A Regional Approach to Ageing Well Community of Practice

3rd June 2021

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

Welcome and Introductions

Frailty – what's the latest?

Dr. Dan Cowie

Clinical Lead

Updates linked to Frailty ICARE

Consider

- Study – predictors or frailty (Lower cognitive functioning, polypharmacy, and pain) and vitality (male sex, moderate alcohol use, more emotional support received, and no hearing problems - https://www.karger.com/Article/FullText/512049

Respond

Healthy Ageing

- Ageing Better – Transforming later lives - https://www.ageing-better.org.uk/sites/default/files/2018-07/Ageing-Better-Transforming-Later-Lives.pdf

Community Connectivity

- BMJ article – Community Centre approaches to reducing HI - https://bmjopen.bmj.com/content/10/8/e036044

Updates linked to Frailty ICARE

LTC Care

- UCL decision support tool for patient with dementia and COVID-19 - https://www.ucl.ac.uk/psychiatry/sites/psychiatry/files/endemic_decision_aid_26_08_20_v.2.pdf

Community Crisis Response and Recovery

- Article- Age and Ageing. Follow-up services for delirium after COVID-19—where now - https://academic.oup.com/ageing/article/50/3/601/6106229

Frailty Hospital Care

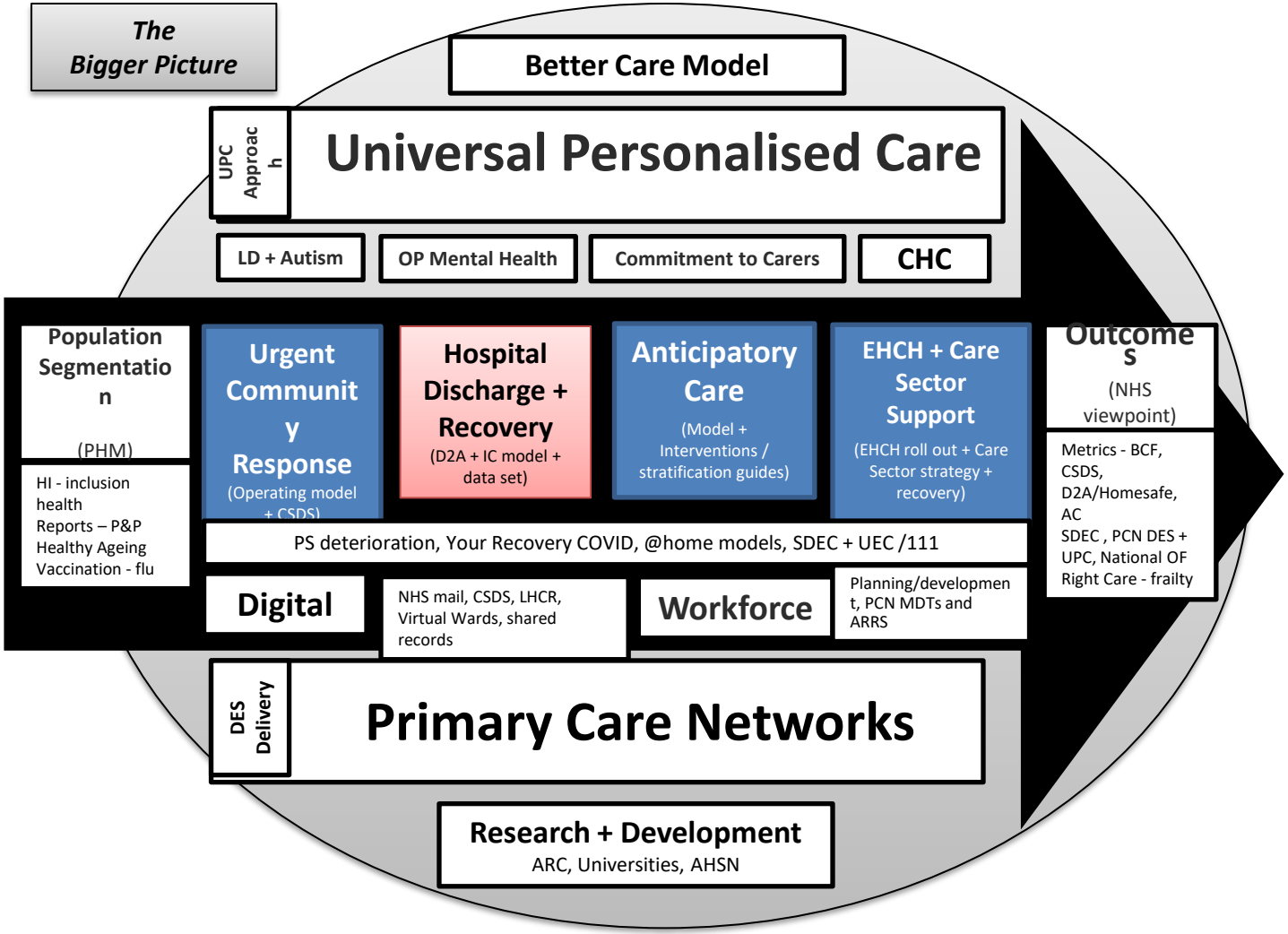
- Acute Frailty Service (apart of SDEC) - https://future.nhs.uk/SDEC_CommunityofPractice/view?objectID=18189424
- Article - A systematic review. Age and Ageing. What is the relationship between validated frailty scores and mortality for adults with COVID-19 in acute hospital care - https://academic.oup.com/ageing/article/50/3/608/6097011

