A Regional Approach to Ageing Well Community of Practice

1st April 2021

National Innovation Centre for Ageing

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House Keeping

- Mute microphones 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

Welcome and Introductions

Frailty – what's the latest?

Dr. Dan Cowie

Clinical Lead

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Updates linked to Frailty ICARE

Consider

- Frailty Index changes predicted mortality independently of baseline FI differences - https://academic.oup.com/biomedgerontology/advance-article-abstract/doi/10.1093/gerona/glaa266/5939950?redirectedFrom=fulltext
- Predictors of frailty and vitality study. Overlap with some markers. Understand both could help with population predictions - https://www.karger.com/Article/FullText/512049
- Frailty and immigration - highest frailty risk - https://link.springer.com/article/10.1007/s10903-021-01169-9
- Socioeconomic status affects the risk of multimorbidity, frailty, and disability independently - https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(19)30226-9/fulltext

Respond

Healthy Ageing

- Inclusion Health Tool for PCN – addressing inequalities – online tool, 10mins to complete with report - https://www.inclusion-health.org/pcn/
- Health Creation paper: Useful guides for PCN to reduce Health inequalities - https://thehealthcreationalliance.org/wp-content/uploads/2021/02/PCNs-workshop-series-report-FINAL-_-2-February-2021-.pdf
- Mental Health and Housing. Calculating an investment case – framework for combined data collection -https://www.nhsconfed.org/-/media/Confederation/Files/Networks/MentalHealth/MHEC-supported-housing-2021.pdf
- Article. Frailty final common pathway for premature death due to chronic disease – prevention at disease onset is crucial - https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-021-01904-x

Community Connectivity

- ROI tool – NHS and Social Care return investment tool, PHE – https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/860616/Older_Adults_NHS_and_Social_Care_ROI_Tool_-_Technical_Report__2_.pdf
- Frailty and social isolation – increased risk of mortality - https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16716

Updates linked to Frailty ICARE

LTC care

- The Poly-pharmacy Prescribing Comparator tool is to highlight variation and to support CCGs and GP practices in addressing their poly-pharmacy work (video/ how to access) - https://wessexahsn.org.uk/projects/323/nhs-bsa-polypharmacy-prescribing-comparators
- Delirium and COVID – interesting article - https://academic.oup.com/ageing/advance-article/doi/10.1093/ageing/afab014/6106229
- Primary Care 'top tips' dealing with COVID - https://elearning.rcgp.org.uk/pluginfile.php/149508/mod_page/content/101/Coronavirus%20-%20what%20to%20do%20in%20primary%20care_18_02_21.pdf

CGA and care planning

- New EHCH guide (care provider alliance). This guide provides advice for care home managers on how to support their residents to benefit from the service - https://careprovideralliance.org.uk/enhanced-health-in-care-homes-cpa-guide
- King's Fund. Remote working Toolkit for GP and PCNs - https://www.kingsfund.org.uk/publications/remote-working-toolkit-general-practices-pcns

Community Crisis response and recovery

- NHS confederation. Case studies of learning in community service delivery (8 themes) - https://www.nhsconfed.org/networks/community-network/shared-learning-in-community-health-services

Frailty hospital care

- Acute Frailty Network – series of webnairs. Useful viewing - https://future.nhs.uk/connect.ti/SDEC_CommunityofPractice/view?objectId=24775536
- BGS silver book II - Quality urgent care for older people ://www.bgs.org.uk/policy-and-media/leading-experts-in-frailty-launch-the-silver-book-ii-in-collaboration-with-the

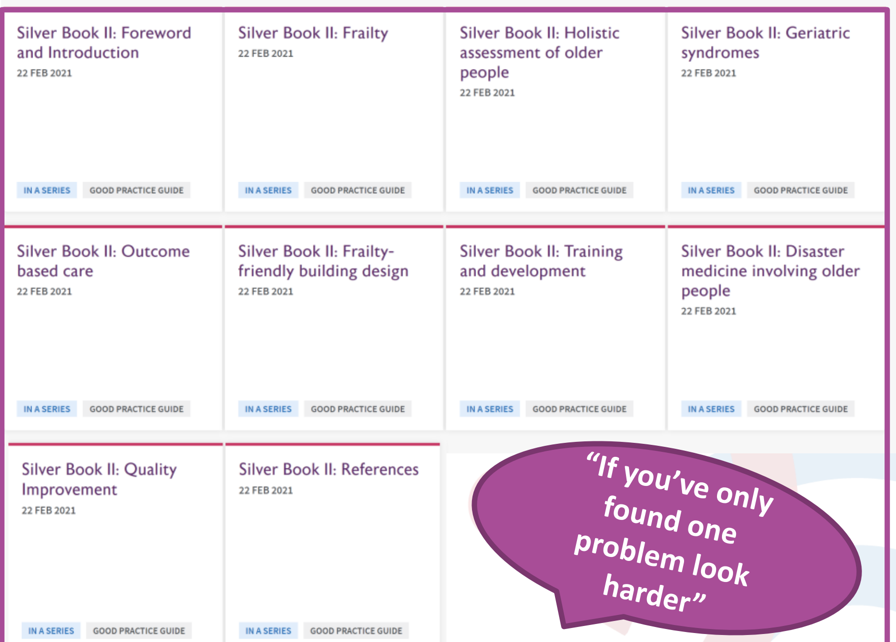
Digital

- Age briefing Paper. Digital excluded review - https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/active-communities/digital-inclusion-in-the-pandemic-final-march-2021.pdf

Workforce

- King's Fund. Remote working Toolkit for GP and PCNs - https://www.kingsfund.org.uk/publications/remote-working-toolkit-general-practices-pcns
- Personalized Care – training support and embedding PC roles in PCNs - https://future.nhs.uk/PCCN/view?objectid=96252581

Silver Book II: NHS Elect, Prof Simon Conroy



Same:

- Ageing population challenges, biggest growth over 85s
- First 72 hours acute care in response to significant frailty seen in secondary care
- Acknowledges out of hospital care and wellness
- Acknowledges challenges of single system specialties
- More likely to be admitted from A&E- complexity
- Context specific guidance

Different:

- International resource
- BGS supported development and published
- Outcomes
- Workforce development
- Under prescribing

Who is in hospital?

