A Regional Approach to Frailty Community of Practice Meeting 4

6th December 2018

Lesley Bainbridge
Clinical Lead

Welcome and Introductions

Frailty ICARE: *what's the latest?*

1. Who and what the CoP
2. Discourse Platform

   can be set up, need to give consent for details to be uploaded – email to follow for action
3. Quarterly Bulletin from April
4. Meetings 2019; calendar invites?
5. Evidence growing: picking up the conversation with all the universities in relation to the ARC bid

Frailty ICARE: *what's the latest?*

6. Approach from the British Medical Bulletin; review article
7. Clinical Leadership Group: showcasing for 'not the usual subjects' – took up a couple of suggestions for filming
8. Nurse Ambassadors Older People; shout out for them and Frailty ICARE at CNO conference
9. Sunderland; ACE Project [action on care of the elderly] to support nursing developments
10. Teesside University; early interventions and exercise promotion

Frailty ICARE: *what's the latest?*

10. Workforce Developments:
    - EnCop interest growing
    - subgroup to be established to refine competencies
    - support of ICS Workforce workstream – meeting with HENE being planned [Lisa Crichton-Jones]
    - job descriptions for 3 cross organisation assessors being developed – funding options being explored

Frailty ICARE: *what's the latest?*

11. Digital Projects:

- business case template submitted yesterday
- 4th project added

project D allows for improvements in care delivery from the perspective of those receiving care services and those delivering them through the timely access to information via a shared care record

[**project A** allows for the continued development of our Community of Practice [CoP] which is the exemplified opportunity that we have for sharing and spreading knowledge about optimum care and services and how this can be achieved across the region

project B allows for the development of something beyond Care Closer to Home with a regional portal, but for which Frailty CARE can be the exemplar

project C allows for collation of all the clinical digital projects currently underway in order to consider them further in terms of evaluation, standardisation and spread while at the same time allows for consideration of new approaches to digital care]

Showcasing CoPper: Voluntary Sector

Jane Hartley
Voluntary Organisations Network North East

involve consider assess respond evaluate

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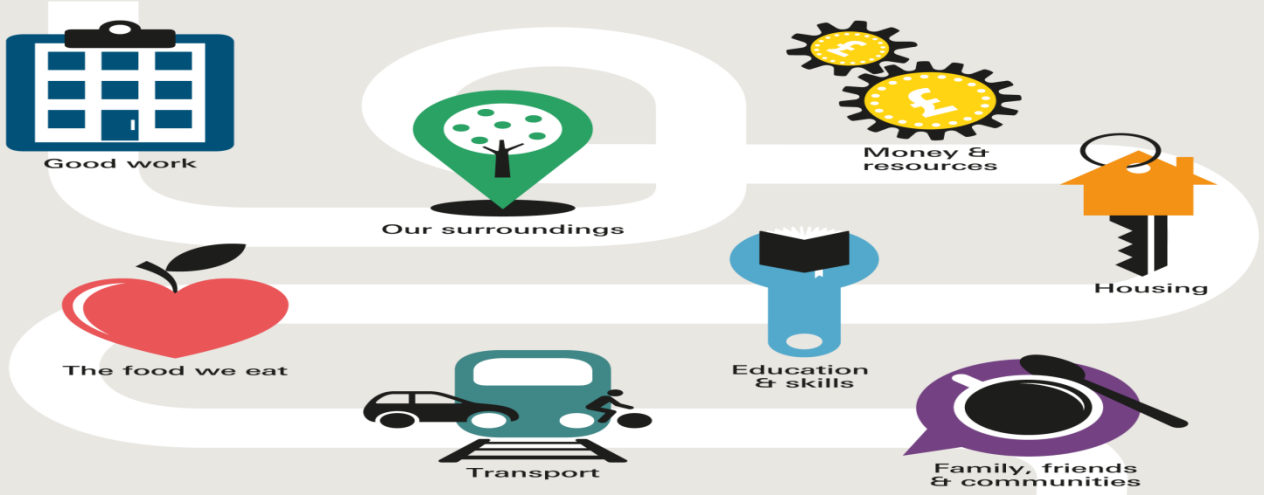
The role of the Voluntary, Community and Social Enterprise (VCSE) Sector in supporting health & wellbeing

Jane Hartley
Health & Wellbeing Associate
VONNE & NE Regional Social Prescribing Facilitator/NHSE

What makes us healthy?

