Integrated Frailty Care at Neighbourhood Level

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Luton and Milton Keynes CCG

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Cambridge Community Services
**Older People: Over 65’s**

The main aim of this programme is to **promote healthy ageing, to case find frail elderly, proactively manage their care and reduce the need for older people**, those aged over 65, to be urgently admitted to hospital.

This will be achieved through system-wide agreement, development and implementation of a **Framework for Frailty in Luton**; clearly describing the interventions and services across health & social care that will **support older people with healthy ageing and to remain in their own home for as long as possible**.

And where this is no longer possible, **ensuring that the best possible care is provided for older people in residential & nursing settings**.

The framework describes the offer for each frailty cohort; fit, mild, moderate and severe.

### A Framework for Frailty in Luton

<table>
<thead>
<tr>
<th>Covert Identification</th>
<th>Fit</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ageing Well Advice &amp; Signposting</td>
<td>Supported Self Management</td>
<td>MDT Care &amp; Support Planning</td>
<td>MDT Case Management &amp; End of Life Care</td>
<td></td>
</tr>
</tbody>
</table>

### Covert Identification

- **Fit**
  - F2 score: 0.0 - 0.12 Frailty
  - Frail: Choice of Frailty Assessment Tool e.g. Edmonton Frail Scale: 0-7 (55% Not Frail, 45% Vulnerable)
  - Risk assessment: 1 - 3 (1 Very Fit, 2 Well, 3 Managing well)
  - Plus: Clinical judgement

- **Mild**
  - F2 score: 0.13 - 0.24 Mild Frailty
  - Frail: Choice of Frailty Assessment Tool e.g. Edmonton Frail Scale: 8-9 (85% Mild Frailty)
  - Risk assessment: 4 - 5 (4 Vulnerable, 5 Mild Frail)
  - Plus: Clinical judgement

- **Moderate**
  - F2 score: 0.25 - 0.36 Moderate Frailty
  - Frail: Choice of Frailty Assessment Tool e.g. Edmonton Frail Scale: 10-11 (85% Moderate Frail)
  - Risk assessment: 6 - 7 (6 Moderate Frail)
  - Plus: Clinical judgement

- **Severe**
  - F2 score: >0.36 Severe Frailty
  - Frail: Choice of Frailty Assessment Tool e.g. Edmonton Frail Scale: 12-17 (10-20 Severe Frail)
  - Risk assessment: 8 - 9 (8 Very Severe Frail, 9 Terminality 10)
  - Plus: Clinical judgement

SyntoOne icon
## Comparison of Frailty Prevalence
*(National versus Luton)*

<table>
<thead>
<tr>
<th>Frailty Category</th>
<th>eFI score range</th>
<th>Prevalence n (%) National Estimates (Reeves et al. 2018)</th>
<th>Prevalence n (%) Luton</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit</td>
<td>0-0.12</td>
<td>591527 (61.3)</td>
<td>7290 (40%)</td>
</tr>
<tr>
<td>Mild</td>
<td>&gt;0.12-0.24</td>
<td>248986 (25.8)</td>
<td>6795 (37%)</td>
</tr>
<tr>
<td>Moderate</td>
<td>&gt;0.24-0.36</td>
<td>98096 (10.2)</td>
<td>3035 (17%)</td>
</tr>
<tr>
<td>Severe</td>
<td>&gt;0.36</td>
<td>25877 (2.7)</td>
<td>1245 (7%)</td>
</tr>
</tbody>
</table>

- The odds of being moderately and severely frail among elderly population living Luton is 2.05 times higher than the national estimates.
- The odds of being mildly frail among elderly population living Luton is 1.69 times higher than the national estimates.
Improving Care for Older People, those over 65, in Luton:

What are the desired outcomes?

- Older people are supported with healthy ageing and to remain in their own home for as long as possible. And where this is no longer possible, ensuring that the best possible care is provided for older people in residential & nursing settings.
- Older people will experience improved health and care that focuses on ‘what matters most to them’.
- Older people will experience less need to be urgently admitted to hospital.
- Older people will experience less use of unnecessary medicines.
- Older people will be supported to stay stable, strong & safe.
- Older people’s chances of a ‘first fall’ being injurious is reduced.
- Older people will experience effective treatment of injurious falls, helping them return to maximum independence.
- Older people who are multi-fallers have their well-being maximised.
- Older people will have the chance to discuss their wishes and preferences.
- Older people will be cared for and die in their preferred place.
A Framework for Frailty in Luton: Change in Practice

Improving Care for Older People, those over 65, in Luton: What clinical behaviours will change?

