Making our health and care systems fit for an ageing population

David Oliver, Catherine Foot, Richard Humphries

The King's Fund
Ideas that change health care

This slide set summarises The King's Fund report, *Making our health and care systems fit for an ageing population*.

Download the full report:

www.kingsfund.org.uk/olderpeople

- By 2030, one in five people in England will be aged over 65.

- That we are living longer is a cause for celebration, but it presents major challenges to our health and care system.

- We could do much better at providing the services that older people want, co-ordinating around their needs and focusing on keeping people well and out of hospital and long-term care.

- This report aims to be a single, accessible reference guide for local health and care leaders interested in improving their services for older people.

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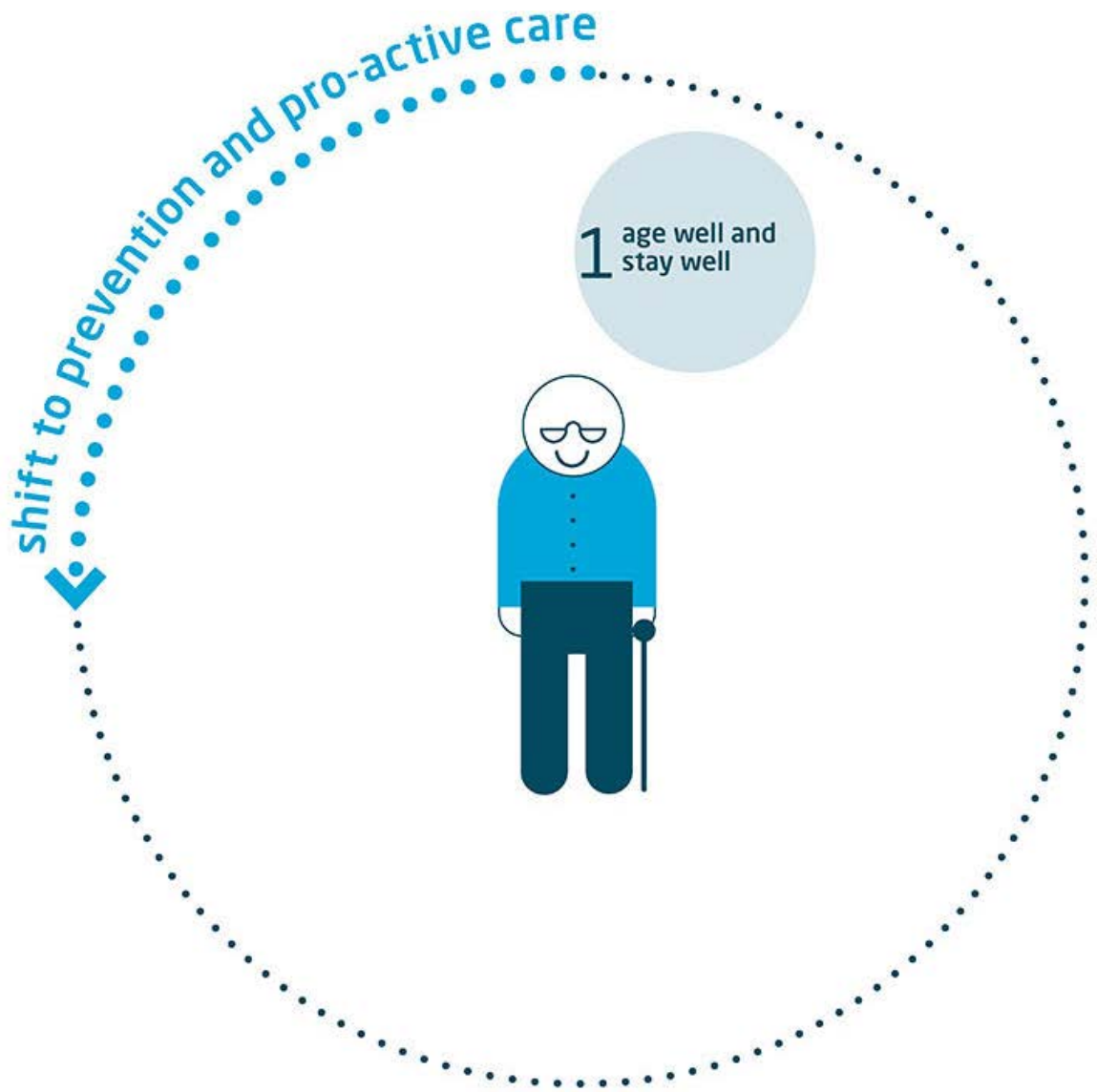

