Population Health Management: Pre-Frailty
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healthwatch
Barking and
Dagenham

Contents

Introduction

This report presents a summary of the findings from 2 workshops run by Healthwatch as a part of the Population Health Pilot in the borough. The aim of these workshops was to design interventions from the bottom up that would prevent the pre-frailty from advancing into actual frailty with these interventions being proposed and designed by the cohort themselves.

Participants were drawn from a cohort of those identified as pre-frail in the borough, and particularly those aged over 50 and diagnosed with hypertension.

The outcomes from these workshops, along with suggestions for improving future levels of engagement, are presented here under thematic headings requested by NHS North East London.

Methodology

The project is based on an inclusive, qualitative methodology which prioritises listening to and drawing out the experiences and perspectives of NHS patients in a pre-frail cohort. The principle research method is the facilitation of two interactive workshops, each lasting around 2.5 hours. The principle aim of the workshops was to gain a rich understanding of the experiences and view of this cohort and the healthcare provision they currently access and would like to access in the future. Ultimately, the focus of each session was on understanding from the user perspective how services are preventing and could better prevent people moving from pre-frailty to frailty. It has a wide-ranging focus aiming to elicit novel and revelatory responses.

Recruitment, Sampling and Generalisability
The workshop brought together participants fitting the definition of pre-frailty to discuss their experiences. Participants were selected using a mixture of purposive and convenience sampling. GPs local to the Borough reached out to a large number of current patients who have a diagnosis connected to pre-frailty – for the most part, this was patients with chronic hypertension. Each GP service called between 30 and 60 people in the days leading up to the workshop, asking if they would be interested in attending, leading to 8 patients attending (5 in session 1, 3 in session 2). Each participant shared that they had at least one current health condition which related to the definition of pre-frailty, with almost all sharing that they have two or more. Whilst participants were not asked to disclose their condition or any medical history and were advised that this was not necessary for the discussion, all chose to share aspects of this at points of the workshops. This is a highly positive sign that people felt comfortable with the research process.

In qualitative data collection, there is often not a clearly defined required sample size: qualitative research is concerned with the richness of data and human experiences shared rather than statistical weightings. In the data and experiences provided by the 8 participants, there are clear commonalities which are indicative of themes and shared experiences across the cohort. Whilst 8 is a relatively low number in comparison to the population size (e.g. everyone with hypertension in the Borough), the evident commonalities emerging allowed the researchers to draw out a strong set of limited findings which are likely representative of many in the pre-frail cohort. In the analysis presented below, caveats are provided to demonstrate any limitations of the data and the tone of the findings is one of occasional caution (e.g. it seems that...) rather than declarative certainty, as expected in this type of community research.

Method: Facilitated Interactive Workshops
It is common for focus groups to be used in community engagement and community research, particularly on areas of broad interest such as healthcare. The principle method used in this piece has much in common with focus groups but aims for greater level of discussion between participants (rather than only between participants and

researchers). The facilitation element of the workshop also places significantly more emphasis on the conditions of discussion, aiming to create a less-formal, more relaxed environment for people to not only feel comfortable in sharing their views and experiences but to enjoy the discussion, too. Community research, in our view, should aim to provide a benefit to participants rather than be entirely extractive.

The interactive workshops are based on principles of inclusive dialogue in which the voice and interests of participants are given outright priority. Whilst there is an overarching structure, there is significant scope provided for participants to lead conversation, open up tangential areas, provide anecdotes, pose their own questions, etc. The facilitators are present to support good, inclusive conversation, mitigate any tensions or unhelpful dynamics and to keep time – the rest is down to the participants. This is a qualitative difference to the traditional focus group and is especially helpful when discussing sensitive topics with people who do not usually speak in public or share personal experiences with strangers.

Distinctively in these two workshops, the patient-participants were joined by a small number of healthcare professionals, mostly GPs. This allowed any medical or NHS-focused questions to be dealt with by experts as and when they arose (e.g. does the NHS have a service for XXXX in the Borough?). It also provided the opportunity for the healthcare professionals to listen first-hand to the perspectives of patients in an environment which was non-transactional and outside of their usual workplace dynamic. The professionals were informed that their role in this would be limited to specific aspects such as asking questions and any other contribution made should be provided as 'patients' rather than representatives of the NHS. The feedback afterwards was that the experience was interesting, new and useful for many of the GPs taking part and helpful to the participants' conversation.

