joint improvement team

creativity, collaboration and continuous improvement

The Frail Older Person
A Challenge To Health Services

Dr Anne Hendry

National Clinical Lead for Integrated Care

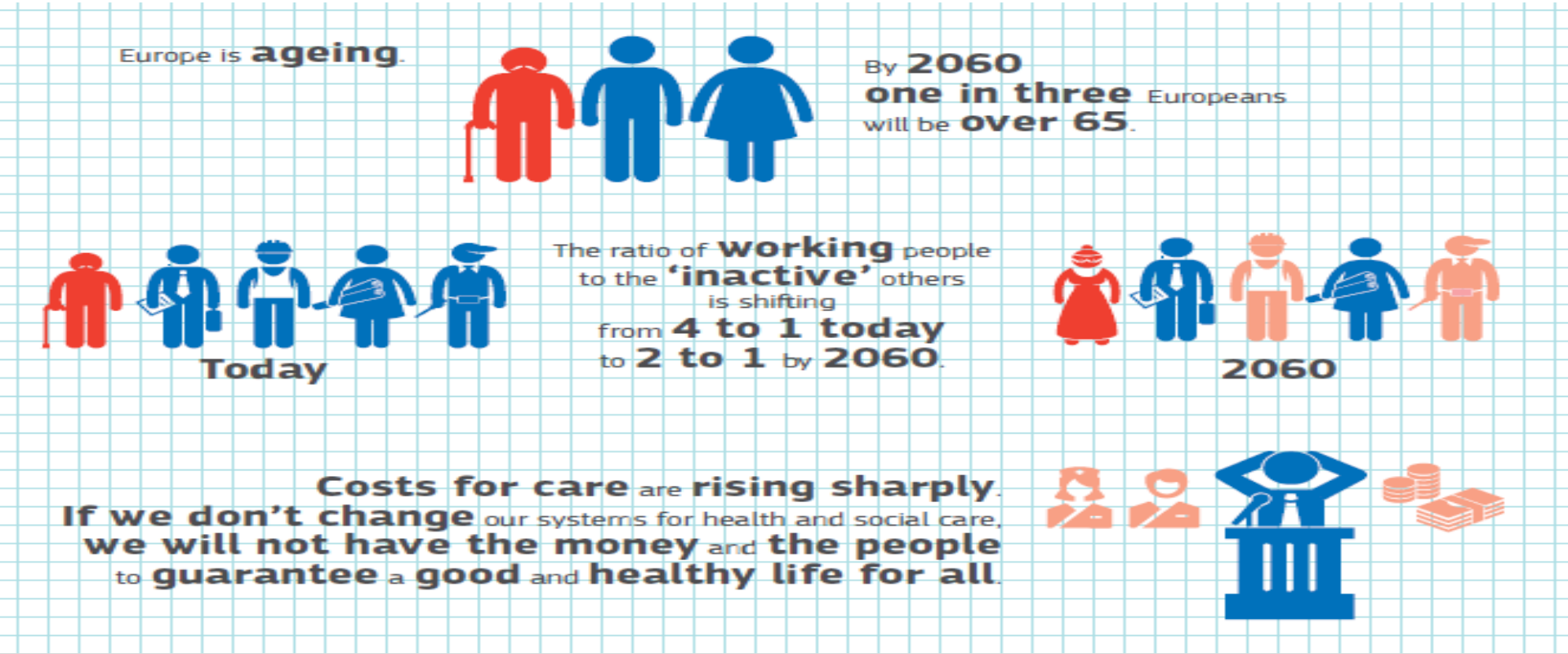
JIT is a strategic improvement partnership between the Scottish Government, NHSScotland, COSLA and the Third, Independent and Housing Sectors

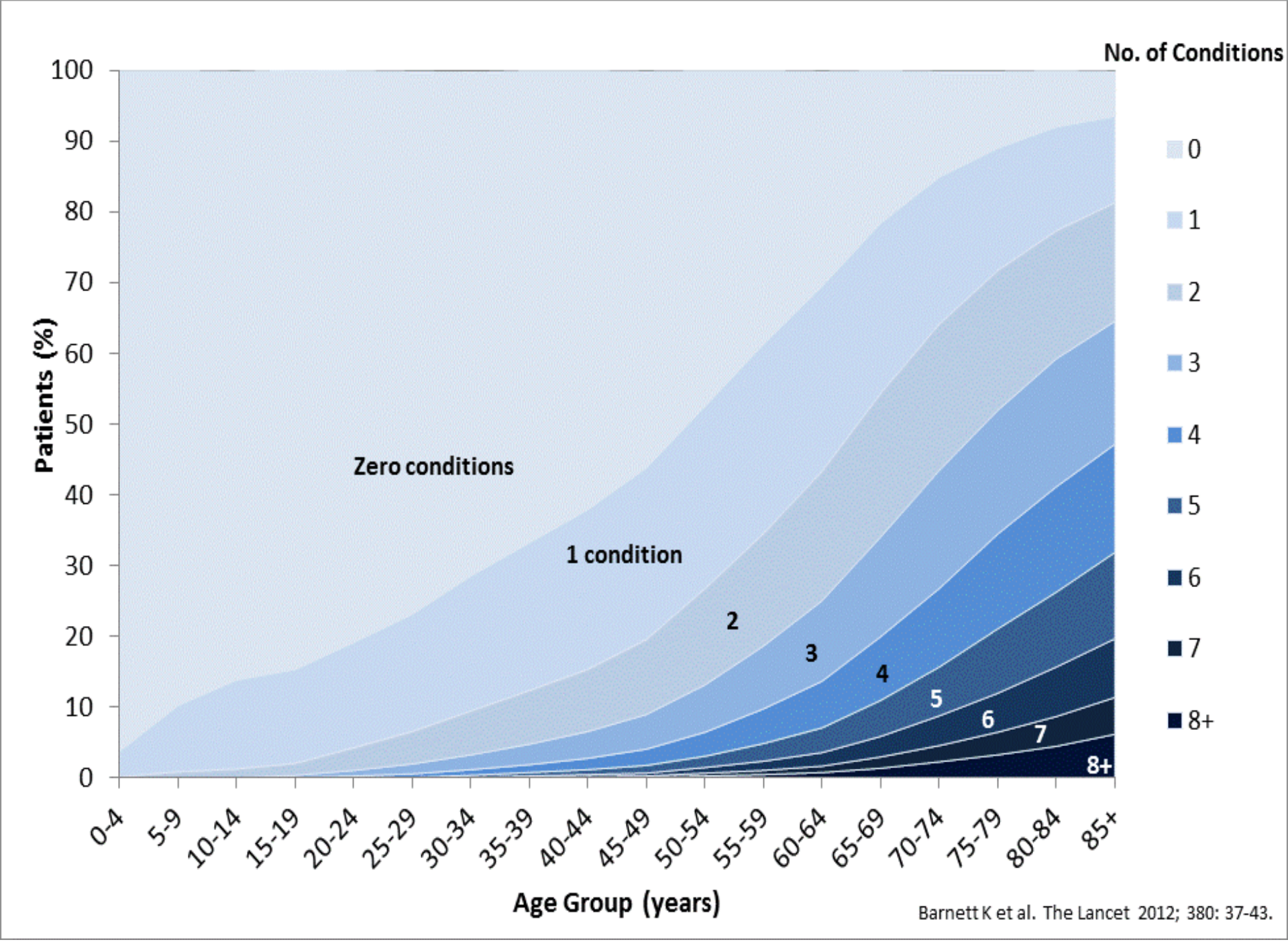
joint improvement team
creativity, collaboration and continuous improvement

