An Tionól Saoránach The Citizens' Assembly

Paper of

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delivered to

The Citizens' Assembly

on

10 June 2017

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Saturday, June 10th, 2017

"What is it like to age in Ireland – and what are the opportunities?"

Thank you for inviting me to be part of today's meeting and giving me the opportunity to address you prior to your very important deliberations – I envy your opportunity to make such a major contribution and thank you for agreeing to take on such a responsible and onerous task on our behalf.

Our "Declaration of Independence" – speaks to us of constructing a national policy based on the people's will, with equal right and equal opportunity for every citizen. Quality of healthcare access is one of those rights every person should be entitled too.

We celebrated William Butler Yeats 150th birthday a couple of years ago (2015), he was a member of our Senate from 1922 to 1928 (he won the Nobel Prize for Literature in 1923, while a sitting senator). He spoke at its opening session on December 12th.

He wrote many of his greatest works between the age of 50 and 75, and he attributed this to his "general acquisition of personal wisdom" – which ties in nicely with one definition of age I am including in the presentation to you today –

"Old age is not a disease, it is strength and survivorship, triumph over all sorts of vicissitudes and disappointments, trials and illnesses" (M Kuhn 1978)

He wrote "Sailing to Byzantium" in his early 60s'. In it he challenged us by saying "That is no country for old men".

For Yeats, Byzantium represented the perfect fusion of art, religion and culture "of what is past or passing or to come"! In effect he introduces the main themes of old age and the relationship of nature and art – and throws down a challenge to us all.

So today, you have an opportunity to address some of these challenges, make some recommendations and "make Ireland one of the best countries to retire and grow old in."

We should not reinvent the wheel – we should avail of the trusted and respected resources we have, like the Royal College of Physicians of Ireland (RCPI) in conjunction with Healthy Ireland (HI) that have been leading the way with policy groups around Exercise, Alcohol, Smoking, Obesity and Ageing. The RCPI along with the Health Service Executive and Department of Health have developed all the Clinical Progammes, but in particular The National Clinical Programme for Older People (NCPOP) and the Integrated Care Programme for Older People (ICPOP). These programmes working in tandem with the other groups, clinical programmes and services should be enabled and empowered to support Ireland grow and develop into a society and country where we will enjoy growing old. We must be innovative and challenging in our thoughts, suggestions and recommendations.

The Irish Longitudinal Study in Ageing (TILDA) will be a powerful resource to us in years to come in helping shape and drive policy. It is giving us a lot of descriptive information about how we can age, and I could not go into it all here. This study highlights some of the important contributions older adults are making in Irish society today:

- 41% providing informal child care,
- 53% doing volunteering work regularly, and
- over half providing financial assistance to both their own children and parents.

It also highlights some of the needs and challenges of this group with

- 4% of people receiving formal care at home,
- 8% receiving informal care at home (One in 20 of those 70-79yrs received home help services which increased to 21% of those ≥ 80yrs).
- 25% of people were living alone,
- 15% needed an overnight stay in hospital,
- 92% visited their GP,
- 37% had 3 or more chronic illness.

The most frequently used community services were the optician (12%), dental services (11%), Public Health Nurse (7%) and physiotherapy (5%). Use of these and other services will grow in the years ahead simply as a result of the ageing demographics you have heard about. 52% participated weekly in either exercise or a hobby.

There will be much more information coming from TILDA in the years ahead, in relation to information like this and also information around evolving health and ageing challenges including frailty.

The knowledge that we are living longer challenges us to ensure that these years gained are healthy years.

We need to work into our daily lives attitudes and behaviours that maximise our health and delay the onset of disabling illness. Oddly, we need in essence to spend a longer time living healthily and a shorter time dying!.

You have already heard about the changing ageing demographic, and the opportunities this gives us to plan and get things right for us all now and in the years ahead.

Thankfully most of us will live longer but need to prepare ourselves for this, and take some level of personal responsibility – helped by health promotion and education to minimize the time spent living with dependence and disability – promote independence, and have easy access to supports if disabled or dependent.

Planning effectively for population ageing and the predicted growth will have positive consequences for the health and wellbeing of Irish people.

There are 3 pillars on which to base this positive approach. They are: - personal, societal and political – each has a role to play.

So to the How!

