Outcomes and Metrics: without data we're just another person with an opinion

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NEQOS

Background

- Produce a ‘regional outcomes framework’ for frailty

- Frailty-related suite of validated measures
  - 81 metrics in long list to 23 in final short list
  - Taken from across the health and social care system
  - Baseline / current position is presented
  - Best reflection of the broad recommendations of the framework
  - Represent impact at a person, community and local system level

- Are the metrics chosen the right ones?

Regional Frailty Community of Practice report

- Collaborative work between NEQOS and NECS
- Two parts: main report and supporting (technical) document

- Data presentation and style of report
  - One metric per page
  - Limited narrative
  - Range of chart types
- ‘Front-line friendly’
- Further development required as the work evolves

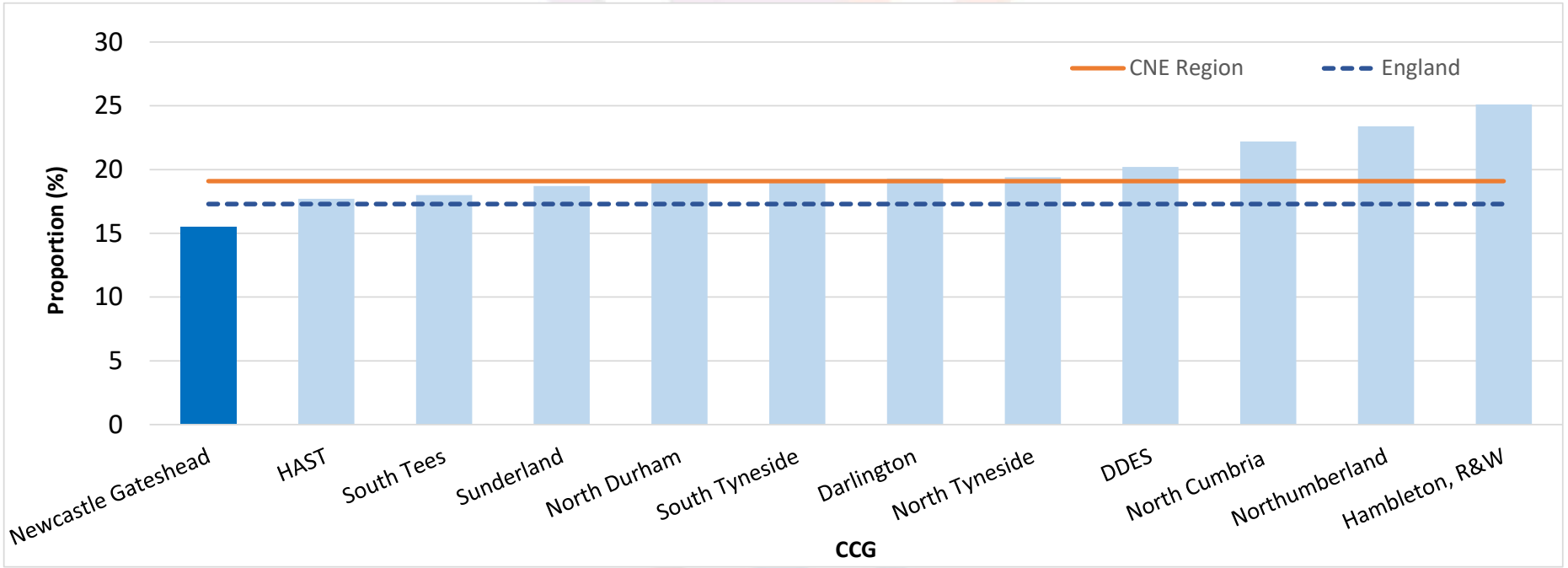
For consideration……

- This is the **first draft**, based on the metrics chosen by regional and national experts
- Metric presentation is at CCG, LA or hospital Trust level
- Lower level reporting is possible where the data is available
  - Agreed definitions required
  - Supporting information table
  - Some metrics may be a proxy
- Metrics absent from the first report draft
  - Prevention (smoking, physical activity, housing status)
- Inclusion of local data collections is possible
  - Adequate benchmarking or targets to consider?
- Need for more qualitative patient / service user / staff feedback not just quantitative data?

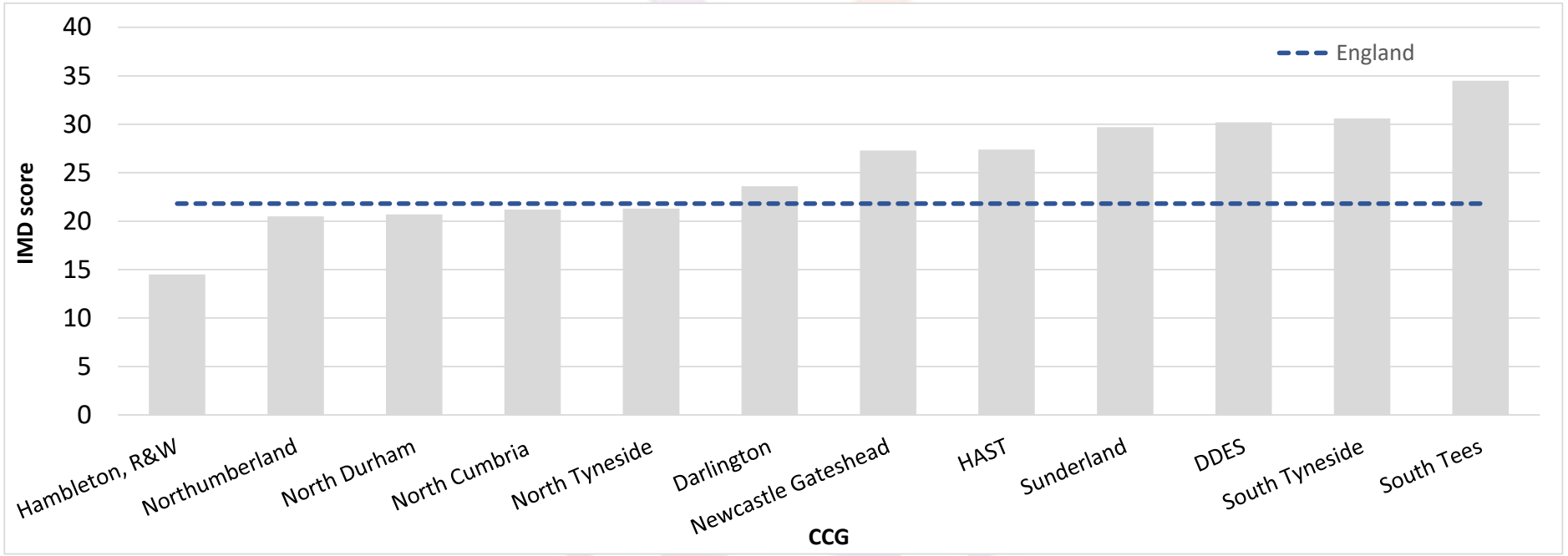
Points for feedback and discussion

- What do you find most useful regarding each metric?
- Alternative suggestions
  - Data definition
  - Data presentation or style
- Organisation level reported?
- Local knowledge / observations which explain variation
- Suggestions of other information to include or remove

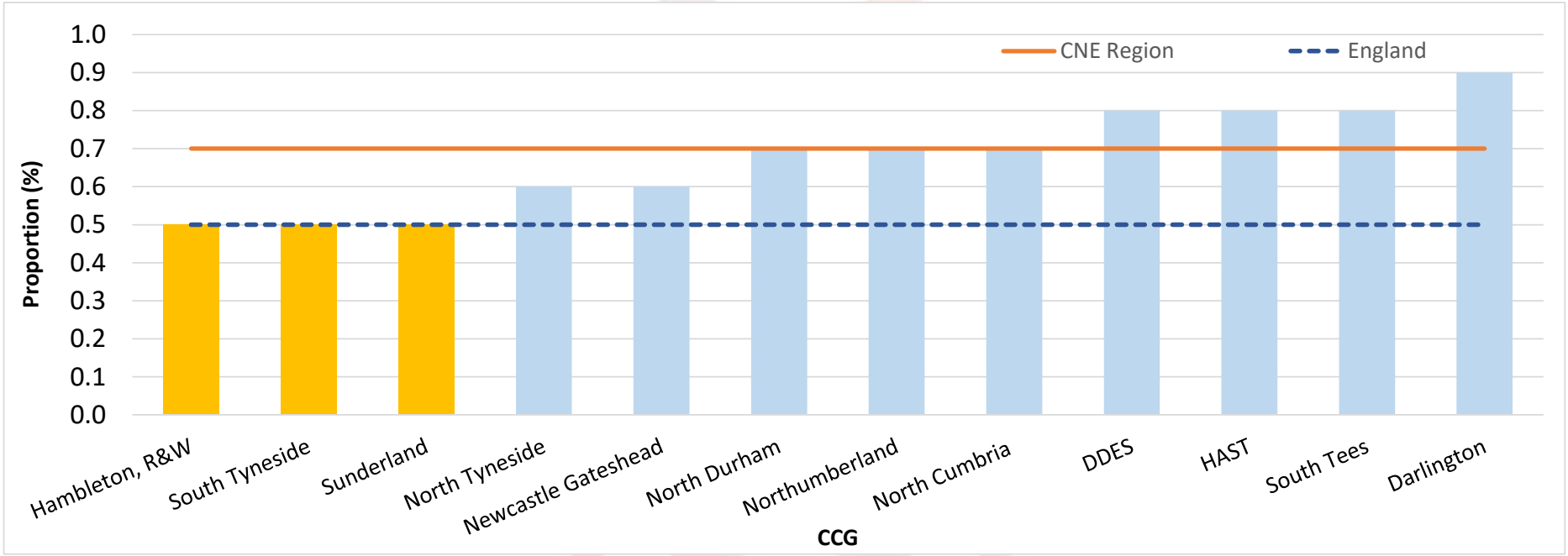
Proportion of patients aged 65 years and over (2017)



GP practice deprivation score estimate (2015)



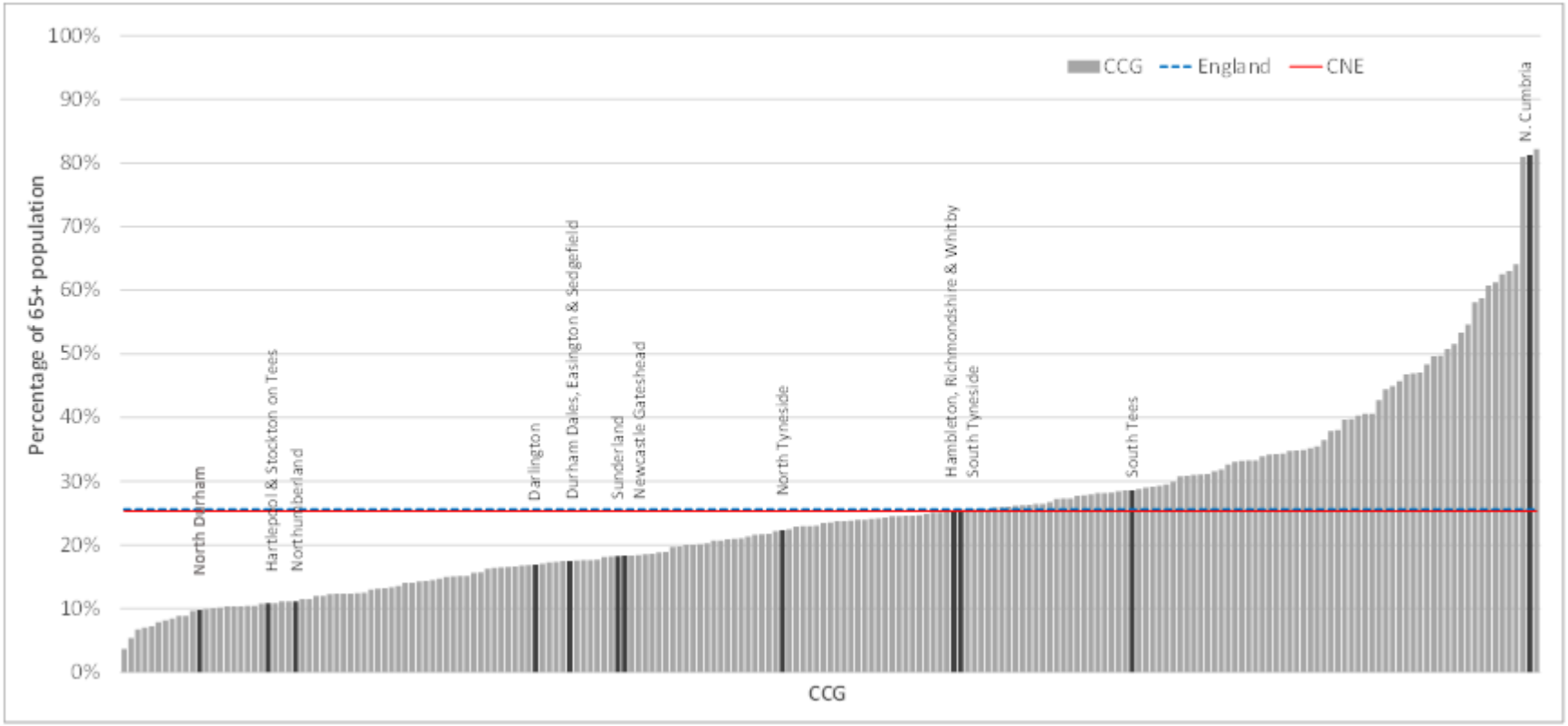
Proportion of patients who live in a nursing home (2014/15)



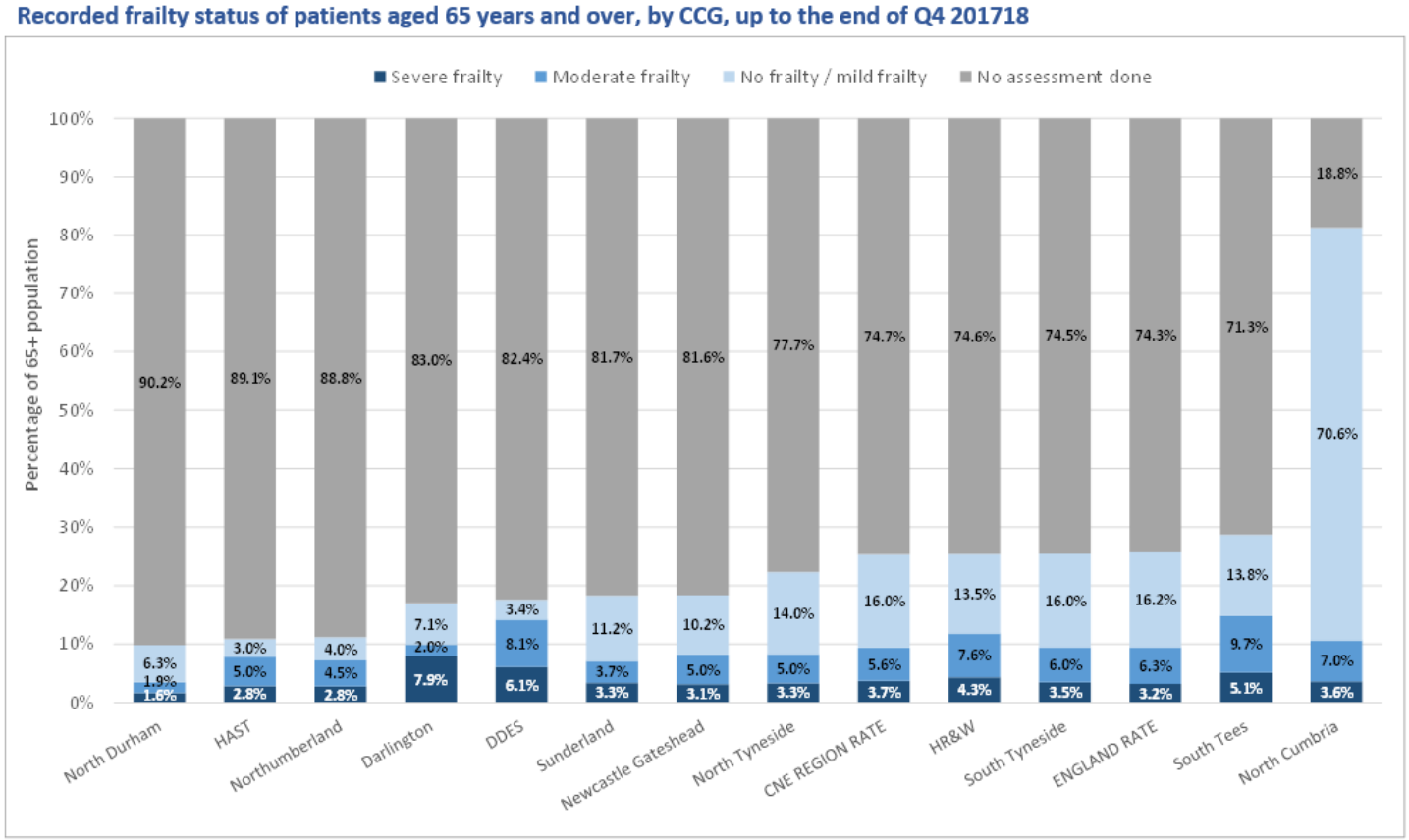
Summary of contents

1. Patients aged 65 years or over who have had a frailty assessment

Proportion of patients aged 65+ years who have had a frailty assessment using the appropriate tool up to the end of Q4 2017/18

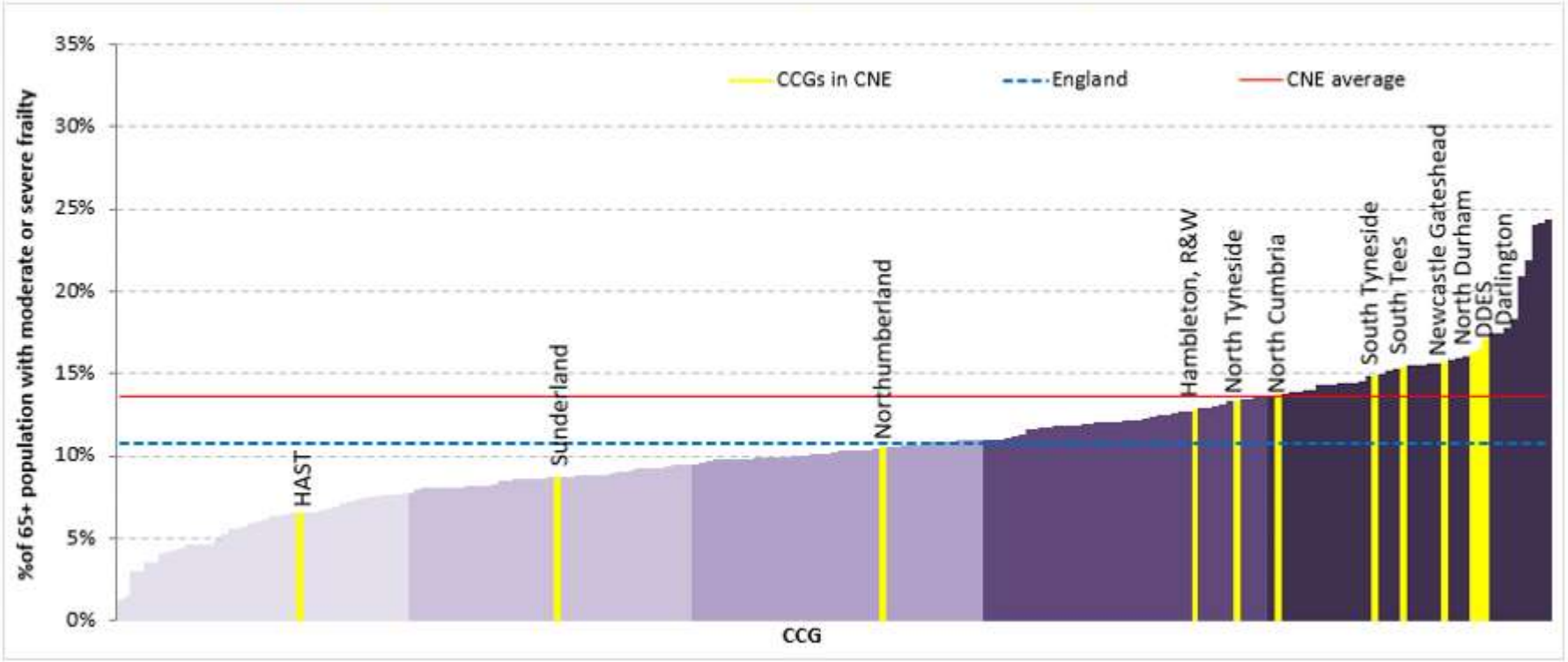


2. Patients aged 65 years or over who are identified as living with frailty, and the severity of their condition



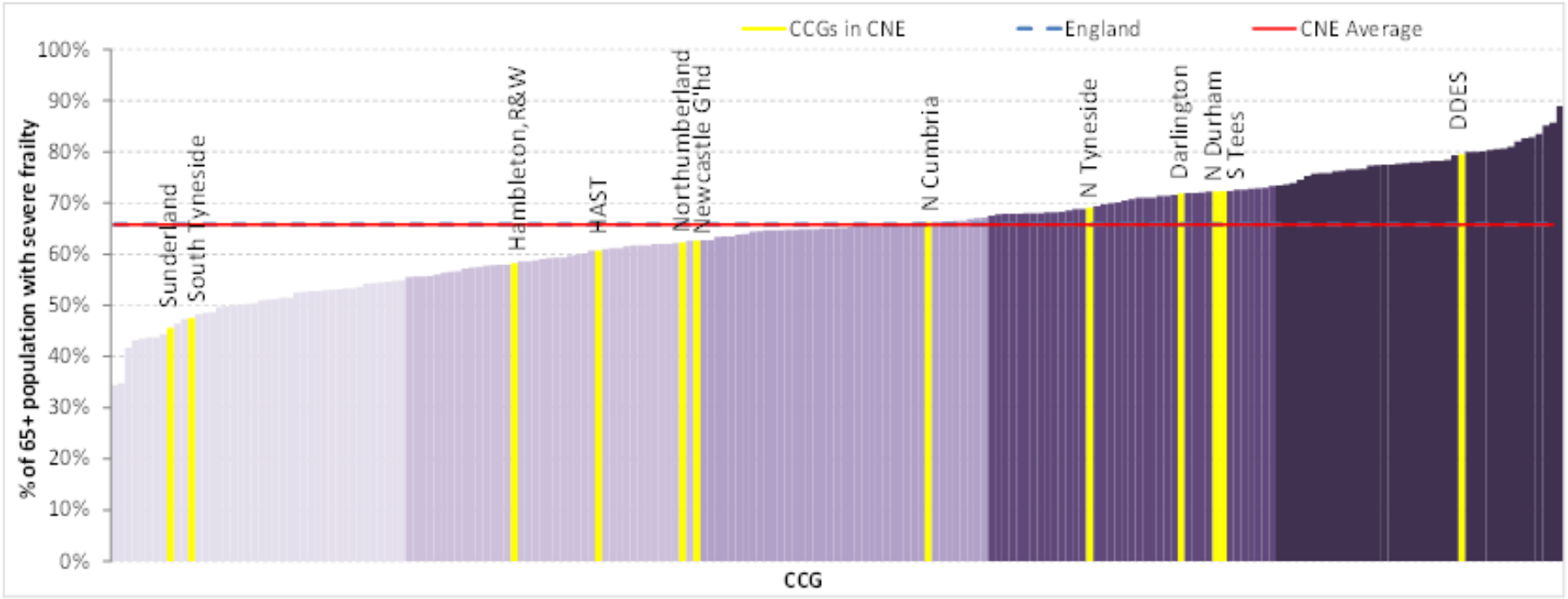
3. Patients aged 65 years and over with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months

Proportion of patients aged 65+ years with moderate or severe frailty, who have had a fall, by CCG, to the end of Q4 2017/18



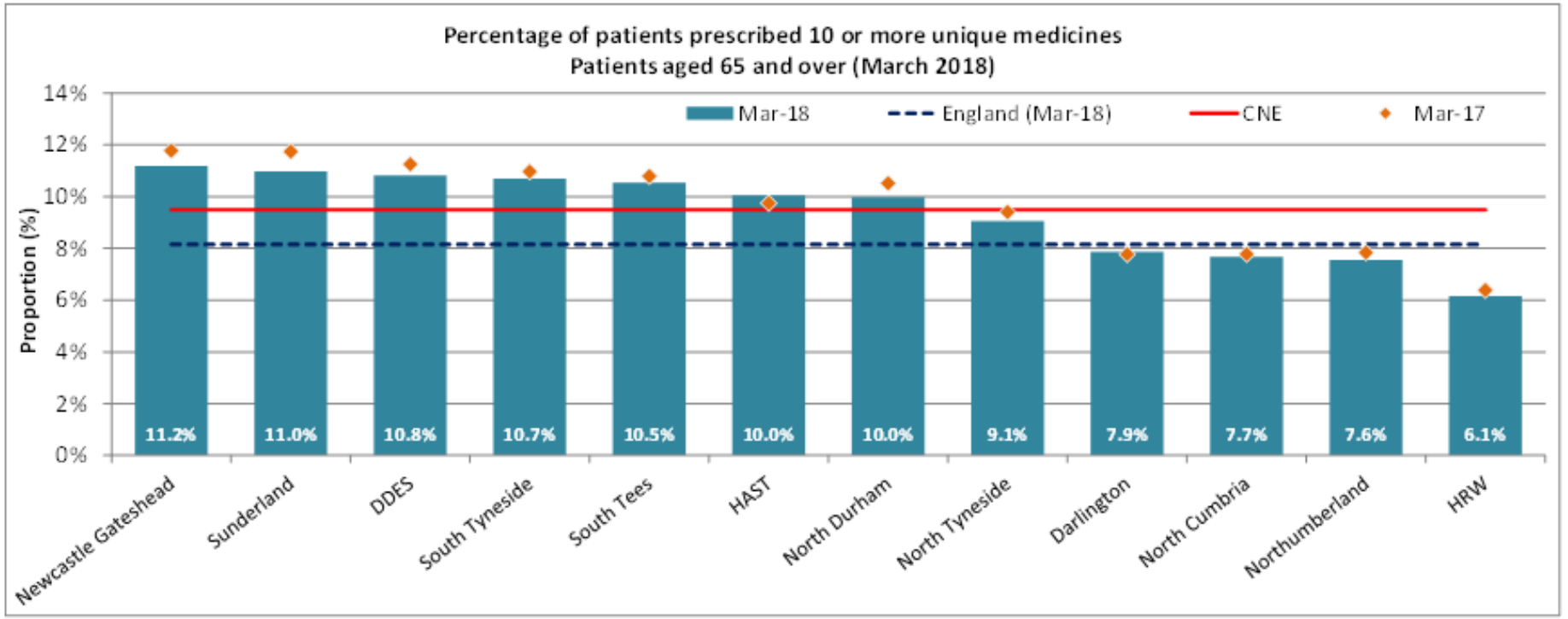
4. Patients aged 65 years and over with severe frailty who have received an annual medication review

Proportion of patients aged 65+ years with severe frailty, who have received an annual medication review, by CCG, to the end of Q4 2017/18



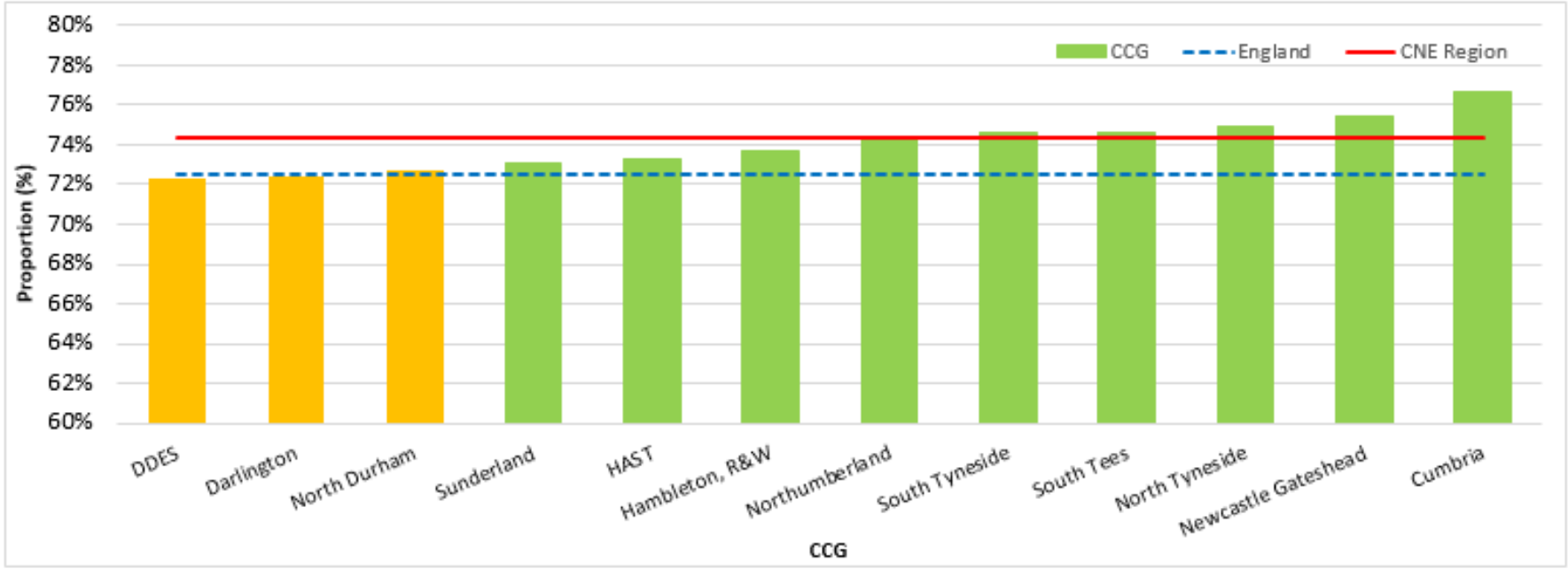
5. Patients aged 65 years and over with 10 or more unique medications

Polypharmacy at CCG level



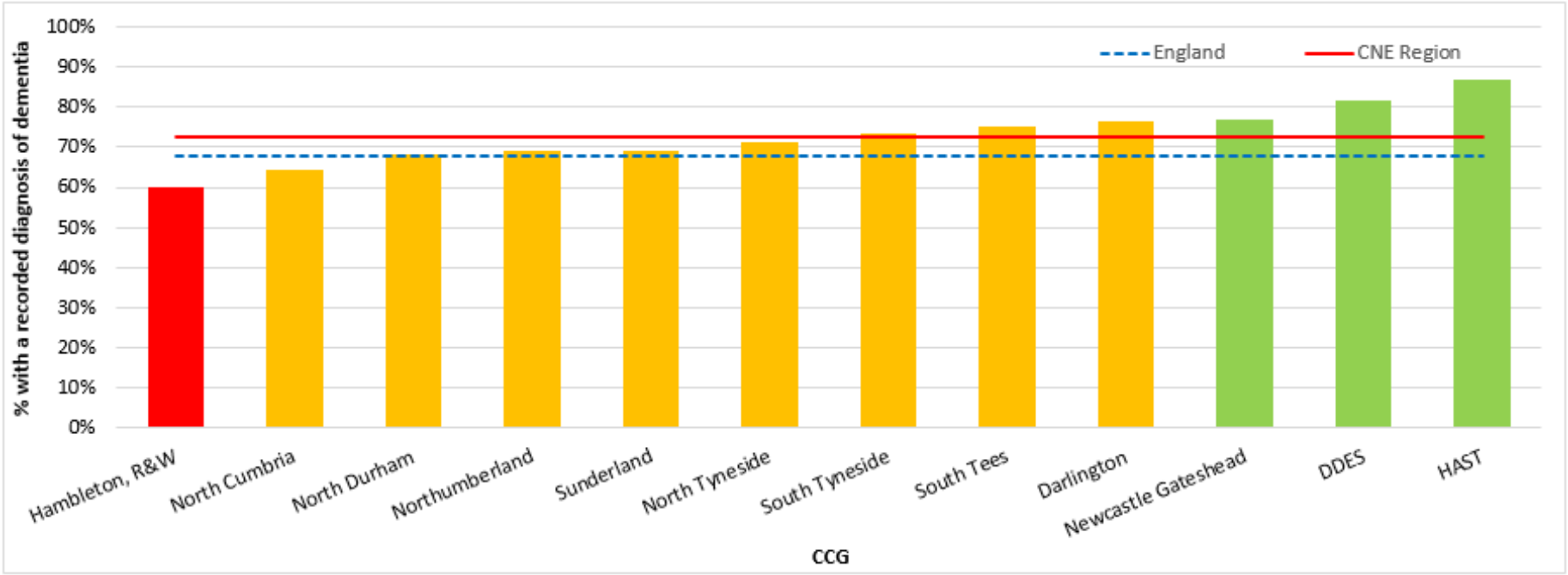
6. Flu immunisation rate in people aged 65 years and over

Proportion of patients aged 65+ years who have received the seasonal influenza vaccine by CCG, winter season 2017 to 2018

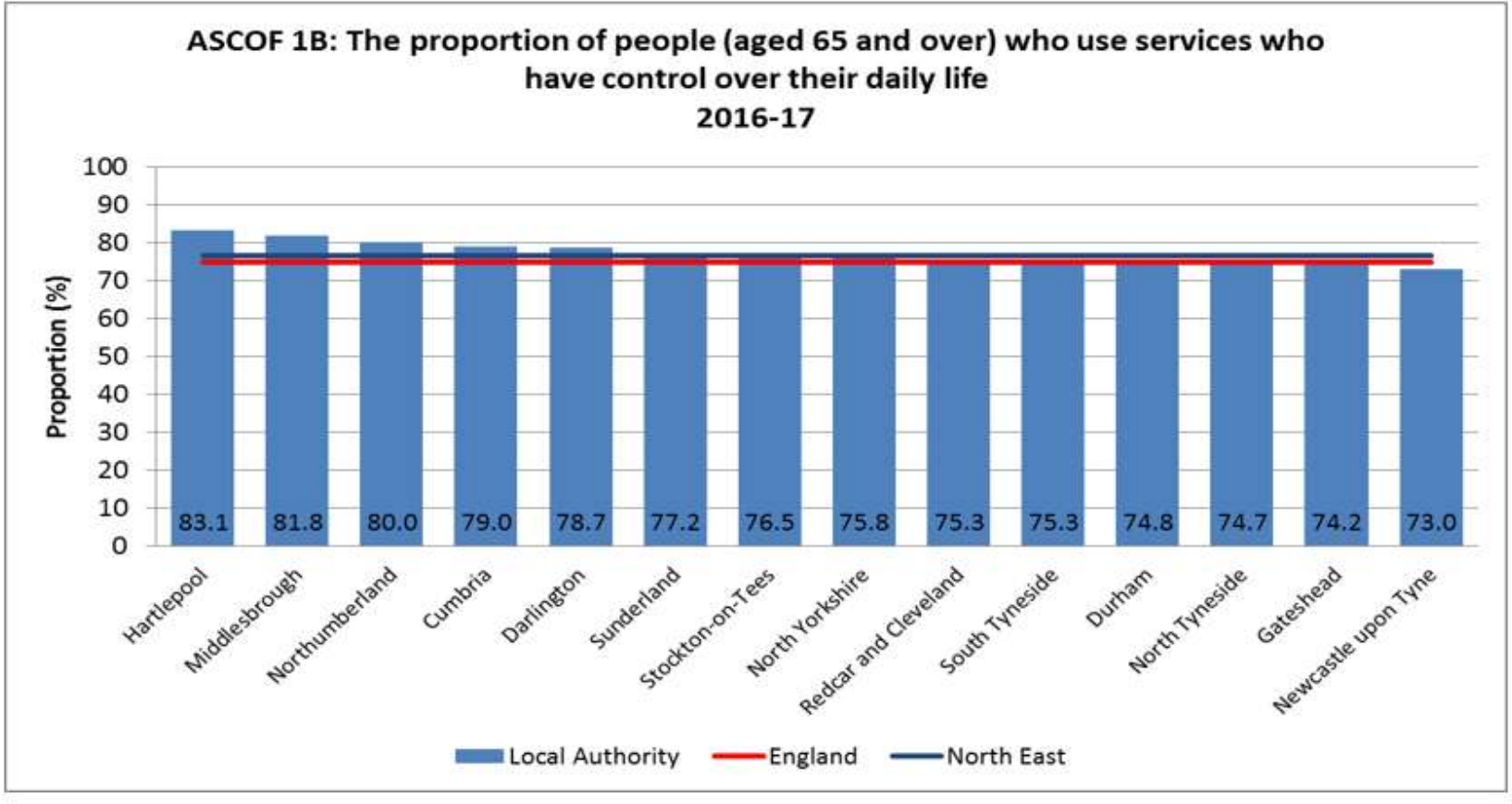


7. Dementia: 65+ years old estimated diagnosis rate

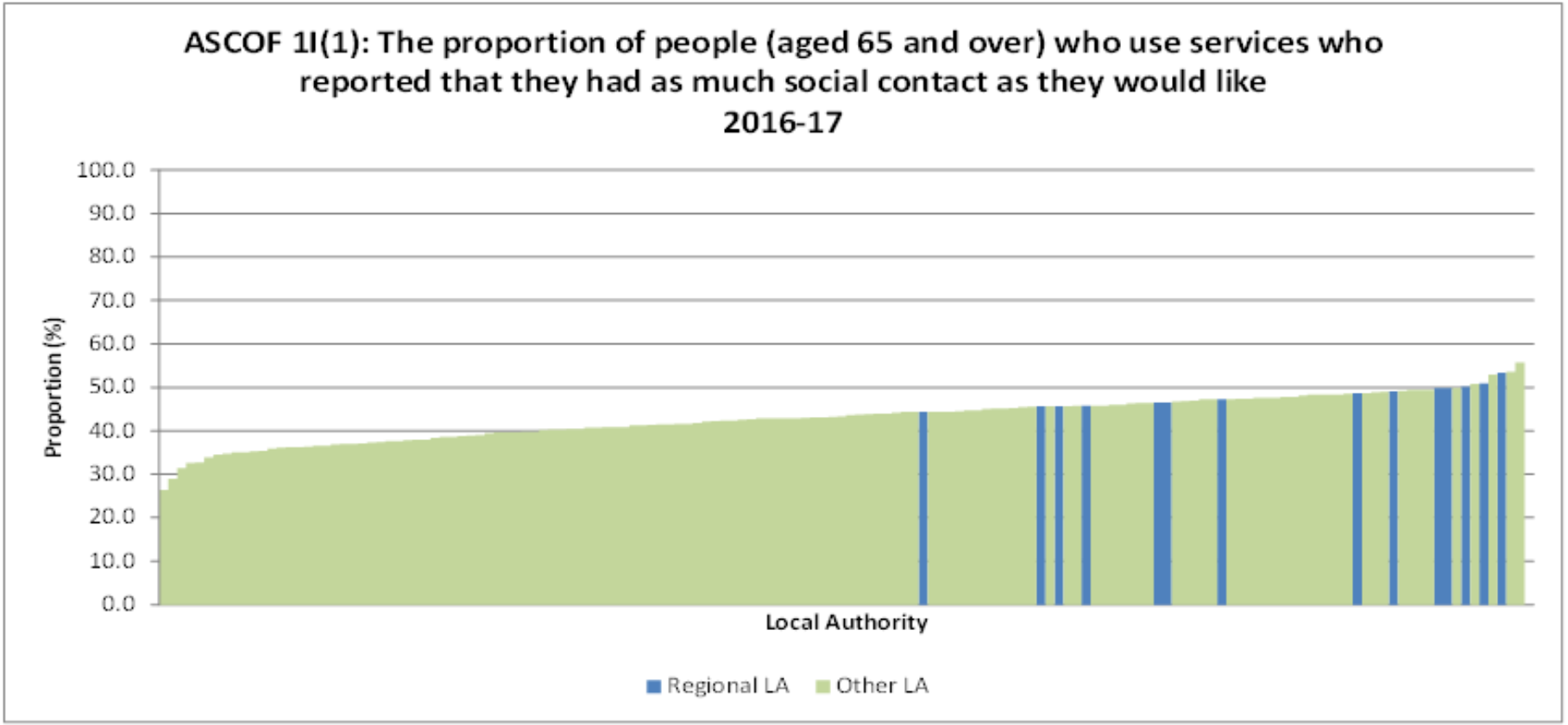
The rate of those aged 65+ with a recorded diagnosis of dementia in the general practice record expressed per person estimated to have dementia (July 17 - June 18)



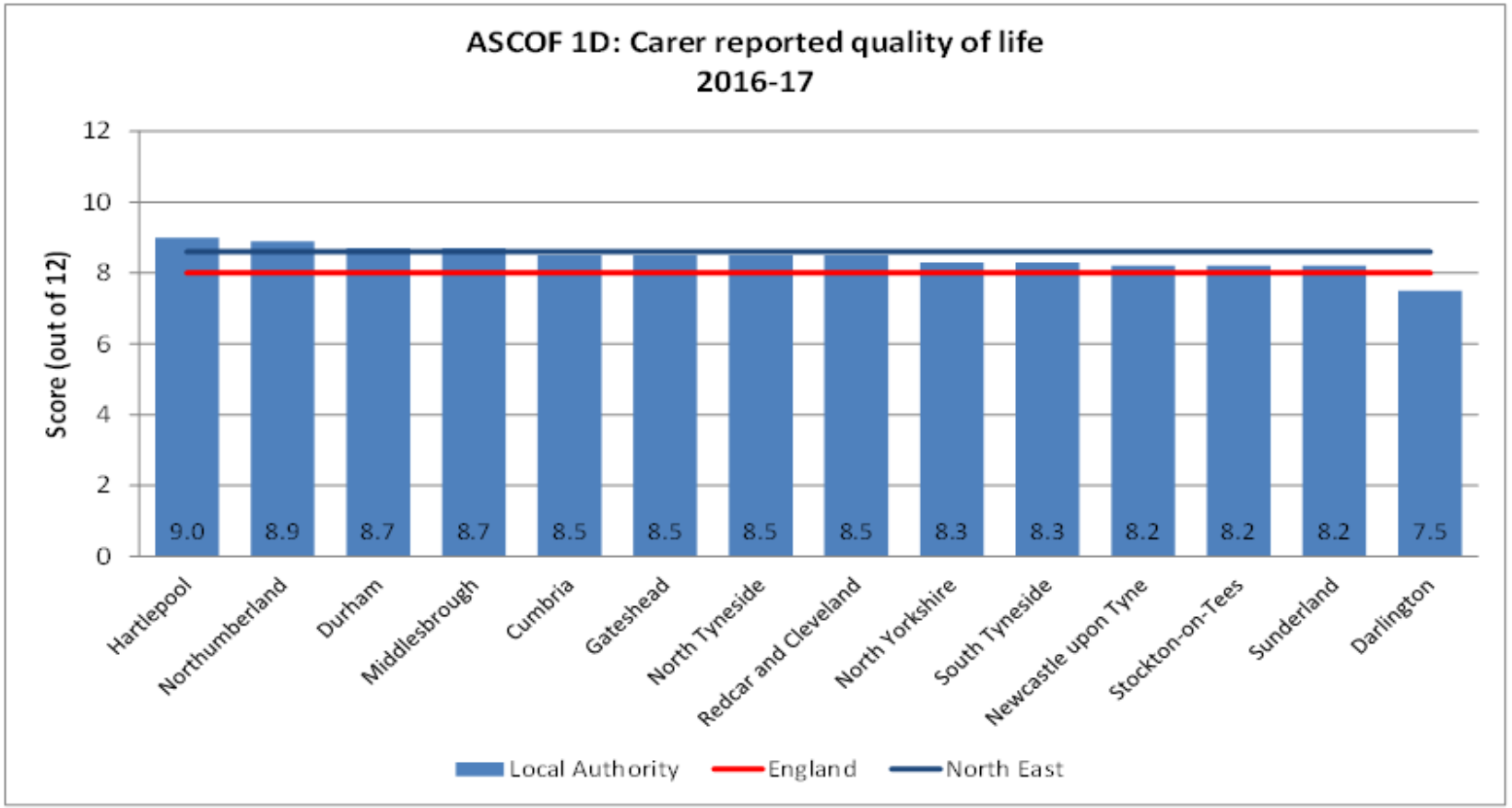
9. The proportion of people (aged 65+ years) who use services who have control over their daily life



10. The proportion of people (aged 65 and over) who use services who reported that they had as much social contact as they would like

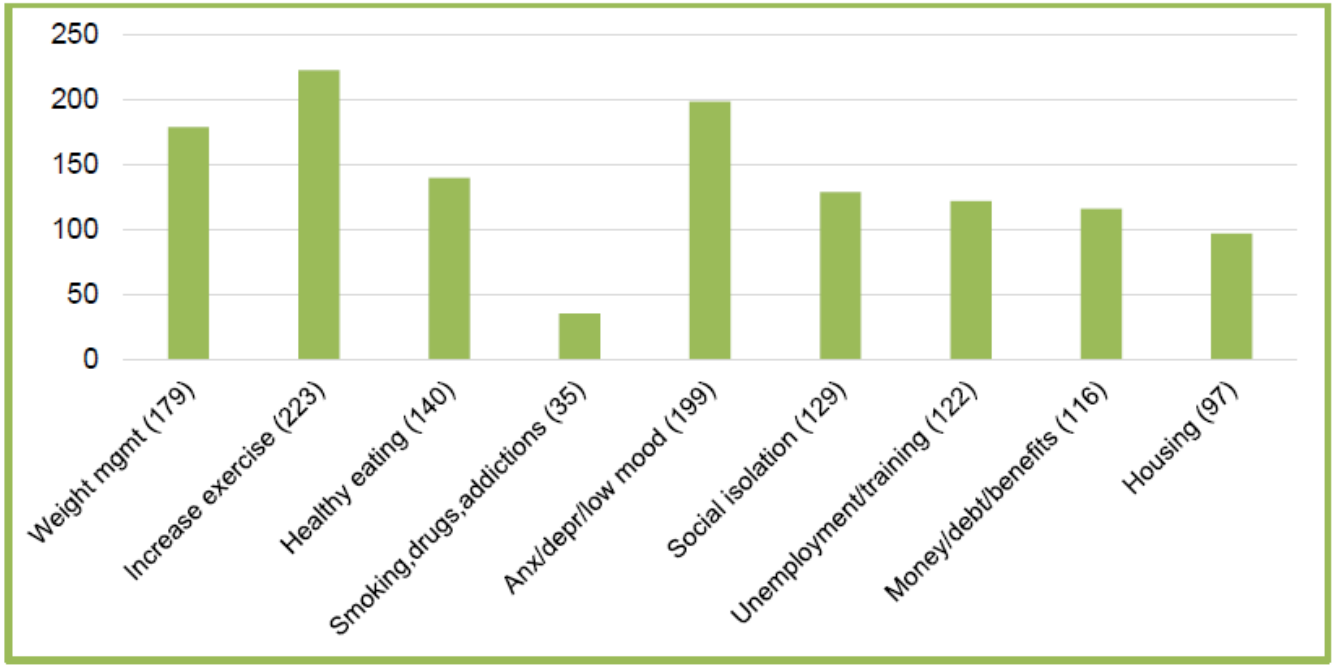


11. Carer reported quality of life



12. Proposal to include an indicator to measure Loneliness

13. Proposal to include an indicator to measure the number of people referred into Social Prescribing Schemes

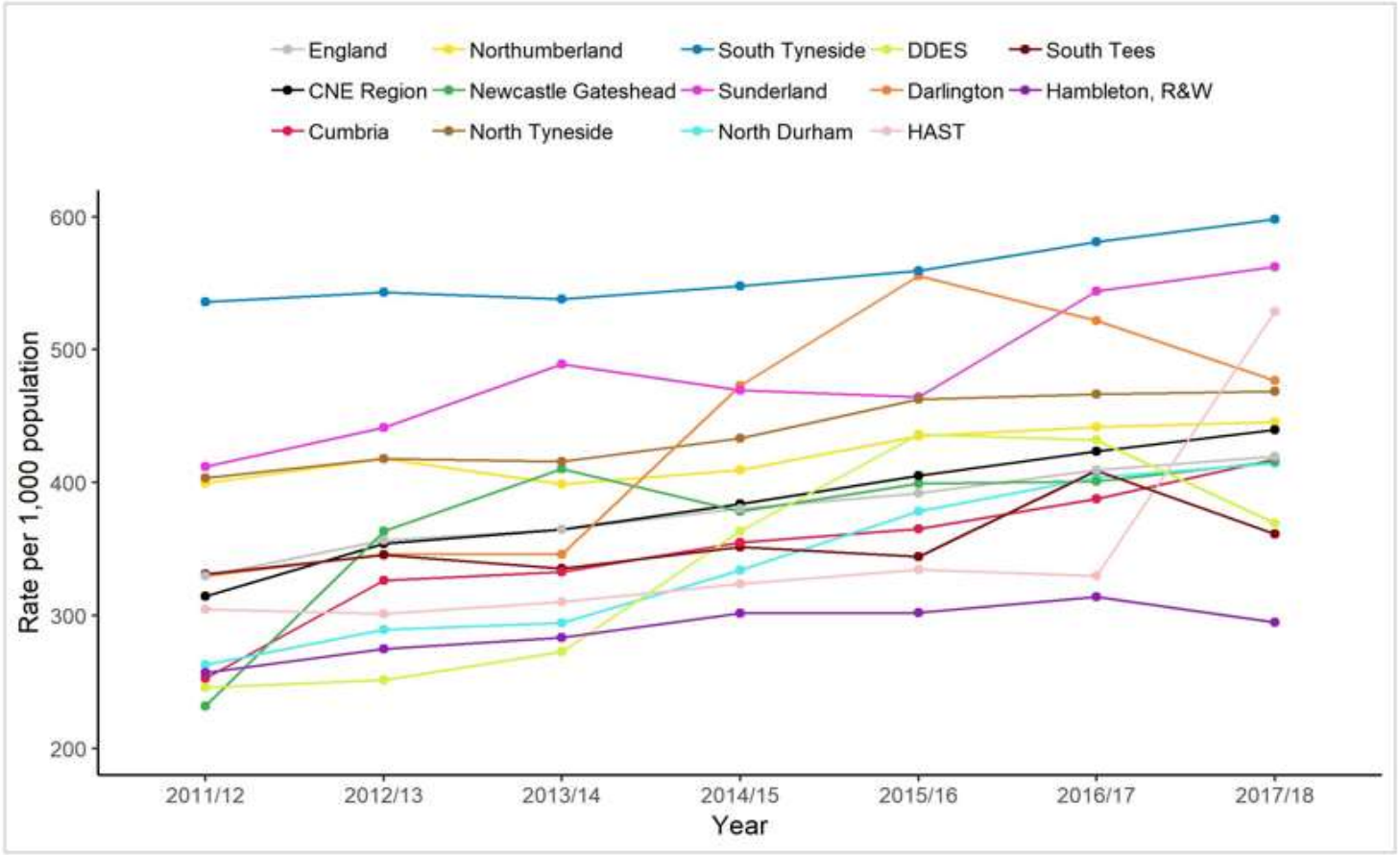


Taken from Bromley by Bow report.

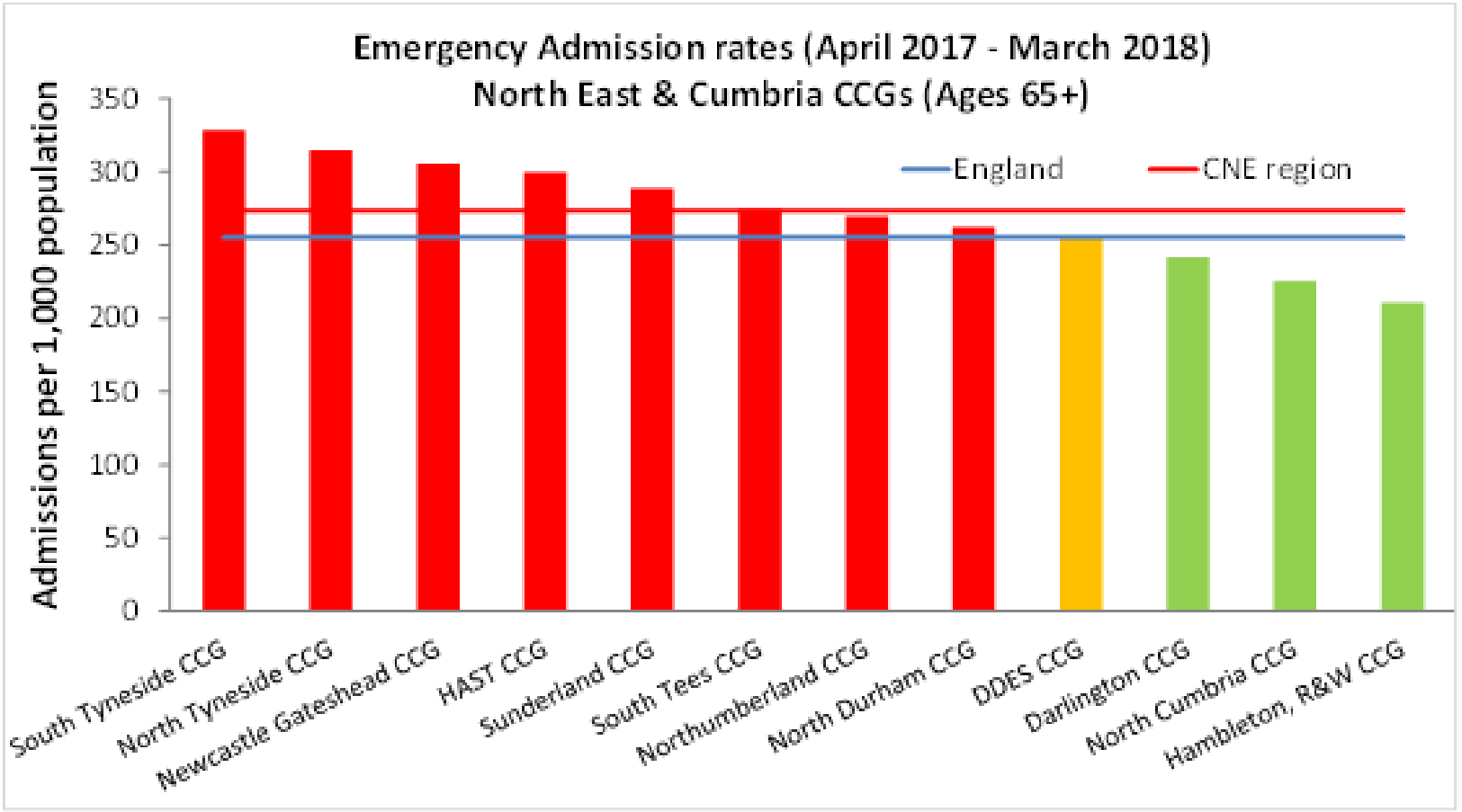
Chart shows the support required by client, based on the initial referral to social prescribing.

14. A&E attendance rates for patients aged 65 years and over

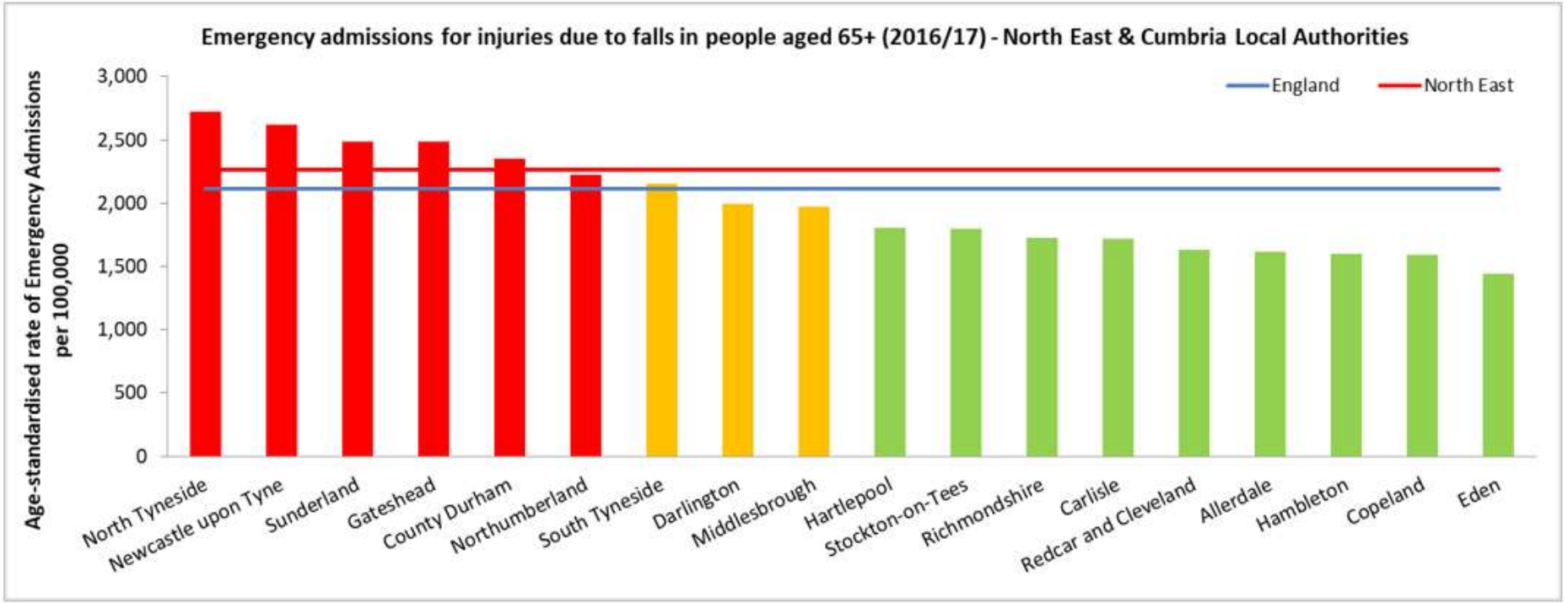
Trend in the A&E attendance rate (per 1,000 population) for patients aged 65 years and over, from 2011/12 to 2017/18



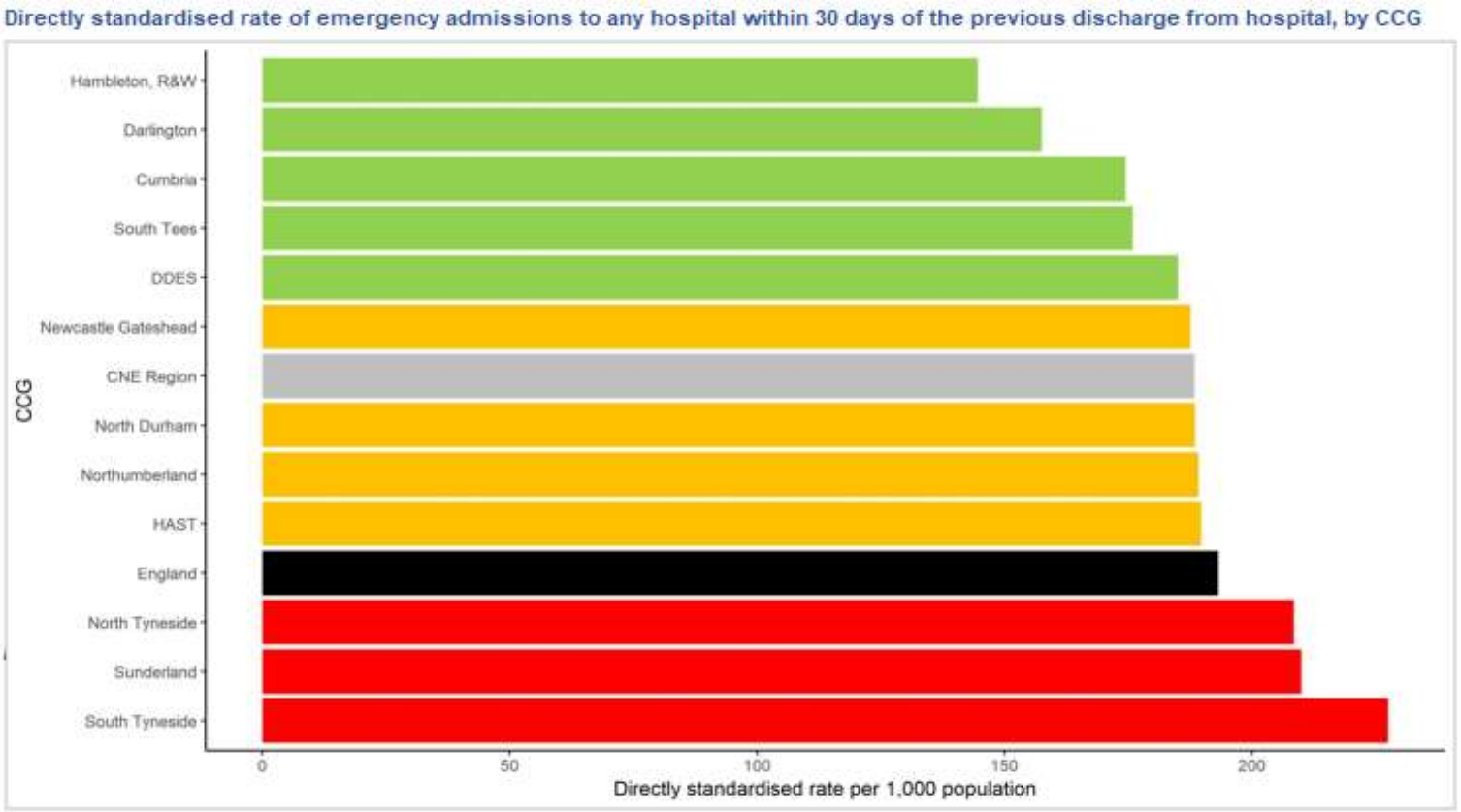
15. Emergency admission rate per 1,000 population aged 65 years and over



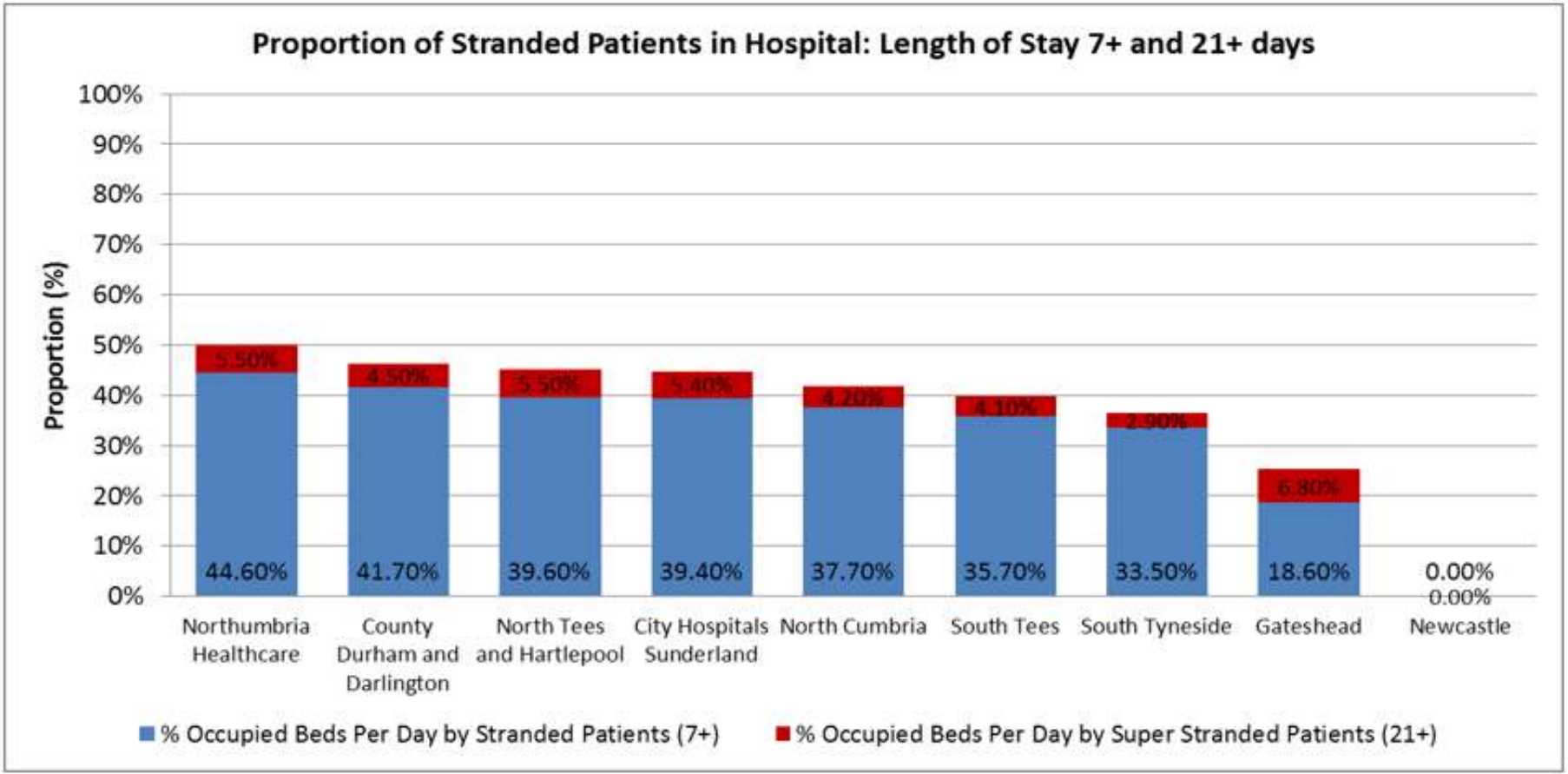
15. Emergency admission rate per 1,000 population aged 65 years and over for injuries due to falls



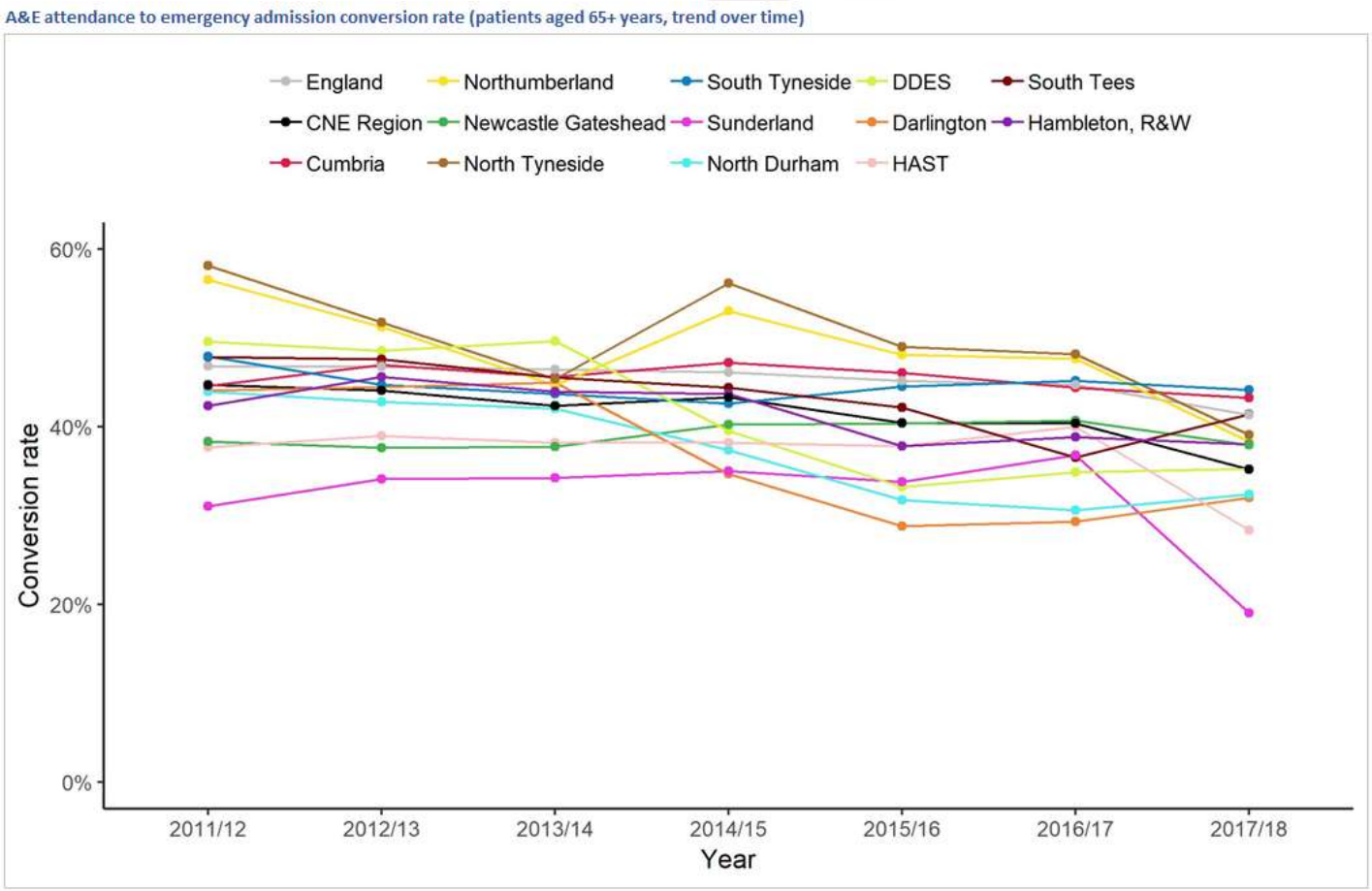
16. Emergency readmissions within 30 days of discharge from hospital (patients aged 65 years and over)



17. Proportion of Stranded Patients in Hospital: Length of Stay 7+ and 21+ days

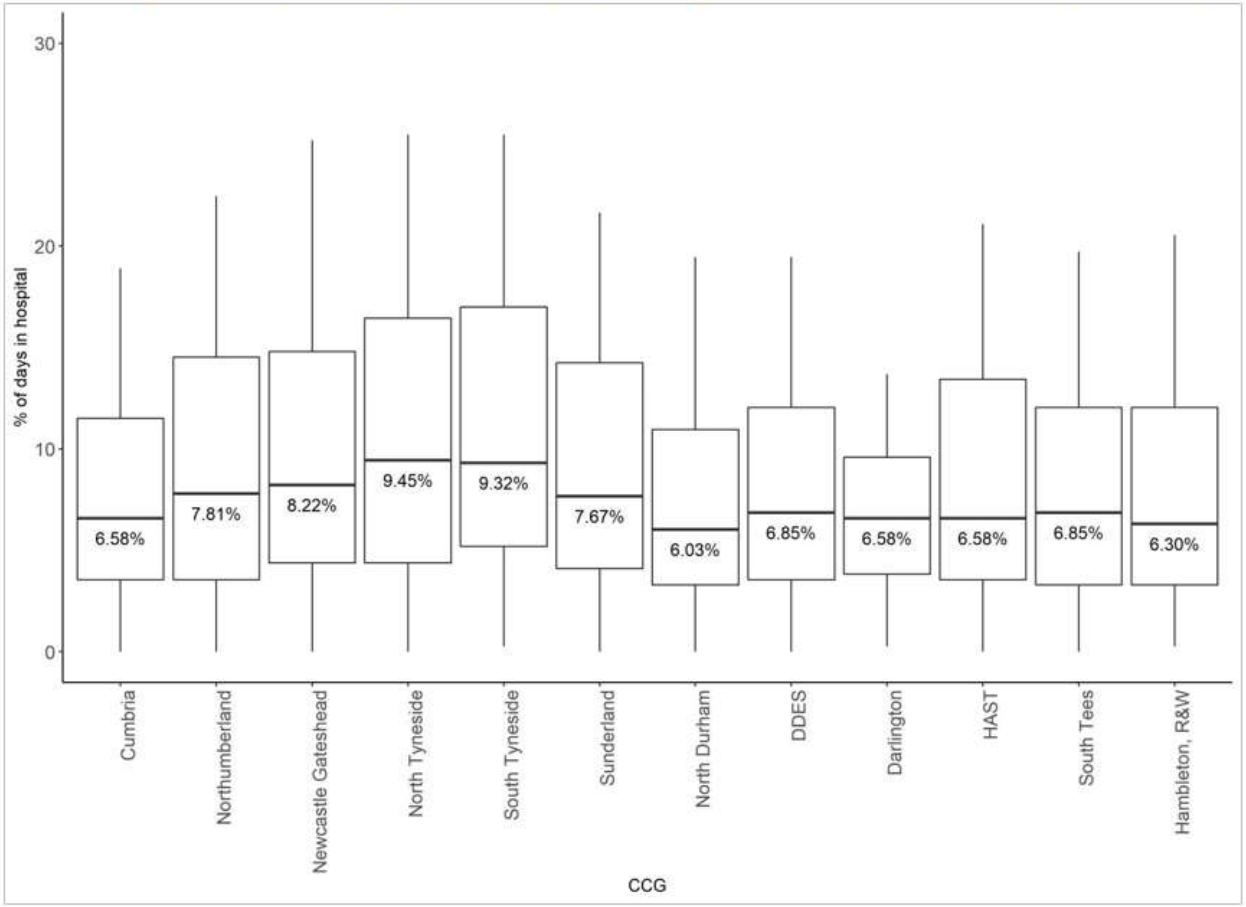


18. Conversion rates from A&E attendance to hospital admission



19. Hospital activity in the last year of life

The percentage of the last year of life spent in hospital, for patients aged 65 years and over who died in hospital in 2017/18



20. Hospital Trust indicator set

Falls with Harm (July 2018)

Trust	Falls with Harm Number	Falls with Harm %	England Average	Region Average	England Worst	England Range	National Trend
CDD	9	0.74	0.34	0.46	1.24		
Gateshead	4	0.54	0.49	0.46	2.27		
Newcastle	3	0.15	0.28	0.46	1.04		
North Cumbria	2	0.43	0.49	0.46	2.27		
North Tees	3	0.34	0.49	0.46	2.27		
Northumbria	15	0.87	0.34	0.46	1.24		
South Tees	6	0.41	0.34	0.46	1.24		
South Tyneside	3	0.31	0.49	0.46	1.78		
Sunderland	1	0.17	0.34	0.46	1.24		

Pressure ulcers (all) - July 2018

Trust	Pressure Ulcers - All Number	Pressure Ulcers - All %	England Average	Region Average	England Worst	England Range	National Trend
CDD	25	2.06	4.39	4.28	9.55		
Gateshead	17	2.28	4.28	4.28	14.20		
Newcastle	77	3.79	3.65	4.28	8.13		
North Cumbria	17	3.68	4.28	4.28	14.20		
North Tees	2	0.22	4.28	4.28	14.20		
Northumbria	91	5.27	4.39	4.28	9.55		
South Tees	85	5.85	4.39	4.28	9.55		
South Tyneside	89	9.15	5.13	4.28	17.01		
Sunderland	29	4.99	4.39	4.28	9.55		

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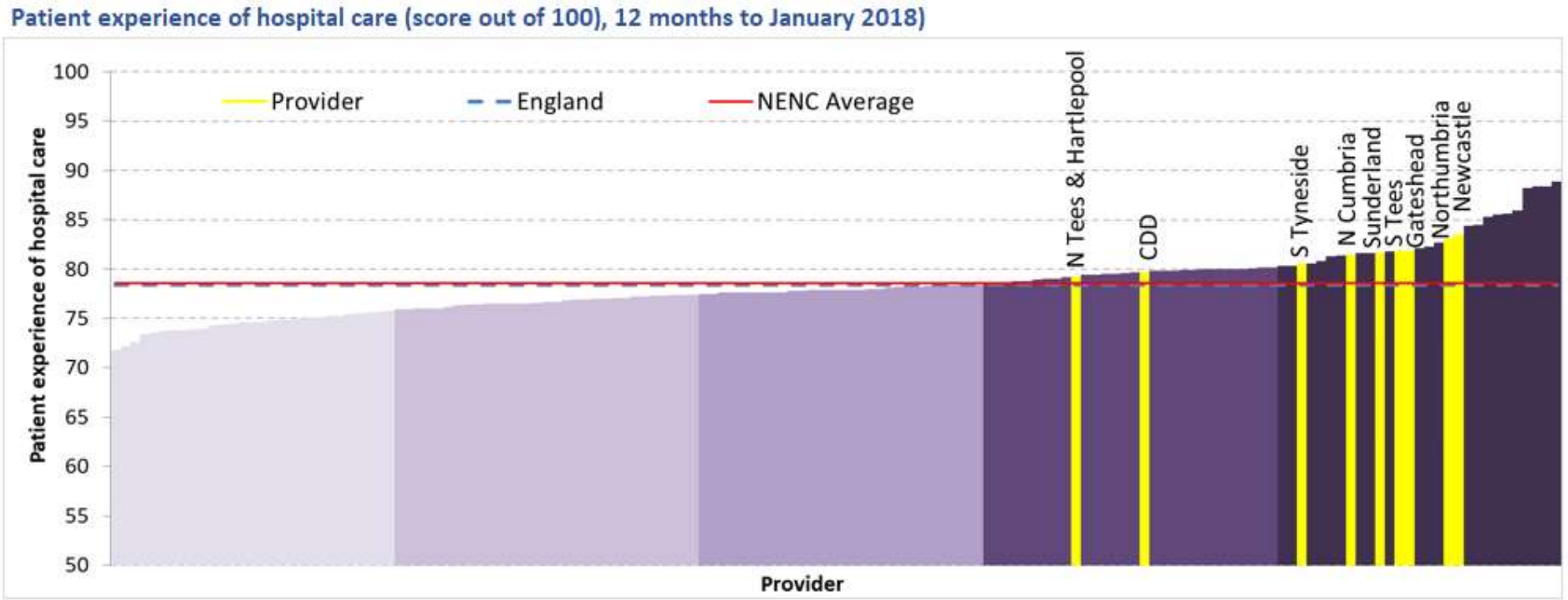
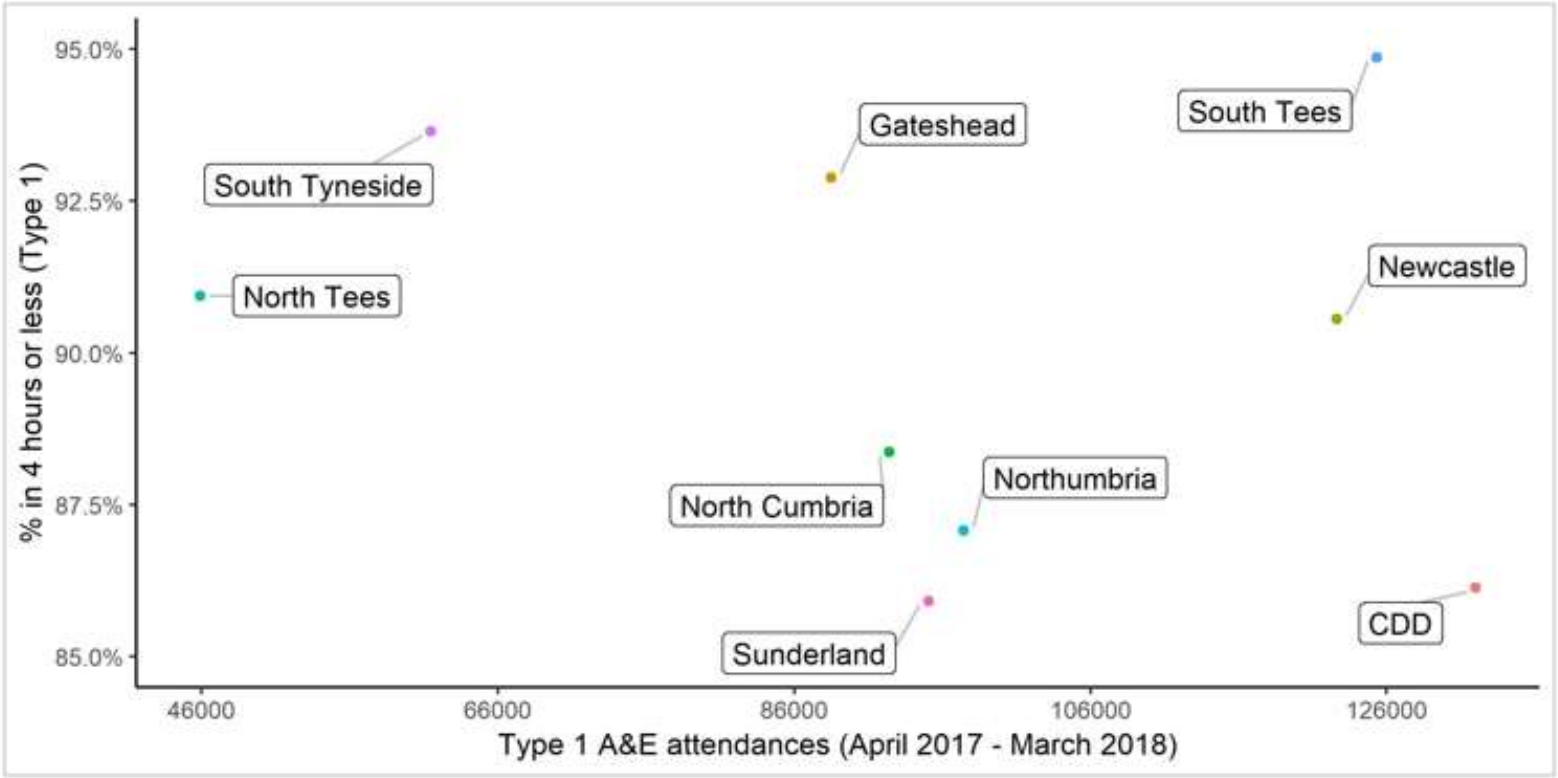
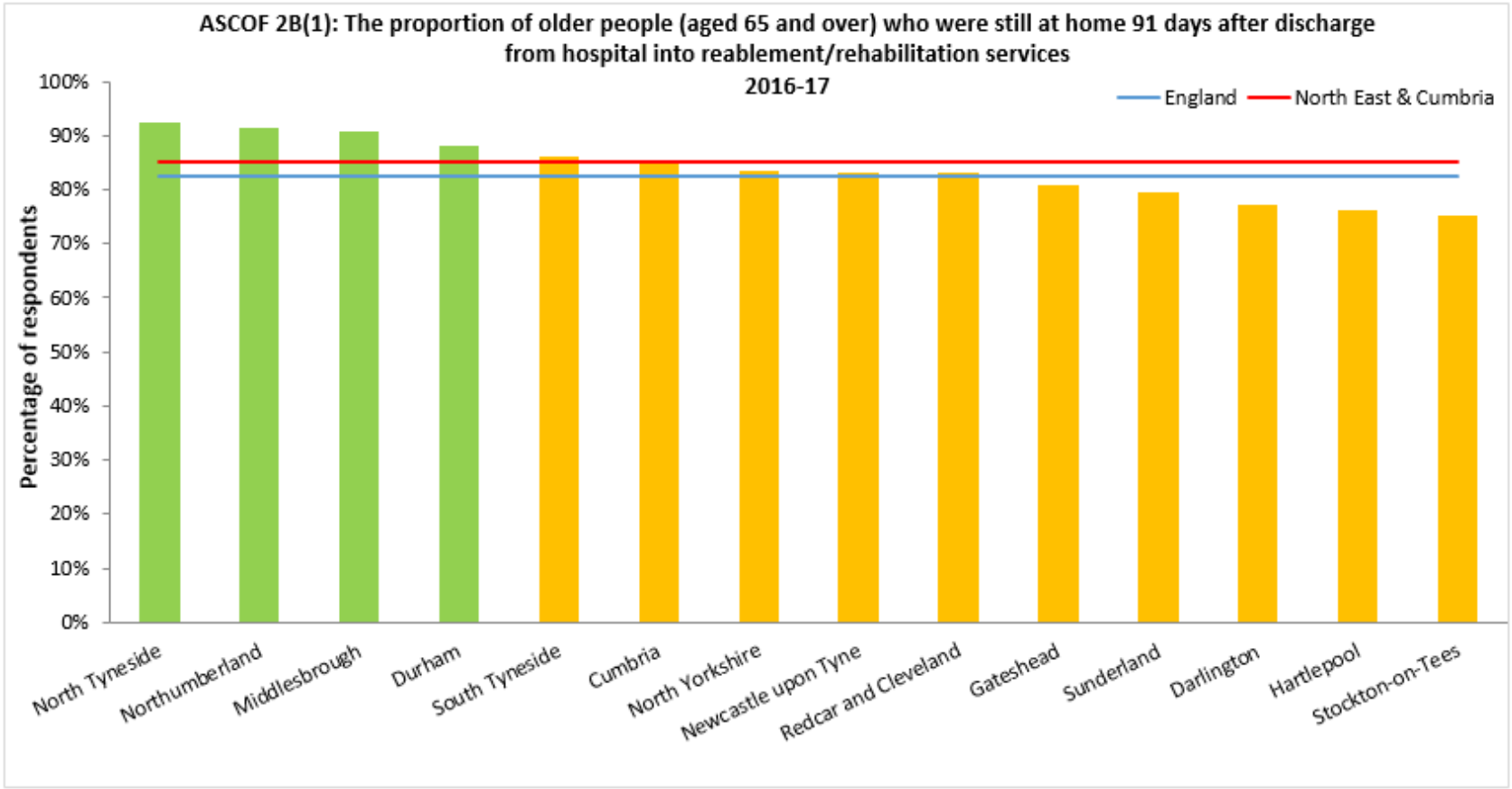


20. Hospital Trust indicator set

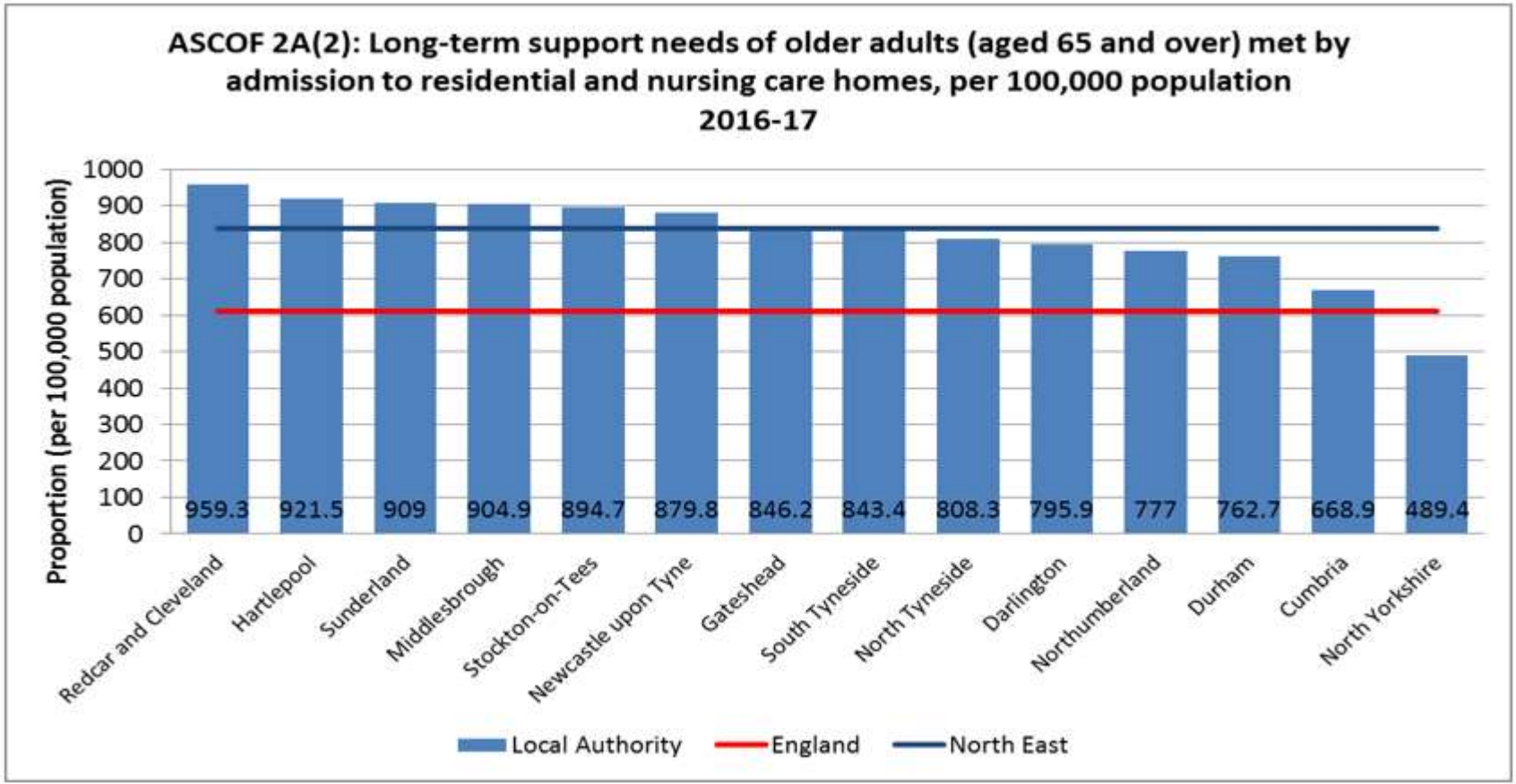
The proportion of patients attending Type 01 A&E departments where the time waited from arrival to admission, transfer or discharge was less than 4 hours (2017/18)



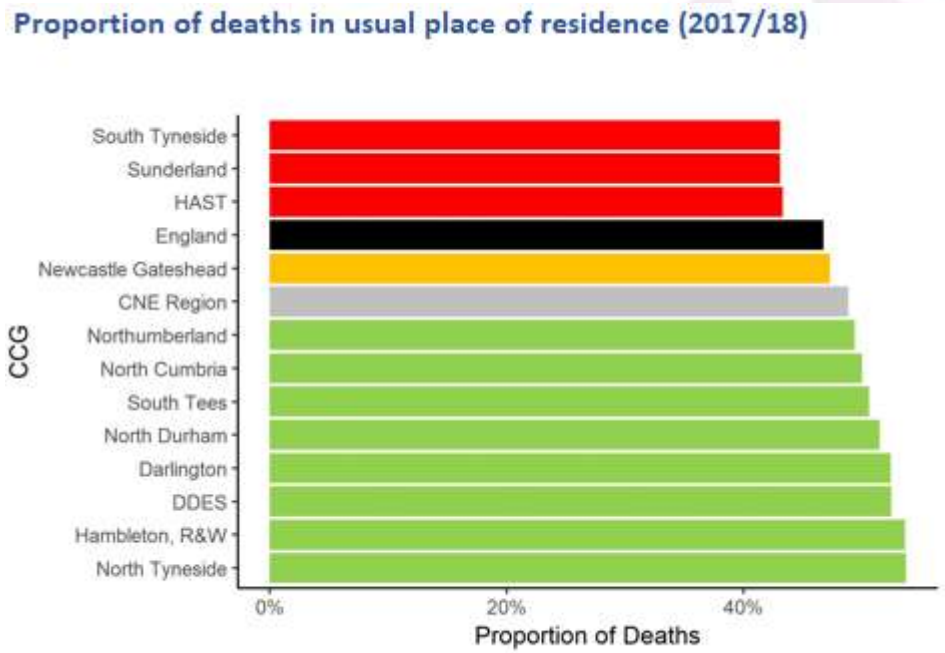
21. The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

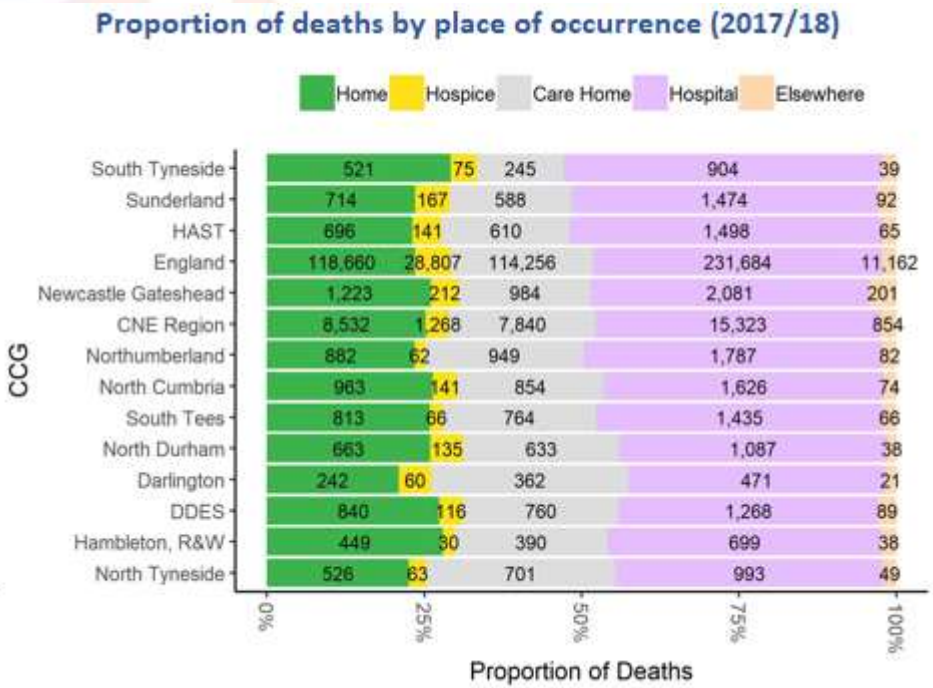


22. Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes



23. Proportion of deaths in usual place of residence





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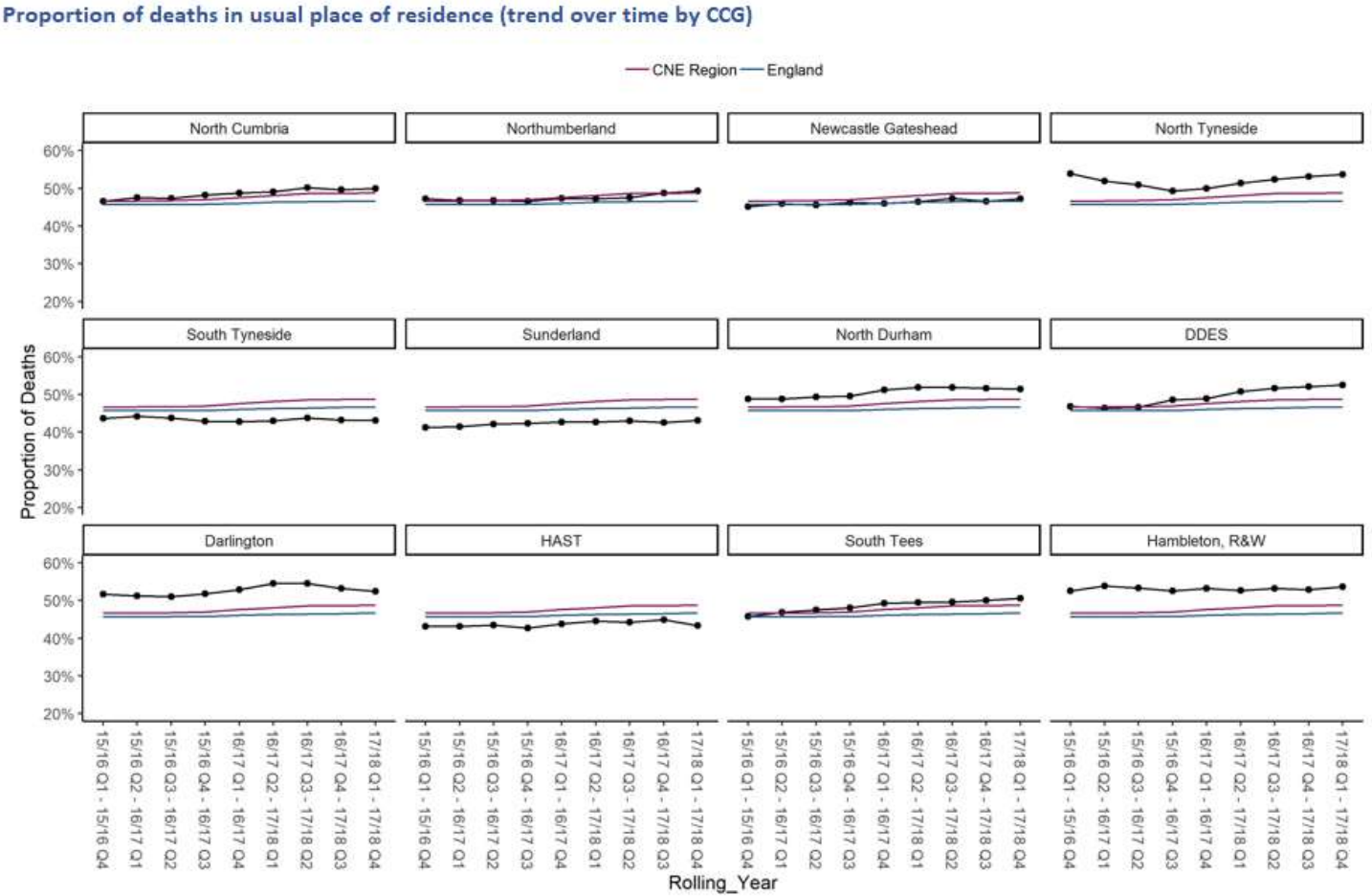

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Acknowledgements:

- Adam Fearing (Health Information Analyst, NEQOS)
- Kayoung Goffe (Health Information Analyst, NEQOS)
- Tracy Hinshaw (Business Intelligence, NECS)
- Claire Laing
- Core Frailty Team in CNE

Questions or comments?

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