The North East Frailty Summit
Monday 5th December 2016, Hilton Hotel, Gateshead

Poster Abstracts

#FrailtySummit16

Competition Results

Winners:

No 5. Improving GP Services to Care Homes = Better Patient Experience – Download Poster

No 23. Audit of the effectiveness of community geriatric input and emergency healthcare planning in achieving the preferred place of care for frail elderly patients – Download Poster

Highly Commended

No 19. Innovation of Frailty Specialist Nurse Service Creation into Gateshead Inner West Locality: A 1-Year review of Service Implementation, Quality Indicators and Patient Cohort Impact

Data and Business Intelligence	
1	**Potential methods of identifying care home residents and their challenges** Download Poster
	Accurately identifying a population's care home cohort is a challenge which affects commissioners' ability to monitor effectiveness of services, identify areas of improvement & manage a small proportion of patients who require the most complex care (& have associated high costs). Whilst there are multiple methods for identifying this cohort, the disconnect between private care providers, the NHS & Local Authorities does not allow for a coherent dataset which follows the patient. This poster aims to discuss the different methodologies being used locally and nationally to identify this high risk, high cost population – and address the challenges which these methods raise. Methods that will be looked at include but are not limited to: primary care read code identification; provider led Local Authority vacancy information datasets; address and postcode proxies in secondary care datasets. The poster will then go on to make suggestions for a local fit for Newcastle Gateshead CCG which will improve our ability to confidently identify and manage these patients and their complex needs.
	Claire Laing NHS Newcastle Gateshead CCG Claire.laing1@nhs.net
2	**Exploration and assessment of different methodologies used to segment populations into risk stratified groups** Download Poster
	Segmenting populations into defined groups based on factors such as age / deprivation / disease registers is an accepted method used in both primary and secondary care of identifying high risk / high cost groups. Using risk stratification systems in order to segment populations is not a new idea, but there are currently a plethora of different methodologies being used. Moving towards STP footprint

	based working, many organisations are reassessing the methods being used, and moving away from the traditional age based partitions of paediatrics, adults, and frail elderly. This poster aims to assess a range of different methodologies and discuss how they are being used locally, nationally and internationally. Methods that will be looked at include but are not limited to: CPM tiers; co-morbidity based stratification; socio-economic modelling. Taking learning from health colleagues who have used innovative approaches to population segmentation, the poster will highlight case studies of successfully stratified population groups & discuss potential methods for the local STP footprint to consider during future planning sessions.
	Claire Laing NHS Newcastle Gateshead CCG Claire.laing1@nhs.net
3	**Frail Older People Population Profile** Download Poster
	The measurement profile for Frail Older People contains an overview of quantitative and qualitative measures which relate to frail older people, in order to present the current state and variation across the North East and North Cumbria area and compared to England. Information presented in the profile has been taken from a wide range of sources and includes the following measures at CCG level: Dementia prevalence and achievement of ongoing management indicators, Palliative care register size, Secondary care activity for frail older people (A&E attendances and emergency admissions), Quality of care in health and social care (patients with support needs met, social isolation), Place of death. The profile provides objective evidence of the current major strengths and challenges for the NENC region in terms of population health and healthcare to enable the identification of priorities for action. Changes in the region's population health can be monitored and an indication of where there is wide variation in healthcare provision or in areas requiring improvement. The AHSN NENC can use this information to evaluate the impact of the frail elderly projects within the programme and the key achievements of each to date.
	Andrea Brown NEQOS Andreabrown3@nhs.net
Enhanced Care in Care Homes	
4.	**Prevention of avoidable admissions to hospital** Download Poster
	Information for poster re avoidable admissions and SCHST In Newcastle, there are over 18,000 patients aged 75 or over and it is estimated that this figure will increase to 20,295 by 2020. Nationally, there has been a 31% increase in hospital admissions for people over 75 years in the last 10 years. It is estimated that one fifth of these admissions are preventable. One third of residents admitted acutely to hospital die during that admission. In response to this identified need, the Specialist Care Home Support Team (SCHST) was commissioned. This team is multi professional and presently works into 22 Care Homes in Newcastle. Team members proactively identify those residents that are most at risk of admission. The team work alongside care home staff to plan care for residents and are proactive in initiating

	discussion with GP, patients and their families about future care. This includes implementing strategies with the aim of reducing inappropriate hospital admissions. These strategies/emergency health care plans are followed by staff in the homes, and are widely recognised by other health care professionals. The team deliver bespoke training for example end of life care and catheter associated urinary tract infections. Training is developed depending on care home staff needs with an aim to improve confidence and competence of staff and therefore reduce inappropriate admission.
	Gillian Elsender The Newcastle upon Tyne Hospitals NHS Foundation Trust Gillian.Elsender2@nuth.nhs.uk
5.	**Improving GP Services to Care Homes = Better Patient Experience - WINNER** Download Poster
	Evidence - •Estimated 325,000 older people live in care homes in England, approx 4% of the population aged 65 and over (2015, Health Foundation) •People aged >65 years account for 65% of hospital admissions and 70% of bed days. •People >65 years make up a third of GP workload. •68% of care home residents have no regular review •44 % have no review of medications (NHS England) Setting - •GP Practice •20,000 patients approx. •12 GP's. •Eight care homes / one supported living accommodation, 239 residents. Issues prior : •Access to practice staff •Continuity of Care •Communication difficulties •Professional support •Lack of teaching opportunities Methodology 1 wte Matron for surgery provided a proactive long term conditions service to 239 residents living in 8 Care Homes and 1 Supported Living Establishment and monitored for a 6 month period. Daily service Monday – Friday Direct advice telephone line. Findings (Feb – July 2016) •1084 visits completed by nurse = 37% increase (compared to Feb – July 2015) •356 GP visits saved (compared to Feb –July 2015) = 52% •% (TBC) of this cohort of patients had a regular medication review. Conclusion / Recommendations Benefits – residents / nursing /care staff / GPs:- •Continuity – same nurse attending for residents / staff / families. •Improved access - Dedicated mobile phone, contact nurse directly /information & visits. •Care Staff – support clinical / non clinical issues. •Education – Supporting staff completing training courses. •Communication - improved with staff / residents, DAILY contact. •Matron taken on permanent •Mobile working to be considered – contemporaneous record keeping / reducing travel time, more residents seen

