A Regional Approach to Ageing Well

Community of Practice

6 October 2022

Academic Health Science Network North East and North Cumbria

National Innovation Centre for Ageing

involve consider assess respond evaluate

ICS Integrated Care System North East & North Cumbria

House Keeping

During the session

We will keep participants muted whilst we are presenting. This avoids distracting our speakers and reduces sensory stimulation which is important for some people. However, if you wish to ask a question you can do this by adding it to the chatbox. We will address as we go or follow up afterwards.

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.

After the event

Presentations will be circulated following the event

The webinar is being recorded and will be available after this session. Head over to the AHSN NENC's YouTube channel at: youtube.com/ahsnnenc and click the subscribe button and notification bell, to keep up-to-date on further video content, webinars, workshops and live events.

Agenda

1.	Welcome and Introductions	Dan Cowie, Clinical Lead
2.	Frailty – What's the latest?	Dan Cowie, Clinical Lead
3.	**Presentations:**	
	NoRA AHSN funded North East Ambulance Service Project exploring frailty in the out of hospital emergency population who reside in the North East	Karl Charlton, Research Paramedic, North East Ambulance Service NHS Foundation Trust
	Frailty case finding	Jon Quine, Kim Teasdale and Kay Chapman, North of England Commissioning Support
	Phase 1: Evaluation of the 'identifying dementia needs' Tool	Lesley Bainbridge, Ageing Well Clinical Lead and Juliana Thompson, Healthcare Workforce Research Consultancy
4.	Any Other Business	All
5.	Date and Time of Next Meeting: Thursday 1 December 2022 at 14:00-16:00	
6.	Close	

Welcome and Introductions

Frailty - what's the latest?

Useful Reads

- **Implementing Virtual Wards for People with Frailty** - https://www.bgs.org.uk/ImplementingVirtualWards
- `THINK acronym DOT† when considering whether a patient is suitable for Hospital at Home:
  - **Drink** – can they get a drink on their own, or do they have someone who can get it for them?
  - **Once a day** – can they cope with a visit from the team only once a day?
  - **Toilet** – can they get to the toilet on their own, or do they have someone who can help them?
    - If a patient meets all three of these criteria, they are more likely to be suitable for Hospital at Home care.
- **Intellectual Disability Frailty Index** – Practical Version, under review - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9305773/
  - Going from 51 to17 deficits in assessment (e.g. physical health, cognitive functional, social health, ADLs etc.)
  - Promising results for validity and practically of use.
- **Frailty, Diversity and Communication** - https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2022/05/Frailty-Diversity-Communication-Report-1.pdf
  - Research study looking at language, interesting read! Clearly the access to personalized conversation is critical.

Anticipatory Care

Finding Phase 1:
Phase 1 ended July 2022

Supporting People

- Since the last reporting period NHSE has released a draft of the Anticipatory Care Framework 'for information only' via the FutureNHS Collaborative Platform. Plans for rollout have yet to be included. The Framework details the Anticipatory Care operating model. The model will initially target individuals with multiple long-term conditions (MLTC) who are at greatest risk of using unplanned care, including people living with frailty, populations experiencing health inequalities, and people reliant on unplanned care for routine care needs.
- A national AC Planning Dashboard is being developed to provide systems and places with the data which they need to make informed decisions about which cohort to prioritise locally for AC – Useful national Tool, but cannot get patient level data.
- Supporting People Working Group meet again to explore further digitalization of PCSP – ToR, looked at ‘finding’ and ’measuring’ part of the AC work:
- Funding – Frailty RAIDR dashboard and progressing AC case finding tool
- Measuring – Work continues on “outcomes’ Power BI tool
- Supporting Group
  - A GNCR ACP project team (sub-group of the technical platform group) has been set up to accelerate the development work of digitising ACPs under GNCR, with initial focus on Foundation Trust digitisation and sharing of Deciding Right documentation - which has been adopted across the region for recording care decisions in advance.
  - Funding has been confirmed for a 0.5 FTE analyst (September – December 2022) to support acceleration of the GNCR solution for digitising ACPs.
  - Data set Group meeting today – exploring the an Ageing Well MDS and standardisation of primary care templates