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Goal

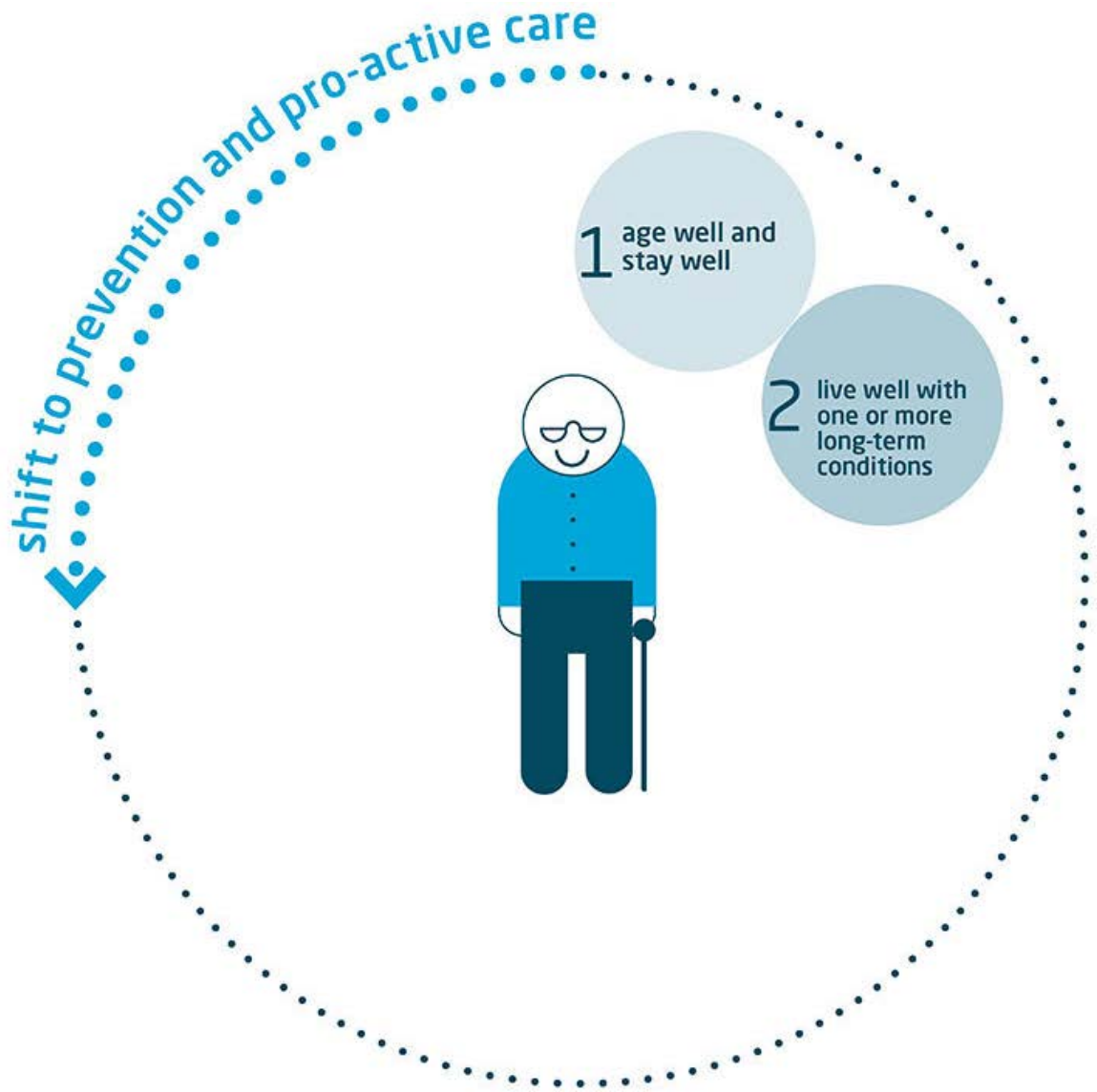
Older people should be able to enjoy long and healthy lives, feeling safe at home and connected to their community.

Current situation

- There remain major inequalities in life expectancy at 65.
- 11 per cent of people aged over 75 report feeling isolated, and 21 per cent feel lonely.
- 34 per cent of people aged 65–74 are obese, and only 8 per cent of women over 75 take the recommended levels of physical activity.
- Uptake of influenza and pneumococcal vaccinations is below the levels set by international targets and national guidance.

What we know can work:

- life-course approaches to health and wellbeing that address the wider determinants of health
- ensuring that we get housing right for older people
- preventing social isolation and promoting age-friendly communities
- cold weather planning
- promoting healthy lifestyles and wellness
- adequate treatment for ‘minor’ needs that limit independence
- vaccination
- national screening programmes.



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Goal

Older people with simple or stable long-term conditions should be enabled to live well, avoiding unnecessary complications and acute crises.

