau Gwent	604	621	838	563	646	3275
Caerphilly	1399	1402	1816	1154	1231	7002
Monmouthshire	784	825	1043	695	864	4211
Newport	1127	1222	1472	1085	1156	6062
Torfaen	797	844	1105	683	712	4141
Total by age band	4177	4914	6274	4180	4609	24154

Source: Census 2001

**Happily
Independent**

What we stand for: Principles & values



The underpinning principle of the **Gwent Frailty Programme** is to provide:

'Help when you need it to keep you independent'

The mantra for those delivering services is to provide help that is

Sustaining independence.

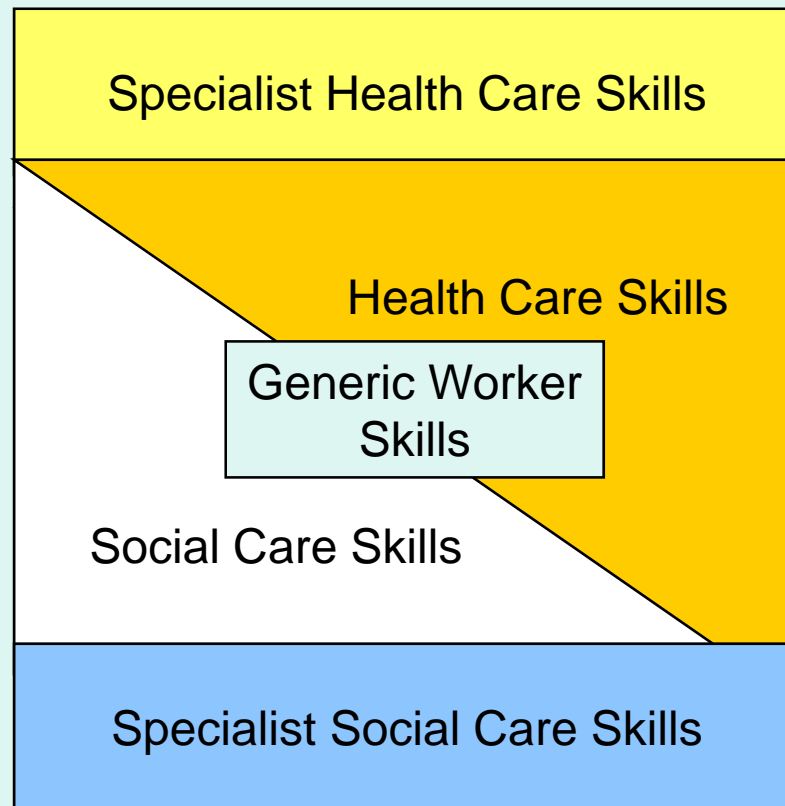
Outcomes:

What frail people tell us they want



- ❁ Be able to remain living in their own home with support
- ❁ Receive services in their home
- ❁ Be listened to by people who are responsible for providing services to assist them
- ❁ Have their health and social care problems solved quickly and considered as a whole rather than individually.

Frail Elderly Workforce Skills Matrix



Generalist as the New Specialist (Intermediate Care)

- GP's Changing Roles
- Geriatrician Changing Roles
- AHP's Changing Roles
- Training In The Community

Common Service Characteristics (I.C)

	Urgent Response & Intervention	Reablement & Independent Living
ACCESS	Via locality Single Point of Access	Via locality Single Point of Access
HOURS OF OPERATION	7 days a week 365 days a year 8am to 10pm	7 days a week 365 days a year 8am to 8pm
RESPONSE TIME	2-4 hours (for both health and social care components)	24 hours
ASSESSMENT	Comprehensive Needs & Frailty Index Assessment	Agreed shared assessment document
SERVICE PROVISION	Management/Hospital @ Home upto 14 days	Approximately 6 weeks rehabilitation and reablement support No charge to user for first 6 weeks
ACCESS TO	'Hot Clinics' for rapid access to specialist and diagnostic support (Monday to Friday)	Specialists including psychology, dietetics, pharmacy, speech & language therapy, podiatry, EMI teams. Rapid access to equipment and adaptations.
WORKFORCE	Flexible Health & Social Care Workforces	Flexible Health & Social Care Workforces

Components of Comprehensive Needs Assessment

Components

- 1 Medical assessment
- 2 Assessment of functioning
- 3 Psychological assessment
- 4 Social assessment
- 5 Environmental assessment

