A Regional Approach to Ageing Well

Community of Practice

1 February 2024

Academic Health Science Network
North East and North Cumbria

National Innovation Centre for Ageing

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ICS Integrated Care System
North East & North Cumbria

Welcome and Introductions

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.	**Today's Focus: falls** • Improving Quality of Life, Functional Capacity, and Strength in Older Adults: Utilising Minimal-Dose Resistance Training • St Martin's Lifting Cushion Pilot • Gateshead 'Falls Car': the journey so far	Liam Pearson PhD Candidate and Senior Lab Technician Northumbria University Louise Burn, NECS Patsy Wright, Lesley Carr, Gateshead Rapid Response Team
4.	Any Other Business	All
5.	Date and Time of Next Meeting - TBC	
6.	Close	

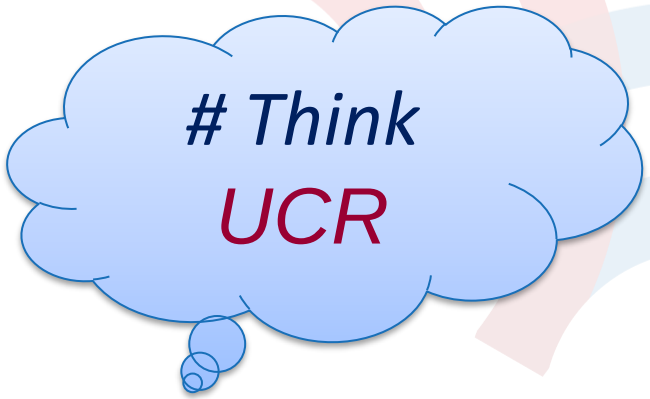
Frailty - what's the latest?

NENC UEC Winter Priorities 2023/24

Principles	ACTION	Detail	If Funding?	Impact / Metrics
Getting people to the right place first time Improving Discharges and Transfers of Care	**1a.** Implement a System **Clinical Assessment Service** with a focus on Category 3 and Category 4 validation across the system **1b. Whole system focus on Frailty** with push and pull models to UTCs and UCRs	1. Lead provider/ alliance model for CAS delivery – system-wide focus 2. Non-ambulance dispositions in place 3. All UCRS and VWs on DOS 4. 100% access for paramedics to UCRs 5. Acute Frailty pathways joined to local SPOAs	Fund testing of Lead Provider/ Alliance model for System CAS with evaluation ARI Hubs	• Fewer touchpoints for patients • More hear/ see and treat • Increased utilisation of alternatives to ED – UTC, UCR, SDEC, Falls Teams, Frailty Services • Reduced numbers of over 75s frail patients in beds – using 20% of all bed days Reduced ambulance handover times to 15 min • Improved Cat 2 performance to 18 mins • Greater safety and quality of care for frail/all
Keeping the system flowing well	**2.** Whole system focus on **Reduced Ambulance Handover Delays to 15 minutes**	1. Strengthen LADB powers and capability 2. Set trajectories for all FTs to 15 minutes over time 3. Manage through LADBs 4. Spotlight and support through UEC Network	Fund interface functions that support handovers inc SDEC	• Reduced ambulance handover times to 15 min • Delivery of Cat 2 performance to18 mins • Reduced patient harm due to reduced undifferentiated patients out in system
	3. Delivering 4 Hour Standard Extra MDT Staff in UTCs & ED Front Door Navigation/ Streaming	1. Front of house navigation in all EDs 2. Implement MDT staffing models in UTC–style services 3. Manage through LADBs	Fund MDT staffing including Senior Navigators	• ED ability to focus on high acuity resulting in better A&E performance • Supports flow and flexible staffing models

Frailty – Winter Priorities

- Focus on improving the integration of UEC – between services and in Places.
- ‘Joining the dots’ an overarching ‘#Think’ campaign.
- Areas of focus, include:
  1. **Ambulance:** A standard UCR Offer for NEAS / team
  2. **Care Homes:** Looking at NEAS call outs / Cat 3 and 4 calls
  3. **Acute and Community interface:** Focus on step-up from UCR to Frailty Virtual Wards



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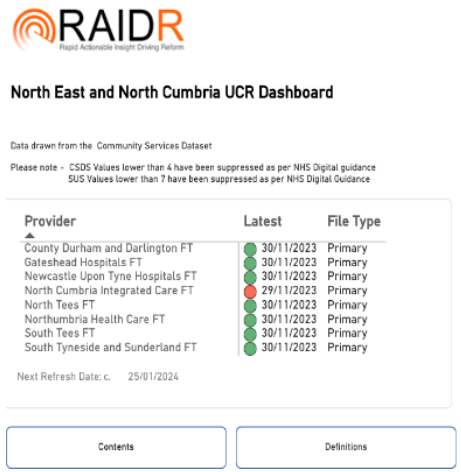
Urgent Community Response (UCR) - Update

- NENC ICB continues to **exceed the 70% 2-hour (UCR) standard threshold** - all Trusts are publishing data via the National UCR Dashboard.
- Over past year, there has been a **sustained upward trend** in the actual number of UCR standard and all referrals across the NENC ICB.
- New NENC **UCR Power BI dashboard** is being tested - this provides additional functionality to the national dashboard e.g. allowing us to understand referrals by local authority area and through a health inequality lens.
- **Data Quality exercises** are continuing to reduce 'null' or 'not known' reasons for referral or source of referral to 2-hour UCR services, as well as gaps in ethnicity data.
- **Ambulance referrals –** huge amount of work being undertaken including:
  - Development of a standardised UCR Offer for ambulance service/places.
  - Continued roll out of electronic referrals from the ambulance service to UCR services.
- Work ongoing to maximise **care home UCR referrals** - UCR Leads continue to promote their service offer to care homes, through a multi-pronged approach.

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


RAIDR

Rapid Actionable Insight Driving Reform

North East and North Cumbria UCR Dashboard

Data drawn from the Community Services Dataset

Please note - CSDS Values lower than 4 have been suppressed as per NHS Digital guidance
SUS Values lower than 7 have been suppressed as per NHS Digital Guidance

Provider	Latest	File Type
County Durham and Darlington FT	30/11/2023	Primary
Gateshead Hospitals FT	30/11/2023	Primary
Newcastle Upon Tyne Hospitals FT	30/11/2023	Primary
North Cumbria Integrated Care FT	29/11/2023	Primary
North Tees FT	30/11/2023	Primary
Northumbria Health Care FT	30/11/2023	Primary
South Tees FT	30/11/2023	Primary
South Tyneside and Sunderland FT	30/11/2023	Primary

Next Refresh Date: c. 25/01/2024

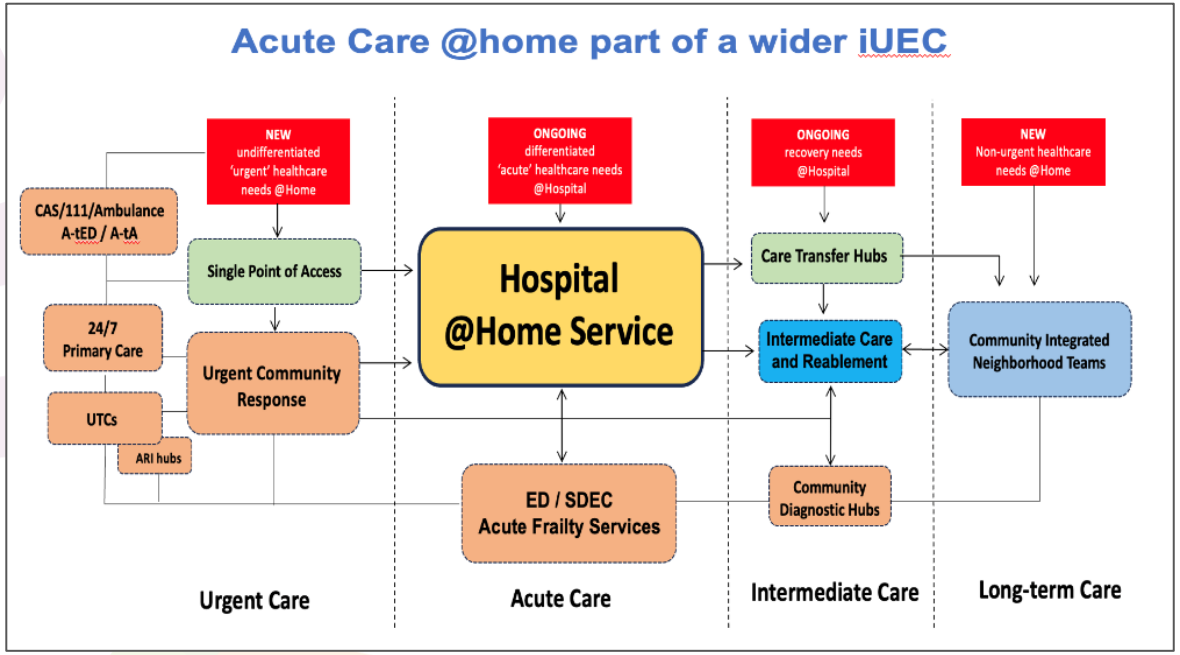
Contents | Definitions

New resources from NHS England:

