LONDON SOUTH BANK UNIVERSITY

Faculty of Health and Social Care

Health and Social Care for Older People

Graham Lister, Visiting Professor LSBU

Member of the Chalfonts and Gerrards Cross Hospital League of Friends

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

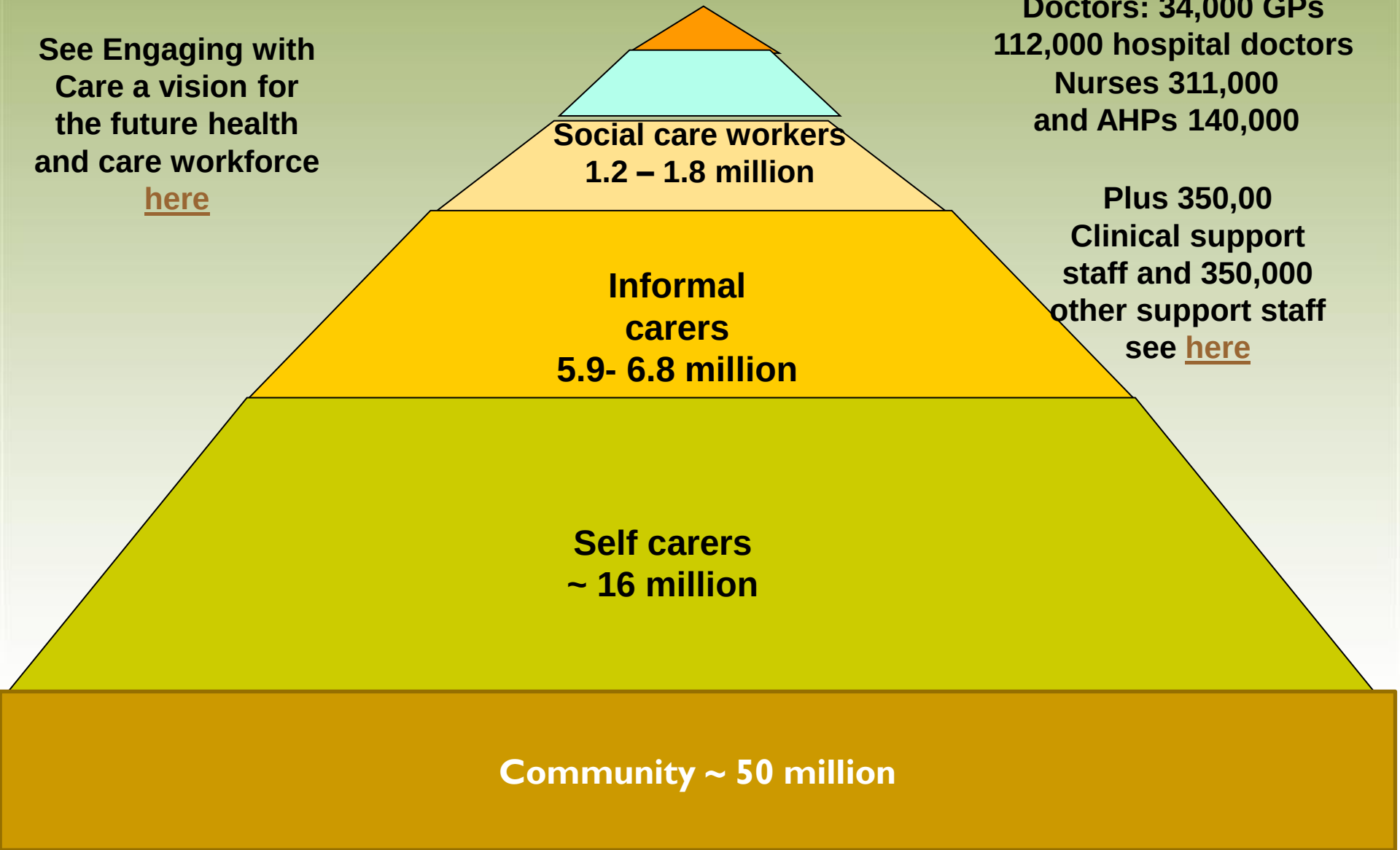
- "The elderly"
  Are as different as
  Me (78) and my mum
  Who died at the age of 99 since I first gave this lecture
  "The elderly" are our biggest problem and our greatest resource

Trends over 20 years:

- Success of medical technology means by 2030
  - Ageing 3.5 yrs +LE 65+ = 25% of population
  - 1.5 yrs more spent in poor health = 20% increase
  - But independence at 85 also increased from 68-81%
- Major health problems expected in 2030
  - Mental illness 17% ~ No of cases doubled
  - Obesity ~ 25-35%, Alcohol problems ~ 25%
  - Diabetes, Cancers, Parkinson's, Dementia
  - Falls and fractures, mental confusion
  - Chronic disease and conditions 21% in 1972, 35% in 2004 and probably over 40% by 2030

Who Provides Our Care

See Engaging with Care a vision for the future health and care workforce here



Doctors: 34,000 GPs
112,000 hospital doctors
Nurses 311,000
and AHPs 140,000

Plus 350,00 Clinical support staff and 350,000 other support staff see here

Self Care and Co-Production

- Some 16m people in England have long term conditions, forecast to increase to 20m 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 long-term conditions require self-care
    - Need for more support for Community Groups
    - That help people sustain each other in self- care
- This must be co-produced with community groups

The Future of Informal Care

- 70% of support care is provided by informal carers who help to look after 7 million people
- Demand for care will increase by 25-30%
- But note trends towards:
  - Increasing numbers of carers will be 75+ in 2030
    - Ability to care declines sharply over age of 75
  - Elderly likely to be divorced and alone, of the 65+
    - Single person household now 32% could rise to 40%+
    - Those living alone more likely to have chronic illnesses
    - And make greater use of GP and A&E services
    - 20% of GP appointments are for non-medical needs
    - 16% live in relative poverty (after housing costs)

The Future of Social Care

- 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 and physical, mostly older people, to address their needs with families, communities, voluntary and public services.
- Caseloads 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
- Leaving the EU will reduce no of care workers available

The Future of Homes for the Elderly

- 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.
- By 2035 demand is forecast to rise fourfold
- There were 340,000 housing units in England with support for elderly residents in 2015 demand is projected to rise to 535,000 by 2030.
- But numbers of homes and places has declined in recent years due to financial pressure and failure to achieve acceptable standards of care.
- Current trends show these targets will not be met

Primary Care Pressures

- 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 of these patients are now over 65 but by 2030 there will be 400
- People over 85 visit primary care 12-13 times a year, more than twice the average of 5-6 visits per person
- GPs under strain as care needs are increasingly complex
- 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
  - Many GPs now work part time
  - Systems to support continuity are poor
- Numbers of GPs and Community Care Nurses are declining though overall number of primary care staff is increasing

Hospital stay trends

- People over 70 average 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 of hospital care:
  - Confusion, affects from 15-50% of over 70s
  - Dealing with 27 health professionals.
- Failure to manage transition from hospital to home is a major source of pressure in care.
  - Due to inadequate coordination
  - And lack of funding for social care

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".
  - He had a good point but in the NHS, no one was prepared to listen Matt Hancock told me they were taking action but I don't see it.

Care should include support for Dying

- 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 people's 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 were trying to define irrelevant boundaries
  - By 85 some 30% of people have Dementia
  - 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.

Preparing for the Future

- The response to these challenges resulted from consultations across the NHS led by Simon Stevens:
  - The NHS Five Year Forward View 2014
  - The NHS 10 Point Efficiency Plan 2014
  - The General Practice Forward View 2016
  - The Integration and Better Care Fund Policy Framework 2017-19
  - NHS Long Term Plan 2019
  - GP Contract 2019 and CCG Contract Guidance
  - Universal Personalised Care: Implementation Plan 2019
- These plans show a major evolutionary change responding to demand and led by best practice not top down instruction.
  - Unfortunately they were not matched by ideas for the funding and operation of social care due in ~~2018- 2020~~ Lord knows when

The NHS Five Year Forward View

The Forward View here recognises future financial constraints: sets priorities for achieving service improvements and financial sustainability, including:

- **To provide urgent and emergency care:** 24 hrs a day 7 days a week by working with community services and councils to reduce pressures.
- **To reverse the decline in primary care funding**: more GPs, Clinical Pharmacists and Mental Health Therapists and extended evening and weekend appointments.
- **Improve services for cancer patients and people with Mental Health problems:**
- **Improved prevention and care services:** to enable frail and elderly people to live independent lives by integrated funding and provision of health and care services.
- **Implementing the NHS Ten Point Efficiency Plan**: recognising the skills of all staff and their leadership skills and using technology innovations to transform services.
- **The NHS will improve efficiency by 2.4%:** providing better, safer care to more people

