Northern Excellence in Active and Healthy Ageing Symposium

Tuesday 6th June 2017, Horizon Leeds

Symposium Agenda

Registration	**08:45 – 09:30**
Welcome Address, Richard Stubbs	09:30 – 09:45
Keynote 1, Professor Maddalena Illario	09:45 – 10:15
Keynote 2, Professor Martin Vernon	**10:15 – 10:45**
Northern AHA Exemplar Practice – Yorkshire and Humber	10:45 – 11:00
Coffee Break	**11:00 – 11:15**
Northern AHA Exemplar Practice – North East	11:15 – 11:30
'Raising the Bar' Lessons from Wales, Scotland and Northern Ireland	11:30 – 11:50
Domestic, European and Global Partnership Working	11:50 – 12:10
Morning Speakers' Panel Q&A	12:10 – 12:30
Lunch and Group Photo	**12:30 – 13:00**

Ageing Well

Aligning Northern Collaboration & NHS England Priorities in Frailty

Martin Vernon

NCD Older People

6th June 2017

NHS England

Projected UK age structure

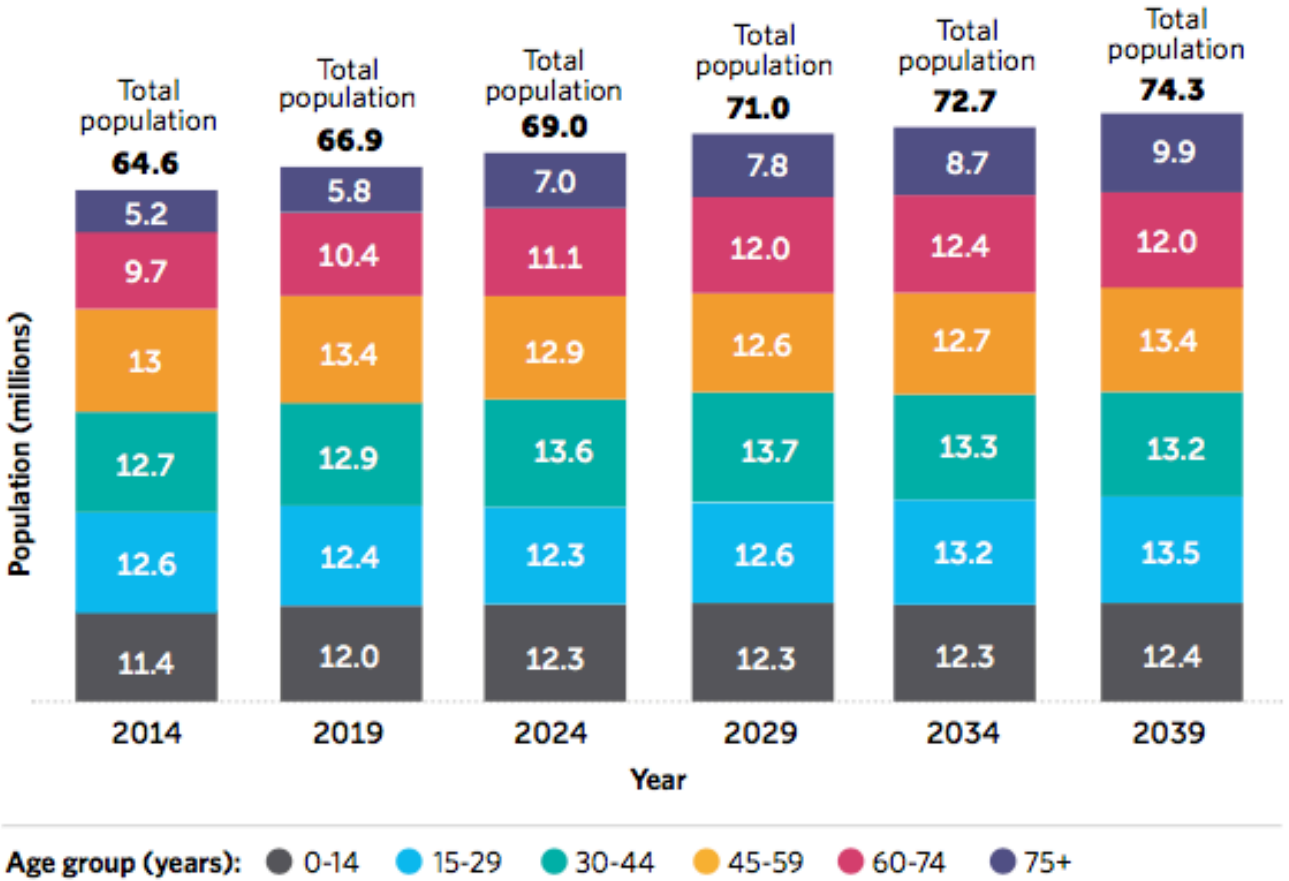


Figure 1.1: Population estimates and projections, based on ONS principal population projections, 2014[3].

Foresight, 2016

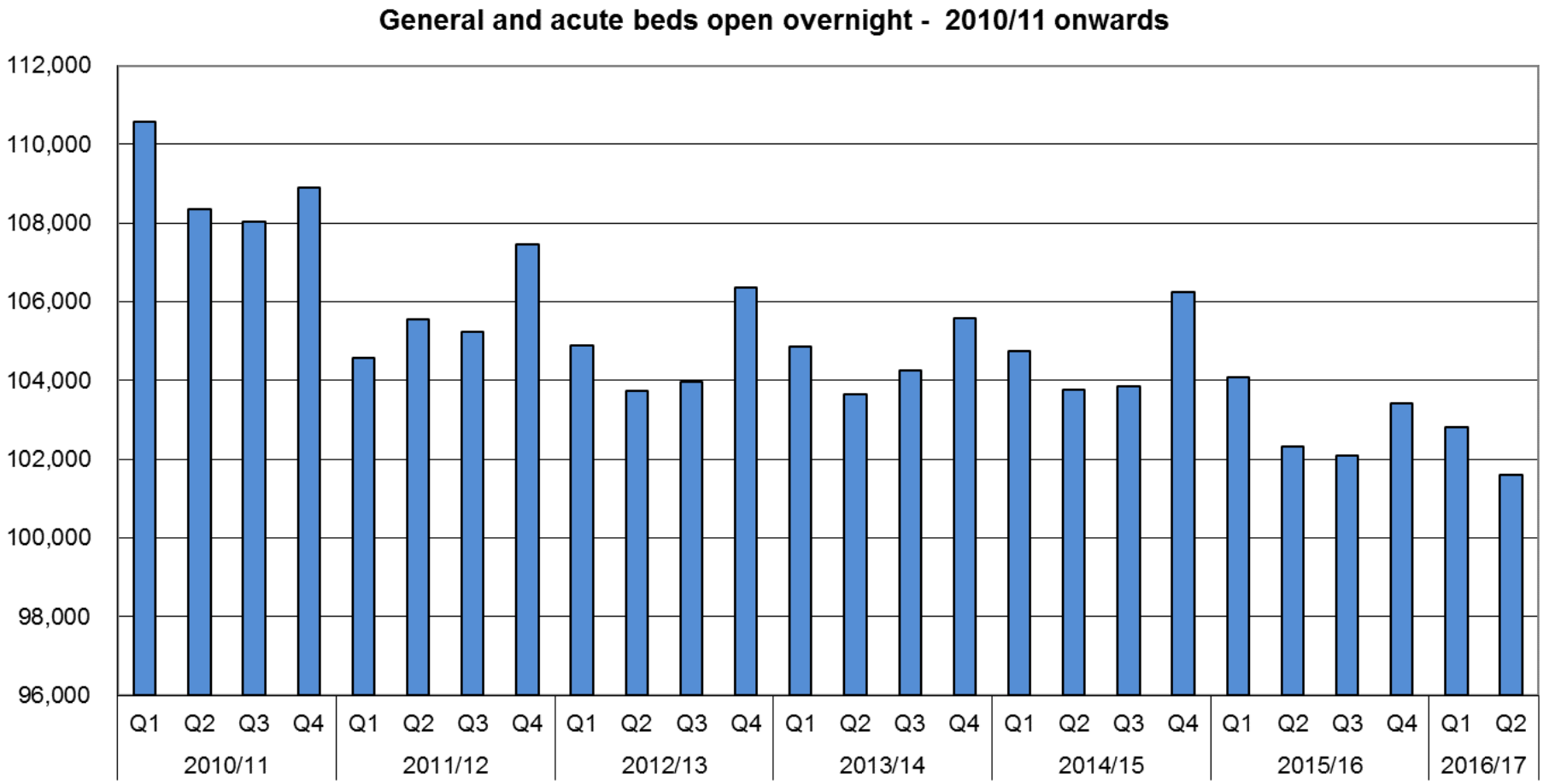
NHS England

Ageing impacts

- **15 million** live with a long term condition (LTC)
- **58% people with a LTC are over 60** (14% under 40)
- A&E attendances by people aged 60+ ↑by two thirds 2007 to 2014
- 2010-15: ↑18% emergency hospital older people admissions

