Health & Independent Living Support

Community Frailty Interventions

www.hils-uk.org

HILS Services

Support at Home

- Meals on wheels
- Tea and breakfast packs
- Pop-in visits
- Nutrition & Wellbeing service
- Active Ageing home-based exercise
- Key safe installation
- Advocacy (older people)

Crisis Support

- Food bank on wheels
- Emergency food for day centres and residential care homes
- Home from hospital packs
- Free meals on hospital discharge or Hospital at Home

Support for Groups

- Food for groups
- Food for day and residential care
- Room hire
- Small charity support
- Nutrition Awareness Training

Community Activities

- Health and Wellbeing hubs Lunch clubs
- 10-2 clubs
- Group exercise sessions (chair-based and strength and balance)
- Dementia fun clubs

HILS Impact – 2024-2025

Over
18,000
people supported through over
2.1 million
caring interventions

1 million
hot meals & desserts, teas, and breakfasts delivered to over
11,300
people, 365 days of the year, come rain or shine!

Over 4,300
nutrition & wellbeing interventions delivered to help people maintain weight, and stay healthy

34,500
lunch club meals provided to
3,100
people at community groups

Over 3,800
one-to one **exercise sessions** delivered to
691 Active Ageing clients

Over 12,000
visits to our community hubs
by 260
people across Hertfordshire

Over
3,100
food and grocery packs delivered to people leaving hospital, or in financial difficulty

Over
3,700
interventions delivered by our Advocacy team

Over
1,800
Pop-in visits made to check people are safe and well

617
care home staff trained by our Nutrition Awareness Team

HILS services that tackle frailty

The Problem

Frailty is driving increasing demand across primary care, urgent care, community services, social care and unpaid carers.

HILS' solution

HILS services target and address:

- Malnutrition
- Deconditioning
- Dementia
- Social isolation
- Short-term and long-term

Frailty services

- Meals on wheels
- Nutrition and Wellbeing service
- Active Ageing – Exercise at Home
- Crisis intervention support
- Nutrition Awareness service (care homes)
- Dementia fun clubs
- Community hubs day services

HILS provides community-based frailty infrastructure and resilience, delivering evidenced, measurable outcomes, across nutrition, falls prevention, independence and discharge support.

Meals on wheels

The problem

- Only ~15% of Local Authorities in England commission a meals on wheels service
- Alongside the demographic shift, there are more people living with unmet care needs
- Home care and unpaid carers are often unable to provide appropriate food and hydration support

The cohort

- People who are unable to meet their own food needs due to frailty, disability, lack of support network, temporary ill health or crisis
- c.11,000 meals on wheels clients annually
- Average age – 87
- 32% of clients have no family or friend support
- 74% of clients have a mental or physical impairment (including poor mobility, at risk from falls, have dementia, or are confused)
- 30% have a visual, hearing, or speech impairment that affects daily life

The intervention

- 365-day service; same-day response
- Hot meals, desserts, tea and breakfast packs *(c.1 million per annum)*
- Daily wellbeing checks – environmental, social, physical and mental changes
- Cross referral to NHS, social care, VCFSE partners for preventative or crisis support

Service aims:

Increasing independence; prolonging time living at home; reduction in need for social care; reduction in GP visits; reduction in malnutrition; admission avoidance; improved quality of life; reduced carer breakdown.

HILS impact on health & wellbeing

96%

of meals clients say that they feel happier as a result of their meals service

1 in 10

over 65s in the UK are malnourished

Frailty costs the UK healthcare system **£5.8 billion** per year

98%

of meals clients tell us they feel **better nourished**

86%

of meals clients say they were able to **recover more quickly**, following a period of ill health or personal difficulty

92%

of meals clients tell us they **feel healthier**

HILS impact on independence

93%

of meals clients tell us that they **feel more independent** as a result of their meals service

90%

of older people want to remain in their own home

98%

of meals clients tell us that the **service has reduced their need for other help** and support (e.g. care visits)

Needing help with just one 'Activity of Daily Living' **doubles the risk** of a nursing home placement

83%

Of meals clients tell us they were able to recover more quickly from a period of ill-health or difficulty as a result of the service

97%

of meals clients tell us they feel more secure knowing someone will check that they are okay