Global Challenge

By 2018, 10% of the global population will be over 65

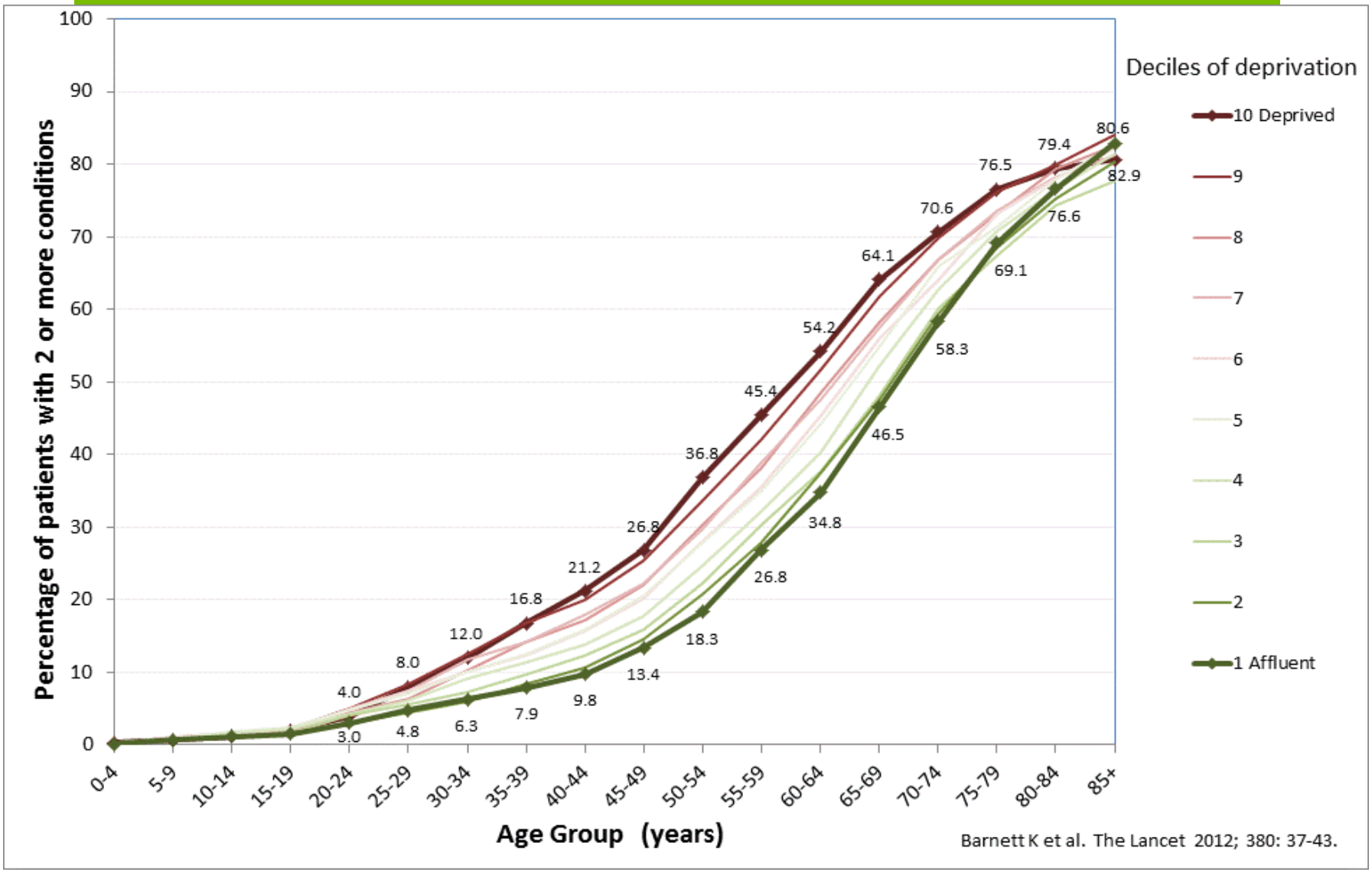
- 1 in 4 Japanese
- 1 in 5 Western Europeans





Barnett K et al. The Lancet 2012; 380: 37-43.

People living in more deprived areas develop multiple conditions around 10 years before those living in the most affluent areas



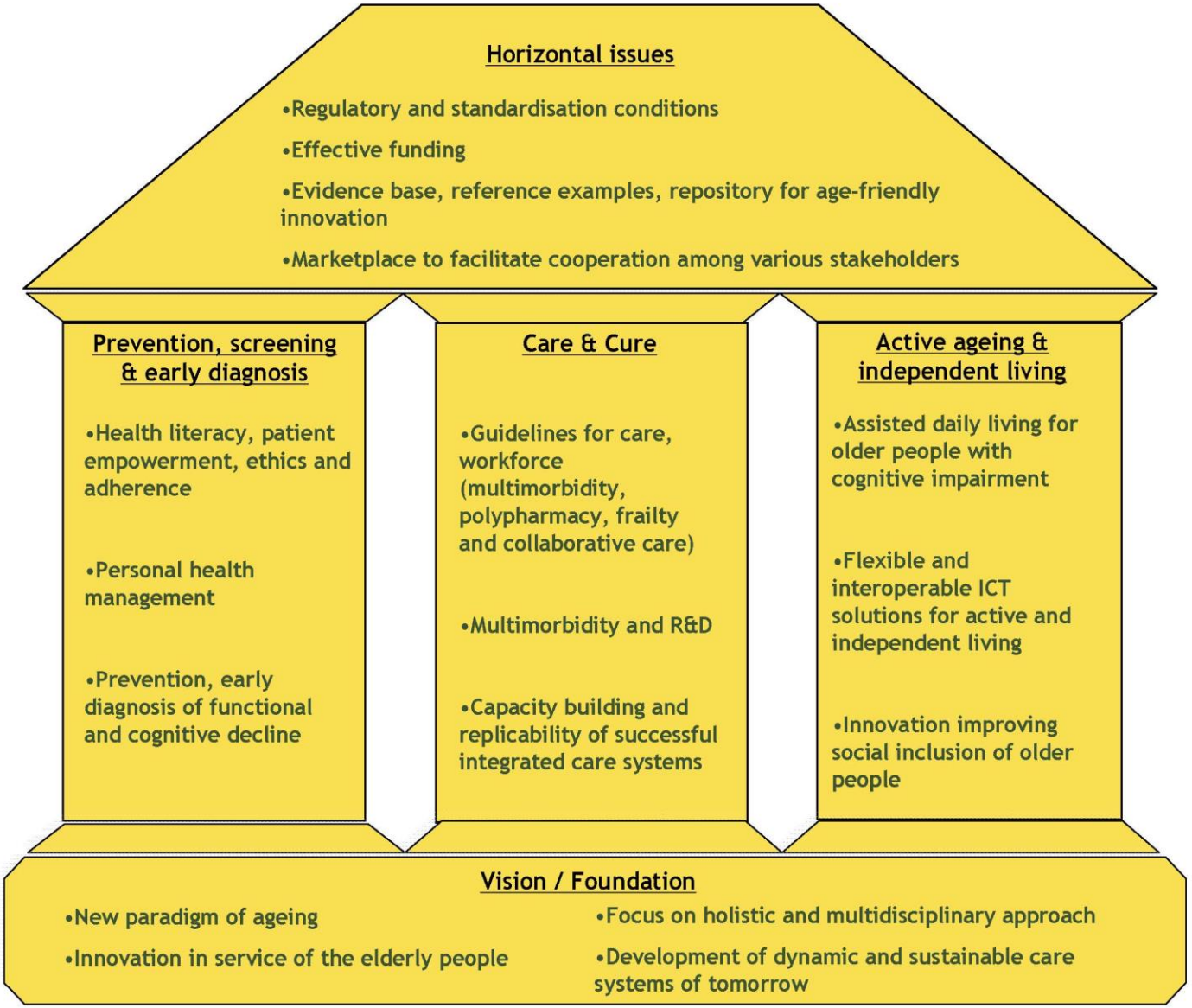
Barnett K et al. The Lancet 2012; 380: 37-43.