Urgent Community Response

- Two-hour UCR services operating at a minimum 8am till 8pm, 7 days a week are already in place across the NENC ICS.
- **Data Quality** - As UCR data is now nationally reported there is a real impetus to ensure we are recording and reporting correctly so that the ICS are truly represented. Providers have been validating the May 2022 CSDS data against their local data. It is expected that the validation will provide a measure of confidence in the data that is in CSDS and an understanding of where we need to focus so we can ensure our regional data is a true reflection of all the activity that is happening.
- **Priority Pathways** - Following the August 2022 UCR Maturity Matrix return, feedback has been provided by the Regional Team. Feedback highlights areas of good practice and challenges. **Falls** will be an area of National focus into Q3 & Q4. Systems will be asked to understand any potential quick wins with regards to reducing ambulance conveyance for falls both in care homes and for people in **their own home.**
- **Development Work** - Proposals for **system development funding** to support ICS delivery of UCR, were submitted to the Regional Team on 29 July 2022. Oversight has approved/supported the bids submitted on behalf of the ICB Exec. The funding will support improvement projects aimed at increasing referrals from Ambulance Trusts to UCR services and standardising the **capture of metrics** across UCR services around patient **experience and staff feedback**. Further proposal received against winter preparedness funding – to be discussed at Ageing Well Core Steering Group. Proposal is for a project aimed at reducing unnecessary **NEAS callouts for falls** and improve outcomes for residents in three care homes, through the provision of Manga lifting cushions and upskilling of care staff to increase their confidence in managing non-injurious falls.
- **CSDS Onboarding** - Phase 5 onboarding sessions held with five providers; registration for CSDS completed by four more providers.
- A lot of work exploring **Admission Avoidance and Discharge** – where UCR fits into the wider Urgent and Emergency Care system (e.g. Virtual Wards, Intermediate Care, Better Care Fund, etc.

Enhanced Health in Care Homes

- Awaiting commencement of EHCH agenda within Ageing Well Safety Oversight Group – governance and leadership to be confirmed
- Health Call are scheduling development of HIE Care Homes viewer for January 2023
- AHSN-led planned work for rollout of underbed sensors is awaiting DISC funding approval
- The national EHCH framework will be updated this year. Still awaiting the National EHCH outcomes dashboard

Digital and Information Technology

i-CGA Digital Tool

- Qualitative, feasibility study complete and evaluation written up
- A lot of practical learning, take home messages - concept is great, but interoperability and technical infrastructure was most challenging
- Further conversations needed about interoperability solutions

Community Health Services Digital

- Working on the Strategy for End of Nov – Strawman event last week to get feedback on 'draft version'
- Working to set up a network across digital leads into "community services' to help with local implementation of the 7 plus national priority areas.

Website - www.frailtyicare.org.uk.

- Updated - take a look!

Workforce Projects and Research/ Evidence

EnCOP

- EnCOP funding has been secured until 31 March 2023.
- EnCOP Business Case v.1: Comments have been received from the group and the scoring matrix has been received relating to the original funding. Currently waiting for testimonies. Benchmarking will be added regarding other Frameworks. v.3 circulated for comment.
- Enhanced Care for Older People (EnCOP) Webinar 'Using and creating evidence for enhancing care for older people' held on 23 August 2022.
- Updated Workforce webpages on Frailty ICARE re. Enhanced Care for Older People (EnCOP) Assessment Toolkit Domains see: EnCOP Assessment Toolkit Domains « I-Care (frailtyicare.org.uk)

Evaluation and Research

- The Frailty Evaluation Framework has been developed and the next phase will be testing.
- NHSE Hydration Bid: minor points of clarity requested by NHSEI and provided and confirmation of success subsequently received. A pre-launch meeting with NHSEI arranged for 5th October which will be followed by a launch webinar on 12 November where every team will present their projects.