Nutrition
and
Wellbeing

The problem

- Malnutrition as a primary and secondary factor for hospital admission is rising
- Unintended weight loss is a key factor in frailty
- Public Health's national focus is on obesity
- Misinformation abounds on eating and drinking well, and in particular in older age

The cohort

- Meals on wheels clients who are losing weight unintentionally
- Clients receiving the two-week 'enhanced' hospital discharge meals on wheels service, particularly those who have lost weight during a hospital stay
- Meals on wheels clients who have nutrition or hydration concerns
- Clients in HILS dementia clubs and community hubs

Service aims

- To reduce avoidable malnutrition; improve understanding of nutrition and hydration

The intervention

- Home visiting service to provide holistic screening:
  - malnutrition risk (MUST)
  - determining concerns around sight, hearing, falls risk, mobility, chewing/eating difficulties, continence, mental health, and social-wellbeing
  - nutrition guidance; menu personalisation
  - food fortification and free food boosts
  - onward referral if needed (NHS SALT, Bladder and Bowel service, dietetics etc)
- Telephone screening/ support service based on the Patient Association Nutrition Checklist
- Input from HILS nutritionist or dietitian

HILS Impact on malnutrition

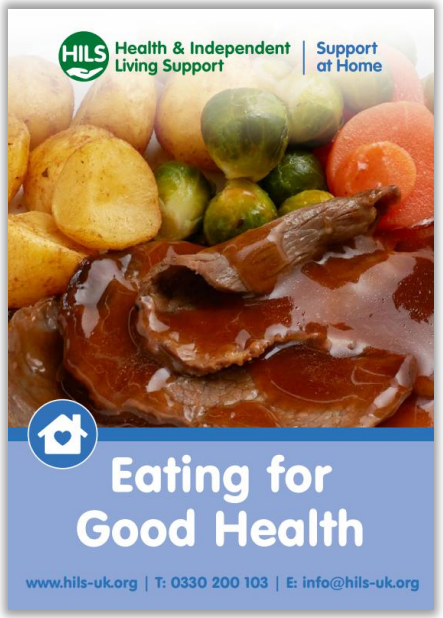
Academic evaluation

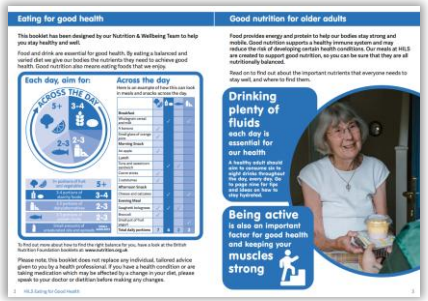
(Cohort 399 meals on wheels clients; intervention – Nutrition and Wellbeing screening, advice, support))

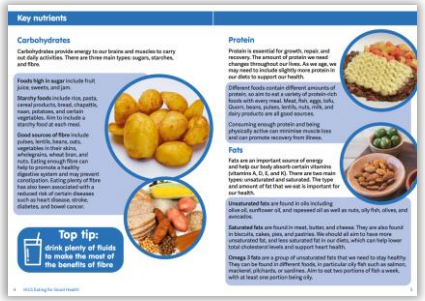
Initial screening revealed:

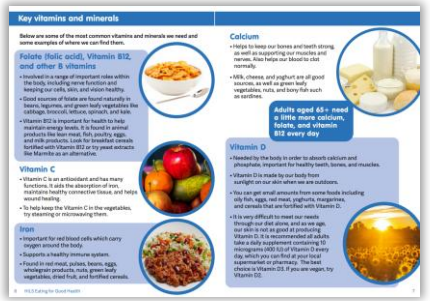
- 26% of clients were at medium (12%) or high (14%) risk of malnutrition utilising the MUST tool
- 10% had previously been prescribed ONS
- 75% were deemed to be frail (utilising PRISMA 7 & grip-strength measurement tool)
- 20% were lonely
- Frailty was significantly related to malnutrition risk (p=0.049).
- Those at low risk of malnutrition were significantly more likely to report an incontinence concern than those at high risk (p=0.037).

