Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
Blended Training / Workshop on Co-Production Approaches

22nd January 2019, Monkton Hall, Jarrow

Prevention of Frailty & Healthy Ageing Project

Background

Frailty is not an inevitable part of ageing. When present it can be associated with dramatic deteriorations in physical and mental health as a result of apparently small events such as infection, leading to complications such as falls and hospitalisation. Frailty can lead to older people becoming less physically independent and more socially isolated.

The South Tyneside Frailty Steering group have adopted the following British Geriatrics Society "Fit for Frailty" definition:

For individuals aged over 65 "frailty is a clinically recognised state of increased vulnerability. It results from ageing associated with a decline in the body's physical & psychological reserves".

There are a number of initiatives being implemented locally in Health and Social care to support individuals already living with Moderate and Severe Frailty. Preventing the ***onset*** of frailty (or supporting healthy ageing) was identified as one of the top 5 priorities at the South Tyneside stakeholder frailty event held in June 2018, but there is not yet a coordinated approach to support this.

Increased levels of physical activity are known to delay the onset and slow the progression of frailty. Supporting and promoting active lifestyles in older people was therefore agreed as an ideal co-production project to take forward from this workshop.

Objectives

To co-produce services with the local population that will:

1. **prevent or delay the onset of frailty**
   -healthy population, all ages
   -vulnerable and mildly frail groups

2. **slow the rate of progression of frailty**
   -established moderate & severely frail groups

3. **reduce loneliness and social isolation in over 65s**

Terminology

The **Rockwood Clinical Frailty Scale (CFS)** is a validated tool already being adopted locally in Health, Social and Third Sector care to confirm the presence and assess the severity of frailty. It will be useful for identifying and defining target populations for co-production and is referred to in this document. Please see *Appendix* 1 for the full scale, the relevant categories are:

-healthy (1-3), vulnerable (4), mild frailty (5), moderate frailty (6), severe frailty (7).

The **electronic Frailty Index (eFI)** is a computer based score which is calculated from existing health records (automatically generated by GP EMIS computer records). It is a validated "cumulative deficit" model useful for identifying those at risk of frailty. Because it is a calculated score it can't be used for diagnosis on its own, it requires clinical judgement & assessment of the individual (such as with the CFS). See *Appendix 2* for details of the conditions and symptoms used.

Workshop process

Facilitated one day workshop, led by Sarah Keetley (NTW Transformation lead). Those present:

Michael Campbell	Joint Strategic Integration manager, Joint Commissioning Unit
Stephen Carter	Senior Public Health Advanced Practitioner
Grahame Cassidy	CEO, Age Concern Tyneside South
James Crosbie	Integrated Training Post, South Tyneside CCG
Jo Farey	Head of Commissioning, South Tyneside CCG
Rob Holland	Safe Care lead, Intermediate Care Therapy team
Guy Nokes	Commissioning Support Officer, North of England Commissioning Support
Stephen O'Brien	Community Matron
Catherine Reay	Operations Manager, Community Services
Helen Ruffell	Operation Manager, South Tyneside CCG
Emma Taylor	Senior Communication Officer, North of England Commissioning Support

Target Populations for co-production

Importantly, this is ***not*** restricted to the frail population of South Tyneside. It should be anyone from the local population who can contribute to the co-design and co-production of the stated objectives.

During the workshop we identified the following four distinct groups and discussed potential opportunities to engage & communicate with them. Participants in each group will be asked to:

- discuss “what matters to me”
-respond to co-design questions agreed during the workshop
-consider involvement in facilitated co-production meetings / workshops.

1. **The general public: local residents living in South Tyneside**
   -Public places: GP surgeries, Leisure Centres, workplaces, shopping centres
   -Standard agreed questions plus “what matters to you”

2. **Aged 65 and over: healthy, vulnerable and mildly frail**
   -as above, plus:
   -Third sector & community groups (attend existing meetings & arrange group work)
   -consider identifying individuals using eFI or CFS from health, social & third sector records, invite to participate.

3. **Aged 65 and over: already moderately and severely frail**
   -as above, plus:
   -Community Matrons & integrated teams (Clarendon)
   -Care Homes. Ad hoc visits and planned meetings / group work, “we go to them”

4. **Carers**
   -In all of the above interactions, involve carers, including by themselves, plus:
   -identify & approach local carers group for group discussions, meetings and contacts.
   -consider separate co-production group work / meetings where carers can speak freely

Questions

Agreed questions to be included in discussions and group work, to standardise process between different groups and levels of engagement.

Moderate & severely frail group and their carers:

-Can you think of anything that would have allowed or encouraged you to be more physically active earlier in your life? What prevented you from being more active?

-Can you think of anything that would allow you to become more physically active than you are nowadays? What is stopping you from being more active?

-What would need to happen to allow you to get out more and meet people? What is stopping you?

-What was the "tipping point" from being more independent and losing your confidence or needing more help?

Healthy, vulnerable & mildly frail group and their carers:

-Can you think of anything that would allow you to become more physically active than you are nowadays? What is stopping you from being more active?

-What would need to happen to allow you to get out more and meet people? What is stopping you?

Carers:

-When did you notice the biggest change in you loved one?

-Can you think of anything that will allow / would have allowed them to remain independent and more physically active for longer?

-What would help you as a carer, to support your loved one & for your own wellbeing?

To all:

-What would a really good service look like to support people to be more physically active and less lonely as they grow older?

-"What matters to you?"

Next Steps

1. Workshop participants to discuss (by exchange of emails in the first instance) whether we believe this is a useful and deliverable co-production project.

2. It is likely different workshop attendees will be able identify patient groups that they already work closely with and engage with them alongside their existing relationship in the first instance, before developing more specific co-production processes with them.

3. Establish timescales for co-production process and implementation of outcomes, including scheduled further meeting(s) of our workshop group to check progress.

4. From the outset, agree to implement the co-production outcomes as far as possible (recognising that some aspirations will not be achievable due to financial or other restrictions)

Appendix 1:

Rockwood Clinical Frailty Scale

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Appendix 2:

Electronic Frailty Index (eFI)

Appendix: Table 1: List of 36 deficits in the eFI