Specialised Clinical Frailty Programme

Programme Outline

July 2018
Content

1. Context and Design Principles of Programme

2. The Specialised Clinical Frailty Programme

3. NHS Elect / Development of the Specialised Clinical Frailty Network

4. The clinical focus of the Programme
(1) Context to Establishing this Programme

• There has been increasing feedback – both from our regional directors of specialised commissioning and from a number of specialisms – that **clinically frail patients are being inappropriately referred to and / or accessing specialised treatments**, when there may be more clinically appropriate care pathways that would deliver a better experience for those patients (e.g. Enhanced care package)

• At present there is **no standardised national approach** in place for screening appropriateness of specialised service / triggering & supporting a shared decision making process with patients by clinical frailty

• In 2017/18 NHS England will spend ~£16.6bn commissioning 149 specialised services for patients across England. We have a duty to maximise the value we get for that investment by **ensuring each patient gets the most appropriate and highest quality care possible**

• The clinical leadership team (CLM) agreed, in August, to look at a potential programme of work on clinical frailty assessment. Specifically, we wanted to look at the **feasibility of the ‘Rockwood scale’** - a 9-point scale hospital clinicians can use to assess clinical frailty and potentially screen patients for appropriateness of certain specialised treatments that NHS England directly commission from providers. This work is **supported by senior NHSE leadership**

• There is already a **significant amount of work going on across the NHS on clinical frailty**. Members of the Acute Frailty Network (~70 hospital trusts taking forward projects on developing better care packages for acute frail) have successfully adopted the Rockwood frailty scale in order to identify frail patients, although their focus has often been on urgent & emergency care referrals (e.g. emergency department), rather than access to specialised treatments

• **Next steps for Specialised?** Linking in with wider system work (i.e. Professor Martin Vernon’s work and long-term conditions team). Working with active partners (i.e. specialist societies & colleges) already leading service improvement work in this area to test the feasibility of screening clinical frailty / triggering shared decision making processes (using the Rockwood scale) in a number of specialty areas.
(1) Principles to Support Programme Design

**PRINCIPLES / CRITERIA TO SUPPORT PROGRAMME DESIGN**

**a. WHY - Our key messages**

1. To improve patient care & outcomes (i.e. ensure most appropriate treatment and pathways for clinically frail patients)
2. To support clinicians more effectively engage with patients and their support ('shared decision making')
3. To enhance integration of care for clinically frail (e.g. pre-planning post treatment care packages with relevant MDTs, improving interface between 'referring clinicians' and specialists)

**b. WHAT is the programme**

4. Clinically-led programme, with key decisions and responsibility sitting with the relevant clinical chair(s)
5. Service improvement – any programme or pilots to focus on real world (and continuous) improvements, and that (a) can be spread, and (b) are sustainable
6. Going with the grain – build on / adopt existing work on clinical frailty assessment. Being clear what is and is not practical for clinicians / hospitals
7. Measurability – putting a premium on data and selection of pilot areas where impact of a clinical frailty score in a specialised area can tracked
8. Co-production – fully partnering with stakeholders (e.g. specialist societies, royal colleges, patient groups) to design pilots and will be needed to co-badge any recommendations / toolkits
9. Set methodology – while the design of pilots may be different for different areas, we should ensure a rigour in how all pilots are designed, with key set questions designed in
10. Appropriate resourcing / Dedicated support – this work should not create extra burdens for participants. Clinical leaders and each pilot site should be assigned dedicated programme and project support
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.


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(1) The NHS Change Model
(2) Specialised Clinical Frailty Programme

- The case for establishing a programme of work on frailty within Specialised Services was developed through the Specialised Commissioning Clinical Leadership Group during 2017/18.

- The Programme is now included within the Specialised Commissioning Operational Plan for 2018-19 (and is Objective 12 of 19 Key Objectives for Specialised Commissioning within 2018-19)

- It has been agreed that James Palmer (Medical Director for Specialised Commissioning) will be SRO for the Programme. Clinical Leaders Meeting will be the Programme Board for the Programme.

- The programme aims to explore the opportunities of identification of frailty within specialised services and how frailty-focussed care pathways might improve clinical outcomes for complex treatments.

- Specifically, the programme will involve testing the feasibility of the Rockwood Clinical Frailty Scale (CFS) in specialised service setting and whether it can enhance appropriateness of specialised treatment.

- Through the newly established Specialised Clinical Frailty Network, 30 test sites covering 6 speciality areas will test the use of the CFS alongside a greater focus on frailty within specialised service pathways.
We work in partnership with patients, clinicians and other stakeholders to commission specialised services that are high quality, equitable, accessible, sustainable and affordable. By working in this way and in collaboration across whole pathways we ensure the best outcomes and positive experience.

