A Regional Approach to Ageing Well Community of Practice

3 February 2022

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

During the session

We will keep participants muted whilst we are presenting. This avoids distracting our speakers and also reduces sensory stimulation which is important for some people. However, if you wish to ask a question you can do this by adding it in the chat box. Please feel free to turn your camera on and off as you need to. If you need it off the whole time, that is totally fine.

If you need a break at any time during the session then please leave the meeting and re-join again when you feel ready.

Accessibility

Information on accessibility features in Teams can be found here: https://support.microsoft.com/en-us/office/accessibility-support-for-microsoft-teams-d12ee53f-d15f-445e-be8d-f0ba2c5ee68f and you can contact us with any other accessibility questions.

Agenda

1. Welcome and introductions
2. Quick update on regional work
    - Ageing Well funding
    - Planning
    - Digital (including AC and UCR)
    - Workforce and research
    - Metrics and outcomes
    - Universal Personalised Care
3. i-CGA presentation and discussion

Welcome and Introductions

Ageing Well Funding

North East and North Cumbria

National allocation (2021) is approx. 16M

Principle 1 - The majority* of **Ageing Well System Development Funding (SDF)** will be deployed via CCGs to relevant place-based ageing well programmes with funds targeted, in the first instance and as appropriate, to support delivery of the **Urgent Community Response** (UCR) and 2hour crisis response whilst together supporting the roll out of the **Enhanced Health in Care Homes (EHCH**) and development of the **Anticipatory Care (AC)** support offer.

Principle 2 - *Having first considered funding requirements against Urgent Community Response and the other national priorities above, places should be free choose to fund other initiatives that also **support transformation of community health services**. For example, *continuation of projects* or *additional projects* as per the 'Ageing Well' ICP plans that were submitted in January 2021.

Principle 3 - *In addition to the System Leadership Funding, a proportion of SDF (£250k) will be deployed at the Ageing Well Network ICS level to continue the support of the existing **regional Ageing Well programmes already underway.**

Principle 1

Urgent Community Response

2 hour standard for UCR, **2 day standard** for reablement and a **single point of access** for UCR utilising 111

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

Enhanced Health in Care Homes

Enhanced support & better co-ordinated care, **reablement** and **rehabilitation**

Enhanced Health in Care Homes & 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

Anticipatory Care

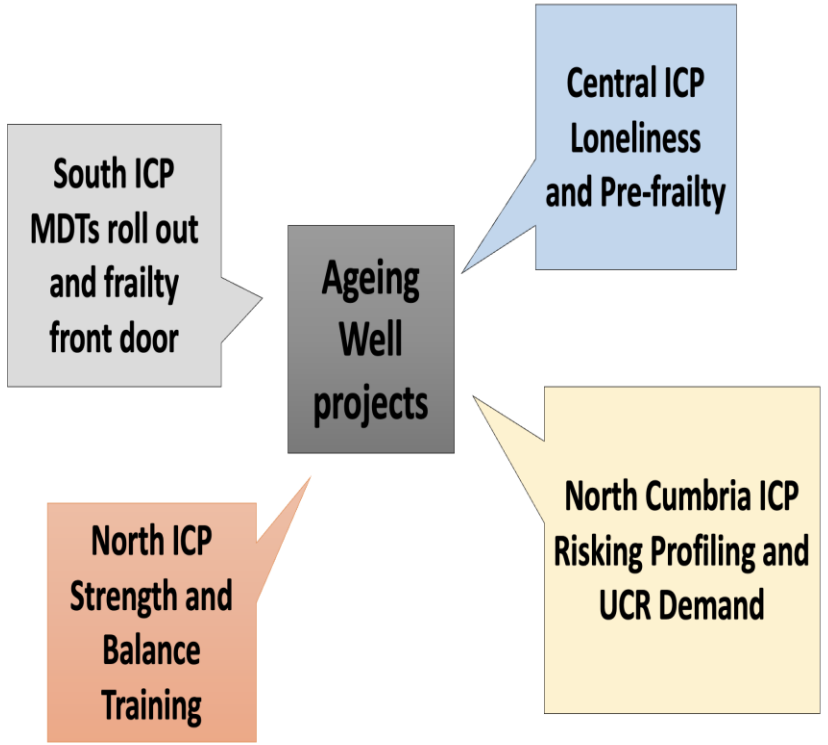
Helping people with **complex needs stay healthy** and functionally able

Anticipatory Care (AC) - 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 patients

Note: The Hospital Discharge programme has clear overlap from a funding, planning and delivery perspective to the Urgent Community Response priority within Ageing Well and requires close consideration of alignment.