NHS England

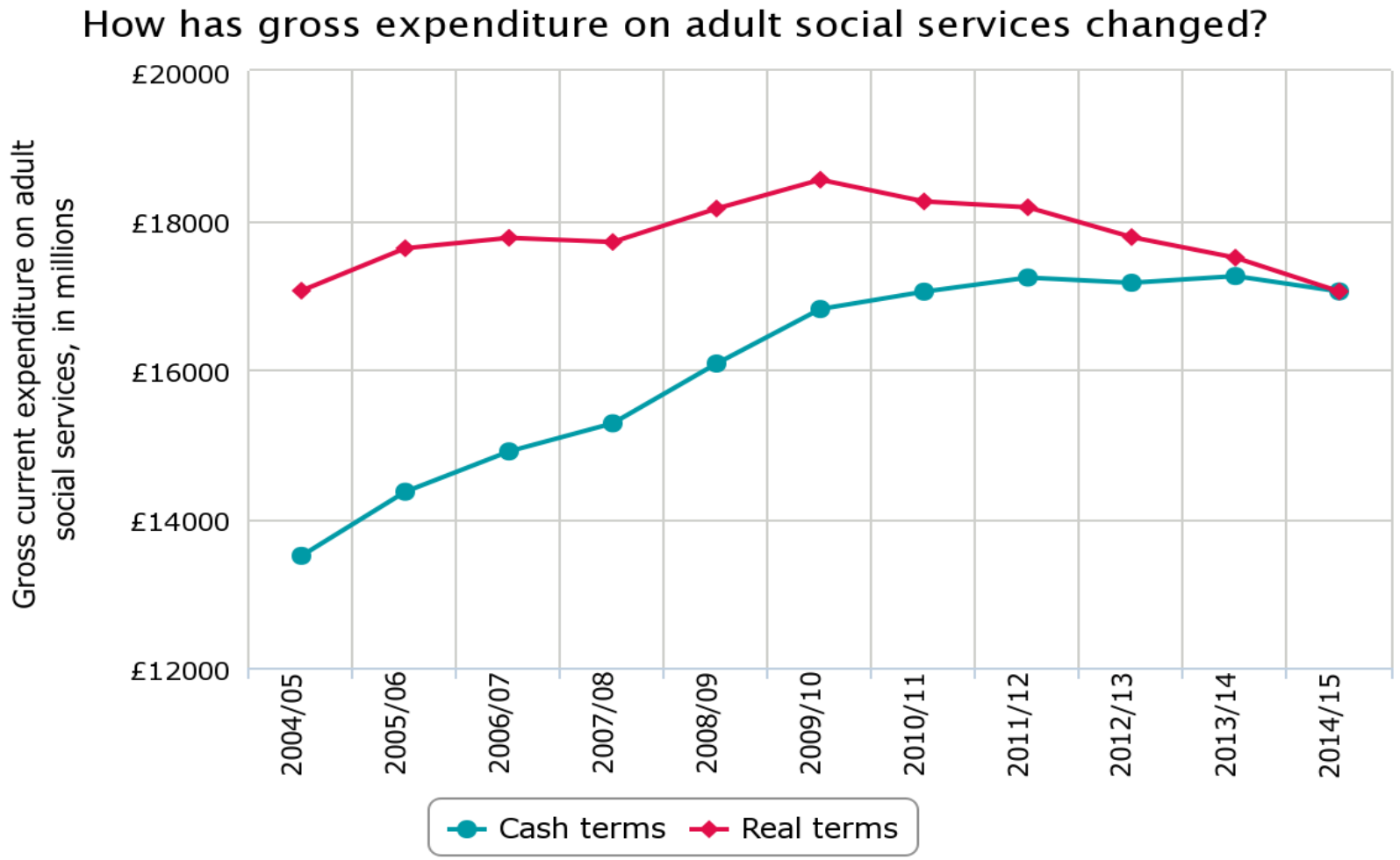
Acute bed numbers



8% reduction in general and acute beds since 2010: NHSB 2017

NHS England

Spend on adult social care



NHS England

Ageing population: key outcomes

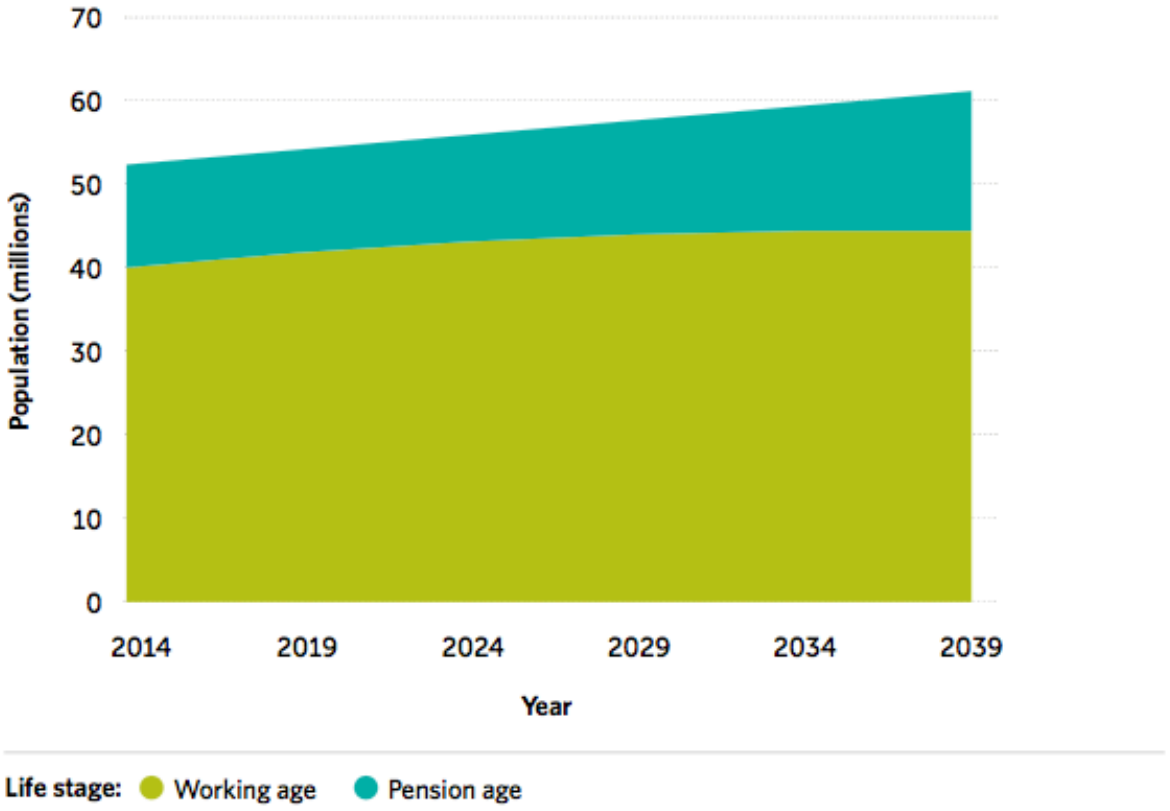
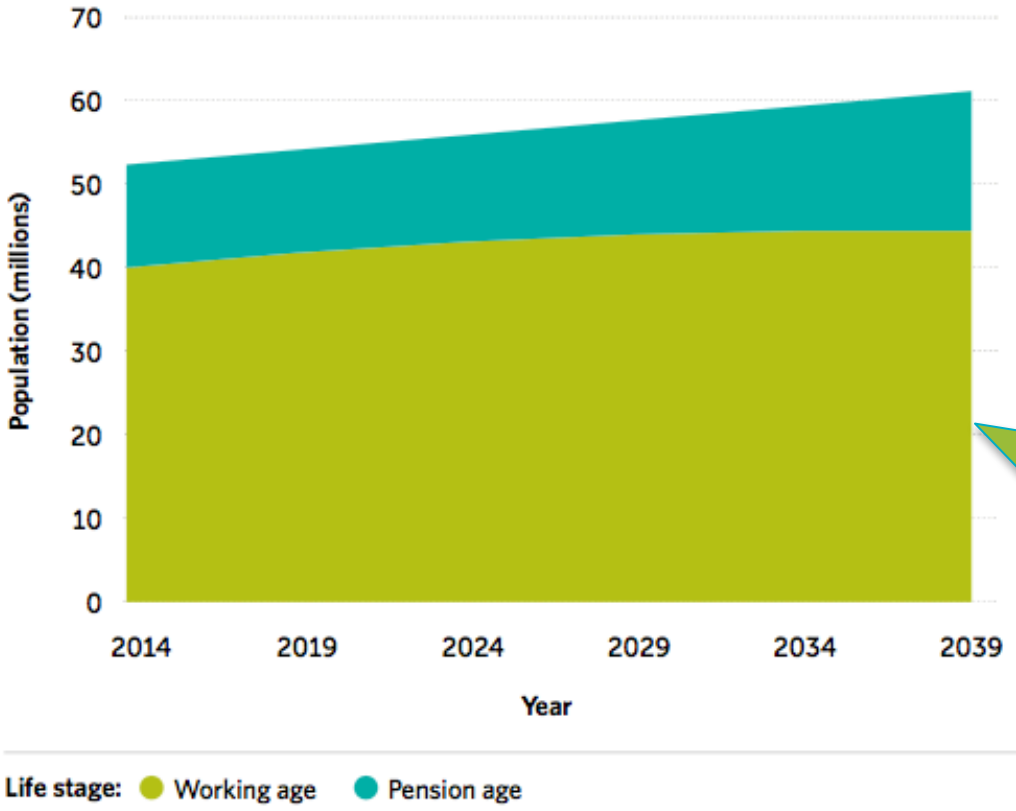


Figure 1.4: Estimates and projections of UK working and pensionable age populations, 2014-2039[9].

Foresight, 2016

NHS England

Ageing population: key outcomes



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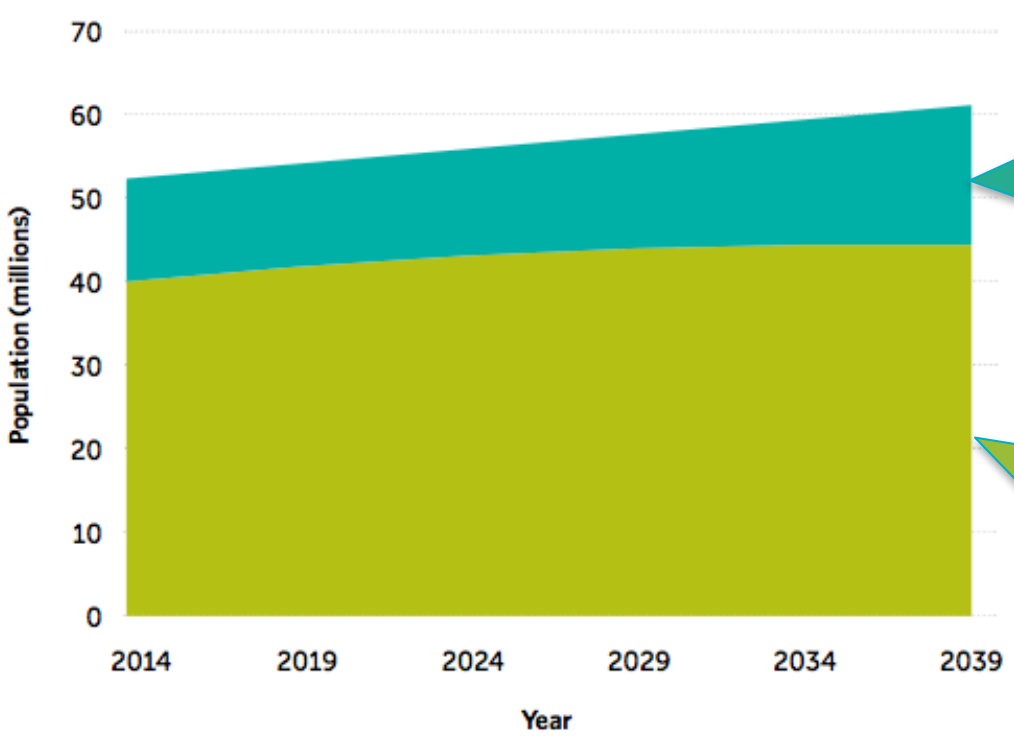
KEEP THESE PEOPLE HEALTHY AND WORKING

Foresight, 2016

NHS England

Ageing population: key outcomes



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KEEP THESE PEOPLE AGEING WELL

KEEP THESE PEOPLE HEALTHY AND WORKING

Foresight, 2016

Find → Recognise → Assess → Intervene → Long-term

5YFV: Older People

- Focus on prevention
- Integration of care
- Stronger community services
- Lead role of GPs

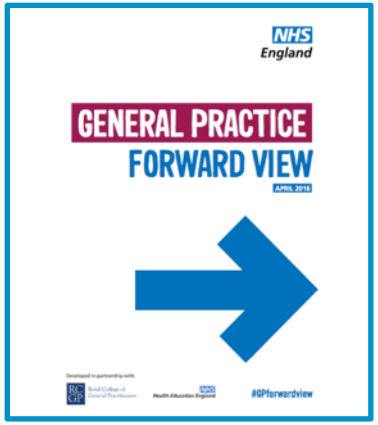
- **Prevent *modifiable* aspects of unhealthy ageing & *unnecessary* hospital admission**
- **Enabling people *greater control* of their care**: shared health & social care budgets
- **Support unpaid carers with partnerships:** NHS, voluntary organisations, communities
- **Break down barriers** to support people with multiple health conditions: ***older people living with frailty***
- Support communities to choose **effective new care delivery options** which **integrate out of hospital care, primary care & other community based providers**
- **Improve support to older people in care homes**

Find → Recognise → Assess → Intervene → Long-term

NHS England

GPFV: Older People

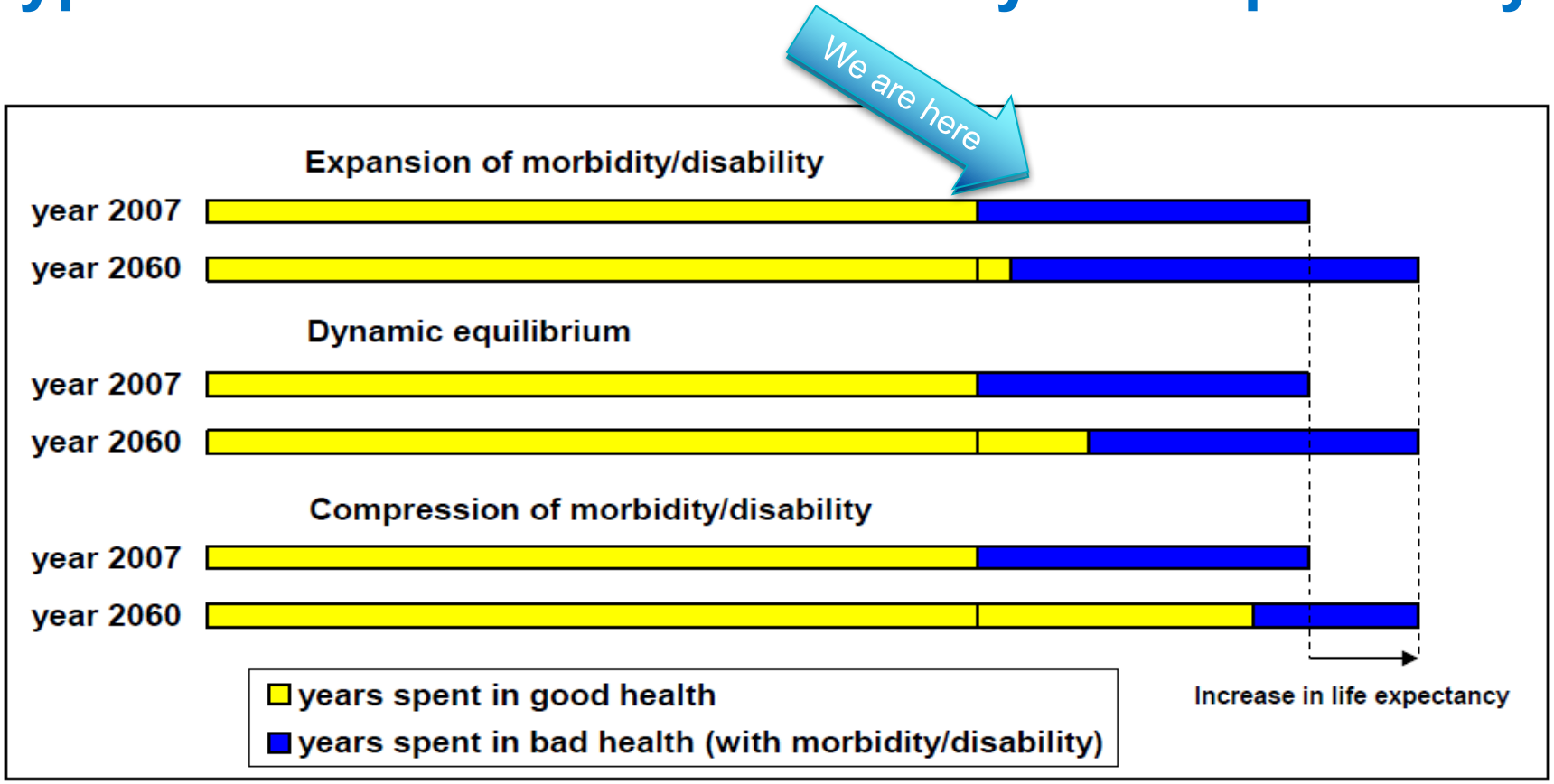
- Greater focus on prevention
- Better integrated
- Stronger community services
- Lead role of GPs



