Frailty:

What has COVD 19 taught us?

Hosted by

Dr Ian Sturgess Clinical Lead UEC Frailty &

Chris Morrow-Frost Clinical Head of UEC Improvement and Transformation
NHS England & Improvement Midlands Region

30th April 2020

11:30 Chair's opening & housekeeping – Dr Ian Sturgess

11:40 Virtual Clinics for Local Systems – Steve Corton Better Care

11:50 Your thoughts: presentations from STP MDTs in

- **Northamptonshire**
- **Derbyshire**
- **Dudley**
- **Coventry & Warwick**
- **Leicestershire**
- **Shropshire**
- **Lincolnshire**

12:25 Delegate further thoughts and questions

12:45 Corona Virus Pandemic – A Paradigm shift – Dr Bola Owolabi

12:55 Closing remarks – Dr Ian Sturgess

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Chris Morrow-Frost Clinical Head of UEC Improvement and Transformation NHS England & Improvement Midlands Region

30th April 2020 11:30 – 13:00

Introduction
Frailty : What has COVID 19 taught us?

Dr Ian Sturgess	Introduction
Teams Etiquette	1. Please make sure you are on mute and with your camera off on Teams – unless you are a speaker. 2. All other phones on mute. 3. Please use the ‘comment’ function to make comments and raise potential questions for the Q+A session.
Recovery Planning	1. Outcomes (COVID and non-COVID acute illness) – - For those patients living with frailty managed by alternative pathways - For those not accessing appropriate care – both frail and non-frail
What do you need from the Regional Team or others?	- Please let us know via the comments box on Teams or via email afterwards

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS England

Virtual Clinics

for Local Systems

Steve Corton
Better Care Manager – West Midlands

Stephen.Corton@nhs.net

The Better Care Fund

Virtual Clinics for Local Systems

- **Virtual** meeting with SYSTEM partners (MS Teams; Zoom; Other) to offer **support** on the requirements of the Discharge Guidance - **Clinic**.
- Core team from the Region – ECIST, LGA, ADASS, Better Care, NHSE/I (inc Ageing Well; CHC specialist). **Additional National level input** tailored to needs of the system partners
- Ask questions, discuss challenges, potential solutions, tap into transferable good practice.
- All those involved in discharge, at all levels and from all organisations (local government, health, housing, voluntary and community sector, social care providers).
- **IT IS NOT** – a regulatory forum; a performance assessment; a mediation for arguments
- Pilot in the West Midlands to begin with before considering Midlands wide scope.
- What we ask: You have a clear **shared** idea of the challenge(s) you need help with
  You come to us as system partners with a collective spirit

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What people have said so far:

'***Thanks all for time on video call from yourself and your wider team' –***
Programme Manager, STP Planned Care

'The challenge you gave us about LLOS has really focussed us' –
Senior Commissioning Manager, CCG

'Great clinic yesterday. It was helpful to get insight from the team and also identify that we had a feedback loop gap' –
Discharge Lead, Acute Trust

Your experience,

Your thoughts…

Frailty : What has COVID 19 taught us? (Northamptonshire – Renchu Hesketh, Frailty Lead and Head of Performance)

Presenter name	Northamptonshire
What are the top 3 positive learning points they have found through the COVID challenge as a system with particular reference to patients living with frailty?	1. Able to use COVID 19 to progress some of the issues we have struggled to progress previously due to funding arrangements 2. System ability to pull together and enable rapid discharge of patients 3. Ability to create extra capacity at pace for most vulnerable and to support system demand for example hot sites to support care homes 4. Digital consultations within primary care
What are the top 3 'knotty problems' which have been challenging for the system to solve regarding the COVID challenge around patients living with frailty?	1. Challenges to progress projects not yet embedded during staffing challenges and uncertainty – Frailty SDEC 2. Ability to further develop integrated health and care teams in the community around PCN footprints with varying demands on primary care and community trust 3. Supporting care homes at pace to prevent unnecessary admissions to hospital
What do you need help with in the near future?	*Digital solutions across the entire system – some implemented better than others but still gaps where older infra-sructures are in place.*

Frailty : What has COVID 19 taught us?
(Derbyshire: Jonathan Wardle, Senior Place Manager)

