Preparing for an increasingly older generation

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Transforming health and social care in Kent and Medway

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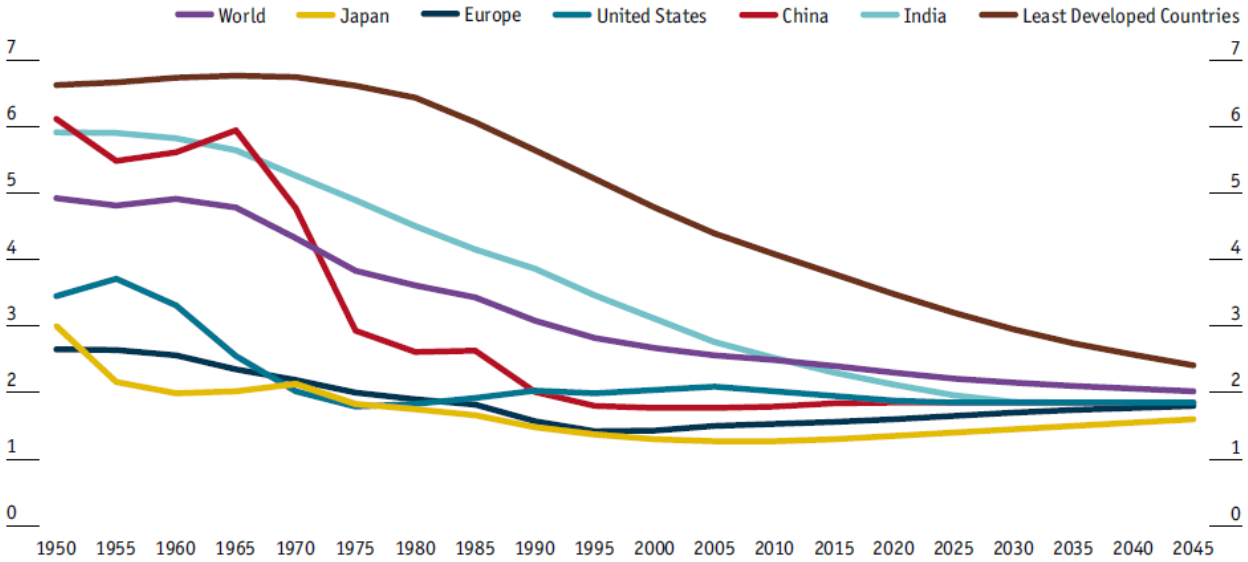
Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Preparing for an increasing older generation

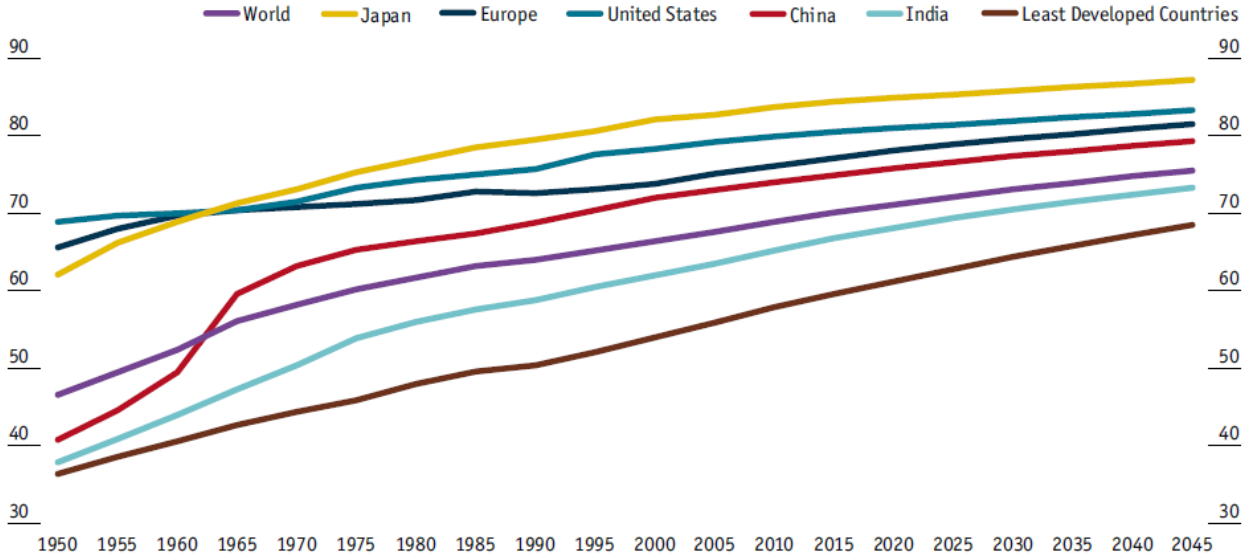
- Understanding an ageing population
- Implications for healthcare
- 10 high impact areas
- Ageing well
- Good practice examples

