



OLDER
PEOPLE

Citizens' Assembly

June 10th, 2017



What is it like to age in Ireland ?

Diarmuid O Shea

Inspiring change to make our country a place you
want to grow old in!



What is Ageing?

When I get older, losing my hair,
Many years from now, will you still
be sending me a Valentine, birthday
greetings, bottle of wine...

When I'm

Beatles 1962



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





Average life expectancy over time



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tilda

The Irish Longitudinal
Study on Ageing

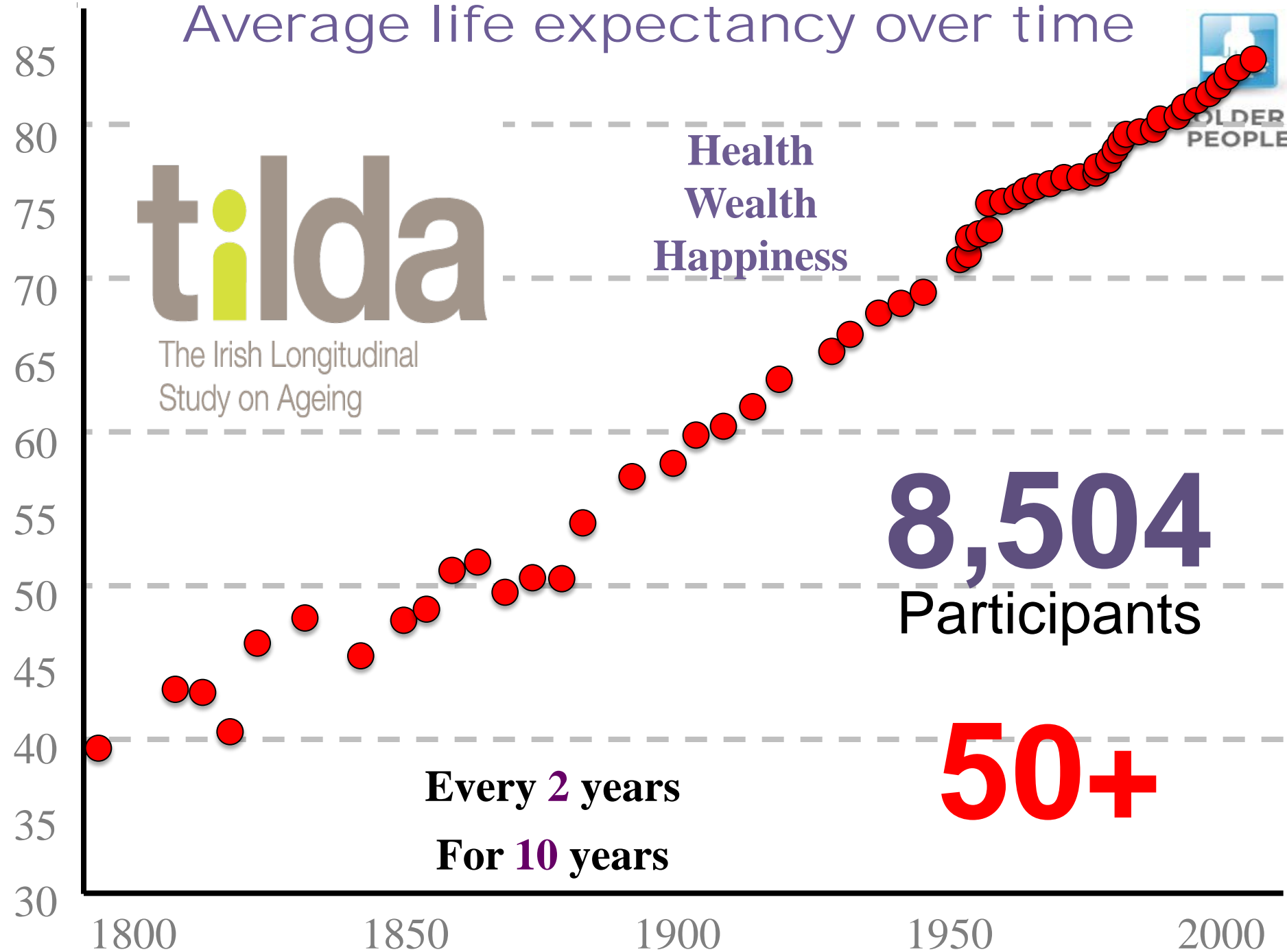
Health
Wealth
Happiness

8,504
Participants

50+

Every 2 years

For 10 years



Providing Evidence for Policy

***Modifiable risk factors for Stroke,
Heart failure, Kidney disease,
Dementia***

Frailty, Falls

Promote Independent living

Extended life span

Healthy life years

What is the Ireland of today like?



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95% live at home

5% in NH

25% live alone

4% formal care

8% informal care

Urban/Rural switch



92% visited GP

15% stayed
overnight in hospital

7% known to PHN

Population Projections - The Planning Imperative



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“Frailty is the most problematic expression of population ageing” - we need to be able to recognize it, understand it and manage it

