A Regional Approach to Ageing Well

Community of Practice

5 October 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: • Let's not talk 'Virtual Wards' • Supporting Virtual Wards to be Inclusive for Older People with Dementia, Delirium, and Mental Health Needs	
4.	Any Other Business	All
5.	Date and Time of Next Meeting - Thursday 7 December 2023 at 14:00-16:00pm	
6.	Close	

Welcome and Introductions

Frailty - what's the latest?

Ageing Well Priorities

The National NHS Ageing Well *priorities* [shown below] together with our NENC ICB-wide Older Person's Workforce Development [ENCoP] and Community Health Digital and Outcomes Programmes [e.g., Ageing Well Outcomes Framework] are in keeping with the NHS Long Term Plan and aligned to the NENC ICB Better health and wellbeing for all Strategy's goals and ambition.

1. Urgent Community Response	2. Proactive Care (Formally known as Anticipatory Care)	3. Enhanced Health in Care Homes	4. Community Health Services Digital	5.Supporting the workforce
Providing urgent care to people in their own homes within two-hours if their health suddenly deteriorates	Enabling proactive and personalised care and support for people living with frailty and/or multiple long-term conditions	Enabling proactive care and support to residents and their families	Driving forward digital transformation with community health services to enhance patient care	Developing and empowering the workforce to meet the specific needs of older adults now and in the future through substantive implementation of the evidence based Enhanced Care for Older People competency framework (EnCOP).
Better health & care services	Fairer outcomes for all; Longer & healthier lives	Better health & care services	Harnessing new technology and making best use of data	Supporting and growing our workforce

+ Virtual Wards

Urgent Community Response (UCR)

Objectives 2023-24
1. Increase the number of people accessing timely UCR services within 2-hours
2. Increase the number of UCR referrals from all key routes, including step-down recovery (when needed)
3. Increase the number of UCR services that offer all 9 clinical conditions/needs including a 24/7 falls offer
4. Improve patient access (equitable), safety, experience, and staff satisfaction within UCR services

Key updates

- 2-hour UCR services continue to operating at a minimum 8am to 8pm, 7 days a week across the NENC ICS.
- Since March 2023, there has been a sustained upward trend in the actual number of standard and all referrals across the NENC ICB.
- Recent focus has been on development of Winter Planning proposals - aimed at improving the integration of UEC, between services and in 'Places':
  - **i. Ambulance**
    - Referral to 2-hour UCR services for people whom an ambulance has been dispatched instead of conveyance (Paramedic referral - Push)
    - Direct referral into UCR services from CAS clinicians in NEAS (Push)
    - UCR clinicians access the ambulance stack and review Cat 3 and 4 and remove cases suitable for UCR response (Pull)
  - **ii. Care Homes**
    - 'Think' campaign for care homes to utilise the local UCR services as alternative to 111/999
  - **iii. Acute and Community interface**
    - Focus on step-up from UCR to Frailty Virtual Wards

Proactive Care

Overarching objective 2023-24
Improve support for Integrated Neighbourhood Teams (INTs) to implement the national Proactive Care model.

Key updates

- Proactive Care case finding tool now ‘live’ in RAIDR.
- North Cumbria Personalised and Anticipatory Care Pilot evaluation underway - exploring the views of staff involved in the regional implementation of the personalised anticipatory care programme using the Year of Care approach.
- Proactive Care resource toolkit, to support places implement their Proactive Care model, is being developed with the support of the Year of Care Partnership.
- Work ongoing to develop an Ageing Well Minimum Data Set as part of a wider programme to standardisation and sharing of electronic templates for Ageing Well.
- Continuing to link with the GNCR project team re digitalisation of ACPs, to enable better joined-up care for people as they move between different parts of the health and care system.

Enhanced Health in Care Homes (EHCH)

Overarching objective 2023-24
1. Improve support for Integrated Neighbourhood Teams (INTs) to implement the national EHCH model. 2. Reduce variation in EHCH outcomes across the ICB.

Key updates

- Development of a care home composite data set section in the Ageing Well interactive dashboard (Power BI Tool), to inform continuous improvement – work is progressing and has been showcased at the national EHCH meeting and the Falls and Frailty Conference.
- National EHCH Framework refresh (version 3) still pending.
- North East & Yorkshire EHCH Network has recently been reconvened by colleagues in the NHSE Regional Team.

Community Health Services – Digital (CHSD)

From Ageing Well Action Plan 2023-24:

Objective 1	Improve the use and quality of data within the Community Service Data Set (CSDS)
Objective 2	Increase the number of community providers utilising the Great North Care Record (GNCR) / Shared Care Record
Objective 3	Increase learning and sharing of digitally enabled community care and support across the ICB

1. CSDS Data Quality exercises under way:

- Focus on source of referral, reason for referral and ethnicity
- Reducing gap between local data and flow to national dashboard
- Comparing activity figures with trajectories for Q1 (14% above projected activity!)
- Two additional Community service providers sending data to CSDS since June (Durham council and North East Podiatry)

2. Working with GNCR team to identify and connect community providers to the shared care record:

- 13 providers now sharing and 12 viewing (up from 10 and 8 in March)

3. CHSD Community of Practice

- Established group as a CoP in May, held bi-monthly
- Working in line with draft CHSD strategy on strategic priorities (previously shared with this AW CoP)
- Signposting to LA and ASC digital developments and groups
- Focusing on FT community teams' digital priorities – survey underway looking at systems, successes, challenges and opportunities

Workforce: Enhanced Care for Older People (EnCOP) Competency Based Framework

Overarching objective 2023-24
Increase the uptake and utilisation of EnCoP as a workforce development programme across the ICB.

Key updates

- Continued roll out of the EnCOP programme to support the workforce to deliver proactive and personalised care.
- Latest webinar (September) covered ‘Recognising, Managing & Supporting Older People with Swallowing Difficulties’.
- Next session is scheduled for 17 October and topic is ‘Better mealtime for people with dementia living in care homes’.