- All health and care professionals will start to recognise signs of frailty and check clinical records/care plans to confirm if a frailty score is available and/or if a frailty assessment has been carried out.

- All health and care professionals will start to experience more satisfying consultations.

- GPs (supported by other health & care professionals) will be expected to:
  - identify possible frailty by using an appropriate scoring tool (the electronic Frailty Index eFI is being used in Luton),
  - confirm level of frailty using a number of assessment tools,
  - identify those who have had a previous fall and
  - share this information with other health & care professionals.
## A Framework for Frailty in Luton

### Fit
- eFl score: 0-0.12
- Plus: Choice of Frailty Assessment Tools e.g. Edmonton Frail Score: 0-7 (0-5 Not Frail, 6-7 Vulnerable)
- Rockwood Score: 1-3 (1 Very Fit, 2 Well, 3 Managing Well)
- Plus: Clinical Judgment

### Mild
- eFl score: 0.13-0.24
- Plus: Choice of Frailty Assessment Tools e.g. Edmonton Frail Score: 8-9 (8-9 Mild Frail)
- Rockwood Score: 4-5 (4 Vulnerable, 5 Mildly Frail)
- Plus: Clinical Judgment

### Moderate
- eFl score: 0.25-0.36 Moderate Frailty
- Plus: Choice of Frailty Assessment Tools e.g. Edmonton Frail Score: 10-11 (10-11 Moderate Frailty)
- Rockwood Score: 6 (6 Moderate Frail)
- Plus: Clinical Judgment

### Severe
- eFl score: >0.36 Severe Frailty
- Plus: Choice of Frailty Assessment Tools e.g. Edmonton Frail Score: 12-17 (12-17 Severe Frailty)
- Rockwood Score: 7-9 (7 Severe Frail, 8 Very Frail, 9 Terminally ill)
- Plus: Clinical Judgment

### Ageing Well Advice & Signposting

### Supported Self-Management

### MDT Care & Support Planning

### MDT Case Management & End of Life Care
## A Framework for Frailty in Luton

<table>
<thead>
<tr>
<th>Fit</th>
<th>Core Offer</th>
<th>Ageing Well Advice &amp; Signposting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohort Identification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognising signs of frailty during all health &amp; care encounters:</td>
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<td></td>
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<tr>
<td>3 or more of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unintentional weight loss, as evidenced by a loss of at least 10 lbs or greater than 5% of body weight in the prior year;</td>
<td></td>
<td>Signposting:</td>
</tr>
<tr>
<td>Muscle weakness, as measured by reduced grip strength</td>
<td></td>
<td>'A practical guide to Healthy Ageing' - Age UK Booklet</td>
</tr>
<tr>
<td>Physical slowness</td>
<td></td>
<td>Total Well-Being Luton (Lifestyle services incl. social prescription and IAPT)</td>
</tr>
<tr>
<td>Poor endurance, as indicated by self-reported exhaustion; and</td>
<td></td>
<td>Falls Prevention Awareness - Guidance for non-medical interventions: vision, feet &amp; footwear, home hazards.</td>
</tr>
<tr>
<td>Low physical activity, as scored using a standardized assessment questionnaire</td>
<td></td>
<td>Health Promotion:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Community Pharmacies</td>
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<tr>
<td></td>
<td></td>
<td>✓ Opticians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Making Every Contact Count</td>
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<tr>
<td></td>
<td></td>
<td>Interventions:</td>
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<tr>
<td></td>
<td></td>
<td>Medication Use Review (MUR) - Community Pharmacies</td>
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<tr>
<td></td>
<td></td>
<td>Utilising tools to improve medicines safety</td>
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<td></td>
<td></td>
<td>Encouraging / confirming self-assessment of home environment and / or home support to help them</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disability Resource Centre (DRC) Support and guidance</td>
</tr>
</tbody>
</table>
Healthy Ageing Programme

This programme will be:

✓ Invite those **scoring as mildly frail** to participate in a 12 week activity/exercise programme to improve their strength, balance, stamina and/or flexibility.

