A Regional Approach to Ageing Well Community of Practice

5 August 2021

House Keeping

- Mute mics when not speaking
- Use the chat box for questions and we will address as we go or follow up afterwards
- Presentations will be circulated following the event
- The event will be recorded and shared

Welcome and Introductions

Mapping of policies and innovations to develop new models of health and social care that support people in later life in North East England and South East Scotland

Dr Nav Aujla

Senior Research Associate

Population Health Sciences

Newcastle University

involve consider assess respond evaluate

Ageing Well Steering Group – updates

- Ageing Well funding allocations approved
- T+F group to be set up to support UCR 2hr
- Active engagement in national Anticipatory Care model
- Continued matrix working with other ICS workstreams
- Linked into NEY Ageing Well groups

Digital and Information Technology

i-CGA (CHA) Digital Tool

- Codification of the tool underway
- Pilot start September – workshops next few weeks (Gateshead)
- Pilot 2nd phase – end of the year (discussing interoperability)
- Early proposal to an evaluation strategy has been drafted

Community Digital Strategy

- Paul Danvers in post
- Focus on ageing well and wider community
- Mapping exercise and scoping of 'strategy' approach
- Workshops TBA from September onwards

Website - www.frailtyicare.org.uk.

- Updated - take a look! Exploring alignment with NE&NC ICS website.

Jackie's story

- Completed (www.jackiestory.co.uk). Discussing launch approach and sharing

Workforce Projects

EnCOP

- Further resources on the website
- Presented at NENY NHSEI WFD forums to identify common ground
- Meeting with HEE September to share competencies as they are exploring
- ARC research planned;

  pre and post EnCOP [intervention] where no comparative service

  using EnCOP intervention & control where comparative services available

Gateshead Primary Care Workforce Planning Project

- No further update

Metrics and outcomes update

Continued conversations with CCG, NECS and NEQOS colleagues to:

- Update frailty metrics
  - aligning with national outcomes in UCR/EHiCH/AC/UEC
  - to include consideration of inequalities
  - to review the NHS benchmarking Tool but not all organisations are members….is this something we should be doing as a region?
  - NHS viewpoint/Insights platform has PCN and Population and Person dashboards
- Updating of the functionality of frailty framework
  - Excel vs RADIR vs Power BI tools
- Alignment to ‘Jackie’s story’ impact statements
- Alignment to Population Health Management programme and potentially national Anticipatory Care Model (roll out)

Metrics and outcomes next steps….

Do you know who your ‘Place’ BI lead is?

NENC – Peter Bell (peter.bell1@nhs.net)

North ICP – Bob Gaffney (bob.gaffney@nhs.net)

Central ICP – Bob Gaffney (bob.gaffney@nhs.net)

South ICP – Craig Nightingale (craig.nightingale3@nhs.net) and Andrew Rowlands (a.rowlands2@nhs.net)

Are you in receipt of metrics/outcomes you think are important to include?

for example – optometry suggesting some data from RNIB

Is there a group/workstream/meeting you are aware of where it may be helpful to link with and for us to offer some information/support/Q&A session?

Research and Development update

- RCF: supported living data analysis underway
- ARC EnCOP quantitative: continues
- ARC Frailty [standardisation of evaluation for frailty pathways]: - -
  - engagement forums completed [70 participants]
  - 51 respondents to questionnaire 1 [73%]
  - international expert panel including all UK including Channel Islands, Greece, Norway, Nepal, Qatar, Australia, New Zealand, Romania, Saudi Arabia, Switzerland

Universal Personalised Care update

- Funding approved for 2021/22. Aim is to support capacity to implement Personalised Care approaches across a range of services. Also significant workforce development element.
- Continuing to link with all ICS workstreams to raise profile of Personalised Care across every area and support workstreams in ways to embed approaches.
- Looking to develop support for Primary Care roles (Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators).
- Aiming to establish Personalised Care Community of Practice – first meeting likely to be arranged for the Autumn.
- Continuing to promote training for staff through the Personalised Care Institute
- Continuing to promote the Peer Leadership Development Programme: About the Peer Leadership Development Programme and who can join (futurelearn.com)

Making sense of ‘Ageing Well’

- An *NHSE lens*
- *The bigger picture*

Mentimeter questions – *Before….*

1 **Are you aware of the three AW priorities?** Yes / No. If yes how confident are you to describe them (1 not confident at all to 5 very confident)

2 **How involved have you been in your local AW discussions?** (1 not involved at all to 5 very involved and feel fully engaged)

3 **Please indicate your role / involvement within Ageing Well** (Providing, Commissioning & Contract Monitoring, Education, Governance/Audit/Evaluation/Research/Business Intelligence)

For each of the NHSE Ageing Well priority areas lets consider…..

