Enhanced Care for Older People Learning Session One

Lynne Shaw
Strategic Workforce Development Lead
October 2021

Housekeeping

- Please ensure microphones are muted and during presentation cameras are turned off.
- If you have any questions throughout the session then please use the chat facility. We will attempt to address questions, if we can't then we will follow up after the event.
- The event will be recorded and shared.
- The webinar recording and presentation will be circulated and uploaded on to the website following the event.
- If you need to take a break at any time throughout the session please feel free to do so.

Session Aim & Linked Competencies

Aim:

To develop an understanding of frailty, the needs and care associated with it and the approach taken across the north-east and north Cumbria to promote healthy ageing and develop and deliver relevant care.

Linked EnCOP Domains:

Domain A: Values, Attitudes and Ethics
Domain B1: Inter-professional and inter-organisational working and communication
Domain C1: Leading, organising and managing care
Domain C2: Improving Care
Domain 2.1: Frailty - Understanding, Identification and recognition
Domain D2.2: Assessing, planning, implementing and evaluating care
Domain D2.3: Ageing well - Promoting and supporting holistic health and wellbeing
Domain D2.4: Ageing well - Promoting and supporting independence and autonomy
Domain: 2.5: Physical health in Frailty

Living with Frailty
it's all about our people!

Dan Cowie
Clinical Lead, North East and North Cumbria Ageing Well Network
October 2021

Introduction

- Ageing is evitable, but poor health and wellbeing because of ageing is not.
- The personal and societal consequences of unhealthy-ageing are all too evident.
- There is no typical older person. The diversity seen in older age is not random, marked inequalities and inequity exist and can contribute.
- Older people are the greatest (+ growing) consumers of H&C services.
- We could all potentially live longer, better at home, if we start to think differently about ‘healthy-ageing’ and offer ‘age-friendly’ services
- Over the last 3 years the NE&NC Ageing Well network, a partnership between the NHS and Academic Health Science Network [AHSN] has embraced collective thinking, learning and sharing around older people.

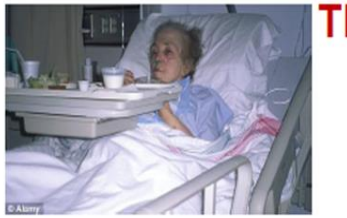
What and where is Frailty?

NHS England has defined frailty as

'a progressive, long term health condition characterised by a loss of physical and/or cognitive resilience'

" I know it when I see it but what I see may not be the same as what everyone else sees"

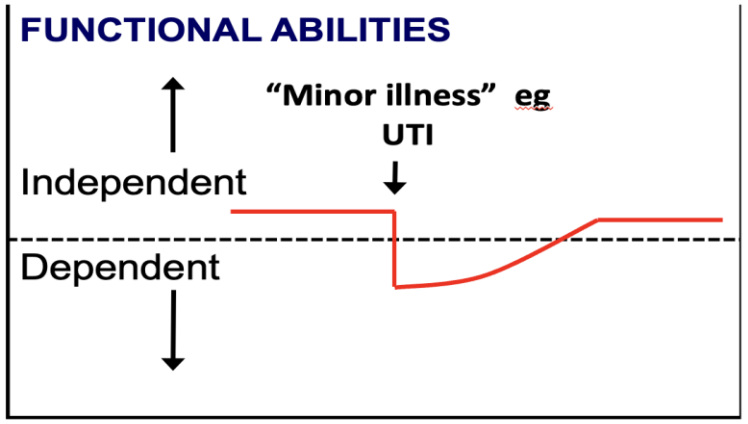
Community dwelling adults aged 65+ = 7% - 12%
Community dwelling adults aged 85+ = 25% - 50%



The Frailty Paradox
Not recognised
Not diagnosed
Not recorded

Chen, X, Genxiang, M, Sean X (2014) Frailty Syndrome: an overview. Clinical Interventions in Aging 2014:9 433–441

Frailty syndromes present in crisis



Hyper-acute Frailty syndromes:

- Immobility
- Falls
- Delirium
- Fluctuating disability
- Incontinence

(Clegg, Young, Rockwood Lancet 2013)

What does Frailty mean to the individual?

Frailty can be described as a 'collection of modifiable health and social needs'. For the individual with frailty, it goes beyond physical health and includes psychological, social, environmental domains

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What is Healthy Ageing?

The **World Health Organization** definition:

'It is the process of developing and maintaining the functional ability that enables wellbeing in older age'

Functional ability is an interaction between *intrinsic capacity* (e.g. physical and mental) and *environmental characteristics* (e.g. home, community and society) to enable people to be and do what they value

Tackling the challenge through different 'lens'

The National NHS Ageing Well Lens

The three elements of the Ageing Well Programme

Urgent Community Response

2 hour standard for UCR, **2 day standard** for reablement and a **single point of access** for UCR utilising 111