Principle 2

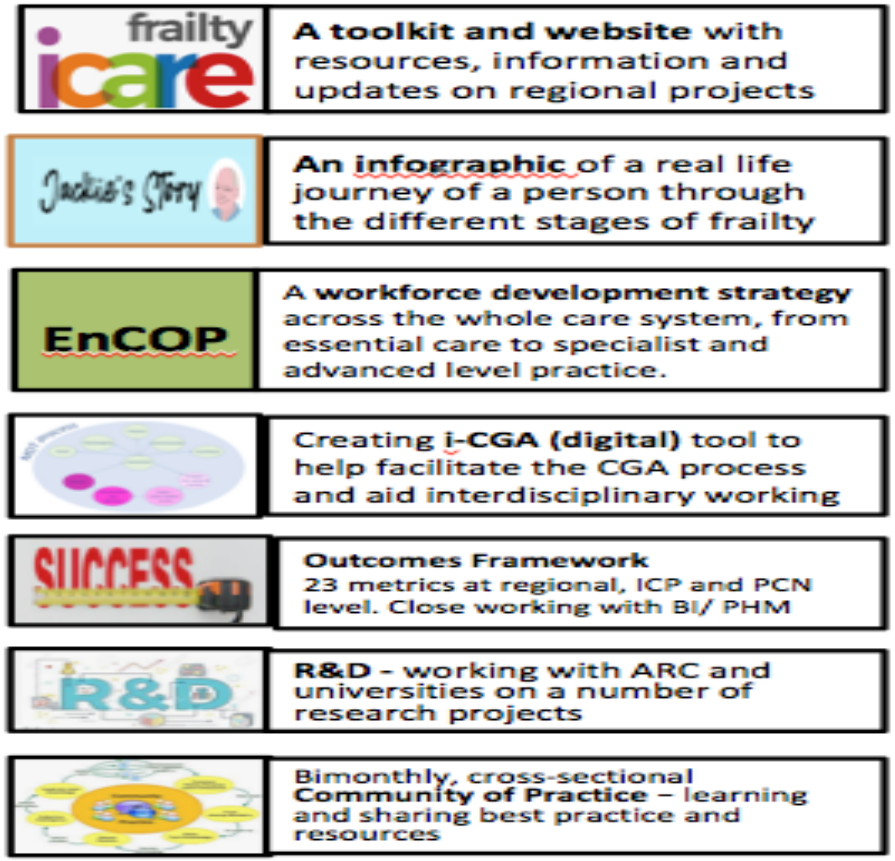
ICP	National Ageing Well SD funding (approx. 900,000)	Update on 2020 Projects
South Paula Swindale	Focus on embedding administrative support within **MDTs across PCN.** Measuring impact on EHCH delivery and preparing for future delivery of UCR and anticipatory care model	Microsoft verPoint Presentat
North Steve Parry	Focus on falls and **Strength and Balance Training** across care homes and wider sector. Measuring impact on URC and supporting Anticipatory Care model.	Microsoft verPoint Presentat
North Cumbria Linda Hains	Focus on **frailty identification**, risk stratification and proactive support for people with complex needs supporting URC and Anticipatory Care models	Microsoft verPoint Presentat
Central Louise Burn	Focus identifying people who are **lonely and pre-frail to offer anticipatory support** and reduce future needs on health and social care system, support the UCR model	Microsoft verPoint Presentat



