NHS Elect

Developing a System-Wide Urgent Community Response Service for Patients Living with Frailty

How do we improve health and social care across the frail population as a whole rather than just focusing our efforts within individual organisations?

That is the challenge now facing the NHS and partner organisations and it is what the System Wide Frailty Network was set up to address. Building on the work of its predecessor, the Acute Frailty Network, its aim is to support partner organisations to work in a more joined-up way to improve the care of patients with frailty across the entire system. Clearly, it is impossible to change the system all at once so the Network supports organisations to prioritise and agree an improvement project to test their approach and embed frailty best practice so it can be refined and then scaled up across the system.

The first cohort of the System Wide Frailty Network, in October 2022, brought together seven integrated care boards from across England and Wales. They received a range of specialist support from Network facilitators, including how to build relationships across different organisations; developing clarity about the nature of the service they provide and the model of care; establishing measurement criteria to assess the impact of improvement work; and agreeing the steps that needed to be taken to improve the service.

Humber and North Yorkshire Integrated Care Board (ICB) and City Health Care Partnership CIC (CHCP) were part of that cohort. This is their story…

City Health Care Partnership CIC is a partner organisation delivering community services in the Hull and East Riding of Yorkshire sub-system of the Humber and North Yorkshire ICB. CHCP services cover an area of around 1,000 square miles and has a population of 700,000 people. The region includes five acute hospitals across three trusts, 12 primary care networks, two local authorities, one ICB, one community provider, one mental health provider and one ambulance trust. Across the region, around 28,000 people are living with moderate or severe frailty and, as the population ages, the number of frail patients is rising.

Ageing Well agenda

Hull and East Riding of Yorkshire's Ageing Well agenda has been the focus of frailty improvement work across the health and social care system over the last six years. It includes proactive and reactive processes to support frail older people.

Proactive care for patients with frailty

The Jean Bishop Integrated Care Centre was built in 2018 to address health inequalities in the region and improve outcomes for people with frailty by helping them to avoid unnecessary hospital admissions. It brings together a range of holistic services under one roof which can help frail people remain fit and healthy and live independently for longer.

Patients are invited into the Integrated Care Centre with their families. The centre has dedicated transport to get them to their appointment, on-site diagnostics including an X-ray suite and hot meals provided by the voluntary sector. They typically attend for around half a day and can see a range of different on-site specialists, including doctors, social workers, physiotherapists and occupational therapists. The medicines management team is on hand to carry out a review of current medication to minimise the risks of polypharmacy.

To date, the centre has identified 3,200 home-dwelling people at risk of severe frailty in the region and invited them to attend for a comprehensive geriatric assessment.

In a review by The University of Hull[1], 79% of respondents were very positive about the centre and felt there was nothing that could have been improved. Words like "first class" and "convenient" were used to describe it and they also commented that they valued their involvement in decision-making. Between April 2019 and September 2022, the centre contributed to a 13.6% reduction in emergency hospital attendances for patients aged over 80 and a 17.6% drop in emergency department attendances for care home residents.

[1] Proactive Anticipatory Care Evaluation: The experiences of people using the Jean Bishop Integrated Care Centre

Frailty advice and guidance phone line

In 2020 CHCP introduced a dedicated phone line for carers and allied health professionals requiring emergency advice and guidance concerning frail patients. It received 12,000 calls in the first two years of the pandemic. System benefits included a sustained reduction in Emergency Department attendances. There is further detail about this in the UCR section later in this case study.

An urgent community response for frail patients

Although CHCP were pleased with the improvements being implemented as part of the Ageing Well agenda, it wanted to go further and integrate an urgent community response for patients with frailty. The frailty team – led by Consultant Community Geriatricians, Dan Harman, Anna Folwell and Libby Lloyd – was keen to ensure that people affected by frailty received the right care when they were in crisis. They wanted to be sure, too, that the data they were collecting was correct and would enable them to demonstrate outcomes in a meaningful way. Dan said:

"You can't just focus on a proactive or a reactive response to frailty, you need a holistic approach. An effective urgent community response can prevent a frail patient from dropping into needing emergency care. Similarly, if a patient presents with an acute illness, you need to be able to treat that successfully and then provide a comprehensive geriatric assessment at a later date to avoid subsequent deterioration and potential avoidable hospital admissions."