Jonathan Wardle	Derbyshire
What are the top 3 positive learning points they have found through the COVID challenge as a system with particular reference to patients living with frailty?	1. **Responsiveness** : Many changes have been made very quickly, enabled by a single unifying purpose, replacement of big bureaucratic meetings with frequent, regular, well attended brief videoconferences, and the removal of many financial constraints. Fear of making the wrong decision has been trumped by the fear of the consequences of not doing anything. 2. **Leadership and relationships:** Clinical leadership to come to the fore, frequent conversations between clinical leaders and managers has allowed rapid problem solving and decision making enthusiastic support for innovation as well as greatly improved relationships. 3. **Raising profile** of the frail and vulnerable persons agenda especially regarding non traditional / non clinical support for care homes/ at home population
What are the top 3 'knotty problems' which have been challenging for the system to solve regarding the COVID challenge around patients living with frailty?	1. With all focus on urgent capacity, how many people are quietly becoming frail, lonely or poorly alone at home. 2. A single **electronic patient record** remains an aspiration 3. Organisational boundaries remain, although there are some great examples of joint working, barriers to a **single team** across organisational boundaries haven't been removed
What do you need help with in the near future?	- Maintaining the get things done approach and engaged clinical leadership - Support for evaluation of change - Move to outcomes based 'commissioning' - Dynamic real time BI to understand activity and demand in community services and General Practice

Frailty : What has COVID 19 taught us?
(Dudley: Andrew Hindle, Commissioning Manager)

Presenter name	STP / Organisational Name
What are the top 3 positive learning points they have found through the COVID challenge as a system with particular reference to patients living with frailty?	1. Prioritising Advanced care plans/ Treatment Escalation Plans has resulted in reduced admissions and patients being care for in their preferred place of care. 2. Ability to progress initiatives rapidly e.g. formation of a 24/7 Community End of Life Rapid Response Team, Video consultations and use of existing IT solutions, redefining work patterns to increase capacity and resilience. 3. Improving the data intelligence and surveillance of care homes for COVID-19 outbreaks, deaths, admissions that enables clinical response to be focused and prioritised according to need.
What are the top 3 'knotty problems' which have been challenging for the system to solve regarding the COVID challenge around patients living with frailty?	1. Delays and a lack of community swabbing for people with frailty and particularly in care homes until too late for interventions. 2. Data intelligence has been cumbersome and delayed which has been challenging in part due to public health based in DMBC rather than NHS systems. Some of this is due to care homes trying to keep figures under wraps. 3. Less face to face contact may have negative consequences to this cohort of patients. 4. Healthcare staff apprehension about virus. 5. Communication gap between Primary and Secondary care and different teams in the secondary care and full focus on Covid patients means non Covid frail patients did not receive appropriate treatment
What do you need help with in the near future?	- Success stories of initiatives that support people with frailty and particularly those that are implemented without long protracted business cases. - To divide teams (also healthcare services including hospitals) to focus on disaster (Covid in this instance) and normal activity so frail/other unwell patients are not denied of treatment. - Needs to be a large public education campaigns about planning future care

Frailty : What has COVID 19 taught us?
(Leicestershire: Rachel Marsh, Clinical Director)

