Improving co-ordination: Improving care

Supporting people with dementia in the community

Lynn Flannigan
Improvement Advisor
Focus on Dementia
ihub
Healthcare Improvement Scotland
Lynn.Flannigan@nhs.net
@lynnflannigan1

Enabling health and
social care improvement

Declaration of interests

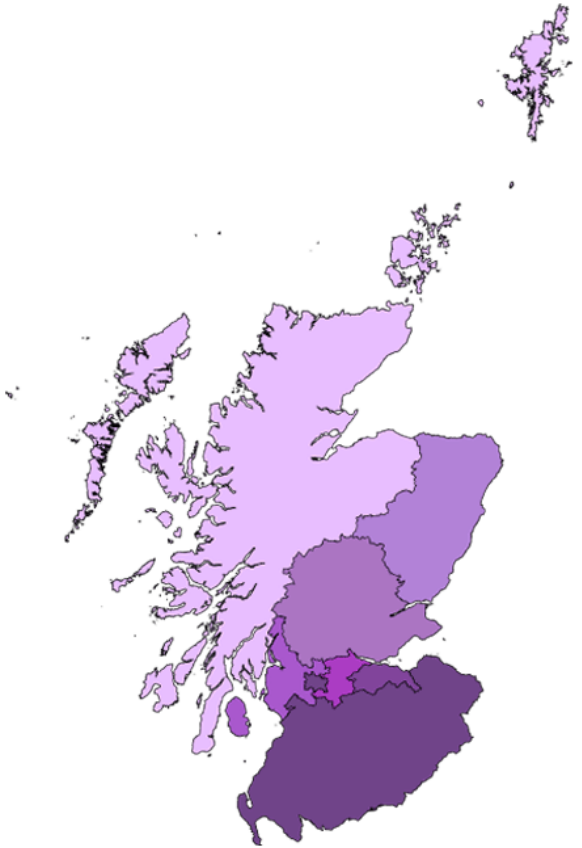
- I am employed by the NHS (Healthcare Improvement Scotland)
- The work we do is funded by the NHS and commissioned by the Scottish Government

Todays session

- Provide national dementia context
- Care co-ordination evidence base and approaches
- Focus on Dementia Portfolio
- Work, methodologies and key findings

Scottish Context for Dementia

- 5.2 million population
- 90,000 people with dementia
- 3,000 people under the age of 65
- Dementia priority since 2010
  Third dementia strategy



Scotland's National Dementia Strategies 2010-2020

National Dementia Strategy 2010

- 8 Actions
- Charter of Rights – PANEL Principles
- Diagnosis and post diagnostic support
- Improving care in general hospitals
- Standards of care
- A Skills and Knowledge Framework

National Dementia Strategy 2013

- 17 commitments
- Diagnosis and post diagnostic support – 5 Pillar Model
- Coordinated community care – 8 Pillar
- Acute care and other hospitals/NHS settings

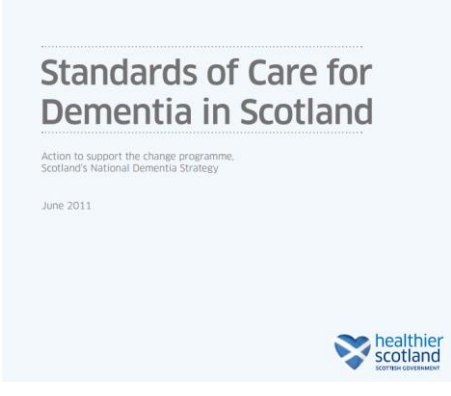
National Dementia Strategy 2017

- 21 Commitments
- Timely, skilled and well-coordinated support – diagnosis to end of life
- Consistently person-centred and flexible
- On-going system re-design
- Palliative and end of life care

A vision for dementia in Scotland

Our shared vision is of a Scotland where people with dementia and those who care for them have access to timely, skilled and well co-ordinated support from diagnosis to end of life which helps achieve the outcomes that matter to them.

Scottish Government, Dementia Strategy 2017-2020.

