The Hearing Aid Podcasts

Series 12 Episode 5

Community Frailty Services

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Guests: Dr Tom Woodward, Emma Davy and Kerry Standish

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Learning objectives:

Knowledge:

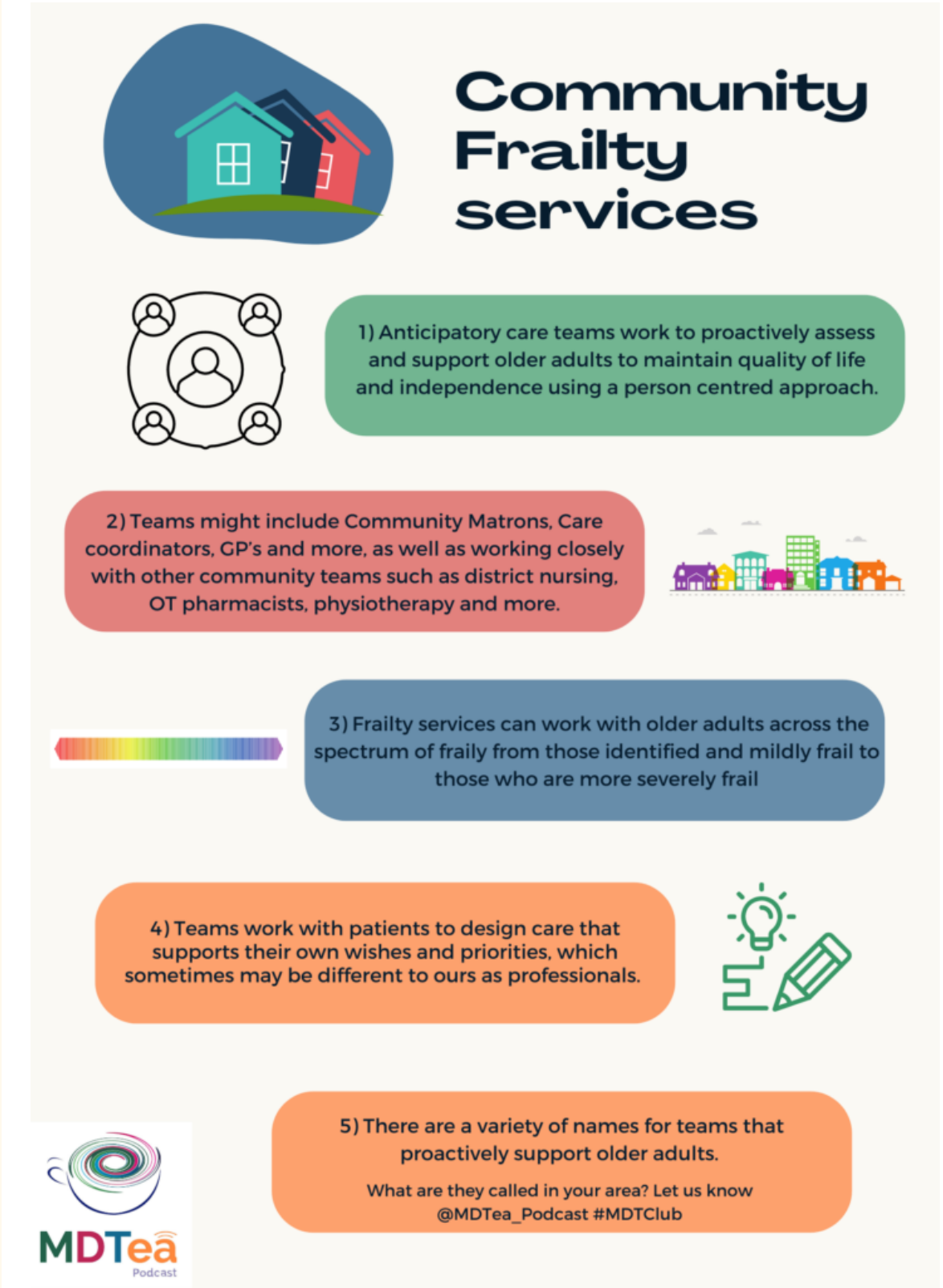
- To know the range of professionals working as part of community frailty teams

