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## **Briefing paper**

Health and social care services that support the needs of older people

Author: Professor Jill Manthorpe – King's College London



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### Key messages:

- Whilst there is substantial evidence that population ageing does not cause unsustainable inflation of health and social care budgets, cuts in local government services are deep and having effects on whole services. Cost and patient shunting practice are likely to undermine further the parlous state of local government finances.
- When talking about 'integration', it is important to clearly set out what is being integrated with what or whom.
- It is important to be mindful of the stresses inherent in services that do not know what is happening to their contracts or futures. Communities of practice or similar local initiatives can help practitioners understand each other's demands and pressures.

## Introduction

'Imagine yourself without some or most of your basic abilities – the things which you rely on in everyday life, often unthinkingly because they are there, which go to make you a person in your own and others' eyes: imagine yourself in this situation permanently or temporarily, from birth or at a later stage of life: imagine yourself with or without ill-health as well as a disability – with full or with limited ability to think or judge for yourself, with or without a close carer, a caring relative, friend or neighbour – with a reasonable income or not – resilient or worn down – with needs, wishes, fears and anxieties, hopes, abilities, a contribution to make . . . What help would you need for a reasonable life? ie, reasonable in your eyes? – How would you want that help to be given? – How would you want decisions to be made?

Answers to these questions help to define social care – a definition which for each individual varies with the hugely variable circumstances of ability, disability, life...'

(Plank, 2015)<sup>1</sup>

This briefing explores how the structure and delivery of health and social care may best be developed to meet the needs of older people in the UK (United Kingdom), focussing on England in the main. Health services and systems need to be designed to support older people with complex and/or multiple conditions – because their needs are often poorly met by the current arrangements in the NHS that focus on acute care. But other problems arise from the separation of responsibilities between the NHS and local authorities. The need for more integrated care is often presented as a magic solution to these problems and this briefing considers the need for caution about seeing any one organisational change as simple or easy to do. Within social care in England in particular, there is not a lot of integration (there are over 25,000 care providers for example) and poor outcomes and experiences are often feared or reported.

## A (brief) background

How did we get to this position? A short briefing paper is not a historical monograph but a bit of history helps. It helps in understanding the world we are in, but also what has been tried before, and, when working with older people, in understanding their expectations.

Many reports start with a standard history – going back to the founding of the welfare state – for obviously the setting up of the NHS is a pretty good place to begin; but others go back further and talk about continuities with the Victorian Poor Law and the establishment of workhouses and poor law hospitals and asylums. These are useful accounts. But in this briefing paper I am going to ask readers to look around the area where they work and see some of the past or listen to accounts of earlier systems.

First – in many areas there are NHS hospitals – whether teaching or acute, whether Foundation or Trusts. Most of them will be orientated to treatment for medical conditions that have enabled local populations to live well, to avoid disabilities and sickness that would have dominated the lives and worries of their parents or grandparents. They stand amid the ghosts of separate hospital provision for older people that was closed down – long-stay geriatric wards, poor law infirmaries, wards for the incurable, and wards or hospitals for mental illness, including what we would now term dementia.

Second, down local streets or on housing estates there will be large and not so large local authority (council) buildings – again some survivors of the Victorian age – in which local services were funded (by local taxation/rates) that evolved to include responsibilities for people who were too ill or frail or unable to care for themselves. The Second World War prompted many such services, funded by local authorities, to provide living accommodation for older people in hostels, help at home with housework and care for the sick (to enable women to work), home delivered meals, and other aids and assistance. Following the War, such services were permitted, then made mandatory, but from their beginning it was seen as a matter of dignity that people would pay for them. Later on local authorities were able to build day centres, sheltered housing, old people's homes, and develop their home help services. You may look for these and find some – but many have gone – closed or been sold/ transferred to other providers. Interestingly (but beyond the scope of this review), central government has renewed local authority's public health responsibilities.

Third, there are now huge private providers (and some not for profit providers) of care services, particularly home care and care home businesses. You will no doubt recognise some of the big chains – but in your area there are also small family owned businesses and some not for profit suppliers – some of these having their origins in provision for retired employees or in religious organisations.