EIP AHA Objectives

- Increase by 2 the average number of healthy life years in the European Union by 2020

- Use innovation (technology, care process and social innovation) to achieve a Triple Win:
  - improve health and quality of life of older European citizens
  - support sustainability and efficiency of health and care
  - enhance competitiveness and business foundation for SMEs

Strategic Framework of the EIP on AHA



Frailty

Health state related to the ageing process.
Multiple body systems lose their in-built reserves.
Unpredictable deterioration from minor stressors.

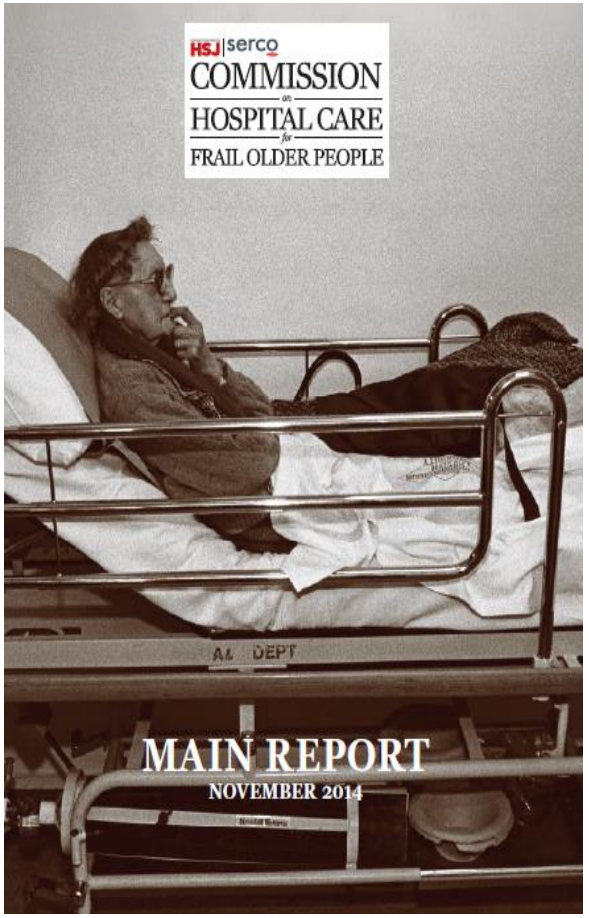
Frailty syndromes

- **Falls**
- **Immobility**
- **Delirium**
- **Incontinence**
- **Susceptibility to medication**

Increased risk of disability, dependency and death

Increased demand for

- **GP and acute care**
- **Long term care and social support**



Scale and cost of Falls

In people 65 years and over:

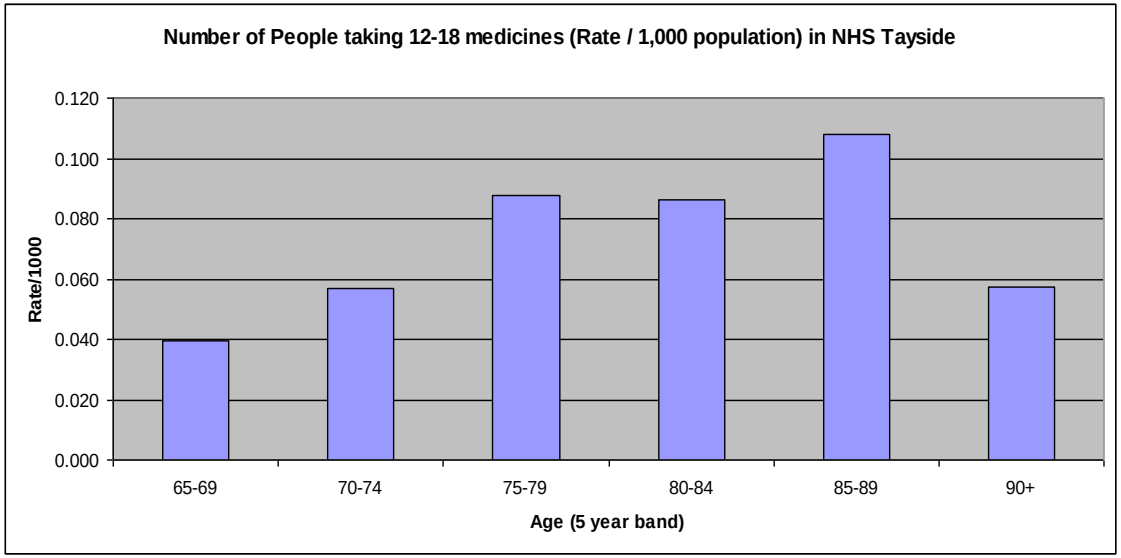
- Largest single presentation to the **Ambulance Service**
- Leading cause of **Emergency Department attendance.**
- Responsible for over **390,000 emergency bed days.**
- Implicated in up to **40% care home admissions.**

Hip Fracture costs to health and social care services in Scotland estimated to exceed **£471m each year (rising to £666m by 2020):**

– 45% long term care
– 40% NHS
– 15% care at home

(**£39,500 per hip fracture)** ***(Craig 2012)***

Polypharmacy



- Estimated risk of adverse drug reactions :
  - * 6% on 2 medications
  - * 50% on 5 medications
  - * 100% on 8 or more ***(Larsen & Martin, 1999)***
- 16% of older people use one or more potentially inappropriate medications ***(Howard et al 2004)***
- Rate of medicine-related hospital admission is 5-30% in older people

Delirium

- Present in around 120 patients per 1000 hospital beds
- Only around 20 – 25% are detected
- Generally poorly managed

- Distressing for patients, carers and professionals
- Marker and accelerator for dementia
- 1 in 5 mortality at one month
- High rates of long term care
- High health and social care costs

Rockwood – Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 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.

5 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.

6 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.

7 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).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

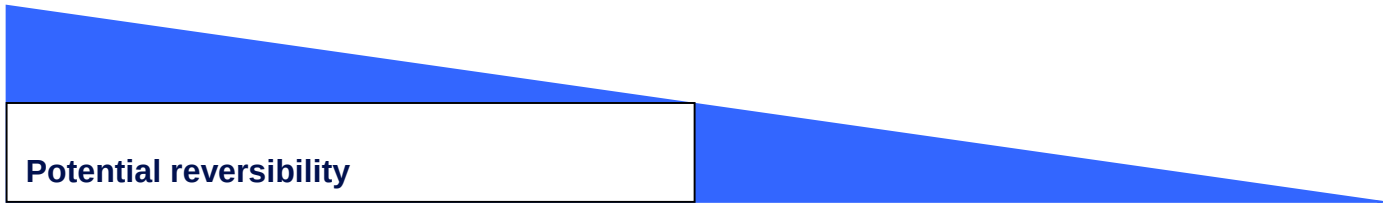
The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