Total fertility, 1950-2045
(children per woman)



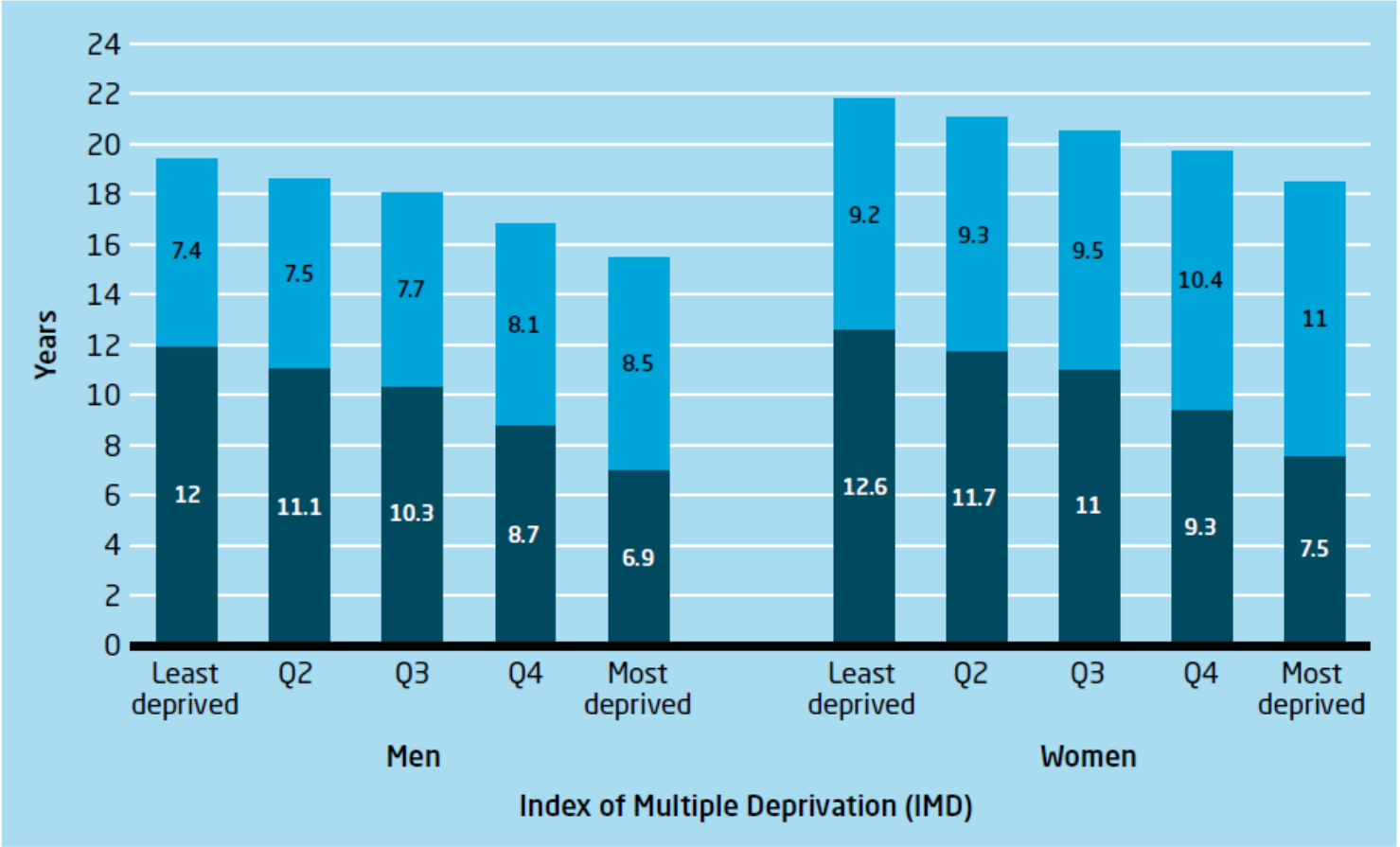
Source: UN Population Division.

Life expectancy, 1950-2045
(years)



Source: UN Population Division.