- Urgent community response and ambulance referral resource
- Technology enabled care referral guidance

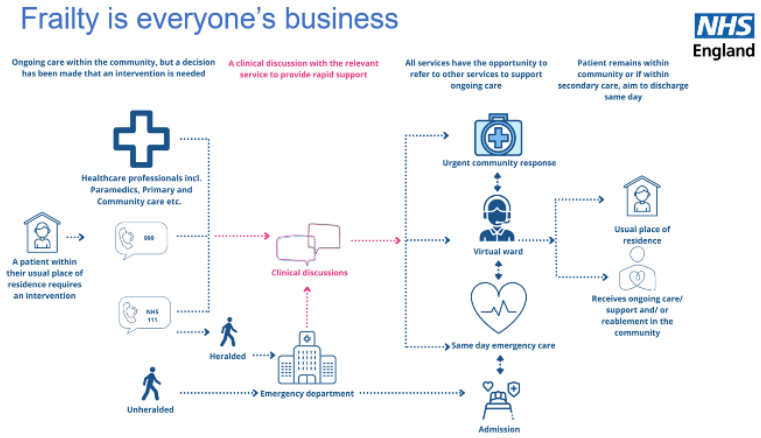
Virtual Ward - Update

- As of 31 December 2023:
  - All FTs operate respiratory virtual wards
  - 8/8 FTs are now live with frailty wards
  - 3/7 providers have digital enablement platforms
  - Aim to have all providers with digital technology in place by March 2024 [rolling out Healthcall platform]
- Strategic Commissioning Framework exploration.
- Options appraisal for future funding to ICB executive.



Pathway	North'berland and North Tyneside		Newcastle		South Tyneside and Sunderland		Gateshead Health		County Durham and Darlington		North Tees and Hartlepool		South Tees		North Cumbria	
	Step up	Step Down	Step up	Step Down	Step up	Step Down	Step up	Step Down	Step up	Step Down	Step up	Step Down	Step up	Step Down	Step up	Step Down
Respiratory	✓	✓	✓	✓	TBC	✓	✓	✓	TBC	✓	✓	✓	✓	✓	✓	✓
Frailty	✓	✓	✓	✓	TBC	✓	✓	✓	TBC	✓	✓	✓	✓	✓	✓	TBC
Cardiology		✓														
Colorectal		✓										TBC				
T&O		✓														
Lung Cancer		✓														
Paediatrics		✓														
Rehabilitaion		✓														
Hospice at Home								✓								
Community MDT							✓									
Luscii Digital monitoring						✓										

Acute Frailty - Update



- SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.
- Self assessment undertaken in July 2023 on a range of maturity indice linked to:

Acute Frailty recommendations	NENC response
clinical frailty score within 30 minutes	All can do this!
Acute frailty service supports front door assessment of appropriate patients and **'fi**t to sit' and swift onward referral to alternatives	In place in 50%+ but access to alternative limited/improving
Shared care records - 24 hours of discharge.	Using GNCR and place-system improving
Clinicians across the healthcare system have direct access to frailty services - minimum of 12 hours a day, 7 days a week	Mixed picture – working towards it
Staffing model consists of a multi-disciplinary	Appears to be in place - some geriatrician input limited
Collaboratively with social care, third sector and voluntary organisation	Informal links and in place overall with VCSE
Hospital uses one Clinical Frailty Scoring (CFS)	Yes - CFS
For 80% of patients their stay in acute frailty is under 8 hours.	No – monitoring difficult

CQUIN - Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up. Of the denominator, the number of patients who have a documented assessment against the clinical frailty scale (CFS) with appropriate response where moderate-severe frailty (CFS score of 6 or more) is identified, including: initiation of a comprehensive geriatric assessmen (CGA), and/or referral into the acute frailty service (AFS).

Single Point of Access (SPoA) - Update

- One of the Urgent and Emergency Care 10 high impact interventions.
- Provides a single, simple route for referrals.
- Staffed by qualified clinicians, able to ensure patients get referred to the most appropriate service for their needs.
- Drives standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
- NEY NHSE interest in exploring some work across NENC.

Key messages from self-assessment against ‘maturity indices’

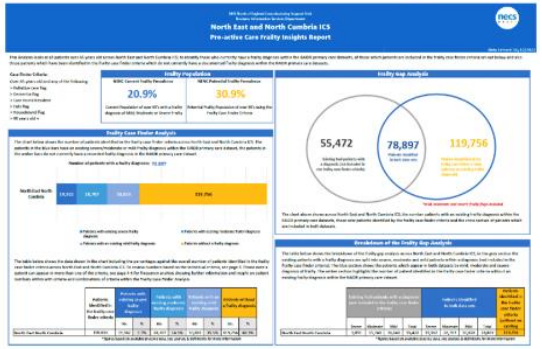
- SPoAs are implemented at ‘Place’ level across NENC.
- Different levels of maturity.
- Further work needed to gain a shared understanding of SPoAs and how this supports the ' no wrong door' approach and minimises 'hand-offs’ in the context of iUEC.
- SDEC separate in all areas, except NTH where some elements/pathways linked to iSPA (e.g. IV A/Bs).

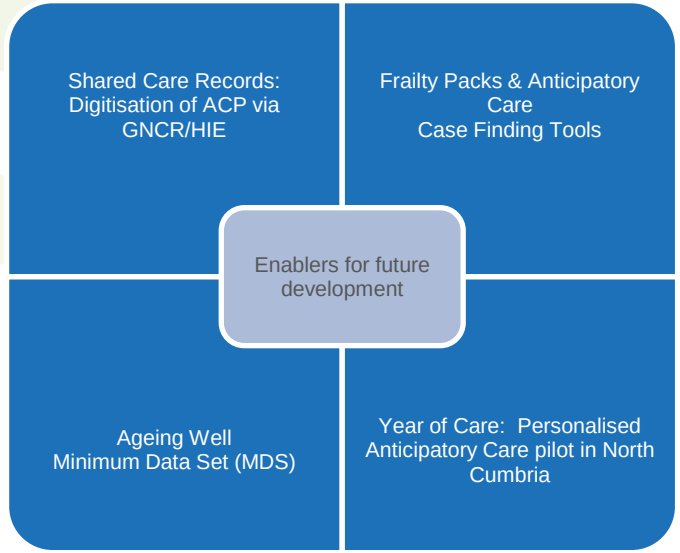
Proactive Care - Update

Overarching objective 2023-24

Improve support for Integrated Neighbourhood Teams (INTs) to implement the national Proactive Care model.

- Case finding tool now ‘live’ in RAIDR.
- North Cumbria Personalised and Anticipatory Care Pilot – report detailing key findings and lessons learnt expected very soon.
- NENC Toolkit in development to support place-base delivery, taking into consideration learning from the North Cumbria Pilot.
- Linking to funding within Primary Care, Community Services and VCSE and development of Integrated Neighbourhood Teams [Fuller Stocktake].





[Proactive care: providing care and support for people living at home with moderate or severe frailty] - published in December 2023, aims to support a more consistent approach to proactive care for people living at home with moderate or severe frailty.

