The ageing aren’t only the old; the ageing are all of us – Alexandra Robbin
Older persons by numbers

**NEED**
- **2011 – 2026**
  - >65 yrs population  \(+60%\)
  - >85 yrs population  \(+100%\)

(Source: CSO)

**LIFE EXPECTANCY 1993 - 2013**
- >75 female  \(+29%\)
- >75 male  \(+39%\)

(Source: Eurostat 2014)

**INPATIENT DISCHARGES 2015 - 2021**
- >75 yrs will increase  \(+28%\)

(Source: HIPE)

**ACCESS**
- **ADMISSION RATE**
  - >75 yrs  \(48\%\)
  - >95 yrs  \(64\%\)

(Source: SDU 2016)

**DEMENTIA IN IRELAND**
- 50k with dementia
- 4k new cases every year
- 100k cases by 2026

(Source: ICGP 2014)

**RESOURCE**
- NHSS - €940
- Home Care and Transitional Care
  - 15,000 HCP
  - 130 iHCP

€20 million

**ACUTE INPATIENT BED DAYS USED > 65 YRS**
- 2015 1,724,106
  - (51.5% of total bed days)

(Source: DoH Key Trends 2015 p.35)

**LONG TERM CARE**
- 23k people
  - 80% Private
  - 20% Public

(Source: SCD Operational Plan 2016)

1 in 4 patients in acute hospital with dementia / delirium (INAD 2014)

€1.69 billion per year
Figure 4.7: Projected cumulative increase in population 65 years and over versus total population

Source: Central Statistics Office (CSO)
### Acute Hospital Summary Statistics, 2005 to 2014

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Beds</td>
<td>12,094</td>
<td>12,110</td>
<td>12,123</td>
<td>11,847</td>
<td>11,538</td>
<td>11,159</td>
<td>10,849</td>
<td>10,492</td>
<td>10,411(b)</td>
<td>10,480</td>
<td>-13.3%</td>
<td>0.7%</td>
</tr>
<tr>
<td>In-Patients Discharges</td>
<td>355,707</td>
<td>374,398</td>
<td>593,357</td>
<td>592,133</td>
<td>583,486</td>
<td>583,017</td>
<td>583,053</td>
<td>616,934</td>
<td>619,821</td>
<td>692,763</td>
<td>12.1%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Bed Days Used</td>
<td>3,518,299</td>
<td>3,551,249</td>
<td>3,602,505</td>
<td>3,572,676</td>
<td>3,479,835</td>
<td>3,441,538</td>
<td>3,334,248</td>
<td>3,351,489</td>
<td>3,332,974</td>
<td>3,360,587</td>
<td>-3.9%</td>
<td>1.4%</td>
</tr>
<tr>
<td>% Bed Days Used by Patients Aged 65+</td>
<td>48.7</td>
<td>48.2</td>
<td>47.3</td>
<td>47.6</td>
<td>48.3</td>
<td>49.4</td>
<td>49.3</td>
<td>49.9</td>
<td>50.9</td>
<td>51.5</td>
<td>5.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Average Length of Stay in Days</td>
<td>6.33</td>
<td>6.18</td>
<td>6.07</td>
<td>6.03</td>
<td>5.96</td>
<td>5.90</td>
<td>5.72</td>
<td>5.43</td>
<td>5.42</td>
<td>5.43</td>
<td>-11.3%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Surgical In-Patients</td>
<td>136,670</td>
<td>141,985</td>
<td>148,771</td>
<td>148,485</td>
<td>150,381</td>
<td>153,269</td>
<td>155,034</td>
<td>135,202</td>
<td>134,022</td>
<td>134,118</td>
<td>-3.3%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Day Cases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>1,253</td>
<td>1,418</td>
<td>1,545</td>
<td>1,737</td>
<td>1,772</td>
<td>1,857</td>
<td>1,936</td>
<td>2,049</td>
<td>2,021</td>
<td>2,006</td>
<td>41.4%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Day Cases</td>
<td>442,785</td>
<td>661,638(b)</td>
<td>716,276</td>
<td>770,617</td>
<td>819,254</td>
<td>857,854</td>
<td>883,422</td>
<td>915,254</td>
<td>931,381</td>
<td>957,258</td>
<td>44.7%</td>
<td>2.8%</td>
</tr>
<tr>
<td>% Day Cases Aged 65+</td>
<td>28.0</td>
<td>33.7</td>
<td>33.4</td>
<td>33.8</td>
<td>35.3</td>
<td>36.3</td>
<td>36.4</td>
<td>37.0</td>
<td>37.7</td>
<td>11.9%</td>
<td>1.8%</td>
<td></td>
</tr>
<tr>
<td>Surgical Day Cases</td>
<td>84,232</td>
<td>86,948</td>
<td>92,213</td>
<td>98,841</td>
<td>107,465</td>
<td>115,846</td>
<td>127,544</td>
<td>138,668</td>
<td>142,728</td>
<td>148,072</td>
<td>75.8%</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Total Discharges</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Patients and Day Cases</td>
<td>998,552</td>
<td>1,235,036(b)</td>
<td>1,311,633</td>
<td>1,362,750</td>
<td>1,402,742</td>
<td>1,440,871</td>
<td>1,466,475</td>
<td>1,532,188</td>
<td>1,546,592</td>
<td>1,580,021</td>
<td>27.8%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Daycases as a % of Total Discharges</td>
<td>44.3</td>
<td>53.5(b)</td>
<td>54.8</td>
<td>56.5</td>
<td>58.4</td>
<td>59.5</td>
<td>60.2</td>
<td>59.7</td>
<td>60.2</td>
<td>60.6</td>
<td>13.2%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Emergency Department Attendances</td>
<td>1,249,659</td>
<td>1,245,001</td>
<td>1,296,091</td>
<td>1,150,674</td>
<td>1,253,178</td>
<td>1,232,908</td>
<td>1,226,820</td>
<td>1,278,522</td>
<td>1,252,685</td>
<td>1,217,572</td>
<td>-2.6%</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Out-patient Attendances</td>
<td>2,453,000</td>
<td>2,796,331</td>
<td>3,087,448</td>
<td>3,288,917</td>
<td>3,419,705</td>
<td>3,583,290</td>
<td>n/a</td>
<td>2,355,030</td>
<td>3,071,995</td>
<td>3,206,056</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Good news...Bad News