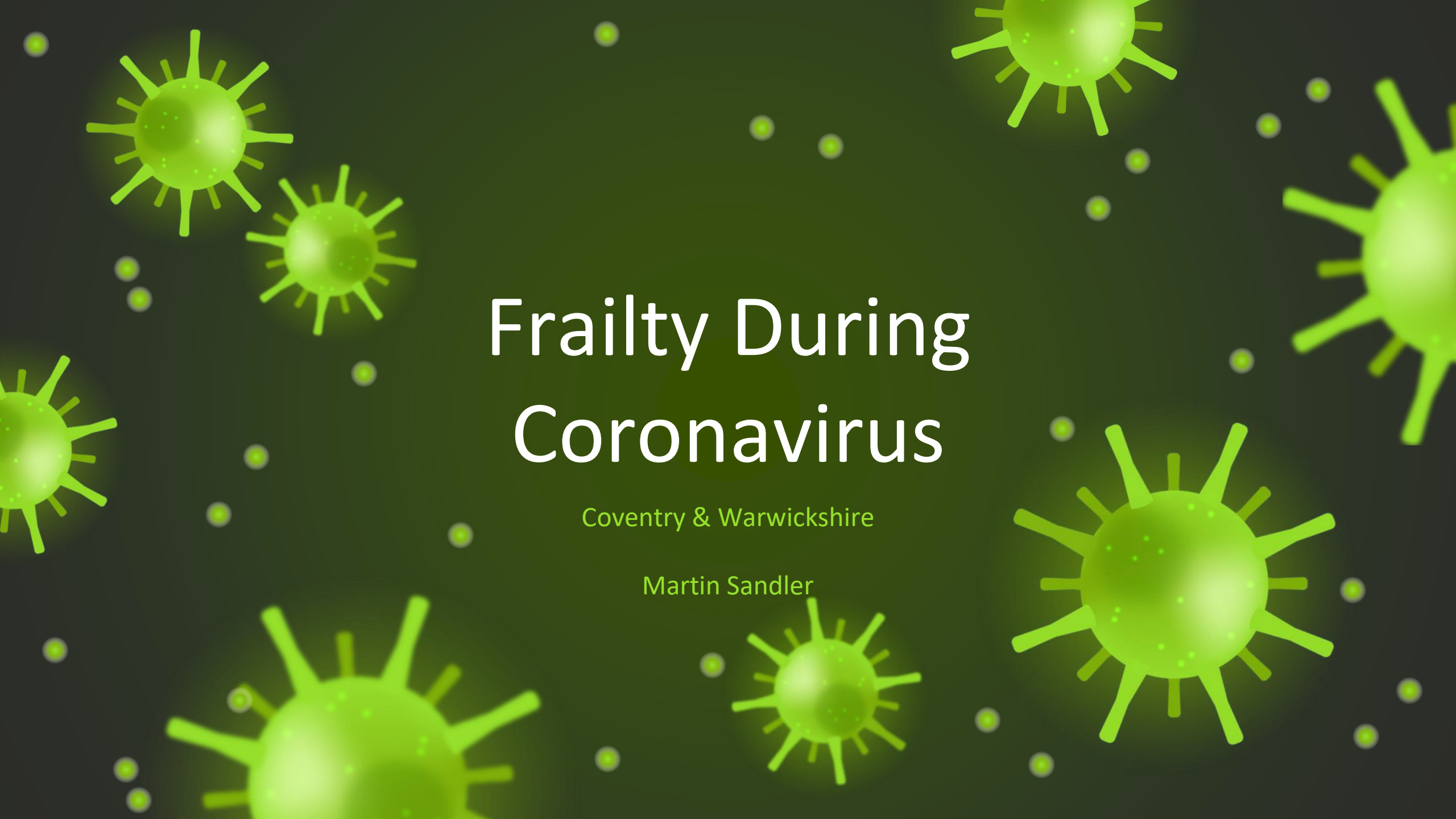
Presenter – Rachel Marsh, Clinical Director, Emergency and specialist medicine, UHL	**Leicester, Leicestershire & Rutland**
What are the top 3 positive learning points they have found through the COVID challenge as a system with particular reference to patients living with frailty?	1. We are one system, with interdependent systems of care – but when we *really* try, no organisational barrier will stop us from providing the right care for our frail patients 2. We can design / adapt / deliver services to best meet the needs of our system rapidly when we adapt the principles of 'teaming' 3. Fully engaged and intelligent clinical leadership, coupled with sensible management capacity, can be truly transformative
What are the top 3 'knotty problems' which have been challenging for the system to solve regarding the COVID challenge around patients living with frailty?	1. Misaligned and conflicting guidance from different government departments and/or national bodies e.g. management of care home patients discharged from hospital 2. Communicating pathway changes to all parts of the system in a timely manner in the midst of 'comms overload' 3. Implementing the 3 hour metric within the 'hospital discharge spec' in a safe and timely manner for complex patients
What do you need help with in the near future?	1. Clear mandate and process across health and social care to ensure that no patient is delayed in a hospital bed because of funding decisions 2. How are systems working with ambulance providers to ensure that any frail patients on the general 'stack' are referred appropriately to the sub-regional Clinical Assessment Teams to prevent unnecessary conveyance? 3. Evaluation frameworks to measure the impact of changes to pathways from a systems perspective