There are four main implications of this – most pertinent to England but applicable to the rest of the UK. First we talk about social care as if it is one body; it is not. Second, it covers a wide range of services – ranging from specialist clinical services staffed by professionals, including some doctors, but also nurses and other allied professions to very small independent community groups running largely with volunteers, who may see themselves more as community groups rather than care providers. And third, while local authorities have some responsibility for shaping the market of social care and pay for some care services for some older people, they are not able to control what happens to any great extent. For example, in many care homes a majority of residents pay their own fees. And finally, the question of funding is complicated in social care. At the level of the individual there is local authority means-testing – often unpopular – but also social security benefits to cover the extra living costs incurred by disability and providing family care (some also means tested). There is a complicated mix of funding streams from central government – spanning direct grants to local authorities for social care but also housing and care services. There are government rules on how local authorities should spend their money and what they should set as thresholds for eligibility, and there is pressure to reduce public expenditure.

In Scotland, things are slightly different and one interesting development from devolution has been the 'natural experiment' occurring in social care between England, Scotland and Wales, with Northern Ireland having a long tradition of more integrated commissioning and services. In Scotland the Community Care and Health (Scotland) Act 2002 introduced free personal care as a legal entitlement for people aged 65 or over, although services which are not personal care are chargeable (eg housework, laundry or shopping).

It is not so much how things are organised but what happens in practice that has led to a chorus of demands again to 'do something' about the 'crisis' in social care. Key problems are social care quality; social care sufficiency and social care capacity. Again, just to provide concrete examples of this, you will find that there is high turnover among social care staff; many experience problems in getting enough home care support at the right time for people leaving hospital and you will likely hear that older people's needs are now not 'high enough' to get local authority social care support. A telling figure is that while the numbers of older people are rising, the numbers of older people receiving publicly funded social care support are falling.<sup>7</sup>

Currently there are two Commissions on this very subject proposed or underway,<sup>2,3</sup> and the 'crisis' of social care is reported as a reality in many circles,<sup>4,5</sup> or imminent.<sup>6</sup> Indeed, its very demise in the form of public funding has been prophesied.<sup>7</sup> For some, the term crisis is insufficient – social care is becoming a 'catastrophe'.<sup>1</sup>

We have been here before - in a mild sense. In 2014, the King's Fund published the interim report of the Commission on the Future of the Health and Social Care in England (the Barker report), *'A New Settlement for Health and Social Care'*.<sup>8</sup> It opened with a discussion of the history of relations between health and social services, called for "better integration," and predicted "hard choices" lay ahead. While the history provided by many report writers is a useful corrective to professional and public ignorance about how health and social care have evolved,<sup>1,2</sup> the Barker report followed others in being rather vague about the mechanisms of integration across disciplines, sectors, businesses and localities and was met by what Chris Ham, Director of the King's Fund, termed a deafening silence from the three main political parties.<sup>9</sup>

### **The weight of evidence – solutions and resolutions**

While older people seem almost to be blamed for the crisis in care; there is substantial evidence that population ageing does not cause unsustainable inflation of health and social care budgets although it contributes to rising demand and greater expectations and may continue to do so among the 'younger old'. The main drivers of rising healthcare costs are improved technology and the costs of professional practice, not just ageing (see Evans et al 2001).<sup>10</sup> More than half of all NHS expenditure in England goes on those under 65, as does virtually half of social care expenditure (Barker 2014). Social care funders in local authorities (commissioners) have responsibilities for care and support for other age groups, and some of their needs and numbers are increasing, such as people with profound and complex disabilities who are now living into adulthood. For many local authorities this group present a major resource challenge even if the high eligibility thresholds for social care remain in local authorities.<sup>11</sup>

Tighter eligibility rules (in response to budget cuts and as a consequence of wanting to target services) have reduced access to publicly funded social care overall, so much so that there can seem little left to integrate. To take care home services as one example (and drawing on UK figures since there is not much difference between different regions/countries), 175,000 older residents (43.4%) paid the full costs of their care home fees in 2012.<sup>12</sup> A further 56,000 (14%), while being funded by local authorities, also relied on 'top-ups' from family or friends. Thus a total of 231,000 older residents were paying in full or in part from their own or their families' resources – that is, 57% of all (403,000) older residents of independent sector care homes in the UK. The remaining 43% of residents either had their fees paid in full by local authorities (143,000) or by the NHS's Continuing Healthcare scheme (29,000).<sup>6</sup>

