A Regional Approach to Ageing Well Community of Practice

7th October 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

Ageing Well – national updates

- **Funding**
  - H1 funding allocated for UCR delivery.
  - H2 release subject to CSDS onboarding completion
- **Contracts**
  - PCN contracts specifications for Health Inequalities, Anticipatory Care, Impact and Investment Fund (5 areas) etc.
- **Priorities (national)**
  - **EHCH**
    - 4 clinical areas of focus (working groups on delivery/workforce)
  - **Anticipatory Care**
    - PCN delivery delayed, ICS support should commence
  - **UCR**
    - CSDS onboarding phases plus transformational model delivery.

Resources, Guidance and Tools

- BGS guidance ‘ Ambitions for change: improving healthcare in care homes’ - https://www.bgs.org.uk/resources/ambitions-for-change-improving-healthcare-in-care-homes
- Cabinet Office ‘call for evidence’ – The National Resilience Strategy - https://www.gov.uk/government/consultations/national-resilience-strategy-call-for-evidence
- Local Government – Reducing preventable admissions to hospital and long-term care - High Impact Change Model - https://www.local.gov.uk/reducing-preventable-admissions-hospital-and-long-term-care-high-impact-change-model
- BGS guidance on frailty, elective and emergency surgery - https://www.bgs.org.uk/resources/guideline-for-the-care-of-people-living-with-frailty-undergoing-elective-and-emergency
- Inequalities toolkit - https://khub.net/group/guest

Digital and Information Technology

i-CGA (CHA) Digital Tool

- Pilot start November (delayed) – PCNs in Gateshead
- Process + Feasibility evaluation study proposal
- Interoperability 'data' proposal being drafted for funding

Community Health Services Digital

- Ageing well and wider community
- Mapping exercise and scoping of 'strategy' approach
- Anticipatory Care focus – 'enabling toolkit'
- Urgent Community Response – CSDS onboarding phases towards April (via T&F group)

Website - www.frailtyicare.org.uk.

- Updated - take a look!
- Place-holding agreed for Ageing Well on new NE&NC ICS website.

Jackie's story

- Completed (www.jackiestory.co.uk).
- Launch tools developed

Workforce Projects

EnCOP

- Continues to grow
- Newly developed resources:
    - learning sessions planned; first one mid-October

Metrics and outcomes update

Continued conversations with NECS and NEQOS colleagues to:

- Update frailty metrics (aligned with national outcomes)
- Updating of the functionality of frailty framework (platform) e.g. New Report completed.
- Alignment to Population Health Management programme, Health Inequalities and potentially national Anticipatory Care Model

Universal Personalised Care update

NENC Programme Funding Priorities 2021/22:

- Continue to support embedding of Personalised Care into all workstreams
- Workforce development
- Maternity focus
- NHS@home
- Supporting Primary Care
- Peer Leadership
- Health Inequalities

First Personalised Care CoP held 6th October

NENC video: BETTER CARE -Personalised Care (vimeo.com)

Building the Evidence

Building the Evidence 1

EnCOP

Lesley Bainbridge

Juliana Thompson

involve consider assess respond evaluate

It started like this

Study 1: Gateshead care home workforce competencies (NG CCG funded)

Aim: explore the experiences and competencies of the Gateshead Care Home workforce team to inform workforce development for the delivery of the Gateshead Vanguard service model

- Uni-professional focus groups (45 staff; 8 groups)
- 2 x Multi-disciplinary workshop – 28 staff

What is needed:

- Competency framework that is agreed across the **whole system**
- Agreement across the whole system of who can assess competency
- Assessors are adequately prepared and regularly updated
- Assessment processes are valid and reliable and accepted by all organisations involved.

