A Regional Approach to Ageing Well

Community of Practice

1 June 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.	Presentation:	
	Challenge North Tyne 2023 – Supporting people in later life at home, work and play. Presentation of ongoing accelerator programme supporting 29 SME's to develop and test innovative solutions.	Hermina Ely, Health and Social Care Tech Innovation Manager, Innovation Supernetwork
4.	Any Other Business	All
5.	Date and Time of Next Meeting - Thursday 3 August 2023 at 14:00-16:00pm	
6.	Close	

Welcome and Introductions

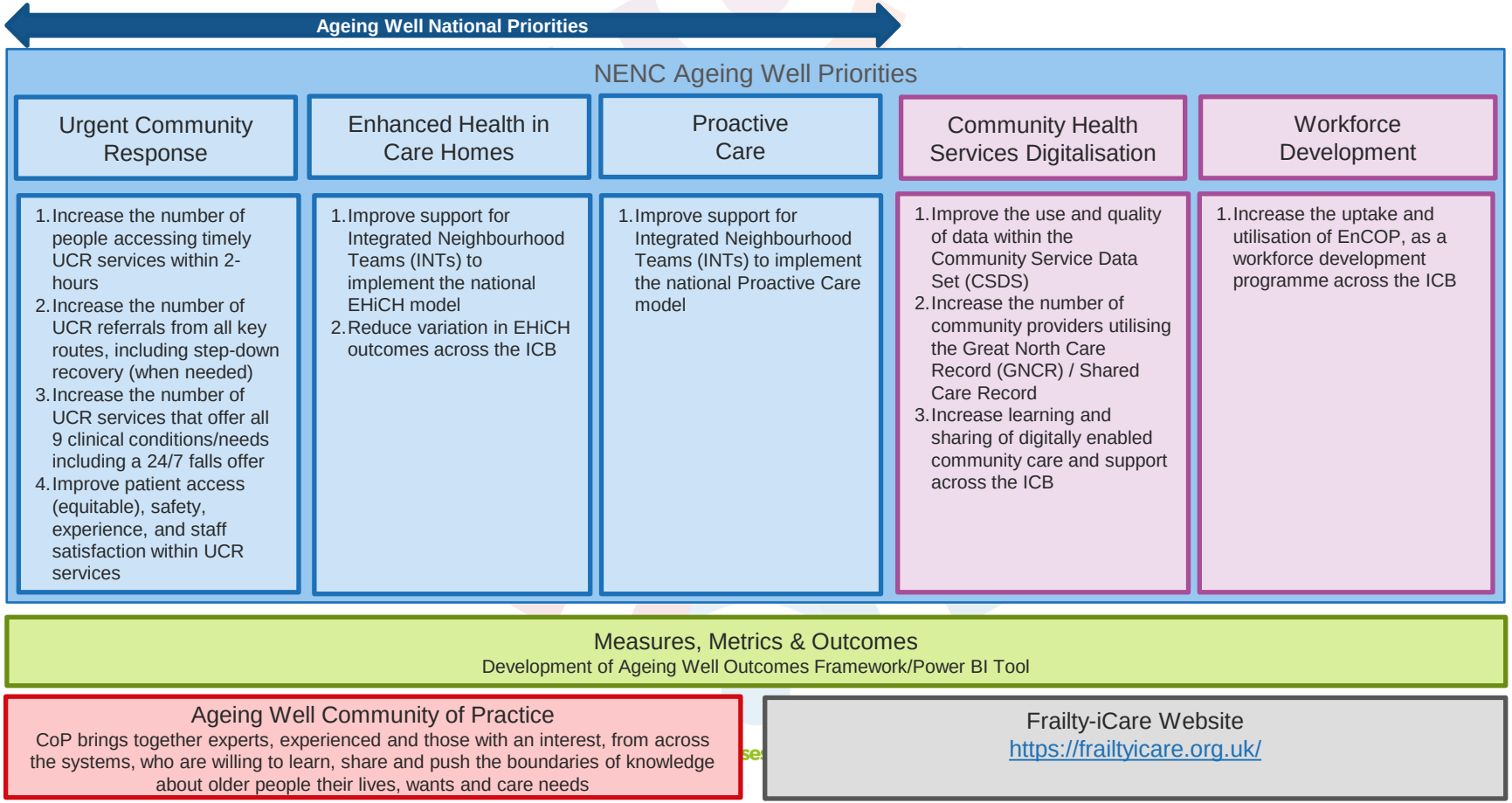
Frailty - what's the latest?

