frailty icare

NHS England

A Regional Approach to Frailty Community of Practice Meeting 7

9th April 2019

Lesley Bainbridge
Clinical Lead

Academic Health Science Network North East and North Cumbria

National Innovation Centre for Ageing

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Join our journey... Developing Integrated Health and Care North East and North Cumbria

Welcome and Introductions

Frailty ICARE: *what's the latest?*

1. **Workforce:** LB meeting HEENE regarding developments to support introducing EnCOP or national Frailty Capability Framework 9th May

2. **Digital:** in discussion with NUTH re funding for projects and posts

3. **Ageing Well ICOPE Programme:** developing framework for monitoring and evaluating delivery of urgent community response services, ageing well community teams, enhanced health in care homes – still draft – 2 hour waiting time for crisis response and a 2 day waiting time for reablement will be met by 2023/24

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Frailty ICARE: *what's the latest?*

4. **ICS Mental Health workshop:** 9th May, focussing on;
   - older people
   - employment
   - zero suicide ambition
   - child health
   - LTC and persistent physical symptoms
   - improving physical health those receiving treatment of a MH or LD condition
   - optimising MH services

5. **NHSE MH Transformation Funds [draft]:** clinical network planning and data quality workshop 30th April in line with the LTP, transformation funds for MH crisis and liaison services, split between CCG baselines and transformation funding, local areas will only be able to access the transformation fund if they are able to demonstrate that the CCG baseline funds are being used for the intended purpose, additional ring-fenced funding will be made available to acute alternatives over the course of the next 3 years

Showcasing CoPper: Metrics

Beth Tear, Senior Information Analyst, NECS

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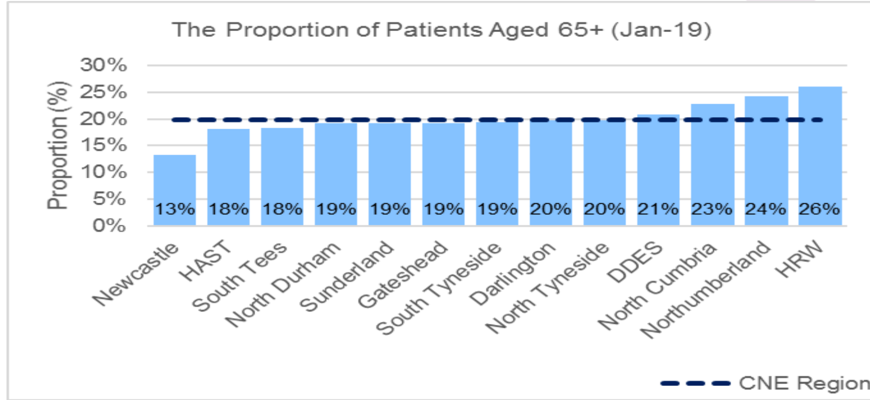
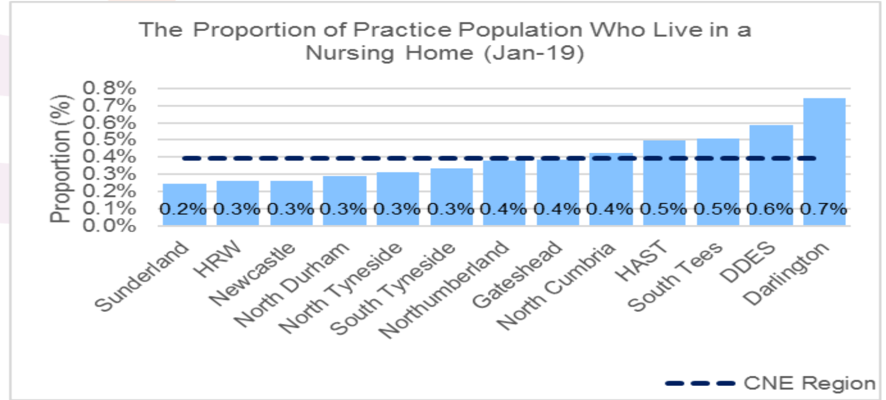
Frailty Outcomes Framework
Updated to January 2019

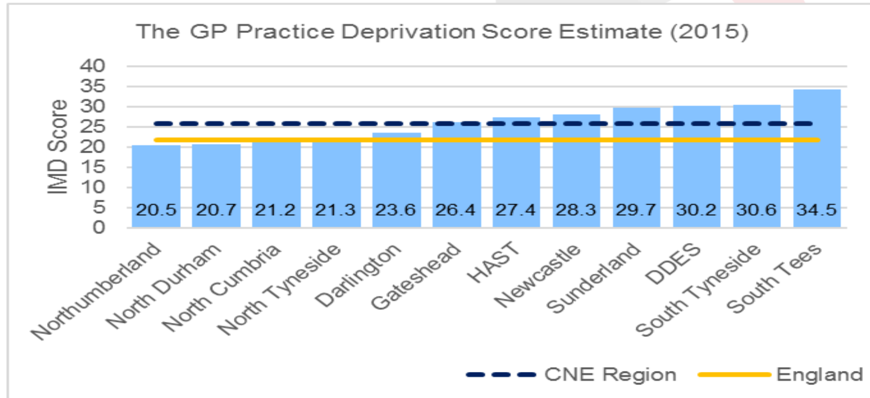
Improvement Areas by CCG

North Cumbria ICP			
CCG		**Top Three Improvement Areas**	
North Cumbria	Dementia Diagnosis	Depression Diagnosis	Medication Review
Northern ICP			
CCG		**Top Three Improvement Areas**	
Northumberland	Frailty Assessment	Dementia Diagnosis	Falls amongst frail population
North Tyneside	Unplanned Admissions	Emergency Readmissions	Dementia Diagnosis
Newcastle	Polypharmacy	A&E to Admissions Conversion	Service users with control over daily life
Gateshead	Dementia Diagnosis	A&E to Admissions Conversion	Care/Residential Home Admissions
Central ICP			
CCG		**Top Three Improvement Areas**	
South Tyneside	Unplanned Admissions/Readmissions	A&E Attendance Rates	Reablement
Sunderland	Unplanned Admissions/Readmissions	A&E Attendance Rates	Reablement
North Durham	Flu Immunisation	Dementia Diagnosis	Frailty Assessment
Southern ICP			
CCG		**Top Three Improvement Areas**	
Darlington	Medication Review	Service users with control over daily life	Carer reported quality of life
DDES	Falls amongst frail population	Frailty Assessment	Flu Immunisation
HAST	Frailty Assessment	Medication Review	A&E Attendance Rates
South Tees	Depression Diagnosis	Reablement	Stranded patient: LOS (21+ Days)

Demographic Information







In order to understand the context of organisational achievement for each metric, key information relating to the populations has been presented.

The proportion of patients aged 65 years and over is taken from the quarterly published practice populations to HSCIC.

The GP practice deprivation score estimate (2015) is based on the registered population of each GP practice

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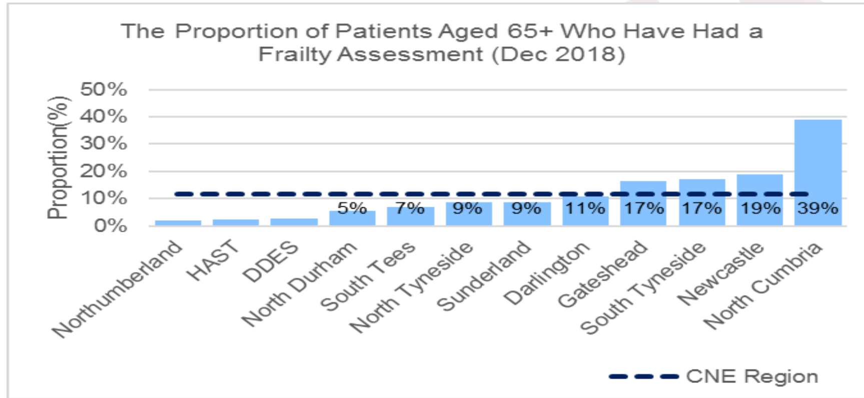
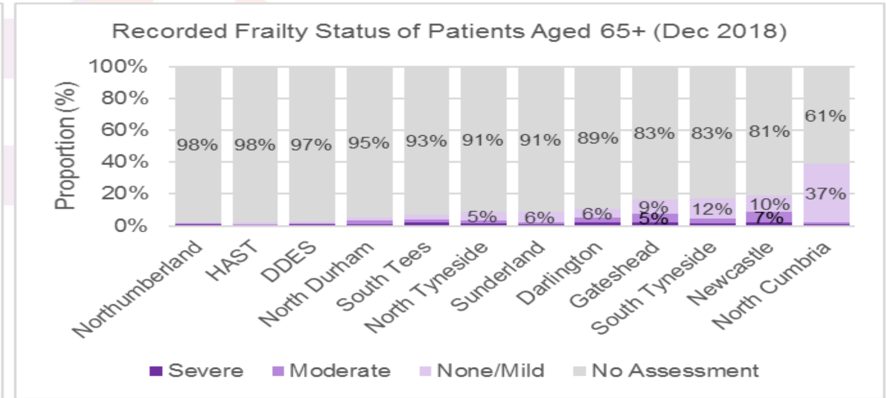
Frailty Assessments & Recorded Status

