LONDON SOUTH BANK UNIVERSITY

Faculty of Health and Social Care

Health and Social Care for Older People

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Who are the elderly needing care?

- Pensioners 11.3 m rising to 13.5 m by 2030
- 75+ rising from 4.7 m to 8.2 m by 2030 but
- Only 28% of 75+ say their health is "not good"
- Care needs and preferences are individual

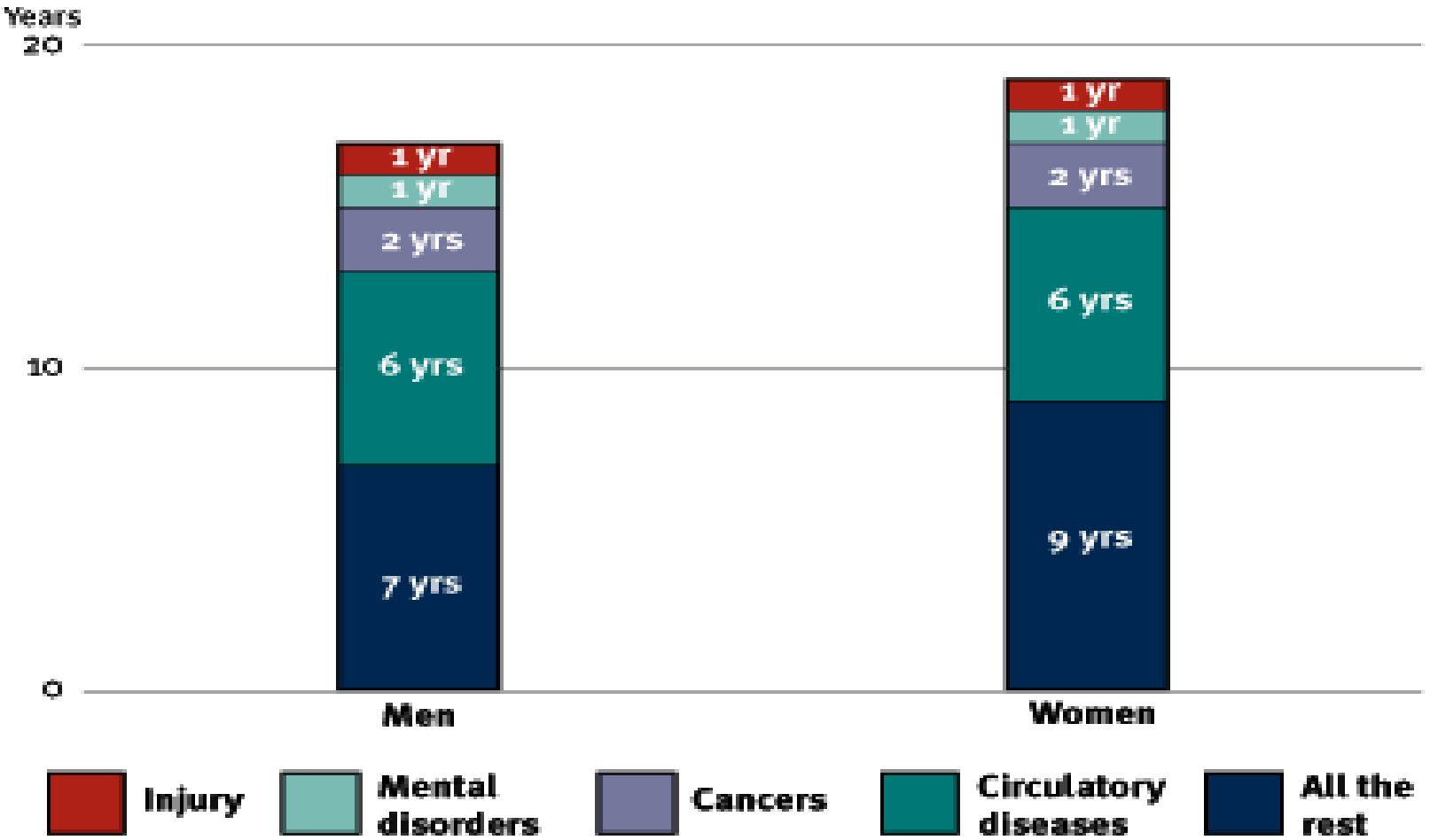
- "The elderly"
  Are as different as
  Me (75) and my mum
  Who died at the age of 99 since I first gave this lecture
  "The elderly" are our biggest problem and our greatest resource