	Deborah Donnelly Consett Medical Centre deborahdonnelly@nhs.net
6.	**The Newcastle Care Homes Programme**
	The Five Year Forward View highlighted the need for clinicians to enhance care in care homes, bridging any gaps in equality of care. The Newcastle Care Homes Programme was established to achieve this. The programme has sought to overcome traditional challenges faced in the care homes such as avoiding acute admissions to hospital; improving the skills, confidence and capacity of the workforce; improving integration of health and social care; improving standards in end of life care, and improving use of medicines in older people. This programme comprises specialist nurses, GPs aligned to care homes, and a medicines optimisation team working together with care homes. This programme has enabled true collaborative working between professionals and with patients, to complete holistic, multidisciplinary assessments and reviews. This has improved the quality, safety and value of patient care in a number of care homes across Newcastle upon Tyne.
	Benjamin Kelly-Fatemi NHS Newcastle Gateshead CCG Benjamin.kelly-fatemi@nhs.net
7.	**Transferring Care: Improving The Safety And Quality For Patients Moving Between Hospital And Care Homes** Download Poster
	Approximately 325,000 older people in the UK live in care homes, experiencing 40-50% more emergency hospital admissions than the general over 75 years old population. Research demonstrates increased vulnerability to adverse outcomes at touch points between care settings, with inadequate communication and poor co-ordination common. A small quality improvement project was undertaken, within a district general hospital introducing a new Transfer of Care document. Plan, Do, Study, Act [PDSA] methodology was used. Several behavioural change interventions were employed, considering the local context and included audit and feedback, case-based discussion and championing by local opinion leaders. The overall aim was that 100% of patients would have transfer information rated as good or excellent. Demonstrable improvements were measured in the standard of written information provided at transition of care: - Quality 57%, Accuracy 41%, and Completeness 66%. However in 16% of cases the audited documents were rated as poor with reported information gaps. Conclusions drawn are that utilising a structured framework for implementation was essential and PDSA cycle was an effective tool. Cross boundary aspects emphasized the difficulties of differing perspectives, priorities and role conflicts and the significant effect that context has on behavioural change. Equally, variances in results show that the introduction of a structured document alone is not guaranteed to positively influence behavioural changes or improve care quality therefore further refinement of this process is required with focus on education to raise awareness of the benefits to frail older patients will be crucial in achieving a consistent and sustainable improvement.
	Lynne Shaw Gateshead Health NHS Foundation Trust Lynne.shaw@ghnt.nhs.uk
8	**Enhancing the health of care home residents in Gateshead: An exploratory, qualitative study of the development of the vanguard programme** Download Poster
	Frailty is common amongst care home residents, and enhancing health in care homes is one of the priorities of NHS England's new care models programme. Gateshead was selected by NHS England as one of six vanguard sites, to take a lead on the development of radical ways

	of working with care homes, and act as inspiration to the rest of the health and care system. The aim of this study was to explore stakeholders' understanding and views of proposed changes, including barriers and facilitators to the development of new ways of working, and to identify priorities for evaluation of the Gateshead care home vanguard. Design & participants 1) Qualitative interview study with commissioners and providers of services to, and within, care homes, local third sector organisations. 2) Review of published evaluations of similar integrated health and social care programmes 3) Documentary analysis Results Findings from the different components of the study will be presented. They emphasise the shared vision for care in Gateshead, but highlight some of the professional, cultural and practical challenges to change. Conclusions Anticipating well recognised barriers to effective programme implementation and evaluation, being sensitive to the local context and open to novel approaches to data capture may be some of the factors that will help the vanguard make a measurable different to care home health in Gateshead
	Rachel Stocker Newcastle University and Newcastle Gateshead Clinical Commissioning Group rachel.stocker@newcastle.ac.uk
9.	**Empowering, Enabling & Enhancing Care: Leading the way to 'Gold-Standard End of Life Care' within the Care Home setting in North Tyneside** Download Poster
	Our Aim was to provide/develop a dedicated Specialist Palliative Care resource for Nursing Home teams to improve the standard of Palliative and End of Life Care delivered to their patients promoting preferred place of care /death. Our Model in Practice: • A Palliative Care Register is now established in each Nursing Home utilising the Prognostic Indicator Guidance from the Gold Standard Framework. • Introduction of the 'Deciding Right' initiative. • Embedding the 'Five Priorities of Care'. • Fortnightly Multidisciplinary Team Meetings in each Nursing Home established / mechanism for patient referrals to the team, opportunity to be proactive. • Weekly data collected on patient Admissions, Deaths and Discharges – appropriate discharges expedited from secondary care. • After Death Analysis embedded in each nursing home as a mechanism to significantly reflect on positive and negative outcomes of the episode of care to continuously improve service delivery. Alignment with the organisational wider objectives: • Continuously improve Quality, Safety and the Patient Experience. • Supporting and developing staff to enable them to achieve their best. • Achieving financial sustainability. • Working with our partners to provide an integrated health service for our local population. • Encouraging staff to be innovative when delivering and planning services. Recent runner – up in the National HSJ Awards.
	Pamela Ransom

	Northumbria Healthcare NHS Foundation Trust Pamela.ransom@nhs.net
Medicines Optimisation	
10.	**Challenges of Medicines Optimisation in an Intermediate Care setting** Download Poster
	Gateshead Intermediate Care beds are housed at Eastwood Promoting Independence Centre, which is a Gateshead Council run facility. Medicines Management processes are overly complex and Local Authority systems drive the Medicines Management of patients rather than the patients' needs. The processes are convoluted, time-consuming and prone to error, and contribute towards patient risk. The introduction of a Pharmacist Independent Prescriber at Eastwood has enabled many of the issues surrounding current Medicines Management processes to be addressed. These issues include waste, medication errors, missed doses, hospital discharges and pharmacy interventions. The inclusion of a pharmacist at the weekly MDT at Eastwood has facilitated a smoother transition of Medicines Management from Secondary Care to Intermediate Care, and from Intermediate Care back to Primary Care, and vice versa.
	Clare Macgregor Gateshead Health NHS Foundation Trust clare.macgregor@ghnt.nhs.uk
11.	**Understanding how primary care might offer systematic evidence based medication reviews** Download Poster
	Polypharmacy is rising and increasing with age. Polypharmacy can be harmful, leading to inappropriate prescribing, risk of drug interactions and adverse drug events1 and has been showed to lead to hospitalisation2. Medication review can now be done in a more systematic way with guidance from STOPP/START3. Development of STOPP criteria into a protocol within SystemOne electronic Health Record (EHR) has produced an easy format for primary care to identify potentially inappropriate medications. We are undertaking a quality improvement project (QIP) to understand how STOPP can be used to inform medication reviews for care home residents; our aim is to improve care for frail and elderly people living in care homes. Medication reviews will be undertaken by General Practitioners, a Clinical Pharmacist and an Advance Nurse Practitioner. Before and after qualitative data has being collected from practitioners and care home staff via surveys and patient stories. A STOPP template, developed within Systemone has allowed collection of data on medications ceased, primary care contact, out of hour's consultations and secondary care admissions and referrals. The York Health Economics Consortium are undertaking a cost consequence analysis (CCA) as part of this QIP. Practitioners have found STOPP to be beneficial, feedback has included: "Quicker than me performing reviews from scratch" and "thorough review of medication can only improve care". A noticeable comment was "One patient relative delighted to be given opportunity to review/reduce Mother's medication". 3 practitioners have undertaken medication reviews with the use of STOPP –within one care home alone 18 medications were stopped, with a further 17 having a dose reduction - CCA continues on this project.
	Dr Kate Connolly HEE Yorkshire and Humber Sarah.De-Biase@yhahsn.nhs.uk
12.	**An integrated approach to medicines optimisation: our Northumberland Vanguard**