### Priorities

1. Implementation of NHS England’s clinical priorities
   - (1) During 2018/19, we will support the delivery of the MH 5YFV and deliver the specialised elements of the Mental Health clinical priority
   - (2) During 2018/19, we will support the delivery of the Transforming Care clinical priority
   - (3) During 2018/19, we will support delivery of the Cancer Strategy and deliver the specialised elements of the Cancer clinical priority
   - (4) During 2018/19, we will deliver our clinical work programmes.

2. Affordable access to new drugs and technologies that improve outcomes
   - (5) By March 2019, we will have established a full team, frameworks, processes and tools to negotiate new and affordable drugs for patients and begun delivering deals.
   - (6) By October 2018, the first patient will receive treatment at the Christie NHS Foundation Trust using Proton Beam Therapy.
   - (7) Over 2018/19, we will ensure mechanisms are in place to ensure clinically and cost effective innovative medical devices, diagnostics & digital health care products are introduced.

3. Improving value and reducing variation in specialised services
   - (8) By March 2019, we will have delivered the planned QIPP saving (3.2% circa £524m) and developed plans for 2019/20.
   - (9) Over 2018/19, we will deliver a programme of analysis for our top 20 specialised service areas, identifying variation in spend and activity at a CCG population.
   - (10) Over 2018/19, we will utilise regional resources to accelerate service change across a further 10 services.

### Enablers

1. Ensure high quality, aligned and effective clinical and operational leadership
   - (11) By March 2019, we will have rationalised and centralised our device procurements, resulting in commissioner savings on high cost tariff-excluded devices.
   - (12) By March 2019, run pilots for clinically-frail patients to receive the most appropriate clinical care and patient pathways.
   - (13) Over 2018/19, release capacity on POCs through supporting delivery on leaner clinical policy development.
   - (14) During 2018/19, we will improve patient safety, clinical effectiveness and patient experience through initiating roll-out across all regions and POCs of the Quality Assurance Improvement Framework (QAIF).

2. Better integration in local health and care systems of specialised services
   - (15) By March 2019, we will have established specialised services planning boards to work with all local systems through STPs/ICSs.
   - (16) By October 2018, we will have agreed how we work with NHS Improvement and with the seven regional teams.

3. Strengthen information flows and performance assurance
   - (17) By March 2019, we will have aligned and integrated our BI and informatics functions and systems under a single Information Strategy
   - (18) Over 2018/19, we will improve our use of benchmarking and metrics for commissioning, procurement and service change.
   - (19) By September 2018, we will have refreshed the Strategic Priorities and associated assurance and reporting.
**Frailty Programme**: To explore the opportunities of identification of frailty in specialised services and how frailty-focussed care pathways might improve clinical outcomes for complex treatments

- **Pilot the effective use of a frailty tool to improve decision making across 6 specialties**

- **Deliver a sustainable model of care that integrates frailty pathways of care within pilot sites**

- **Spread the change model for the adoption of the frailty tool across providers of pilot specialties and into other specialties**

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<tr>
<th>Programme</th>
<th>Frailty</th>
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<tr>
<td>Head of prog.</td>
<td>Nathan Hall</td>
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<tr>
<th>Milestones</th>
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<tbody>
<tr>
<td>Q1. Agree service level agreement with NHS Elect for delivering SCFN</td>
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<td>Q2. Establish programme management structures</td>
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<td>Q2. Commence wave 1 pilots</td>
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<td>Q2. Identify wave 2 pilot sites</td>
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<td>Q4. Commence wave 2 pilots</td>
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<td>Q4. Evaluate wave 1 pilots</td>
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<td>Q4(end). Evaluate wave 2 pilots</td>
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<tr>
<td>Q4. Work with NHS Elect to ensure delivery of wave 1 and 2 pilots successfully develops sustainable models of care</td>
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<tr>
<td>Q3. Build case for continued programme investment for 2019-2021 programme funding round</td>
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(2) Specialised Clinical Frailty Programme

**Frailty Programme:** To explore the opportunities of identification of frailty in specialised services and how frailty-focussed care pathways might improve clinical outcomes for complex treatments

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**Milestones**

- **Q2.** Develop comms strategy with comms team input
- **Q2.** Agree strategy with CLM
- **Q2.** Implement expert frailty advisory panel of national/international experts
- **Q3.** Engage key external stakeholders include royal colleges, BGA, PPV groups
- **Q3.** Engage key internal stakeholders including Spec Com national and regional teams, NCDs and SSCC
- **Q4.** Develop and update strategy following evaluation of W1

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**Milestones**

- **Q1.** Agree service level agreement with NHS Elect for delivering SCFN
- **Q4.** Review methodology of programme with end of Stage 1 report

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• A Programme Budget for 2018-19 of £800k has been approved in full by the Chief Finance Officer and the Director for Specialised Commissioning in NHS England.