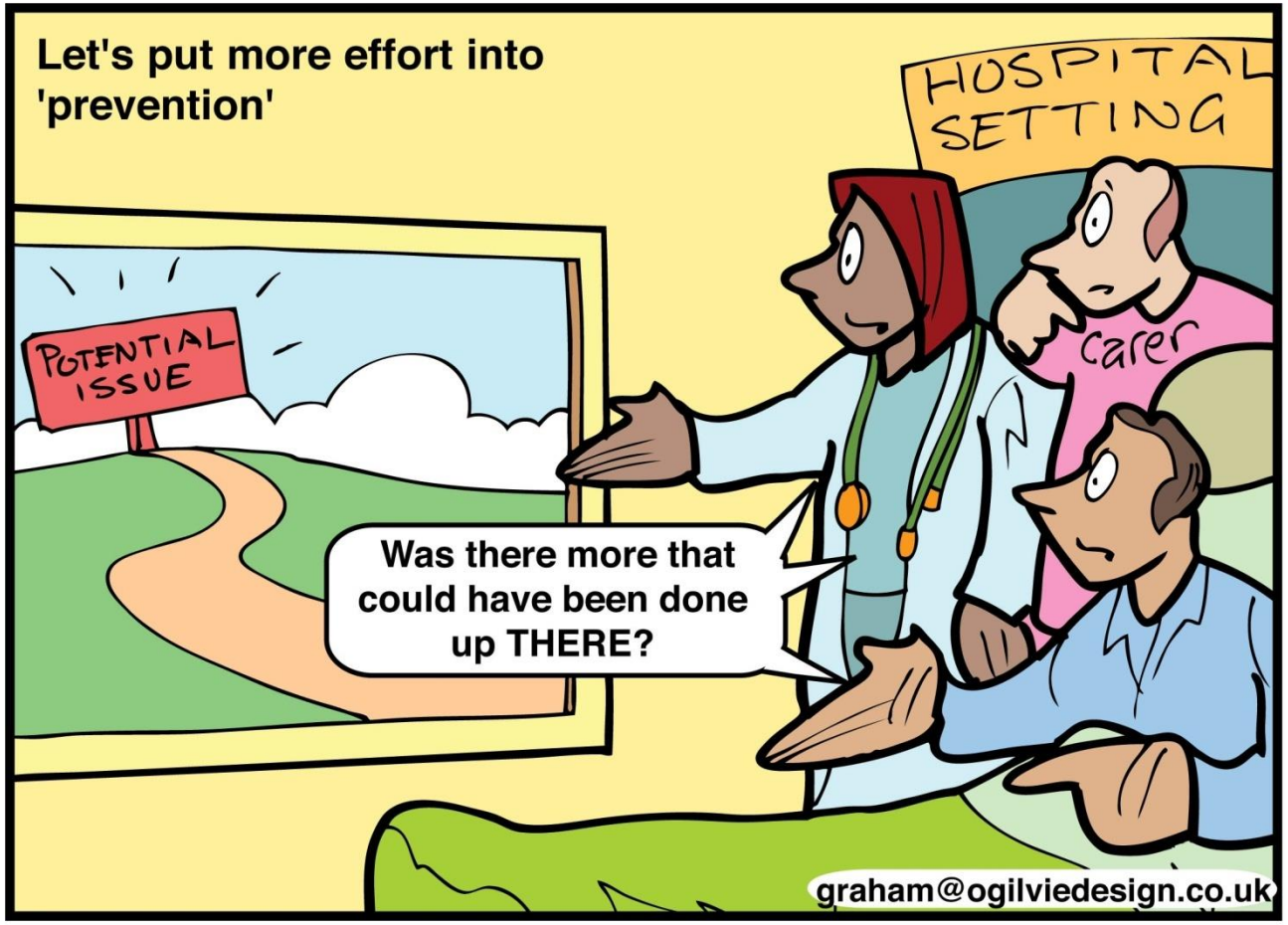
Frailty as a dynamic functional state

Robust	Frail	Functional Limitation	Disability	Dependency
				



joint improvement team
creativity, collaboration and continuous improvement

Anticipatory Care
Early Intervention



Evidence base – Falls

Evidence base

Multifactorial assessment and targeted intervention

24% (14 - 47%) reduction in falls

Exercise only:

32% (18 - 42%) reduction in falls

From:

Cochrane Review: Interventions for preventing falls in older people living in the community, Gillespie et al, 2012

Comprehensive Geriatric Assessment
G Ellis – Cochrane review

For every 100 patients treated...	Ward	Team
Age criteria alone...	-4* (NNT 25)	+7
Needs based criteria...	-16* (NNT 6)	+1

*p<0.05

BMJ

BMJ 2011;343:d6799 doi: 10.1136/bmj.d6799

EDITORIALS

Comprehensive geriatric assessment for older adults

Should be standard practice, according to a wealth of evidence

Andreas E Stuck *professor of geriatrics*[1], Steve Iliffe *professor of primary care for older people*[2]

Table 1| **Selected comprehensive geriatric assessment based programmes with favourable effects according to results of systematic analyses or individual randomised controlled trials**

Setting	Patient group	Programme description
Hospital[2]	Patients at acute care hospital admission	Acute care for the elderly unit[4]*
	Patients staying in acute care hospital selected for subsequent subacute care	Inpatient geriatric rehabilitation; orthopaedic geriatric rehabilitation[3]*
Ambulatory	Patients admitted to emergency department	Short assessment in emergency department[5]†
	Patients with chronic conditions	Interdisciplinary primary care models; outpatient assessment and geriatric evaluation and management programmes; proactive ambulatory rehabilitation programmes[6]*
	Patients in end of life situation	Palliative care programmes[6]†
	Older non-disabled people living in the community	Preventive home visits[7]*; health risk appraisal for older people[8]†

*Favourable effects according to results of systematic analysis.

†Favourable effects according to randomised controlled trials.

Innovations in Integrated Care in Europe and Around the World

The King's Fund HSPRN

Authors
Nick Goodwin
Anna Dixon
Geoff Anderson
Walter Wodchis

January 2014

Providing integrated care for older people with complex needs

Lessons from seven international case studies

Key messages

- Integrated care is a process that must be led, managed and nurtured over time. Initiatives often have to navigate and overcome existing organisational and funding silos.
- There is no single organisational model or approach that best supports integrated care. The starting point should be a clinical/service model designed to improve care for people, not an organisational model with a pre-determined design.
- Fully integrated organisations are not the end (goal).
- Greater use of ICT is potentially an important enabler of integrated care but is not a necessary condition.
- Professionals need to work together in multidisciplinary teams (with clearly defined roles) or provider networks – generalists and specialists, in health and social care. However, patients with complex needs that span health and social care may require an intensity of support that goes beyond what primary care physicians can deliver.
- Important service-level design elements of care for older people with chronic and multiple conditions include holistic care assessments, care planning, a single point of entry, and care co-ordination.
- Success is more likely where there is a specific focus on working with individuals and informal carers to support self-management.
- Personal contact with a named care co-ordinator and/or case manager is more effective than remote monitoring or telephone-based support.

Seven Key Lessons (Goodwin, 2015)

