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Perspective 1

Summary from roundtable discussion on Better care for frail older people – March 2014

Deloitte Centre for Health Solutions hosted a roundtable discussion for commissioners and providers of health and social care services to explore how to deliver improvements in each place of care that frail older people may find themselves. The aim was to explore some of the key findings highlighted in the Centre's report *Better care for frail older people* and how the adoption of new business models, incentives and the accelerated use of new technologies might improve patient outcomes and deliver higher quality, more cost effective services. This paper summarises the debate.

The roundtable held in March 2014, chaired by Karen Taylor Director of the Centre for Health Solutions, explored the following themes:

- the challenges that need to be overcome to provide better care for frail older people in each place where care is provided
- overcoming ageism - the last "ism" tolerated by society
- empowerment and choice and a focus on prevention and care co-ordinated around the individual
- catalysts for change – giving older people a voice.

A brief opening presentation was provided by the renowned gerontologist Dr Bill Thomas, founder of the Eden Alternative and Green House Project, which is transforming the culture of long-term and community based residential care in the United States. These innovative models of care are focussed on de-institutionalising long term care and on the emotional wellbeing of residents. Dr Thomas's long held ambition is to rid society of the "loneliness, helplessness and boredom" experienced by older people and the isolation and depression that often occurs in traditional nursing home settings.

The key challenges to better care for frail older people in each place of care

Integration of services and partnering with volunteers and the voluntary sector

There was broad agreement of the need to connect funders and providers of health and social care services and to give more recognition to the wealth of 'non-formal' community care that's available, for example volunteers and the voluntary sector. This was seen as particularly important given that a complete solution cannot and will not emerge from a single part of the care system. Forging sustainable partnerships with multiple parties was seen as an important challenge that must be addressed and one which requires all parties to subjugate their own vested interests and move away from traditional models of care. Local commissioners and providers are starting to grasp the nettle and transform older people's services by engineering a shift towards prevention, anticipatory care and care closer to home.

Engaging the public

The scale and current costs of caring for frail older people suggests that improving care will require health and social care staff and informal carers to work differently. It also requires a fundamental shift in the behaviour of the public. There is a need therefore to convince the public to take some responsibility for their older relatives and neighbours and to help encourage them to lead healthier lives so as to reduce the likelihood of their dependence on health and social care in old age. This requires policy makers to start a serious conversation about the current challenges and the implications for the types and location of services that might be needed in the future. Such conversations have been lacking or even deliberately avoided due to the sensitivities of the issues that need to be addressed. The public also need to become more proactive about planning for their own old age. People should make their wishes known and should consider establishing powers of attorney and writing living-wills. Equally important, people should decide what they want to get out of old age and what actions they may need to take to enable them to live well in their twilight years.

Changing perceptions

Changing perceptions, both in terms of old age in general but, more importantly, of those working in health and social care is a key challenge. There was a general agreement that in the wake of the Francis enquiry into the failings at Mid Staffordshire, there is an opportunity to put older people at the heart of everything that health and social care stands for, to empower them and increase their independence and quality of life. The challenge, however, is to shift societies perception of old age from a negative to a positive and to shift the focus of care home services from "what do we lose from moving into a care home environment" to "what can we gain from moving into a care home environment". The goal should be for old age to be perceived as comparable to, if not better than, any other age. To move towards this goal the care industry will need to develop its workforce and recruit talented and qualified individuals. A key challenge is to overcome the current perception that working in social care means low pay and inadequate support and training and to ensure that it provides adequate remuneration and development opportunities and is seen as a profession to be proud of.

The economics of system redesign

Given the current financial challenges that have affected health and social care and the fact that the financial position is likely to get worse before it gets better, the focus and rhetoric is on saving costs by shifting the provision of care more into the community. However, there was a strong perception that the evidence to support this is lacking and, where evidence is provided, it is not convincing. Even where there is clear evidence of improved quality of care, the lack of financial incentives to encourage the delivery of care in the community is a real barrier to adopting new ways of working. There were also concerns that the NHS will continue to operate in silos and rely on short term initiatives or run pilots which are subsequently abandoned, thereby wasting resources and the opportunity to truly transform services.

