Making health and care systems fit for an ageing population. How partnership working and integration can help

Professor David Oliver
Consultant Physician/Geriatrician, Royal Berks
Visiting Fellow, the Kings Fund
President-Elect, British Geriatrics Society
Visiting Professor of Medicine for Older People, City University, London
Groups most likely to benefit from integrated care and partnership working? e.g.

• People (all ages) with complex or multiple long-term conditions reliant on multiple services
• Mental health
• Physically Disabled/Learning Disabled
• Care towards the end of life
• Older people – including those with frailty, complex needs
By 2030 men aged 65 will live on average to 88 and women to 91

51% more over 65, 101% more over 85

Welsh Government Projections

• “The number of people aged 65 and over in Wales is projected to increase by 292,000 or 50% between 2012 and 2037”

• “The number of people aged 16 to 64 is projected to decrease by 60,000 or 3% between 2012 and 2037”
“Seventy is the new Sixty” But inequalities in healthy ageing

Index of Multiple Deprivation (IMD)

Source data: Health Statistics Quarterly 50, summer 2011, ONS

Figure 17: 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
The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions. More people have 2 or more conditions than only have 1.

**Multimorbidity in Scotland**

*(Scottish School of Primary Care Barnett et al Lancet May 2012)*
Most people with one long term condition have multiple conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of patients with this condition (Scottish School of Primary Care Guthrie BMJ 2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>52</td>
</tr>
<tr>
<td>Hypertension</td>
<td>14</td>
</tr>
<tr>
<td>Heart failure</td>
<td>13</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>22</td>
</tr>
<tr>
<td>Diabetes</td>
<td>13</td>
</tr>
<tr>
<td>COPD</td>
<td>8</td>
</tr>
<tr>
<td>Cancer</td>
<td>24</td>
</tr>
<tr>
<td>Painful condition</td>
<td>17</td>
</tr>
<tr>
<td>Depression</td>
<td>61</td>
</tr>
<tr>
<td>Schizophrenia or bipolar</td>
<td>81</td>
</tr>
<tr>
<td>Dementia</td>
<td>65</td>
</tr>
<tr>
<td>Any other condition</td>
<td>70</td>
</tr>
</tbody>
</table>

E.g. Only 18% with COPD just have COPD
Figure 7: Prevalence of mobility problems* in men and women aged 65+, England 2005

Source: HSE 2005. Copyright © 2011, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
Figure 4: The consensus* estimates of the population prevalence of late onset dementia in men and women aged 65+, UK, 2007.
Panel 1: Frequent clinical presentations of frailty

Non-specific
Extreme fatigue, unexplained weight loss, and frequent infections.

Falls
Balance and gait impairment are major features of frailty, and are important risk factors for falls. A so-called hot fall is related to a minor illness that reduces postural balance below a crucial threshold necessary to maintain gait integrity. Spontaneous falls occur in more severe frailty when vital postural systems (vision, balance, and strength) are no longer consistent with safe navigation through undemanding environments. Spontaneous falls are typically repeated and are closely associated with the psychological reaction of fear of further falls that causes the patient to develop severely impaired mobility.

Delirium
Delirium (sometimes called acute confusion) is characterised by the rapid onset of fluctuating confusion and impaired awareness. Delirium is related to reduced integrity of brain function and is independently associated with adverse outcomes. Roughly 30% of elderly people admitted to hospital will develop delirium, and the point prevalence estimate for delirium for patients in long-term care is 15%.

Fluctuating disability
Fluctuating disability is day-to-day instability, resulting in patients with “good”, independent days, and “bad” days on which (professional) care is often needed.
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 in right place with right capacity at right time**
“We need to be careful about assuming that failure is just the responsibility of the individual institution. Most failing trusts tend to sit within wider failing local health and social care economies. A model that concentrates solely on improving individual trust leadership, without tackling the wider underlying structural issues and ensuring the whole system can work together is likely to fail”
• There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they’re falling in.”
Somerset Levels 2014
• “When we say the hospital is full, we really mean, the community is full”
Major geographical variation in admission rates and bed occupancy

Figure 2  Needs-weighted emergency bed days per person over 65, per annum, national distribution