Joint Forward Plan

NHS
North East & North Cumbria

- All Integrated Care Boards and partner NHS Trusts are required to publish a Joint Forward plan covering 2023/24 – 2028/29
- Joint Forward Plans will be reviewed, updated, and published again each year in March
- Three key principles in the national guidance on joint forward plans:
  - Principle 1: Fully aligned with the wider system partnership's ambitions
  - Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments
  - Principle 3: Delivery focused, including specific objectives, trajectories, and milestones as appropriate
- The national guidance encourages local systems to use the Joint Forward Plan as the 'Delivery Plan' for the ICP integrated care strategy in relation to NHS services.
- Draft action plans required by 26 May 2023, prior to wider stakeholder engagement on the draft overarching Joint Forward Plan
- Final version of Joint Forward Plan expected to be published in September 2023

Ageing Well Plan - Overview



Ageing Well *interdependent programmes*

Workforce

Bringing EnCoP into regional and national workforce initiatives

Social Care

EHiCH quality/harm, workforce, (e.g., BCF/ ASCF) and Social Care Offer

Virtual Wards

Frailty VW roll out, expansion and alignment with wider Community Health Services

Primary Care

Embedding Proactive Care and EHiCH into as part of Fuller Stocktake and Recovery Access Plan

Healthier and Fairer

Alignment of Proactive PHM approaches into HI and prevention work

UEC

IC national Framework, MDS, Discharge, Reconditioning as part of UEC Recovery Plan

Digital

CHS Digital Implementation, CSDS and technology-enabled services [SCR, DiS, VW, UCR etc.]

Personalised Care

Embedding UPC in all aspect of services and approaches

Health Inequalities

Optimising CORE20plus5 and PHM approaches in all AW areas

Urgent Community Response

- 2-hour UCR services are operating at a minimum 8am to 8pm, 7 days a week across the NENC ICS.
- Continued areas of focus:
  - Increasing referrals from ambulance services to UCR via pull/push model
  - ‘Place-based’ community falls response
  - Care home ambulance conveyance avoidance
- Updated Technical Guidance has been published - additional service type codes will allow for more complete reporting in line with the UCR standards, including District Nursing.
- Monitoring of UCR indicators across ICB via Integrated Delivery Report.
- Anticipate shift towards evidencing impact.

