A Regional Approach to Frailty Community of Practice Meeting 5

4th January 2019

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Clinical Lead

Welcome and Introductions

Frailty ICARE: *what's the latest?*

1. **Evaluation:** ARC bid……..
2. **Workforce:** job descriptions for 3 cross organisational competency assessors completed and sent off for matching, met with ICS Workforce Director and HENE regarding commissioning of supporting educational components, growing momentum for participation
3. **Social Prescribing:** NHSE guide expected as part of Long Term Plan and the Common Outcomes Framework along with 3 specific codes but building on discussion at last CoP

Frailty ICARE: *what's the latest?*

- EMISNQNO183 - Not suitable for social prescribing
- 8T09 - Referral to social prescribing service
- EMISNQRE582 - Referral to social prescribing service from other agency
- EMISNQRE581 - Review of social prescribing plan
- ESCTSI71 - Signposting to social prescribing service
- 8IEp - Social prescribing declined
- 8BAf - Social prescribing for mental health
- 9NSE - Social prescribing offered
- EMISNQSO62 - Social prescribing plan completed
- ESCTSI95 - Signposting to health and wellbeing worker
- ESCTSI61 - Signposting to voluntary community service
- EMISNQRE590 - Referred for social/financial support

Not currently extracted

Can only do so if data sharing agreement among practices

Frailty ICARE: *what's the latest?*

- 13% of people living with frailty in Newcastle meet Ways to Wellness eligibility criteria
- 6% for severely frail
- link social prescribing referral to those identified as frail and also to unplanned secondary care activity?

Frailty	Total	W2W Eligible	%
Mild	7,788	825	17.2%
Moderate	3,669	361	9.8%
Severe	1,672	106	6.3%
Grand Total	**10,129**	**1,292**	**12.8%**

Frailty ICARE: *what's the latest?*

4. **Digital:** job description completed for strategic clinical digital lead and support completed and sent for matching, process to access funding still being finalised
5. **Mental Health:** joining sub-group of mental health ICS workstream to avoid duplication/wasted effort etc
6. **New Supporting CoPper Medicines:** Steven Barrett

Showcasing CoPper: Metrics

Bob Gaffney
Business Intelligence Manager
North of England Commissioning Support Unit

involve consider assess respond evaluate

North of England Commissioning Support

Frailty Outcomes Framework 2017/18 Baseline Report

involve consider assess respond evaluate

Primary Care

Part of system	No.	Metric
Primary Care	1	Number of patients who have had a frailty assessment
Primary Care	2	Number of patients who are identified as living with frailty, and the degree of their condition (mild, moderate, severe)
Primary Care	3	Number of patients with frailty who are recorded as having had a fall in the preceding 12 months
Primary Care	4	Proportion of people with severe frailty who have had a medication review
Primary Care	5	Number of patients with 10 or more unique medications
Primary Care	6	Flu immunisation rate in people aged 65+
Primary Care	*8*	*Patients on the MH registers (dementia, depression and anxiety) and with frailty*

Secondary Care

Part of system	No.	Metric
Emergency / Secondary Care	14	A&E attendance rates for patients aged 65+ years
Emergency / Secondary Care	15	Unplanned admission rates for patients aged 65 years or more
Emergency / Secondary Care	16	Emergency readmissions within 30 days of discharge from hospital
Emergency / Secondary Care	18	Conversion rates (A&E attendance to hospital admission)
Emergency / Secondary Care	19	Hospital activity in the last year of life
Emergency / Secondary Care	20	ED attendance, 4 hr compliance, hospital admission rates, LOS, Falls, pressure ulcers, improved experience, discharge to normal place of care.

Care in the Community

Part of system	No.	Metric
Care in the community	9	The proportion of people who use services who have control over their daily life
Care in the community	10	The proportion of people who use services who reported that they had as much social contact as they would like
Care in the community	11	Carer reported quality of life
Care in the community	*12*	*Measurement of Loneliness*
Care in the community	*13*	*Referrals into Social Prescribibng*

Hospital / Social Care Interface

Part of system	No.	Metric
In hospital delays	17	Stranded patient: LOS 7+ / 21+ days
Social care - discharge	21	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
Social care - discharge	22	Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Other

Mental Health	7	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
Mortality	23	Percentage of deaths in usual place of residence