- One hospital
- One day

- 97.6% occupancy
- 451 patients

- 71.4% aged 65+
- 322 patients

Average Age 81.3

17%

27%
3

22%
2

31%
1

3%

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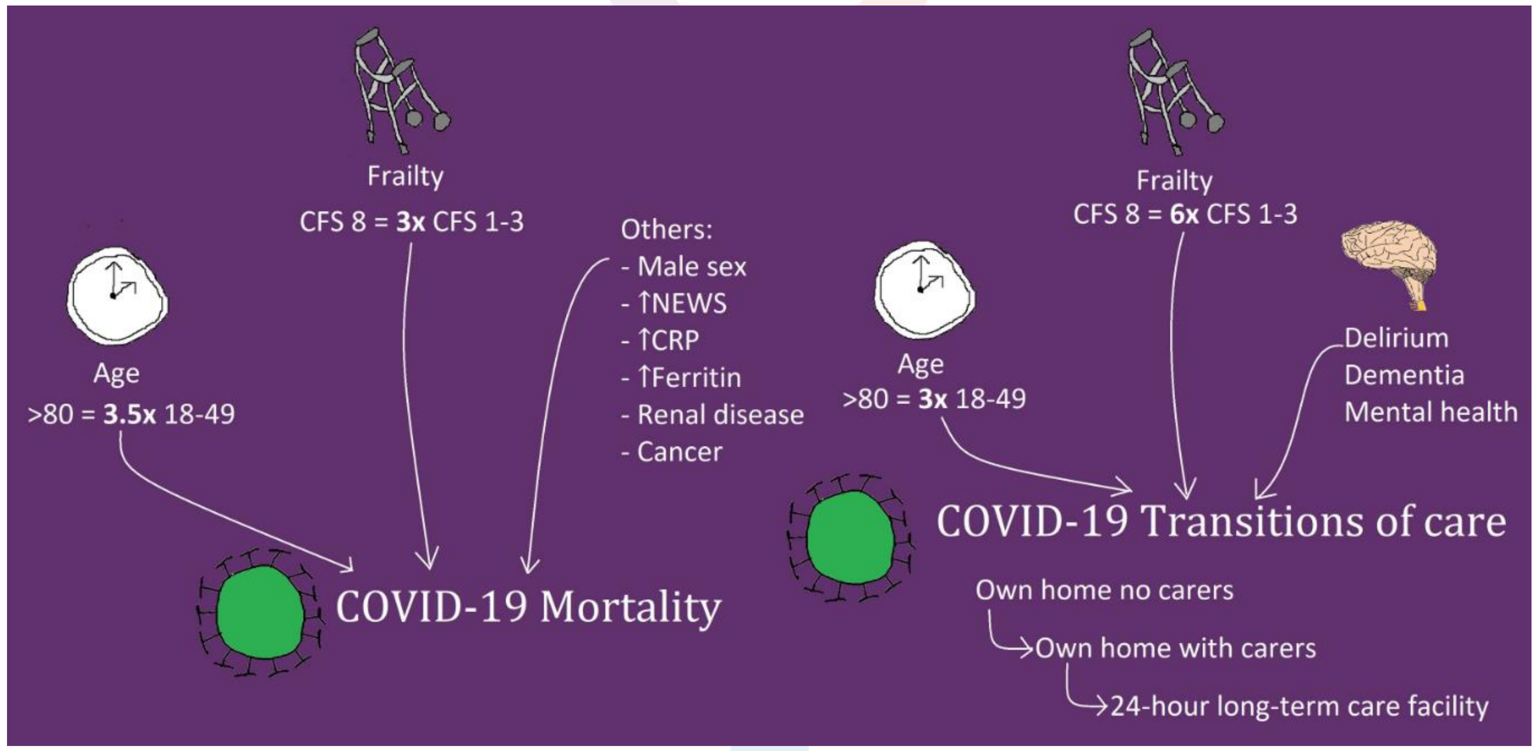
Nurse Ambassadors Older People
Lynne Shaw, Angela Fraser

BGS update (studies) – *Frailty, COVID and delirium*

- **CovidCollab study, multinational,** showed:
  - Age and frailly are independently linked with mortality and increased needs in survivors.
  - An increased likelihood of transition to a higher level of care on discharge with increasing age, frailty, delirium, dementia, and mental health problems.
  - Quality of life is individual and subjective, but for some, these transitions in care will have been hugely significant
    - https://www.bgs.org.uk/blog/presenting-the-results-of-the-covid-collaborative

- **Delirium, UK hospitals, world delirium awareness study**, showed:
  - Delirium affected 15% of patients who were screened on this day on admission.
  - Two-fold increased risk of death within 30 days
  - An increased length of stay of three days compared to those without delirium.
  - Prevalence increased with frailty severity.
  - Unfortunately, delirium had not been recognised by the usual care team in two thirds of cases. The most severely frail were also the least likely to have their delirium recognised.
    - https://www.bgs.org.uk/blog/geriatric-medicine-research-collaborative-publish-results-of-first-round-of-delirium-audit-in

Study outcomes (CovidCollab) – *frailty and outcomes*



Digital and Information Technology

i-CGA (CHA) Digital Tool

- Specification signed off
- HC building the ‘tool’ – likely completion end of March 2021
- Codification of the tool under discussion (challenging)
- Engagement events (iterations of the tool)
- Gateshead locality identified to pilot (Autumn for pilot 2nd phase)
- Drawing up implementation plan
- Early proposal to an evaluation strategy has been drafted

Website - www.frailtyicare.org.uk

- Updated take a look!
- Exploring alignment with NE&NC ICS website

Jackie’s Story

- Our ask:
  - Nearly there!!
  - Could you review the overall ‘content’, wording and suggest any changes and improvements please
  - Following completion, we need you consider engagement/usability

Workforce Projects

EnCOP

- All ICPs included
- Final draft of supporting assessment toolkit completed
- Facilitator guide almost completed
- Looking for PPI forums to add to engagement started
- Ncle University scoping project underway [NE OP WFD]

Workforce Planning [Gateshead - primary care]

- Project completed [primary care workforce planning tool], expected to continue via 'Gateshead System' team

Research and Development update

- RCF: supported living project data collection to start
- ARC EnCOP quantitative: to start, qualitative ongoing with PPI and research diaries
- ARC Frailty: patient and public events
- ARC EnCOP Implementation: unsuccessful, no formal feedback yet

Metrics and outcomes update

- Continued conversations with NECS and NEQOS colleagues to:
  - Update frailty metrics (aligned with national outcomes)
  - Updating of the functionality of frailty framework
  - Alignment to "Jackie's story' impact statements
  - Alignment to Population Health Management programme

Universal Personalised Care update

Claire Braid

Personalised Care Programme Manager – NENC

NHSE/I

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Universal Personalised Care update

- Training modules – continuing to recruit. Low uptake for 2-day Health Coaching and Quality Improvement in Primary Care offers.

