Our Vision - Older and Better - Living longer, living better

Older people in Scotland are valued as an asset, their voice is heard and all older people are supported to enjoy full and positive lives.

The Outcomes we want to see

Older people and their carers get the information, advice, services and support they need to help them stay well; to live as they want; to feel safe; to have meaningful activities and opportunities to meet and support each other.

Our Priorities – how we will make this a reality

- Promote across the whole system an ethos that is holistic and person centred; anticipatory and outcomes focused; supports people to self manage and enables greater independence and control
- Support the vital role of unpaid carers
- Build capability and resilience of community and voluntary sector partners
- Provide flexible and sustainable models of health, housing and social care that enable and support more people to live at home
- Develop care homes to have a greater role in rehabilitation
- Implement a Frailty pathway to improve quality and outcomes and support older people with multiple and complex care needs to remain at home

Our Recommendations - what we need to do to make an impact

Community capacity building

Models of housing, care and support at home

Future role and opportunities for care homes

Frailty Pathway

1. Proactive anticipatory care approaches

1.1 Systematic use of risk prediction tools to identify frail older people
1.2 Proactive integrated care management approach for those at greatest risk
1.3 Widespread use and sharing of anticipatory care plans

2. Effective care at times of transition

2.1 Safe, effective community based assesment/ rehabilitation/ intermediate care
2.2 Triage / rapid assessment of older emergency admissions / A&E attenders
2.3 Pharmaceutical care for older people

3. Interventions that maximise potential for return home from hospital

3.1 Comprehensive geriatric assessment and rehabilitation in hospital
3.2 Early identification and effective management of delirium

3.3 Proactive discharge planning involving all partners

1.1 Health and social care staff identify older people who are frail and at greatest risk of emergency admission to hospital or institutional care.

1.2 CH(C)P health and social care teams deliver a proactive integrated care management approach that targets frail older people with complex needs at greatest risk of emergency admission to hospital or institutional care

1.3 Care providers in CH(C)Ps support the use and sharing of Anticipatory Care Plans (ACPs): a summary or shared record of preferred actions, interventions and responses that care providers should make following a clinical deterioration or crisis in the person's care or support.

2.1 The CH(C)P provides a range of Intermediate care services that act as a bridge at key points of transition in the journey from home to hospital and back home again, and from illness to recovery. These services include rapid access to safe and effective alternatives to hospital admission.

2.2 Pathways through A&E and admissions wards are configured to identify frail older people with physical, functional and cognitive impairments and stream them to geriatric assessment within 24 hours of admission.

2.3 The CH(C)P, working with local GPs and community pharmacists, ensures regular review and reconciliation of medicines prescribed for frail older people and development of personalised pharmaceutical care plans that support them to take their medication safely.

3.1 Frail older people admitted to hospital receive co-ordinated multi-professional Comprehensive Geriatric Assessment and rehabilitation.

3.2 Pathways through acute hospitals are configured to deliver bundles of care that prevent, detect and effectively manage delirium.

3.3 Health, social care and independent providers together eradicate

delayed discharges, including delays in short stay specialty beds.

Implementation and Improvement support – how we will deliver this

1. Engagement and Consensus Building

Adopt a community development approach to local and national engagement that frames the vision in a positive light and in the language of outcomes for older people.

At the same time, build local and national consensus through co-production principles grounded in the values of mutuality, quality, outcomes and best value.

Create, across Scotland, a social movement that unleashes the potential of the workforce to live these values.

2. Establish a national Programme Board

To oversee the engagement and consensus building, promote congruence with national quality and community care outcomes policies and harnesss the synergy from related programmes such as Long Term Conditions, Dementia Strategy, Carers Strategy, Rehabilitation Framework, Delayed Discharge, Intermediate Care and Telecare programme.

Develop an action plan and delivery framework for monitoring the implementation of the recommendations in each partnership.

3. Progress integration where there is a collaborative advantage

Promote horizontal, vertical and virtual integration as best fits the local partnership context. This may range from full integration of CH(C)P structures, services and budgets to alignment / pooled budgets for specified services.

Across Scotland there is a growing appetite for fully integrated and singly managed services for Intermediate care that manage frailty and transitions at the interface between hospital and community, including community rehabilitation, falls prevention and specialist health support to care homes. In some partnerships this integration may extend to telehealthcare support.

4. Align financial / contractual levers.

Although limited potential at the level of an individual practice, there is an opportunity to align levers at a locality / sub CH(C)P level. An option may be to

realign existing enhanced services (SESP) as strategic bundles to support primary and community care teams to implement key recommendations

5. Leadership

National – support strategic leadership roles to drive the pace of implementation of the programme and its components.

Local – Establish, in each NHS Board area, a Managed Care Network for older people with distributed multi-professional and multi-agency local leadership to provide momentum and drive.

Each MCaN will be tasked with delivering a whole system approach to service improvement, quality, education and practice development :

- Better efficiency and productivity through reduced waste and tackling variance
- Redesigned proactive, co-ordinated team based care across sectors
- A framework for an integrated managed service for Intermediate care and specialist community based support
- Quality assurance– feedback on suite of local and national quality indicators
- Ongoing engagement with frail older people, carers and voluntary services
- Multi-professional and multi-agency leadership for service improvement
- Learning and practice development support for staff, service users and carers

6. Identify, test and spread ehealth and telehealthcare solutions

Hold an action focused event in spring of 2010 for partnership operational and clinical leads for LTC and older people. Involve NHS 24, SCT and JIT Telcare programme, ehealth and ecare programmes. Aim is to share what works, identify barriers and what development bursts are required to enable the system to support older people to be independent and remain at home.

Through this event develop an action plan, milestones and performance indicators for adoption and spread of the technological solutions.

7. Workforce

Promote a social movement that cocreates the culture and behaviours that are holistic and person centred; anticipatory and outcomes focused; supports people to self manage and enables greater independence and control

Hold an OD / HR event in spring / summer of 2010 in partnership with Delivering through People to share solutions and spread innovative approaches that

- Build workforce capability by skill mix, joint working and joint training

- Lever, through job planning, additional capacity for mentoring, support and outreach into the community of specialists across the pathway