# Summary document: NW Surrey Strategy For Adults With Complex Needs and Frailty

**Purpose of this document;**

Across NW Surrey there have been a number of initiatives developed which support the improvement in the quality of care for adults with complex needs and or at risk of, or living with frailty. As these have developed there is an appetite and ambition to;

- Align these initiatives with national priorities and best practice
- Provide consistency in the quality and delivery of services and
- Support more community based, integrated initiatives to reduce the number of adults with frailty being admitted to hospital.

This document describes the approach, and care model, which underpins this ambition and aligns with the 3 key priorities of the Surrey Health and Wellbeing Board 10 year strategy (1);

**1. Helping people in Surrey to lead a healthy life**

**2. Supporting the mental health and emotional wellbeing of people in Surrey**

**3. Supporting people to fulfil their potential**

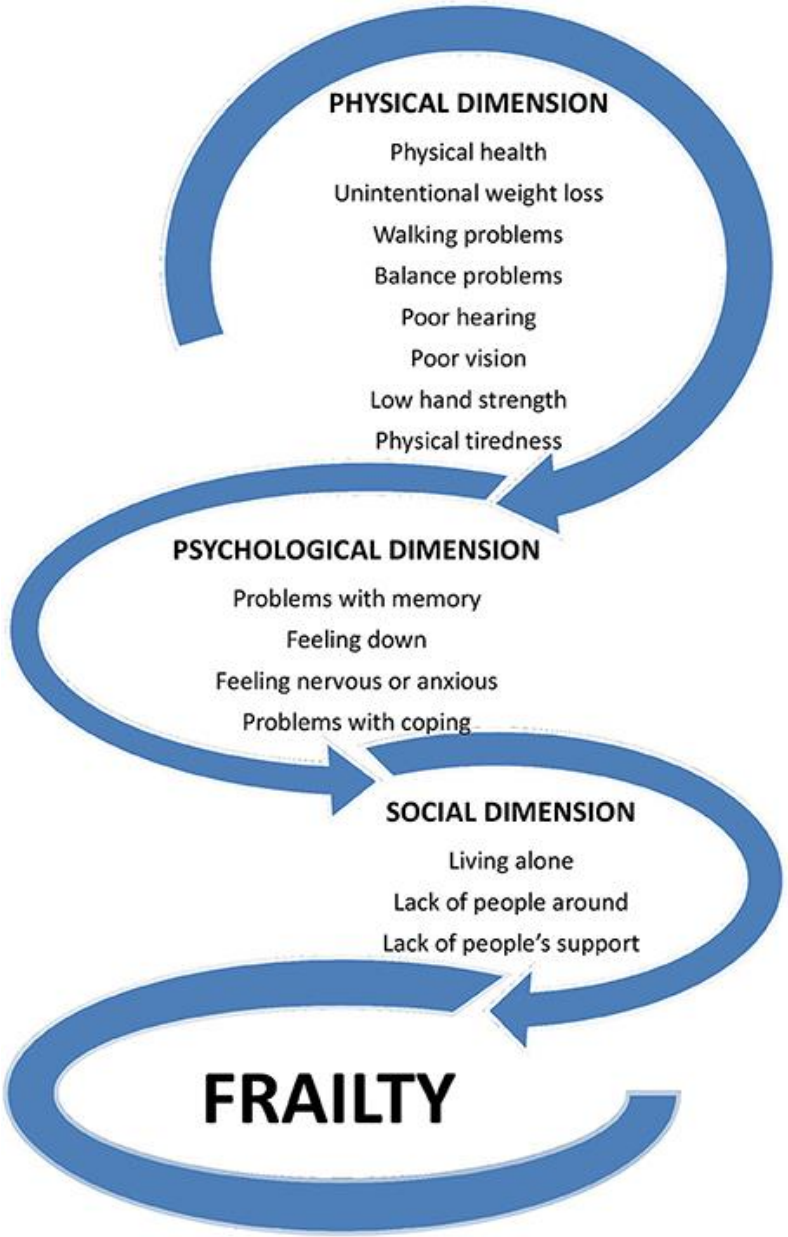
And the Department of Health and Social Care white paper Integration and innovation: '**Working together to improve health and social care for all'** (2)