- Contractual measures: **improve hospital/GP interface**
- **Support people living with long term conditions to self care: early frailty**
  - **Care planning**
  - Local community pharmacy pathways to promote self care
- Voluntary sector organisation support to GP through **social prescribing**: call off services
- **Develop digital interoperability** to give **access to a shared primary care record**
  - **Summary care records access in community pharmacies**
  - Accelerated access to patient records **across different services**
  - Permit healthcare professionals in different settings to **update & inform practices**

NHS England

Hypotheses: evolution of healthy life expectancy



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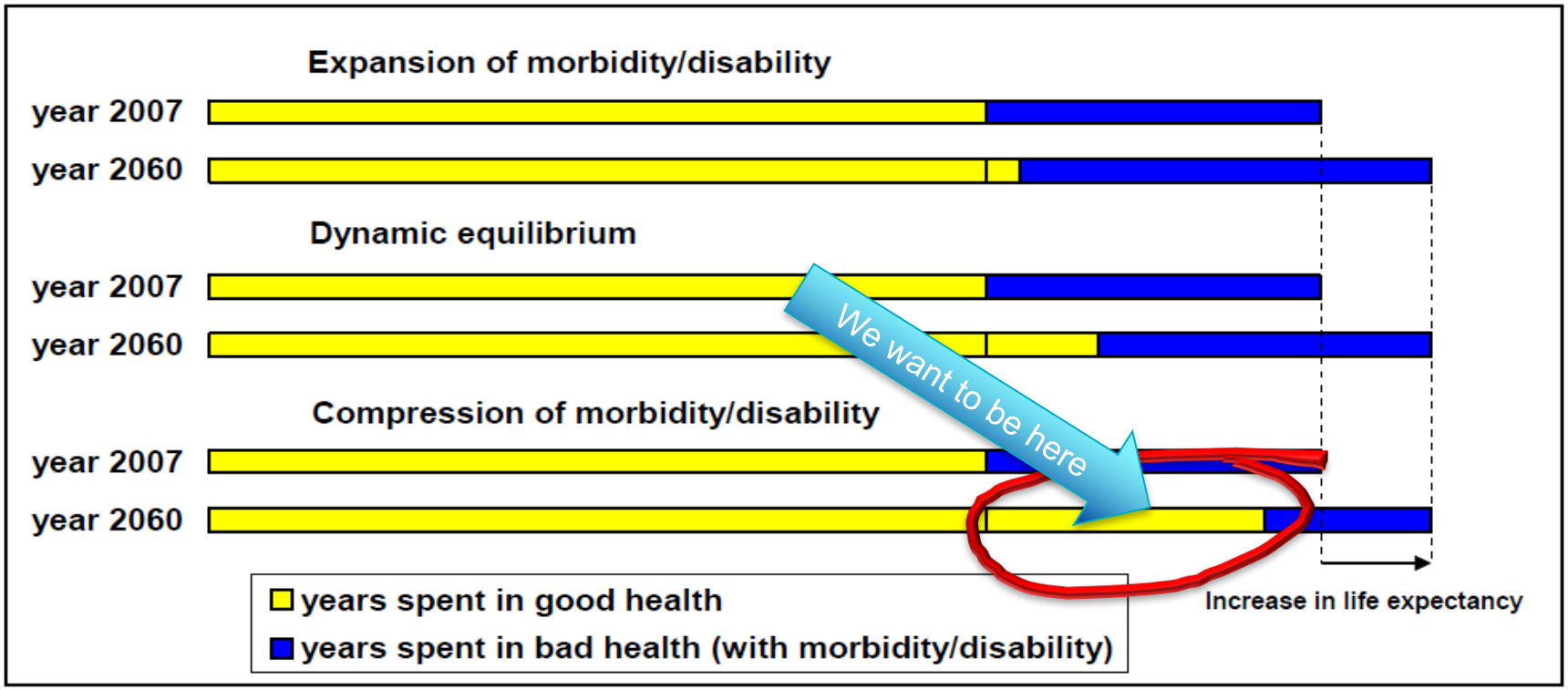
Policy: increase disability free life



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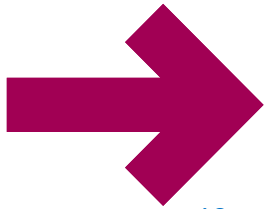
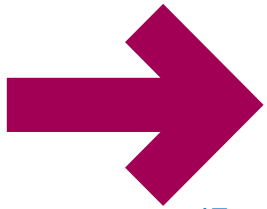
This is not just about now…

- The demand of care for older people will continue to increase
- Many of these will have frailty, multi-morbidity, and/or disability
- Care systems must be equipped for **complexity** to manage flow
- The **only** feasible approaches to this are:
- **Reduce demand** through prevention (attenuation)
- **Optimise current care systems** to keep them effective



NHS England

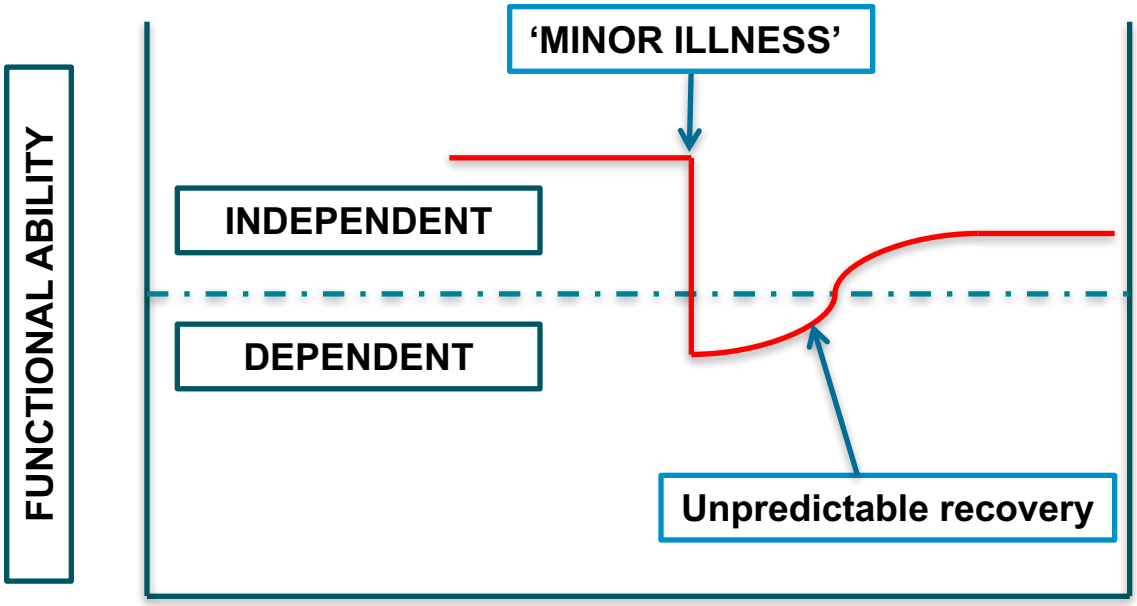
Frailty as a long term condition



NHS England

What is frailty?

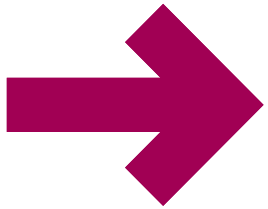
- ***A long-term condition characterised by lost biological reserves across multiple systems and vulnerability to decompensation after a stressor event***
- ***'The most problematic expression of human ageing facing the NHS today'* (Clegg)**



NHS England

The Frailty phenotype

- **People aged >60: 14% & those >90: 65%**
- More common in **women** (16% v 12%)
- In England1.8m people >60 and 0.8M people>80 live with frailty
- 93% frail people have **mobility problems**
- 63% need a **walking aid**
- 71% frail people **receive help**



Fried et al. J Gerontol (2001) 56(3): M146-M157
Gale et al. Age Ageing 2015;44:162-165

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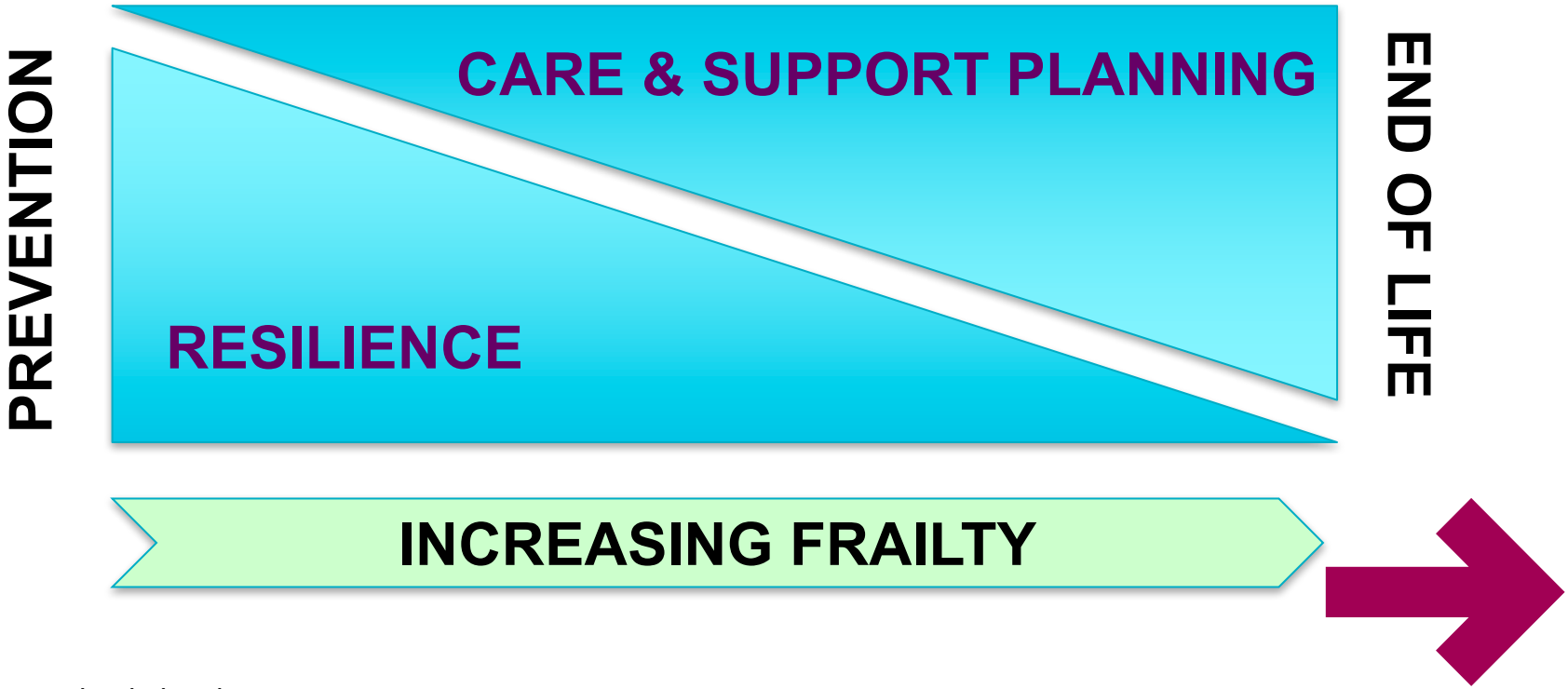
Frailty as a Long Term Condition

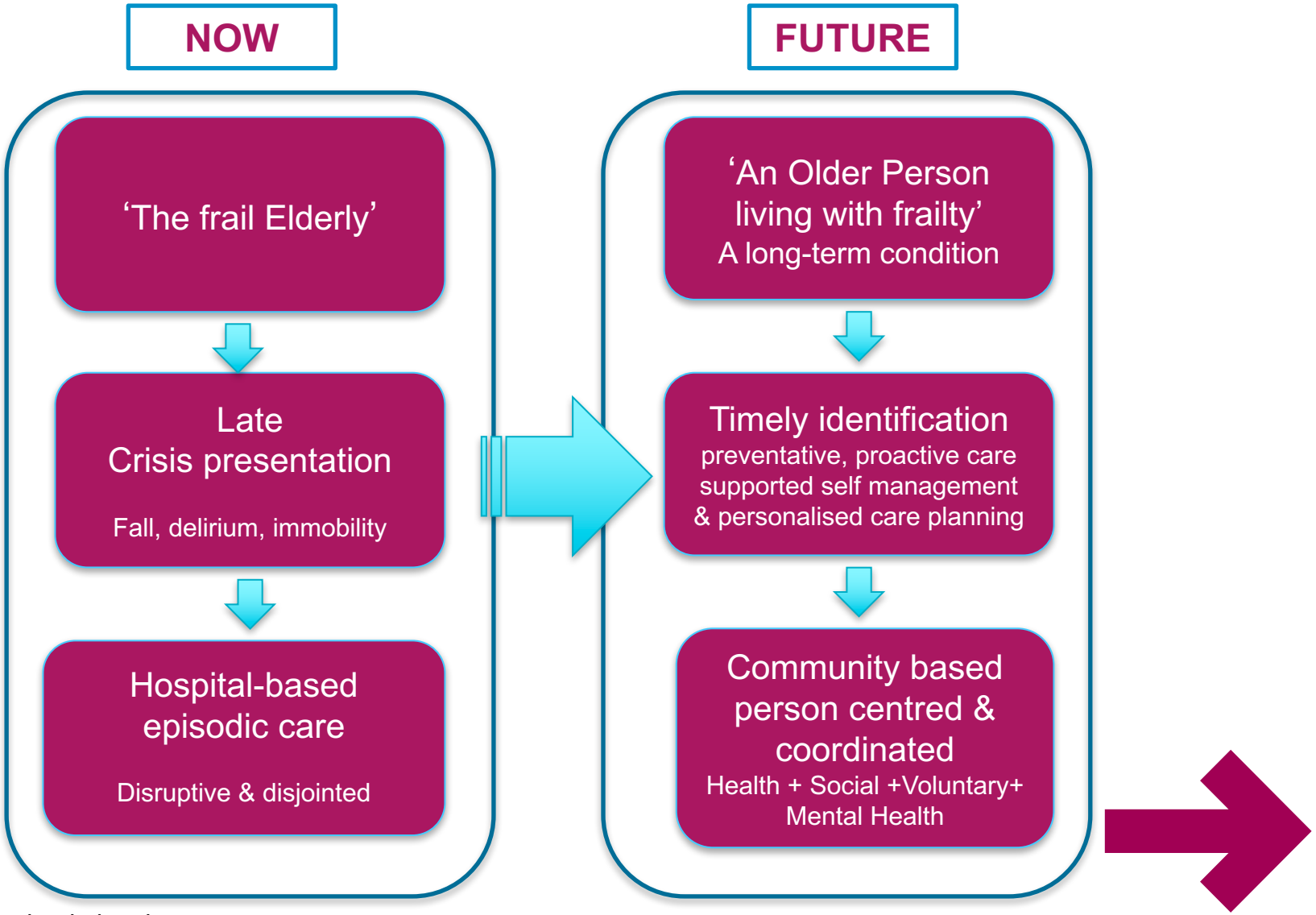
- A long term condition can be **diagnosed**, is **not curable** but **can be managed** and **persists**

- As resilience is lost, care and support planning assumes greater importance through to the end of life



NHS England

Frailty as a Long Term Condition



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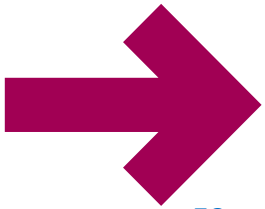
Changing the script..

