LLR Frailty programme: Progress update

Context

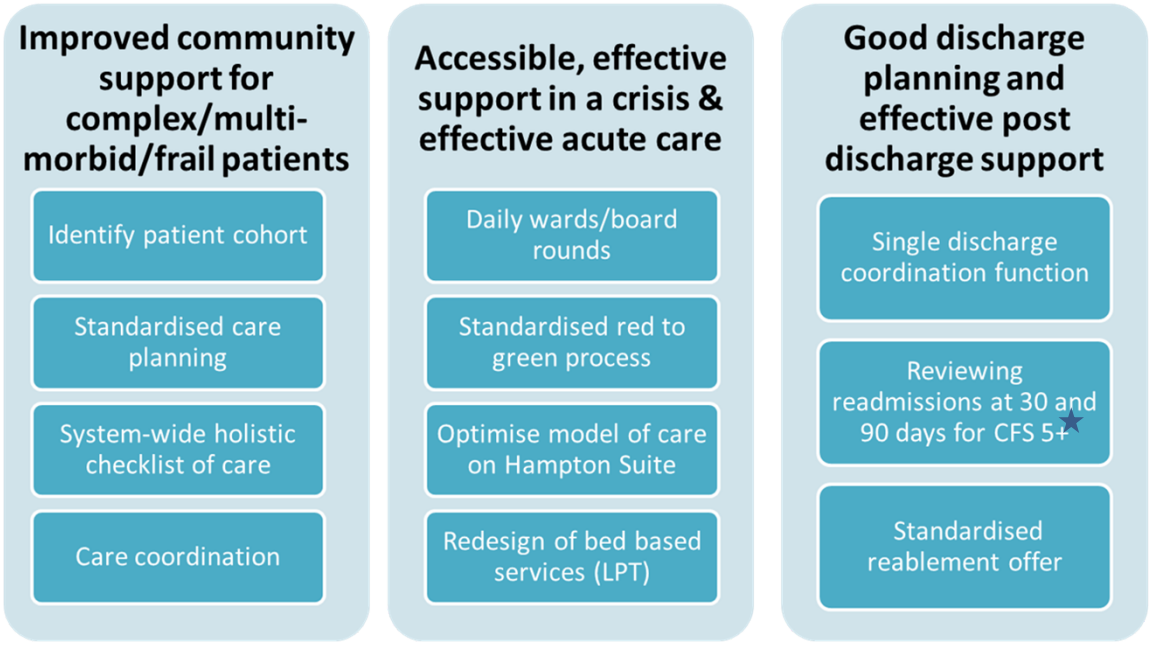
1. The period from December 2017 to March 2018 saw unprecedented pressure on the Leicester, Leicestershire & Rutland (LLR) health and care system. This pressure was noted in every part of the economy, from primary care to social care to secondary and community care, with services stretched and staff fatigued across the system. This was in spite of all non-urgent elective surgery being cancelled at University Hospitals of Leicester (UHL), along with some cancer cases.

2. Analysis of UHL data suggests that the issue was not the volume of patients (attendances and admissions have increased in months 11 and 12 but not by a significant amount) but the acuity of the patients being seen. The case-mix noted, particularly through the Emergency Floor and the Admission Units, was largely frail, multi morbid patients over the age of 70. Whilst younger cohorts of multi-morbid patients were of course seen, these were surpassed by the quantity of frailer, older people – at any one time, it was estimated that 80% of beds within UHL were occupied by patients who were over 70, with specific frailty markers, inc. multi-morbidity. The pressure on discharge services was also great – although the system maintained a reasonable Length of Stay and commendable Delayed Transfer of Care (DTOC) rate compared to peer areas, readmissions rates increased as the pressure grew.

The LLR Frailty Task Force

3. To avoid a repeat performance in winter 2018/19, the system instigated the Frailty Task Force and Frailty Working Group in June 2018, led by John Adler, with the mandate to tackle these issues head on before winter 18/19. The Task Force was tasked with holding to account the delivery of other related LLR programmes of work (such as the Integrated Community Services work) and the working group was tasked with delivery of the short term, immediate changes required across the LLR system pre-winter 18/19.

4. The first step in this was to agree the interventions the system needs to deliver in order to reach our aim. These interventions are shown in the diagram below and are broadly split into 3 categories:



**CFS stands for the Clinical Frailty Scale, which is a frailty classification system*

5. These interventions were aligned to the Kings Fund interventions as requested by the LLR Clinical Leadership Group and include comments from clinical and practitioner colleagues across the health and care system.