Frailty : What has COVID 19 taught us? (Shropshire: Emma Pyrah, CCG)

Presenter name	STP / Organisational Name
What are the top 3 positive learning points they have found through the COVID challenge as a system with particular reference to patients living with frailty?	1. Covid has determined a new way of working where organisational boundaries are dismantled, remote working has not been a barrier to facilitating change and new technology has brought organisations together and enhanced the way we deliver care 2. Patients are placed in the centre of planning and pathways are centred around patients 3. Using the learning from the work initiated pre COVID (Primary Care, SaTH consultants outreach and T&W Care Home MDT) to progress at pace the project of Advance Care Planning/Anticipatory Care Planning and ReSPECT for Care home residents with a high level of frailty
What are the top 3 'knotty problems' which have been challenging for the system to solve regarding the COVID challenge around patients living with frailty?	1. Isolation of frail individuals in the community and remote risk management of vulnerable people in the community without/limited face to face contact 2. Enhanced community reassurance offer and the volunteer group offer 3. Change from a local solution to Bed Tracking to the national tracker caused delay in information being available with instability of information flow 4. Difficulties accessing PPE for care sector providers to be able to care for individuals safely whilst protecting their staff, made more challenging by lack of supply of PPE combined with increasing cost to purchase
What do you need help with in the near future?	- Care workforce emotional and well being support - Data flow - How to incorporate the learning and establish a system model of Care Home support aligning with the PCN Enhanced Health in Care Home DES - Assurance modelling for frail older carers-offer of support to maintain independence - Impact post Covid 19 • remodelling of reablement/rehab recuperation and recovery offer post Covid 19 • Length of time for recovery following Covid 19 • Consideration of the Covid 19 population changes the age profile of frailty

Frailty : What has COVID 19 taught us? (Lincolnshire: Melissa Hall, Senior Programme Manager)

Presenter name	STP / Organisational Name: LINCOLNSHIRE
What are the top 3 positive learning points they have found through the COVID challenge as a system with particular reference to patients living with frailty?	1. There are alternative pathways/services 2. Integration – can be done rapidly 3. Embedding best practice tools Edmonton, Spict for All, EPaCC's 4. Virtual MDT's working well , palliative care huddle calls sharing work load
What are the top 3 'knotty problems' which have been challenging for the system to solve regarding the COVID challenge around patients living with frailty?	1. Rockwood (top down approach, acute settings) 2. Where have all the frail patients gone? Post Covid surge? 3. Managing delirium in the community 4. Covid cells put everyone back into silo working Frailty not a silo it is everyone's business!
What do you need help with in the near future?	- 1 Support links with General practice - 2 Links with LD, Mental Health, Homeless (Vulnerable adults)


Frailty During Coronavirus
Coventry & Warwickshire
Martin Sandler

Challenges

There are a few worth particular note:
Care Home Sector
Engagement of 1/3 acute providers
Ambulance Service Participation
Data availability and support
Localised lack of integration with primary care
Timing!

Some of these are not entirely new but highlighted during the crisis

Some Success

And promise of more
System wide use of data
Improvement of acute response in major provider
Warwickshire integration proceeding apace
Recognition of care home and dom care pivotal role

Do we need help?