FROM

'What's the matter with you?'

TO

'What matters to you?'



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Prevention..upstream

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Routine frailty identification

- Routine frailty identification in primary care has 2 potential merits:

1. **Population risk stratification**
2. **Targeted individualised interventions for optimal outcomes**

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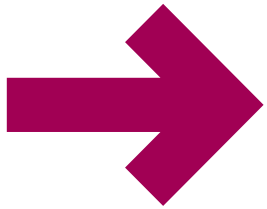
Frailty identification

- **Distinguishing fit from frail & frail from fit…**
- ***…is the most pressing clinical task of our age***
- Frailty is linked to acquisition of multiple Long Term Conditions
- Can be achieved for individuals or populations
- Can therefore help **target interventions** more effectively



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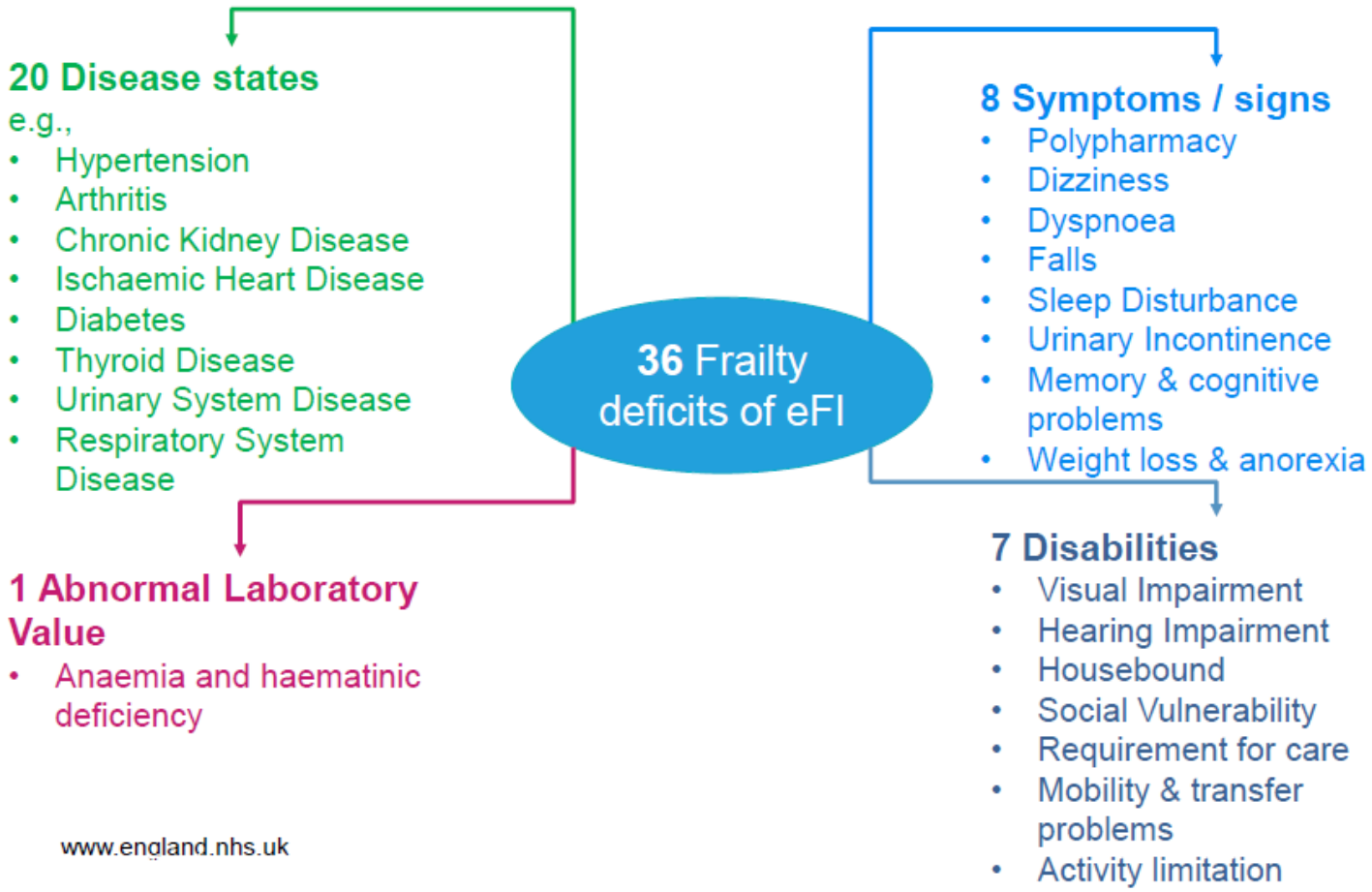
Electronic Frailty Index (eFI)



Clegg et al: Age Ageing2016: 45:353-360

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Electronic Frailty Index (eFI)

- The eFI has robust predictive validity for predicting outcomes (age 65-95)
- 1,3 5 year risk mortality, hospitalisation, nursing home admission
- The prevalence of people who were fit, had mild, moderate or severe frailty was 50%, 35%, 12% and 3% respectively
- Severe frail had on average 2.2 comorbidities and were taking 8 medications
- One year risk almost doubles for mild frailty and quadruples for severe frailty
- Routine implementation of the eFI will support delivery of evidence-based interventions to modify frailty trajectories

One year outcome (hazard ratio)	Mild frailty	Moderate frailty	Severe frailty
Mortality	1.92	3.1	4.52
Hospitalisation	1.93	3.04	4.73
Nursing home admission	1.89	3.19	4.76

Outcomes by stage of frailty

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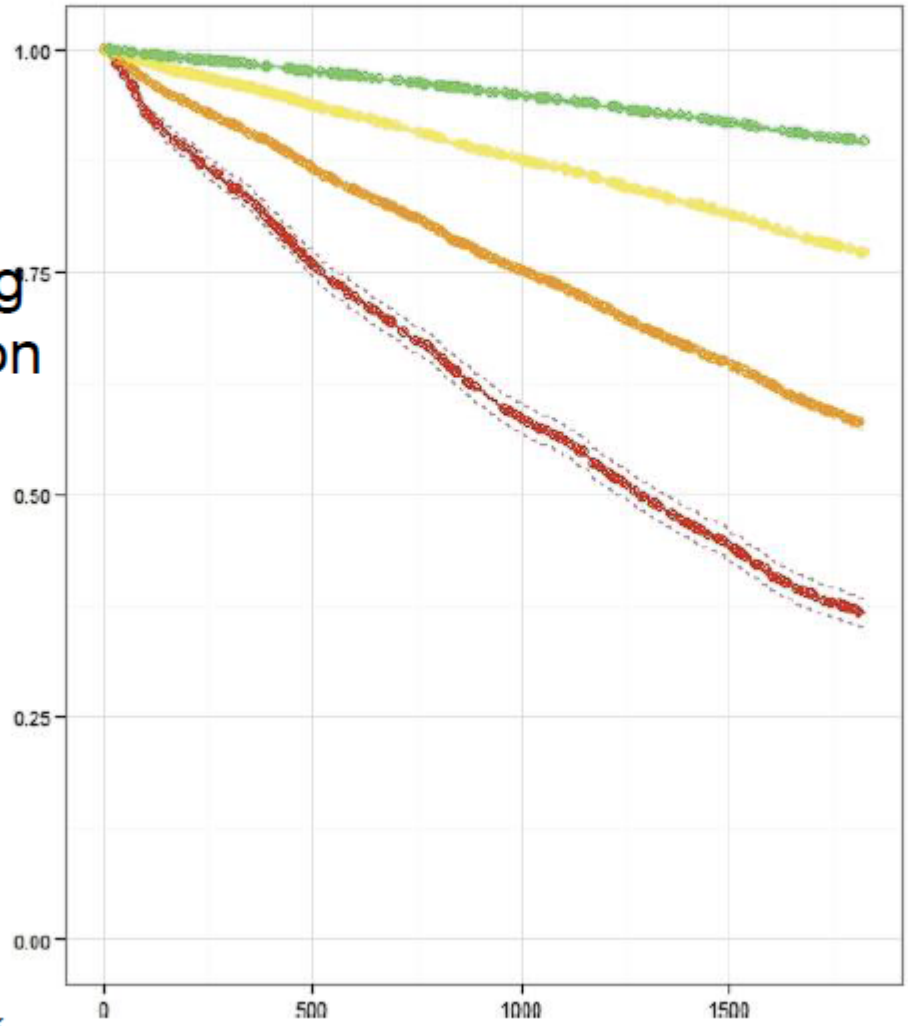
Time (days) → 5 yrs

Reducing proportion alive



Fit

Mild frailty

Moderate frailty

Severe frailty

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GMS GP Contract 2017/18

- Practices will use an appropriate tool e.g. Electronic Frailty Index (eFI) to identify **patients aged 65 and over who are living with moderate and severe frailty**

- For patients identified as living with **severe frailty**, practice will deliver a **clinical review** providing an **annual medication review** and where clinically appropriate **discuss whether the patient has fallen** in the last 12/12

- Where a patient does not already have a Summary Care Record (SCR) the practice will **promote this seeking informed patient consent to activate the SCR**

- Practices will **code clinical interventions** for this group

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Frailty verification: direct assessment

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

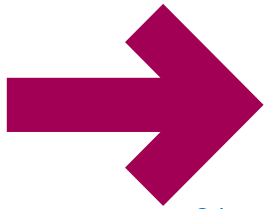
* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

NHS England

GMS GP Contract 2017/18: Data

- number of patients recorded with a **diagnosis of moderate & severe frailty**
- number of **severe frail patients with an annual medication review**
- number of **severe frail patients recorded as having fall in last 12/12**
- number of **severe frail patients providing consent to activate enriched SCR**
- NHS England will use data to **understand nature of the interventions made**
- And **prevalence of frailty by degree among practice populations & nationally**
- Data **will not be used for performance management purposes**



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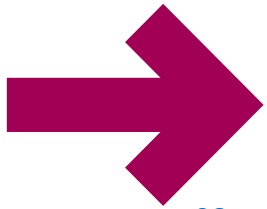
Why Falls?