Digital

- Digital inclusion in mental health - https://amhp.org.uk/digital-inclusion-guide/

Workforce

- Frailty E-learning modules - https://portal.e-lfh.org.uk/Component/Details/683810


The Bigger Picture
Better Care Model
UPC Approach
Universal Personalised Care
LD + Autism
OP Mental Health
Commitment to Carers
CHC
Population Segmentation
(PHM)
HI - inclusion health
Reports – P&P
Healthy Ageing
Vaccination - flu
Urgent Community Response
(Operating model + CSDS)
Hospital Discharge + Recovery
(D2A + IC model + data set)
Anticipatory Care
(Model + Interventions / stratification guides)
EHCH + Care Sector Support
(EHCH roll out + Care Sector strategy + recovery)
Outcomes
(NHS viewpoint)
Metrics - BCF, CSDS, D2A/Homesafe, AC
SDEC , PCN DES + UPC, National OF
Right Care - frailty
PS deterioration, Your Recovery COVID, @home models, SDEC + UEC /111
Digital
NHS mail, CSDS, LHCR, Virtual Wards, shared records
Workforce
Planning/development, PCN MDTs and ARRS
DES Delivery
Primary Care Networks
Research + Development
ARC, Universities, AHSN

Ageing Well - *Offering all Adults the opportunity to Live their Best lives for Longer at Home*

www.frailyicare.org.uk

UNIVERSAL PERSONALISED CARE

Enabling choice and shared-decisions across a life course

Population Segmentation & Risk Stratification

focus on vulnerability and inequality

Anticipatory Care

EHCH + Care Sector Support

UCR + Hospital Discharge/ Recovery

Healthy Ageing support and enabling **Communities to Connect**

Support for **Long Term Conditions, Frailty** and **End of Life**

Timely access to **Crisis Response** and **Rehabilitation** at or close to home

A coordinated **Discharge** and **Recovery** on leaving hospital

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

PRIMARY CARE NETWORKS

People, teams and technology at work

Digital and Information Technology

i-CGA (CHA) Digital Tool

- Specification signed off
- Tool built – hazard workshops done, further testing June
- Codification of the tool under discussion (challenging)
- Gateshead locality identified to pilot – start end of July
- Pilot 2nd phase – end of the year
- Implementation plan developed, with guides
- 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 v2

Our ask:

- Completed
- Discussing launch approach and sharing

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Workforce Projects

Gateshead Primary Care Workforce Planning Project

- No further update

EnCOP

- Continues to grow
- Newly developed resources on the website:
  - local assessor facilitator guidance
  - updated framework
- NHSE ACP Competency Assessment; benchmarked and assured complementary with the added bonus of EnCOP includes evidence examples and competency assessment

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 and potentially national Anticipatory Care Model (roll out)

Research and Development update

- RCF: supported living project data collection underway
- ARC EnCOP quantitative: continues
- ARC Frailty [standardisation of evaluation for frailty pathways]:
    - international expert panel recruited
    - almost completed engagement forums

Jackie’s Story and Planning (conversation)

Jackie's story

Without CGA we wouldn't know all those things about Jackie.