Proactive Care

Case Finding Tools in RAIDR

Shared Care Records: Digitisation of ACP via GNCR/HIE

Enablers

Ageing Well Minimum Data Set

Year of Care: Personalised Anticipatory Care pilot in North Cumbria

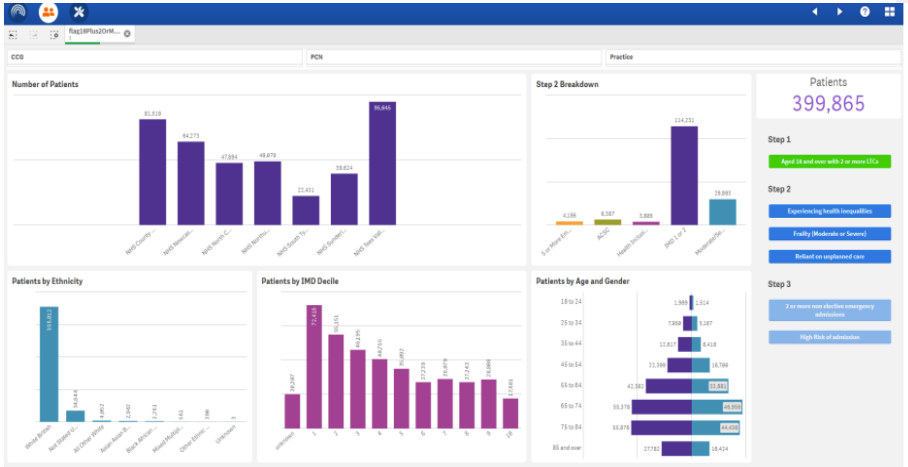
Great North Care Record

YEAR OF CARE PARTNERSHIPS

involve consider assess respond evaluate

Work to develop a 'Proactive Care Toolkit' is commencing in June 2023

RAIDR Anticipatory Care Aggregate Dashboard

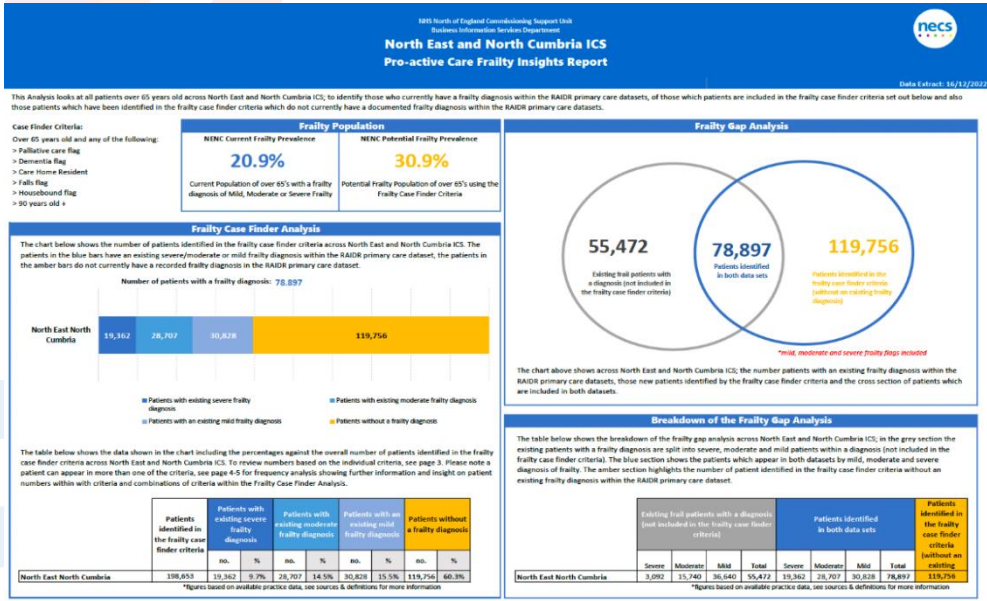


necsu.nhs.uk

Official-Sensitive: Commercial

RAIDR
Rapid Actionable Insight Driving Reform

Frailty Insight Report



NHS North of England Commissioning Support Unit
Business Information Services Department

necs

North East and North Cumbria ICS
Pro-active Care Frailty Insights Report

Data Extract: 16/12/2022

This Analysis looks at all patients over 65 years old across North East and North Cumbria ICS; to identify those who currently have a frailty diagnosis within the RAIDR primary care datasets, of those which patients are included in the frailty case finder criteria set out below and also those patients which have been identified in the frailty case finder criteria which do not currently have a documented frailty diagnosis within the RAIDR primary care datasets.

Case Finder Criteria:
Over 65 years old and any of the following:
> Palliative care flag
> Dementia flag
> Care Home Resident
> Falls flag
> Housebound flag
> 90 years old +

Frailty Population

NENC Current Frailty Prevalence	NENC Potential Frailty Prevalence
20.9%	30.9%
Current Population of over 65's with a frailty diagnosis of Mild, Moderate or Severe Frailty	Potential Frailty Population of over 65's using the Frailty Case Finder Criteria

Frailty Gap Analysis

55,472 — Existing frail patients with a diagnosis (not included in the frailty case finder criteria)
78,897 — Patients identified in both data sets
119,756 — Patients identified in the frailty case finder criteria (without an existing frailty diagnosis)

*mild, moderate and severe frailty flags included

The chart above shows across North East and North Cumbria ICS; the number patients with an existing frailty diagnosis within the RAIDR primary care datasets, those new patients identified by the frailty case finder criteria and the cross section of patients which are included in both datasets.

Frailty Case Finder Analysis

The chart below shows the number of patients identified in the frailty case finder criteria across North East and North Cumbria ICS. The patients in the blue bars have an existing severe/moderate or mild frailty diagnosis within the RAIDR primary care dataset, the patients in the amber bars do not currently have a recorded frailty diagnosis in the RAIDR primary care dataset.

Number of patients with a frailty diagnosis: 78,897

	Patients with existing severe frailty diagnosis	Patients with existing moderate frailty diagnosis	Patients with an existing mild frailty diagnosis	Patients without a frailty diagnosis
North East North Cumbria	19,362	28,707	30,828	119,756

The table below shows the data shown in the chart including the percentages against the overall number of patients identified in the frailty case finder criteria across North East and North Cumbria ICS. To review numbers based on the individual criteria, see page 3. Please note a patient can appear in more than one of the criteria, see page 4-5 for frequency analysis showing further information and insight on patient numbers within with criteria and combinations of criteria within the Frailty Case Finder Analysis.

	Patients identified in the frailty case finder criteria	Patients with existing severe frailty diagnosis		Patients with existing moderate frailty diagnosis		Patients with an existing mild frailty diagnosis		Patients without a frailty diagnosis	
		no.	%	no.	%	no.	%	no.	%
North East North Cumbria	198,653	19,362	9.7%	28,707	14.5%	30,828	15.5%	119,756	60.3%

*figures based on available practice data, see sources & definitions for more information

Breakdown of the Frailty Gap Analysis

The table below shows the breakdown of the frailty gap analysis across North East and North Cumbria ICS; in the grey section the existing patients with a frailty diagnosis are split into severe, moderate and mild patients within a diagnosis (not included in the frailty case finder criteria). The blue section shows the patients which appear in both datasets by mild, moderate and severe diagnosis of frailty. The amber section highlights the number of patient identified in the frailty case finder criteria without an existing frailty diagnosis within the RAIDR primary care dataset.

