Healthy Ageing in Torbay

Torbay Health & Wellbeing Board
28 January 2020

Content

We will cover:

- **Ageing Well Torbay – progress & legacy**
- **Age-Friendly Torbay – plans & timetable**
- **Enhanced Health in Care Homes – local update**
- **Frailty and Falls – update on STP programme**

Ageing Well Torbay – progress & legacy

Ageing Well Torbay

Building Community

Connecting people and place to build community and reduce social isolation

Torbay Community Development Trust
www.torbaycdt.org.uk info@torbaycdt.org.uk

AGEING WELL TORBAY

Our six year project, funded by the **National Lottery Community Fund**, which aims to reconnect communities and reduce social isolation amongst the population of people over 50 across Torbay.

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AGEING WELL TORBAY

Ageing Well Torbay is part of **Ageing Better**, a programme set up by **The National Lottery Fund** the largest funder of community activity in the UK.

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AGEING WELL TORBAY

The sheer scale of the potential is limitless. Across the whole programme we have worked with

4,061 people

1ncluding **1,609** isolated people

In our first 4 years.
These numbers will have increased by the time you read this.

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AGEING WELL TORBAY

46%

Loneliness rates have dropped across all the measures we use.

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Self reported visits to GP has reduced by

32%

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59%

of people report improvements in mental well being from entry to follow up.

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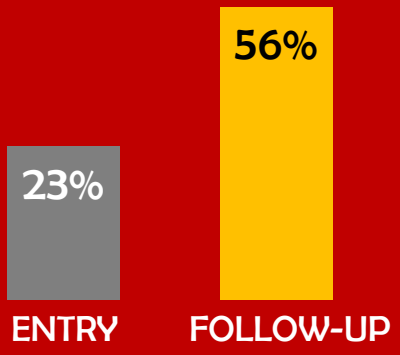
AGEING WELL TORBAY

People's ability to use their expertise to benefit their community



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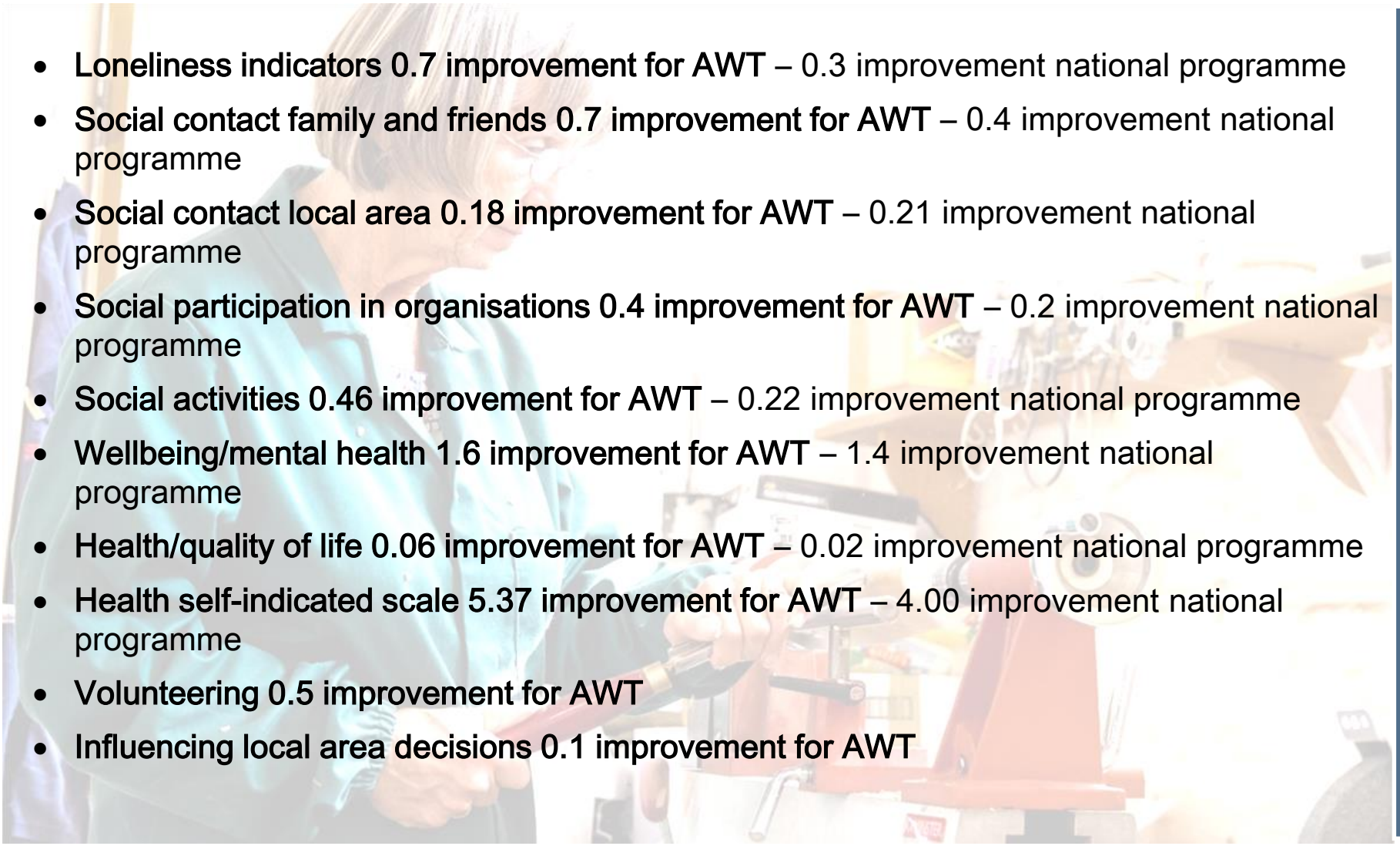
AGEING WELL TORBAY

