Linking Primary Care and British Red Cross

A proactive approach to supporting people with mild frailty in Midlothian

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Why focus on frailty?

Frailty has been described by one of Midlothian's GPs as primary care's 'global warming' in that services will be unable to meet growing demand and could 'fall over' in the medium to long term if we, as a health and social care system do not change.

The Midlothian H&SCP wanted to improve person-centred care for people living with (mild) frailty by:

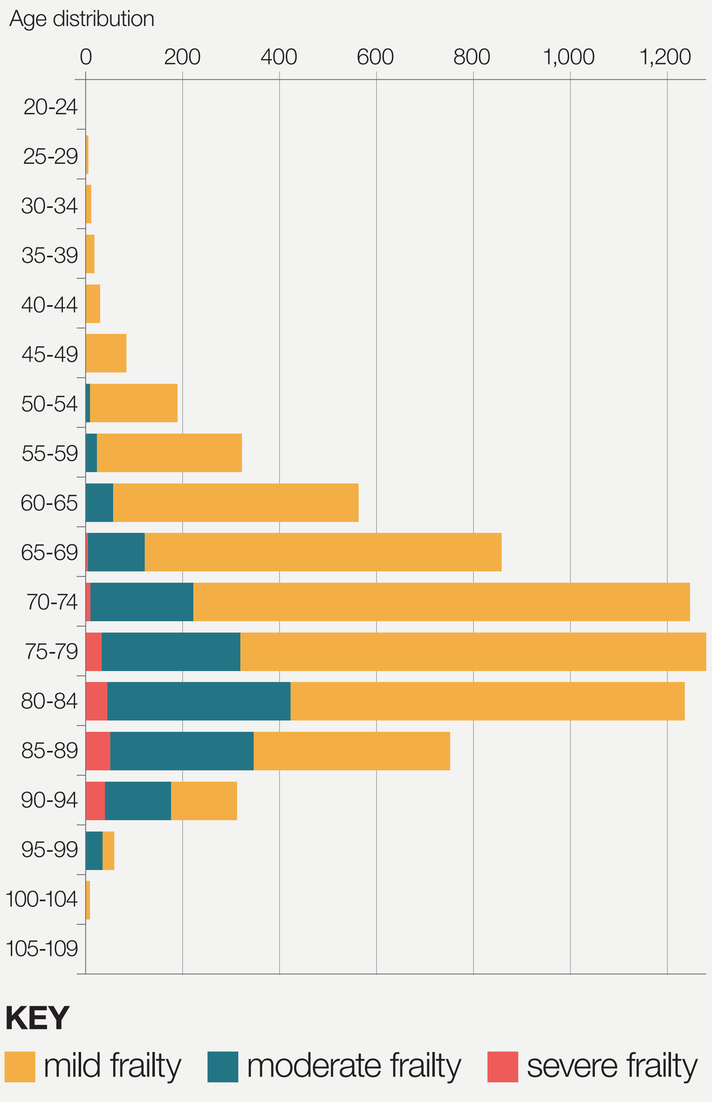
- shifting from being reactive to pro-active
- developing a robust process using eFI
- building relationships between third sector and primary care.

The Electronic Frailty Index (eFI) developed by the NIHR CLAHRC[1] gave Midlothian H&SCP an opportunity to better identify people living with frailty (rather than rely on age and hospital activity data) and develop a partnership between three GP practices and the British Red Cross.

This project is funded by Healthcare Improvement Scotland (HIS) and routinely directs all people living with mild frailty to the British Red Cross' Neighbourhood Links service. It is not left to chance, nor is in response to a crisis, so promotes early intervention and self-management, key approaches for Midlothian H&SCP.

1 National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC)

Figure 1. Age of people with frailty



> **"Sandie's visits made me aware of services I hadn't heard of. Now I have handrails where required, attendance allowance and am due to have heating upgraded."** – *Client A*

> **"The service was excellent and carried out by someone who cared and had my interests at heart."** – *Client B*

What the project did

Three out of the 12 GP practices in Midlothian agreed to contact people living with mild frailty by letter – around 1400 people – and encourage them to access the Neighbourhood Links service. This offers a 'good conversation' about what matters to the individual. The comprehensive assessment covers practical, emotional and social issues and then connects people to HSCP services, other relevant statutory agencies such as DWP and third sector support.

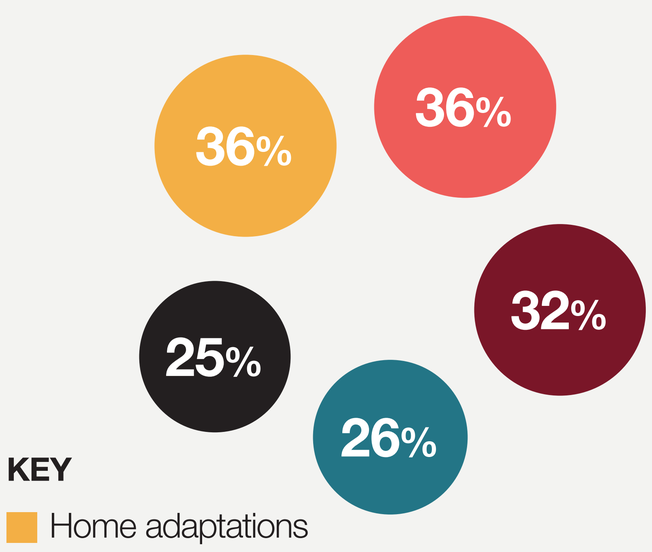
Results

To date, 104 people have contacted British Red Cross, with 94 accessing the service. Letters from the GP Practice alone were not enough for people to opt into this service and data sharing remains a barrier.

Contacting people not in crisis is a challenge. Those opting out said they felt fit and independent and did not need any support, but welcomed the information provided.

Follow up phone calls and British Red Cross having a presence at the Flu clinics significantly improved uptake.

Figure 2. Types of interventions (n=94)



Main Benefits

Prevention

Almost 75% of people said they had mobility issues. 22% had fallen in the last 6 months. Installing grab rails and ensuring walking aids are adequate are important interventions to reduce falls risks, as well as onward referral to specialist input.

26% have accessed groups via British Red Cross' Local Area Co-ordinators service to overcome loneliness and isolation.

Carers needs

1 in 3 were unidentified carers and went onto access services at VOCAL (Voices of Carers Across the Lothians) e.g. Power of Attorney, Respite.

Future planning

Important conversations about DNACPR, Power of Attorney, Emergency Care Plans that can be shared on social work and GP systems.

Finances

DWP referrals for Attendance Allowance equates to over £48,000/year raised for 11 people. This is expected to increase to over £100 000.

Before eFI, Midlothian H&SCP:

- estimated 4000 people living with frailty
- had a limited idea of people's needs
- knew that the route into support was typically in response to a crisis, or by chance with very few referrals from primary care.

Midlothian H&SCP now knows that:

- there are over 8000 people living with frailty, most of them 'mild' (@6000)
- there are unmet carer needs, basic home adaptations required, people not accessing benefits and a need to link with groups and activities to reduce social isolation and maintain independence
- we are reaching people before crisis and excellent relationships have developed between British Red Cross and primary care colleagues, evidenced by referrals from GP practices outwith this project.

What next?

- looking at the impact on the number and quality of GP contacts with service users
- test of change to allow British Red Cross to directly assess and order simple home adaptations, so ensuring a quicker outcome for service users, avoiding duplication of assessments and having a positive impact on social care waiting lists.

Midlothian Health & Social Care Partnership

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In partnership with British Red Cross