	Existing frail patients with a diagnosis (not included in the frailty case finder criteria)				Patients identified in both data sets				Patients identified in the frailty case finder criteria (without an existing
	Severe	Moderate	Mild	Total	Severe	Moderate	Mild	Total	
North East North Cumbria	3,092	15,740	36,640	55,472	19,362	28,707	30,828	78,897	119,756

*figures based on available practice data, see sources & definitions for more information

Community Health Services - Digital

Ensure CHS providers access Shared Care Record as a priority in 2022/23

(CSDS) Deliver radical improvements in quality & availability against national data requirements & clinical standards

Work towards achieving a core level of digitisation by March 2025 in line with Frontline Digitalisation

Costed three-year investment plans include community sector delivery against WGLL

Community Transformation (Digital), early focus on Ageing Well priorities

Support Ageing Well national objectives in the following areas:

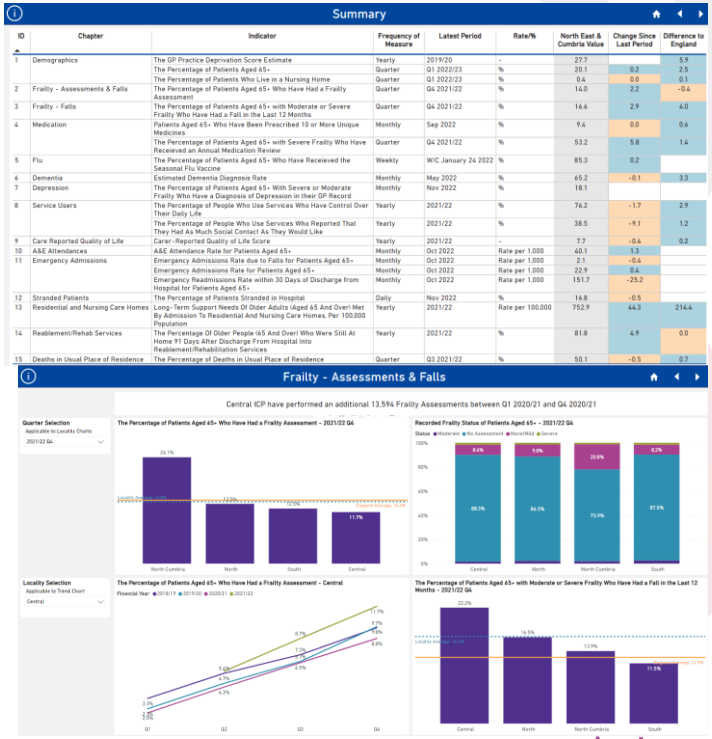
- Anticipatory Care – including digitisation and sharing of Palliative Care documentation and Care Plans
- Enhanced Health in Care Homes digitisation
- Urgent Community Response

Current focus

- Community **Digital Strategy** – finalisation with NENC Digital Team
- UCR digital support – Community Services Data Set **(CSDS) onboarding** community providers
- 13% increase in **UCR 2hr trajectories** from this year to next
- 45% increase in 2hr referrals from June to Dec ‘23 on UCR dashboard, driven mostly by **Data Quality** improvements
- **Virtual Wards** digital platform planning
- Supporting digitisation and sharing of palliative care documents and flags with 999, supporting EoL patients in preferred place of death

Metrics, Measures and Outcomes

Ageing Well Frailty Outcomes Framework Dashboard



Summary

ID	Chapter	Indicator	Frequency of Measure	Latest Period	Rate/%	North East & Cumbria Value	Change Since Last Period	Difference to England
1	Demographics	The GP Practice Deprivation Score Estimate	Yearly	2019/20	-	27.7		5.9
		The Percentage of Patients Aged 65+	Quarter	Q1 2022/23	%	20.1	0.2	2.5
		The Percentage of Patients Who Live in a Nursing Home	Quarter	Q1 2022/23	%	0.4	0.0	0.1
2	Frailty - Assessments & Falls	The Percentage of Patients Aged 65+ Who Have Had a Frailty Assessment	Quarter	Q4 2021/22	%	14.0	2.2	-0.4
3	Frailty - Falls	The Percentage of Patients Aged 65+ with Moderate or Severe Frailty Who Have Had a Fall in the Last 12 Months	Quarter	Q4 2021/22	%	16.6	2.9	4.0
4	Medication	Patients Aged 65+ Who Have Been Prescribed 10 or More Unique Medicines	Monthly	Sep 2022	%	9.4	0.0	0.6
		The Percentage of Patients Aged 65+ with Severe Frailty Who Have Received an Annual Medication Review	Quarter	Q4 2021/22	%	53.2	5.8	1.4
5	Flu	The Percentage of Patients Aged 65+ Who Have Received the Seasonal Flu Vaccine	Weekly	W/C January 24 2022	%	85.3	0.2	
6	Dementia	Estimated Dementia Diagnosis Rate	Monthly	May 2022	%	65.2	-0.1	3.3
7	Depression	The Percentage of Patients Aged 65+ With Severe or Moderate Frailty Who Have a Diagnosis of Depression in their GP Record	Monthly	Nov 2022	%	18.1		
8	Service Users	The Percentage of People Who Use Services Who Have Control Over Their Daily Life	Yearly	2021/22	%	76.2	-1.7	2.9
		The Percentage of People Who Use Services Who Reported That They Had As Much Social Contact As They Would Like	Yearly	2021/22	%	38.5	-9.1	1.2
9	Care Reported Quality of Life	Carer-Reported Quality of Life Score	Yearly	2021/22	-	7.7	-0.4	0.2
10	A&E Attendances	A&E Attendance Rate for Patients Aged 65+	Monthly	Oct 2022	Rate per 1,000	40.1	1.3	
11	Emergency Admissions	Emergency Admissions Rate due to Falls for Patients Aged 65+	Monthly	Oct 2022	Rate per 1,000	2.1	-0.4	
		Emergency Admissions Rate for Patients Aged 65+	Monthly	Oct 2022	Rate per 1,000	22.9	0.4	
		Emergency Readmissions Rate within 30 Days of Discharge from Hospital for Patients Aged 65+	Monthly	Oct 2022	Rate per 1,000	151.7	-25.2	
12	Stranded Patients	The Percentage of Patients Stranded in Hospital	Daily	Nov 2022	%	16.8	-0.5	
13	Residential and Nursing Care Homes	Long-Term Support Needs Of Older Adults (Aged 65 And Over) Met By Admission To Residential And Nursing Care Homes, Per 100,000 Population	Yearly	2021/22	Rate per 100,000	752.9	44.3	214.4
14	Reablement/Rehab Services	The Percentage Of Older People (65 And Over) Who Were Still At Home 91 Days After Discharge From Hospital Into Reablement/Rehabilitation Services	Yearly	2021/22	%	81.8	4.9	0.0
15	Deaths in Usual Place of Residence	The Percentage of Deaths in Usual Place of Residence	Quarter	Q3 2021/22	%	50.1	-0.5	0.7