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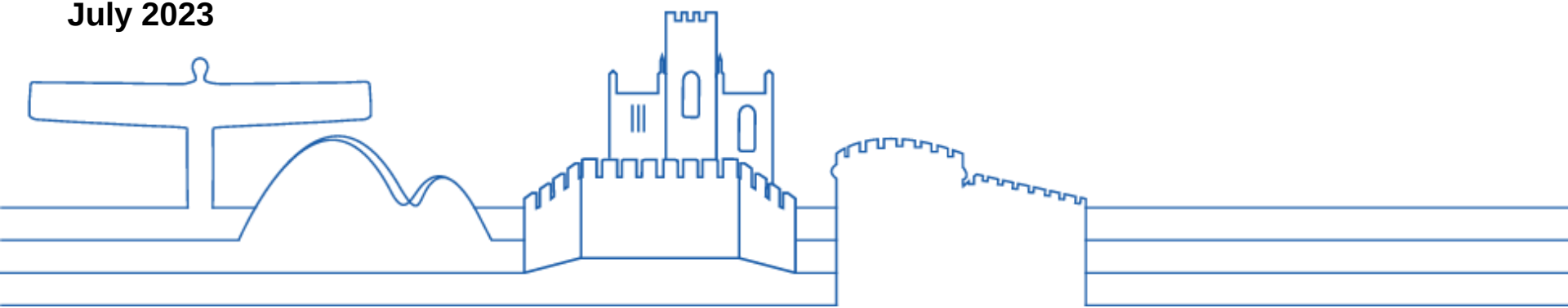
Let's not talk 'Virtual Wards'

Dr Dan Cowie

July 2023



Overview, lets think of:

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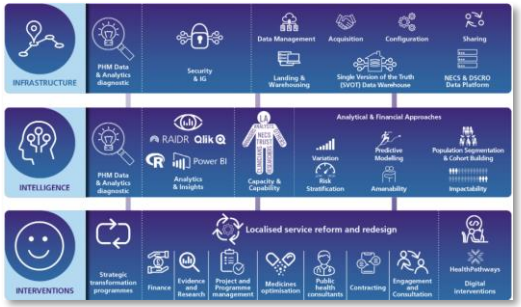
1. Jackie

2. People supporting Jackie



3. Data, Intelligence and Impact

Starting with an apology!

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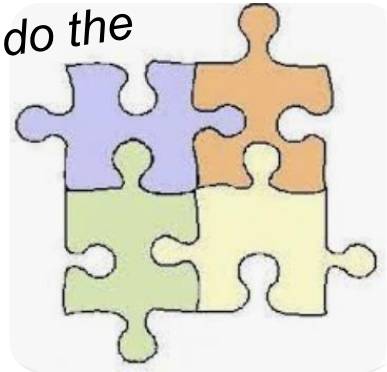
1. We've broken up the jigsaw

2. Teams are trying to keep it together

3. Lets put it back together - do the pieces still fit?



Another apology…

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If we can get Virtual Wards right for Jackie [an older person living with frailty], we can get them right of everyone!

It’s all about Jackie!

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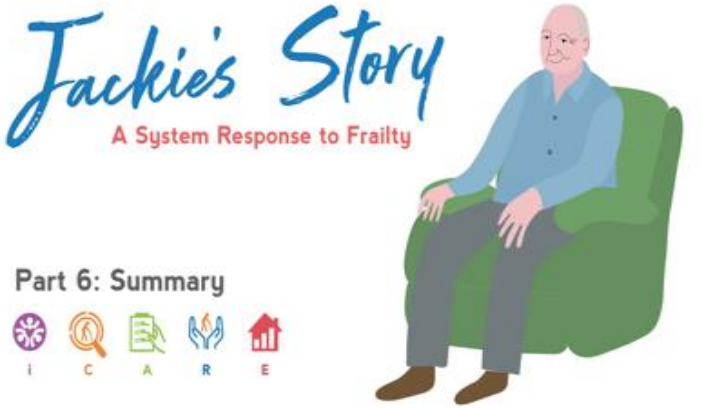
- Choice & shared-decision-making
- Personhood
- Care Network (unpaid carer)
- Best care – what matters!
- Tackling unmet need - living with frailty!
- Trust and relationships



https://jackiesstory.co.uk

It’s all about people supporting Jackie!

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- Time (capacity)
- Confidence (capabilities) – ‘geriatise
- Satisfaction (wellbeing)
- Clear decision making
- Communication - Team of Teams, IT and Technology-aided support
- Trust and relationships

http://frailtyicare.org.uk/making-it-happen/workforce/enhanced-care-of-older-people-with-complex-needs-encop-competency-framework/

Skills for Care: Virtual Wards and UCR capabilities Framework
- https://www.skillsforhealth.org.uk/info-hub/virtual-wards-and-urgent-community-response-framework/

Defining a Virtual Ward offer…

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*"support patients who would **otherwise be in hospital** to received short-term, acute care, access to diagnostics, monitoring and treatment they need in their **own residence** as an alternative to hospital or support early discharge from hospital"*

BUT…. not all people and homes are the same!

[1] The UK Hospital at Home Society (www.hospitalathome.org.uk)
[2] British Geriatric Society. Bringing hospital care home: Virtual Wards and Hospital at Home for older people - https://www.bgs.org.uk/virtualwards
[3] Supporting clinical leadership in virtual wards – A guide for integrated care system clinical leaders - https://www.england.nhs.uk/long-read/supporting-clinical-leadership-in-virtual-wards-a-guide-for-integrated-care-system-clinical-leaders/

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Inequity leads to poorer outcomes!