Maybe

- Involvement of ambulance service
- Engaging large provider
- Analyst support

But making progress now – Covid 19 has added impetus

Intervention may be counterproductive

Delegate experience,
thoughts and questions…

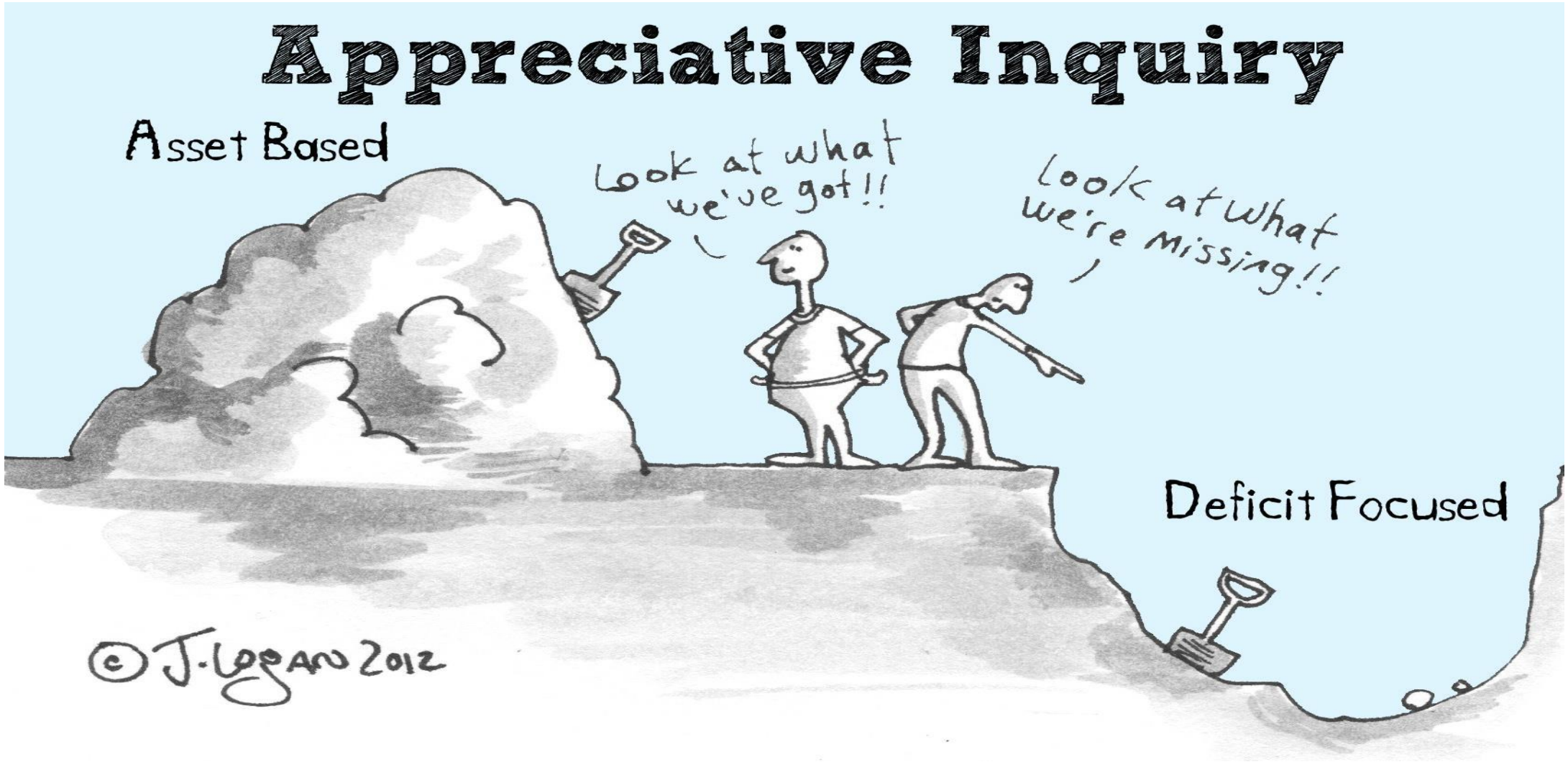
Corona Virus Pandemic – A Paradigm Shift

Dr Bola Owolabi

National Specialty Advisor for Older People and Integrated Person Centred Care

NHS England and NHS Improvement

Appreciative Inquiry



Why?

- In every situation something works… find it and let it flourish.
- What we focus on becomes our reality… focus on possibilities we find possibilities – focus on problems we find problems.
- There are always multiple realities – different ways of seeing.
- The way we ask questions either creates or denies possibilities. So be mindful how we do this.
- When we carry forward to the future some of our old ways - then they should be the very best of our old ways.

Accelerating Change- Ageing Well programme

Urgent Community Response

2 hour standard for UCR, **2 day standard** for reablement and a **single point of access** for UCR utilising 111

Enhanced Health in Care Homes

Enhanced support & better co-ordinated care, r**eablement** and **rehabilitation**

Anticipatory Care

Helping people with **complex needs stay healthy** and functionally able

#AgeingWell **@AgeingWellNHS** **#NHSLongTermPlan**

Chair’s closing remarks

Learning from COVID, What is next?

For further information, requests for support and advice or a copy of these slides please email chris.morrow-frost@nhs.net