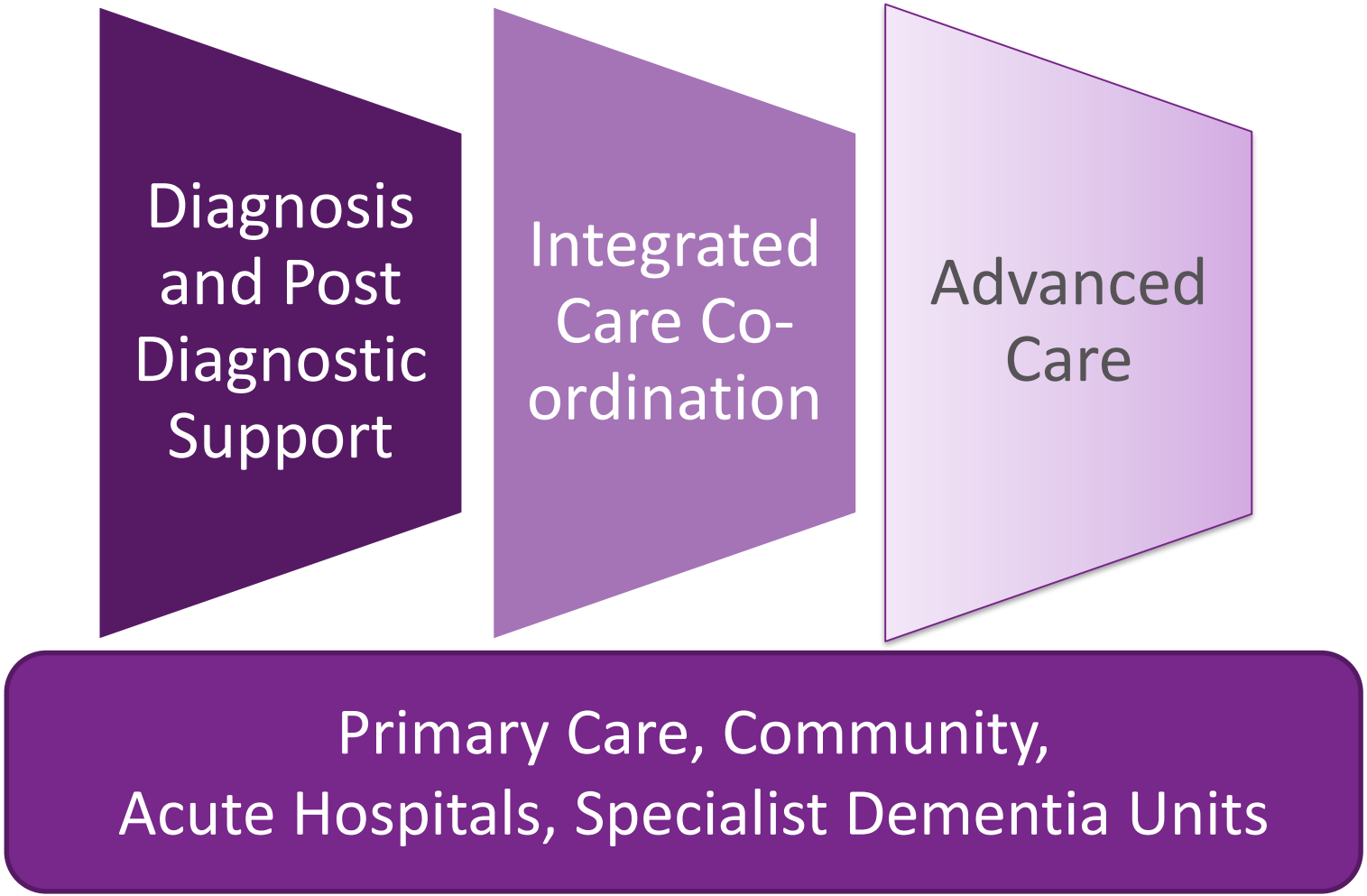


Healthcare Improvement Scotland

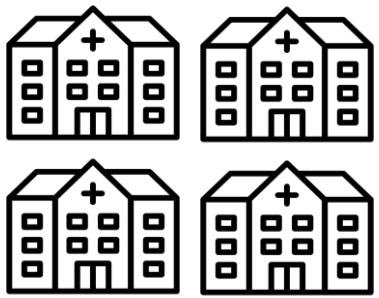
Focus on Dementia: Scotland's improvement programme for dementia

To Improve the quality and experience of care and support for people with dementia, staff and carers, supporting key commitments of Scotland's dementia strategy.