Jackie

- Personhood – *what matters to me!*
- Disability e.g., vision, hearing, immobility
- Health Inclusion Groups e.g., homeless
- People living with dementia, neurodiversity e.g., reasonable adjustments
- Digital exclusion

Teams/place of residence

- Access + skills of teams, services and integration
- Informal carer, family networks and formal care.
- Living in care homes, supported living or alone
- Buildings, living space, access to equipment, communication, Wi-Fi

Enablers for success: virtual wards including hospital at home
https://www.england.nhs.uk/wp-content/uploads/2022/04/B1382_supporting-information-for-integrated-care-system-leads_enablers-for-success_virtual-wards-including-hos.pdf

But we must follow the evidence!

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*"It is essential that patients treated in virtual ward beds would otherwise have required an **inpatient admission**. If patients are well enough to be at home without any acute intervention, the clinical rationale for **remote monitoring** is very limited".*

Virtual Wards: urgent care policy must follow the evidence. BMJ 2023 - https://www.bmj.com/content/380/bmj.p343

What's the evidence?

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For Jackie

- Hospital at Home patient satisfaction may be higher than for inpatient care
- Cost implications is uncertain for Jackie
- Patient selection and the identification of appropriate clinical outcomes

For people supporting Jackie

- Concerns around caregiver burden
- Evidence for carer experience is limited
- Cost implications is uncertain for Jackie's carers
- Use of digital technologies
- Workforce: staffing, skillset and competencies

For quality and value

- Most clinical outcomes including mortality better or at least equivalent to inpatient care
- Reduced rate of admission to residential care following treatment at home in either step-up or step-down models
- Length of stay evidence mixed: step-up models can increase length of stay but this may indicate identification of unmet need
- A CGA using a hospital at home approach delivers equivalent quality adjusted survival outcomes - reduced institutional care, and is cost effective
- Hospital at home approaches can also facilitate early discharge
- Cost-effectiveness uncertainty: estimates vary and likely to be overestimated
- Aligning and integrating with other programmes: UCR, same day emergency care & unscheduled care
- Barriers and facilitators operate at multiple levels (organisational, clinical and patient)

Norman, Bennett & Vardy (2022): Virtual wards: a rapid evidence synthesis and implications for the care of older people https://pubmed.ncbi.nlm.nih.gov/36633298/

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What are we trying to achieve?

*Experienced, effective **Integrated Teams** (technology-aided) supporting **Jackie** during a crisis and after to improve independence and wellbeing, so **freeing up hospital and community-beds** for Jackie when needed!*

Supporting Jackie's needs and wishes

Shared-decisions on 'what matters' – Personalised Care Planning for now and the future!

Good experience and wellbeing – reduce risk of deconditioning, delirium and hospital-acquired infection being supported at home.

Choice: Many older people **prefer** to receive healthcare at home

Independence – early intervention minimising impact with access seamless homebased recovery

Timely access to support – access to [first-line diagnostics, interventions and monitoring]

Feeling safe @home - Technology-aided support by monitoring for early signs of deterioration

Telling the story once – integrated responsive and recovery teams

British Geriatric Service. Joining the dots: A blueprint for preventing and managing frailty in older people - https://www.bgs.org.uk/Blueprint

Freeing up beds for Jackie, when needed!

Urgent Community Response

Predicated 39 bed days saved per day more in 2023/24 (NENC)

Assumptions
- Average avoidance 51.2%
- LoS 4.9 days, 75 per day
- 13% increase in people seen

Virtual Wards

Predicated bed days saved against planned trajectory **in March 2024**
NuTH - 600 bed days
N'Tees - 1,920 bed days

Assumptions:
- Each patient saves 7.5 bed days as per average respiratory LoS
- Patients stay on VW for the duration and are not admitted to a physical ward
- Number of patients admitted to the VW in March, will meet the forecasted 80% capacity target

So, what are we really talking about?

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Primary and Community Care Integration

UK Parliament
Committees

Intermediate Care [IMC]

Crisis Response + Home-based IMC

HOSPITAL TO HOME
INTERMEDIATE CARE

Integrated Neighbourhood Teams

Urgent and Proactive Care Coordination

Personhood - ‘what matters to me’

Intermediate care including reablement. Quality standard [QS173] - https://www.nice.org.uk/guidance/qs173

However, care and support rarely takes a pathway approach!

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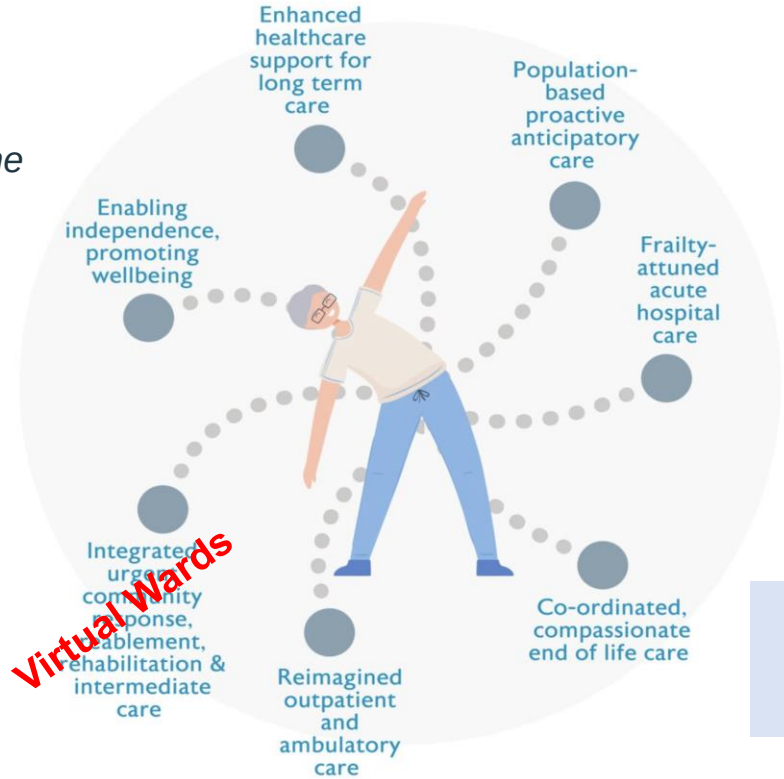
"If I fall or become acutely unwell, I can get the right help at the right time from the right person at home, or closer to home, and a team of professionals coordinate my care and support my recovery."