Skills:

- To consider the range of assessments, interventions and referrals frailty and anticipatory care services might provide for a person

Attitudes:

- To consider which patients you might provide care for may benefit from input from community frailty teams



Social media:

We saw this video of a 92 year old gentleman diving in Rhodes, Greece. We discussed how it challenges our social biases and expectations of aging, and demonstrates

beneficial activities such as cardiovascular exercise, strength work and the impact nature of the diving may be beneficial in loading the bones which we know can reduce or prevent sarcopenia and osteoporosis.
Although we did decide we wouldn't be employing his breakfast choice of 4 raw eggs and a dash of lemon!
Stephen has been working on creating a new podcast as part of the MDTea podcast family. Med reg news is designed for medical trainees to keep you up to date with developments in your speciality. There are currently gastroenterology, cardiology and geriatrics episodes. You can find it now my searching 'Med Reg News' on all podcast platforms.

https://www.instagram.com/reel/CgCZ10MD6z5/?igshid=NDBlY2NjN2I=

Paper of the week:

Anticipatory care planning for community-dwelling older adults at risk of functional decline: a feasibility cluster randomised controlled trial

Brazil et al, 2022, BMC Geriatrics, 22:452

Acknowledged that as the population of older adults increases, more people require complex care in the community and authors acknowledge this can be difficult for patients, family carers, GP and community services to collaborate on.

This paper is a feasibility randomised cluster trial in 8 GP practices: 4 in N.Ireland, 4 in Republic of Ireland . GP surgeries were randomised to usual care or intervention arm. The study aimed to recruit aimed 64 total patients, 32 per arm, 8 per GP surgery

Inclusion criteria- >70 years of age, enrolled with GMS (R.Ireland health system)/NHS primary care, multimorbidity, at least 4 regular meds, able to complete questionnaires in english language.
Exclusion criteria- receipt palliative care, cognitive impairment, psychosis, homelessness, long term inpatient or nursing home care
GP drew sample of eligible patients and invited to complete PRISMA 7 questionnaire. >2= functional decline and these were invited to study.

Study nurses undertook 3 day study programme, were employed by study not the GP practices. Nurse gathered Medical summary from GP practice, then homevisit to assess patient social and health concerns. Nurse provided Pharmacist with pt medications for review and if required a telephone conversation with Pharmacist and Nurse and patient.

Nurse drafted a summary report of assessment including pt goals, care preferences, identified challenges, action list. GP recommended actions, feedback, confirmed suggested care plan, Study nurse recontacted patient by appointment or telephone and identified priorities, options for support.

Usual care received standard requestable GP appt care.
55 patients were included, 34 in intervention group, 31 in usual care group
There were some discrepancies between groups but overall comparable groups. no assistant living in intervention vs 13% (4.31) in standard care group.
2x more people lived with extended family in intervention (8/34) vs standard (4/31)

Average time by nurse per pt was 441.28 min (SD=106.43) inc travel, admin, consultations with pt, GP and pharmacist. This included an average time of 165.50 min (66.47min SD) direct patient contact.

Pharmacist made 7.8 medication interventions per patient, totalling 265 total interventions including medicine optimisation, queries and advice.

Cost per intervention €769 per patient, with a mean reduction €320 per pt in intervention arm- this result was not statistically significant.
The mean increase in QALY was 0.01 per pateint in the intervention arm, when controlling for baseline EQ-5D-5L scores showed reduction on 0.001 per pt (CI -0.05, 0.02, P= 0.423) which was also not statistically significant.
34 qualitative patient interviews were conducted at 12 weeks, (19 intervention/15 control)
There was unanimous acceptance of ACP intervention, home visits appreciated by participants. Person centred approach built rapport and participants found the medicine review as very helpful.

– shown there is a need for a definitive study to be developed
– >70% pt accept .: can be implemented
– some indication for cost effectiveness
– would be useful to know long term benefits to patients of the care planning on outcomes.

