

Joining the Dots





We are an older people's charity set up in 2011 with the "aim of improving the lives of older people within the Mid & East Antrim area."





Need for Integrated Community Development Approach

Current Policy	In Practice
Long Term Strategies - Prevention & Early Intervention via a Wellness Population Based Approach	Short Term Funding – Prioritises Crisis Agenda of Illness / Waiting Lists / Workload / Staffing / Health Inequalities
Co-Production	Community & Voluntary Sector seen as a "free resource" / One way referrals
Integration / Multi Disciplinary Teams	Silo Working and/or Duplication
Holistic Person Centred Care by Making Every Contact Count	Single Condition Pathways built around Medical Model of Delivery / Health Literacy
Localism & Empowerment	'Do To' Model / Health 'politics' / Mismatch in Council Area / One Size Fits All
Fund What Works	Pressure to become Self Sustainable & Innovate

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#IMPACTAgewell



Having Healthier Conversations

Self-care

Local Pharmacy

help deal with your cold and flu

Your GP

Emergency Department

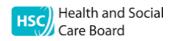
However call 999 or go to ED if you: have difficulty breathing

- As a charity, MEAAP could keep doing what we had always done, or we could try and implement something new.
- In November 2015, The Dunhill Medical Trust sought proposals around "Develop a Network of Care for Older People at a Local Level."

We worked with a wide range of Health

Care Professionals & local Council to



















We co-produced IMPACTAgewell® with all of these partners involved.

review & learn from existing MDT models,

Social Prescribing Models & Current Policy.

Dunhill Medical Trust



Aims of IMPACTAgewell®

Improve health & wellbeing of older people

Build knowledge & diversity



Integrated, valued & safe partnerships

Reduce cost of health & social care support



IMPACTAgewell® Hubs – April 2017



Target Audience for Pilot

Those most at risk/vulnerable from isolation & loneliness, co-morbidity & polypharmacy

Referral Criteria (All Partners Can Refer)

- 65 years & over.
- Living alone or with another person aged 60 years & over.
- 2 long term health conditions (including "Recoverable Frailty" as per Rockwood CFS from 1st Nov 18)
 OR
- 1 long term health condition & in receipt of/entitled to domiciliary care support.

Reciprocity - Everyone involved is financially resourced!



Putting Social Needs on a par with Medical Needs

SOCIAL DETERMINANTS OF HEALTH

The social determinants of health are the conditions in which we are born, we grow and age, and in which we live and work. The factors below impact on our health and wellbeing.



Childhood experiences



Housing



Education



Social support



Family income



Employment



Our communities



Access to health services

Source: NHS Health Scotland

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It's the little things that matter...

- Sally actually likes to be called Betty!
- Betty had a cupboard full of tablets! She received a Medications
 Use Review by Community Pharmacy which helped her
 understand how to use her inhaler correctly.
- Betty didn't know who to talk to about getting a grabrail in her bathroom – IMPACTAgewell® referred to Trust.
- Betty was worrying about **falling outside on her path** IMPACTAgewell® connected Betty to her local Handyperson service for powerwashing.
- Betty also got support from IMPACTAgewell® to use community transport to attend her local luncheon club, both of which she never new existed! And recently had a benefits check so can now heat her home without worrying about the bills!



Stories Are Evidence



https://youtu.be/JWtrx3zJ0U8

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Emerging Evidence



TARGETS	YEAR 1	YEAR 2, QUARTER 3
Create 6 Locality Hub Groups around 6 GP Practices in Mid & East Antrim	6 Locality Hubs created & meeting monthly.	11 Locality Hubs meeting bi-monthly.
Identify 1,100 Older People whom agree to uptake the IMPACTAgewell® service	391 referrals = 174 supported 191 declined 26 pending	671 referrals = 299 supported 349 declines 23 pending
Create 36 Local Community Partnership Agreements for Groups offering 13,200 Funded "Social Prescriptions"	14 Partnerships created, however low uptake rate by older people to participate in "Social Prescriptions"	18 Partnerships created.

