THE IMPENDING CRISIS OF OLD AGE

A challenge to ingenuity

A report and essays by F. D. Acheson, M. S. Butts
Vera Carstairs, J. Grimley Evans, A. A. Gatherer
Hugh Mellor, Alan Norton, D. Peckham
R. F. A. Shegog, M. Keith Thompson, T. Whitehead
K. G. Wright, Joe Young, and Joy Young
Edited by R. F. A. Shegog

Unlike many other client groups, it is possible to make a fairly accurate prediction of the numbers of elderly likely to live beyond the age of 75 at any point of time. The care of this special group, which incorporates a series of different problems, main among which is the substantial number of elderly mentally ill who constitute an already pressing problem in the NHS, is likely to raise a requirement for special policies which cross many existing boundaries of statutory responsibility and is certainly likely to be one of the major issues of the future.

The failure on the part of the Royal Commission which reported in 1979, to go beyond a fairly narrow 'health service' view, together with the evidence of mounting crises in the meantime, has pointed up the need for such a wide-angled and independent view of the position. This book is the result of a commission by the Trust to a distinguished band of professionals covering the main interests in the care of the elderly who were invited to make a comprehensive review of the question, taking note of relevant current moves.

The contributions lead to the important conclusions of the group, the outstanding of which is that it is political will married to administrative action to reallocate existing resources which is required in the first instance. It is hoped that this observation will be well heeded before the inevitable burden becomes intolerable to the community at large.

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Preface

As part of the celebrations of 30 years of the National Health Service in July 1978, the Trust, at the request of the then Secretary of State, organized a private seminar for Ministers and the 'top of the office' civil servants of the DHSS, the objective of which was to discuss the major problems which the NHS was likely to face in the future, based on a series of position papers.

One of the matters singled out for special debate and recommended for close attention was the care of the elderly. In particular one of the distinguished contributors, Professor E. D. Acheson, Professor of Clinical Epidemiology at the University of Southampton, pointed out that unlike many other client groups, it is possible to make a fairly accurate prediction of the numbers of elderly likely to be living in the population at a particular date in the future and that in the next two decades a marked increase in those over 75 was inevitable. The care of this special group, which incorporated a series of different problems, main among which was the substantial number of elderly mentally frail who constituted an already pressing problem in the NHS, was likely to raise a requirement for special policies which crossed many existing boundaries of responsibility.

Subsequently, the Trustees accepted this as one of the major issues of the future and invited a band of professionals covering the main interests in the care of the elderly to make a comprehensive review of the question, taking note of relevant current moves. The failure on the part of the Royal Commission which reported in 1979, to go beyond a fairly narrow 'health service' view, together with the evidence of mounting crises in

the meantime, has pointed up the need for such a wide-angled and independent view of the position.

The Trust is grateful to Professor Acheson, who was Chairman of the Working Group and to its members for the enormous pains they have taken to ensure the widest consideration of the problem and for the contributions and the important conclusions in this book. It is to be hoped that the outstanding general conclusion that it is political will married to administrative action to reallocate existing resources which is required in the first instance, will be well heeded before the burden becomes intolerable to the community.

G. McL.

Introduction

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In 1978 the Nuffield Trust held a special seminar to mark the thirtieth anniversary of the establishment of the National Health Service and took the opportunity to invite discussion on the problems which would face the NHS in the next three decades. It became clear that although advances in medical science were likely to take place which would have a profound influence on patterns of care during this period their direction and impact were at present unpredictable and speculative.

However one problem was identified which differed from the others in that it was the inevitable consequence of past events and was already casting an unmistakable shadow. This is the marked increase in the numbers of very elderly and frail people which will occur in Britain in the next twenty years, and the consequent profound effects on society and its social and health services. This was selected by the Trustees from the various questions raised at the seminar as the prime issue for detailed study and is the topic of this book.

The problems of the ageing society have been the subject of a number of important studies in recent years. Most of these have dealt with a single aspect, for example the condition of the elderly in Britain living at home, the organization of care of the aged in hospital or the practice of the medical care of the elderly. Perhaps the most comprehensive has been the Proceedings of a conference on 'The Care of the Elderly' held in the United States in 1977 and edited by A. N. Exton-Smith and J. Grimley Evans. This published contributions on the mental, physical and social consequences of ageing, on community and institutional care in Britain and the United States, and on the provision and training of appropriate manpower. It did not, however, consider pensions and other benefits in cash or in kind

for the aged or the problems of communication and interaction between the various organizations with a responsibility for them.