Elements

- Co-morbid conditions
- Medication review
- Nutritional status
- Activities of daily living
- Gait and balance
- Mental status
- Assessment of needs, assets and resource eligibility
- Home safety, transportation and tele-health

Urgent Response & Intervention

Comprises of three key elements:

- ✿ **Urgent Comprehensive Assessment (Health & Social Care)**
- ✿ **Rapid Response Intervention (health)**
- ✿ **Social Care Crisis Intervention**

Proposed Capacity Model (Crisis Management)

- **Aims**
 - Better management at home or in a community setting.
 - Engagement with care homes and the independent sector.
 - Management of patients in Accident & Emergency
 - Patients handed over to DN teams on discharge from service
- **Main Functions**
 - Assessment of 200 new patients per month for acute exacerbations of chronic conditions and associated disorders.
 - Follow-up of 200 patients per month.
 - 7-day presence in A & E and MAU to assess patients and prevent admissions, pulling them back into the community, as required.
 - Daily Hot Clinics for each borough, run by ACAT/RRT for the provision of advice for GPs.
 - Formal links with other specialties, including General Medicine, Falls, Trauma & Orthopaedics.
 - On-going management of patients at home for a 5 – 7 day length of stay (care package)
 - The Gwent-wide combined team of ACAT, Rapid Response and PATH to provide around 70 virtual beds across Gwent.

Staffing Model (Crisis Management)

- Based on population of 70-90k
 - 1 wte Consultant Specialist
 - 2 wte Staff Grades or GPswSI (salaried GPs)
 - 4 wte Band 7
 - 10 wte Band 6
 - 3 wte Band 4 Reablement Officers
 - 1 wte Band 6 OT for Reablement
 - 1 wte Social Worker
 - Approx 50 wte generic Health & Social Care Support Workers, and/or Rapid Access to Immediate Home Care
 - 1 wte Secretarial Staff and 2 wte Typists shared with the Reablement Team

Independent Living & Reablement

- Approximately 6 weeks coordinated review and reablement to sustain independence
- Rapid access to equipment and minor adaptations
- Care & Wellbeing Workers able to work across the different elements of the integrated locality team

Proposed Capacity Model for Locality Reablement Teams (1)

Based on 70-90k population

- 5 WTE Occupational Therapists (able to work across ACAT, PATH and Reablement)
- 5 WTE Physiotherapists
- 50 Band 3 Generic Support Workers*
- 2 WTE Case Managers (role needs to be clarified)
- 2 WTE Social Workers

* Proportion of generic support workers up-skilled to perform some functional assessments?

Shared resources:

- IT officer
- Training and Development officer
- Administrative Support
- Hot clinics for Falls, Gen Med and Orthopaedics

Proposed Capacity Model for Locality Reablement Teams (2)