- Most ICP areas are at the beginning of their Personalised Care journey. NENC high level priorities agreed, next steps are to support ICPs to map where they are against these priorities and create delivery plans.

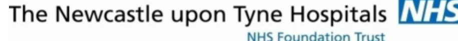
- PAM – mixed views from Personalised Care ICP leads on future use of PAM. Health System Support Framework expected June. Webinar on HSSF 22nd April: Understanding the Health Systems Support Framework for Supported Self-Management measures and interventions - Supported Self- Management workspace - FutureNHS Collaboration Platform

- Leeds case study – Personalised Care, frailty and population health management: Leeds PHM approach leads to Pers Care - Personalised Care Collaborative Network - FutureNHS Collaboration Platform

Falls, frailty and care and support planning

Pilot feasibility across Newcastle and Gateshead CCG

Funded by a grant from North East and North Cumbria Academic Health Science Network (AHSN)



The aim of the pilot programme was to develop and evaluate the inclusion of falls assessment and prevention (in the context of frailty) within existing care and support planning processes (CSP) in general practice

With the aim of informing a future local incentive scheme

Operational Group

- Year of Care team
- Falls Co-ordinator
- Primary Care Nurse Lead(s)
- Consultant Geriatrician
- CCG Representatives
- Research team (NECS/ Northumbria University)

2 core questions:

- How do we introduce falls prevention and assessment in a systematic way to general practice for people already experiencing care and support planning ?
- What needs to be done to introduce care and support planning for people living with frailty in the future?

Year of Care training sites – Feb 21

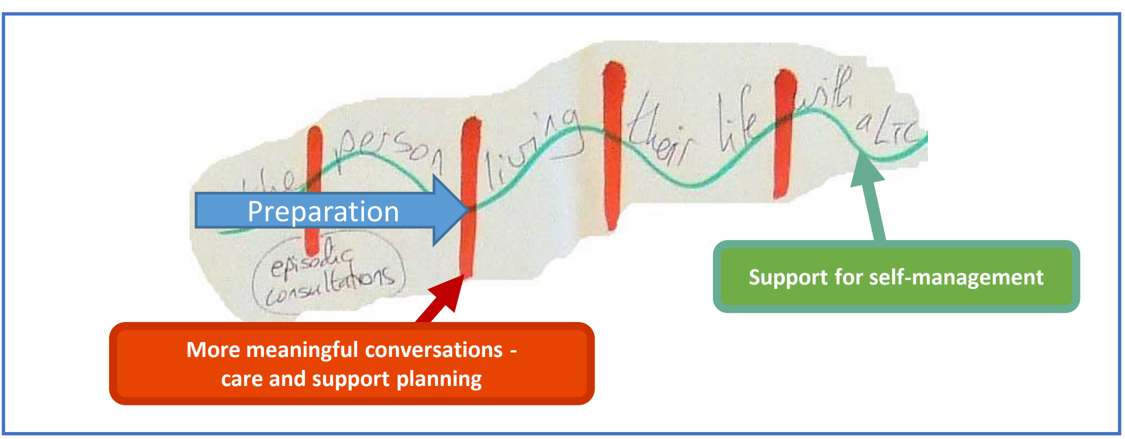
Shetland Islands

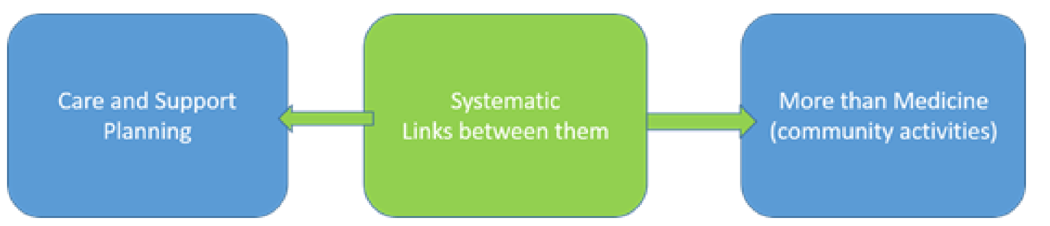
Red
Year of Care pilot sites for diabetes 2007
Yellow
NHS diabetes roll out programme 2009-11
White
PHB with integrated care teams
Green
LTC and diabetes
Blue
British Heart Foundation

Jersey

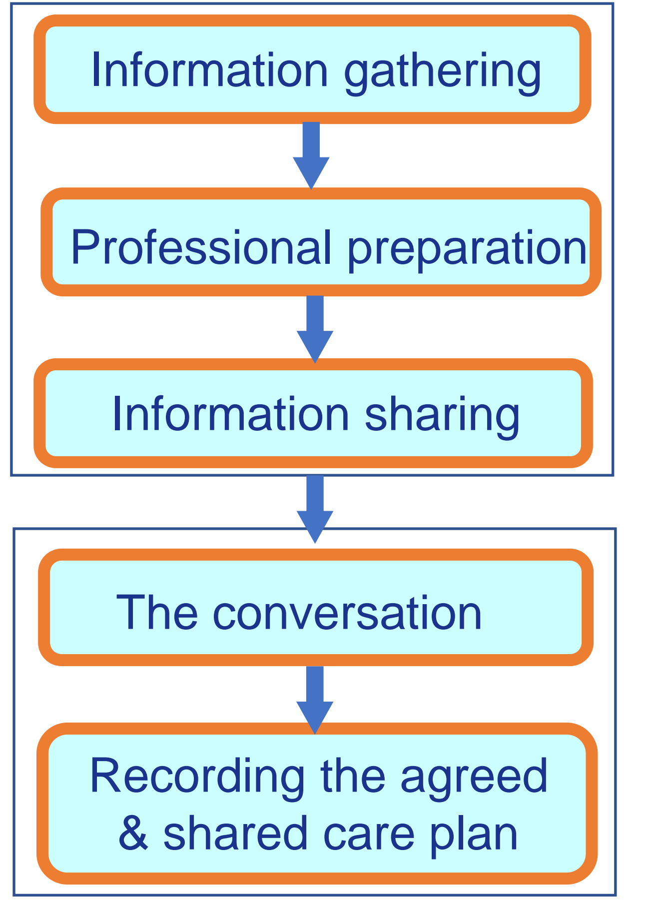
Singapore

Care and support planning core principles





Care and support planning: the process



Disease surveillance
Tests and checks performed where needed

Triage and identification of clinical issues
- review of results and red flags
- initial medicines review
- promotes continuity

Preparation
Results/agenda setting prompts sent to patient > 1 week before conversation

Conversation
A meeting of equals and experts

Prepared practitioner and patient:
- review how things are going
- consider what's important
- share ideas
- discuss options
- develop a care plan

Care and Support planning across NGCCG

CSP allows for a ‘better conversation’ between a prepared person and a trained practitioner, to focus on all the issues a person may be living with.