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Falls and older people

- Older people have highest risk of falling*
- **30%** people aged **65+** fall at least once/year
- **50%** of people aged **80+**

*NICE CG161

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Falls mortality

- Falls associated with ↑ **mortality** in adults 65+
- Ground level admitted falls +65: only 33% went home without assistance*
- 1 year mortality 33% for all admissions
- 1 year mortality for those discharge alive 24%
- Those discharged to nursing facility had 3X risk of death in 1 year (HR=2.82)

*Ayoung-Chee et al (2014) Long term outcomes of ground level falls in elderly. J Trauma & Acute Care Surgery: 76 (2) 498-503

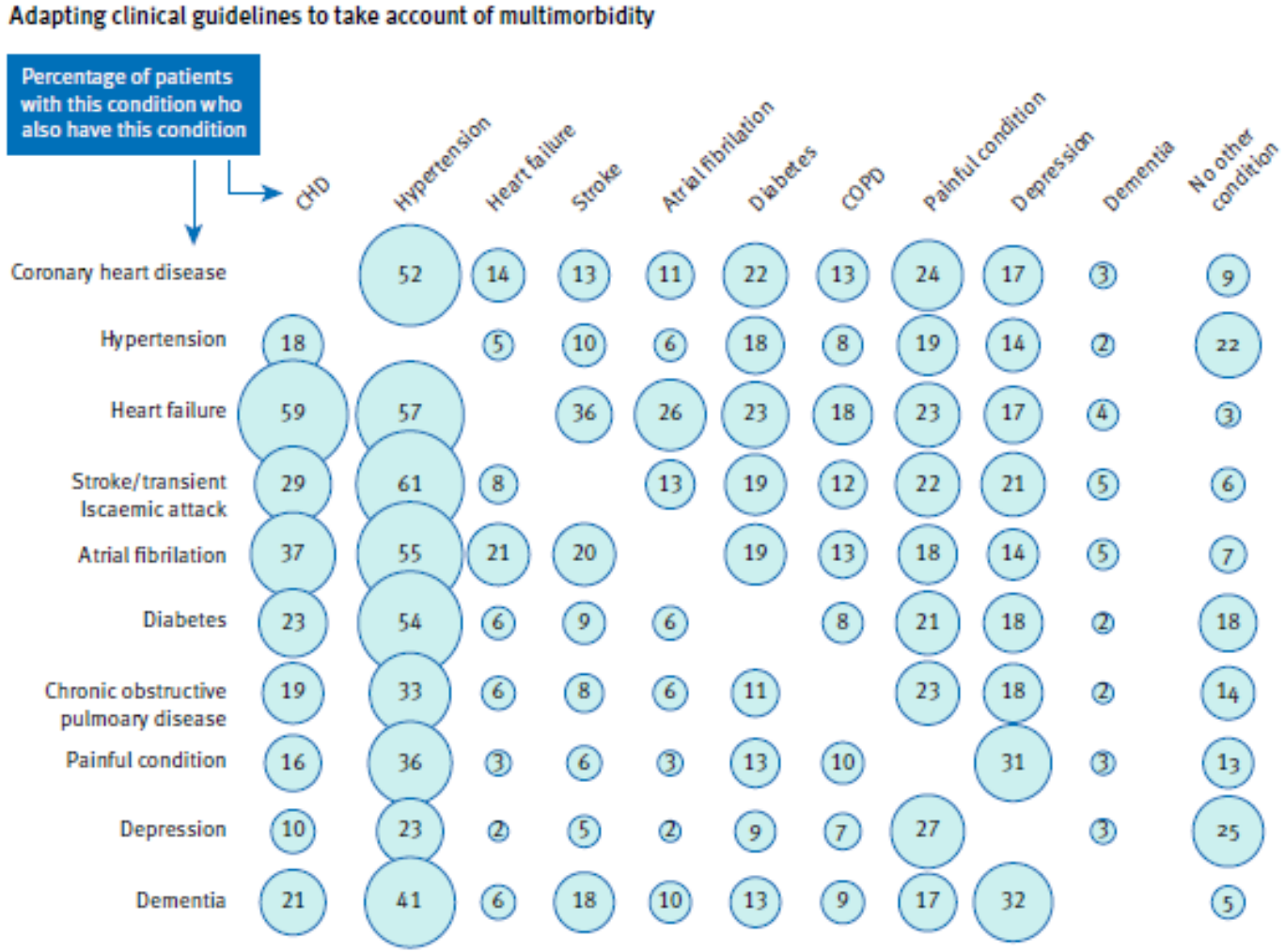
Why medications?

Multimorbidity NG56

Tailoring care to the needs of individuals

NHS England

Multimorbidity: what matters to you?



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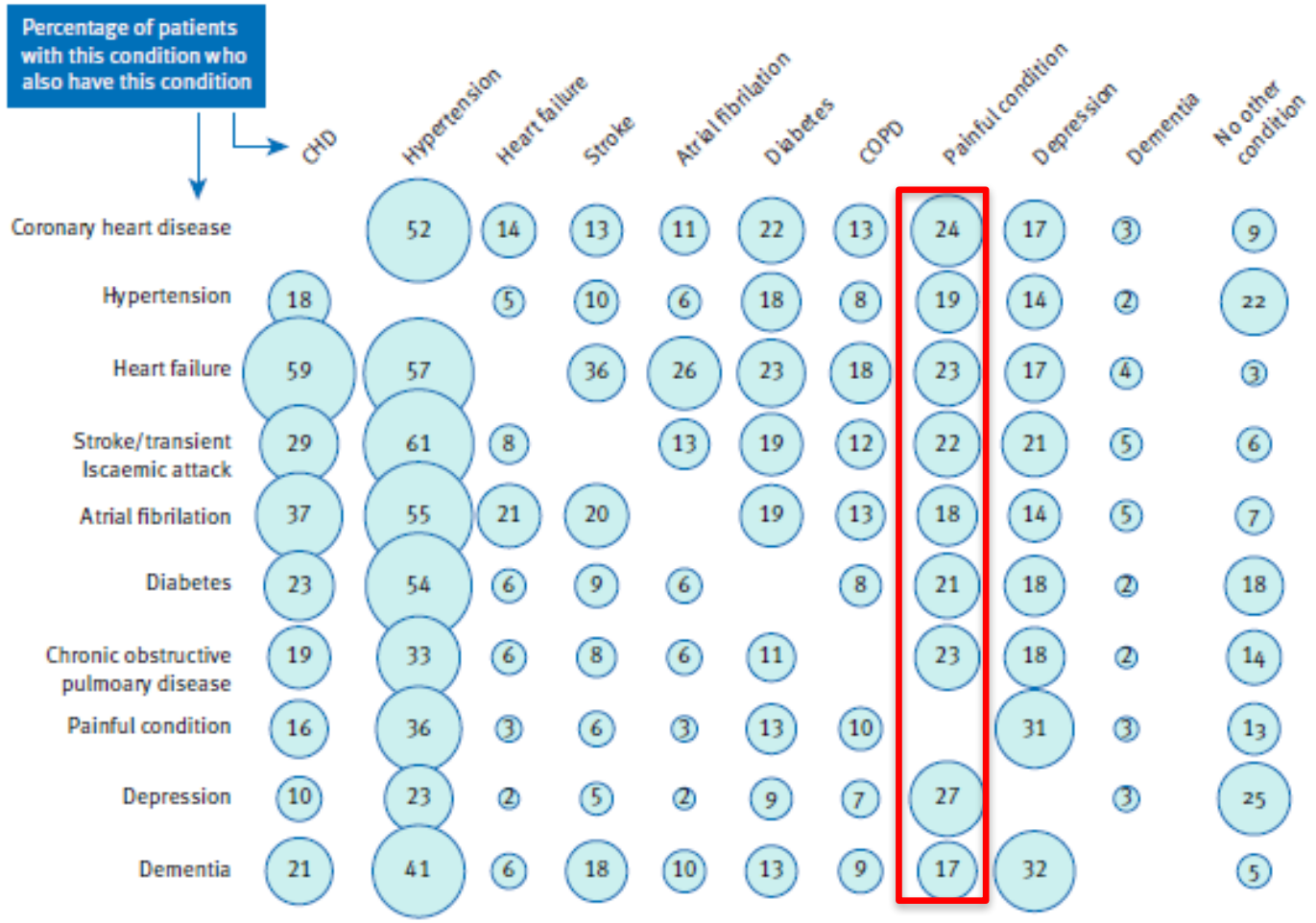
Multimorbidity: pain

Adapting clinical guidelines to take account of multimorbidity



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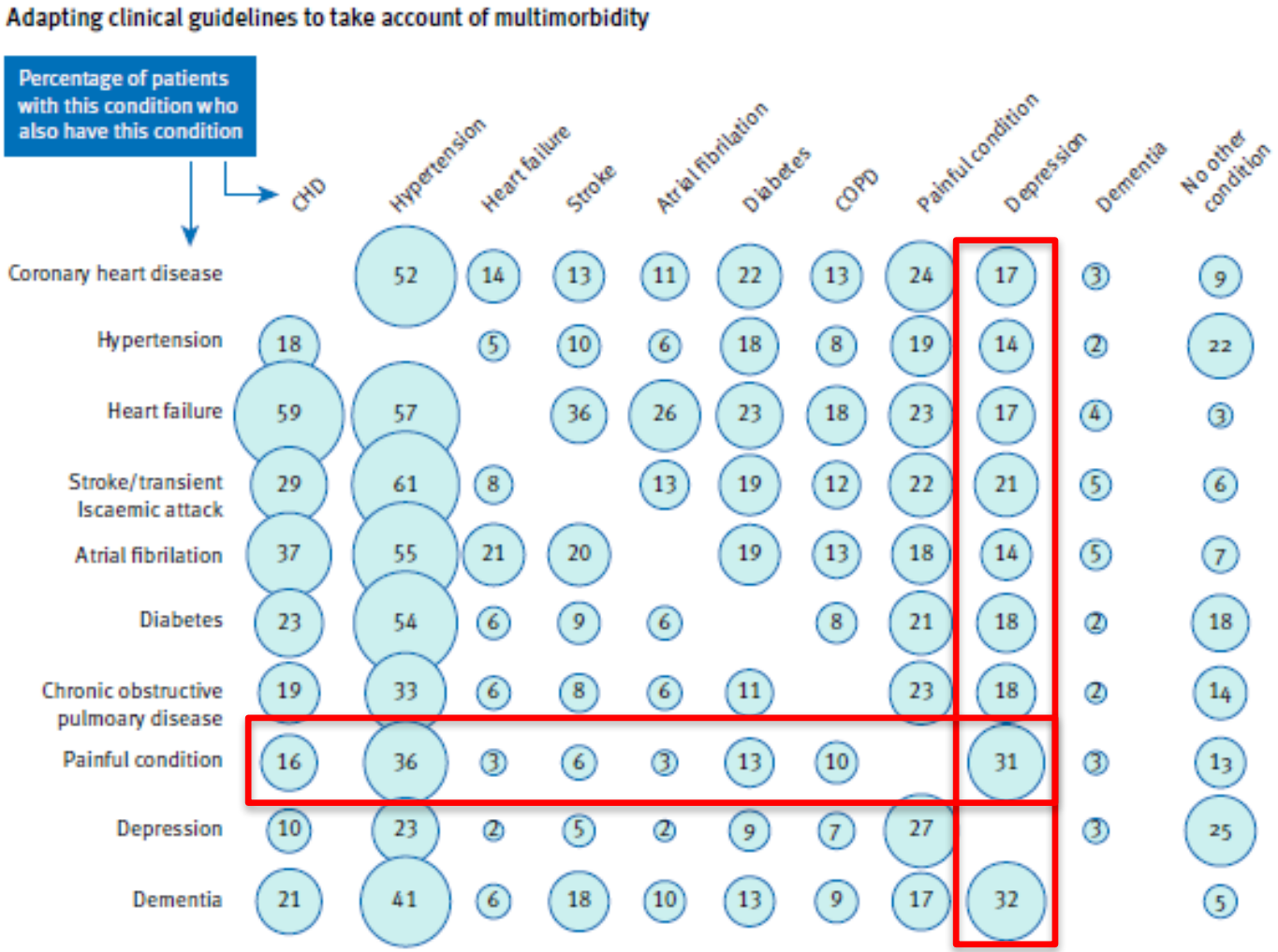
Multimorbidity: depression



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RightCare scenario:
The variation between standard and optimal pathways

Janet's story: Frailty

Find → Recognise → Assess → Intervene → Long-term

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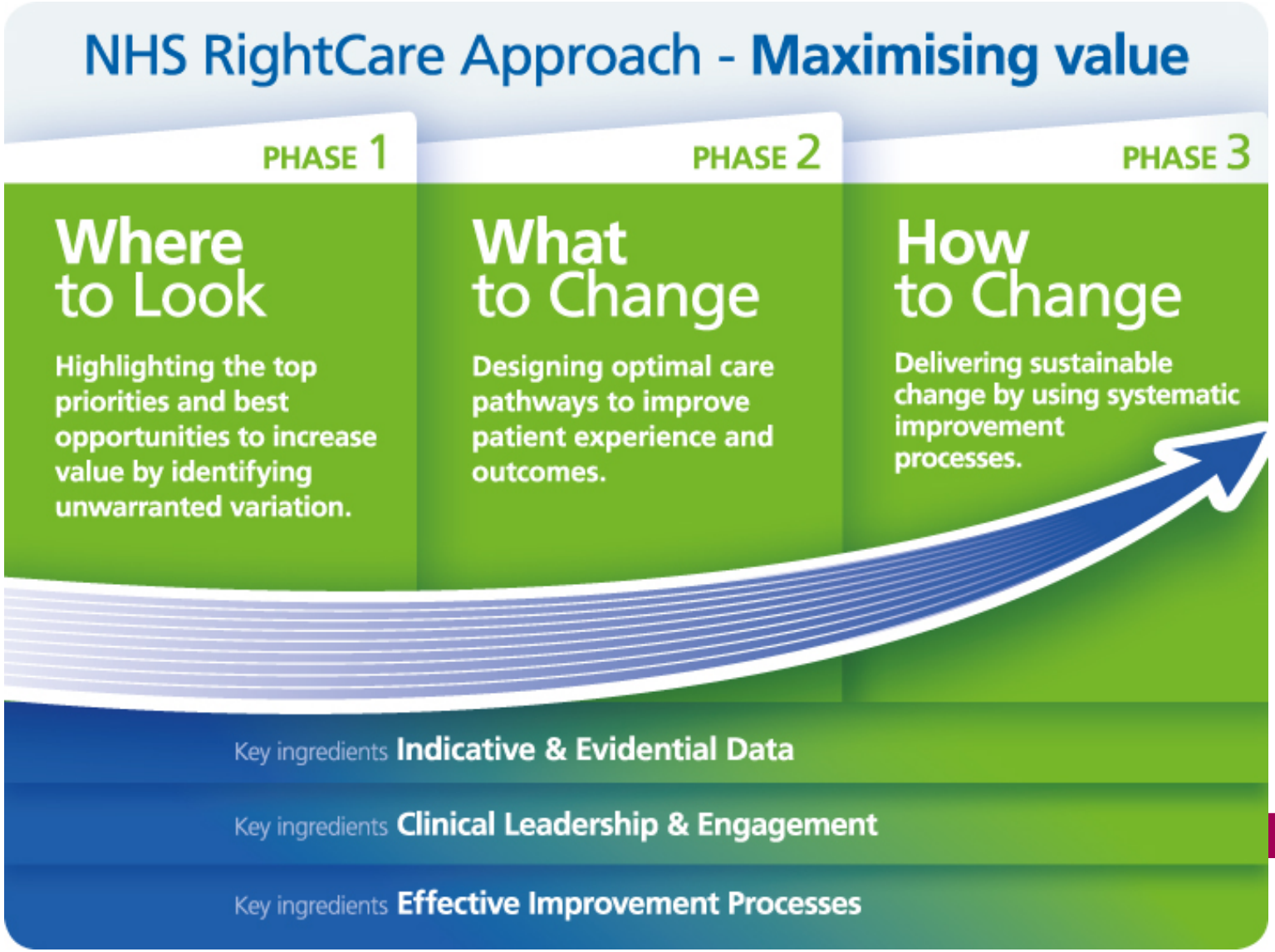
The RightCare approach



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Questions for GPs & commissioners

In the local population, who has overall responsibility for:

1. Promoting frailty as a condition for which targeted interventions must be planned and delivered?
2. Identifying individuals living with frailty?
3. Planning care models to address key stages of frailty (pre/early, moderate or severe)?
4. Identifying and reporting on measurable positive and negative frailty associated outcomes?
5. Quality assurance and value for money of frailty care?
6. Getting best value for money from the investment by caring agencies re frailty?
7. How do we do the right thing for the patient and at the same time recognise that costs shift from health to social care?

