Better Local Care Hampshire Multispecialty Community Partnership Vanguard

Deep Dive Evaluation Report

Eastleigh Frailty Clinic, April 2017

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1 EXECUTIVE SUMMARY

1.1 Introduction

RSM PACEC were appointed to by the Southern Health NHS Foundation Trust on behalf of the Hampshire MCP Vanguard to complete an evaluation of the NHS Vanguard Pilot to implement a new care model with GPs called a multi-specialty Community Provider (MCP), known locally as Better Local Care.

This report is one of a series of Deep Dive Evaluation Reports which aim to evaluate a selection of the projects supported under Better Local Care to explore the outputs, outcomes and impacts, the successes and challenges and importantly the learning which can be used to improve the projects in the future. This Deep Dive Evaluation report focuses on the Eastleigh Frailty Clinic.

The Frailty Clinic was established for patients in the Chandlers Ford area who require a comprehensive health assessment and co-ordination of health and social care which cannot be provided within a standard 10 minute GP appointment. It was established in September 2016 and was active for patients registered with the St Francis and Park surgeries, with planned expansion to Brownhill surgery and Fryern surgery. The assessments are conducted in the Park Surgery, Chandlers Ford.

By March 2017 8 clinics have been provided, attended by 32 patients and 30 carers. The clinics are delivered by a consultant geriatrician and two specialist nurses (one mentla health and one Advanced Nurse Practitioner). They are supported by the lead GP who provide clinical leadership, a clinical administrator and a Medicines Optimisation Pharmacist who undertakes a medicines review for each referred patient.

The overall aims of the Eastleigh Frailty clinic are to:

- Increase integration of health and social care in the local community and improve the co-ordination of earlier integrated care to support patients who are frail; and
- Translate evidence into workable solutions that produce good clinical outcomes for the patient and minimise unscheduled primary and secondary care episodes.

1.2 Policy Context and Need

There is a strong rationale for the development of the Frailty clinic. A review of local and national documents policy highlights that the development of local, community based services to support frail, older people is consistent with key policies. Furthermore, the processes that have been put in place to deliver the frailty clinic are consistent with NHS Guidance on developing integrated care pathways for older people[1] and the NHS Commissioning for Quality and Innovation Guidance (which notes that frail, elderly patients should be identified and care plans put in place)[2].

[1] NHS Five Year Forward View (2014).

[2] Safe, compassionate care for frail older people using an integrated care pathway. Practical guidance for

A review of demographic statistical data for the area also suggests that there is a high level of need to provide an intervention to support frail elderly patients. There are 128,900 (18%) people aged over 65 years in the Eastleigh area, slightly more than the national average of 17%[3]. There is a higher proportion of older people and retirees in the Park and St Francis Surgeries compared to the BLC and national populations, suggesting a higher proportion of frail patients than in other areas. Data from the GP Survey also shows that there has been a 3% increase in the proportion of patients who have reported moderate mobility issues.[4]

1.3 Impact and Outcomes

Evidence on the overall effectiveness of the programme has been reported through:

- Consultations with key staff from the clinic;
- A patient survey; and
- A review of pseudonymised patient level primary and acute care data.

Whilst the clinic has only been operational for seven months, GPs who refer into the clinic believe the introduction of the clinic has been beneficial to patients, and has reduced their workload, allowing them to focus more effectively on those patients whose health care needs can be addressed within the average 10 minute GP appointment time.

Clinical and social care staff who run the clinic noted that, because sufficient time is available to undertake comprehensive assessments, this provides the opportunity to refer patients to a full range of health and social care services. This allows them to remain as independent as possible for as long as possible.

Feedback provided by 15 patients via a telephone survey was generally very positive, all patients reported high levels of satisfaction with the care they received via the clinic, although only 20% of respondents reported that they are now using less unscheduled care because of the clinic.

1.3.1 Use of Primary and Acute Hospital Care Services

Although the clinic is still relatively new, it is important to consider if the clinic has impacted upon the need and demand for other health and social care service. A review of anonymised GP patient data for those who attended the earliest clinics (6 patients), suggests that there has been less demand for primary care services in the six months following the clinic (this includes GP appointments, home visits and appointments with the practice nurse). The impact of the clinics on unscheduled care is less clear, whilst 20% of patients who responded to the patient survey reports that they have used EDs and MIUs less since attending the clinic a review of CSU data suggests that there has no change in ED attendances and admissions over the past year amongst the clinic's patients.

commissioners and nursing, medical and allied health professional leaders. NHS England 2014.

[3] ONS population projections data (2015).

[4] GP Patient Survey (2016)

1.4 Recommendations

A number of recommendations have emerged so far, relating to the ongoing development of the frailty clinic:

- Recommendation 1: Development of a Project Manager / Administrator. Feedback from staff indicates that the clinic could be delivered more effectively. Project leads should seek additional funding to support this post.
- Recommendation 2: Development of Project Management Information Process. Whilst it is recognised that all patient information is collated via the EMIS system, a process to collate activity and outcome data specifically relating to frailty clinic patients outcomes would be a useful tool to monitor the impacts achieved by the clinic going forward.
- Recommendation 3: Rolling out the clinic to the remaining surgeries in the locality. The clinic is running every three weeks. Clinic leads should investigate the potential of expanding the clinic to allow staff from the other surgeries in the locality to refer directly. It is noted that this would also be dependent on gaining additional input administrative staff at each practice. There also needs to be sufficient staff who complete the assessments at the clinic when demand increases.
- Recommendation 4: Using the EQ-5D as part of the assessment. Staff undertaking the assessments at the clinic should have administrative support to include the use of ED-5Q as part of the assessment process, this could be repeated with the patient, six to eight weeks after the clinic as part of a general follow-up to ascertain the impact on patient general well-being.

2 INTRODUCTION AND BACKGROUND

RSM PACEC was appointed to by the Southern Health NHS Foundation Trust on behalf of the Hampshire MCP Vanguard to complete an evaluation of the NHS Vanguard Pilot to implement a new care model with GPs called a multi-specialty Community Provider (MCP), known locally as Better Local Care.

Better Local Care multispecialty community provider vanguard, will support people in taking a more active role in managing their own care and will offer access to improved care where needed. The aim of Better Local Care is:

> *To improve the health, well-being and independence of people living in our natural communities of care, making Hampshire an even greater place for all our residents to live.*

Better Local Care has four key themes:

- Improving access to care: So it's easier for people to get a same-day or urgent appointment at their GP surgery, and so people with complex health problems get more input from their GP.
- Joining up the professionals that support the same people: So doctors, nurses, social and voluntary sector workers and volunteers are part of the same extended team, making care more straightforward (especially for people with complex needs).
- Bringing specialist care nearer to you: So patients can see the professional they need, sooner: For example physiotherapists and mental health workers in local GP surgeries.
- Concentrating on prevention: to support people earlier, and help them make the right choices about their health and wellbeing, to stay independent and reduce the need to go to hospital.

The Better Local Care Vanguard is a partnership of General Practitioners (GPs), NHS providers and commissioners, Hampshire County Council, local councils of voluntary services, a number of local community, voluntary and charity organisations[5].

This report is one of a series of Deep Dive Evaluation Reports which aim to evaluate some of the projects supported under Better Local Care to explore the outputs, outcomes and impacts, the successes and challenges and importantly the learning which can be used to improve the projects in the future. This Deep Dive Evaluation report focuses on the **Eastleigh Frailty Clinic**.

2.1 Overview of Eastleigh Frailty Clinic

The Frailty Clinic was established for patients in the Chandlers Ford area who require a comprehensive health assessment and co-ordination of health and social care which cannot be provided within a standard 10 minute GP appointment. It was established in September 2016 and was active for patients registered with the St Francis and Park surgeries, with planned expansion to Brownhill surgery and Fryern surgery. The assessments are conducted in the Park Surgery, Chandlers Ford or, when space allows, at St Francis surgery

[5] http://www.southernhealth.nhs.uk/inside/better-local-care/

2.1.1 Timescales

- Project Start Date: The first clinic was held in September 2016.
- Frequency: The clinic is held once every three weeks. At the time of this reports publication there have been a total of 8 clinics (the most recent held in March 2017)
- Duration: c.1.5 hours per patient, per clinic (1 hour comprehensive general assessment, 0.5 hour community independence team assessment). A full clinic (7 patients) lasts for 4 hours.
- Clinic size: between 2 – 7 patients per clinic depending on clinician availability

2.1.2 Objectives / outcomes

The overarching objectives for the Eastleigh Frailty Clinic are to:

- Increase integration of health and social care in the local community and improve the co-ordination of earlier integrated care to support patients who are frail; and
- Translate evidence into workable solutions that produce good clinical outcomes for the patient and minimise unscheduled primary and secondary care episodes.

2.1.3 Inputs to the Clinic include

- Staff time: An estimated 32 hours per week shared across seven members of staff
- Finance: To date Better Local Care has committed £3,000 in terms of financial resources to support the set-up of and implementation of the clinic.

2.2 Methodology

Our methodology used a mixed method approach and the main strands are detailed below:

- Telephone survey with patients: our team conducted a survey of 15 patients involved in the Eastleigh Frailty Clinic
- Online staff survey: analysis of the views of Frailty staff provided as part of the overall programme staff survey.
- Analysis of quantitative primary and acute care data: including a review of relevant EMIS and CSU data.
- Consultations with key staff from the clinic: conducted through telephone surveys in semi-structured interview format
- Review of Patient and carer feedback data collated by clinic staff: Using quantitative survey (Appendix 1).

2.2.1 Limitations

RSM PACEC would like to thank the staff at Park and St. Francis Surgeries, Better Local Care, and others who have contributed to this evaluation report. There remain some limitations to the data and methodology as detailed below.

At this stage of the project and in the interest of accurate reporting it is worth identifying a few limitations to the methodology used to acquire the above data. There was difficulty accessing certain data sources and a limited sample size. Moreover, further research into certain areas of the clinics operation is recommended in future. These key limitation areas are highlighted below;

2.2.2 Sample size

8 clinics have been delivered to date and 32 patients have attended (plus 30 carers). Although the clinic has been well received by staff and patients, so far it has only been used by a relatively small number of patients therefore caution should be used if extrapolating the findings to a bigger popultaion.

2.2.3 Control group

National data was used as a benchmark for some key statistics, as a similar relevant frailty clinic was not available to use key benchmarking and compare control group responses in survey responses.

2.2.4 Other contributions

Our evaluation revealed that numerous individuals contribute to the clinic's operations on a voluntary basis for tasks such as recepitionists and transport arrangements. Further research is needed in this area to incorporate these individuals' work into the operation model of the clinic in the event of wider implementation. Furthermore, it was noted that a pharmacist also conducts a medicines review for the clinic patients, there are potentially presrciption savings that can be achieved by this process, however, it was not possible to calculate this as part of this evaluation.