This book differs from those that have gone before both in its terms of reference and its method of preparation. In respect of the former the Trust's intention is that it should be as comprehensive as possible and that it should extend its enquiries beyond hospital and community health services and institutional care to include special housing, pensions and benefits, and the voluntary and private sectors. Whatever other shortcomings it may have the study cannot be accused of being narrow or restricted in outlook.

The book has been prepared by a working group under the Chairmanship of the author of this introduction. As is usual in such cases it proved impossible to bring together a group large enough to encompass all the important aspects of the problem and yet sufficiently small to allow maximum interaction and discussion. In the event although the team included medical and nursing experts from the Health Service, an economist, a sociologist, experts from the social and housing services, and the voluntary sector, it was necessary to seek advice from outside the group on various important issues notably those relating to the rehabilitation services.

It is usual for studies of this sort to fall into one of two categories. Either formal contributions are invited and published together with the subsequent discussion and conclusions or the report is limited to a statement of evidence and recommendations on which agreement has been reached. In this case an intermediate method was used which allowed a maximum opportunity for exchange of views about the evidence in advance of preparation of the chapters attributed to individual authors. These, although influenced and coloured by the previous discussions, are enlivened by expressions of view attributable to the individual authors. The agreed conclusions and recommendations of the group are contained in a separate section which immediately follows this chapter.

The structure of the book

The remainder of the book falls into four parts. The two essays in Part I delineate the scale and depth of the problem in

demographic and sociological terms, and describe the frequently traumatic and belittling effect of compulsory retirement.

Part II devotes chapters to the principal aspects of the existing Health and Social Services for the elderly including voluntary and independent support, support in the home, sheltered and residential accommodation, psychogeriatric care, primary care, nursing units and hospital care.

Part III deals with various aspects of organization and structure including the role of information, aspects of quality of care, the relationship between the national health service and local government and finance.

Part IV is perhaps the most important part of the book. It sets out brief case histories of innovations, all the more remarkable because they are so little known and all of which have as an objective the integration of a wide spectrum of services which are usually the responsibility of different authorities. Their existence and success in spite of current financial difficulties is a tribute to ingenuity, initiative and perseverance, and provide a basis for optimism.

The context

Although it is now widely realized that an increase in the numbers of elderly in Britain is inevitable, the true significance of some of the underlying trends is not generally understood. As Vera Carstairs points out in chapter 1, the tide of increase of those elderly who are least dependent and most able to help others (that is to say those aged 65–74) is already past its flood and on the ebb. However the numbers of those in the next decade of age does not reach its peak until 1990 while the maximum number of those over 85 years of age will not occur until the end of the century. At their peaks the numbers of persons in these age groups will be respectively 400,000 and 300,000 more than today's figures. In other words there will be an increase in the numbers of people in England and Wales over the age of 75 greater than the present population of Liverpool by the end of the century. Moreoever, it has been estimated that one in twenty of the population will suffer from incontinence. In parallel with these increases other demographic and social changes are occurring the effect of which

will be to diminish the number of able-bodied relatives available to share in the care of the elderly.

The trends are truly a cause for alarm and attention not only because of their scale but because of the enormous penalties associated with them in terms of human suffering and financial costs. As Michael Butts points out in chapter 12, the prevalence of illness and dependency of almost every kind increases steeply with age. Thus, if current rates of disability and dependency continue to prevail, by the end of the century at least half of the additional 300,000 elderly over 85 may need assistance with bathing, a fifth of those living in their homes may be bedfast or home-bound, and a substantial proportion will be suffering troublesome incontinence.

Perhaps the most serious feature of all has been the deterioration in society's attitude to the aged which has occurred in parallel with their increase in numbers. It is pointed out in chapter 1 that the rapid development of technology has had the effect of depriving the skills of the middle-aged and elderly of their relevance. Far from being the valued repository of experience, the elder is now often seen as an obsolete relic of bygone times. In the past the rarity of survival to old age itself contributed to the veneration of the elder. The way in which the term 'geriatric' has become derogatory and is belittling both to staff and patients indicates society's current valuation of the elderly frail.

At first sight little that seems hopeful for the alleviation of these problems can be glimpsed on the contemporary scene. If lack of money lies at the root of the issues it is difficult to see where new funds are to come from in the present extended recession, and yet in the face of the demographic imperative described above this cannot be permitted to be an alibi for inaction. The latest proposals for reorganizing the NHS will abolish conterminous boundaries and will thus bring about the final rupture of the relationship between health and social service. We hope that these factors will force reappraisals which prove creative.