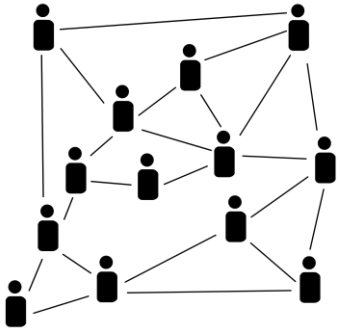
- Improving quality
- Improving access
- Improving knowledge , understanding and confidence to support people with dementia
- Improving experience


Diagnosis and Post Diagnostic Support
Integrated Care Co-ordination
Advanced Care
Primary Care, Community,
Acute Hospitals, Specialist Dementia Units

How we work



Demonstrator Sites



Learning and Improvement Networks

Toolkits and publications

Improvement approaches

Relational approaches/ technical approaches

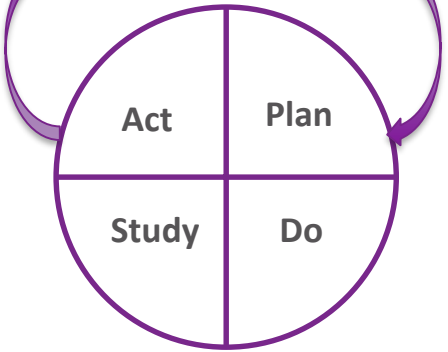
- Design
- Understand
- Person at the heart of what we do
- Implement
- Evaluate
- Embed/ sustain
- Evaluate and spread learning

Model for Improvement

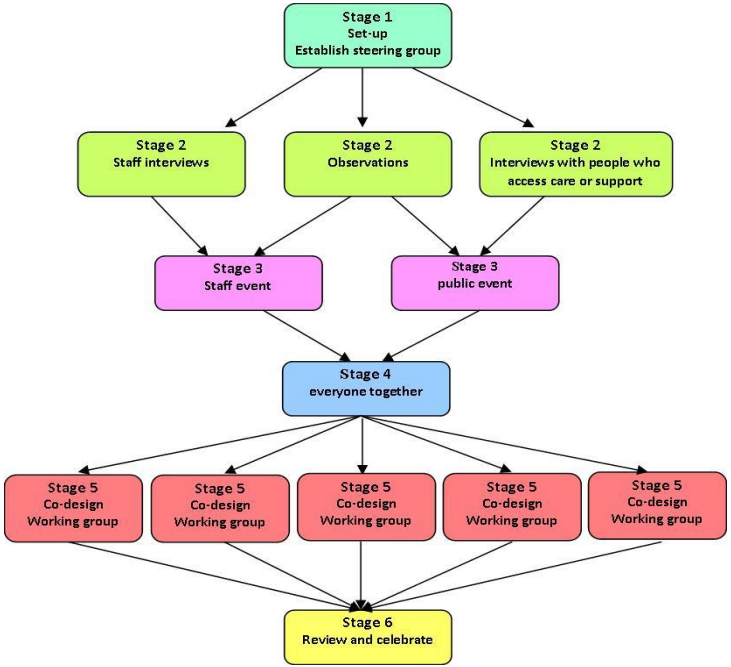
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in an improvement?



Improvement approaches



Care co-ordination definitions

“ a proactive approach to bringing together care professionals and providers to meet the needs of service users to ensure that they receive integrated, person-focused care across various settings.” (WHO 2018)

“Care coordination was defined as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.” (EU Joint Action on Dementia)