Trends over 20 years:

- Success of medical technology means by 2030
  - Ageing 3 years more, 65+ = 25% of population
  - Greater infirmity ~ 1½ year more = 20% +
  - But independence at 85 increasing from 68-81%
- Major health problems expected in 2030
  - Mental illness 17% ~ No of cases doubled
  - Obesity ~ 35%, Alcohol problems ~ 25%
  - Diabetes, Cancers, Parkinson's, Alzheimer's
  - Falls and fractures, mental confusion
  - Chronic disease and conditions 21% in 1972, 35% in 2004 and probably up to 45% by 2030

Unhealthy Years at the End of Life 1999

Fig 2.7 Unhealthy years at the end of life



Figures include some double-counting, as individuals may suffer from more than one condition

Source: Bone M, Bebbington A, Jagger C, et al. (see References Section)

Self Care and Co-Production

- Some 16million people in England have long term conditions, forecast to increase to 30m by 2030
- Steps have been taken to:
  - Develop training and aids to self care including:
    - Expert patient training programmes
    - Gadgets to monitor conditions such as diabetes
    - Training aids to prevent falls and applications to monitor falls and movement of confused people
- But training and technology is not enough, we need
  - To address mental wellbeing, loneliness and purpose
  - Community organisation, support for co-production

The Informal Care Crisis

- 70% of support care is provided by informal carers who look after 7 million people
- Demand for care will increase by 25-30%
- But note trends towards:
  - Declining volunteerism and family support
  - Increasing numbers of carers will be 75+ in 2030
    - Ability to care declines sharply over age of 75
  - Older people more likely to be divorced and alone
    - Single person now 32% of households
    - 12% of households are women over 60 living alone
      4% of households are men over 65 living alone

The Social Care Crisis

- There are some 90,000 professional social workers in England in NHS and LAs (and 5% in other) about 24,000 LA SWs work with adults.
- They help people with multiple problems including mental problems and disabilities, mostly older people, to address their needs with families, communities, voluntary and public services.
- Case loads typically 30 (but for some it can be as high as 100 people). They provide access to 1.1 to 1.6 million care support staff such as home helps.
- But number of SW posts is declining, due to financial pressures and many leave SW posts.
- And inadequate training of care support staff is evident

The Care Home Crisis

- There are some 250,00 people in 10,000 residential care homes for elderly people in England, about 4,500 with nursing support and 5,500 without but all with increasing dependency.
- But numbers of homes and places has declined in recent years due to financial pressure and failure to achieve acceptable standards of care.
- This has been a failure by providers, by the LAs who fund most residents and by regulators.
- There are of course many other residential options including sheltered housing and home care.

The Continuity of Care Crisis

- There are about 1,750 patients for each whole time equivalent GP and about ½ wte practice nurse, and ½ a community nurse (health visitor or other)
- 300 are now over 65 but by 2030 there will be 400
- People over 85 visit primary care 12.6 times a year, more than twice the average of 5.3 visits per person in 2006
- Continuity of primary care is vital for older people but
  - Patients are now registered with a practice not a GP
  - GPs are no longer responsible for 24 hour care
  - Systems to support continuity are poor
  - Use of locums undermines continuity of care
- Numbers of Community Care Nurses are declining

Hospital stay crisis of care

- People over 70 average of over one hospital visit per year (general population one every 5 years)
  - More than 50% of bed days are used by 65+
- Hospitals are increasingly intensive as number of beds declines and length of stay reduces
- The patient experience may be:
  - Confusion, affects from 15-50% of over 70s
  - Dealing with 27 health professionals.
  - Some of whom seem to have lost their ethic of care
  - Perhaps due to insensitive target chasing.
- Failure to manage transition from hospital to home is a major source of crises in care.

