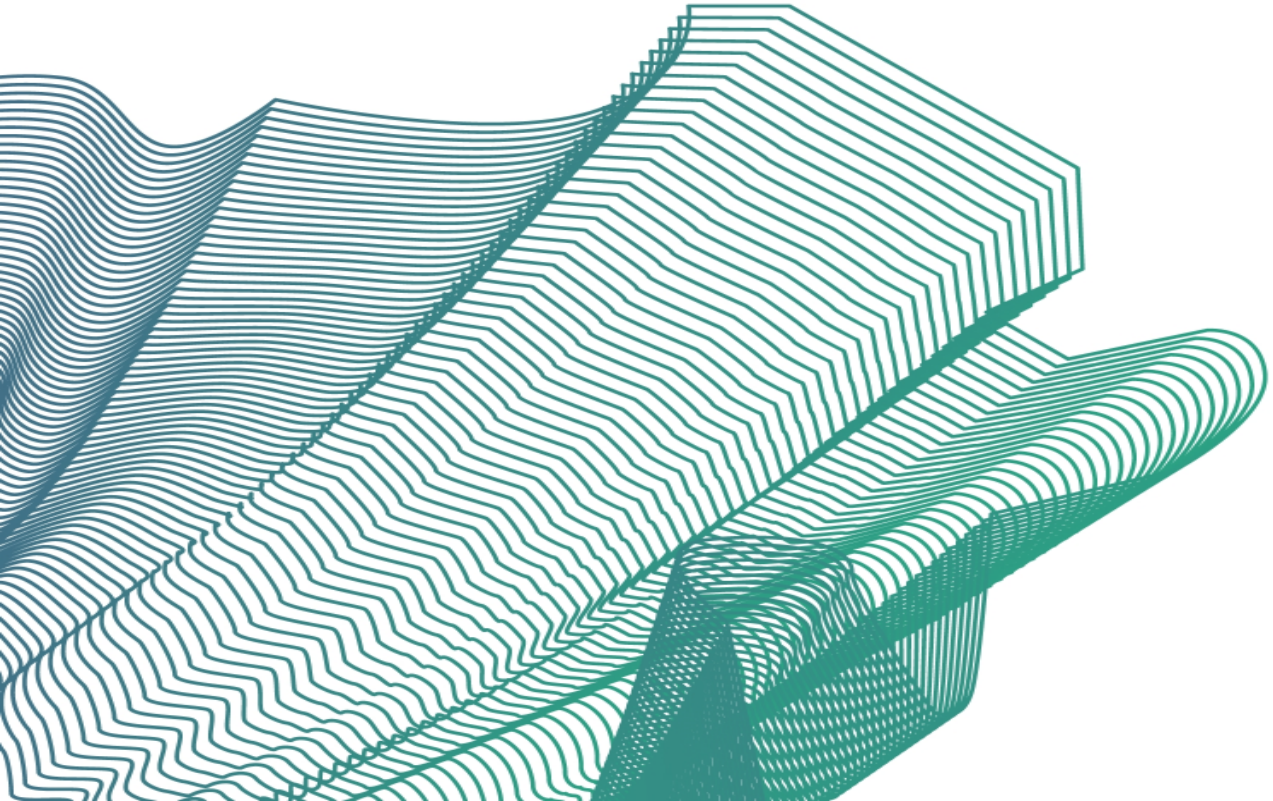
ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Health and Well Being Board

Rotherham High Impact Frailty Update

February 2024



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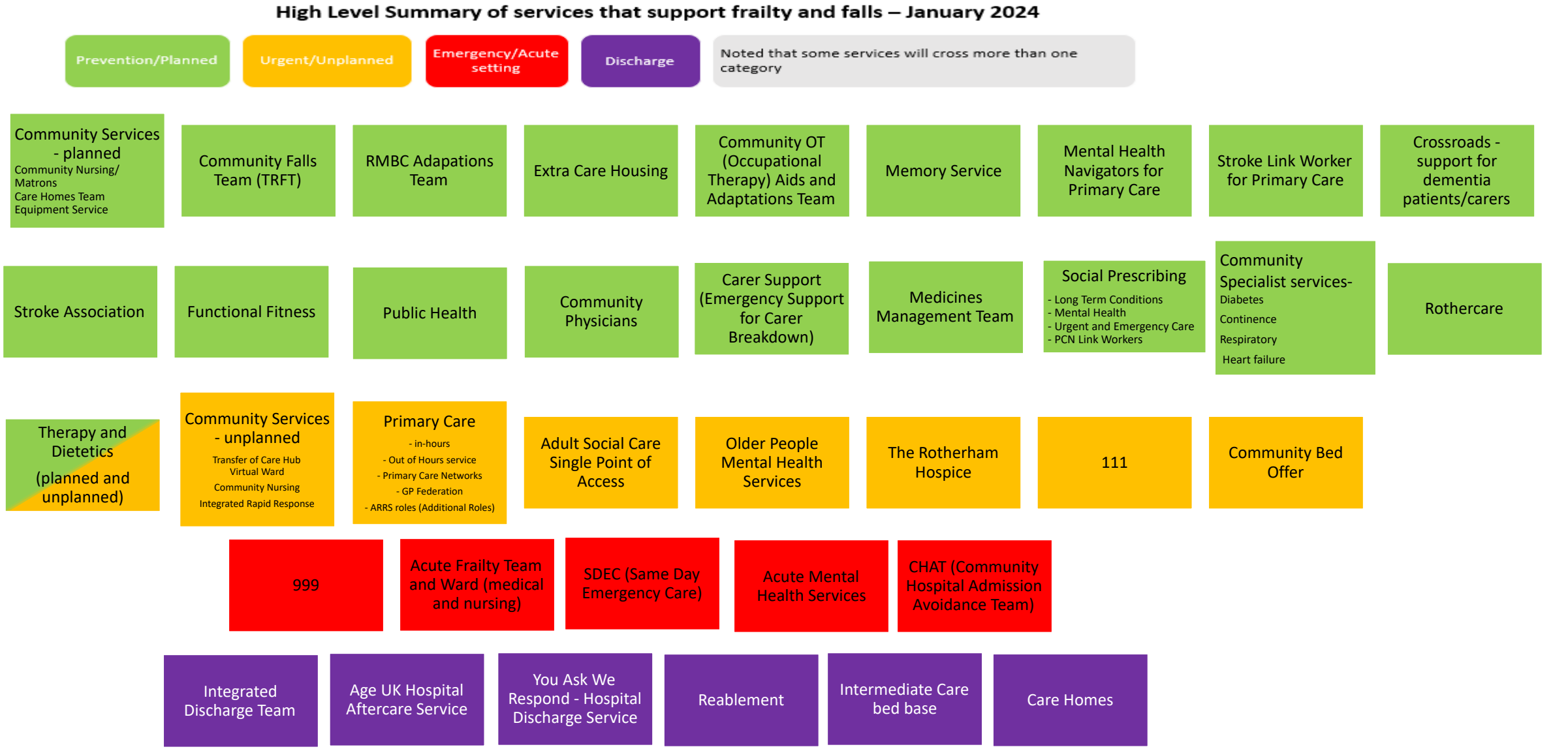
The Brief