We wouldn't know Jackie had Good Care

Acknowledgment:
NHSEI Better Care Fund Team NENC, Jayne Robson

Jackie's Story

A System Response to Frailty

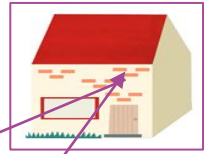
Identifying changing and increasing needs?

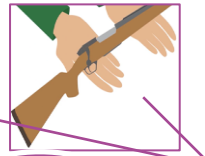
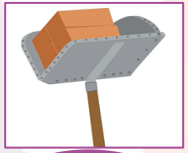
Understanding CGA

- Good **evidence-base**
- Consider in moderate frailty, definitely for **severe frailty**!
- **Five inter-related components** – social, functional, physical, environmental and psychological
- Undertaken by **specialist practitioner** with **MDT access**
- **Should be 'dynamic'** – responsive, based on changing need, initiated anywhere within the health and care system as well as proactive and cyclical.
- Identifies **problems and actions** ('what matters' to the person)
- Results in **Personalised Care and Support Plan** including ACP and Emergency Health Care Planning (when appropriate)







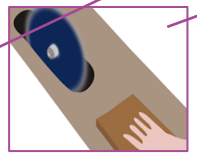
carersUK
making life better for carers


Physical
Psychological
Social
Functional
Environmental

Clot Busters

Penicillin Allergy

Personal
Care
Plan

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? WFD ?

Ageing Well
(NHS LTP priorities)

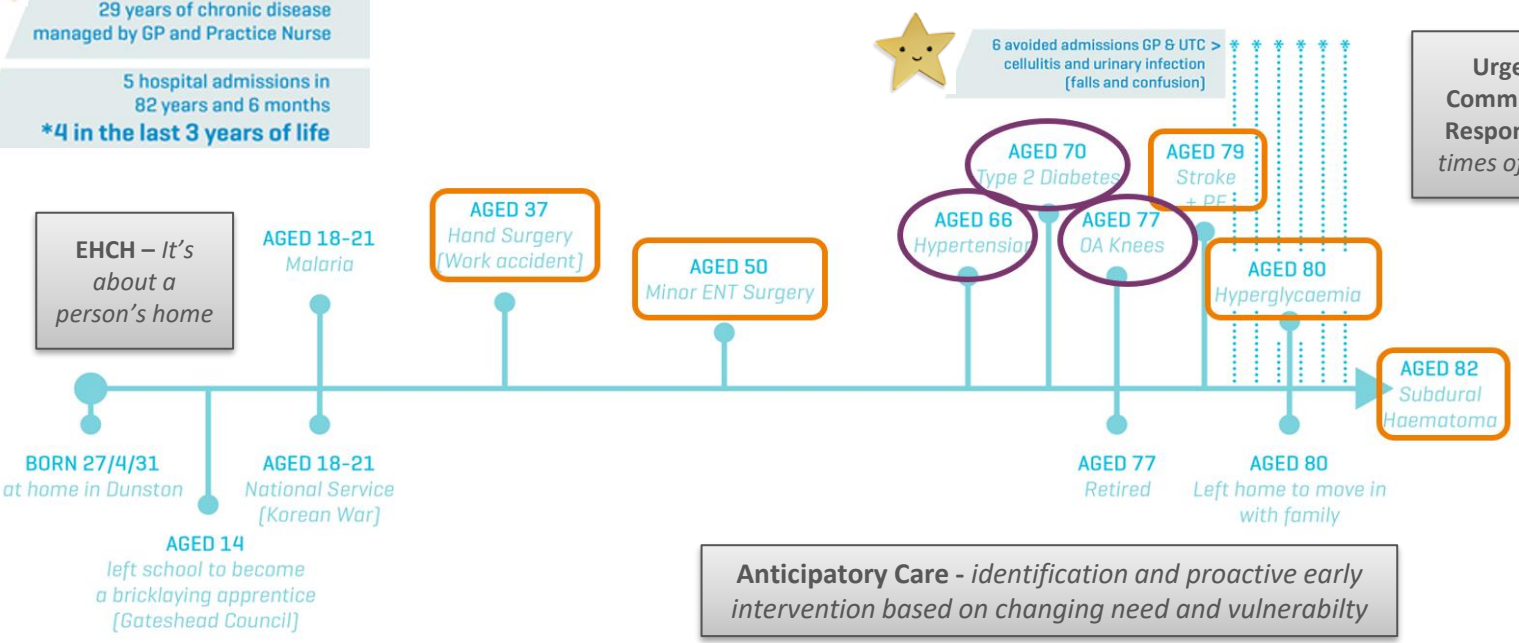
Universal Personalised Care - *offering choice, shared decision-making, self-management and Care and Support Planning*