As noted above, Fernandez and colleagues (2013) have shown that the number of older people receiving state supported community based social care in England fell substantially, by at least 31% between 2005-6 and 2012-13.<sup>13</sup> This has occurred without much public debate, just as the transfer of care homes from the public sector (local authority) to the commercial occurred quietly in the 1990s. For many care homes their relationships with primary care, let alone secondary healthcare, has been disappointing. For older residents there are feelings of being disenfranchised from the NHS once they move to a care home. A recent report from the Alzheimer's Society (2016),<sup>14</sup> drawing on a survey of care home managers, found that almost half of the survey participants thought the NHS was not providing adequate and timely access to services such as physiotherapy, continence services, and mental health services for their residents with dementia. Instances were reported by the managers and residents' families of care home residents being left bed-bound, incontinent, and sedated because the healthcare services were too slow in responding to their needs.

The view that a heroic restructuring of health and social care is needed has its adherents although most commentators focus on the short-term problems or crisis management.<sup>1</sup> There are mixed views about social care being free at the point of use – ranging from those in the baby boomer generation wanting to keep and pass on their generation's housing wealth while having their own care paid for by a third party, while others see it as firmly part of the social contract and a necessary ingredient of integration.<sup>4</sup> And, as the Scottish system of 'free' personal care shows, there are debates over what actually is personal care. There is greater consensus that long term or chronic underinvestment in social care means that social care services cannot keep up with hospital discharge, so causing delays, while split budgets lead to cost-shunting with inevitable disputes, complaints and inconsistencies, as occurs with Continuing Healthcare funding. The short term problem requires funding to be mobilised, especially for social care. The Barker report outlined the options available, from restricting the healthcare offer (no more tattoo removal), through increased co-payments (charges for general practitioner consultations and the like), to tax changes that reflect the unprecedented affluence of the older population.

So will integration be the answer? It is widely seen as so in England, and devolution in areas such as Greater Manchester is taking it to a different dimension by including health and social care.<sup>15</sup> Over a decade ago it was argued that the necessary ingredients for integration are close knit professional networks, a mutual sense of long term obligation, little concern about reciprocity, a high degree of mutual trust, and an acceptance of joint working arrangements as core business.<sup>16</sup> Last century (just) Leutz (1999) developed five rules that seem to have stood the test of time (see Box 1) and may be helpful to all those advocating the 'integration solution'.<sup>17</sup>

### Box 1

Integration of services: Leutz's rules.<sup>17</sup>

- You can integrate all of the services for some of the people or some of the services for all of the people, but you can't integrate all of the services for all of the people.
- Integration costs before it pays.
- Your integration is my fragmentation.
- You cannot integrate a square peg and a round hole.
- The one who integrates calls the tune.

This may explain why when talking about integration in relation to social care for older people (and probably for other users of social care services) everyone needs to be extra clear about sharing understandings. A more sparingly use of integration might assist medical and social care colleagues to think about whether what is being discussed is alignment of health and social care (also termed co-ordination or even co-operation), the adequacy of services (both for individuals but for the whole health and care economy), and their affordability (which in social care, more than in the great part of the NHS, means actual payments by individuals as well as taxpayers). The Care Quality Commission recently reported hearing of many initiatives that aimed to deliver integrated care and indeed seeing some good practice. Yet, it observed, 'we did not find many examples of it working really well'.<sup>18</sup>

## The role of medical professionals – including actions that doctors can take

The Barker report and others sketched out the range of choices necessary to improve health and care services for older people. These include restricting the healthcare 'offer' and extending co-payments which may raise more indignation than money.<sup>19</sup> Raising taxation to fund running costs and investment is likewise outside the remit of local professionals. These are the "hard choices" for politicians that will probably need all party agreements to make – a refreshed Barker report's 'new settlement' that the former Care Minister Norman Lamb is proposing.<sup>3</sup>