The Good news

44% of those aged ≥ 52 self-rate their health as either ‘excellent’ or ‘v good’, 35% as ‘good’ (TILDA Wave 2)

The Not so Good news

A high prevalence of people living with chronic conditions (doctor diagnosis)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>High BP</td>
<td>37%</td>
<td>39%</td>
</tr>
<tr>
<td>History of heart attack</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>27%</td>
<td>41%</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>4%</td>
<td>24%</td>
</tr>
<tr>
<td>Lung disease</td>
<td>4%</td>
<td>6%</td>
</tr>
</tbody>
</table>
A gentleman spoke about “having a fall at home....he had a fracture and spent one month in hospital after theatre....the nurses all worked very hard in that unit and that the food was very good. He was subsequently transferred to another hospital afterwards where he said he had excellent care and had a bath for the first time in months”.

A lady said “she had a good experience in a hospital where she received excellent care at night. The nurses introduced themselves and made her very comfortable”.
Older People
In-patient Experiences

A husband spoke of wife’s admission to hospital in severe pain:

- Waited hours to be seen by doctor,
- 3 days waiting for transfer to specialist hospital,
- On trolley with no blankets or pillow,
- “It was like a war zone”,
- Put into small room like a “dungeon”, with no call bell and very dark,
- She resorted to calling 999 from room asking where she was,
- Moved straight away to a bed,
- In recovery, sent to clinic and medications increased,
- She sustained a fall attributed to multiple medications.

A lady spoke about “the very good care her husband received in one hospital but said that the care in two other hospitals was not so good in her opinion. She is reluctant to ever return to one hospital and would prefer to stay at home instead”.

A gentleman whose wife is currently in hospital spoke about:

- How he was not allowed to visit during meal times,
- After meal time he would find his wife’s tray untouched,
- In many cases the bed trolley is not even pushed up close to the patients where they could access the meal,
- His wife now suffers from significant weight loss and he now insist on being present for meals”.

A Collaborative Exercise Conducted by HSE Quality Improvement Division & Age Friendly Ireland (July 2015)
Not short on reports about this!

1968: The Care of the Aged

1988: The Years Ahead... A Policy for the Elderly

2012: National Clinical Programme For Older People

2013: Positive Ageing – Starts Now!
In reply to your recent letter, the question of a career structure for young doctors is causing a lot of concern. In the process of the present negotiations on Junior Hospital Doctors, we have been insisting on the institution of a career structure.

With regard to general practice, we are expecting a report very shortly from the Council, on general practice. We are pressing for unrestricted entry to the GMS, provided the doctor has had adequate vocational training. What constitutes adequate training will be defined when the report of the Council on General Practice comes.