Frailty - Assessments & Falls

Central ICP have performed an additional 13.5% Frailty Assessments between Q1 2020/21 and Q4 2020/21

NENC Enhanced Health in Care Homes Report (AHSN/NEQOS)

- Provides opportunity to identify variation which may stimulate further investigation on a local level – not meant as a performance report.
- Report is divided into 7 chapters:
  1. Care home capacity and rating
  2. Care home occupancy
  3. Deterioration and deterioration management tools in care homes
  4. Urgent community response and place of death
  5. Personalised care in care homes
  6. Dementia and mental health
  7. Preventative care and prescribing practices

Quality measures

Development of UCR patient and staff questionnaires (Tees)

involve consider assess respond evaluate

Enhanced Health in Care Homes

- Awaiting EHCH refresh

EnCOP

Our EnCOP Hall of Fame

NHS
Harrogate and District
NHS Foundation Trust

NHS
North East and
North Cumbria

NHS
South Tees Hospitals
NHS Foundation Trust

Gateshead
Council

akari
care

NHS
County Durham
and Darlington
NHS Foundation Trust

Roseberry Care

NHS
Northumbria Healthcare
NHS Foundation Trust

Four Seasons Health Care

Eden & Copeland PCN's

NHS
South Tyneside and Sunderland
NHS Foundation Trust

NHS
North Tyneside

"EnCOP just seems to pull everything together for me to consolidate and build on my professional knowledge and practice.."

"Everyone should be EnCOPped!"

"Based on what we have learned from implementation to date, we are aiming to continue to use EnCOP as a vehicle to underpin restorative peer supervision and support."

"EnCOP can help with patient flow.."

"Before EnCOP I never thought of frailty as a long term condition.."

"I've learned such a lot.."

"Understanding CGA has improved my assessment with older people"

"You know what? I never expected to enjoy it so much!"

"I am cross nobody told me about this language of frailty'.

UCR?

EHCH?

VW?

A/PC?

MDT?

'There will not be enough acute geriatric teams so that they alone can be charged with medical care of frail older adults. The goal should be to “geriatrise” how we provide health care if we are to do right by our ageing population.’

Dr. Ken Rockwood

https://www.bgs.org.uk/blog/how-older-people-move-in-bed-when-they-are-ill

2008 2023

You Said
We Did

There is still
MUCH
to be
DONE
Let's not lose sight
FINISH STRONG

PROPOSAL

‘The BGS remains a friend and supporter of EnCOP.’

‘…followed EnCOP closely since it’s inception’

‘… has developed an EnCOP family’

British Geriatrics Society
Improving healthcare for older people

Harjoy Warren House
[illegible]

Telephone [illegible]
Email [illegible]
Website [illegible]

BGS

23 May 2023

Dear Lesley,

I am delighted that you asked me, in my capacity as President of the British Geriatrics Society, to write in support of your business case to extend the funding for the Enhanced Care of Older People (EnCOP) initiative. I have followed EnCOP closely since its inception, spent a delightful day with you at your EnCOP celebration event in March 2023 and then was pleased to see the team present as part of the Education theme at the Spring Meeting of the British Geriatrics Society in Edinburgh this month. That presentation at the national BGS meeting set our Twitter-feed alight with colleagues keen to learn more and to replicate your success.