^{*191} declines in Year 1 - 71% (135) older people did meet the criteria but self-reported "enough support" from family, friends and their community to meet their health and wellbeing needs.



Emerging Evidence

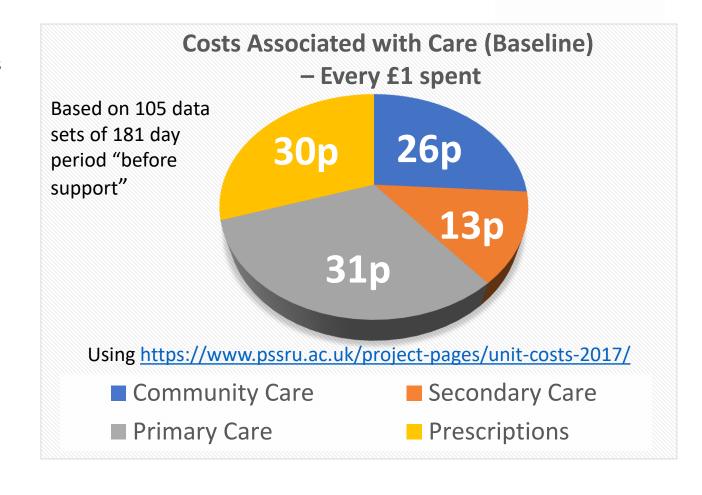


Average age of the cohort is 80, ranging from 66 to 93 years old. Around 40% of service users are aged between 80-86, while less than 10% are aged between 66 -72.

The benefits can be calculated splitting the data in a number of ways, including: age; location; living status; number of long term health conditions.

As of Dec 2018, we have just tested & secured data sets from NI Ambulance Service!

CARE, this is a small dataset and the data shown here are to provide a flavour of the potential scale of benefit.



We anticipate having more data on the FROI and cost-benefit available, with the Full Year 2 Interim Evaluation Report available September 2019.



Together we are...

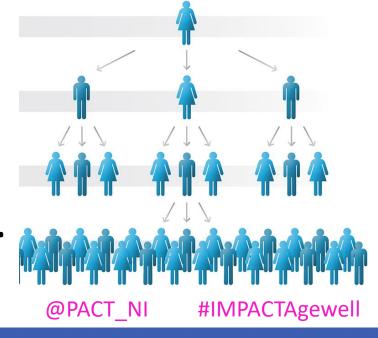
- Breaking down the silos & sharing information;
- Spending time to learn all about what services and support each of the hub team can provide;
- Supporting prevention & early intervention;
- Giving older people a strong voice & actively involving them in creating their own solution – active vs passive;
- Investing in a asset based community development approach to health & wellbeing;
- & Influencing **policy & practice**.



1. Continue to measure 'change over time'.

- 2. Secure local sustainability.
- 3. Scale up in MEA (11/27).

4. Be supported to share and cascade our learning.







BCCP Project

MEAAP & Carrickfergus Healthcare Pharmacy

Healthy Steps to Aging – Project Aim









Frailty



Potentially reversable

16% of people aged 60-64

36% aged 80 (CARDI, 2014).

Can be supported via multidisciplinary approach

Frailty Toolkit for Primary Care



Includes:

- · Case finding tools and advice
- How to populate frailty registers and read coding
- Comprehensive geriatric assessment
- Care coordination
- Care planning
- Medication review in frail older people

http://www.nhsiq.nhs.uk/improvement-programmes/longterm-conditions-and-integrated-care/long-termconditions-improvement-programme/house-of-caretoolkit/national/commissioning/tools-andlevers/enhanced-services-resources.aspx

Identifying Frailty

Can be identified in a simple encounter – Rockwood Clinical Frailty Scale (3-5)

Ask simple Questions

Clinical Frailty Scale*



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



 Well – People who have no active disease symptoms but are less fit than category I. 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 fraitly progressively impairs shapping 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.