Joining the dots: *A blueprint for preventing and managing frailty in older people: Jackie's Seven-Touchpoints*
https://www.bgs.org.uk/Blueprint

Virtual Wards – where next?

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- Consolidation and strengthening of existing **Intermediate Care** reducing duplication and fragmentation by investing in **evidence-informed** and **data-driven** decisions [1]

- Fostering collaboration, developing **community-led alternatives**, **expanding the diversity and use of virtual wards** and the use of **secure data** to model future demand [2]

[1] British Geriatric Society. Bringing hospital care home: Virtual Wards and Hospital at Home for older people - https://www.bgs.org.uk/virtualwards
[2] NHS confederation. Matthew Taylor. The potential of care coordination - https://www.nhsconfed.org/articles/potential-care-coordination

Intermediate Care: Evidence-informed decisions

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- Identifying the 'active ingredients' to success can be difficult! [1]
- But we know what works:

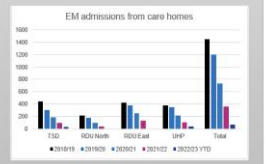
PROMOTING AND PLANNING FOR AGEING WELL - https://jackiesstory.co.uk

Frailty status	Evidence-based intervention
Not frail - mild frailty 	• Behavioural change techniques • Lifestyle intervention • Good long term conditions management • Exercise interventions and physical activity • Nutritional interventions • Osteoporosis risk assessment*
Moderate frailty 	• Nutrition interventions • Immunisation (COVID, influenza, pneumococcal vaccination) • Comprehensive Geriatric Assessment (CGA) with primary care and MDT, supported by community geriatrics, encompassing: ○ Patient goals ○ Long term conditions review ○ Polypharmacy review ○ Advance Care Planning ○ MDT assessment of function • Hospital-at-home • Reablement
Severe frailty 	• Immunisation (COVID, influenza, pneumococcal vaccination • Comprehensive Geriatric Assessment (CGA) with primary care and MDT, supported by community geriatrics, encompassing: ○ Patient goals ○ Long term conditions review ○ Polypharmacy review ○ Advance Care Planning ○ MDT assessment of function • Hospital-at-home • Bed-based intermediate care

Table 2: Evidence based interventions by tier of frailty

Comprehensive Geriatric Assessment - *Industrialize!*

One CGA = One less hospital admission per year/care home patient



For NENC this could mean 350 bed days saved per day!

Based on the following:

- In 2022/23 there were 18,921 emergency admissions from NENC care homes.
- These admissions involved 11,765 individual patients.
- Average LoS is 11 days.

[1] Health Foundation. Integrated Care Transformation programme to explore the long-term impacts of new care models on hospital use [Clarke et al., 2020] https://www.health.org.uk/publications/reports/the-long-term-impacts-of-new-care-models-on-hospital-use-midnotts

Intermediate Care: Data-driven decisions

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- Urgent Crisis Response
  - CSDS – Data Quality challenge
- Virtual Wards [Homebased IMC]
  - SitRep – MDS development, aligning to CDS/CSDS?
- **Intermediate Care Framework**
  - By autumn 2023 - Planning Framework for the rapid discharge into IMC
  - A new IMC SitRep [changes in community discharge sitrep]
  - Exploring Transfer of Care Data Hub
  - Potential new national standard - length of stay to transfer into IMC, superseding the SitReps (via the Faster Data flows project)
  - Exploring a Minimum Data-Set for IMC and recovery - Health and Social Care Shared Care Records

Intermediate Care [Urgent Community Response]: Data-driven decisions

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Jackie's profile
- 81.5% - aged 65+
- 22.3% - most deprived centile [Eng. 10.4%]

Jackie's needs
- 46.5% catheter problems
- 23.3% End-of-Life support

How teams support Jackie
- 74.3% face to face [Eng. 67.4%]

Which teams are working together
- 59.6% self/carer/relative
- 13.2% care homes
- 13.1% GP
- 7.0% Comm. Health Services
- 1.8% Ambulance Service

How teams feel [CDDFT survey]
- Gaps in social care, primary care, IMC beds and information sharing.
- Feels competency is okay, further skills training beneficial.

Jackie staying at home
- 64.9% remain at home [Eng. 56.8%]

Jackie experience (GHFT)
'*Patient feels ready to attend next available Strength and Balance Group following UCR support'.*