Developing an effective urgent community response sits alongside wider system aims for improving the outcomes of people living with frailty. These are:

- Anticipatory care
- Falls
- Enhanced health in care homes
- Virtual ward (hospital at home)
- Speciality MDT (Parkinson's, dementia, COPD, diabetes, long Covid, falls)
- Same day specialist support (advice and guidance)
- Intermediate care and rehabilitation

Joining the System Wide Frailty Network

The frailty team was aware of Professor Simon Conroy's work on frailty improvement and his leading role in the new System Wide Frailty Network. They joined the first cohort with the aim of developing their urgent community response for frail patients and building on the improvement work already underway in the other workstreams delivering the Ageing Well agenda.

Lisa Godfrey from the System-Wide Frailty Network, who worked alongside the team from Hull and East Riding of Yorkshire, said:

"System-wide improvement is a complex process with many different components. One of the most important benefits of working with the Network is that it enables organisations to start to break things down into manageable chunks, at the same time as receiving specialist support. It is about establishing 'the art of the possible' – articulating what issues organisations are trying to address and then working to develop possible solutions based on proven quality improvement methodology. The Network's approach is to work as an extension of the improvement team, rather than trying to impose its own ideas about how things should be done."

Leadership and training

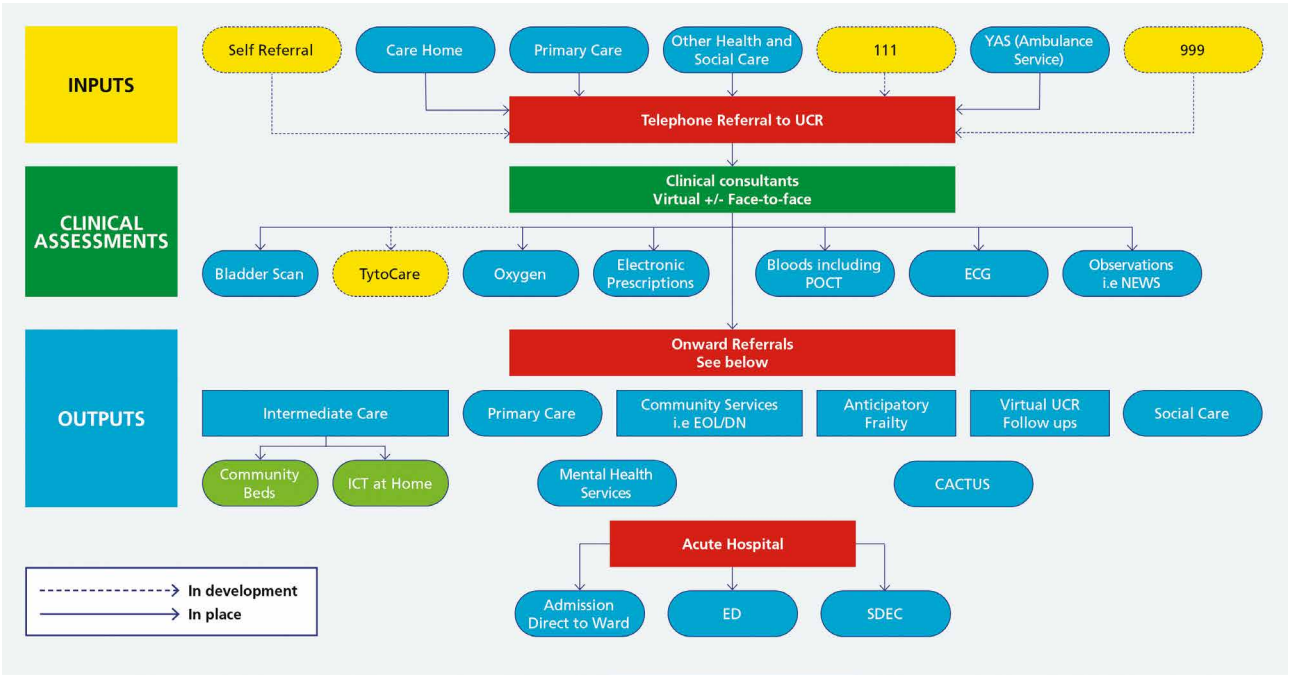
Hull and East Riding of Yorkshire established a frailty improvement team, with representatives from across the Health and Care Partnership including the CCGs and adult social care. Alongside their clinical work with patients, community geriatricians Dan Harman and Anna Folwell – who are employed by City Health Care Partnership CIC - provide a strategic leadership role, and frailty training for clinical colleagues. Dan explained:

An increasing amount of time was dedicated for non-clinical roles and we were given dedicated strategic clinical leadership time. We began with a handful of doctors who have undergone frailty training and now we have 16, 12 of whom are GPs with an Extended Role in Frailty (GPwER). Many of the GPs also continue to work in primary care so are able to transfer their specialist skills into general practice. A GP vocational Training Scheme is in place and every six months we take on five new GP trainees. We also mentor Advanced Clinical Practitioners.

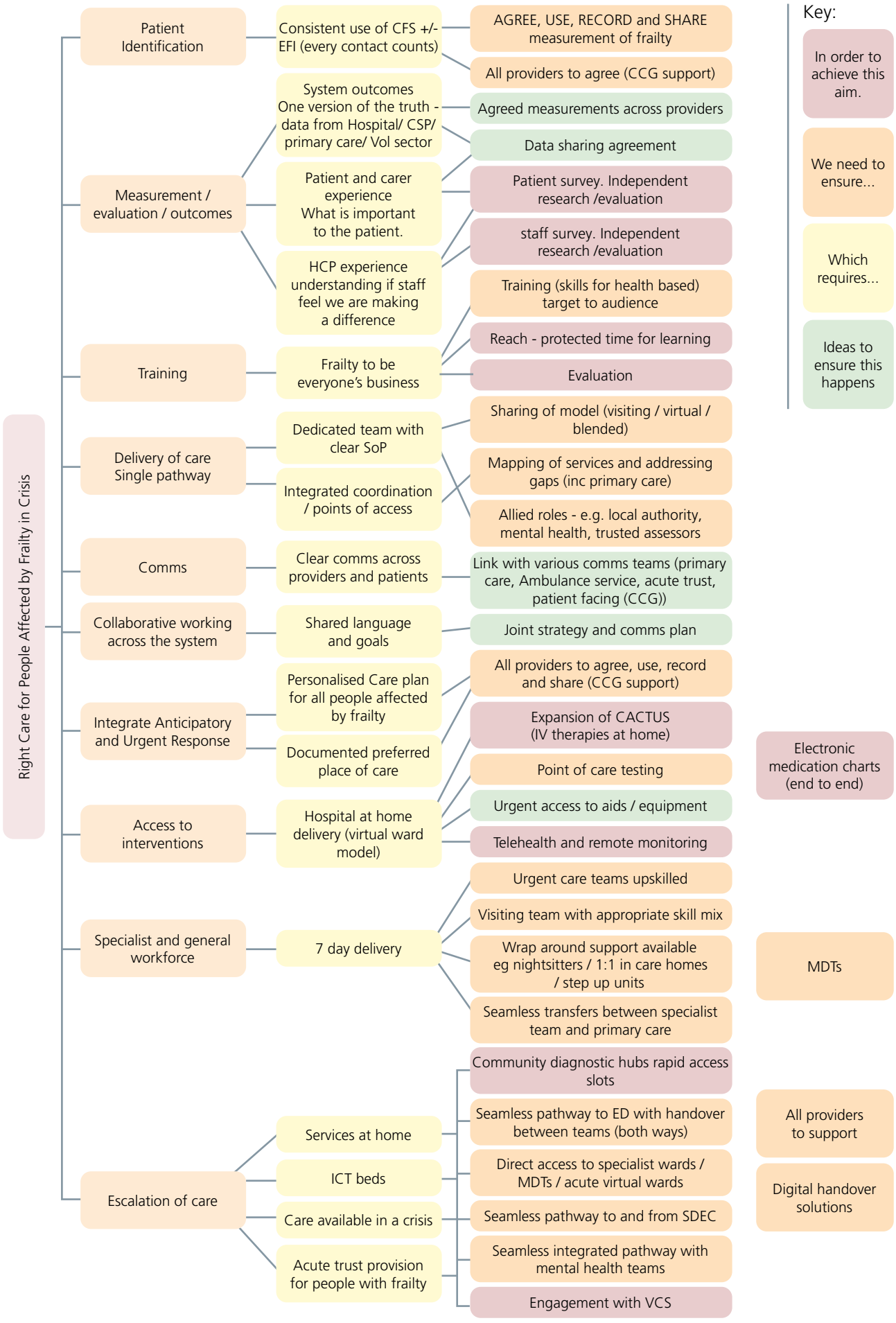
"Our aim is to increase the understanding of frailty across the workforce. We are NHS consultants but our role within the partnership gives us a level of flexibility – we can influence the way services are delivered to frail patients across the region. We work closely together operationally and clinically and this is a supportive environment in which it is safe to question and challenge."