The NHS Funding and Efficiency 10 Point Plan

- The NHS Five Year Forward View includes a plan to improve efficiency by 2.4% see here by steps to:
  1. Reduce demand for hospital beds by extending home care and care in the community
  2. Reduce use of temporary agency staff
  3. Make better use of NHS procurement power
  4. Improve use and price of medicines, to reduce waste, extend use of drugs that save future health costs and improve negotiations with suppliers.
  5. Reduce avoidable demand for services, by better referral and prevention services
  6. Reduce unwarranted variation in the quality and efficiency of services
  7. Make better use of estates, infrastructure and clinical support services
  8. Reduce administrative costs
  9. Collect income more effectively
  10. Ensure improved financial control

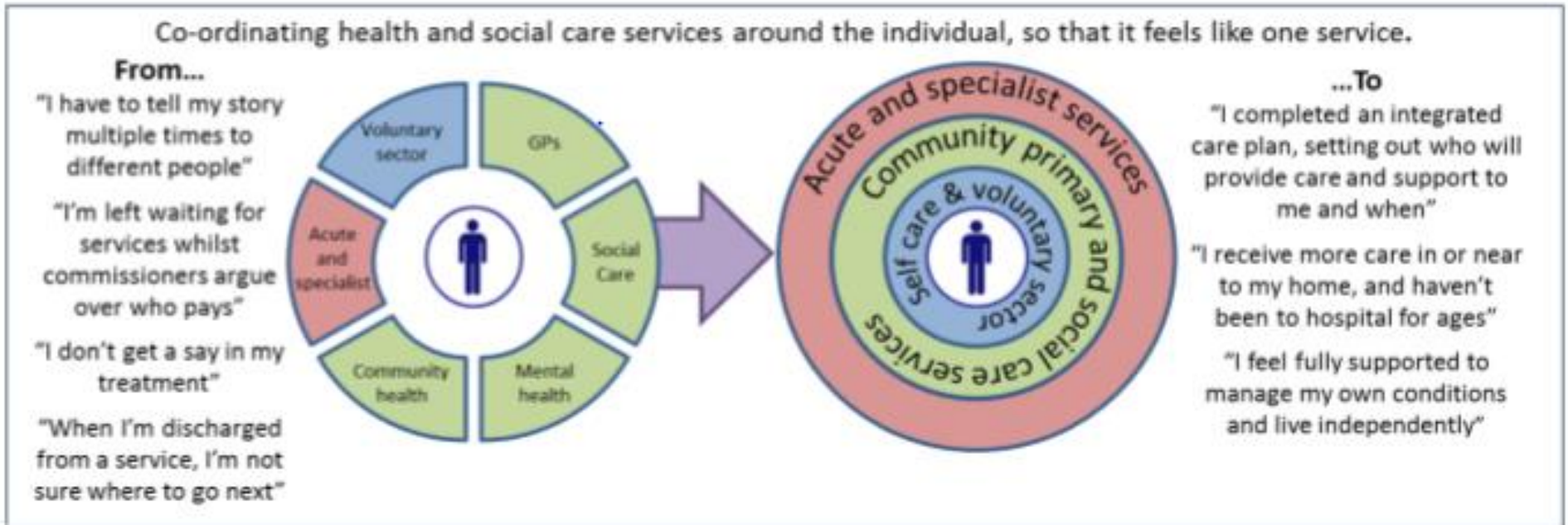
The General Practice Forward View

- The GP Forward View 2016 (see here) promised:
  - More funding – 14% increase £2.4b more by 2021
  - Plus £500m - Sustainability & Transformation Plans
  - Includes £40m resilience + £16m for GP "burn out"
  - £206m for 2x growth of GPs + Clinical Pharmacists + Receptionist + Practice Nurse Development + 1,000 Physician Associates + 3,000 Mental Health Workers
  - £246m for practice redesign, increased use of IT to enable online services, new models of care, improved co-ordination with hospital care
  - £900m capital investment in primary care facilities.

Integration and Better Care

The Integration and Better Care Fund Policy Framework 2017-19 (see here) called for:

- Better integration with Voluntary, Community and Social Enterprise to support group and individual self-care
- Better integration of Primary Care and Social Care
- Better integration with Acute and specialist services.



