Making Services Fit for Our Ageing Population

David Oliver

The King’s Fund Integrated Care Summit May 8 2013
First Francis Enquiry

• “Many of the cases in which patients and their families have reported concerns have involved elderly patients. The multiple needs of such patients in terms of diagnosis, management, communication and nursing care are in many ways distinct from those of younger patients. The latter can more often be safely treated only for the condition for which they have been admitted…”

• “Older patients will often present with a complex of medical and care problems requiring a skilled and all-embracing multi disciplinary team approach. Active management with the assistance of specialist advice will often be needed.”
Ageing and Health – the upside

• Changing demographic: Key facts and figures
• Success story for society and healthcare
• Contrary to stereotypical, ageist attitudes...
• Most elders **not** ill, unhappy, dependent, isolated etc.
• Many stay active/working/volunteering/contributing
• (And so what if they don’t, can’t?)
• Let’s stop catastrophising and labelling
• Need more focus on prevention (primary and secondary) across the life-course – major gaps, wider determinants
• Help to age well “in place” and support unpaid carers.
Ageing and Health – challenges

• Inequalities
  – Absolute life expectancy at birth and at 65
  – Healthy Life expectancy at 65
  – Multiple advantages/disadvantages

• More people living with LTC
  – Multiple conditions (and meds)
  – Common conditions of ageing (including dementia)
  – Frailty Syndrome
  – Co-morbid disability (e.g. mobility problems)/dependence

• Potential crisis in workforce and in number of unpaid carers
• Retirement (age and income)
• Long term social care funding
• Housing stock
Older people (with complex needs) as “core business” for services

• Ageing is an irreversible “game-changer” for:
  – Primary care
  – Community Services/Intermediate Care
  – Social care
  – Nursing and Residential Homes
  – Acute Secondary Care

• Older people most likely to:
  – be using multiple services
  – be seeing multiple professionals
  – have illness complicated by loss of function, fluctuating disability, impaired cognition
  – rely on support and advocacy from informal carers

• To benefit from more “joined-up” or integrated services
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)
House of Lords “Ready for Ageing” Report 2012 (England)

• By 2010 there will be...(compared to 2010)
  – 51% more people over 65
  – 101% more people over 85
  – 50% more people with 3 or more LTC
  – 80% more people with dementia

• Twice as many **unpaid carers** (6.4 m)...

• ..as staff employed by NHS/Social Care

• Demand for informal care to parents from adult children is expected to rise by 50% by 2030

• Supply of care projected to rise by only 20%
It’s time we caught up with this reality and designed services around the people who use them most. Move away from “right bed wrong patients”

- “We need to make services age proof and fit for purpose” Philp 2008

- “when we design services for people with one thing wrong at once but people with many things wrong turn up, the fault lies not with the users but with the system, but all too often we label these patients as inappropriate and present them as a problem” Rockwood 2005

- “Sir David Nicholson asserts that hospitals are very bad places for older people. Here’s a radical suggestion – make hospitals good places for older people.” McMurdo BMJ 2013
Service quality for older people?

• Much excellent practice to celebrate
• But widespread evidence that we could and should do much better in all domains of quality:
  – Outcomes (and interventions to deliver)
  – Safety
  – Experience and person-centred-ness
  – Efficiency (unwarranted variation and interface issues)
  – Fairness/equity/age-discrimination
  – Access/responsiveness

• Need to focus on constructive, relevant solutions…

• Quality **within** each service as important as integration
How to get better? (within individual services)

- Education, training, skills, revalidation, regulation
- Focus from/support for leaders at all levels
- Outcome indicators, financial instruments/incentives
- Standards and data
- Ensure adequate capacity/workforce
- Full involvement of older people and carers
  - Own care and treatment
  - Service design, education, training, feedback
- Sustained focus on prevention, LTC, anticipatory care
- Rapid, credible response in crisis
- Equitable access to healthcare (e.g. nursing homes)
- Combat ageism/discrimination
- Adequate Assessment and diagnosis
- Focus on rehabilitation/discharge planning
- No shortage of good practice guidance or living examples....
QUALITY CARE FOR OLDER PEOPLE WITH URGENT & EMERGENCY CARE NEEDS

Dementia
Commitment to the care of people with dementia in hospital settings
The care of frail older people with complex needs: time for a revolution

The Sir Roger Bannister Health Summit, Leeds Castle

Author: Jocelyn Cornwell

March 2012

• Recommendations for:
  – Senior Leaders
  – Team Leaders
  – Professional bodies/societies
  – Policy makers, government, NHS commissioning board
  – Think tanks and commentators
Comprehensive geriatric assessment for older adults admitted to hospital: meta-analysis of randomised controlled trials

Graham Ellis consultant geriatrician and honorary senior clinical lecturer¹, Martin A Whitehead consultant geriatrician², David Robinson consultant geriatrician³, Desmond O’Neill associate professor of gerontology⁴, Peter Langhorne professor of stroke care⁵
Benefits of CGA (Ellis and Langhorne)

• 22 trials. 10,000 + participants, 6 countries
• Patients more likely to be *living at home* at end of scheduled follow up (OR 1.16)
• And at median follow up of 12 months (OR 1.25)
• Compared to general medical care
• Less likely to be *living in residential/nursing care* (OR 0.78)
• Less likely to *die or experience deterioration* (OR 0.76)
• More likely to experience *improved cognition* (Mean difference 0.08)
• *Specialist wards* had better outcomes than teams for
Integration – a further quality domain?

• “Systems designed to treat occasional episodes of care for normally healthy people are being used to deliver care for people who have complex and long term conditions. The result is often that they are passed from silo to silo without the system having ability to co-ordinate different providers”
  
  *S Dorrell HSJ 2011*

• “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, its about better outcomes for patients... supporting clinical commissioning groups to commission for people – not specific diseases”
  
  *Futures Forum Report on Integration 2011*
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.

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<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
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Older people and their carers aren’t demanding “integration” but responsive, accessible, joined-up, understandable services.

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.

Jo Ellins¹, Jon Glasby¹, Denise Tanner², Shirley McIver¹, Deborah Davidson¹, Rosemary Littlechild², Iain Snelling¹, Robin Miller¹, Kelly Hall¹, Katie Spence¹ and the Care Transitions Project co-researchers.³

¹ Health Services Management Centre, University of Birmingham
² Institute of Applied Social Studies, University of Birmingham
³ Solihull, Leicester, Gloucestershire, Manchester
To deliver what **people** want, **systems** count.

From NHS Institute LTC in Older People. Gilmour Frew.
Integrated Care for Older People *(any system)*

A personal View

- Stop blaming acutes, tariffs etc for all the ills
- Don’t imagine that structural/organisational integration solves all
- Don’t start with this.. (its back to front)
- Integrate around the person because it’s the right thing to do
- Don’t use “everyone is talking about integration but no-one can agree a definition” as an excuse for inaction
- Don’t over-promise (or believe) incredible figures on cost-saving
- Look at evidence for what works (preferably peer reviewed)
- Learn from others who have implemented and evaluated (adoption at pace and scale trumps “innovation”)
- Avoid “this wouldn’t work for us” mentality
- Get all the players round the table in a safe space and accept that dis-integration is everyone’s fault/responsibility
Integrated care for older people
(a personal view)

• Agree a set of **high level principles** for organising care
• “Balanced scorecard” of “**integration indicators**” across a health and social care economy
• Accept that **every part of the care pathway is fundamentally interdependent** – end silos
  – Primary and secondary prevention
  – Living with (multiple) LTC, frailty, dementia, disability
  – Rapid support close to home when things go wrong
  – Urgent care (front door, inpatient spell, discharge, post discharge)
  – Step up and step down rehab/intermediate care/reablement etc
  – Social care
  – Long term residential and nursing home care (transition and healthcare input)
  – End of life care planning and support
• Agree a **common set of standards for delivery**
• Map out how far away you are from delivering them
• Look at what **individual providers** can do to improve
• **Then and only then**, mention the “I” word as the solution to problems
Domino Project *Norwich and Norfolk (ongoing)*. Shared Principles

- “No blaming or scape-goating of individual organisations”
- “Whole system challenge needing whole system solution”
- “Identify bottlenecks, processes and **behaviours** that negatively impact upon system and organisational flow”
- “Create culture of trust & continuous quality improvement”
- “Share learning from the project “
- “Ensure the mind-set is , no organisational ‘bias’, this is about patients, not organisational boundaries”
- “We have a positive mind-set – **we can, we will, we must**”!!”
- “Clinicians and managers work together, lead from front to make change happen back at base and maintain momentum”
- “We work at PACE!! (No endless meetings that fail to deliver)”
Locality scorecard Northwest SHA
(From Audit Commission Value for Money in Health and Social Care 2011)

• Non-elective admissions in over 65s per 1000 population
• Non-elective bed days “ “
• Non-elective readmissions within 28 days “ “
• And within 90 days
• Number of delayed transfers of care for people over 18 per 100,000 pop
• Proportion over 65 who are discharged from hospital direct to residential care
• Permanent admissions to residential care per 100,000 population
• Proportion of local authority spend on nursing and residential care in over 65s
• Proportion of all deaths occurring at home for over 65s
All standards and **timings** are for discussion and development

Frail Elderly Pathway – Care standards (time based)

All standards relate to patients assessed as being ‘frail’

**Home/care home**

**Crisis**

**Acute**

**Trf of care**

**Home/care home**

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**Std H1.** All patients remotely identified as an emerging risk (by e.g. the Devon tool) will be assessed* within **7 days**

**Std H2.** Primary care will respond to a request for a GP visit and make a ‘treat/refer/admit/no action’ decision within **4 hrs**

**Std C1.** For all patients identified as being at risk of admission to an acute hospital, an assessment *will be initiated within **2 hrs** of the request

**Std C2.** All patients in crisis will start to receive a package of enhanced support at home within **2 hrs** of the need being identified. NB working patterns

**Std C3.** Within **XX hrs** of the need being identified for a Community bed, all patients in crisis will be transferred to that bed

**Std A1.** On arrival in ED / admissions unit, all elderly patients at risk of adverse outcomes will be ISAR scored within **4 hrs**.

**Std A2.** Patients with an ISAR score of 3 or more will be notified to the CGA case manager and assessed* within **XX hrs**

**Std A3.** All patients in hospital will be assessed* before they leave hospital. HOLD pending D2A discussions

**Std T1.** All patients will be transferred to the most appropriate care setting following a decision of ‘medically fit for discharge’ as follows:

- **T1a.** For first time care home placement: Arrival by **17.00** within **XX days** of the decision
- **T1b.** For return to care home: Arrival by **21.00** if decision by **14.00**. By **12.00** next day if decision after **14.00**
- **T1c.** For assessment bed / I.C. bed: Arrival within **24 hrs** between **10.00** and **16.00**

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**Nottinghamshire Work in Progress**

* All assessments are carried out using a Comprehensive Geriatric Assessment (CGA) approach
South Warwickshire NHS FT Project
(see Philp I HSJ 2012 and HSJ awards) “integrated care for frail older people”

• “Get in early” Including use of structured easy-care tool for CGA
• “Invest in alternatives” to acute hospital care
• “Decide to admit”
• “Provide acute care by old age specialists”
• “Discharge to assess”
• Even over 2 years
• 31% reduction in LOS
• 31% increase in n (discharges)
• 15% reduction in mortality of over 80s
• 15% reduction in care home placements
No room for defeatism. There is plenty we can do to improve health and healthcare for older people.

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