However we discussed some of the strengths and limitations of this study.

Strengths	Weaknesses
design: cluster randomised control trial	cross country, different systems, NI NHS, ROI private-public but >70 free access to primary Health services- .: comparable
public consult in design	excluded cognitive impairment with MMS >20
	aimed 64 participants, 55? unclear don't state total complete, no subject attrition reported.

Jean

Last episode Jean was found by her carers acutely unwell and unable to mobilise. She was managed at home by the local 2hr response service who visited her, undertook a physical assessment, took bloods and began IV antibiotics at home. They worked with

her care agency and the services occupational therapist arranged for support workers to come and provide a more appropriate pressure mattress and commode.

Whilst Jean recovered and did not require hospital admission she's not quite back to how she was before the infection. Following this her GP refers her to the local anticipatory care services. First she meets a community Matron who comes to visit her at home and begin a comprehensive geriatric assessment.

In this episode we speak to Dr Tom Woodward who is a GP and Clinical lead for Redhill Phoenix Primary care network, Emma Davy, South Tandridge Community Matron and Kerry Standish North Tandridge PCN Community Occupational Therapist.
Teams like Emma's community team and anticipatory care hubs in some areas can help teams interconnect and navigate between the different services a person might be known too to support both the professionals and the patients themselves

Emma spoke about beginning a comprehensive geriatric assessment with her patients. She uses a template to guide her discussion and questions. We've included a version of it in the show notes, but I really like it because its a nice simple layout, but has patient wishes in the middle, which I think helps keep the discussions we might have patient centred.

CGA template

After completing her assessments, Emma is able to create a plan with Jean patients that enables her and those who support her to manage Jeans health, keep well for longer and anticipate future care needs based on Jeans long term conditions. The Community Matron becomes a central contact point for Jean and her family so that when new services become involved she can liaise with them to ensure continuity of information. She also helps them to understand what each persons role is and how to keep Jeans care person centred.
Regardless of what your local team is titled, their design will vary based on the needs of your local population.
These teams that Emma works with and Kerry alongside use the whole MDT to take a proactive approach to supporting older adults like Jean.

Like Kerry said its about not waiting until there is a crisis event such as Jeans Fall or her reduced mobility (12.4) this series, but thinking ahead during the time someone is well to work with them to maintain or improve their abilities and quality of life.

Wessex academic health science network have a nice graphic of frailty fundamentals and we will see how as we go through the series each of the teams we chat to can fall into this whole team approach
In 2014 the kings fund report encourages a move 'from high cost, reactive and bed-based care to care that is preventive, proactive and based closer to people's homes, focusing as much on wellness as on responding to illness.' And in the same document they report that 'what they value in terms of wellbeing and quality of life, older people report that health and care services when they become ill or dependent are only part of the story'
The report talks about being able to remain at home in clean, warm affordable accommodation, be socially engaged and able to do activities that 'give their life meaning' whilst contributing to society and more.

That is what teams like this are doing, clinicians like Emma work with patients to proactively meet their needs in a way that empowers the person and enables them to have all these things we know older people value.

The report also talked about how integrated care can improve peoples experience and outcomes of care, and having someone to support patients to navigate the complex health system can really enhance patients experience- and reduce duplication. Including the whole MDT in discussions about older adults living with frailty means that care can be individualised and the RCGP says this is important to improve frailty.

BGS Fit for Frailty document

Thinking about wider NHS policy, the NHS Long Term Plan outlined the importance of designing services that meet the needs of older people living with frailty or multiple long term chronic conditions as a priority. They are:

1) Improve NHS Care in care Homes
2) Identify and provide proactive support to older people living with frailty in the community
3) Enhance rapid response at the time of crisis

As we are chatting with the different teams this series its starting to be a bit clearer how they are working with these goals to improve care and outcomes for the older adults they work with.