2.2.5 Data availability

There was difficulty acquiring data which could inform our evaluation of the value for money of the clinic, cost per patient data and larger trends had on hospital appointments etc. Significant differences in the sample sizes for GP patient survey data between practice and locality geographic levels (locality level statistics aggregate responses across c.10 practices or c1,100 responses, compared to c.100 responses included in the individual Park and St Frances Surgery data. Trends at practice level therefore appear more volitile)

2.2.6 Timescales

At the time of the evaluation the clinic had only been operating for seven months, therefore this limits the amount of impact data that is available and also it is not possible to review any trends in the data.

2.3 Structure of the Report

The structure of the remainder of the evaluation report is as follows:

- Section 3: Context Needs and Objectives
- Section 4: Model and Activity to date
- Section 5: Outputs and Outcomes;
- Section 6: Project Costs and Value for Money;
- Section 7: Emerging conclusions

3 CONTEXT, NEED AND OBJECTIVES

This section provides a brief description of frailty, an overview of the NHS policy context relating to frailty, and an short summary of the Eastleigh Frailty clinic.

3.1 Defining Frailty

Frailty is a condition and a consequence of ageing (Clegg et al, 2013). Frailty develops because of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home.

A frail person is usually at a higher risk of a sudden deterioration in their physical and mental health. Frailty is distinct from living with one or more long-term conditions or disabilities, although there may be overlaps in their management (British Geriatric Society 2014).

Between a quarter and half of people older than 85 are estimated to be frail, with overall prevalence in people aged 75 and over approximately 9% (Collard et al, 2012). People with frailty have a substantially increased risk of falls, disability, long-term care and death. Frail older people and their carers need support to help them live independently, understand their long-term conditions, and learn to manage them.

Since frailty is a complex and fluctuating syndrome, patients will enter the pathway at different levels, or may require identification in primary care in order to access appropriate services along the pathway. However, identification of frail people and the level of frailty can be a challenge. While many experienced clinicians can instinctively recognise a frail person, there is a reported need to support identification using case-finding tools and techniques[6].

Frailty is an increasingly urgent issue facing health care service design. Older people are the main users of health and social care services; approximately 10 per cent of people aged over 65, and 25 to 50 per cent of those aged over 85, are living with frailty. Research suggests that only half of older people with frailty syndromes receive effective health care interventions[7].

The British Geriatric Society recommends: Older people should be assessed for the presence of frailty during all encounters with health and social care professionals. Gait speed, the timed-up and-go test and the PRISMA questionnaire are recommended assessments[8].

3.1.1 Frailty Clinic Definitions

The clinic identified the Rockford Frailty scale mainly as the easiest to use visual scale for frailty. In practice frailty patients were those with the triad of mobility problems, carer needs and often cognitive problems (for example memory loss). Whilst these complex healthcare problems are usually apparent to a GP they “cannot be sorted within a standard 10 or 20 minute consultation with a GP”.

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[6] https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf

[7] http://www.bgs.org.uk/fitforfrailty-2m/campaigns/fit-for-frailty2/fff2-campaign/fff2-lite-vn

[8] Fit for Frailty: Consensus best practice guidance for the care of older people living with frailty in community and outpatient settings. British Geriatric Society (2014).

Clinical staff involved in the clinical noted that they were able to identify (and refer) the highest risk patients who, crucially, had not previously had a full health and social care review. All patients seen would have been expected to deteriorate and were at high risk of admission or dying in the following 12 months. Mortality in this group was around 10%.

3.2 Policy Context

3.2.1 National Policy

The NHS Five Year Forward View[9] notes that the NHS faces challenges relating to a number of conditions including frailty and service pressures are building. It also highlights that primary care should build on the strengths of 'expert generalists' and proactively target frail elderly patients by expanding the leadership of primary care to include nurses, therapists, consultant physicians, geriatricians and community/social based professionals.

The NHS published guidance on the safe, compassionate care for frail older people using an integrated care pathway[10]: The guidance notes that frailty presents a unique challenge to care providers as it requires coordinated, person-centred care than can rather than treating a collection of diseases. To do this it is important to involve the whole health and social care economy and ensure that the right skills and services are in the right place at the right time; and that older people and their carers are involved in designing services.

NHS Commissioning for Quality and Innovation (CQUIN) Guidance for 2016/1711 notes that frail elderly patients should be identified and appropriate care plans put in place. This is further emphasised in the NHS England guidance[12] in the care for frail older people which recommends:

- Establishment of case-finding in primary care and a register of frail older people.
- Systematic screening for frailty in people over the age of 75 in primary care, at hospital admission and in the community setting.
- Comprehensive geriatric assessment using shared templates across all providers.

The Better Care Fund focusses on transforming the care of older people, reducing duplication, driving healthcare closer to home, and focusing on primary and secondary prevention as set out in the NHS England Planning Guidance 'everyone counts planning for patients 2014/15 to 2018/19. Primary care commissioners should ensure that the needs of frail older people are at the heart of their commissioning. Older frail people are most in need of medical continuity and will have significant medical requirements. Primary care commissioners should show that they understand and resource these issues, including ensuring GPs provide adequate medical support to care home residents.

[9] NHS Five Year Forward View 2014
[10] Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. NHS England 2014.
[11] https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf
[12] Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders. NHS England (2014)

3.2.2 Local Policy

The West Hampshire CCG Operating Plan[13] is focused on reducing admissions to acute hospitals and improving the quality of care, it has three key aims:

1: Close the 'health and well-being' gap

2: Close the care and quality gap

3: Close the 'funding and efficiency' gap.

One of the priorities under Aim 1 is to support vulnerable people and those with complex needs, which includes the following key performance indicator:

- Develop and implement a local 'frailty model' to identify older people who are becoming more frail and ensure a proactive programme of support tailored to individual need.

The Eastleigh Frailty intervention is directly aligned to this local key performance indicator.

3.2.3 Local issues and context

The GP Forward View notes that a growing and ageing population means that population-oriented primary care is core to the country's health system. In the West Hampshire CCG area, one in ten people over the age of 60 are income deprived.[14] The more deprived districts in West Hampshire are Andover town, central and south Eastleigh, Waterside, Winchester and New Milton in New Forest. For many older people, ageing is associated with frailty. Patients who are frail are also at a higher risk of admission to hospital, falls or need for long-term care than other patients. The CCG area is experiencing an increase in the number of people with long-term conditions and an ageing population. 1.3% of the patient population aged 55 and over are suffering from ambulatory care sensitive conditions.[15] ACS conditions are chronic conditions for which can be prevented through better case/self-management. Of the patients registered in the three practices involved in the frailty pilot, over 20% are aged 65 and older and approximately 3% are aged 85 and over. Eastleigh North & Test Valley South Locality Plan notes that the locality is experiencing an ageing demographic and expects those aged 65 and over to grow by 26.1%.[16]

The Eastleigh and Test Valley North Locality Plan noted that there was an inconsistent frailty care model across the locality (e.g. geriatrician at the front door). Priority three of the plan is to have integrated and responsive frailty care services. This includes signposting and support, introducing extended primary care teams, delayering specialist care and falls prevention.

[13] West Hampshire CCG Operating Plan 2016 -17. Year 1 of Sustainability and Transformation Plan

[14] West Hampshire CCG Strategic and Operating Plan (Revised: 2015)

[15] NHS Secondary Users Service data

[16] Eastleigh North and Test Valley South Locality Plan, West Hampshire CCG, 2016 (Public Health England data)

3.2.4 Summary of strategic fit

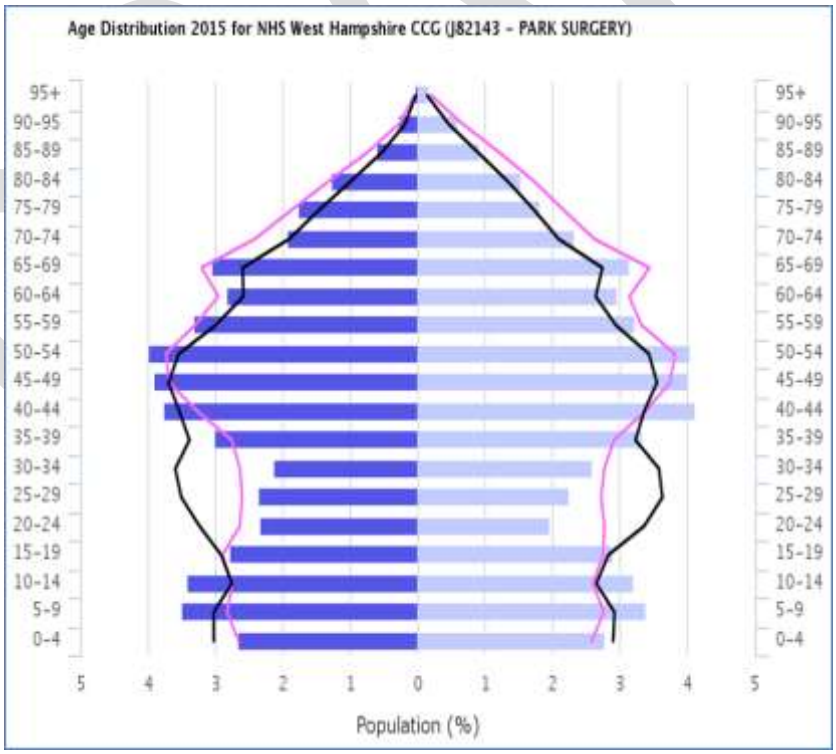
There is strong alignment between the aims and objectives of the Eastleigh Frailty intervention, and both local and national policy context, which supports the identification of frail patients and the provision of a person centred services to support them to remain independent and to stay at home as long as possible.

3.3 Evidence of Need

There are several identified drivers for the project. The following tables provide summary demographic data and GP Patient Survey data to indicate the need for the development of a frailty clinic in the area. The data offers a comparison at Better Local Care, Locality, and practice level across a variety of variables. These include an increased aging population (number of retirees); overall patient health (long-term health conditions, mobility issues); and overall service satisfaction (waiting times, time spent with GP).

There are 14,989 patients registered with the Park and St Francis Surgery, of whom 19.8% are over the age of 65, which is slightly higher than the Eastleigh locality average of 18%[17]. The locality plan[18] also notes that 2.7% of the population are over 85, this would equate to 405 patients in the surgery. The following chart (Figure 3:1) provides an overview of the age structure of registered patients.