Data source: NENC ICB UCR Monitoring Report – based on March 2023 published data

Seeing more people like Jackie

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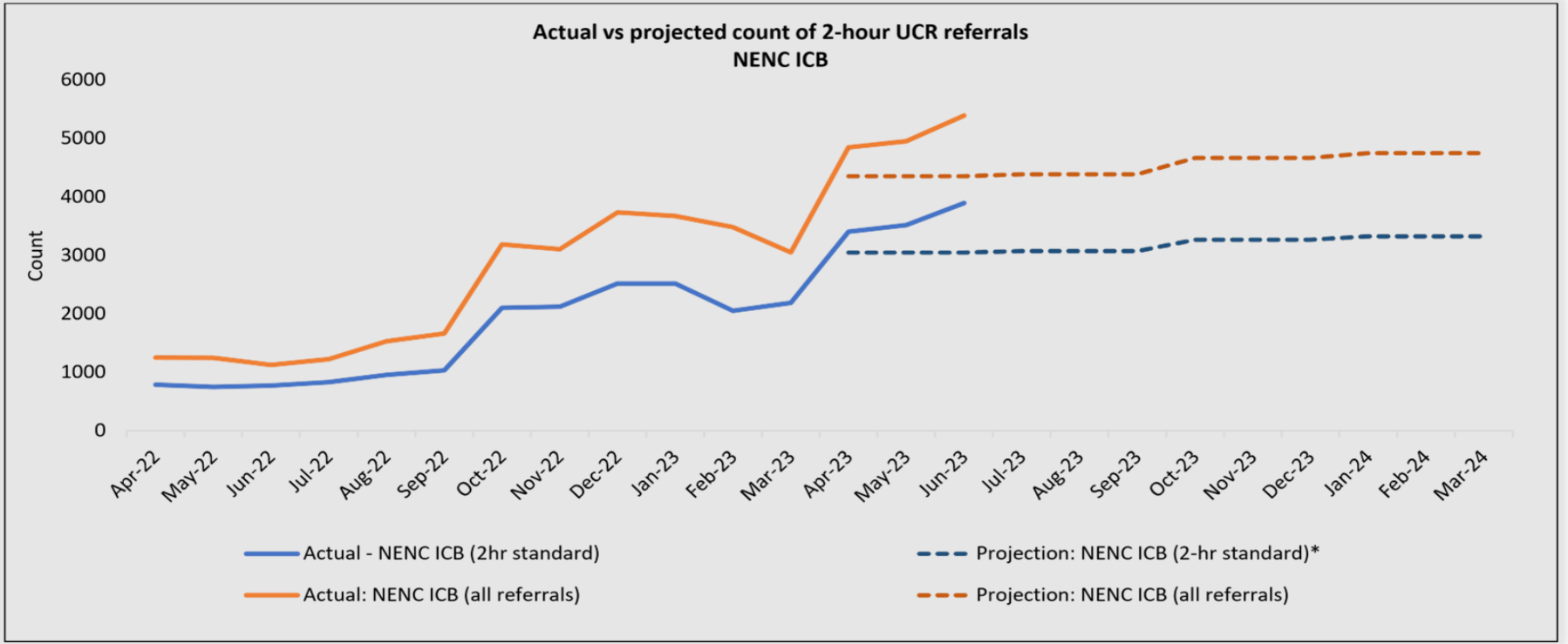

Intermediate Care [Virtual Wards]: Data-driven decisions

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Jackie's profile
- 77% aged 65+

Jackie's needs
- 35% Frailty
- 65% Respiratory

How teams support Jackie
- Step-up
- Step-down
- **DQ issues with % of unknowns*

Which teams are working together
- 17% In-patients
- 32% GP
- 9% Community Health Services
- 1% UCR
- 1% 999
- 40% Not unknown!

How long to teams look after Jackie
- 12% over 14 days
- 20% zero days

Jackie staying at home
- 71% remain at home
- 7% admitted to hospital
- 22% other

Jackie experience
Example of patient feedback on best aspect of care: *'Being at home with the knowledge that a professional/medical team were visiting and available via the telephone 24 hours should I need them'.*(Northumbria)

Data source: Last 3-months of Virtual Ward activity derived from the Sitrep (figures for **NuTH and North Tees combined**, not global ICB)

Example, focusing on a population [e.g., Jackie in a care home]: Data-driven decisions

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A range of indicators relating to best practice of care home residents

Triangulation of intelligence to tell the full story for Jackie living in a care home

A range of impact measures and outcomes for care home residents

Virtual Wards: What should we measure going forward?

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Jackie

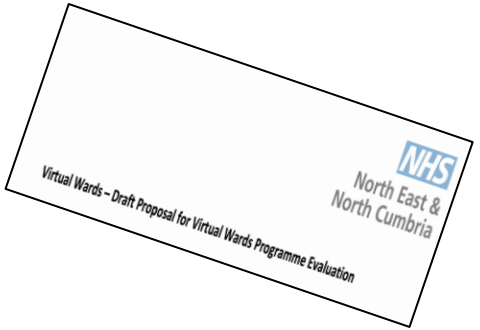
Profile – digital literacy, frailty, HI.
Population selection.
Presenting problems – complexity and acuity.
Experience, satisfaction.
Carer and family experience.

Teams

Recruitment, experience and satisfaction, skills.
Patient flows in – UCR, HIU, A&E, Hospital.
Patient flows out – PC, Community Nursing, VCSE.
Technology use, safety and feasibility – experience.

Value – Quality / Cost

Quality: Personhood and frailty care, Interventions, capacity vs utilisation, access.
Cost: Re-admission rates, bed usage, reducing overnight hospital stays, impact on primary care, pharmacy, social care, care homes.



Virtual Wards as part of an *Integrated Primary and Community Care 'offer' for Jackie*

