frailty icare

NHS England

A Regional Approach to Frailty Community of Practice Meeting 9

13th June 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

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Frailty ICARE: *what's the latest?*

1. **Workforce:** LB re-pitch to ICS Workforce workstream on 24th June for competency assessor posts

2. **Digital:** process agreed for accessing funding to test innovations via ICS Digital workstream; LB met with them regarding requests from housing CoPpers and waiting feedback from Gateshead LA that they don't have anything available already via their Grandcare project

3. **Ageing Well ICOPE Programme:** still progressing, currently working with NHS Digital to refine definitions and to develop the Community Services Dataset [CSDS]

Frailty ICARE: *what's the latest?*

4. **What's next for Frailty Icare?:** seeking understanding of where it fits within remaining ICS workstreams [digital, workforce, mental health, learning disabilities, acute care, prevention] to plan further

Showcasing CoPper:

Frailty Data and RAIDR

Bob Gaffney
Kim Teasdale

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Partners in improving local health

North of England
Commissioning Support Unit

Frailty data and RAIDR

Community of Practice Meeting – 13/06/2019

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Content

1. About RAIDR
2. Frailty national and local context
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5. Additional Ideas / Suggestions
6. Questions and Next steps

About RAIDR

- Business Intelligence tool
- Range of dashboards
- Used across Y&H and NCNE as well as Derbyshire (and nationwide – RAIDR111)
- Includes multiple data sources
- Users can self-serve, drill, access printable reports, receive reports auto-pushed, export data and images
- Enables actionable insight at an integrated care system/community/place/network and patient level
- Developed by Info Analysts in collaboration with clinicians
- Roadmap / developments informed by user feedback / User Group
- Current user base is mainly CCGs and GP practices, and Trusts supporting Urgent and Emergency Care

Business Intelligence Model

We deliver 5 levels of Business Intelligence

We have specialist teams in data management; applications; analysis; insight and intelligence dedicated to improving outcomes

5 Clinical Commissioning Intelligence
Specialist deep dive detailed analysis and in-depth insight reporting. Clinical and epidemiological interpretation identifying opportunities and providing evidence backed recommendations to inform strategic commissioning decisions.

4 Intelligence Analysts
Intelligence and insight reporting including customer-focused narrative, highlighting key points, recommended actions and providing value-adding insight. Delivered in conjunction with specialist teams across NECS.

3 Information Analysis
Analysis and reports including statutory returns, routine reports, and ad hoc reports, highlighting data quality and trend changes, in formats agreed with customers.

2 BI Tools e.g. RAIDR
Provision of BI applications and portals to access a range of reports, data sources, and interactive tools, from high level trends to patient level data, benchmarking, variation, risk stratification, etc.

1 DSCRO Data Management
Acquisition, cleansing, grouping, costing, pseudonymisation, validation, reconciliation, and management of national and local data sets.

Frailty – NHS Long Term Plan

NHS Long Term Plan; nine mentions of **frailty**

“1.17: Extending independence as we age requires a targeted and personalised approach, enabled by digital health records and shared health management tools. Primary care networks will from 2020/21 assess their local population by risk of unwarranted health outcomes and, working with local community services, make support available to people where it is most needed. GPs are already using the Electronic **Frailty** Index (Efi) to routinely identify people living with severe **frailty**. Using a proactive population health approach focused on moderate **frailty** will also enable earlier detection and intervention to treat undiagnosed disorders, such as heart failure. Based on their individual needs and choices, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which will include musculoskeletal conditions, cardiovascular disease, dementia and **frailty**. Integrated primary and community teams will work with people to maintain their independence: for example, 30% of people aged 65 and over, and 50% of those aged 80 and over, are likely to fall at least once a year . Falls prevention schemes, including exercise classes and strength and balance training, can significantly reduce the likelihood of falls and are cost effective in reducing admissions to hospital.”

Frailty – National GP Contract

Frailty metrics have been included as part of the GMS Core Contract Data Collection from 1st July 2017. This is collected quarterly directly from GP practices across England, and relates to only those aged 65+ years. *There are 7 metrics in total.*

These metrics directly relate to identification of frailty, the severity of the condition, those who have had a fall and patients who have received a medication review.

E.g.