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

oring frailty in people with dementia

e degree of firsity corresponds to the degree of dementia.
Immon symptoms in mild dementia include forgetting the
talk of a recent event, though still remembering the event itself,
seating the same question/story and social withdrawal.

moderate dementia, rocent memory is very impaired, even ough they seemingly can remember their past life events well ey can do personal care with prompting.

severe dementia, they cannot do personal care without help.

- * 1. Conwhat Study on Health & Aging Neversh 2008.
- 2 K Abstwood et al A global clinical measure of Rives and foliou in olderly people ICHA 2003 LTS485-495.

6 2007-2009. Veneza (J. Ali rights revenue). Genetric Phobins. Pleasant, Outhouse University Halfas, Canada, Permosoni grafted to says for revent that inhaudinal projects only.



PRISMA-7 Questionnaire

- 1. Are you older than 85 years?
- 2. Are you male?
- 3. In general do you have any health problems that require you to limit your activities?
- 4. Do you need someone to help you on a regular basis?
- 5. In general do you have any health problems that require you to stay at home?
- 6. In case of need can you count on someone close to you?
- 7. Do you regularly use a stick, walker or wheelchair to get about?

Community Pharmacists

Weekly or Monthly contact

Understand and improve older peoples knowledge, adherence to Medication

Centred in the Carrickfergus surgery with established relationships with GP, Trust and com/nav



Healthy Steps to Aging - Project Objectives

1. Build capacity of Community Pharmacists to recognise and support frailty

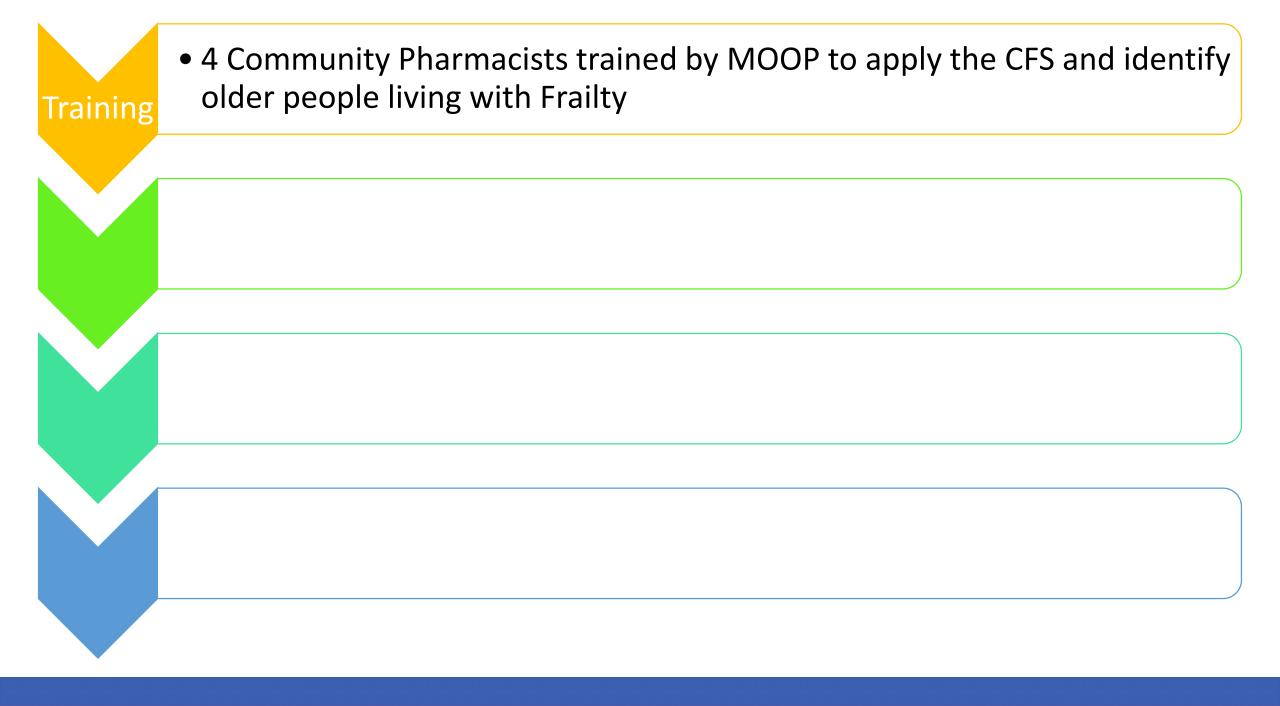
2. Enhance the partnership between MEAAP, Community Pharmacists and local GP Practices within Carrickfergus area.