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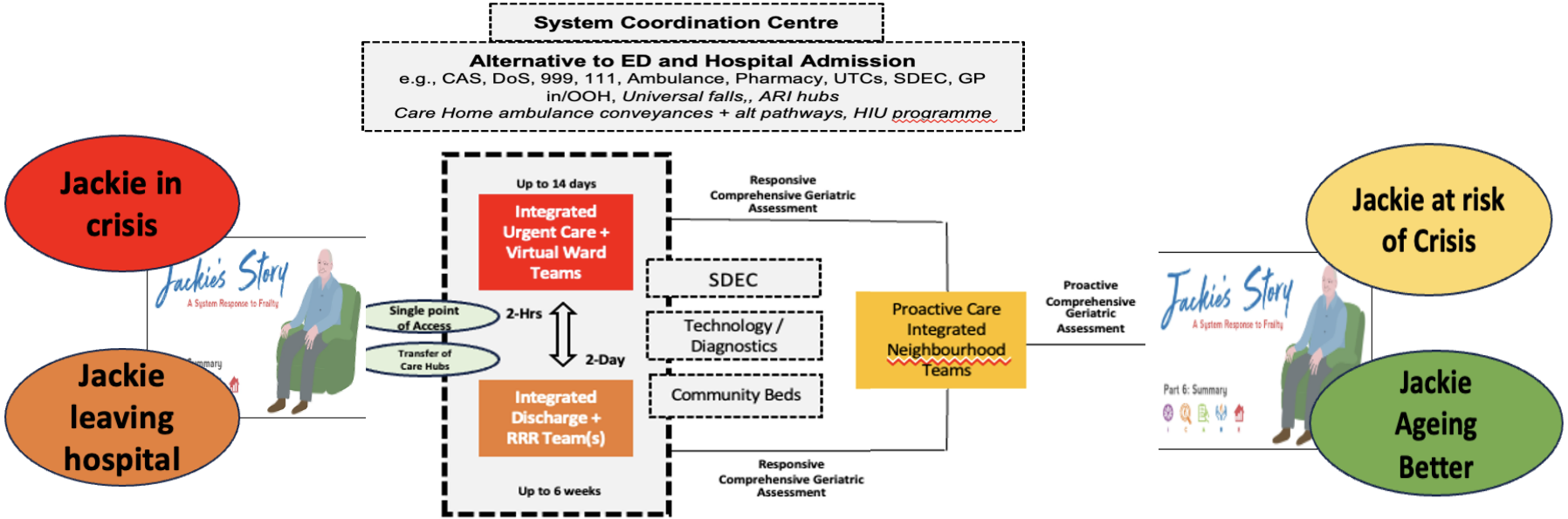

1. *Streamlined and equitable access to urgent care and advice*

2. *Proactive and personalised care* from multidisciplinary teams

3. *Helping people stay well for longer*

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Virtual Wards Guidance:

Supporting Virtual Wards to be Inclusive for Older People with Dementia, Delirium, and Mental Health Needs

Version 1.0
Published December 2023

Contents

Version 1.0
Published: December 2023

This document has been produced by the Northern England Mental Health Clinical Network (MHCN) in collaboration with stakeholders from across the North East and North Cumbria region with specialist knowledge and experience in areas including ageing well, frailty, dementia, and older people's mental health.

Context

The guidance in this document intends to support providers and commissioners involved in virtual ward development and delivery to consider how virtual wards can be inclusive for older people with dementia, delirium, and mental health needs.

A series of meetings were hosted by the MHCN in June, July and August 2023 to facilitate this work. These meetings focused on developments and core priorities at a national, regional, and local level. This document outlines key themes from these discussions and additional considerations for what high-quality care in a home setting looks like for these patient groups, taking into account patient and carer, healthcare professional, and wider service perspectives.

Background

Virtual wards offer an alternative to hospital inpatient care which is safe, efficient and person-centred and enabled by technology, with the aim of supporting early discharge from hospital and preventing avoidable hospital admissions[1]. For older people and people with frailty, evidence suggests that clinical outcomes, including mortality, are equivalent or better than inpatient care in both step-up models of admission avoidance and step-down models of early discharge[2].

> "In recent years, healthcare professionals have been considering new ways to respond to the acute care needs of older people with frailty and other long-term conditions. Urgent care is needed but hospitals bring risks for older people as well as benefits, and community-based alternatives are increasingly being explored. This has resulted in a shift in focus within the NHS and internationally towards providing hospital-level care in a person's home environment."
>
> ***Bringing Hospital Care Home: Virtual Wards and Hospital at Home for Older People British Geriatrics Society Report***

Initial implementation has focused on acute respiratory and frailty virtual wards, with the term 'Hospital at Home' often used interchangeably, and systems are expected to build virtual wards into their long-term strategies and operational budgets to ensure they can be sustained[3]. It is important to consider how these models of care can be inclusive for older people with dementia, delirium, and mental health needs.

[1] Virtual Ward Definitions and Reporting v1 - Virtual Wards Network - FutureNHS Collaboration Platform
[2] Norman, G., Bennett, P., & Vardy, E. R. (2023). Virtual wards: a rapid evidence synthesis and implications for the care of older people. Age and Ageing, 52(1)
[3] Implementing 'Virtual Wards' for older people with frailty | British Geriatrics Society (bgs.org.uk)

Key Themes

Key Themes

Specialist Involvement

Specialist input is recommended throughout assessment, admission, and discharge, including transfer of care. Multidisciplinary teams should include, or have timely access to, liaison psychiatry and/or colleagues who specialise in dementia i.e., specialist nurses. In addition, partnership working with the voluntary and community sector is encouraged to enhance support available, such as developing links with local carer organisations.

Accessibility

To ensure health inequalities are not worsened, barriers to accessing virtual wards should be addressed, for example digital exclusion and geography (e.g., rurality). As required, reasonable adjustments should be made i.e., if a patient has a sensory impairment, to ensure a patient is not excluded from a virtual ward when they could otherwise be safely supported.

Delivery

Virtual wards are digitally enabled but a hybrid model of delivery, combining digital and face-to-face elements, is important for these patient groups to assist with the ongoing assessment and management of both patient and carer needs. Where virtual conversations or digital monitoring form part of a virtual ward stay, appropriate support should be offered i.e., training or assistance to use technology.

Key Themes

Personalised Care & Care Planning

Good care planning should underpin a virtual ward stay and include developing an understanding of what is important to the patient and their carer(s), capacity assessment, and support for decision-making. A Comprehensive Geriatric Assessment (CGA) should be completed to outline ongoing needs and assess who needs to be involved in the patient's care. Conversations around advanced care planning and anticipatory care, with palliative and end of life care input as appropriate, are advised – including completion of an Emergency Health Care Plan; Deciding Right can also support making care decisions in advance.

