Brent NHS
Teaching Primary Care Trust
Working with our partners for a healthier Brent
www.brentpct.nhs.uk

BRENT COUNCIL

POPP - PARTNERSHIPS FOR OLDER PEOPLE PROJECTS

Update at the end of a 2 year project… and next steps

WHAT WERE WE TRYING TO DO?

- Targets:
  - Preventing avoidable hospital admissions
  - Preventing people needing to go into residential care
  - Changing the way we do things locally – more joined up services

WHAT HAS HAPPENED SO FAR

- Integrated Care Coordination Service
- Holistic assessment and problem solving
- Co-ordinating care around individuals
- Voluntary Sector Partnerships
- Some sharing of IT across LA and PCT
- Links with Central Middlesex and Northwick Park Hospitals
- Work with GPs - Case finding, and EARLI Pilot

HOW HAVE WE DONE?

- Savings
  - Avoided hospital admissions - between £229,000 and £2.8 million net savings over 2 years
  - Avoided A&E attendance - between £282,000 and £781,000 per year
  - Residential Placements – no impact
  - Supporting people at home – ICCS contributes to the overall increasing number – 9.7 % of older population across Brent compared with 8.4% in 06/07

MODEL FOR IDENTIFYING SAVED ADMISSIONS

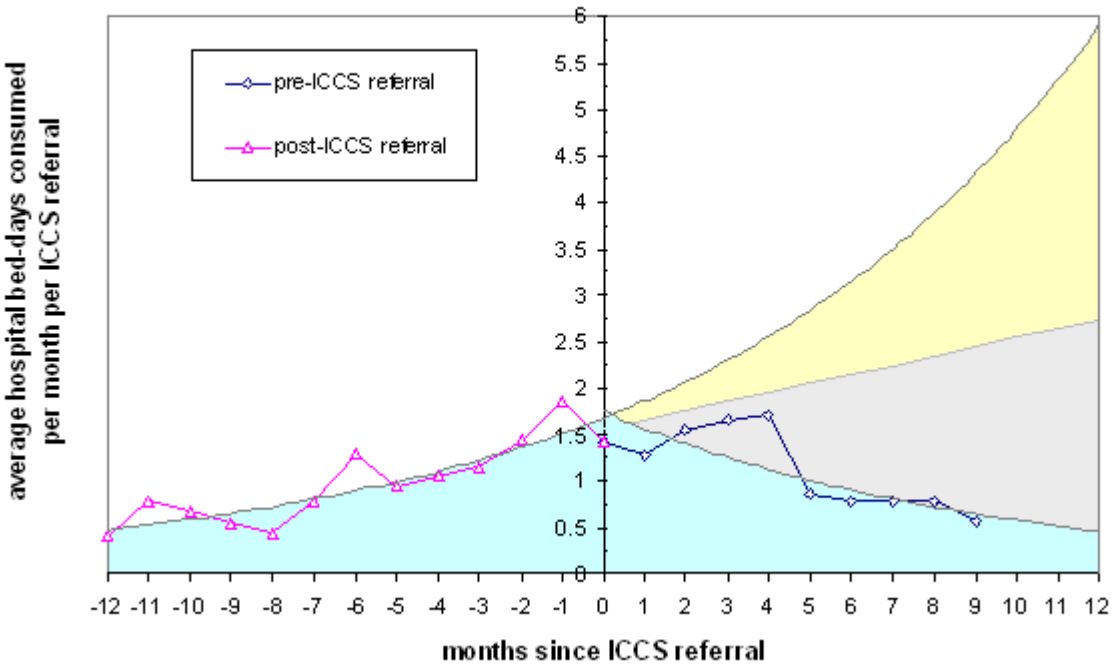

Figure 3A: Average bed-days consumed per client per month pre and post ICCS referral including prevention effects

HOW HAVE WE DONE?

- Number of falls reduced significantly:
  - 34% reduction after 2 months
  - 90% reduction after 5 months
- Impact on wellbeing not yet known though anecdotally people are better informed, anxiety is reduced and people and their carers feel supported
- Activities of daily living – no significant change in ability to undertake these – though risks are likely to be reduced

WHO HAVE WE WORKED WITH?

- Over 1000 people over the 2 years
- Almost half referrals come from GPs
- Over half the people we work with are over 80
- 60% female 40% male
- Balance between localities better in relation to population need
- Generally targeting those in most need – taking into account risk factors like age, living alone and income
- We still need to improve our reach into some community group, particularly Asian ethnicities

WHOLE SYSTEM CHANGE – DOING THINGS DIFFERENTLY

- Testing out news ways of working – CCs being placed out in clinics, older people's services, hospital discharge, to see if a preventative approach impacts on keeping people out of residential care.
- Lots of local changes
  - PCT and Local Authority committed to a joint approach to community services
  - Joint Intermediate Care Strategy
  - LA Social Care Transformation Process
  - PCT reconfiguration of Community Services

EMERGENCY AT RISK LIKELIHOOD INDICATOR - EARLI

- An evidence based tool, developed and researched by GPs, which has been shown to identify older people at risk of unplanned hospital admission.
- Research in Runcorn, completed with University of Liverpool, found questionnaire predicted vulnerability to unplanned hospital admission.
- A simple sheet with 6 questions that can be completed by older people
- Brent project funded through POPP provided external contact to support GPs which was very well received
- Coaching sessions on the use of IT to record EARLI and further information on access routes to services highly valued

EARLI QUESTIONNAIRE

QUESTIONNAIRE FOR PEOPLE OVER THE AGE OF 75

Please answer the following questions by putting a cross in the relevant box as shown in the following example:

Example ☒ YES NO

Please complete all questions

Have you ever had any of the following illnesses (please put a cross in the appropriate box)

1. Heart problems ☒ Yes No
2. Leg Ulcers Yes ☒ No

Please answer Yes or No to the following questions by putting a cross in the appropriate box:

3. Can you get out of the house without help? Yes ☒ No
4. Do you have problems with your memory and get confused? Yes ☒ No
5. Have you been admitted to hospital as an emergency in the last 12 months? ☒ Yes No
6. Overall, would you say your state of health is good? Yes ☒ No

Thank you for taking time to complete this questionnaire