Tracy Means
Head of Nursing Community
York Scarborough Teaching Hospital

Tara Kadis
Lead Nurse Diabetes & Endocrinology
York Scarborough Teaching Hospital

Delegation of Blood Glucose Measurements & Insulin Administration in Care Homes

Insulin Administration in Care Homes

Tara Kadis
Lead Nurse
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Your diabetes
Vale of York diabetes community

Background

- Significant increase in the older person population
- The likelihood of developing diabetes increases with age
- 1 in 4 people in Care Homes has Diabetes
  - Highly vulnerable group
  - Challenging medical & nursing needs
  - High rates of hypoglycaemia and preventable & unnecessary hospital admissions

Your diabetes
Vale of York diabetes community

Locally: Vale of York - 58 Residential Care Homes

- Increasing demands on Community services, more complex patients being discharged to Community services earlier than previously
- Advances in Diabetes management recommending more intensive treatments and technology
- Covid legacy – fewer community staff verses reduced access

Team	AM	PM	Total visits a day
North	29	7	36
SHAR	25	14	39
South	21	6	27
East	26	11	37
West	13	6	19

158 visits per day for insulin administration

Your diabetes
Vale of York diabetes community

What we have already done?

Policy for Community Senior Health Care Support Workers in insulin administration

- Task of administering insulin in patients with Type 2 patients
  - Competency package, developed by Diabetes Specialist Team and Community services (2017)
    - 2 hours initial training on:
      - What is diabetes
      - Management of acute complications
      - Practical session on insulin administration
    - Competency based assessment with RN – sign off
    - Every 3 years refresher - classroom based sessions

Your diabetes
Vale of York diabetes community

Diabetes UK, Trend UK, Royal College of Nursing (RCN), NHS England and Improvement (NHSEI)

National competency framework

- **Personalised care and empowerment**: can improve continuity in the member of staff who provides this service, and as people will not need to wait until a registered nurse can get to where they live, they will receive injections at the time appropriate to their routine and care plan.
- **To support the development of care home workers:** We want to formalise policies for those who have already developed their skills in the care of people with diabetes.
- **To help prevent transmission of COVID-19**: By minimising the number of different health and care professionals who enter vulnerable people's homes or adult social care settings, we can minimise the risk of transmission in those settings.

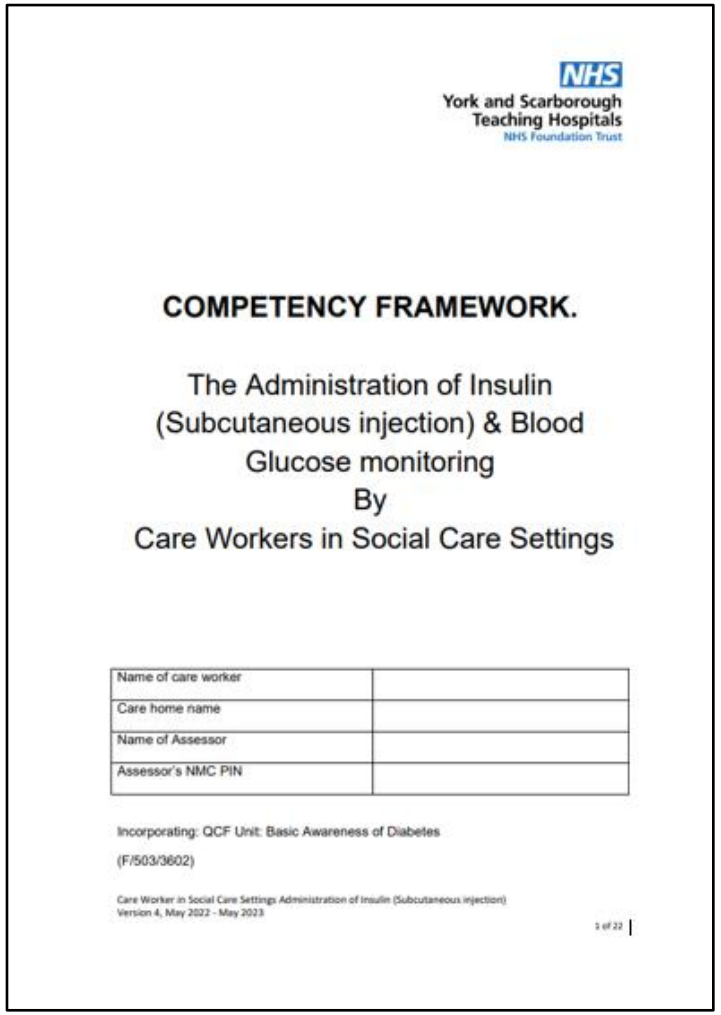
Your diabetes
Vale of York diabetes community

New Policy

- Policy for Care Home Workers to take on the task in patients with type 2 diabetes on daily / twice daily insulin
  - Patient would remain under care of Community District Nursing team – at least weekly visits,
  - Care Home Workers – supported through competency training from both Community District Nurse team and Specialist Diabetes team
  - Format the same – Diabetes team will train in the Care Home
  - Shared liability for staff

Your diabetes
Vale of York diabetes community

Policy now approved



NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

COMPETENCY FRAMEWORK.

The Administration of Insulin (Subcutaneous injection) & Blood Glucose monitoring By Care Workers in Social Care Settings

Name of care worker	
Care home name	
Name of Assessor	
Assessor's NMC PIN	

Incorporating: QCF Unit: Basic Awareness of Diabetes

(F/503/3602)

Care Worker in Social Care Settings Administration of Insulin (Subcutaneous injection)
Version 4, May 2022 - May 2023

1 of 22

[insulin-administration-competency-framework (yha.com)]

Your diabetes
Vale of York diabetes community

Next steps

- Pilot sites
  - 2 Pilot sites currently
    - Birchlands Care Home
    - The Chocolate Works
- Training by Community Diabetes Team
  - Theory based knowledge and skills
- Glucose monitoring training for staff supported by GlucorX using the HCT glucose meter
- Competency training portfolio completed with the Community District Nurse Team

Your diabetes
Vale of York diabetes community

Our Shared Vision !

1. To support improved patients outcomes
2. Facilitate closer working relationships and access to support for Care Homes
3. Develop knowledge and skills for staff

Further information:

Tara.kadis@nhs.net

Tel: 07778 599886

Your diabetes
Vale of York diabetes community

York and Scarborough Teaching Hospitals
NHS Foundation Trust

Project to prevent or improve bladder & bowel health for care home residents

Stefanie Barnish – Specialist Bladder & Bowel Nurse

Gerry Rook – District Nurse

The Queen's Nursing Institute

NHS
York and Scarborough Teaching Hospitals
NHS Foundation Trust

Overall Aim of Project

- To improve or prevent continence related issues for people who are living in 2 care homes in the York & Selby area, maintaining independence for longer and improving quality of life.

Specific Aims

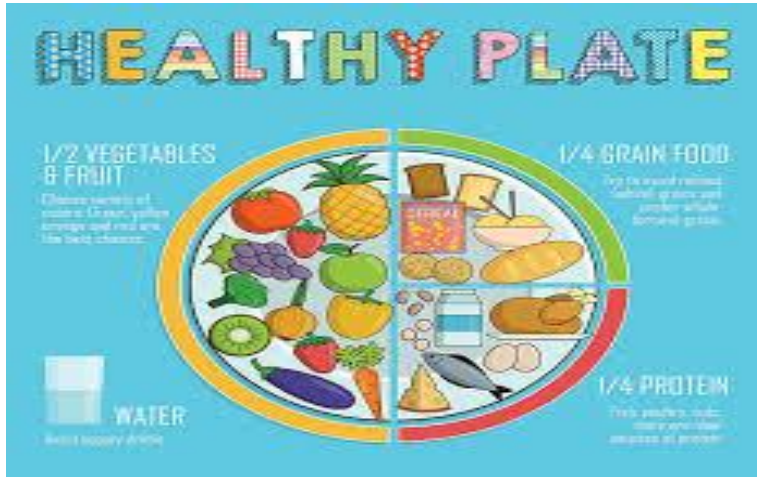
- To educate staff to complete screening tool or support residents to complete on admission to the care home.
- To train and educate staff and residents
- To provide alternative management plan

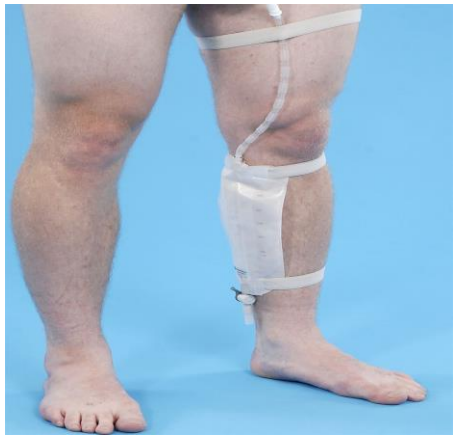
Qni The Queen's Nursing Institute

Onboarding

Education

- Carers
- Residents





Case Study One

Case Study Two

North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership

Abigail Combes
Head of Legal and Regulatory Services
NHS North Yorkshire and York Health & Care Partnership

Liberty Protection Standards and Mental Capacity

North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership

Maureen has dementia. She lived at home with some support until she was moved into a residential home 2 years ago. She now requires nursing care. Who would be her next of kin for these conversations?

Simon has a learning disability. He does not have capacity to make decisions about his accommodation or care needs. He is 19 years old. He lives in a supported living placement funded by the Local Authority. His mum is appointee for his benefits but there is no Power of Attorney or Deputyship in Place. His father is not involved in his care.

Simon has recently been unwell and needs to be moved into a specialist facility. What is his mum's role in that decision?

North Yorkshire County Council

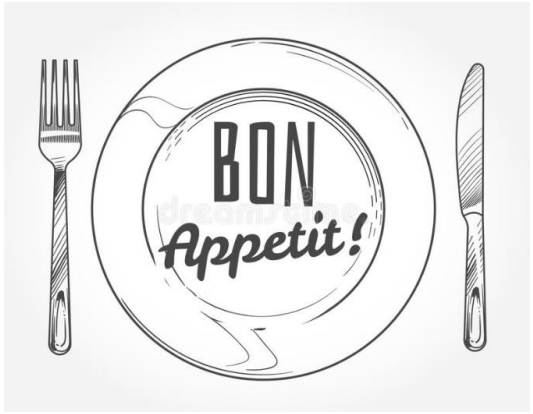
Humber and North Yorkshire Health and Care Partnership

LPS Update

- Liberty Protection Safeguards are intended to replace the current Deprivation of Liberty regime
- Consultation closed July 2022
- Outcome of consultation not yet published
- Single authorisation to cover multiple settings
- System work to standardise approach
- Involving the care sector

North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership



Lunch

12:00-13:00

Don’t forget to visit the stands !

Dr Helena Ebbs
GP Quality Lead
South Hambleton and Ryedale Primary Care Network
(SHaR PCN)

Advance Care Planning: Why Does Thinking Forward Matter?

"Advance care planning: why does thinking forward matter?"

Dr Helena Ebbs

GP Clinical Lead

South Hambleton and Ryedale Primary Care Network

What do we mean by Frailty?

- A clinically recognisable state of increased vulnerability resulting from aging-associated decline in reserve and function
- Compromises the ability to cope with everyday or acute stressors

"The Frailty Syndrome: Definition and Natural History" Qian-Li Xue Clinics in Geriatric Medicine


AMERICAN COLLEGE of CARDIOLOGY
NCDR | ACC Accreditation Services
KNOW YOUR PATIENTS' FRAILTY
Use the Canadian Study of Health and Aging Clinical Frailty Scale to assess the patient's current condition.
The nine-point Clinical Frailty Scale can help determine if a patient is at risk for poor outcomes and can guide communication between clinicians and patients.
Scoring Frailty in People With Dementia
The degree of frailty corresponds to the degree of dementia.
Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.
In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well.
In severe dementia, they cannot do personal care without help.
HOW TO MEASURE FRAILTY IN YOUR PATIENTS
VERY FIT
People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
1
WELL
People who have no active disease symptoms but are less fit than those in category 1. Often, they exercise or are very active occasionally, e.g. seasonally.
2
MANAGING WELL
People whose medical problems are well controlled, but are not regularly active beyond routine walking.
3
VULNERABLE
While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up," and/or being tired during the day.
4
MILDLY FRAIL
These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
5
MODERATELY FRAIL
People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
6
SEVERELY FRAIL
Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
7
VERY SEVERELY FRAIL
Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
8
TERMINALLY ILL
Approaching the end of life. This category applies to people with a life expectancy < 6 months, who are not otherwise evidently frail.
9

In other words….

FRAILTY = VULNERABLE to a BIG IMPACT from a SMALL HIT

Why do we need to think forward?

1. Hear people
2. Empower people
3. Enable people
4. Plan resources we'll need
5. Plan the responses to challenges
6. Plan for gaps

What do we need to talk about?

What are they noticing

What is changing

Fears

Hopes

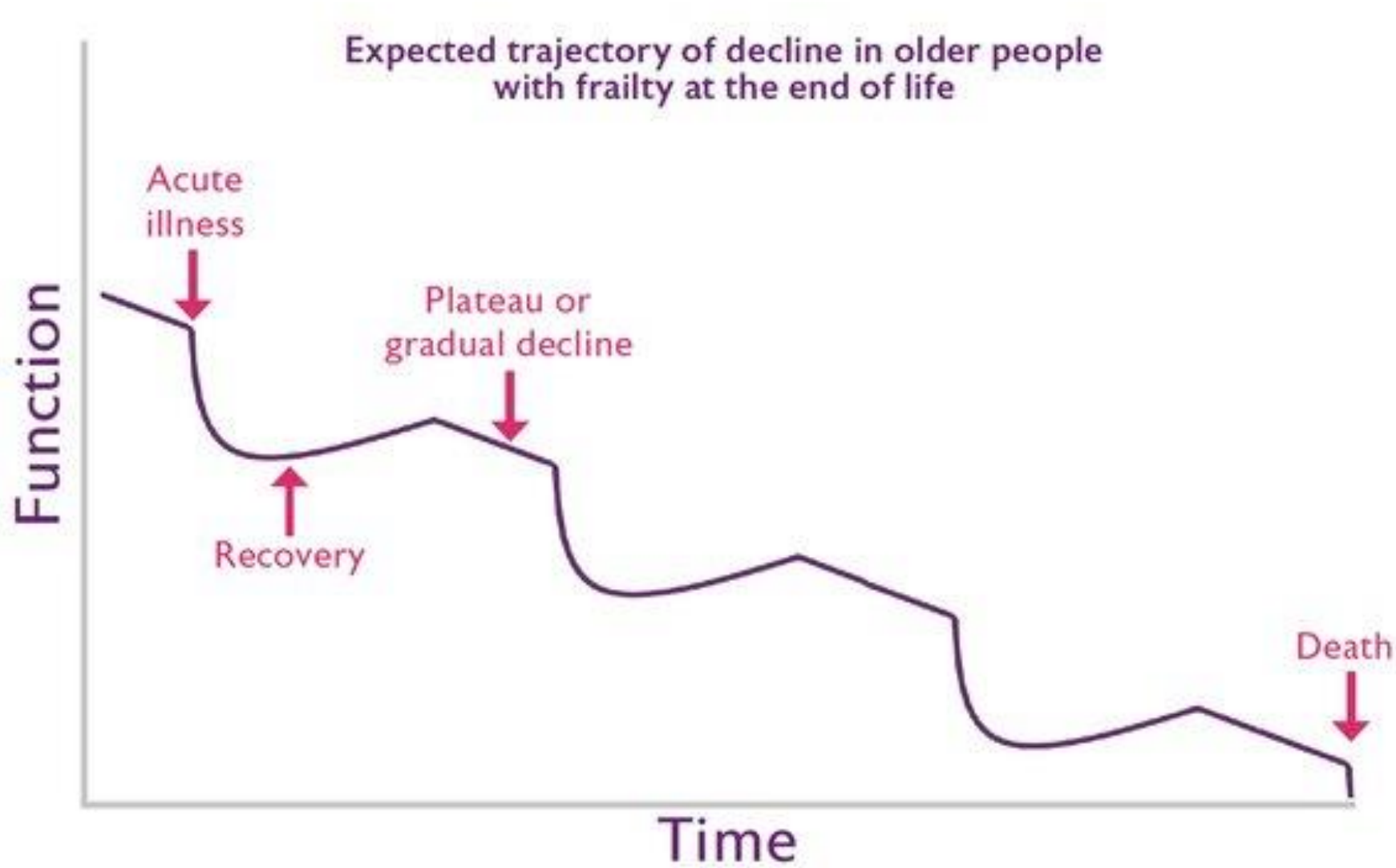
Priorities

Red lines

ADVANCE not advanced

- ADVANCE, like “in advance”

- Not ADVANCED like super brilliant all singing dancing


Expected trajectory of decline in older people with frailty at the end of life
Acute illness
Plateau or gradual decline
Recovery
Death
Function
Time

Why do frail people need ACPs?