Ageing Well Torbay						
TORBAY Ecorys statistics summary, sample = 1299 isolated people, Female = 843, Male = 421, 31/12/2019						
ALL PROGRAMMES Ecorys statistics summary, sample = 33,382 isolated people, Female = 21,587, Male = 10,011, 31/12/2019						
Category	**IV**	**NV**	**% Improvement**	**Entry Average**	**Follow-up Average**	**Points Improvement**
Social Isolation and Loneliness De Jong	**3.8**	**3.1**	**-18.42**	**3.8** (3.2 ALL)*	**3.1** (2.9 ALL)*	**0.7** ↓ (0.3)*
Social Isolation and Loneliness UCLA	**6.1**	**5.4**	**-11.48**	**6.1** (5.5 ALL)*	**5.4** (5.1 ALL)*	**0.7** ↓ (0.4)*
Social Contact - children, family or friends	**3.23**	**3.48**	**7.7399**	**3.23** (3.29 ALL)*	**3.48** (3.40 ALL)*	**0.25** ↑ (0.11)*
Social Contact - local area, speak to non-family member	**6.89**	**7.07**	**2.6125**	**6.89** (6.66 ALL)*	**7.07** (6.87 ALL)*	**0.18** ↑ (0.21)*
Social Participation - membership of clubs, organisations and societies	**1.1**	**1.5**	**36.364**	**1.1** (1.1 ALL)*	**1.5** (1.3 ALL)*	**0.4** ↑ (0.2)*
Social Participation - How often taking part in social activities compared to others of your age.	**1.24**	**1.7**	**37.097**	**1.24** (1.48 ALL)*	**1.7** (1.7 ALL)*	**0.46** ↑ (0.22)*
Wellbeing - Mental health SWEMWBS (short version)	**20.6**	**22.2**	**7.767**	**20.6** (21.4 ALL)*	**22.2** (22.8 ALL)*	**1.6** ↑ (1.4)*
Health - Quality of Life EQ-5D-3L (five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression)	**0.48**	**0.54**	**12.5**	**0.48** (0.61 ALL)*	**0.54** (0.63 ALL)*	**0.06** ↑ (0.02)*
Health - EQ VAS (self-indicated - "worst possible" to "best possible" health)	**61.94**	**67.31**	**8.6697**	**61.94** (62.94 ALL)*	**67.31** (66.94 ALL)*	**5.37** ↑ (4.00)*
Volunteering	**1**	**1.5**	**50**	**1**	**1.5**	**0.5** ↑
Influencing - personally influence decisions that affect your local area	**2.4**	**2.5**	**4.1667**	**2.4**	**2.5**	**0.1** ↑
Participants in AWT programme				**8467**		
Volunteers in AWT Programme				**2016**		
* ALL 14 Programmes						



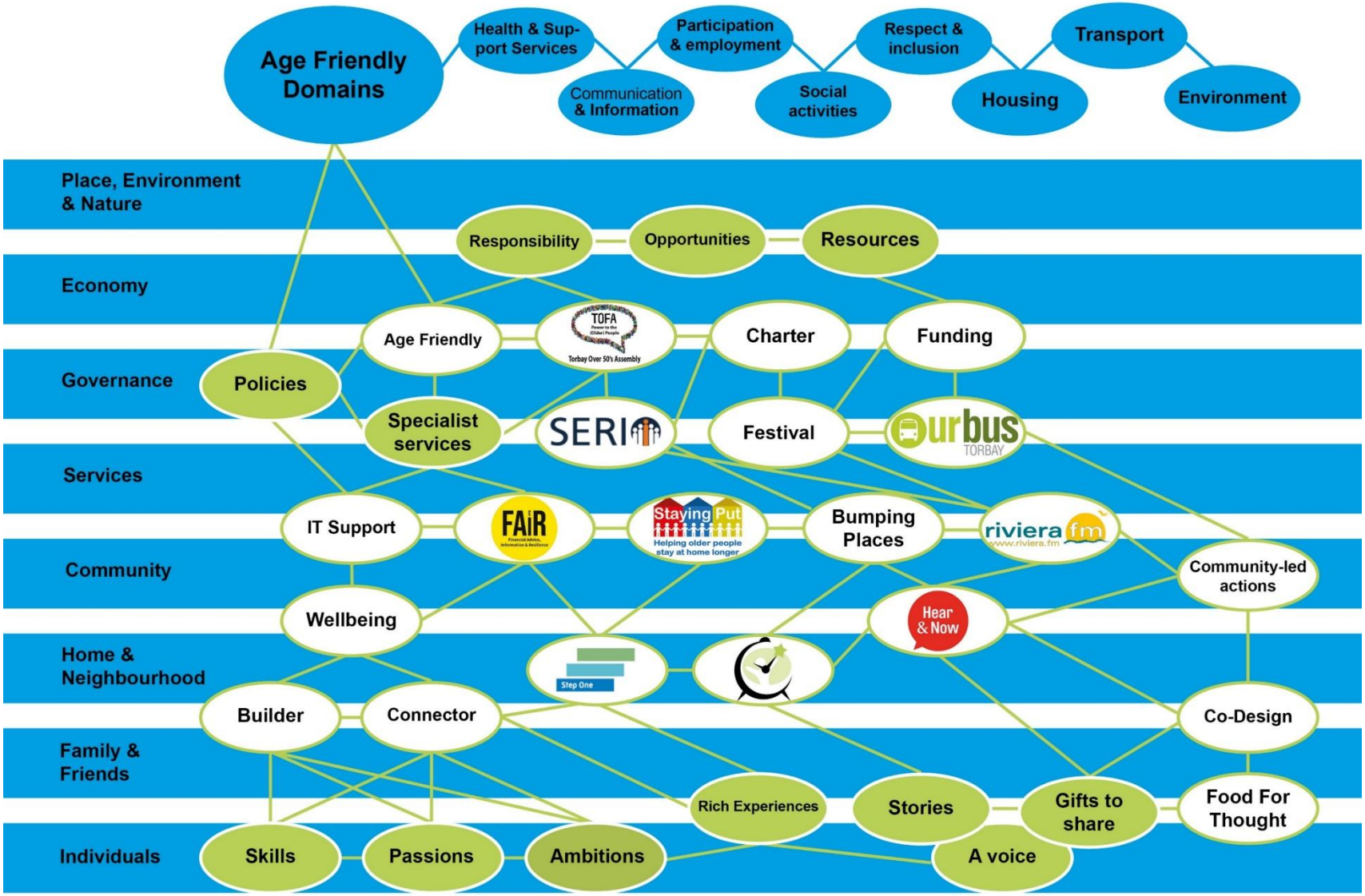
- **Loneliness indicators 0.7 improvement for AWT** – 0.3 improvement national programme
- **Social contact family and friends 0.7 improvement for AWT** – 0.4 improvement national programme
- **Social contact local area 0.18 improvement for AWT** – 0.21 improvement national programme
- **Social participation in organisations 0.4 improvement for AWT** – 0.2 improvement national programme
- **Social activities 0.46 improvement for AWT** – 0.22 improvement national programme
- **Wellbeing/mental health 1.6 improvement for AWT** – 1.4 improvement national programme
- **Health/quality of life 0.06 improvement for AWT** – 0.02 improvement national programme
- **Health self-indicated scale 5.37 improvement for AWT** – 4.00 improvement national programme
- **Volunteering 0.5 improvement for AWT**
- **Influencing local area decisions 0.1 improvement for AWT**