Current situation

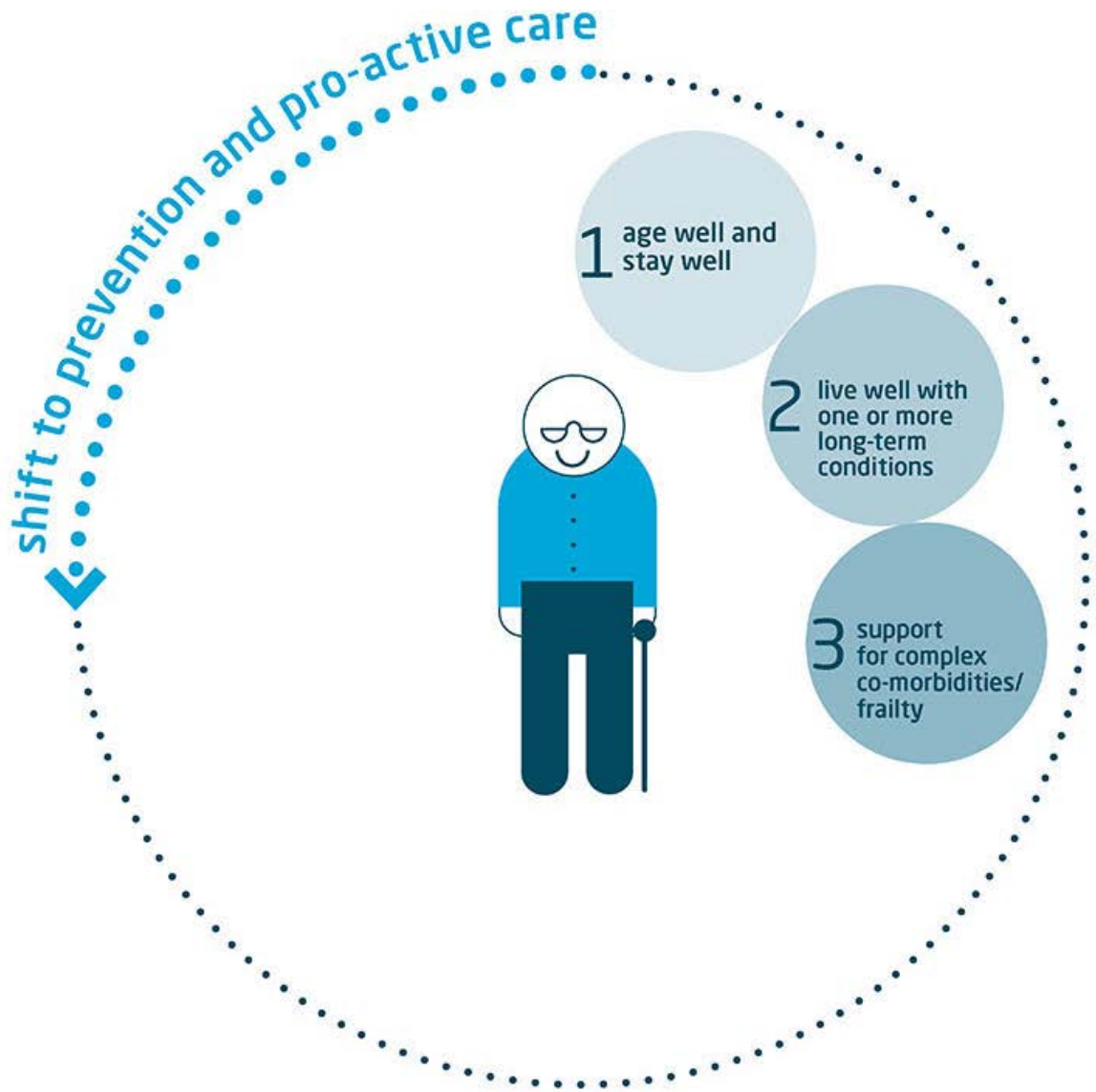
- Most people aged over 65 do live with a long-term condition, and most over 75 live with two or more.
- Older people receive poorer levels of care than younger people with the same conditions.
- General medical conditions are treated more effectively than common geriatric conditions.

What we know can work: (1)

- providing continuity and care co-ordination
- using population risk stratification
- case management delivered through integrated locality-based teams
- involving older people and their families in planning and co-ordinating their own care
- personal care budgets and direct payments
- telehealth.

What we know can work: (2)

- providing support and education for family and volunteer carers
- ensuring that older people receive the same care and support as younger people with the same condition
- improving care and treatment for the common conditions of ageing.



