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**Health Equity Fellowship Project Progress Report.**

## Introduction

This project, through the Health Equity Fellowship, has provided an opportunity to make positive efforts towards improving Health Inequalities through Nimbuscare - the Organisation I work as part of. Nimbuscare is an Organisation providing Health and Care services to patients across the City of York and throughout North Yorkshire, including Urgent Care, Diagnostics and Frailty Services.

When looking for opportunities to make a positive impact and improve upon Health Inequalities I found it challenging to obtain full practice data sets regarding frailty and I have been unable to find an accurate figure of the total number of people living with frailty in the city.

Within this progress report I will outline the project to date, providing an overview of the theoretical understandings of frailty and its link with Health Inequalities, and the frailty service provision from the York Integrated Community Team (YICT), provided by Nimbuscare.

## Aim and Objectives

The central aim of this project is to enhance understanding of the number of patients living with frailty in York by working to obtain data that reflects the full range of frailty present within the city. This project also aims to improve data accuracy, with the objective of using this data to better support patient care and inform future healthcare strategies regarding frailty and an ageing population.

Key objectives within this project include:

- To identify and understand the current reality of frailty seen within Primary Care through GP practices. We aim to achieve this by collating the codes used within patient records for frailty identification.
- To create/adapt templates to ensure consistent coding of frailty across healthcare settings.
- To embed a coding system to analyse and quantify the number of frail patients effectively.

## Frailty

Frailty can be defined as "how our bodies gradually lose their in-built reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment. In medicine, frailty defines the group of older people who are at highest risk of adverse outcomes such as falls, disability, admission to hospital, or the need for long-term care" (Young, J, 2013). [i] Within frailty 'resilience' describes a patient's ability to bounce back from an incident or a setback, such as those stated above. When this occurs, it can be more difficult for those with frailty to recover and return to a baseline level of activity or independence, and in some cases, it can result in their frailty worsening. This continued decline in health and increased care needs in those living with frailty has a significant impact on health and social care systems.

There are multiple tools used to identify and stratify an individual's level of frailty. A tool utilised for assessment is the Electronic Frailty Index (eFI). Which uses patient record data to automatically calculate a score to identify if an individual is likely to be experiencing a degree of frailty (NHS, No Date a). Another commonly used tool for this identification is the Rockwood Clinical Frailty Score (RCFS). This enables clinicians to assess and record an individual's degree and severity of frailty, incorporating multiple contributing factors (the levels of frailty from 1 - 9 can be seen in Figure 1.). A patient's score can help clinical and social care teams assess and identify patients with further needs, adapting and providing care appropriate to an individual.

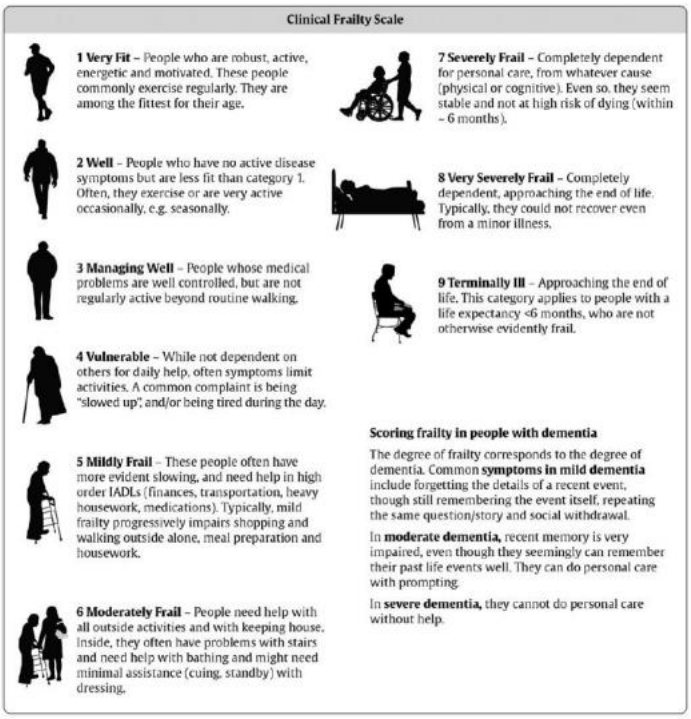


Figure 1.Clinical frailty scale. Adapted with permission from Moorhouse P, Rockwood K. Frailty and its quantitative clinical evaluation R Coll Physicians Edinb. 2012;42:333-340.

Source: NHS (No Date b)

Estimates suggest that there are 1.8 million people in England aged over 60 living with frailty (NIHR 2017), whilst the BMA (2018) state that 50% of people over 65 years old in England experience mild to severe frailty. Within the City of York, it has been difficult to obtain accurate figures on the number of patients living with frailty. Currently we only have estimated figures which are extrapolated from the number of patient suffering falls. As discussed above tools such as the RCFS can be used when patients are assessed by clinical teams. If this data was able to be collated for the city as a whole, it could potentially give us a greater understanding of total number of people living with frailty in our locality, and the level of severity of frailty in these patients.