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



Source: Office for National Statistics 2011a

	Pension		Health care		Long-term care	
	2007 (%)	Change 2007–60 (% of GDP)	2007 (%)	Change 2007–60 (% of GDP)	2007 (%)	Change 2007–60 (% of GDP)
Austria	12·8	0·9	6·5	1·5	1·3	1·2
Belgium	10·0	4·8	7·6	1·2	1·5	1·4
Bulgaria	8·3	3·0	4·7	0·7	0·2	0·2
Cyprus	6·3	11·4	2·7	0·6	0·0	0·0
Czech Republic	7·8	3·3	6·2	2·2	0·2	0·4
Denmark	9·1	0·1	5·9	1·0	0·9	1·4
Estonia	5·6	−0·7	4·9	1·2	0·1	0·1
Finland	10·0	3·3	5·5	1·0	1·8	2·6
France	13·0	1·0	8·1	1·2	1·4	0·8
Germany	10·4	2·3	7·4	1·8	0·9	1·4
Greece	11·7	12·4	5·0	1·4	1·4	2·2
Hungary	10·9	3·0	5·8	1·3	0·3	0·4
Ireland	5·2	6·1	5·8	1·8	0·8	1·3
Italy	14·0	−0·4	5·9	1·1	1·7	1·3
Latvia	5·4	−0·4	3·5	0·6	0·4	0·5
Lithuania	6·8	4·6	4·5	1·1	0·5	0·6
Luxembourg	8·7	15·2	5·8	1·2	1·4	2·0
Malta	7·2	6·2	4·7	3·3	1·0	1·6
Netherlands	6·6	4·0	4·8	1·0	3·4	4·7
Poland	11·6	−2·8	4·0	1·0	0·4	0·7
Portugal	11·4	2·1	7·2	1·9	0·1	0·1
Romania	6·6	9·2	3·5	1·4	0·0	0·0
Slovakia	6·8	3·4	5·0	2·3	0·2	0·4
Slovenia	9·9	8·8	6·6	1·9	1·1	1·8
Spain	8·4	6·7	5·5	1·6	0·5	0·9
Sweden	9·5	−0·1	7·2	0·8	3·5	2·3
UK	6·6	2·7	7·5	1·9	0·8	0·5
European Union	10·2	2·4	6·7	1·5	1·2	1·1

Data are from the European Commission.[10] GDP=gross domestic product.

Table: **Projected increases in age-associated government expenditure as proportion of GDP in the European Union, 2007–60**

Lancet 2013; 381: 1312–22

The King's Fund 2014

Ageing well - What we know can work

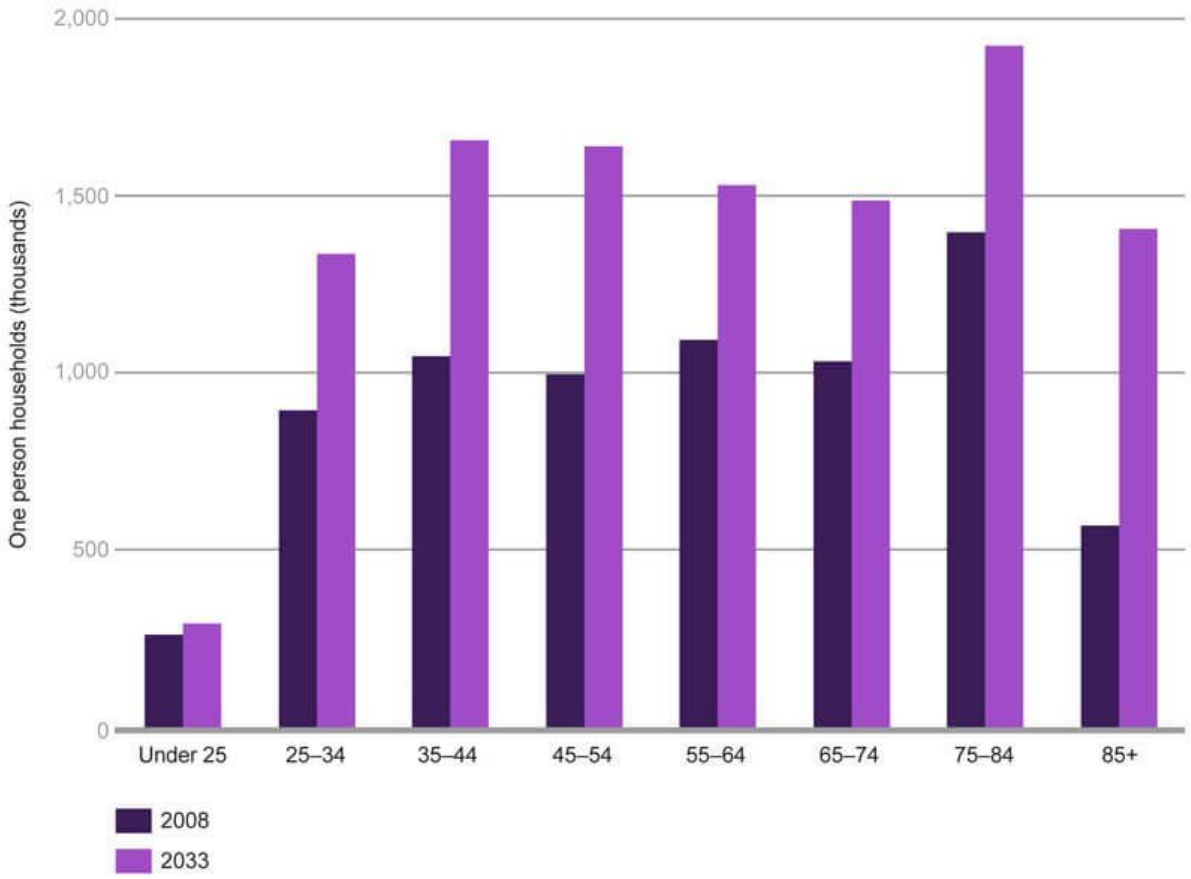
- Life course approaches that address wider determinants of health
- Getting housing right
- Prevent isolation and loneliness and support age friendly communities
- Winter preparedness
- Promoting healthy lifestyles
- Minor needs that limit independence
- Vaccination
- National Screening Programmes