AS LITTLE AS **10%** of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:



But the picture isn't the same for everyone.

The healthy life expectancy gap between the most and least deprived areas in the UK is: **19** YEARS

The Health Foundation

References available at www.health.org.uk/healthy-lives-infographics

VCSE role in Health, Wellbeing & Care

- 'VCSE sector has significant expertise that is invaluable in helping us achieve improvements across the health, social care and public health system' *Department of Health, NHS England and Public Health England*
- Support focus on early intervention, prevention & self care/management – NHS & LA (Care Act)
- Key to NHS strategic shift - acute care > prevention, community based care & support & self management

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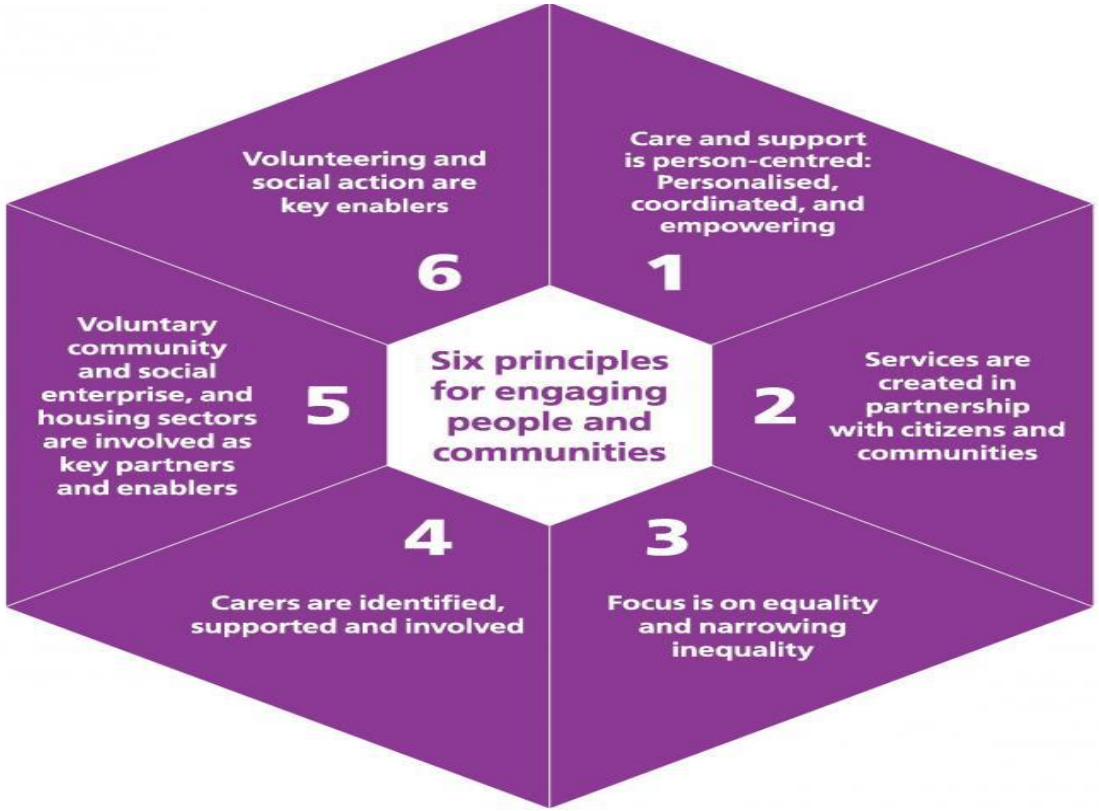
NHSE Five Year Forward View



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The VCSE supporting health & wellbeing and tackling inequalities

- **No wrong door** -The sector's strength lies in its holistic, community-embedded and personalised approaches.
- **Track record of trust –** local people trust us!
- VCSE organisations **promote understanding of the specific needs of their communities**.
- Its **diversity, flexibility** and level of **innovation** helps it reach and support those **hardest to engage**
- Builds **emotional resilience** and promotes **self-care** and **independence**
- Facilitate **asset based approaches** and **co-production**
- Expertise of **lived experience in designing more effective, sustainable services**

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VCSE Review
Investing in partnerships for health and wellbeing

A connected society: a strategy for tackling loneliness

- **‘GPs in England will be able to refer patients experiencing loneliness to community activities and voluntary services by 2023’**

  Theresa May Oct 2018

‘The practice known as ‘social prescribing’ will allow GPs to direct patients to community workers offering tailored support to help people improve their health and wellbeing, instead of defaulting to medicine.’