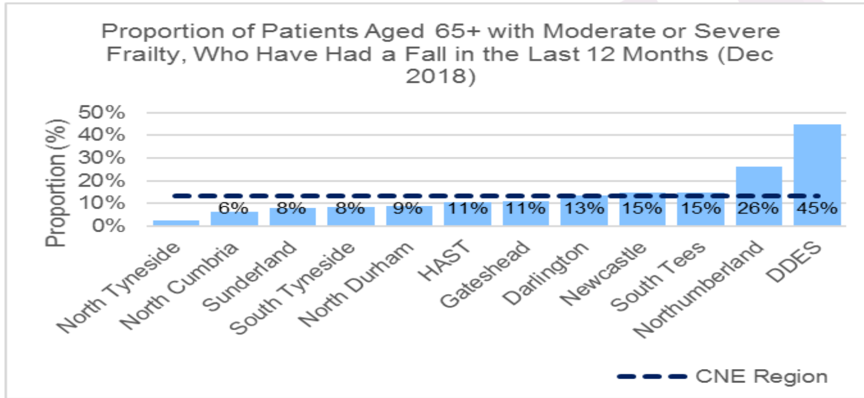


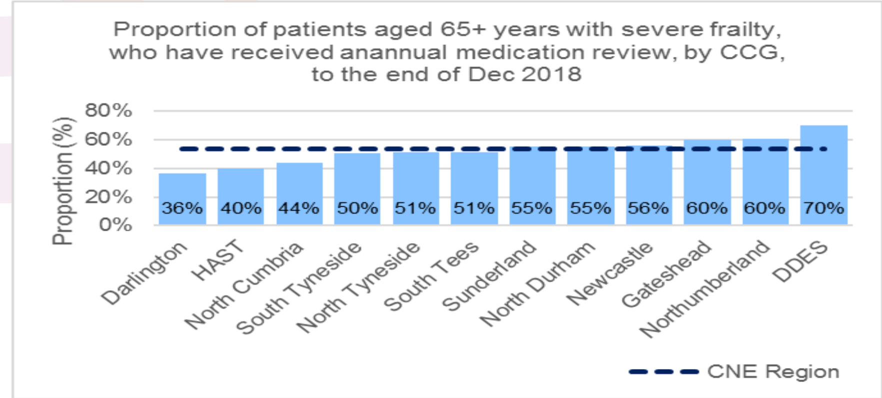


Data regarding frailty assessments has been taken from the nationally published GMS PMS Core Contract Data Collection.

The proportion of patients aged 65 years and over who have had a frailty assessment recorded varies substantially by CCG. North Cumbria has a much higher rate of assessment than their peers.

Frailty Assessments – Falls and Review



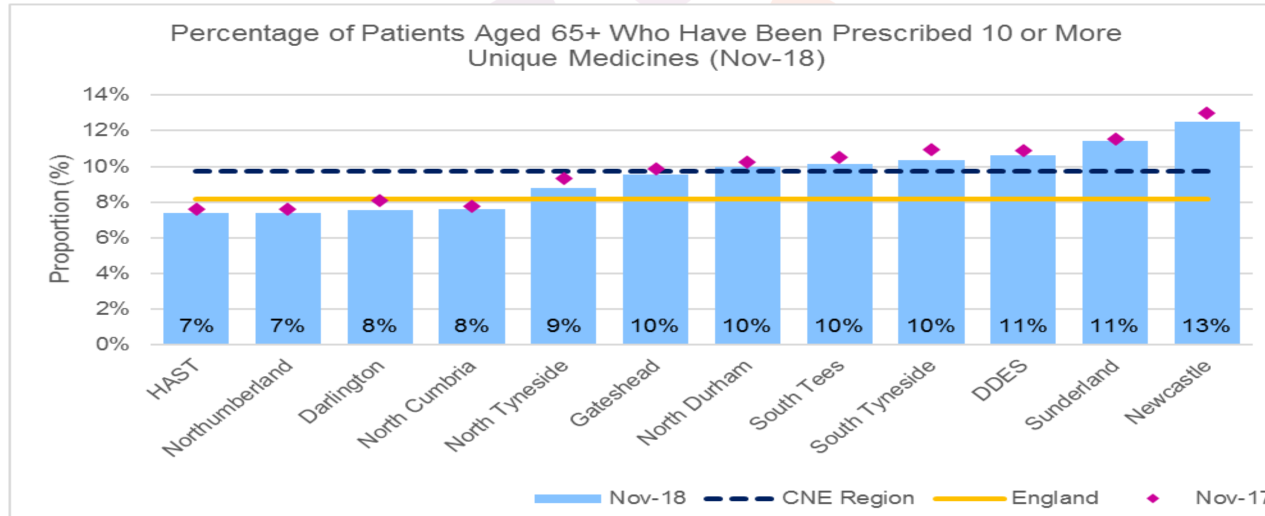


Across CNE, the proportion of patients aged 65+ years with moderate or severe frailty who have had a fall recorded in primary care ranges from 3% to 45%.

The proportion of patients aged 65+ years with severe frailty who have received a medication review ranges from 36% to 70%, as shown in the chart above.

An increase in frailty assessments, however, would present a much clearer picture for both falls and medication reviews.

Polypharmacy

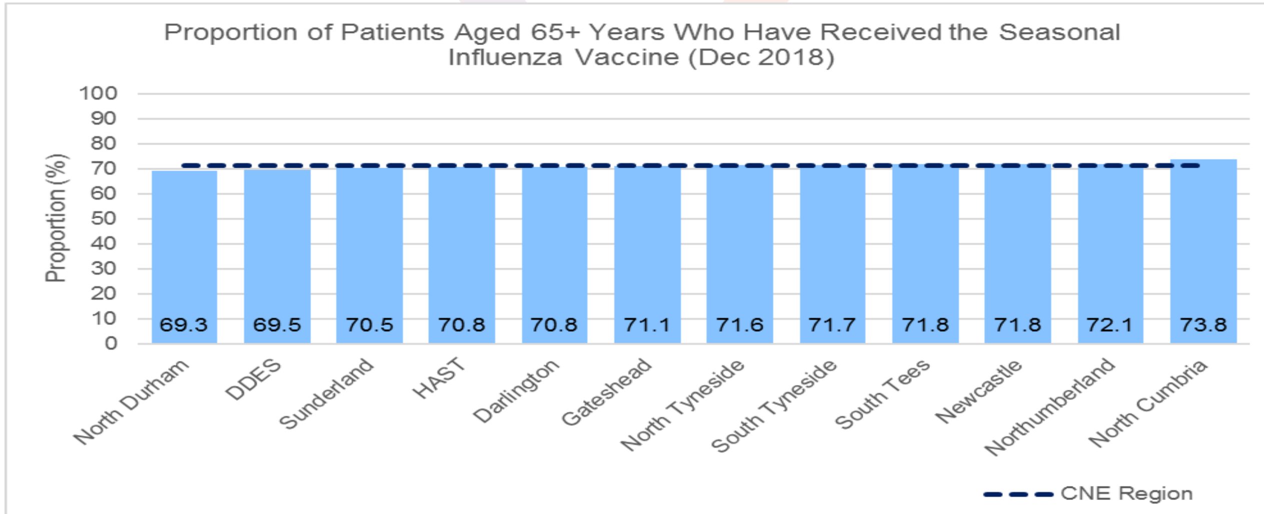


In November 2018, 9.7% of the population were concurrently receiving 10 or more unique medicines. This was a decrease from 10% in November 2017, a reduction of 0.3%.

The percentage of over 65 year olds receiving 10 or more unique medicines in the region remains higher than that for England as a whole with considerable variation reported between CCGs.

In Newcastle, 12.5% of the population receive 10 or more medicines while this figure is 7.4% in Hartlepool and Stockton. Significant variation at practice level is also apparent.

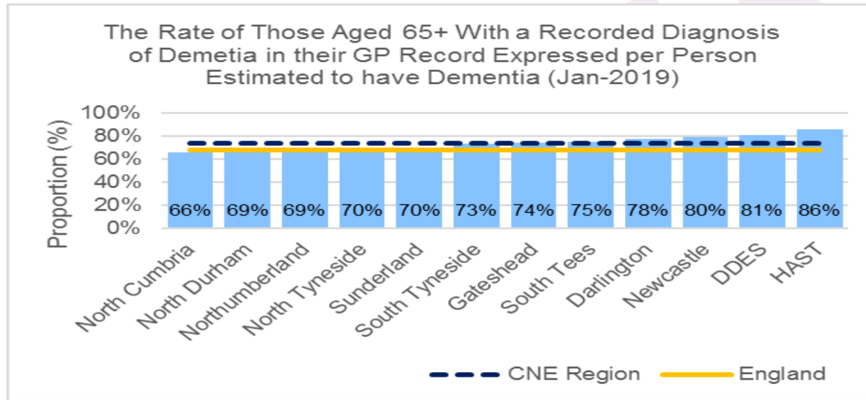
Flu

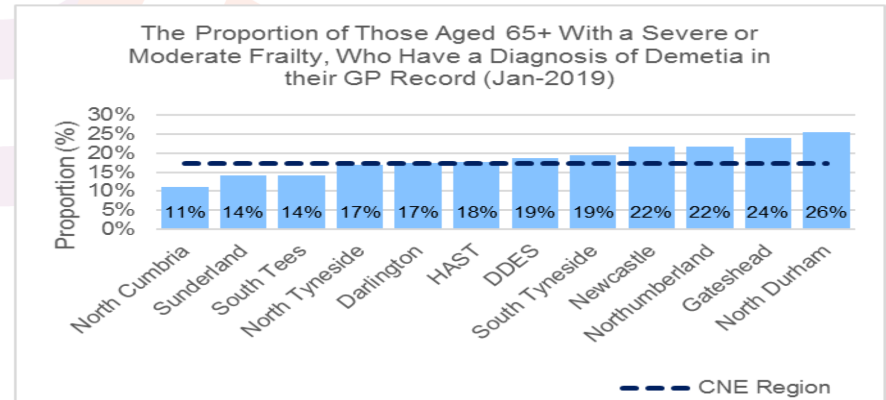


The cumulative influenza vaccine uptake in those aged 65+ years for the latest period for CNE is 71.2% so far this year. There is little variance across the CCGs in CNE.