• The bulk of the £800k budget (555K) is to be used to procure external expertise and support from NHS Elect (who currently run the Acute Frailty network) to support the test sites. On the 25 May the Commercial Executive Group (CEG) approved the business case for this single tender, and on 4 July we received DH ministerial sign off.

• The remainder of the budget funds the small Programme Team within NHS England Specialised Commissioning.

• An SLA has been agreed with NHS Elect, specifying NHS Elect’s support to the programme.

• **Programme Team**

• A programme team within NHS England is being established:

  • Richard Fluck has been appointed as the Associate Medical Director for this programme and will work one day a week during the life course of the programme.

  • Nathan Hall is the new 8d Head of Programme and will be seconded in from the Improving Value team to work full time on the SCG programme for the life course of the programme.

  • A part-time Clinical Policy Fellow will commence in October 2018. A Band 7 Policy Manager post is yet to be recruited to.
(2) Programme Governance & Reporting

<table>
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<tr>
<th>Meeting Type</th>
<th>Description</th>
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<tr>
<td>Very High Level Monthly delivery report from Head of Programme</td>
<td>Oversight of delivery against SC operating plan objectives. Agreement to extension of programme and associated budget.</td>
</tr>
<tr>
<td>6 weekly report from Head of programme &amp; Associate Medical Director</td>
<td>Agreeing programme plans Authorising significant deviations from plans Overall agreement of strategic direction for the programme Approving programme products and end project reports</td>
</tr>
<tr>
<td>Monthly updates and discussion on all aspects of programme. Draft products / outputs.</td>
<td>Monitoring and review of programme plans &amp; implementation Agreement to operational approach &amp; delivery Development of programme products and end project reports Clinical input and engagement from relevant CRG reps</td>
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<tr>
<td>SCOG – Specialised Commissioning Oversight Group</td>
<td>Role and Function to be agreed</td>
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<tr>
<td>Clinical Leadership Meeting – Programme Oversight Group</td>
<td>Fortnightly meeting – NHS Elect &amp; Head of Programme</td>
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<tr>
<td>SCF Programme Meeting</td>
<td>Expert advisory panel (tbc)</td>
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(3) NHS Elect – Agreed Overall Outcomes

- Provide expert support (as detailed later in the specification) to a set of 30 test sites who will work together to test the practical application of using an agreed clinical frailty assessment tool (specifically the ‘Rockwood 9 point scale’) in specialised service settings. This support will adopt an improvement collaborative approach and allow the identification of learning around if and how the application of such tools can inform and enhance treatment decision making in specialised services. This learning will be summarised for NHS England on completion of Waves 1 and 2 (i.e. learning from wave 1 will be available to NHS England before completion of wave 2).

- NHS Elect will ensure there is a group of leaders (including clinical leaders) across these test sites that have a detailed knowledge of Quality Improvement tools and techniques and how to use these locally to support improvement and are connected with one another through established action learning sets.

- NHS Elect will work with each individual site to develop its own outcome, process and balancing measures to be able to determine where each site has made a statistical improvement as part of their time in the Network. NHS Elect will ensure that these measures are linked to the objectives of the programme.

- These measures will form a sound foundation for sites improvement work going forward, once their involvement in the programme is complete. They will also support NHS England to better understand the impact of frailty focussed pathways on both clinical outcomes and healthcare resource use.

- A set of toolkits (including case studies & good practice material), agreed with NHS England on what, where, when, who, how and why to implement clinical frailty assessment and management within Specialised services. This work will allow test sites to showcase their work to the wider NHS. Such toolkits will be developed with the NHS England Specialised Clinical Frailty Programme Group and agreed/endorsed through the NHS England (Specialised Commissioning) Clinical Leaders Meeting (CLM).

- The overall learning from phase 1 will be summarised in an end of Phase 1 report developed by NHS Elect and reported to NHS England.

- NHS Elect will use the Kirkpatrick evaluation model to evaluate the delivery of these outcomes.
To enable the outcomes outlined in NHS Elect will deliver:

- Four national events (two for each wave) designed to support participating test-sites to test new models of care and to share experience with one another. The agenda for these events to be agreed with NHS England.

- Two improvement masterclasses for participating test-sites (one covering measurement for improvement the other tbc in agreement with NHS England).