The Paediatric Services are under survey at the present time. While there are adequate services in Dublin, Cork, Galway and Limerick, it is my personal opinion that many more Paediatricians are required in the country.

Vacancies in Geriatrics are limited. It is felt that one or at most two Geriatricians should be capable of organising this service in each Health Board area. In many cases they would only be required to deal with specialist problems.

General Medicine at Hospital level will be expanded and there will be many more posts created over the next five years. Indeed, it is envisaged that Consultant Physicians will be doubled.

........../CTD
Pattern of Frailty

Stressor event

- Instability (Falls)
- Immobility
- Incontinence
- Changes in cognition
- Iatrogenic

Increased care needs
Admission to hospital
Admission to long-term care

Multiple underlying causes can often be improved with appropriate assessment and intervention including rehabilitation

Adapted from Clegg (2013)
## Risk Stratification Based on Frailty Prevalence Data From Wave 1 of TILDA

<table>
<thead>
<tr>
<th>Frailty State</th>
<th>At risk</th>
<th>High risk</th>
<th>Very High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit (Non-frail)</td>
<td>60.7% (4,963)</td>
<td>25.4% (2,080)</td>
<td>10.0% (814)</td>
</tr>
<tr>
<td>Mild frailty (Pre-frail)</td>
<td>25.4% (2,080)</td>
<td>10.0% (814)</td>
<td>3.9% (318)</td>
</tr>
<tr>
<td>Moderate Frailty (Frail)</td>
<td>10.4% (814)</td>
<td>3.9% (318)</td>
<td></td>
</tr>
<tr>
<td>Severe Frailty (Frail)</td>
<td>3.9% (318)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Age ≥50 years

<table>
<thead>
<tr>
<th>% (n)</th>
<th>% (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>60.7% (4,963)</strong></td>
<td>59.8% (58.5-61.0)</td>
</tr>
<tr>
<td><strong>25.4% (2,080)</strong></td>
<td>25.4% (24.4-26.3)</td>
</tr>
<tr>
<td><strong>10.0% (814)</strong></td>
<td>10.4% (9.6-11.1)</td>
</tr>
<tr>
<td><strong>3.9% (318)</strong></td>
<td>4.0% (5.0-6.1)</td>
</tr>
</tbody>
</table>

### Age ≥65 years

<table>
<thead>
<tr>
<th>% (n)</th>
<th>% (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>44.3% (1,555)</strong></td>
<td>42.1% (40.2-44.0)</td>
</tr>
<tr>
<td><strong>33.3% (1,168)</strong></td>
<td>33.0% (31.4-34.7)</td>
</tr>
<tr>
<td><strong>15.6% (546)</strong></td>
<td>16.5% (15.1-17.9)</td>
</tr>
<tr>
<td><strong>6.9% (242)</strong></td>
<td>8.3% (7.2-9.5)</td>
</tr>
</tbody>
</table>

### Age ≥75 years

<table>
<thead>
<tr>
<th>% (n)</th>
<th>% (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>31.8% (430)</strong></td>
<td>30.1% (27.4-32.8)</td>
</tr>
<tr>
<td><strong>36.4% (495)</strong></td>
<td>35.6% (32.9-38.3)</td>
</tr>
<tr>
<td><strong>20.5% (277)</strong></td>
<td>21.0% (18.7-23.4)</td>
</tr>
<tr>
<td><strong>11.3% (153)</strong></td>
<td>13.2% (11.1-15.4)</td>
</tr>
</tbody>
</table>

* Frailty Index (FI) score cut-offs from study of 516,000 individuals aged 65-95 in UK (Clegg et al. Age Ageing 2016)
† Weighted prevalence estimates with 95% Confidence Intervals.
Experience of Frailty in acute hospital setting....

Dementia
Depression
Infection
Arthritis
Polypharmacy
Pain
Falls
Dehydration
Loss of mobility
Constipation
Hyperglycaemia
Heart Failure
Incontinence
Delirium
What Does Good Care Look Like?
Inpatient, Outpatient, Outreach, Integration

Ambulatory Day Hospital - Specialist Geriatric Services

Acute Setting

- Emergency Department/ Acute Medicine
- Acute Inpatient Care
  - Specialist Geriatric Wards
- Rehabilitation On/off acute site

Community Setting

- Primary Care/ Community
- Home and Long Term care living

Day Hospital HUB (CGA)

Target Functions

1) Provision of Comprehensive Geriatric Assessment
2) Integration of access to
   1) Community Services
   2) Rehab Review Beds (by MDT team)
   3) Respite beds (by GP and PHN)
3) Reduction in Length of Stay

National Care of the Elderly Programme 2012
Comprehensive Geriatric Assessment (CGA)

“Organised approach to assessment designed to determine an older persons medical conditions, mental health, functional capacity and social circumstances. Its purpose is to coordinate and develop an integrated plan for treatment and rehabilitation, support and long term follow up.”