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What is Social Prescribing

Social prescribing connects people to community groups and services through the support of ‘link workers’, who give people time and co-produce a plan to meet the person’s health and wellbeing needs based on ‘what matters to me’.

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The High Impact Action: social prescribing

- Why Social Prescribing?
- Reduces pressure on General Practice and A&E
- Improves support for people with wider ‘social’ needs
- Reduces health inequalities – for those who use the NHS the most, complex needs

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Impact

- **On the NHS:** On GP consultation rates, A&E attendance, hospital stays, medication use, social care
- University of Westminster led an evidence review, looking at the impact of social prescribing on demand for NHS Healthcare
- Average of 28% less GP consultations & 24% less A&E attendances, where social prescribing ‘connector’ services are working well

https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network

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Why Social Prescribing

- ‘I’ve got six things wrong with me, I’m on 10 different drugs, I’ve been in and out of hospital for years, but the biggest problem I suffer from is ‘four-walls-itis’

- ‘As a local GP social prescribing has been one of the most significant improvements in my ability to care for my patients in recent years. The noticeable improvement in people , who have been struggling with long term problems both mental and physical that had seemed to have reached the end of what medicine could offer them, is remarkable.’

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Social Prescribing Connector Scheme

- NHS England wants every local area to have a social prescribing connector scheme, which enables all GPs to refer people with wider needs.
- Connector Scheme = Referrals to Link Workers
- Link workers give people time, co-produce support plans and practically connect people to community groups, services and support
- Ideally hosted in VCSE sector, commissioned by CCGs/ LA's.

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A Model for Social Prescribing

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- Link worker role isn't just signposting or navigating
- Builds relationship and empathy with patients
- Enabling and supporting a patient to assess their needs
- motivate and support individuals to achieve the change(s) that they want to achieve
- Co-producing solutions for them making use of appropriate local resources
- Provides continuity and support

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Social Prescribing Activities

- Often delivered by smaller community groups at neighbourhood level

- THE VCSE at local level requires funding to sustain and to absorb increased demand via social prescribing

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The ‘Rotherham Model’

- Voluntary Action Rotherham (VAR) on behalf of the CCG delivers 2 Social Prescribing (SPS) programmes.
- LTC programme works with all GP practices as part of the integrated case management approach. Patients are identified as part of the MDT, over 75’s health check & GP discretion. Referred to a VCS adviser aligned to each GP practice. Operating since 2012. Over 7,500 referrals
- Mental Health SPS works with cluster groups of patients referred by RDASH to a VCS advisor. Operating since 2014 . Over 450 referrals
- Recently extended to integrated locality work, pilot linking with Personal Health Budgets, referrals from Alcohol Liaison Service

What the evidence is showing us – impact on health & demand

- **Health and wellbeing** – Over 80% improvements for LTC patients and over 90% for MH service users. Over 72% of all SPS patients are referred on to a service to help tackle loneliness & isolation

- **Reduction in demand for services –** for the LTC service consistent reductions in use of services 6-11% reduction in non elective inpatient stays and 13-17% reduction in use of A&E services. MHS - over 50% discharge from services for those eligible for discharge review

- **Impact on GP time** – pilot study shows 28% reduction in face to face appts 14% reduction in telephone appts – findings are consistent with others across country. Helps patients manage symptoms, supports carers, impact on medication usage

- **Financial savings** – cost avoidance and return on investment plus significant additional benefits to patients/ users & sector

What Social Prescribing means to patients

‘Before social prescribing I was very isolated, shut off from the world, struggling to leave the house, lost, helpless battling every day to keep going. Nothing to live for, nothing to get up for, nothing to get ready for, nothing to do, nowhere to go. There’s no point in being stuffed full of tablets if you have no purpose in life, this has given me a light to my life. Kerching!’