Kings Fund Report Emergency Bed Use in Older People 2012
Same for care home placement

Figure 11: The percentage of people aged 65 and over who are admitted to hospital from their own home and discharged to residential and nursing care in 2009/10
And Intermediate Care (step-up, step down, bed-based and home-based)

One example of many From National Audit of Intermediate Care 2013
% of patients who could potentially be in other settings

*(Edwards N Kings Fund Community Services 2014)*

**Figure 1** Top seven alternative services required

Source: The Oak Group
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.
Co-ordinated care for people with complex chronic conditions

Key lessons and markers for success

Author
Nigel Edwards

February 2014

Community services
How they can transform care

Making integrated care happen at scale and pace

March 2013

Authors
Chris Ham
Nicola Walsh

Why integrated care matters
The King's Fund has been instrumental in making the case for integrated care (Ham and Curry 2011; Ham et al 2011; Goodwin et al 2012). Our argument is that the current fragmented services fail to meet the needs of the population and that greater integration can improve the patient experience and the outcomes and efficiency of care. This case was accepted by the NHS Future Forum, and the government in its response made commitments to promote integration. The challenge now is to convert policy intentions into meaningful and widespread change on the ground.

The aim of this paper is to support the process of ‘making it happen’ by summarising the steps that need to be taken to make integrated care a reality: we have drawn on our own experience and that of others in areas where local leaders have identified integration as a key strategy. At the end of the paper we acknowledge that changes to national policy and to the regulatory and financial frameworks are needed for local leaders to fully realise a vision of integration.

The case for integrated care is reinforced by the need to develop whole-system working to address the demands arising from an ageing population and increases in the number of people with multiple long-term conditions. The evidence of the benefits, in particular the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be co-ordinated around the needs of people and populations. Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place.

We start from the assumption that the unmet need of mental and social services pressures facing health and social care cannot be tackled by making incremental adjustments to existing services and ways of working. A step-change is needed, given the prospect that public services face a decade of austerity in which budgets will either not increase (in the case of the NHS) or face further cuts (in the case of local government).

Making best use of the Better Care Fund
Spending to save?

Evidence summary
January 2014

Commissioning and funding general practice
Making the case for family care networks

Polypharmacy and medicines optimisation
Making it safe and sound

The King's Fund
13-15 Cavendish Square
London W1G 0DB
Tel: 020 7937 7400
Regrettant charity: 1230904
www.kingsfund.org.uk

The King's Fund is an independent charity working to improve health and healthcare in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

© The King’s Fund 2013
Sam’s Story

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
National Voices “I statements”

- Care co-ordination
- Information
- Shared decisions and care planning
- Medicines
- Self-management
- Care transitions
- Managing at home
Person-centred co-ordinated care?

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.

National Institute for Health Research
Service Delivery and Organisation Programme

Jo Ellins\textsuperscript{1}, Jon Glasby\textsuperscript{1}, Denise Tanner\textsuperscript{2}, Shirley McIver\textsuperscript{1}, Deborah Davidson\textsuperscript{1}, Rosemary Littlechild\textsuperscript{2}, Iain Snelling\textsuperscript{1}, Robin Miller\textsuperscript{1}, Kelly Hall\textsuperscript{1}, Katie Spence\textsuperscript{1} and the Care Transitions Project co-researchers.\textsuperscript{3}

\textsuperscript{1} Health Services Management Centre, University of Birmingham
\textsuperscript{2} Institute of Applied Social Studies, University of Birmingham
\textsuperscript{3} Solihull, Leicester, Gloucestershire, Manchester

The Kings Fund Ideas that change health care
Making our health and care systems fit for an ageing population

Authors
David Oliver
Catherine Foot
Richard Humphries

Also check out our conferences in October 2013 on Services for Older People and Care Co-ordination
10 inter-dependent components of care (the “what?” and “how?” more than the “who?” and “where?”)

- healthy, active ageing and supporting independence
- living well with simple or stable long-term conditions
- living well with complex co-morbidities, dementia and frailty
- rapid support close to home in times of crisis
- good acute hospital care when needed
- good discharge planning and post-discharge support
- good rehabilitation and re-ablement after acute illness or injury
- high-quality nursing and residential care for those who need it
- choice, control and support towards the end of life
- integration to provide person-centred co-ordinated care.
Improving care for an ageing population: what works?