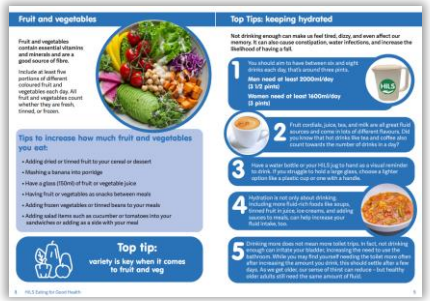
At rescreening (3 and 6 month) results revealed:
Nutritional status remained stable or improved for 88% of clients who were malnourished, or at high risk, as a result of the interventions, including no longer needed oral nutritional supplements.

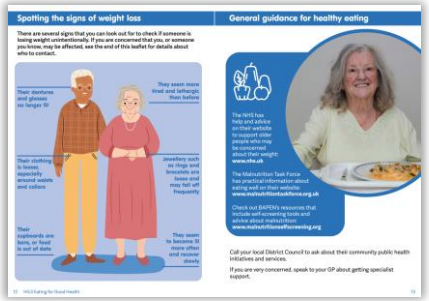













Active
Ageing:
Exercise
at Home

Service aims:

Improved strength and balance; increased mobility/activity; reduction in likelihood of falls; increased confidence and quality of life

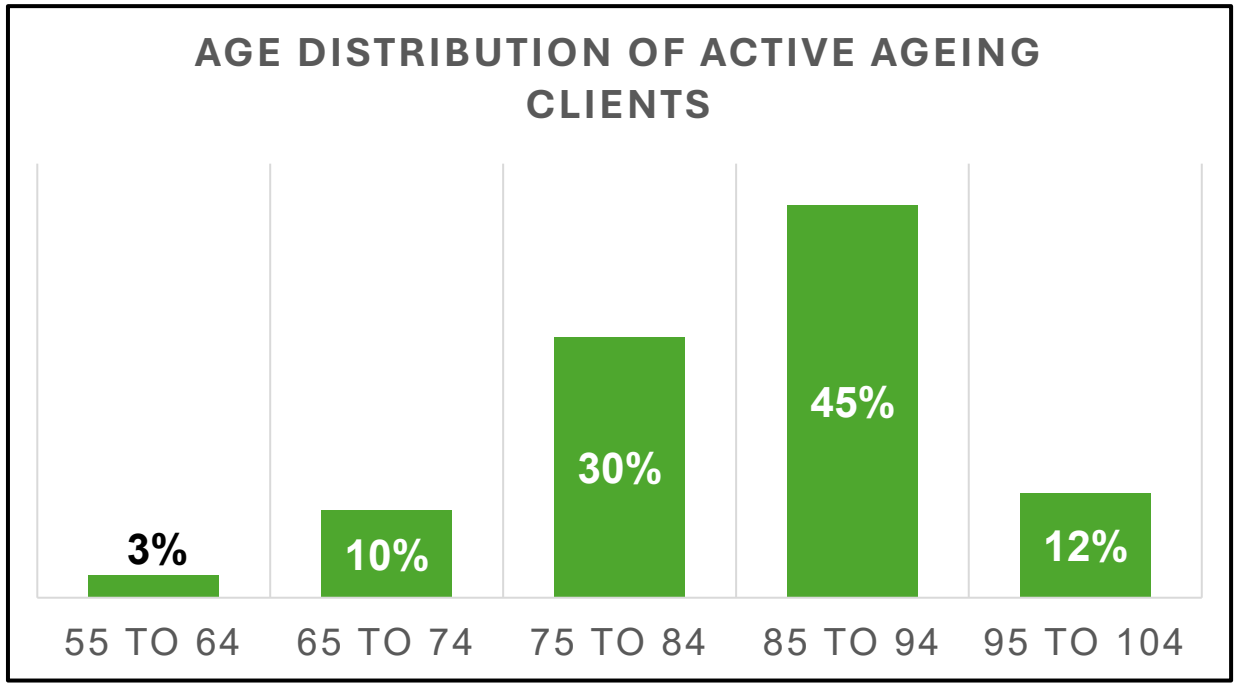
Programme:

- Eight-week personalised, goal focused, strength and balance or chair-based exercise at home
- One hour per week - sessions tailored to the needs of participants and personalised outcomes
- Can support stroke-recovery, specific conditions (Parkinson's, MS), dementia (with carer), reablement

