Why older people are different, but the same

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I: Ageing, health and “optimal ageing”
Ageing a success!! for society, preventative and curative medicine & for our longevity

Source: ONS, 2011
From “rectanguralisation” to “elongation” of survival curve.

Distribution of death England 1841 - 2006

1947 NHS Founded, 48% died before 65. In 2015 its c 12%
By 2030 men aged 65 will live on average to 88 and women to 91

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

Workforce Implications

Disability-free life expectancy

Figure 4: The average number of years that people live free of disability at age 65 in England, 2005-07 to 2009-11

Source: Office for National Statistics (2014a)
n (difficulties with ADL) by age

Figure 7: Number of difficulties with activities of daily living by age, England, 2012/13

Source: English Longitudinal Study of Ageing (2014)
Ageism, Age-Discrimination, Negative Language and Perceptions

- 2010 Equality Act bans age-based discrimination
- “differentiation” is OK where justifiable as means of achieving legitimate aim
- NHS Constitution clear on rights based on need only
- Centre for Policy on Ageing Reviews showed evidence of endemic ageism across services
- Extends to stigmatising services or staff working in them
- Phrases like “acopia” “social admission” “bed blocker” shape attitudes
Negative language and perceptions (also against services/staff for older people)

Older people with complex needs/frailty as “core business” in modern healthcare

› Any practitioner training 2015 with the youngest case-mix they are likely to see in their career
› Have they all realised this?
› Our values, priorities & tacit “prestige hierarchy” haven’t caught up with ageing population
› Training, workforce planning, skills likewise
› Research priorities

› Most of all, services & systems need to be geared up to the people who actually use them
II: Older people as “core business”

Now and in the future
Following the money.

NHS Constitution Technical Annexe

Figure 13 - Chart showing indexed costs for each 5 year age bracket as a proportion of cost for those aged 85+ (General and Acute)
Figure 4.3: Distribution of long-term conditions (LTCs) by age of A&E attendee, 2012/13

Source: Nuffield Trust and Health Foundation (2014)
Emergency hospital admissions via accident and emergency departments in England: time trend, conceptual framework and policy implications

Thomas E Cowling¹, Michael A Soljak¹, Derek Bell² and Azeem Majeed¹

Figure 1. Proportion of Emergency Admissions in which Patients were Admitted via A&E, or via a GP, in England, 2001–02 to 2010–11.
Over 65s in hospital (England) HES Data

68% bed days in over 65s. Median age new acute patient = 72.
Rapid rise in Delayed Transfers (DTOC)

Key facts

- 62% of hospital bed days occupied by older patients (those aged 65 or over) in 2014/15
- 18% increase in emergency admissions of older people between 2010/11 and 2014/15 (12% increase for whole population)
- £820 million - our estimate of the gross cost to acute hospitals of older patients in hospital beds who are no longer in need of acute treatment

- 1.15 million bed days lost to reported delayed transfers of care in acute hospitals during 2015 (up 31% since 2013)
- 2.7 million - our estimate of hospital bed days occupied by older patients no longer in need of acute treatment
- 11.9 days - average length of inpatient stay for older patients in 2014/15 (based on emergency admissions only)
- 5% - percentage of muscle mass that older people can lose per day of treatment in a hospital bed
- 54% - hospitals in our survey who told us that discharge planning is not started soon enough to minimise delays for most patients

Department of Health

Discharging older patients from hospital

The King's Fund

Ideas that change health care

BRITISH GEROGERIATRICS SOCIETY
Social care funding and provision crisis

C 40% cuts to LG funding since 2010

Of 2.8 M with “substantial” or “moderate” needs

C 900,000 no support

Further cuts on the way

Better Care Fund = a sticking plaster

Voluntary sector also hit by LG cuts

Dilnot recommendations –into long grass

Care Agency recruitment issues

Care Home Business Model in trouble
NHS Benchmarking Intermediate Care Audit 2015. Median Age 83 – most frail

Referrals
Per 100,000 population

<table>
<thead>
<tr>
<th>Crisis response</th>
<th>Home based</th>
<th>Bed based</th>
<th>Re-ablement</th>
</tr>
</thead>
<tbody>
<tr>
<td>543</td>
<td>808</td>
<td>266</td>
<td>497</td>
</tr>
</tbody>
</table>

Beds commissioned
Per 100,000 population

<table>
<thead>
<tr>
<th>Crisis response</th>
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<th>Re-ablement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25.6</td>
<td></td>
<td></td>
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</tbody>
</table>

Waiting times
Referral to assessment

<table>
<thead>
<tr>
<th>Crisis response</th>
<th>Home based</th>
<th>Bed based</th>
<th>Re-ablement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.7 hours</td>
<td>6.3 days</td>
<td>1.3 days</td>
<td>8.7 days</td>
</tr>
</tbody>
</table>

