onenortherndevon

Healthy Ageing Northern Devon

HAND

FEBRUARY 2024 UPDATE

Community Prevention

Falls Management & Exercise Programme

Tackling loneliness with transport

National Reconditioning Games

Enhanced health in care homes

Acute Hospital at Home

Anticipatory Care pilot

Live Longer Better

Progress in Prevention Theme : Connecting Actively With Nature and Wellbeing Walks - Active Devon

Connecting Actively with Nature February 2024 Update:

- New nature connection project awaiting funding decision, would impact several communities in Northern Devon if successful

Progress so far:

- c3000 over 55's active across Devon
- Cross sector partnership of 60+
- Over 200 individual projects, many sustained
- 50% with a disability or LTHC at baseline
- 50% continue to be active following CAN
- Increases in Brisk walking and mental wellbeing
- Future work being scoped based on learning. Focus on places and people in need, tackling health inequalities and improving nature quality and access
- Supported many individuals and CiCs to develop resilience and skills and understanding of audience and health sector

Wellbeing Walks Update:

- We continue to train and support local volunteers to lead and set up Ramblers Wellbeing Walks.
- Short, friendly, regular and inclusive, these walks are designed to be the perfect first step back onto activity and social contact for inactive and isolated individuals.

Progress in Urgent & Emergency Care theme - Frailty work in NDDH

Frailty work at North Devon District Hospital. Lead: Hannah Hopkins

- Pilot of frailty and short stay beds on Alex Ward. Frailty beds will be managed by an MDT which will provide Comprehensive Geriatric Assessments and personalised care planning for these patients.
- b) Virtual ward: funding has been received to provide a virtual ward for patients who would have been in an acute hospital bed but who instead are managed virtually in their own homes, this will include older people with frailty.
- ED development
- Frailty CQUIN
- Ambulatory hubs

February Update 2024:

- Frailty AHAH continues to flourish with some excellent feedback from the visiting ECIST geriatrician.
- Identification of frailty across community and acute services is improving
- Push on improving take up of frailty education package
- Virtual Wards - now called Acute Hospital at Home (AHAH)!
- Working hard towards meeting our target of an average of 5 frailty AHAH beds filled per day in the North. We managed to achieve 7 on a couple of occasions and this is testament to the hard work of the staff.
- We have started to test the new community to acute AHAH process with the UCR team referring patients to AHAH and AHAH doing a visit at home with a junior doctor, PA or ACP providing the medical assessment. Remote consultant support and responsibility underpins the medical aspect of the care.
- Our new CGA (agreed across the trust) is being tested in acute and community settings and this should ensure much better transfer of information from acute to community and vice versa for our frail older people.
- A network of Trust frailty champions in the North is being set up to share care and best practice.
- We continue to see great outcomes and have been receiving positive patient/relative feedback

> *“My Mum and I just wanted to let you know that the team have been excellent, it was a relief to my Mum to know they had support when my Dad was at home”*

Progress in Urgent and Emergency Care Theme: Community Health and Social Care Services - Northern

February 2024 Updates:

- The two main workstreams Health and Social Care Teams have been focusing on are falls and frailty
- Community Teams have also been concentrating on reducing ‘no criteria to reside’ numbers and consequently we have significantly reduced the numbers of people that are awaiting care in order to be safely discharged from hospital. This is a work in progress, as local teams and H & SC leadership continue to push the boundaries of what is possible to achieve within current market conditions
- UCR (Urgent Care Response – 24 hour response) have been asked to focus on care homes with the highest rates of conveyance to ED - in order to reduce the rate of avoidable or unnecessary admissions. This has resulted in an increased level of referral to the team
- Training staff on the importance of the Advance Care Planning, has also been another key area of focus - with the aim of ensuring those within the last years of life have been able to express their needs and desires to support appropriate action planning
- Care Home Educator team continue to support homes around themes related to recognising deterioration – including restore 2 and diabetes management.