Primary Care

Part of system	No.	Metric	Exceptions
Primary Care	6	Flu immunisation rate in people aged 65+	
Primary Care	1	Number of patients who have had a frailty assessment	Best Practice: North Cumbria (Possible Data Quality Issue?) Low Outlier: North Durham, HAST, Northumberland
Primary Care	2	Number of patients who are identified as living with frailty, and the degree of their condition (mild, moderate, severe)	Best Practice: South Tees, DDES Low Outlier: North Durham
Primary Care	4	Proportion of people with severe frailty who have had a medication review	Best Practice: DDES, North Durham, Darlington Low Outlier: Sunderland, South Tyneside, HRW
Primary Care	3	Number of patients with frailty who are recorded as having had a fall in the preceding 12 months	Best Practice: HAST, Sunderland , Northumberland High Outlier: Darlington, DDES, North Durham
Primary Care	5	Number of patients with 10 or more unique medications	Best Practice: HRW, Northumberland, North Cumbria High Outlier: Newcastle Gateshead, Sunderland, South Tyneside

Secondary Care

Part of system	No.	Metric	Exceptions
Emergency / Secondary Care	16	Emergency readmissions within 30 days of discharge from hospital	Best Practice: HRW, Darlington High Outlier: South Tyneside, Sunderland, North Tyneside
Emergency / Secondary Care	18	Conversion rates (A&E attendance to hospital admission)	Best Practice: Sunderland, HAST High Outlier: North Cumbria, Sunderland
Emergency / Secondary Care	19	Hospital activity in the last year of life	Best Practice: North Durham High Outlier: North Tyneside, South Tyneside
Emergency / Secondary Care	14	A&E attendance rates for patients aged 65+ years	Best Practice: South Tees, DDES, HRW High Outlier: South Tyneside, Sunderland, HAST
Emergency / Secondary Care	15	Unplanned admission rates for patients aged 65 years or more	Best Practice: Darlington, North Cumbria, HRW High Outlier: South Tyneside, North Tyneside, Newcastle Gateshead

Care in the Community

No.	Metric	Exceptions
9	The proportion of people who use services who have control over their daily life	Best Practice: Hartlepool, Middlesbrough, Northumberland Low Outlier: Newcastle upon Tyne
10	The proportion of people who use services who reported that they had as much social contact as they would like	Best Practice: Redcar and Cleveland, Hartlepool, Cumbria Low Outlier: North Yorkshire
11	Carer reported quality of life	Best Practice: Hartlepool, Northumberland Low Outlier: Darlington

Hospital / Social Care Interface

No.	Metric	Exceptions
17	Stranded patient: LOS 7+ / 21+ days	
21	The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Best Practice: North Tyneside, Northumberland, Middlesbrough Low Outlier: Stockton, Hartlepool, Darlington

Other

Part of system	No.	Metric	Exceptions
Mental Health	7	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	Best Practice: HAST, DDES, Newcastle Gateshead Low Outlier: HRW, North Cumbria
Mortality	23	Percentage of deaths in usual place of residence	Best Practice: North Tyneside, HRW, DDES Low Outlier: South Tyneside, Sunderland, HAST

Improvement Areas by CCG

Falls
Polypharmacy
A&E Attendances
Unplanned Admissions

North Cumbria ICP			
CCG	***Top Three Improvement Areas***		
North Cumbria	**A&E to Admission Conversion**	**Dementia Diagnosis**	Care / Residential Home Admissions
Northern ICP			
CCG	***Top Three Improvement Areas***		
Northumberland	**Frailty assessment**	Medication Review	Unplanned Admissions / Readmissions
North Tyneside	**Unplanned admissions**	**Emergency Readmissions**	**Hospital activity in the last year of life**
Newcastle Gateshead	**Polypharmacy**	**Unplanned admissions**	**Service users with control over daily life**
Central ICP			
CCG	***Top Three Improvement Areas***		
South Tyneside	**Medication review**	**Polypharmacy**	**Unplanned Admissions / Readmissions**
Sunderland	**Medication review**	**Polypharmacy**	**Unplanned Admissions / Readmissions**
North Durham	**Frailty assessment**	**Falls amongst frail population**	Dementia Diagnosis
Southern			
CCG	***Top Three Improvement Areas***		
Darlington	**Falls amongst frail population**	**Carer reported quality of life**	**Reablement**
DDES	**Falls amongst frail population**	Polypharmacy	Flu immunisation
HAST	**Frailty assessment**	**A&E attendance rate**	**Reablement**
South Tees	Falls amongst frail population	Polypharmacy	A&E to admission conversion rate
HRW	**Medication review**	**Service users with enough social contact**	**Dementia Diagnosis**

Any Other Business