Life-course approaches to healthier ageing

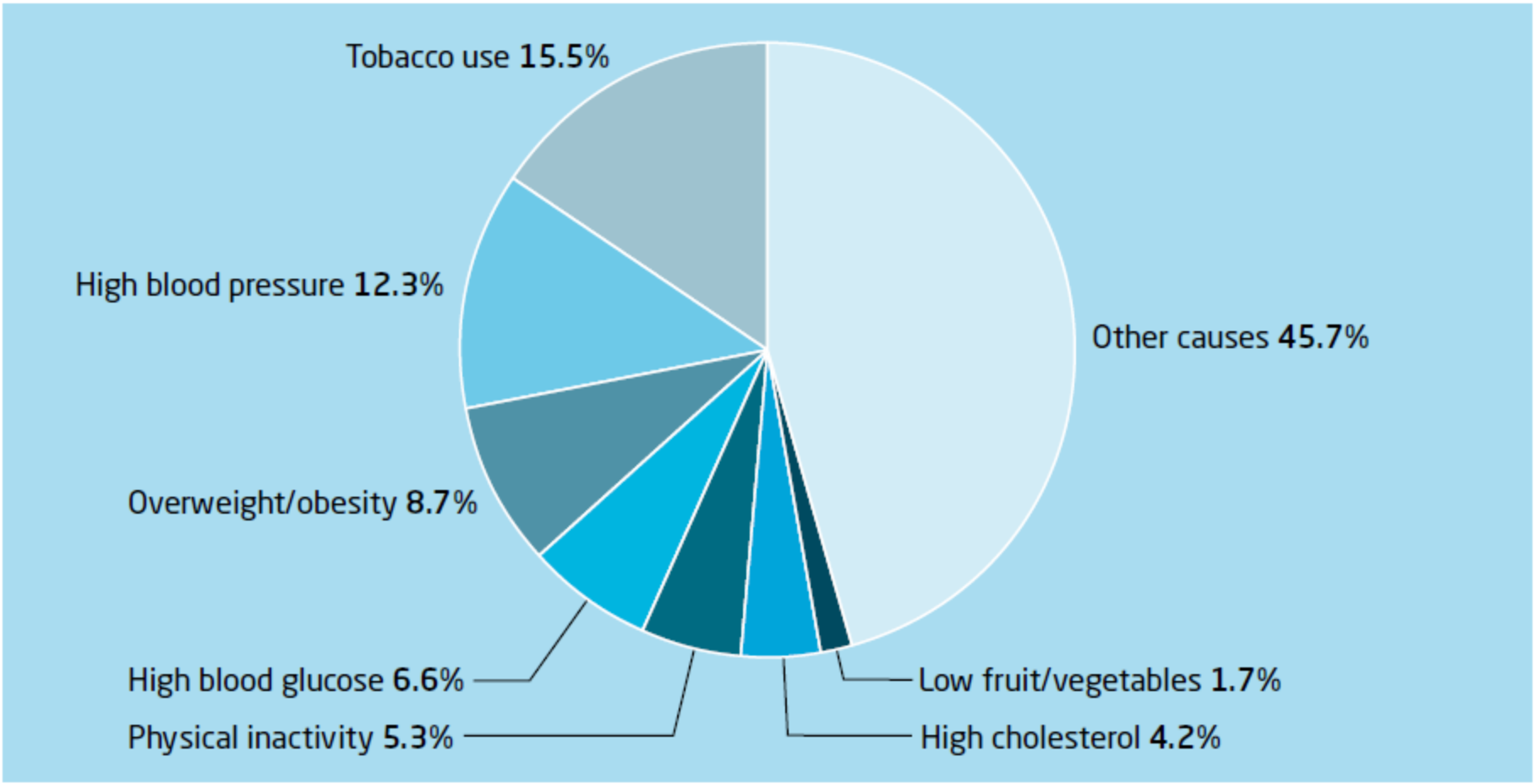
Direct impacts of actions on health outcomes