Cost per service user

<table>
<thead>
<tr>
<th>Crisis response</th>
<th>Home based</th>
<th>Bed based</th>
<th>Re-ablement</th>
</tr>
</thead>
<tbody>
<tr>
<td>£821</td>
<td>£1,205</td>
<td>£1,484</td>
<td></td>
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</tbody>
</table>

Length of stay
Against 6 week recommended in “Halfway Home”

<table>
<thead>
<tr>
<th>Crisis response</th>
<th>Home based</th>
<th>Bed based</th>
<th>Re-ablement</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.3 days</td>
<td>26.8 days</td>
<td>34.5 days</td>
<td></td>
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</tbody>
</table>

Outcomes
% of patients whose dependency was maintained or improved

<table>
<thead>
<tr>
<th>Crisis response</th>
<th>Home based</th>
<th>Bed based</th>
<th>Re-ablement</th>
</tr>
</thead>
<tbody>
<tr>
<td>71.7% improved</td>
<td>20.6% maintained</td>
<td>6.2% maintained</td>
<td>7.7% deteriorated</td>
</tr>
</tbody>
</table>

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Ideas that change health care

British Geriatrics Society
Emergency readmissions in 28 days c 14% for over 75s (half in first 7 days)
Impact of long stays

- Evidence points to older people typically having longer stays in hospital. The following charts show the impact of long stays in hospitals.
- Spells with a length of stay of more than 21 days account for 5% of total spells, yet account for 41% of total occupied bed days, indicating the resource being utilised by the “long-stayers”.

NHS Benchmarking Network

BRITISH GериATRICS SOCIETY
III: Need for differentiation based on frailty and clinical complexity
Crucial role of carers

› Already around 6 million people in the UK are **carers for an older relative**
› By 2022, the supply of carers will be outstripped by demand
› 1.5 M are over 65 – many in poor health
› < 5% get statutory support
› *House of Lords “Ready for Ageing” report 2013. Age UK 2015*
› Carers are key to maintaining people at home, supporting them in hospital, supporting their discharge
› We need to work with them and support them
Multimorbidity in Scotland

(Scottish School of Primary Care Barnett et al Lancet May 2012)
So Single disease services often unfit
Scottish School of Primary Care Study Guthrie BMJ 2012

% of patients with this condition...
...who also have this condition (% = % of all patients with the condition)

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>52</td>
</tr>
<tr>
<td>Hypertension</td>
<td>18</td>
</tr>
<tr>
<td>Heart failure</td>
<td>57</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>61</td>
</tr>
<tr>
<td>Diabetes</td>
<td>54</td>
</tr>
<tr>
<td>COPD</td>
<td>33</td>
</tr>
<tr>
<td>Cancer</td>
<td>54</td>
</tr>
<tr>
<td>Painful condition</td>
<td>35</td>
</tr>
<tr>
<td>Depression</td>
<td>23</td>
</tr>
<tr>
<td>Schizophrenia or bipolar</td>
<td>18</td>
</tr>
<tr>
<td>Dementia</td>
<td>14</td>
</tr>
<tr>
<td>Any other condition</td>
<td>20</td>
</tr>
</tbody>
</table>

E.g. Only 18% with COPD just have COPD
Figure 14: Prevalence of dementia amongst males and females in England, 2014

Source: Age UK and University of Exeter Medical School (2015)
Electronic Frailty Index (England) n = c 227,648 (© Prof John Young NHS England)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Mild frailty (HR, 95% CI)</th>
<th>Moderate frailty (HR, 95% CI)</th>
<th>Severe frailty (HR, 95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 yr care home admission</td>
<td>2.00 (1.68 to 2.39)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>5.94 (4.61 to 7.64)</td>
</tr>
<tr>
<td>3 yr care home admission</td>
<td>1.52 (1.37 to 1.69)</td>
<td>2.70 (2.41 to 3.04)</td>
<td>3.42 (2.84 to 4.12)</td>
</tr>
<tr>
<td>5 yr care home admission</td>
<td>1.56 (1.43 to 1.70)</td>
<td>2.34 (2.10 to 2.61)</td>
<td>3.00 (2.42 to 3.70)</td>
</tr>
<tr>
<td>1 yr hospitalisation</td>
<td>1.85 (1.81 to 1.88)</td>
<td>2.96 (2.90 to 3.02)</td>
<td>4.62 (4.50 to 4.74)</td>
</tr>
<tr>
<td>3 yr hospitalisation</td>
<td>1.71 (1.69 to 1.73)</td>
<td>2.54 (2.51 to 2.58)</td>
<td>3.64 (3.57 to 3.70)</td>
</tr>
<tr>
<td>5 yr hospitalisation</td>
<td>1.63 (1.61 to 1.64)</td>
<td>2.43 (2.40 to 2.46)</td>
<td>3.59 (3.54 to 3.65)</td>
</tr>
<tr>
<td>1 yr mortality</td>
<td>1.91 (1.78 to 2.04)</td>
<td>3.39 (3.15 to 3.65)</td>
<td>5.23 (4.73 to 5.79)</td>
</tr>
<tr>
<td>3 yr mortality</td>
<td>1.74 (1.68 to 1.81)</td>
<td>3.02 (2.90 to 3.14)</td>
<td>4.56 (4.29 to 4.84)</td>
</tr>
<tr>
<td>5 yr mortality</td>
<td>1.66 (1.62 to 1.71)</td>
<td>2.73 (2.64 to 2.81)</td>
<td>3.88 (3.68 to 4.09)</td>
</tr>
</tbody>
</table>
Clegg et al Lancet 2013 Frailty

