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CONTENTS

INTRODUCTION

This initial section gives the aims of the report and the structure which has been adopted. It touches upon the range and complexity of issues which affect the health of older people, and especially older Londoners. Gaining a truly comprehensive picture is not easy but particular attention is given to the health and social care boundaries. With conflicting messages about the relative health and social care status of older people in London it is important to try to gain as clear as possible a picture.

The health of older people is affected by many different aspects of society beyond what is customarily thought of as the health care system. In this analysis of what is happening in London particular attention is given to the relationship between the health and social care systems, and especially the contribution by local authority Social Services departments to the promotion and maintenance of good health. This review makes use of both factual source information and of the informed views of a variety of stakeholders in and associated with the systems.

It has thus been possible to develop a snapshot of older Londoners and their health needs but this account does not set out to be a comprehensive, in-depth research study. Particular effort has been made to determine whether older people in London have greater or distinctive needs compared to other parts of the country, and to establish whether the service response in London is or needs to be different.

What follows is an analysis of the numbers and circumstances of older Londoners, their health and social care needs, and an assessment of how well statutory and other services are meeting these needs. A review of issues emerging leads to an argument for an approach which embraces both health and social care systems at operational, locality and strategic levels.

Meeting the needs of London's older residents is one of the major challenges facing purchasers and providers of health and social care services in the capital. The needs of older people vary enormously, especially in London with its great range of social, economic and ethnic characteristics. This is, of course, a far from homogenous group, which may help explain the apparent lack of priority accorded to older people within the health care system. Older people do have needs associated with ageing but they have others which are not. It is important to bear in mind that effectively people age at different rates so that chronological age can sometimes be a misleading notion. The numbers of black minority ethnic older people in London will soon be very significant, those of Irish born older people should already be well known to policy makers.

So getting to grips with how well the health needs of older people are being met is by no means straightforward. There is certainly some perception that "the health system" is failing older people. For example, there is a growing concern that the National Health Service is seeking to reduce its commitment to long-term care without ensuring that this responsibility can be properly accepted by local authorities and other social care agencies.

But there is another more positive side to this story. Only two London Health Authorities were above the England and Wales average for mortality rates from coronary heart disease in persons aged 65 - 74 years (1990 - 92) whilst only three were above average for strokes in the

same age group. Interestingly, for younger ages there were more Authorities above the average in both cases. Taking this information (from the 1995/96 Pocket Guide to the NHS in London) at face value not only does London appear in a better light than the rest of the country but older people fare better than others.

Meanwhile the Third Report from the Parliamentary Health Committee (July 1996) provided an important national backcloth against which to review long-term care needs of older people. The Committee's main conclusion sought to dispel doom and gloom :

> *" There has been considerable media and public speculation about the 'crisis' the country supposedly faces in paying for long-term care in the future. We believe that much of this speculation has been founded on unsound evidence, or indeed been downright alarmist, and that the problems the country faces in relation to paying for long-term care, although real, are more manageable than many recent commentators have suggested."*

Perhaps, though, the Committee hit the right note when it went on to recommend that the Department of Health should ensure further research on the health status of older people because of the lack of robust data currently available. The changes in numbers of older people were considered to be much easier to predict than the potentially more concerning trends in incidence of living alone and health status. These are important issues for London as elsewhere.

As this debate continues older people have to try to maintain an acceptable standard of life - acceptable to themselves and to society as a whole. The health care system has an important part to play in this but it is only one part. The health of older people in the broadest sense is

dependent upon a number of key determinants, including housing, environment and economic status. The Health Education Authority in collaboration with the Centre for Policy on Ageing is developing a framework for promoting the health of older people. Four perspectives have been identified as the basis for understanding needs, identifying effective responses and actions, and agreeing indicators for measuring progress :

- tackling diseases primarily through primary and secondary prevention measures which address lifestyle and other risk factors
- ensuring personal independence and autonomy through maintaining and restoring physical and mental functional capacity; measures focus on personal mobility and effective rehabilitation
- active participation and active use of services; dependent on social networks and accessible and responsive service provision
- supportive public policies and a social climate which recognises the rights and value of older people in society; this requires changes in structures and attitudes in society

Good health is about being able to take part in life, to contribute and to exercise choice and control - in essence about retaining a role and place in life.

The section on Demographic Background seeks to establish the numbers of older people living in London, broken down by suitable age ranges. Clearly the projected changes in these numbers would have important potential implications for health purchasers and providers, since older people are a significant user of services. In this basic demographic profile there is a limit to the amount of qualitative information available but particular attention has been given to that relating to limiting long-term illness and disability. As well as changes in overall numbers, the

movement of older people is important to trace: in and out of London and between different parts. Comparisons with the position in the rest of the country are important: to an extent the London picture has to be seen in context of the rest of the country, trying to identify what is (or may be) different and distinctive about the capital.

With this quantifiable information as a base the next section of this report provides a conceptual framework for considering the health and social care needs of older people, and the ways in which these needs are assessed. Different approaches to need are examined. Information has been drawn from local analyses of needs by health and local authorities. The picture here seeks to take account of the different meanings of need and how these can impact upon the health and social systems' assessment of appropriate responses. One of the known distinctive features of London is the number of older minority ethnic people compared to other parts of the country. Detailed analyses have been made of their needs and how these are being responded to, including particular reference to Irish older people who currently form by far the largest minority group of older people in the capital.

This is followed by the development of a framework for considering the service provision parts of the health and social care system which affect older people. Service configurations in London are then described and set within this framework, and analysis made of how these and current ways of working are coping with the changing health and social care needs of older people in London. The components of provision are looked at on the basis of five geographical sectors covering the whole of London: more detailed examination is given of a number of locations, including the views of some older people themselves. The importance of the independent sector is not overlooked, with attention being given to the effect on care patterns of a relatively small number of residential resources located in the capital.

A review has been undertaken of the financial situation faced by local authorities in London. A detailed analysis has been made of actual levels of expenditure across the capital on Social Services and other provision, and also of the bases behind these levels - the Standard Spending Assessments. Within Social Services a comparison has been made between older people and other user groups. This analysis supplements the more detailed account of NHS financial resources in London, considered elsewhere.

These four sections of the report are drawn from specially commissioned pieces of work, the reports of which are available in their entirety. Together they form the basis of analysis and research for the rest of this account. The analysis of key issues is also significantly influenced by the views obtained from a variety of important players in the health and social care sectors speaking in their personal capacities. Not least some attempt has been made to listen to the views of older people themselves. In the time available this has been a limited exercise and is one of several issues worthy of further attention.

In this way it is hoped that this report has thrown some light on the often complex and confusing picture which makes up the health of older people in London. Inevitably the picture is not a complete one but it is considered that a clearer and more considered view has nevertheless emerged. The analysis of issues leads to the conclusion that for significant improvement to be made further attention should be paid to systemswide developments at different levels which involve both health and social services in partnership with older people themselves.

DEMOGRAPHIC BACKGROUND

Principal Findings

London has fewer older people than elsewhere

Numbers are set to decline to 2006 before rising again

London's older people have a slightly older age profile : numbers of 85 years and above will increase to 2011

Women significantly outnumber men especially amongst the older groups

Black minority ethnic older people comprise 6% of the total now but will triple by 2011

Irish older people already make up 5% of the total

13,000 older people leave London each year, of which 2,000 go to communal establishments

London has above average older people living alone (of whom 77% are women) : the proportion is increasing whilst numbers are declining

Older people are more likely to lack basic household amenities

A lower proportion of older people live in residential care and nursing homes in London but this is compensated by those "placed" outside the capital

The picture for London as a whole can hide many variations including very small pockets of deprivation

Introduction

This overview paper is based upon work undertaken by the London Research Centre, whose three reports are available separately. These reports draw heavily from the 1991 Census, the

National Health Service Central Register, LRC Projections, OPCS Surveys of Disability 1985/6; they contain an important amount of information about older people in London from which it has been possible to draw some key aspects. This present paper, therefore, is rooted in the hard evidence of collected data. Its purpose is to provide an introductory account of older people in London, and in particular their health and social care needs and how these are being addressed.

The emphasis here is on a picture of London. Some reference is made to areas within London or to groupings of health or local authorities. In addition it is at times useful to compare the situation elsewhere with that in London. The basic picture is one of fewer and fitter older people in London compared to elsewhere but with inevitable variations.

Numbers of Older People

In 1991 approximately one person in six resident in Greater London was of pensionable age, some 1.1 million in total. This is slightly below the national proportion but London's pensioners have a slightly older age profile. About 6% of London's pensioners were from non-white ethnic groupings. Whilst this figure is far higher than the rest of the country the really important factor here is that it is expected to triple in 15 years time by 2011.

In recent years the older age groups (aged 80 years and above) have increased whilst the numbers of younger pensioners have gone down. There is an annual net loss of 11,000 pensioners to other areas, mostly elsewhere in the South East. Within London there is a movement of older people away from five, mainly inner, health authorities towards outer London. Of the 11,000 2,000 go to communal establishments outside the capital and are, of course, much more likely to have a long term illness. It is less clear whether the remaining

"emigrants" are the fitter or the less fit, the relatively well off or the poor : the most likely explanation is that a significant number are at the younger end of the pensioner group and, therefore, more likely to be relatively fit and well.

Looking ahead London's older population is expected to decline from 1.126 million in 1991 to 992,000 in 2006 before starting to rise again. Whilst in numerical decline London's older population will continue to get older with numbers over 85 years rising from 101,000 in 1991 to 114,000 in 2011.

These are the very basic numbers - they contain some variations which will be referred to below. In addition their impact has to be viewed in the light of current and future policy, practice and other changes which will affect the quality of life for older people. It is not unreasonable to conclude from the population figures alone that this should be seen as a period for ensuring adequate responses rather than for crisis management. But if this is true then it is for the overall situation in London. Local situations also have to be considered : there are obviously parts of London where needs are likely to be greater than elsewhere. Health authorities can cover large areas (as many as three London Boroughs) with contrasting localities. Otherwise affluent areas can contain pockets of deprivation, sometimes hidden. Older people's individual needs and other circumstances are often very specific. National and Londonwide trends are important for policy makers but of less interest to individuals in need.

