Integrated Care Matters
Preventing and Managing Frailty:
Knowledge Tree Branch
Community liaison service and frailty in acute hospital

Scotland
Cantley, P et al. (2016) Hospital at home as an enhancement to an existing rapid response team in a semirural setting in Scotland. International Journal of Integrated Care, 16(6):A99, pp. 1-8 (Conference abstract)

This conference abstract reports on an example of fully integrated working at ground level. Ring fenced funding from an integrated Health and Social Care Board is reported as the key to its success.

Gardner, J (2015) Development of a rapid access frailty service (Quality Improvement Hub case study)

The aim of this project is to improve outcomes for frail elderly patients by reducing avoidable hospitalisation and supporting patients to be cared for in their own home/communities. This case study reports on results, patient experience, efficiency savings, sustainability and lessons learned.

Health Improvement Scotland ihub (2017) Frailty at the front door (website)

“The aim of this collaborative is to improve the processes of identifying frailty and coordinating care to deliver better experiences and outcomes for people living with frailty. While this specific work is focused on the front door of acute care, it is driven by an approach that recognises the importance of thinking about flow across the whole system. Getting the care pathway right for older people and people living with frailty in acute care has a wider impact on the whole system.”

The Knowledge Network (2017) Hospital at Home (Online resource)

This online resource produced by NHS Education Scotland’s Knowledge Network provides an overview of the Hospital at Home approach, with tools, resources and presentations, including content specific to frailty, such as Hospital at Home: Frailty at their Front Door: Presentation by Dr Angela Wilkinson (2015).

The Knowledge Network (2015) Living well with frailty (Online resource)

Resources from the Living Well With Frailty event which took place on 27th October 2015 and explored good practice in care for people living with frailty.

England
Baillie, L et al. (2014) Care transitions for frail, older people from acute hospital wards within an integrated healthcare system in England: a qualitative case study. International Journal of Integrated Care, 14 (Journal article)

The study aimed to investigate care transitions of frail older people from acute hospital wards to community healthcare or community hospital wards. Findings focus on: care transitions within a vertically integrated healthcare system, interprofessional communication and relationships; patient and family involvement in care transitions.

This report showcases examples of new approaches that are putting integration of care into practice. The case studies included were selected as examples of collaboration between GPs and geriatricians that provide innovative and interesting ideas about the care of older people. The case studies cover three main areas: ageing well and staying well; extending primary and community support; and integrated care in acute settings.

BBC Radio 4 (2017) The State We’re In. In Sickness and in Social Care. (Radio programme)

Dr Kevin Fong reflects back on his own medical career to explore why today’s ageing population is now such a challenge and what’s being done to address the complex needs of older people - “whether it’s discharging them from hospital or trying to support them in the community”.


This paper is a report of a literature review of experimental evidence describing interventions to manage the older adult in the acute care hospital setting. From the 26 papers reviewed, the following conclusions around providing optimal health outcomes for older people admitted to acute care are derived: (1) a team approach to care delivery either directly in a designated unit for older patients or indirectly using gerontological expertise in a consultancy model; (2) targeted assessment techniques to prevent complications; (3) an increased emphasis on discharge planning and (4) enhanced communication between care providers across the care continuum.

NHS (2017) Acute Frailty Network (Online resource)

This online resource includes newsletters, a blog and case studies from English authorities around patient-centred and holistic approaches to frailty.

Pearson, M et al. (2017) Improving Hospital at Home for frail older people: insights from a quality improvement project to achieve change across regional health and social care sectors. BMC Health Services Research, 17 (Open peer review report)

This paper reports on a quality improvement approach in England to change practice in order to deliver a Hospital at Home programme for frail older people, using a Plan-Do-Study-Act (PDSA) cycles model. The benefits of the PDSA model are discussed, including the pace of change it facilitates.


This interview-based study with 42 support workers across England explores the support worker functions in community mental health teams for older adults in relation to roles, boundaries, supervision and training. Results include discussion around the negotiated boundaries of support workers and includes discussion around issues of authority, lack of tailored training, low pay and time pressures.
International Examples

Burns, P.R and Elliott, C (2016) *What are the essential ingredients to successful delivery of integrated care to help keep frail and complex patients well, and out of hospital?* *International Journal of Integrated Care, 16*(6) (Conference abstract)

This conference abstract describes a project that observed successful models of integrated health and social care in Washington, DC and Barcelona to inform the implementation of a multidisciplinary 'neighbourhood team'. Key learning points from international contexts prior to implementation in England are identified.


A review of the current state of knowledge on frailty in the acute care setting, including its prevalence and ability to both predict the occurrence and outcomes of hospitalization. Includes approaches to detection of frailty, prevalence of frailty in acute care, risk of hospitalisation, outcomes of hospitalisation and overview of specific topics including delirium, disability, geriatric trauma, intensive care units, surgery, oncology, cardiovascular disease, chronic kidney disease and medications.


The province of Quebec has made a commitment to improving the quality of care for those with chronic conditions. The goal of the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) is to develop systems and mechanisms which can provide coordinated, efficient and effective services to frail seniors living in the community. The purpose of this report is to provide the context and results of the project to date.

McMaster Health Forum (2016) *Strengthening care for frail older adults in Canada* (Report)

This brief serve as the basis for discussions by the citizen panel on how to strengthen care for frail older adults in Canada. It includes information on the underlying problem; three possible options to address the problem; and potential barriers and facilitators to implement these options.

Robert Wood Johnson Foundation (2011) *Bringing Community Supports to "Invisible" Frail Elders in Manchester, N.H.* (Online article)

Overview of *Community Partnerships for Older Adults*, an eight-year, $28 million national initiative of the Robert Wood Johnson Foundation that supported 16 communities to create collaborative partnerships to address the many gaps and inefficiencies in long-term care and supportive systems for vulnerable older adults in New Hampshire, USA.

Royal College of Psychiatrists (2016) *Integration of care and its impact on older people’s mental health* (Report)

This report on research and evidence around older adults with mental illness and the impact of integration, includes a section on frailty (pp.6-9). It includes overviews of programmes in the USA, Canada, the
Netherlands, France, Italy and the UK, with conditions for success and effectiveness. It also highlights the large body of evidence from the international literature evaluating integrated care for frail older adults.

**Additional Resources**

**King’s Fund (2016) Delivering integrated care for older people with frailty (Videos and pdfs)**

This conference focused on the ways in which integrated care can be delivered for older people with frailty, looking at interactions between acute, primary, community and social care services, older people living with complex co-morbidities and ways in which older people with frailty can be supported to maintain their health and wellbeing.

**National Institute for Health and Care Excellence (2015) Nice Guideline: Older people with social care needs and multiple long-term conditions (Online resource)**

This guideline includes recommendations on: identifying and assessing social care needs; care planning, including the role of the named care coordinator; supporting carers; integrating health and social care planning; delivering care; preventing social isolation; and training health and social care practitioners.

**National Institute for Health and Care Excellence (2015) Nice Guideline: Dementia, disability and frailty in later life – mid-life approaches to delay or prevent onset (Online resource)**

This guideline covers mid-life approaches to delay or prevent the onset of dementia, disability and frailty in later life. The guideline aims to increase the amount of time that people can be independent, healthy and active in later life.

List compiled by [Iris Evidence Search and Summary Service](https://www.irissexs.org).