There are many resources aimed at improving care for people living with dementia in hospital settings which may be adapted to support meaningful care in a home setting such as Getting to Know Me and This is Me. Risk reduction tools, such as The Herbert Protocol – a form which can be used by police and other agencies in the event of a person with dementia going missing, are also available.

Capacity

It is important to remember that just because someone is living with dementia, it does not mean that they lack capacity to make decisions. It is essential to engage a person in decisions around their care to the level that they can be involved. Capacity is decision specific – people living with dementia may be unable to make complex decisions, but are able to make other, more straightforward ones; though this should be assessed on an individual basis. Where a person lacks capacity to make a decision, their wishes and beliefs should always form part of the best interests' process in making the decision. Good communication is key to support this.

[No Title]

Key Themes

Communication

People living with dementia (PLWD), or those with mental health conditions, may need extra time for communication. PLWD may also benefit from information in different modes e.g., in a simple written form to refer to, or pictorial aids. It should not be assumed that someone's expressive communication is equal to their receptive understanding; a person with dementia may be unable to express themselves well but understand a lot more, or conversely appear to express themselves well but have more limited understanding of information.

The Triangle of Care emphasises partnership working, in particular carer engagement. Clear communication with relatives and caregivers is essential. Whilst it is always important to listen to the person with dementia, carers can help to provide additional information and history, support communication with the person with dementia, and offer reassurance. There are also voluntary sector services which may enable more effective communication in a virtual ward setting, such as Alzheimer's Society Dementia Advisors. Networking with local VCSE organisations to understand how they may be able to support virtual ward developments is recommended.

Carer Involvement

It is important to recognise that carers are often 'partners in care'. As such, they should be involved in shared decision-making conversations and, as agreed, provision of care throughout a virtual ward stay. Carer assessment is advised to ensure suitable support is being provided and to minimise the risk of carer burden. It may be helpful to provide additional resources and/or signposting to carer organisations and advocacy support.

Key Themes

Workforce

The Skills for Health Virtual Ward and Urgent Community Response Capabilities Framework outlines the requirement for Tier 2 and 3 practitioners to be able to:

> c) Apply a range of physical assessment and cognitive clinical examination skills appropriately, systematically, and effectively, including for delirium and dementia, and escalate or refer as appropriate.

Ongoing education and development opportunities should be available to both the specialist and non-specialist workforce. For example, training on how pain may present differently in patients with dementia, how different subtypes of dementia may present, and how to assess and respond appropriately. This may be supported by existing Competency Frameworks, such as Enhanced Care of Older People (EnCOP).

Building and maintaining relationships, communication, and leadership are all recognised as key enablers for the delivery of high-quality care. Clear governance structures and clarity around responsibility, e.g., in out-of-hours protocols, is also essential to ensure patients are receiving preferred care on a virtual ward. It is recognised there will be local variation in virtual ward models due to factors such as available resource and capacity.

Data

Multi-level integration forms a key part of virtual ward models and, as such, the importance of system-level reporting and data flows is emphasised in NHS guidance. Alongside required data collection, services may find it helpful to use existing data sets, such as the Mental Health Services Data Set (MHSDS), for benchmarking and to assist with evaluation.

Good Care Considerations

[No Title]

Good Care Considerations

In line with the Comprehensive Geriatric Assessment Toolkit, there are several core elements to support good clinical care in older patients, whose needs are often complex (i.e., multimorbidity) and require a multi-dimensional, holistic approach towards assessment and management. Some people may be dependent on a caregiver to meet these needs, and this should be reflected in care planning. It is also important to recognise:

> "Patients with dementia, delirium, or psychiatric illness may not give consent or participate in examination. Consideration must be given to whether the patient has capacity to agree or refuse examination and, if not, assessment performed bearing in mind the best interests of the patient using provisions of mental capacity legislation.
>
> This is likely to be the case for most aspects of clinical examination which are unlikely to be burdensome, harmful or limiting to the person's liberty – however if the patient has previously refused interventions and assessments it should not be assumed that a change in their ability to consent or refuse means that examination is now acceptable.
>
> Discussion with the patient's advocate(s) or healthcare power of attorney is also important here."

Comprehensive Geriatric Assessment Toolkit for Primary Care Practitioners
British Geriatrics Society

Good Care Considerations – Screening

For Undiagnosed Dementia (at assessment and during admission)

- Assessment of functional capabilities
- Level of cognition should be assessed using a validated cognitive assessment tool such as the 6-item cognitive impairment test (6CIT) or the Mini-Cog
- Where dementia is suspected, this should be taken into consideration during management and onwards referral for formal diagnosis should be made through local pathways

For Delirium (daily)

- The 4AT delirium tool is recommended. Other tools include the short Confusion Assessment Method (short-CAM). Where delirium is diagnosed, ensure appropriate support and follow-up is provided
- PINCH ME (Pain; Infection; Nutrition; Constipation; Hydration; Medication; Environment) is a useful mnemonic to help identify potential causes of delirium
- Remember the two main types of delirium, as hypoactive delirium is often overlooked. There is also mixed delirium, with features of both types:

  Hyperactive delirium: predominantly restless and agitated
  Increased motor activity, reduced control of activity, restlessness, sleep disturbance

  Hypoactive delirium: predominantly drowsy and inactive
  Decreased activity, decreased amount/speed of speech, listlessness, withdrawal, reduced awareness, reduced appetite

Good Care Considerations

Nutritional assessment

- Fluid intake should be monitored to ensure good hydration
- Assess oral health and hygiene, including swallow and checking of dentures if these are worn
- Specialist input should be available, with onward referral as required to Speech and Language, Dietetics etc.
- Where carers are involved in providing support for nutrition and hydration, training and education should be provided to ensure that they also have a good understanding of the person's current needs, along with the associated risks if these needs are not met, i.e., malnutrition and dehydration

Tool: Malnutrition Universal Screening Tool (MUST)
Resource: Hydration in Older People e-learning

Stool monitoring

- In line with nutritional assessment, constipation can be a sign of dehydration. Constipation in people with dementia may also contribute to a worsening of confusion and is recognised as a potential cause of delirium. Monitoring is therefore recommended to identify when a patient may be experiencing constipation in order to facilitate prompt management. Preventative approaches to maintain bowel health are also key (i.e., diet)

Tool: Bristol Stool Chart

Good Care Considerations

Mood assessment

Depression in older people is often under-recognised, with symptoms of depression being under-reported and possibly attributed to the effects of ageing. It is therefore vital to assess mood carefully.