Metrics, Measures and Outcomes update

- Development of Power BI Tool – to be released to Ageing Well MMO Group and AW Steering Group for feedback before wider dissemination.
- SDF Ageing Well - winter preparedness and implementation support/improvement projects monies have come down to regional finance. The funding request for focused regional work to standardise the capture of metrics across all UCR Services from the staff and patient experience has been granted.
- Regional Ageing Well Frailty Outcomes Framework Report: Qtr. 1 2021/22 received and circulated

Personalised Care

Personalised Care Community of Practice meeting held 5 October – focus of meeting Personal Health Budgets - a national perspective and how can we do better locally with PHBs?

Academic Health Science Network
North East and North Cumbria

NHS
North East Ambulance Service
NHS Foundation Trust

Measuring frailty and its association with key outcomes in the ambulance setting: a cross sectional observational study

Prepared by

Karl Charlton

Research Paramedic

Study team

Karl Charlton* – NEAS

David Sinclair* – Newcastle University

Daniel Stow – Queen Mary University, London

Barbara Hanratty – Newcastle University

Emma Burrow - NEAS

Aims

- Measure frailty prevalence in the ambulance setting using CFS
- Describe the relationship between frailty and key ambulance outcomes (probability of conveyance to hospital, duration on scene by ambulance personnel)
- Impact local (national?) paramedic practice regarding recognition and measuring frailty

Methods

Design – cross sectional study

Setting – NEAS wide

Participants – patients aged ≥ 50 years of age and attended by a study trained paramedic - C1 calls, GCS < 15 or unconscious patients were excluded

Exposure measurement – study paramedics (n=100) undertook an online training package regarding frailty and how to use the CFS. They then used routinely collected data and clinical judgement to assess frailty at 2 time points: day of contact and 2 weeks before

Routine and study data collected from anonymised electronic patient care records

Definitions – frail (CFS 5-9), Pre-frail (CFS 4), Robust (CFS 1-3)

Results

- 3056 data sets included in the study
- Mean age 73.9 years, 54.1% female
- Frailty prevalence was high (65.7% frail, 11.9% pre-frail, 22.4% robust) and higher in urban v rural areas (60.2% v 52.6%)
- NEWS2 scores higher in frail and pre-frail individuals v those considered robust
- Frailty prevalence increased with social deprivation

Results

- Most callouts (2275, 74.4%) resulted in conveyance to hospital, median duration on scene 47.1 minutes
- Duration on scene for frail patients was on average nine minutes longer than for robust patients
- NEWS2 ≥5 resulted in shorter duration on scene
- Frail patients were 22% less likely to be conveyed to hospital than robust or pre-frail patients BUT when paramedics assessed a patient's CFS to have increased over the past two weeks, their odds of conveyance increased (OR: 1.6)

What we didn’t find

- Gender had no significant effect on pre-frailty and frailty among ambulance patients
- There were no statistically or clinically significant seasonal effects or variation in patient CFS scores over the study period
- Age, gender, social deprivation and rurality were not associated with increased OR of conveyance to hospital

Impact

- Results paper under peer review
- Preprint available
- Advancing paramedic practice, application of frailty in various contexts
- Identifying future research opportunities

www.neas.nhs.uk

/North East Ambulance Service

@NEAmbulance

Frailty Case Finding

Jon Quine, PHM Strategic Lead

Kim Teasdale, Head of Analytics (Project Analytics and Insight)

Kay Chapman, Principle Information Analyst

North of England Commissioning Support

Identifying Dementia Needs

pilot evaluation and further development of a tool to inform levels of care provision need for residents with dementia