Enhanced Health in Care Homes

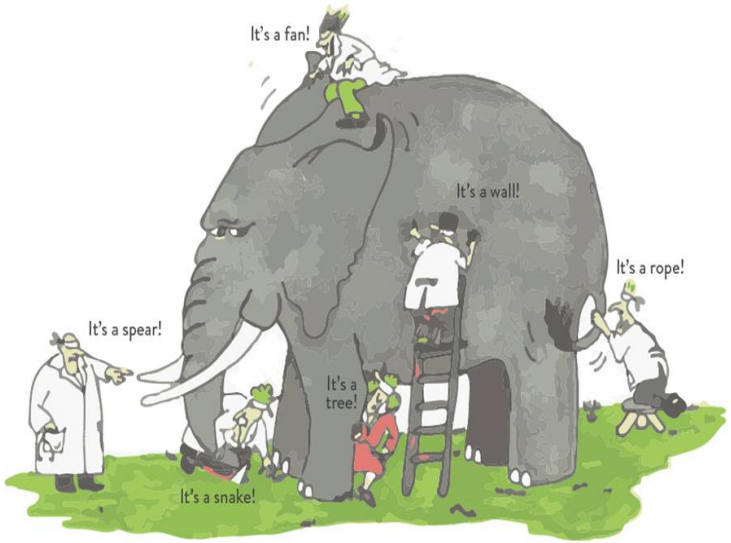
Enhanced support & better co-ordinated care, **reablement** and **rehabilitation**

Anticipatory Care

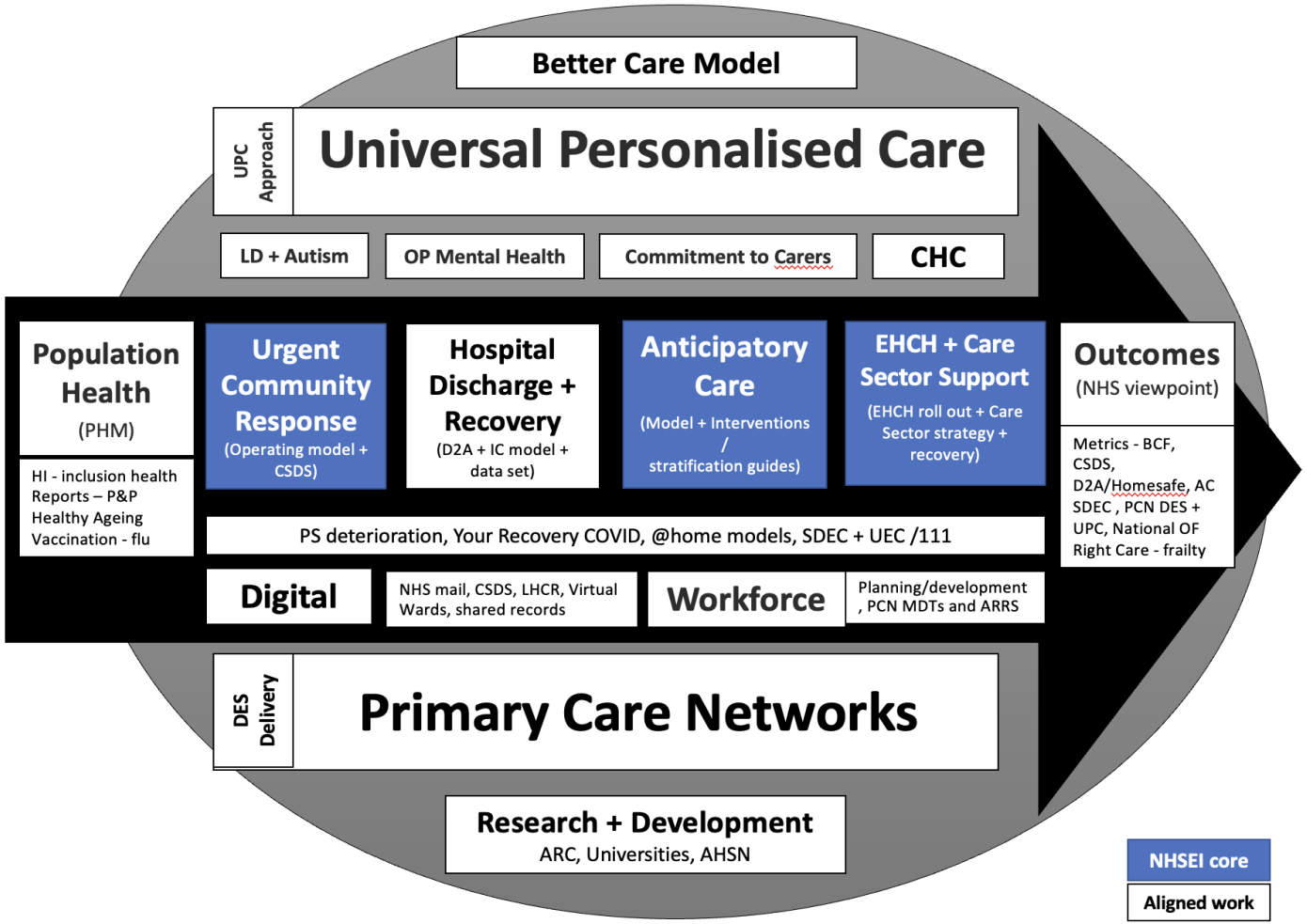
Helping people with **complex needs stay healthy** and functionally able