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Enhanced Health in Care Homes - Update

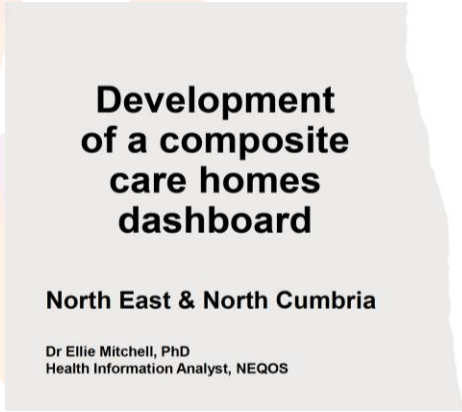
Overarching objective 2023-24

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

[Providing proactive care for people living in care homes – Enhanced health in care homes framework]

Published in November 2023, sets out the key principles for delivering proactive, personalised care for people living in care homes (including those with learning disabilities or autism, mental ill-health or rehabilitation needs).

- NENC ICB care home dashboard to support place-base service in development.
- Linking to funding within Primary, LA and Community Care.



frailty icare

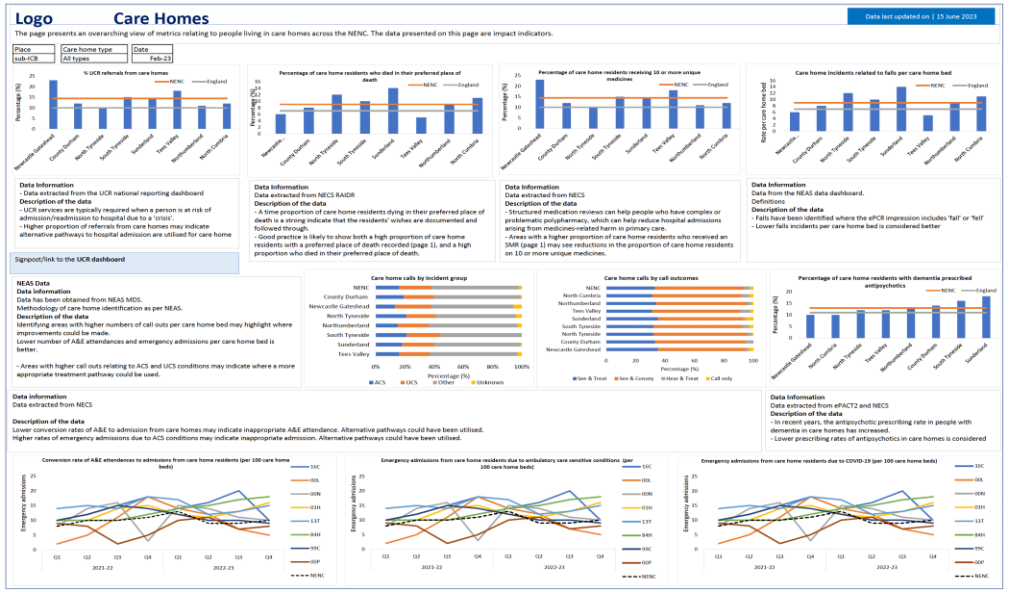
necs

Academic Health Science Network North East and North Cumbria

NHS North East and North Cumbria

NHS

North East Quality Observatory Service



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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:
   - Reducing null and not known entries for source of referral, reason for referral and ethnicity
   - Reducing gap between local data and flow to national dashboard, whilst total activity is far ahead of projections
   - Working on improving and increasing flow of ambulance service referrals to UCR
2. Working with GNCR team to identify and connect community providers to the shared care record:
   - 17 providers now viewing and 14 sharing (up from 13 and 12 in Oct)

3. CHSD Community of Practice
   - Established group as a CoP in May, held 5 times so far
   - Working in line with draft CHSD strategy on strategic priorities (previously shared with this AW CoP)
   - Focusing on FT community teams' digital priorities – survey complete and discovery report produced, 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 - 25 January 2024: Older People and their Mental Health, Chris Cairns, Nurse Consultant - Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

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MEMORIAL UNIVERSITY

Improving Quality of Life, Functional Capacity, and Strength in Older Adults: Utilising Minimal-Dose Resistance Training

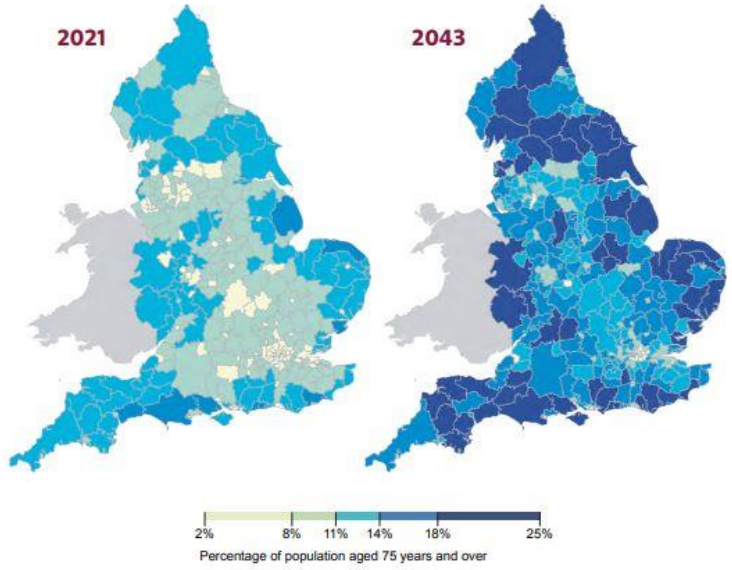
Liam T. Pearson-Noseworthy MRes, BSc (Hons), SFHEA

PhD Candidate & Senior Lab Technician, Northumbria University

Research Into Ageing IS Important!

World Health Organization

Chief Medical Officer's
Annual Report 2023
Health in an Ageing Society



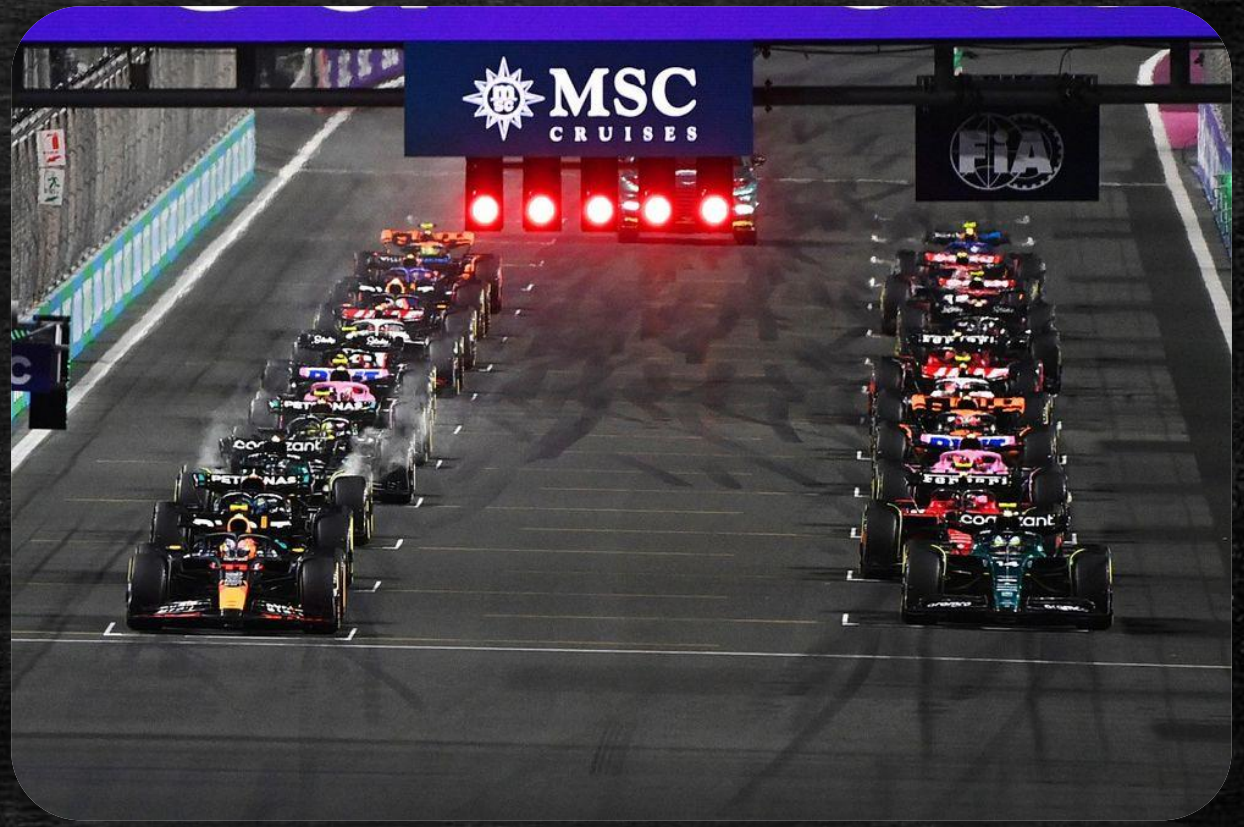
Why?