	Pharmacy Service Download Poster
	The vision for the Northumberland Vanguard Pharmacy team is to improve medicines use across Northumberland through working collaboratively with health care colleagues and across primary and secondary care. Pharmacists have linked with community nursing and general practitioners, and provide a medicines optimisation service to patients with complex medicines needs; frail older people in their own home or care homes. A pilot hub has been set up in Blyth where pharmacists see patients seeking home visits (Acute Visiting Service; AVS) and actively seek patients to review and reduce risk of admission and/or harm from medicines (Complex Patients). Other parts of the Vanguard programme are exploring better use of skill mix in primary care (GP Pharmacists Programme, Community Pharmacy led care home reviews) and integrating better with secondary care (Frailty Assessment Service at Northumbria). We are rolling out services to North and West Northumberland. We have use the IHI Model for Improvement to develop and implement the programme. The service started in July. Data to September 2016 are showing promising results. In the AVS we have assessed 256 patients (21.1% of all patients requesting an acute visit from a GP) and redirected 160 visits to the pharmacist saving an estimated 40 hours of GP time. Pharmacists have made 226 interventions with 91 high impact interventions (RIO score of 2 or 3). 139 complex patients have been bee reviewed with 293 interventions made (124;42% were RIO 2/3 interventions). A common intervention is to stop medicines (no indication or inappropriate), with 131 medicines stopped saving £15,327 (annualised costs). We are planning patient experience and outcome data.
	Wasim Baqir Northumberland Vanguard Wasim.baqir@nhs.net
13.	**Integrating Medicines Optimisation into the Care Home Setting**
	The Newcastle Care Homes Programme is a multidisciplinary programme team comprising nurs GPs aligned to care homes, and a community geriatrician working together with care homes to enhance the quality of care for residents. In 2015, a medicines optimisation service was establi as an integreal part of this programme of care. The aim of this service is to enhance the quality, efficiency and effectiveness of primary healthcare for older, vulnerable adults, focussing initially patients in care homes. The service has achieved this through: • Systematic, proactive review and rationalisation of medication in care homes in Newcas reduce unnecessary polypharmacy and to manage any potential adverse interaction between drug, aging and disease. • Integration of a pharmacist and a pharmacy technician to complete the multidisciplinar team establishment within the Newcastle Care Homes Programme, to optimise the qua care for older people, especially those people with complex needs. Core duties of the team include: • In-depth medication reviews and person centred care plans • Assess and reassess the risks and benefits of medicines • Stop and start medicines • Shared decision making • Attend weekly MDT meetings and provide expert clinical advice • Improve medicines safety • Ensure cost effective care and use of NHS resource • Support self-administration
	Benjamin Kelly-Fatemi NHS Newcastle Gateshead CCG Benjamin.kelly-fatemi@nhs.net
14	**Review of PRN medication prescribing in Care Homes in Gateshead – does it meet**

	recommended guidelines? Download Poster
	Good practice guidelines recommend that when prescribing prn (as required) medication, instructions should include the indication for the medication, the dosage interval and the maximum daily amount. Following discussions at the Gateshead Care Home MDT meeting, concerns were raised regarding prn prescribing - in particular for sedative medications. To get an appreciation of prn prescribing in Gateshead Care Homes, we asked our Older Persons Specialist Nurses to document for up to the next 10 patients they saw which prn medications were prescribed and for each medication whether the good practice guidelines had been followed. Data was collected for 117 different prescriptions, in 12 different homes. With patients having between one and four prn medications prescribed. The majority of medications were pain relief (40%) or laxatives (25%). 13% were potentially sedative medications (anxiolytics or hypnotics). In one fifth of prescriptions none of the criteria were met and all of them were met in 27%. Only one third of sedative medication had all 3 criteria prescribed. For all prn medication only a quarter were prescribed according to good practice guidelines, this improved to one third when looking at sedative medication. It is important that we try and increase this in order to reduce the risk of harm to patients in care homes. We are currently reviewing this as part of the Gateshead Care Home Vanguard including looking at a homely medicines policy for simple analgesia and lative.
	Dr Louise Crabtree Gateshead Health NHS Foundation Trust louise.crabtree@ghnt.nhs.uk
15.	**Stopp Start 2 Toolkit** Download Poster
	NICE medicines evidence commentary: "An Irish cohort study involving older people found that potentially inappropriate prescribing, identified using the STOPP criteria, was associated with increased visits to the emergency department and the GP. Medication omissions (defined by the START criteria) were associated with functional decline and reduced quality of life. Shared decision making should be an integral part of all decisions regarding starting and stopping medications. NICE guideline on medicines optimisation recommends that a screening tool (for example STOPP/START) should be considered in older people to identify potential safety incidents." Produced by the Cumbria NECS Medicines Optimisation team, on behalf of Cumbria CCG, the original resource has been popular with clinicians from many CCGs and trusts around the country and Version 2 has been eagerly awaited. STOPP START 2 includes updated information on the importance of a person-centred approach to shared decision making, renal function, anticholinergic burden and choosing between stopping or continuing medication. It is has been through the Cumbria CCG and NECS governance processes, is referred to in CPPE's Polypharmacy educational materials for pharmacists, the principles are validated by academic papers and NICE's multimorbidity guidance; the toolkit itself is also in the process of NICE accreditation. *Link: http://medicines.necsu.nhs.uk/download/stopp-start-2-cumbria-print-version/*
	Helena Gregory NHS Cumbria Clinical Commissioning Group, North of England Commissioning Support Helena.Gregory@cumbria.NECSU.nhs.uk
Miscellaneous	
16.	**CARE 75+** Download Poster