	2006	2011	2026	2041
Total Population	4.2	4.6	4.8	4.9
> 65 yrs	467900	535400	885600	1300000
> 85 yrs	47800	58400	116300	248200
In LTC				
5%	22613	22341	44255	65000
4%			35404	52000



What do I want as I age?

What do I want as I age?

- Live well, live long
- Be happy
- Be supported when I am challenged

What does this require?

- Information
- Education
- Personal effort
- Access to health care
- Societal support
- Government & Policy

**“Old age is not a disease - it is strength and survivorship,
triumph over all sorts of vicissitudes and disappointments,
trials and illnesses”** M Kuhn

Personal, Societal and Policy Responsibility are all connected



Smoking & Alcohol



Personal, Societal and Policy Responsibility are all connected



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Exercise
Smoking
High Blood Pressure
Obesity
Alcohol
Diabetes



Overweight at 40yrs – live 3 years less
Obese at 40yrs – live 7 years less
Obese and smoke at 40yrs – live 14 years less



Diet and Exercise

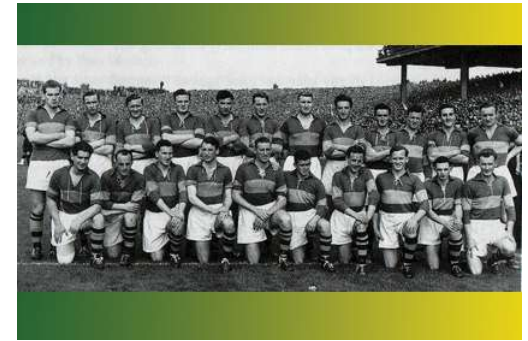


Personal and Societal and Policy

Social connectedness



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What is the landscape of illness like in the Ireland of today?



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High Blood Pressure
Diabetes
Cholesterol
Stroke
Heart Disease
Cancer
Dementia