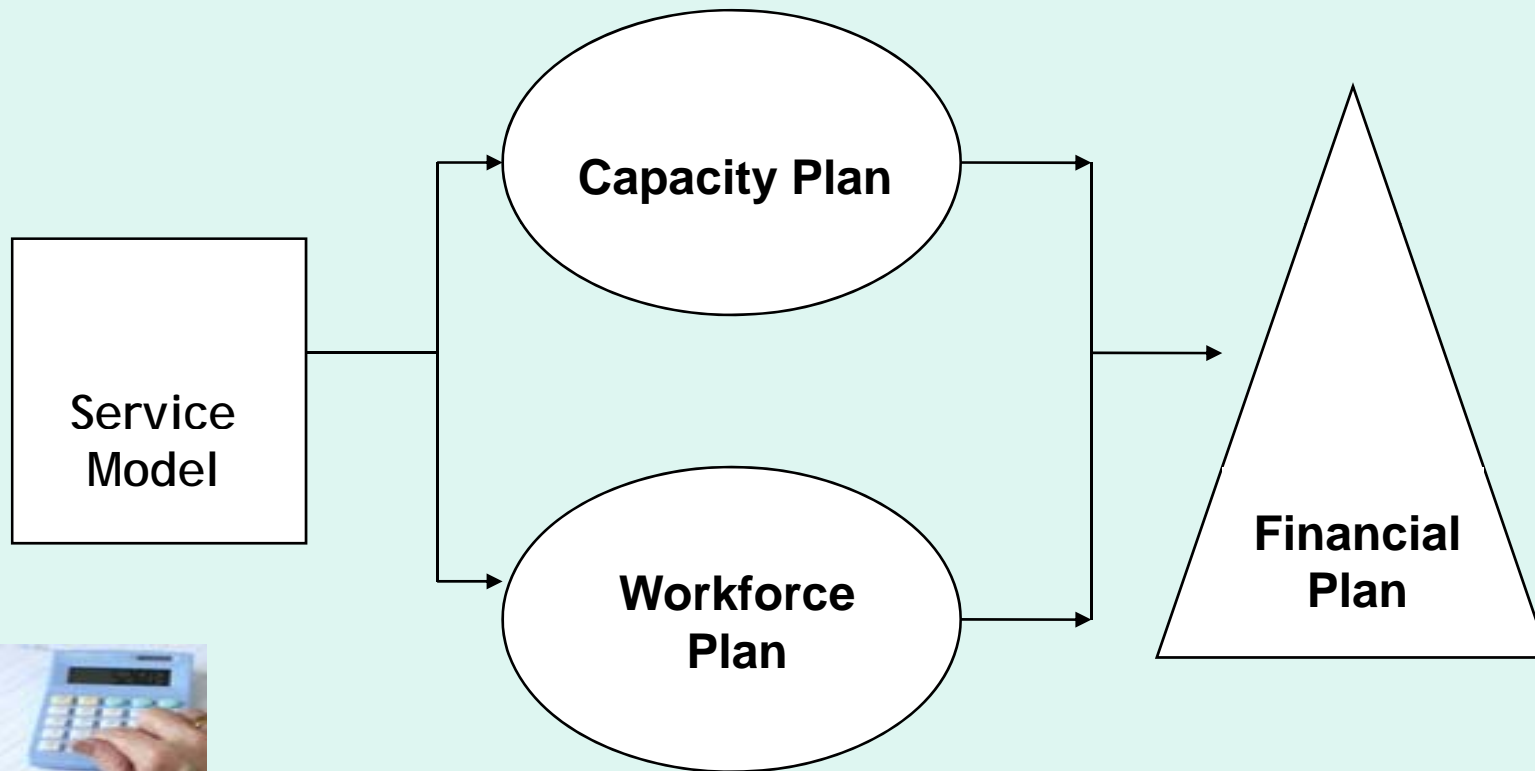
Sessional support from:

- 2 WTE Dieticians
- 2 WTE Speech and Language Therapists
- 2 WTE Psychiatric Liaison Nurse (1 for older people, 1 for younger people)
- Podiatrist – unable to quantify because many clients using private
- 1 WTE Community Pharmacologist attached to PATH and Reablement

Implementation Workstreams

- **Communication & Stakeholder Engagement**
- **Workforce Planning**
- **Governance & Structure**
- **Outcome Indicators, Performance and Continuous Improvement**
- **Information sharing & Single Point of Access**
- **Locality Planning** (including longer-term care and interfaces with other services)
- **Financial Modelling/ Building the Business Case**