How it works

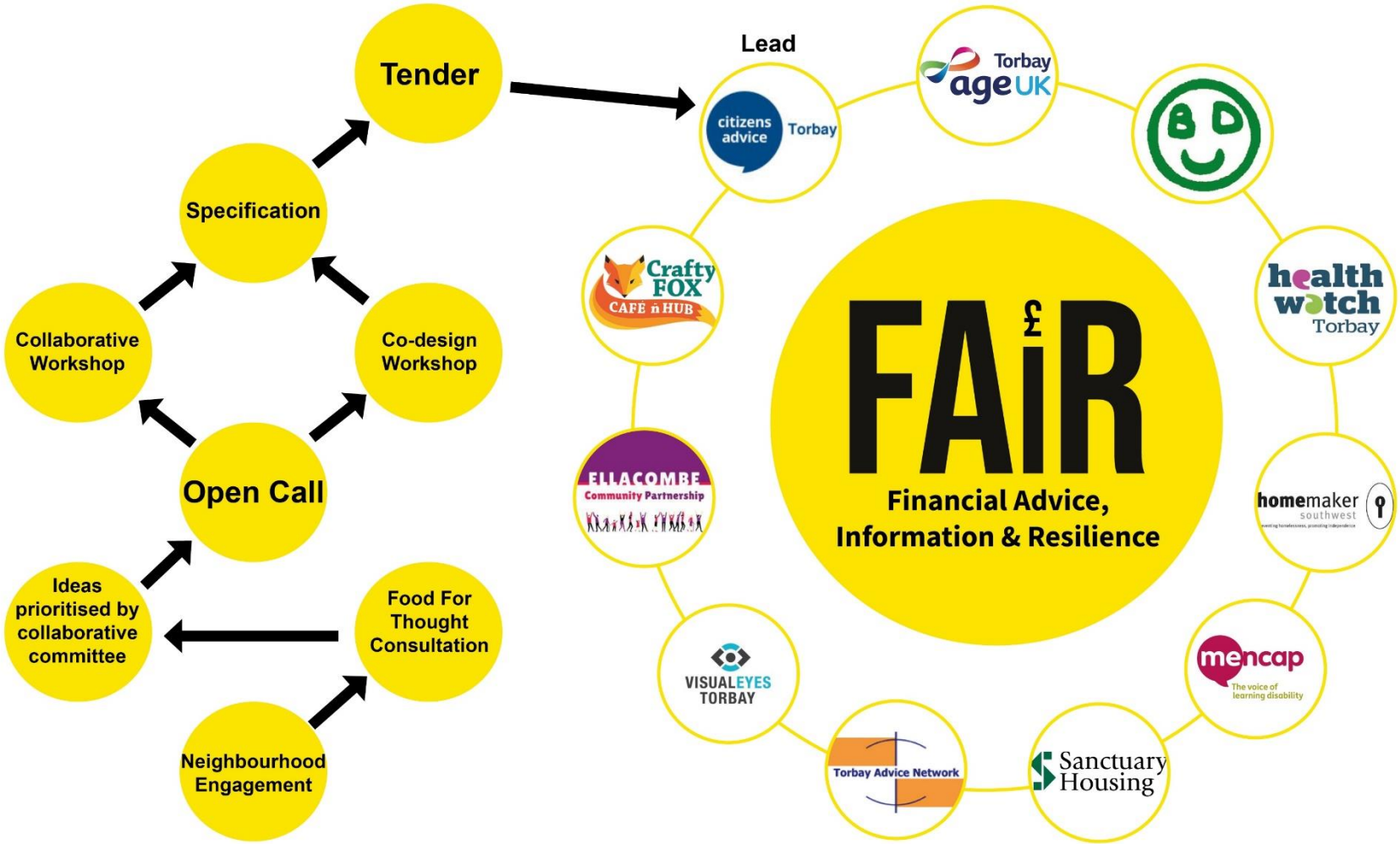
Asset mapping
Consultation
Codesign
Community lead actions
Meeting and bumping spaces

Collaborative commissioning
Peer support
Partner networks
Assemblies/forums
Learning
Celebrating

Ageing Well Torbay – How it works



Collaborative Commissioning



Staying Put - Consortium of Partners

Healthwatch,
Age UK, Ellacombe Community

Staying Put
Helping older people stay at home longer

Connectors

Our community building enabled us to identify 1,487 Community Connectors in 4 years. Connectors are central to Community Building. While other models of community development do to, for or with people, ABCD is of the people.

Timebank

We have created 13 Neighbourhood Timebanks with 425 members, exchanging 10,995 hours. We still need to make people feel it is OK to ask for others time.

Timebank

TORBAY TOGETHER

Torbay Together the sharing website.

Helping you find and share activities, information and skills in Torbay.

Working with the Torbay Together Strategic Partnership

www.torbaytogether.org.uk

Torbay Community Development Trust

Developing stronger communities by:

supporting people

supporting groups to thrive

making connections & stimulating co-operation by bringing people together

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Ageing Well Torbay – Impacts

The potential is limitless.
Through our Community Building work we have identified

1,487
connectors/good neighbours and worked with

1,609
isolated people In our first 4 years.
These numbers will have increased by the time you read this.

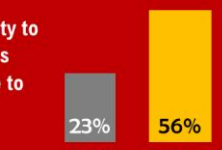
Our communities are shifting back into a space where they can see opportunities to get on with things themselves.

600 groups and activities mapped to date, **250** new citizen-led activities stimulated.

84% increase in the proportion of participants talking to neighbours or others in their community.

We have found the hard to reach - and kept them found.

People's ability to use their skills and expertise to benefit their community.



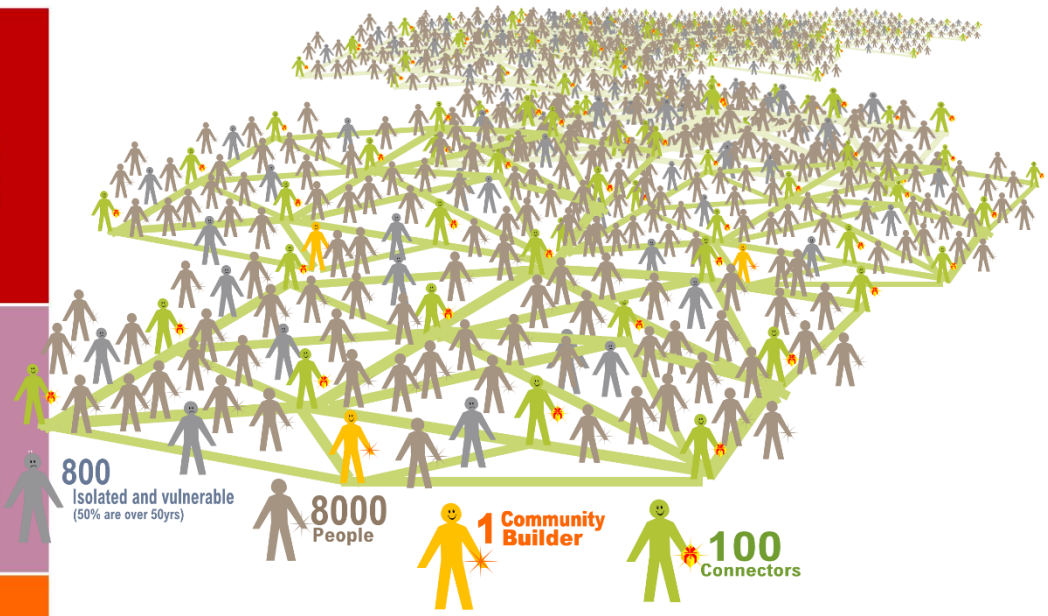
46%
*Loneliness rates have dropped

Our Community Builders find 'places of welcome'. We 'mystery shop' cafes, pubs, hang out areas, shops, community centres – anywhere where people have the chance to interact. In some communities there aren't enough of these 'bumping places' - so we have helped the community create their own.