6 Mar 2014

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.

This slideset summarises our report. Making our health and care systems fit for an ageing population. It highlights nine components of care (and an integrated system to support these components) that need to be improved to provide person-centred, relevant care for older people. The slideset sets out the current situation and provides practical guidance on actions that will make a difference.

Making our health and care systems fit for an ageing population

David Oliver, Catherine Foot, Richard Humphries

Related document:
- Improving care for an ageing population: what works? slideset

Related links:
- Making our health and care systems fit for an ageing population
- Improving care for an ageing population
- Making care fit for an older population

More on:
- Quality of care
- Integrated care
- Patient experience

Related blog:
• By 2030, one in five people in England will be over 65

• Population ageing 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, coordinating around their needs and focusing on keeping people well and out of hospital and long term care

• Our paper aims to be a single accessible reference guide for local health and care leaders interested in improving their services for older people
10 components of care.

Recognise multiple interdependencies and transitions. End silo-thinking. Focus on the “what” less than the “where and by whom”
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 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
shift to prevention and pro-active care

1. age well and stay well
2. live well with one or more long-term conditions

The King's Fund
Ideas that change healthcare
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 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
The King's Fund

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

Ideas that change health care
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 over 65 and 1 in 2 over 80 fall each year

- There is considerable underdiagnosis 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
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
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 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

The King's Fund
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 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
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
6. Good discharge planning and post-discharge support
Goal

Discharge planning needs to start at first contact with 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
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
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement

The King's Fund
Ideas that change health care
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 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
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
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement
8. Person-centred, dignified long-term care

The King's Fund
Ideas that change health care
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 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
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
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement
8. Person-centred, dignified long term care
9. Support, control and choice at end of life

The King's Fund
Ideas that change health care
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
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
6. Good discharge planning and post-discharge support
7. Effective rehabilitation and re-ablement
8. Person-centred, dignified long-term care
9. Support, control and choice at end of life
10. Shift to prevention and pro-active care
Making it happen: integration

• Create a safe space for genuine interagency leadership with shared sovereignty and moving away from sectional interests or “reciprocity” though look for “win/wins” for all organisations

• 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

The Kings Fund  Ideas that change health care
Lessons from experience: making integrated care happen at scale and pace

1. Find common cause with partners and be prepared to share sovereignty.
2. Develop a shared narrative to explain why integrated care matters.
3. Develop a persuasive vision to describe what integrated care will achieve.
4. Establish shared leadership.
5. Create time and space to develop understanding and new ways of working.
6. Identify services and user groups where potential benefits from integrated care are greatest.
7. Build integrated care from the bottom up as well as the top down.
8. Pool resources to enable commissioners and integrated teams to use resources flexibly.
9. Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector.
10. Recognise that there is no ‘best way’ of integrating care.
11. Support and empower users to take more control over their health and wellbeing.
12. Share information about users with the support of appropriate information governance.
13. Use the workforce effectively and be open to innovations in skill-mix and staff substitution.
14. Set specific objectives, and measure and evaluate progress towards them.
15. Be realistic about the costs of integrated care.
16. Act on all these lessons together as part of a coherent strategy.
How to start
*(only get into structural/organisational/cost-shifting etc afterwards)*

- ‘Walk’ the journey for older people from healthy active ageing, right through to end-of-life care – recognising multiple dependencies
- Design services around the person
- Agree some key performance standards that all organisations can aspire to achieve
- Make sure everyone gets their own house in order on quality before slinging mud – “its not us, its them”
- Map out which elements of good practice/performance are already provided and where the gaps are
- Identify early priorities for change and quick wins
- Build in whole system and person-centred outcome measures from the start
- Ensure that the work is informed by meaningful input from older people and their carers
There is plenty we can do to improve the offer to our older citizens and plenty of good practice already out there.

Thank you

D.Oliver@kingsfund.org.uk
David.Oliver@royalberkshire.nhs.uk