Traditionally delivered to those with defined single or multiple long-term conditions

Well established across NGCCG with 57/60 practices already delivering CSP for people with long term conditions

This study worked with 7 practices between July 2019-Jan 2020 to pilot the feasibility of incorporating falls and frailty topics within CSP

2,061 patients from 1 of 7 practices during study term

Many of the deficits in the Electronic Frailty Index (eFI) are long term conditions (or associated with)

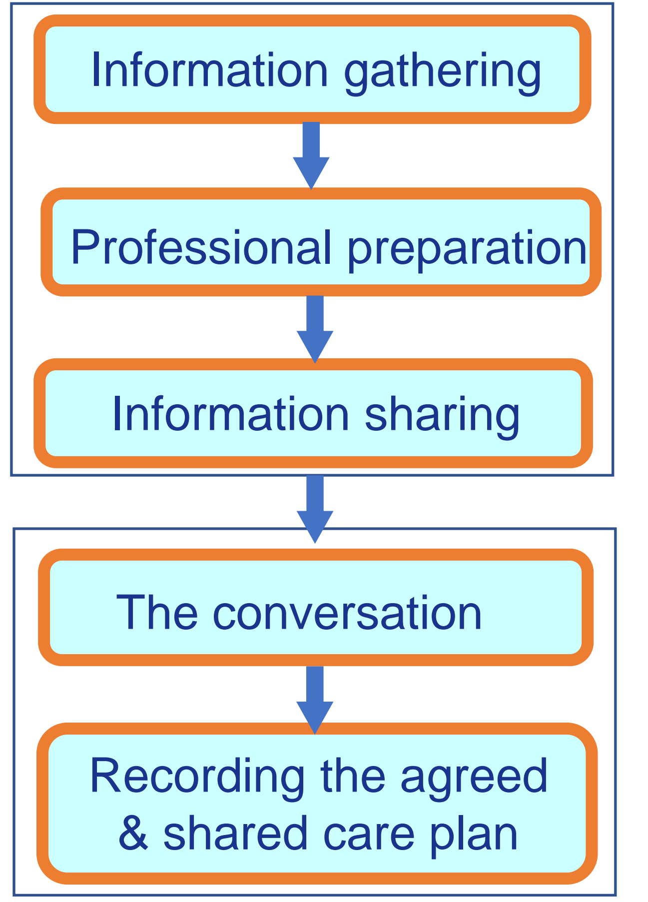
- Memory & cognitive problems
- Cerebrovascular disease
- Dizziness
- Parkinsonism & tremor
- Sleep disturbance
- Visual impairment
- Hearing impairment
- Hypertension
- Ischaemic heart disease
- Atrial fibrillation
- Heart valve disease
- Hypotension/syncope
- Heart failure
- Peripheral vascular disease
- Dyspnoea
- Respiratory disease
- Peptic ulcer
- Weight loss & anorexia
- Urinary incontinence
- Urinary system disease
- Chronic kidney disease
- Osteoporosis
- Fragility fracture
- Arthritis
- Diabetes
- Thyroid disease
- Skin ulcer
- Anaemia/haematinic deficiency
- Falls
- Foot problems
- Housebound
- Mobility & transfer problems
- Activity limitation
- Social vulnerability
- Requirement for care
- Polypharmacy

Unsurprisingly, practices where a wide range of conditions were included in their current CSP recall already involved **67% of registered people over 65 years, with a verified frailty score** (mostly mild or moderate)

Practice profiles

Practice number	Months of data collected	List size (rounded)	% >65 years	Social deprivation quintile*	BME %	Electronic medical record
Gateshead						
Practice 1	4	10,000	18.2	4	1.9 Asian, 1.7other non-white	EMIS Web
Practice 2	2	16,000	22.0	4	1.3 Asian	EMIS Web
Practice 3	7	16,000	28.1	8	1.1 Asian	EMIS Web
Practice 4	7	6,000	12.4	2	1.2 mixed, 3.6 Asian,1.2 Black, 1.0 other non-white	EMIS Web
Newcastle						
Practice 5	4	10,000	11.2	2	2.0 mixed, 28.6 Asian, 3.3 black, 2.7 other non-white ethnic	SystmOne
Practice 6	0	10,000	13.9	1	1.7 mixed, 11.6 Asian, 3.3 black, 2.1 other non-white ethnic	EMIS Web
Practice 7	4	13,000	22.8	9	1.5 mixed, 7.5 Asian, 2.3 other non-white ethnic	SystmOne
Practice 8	7	10,000	21.4	2	1.4 mixed, 7.6% Asian, 1.9 black	EMIS Web

Care and support planning: the process



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Information gathering appointment

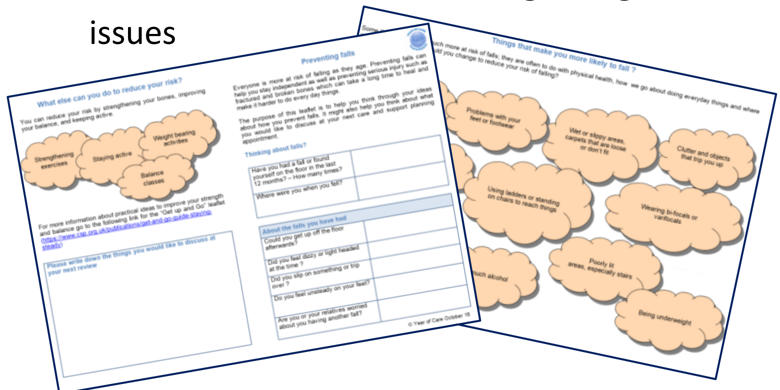
Over 65 with a validated frailty score :

Ask falls questions and record/code answer. In the last 12 months:

1. Have you had a fall including a slip or trip?
2. Have you had a blackout or found yourself on the floor?
3. Have you noticed any problems with your balance (e.g. whilst walking, standing up from a chair or dressing?)