Other Important Trends

At this early scene setting stage it is relevant to draw attention to a small number of other key national trends affecting older people :

- older people are now more likely to have spouses and children

- there is a small but rapidly increasing number of divorced older people
- there has been a decline in co-residence between generations
- more older people are living alone
- fewer older people have children living nearby
- the proportion of very old people living in institutions has increased
- older people are now less likely to be in paid employment
- younger pensioners provide a significant amount of informal care for their parents and other older people

(Source : "Population Review : (5) The population aged 60 and over", Population Trends 84, HMSO 1996 - Emily M. D. Grundy)

Looking at the numbers

The 1991 Census shows that 1 in 6 of London's residents were older people (of pensionable age) compared to nearly 1 in 5 in the rest of Great Britain., and that this difference is apparent in each of the key age groupings (60/65 to 74, 75-84, 85 and over). This contrast also applies to London and other metropolitan areas. The LRC source material shows important differences between parts of the capital. Notably the proportions of older people in Outer London were closer to the national average than were those for Inner London. There were substantial differences between the proportions in boroughs even within these areas. The proportion of pensioners varied from 13.8% in Haringey to 20.5% in Barking & Dagenham, which (with Bromley and Richmond) was actually above the national average. These big numbers hide important very local variations such as the central area of Westminster and the City of London having higher proportions of pensioners than the Outer London average.

An important aspect of the raw numbers is the extent to which women outnumber men, with the difference tending to increase with age. The following gives an indication :

age	women	men
65 years	30,961	27,845
75	25,742	17,064
85	13,480	5,588
95	1,335	229

(Greater London, 1991)

Significantly, therefore, when planning services for older people, especially those aged 85 years and above, statutory agencies and their partners should explicitly acknowledge that their patients/clients etc. are predominantly women. This has implications for the services themselves and for how they are delivered. These patterns are true for Great Britain as a whole.

Isolation - Older People Living Alone

London has 400,000 older people who live on their own, just over 35% of all older people (compared to an England average of 32% and higher than all Metropolitan Districts except Tyne and Wear). Of these the great majority are women - over 77%. At 14.4% the proportion of lone pensioner households in London is slightly below the Great Britain figure of 15.1%. The ageing profile of the elderly population means that the proportion of older people living alone is set to rise still further, with large increases expected after 2006. This incidence is spread across London : Havering is the only borough in which less than 30% of all pensioners live alone. The significance of these figures is not so much that older people living alone have greater health and social care needs but rather that when they do then there is less likelihood of informal carers being available to assist the statutory services.

Many people have no problem with isolation. It is loneliness (which does not necessarily accompany isolation) which often leads to a decline in overall health accompanied by a lack of role and purpose in life. Sustaining and enhancing older people's social and emotional contexts is where voluntary organisations can play an important part in the overall health system.

Ethnic Groupings

The 1991 Census collected for the first time information on ethnic grouping of people. This showed that nearly half of all Great Britain's minority ethnic residents over pensionable age live in London. Overall more than 20% of London's residents were from black minority ethnic groups but the figure for older people was less than 6%. As the longest established groups Black Caribbeans and Indians (i.e. not including Bangladeshis and Pakistanis) had the highest proportions over pensionable age at 8% and 6% respectively. The relative proportion naturally diminishes with the older age groups so that just over 2% of residents aged 85 years and over are from minority ethnic groups.

Whilst Black Caribbeans of pensionable age are relatively evenly distributed across London at around 2% of pensioners Indians form 4% of pensioners in the North West London region.

There is a relatively high proportion born in Ireland among London's pensioners - 5% in total but with more in the younger group than those aged 75 years and above. Proportions in North West and North Central London at over 7% and 6% respectively are substantially higher than in the rest of the capital and for the statutory authorities in these areas clearly represent an important user group. There is some suggestion that the numbers of older Irish people are

underestimated. Generally limitations of reliable information are a problem in respect of this important group of older Londoners.

Pensioner Households Lacking Amenities

Less than 1% of all households in London lack one or both of the basic amenities (bath/shower and inside toilet) but pensioners are nearly twice as likely to be lacking or sharing one or both of these as are non-pensioners, with those in London more likely to be without exclusive use than those in any other area. Lone pensioners tend to fare worse than others. As with tenure the proportion of pensioner households lacking or sharing the basic amenities varied greatly for different boroughs rising to nearly 1 in 8 lone pensioners in Newham.

Overall only 39% of households with pensioners had one or more cars. For lone pensioners the figure drops below 16% representing some 337,000 older people living on their own without a car.

This information regarding basic and other amenities should be born in mind by policy makers and service providers when considering the composition of their older population.

Older People in Communal Establishments

Nearly 36,000 older people were recorded by the 1991 Census as not living in private households, of which most were in hospitals, care homes or hotels (communal establishments). Of course, many of this group of older people are particularly well known to the health and social care systems because of their placement and financial responsibility. Altogether 32,643 were living in nursing or residential care homes, housing association homes or hospitals in London. The overall proportion of pensioners resident in communal establishments is much

lower in London than the rest of the country. It is also clear that within London communal establishments a higher proportion of pensioners were either in hospital or other NHS homes. This indicates a very low provision of non-NHS care homes within the capital. Overall the low level of provision is a significant factor with an annual net loss to London of 1,900 pensioners moving to care homes outside London (the LRC report explains why this figure may be understated). Of these 86% moved to private nursing or residential care homes. The continuing ageing of the elderly population means that (all things being equal) there will be a growing need for medical and care establishments or the development of alternative arrangements for long-term care of older people. This low level of provision is a distinctive feature of London which receives further attention later in this report.

Also of interest here is the information provided on different rates of residence in communal establishments across the capital. The distribution of pensioners resident in communal establishments across the London Boroughs differed widely from the overall distribution of pensioners. The percentage of pensioners resident in communal establishments varied from 1.4% in Bexley to 6.5% in Kensington & Chelsea (although this latter figure is somewhat distorted by the relatively high number of non-care establishments).

Limiting Long-term Illness

The 1991 Census asked for the first time whether each person had a long-term illness, health problem or handicap which limited the daily activities or work they could do; instructions were given to questioners to include problems due to old age. Of course, this definition does not cover all aspects of need but is less limited than the usual classification of disability.

Around 38% of all pensioners in London had a limiting long-term illness (LLTI), which was lower than all other metropolitan areas and just below the national average. Rates of LLTI were higher among pensioners without exclusive use of basic amenities or without a car than among those pensioners with these facilities. There is thus a clear link here for policy makers even if this is not clearly a causal one.

Of the 35,100 pensioners resident (as non-staff) in communal establishments more than 31,000 had a LLTI. The balance was made up mainly by those in hotels, hostels and the like. It may be considered surprising that there were more than 400 pensioners in hospitals and nursing homes without an LLTI. Within the capital East London had a much higher incidence of LLTI among pensioners generally than did the other London regions, in fact the only region above the national average.

Although the overall picture suggests that London's pensioners are (by this definition at least) relatively healthy compared to elsewhere it is important to be aware of other key aspects emerging in respect of London

- the proportion of pensioners with a LLTI increased from 25% of 60-64 year olds to 66% aged 85 years and above
- whilst a higher proportion of men than women aged 60 - 74 years had a LLTI the position is reversed for those aged over 74 years
- the proportion of pensioners living alone who had a LLTI was (at over 40%) higher than those living with others

- the proportion of pensioners resident in households in Inner London who had a LLTI was (at 39%) higher than the Great Britain average (37%) whilst the Outer London proportion was (at 35%) lower
- the proportion varied across boroughs from 31% in Kensington & Chelsea to 44% in Hackney
- as with other age groups the boroughs with the poorest housing and economic conditions such as Hackney and Newham were those with the highest proportion of pensioners with LLTI

Looking Ahead

The LRC Report contains detailed Borough based information from its annual set of demographic projections to 2011. As already indicated the overall pattern is one of a declining older population to 2006 and then rising again. But this hides the continuous increases in the older age groups, especially those aged 90 years and above. Looking further ahead there are significant increases projected in the second and third decades of the next century which are likely to have important implications for health and social care resources.

The number of older people living alone (whilst significant) is presently declining and will continue to do so albeit it at a reduced rate to 2006 when it will increase once more. By 2011 it is estimated that 40.6% of older people in London will live alone compared to 36.8% in 1991.

Another element of the projections concerns ethnicity. By 2011 nearly 18% of London's over 60s will be from black minority ethnic groups. Each of the minority groups is projected to increase in numbers and proportions, the two largest, Black Caribbeans and Indians, to more than 5% each of London's over 60s in 2011. Clearly this change is of major importance for

purchasers and providers of services and is examined in more detail elsewhere in the report. The balance of minority ethnic groups in each borough will be of significance in determining projected changes in numbers.

Looking at the rest of the country the number of residents aged 60 years and over is expected to remain fairly stable to 2001 and then to increase in numbers and proportion to 2011.

HEALTH AND SOCIAL CARE NEEDS

Principal Findings

Of the different ways of looking at needs those for older people should be examined from a person-centred, integrated perspective

Most health and social care agencies adopt an approach which redefines needs in terms of services currently available

Older people's needs are not static, nor do they follow agency boundaries

Local Authority Community Care Plans (CCPs) largely ignore individuals' and communities' health needs

CCPs across London show little consistent or systematic approach

The stated commitment to collaboration between health and social care agencies has produced little substantive change - there is little real vision evident

A quantification of needs of older people is difficult to obtain - weaknesses across the systems are more evident

Older people in London show better health on a number of indicators :

after adjusting for age and sex older Londoners are 8% less likely to report limiting long term illness and 12% less likely to report acute ill health compared to elsewhere

But the numbers are still high : 409,000 with a disability, of which 52,000 in the High Category; 41,000 older people living at home have a High Category disability (numbers are declining to 2006 then rising again)

Older people from minority ethnic groups report higher levels of ill health

There is some evidence that Irish older people are more prone to ill health, loneliness and depression

Introduction

This section examines health and social care needs of older people in London, set within a framework of what is meant by needs. Its focus is on longer term needs particularly those which cross the boundaries imposed by different responsibilities of health and social care agencies. It does not, nor was intended to, claim to be a comprehensive analysis but rather to paint a picture of life in the capital. It largely avoids issues of acute health needs although some information is provided. Particular attention is drawn to the still relatively unexplored questions of needs of minority ethnic older people, especially of Irish older people who presently form much the largest minority group.

An Integrated Approach to Need Definition

Any analysis of need has to take account of the different perspectives which are possible. **Linda Challis and Joanne Pearson** have sought to create a framework by looking at different interpretations. This analysis occupies the first part of their report. This shows the complexity of the situation which is being described. Not only do theoretical interpretations differ (normative, felt, expressed, comparative) but at any one time an individual's needs could be any permutation of these.

In addition, the care of older people's physical health is characterised by the need to deal with fluctuating conditions : many long term conditions mean an individual can feel well one day and not the next. The difference between "in need" and "not in need" may be far from clear cut. Wider issues such as equity and social justice have to be considered. In practical terms, there is plenty of room for interpretation by local decision makers of which needs should be met.