Next Steps

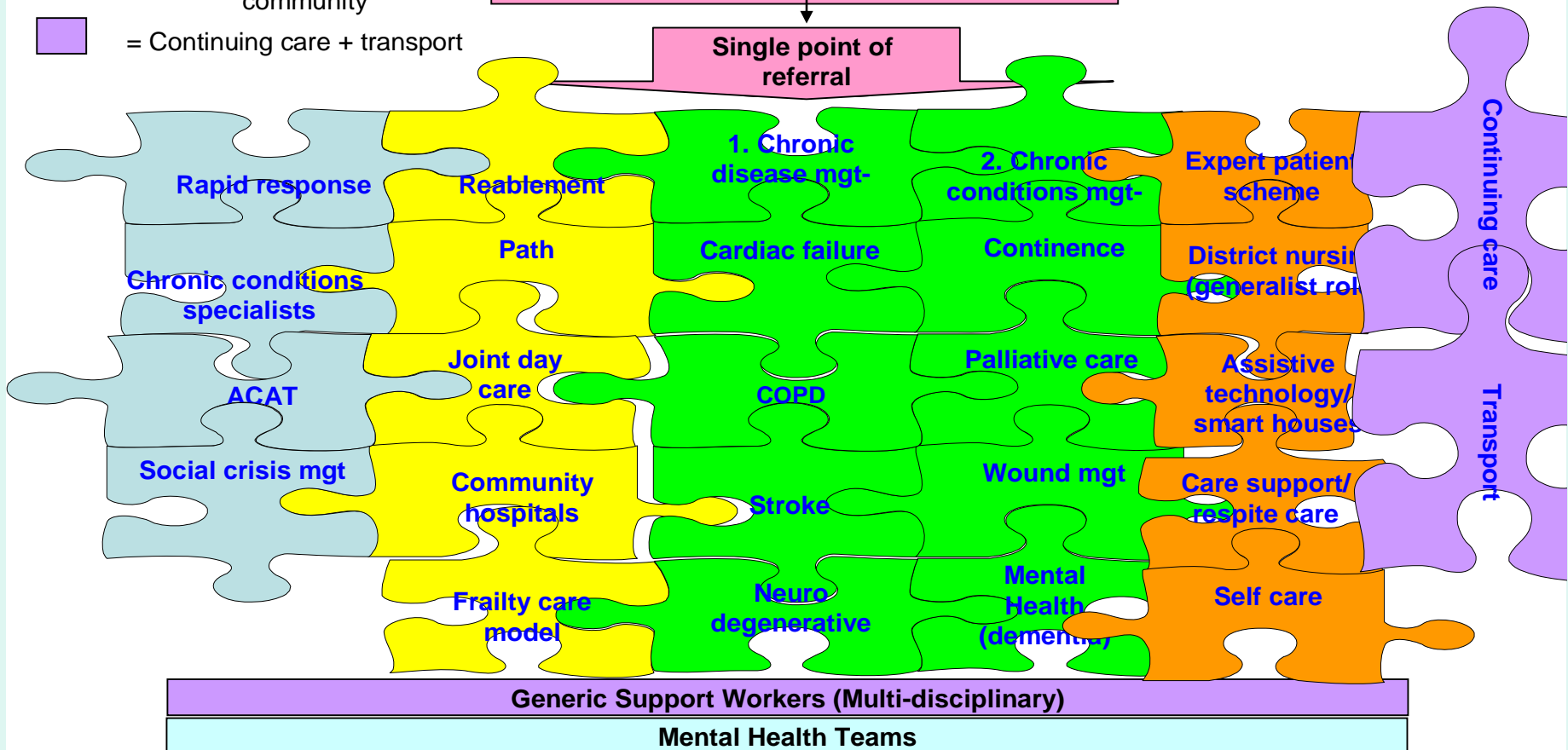
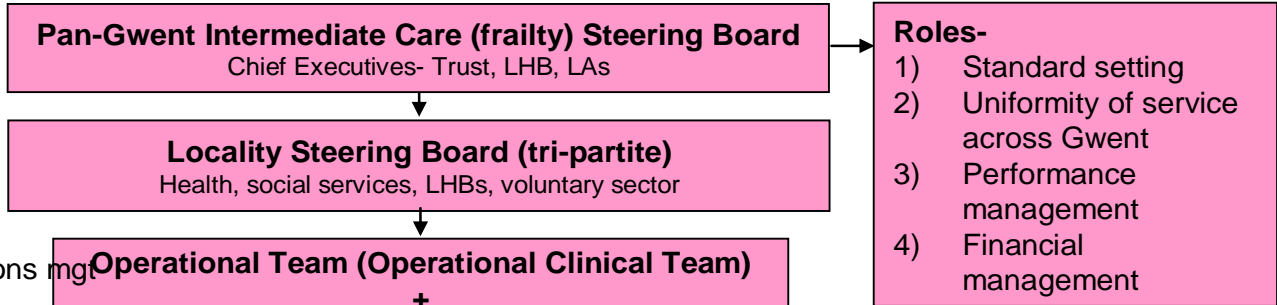


Key Milestones

- Business case submitted by October 2009
- Groundwork from workstreams completed by end of March 2010
- First locality ready for roll out April/May 2010
- Implemented in all localities by end of March 2011

Integrated Intermediate Care (frailty) Model (Gwent)

- = Prevention of admission
- = Early supported discharge
- = Chronic long terms conditions mgt
- = Independent living within the community
- = Continuing care + transport



Paul Williams

Director General, Health & Social Services

Chief Executive, NHS Wales

I want the service to focus on:

- *Changing behaviour not structures;*
- *Collaboration not confrontation;*
- *Planning not commissioning;*
- *Whole systems not hospitals;*
- *Clinical engagement;*
- *Partnership working; and*
- *Wellness not illness*

(1st October 2009)