Area	Scale of problem in relation to public health	Strength of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Quicker	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

One person household projections by age of household 2008 - 2033



Burden of disease among people aged 60 and over



Source: World Health Organization

Health and social care integration

£5.3bn
total pooled budget in the first year of the Better Care Fund

£511m
Departments' and partners' estimated savings from the first year of the Better Care Fund

2020
target date for integrated health and social care services across England

87,000	actual increase in emergency admissions to hospitals between 2014-15 and 2015-16, against a planned reduction of 106,000, as reported in Better Care Fund metrics
185,000	actual increase in delayed transfers of care between 2014-15 and 2015-16, against a planned reduction of 293,000, as reported in Better Care Fund metrics
628	permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population in 2015-16, exceeding the target of 659 per 100,000
82.7%	of older people who were still at home 91 days after discharge from hospital receiving reablement or rehabilitation services in 2015-16, exceeding the target of 81.9%
£900 million	NHS England's expectations of savings from the roll-out of new care models by 2020
90%	proportion of local areas that agreed or strongly agreed that the delivery of the Better Care Fund plans had a positive impact on integration locally
£2.1 billion	NHS Sustainability and Transformation Fund for 2016-17, of which £1.8 billion was allocated to covering NHS deficits rather than transformation

Features of the PACE Program

Targeting the population most likely to benefit	Enrolls Medicare beneficiaries age 55 and older who need long-term care but are able to safely live at home. Most enrollees also have Medicaid.
Assessing patients' health-related risks and needs	On Lok staff–including a physician, home care nurse, and a social worker–assess applicants' physical and mental health as well as their support networks to determine whether they can safely remain in their homes.
Developing patient-centered care plans	Interdisciplinary care teams develop care plans based on elders' needs. Care planners prescribe a comprehensive list of medical and social services patients may benefit from, such as physical therapy to improve their balance. Team members build on their long-term relationships with elders and their families to initiate discussions about end-of-life care.
Engaging patients and family in managing care	The heart of On Lok is its PACE centers, where elders come from one to five days a week to socialize, eat, play games, attend performances, and exercise. They also receive rehabilitative and psychotherapy services at the centers, and see their primary care physicians, dentists, and podiatrists as needed.
Transitioning patients following hospital discharge	Staff providers review new medications that may have been provided in hospital, oversee follow-up care, and respond rapidly to urgent problems.
Coordinating care and facilitating communication among providers	An interdisciplinary care team provides all primary care services and oversees specialist referrals to ensure care is well managed. Team members have daily briefings to review problems and adjust care plans to accommodate changes.
Integrating physical/ behavioral health care	A cadre of licensed clinical social workers or psychologists offers therapy to elders as well as advice to primary care staff, for example on trying nondrug therapies for dementia patients' mood disturbances.
Integrating health and social services	PACE provides all long-term services and supports, as well as medical services. On days when elders do not come to the PACE center, they may have meals delivered and receive help in dressing, bathing, and other tasks in their homes.
Making care or services more accessible	Most services are provided in PACE centers or people's homes. On Lok teams are encouraged to do whatever it takes to promote elders' well-being, whether taking them shopping for walking shoes or arranging for pet care when they are hospitalized. Since On Lok offers hospice-like services, elders do not have to enroll in formal hospice programs at the end of their lives, if they prefer not to.
Monitoring patients' progress	Teams repeat assessments every six months, or more often if elders' status changes. Responding rapidly to elders' changing needs helps avoid common complications that can lead to hospitalizations, such as dehydration or infections. Special teams of physicians, nurses, and social workers make regular rounds to visit nursing home residents and also make urgent visits.