Juliana Thompson, Healthcare Workforce Research Consultancy
Lesley Bainbridge, Clinical Lead Ageing Well & Home Group
October 2022

involve consider assess respond evaluate

Building Evidence

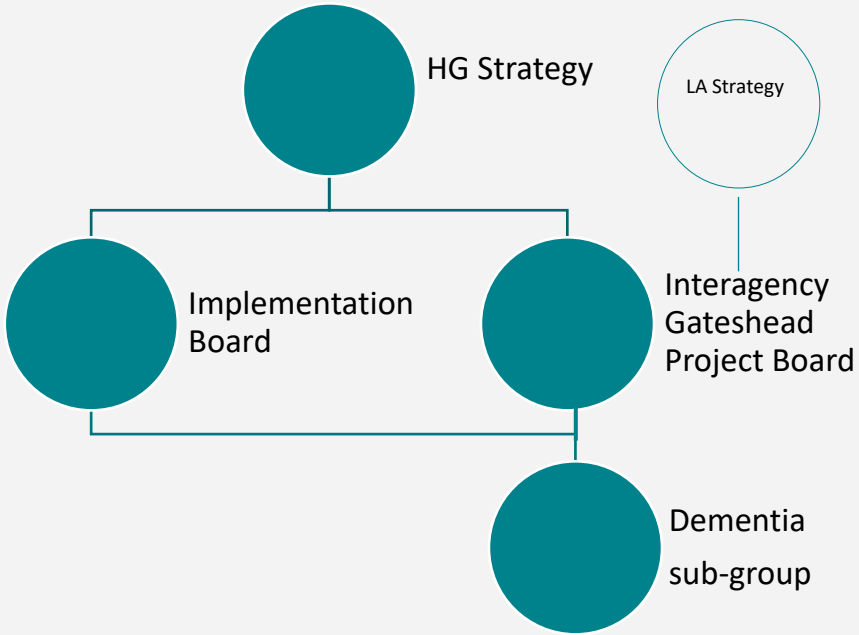
White Paper published 1st December ‘People at the Heart of Care’

Three Objectives covering *choice, control and support for independent living* that should include *access to tailored care and support*

- At least £300m to integrate housing into local health and care strategies
- Expanding the choice of housing options
- *Making every decision about care a decision about housing*

Department of Health & Social Care

Integrating health, housing & care

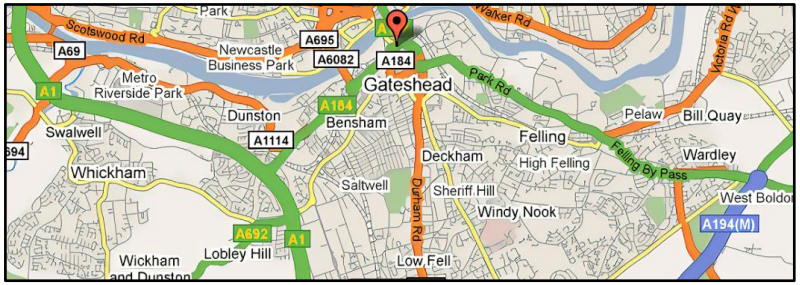


- Dementia friendly community;
  - *living*
  - *supporting*
  - *dying*
  - *preventing*
  - *diagnosing*
- Dedicated social worker but interagency shared decision making

Presentation

- Background
- Phase 1
  - Aims and objectives
  - Methods
  - Findings
    - The tool
    - How it was developed?
    - How it is used?
    - Completed tools analysis
  - Conclusions and recommendations
- Phase 2
  - Aims and objectives
  - Methods

Background



- Local population – 98% rise in rates of dementia in the next 20 years
- Increased need for supported housing, including for those with dementia
- The Care Act, 2014 – LAs assess needs of people requiring social care, and eligibility determination of care needs. Not just for people with dementia.