- More admissions in last year of life
- Less likely to have care preferences recorded
- More likely to die in hospital
- More likely to die without anticipatory care medications

- Data from Pickering Medical Practice Mortality review 2018-19

What do GPs usually mean by Advance Care Plan (ACP)?

1. DNAR status
2. Preferred place of care
3. Preferred place of death
4. Ceiling of care
5. Next of kin

A word on Treatment Escalation Plans

Sometimes an ACP isn’t enough.

Recording clear guidance for treatment escalation is often extremely valuable in a crisis, where people feel an ACP can come up short.

NHS

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

Surname: Test	
First Name: Patient Nine	
Hospital Number:	
NHS Number:	
DOB: 01-Jan-1945	

PART A: Advance Care Planning

Life Expectancy
Would you be surprised if this patient died within the next 6-12 months?

If No →

1. Refer to End of Life Guidelines
2. Discuss Preferred Priorities of care and give information on Advance Decisions to Refuse Treatment.
3. Consider treatment options & resuscitation status
4. Update the Electronic Palliative Care Coordination System

Is there a known Advance Decision to Refuse Treatment (ADRT)? Yes ☐ No ☐

Does the patient have Mental Capacity to make decisions regarding Resuscitation and Treatment Escalation?
Yes ☐ No ☐

If No → Decisions regarding resuscitation and/or treatment escalation MUST be made in accordance with the Mental Capacity Act (2005). Assessment of capacity must be undertaken and decisions taken must follow Best Interests processes as per s4 MCA (2005) and be recorded in the clinical notes.

In the event of cardiorespiratory arrest this patient is:

FOR RESUSCITATION Call 222 or (9)999	☐ Tick
NOT FOR RESUSCITATION	☐ Tick

Sign:
Date: 8 January 2018
Name:
Title:
GMC/NMC No:

Personal preferences to guide this plan (when the person has capacity)

How would you balance the priorities for your care? (you may mark along the scale if you wish):

Prioritise sustaining life, even at the expense of some comfort — Prioritise comfort measures, Even at the expense of saving life

Considering the above priorities, what is most important to you? (optional)

If treatment in hospital would be unlikely to improve your health, where would you like to be carer for?

Focus on life-sustaining treatment as per guidance below Clinician signature	Focus symptom control as per guidance below Clinician signature

Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support:

Where possible, treatment decisions should be informed by discussion with the multidisciplinary team
PART B: If the patient is currently very unwell or in the event their condition deteriorates

Is admission to an acute district hospital appropriate?	**Yes** ☐	**No** ☐
Is admission to a community hospital appropriate?	**Yes** ☐	**No** ☐
Is De-activation of Implantable Cardioverter-Debrillator (ICD) appropriate?	**Yes** ☐	**No** ☐

Document rationale for treatment decisions an resuscitation status (be as specific as possible)

Have the treatment decisions in part A and/or part B been discussed with:

Patient
☐ **Yes** - date: ☐ **No** - document reason below
☐ **Patient lacks capacity** ☐ **Other** - please state:

Relatives:
☐ **Yes** - date: **No** ☐

Give details (include name of Lasting Power of Attourney if Appointed or IMCA if patient lacks capacity and has no relatives):

Document discussions in medical notes. Date decisions communicated to nursing team:

All treatment decisions above should be reviewed as the patient's clinical condition changes

Part C: If appropriate discuss the patient's wishes regarding organ donation
For TEP of end of life patients being discharge to their home or another healthcare setting the original of this document should travel with the patient and a photocopy kept in the notes of the current provider.

Sliding Doors: two versions of a case study

Sheila:

- 95yrs old, care home resident
- Moderate-severely frail
- Gradually steeper decline over 6 months, eating less, needs more physical help for everything
- Has a DNAR. Preferred place of care & death noted as care home on GP record, but not written down in the care home.
- Uncomplicated dementia: no challenging behaviour but memory not good, complex conversations would be difficult
- Thursday morning staff note “not rousable”. In a deep sleep, appears comfortable
- Senior on duty: calls 999

What are the risks of staying put?

- For her:

1. Deterioration
2. Death
3. Discomfort
4. Not having her wishes met as we do not know what they were

What are the risks of staying put?

- For me:

1. Complaint from family that treatment wasn’t aggressive enough if she deteriorates
2. Litigation
3. Uncertainty around level of risk that is appropriate

Version 1

- Paramedics arrive.
- They note frailty. Family live at a distance so not present for discussion
- Staff report steep and sudden change
- Sheila is taken to hospital. She is in A&E semi-conscious for 14 hours
- She is transferred to a medical ward and then another ward 24hrs later
- She is cannulated, has blood taken, has a chest xray, is catheterised
- She is given intravenous antibiotics
- She dies 72 hours later. Her family are not present.

Version 2

Sheila:

- 95yrs old, care home resident
- Moderate-severely frail
- Gradually steeper decline over 6 months, eating less, needs more physical help for everything
- Has a DNAR, pref place of care & death written as care home
- Uncomplicated dementia: no challenging behaviour but memory not good, complex conversations would be difficult
- Family conversations have been had on admission to care home and since decline: everyone noticing the decline
- All family say: the main priority is to avoid hospital and if she worsens keep her comfortable

Version 2 contd….

- Sheila says “I would rather die than go to hospital. I want to die at home”
- Treatment escalation plan says: Not for admission or escalation of ordinary community treatment unless comfort cannot be achieved in her care home. Priority is comfort and being with family in the event of a deterioration.
- Thursday morning staff note “not rousable”. In a deep sleep, appears comfortable
- Senior on duty: calls Care home lead GP.
- GP does an immediate video call. District nurse visits immediately and ensures End of Life Care treatment available if needed
- Sheila dies in her own bed with her family around her 48hrs later.

Comments on Sheila’s story?

Who can ask and record care plan wishes?

- *I'm not senior enough am I?*
- *It's the GPs job isn't it?*

The purpose of a GP ward round in care homes

- Lots of things but especially:

"Where people living in care homes are identified as likely to die within the next twelve months, ***it is good practice to ensure that the personalised care and support plan includes information on the person's priorities and preferences for end of life care, advance care planning and treatment escalation plans*** *or emergency care and treatment plans and that arrangements are in place to coordinate across multiple providers"*

- How can you prioritise care planning above acute needs?

Questions?

- Helena.ebbs@nhs.net
- @helenaebbs

Mel Johnson
Assistant Director of Patient Safety
Yorkshire & the Humber Improvement Academy

Dr Elizabeth Sweeting
Patient Safety Collaborative Workstream Lead/ GP Trainee
Yorkshire & the Humber Improvement Academy

Learning From Medicine Errors

National Patient Safety
Improvement Programmes

Medicines

Learning From Medicines Errors

Y&H Patient Safety Collaborative

@NatPatSIP / @MatNeoSIP

www.improvement.nhs.uk

Delivered by:
The AHSN Network
Y&H Patient Safety
Collaborative

Led by:
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NHS Improvement

Making Care Safer

We all need to accept that:

> Errors are common and cannot be completely eliminated

> We are human, we make mistakes!

> People don't go to work to do a bad jab

> Need to report and learn

> Reporting and understanding errors and near misses can lead to:

> Improved **awareness**

> **Increased learning leading to improvement**

> Improved **communication** and **team working**

Safer Care

What is a medication error and a near miss?

> A **medicines error** is any incident in the medicines use process:
> prescribing
> preparing
> dispensing
> administering
> monitoring
> providing advice on medicines.
> Not all medication errors cause harm
> Errors can result in severe harm, disability and death

> A **near miss** is when a potential error has been stopped:

“An error caught before reaching the resident”

All these opportunities for an error to occur can make it tricky to understand what actually happened.

Medicine Errors - Examples

> Resident was administered the wrong medication/dose/route
> Resident was administered an out of date medicine
> Administered to the wrong resident
> Medication not given (no clear reason)
> Incorrect timing of medication (late/early)
> Administration of medication recorded incorrectly or not recorded

Near Miss – Examples

> Carer takes meds to resident who doesn't recognise them. Realise for different resident therefore not administered.
> Medication administration not recorded at time of delivery, identified at end of round and signed drug chart

Understanding what happened

The individual approach:

> Focus on the colleague who made the error: The risk is that this leads to blame which is damaging for individuals and organisations. It does not get to the true cause and therefore the error will keep happening.

The systems approach:

> Understanding all the reasons behind what went wrong allows us to make the necessary changes to reduce the chance of it happening again.

So how can we make it better?

Yorkshire Contributory Factors Framework

- The tool is based on **‘Human Factors’**, it aims to improve understanding and learning by **focussing on systems rather than individuals**.

- It incorporates the Yorkshire Contributory Factors Framework which is based on research surrounding the true cause of safety incidents.

https://improvementacademy.org/tools-and-resources/the-yorkshire-contributory-factors-framework.html

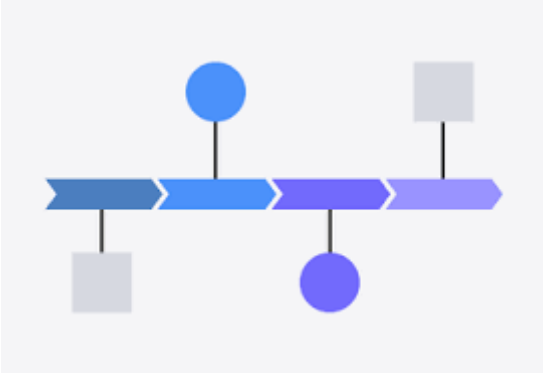
Elements of the tool

> **Step 1** – Complete the timeline
> **Step 2** – Capture the teams (& residents) perspective re what happened
> **Step 3** – Complete the Yorkshire Contributory Factors Framework
> **Step 4** – Capture the key contributory factors and areas of good practice
> **Step 5** – Share the report with the team so all can learn and change

Step 1 - Timeline

Aimed at capturing key events when they occurred.

Provides a simple structure for describing what happened, **the order in which actions were taken and changes noted**. It will also show any delays in actions being taken.

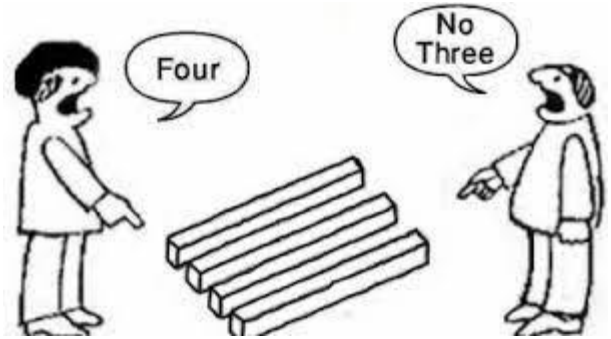


Step 2 – Capture of teams (and residents) opinions

> When you ask people what happened you will often get different stories based on different perspectives.

> To get a more complete picture of actual events you need to **capture the thoughts of those involved** – including the resident**(s)** wherever possible.

> This will help you get a **rounded view** when you are sharing your findings and deciding on any changes to make.



Step 3 - The Yorkshire Contributory Factors Framework

The tool is based around **5 themes** known to have an effect on resident safety:

1. **Situational factors**
2. **Local working conditions**
3. **Organisational factors**
4. **External factors**
5. **Communication & Culture**

Each section has prompts that relate to possible issues with residents care to help you consider if these things could have contributed to the medication incident.

Remember to **consider & capture things that went well along with things that didn't**, so this can be fed back to the team.

Situational factors

Was there something about the **team** or **individual** staff members, the **tasks** staff were performing, or perhaps the residents themselves that made the incident more likely?

Domain 1: Situational Factors			
Individual factors			Comments
Were there any reasons the problem was more likely to occur with the staff member involved?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include: ** reasons are not limited to the given examples*			
Inexperience in giving medications	Lack of recent experience in giving medications		
Usually work in another home	Agency member of staff		
Staff member was tired	Staff member was stressed		
Staff member was rushed	Staff member was distracted		
Team factors			Comments
Were there any reasons the problem was more likely to occur within the team involved?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
Team do not usually work together	Team do not delegate jobs well		
Team do not respect each other	Team have had recent conflict		
Team have previously been involved in a medication problem / incident / error	Team have poor morale		
Task characteristics			Comments
Were there any reasons the problem was more likely to occur for this medication/ medication task?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
Unfamiliar / less commonly used medication	Medication looks or sounds similar to other medication (i.e. Quetiapine and Quinine)		
Unfamiliar / less commonly used medication dose	Medication dose requires more than one tablet (i.e. 6 x 5mg tablets)		
Unfamiliar / less commonly used medication route (i.e. sublingual/ inhaled / injectable/ patch)	Medication has added administration rules (i.e. after food/ empty stomach) or directions for use (i.e. topical creams)		
Medication was recently added to MAR chart/ electronic MAR chart / prescription	Medication task has added complexity (i.e. controlled drug requiring extra checks)		
Resident factors			Comments
Were there any reasons the problem was more likely to occur involving this resident?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
Resident takes lots of medications (10 or more medications prescribed)	Resident lacks awareness of the medications they take		
Resident has particular dislike for taking their medications (i.e. due to fear)	Resident can be distracting when they take their medications		
Resident cannot take medication orally (i.e. poor swallow/ may be PEG fed)	Resident has a physical disability which makes their medications hard to take		
Resident has a similar name to another resident	Resident has had recent medication changes (i.e. following hospital admission/ discharge)		

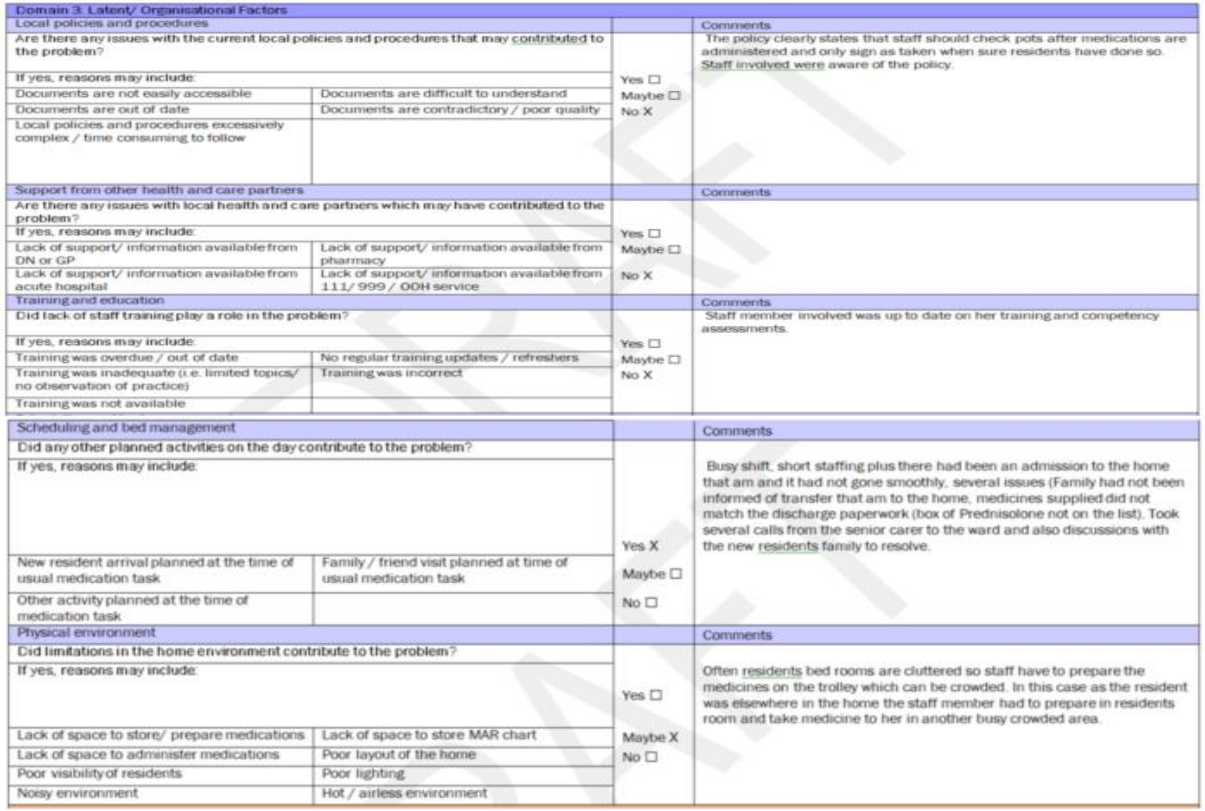
Local Working Conditions

Focusses on **what was happening in the home** at the time of the incident, perhaps here were **poor staffing** levels, **equipment** was unavailable or staff were **poorly supervised**?