Progress in Anticipatory Care theme - FAME

FAME (The Falls Management and Exercise programme)

£84,000 has been granted from Devon ICS falls prevention fund to:

- Identify and train 4 L4 Postural Stability Instructors
- Run seven FAME 24-week programmes across Northern Devon – (one in each One Community - 100 participants in total)
- Facilitate improved mobility along with social interaction for participants
- Work to ensure sustainable relationships and activities continue beyond the programme
- Leave a legacy of PSIs able to deliver FAME in Northern Devon
- **Project Lead**: Simon Rapsey

February 2024

- All courses currently reaching conclusion and entering the final assessment phase
- Data being supplied to Flexifit Exeter University study
- Funding has ended however planning is happening to keep the courses running wherever possible with a number of options being explored - eg Pay as you Go

Professional and self-referrals for those interested in attending please contact Anita@vistawellbeing.org.uk

Progress in Anticipatory Care theme - FAME continued

February 2024 Update: Example mid term data from Braunton group:

- Average 20% improvement in confidence as assessed by Short FESi.
- Average 25% improvement in Functional Grid scoring. Functional Grid assesses a range of physical attributes including time to rise from a chair, ability to reach forward, ability to turn around and flexibility measures.
- One participant halved their time for the timed up and go test from 29.3 seconds to 14.5 seconds.
- All participants expressed a wish to continue and a willingness to pay. They are willing to pay between £2 and £10 per session, with most people suggesting £5 as a reasonable cost. Some participants would be capable of joining other activity groups, but many are living with progressive disease that is likely to limit their progress.
- Participants were asked what was most valuable to them about the programme.
- 'Being given instructions on how to tackle daily tasks in a way to prevent falling. For example, climbing stairs'
- In the second half of the programme they are now focussing on getting down and up from the floor, which is a more challenging phase now basic skills are in place.

Participants asked were asked what they have found useful about the course……

"I have gained confidence in walking'"

"My flexibility and movement around my trunk has improved'"

"'the balance and walking exercises'"

"Learning to sit and stand correctly'"

"Being given instructions on how to tackle daily tasks in a way to prevent falling. '"

Progress in Anticipatory Care theme - Enhanced Health in Care Homes

Enhanced Health in Care Homes - Reconditioning Initiatve

The EHCH Reconditioning Initiative is aimed at increasing activity in care home residents to reduce deconditioning. Care Homes receive regular visits from our Activity Facilitator who engages with residents, family members and staff. The Activity Facilitator gives guidance on basic personalised exercises for residents and supports family and staff to assist. He also signposts to relevant activities in the community and online and makes links with voluntary and other organisations that may benefit residents. He also educates staff, patients and families on the importance of staying active. Care Homes can also apply for funding to purchase equipment and access programmes/ opportunities that meet the needs of the Care Home and residents. A Project Co-ordinator supports the care homes to apply for the funding, collects data for outcome measures and supports the Activity Facilitator. We also provide free online training to care home staff on activity in older adults and encourage engagement with the "Live Longer Better" approach. The project also involves training and support for care home teams working within local Primary Care Networks to help prioritise activity and address deconditioning in care home residents.

Project Leads: Dr Fiona Duncan, Caroline Sanford. Project Co-ordinator: Liv Sanford
Activity Facilitator: Andrew Jeffery

February 2024 Updates:

- Work is currently being focused on the evaluation of the programme to date - with a view to recommendations for future provisions.

Progress in Anticipatory Care theme - NHS Long Term Plan for anticipatory care

NHS Long Term Plan - What is Anticipatory Care?

Anticipatory Care is an NHS Long Term Plan commitment that aims to provide proactive and personalised health and care for a targeted subset of individuals living with multiple long term conditions (MLTC) who could benefit most, delivered through multidisciplinary teams (MDTs) in local communities. The Anticipatory Care national framework excludes those living in care homes.

Six Core components of the Anticipatory Care framework:

1. Case identification
2. Holistic assessment
3. Personalised care and support planning
4. Multidisciplinary working
5. Co-ordinated care
6. Interventions and support

What are our aims?

To create an Anticipatory Care model for North Devon, which follows the national framework whilst attending to the needs of our local population and best using our local resources. All four Primary Care Networks (PCNs) will follow the same model but there will be flexibility to allow for differing needs across the PCNs. There will be a collaborative approach with the ICS. Initial trail is in Torridge PCN.