The analysis examines the increasing overlaps between health and social care needs of older people; the fluctuating conditions referred to above emphasise the importance for mixed health and social care packages of support. It crucially contrasts service based and population based models of needs assessment (and the population based model can in fact be based upon a variety of sources - individual, locality, regional etc.). Different frameworks for health needs assessment are examined - disease groups, client groups, locality and lifecycle framework (which is given particular attention). This introductory analysis concludes that in reality "need", "older people" and "health" are all slippery concepts .

A more detailed contrast is provided between a person-based definition of need (encompassing individual wants) and a service-based definition which relates to numbers of beds, places etc. within both public and independent sectors. This contrast is at the essence of how different pictures of need can be built up. The analysis gives particular attention to a policy maker's and planner's perspective, not to the exclusion of other key perspectives but because of the importance that making or implementing policy has in assessing needs. Here, demographic data, prevalence data and activity data are identified as key : specific local sources are noted and it is within this framework that Challis and Pearson have examined Community Care Plans (CCPs) from London authorities and also material from NHS Trust Reports, some reports from Public Health Departments, GP Practices and Health Authorities.

Examining the Plans

The rationale for the concentration on CCPs was that if anywhere it would be here that an integrated definition of older people's needs would be put into practice. Although the Plans are the responsibility of Local Authorities, they are required to involve Health Authorities in their preparation. Longer terms needs of older people have continued to be a major element of Community Care policy and practice issues. If anything the legislation has heightened debate about needs and whose responsibility it is for meeting them.

Challis and Pearson found that all Community Care Plans are presented as documents agreed by both Social Service and Health Authorities; the significance of good working relations has clearly been accepted. But worryingly **they have concluded that the CCPs do not deal in any depth with the medically focused health needs of older people**. Whilst several Plans produce summaries of local health policies, these are at a high level of generality. The inference, at least, is that agencies are not building up their pictures of local need on the basis of an integrated, person-centred definition.

In general terms it is possible to identify some main findings from this analysis of CCPs:

- there is a variety of approaches to what is meant by "need" and "unmet need"
- different sources are used for compiling needs information
- comparisons are made with other Boroughs but not consistently

- targeting emerges as a significant technique
- service-based approaches are very prominent, but within an overall policy shift from institutional to home-based care
- the needs of minority ethnic groups are recognised by all agencies, although more by some than others
- there is some involvement of users and carers in needs assessments, sometimes on a properly collaborative basis - but again with little consistency
- policies and procedures tend to dominate consideration of needs, including "needs banding" following assessments; eligibility criteria (in theory at least) being prominent gatekeepers to services
- the mixed economy of care appears to be well recognised, including the promotion of the independent sector
- very little attention is given to health promotion and the prevention of ill health
- the mechanics of joint working and the spirit of collaboration seem generally strong; it is less clear that this has led to a consistent approach to how need is thought about and quantified
- the continuing implementation of hospital discharge policies remains a high priority
- there have been limited attempts only to focus upon GP Practices and Primary Care in general
- major national policy changes tend to be noted rather than used as key determinants of impacting upon need (including LIZ)
- there has been little evidence of new thinking about responses to needs.

In terms of consistency and a systematic approach, the CCPs may be seen to fall well short of what is needed for London. Yet they are the only source for this purpose, at least according to Challis and Pearson. No other source has 'the potential for comprehensiveness'. Yet the absence of translation of health oriented information into plans is noticeable. The examples given are of almost no instances of the use of estimates of hip operations to predict the numbers of older people who may need help at home nor of estimates of the incidence of dementia to determine the level and type of assistance which may be required. The picture in reality is some way removed from the integrated definition of need framework which had been drawn up.

From the source material available to the researchers obtaining a quantitative analysis of older people's needs proved difficult. It will already be recognised that such information which is available is generally service based rather than relating to the integrated model which Challis and Pearson have promoted. The CCPs show that authorities are well aware of the significance of continued development of the mixed economy of care. This still means that the picture of older people's needs is less clear than it might otherwise have been. **The needs indicated below give an indication of the statutory agencies' (Health and Social Services) concerns :**

- implementation of effective hospital discharge policies and procedures
- importance of carers' needs and issues - especially support and information (acknowledged by Health as well as Local Authorities)
- information and advocacy for users - better and more targeted
- making services more accessible : obtaining a better focus on priority needs, clearer eligibility criteria, streamlined assessments
- meeting needs "out of hours"
- practical domestic assistance
- promoting a concentration on rehabilitation in different forms but including post hospital and other intensive support
- day care (identified in relatively few instances)
- transport
- sheltered housing
- more targeting of residential care and nursing home needs, e.g. culturally sensitive, terminal care, combined social/nursing/medical
- a variety of respite care
- depression and dementia amongst older people identified as part of a general major mental health issue
- elder abuse recognition (and the beginnings of a response)
- self care development promoted by a small number of Local Authorities

What is striking about this indication of outstanding concerns (apart from its length) is that just about all of the concerns (in effect unmet needs) involve a multi agency responsibility. It is

difficult to quantify these needs, not least because of some Local Authorities' fear of the financial consequences of being explicit about unmet need. But the picture emerging is not an optimistic one and already shrouded in the mists of cross agency responsibilities.

The Extent of Needs in London

The London Research Centre (LRC) study by Doreen Kenny (Estimating Levels of Need among Older People) throws greater light on the extent of needs in London. The analysis is based upon a model developed by the District Audit Service and relies heavily upon the OPCS Survey of Disability in Great Britain 1985/6, which examined ability to perform certain tasks.

In the analysis need is equated to disability in order to estimate needs which are likely to be required to be met by social care. So it is important to bear in mind that this is a far from comprehensive definition, and certainly not equivalent to the integrated definition put forward by Challis and Pearson. Calculations of disability rates are brought forward to 1995/6 on the assumption that there has been no change in the prevalence rate. It is the incidence of Limiting Long Term Illness (not precisely the same definition on disability) which has been applied across London. The London rate of LLTI per 1000 population is compared to Great Britain as a whole:

Rate of LLTI per 1000 population

	Great Britain	London
65-74	**331.7**	**314.8**
75-84	**485.0**	**467.5**
85+	**698.8**	**671.5**

A slightly lower prevalence rate is thus indicated. When translated into numbers of older people (65 years and over) with disabilities (categorised by severity) the following base figures emerge:

Severity Levels (Older People with Disabilities in London)

(low)	1/2	3/4	5/6	7/8	9/10 (high)
	117,820	87,540	82,650	68,670	52,230

This totals 408,910 older people in London with a disability of which 52,230 are in the high need category. This information has been further refined by looking at the information in the OPCS Survey on the amount of help needed by disabled adults with self-help activities. Using the percentages that this analysis provides, the following estimates are arrived at for older people with disabilities in London:

Needs (Older People with Disabilities in London)

	Low	Moderate	High	Total
65-74 years	111,070	24,460	11,540	147,070
75+ years	150,920	65,980	44,920	261,820
TOTAL	261,990	90,440	56,460	408,890

The Needs categories are broadly defined as

High:	needing a lot of help with self care activities, during every day and at least once a night
Moderate:	occasionally needing help during day or night
Low:	not needing help every day, may have other needs.

By removing the numbers of older people living in communal establishments, it is estimated that those in need in private households in London in 1996 are:

Needs

	Low	Moderate	High	Total
65-74 years	107,720	22,600	8,700	139,020
75+ years	145,340	56,590	32,440	234,370
TOTAL	253,060	79,190	41,140	373,390

Looking at older people living alone, the OPCS Survey of Disability found that the proportion decreased as the level of severity increased; although it has to be remembered that more older people live alone than the national average. The projections of those in the High Need category show that total numbers increase from 9710 in 1996 to 10,000 in 2001 and then decline to 9570 in 2006 and 9350 in 2011. Of these total numbers 87% are in the 75 years+ age group. This group of vulnerable older people should be of particular concern to Health and Local Authorities.

The total numbers in the High Need category are projected to decrease from 56,460 in 1996 (see above) to 55,010 in 2001 before dropping to 52,880 in 2006 and 51,610 in 2011.

The Borough estimates which are provided give a very tangible indication of the scale of the issue facing the public authorities. Those with High Needs living alone at home range between 430 (in Barnet and Bromley) and 200 (in Kensington and Chelsea). These are clearly significant numbers and are only 30/40% below those living in communal establishments.

The LRC analysis also contains **some illustrative service responses**, following the District Audit Service classification. These examples should be treated cautiously as they are not only based on a non-integrated definition of need but only look at the provision of personal social services. it could be said, therefore, that both the needs assessment and the response is understated. Professional judgements may, of course, affect service levels. Nevertheless this does provide some indication. This analysis produces the following illustrative service response required for older people living at home:

	9, 710	require residential or intensive domiciliary care
	63,410	require medium domiciliary care
and	127,910	require minimum support.

If the residential care option is omitted (a crude but not inappropriate option) this accounts to 350,740 home care hours per week, 328,670 day care hours per week, 356,490 days meals on wheels per week, 77,680 weeks respite care per year and 127,910 hours domestic help per week.

Are London's older people healthier than elsewhere?

In her Background Briefing Paper **Maria Evandrou** addresses the question of whether London's older people are in fact healthier than elsewhere. Using General Household Survey (GHS) 1994/5 material she concludes that "**even after controlling for differences in age and sex composition older Londoners report better health on a range of indicators".** Examining socio-economic characteristics she finds that for Londoners as the rest of the country ill health tends to increase with deprivation but that again Londoners appear healthier than their counterparts elsewhere. There are two interesting exceptions in the most affluent and the most deprived. The GHS material also shows that for functional capacity and daily living activities older Londoners consistently perform better than counterparts in Other Metropolitan and Non-Metropolitan areas.

The demographic analysis from LRC showed **the growing numbers of minority ethnic older people and the significant numbers of Irish older people already evident in London**. Using a specifically constructed database Maria Evandrou has examined how patterns in self-reported morbidity and health care use vary with ethnicity and whether differential levels in utilisation are accounted for by morbidity patterns.

The findings emphasise the variation in social and economic positions of minority ethnic older people in both London and Great Britain as a whole. The proportion of this group is currently small, however increasing numbers present important challenges to purchasers, planners and care managers. With the exception of Chinese elders most are at the younger end of the pensioner group.

Older people from minority ethnic communities report higher levels of ill health compared to white older people. They report higher levels of GP consultations, particularly amongst Indian, Pakistani and Bangladeshi older people. But this higher use is not explained by higher levels of acute or chronic indicators of morbidity. They also report higher levels of outpatient attendance. Other studies have found consistently low take up of preventative and screening services. Figures from the 1991 Census show that in the younger 50 - 60/65 years age group there is a consistently higher occurrence of LLTI amongst minority ethnic groups : Black Caribbean 22.7%, Indian 25.3%, Pakistani 29.9%, Bangladeshi 37.6%, Irish 21.7% compared to 17.2% (other) White. There is an argument for extending the age range for entitlement to an assessment to this group.

