The Future is Frail

and its everyone’s business

Dan Cowie/Jenny Steel

Regional event session

July 2018

Care Closer to Home Programme

Cumbria, the North East and Hambleton, Richmondshire & Whitby

Agenda

- Purpose and aims of the day
- Setting the scene
- Overview of the Frailty I-CARE framework
  - building the framework through localities and the Community of Practice
- What's happening in your areas?
  - table discussions / mapping exercise against the Frailty I-CARE framework
- Introduction to our 'best practice' approach (building our tools/resources/recommendations)
- What next? – including events and programme support
- Summary and close

Aims

- Understand the importance of frailty
- Understand frailty ICARE
- Explore local frailty work
- Align local work to ICARE framework
- Understand next steps and future involvement and support

CNE delivery programmes & enabling strategies

Optimising Acute Services

Out of Hospital & Primary Care

- Vulnerable services
- Care Closer to Home (Frailty Pathway)
- Mental Health
- Continuing Health Care (CHC)
- Prevention
- Cancer
- Learning Disabilities
- Urgent & Emergency Care

Supported by enabling strategies – System Development, Workforce, Estates, Comms & Engagement, Transport, Demand Management, Digital

What is frailty?

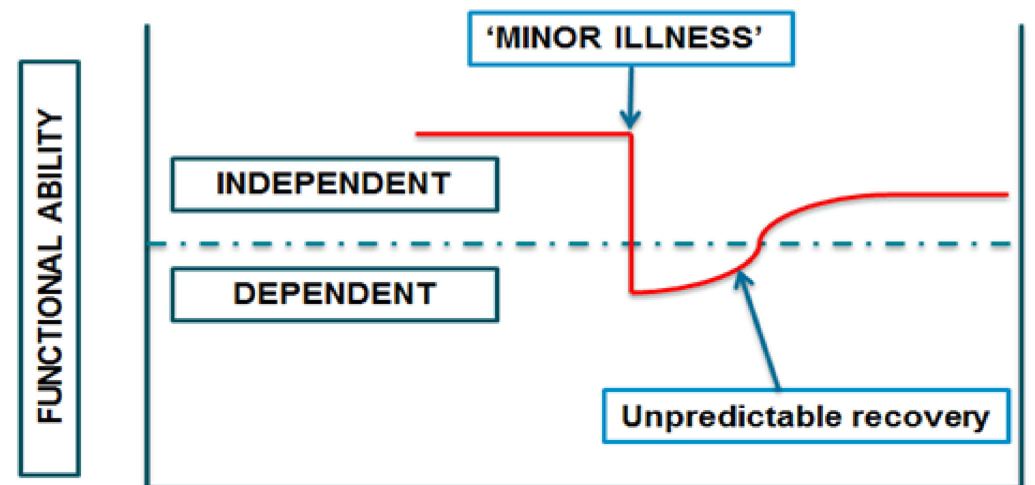
- It is a Long Term Condition making a person vulnerable to decompensate following a trigger
- Most problematic expression of human ageing facing the NHS (Clegg)