Study 2: Development of a workforce competency framework for caring for older people (NG CCG funded)

Draft framework:

- attendance at weekly Gateshead Vanguard 'Pathways of Care' (PoC) meetings
- review of the existing workforce competency framework literature
- Multi-disciplinary workshop – 60 staff

4 domains: values, attitudes and behaviours; workforce collaboration, co-operation, communication and support; leading, organising, managing and improving care; knowledge and skills for care delivery

3 levels: essential; specialist; advanced

ALL PROFESSIONS, ALL SECTORS

Study 3: An integrated system based approach to workforce development for EnCOP (Pilot of NHS and CH staff working in 2 care homes) (NG CCG funded)

Aims:

1. Gap analysis to understand workforce development need
2. Understand capacity, capability and agreement for cross system practice based learning and assessment
3. Develop solutions to barriers

36 self-reported questionnaires; 21 observations of 71 staff's practice; 10 interviews/ focus groups with 29 staff; 2 x workshops with 23 education/recruitment staff from 16 organisations

What we found:

- Geriatricians were the only staff achieving all advanced competencies
- GPs were not working at advanced and in some cases, not at specialist level
- OPSNs band 7 achieved all specialist competencies, require programmes to become advanced; band 6 achieved few specialist competencies
- CH staff were 'better than they thought they were'
- No standard way of developing/assessing competence
- No cross- sector support
- Too much reliance on online/training/education sessions that are not relevant, not meaningful, not easy to access

Recommendations

- Whole system approach to workforce development
- Agreement across all sectors to adopt standard approach eg EnCOP
- Develop the infrastructure for practice-based learning and assessment that is accessible to all
- Invest funding and resources
- Evaluate outcomes

Study 4: An evaluation of the impact on staff of the pilot Enhanced Care for Older People (EnCOP) workforce competency development programme (ongoing)

- 1 x pre and 3 x post EnCOP programme questionnaires that measure:
  - relevance and applicability of the EnCOP programme to staff's work
  - staff's knowledge, confidence and competence in caring for older people
  - the extent to which EnCOP is applied in practice and results in changes in behaviour
  - the impact of engaging in the EnCOP programme to staff wellbeing, and staff turnover
  - Staff will also be invited to take part in a post EnCOP programme group discussion about the impact, relevance and applicability of the EnCOP programme to their practice, and the barriers and facilitators to engaging with the programme and embedding it into staff development.

Study 5: Evaluating the impact of EnCOP (ongoing) (NIHR ARC funded)

Pre and post EnCOP comparisons; control group comparisons

Physical Health indicators

- Number who have had a frailty assessment
- Number are identified as living with frailty, and the severity of their condition
- Number with moderate or severe frailty who are recorded as having had a fall in the preceding 12 months
- Number with severe frailty who have received an annual medication review
- Number with 10 or more unique medications
- Flu immunisation rate
- Dementia: estimated diagnosis rate
- Proportion of deaths in usual place of residence

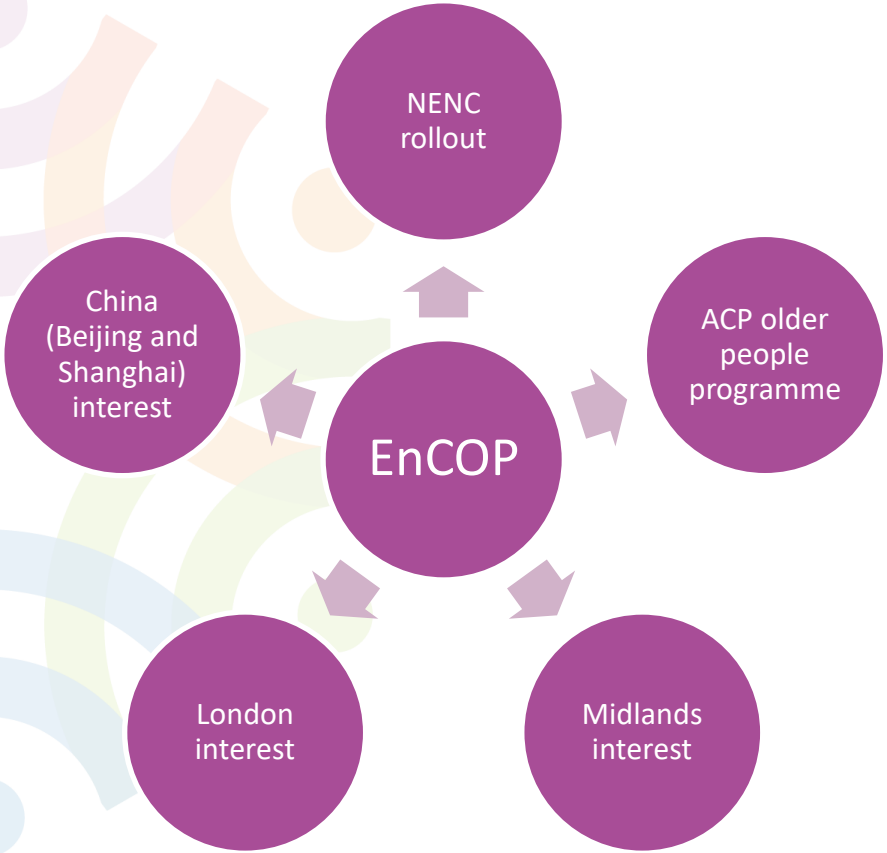
Mental health indicators/Quality of life