The downward escalator

Little is known for certain about the factors which determine the rate at which the health of old people declines. There seems

to be general agreement, however, that breaking of social contacts and removal from familiar surroundings such as occurs when an elderly person moves from home to sheltered or residential care or to hospital may be deeply disturbing and damaging and hasten decline. For this reason there emerged in our discussions a view that although one removal might in many cases be beneficial, policies should minimize the need for repeated moves. The ideal should be a flexible and if necessary increasing amount of support from health and social services in the chosen accommodation. Except during the crises of major illnesses and in those cases where extreme mental or physical disability has supervened, help should be taken to the elderly, not the elderly to help. Once the benefits of a policy of 'least removals' is clearly seen the spread of flexible integrated schemes such as the experiments at Stockport and Southampton will be inevitable.

Choice, paternalism and privacy

Many people suffer a decline in their reasoning power and in their initiative in their later years. Nevertheless within the limits set by the mental and physical condition of the individual it was the group's opinion that every means should be used to encourage freedom of choice. It was hoped that this would tend to retain a sense of personal identity and self respect. The point is raised by Shegog and Wright in chapter 12 in their discussion of the advantage of cash benefits instead of benefits in kind for the elderly. Individual circumstances must decide cases: but as the authors say where arguments are evenly balanced either in general principle or particular application, the decision should fall on the side of greater freedom. One of our most important conclusions calls for the shaping of a financial strategy in accord with this principle.

It was the view of the group that privacy (where desired) and the retention of personal belongings should be assured for the elderly in institutional care, the preservation of these being necessary for a sense of identity. Our inability to find any statistical data concerning the numbers of single bedrooms in residential homes for the elderly suggests that the high priority we place upon privacy may not be widely shared.

Linked with the issues of choice and privacy is the need to

plan and provide for the care of the elderly among those groups whose cultural and religious background differs from the majority and who have arrived in Britain comparatively recently. We draw attention to this problem.

The dissemination of good practice

At first glance both the existence of differing standards of care on opposite sides of the same street and the existence of shining examples of excellence which pass unnoticed are deplorable. We recognize that this is the most difficult unsolved problem we have considered, but it is also the point of greatest hope. Shegog deals with some of the options in chapter 11. Action by ministerial 'fiat' or by the imposition of minimal standards are both likely to be politically unacceptable. We believe that the best way forward is that central government should work out a model partnership agreement between health, social services, housing, and the voluntary and private sectors to operate at district level, and encourage its achievement in every district.

Conclusions

1. The startling growth in the numbers of the old, especially those aged over 85, which is described in the Introduction and in chapter 1 poses a challenge to society which is likely to reach its peak by the end of the next decade and to continue with us for at least another. By the year 2001 it is believed that the number of the over 85s will be 60 per cent above its present levels, reaching a maximum in Great Britain of 880,000 or 1·6 per cent of the whole population. This dramatic increase is in the age-group which suffers from the greatest physical and mental disability and which requires six times more resources from the health services and twenty-six times more from the personal social services than the average for the rest of the adult population. If this pre-destined tide is disregarded, there will be great personal distress, physical and mental, and there will be public resentment of what will be seen as a blot upon our society when tested by its treatment of those experiencing disability, anxiety, and social distress. Our aim has been to examine how we are coping with this situation. Our conclusion is that despite some meritorious exceptions our system of health and social services is reacting to events too sluggishly to avoid the threatened crisis. We do not, however, accept the pessimism which is often expressed about our ability to change. For reasons explained below, we believe that it is within our power to adjust our present systems and resources towards a solution of the problem.

ALIBIS

2. There are two different excuses which are to be heard. One is that the admittedly uneven quality of our public services is

the premium paid for the value we place upon local decision making. But delegation of authority seems an empty excuse for abdication of responsibility. Central government, and only central government, is in a position to delineate national objectives and check upon progress towards them. The second excuse for failure is our national lack of economic resources. The principal recommendations which follow do not involve, with certain specified and comparatively small exceptions, fresh resources. Although no one can be certain until the matter is put to the test, it is our considered opinion (given no reduction in basic revenues) that a vast improvement can be achieved by a radical re-adjustment of existing resources within the whole field of health and social services and by a strongly defined partnership with voluntary effort.

3. Resources are wasted through inefficiencies within the present system. A few examples are the 'blocking' of acute hospital beds, the misuse of many long stay beds, the lack of preventive action, the poor linkage of resources in the public residential sector, a failure to exploit to the full private resources and, as discussed in chapter 14 and other chapters, waste of time and effort passing the buck between the taxpayer and ratepayer or between the hospital and domiciliary services. As to voluntary work, whilst it already makes an important contribution by running its own institutions, by providing reliable help in the home and by participating in management, the value and size of this volunteer army could be greatly increased if 'accepted by management as essential partners' (1).