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Goal

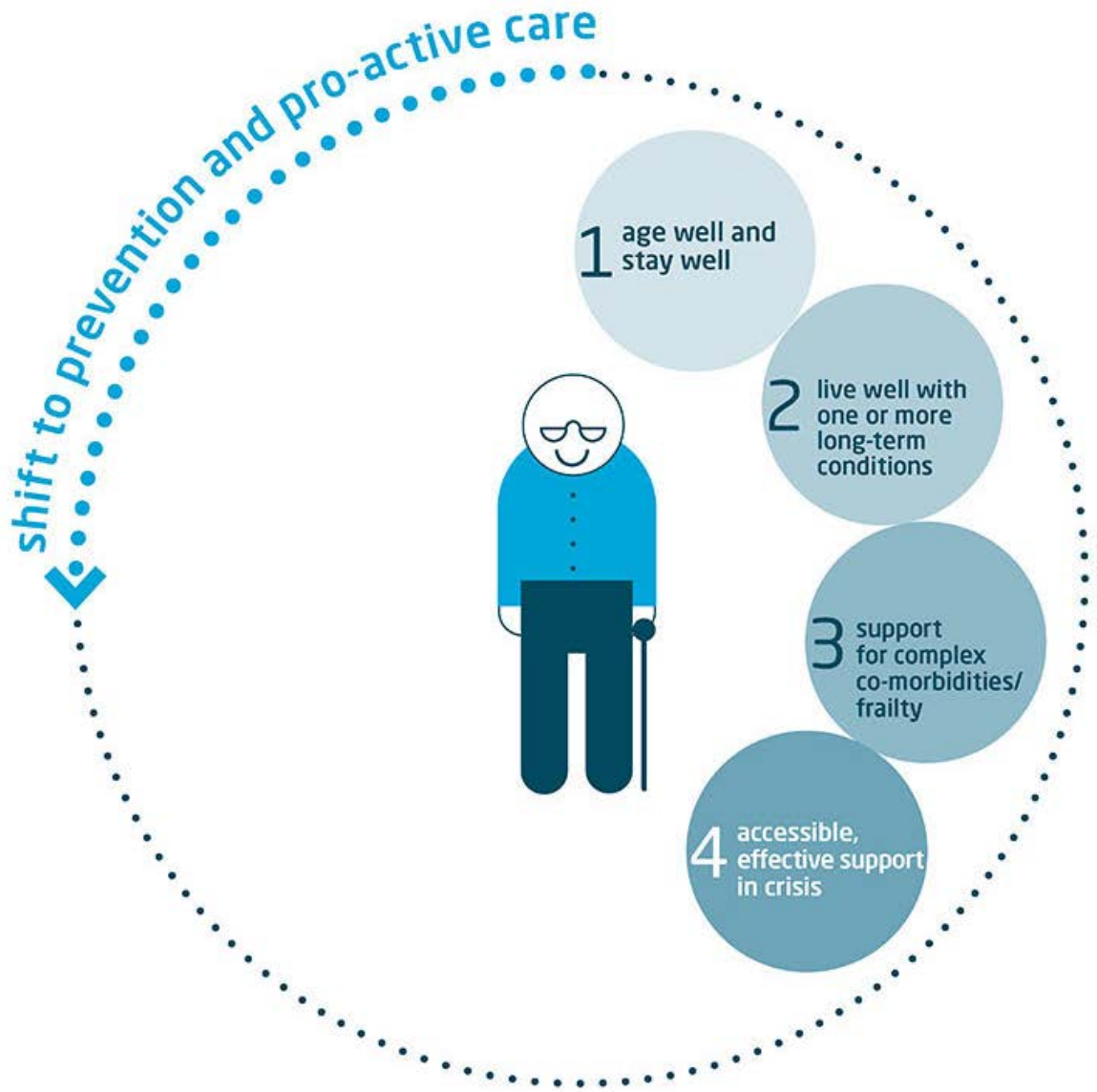
Health and care services should support older people with complex multiple co-morbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications.

Current situation

- Frailty is common but too often neglected.
- Around 1 in 3 people aged over 65 and 1 in 2 over 80 fall each year.
- There is considerable under-diagnosis of dementia compared with expected rates.

What we know can work:

- recognising the importance of frailty
- using frailty risk assessment and case-finding
- using proactive comprehensive geriatric assessment and follow-up for people identified as frail
- promoting exercise for frail older people
- falls prevention
- providing good care for people with dementia
- reducing inappropriate polypharmacy.



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Goal

When the health or independence of older people rapidly deteriorates, they should have rapid access to urgent care, including effective alternatives to hospital.