Domain 2: Local Working Conditions			
Medication, Equipment and Supplies			Comments
Were there difficulties obtaining the correct drugs and/or working equipment and/or supplies?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
Medication shortage from the supplier	Delay in receiving order medication from the supplier		
Missing MAR chart	Incomplete/ damaged/ messy MAR chart		
Lack of supplies for medication administration (syringes/ measuring cups/ pill cutters)	Lack of required monitoring equipment (i.e. blood glucose meter/ blood pressure monitor)		
Management of staff, staffing levels and staff workload			Comments
Was there a reduction in staffing or increase in staff workload at the time of the problem?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
High unplanned absence (sickness/ childcare/ other caring responsibility at home)	High planned absence (annual leave/ parental leave/ long term sickness)		
Inability to access or use agency staff	Agency staff did not attend		
Increased workload	Lack of adequate staffing skill mix		
Lines of responsibility, supervision and leadership			Comments
Was there a lack of visible management and leadership at the time of the problem with less support available for staff?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
No supervisor working at the time	Staff members were not clear of their job roles or responsibilities / scope of duties		
No registered manager in the home	No or limited support from management / leadership team to promote wellbeing		

Organisational Factors

Focusses on **how the care of the residents was being organised**. Includes **communiction** with colleagues from other organisations, **staff skills** and possible challenges in the **home layout**.



Domain 3: Latent/ Organisational Factors			
Local policies and procedures			Comments
Are there any issues with the current local policies and procedures that may contributed to the problem?			The policy clearly states that staff should check pots after medications are administered and only sign as taken when sure residents have done so. Staff involved were aware of the policy.
If yes, reasons may include:		Yes ☐	
Documents are not easily accessible	Documents are difficult to understand	Maybe ☐	
Documents are out of date	Documents are contradictory / poor quality	No X	
Local policies and procedures excessively complex / time consuming to follow			
Support from other health and care partners			Comments
Are there any issues with local health and care partners which may have contributed to the problem?			
If yes, reasons may include:		Yes ☐	
Lack of support/ information available from DN or GP	Lack of support/ information available from pharmacy	Maybe ☐	
Lack of support/ information available from acute hospital	Lack of support/ information available from 111/ 999 / OOH service	No X	
Training and education			Comments
Did lack of staff training play a role in the problem?			Staff member involved was up to date on her training and competency assessments.
If yes, reasons may include:		Yes ☐	
Training was overdue / out of date	No regular training updates / refreshers	Maybe ☐	
Training was inadequate (i.e. limited topics/ no observation of practice)	Training was incorrect	No X	
Training was not available			
Scheduling and bed management			Comments
Did any other planned activities on the day contribute to the problem?			
If yes, reasons may include:		Yes X	Busy shift, short staffing plus there had been an admission to the home that am and it had not gone smoothly, several issues (Family had not been informed of transfer that am to the home, medicines supplied did not match the discharge paperwork (box of Prednisolone not on the list). Took several calls from the senior carer to the ward and also discussions with the new residents family to resolve.
New resident arrival planned at the time of usual medication task	Family / friend visit planned at time of usual medication task	Maybe ☐	
Other activity planned at the time of medication task		No ☐	
Physical environment			Comments
Did limitations in the home environment contribute to the problem?			
If yes, reasons may include:		Yes ☐	Often residents bed rooms are cluttered so staff have to prepare the medicines on the trolley which can be crowded. In this case as the resident was elsewhere in the home the staff member had to prepare in residents room and take medicine to her in another busy crowded area.
Lack of space to store/ prepare medications	Lack of space to store MAR chart	Maybe X	
Lack of space to administer medications	Poor layout of the home	No ☐	
Poor visibility of residents	Poor lighting		
Noisy environment	Hot / airless environment		

External Factors

Covers **equipment design** and any **policies and procedures** that help or hinder staff.

Domain 4: Latent/ External Factors			
Design of medication, equipment or supplies			Comments
Were there any characteristics about the medication, equipment or supplies that was unhelpful?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
Medication box was similar in appearance	Tablet/ capsule was similar in appearance once removed from the box		
Medication was difficult to remove from packaging	Medication was difficult to administer/ take (i.e. inhaler/ large tablet)		
The compliance aid (if used) did not have space to record the medication warnings	Confusing equipment design		
Medication box was incorrectly labelled / did not contain the correct medication	The compliance aid (if used) was incorrectly labelled / did not contain the correct medication		
External policy context			Comments
Did any regional/ national policies influence the problem?		Yes ☐ Maybe ☐ No ☐	
If yes, reasons may include:			
Conflicting local and regional/national policy			
Recent change in how medicines are prescribed / ordered / dispensed outside the organisation	Regional/ national policy updates not disseminated locally in a timely manner		

Communication & Culture

We know that when things go wrong there was often a **breakdown in communication**. Be it accuracy of care records or messages not being passed on. Another key factor is the **safety culture in the home** i.e. ability of all team members to raise concerns and how these concerns are listened to and acted upon.

Domain 5: Communication and Culture			
Communication			Comments
Did poor verbal and written communication contribute to the problem?			
If yes, reasons may include:		Yes ☐	
Poor communication between staff whilst working together	Poor communication between staff and other healthcare providers	Maybe ☐ No ☐	
Poor communication between staff and residents	Poor communication between staff and relatives / close friends		
Lack of effective handover between shifts	Lack of effective handover whilst on breaks		
Lack of easy to view visual guidance on important issues (i.e. posters)	Lack of feedback from management to staff on issues / after events		
Issues with electronic methods of information transfer (i.e. fax/ email/ electronic MAR chart)	No access to residents medical notes / nursing notes / care notes		
Culture			Comments
Did the safety culture in the home influence the problem?			
If yes, reasons may include:		Yes ☐ Maybe ☐ No ☐	
Staff have expressed a fear of asking questions or raising concerns	Staff have expressed a fear of reporting near misses		
Staff have expressed a fear of reporting problems / incidents / errors	Lack of clear problem / incident / error reporting systems		
Staff are not supported to take ownership / responsibility for their own actions	Staff have no/ limited access to support following an incident		
Residents/ families are not encouraged to have a role in promoting their own safety	Errors are not handled appropriately in this organisation		

Step 4 – Capture any contributors to the error and examples of good practice

This is a **simple summary** of your report

Key messages to be shared with the team to ensure everyone is **learning** and can **celebrate** examples of good practice.

Step 5 – Share your findings

In order to **maximise the learning** and potential change needed it is important that your **findings are shared to all members of your team** but also with **other homes** who are facing similar challenges.

An example: What happened?

- You are a new manager of a specialist residential home for people with dementia, you have been in post 3 months. The team have gradually told you your predecessor was very strict, errors were taken seriously and staff commonly disciplined.
- You get a call at 9.30 pm from the night carer, she says a tablet has been found in a pot allocated to one of the residents, it is Paracetamol and both am and lunchtime doses were signed for by senior carer Bev.
- You log the error and agree the resident has suffered no harm.
- The next AM you inform the GP and residents family and use the YCFF to better understand what happened.

You speak to the Bev and ask her to describe her day:

- Only senior on duty, 1 carer down. 7th consecutive day on duty as covering sickness. No runner for meds round and no one to delegate meds to as other staff on duty weren't signed off as competent
- Admission that am, poorly planned by hospital, took 3 hours to sort out.
- No meds errors logged for 6 months for Bev, she understood the policy.
- Resident was confused, agitated and wandering, remembers spending quite some time persuading her to take meds.
- Residents room where meds are prepared is very cluttered and messy, staff not yet had time to clean and tidy. No clear space to prepare the medicines.

You speak to 2 other carers on duty that day

- Day very busy and felt chaotic, hard to concentrate or get tasks finished.
- Reported seeing meds left in pots before but have managed to catch issue and put it right, never reported to anyone as a problem as worried re potential consequences and no harm had been caused.

So, what things contributed to Bev making the error?

Situation	Contributory factors	So what can you do differently?
No meds errors logged for 6 months for Bev, she understood the policy.		Share her learning with the rest of the team
Only senior on duty, 1 carer down. 7th consecutive day on duty as covering sickness. No runner for meds round and no one to delegate meds to as other staff on duty weren't signed off as competent.	Short staffed Too busy Poor skill mix Stressed Tired	Review skill mix, train more staff re meds admin? Role of runner
Admission that am, poorly planned by hospital, took 3 hours to sort out.	Distracted External factors	Could anyone ese deal with the admission? Feedback issues to the hospital & commissioner?
Resident was confused, agitated and wandering, remembers spending quite some time persuading her to take meds	Resident factors Lack of time	Look at a plan for that residents meds, where and when is best to administer?
Residents room where meds are prepared is very cluttered and messy, staff not yet had time to clean and tidy. No clear space to prepare the medicines.	Poor work environment	Review how meds are prepared. Review cleaning rosters?

In summary

> When things go wrong it is very rarely due to one person making a mistake – often lots of factors involved.

> Need to accept we are human we make errors. We need to make processes and systems safer.

> To reduce chances of it happening again there is little gained by telling someone to not do it again – you have to understand what happened and ‘fix’ **all** the things that contributed.

> The YCFF is a tool to help you understand what happened as a team and work together to make things safer.

> It will also help you identify all the good practice

Using the tool

> We co designed the prompts with 2 care home teams.

> Paper tools that can be completed

> Training slides and example scenarios available

> Once you start to see common cases of error consider what you can do: interruptions audits, safety huddles etc.

“I have used the tool you gave us, which I like very much and will continue to use! One person was devastated after making their first error (new colleague) and breaking it all down the way we did was really reassuring for her.”

Other Uses for the Tool

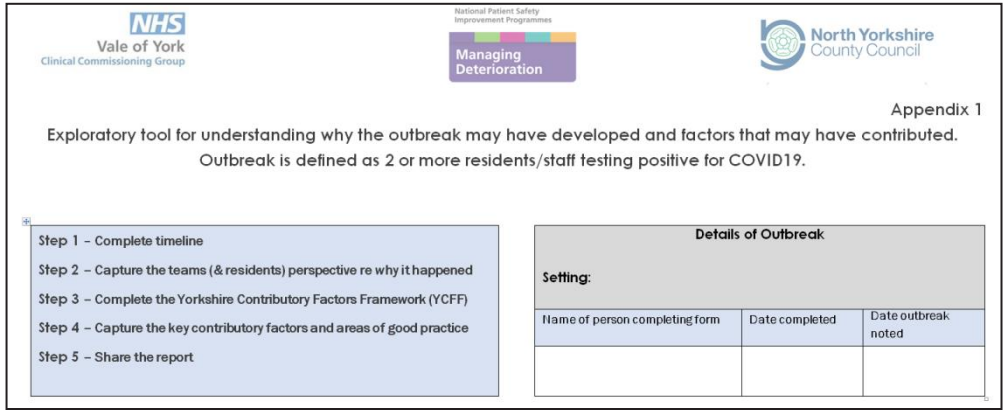
> COVID Outbreaks – used extensively across North Yorkshire to understand cause and help prevent.

> Pressure Ulcers – designed and used extensively on hospital wards, being adapted to care homes

> Falls – Designed and used on hospital wards, considering adaptation for care homes

> Pre term labour in Maternity

> Other uses????



NHS Vale of York Clinical Commissioning Group

National Patient Safety Improvement Programmes
Managing Deterioration

North Yorkshire County Council

Appendix 1

Exploratory tool for understanding why the outbreak may have developed and factors that may have contributed.
Outbreak is defined as 2 or more residents/staff testing positive for COVID19.

Step 1 – Complete timeline
Step 2 – Capture the teams (& residents) perspective re why it happened
Step 3 – Complete the Yorkshire Contributory Factors Framework (YCFF)
Step 4 – Capture the key contributory factors and areas of good practice
Step 5 – Share the report

Details of Outbreak Setting:		
Name of person completing form	Date completed	Date outbreak noted

What next?

Talk to us:

Melanie.johnson@yhia.nhs.uk

Elizabeth.sweeting@yhia.nhs.uk

North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership

Neil Bartram

Business Relationship Manager
North Yorkshire County Council

Digital Session

Digitising Social Care

Neil Bartram – North Yorkshire County Council

Person Centred Care

CARE NHS

We provide:

We can provide:

Day care & Lunch clubs

Housework & maintenance

Befriending schemes

Welfare benefits checks

We provide:

Short and long term residential care

With or without nursing support

Care at home

Homecare
Supported living
Extra care
Shared Lives

Healthcare

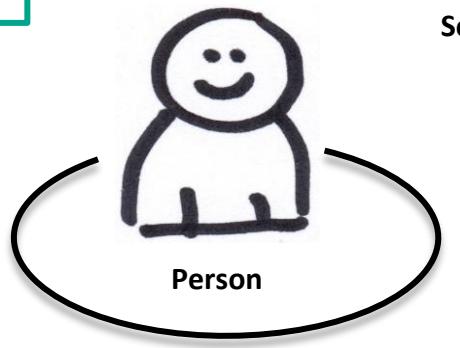
Integrated Care System

Voluntary Sector

Social care

We provide social support, informal care and advocacy

Friends and Family



Person

Local Authority

We assess people's needs, and commission person centred care

People at the Heart of Care

On the 1 December, The Department of Health and Social Care published the White Paper *People at the Heart of Care* which outlines the 10-year vision for the reform of the sector.

The White Paper recognised that when technology is embedded seamlessly into care and support services, it can help people to live happy, fulfilled lives in their homes and communities.

To support this goal, and the government's wider ambitions for reform, the White Paper committed to **invest at least £150m** in digitising the social care sector.

Digitising Social Care Programme

Supporting adoption of care tech which can reduce demand on social care services and the NHS

Ensuring the right information is available at the right time to the right people

Improving quality, safety and personalisation of care

Improving productivity and freeing up more time to care

What we are doing currently

- *Unified Technology Fund (UTF) – Basic infrastructure (e.g. WiFi)*
  - *£170k for North Yorkshire, £38k for York. Total for the HNY ICS is £525k.*
  - *£147k from Digital First Primary Care for North Yorkshire & York.*
  - *Referral from DREaMS Team. Digital maturity assessment.*
  - *Local delivery partner for North Yorkshire & York is NYCC Technology & Change*
- *Digitising Technology Fund (DTF) – Digital care records, sensor based falls*
  - *£700k + £779k for HNY ICS*
  - *DREaMS Team managing fund and demand*
  - *Digital care records, assured suppliers only (9 available)*
- *Care Home Connectivity (TBC)*
  - *Awaiting national launch and application process*
  - *Upgrades to current Broadband services to minimum speeds of 30Mbs*
  - *Funding to come via HNY ICS*
  - *Satellite/Low-Earth-Orbit connectivity pilots. Where no other Broadband available.*

What we are doing currently

- *Better Security Better Care*
  - *Cyber Security under-pinning digital social care records*
  - *Data Security and Protection Toolkit (DSPT)*
  - *Regional support available to all care providers*
  - *Enables access to secure email, Proxy Ordering, Shared Care Records*
  - *Not just a technology issue*

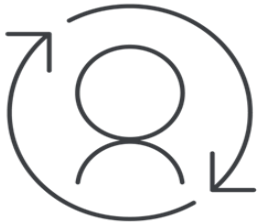
What we are doing currently

- *Better Security Better Care*

21/11/2022					
Count of Site Compliance Simplified (For Pivot)	Column Labels				
Row Labels	Not Registered	Registered	Approaching Standards	Standards Met	Grand Total
NHS Humber and North Yorkshire ICB	**8.21%**	**7.09%**	**6.97%**	**77.73%**	**100.00%**
Care Home	5.39%	6.64%	5.92%	82.05%	100.00%
Home Care	12.95%	7.83%	8.73%	70.48%	100.00%
NHS North East and North Cumbria ICB	**15.58%**	**8.22%**	**1.96%**	**74.24%**	**100.00%**
Care Home	9.59%	7.26%	2.21%	80.93%	100.00%
Home Care	26.08%	9.91%	1.51%	62.50%	100.00%
NHS South Yorkshire ICB	**27.86%**	**13.10%**	**5.14%**	**53.90%**	**100.00%**
Care Home	19.76%	12.39%	5.31%	62.54%	100.00%
Home Care	38.26%	14.02%	4.92%	42.80%	100.00%
NHS West Yorkshire ICB	**20.53%**	**8.75%**	**3.04%**	**67.68%**	**100.00%**
Care Home	8.70%	7.97%	1.81%	81.52%	100.00%
Home Care	33.60%	9.60%	4.40%	52.40%	100.00%
Grand Total	**17.17%**	**8.87%**	**3.93%**	**70.03%**	**100.00%**

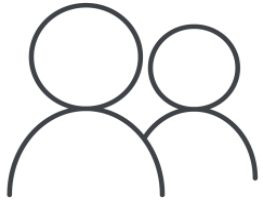
National Support

CARE NHS



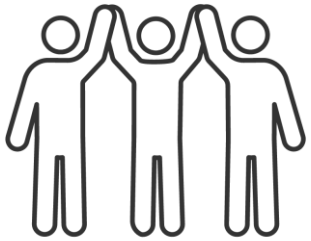
Implementation support

Standards & regulation



Evidence building and benefits realisation

Partnership with policy



Skills and national networks

Market assurance

Charging reform

Connectivity & cyber

DiSC Programme Objectives

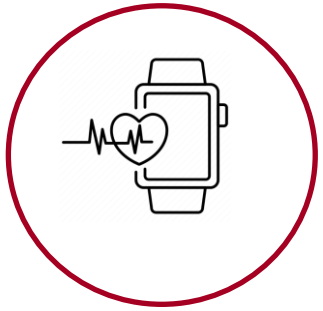
80% of adult social care CQC registered providers will have adopted a digital social care record by March 2024

By March 2024 sensor based falls prevention and detection technologies, such as acoustic monitoring, will be in use in care homes for the residents they have identified as most at risk of falls, reaching at least 20% of residents nationally

Testing other types of care tech, driven by the benefits case and local need.

Example benefits

Reductions in overall administrative task time



Improved safety and quality of care

Reduced costs for paper and printing

Improved management and oversight

Increased compliance against Regulation and standards

Improved data quality and management

Resources

Digital Social Care	The Hubble Project: technology-enabled care - Digital Social Care Adopting Digital Care Records - Masterclass Series - Digital Social Care
Assured Provider Framework	Assured Supplier List - Digital Social Care
Guidance on Buying a DSCR	Care Guidance on Buying a Digital Social Care Record | Digital Social Care
Care Homes Connectivity	Care Home Connectivity - NHS Digital
Data and Cyber Security	Better Security, Better Care. - Digital Social Care
GP Proxy Access	NHS England Proxy Access to Ordering Medication Webinar and Slide Deck - Digital Social Care
NHSmail	NHSmail - Free email for social care - Digital Social Care
Skills and Networks	Digital Skills Framework - Digital Social Care Digital Skills & Training - Digital Social Care

Neil.Bartram@northyorks.gov.uk

Rachel Binks
Nurse Consultant Digital & Acute Care
Airedale NHS Foundation Trust

Heather Bygrave
Relationship Team Manager
Immedicare

The Impact of Telemedicine in Care Homes

immedicare

Telemedicine Service

Nursing and Residential care homes

Heather Bygrave, Lead Relationship Manager

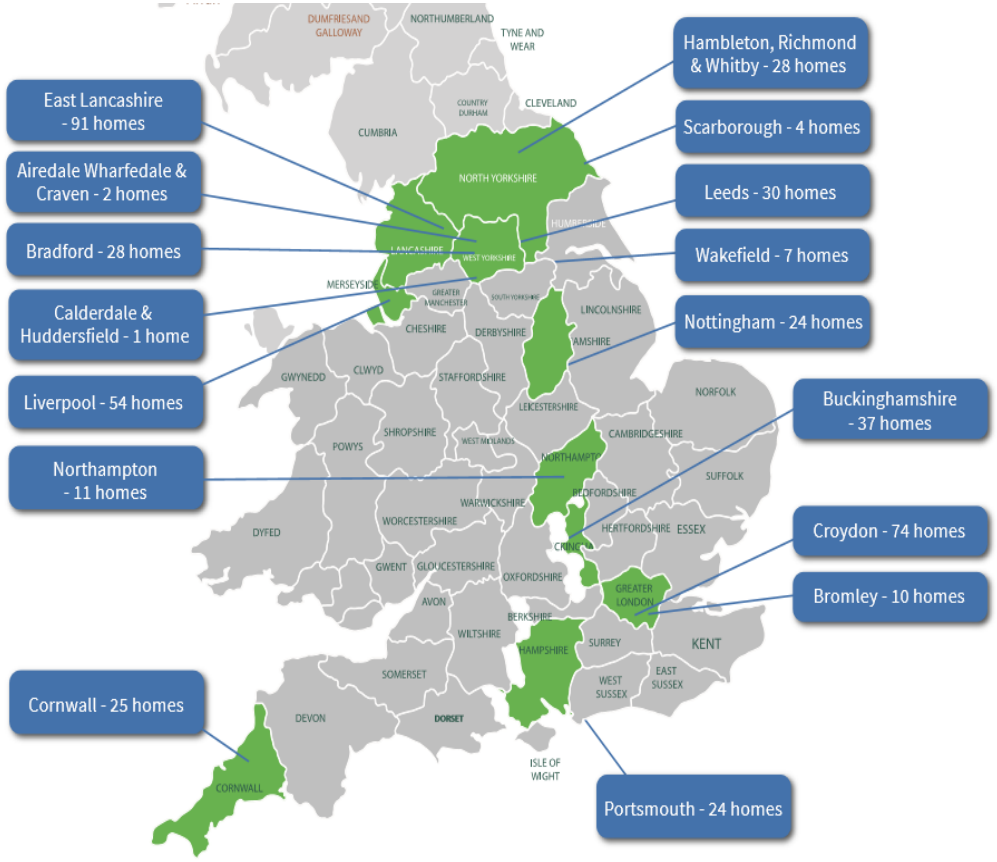
Rachel Binks, Nurse Consultant – Digital & Acute Care
rachel.binks@nhs.net

NHS Airedale NHS Foundation Trust

In partnership with Airedale NHS Foundation Trust and Involve

involve

Right place - replicable model

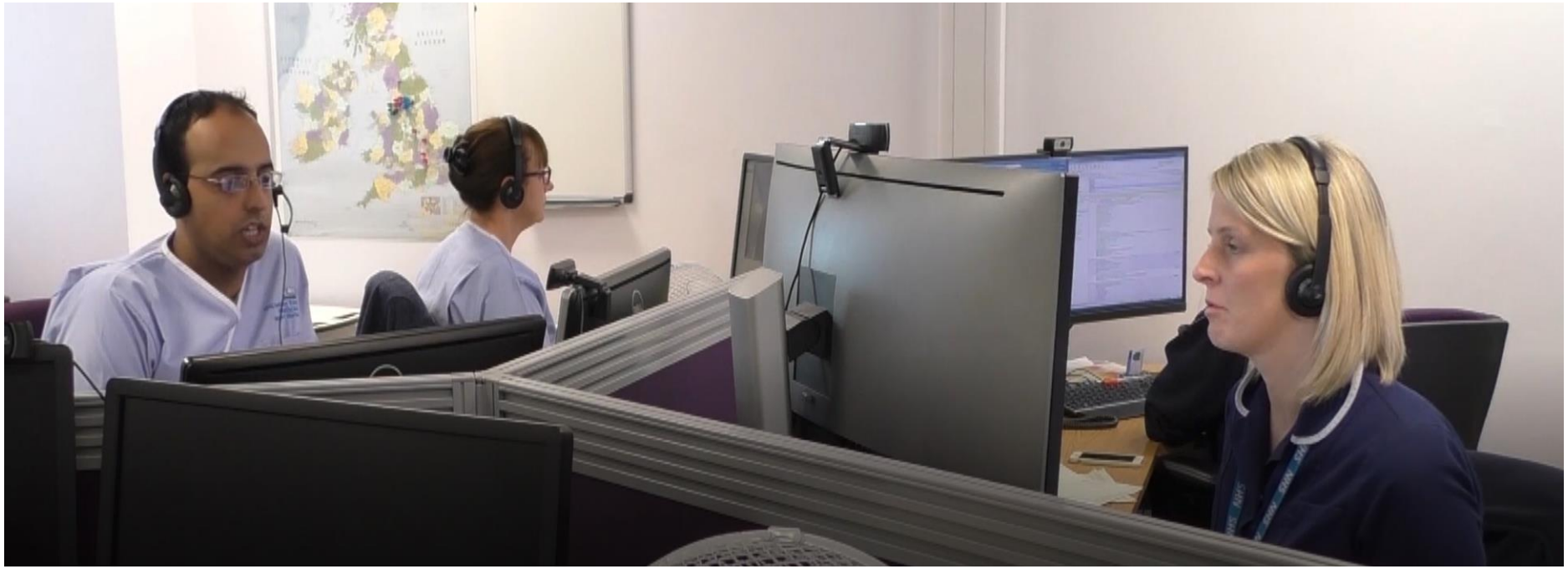


- 44 Prisons
- >700 Nursing/Residential Care Homes
- **Supporting > 20,000 residents**
- >40,000 clinical video consultations each year

Immedicare LLP. Airedale General Hospital. Skipton Road, Steeton, Keighley, West Yorkshire BD20 6TD t: 0330 088 3364 e: enquiries@immedicare.co.uk

Our services

- **90%** of residents remain in their place of residence
- **60%** of calls managed by hub clinical team
- Based at Airedale NHS Foundation Trust
- Secure **N3** / Web based video and call centre management providing HD call quality



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Care anywhere

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In our Digital Hub

In the Care Home

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Digital care hub

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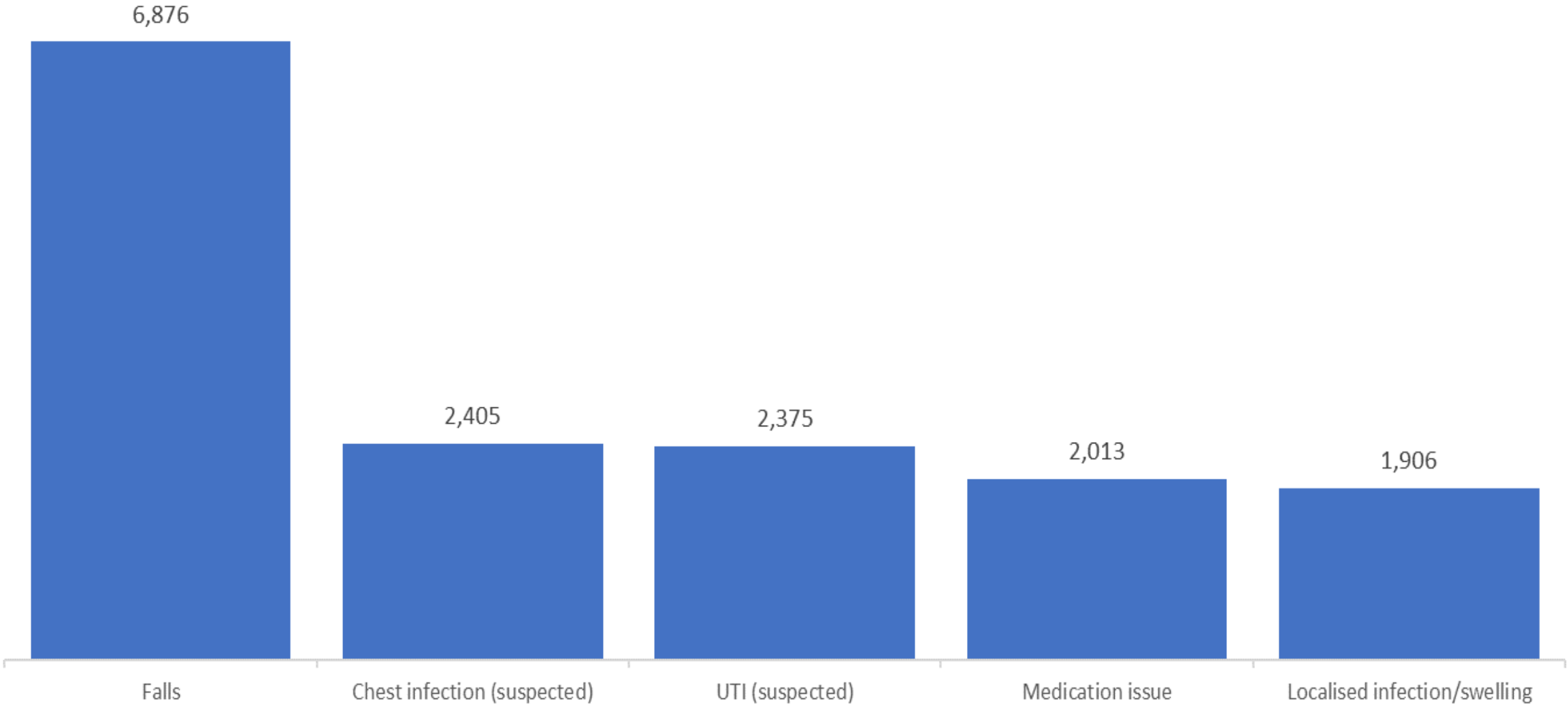
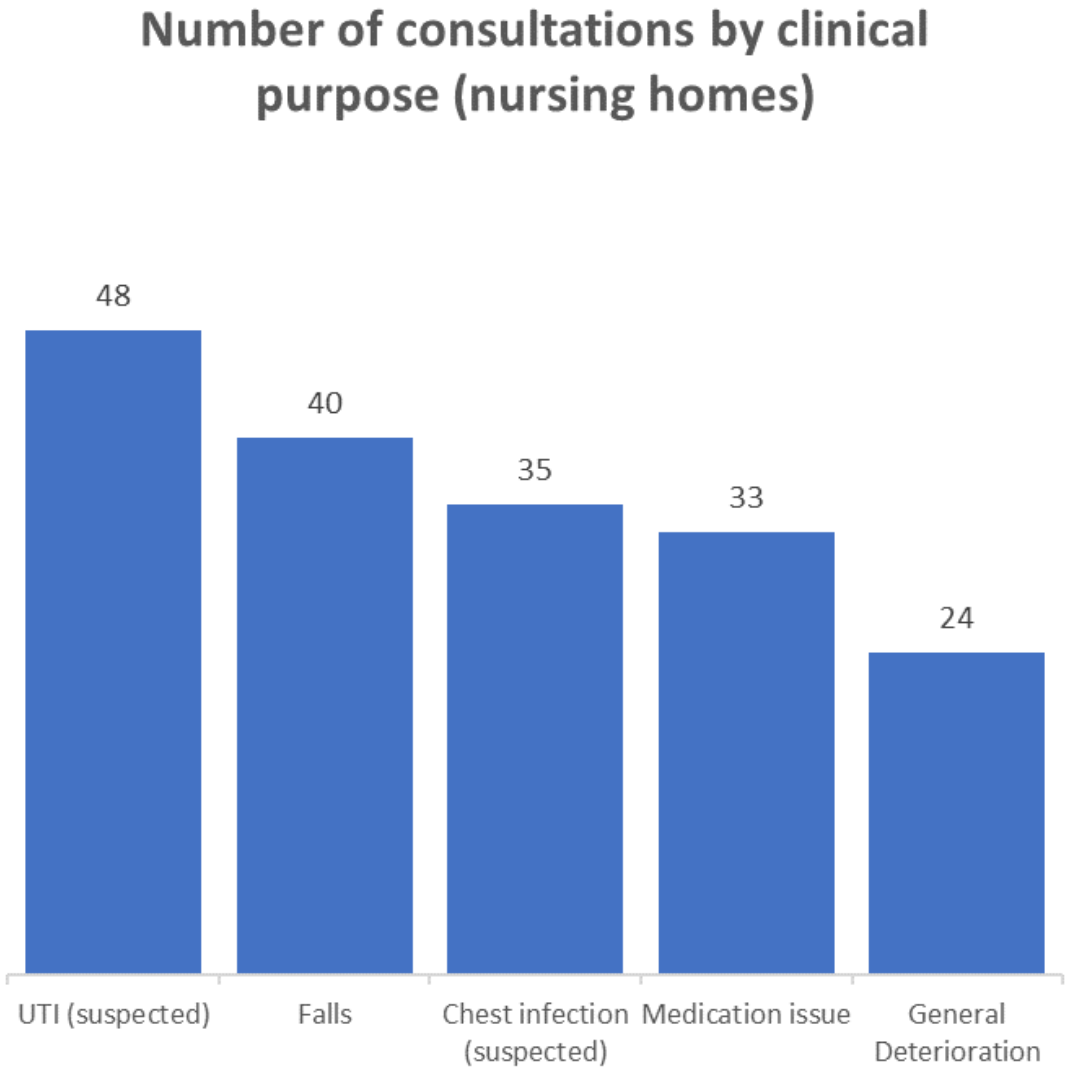
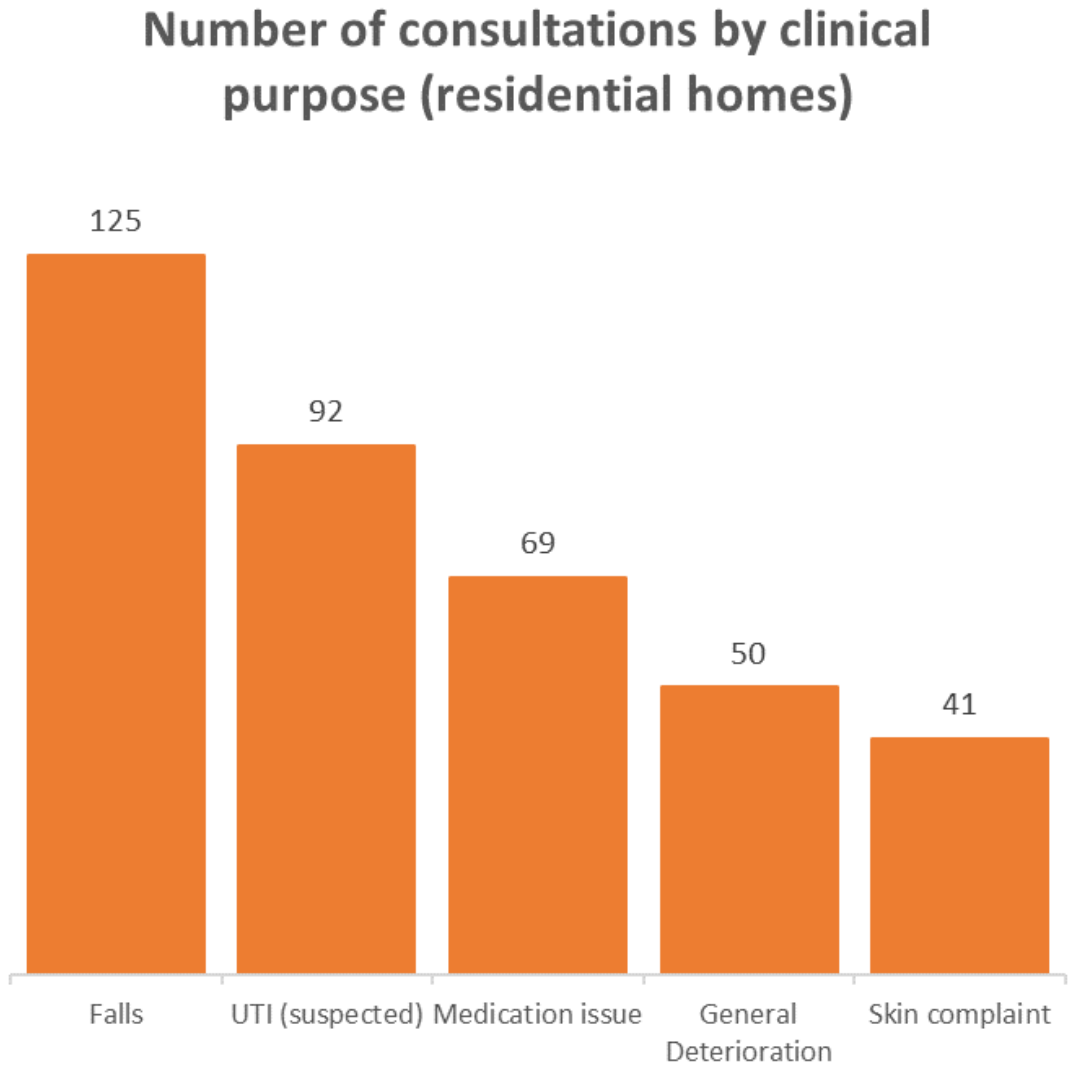
Consultations by purpose (12 months)



Consultations by purpose - VoY





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Top 10 reasons to call us

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Reason for Call

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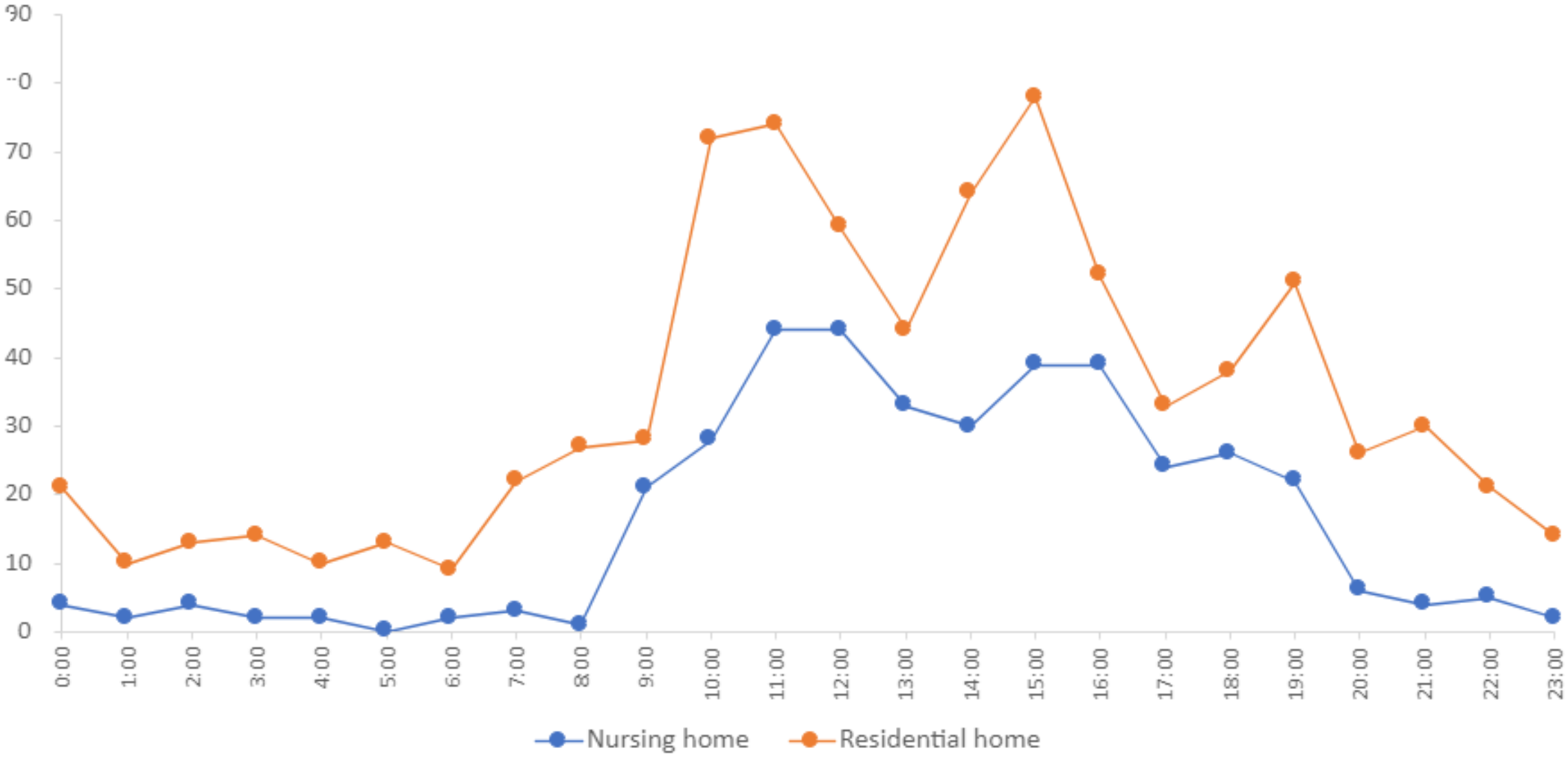
Nursing Homes

Purpose	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Abdominal pain	1	0	0	0	2	4	0	2	0	0	1	2
Advance Planning / DNAR	2	1	0	0	2	0	0	1	0	0	0	0
Agitation / Confusion	3	3	4	1	6	5	4	3	6	3	2	3
Anxiety / emotional distress	0	1	3	0	2	1	1	0	0	1	2	3
Basic wound dressing (Pendle)	0	0	0	0	0	0	0	0	0	0	0	0
Bowel concerns	5	3	3	6	2	2	3	1	2	3	1	4
Breathlessness	10	9	6	7	7	5	5	4	2	5	9	6
Catheter concern	2	1	2	1	0	2	1	0	1	1	0	1
Cellulitis	5	1	1	4	4	3	4	5	2	2	9	5
Cerebral event (suspected TIA / Stroke)	0	0	1	1	1	1	0	1	2	1	2	2
Chest infection (suspected)	27	17	12	16	11	9	9	9	22	35	48	35
Chest pain	2	0	1	0	2	2	0	2	2	1	0	1
Constipation	2	0	0	1	3	1	2	1	0	3	1	5
Continence	1	0	0	0	0	0	1	0	0	1	1	0
Death	0	0	1	1	0	0	0	0	1	1	0	1
Dehydration	5	2	2	0	3	4	4	1	5	3	2	12
Dental issue	0	0	0	0	0	0	0	0	0	0	1	0
Diabetes concern	1	3	6	4	5	0	1	1	0	1	0	5
DVT (suspected)	0	0	0	1	1	0	0	0	0	1	1	0
ENT issue	1	0	4	3	3	1	2	1	1	0	2	0
EOL Symptoms	2	3	0	3	4	1	2	1	4	3	3	3
Equipment failure	0	0	0	0	0	0	0	0	0	0	0	0
Eye Infection	4	1	4	1	4	7	1	6	1	7	4	1
Falls	15	21	14	10	17	9	16	17	14	26	28	28
Fracture (suspected)	2	1	6	2	4	2	0	4	4	3	4	0
General Deterioration	18	10	13	7	20	14	24	16	9	14	22	20
GI Bleed	0	0	0	0	1	0	2	1	1	1	1	0
GU issue	2	0	1	2	3	3	0	1	0	3	2	1
Head Injury	5	1	6	4	5	2	2	3	5	3	7	2
Hematemesis / melaena	1	0	1	0	0	0	0	1	0	0	0	1
Localised infection/swelling	6	3	15	3	10	9	8	11	4	8	10	12
Medication issue	3	4	10	8	4	6	4	2	6	4	7	2
Medication review	5	3	3	7	6	3	1	3	1	8	9	1
Mood disorder	2	1	1	2	1	1	0	2	1	1	0	0
Nausea	1	0	1	0	1	0	0	2	0	0	0	0
Pain Management	7	6	10	5	2	4	7	8	5	4	9	9
Reduced appetite / weight loss	0	1	0	2	1	0	0	0	1	1	0	0
Seizure	1	0	1	2	1	2	5	0	0	2	1	2
Sepsis (suspected)	5	8	7	5	6	2	6	2	3	9	5	7
Skin complaint	17	8	8	7	11	9	7	12	16	14	13	12
Spinal Cord Compression (suspected)	0	0	0	0	0	0	0	1	0	0	0	0
UTI (suspected)	6	8	5	13	8	10	10	11	7	14	10	7
Unresponsive	6	0	1	3	3	1	4	2	1	0	1	2
Viral illness	12	6	5	3	2	3	2	4	0	6	9	4
Vomiting	3	1	9	3	1	2	2	1	14	6	3	3
Wound care	1	0	1	5	4	2	4	1	1	5	5	1

Consultations by Hour



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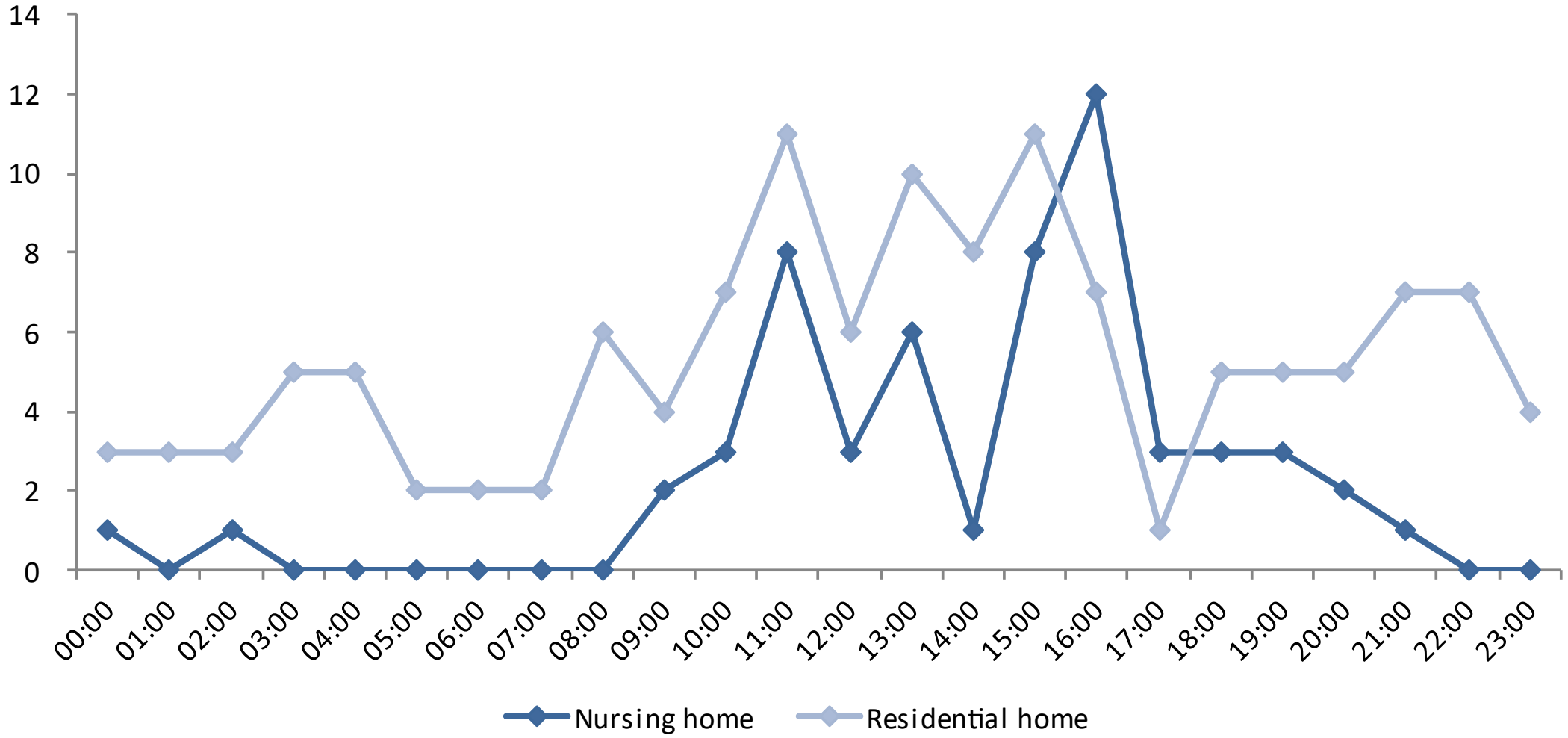
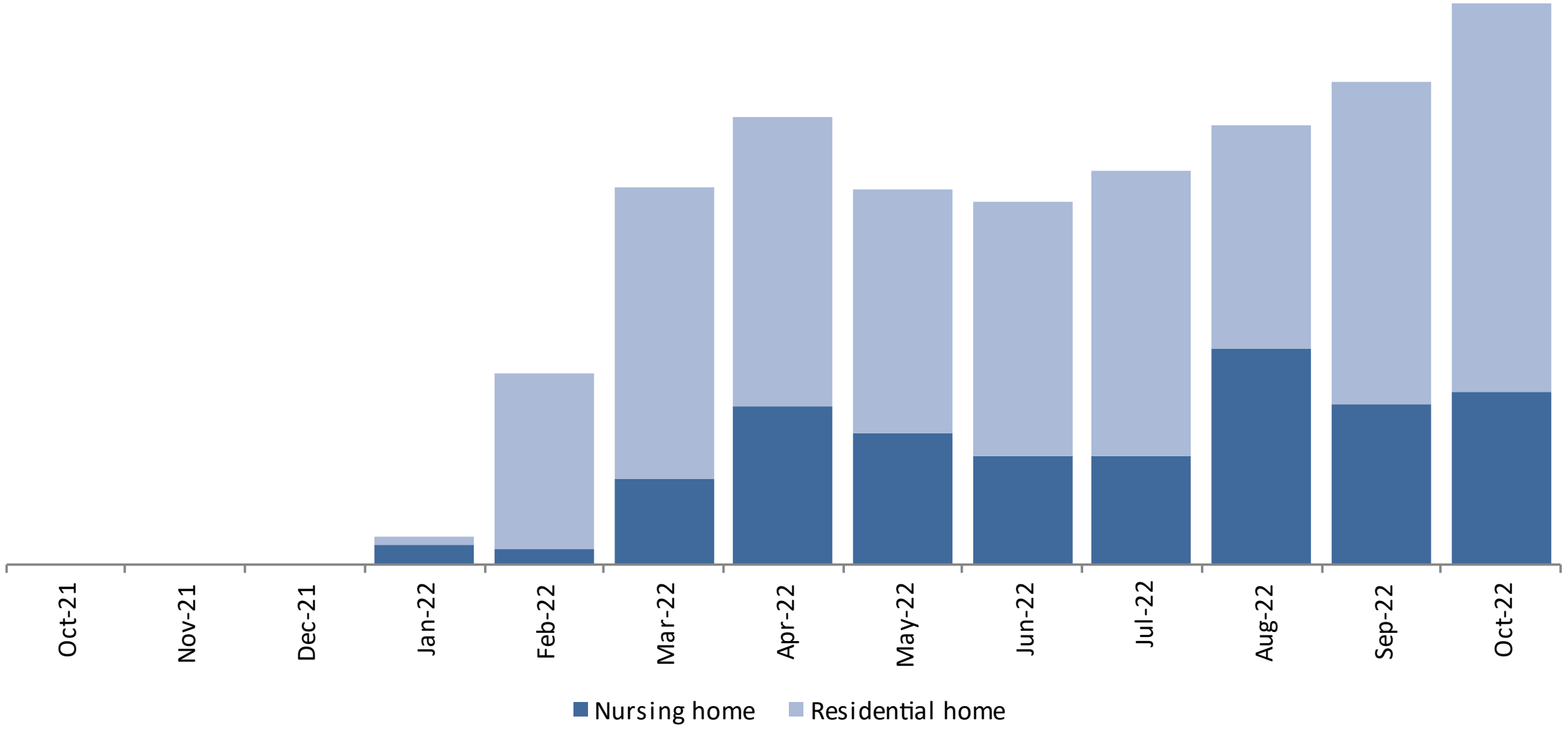
VoY Consultations



Monthly Consultations VoY



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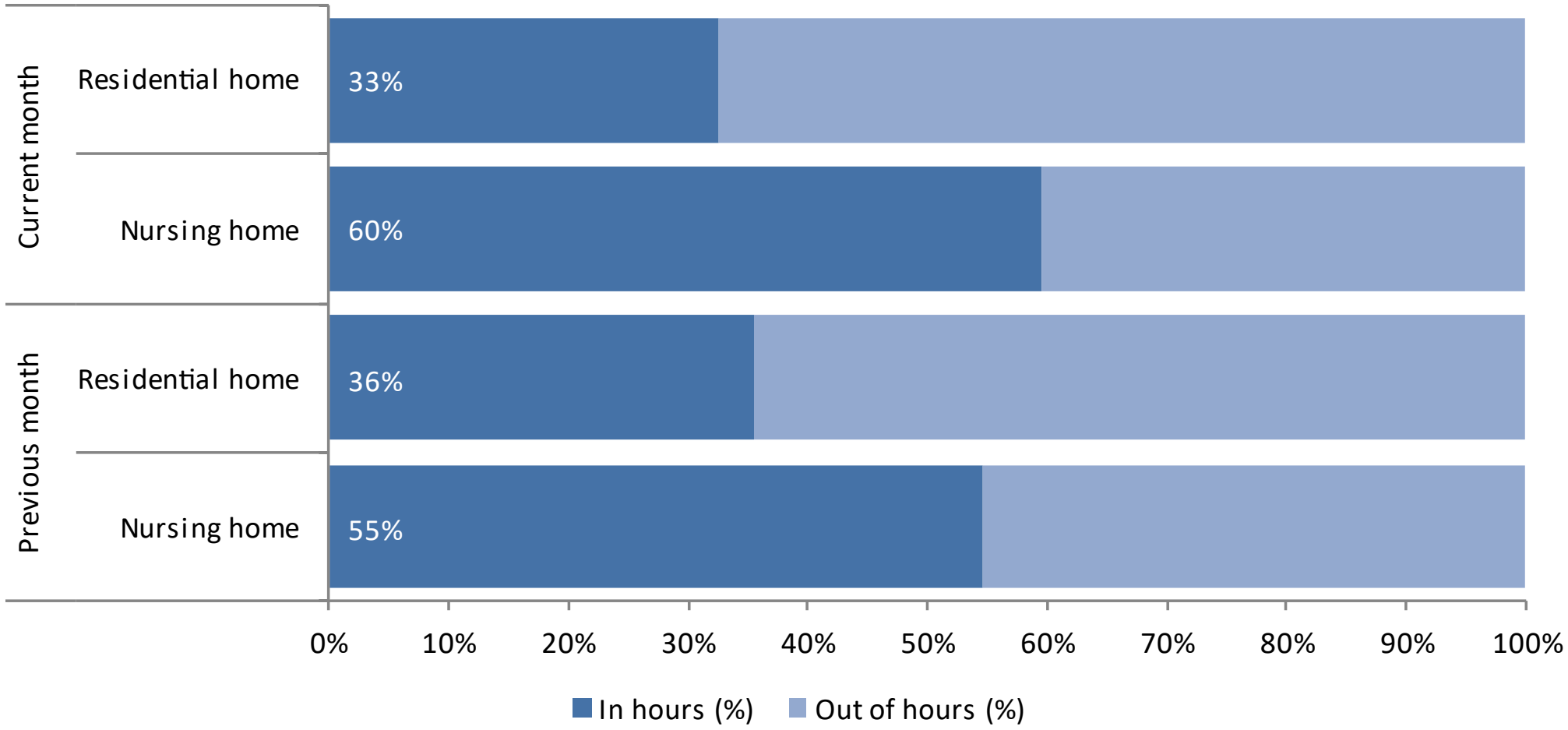
Consultations by Time



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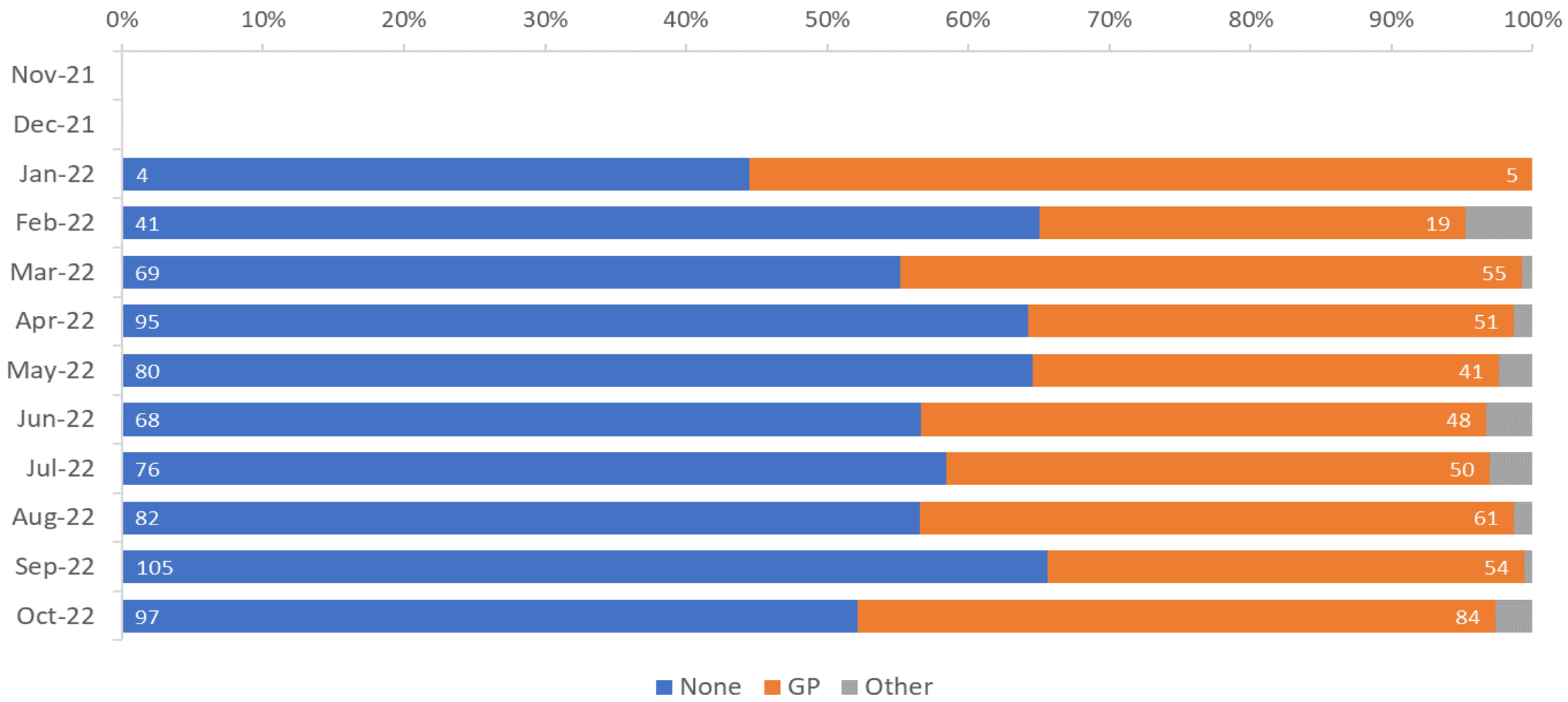
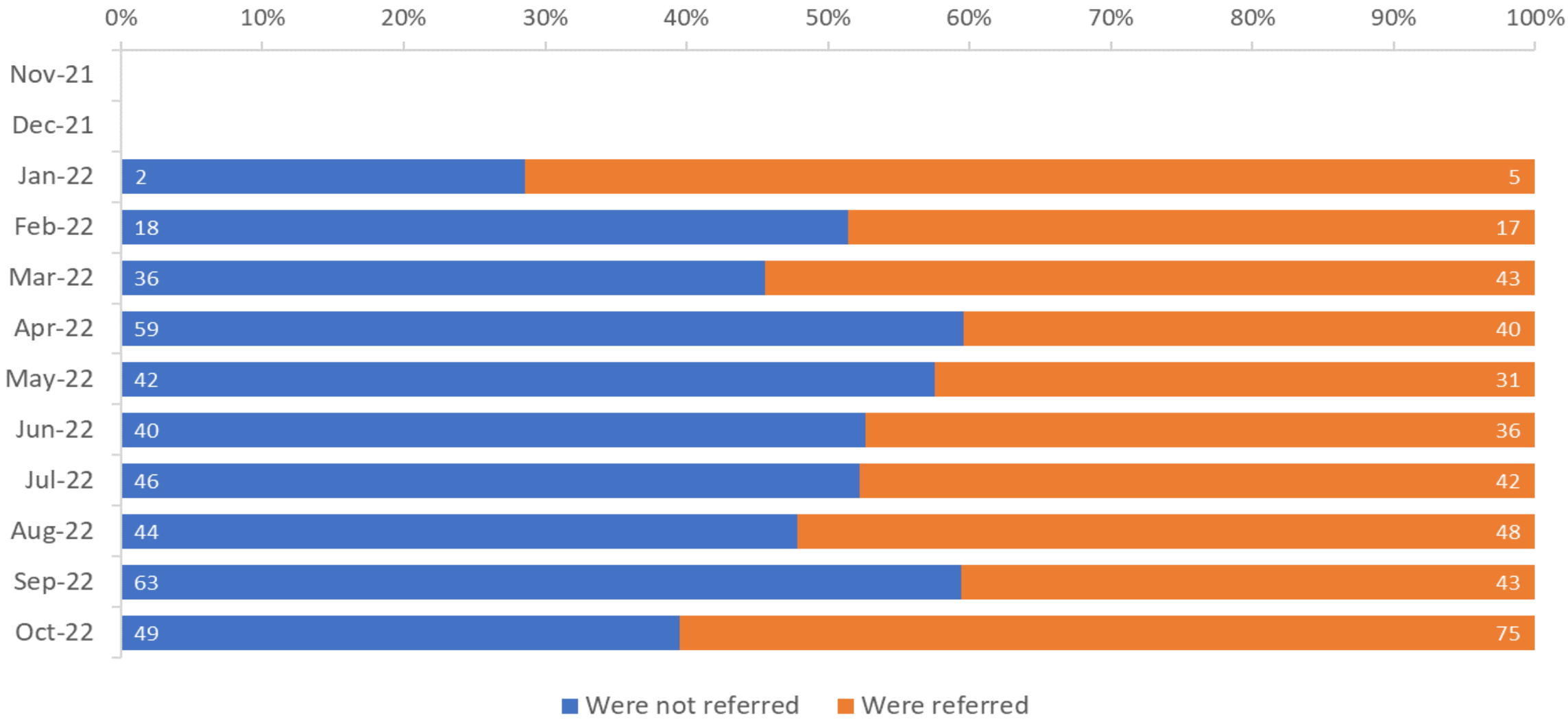
Onward Referral



1210 consultations from January 2022 – October 2022

717 (59%) – No onward referral **468 (39%) – Referred to GP** **25 (2%) referred to other HCP**

Onward Referral to a GP



779 thought to have required a GP (by Care Home staff)

51% – Not referred to a GP

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Primary care contact audit 72-hours post-telemedicine consult

130 patient records

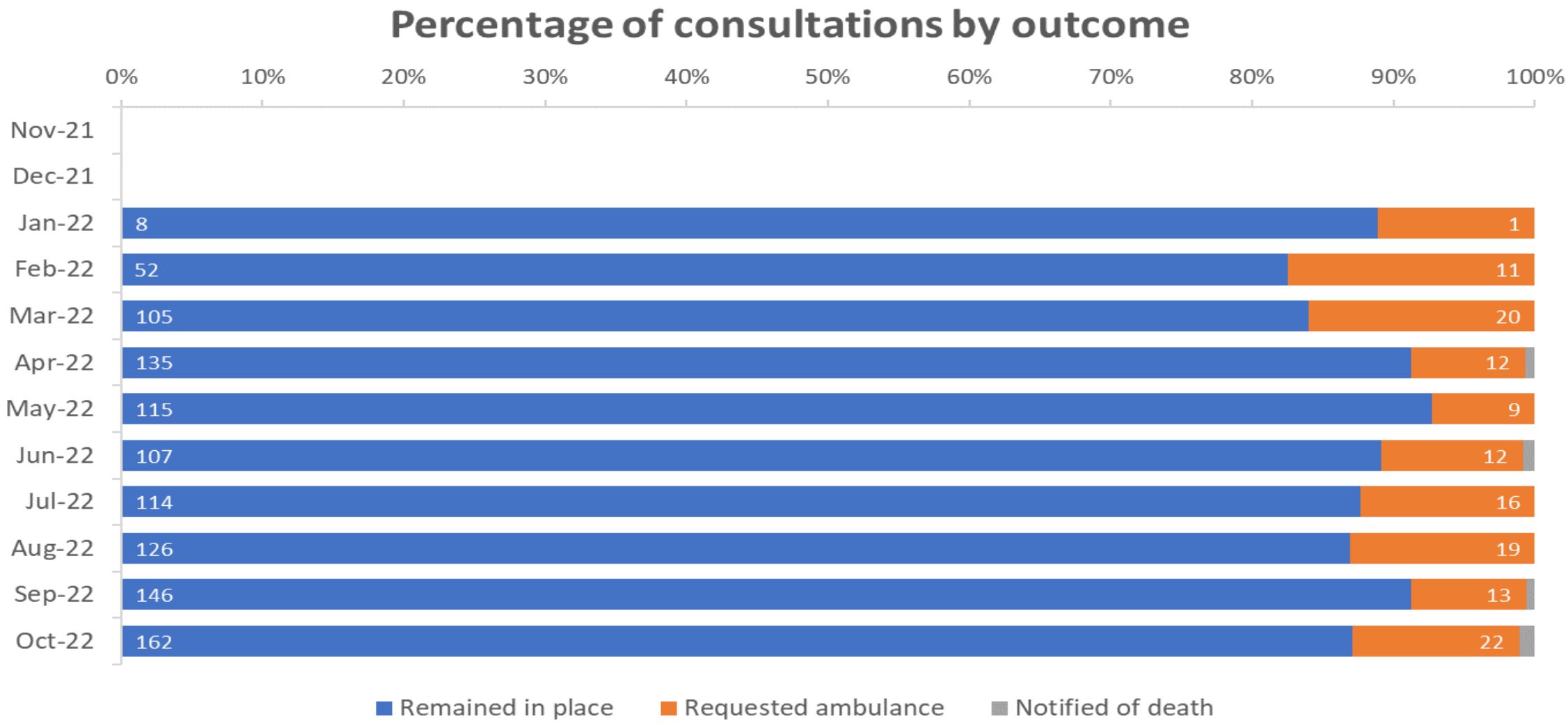
- No GP referral following TM consultation (would have called a GP)

Did telemedicine just ‘delay the inevitable’

- We found that:

  - In 114 (88%) - no contact was made with the surgery within 72 hours of the telemedicine consultation
  - In 11 (8%) - contact with the GP within 72 hours: 6 x deterioration, 5 x routine care home visit
  - In 5 (4%) - there was a related or unrelated A&E attendance or hospital admission
    4/5 unavoidable injury

Outcome



1210 consultations since January

88% remained at home

11% ambulance requested

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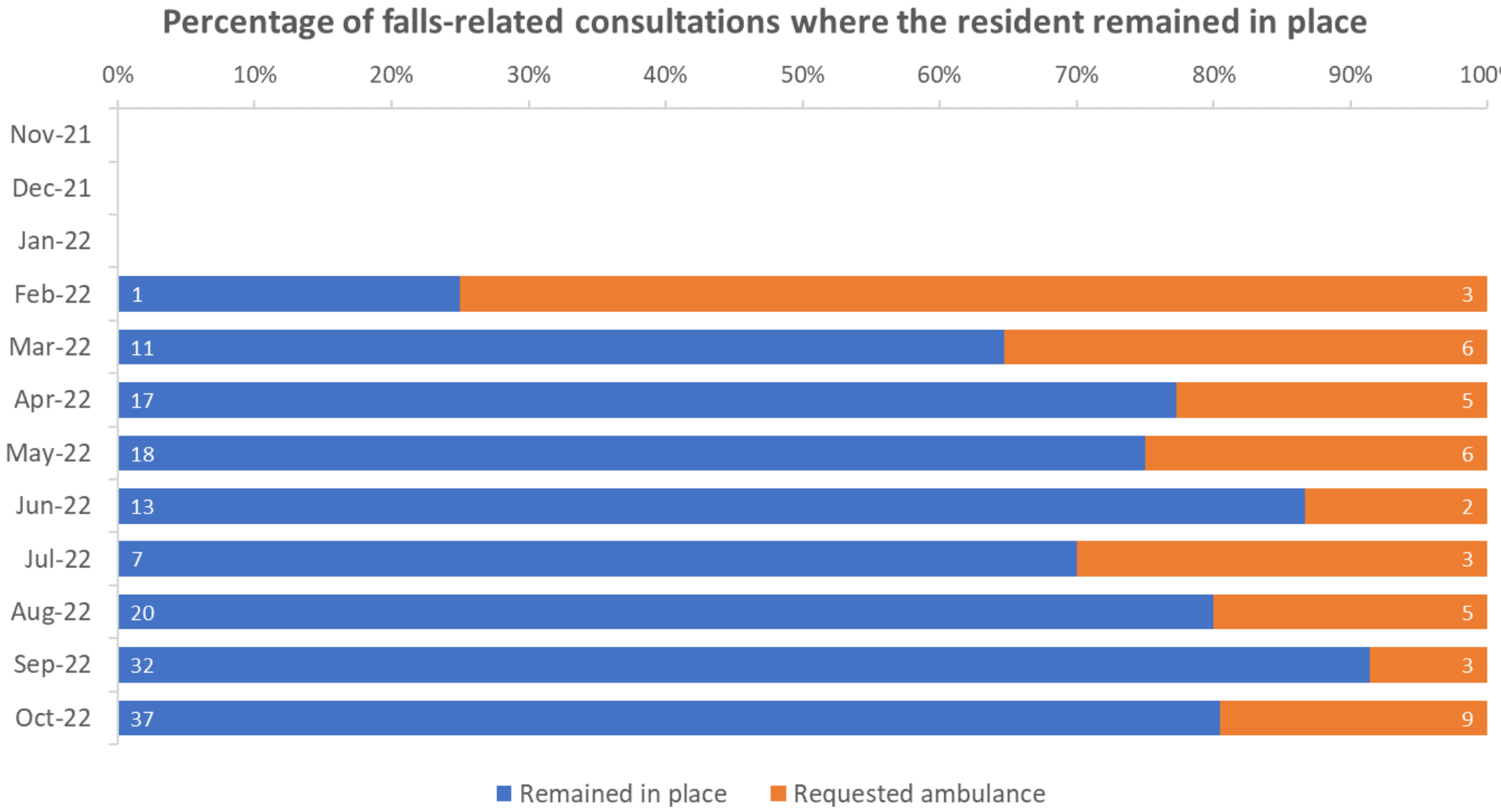
Falls Calls – 79% remained at home/not conveyed



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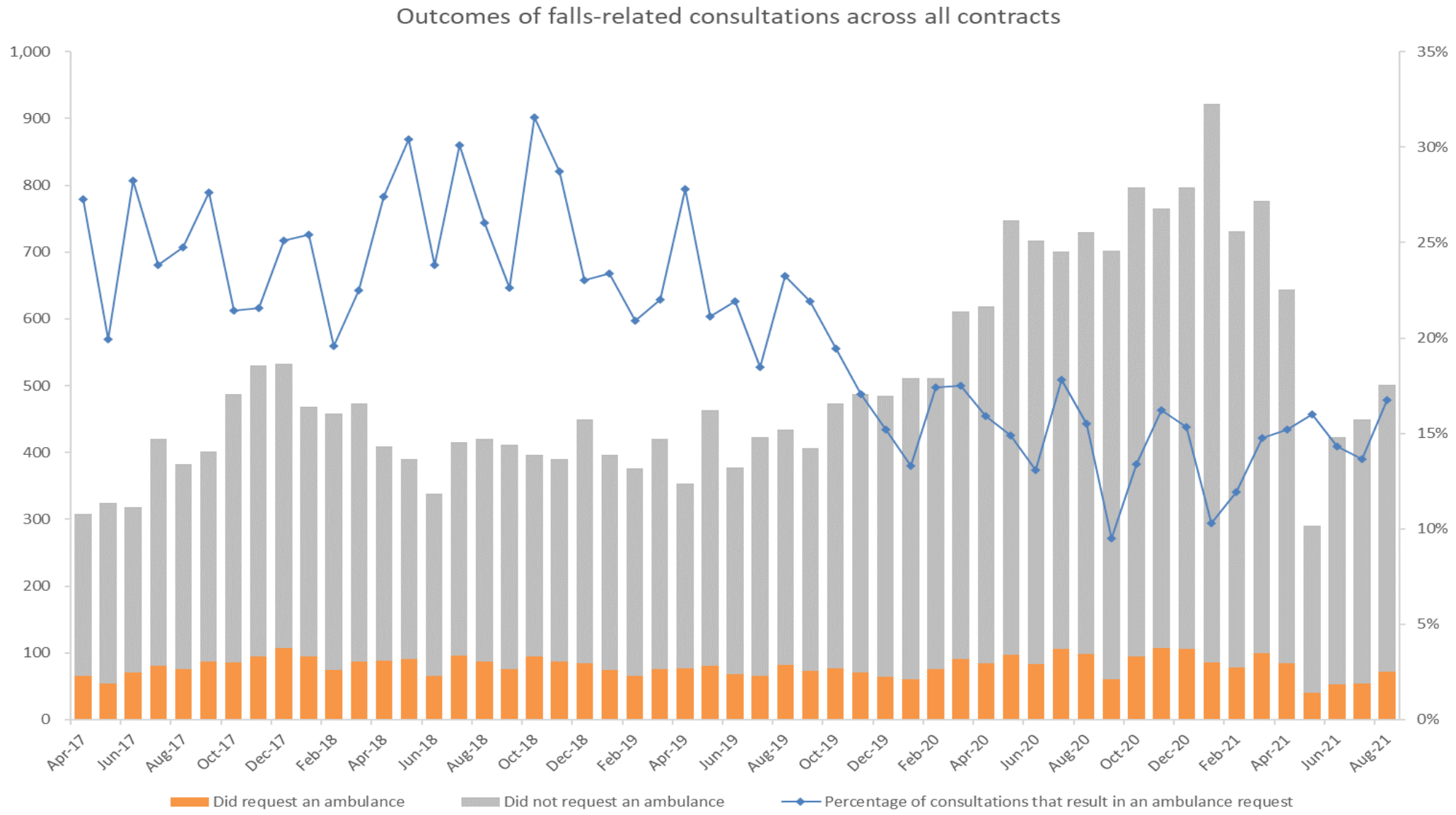
Falls-related consultations



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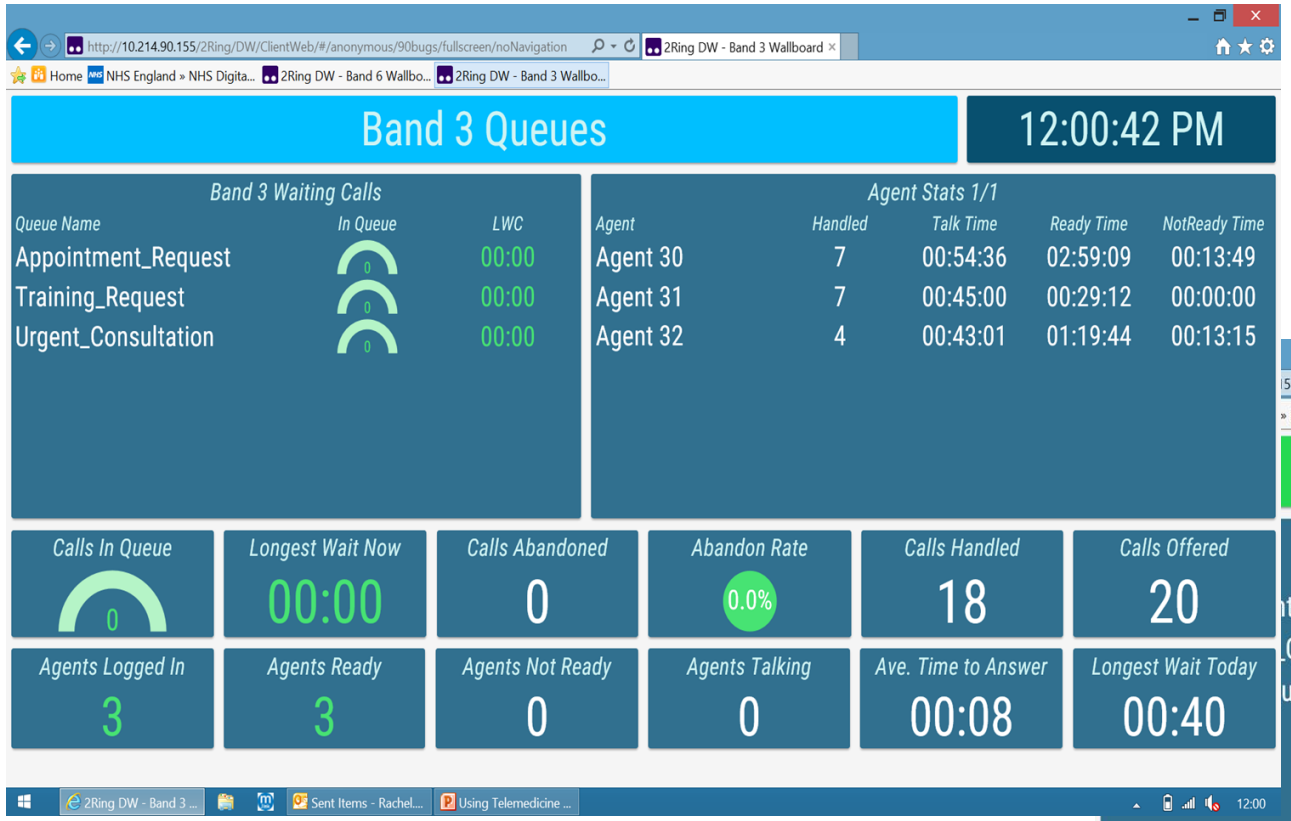
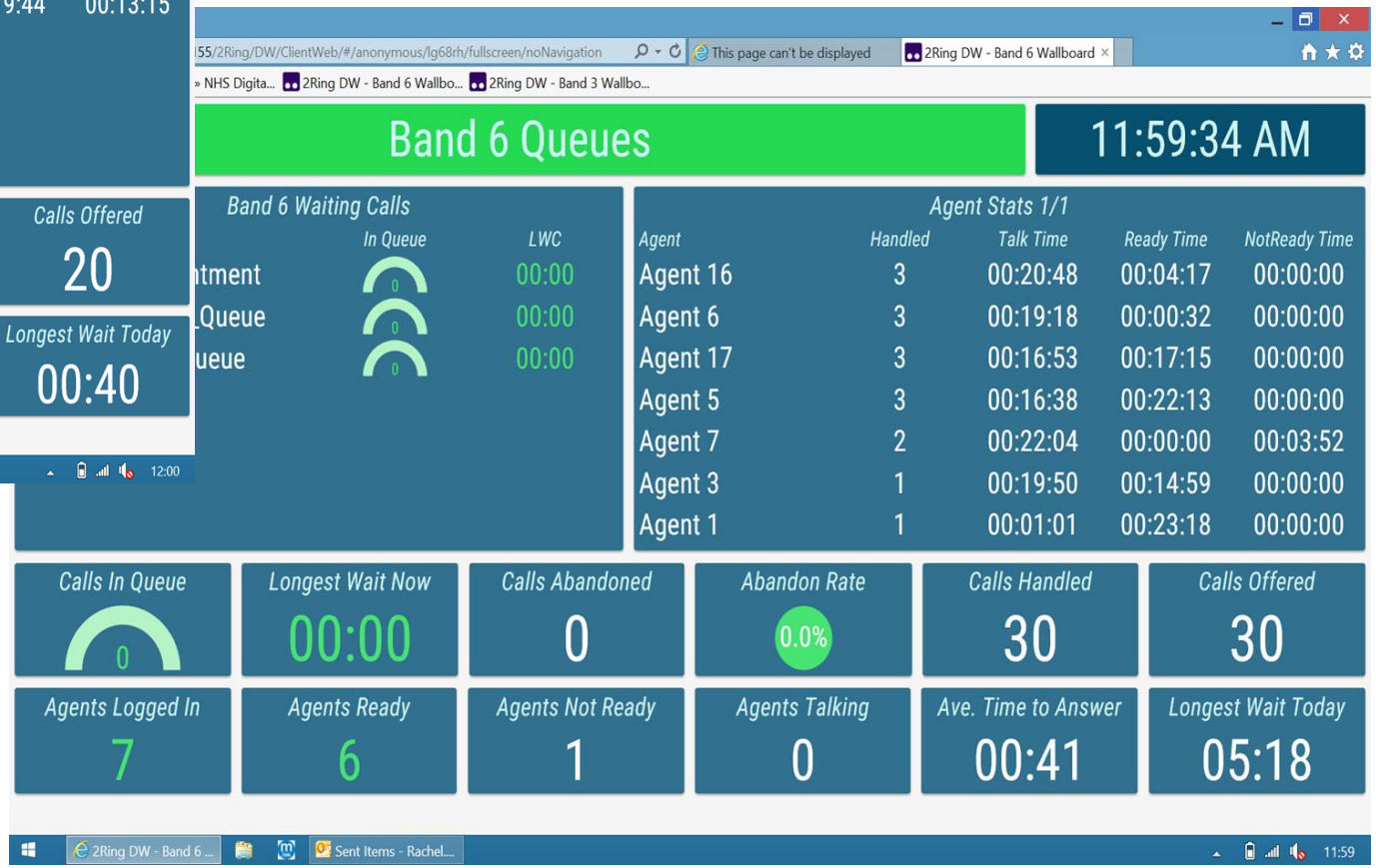
Wall Boards





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Weekly KPIs

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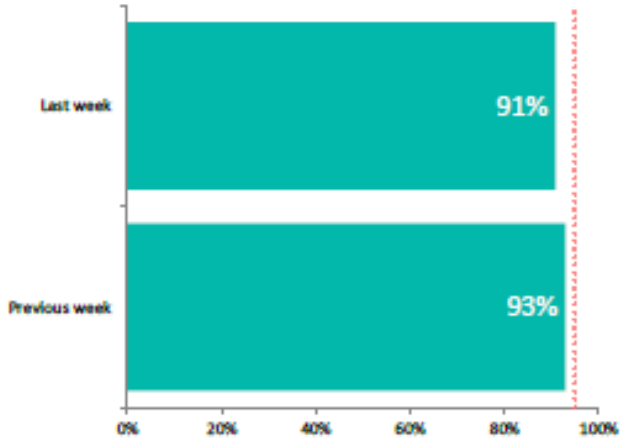
Week Number: 2021-02

Calls answered within five minutes vs. previous week



Average time to answer
00:01:41

Calls handled
926

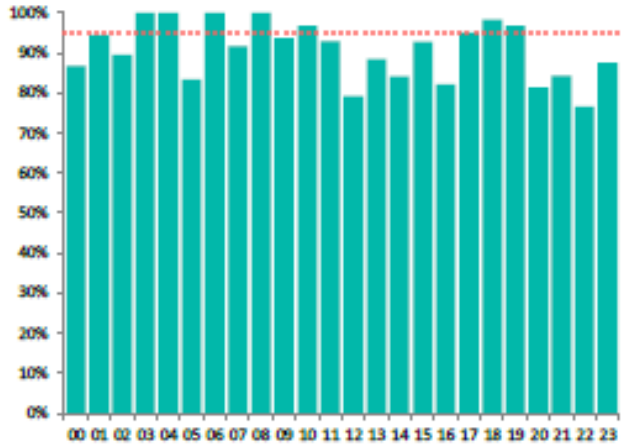
Median time to answer
00:00:32

Calls abandoned
43 (excl. < 1 min.)
65 (incl. < 1 min.)