Positive answer to any question: Health Care Assistant completes and records lying and standing BP

Patients who respond positively to questions are given a Preventing **Falls self-assessment leaflet by the HCA** and encouraged to bring it to the CSP conversation having thought about issues



Preventing falls

Everyone is more at risk of falling as they age. Preventing falls can help you stay independent as well as preventing serious injury such as fractured and broken bones which can take a long time to heal and make it harder to do every day things.

The purpose of this leaflet is to help you think through your ideas about how you prevent falls. It might also help you think about what you would like to discuss at your next care and support planning appointment.

Thinking about falls?

Have you had a fall or found yourself on the floor in the last 12 months? – How many times?	
Where were you when you fell?	

About the falls you have had	
Could you get up off the floor afterwards?	
Did you feel dizzy or light headed at the time ?	
Did you slip on something or trip over ?	
Do you feel unsteady on your feet?	
Are you or your relatives worried about you having another fall?	

What else can you do to reduce your risk?

You can reduce your risk by strengthening your bones, improving your balance, and keeping active.

Strengthening exercises

Staying active

Weight bearing activities

Balance classes

For more information about practical ideas to improve your strength and balance go to the following link for the "Get up and Go" leaflet (https://www.csp.org.uk/publications/get-and-go-guide-staying-steady)

Please write down the things you would like to discuss at your next review

© Year of Care October 18

Things that make you more likely to fall ?

...uch more at risk of falls; they are often to do with physical health, how we go about doing everyday things and where ...ld you change to reduce your risk of falling?

Problems with your feet or footwear

Wet or slippy areas, carpets that are loose or don't fit

Clutter and objects that trip you up

Using ladders or standing on chairs to reach things

Wearing bi-focals or varifocals

...uch alcohol

Poorly lit areas, especially stairs

Being underweight

The conversation

Recording the agreed & shared care plan

- Ask patient for their own self reflections from "self-assessment leaflet"
- Identify any concerns /risks/agree a plan for self management or/and referral

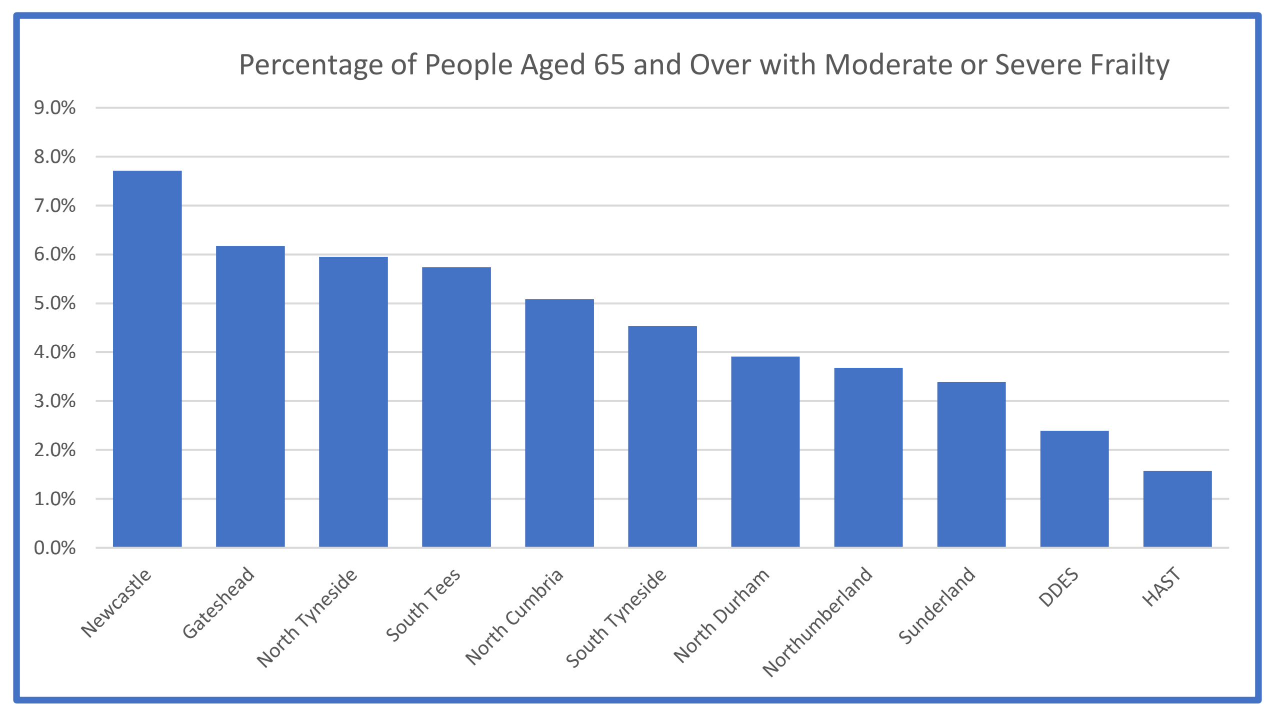
CSP Conversation: "practitioner" professional story would include

- >65 but not frail or no falls or instability – positive messages about ageing e.g. physical activity
- >65 and falls positive – discuss falls self-assessment and issues (including BP)
  - Potential outcomes
    - Self management (e.g. leaflet 'Get up and go', optician review , advice on alcohol)
    - Physical activity – general community support , strength and balance 'Staying steady classes'
    - GP for medication review or further assessment
    - Referrals e.g. to OT, podiatry, community falls team
    - Referrals to specialist falls team/other services

Key changes in process and practice

- IT templates altered to accommodate additional aspects (building into existing LTC/CSP reviews)
- Patient resources: self – assessment tools, Get Up and Go leaflet
- A checklist based on the SPLATT acronym (Symptoms, Previous falls, Location, Activity, Time, Trauma) was offered to clinicians as a framework to identify potential underlying causes of falls.
- The teams were also made aware of local resources such as strength and balance classes and other interventions to support healthy ageing/prevention.