✓ initially piloted for **South East Luton Cluster GP Practices** and

✓ academically evaluated by **University of Bedfordshire** to provide an evidence base of impact of the health ageing programme on people’s frailty levels.
Improving Care for Older People, those over 65, in Luton:

Case Study

- 74 year old lady, osteo-arthritis, ischaemic heart disease.
- efi score - moderately frail.
- GP carried out observations & assessment including frailty assessment ‘time up and go test’ (TUGT).
- TUGT result was over 30secs. Amended read-code to severely frail.
- Identified need to refer to Community Falls team.
- Identified need to provide patient with Tel. No. for Total Well-being Luton (for support with increasing activity, isolation).
Complex Care (Adults):
Models of Care: Key Components

Primary Care Home (Networks/Neighbourhoods)

- Personalisation
  - Support of Self Care / Social Prescription
  - Standardised Outcome Care
- Complex multi-specialty care management
- Enhanced Health in Care Homes
- Rapid Response to unplanned crisis
- Facilitated/Supported discharge (Home/Bed)
- End of life Care

Joined up physical & mental health

Population Health Management - Outcome-based Commissioning - Co-produced Design & Delivery
Workforce Planning & Development - Digitalisation & Shared Care Record
The model of care will provide integrated co-ordinated care for all over 65’s – and will include the following key elements commissioned from and provided by a range of providers.
How will we measure outcomes/impact?

- Joint University of Bedfordshire/Luton CCG PhD studentship will academically evaluate implementation of the Luton Framework for Frailty, including the effectiveness/utilisation of the Comprehensive Geriatric Assessment (CGA) carried out by MDTs and the subsequent interventions.

- Outcome measures will include quality of life, the number of hospital admissions, rate of institutionalisation, health and social care expenditure, and mortality.
Mrs M (66) lives with her daughter and 3 grandchildren. She has severe asthma and has been admitted to hospital 5 times in the last year with acute exacerbations.
Palliative Care/Advanced Planning

Education and training for Family and professional carers

Care home pharmacy assessment

Confusion

Multi morbidity management

Behaviours

Falls prevention

Nutrition

Personalised advanced care planning/palliative care

Hydration

Activities and interest

Risk of falls

111*6 for clinical support 24/7

Physical and cognitive deterioration

Mary has been living in St Janes care home for 8 years and now does not recognise her family due to dementia. Her main problems are recurrent UTI and poor mobility

Activities and interest
Typically a 30 to 90 DAY PERIOD

The IRR and CM will decide when and how the ICM begins. ICM can start before the next MDT meeting.

Does the patient need to be stepped up in their treatment?

NO

ICM INTERVENTIONS CARRIED OUT BY THE PARTNER AGENCIES & OVERSEEN BY THE LEAD PROFESSIONAL (USUALLY THE CM)

Yes

Can we step down, or have we reached the 90 day point?

NO

MDT - ICM INTEGRATED RESPONSE

STEP UP

INTEGRATED RAPID RESPONSE

MANAGED BY

COMMUNITY NURSING OR OTHER LEAD PROFESSIONAL

MDT COORDINATOR

GP

Close relationship working as a team

Single service routine & planned interventions as/if required

ALL patients stepped down from ICM will have a Personalised Care and Support Plan, a copy of which will be held by appropriate partner agencies.
Enhanced Collaborative Model of Care

☐ Patients over 65, moderately or severely frail with 2 or more unplanned admission.

☐ Phase One circa 800 people at any one time.

☐ Support people to stay safely at home and prevent avoidable admission.

☐ Result in a significant reduction of admissions for this group when they are on the cohort.
What is different?

- Named patients proactively case managed and supported with a personalised care plan including admission avoidance.
- Daily safety huddle at the community services base for the named cohort of patients to address concerns.
- Weekly MDT meetings with whole system partners, supported by Consultant Physicians from the local hospital.
- Development of new pathways as part of the model development e.g. IV Pathway, Step Up Beds.
Identification of the patient cohort

- The patients are being identified from GP frailty data and via a data stream from the Luton and Dunstable Hospital, which is updated on a daily basis through a data analysis tool.