Figure 3:1 Park and St Francis Surgery population Structure



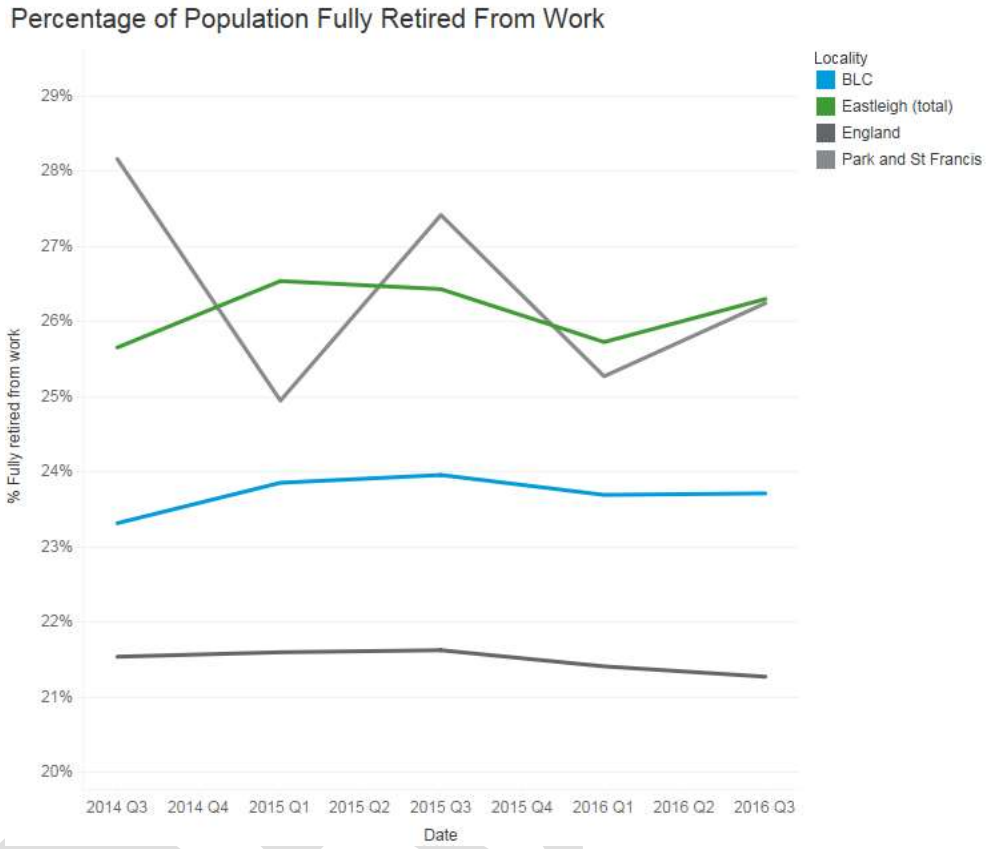
Source: Park Surgery, East Hampshire CCG population data, National General Practice Profiles

[17] GP Survey Data

[18] Eastleigh North and Test Valley South Locality Plan, West Hampshire CCG, 2016 (Public Health England data)

Figure 3:2 below shows that on average a higher proportion of the overall population are retired within the Park and St Francis Surgery compared with national and BLC averages, and are similar to the average within the wider Eastleigh locality. This suggests potentially a higher number of frailty patients within the area due to its aging population.

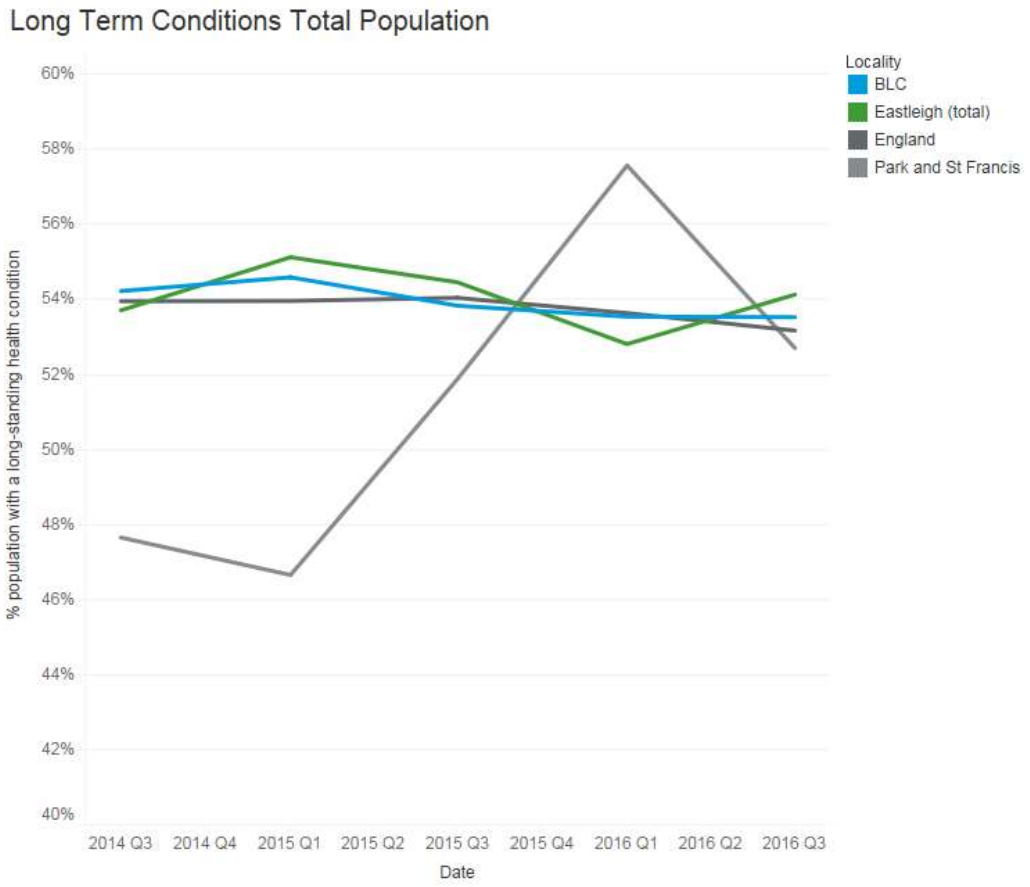
Figure 3:2 Average Populations Retired



Source: GP Patient Survey 2014-2016

Figure 3:3 overleaf shows that within Park and St Francis Surgery the overall number of patients with long-term health conditions has increased between the third quarter of 2014 (just under 48%) and the third quarter of 2016 (just under 53%). This 5% increase indicates that there are potentially increased reliance on the surgery.

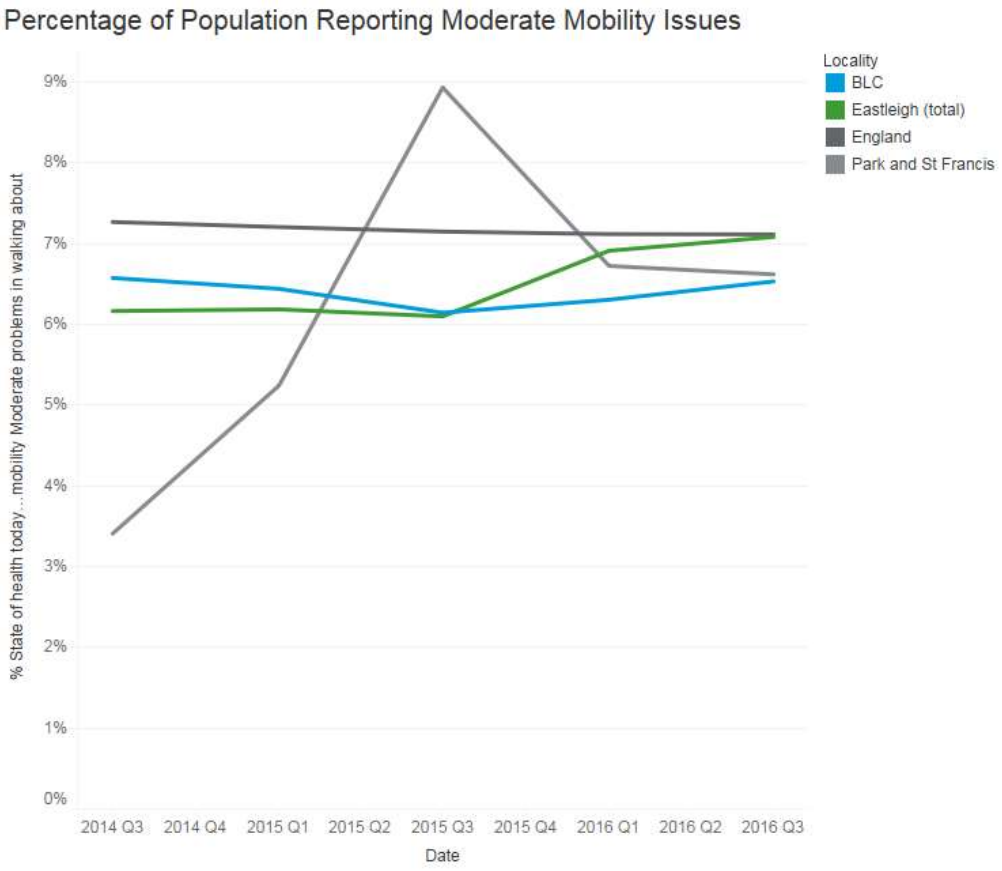
Figure 3:3 Average Populations with Long-term Health Conditions



Source: GP Patient Survey 2014-2016

Figure 3:4 shows that between Q3 2014 and Q3 2016 there has been a 3% increase in the total population reporting moderate issues with mobility. While the current figure is marginally below the English average, reports of mobility issues have increased both within the individual surgery, and the overall locality. Locality figures have increased by 1 percent between Q3 2014 - Q3 2016.

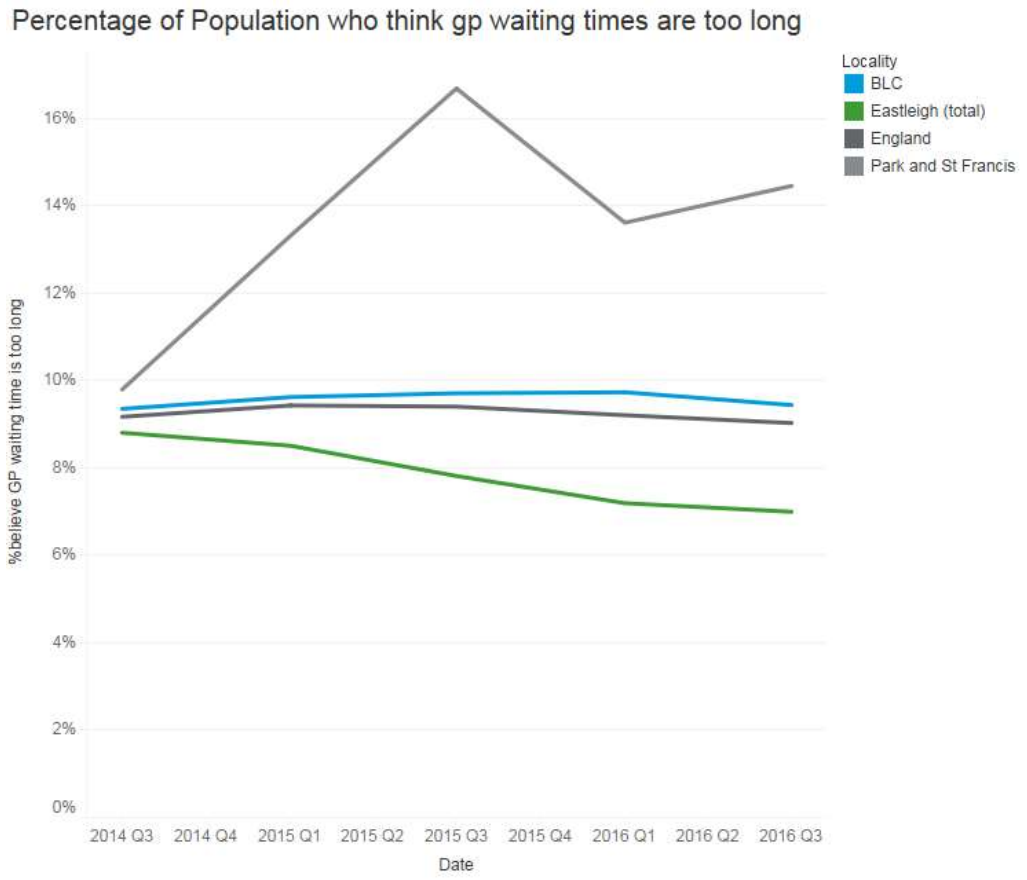
Figure 3:4 Average Populations Reporting Moderate Mobility Issues



Source: GP Patient Survey 2014-2016

Figure 3.5 indicates that just under 10% of respondents using the surgery in Q3 2014 reported that they believe waiting times are too long. This is above the English, BLC, and Eastleigh average. Furthermore, whereas national, BLC, and locality level responses have remained largely constant in the last two years practice level responses have shown over a 4% increase in participants who believe that waiting times are too long.