Watergate Court: Home Group

- 82 extra care apartments for over 55s
- Technology supported
- Community hub
- Restaurant
- Coffee bar
- Treatment rooms
- Guest rooms
- Assisted bathrooms
- Services range from domestic services to care for residents with dementia

Living with dementia at Watergate Court

- Home Group's Implementation Board: oversees the implementation of the company's strategic plans.
- One of the plans is to build a safe and accepting community at WGC for residents with dementia (RwD). The implementation board includes a Dementia Subgroup which links with the Interagency Gateshead Project Board for WGC.
- Responsible for defining the service offer to meet the needs of those living with dementia in WGC in order to support the care and commercial objectives of Gateshead Local Authority and Home Group.
- 15 dementia friendly apartments specifically for residents with dementia (RwD).
  - Agreement with Gateshead LA to accommodate mix of RwDs with low, medium and high level care provision needs.
  - The driving force from the LA was to develop a 'community' where people with different levels of dementia can live within a wider community of older people, rather than a residential care facility for people with high levels of dementia. The aspiration is to support RwDs to live in WGC independently until death, or for as long as possible in a safe, supportive community environment.

Determining level of care provision need

- To ensure mix, and appropriate levels of care provision, a method of determining care provision level is required. Needs to consider individual needs, and population needs.
- **Existing tools: Don't inform level/type of care provision**
  - Screening for dementia
  - Assessing function, behaviour, quality of life, depression, carer burden (used clinically, but most often for research outcomes)

Existing tool: May have potential

- The Care Needs Assessment Pack for Dementia (CARENAPD) (McWalter et al., 1998)
- Camberwell Assessment of Need for the Elderly (CANE) (Reynolds, et al., 2000)
- Pool Activity Level (PAL) instrument (Pool, 2012) Doesn't inform care provision needs

Detailed information to inform individual care plans, don't inform population-based needs or care-package type; not validated specifically for extra care

Conclusion: A tool needs to be developed that ensures mix, and appropriate levels of care provision, and that considers individual needs, and population needs

Watergate Tool

- The tool was developed by a group of healthcare professionals with expertise in the care of older people with dementia. It uses a range of ‘suggested considerations’ criteria to consider RwDs’ cognitive, functional, social, physical and mental health status, which are then used to inform levels of care provision need. Level of care need then informs the type of care package offered:
  - Low level = 0-7 hours care package per week
  - Medium level = 7-14 hours care package per week
  - High level = >14 hours care package per week

- By informing care package type for individuals, the required mix of RwDs per WGC’s population plan could be achieved, and individual RwDs would receive the appropriate level of support.

Phase 1: Aims and objectives

- Home Group piloted the tool in Watergate Court, and required a service evaluation of the pilot. A process evaluation was commissioned.
  - The efficacy and accuracy of outcomes evaluations are compromised by a lack of attention to the internal development and workings of the tools themselves. A number of 'process', 'determinant', and 'implementation' factors regarding how tools are applied in practice can impact on the effectiveness of outcomes for service users/clients and organisations:
    - Process: description of the intended use of the tool, and whether the tool is actually used as intended.
    - Determinants: barriers and enablers to effective use of the tool.
    - Implementation: reach, effectiveness, adoption, implementation, and embeddedness/normalisation into practice of the tool.
- **The primary aim of this project was to evaluate a tool to inform levels of care provision need for RwDs**. Evaluation focused on process, determinant and implementation factors, as well as evaluating staff's views and experiences of the effectiveness of the tool in informing care provision needs.
- A secondary aim was:
  - to explore whether suggested considerations on the current version of the tool could inform trends across the population about what factors inform decisions about levels of care provision provided.

Phase 1: Methods

- Analysed documents relating to development of the tool
- Interviewed healthcare professionals involved in development of the tool (5 from the panel of 7)
- Observed multi-disciplinary team meetings at Watergate Court where residents/potential residents with dementia care provision needs were discussed, decided and reviewed. The tool was integral to these meetings (on RwD admission, than after 3 months)
- Interviewed MDT members involved in using the tool (6 from a panel of 7)
- Analysed completed tools

Phase 1: Findings – the tool

Why is it needed?