	There is under-recruitment of older people to research studies. Exclusion criteria, ethical dilemmas, patient preference and risk of bias are particular problems faced by researchers recruiting from this particular population. The Yorkshire & Humber Collaboration for Leadership in Applied Health Research and Care (Y & H CLAHRC) has developed the **Community Ageing Research 75+ (CARE 75+)** (UKCRN 18043) cohort study to increase participation of older people in clinical research. **CARE 75**+ is recruiting community-dwelling older people (≥75years) from GP practices in **Bradford (Tong, Manningham, Saltaire, Shipley)** and **Leeds (Rawdon)**, and imminently from other UK sites. To date, 240 older people have been recruited. Target is 1000. **CARE 75+** is using an innovative cohort multiple Randomised Controlled Trial (cmRCT) design. As well as collecting observational health, social and economic outcome data, this study design is a platform for additional studies (**sub-studies)** including qualitative studies, and feasibility studies, and will eventually support RCTs.
	Sarah De-Biase HEE Yorkshire and Humber Sarah.De-Biase@yhahsn.nhs.uk
17.	**HSRN pain and frailty** Download Poster
	Prevalence rates of persistent pain in community-dwelling older people is over 40%[1]. Frailty is an abnormal health state related to the ageing process. Approximately one in ten people over 65 years, and between a quarter and a half of those aged over 85 years are frail[2]. It is unclear whether pain is more prevalent in older people with frailty. Aim:To identify cohort and cross-sectional studies that reported pain outcomes in older people (>65 years) with well-characterised frailty (fit, pre-frail, frail) and compare pain prevalence across the categories. Methods: We searched databases (including CINAHL, MEDLINE and Embase) for cohort and cross-sectional studies reporting pain in community-dwelling older people which included a validated frailty measure (Fried Phenotype Model, or the Cumulative Deficit Model). Results: The mean age of participants ranged from 71 to 82 years. Pain prevalence was higher in older people with frailty compared with people characterized as pre-frail or not frail (Table 1). Five studies reported significant differences. Conclusion: Pain is more prevalent in older people with frailty compared to pre-frail or not frail older people. However, a lack of prospective data precludes inferences as to whether pain or frailty is the antecedent. Future prospective studies will help determine whether pain is a potential stress factor which contributes to the development or acceleration of frailty or, alternatively, if frailty predisposes to pain.
	Sarah De-Biase HEE Yorkshire and Humber Sarah.De-Biase@yhahsn.nhs.uk
18.	**#I can Prevent Delirium Project** Download Poster
	The goals of the project were to increase staff awareness and confidence in being able to suspect, spot and stop delirium, and to strengthen therapeutic links between liaison psychiatry and acute hospital teams. The #IcanpreventDelirium project was born. Delirium is a common condition in acute hospital patients, the prevalence on medical wards of around 20-30% the majority of patients go undetected and delirium continues to have high morbidity and mortality rates. We developed a short teaching session for staff members at 3 hospitals in the region. Face to face teaching sessions, available to all members of the multidisciplinary team were delivered. A total of 169 staff were trained. Confidence in predicting, recognising and managing delirium rose significantly from pre levels. Delirium is a serious and common condition in acute hospitals. Education such as this programme was welcomed by staff and has resulted in increased staff confidence levels with regards to recognising and managing delirium. We have gone on to organise

	conference with 150 delegates attending and developed a brand to promote Delirium awareness. Video and teaching aids are now available.
	Dr Eleni Fixter HEENE Eleni.fixter@nhs.net
Primary and Community Care	
19.	**Innovation of Frailty Specialist Nurse Service Creation into Gateshead Inner West Locality: A 1-Year review of Service Implementation, Quality Indicators and Patient Cohort Impact – HIGHLY COMMENDED**
	Background: Frailty is a multidimensional syndrome characterised by loss of physiologic and cognitive reserve that confers vulnerability that predisposes to the accumulation of deficits as well as adverse outcomes from acute stressors. Frailty correlates with increasing age, but is not an inevitable consequence of ageing. **Objective:** Innovative service improvement project to introduce a Frailty Specialist Nurse Service into the sub-regional locality. Primary outcome was coordinated, effective and longitudinal care of the frail elderly patient cohort with secondary outcomes including factors such as monitoring the effects of the service in reducing GP and Out of Hours emergency contact rates and decreasing hospital admission incidence. **Implementation:** 4 GP Practice stakeholders in Gateshead Inner West with 1 Frailty Nurse Specialist appointment to work across sites coordinating eligible patients. **Results:** 114 patients seen in 1 year. 72 female and 42 male. 70/114 (61%) patients added to Frailty caseload with remainder discharged following social service care package commencement, optimised occupational health input or Rockwood Frailty Score 5 or below. 87% decrease in GP contact with 8/70 (11%) admitted to hospital for acute pathology only. 14/70 admitted to emergency respite and 5/70 moved to 24 hour care without hospital admission intermediate step. **Discussion:** Innovation success achieved in year 1. Service commended nationally with Clinician of the Year 'Final 3' shortlisting for Frailty Nurse output. Continuity of care, coordination of services and secondary outcome measures all achieved with quantitative results as stated herein and qualitative, comprehensive positive feedback throughout.
	Laura Maitra Gateshead CBC Laura.Maitra@nhs.net
20.	**Integrated Care in Gateshead: Implementing a Clinical Access Nurse role within an adult social care team**
	The Better Care Fund in Gateshead has seen the development of 11 initiatives supporting integrated care for older people. One such initiative has been around the development of a single point of access which has been introduced to support professionals, patients and their families access a range of urgent and non-urgent intermediate health care and social care services. Using the existing single point for adult social care referrals as a foundation on which to develop; the new single point of access is now accessible 24/7. A Nurse was introduced to the developing single point of contact to support the team to manage enquiries and ensure that health needs are considered and client outcomes are not therapy and socially 'top heavy'. Focusing on safety, quality and experience; the Nurse works in the interface between social care and health, problem solving and promoting working relationships. The Nurse role has developed well and there have been a number of learning points and celebrations since the implementation of the post. The poster proposed will showcase key developments and celebrations of this innovative development supporting integrated ways of working and will outline learning to share with health and social care colleagues.
	Angela Fraser

	Gateshead Health NHS Foundation Trust angela.irving@ghnt.nhs.uk
21.	**eFI** Download Poster
	Background • Approximately one in ten people over 65 years, and between a quarter and a half of those aged over 85 years are frail. • Frailty is associated with adverse outcomes including worsening disability, hospitalisation and mortality. • Routine identification of frailty to guide better care is recommended in international guidance. Clinical frailty assessment tools and self-report questionnaires require additional resource and may be inaccurate. • Our objective was to develop, validate and implement an electronic Frailty Index (eFI) using routinely available primary care Electronic Health Record (EHR) data (Clegg et al. 2016). **Development and validation of the eFI** • We developed, internally validated and externally validated the eFI in a retrospective cohort study using the ResearchOne and THIN databases. • EHR data from 931,541 patients aged >65 were included. • 2,171 Read codes were used to construct 36 eFI deficit variables (see table 1). • The eFI was calculated as the number of deficits present in an individual as a proportion of the total possible. • Mild, moderate and severe frailty categories were defined by eFI quartiles. • Robust predictive validity was demonstrated for outcomes of nursing home admission, hospitalisation and mortality **National implementation and impact** • The eFI has been implemented into the SystmOne and EMISWeb primary care electronic health records, so is now available to GPs caring for around 90% of the UK population. • We have established a frailty collaborative to develop and evaluate new models of primary care for older people with frailty as part of the Yorkshire and Humber Academic Health Science Network Improvement Academy. • We have engaged locally, regionally and nationally with 55 CCGs to develop new models of frailty care using the widespread availability of the eFI to enable delivery of evidence-based interventions to potentially modify frailty trajectories and improve outcomes for older people. • Examples of new models of frailty care that have been implemented using the eFI include a tiered, whole systems approach to care for older people; identification of older people with frailty for medication review as an especially high risk group; and proactive falls prevention services.
	Sarah De-Biase HEE Yorkshire and Humber Sarah.De-Biase@yhahsn.nhs.uk
22.	**North Tyneside New Models of Care (Care Plus)** Download Poster
	A non-vanguard site with financial pressures that remained committed to delivering greater patient care for frail patients. North Tyneside New Models of Care (Care Plus) is a partnership between Health services (Hospitals, community and GP Practices), Social care and Age UK who work together to provide: •Coordinated proactive and reactive care for a stratified population defined as severe or moderate on the frailty index •Core General Medical Services sub contracted services for patients whilst registered within the service. •Promoting independence guided conversations and support via Age UK Promoting

