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Conference Abstract

Improving lives through integrated care in Scotland

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Abstract

Problem Statement: An ageing population is to be celebrated but the increasing prevalence of multimorbidity challenges our health and care system in Scotland. Around half of the £4.4 billion annual health and social care budget for older people is invested in hospitals and care homes.

Description: The Reshaping Care for Older People Programme was launched in 2011. Co-produced with political, organisational and community interests, it aims to support older people to enjoy full and positive lives in their own home or in a homely setting through greater investment in preventative, anticipatory and integrated care and effective use of technology. A key aspect is a Change Fund (£300 million over 4 years to 2015). This is existing funding released only on receipt of plans prepared and agreed between local government, health, housing, voluntary and independent sector partners and involving older people, carers and the public.

Change Plans describe how partners will implement evidence based interventions, innovation and improvement across a system wide pathway. Examples include:

- empowering older people and their carers to remain active, independent and connected with families, friends and social network
- building community capability for low level preventative supports and suitable housing capacity
- applying a national risk prediction tool and spreading anticipatory care and early interventions
- ICT support for people to have greater choice and control over their conditions
- enabling local teams to deliver coordinated and integrated care and support at home, or closer to home
- effective management of transitions of care

The Joint Improvement Team (JIT) leads a cross sectoral national improvement network and supports all 32 local partnerships to test new approaches, spread good practice, understand variation and use joint commissioning and resourcing to improve outcomes for individuals, their families and local communities.

The focus will be extended to all adults and supported by a new legislative framework and specified outcomes for integrated care.

Conclusions

Impact at just over 2 years:

- 80% of people receiving support at home benefit from telecare
- Rate of bed days in hospital for people aged 75+ following an emergency admission are down by 10.7% in 3 years

- An average of 1000 less hospital beds required for emergency admissions aged 65+ than 'expected' based on the 2008/09 age related rate
- Around 6,500 fewer residents in care homes than projected
- Delays in discharge from hospital are at an all time low
- Increased carer's assessments, opportunities for short breaks, information and advice, training, income maximisation and advocacy.

Transferability: Success factors that have enabled integrated care at pace and scale offer transferable learning for other systems: adaptive and collaborative leadership; coproduction with citizens; innovative use of ICT; use of funding and contracts as a catalyst for change; use of data and quality improvement approaches to support spread; joint commissioning and resourcing for sustainable change; and judicious use of legislation to create a stable joint governance framework.

Keywords

ageing, care integration, quality improvement programme, ICT, coordinated care, commissioning

Powerpoint presentation:

<http://www.integratedcarefoundation.org/content/open-session-measuring-impact-integrated-care-0>