Two-hour urgent community response

One of the aims of the frailty improvement project was to provide a two-hour urgent community response (UCR) service for frail older patients in crisis. The improvement team created a functional map showing where telephone referrals to its UCR service were coming from, including primary care, care homes and the ambulance service. Once referred to the service, patients undergo a clinical consultation, either virtually via video link or phone or face-to-face with a visit from a clinical support worker or healthcare assistant using digital devices (Tytocare) to allow remote examination.



A driver diagram was then created showing the steps needed to achieve this aim.



Digital technologies

The team used PDSA (plan do study act) cycles to test out improvements made to its two-hour urgent community response (UCR) service for frail older people in crisis. The improvement team created a functional map showing where telephone referrals to its UCR service were coming from, including primary care, care homes and the ambulance service.

The urgent community response team carries out visits to frail people in their own homes, with clinical support workers and healthcare assistants using state-of-the-art technologies such as digital stethoscopes (Tytocare) to check heart and lung function, oral health and skin examination. Point of care testing was also introduced to assess for markers of infection. A lot of consultations – particularly those carried out alongside GPs and care homes – are done remotely via video or phone by a senior clinician. Onward referrals can then be made to a range of different services including primary care, community services and the acute hospital as needed.

Working with Yorkshire Ambulance Service

The frailty team analysed how frail patients in crisis were accessing care. They found that 95% of the calls were from paramedics to the UCR line. Of these calls, historically approx. 70% would have resulted in conveyance and now this has consistently reduced to approx. 15%. Yet they also knew that the majority of frail patients would prefer to be treated at home or in their care home. The region also runs virtual wards and an anticipatory care service which can support this objective. To understand how 999 calls are triaged and categorised, Dan recently spent a day with Yorkshire Ambulance Service. To help relieve pressure on the service, the aim going forward is to begin using the skillset of its urgent community response team who may be able to get to the patient more quickly than the ambulance teams in some circumstances and treat them safely, depending on the category of emergency. This "Push" Model from Yorkshire Ambulance Service to the Frailty Team went live in early February and has already started receiving referrals.

Overcoming challenges

Among the challenges faced by the team at Hull and East Riding of Yorkshire were:

i. Clinical delivery pressures

Although he had dedicated time for non-clinical work, nevertheless, Dan found that clinical pressures meant he was unable to utilise the support of the System Wide Frailty Network as fully as he would have liked. The pressures on the project leads increased over time as the number of people in the local frailty improvement team declined due to their own workplace commitments. Dan said: "We got lots from our involvement with the Network, but we could have got even more without these competing pressures."