44%
increase in valued friendship.

Self reported visits to GP have reduced by
32%

59%
of people report improvements in mental well being through being involved.



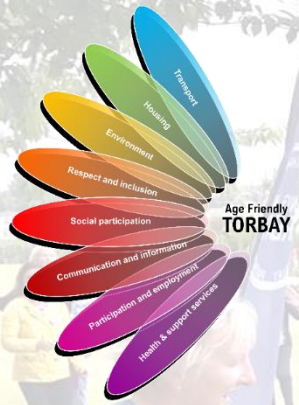
'Making genuine friends, many living alone and feeling isolated, we now know we can contact each other - whether we need to talk, help in an emergency, help on a practical level or would like some company. These are the important things.' *Julia*

All statistics about our work have been provided through a collaboration with our participants, staff, SERIO Plymouth University and Ecorys Lottery appointed evaluators.

*Based on the 6-item De Jong Gierveld Loneliness Scale measuring overall, emotional, and social loneliness .

Age-Friendly Torbay – what will it mean for us?

Age-Friendly Global Initiative

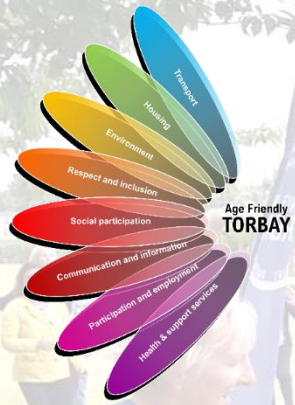


WHO Global Network for Age-friendly Cities and Communities

CENTRE FOR AGEING BETTER

- A global initiative
- Create **a world in which everyone can live a long and healthy life**
- Lead by he WHO lead on the global initiative - **WHO Global Network for Age-friendly Cities and Communities.**
- 900+ Cities and Communities, 14 Network Affiliates, 41 Countries covering 230 Million People
- **We joined UK Network for Age-friendly Communities** in January 2019 (currently 36 communities in UK).
- The overarching aim is a society where everybody enjoys a good later life and by 2040, we want more people in later life to be in **good health, financially secure, to have social connections and feel their lives are meaningful and purposeful.**

Age-Friendly Domains

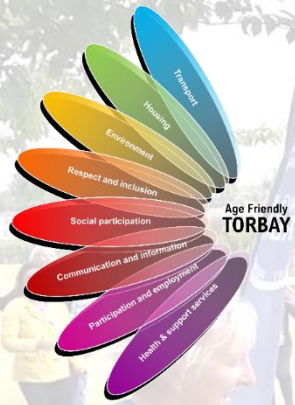


WHO Global Network for Age-friendly Cities and Communities

CENTRE FOR AGEING BETTER

- Health and community support services
- Communication and information
- Participation and employment
- Social participation
- Respect and inclusion
- Housing
- Transport
- Environment: Outdoor spaces and buildings

Age-Friendly WHO Application



WHO Global Network for Age-friendly Cities and Communities

CENTRE FOR AGEING BETTER

- A letter from our community leader (Steve Darling)
- Application form, which includes
- Baseline data survey (already done for AWT over 2015/2016)
- Summary of age-friendly actions (there is a meeting on 21 Jan for representatives of council, NHS, TCDT and community (TOFA) to start to compile a summary from 2015 to 2019 - AWT initiatives will be part of this)
- A three year action plan developed by steering committee (we are hoping to get a regular group meeting on a monthly basis to prepare the action plan). AWT has created a template
- A commitment to provide image and story of one of our initiatives at least once a year.
- Our aim would be to achieve membership by Sept/Oct 2020 to be announced at the AWT festival.

Enhanced Health in Care homes – implementation in Torbay

The Enhanced Health in Care Homes framework – learning from vanguards & integrated care systems

Jacquie Phare – system Director nursing and Professional practice (Torbay) TSDFT

Slides from EHCH conference Nov 2018. Dr Ned Nay**lor**

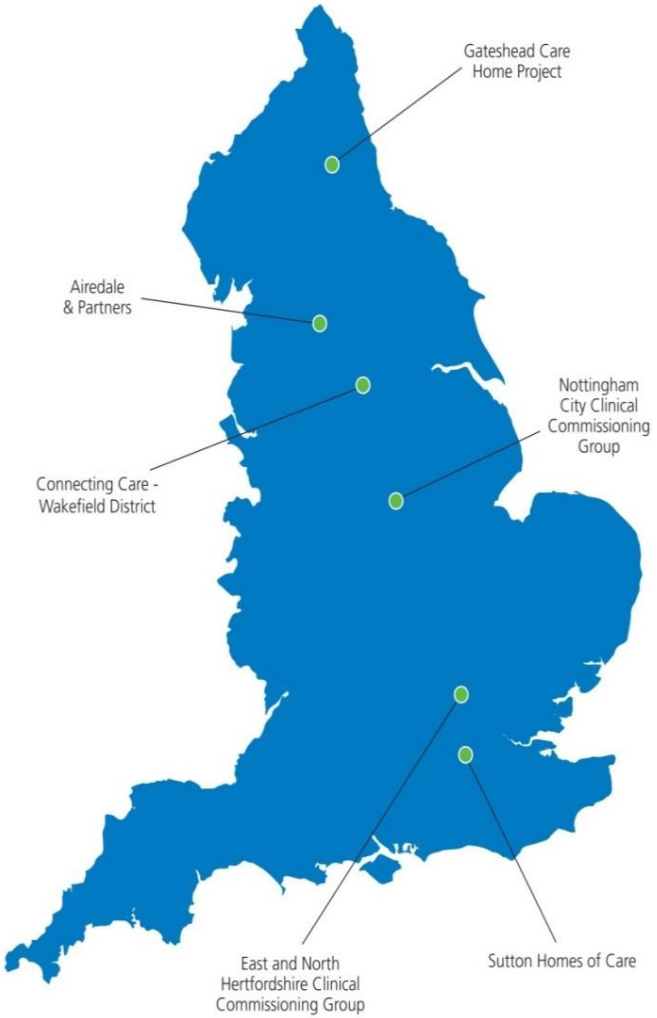
Deputy Director
System Transformation Group
NHS England
& Emma Self EHCH event 29 January 2020 Community Nursing Lead and Delivery and Policy Lead for EHCH
NHS England and NHS Improvement

Torbay Health and Well Being Board 28 January 2020

The care home population

- Approx 330,000 care home residents in England, with one in seven people over 85 living in a care home and growing
- Care home residents are a frail, vulnerable population with increasingly complex needs
- We know that while some residents get fantastic care, others don’t
- Care homes residents are admitted to hospital around 250,000 times each year, with 35-40% admissions potentially avoidable
- There are approximately three times as many care home beds as NHS beds in England, with the sector under significant pressure

Enhanced Health in Care Homes – the Vanguard ‘Care Home 6’



- **Six sites across the country**
- **Providing joined-up primary, community and secondary, social care to residents of care/ nursing homes and Extra care Living Schemes**
- **Integrated care across a place and population**