The ambition for vaccine coverage in 2017 to 2018 was to reach or exceed 75% uptake for people aged 65+ years (as recommended by the World Health Organization (WHO)).

Dementia

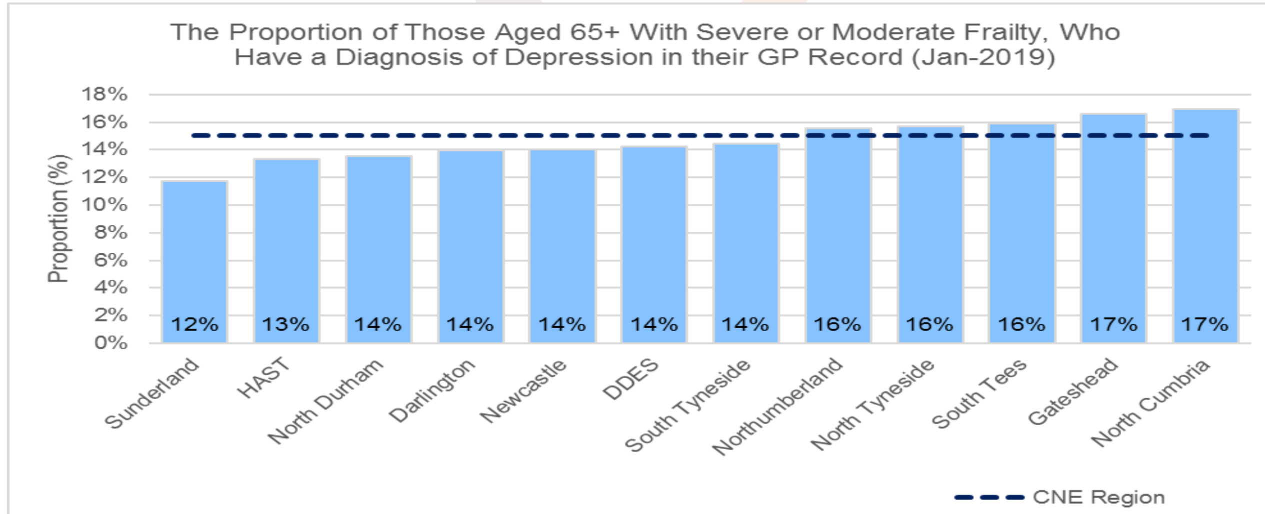




The estimated diagnosis rate of dementia in those aged 65+ years for the latest 12 months varies across the CNE region from 66% in North Cumbria to 86% in Hartlepool and Stockton on Tees CCG. The CNE average is 74% which is higher than the England rate of 68%.

The proportion of those living with moderate or severe frailty who have dementia also varies across the region. North Cumbria has the lowest rate in the region with 11% of patients having a dementia code on their GP record, North Durham has the highest proportion at 25%. Note that the frailty data used here is from GP records as opposed to GMS PMS Core Contract Data Collection.

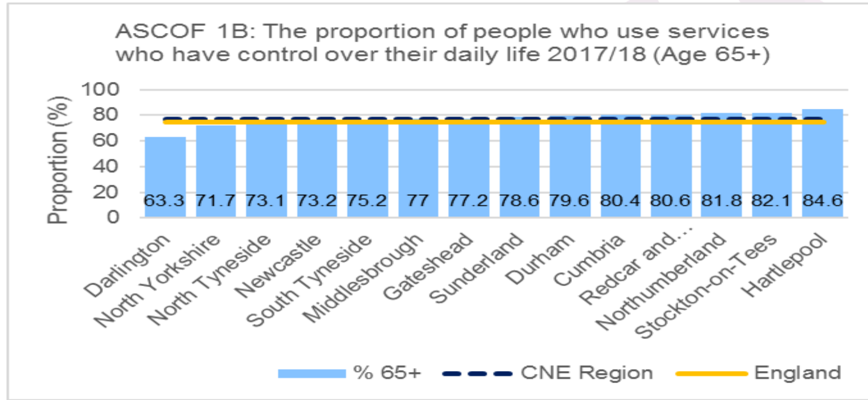
Depression

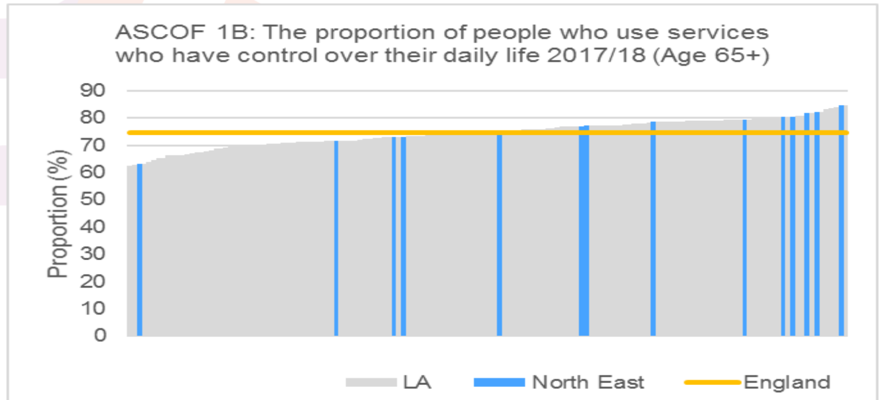


The risk of mental health conditions (such as depression and anxiety) and cognitive decline has frequently been reported to increase as the number of chronic conditions increases (and with age).

The proportion of those living with moderate or severe frailty who have depression varies across the region. North Cumbria has the highest rate in the region with 17% of patients having a dementia code on their GP record. Sunderland has the lowest proportion at 12%. Note that the frailty data used here is from GP records as opposed to GMS PMS Core Contract Data Collection.

Service Users with Control over their Daily Life



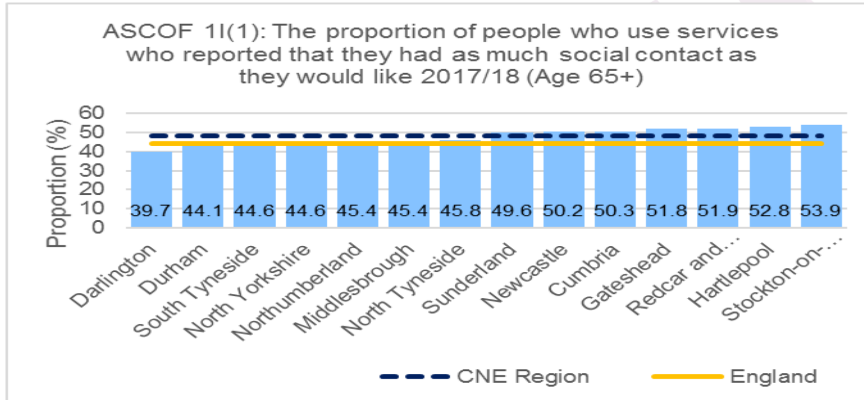


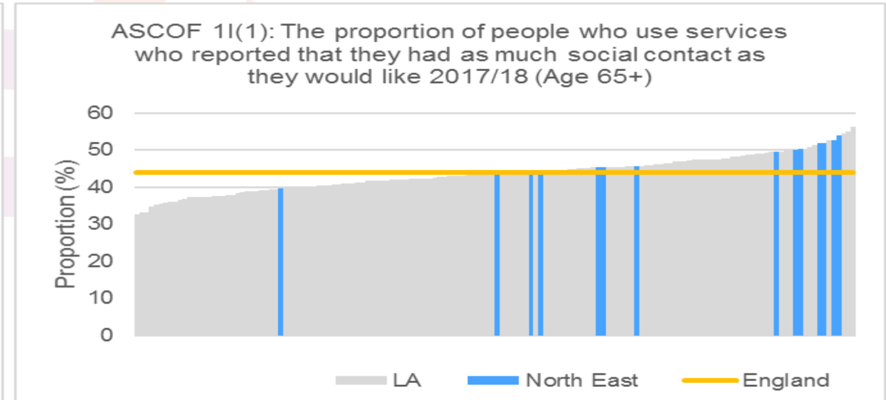
The data presented shows the North East region to have a higher proportion (77.2%) than the England average (74.8%) for this indicator.

There is some variation between regional local authorities with Hartlepool achieving the highest outcome (84.6%) compared to Darlington reporting the lowest outcome (63.3%).

Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

Service Users with Contact



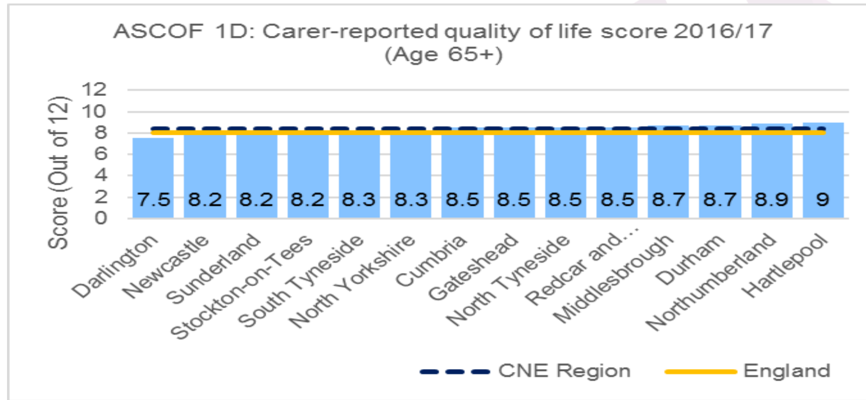


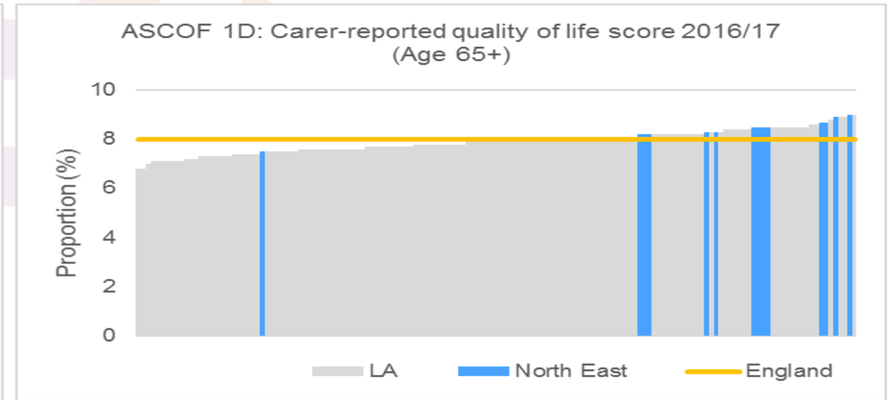
The data presented shows the North East region to have a higher proportion (47.9%) than the England average (44.0%) for this indicator.

There is some variation between regional local authorities with Stockton-on-Tees achieving the highest outcome (53.9%) compared to Darlington reporting the lowest outcome (39.7%). All local authorities with the exception of Darlington in the region have reported above the England average for this measure.

Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

Carer Reported Quality of Life





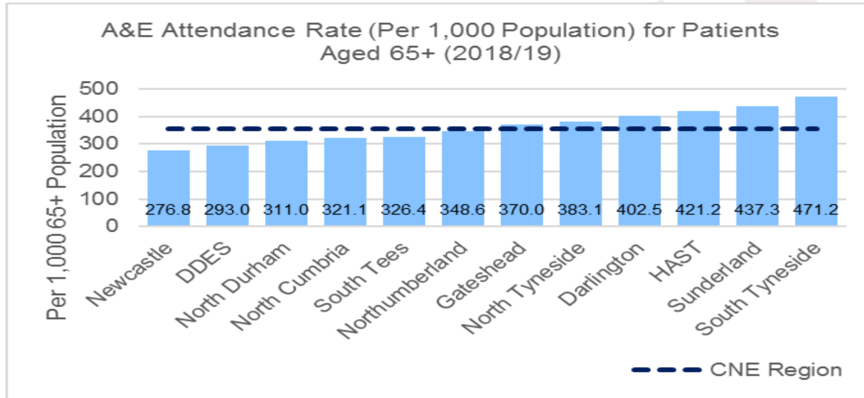
The data presented shows the North East region to have a higher score (8.4) than the England average (8.0) for this indicator.

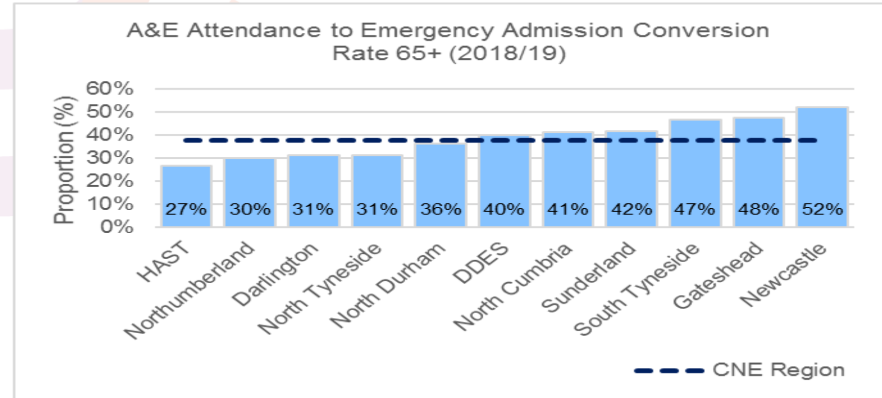
There is some variation between regional local authorities with Hartlepool achieving the highest outcome (9.0) compared to Darlington reporting the lowest outcome (7.5).

Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

Note this figure has not been refreshed in the data packs for 2017/18

A&E Attendances and Admissions

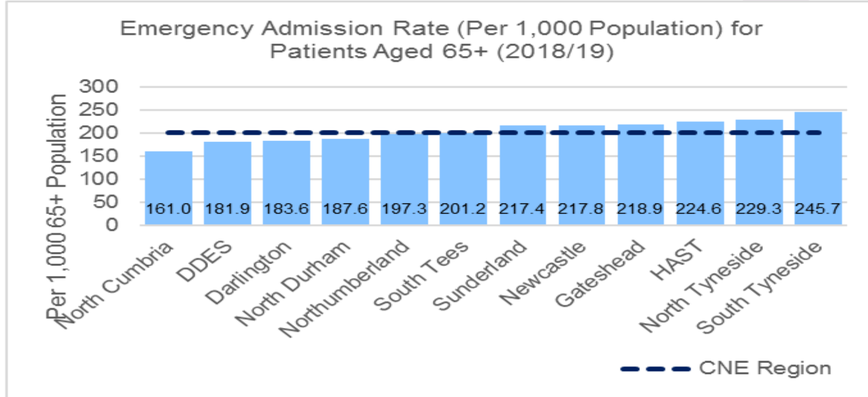


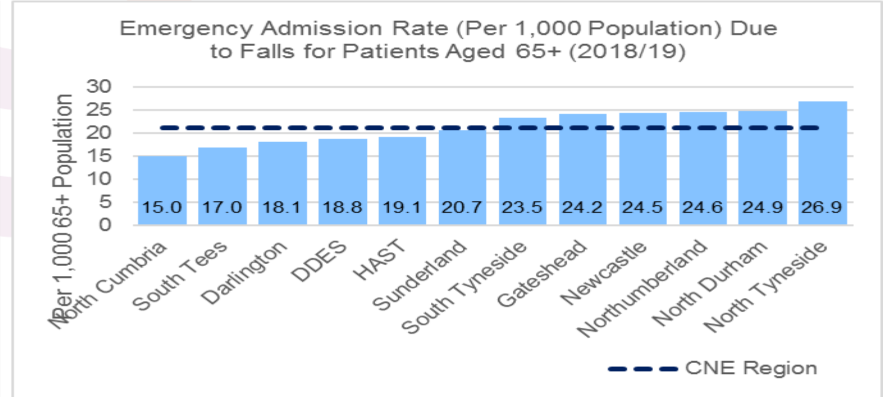


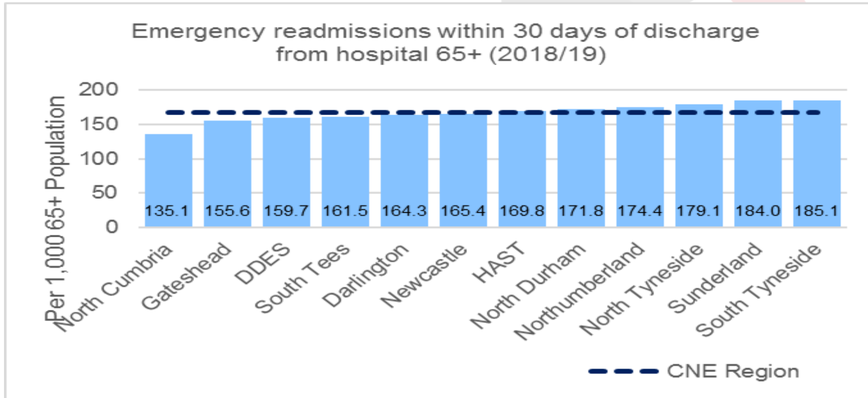
The data presented here relates only to attendances at A&E Type 1 departments (consultant-led, 24 hour service) and Type 3 departments (Other A&E / minor injury departments, doctor- or nurse-led). For 2018/19 YTD there is a wide range in A&E attendance rates across the CNE region, from 276.8 per 1,000 population in Newcastle to 471.2 in South Tyneside. The CNE region A&E attendance rate for this period is 356.0 per 1,000 population.