Principle 3

The following programmes are at different stages in their development and implementation, but all are focused at ICP and place-level:

- **Workforce Development (150K)** – Enhanced Care of Older People with Complex Needs (EnCOP) competency framework - http://frailtyicare.org.uk/making-it-happen/workforce/enhanced-care-of-older-people-with-complex-needs-encop-competency-framework/
- **Digital Comprehensive Geriatric Assessment (50K)** – tool to facilitate an integrated CGA developed by Health Call - http://frailtyicare.org.uk/making-it-happen/information-sharing/digital-comprehensive-geriatric-assessment-icga-pilot/
- **Metrics and Outcomes** (50K) – Align and develop the Frailty ICARE framework to the ICS Population Health Management and wider evaluation approaches - http://frailtyicare.org.uk/making-it-happen/measures/



Planning Guidance
Ageing Well lens

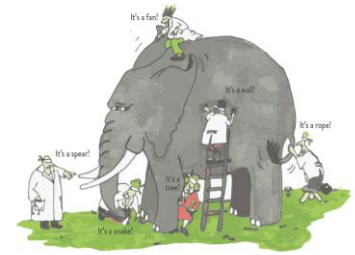
Deadlines

Narrative plans should be submitted at ICS level for **draft submission by 12noon Thursday 17 March 2022** and for **final submission by 12noon Thursday 28 April 2022**

Date	Key milestones
w/c 28 February 2022	Functional templates issued and collection portal open • Activity and performance (SDCS) • Workforce (SDCS) • Workforce (HEE e-collection)
Thursday 17 March 2022 (noon)	Submission deadline (Draft plans): Activity and performance Workforce Finance: system and provider Narrative
28 April 2022	MH Workforce (Draft plans)
Thursday 28 April 2022 (noon)	Submission deadline (Final plans): Activity and performance Workforce MH Workforce Finance: system and provider Narrative
23 June 2022	MH Workforce (Final plans)

The bigger picture lens

(supporting people to see the 'whole' elephant)



Better Care Model

UPC Approach

Universal Personalised Care

LD + Autism | OP Mental Health | Commitment to Carers | CHC

Population Health (PHM)

HI - inclusion health
Reports – P&P
Healthy Ageing
Vaccination - flu

Urgent Community Response (Operating model + CSDS)

Hospital Discharge + Recovery (D2A + IC model + data set)

Anticipatory Care (Model + Interventions / stratification guides)

EHCH + Care Sector Support (EHCH roll out + Care Sector strategy + recovery)

Outcomes (NHS viewpoint)

Metrics - BCF, CSDS, D2A/Homesafe, AC SDEC , PCN DES + UPC, National OF Right Care - frailty

PS deterioration, Your Recovery COVID, @home models, SDEC + UEC /111

Digital — NHS mail, CSDS, LHCR, Virtual Wards, shared records

Workforce — Planning/development , PCN MDTs and ARRS

DES Delivery

Primary Care Networks

Research + Development
ARC, Universities, AHSN

NHSEI core

Aligned work

involve consider assess respond evaluate

involve consider assess respond evaluate

Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity – keeping patients safe and offering the right care, at the right time, in the right setting.

- Reduce 12-hour waits in EDs towards zero and no more than 2% **UCR and Discharge**
- Minimise handover delays between ambulance and hospital, **UCR**

Linking with ED's/SDEC/UTC are there patients who could be managed by a UCR as alternative?

What is the gap with your UCR service to be able to support these patients not in hospital?

Is that the right thing for your area?

How will you be able to demonstrate impact? What will you measure?

What might you know about from your work that may contribute?

Transform and build community services capacity to deliver more care at home and improve hospital discharge

Virtual Wards

To have 40-50 virtual bed… …xamples include acute respiratory infecti… …esentations)

Urgen

A… …esponse services

Anticipa

pro… …rail individuals who would benefit most from i…

Enhance… …mes

Ensur… …sistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework

Hospital discharge

Work together with local authorities and partners, including hospices and care home

What might you know about from your work that may contribute?

Please get in touch…..