	Independence Coordinators and volunteers. The Care Plus service currently operates Monday to Friday with an aim of moving to seven day working within the pilot based on agreed assessed need. The workforce is a combination of new posts (GPwSI) and reconfiguration of existing commissioned services to deliver care in a different way for this defined population. North Tyneside Care Plus is aligned to local and national strategy and builds on local existing service developments and locality working in North Tyneside. The project is an essential part of North Tyneside's Five Year Strategic Plan which outlines a whole system model that puts the individual at the centre of care, empowering them to live more healthy independent lives, focusing on anticipatory care and maximising choice and control.
	Gary Charlton NHS North Tyneside CCG Gary.charlton@nhs.net
23.	**Audit of the effectiveness of community geriatric input and emergency healthcare planning in achieving the preferred place of care for frail elderly patients - WINNER** Download Poster
	An Emergency Health Care Plan (EHCP) has been described as a "means of communicating agreed responses to anticipated emergencies" and is part of the NHS NE Strategic Clinical Network 'Deciding Right' initiative. Emergency Health Care Planning undertaken by Sunderland Community Geriatrics team aims to improve care of frail elderly patients by facilitating assessment closer to home, avoiding unnecessary or unwanted admissions and establishing a Preferred Place of Care (PPC). We audited the admissions of 138 patients with EHCPs. 60.1% of patients had an inpatient admission in the 6 months prior to EHCP initiation, compared to 15.9% in the 6 months afterwards. Similarly, total length of stay reduced from 1801 days prior to 167 post initiation. 7/22 admissions were deemed to be 'inappropriate' and not in accordance with established parameters set out in the EHCP. Death in their PPC was achieved in 94.2% of cases. Reduction in admission rates and length of stay cannot be attributed solely to EHCP instigation due to regression to the mean and high rates of death in the medium term. However it is encouraging that the rate of inappropriate admissions was low and the preferred place of care for death was achieved in the vast majority.
	Dr Hannah Filler Sunderland Royal Hospital Hannah.filler@ghnt.nhs.uk
24.	**Taking Comprehensive Geriatric Assessment into Primary Care – a new Community Geriatrician Service in Newcastle** Download Poster
	Frail older people with complex comorbidities often find that their health care is delivered by several clinical teams, which can lead to poor communication and an uncoordinated approach. A Community Geriatrician (CG) can improve management by providing comprehensive assessment in the community, and improving links with General Practitioners. In 2015 Newcastle-Gateshead CCG commissioned a CG post, divided between 2 Geriatricians, initially for 2 mornings per week. 10 Newcastle GP practices were invited to take part in a three month pilot, commencing in June 2016. CGs attended 19 practice meetings. 51 queries about patient care were received directly, via email or by phone. At least one of these prevented an acute hospital admission. 11 patients were visited at home. Reasons for visits included: 1) advice about acute changes in frail patients; 2) long term condition management; 3) assessment of mental capacity; and 4) end of life management. The CGs also provided general advice and education about specific clinical issues. Informal feedback from GPs showed a high level of satisfaction. GPs valued the collaborative approach for management of complex patients, and the signposting to other appropriate services. Further expansion to cover more Newcastle GP practices is planned.

	Dr Jane Noble The Newcastle Upon Tyne Hospitals NHS Foundation Trust NHS Newcastle-Gateshead CCG Jane.noble@nuth.nhs.uk
25.	**Patient experiences of an unplanned admission avoidance programme**
	Objectives To explore the views and experiences of patients on the care they have received whilst enrolled on the Northumberland High Risk Patient Programme (NHRPP). This programme involved case finding of frail patients using a multidisciplinary team (MDT) led community case management programme. Methods A qualitative study using semi-structured interviews with patients enrolled on the NHRPP. Interviews were digitally recorded, transcribed and subject to thematic analysis. Results 16 participants took part. Four main themes emerged from the data: awareness and understanding of the NHRPP, confidence in the primary healthcare team, limitations of home care and the active role of being a patient. Despite having a low level of awareness of the details of the NHRPP participants did think that its broad aim made sense. Participants discussed their high level of satisfaction with their care and access. However, some limitations of alternatives to hospital care were identified. Conclusions This study has identified that a programme of MDT led case management was generally very well received by patients and their families. However, a number of factors were identified that could improve the implementation of the programme and further research needs to be undertaken to address these.
	Dr Rachel Duncan Institute of Health and Society, Newcastle University r.duncan@ncl.ac.uk
26.	**Frailty trajectories in the last year of life: analysis of a frailty index generated from routine primary care electronic health records**
	Frailty is a health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Providing appropriate, effective and timely care for frail older adults can be a challenge. We investigated the potential of a frailty score – the electronic frailty index (eFI) - available in routine electronic health records (EHRs), to contribute to end of life care. We requested anonymised primary care EHR data from ResearchOne for individuals aged 75+ who died between 2015 and 2016. These individuals were matched to individuals aged 75+ with no record of death in the same time period. Monthly frailty scores were calculated over one year using the eFI. We examined longitudinal change in frailty scores and used latent class analysis to identify unobserved classes of patients and their associated mean eFI trajectories. In total, 30,000 records were extracted. Preliminary analysis in a random subset of 1000 patients (54.6% female, mean age 85.8, sd 6.2) identified three latent classes of eFI trajectory: low-stable, high-stable and accelerating-accumulation. A higher proportion of deaths were observed in the accelerating-accumulation class. Ongoing work is investigating whether a specific change point in eFI could indicate a need to adopt a palliative approach to care.
	Daniel Stow Institute of Health and Society, Newcastle University Daniel.stow@ncl.ac.uk
27.	**What matters in the primary care consultation in the context of frailty: an exploration of the perspectives of older people, family carers and health care professionals** Download Poster

	Working with frail older adults is an important but challenging aspect of primary care. Judging how and when to discuss the likely course and management options with patients may be particularly difficult for health care professionals (HCPs). A good understanding of frailty is also essential for older adults, if they are to make optimal and timely choices about their care. Little is known about how well primary care serves the needs of frail adults. The aim of this study was to explore what matters in the primary care consultation for older people living with frailty, their family carers, and healthcare professionals. Methods • Scoping review of the literature • Qualitative interview study with 10 older adults living with frailty, 4 family carers, and 9 primary care HCPs • Stakeholder workshop Emerging findings from the qualitative study suggest all parties value: trusting, long-term relationships; sufficient time for complex consultations; and, HCPs who have experience working with older people with frailty. A lack of awareness of support available to older people with frailty is recognised, and HCPs acknowledged the absence of any framework to prioritise problems within encounters with people living with frailty. Our findings will inform the need for, acceptability and content of interventions to support HCPs to manage frailty. The priorities for HCPs will be shared. Funding: NIHR CLAHRC Yorkshire and Humber.
	Louise Schreuders School of Healthcare, The University of Leeds l.w.schreuders@leeds.ac.uk
28.	**Wrapping Services around the Older Person** Download Poster
	By 2020 there will be a sustainable health and social care economy in Darlington that places citizens, particularly the older person, at the centre of the model and builds strategies and services around them. Personal responsibility, prevention of harm, self-management of conditions, prompt access to primary and easy access to acute (physical and mental health) services will form a continuum of provision in Darlington, with more specialist services provided elsewhere. A range of stakeholders continue to work collaboratively to improve the offering to Darlington residents. These initiatives include: • Multi-Disciplinary Practice Meetings with the Voluntary Sector acting as broker • Development of a Single point of access • Re-ablement schemes to ensure patients independence is maximise • Community Matron Alignment to GP practice and Care Homes • Developing the social prescribing model • Implementation of Nutri-call to monitor patient baseline data to trigger appropriate inp • Community Hubs Development- Population based services • Increasing the use of digital health • Awarded Healthy New Towns status (inc dementia friendly hub, virtual care home, self-management) • Luncheon club • Good friends to keep a watchful eye on older, isolated and/or vulnerable neighbours • Safe and well-being visits carried out by Fire Service • Accelerated provision of flu vaccinations for care homes • Launching discharge to assess • Predictive modelling Award winning- Information Sharing Agreement
	Rebecca Warden

	NHS Darlington CCG, Darlington Borough Council and County Durham and Darlington NHS Foundation Trust Rebecca.warden@nhs.net
29.	**Multi Disciplinary Case Management of Frailty in the Community through Practice Based Care** Download Poster
	Referrals come from professionals within the practice, self -referrals and proactive case finding. Patients receive a Comprehensive Geriatric Assessment looking at all aspects of clinical and social care. The OT works collaboratively with patients to identify problems and goals around their daily needs and aspirations, creating a personalised care plan tailored to the individual's needs. This practice based community partnership has demonstrated:- -Identifying the pre frail and providing targeted intervention reduces risk of admission, encourages self- management and optimizes independence and safety. -High quality cost effective care, helping people remain physically and emotionally well reduces needs for support, avoids crisis and reduces primary/secondary care attendances -Support for GP's, it's not always necessary for patients to be seen by a GP, other professionals can support. -Continuity, follow up and a single point of contact for the older patient giving them confidence and reassurance.
	Kathryn Hubbard Oxford Terrace and Rawling Road Medical Group Kathryn.hubbard@nhs.net
Secondary Care	
30.	**The Impact of a Frailty Liaison Team working in a Short stay Medical Unit** Download Poster
	As part of our on-going Frailty strategy group we have been exploring how the role of the frailty nurse could make an impact on patients accessing emergency care who come into the hospital via our Short Stay Unit. Clinical evidence suggests that those patients with a Multi-disciplinary team approach using a Comprehensive geriatric assessment have the best outcomes when planning patient care and discharge. As part of the frailty group we looked at a small team having an interface session with one of the Geriatricians on a weekly basis. The team comprised of a Frailty Nurse, Physiotherapist and Geriatrician. The Frailty nurses screened for frailty in the morning using 'Think frailty tool' and collated background information, patient baseline, presenting complaint- this was then triaged with the Geriatrician in the afternoon. The Frailty Liaison Team then had a ward round in the afternoon this identified a working diagnosis, plan of care, influenced patient flow, estimated date of discharge. This work was followed up by the frailty nurses 24/48 hours later and we also looked at patient outcomes 4 weeks post interface. This was a small study but demonstrated the need for MDT working an early CGA intervention.
	Deborah Whitaker Gateshead Health NHS Foundation Trust deborah.whitaker@ghnt.nhs.uk
31.	**Impact of a Frailty Inreach Service on the Integrated Admissions Unit** Download Poster
	Aim City Hospitals Sunderland NHS Foundation Trust is a 735 bedded acute secondary care provider serving a population of 340,000 across the north east of England. In 2014 Sunderland

	Royal Hospital participated with 11 other trusts in the national Frailsafe project with the aim of improving the management of frail elderly patients in hospital. We were keen to assess the impact of our Frailty team inreach service providing comprehensive geriatric assessment within a front of house environment. Methods Initially one consultant ward round on the medical admissions unit each morning. Subsequent addition of an elderly care nurse practitioner and frailty pharmacist. Developed close links with complex discharge team and interface therapy service. Progressed to full daily cover with dedicated team and expansion into the emergency department within one year. Outcomes / Results A retrospective case matched analysis demonstrated a reduction in length of stay by 1.4 days, reduction of inpatient mortality by 3.5% and reduction in readmission rates by 6.5% for those seen by the Frailty team compared to a group of patients who met the Frailty criteria but were admitted outwith the Frailty team hours of operation. We estimated a potential saving of more than 16000 bed days over 16 months. Conclusion Early comprehensive geriatric assessment has improved patient outcomes by ensuring Frail patients get the right care in the right place at the right time. Close working with front of house services has raised the awareness of Frailty and challenged attitudes to the inevitability of hospital admission. 2016 sees the introduction of a locally agreed CQUIN, development of an electronic Frailty assessment tool and ongoing efforts to secure funding in order to expand the team and work beyond our current remit.
	Deborah Mayne City Hospitals Sunderland NHS Foundation Trust Deborah.Mayne@chsft.nhs.uk
32.	**Coventry Primary Care Frailty Team** Download Poster
	The scheme involved the Acute Trust, Community Trust, Coventry City Council Social Care, Age UK in co-designing the service and providing active care to patients as a multi-disciplinary team based from the hospital. In practice, the innovations include: •GP in ED service (reviewing c. 900 patients per month, with frail patients directed to the GPs). •Multi-disciplinary team and assessment includes Social care and Voluntary sector. •New clinical interventions e.g. Comprehensive Geriatric Assessment, frailty care plans available to all services. •Access to patient GP records through Extended Hours service. •Dedicated GP led primary care service to see and treat frail patients across wards. •New support roles e.g. Nurse Care co-ordinators (directing care in accordance with patients' frailty plan) and Voluntary sector 'Navigators' to settle patients. •West Mids Fire Service provide transport, re-settlement services and health and wellbeing checks. Results are promising and the service is now operational and scaling: e.g. reduction in admissions by 38%, LOS by 62% from 11.1 to 4.2 days, greatly increased patient experience as recorded by our Academic partner (Warwick University).
	Adrian Woolmore Capita Health Partners adrian.woolmore@capita.co.uk
33.	**Using audit to explore frailty incidence within the acute care setting** Download Poster
	Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years [BGS 2014] Understanding an individual's level of frailty allows for predictions of morbidity and mortality which ultimately can improve the safety and quality of care delivery as well as

