Our Impact; Delivering joined up Person Centred Care

- **Enhanced Care at Home; South Eastern ICPs**

Dr Grainne Doran; Chairperson North Down ICP

#ICPchange

Integrated Care Partnerships
Health and Social Care

BACKGROUND

- Transforming Your Care highlighted that Northern Ireland has the fastest growing population in the United Kingdom
- In 2011, 15% of the population in Northern Ireland were aged 65+
- The south eastern LCG locality has the highest overall proportion of elderly residents as a percentage of the total locality population (15.88%), a trend that is expected to continue (19.66% of total population by 2021).
- SELCG area has anticipated by 2019 of
  - 65-84years 32%
  - >85 years 45%

Integrated Care Partnerships
Health and Social Care

Enhanced Care At Home

NEED FOR TRANSFORMATION

- A+E pressures
- Trolley waits
- Delayed discharges
- Hospital acquired infection
- Confusion and agitation increasing morbidity

- 50% of patients aged >65 years who attend ED are admitted
- In the south eastern locality, 35.6% of all hospital admissions are aged 65 or over

Integrated Care Partnerships
Health and Social Care

Enhanced Care At Home

An opportunity to transform the care of the frail elderly in our community by providing the best care in the right environment

Integrated Care Partnerships
Health and Social Care

What is Enhanced Care At Home?

The provision of appropriate community based care and condition management to support patients through brief periods of illness or debility in their own homes avoiding the need for A+E attendance or hospital admission.

Integrated Care Partnerships

Health and Social Care

Aims and Objectives

- To ensure patients receive the best care in the best setting
- To provide brief but timely and appropriate intervention
- Reduce the unwanted outcomes of hospital admission
- hospital acquired infection
- confusion caused by changing environs
- Reduced independence
- Disruption of social networks
- Improve continuity of care for patients

Integrated Care Partnerships
Health and Social Care

What is enhanced?

- Enhanced **district nursing services** provide appropriate timely monitoring of and care for the patient in their own home.
- The **GP** provides the medical care that would otherwise have been provided by secondary care to the patient supported by and liaising with a multi-agency, multi-disciplinary 'team' coordinated by the District Nurse
- GP and district nurse have timely access to **specialist advice** and support from Care of the Elderly Consultants and specialist community teams.
- Enhanced access to diagnostics with **rapid reporting** of CXR and blood investigation.
- Access to **community and voluntary sector** support is facilitated where required.

Integrated Care Partnerships
Health and Social Care

Enhanced Care At Home

Linking, promoting and dovetailing into existing services to address the patients acute and long term needs for example:

- Direct Access Diagnostics
- COE One stop clinics
- IV fluids/antibiotics at Home
- Specialist nursing teams – respiratory, cardiac failure, diabetes
- Community Palliative Care
- AHP
- Social services
- Community Pharmacy Services
- Enablement Services
- Voluntary and Community Services
- Carers Support

Integrated Care Partnerships
Health and Social Care

Benefits for patients

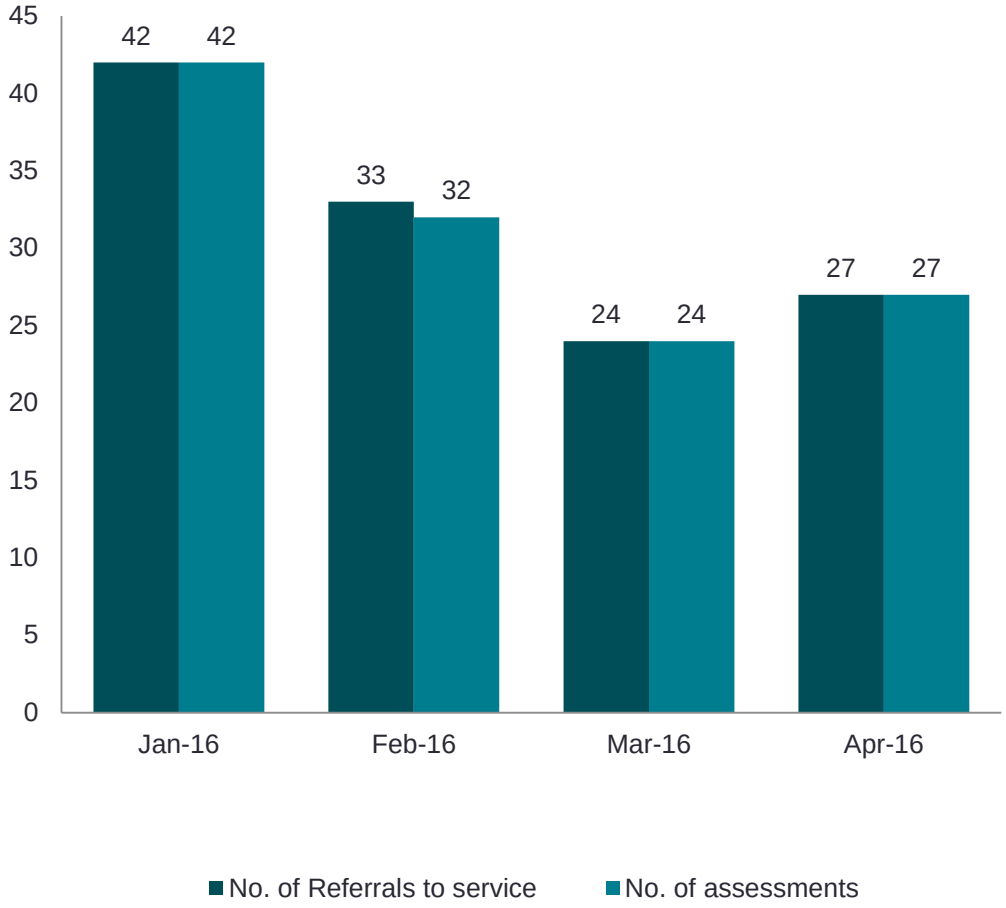
- Remain in a familiar environment reducing confusion
- Normal routine can be preserved reducing risk of loss of function and independence
- Receive care from a team familiar with their condition and needs
- Reduced risk of hospital acquired infection
- Reduced travel and parking difficulties for relatives

Integrated Care Partnerships
Health and Social Care

Patient and carer stories

Watch the video at:
http://www.hscboard.hscni.net/enhanced-care-at-home-video/

ECAH Activity



Jan – April 2016

Total Referrals = 126

Diagnosis on referral: COPD, Cellulitis, UTI, Asthma

LOS = 78% staying for <9days

Integrated Care Partnerships
Health and Social Care