Moving **Forward** Together.

Older People's Care

Workstream Overview

What is the Older People's Care Workstream

Older People's Care is described under Moving Forward Together as:

The range of services that combined provide treatment and care for the older population – often those with multiple conditions, complex needs such as dementia, or the frail elderly – delivered in people's homes, communities and in hospital settings

The Older People's Workstream will look at new ways of working to link hospital and community services and deliver more care in or closer to people's homes. We will focus on early intervention and identifying opportunities support people to live well at home or in a homely setting independently and connected to their community.

What are our priorities

The Older People's Care Workstream is going to initially focus on these areas to transform health and social are services:

1. **Maximising intensive community support** and testing new models of care such as consultant geriatricians outreach into communities and the use of frailty practitioners to provide more care in peoples homes or care homes

2. **Early identification and Prevention of Frailty** by developing a set of tools to identify risk much earlier to support independence, prevent avoidable hospital admissions and promote community based care

3. **Develop a dementia framework** that examines new approaches to care as alternatives to inpatient hospital care with community based facilities and arrangements so that care can be delivered more locally

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Maximising Community Intensive Support

This project will look at how we can deliver services that were traditionally provided in acute hospitals in the community setting to deliver more care at home or in a homely setting

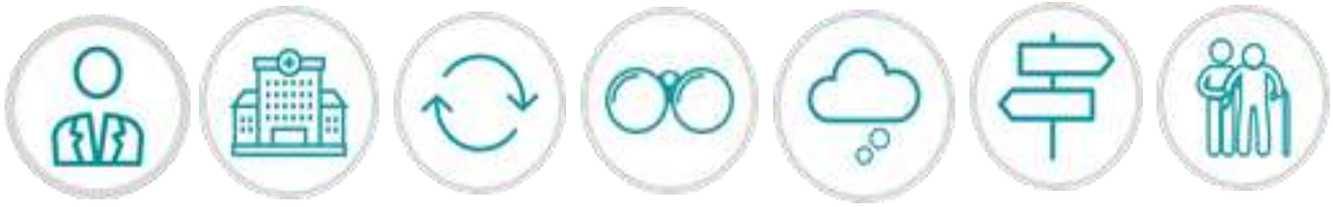
Based on the principles and concepts set out in Moving Forward Together we have identified the need for new ways of working to provide some components of acute hospital care in the community.

We will develop opportunities for some consultant geriatricians to spend more time supporting GPs, advanced practitioners and other teams to proactively provide treatment, care and rehabilitation to older people in their own homes, care homes or in supported accommodation as an alternative to hospital admission.

There are also initiatives to review and make better use of ‘day hospitals’ and improve how the range of community and hospital services interact with each other to support individuals and prevent hospital admission.

Example: Early identification and prevention of frailty

This project will develop an eFrailty tool alongside Health Improvement Scotland to help identify the likelihood of someone becoming frail and interventions prevent loss of independence



Based on the principles and concepts set out in Moving Forward Together and working with partners we have identified the need for an innovative digital solution to identify frailty and move away from a ‘treat and fix’ model to an anticipatory care model

I. Develop an ‘eFrailty’ tool to identify moderate frailty in community settings before people need acute hospital care

I. Promote interventions such as exercise classes and provide support to improve function, promote independence and improve wellbeing

What is frailty

Frailty is not an illness, but a syndrome brought about by the combined affects of ageing and long-term conditions. It leads to low resilience to physical and emotional crisis and functional loss leading to gradual dependence on care. People who are frail are more at risk of falls and even if still managing to live independently at home they can become isolated and disconnected from their community.

Identifying frailty

The eFrailty tool uses a range of information that GPs capture when people visit them to produce a score based on 36 ‘deficits’ such as medication that predicts someone’s risk of frailty. People need to interact with their GP to generate the information, but if they do we can Identify people with frailty before they become so frail that they depend on hospital and other support services, providing the opportunity for preventative interventions and maintaining independence.

Interventions to reduce frailty

We will look to use existing community services and work closely with community planning partners and the Third Sector. This might be as specific interventions by teams to look at home adaptations, medication reviews and management of disease. However, it could also include community-based exercise classes that specifically focus on improving strength and balance, but also might include other less structured social activities and clubs to get people out the house and more active whilst reducing isolation.

The benefits we expect to see

By using the **eFrailty tool** we will have population level screening that will help us identify some people at risk of becoming frail much sooner

- We can actively target people who are currently moderately frail and offer interventions to manage and reverse their frailty to:
  - Reduce hospital admissions and mortality associated with frailty e.g. prevention of falls and fractures
  - Support people to live independently at home and reduce the need for care at home or admission to care homes
- The interventions offered will also look to promote wider community participation to reduce levels of isolation
- Encourage whole system multidisciplinary team working across health and social care and with community planning and Third Sector partners

Tell us what you think

What are your thoughts about the 3 priority areas that we have initially chosen to transform Older People's Care?

What areas do you think we need to focus on to transform Older People's Care in the future?

Is there anything your organisation does to promote activity and reduce isolation in older people?

Any other feedback or comments