Age UK NHS Long term plan review
Additional episode resources:
https://www.slideshare.net/WessexAHSN/eating-and-drinking-well-supporting-people-living-with-dementia

https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-04/kf_making_systems_fit.pdf

https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-23/fff2_full.pdf

https://www.nationalvoices.org.uk/sites/default/files/public/publications/im_still_me.pdf

https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/frailty-resources/#sharing

https://www.england.nhs.uk/wp-content/uploads/2017/03/toolkit-general-practice-frailty-1.pdf

https://www.nhsbenchmarking.nhs.uk/news/audit-into-action-managing-frailty

Curriculum Mapping:

NHS Key Skills Framework	Core	Communication 2:	Communicate with a range of people on a range of matters
		Personal and People development:	Contribute to own personal development
		Quality	Maintain the quality of own work
	Health and Wellbeing	HWB4 Level 2	
		HWB4 Level 3	Enable people to meet ongoing health and wellbeing needs. Plan , deliver and evaluate care to meet peoples health and wellbeing needs

Foundation training Curriculum	Foundation Year 1	Section 2.6 Interface with HCPs Section 2.7 Interaction with Collegues Section 4:20 Healthcare resource management	Describes the structure and importance of the wider healthcare team Works effectively within the healthcare team for the benefit of patient care Makes clear, concise and timely written and oral referrals to other healthcare professionals within the hospital Acts as a member of the multidisciplinary professional team by supporting, respecting and being receptive to the views of other healthcare professionals Works effectively with others towards a common goal e.g. accepts instructions and allocation of tasks from seniors at handovers and multidisciplinary team meetings Demonstrates understanding of the organisational structure of the NHS and independent sector and their role in the wider health and social care landscape Describes hospital and departmental management structure

	Foundation Year 2	Section 2.6 Interface with other healthcare professionals Section 2.7 Interaction with Colleagues	Demonstrates ability to make referrals across boundaries / through networks of care (primary, secondary, tertiary) Demonstrates initiative e.g. by recognising work pressures on others, providing support and organising / allocating work to optimise effectiveness within the clinical team
		Section 2.7: continuity of care/ Interaction with colleagues	

GP training Curriculum		Clinical management	Contribute to an organisational and professional approach that facilitates continuity of care (e.g. through adequate record keeping and building long term patient relationships) Organise follow up of your patients after referral through multiprofessional, team bases and structured approaches including monitoring, reviewing and regular care planning.
		Managing complex and long term care	Demonstrate the ability to effectively 'navigate' patients with multiple problems along and between care pathways, enabling them to access appropriate team members and services in a timely and cost-effective manner.
		Working with colleagues and in teams	Enhance working relationships by demonstrating understanding, giving effective feedback and maintaining trust. Appropriately seek advice from other professionals and team members according to their roles and expertise.
		Working well in organisations and systems of care	
		Organisation, management and leadership	Show commitment to a process of continuing professional development through critical reflection

		Community orientation	and addressing of learning needs. Recognise the importance of distributed leadership within health organisations, which places responsibility on every team member and values the contribution of the whole team Describe the current structure of your local healthcare system, including various role, responsibilities and organisations within it, applying this understanding to improve the quality and safety of care you provide.
Core medical training curriculum		Managing long term conditions and promoting patient self care:	Define the role of rehabilitation services and the multi-disciplinary team to facilitate long-term care Recognise importance of multi-disciplinary assessment Contribute to effective multi-disciplinary discharge planning

Internal medicine training curriculum (Stage 1)		Cat 2.3 . Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	Communicates effectively with clinical and other professional colleagues Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations

Geriatrics and higher specialty training curriculum		30: Rehabilitation and Multidisciplinary team working 31: Planning transfers of Care including discharge	Define the role of rehabilitation services and the multi-disciplinary team to facilitate long-term care Roles and expertise of different members of interdisciplinary team Physical therapies which improve muscle strength and function Therapeutic techniques/training to improve balance and gait Aids and appliances which reduce disability. Understand the structure, roles and responsibilities of the multi-disciplinary team including the importance of outside agencies, and the way in which individual behaviours can impact on a group Role of the geriatrician and the multidisciplinary team in discharge planning