RECOMMENDATIONS

The role of central government

4. In dealing with any one group, but particularly in the case of the old, the health and social problems of the individual interconnect closely. A successful policy for care of the old depends upon a combination of housing, food, care, and social contact suitable to each individual. A break at any point in the chain nullifies the value of the rest. It seems therefore self-evident that any plan or operation in this field should be

comprehensive and therefore jointly designed and followed through by all Departments involved and the recommendations which follow seek to establish such co-ordination. So far joint functional co-operation within government is sporadic and reactive, and myths such as that housing and health are disconnected topics are created and defended. In 1975 a proposal was published for the creation of government machinery for the study and determination of social policies in matters falling within the scope of different Departments of State. (*A Joint Framework for Social Policies.* Report by the Central Policy Review Staff).

5. It would appear that this proposal met with determined opposition by the various independent Departments of State, and has made little progress. Without some such mechanism however, the Working Group believe that major issues of social policy cannot be investigated and presented for serious consideration. It is evident from our enquiries that neither Parliament nor the political parties have as yet themselves the means for investigation as preparation for policy formation in complex fields, although the new Commons Select Committee system should have the potential for comprehensive studies. The Working Group is not proposing the establishment of still larger Departments of State but does strongly *recommend that in a field of social policy, such as care of the old, accountability and planning should be integrated within and between Departments and the responsibility clearly designated at Ministerial level for taking a lead in changing the system towards this goal.* Although the importance of collaboration between the NHS and local government is underlined in paragraph 24 of *Patients First* and its Annex, we are pessimistic about its future under the new structure, not only because the care of the old is overlooked but also because reliance is placed upon the existing ineffective structure of joint consultative committees. In the current plans for re-structuring the NHS, little or no consideration seems to have been given to the creation of a system which will encourage the integration of services at district level on the basis of resources contributed by County Councils, District Councils, District Health Authorities and Voluntary Organizations and provide for properly constituted bodies or

designated officials competent to carry through the plan at local levels. We must doubt the capacity of either District or Regional Health Authorities to undertake action without firm help from central government and also from Local Authorities which must themselves adjust their working methods so that powers are delegated when necessary for joint operations at local level. Because the creation of effective and integrated services are crucial to the welfare of the old, *we recommend that central government should intervene decisively to ensure the creation of joint planning and implementation machinery at district level.* (In paragraphs 14, 30, and 43 below we refer to the implications of this recommendation for financial strategy and operational practice).

The deployment of resources

6. The roles set for management as defined in chapter 11 and personal skills in performing them greatly affect the quality of care. In the case of the NHS, because it lacks itself a central management, this responsibility begins with the Secretary of State and stretches out through the DHSS and Health Authorities to include the doctor and the professionals working with him for the individual patient. The degree of leadership coming from management at all levels is of particular importance in a complex system such as the health and social services constitute where weak management can undermine standards of performance. Further, management is constricted within separate and distinct systems, but has to live with the knowledge that failure in any one system will mar the performance of the rest. The good manager has therefore to form reliable links across demarcation lines with other services' managers.

7. It is however insufficient to rely upon individual assumption of leadership to overcome the fog of uncertain responsibilities. For instance, in a survey of the management of mental illness hospitals, it has been said (2) that 'too often the task is split between a number of consultants and nursing officers none of whom believes the elderly to be his special responsiblity'. We find such criticism to be valid on a much wider scale and to apply generally in managing care of the old across the whole field of health and social services. *We recommend that respon-*

sibility for planning services for the old and accountability for monitoring operations be defined so that no element of doubt can remain, particularly at district level.

8. Planning can act as a catalyst in effecting a general improvement of services by presenting the occasion for examining examples of excellence and challenging obsolete beliefs. In Part IV there are described a number of excellent instances of management initiative in establishing joint team working between the NHS, Social Service, Housing, and other departments. Such achievements are often due to experience and training in 'corporate planning' which however, are lacking in many managers at all levels.

9. Someone appointed to a senior post whether in clinical medicine, social work, administration, or any other profession is likely to hold it for a quarter of a century or more however indifferent the performance. First selection and 'refreshment' by continued education are therefore crucial to the quality of the service, and yet in certain areas are neglected. It is the responsibility of senior staff to remedy failures in this respect. Equally important is the creation of a national policy on standards for appointment and tenure.

10. In the final paragraph of these conclusions and in chapter 11, we comment upon the need to educate senior management for these tasks and the absence of any adequate provision. *In addition to specialist skills, senior managers at every level need professionally presented analyses of policy and project innovations to equip them for the difficult environment in which they operate* (3). Education of this nature ought also to be used deliberately as a communication bridge between different levels of management and different services.