EHCH framework – elements and timecales

Care model element	Sub-element	Time to implement
Clinical elements		
1. Enhanced primary care support	Access to consistent, named GP and wider primary care services	< 1 year
	Medicines reviews	< 1 year
	Hydration and nutrition support	< 1 year
	Out of hours/emergency support	< 1 year
2. MDT in-reach support	Expert advice and support for those with the most complex needs	1 year – 2 years
	Helping professionals, carers and those with support needs to navigate the local system	1 year – 2 years
3. Reablement and rehabilitation to promote independence	Aligned and effective rehabilitation and reablement services	< 1 year
	Developing community assets to support resilience and independence	1 year – 2 years
4. High quality end of life care and dementia care	End of life care	< 1 year
	Dementia care	< 1 year
Enabler elements		
5. Joined-up commissioning and collaboration between health and social care	Co-production with providers and networked care homes	< 1 year
	Shared contractual mechanisms	1 year – 3 years
	Access to appropriate housing options	1-5 years
6. Workforce development	Training and development for care staff	< 1 year
	Joint workforce planning	1 year – 2 years
7. Harnessing data and technology	Linked health and social care data sets	1-3 years
	Access to care record and secure email	< 1 year
	Better use of technology	1-3 years

EHCH Care Model Framework

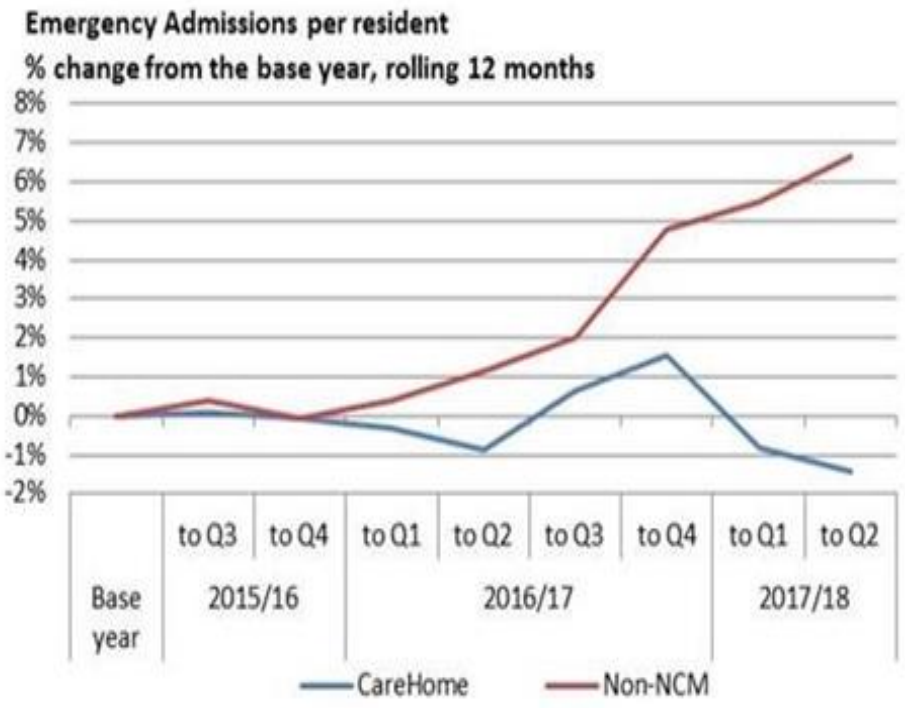
- **The Enhanced Health in Care Homes (EHCH) framework was published September 2016**
- **Based on the common coordinated interventions being delivered in the vanguards**
- **Significant research base to support the model**
- **Aims to describe the care model and describe plan for spread**
- **Care model has seven core elements and 18 sub elements**
- **Clear signal to spread the care model**

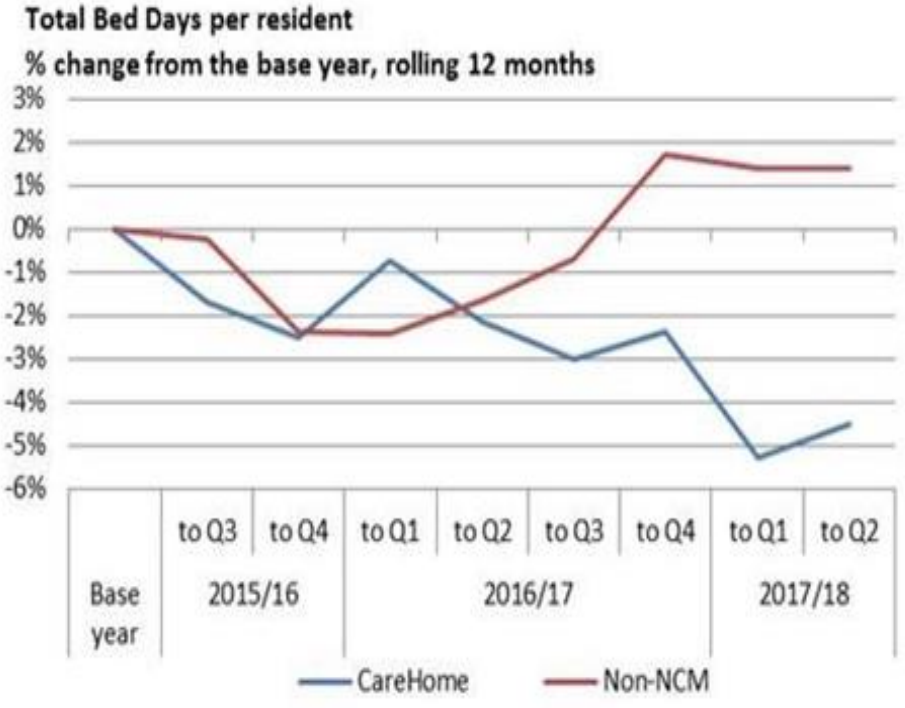
Real impact for people

- **Red bag**
- **Portrait of a Life**

- **Faster access to the right care, from a range of professionals**
- **Care from a team that residents and their families know**
- **Better coordination and information sharing among people providing care**
- **Better-supported care homes staff**
- **Fewer trips to hospital**