Healthy Ageing

Support for LTCs

Community Connectivity

CGA and Care Coordination



Anticipatory Care - *identification and proactive early intervention based on changing need and vulnerabilty*

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Jackie's Journey continued…..

1. Physical health is the most obvious of all the health signs [WHO 2020]
   social, psychological, environmental & functional context to identify needs holistically

2. Long relationship with primary care team for LTC
   multi-morbidity, disability and frailty overlap, recognising changing need

3. Respond to changing needs and what matters
   understand social context
   managing occupation in later life – likes and function
   case management / care coordination
   rapid response
   access to specialists

4. Remember family carer support

North East & Yorkshire Region:
The Commitment to Carers Programme

Supporting Unpaid Carers

Campbell McNeill, Leadership Support Manager, NE&Y Region Safeguarding Team– campbell.mcneill@nhs.net

NHS England and NHS Improvement

The Carers Voice:

https://www.gatesheadcarers.com/blogs/voices-of-the-pandemic

Aims of the session

- An overview of how Carers are defined
- An overview of the impact caring has on Carers
- An overview of the Long Term Plan Ambitions for Carers
- An overview of how we are working to achieve those ambitions
- A discussion on the many links with the Personalised Care Agenda

Who is considered a Carer?

‘A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid’

NHS commissioning » Who is considered a carer? (england.nhs.uk)

NICE Guidance (NG150)

https://www.nice.org.uk/guidance/ng150

1.1 Information and support for carers: overarching principles

The right to information and support

1.1.1 Local authorities should provide information to carers to support them in their caring role. Information provision must meet the requirements of the Care Act 2014.

1.1.2 Practitioners in health and social care (including healthcare professionals in primary and secondary care, social care practitioners, care and support workers and personal assistants) should use every opportunity to tell carers they have a right to information and support and how to get it (see section 1.2).

carersUK
making life better for carers

NHS

Unpaid carers save £119 billion a year

11 May 2011

New estimates, calculated by charity Carers UK and the University of Leeds, show the care provided by friends and family members to ill, frail or disabled relatives is now worth a staggering £119 billion every year. (1)

- The figure has risen by over a third since the 2007 estimate, which stood at £87 billion
- Carers' contribution now far outstrips the total cost of the NHS (£98.8 billion). (2)
- The figure amounts to £2.3 billion per week and £326 million per day.

New estimates show that there are around 6.4 million people in the UK providing care for ill or disabled loved ones that would otherwise cost the state £18 an hour, meaning that each carer saves on average £18,473 a year.

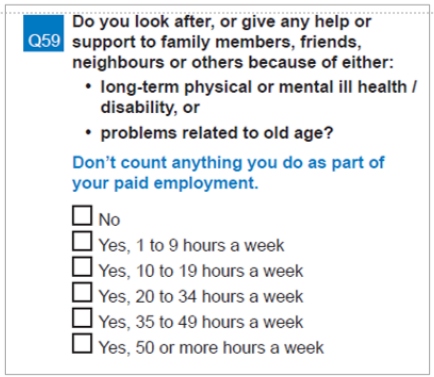
Unpaid carers save £119 billion a year - Carers UK

GP PATIENT SURVEY BACKGROUND

Survey Size — Sent to around **2.3 million patients registered with a GP practice**. Received around **740,000 responses** in 2020. The response rate in 2020 was 31.7%

Criteria — Patients **aged 16 or over** can be sent a survey and have to have been **registered with current GP practice for 6 months or more** at the time of sampling

Orgs — The 2020 survey covered **6,821 GP practices** and all 135 Clinical Commissioning Groups



Q59 **Do you look after, or give any help or support to family members, friends, neighbours or others because of either:**

- **long-term physical or mental ill health / disability, or**
- **problems related to old age?**

Don't count anything you do as part of your paid employment.