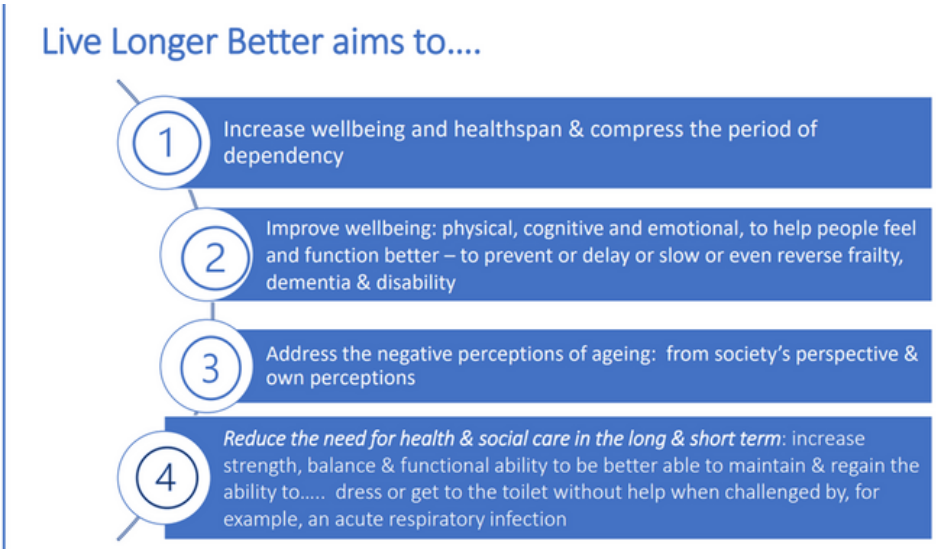
Leads for this work:

Dr Fiona Duncan (GP and Specialty Doctor in Healthcare for Older People) and Caroline Sanford (Joint Lead Manager for Northern Primary Care Collaborative Board)

February 2024 Updates:

- Project now being extended into Barnstaple Alliance PCN
- We are bringing the Cost of Living Work under the umbrella of aniticpatory care
- The Pilot project supports those over 65 with frailty and complex medical and social needs, who are under the Community Matron caseload.
- The weekly Anticipatory Care MDT provides the older person with holistic, person-focussed health and social care input.
- We are expanding the pilot into Barnstaple Alliance PCN
- Great engagement noted so far from the health and social care teams
- Personal Wellbeing measured before and after intervention
- Medications reviewed in 100% of cases and better tailored to the person
- More timely input from wider health and social care teams has been noted

Progress in Prevention Theme: Live Longer Better



It is based on the premise that there are 3 key factors negatively affecting our healthspan:
1.Disease and illness
2.Loss of fitness
3.Negative self-perceptions and ideas of ageing

Progress:

Dr Kay Brennan, Clinical Advisor to NHS Devon has supported over 130 individuals and groups access the learning programme, which forms part of the Live Longer Better experience. This has included:

- Health and social care professionals
- Volunteers working in primary, secondary and community sectors including care homes,
- Primary care networks and general practice,
- Community mental health alliance groups, DPT and Talkworks,
- One Community representatives,
- Council leaders,
- Community voluntary groups and social enterprises
- Individual citizens
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NEXT STEPS: February 2024

- Kay Brennan and Tom Mack are working with the LLB national team and Mark Fishleigh from Learning with Exeperts to develop and land a PCN based project to increase the effectiveness and the impact of the Live Longer Better programme in Northern Devon.

- This would involve targeted comms to a cohort of older patients to engage them in a supported and coached process of learning and activity.

- This could potentially lead onto digital pathways linked to patient records and GP data systems signposting and referring patients to suitable activity locally.

LEADS: Dr Kay Brennan and Tom Mack (Active Devon)

Progress in Prevention Theme - Tackling Loneliness with Transport

Connecting You (Tackling Loneliness with Transport)

£50,000 has been awarded to One Northern Devon from DCC to deliver projects across Northern Devon.

Programme:

- Nature on Prescription, building a social prescription by offering links to nature including Active Walks, and activities, ensuring transport is included in the prescription for communities of North Devon and Torridge
- Tarka Line Creatives, engaging harder to reach beneficiaries with wellbeing through creative activities using the Tarka rail line.