Some particular London characteristics of minority ethnic older people should be noted :

- more likely to experience overcrowded conditions
- less likely to have a hospital inpatient stay
- more likely to live in extended families

The higher utilisation of GP and outpatient health care may indicate lack of effective consultation, or perceived lack. The evidence by itself does not say anything about the quality of services offered but it clearly raises questions.

In her contribution **Mary Tilki (Federation of Irish Societies and Research Centre for Transcultural Studies in Healthcare, Middlesex University)** asserts that Irish older people experience 5/10% above average incidence of LLTI, with men being particularly affected and Inner London residents faring worst. First hand evidence suggests a high rate of all cancers, coronary heart disease and respiratory disorders in the Irish community. Although the demographic information sources are again limited it is known that isolation is more pronounced among Irish older people than it is for other minority ethnic groups. It is contended that isolated Irish older people are more vulnerable to loneliness and depression because of the general weakness of social support networks.

REVIEW OF SERVICES

Principal Findings

Turbulence in the systems mean that it is difficult to get a steady picture of service performance, heightened in London by the numbers of agencies

There is little general agreement on models of care for older people, and performance benchmarks for monitoring

There is a shortage of strategic direction and of clear objectives

All Health Authorities are trying to move some part of acute provision out of hospital beds and gain greater flexibility through purchasing but for Continuing Care the situation is less clear-cut

The development of multidisciplinary community services is patchy; there is some concern about the lack of Geriatrician involvement in Continuing Care and the apparent absence of a Community Geriatrician anywhere in London

The voluntary sector continues to play an important role across a range of provision and the independent sector is seen to be of growing importance

Historic patterns of care still dominate, leading to great variety across London

Interface problems are significant : GPs/ Primary Health and Social Care, Acute and Rehabilitative Care, Geriatricians/GPs

Older people in London make above average GP consultations and visits to outpatients and casualty but below average inpatient and day patient stays

Indian, Pakistani and Bangladeshi older people in London make above average use of GPs although it is unclear why

There is poor information for minority ethnic older people about services

Better data is needed on the performance of services for Irish older people

The provision of residential care and nursing home places is much lower in London

But London Local Authorities support slightly more older people in residential care homes and only slightly less in nursing homes than elsewhere

Home Care contact hours are increasing although numbers supported is going down; provision is above average for England but below for Metropolitan Districts

Older Londoners in general use Social Services less than elsewhere but by contrast those in the greatest need receive more

London expenditure on Social Services remains high compared to elsewhere but the gap is decreasing

Unmet need of older people is strongly in evidence : Social Services spending continues to outstrip Government allocation

Over the last 10 years London Social Services staff has gone down by 12% but London Local Authorities still employ above average numbers

There are high variations in spending on older people by Local Authorities across London

Overall the picture is murky and varied, there is a general "churning" :

- too many boundaries
- too much organisational change
- too many placements out of London
- a continuing problem in pulling together the NHS and Local Government cultures
- the relative weakness of Primary Care

1. Introduction

The aim of this part of the analysis is to assess **how well London's health and social care services are performing in relation to those needs of older people which have been identified**. Again the main focus of attention has been upon longer term care rather than, say, acute medical or help with domestic tasks. The perhaps ambitious aim was to look across London and across the systems, to determine what was working well and what was not. It was important to try to find what was distinctive about London compared to other places but also to be aware of key differences within the capital.

The Centre for Policy on Ageing was commissioned to do this work, which had three main parts :

to identify favoured organisational models for the delivery of services

to describe the configuration of services in the context of these models

to consider how current configurations are performing

It is useful to begin with **some scene-setting information about the environment in which the systems work and the degree of turbulence with which they have to deal**. It is possible to draw some broad conclusions about the impact of changing needs but there are no readily available and widely accepted models which health and social care agencies can adopt.

An important ingredient of the London environment is the growing importance of the independent sector - both private and voluntary. There is a varied pattern across London involving residential care as well as other types of provision. The voluntary sector has long been part of London's health care system, being an essential part of the support which bolsters statutory care. Its importance is also because it frequently operates across the boundaries of health and social care, reflecting its focus on the user's experience and priorities.

The importance of informal carers is reflected by the growing support provided by statutory agencies, health as well as social care.

The amount of imposed organisational change being experienced by the systems means that important adjustments have to be made even before changing needs are taken into account. This is, of course, a national phenomenon but because there are so many organisational units in London (purchasers and providers) its effects may be particularly significant. Service development may be suffering as a result. Certainly there has been a steady increase in emergency admissions.

There is a problem about the lack of any mechanism for assessing performance on a Londonwide basis. In an area the size of London some variations in service configuration would be expected as well as similarities : the different characteristics have to be taken into account. **The basic questions which have to be answered are**

- **is the range of services sufficiently comprehensive**
- **is the quality adequate**

One way into this big agenda is to look at how well particularly important "sub- processes" in the care of older people are being conducted e.g. discharge from in-patient care, management

of fractured neck of femur cases. Operational protocols such as these increasingly form the basis for audit and performance appraisal.

For older people, at least, it would appear that population needs assessment makes relatively little impact on service configuration.

C.P.A. conclude that perhaps the most well established approach to assessing service performance is the familiar one of considering the level of resources (doctors, beds, etc.) available - in other words is there enough of whatever is required to "do the job"? Of course, this does not really match up to the integrated needs models put forward by Challis and Pearson. Indeed the norms identified by C.P.A. as still being of some relevance date back to 1989.

Various process indicators have been cited in literature to help determine performance, these include waiting times, efficiency of bed use, rate of unplanned admissions and inappropriate care settings. Additionally, of course, outcome measures can help register the impact of services, notably quality of life measures but also giving respite to informal carers.

Such measures may be applied to the specialty of elderly care medicine, day care services, continuing care, the effectiveness of over 75 years assessments, health promotion activities. For the purposes of this review attention is given particularly to the provision of health care through statutory services together with overlapping social care. The C.P.A. further paid particular attention to six districts across London which gave coverage to all five "King's Fund London Clusters".

2. Models of Care

This part of the review seeks to identify models of good practice against which to set what is actually happening in London. It looks at the specialist services for in-patient care, day care and in the community, as well as other community, non-institutional options.

In recent years circumstances have re-shaped traditional specialist models of care for older people. These forces have included improvements in acute medicine, the shift to long term

care in the community, and the growth in numbers of frail older people. The C.P.A. analysis is that specialist services have become more concerned with acute episodes and have become more integrated with general medicine. New kinds of community-based services are developing, some as alternatives to hospital care and more responsive to the wishes of GPs. As these changes have taken place the challenge has been to retain the threefold emphasis on assessment, appropriate care and recovery through rehabilitation. How well the range of services is performing has to embrace all three of these key components.

So far as inpatient service for **acute physical illness** is concerned separatist and integrated models can be found across London, the difference being the relationship between acute care for older people and general acute medicine. Although the integrated model has gained favour over recent years there is general disagreement and uncertainty about the best way of organising acute care for older people. Inevitably there is some degree of local variation across London. However, there does seem to be some consensus that

- acutely ill older people should not be denied access to the same high quality hospital care as younger patients with the same problems
- many older people will benefit from a kind of specialist care distinct from that offered by general acute medicine

Whilst both models are perceived as capable of working well it is considered that too often an unsatisfactory merging of the two is what occurs in practice. It is clearly important that (whatever is the model in operation) there are links to effective rehabilitation services, which are vital for effective recovery in many cases.

Concern has also been expressed by geriatricians about their diminished involvement in **continuing longer term care**. Many are searching for new relationships with GPs and Social Services, for example, in order to improve the effectiveness of an emerging new model of care. Community geriatricians have been advocated but no such London appointments were identified by C.P.A. The arguments for such a post reflect the perceived inadequacies of the traditional models of service delivery in the face of changing circumstances affecting community care.

As promotion of care for older people in their own homes is a Government policy priority the linkages between the different service sectors are now in sharper focus, affecting medical, nursing, personal and domiciliary care. **A major objective here, therefore, is to develop the quantity and range of community based services backed up by hospital or other residential care as necessary.** How different parts of London are setting about this key task may be an important indicator of how well they are doing.

The cost implications of providing complex packages of long term home based care are impacting on both Health and Local Authorities. So far as older people are concerned respective agency responsibilities are less important than the ability of the systems to devise means to ensure that the sum total of resources is used effectively. Problems at the service interface are well known and apply to London as elsewhere. An important issue is the extent to which they apply to London. Inappropriate use of acute beds is clearly evident but not consistently so across the capital. Understanding the real impact of the low level of nursing and residential care provision in London is important here, bearing in mind that total supported places includes a significant number placed outside London. The interface between GPs/Primary Health Teams and Social Care Teams is particularly problematic in London because of the pressures of demand, the number of single handed GP Practices and the sheer logistics of so many interfaces. Often "gap filling services" by local Age Concerns and other organisations are important ingredients but inevitably these show some variation across London.

It is important here at least to acknowledge **the wide-ranging contribution made by the voluntary sector** to the health of older people and to the operation of the health and social care systems in London. Across the capital there is an array of organisations (with paid staff and volunteer support) involved in activities which include health promotion, practical assistance, rehabilitation, counselling, transport support and advocacy for users amongst a long list of others.

What conclusions then can be drawn from the survey of organisational models undertaken here? C.P.A. offer the following :

- fundamental changes taking place mean that many parts of the system are very unsettled

- the requirement to shift care from hospital to community is leading to various innovations but also uncertainty and division
- accompanying this is a shift from specialist to generic provision but with the challenge of at the very least maintaining care standards
- ways are being sought to develop social care provision which is more responsive to older people's desires and more closely integrated with health provision

The next section looks at how these sort of shifts are occurring in London.

3. Shifting the Balance of Provision in London

This section looks at how well the statutory agencies are performing in terms of shifting the balance from hospital to community care and the position in relation to specialist and generic health care provision. As the C.P.A. review points out this proved a difficult task to address since information on current provision and outcomes was harder to obtain than that on outline proposals to change service configurations. This material was supplemented by interviews with various key players in the systems to gain a picture of how well services were coping with changing needs, mindful of the models of care previously described.

An important starting point was the finding that **all London Health Authorities are trying to move some part of acute provision for older people out of hospital beds. The situation with regard to Continuing Care is, however, somewhat more variable.** And the emphasis is on piecemeal rather than strategic change, with little if any attempts to think through systemswide implications for service change. C.P.A. found that Health Authorities across London are developing measures to prevent unnecessary hospital admissions and to speed up discharges. by providing "extra" health and/or social care support in people's own homes. There are variations as to how this is being achieved, sometimes crucially involving voluntary support as well as temporary Social Services input.