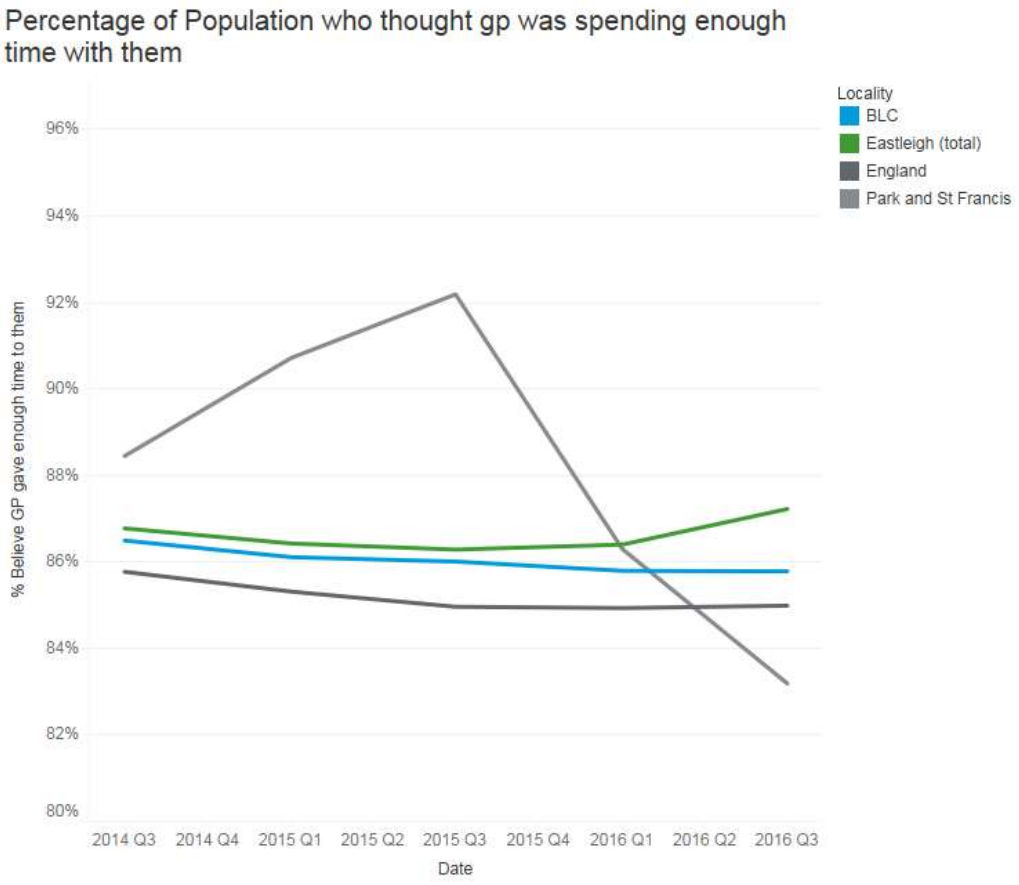
Figure 3:5 Average Populations Reporting that GP Waiting Times are too long



Source: GP Patient Survey 2014-2016

Figure 3.6 indicates that initially in the third quarter of 2014 over 88% of respondents believed that they were given enough time with their GP. This figure is above English, BLC, and Eastleigh averages. However, there has since been a marked decline, to below the national average, at just over 83%. Consultation with local health representatives has suggested that this is likely due to increased pressures on local services.

Figure 3:6 Average Populations who thought GP gave them enough time



Source: GP Patient Survey 2014-2016

The establishment of the frailty clinic is expected to help those most reliant on the GP service to establish a care plan and access the correct services in a more efficient manner. The assumption is that the clinics can save time for both the elderly using the service, as well as their general practitioners. This could potentially reduce overall pressures within the surgery, and increase patient satisfaction with waiting times.

3.4 Objectives

The overall aims of the Eastleigh Frailty clinic are to:

- Increase integration of health and social care in the local community and improve the co-ordination of earlier integrated care to support patients who are frail; and
- Translate evidence into workable solutions that produce good clinical outcomes for the patient and minimise unscheduled primary and secondary care episodes.

3.4.1 Rationale and Assumptions

The logic model that was developed by the project manager notes that the rationale and assumptions for the project are:

- Clinical and care outcomes will be improved for people with complex health and care needs, through extended multi-practitioner care teams providing integrated care at a practice and locality level.
- Health and social care professionals will be able to change working culture and practices.
- Proactive care will reduce demand on acute services.
- Patients experience will be improved by a team-based approach to the delivery of their care, and holistic assessment and joint care planning to achieve their own health related goals.
- Safety, quality and systems will be safeguarded e.g. shared care records and teams.

3.4.2 Long-term outcomes

The long-term outcomes for the frailty project are expected to be:

- Improved healthy life expectancy
- Improved patient experience and engagement in health decisions
- Shift of care from acute to community settings
- More sustainable local health and care economy
- Improved knowledge & skills of staff in management of Frailty
- Organisations & clinicians aligned to provide the best possible care

3.4.3 Key Performance Indicators

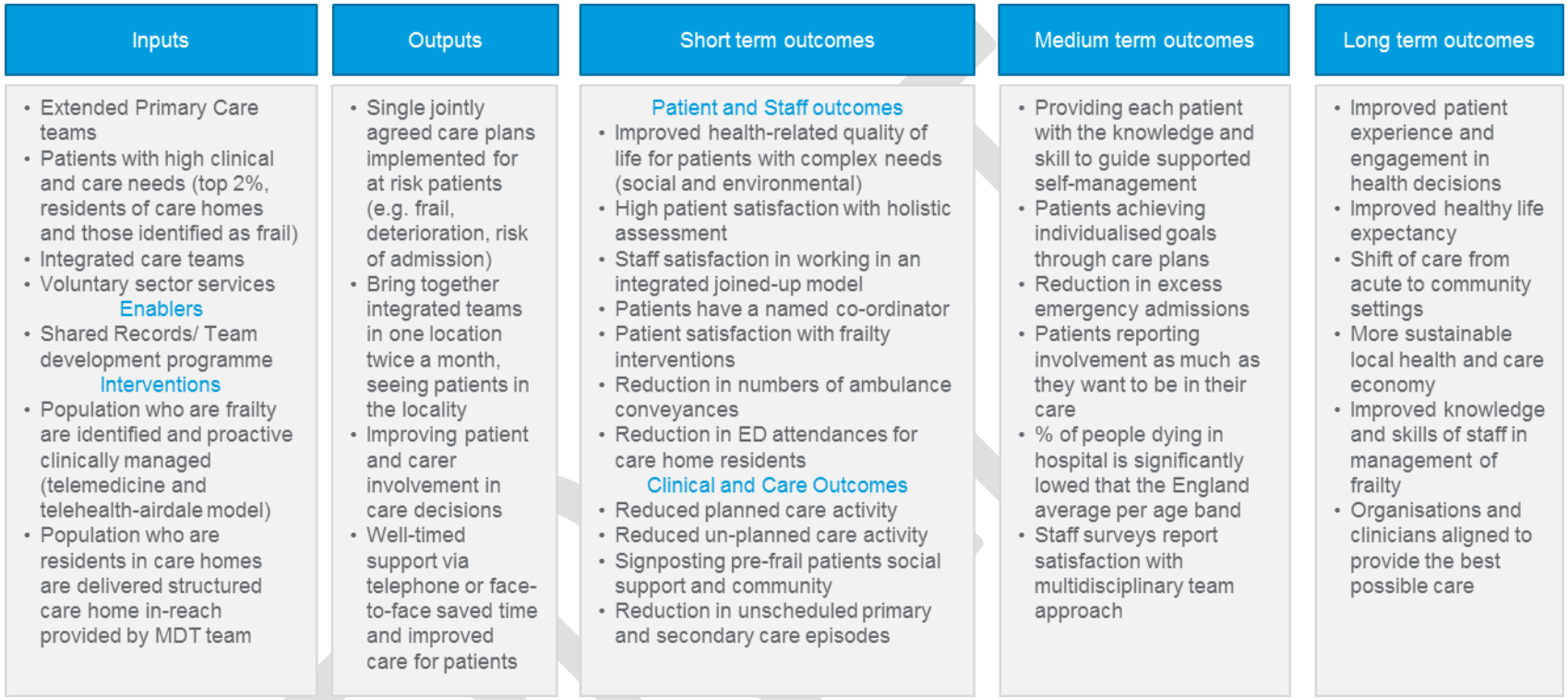
The key performance metrics identified for use in evaluating the clinic's effectiveness are:

- Impact on use of primary care services by clinic patients; and
- Impact on use of acute Hospital service (such as the Emergency Department and Minor Injuries Unit).

3.4.4 Logic Model

The logic model that was developed by the frailty clinic staff is set out in Figure 2.1 overleaf.

Figure 3.1 Frailty Clinic Logic Model



4 MODEL AND ACTIVITY TO DATE

The clinic provides a one hour comprehensive assessment of all medical and social care problems per patient, followed by a half hour social support advice session, bringing together primary, secondary and community healthcare in one clinic.

Staff involved in the development of the clinic noted that they considered a range of frailty assessments for use in the clinic, and agreed on a simple 3-point tool. The key areas covered during the assessment are:

- Mobility
- Carer Needs
- With or Without Memory Problems.

This frailty clinic is currently at a proof of concept stage running at low cost, and supported by good will from staff in the GP Practice, the local hospital and the council social care staff. By the end of March 2017, 8 clinics had been provided – approximately one clinic every three weeks

The clinic is delivered by a consultant Geriatrician, two specialist nurses and a member of staff from the local Community Independence team, who are also supported by a part-time clinical administrator, the Practice Manager and a GP who established the clinic and provides clinical guidance. The following table summarises the staff input to date.