Addressing ageism – the last 'ism' tolerated by society

A recurring theme throughout the discussion was societies acceptance of ageism and the fact that ageism is the underlying driver for many of the problems associated with caring for frail older people. It was argued that ageism has the power to take human beings and reduce them to a number of negative stereotypes which then translates into the way the western world cares for older people, too often adopting a mass institutionalisation approach. An example of ageism is the criteria in which we judge older peoples performance, they are considered good if they can still drive, walk up the stairs, live independently etc. The focus is on what they have or haven't lost since adulthood. This needs to be turned on its head with the focus being on what they can do or can gain from their older age.

In the UK and America this ageism culture is fuelled by the general media which consistently portrays the needs of older people as "a burden" "an unprecedented cost to society" or "a time bomb" and "grey tsunami" and fails to recognise or highlight the significant value they bring, and will continue to bring through e.g. volunteering and supporting families, communities and society in general. Furthermore, medical interventions have distanced older people even further from society and contribute to an ageist mentality by prolonging life expectancy. However for many older people this has simply increased the number of years lived in ill-health and, perhaps more importantly, the number of years out of work thereby increasing costs to healthcare associated with long term treatment and to society more generally due to increased need for social care and support.

There was consensus that we are currently at the tipping point of change and a realisation that current ways of working cannot sustain an aging population. First and foremost, this means addressing society's perception of older people. As Dr Thomas noted, "There is a real need to reframe ageing from the concept of decline to a concept of potential and development. Indeed, the risk is that we create more disability among older people by communicating the idea that when you're older, you are less worthy and you have less standing in society. Indeed, by using institutional models of care, we make older people more dependent and even less capable of taking care of themselves."

There was a great deal of support for the idea of restoring a sense of purpose and connection to society in older people. Older people need to be made to feel that being 80 is a great achievement and a great age to be, and that happiness is as easily if not more easily achieved. Suggestions regarding how to do this included developing older people as role models or ambassadors, to give responsibility to older people to advise and educate other older people on health issues community care support, or even to befriend the young and help bridge the generation gaps and tackle ageism from the bottom up.

Empowerment and choice - giving older people their own front door

Optimising care in each place of care was also a key focus. It was noted that people are far more capable of independence than we often assume, we just need to create the right environment and circumstances for this to happen. Institutionalisation, no matter how good the quality of care, will and always does promote loss of independence and even induces increased disability in older people. Residents need to be transformed into tenants and moved to smaller more independent modes of living. This model has been adopted for people with learning difficulties with great success. Indeed, the concept is simply about empowering the individual. It's not about stigmatising all care homes but identifying other suitable options for older people. It is unlikely that there will be a single 'best option' but what's important is that there are more alternatives available which will, in turn, help us move away from the current linear models of care and provide more choice in terms of types of accommodation, or places of care. For example, extra-care housing which provides its residents with more independence and autonomy is increasing in popularity. For the next generation of frail older people choice is something they will be used to, and will expect. Therefore choice, in terms of types of accommodation available, is going to be increasingly important.

Personalised budgets have the power to enable older people to commission their own care. This represents another way to create an empowering environment and increase quality of life. To be successful, however, education of older people must occur in tandem so they have an awareness of what's available, their rights and responsibilities and what to expect.

As well as empowering older people, there is also a need to focus on empowering care staff to deliver higher quality care through recruiting and developing talent. Current society stigmatises those who work in a role that involves caring for older people, especially in providing home care or care in care homes. On the whole this is not looked on as a desirable or indeed valued career and staff are not given proper recognition of the complex medical care that they often deliver. Medical career structures suggest the more senior you are the more focussed and specialist you become. This approach to training needs to change, as caring for increasing numbers of people with multiple chronic conditions requires more generalist clinicians who understand the requirements of whole person healthcare. A revised approach to training should provide an opportunity for community care staff to take on roles and services traditionally provided by secondary care, which may also help generate some of the cost savings that are so desperately needed if universal healthcare is to be sustained. Assistive technology is one way of bridging the gap between the capabilities of a relatively generically trained workforce and a more specialist workforce.