# Defining Frailty

**NHS England description;**

- ***'Frailty is where someone is less able to cope and recover from accidents, physical illness or other stressful events.***
- ***It should be treated as a long term condition throughout adult life. This means starting with prevention and early identification of frailty and supporting people appropriately on the basis of their needs through to the end of their life'.***

***(Although the majority of people with frailty are older adults, younger adults are also at risk of frailty).**
**There is a risk of significant harm to patients with frailty if health interventions are planned for them in the absence of recognition of their frailty.**



# Focus on adults with complex needs and frailty- the case for change

- Advancements in medicine have meant that people are living longer, but they are also increasingly living with multiple long term medical conditions, which brings a number of challenges for the wider NHS and Social Care Sector
- Frailty is an increasingly urgent issue facing health care services. Older people with frailty and complex co-morbidities are proportionately the biggest users of health and social care services. They are also the most likely to use multiple services and risk disjointed care and support.
- Increasing numbers of people are at risk of developing frailty and people living with frailty are experiencing unwarranted variation in their care (3)
- Supporting people to age well is one of the ambitions of the NHS Long Term Plan (4). As the population ages, frailty is becoming a more prevalent condition presenting local health systems with a number of key challenges.

**People who are frail, or at risk of becoming frail, require multiple agencies to work together to plan and deliver a coordinated package of care and support, to enable them to achieve positive person-centred outcomes.**

**There is a collective commitment of the health and care system across NW Surrey for a consistent and coordinated approach to cross organisational, multi-disciplinary integrated working, to deliver health and care, focusing on frailty (see appendix 1a and 1b).**

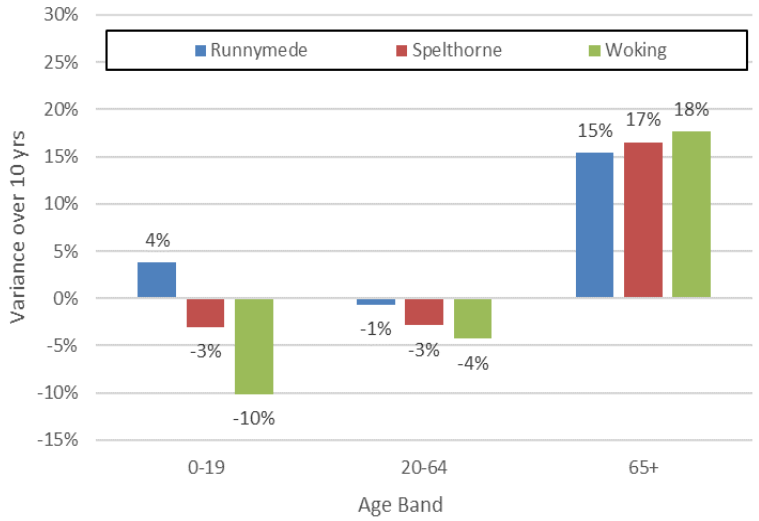
* Other strategic partners who will be involved in the development of frailty pathways include;

- SECAmb
- Surrey and Borders Partnership NHS Foundation Trust

# The case for change (cont.)

- Frailty develops insidiously over five to ten years and ranges from the pre-frail (who are at risk of developing frailty), to the mildly frail (who may be able to self-care), to the moderately frail (who might benefit from case-management), to severe frailty (where care planning and end-of life care may be appropriate).
- The prognosis of frailty is poor. For any given stage of frailty, about 40% of individuals progress to a more frail stage, while only 25% recover to a less frail stage. Moreover, once an individual becomes frail, they have a less than 1% chance of ever becoming non frail again and this chance reduces over time. Hospital admission can be a key trigger to frailty amongst non-frail people and can seriously impede recovery and discharge in frail individuals . Evidence shows that complex interventions for those with frailty, in community settings, can reduce hospital admissions and reduce readmission in those recently discharged from hospital (5)