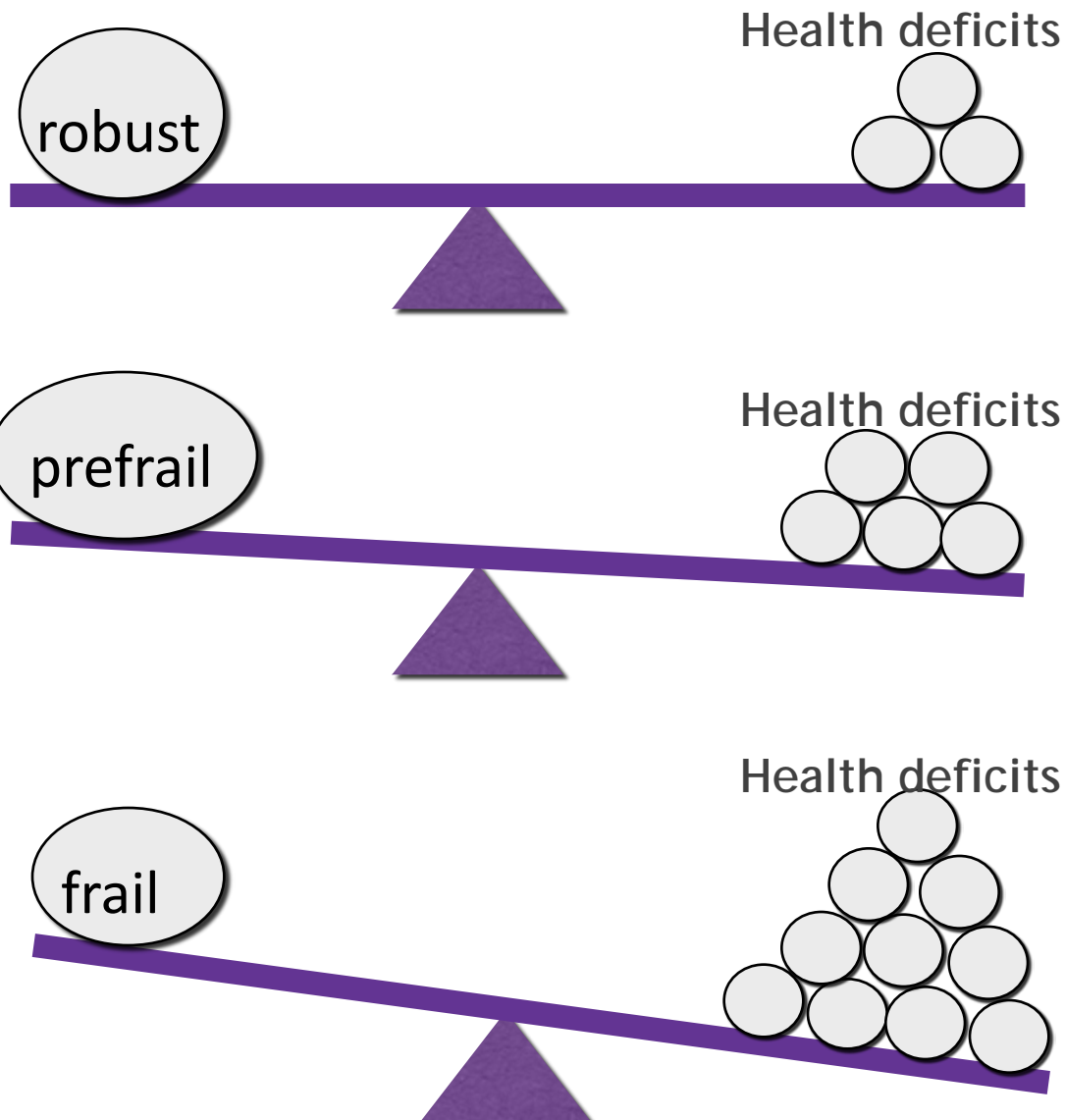


Falls

Frailty

37% have three or more illnesses
4% on ten or more medications

Cumulative Deficit Model (Frailty Index) (Rockwood et al 2005)





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How am I likely to age?

At Birth	76 yrs for a man 80 yrs for a woman	Frail
At 60	19 yrs	
At 65 (m) (f)	16.6 19.8	4%
At 70	12 yrs	7%
At 80	7 yrs	16%
At 90	4 yrs	26%





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Prevention is better than cure – but accidents do happen!

A well intentioned action.....