- This is available as a live dashboard to key staff working on the project across organisations.

- The patients are over 65, identified as either moderately or severely frail, and have had two or more unplanned hospital admissions in the past year.

- It shows the number of patients currently on the cohort and a breakdown of which patients are in hospital, alongside other relevant details.
What this means in practice (1)

The model focusses on some specific key processes that brings together clinicians to review complex patients, ask questions, share information and take action:

- The identification of a lead professional for cohort patient to support proactive case management and care planning.
- The daily safety huddle, attended by CCS community clinicians, social care, primary care and Luton and Dunstable clinicians.
- The weekly MDT, to which all partners including the third sector are invited.
- Monthly MDT meeting with GP clusters supported by AHF coordinators.
- Encouraging all staff to ask 5 simple questions to support conversations that enable identification of a patient’s immediate needs.
What this means in practice (2)

- L&D Consultant hotline available for community staff 9am to 9pm, Hot clinics for specialist geriatrician review.

- A pathway enabling more IV antibiotics to be delivered in community clinics or at home, rather than in hospital.

- Step up beds, which are a step between community and hospital for patients who need 24 hour care for an urgent condition that can be managed in the community.

- More medication reviews undertaken by pharmacists and pharmacy technicians.

- Reinvigorating a previous initiative, where community patients wear a pink bracelet, allowing them to be easily identified by other clinicians and in A&E that indicates they have a personalised care plan to support them in community.
Five conversation-starters to support identification of need

1. Who visits you, how often and what do they do for you?
2. Have you fallen recently, or are you worried about falling?
3. Do you feel confident managing your own medication?
4. Do you tend to forget things and struggle to recognise people?
5. What help do you need with washing, dressing, shopping, cooking and cleaning?
The care planning process

- Asked 5 questions by the At Home First Co-ordinator
- Patient made aware of who to contact and how they feel they need help or support
- If stable, follow up with a call after 2 months
- Onward referral if required for long term condition management, memory assessment, falls assessment, medication review, voluntary sector or social services
- Hospital avoidance care plan developed for those who need it
Results so far

- Successful joint working across teams and organisations at the daily safety huddle and weekly MDTs.

- The number of patients who have been asked the 5 questions is 859.

- The number of patients who have ever been on the cohort who have a CCS Care Plan that is in a format to enable it to be shared across the system is 702.

- We are seeing a reduction in the number of emergency admissions for this cohort of patients, which are likely to be related to proactive working.
**Results so far**

Emergency Admissions

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Original Cohort Tracked</td>
<td>132</td>
<td>140</td>
<td>154</td>
<td>141</td>
<td>146</td>
<td>85</td>
<td>87</td>
<td>101</td>
<td>79</td>
<td>74</td>
<td>90</td>
<td>80</td>
<td>1309</td>
</tr>
<tr>
<td>Oct End Cohort Tracked</td>
<td>141</td>
<td>150</td>
<td>161</td>
<td>150</td>
<td>161</td>
<td>155</td>
<td>145</td>
<td>109</td>
<td>92</td>
<td>81</td>
<td>101</td>
<td>93</td>
<td>1539</td>
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<tr>
<td>Nov End Cohort Tracked</td>
<td>142</td>
<td>150</td>
<td>168</td>
<td>155</td>
<td>164</td>
<td>162</td>
<td>152</td>
<td>166</td>
<td>102</td>
<td>94</td>
<td>103</td>
<td>94</td>
<td>1652</td>
</tr>
<tr>
<td>Dec End Cohort Tracked</td>
<td>145</td>
<td>156</td>
<td>168</td>
<td>156</td>
<td>163</td>
<td>165</td>
<td>154</td>
<td>179</td>
<td>151</td>
<td>105</td>
<td>108</td>
<td>97</td>
<td>1747</td>
</tr>
<tr>
<td>Jan End Cohort Tracked</td>
<td>151</td>
<td>157</td>
<td>172</td>
<td>160</td>
<td>165</td>
<td>169</td>
<td>162</td>
<td>188</td>
<td>166</td>
<td>174</td>
<td>115</td>
<td>101</td>
<td>1880</td>
</tr>
<tr>
<td>Feb End Cohort Tracked</td>
<td>154</td>
<td>162</td>
<td>173</td>
<td>163</td>
<td>169</td>
<td>176</td>
<td>166</td>
<td>190</td>
<td>173</td>
<td>181</td>
<td>185</td>
<td>110</td>
<td>2002</td>
</tr>
<tr>
<td>Mar End Cohort</td>
<td>158</td>
<td>163</td>
<td>181</td>
<td>170</td>
<td>180</td>
<td>183</td>
<td>173</td>
<td>196</td>
<td>183</td>
<td>190</td>
<td>199</td>
<td>197</td>
<td>2171</td>
</tr>
</tbody>
</table>