Applicability of the PACE model in the UK

Legal constraints

- The PACE model is based on pooled budgets and capitated funding
- A new funding model / flow whereby all benefits (DLA, AA and PIP) are paid directly to a UK 'PACE' organisation would be required in order to directly implement the US PACE model
- PACE is a provider-led model which requires full financial risk to be assumed
- It is a legal requirement for the provider to be a not-for-profit organisation
- A State Readiness Review is conducted for all potential PACE organisations

Workforce

- PACE workforce can be directly applied to that of the UK as the same roles exist
- PACE provides case management organised in day-care centres through multidisciplinary teams
- The team takes shared accountability for managing patients, providing services and promoting co-ordination and continuity of care to every individual – this is replicable in the UK
- PACE is available 24/7, 365 days a week

Information Sharing

- A data system facilitates the PACE model by collecting information on all aspects of a patient's health status; it also forms the basis of the patient's care plan
- This is in potential conflict with UK laws around information governance

Finance

- 90% of PACE enrolees are eligible for dual Medicare and Medicaid funding i.e. are from low-income background
- Participants who are dual Medicare and Medicaid eligible pay nothing towards the cost of their PACE care
- There are 10 million Americans who are dually eligible
- In the UK, nursing home care is mainly self-funded. Individuals receive free nursing home care only if their capital is less than £14,000

PACE is a non-bed based solution for frail elderly who require nursing-home level care. The use of pooled budgets, capitated funding, and particularly its workforce model all have direct applicability to localities in the UK.

De Hogeweyk, Weesp, Netherlands and Belong Villages, UK

- *Stedelijk* - urban
- *Goois* – old Dutch
- *Ambachtelijk* - trades
- *Indisch* - Indonesian
- *Huiselijk* - homemakers
- *Cutureel* – theatre/cinema
- *Christelijk* - religious

Intergenerational communities

Mehrgenerationenhäuser, **Hanover, and Apples and Honey Nightingale Nursery, Clapham**

Humanitas Care Centre, Deventer, Netherlands and LinkAges, Cambridge

Concluding thoughts

- Fear about an ‘agequake’ in healthcare costs is simplistic but funding will only get tighter
- A societal response in attitudes, working and retirement patterns, and how we live as a community needs addressing as much as revised healthcare provision
- Social determinants are key to healthy ageing
- The health and social care divide continues to challenge

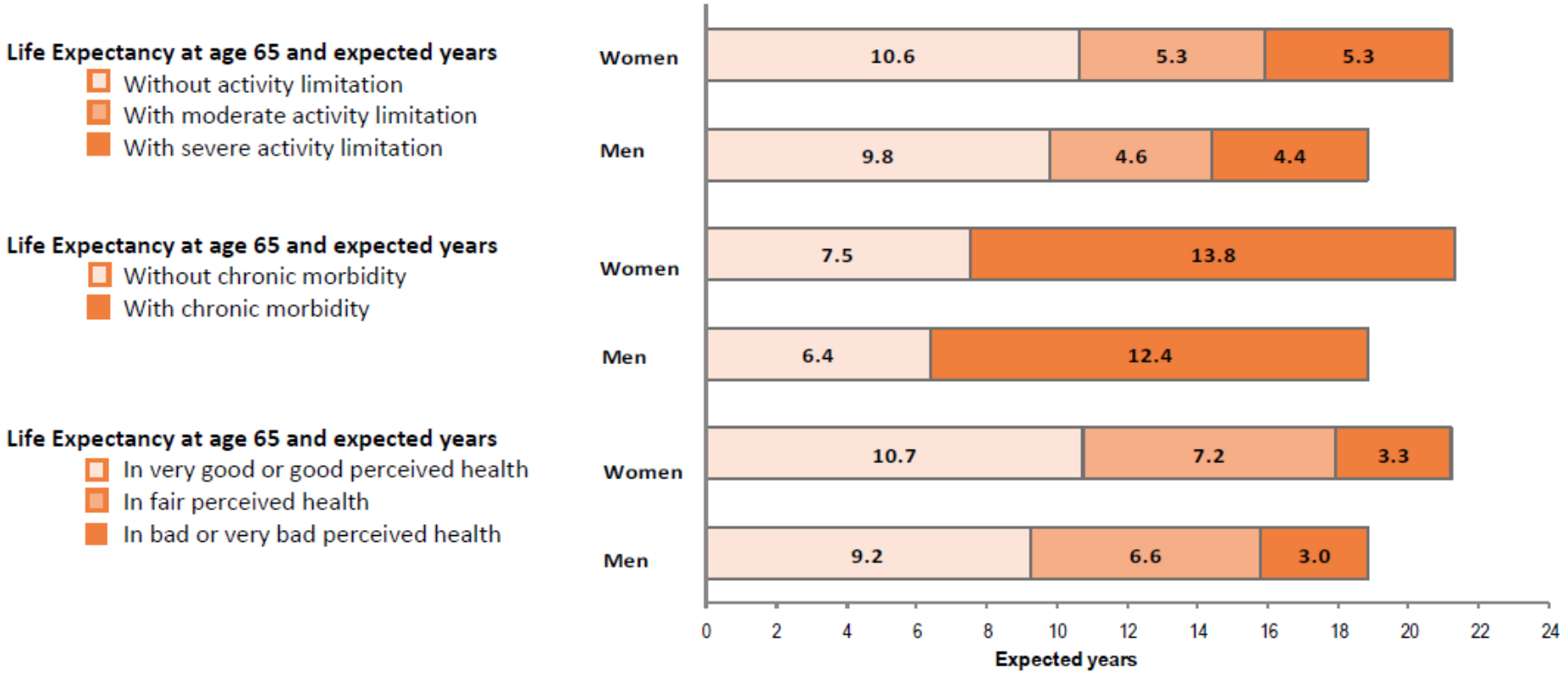
	1850–1900	1900–25	1925–50	1950–75	1975–90	1990–2007
0–14 years	62·13%	54·75%	30·99%	29·72%	11·20%	5·93%
15–49 years	29·09%	31·55%	37·64%	17·70%	6·47%	4·67%
50–64 years	5·34%	9·32%	18·67%	16·27%	24·29%	10·67%
65–79 years	3·17%	4·44%	12·72%	28·24%	40·57%	37·22%
>80 years	0·27%	−0·06%	−0·03%	8·07%	17·47%	41·51%