Nimbuscare works across 11 independent member practices within York, it is therefore important to ensure recording of frailty data is relative and comparable between these practices. A singular identification and documentation process, recording the severity and number of patients living with frailty ideally needs to be implemented. Identification of these patients living with frailty could then enable improvements in targeting of care and service provision through YICT, to those most at need.

YICT provide frailty services to patients across the city of York which is accessible through self-referral or referral from another Health Care Professional. Patients are managed within a multidisciplinary team including GPs, Nurses, Dieticians, Social Prescribers, Physiotherapists, Occupational Therapists and Carers, who link with the voluntary sector such as Age UK, to provide care for patients within their service. YICT aims to provide patient centred individualised care with an anticipatory focus, completing a comprehensive geriatric assessment, helping to reduce hospital admissions and maintain patient independence at home holistically by reducing the impact of stressors on patient resilience.

In frailty theory stressors are factors which can negatively impact a patient's health causing decline or reduce levels of independence. The Social Determinants of Health model

described by Dahlgren and Whitehead (1991) explains how multiple factors including socioeconomic, cultural and environment aspects play a role in people's health (Figure 2.), all of these factors could potentially become a stressor for a patient living with frailty and should be assessed holistically in services targeted at those living with frailty such YICT.

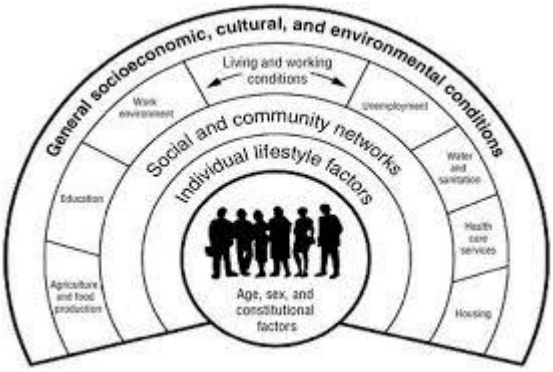


Figure 2: Dahlgren and Whitehead (1991)

**Methodology**

This project intended to use a mixed methodology to obtain information using an explanatory sequential design (Creswell, J, 2014). Using this research method has allowed me to research theoretical understanding of frailty and health inequalities whilst also looking at the ways in which practice coding takes place to understand the number of patients experiencing frailty.

As of February 2025, this project is currently in the qualitative research method stage where I am in contact with stakeholders to obtain the clinical coding used by each practice to record frailty. Through contacting all GP Practices in York to obtain their clinical coding used to identify a patient as frail, I identified that many practices are using practice templates to record frailty. I hope that by identifying the codes used I can take steps towards appropriate data-sharing agreements that would allow clinical searches to take place to ascertain the total number of patients coded as 'frail'. I then intend to use the process set out below to progress this project.

1. Interviews with key Frailty Leads to understand coding of Frail patients within their practice (Establish the specific codes used).
2. Data Sharing Agreements drawn up and put in place with York GP Practices.
3. SystmOne report created to identify all patients with specific frailty coding on their patient record and the area they live in. This data will be pseudonomised.
4. Pseudonomised data is compared with YICT registered patient list.
5. Data analysis to take place to consolidate findings.

**Result to date and conclusion**

This project is still in progress as we work towards creating a comprehensive data set of those living with frailty. However, there is visible impact that the work of YICT is strengthening patients' resilience. This is achieved through their holistic approach which includes reducing health inequalities, such as ensuring appropriate referrals and support for mobility issues, and social care.

An unexpected but valuable result of this project so far is the connections it has enabled. By researching this topic area, I have engaged with professionals and experts within Primary Care and the Integrated Care Board. Initially, I was unaware of existing efforts to improve frailty data collection across York and North Yorkshire, but since undertaking this project I have become aware of initiatives and projects seeking to address this gap. I have also had the opportunity to gain understanding of current data collection projects through the York Integrated Care Board. These connections have broadened my understanding and awareness of this topic and how I can build upon complimentary initiatives to deliver similar aims, working to address data gaps. This has created space for collaboration within this topic area.

Another result of this project has been gained through the development of an equity and access plan for Nimbuscare. By researching health inequalities, useful information has been gathered and informed the equity and access plan for our patients. A particular area which has proved useful has been *Health Inequality Theory and the Social Determinants of Health* as our equity and access plan looks to make considerations from this model for the many services Nimbuscare provides for the variety of patients we consult with. This learning has inspired all services to be reviewed under the lens of Health Inequalities. A real-life example of this has been seen recently following a review of accessibility for Nimbuscare services, where a need for patient transport was identified due to limited transport links. Following this Nimbuscare have worked with an existing provider to offer transport for patients who require it, to clinical sites from their home.

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