The Care Closer to Home (CCH) and Frailty iCare Programme – progress update

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North East and North Cumbria

Joint Scrutiny Committee for the North of the ICS Patch

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The Care Closer to Home Frailty iCare Programme

Purpose:

The purpose of this report is to provide the Joint Scrutiny Committee with a progress update on the work of the Care Closer to Home programme of the North East & North Cumbria (NENC) Integrated Care System (ICS).

Introduction

The over-arching scope of the CCH programme of work is to support the local delivery of outcomes which look to ensure the provision of an improved range of Out of Hospital Services (including statutory, independent and voluntary sectors) with consistently high standards and improved patient satisfaction, that provide earlier intervention, better coordinated care, support independence and reduce the length of hospital stays.

The CCH work-stream has prioritised 'frailty' as an area of focus and has developed a 'Frailty Toolkit' for preventing frailty and supporting older people, families and communities living with frailty.

The ambition is to work more collaboratively across the wider health and care system to improve the quality of life for our aging population, whilst exploring the significant economic case for change.

The Impact of Frailty/the Case for Change

The presence of frailty, and its severity, correlates with poor outcomes, such as poor quality of life, institutionalisation, mortality and increasing cost to health and care systems.

Looking after the frail elderly is one of the biggest challenges facing primary care: GPs, dentists and community pharmacists.

Caring for the frail elderly also presents huge challenges to social care, housing and residential care providers and the whole spectrum of third sector services.

There is a spectrum of frailty from mild to moderate through to severe, ultimately leading to end of life.

Frailty is common amongst older adults, with the overall prevalence of frailty in people aged over 60 estimated to be around 14%. In England, there are 1.8 million people aged over 60 and 0.8 million people aged over 80 living with frailty. The prevalence of frailty increases with age, resulting in 5% of people aged 60-69 living with frailty and up to 65% of people aged over 90 living with frailty. Frailty is also considered more common in women (16% versus 12%).

The CCH approach

It is understood that local health and care systems will have, or will be developing, their own plans but the common vision for these plans should be to:

'Enable people and communities to look after themselves and remain well, independent and healthy but, when needed, offer care and support at or close to their homes, in a way that identifies issues early, resolves them quickly and prevents people going into hospital unnecessarily or supports them through transfers of care when needed'.

The CCH Frailty Project is seeking to facilitate efficiency through the sharing of knowledge, learning and evidence-based Good Practice and by providing support to local commissioners and providers. This is being delivered in several ways as summarised below:

- A regional frailty Toolkit is being developed (incorporating evidence-based approaches to care across the frailty journey, key resources and local examples of good practice).
- The Toolkit is underpinned by a dashboard of key outcome metrics.
- Local health and care economies will be able to benchmark existing care provision and metrics against others in the region, identify their priorities and then draw on the Toolkit to introduce new initiatives and improve the care and support they offer.
- A regional frailty 'Community of Practice' (CoP) has been established to drive the work forward, bringing together a wide range of professionals from across the regional health and care system, who understand frailty and older people's services.
- A Workforce competency framework has been developed for registered and non-registered staff working anywhere in the care system and plans are afoot for testing it in a variety of settings in the coming months. A longer term vision is for the development of an apprenticeship. A workforce lead 'CoPper' has been identified, supported by clinical leads and linked to the regional ICS workforce programme.
- The programme is also collaborating with local Universities as part of an ARC bid where Frailty has been chosen to be one of the key themes supported by 'evaluation CoPpers.
- Academics and librarians have agreed to support the evaluative methodology surrounding the toolkit and strengthen the presentation of supporting evidence.

- A simple web-based digital platform for the Frailty Toolkit has been set up.
- Working in partnership with Newcastle Hospitals Trust, we have been successful in securing funding from Health System Led Investment in Provider Digitisation over the next 3 years to support digitisation of the Frailty ICARE work. Three digital projects are underway which look to support our regional CoP, the Frailty ICARE website and a patient-facing pathway.
- We are also working to support the regional digital access portal.

Next steps:

- To continue to develop the Frailty Toolkit to offer a region-wide common understanding of frailty and establish a supportive way for learning and sharing best practice to support local health and care system planning.
- To continue to facilitate and support a region-wide CoP, where initiatives are shared, learning and recommendations agreed, plans made for wider sharing through local forums and the Toolkit kept iterative.
- To take advantage of digital solutions to further enhance the technological platform for the Frailty Toolkit and frailty CoP to better facilitate access through the implementation of the DCJS-funded Projects.
- To support the reduction in financial costs, time spent and resource utilisation across the health and care system by: improving current practice, streamlining and aligning services to avoid duplication, thereby working more efficiently and cost effectively whilst improving patient experience.
- To work across the whole health and care system: to support carers and family members taking a 'whole family' approach and to support people with daily living tasks, promoting independence and the ability to live at home for as long as possible.
- To explore potential integration of services and shared pathways of care.

Conclusion:

The work of the CCH programme and the focus on frailty is generating a huge amount of interest and enthusiasm both locally and nationally. The approach to this work and specifically the Frailty Toolkit and Community of Practice has real potential to support and facilitate both local and 'at scale' transformation.