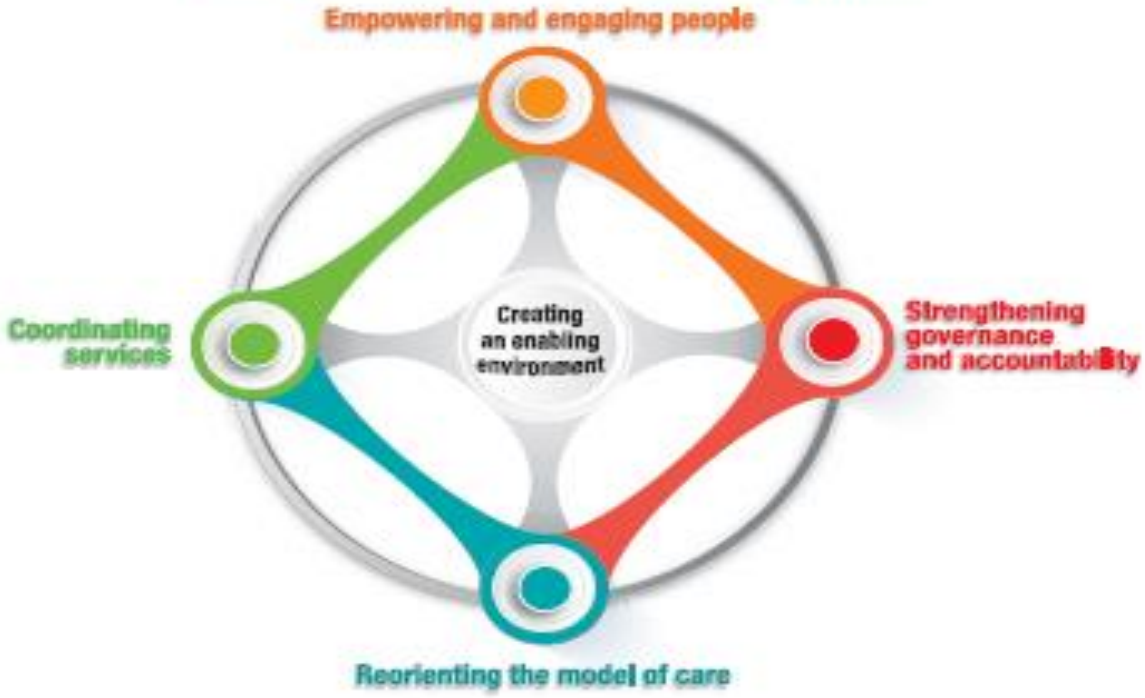
Theme	Characteristics
1 Population-health management	The ability to have an in-depth understanding of the health needs of communities supported through data that can provide intelligence on the priorities that should be addressed
2 Primary and secondary prevention	The ability to support people to live better with their conditions, for example through educational programmes or self-care support
3 Personalised care co-ordination	The ability to plan and co-ordinate services effectively around people's needs helps to overcome fragmentations and improve care experiences ad outcomes
4 Effective ICT systems	Care professionals must be able to communicate well with each other and people must be able to interact effectively with care providers in a way that supports shared decision-making.
5 Integrated delivery system	Care systems need to be responsive to people's needs, especially during times of crisis. The inability of provider networks to respond in real-time means that care co-ordination efforts are undermined.
6 Building social capital and collaborative capacity	Promoting shared values and understanding can help provide the necessary commitment to take integrated care forward.
7 Research and evaluation	Measuring, monitoring and responding to evidence to judge or benchmark care quality and outcomes is essential to improving quality of care through integration

Towards people-centred and integrated health services

World Health Organization | Service Delivery and Safety

WHO/HIS/SDS/2015.8

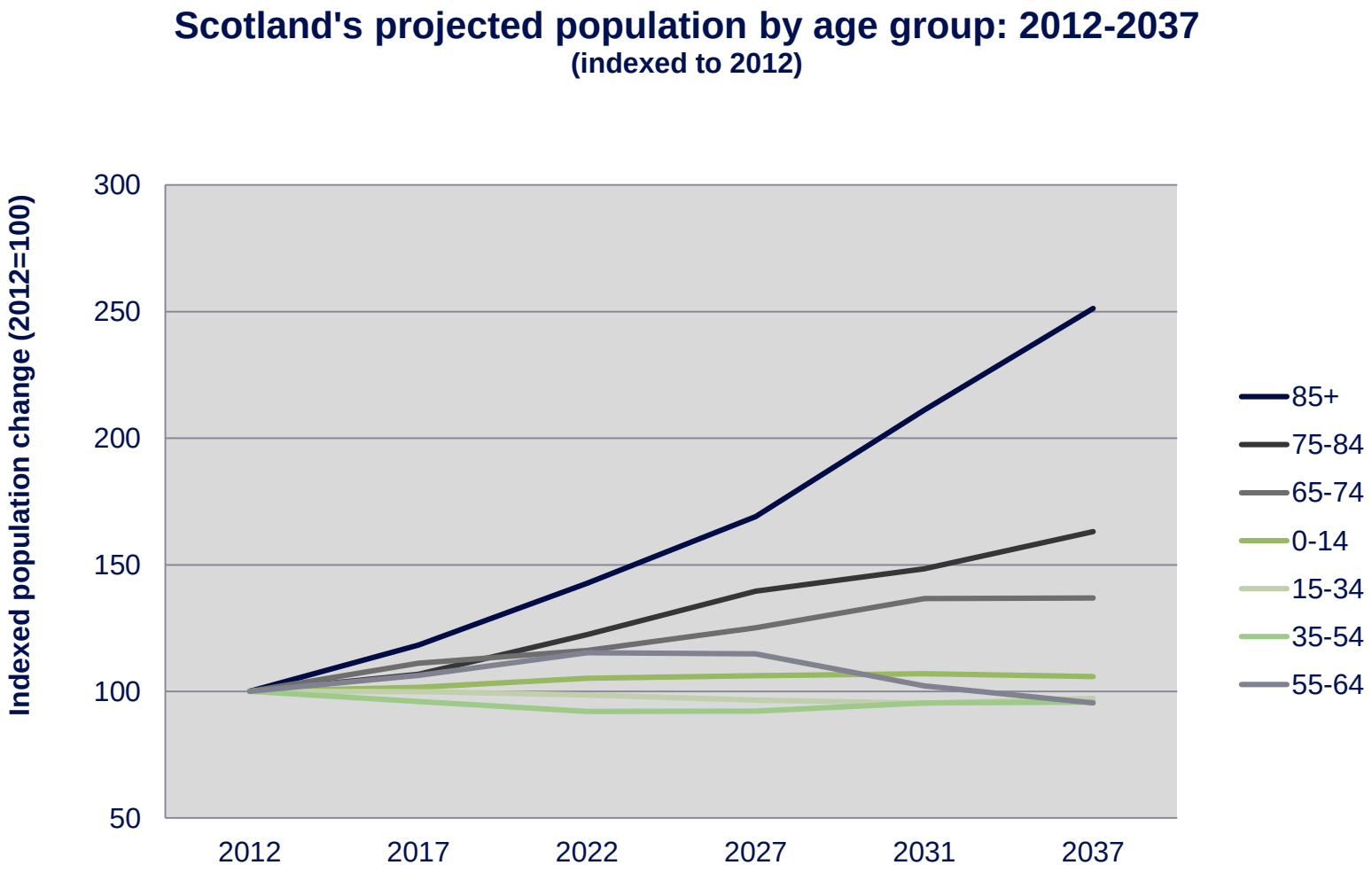
The interdependency of the five strategic directions to support people-centred and integrated health services



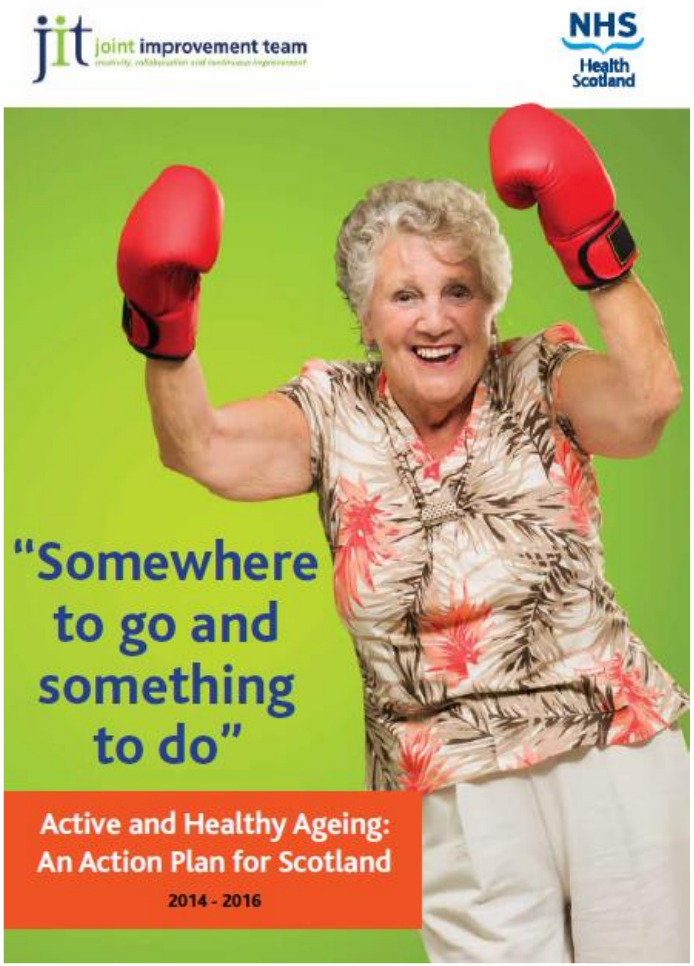
Population 5.4 million

- **@ £12 billion budget**
- **14 Health Boards**
- **32 Local Government Authorities**
- **Integrated healthcare delivery system**
- **Universal coverage**
- **Free personal care for 65+**
- **New legislation to integrate health and social care**