- Number with depression or dementia, and who have moderate or severe frailty
- The proportion of people who use services who have control over their daily life
- The proportion of people who use services who reported that they had as much social contact as they would like
- Carer reported quality of life
- Measurement of loneliness / reduced loneliness
- Number of people referred into social prescribing schemes

Emergency/hospital care indicators

- A&E attendance rates for patients
- Emergency hospital admission rates
- Emergency readmissions within 30 days of discharge from hospital
- Proportion of stranded patients in hospital: Length of stay 7+ and 21+ days
- Conversion rates from A&E attendance to hospital admission
- Hospital activity in the last year of life
- Hospital Trust indicator set (Falls with harm, Pressure ulcers, Patient experience of hospital care, A&E waiting time 4 hour standard)
- Number who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes

- 3 x publications
- 2 x invited talks (1 in Australia)
- 3 x conference presentations (1 in Malta)



Building the Evidence 2

Digital CGA

Dan Cowie

Glenda Cook

involve consider assess respond evaluate

It started like this

i-CGA Evaluation

- CGA is a proven tool in frailty assessment
- i-CGA digitised tool presents an opportunity for a fully integrated approach to the CGA
- Initial rollout to practices in the Gateshead area beginning in November 2021

- **Pilot study aims**
  - Establish the feasibility and accessibility of i-CGA in primary care
  - Assess methods to be adopted in a subsequent outcome evaluation of i-CGA during phase two of implementation across the region

i-CGA Evaluation

- **Evaluation plan**
  - Qualitative investigation of i-CGA of the usability, acceptability and impact
  - Quantitative investigation of the impact of i-CGA patient and service outcomes with embedded economic analysis
  - Data interpretation and production of deliverables

- **Key steps**
  - Understanding the requirements of key stakeholders
  - Data access and consolidation
  - Identification of feasible, impactful and realistic evaluation outcomes

Building the Evidence 3

Frailty Care

Lesley Bainbridge

Juliana Thompson

involve consider assess respond evaluate

It started like this

Started with a chat about results of an audit…..

- Local practice nurse frailty pathway initiative appeared to be achieving outcome improvements.
- Original plan was to compare this with another pathway to evaluate impact.
- Literature review (in review) identified that:
  - evaluation and comparison of frailty care pathways is challenging due to weaknesses, inconsistencies and differences in evaluation
  - a standardised evaluation toolkit that incorporates evaluation of how pathways are operated is required for evaluating the impact of frailty pathways of care.

Development of a standard evaluation method for evaluating the impact of frailty care pathways of care and outcomes (NIHR ARC funding)

2 round Delphi study

- PPI consultation event
- 6 workshops to develop statements 80 experts (UK, Europe, Middle East, Far East, Australasia)
- Round 1 questionnaire 63 respondents (79% response rate)
  - 81% consensus agreement
- In process of developing round 2
- Future: Final workshop, final PPI event

- **Development of an evaluation toolkit for use internationally**
- **Apply for NIHR funding to compare local pathways using the toolkit**
- **Evaluation of the toolkit**

Plans for further 2 + publications & conference presentations

Building the Evidence 4 Supported Living

Lesley Bainbridge
Juliana Thompson
Mick Hill

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It started like this

2018 Anecdotal evidence that those living in supported housing can have the same complex needs as many of those living in care homes and at the time they were excluded from EHCH framework.