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Areas worked

37% operate across the region and beyond

30% operate across one local authority

33% operate at village or neighbourhood level

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Community Foundation serving North East and North Cumbria

Most common beneficiary groups

- **19%** unemployed and workless
- **41%** children and young people
- **19%** deprived urban areas
- **25%** people with physical disabilities
- **37%** older people
- **25%** health and mental health
- **17%** people in rural areas

In the North East there are **7,000** formal third sector organisations

Workforce

- **45%** of employees are part time
- **10.8M** volunteer hours
- **150,000** volunteers
- **37,500** employed by the third sector in the North East
- **£78-£131** value of volunteer hours

Organisations

- **67%** experienced income stability in 2014-16
- **25%** have used reserves for essential costs
- **48%** are under £10,000
- **13%** are £100,001-£500,000
- **23%** in the poorest areas are most likely to be in a vulnerable financial position
- **10%** have no reserves
- **33%** are £10,001-£100,000
- **6%** are £500,001+

Organisations heavily dependent on public sector funding are in a more vulnerable financial position than those mainly funded by private sector funding.

What's Different in North East

- Highly Localised Focus - neighbourhood
- Large proportion of smaller VCS orgs - 50K or less
- Few larger orgs locally
- Asset poor
- Historically heavily dependent on public sector funding – particularly smaller/medium orgs
- Inequalities across geography of NE

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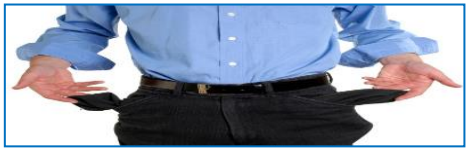
The challenges: the sector is struggling

- More demand for services & support
- Less money and fewer staff
- Core Activity often not funded through contracts
- Larger contracts
- Gov Grant/EU programmes prohibitive to smaller orgs
- Payment by results type contracts
- Procurement processes prohibitive particularly for smaller groups



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VONNE (Voluntary Organisations Network North East)

Regional Voluntary, Community & Social Enterprise (VCSE) Sector Infrastructure Body

Mission: 'To support the development and sustainability of a strong, effective and well governed VCSE and promote engagement, involvement and collaboration with the sector as a valued partner.

- Over 1000 VCSE members, Over 2000 subscribers to e-bulletins
- Bring together both Infrastructure & thematic VCSE in the region
- Health & Wellbeing Network – VCSE, Commissioners, Providers
- NE Regional Social Prescribing Network host – part of a national network
- Represents VCSE at Strategic level in health forums i.e. Regional Frailty Community of Practice, STP Prevention Board
- Working with Dr Toby Lowe & 'Collaborate' to support establishing Regional & Sub Regional Communities of Practice for Commissioner & Providers in response to the Collaborate report ' Funding & Commissioning in Complexity'

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Local Infrastructure Organisations (CVS)

TYNE AND WEAR

Newcastle Council for Voluntary Service (includes Gateshead)

Voluntary and Community Action Sunderland

Inspire South Tyneside

North Tyneside Organisations Development Agency

NORTHUMBERLAND

Community Action Northumberland

Community and Voluntary Action Blyth Valley

Northumberland Community Voluntary Action

TEES VALLEY

Catalyst Stockton on Tees Ltd

Middlesbrough Voluntary Development Agency

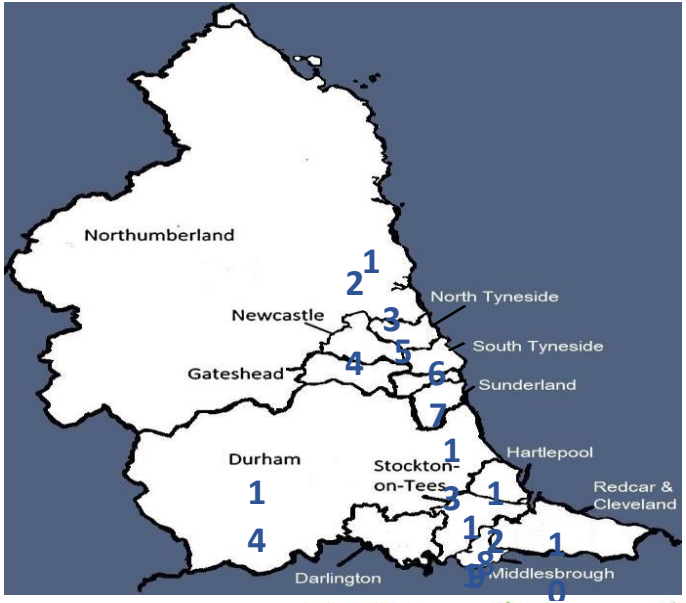
Redcar & Cleveland Voluntary Development Agency