Hospital care at home (as distinct from the above) is seen to have different functions around London. But as with the "extra" home care schemes it tends to suffer from a low rate of referrals and therefore high unit costs. Perhaps this is one factor resultant from what is

considered to be the generally high quality. However, problems often remain with securing the involvement of any one or more of GPs, Social Services and carers.

All the authorities examined purchase some NHS inpatient beds for physically frail older people. Some, but not all, are also paying the full costs of beds in independent nursing homes. **Authorities were considered to be generally seeking more flexibility through purchasing and away from inpatient beds.** Where (untypically) nursing home beds are relatively well provided a particularly flexible approach is possible. In some places alternative community provision such as nursing homes is being developed. The supply of inpatient continuing care beds varies significantly, including some relatively "well off" provision in East London. The same authority can have an inequity of provision between different areas and also different "styles" of provision (nurse managed or consultant led beds, for example). All of this variety, of course, emphasises the continuing importance of historic patterns of provision across the capital and within particular districts : health care in London has not grown up on a systematic basis and cannot readily be converted into one.

The development of long term packages of care in the community is seen as a clear priority for many authorities. But only one example was found of a Health Authority setting up a designated scheme for long term home based intensive care packages. It is considered possible that the development of community based provision for elderly mentally frail is moving more rapidly through CMHTs. For physically frail older people no community based geriatricians were identified in London, although at least two Community Trusts have indicated their wish to appoint. Recruiting community nurses with above average skill levels is also seen as a difficulty. Clearly although policy may have shifted away from the hospital base the expertise is proving slow to follow.

Turning to **the balance between specialist and generic health care provision** C.P.A. gained the overwhelming impression that more older people should have a specialist geriatric input to their acute hospital care, although it is pointed out that their informants included no general physicians. In some of those London hospitals which have integrated Care of Older People with General Acute Medicine more attention is now being paid to the acute phase of illness than to rehabilitation and post discharge arrangements. There seems to be particular problems with this interface in East London. Problems are also reported with hospitals discharging to

Social Services Departments other than their local one. This may be a serious issue across London with the known reliance on out of London placements. Some concerns are also reported around the need to shift away from age-related to needs-related admission procedures : where the former are in operation the age threshold tends to vary and where the latter specialist input should not be neglected.

Different hospitals within the same health and local authority may (and sometimes do) operate different admission procedures for older users. Examples are reported of close links between geriatric units and stroke and orthopaedic units, this being a means of ensuring that some geriatric expertise reaches admissions to non geriatric beds.

The development of rehabilitation facilities is a major priority for some authorities. Many different approaches are evidenced : separate inpatient unit, integrated acute/rehabilitation beds, separate beds for stroke or orthopaedic patients, domiciliary rehabilitation schemes, day unit focus.

Relations between Geriatricians and GPs vary across London. Many of the former are worried by the shift to GP responsibility, a concern shared by some GPs. In at least one Health Authority discussions are being held with GPs about training and accreditation in order to work in residential care and nursing homes. In spite of the particular difficulties already referred to many London SSDs are beginning to consider ways in which they can develop links with GP Practices as the basis for some sort of co-ordinated primary health and social care provision. Similarly both Health Authorities and Trusts are reporting some progress in their local versions of the move to a Primary Care led NHS.

4. An Analysis of Provision in Parts of London

A comparison of service provision for older people in selected London authorities is provided as part of the C.P.A. analysis. It gives some indication of the variation but does not seek to examine differences of effectiveness, which would be even more difficult to obtain than these incomplete basic figures.

Maria Evandrou's analysis gives an indication of how usage of health services by older people in London compares with elsewhere. GHS 1994/5 data shows that older people in London are more likely to have consulted a GP in the last two weeks or to have attended an outpatient/casualty department in the last three months but less likely to have stayed in hospital overnight or as a day patient than elsewhere in Britain. But the differences are not great.

But is usage related to morbidity? Older Londoners reporting ill health consult GPs as per the Great Britain average. Those reporting no ill health are over 10% more likely to consult than the GB average. Older Londoners reporting ill health are 11% less likely to attend as hospital outpatients in the last 3 months compared to the GB average but those reporting no ill health 33% more likely to attend. Older people in London with ill health are 6% less likely to have had an in patient stay in the last 12 months than the GB average.

Maria Evandrou concludes that the fact that in London "not ill" older people consult GPs and use outpatients more than the national average suggests either that morbidity is not a good indicator of need for health services or that they are using primary health care when community services might be more appropriate.

Tahera Aanchawan and Saber Khan report that it is not clear why the rate of utilisation by Pakistani, Bangladeshi and Indian older people of GP services is high. But there are some indicators that would suggest that it could be due to higher levels of morbidity and the communication that takes place between GPs and older people. Knowledge of what community health services can provide and how to access them is very low amongst black and minority ethnic older people; in addition referrals are low. More information is required on what happens during GP consultations with black and minority ethnic older people. So far as hospitals are concerned several key issues have been identified by black older people : lack of interpreting skills, lack of a place to worship and insensitivity toward religious beliefs, inappropriate meals, and a general shortage of information on what medical interventions were to be received. These issues are concerned with how services are delivered and often do not have resource implications; the majority of London Boroughs have interpreting facilities which are often not used. Black and minority ethnic older people report very poor knowledge of hospital discharge policies : the most recent survey of Asian women discharged from one

London hospital showed that none of them had received any form of written communication about their care, treatment or discharge plan.

Mary Tilki reports that Irish people in general are significantly more likely to avoid consulting GPs for "trivial" illnesses but use them more frequently for "serious" ones. Older Irish people have low expectations of health services and there is some ignorance about the services which are available. Many are seen to be wary of mainstream services which are not sensitive and sometimes even hostile to the needs of Irish people. Culturally specific services which do exist (for example the GP and CPN service in the Haringey Irish Community Care Centre) prompt a high level of uptake.

Clearly the collection of better data is a key first step in determining how services might better meet the needs of this important group of older Londoners. Both health and social care agencies need to improve the ways and means by which they engage and consult with their local Irish communities. Partnership with voluntary organisations as well as individual users and carers is essential to develop services which meet needs in a properly effective way. There is little clarity about what cultural sensitivity means in respect of older Irish people but the employment of sufficient numbers of Irish staff is considered a good starting point.

5. Trends in Social Services Activity, Staffing and Expenditure

The London Research Centre has analysed **the trends in the main areas of social services used by older people in London**. This shows changes in rates of activity since the early 1980s together with current rates for London compared to the rest of the country. Some information is also given on staffing levels and on expenditure, which is considered in the more detail in the following section.

During this period, of course, Social Services Departments assumed additional responsibilities with the implementation of the Community Care legislation.

In London the 1980s did not see the huge increase in private residential care experienced by most of the rest of the country. Since 1991 the total number of residential care places has declined in London as it has elsewhere whilst the number of nursing home places in London

more than doubled between 1989 and 1994. **However, the rate of provision in London remains much lower than the England average : two thirds of residential places and less than half nursing home places.**

Looking at actual numbers of older people supported by Local Authorities it becomes clear that a significant number are being placed outside of the London area. This has important implications for how the systems operate as it means that a significant number of discharge and other arrangements involve many different cross agency workings.

The key points, therefore, are

London has significantly fewer residential care places (22.8 per 1,000 65 & over) compared to the national average (33.4) as well as nursing home places (10.3 compared to 21.6).

London authorities support more older people in residential care homes (13.8 per 1,000 65 & over) than the England average (13.2) and almost as many in nursing homes (17.7 compared to 18.2).

The relatively high number of supported placements by Local Authorities in other boroughs (many of which are outside London) present significant cross boundary issues, including for discharging hospitals and Community Trusts : 32.8% in London compared to 11% in England (residential care and nursing homes in 1995).

Turning to **domiciliary care** there was an increase of 58% in contact hours in London between 1992 and 1995 while households supported declined by 3%, indicating more help but fewer recipients. London provides 19% more home care than England as a whole but 8% lower than the average for Metropolitan Districts. Of importance here is the increase in independent sector provision, to 22% of contact hours in 1994 compared to 17% in England.

The rate of provision of **places in day centres** for older people was 70% higher in London than in England as a whole with 20% provided by the independent sector, this latter figure suggesting the continuing importance of the voluntary sector in this aspect of provision. Total

places for older people purchased or provided by London authorities numbered over 40,000 in a 1994 sample week. But rates of provision per thousand older people range widely across London from under 10 to over 100.

In her report Linda Challis points out that data on **volume of community care assessments** carried out indicates the variation in Social Services activity. So, according to local information, one authority carried out 1,750 complex assessments in 1995/6, another 6,000 and a third 624 in six months. Prof. Challis's conclusion is that this variation has less to do with respective sizes of population and more to do with "need" being determined by size of service stock and by how the systems operate. If this is true it shows an inconsistent and inequitable picture across London.

In her analysis Maria Evandrou helps address the issue of whether older Londoners get a better service from Social Services than those living outside the capital. For older people as a whole she finds lower service utilisation rates. However, receipt of Social Services is markedly higher amongst those in need of support for daily living activities, indicating that services are generally being targeted on those in greatest need. Older people living alone were found to be twice as likely to have a home help than those living with other household members. But unmet need was also evident : between 1980 and 1994/5 use of both Social Services and District Nurses/Health Visitors declined amongst older people unable to walk out of doors unaided.

For London's minority ethnic older people there is a now well-documented pattern of poor take up of mainstream day and residential social care which has led to the development of important services by the voluntary sector. This poor take up can be attributed to

- inappropriateness to cultural and religious needs
- inflexibility about diverse needs
- lack of awareness by older people
- inaccurate assumptions by providers
- communication difficulties
- lack of commitment to address the issues

Issues needing to be addressed are

- building the capacity of minority ethnic voluntary organisations
- coping with current high unit costs due to relatively small population
- future development of specialist provision compared to mainstream, age-specific compared to integrated
- incidence of age-related conditions amongst the 50 - 60/65 years age group

Over the last 10 years the number of Social Services staff has decreased by 12% over the last 10 years whilst in England as a whole it has increased by the same number. The decrease was especially prominent amongst residential care staff as Local Authorities reduced their own provision. But London authorities still employ more staff per thousand all ages population than the rest of the country : Inner London 6.9, Outer London 4.8, Metropolitan Districts 6.2, England 4.9. Whilst these figures are of some interest their real significance requires much more exploration than has been possible in the LRC's analysis. They do, of course, refer to all staff - as with health agencies there are problems obtaining information on staff working with older people. The relatively small size of London Boroughs means that more staff proportionately are employed in London in central and strategic positions than for other authorities. Again the number of boundaries in London presents something of an issue.

In overall terms expenditure in London on Social Services remains high. By 1992/3 the rate of expenditure was 58% above the England and Wales level compared to 82% in 1980/1. The introduction of Special Transitional Grant (the transfer of Social Security funding for Community Care) further reduced the differential to 50% - still, of course, a significant figure. This represents net spending per head of the older population in Inner London of £865 and £425 in Outer London compared to the Metropolitan Districts figure of £393.

To understand more about the expenditure patterns of London Social Services Departments (SSDs) the analysis shifts to that undertaken by the **Association of London Government.** The focus here is on **SSDs and spending on the Personal Social Services (PSS)** but the impact made by Local Authorities on the health of older Londoners is by no means limited to

this function. Their roles in relation to Housing, Leisure, Health Promotion, Accessible Transport and others are all relevant.

Although Local Government is directly accountable to its local residents through the ballot box in a way which the NHS is not, in reality there is strong Central Government constraint on what and how it spends. The Standard Spending Assessment (SSA) is essentially a mechanism for distributing resources amongst Local Authorities by Central Government. One of the five blocks is Personal Social Services, of which Elderly residential and Elderly Domiciliary form two sub-blocks. Together with powers to cap Local Authorities expenditure levels and the growth of specific grants there is now more similarity with NHS centralised funding.

The great majority of PSS financial analysis relates to Net Expenditure. Income from charges makes up the difference between Net and Gross Expenditure on services. There is little systematic information on income from charges for domiciliary services (home carers etc.) but the indications are that all SSDs now charge and most use a means tested method. For residential care the means tested charging mechanism is largely determined by the Department of Health. In London average amounts collected per person supported vary from £4498 to £5705. This amount of variation is interestingly (at 4% average deviation from the norm) far less than the variation in spending per head over 65 years, from £344 to £1253 or 33% average deviation from the norm.

The Association of London Government surveyed out-turn net revenue expenditure for all London SSDs for 1994/5 (actuals), 1995/6 (projections) and 1996/7 (estimates).

Despite some limitations (including comparisons with outside London) some broad conclusions can be drawn :

- older people (37%) and children (32%) dominate PSS expenditure
- total net spend on older people in London increased from £548m in 1994/5 to £656m in 1996/7 (excluding STG), an increase of 19.7% compared to 21% for England
- increase over the same period in London were 29.7% for Other Adults and 2.3% for Children

- there are consistently high variations in PSS expenditure across London, although more for Children than for Older People
- Inner London expenditure per head is much higher than Outer London
- Education shows nothing like the level of disparities between Boroughs experienced by PSS spending

Between 1994/5 and 1996/7 the PSS SSA for London increased by 18.9% compared to 24.3% for England as a whole. This increase in London SSDs' ability to spend is entirely due to the emergence of Special Transitional Grant (STG) to fund new Community Care responsibilities. In real terms, therefore, there were significant reductions.

Detailed analyses of individual Borough SSAs show that these cover a huge range with the highest value (per capita) three times that of the lowest in each of the three years reviewed. However, unlike expenditure patterns, variations between Older People's SSA sub blocks is much smaller than the total. **It is interesting to compare expenditure levels and SSAs :**

- there are significant divergences despite recent pressure from Central Government
- overall expenditure exceeds SSAs (doubtless balanced elsewhere in Local Authorities portfolios)
- over the three year period the expenditure/SSA relationship remained consistent for total PSS but fell for Elderly (in London from 32% above SSA to 8%)
- for each year the indication is that the need to spend on social care for older people is greater in London than elsewhere (by comparing aggregate ratios between expenditure and SSA)

The future would only seem to offer further tensions for London SSDs so far as expenditure levels are concerned. These involve the inadequacies of the SSA system itself as well as the distribution mechanism adopted. The analysis of spending patterns seem to indicate underfunding by Central Government certainly when the additional responsibilities of Community Care are taken into account. **The well known NHS interface issues** (fewer hospitals/hospital beds, more efficient hospital performance, impact of continuing agreements,

joint initiatives for other adult groups) put pressure on SSD resources which SSAs so far largely ignore.

The basic picture of below national average needs and above average expenditure levels seem less clear-cut following this analysis.

6. Some Conclusions

As the C.P.A. review indicates there are **real problems in trying to gain an overall picture of how well services are performing**. The lack of hard information was a major difficulty for the researchers. But there were also few examples of Health Authorities providing a strategic view of what is required for this group of its population. Of course, the size and lack of homogeneity of the group creates real difficulties. It may be the case that a single, albeit wide-ranging, strategic vision for the health of older people is inappropriate because it has no roots in practicalities. But it may also be the case that it is simply lack of prioritisation that has led to this strategy-free zone.

The review leaves a mixed picture

- some examples of leading edge developments
- some examples of integrated, needs-led, specialised/age-related policies which are appropriately locally sensitive
- turbulence specific to London especially around the future of certain hospitals
- the knock on effects of Local Authority resource difficulties
- fears of problems being stored up, for example SSDs not addressing mid/low level dependency needs and post discharge social support
- real variability across London, for example some HAs increasing NHS Continuing Care provision whilst others are reducing it
- increasing (but largely unplanned) involvement of the Independent Sector

Specific successes identified are the improvement of discharge arrangements, some local leadership by clinicians and managers, the quality of some hospital services for older people and (perhaps surprisingly) little evidence of clear age discrimination.

AN ANALYSIS OF THE SITUATION

Principal Findings

WHAT'S WRONG?

Looking at aggregate needs and resources - it could be said that nothing very much seems amiss

But on closer analysis matters seem to be far from satisfactory - adjustments are required

Older people themselves tend to have low expectations possibly contributing to a low overall priority

Service changes and losses can cause a feeling of dismay and concern amongst older people

Too many boundaries lead to inefficiencies and an uncomfortable degree of variation

There is a lack of co-ordination (perhaps even chaos) in both assessment and service response, based upon a lack of consensus and leading to inadequate integrated care plans

Although Social Services expenditure and services for older people remain higher than average the gap is diminishing and needs outstrip supply

Ageism continues to provide an inhibiting backcloth, perhaps contributing to the lack of vision

WHAT WOULD MAKE IT BETTER?

A greater cohesiveness between the health and social care systems, building up from integrated teams at primary care level

More expertise in both meeting older people's needs and working across boundaries

More emphasis on trying different ways of working to develop good models

A greater clarity about what constitutes good health for older people and means to achieve it

Working across and reducing organisational boundaries

Involving older people more in decisions about themselves and their communities

This analysis examines the position from the perspectives of

- older people
- London
- the health and social care systems
- moving ahead

1. INTRODUCTION

Although **the information available is sometimes both confusing and patchy** it is important to be able to make some analysis of what is happening regarding the health and social care of older people in London, and of how to move forward.

Generally it would seem that London is not a bad place to be old and unwell or unfit, at least according to the aggregate figures on needs and resources. **But the reviews undertaken of both needs and services emphasise the differing circumstances across the capital and the lack of consistent responses**. In a city the size of London this should not be a surprise : if you are old in London where you live can significantly affect your health and social care status. In addition, both the health and social care systems (in different ways) seek to develop localised responses. The reported problems and expressions of concern show that there are indeed issues to be tackled, here and now as well as planning for the future.

This is a good time to think ahead. The Parliamentary Health Committee's line of "Don't Panic" is probably right. It is important to take advantage of the current organisational fluidity as well as the growing national concern that older people's needs in general should be given a higher priority. How, then, to address this issue in London?

2. OLDER PEOPLE

What we know about the health and social care needs of older people emphasises the importance of making various connections, including between illness and disability. Many older people in London have needs which require both health and social care responses. **The**

Medical Research Council (Health of UK's Elderly People 1994) has pointed out that loss of social and economic resources has direct implications for the extent to which older people are able to cope with disease and disability. The work of the London Health Partnership and others has highlighted the prevalence of anxiety (whether or not clinically diagnosed) amongst older people. **Older people's needs are multi-faceted** and assessments by professionals and others must recognise this vital aspect. The assessment offered by GPs to all over 75 years could form the basis of a properly holistic analysis of need but anecdotal evidence suggests that its application is at least patchy in London as elsewhere.

The linkage between the prevention of illness and disability and the promotion of good health (in the broad sense) has been largely neglected with regard to older people. As already indicated the Health Education Authority and Centre for Policy on Ageing are presently developing a policy framework for promoting the health of older people.

The whole question of older people's needs is often beset by a lack of clarity around **what is meant by need**. Linda Challis's contribution makes some effort to throw light on this matter. When considering needs, attention should be given to the different strata **(e.g. individual, community, locality)** and the relationships between these. Needs of older people in London have to be placed in this perspective and perhaps an up-to-date picture is required of the extent to which community and/or locality initiatives can actually benefit the health and social care needs of individuals. Attention has been drawn to the major role played by the voluntary sector in the provision of social care for black and minority ethnic older people. Sometimes unexpected developments can follow. In another part of the country, when asked for their top priority, a group of older people indicated some facilities for younger people (to stop them pestering the older people).

Specific efforts have been made to seek the views of older Londoners themselves, including black and minority ethnic older people. These have been pulled together and form a separate part of this report (to follow). **Older people tend to have low expectations of their needs being met but often have a different line on what should be priority improvements.** In her detailed analysis of needs, Professor Challis drew attention to the "mercurial quality" of 'need' and 'unmet need' as well as commenting upon the differences between 'needs' and 'wishes'.

Some attempts are clearly being made to involve older people in decision making at policy level, both directly and indirectly through advocate agencies. However, the overall position in London is mostly one of a gap between the decision makers and the recipients, the "doers" and the "done to". Work in Victoria in 1994/5 showed that the statutory agencies have to make skilful and sustained efforts in order to facilitate older people to participate in looking at the needs of their area. Doing this across health and social care seems to help. Better than most of us older people (sometimes with assistance) know that a need is a need, not a health need or a social care need. But the systems are confusing and complex. Unsurprisingly expectations are often low. However, there are benefits to be obtained, not only from gaining an additional perspective on needs (and wishes) but also from the aspect of citizen involvement in decision making.

It is important not to underestimate **the effect of change on older people** in particular. Perhaps this is an aspect which impacts especially upon older Londoners : the actual or threatened loss of long-established hospitals and other facilities can cause older people to become pessimistic about their own and others' situations.