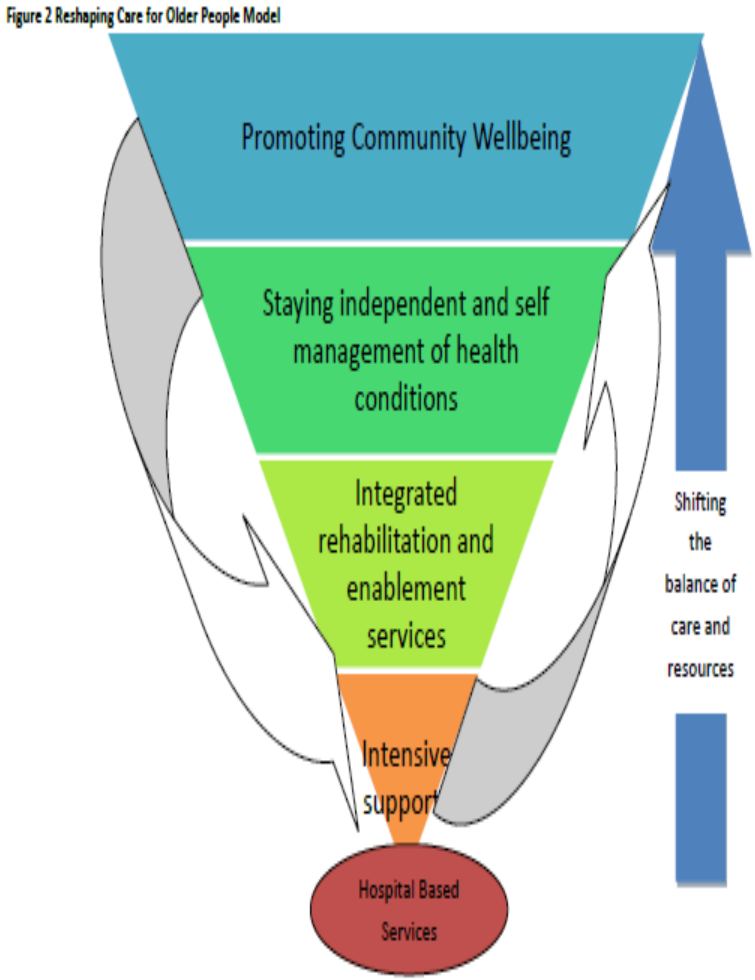
Projected % change in Scotland's population by age group, 2012-2037



Active and Healthy Ageing



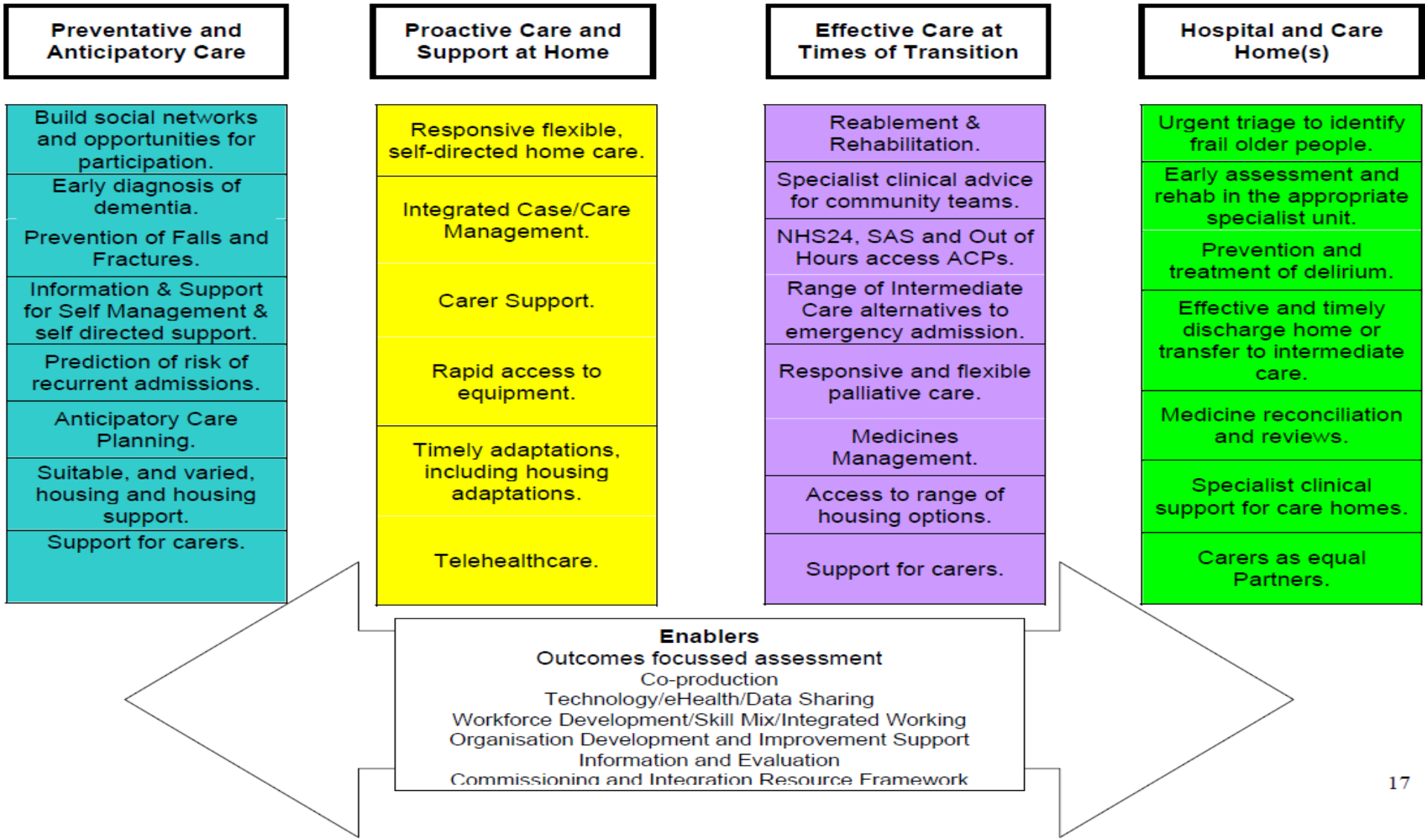
- "I want to have fun and enjoy myself"
- "I wish to remain connected to my community and friends"
- "Don't talk about me without me"
- "I wish to be able to contribute to society for as long as I want and to be treated with respect"