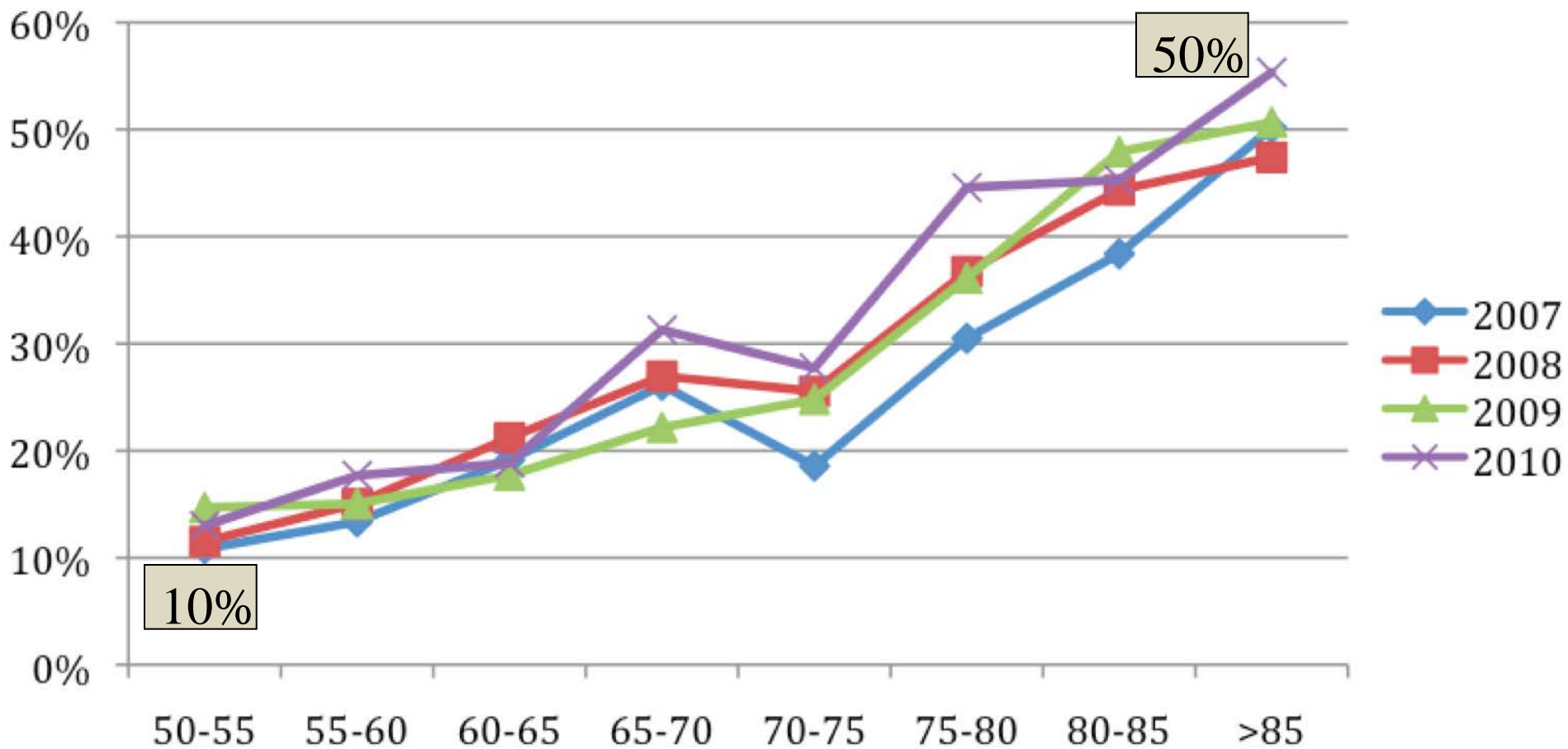


<https://www.youtube.com/watch?v=mi1xehz0K64>

Falls



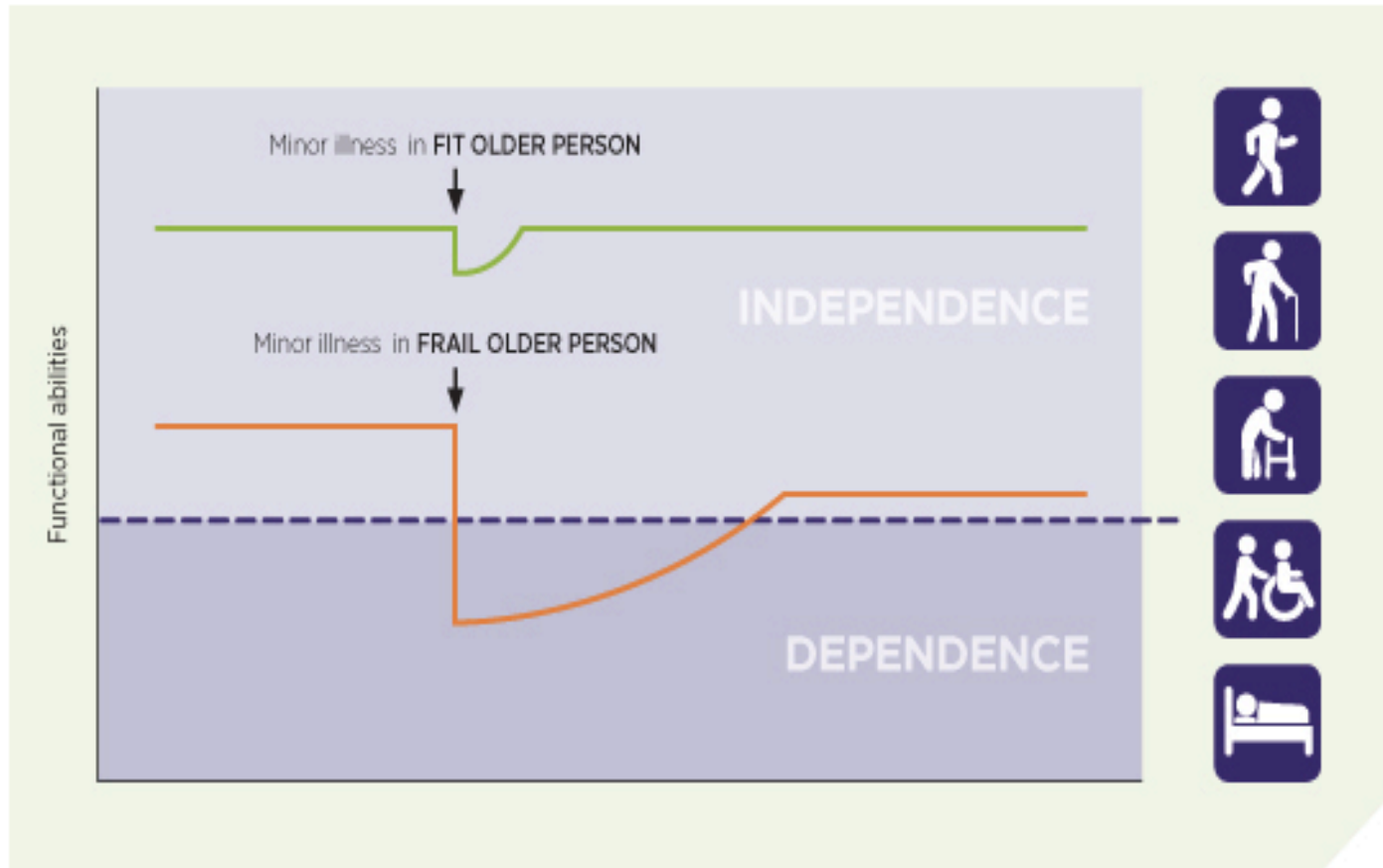
% of Falls admitted by Age Group





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Vulnerability of frail older person to change in health status after minor illness



Falls

Infections

Dementia

Stroke

Cancer

Fig 1. Frail older people display low resilience to minor stressors (e.g. urinary tract infection).²

This figure adapted from Clegg A, Young J, Iliffe S, et al. Frailty in elderly people. Lancet 2013;381:753(Figure 1) with permission from Elsevier.



Professional and Public Perception



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“At every stage seek out opportunities to improve how we age and how we support those who are challenged as they age”

New care paradigm for Older People and Frailty

John Young



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TODAY

'The Frail Elderly'
(i.e. a label)



Presentation late & in crisis
(e.g. delirium, falls, immobility)