Personal incomes and benefits

11. In chapter 14 there is mention of the relationship between cash benefits and services. We agree that where the argument in favour of one or the other is finely balanced either on general principle or particular application, the decision should be in favour of benefits and greater individual freedom. The system

of care, however, must be dependent on an effective amalgam of both cash benefits and welfare services each of which is discussed in the following paragraphs, separately but with an awareness of their relationship.

12. A recent official report recommends a review of the system of pensions and income maintenance (4). We regard this as urgently necessary. The illogicality and unethical nature of some of today's regulations seems a symptom of political lethargy bogging down financial policies in this field. Long stay elderly patients in hospital have most of their basic retirement pension payments stopped, although perhaps anomalously the mentally handicapped retain their Non Contributory Invalidity Pension. The fact that the old or any other handicapped group pays 'hotel' charges in hospital by the surrender of personal income cannot be justified except by a decision to impose hotel charges on all patients. Equally iniquitous is the earnings rule by which the pension payments of the fit elderly who work can be reduced. We find it also alarming that no thought appears to have been given to the future implications of the Social Security Pensions Act (1975) upon these various procedures. There should be continuous monitoring of the extent to which compulsory retirement imposes poverty and predisposes to dependence on welfare services.

13. A further feature of this morass is the development of Supplementary Benefit into a kind of 'negative income tax' which as explained in chapter 14 through a means test eliminates many of modest means from a package of benefits. It might be in the national interest to widen special income supplements for disability so as to enable more people to make their own arrangements for help in their own home or in a private or voluntary nursing unit. In fact the present system of cash benefits is so complex that it is difficult for an old person even with good advice to achieve the intended benefit, particularly if not in receipt of Supplementary Benefit. There is no logic about a system which through supplementary benefit, attendance allowance, and other cash payments subsidizes individuals in their own homes, sheltered accommodation or private institutions at the taxpayer's expense but, on their

admission to Part III homes, transfers the whole of the cost to the ratepayer; and, on admission to hospital, then cancels the charge to the ratepayer but makes no acknowledged subsidy to the hospital towards raising the standard and comfort of long-stay care. The principles of a logical policy are surely not very difficult to unravel. Whenever income supplements are necessary, the taxpayer should foot the bill and the subsidy should stay with the individual to help meet the cost of accommodation and attendance wherever provided. Such a policy will harmonize with the requirements of society at the end of the century when national retirement pensions are forecast to be significantly higher at real levels than today. But treatment costs should not usually be met by income supplements. There are known risks in a policy of cash benefits for treatment if proper clinical assessment cannot be guaranteed in the interests both of the individual and the exchequer. Less risky but equally beneficial could be an increase in services through contracting out by the NHS of long-stay patients to independent nursing homes. There appears to have been no assessment of the benefits or disadvantages of such a policy, though it has been in operation since the institution of the NHS. We have also remarked upon the lack of thrust behind equity sharing schemes in the development of sheltered accommodation. *We recommend a review of the whole system of cash benefits and subsidies, and especially of the working of the means test.*

Expenditure on services

14. The DHSS undertook an outstanding initiative in instituting the arrangements for 'joint financing' between the NHS and local government, the effects of which are notable in the pioneering schemes described in Part IV (chapter 15) of this report. We doubt however whether these procedures will be lastingly successful without some re-thinking of objectives. What is required to make our existing system responsive to the needs of the individual is real joint financing and accountability instead of a *sub rosa* transfer of financial responsibility from the taxpayer to the ratepayer. Only real joint financing will mould the various systems into an integrated service devoted to the interests of the individual. *In such a strategy 'joint financing' monies should become bridging finance to cover the*

costs of maintaining over the limited period of transfer the expense of two systems, the old and the new. Because we do not accept that procedural obstacles to these propositions should be allowed to hold up progress for ever more, we recommend that on an experimental basis the NHS should delegate responsibility to local authorities or specially incorporated bodies, for agreed programmes over a fixed period of years. A remarkable instance of how such experimental delegations might take shape, is given by the Nimrod project (chapter 15 section 3, 1). This kind of joint working could also apply to 'nursing units' as discussed in para 25. Equally there may be instances where Local Authorities could usefully delegate limited programmes to the NHS.