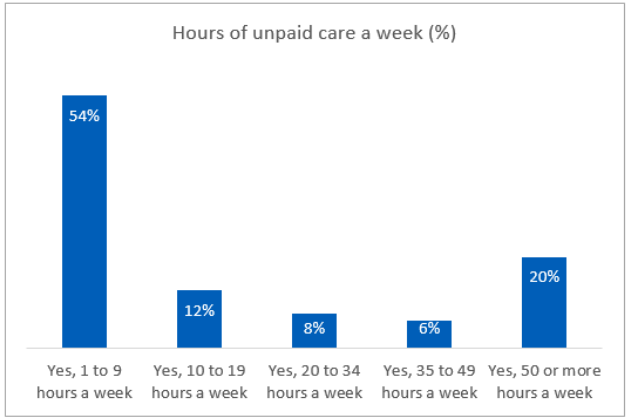
- ☐ No
- ☐ Yes, 1 to 9 hours a week
- ☐ Yes, 10 to 19 hours a week
- ☐ Yes, 20 to 34 hours a week
- ☐ Yes, 35 to 49 hours a week
- ☐ Yes, 50 or more hours a week

'Non carers' are those who answered 'No' to Q59 and 'Carers' are those who answered one of the following to Q59:

- 'Yes, 1-9 hours a week'
- 'Yes, 10-19 hours a week'
- 'Yes, 20-34 hours a week'
- 'Yes, 35-49 hours a week'
- 'Yes, 50+ hours a week'

In 2020, **we received surveys from 135,000 carers**

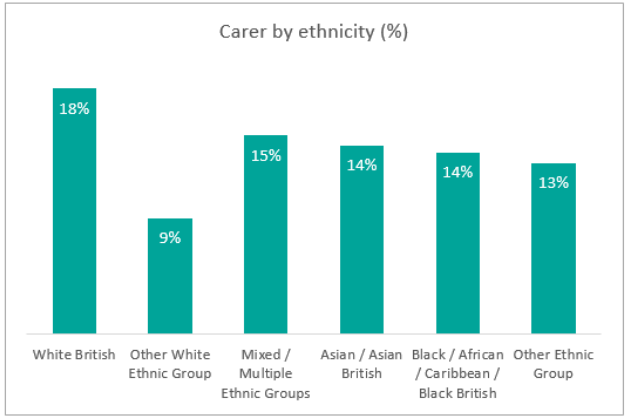
Carer demographics: GP Patient Survey

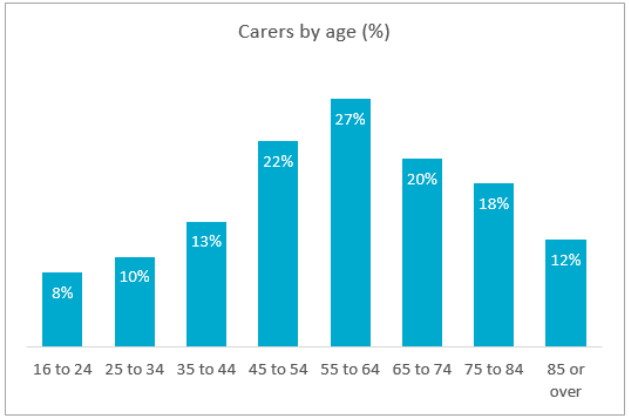


Most carers provide 1 to 9 hours of care per week (54% of carers). A fifth of carers provide 50 hours or more (20%).