1. Why is this a priority area?
2. Who are the people & what are their needs to be met?
3. What outcomes are expected?
4. Expectations from ‘systems’

Making sense of NHSE Ageing Well Ask

August 2021

NHS England and NHS Improvement

Three Key Pillars for delivery

Urgent Community Response

All systems have a universal coverage of a 2 hour crisis response at home service operating 8am-8pm 7 days a week at a minimum, and using a model in line with national guidance. All services should be accepting referrals directly from all key sources incl. 111, 999, general practice, social care ,care homes and SDEC services

Why is it a priority	What are the needs to be met	Expected outcomes
Deliver a consistent community offer available to all that is reflective of the local needs, including care home residents	All adults who are experiencing a crisis which can be defined as a sudden deterioration n a person's health and wellbeing.	Improved integrated working and reduction in multi agency assessments and referrals providing a streamlined offer of health and social care
Accelerate urgent treatment closer to home through integrated care pathways that reduce duplication and are tailored to individual needs.	The crisis may have been caused by a stressor event which has led to an exacerbation of an existing condition or the onset of a new condition or significant deterioration in clinical state or baseline functioning.	No wrong door approach – single point of access
Increase choice and deliver a personalised response and tailored health and social care needs that support choice and	A health or social care need requires urgent treatment or support within two hours and can be safely delivered in the home setting	Better decision making and personal choice of how care and treatment is provided e.g. Access SDEC / diagnostic hubs or community assets
Work with digital transformation and build on the remote possibilities explored through Covid for monitoring health care and shared care records – tell your story once	Common clinical conditions: Falls, decompensation of frailty; reduced function/deconditioning reduce mobility; palliative/ EoL crisis support; confusion/delirium; urgent equipment provision; catheter care; urgent support for diabetes; unpaid carer breakdown which if not resolved will result in ill health	Reduce the pressure on Acute hospital services for non-emergency conditions and treatments.
Reduce risk of deconditioning in hospital or acquired infections		

Key regional roles with ICS	Key roles of ICS with place	Key role of Providers/ Place
Lead on implementation and performance management in each region consistently, including ensuring each provider of 2H is submitting to CSDS. Quarterly monitoring and reporting to regional leads and into national team.	Set a trajectory to delivery 2H response in line with expectations and ensure delivery across the whole system and in place and facilitate peer learning between ICSs	Development of local delivery models and trajectories in line with technical guidance and operational policy supporting integrated care pathways and embracing digital transformation in delivery of the service.
Work with systems to help ensure providers are appropriately funded to delivery these services. Discuss and agree further areas of implantation support policy guidance needed nationally.	Ensure robust contractual, governance and finance arrangements are in place to support delivery at pace	Being responsive to population needs and to addressing health and access inequalities by monitoring, evaluating, reporting and responding to appropriate patient experience data and key metrics
Ensure planning and operational connectivity with BCF, CHC, social care, UEC and PCNs	Support the development of multiple referral pathways including 111 and ambulance providers and ensure all relevant providers are submitting to CSDS and reporting in UEC BI systems	Collection of high quality and timely data to CSDS

EHCH & Care Sector Support (CSS)

1.Deliver EHCH programme in full for care homes and explore extending this to the wider care sector
2.Develop the NHSEI care sector vision, strategy and operating model
3.Lead care sector related restoration, recovery and transformation post-COVID-19

Why is it a priority	What are the needs to be met	Expected outcomes
To have a clear NHSE care sector vision, strategy and operating model to support LTP objectives and clearer outcomes and improvements.	Increased number of completed PCSP that reflect the needs and wishes of the person and regular reviews.	Increased number of people to remain supported in their own home/care home with a personalised plan of care and support that is strengths based focusing on what's strong not what's wrong.
Create a single care sector support offer which leads to the development of a single approach between the care sector and the NHS encouraging a structured national approach to reducing inequalities and duplication.	Triangulated care and support to enable multi disciplinary decision making with the person at the centre to support informative decision making.	Improved experiences for those in receipt of health and social care and their carers/families.
Understand the impact of deconditions through COVID-19 and learning from innovation and new models of working	Early detection and support of deterioration through standardised assessment and monitoring tools, shared care records and increase in virtual digital technologies.	Right care at the right time in the right place.
Ensure contractual elements for EHCH are delivered and the delivery of non-contractual agreed programme priorities	Training and education opportunities to the workforce to enable more informed care and support.	Improved management of conditions and concerns whether they be health, social or mental health.