Tees Valley Rural Community Council

COUNTY DURHAM

Durham Community Action

East Durham Trust



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Resources

‘Making Sense of Social Prescribing’ - *Guide*

https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network

National Social Prescribing Network

email: socialprescribing@outlook.com

https://www.westminster.ac.uk/social-prescribing-network

NHS England – On Line platform & register for Events

Email: england.socialprescribing@nhs.net

Penny Butcher Project Manager, Personalised Care, Supported Self Management (Social Prescribing) penny.butcher@nhs.net

Thank you

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Metrics: the future

Today's Picture

- Regional approach
- Local plans
- Quarterly reporting *but need to develop an understanding of re-fresh timings and local availability*
- Evidence:
    - for practice
    - for assurance
    - for opportunities
    - for challenges
    - for priority setting in the short, medium and long term
- Considering national policy

Proposal: routine reporting

- Quarterly reporting of the 23 indicator Frailty ICARE outcomes framework
- Developed by the NECS North Locality BI team for all localities in the region
- Contents will include a standard presentation of the metrics and a tailored summary for each locality outlining :
    a) priority areas for action
    b) areas of potential improvement
    c) areas of high performance
- Once the final product is agreed, production of the report will pass to the NECS BI Central team
- Reporting will be delivered out of the current CCG SLAs with NECS
- Work can begin immediately and a draft report is expected to be in place by the end of December

Proposal: consultation with locality teams

- A time limited piece of work to consult with each locality team on an individual basis [funding to be secured]
- To consist of a session delivered in each locality (minimum of two hours, maximum of half-day) with the following objectives:
    - explain the purpose of the framework and each of the 23 metrics
    - explain and discuss the key findings for each individual locality
    - gain feedback on the metrics format from the locality teams

- The consultation sessions will be carried out by the NECS BI locality teams
  North: Ncle Ghd, Nth Tyneside, Sth Tyneside, Sland, Nland *[Bob Gaffney]*
  South: Darlington, Nth Durham, DDES, Sth Tees Hast *[Craig Nightingale]*
  North Cumbria: *[Pete Bell]*

Consultation: feedback to Care Closer to Home Team

- Feedback from the locality teams will be collated by NECS north BI Lead and reported back to clinical leads [LB, DC, JS]
- A revised (final) outcomes framework report will then be agreed
- NECS BI locality teams met during the consultation period will then provide ongoing support to the frailty locality teams

- The consultation and collation of feedback will be completed between January and March 2019 [subject to the availability of frailty locality teams for consultation sessions]

Data Frequency

No.	Part of system	Metric	Purpose	Data frequency
1	Primary Care	Number of patients who have had a frailty assessment	Clinical verification of frailty	Local Collection: Monthly Published Data: Quarterly
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	Local Collection: Monthly Published Data: Quarterly
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	Local Collection: Monthly Published Data: Quarterly
4	Primary Care	Patients aged 65 years and over with severe frailty who have received an annual medication review	Management of f frailty	Local Collection: Monthly Published Data: Quarterly
5	Primary Care	Number of patients with 8/10/15/20 or more unique medications	Prevention / optimising care	Local Data: Monthly
6	Primary Care	Flu immunisation rate in people aged 65 years and over	Admission Avoidance	Published Data: Weekly / Monthly
7	Mental 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	Local Collection / Published Data: MonthlyAnnual
8	Primary Care	Proposed indicator - Patients aged 65 years and over, with depression or dementia, and who have moderate or severe frailty	Management of f frailty	Local Data: Monthly

Data Frequency

No.	Part of system	Metric	Purpose	Data frequency
9	Care in the community	The proportion of people who use services who have control over their daily life	Older people staying independent	Published Data: Annual
10	Care in the community	The proportion of people who use services who reported that they had as much social contact as they would like	Social isolation	Published Data: Annual
11	Care in the community	Carer reported quality of life	Prevent social isolation, maintain good physical and mental health	Published Data: Annual
12	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	-
13	Care in the community	Proposed indicator - Number of people referred into social prescribing schemes	-	-