Table 4.1 Frailty Clinic delivery staff

Staff	Grade	Approximate time provided (per month)
Consultant Geriatrician	Consultant	4 hours
Specialist Nurse (x2)	Band 6	4 hours
Community Independence Team Manager	TBC	4 hours
Clinical Administrator	Band 4	15 hours
Medicines Optimisation Pharmacist	Band 8b	3 hours
GP co-ordinator / oversight	GP	2 hours
Total Staff Input		32 hours

Source: Clinic background documentation and internal consultations

4.1.1 Other contributions

In addition to the frailty clinic staff noted above, receptionist staff and the Practice Manager of St Frances Clinic also provide ad hoc support to the frailty clinic e.g. by ensuring that all GPs have the appropriate referral forms, ensuring patients have copies of any necessary paperwork to bring the

clinic, arranging patient transport where required and contacting the Community Transformation Team.

The Transformation Team (detailed in section 4.3) provide support prior to the clinic with bloods tests and form completion. In addition, a transformation team pharmacist has also provided IT support and pharmacy advice to the consultant geriatrician in the past. The medication reviews conducted by the Medicines Optimisation Pharmacist (detailed in section 4.2) are also undertaken with prior to the clinic on a voluntary basis. On occasion organisations such as carers have come together to support patient education and help individuals progress through the clinic.

4.1.2 Screening and referral

This frailty clinic is referred to as a wellbeing clinic when discussed with patients. Representation by patient groups at the planning meetings fed back that wellbeing was better accepted than frailty by patients. Frailty is a term used and understood by clinicians and is more specific than wellbeing in clinical discussion.

The aim is to reduce the number of healthcare crises for patients, and reduce the pressure on general practice. The clinical lead for the clinic noted that:

- Patients should meet criteria for frailty, at any age, and be likely to benefit from an integrated care holistic approach.
- Frailty is usually a combination of mobility problems, a requirement for care support and, often, memory problems. Referrers are asked to indicate the key healthcare problem that is being presented on the referral form.
- This clinic focused on patients who are facing self-care and social problems who are at risk of admission, but can manage in the community for at least a week.
- Patients should be able to get to the surgery with ambulance transport. Fully bedbound patients should be referred for domiciliary assessment by the transformation team. Transport arrangements are the same as for any separate NHS clinic.
- This clinic is not for acutely ill patients who would usually be referred for admission or to the Rapid Assessment Unit.

Patients may be identified by anyone involved in healthcare within the surgery although referrals then come in via the patient's usual GP.

4.2 Medicine Review

Before patients attend the clinic, a Medicines Optimisation Pharmacist conducts a review of the patient's medical history. This takes roughly an hour per patient. This service is currently carried out on in an ad hoc voluntary manner by a locally qualified professional employed by the West Hampshire CCG.

The Pharmacist is notified by clinic administrators about patients who have an appointment to attend a clinic, and in advance conducts a detailed medication review (via the patient records on EMIS). This is to identify possibly outdated prescriptions, prescription omissions, dosage levels or drug interactions as many patients in have accumulated a large number of medications from different specialists over the year. This frailty clinic provides an opportunity to carry out a more in-depth review. The pharmacist then summarises the list of drugs onto a clinical consultation with bullet points of key details for the clinician to discuss with the patient or review.

4.3 Transformation Team

Receptionist staff and the Practice Manager at the St Frances surgery also assist with the coordination of home visits by the Transformation Team which take place before patients attend a clinic. The transformation team must be told at least 7 days before a clinic is arranged to take place so that they can attend to patients in a home visit. During these home visits the transformation team provide support to the clinic by taking blood tests, completing forms and providing patients with paperwork which they may need to bring to the clinic. In addition, a transformation team pharmacist also provides occasional IT support and pharmacy advice to the consultant geriatrician.

4.4 Assessment methods

A range of tools were used to assess patient frailty level. These include:

- Rockwood Scale: a clear visual scale with a short description of stages of frailty from 1 to 9. Benefits of this scale included the ability to identify which patients were housebound, and which would be able to attend the clinic.
- EMIS Electronic Frailty Index: this allowed for the identification of a wider population whose needs had been previously assessed and had assorted health and social care needs. This was identified as a future potential indicator, but not necessary for the current clinic.
- Comprehensive Geriatric Assessment: The Comprehensive Assessment model applied was flexible to suit the approach of the clinician and the problems presented by the patient. The core components were to identify all existing problems and patient concerns; to address each of these and generate an action plan for each with appropriate history and physical examination.

Staff from the clinic noted:

"It's about pre-empting problems. It's one step down from the Rapid Assessment Unit – which is more serious and often hospital based. Getting systems in place to prevent ongoing hospital interventions."

Patient's were originally identified using an EMIS compatible search application. The number of clinics to be provided each month was based on the size and population demographics. In the development of the project clinical staff estimated that between four and seven assessment slots would be required every three weeks to meet the demand, based on the 15,000 patients within the practice. To date the clinics have been able to meet the required demand.

4.5 Transport

Clinic staff noted that transport difficulties for frailer patients' need to be factored into the clinic logistics, and has required a greater investment of time by co-ordinating staff than originally anticipated. While most patients are brought to the clinic by friends or family, several patients are housebound and need special transport arranged to ensure they can attend. GP practice administration staff can arrange transport through the hospital visitation system is made aware in advance of any need to arrange transport are for patient and will help to coordinate this as necessary.

There was originally some difficulty coordinating transportation for patients due to its address being registered to a surgery. This caused some confusion about its eligibility for 'hospital clinic transportation' which required the clinic to prove its suitability criteria. The surgery has now been approved by the hospital booking transport system. To date, an estimated five patients have had their transport arranged for them in this manner.

4.6 Operation timeline

The project was established as a proof of concept and the first clinic was held in September 2016. The following table summarises the clinics held to date and the number of patients assessed.

Table 4.2 Clinics held to date

Dates	No. of clinics	Total number of patients assessed	Total number of carers supported
Sept 2016	1	4	3
Nov 2016	2	10	10
Dec 2016	1	4	4
Jan 2017	1	2	2
Feb 2017	1	5	5
March 2017	2	7	6
Total	**8**	**32**	**30**

4.7 Scope

As summarised above, to date 32 patients have been assessed since September 2016 with support for 30 carers many of whom were also patients at the surgery, 62 people in total.

All of the nine GPs in the practice are now actively referring to the clinic. Two GPs from the other local surgeries have also actively referred now as the process is shared across practices.

Feedback from staff involved have suggested that the outcomes achieved to date, include:

- Reduced visits and risk of admission (to an acute hospital);
- Earlier problem identification and referral e.g. prostate Cancer; and
- Patients and clinicians valued the time allowed.

4.8 Successes, Challenges and Learning

4.8.1 Lead GP patient reviews

The lead GP for the clinic collated brief summaries of the outcomes achieved as well as providing feedback from staff on the impact on staff time and resources. These highlight that, following the assessment at the clinic, most patients were referred for social care, Occupational Therapy or tele-care (sometimes all three). The following extracts from referring GPs, provide an illustration of some of the outcomes that can be achieved as a result of services that were provided through the clinic:

- Social care package put in place as a result of the clinic: *"Significant impact here – patient seen by GP prior and was unwell with severe concerns. Patient was seen 4 months later by GP - was well and independent living with memory issues. All team very delighted."*
- Tele-care and other social care packages put in place as a result of the clinic: *"Reduced frequency of attendance at GP surgery after frailty clinic. Partner better supported."*
- OT and social care packages put in place: *"Reduced frequency of attendance at GP surgery after frailty clinic. Appointments easier. Partner supported more and spouse attended GP for the first time in several years."*

Source: Anonymised Evaluation of Frailty/ Wellbeing clinics

Both the staff delivering the clinics and staff in the GP practice noted that, one of the advantages of integrated working that has helped the clinic work more smoothly has been the fact that the clinic is delivered in a community setting, in the same locality as referring GPs, nurses and OTs and Physios. The close proximity has allowed professional staff to share patient care plans more easily and to address any queries more quickly that would have been the case otherwise.

Staff from the clinic noted that one of the major challenges has been developing the service within the context of decreasing resources in both health and social care. Social care budgets are particularly stretched and whilst social care staff have been fully engaged with the project there is a concern that the budgetary pressures will make it more difficult to offer patients a full range of health and social care services.

4.8.2 Sustainability

The current project is run with very few additional resources and has relied on good will and additional input from key staff such are already employed by the Trust or the Council. Therefore, in this respect the clinic was developed as a re-configuration of services rather an additional service or a bolt-on. To date the clinic has been operating on a small scale with limited administrative support.

Clinics staff noted that to make the clinic sustainable in the long term and to continue to maximise opportunities for continued integrated working, a dedicated administrator / project manager would be required in a part time role. Particularly as the service is further expanded to support patients from other surgeries within the locality.

5 OUTPUTS AND OUTCOMES

This section of the report summarises the key findings from:

- Telephone survey carried out by RSM PACEC staff with 15 clinic patients;
- Patient and carer feedback collated by clinic staff;
- Quantitative Primary and Acute Care data; and
- Interviews with clinic staff / key stakeholders.

5.1 Patient survey

All twenty five patients who completed assessments at the clinic completed forms providing their consent to share information, nineteen consent forms were available to the evaluation team. Members of the evaluation team contacted all 19 patients, 15 of whom agreed to complete a brief telephone survey relating to their level of satisfaction with the clinic, followed by the EQ-5D[19] to provide an indication of how patients rate their health and well-being (Appendix 1). The following paragraphs summarise the key findings from the survey, the raw data is set out in Appendix 2.

As shown in the following table all respondents were aged 75 or over and two thirds of the surveys (67%) were completed by carers on behalf of the patient.

Table 5.1 Age Group of Patient Survey Respondents

Age Group	Percent	Total
75-84 years old	53%	8
85+ years old	47%	7

Source RSM PACEC: Frailty Clinic Patient Survey - Q2: What is your age group (tick one)?

As set out below one third of respondents reported that they had a care plan developed as a result of their attendance at the clinic.

[19] EQ-5D is a standardised measure of health status developed by the EuroQol Group in order to provide a simple, generic measure of health for clinical and economic appraisal. EuroQol Group. EuroQol-a new facility for the measurement of health-related quality of life. Health Policy 1990;16:199-208

Table 5.2 Did you have a care plan developed as a result of attending the clinic?

	Percent	Total
Yes	33%	5
No	33%	5
Don't recall	33%	5
Total		**15**

Source RSM PACEC: Frailty Clinic Patient Survey Q6

Of the five respondents who had a care plan, four of them reported that they had the opportunity to discuss and contribute to their care plan.

The majority of patients interviewed (60%, n=12) reported that they had accessed additional health and social services as a result of attending the clinic. Of these, nine respondents could provide details of the services they received. The following table sets out the additional services accessed as reported by patients and carers.

Table 5.3: Additional services have you been referred to / accessed?