Data derived from reference 12 and the Human Mortality Database.

Table 2: **Age-specific contributions to the increase in record life expectancy in women from 1850 to 2007**

Lancet 2009; 374: 1196–208

Life and health expectancies at age 65 based on activity limitation (Healthy Life Years), chronic morbidity and perceived health for United Kingdom (Health data from SILC 2014)



Ageing Well: Older people in Kent

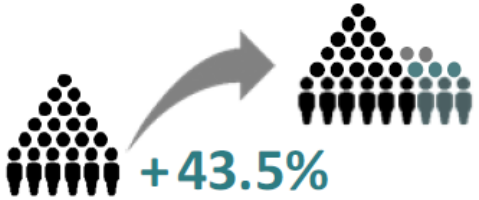
KENT PUBLIC HEALTH OBSERVATORY
Heath and Social Care Maps

POPULATION GROWTH

In the 10 years between 2015 and 2025

65-84 year olds

Aged 85+

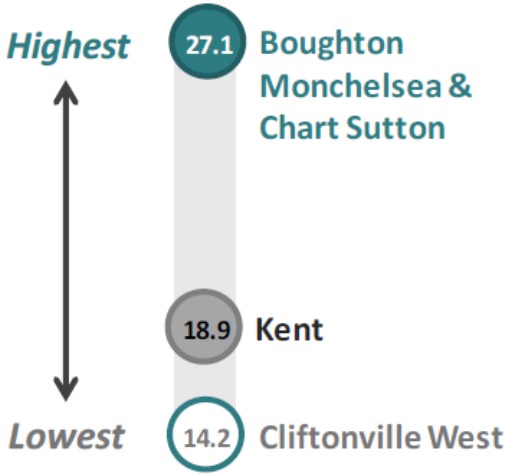


Source: ONS population projections

LIFE EXPECTANCY

at age 65

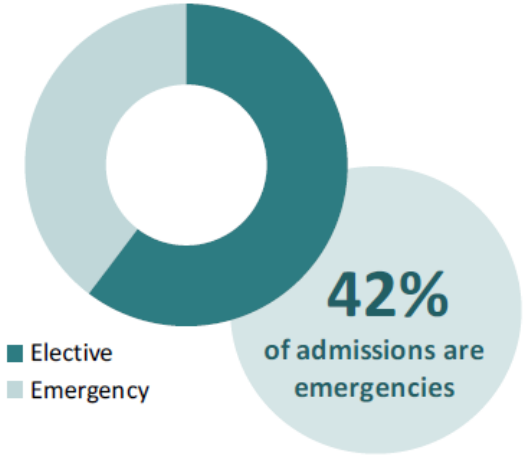
Ward-level life expectancy (men)