Community Health Services Digital

Identify digital priorities to support the delivery [illegible]-of-hospital models of care through th[illegible]ystem digital investment pla[illegible]

Population [illegible]

AW and U[illegible]ling referrals, personal health budgets, a[illegible]personalised care and support plans are key enablers of population health and prevention.

What might you know about from your work that may contribute?
Please get in touch.....

Digital and Information Technology

i-CGA (CHA) Digital Tool

- Pilot started in January (PCNs in Gateshead)
- Process + Feasibility evaluation study proposal

Community Health Services Digital

- Strategy focus – 'finding, supporting and measuring what matters' to support AW and Anticipatory Care
- Urgent Community Response – CSDS onboarding phases towards April (via T&F group) including work on falls and UCR

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 and Research/ Evidence

EnCOP

- Currently exploring apprenticeship options with the Health Innovation Network, Newcastle and Northumbria Universities relating to the specialist level of the EnCOP framework.

Evidence and Research

- Developing a Framework for Evaluating Frailty Pathways: expert panel review of non-consensus elements completed

- NHSEI Hydration: CoPpers currently drafting bid [see next slide]

NENC Ageing Well Network: hydration project

The Idea

Develop an educational package [the intervention] through research with a focus on care homes but with vision to roll out to supported housing in line with the Enhanced Health for Care Homes [EHCH] framework which is one of three national ageing well priorities.

The Rationale

Previous success with NGCCG Care Home Vanguard Programme resulting in a 35% decrease in non elective admission to hospital for care home residents with a UTI and a 26% reduction in oral nutritional supplement [ONS] prescribing.

The Process

- Synthesis review of approaches nationwide to determine best practice and innovation ideas e.g. those listed in supporting information
- Literature review to determine evidence and gaps in evidence
- Creative approaches for collaborative learning; blended to consider face to face restrictions and time but including workshops too
- Establish competencies for practice linked to regional Enhanced Care of Older People [EnCOP] workforce development programme
- Evaluate including qualitative measures too e.g. quality of records reflecting practice, staff experience

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)
- Alignment to Population Health Management programme, Health Inequalities – proposal submitted for Analyst to join the Ageing Well programme

