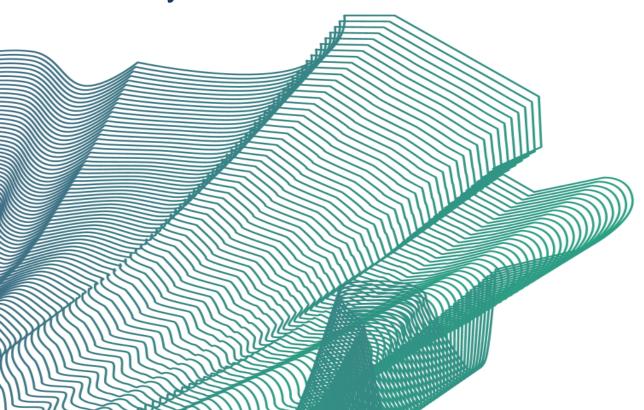


# Health and Well Being Board Rotherham High Impact Frailty Update

February 2024





Rotherham
Clinical Commissioning Group

Rotherham, Doncaster and South Humber

The Rotherham
NHS Foundation Trust







## 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**

#### High Level Summary of services that support frailty and falls - January 2024

Emergency/Acute setting

Discharge

Noted that some services will cross more than one category

**Community Services** - planned

Community Nursing/ Matrons Care Homes Team **Equipment Service** 

Community Falls Team (TRFT)

**RMBC Adapations** Team

Extra Care Housing

Community OT (Occupational Therapy) Aids and **Adaptations Team** 

**Memory Service** 

Mental Health Navigators for **Primary Care** 

Stroke Link Worker for Primary Care

Community

Diabetes

Continence

Respiratory Heart failure

Crossroads support for dementia patients/carers

Stroke Association

**Functional Fitness** 

**Public Health** 

Community **Physicians** 

**Carer Support** (Emergency Support for Carer Breakdown)

Medicines Management Team **Social Prescribing** 

- **Long Term Conditions** Mental Health
- **Urgent and Emergency Care PCN Link Workers**

Specialist services-Rothercare

Therapy and Dietetics (planned and unplanned)

**Community Services** - unplanned

> Transfer of Care Hub Virtual Ward Community Nursing **Integrated Rapid Response**

**Primary Care** 

- in-hours - Out of Hours service - Primary Care Networks - GP Federation - ARRS roles (Additional Roles)
- **Adult Social Care** Single Point of Access

Older People Mental Health Services

The Rotherham Hospice

111

Community Bed Offer

999

Acute Frailty Team and Ward (medical and nursing)

SDEC (Same Day **Emergency Care**)

Acute Mental **Health Services**  **CHAT (Community Hospital Admission** Avoidance Team)

Integrated Discharge Team Age UK Hospital

You Ask We Discharge Service

Intermediate Care bed base

Care Homes

Aftercare Service

Respond - Hospital

Reablement



# 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

- NHS England » NHS Long Term Plan
- 2. <u>Prevention in social care (scie.org.uk)</u>
- 3. NHS England » Delivery plan for recovering urgent and emergency care services January 2023
- 4. <u>Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge (england.nhs.uk)</u>
- 5. <u>Chief Medical Officer's annual report 2023: health in an ageing society GOV.UK (www.gov.uk)</u>
- 6. <u>Health Wellbeing Strategy 2018 New branding.pdf (rotherham.gov.uk)</u>
- 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

<u>http://www.bgs.org.uk/Blueprint</u> (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