3. Improve health literacy for older people in terms of frailty and recognising the links to the social determinants of health, promoting a self-care health and wellbeing model.





Project Outline



• 4 Community Pharmacists trained by MOOP to apply the CFS and identify older people living with Frailty • MEAAP & Carrickfergus Pharmacists will identify 24-30 (2x 12-15) participants) older people living with frailty & their carers **Participants**

Training

 4 Community Pharmacists trained by MOOP to apply the CFS and identify older people living with Frailty

Participants

MEAAP & Carrickfergus Pharmacists will identify 24-30 (2x 12-15 participants) older people living with frailty & their carers

Project

 2x 10 week programme – First session will identify Health literacy and asset mapping with participants to determine relevant personalised content Training

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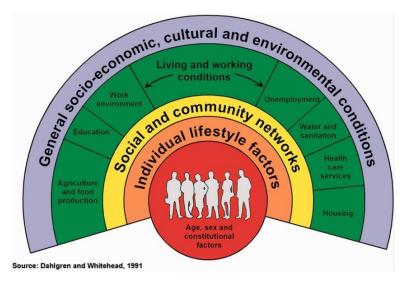
Partners

 Community pharmacists will facilitate 8 pharmacy led sessions and cofacilitate with community/voluntary partners



BCPP Strategic Outcomes	BCPP Project Outcomes	
	1.1	Participants' health literacy is improved
Project participants are	1.2	Participants have improved understanding of the social factors (e.g. money worries, housing, stress) that can influence health (social determinants)
enabled and supported to achieve their full health and wellbeing potential	1.3	Participants are more confident to self-manage their health and take action on factors which influence health
Weilbeing potential	1.4	Participants have improved knowledge of services and support for health and social issues
	1.5	Participants' health and wellbeing is improved
2. Pharmacy is enabled and supported to fulfil their role as advocates for public health within communities	2.1	Pharmacists are more aware of health issues in the participants' community
	2.2	Pharmacists have better understanding of the context and conditions of people's lives and factors that influence health (social determinants)
	2.3	Pharmacists have improved health literacy understanding and skills
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	2.5	Pharmacy services are better utilised
3. Community partners are enabled and supported to recognise and address health inequalities in their community	3.1	Community partners are more aware of health issues in the participants' community
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4. <u>Social capital</u> is increased to build connected and engaged communities	4.1	Participants have an improved sense of connectedness and belonging
	4.2	Participants develop new skills, knowledge and experience in their community
	4.3	More equal relationships are developed between the participants, community partner and pharmacy

1st session discuss and manage own needs/gaps in terms of knowledge and information



Promote and support management of participants own self care

Identify skills and assets of participants



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Enhance ability to identify, manage and optimise drug treatment for frailty

Attend 4 cofacilitated sessions MEAAP/external community/voluntary organisations

Host 4 pharmacy led sessions

Continue to provide support beyond the project



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Gain valuable insight and knowledge on how to facilitate guided discussions around frailty for an individual and community

Identify and invite four relevant external community/voluntary organisations

Develop the relationship between community and pharmacist – increase social prescribing



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Enhance older persons feeling of being connected to community and pharmacy

Asset mapping will share participants knowledge of local groups/organisations

Equal relationships





Thank you! Questions?

For further information



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