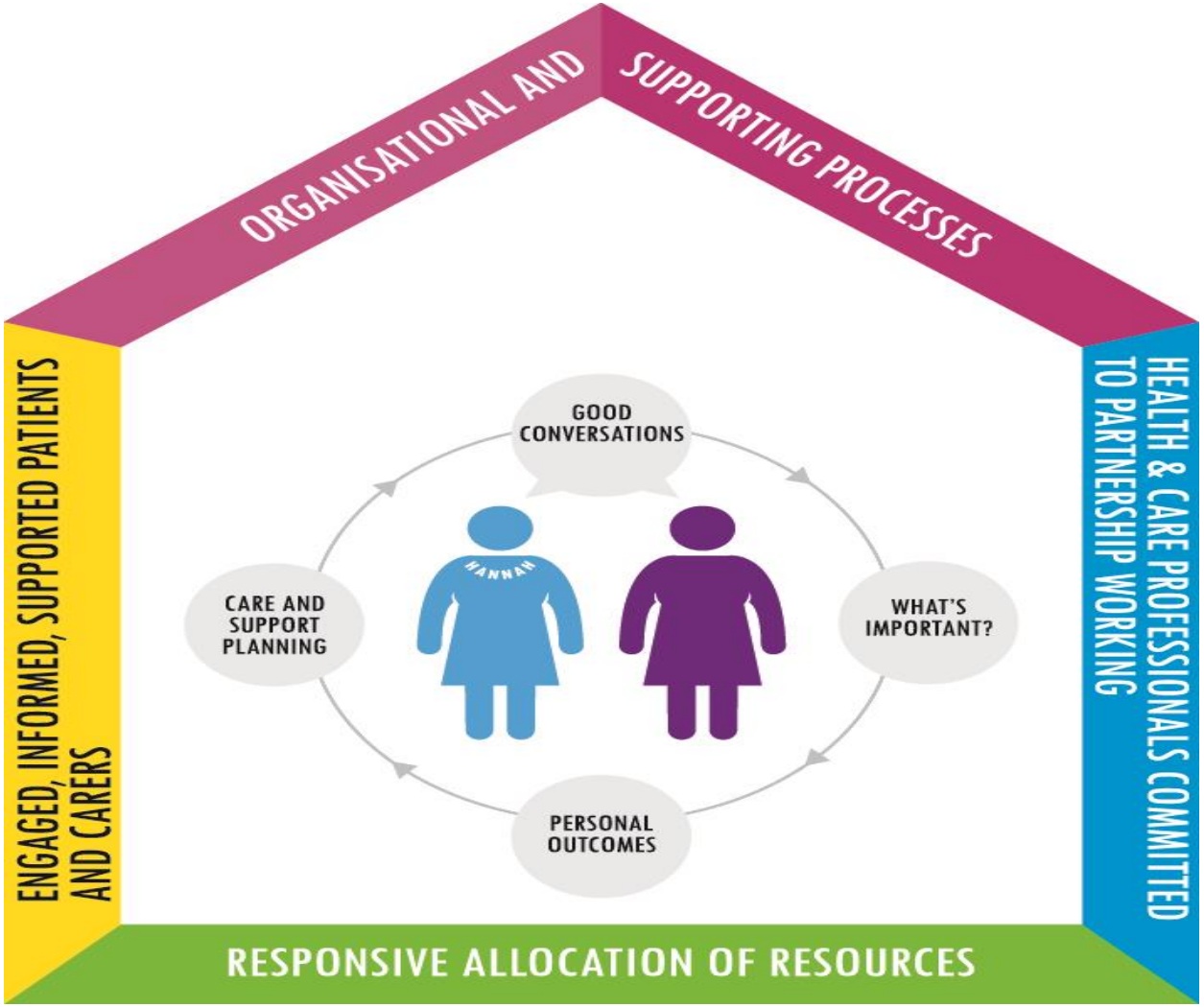
Reshaping Care for Older People

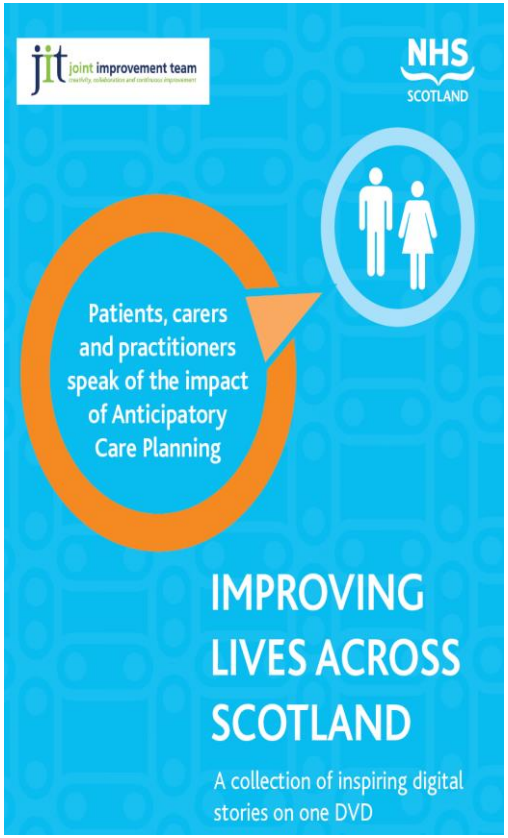
- 10 Year Programme to 2021
- £ 300 million Change Fund 2011-15
- 32 Partnerships between
  NHS: primary, acute, mental health
  LA: social care & housing
  Third and Independent sectors
  Older people and carers
- Change Plans signed off by all partners
- 20% of funding to be invested in direct or indirect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