Workshop Flow
The workshops ran in 3 linked phases:

1. Information and icebreaker: people were provided with a clear introduction to the project, key definitions (e.g. pre-frailty), information on people's roles in the room and to the ethos of the project. Participants then took part in an informal icebreaker activity.
2. Exploring people's views and experiences: people were asked to list and discuss the services they access or have accessed and the barriers to accessing these services, prompting wide-ranging discussions of the groups' experiences.
3. Practical activity: people were asked to consider one of the services or approaches they have encountered and develop a logic for how it could better prevent frailty. Participants developed a basic Theory of Change for a specific intervention, proposing an activity or change they would like to see and showing logically how it would help people who are in a pre-frail state to improve their quality of life or healthcare outcomes. These were purposely developed without critique or sense-checking from healthcare professionals, in order to illicit novel and less-restricted responses and avoid statements such as 'well that's not really how it works...'.

Data and Reporting

Two types of data were collected during the workshops. Firstly, the verbal contributions made by participants collected in fieldnotes by researchers and secondly, the written contributions on post-it notes and flipchart paper. This data was then analysed by the researchers, coded into themes and reported in a structure which blends the needs of the NHS-practitioner audience and the ground-up themes from the voice of participants. This is what is presented below.

Summary Findings

The findings in this report are presented in 4 thematic areas as requested by NHS North East London.

1. **Service and Provisions Accessed in the Borough and Barriers to Access**

To set the context for the session and to better understand the needs of the participants in the room, the first interactive activity asked participants to list all of the health provision that they currently access, or have recently accessed. This also served as an effective exercise in steadily opening the group up to dialogue with each other, as all participants use the NHS and related services on a regular basis, and so had this in common.

Participants initially listed lots of primary and secondary NHS provision (there were a couple of passing references in discussion to tertiary care such as overnight stays in hospitals) as shown below:

GP	A&E	999
111	Dentist	Optician
Outpatient clinic	NHS website	Walk in centre

Widening Conceptions of Healthcare Interventions

With some group discussion and facilitator prompting, participants were able to widen their input to include an array of wider preventative and supportive community and voluntary sector provision too. Most of the examples given by participants were still reactive (i.e. in response to an event) and specialised to presenting needs (related to an existing aspects of pre-frailty), but did include some more general preventative activities such as fitness classes or gym attendance. For many, it appeared that this was the first time that they had fully considered the question of what constitutes health provision, providing the opportunity to positively frame their own choices and extant activities and consider the much wider picture of activities which enhance their wellbeing. Examples of the feedback include:

Fitness classes	Gym	Physio
Smoking clinic	Pharmacy	Community sessions

Widening Conceptions of Healthcare Provider

Over the course of the discussion there was also a clear recognition that unpaid carers such as family and friends comprise a critical element of health provision for participants, and in the Borough more generally. Many participants hold the dual role of provider and recipient of unpaid care. Crucially, the discussion in the first session became much richer and relaxed as unpaid care became recognised by the group, including the healthcare professionals in the room, as a legitimate and valued healthcare function. It was highlighted and discussed in the first of the two sessions that greater training for and recognition of unpaid carers could have a range of positive outcomes for both carers and recipients of care. This was especially felt to be the case with the introduction of "novel" terminology, like frailty and pre-frailty, with which the carers and those that they care for are unlikely to be familiar. It was felt that a clear recognition from local statutory services that unpaid carers are a central part in pre-frailty interventions provides an opportunity to highlight and reinforce the value added by this oft-hidden and excluded cohort: a chance to bring them into the fold.

Telephone and Online

Nearly all participants in both groups used the telephone to access and receive services and provision. This was often as a matter of necessity rather than preference, especially with regards to consultations with GPs and clinical specialists – participants were begrudgingly making do with the only option provided. All participants were aware of at least some form of online health content and support, such as the NHS website, but most were reticent to use this and saw it as a minor part of their care. There are close links here to barriers to accessing services, and these were discussed next in the sessions.