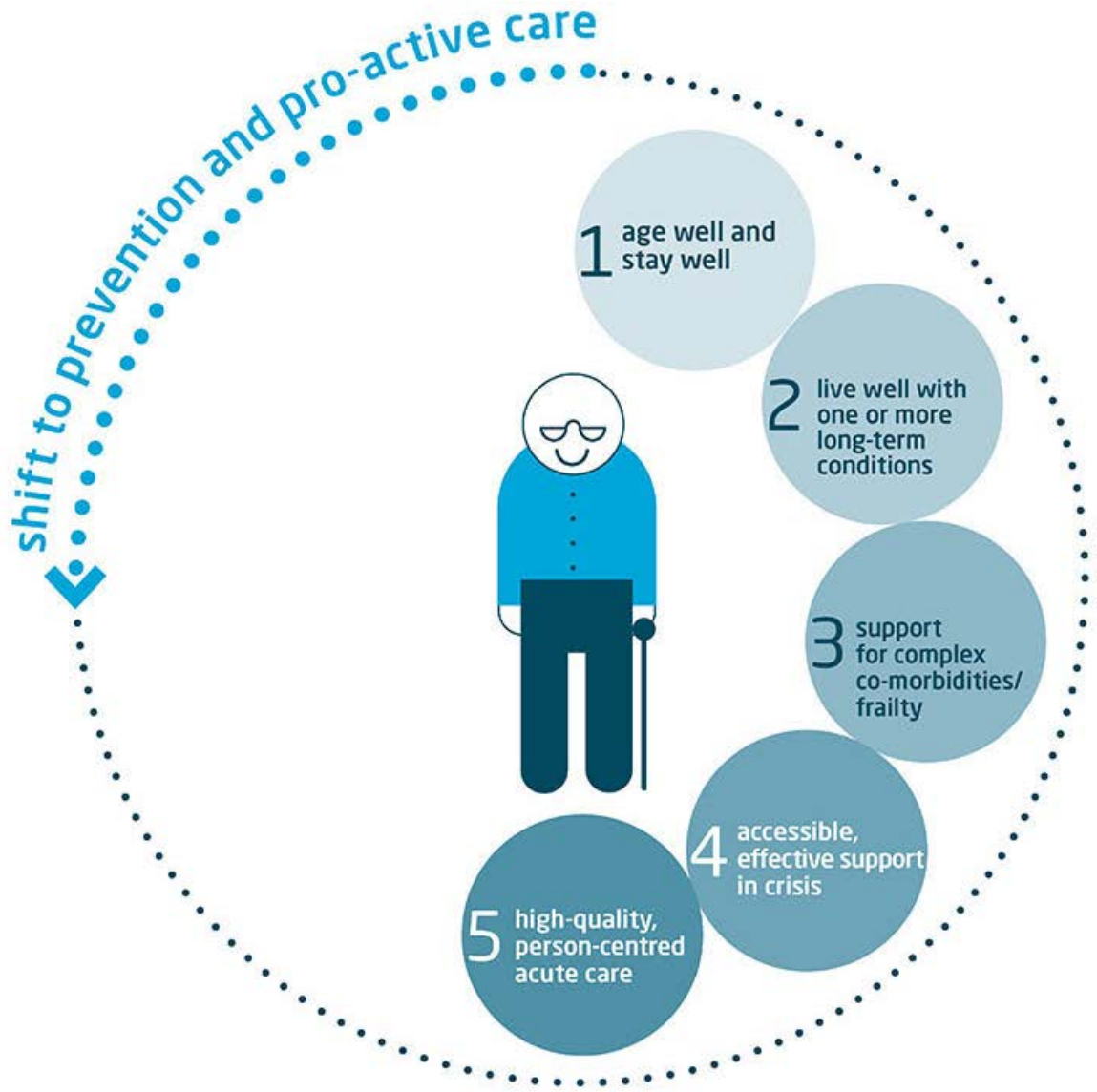
Current situation

- Older people are more likely to call an ambulance from home, more likely to be taken to hospital, and then more likely to be admitted than younger people.

- People aged under 65 use an average of 0.2 emergency bed days per year, while people over 85 use an average of 5 bed days.

What we know can work:

- promoting continuity of primary care
- providing urgent access to primary care
- providing urgent, co-ordinated social care
- ensuring that ambulance services implement shared care strategies with other services
- using admission-prevention Hospital At Home services
- using virtual or community wards
- providing telecare for older people at risk
- discharge-to-assess models
- providing rapid access ambulatory care clinics
- using community and interface geriatrics.


shift to prevention and pro-active care
1 age well and stay well
2 live well with one or more long-term conditions
3 support for complex co-morbidities/ frailty
4 accessible, effective support in crisis
5 high-quality, person-centred acute care

Goal

Acute hospital care must meet the needs of older patients with complex co-morbidities, frailty and dementia.

Services should provide adequate access to specialist input, minimise harms and ward moves, and provide care that is compassionate and person-centred.

Current situation

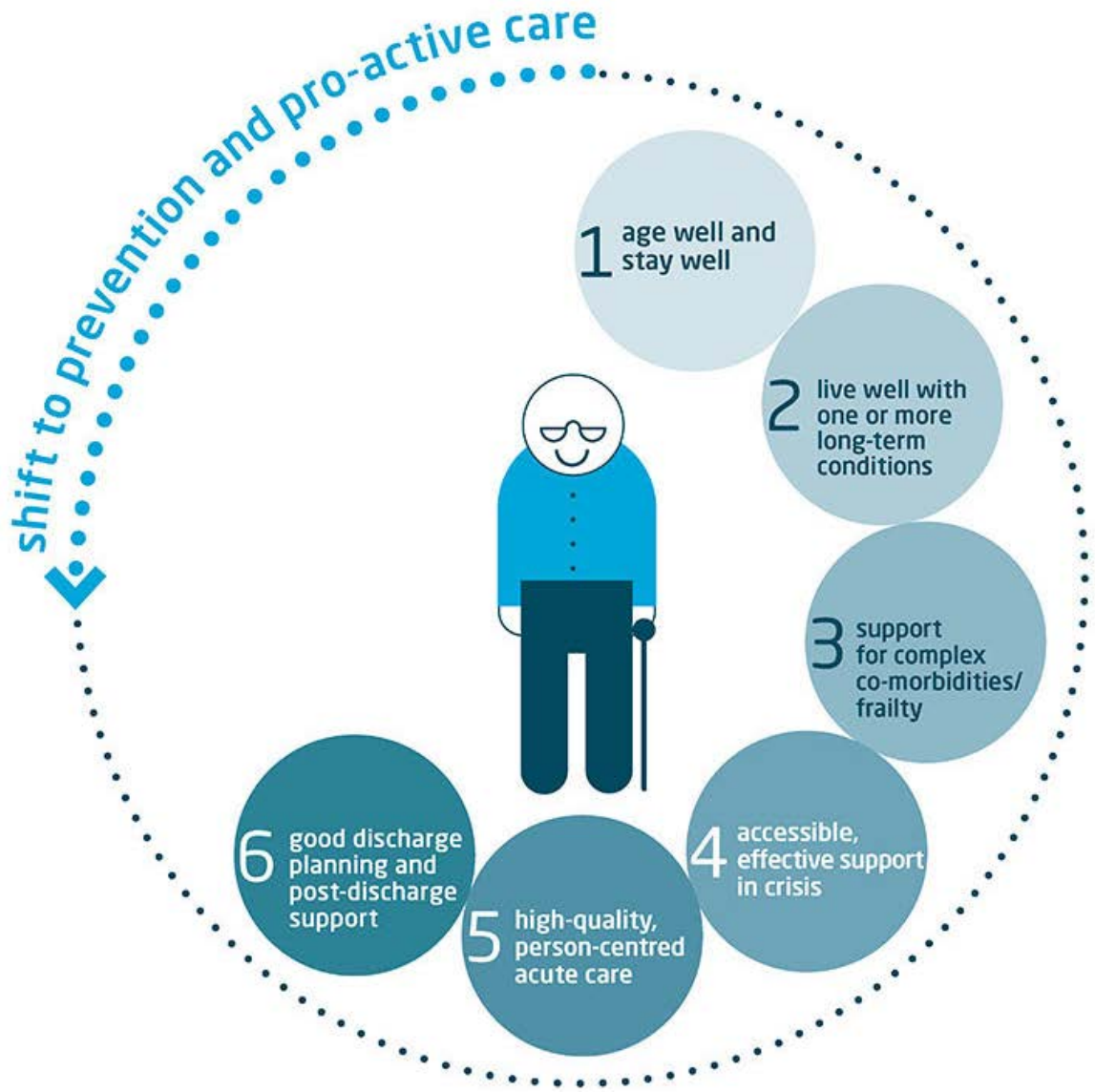
- People aged over 65 also account for 80 per cent of hospital admissions that involve stays of more than two weeks.

