North Tyneside Ageing Well Strategy

2020 - 2025

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- Northumbria Healthcare NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- North Tyneside Council
- Healthwatch North Tyneside
- Age UK North Tyneside
- North Tyneside Community Healthcare Forum

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Foreword

People in North Tyneside can now expect to live longer with the number of people aged 85 and over set to increase by 24% by 2030. Despite the increase in life expectancy which is good news, in North Tyneside overall it remains lower than the national average including the number of years people expect to live in good health. Within North Tyneside there is a variance of life expectancy and years lived in good health, a gap that needs to be closed.

For many people, old age is feared because it is associated with disability and disease, and while the prevalence of disease increases with age, the ageing process is not the principal cause of disabling disease. Biological ageing alone is believed to have little effect until around the age of 90 and only 25% of the ageing process is believed to be genetically determined.

While some diseases appear to be related to the ageing process, many of the disabling diseases of old age are preventable. The main reason that disease occurs more commonly each decade is that people have lived for another ten years, exposed to risk factors in their lifestyle and environment that cause disease. These risks can be reduced at any age, even at the age of 60 or older.

Frailty therefore, is not an inevitable part of ageing, prevention, early recognition and management requires a consistent, collaborative approach in partnership with the residents of North Tyneside.

Our partnership commitment across health, public health, social care, community and voluntary organisations is to work together to enable local residents to age well and live longer in good health. We want people to remain healthy, active and connected. In order to support this we will work collaboratively to deliver person centred joined up services that are inclusive, recognise and value the important role that families and carers play.

Together we will promote healthier ageing and continue to address inequalities through population health management.

The aim of this strategy is to:

"Support North Tyneside residents to age well; remain healthy and independent for as long as possible".

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Introduction

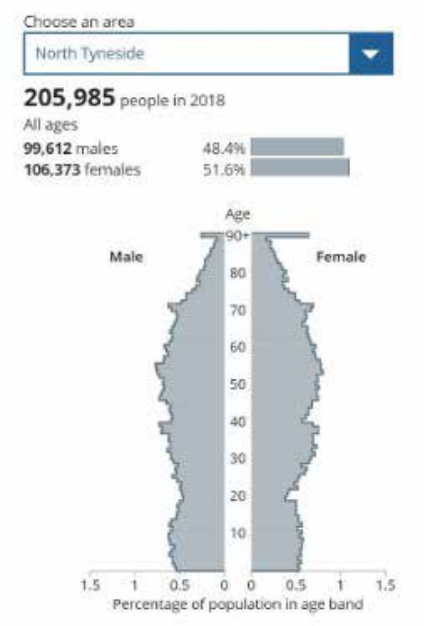
Supporting people to age well is one of the NHS Long Term Plan (NHS England 2019) ambitions. For older people it is important to slow down or reverse some of the health challenges associated with ageing. It is essential that older people are supported to remain as healthy and independent as possible for as long as possible and they receive the highest quality care when they need it.

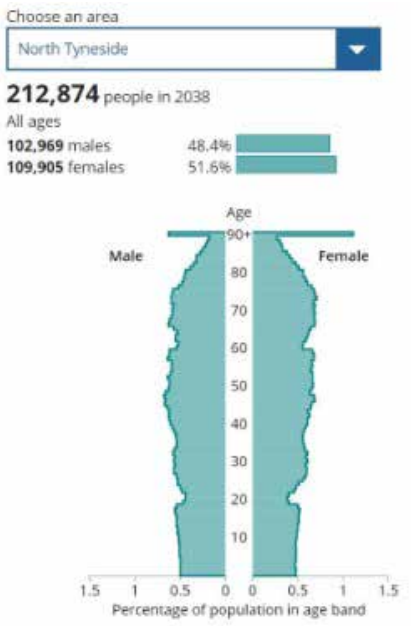
There are significant differences between life expectancy and healthy life expectancy. A male born in England today has a life expectancy of 79.9 years, of which they can expect to live 63.4 years in good health. In North Tyneside these figures are lower, with life expectancy at 78 years and 62.2 years in good health. Closing this gap would have significant benefits to quality of life as well as for the health and social care economy.

Frailty is a distinctive health state related to ageing in which multiple body systems gradually lose their in-built reserves. Around 10 per cent of people aged over 65 years have frailty, rising to between a 25% and 50% of those aged over 85 years (BGS 2020). However, frailty is not an inevitable part of ageing; it should be considered as a long term condition that requires recognition and management.

Population projections indicate an ageing population for North Tyneside:

- There are approximately 90,000 people aged 50+ registered with GP.
- The number of people aged 65 years will increase significantly by 2025.
- The number of people aged 85 is projected to increase by 24% by the year 2030.
- The number of permanent admissions to care homes per 100,000 is higher in North Tyneside than England. For over 65's this is 740.9 and 580 respectively.
- Rightcare data indicates admission rates for length of hospital stays of over 7 and 21 days for people aged 75-84 and 85+ are higher than rates across England.
- The percentage of the population with a limiting long-term illness is significantly higher than the average for England. There are approximately 2000 people in North Tyneside with dementia. The prevalence of dementia nationally is expected to increase by 20% between 2019 and 2025, and by 40% between 2019 and 2030.
- 42.9% of people aged 65 years, and who use adult social care services, reported that they had as much social contact as they would like.