| Area | 2021 | 2031 | 2041 | Variance | |
|---|---|---|---|---|---|
| Runnymede | 89429 | 92219 | 93039 | 10 year Variance | 20 Year Variance |
| 0-19 | 20744 | 21527 | 20911 | 4% | 1% |
| 20-64 | 53486 | 53147 | 52687 | -1% | -1% |
| 65+ | 15199 | 17545 | 19441 | 15% | 28% |
| Spelthorne | 100052 | 100824 | 101394 | 10 year Variance | 20 Year Variance |
| 0-19 | 23880 | 23161 | 21913 | -3% | -8% |
| 20-64 | 57301 | 55672 | 54892 | -3% | -4% |
| 65+ | 18870 | 21991 | 24589 | 17% | 30% |
| Woking | 101008 | 99115 | 98808 | 10 year Variance | 20 Year Variance |
| 0-19 | 25452 | 22868 | 21688 | -10% | -15% |
| 20-64 | 57709 | 55253 | 53500 | -4% | -7% |
| 65+ | 17848 | 20995 | 23620 | 18% | 32% |




- Over the next 10 and 20 years there will be significant population changes
- There is likely to be significant increases for the older population aged 65 and over
- There will be decreases in the younger age groups. Significantly a 10% reduction in Woking for the 0-19 year old population.
- As the average cost and acuity of a 65+ year old is significantly more than an average younger person it is vital our systems are developed to deal with this increase.

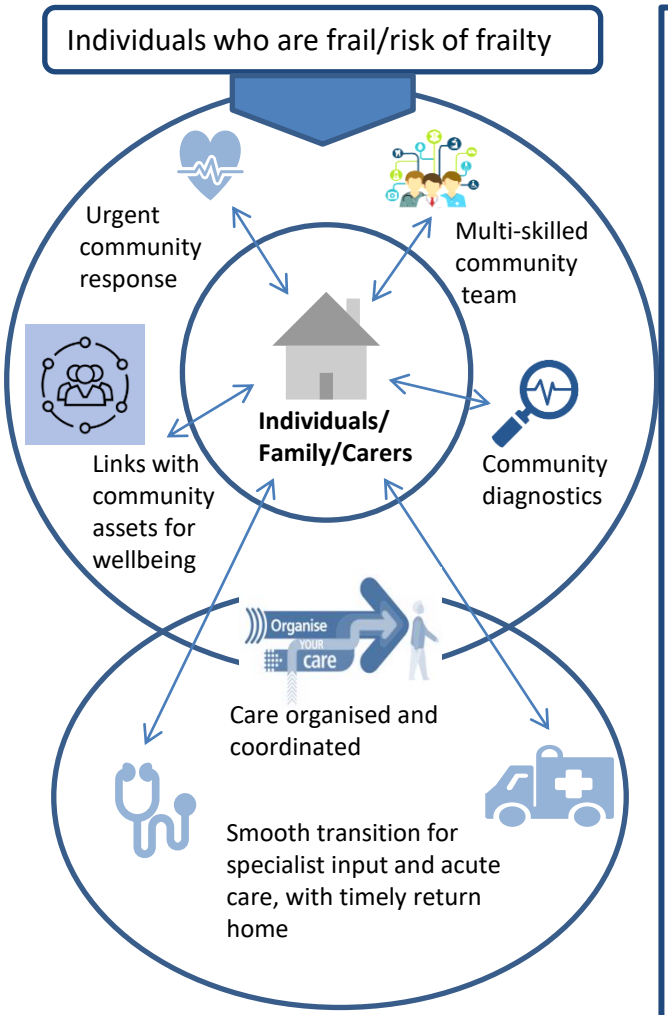
***There is a requirement for a system response to develop a strategy and framework to plan for this significant pressure.**

# NW Surrey Strategy on a page for adults with complex needs and frailty

1. Prevention and early diagnosis
2. Integrated community approach
3. Urgent Community response
4. Inpatient acute care
5. End of life care

## Enablers;

- Population data for risk stratification and identification of those frail/at risk of frailty
- Care coordination and information sharing (Surrey Care Record)
- Aligned approach to workforce development and resources
- Aligned approach to organisational development and culture change
- Aligned incentives and system outcomes
- Aligned approach to information sharing and IG
- System leadership to drive the frailty strategy




## Features;

- Person centred care **'what matters to people'** rather than, 'what is the matter with them'.
- Focus on health and wellbeing in the widest sense **(including mental health and wellbeing)**
- Community care, close to where people live, **including those who live in care homes**
- A move away from a purely biomedical model of care (physical and biological factors for ill health), to include social prescribing and wellbeing services; **'addressing the needs of the whole person' including support for carers**
- Integrated case management with anticipatory care planning including crisis contingency plans
- Integrated community MDT working will be the norm and includes health, care and the voluntary sector via community hubs (including hospices); **'all skills in one team'**
- Care coordination and monitoring via care coordinators
- **Urgent community response** to avoid hospital admission
- Seamless and timely **access to specialist acute care**
- **Integrated discharge**, linking with community MDTs, will support early repatriation home
- **Supporting those at End of Life** (and families/carers) to have more say with planning their care and support needs.