- Frailty, not aging, has robust predictive validity for

  mortality

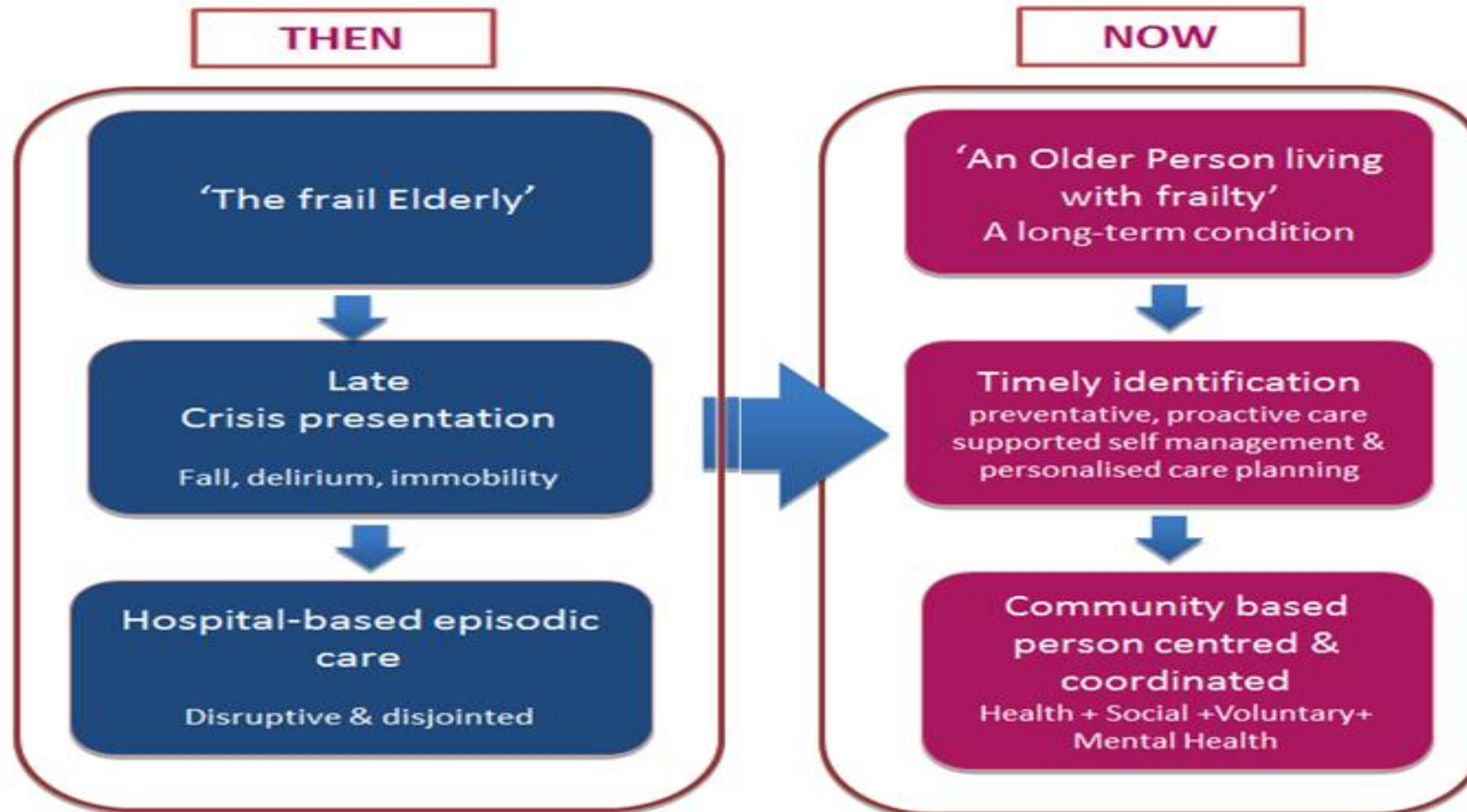
  hospitalisation

  care home admission



Why is frailty important?

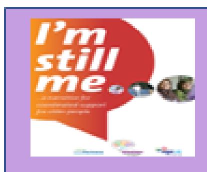
Frailty of tomorrow!



I-CARE : Preventing frailty and supporting older people, families and communities living with frailty

Enhance the voice of older people and tackle the frailty challenge together

INVOLVE



MAKING IT HAPPEN

CONSIDER

High risk groups of people

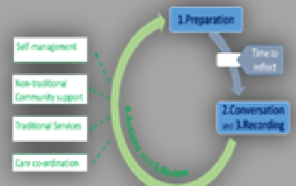
- Over 85s
- Over 65s with multimorbidity or those who have experienced frailty syndrome
- Care home residents or housebound
- Taking 10 or more medications
- Known to community nurses or social care [inc. Continuing Health Care]
- Existing primary care registers
- Complex neurological problems
- Severe mental illness [older people]

Using frailty tools

Clinical Frailty Scale, electronic Frailty Index, PRISMA-7
Gait speed - timed up and go test or Edmonton Frailty Scale

ASSESS

Care + Support Planning
Conversations on 'what matters' to people



Verify frailty (Clinical Frailty Scale)

Classify severity (Clinical Frailty Scale)

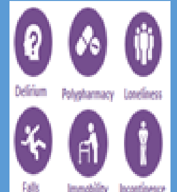
Vulnerable → Mild → Moderate → Severe

RESPOND

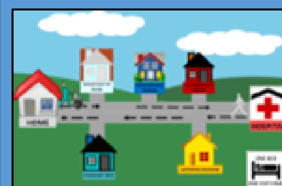
Healthy Ageing by keeping active and independent with access to frailty friendly homes

