Making Services fit for an ageing population.
Starting today.

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BGS President-elect

The King’s Fund Older People Services Conference
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By 2030 men aged 65 will live on average to 88 and women to 91

51% more over 65, 101% more over 85

Why Older People?

› Ageing demography – present & future
› Unpaid carers
› Workforce
› Multiple long-term conditions
› Dementia
› Frailty syndrome
› Functional or sensory impairment, disability
› Isolation and loneliness
› Healthier active ageing, prevention, inequalities
Why now? The “perfect storm”

- Francis Report & Dept Health (DH) response
- DH Vulnerable Older People Plan/Mandate
- Equality Act
- Future Hospitals Commission
- Dementia Strategy and PM Challenge
- Keogh Mortality Reviews
- Care Quality Commission & Ombudsman
- Patients’ Association, National Voices
- Focus on Integration (all four nations)
- Financial Challenge to Health and Social Care
Figure 3  Annual cost* by age and service area for Torbay (population 145,000), 2010/11

*Costs of primary care and prescribing are not included
Source: Torbay Care Trust (reproduced with permission)
Quality in Services for Older People.

*Must do better*

- **Outcomes**
  - Consistent application of *evidence-based interventions* known to achieve these outcomes

- **Safety** and avoiding *harm*
  - Most high volume safety incidents affect older people
  - Loss of function, delirium etc as harms?

- **Experience**
  - Dignified, person-centred care with choice, information, control, communication, involvement etc

- **Efficiency**
  - Minimising unwarranted variation – “best as good as rest”
  - Reducing inefficiencies at transitions and interfaces
  - Reducing duplication, and “death by assessment”

- **End ageism and age-discrimination**
  - Whilst encouraging *appropriate adjustment and differentiation* to allow for different needs/groups

- **Access and responsiveness**

- **Continuity/co-ordination/integration**

- **Right service and skills in right place at right time**
### Individual health and social care event timeline over a three-year period

This figure shows all contacts that one individual person had with all health and social care services over a three year period.

<table>
<thead>
<tr>
<th>Service</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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</thead>
<tbody>
<tr>
<td>High intensity social care service</td>
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<td>Other social care service</td>
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<tr>
<td>Social care assessment</td>
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<tr>
<td>Inpatient - discharge</td>
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<td><img src="image" alt="Legend" /></td>
<td><img src="image" alt="Legend" /></td>
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<td>Inpatient - admission</td>
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<tr>
<td>A&amp;E visit</td>
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<tr>
<td>Outpatient visit</td>
<td><img src="image" alt="Legend" /></td>
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<tr>
<td>GP visit</td>
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Understanding and improving transitions of older people: a user and carer centred approach

- Poor communication between services
- Lack of adequate assessment and planning prior to transition
- Inadequate notice of/preparation for transition between services
- Inadequate consultation and involvement
- Over-reliance on informal support
- Inattention to the special needs of particularly vulnerable groups
- An increased risk of premature transition and/or transition to inappropriate care settings due to service pressures and inter-agency tensions.
A “new deal” in complex needs/frailty?
Sam’s Story, Animation

Integrating around the person?

- “No single ‘best practice’ model of integrated care exists. What matters most is clinical and service-level integration that focuses on how care can be better provided around the needs of individuals, especially where this care is being given by a number of different professionals and organisations”

  - Kings Fund Integration Report 2011

- “Integrate around the patient, not the system. Integration is not about structures, organisations or pathways, it’s about better outcomes for people... not specific diseases”

  - Futures Forum Report on Integration 2011
Integration means “Person-Centred Co-ordinated Care”

Integrated care: what do patients, service users and carers want?

Top Lines
People want co-ordination. Not necessarily (organisational) integration.

People want care. Where it comes from is secondary.

- knowledge of the patient/service user/carer as a person, including their home circumstances, lifestyle, views and preferences, confidence to care for themselves and manage their condition(s), as well as their health status and symptoms
- knowledge of the relevant condition(s) and all options to treat, manage and minimise them, including knowledge of all available support services
**Statements describing good integration**

There were no big gaps between seeing the doctor, going for tests and getting the results.

I was always kept informed about what the next steps would be.

The professionals involved with me talked to each other. I could see that they worked as a team.

**Care co-ordination**

I always knew who was the main person in charge of my care.

I had one first point of contact. They understood both me and my condition, I could go to them with questions at any time.

That person helped me to get other services and help, and to put everything together.

**Information**

I could see my health and care records at any time to check what was going on. I could decide who to share them with, I could correct any mistakes in the information.

Information was given to me at the right times. The information was appropriate to my condition and circumstances.

I was told about the other services that were available to someone in my circumstances, including local and national support organisations.

The information I was given was comprehensive: it was not just medical, but also helped me understand the impact of my health status on other parts of my life.

The information I was given included how to manage financially.

I was not left alone to make sense of information. I could meet (or phone/email) a professional when I needed to ask more questions or discuss the options.

**Shared decisions/care planning**

I was as involved in discussions and decisions about my care and treatment as I wanted to be.

My family or carer was also involved in these decisions as much as I wanted them to be.

I worked with my main professionals to agree a care plan.

I know what is in my care plan. I know what to do if things change or go wrong.

My care plan was clearly entered on my record.

When I used a new service, my care plan was known in advance and respected.
Medicines/self management

I was as involved as I wanted to be in decisions about my medicines – whether they were needed, and which one to choose.

If I needed a new medicine, its purpose, potential side effects and how to take it were explained to me. I was given written information about this.

I had a key professional who helped me to manage my medicines and to check how they were working.

I had regular, comprehensive reviews of my medicines.

I was offered the opportunity to become more educated about how to manage my own symptoms. This helped me to set goals. I agreed the goals with my main professional(s).

Transitions

When I was discharged from a service, there was a plan in place for what happened next. This was delivered without unnecessary delays.

If I moved from one care setting to another:

- I knew in advance where I was going, what I would be provided with, and who would be my main point of professional contact
- I was given information about any medicines I was taking with me – their purpose, how to take them, potential side effects
- Information about me, including my views and preferences and any agreed care plan, was passed on in advance
- I was still allowed to see and work with, as appropriate, preferred professionals who I already knew and knew me

When I went to a new service, they knew who I was, what my circumstances were, and about my own views and preferences, and any care plans I had made.

If I moved across geographical boundaries I did not lose entitlements to care.

Managing at home

When I needed support to live at home, services worked together to provide it. I had a say in who would come and provide my care and when.
10 Components: Today’s event is organised around them.
Multiple interdependencies between components and transitions

End “Silo” thinking.

Focus on transitions/interfaces

Capacity in right place at right time in sufficient quantity and access
Who has a stake in helping Sam support himself?

The King's Fund
Putting it together...from talk to action

- Transform services **at scale and pace**
  - Tinkering incrementalism won’t save us
- But **change** must be **sustainable**
  - End “projectitis” and “pilotitis”
- **Lived differences** for older people and carers...
- **Shift towards prevention**, wellbeing, anticipatory care
- **End discriminatory** attitudes and practices
- **Workforce** with right skills, values in right place
- **Rapid adoption of best practice**
  - empirical evidence & high quality services
- Deliver it **within** each component
  - “the best as good as the rest”
- **Minimise unwarranted variation**
- **Integration**
  - To deliver continuity and co-ordination
  - To solve problems at transitions/interfaces
  - To end duplication, and “death by assessment”
  - Reduce inefficiencies
Enjoy today and the challenge beyond. Thank you

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