- *CCDCMI10: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have had a frailty assessment using an appropriate tool up to the end of the reporting period.*
- *CCDCMI12: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of **moderate frailty** diagnosed using an appropriate tool up to the end of the reporting period.*
- *CCDCMI13: Quarterly (cumulative) count of the number of registered patients aged 65 years or over, who have a diagnosis of **severe frailty** diagnosed using an appropriate tool up to the end of the reporting period.*

Frailty – Regional picture

A regional frailty toolkit, '*Frailty I-Care*', has been developed in order to create a common understanding of frailty, establish a supportive way for learning and sharing best practice and to achieve optimum outcomes for the population of each local health economy.

- It contains an overview of quantitative and qualitative measures which relate to frail or older people (65+years), in order to present the current state and variation across the North East and North Cumbria area and compared to England as a whole.

- There are 23 metrics that pull data from Primary Care, Mental Health, Care in the Community, Secondary Care, Social Care, Mortality and Emergency Care

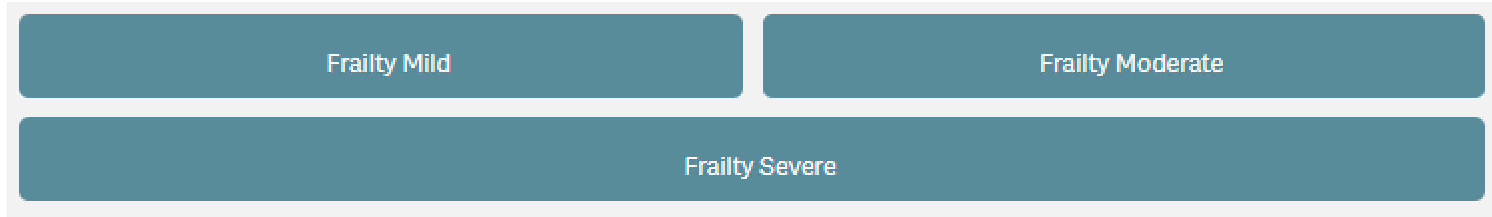
Frailty – I-Care metrics

Primary Care	Patients aged 65 years or over who have had a frailty assessment
Primary Care	Patients aged 65 years or over who are identified as living with frailty, and the severity of their condition
Primary Care	Patients aged 65 years and over with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months
Primary Care	Patients aged 65 years and over with severe frailty who have received an annual medication review
Primary Care	Patients aged 65 years and over with 10 or more unique medications
Primary care	Flu immunisation rate in people aged 65 years and over
Mental Health	Dementia: 65+ years old estimated diagnosis rate
Primary Care	Proposed indicator - Patients aged 65 years and over, with depression or dementia, and who have moderate or severe frailty
Care in the community	The proportion of people (aged 65+ years) who use services who have control over their daily life
Care in the community	The proportion of people (aged 65+ years) who use services who reported that they had as much social contact as they would like
Care in the community	Carer reported quality of life
Care in the community	Proposed indicator - Measurement of loneliness / reduced loneliness
Care in the community	Proposed indicator - Number of people referred into social prescribing schemes
Emergency care	A&E attendance rates for patients aged 65 years and over
Emergency care	Emergency hospital admission rates for patients aged 65 and over
Emergency care	Emergency readmissions within 30 days of discharge from hospital (patients aged 65 years and over)
In hospital delays	Proportion of stranded patients in hospital: Length of stay 7+ and 21+ days
Emergency / secondary care	Conversion rates from A&E attendance to hospital admission (patients aged 65+ years)
Emergency care	Hospital activity in the last year of life (patients aged 65+ years)
Secondary care	Hospital Trust indicator set (Falls with harm, Pressure ulcers, Patient experience of hospital care, A&E waiting time 4 hour standard)
Social care - discharge	Older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Social care - discharge	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes
Mortality	Proportion of deaths in usual place of residence

RAIDR Demo

Frailty in Primary Care

RAIDR – Current Primary care – Prevalence (Mild, moderate, severe)



- Clinically assessed patients not those with risk of frailty score
- Ability to look at prevalence – Mild, Moderate and Severe – actual and rate
- Identify areas around DQ improvement needed
- Current all ages – needs to be Over 65s only
- Look at Frail population with multiple co-morbidities – individual GP practice, Primary Care Network (PCN) or CCG level

RAIDR – Moderate frail with a fall – Aggregate level

Sheet:

Prevalence Bar Chart
Prevalence Funnel C...