- Successive audits have shown consistent failures to provide even basic assessments or treatment plans for some of the common harms of hospitalisation.

- Numerous reports have documented failings in older people's experience of care in hospital.

What we know can work:

- using comprehensive geriatric assessment
- focusing on older patients with frailty
- specialist elderly care units and wards
- liaison and in-reach services for frail older people under other medical and surgical specialities
- maximising continuity of care
- improving safety and preventing avoidable deaths
- minimising harms of hospitalisation
- improving care for inpatients with dementia and mental health problems
- focusing on dignified person-centred care.



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Goal

Discharge planning needs to start at first contact with the hospital and be standardised and embedded in practice, with older people and their carers fully and promptly involved.

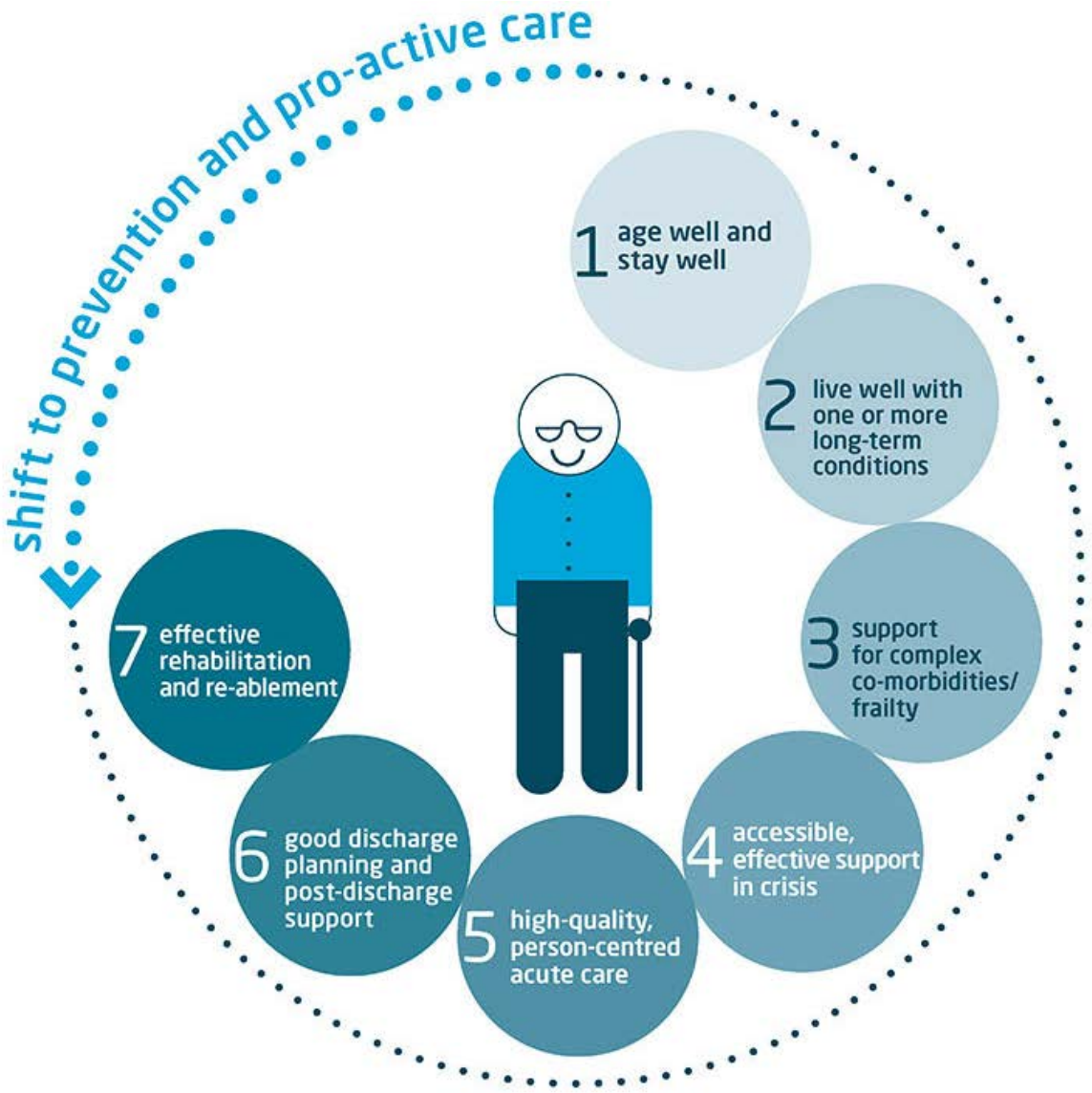
The NHS and social care should work together to ensure that patients can leave hospital once their clinical treatment is complete, with good post-discharge support in the community.