Barriers and Hurdles

When asked to list the barriers that they face in accessing, or attempting to access, services and provision, participants responded much more readily and in a greater level of detail than they did in response to being asked which services and provision they use. There was a clear split in how participants in the first session saw barriers with some barriers being seen as being large, almost insurmountable issues whilst others were smaller problems or hold-ups that caused disruption and/or discontent and make accessing services seem harder and less achievable. These latter, smaller, and often recurrent, issues were classified as being hurdles, but it was recognised by participants that repeated hurdles had led to individuals missing out on or opting out of healthcare.

Commonly cited barriers included:

Language	Transport	Systems
Internet access	Waiting times	Work

There was a great deal of crossover between barriers and hurdles in many cases, but where hurdles were discussed, these were often more in the form of personal experience, and often quite emotive. Key examples include:

Repeat prescriptions not working	Notes and files not being shared	Long wait times to book appointments
Long gaps between making an appointment and seeing a GP	Referrals not being made	Not being aware of what is available

Overall, there was a very wide range of both barriers and hurdles discussed and listed in both sessions and additionally there was a good recurrence of the same barriers and hurdles across all participants in both sessions. This, coupled with the already developed levels of understanding of barriers to access in Barking and Dagenham, suggests that the data gathered is reliable and indicative of the wider picture for this cohort of service users.

2. Participant Designed Interventions

The main part of each workshop was participants being asked to design an intervention which they feel would help slow or prevent people who are pre-frail from moving into frailty. To guide participants and to give logical structure to their interventions, they were asked to use a template of a vertical logic model that is based on a single pathway of a Theory of Change. This template can be seen below:

Activity	This is what the new intervention or approach is.
	SO THAT
⬇	What is the first thing that it helps with? EG: - Are you able to see a specialist/GP/any health provider quicker? - Are you physically fitter? - Are you better able to make decisions about your health and lifestyle? - Do you have more information about aging?
	SO THAT
⬇	What is the second thing that changes here in the chain as a result of the below? EG: - Does seeing someone quicker stop health issues deteriorating? - Are your health conditions improving as a result of increased physical fitness? - What are these informed decisions changing? - Do you feel better prepared for aging? - Are you more motivated or bought in?
	SO THAT
⬇	Is there are third (and fourth) thing that happens?
	SO THAT
Aim	People in the pre-frailty cohort are prevented from moving into frailty

By using this model, with a clearly defined aim which was understood by participants, and the prompting of participants with *"So that?"* questions, each group was able to draw a logical link between the intervention that they proposed and the aim of the intervention with key, measurable steps in between. Where possible participants were asked to define what success looked like or how it could be measured at each stage in the logic model.

In all 5 interventions were designed with varying degrees of complexity and detail. From these 5 interventions, 4 are documented here with commentary detailing common linkages between them and other relevant outputs from the workshop. One participant who created an intervention did not wish to present this back to others in the workshop or for it to be shared as it was personal to her. The content of this was very similar to that of Intervention 2 though and so no completely unique data or insights have been omitted.

Intervention 1: The provision of more fitness and hobby clubs

This group acknowledged that there is provision in the borough, such as exercise classes, which can be accessed by everyone, but felt that much of it was not suitable to them personally because of their age, fitness levels and their interests. One participant

commented that she is not excluded from provision in any formal way but that she self-excludes because she would feel uncomfortable in certain situations, such as a spin class.

The group which co-designed this intervention feel that a wider range of activities including hobby clubs, such as sewing and model making, as well as more fitness based provision would help to create a virtuous circle of people doing more, feeling better and then doing even more.

Activity	More age, health and interest appropriate fitness and hobby clubs are run in the borough	
	"So that?"	
⬇	There are more suitable things for pre-frail people in the borough to do.	Measurement: Increased amount of provision
	"So that?"	
⬇	Pre-frail people in the borough get out more and do more	Measurement: Number of activities taken up and time spent moving each day increasing
	"So that?"	
⬇	People feel more confident and improve their physical fitness and continue to do more.	Measurement: Increased confidence, mental and physical health.
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

Intervention 2: Improving access to existing provision and prioritising at risk cohorts.

