# NAPC ANNUAL CONFERENCE 2019

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# Working with community trusts to improve the care of older patients

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# Frailty 100 Day Challenge

## Improving outcomes for people living with frailty in Lincolnshire

100 Day Challenge Summary Report

August 2019

NHS Lincolnshire Sustainability and Transformation Partnership

NHS Lincolnshire Partnership NHS Foundation Trust

Lincoln & South Lincolnshire age UK

NHS Lincolnshire Community Health Services NHS Trust

Home first

NHS United Lincolnshire Hospitals NHS Trust

Public Health Lincolnshire

NHS Lincolnshire East Clinical Commissioning Group

NHS Lincolnshire West Clinical Commissioning Group

Lincolnshire County Council

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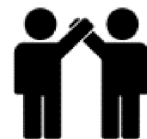
St Barnabas

# What was the learning agenda for teams?

The 'learning agenda' provides a set of **key questions that teams are encouraged to explore** when building their goals and initial ideas.

### Joined up approaches to identification and assessment

How do we create a more joined up approach to identifying frailty and understanding people's needs?



### A seamless experience of care

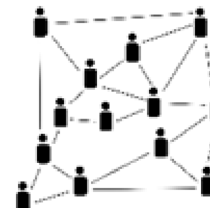
How can we create a seamless experience of care – to reduce duplication and ensure that people don't fall through the net, or 'go round in circles', within neighbourhoods or in crisis?

### Keeping the person at the centre of their care and support planning

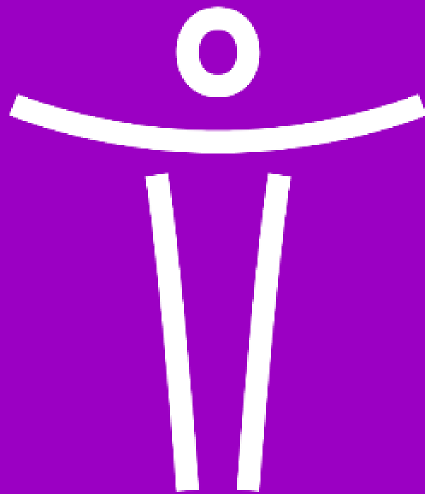
How can we work with people, their family, friends or carers to understand what is important to them, build on their strengths and support them to achieve their outcomes, including if their circumstances change?

### Supporting people to live well in the community

How do we enable people to manage their needs and meet their goals, at home or in their neighbourhood?



# I'm Still Standing (Stamford)



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**Team focus:** Falls prevention for people with severe and moderate frailty

**Team member organisations:** Rutland CC, St. Barnabas, LPFT, Lincs CVS, Lakeside Practice, Macmillan, LCHS, NWAFT, Evergreen
**Sponsors:** Kirtseen Redmile (STP), Tracy Webb (Rutland Council)

The Stamford team worked on a range of ideas that spanned 5 core themes:

- Taking a **population health management approach for their cohort through MDT working** and proactive follow-up
- Improving the process of **identification** for moderate and severely frail fallers
- **Training** to improve awareness and understanding of falls prevention (with a particular focus on community involvement including care homes)
- Testing different approaches for **timely, holistic assessment** at both the pre- ('at risk') and post-fall stages
- A **rapid-response falls service** for frail fallers, to provide assistance quickly and prevent unnecessary admissions into hospital

During the Challenge…

Identification of **92 fallers** who had a **moderate or severe level of frailty** (9 of whom live in Rutland, with 6 agreeing to be referred to the Rutland Falls Team)

**31** people participated in **Falls Prevention awareness training**, delivered with input from NWAFT Falls Specialist nurse and NWAFT Frailty Consultant.

The following slides provide a **case study** and **recommendations** discussed at the Sustainability Review.