Current situation

- Around 1 in 4 people over 75 in hospital beds have no medical need to be in hospital.
- Older people frequently report uncertainty, lack of confidence and lack of support on discharge from hospital.
- Older people with complex needs, including long-term conditions and frailty, are at particularly high risk of readmission.

What we know can work:

- early senior assessment, assertive discharge planning, and a clear focus on patient flow
- a concerted focus on discharge planning throughout hospital stay, and the ability to discharge seven days a week
- involving older people and their carers in discharge plans
- ensuring integrated information systems and structured multi-professional communication
- strengthening post-discharge assessment and support
- reducing delayed transfers of care.



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Goal

Older people should receive adequate rehabilitation and re-ablement when needed, to prevent permanent disability, greater reliance on care and support, avoidable admissions to hospital, delayed discharge from hospital, and to provide adequate periods of assessment and recovery before any decision is made to move into long-term care.

Current situation

- Most people aged over 65 presenting acutely to hospital have impairment in one or more activities of daily living and many have not returned to baseline levels of mobility or functional independence on discharge from hospital.

- The National Intermediate Care Audit for England concluded that there are only around half the beds and places needed to ensure that no older person is in a hospital bed if it can be avoided.

What we know can work:

- shared and comprehensive assessment of needs and personalised plans
- implementing evidence-based best practice
- commissioning for outcomes
- home-based rehabilitation and re-ablement
- community hospital-based rehabilitation and re-ablement
- using alternative providers
- providing workforce training in re-ablement
- successful ending of and transition from rehabilitation and re-ablement.

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Goal

Though some people make a positive choice to enter long-term care, older people should only generally move into nursing and residential care when treatment, rehabilitation and other alternatives have been exhausted.

Residents should consistently receive high-quality care that is person-centred and dignified, and have the same access to all necessary health care as older people living in other settings.

Current situation

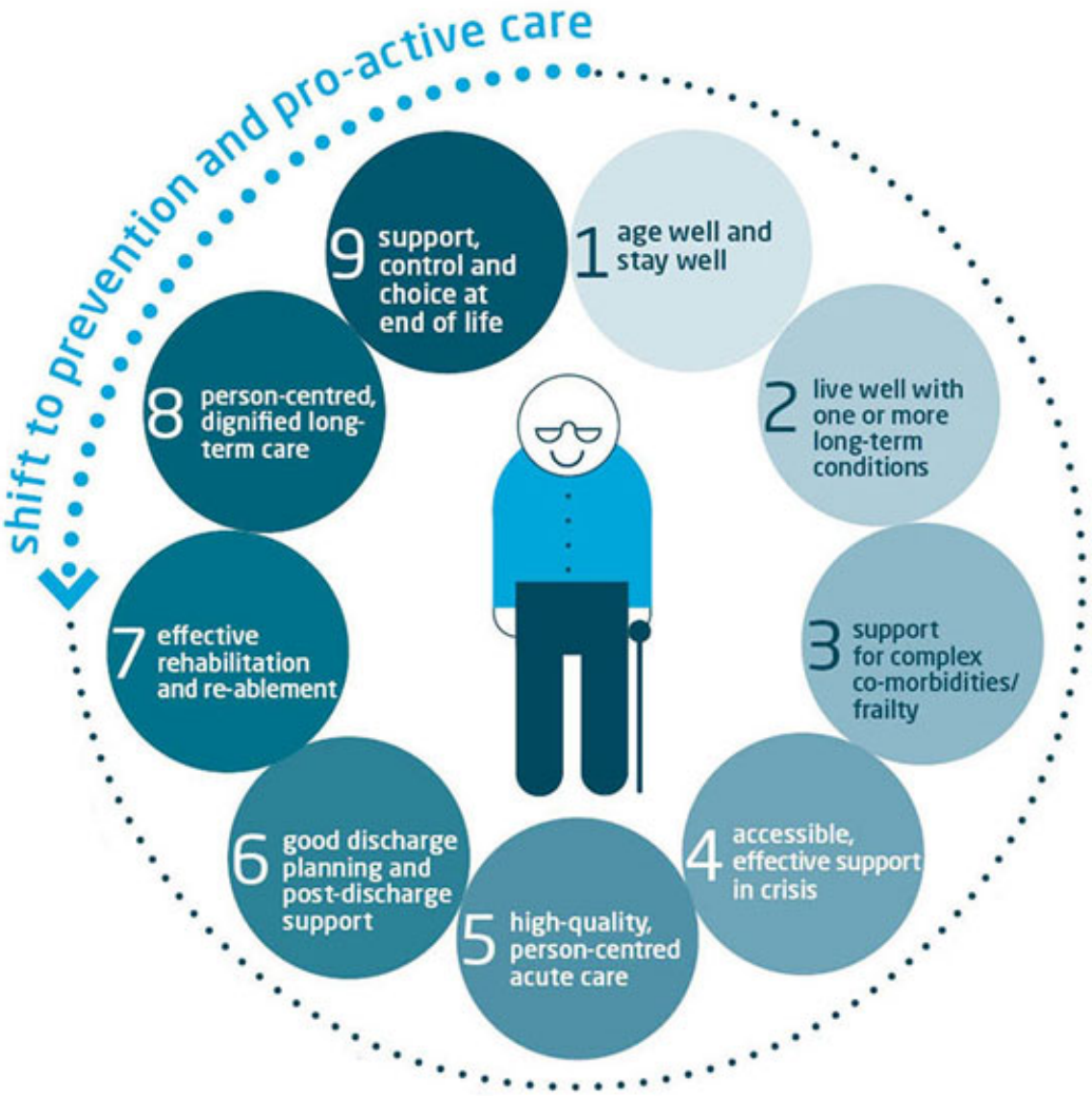
- There are an estimated 390,000 people aged over 65 in care homes in England – four times as many as in hospital beds at any given time.