AIM: 200 participants taking part in activities to reduce loneliness

Key Partners:

- One Ilfracombe
- Tarka Line Creatives
- Devon and Cornwall Rail Partnership
- Devon County Council
- **Project Leads**: Simon Rapsey / John Thornton

Progress Updates February 2024:

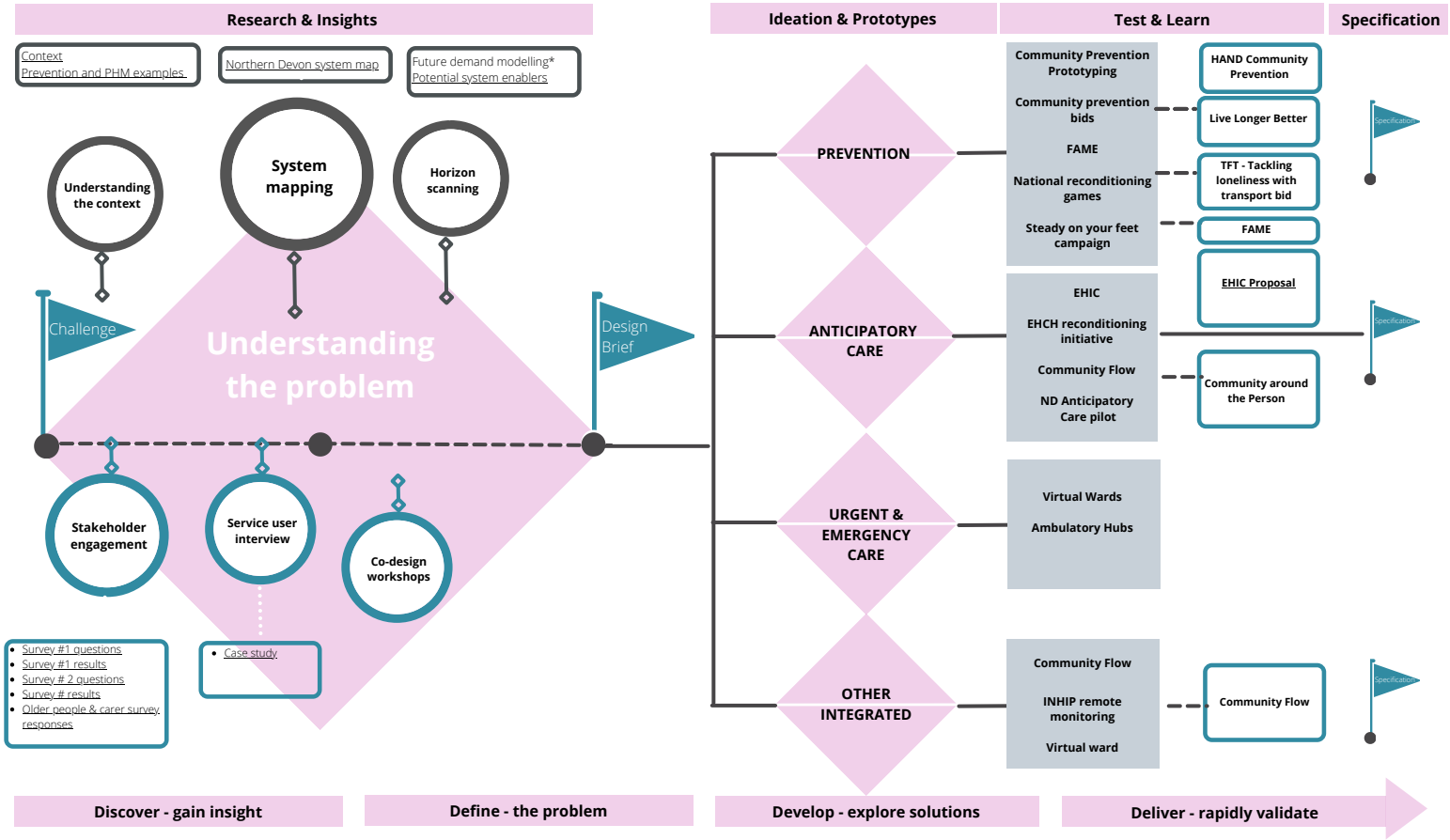
- Project has now officially finished.
- Full Evaluation due to be published by the end of March 2024 (led by Devon Communities Together on behalf of DCC) for submission to Department for Transport. To be shared when available.

HEALTHY AGEING IN NORTHERN DEVON

WHERE WE ARE IN THE DOUBLE DIAMOND DESIGN PROCESS

Following two whole-system workshops, which gathered broad insights across the whole ageing well pathway, it was agreed that work would be split into the following domains:

- Prevention
- Anticipatory care
- Urgent & emergency care
- Maintenance



You can see the key themes of our discovery stage from engaging with older people, carers, families, GPs, nurses, therapists and others here.

The following pages highlight progress made against those themes through a variety of projects we are testing together and learning from.