This group recognised that there is provision that already exists in the borough and that much of this is good and suitable. However, many times this provision is at full capacity and people in the pre-frail group are unable to access it because of barriers.

The specific example from the workshop was of a lady who has had a double knee replacement who would like to regularly take part in a water aerobics class that runs at a local leisure centre. These sessions though fill up very quickly and are typically only available to book online. This lady does not use the internet and so is reliant on what availability is left. This is often none and so she does not take part in the classes and is not managing her knee pain.

This group independently articulated the same virtuous circle as those in Intervention 1, but also felt that it was important that pre-frail people are able to set their own goals. For the individual here this was to be able to play fully with her grandchildren. This would be a big motivating factor for her and something that she could qualitatively assess.

Activity	Improving access to existing provision and prioritising at risk cohorts.	
	"So that?"	
⬇	More provision is prioritised for pre-frail people in a way that they are able to book and access.	Measurement: Being able to book onto classes over the phone or in person and quotas being ring-fenced for those at risk/ in need.
	"So that?"	
⬇	People are able to do more and improve their fitness, pain management and confidence.	Measurement: Physical outcomes, including less reliance on painkillers, and loneliness indicators.
	"So that?"	
⬇	Quality of life improves and people carry on do more of what they want to do	Measurement: Should be defined by the individual as part of an action plan. EG: Being able to play properly with grandchildren
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

Intervention 3: Creation of a single point of access for provision in the Borough.

This intervention recognised that many pre-frail people, including those in the session, often have several and/or complex needs and that accessing several forms of provision through different providers and channels can lead to missed opportunities for interventions and patient drop out.

Much like interventions 1 and 2, this also focusses on increased motivation and subsequent behavioural change, but it aims to bring it about in a slightly different way.

An important, parallel strand, of work emerged from this group in the workshop too around better and more file sharing between hospitals and GPs. A patient needing to repeat their health problems and issues is seen was seen by the group as a significant hurdle to those with several need and so minimising the amount of times that a person needs to tell their story to health professionals would minimise this. It was also felt that this could lead to a better standard of care health professionals will be better briefed and more efficient in using their time with patients.

Activity	Creating a single, user-friendly point of access for patients in the borough	
	"So that?"	
⬇	People have more and better awareness of, provision in the Borough.	Measurement: Increased knowledge of provision including support groups, voluntary sector provision and exercise classes.
	"So that?"	
⬇	People feel empowered to make their own health choices and take up more provision	Measurement: Increased uptake of provision including support groups, voluntary sector provision and exercise classes.
	"So that?"	
⬇	People feel themselves getting healthier and are better able to manage their own conditions	Measurement: Physical and mental health indicators
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

Intervention 4:Greater continuity in provision

This intervention was designed in the second workshop but has a strong overlap with Intervention 3, which was designed in the first workshop. The recurrence of the theme of patient repetition being felt to be problematic is suggestive of this being a widespread issue and cause of patient discontent.

This proposed intervention recognises that one to one care and patients always seeing the same GP or other relevant health professional is not possible. However, where there are smaller at risk cohorts, such as those classed as pre-frail with a number of longer-term and more complex needs, this could be an aspiration. It is felt that by building stronger relationships and having greater continuity in care here that patients will receive better care and be more inclined to access provision when they need it.

Activity	Providing greater continuity of in care for people with long-term, complex conditions	
	"So that?"	
⬇	Patients are, where possible, seen and treated by the same healthcare professionals	Measurement: More and better relationships between the patient and the professional
	"So that?"	
⬇	More continued conversations and more trust between the patient and the professional	Measurement: Less repetition and less dropping out of provision
	"So that?"	
⬇	More confidence and inclination to access healthcare when needed	Measurement: Greater uptake of provision and more early interventions
	"So that?"	
Aim	People in the pre-frailty cohort are prevented or slowed from moving into frailty	

3. Delivering Quality Services and Managing Expectations

In both sessions, there was a wide-ranging discussion between participants, added to by the healthcare professionals in the room, on the distinctiveness of the NHS and the role it can play in contemporary society. This was not a predetermined focus of the workshops or part of the outline structure – it arose somewhat organically and became a useful tangent to the more practical discussion of specific services in the Borough. In order to do justice to the workshops in this report, an overview of this discussion is captured in this short section, providing an indication of the nuance of the discussion around service provision.