Evaluating falls and frailty

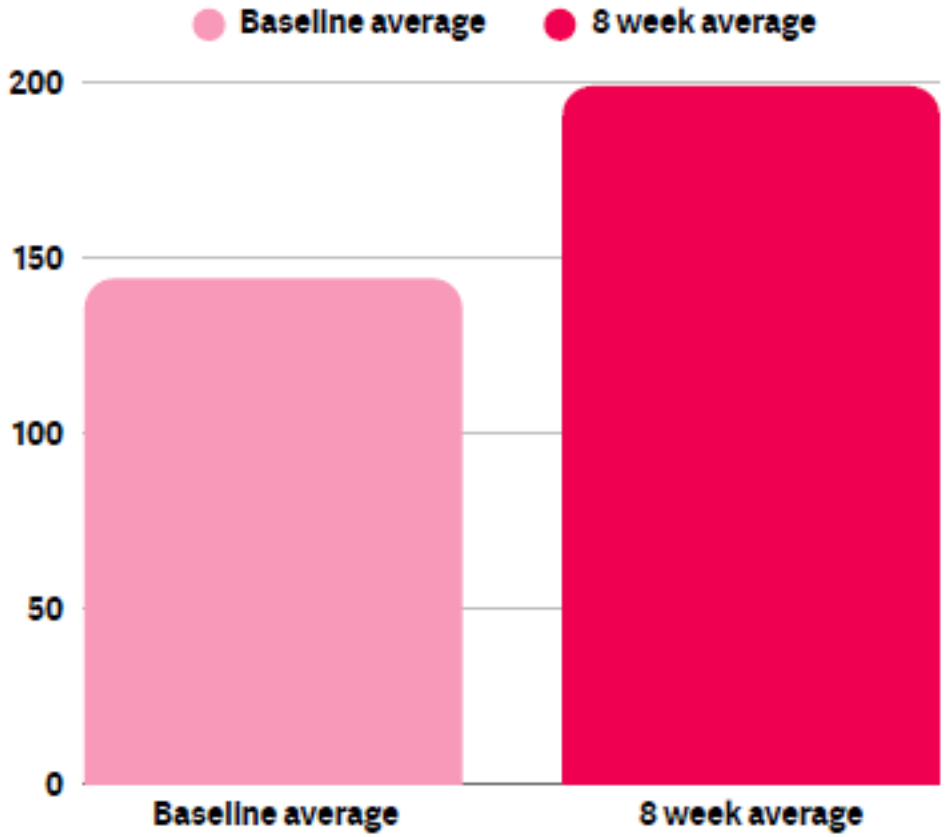
- The programme is targeted at older people who are frail, at risk of falls, and homebound.
- Individual progress is evaluated at week one, eight, and six months after completion.
- Evaluation tools include: Berg Balance, FRAT, Rockwood (CFS), PRISMA, ONS Wellbeing.
- Public Health Hertfordshire evaluation showed service led to significant reduction in the use of social care:

https://www.hertshealthevidence.org/documents/epi-content/hils-active-ageing-use-of-adult-social-care-services.html)