	positively impact upon care experience. It makes sense therefore to identify those older people living with frailty among a hospital's inpatient users, hence a snap shot audit was undertaken, within in a medium sized acute NHS Trust whereby every inpatient ward other than maternity and children's services were included in the census. Each ward was visited by a team of nurses skilled in the specialist care of older people and using the Rockwood frailty scoring tool and case based discussion with the ward teams the following was noted: • Hospital occupancy was 98% • Total number of patients was 451 • 74% patients were over 65 years • 18% patients were very fit / fit / managing well • 27% patients were vulnerable / mildly frail • 22% patients were moderately frail • 30% patients were severely / very severely frail • 3% patients were receiving end of life care These findings demonstrate that frailty can be found within all specialities of acute care and so must imp shape future care delivery models and any reorganisation of services should include an evidence based multidisciplinary model of care. Get it right for older people and you get it right for everyone.
	Lynne Shaw Gateshead Health NHS Foundation Trust Lynne.shaw@ghnt.nhs.uk
34.	**Hospital Wide Comprehensive Geriatric Assessment (CGA) for frail older people** **Download Poster**
	CGA is widely recommended for older hospital inpatients. In this NIHR funded project we have carried out an umbrella review to define key elements, principal outcomes and beneficiaries of in hospital, and a survey of UK hospital practice in providing CGA for frail hospital inpatients. **Umbrella review:** From 715 titles, we selected 12 reviews for data extraction and analysis We identified a common definition of CGA. Key outcomes included mortality, institutionalizatio and dependency. The main beneficiaries were older people (≥ 55 years) in acute care. Frailty wa not generally identified and patient related outcomes were not usually reported. **National Survey:** We asked all UK hospitals to identify services which provided CGA. All participating hospitals (n=45) described the provision of CGA and have returned descriptions 82 services. Of these, the majority (73/82, 89%) used clinical assessment in preference to scree tools (36/82, 44%) or criteria (38/82, 46%) to identify recipients of CGA. Most services (58/82, 7 did not use standard methods for measuring frailty. A range of settings and team configuration have been identified. **CGA toolkit:** The research team are currently developing a multi-level toolkit to facilitate hospital wide delivery of CGA which will be evaluated during 2017.
	Stuart Parker Newcastle University Stuart.parker@ncl.ac.uk
Self-care and Supportive Care	
35	**My Equipment Newcastle** Download Poster
	My Equipment Newcastle is Newcastle City Council's online self-help tool. It is designed for use by individuals who may be struggling with things like bathing, getting on and off the toilet, going up and down stairs or getting in and out of their home where simple equipment such as a raised toilet seat or grab rail may be the answer. Individuals or their carers follow a step by step guide and receive professional advice to help them choose the right equipment for their home without having to wait for an assessment**.**
	Fiona Richardson

	Newcastle City Council Fiona.s.richardson@newcastle.gov.uk
36.	**Self-management support (SMS) Saltaire** Download Poster
	The degree to which older people become engaged in 'self-management' is a critical part of future service delivery for people with frailty if they are to age more healthily. However, Self-Management Support (SMS) interventions are not routinely offered to people with frailty. Aims: Understand the barriers and enablers to healthy ageing in older people with mild frailty, and design a SMS intervention for this population taking into account the barriers and enablers identified.
	Sarah De-Biase HEE Yorkshire and Humber Sarah.De-Biase@yhahsn.nhs.uk
37.	**Self-Care and Engagement Programme** Download Poster
	Delivered in partnership with the North of England Mental Health Development Unit (NEMHDU) the Care Home Programme has co-designed a volunteering programme to take a fresh approach. Feedback from early consultation showed that older people open up and connect better with their own peer groups. This volunteering programme requires our volunteers to connect with their own support networks where trust has already been built and friendships have formed, opening up opportunities to gain insight into the aspirations of older people. This project will provide volunteers with the skills and knowledge necessary not just to better manage their own care, but to engage with the wider population of Gateshead and Newcastle. Some volunteers have gained a considerable amount of confidence and one volunteer said "I've learned not to just accept what I'm told but to challenge this; I now understand that I'm allowed to have expectations when it comes to my own healthcare". The delivery of the first programme is now complete and a second cohort is underway. So far 20 volunteers have been recruited. In Gateshead we've seen great success so far with 300 older people attending sessions ran by the volunteers throughout the community.
	Lindsay Gibbins NHS Newcastle Gateshead CCG Lindsay.gibbins@nhs.net
38.	**Gateshead Older People's Wellness Hub**
	Gateshead Older People's Assembly currently delivers a range of projects and activities aimed at reducing frailty in older people across the borough, by targeting the following issues: • Malnutrition • Falls • Loneliness and Isolation At our centre in Deckham, Gateshead, we undertake the following projects and activities: • Reminiscence Group • Art Group and Craft Group • Social Group • 'Staying Steady' postural stability class • Free Tai Chi for over 50s • Over-50s Circuits Class • Dancercise • Community Garden • Pay what you can Community Cafe • Cooking/Eating Well Project

	• Walking/Activity Group All of these activities are scheduled and arranged so that anyone over 50 can access our services at any level, free of any barriers, as often as they wish. Working closely with Public Heath and Primary Care providers, we have developed our activities to be inclusive and supportive of all older people. We have produced monitoring and evaluation reports to demonstrate the effectiveness of our programmes. The poster will feature a central hub (our centre), with all of our wellness and wellbeing activities, and how they interact with each other. The poster will also demonstrate links to the 5 ways to wellness, Gateshead MBC's health priorities, and our organisation's strategic plan – which is a user-led document.
	Craig Bankhead Gateshead Older People's Assembly craig@gatesheadopa.org.uk
39	**Equal Arts – examples of imaginative, relationship centred support** Download Poster
	Equal Arts is based in Gateshead and is the North Easts' leading creative ageing charity – with dynamic programmes for older people. We deliver training to care staff and artists in the field a are involved in national and international research **HenPower** Hen-keeping is a catalyst for creative and meaningful activities and helps build relationship between older people, care setting staff and residents and schools. The programm now being delivered in 60 care homes nationally and has reached as far as Australia and the Netherlands. **Creative Friends** A new type of befriending scheme, Creative Friends matches up small groups of older people (tv four) who have similar interests and supports them to visit museums and galleries and take part interesting challenging creative activity. Open to anyone 55+ who feels they would benefit from support to explore new cultural and creative experiences. **Creative Ageing Challenge** We are working with cultural venues in the North to deliver creative programme for older peop designed to be dementia friendly, which focuses not on reminiscence but on the "imagination" model. Each group decides on a Creative Challenge which then gets taken on by the wider community, involving schools and young people, in order to raise the profile of the work and raise funding fo future programme.
	Alice Thwaite Equal Arts alice@equalarts.org.uk
Technology in Care	
40.	**Jointly for Carers for Carers** Download Poster
	Jointly is a mobile and online tool designed to help people looking after someone. It aims to make caring a little easier, less stressful and a lot more organised by making communication and coordination between the people who share the care as easy as a text message. Jointly combines group messaging with other useful features including to-do and medication lists, calendar and more. With Jointly a carer can create a circle of care for the person they are looking after by providing relevant information including the name of the cared for, their date of birth, their caring needs/condition/diagnosis, their allergies, likes and dislikes and any further information relevant to the individual