Services Received	Percent	Total
Personal care services	44%	4
Respite care	11%	1
Tele-care / tele-services	0.0%	0
Occupational therapy	56%	5
Other, please specify:	67%	6
Total Patients receiving additional care service as a result of the clinic		**9**

Source RSM PACEC: Frailty Clinic Patient Survey Q10b

As shown above the most frequent service was occupational therapy, one patient noted that they had an access ramp installed after being referred to the occupational therapy service. Other services included a home visit from a consultant, a home visit from a representative from Attendance Allowance, referral to the Princess Royal's Trust and referral for an MRI scan.

One carer commented:

"My husband felt depressed so we were referred to a depression clinic to see a psychiatrist. As a result he has gone from being severely depressed to moderately depressed".

Respondents were also asked to what extent they agreed with a series of statements relating to the impact that the clinic may have had on them, and the extent to which it affected their use of health services. Responses are set out in the following table, green highlighted text indicates positive

findings of note, amber text denotes statements for which there is scope for improvement in results. Please note the small number of respondents (n=15, c.50% of patients that had attended clinics at the time of writing).

Table 5.4: Please rate the extent to which you agree or disagree with each of the following statements.

Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	N/a	Response Total
The clinic lead to a change in my care	0%	57%	14%	14%	0%	14%	14
I feel more able to self-manage my health and well-being because of my appointment at the clinic	0%	43%	36%	21%	0%	0%	14
The well-being clinic enabled me to access additional care and support services	27%	40%	13%	13%	0%	7%	15
The well-being clinic has supported me to live independently at home	0%	20%	47%	20%	0%	13%	15
The staff were knowledgeable and understanding about my healthcare needs	33%	40%	13%	0%	0%	13%	15
I feel satisfied with the service I received from the well-being clinic	33%	47%	7%	7%	0%	7%	15
I feel that all the healthcare professionals in the project operated as a real team	47%	40%	13%	0%	0%	0%	15
The support I received from the clinic changed my life	0%	40%	20%	27%	13%	0%	15
I wouldn't have got the level of support I received at from the well-being clinic in a ten minute GP appointment	13%	53%	27%	0%	0%	7%	15
Since attending the clinic, I have not called 111 or used GP out of hours services so much	0%	20%	53%	13%	0%	13%	15

Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	N/a	Response Total
Since attending the clinic, I have not needed to attend A&E so much	0%	20%	53%	13%	0%	13%	15
Since attending the clinic, I have not required as many GP appointments.	0%	0%	73%	13%	0%	13%	15
The well-being clinic is a valuable addition to the NHS	53%	40%	7%	0%	0%	0%	15
I was satisfied with the way my health condition was handled	33%	53%	13%	0%	0%	0%	15
I feel happier in my life now	13%	53%	27%	0%	0%	7%	15

Source RSM PACEC: Frailty Clinic Patient Survey- Q11

As set out in the table above, there were generally high levels of satisfaction with the clinic (for example 86% of patients agreed or, strongly agreed that they were satisfied with the way in which their health condition was handled). 67% of patients agreed or strongly agreed that clinic enabled them to access additional care and support services.

Patients were also asked to provide further comments about the clinic and one carer noted:

"Everyone very helpful and I feel that everything is now coming together. Husband walks better because of physio and is less depressed because of help from Psychiatrist. We've been very lucky attending this clinic."

Patients were also asked to consider if the clinic had impacted upon their use of other health and social care services, only 20% of respondents agreed that since attending the clinic they have not needed to attend A&E or use Out of Hours services as much. The vast majority of respondents were unable to state definitively that they had accessed their GP less frequently following the clinic. This is not surprising given the fact that the patient cohort exhibits high levels of long term conditions, and multiple co-morbidity.

5.1.1 Self-Reported health and well-being (post clinic)

Patients were also asked to rate their current state of health and well-being across five dimensions using the EQ-5D. This was therefore between 1 and 5 months after the clinic assessment had taken place.

Clinic staff noted that the EQ-5D was expected to be provided to each patient prior to the clinic but the clinic had insufficient administrative resources to achieve this for all patients. The following paragraphs summarises the findings from these responses after the clinic.

Using the EQ – 5D a score of five indicates that a person has no reported health problems, a maximum score of 25 indicates severe health problems across all five dimensions. One respondent declined to complete the EQ-5D, and one respondent declined to complete the final element of the form which asks respondents to rate their well-being on a scale from 0-100 (the EQ VAS). Therefore, complete EQ-5D scores are available for 13 respondents in total.

The table below provides an overview of the EQ-5D scores by age and gender of respondent.

Table 5.5 Summary of EQ-5D scores

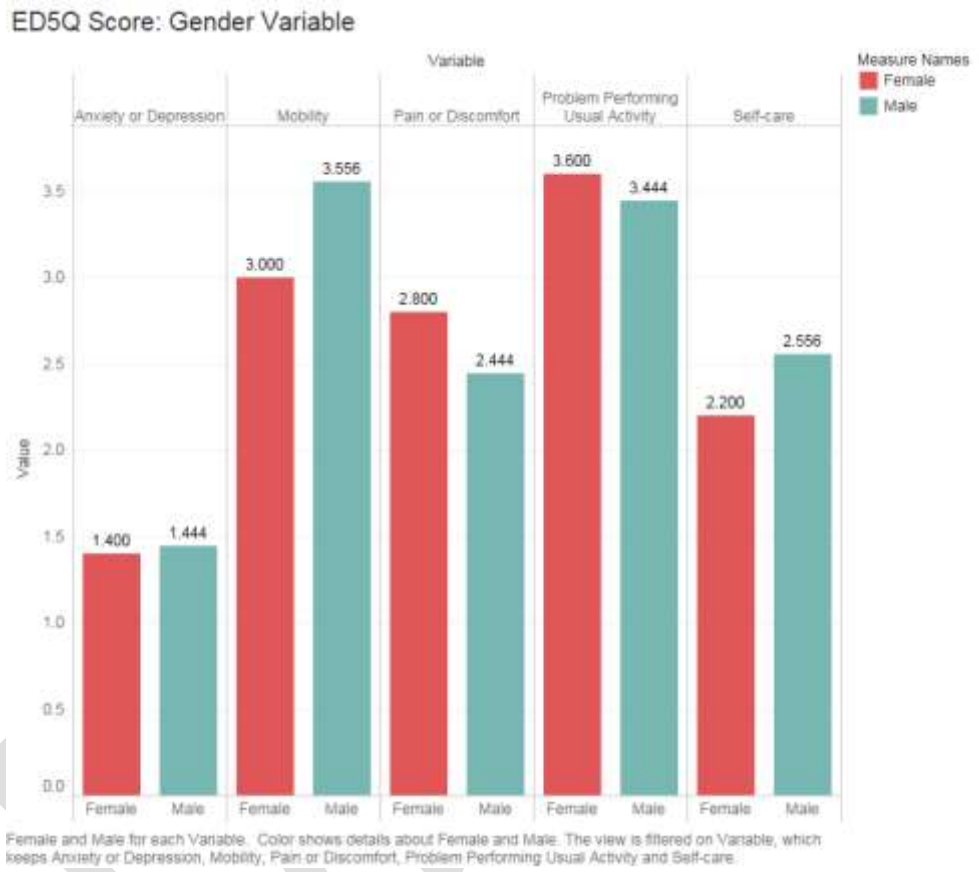
Respondent	Gender	Age Group	ED-5D score	EQ-5D %	Self-Reported Health rating (0-100): EQ - VAS
1	Male	75-84 years old	15	44.9	70
2	Male	75-84 years old	15	44.9	70
3	Male	85+ years old	9	73.5	80
4	Female	75-84 years old	10	69.8	60
5	Male	85+ years old	20	-16.1	20
6	Male	85+ years old	8	82.6	60
7	Female	75-84 years old	14	27.7	25
8	Female	85+ years old	9	64.8	xx
9	Male	75-84 years old	13	50.4	50
10	Male	85+ years old	11	66.4	70
11	Male	85+ years old	xxx		xxx
12	Male	75-84 years old	10	69.8	70
13	Female	75-84 years old	15	30.2	60
14	Female	75-84 years old	17	10.1	50
15	Male	85+ years old	20	-20	20

Source: RSM PACEC. Frailty Clinic patient survey: EQ – 5D scores

The average rating of the EQ-5D across the 14 patients who completed it was 42%, this compares to a study of the general UK population[20] that found an average score of 57%.

A review of the scores set out in the above table does not highlight any significant differences in the scores between males and females or different age groups. The average rating for females was 40% and the 44% for males. The average scores for males and females against each one of the five dimensions is set out in the following chart.

Figure 5.1 Gendered summary of EQ-5D scores



Source: RSM PACEC. Frailty Clinic patient survey: EQ – 5D scores

As shown above both males and females were more likely to report difficulties with mobility and problems performing usual activities that the other dimension with males reporting slightly more difficulty with mobility than females; and females slightly more difficulties in performing usual activities than males.

The final element of the EQ-5D also asks respondents to rate their health and well-being on a scale of 0-100 (with 0 being the worst health you could imagine and 100 being the best). On average males rated their overall health slightly better, at 56% compared to 49%.

[20] https://www.healthcareconferencesuk.co.uk/userfiles/Andrew_Bateman.pdf

Gender	average VAS	range
M	56	20 - 80
F	49	25-60

Source: RSM PACEC. Frailty Clinic patient survey: EQ – 5D scores (n=14)

5.1.2 Records of actions taken

Full records of social care actions and reported impact on care by staff were retrieved.

Healthcare interventions took place with all patients. These varied from a change in medication, to a new diagnosis or dementia to investigations such as CT scans. Interventions took place earlier and because the whole team were represented interventions such as prescribing took place the same day with help from the cover GP or cover consultant psychiatrist.

5.1.3 Patient Interviews

RSM PACEC staff conducted interview with five patients who had attended the wellbeing clinic. Feedback was mixed, with some feeling they strongly benefited from the clinic but others feeling it wasn't relevant to their needs.

"It was so open and we had the doctor for 40 minutes listening to anything we had to say…and then we went around and saw several people."

"They asked me what I wanted, what was my aim for this year. I said I wanted to get my back pain sorted and to walk better…they said they can't do any of that. So what's the point of going? Somebody else with different problems to me probably found it wonderful."

While attempts were made to stratify the practice population as a basis for targeting clinic attendees, this feedback suggests scope to improve accuracy in patient identification.

5.1.4 Carer interviews with psychology lead

A further six carers had more in depth qualitative interviews asking about their experience at the clinic. Below are summaries of comment made by carers, both positive points and feedback for improvement.