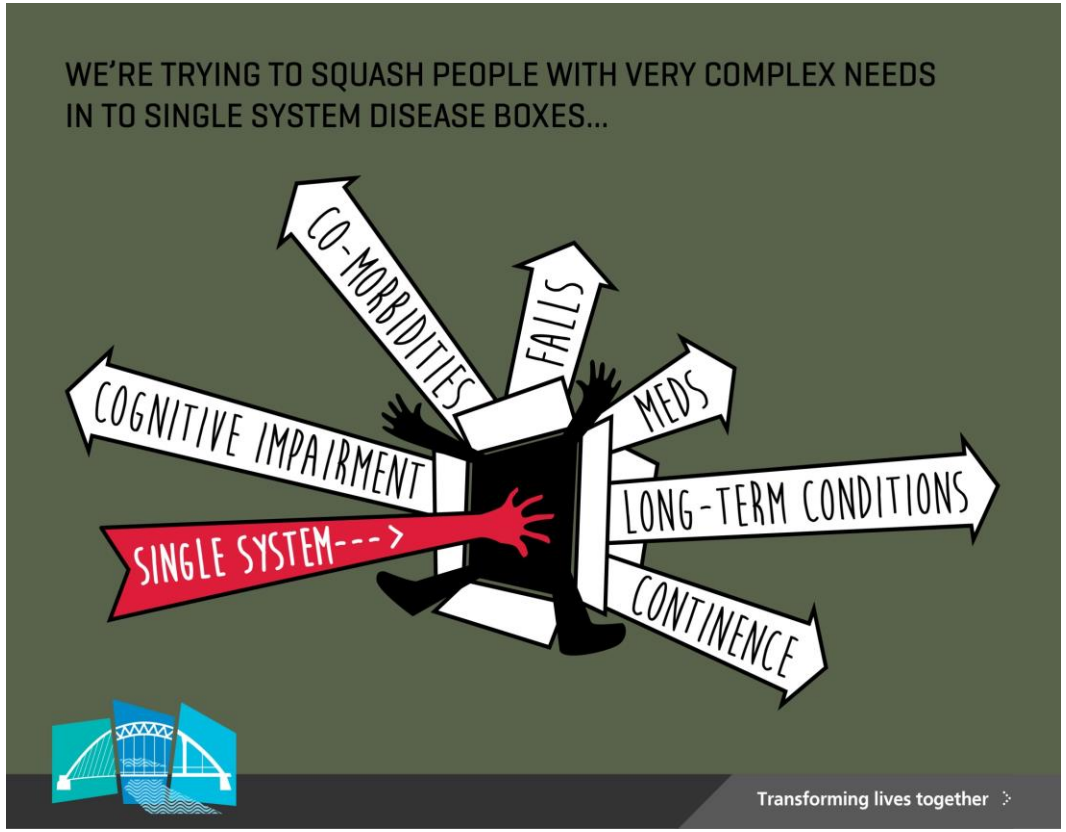
HealthCall

NHS

Comprehensive Geriatric Assessment

- Caroline Coulson
- Dr Dan Cowie
- Lesley Bainbridge

How should we support people living with frailty?



A New Care Paradigm for Older People Living with Frailty

NHS England

TODAY	TOMORROW
'The Frail Elderly' (i.e. a label)	"An older person living with frailty" (i.e. a long-term condition)
Presentation late & in crisis (e.g. delirium, falls, immobility)	Timely identification for preventative, proactive care by personalised care and support planning
Hospital-based: episodic, disruptive & disjointed	Community-based, person centred, co-ordinated care & support