EnCOP builds competencies in care of older people across multiple disciplines in multiple parts of the system. It has developed an extensive community of practice – an EnCOP family – that further spreads good practice in the care of older people, delivering impact well beyond the initial footprint of EnCOP attendees. It is a compelling model of how to use education to drive up standards, because it recognises that evidence-based care of older people is delivered by multidisciplinary teams, and that people living with frailty present in all parts of the health and social care systems.

EnCOP is a relatively unique proposition both in the UK and internationally and should be regarded as a jewel in your regional crown. I know from colleagues around the UK that they are envious of your success in extending competencies in care of older people across the wider workforce. They are keen to emulate your models of working elsewhere. I hope that colleagues in the North East are able to fund your continued work, and that they can work with you to further capture the impact and cost-benefit of your interventions in ways that will allow the approach to be rolled out in other parts of the country.

The BGS remains a friend and supporter of EnCOP. Please let us know what we can do to support your ongoing work.

Yours sincerely,

Adam Gordon PhD MBChB MMedSci (Clin Ed) FRCP FRCPE

Professor of Care of Older People, University of Nottingham
President, British Geriatrics Society

‘…envious’

‘…extending competencies of care across the wider workforce’

‘…a compelling model of how to use education to drive up standards’

Evaluation, Evidence and Research

- EnCOP; quantitative ARC funded study due for completion September 2023, qualitative evaluation capturing the experiences of the workforce continues

- Hydration Project; second workshop held; competencies drafted

Personalised Care

- NECS have been commissioned to improve Personal Health Budget offer across NENC, focused on pathways, processes and data collection. NENC is behind national trajectories for PHB uptake. Benchmarking underway.
- Personal Wheelchair Budgets Task and Finish group established and has met twice to address issues with PWB uptake and data collection. Wheelchair services and PWB mentors engaged.
- Patient Activation Measure – challenges persist with meeting digital access requirements for online platform. Working with Digital ICB to address this.
- Personalised Proactive Care pilot underway in North Cumbria – two PCNs participating. Working on implementing personalised care and support planning approach and holistic assessment with people in the Proactive Care cohort.
- Workforce Development Lead now in place to work across NENC in 2023/24. Successful engagement event held in North Cumbria, looking to replicate in North East. Offer includes support for systems and services in training staff in personalised care approaches.
- Place-based projects continuing, aiming to embed various components of the Universal Personalised Care model in local areas.
- Joint forward view action plan being developed to embed personalised care across all NENC workstreams over the next 5 years.

Challenge North Tyne

Hermina ELY

Health and Social Care Tech Innovation Manager

NORTH OF TYNE COMBINED AUTHORITY

North East Local Enterprise Partnership

Innovation SuperNetwork™ NORTH EAST ENGLAND

Supporting people in later life at home, work and play

Join us to help define the opportunities for innovation to support elder citizens to live happier, more connected lives.