In North Tyneside it is essential that health and social care respond to the changing demographic and pressures on the health and social care system. We will do this by supporting people to age well and minimise the impact of frailty which will help maintain their mental and physical health, and independence for as long as possible.

Whilst significant steps have already been made to improve services for older people in North Tyneside, in order for us to meet these challenges, there needs to be a considerable step change in our improvement work.

This document outlines the joint health and social care strategy to support people to age well in North Tyneside for the next five years. Each year there will be a separate action plan that will identify and publish the outlining key priorities for that year.

Our strategy has one strategic aim:

Support North Tyneside residents to age well; remain healthy and independent for as long as possible.

This aim will be delivered through three key work streams which aim to keep older people:

1 Healthy

2 Active

3 Connected

Central to the delivery of this strategy are four key principles:- **Integrated, Person Centred, Safe and Inclusive**

1 Healthy

2 Active

3 Connected

Integrated

- Health and social care services
- Digital systems
- Workforce, contracting, commissioing, and monitoring
- Transition between working age, frailty and palliative care services

Person Centred

- Shared decision making
- Realsitic medicine central to all care decisions
- Focus on 'what matters to me'
- Co-production commitment to involve carers, service users and professionals in reviewing and developing services

Safe

- Services
- Housing
- Environment
- Awareness of safegarding vulnerable groups

Inclusive

- Services are accessible to all including those with physical disability, learning disability or autism
- Better co-ordinated care across systems
- Referals may be redirected but are not rejected

1 Healthy

Find

Structured case finding approach to identify people at risk of frailty and falls allowing for early intervention

Screening for depression, anxiety and cognitive impairment in older people presenting to health services

Safe and well checks provided by partner organisations

Partner organisations and networks to actively identify those at risk of falls and support referral for support

Recognise

Training programme for health and social care staff to improve recognition of frailty syndromes, use of the Rockwood score and falls risk assessment

Work with community services, opticians, dentists, allied health care professionals, voluntary sector and wider community networks, to improve recognition of frailty and facilitate referral into the integrated frailty service

Assess

Single point of access to integrated frailty services where an appropriate holistic assessment or comprehensive geriatric assessment can be completed

Provision of multidisciplinary 'one stop shop' assessment

Intervene

Gold standard long term conditions management in the community

Provide care co-ordinations to support and facilitate referral to other services

Integrated mental health provision

Integrated frailty service providing;

- Proactive care
- MDT interventions
- Home based intermediate care
- Bed care based intermediate
- Specialist inpatient and outpatient services
- Deliver 2 hour urgent response

Long term

Locality based care coordination teams.

Support people to live independently longer at home in the community

Introduction of a patient passport to go alongside EHCP and DNAR documentation as part of advanced care planning and End of Life strategy

Enhanced health in care homes

Integrated, Person Centred, Safe and Inclusive

2 Active

Physical activity

Ensure that community based physical activities are provided by a range of partners to meet all needs including addressing falls

All activity information available through Living Well North Tyneside

Active North Tyneside

Support HOW fit across the age continuum

Emotional wellbeing

Ensure a range of support is available in the community via different mechanisms including health, social and voluntary sectors

Social prescribing and care navigators are available to support people through primary care networks

SIGN PLUS database

Connecting people locally

Support a digital poverty strategy

Population health

Public health messages are encouraged through Making Every Contact Count

Support healthy eating and weight management initiatives across sectors

Smoking cessation accessible to all including hospital inpatients and housebound people.

Support brief interventions for alcohol reduction

Environmental

Different housing to cater for individual needs including care homes, sheltered, supported living and extra care.

Ensure an efficient accessible public transport system

Accessible public toilets

Accessible public recreation, leisure and cultural facilities

Support a cycling strategy and encourage cycle lanes

Accessible parks and public spaces

Integrated, Person Centred, Safe and Inclusive

3 Connected

Social isolation

Raise awareness of social isolations

Comprehensive activities program for older people detailed in Living Well North Tyneside

Improve digital connectivity

Community based social activities provided by a range of partners to meet all needs including those living with dementia, carers, falls and frailty

Carer support

Programme to consistently identify and code carers in general practice

Support via North Tyneside carers centre and wider voluntary sector

Provision of respite care beds

Information on a range of services to support carers through Living Well North Tyneside

Voluntary sector befriending programmes

Commitment to Carers strategy

Assistive technology

Digitally enabled intermediate care beds

Digitally enabled extra care housing schemes

Expansion of Care Call

Commitment across services to improve information available through different mediums

Single patient record

Commitment to a single record for use in integrated frailty services

Patient passport – patient held document containing key information

Capacity and demand system

Digital inclusion

Development of a joint strategy to address the digital divide

Voluntary sector support to increase use of online activities and services

Provide accessible information, advice and guidance

Review and monitor routes to access services to ensure accessibility'