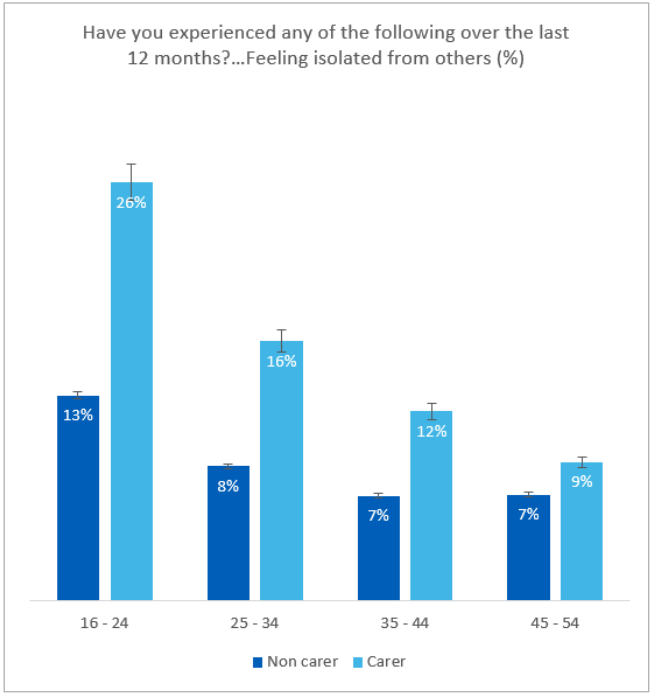
White British patients were most likely to report being a carer (18%)

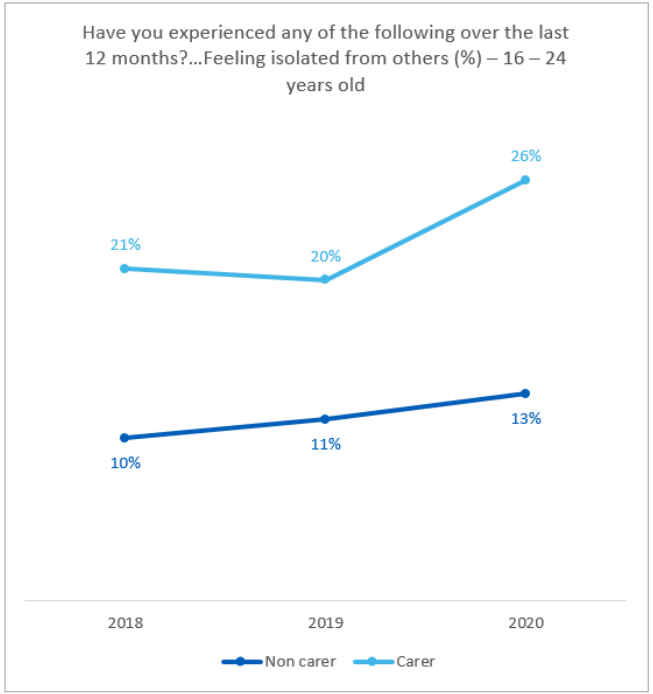
Patients aged 45 to 64 were most likely to report being a carer (More than a fifth of patients this age)





Carers across younger age groups were more likely to report feeling isolated from others