Exercise regularity

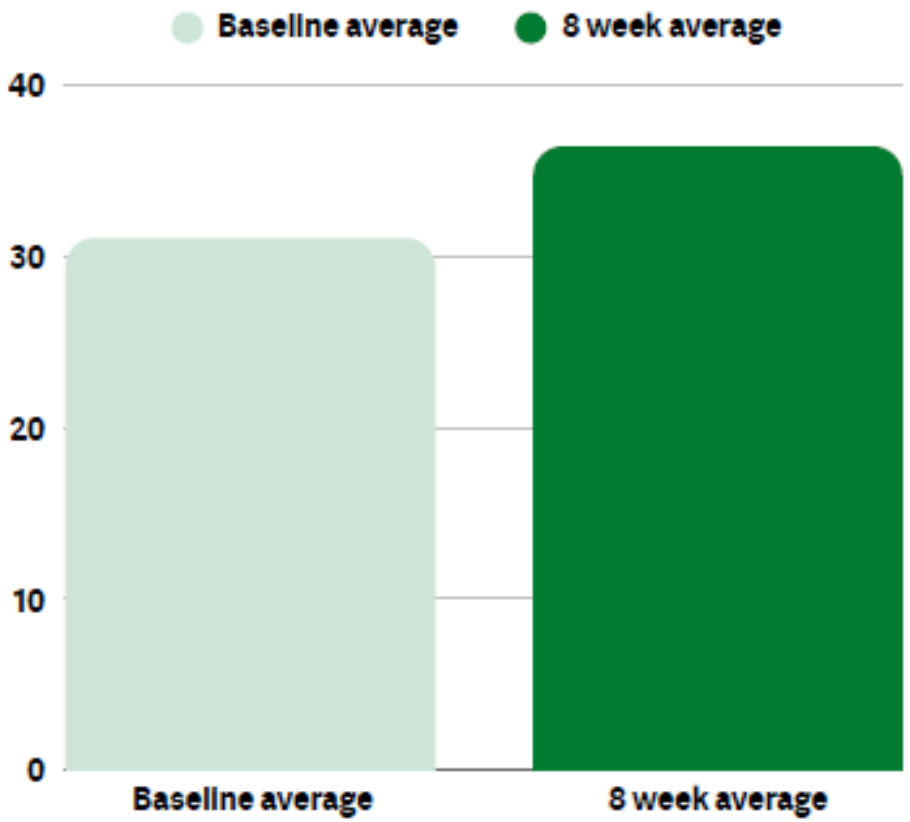
- The programme aims to increase exercise and activity long term.
- Personal goal setting and motivational techniques help build confidence in undertaking tasks of daily living and mobilising inside and outside the home.
- The majority of Active Ageing clients increase their activity levels and undertake more exercise by week eight of the programme and beyond.



Increase in minutes of exercise per week taken as an average of participants from baseline to eight weeks.

Improvement in balance

- The programme is designed to improve balance and reduce the likelihood of falls.
- Although there is a wide spectrum of ability (due to the age and health of participants), the majority of participants show significant improvements in balance, and in confidence in undertaking activities of daily living.



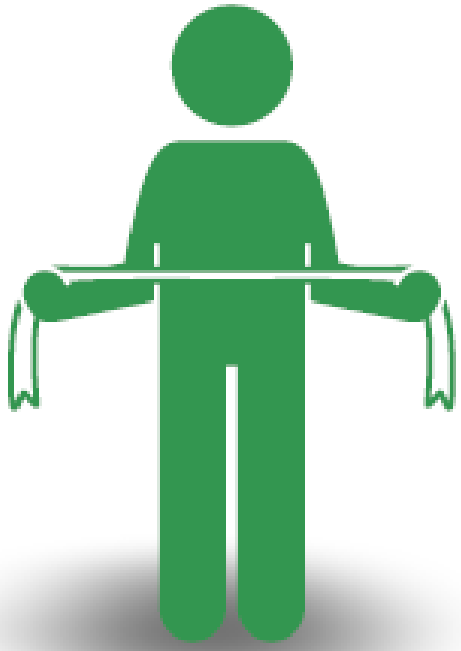
Berg Balance score increase taken as an average of participants from baseline to eight weeks.

General health and mobility

Change after eight weeks

72%

of Active Ageing clients say their **general health has improved**



79%

of Active Ageing clients say their **mobility has improved**

Sustained impact

6 months after completion:

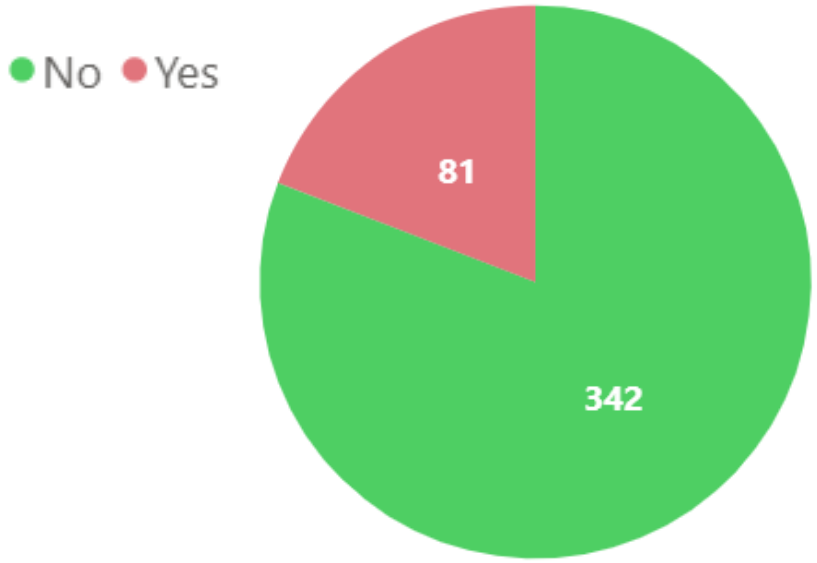
82%

are continuing **to undertake impactful exercise**

78%

continue to see an **improvement in their ability to undertake day-to-day tasks**