Data Frequency

No.	Part of system	Metric	Purpose	Data frequency
14	Emergency care	A&E attendance rates for patients aged 65 years and over	Activity indicator	Local Data: Monthly
15	Emergency care	Emergency hospital admission rates for patients aged 65 and over	Activity indicator	Local Data: Monthly
16	Emergency care	Emergency readmissions within 30 days of discharge from hospital	Quality of discharge / patient management proxy?	Local Data: Monthly
17	In hospital delays	Stranded patient: LOS TBC (7+ / 14+ / 21+ days)	DTOC indicator, but better data frequency	Local Data: Monthly
18	Emergency care	Conversion rates from A&E attendance to hospital admission (patients aged 65+ years)	Activity indicator	Local Data: Monthly
19	Emergency care	Hospital activity in the last year of life	Links https://www.mariecurie.org.uk/globalassets/media/documents/media-centre/2018/emergency-admissions-report.pdf https://www.nuffieldtrust.org.uk/files/2017-01/marie-curie-end-of-life-full-web-final.pdf	Published Data: Annual

Data Frequency

No.	Part of system	Metric	Purpose	Data frequency
20	Secondary Care	Hospital activity in the last year of life (patients aged 65+ years)	Activity indicator	Local Data: Monthly
21	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?	Published Data: Annual
22	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	Published Data: Annual
23	Mortality	Percentage of deaths in usual place of residence	Enabling people to die outside of hospital	Published Data: Annual

NHS

North East Quality Observatory Service

Development of Frailty Metrics

Andrea Brown

AHSN NENC Measurement Programme Lead

involve consider assess respond evaluate

Development of New Indicators

North East Quality Observatory Service

- Since April 2009, NICE has had responsibility for overseeing the development of indicators for quality improvement and judgement
- NEQOS supports NICE as their National Collaborating Centre for Indicator Development
- The role of NEQOS is to develop indicators to measure:
  - outcomes that reflect the quality of care
  - processes that are linked by evidence to improved outcomes for
- Draft indicators are piloted/tested with sample practices in England
- A number of draft indicators relating to frailty are currently being tested in a national pilot - results available June 2019

The Pilot Process

North East Quality Observatory Service

Piloting provides an understanding of how potential indicators work in practice, including any unintended or adverse consequences. The aim is to establish how much, and which types of, activity and effort are required to meet the new indicators and making them work in the real world.	
June	A NICE Committee decides which potential indicators should be tested through a piloting process, based on clinical evidence and NICE standards and guidelines.
July – Aug	A representative sample of GP practices in England are provided with clinical information, codes and detailed guidance in preparation for the start of the pilot, supported by NHS Digital.
Sept - March	This is the period in which the pilot will run (approximately 6 months). A baseline data extraction is taken at the start to establish the existing level of data recording.
April - May	Once the pilot ends, a second data extraction takes place to record the extent of additional data recording during the pilot period. Focus groups and interviews take place to obtain feedback on staff experience.
June	The findings from the pilot are analysed and presented to the NICE Committee, alongside the results of a public consultation. Successful indicators are added to the NICE Indicator menu.
Autumn	NHS Employers & the General Practitioners Committee (GPC) of the BMA use the Indicator menu to decide which indicators may be included in QOF or other contracts from the following 2020

Frailty Metrics: future update

NHS
North East Quality Observatory Service

- Current indicator pilot is due to end in March 2019
- Indicator topics currently being tested are:
  - Frailty and multimorbidity
  - Alcohol
  - Familial hypercholesterolaemia
  - HIV (selected practices only)

- Findings will be presented to NICE in June 2019.
- Successful indicators will then be available on the NICE menu https://www.nice.org.uk/standards-and-indicators

GIRFT Position

1. *Speciality Geriatric Medicine visits - just completed 3 pilot visits around England the last one being Northumbria - this is to refine the data pack which is due to be finalised by end of January/February - the data is currently hospital focused (partly because complete data for benchmarking limits what we can use) but the aim is to include some system measures from Right Care or other data plus NHS benchmarking data*
2. *Frailty as a cross-cutting theme – still at an early stage and don't have a final view but broadly the approach could be to look at frailty within hospital particularly in surgical specialities where an initial data view shows significant increases in LOS, mortality, 7 and 21 day stranded, or looking a frailty as a system possibly supported by local data - from all of the pilot visits very rapidly get into territories where CCGs or SDP based input makes sense so looking at the local meetings beyond the geriatric medicine speciality may make sense; perhaps having a part1 and part 2 visit involving other stakeholders*
3. *In areas such as the NE where there has been regional developments such as Great North Care Record, web support and agreed metrics things may be best to nuance further with a variation in the classic GIRFT visit*
4. *Priority is to agree the national data pack (for hospitals) soon but nothing else is fixed*

Any Other Business