This briefing paper suggests three 'promising areas' for medical professionals. First the fostering of a sense that cost and patient shunting practice are likely to undermine further the parlous state of local government finances. As Plank's (2015) analysis of what is happening in one area (Cambridge) shows, cuts in local government services are deep and having effects on whole services, not just at the margins.<sup>1</sup> Support for local government managers sounds trite but it may be helpful to them. Second is to be careful about 'integration' being seen as the one-word answer to every problem – and particularly being careful to say what is being integrated with what or whom. Much social care for example is provided by family carers, who generally want services and professionals to talk with each other and to 'be joined up' but who do not want to be integrated themselves. And housing and care services, which are a major element of social care (sheltered housing, extra care housing, retirement villages, and hostels) are part of the mosaic of social care – not necessarily integrated but wanting to collaborate. Third is being mindful of the stresses inherent in services that do not know what is happening to their contracts or futures. Communities of practice or similar local initiatives can help practitioners understand each other's demands pressures – as a recent small drama performance in a rural area attended by GPs, nurses and care home managers illustrated (see Box 2).<sup>20</sup>

### Box 2

Let's Talk is designed to stimulate discussion about working relationships that originated in the United States.<sup>20</sup> It has been adapted for the UK social care context by a social enterprise organisation, Dignity in Dementia. Let's Talk uses role play, workshop discussions and a range of other tools to challenge the traditional hierarchies played out in social care settings (known to impact adversely on quality and safety). Role play situations are devised and presented to a group of local professionals and service users and carers. For example a care worker might play the role of the GP or the GP a care home manager. The advantage of using this approach is that it dramatizes potentially difficult thoughts, practices and conversations and enables people to discuss them more objectively without blaming colleagues or getting heated.

Behind these micro-level ways of working at individual, team and practice level lie three 'monoliths' that shadow all solutions. They are not problems in themselves but get seen as problems rather than potential solutions. The first is the social care workforce, which like other healthcare workforces such as community nursing, is ageing and will need replenishing. In social care, even more than in nursing, migrants from the EU (European Union) and beyond, have shored up workforce shortages and high staff turnover. Is this sustainable? What will be the impacts of leaving the EU? Will the Living Wage attract and retain staff? Will the NHS 'poach' social care staff to fill its own vacancies? And what can unqualified and non-regulated staff be expected to do? Questions about duty of care and clinical responsibilities will be in sharper relief if increasing numbers of older people (and others) take up Personal Health Budgets. But there are wider issues about medical practitioners recognising the stress of working in social care among their patients.

Second are family carers – the lynchpin of care for older people. Medical practitioners have been given much advice about not ignoring family carers, being able to respond to them in a systematic way (eg by attention to their patient records systems enabling linking up of carer with the person they are supporting) as well as individually in person.<sup>21</sup> But carers sometimes say that they are under-recognised and that services that they are 'signposted' to do not exist or are not accessible. A separate briefing paper in this series on *Supporting*

*carers* further explores some of these issues. For medical practitioners involved in direct commissioning these areas are important to consider when making decisions in Clinical Commissioning Groups or locality forums.

And third, perhaps most importantly in any briefing paper about older people, are older people themselves. For medical practitioners there are numerous ways to hear their opinions of local and national influences on health and care, and their own experiences (such as through local Older People's Forums or Age UK or patient participation groups) (including HealthWatch (England), Community Health Councils (Wales), the Scottish Health Council and the Patient Client Council (Northern Ireland)) and patient surveys; there are also major local authority surveys which sometimes paint a more content picture than the crises reported. They too have an important part in ensuring that services meet the needs of older people by being active advocates, critical friends as well as supporting the NHS and care sectors through their volunteering and caring work today, and their current contributions and past commitments to the NHS.

### **Competing interests**

JM is a trustee of the Orders of St John Care Trust and of the Centre for Policy and Ageing. Much of her research at King's College London is funded by the Department of Health and the NIHR. The views expressed in this briefing are those of the author alone and should not be interpreted as being shared by the Department of Health or the NIHR

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