Care co-ordination - the evidence

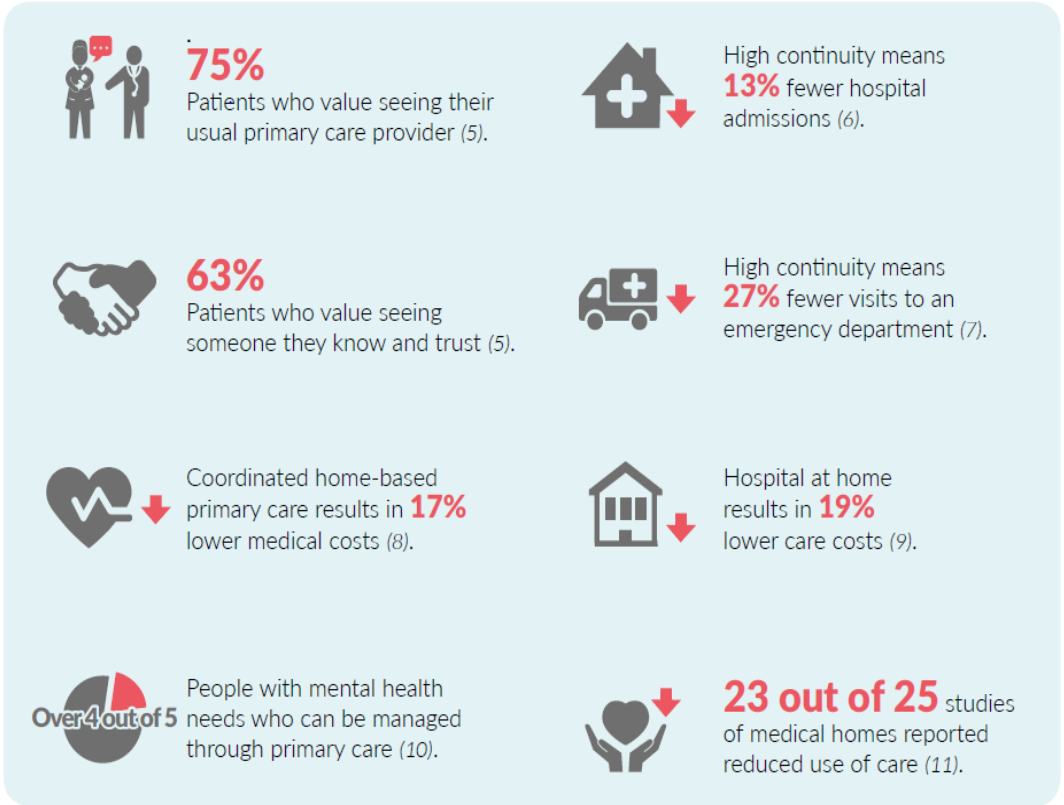
Key Elements

- Continuity with a single named individual responsible for coordinating care and a single point of access through the individual's journey
- Involvement of carers
- Services having adequate knowledge about each one's role and of all available resources in the local area
- Effective exchange of information, which should be relied upon in order to manage all required patient care activities
- Integration and collaboration of care activities in all care settings and sectors.

Priority Practices

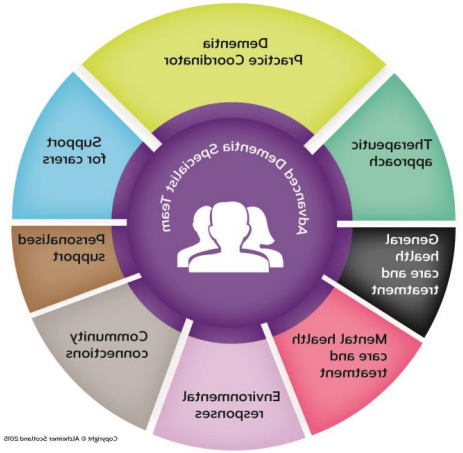
- Continuity with a primary care professional
- Collaborative planning of care and shared decision making
- Case management for people with complex needs
- Co-located services or a single point of access
- Transitional or intermediate care
- Comprehensive care along the entire pathway
- Technology to support continuity and care coordination
- Building workforce capacity.

Care coordination benefits



(World Health Organisation 2018 https://apps.who.int/iris/handle/10665/274628)

Supporting people with dementia in the community



PDS Leads & Practitioner Networks
3 Test Sites Primary Care
Dementia friendly toolkit
Quality Improvement Framework

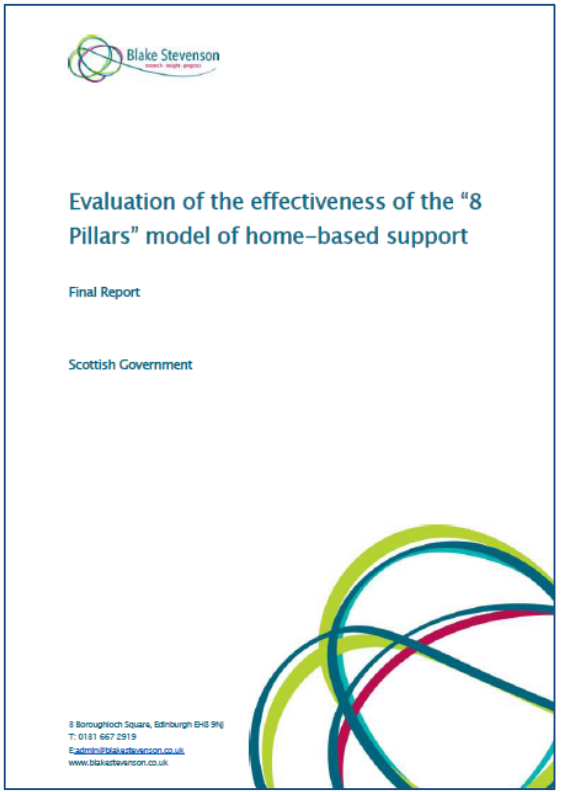
Tested 8 Pillars model in 5 areas
Critical Success Factors for co-ordinated care framework
Care co-ordination commission (demonstrator site)