The bigger picture lens

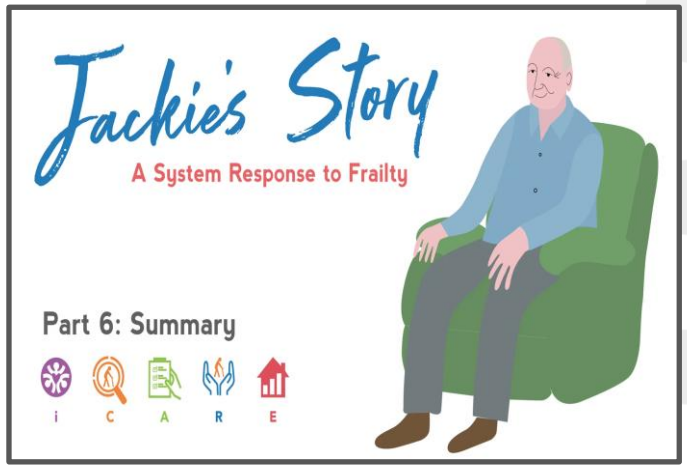
(supporting people to see the 'whole' elephant)



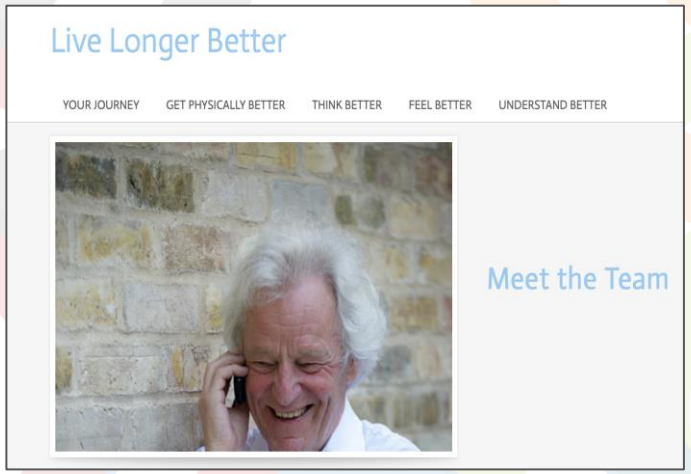
What do you see?



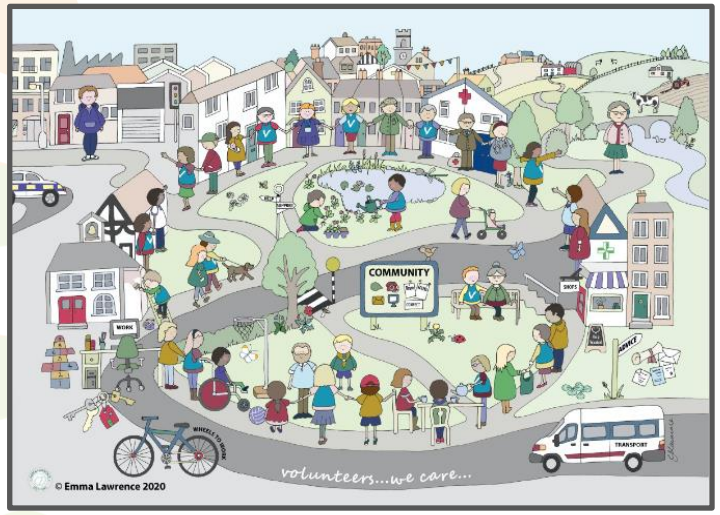
But …. it's all about the people and communities!



Life course approach - https://www.jackiesstory.co.uk/



Live Longer Better Website - https://www.livelongerbetter.net/about-muir-gray.html



Centre for Ageing Better: State of Ageing in 2020 (UK snapshot) - https://ageing-better.org.uk/state-of-ageing-20

Jackie's Story

A System Response to Frailty

How should we support people living with frailty?

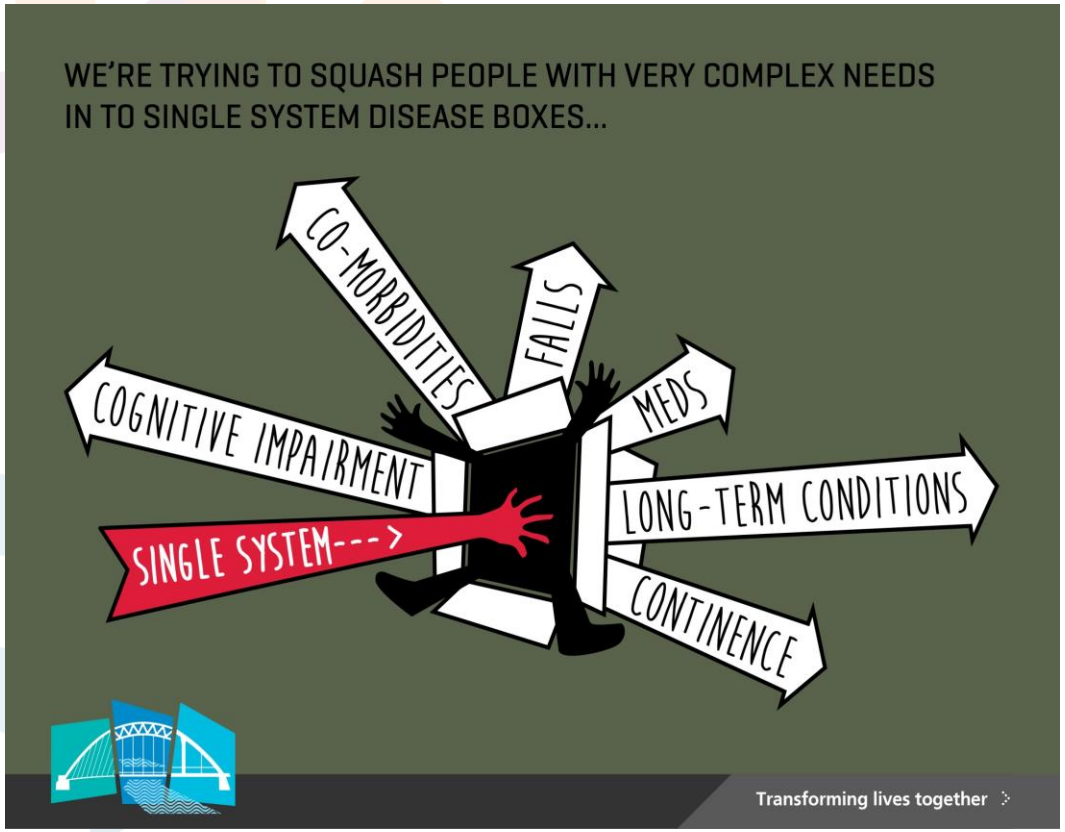
A New Care Paradigm for Older People Living with Frailty