- Some simple screening questions are outlined in the Comprehensive Geriatric Assessment Toolkit. If more formal assessment is required, a tool such as the Geriatric Depression Scale (GDS) may be helpful – this is validated for older people with no, mild or moderate cognitive impairment
- In people with dementia, presentation can be atypical, and a person might have difficulty expressing that they are feeling depressed. The Cornell Scale is a helpful screening tool for depression in dementia, though specialist input and referral should be considered as indicated
- Additional screening of carers for stress/carer burden is recommended, with follow-up as appropriate

Good Care Considerations

Polypharmacy

- A comprehensive medication review should be undertaken to ascertain what medication a person is taking, if they are taking their medication correctly, and their understanding about the medication they are taking
- Anticholinergic medications can have significant adverse effects in people with dementia and delirium so should be a particular focus during medication review. Medichec and ACB Calculator are useful tools to help assess anticholinergic burden and identify medications that might have a negative effect on cognitive function and/or other adverse effects in older people
- Pharmacy input within the multidisciplinary team is recommended to support medicines optimisation and reduce the risk of polypharmacy issues
- People with mental health conditions may have complex psychopharmacology regimes. Unless urgently necessary, it is generally advisable not to alter these during periods of acute physical health care. If necessary to do so, seeking specialist advice is recommended.
- Any changes to medication should be communicated clearly to the patient, carer, and other healthcare professionals involved in the person's care, including during discharge and transfer of care (i.e., to GP)

Tools: NO TEARS tool; STOPP-START decision aid; Medication Appropriateness Index (MAI)

Good Care Considerations

Vision and hearing impairment

- Sensory impairments can compound cognitive impairment and mental health needs. It is important to take time to communicate well and make reasonable adjustments as needed: Dementia, sensory impairment and communicating
- If a person uses hearing aid(s), these should be checked to ensure they are fitted correctly and working properly
- If a person wears glasses, ensure these are worn as required and clean, with an up-to-date prescription

Pain assessment and presentation

- Recognising and assessing pain in older people can be complex, but recommendations are available to support healthcare professionals: Assessment of Pain in Older People: UK National Guidelines
- Pain may also present differently in people with dementia, and presentation can differ depending on dementia subtype: Pain and dementia - Dementia UK

Tools: Abbey Pain Scale; Pain in Advanced Dementia; Doloplus; Bolton Pain Assessment Tool; DisDAT

Good Care Considerations – Deterioration

Signs of deterioration

- Development of, or increase in, delirium (NB: remember hypoactive delirium)
- Increased confusion
- Worsening oral intake
- Altered responsivity
- Decreased mobility
- "*Just not right*" – carers know the person best
- Agitation – always think about pain, especially in this situation

For further assessment at these times, consider utilising point-of-care testing. Visiting hospital may also be required to access further tests which can aid clinical decision-making and inform whether home-based treatment can continue.

Remember that hospital can be 'Attend to Assess' rather than always 'Attend to Admit'.

Quality Indicators

[No Title]

Quality Indicators

The need for evaluation is acknowledged as a key part of virtual ward development. The following list outlines some suggestions which may be helpful to consider when assessing quality of care in these patient groups. This list is not exhaustive but intends to provide a starting point for further conversation.

Indicator: Reduced delirium

- How many delirium assessments are being conducted; use of 4AT tool (screening for delirium)

Indicator: Reduced pressure sores

- Risk assessment for pressure sores; prevention; management and outcomes

Indicator: Reduced falls

- Multifactorial risk assessment; prevention (i.e., use of falls prevention checklist); interventions and outcomes

Indicator: Access

- How many people with a dementia diagnosis/delirium/mental health needs are accessing virtual wards

Indicator: Management of acute issues

- Length of stay; admission avoidance

Indicator: Outcomes

- What are the rates of hospital admission despite a virtual ward admission in these patient groups; how many people are in home/community, or in a different care setting, following admission

Additional Resources

Additional Resources

Carers

- Virtual Wards | Carers UK
- A Practical Guide to Healthy Caring | PHE
- Carers Information Hub | Rethink

Dementia

- Resources for Professionals | Alzheimer's Society
- Dementia Training Standards Framework | Health Education England
- Dementia: assessment, management and support for people living with dementia and their carers | NICE Guidance

Delirium

- Greater Manchester Community Delirium Toolkit | Dementia United
- Delirium Resources | Health Education England
- Recognising and preventing delirium | NICE
- Delirium: prevention, diagnosis and management in hospital and long-term care | NICE Guidance

Frailty

- Bringing hospital care home: Virtual Wards and Hospital at Home for older people | British Geriatrics Society
- Guidance Note: Frailty virtual ward (Hospital at Home for those living with frailty) | NHS England
- Frailty Framework of Core Capabilities | Skills for Health

Mental Health

- Mental Health in Older People | A Practice Primer
- Diagnosis and management of common mental health problems in older people | RCGP
- Managing Depression In Older People | RCGP

Polypharmacy

- Guidance on Pharmacy Services and Medicines Use within Virtual Wards | NHS

NHS
North East and
North Cumbria

Thank You

Date and Time of Next Meeting

Thursday 7 December 2023 at 14:00-16:00pm