Testing Advanced Model in Dundee Care Homes

Ref: Alzheimer Scotland models
https://www.alzscot.org/

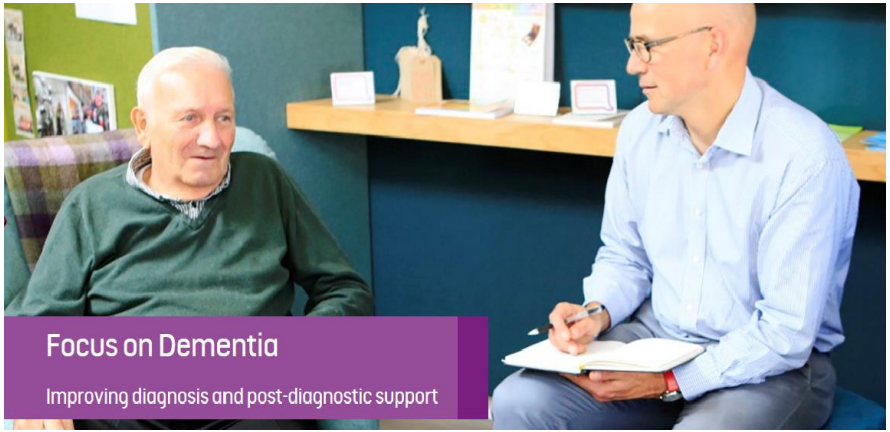
8 pillar testing

- Five areas: Greater Glasgow and Clyde, Highland, Midlothian, Moray and North Lanarkshire
- The test sites began operation in late 2013 and the original two-year duration was extended to June 2016.



Post diagnostic support in primary care

COMMITMENT 2: We will test and independently evaluate the relocation of post-diagnostic dementia services in primary care hubs as part of modernisation of primary care.



By March 2020:

- people with dementia will have access to post diagnostic support from a primary care setting.
- people with dementia and carers will experience high quality post diagnostic support from a primary care setting.
- staff within these sites will have improved knowledge, understanding and confidence in supporting people with dementia and carers.

Identification of critical success factors

Methodology

- Appreciative Inquiry approach in 1 health and social care partnership – Midlothian
- Focus groups/staff interviews
- Quantitative analysis of health and social care data to model care pathways

Findings/Outputs

- 12 critical success factors
- Local data support/advice
- Formal report
- Framework for spreading the learning

Palliative and end of life care coordination

Vision: By 20:20, Everyone in Scotland who needs palliative care will have access to it

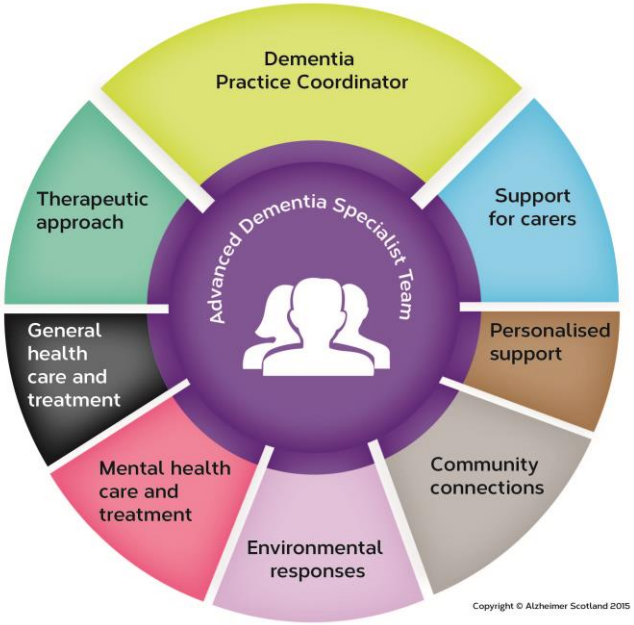
Strategic Framework for Action, Commitment 1: We will provide Health and Social care Partnerships with expertise in testing and implementing improvement s to identify those who can benefit from palliative and end of life care and in the co-ordination of their care.