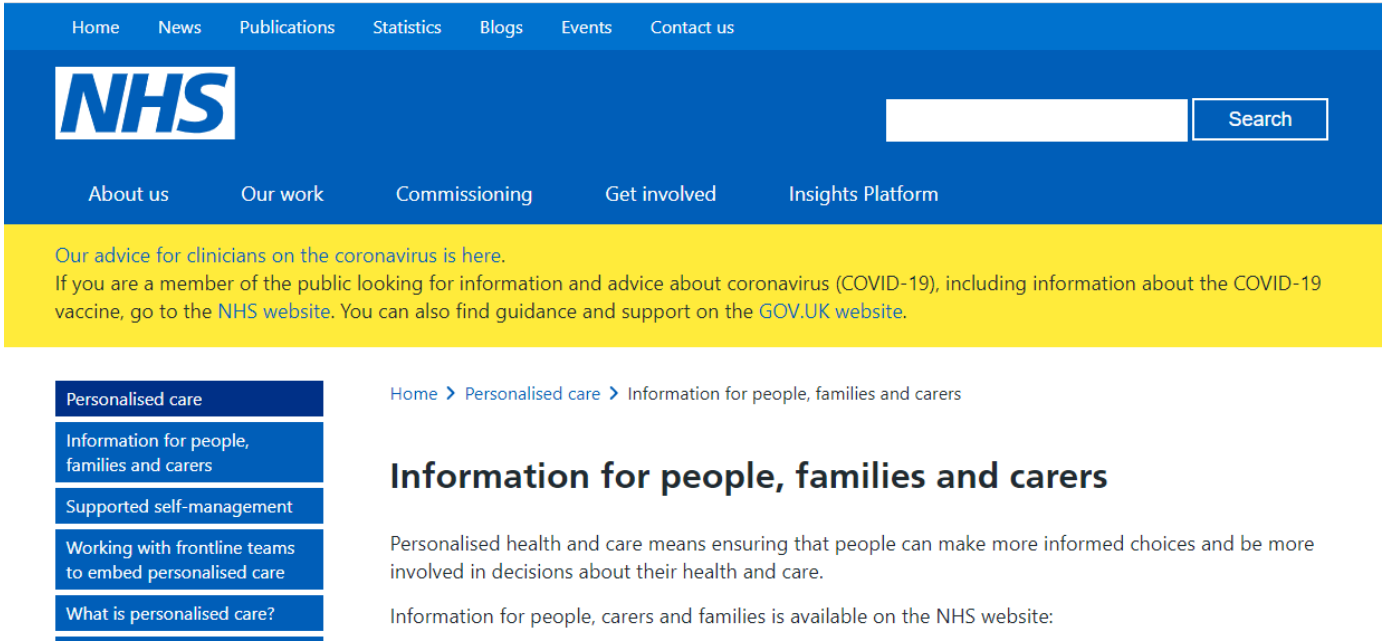


There was a sharper increase for carers in reporting feeling isolated for carers aged 16 to 24 compared with non carers of the same age (a 6 percentage point increase)

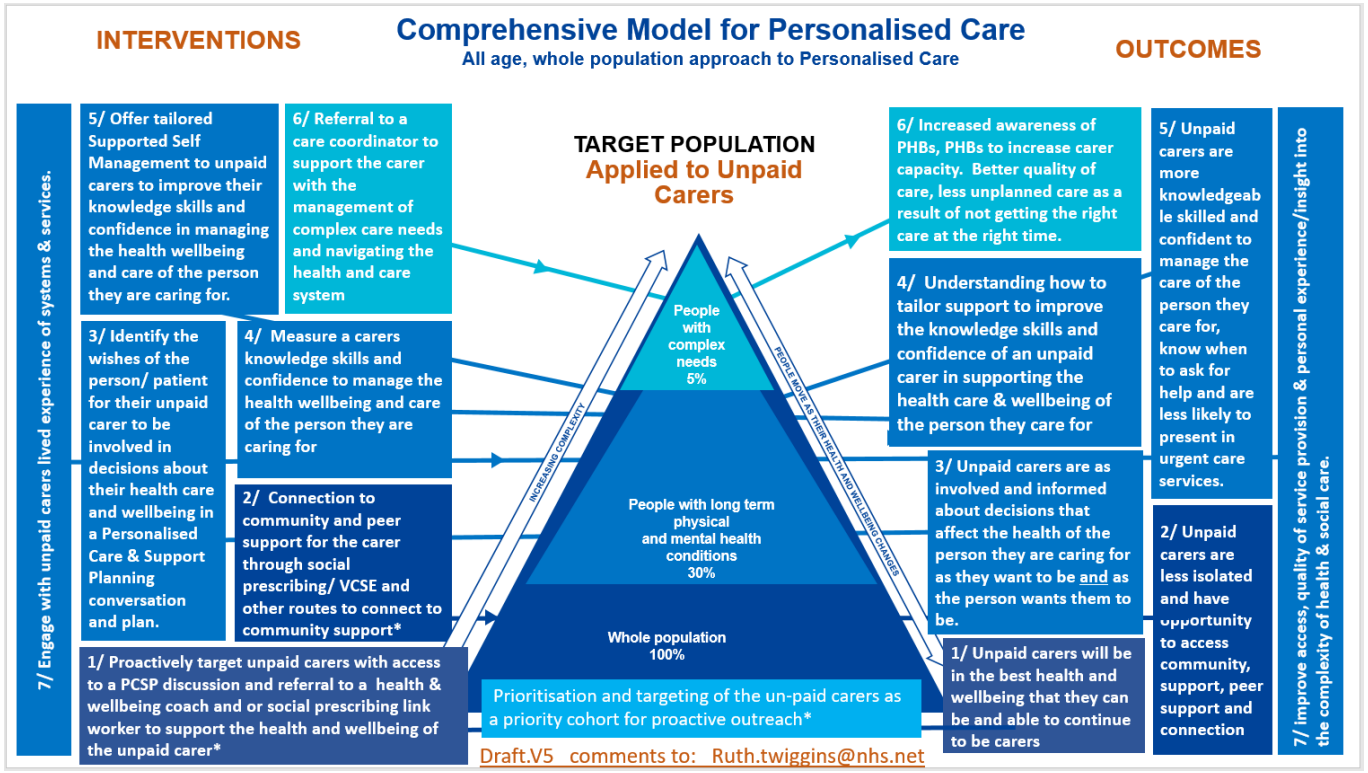
Delivering the LTP ambitions from the Region