Progress against plans

6. In the 24 weeks since the launch of the programme, significant progress has been made in the implementation of the interventions outlined above. Progress has largely been as a result of the LLR health and care system coming together to act as a 'team of teams', with all LLR patients at the centre of the design and implementation. Previously, the LLR system has become stuck on standardisation of all services, which has proved difficult to implement on place-based/locality footprints. The work of the task force and working group has effectively looked at the *outcome required* for the patient and designed a service around delivery of the outcome. This has overcome many of the traditional barriers noted in previous LLR change programmes and should be a change model used in the future.

7. Of equal importance has been the escalation route available to the programme – the LLR Clinical Leadership Group and the LLR Senior Leadership Team have offered support in multiple areas of the programme where progress had either stalled or been delayed; this level of support has been useful both practically and strategically and will lead to further positive changes in the future.

8. Progress against each of the 3 high level asks is summarised below:

Improved community support for complex/multi-morbid/frail patients

- Identify patient cohort
- Standardised care planning
- System-wide holistic checklist of care
- Care coordination

- Frailty identification system in use across the system
- IMT systems aligned to produce a frailty flag from all 3 of these systems, launched in November

- Frailty template of the LLR Integrated care plan redesigned, resulting in more relevant, holistic information being collated. Launched in November 2018
- Visible and enactable in all providers via Summary Care Record or SystmOne access where patients have consented access

- Frailty Checklist embedded within the LLR Integrated Care Plan to enable the system to record what interventions have been delivered to our patients. Launched in November 2018.

- Care coordination pilots started across LLR, linking up health and social care services where gaps were noted. Launched in October 2018.

Accessible, effective support in a crisis & effective acute care

- Daily wards/board rounds
- Standardised red to green process
- Optimise model of care on Hampton Suite
- Redesign of bed based services (LPT)

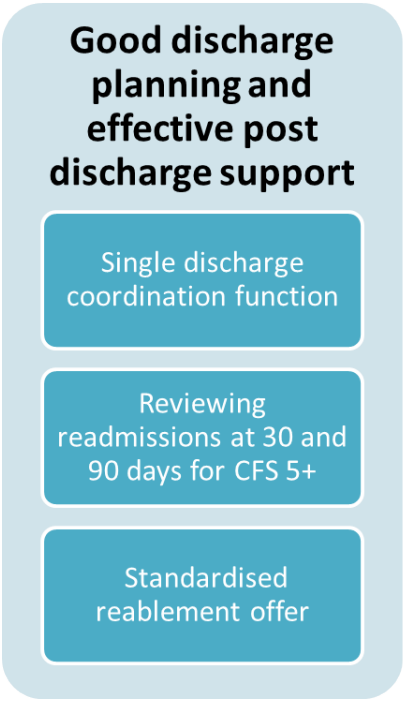
At September 2018, increases noted in both board and ward rounds:

- Board round M-F: 84%, Board round M-S: 42%
- Ward round M-F: 95%, Ward round M-S: 59%

- 90% of all eligible areas reporting use of red2green processes, with themed analysis feeding through to partners regularly

- Patients discharged from the Hampton Suite are flagged to GP's for MDT review through the Integrated Locality Teams if clinically appropriate. Full model and pathway under review

- Community Services Redesign work programme continues to design the offer for out of hospital care. Due to report in December 2018



'Integrated Discharge Team +' will be launched in December 2018, with additional staffing to ensure complex patients are discharged with a holistic review of their requirements. This will reduce stranded and super stranded patients as well as minimise DTOC's

- Readmission risk score recorded onto NerveCentre; all patients with a score of 45+ will be flagged to GP for consideration of referral to MDT review. Specific focus on areas of the Trust with higher benchmarked readmission rates.

- Not yet started – review due to begin in December 2018

Impact of the programme

9. The full impact of the programme on the overall emergency activity trend is not yet expected to materialise fully, given the infancy of the programme. However, early data shows a positive management of any growth the system would normally see at this point in the year. Taking emergency admissions for the over 65's, staying in UHL for more than 6 hours, the LLR system is holding stable with a breakeven position when compared to the proxy plan in use for this programme.

10. For the City in particular, the data shows a reduction of 80 admissions against proxy plan, which is a positive outcome. Naturally, causative conclusions cannot be drawn from this alone, as this programme is one of many in a vastly complex health and care environment.

11. Equally, there are significant differences between the 3 LLR CCG's within this position and it must be recognised that the impact noted of the programme will increase as processes and changes become embedded across the system of care being built.

Next steps

12. The Frailty programme was intended to be a time limited group, focussing on solutions for this winter. The recommendation of the Task Force has been that the programme continues for the rest of the financial year to ensure full delivery of the original aims. This is being considered at the LLR Senior Leadership Team in November 2018.