Community connectivity with access to Voluntary Community and Social Enterprise Sector

Personalised support for Long Term Conditions addressing falls, immobility, mental health and medication



Access to Comprehensive Geriatric Assessment and case management to optimise nutrition, incontinence, vison/hearing, cognition, end of life and dementia care



Crisis response and recovery services with frailty-focused transport and timely transfers of care from hospital including families

Timely access to experts offering frailty-based care in hospital

EVALUATE

- Frailty assess + diagnose
- Dementia diagnosis
  Flu-coverage
- Social contact happiness
  Reduced loneliness
- Fall in the preceding 12 months
  Written care plan reviewed
  Medications reviews
  Control over their daily life
  MH registers and frailty
- Effective IC services
  Care home placement
  Deaths in usual place
  Carer-reported quality of life
- A&E attendance
  Unplanned admission rates
  Emergency readmissions
- Stranded patient
  Attendance to Admission rates

Community of Practice

The final list of metrics – part 1

North East Quality Observatory Service

No.	Part of system	Metric	Purpose	ACO / ICS framework
1	Primary Care	Number of patients who have had a frailty assessment	Clinical verification of frailty	Transformation Drivers
2	Primary Care	Number of patients who are identified as living with frailty, and the degree of their condition (mild, moderate, severe) - data quality issues here	Identification of frailty	Transformation Drivers
3	Primary Care	Number of patients with frailty who are recorded as having had a fall in the preceding 12 months	Targeted approach to falls prevention	Transformation Drivers
4	Primary Care	Proportion of people who have their written care plan reviewed with them regularly (minimum requirement annually)	Avoidance of adverse outcomes	Care Quality and Experience
5	Primary Care	Number of patients with 8/10/15/20 or more unique medications	Prevention / optimising care	Care Quality and Experience
6	Primary care	Flu immunisation rate in people aged 65+	Prevention of complications, reduce hospital admissions	Sustainability
7	Primary Care	Patients on the MH registers (dementia, depression and anxiety) and with frailty	Identify the patients with this combination of conditions	Prevention / optimising care
8	Care in the community	The proportion of people who use services who have control over their daily life	Older people staying independent	Health and Wellbeing
9	Care in the community	The proportion of people who use services who reported that they had as much social contact as they would like	To report extent of social isolation	Health and Wellbeing
10	Care in the community	Reduced loneliness (e.g. R-UCLA loneliness scale assessment)	Loneliness can have a negative impact on both physical and mental health	Health and Wellbeing
11	Care in the community	Number of people referred into social prescribing schemes and number of people rejecting a referral	Reduce loneliness and obtain a 'sense of purpose'	Health and Wellbeing
12	Care in the community	Carer reported quality of life	Prevent social isolation, maintain good physical and mental health	Health and Wellbeing

The final list of metrics – part 2

NHS
North East Quality Observatory Service

No.	Part of system	Metric	Purpose	ACO / ICS framework
	(Ctrl) tal Health	The rate of those aged 65+ with a recorded diagnosis of dementia compared to those estimated to have dementia based on the CFAS II model	The system (including GP practices) are able to affect this	Care Quality and Experience
14	Emergency care	A&E attendance rates for patients aged XYZ	Activity indicator	Sustainability / CQE
15	Emergency care	Unplanned admission rates for patients aged X years or more	Could look at falls / specific diagnoses / residential status as subset of this metric	Sustainability / CQE
16	Emergency / secondary care	Conversion rates (hospital (A&E?) attendance to admission)	Avoidance of adverse outcome (admission is system failure)	Sustainability / CQE
17	Emergency care	Emergency readmissions within 30 days of discharge from hospital	Quality of discharge / patient management proxy measure	Sustainability / CQE
18	In hospital delays	Stranded patient: LOS TBC (7+ / 14+ / 21+ days)	DTOC indicator, but better data reporting frequency	Care Quality and Experience
19	Social care - discharge	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Intermediate Care proxy	Care Quality and Experience
20	Social care - discharge	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Older people staying independent	Health and Wellbeing / CQE?
21	Mortality	Percentage of deaths in usual place of residence	Enabling people to die outside of hospital	Health and Wellbeing / CQE?
22	Emergency care	Hospital activity in the last year of life	Links to work published by Marie Curie, Nuffield Trust	Sustainability / CQE
23	Emergency care	ED attendance, 4 hr compliance, hospital admission rates, LOS, Falls, pressure ulcers, improved experience, discharge to normal place of care.	Bundle of hospital quality measures	Sustainability / CQE