# NW Surrey ambitions for Integrated Provision

Shared care record


Single point of access


Community Navigation


Access to urgent care within 2 hours

The individual,

what and who matters to them, at the heart of decision making.


Timely return from hospital

Reablement and social prescribing


Keeping safe at home


Multi-disciplinary team working

# Integrated Delivery model: adults with complex needs and frailty

**Routine proactive and reactive care**

Individuals identified as frail/ pre-frail

Shared care with community hubs

Referred to community hub

Medical overlay via the reactive hub pathway . Access to community diagnostics/point of care testing

Seen by the hub integrated MDT . Proactive personalised care planning; holistic approach to wider determinants of health and wellbeing. Individual has access to the hub through a named care coordinator. GP informed through EMI.

Multidisciplinary Comprehensive Geriatric Assessment (CGA)

- Social assessment by Hub coordinator
- Acute frailty GP/Geriatrician
- Comprehensive health assessment by Hub matron
- Medication review by pharmacist
- Social care input from Hub social worker
- Mental health assessment
- Community diagnostics

**Planned care**

Primary and community care:

- GP interventions for health care
- General wellbeing support/social prescribing
- Health care at home /care home (community nursing, therapies, AHP services)
- Long term placement support
- Reablement/ supported living/community adaptations
- Routine care
- Social Care support
- Medicines management
- Mental health (including dementia and delirium)
- Enhanced health in care homes
- 2 week cancer wait
- PEoLC
- Referral for secondary care interventions /pre-operative advice and guidance

**Urgent crisis response**

Referred via the SPoA to the Urgent Community Response


Arrives at A&E

Assessed and referred to **Urgent Community Response or community hub**

Referred for on the day investigation /imaging (CT) & return home

Triaged in and referred to the Home First, front door Frailty team/ Senior Adult Medical Team

Admitted to acute care – discharge planning started

**Referral via single point of access for on-going health and wellbeing needs**

Usual place of residence with community support (Nursing , AHPs, Hub MDT)

Usual place of residence with rehabilitation/ reablement support/falls/adaptions/social prescribing

Referral to virtual ward for acute intervention and monitoring at home

Referral to community hospital for step up/step down

Placement for short or long term residential / nursing care

Community support for End of Life Care wishes

# Our Vision for NW Surrey

**The ambition foradults with complex needs and Frailty is to;**

- Understand it
- Recognise it
- Manage it, and
- Cultivate and embed integrated partnership approach to develop and commission appropriate pathways of care.

**The aim is to;**

- intervene earlier
- support wellbeing and independence
- deliver integrated care closer to home

**And to agree a set of principles that are;**

- Person-centred
- Proactive
- Multi-disciplinary/across agencies
- Local – building on community assets

# Our Guiding Principles

## ACCESS

**Risk stratification** to identify those who are at risk in order to proactively intervene to support good health.
**Develop urgent community response teams**, to support frail individuals with health to avoid hospital admissions and **integrated discharge** to help those leaving hospital to return and recover at home (including care homes)

## EQUITY


**Deliver appropriate, timely and quality health and care** and support that does not differ in quality irrespective of the patient or patient's group such as their age, gender, cultural background and ethnicity

## PERSON-CENTERED

**Individuals will be at the centre of their care** and have more say about the care and support they receive, particularly towards the end of their lives.
Offer more support for people who look after family members, partners or friends

## QUALITY

**The promotion of a Multidisciplinary Team (MDT) approach** where doctors, nurses, and other allied health and social care professionals work together in an integrated way.
Sharing tailored care and support that avoids duplication and fragmentation between different services

## PARTNERSHIP

**Integrated cross organisational working** to develop and deliver services (including the voluntary and care sector); helping people live well and independently at home for longer (including care homes)