2018 to 2021

2019 Can we formally collate data to begin to understand their needs and perhaps better plan to meet them?

Healthcare needs of older people residing in a sheltered accommodation facility (NIHR RCF funding) (ongoing)

Anonymised data from 2 sources:

- GP records
- SA records
- 52 residents

SAMPLE CHARACTERISTICS				
	Minimum	Maximum	Mean	SD
Age in years	20	88	69.50	11.701
Length of Stay (sheltered housing facility) in Months	1	204	39.96	42.777
Number of Long Term Conditions	0	8	2.86	2.209
Number of Medications taken daily	0	12	4.52	3.489
Number of GP Appointments in the Past 12 months	0	21	4.69	5.097
Number of unscheduled hospital visits (A&E) / Admissions	0	4	0.42	0.915
Smoking status	1	3	1.94	0.810
Self-Reported Alcohol (units per week)	0	42	6.98	11.081
Body Mass Index	12	44	27.42	6.859

	%
Gender	F = 42%: M =58%
Reason for moving in	Crisis = 26%: Planned = 74%
Formal care plan in place	Yes = 25%: No = 75%
Multi-morbidity present	Yes = 73%: No = 27%
Polypharmacy present	Yes = 58%: No = 42%
Care needs	Stable = 80%: Increasing = 20%
eFI	No/vulnerable = 79%: mild = 17%: moderate = 4%

Frailty was assessed using both Frailty EFI and Frailty CFS. The outcome of these assessments were only poorly correlated.

Cluster analysis

Clustered based on the following key variables:

- Age
- length of stay in current accommodation
- EFI score
- number of long term conditions
- number of medications
- number of GP appointments in the last 12 months
- number of unscheduled hospital attendances in the last 12 months
- cognition level.

Some not so surprising, and some surprising results……..

‘Residentially stable’	‘Residentially challenged’
Shorter duration of stay.	Longer duration of stay
Lower EFI Score	Higher EFI Score
Lower number of unscheduled A&E visits.	Higher number of unscheduled A&E visits.
Females over-represented.	Males over-represented
Renal disease under-represented	Renal disease over-represented.
NON-SIGNIFICANT tendency for falls risk NOT to have been identified.	NON-SIGNIFICANT tendency for falls risk to have been identified.
NON-SIGNIFICANT tendency NOT to have a sensory impairment.	NON-SIGNIFICANT tendency to have a sensory impairment.

The presence (or absence) of named medical conditions were tested for significance against frailty precursors, frailty outcomes and cluster group membership. The question at stake was whether (or not) any particular medical diagnosis might act as a useful proxy indicator (or red flag) of either frailty risk or residential instability. The following diagnoses were assessed as potential candidate variables:

- hypertension; diabetes mellitus; musculoskeletal conditions; respiratory conditions; cardio-vascular disease; renal disease; mental health conditions; dementia; stroke or other neurological conditions; cancers; thyroid disease.

Only renal disease was found to stand out as a potential proxy indicator

.

For instance, people living with renal disease were:

- More likely to have a sensory impairment
- More likely to have a higher frailty score [EFI]
- Tended to be older
- Had been residents for longer
- Had more comorbidities and long term conditions
- Were taking a greater number of medications
- Had made more scheduled GP appointments in the past 12 months
- Made a greater number of unscheduled hospital visits

Going forward

- Literature review – accepted for publication
- Plans for 2 further publications
- Plan to apply for funding to 1) extend the study? 2) investigate renal disease as a proxy indicator? 3) investigate correlation (or lack of) between eFI and CFS

Building the Evidence 5

Introducing NEWS

Lesley Bainbridge

Phil Hodgson

involve consider assess respond evaluate

It started like this

‘There isn’t any evidence, I had a whole day on it yesterday’

‘They [obs] have to be considered within the context of the whole clinical picture’

‘Illness in old age most often presents as a functional change’

What happens if you consider Barthel and care home staff experience as well as the quantitative side of care ?