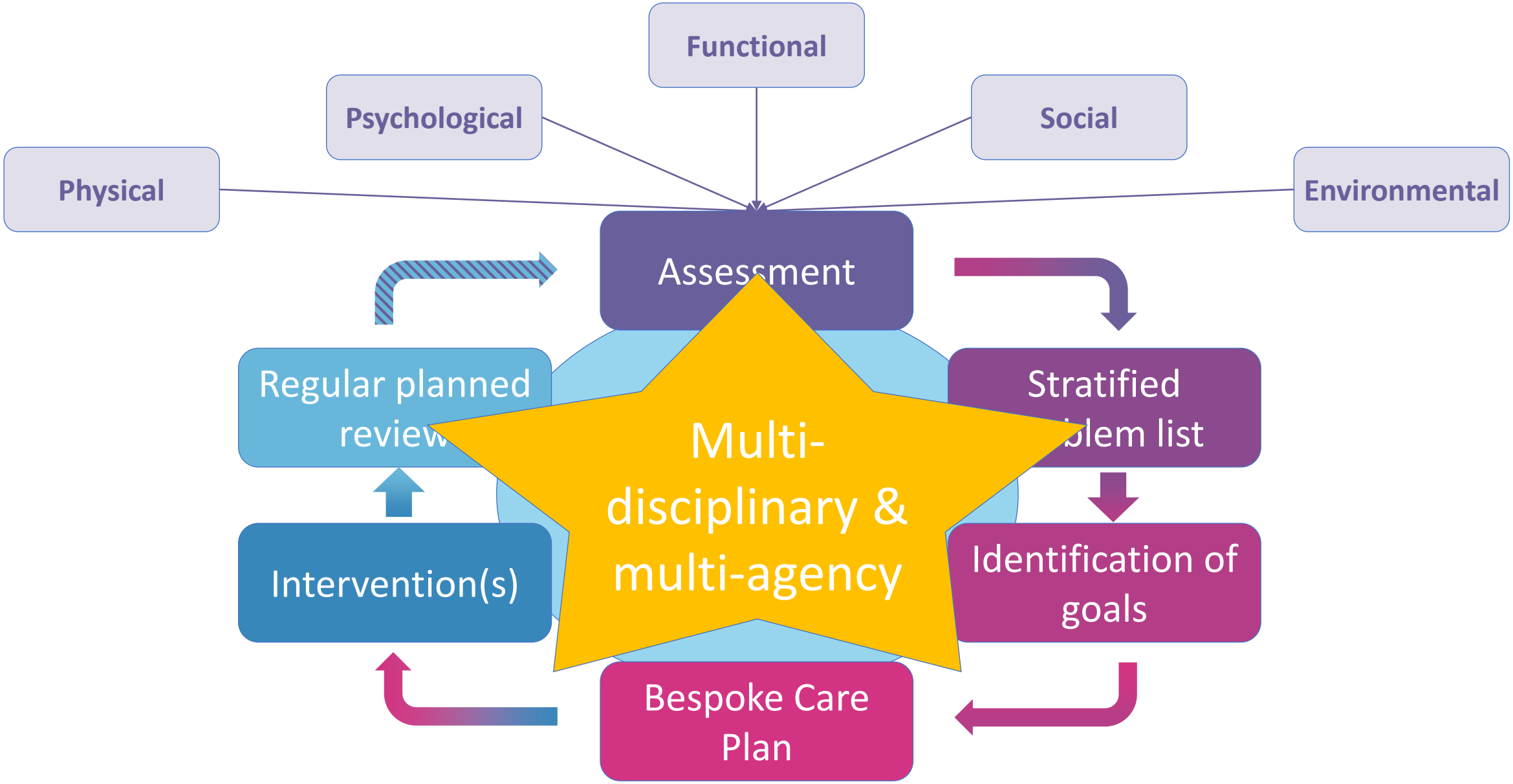
www.england.nhs.uk

With thanks to John Young

Frailty Fulcrum – *the multi-dimensional nature of frailty!*

Considering all frailty domains

Comprehensive Assessment: Gold Standard

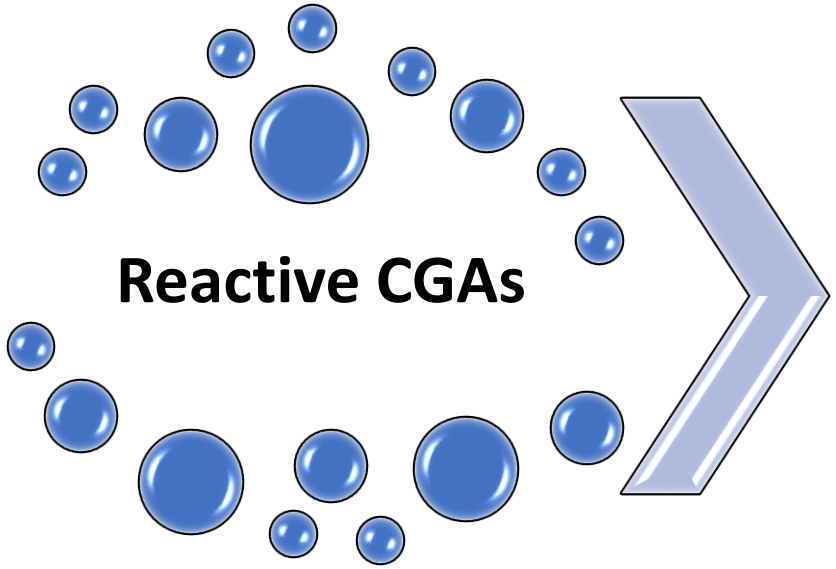


The Dilemma: working out who needs CGA

- Not all older people are frail
- Not all those frail need a CGA

consider for moderate frailty, definitely for severe!