Figure 1: Vulnerability of frail elderly people to a sudden change in functional status after a minor illness.
Frailty Syndromes (how people with frailty present to services).
*Clegg, Lancet. BGS “Fit for Frailty”*

› “Non-specific”
  • E.g. fatigue, weight loss, recurrent infection

› Falls/Collapse

› Immobility/worsening mobility

› Delirium (“acute confusion”)

› Incontinence (new or worsening)

› Fluctuating disability

› Increased susceptibility to medication side effects
  • e.g. Hypotension, Delirium
Mudge et al 2011 function in acutely admitted older patients

Figure 1. Percentage of study participants (n = 615) requiring help with each activity of daily living, at baseline, hospital admission, and hospital discharge.
Older people and the integration and care co-ordination agenda

- Older people
- Especially with complex needs/frailty
- Most likely to use multiple services
- See multiple professionals
- And suffer at hand offs between agencies
- And from disjointed, poorly co-ordinated care

- Need move to “person-centred co-ordinated care”
  – National Voices 2013
IV: What a bespoke age/frailty-friendly AEC service might look like
Access to usual AEC not age-restricted or age-defined

- And if older people use existing AEC

- Need age friendly, dementia/disability/frailty friendly environment
- Skilled, trained staff
- Access to speciality input
- Rapid access to community services
Pragmatic ways of identifying/seeing/referring suitable patients

› Specialists at hospital front door
› Open late enough to make a difference and allow completion of assessments
› Use of quick case finding/screening tools
› Easy, clear referral pathways in from GPs/Community teams (or acute teams receiving referrals)
› Ability to take people out of trolley/bed areas
Allow/support initial Comprehensive Geriatric Assessment (CGA)

Key elements of comprehensive geriatric assessment
- Medical assessment
  - Problem list
  - Comorbidities
  - Medications
  - Nutritional assessment
- Functional assessment
  - Basic activities of daily living
  - Instrumental activities of daily living
  - Gait and balance assessment
  - Exercise/activity assessment
- Psychological assessment
  - Cognitive status
  - Assessment of mood
- Social assessment
  - Informal social support
- Environmental assessment
  - Care resource eligibility/financial assessment
  - Home safety
  - Access to transport facilities

“a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail elderly person in order to develop a coordinated and integrated plan for treatment and long-term follow-up”

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Workforce with right skills in right place

- Acute geriatricians
- Acute or GIM Physicians with right training/values
- Gpswsi
- OTs, PTs, ANPs/CNS, Social Care
- “In reach” or “discharge to assess” or “liaison”
- Including access to mental health for older people
- Access to intermediate or social care before admission to “deeper ward” = only option
- If outside General Hospital setting needs
  - Rapid first response
  - Access to rapid diagnostics
V: Is it happening?
No specific national audit/survey but. Intelligence from

- Numerous case reports/papers
- NHS Benchmarking acute care audit
- NHS Benchmarking IC audit
- Acute Frailty Clinical Network
- Scottish Older People in Acute Care (OPAC)
- ECIST/ECIP Network
- RCP Future Hospitals

Not just on AEC for older people with frailty but
  - Acute geriatrics
  - Acute frailty units
  - Interface/early discharge models
  - Rapid access intermediate care teams
Nature of data

- More centred on Quality Improvement or pragmatic service evaluation/case reports than RCTs
- Impact for patients clearer than whole systems
- Wider system-dependent
- Some examples of many write ups
  - Koduah et al Epping (big numbers)
  - Lasserson et al Oxon (big numbers)
  - Jones S et al HEFT
  - South Warwicks/Sheffield health foundation
  - Poole RACE
  - Health Improvement Scotland e.g. Lanark, Forth
Thankyou. And questions/comments?

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