Impact for systems

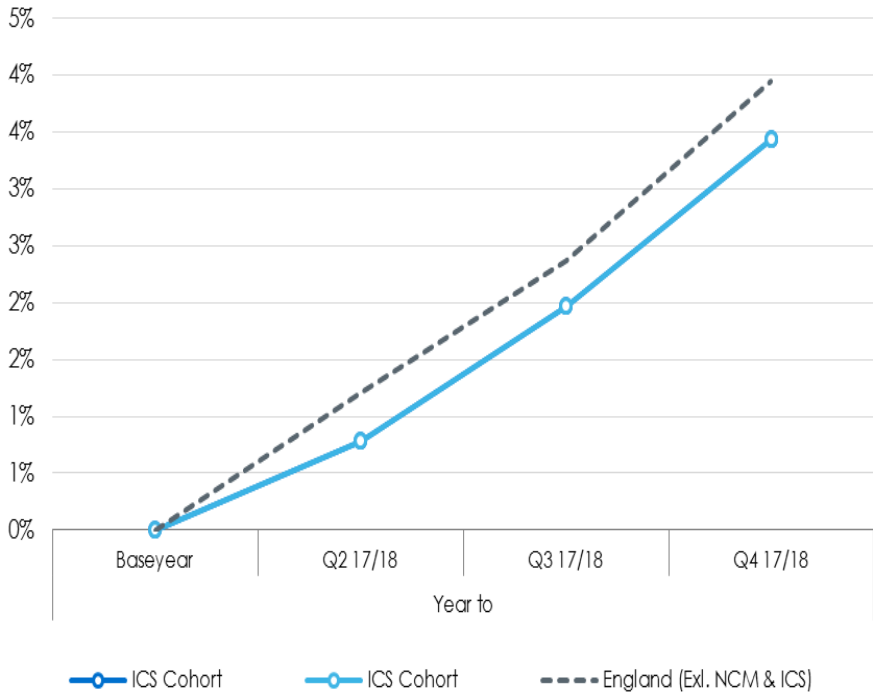




Impact for systems

Emergency admissions per resident per year

Rolling 12 month average - % Change from yr to Q1 2017/18

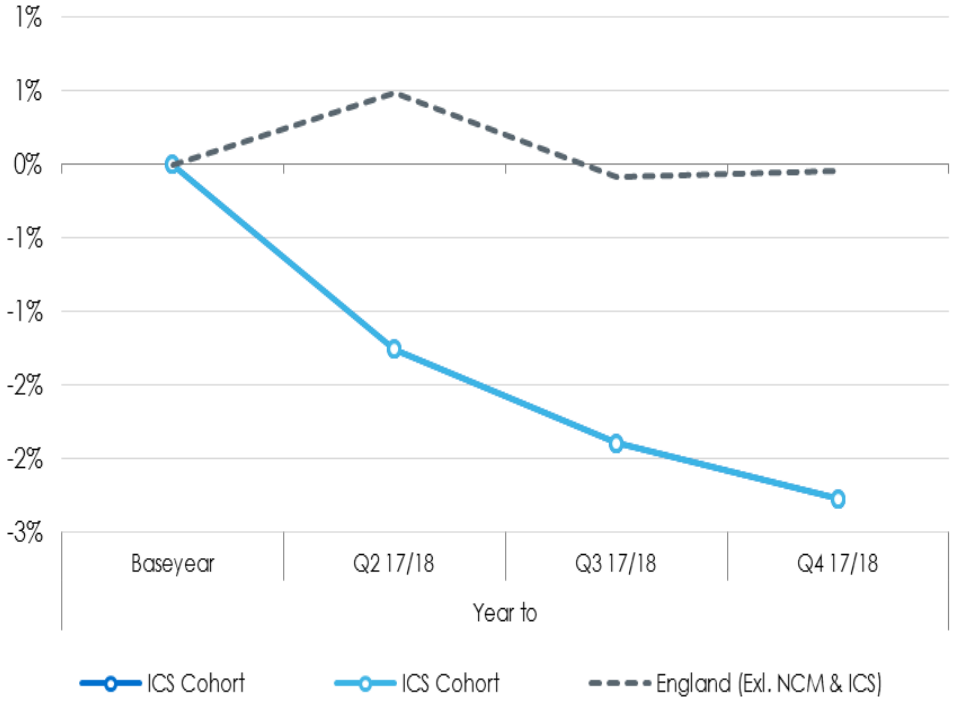


ICS Cohort	0%	1%	2%	3%
England (Exl. NCM & ICS)	0%	1%	2%	4%

*Data pending QA

Total bed days per resident per year

Rolling 12 month average - % Change from yr to Q1 2017/18



ICS Cohort	0%	-1%	-2%	-2%
England (Exl. NCM & ICS)	0%	0%	0%	0%

*Data pending QA

EHCH framework refresh

- Original framework published 2016
- Refresh commenced June 2019, complete January 2020
- Wide range of stakeholders
- Drawing on the experiences of the Communities of Practice

- Givens:
  - light touch
  - can add sub-elements if wished
  - models to be developed locally based on the evidence in the framework

Proposed additional sub elements nationally

- Oral Health
- Falls, balance and strength
- Mental Health
- Flu prevention and management
- Continence promotion and management
- Wound care/pressure ulcer prevention

Commissioned supporting infrastructure

- Directed Enhanced Service (DES) from 2019/20:
  - National addition to the core GP contract
  - Year 1: form Primary Care Networks, with clinical directors, clinical pharmacists, social prescribers & extended opening
  - Year 2: delivery of five service specifications
  - Year 3: two more service specifications
- First community services core standard specification:
  - what community services should deliver to support Ageing Well and the Long Term Plan
  - A national community service spec has not been issued before

Next steps nationally

- Draft framework near finalised
- Awaiting detail of Primary Care Network specification for EHCH
- National team recruitment ongoing
- Linking in formally to regional teams to agree monitoring and reporting
- Services locally commissioned to support delivery
- Quality Improvement focus from Ageing Well and Patient Safety Collaborative

Local developments and 2020 plans

- An EHCH delivery Group was set up in September 2019 across the Torbay and South Devon footprint with a range of stakeholders
- A benchmarking gap analysis has been completed against the 7 elements & 18 sub elements
- Five key areas of work have been agreed including:
  - ✓ Using information to support care homes
  - ✓ Specialist support to care homes
  - ✓ Implementing RESTORE2
  - ✓ Education and Training
  - ✓ Personalisation for care home residents
- Launch event with 170 delegates 29 January

Frailty & Falls – implementation of the STP workstream

What is frailty?...

Frailty is a gradual diminution in reserves, leaving us vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication or environment.

Frailty describes a group of people at highest risk of adverse outcomes such as falls, disability, admissions to hospital, or the need for long term care.

