Northumberland
Frail Elderly
Pathway

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What’s special about the Frail Elderly Pathway

• Patient centered joint working across the entire health and social care system for over 26,000 older people
• Successfully involving patients, their families and key stakeholders in developing the pathway
• Improving health and wellbeing of patients through a consistent evidence based approach across the health and social care system
• Significant reductions in unnecessary admissions to hospital and residential care
• More people with very complex needs are being supported to live at home for longer
• Improving access to specialists
• Patient experience has improved significantly across health and social care
Why was action needed?

- Northumberland has:
  - Higher than average elderly population
  - 8.8% aged >75 (compared to 7.7% for England)
  - Higher than average non-elective admission rates (HSCIC)
  - Higher than average admissions for acute conditions which should not normally require hospital admission (HSCIC)
  - Community and social care staff managed by acute provider
  - Long history of collaborative working
Key elements of success

- Frail Elderly Registers
- Structured screening & assessment
- Consistency across 1st & 2nd care
- Regular monthly MDT review
- Care planning & active case management
- Social care input to practices
- Consultant geriatric input to community
- Pharmacy input to community
- Community Matrons working into nursing homes
Key elements cont.

- Cross-boundary working
  - Primary/Community/Secondary Care
  - Health/Social Care
- Multi-agency working – including mental health, ambulance services, NHS 111, OOH GP service
- Single Point of Access
- Multidisciplinary, multi-agency learning events
- Information sharing & communication
- Clinical Testing & Patient Testing
- Closing the commissioning loop
High-risk cohort identified

Initial screening visit

Recordable

Outcomes-focused

Sustainable

Integrated approach

Targeted assessment & management

Consistent

Measurable

Systems Alignment

Clinical & Patient Testing

Primary Care

Northumberland
Northumberland County Council

Northumberland Clinical Commissioning Group

Northumbria Healthcare NHS Foundation Trust

MDT Review

Secondary Care

Community Services

Systems Alignment

Recordable

Consistent

Measurable

How the Frail Elderly Pathway works
Stakeholder engagement and involvement - governance structure

Northumberland Integration & Urgent Care Board

- Financial Mechanisms
- Urgent Care Operations Group
- High Risk Patient Group
- Community Hospitals Review Group

- Clinical Testing Group
- Patient Testing Group
- Metrics & Performance

Northumberlad County Council
Northumberland Clinical Commissioning Group
Northumbria Healthcare NHS Foundation Trust
Involving patients and their families

• Involvement from Carers Northumberland during development
• Patient feedback
• Patient testing group – facilitated by local Healthwatch
Developing the evidence base

- Whole-system metrics
- Process and outcomes
- Consistency of coding and recording
- Patient satisfaction
Funding Streams

PCIS (Primary Care)

Frail Elderly Pathway

CQUIN (Secondary Care)

LINs (Community Care)
Delivering value for money

Emergency admissions and ambulatory care activity by month
(Northumberland CCG)

Number of admissions

- Emergency admissions (Apr 09 - Mar 12)
- Emergency admissions (Apr 12 - Jul 13)
- Total activity (inpatient and ambulatory care)
- Full Trend
- Apr 09 - Mar 12 trendline

Northumberland County Council
Commissioning Group
NHS Foundation Trust
Frail Elderly Pathway in action

Mr A case study

• 93 year-old male
• Lives alone in upstairs flat
• Socially isolated
• Medical history includes heart disease, stroke, arthritis and deafness
• Infrequent attender
• Added to FER December 2012 following concerns raised by daughter
• 4 x A&E attendances in previous 12 months with unexplained collapse
How we supported Mr A

• Nurse assessment:
  – Positive screening assessments for low mood, cognitive impairment & falls risk

• GP assessment:
  – Significant postural blood pressure drop
  – Confirmed diagnoses of depression and cognitive impairment
  – Dementia screening bloods showed anaemia & low vitamin B12

• MDT
  – Discussed with GPs, Community Matron, Social Worker
Actions taken:

– Meds review – blood pressure lowering medication stopped
– Commenced on antidepressant & B12 replacement
– Commenced on B12 replacement
– Referred 24-hour ECG & CT head
– Referred OA Psychiatry
– Pharmacist medication review & MUR
– STSS and subsequent longer-term care package arranged
Benefits to Mr A

- On the radar – PHCT/social care/psych
- Daily social care (& company)
- OOH GP service aware of needs & daughter’s contact details
- Alleviated daughter’s concerns
- Previously unidentified medical needs addressed
- *No further collapse, A&E attendance or hospital admission since December 2012*
Joining together…

improving care