Working Together To Improve Outcomes for Older People: Reshaping Care in Scotland

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JIT is a strategic improvement partnership between the Scottish Government, NHSScotland, COSLA and the Third, Independent and Housing Sectors

@jitscotland  www.jitscotland.org.uk
Demographic change for population aged 65+ Scotland
Potential impact on emergency bed numbers 2007-2031

<table>
<thead>
<tr>
<th>Year</th>
<th>Beds</th>
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<tbody>
<tr>
<td>Y/E Mar 2007</td>
<td>7496</td>
</tr>
<tr>
<td>Projected</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>8382</td>
</tr>
<tr>
<td>Projected</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>10542</td>
</tr>
<tr>
<td>Projected</td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>12600</td>
</tr>
<tr>
<td>Projected</td>
<td></td>
</tr>
<tr>
<td>2026</td>
<td>14700</td>
</tr>
<tr>
<td>Projected</td>
<td></td>
</tr>
<tr>
<td>2031</td>
<td>16798</td>
</tr>
</tbody>
</table>

Calendar year ’07 estimate

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2020 Vision for Quality

Everyone is able to live longer healthier lives at home or in a homely setting.

- Integrated health and social care, with a focus on prevention, anticipatory care and supported self management.
- Care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm.
- There will be a focus on ensuring that people get back to their home or community as soon as appropriate, with minimal risk of readmission.
Reshaping Care for Older People

- **10 Year Programme to 2021**
- **£ 300 million Change Fund 2011-15**
- **32 voluntary partnerships between**
  - NHS: primary, acute, mental health
  - LA: social care & housing
  - Third and Independent sectors
  - Older people and carers
- Change Plans signed off by all partners
- **20% of funding to be invested in direct or indirect support for carers**
Reshaping Care Pathway

Preventative and Anticipatory Care
- Build social networks and opportunities for participation.
- Early diagnosis of dementia.
- Prevention of Falls and Fractures.
- Information & Support for Self Management & self directed support.
- Prediction of risk of recurrent admissions.
- Anticipatory Care Planning.
- Suitable, and varied, housing and housing support.
- Support for carers.

Proactive Care and Support at Home
- Responsive flexible, self-directed home care.
- Integrated Case/Care Management.
- Carer Support.
- Rapid access to equipment.
- Timely adaptations, including housing adaptations.
- Telehealthcare.

Effective Care at Times of Transition
- Reablement & Rehabilitation.
- Specialist clinical advice for community teams.
- NHS24, SAS and Out of Hours access ACPs.
- Range of Intermediate Care alternatives to emergency admission.
- Responsive and flexible palliative care.
- Medicines Management.
- Access to range of housing options.
- Support for carers.

Hospital and Care Home(s)
- Urgent triage to identify frail older people.
- Early assessment and rehab in the appropriate specialist unit.
- Prevention and treatment of delirium.
- Effective and timely discharge home or transfer to intermediate care.
- Medicine reconciliation and reviews.
- Specialist clinical support for care homes.
- Carers as equal Partners.

Enablers
Outcomes focussed assessment
Co-production
Technology/eHealth/Data Sharing
Workforce Development/Skill Mix/Integrated Working
Organisation Development and Improvement Support
Information and Evaluation
Commissioning and Integration Resource Framework
Improvement Network

Cross sector collaborative to support innovation and test and spread actions which collectively improve outcomes

- WebEx virtual meetings and e-bulletins
- Communities of Practice and themed learning events
- Online portal to share good practice, evidence and resources
- Training in improvement, spread and sustainability
- Use of measurement for improvement and benchmarking

- Support to adopt assets and outcomes based approaches
- Learning from the experience of people who use services
- Coaching / mentoring to build local capacity and capability
Collaboration with Third Sector

Helping you to cope with your symptoms and improve your quality of life

The Caring Together programme for patients with heart failure

A partnership programme by:

The Scottish Government, NHSScotland, COSLA and the Third, Independent and Housing Sectors
Building Community Capacity
Peer support and web based information and advice to help people manage their conditions
Technology Enabled Local Integrated Networks of Care and Support
SPARRA Risk Prediction Tool

**Hospitalisation** (3 years)

**Psychiatric Admission** (3 years)

**Outpatient** (1 year)

**Emergency Department** (1 year)

**Prescribing** (1 year)

**Outcome Year** (1 year)

**PRE-PREDICTION PERIOD**

- How many previous emergency admissions has the patient had?
- How many outpatient appointments did the patient have?
- Any A&E attendances in the past year?
- Any previous admissions for a long term condition (such as epilepsy?)
- Any prescriptions for e.g. dementia drugs? Or substance dependence?

**OUTCOME PERIOD**

- What age is the patient?
- How many prescriptions?
- Any recent admissions to a psychiatric unit?
- What type of outpatient appointments did the patient have?
10 Anticipatory Care Interventions
Targeted and tailored to the individual

- Self management advice and support including for dementia
- Polypharmacy reviews of safety, efficacy and adherence
- ‘Thinking Ahead’ Anticipatory Care Plans electronically shared
- Physical activity, falls prevention and management
- Identification and support for carers
- Coordinated case management for complex support
- Reablement and ‘step up / step down’ Intermediate Care
- Comprehensive Geriatric Assessment for frail older people
- Telehealth and Telecare
- Equipment and adaptations
Key Information Summary

The Key Information Summary (KIS) provides a concise overview of a patient's medical history and preferences.