Positive Carer Feedback	
	I felt like my voice [as the carer] was heard We learned a lot from attending – we found out were eligible for attendance allowance and realised that we already had a care plan with health professionals that we were previously unware of It was great to speak to the social worker and learn about the benefits and organisations available It was useful to have so much time with the consultant. He as able to recommend some

new medication for my wife to help with her symptoms We were able to get a referral to physio therapy after discussion with professionals at the clinic I really valued meeting with a pharmacist and asking about the side effects of medications that my husband takes

Source: Evaluation of Wellbeing Clinic: The Carer perspective (interview transcript)

Other Carer Feedback
Because we met with people separately, we found that there was some repetition. I don't think the professionals talked to each other between meetings about what had already been covered No actual plans or action points came out of the meeting. It would be nice to have some things followed up more The clinic felt slightly disjointed at times…it felt a bit like musical chairs, which my wife found quite disorientating We didn't come away with any sort of care-plan (except physio referral), which I think would have been helpful Our GP didn't know much about the clinic so he couldn't really tell us It might have been useful to have a mental health professional there. My husband suffers a lot with depression now. I don't think this was taken into account on the day I was never really asked about how I was coping as a carer…it would be nice to have a space to talk about this more

Source: Evaluation of Wellbeing Clinic: The Carer perspective (interview transcript)

5.1.5 Routine feedback data

Prior to the involvement in the wider Better Local Care evaluation the lead GP had developed evaluation forms capture feedback from patients and carers. These forms were issued by clinic staff to staff, patients and carers and 15 were returned. The responses spanned a number of clinics and certain feedback notes improvements over time. The key questions asked were:

a) What went well at the clinic
b) Areas that could be improved; and
c) Things learnt today after the clinic.

The feedback sheet also asked for a score to be given for the clinic out of ten. These all reported high levels of satisfaction (ranging from 8 to 10). The following summarises the feedback from patients, carers and staff.

Q1. What went well [at the clinic]?	
Patients/ Carers	Good team work Presence of pharmacist great help in medication RIV and identifying problems and solutions of administering meds It felt good talking, expressing my feelings Positive to see both health and social care at one meeting and learn of the help and support available
Staff	All went on time Good patient flow Having pre-assessment info & CIT checklist done Med review beforehand Bloods taken by Transformation team Patients who had been seen for pre-assessments had filled in forms which helped to steer discussions Quality time spent in discussion with patients and careers Quick referral to services including Older Persons Mental Health unit without needing GP time

Source: Q1 - Wellbeing clinic evaluation feedback forms

Q2. Areas that could be improved	
Patients/ Carers	A coach which patients can get on Communication over transport, when it is coming or going back More high chairs in the waiting room
Staff	Navigation of EMIS Move CIT input so patients didn't have to wait after their initial appointment time Holes in the process /pathway of patient journey Smoothness of using 2 systems (RiO/ EMIS) and emails

	Access to system prior to clinic and updating of records was difficult due to time
	Being able to view blood results for patience from other practice
	Patients not sure who they are seeing next
	Implement arrival system to screen patients arrival to clinician
	Provide contact number for patients in case there are problems attending on time

Source: Q 2 - Wellbeing clinic evaluation feedback forms

Q3. Things I have learnt today after the clinic	
Patients/ Carers	Social services can provide call prompts to take meds
	Liked to know about information about support team
Staff	Preparation before the clinic is essential
	Refer to CIT even if there appears to be no social need
	Benefit of utilising a GP immediately
	No time to do EMIS documentation and RiO Well Being Plan
	Emis patient records to allow me to build picture of client before appointment

Source: Q3- Wellbeing clinic evaluation feedback forms

5.2 Staff Feedback

Whilst a BLC programme wide staff survey was issued to all staff involved in Vanguard funded projects none of the staff who have been involved in the Eastleigh Frailty clinic completed the survey. The following paragraphs provide an overview of the key themes that have emerged from four interviews with clinic staff and feedback collated by the clinical lead for the project.

5.2.1 Impacts on Staff

All of those who provided feedback, either directly to the evaluation team or, via the clinic lead reported positive impacts of the progamme to date:

GP feedback
Benefits for Clinicians: *For the GP there is clear benefit as the clinic reduced visits and consultations; it took away the pressure of sorting the patient in a short consultation; reduced the burden of trying to co-ordinate care in time outside normal surgeries; it ensured the patient was safe; and reduced time spent chasing appointments.* *For those providing care in the clinic it allowed rapid access to colleagues for opinions, same day treatments and same day referrals. There was the satisfaction of knowing both health and social care was being addressed in a co-ordinated manner on a same day basis. For the administrators there was a contribution to a continuity and co-ordination of an otherwise slower and fragmented service. This was offset against additional time required.*

Source: Clinic staff feedback.

5.2.2 Patient impacts

The table below highlight the identified patient benefits from feedback gathered by staff of the frailty clinic:

GP feedback
Benefits for Patients *There is an identified benefit for patients as they had an hour general assessment and a half hour social assessment instead of a ten minute GP appointment. The service increased awareness and reduced delays in access to other services. The risk to patients is over investigation, but in this group the prevalence of disease is high so investigation is usually appropriate.* *For the carers and relatives it is a significant time period in which to understand the needs of their relative and the options for social care support. For this group benefit was reported as high.*

Source: Clinic staff feedback.

5.3 Primary and Acute Care data

As the first clinic did not start until September 2016 a full year's data on health and social care usage is not yet available. However, it was considered important to give an indicative overview of the impact that the frailty clinic has had on health care services for patients.

5.3.1 Primary Care data

Anonymised data was extracted from the Surgery's patient data system (EMIS) for the clinics first six patients. This data focused on the use of primary care service before and after attendance at the clinic. It showed that that these six patients used primary care service (GP surgery appointments, Practice Nurse appointments and Home Visits) 35 times in the six months prior to their attendance at the frailty clinic and 25 times after their assessment at the frailty clinic.

Table 5.6 Example of Patient Primary Care Service use pre and post clinic

	Pre - Clinic			Post - Clinic		
Patient	GP	Home Visit	Nurse	GP	Home Visit	Nurse
A	3	2			3	2
B	11		4	6		3
E	7	1			1	1
F	2	1		2	1	
G	2			3	1	
I	2			2		
Total	27	4	4	13	6	6

As summarised above, overall there was a reduction in the primary care appointments and home visits, given that the approximate cost of providing a GP appointment is £33 per 9 – 10 minute appointment[21] this can generate savings costs to the practice. Based on these six patients there is an estimated efficiency saving of £170 for six months. If this data was extrapolated to all patients over a year it demonstrates the potential efficiencies that can be achieved.

5.3.2 Acute Care data

Staff at the clinic submitted an information request to the Commissioning Support Unit (CSU) for pseudo –anonymised data on Emergency Department (ED) attendances and admissions and the use of Minor injury Units (MIUs) by frailty clinic patients. This data was provided for 2015/16 and 2016/17 at an aggregate level (i.e. for all clinic patients), therefore it was not possible to identify any changes in the level of use of ED and MIU at an individual patient level. The data indicates that there was no change in the level of use of ED by clinic patients or, in the the number of hospital admissions. No patients had accessed MIUs whilst this data suggets that the clinic had no impact on the level of use of acute care services. However, as noted above given that a full year's post clinic data is not yet available it is possible that this will not accurately refelct the impact of the clinics. Further data will be collected when more clinics have been delivered.

[21] PSSRU. Unit Costs of Health and Social Care 2016

6 PROJECT COSTS AND VALUE FOR MONEY

6.1 Introduction

This section provides an overview of the value for money provided by the Frailty Clinic by considering the total cost to run the clinic. This includes BLC funding, support provided in-kind by staff at the surgery and other Southern Health Trust staff plus any savings that have been accrued to the wider health economy through a reduction in the use of other health services in the acute and primary care sectors. This assessment has been based on:

- Patient data as extracted from the EMIS system;
- Acute hospital services data (provided by the CSU); and
- Southern Trust financial data.

6.2 Budget and spend

To date the Frailty Clinic has received £3,000 from BLC to support the set-up of the clinic. No specific budgetary breakdown to deliver the clinic has been developed, at this stage. The following table sets out financial data relating to the cost to the deliver the project as provided by staff from the Surgery.

6.2.1 Project Costs

The table below highlights the overall cost of the frailty clinic as identified through consultation:

Table 6:1 Frailty Clinic costs

Cost element	Value
Administrative Cost per Frailty clinic	£150 (£15 per hour, assumed 10 hours)
Health and Social Care Staff	Not net cost as service reconfiguration We have requested total staff FTE to cost this although we note staff time is not funded through BLC
Estimated future staff consultation cost per patient per clinic	£117-£157

Source Frailty Clinic staff

Consultation with the staff running the clinic indicated that each individual clinic costs the NHS £150 (£15 an hour for 10 hours) in administration. As the clinical staff and the social care/community staff are already employed prior to the clinic there is no additional net cost. Therefore the estimated cost to run the Frailty Clinic from September 2016 to March 2017, thirty-two patients, was £1,200.

It is suggested that each prevented admission saves the NHS a minimum of £2,197[22], but this saving is likely to be higher for complex frail older patients with social care needs.

Feedback from those involved in the clinic reveal that the service is more efficient and integrated than their usual service provision and in this setting preventing one admission per fifty eight patients seen would make the clinic cost effective.

Staff time was provided to the project in-kind, therefore the clinic effectively operated as a service reconfiguration. Estimates of staff time and clinic costs if additionally funded are between £117 and £157 per patient dependent on level of need. Funding an additional service on top of existing services for twenty five patients would be an additional cost of up to £3,925. A total service cost of £4,875.

As an additional service, by preventing one admission per eleven patients the clinic would be cost effective. Observations by the clinicians attending suggest this level of admission prevention has been exceeded. There are also extra cost savings if there is reduced service demand and more efficient provision of care. This does not take into account the quality of life benefits for individuals.

6.3 Value for Money

6.3.1 Use of Primary Care Services

EMIS data was extracted for the first six clinic patients and their use of primary care service before and after the clinic was assessed. It indicated that overall 10 less primary care appoints were required for these patients in the six months following the clinic than the 6 months before, this equated to an efficiency saving of £170. If this figure was extrapolated upwards for all 32 patients for a full year this wold equate to efficiencies of around £1,800.

6.3.2 Use of Acute Hospital Services

The CSU provided aggregate data on the use of ED and MIUs for all frailty clinic patients. This data indicated that there were was no change in the level of use of unscheduled for these patients from 2015/16 to 2016/17. However, given that the clinic has only been operational for seven months and that 14 of the patients have attended the clinic since January 2017, staff at the surgery may want to consider reviewing this data in October 2017, when the clinic has been operational for at least one year.

6.4 Summary of Value for Money

Qualitative feedback from both staff and patients (see section 5) indicates that the frailty clinic is effective and that patients are satisfied with the level of care they have received through it. As set out above, data from the EMIS system indicates that the frailty clinic lead to an overall reduction in the use of primary care services. The cost of these appointments is in region of £170[23], this data is

[22] Unit costs of Health and Social Care 2010. Personal Social Services Research Unit at the University of Kent at Canterbury and the London School of Economics and Political Science

[23] PSSRU Unit Costs of Health and Social Care 2016

annualised and extrapolated for all 32 patients it indicates that efficiencies in the region of £1,800 could be achieved.

7 EMERGING CONCLUSIONS

7.1 Introduction

The following paragraphs provide an overview of the key findings relating to the evaluation of the Eastleigh Frailty Clinic, the next steps and our recommendations going forward.