NHS England

TODAY	TOMORROW
'The Frail Elderly' (i.e. a label)	"An older person living with frailty" (i.e. a long-term condition)
Presentation late & in crisis (e.g. delirium, falls, immobility)	Timely identification for preventative, proactive care by personalised care and support planning
Hospital-based: episodic, disruptive & disjointed	Community-based, person centred, co-ordinated care & support

www.england.nhs.uk

With thanks to John Young[45]



North-East and North Cumbria Ageing Well Network - *what are we doing?*

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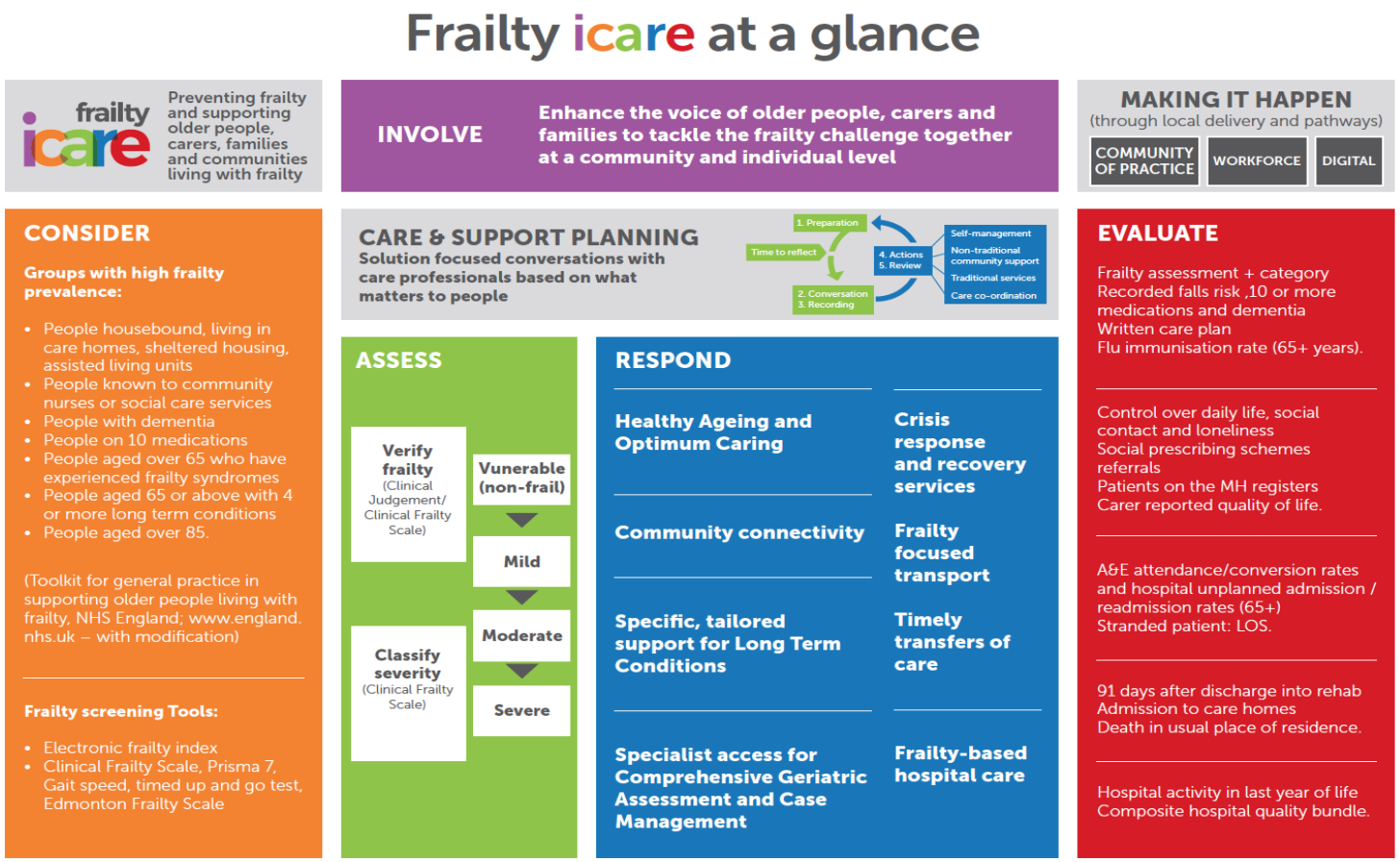
We need….