The NHS Long Term Plan

The plan see here represents an agreement with Government on priorities and funding for the NHS. It builds on the 5 year Forward View and calls for:

- **More investment in Integrated Primary and Community Care**
  - Redesigned to reduce pressure on emergency hospital services.
- **More personalised care.**
  - Supported by use of digital technology in primary and outpatient care
- **Greater focus on community health, wellbeing and prevention**
  - Integrated Care Systems engaging NHS, LAs and local communities
  - £4.5 bn for Community Care including Pharmacy and Social Prescribing
- **More investment in Mental Health services**
- **Supported by 3.4% per annum funding increase in real terms**
  - Increased to 4.5% p.a. by 1.1% p.a. cash saving (from overall 2.4% efficiency target) this would equate to 6.5% increase if inflation were 2% (though Brexit may effect this)

Primary Care Networks

As a result of 2019 BMA/DH negotiation of GP contracts Clinical Commissioning Groups were asked to fund the creation of Primary Care Networks with a target of June 2019 in the NHS Operational Planning and Contracting Guidance 2019/20 here £1.50 –£2.00 per head funding.

The concept of Primary Care Networks enabling larger teams of health and social care professionals to work with local community organisations emerged from case studies demonstrating their cost effectiveness see here.

There is limited NHS guidance on how to set up PCNs but as in our case networks usually serve 30-50,000 people.

PCNs should select a Clinical Director define their catchment area and determine their governance and finance structure. See the BMA Primary Care Network Handbook here

Plans for Universal Personalised Care

This NHS plan see here developed from consultations with NHS, professional and VCSE organisations. It shows how lessons learnt from Vanguard programmes, such as BOB ICS could be implemented across the NHS, its principles include :

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets.

Community support enabled by Social Prescribing is described as a fundamental basis for Personalised Care by James Sanderson Director of Personalised Care NHS England

See also the Framework for Social Prescribing for AHPs here

Vanguard STP models of care

- In 2015, the NHS invited NHS organisations and partnerships to apply as Sustainable Transformation Partnerships (STPs) to become 'vanguards' for new care models programme, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services 50 models were chosen
- The Buckinghamshire, Oxfordshire and West Berkshire STP (BOB) Integrated Care System was developed through this process.

Aims of the Integrated Care Strategy

The STP known as BOB developed its Integrated Care Strategy (see here) with the following aims:

- Shift the focus from treatment to prevention.
- High quality primary, community and urgent care.
- Collaborate to deliver equality and efficiency.
- Improve mental health services
- Better commissioning for value and outcomes
- A flexible and collaborative workforce.
- Better use of digital technology for patients

The Integrated Care Strategy

The Buckinghamshire, Oxfordshire and West Berkshire Integrated Care Strategy was developed through consultation and pilot programmes at Thame and Marlow, key components include:

- Better integration of Community, Primary, Acute and Social Care
- Greater focus on key fields, e.g. prevention and wellbeing, Mental Health and Cancer care, Diabetes and
- Community Hubs for Health and Wellbeing serving 125-150,000 people, with hospital at home and day hospital services closer to home with VCSE.
- Integrated teams working with Primary Care Networks and local groups in communities of 30-50,000 people to provide integrated health and social care including: community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists
- Greater use of IT e.g. online appointments, access to health records and devices that support self care and monitoring – this requires patient learning

What we have learnt

- We have learnt from these national and regional initiatives through consultations led by Buckinghamshire Healthcare NHS Trust (BHT) and talks with Friends from Marlow Community Hub, that:
  - Our Hospital would be an ideal location for a Community Hub being centrally located for the population of South Bucks and Chiltern (population 160,000) it is sited on the border of these districts.
  - We have a quiet location, good access, parking, garden, space and rooms (currently housing medical records) and adjacent empty Community Clinic.
  - We offer 30 clinics and services at the hospital and in people's homes, the Friends are supporting the development of further services.
  - We are close to three Primary Care Practices working together in a Primary Care Network (pop 31,000) we hope to help them develop as a Local Integrated Team for Social Prescribing and other services.
  - We were told that Community Engagement is crucial but can take a long time to develop, we are therefore working with District, Town and Parish Councils, BHT, Charities and local groups to increase community engagement in this exciting development.

What could the League of Friends offer?

- We have some financial resources, local knowledge and support from community groups and organisations.
- We could support the refurbishment of rooms at our hospital or the adjacent Community Clinic with suitable décor computing facilities and coffee machine to support Social Prescribing. We have collected some £3000 for this purpose and have other funds totalling some £2m.
- We could support the development of clinics as we have for audiology and hopefully ear cleansing and other services for older patients.
- We could bring together PCN services such as Social Prescribing and BHT services such as CATS (Community Assessment and Treatment)
- We could support facilities for a patient ICT centre to help people use the technology to support hospital at home services and to monitor it.
- We could develop further our communication with community groups and organisations, we already held meetings to support befriending
- We can help to transform services around the needs of older people

This is the Care We Want