This table shows how the project has impacted on the admissions of each Cohort.

After patients become part of the project there is a decline in their number of admissions which has currently been sustained with each group.

There was a reduction in annual admissions for the overall cohort from 2,399 from the 31<sup>st</sup> August 2018 to 2,171 on the 31<sup>st</sup> March 2019.
Patient Feedback Survey

“The Community Matron was always at the end of a phone or was able to visit. He was supportive with any emergencies or where assistance was required.”

“The service received from the staff was marvellous. This was very helpful to both my husband and me as the main carer. I felt reassured when I was worried. Information and medical advice was valuable. I was advised about checking blood pressure and other services that my husband could be referred to.”

“The medical programme was very thorough and I felt fully supported. Staff were very friendly and built a rapport with my mother. My worries were alleviated as there was someone to call on.”
### Partner Feedback

<table>
<thead>
<tr>
<th>Working Well</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary approach to care and treatment in the community. Seamless service between inpatient and community services. Ensuring the right patients get the right care at the right time.</td>
<td>Multiagency approach is what everyone has been saying for years will work, finally this is an opportunity to move things forward collaboratively.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Next Steps</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to: Improve how we share records and care plans, Improve how we ask about goals of care and ceilings of treatment, Engage the Older People’s mental health services in the process.</td>
<td>Need further work on how to address appropriateness of what care is right for the patient. Need to refine how we do anticipated care and also need to work out how to share plans better.</td>
</tr>
</tbody>
</table>
Enhanced Collaborative Model of Care

- Next steps:
  - 2 networks (approx 3500 patients)
  - Care Home severely frail and Multiple LTC-moderately frail
  - Defined duties, roles and responsibilities. Standard operating procedures
  - Proactive and intensive case management
  - Increased workforce capacity
  - Increased investment
  - Business as usual for other networks
# A Framework for Frailty in Luton: Competencies

<table>
<thead>
<tr>
<th>Mild</th>
<th>Foundation</th>
<th>Core</th>
<th>Enhanced</th>
<th>Advanced</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication skills - particularly signposting/advice/coaching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand / recognise frailty and what it means for their role</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Assessing frailty- scoring tools/using assessment tools</td>
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<tr>
<td>Working as part of a system, culture change, seeing the bigger picture</td>
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<tr>
<td>Dementia Friendly</td>
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</tr>
<tr>
<td>Staff to understand who the patient needs to be referred to.</td>
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<td></td>
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</tr>
<tr>
<td>Understand referral process, inclusion and exclusion criteria.</td>
<td></td>
<td></td>
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<tr>
<td>Understanding the resources available.</td>
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<tr>
<td>Strong advocacy.</td>
<td></td>
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</tr>
</tbody>
</table>
THE CO-DESIGNED BLMK MDT MODEL:

- MDT manager / Co-ordinator
- GP (with expertise in care of the elderly)
- GP (generalist input)
- Case lead (drawn from the roles below)
- Social care professional
- Individual’s GP (or practice representative)
- Nursing professional
- Pharmacist professional
- Therapy professional
- Mental health worker
- Third-sector expert
- Social prescribing link worker
- Administrator

- hospital geriatrician or other acute input
- specialist nurse (e.g. diabetes, COPD)
- palliative care specialist
- housing, police
WE HAVE EXTRAPOLATED THIS MDT PROFILE TO IDENTIFY THE WORKFORCE IMPLICATIONS ACROSS BLMK
THIS RESULTS IN THE FOLLOWING WORKFORCE REQUIREMENTS TO DELIVER MDT PROFILE: PLACE AND BLMK-LEVEL (1) – THE CORE MDT OF DO’ERS