WHOLE SYSTEMS THINKING

To make sense of Ageing Well and frailty through the lens of different audiences, to shape conversations and relationships that will deliver for local people and communities!

The ‘Ageing Well Network’

- An ICS programme
- NHS and AHSN led
- Covers NE & NC ICS geography
- Fortnightly steering group
- Bi-monthly Community of Practice
- Collaboration, collaboration!!!



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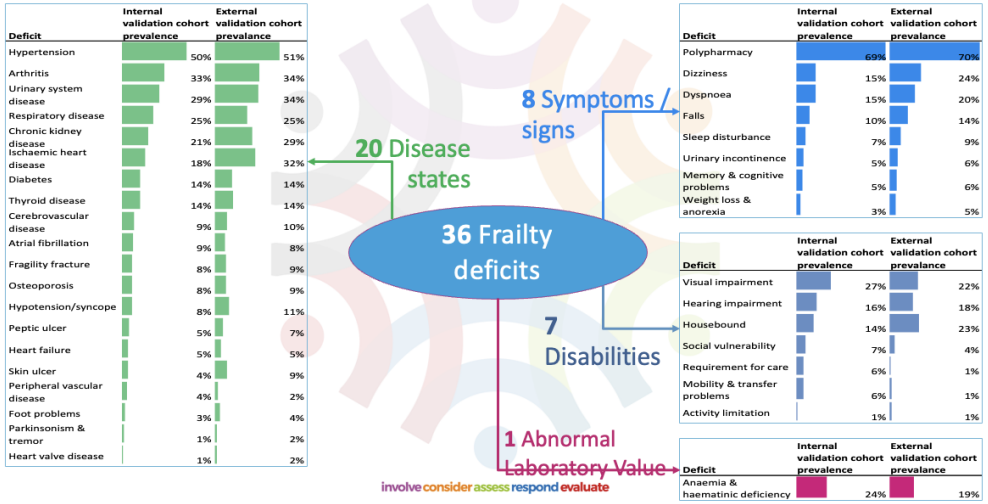
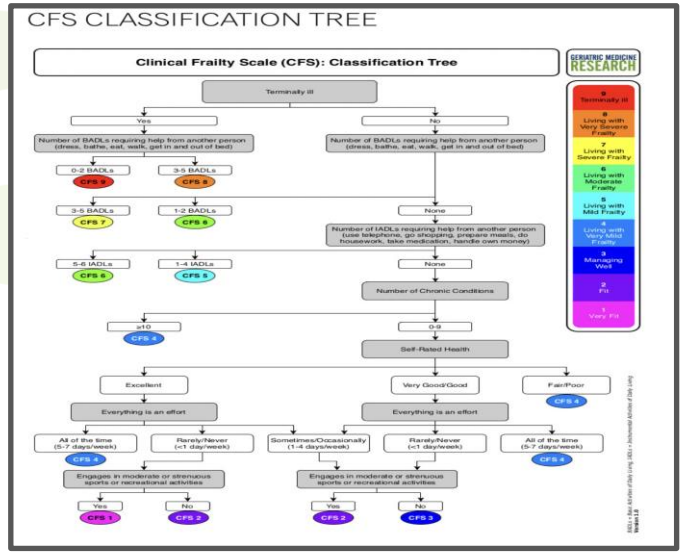
http://frailtyicare.org.uk

eFI and Clinical Frailty Scale

- **eFI**
  - Population screening (36 deficits)
- **CSF**
  - Modifications in 2020
  - Classification TREE – experienced users

Deficits that make up the eFI



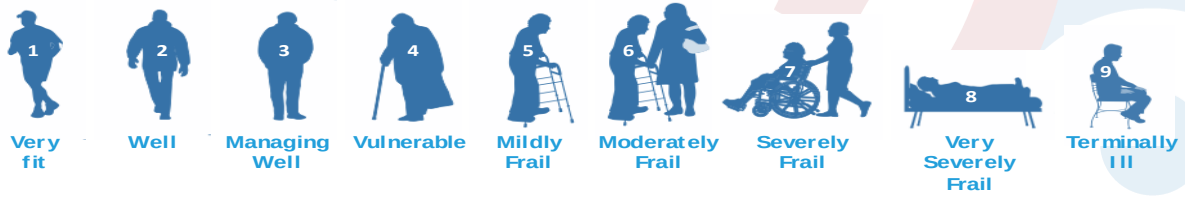


Confirming and classifying Frailty

John

Mike

Barbara



Category	Factors to consider	John	Barbara	Mike
1. Very Fit	• Robust, active, energetic and motivated. • Exercise regularly. • Among the fittest for their age.	√ √ √		
2. Well	• No active disease symptoms • Less fit than category 1. • Active but less regularly e.g. seasonally.			
3. Managing Well	• Medical problems well controlled • Not regularly active beyond routine walking.			
4. Vulnerable	• Not dependent on others for daily help. • Symptoms limit activities. • Complain of "slowing up", being tired during the day. • Rate their health as no better than "fair". • Families and friends note some withdrawal e.g. needing encouragement to go to social activities. • Memory problems may begin to impact on function (e.g. have to look up familiar recipes, misplace documents) but usually do not meet dementia criteria.			√ √ √ √ √
5. Mild frailty	• More evident slowing • Need help in high order Instrumental activities of daily living (IADLs) e.g., finances, transportation, heavy housework, medications. • Impairs shopping and walking outside alone, meal preparation and housework. • Several illnesses, and take several medications. • May exhibit mild dementia (e.g., remember recent event but forget details, ask same question, or tell same story several times a day) • Social withdrawal.		√ √ √ √	
6. Moderate frailty	• Need help with all outside activities and with keeping house. • Problems with stairs • Need help with bathing • Minimal assistance (cuing, standby) with dressing.		√ √ √	
7. Severe frailty	• Completely dependent for personal care, from whatever cause (physical or cognitive). • Seem stable and not at high risk of dying (within ~ 6 months).			
8. Very severe frailty	• Completely dependent • Approaching the end of life. • Could not recover even from a minor illness.			
9. Terminally Ill	• Life expectancy <6 months. • Not otherwise evidently frail.			