NCPOP, 2015
Evidence that this works if implemented – St James Hospital – 2 Year Review of MedEl Specialty Take system

**Bed days saved and Improved outcomes**

- Bed day usage by over 75’s admitted under the acute system down >22,000 bed days
- In patient consults down by more than 50%
- In patient Rehab waiting lists virtually eliminated
- Listings for LTC down 33%
Evidence that this works if implemented - St James’s Hospital

22,104 less bed days used to treat ≥75s in year 2 compared to 2013

<table>
<thead>
<tr>
<th></th>
<th>&lt;50</th>
<th>50-64</th>
<th>65-74</th>
<th>75-84</th>
<th>&gt;85</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed days 13Q2-14Q1</td>
<td>8796</td>
<td>13119</td>
<td>13651</td>
<td>38072</td>
<td>35646</td>
</tr>
<tr>
<td>Bed days 14Q2-15Q1</td>
<td>10954</td>
<td>12778</td>
<td>16160</td>
<td>32014</td>
<td>23270</td>
</tr>
<tr>
<td>Bed days 15Q2-16Q1</td>
<td>9367</td>
<td>14169</td>
<td>13205</td>
<td>27924</td>
<td>23690</td>
</tr>
</tbody>
</table>

2013 vs 2016: +6.5% +8% -3.3% -26.7% -33.5%
Evidence that this works if implemented – FITT Team Beaumont Hospital
Reduced transfer rates from nursing homes supported by outreach older persons services Mater

Rate calculated per bed per year

- ED transfer rate
- Admission rate
- Referral rates to MCMOP


- ED transfer rate: 0.93, 0.78, 0.75, 0.61, 0.56, 0.58, 0.43, 0.48
- Admission rate: 0.42, 0.37, 0.35, 0.28, 0.32, 0.36, 0.31, 0.27
- Referral rates to MCMOP: 0.17, 0.30, 0.31, 0.32, 0.31, 0.26, 0.29
However...

Despite notable pockets of success in implementing model of care in recent years, clear that a more concerted drive needed to ensure that initiatives are sustained, supported and get mainstreamed.
4 Integrated Care Programmes

These four areas will allow us to tackle the most pressing challenges in our health and social care systems, and improve outcomes and experiences for the greatest number of patients.

- ICP for Prevention and Management of Chronic Disease
- ICP for Older Persons
- ICP for Patient Flow
- ICP for Children

PERSON-CENTRED, CO-ORDINATED CARE
<table>
<thead>
<tr>
<th><strong>Complex and often poorly defined</strong></th>
<th><strong>Working across traditional boundaries (agencies)</strong></th>
<th><strong>Integration needs to be wider than health and social care</strong></th>
<th><strong>Designed ‘with’ rather than ‘for’</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>New roles and ways of working</td>
<td>Different values, mind set and approach</td>
<td>Longitudinal and difficult to show ‘evidence’</td>
<td>More a mission than a programme</td>
</tr>
<tr>
<td></td>
<td>(population v disease, inter-professional, shared decision making).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10-Step Integrated Care Framework for Older Persons

1. Establish Governance Structures

2. Undertake Population Planning for Older Persons
   - Risk Stratification
     - Very high risk: 1% OP, 10% C
     - High risk: 4% OP, 17% C
     - At risk: 15% OP, 25% C
     - Minimal risk: 80% OP, 48% C

3. Map Local Care Resources
   - Supports to Live Well
     - Enable older persons to live well in the community
       - Community Transport
       - Social Activities
       - Home modifications & handy person
       - Medication Management
       - Shopping
       - Harness Technology
       - Support carers
       - Information & Advice

4. Develop Services & Care Pathways
   - Rehabilitation
   - Ambulant Day Care
   - Acute Care
   - Nursing Homes
   - Dementia
   - Falls etc..