- Ensure right mix of RwDs
- ensure appropriate level of support
- to inform holistic, robust decisions
- make sure WGC is suitable
- ensure care is not over/under provided
- ensure value for money
- reduce inappropriate moves in and out of WGC
- anticipate workforce requirements to care for RwD.

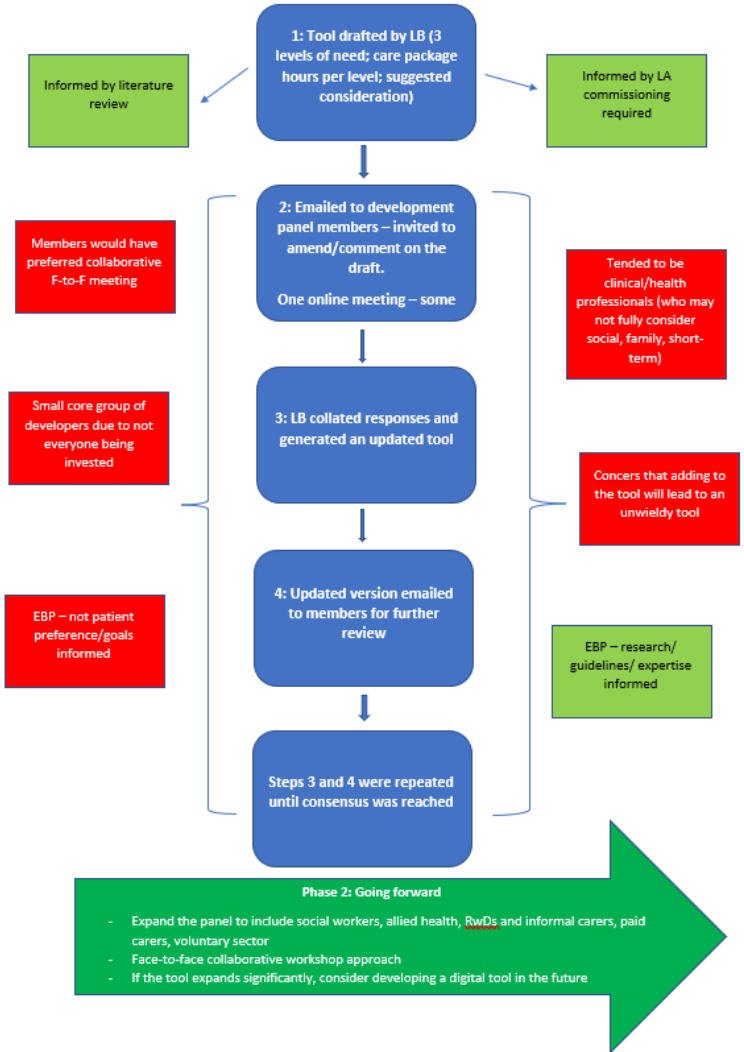
What does it do?

- Guide/aid to support MDT holistic assessment of WGC's RwD's level of care provision.
- Prompts/guides MDT discussion about RwD's care provision needs.
- Identifies further information required about RwDs before decisions can be made (staff can then collect this information to bring back to subsequent meetings).
- Provides a consistent approach to care provision assessment.
- Anticipate potential for changing needs if used to review/re-assess at regular intervals.
- Anticipates workforce needs.
- Supports professional development in the care of RwDs.

What it could do

- Rapidly identify short-term/fluctuating changes in needs to ensure RwDs receive timely, appropriate care as needed.
- Anticipate/guide workforce development needs of the whole workforce (e.g. guide training priorities, resources, recruitment, etc.).
- Provide evidence for care provision decisions (e.g. for families, other sectors, commissioners, etc.).