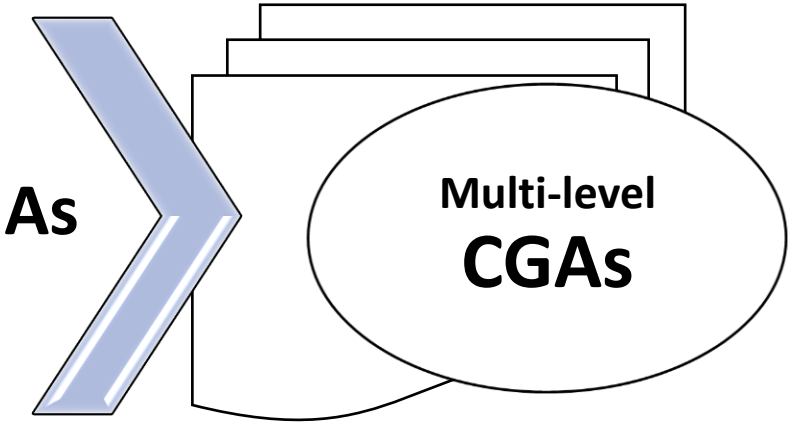
Opportunities for multi-level and focused CGAs



- Urgent Community Response
- Patient Deterioration Programme
- A&E / Frailty SDEC
- Discharge to Assess

Proactive CGAs

- EHCH MDTs
- Anticipatory Care MDTs
- CHC assessments
- Commitment to Carers
- LD and Autism
- Virtual Wards



- Across professionals and teams
- Across services and systems

Health *Call*

NHS

Background

Social Assessment
Physical Assessment
Psychological Assessment
Functional Assessment
Environmental Assessment

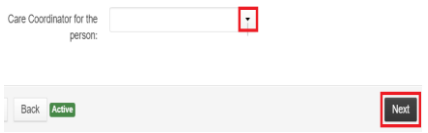
- CGA: a holistic collection of data in 5 domains
- Well evidenced tools used as a starting point
- Then co-designed with many professionals from a variety of disciplines
- Potential benefits:

- Holistic data collection = less chance that important factors affecting health are missed
- One tool that professionals from different organisations can easily access and contribute to = improved MDT working for care planning
- Integration with GP systems = sharing of codifiable information

HealthCall

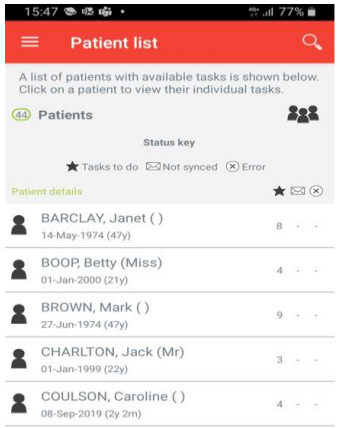
The pathway

1



Patient is assigned to a coordinator of care

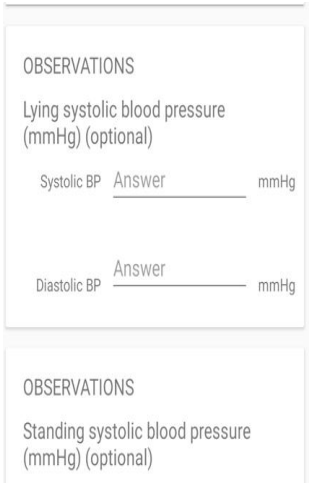
2



Coordinator logs into our app..

… and completes the 5 domains of data collection…

3



4

… with help from the linked tools where necessary or referral to other MDT or non-MDT practitioners

Coordinator prompted to complete an active problem list at each domain and automatically amalgamated into a PDF.

5

Problem List Amalgamation

Social problems	Test
Psychological problems	Test
Physical problems	Test
Environmental problems	Test
Functional problems	Test

6

… Consideration of MDT involvement or not?

7

… Generation of Personalised care and Support Plan

Jackie’ Story

Jackie's Story

A System Response to Frailty

Lets explore the i-CGA and Jackie's Story – moderate to severe frailty stage

Health Call

NHS

Where we are now

- x2 clinical testing sessions and x5 hazard workshops undertaken
- Build is live – x3 users due to start using the pathway within the next two weeks

What comes next

- 6-month pilot
- Evaluation undertaken in this period by Northumbria University – ‘added value’ exploring the usability through a process evaluation methodology
- Interoperability (in both directions) discussions taking place – data sets
- Discussions with wider MDT members we hope to take part in the pathway