Making Health and Care Systems fit for an Ageing Population

King’s Fund Paper

Prof David Oliver
Consultant Geriatrician, Visiting Fellow KF & BGS
President-elect
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When NHS founded, 48% died before 65, now it’s c 14%. LE at was c 71 for women and 66 for men. Now it’s c 83 for women and 79 for men.

Distribution of death England 1841 - 2006

By 2030 51% more over 65, 101% more over 85

Implications for retirement, pensions, workforce and unpaid carers

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

Need focus on prevention (primary, secondary), wellbeing, inequalities and active ageing. Both across “life course” and “mature life course”
Some key resources on prevention & healthy ageing
(bear in mind that "prevention can be 1y, 2y or 3y)

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

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

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...

National Voices “I statements”
- Care co-ordination
- Information
- Shared decisions and care planning
- Medicines
- Self-management
- Care transitions
- Managing at home
We can’t solve our financial challenges if we don’t focus on care for older people.

*Published 6/3/14 2014: Basis for today*

- Blog [http://www.kingsfund.org.uk/blog/2014/03/time-has-come-make-health-and-care-services-work-for-our-ageing-population](http://www.kingsfund.org.uk/blog/2014/03/time-has-come-make-health-and-care-services-work-for-our-ageing-population)

**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

**c. 80 good practice examples here..**

**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.
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.

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.

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

Finally...

Enjoy today and the challenge beyond.
Thank you.