Especially in London great care has to be taken not to think of older people as a single homogenous group. The contribution made by some older people as carers of others is of major importance. **Many older people here as elsewhere lead active and vigorous lives making an important contribution to society whether at local, community, regional or national level.**

3. LONDON

The sheer complexity and scale of the health and social care system in London is of real significance :

16 Health Authorities
33 Local Authorities
68 NHS Trusts
1666 General Practices (of which 362 Fundholding)

The number of boundaries in London is enormous : not only does it affect day-to-day working arrangements (in achieving effective hospital discharge, for example) but it also means that any sort of forward planning becomes very difficult to effect with so many partners potentially involved. The well-documented difficulties experienced by London GPs and other Primary Health Care workers in engaging with other parts of the system should also be included in the ingredients. It then becomes clear that no matter how much information there is to hand and how acute is our awareness of what is happening, the achievement of real improvements in lives of older people may still be illusory.

There is also a **significant amount of isolation for older people** (especially women) in London. Of itself, this does not equate to a greater degree of illness or disability but it does mean that when it occurs, it is more difficult and costly to deal with. It may also lead to loneliness and depression, the causes and effects of which are still not given sufficient prominence in analyses of health matters (but which are prominent in the work of the London Health Partnership). The environment in which older people (and others) live can, of course, have a major impact on their health status. Of particular relevance is the extent of social isolation caused by friends and relatives moving away (shortage of Council housing, high rentals, etc.) and the numbers of people who have always lived alone. **Only Tyne and Wear amongst metropolitan areas has a higher proportion of older people living alone. Compared to Other Metropolitan and Non-Metropolitan Authorities older Londoners who live alone have a lower frequency of social contacts outside the household.** Concerns about security are by no means unique to London but are undoubtedly relevant in many parts. Finally, there is an important cost factor : pensioners in London (unlike public sector and other workers) do not receive a London Allowance. A relatively generous concessionary travel scheme certainly helps but the higher costs of life in London are often more keenly felt by older people than others. The MRC made the point in its report :

> *"old age is a time of life when difficulties in coping with disease and disability are greatest, owing to the loss of social and economic resources generally more available to younger people".*

A further question here is **whether the needs of London (the city) equate at all to the needs of older people.** The major developments in the capital tend to be concerned with economic

development or other infrastructure issues. For most older people the only impact of Docklands and whether or not to proceed with Heathrow's Terminal Five is the extent to which these developments disrupt their lives. The population figures show that there are proportionately fewer older people living in the most deprived parts of the capital, which understandably receive some special attention.

It could be said, therefore, at both macro and micro levels that older people are significantly London's hidden population.

The Greater London Forum for the Elderly is the umbrella organisation for local forums in most of the London Boroughs. It comprises representatives of older people's organisations, whose main concern is to make known the views of older people. Their stated concerns give a flavour of **what some older people think about health and social care in London:**

- hospital closures (inc. relocations) especially A & E
- reductions in the numbers of hospital beds
- need for Ambulance Service to have better information on bed vacancies
- discharges from hospital whilst still in need of medical care
- older women not being able to have breast screening
- problems with the 75+ years assessments : not being offered consistently, not being properly undertaken, sometimes even seen as a threat
- significant numbers not registered with a GP : recently moved, not bothered to register, registration turned down
- lack of awareness of what makes for "good health" in old age, older people not asking the right questions, having to counter ageist assumptions - unequal treatment is still an issue; 'income poor' older people are too often dominated by the need to eat, stay warm, etc. to think about good health
- "Healthy Cities and Older People" tends not to reach the frailer, housebound person

- home owners in London can be much worse off than elsewhere; their 'capital rich, income poor' status can affect income benefits; there is no London Weighting for pensioners
- free travel throughout London does make a real difference and is a major asset for good health; Taxicard is valuable so far as it goes but charged rides are expensive and not all boroughs operate the scheme
- a lack of close caring communities provided by neighbours and families
- a real shortage of (free/cheap) dental and optical services
- a strong feeling that social care is an entitlement and should be free
- a lack of consistency around how older people relate to their GPs : tends to be every week or never!
- older people consider the NHS to be under real threat, with a possible change of Government not offering much encouragement; private medicine is seen as an important threat; investment statistics put out by successive Secretaries of State are simply not believed
- in conclusion, a breakdown of the social and economic contract between the State and Older People

The analyses of needs and services clearly indicate that addressing any one of these issues (or indeed a group of them) would not necessarily make more than marginal improvements. For London this does not seem enough. Instead what is required is an analysis and understanding of the systemswide issues involved.

3. THE HEALTH AND SOCIAL CARE SYSTEMS

So far as the health and social care of older people is concerned it can be argued that there is inadequate vision, little consensus on a strategic way forward, and generally poor connections across the systems. All of this adds up to problems in ensuring service effectiveness and little person-centred planning of responses to needs. It is important not

to confuse needs with perceived "quota requirements". Older people need specific responses, rather than a standard allocation of beds, day centre places etc. There is a clear lack of service sensitivity towards black and minority ethnic older people by both health and social care systems. There is a danger that professionals re-interpret needs in terms of their own perspectives and pre-occupations, or as "required" numbers of particular provision.

Person-centred planning is a concept now making much important impact in the learning disability world. The review of needs analysis in London showed little evidence that older people were as yet benefiting from the approach. In essence this simply involves placing the older person and her/his needs centre stage and seeking to construct or help construct an appropriate response. It helps focus on the views of the older people themselves. It enables a greater attention to needs and thinking about appropriate responses rather than simply shifting into "how much of service A can we provide" mode. The basic data of numbers of older people compared to resources available suggests London should be a good place to develop this sort of approach. But this is not born out by the reported pressures on services. One conclusion is that we do not know enough about needs, and in particular about older people's own stories of their needs and how these might be met.

Further clarity is required in relation to decision making at both policy and operational levels. There needs to be greater connections between available information on needs and decisions on allocation of resources. For each individual information should be available on all her/his appropriate life circumstances. The population information clearly shows that women make up much the larger proportion of this age group. In London as elsewhere, all too often individual needs assessments are being undertaken in isolation from one another, often with little cross-referencing. The nature of primary care in London (many overlapping catchment areas and single-handed GP practices) means that it is likely that this situation is worse in London than elsewhere. Similarly it appears to be more difficult for agencies to share their needs information and subsequent decision making on anything like a systematic basis. Most London Health Authorities have two or even three Boroughs within their areas. Many of these seem to have been slower than their county colleagues to adopt a locality approach based upon borough boundaries. Consequently needs profiling across health and social care appears less well-developed than elsewhere.

The role of Public Health Departments in resource allocation/needs response decision making may require more study. It is not clear that the information as well as the skills and expertise contained therein are sufficiently taken into account, both in policy formulation and implementation. There is at least a hint that the mechanics of resource allocation (especially contracting mechanisms) have become more important than ensuring decisions are being taken on the basis of the best possible information available.

A further aspect of clarity in relation to needs which is seen to be giving some cause for concern is that of **monitoring**. Clearly monitoring and ensuring efficiency is important. More attention should be paid to building up models which analyse the cross systems relationships of different component parts of health and social care for older people (acute, rehabilitation, continuing health care, social care, etc.). To do this properly, of course, a clarity is required around respective roles and objectives. From the review undertaken of London agencies' analyses of needs it is far from obvious that precise and consistent objectives are in place. More attention should be given to ensuring that older Londoners are aware what it is that commissioning agencies are seeking to achieve, and therefore what they might expect to receive and in what circumstances.

When considering the needs of a particular older person, it is often necessary to consider also the situation of his/her spouse and/or other carers. **The contribution by informal carers** is enormous (but difficult to quantify) and it is vital that their circumstances are considered when assessing needs of the older person. Attention should be given to involving carers (generic term) in the needs assessment process - both analysing the needs and determining the response. Where spouses or other close partners/relatives are concerned, there can be times when their own needs are considered in conjunction. All carers can usefully play a part in assessing needs (including their own) and thinking about appropriate responses in which carers will of course play a significant part. Social Services Departments tend to be more progressive (or perhaps less defensive) in their approach to and recognition of carers. But Health Authorities too should develop policies and practices which enable carers to participate in assessing and responding to needs.

As the contribution from the Greater London Forum points out there is **a general lack of clarity about what constitutes "good health" in old age. Particular views (especially**

from professionals) are not lacking but what is missing is a consensus. There is no sense within London of the various components across the health and social care systems pulling together for a common purpose, with any sort of recognition of what the clear goals might be. Senior Health Service Managers indicate that there is a real tension between focusing upon strategic planning (which is what the above situation calls for) and the emphasis on enhancing "performance" as presently required by Department of Health driven efficiency measures. For Directors of Social Services the equivalent tension is between delivering on the Community Care Plan and keeping within budget - with the latter priority invariably winning out and dominating the deployment of management time. In their recent consultation exercise for North Thames Regional Office the Policy Studies Institute had "a huge diversity of responses" from 93 statutory agencies, practitioners, voluntary organisations and independent sector; this applied across all groups of staff and professionals and "consensus was rarely reached". The definitions of a "satisfactory outcome" or "cost effectiveness" are difficult and constantly shifting as knowledge and expectations change. However, it is important that in this debate the interests and perspectives of users must be central.

The needs analysis has demonstrated the importance of taking a holistic approach to older people's needs and wishes. The challenge for both commissioners and providers of services is to design a response which is appropriate. There are clear implications here for a systems-wide review. At this stage it is important to bear in mind that reviewing and determining the effectiveness of specific services, or even of particular parts of the health and social care system, almost certainly does not provide a comprehensive picture. **Whether services are 'working' is important, whether the systems are 'working' is crucial.**

It is important to examine the impact of ageism within the health and social care systems. There have been strong assertions that older people are treated less well than others, particularly within the health system. In her study of older people and community care, Beverley Hughes identifies how age discrimination permeates most parts of the social and economic fabric of society. She indicates that while older people "consume proportionately more of both hospital and community based health services (they) may not have always had the most efficacious investigation and treatment". She sees assessment of needs as particularly problematic: "research has suggested that the assessment of older people has tended to be restricted to the assessment of need for specific services, often requested by a carer, or GP as

other third party". There is a tendency for some health practitioners to view medical problems as inevitable consequences of old age and therefore not as "legitimate need". She identifies five principles of anti-ageist practice: empowerment, participation, choice, integration, normalisation.

Age discrimination can be seen in various aspects of the systems. In London as elsewhere, consultant geriatricians are often seen as the poor relations compared to other areas of medicine. Some react to this by emphasising their hospital base so as to be close to other medical power bases, so shifting away from a community focus. Similarly there is a need for more GPs in London to take a specialist interest in old age medicine rather than seeing it as basic and uninteresting. In Social Services work with older people is often regarded as lower status than that with children, where there are more positions for social workers as opposed to other social care practitioners. In nursing the issue is perhaps less of status than a lack of recognition by some that nursing older people not only requires some specialist skills but also an approach which is based upon the whole person and her/his needs. The lack of attention given to depression among older people may have an ageist component to it, not enough being done to challenge its inevitability and to treat it.

