Learnings from the HSJ Integrated Care Summit 2019
Interactive Discussion Groups

Session Theme: Prioritising prevention: Reducing demand and ensuring public health and wellbeing

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Questions Posed

A group of senior NHS executives (mostly chief executives / directors of NHS Acute Trusts, CCGs, Local Authorities and ICS leads) were presented with three questions for a 30 minute discussion:

With the advent of the NHS LTP and PCNs, what are the drivers and barriers for managing frailty?

1. How do we maximise the drivers and overcome the barriers at a local system level to achieve better outcomes in frailty?
2. There is good evidence and supporting NICE guidance to show that malnutrition is a key driver to improving outcomes in frailty. How can this be achieved? The group were given some background information on the benefits of managing clinical malnutrition – clinical, patient and health system benefits. They were asked (for the purposes of this workshop) to accept the evidence in order to address the following question:

How can this improvement be achieved?

Outcomes and Learnings

- The frailty agenda is a key area for the new integrated heath as social care system and there are a number of new drivers – Population Health management is a major priority with frailty being a very important aspect of this approach
- There is a palpable shift from the old provider / commissioner split to a more integrated whole system, proactive approach. This provides opportunities to improve outcomes for frailty.
- New initiatives will be supportive of better management - at scale working (ICS), PCNs, new primary care roles e.g. social prescribers, clinical pharmacists.
- There is a great opportunity to manage / prevent clinical malnutrition as part of the wider frailty agenda.

- In order to maximise this opportunity, there needs to be raised awareness and increase in training of people / HCPs in the new system so they are supported and able to integrate malnutrition into the routine identification and management of frailty

1. With the advent of the NHS LTP and PCNs, what are the drivers and barriers for managing frailty?

Drivers:

- Population health management (risk stratification)
- Earlier intervention
- Neighbourhood and place-based care (PCNs / CCG level) and joined up system
- 'Refreshing' of systems – ICS, PCN, GP practice / primary care at large
- Assets in the community including voluntary sector (joined up care)
- Progress so far on integrated working at provider level (an opportunity)
- The need to prevent frailty (part of previous agenda) - use technology
- New roles e.g. social prescribers, clinical pharmacists
- Will PCNs be more than GP practices?
- Vital science programme – which includes citizens
- PCN DES – proactive registry of frail patients
- Existing data is there but underutilised at the moment
- Money (funds) allocated
- Aligning with existing priorities to patients e.g. heart failure, frailty and COPD

Barriers:

- Another organisational reset - may take time to settle again
- Wrong perception that 'hospital is safe'
- Big (maybe unrealistic) expectations of PCNs, limited resource (inclduing GP capacity), expect PCNs to solve the problems. Will they be more than GP practices?
- Workforce recruitment and capacity - for HCPs and voluntary sector sector
- Workforce development and training. Also training will vary according to the need of the local population (and therefore need of HCP / voluntary sector)
- Lack of release of resource to community
- New roles
- Expectations of the population now
- Silo working - not joining up currently so will take some effort and time (drivers are there to make it happen but how quick and how well?)
- 'Confused' landscape - who is accountable for what?
- Disparity in stages of development of PCN (and pathway development for frailty)
- System not joined up from the start - when patients are admitted to hospital – how is discharge followed-up?
- Specificity for PCN from the top - how much flex is there then at local level
- Funding

- Not knowing the ‘read code’ - IT systems not joined up, and awareness is not there
- Not having access to the data or knowing what is there
- No clear diagnosis, what is exactly is frailty (accurate and consistent diagnosis)

2. How do we maximise the drivers and overcome the barriers at a local system level to achieve better outcomes in frailty?

- Workforce mix - identify skills needed, build the workforce and train appropriately
- Role of pharmacists - key role
- Identify local priorities - use the data available e.g. look at increased admissions / readmissions
- Have clear accountability (responsibility), outcomes, systems/pathways
- Enhanced care within care homes/own homes

3. There is good evidence and supporting NICE guidance to show that malnutrition is a key driver to improving outcomes in frailty. How can this be achieved?

- Not a priority up to now - however if it all becomes truly joined up (in line with the NHS LTP), this may be an opportunity
- Technology - link technology in with AHPs and providers, and then with carers / patients (e.g. Amazon Alexa)
- Education of workforce - when to be concerned regarding nutrition (malnutrition / under nutrition), but this also needs to be sustainable (and realistic with what is actually possible)
- Education of family / carers and local population
- Connecting up local priorities - link systems to alert the need for a ‘MUST’ score when an individual is classified as frail
- Wider determinants of health - link with risk of malnutrition and frailty
- Social prescribing leads to be aware of malnutrition and could they screen for risk as a first step?