2016 to 2021

‘It isn’t straightforward, there is a complex relationship between older age and the physiological response to acute illness’

Introduction of technology-enabled NEWS in care homes

Evaluation of:

- Relationship between NEWS score and frailty, cognitive impairment, dependency, functional ability and treatment outcomes.
- Explore staff experiences of facilitators and barriers to the use of NEWS
- Impact on clinical decision-making in relation to treatment of the acutely ill older care home resident.

Four participating care homes: 276 residents (quant data), 13 staff (qual data).

Introduction of technology-enabled NEWS in care homes

Findings:

- Changes in NEWS ($p < .0001$) and functional ability ($p = 0.013$) linked with hospital admission
- Changes in frailty ($p = 0.551$) were not linked with hospital admission (baseline levels too high)
- Benefits to staff: reassuring gut feeling, empowering communication & role (“proof”), aids to decision-making
- Barriers to use: only related to technology use in the homes

Introduction of technology-enabled NEWS in care homes

Discussion points:

- NEWS assisted understanding, but also dependent on existing knowledge of complex multi-morbidities
- Need to consider frailty, delirium, response to acute conditions, etc. to facilitate full decision
- Not used as early warning score for earlier detection, helped staff convert nuanced understanding of complexity into clear decision-making processes

To-date – 1 publication and a conference presentation

Building the Evidence

local project evaluation plans and ideas

Area	North	North Cumbria	South	Central
Focus	Strength + Balance Training	Frailty identification + MDTs	MDTs	Loneliness + pre-frail
Audit questions	Audit e.g. any difference in referrals to specialist falls services or differences in EHCH services, or in number of falls in the homes?	Audit e.g. what is the prevalence comparing eFI and verified levels of frailty	Audit e.g. any differences in outcomes per PCN, differences in discipline make up of MDTs?	Audit e.g. how many of the people identified were actually 'unseen'
Research	Teaching, training approach, implementation of the model?	Embedding 'digital' approaches	New roles, workforce	PHM implementation etc.

These questions are examples and methods that can be aligned to ICP Ageing Well projects

- **Implementation**
  - Does the increased funding matched the increased workload of existing staff or workload of a brand-new workforce?
  - Have PCNs implemented each component of the national strategy?
  - Is the population cohort being accurately identified?
  - Are the services (eg wider rehab services) in place that are required for the programme to work effectively?
  - What are the barriers and enablers for successful implementation?
  - What systems / culture / relationships have been developed in order to implement the programme?
  - What governance processes have been established to implement the study?
- **People experience of care**
  - Have patient and carer experience changed?
- **Staff experience of delivering care**
  - Has experience of staff in delivering care improved changed?
- **Improving population health outcomes**
  - Does tracking patients through the whole pathway demonstrate a change in population health?
    eg a movement between levels of frailty, levels of wellbeing, quality of life, etc or a reduction in use of unnecessary or potentially harmful medication?
- **Providing high value care / improving resources use**
  - What is the effect of the programme on healthcare utilisation?
  - Has the programme resulted in a shift from emergency inpatient care to outpatient/out-of-hospital elective care?
  - What is the effect of the programme on wider (non- healthcare) resource use such as social care, benefits, housing, employment, voluntary sector, criminal justice sector?
  - Economic analysis: How have healthcare costs changed as a result of the programme?
  - Economic analysis: How have wider overall costs changed as a result of the programme, taking into account changes in costs related to healthcare, social care, benefits, housing and investment?
  - Economic analysis: What have been the economic costs and savings of the programme (healthcare and also wider), in relation to health and wellbeing benefits for patients and carers and in relation to population health outcomes?

Date and Time of Next Meeting

Thursday 2 December 2021 at 2-4pm