# Stamford case study:

*A proactive approach to falls management*

**What happened?**

- Mr P lives at home with his wife and was referred to Jemma for a falls assessment (Practice Care Coordinator) by his GP after experiencing falls at home. Mr P was marked as moderately frail on the practice register, but was not currently known to any other services
- Jemma visited Mr P at home and had a conversation with him and his wife about how they were doing. Jemma used the Edmonton assessment tool and found that he scored as severely frail
- Jemma identified that Mr P had been falling due to his severe COPD, which was causing his oxygen levels to drop

**What was the outcome?**

- Jemma was able to bring this information back to the GP and Mr P was referred to appropriate services including the community therapy team for strengthening exercises
- Mr P was also referred to St Barnabas so that he can receive appropriate support through the palliative care pathway

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# Stamford: Recommendations & next steps

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**Recommendation: Taking a Population Health Management approach to falls through MDT working.**
*What next?:* Continuing to work with colleagues in Rutland and from Public Health to develop the approach, and work through the neighbourhood MDT

**Recommendation: Frailty identification - create system for all neighbourhoods where they recognise their severe & moderately frail fallers** (building on the falls inbox tested by team)
*What next?:* Continue to use the Falls Inbox at Lakeside Practice and explore how this approach (including capacity for follow-up) could be scaled for other neighbourhoods

**Recommendation: Expanding provision of falls prevention awareness and training, by using a 'train the trainer' approach and building on 3rd sector skills and capacity.**
*What next?:*
- Monthly 'Push the Prevention' awareness sessions run by Neighbourhood team, using the resources developed for the initial training session, opened up to all community stakeholders
- Working with all Care Homes: recommended expansion of exercise programmes and Falls Prevention training with staff. The learning from Stamford will contribute to the development of the Lincolnshire Frailty Model

**Recommendation: Building on the learning from Rutland and Leicestershire and adopting the use of holistic pre- and post-fall holistic assessments.**
*What next?:* Continue use in Stamford and connect the learning into the development of the Lincolnshire Frailty Model

**Recommendation: Develop local rapid response falls service to provide appropriate support at point of need & prevent unnecessary attendances at A&E / unplanned hospital attendances.**
*What next?:*
- EMAS, Evergreen and the ASC Wellbeing Service collaborating to continue testing this approach (discussion re: role of the Urgent Care Centre in the Falls Pathway)
- A collaborative approach between LCHS/ LCC/ St Barnabas/ LPFT therapy teams. LCHS Therapy Lead to have discussion with NWAFT.

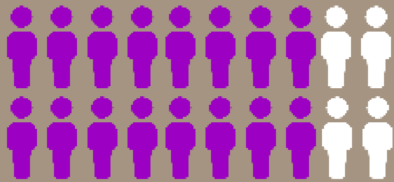
# What did team members say?

"Great opportunity to make new relationships and working connections"

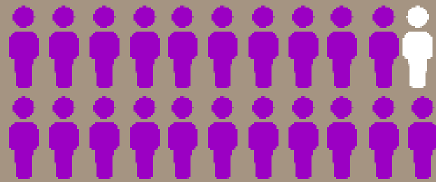
"I've strengthened relationships across multiple organisations that I wouldn't previously have interacted with"

"Great work within neighbourhood team and massive drive effort - now needs to be supported by executive teams to sustain and expand"

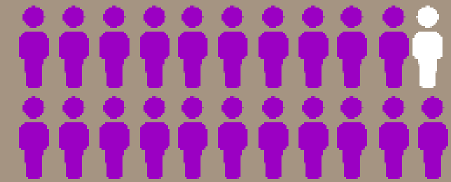
"Fantastic to network, valuable resources gained"



82% of people at the Day 100 event agreed that there are things they are doing differently now that **they weren't doing before the 100 Day Challenge.**



95% of team members who gave feedback at milestone events said that they'll use the learning from the Challenge in other aspects of their work



95% of team members who gave feedback at milestone events said that they have strengthened relationships with colleagues through participating in the Challenge

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