Reshaping Care Pathways for Older People

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Reshaping Care for Older People

10 Year Programme to 2021
£300 million Change Fund to 2015

32 Partnerships between
NHS: primary, acute, mental health
Local Authority social care, housing
Third and Independent sectors
Older people and carers

Joint Strategic Commissioning

Multi-sector Improvement Network
Adapted breakthrough collaborative
### 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
Technology Enabled Integrated Community Team
National Risk Prediction Tool

SPARRA predicts 95% of emergency admissions

**PRE-PREDICTION PERIOD**
- Any A&E attendances in the past year?
- Any prescriptions for e.g. dementia drugs? Or substance dependence?
- Any previous admissions for a long term condition (such as epilepsy?)

**Hospitalisation (3 years)**
- How many previous emergency admissions has the patient had?
- What age is the patient?
- How many prescriptions?

**Psychiatric Admission (3 years)**
- How many outpatient appointments?
- What type of outpatient appointments did the patient have?

**Outcome Year (1 year)**
- Any recent admissions to a psychiatric unit?

**OUTCOME PERIOD**
- Outpatient (1 year)
- Emergency Department (1 year)
- Prescribing (1 year)
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

Electronic Sharing of ACP

KIS Information Flow
Patient and GP Consultation

Secure, encrypted Patient Information sent

GP Practice

KIS Information Summary (KIS)

Secure Login

ECS Store

NHS 24

Accident and Emergency

Hospital Pharmacy

Scottish Ambulance Service

Out of Hours
Reshaping Care and Integration Improvement Network

> Coordinator with QI expertise
> Collaborate with other improvement programmes
> Named JIT lead for with each of 32 partnerships
> Learning events, webex sessions, e-bulletins
> Range of Action learning / communities of practice
> Support to use data for improvement
> Link to Scottish Community Care Benchmarking Network
> Links to education and leadership development
Learning

‘A mature partnership takes time to develop and requires commitment from all’.

‘The scope of this programme encompasses not just all of the core resources applied to health and social care but also the resources within local communities, much of which is not within public agency budgets. Ensuring that all these resources are applied to a consistent strategic vision requires sophistication in partnership working beyond even the most mature of partnerships.’

‘The degree of professional engagement across the sectors has developed positive relationships, creativity and new innovations, all of which support the transformational change that will be required.’
Focus on leadership and development needs of the workforce in the provision of integrated health and social care

Cross sector action learning sets demonstrated positive changes in attitudes and behaviours ….’leaving the past behind’

Improved awareness of each others’ roles, culture and ethos

Development of relationships, trust and respect to a level where real progress could be made on complex issues

Exploring problems in a different, rigorous, multi-layered way in a safe but structured environment brought forward solutions

Next steps - build sustainable cross sector capacity for leadership and Quality improvement with JIT and QI Hub partners
Demonstrating Impact to inform commissioning

**National Indicators to drive Performance Improvement**
- Emergency inpatient bed day rates for people aged 75+
- Number and accumulated bed-days for delayed discharge from
- Percentage of people aged 65+ who live at home
- Percentage of last 6 months of life spent in a community setting
- Profile of intensive (10 hours + per week) home care

**Local Indicators** to drive local system redesign and improvement

**Personal outcomes** – qualitative feedback of impact on users and carers

**Resource Shifts** – within and across sectors

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[Logos: The Scottish Government, COSLA, Healthier Scotland, NHS Scotland]
Integrated Resource Framework:

patient / client level linked health and social care data

Scotland - Over 65 Health and Social Care Resource Use 2010/11
Total Resource £4.4bn

- Emergency Admissions: 31%
- Other Hospital: 19%
- Prescribing: 9%
- Home Care: 9%
- Health Community: 8%
- Care Home: 14%
- General Medical Services (GP): 4%
- Other Social Work: 6%
- Other Hospital: 19%

The Scottish Government
COSLA
Healthier Scotland
NHS Scotland
Impact of ACP

1. Nairn Study:  Baker, Leak et al Br J General Practice Feb 2012
   RCT with a net saving of £190 per patient for the ACP cohort

2. Highland study of emergency admissions and bed days for older
   people in care homes and the top 1% risk group living at home
   2 cohorts matched for SPARRA risk – 1556 in each cohort
   No ACP - emergency admissions and bed days ↑ by 51% and 49%
   ACP - emergency admissions and bed days ↓ by 38% and 49%

Scaling Up - the GP Contract will lever over 40,000 additional ACPs by
2014 and over 80,000 by 2015
Polypharmacy Review

> Tayside - 20% of 65+ emergency admissions were medicine related
> 17% of over 75s on 12 or more repeat medications
> Local Test of Change - Medication review of people aged 75 or over

> One off Multi-professional intervention – GP, pharmacist, geriatrician
> Clinic costing £50 per patient
> Prescribing savings per patient = £132 pa  Net saving @ £80 pa

> Extrapolate savings to 17% of population over 75s
> Amplified by reduced costs of ADR and associated emergency admissions

> Scaling Up - National Chronic Medication Service and GP Contract now lever a Polypharmacy Review
82 yr old man with previous stroke presents with falls and declining mobility. 84 yr old wife is sole carer and is struggling to cope. Expectation is admission to hospital or care home.

> Problems: drug related sedation, constipation, poor mobility, UTI.
> Undiagnosed vascular dementia and BPH.
> Carers, OT and PT commenced. Medication rationalised.
> Day 2 starting to mobilise with zimmer.
> Sleep improved, more awake during daytime.
> Dementia, ACP, DNA CPR and carer assessment discussed.
Hospital at Home Team discharge day 4. Wife delighted.
Lanarkshire Intermediate Care

*Increased number of older people accessing CGA despite reduced number of inpatient beds*
## Managing Demand in Stirling

<table>
<thead>
<tr>
<th>Year</th>
<th>Care at Home Service Users</th>
<th>Older People in Care Homes</th>
<th>Balance of Care</th>
<th>Cost of Care (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>1285</td>
<td>670</td>
<td>18%</td>
<td>Homecare: £6.7m, Care Homes: £9.6m</td>
</tr>
<tr>
<td>2013</td>
<td>1403</td>
<td>472</td>
<td>35%</td>
<td>Homecare: £6.7m, Care Homes: £7.3m</td>
</tr>
</tbody>
</table>
Fewer older people in hospital

Comparison of Actual and 'Expected' trend in emergency bed use aged 65+: at 2007/08 rates

Source: ISD data
Chart by P Knight JIT
p 2011/12 Provisional
Significant reduction in rate of emergency bed days for over 75s
<table>
<thead>
<tr>
<th>Quality of Life</th>
<th>Process</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling safe</td>
<td>Listened to</td>
<td>Improved confidence/morale</td>
</tr>
<tr>
<td>Having things to do</td>
<td>Having a say</td>
<td>Improved skills</td>
</tr>
<tr>
<td>Seeing people</td>
<td>Treated with respect</td>
<td>Improved mobility</td>
</tr>
<tr>
<td>Staying as well as you can</td>
<td>Responded to</td>
<td>Reduced symptoms</td>
</tr>
<tr>
<td>Living where you want/as you want</td>
<td>Reliability</td>
<td></td>
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<tr>
<td>Dealing with stigma/discrimination</td>
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The Future

Establishing which aspects of services and supports are contributing to attainment of which outcomes - and how

Identifying which outcomes are not being met for people

Informing service development, planning and commissioning

Informing local and national policy, strategy and contracts