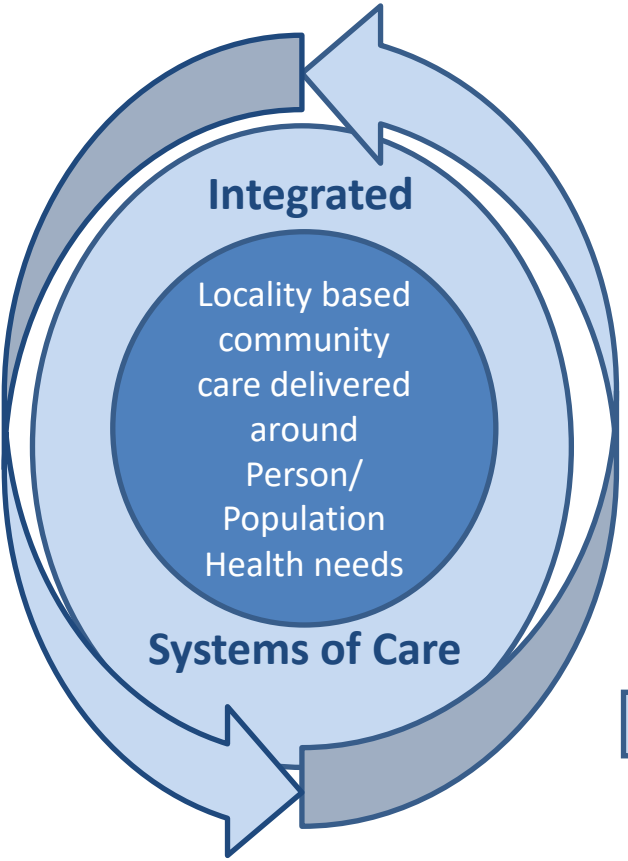
***These principles align with those developed across NW Surrey for Enhanced Health in Care Homes**

# Our Frailty model

**Increasing numbers of people seen in community settings**

**Admission avoidance**

1. Prevention and early diagnosis
2. Integrated community approach
3. Urgent Community response
4. Inpatient acute care
5. End of life care




**Prevention and Proactive Care -**

- Early identification
- Integrated Case Management

(patient centred approach for admission avoidance, anticipatory care planning).

**Emergency/ Reactive Care** – Community urgent response for admission avoidance, to avoid hospital admission to keep people well at home.

**Acute Care** - Specialist intervention via the 'Older Person's assessment unit, with repatriation at the earliest opportunity.

**End of Life Care** Individuals will have more say about the care and support they receive, towards the end of their lives.

**Increasing level of acuity (ill health)**

# Our 5 key elements for people with long term conditions and frailty

## 1. Prevention and early diagnosis

- Promotion of health and wellbeing in the widest sense – e.g. flu and COVID vaccination, health checks.
- Access to wellbeing services/ social prescribing
- Population segmentation to identify those most at need
- Address health inequalities and link with wider determinants of health
- Support for long term conditions and clear care pathways
- Support for carers

## 2. Integrated community approach

- Risk stratification to identify those at risk of frailty (long term conditions and multi-morbidity)
- Develop an integrated patient centred care plan, including a focus on social aspects of care/mental health (including dementia)/learning disabilities and autism
- Integrated MDT approach across health, care and the voluntary sector, to reduce duplication and handoffs, including reduction in over medication
- Greater access to diagnostics in the community
- Care homes involved as system partners
- Focus on wellbeing and risk reduction - i.e. falls

## 3. Urgent Community response

- Delivery of 2hr urgent community response and 48hr reablement
- Ensure there is a specific focus on those in residential care, including nursing homes
- Specialists embedded as part of the team
- Seamless transition from in hours care to OOHs
- Good links with specialists in each local system with specialist skills shared across the system
- Specialists in the community could offer hospital in- reach
- Hospital at home

## 4. Inpatient acute care

- Rapid specialist review in Older Person's Assessment Unit (OPAU), within 48hrs
- Early dialogue with community team (e.g. via wellbeing coordinator)
- Early supported discharge with specialist support at home
- Senior clinical input into community hospitals and urgent community response teams to reduce admission rates
- Streamline care pathways between acute and community to reduce multiple patient follow up appointments