<table>
<thead>
<tr>
<th></th>
<th>Central Bedfordshire</th>
<th>Bedford</th>
<th>Milton Keynes</th>
<th>Luton</th>
<th>BLMK total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT manager / co-ordinator</td>
<td>7.1</td>
<td>4.9</td>
<td>6.9</td>
<td>5.1</td>
<td>31</td>
</tr>
<tr>
<td>GP with interest in care of the elderly</td>
<td>1.8</td>
<td>1.2</td>
<td>1.7</td>
<td>1.3</td>
<td>1.7</td>
</tr>
<tr>
<td>GP (generalist input)</td>
<td>7.1</td>
<td>4.9</td>
<td>6.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Social care professional</td>
<td>7.1</td>
<td>3.4</td>
<td>4.9</td>
<td>3.6</td>
<td>16.9</td>
</tr>
<tr>
<td>Nursing professional</td>
<td>5.0</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Pharmacist professional</td>
<td>5.0</td>
<td>3.4</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Therapy professional</td>
<td>7.1</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Mental health worker</td>
<td>7.1</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Third-sector expert</td>
<td>7.1</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Social prescribing link worker</td>
<td>7.1</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
<tr>
<td>Administrator</td>
<td>7.1</td>
<td>4.9</td>
<td>4.9</td>
<td>5.1</td>
<td>16.9</td>
</tr>
</tbody>
</table>

Whole Time Equivalents

- Core MDT team (2024)

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THIS RESULTS IN THE FOLLOWING WORKFORCE REQUIREMENTS TO DELIVER MDT PROFILE: PLACE AND BLMK-LEVEL (2) – CASE-SPECIFIC INPUT FOR MEETINGS

### Extended MDT team (2024)

<table>
<thead>
<tr>
<th>Role</th>
<th>Central Bedfordshire</th>
<th>Bedford</th>
<th>Milton Keynes</th>
<th>Luton</th>
<th>BLMK total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital geriatrician or other acute input</td>
<td>0.169</td>
<td>0.116</td>
<td>0.164</td>
<td>0.122</td>
<td>0.6</td>
</tr>
<tr>
<td>Specialist nurse (e.g. diabetes, COPD)</td>
<td>0.260</td>
<td>0.179</td>
<td>0.252</td>
<td>0.187</td>
<td>0.9</td>
</tr>
<tr>
<td>Palliative care specialist</td>
<td>0.078</td>
<td>0.054</td>
<td>0.076</td>
<td>0.056</td>
<td>0.3</td>
</tr>
<tr>
<td>Housing representative</td>
<td>0.065</td>
<td>0.045</td>
<td>0.063</td>
<td>0.047</td>
<td>0.2</td>
</tr>
<tr>
<td>Police representative</td>
<td>0.039</td>
<td>0.027</td>
<td>0.038</td>
<td>0.028</td>
<td>0.1</td>
</tr>
</tbody>
</table>

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POSSIBLE ACTIVITY AND FINANCIAL BENEFITS FROM THE MDT APPROACH

We have used the (limited) evidence base on MDT-style working for a frail elderly population to calculate the potential benefits in terms of impact on activity and cost, relating to:

- Non-elective (NEL) admission avoidance (including associated A&E visit)
- Avoidance of first outpatient appointment following NEL admission
- Avoidance of follow-up outpatient appointments following NEL admission
- Reduction in ambulance conveyances of NEL admissions

Several important qualifications must be noted:

- These are cautious estimates and take the lower range of benefits from the evidence base
- The benefits set out here focus on NEL admissions, as reflects the evidence base – they therefore do not include wider financial and non-financial benefits relating to improved outcomes, improved experiences of care, and greater professional satisfaction
- The evidence base is not sufficiently detailed to be able to pinpoint benefits related to specific team members’ input – the impact of the additions to the core team made in workshop two was therefore to increase cost but not stretch benefits proportionately
- NHS England does recognise that the usual 1:1 return on investment equation does not stack up in this area – hence additional ‘no-strings’ national investment in MDT models
POSSIBLE ACTIVITY AND FINANCIAL BENEFITS FROM THE MDT APPROACH

Costs and financial benefits in 2024

- Workforce cost in 2024: £11.68m
- Possible financial benefits in 2024: £3.79m