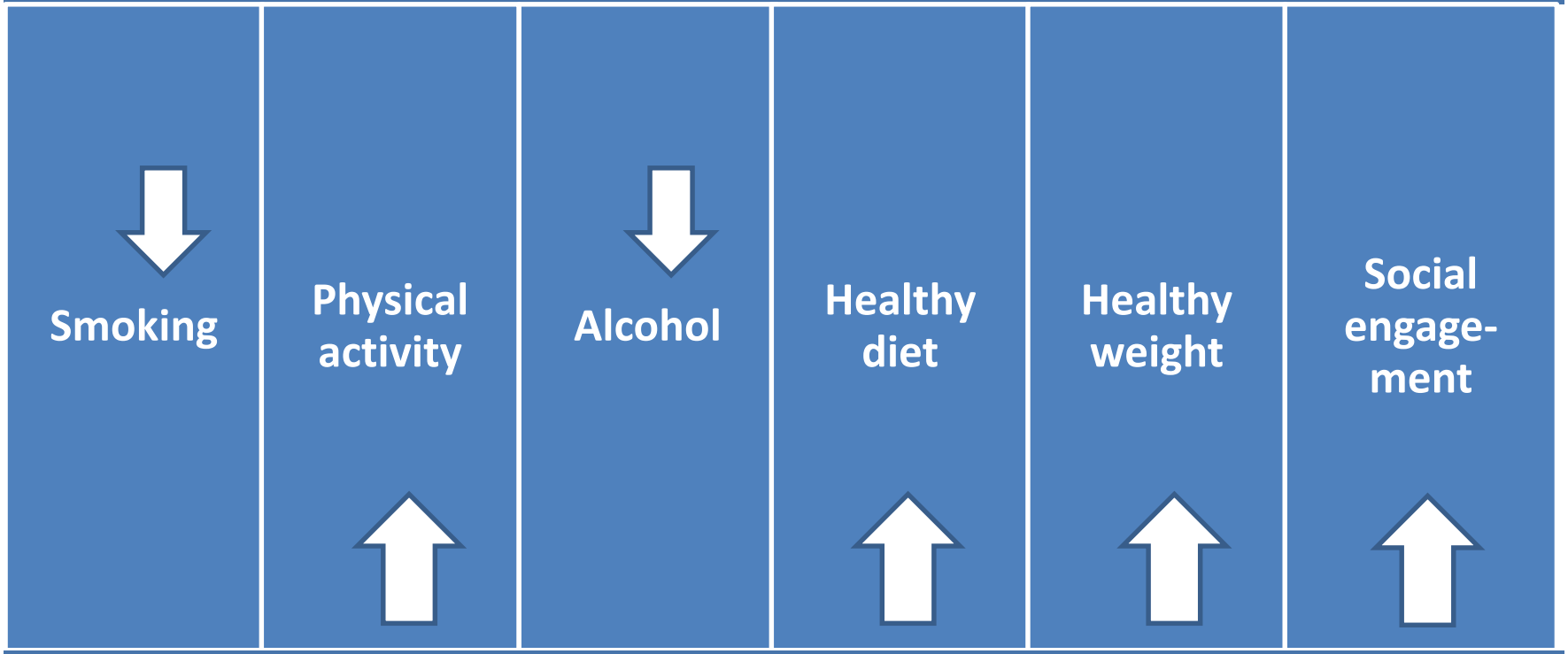
[NHS England 2013]

Key facts

- Frailty is age-related but onset & deterioration may be delayed
- First signs can appear at a relatively young age
- Slow progression; large window of opportunity to act
- Frailty is the strongest predictor of system activity & costs
- Disability, wellbeing and social factors are as important as medical conditions – high association with social isolation / loneliness
- Higher reported frailty in females
- Housing type is a major predictor of frailty
- Earlier onset in more deprived areas – 10-15 years difference across Devon

What does the evidence say we should be doing?

Population level prevention



Identification & Assessment

Comprehensive Geriatric Assessment

'was found to increase the likelihood of being alive, and reduce the likelihood of needing long-term care, after an emergency admission' [NHSE 2014]

Interventions for people living with severe frailty

- Comprehensive assessment
- Shared care & support plan
- High quality nursing or residential care as & when needed
- Link on to end of life care & ACP

Interventions for people living with moderate frailty

'Living well with co-morbidities'

- Case finding
- Comprehensive assessment & follow up
- (Shared) care plan
- Reduced polypharmacy
- Falls prevention (assessment, medication, strength & balance)
- Carer assessment & signposting
- Home adaptation & assistive technology

Interventions for people living with mild frailty

'Living well with simple or stable long-term conditions'

- Identification
- Primary prevention measures
- Optimised treatment & self-management
- Falls prevention (assessment, medication, strength & balance)
- Goal orientated physical exercise & cognitive activity
- Improving social connectedness
- Social prescription / signposting to self-care

Interventions to prevent or delay frailty

We should be developing:

- *group based physical interventions*
- *with a social interaction component*
- *and possibly some cognitive intervention*
- *+ public health approaches*

How will we achieve this in Devon?

What is our vision?

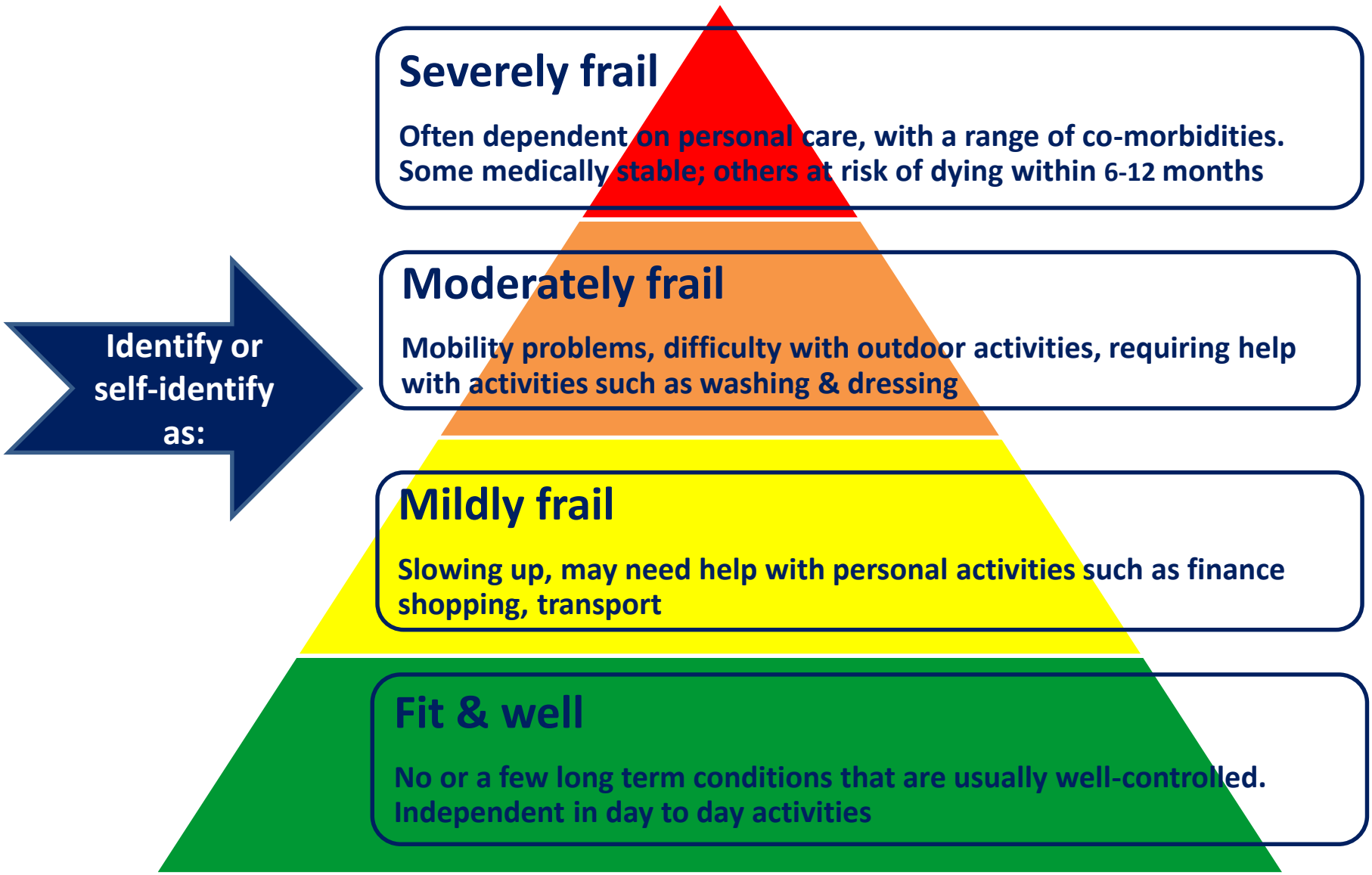
Healthy ageing…

People in Devon live into older age with high levels of health and wellbeing. They live independently as long as possible, in a dwelling of their own choice.