National Clinical Programme for Older People

As in every developed and indeed developing country, demographic changes will impact on the way services are delivered with an increasing number of frail older people requiring identification, assessment, management and care. While this is a challenge it also creates a great opportunity to show what values we hold true in society.

In 2010, the Royal College of Physicians of Ireland in partnership with Health Services Executive set up the National Clinical Programme for Older People in Ireland. This clinically led group developed and published a '*Specialist Geriatric Services Model of Care, Part 1: Acute Service Provision' in 2012,* highlighting the need to change health care practices in response to the needs of the older population.

The original model published in 2012, recommends that older people should have access, if required, to the following services in secondary care:

- Dedicated in-patient Specialist Geriatric Wards (SGW);

- Specialist Geriatric Teams (SGT);
- A Comprehensive Geriatric Assessment for all those identified as frail, at risk, older people to fully assess their individual needs and the range of services they require;
- Access to in-patient rehabilitation facilities;
- Ambulatory day hospital services; and
- Improved links with community based services (residential care and home supports).

This detailed model is currently being revised. One additional component that has been developed by the NCPOP is a document on Comprehensive Geriatric Assessment (CGA).

CGA is fundamental to the assessment, planning and intervention required to meet the health and social care needs of the older person that is frail or at risk of frailty. Rather than the traditional way of working separately, CGA facilitates doctors, nurses, physiotherapists, occupational therapists, social workers and other members of the team to work closely together to ensure an integrated assessment and response to the older person's individual needs. If adequately resourced this can be available to an older person in the community or in the hospital. CGA has the potential to improve the care people receive in hospital, reduce unnecessary hospital admissions, lengths of stay and readmissions. As technology adapts to the complex health care environment we will see vast improvements in confidential information sharing across the health and community sectors. This should support and aid efficiencies, safety and improvements in care provided.

At the core of all of this there will need to be an ability to understand, recognize and identify frailty. This has the potential to become a key enabler to drive the changes that will facilitate the understanding of the need for CGA. At the centre of CGA is the patient and person. For them and them alone we need to break down the silos of cared based on single diseases, single organ failure and multiple care settings. We need a coordinated, multidisciplinary approach, an approach that is the essence of true integrated care.

Comprehensive geriatric assessment is defined as a "*multi-dimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up" (Rubenstein, L.Z., et al., 1991)*. It emphasizes improving the quality of life and

functional status of the older adult and at the same time, improves prognosis and outcome for this frail group of older people.

The CGA guidance document (published by the NCPOP), includes a review of what comprehensive geriatric assessment is, and the recommended interventions arising from it.

The aim of the guidance document is to act as a practical resource to assist with the comprehensive assessment of older people in order to improve outcomes for frail, older patients. It does not address the interventions but it is implicit that a coordinated multidisciplinary plan is implemented following CGA.

The guide is primarily intended for use by medical, nursing, health and social care professionals working across many settings, but should also prove useful for education providers. The information in the guide is grounded on evidence based practice and multidisciplinary expert opinion.

The main focus of the guidance document is on the assessment of older people across the integrated services - in the specialist geriatric ward acute hospital, emergency departments, outpatient clinics and ambulatory day services. It is recognized, however, that all older people should have equal access to specialist geriatric expertise regardless of the setting.

We have a great opportunity now to build on the foundation of knowledge and research that exists to enable us to improve on how we provide and deliver care to the older people on our society. Let us hope that we use this knowledge and research wisely. Your contribution over the life of this Citizen's Assembly has great potential to move things forward in this regard.

Integrated Care

This requires society and government to continue support the development of services for older people with policy and funding. It requires focused reconfiguration of acute hospital and community services and true integration across these services.

It also requires society to make it unacceptable that these services are not available when we are older and require access to this type of care and support. They should also be easy to access.

We need access to acute care – we also need access to get out, indeed, not come in in the first place, if that can be avoided!

A survey carried out in 2011 by the NCPOP identified that only 30% of acute hospitals admitting people over the age of 65 years acutely had a dedicated Specialist Geriatric Care Ward (SGW). A repeat survey is currently being completed and based on a number of hospital visits this year the NCPOP programme anticipates that this penetration rate has increased to approximately 70%, with the majority having improved dedicated multidisciplinary input. We have however a lot more progress to make.

We need pathways of care to improve patient flow through the system.

The acute sector has responded to the increased presentations of older people due to demographic trends and the high prevalence of chronic disease by increasing the number of people treated on a day case basis and by decreasing the length of hospital inpatient stay for the majority of older people. More needs to be done.