**Hospital-based: episodic,
disruptive & disjointed**

TOMORROW

**"An older person living with
frailty"**
(i.e. a long-term condition)

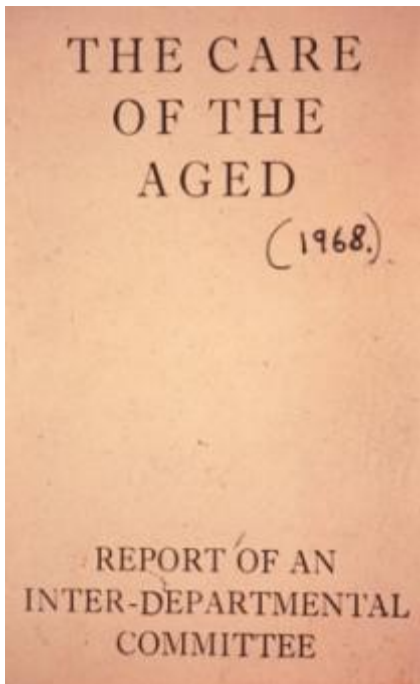


**Timely identification for
preventative, proactive care by
supported self-management &
personalised care planning**

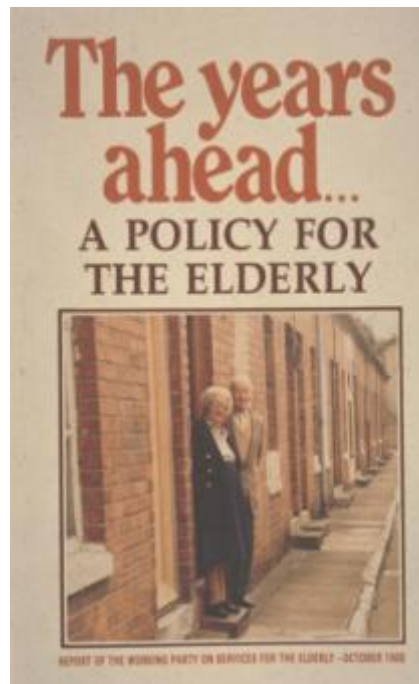


**Community-based: person-
centred & co-ordinated**
(Health + Social + Voluntary
+ Mental Health)

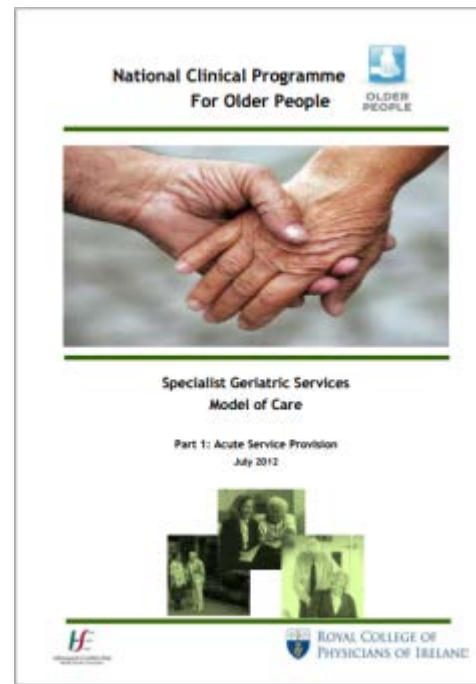
Not short on reports about this!



1968



1988



2012



2013



National Clinical
& Integrated Care Programmes
Person-centred, co-ordinated care

Specialist Geriatric Services Model of Care (2012)



National Clinical Programme
For Older People



Specialist Geriatric Services
Model of Care

Part 1: Acute Service Provision
July 2012



ROYAL COLLEGE OF
PHYSICIANS OF IRELAND

4 Integrated Care Programmes

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.



**PERSON-CENTRED
&
CO-ORDINATED CARE**



ICP for Prevention and
Management of Chronic
Disease



ICP for
Older Persons



ICP for
Patient Flow



ICP for
Children

10-Step Integrated Care Framework for Older Persons



National Clinical
& Integrated Care Programmes
Person-centred co-ordinated care



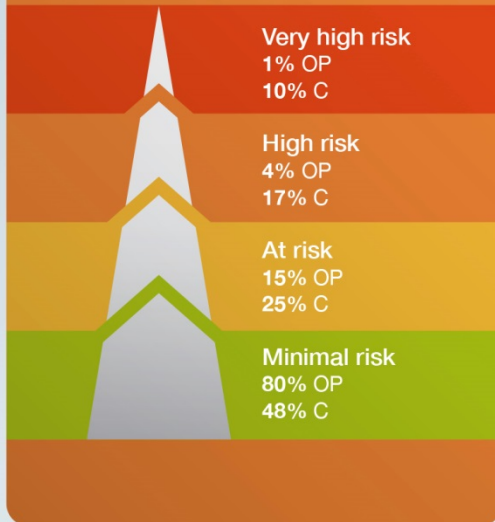
1 Establish Governance Structures

2 Undertake Population Planning for Older Persons



Risk Stratification

% Older Persons / % Cost



3 Map Local Care Resources



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

4 Develop Services & Care Pathways



- Rehabilitation
- Ambulatory 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



