

Making Health and Care Systems fit for an Ageing Population

King's Fund Paper

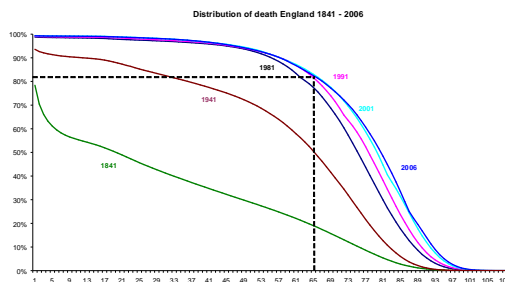
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GSF 10th Annual Conference 26th September 2014

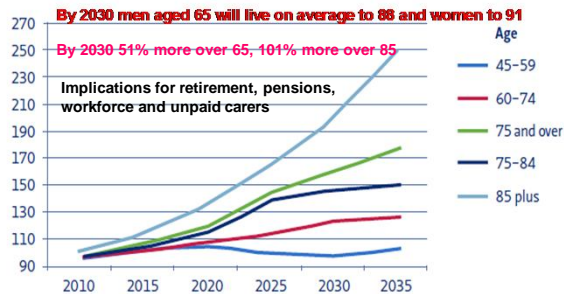
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When NHS founded, 48% died before 65, now its c 14%.
LE at was c 71 for women and 66 for men.
Now its c 83 for women and 79 for men



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Figure 1. Projected population by age, United Kingdom, 2010-35 (2010 = 100)



Source: Office for National Statistics (Oct 2011) National Population Projections 2010-based Statistical Bulletin.

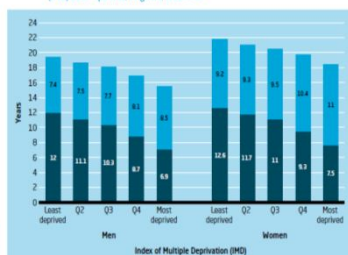
Let's stop catastrophising and using words like "time-bomb" or "tsunami"

- > Ageing = a victory for modern healthcare
- > And for wider societal prevention
- > Gives us a better chance for longer healthier life
- > Most over-75s self rate health as "good" or better
- > Many don't report *life-limiting* LTC
- > Overall health in old age may be improving
- > Most aren't "lonely" or "isolated"
- > Self-reported happiness peaks in 70s
- > Older people make active contribution to economy through paid work, spending, volunteering, as unpaid carers or grandparents

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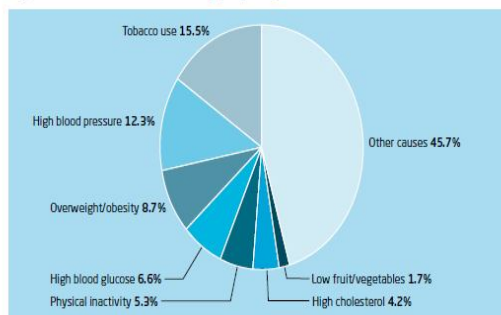
Need focus on prevention (primary, secondary), wellbeing, inequalities and active ageing. Both across "life course" and "mature life course"

Figure 3 Life expectancy with disability (LEWD) and disability free life expectancy (DFLE) for men and women at age 65, by Index of Multiple Deprivation (IMD) 2007 quintile, England, 2006-08



TheKi Source: Office for National Statistics 2011a

Figure 4 Burden of disease among people aged 60 and over



Source: World Health Organization 2011b

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Some key resources on prevention & healthy ageing
(bear in mind that "prevention can be 1y, 2y or 3y")

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE
PUBLIC HEALTH DRAFT GUIDELINE
Dementia, disability and frailty in later life – mid-life approaches to prevention

HEALTH CARE QUALITY FOR AN ACTIVE LATER LIFE
Promoting quality of prevention and treatment through information, August 2008 to 2012

HEALTH SERVICES MANAGEMENT CENTRE
Research that makes a real difference
August 2008 HSMC policy paper 3
"The billion dollar question": embedding prevention in older people's services - 10 "high impact" changes
Kerry Allen and Jon Gladby, Health Services Management Centre, University of Birmingham

World Health Organization
DRAFT
Ministerial Meeting of the Regional Committee for Europe
Copenhagen, 19-20 March 2012
Strategy and action plan for healthy ageing in Europe, 2012-2016

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What ageing means for health & services?

- › Focus paper unashamedly on older people who are living with worsening health and who do need support
- › **Multiple** Long Term Conditions
- › Including common **age-related** ones
- › Move to person-centred **not (single) disease** centred model
- › **Polypharmacy**
- › **Frailty syndrome** and the way people with frailty present to services
 - e.g. falls, immobility, delirium, "failure to thrive"
- › **Dementia**
- › Worsening **mobility**
 - (esp. **after acute illness or injury**)
- › **Sensory impairment**
- › Role of **family/carers**
- › **Workforce** skills, knowledge, values, attitudes, planning, deployment
- › Care towards **end of life**

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Older People with complex needs are "core users" – a disadvantaged majority?

- › Care Home residents
- › Users of statutory social services
- › Primary care
- › Intermediate care
- › Acute hospitals

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Older people and the integration & care co-ordination agenda

- › Older people with complex needs
- › Most likely to use multiple services
- › See multiple professionals
- › Experience multiple transitions and "hand offs"
- › Be most bewildered by them
- › And be let down by the system
- › Even when the professionals concerned are all caring and well-intentioned...

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National Voices
People shaping health and social care

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

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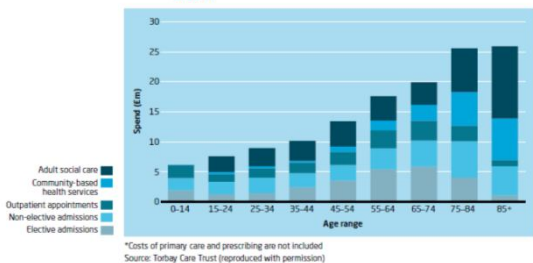
National Voices "I statements"

- › Care co-ordination
- › Information
- › Shared decisions and care planning
- › Medicines
- › Self-management
- › Care transitions
- › Managing at home

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We can't solve our financial challenges if we don't focus on care for older people

Figure 1 Annual cost* by age and service area for Torbay (population 145,000), 2010/11



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- > Free at http://www.kingsfund.org.uk/sites/files/kf/field/publication_file/making-health-care-systems-fit-for-an-ageing-population-oliver-foot-humphries-mar14.pdf
- > Free slideset at <http://www.kingsfund.org.uk/audio-video/improving-care-ageing-population-what-works>
- Blog <http://www.kingsfund.org.uk/blog/2014/03/time-has-come-make-health-and-care-services-work-our-ageing-population>

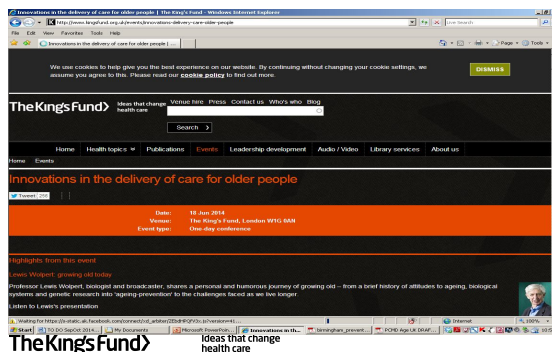
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Structure of paper

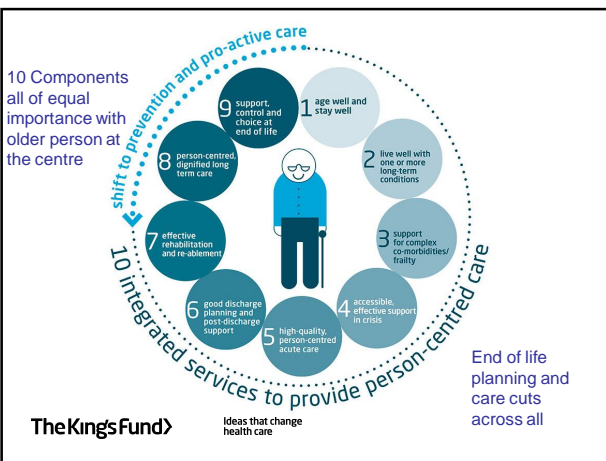
- > Intensely practical
- > Aimed at those leading local services
- > 10 sections
- > For each:
 - Goal
 - Current situation
 - "what we know can work"
 - Key references and resources
 - Good practice examples from around the UK (*despite* austerity and upheaval)
- > Field tested/reviewed with many service leaders
- > Widely endorsed. Cited by NHS England.

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c. 80 good practice examples here..



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Chapter 9: Support, control and choice towards the end of life

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.

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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 over a month

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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

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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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How to use the paper as a framework in designing integrated services

- > The patient at the centre
- > Ensure all key agencies in the working group
- > Strong patient/carer voice from outset
- > Set out high level goals everyone signed up to
- > Some performance indicators (for whole system)
- > Walk the whole journey of care
- > How close are you to delivering the vision?
- > *What can each organisation/profession do better?*
- > *What's happening at interfaces/transitions?*
- > *And with duplication*
- > *Only then* get into structures/money

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Finally...



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Enjoy today and the challenge beyond. Thank you



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