At points, the discussion of services and the future of NHS provision pivoted to a wider, background issue of what citizens can and should expect of NHS services. Is it reasonable for people to expect immediate, on-demand services from the NHS? Are prevailing norms from other sectors exacerbating people's frustrations? Are patients asking too much? Are healthcare professionals too busy to care about the journey of individual patients beyond specific transactions?

The first point to note is that there is no fixed conclusion here. The discussion was highly nuanced and not focused on blame or judgement at all. It was felt that many of the issues discussed underpin much of the conversation about on services for pre-frail and frail groups.

Some of the discussion was based around the analogy of popular subscription delivery services such as Amazon Prime and how a society which now relies on these services for consumer goods and a wide range of services in everyday life are perhaps expecting a similar standard of service from the NHS. This was a multi-faceted discussion. For some, the focus was on speed and immediacy of provision: perhaps citizens now expect to access healthcare straightaway because more people can obtain a greater speed of service in other areas of life. A clear commonality between participants was the high degree of frustration with waiting for GP surgeries to answer the phone or waiting times in hospital emergency departments, for example.

Another facet was 'choice'. For many people and in many other areas of life, there are increasing expectations about having a range of options in transactions and being permitted to choose between those for an option that best suits one's needs: bespoke, customised products and services are increasingly the norm in many other areas of life, from the weekly shop to buying insurance. It was suggested by some that people's experience of choice offered in other areas was affecting their expectations of the NHS in a way that was not realistic in the current system, and not desirable for a public service.

Finally, related to both speed and choice, the weight of customers' opinions and perspectives was also felt to have increased in other sectors. People are asked for feedback immediately after online purchases and people's freedom to choose means that they are in the driving seat of consumption. It was suggested that this is increasingly leading to patients demanding a more significant role in dictating what care they receive, what medical interventions are relevant and the terms of their engagement with medical professionals. People's access to Google provides more access to information but not necessarily a more appropriately-informed patient cohort. The example of someone demanding an intervention that was entirely inappropriate for their condition because they had seen it used on television or in popular culture was used for illustration here.

The discussion of the societal factors behind our expectations of the NHS began in one session with the statement from a GP: 'I just think that some patients expect too much: we're not Amazon Prime'. To the facilitators, this felt as much a declaration of personal

frustration as a substantive social commentary. Over the course of a discussion, this statement and others like it were deconstructed and more nuance was brought to the conversation. There was a useful discussion of how, in the experiences of both patients and professionals, the structural challenges in the NHS were preventing them from meeting some of the most basic expectations, such as being able to get an appointment. It was felt by some that expectations for some people used to priority services in other facets of life, were too high. But, more pressingly for the aim of this research, health and social care services were not able to effectively prioritise provision for those soon to be most in need: the frail and pre-frail groups.

The analogy of Amazon Prime came up repeatedly and the difference between Amazon Prime and the NHS was drawn out through the conversation. With a Prime membership, the customer is given priority in exchange for subscription fees – money. In a free-at-point-of-use NHS, money is or should not relevant to the care received. It was felt in both groups that prioritisation should be based on need and vulnerability and for a pre-frail group, prioritisation should be on those factors which, when combined, hinder ones resilience to recover from illness and maintain wellbeing.

The discussion in both groups ultimately turned to the limits of the current healthcare system. These ranged from IT systems not being adept in prioritising care needs to the reliance on digital services not accounting for digital poverty and exclusion. As discussed above, for the pre-frail cohort representative in both groups, these were both significant barriers to preventing frailty.

Ultimately, it was felt that expectations of NHS services are likely to be rising at a time when services are under almost-unprecedented demand. This is a challenging dynamic for the population at large. In relation to this research, though, pre-frail patients and healthcare professionals are subject to similar pressures within the same system. There are some obvious barriers and hurdles to provision that are not related to patients' expectations or healthcare professionals care, they are caused by a structure under significant pressure which, for many of those attending these workshops, was felt to be under-resourced. The preventative measures suggested here, and the many more that could be developed, are likely to save on NHS pressure in the long-term providing the funding can be made available to invest upfront, which is a clear aim of Population Health Management.

