Edinburgh GIRFE pathfinder initiatives summary
November 2023

Nine initiatives have been submitted for national consideration and peer review. We are taking forward 2 initiatives as local tests of change (Winter planning cycle). One of the tests of change we are progressing (frailty/delirium) is initiative no.9, summarised below.

Initiative number & working title	Specific segment or group	Insight about what matters to this group	Outcome:	Concept:	Prototype: ideas to work-up and test	Measure/ indicators: to work-up as part of EHSCP outcomes framework	Connections for consideration / development
9. Being me	Older people returning home from hospital with a delirium discharge coding	I don't remember when I was confused in hospital. I don't trust what people are telling me. I feel less confident to say and do things. I want to get back to being me. My family don't want to talk about it and no-one knows how to help.	I have the right range of care and support to live well at home. I've returned to my normal activities, routines, and interests and I'm reducing my frailty risk/improving outcomes. Everyone involved in my care and support knows about my delirium risk & presentation, how to treat well at home and when I	When I came home from hospital my husband and friends had information on how to support me to recover from delirium. Everyone involved in my care and support was able to do their bit to help getting me back to being me.	Initial thoughts to inform what we could work-up and test: **Being me:** • My family and friends have an information leaflet on what they can do to help me recover at home, we've spoken about my delirium experience and if I'm back to/how I can get back to being me. • I've had a good conversation with one of the practitioners/support workers involved in my care and support about what's happened to me, what matters to me, and how we can build on my strengths as I recover at home. • My GP practice has coded Delirium +/- dementia in		Scottish Care and independent sector provider networks EVOC & voluntary sector provider networks Home First SRO EHSCP Older People & Carer SRO EHSCP One Edinburgh SRO Edinburgh Clinical Frailty Steering Group/Operational Group Edinburgh Dementia Delivery Group

Initiative number & working title	Specific segment or group	Insight about what matters to this group	Outcome:	Concept:	Prototype: ideas to work-up and test	Measure/ indicators: to work-up as part of EHSCP outcomes framework	Connections for consideration / development
			need to go into hospital.		the GP clinical system as priority 1 code • A pharmacist has reviewed my medication and agreed treatment with my GP • I've been offered a post-discharge follow-up with day hospital/Older people's MH team/older people's rehab & assessment team • The community nurse team has been to see me and we've reviewed a range of things like: my eating, drinking, sleeping, hearing, sight, mobility, what matters to me about my health & wellbeing and agreed a self-management plan. • I've been linked-in with support available in my community through voluntary orgs and groups so I can stay connected and do activities I enjoy • We've (my husband and I) had a few Future Care Planning conversations with people involved in my care and support (community hub & cluster		Primary Care Support Team Edinburgh multiagency frameworks and practice models via EHSCP Change Board Edinburgh Social Prescribing SRO Primary Care and Health Inequalities Service Manager

Initiative number & working title	Specific segment or group	Insight about what matters to this group	Outcome:	Concept:	Prototype: ideas to work-up and test	Measure/ indicators: to work-up as part of EHSCP outcomes framework	Connections for consideration / development
					teams/community nursing/GP practice teams/carer support orgs/3rd sector older people support services) recording on my KIS: - frailty assessment - cognitive assessment - falls assessment - Power of attorney arrangements and contacts - Next of kin/preferred contact/carer details and telephone number - Previous delirium, known triggers and agreed treatment plan - Long term conditions review. - My preferred place of care and contact details of community teams/orgs involved in my care and support - What's important to me about future care and treatment, alternative care (eg community nursing		

Initiative number & working title	Specific segment or group	Insight about what matters to this group	Outcome:	Concept:	Prototype: ideas to work-up and test	Measure/ indicators: to work-up as part of EHSCP outcomes framework	Connections for consideration / development
					& hospital@home) to going into hospital, and what people should know when I need to go into hospital. Everyone involved in my care and support is part of a multi-agency framework which enables them to work alongside me as equal partners in my care and support. A partner can arrange a review meeting on my behalf with cross-sector teams/agencies involved, to ensure my voice is heard and I can drive/direct the care and support that is right for me.		