7.2 Policy Context and Need

There is a strong rationale for the development of the Frailty clinic. A review of local and national documents policy highlights that the development of local, community based services to support frail, older people is consistent with key policies. Furthermore, the processes that have been put in place to deliver the frailty clinic are consistent with NHS Guidance on developing integrated care pathways for older people[24] and the NHS Commissioning for Quality and Innovation Guidance (which notes that frail, elderly patients should be identified and care plans put in place)[25].

A review of demographic statistical data for the area also suggests that there is a high level of need to provide an intervention to support frail elderly patients. There are 128,900 (18%) people aged over 65 years in the Eastleigh area, slightly more than the national average of 17%[26]. There is a higher proportion of older people and retirees in the Park and St Francis Surgeries compared to the BLC and national populations, suggesting a higher proportion of frail patients than in other areas. Data from the GP Survey also shows that there has been a 3% increase in the proportion of patients who have reported moderate mobility issues.[27]

In addition to this feedback from staff involved in the development of the clinic also suggests that:

- There was a need to reduce the high level of GP appointments and home visits for a relatively small proportion of patients whilst providing them with care that will better address their needs
- Current care provided via Primary Care practitioners alone is not able to address the complex health and social care needs of frail patients.

7.3 Impact and Outcomes

Feedback from GPs who established the clinic and who refer into the clinic has been very positive. Whilst the clinic has only been operational for seven months the GPs noted they believe that the introduction of the clinic has been beneficial to patients and has reduced their workload, allowing them to focus more effectively on those patients who health care needs can be addressed within the average 10 minute GP appointment time.

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[24] NHS Five Year Forward View (2014).
[25] Safe, compassionate care for frail older people using an integrated care pathway. Practical guidance for commissioners and nursing, medical and allied health professional leaders. NHS England 2014.
[26] ONS population projections data (2015).
[27] GP Patient Survey (2016)

Clinical and social care staff who run the clinic noted that, because more time is available to undertake the assessments (i.e. typically 1 hour and 30 mins) and the service is completely integrated, this provides the opportunity to complete a comprehensive assessment and refer the patient to a full range of health and social care services. This allows them to remain as independent as possible for as long as possible, whilst reducing attendances at ED and MIU.

Feedback provided by 15 patients via a telephone survey was generally very positive, all patients reported high levels of satisfaction with the care they received via the clinic, although only 20% of respondents reported that they are now using less unscheduled care because of the clinic.

7.3.1 Use of Primary and Acute Hospital Care Services

Although the clinic is still relatively new, it is important to consider if the clinic has impacted upon the need and demand for other health and social care service. A review of anonymised patient data for those who attended the earliest clinics (6 patients), suggests that there has been less demand for primary care services in the six months following the clinic (this includes GP appointments, home visits and appointments with the practice nurse). The impact of the clinics on unscheduled care is less clear, whilst 20% of patients who responded to the patient survey reports that they have used EDs and MIUs less since attending the clinic a review of CSU data suggests that there has no change in ED attendances and admissions over the past year amongst the clinic's patients.

7.4 Recommendations

A number of recommendations have emerged so far, relating to the ongoing development of the frailty clinic:

- Recommendation 1: Development of a Project Manager / Administrator. Feedback from staff indicates that the clinic could be delivered more effectively. Project leads should seek additional funding to support this post.
- Recommendation 2: Development of Project Management Information Process. Whilst it is recognised that all patient information is collated via the EMIS system, a process to collate activity and outcome data specifically relating to frailty clinic patients outcomes would be a useful tool to monitor the impacts achieved by the clinic going forward.
- Recommendation 3: Rolling out the clinic to the remaining surgeries in the locality. The clinic is running every three weeks. Clinic leads should investigate the potential of expanding the clinic to allow staff from the other surgeries in the locality to refer directly. It is noted that this would also be dependent on gaining additional input administrative staff at each practice. There also needs to be sufficient staff who complete the assessments at the clinic when demand increases.
- Recommendation 4: Using the EQ-5D as part of the assessment. Staff undertaking the assessments at the clinic should have administrative support to include the use of ED-5Q as part of the assessment process, This could be repeated with the patient, six to eight weeks after the clinic as part of a general follow-up to ascertain the impact on patient general well-being.

APPENDIX 1 PATIENT SURVEY

FRAILTY CLINIC PATIENT SURVEY

Patient profile information

TO BE COMPLETED BY INTERVIWER – WE HAVE THIS DATA

Q1 Are you (Tick one)

Male	☐
Female	☐

Q2 What is your age group? *(Tick one)*

55-64 years old	☐
65-74 years old	☐
75-84 years old	☐
85+ years old	☐

Q3: Are you (Tick one)

patient	☐
carer	☐

7.1 About the Process

Q4. Before attending the well-being clinic, were you given enough information about what it entailed and what the benefits could be? *(Tick one)*

Yes	
No	

If no, why not? (e.g. what additional information would you have liked to have received?)

Q5. How satisfied or dissatisfied were you with the overall consultation that took place in the clinic? *(Tick one)*

Very satisfied	
Satisfied	
Neither satisfied or dissatisfied	
Dissatisfied	
Very dissatisfied	

If dissatisfied, please say why.

Q6. Did you come away with a care plan? *(Tick one)*

Yes (Go to Q8	
No (Go to Q10)	
Don't recall (Go to Q10)	

Q.7. If yes, did you have the opportunity to discuss and contribute to your care plan? (Tick one*)*

To a great extent	
To some extent	
To a small extent	
Not at all	

Please explain your answer?

Q8 How useful was the plan for your care? *(Tick one)*

Very useful	
Useful	
Somehow useful	
Not useful	
Not at all useful	

If not useful, please say why.

Q9.How satisfied or dissatisfied were you with the length of time it took to get an appointment at the well-being clinic? *(Tick one)*

Very satisfied	
Satisfied	
Neither satisfied or dissatisfied	
Not very satisfied	
Not at all satisfied	

If dissatisfied, please say why.

Q10. Have you been able to access any additional health and personal care services as a result of attending the well-being clinic *(Tick one)*

Yes	
No	
Not sure	

Q10b. If so what services have you been referred to / accessed (please tick all that are relevant).

Meals on wheels	
Personal care services	
Respite care	
Tele-care / tele-services	
Occupational therapy	
Other	

Other – please specify

Outcomes and Satisfaction

Q11 Please rate the extent to which you agree or disagree with each of the following statements. *(Tick one per row)*

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not applicable
The clinic lead to a change in my care						
I feel more able to self-manage my health and well-being because of my appointment at the clinic						
The well-being clinic enabled me to access additional care and support services						
The well-being clinic has supported me to live independently at home						
The staff were knowledgeable and understanding about my healthcare needs						
I feel satisfied with the service I received from the well-being clinic						
I feel that all the healthcare professionals in the project operated as a real team						
The support I received from the clinic changed my life						
I wouldn't have got the level of support I received at from the well-being clinic in a ten minute GP appointment						
Since attending the clinic, I have not called 111 or used GP out of hours services so much						
Since attending the clinic, I have not needed to attend A&E so much						
Since attending the clinic, I have not required as many GP appointments.						
The well-being clinic is a valuable addition to the NHS						

I was satisfied with the way my health condition was handled						
I feel happier in my life now						

Q12 How good was your overall experience of the well-being clinic? *(Tick one)*

Very good	
Good	
Neither good nor poor	
Poor	
Very poor	

If poor, could you please explain your answer?

Q13 Would you recommend the service to friends and relatives? *(Tick one)*

Definitely	
Probably	
Probably not	
Definitely not	
Very poor	

If not, could you please explain your answer?

Q14 How could the well-being clinic be improved?

Q15 Looking back on the clinic; what do you think the three most significant outcomes for you were?

1: 2: 3:

EQ – 5D

Finally, I would like to ask you some general questions about how you would rate your health and well-being today:

MOBILITY

I have no problems in walking about □
I have slight problems in walking about □
I have moderate problems in walking about □
I have severe problems in walking about □
I am unable to walk about □

SELF-CARE

I have no problems washing or dressing myself □
I have slight problems washing or dressing myself □
I have moderate problems washing or dressing myself □
I have severe problems washing or dressing myself □
I am unable to wash or dress myself □

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities □
I have slight problems doing my usual activities □
I have moderate problems doing my usual activities □
I have severe problems doing my usual activities □
I am unable to do my usual activities □

PAIN / DISCOMFORT

I have no pain or discomfort □
I have slight pain or discomfort □
I have moderate pain or discomfort □
I have severe pain or discomfort □
I have extreme pain or discomfort □

ANXIETY / DEPRESSION

I am not anxious or depressed □
I am slightly anxious or depressed □

I am moderately anxious or depressed □
I am severely anxious or depressed □
I am extremely anxious or depressed □

We would like to know how good or bad your health is TODAY.
On a scale is of from 0 to 100, how well do you feel today?
100 means the best health you can imagine.
0 means the worst health you can imagine.

Do you have any further comments on the well-being clinic?

APPENDIX 2 – BACKGROUND TO THE RESEARCH

PACEC Limited were appointed by the Southern Health NHS Foundation Trust to complete an evaluation of their NHS Vanguard Pilot to implement a new care model with GPs called a multi-specialty Community Provider (MCP), known locally as Better Local Care.

Better Local Care will support people in taking a more active role in managing their own care and will offer access to improved care where needed.

The aim of Better Local Care is:

> *To improve the health, well-being and independence of people living in our natural communities of care, making Hampshire an even greater place for all our residents to live.*

Better Local Care has four key themes:

Improving Access to care:	HBLC seeks to provide more straightforward access to a wider range of care such as, providing urgent appointments and increase out of hours contact, in order for people with complex health problems to get more input from their GP.
Joining up the professionals that support the same people:	HBLC aims to roll out Extended Primary Care Teams across Hampshire by joining professionals (doctors, nurses, social and voluntary sector workers) that support the same people. This will be done in the aim of improving care for those complex health and care needs, making the process more straightforward.
Concentrating on prevention:	Upgrading prevention is essential to ensure the health system is sustainable. Embedding primary prevention and self-care into models will allow patients to manage their own health needs, support people earlier, help them make the right choices about their health and wellbeing, and reduce the need to go to hospitals.
Bringing specialist care nearer to you:	Specifically focused on specialist support becoming more available to patients in their communities and reducing the time taken to access specialist input, so patients can see the professional they need, sooner. For example physiotherapists and mental health workers in local GP surgeries.

Better Local Care is a partnership of GPs, NHS providers and commissioners, Hampshire County Council, local councils of voluntary services, a number of local community, voluntary and charity organisations.

7.1.1 Purpose of Deep Dive Evaluations

Early discussions with the MCP evaluation team identified a need to produce early write-ups of progress and outcomes in respect of 5 relatively mature MCP projects. The write-ups provided an

independent assessment of the evidence available to demonstrate the activity, outputs and outcomes delivered by the MCP projects, including the Paramedic Home Visiting Service (PHVS) project.

The Deep Dive evaluation provide an independent assessment of system components, from key enablers to funded interventions by care need. This Paramedic Home Visiting Service deep dive report builds on the early write-up and adds to this with more analysis and provides an update on information such as detail on finance, on-the-ground activity data and sustainability to date.