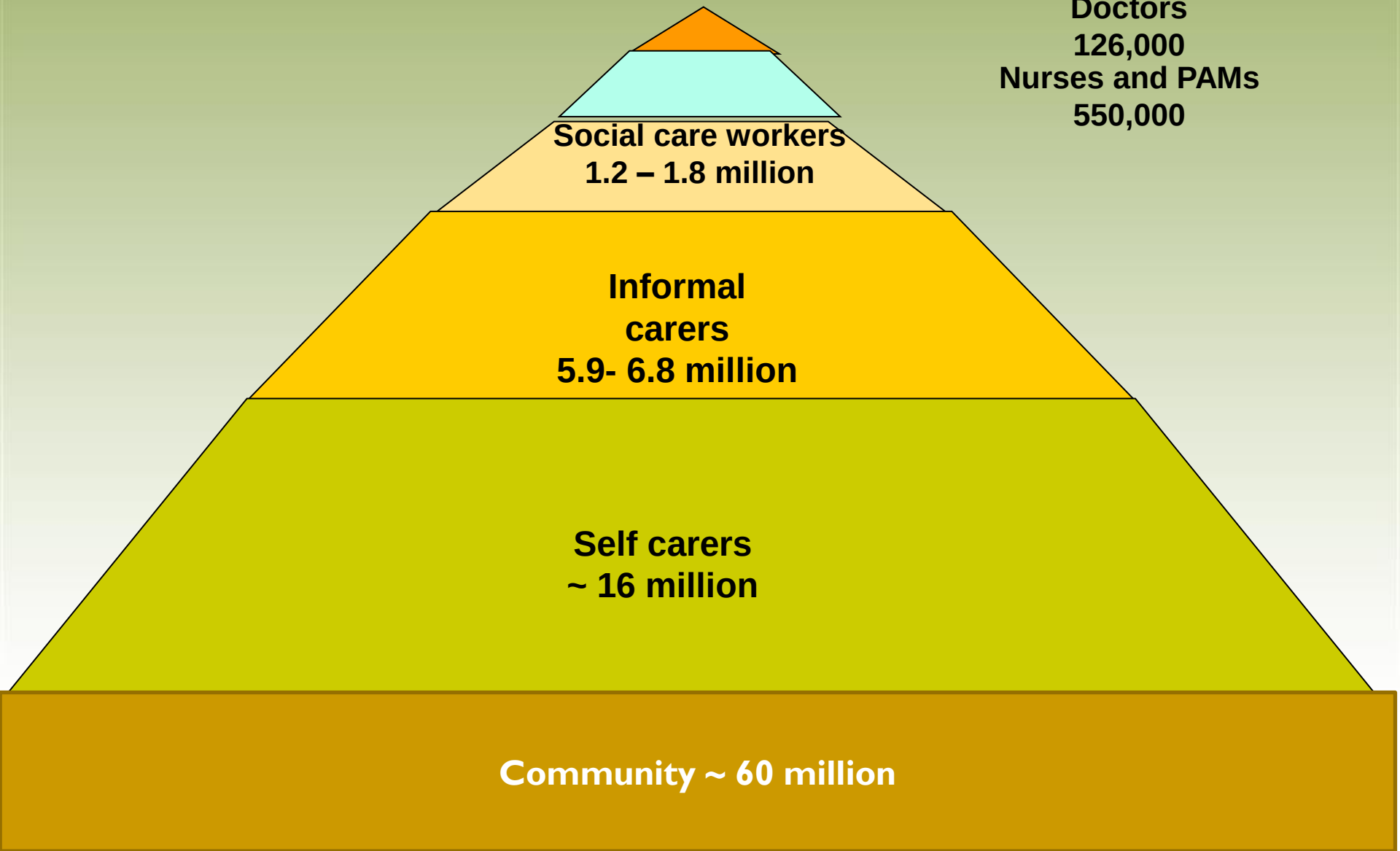
Care also includes support for death

- Most people (56%) want to die at home
- Or in a hospice (24%) but
  - 56% die in NHS and 10.5 in other hospitals
  - 10.4% die in care homes,
  - Only 4.3% die in hospices and
  - 18.6% die in their own home
- Better support in peoples homes and
- More hospice care is needed but we also need
- Better care and dignity for death in hospitals

Physical/ mental /social/ primary/acute care.

- We are trying to define irrelevant boundaries
  - By 85 some 30% of people have Alzheimer's
  - 30% Residential care occupants ~ AD or confused
  - 68% Nursing home occupants ~ mental impairment
  - Physical and mental impairment often combine
- Many elderly people need a continuum of physical /mental/primary/acute health and social care
  - This includes: friendship, staying physically and mentally healthy, housing, holidays, finance, shopping, transport, family contact and many other aspects of a better life in old age.

Who Provides Our Care



What reforms are being implemented?

- Current policy for modernising health and care:
  - Integration of health and social care through Health and Wellbeing Boards bringing NHS and LAs together and engaging with community partners.
  - Development of Integrated Care Systems to commission health and care services
    - Yes but we have been struggling to integrate in similar ways for 20 years and have not succeeded
  - Personal care plans for those with long term conditions with a cap on personal care costs.
    - Yes but this risks turning Social Workers into budget managers rather than client helpers and so far less than 6% of those with long term conditions have written personal care plans

Will current reforms work?

- Pilots programmes* to integrate working of health and social care teams suggests:
  - Staff have noted positive improvements, but
  - Patients/clients do not report improvements
  - A wide range of detailed measures matched to local conditions and needs is required.
  - There are no simple organisational or systems magic bullets.
  - It will take time, investment and responsive leadership.