Challenge North Tyne

Funded by: North of Tyne Combined Authority

Delivered by: North East Local Enterprise Partnership

Innovation SuperNetwork™ North East England

Photo credit: Peter Kindersley

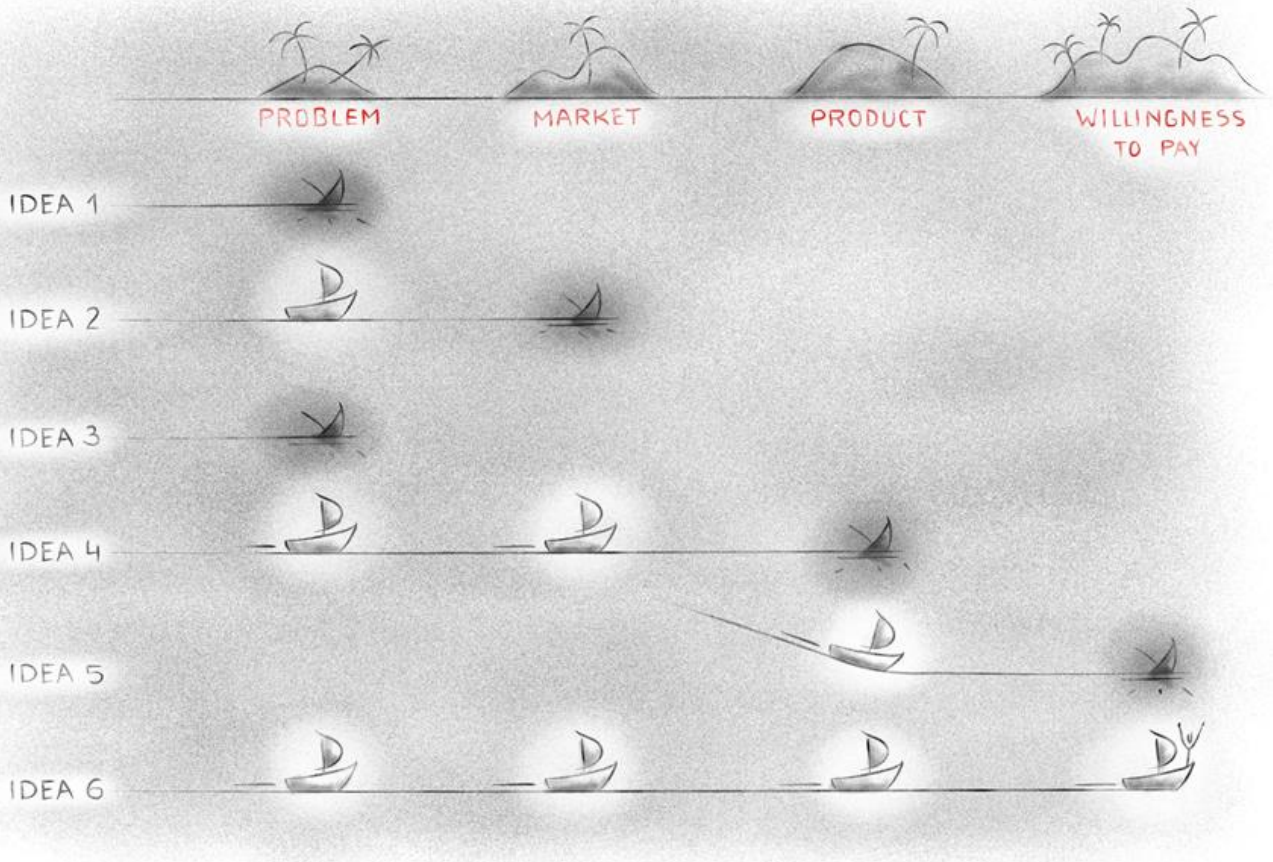
What is Challenge-Driven Innovation?

Challenge-driven innovation aims to define **priority issues** that, due to their complexity, do not have effective solutions currently available and these areas are **too important** to wait for the market to respond.

Challenges are defined and run for a set period to enable radical collaboration by key stakeholders and communities, by:

- defining shared priorities,
- focusing attention, and
- providing a space and framework in which impactful and sustainable solutions can be rapidly co-created, tested and iterated.

"Man cannot discover new oceans unless he has the courage to lose sight of the shore." Andre Gide


PROBLEM
MARKET
PRODUCT
WILLINGNESS TO PAY
IDEA 1
IDEA 2
IDEA 3
IDEA 4
IDEA 5
IDEA 6

50 no. Small and Medium sized enterprises and charities have:

1. £5,000 in grant funding to test their ideas.
2. Opportunities to work with key stakeholders and users.
3. An accelerator programme to support their solution development.
4. Opportunity to pitch for additional funding for solutions that show the biggest impact.

Challenge supporters (potential partners or test beds) from:

Charities

Banking and Commercial sector

Health and life sciences

Social Housing Providers

Universities and research

Utilities and energy

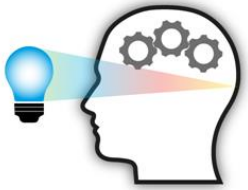
Culture and creative

Social Services

Care homes and service providers

Sports and leisure

Transport



> *"The services are not joined up – you end up confused about who is offering what and how they all fit together."*

Challenge North Tyne

… a huge breadth of

North of Tyne Combined Authority

North East Local Enterprise Partnership

Innovation SuperNetwork North East England

QUALITY OF LIFE		
Circadian Lighting	We aim to improve quality-of-life and lengthen independence for the elderly using a uniquely compact IoT solution in a circadian bulb.	
Station Masters Centre	Our aim is to rediscover the joy of food through sensory training and food play workshops with older adults	
Safer Date	Safer Date is the safest dating app in the world, and we aim to make our onboarding process more simple for our aging population to make it more accessible and so we can play a part in reducing loneliness.	
Purch It Ltd (The mobile apprebranded to "vieMo")	For Gen X and older, looking for a quick way to find products with a couple of taps, scan any movie, show or sporting event to find unique deals, promotions and productions. Discover more, with vieMo. (NB The Purch It App is being rebranded to "vieMo" due to a similar company in the USA)	
Robtic	We aim to improve indoor air quality and ventilation through the use of window automation and control. Robtic is developing a smart window system for the home of the future.	
DigiMonk Ltd	We want to enable effective and efficient recovery, rehabilitation, and independence of patients who suffered a stroke (or are suffering from Dementia) through a wearable Smart Glove.	
Sensmart Ltd	Sensmart aim to reduce detrimental effects of malnutrition and dehydration in the form of a alternative multi-sensory communication aid that allows active engagement surrounding daily dietary constitution. This is aimed at individuals limited by an impairment or disability using our innovative solution Numenyu, Numenyu is a menu that incorporates visual, auditory, tactile and olfactory stimulation in order deliver promoting independence and choice.	
IDRATEK LTD	Our aim is to provide improved oversight, convenience, and peace of mind for carers and the cared for, using unobtrusive and easy to retrofit components of our smart home technology	
Forgit IT	Forgit aims to help people with strength difficulties in their fingers to make them more independent with daily tasks such as opening bottes, jars and tins through the invention of easy to use gadgets.	