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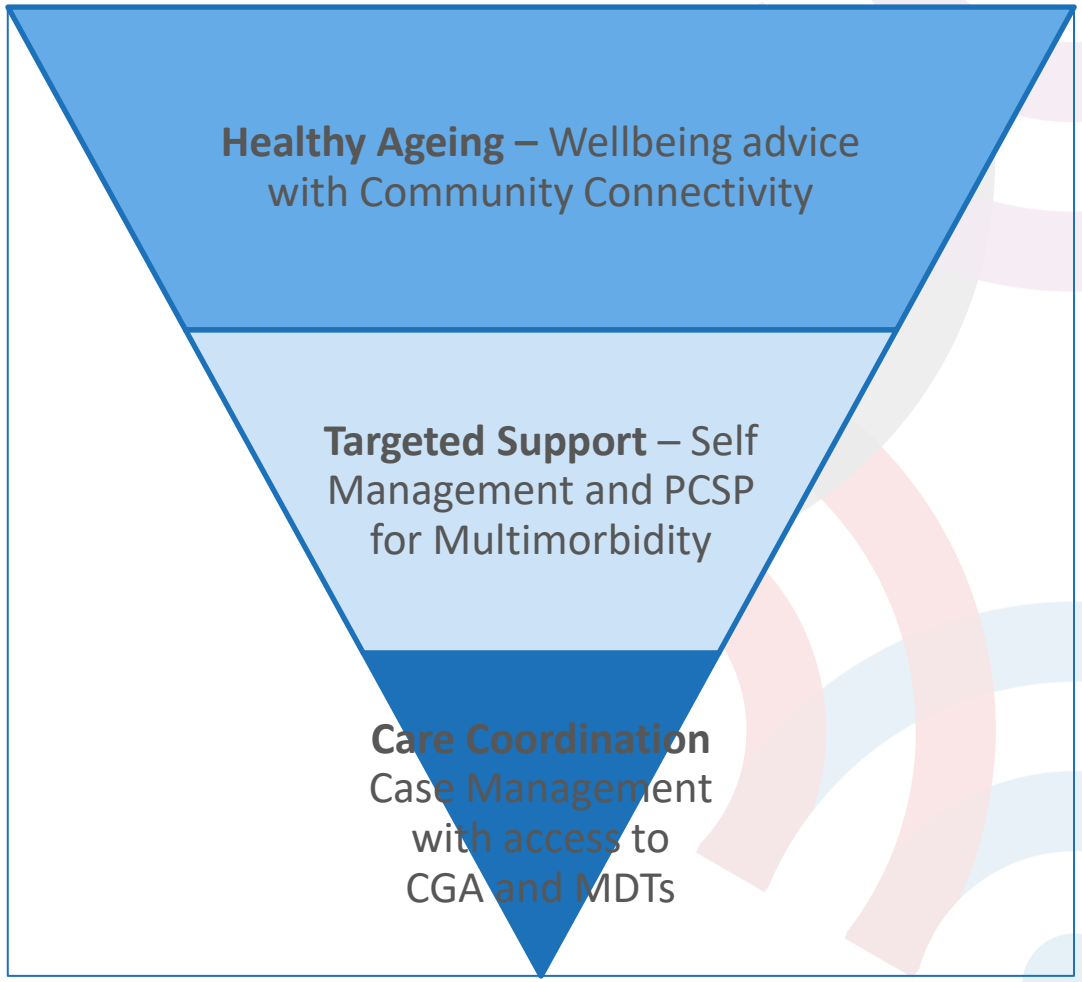
RESPONDING

Personalised Ageing Well
(shared decisions, choice and what matters)



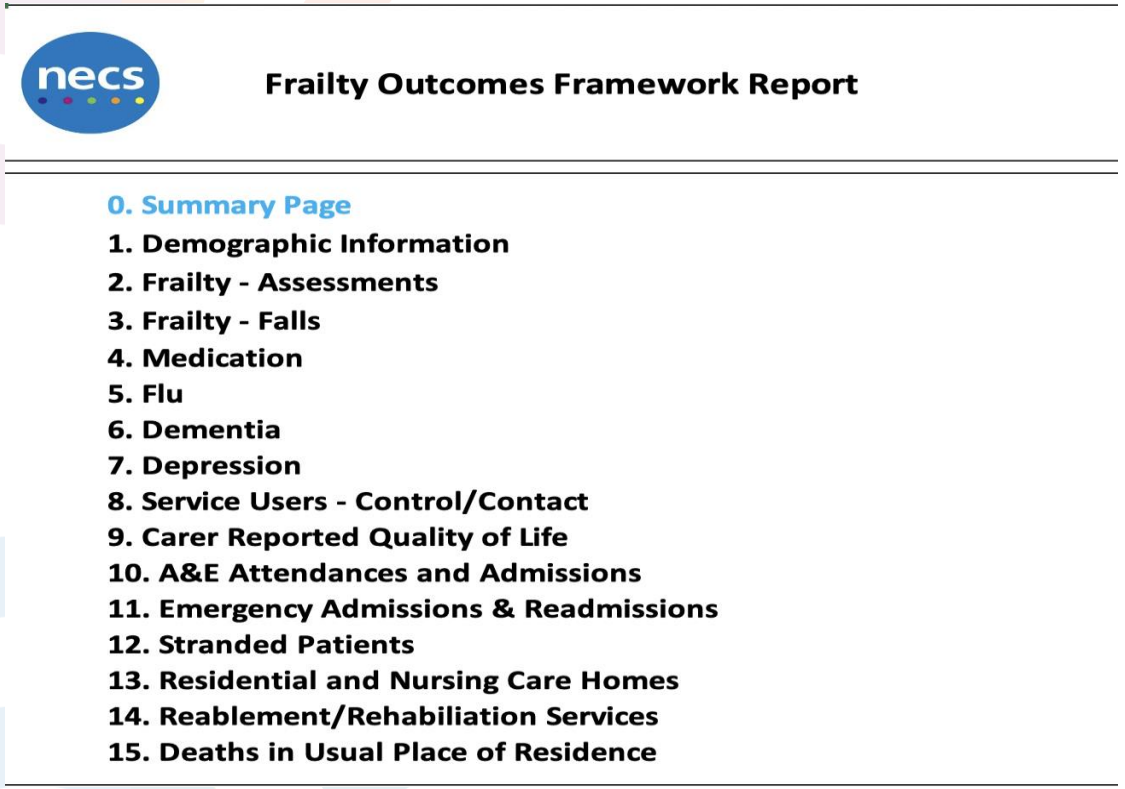
EVALUATE

Improved wellbeing and activation with healthy behaviors, independent living and social connectivity e.g. PAM

Improved access to services, notably in times of crisis and transition e.g. CSDS

Improved experience of those receiving as well as offering services e.g. ASCOF

Improved value through timely and appropriate use of services e.g. Acute Activity



Collaboratively shaping the older person's narrative!

Leadership – connecting, pulling and distributed

Subsidiarity – Primacy of Place

Navigating complexity – audiences and language

Collaboration Commitment – cultural shift to real partnerships

Large Scale Change – want to, polarities, incremental change, lots of lots

Evidence led-decision making – evaluating complexity, local intelligence

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''If relationships were an Intervention, NICE would mandate them''

Regional Projects

frailty icare	**A toolkit and website** with resources, information and updates on regional projects
Jackie's Story	**An infographic** of a real life journey of a person through the different stages of frailty
EnCOP	**A workforce development strategy** across the whole care system, from essential care to specialist and advanced level practice.
	Creating **i-CGA (digital)** tool to help facilitate the CGA process and aid interdisciplinary working
	**Outcomes Framework** 23 metrics at regional, ICP and PCN level. Close working with BI/ PHM
	**R&D** – working with ARC and universities on a number of research projects
	Bimonthly, cross-sectional **Community of Practice** – learning and sharing best practice and resources

ICP Projects

South ICP
MDTs roll out and frailty front door

Central ICP
Loneliness and Pre-frailty

Ageing Well projects

North ICP
Strength and Balance Training

North Cumbria ICP
Risking Profiling and UCR Demand

Supporting people, teams and technology at work

Royal College of Nursing

'Whatever care setting you work in, you will be regularly caring for older people with a diverse set of needs, which in turn require diverse expertise'.

https://www.rcn.org.uk/clinical-topics/older-people

EnCOP Competency Record Name: Place of Work:	Essential Level		Specialist Level		Advanced Level	
	Staff Member Initial & Date	Assessor Initial & Date	Staff Member Initial & Date	Assessor Initial & Date	Staff Member Initial & Date	Assessor Initial & Date
Domain A: Values, Attitudes and Ethics						
Domain B1: Inter-professional and inter-organisational working and communication						
Domain B2: Teaching, learning and supporting competence development						
Domain C1: Leading, organising and managing care						
Domain C2: Improving Care						
Domain D1: Communication with older people, families and friends						
Domain 2.1: Frailty - Understanding, Identification and recognition						
Domain D2.2: Assessing, planning, implementing and evaluating care						
Domain D2.3: Ageing well - Promoting and supporting holistic health and wellbeing						
Domain D2.4: Ageing well - Promoting and supporting independence and autonomy						
Domain: 2.5: Physical health in Frailty						
D2.5.1 Physical health in frailty: Falls prevention and management						
D2.5.2 Physical health in frailty: Promotion of continence and prevention and management of incontinence						
D2.5.3 Physical health in frailty: Risk assessment, prevention and management of malnutrition and dehydration						
D2.5.4 Physical health in frailty: Pain						
D2.5.6 Physical health in frailty: Skin Health						
Domain D2.6: Pharmacology						
Domain D3: Management of Dementia						
Domain D4: Management of mental health						
Domain D5: End of life care						

Final Competency Level Achieved	Essential (tick)	Specialist (tick)	Advanced (tick)
All			
Partial			
None / Not Appropriate			