Devon Frailty and Falls Prevention STP

Identifying the target population

Level	Tool/s	Who
Individual	Rockwood Clinical Frailty Scale	Core & wider workforce
Cohort	Practice frailty identification system	General practice team
Population	Online information / questionnaires Promotional or social marketing campaigns	Self-identification - general population 55+ supported by: Active Devon Community organisations Lifestyle services


Identify or self-identify as:
Severely frail
Often dependent on personal care, with a range of co-morbidities. Some medically stable; others at risk of dying within 6-12 months
Moderately frail
Mobility problems, difficulty with outdoor activities, requiring help with activities such as washing & dressing
Mildly frail
Slowing up, may need help with personal activities such as finance shopping, transport
Fit & well
No or a few long term conditions that are usually well-controlled. Independent in day to day activities

Implementing effective interventions

Severe

- Comprehensive assessment
- Advance Care Plan
- Consider de-prescribing
- Shared care plan
- Enhanced support to care homes

Moderate

- Comprehensive assessment
- Falls assessment
- Consider de-prescribing +/- advance care plan
- Shared care plan
- Community MDT assessment & support

Mild

- ‘Menu’ of effective interventions
- Signposting / social prescription to evidence based interventions
- Support for self-care (e-learning patient education, HOPE)

Fit 55+

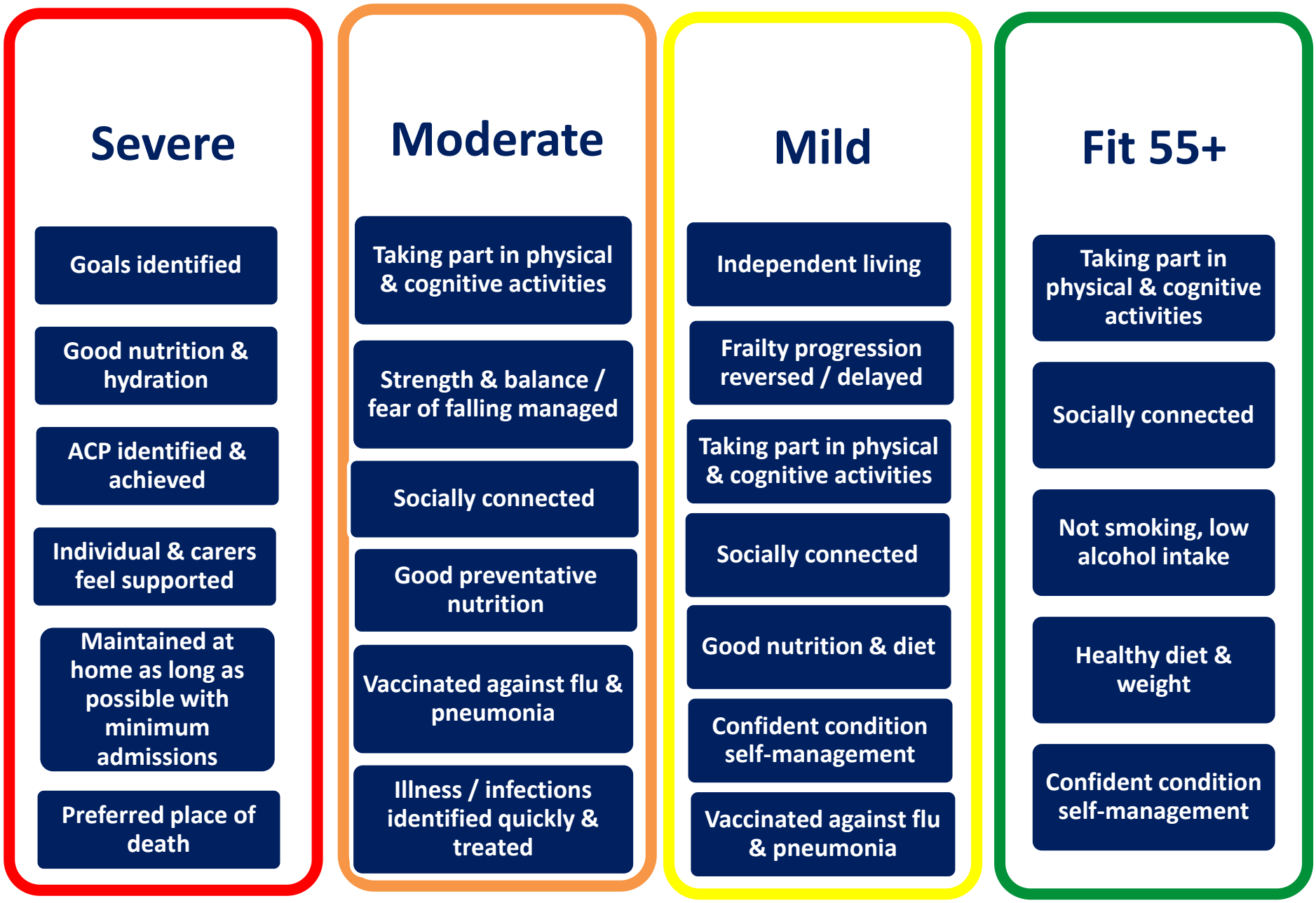
- Information to promote self-care & community activities
- Signposting to effective interventions
- Promotion of physical activity to prevent or delay frailty onset & falls risk

[+]Expansion of NHS strength & balance classes across Devon & testing of community models

[+]Active Devon work with leisure & community providers for people with early frailty

[+]Development of fracture prevention services in all four localities

Identifying meaningful outcomes


Severe
Goals identified
Good nutrition & hydration
ACP identified & achieved
Individual & carers feel supported
Maintained at home as long as possible with minimum admissions
Preferred place of death
Moderate
Taking part in physical & cognitive activities
Strength & balance / fear of falling managed
Socially connected
Good preventative nutrition
Vaccinated against flu & pneumonia
Illness / infections identified quickly & treated
Mild
Independent living
Frailty progression reversed / delayed
Taking part in physical & cognitive activities
Socially connected
Good nutrition & diet
Confident condition self-management
Vaccinated against flu & pneumonia
Fit 55+
Taking part in physical & cognitive activities
Socially connected
Not smoking, low alcohol intake
Healthy diet & weight
Confident condition self-management