Identification	• Map the current provision for carers across the Region's ICS / LA and VCSE • Focus on vulnerable communities by extending the Mind The Gap projects • Promote the offer to Working Carers in the NHS
Quality Markers	• Build and maintain a Regional hub of good practice • Roll out primary care Quality Markers across the Region's ICS
Passports	• Build and maintain a Regional hub of good practice • Support roll out of carers passports across the Region's ICS
Young Carers	• Roll out GP Top Tips across the Region's ICS • Support the Health Champions network
Contingency	• Build and maintain a Regional hub of good practice • Support the roll out of contingency planning across the Region's ICS • Support the roll out of Carer's UK Jointly App through the PCNs

Personalised Care



https://www.england.nhs.uk/personalisedcare/information-for-people-families-and-carers/


INTERVENTIONS
Comprehensive Model for Personalised Care
All age, whole population approach to Personalised Care
OUTCOMES
7/ Engage with unpaid carers lived experience of systems & services.
5/ Offer tailored Supported Self Management to unpaid carers to improve their knowledge skills and confidence in managing the health wellbeing and care of the person they are caring for.
6/ Referral to a care coordinator to support the carer with the management of complex care needs and navigating the health and care system
3/ Identify the wishes of the person/ patient for their unpaid carer to be involved in decisions about their health care and wellbeing in a Personalised Care & Support Planning conversation and plan.
4/ Measure a carers knowledge skills and confidence to manage the health wellbeing and care of the person they are caring for
2/ Connection to community and peer support for the carer through social prescribing/ VCSE and other routes to connect to community support*
1/ Proactively target unpaid carers with access to a PCSP discussion and referral to a health & wellbeing coach and or social prescribing link worker to support the health and wellbeing of the unpaid carer*
TARGET POPULATION
Applied to Unpaid Carers
People with complex needs 5%
People with long term physical and mental health conditions 30%
Whole population 100%
INCREASING COMPLEXITY
PEOPLE MOVE AS THEIR HEALTH AND WELLBEING CHANGES
Prioritisation and targeting of the un-paid carers as a priority cohort for proactive outreach*
6/ Increased awareness of PHBs, PHBs to increase carer capacity. Better quality of care, less unplanned care as a result of not getting the right care at the right time.
4/ Understanding how to tailor support to improve the knowledge skills and confidence of an unpaid carer in supporting the health care & wellbeing of the person they care for
3/ Unpaid carers are as involved and informed about decisions that affect the health of the person they are caring for as they want to be and as the person wants them to be.
1/ Unpaid carers will be in the best health and wellbeing that they can be and able to continue to be carers
5/ Unpaid carers are more knowledgeable skilled and confident to manage the care of the person they care for, know when to ask for help and are less likely to present in urgent care services.
2/ Unpaid carers are less isolated and have opportunity to access community, support, peer support and connection
7/ improve access, quality of service provision & personal experience/insight into the complexity of health & social care.
Draft.V5 comments to: Ruth.twiggins@nhs.net

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