Percent

Practice	Percent
Practice 8	2.2
Practice 7	2.0
Practice 26	1.8
Practice 13	1.4
Practice 3	1.1
Practice 10	1.1
Practice 6	0.9
Practice 18	0.9
Practice 4	0.6
Practice 12	0.6
Practice 22	0.5
Practice 2	0.5
Practice 16	0.4
Practice 14	0.4
Practice 1	0.2
Practice 9	0.1
Practice 21	0.1
Practice 15	0.0
Practice 5	0.0
Practice 24	0.0
Practice 19	0.0

Asthma
Anxiety Disorders
Dementia
COPD
Falls ✓
Atrial Fibrilation
Hypertension
Heart Failure
Depression
Elevated Cholesterol
Bi Polar
Mental Health
BMI>=30
Learning Disabilities
Epilepsy
Osteoporosis
Bronchiectasis
Palliative Care
Cancer
Stroke
TIA
CHD
CKD
UTI
Parkinsons
Schizophrenia
Psychotic Disorders
Type I Diabetes
Type II Diabetes
Diabetes QOF Def.
Frailty Mild
Frailty Moderate ✓
Frailty Severe

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RAIDR – Moderate frail with a fall – Patient level

Sheet: Prevalence (PID)

Patients with the following conditions: Select an NHS Number to view diagnosis related records

NHS Number	Age	Gender	Co-Morbidities	count	Practice
Totals				**286**	
NHS# 100611	100	F	CKD, HouseBound, Palliative	1	P14
NHS# 106386	100	F	Atrial Fibrillation, Constipation, HouseBound, Hypertension, Palliative, UTI	1	P14
NHS# 107913	98	F	Atrial Fibrillation, CKD, Constipation, HouseBound, Hypertension, Palliative, UTI	1	P14
NHS# 106923	98	M	CHD, CKD, Hypertension, Palliative	1	P14
NHS# 90223	96	F	Atrial Fibrillation, CKD, Cancer, Hypertension, Hypothyroidism, UTI	1	P14
NHS# 101579	96	M	Anxiety, CKD, HouseBound, Hypertension, UTI	1	P14
NHS# 93522	95	F	CHD, CKD, COPD, Dementia, Heart Failure, HouseBound, Palliative, UTI	1	P14
NHS# 90855	93	F	CHD, HouseBound, Hypothyroidism, TIA, UTI	1	P14
NHS# 92094	93	F	Hypertension, Stroke	1	P14

Related records

Single NHS number selection required.

Anxiety Disorders | Falls ✓ | COPD
Asthma | Heart Failure | Dementia
Artial Fibrilation | Hypertension | Depression
Bi Polar | Elevated Cholesterol
BMI>=30 | Mental Health
Epilepsy | Learning Disabilities
Bronchiectasis | Osteoporosis
Stroke | Palliative Care
Cancer | TIA | CHD
Parkinsons | Schizophrenia | CKD
UTI | Psychotic Disorders
Type I Diabetes | Type II Diabetes
Diabetes QOF Def.
Frailty Mild | Frailty Moderate ✓
Frailty Severe

RAIDR developments – what do we need?

Users to be able to identify and target the support for their frail population and for clinical teams to be able to identify quickly and easily, those frail patients most at risk of a fall or hospital admission.

F	Prone to falls
R	Reduced mobility
A	Acute confusion
I	Incontinence
L	Living in a care home

ROCKWOOD, GAIT, GUAG, Efi etc *

And …..