## 5. End of life care

- Promotion of earlier conversations with patients, carers, family regarding End of Life
- Promotion, use and maintenance of Treatment Escalation Plans and Advance Care Planning
- Specialist outreach to support end of life care in the community i.e. respiratory nurses supported by palliative care nurses for continuity
- Joined up palliative care with NHS and hospice teams
- Support for carers and families, including post bereavement support (20-30% bereaved adults not getting support from organised services – ONS 2015)

# Present state

**Primary care** | **Community** | **Acute**

Priority Areas

- **Routine care**
- **Anticipatory and proactive care**
- **Urgent community response**
- **Mental health (including dementia and delirium)**
- **EHICH**
- **2 week cancer wait**
- **PEoLC**

- **identification of Frailty**
- **Routine care**
- **Home visiting**
- **EHICH**
- **Social prescribing**
- **PEoLC**

- **2hr UCR**
- **Urgent treatment centres**
- **48 hr reablement**
- **Same day Community nursing**
- **Care homes team**
- **OOH GP home visit via 111**
- **SECAmb home visit via 111**
- **Community hub proactive and anticipatory care**
- **PEoLC**
- **Social Care provision/ packages of care**
- **Mental Health**
- **SECAmb**

- **ED**
- **RAC**
- **Frailty Assessment**
- **Elective**
- **inpatient Care**
- **Non-elective impatient care**
- **D2A pathways**

**Key issues with present pathways**;

- Disjointed
- Numerous referral pathways/entry points
- Number of different organisational teams involved in the delivery of frailty
- Possibility for error/ loss of continuity for patient care

**Solutions;**

- Single team involved in the delivery of frailty pathways across NW Surrey (health, care and the voluntary sector)
- Reduce the number of entry/referral points
- Continuity of care through ‘one team’ working across all pathways (proactive/reactive/long term care and EoLC)

# Future state: NWS Integrated Frailty Service

**Primary care**

**Community and acute teams in one service**

## Priority Areas

- Routine care
- Anticipatory and proactive care
- Urgent community response
- Mental health including identification of dementia and delirium
- EHICH
- 2 week cancer wait
- Perioperative optimisation
- PEoLC

- Standardised process for identification of Frailty
- Routine care
- Home visiting
- EHICH
- Social prescribing
- PEoLC

**Single entry point**

- 2hr UCR
- Urgent treatment centres
- 48 hr reablement
- Same day Community nursing
- Care homes team
- OOH GP home visit via 111
- SECAmb home visit via 111
- Community hub proactive and anticipatory care
- PEoLC
- Social Care provision/ packages of care
- Mental Health
- Social prescribing
- Perioperative optimisation
- SECamb

- ED
- RAC
- Frailty Assessment
- Elective inpatient Care
- Non-elective impatient care
- D2A pathways

## Integrated Frailty Team

- **Clinical Triage**
- **Referral to the appropriate service – right time/ first time (GIRFT)**
- **Care coordinator manages pathways and communication and liaison between services & with primary care**

https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-10-09/RCGP-Integrated-care-for-older-people-with-frailty-2016.pdf

# A Single Point of Access (SPoA) for adults with complex needs and Frailty

**Professional Referral:**

- GP
- Paramedic (GP Home Visiting)
- CSH Community Teams
- SECAmb
- Local Authority
- Hospice
- Voluntary Sector
- Care Homes
- Acute facing discharge coordinators

**Individual referral:**
/Patient
/Carer to care co-ordinators

## SPoA

- **Clinical Triage**
- **Senior Clinical decision maker**
- **Shared care plans**
- **Care coordination and referral to the appropriate service – right time/ first time (GIRFT)**
- **Care coordinator to manage pathways and provide communication and liaison between services.**
- **Community facing discharge coordination**

**Care coordinator acts to navigate care for the individual and manages the patient journey, liaising with appropriate services , referring to clinical triage where required.**

Consistency of coordination

## Integrated Frailty Team – cross organisational collaboration

- Acute assessment
- Anticipatory and proactive care
- Community diagnostics
- Carers support and access to voluntary sector
- Discharge support
- General wellbeing support/social prescribing
- Health care at home /care home (community nursing, therapies, AHP services)
- Long term placement support
- Reablement/ supported living/community adaptations
- Routine care
- Social Care support
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