Regional a ‘frailty framework’

Community of Practice

to explore frailty, best practice and support local care and wellbeing delivery

Frailty digital platform

interactive frailty ‘tool’ for ‘sharing’ resources, best practice and learning

Academic collaboration

for evaluation and evidence-building

Outcomes and metrics

for benchmarking and supporting ‘sharing + learning’ of best practice

Understanding frailty across our region

Care Closer to Home Programme
Cumbria, the North East and Hambleton, Richmondshire & Whitby

What is the current level of awareness around frailty in your area (both your geographical locality and your team/service)

For example,

Frailty forum/networks

Frailty champions

Training and education

Use of the word!

Workforce planning – exploring new roles e.g. frailty nurses, MDT teams

Dedicated pathways – 'prevention to intervention'

How is frailty currently being identified across your local system and how is this information being shared?

For example,

GMS guidance for practices

A&E teams – ‘frailty scores’

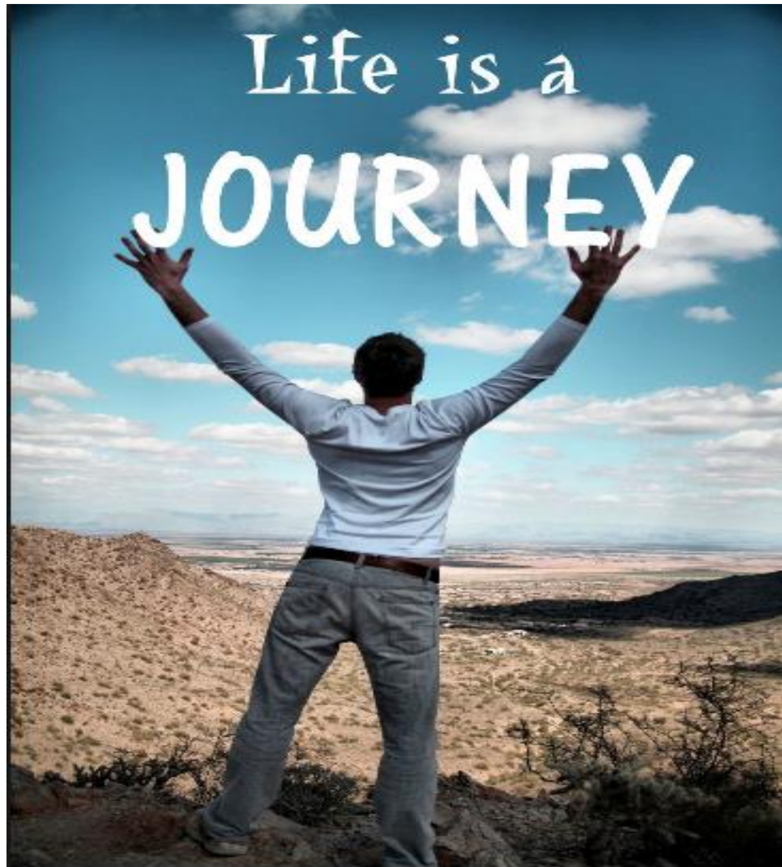
Letter – correspondence (referencing frailty scores)

Social care – sharing of care plans with frailty recognition

VSCE sector and care homes

Fire services

What services do you currently have in place at different stages along a person's 'journey of frailty', from prevention/risk reduction all the way through to end of life care?



For example,

Healthy ageing initiatives - targeted

Primary Care Teams – Year of Care

MDT in place across the community

A&E frailty units/pathways

Discharge to Assess pathways

NEAS ‘rapid response’ pathways/initiatives

Care home programmes

Intermediate Care beds, team targeting frailty

What support is needed to improve care for people living with frailty in your locality/service?

For example,

Local priorities identified?

Leadership – setting up a forum, local network

Exploring pathways of best practice – resources, information

Evaluation and outcomes

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

frailty icare

Care Closer to Home Programme
Cumbria, the North East and Hambleton, Richmondshire & Whitby

Mapping local work to frailty ICARE

Table discussions

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

frailty icare

Care Closer to Home Programme
Cumbria, the North East and Hambleton, Richmondshire & Whitby

What's going on in your area?