5. Develop New Ways of Working
   - New roles including case management approach for long term complex needs in-reach and outreach

6. Develop Multidisciplinary Teamwork & Create Clinical Network Hub
   - Co-ordination between care providers

7. Person-centred Care Planning & Service Delivery

8. Monitor & Evaluate
   - Track service developments
   - Measure outcomes
   - Staff and service user experience

9. Enablers
   - Develop workforce
   - Align finance
   - Information systems
2016, 6 ICPOP Pioneer Areas across acute hospitals and CHOs
STEP 1: Establish Governance Structures

National Steering Group

National Working Group

Local Implementation Teams
STEP 2: Undertake Population Planning for Older Persons

Planning for Trends in Population Complexity
STEP 3: Map local care resources against current and anticipated demographic needs

Map out existing Clinical care resources spanning Hospital and Community

Identify structures and pathways already in place spanning Hospital and Community

Identify special interest voluntary groups for older people in the community

Identify existing resources, centres, clubs and initiatives for older people in the community
Map Local Resources

https://finder.healthatlasireland.ie/
## North Mayo Services
(Clinical resources & Service provision)

<table>
<thead>
<tr>
<th>Area</th>
<th>North Mayo PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHN</td>
</tr>
<tr>
<td>Ballina</td>
<td>6.83</td>
</tr>
<tr>
<td>C’molina</td>
<td>1.0</td>
</tr>
<tr>
<td>Achill</td>
<td>2.0</td>
</tr>
</tbody>
</table>

### Service Provision

<table>
<thead>
<tr>
<th>Service Provision</th>
<th>Variance (from target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fair Deal Bed Occupancy (North Mayo)</td>
<td>82-90% occupancy</td>
</tr>
<tr>
<td>(Achill, Belmullet, Ballina)</td>
<td></td>
</tr>
<tr>
<td>HCP</td>
<td>-3.7%</td>
</tr>
<tr>
<td>HH Hours (ex HCP)</td>
<td>17.9%</td>
</tr>
<tr>
<td>Subvention</td>
<td>-31%</td>
</tr>
</tbody>
</table>
STEP 4: Develop Services & Care Pathways

- Access to Rehabilitation
- Ambulatory services e.g. Day Hospital
- Falls, Frailty, Dementia-Specific Care Pathways
- Pathways for Groups with specific needs e.g. those resident in nursing homes
Primary and Secondary care roles focussed on the care of older people with complex needs

- Case Management
- AHP roles
- Specialist Care provision in community

- Working across traditional care boundaries
- Ensuring resources directed to where they have most benefit
- Patient Centred Approach
STEP 6: Develop Multi-disciplinary Teamwork & Create Clinical Network Hub

Ensure MDT Approach at heart of all interventions for older people
STEP 7: Person-centred Care Planning & Delivery

USING A LONGER-TERM APPROACH

- Comprehensive Geriatric Assessment and Treatment Plan
- Single Assessment Tool
- Assessment of carer’s needs
- Ensure patient and carer’s voice are central to all care planning
STEP 8: Supports to Live Well

Enable older persons to live well in the community

- Community Transport
- Social Activities
- Home modifications & handy person
- Medication Management
- Shopping
- Harness Technology
- Support carers
- Information & Advice
STEP 9: Enablers

WORKFORCE
- Gerontologically attuned workforce
- New roles developed

FINANCE
- Enabling appropriate funding mechanisms
- Facilitating economic evaluation of the programme

INFORMATION SYSTEMS
- Single Assessment Tool (SAT)
- E-Health, Telemedicine – remote patient monitoring
- Electronic referrals
- Electronic patient record – Handover and care transition
- E-discharge
- E-Prescribing etc.
- Case finding
STEP 10: Monitor & evaluate

1. STRUCTURAL METRICS
2. PROCESS METRICS
3. OUTCOME METRICS
Progress towards a new care paradigm for Older People & frailty

**TODAY**

- ‘The Frail Elderly’ (i.e. a label)
- Presentation Late & in Crisis (e.g. Delirium, Falls, Immobility)
- Hospital-based: Episodic, Disruptive & Disjointed

**TOMMORROW**

- “An Older Person Living with Frailty” (i.e. a Long-term Condition)
- Timely Identification for Preventative, Proactive Care by Personalised Care & Support Planning
- Community-based Person Centred, Coordinated Care & Support (Health + Social + Voluntary + Mental Health)
Real change takes time....

“....how the approach I had been part of creating to deal with 24–hour media and to demonstrate a decisive government, was entirely the wrong one for ensuring successful delivery...real delivery is about the grind, not just the grand.”

Peter Hyman, 2016, Head Teacher, previous Blair adviser
Older Persons Care is ‘core business’ for the health service

Everyone is part of the solution

Age-friendly = Friendly for all!
If you want to know more...
Transforming Care of Older People
May 23rd 2017
Thank you

Your Involvement matters

ICPOP & NCPOP Programme Teams