The A&E attendance to emergency admission conversion rate for 2018/19 varies substantially across the CNE region from 27% in HAST CCG to 52% in Newcastle. The CNE region conversion rate for this period is 38%. It is possible that variation can be due to differences in patient pathways and data recording across the hospital Trusts and the availability of services such as ambulatory care within the inpatient setting.

Emergency Admissions & Readmissions



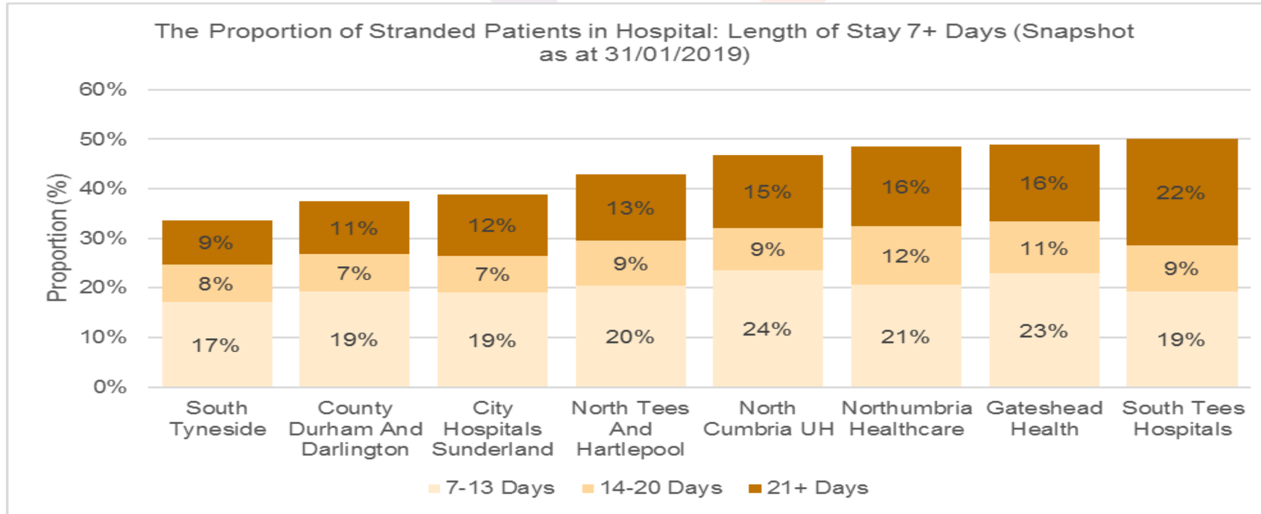




The emergency admission rate for over 65s varies across the CNE region from 161 per 1,000 population in North Cumbria, to 246 in South Tyneside. South Tyneside has the highest admission rate and readmission rate in the region.

North Cumbria also has the lowest rate of falls related admissions.

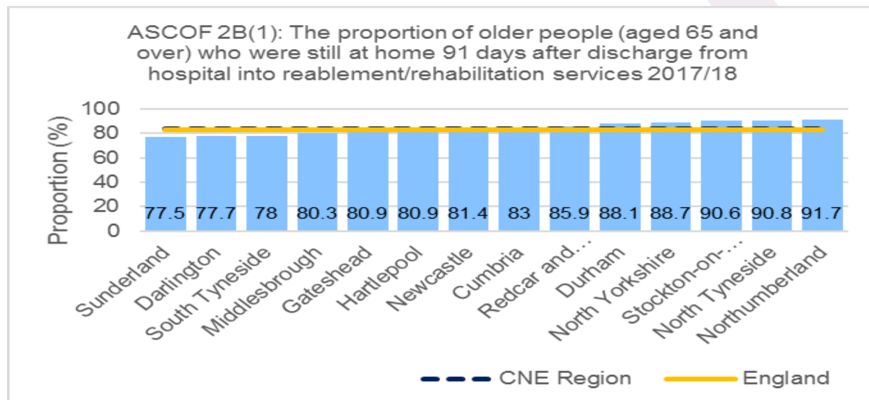
Stranded Patients

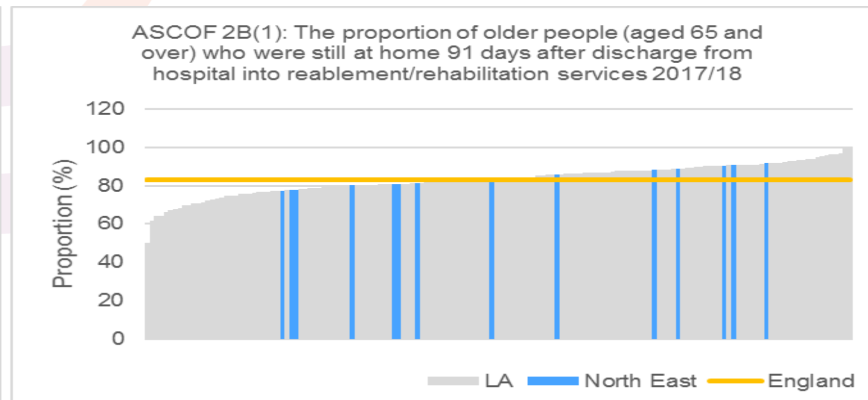


The data presented shows the Cumbria and North East region to have varied proportions of Stranded Patients with Northumbria Trust reporting 50% and South Tyneside reporting 39% for patients with a length of stay of 7 or more days.

Note, Newcastle Trust have not yet provided data for this measurement. This metric presently does not have a published regional or national benchmarking position for comparison.

Reablement/Rehabilitation Services



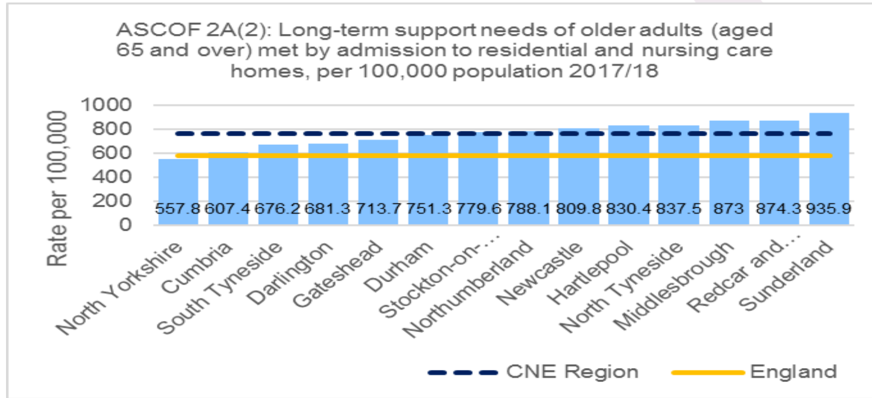


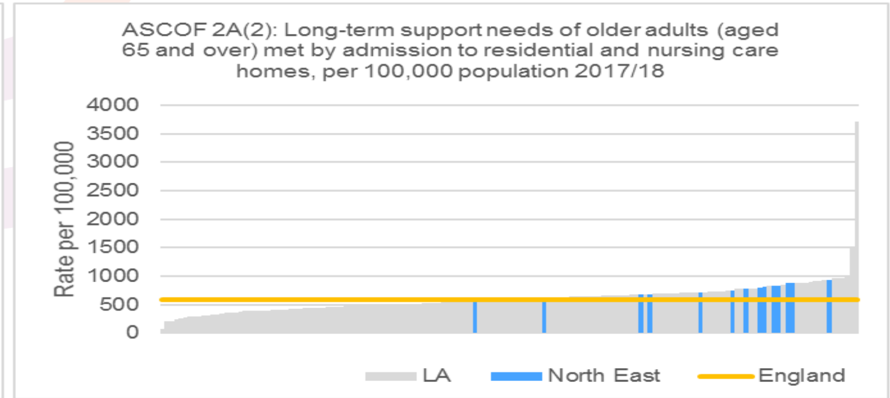
The data presented shows the North East region to have a slightly higher proportion (84.0%) than the England average (82.9%) for this indicator.

There is some variation between regional local authorities with Northumerland achieving the highest outcome (91.7%) compared to Sunderland reporting the lowest outcome (77.5%).

Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

Residential and Nursing Care Homes



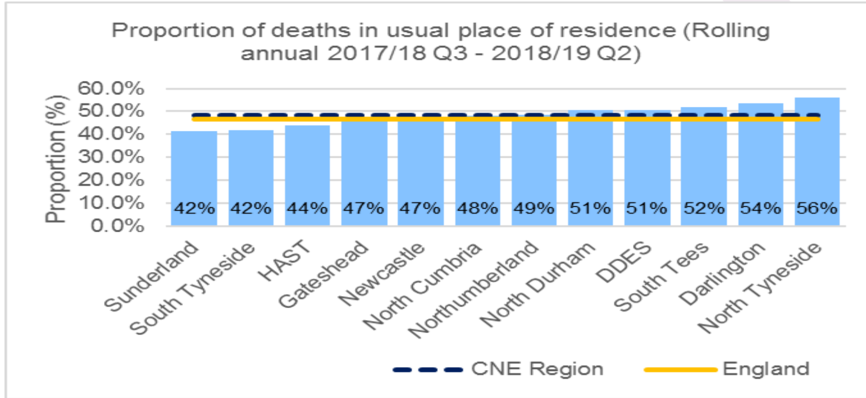


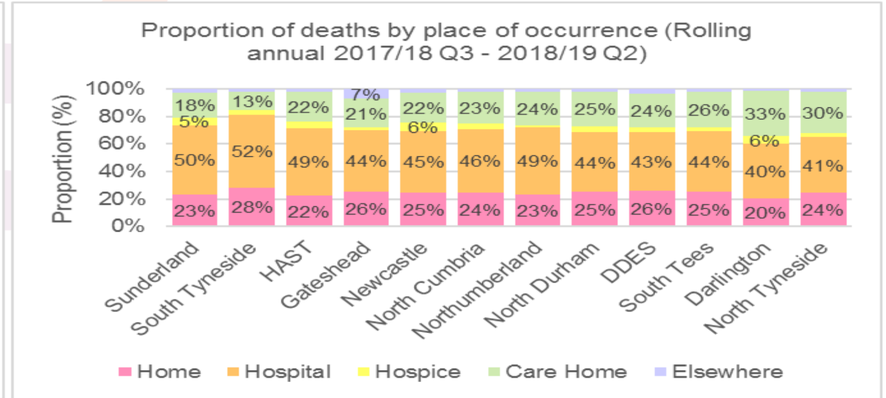
The data presented shows the North East region to have a higher rate per 100,000 population (765.5) than the England average (585.6) for this indicator.

There is some variation between regional local authorities with Sunderland reporting the highest proportion of permanent admissions (935.9) compared to South Tyneside (676.2).

Cumbria and North Yorkshire have also been included for the scope of this project, but will not be included in the North East regional figure.

Deaths in Usual Place of Residence





The data presented in the top left chart shows the proportion of deaths in the usual place of residence and relates to ALL deaths, not limited to those aged 65+ years. The CNE region has a higher rate of deaths in the usual place of residence than England overall however there is variation across the CCGs from 42% in both Sunderland and South Tyneside CCGs to 56% in North Tyneside CCG.

The top right chart shows all deaths for each CNE region CCG in the period by place of occurrence and shows that 24.5% of deaths in the period occurred at home, which is slightly higher than the England rate of 23.5%.

Metrics: for discussion

- Quarterly report?
- Quarterly report but with [top 3 prioritites] opportunities frozen in year and only updated on an annual basis?
- NECS BI Team to produce quarterly reports, then locality teams to support with drilling down the data in line with local priorities and action plans?
- To support the above, NECS pursuing building frailty in to RAIDR, building in to population segmentation work to deliver the ability to drill down to smaller geographies, primary care network level or whatever for both current frailty metrics (where that is doable) as well as other data?

Showcasing CoPper:

Integrated Discharge Pathways

Gemma Unmpleby, Senior Commissioning Manager
NHS Hambleton, Richmondshire & Whitby CCG

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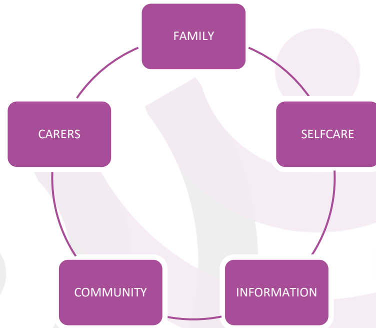

Our Services

COMMUNITY BEDS

THE D2A Model

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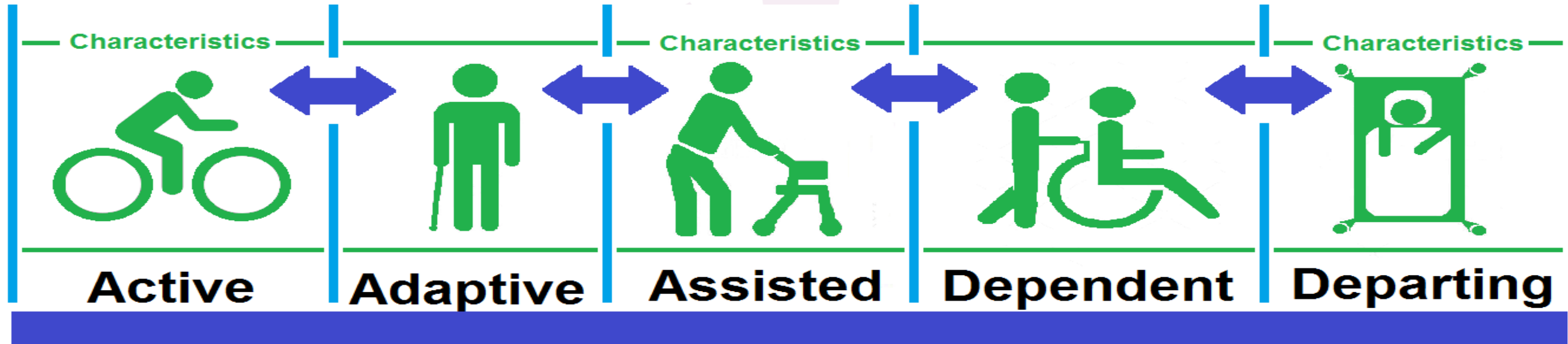
Frailty Pathway



Level of Frailty Identified

All GP Practices run EFI on practice population:
0 = Fit
0.25 = Mild
0.5 = Moderate
0.75 – 1 = Severe
(Share with CCG for Population profiling)

Fit

Population Profile 50%

- Age Concern - Guide to health ageing

Mild

Population Profile 35%

- Age Concern Guide to Healthy Ageing
- Assessment from PCNW
- Falls Assessment (L2)
- Signposting
- Advice & Guidance (PC)
- Living well
- Self care
- Social prescribing
- Targeted interventions

Moderate

Population Profile 12%

- Assessment from PCNW
- Falls Assessment (L2)
- Care co-ordination (ILT)
- Social Care package
- 6 Week Reablement service (START)
- Advice and guidance via GP from geriatricians
- Geriatric Outpatient apt
- Medication review – Clinical Pharmacist

Severe

Population Profile 3%

- Case Management (ILT)
- Comprehensive Geriatric Assessment
- Falls Assessment
- Limited acute interventions
- Medication review - Clinical pharmacist
- GSF register
- DNAR-CPR orders/LPA/ ACP
- Palliative + EoL care
- Effective NYCC planned

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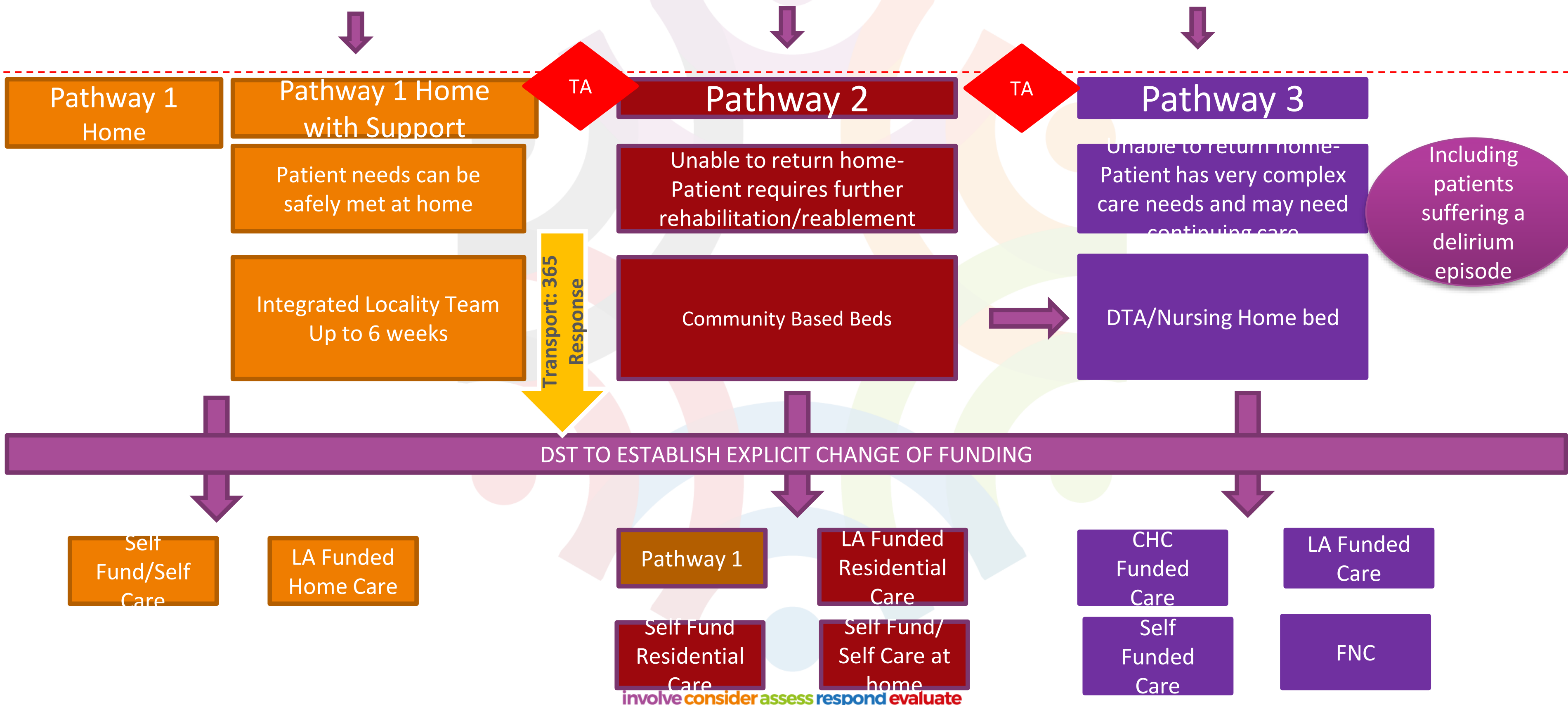
Background