How was it developed?



How was it used?

Completed tools analysis: does it work?

- Small sample, but able to explore tool outcomes at 2 points (admission and 3 months) for individual RwDs.
- Of RwDs assessed at both points in time (n=13), tool scores remained the same for 11 RwDs (i.e. the care package hours required anticipated at the initial MDT ARM and informed by the tool matched those actually required). This may indicate that the support actually needed for these RwDs was accurately determined/ anticipated in the original MDT ARM using the tool.
- In two cases, tool scores at the 3 month MDT ARM were different from those at the initial moving in assessment. However, this was because in these cases, RwDs' needs had changed. Using the tool at regular MDT reviews assisted in identification of, and response to, changes in needs.
- However, as at present social, risk and safety, and short term fluctuating needs criteria are limited aspects of the tool. These aspects are recorded in written, unstructured notes. It is possible that including these as specific criteria may improve identification/response to changes even further.

Completed tools analysis: needs trends

Not possible to obtain a very meaningful analysis of trends across the population about what common factors inform decisions about levels of care provision provided: a) small numbers b) current version does not include enough social factors – rely on notes. As only 1 RwD in the medium group. This level has not been included.

Most common reasons:

Low:

1. 71% manage simple tasks independently, can get up independently/alert after a fall, or recognise family and friends
2. 43% manage own continence needs

High

1. 80% have anxiety/depression/emotional needs
2. 60% have weight/appetite changes, incontinence, require full assistance with meds, are unable to independently get up/alert after a fall, or have unpredictable changes in presentation

Phase 1: Conclusions and recommendations

There is a need for the tool

Development of the tool:

- To improve and develop the tool, a phase 2 development and testing phase is required.
- At present, the tool is clinically/health biased. To ensure the inclusion of social needs, family needs, underlying risks and safety, and short-term fluctuating needs, the phase 2 development panel should include:
  - Stronger social work/LA presence
  - Allied health professionals (e.g. physiotherapy, occupational therapy, dietitian).
  - RwDs and informal carers (families)
  - Paid carers
  - Voluntary sector (e.g. Alzheimer's Society)
  - Continence nurse
- The phase 2 development panel needs to consist of experts who can fully invest time/effort into the development of the tool.
- Phase 2 tool development should use the following approach:
  - Evaluation team to develops a draft tool informed by the phase 1 tool and findings of the evaluation
  - Present the phase 2 draft tool to the phase 2 development panel in a face-to-face workshop(s) where the panel members can work collaboratively together to develop the tool.
- As it is likely that the tool will expand during the phase 2 development process, consider developing a digital tool in the future.

Use of the tool

- Where possible, Home Group staff as well as social worker assessors should visit potential RwDs in their own homes prior to their move to WGC in order to obtain high quality, accurate information.
- As the tool is intended to be used with MDT practice, consider changing its name to include 'MDT' in the title (e.g. Tool for the Multi-disciplinary Assessment of the Care Provision Needs of People with Dementia Residing in Extra Care Facilities).
- The effectiveness of the tool depends on the effectiveness of the MDT ARM and quality of information available about RwDs. It is therefore essential that MDT ARM meetings are 'open forum discussions', and users of the tool high quality, accurate RwD information is available.
- To maximise effectiveness of the MDT ARM, participants need to be competent in: the requirements of their own role/leadership within their own role; collaborative MDT working; supporting/being open to professional development. Workforce development initiatives should focus on these areas. Consider using case studies that include tool use as the basis for training/development.
- Regularly review RwDs' care provision needs at regular MDT ARMs that include use of the tool.
- Once the tool has been fully developed, consider analysis of completed tools to identify common considerations/factors that inform care provision decisions. This will support consistency of decision-making, anticipate common needs across the population, and inform workforce and resource decisions.
- Once the tool has been fully evaluated and validated, consider its use in other extra care facilities, and adapting it for care home and community settings.

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