Falls following programme completion



Client feedback

In our Active Ageing service:

98% of respondents said that **they enjoyed** the Active Ageing programme.

98% of respondents said that **they were motivated and inspired** by their instructor

Active Ageing Net Promoter Score (NPS):

78%

**An NPS over 70% is considered world class*

Reduction in falls

- Average age of clients evaluated is 83
- HILS has evaluated 2,280 clients who received support through the Active Ageing programme
- Of these, 58% (1,320 clients) fully completed the programme
- 81% of Active Ageing clients report having had no falls 6 months after programme completion
- This equates to 1,070 clients having had falls prevented as a result of the programme

Crisis support

- Food bank on wheels
- Emergency food for day centres and residential care homes
- Home from hospital food packs
- Two weeks of free meals on hospital discharge or whilst in Hospital at Home / virtual wards

Post-hospital support

Regaining independence post-hospital

How do we support people leaving hospital?

Two weeks of free meals on wheels* (including Tea & Breakfast Packs) upon discharge, ensuring that people are well-nourished in the crucial window of recovery after returning home.

Free 'Home from Hospital' grocery packs* containing three days worth of essential groceries - preventing people coming home to empty cupboards.

If a referral is received before 8.30am, HILS will deliver a meal the same day, supporting speedier discharge.

59,527
free meals, teas, and breakfasts delivered to people leaving hospital

2,265
people supported with two weeks of free meals

HILS' frailty model - system partnership

HILS' prevention model within the health and care system

HILS' cost-effective holistic early intervention model is an integral part of Hertfordshire's health and care system:

- It both prevents and addresses malnutrition, falls, frailty, memory loss, and isolation by supporting clients and carers to manage their own health improvement and maintenance

- It supports co-ordinated care for frail people across the system including waiting well, hospital discharge, reablement, and Hospital at Home/ virtual hospital, reducing demand for statutory services

- 18,000+ people supported in 24-25
  11,300+ meals clients
  4,300+ nutrition interventions
  3,800+ exercise sessions

Why has HILS' model been effective?

- Support is personalised around clients' needs and outcomes.
- HILS is independent and trusted, reducing fears about loss of independence and control.
- Continuous service evaluation, improvement and development cycle
- Hertfordshire County Council, Public Health Hertfordshire, Hertfordshire Community NHS Trust, and the Better Care Fund have supported HILS' preventative model, research, innovation, and service development.

What is needed to expand provision across the ICB?

- Commitment to develop and fund evidenced VCFSE services across the ICB, including HILS'.
- Partnership approach to developing services (e.g. utilising existing infrastructure).
- Data sharing - Evidence of cost avoidance within the NHS is currently based on client-reported outcomes. Further evidence requires sharing of NHS data or capacity to undertake the analysis using HILS' data.

Opportunities to increase impact – system support

- **Polypharmacy** – spotting stockpiling and reporting for community pharmacist or GP review
- **Advance Care Planning** – trusted intermediary to provide opening conversation/ reassurance
- **Additional reablement support** – Nutrition and Active Ageing interventions targeted at frail leaving hospital
- **Prevention of admission** – targeted meals and Nutrition and Wellbeing support whilst on virtual wards
- **Waiting well** – nutrition/exercise prior to admission
- **Care closer to home** – support with blood pressure testing/ non-clinical tasks or interventions
- **Earlier frailty identification** – data sharing - FRAT, CFS
- **Pathway and system integration** – further opportunities across the VCFSE
- **HILS wider services** – Pop-in visits (visual checks for system partners), medication reminders, Advocacy, dementia clubs and community hubs etc


Any questions
or thoughts?
HILS