Scotland's National Dementia Strategy 2017-2020, Commitment 5: We will test and evaluate Alzheimer Scotland's Advanced Care Dementia Palliative and End of Life Care Model.
Commitment 6: We will work with stakeholders to identify ways to make improvements in palliative and end of life care for people with dementia.

- 1 in 3 people over 65 may die with dementia (Elliot et al 2014)
- AD/Dementia now account for around 10% of all deaths (NRS 2017)
- The age group most likely to be given a diagnosis 80-84 (SG 2016)
- By 2020 the no. people diagnosed will be 19,473/year (SG 2016)
- 2 in every 5 people with dementia die in hospital (Sleeman et al 2014)
- ¾ of people with dementia had at least 1 ED attendance in their last year of life, 44.5% on the last month (Sleeman et al 2017)
- Of those who survive to be discharged, one in five will die or be readmitted within 30 days, and three in five within a year (Reynish et al 2017)
- 26% stay a period in excess of 3 months (McCarthy 1997)
- People with dementia who received palliative care typically did not begin receiving it until 2 weeks before death (Zheng et al 2013)
- People who died in acute care less likely to be referred to palliative care and less likely to be prescribed palliative medicines (Sampson et al 2006)

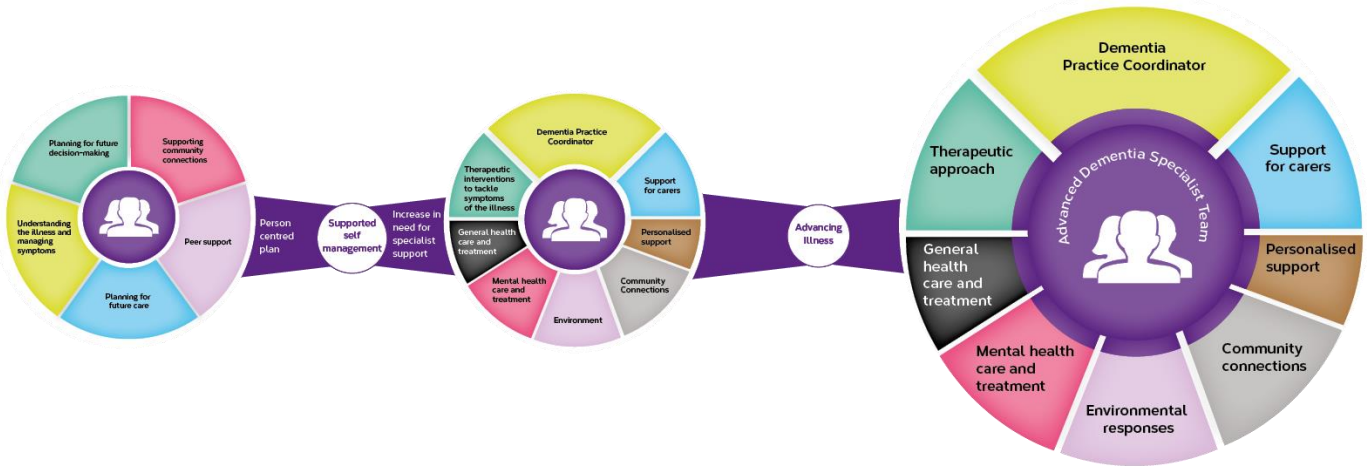
Palliative and end of life care coordination

- Dundee Health and Social Care Partnership
- Testing of palliative and end of life care identification tools – FAST, PPP
- Testing of Alzheimer Scotland Advanced Dementia Practice Model
- Review of care pathway



Whole system redesign

- Implementation of whole system redesign in 1 Health and Social Care Partnership
- “Our shared vision is of a Scotland where people with dementia and those who care for them have access to timely, skilled and well co-ordinated support from diagnosis to end of life which helps achieve the outcomes that matter to them”.



Critical Success Factors

- Involving people with dementia, carers and staff
- Partnership working across sectors and organisations
- Method: using Quality Improvement approaches
- Focus on outcomes that matter
- Staff empowerment and leadership
- Sharing our learning as we go.

Take Home Messages

- Care coordination may mean different things to different people and in different contexts
- There are a number of key elements to successful key coordination
- Our learning is transferable to other conditions and settings

Keep in touch

website: ihub.scot/focus-on-dementia/

email: hcis.focusondementia@nhs.net

twitter: @FocusOnDementia

@lynnflannigan1

Enabling health and
social care improvement