**KIS**
- Patient Wishes
- Resuscitation
- Medical History
- End of Life Plan
- Anticipatory Care Plans
- Self Management Plans
- Mental Health Plans

**ePCS**
- Alerts
- Medications
- Allergies
- Demographics

**ECS**
- Secure Login
- Secure Patient Information

**KIS Information Flow**
- GP Practice
- Secure, encrypted Patient Information sent
- Key Information Summary (KIS)
- ECS Store
- NHS 24
- Accident and Emergency
- Hospital Pharmacy
- Scottish Ambulance Service
- Out of Hours
Increased Adoption of Anticipatory Care Planning – data from Forth Valley

NHS Forth Valley KIS/EPC Uploads

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Falls prevention and urgent response

Non injured falls in the Elderly - Conveyance Scotland 2012 - 2014
Community Hospitals and Intermediate Care
Community of Practice
Supported at Home
76% are managed in their own home instead of Hospital by the ASSET team

Patients accepted by ASSET in 29 Months
2,864

5.7 days
Length of Stay

5.6 / Day

North Lanarkshire

Change in Over 75 Admission Rate 2011-2013
12%
15%
12%
9%
6%
3%
0%

ASSET localities

Value £2 Million+

Beds Closed 50
Immediate Management of Delirium

There's no TIME like the present

For patients aged 75 and over when clinical history suggests delirium, or assessment tool (e.g., the 4AT or CAM) positive

Initiate all elements of this CARE BUNDLE within 2 hours

Delirium Care Bundle

<table>
<thead>
<tr>
<th>Care Bundle Elements</th>
<th>Care Bundle Elements</th>
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<tbody>
<tr>
<td>T THINK about possible triggers</td>
<td>Acute illness, pain, trauma</td>
</tr>
<tr>
<td>I INVESTIGATE</td>
<td>Carry out early warning score</td>
</tr>
<tr>
<td>M MANAGE</td>
<td>Medication, infection, hypoxia</td>
</tr>
<tr>
<td>E EXPLAIN</td>
<td>Document ‘DELIURIUM’ diagnosis</td>
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</table>

What is delirium?

Delirium (sometimes called acute confusional state) is a common serious condition for older people. This medical emergency is often under-recognised and often poorly managed. Delirium is the most common complication of hospitalisation in the elderly population. The incidence is also higher in those with pre-existing cognitive impairment.

The prevalence of delirium in people on medical wards in hospital is about 20% to 30%, and 10% to 50% of people having surgery develop delirium. In long-term care the prevalence is under 20. People who develop delirium may:

- have an increased incidence of dementia
- have more hospital-acquired complications, such as falls and pressure sores
- be more likely to need to be admitted to long-term care if they are in hospital
- be more likely to die. (NCCE, 2011)

Recognising delirium

Sudden onset of:

- reduced mobility and appearance
- withdrawal (hypactive delirium)
- disturbances in usual mood, communication or orientation
- restlessness, agitation, sleep disturbance
- confusion or worsened confusion
- impaired concentration and attention
- responding to hallucinations, and
- fluctuations in these symptoms and presentation.

Suspecting delirium

If you suspect a diagnosis of delirium:

- assess this as a medical emergency
- assess for delirium using a locally agreed tool, such as 4AT or CAMS
- once a diagnosis of delirium is made and documented, use the TIME bundle (checklist to identify Triggers, Investigate cause, Create a Management plan and Engage with patients and families)
- refer to the Scottish Delirium Association (SDA) Delirium Pathway or local pathway
- remember sedation is only used where appropriate (refer to SDA pathway/local protocol), and
- ask families or carers — “Is this usual behaviour for your relative?”

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Number of older people whose discharge is delayed over 72 hr by Sector, Glasgow HSCP
39% of CHANGE FUND SPEND 2014/15 SUPPORTED CARERS

2.5 Million MORE DAYS IN OWN HOME THAN ‘EXPECTED’

17% FEWER OLDER PEOPLE CONVEYED to HOSPITAL after a fall (non-injured)

10% REDUCTION IN RATE OF 75+ EMERGENCY BEDDAYS OVER 5 YEARS

1250 PER DAY FEWER PEOPLE AGED 65+ IN HOSPITAL BEDS THAN ‘EXPECTED’

Over 4 in 5 IN RECEIPT OF FORMAL CARE AT HOME HAVE TELECARE

5500 PER DAY FEWER PEOPLE IN CARE HOMES THAN ‘EXPECTED’

19% FEWER PEOPLE DELAYED IN HOSPITAL OVER 2 WEEKS
Integrated Resources - Minimum to be delegated

Scotland total =£12.3bn

Minimum to be delegated to Integration Authorities =£7bn

Expenditure (£m)

Hospital
Community Health
Family Health Services & Prescribing
Social work

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Expenditure (£m)

Hospital
Community Health
Family Health Services & Prescribing
Social work
Local integrated networks of care and support

Health and Social Care Integration

Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

www.scotland.gov.uk/HSCI
Follow us on Twitter @scotgovIRC

There’s no ward like home
http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration


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