10 Monitor & Evaluate

- Track service developments
- Measure outcomes
- Staff and service user experience



9 Enablers

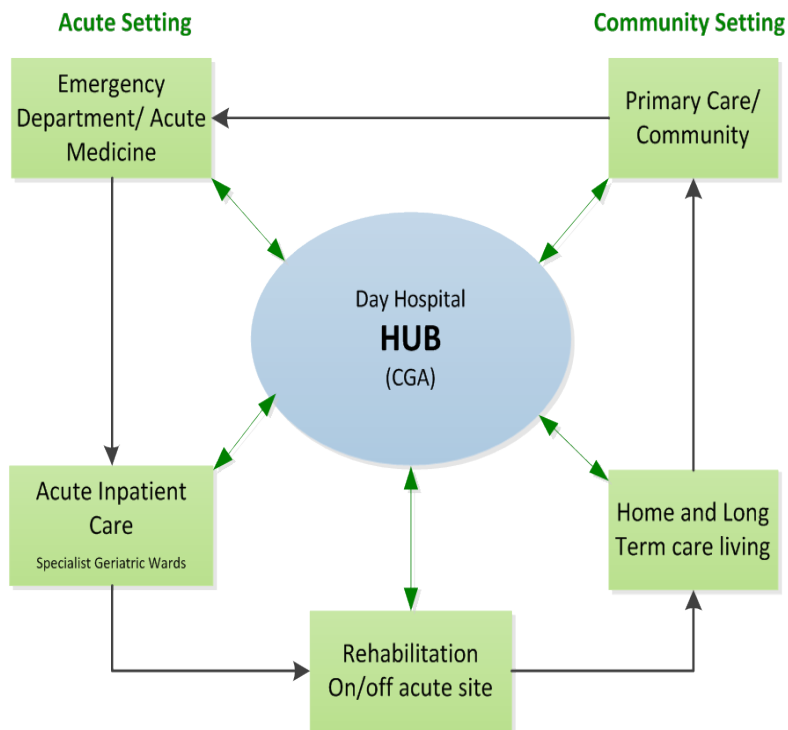
- Develop workforce
- Align finance
- Information systems



What Does Good Care Look Like?

Inpatient, Outpatient, Outreach, Integration

Ambulatory Day Hospital - Specialist Geriatric Services



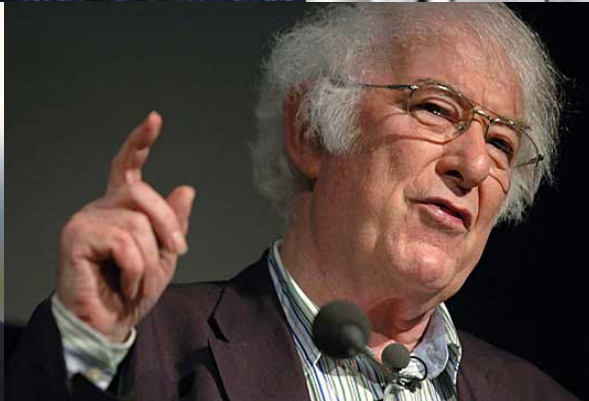
Target Functions

- 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





*"We thread the needles eyes, and
all we do.....All must do together"*



Take home messages

Older Persons Care and support is 'core business' for the health and social care services (and our country)

and everyone is part of the solution

You as our "Citizens Assembly" are in a unique position to contribute to this

Age-friendly = Friendly for all!



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Thank you



Your Involvement matters

ICPOP & NCPOP Programme Teams



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive