A Regional Approach to Ageing Well Community of Practice

1st October 2020

Academic Health Science Network North East and North Cumbria

National Innovation Centre for Ageing

involve consider assess respond evaluate

Join our journey... Developing integrated Health and Care

House Keeping

- Mute mics when not speaking
- Use the chat box for questions and we will address as we go or follow up afterwards
- Presentations will be circulated following the event
- The event will be recorded and shared. If you have any objections please let us know.

Welcome and Introductions

Frailty – what's the latest?

Dr. Dan Cowie

Clinical Lead

COVID-19 and frailty

Assess:

- BGS response – COVID-19 risk calculator. Think frailty (isolation, functional issues) NOT just Multiple Morbidity –https://www.bgs.org.uk/resources/identifying-older-people-most-vulnerable-to-covid-19

Healthy Ageing

- Centre for Ageing Better report - One in five excess deaths during winter are attributed to cold housing.https://www.ageing-better.org.uk/news/millions-cold-and-damp-homes-could-be-greater-risk-covid-19-winter
- Inequalities report (more diverse leadership, better cross alignment [housing, poverty etc.]

https://www.nhsconfed.org/resources/2020/09/health-inequalities-time-to-act

Community Connectivity

- Living the values of place-based working, system by default and the importance of local relationships over national hierarchy
- New relationship between NHS and people and communities (introduction)https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/REPORT_People-and-communities-Reset_FNL.pdf
- How health and care systems can work better with VCSE partner (5 ways and case studies) https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Working-better-with-the-VCSE_FNL.pdf

CGA and care planning

- ACP in the community – investment and training for those working in health and social care, better coordination of electronic medical record systems, and staff and public education and awareness raising is neededhttps://www.cebm.net/covid-19/advance-care-planning-in-the-community-in-the-context-of-covid-19/
- Evidence review and debate – guidelines, focusing on palliative care in the community (really interesting read). Useful tips.https://www.cebm.net/covid-19/covid-19-guidelines-for-community-palliative-care-which-is-the-best-in-show/

Crisis response and recovery

- Concept of Long COVID' – Your Recovery Work. But specific request for supporting people with dementia – BLOG calling for national strategy for the rehabilitation for people with dementia post COVID-19 - https://www.nhsconfed.org/blog/2020/09/ensuring-people-living-with-dementia-do-not-pay-a-greater-price-for-the-pandemic
- BGS links to all things 'rehab' post COVID-19 - https://www.bgs.org.uk/resources/covid-19-rehabilitation-of-older-people
- Interesting 'rehab pathway' approach (article) - https://www.bsrm.org.uk/downloads/covid-rehab-pathway-leeds--jrm-aug2020.pdf
- NHSE aftercare needs of inpatients recovering from COVID-19 - https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0705-aftercare-needs-of-inpatients-recovering-from-covid-19-aug-2020.pdf

Theme Digital – reflection!

https://www.ageing-better.org.uk/sites/default/files/2020-08/landscape-covid-19-digital.pdf

- Many more people accessing ‘digital’ services. For example, three times more 70-year-olds registered for online banking during lockdown compared to the same time last year.
- However, many more services not offering ‘non-digital’ alternatives and age is the greatest predictor for digital exclusion.
- In addition to age, they are also likely to be in worse health, poorer and less well educated than their peers: 71% of those offline have no more than a secondary education, and nearly half (47%) are from low-income
- **Thought,** are we:

‘Widening of the digital divide’ ?

Updates linked to Frailty ICARE

Assess

- Hospital frailty tool (automatic) tracking - assessing frailty via codes.
- file:///Users/Danielcowie/Downloads/Frailty_Opportunity_Identifier__A_Practical_Guide.pdf

Consider

- Australian tool – prevalence estimates - https://uofadel.maps.arcgis.com/apps/MapSeries/index.html?appid=ab3ffe3e59c34053acf6f56d3368fb78
- A frailty-case finding tool (Durham) published - https://academic.oup.com/ageing/advancearticle/doi/10.1093/ageing/afaa119/5868063?guestAccessKey=36ef3bd2-df98-4b44-a7fe-9a47e9f64350

LTC tailored care

- Medication - slide pack proxy medication ordering or care homes (setting it up) - https://future.nhs.uk/DigitalPC/view?objectID=72672357
- Structured Medication Reviews for PCN (needed those with severe frailty and others) - https://www.england.nhs.uk/wp-content/uploads/2020/09/SMR-Spec-Guidance-2020-21-FINAL-.pdf

CGA and care planning

- NICE impact study on End of Life care (in adults, last 2-3 days in acute settings) - https://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/measuring-uptake/End-of-life-care-impact-report/nice-impact-end-of-life-care.pdf

Crisis Response and Recovery

- NHSE hospital discharge service policy (4 pathways, single co-orindator and home first policy)https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model and action cards (for staff) - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911214/Hospital_discharge_service_requirements_action_cards.pdf
- Social Care 'winter plan' - BGS support plan (chief nurse, free PHE, funds transport for staff, test results prior to discharge)https://www.gov.uk/government/publications/adult-social-care-coronavirus-covid-19-winter-plan-2020-to-2021/adult-social-care-our-covid-19-winter-plan-2020-to-2021

Workforce

Report - creating a workforce for the future – new collaborative approach between NHS and colleges of Englandhttps://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/Report_Creating-the-workforce-of-the-future_FNL.pdf

Theme Housing – reflection! https://www.ageing-better.org.uk/news/millions-cold-and-damp-homes-could-be-greater-risk-covid-19-winter

- One in five excess deaths during winter are attributed to cold housing
- There is strong evidence of poor housing impact on ‘health outcomes’
- A winter lockdown could also see increased fuel poverty, significantly affecting people health outcomes
- It make sense to invest in our housing. For example, every £1 spent on improving warmth in homes occupied by at risk households can result in £4 of health benefits.
- We must urgently improve relationships between housing and health and social care providers at a local level
- **Thought:**

Have we all really experienced lockdown equally?

Digital and Information Technology

CGA (CHA) Digital Tool

- Delivering CGA and care planning across boundaries/services bring together MDT (supporting team and people with increasing frailty)
- In partnership with Healthcall
- Specification ready – sign off
- Looking for two pilot sites (across region)
- Need to plan for education/training
- Need to plan evaluation of pilot

Jackie's Story

- Work to be done
  - Voice over (introduction/ending)
  - Risk and impact statement to be added
  - Overall review by COP
- Following completion - need to consider engagement/usability
- Latest version – www.rawtest.co.uk

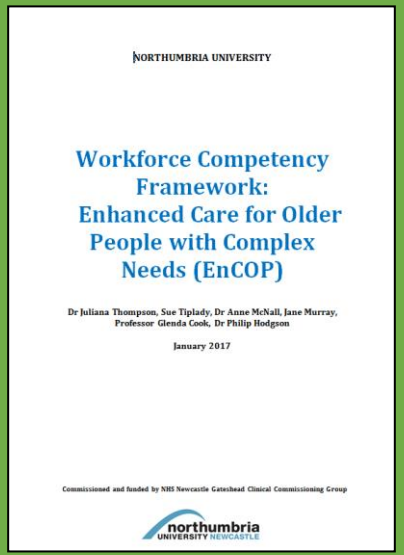
Workforce Projects

Workforce Planning [primary care]

- Funded via HEE, taking place in Gateshead (across 2 PCNs)
- Explore population needs and workforce (now and future)
- Exploring best practice across partners to consider what's working well and gaps (where best practice adoption could be done)

Workforce Development [EnCOP]

Enhanced Care of Older People Competency Framework 2016-2018


NORTHUMBRIA UNIVERSITY

Workforce Competency Framework: Enhanced Care for Older People with Complex Needs (EnCOP)

Dr Juliana Thompson, Sue Tiplady, Dr Anne McNall, Jane Murray, Professor Glenda Cook, Dr Philip Hodgson

January 2017

Commissioned and funded by NHS Newcastle Gateshead Clinical Commissioning Group

northumbria UNIVERSITY NEWCASTLE

- Led by Northumbria University
- Partnership with NHS NGCCG

www.enhancedcare.org/workforce

Enhanced Care of Older People Competency Framework 2018-2020

www.frailtyicare.org.uk

involve.consider.assess.respond.evaluate.

Aim and Objectives

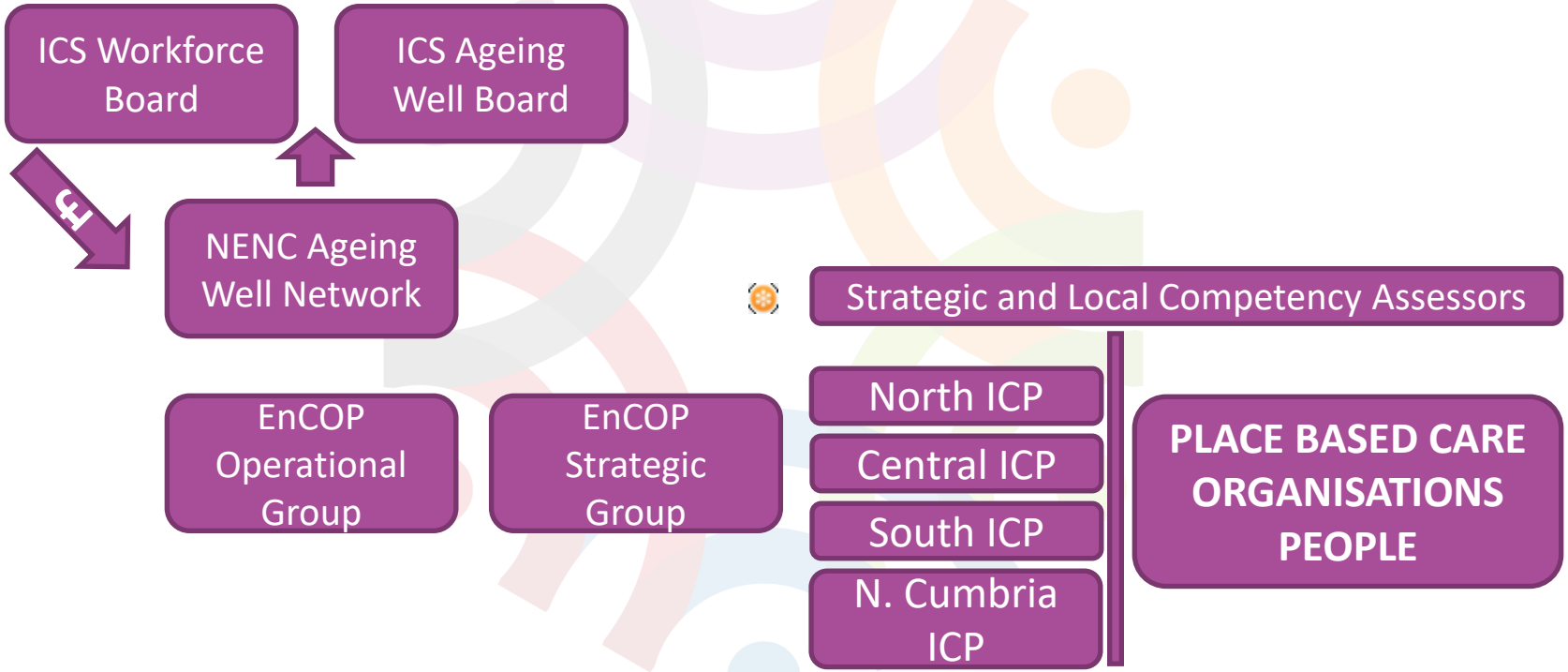
Aim:

To successfully embed each level of the EnCOP framework across a range of organisations in each ICP and involving a variety of staff disciplines.

Objectives:

- to establish and embed the role of strategic competency assessors
- to identify and establish local competency assessors in each ICP
- to establish a common understanding of EnCOP in each ICP
- to identify local leaders to act as champions in each organisation
- to establish a regular strategic forum well attended by local champions
- to have an established link between EnCOP and HENE
- to continue successful relationship with ICS workforce workstream

The Structure



Meet the People through Jackie

https://vimeo.com/350962994

- Regular health care started age 66 with 1st LTC; *many years of successful care by primary care team*
- Case management; CGA, *care planning and coordination*
- 247 rapid response care; *with access to treatment*
- MDT; *primary, secondary, community health and care*
- Personal care package; *independent care sector*
- Access to specialists; *geriatrician, neurosurgeon*
- Family carers; *didn't need a care home*

acknowledgment: NHSEI Better Care Team NENC, Jayne Robson

System, places and organisations

System Jackie's Life	North Places	Middle Places	South Places
Primary Care	North Cumbria	North Durham ✓	North Tees
Secondary Care ✓	Northumberland ✓	Sunderland ✓	South Tees ✓
Community Health ✓	North Tyneside	South Tyneside ✓	
Care Home ✓	Newcastle		
Domiciliary Care ✓	Gateshead ✓		
Community Care ✓			
Mental Health CNTW			
Mental Health TEWV			
NEAS			

EnCOP Framework		
Essential	Specialist	Advanced

Frailty Network: Operational Update

Steering Group New Members:

- Jayne Robson (Better Care Manager, NHSE Cumbria and North East)
- Ken Haggerty (Independent Care Sector Lead, NHSE)
- Kathryn Dimmick (Ageing Well Lead, NHSE/I)
- Lesley Young-Murphy (North ICP)
- Anita Barker, (North Cumbria ICP)
- Jenny Steel, (Interim Lead Central ICP)
- Catherine Monaghan (South ICP)

Ageing well funds to ICP – circa 120K

Metrics – Reminder

- 23 metrics developed by experts in the frailty field locally and nationally
- CCG based and aggregated for a regional picture
- Different areas have used these in different ways over the last couple of years
- Some have added metrics relevant to their local priorities
- Others have focused on only a few


Presentation


Presentation

Things have progressed and we now have PCN's supported by Population Health Analytics to enable local decision making

Metrics – Next Steps

- Agree that the 23 metrics are still relevant
- But need to be PCN based rather than CCG
- With trends over time ‘how are we doing?’ ‘what impact are we having?’
- Platform – RADIR, there is a frailty dashboard and this is being reviewed to see what the overlap is or if there are any gaps. Consideration being given if 23 metrics can be included on a dashboard
- However RADIR is not available to everyone
- Consideration to be given to the ICS/ICP investment and how we measure impact.

Metrics/Analytics – Dr Andrea Brown (update)

1. **Risk factors for frailty – work completed**

- Risk factors for the development and progress of frailty literature review document shared with Dan and Janet following the Frailty Metrics group meeting on 4th September.
- The findings from this have been used to populate key statements relating to Jackie's story and provide local context to the impact of various risk factors on different stages of frailty (already shared with Dan).

2. **Other metrics linked to frailty - ongoing**

- Linked to the above risk factors work, there is also additional work to be done relating to those who are pre-frail, and the contribution of various risk factors.
- It was thought that this pre-frail group was relatively diverse in its makeup.
- Other metrics relating to frailty are to be considered, including loneliness / social isolation and social prescribing. The impact of COVID can also be considered.
- Information from research at Newcastle university may support this work.

3. Hospital Frailty Risk Scores – to commence

- One of the NEQOS analysts is going to start working on this shortly with Tony Roberts (NEQOS/South Tees FT) to understand the difference between frailty scores from primary and secondary care.
- We will link with NHSI colleagues on this work.

Housing CoPpers Celebration:

Glenda Cook
Professor of Nursing Northumbria University
Lindsay Courtney
Strategic Lead Care and Innovation Home Group
Innovation House nominated for People's Award in DYNAMITES 20 awards
https://www.dynamonortheast.co.uk/events/dynamites-20/

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