	Once a Jointly circle has been set up, carers can start using jointly to organise care. Carers can use it on their own or they can invite others to join them and share the care. Jointly works on iPhone, iPad, Android devices and on most modern web browsers (home computers, laptops, smartphones, tablets etc) Jointly is now being offered FREE of charge by Newcastle City Council to all carers in Newcastle.
	Fiona Richardson Newcastle City Council Fiona.s.richardson@newcastle.gov.uk
41.	**Healthcall Undernutrition – using digitally enabled 3rd sector lunch clubs to reduce Undernutrition and Social Isolation in hard to reach patients.** Download Poster
	Problem: Social isolation, loneliness and undernutrition are both causes and consequences of each other and major problems in England, linked with poor quality of life, clinical outcomes and premature death and cost the overall health economy. There are independent interventions within Darlington to tackle social isolation and undernutrition: • Health Call Undernutrition (HCUN); a telehealth solution remotely monitoring patients at risk of undernutrition. Supports self-management, improve quality of care and patient pathways. Demonstrated cost and capacity efficiencies. • Age UK Darlington Friends Lunch Clubs; reduce social isolation and provide a nourishing meal Intervention: Partnering with Age UK Darlington, engaging individuals considered 'hard to reach', whilst digitally enabling the luncheon clubs, providing a social opportunity, a nutritious meal and access to expert dietetic input. Individuals, with support of volunteers, will monitor their own weight, entering the data on the HCUN web portal. Supporting empowering individuals to self-manage their own nutritional health. Impact: Promoting social inclusion, self-monitoring and self-managing undernutrition in key vulnerable patients will: • Reduce undernutrition and secondary consequences • Reduce social isolation and loneliness • Provide a sustainable self-management pathway • Reduce unnecessary activity in clinical services • Improved patient digital capabilities • Improved patient awareness of available support
	Catherine McShane County Durham and Darlington NHS Foundation Trust catherinemcshane@nhs.net
Technology in Care	
42.	**How digital telehealth technology is helping look after the frailest care home residents in Sunderland** Download Poster
	As part of Sunderland's New Care Model the needs of our most vulnerable and frail patients in care homes have been a particular focus. Our model provides enhanced care which includes a multi-disciplinary team approach. This is complimented with the introduction of a new and exciting telehealth technology designed by the teams for the residents. Training provided to the care home teams has helped to embed this technology. The digital technology tracks the health of residents so that any changes in their condition

	can be quickly picked up, giving them and their families the reassurance that they are receiving the best care possible. The digital tablet is used for: • Collecting information about a resident's weight • Collecting regular information about a person's health, including their blood pressure, oxygen levels, respiratory rate and temperature (NEWS – National Early Warning Score) • Monitoring the pain levels of residents who aren't able to communicate • Collecting information each month (or more regularly) depending on residents' needs This information is then used by the healthcare professionals to help detect any problems and to spot and signs of deterioration. The cloud based system can be accessed by those involved in the residents care. Working in partnership with Newcastle and Gateshead CCG the technology will include new functions to monitor Hydration and falls helping us to look at a number of factors which contribute to the frailty of residents.
	Rachael Forbister NHS Sunderland CCG rachael.forbister@nhs.net
Workforce Development	
43.	**Competency Based Framework – Therapy** Download Poster
	National drivers recommend Intermediate Care, interagency working and auxiliary staff development to provide economical, efficient services (DOH 2013, National Collaboration for Care and Support 2013, NHS Benchmarking Network 2014). 2015 provided an exciting Better Care Fund opportunity in a Therapy Educator to develop a competency based framework for local authority support workers to achieve competence in following Occupational Therapy and Physiotherapy interventions within Gateshead's Intermediate Care Beds. With limitations in therapy provision, the project also aspired to provide a consistent approach. Maximising the independence, health and wellbeing of consumers of the service. The year project involved partnership working between local authority, health and education, challenging professional and organisation boundaries. Investigations demonstrated experience of therapy was inconsistent with no evidence of competence and a care record audit contributed to identifying 19 therapeutic competencies. A multifaceted assessment team, service development strategies and standardised performance criterion helped support cultural and behavioural changes. However experiential learning integrated theory into practice and although behavioural changes were evident, other challenges encountered limited implementation. The project has been extended, to enable a more robust evaluation that could contribute to the wider care home review. 56% of staff have attended 17 subject training sessions with continual competency achievement.
	Carolyn Brayson Gateshead Health NHS Foundation Trust carolynbrayson@gateshead.gov.uk
44.	**Teaching Care Homes Project**
	CareHome Nursing is seen as a low priority career choice for Registered Nurses, one where little innovation, development or professional opportunity exists, a sector where there is a high turnover of staff. Injecting some innovation and energy to create a clear and positive image of Carehomes is an essential part of any health integration plan. Working with partners Northumbria University, NHS Community Provider, Foundation of

	Nursing Studies we developed four workstreams and the International Longevity Centre to evaluate outcomes. **Creating a new approach to Care Home Nursing, Building academic partnerships and learning** Chester Court works with Northumbria University and NHS community provider to host four seminars for twenty RNs and facilitates clinical practice visits in the carehome, allowing for learning and discussion with peers and First and third year Student placements. **Building Leadership capacity and creating innovation through culture change** Six practice and culture workshops for carehome staff with tailored coaching and mentoring to provide infrastructure to support the change. **Improving the image of Care Home Nursing** With Northumbria University publish four professional articles to create interest and a vibrancy in CareHome nursing. **Providing learning locally** Presentations and Masterclasses at events to support CPD requirements, sharing and disseminating experiences.
	Julia Atherton Chester Court Care Home - Barchester Healthcare Julia.atherton@barchester.com
45.	**Care Home Champion Programme** Download Poster
	The voice of the care sector is important at all levels to ensure the new care models are fit for purpose. The Care Home Programme recognised a lack of care home representation which was a major concern. Through our Care Home Champions programme we now feel that positive steps have taken place to engage staff. Within the team we recognised that communication is key to ensure staff at all levels understand the programme. To communicate with each care home, a peer support network has been developed through the Care Home Champions Programme. A budget has been set aside to pay for a representative from each care home to allocate one full day to the Care Home Programme bi-monthly, this may become more regular. The Care Home Champion spends three hours with the team to be briefed or discuss challenges faced. They are then paid for three hours to distribute this information within their care home. They can allocate this time how they like, whether it's part of a team meeting or one to one sessions. A community group has been established on What's App and a 'buddy' system naturally evolved with champions exchanging contact details on the first day.
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