Key regional roles with ICS	Key roles of ICS with place	Key role of Providers/ Place
Clear governance and monitoring arrangements with transformation owned at place, driven & assured through regional in-reach ensuring inequalities are addressed as a priority.	Develop and foster co-production and collaboration through the programme by brokering local relationships between LGA, providers and regions and supporting them in identifying approach to local areas	Provide quality in care which is safe, person centred with dignity and respect at the core aligned with CQC registration requirements.
Provide a platform for the provision of local sector expertise, build and sustain care sector relationships to influence policy and direction	Determine how priorities will be sustained after EHCH programme has been delivered.	Engage with ICS and PCN in transformational engagement and improving practice, care and support to individuals.
Assist ICSs to translate national policy and guidance to local delivery and support ICSs to understand and use the contractual levers and guidance to enable full rollout of EHCH.	Identify system specific inequalities which may differ to generic national inequalities, and ensure these are addressed at ICS level	Have an understanding of the clinical priorities for residents in care homes and share good practice examples and seek support where required.

Anticipatory Care

1.To drive a minimum standard of AC through our comprehensive operating model and contractual mechanisms.
2.To provide a structured model of proactive and holistic care delivery for complex, multimorbid & frail people

Why is it a priority	What are the needs to be met	Expected outcomes
To enable individual and population to live healthy, independent lives within their home	Understanding local population health management and current maturity of AC and roadmap for implementation and the varying needs of CYP and Adult populations	Increased use of social prescribing to support a comprehensive proactive needs assessment and self management.
Reduce the need for care in formal settings such as care homes or requirement of traditional formal care within their own home.	All people who are at risk of a long term condition or currently live with a long term condition that currently impacts or is likely to impact on their health, mental health and wellbeing	Increases in supported self management encouraging people to take positive decisions and make choices about their health, wellbeing and health related behaviours.
Have a consistent principles and understanding of what is Anticipatory Care accepting their will be variation of needs at place/ neighbourhoods.	End of Life and Palliative care support that is tailored to the needs of the individual.	Integrated pathways with wider networks to support professional education, advice, self monitoring, early warning signs and access to appropriate care and support.
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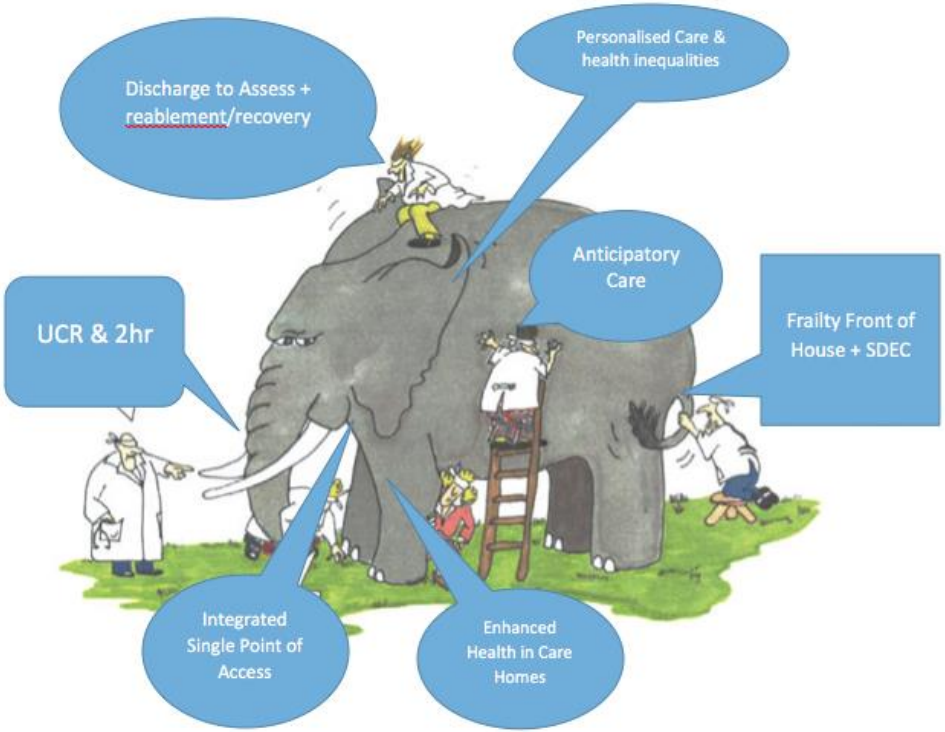
Key regional roles with ICSs	Key role of ICSs with place	Key role of Providers/ Place
Critical support around variation in approach and data-led approaches	Ensure move towards system wide approaches to data analysis, risk stratification, impact analysis and collaborative arrangements which support AC	Develop of arrangement to support cross sector MDT working including drawing down on ARRS funding.
Monitoring of ICS level progress against contractual requirements (PCN DES, NHS Standard Contract)	Engagement and collaboration with regional leads around assurance and delivery and monitoring progress on contractual requirements	Upskill teams to work in a digital first, collaborative way and enable advanced practice
Cross sector engagement through AC Governance structure	Ensure financial and contractual arrangements to support delivery, developing clear ambitions and trajectory for AC.	Alignment of staff to work with VCSE and wider partnership working to support integrated care.