A slimmed down version of the 23 metrics report with additional reporting around the recently frail or about to become frail would seem to fit

Proposed screens (1) – PCN level

LocalityName
Middlesbrough

CCGName
NHS South Tees CCG

Sheet:

% of practice population with a frailty assessment

Park End	Hemlington	Thorntree	Oakfield	Hirsel	Westbourne	Kings Rd	Parkway	Prospect	Resolution	Discovery	Erimus	Coulby	Cambridge	Endeavour	Martonside	Village Med	Woodlands	Fulcrum	Park	Newlands	Crossfell	Borough Rd	Linthorpe	Haven MP
0.67	0.55	0.45	0.31	0.30	0.22	0.19	0.18	0.18	0.18	0.16	0.14	0.14	0.14	0.13	0.13	0.12	0.11	0.11	0.11	0.10	0.10	0.09	0.07	0.04

Average (0.2)

Patients on frailty register:
21,642

Level of Frailty
Assessed level of frailty for all patients on register: 61.1% moderate or severe
Mild · Moderate · Severe

Frailty and Falls
Number of patients by frailty who have had a fall in the previous 12 months: 23.5% of severely frail patients reported as falling
Fall - Not Frail · Fall - Severe

Frailty patients who have had a medication review in the last 12 months
Frailty patients who have had a flu vaccination in the last 12 months
Frailty patients who have more than 10 + medications prescribed
Frailty patients with a diagnosis of dementia against estimated diagnosis rate

100% 80% 60% 40% 20% 0%

Number of pts by frailty level who have had a fall in last 12m

Frail patient who have had a med review in last 12m

Frail patient who have had a flu vacc

Frail patient who have more than 10+ Px

Frail patient who have diagnosis of dementia against estimated rate

Proposed screens (2) – GP Practice

% of practice population with a frailty assessment

0.67

Acklam Rd

Patients on frailty register:
212

Level of Frailty

Assessed level of frailty for all patients on register: 54.3% moderate or severe

Mild · Moderate · Severe

Frailty and Falls

Number of patients by frailty who have had a fall in the previous 12 months: 0.25% of severely frail patients reported as falling

Fall - Not Frail · Fall - Severe

Frailty patients who have had a medication review in the last 12 months

Frailty patients who have had a flu vaccination in the last 12 months

Frailty patients who have more than 10 + medications prescribed

Frailty patients with a diagnosis of dementia against estimated diagnosis rate

Number of pts by frailty level who have had a fall in last 12m

Frail patient who have had a med review in last 12m

Frail patient who have had a flu vacc

Frail patient who have more than 10+ Px

Frail patient who have diagnosis of dementia against estimated rate

Proposed screens (3) – Q&P (I-Care)

Ind_FiscalYear 2018/19 | YTDorPeriod Period | frameworkName Mortality

Sheet: Scorecard

Year
Time Period
IndicatorLevel
Practice CCG
Organisation
Framework
Domain
Indicator

Please make the sel...