Can we use frailty for prevention?

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Potentially modifiable risk factors

- ❑ Alcohol excess
- ❑ Cognitive impairment
- ❑ Falls
- ❑ Functional impairment
- ❑ Hearing problems
- ❑ Mood problems
- ❑ Nutritional compromise
- ❑ Physical inactivity
- ❑ Polypharmacy
- ❑ Smoking
- ❑ Social isolation and loneliness
- ❑ Vision problems

Targeted interventions for those at most risk :

- ❑ Good foot care
- ❑ Home safety checks
- ❑ Vaccinations
- ❑ Keeping warm
- ❑ Readiness for winter

Stuck et al. Soc Sci Med. 1999(Systematic review of 78 studies)

NHS England

What we've done so far nationally

NHS England

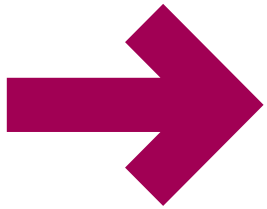
https://www.england.nhs.uk/wp-content/uploads/2017/04/supporting-guidance-frailty-identification.pdf

Supporting routine frailty identification and frailty through the GP Contract 2017/2018

NHS England

What we're doing nationally

- **Promotion of electronic frailty index** and GMS Contract 2017/18
- **Economic modelling** of impact of frailty
- **Rightcare LTC** Commissioning for Value (Frailty and Multimorbidity)
- **Tailored Care for multi-morbidity and frailty**
- **Community Services:** Care homes, Intermediate Care, Falls



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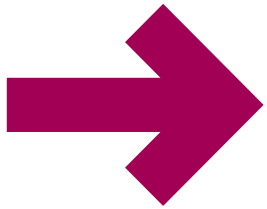
What we need help with

- What are you doing in this space now that aligns with our work?
- How can you help deliver best value care for all people with frailty?
- Do you have scalable propositions that fit with our priorities?




Thank you

Symposium Agenda

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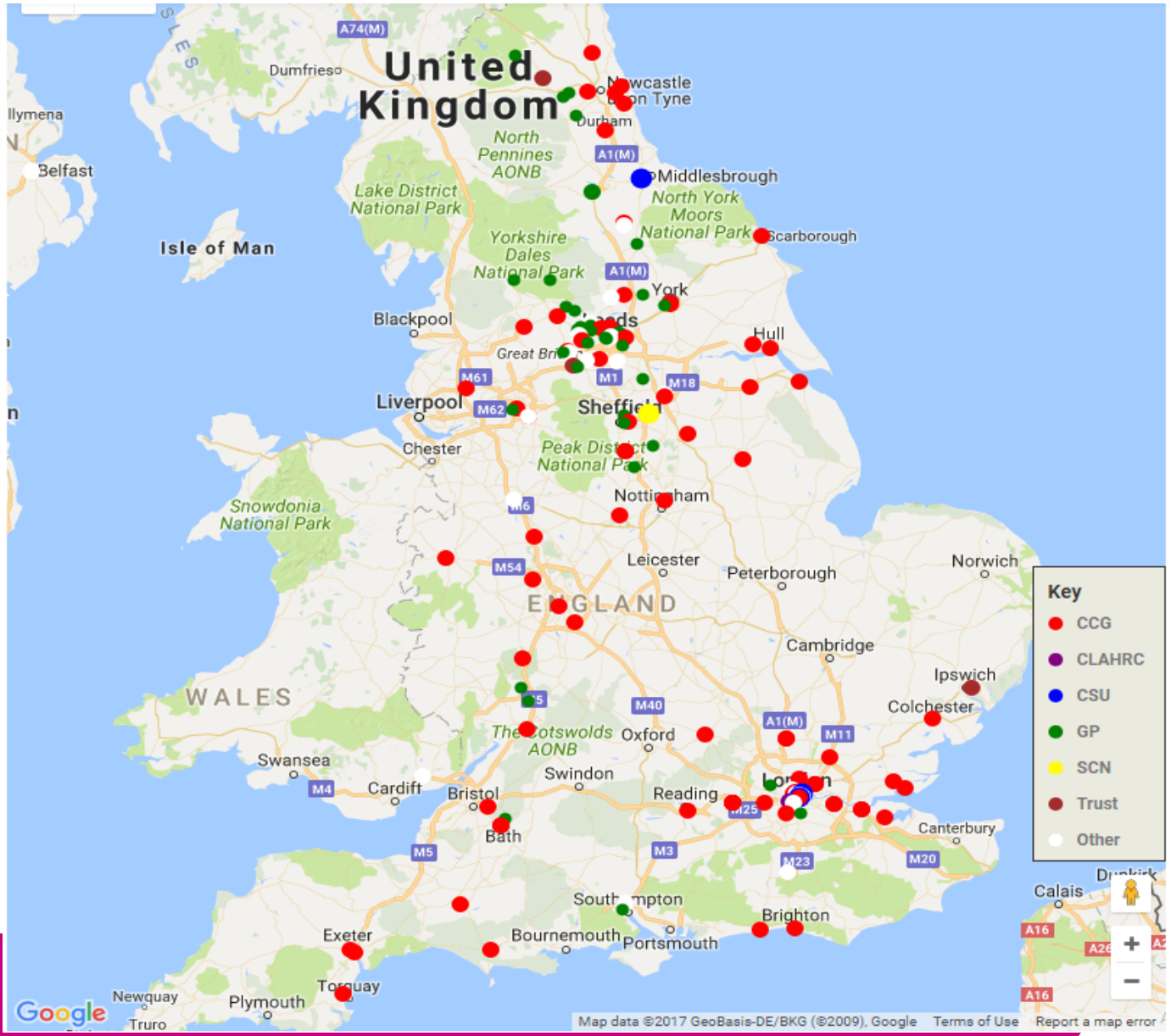
electronic Frailty Index:

Supporting Routing Frailty Identification in Primary Care

Sarah De Biase

Healthy Ageing Collaborative Programme Manager

Academic Unit of Elderly Care & Rehabilitation, BTHFT | Y&H AHSN Improvement Academy| Connected Yorkshire, Connected Health Cities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Bath
Canterbury
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Brighton
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Plymouth
Newquay
Truro
North Pennines AONB
Lake District National Park
Yorkshire Dales National Park
North York Moors National Park
Peak District National Park
Snowdonia National Park
The Cotswolds AONB
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Practicalities of eFI Implementation

- **eFI** identifies patients at risk of/likely to have frailty**: does not diagnose frailty**

- **Draws clinicians in to those who require further assessment to enable frailty diagnosis** i.e. using principles of CGA/holistic assessment

- **Clinical oversight paramount**
- False positives/negatives and/or clinical disagreement with patient eFI scores

e.g. 75 year old man with 3 LTC highly independent eFI > 84yo female residing in care home with end stage dementia

- Other frailty screening tools available **e.g. Clinical Frailty Scale**
- Supports frailty diagnosis & severity grading
- Supports opportunistic case finding

i.e. by other health & care professionals within & beyond primary care

- **Data quality & eFI reliability**
- Ensure GP informed of service use/deficits identified
- Appropriate to reach a consensus locally as to which deficits are less well coded & set about selecting codes to use to improve coding

- **What care approach would be best for the individual?**
- LTC/guideline specific mx
- or holistic assessment & individualised care & supporting planning

- **Limitations within EHRs in terms of application**
- EMIS population report/SystmOne patient report
- Not in other modules of EHR systems i.e. no trust wide reporting (unless local soln.)

Identify Risk of Frailty: What next?

Evidence for:

- Individualised multifaceted & MDT assessment
- Care and Support Planning
- Case management
- Medication review
- Supported self management
- Multicomponent exercise interventions
- Advance Care Planning

EffectivenessMatters

May 2017

Recognising and managing frailty in primary care

- Frailty is a distinct health state where a minor event can trigger major changes in health from which the patient may fail to return to their previous level of health
- Simple tests that have been recommended by NICE for frailty in primary care are gait speed, self-reported health status and the PRISMA 7 questionnaire
- Exercise programmes, particularly high intensity interventions, may improve gait, balance and strength and have positive effects on fitness
- Medication review forms part of the holistic medical review of people with frailty
- Supported self-management can improve health outcomes. However, the value of case management is still to be proven
- Discussion about end-of-life care is important to most older people, but is often neglected

This issue of *Effectiveness Matters* has been produced by CRD in collaboration with the Yorkshire and Humber AHSN Improvement Academy and updates a previous issue published in January 2015. The views expressed in this bulletin are those

eFI implementation…

- **Micro**: GPs using it to understand frailty prevalence within GP practice population

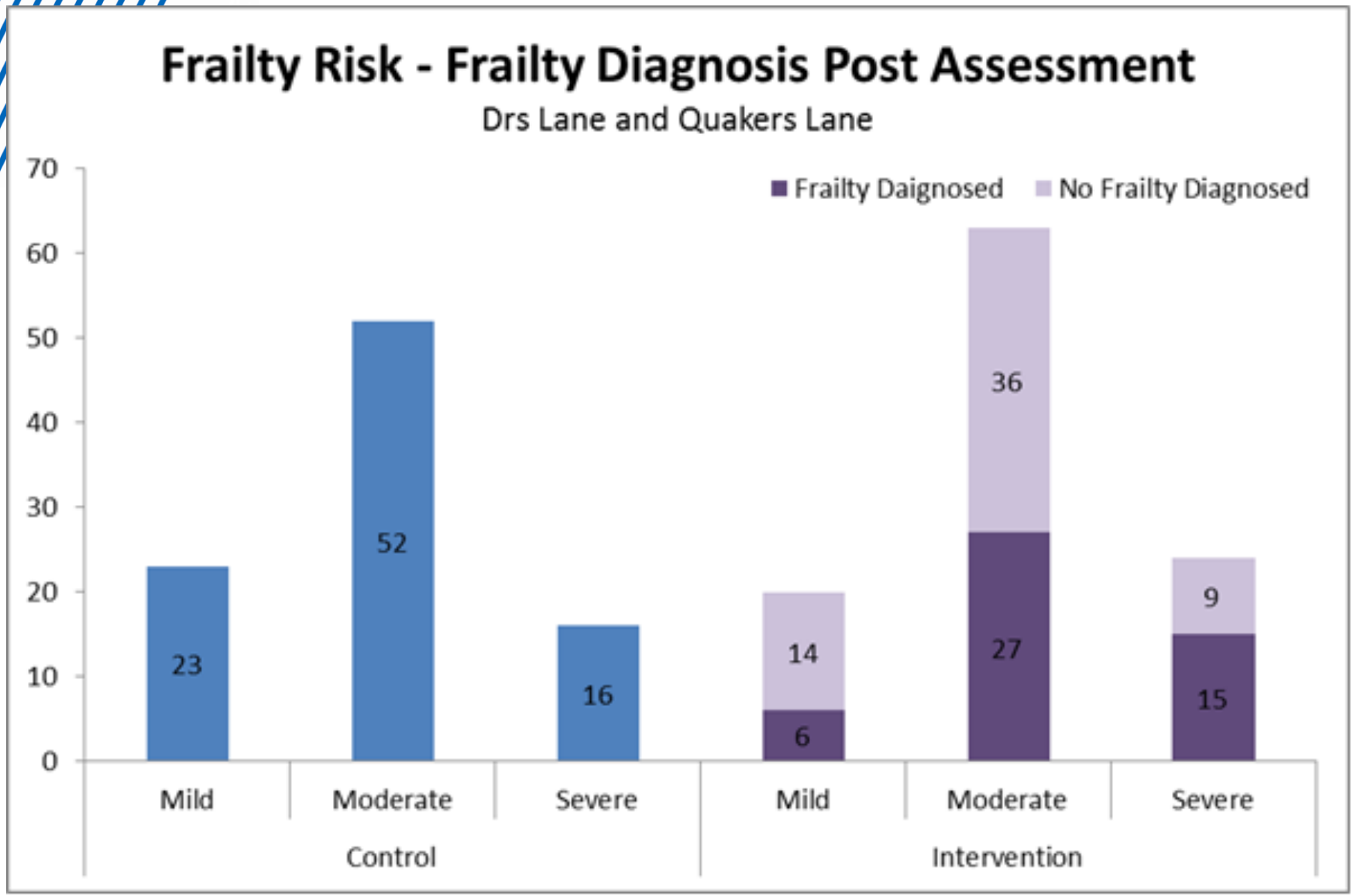
e.g. Home Based (frailty) Assessments

- **Meso:** GP federations/CCGs using it to identify specific frailty cohort(s) to offer targeted intervention

e.g. Care of Frail Elderly Schemes

- **Macro:** Whole Systems/STPs using eFI alongside other data sets to give rich picture of population need which includes frailty & develop new models of care
- e.g. North West London Whole Systems Care for > 65 year olds

NHS Hambleton, Richmond & Whitby CCG: Home Based Frailty Assessment (mCGA)


Frailty Risk - Frailty Diagnosis Post Assessment
Drs Lane and Quakers Lane
Frailty Daignosed
No Frailty Diagnosed
70
60
50
40
30
20
10
0
23
52
16
14
6
36
27
9
15
Mild
Moderate
Severe
Mild
Moderate
Severe
Control
Intervention

More detailed assessment & referral onto the appropriate services

Need a protocol for on-going management of these patients

Nurses doing assessments which they didn't do previously – depression, cognitive assessments etc.

