WORKING TOGETHER TO IMPROVE HEALTH AND CARE IN BROMLEY

Development of an Integrated Frailty model

Borough Based Board: July 2021

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Vision & Principles

‘Our vision is to provide world class service for patients living with frailty.’

The proposed model is centered around the needs of patients with frailty, that helps to keep patients out of hospital using integrated One Bromley pathways

Frailty Service Principles

- **Early identification** of people living with frailty across the system.
- **Comprehensive Geriatric Assessment** & **Anticipatory management plans** for all known patients with frailty.
- **Standardised information systems** that provides **shared records** across one integrated system.
- We **take frailty care to the patient** whenever possible (moving the **‘Front door’ to the community**)
  - -Providing **same day frailty ambulatory service** where possible
  - -Direct access to **Intermediate Care resources**
- Multidisciplinary teams working across the **integrated service** – one team, one service, One Bromley
- **Admission avoidance :** acute hospital admission is the last resort and not default.
- **Robust governance** principles underpinning practice
- **Research, training ,education and data** to drive innovation.
- **Optimal functional assessments** in patient’s usual residence.

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Proposed Integrated Frailty Model

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NHS King's College Hospital NHS Foundation Trust

GP/GP Alliance

Community Nursing/Matrons

Bromley Health Care

ICN Integrated Care Network

Oxleas

Social Care

Bromleag Care Practice

Residential Care/ Nursing Homes

St Christopher's Hospice

Bromley Well/ Bromley Third Sector Enterprise

Enablers: Workforce, PHM, defined KPIs, integrated IT and information governance, agreed frailty thresholds and tools (i.e. for assessment)

SPA entry portals in place:
- CCC/ SPA (BHC)
- BCCC (St.C)
- SPA (BTSE)

1a) **Frailty Entry Portal**

999 & 111

Key
Blue: In place
Grey: To be developed
Green: Proactive
Orange: Urgent community
Red: Acute

2 **Frailty response & Intervention Team**

BHC- Rapid Response

4b) Frailty Hot Clinics

Accelerator programme

6 **Frailty Wards**

Patient's Usual Residence

Virtual Ward

4a) **Same Day Frailty Ambulatory Care**

5 **Frailty Assessment Unit**

Other Wards

Frailty In-reach

1b) **Proactive Care:**
- Operational changes

Patient identification (PHM & risk stratification)

Case Management (Proactive Care +)

3 Step up/Step Down Intermediate Care Beds

Emergency Department

Frailty Team

PROACTIVE

URGENT COMMUNITY RESPONSE TO CRISIS

ACUTE

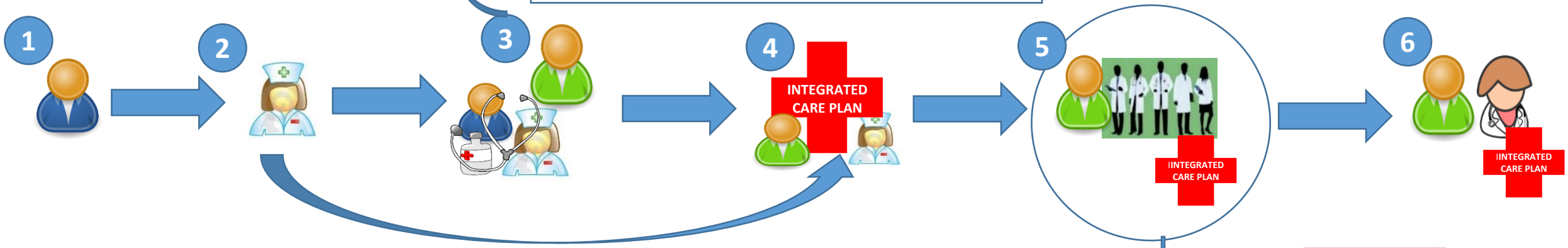
Self-management, Case Management, Anticipatory care planning & End of Life Care

Urgent Community Response and Recovery

Responsive pathways to needs & preferences (Right Care, Right Place)

Existing Proactive Care Pathway

Referrals not requiring a full MDT:
Signposting & direct referrals onto the correct pathway (i.e. Care Navigator)



Proactive Care pathway explanation step by step

1) ***Patient Identified*** for Proactive Care pathway- referral managed by MDT Liaison

2) ***Initial Community Matron triage***: Data gathering & signposting

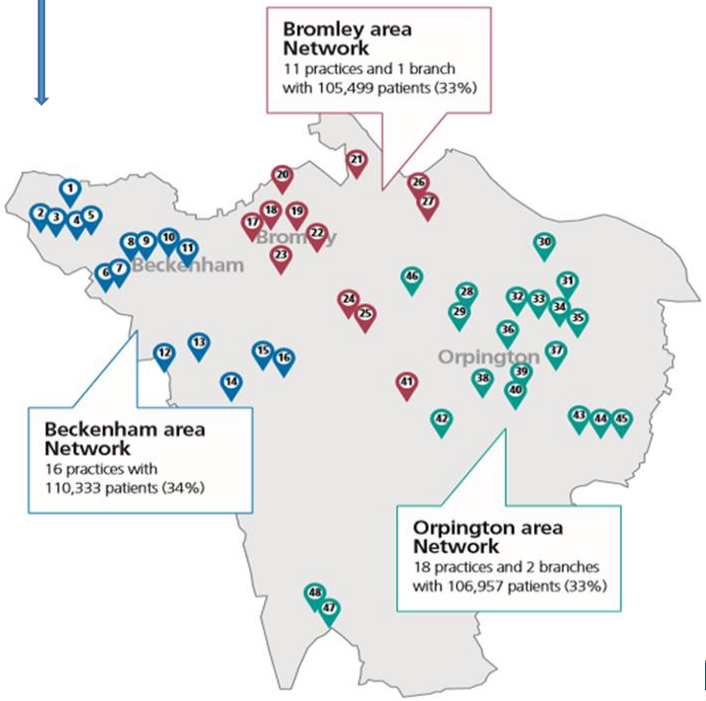
3) ***Level 1 MDT assessment***: Signposting patients onto the correct pathway including direct referrals & level 2 full MDT