Source: PCMD, 2012-2016

HOSPITAL ADMISSIONS

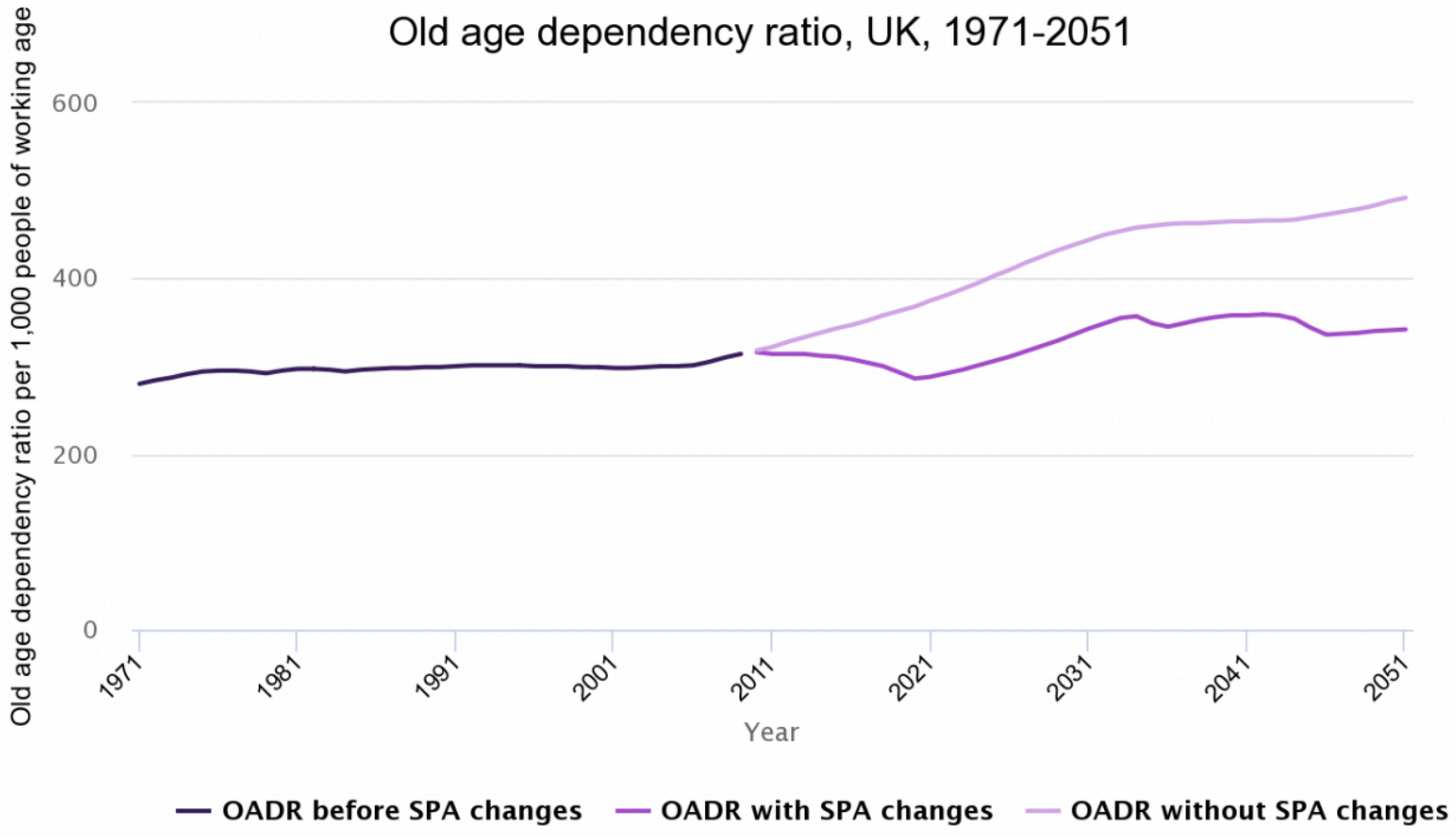
Age 65+



In 2016/17:

Source: SUS, *age-standardised

Images from Noun project


Old age dependency ratio, UK, 1971-2051
Old age dependency ratio per 1,000 people of working age
600
400
200
0
1971
1981
1991
2001
2011
2021
2031
2041
2051
Year
OADR before SPA changes
OADR with SPA changes
OADR without SPA changes

The ageing population creates economic and social benefits

- over-65s make a net contribution to the UK economy of £40 billion after health and social care costs[1]
- volunteering has a hidden value of £10 billion per annum
- growing numbers of over 65s engage in full or part time work
- spending power of £76 bn, to rise to £127 bn by 2030
- provision of social care worth £34 bn, growing to £53bn by 2030
- donations of £10 bn to charities and family.

1) Women's Royal Voluntary Service (2011). Article. Gold age pensioners: valuing the socio-economic contribution of older people in the UK