More considered approach to medications reconciliation

House bound patients being seen at home

Interventions for managing early frailty are not in place in the wider system

Increased identification of frailty, falls, AF and dementia

Not sure if the patients understand they are being care for in a different way – but they like seeing the nurses and appreciate things being sorted

It seems to be identifying significant unmet need

Identified the need to streamline how we [GPs} refer need a single point of access

What is the Mild Frailty Offer?

The Health Foundation

Supporting self-care

Helping older people live well

Modifiable risk factors:

- Alcohol excess
- Cognitive impairment
- Falls
- Functional impairment
- Hearing problems
- Mood problems
- Nutritional compromise
- Physical inactivity
- Polypharmacy
- Smoking
- Social isolation and loneliness
- Vision problems

age UK
Love later life

NHS

A practical guide to
healthy ageing

Stuck et al (1999) Risk factors for functional status decline in community-living elderly people: a systematic literature review. Social Science Medicine 48(4): 445-469

North Durham CCG:
Care of Frail Elderly Scheme

Main elements of scheme:

1. Identification of frail patients and maintenance of a 'disease register' of frail patients.
2. Regular assessment of these frail patients (at least annually)
3. Creation a care plan for frail patients

Identification of Frail Patients:

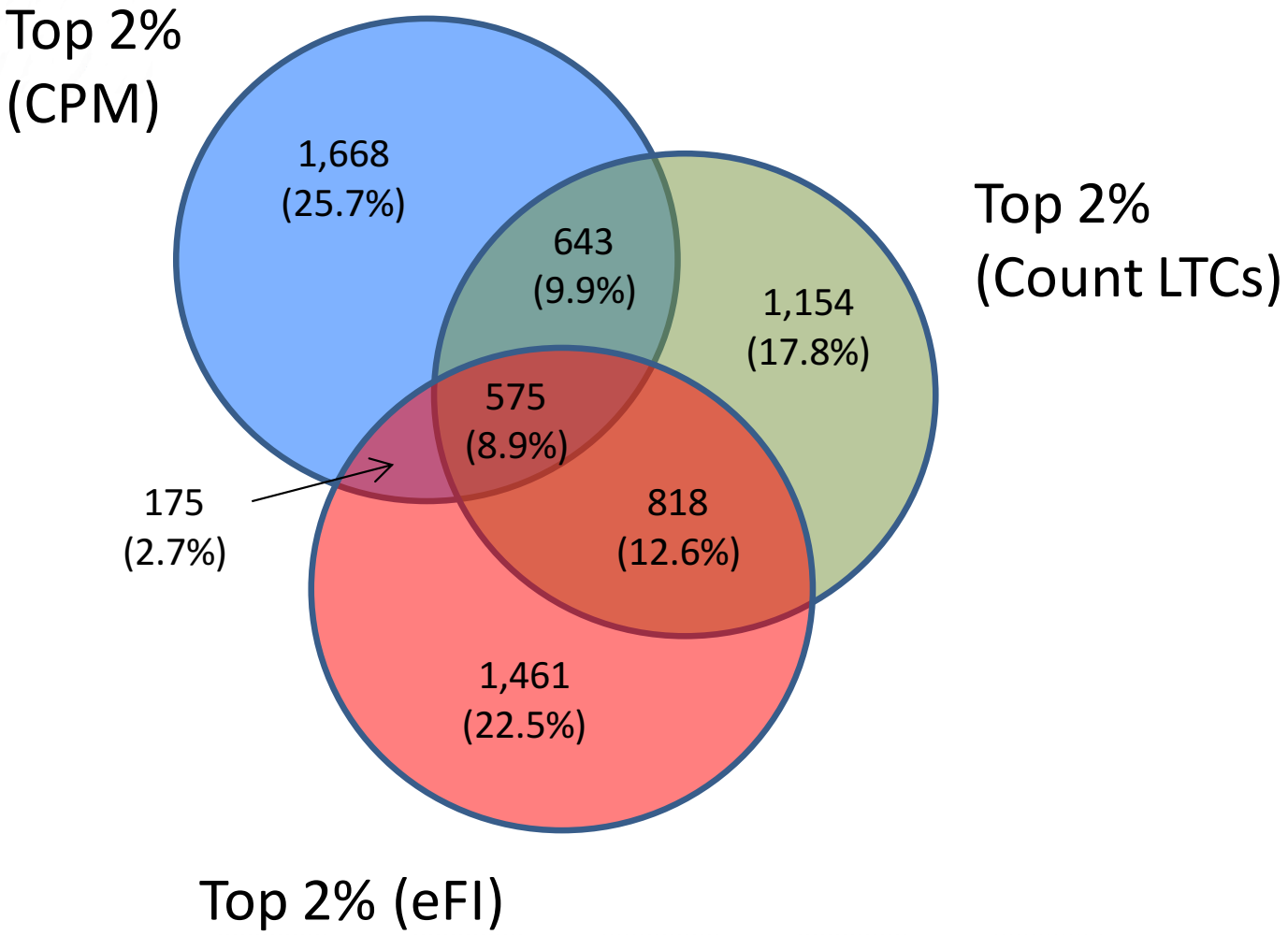
- Clinicians' knowledge of their practice population
- Identification following presentation (to primary or secondary care) with a 'frailty syndrome' e.g. delirium, fall
- eFI

Key assessment areas (BGS Fit for Frailty):

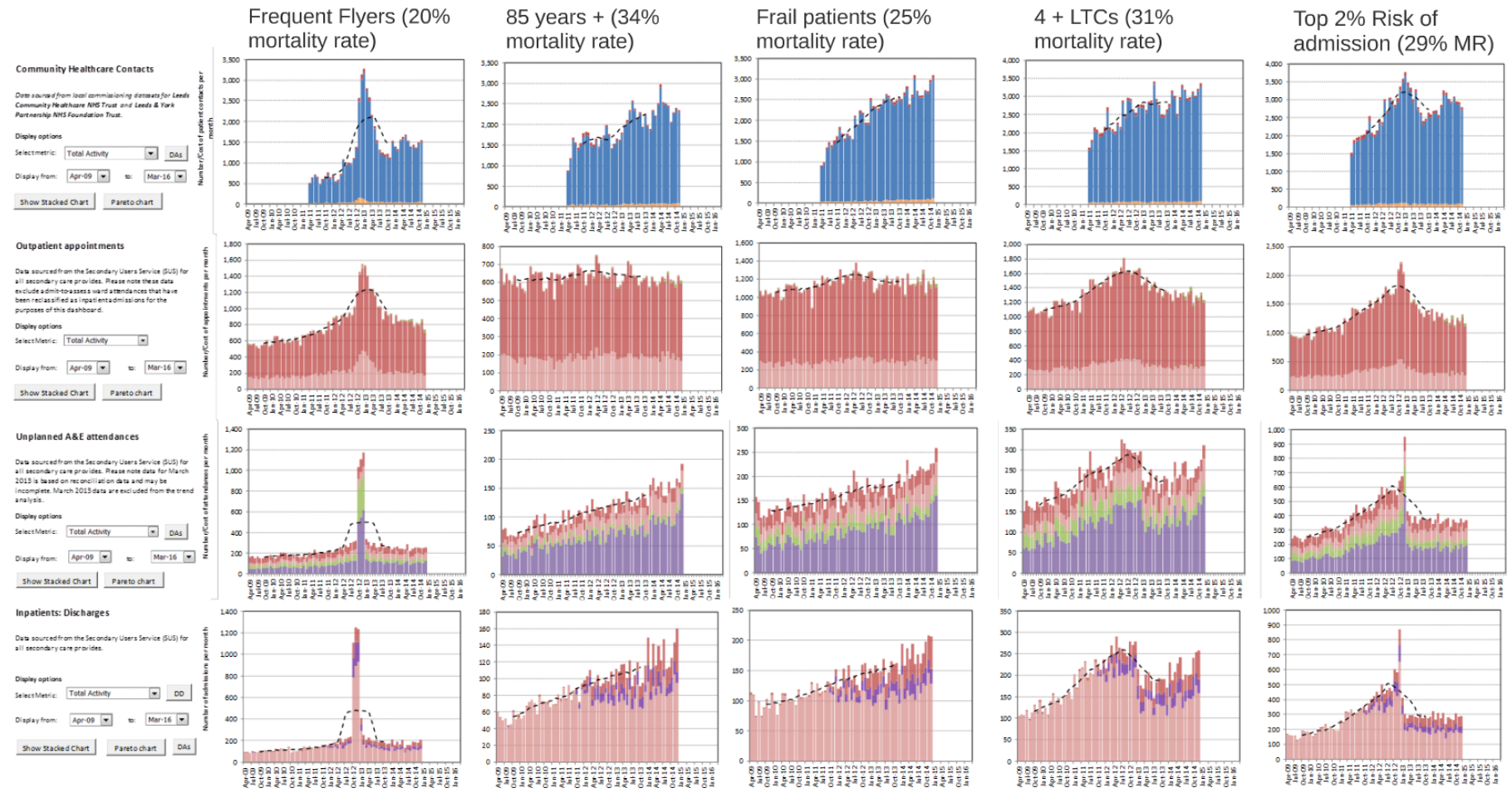
- Dementia
- Depression
- Nutrition
- Polypharmacy
- Falls risk
- Continence
- Vision and hearing
- Mobility and inactivity
- Alcohol and smoking
- Social isolation and loneliness

- Built a SystmOne eFI pt level report - calculates an eFI for every patient on the practice list

Leeds Intelligence Hub
Identifying Care Management Cohorts



Cohort Comparison



NHS Leeds North Clinical Commissioning Group

NHS Leeds South and East Clinical Commissioning Group

NHS Leeds West Clinical Commissioning Group

Leeds City Council

Leeds Integrated Dashboard: Patients with 7 or more deficits (eFI > 0.19)

Unplanned A&E attendances

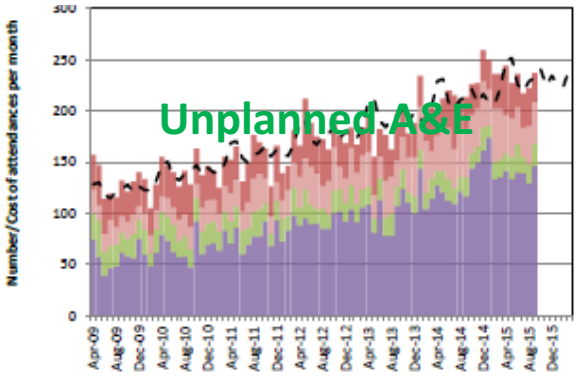
Data sourced from the Secondary Users Service (SUS) for all secondary care provides. Please note data for March 2013 is based on reconciliation data and may be incomplete. March 2013 data are excluded from the trend analysis.

Display options

Select Metric: Total Activity | DAs

Display from: Apr-09 to: Mar-16

Show Stacked Chart | Pareto chart



Inpatients: Discharges

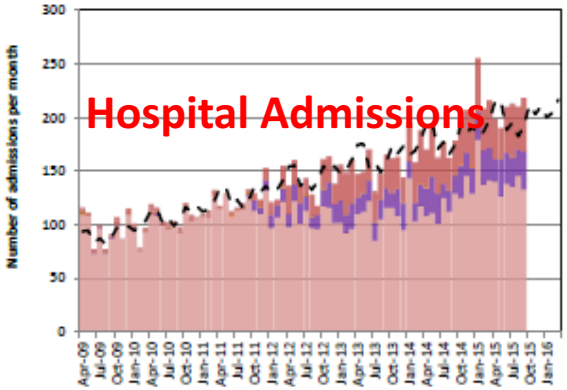
Data sourced from the Secondary Users Service (SUS) for all secondary care provides.