ii. Workforce challenges

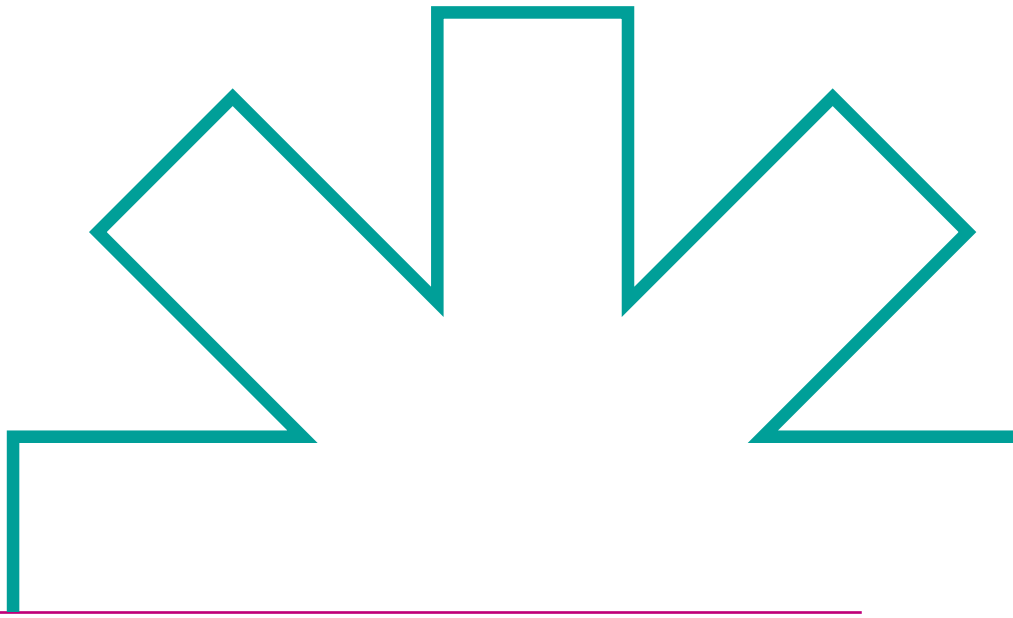
CHCP built its urgent community response model based on the staffing it had when it joined the Network. But staff numbers have reduced which has placed the system under pressure and staffing remains a major risk due to ongoing challenges. On the positive side, this has challenged the team to work more efficiently, including embracing new technologies.

iii. System expectations

Dan explained: "There is constant pressure to go quicker so you can do more. But some of the urgent community response calls can take an hour or longer. On paper, seven or eight calls a day doesn't sound a lot, but it can be really hard work. It is about balancing system expectations against what is possible. We have embraced technology to become as efficient as we can. It works well but it is not infallible. If we go somewhere where the internet connection is poor, that can slow everything down. Staff need to be properly trained, too."