15. Effective incentives to encourage those providing care are by no means all monetary ones. Chapters 8 and 10 indicate how the existing pattern of incentives may work in some respects against the interests of the old and handicapped. *We recommend that the whole question of incentives for staff working in the services for which there is political priority should be re-examined at a high level.*

16. Despite the frequent launching in recent years of memoranda advocating priority for the handicapped groups including the old, no credible strategy has been drawn up to achieve the proclaimed aim. Organizational impediments to re-distributing resources are built into the structure (5). Expenditure has continued to favour other parts of the NHS. Delegation of authority to Districts under the Patients First memorandum coupled with the preference for small hospitals (6) will, judging from past experiences, reinforce the impediments to change and could be a disadvantage to the interest of the old, unless accompanied by a strategy unequivocally designed to re-distribute resources to match the changing proportions between the age groups in the population and their known higher consumption of resources.

17. *The observations and recommendations we have made concerning financial policy sufficiently demonstrate the need for a major re-appraisal of existing procedures by an inter-Depart-*

mental group with the purpose of creating one coherent financial strategy for the care of the old.

Towards an integrated service

18. The considerable overlap in the services provided to severely handicapped old people has been demonstrated (7). It is difficult to discern the medical or social difference in the cases of many in long-stay hospital beds, in nursing homes, in Part III homes, in sheltered accommodation, and in their own homes. The conclusion to be drawn is not simple, because to preserve freedom of choice for the individual, there must be some overlap of services. On the other hand the degree of overlap which exists in some of these areas has been created and maintained more in the interest of the professions than of the client and is seriously wasteful of resources. Some of the effects of the present disjointed systems of care are:

'Blocked' acute beds, occupied by patients on sufferance.

Inefficient hospital discharge procedures.

Inconsistent criteria for the admission of people to hospital and to sheltered and residential accommodation.

In some parts of the country, a remaining stigma attached to Part III homes.

Ineffective procedures for preventing and dealing with medical and social crises in the home.

19. The remedies for present defects consist, firstly in each service setting its own house in order; secondly, and this may be the easiest approach to the first task, in moving towards an integrated service operated by the various authorities working in partnership. In the chapters 3–10 of this Report particular defects and remedies have been discussed. The more important of these are highlighted in the following paragraphs.

At home

20. The problems of care in the individual's own home, described in chapter 3, are most acute in the fields of preserving independence despite handicap and of summoning help in a serious emergency. *The lines of progress lie in developing alarm equipment, in encouraging the preventive role of the GP and the primary care team and in expanding volunteer contact systems,*

which we have illustrated or discussed in chapters 8 and 15. Change in any of these will affect policy on both Part III and sheltered housing.

Sheltered housing

21. The burden on Wardens is becoming intolerable as recorded in chapter 6. Apart from policy on linkage with Part III accommodation, the major problem arises where there is a shelving of responsibility by the health and social services for supporting handicapped residents because of the existence of a conscientious and experienced Warden. This issue is likely to be also confused by budgetary boundary lines. There can be friction between the community health services and housing services working within unco-ordinated financial restraints; and between County Social Services and District Council Housing Departments subject to different political masters.

22. These Gordian knots are to be cut only by better co-ordination of social policies at central government level and by local determination to create a viable system by using resources regardless of origin. Some examples of this last have been mentioned in Part IV. *The creation of partnership agreements referred to in para 43 below would be a major step in the required direction.*

Part III homes

23. The task of the residential worker in supporting individuality within a group setting and despite severe handicap has been convincingly portrayed in chapter 5 and constitutes a particular skill contributed to the care of the old by Social Services staff. Not all Part III homes however are full of the severely handicapped; they cross a spectrum today from something akin to a private hotel at one side to a nursing home at the other. Such a wide spread of variability and choice is ideally in the interests of the individual client. We believe however that there is a not undesirable trend towards a new pattern of care, and that this is due to several factors—the growing numbers of the old, changing attitudes in society and a re-examination of local programmes, triggered sometimes by reduced resources but aimed at the better preservation of

individuality. Indications of the new pattern are, firstly, improvements in the quality of care due to the team approach as well as advances in the technology of alarm systems which together presage an increase in the numbers of the old and handicapped who can be cared for in their own home. Secondly, the difference between the old people's home and the sheltered housing scheme is decreasing, as the image of the 'home' is improved and more private bedrooms and toilets are provided and at the same time it becomes necessary to organize 'extra care' in sheltered housing. In the future the principal difference may lie only in whether the individual's flat has a kitchen. Thirdly, the very severely handicapped or those in temporary care may best be cared for in the 'nursing units' discussed in para 24, where the best skills of the nurse and residential worker can be joined in partnership. *We therefore recommend that all future planning should take full account of the need for a close association between the housing service, social service and health services in every sheltered scheme and also for a close partnership between the health and social services in the construction or conversion of selected 'homes' as 'nursing units'.*