Display options

Select Metric: Total Activity | DD

Display from: Apr-09 to: Mar-16

Show Stacked Chart | Pareto chart | DAs



Readmissions/Caseload Analysis

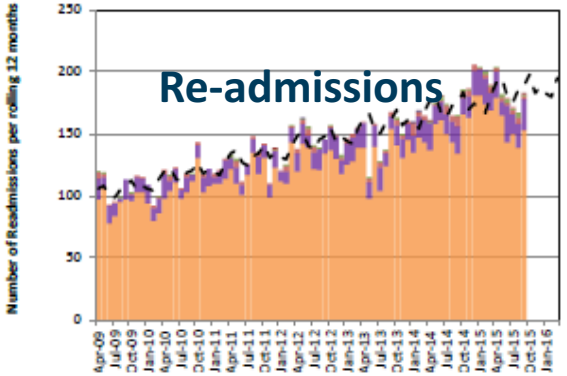
Data sourced from the Secondary Users Service (SUS) for all secondary care provides.

Display options

Select Metric: Number of Patients

Display from: Apr-09 to: Mar-16

Show IPRA Stacked Chart | Pareto chart



Adult Social Care Referrals, Assessments & Reviews

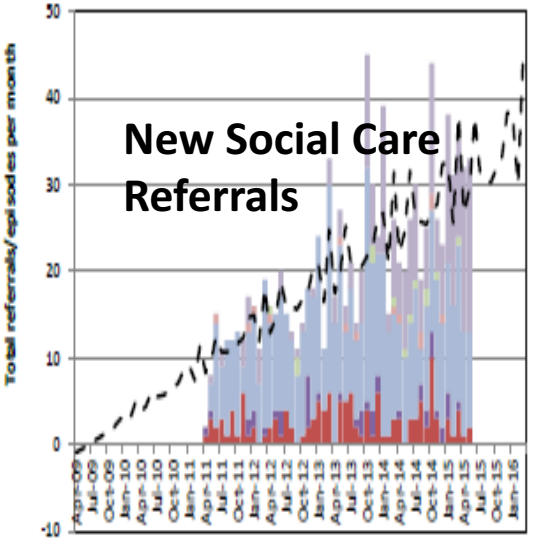
Data sources from Leeds City Council's ESCR record management system.

Display options

Select Metric: Total Activity

Display from: Apr-09 to: Mar-16

Show Stacked Chart | Pareto chart | DAs



Adult Social Care Commissioned Services

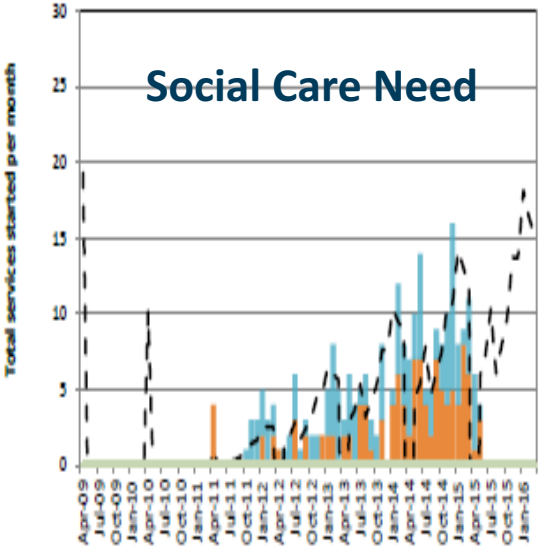
Data sources from Leeds City Council's ESCR record management system.

Display options

Select Metric: Monthly Activity | DDs

Display from: Apr-09 to: Mar-16

Show Stacked Chart | Pareto chart | DAs

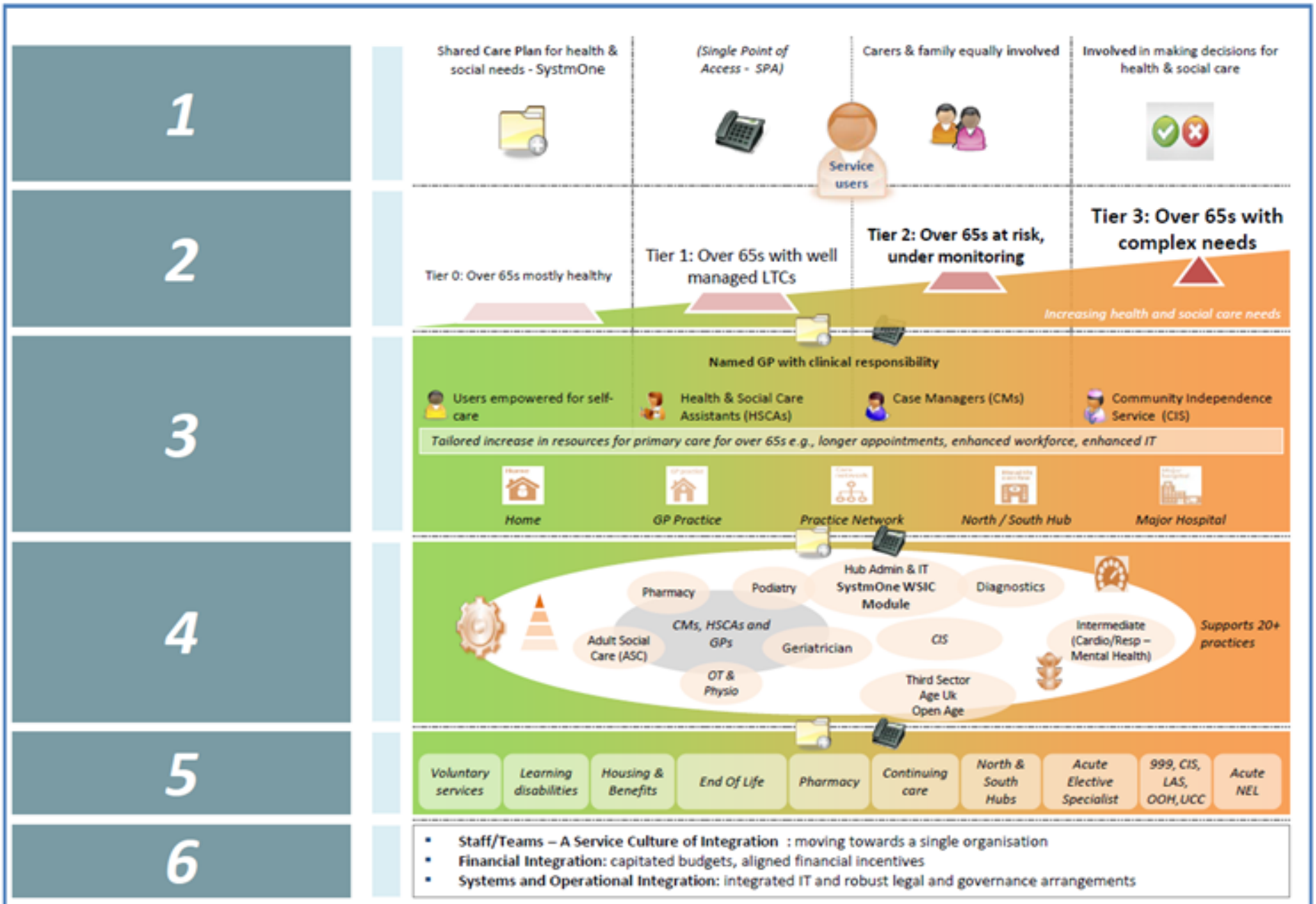


Leeds City Wide eFI Implementation

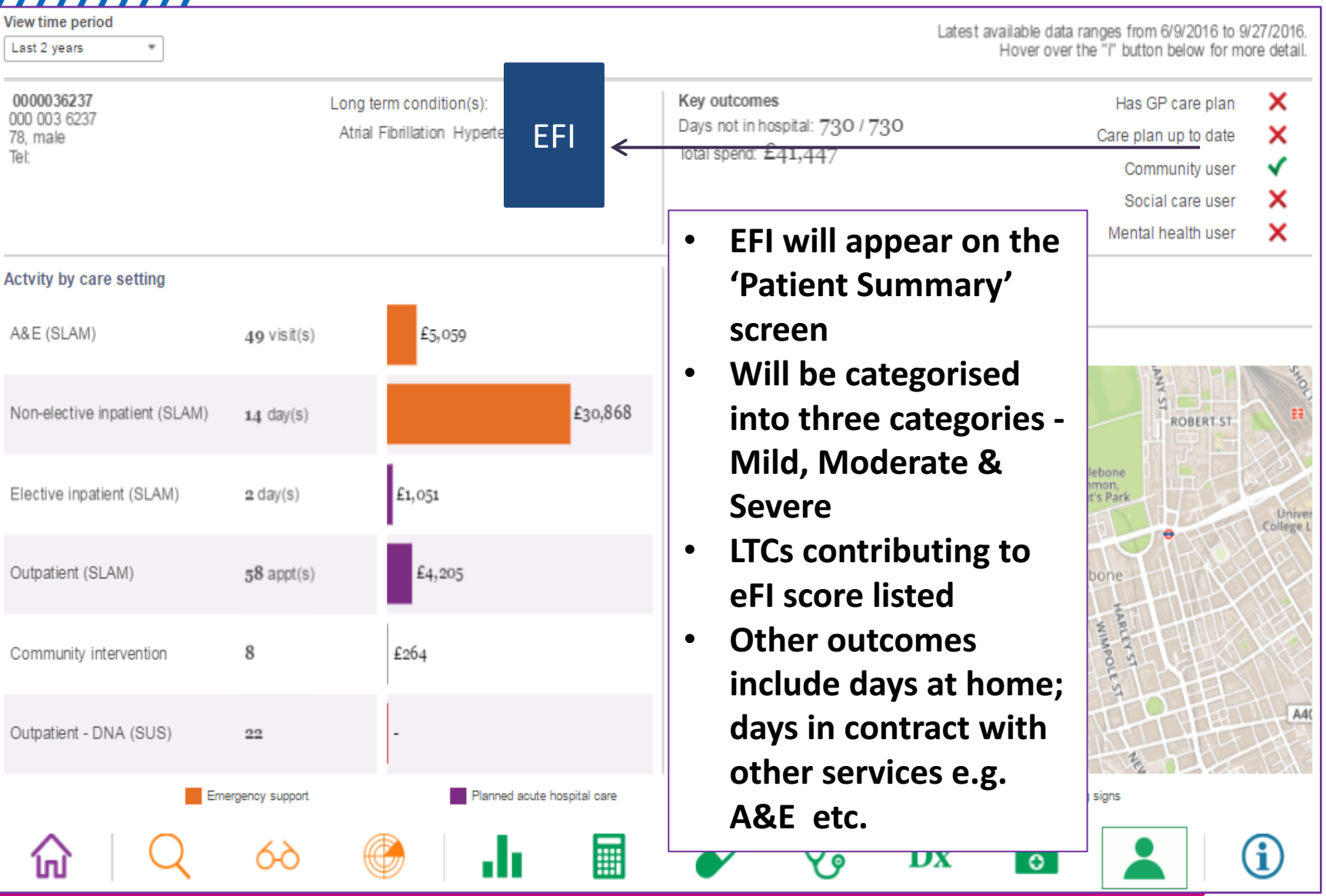
Using the eFI to stratify their populations according to need:

- **Healthy adults**
- **At risk** – asthma, smokers, obese, excess drinking (target for PH interventions)
- **Single LTC** – conditions from a single domain (i.e. if you had 3 cardiovascular conditions this would still be classed as one condition as could still be managed in same pathway)
- **Multiple LTCs** – conditions from 2 or more domains.
- **Frail** – using the eFI but they exclude the deficits related to long-term conditions so this group have impaired functional ability. The theory is care model for this group needs to be community based (even more so that multiple LTCs)

West London CCG Whole Systems Model of Care …… on one page



eFI in the NWL WSIC Dashboards



- **EFI will appear on the 'Patient Summary' screen**
- **Will be categorised into three categories - Mild, Moderate & Severe**
- **LTCs contributing to eFI score listed**
- **Other outcomes include days at home; days in contract with other services e.g. A&E etc.**

eFI Next Steps

- **Optimise eFI within EHRs**: SystmOne eFI patient level protocol; EMIS population level report

- Role of eFI in Secondary Care:
- **Cross –validation of eFI with HoW-CGA Frailty Index** (derived from HES) with Nuffield Trust; Acute Frailty Network collaboration
- **Aim:** to identify which evidence based frailty screening approach is best to use in which setting

- **eFI Revalidaiton: 55 deficit eFI**
- University of Leeds & University of Manchester research collaboration
- Will include mood deficits/mental health deficits
- Analysis will consider frailty in context of **co-morbidities/clusters of 'deficits'** and **reversible versus chronic 'deficits'**

Summary:
eFI Supporting the NHS England 5YFV

- **Helping to case find those at risk of frailty** i.e. breaking down barriers to support people with multiple health conditions
- **Support practices/CCGs & communities to choose effective new models of care options** which integrate out of hospital care, primary care & other community based providers
- **Supporting people living with mild frailty** i.e. self care offer
- **Facilitating partnership working between Voluntary Sector & Primary Care**
- **Optimisation of digital systems** to support high quality care

Contact Details

@Improve_Academy

@ImprovementAcademy

www.improvementacademy.org

t: 01274 383966

e: academy@yhahsn.nhs.uk

Improvement Academy
Part of the Yorkshire & Humber AHSN