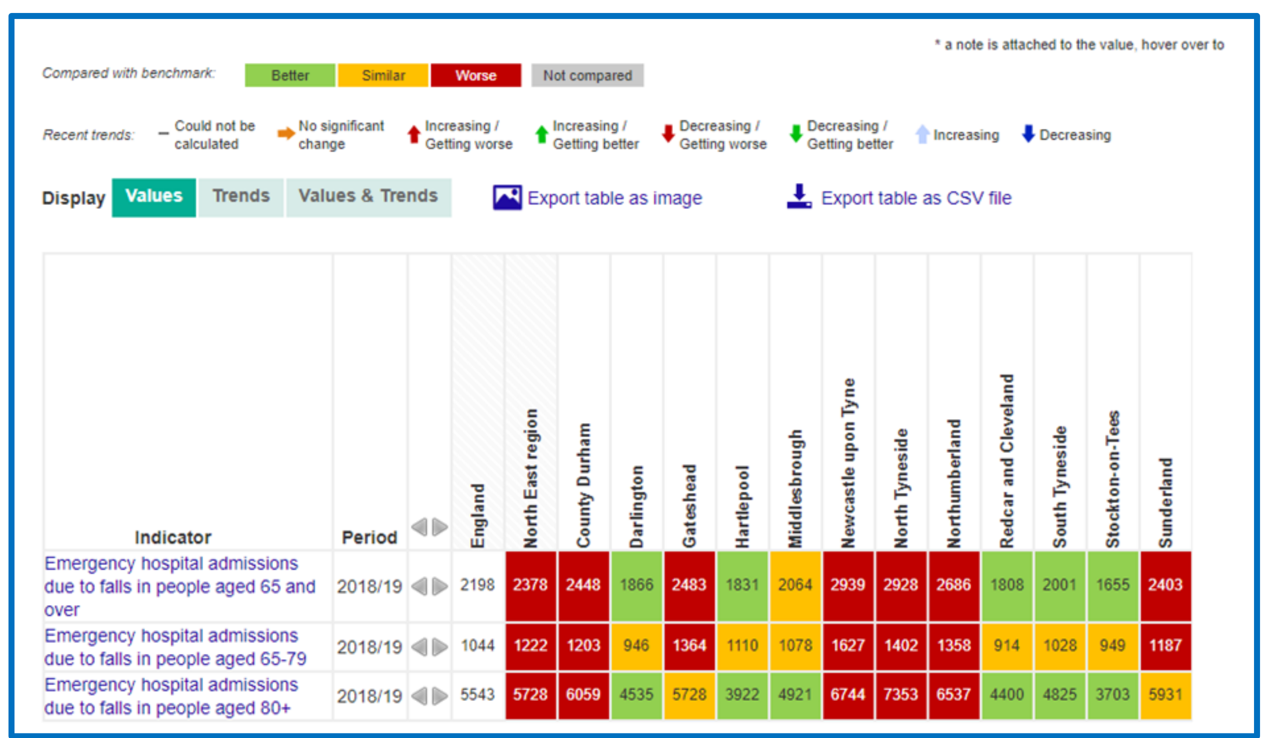
Why focus on frailty ?



Source: North of England Commissioning Support Unit (NECS), March 2020.

Why falls ?

Emergency admissions due to falls in those aged 65 and over (per 100,000 of the population)



* a note is attached to the value, hover over to

Compared with benchmark: Better Similar Worse Not compared

Recent trends: – Could not be calculated; No significant change; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; Increasing; Decreasing

Display: Values | Trends | Values & Trends — Export table as image — Export table as CSV file

Indicator	Period	England	North East region	County Durham	Darlington	Gateshead	Hartlepool	Middlesbrough	Newcastle upon Tyne	North Tyneside	Northumberland	Redcar and Cleveland	South Tyneside	Stockton-on-Tees	Sunderland
Emergency hospital admissions due to falls in people aged 65 and over	2018/19	2198	2378	2448	1866	2483	1831	2064	2939	2928	2686	1808	2001	1655	2403
Emergency hospital admissions due to falls in people aged 65-79	2018/19	1044	1222	1203	946	1364	1110	1078	1627	1402	1358	914	1028	949	1187
Emergency hospital admissions due to falls in people aged 80+	2018/19	5543	5728	6059	4535	5728	3922	4921	6744	7353	6537	4400	4825	3703	5931

Source: Public Health England. Public Health Profiles. [July2020] https://fingertips.phe.org.uk © Crown copyright [2020]

Data sources for evaluatio

Quantitative	**Qualitative**
➢ National data on practice size and demographics ➢ NECS: Background data on frailty, LTCs and CSP from LIS scheme across NGCCG ➢ NECS: Pilot practice data on pilot scheme activity from NECS ➢ Practice desktop exercise ➢ Outcome Cards	➢ Training observations ➢ Semi-structured interviews with practice staff

Implementation – Training

- What is frailty and how it is identified?
- Falls risk factors
- How to incorporate the new process into care and support planning (including providing resources)
- Undertaking and interpreting lying/standing blood pressure
- Having meaningful conversations about falls and frailty (including how to ask the questions)
- Interventions to support healthy ageing/prevention

Implementation challenges

- Accessing practice teams and staffing changes
- Practice Champions and dissemination of information within practice
- Overall team collaboration within the practice and CSP “readiness”
- Fitting in lying and standing BP into an already “tight” information gathering review

Evaluation challenges:

- Currently practice data recorded and collected for different purposes (monitoring/ individual care) didn’t always “match” data collected for study purposes
- Some Read codes proved not to be “unique” to the project
- Poor completion of Outcome cards at practice level
- COVID – impacted on some final interviews with staff

Key Findings: Qualitative Results

- The researchers observed the training to be well received
- Practitioners acknowledged that including falls in the CSP process enabled them to broaden the content of conversation to include frailty
- Many reported feeling more confident in discussing frailty topics within all their clinical practice.

"Frailty and falls, before doing the training, I wasn't really sure what to do with it. And I think just being able to speak to people about that. But also [...] just being able to speak to the GPs about maybe changing their meds slightly if they are on anti-hypertensives. But I suppose also talking to them about staying hydrated and things like that "

"I suppose it highlights with the patient that it's not normal, they don't have to just put up with it. So... because a lot of them they will say 'ah, that's just me age' but I suppose it just says 'it doesn't have to be like that, there's something you can do"

Key Findings cont…

- **Practitioners reported modifying medicines, promoting self-management and signposting to formal strength and balance classes as outputs of a falls discussion within the conversation.**

"A lot of the people who fall, when you drill down you find it's to do with something that might have been avoided. And it's really trying to get in before that […] by asking those questions, to get people to think a bit more"

"The questions are good but I suspect the self-assessment is even better, because they go home and they chat and then their husband says 'actually, that's the third time you've tripped on that doormat!'"