4) ***Creation of a care plan***

5) ***Level 2 Full MDT involving all One Bromley partners and the patient GP***

6) ***Implementation of care plan***- overseen by clinical lead and coordinated by the Care Navigator with support from MDT Liaison

- The Proactive care pathway operates within each of the 3 Integrated Care Networks (ICNs) to enable patients to live more independently with complex long term conditions and/ or frailty.
- The 3 ICNS meet on a weekly basis as part of an Multi Disciplinary Team (MDT) including a GP chair, Patients GP, Community Matron, Geriatrician, Care Navigator, Mental Health Professional, Social care Case Manager and St Christopher's.



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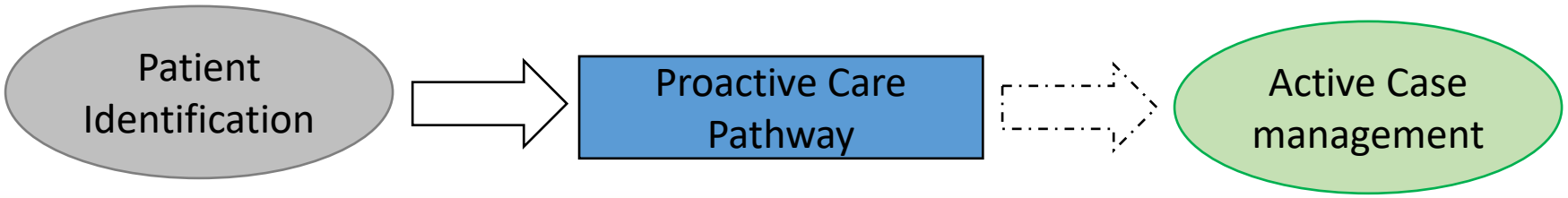
Proactive Care: Scope of Workstream

3 main areas of future development:

Theme 1. Patient Identification	Theme 2. Operational	Theme 3. Case Management
Supporting practices identifying the right patients: a) Approach in identifying the right patients and electronic frailty index (eFI) b) Utilising effective incentives to drive change	Continued refinement to the pathway: Referral source/ triage & Capacity in the current pathway	Development of a case management approach considering the role of: a. Primary Care Networks b. Community Matron/ Nursing c. Social prescribing and the wider role of the third sector.
Alignment frailty integrated care model and key enablers such as Population Health Management, workforce, & IT		



As part of the operational improvements and transformational changes to the pathway, we will continue to engage and seek feedback from GPs, other professional stakeholders and patients. In 2021:

- The Bromley GPA held 2 GP workshop events in April 2021
- Attendance at the 3 GP cluster meetings in May 2021
- BHC will be distributing a survey monkey to seek input and clinical/ professional leads on the pathway.

Progress is monitored via the monthly Proactive care sub-group involving operational and transformation leads across all One Bromley partners

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Urgent Community Care : Scope of Workstream

Status	Workstream	Alignment to Frailty model point(s) of delivery	Description
In progress	**Single Point of Access**	**Frailty Entry Portal (No. 1a)**	Ability to flex for urgent response and speed in discharge
	Accelerator programme Urgent Community	**Frailty response & Intervention Team (No. 2)**	• Funding used for 2 hr/ same day response: • Integrated response & therapy (incl. speech & language), Reablement & home pathway
Gaps/ areas to be developed	**Urgent falls service**	**Frailty response & Intervention Team (No. 2)**	• Focus is on admission avoidance • To refer directly into service • Will require access to equipment and wrap around care
	IV Antibiotics @ Home	**Frailty response & Intervention Team (No. 2)**	
	Community Ambulatory care	**Same Day Frailty Ambulatory Care (No. 4)**	• Focus on admission avoidance • A chaired ambulatory clinic (to include step up beds) • Location TBC- To look at viability/ access to diagnostics and rehab

The first Urgent Community Care workshop is to be held on 30th June 2021 involving a wide range of operational, clinical and professional leads from across One Bromley.

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Urgent Community Care : Scope of Workstream

Status	Workstream	Alignment to Frailty model point(s) of delivery	Description	Opportunities

Gaps/ Developing workstreams	***Acute Frailty Service***	**Frailty Assessment Unit (5)**	• **Early identification** of frailty on arrival in ED for patients 65 years and above.
			• ***Providing a comprehensive Geriatric Assessment (CGA).*** Geriatrician of the day Model.
			• ***Management Plan and clinical decision making:***
			  • MDT approach & management plan,
			  • Supported discharge pathways using One Bromley partners/providers'
			  • Frailty admission pathways to most appropriate ward.
				Business case in development

	Frailty Ward	**Frailty wards (6)**	• An **acute frailty ward** looking at step up and step down • Covering Elizabeth ward, Specialist Geriatric wards and Churchill wards	*Subject to ward reconfiguration*
	Frailty Hot Clinics	**Frailty Hot Clinics – Face to Face /Virtual (4b)**	Hot Clinics aiming for at least 3 times a week to support admission avoidance and early discharge	*Business case in development*

An Acute sub group has been established involving key One Bromley partners to take this work forward.