Symptom	Ageing	Resistance Training
Sarcopenia	✘	✓
Falls Risk	✘	✓
Strength	✘	✓
Nervous System	✘	✓
Functional Capacity	✘	✓
Mental & Physical Quality of Life	✘	✓

Study Objective

I. Ceilings & Floors

Study Objective



Study Objective

"Amount of Exercise"

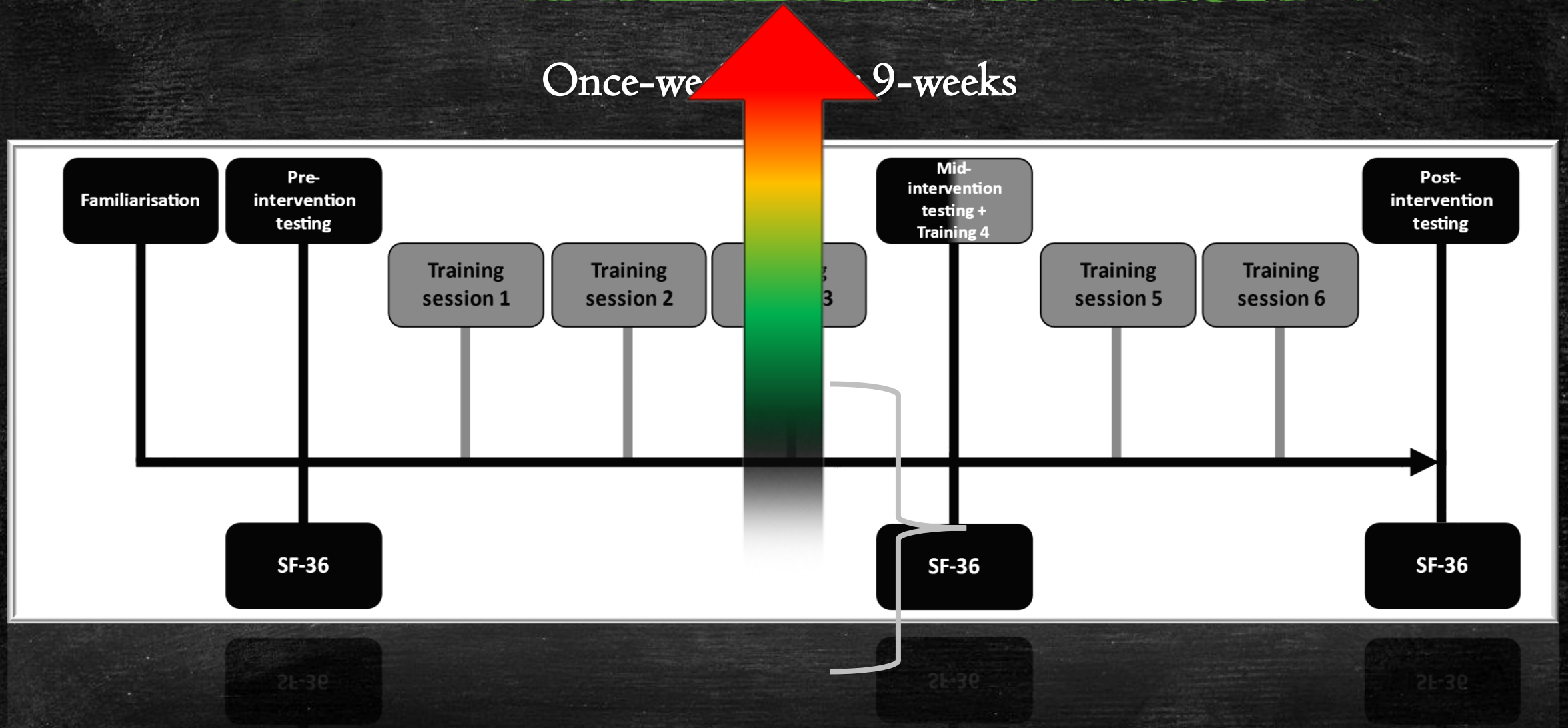
Study Objective

1. Ceilings & Floors

2. Which is *"better"*, controlled-tempo vs. max-intent?

3. THE minimal-dose

Methodology / How It Was Conducted



Intervention / What They Done

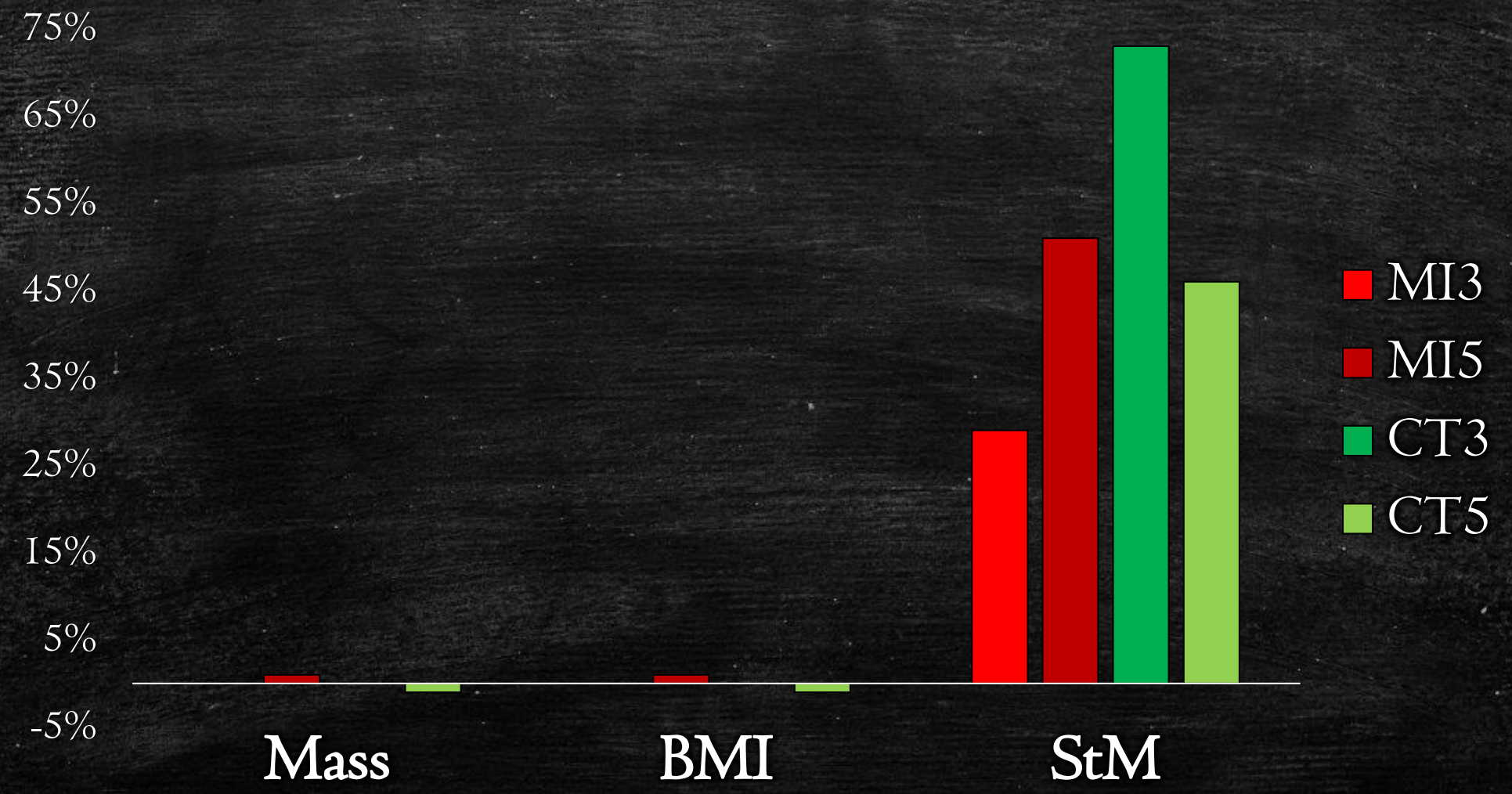
Leg Press at 60% 1-rep-max at either:

- Slow-Controlled Tempo
- Maximal-intent

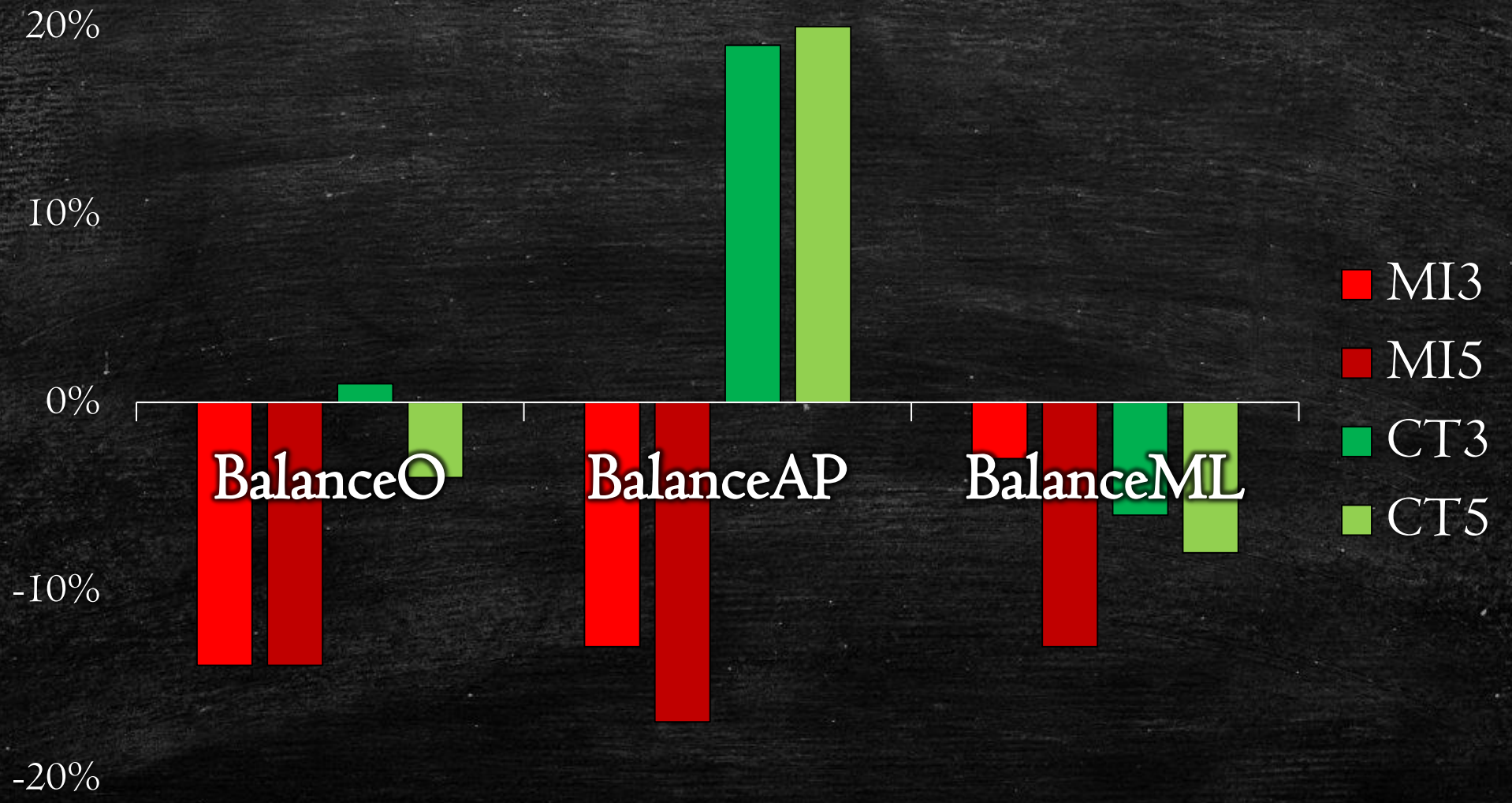
For either:

- 5 sets x 5 reps
- 3 sets x 5 reps

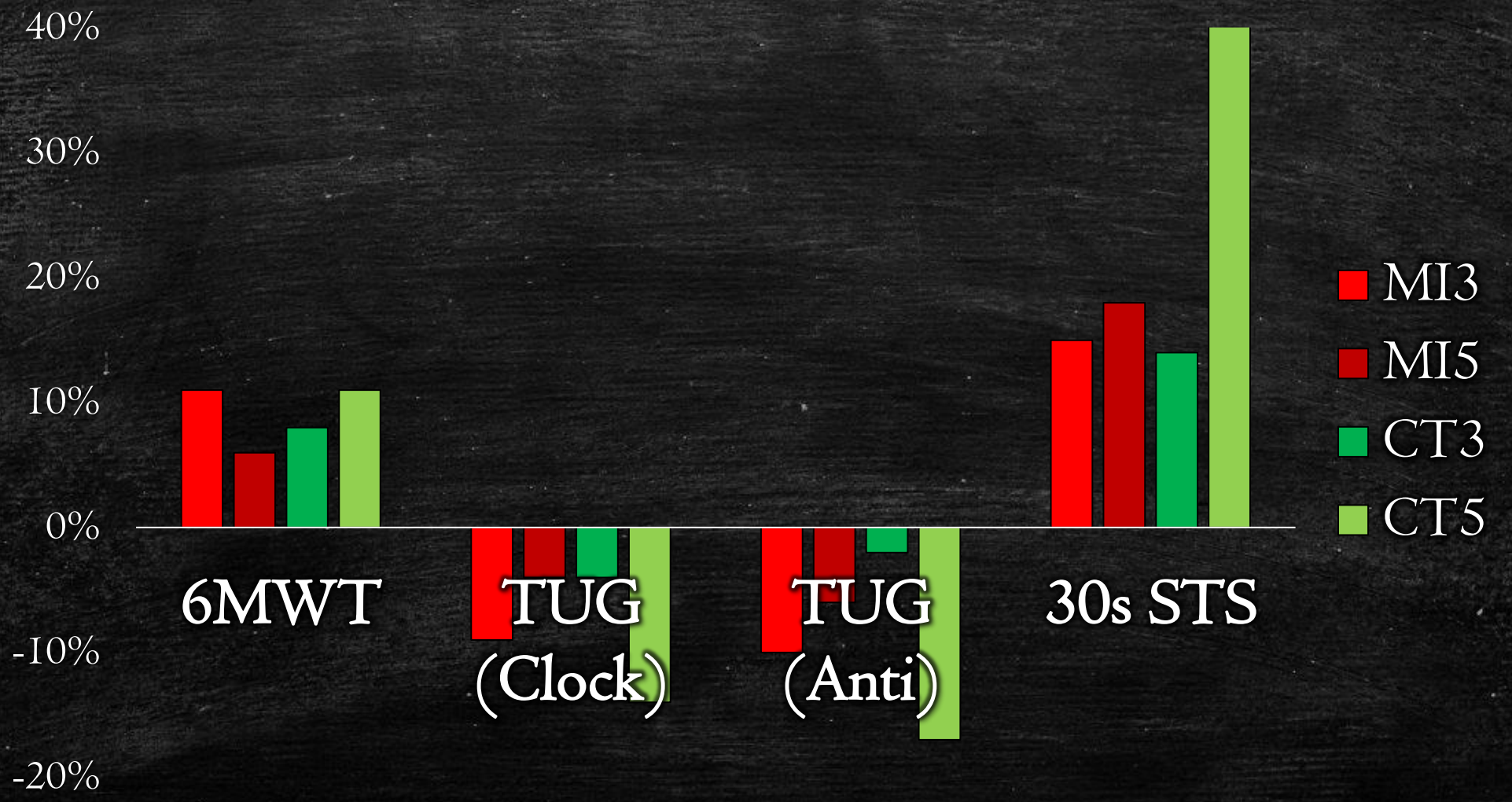
Demographic



Balance



Activities of Daily Living



Strength

IRM Velocity at PRE IRM Weight

Real World Implications

- Once a week
  - 6 out of 10 difficulty (60% IRM)
    - Lower limb exercise
      - For 3 sets of 5 repetitions

May improve your Mental & Physical QoL, Functional Capacity, and Strength*

* = To be confirmed

The Road Ahead

- Support Doctors, GP's, Physiotherapists, and Specialist Exercise Instructors
  - NHS Guidelines
    - Research
      - Lab-based
        - Gyms & exercise classes
          - Home-based

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PARTICIPANTS NEEDED

9-weeks FREE personalised training
+ £50 high-street voucher
+ FREE health screen

Help us investigate once-weekly low-dose leg press on:

- Functional Capacity
- Quality-of-life
- Blood Flow

You will be eligble if:

- You are 60+
- You can take part in weight training (Leg Press - pictured)
- You are looking to improve Strength, Mobility, and Quality-of-Life
- You have not done lower-limb weight training in the past 6-months

Any questions, you can contact me on:

Email: Liam.T.Pearson@northumbria.ac.uk

Twitter: LiamTPearson

Facebook: LiamTPearson91

Liam Pearson MRes, BSc (Hons), SFHEA

Any Questions?

St Martins Care Limited
Lifting Cushions Pilot

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The idea for the pilot

- St Martins proposed introducing Mangar lifting cushions into their care homes for non-injured falls.
- The rationale - they were experiencing significant delays in paramedics attending to callouts for residents who have fallen and are unable to be assisted from the floor. This increases risks associated with a ‘long lie’, increases pressure on NEAS and impacts on staffing levels as a staff member always remains with the resident until the paramedics arrive.

Aim of the Project

- To reduce unnecessary NEAS callouts for non-injured falls through the provision of Manga lifting cushions in 3 of our care homes across Tees Valley.
- To agree a competency framework for training to assess and determine the definition of a non-injured fall.
- To agree key performance indicators to evidence impact of the project and develop an exemplar for roll out across the NEAS region.
- To reduce the potential risks associated with a ‘long lie’, including pressure damage, dehydration, pneumonia, and rhabdomyolysis.

Outcomes

- Improve outcomes for residents who have experienced non-injured falls
- Reduce NEAS callouts for non-injured falls
- Upskill the workforce
- Reduce safeguarding concerns/complaints due to significantly long waiting times
- Reduce pressure on A&E as residents who have had a ‘long lie’ require hospital assessment
- Model to be rolled out across the NEAS region

Management of falls in care homes

- Falls are three times more common among care home residents than in people of a similar age living in their own homes (Public Health England. Falls: applying all our health.)
- Falls in care homes carry a significant burden both to the individual and to the health and care system – 25% of falls in care homes result in serious injuries and up to 40% of admissions from care homes are falls related (Care Inspectorate. Managing falls and fractures in care homes for older people. 2016.) (Cooper R. Reducing falls in a care home. BMJ Quality Improvement Reports 2017;6:u214186.w5626. doi:10.1136/bmjquality. u214186.w5626.).

Management of falls in care homes

- There is a growing body of evidence demonstrating the efficacy of alternative pathways for falls in care homes. Partnerships between independent equipment providers, ICBs, ambulance services and care homes have been shown to safeguard residents who fall, support care home staff in their decision making after a person has fallen and to reduce the cost of post-fall responses to the health and social care system

Case study : Wales Care Home Project

A 2018 partnership with Aneurin Bevan Health Board and the Welsh Ambulance Service saw 600 care homes receive Winncare's Mangar cushion lifting equipment and training including the use of the ISTUMBLE app, and recorded the following results:

1. 87% of falls were managed in-house
2. Falls which would have previously required an ambulance reduced from 379 to 75 (Reduction of 80%)
3. The number of residents conveyed to hospital as a result of a fall reduced from circa 65% to 16%.

Case study: Mid & South Essex ICS

As part of a pilot in Mid and South Essex ICS 81 Raizer II chairs were purchased and distributed across care homes, secondary care and UCR teams.

Care homes were also given access to an interactive post falls assessment tool (to support care staff to identify when it is safe to lift a resident from the floor without calling for assistance from the Ambulance Service) and a Samsung Digital tablet where this app can be accessed.

The pilot resulted in:

1. A reduction in call outs – 244 falls occurred, which would have resulted in 134 call outs. This was reduced to 42 call outs through use of the equipment and technology
2. If costed at £252 for an ambulance call out, the 92 avoided call outs totalled a saving of £23,184 over six weeks.

Pilot

- The 3 care homes were part of the pilot;
  - Woodside Grange Care Home - 116 beds (104 residents)
  - Windermere Grange Care Home- 64 beds (61 residents)
  - Guisborough Manor Care Home – 63 beds (54 residents)

Lifting cushions

3 Eagle cushions were purchased

iStumble

- iStumble is an interactive post-falls assessment tool that helps care staff assess fallen residents and make informed decisions
- The iStumble app takes carers through a series of questions to help determine whether the carer can safely lift the resident themselves with lifting equipment or if they need to call an ambulance immediately
- iStumble has been designed to be intuitive and simple for carers to use, and by answering a few short questions they can decide whether to call 999/111 for an ambulance.

- You can download the app from the App Store

16:29 19%

ISTUMBLE®

Restart

Is the person who has fallen:

- Clear of dangers?
- Are they responsive?
- Are their airways open?
- Is their breathing adequate?
- Do they have a pulse?

Yes to all of the above

No to any of the above

16:01 77%

ISTUMBLE®

Restart

Does the person who has fallen have new neck or back pain?

Yes

No

16:02 77%

ISTUMBLE®

Restart

Does the person who has fallen have:

I *Intense Pain*

New pain since falling, including:

- Headache
- Chest Pain
- Abdominal Pain

Consider both pain from injury caused by fall or medical causes.

Yes

No

16:03 77%

ISTUMBLE®

Restart

Does the person who has fallen have:

T *Trauma to Neck, Back or Head*

- New pain in neck, back or head following fall
- New lump or dent in head with/ without bleeding
- Any new numbness/paralysis in any limbs
- Have they been prescribed any blood thinning medication ?

Yes

No

16:03 77%

ISTUMBLE®

Restart

Does the person who has fallen have:

U *Unusual Behaviour*

- New confusion
- Acting differently to normal self e.g. agitated, drowsy, quiet
- Difficulty speaking e.g. slurred speech, words mixed up, marked stuttering

Yes

No

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16:03 76%

ISTUMBLE®

Restart

Does the person who has fallen have:

M *Marked Difficulty in Breathing or Chest Pain*

- Severe shortness of breath, not improved when anxiety is reduced
- Unable to complete sentences
- Blue or pale lips, blue fingertips, becoming lethargic or confused

Yes

No

16:03 76%

ISTUMBLE®

Restart

Does the person who has fallen have:

B *Bleeding Freely*

- Free flowing, pumping or squirting blood from wound
- Apply constant pressure to injury with clean dressing (elevate if possible)
- Try to estimate blood loss (per mugful)

Yes

No

16:03 76%

ISTUMBLE®

Restart

Does the person who has fallen have:

L *Loss of Consciousness*

- Knocked out
- Drifting in and out of consciousness
- Limited memory of event before, during or after fall
- Unable to retain or recall information/repeating themselves

Yes

No

16:04 76%

ISTUMBLE®

Restart

Does the person who has fallen have:

E *Evidence of Fracture(s)*

- Obviously deformity e.g. shortened/ rotated, bone visible, severe swelling
- Reduced range of movement in affected area
- Unusual movement around affected area

Yes

No

16:04 76%

ISTUMBLE®

Restart

Is the person who has fallen F.A.S.T Test normal?

Facial Movements

Can the person smile as normal?

Yes

No

16:04 76%

ISTUMBLE®

Restart

Is the person who has fallen F.A.S.T Test normal?

Arm Movements

Can the person raise both arms and keep them there?

Yes

No

16:04 76%

ISTUMBLE®

Restart

Is the person who has fallen F.A.S.T Test normal?

Speech

Is their speech normal?

Yes

No

16:04 76%

ISTUMBLE®

Restart

There is no need to call Emergency Services

Use correct lifting aids and correct manual handling techniques to lift the fallen person from the floor:

ELK How-to Video >

Camel How-to Video >

Eagle How-to Video >

Has the person been lifted safely?

Yes

No

16:05 76%

ISTUMBLE®

Reassess Patient

Next Steps

- Do not leave the person unattended
- Treat minor injuries within scope of practice
- Consider a nurse/GP for minor injury treatment
- For further advice call NHS 111
- Observe regularly for changes in condition
- ALWAYS reassess after a lift

Call NHS 111

Email Confirmation

16:01 77%

ISTUMBLE®

Restart

Call Emergency Services

- Keep the person:
  1. Calm
  2. Still
  3. Comfortable
  4. Warm
- Answer all questions and follow instructions from the 999 call taker
- Wait with the fallen person until an ambulance arrives
- Inform their next of kin

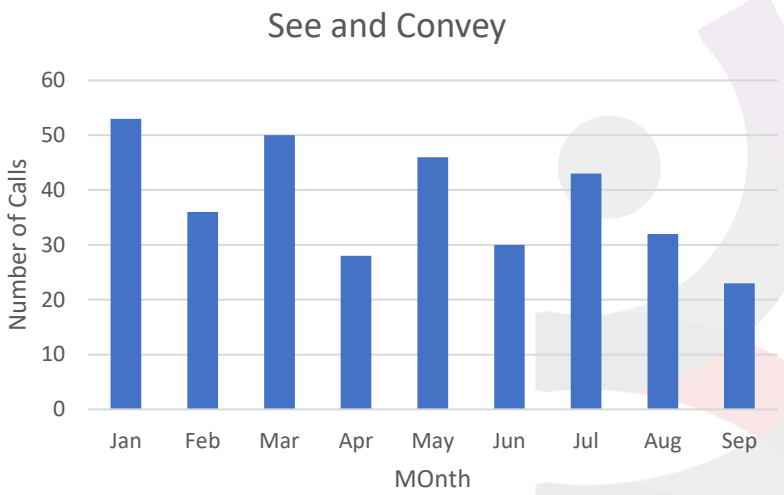
Call Emergency Services

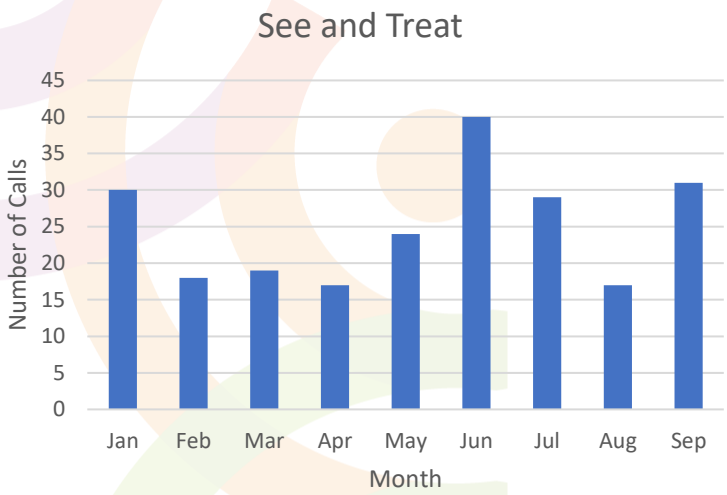
Email Confirmation

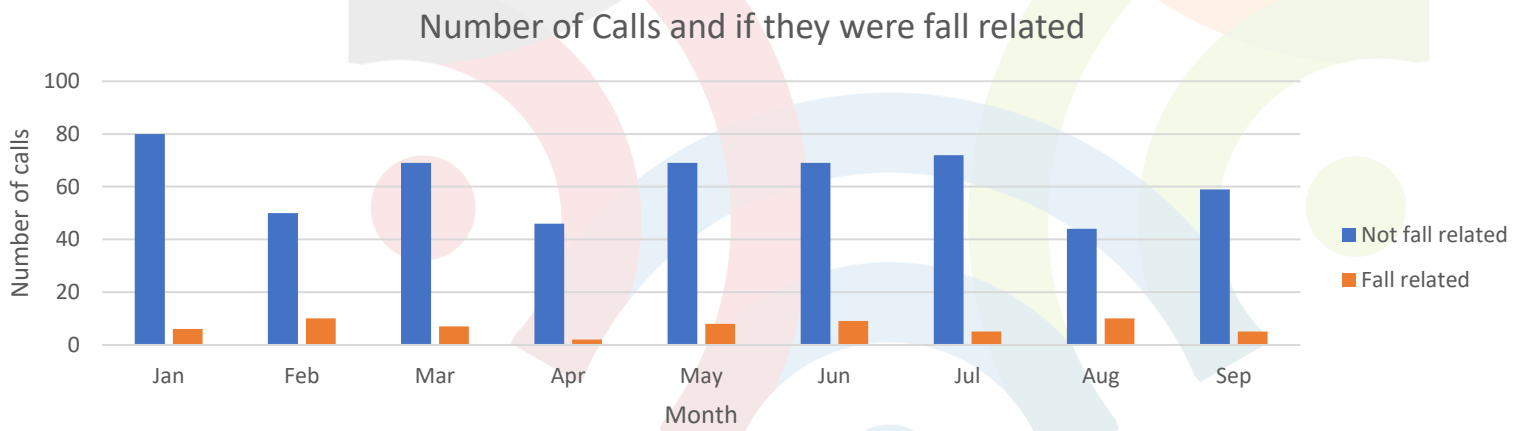
The main challenges to the pilot

- The confidence of the staff to use the new approach to post falls assessment and the practical use of the cushion.
- This was linked to the period time between the training and the purchase of the cushions- delay in the funding being released.
- Additional sessions were rolled out in August and this had positive impact on the staff.
- One of the lifting cushions had a problem and is being repaired. It was placed at Woodside Grange which is the largest care home and has been the slowest to fully implement the pilot.

NEAS data for the 3 care homes







involve consider assess respond evaluate

Results

- The number of calls to NEAS from all 3 care homes between January and September was 620 and a subset of those calls were 62 which were falls related.
- NEAS care home data show very small numbers of falls related calls per month (range 2 – 10) and therefore making it difficult to infer meaningful change from the data.
- In the Wales Home Project Care the pilot work was done across 600 care homes making it easier to see the reduction in ambulance calls with a substantially larger dataset.
- Between 11th of July '23 and the 30th of September '23 St Martins Care have recorded 43 falls requiring iStumble assessment to determine lifting cushion use. Of the 43 recorded, 41 have successfully utilised the lifting cushion and only 2 have required transfer to hospital.

Summary of Staff Experience

How did you cope with residents when they fall?

- *If they have no injuries, we use the hoist or a chair to see if they can manoeuvre themselves. If they can't move them we leave them on the floor until the ambulance comes. When the residents are waiting for the ambulance, we have to leave a member of staff with them, often on the floor, for anything thing up to 4 to 6 hours*

How has this changed during the pilot?

- *First of all, we check they're alright and then we use the iStumble app to take them through the falls assessment. If they're no obvious injuries, we get them on the cushion and lift them off the floor that way.*

Summary of staff experience

What did you think of the training?