Two other aspects are worth mentioning as examples of ageist tendencies. Language and terminology are important. Whilst "geriatric medicine" may be seen as an acceptable term (although not to all Consultants) most older people do not want to be referred to as 'geriatrics' or even patients on the geriatric ward. Such issues do matter in terms of how older people see themselves and see how other people regard them. More extreme is the use of the term "off legs" by some medical practitioners as a serious attempt at categorisation. The lack of clear thinking and of respect is surely unacceptable.

Finally, it is clear that some parts of the system in London continue to see older people as problems first and as patients or clients second. The common use of the term 'bed blocking' demonstrates this. Older people do not block beds, they use them; they are not the problem, it is within the systems (not just one part) that "the problem" can be located. The Director of Age Concern London was properly vehement in her reaction to the apparent decision by one London hospital to ban certain admissions of older people from a particular part of its

catchment area. Just what are older people meant to interpret by such insensitive and discriminatory practices?

The review of service configuration and performance has to be set against this backcloth of age discrimination. The extent to which health and social care policy makers and practitioners are merely reflecting wider societal views of old age is a matter for some debate.

5. MOVING AHEAD

The breadth and depth of problems are such that there is an obvious difficulty in moving ahead. **In a recent review for a new North Thames R & D Programme the Policy Studies Institute noted**

> ***"The main message from the consultation exercise is, perhaps, that there was universal concern about the future health care needs of older people but no agreement on what should take priority or on the best methods of investigation."***

The review further concluded that

> ***"...the lack of liaison, collaboration and co-ordination between the various sectors involved in health care of older people has been such a recurrent theme for so long..."***

Recognition of the systemswide nature of the problem is already apparent. Tackling it in a way which is achievable has clearly been less obvious. One way might be to consider (from the perspective of a small number of different decision making levels) issues requiring "liaison, collaboration and co-ordination". One such division would be into practice/operational, system and wider. Even this presents a daunting challenge but it does also fit into the sort of analysis evident elsewhere in the Commission's reports. Five different aspects are identified below :

- **the importance of cohesion across the systems**
- **the promotion of primary care**

- **the development of leadership and a willingness to experiment**
- **greater equity of provision**
- **greater involvement by older people**

When considering how to make progress on these issues it may be that focusing where possible on a bottom up approach will be most productive, working with local partnerships where these seem most promising.

A major issue in service configuration is the importance of ensuring optimal (or perhaps even adequate) **cohesion and 'balance' across the health and social care systems**. Not enough is known about the 'right' proportions of the different components of care and support (acute, rehabilitation, long-term etc.) which might ensure the most effective, or indeed the most efficient, combination within available resources. Significantly J Grimley Evans (amongst others) has urged that attention be given to the prosthetic/therapeutic 'balance' in order to ensure optimal response to older people's needs. In London the impression gained is one of a lack of cohesion between provider agencies with inadequate attention paid to developing clear service aims and objectives relating to needs. Although the apparent focus on hospital care may be ill-founded more attention could usefully be given to the work of Prof. Peter Millard in modelling care for older people across the systems.

The lack of cohesion across and specialism within the systems may be more pronounced in London than elsewhere (because of the number of Provider agencies) but it is difficult to be conclusive. Certainly the sheer number of boundaries often presents a problem. The significant number of hospital re-admissions of older people may be related to the difficulties experienced by discharging hospitals having to liaise with any one of a number of local authorities. The development of new multi-disciplinary community-based responses seem very slow to get off the ground in London. This sort of team does seem to offer real possibilities in pulling together different professional skills and perspectives. There is perhaps a need for a new specialism in working with older people who are now living in their own homes when they would previously have been in some form of institutional care. Who leads the team will require careful consideration and probably a new kind of skill mix. At the moment the sort of comprehensive skills needed are only possessed by some Geriatricians, who spend most of their time working in or from hospitals.

Discussions lasting two years between district nurses and home carers in one borough had reportedly achieved little. The question of who is entitled to a home bath and whether or not it is actually provided is as much an issue in London as elsewhere. Whether or not services are charged for both confuses older people and gets in the way of smooth joint working. The barriers remain significant.

Access to Primary Care for older people in London has been quoted as an issue. Examples have been cited of patients (in their own homes and in nursing/residential care homes) being taken off GPs' lists because of the workload implications. There is high utilisation by some black minority ethnic groups of GPs but concern that this might indicate reduced effectiveness of treatment. One reason for the (in the main) continuing popularity of GPs among older people is that they get seen reasonably promptly and usually get some sort of treatment (medication) which is immediately available. Elsewhere in the system waiting times can be significant. Too often the whole question of assessment of needs would seem to be prohibiting rather than promoting an effective response. It is vital that the assessment process actually adds value to the identification of need and response to it, rather than merely being a bureaucratic obstacle in the way of the older person's own solution to her/his difficulties. Getting access to aids to living at home may be a good example of this issue.

The role of GPs in helping to ensure a cohesive service seems particularly problematic in London, because of Primary Care issues well-documented elsewhere : more single handed practitioners, poorer quality of premises, a greater sense of bombardment, etc. If GPs are to be at the fulcrum of community based services for older people, it would seem that the majority need to place collaboration higher on their personal agendas. Health Authorities and Social Services Departments have vital roles to play in enabling GPs and other Primary Health staff to develop the potential for joint working. The opportunities for imaginative ways forward are ever increasing, as the Primary Care White Papers showed. In other parts of the country where some (admittedly limited) progress has been made vision and leadership were two of the key ingredients at the start and during the exercises. These components seem thin on the ground in London. Perhaps it is time for a different approach to be taken to develop Primary Care services for older people in London.

Leadership appears as a real issue in ensuring sufficient quality in service provision, both for existing services and the development of new responses. When it is in evidence, it is often consultant geriatricians who are at the fore. But there is no consistency in this group - much depends on personal aptitude and outlook. The system cries out for leadership across health and social boundaries especially in London where the geographical boundaries cause greater disjointedness. Nationally there is an issue about whether commissioning is proving to be a successful tool in improving service effectiveness. This concern has been raised in relation to London and particularly regarding the quality of contracts for older people's care: there are doubts over whether they are driving forward either quality of care or efficiency standards.

Certainly it is clear that some familiar problem areas remain to be addressed in London's services. The prevalence of pressure sores, the quality of care in some nursing homes, insufficient specialist knowledge about rehabilitation, acute hospital care: these and other issues have arisen with some consistency. Whilst many examples were found of commitment and good practice it is clear that quality is sometimes lacking. Practitioners continue to provide decent standards of care despite the often poor premises and low morale, these to be seen in the context of diminishing resources and some increasing needs.

Perhaps due to the very real financial difficulties permeating the systems there is **a reluctance to experiment** with new ways of working. Lack of developmental time and resource is one clear explanation. There is some indication that changing the configuration of older people's services is simply seen as too big an issue, despite an acknowledgement that some change is required (hence the number of small-scale pilot schemes). The impact of new surgical techniques on the treatment of older people must be a key issue for the future. More older people are being treated (successfully) in hospital and lengths of stay are reducing. So while it is beneficial to reduce overlong hospitalisation more older people are being discharged with both health and social care needs. Too early a discharge runs the risk of reducing capacity to recover and possible re-admission. Discharge planning (perhaps especially for short stays) would seem to be in need of particular attention in London.

Access to services and equity in their availability seem problematic for older people in London. The location of and access to health and social care services is critically important to older people and their carers or friends. Hospitalisation can become much harder to bear when

visitors are deterred by lack of accessibility. In London the existence of so many boundaries bring an equity dimension of their own to the question of access. The absence of clearly defined national standards of care mean than obtaining clear benchmarks is less easy. The financial analyses of both health and local authorities show the differing situations across the capital, and also the difficulty in ensuring any overall consistency of response between authorities in the same area. It clearly can make a difference whether any older person lives in Borough A or neighbouring Borough B as well as whether she/he has predominantly health or social care needs. The problems of ensuring effective hospital discharge and after care have already been referred to. How they are dealt with can vary a great deal across London. Whilst these variations are understandable from an organisational or systems perspective, they are not acceptable to the older person who receives a worse service just because she/he lives on the 'wrong' side of the street. The more boundaries there are the more efficient have to become those who are responsible for operating across them.

There seems to be **little significant involvement by older people in decision-making** about resource allocation, although the Victoria Project (previously mentioned) demonstrates the possibilities as well as the hurdles which have to be overcome. The complexity of how health and social care are organised undoubtedly hinders older people's involvement at both policy and practice levels. Support for bricks and mortar hospitals can understandably outweigh that for the less substantive Primary Care alternatives, especially when these seem more remote, less tangible and less easy to comprehend. User involvement is about more than sharing decision making. It can have both practical and longer term efficiency advantages, especially if including the proper use of assessment techniques.

The impression gained for London is that the **monitoring of effectiveness** of care of older people needs to be more systematic and probably more assertive. Whilst there will always be degrees of risk involved perhaps too much presumption is made about ability to cope, especially in circumstances where available informal care and support may be less secure than in other parts of the country. Of course, effective monitoring depends upon having clarity of outcomes based upon the individual and requires service providers to work closely together. As elsewhere this is patchy in London. Agreeing quality of life measures and obtaining a better understanding of ageing are fundamental to achieving this necessary clarity.

Most service providers in London and just about all service recipients would indicate **a shortage of resources** as the main reason why services apparently struggle to meet the needs of older people. Certainly the financial analyses give some support to the notion of a dwindling resource base. But they do not do this on a consistent pan-London basis - greater clarity is needed here. Certainly the crude resource/needs scenario for London does not seem worse than elsewhere, perhaps even better. It is the London complexities as described which provide an important overlay which must be taken into account. Getting a London-wide perspective is difficult when the health and social care systems give little attention in this direction. On a more minor front there seems scope for improvement in the co-ordination of the funding of voluntary sector health and social care projects.

This section has sought to draw on analysis from the detailed picture of health and social care needs and service response for older people in London. **In particular it has emphasised the need for greater clarity, cohesiveness, and involvement of older people in various ways. It points to the need for a systems-wide look at older people's services. A next step in this process might be a London stakeholders' conference/workshop which examines respective roles in moving ahead.**

MAIN CONCLUSIONS

- London has fewer and fitter older people than the national average but with a slightly older age profile;
- More older people live alone in London than elsewhere and have fewer social contacts; 77% of these are women
- For Social Services London continues to spend more than elsewhere but the gap is diminishing; Social Services staff have reduced by 12% in the last 10 years
- The significant number of interagency boundaries, together with the high number of out of London residential care and nursing home places, cause real problems in the effective co-ordination of services
- There is a clear lack of integrated planning at policy and practice level
- Although there are examples of innovation and a great deal of commitment there is little consensus on the way forward for older people's services