National Agenda

- Performance monitored as part of the HICM: Home first/discharge to assess, Trusted Assessment
- Reduce DTOCs and LOS

Local Targets

- Consultation – 'Transforming our Communities' provided a mandate to develop new models of care closer to home
- Poor performance against NHS England target of no more than 15% of DSTs undertaken in an acute trust
- Discharge to Assess for ALL patients


THE D2A Model
Patient no longer has care needs that can only be met in an acute hospital
Hambleton, Richmondshire and Whitby Clinical Commissioning Group
NHS
Pathway 1 Home
Pathway 1 Home with Support
TA
Pathway 2
TA
Pathway 3
Patient needs can be safely met at home
Unable to return home- Patient requires further rehabilitation/reablement
Unable to return home- Patient has very complex care needs and may need continuing care
Including patients suffering a delirium episode
Integrated Locality Team Up to 6 weeks
Transport: 365 Response
Community Based Beds
DTA/Nursing Home bed
DST TO ESTABLISH EXPLICIT CHANGE OF FUNDING
Self Fund/Self Care
LA Funded Home Care
Pathway 1
LA Funded Residential Care
CHC Funded Care
LA Funded Care
Self Fund Residential Care
Self Fund/ Self Care at home
Self Funded Care
FNC
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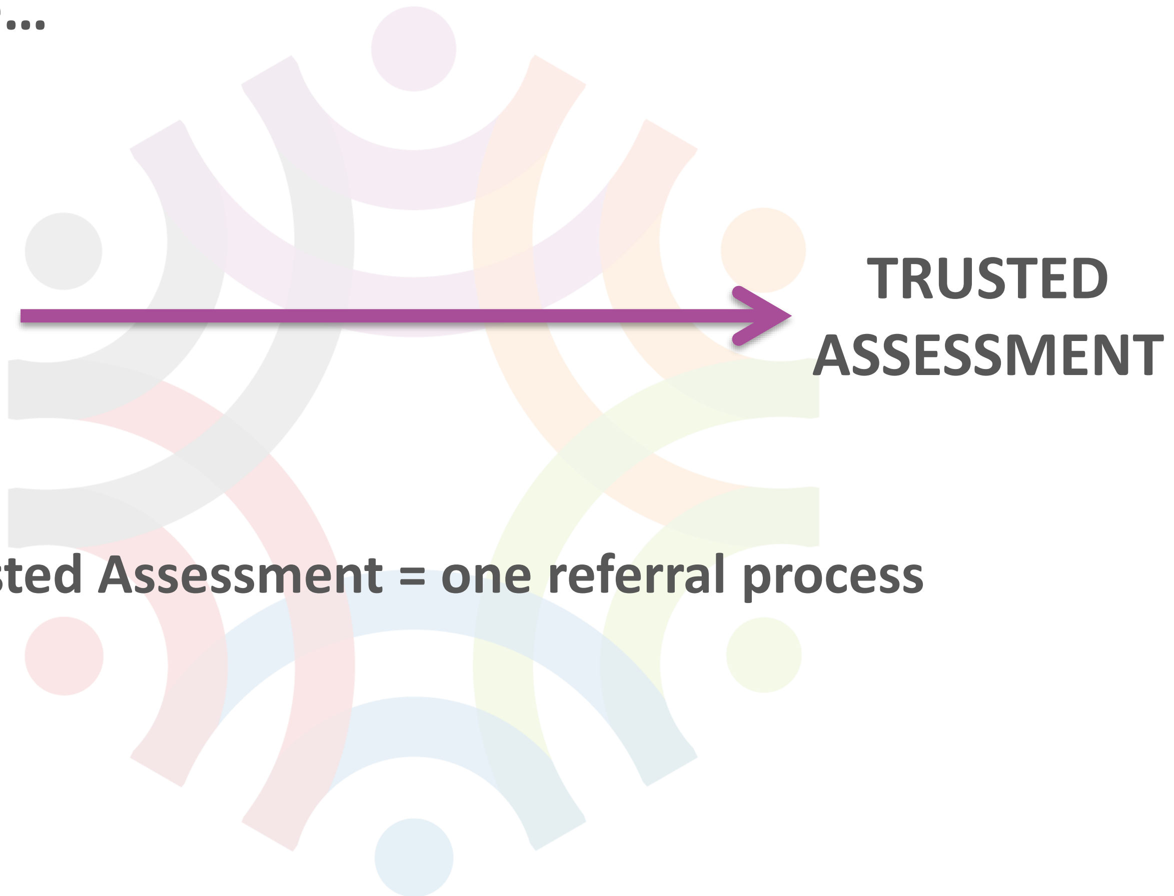
So for everyone…



- Pathway 1
- Pathway 2
- Pathway 3

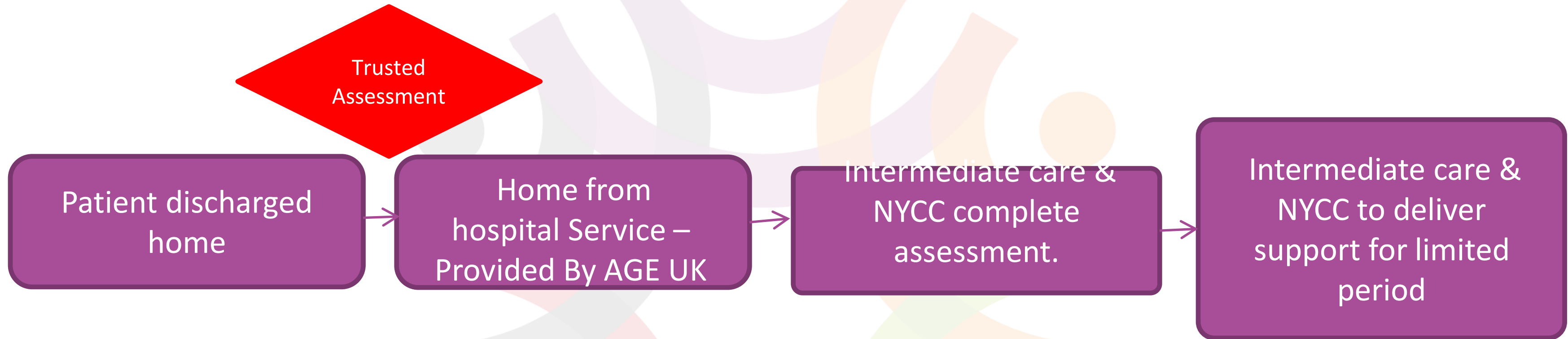
TRUSTED ASSESSMENT

Trusted Assessment = one referral process

One Form

One assessment

Pathway 1 Home with support



Pilot November 2018:

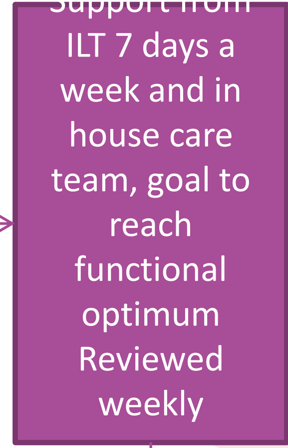
MOU Agreement NYCC and Trust

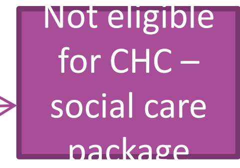
Risk Analysis

Regular Communications

Culture change – "the in-perfect package"

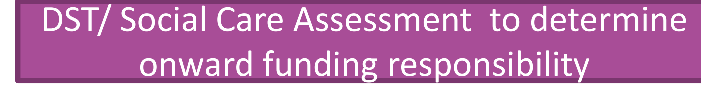
Pathway 2





Patient medically optimised for discharge

Funding



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Monitoring in place

Pathway 3

All transferred Patients to be discussed on the weekly conference call Tuesdays 12pm (Minimum representation : NYCC, CHC, SPoR, CCG)

CCG to receive completed monitoring requirements from each agency each Tuesday following the call

Patient medically optimised for discharge

Patient/ Family Leaflet

Discharge plan agreed through MDT & Family informed of discharge destination to D2A Bed

Trusted Assessment (SPoR Referral Form)

Community Bed Base

Friary (2 ring-fenced beds, all beds can be considered)

Whitby Hospital

Benkhill

Step Up/ Step Down Beds (Referral to Coordination Service)

CCG informed by Discharge Facilitator of placement and Patient transferred to Discharge to Assess Bed.