Reshaping Care Pathway



Innovation in General Practice: House of Care



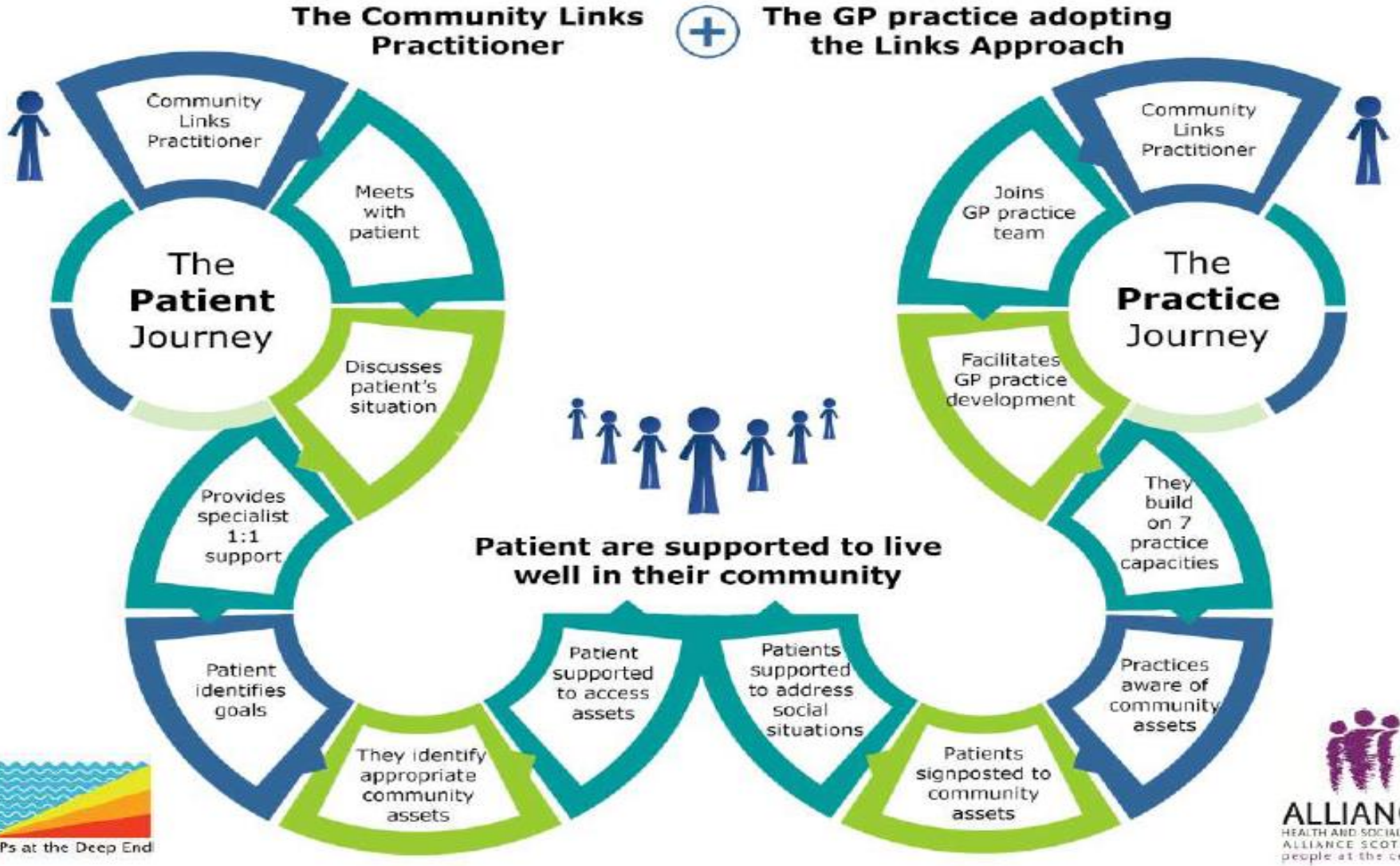


10 Anticipatory Care Interventions

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

Community Connectors



GPs at the Deep End

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

Intermediate Care

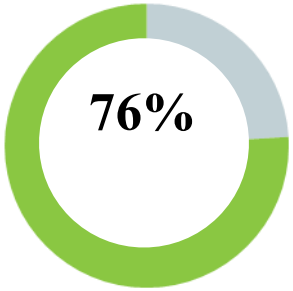
- **Rapid Response / Early Supported Discharge**
- **Reablement Homecare**
- **Step Up / Step Down community beds**
- **Hospital at Home**

North Lanarkshire

HOSPITAL AT HOME

Patients accepted by ASSET in 29 Months

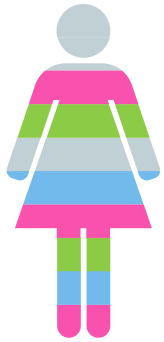
2,864



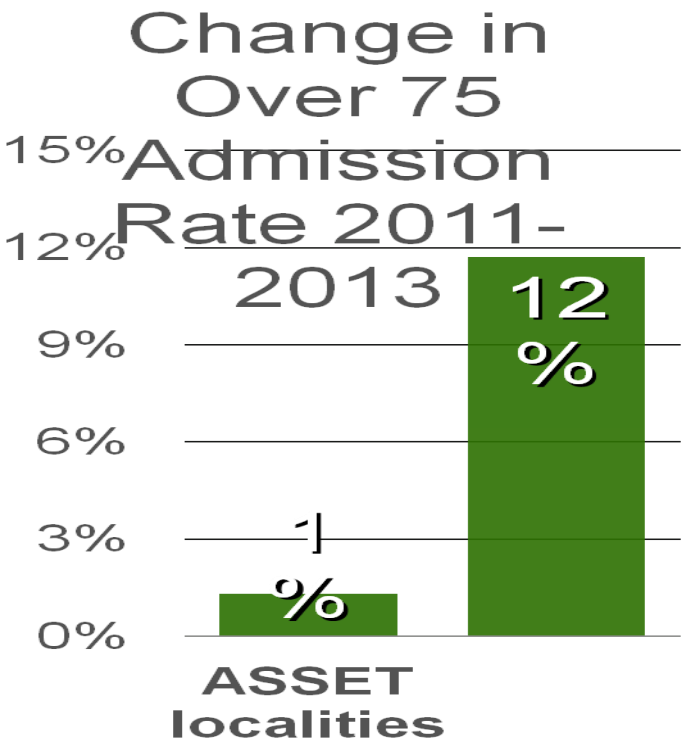
Supported at Home

76% are managed in their own home instead of Hospital by the ASSET team

Length of Stay



5.6 / Day



Beds Closed 50

Value £2Million+

Improving Care for Older People in Acute Care
Think Frailty Driver Diagram

Aim	Primary Drivers	Secondary
To improve the early identification of frailty and ensure that older people who are identified as frail have access to comprehensive geriatric assessment or are admitted to a specialist unit within a day of admission to hospital, by March 2014.	**Identification of Frailty**	**Screening of admission to id** • Apply the 'Think Frailty Tri screening tool on all older identify those who are fra • Promote the use of patien improve care • Ensure patient requireme the care plan
	Care pathway	**Care Pathways** • Ensure inpatients identifie specialist comprehensive • Optimise efficiencies in fl • Create a culture that invo care
	Education, leadership and culture	• Develop an infrastructure 'frailty triage tool' using in • Align work with other rele wider older people's impr centred health and care, • Optimise opportunities fo • Optimise opportunities to practice • Clinical Leadership • Develop measurement fra improvement • Ensure reliable communic at risk patients

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:

- need to stay longer in hospital or in critical care
- 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, and
- be more likely to die. (NICE, 2011)

Recognising delirium

Sudden onset of:

- reduced mobility and appetite, withdrawal (hypoactive delirium)
- alterations in usual mood, communication or attitude
- 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:

- treat this as a medical emergency
- assess for delirium using a locally agreed tool, such as 4AT or CAM-S
- 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 patient 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?"

39%

CHANGE FUND
SPEND 2014/15
SUPPORTED
CARERS

2
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 4 YEARS

1300
PER DAY

FEWER PEOPLE
AGED 65+ IN HOSPITAL
BEDS
THAN 'EXPECTED'

IN RECEIPT OF
FORMAL CARE AT
HOME
HAVE TELECARE

4000
PER DAY

FEWER PEOPLE
IN CARE HOMES
THAN 'EXPECTED'

19%
FEWER

PEOPLE DELAYED
IN HOSPITAL
OVER 2 WEEKS

Building effective relationships and creating local integrated networks of care and support

Health and Social Care Integration

The Scottish Government
Riaghaltas na h-Alba

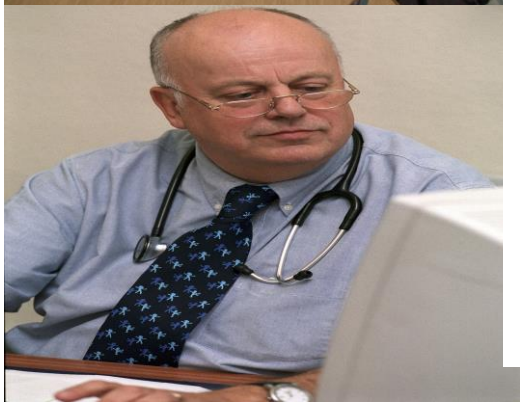
Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

- www.scotland.gov.uk/HSCI
- follow us on twitter @scotgovIRC

There's no ward like home




Technology Enabled Primary Care - Right First Time, All the Time


An Integrated System for Frailty

- Sustainable approach to screening in those at risk
- Identification of new or escalating functional decline
- Early interventions – eg CGA and rehabilitation to reverse functional decline, particularly at times of transition in care settings when high risk of disability
- Case management with anticipatory, coordinated and integrated interdisciplinary care
- Evaluation of outcomes and impact of models of care

International Foundation on Integrated Care

joint improvement team
creativity, collaboration and continuous improvement

http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration

http://www.jitscotland.org.uk/resource/reshaping-care-for-older-people-change-fund-building-on-progress-june-2015/

http://www.knowledge.scot.nhs.uk/chin/intermediate-care.aspx

www.jitscotland.org

anne.hendry@scotland.gsi.gov.uk

@jitscotland