- One of Rotherham's 4 high impact change projects along with ambulatory care, respiratory and diabetes
- Rotherham has an extensive, but disparate falls and frailty offer
- There are opportunities to review our offer including learning from good practice elsewhere to provide a more holistic and integrated approach

Informed by:

- National policy including NHS Long Term Plan, Frailty and SDEC national strategies, Rotherham Joint Health and Wellbeing Strategy
- Shared examples of good practice
  - The Jean Bishop Integrated Care Centre, Hull – Hull CCG
  - Resilience-and-Independent-Living-in-Greater-Manchester.pdf (england.nhs.uk)
  - British Geriatrics Society Blue Print
  - GIRFT and BGS: Six Steps to better care for older people in hospital www.bgs.org.uk/sixsteps
  - NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty
- Workshops held to map as is/to be including a falls workshop

High Level Summary of Falls and Frailty Services



What's working well

- Shared commitment to supporting people to live independently for longer, home first and delivering care closer to home.
- Good partnership working across Rotherham Place at all levels, including VCS, with a willingness work together to improve frailty care
- Acute offer includes MDT approach with frailty consultant, frailty nurses, therapy (CHAT and inpatients) in SDEC/AMU
- Out of hospital pathways for all levels of acuity eg virtual ward, urgent community response, CHAT /social care deflection at the front door, VCS.
- Transfer of Care Hub provides an integrated gateway/contact point
- Emergency care paramedics / specialist paramedics to focus on community-based assessment and management (admission avoidance)

Challenges

Overarching

- Ageing population, increased demand/complexity
- Rotherham health demographic/health inequalities
- Diverse range of services, but largely siloed, doesn't address the holistic needs of the individual/ageing process
- Reactive rather than preventative

Access to information

- To navigate /access the offer
- Access to shared patient/client records

Identifying and supporting frailty

- No single, consistent, frailty assessment tool is used consistently in Rotherham
- We do not have a shared caseload or frailty MDT

Opportunities

- Develop a person centred, integrated/holistic offer focussed on prevention
- Review universal offer and identify key cohorts based on vulnerable groups/health inequalities data eg learning disabilities
- Co-production with citizens and across health, care, VCS

Emergent priorities

1. Review and develop the preventative physical activity offer
2. Conduct a proof of concept trial of a proactive care (previously known as anticipatory care) model for frailty
    a. a person-centred, proactive “thinking ahead” approach whereby health, social care and the voluntary & community sector support and encourage individuals, their families and carers to plan ahead of any changes in their health or care needs.
    b. The aim is to increase peoples healthy years by up to 5 more years
    c. The approach encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the event of a flare up or deterioration in their condition, or in the event of a carer crisis
3. Review the acute frailty offer including front door, acute frailty unit and hot clinics

- Recommendations to be drafted for approval March 2024

References/Resources

1. NHS England » NHS Long Term Plan
2. Prevention in social care (scie.org.uk)
3. NHS England » Delivery plan for recovering urgent and emergency care services – January 2023
4. Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge (england.nhs.uk)
5. Chief Medical Officer's annual report 2023: health in an ageing society - GOV.UK (www.gov.uk)
6. Health Wellbeing Strategy 2018 New branding.pdf (rotherham.gov.uk)
7. The Way Forward for Acute Frailty Same Day Emergency Care (SDEC) (1) - SDEC Collaboration Platform - FutureNHS Collaboration Platform

Frailty Specific:

NHS England » FRAIL strategy

http://www.bgs.org.uk/FrailtyHub

http://www.bgs.org.uk/Blueprint (Frailty Blueprint – 7 touchpoints & 12 recommendations)

http://www.bgs.org.uk/elearning/2023-frailty-identification-and-interventions

http://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources

http://www.acutefrailtynetwork.org.uk/

GIRFT and BGS: Six Steps to better care for older people in hospital www.bgs.org.uk/sixsteps

NHS England » Proactive care: providing care and support for people living at home with moderate or severe frailty