"I don't know whether it's from this pilot but I'm more proactive at reducing people's medication, especially their antihypertensive"

Quantitative Results

- **2061** patients were included in the pilot
- The response rate for those identified at risk of falls was between **30-50%**
- **58-74%** of this group had a positive result for postural hypotension.
- Headline figures suggest that approximately **67%** of those in this target group for falls are already seen as part of CSP in Newcastle and Gateshead
- Only 30 outcome cards were returned so conclusions re patient outcomes can not be reliably drawn
- **Future projects need a dedicated data collection tool designed around an identified research cohort with mechanisms for checking accuracy at all stages**

Further research questions

Further learning about implementation and impact

- Greater understanding of the cohort involved/not involved e.g. the characteristics of the elderly frail population who were not included, the characteristics and issues for the 30% of people who do not attend CSP
- How best to support individual practices to create a culture that values and supports CSP as part of routine care
- The ‘quality’ of the CSP conversation as it applies to falls and frailty
- The outputs of the CSP conversation including the referral and uptake of specific interventions such as strength and balance groups
- The specific issue of asymptomatic hypotension as a risk for falls needs further clarification.
- Clinical support and targeted training would be required for any future role out

Thank you for listening…

Any questions??

Development of a standard evaluation method for evaluating the impact of frailty pathways/models on care and outcomes

Juliana Thompson, Glenda Cook, Lesley Bainbridge, Mark Parkinson

National Institute of Health Research: Applied Research Collaborative North East & North Cumbria (NIHR ARC NENC)

Study for 1 year, from March 2021

The project team

Leads: Juliana Thompson, Glenda Cook, Lesley Bainbridge	
Mark Parkinson, Senior Research Assistant	Northumbria University
Daniel Cowie, GP and Clinical Lead Ageing Well Network NENC	NG CCG
Lindsay Courtney, Intermediate Care Lead	Homegroup
Emma Flewers, Lead Community Nurse Practitioner	Gateshead NHS Foundation Trust
Aja Murray, Statistician	Edinburgh University
Steve Parry, Clinical Senior Lecturer, Consultant Geriatrician, Clinical Director OP NG CCG	Newcastle University
Janet Probert, Strategic Lead Healthy Ageing Team	AHSN NENC

The problem

In order to support people with frailty, a number of frailty pathways/care models have been developed, implemented, and evaluated.

Thompson et al.'s (2020 – in review) literature review of the **key components and outcomes of frailty care pathways in primary and community care**

- Identified key components of effective frailty pathways
- Identified ineffective evaluation of frailty pathways/care models
  - Most studies evaluate one intervention/care pathway.
  - No studies compare a number of interventions/pathways using the same evaluation process. This has led to challenges in drawing conclusions about the effectiveness of interventions/care pathways.
  - Drawing conclusions from across different interventions and populations is challenging, and studies should use a standardised evaluation method across interventions/populations in order to reach meaningful conclusions.

Need for a standard method for evaluating the impact on outcomes of frailty pathways/models, and this is currently not available.

This proposed research seeks to address this requirement and will support the development of a robust evidence base.

What we plan to do

Aim

- Develop a standard evaluation method for evaluating the impact on outcomes of frailty pathways/models of care and outcomes.

Objectives

- Develop a panel of experts in frailty service delivery and evaluation
- Use a Delphi approach to gain consensus of experts about patient outcomes, metrics and methods of evaluation
- Develop a standard evaluation method for evaluating the impact on outcomes of frailty pathways/models of care and outcomes

Method

Delphi method: generate a consensus from surveying the panel of experts.

- 2-round Delphi - suitable when there is a clear literature base from which to establish the survey instrument.
- Survey instrument will also be informed by consultation with older people, carers and members of the public to ascertain what are important patient outcomes from their perspective (Feb 2021)

Process

- Stage 1: Define the problem and statement generation
- Stage 2: Questionnaire rounds
  - Round 1: Distribute the questionnaire to the panel, aggregate and summarise responses, redistribute to the panel for comments
  - Round 2: Analysis of round 1 data will inform the round 2 questionnaire, which will then be distributed to the panel
- Stage 3: Reaching consensus
  - Panellists will consider their own responses in the light of the group responses
  - Panellists invited to a consensus workshop

Achieve consensus of a standard method for evaluating frailty services

Expert panel

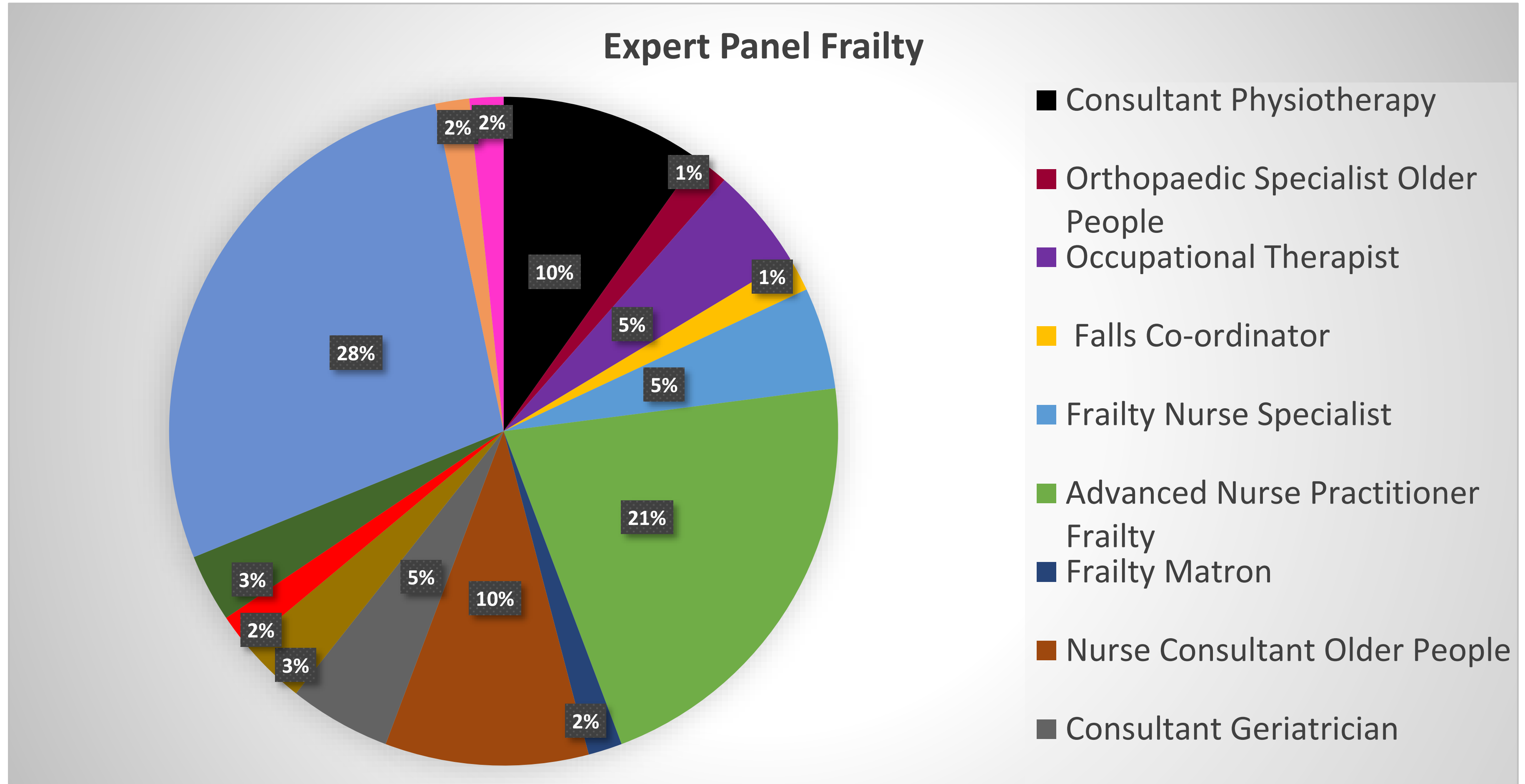
Regional, national, international **clinicians and academics** with expertise in:

- Caring for people with frailty
- Developing frailty care pathways
- Research in frailty care
- Evaluating care pathways/models

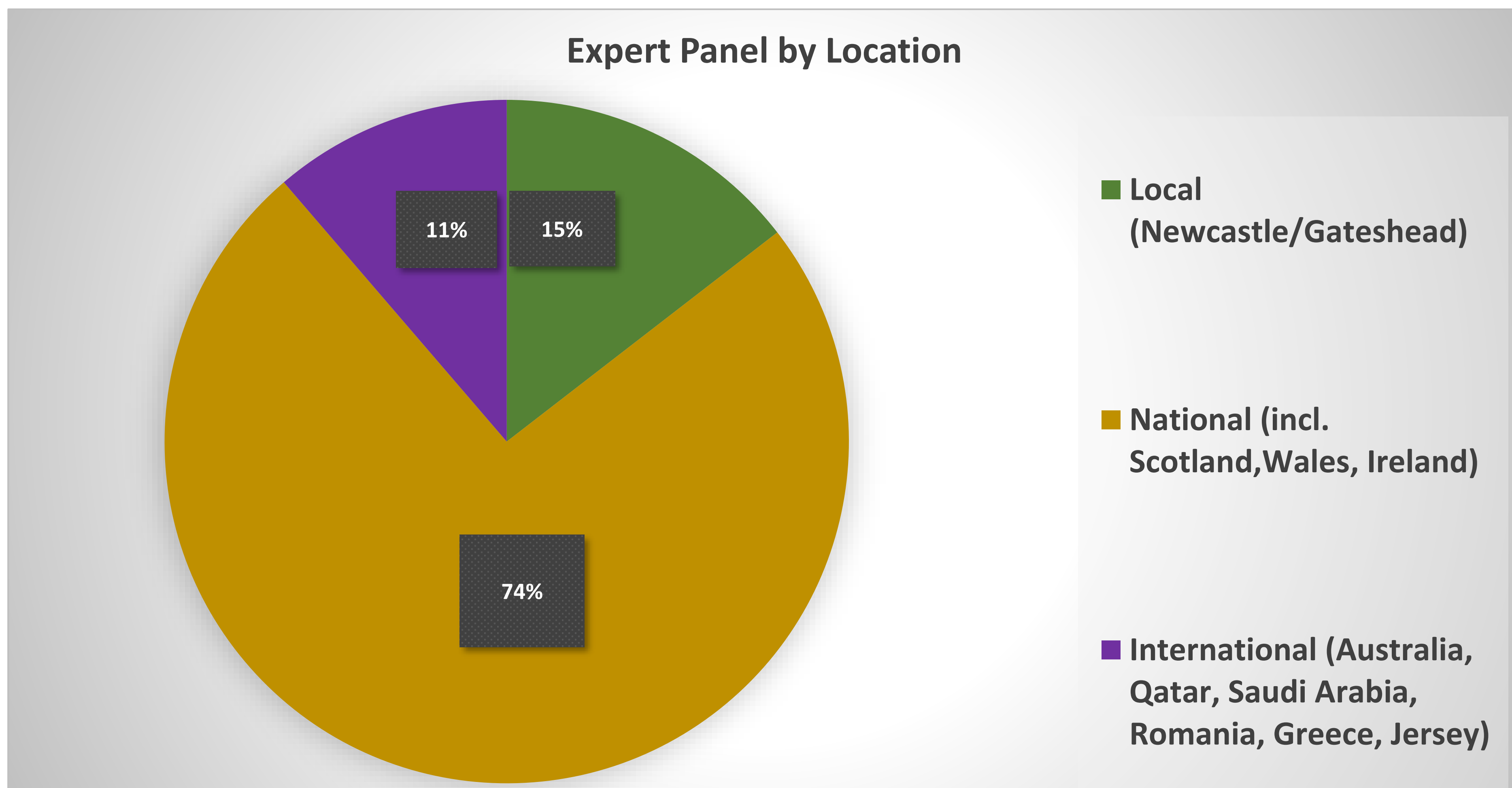
Recruitment of Expert Panel

- With thanks to Lesley Bainbridge, Jo Gough (British Geriatrics Society),Danielle Brazier/Susanne Finnegan (AGILE Research Officers) & Prof. Wendy Moyle (Griffith University, Australia).
- **61** Confirmed Expert Panellists whose specialism is frailty (to date).
- Awaiting responses from a further **15** people, including from **six** Academic Authors listed in our recent Frailty Review.

61 Confirmed Expert Panellists



61 Confirmed Expert Panellists



For further Information…

Please contact:

Mark Parkinson

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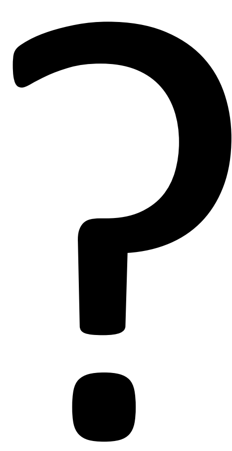
Any questions



Information Sharing Session

Good practices, challenges, issues moving forward

Any Other Business

Date and Time of Next Meeting

Thursday 3 June 2021 at 14:00-16:00

Close

involve consider assess respond evaluate