Date all required EnCOP competencies achieved :	Signed Staff Member Date:	Signed Assessor Date:

http://frailtyicare.org.uk/making-it-happen/workforce/

https://www.youtube.com/watch?v=YpD2m7IqNp4

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… an Ageing Well professional

Breakfast

- Meet the PCN neighbourhood team to discuss ‘priority’ for the week

Morning

- Healthy Ageing / Community Connectivity session / drop –in with Social Prescriber and Health Coach

Lunch

- Catch up with Local Health Watch, Older Person’s Assembly
- Home visiting / advice with Urgent Community Response team

Afternoon

- Multimorbidity Clinic with frailty nurses
- Community MDT for people with increasing frailty

End of the Day

- Ageing Well review of data, intelligence and outcomes. Planning for the future needs

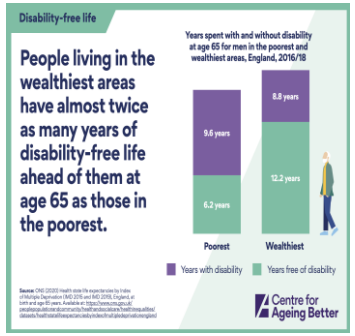
Evening

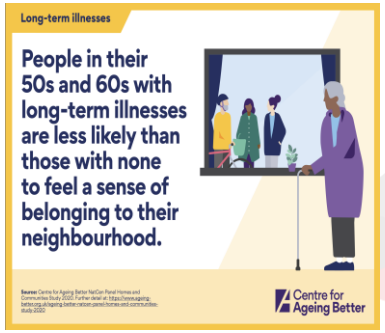
- Some wellbeing, professional development and learning

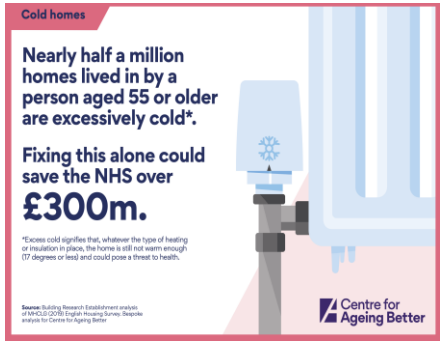
JOIN US

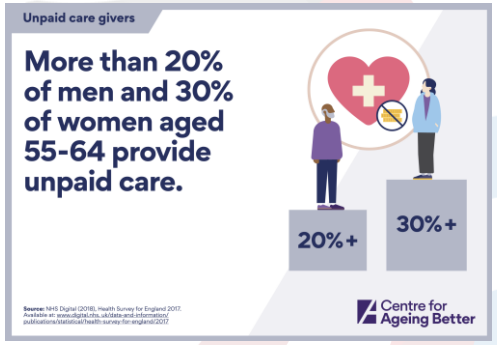
We are on the path to a future of ageing badly

It's ALWAYS time to learn and share, especially now!









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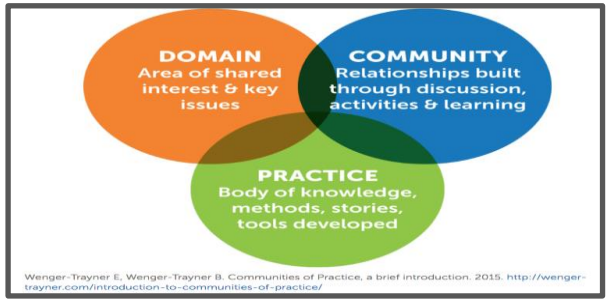
https://ageing-better.org.uk/summary-state-ageing-2020



Ageing Well Community of Practice
http://frailtyicare.org.uk/making-it-happen/community-of-practice/

COVID-19

- **Disability debt, risk of falling and admissions/trauma -** https://www.frontiersin.org/articles/10.3389/fpsyg.2020.565052/full
- ***2021 - The year of Reconditioning* -** https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(21)00003-9/fulltext
- ***The Deconditioning Pandemic* -** https://blogs.bmj.com/bmj/2020/06/15/covid-19-will-be-followed-by-a-deconditioning-pandemic/
- **Physical and mental health, loneliness and isolation -** https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf

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Thanks


why
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QUESTIONS
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Poll: Your thoughts about today's session

Was it easy to book onto the session? Yes / No

Did you find the session went well in this online format ? Yes / No

Was the content of the session relevant to your area of practice / job role? Yes / No

Did you enjoy the session? Yes / No (any comments in the chat please)

Thinking about future webinar's, which topics linked to older person's care would you be most interested in? Please put any suggestions in the chat.

[More information can be found within the Frailty icare website]

[www.frailtyicare.org]

Our EnCOP pages are located in the workforce section

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Ideas for Learning Consolidation & Competency Conclusion

Consolidating Learning:

Reflection on the session & considering application to practice & what this means 'your people'

- Think about this session in relation to your own role
- How much of this was revision?
- What have you learned today ?
- How will this help you in your role ?
- Think about your EnCOP self–assessment; consider which performance indicators this session may relate to and how this can be used as part of your own development / competency achievement.

Competency Domains:
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Website Page and Contact Details

- **Website:** http://frailtyicare.org.uk/making-it-happen/workforce/enhanced-care-of-older-people-with-complex-needs-encop-competency-framework/

- **Email:** Email: **ghnt.encop@nhs.net**