Nursing units

24. There is an overwhelming case for innovation in testing the concept of public sector nursing units (8,9). There are numerous well established precedents in the private and voluntary sector from which one lesson to be learnt is that such nursing units must be dedicated to creating a homely and unregimented atmosphere because otherwise as explained in chapter 9 the client can become isolated and deprived of any prospect of rehabilitation. *The experiment at Reinbek House, Stockport, described in chapter 15* (pp. 236–7) *is therefore invaluable because it seeks to combine medical and social care.*

The elderly mentally ill

25. The damaging effects of dementia, depression, and other mental illness on the individual segregated from normal society and its disturbing and frightening impact on other people have been recorded in chapter 7. The inevitable growth in numbers of those so afflicted, as the population over 85 rises steeply, and the traumatic harm done to close and possibly elderly relatives

if they are not given proper support, together constitute a very serious element in the coming crisis.

26. There is no great difficulty in agreeing upon the model of the service required for the elderly mentally ill. There should in each district be an integrated service under team management made up of in-patient beds and day hospitals, specialist day centre and residential accommodation and, with benefit of counsel, family support. It is desirable that to a controlled degree those afflicted should share facilities with other old and handicapped people.

27. This model is to a large extent the replica of a model service for all the old and handicapped and it is natural to ask why the two services for the old and the elderly mentally ill cannot be united. Apart from the difficulties already mentioned caused by the impact of dementia upon both other elderly people and those attending them, there are also objections to integration due to the separate professional identities of medicine and psychiatry, and also due to the risk that the interests of those afflicted with dementia would be swamped by the greater numbers of physically handicapped old people. Nevertheless this problem of overlapping services is particularly acute for both the GP and the relatives who are left in doubt as to the correct point of reference since it is usually impossible to make a safe advance diagnosis. In addition, resources can be wasted by an unnecessary overlap of services.

28. *The approach to a solution is through the creation in each district of a means for joint assessment and review, with membership from both medicine and psychiatry as well as from the nursing, social, housing, and other services.*

Hospital

29. There can surely be no questioning of the right of the old to the best quality of care in hospital including where applicable the best diagnostic and therapeutic equipment. Yet we have found it impossible to discover how widespread are the alleged instances of elderly patients being given inadequate access to district general hospital facilities, but we have the impression

that it is widespread. Such situations continue because some hospital specialists refuse an open-ended responsibility for the old patient but at the same time do not accept the geriatrician as a colleague of equal status. Further to this, there is the unresolved question, as explained in chapter 10, whether old patients should be in the care of a geriatrician responsible for all patients over a designated age or of a 'physician with an interest' working in partnership with other medical specialists. Responsibility and accountability for service within and outwards from the hospital must be settled beyond question, whatever model of procedure is chosen. Action on this will affect the role of the medical profession and of its specialties. *The original initiative by the Royal College of Physicians* (10) *was obviously opportune but needs to be maintained as friction between medical men on the issue of access to the district general hospitals is continuing to the detriment of the patient.*

A model service?

30. Although probably nowhere is there as yet a model of a total service, there already exist good models of major sections of a comprehensive service. It is evident from these that the fresh thinking and impetus which springs from planning integrated services and partnerships can carry in their wake a solution to the individual service problems of which examples have been given. A recent report on the organization of mental illness hospitals (11) advocates the setting up of a management team responsible for all the services in a District, involving participation by the NHS (including the Chairman of the Cogwheel Division) and by local government.

31. Such joint planning and operational teams in the case of services for the old should include the Housing interest. *We recommend the establishment of such management teams to integrate all services at district level. They should be analogous to those at the centre of the public sector pioneering projects described in Part IV, all of which aim to provide a single service uninhibited to the greatest degree possible by the interests and demarcation lines of individual departments or professions.* All such schemes have commenced with the concept of pooling resources and using them jointly in the best interests of the old

and the handicapped. Maybe these initiatives have been sparked off by the awareness of financial restriction: but the results seem beneficial to old people. The implications are considerable. Substantial funds could be found from the closure of long-stay wards and used to transfer clients to small jointly run nursing units providing opportunities for more suitable care at lower cost. Some substantial savings and benefits may also be found if the ability of old people to maintain their independence in their own homes is increased by the support of alarm equipment. To make progress of this kind practicable on a wide front, the way must be opened up by central government for the use of funds from different sources in joint partnership between the NHS and Local Government Departments. The unnecessary obstruction to good practice caused by existing government rules is becoming always more evident (12).