Ward team deliver Rehab/ reablement plan with goal to reach functional optimum . **Requirement for a DST Checklist as part of weekly reviews.**

visit within 48 hours. Community team to deliver Rehab/ reablement plan with goal to reach functional optimum . **Requirement for a CHC Checklist as part of weekly reviews if not already**

Utilise pre booked DST Slots

DST completed (within 28 days of CHC checklist)

CCG notified of funding outcome & date of DST

CCG confirm date NHS funding ceases (maximum of 5 working days post DST assessment)

Non – Commissioned Services

Patient identified as unsuitable for community bed (justification documented)

Patients NHS Number and justification sent to CCG

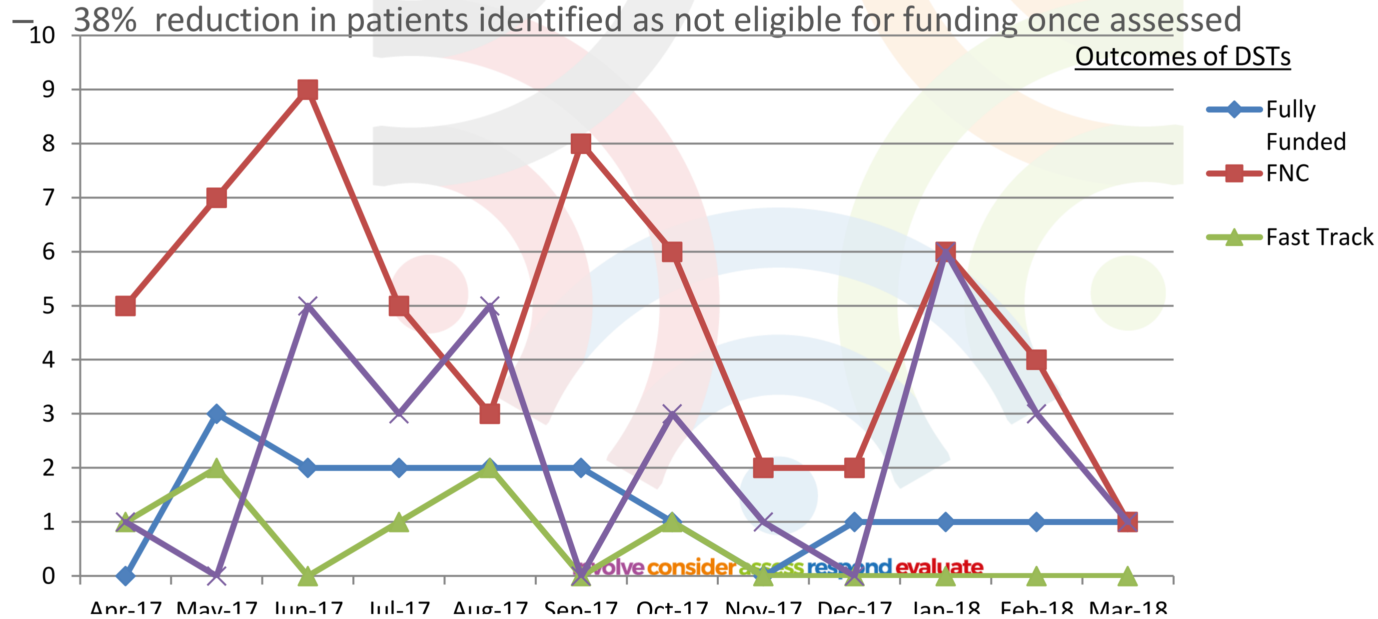
CCG considers Spot Purchase Placement & approves if appropriate (CHC approved provider list only)

CHC Checklist completed in Acute Setting prior to transfer

DST completed within 28 days of CHC checklist.

DST Assessments

- Since the introduction of D2A (mid August 2017) the average number of referrals for DST's have reduced by 30%.
- The outcomes of DST assessments has changed (monthly averages):
  - 14% reduction in fully funded patients
  - 37% reduction in patients awarded Full Nursing Care
  - 100% reduction in patients fast tracked following assessment
  - 38% reduction in patients identified as not eligible for funding once assessed

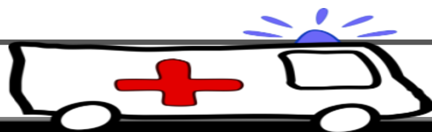


Pathway 3 – End of Year Review

- Enables a period of recuperation within a homelike environment
- Reduced level of need for long term funding
- Fewer patients are going through the CHC assessment process
- Patients who are transferred to a Spot Purchase bed are high need patients who require complex care packages - 85% of patients qualified for funding
- Packages brokered through North Yorkshire County Council on behalf of health
- Savings to the whole system
- Reduced Delayed Transfers of Care
- 0% DST in acute setting

'Off Legs'

Mrs Swale is an 83 year old lady who lives alone in Reeth all her family live down South. Usually she is fully independent and is still driving. She has a background of hypertension and well controlled angina. Taking aspirin and Ramipril.



The neighbours are concerned that she had not been seen around the village and had entered her house to find her on the sofa.

She said that she had been suffering from diarrhoea for three days and was clearly dehydrated. When they attempted to walk her she was too weak to stand. Paramedic complete initial assessment Patient admitted to CDU.

Ward complete a Trusted Assessment Pathway 1: Referral to Social Care requesting a 48 hour response and Home from Hospital Support
A community health assessment requested by Fast Response within 24 hours.

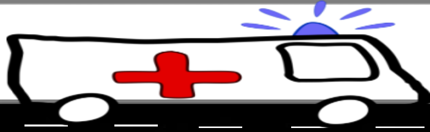
Home from Hospital Service visit patient within 24 hours; check family/ neighbours support in place for the next 24 hours

Social Care Assessment within 48 hours

MAMS Meeting

‘Off Legs’

Mrs Swale is an 83 year old lady who lives alone in Reeth all her family live down South. Usually she is fully independent and is still driving.



Paramedics were called as the neighbours were concerned that she had not been seen around the village and had entered her house to find her on the sofa.

She said that she had been suffering from diarrhoea for three days and was clearly dehydrated. When they attempted to walk her she was too weak to stand. Paramedic complete initial assessment. Patient admitted to CDU – Patient requires therapy assessment and is anxious.

Ward complete a Trusted Assessment Pathway 2: Referral to Step Down Bed.

Patient transferred to Step Down Bed within their locality. 10 hours personal care provided per week.

Therapy Assessment Completed by Community Team

Social Care assessment

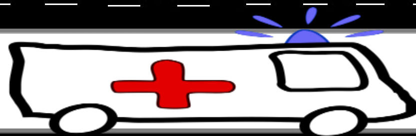
Patient stay 2 week : weekly Therapy support.

MAMS Meeting to deliver Patient Discharge Plan

Pathway 3

Mrs Wensley is an 83 year old lady who lives in West Witton she has moderate dementia. She receives BD carers who help with washing and dressing. Mrs Wensley has a background of type two diabetes and hypertension. She takes, Ramipril, bendroflumethside, metformin and gliclazide.

One of the carers witnessed Mrs Wensley collapsing and call a paramedic.



Mrs Wensley is admitted to the Friarage where she stays for a period of 4 days creating a level of confusion preventing her from going home or to a step down bed. It is felt further observation is required to understand her long term needs

Patient transferred to a commissioned Discharge to Assess bed pathway 3.

Patient spends 4 days in the bed for observation. Following which it is decided a CHC checklist is not required.

Social Care assessment

MAMS Meeting

Patient returns home

Patient Outcomes:

- Home First at the soonest possibility
- Proportionate support in at the right time
- Utilising existing systems and support already in place

- Identifying the right pathway for the individual patient
- Clear pathway home

- Continued reablement and support in the right setting
- Utilising commissioned beds
- Assessment in the right setting

Learning

- Requires good working relationships
- Pragmatic approach
- Clear clinical leadership
- Wide ranging and ongoing engagement as a system

Pathway 1 Home

For patients on a hospital ward who can return home.

- Patient discharged through the Age Uk ‘ Home from Hospital’ service.
- They receive a Patient Centred Care Plan to support their continued independence and self-care management.

For patients on a hospital ward who can return home with additional support from their local Integrated Locality Team.

- Patient discharged through the Age Uk ‘ Home from Hospital’ service.
- They receive ongoing support at home and stay on the pathway for up to six weeks.
- The ward multidisciplinary team completes a single Trusted Assessment for ongoing care needs in the patient’s home, which is shared between social care and community health teams (trusted assessment). Intermediate Care Team or the reablement service provides care and therapy at home to support patients’ recovery to independence. The intensity of the service depends on patients’ needs: they can be seen up to four times a day.
- Daily review process required

Pathway 2

For patients who cannot be discharged home directly but could return there with additional rehabilitation and reablement

- Patients are discharged to a community bed or temporary residential care via trusted assessment for up to 6 weeks.
- The local Integrated Locality Team manage the discharge home during the 6 week temporary placement.
- Daily assessments
- All packages identified via Local Authority Brokerage System

Pathway 3

For patients likely to need ongoing care in a Care Home or Residential setting, who may be eligible for continuing healthcare funding.

- The hospital-based team has assessed these patients as having complex care needs and likely to require daily care at a higher level than pathway 2.
- Patients suffering a delirium episode and require daily care until they are fit for assessment.

Museum Outreach

working to support older people, veterans & others

Ben Jones, Jo Charlton, Assistant Outreach Officers
Tyne and Wear Archive & Museums

involve consider assess respond evaluate

System Update:
What’s going on where?

All

involve consider assess respond evaluate

Care Closer to Home:

1. Review the template

2. Survey monkey or emailed template?

NHS

North East Quality Observatory Service

involve consider assess respond evaluate