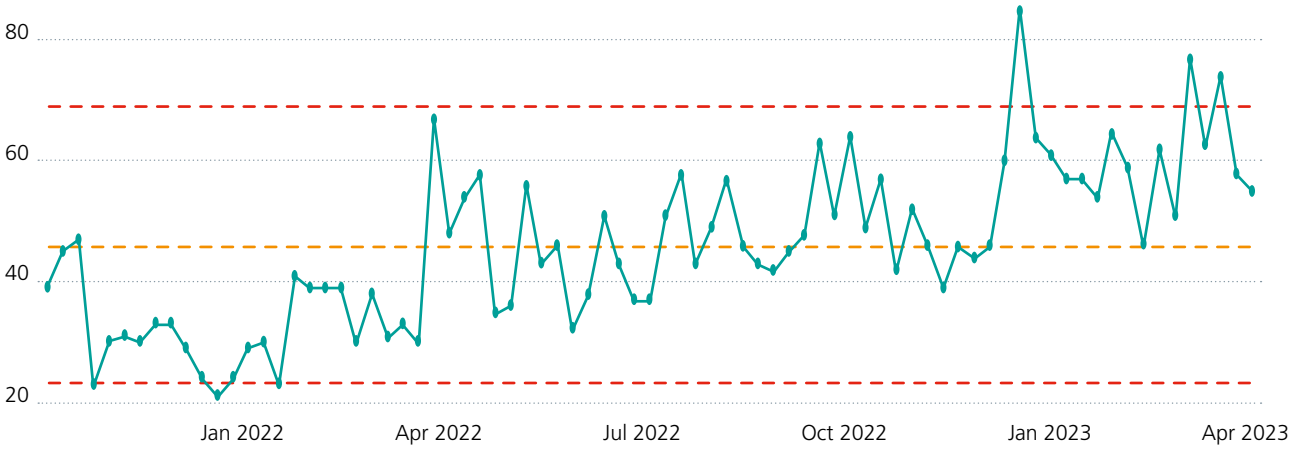
iv. Disseminating learning and outcomes

One of the challenges of system-wide improvement is the logistics of working with a large group of people from different organisations. At Hull and East Riding of Yorkshire there were already five separate workstreams in place as part of the Strategic Oversight Group's Ageing Well agenda. The frailty improvement team used these existing structures to share learning and outcomes from its work on urgent community response for frail patients, which helped it to disseminate information quickly and efficiently across the system.



Impact

Data shows that Hull and East Riding of Yorkshire have made a positive start in its urgent community response work for frail patients.



Week	Num Referrals	LCL	Mean	UCL
26/12/2022	64	24.98	47.57	70.16
02/01/2023	61	24.98	47.57	70.16
09/01/2023	57	24.98	47.57	70.16
16/01/2023	57	24.98	47.57	70.16
23/01/2023	54	24.98	47.57	70.16
30/01/2023	65	24.98	47.57	70.16
06/02/2023	59	24.98	47.57	70.16
13/02/2023	46	24.98	47.57	70.16
20/02/2023	62	24.98	47.57	70.16
27/02/2023	51	24.98	47.57	70.16
06/03/2023	77	24.98	47.57	70.16
13/03/2023	63	24.98	47.57	70.16
20/03/2023	74	24.98	47.57	70.16
27/03/2023	58	24.98	47.57	70.16
03/04/2023	54	24.98	47.57	70.16
10/04/2023	72	24.98	47.57	70.16
17/04/2023	68	24.98	47.57	70.16
24/04/2023	65	24.98	47.57	70.16
01/05/2023	61	24.98	47.57	70.16
08/05/2023	60	24.98	47.57	70.16
15/05/2023	74	24.98	47.57	70.16
22/05/2023	71	24.98	47.57	70.16

Next steps

Building on the work done so far alongside the System Wide Frailty Network, CHCP plans to carry out an Experience Based Design project to involve patients in shaping services going forward. Using what it has learned about quality improvement methodology, the team intends to use the same processes with other workstreams in the Ageing Well agenda. The system has made good progress with using IT in the delivery of urgent community response services and plans to expand this (for example, by implementing electronic medication charts). There are plans to recruit more clinical staff to be able to expand its face-to-face UCR service and Dan has become a clinical adviser to the System Wide Frailty Network to be able to share his knowledge and expertise with others facing similar challenges.

Key learning

Any kind of system-wide improvement work is fraught with challenge. However, Hull and East Riding of Yorkshire's experience shows that it is possible to make changes, albeit gradually. For Dan, some of the most important learning from this process has been:

1. **Planning** – using driver diagrams proved invaluable in plotting the overall aims and structures of proposed changes. Process maps helped the team see how the service currently runs and where there are gaps. SPC charts measure the impact of any changes.

2. **Working with the System Wide Frailty Network** – this proved useful on many levels, from support with data analysis through to networking with other organisations, receiving expert responses to queries and being critiqued on planned improvements. Dan advises "See any feedback as positive rather than a criticism. The Network really wants to help. The team spent a lot of time going through our data which was very useful. With something like this, you get out what you put in. We got a lot, but we could have got even more. The Network is a unique way of linking in with peers who are trying to do the same things as you at the same time. That is very beneficial."

3. **Courage** – leaving the "comfort of the familiar hospital environment" is vital to be able to do something radically different in a community setting.

4. **Be clear about your goals** – it would be easy to become overwhelmed when trying to implement system-wide improvements. Dan says it is important to be clear about your project aim and what you want to achieve.

5. **Have a system mindset** – don't just have one provider organisation in your improvement team. To get true buy-in across the integrated care board, make sure you involve different organisations. Also, don't just involve clinicians but also data analysts, performance, operational and strategic leads.

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