

The UK Perspective challenges for care of the Older People in England

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Background

The UK faces a demographic shift towards an increasingly ageing population. We are expected to see 20% of the population will be over the age of 65 years by 2022. By 2027 the number of people over the age of 85 years will have increased by 60%. This poses a challenges to both health and social care economies to deliver services which will be working to meet increasing demand by a group of people who will have high expectations about control, autonomy and choice about their care and probably despite increasing frailty will choose to remain in their own homes rather than opt for institutional care settings.

In 2003 /04 people over the age of 65 years accounted for 43% of the National Health Services total budget expenditure. Currently people over 65 years occupy over 65 of the acute hospital beds across all clinical specialities. In 2004 this group accounted for 58% of the social services budget. In the same period they received 71% (1.23million) of social care packages of support within their own homes.

The National Health service is funded from taxation and is free at the point of need. The health services in England are driven from central government policy incentives with regional Strategic Health Authority (SHA's) centres which both act to distribute fiscal resources and monitor progress in meeting local health needs. Primary Care Trust's (PCT's) have a dual function in both providing local community based services and also act as commissioners of all health services for defined communities, based on local need. Additionally in some areas General Practice have a similar role in commissioning services to meet the needs of their patient population (Practice Based Commissioning/PBC). This includes both acute hospital services and primary care services from their own provider organisation or from other providers such as the voluntary sector. Local decisions about what best meets needs reflects urban and rural populations rather than being driven by central directives. Large areas of the UK are rural which has implications for staffing, travel and location of services. Many of these will be served by community hospitals with out- reach outpatient facilities, minor injury units some with tele medicine support from urban acute service providers and rehabilitation centres mostly focused on the needs of older people. Strong local partnerships across services encourage better joint working people between health and social care services in order to maximise resource use and develop creative solutions such as ill health prevention.

Challenges

The realities of an increasing ageing population require both national policy and local health and social care systems to review efficiency and service delivery models in order to meet their needs. The shift from a supportive model of care to earlier intervention and most importantly prevention of ill health is seen as the way forward in ensuring systems can meet demands. This is underpinned with a current review of funding and resource management and in the current

economic climate this is significant. The government is launching a green paper "Care & Support" to explore affordability of future care with a specific emphasis on early intervention and prevention to improve the lives of older people.

Recruitment and retention of staff wanting to work with older people remains an issue and there have been a number of national recruitment programmes with national TV adverts to encourage applicants. Recruitment of health staff is also challenging as both doctors and nurses are often reluctant to work in older people specialities. The realities of the demographic shift mean the challenge is that all health professionals working in adult services are caring for older people.

Service Developments

The last 8 years has seen a plethora of policy which has the potential to impact on the health and well being of older people. These central drivers have helped to support change at a local level. These have included a number of specific policy initiatives aimed at improving and sustaining independence and choice. In 2007 the government set this out in a shared vision of transformation for Adult Social Care with emphasis on prevention and early intervention in a document "Putting People First" choice is seen as central to service development and delivery with the greatest emphasis on supporting individual autonomy. Individual social care budgets provides opportunity for a different approach to meeting needs, including using paying friends and family to provide care, use of local amenities for provision of meals rather than the use of a social provider.

In 2001 the National Service Framework for Older People was launched, this set out the governments vision of services for older people with 8 key standards, including tackling end to ageism, intermediate care, falls, general hospital care stroke services, mental health, health and well being and person centred care. This helped services focus on the needs of older people in a systematic way.

Intermediate Care launched in 2001 was a new model of care to support older people to retain and regain independence. The primary intention of this model of care is

1. to prevent unnecessary admissions to hospital instead providing support in the patient's own home including intensive nursing support over an acute episode of ill health, or provide support and rehabilitation following a fall for example.
2. improve the discharge of patients from acute hospital enabling rehabilitation earlier at home.
3. delaying admission to long term care through rehabilitation to regain function and remain at home.

This has resulted in a range of community based services being developed including specialist nursing teams, rehabilitation teams, falls services to both prevent and rehabilitate people, stroke services based in the community to name a few. Additionally small community based hospitals provide inpatient services for short term rehabilitation, or partnerships with private care home providers are common. The model of intermediate care is based on a maximum 6 week recovery model.

In 2005 the government published a national strategy for long term conditions looking at new ways of improving care for people living with a variety of conditions with ongoing needs. Services and support systems of which are primarily primary care based. Including expert patient groups and self help strategies.

In 2006 a new nursing role was developed. The Community Matron a highly skilled community based practitioner developed the use of a case finding model. These practitioners have been developed from existing community nursing roles supported through a new competency framework .Their role is to both seek out and case manage people with long term conditions, using local data such as readmission rates to hospital and local GP based intelligence. These nurses are usually supervised by GP's though some will have ongoing relationships for supervision with community based geriatricians. The success of the model has been dependent on local relationships and robust pathways of care. The introduction of Community Matrons has not led to significant savings but has proved to identify unmet need in a small population and filled that need. This has been an addition to rather than a substitution for other health professional input.

Supporting the changes in community health provision has been the use of assistive technology such as telemedicine and the use of devices to support independent living with a particular focus on people with dementia and the use of assistive technology to enable people to live in their own homes such as central alarm systems, though needs to be applied with supportive personal care packages. There have been a number of national evaluations of the implementation to this approach.

Increasingly there has been an emphasis on ill health prevention and the government is currently working on developing a new strategy which focuses on this and which will be published this summer. This builds on the previous cross government strategy " Opportunity Age" launched in 2005 and is a cross government response to our ageing population. The contribution to this lead by the Department of Health will look at foot-care, falls services and an update of intermediate care to reflect the needs of people with dementia and mental health problems.

This year we launched a National Dementia Strategy to address the needs of people with dementia and their careers. Currently there 570,000 people with dementia in England and 700,000 across the UK. The three devolved governments of the UK are taking a similar approach in addressing this significant and increasingly challenging area of care. The document has 17 ambitious objectives for change including carers, public awareness, Early diagnosis and improving quality of care.

There has been a national commitment in England to improve the health and wellbeing of older people through a variety of central policy specifically looking at the needs of the ageing population with local application. The drive for community based commissioning of services to meet local needs and investment in prevention services in partnership with social care is crucial in delivering flexible services which focus on a personal service and a continuous drive to improve outcomes for older people and their families.

Resources

National Service Framework for Older People dh.gsi.gov.uk / social care

Supporting People with Long Term Conditions

National Dementia Strategy. Living well with dementia

Building Telecare in England

Putting People First. A shared vision and commitment to the transformation of Adult Social Care

Intermediate Care guidance

Partnerships with Older People Pilots

www.dh.gov.uk/en/SocialCare/UK

Community Matrons

www.dh.gov.uk/en/Healthcare/Longtermconditions

www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer/UK