- A series of support webinars for participating test sites to support local leaders develop the skills required to lead change locally.

- Site-visits and 1:1 help to sites as required and agreed with the NHS England Clinical Frailty Programme Group (including access to expertise on measurement and patient experience based design).

- Sustainability assessments with each test-site.

- Access to a web resource repository for all test sites for outputs to be recorded and shared by all participating test sites.

- Development of case studies (including capture of patient stories) – format and content to be agreed with NHS England Clinical Frailty Programme Group.

- Work with NHS England to establish and deliver an advisory panel (including national & international expertise) on Clinical Frailty (this support will include identification and engagement of key international opinion leaders).
The NHS Elect Project Team will include:

<table>
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<tr>
<th>Senior Responsible Officer</th>
<th>Caroline Dove</th>
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<tr>
<td>Programme Director</td>
<td>Deborah Thompson</td>
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<tr>
<td>Clinical Director</td>
<td>Professor Simon Conroy</td>
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<tr>
<td>Site Associates</td>
<td>Simon Griffiths (Cardiac), Lisa Godfrey (Chemo), Mandy Rumley-Buss (Renal)</td>
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<tr>
<td>Measurement Lead</td>
<td>Matt Tite</td>
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<tr>
<td>Project Manager</td>
<td>Emma Backhouse</td>
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<td>Commissioning Advisor</td>
<td>Tbc</td>
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<tr>
<td>Admin Support</td>
<td>Paula Burge</td>
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The project manager will act as the day to day contact with NHS England, reporting to the Programme Director. Engagement with clinical leaders within sites will be led through the Clinical Director.

**Wave 1 (Chemotherapy, Renal Dialysis and Cardiac):**
- Site Visits to commence: July 2018
- First national event: September 2018
- 2nd National event: Feb/Mar 2019
- Other support to teams (as outlined above): July 2018-April 2019
- Wave1 report to be presented to NHS England March/April 2019

**Wave 2 (Adult Critical Care, Spinal Surgery, Neurosurgery):**
- Site Visits to commence: January 2019
- First national event: February 2019
- 2nd National event: Date to be agreed with NHS England
- Other support to teams February 2019- July 2019
- Wave 2 report / overall SCFN report to be presented to NHS England September 2019
# Wave 1 Specialities, Aims & Test Sites

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<thead>
<tr>
<th>Speciality (CRG Chair)</th>
<th>Aim</th>
<th>Test Sites</th>
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| A. Renal (Richard Barker) | To strengthen the shared decision making process between clinically frail patients, at or approaching end stage renal failure, and clinicians to ensure the most appropriate decision on Renal Replacement Therapy (RRT) – i.e. whether to go with dialysis or ‘conservative care’ and type of dialysis. | 1. Birmingham  
2. Nottingham  
3. King’s College Hospital  
4. Lancashire (Preston)  
5. Leeds |
| B. Cardio (Huon Gray) | To strengthen the clinical assessment of clinically frail patients with Aortic Valve Stenosis, reduce the number of inappropriate physician referrals for specialised commissioned interventions – including Transcatheter aortic valve implantation (TAVI) procedures - and enhancing a shared decision making process with patients / family to ensure the most appropriate care package for those patients. | 1. Barts Health  
2. Royal Papworth  
3. Leeds  
4. Southampton  
5. Oxford |
| C. Chemo (Peter Clark) | To strengthen the shared decision making process for lung cancer patients between clinicians, patients, relatives and carers with a ECOG Performance Status assessment of 2, and ensure they are referred to the most appropriate treatment (e.g. chemotherapy, alternative palliative care) | 1. Newcastle  
2. Sheffield  
3. Christie  
4. UCL London  
5. Cambridge |
### (3) Wave 2 Specialities, Aims & test Sites

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<th>Speciality</th>
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<th>Test Sites</th>
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<tr>
<td>D. Neurosurgery (Adrian Williams)</td>
<td>To enhance the appropriateness of emergency referral for clinically frail patients to Neuro-surgical critical care</td>
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<tr>
<td>E. Spinal Surgery (Ashley Cole)</td>
<td>To ensure patients considering surgery for degenerative spinal deformity are fully informed about the risks of surgery for them and are involved in a shared decision making process. To ensure medical and social optimisation and enhance recovery from surgery.</td>
<td>tba</td>
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<tr>
<td>F. Adult Critical Care (Jane Eddleston)</td>
<td>To use the evidence base concerning impact of frailty on outcome following major elective surgery / emergency referrals in decision making / patient selection for suitability of patients for major elective surgery / emergency referrals to critical care bed</td>
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