A Regional Approach to Ageing Well

Community of Practice

2 February 2023

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:	
	Care Home Evaluation Project: Vitalerter (falls prevention/turn alerts)	Robin Blythe (NECS) – AHSN NENC Digital Programme Manager David Knowles, Managing Director, Porters Care
	Improving recording of the Clinical Frailty Scale by physiotherapists in older people's medicine: a quality improvement project	Charlotte Buckland, Clinical Specialist Physiotherapist – Frailty, Newcastle Upon Tyne Hospitals NHS Foundation Trust
	Whole Truth, Untruth and Lies: do they have a place in practice?	Dr Jane Murray, Assistant Professor, Northumbria University
4.	Any Other Business	All
5.	Date and Time of Next Meeting - Thursday 6 April 2023 at 14:00-16:00pm	

Welcome and Introductions

Frailty - what's the latest?

NHSE Delivery Plan for Recovering Urgent and Emergency Care Services – *welcomed but response from Social Care colleagues*

Focus is on getting people of out of hospital, clearing NHS waiting lists and improving ambulance times – as said by the Secretary of State – but the plan itself is a little more wide ranging and while there are **welcome measures** and a recognition of the need for more hospital and ambulance capacity there is also quite a lot missing if it is to have any hope of being successful:

•Lip service is paid to the challenges in social care throughout the plan but no real solutions are suggested, other than restating the money announced in the autumn statement and there isn't any assurance that the **redirected money** and subsequent discharge funds will be used to enable providers to employ more people on better pay, terms and conditions for longer

•Lack of any measures on the **workforce needed** to deliver this plan, and nothing is mentioned at all about the social care workforce – the 300 million vacancies across the health and care system is a massive challenge and there is no plan to solve either

•There is little recognition of the need to join up virtual care at home, community health support and adult social care because while care at home is a massive potential enabler the focus is all on health and clinicians

•There is a missed opportunity to require ICBs and ICPs to properly engage with their social care providers at the top table to plan and design together and the plan itself is evidence of this lack of coproduction as there does not appear to be any **social care input**

•Seems to be little understanding of the hugely valuable **social care assets** in each system and until this happens little real change will happen

Ageing Well Thematic Plan

As part of the planning round we are required to develop a system-wide Ageing Well Thematic Plan covering the immediate priorities and key deliverables for 2023/24, and also the longer-term transformation/development priorities.

As our plan needs to align with national and local priorities, we are proposing a continued focus on:

Urgent Community Response

Maintaining full geographic coverage 8am-8pm, 7 days per week and continue to grow services to reach more people, with a focus on maximising referrals from 111/999

Proactive Care
(previously Anticipatory Care)

Helping people with complex needs stay healthy and functionally able

Enhanced Health in Care Homes

Maintaining a focus on enhanced support and better coordinated care, and delivering against the refreshed national framework (to be published soon)

Community Health Services Digital

Implementation of plans to ensure digital and data enabled community care

System planning for Community Health Services and Personalised Care 2023/24: Relevant Priorities

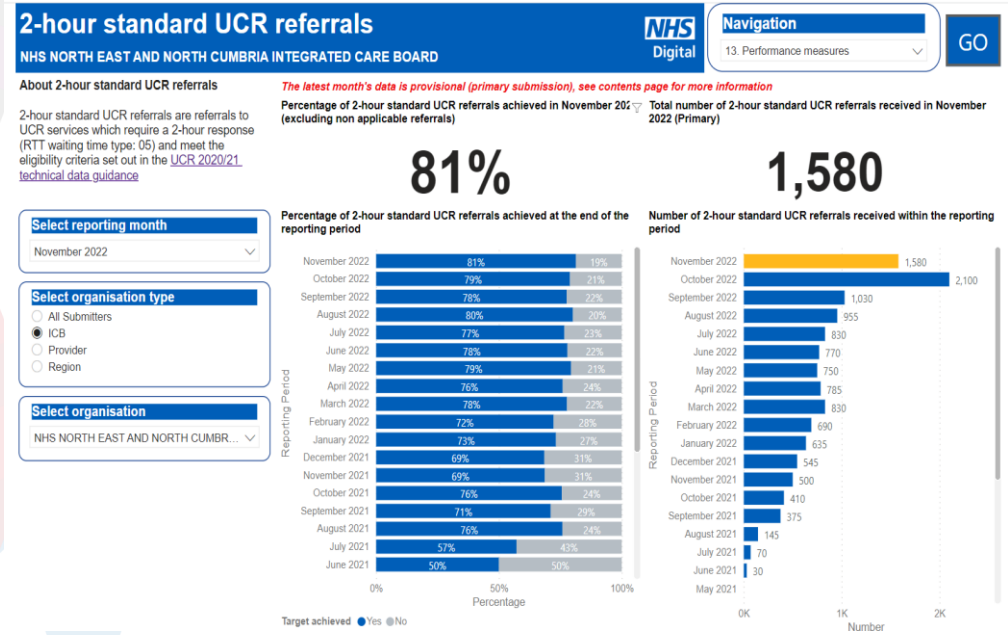
Urgent Community Response (UCR)	• Increase referrals into urgent community response (UCR) from all key routes, with a focus on maximising referrals from 111 and 999, and creating a single point of access where not already in place.
Virtual Wards	• Permanently sustain additional 7,000 beds funded through winter 2022/23 and increase utilisation of virtual wards towards 80% by the end of 2023.
Direct access and self-referral	• Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place: (1) direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations; (2) self-referral routes to falls response services, musculoskeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.
Additional Roles Reimbursement Scheme (ARRS)	• Continue to recruit 26,000 ARRS roles by the end of March 2024.
Deliver the vision outlined in the Fuller Stocktake	• . This includes personalised care, prevention and development of integrated neighbourhood teams.
Address health inequalities	• Take a quality improvement approach to addressing health inequalities and reflect the Core20PLUS5 approach in plans

Anticipatory Care – now referred to as ‘Proactive Care’

Great North Care Record-Advance Care Plans (ACP)	• Overall, this work will enable sharing of personalised care and support plans by addressing intra-operability across the different care systems. • 'As is' and 'To be' process mapping has been undertaken with FTs, some OOHs and a sample of GP practices. • Resource has been confirmed to start to take forward GP Connect work linked to ACPs. • New widgets have been proposed – ‘About Me’, ‘Alerts’, ‘Care Plans’ and ‘Advance Care Planning’. • Technical solution to share information with the Ambulance Service - still to be developed. NEAS, GNCR and the ICB are reviewing options.
Ageing Well Minimum Data Set	• Work is continuing on collating sources for an Ageing Well dataset. This includes NENC Ageing Well codes, EPACC, CGA codes and the North Cumbria info (MIG) to see where there is duplication/gaps and start to bring them together. • It has been recognised that there is a large number of codes to be worked through.
Year of Care (YoC) Anticipatory Care Project	• Steering group for the programme has been established. • PCNs have been recruited (Carlisle Healthcare PCN, Keswick and Solway PCN). • ‘Kick off’ events for each PCN have taken place. • In depth process mapping with each of the PCN working group has taken place, along with development of local action plans.
Anticipatory Care: Finding People	• AC aggregate dashboard developed • Frailty case-finding tool developed • It is anticipated that the tools will be tested with PCNs and be available by the end of March 2023 – however, this will be subject to external assurance, given the dashboards are deemed Class 1 medical devices. Risk captured on the AC Finding highlight report.

2 Hour Urgent Community Response

- Two-hour UCR services are operating at a minimum 8am till 8pm, 7 days a week across the NENC ICS.
- UCR self assessment maturity matrix template – has been completed for NENC a monthly basis since June.
  - All areas are continuing to work towards achieving the KLOEs, linking their UCR to wider integrated UEC and IC systems as well as progressing on the nine clinical priorities.
- Efforts to improve data quality are continuing:
  - Data is now flowing from seven Trusts out of eight into the national UCR dashboard.
  - Local data feeds have been obtained to fill gaps in previous months for some providers and will continue to be obtained for the remaining Trust.
  - Data Quality follow-ups with acute trusts have resulted in 39% increase in 2-hour UCR referrals reflected on national CSDS dashboard.



2-Hour Urgent Community Response (UCR) Supporting Winter Preparedness

'Pull' model - from ambulance call stack

- Colleagues in Tees Valley, in partnership with NEAS, have developed new referral pathway into UCR services - this involves UCR services accessing the ambulance call stack and pulling out appropriate Category 3 and 4 patients – and diverting them, when clinically appropriate and safe to do so, to community health services.
- This is in addition to the 'push' model whereby 111 clinicians can refer suitable patients to the urgent community response services electronically.
- Early findings seem promising, and NTHFT are currently recording an average of seven patients a day being either 'pulled' or 'pushed' from the ambulance call stack.
- Initiative has received recognition from No. 10!

Community Falls Response

- As part of *Going further for winter*, ICBs are required to improve coverage of community-based falls response services across their footprint.
- In response to this, the UCR T&F Group meeting held in January, focused discussions on how we can better join better technology enabled care (TEC) services, UCR services and the ambulance service, using the Warrington case study as an exemplar.
- The pilot of lifting cushions along with staff training in three St Martin's Care Homes is due to commence in late February/early March, once the equipment is available. The evaluation report is expected in June 2023.

Enhanced Health in Care Homes

Currently awaiting expected date for the EHCH refresh

Digital

Overview of CHS Digital – Priorities for 2022-23

- Community Digital Strategy – finalisation with NENC Digital Team
- UCR Digital Support – Community dataset onboarding conversations with providers
- Virtual Wards digital platform planning

Digital

iCGA - pilot completed.

Meeting held December 2022 to discuss Dream Project. iCGA shared with Digital Workstream Lead for potential phase 2 opportunities

Website - www.frailtyicare.org.uk.

Updated Workforce section – take a look!

Workforce Projects and Research/ Evidence

EnCOP:

- Frailty iCARE Website – CMS developments: EnCOP locked/password protected area created for Competency Development Facilitators.
- 13 December 2022: EnCOP Webinar 'End of Life Care in Frailty and Dementia Advanced Care Planning'. 66 participants.
- 17 January 2023: EnCOP Webinar 'Discriminatory Abuse 'Hidden in Plain Sight'
- EnCOP Celebration Event Planning Session held. Adam Gordon will open and host the event and Louise Robinson, Newcastle University will present 'Dementia – from Newcastle to the World!'

Evaluation and Research:

- EnCOP evaluation – funding from ARC for quantitative evaluation –extension has been granted to September 2023, qualitative evaluation capturing the experiences of the workforce continues.
- Hydration Project; first workshop 31st January
- New research innovation lead for ICB is keen that elderly care, frailty and ageing well is high on Chief Executive NENC ICB's list for research and elderly care. A meeting to take place to consider how to strengthen existing links.

Metrics, Measures and Outcomes update

Power BI Tool

- Power BI Tool testing/feedback stage of development. Feedback from those who have had access to the dashboard were overwhelmingly positive.
- Feedback has been taken on board and developers at NECS are reviewing comments/suggestions made.
- Webinar being considered to share the Frailty Case finding tool with PCNs —— to use this as an opportunity to also share the ICARE Metrics Power BI Dashboard.
- Hoping to be in a position to share wider and encourage localities to review and make use of the dashboard as part of their local ageing well system steering groups as well as the PCNs though the webinar above.

Personalised Care

- Working with NECS to develop proposal for additional capacity to improve Personal Health Budget offer across NENC, including data collection. NENC is behind national trajectories for PHB uptake.
- Personal Wheelchair Budgets Task and Finish group established to address issues with PWB uptake and data collection. Wheelchair services and PWB mentors engaged.
- Patient Activation Measure – contract signed and planning comms for roll out of licences to organisations across NENC.
- Personalised Anticipatory Care pilot underway in North Cumbria – two PCNs participating.
- Working to secure Workforce Development Lead role across NENC for 2023/24.
- Place-based projects continuing, aiming to embed various components of the Universal Personalised Care model in local areas.
- Involved in Operational Planning process for personalised care, key elements include continued recruitment of Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators in PCNs.

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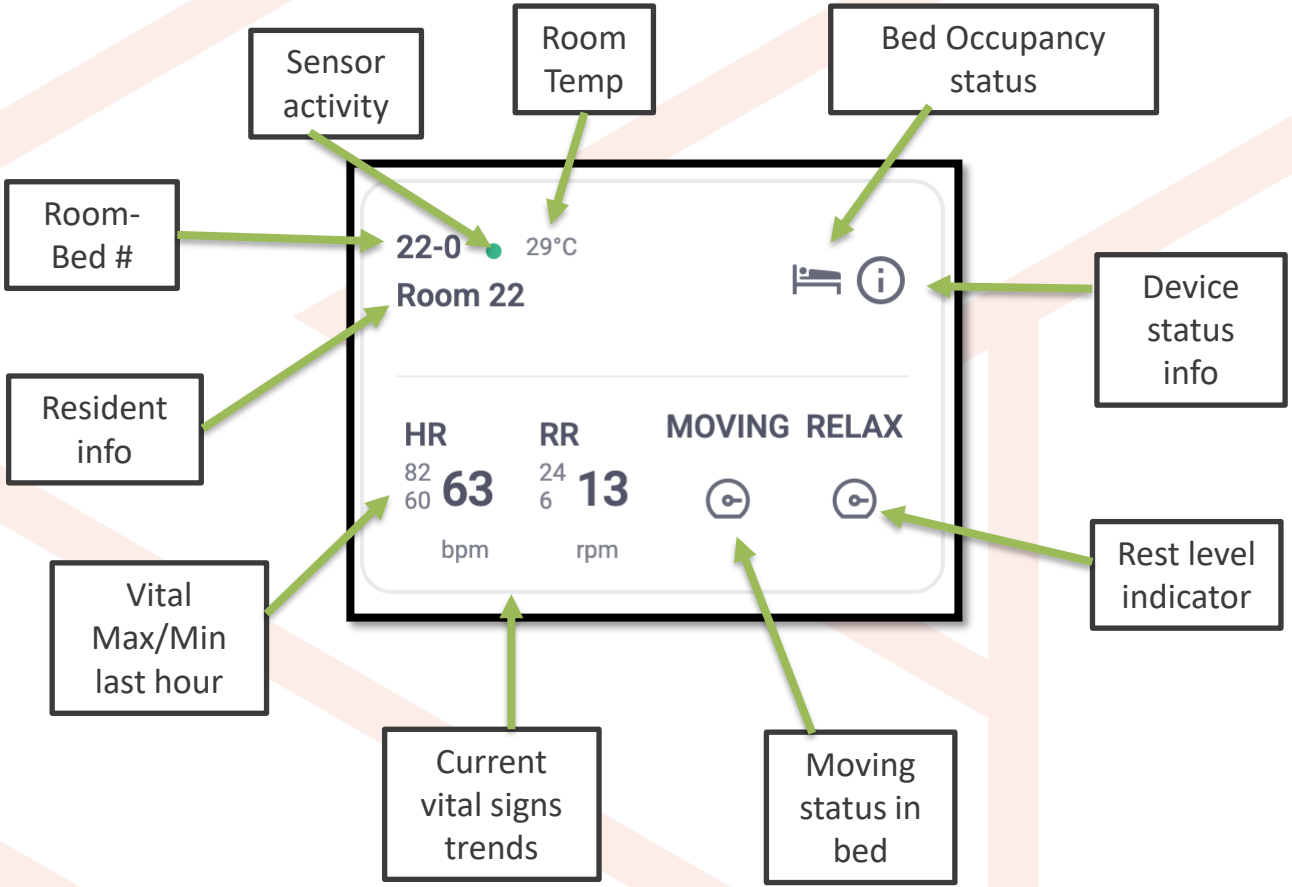
Evaluation Project: Vitalerter in Care Homes

Robin Blythe (NECS) – AHSN Digital Programme Manager

Background

- **Digitising Social Care Programme (DiSC)**
  - 80% of adult social care CQC registered providers will have adopted a **digital social care record** by March 2024
  - By March 2024 **sensor based falls prevention and detection technologies**, such as acoustic monitoring, will be in use in care homes for the residents they have identified as most at risk of falls, reaching at least 20% of residents nationally
  - **Testing other types of care tech**, driven by the benefits case and local need
- **Porters Care (sole UK supplier of Vitalerter)**
  - 4 types of alert
    - **Fall prevention (fewer falls)**
    - **Pressure ulcers (reduce turn checks)**
    - **Heart rate**
    - **Respiratory rate**
  - Monitor alerts - dashboard and mobile app

Bed Status Indicators



Potential benefits (supplier examples)

1st Falls prevention

- **Hospital admissions are reduced** providing a considerable saving to the NHS.
- Having **fewer falls which lead to hospital admission** will drastically **reduce the number of voids** (beds left empty which could result in loss of funding) in Care homes.
- Fewer falls through the use of pro-active monitoring will provide a **better case to CQC for a higher safety rating.**

2nd Pressure ulcer prevention / reduction of manual turns

- The system drastically **reduces the number of pressure ulcers** which develop in the care setting.
- The system **reduces the number of manual turns by over 60%.**
- **Better use of care staff time** as they no longer have to carry out 2 hourly rounds to turn residents.
- Night-time staff now have **more time to work with residents** who are awake at night or to carry out other tasks, such as hygiene care, updating care notes, which can help to relieve the pressure on the day staff.
- **Residents** who are turning themselves **are no longer disturbed every 2 hours.**

Current situation

- Key stakeholders overview
- Minimal impact on residents i.e. no change to existing care protocol/pathways
- Fall alerts and turns in bed
- 30 Vitalerter devices for care home residents
- Timescales
  - 3 month device trial
- Independent real world evaluation
  - “What are the opportunities/benefits Vitalerter brings?”
- **Spread and adopt in NENC?**

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Vitalerter demonstration

David Knowles – Managing Director – Porters Care

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Improving recording of the Clinical Frailty Scale by physiotherapists in older people's medicine: a quality improvement project

February 2023

Charlotte Buckland: Frailty Clinical Specialist Physiotherapist

c.buckland1@nhs.net @AgeWellPhysio

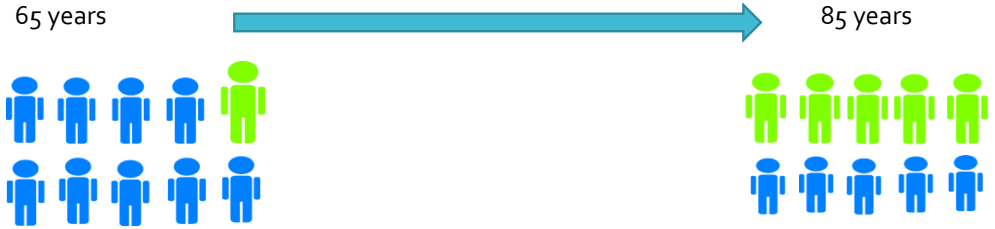
Healthcare at its best
with people at our heart

Problem

- Changing acute patient demographic
- Frailty

  'a state of increased vulnerability to poor resolution of homoeostasis after a stressor event, which increases the risk of adverse outcomes' (Clegg *et al.*, 2013)

  - Prevalence



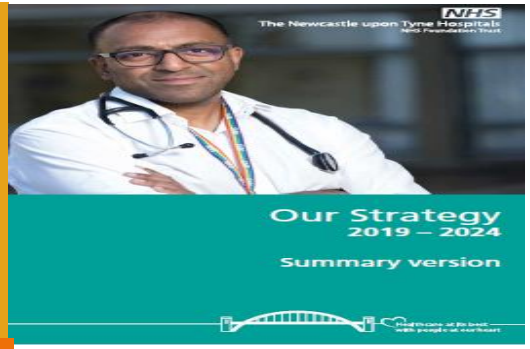
- **Frailty is under-recognised in hospital** (NHS RightCare, 2019)
- **Frailty is 'everyone's business'**
- **Previously, inpatient physiotherapists did not record Frailty status in their clinical assessment**

Strategic Influences

NICE
National Institute for Health and Care Excellence

NG56 Multimorbidity: clinical assessment and management

NG16 Dementia, disability and frailty in later life: mid-life approaches to delay or prevent onset



NHS

NHS RightCare
Frailty Toolkit 2019

NHS

GIRFT - Geriatric Medicine
Feb 2021

Royal College of Physicians

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

BGS
British Geriatrics Society
Improving healthcare for older people

Evidence-based Priorities – Jan'23

Benefits of identifying Frailty

Patient

- Early diagnosis/targeted interventions
- Improve patient experience
- Better patient outcomes
- Lessens health inequality

Organisation

- Supports patient flow
- Reduces LOS
- Reduces secondary care pressures
- Identifies gaps in service/resource
- Informs improvement/research

Staff

- Early identification of patient needs
- Informs care decisions
- Demonstrates commitment to MECC to improve care
- Lessens risk of hospital related harm

Clinical Frailty Scale (CFS)

CLINICAL FRAILTY SCALE

	1	**VERY FIT**	People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	**FIT**	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**, even if occasionally symptomatic, but often are **not regularly active** beyond routine walking.
	4	**LIVING WITH VERY MILD FRAILTY**	Previously "vulnerable," this category marks early transition from complete independence. 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	**LIVING WITH MILD FRAILTY**	People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	**LIVING WITH MODERATE FRAILTY**	People who 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	**LIVING WITH SEVERE FRAILTY**	**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	**LIVING WITH VERY SEVERE FRAILTY**	Completely dependent for personal care and approaching 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 living with severe frailty.** (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILTY IN PEOPLE WITH DEMENTIA

The degree of frailty generally 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.

In **very severe dementia** they are often bedfast. Many are virtually mute.

DALHOUSIE UNIVERSITY

Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

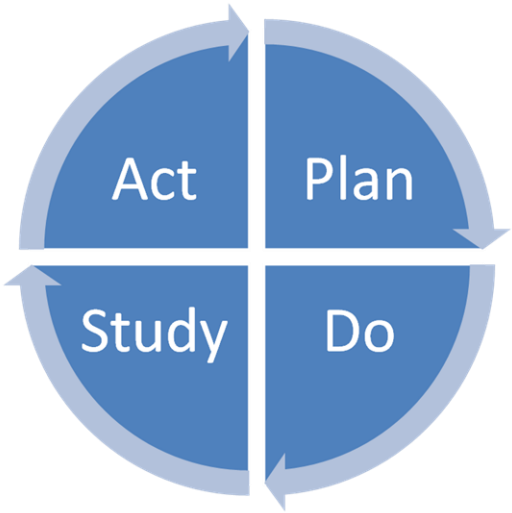
Project Aim


Within 3 months, to achieve a 50% increase in the number of patients with a CFS score recorded within physiotherapy assessment

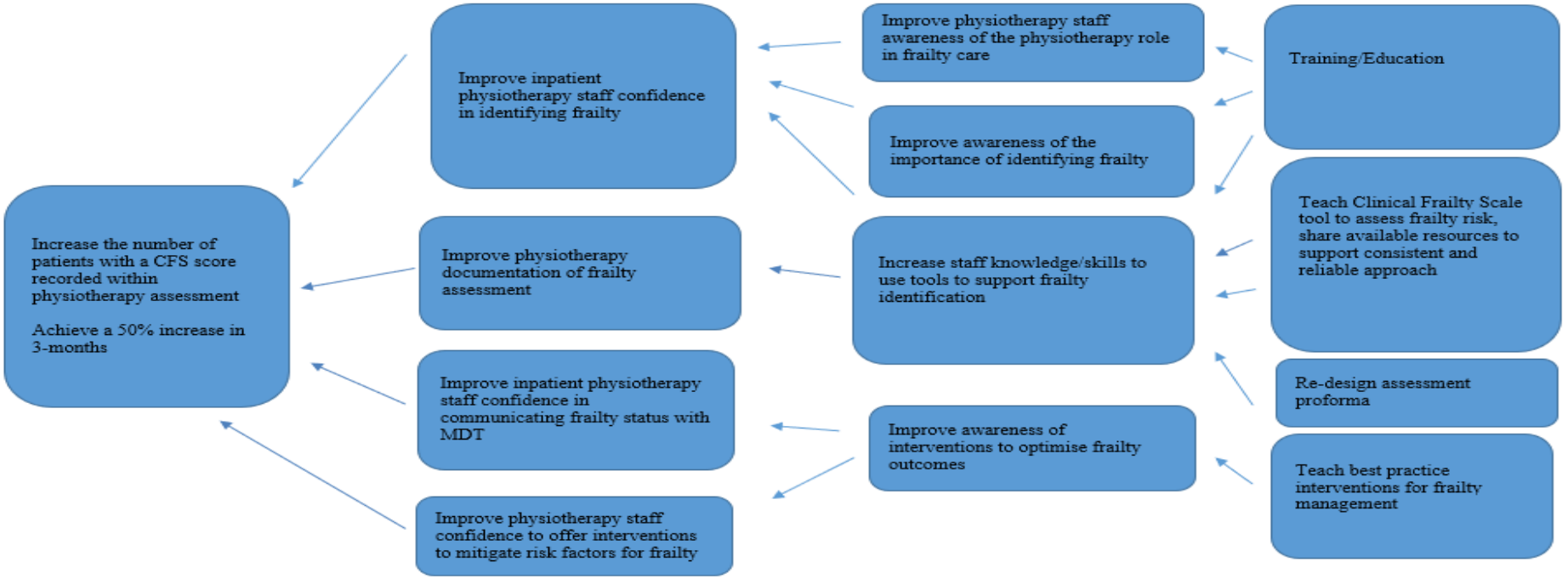
Methodology

Problem analysis

Stakeholder engagement



Driver Diagram



Training Intervention

- What is Frailty?
- Why is Frailty screening important and relevant to me?
- How to test for Frailty?
- What is the physiotherapy role in Frailty?

Assessment Proforma Re-design

On a typical day <u>2 weeks ago:</u>

BADL baseline (note assistance/equipment)

- in/out bed –
- wash/dress–
- toileting –
- indoor walking –
- stairs/steps –

IADL baseline (note assistance/equipment)

- meals –
- meds –
- housework -
- shopping –
- outdoor walking –

Cognition baseline:

Clinical Frailty Score (CFS) score and description:

Improvement Measures

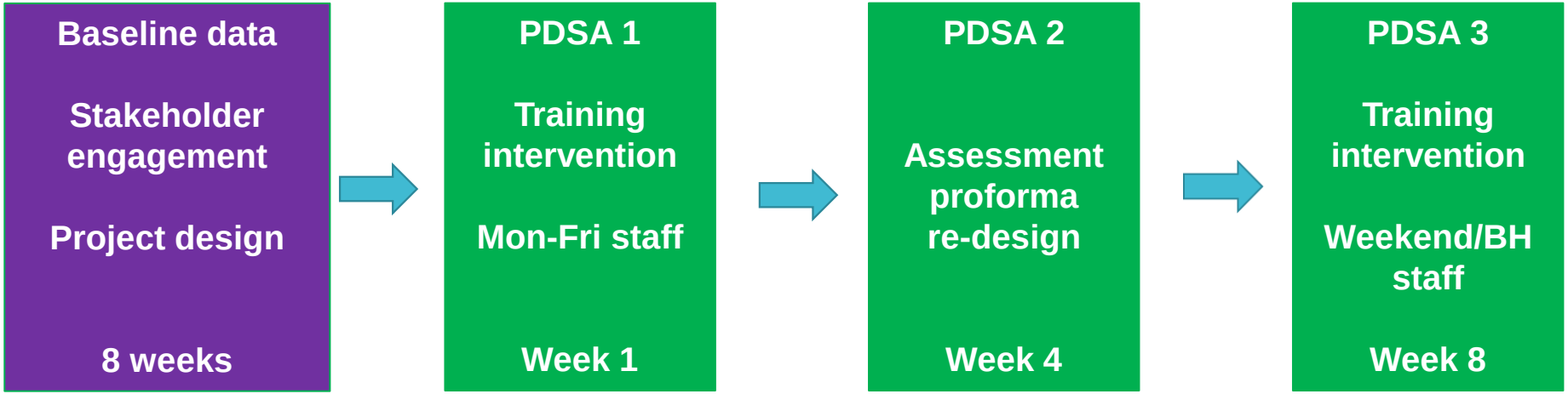
Outcome

- Weekly number of patients with a CFS score within the physiotherapy assessment

Process

- Number of staff who completed training
- Staff knowledge and skills ratings pre/post training
- Number of physiotherapy assessments completed

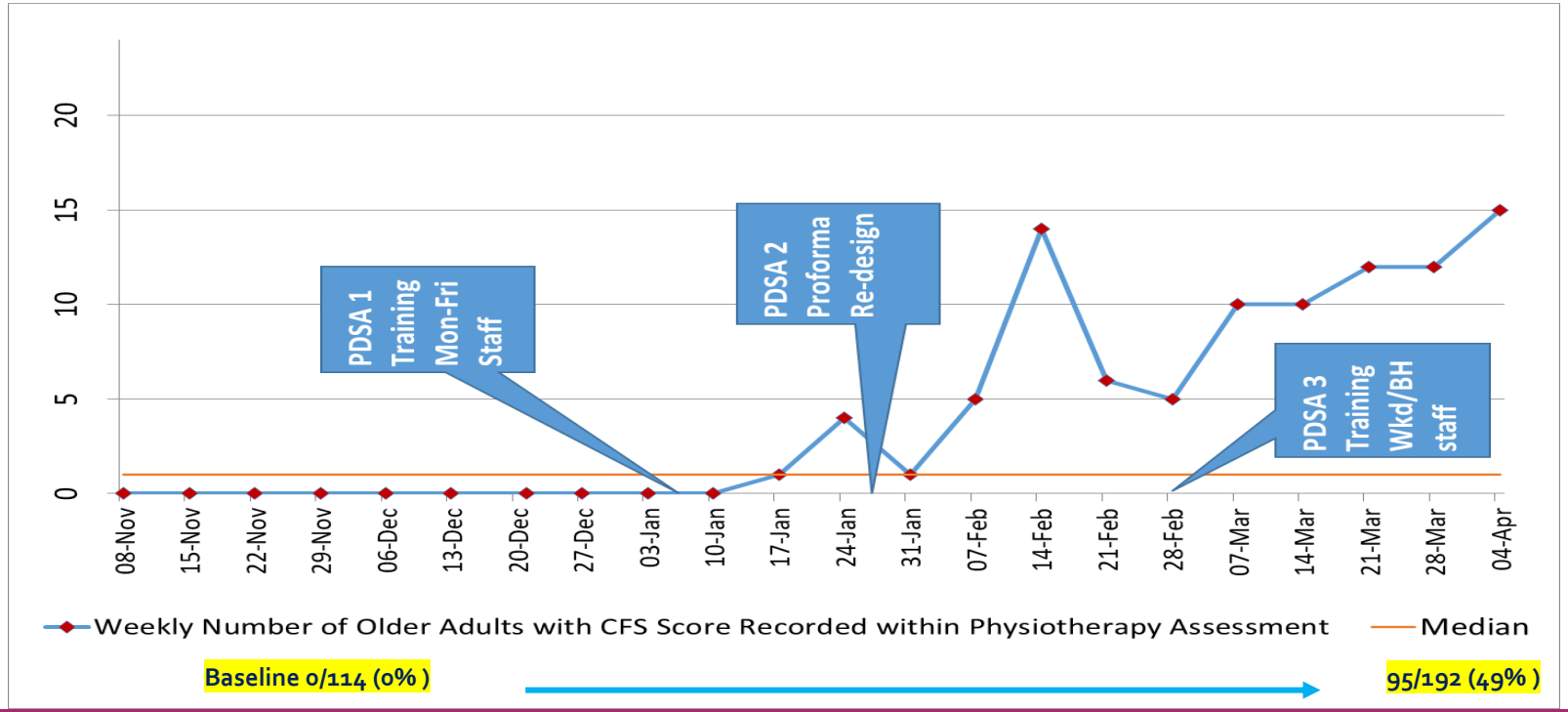
Project Timeline



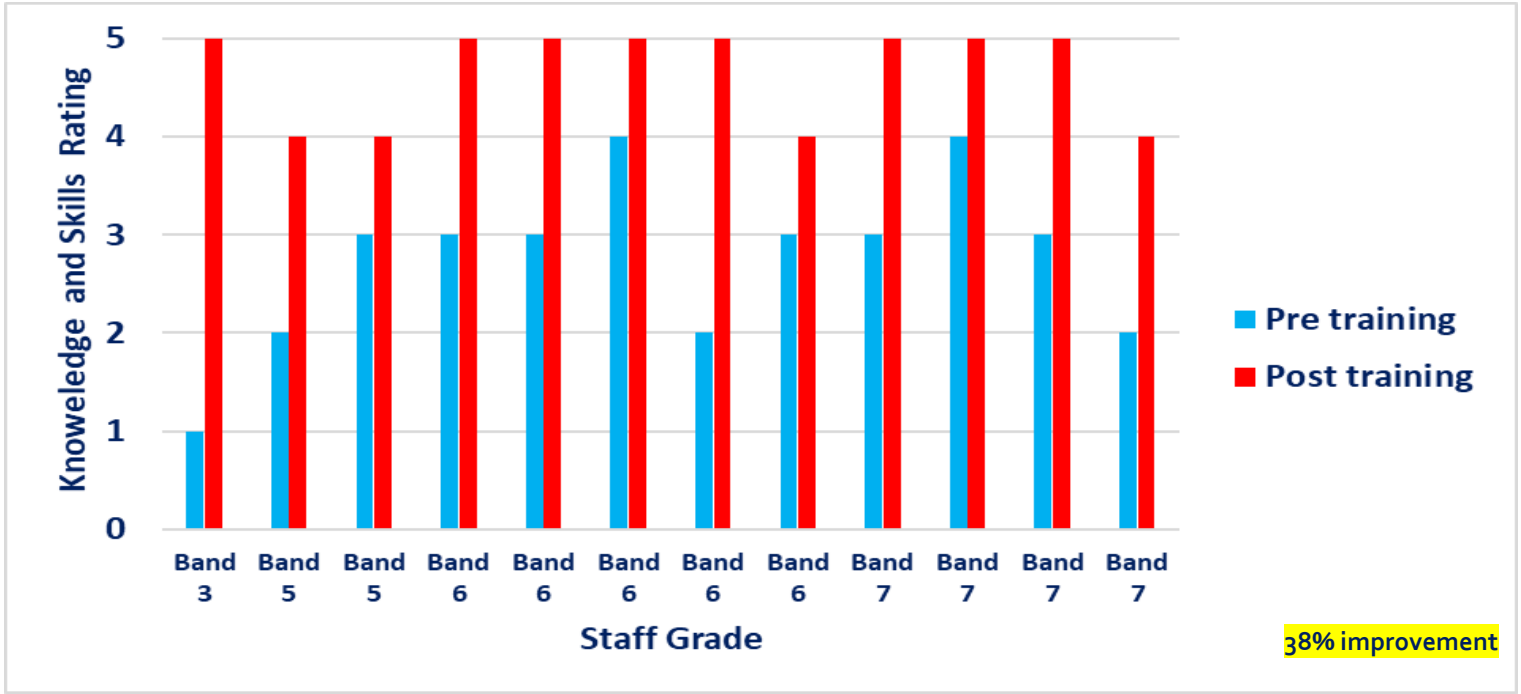
Results

	Baseline Phase	Intervention Phase
Number in cohort	114	192
Number of records analysed (% total)	114 (100%)	192 (100%)
Mean age, range (years)	84, 66-99	84, 66-97
Male: Female	52:62	91:101
Mean number of Long Term Conditions, range	5, 1-13	5, 1-14
Number with diagnosed cognitive impairment (% total)	36 (32%)	64 (33%)
Number with CFS score (% total)	0 (0%)	95 (49%)

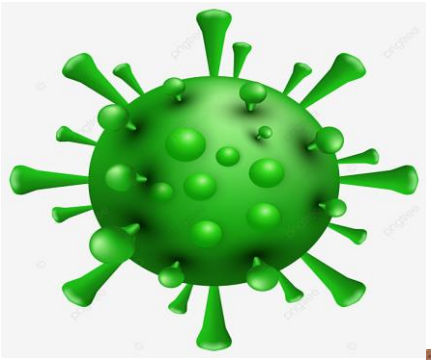
Run Chart


0
5
10
15
20
08-Nov
15-Nov
22-Nov
29-Nov
06-Dec
13-Dec
20-Dec
27-Dec
03-Jan
10-Jan
17-Jan
24-Jan
31-Jan
07-Feb
14-Feb
21-Feb
28-Feb
07-Mar
14-Mar
21-Mar
28-Mar
04-Apr
PDSA 1 Training Mon-Fri Staff
PDSA 2 Proforma Re-design
PDSA 3 Training Wkd/BH staff
Weekly Number of Older Adults with CFS Score Recorded within Physiotherapy Assessment
Median
Baseline 0/114 (0%)
95/192 (49%)

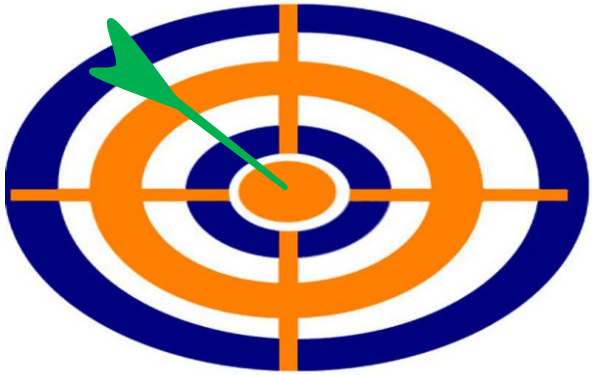
Bar chart of staff knowledge and skills ratings in Frailty Screening



Challenges



Conclusions



- 49% improvement in Frailty identification
- Better Frailty awareness
- Promotes collaborative care

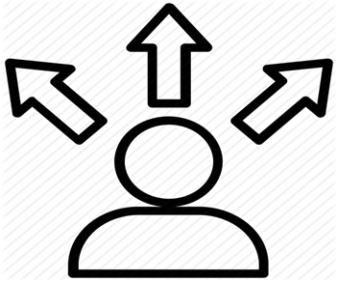
Sustainability

- 85% (53/62) May'22
- 88% (52/59) Nov'22

Spread

- Assessment Suite + 5 wards
- Belsay Day Unit
- Domiciliary Physiotherapy

Next Steps



- Wider implementation
- eCFS
- Workforce development
  - Student teaching
  - Competency framework for physiotherapy
- MDT Frailty care plan, eCGA

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Wholetruth, untruth and lies. Do they have a place in practice?

Dr Jane Murray

Dr Jane Murray 02.02.2023
jane.murray@northumbria.ac.uk

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YES!

- Truth is very individual. Everyone has their own truth
- If my truth is likely to cause distress to someone else, why should I persist with it?
- Is my truth more important than the patients? No.

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The Background

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Definitions

- What is truth?
- What is Untruth?
- What is a lie?

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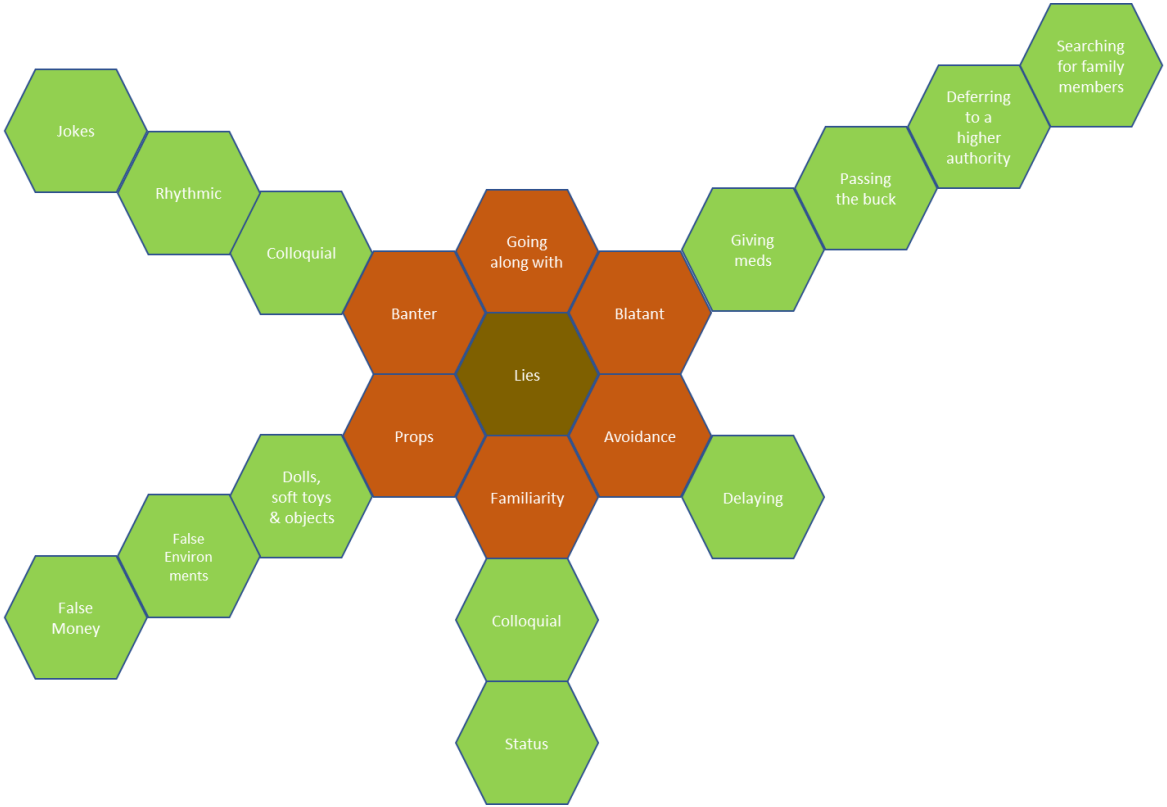
The Taxonomy



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Reflection is Key

- The person is paramount
- Reduce distress
- Engage positively

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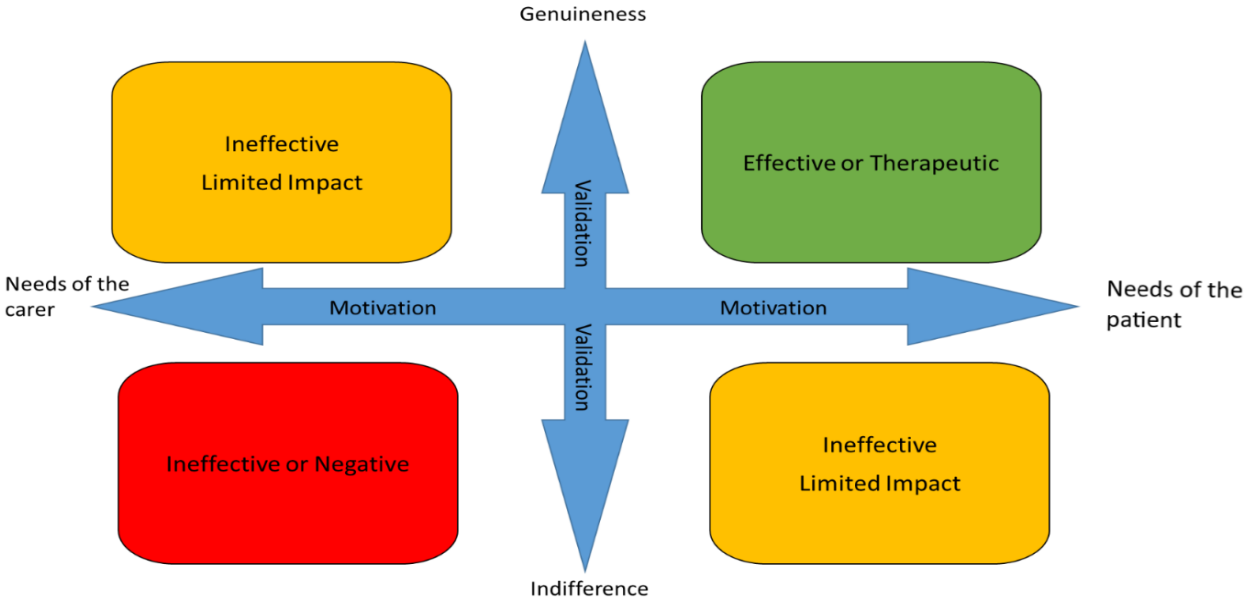
The Lie ARM
(Affective Reflective Model)



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Key messages

- Be genuine
- Validate the recipient's emotions
- Do it for the right reasons

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Opinion

- Lie telling is an effective intervention
- Lie telling supports personhood
- My truth is no more important than the truth of the person with dementia
- The NMC should adjust the Code of Conduct in a similar fashion to the clause on confidentiality

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Any Questions?

Contact details

jane.murray@northumbria.ac.uk

involve consider assess respond evaluate

Date and Time of Next Meeting

Thursday 6 April2023 at 14:00-16:00pm