I-CARE	Focus	What is happening?
Involve	**Engagement:** the views and experiences of older people, their families and carers can be seen across the care system	e.g. focus groups, feedback collated, audit, research
Consider	**Identifying:** using tools and opportunities to recognise those at risk	e.g. electronic frailty index [eFI], data analysis,
Assess	**Assessing:** proactive and reactive responses that verify those at risk	e.g. clinical frailty scale use at episodes of planned and unplanned care
Response		
Heathy Ageing	**Health & Wellbeing:** optimum years of wellness, independence and control	e.g. frailty friendly homes, aids, adaptations, reablement, rehabilitation
Community Connectivity	**Social Connectivity:** access to voluntary, community and social enterprise services	e.g. clubs, café's, carer support
Self-management for Long Term Conditions [LTCs]	**Empowerment and Understanding:** personalised approaches that promote self-care and partnership	e.g. LTC management that considers falls, mental health and medication
CGA and Case Management	**Evidence and the Syndrome of Frailty:** optimising wellbeing at all stages of frailty	e.g. community matrons, practice frailty nurses, social workers, approaches to identifying those requiring case management, access to other professionals to optimise nutrition, incontinence, vision/hearing, cognition, end of life and dementia care
Crisis Response and Recovery	**Right Place, Right Time, Right Person:** hospital only when needed and only for as long as needed	e.g. 24/7 responsive health and social care services, emergency carer respite support, frailty focused transport and timely transfers of care from hospital including families
Acute Hospital Care	**Specialist Care:** timely access and treatment	e.g. interface frailty teams providing early assessment, older people's advice and liaison teams
Workforce	**Knowledge and Skills:** training, education, work based learning programmes	e.g. frailty SIM, masterclasses, use of competency frameworks, clinical supervision
Digital/Technology	**Information Sharing and Care Delivery:** transferring care safely and using technology to provide care	e.g. community and primary care teams using SMS as an electronic record, use of technology to support independent living
OTHER		

Best practice examples and building the framework?

Care Closer to Home Programme
Cumbria, the North East and Hambleton, Richmondshire & Whitby

Best practice examples, critical appraisal, and evidence synthesis

- Case study template (on tables)
- COPPERs – early work:
  - Exploring, appraisal existing work
  - Presenting local examples, top tips, evidence grading, aligning with metrics and prioritisation of work programme.
- Support academics
  - Evidence synthesis and horizon scanning
  - Evaluation of impact and cost-effectiveness
  - Research and Innovation

What next?

Care Closer to Home Programme
Cumbria, the North East and Hambleton, Richmondshire & Whitby

What next – through the COP!

- Align *COPPERs* to local frailty work:

  - Further ‘mapping’ of local work
  - Gathering ‘best practice’ examples
  - Establish COPPER work programme (e.g. prioritisation)
  - Establish ‘best approach’ for supporting local areas
  - September 4th event (e.g. involvement in break out sessions) and beyond

8:45-9:15	Registration	
Morning: frailty focus		
9:15-9:30	Welcome	
9:30-10:00	A National Approach to Frailty	
10:00-10:45	I-CARE: a regional approach to frailty	
10:45-11:15	Digital	
11:15-11:30	Refreshments	
11:30-12:30	Breakout session 1	
12:30 -1.30	Lunch	
Afternoon: system integration focus		
1.30-2.00	National picture for health and social care	
2:00-2.30	Regional Integrated Care System	
2.30-3:00	Workforce Development: Competence and Capability	
3:00-3.15	Refreshments	
3.15-4.15	Breakout session 2	
4.15-4.30	Summary and Next Steps	

September 4th event

Breakout sessions
Involve: engagement – what do older people really think about frailty?
Consider: frailty in primary care
Respond: healthy ageing including community connectivity
Respond: frailty friendly housing
Consider and Respond: CGA and knowing when you need it
Respond: Medication
Respond: care homes, from the periphery into the system
Respond: mental health
Evaluate: outcomes/metrics
Respond: domiciliary Care – the future

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

frailty icare

Care Closer to Home Programme
Cumbria, the North East and Hambleton, Richmondshire & Whitby