- Levels of dependency are rising, so that the population in 'residential' homes now resembles that only found in nursing homes a few years ago.

- People living in nursing and residential homes face wide variation in their access to all necessary health services.

What we know can work:

- preventing avoidable admissions to long-term care
- active commissioning of health and mental health care for care home residents
- information-sharing
- conducting holistic assessments
- providing support and training for care home staff
- using evidence-based frameworks for assessment of quality of life and improvement of relationship-centred care.



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Goal

Older people who are nearing the end of life should receive timely help if they want or need it, to discuss and plan for the end of life.

End-of-life care services should provide high-quality care, support, choice and control, and should avoid over-medicalising what is a natural phase of the ageing life course.

Current situation

- Older people receive poorer-quality care towards the end of life than younger people. They are less likely to be involved in discussions about their options, less likely to die where they choose, and less likely to receive specialist care or access hospice beds.

- In an NAO study, at least 40 per cent of people who died in hospital did not have medical needs that required them to be treated in hospital, and nearly a quarter of them had been in hospital for more than a month.

What we know can work: (1)

- providing workforce training and support
- identifying people in the last year of life
- ensuring effective assessment and advance care planning
- strengthening co-ordination and discharge planning
- ensuring adequate provision of specialist palliative care services
- supporting care home residents to die in the care home rather than in hospital.

What we know can work: (2)

- providing home-based services
- improving end-of-life care for people with dementia
- improving end-of-life care in hospitals
- management of the dying phase and the crucial importance of involving patients and families.

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Making it happen: integration

- In any one local area, teams and organisations working in each of the nine components could all find ways to improve the quality and continuity of their individual practice and services for older people.

- But to deliver the radical transformation that quality and financial pressures demand, we need to go much further.

- We need to drive whole-system changes in the services we provide for older people so that we consistently provide integrated care which is co-ordinated around people's needs and goals.

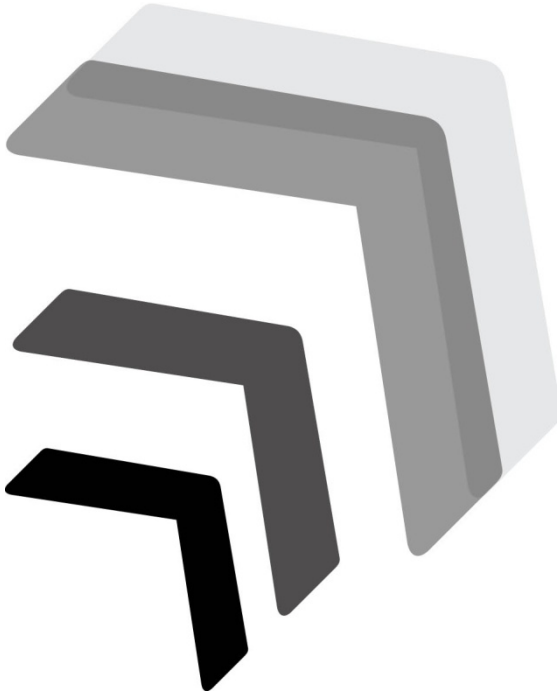
  See Sam's story: www.kingsfund.org.uk/carestory

How to start

- ‘Walk’ the journey for older people from healthy active ageing, right through to end-of-life care – recognising multiple dependencies.
- Agree some key performance standards that all organisations can aspire to achieve.
- Map out which elements of good practice are already provided and where the gaps are.
- Identify early priorities for change and quick wins.
- Ensure that the work is informed by meaningful input from older people and their carers.
- In England, use the Better Care Fund as a lever for change.

For more information

- Read the full report: www.kingsfund.org.uk/olderpeople
- Watch Sam's story: www.kingsfund.org.uk/carestory
- See all of our work on care for an ageing population: www.kingsfund.org.uk/ageingcare



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