- *It was very informative. We had time to ask questions and get answers and if we needed any more information, we were given time to find out. It was quite self-explanatory, it flowed well and made sense. We developed new skills as well as practised the iStumble ap and the use of the lifting cushions*
- *We learned the accountability for filling an incident form. Before their training the incident form would have said the resident was being checked over. After the training we would go through the process of the checks in detail from the iStumble app and print the report from the iStumble app and attach it to the incident report.*

Summary of staff experience

Safety culture

- *We feel there is a reduction in the amount of residents going to hospital and a reduction in the number of safeguarding incidents we have to report. We feel more in control because we know exactly what to do. It gives us peace of mind because the older generation don't like to go to hospital and if you can use the cushion without having hospital and ambulance involved; it's better for them.*

Outcomes for residents

- *Preventing admission to hospital because of a long lie. Preventing the paramedics to see residents who haven't injured themselves but haven't the strength to get themselves off the floor; without the lifting cushion we would have to wait for the the paramedics. We would have tried to use the hoist which the patients don't like it as they're not very dignified to use. The cushion is more comfortable for the residents*

Summary of staff experience

Case studies

1. *One of the residents transferred to hospital had to wait for ambulance for 2hr and 50 mins and the call handler advised that they should leave the resident where they were. A clinician contacted the care home for an update due to time lapsed and advised they should use the lifting cushion to raise the patient from the floor; this stopped a 'long lie' .*
2. *We used the lifting cushion on a female resident and she loved it. She slipped off her chair and couldn't get herself up and she asked us to lift her up.We explained to her what we had to do even before we got the cushion out. She had no injury and we asked her to shuffle on to the deflated cushion and when we started inflating the cushion she was over the moon! When it was fully inflated it was easy to transfer her to her chair. It changed a horrible situation to an enjoyable one for the resident.*

Next steps and costs

- St Martins Care met with NEAS and My Learning Cloud eLearning provider to discuss developing the face to face training into an eLearning module. The costs are £4500 +VAT

- St Martins are working with North Tees and Hartlepool NHS Trust on the next stage of the post falls project to introduce a head injury pathway. This is in response to the change in NICE guidance for anticoagulant medication and a high proportion of care home residents presenting at ED with query head injury, even when there is no evidence or concern.

Next steps and costs

- Currently iStumble only offers 2 options of lift or contact 999. Winncare have quoted an approximate cost of 25K to develop iStumble into a bespoke resource for the ICB geographical area. This would enable further options to be actioned before a direct call to 999 is made. An example of this is practice would be to have UCR as an additional triage following an iStumble outcome of ‘don’t lift’. UCR can be onsite to provide further clinical assessment, prescribe, dress wounds, schedule GP input or escalate to 999.
- The cost of lifting cushions range from the Elk- £1553 +VAT; for the Eagle- £1988 +VAT; for the Camel- £2340 +VAT
- St Martins will be introducing the lifting cushions in their remaining 3 care homes, in November and December

Questions?

Falls Rapid Response Service

Patsy Wright – Band 6 Occupational Therapist Falls Rapid Response Team
Lesley Carr– Rapid Response Team Lead

Initial Aims of the Service

- Reduce hospital admissions
- Improve outcomes for patients – safely maintained at home
- Reduce risk of future falls
- Provide prompt response to patients who have fallen to prevent long lie complications (initially 30 minute response time)
- Reduce pressures on A+E, NEAS and primary care

The Journey…

- 12 month pilot September 2018
- Service operational 7 days a week 7am – 7pm
- Team of 3 Paramedics and 3 Occupational Therapists
- Provided dedicated response for patients over 60 who had fallen in last 24 hours (Newcastle and Gateshead)
- Incrementally extended until March 2023
- April 2023 – incorporated within Gateshead Rapid Response – Nurse Practitioners and Occupational Therapists working together to deliver service (Gateshead)

Gateshead Rapid Response Team

- 24/7 service for patients requiring unplanned care at home who are over 18 and registered with a Gateshead GP
- Input from nurses, occupational therapists, physiotherapists and rehabilitation assistants
- Predominantly acute minor illness or injury with onset within last 24 hours and patients with longer term illness or disability
- Aim to prevent admission/facilitate early discharge and support patients to live as safely and independently as possible

Clinical Assessment
Nurse Practitioner Role

- History taking – establish fall vs collapse, nature of fall ?long lie
- Initial assessment
- Clinical assessment, including baseline observations, neuro assessment, wound assessment, pain management, infection screen, bloods and ECG if appropriate
- Assess for postural hypotension
- Provide therapeutic clinical intervention as appropriate
- Review medication and liaise with GP as necessary
- In collaboration with OT, decide on the most appropriate pathway/safety net/onward referrals

Functional Assessment
Occupational Therapist Role

- Obtain falls history/SPLATT
- Obtain social history and baseline function
- Carry out multi-factorial evidence based falls risk assessment
- Identify frailty and support CGA
- Assess mobility/function following fall
- Environmental assessment
- Equipment provision
- Falls prevention advice
- Onward referrals and signposting to community services
- Address fear of falling and refer to strength and balance programme if able.

Outcomes

- Reduced hospital admissions – patients maintained at home
- Increased onward referrals for support services e.g. assistive equipment, community therapy, strength and balance exercise classes etc.
- Improved pathways e.g. Frailty Team at QEH
- Development of alternative pathway (no direct paramedic input/cat 1 calls)
- Successfully integrated within Gateshead Rapid Response team

Mrs C's Story

- 2 falls within a few hours of each other.
- The second one resulting in a "long lie" overnight.
- 'Legs had just gave way but was aware of everything that happened'.
- Non-injurious fall.

Actions and Outcomes

- Assisted from floor using specialist lifting equipment.
- Paramedic clinical assessment completed.
- Occupational Therapy functional assessment completed.
- No acute medical concerns
- Patient had started new medication the week before. Review of medications required.
- Poor mobility, unsafe at home. Independent prior to fall
- Unable to transfer on and off chair or in and out of bed safely. Patient reported overnight toileting needs.

Mrs C's Story

- Discussed findings and concerns with patient and his wife.
- Agreed to look for bed based rehab as not able to manage at home but did not require hospital admission.
- Short stay arranged at Eastwood Promoting Independence Centre to allow for a period of rehabilitation, and review of medications
- Medication changed which was felt was contributing to falls. Patient rehabbed and returned home
- Referred to a strength and balance programme which she attended after being discharged from Eastwood.

Benefits

- Quick response
- Supported from the floor by specialist lifting equipment.
- Clinical, functional and multifactorial assessment completed.
- Appropriate onward referrals.
- Avoided unnecessary hospital admission.
- Right service, completing the necessary assessments, and at the most appropriate time.

Patient Experience

"excellent service received for my mother who is 98. The service was there in minutes and this caused our family less stress. They were caring and competent and explained what was happening. The team ensured everything was in place for my mother. The service saved the cost of an ambulance and hospital stay"

Patient Experience

"I suffer from sciatica and on the day that the FRRS came out to me the sciatica had caused me to slide onto the floor. I couldn't have got up without them.

I have never had to call 999 for assistance before but the service was absolutely fantastic. I was concerned that I would have to be taken into hospital. Everything was done so that I could stay at home and I couldn't have had better service. They were friendly, helpful and professional, made me feel relaxed and that I wasn't a bother to them. It was a superb service."

Accessing the Team

Referral is via the Rapid Response team

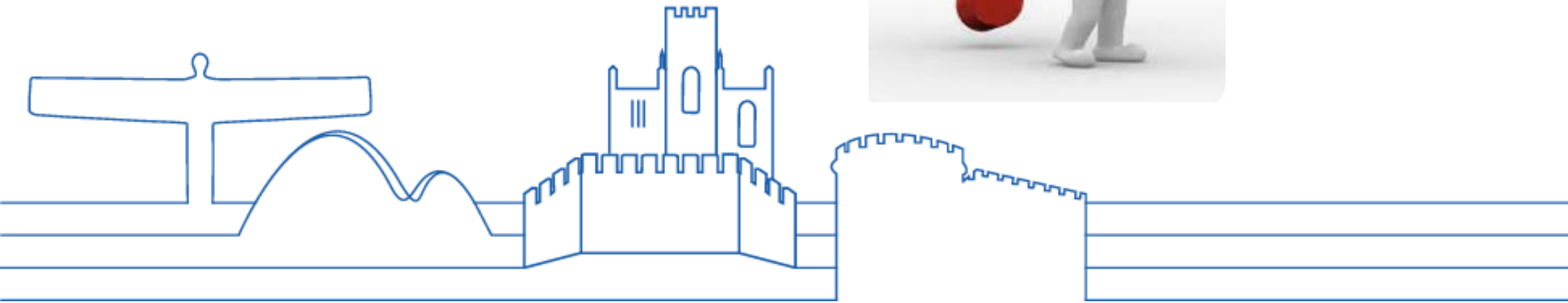
Tel 0191 445 8400

e-mail ghnt.rapidresponse.team@nhs.net

Any Questions?

NHS
North East and
North Cumbria

Thank You



Date and Time of Next Meeting

Next Meeting TBC