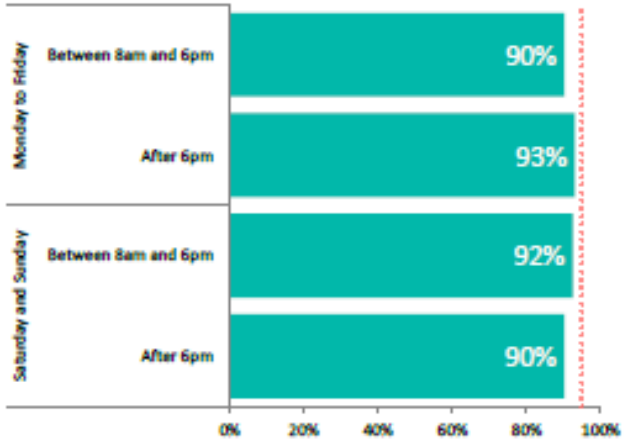
Longest time to answer
00:21:30

Calls abandoned (%)
4.44% (excl. < 1 min.)
6.56% (incl. < 1 min.)

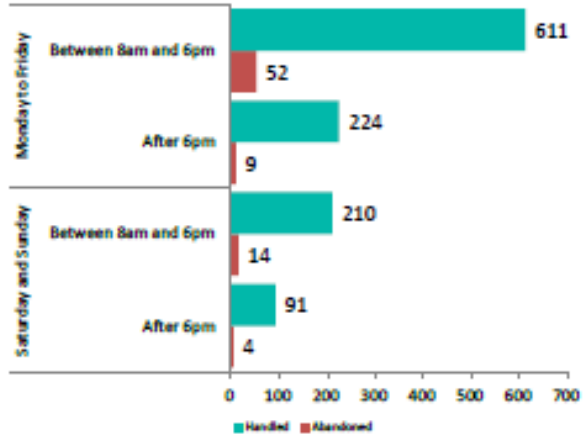
Calls answered within five minutes by hour last week



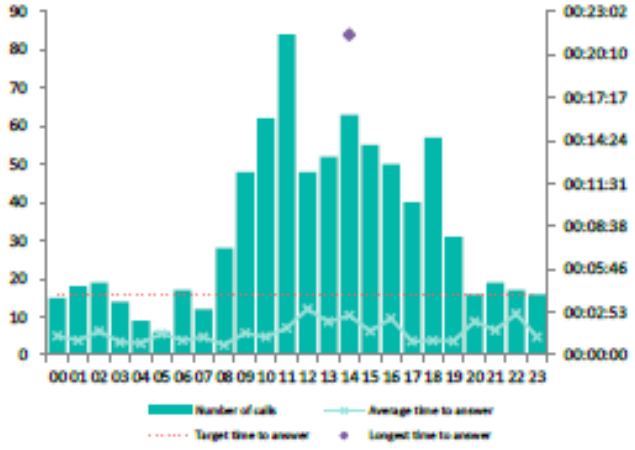
Calls answered within five minutes by shift last week



Calls handled and abandoned by shift last week



Calls answered by hour last week



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12/01/2021 10:32

Innovation Potential

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‘The innovation that telemedicine promises is not just doing the same thing remotely that used to be done face to face, but awakening us to the many things that we thought required face to face contact, but actually do not’

David D ASCH, MD MBA,
Perelman School of Medicine, University of Pennsylvania

Service Enhancements

- **GP Triage/ Immedicare Connect Portal**
- **Electronic Non-Medical Prescribing**
- **MDT collaborative working -** Community Nurses, GPs, Digital Hub, Care Homes, ED, Pharmacists, MH Practitioners, CHC
- **Diversion from NHS 111 and 999**
- **Virtual Training, VVoED and Virtual Clinical Supervision to Care Home Staff** (supporting ongoing development)
- **Virtual Discharge Assessments** – from hospital to the care home
- **Falls and Pharmacy Service**

Virtual Training sessions delivered by Immedicare

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Remote virtual training sessions for care homes delivered by Immedicare

Training Features

- Monthly virtual training sessions for registered and non registered practitioners
- Post training evaluation available for delegates to submit feedback
- Certificates sent to all delegates who attend training
- 12 x 1hr training sessions on the topics listed

- End of Life Care
- Falls
- Behavioural and Psychological Symptoms
- Catheter Care
- Diabetes
- Leg and Foot Ulcers
- Medication Support
- MSK Common Injuries
- Top to Toe Assessment
- Urinary Tract Infections
- RESTORE2
- React to Red (Pressure Ulcer Prevention)

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Questions

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Technology Enabled Health – The art of the possible…

Supporting care home residents to live better for longer

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North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership

Victoria Turner
Public Health Consultant
North Yorkshire County Council

Public Health

North Yorkshire County Council

Health and Social Care: Achieving Excellence Together Conference

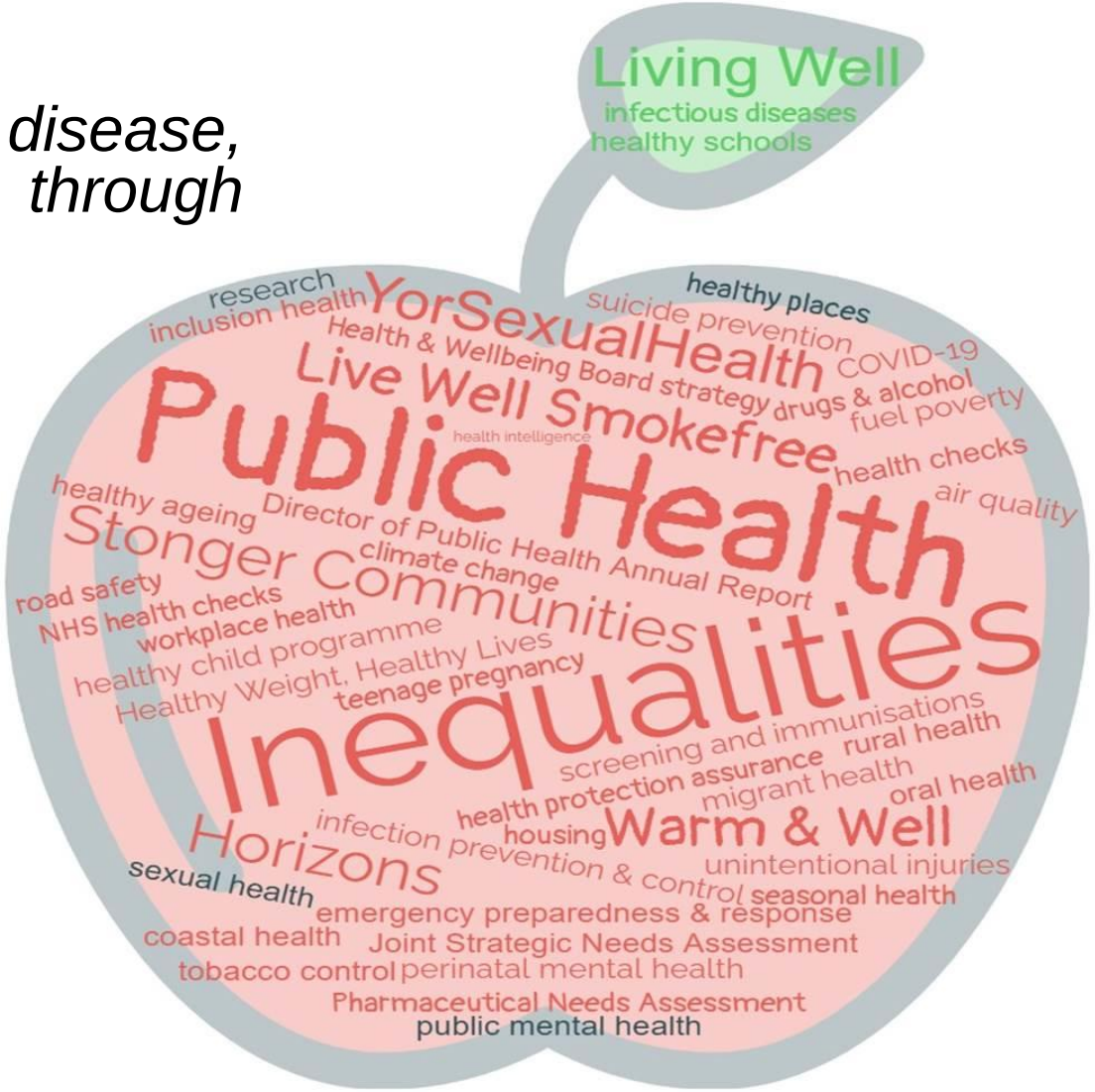
North Yorkshire Public Health Team

What is public health?

"The science and art of preventing disease, prolonging life and promoting health through organised efforts of society." *Sir Donald Acheson*

Public health
- Local Authority
- UKHSA, OHID, NHSE (all previously PHE)
- Universities

3 main areas of PH work:
- Health improvement
- Health protection
- Healthcare public health



COVID-19 Response

- Care settings were priority group under COVID-19 Outbreak Control Plans

Multi-Agency Response & Oversight

- Daily or 2x weekly **gold command**, chaired by AD ASC to ensure strategic oversight of the COVID-19 response in care settings. Includes City of York Council to ensure joined-up approach.
- Daily or 3x weekly **silver command**, chaired by NYCC Public Health, to ensure operational oversight and tailored interventions and outbreak management approach.
- Both were multiagency meetings, with **NHS, CCG, CQC, UKHSA/PHE, CIPCT** and different teams within NYCC all collaborating on a daily basis to ensure support is provided to where it is most needed.

Contact

- Provided **daily calls** for 11 months from the start of the pandemic (coordinated by NYCC QMI).
- From Easter 2021, moved to daily surveys to providers to monitor COVID-19 impact and identify support required, with a dashboard created to RAG rate responses.
- **Support calls** to providers if they have not completed the survey in 3 days – Care Setting Contact Workers
- **Weekly calls** to providers for support – Care Setting Contact Workers
- Daily calls to providers in **COVID transmission high risk areas**
- Daily calls to providers with suspected or confirmed cases or outbreaks – **Care Setting Support Officers (CSSO)**

Support

- **CSSOs** acted as a point of contact for queries and advice on guidance.
- **CSSO Handbook** – practical support available to the market
- **COVID-19 Support Visits** – Quality Improvement Team/Health & Safety Risk Management/Infection, Prevention Control Team/ North Yorkshire CCG/ Vale of York CCG all worked together to deliver support to all **233 care homes & Extra Care Settings as well as 150 domiciliary care providers.**
- Weekly **Care Connected Webinar** run by HAS/NYCC PH, ensuring providers are kept up to date
- **Care Home Visiting Taskforce.**
- **Admissions panel** – public health-led support on risk assessing admissions

What we learned working through the pandemic

- **We work better and are stronger together - working as a system enabled quick and robust support and guidance to providers. Working jointly with City of York Council gives providers covering both areas a consistent message**

Other learning:

- Improving communication with the market – webinars worked well as an alternative to issuing bulletins and links to guidance, a quicker way to deliver training and share guidance. Webinars coordinated by the Council with presentations and involvement of partners including City of York. Weekly Care Connected allowed partners to share information with the market and to receive updates and concerns from the market
- Use of technologies – webinars, snap surveys enabled information to she shared quickly. Remote working enabled virtual support to be offered in a timely manner, reducing footfall in services
- Integration Adult Social Care & Public Health – closer links and shared working across both areas of Health & Adult Services, recognising the skills and knowledge of staff in both areas. Generated opportunities to inform future working practices, post pandemic
- Business Continuity Planning – needs to be a dynamic tool, some providers requiring additional support
- Co-production – working closely with partners, including people who access services and support, their families and providers decisions made and guidance produced were influenced by a range of perspectives and a sense of ownership
- Lived experience – through the Task Force and speaking to people in services we could gain a better insight to people's lived experience. This shaped guidance, practice and discussions so that better outcomes could be achieved for people

Some feedback…

"A proactive relationship-based approach is evidence in NYCC's proactive engagement with care homes, care settings and care users. The positive impact of this is evident in the strength of the relationships forged during the pandemic with these partners.

The dedication, energy and collaborative team working which has made this possible was evident through a 'willingness to pull out all the stops'. There has also been innovation is service delivery.

NYCC's 'user-by experience' centred ethos has paid dividends, with care users describing extremely positive experiences of NYCC's support. They reported feeling more engaged, listened to and their views acted upon more than ever before".

LGA Outbreak Management Peer Challenge, September 2021

"I can't recommend the COVID-19 Care Settings Response enough. As a care home owner, the pandemic has presented challenges to our sector that I have not experienced in the last two decades of our service.

The service from the COVID-19 Care Settings response group was proactive, well organised and reliable despite the unprecedented pressure on them. The contact myself and my team had was incredibly reassuring, realistic and friendly helping to share some of the fears and anxieties we had.

Innovative ways of working were put into action and, I believe , the best foundations for partnership working were put in place.

Thanks so much for all of the support".

Managing Director

North Yorkshire County Council

What's next? Developing a public health menu of interventions for care settings

Physical activity	Nutrition and hydration	Oral health	Falls, frailty and deconditioning	Foot health
Smoking, alcohol and drugs	Sexual health	Dementia	Autism	Infection prevention and outbreak management
Screening and immunisations	Dying matters	Mental health/suicide prevention	Intergenerational programmes	Anything else you'd like to see?

Age Friendly Network

Help us to develop an all age friendly community in North Yorkshire

What do we do?

We want to help North Yorkshire become an age friendly community where people can live healthy and active lives.

How do we do this?

Together with residents aged 50+, we will talk to local services, share information, raise issues that matter to you and work to make change happen.

Get involved?

Become a network member to unite residents and organisations to help shape services. This is your chance to add your voice to create an age friendly community.

Network | Have your say | Be informed | Shape change

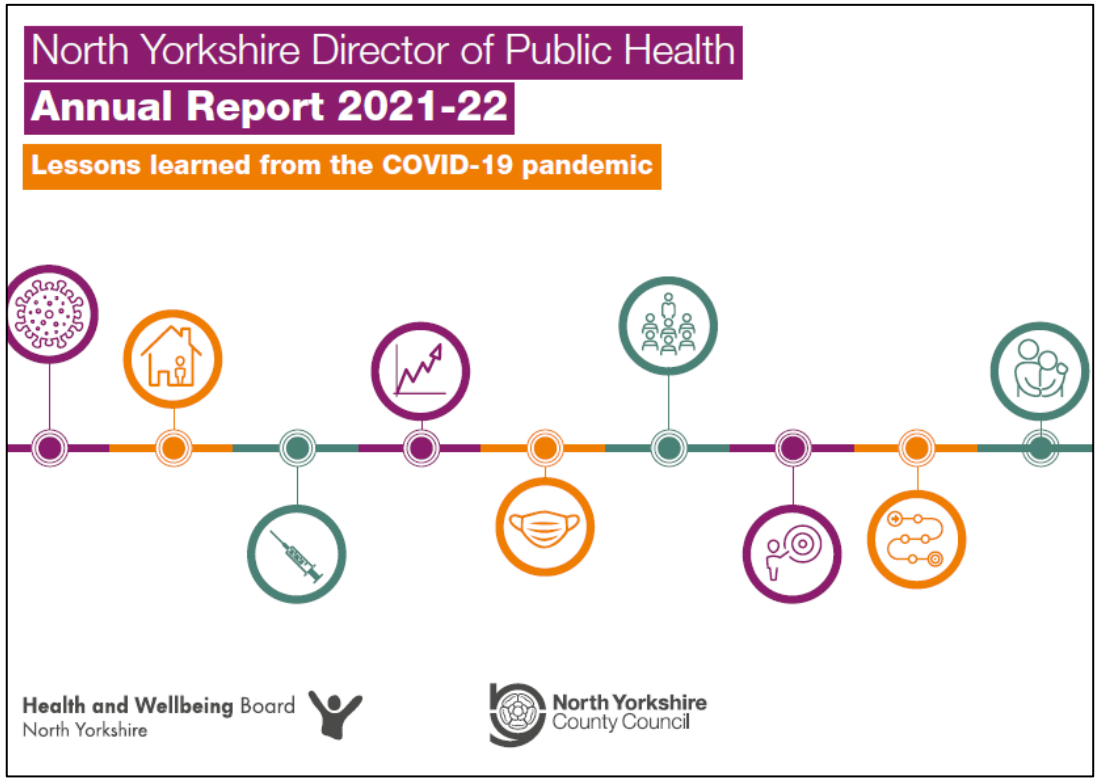
Community First Yorkshire

Find out more: 01904 704177
info@communityfirstyorkshire.org.uk
www.communityfirstyorkshire.org.uk

North Yorkshire County Council

[Age Friendly Network - Community First Yorkshire]

Find out more



https://www.nypartnerships.org.uk/dphar

Contact us: dph@northyorks.gov.uk

North Yorkshire
County Council

Thank you for listening!

Victoria.Turner@northyorks.gov.uk

Eleanor.Whittaker@northyorks.gov.uk

North Yorkshire County Council

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Humber and North Yorkshire Health and Care Partnership

Refreshments

15:00-15:15

North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership

Everyone

What Can We Do Together?

North Yorkshire County Council

Humber and North Yorkshire Health and Care Partnership

Neil Hanson

Laughter Is The Best Medicine !

North Yorkshire County Council

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Pledge

What Can We Do Together?

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Feedback

Feedback

Pledge