Integrated, Person Centred, Safe and Inclusive

5 year ambitions and key milestones

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Healthy	**Optimal long term conditions management for all people in North Tyneside** • People are involved in streamlined year of care planning to maximise health and minimise the impact of long term conditions • Equity of service for all including, housebound patient, those with learning disability and minority groups	• Enhancement of Care Point • Development of Primary care Networks and wider community services	• Training programme for community nurses delivering LTC management • Enhanced links with community matrons and integrated frailty service. • Engage practices/ PCNs with LTC management • Look to develop resources to facilitate self-care • Enhance links with LD teams to ensure vulnerable groups are not excluded from gold standard LTC management • Enhance links for escalation of care to PCN/ NT LTC experts	• Review data at a borough wide and local (PCN/ practice) level and refine implemented programmes • Look towards a tiered system for LTC support and management

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months

Healthy	**Care for older people is fully integrated**
	• The patient is able to tell their story once, their voice is central to care decisions
	• Care is delivered in the right place at the right time by the right individual with the relevant information
	• MDTs work together to ensure that all patient care needs are met
	• Transitions between working age, older peoples and palliative services are smooth
		• STRATA role out
		• Procurement – intermediate care beds
		• Single patient record/ clinical system
		• Patient passport/ EHCP development
		• Joint service specification for Ageing Well service
		• Work with PCNs to ensure that centrally delivered and network delivered services work in an integrated fashion to deliver the enhanced health in care home agenda
			• Launch of Ageing Well hub to include
			  • JDH
			  • Care Point
			  • Care point enhancement
			• Implementation of single patient record for use in frailty services
			• Joint referrals process/ SPA
			• Implementation of STRATA capacity and demand system
			• Link frailty services with specialist services (e.g. respiratory, cardio, Stroke)
			• Connect frailty services with specialist services (e.g. respiratory, cardio, Stroke)
			• Connect frailty services and palliative care services
				• Implementation of single patient record across primary and secondary care for older people
				• MDTs linked to individuals – seamless links between primary and secondary care

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Healthy	**Mental health** • Parity of esteem with physical health • Holistic care is normal for all older people with attention paid to mental and physical health alongside social wellbeing • Mental health services are integrated and accessible to all residents across North Tyneside	• Development of older peoples crisis services • Recruit mental health workers into Integrated Frailty • Review of memory services for older people – to include dementia and delirium services	• Mental health workers established within frailty services • Work with mental health providers to streamline services and pathways across North Tyneside • Mental health is considered in every assessment of an older person	• Review and refinement

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Active	**Physical** • Physical activity for older people is normalised with a range of options to suit preferences and abilities. • Older people in North Tyneside are supported to be active, eat well, stop smoking, reduce alcohol intake and live well **Mentally** • Older people are supported to remain mentally active and active participants in their age friendly communities • The skills and knowledge of older people are recognised and utilised to build, healthy active and cohesive communities	**HOWfit** • Leaflet drop • Website • Goal seeker app • Age UK support • Links to universal via voluntary and third sector • Develop a clear pathway linking the voluntary sector with commissioned older peoples mental health services	• Volunteers to support exercise and activity in care homes • Clear directory of social prescribing options available. • Care coordinator role clearly defined and established • Early relationships between health, social care and the voluntary sector established	• Mature links and joint understanding of activity in health, social care and the voluntary sector

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Active	**Training and development programme** • Structured training programme in place across health, social and third sector organisations, centrally coordinated to ensure 'core' learning • Staff are satisfied in the work place, there are opportunities for development and staff retention is good		• Develop/ source resources for a range of audiences • Communication strategy • Workforce plans across organisations	
	Environment • Safe and well maintained outdoor spaces conducive to physical activity		• Accessibility to universal services	

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Connected	**People and environment** • People and environment • Older people are supported to connect to their communities physically and digitally. • Carers are recognised and supported in their roles • Housing that is digitally enabled, adaptable, accessible, affordable and facilitates people to live independently in their own homes	• Living Well Locally North Tyneside is implemented • Care co-ordinators, navigators and social prescribers are in place	• Support digital technology	
	Data • Used effectively to identify vulnerable individuals and offer proactive care		• Develop a strategy for use effective use of data currently available from multiple sources. • Data sharing agreements in place	• Implementation of strategy
	Technology • Technology is utilised to connect communities and reduce the impact of social isolation. • Digital care options are first line and open to all		• Partnership working with VODA, Age UK and others to reduce digital poverty • Increase access to services via digital, remote and agile working across organisations	

Work stream	Success looks like	Key milestones		
		0-12 months	12-36 months	36-60 months
Connected	**Workforce** • Integrated and flexible workforce equipped to response to pressure points within the service • Stable domiciliary care workforce able to meet demand • Stable care home workforce able to meet local demand		• Sustainable workforce optimising skill mix • Community Care Practitioners across Integrated Frailty service • Advanced care Practitioners employed in Care Homes	

References

British Geriatric Society (2020) https://www.bgs.org.uk/resources/introduction-to-frailty

NHS England (2019) https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Working together in North Tyneside

North Tyneside Council

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Clinical Commissioning Group

healthwatch
North Tyneside

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

age UK

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