Investing in preventing and co-ordinating care around the individual - a leap of faith

The imbalance in investment between medical interventions and preventative measures (general fitness, nutrition etc.) was seen as a real barrier. Yet the widely held view was that increasing the proportion of spend on prevention will improve care for frail older people in the future by reducing the public's dependence on the health and social care system. The main difficulty for policy makers and commissioners is in quantifying the future benefit of preventative measures compared to the obvious and immediate benefit of treating acute episodes of disease. Whole system budgets were seen as a solution to this rather than the current siloed budgeting system. Participants identified the need to frame, more clearly, the economic argument in terms of the costs that will be wasted by staying on the same path. One participant noted that a leap of faith was needed to move to a more preventative

approach to care and that prevention requires public engagement including the public taking more responsibility for maintaining their own health. “A sickness service is unlikely to deliver a wellness service”. To deliver this change, the NHS needs to do a better job of drip feeding prevention messages to the general public. The government also has a part to play as, historically, prevention initiatives have been far more successful if underpinned by legislation e.g. the smoking ban in public areas and wearing seat belts.

Overall, while there has been real progress in the treatment of general medical conditions, age related conditions have received far less investment and attracted fewer incentives. As a result, care services for frail older people are generally of a lower quality. At the same time the capacity of intermediate care and support is widely variable and generally insufficient to meet demand. Given healthcare spending increases with age, the financial imperative to act is clear, but disrupting the status quo requires courage and conviction. Costly inefficiencies include large variations in admission rates and bed occupancy, and the number of people lying in high cost bed based services when they could be cared for at home. It is imperative that this is tackled as a high priority. This requires a fundamental shift towards care coordinated around the needs of the individual, not single diseases, and a model of care that prioritises prevention and supports the maintenance of independence. Incremental change is not sufficient – what is needed is a commitment to change at scale and pace.

Catalysts for change – giving older people a voice

The catalyst for adopting/ using these new models of care will likely be the ’voice’ of the empowered and knowledgeable older person. There is a need to create an environment that encourages this voice. This involves addressing how society views older people (by creating a vision of life beyond adulthood and adding this into current dialogue.

Dr Thomas concluded the discussion by suggesting that the much needed change in the way we care for frail older people would be helped by introducing the idea of “elderhood”, as in childhood, adulthood and elderhood. Furthermore, that we should educate younger age groups to improve their understanding of what to expect when they reach elderhood and how to prepare for this stage of life. To create the right environment for this change, there is a need for:

- best practice in relation to innovative delivery models in the UK (and indeed the world) which are seen to be enhancing care for older people need to identified and shared. Evidence of success and failures need to be evaluated and shared and outcomes need to be better measured to encourage wider adoption of change
- technology to be more widely adopted - indeed technology has the potential to be a real game changer - it has the potential to empower, educate, connect, assist and alert people so as to provide improved quality of life to older people
- defined, customer focussed, outcomes that will drive change, to be built into provider and commissioning organisations business models
- the creation of new models of care delivery which will act as a ’crowbar’ for change

Dr Thomas added that it was important to recognise that this is not about starting from scratch, as examples of innovative care models already exist and, for example in America, to date, roughly 3,000 nursing homes have been closed or moved out of the care home system and their residents moved back into more appropriate accommodation in their communities.

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Further information

Given the wide ranging nature of the discussion and the interest shown by a wide variety of people and organisations the Centre held a second roundtable discussion which focused more on collaboration, integration and a better understanding of frailty. A write up of this second discussion is available on our website **www.deloitte.co.uk/centreforhealthsolutions**.

If you would like to discuss the ideas and suggestions in this document or the Better care for frail older people report please feel free to get in touch.

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