Education

Health awareness and health care knowledge is something that, for many reasons, should not just be targeted at health care professionals but should be delivered across the continuum of learning – from primary, secondary (including transition year), third level and to health care professionals.

Evidence published recently in a Cochrane review clearly demonstrates that admitting an appropriately clinically identified older person to a specialist geriatric ward (SGW), with "gerontologically attuned" nursing staff and allied health professionals who get a comprehensive geriatric assessment (CGA) are more likely to be alive and at home 6 months later.

In the context of inpatient treatment and dedicated services, CGA is associated with better outcomes for frail elderly patients, i.e**.** health improvement and reduction in disability, and a significant increase in being alive and living at home on follow-up (Cochrane 2011).

Identifying this frail older person is a starting point. Thus education around frailty, which will enable us all to recognise, identify, and understand frailty and then respond to it, is a very good starting point.

You would not consider admitting a patient with a heart attack, cancer or stroke to anything other than a specialist unit. In all these situations and cases outcomes including lower mortality rates, less disability and better long-term outcomes have been demonstrated.

We now have similar evidence for the management of the frail older person requiring acute hospital care and we should act accordingly.

Model of Care

The Model of Care for Older People in Acute Hospitals launched and published by Minister Kathleen Lynch and the HSE and Department of Health in 2012 clearly defines requirements for older persons in the acute hospital setting. Times change, expectations change, but principles remain the same. This model of care is now being modernised, it should be implemented.

It includes as core acute hospital services for the older person as being constituted by a minimum of, a dedicated ward, a rehabilitation ward and a day hospital on or near the acute hospital site. We should start by moving from only 30% of acute hospitals having such a ward to all acute hospitals having at least one. That should be the first building block as an acknowledgement of the need and benefit and go from there.

Combine this with the new Integrated Care Programme for Older People and the efforts being made to transform care of older people in Ireland around the country and we are beginning to get a better picture of how we can be at the forefront of improving the care we are delivering.

The overall aim is to implement best practice in acute care of the older person nationally through the establishment of a Specialist Geriatric Service (SGS) to include:

- Geriatric specialist wards, rehabilitation and day hospital facilities
- Comprehensive geriatric assessment
- Liaison with primary care services and discharge planning
- Integrated Care

The NCPOP is also in the process of completing Specialist Geriatric Service Model of Care for Mental Health Services which should be published later in 2017. This along with the new National Dementia Strategy will add further to providing guidance and direction in improving delivery of care.

Summary

Ultimately as we will all age we must plan and ensure that having arrived successfully at healthy old age we will then have access to the necessary services we need.

That may be family support and community services, as the majority of us will continue to live at home, as evidence by the data from the Irish Longitudinal Study in Ageing (TILDA).

Also in this context allowances like the Travel Pass (promoting independence and social connectedness), fuel allowances, home care supports, if they are needed, and the Medical Card with certain defined benefits for the Older Person should be supported and enhanced, by us for us. This should be protected and enhanced by future governments, showing we value the seniors in our society.

For the minority that will need it, they should have access to high quality acute hospital care with focussed specialist geriatric services and community supports and services. Finally, if needed, high quality nursing home services that are not complicated and cumbersome to access will also play an important role.

All these services should be available to us in an equitable, easy to access way. It is this piece of the puzzle that our society and our government must solve. That is your challenge as we meet ours.

There is actually a surprising lack of social, economic and health information on older persons in Ireland. Real opportunity exists to understand the characteristics and needs of our ageing population. We also need to further explore service care models and develop new technologies and treatments to enable independent living. The Irish Longitudinal in Ageing (TILDA), will provide a resource for us to exploit all these opportunities and needs, and inform policy in the years to come.

We had a great meeting on May 23rd, 2017, "Transforming Care of Older People in Ireland" held in conjunction with the RCPI and HSE. All of the speakers highlighted how making your health and care systems fit for an ageing population can be achieved and the work that is going on around our country to further build on improvements that are being made. These type of meetings along with the work you are doing here this weekend will give us further impetus to drive these important changes forward.

Your deliberations and recommendations can make a powerful contribution to how we improve the care and support we provide older people in our country. I look on us all as part of one team – each of us has an important part to play and the whole is definitely greater than the sum of our parts. Thank you again for the opportunity to speak with you today