SERVICES AND SUPPORT		
Wobblefit	We aim to reduce loneliness and improve personal health and fitness in females over the age of 50 with peer-to-peer, symptom-led activities using an online matching service.	
Your Health and Care	'Peggi' is a digital multi-media application designed to transform the way memories are shared, contact with loved ones and carers maintained and reminiscence made easy, reducing loneliness, helping people live longer happier lives.	
Elders Council	Front Door is a telephone helpline which aims to reduce crisis referrals to social care. Delivered by the voluntary sector, it will enable people to easily access information and support. Helpline data assists with service planning and delivery.	
SKILLS AND TRAINING		
Equal Arts	We aim to improve the lives of people living with dementia by using their imagination and creativity which are areas of pleasure and achievement as opposed to focussing on their memory which is their area of deficit and decline. We're developing an e-learning programme which can be accessed by different stakeholders from care staff in care homes, other sector professionals and relatives in order to show how to change society's thinking when supporting people living with dementia.	
VR Care Works	Dramatically raising the quality of care-training through VR and video-real experiences specialising in de-escalation techniques, empathy and dementia awareness training for the social services and other health and public sector.	
Arena North Promotions	Bringing confidence, presentation and interview skills to jobseekers using a train the trainer method, growing a flexible consultancy of 'retirees' by enhancing their own skills from past working lives to pass on to others.	
Experience Art	'Experience Art' is to be delivered through sheltered housing schemes across North of Tyne to include housing support staff who may enhance their work life to deliver art sessions thus improving staff retention.	

STAYING ACTIVE		
Cycling Minds CIC	We aim to enhance the mental and physical well-being and social inclusion of older people through cycling and gather and analyse data from their rides to calculate the associated public healthcare cost and carbon footprint savings per kilometre travelled.	
Strictly Starters Limited	We aim to expand our capacity to teach more adult couples how to dance Ballroom, Latin American and popular sequence dances in village halls across the NE to help them improve their wellbeing and social lives.	
Golf in Society	Our mission is to put golf clubs across the region at the heart of the healthy ageing crisis. We specialise in improving the physical, mental and social wellbeing of older adults and their carers living with chronic illness. Our innovative services create opportunities for all to discover and access the existing infrastructure and green spaces of local clubs. We are inspiring our ageing population to enjoy activity, discover a renewed sense of purpose and keep socially connected for a lifetime at their local club.	
Adventure Mobility	We plan to widen accessibility and improve the mental and physical health for the growing aging population and especially for paraplegics through the easiest approach encouraging people to the outdoors through the motorisation of our All Terrain Wheelchair Nomad/ Tundra.	
Cricketqube	We aim at improving healthy aging in middle-aged citizens by developing an application to track their health records and enhance healthy eating and fitness. Further development would include digitizing GP services with multi-lingual doctors, for effective consultation and to lower the data loss in communication between the doctors-translator-patients.	
Go Local Food	GO Local food will research, acquire and trial innovative market garden tools which are more inclusive and support our vegetable growing cooperative and volunteer community.	

STORYTELLING		
Nebula Labs	We are developing a Virtual Memory Box for older people to retain memories and memorabilia so they can reminisce, recall, and share life stories with carers, family and friends to help improve connections, mental health and reduce loneliness.	
Luk-Luk Productions Film TV & Media	We aim to reduce loneliness and improve mental health in the over 50s by producing an online, magazine type TV programme, FOR the elderly, produced BY the elderly, using industry standard skills and techniques.	
ACT 2 CAM	We aim to raise quality of life for the older generation, reducing loneliness and improving connectedness, through storytelling activities, supported by searchable web-based archive.	

PLEASE get in touch if you would like a **COPY** of the straplines or to be put in touch with any of the solution providers to find out more!

Testing is ongoing and many are looking for opportunities to try out their solutions and test their market.

Tuesday 6th June – 9.30 – 4pm at Newcastle City Library

Define your value, evidence impact & secure funding

Creating a tapestry of funding – and being multi-lingual. A bootcamp for any businesses or charities North of Tyne exploring funding opportunities.

Thanks for your time!

Supporting older people at home, work and play

Hermina Ely

Innovation Challenge Manager

Hermina.Ely@supernetwork.org.uk

Delivering Energy Efficient, Carbon Neutral Homes

Lysa Morrison
Innovation Challenge Manager
Lysa.Morrison@supernetwork.org.uk

involve consider assess respond evaluate

Date and Time of Next Meeting

Thursday 3 August 2023 at 14:00-16:00pm