One common theme across this discussion was that perhaps the most promising way of overcoming these expectations and services pressures was to have more contact between patients and healthcare professionals, to allow the highlighting of simple interventions that could make a big difference to pre-frail groups and to build understanding between both healthcare professionals and patients in a constructive way.

Conclusion

This report commends the efforts of NHS North East London and the healthcare professionals who gave their time to take part in the workshops and the exercises in them. This, very genuine, enthusiasm for bringing about positive change in the way that healthcare is provided in Barking and Dagenham makes the change that much more likely to happen.

Though this work is only comprised of 2 workshops with a relatively small cohort of participants, broad thematic areas of findings did emerge and Healthwatch recommend that NHS North East London take these into account when planning future engagement and service delivery.

Firstly, participants were able to articulate very clearly the big barriers and smaller hurdles that stop them, or slow them, from accessing healthcare. None of these barriers or hurdles were new, but the consistent articulation of them suggests that they should be taken into account when planning future works. Mitigating for language barriers, a lack of understanding of NHS systems and the online/offline divide will be key to involving patients in planning their own services and consulting with them around these.

Secondly, it is likely no coincidence that 3 of the 4 patient designed interventions independently proposed the creation of a virtuous circle whereby the NHS make it easier people to make positive choices about their healthcare and lifestyle which leads to people doing more and better things for themselves. Kicking off this positive loop should feature prominently in planning in the borough for slowing or stopping the move from pre-frailty to frailty. Similarly, 2 of the 4 participant designed interventions recognise that not all cohorts of patients are the same and call for specialist provision and allocations for those with the greatest need. If building resilience against frailty is a health priority in the borough, then prioritising and working with those in danger of becoming frail is an obvious first step.

Finally, though the desire to engage with patients and to have them playing an active role in designing health interventions in the borough is both admirable and genuine, there are challenges in getting patients around the table to engage. It is hoped, and recommended, that the suggestions for widening engagement listed in Section 4 of this report are acted upon. Building grassroots engagement from scratch, or a very low level, is a huge task and, where possible, NHS North East London should look to work with trusted community, voluntary and faith sector groups to reach patients and residents in as wide a variety of ways as is possible and practicable.

Recommendations on Future Engagements

The level of engagement of participants in the two sessions was very good and the support from local GPs was excellent in both. The number of people recruited was, however, lower than was hoped or expected. This may, in part, be due to both unseasonably warm weather and the on-going risks and fears associated with Covid-19.

Therefore, Healthwatch make the following practical suggestions to increase engagement in future, similar events:

- Widening the cohort beyond those aged over 50 and with hypertension. People with other indicators of pre-frailty could also be included so as to widen the pool of potential recruits.
- Running engagements at different times of the day could be explored. Both of the sessions in this work were run in the early evening on a weekday and this may exclude people with caring responsibilities, certain work patterns or those who do not feel safe in later in the day.
- Tagging future engagement sessions onto existing provision or events should be explored. One participant in the second session suggested that attendance may have been negatively impacted by a Zumba class that runs nearby at a similar time and so running an engagement session at the same venue as the Zumba class but directly after may widen uptake.
- Participants could be incentivised to take part, or have their travel costs refunded to them. For participants too, being made aware that they will be able to spend time face to face with their GP in the sessions could be a good incentive for them to take part. If GPs continue to play an active role, then this aspect could be used in recruitment and promotion.
- Anecdotally, the participants in the session held at the GP surgery appeared more comfortable in the environment than those at the Learning Centre. This may be related to familiarity with the venue. It may be that holding the engagements in venues which participants are not familiar with and comfortable in creates a barrier to attending.
- The approach to the ethos of the workshops appears to have been a significant factor in the richness of data created. The focus in future ventures should remain on discussion in a comfortable, enjoyable, participant-led environment facilitated under the ethos of inclusive dialogue.