* National Evaluation of the Department of Health's Integrated Care Pilots RAND Europe, Ernst & Young LLP 2012

What other answers are proposed?

- Andy Burnham (Labour) "move Social Work to NHS"
- And commission together with Local Authorities
  - But would yet another reorganisation change working culture and bring NHS any nearer to communities.
  - Experience of working with NHS suggests it can be highly departmentalised
  - At least he recognises that commissioning is complex and needs to bring in perspectives from:
    - Communities, families and individuals
    - Primary and Secondary Care providers
    - Social care providers and hands on carers
    - Wider aspects of social and community development

Start by listening

- Listening is the foundation for care:
  - Listening to communities of place, interest and need to support community based care.
  - Listening to whole person choices and responding to individual and family needs and resources.
  - Recognising needs for mental/physical health, social support and a range of community services
  - Allowing access to choice from individuals, community groups, health and social workers.
  - Drawing on people like Health Trainers with basic training in listening, befriending and referral.

Invest in what works

- There is a need for a lot more experimentation in new ways of supporting integrated, whole person care. This may involve:
  - Regular GP/SW review for older patients
  - Focus on continuity of care - hospital to home
  - Hospital at home schemes
  - Monitoring devices with community support
  - Support and training for informal carers
  - Time banking schemes
  - Support for community groups
  - Training of care volunteers and much more

What might older people tell us?

- Michael Young, in hospital for what turned out to be the last time, wrote me a note (as Chair of the College of Health, which he founded):
  - "Why can't we record discharge interviews and make them available from people's home phone. There was a lot of important information for me, my family, and maybe my GP but I am sure patients like me can't remember much of it".
  - As always he had a very good point but as so often happens in the NHS, no one was prepared to listen.

The Care We Want