Time Period

will be highlighted in green once selected

Org Name	Update Frequency	Indicator	High or Low	Latest Data	Actual Threshold	Actual Position	Status	Actual Region
South Tees CCG	Quarterly	Frailty Indicator: Number of patients who have had a frailty assessment	High	31/12/2018	95.0	86.5		-
South Tees CCG	Quarterly	Frailty Indicator: Number of patients who are identified as living with frailty, and the degree of their condition (mild, moderate, severe)	Low	31/12/2018	54.5	73.6		-
South Tees CCG	Quarterly	Frailty Indicator: Number of patients with frailty who are recorded as having had a fall in the preceding 12 months	Low	31/12/2018	65.3	52.5		-
South Tees CCG	Quarterly	Frailty Indicator: Patients aged 65 years and over with severe frailty who have received an annual medication review	High	31/12/2018	5000	12500		-
South Tees CCG	Quarterly	Frailty Indicator: Number of patients with 8/10/15/20 or more unique medications	Low	31/12/2018	6000	16545		-
South Tees CCG	Monthly	Frailty Indicator: Flu immunisation rate in people aged 65 years and over	High	31/12/2018	7000	6958		-
South Tees CCG	Monthly	Frailty Indicator: 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	Low	31/12/2018	500	1254		-
South Tees CCG	Annual	Frailty Indicator: Proposed indicator - Patients aged 65 years and over, with depression or dementia, and who have moderate or severe frailty	Low	2018/19	0.23	0.1		-
South Tees CCG	Monthly	Frailty Indicator: The proportion of people who use services who have control over their daily life	High	31/12/2018	65.2	85.3		-
South Tees CCG	Annual	Frailty Indicator: The proportion of people who use services who reported that they had as much social contact as they would like	High	2018/19	65.1	25.6		-
South Tees CCG	Annual	Frailty Indicator: Carer reported quality of life	High	2018/19	12.3	10.5		-
South Tees CCG	Annual	Frailty Indicator: Reduced loneliness (e.g. R-UCLA loneliness scale assessment)	High	2018/19	95	96		-
South Tees CCG	Annual	Frailty Indicator: Proposed indicator - Number of people referred into social prescribing schemes	Low	2018/19	45	54		-
South Tees CCG	Monthly	Frailty Indicator: A&E attendance rates for patients aged 65 years and over	Low	31/12/2018	63.7	78.9		-
South Tees CCG	Monthly	Frailty Indicator: Emergency hospital admission rates for patients aged 65 and over	Low	31/12/2018	25.6	33.3		-
South Tees CCG	Monthly	Frailty Indicator: Emergency readmissions within 30 days of discharge from hospital	Low	31/12/2018	100	100		-
South Tees CCG	Monthly	Frailty Indicator: Stranded patient: LOS TBC (7+ / 14+ / 21+ days)	Low	31/12/2018	100	100		-
South Tees CCG	Monthly	Frailty Indicator: Conversion rates from A&E attendance to hospital admission (patients aged 65+ years)	Low	31/12/2018	100	100		-
South Tees CCG	Annual	Frailty Indicator: Hospital activity in the last year of life	Low	2018/19	100	100		-
South Tees CCG	Monthly	Frailty Indicator: Hospital activity in the last year of life (patients aged 65+ years)	Low	31/12/2018	100	100		-
South Tees CCG	Annual	Frailty Indicator: The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	High	2018/19	100	100		-
South Tees CCG	Annual	Frailty Indicator: Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Low	2018/19	100	100		-

Additional ideas and suggestions

- Trend Analysis – Community in Practice Frailty Leads Group are very keen on this
- Need to look at frailty at a sub-geographical level as there will be variations even across a town (deprivation links to frailty) and across primary care networks (North Team are developing a profile report for a PCN)
- ICS Dashboard – Could we potentially have the ‘frail’ as a population segment/separate screen within ICS?
  - Currently have 11 segments – i.e. Adults with 1-3 LTCs, Adults with 4+ LTCS, Elderly (over 75s) with 1-3 LTCS, Elderly(over 75s) with 4+ LTCs

necs

RAIDR
Rapid Actionable Insight Driving Reform

Questions – and next steps

- Locality support for the outcomes framework
- Support for Primary Care Networks

Partners in improving local health

For further information, please contact:

Bob Gaffney – BI Manager

bob.gaffney@nhs.net

Kim Teasdale – Deputy Head of Information Services

kim.teasdale@nhs.net

Showcasing CoPper: Museum Health & Social Care Service

Juliana Thompson, Senior Lecturer, Adult Nursing
Northumbria University

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Museum Health and Social Care Service

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Aim

Develop a '**Museum Health and Social Care Service**'

- Use resources and collections to support QoL improvements for older people.
- Develop a resource pack of activities that will support health and social care professionals to use TWAM's collection to support a range of healthy ageing and rehab needs.

Background

- Various 'culture, health and wellbeing' projects that TWAM are currently leading/involved in. The MHSCS project will be part of the **'Platinum project'** (a wellbeing outreach project for people over 50 years old).
- Lack of understanding/engagement by health professionals regarding the benefits of art/museum therapies.
- Resource for social prescribing
- Use of medical language/guidelines to increase enga
- Previous resources: Museum First Aid; Recipes for (

How is MHSCS unique?

The MHSCS resource will be unique in that it suggests activities, but also identifies how these activities would specifically support health and wellbeing eg pain management, speech, cognitive stimulation, mental health, social interaction, etc.

MDT involved in resource development

- Nursing:
  - Adult
  - Mental health
- Physiotherapy
- Social work
- Arts
- Museums

- Need service users, OT, SALT, link worker for social prescribing, anyone else?

Early days….

- First meeting 10 May
- Next meeting – early July
- Each member will develop a list of common care needs and related therapeutic interventions/activities that support these needs. These will be collated via the next meeting.

Suggestions/ideas welcome

Continuing our Digital Journey

Rob Brown

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Any Other Business