The bigger picture

(supporting people to see the 'whole' elephant)

Which bit of the Ageing Well Elephant do you see?



Thinking about your ‘place’

- Who can see the whole elephant?
- Who needs to see the whole elephant?
- Which part of the elephant after today would be good to find out more about?

Ageing well - *Offering all Adults the opportunity to Live their Best lives for Longer at Home*

www.frailyicare.org.uk

UNIVERSAL PERSONALISED CARE

Enabling choice and shared-decisions across a life course

Population Segmentation & Risk Stratification

focus on vulnerability and inequality

Anticipatory Care

EHCH + Care Sector Support

UCR + Hospital Discharge/ Recovery

Healthy Ageing support and enabling **Communities to Connect**

Support for **Long Term Conditions, Frailty** and **End of Life**

Timely access to **Crisis Response** and **Rehabilitation** at or close to home

A coordinated **Discharge** and **Recovery** on leaving hospital

Improved wellbeing and activation

Improved access to services

Improved experience

Improved value

PRIMARY CARE NETWORKS

People, teams and technology at work

From policy to practice

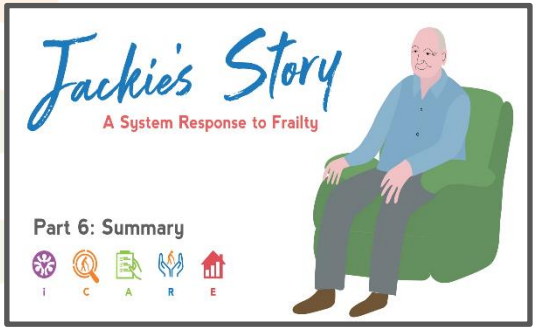
(responsible leadership for differing audiences)

We need to….

Lead change responsibility, enabling the SHIFT from policy to practice by making sense of Ageing Well through conversations and relationships that deliver for people locally!

involve consider assess respond evaluate

It’s all about the people and communities!



https://www.jackiestory.co.uk/

‘Fit for purpose’ MDTs for Ageing Well implementation

List & focused team

Population cohort & wider team with proactive CGA

Proactive plus responsive populations with links to crisis response + responsive CGA

Real-time predictive population planning, workforce development, training and education + cyclical CGAs

ALL + digitally enabled, with active quality improvement monitoring and measuring of impact

involve consider assess respond evaluate

_IN_tegrated Care Systems –*keeping people in, so they don't FALL OUT!*

Commitment to Collaboration FRAMEWORK (importance of inclusivity)

1. Call out the challenges

But seek purposeful solutions to unlock the potential in people, places and communities

Perpetual prevention by intention is crucial

2. Adopt real partnerships

64% of partnerships fail do to relationships

Trusted not changeable and token-ship relationships

Built on mutual objectives – spokes of the wheel

3. Use collective resources for opportunities

System by NAME – does NOT make it easier

Cannot SHUNT RISK – transparency (grown up conversations with open book approach)

involve consider assess respond evaluate

After hearing the presentations and in your role within your local area let's explore:……

1. **Any surprises?**
2. **Preparedness** - what have you got already that meets or will be able to meet (with further development) the expectations and outcomes set out?
3. **Challenges** - what have you not got that you think you need?
4. **Opportunities** - arising from the presentation and from AW plans already underway?
5. **Support** - what really could help you achieve the AW priorities in your role/team/service/place/system?

Mentimeter questions - After…

1. How confident are you with the Ageing Well priorities (1-5).

2. In your area and role, are there any opportunities or challenges you NOW need to explore for achieving the Ageing Well ambitions?

3. What could the AW Network do to help you in your role to achieve the AW ambitions?

(E.G Regular Information Updates, Explore or Research to confirm or provide knowledge in relation to specific areas, Support in Measurement & Evaluation, Workforce Development, Nothing!)


thank you