The independent sector, voluntary and commercial

32. In many areas of Britain up to 50 per cent of handicapped old people in care are dependent on voluntary or commercial nursing and residential homes. Some of these are excellent and except at the small luxury end of the market, they may run less expensively and more flexibly than institutions in the public sector partly because of their being able to be more discriminating in the selection of admissions. There are however obvious opportunities for abuse which are ineffectively guarded against by the existing inspection system in both the NHS and local government (13). There is therefore in any case a need to strengthen the inspectorate, and if this were done, it would be reasonable for the public sector to contract or 'place' out greater numbers of clients, thus developing a reserve capacity against the coming crisis in the care of the very old.

33. As can be seen from the examples given in Part IV, voluntary effort can provide a reliable support in the home. This if developed is a major resource bearing in mind the satisfaction given to both the volunteer and the client. *The public sector's role is to act in partnership with the volunteer groups and to finance the staff required to co-ordinate their efforts. Some very limited public expenditure is involved, but the returns on such investment could be very high.*

34. There are two other important roles for volunteers. The first is the traditional role of participation in NHS and local government management through membership of Authorities. In recent times, however, particularly since the disappearance of hospital house committees, NHS Authority members have not 'made a point of being seen on the wards . . . the frequency of visits in some cases has been plainly insufficient' (14). We recommend that informal visiting be strongly encouraged in the future.

35. Other vital roles for the volunteer are to operate as contact and to man information posts, such as Citizens Advice Bureaux. The old are faced with a bewildering variety of systems and costs from which to find the package to fit their particular need. Social Services Departments provide useful but limited information. But further expert advice and information are essential and best provided by volunteer effort.

36. *There must be ungrudging and unashamed recognition of the part to be played by the voluntary and private sector in completing a comprehensive service to the old. Along with this there ought to be precision about the conditions necessary to its effectiveness,* if the best is to be got from a major national resource. These include recognition by the voluntary organizations themselves that they must form a united front at local level in order to participate in planning the use of resources.

Research and information

37. Research and information, as discussed in chapters 11 and 12, are management services functions and their effectiveness in support of services for the old is to a large extent dependent on their general state of development in support of all caring services. A serious deficiency has been noted in some areas in using data as a means to forecast the specific demands which will arise in the future. We have also found an absolute lack of information on two important indicators of progress in this field, the numbers of health districts where those attending elderly patients have adequate access to the full technical facilities of the district general hospital, and the numbers of Part III homes offering single rooms to residents.

38. One specific suggestion is advanced in chapter 8 which is applicable especially to care of the old—that a special medical record be created in general practice to provide continuity of information about elderly patients.

39. The overall position of research supported by the DHSS in this field has been commented upon in chapter 11. Nothing has been found to suggest that a satisfactory strategy is being worked out. *Across the whole field of health care research, a major priority is to clarify the methodology of comparative studies of care systems and to strengthen research bases for such studies. Until there has been an analysis made of research completed or now in commission, no general recommendations can be considered for the direction of research. It is noteworthy, however, that no cohort studies have been undertaken and we recommend that this deficiency be remedied as a priority, since without them the basis of all thinking about care can only be conjectural.*

PRIORITIES FOR ACTION

40. The old and severely handicapped are served, at worst, by a disjointed system of care which has grown out of indifference and muddle, warring professional interests, and inconsistent budgetary policy. At best, there are examples of inspired leadership and partnership determined to pool resources and reconcile professional roles into a single purpose-built service. Because of these pioneering achievements, there does not appear to be much doubt about what to do nor about the availability of resources to achieve worthwhile progress. Though one single model of a total service does not exist, there are in existence working models of every section of a complete service and most of these have been achieved with equal or less resources than required by the older and defective systems.

41. The difficulty is not what to do but how to do it, how to spread good practice and not just good intentions. We recommend as priorities the following measures.

A strategy for an integrated service

42. A comprehensive and integrated strategy covering the responsibilities of all Departments of State concerned should be thought out and directed to the achievement of the greatest effect from existing revenue sources and the removal of the barriers now placed in the way of local initiative, for instance, the bar on permanent joint financing of integrated service partnerships covering both hospital and domiciliary health services, social services, housing, and voluntary interests. Thus, the procedures envisaged for the Nimrod Scheme at Cardiff should be widely replicated, with the addition of *permanent* joint budgeting. Because in the light of experience we nevertheless consider it unlikely that government will move decisively in this matter, *we look to the Parliamentary Select Committee on Social Services to take a lead in drawing attention to the necessity to break down the barriers of established procedures.*

Partnership agreements and standards

43. The present reluctance to issue national guidelines is misconceived. Excellence cannot be achieved, we agree, by ministerial fiat. But we consider it the responsibility of central government to collect information on a national basis concerning pioneering projects and to assess their cost effectiveness and replicability. If the argument is raised that this responsibility can be exercised at Regional level, we reject it for the reason that our national aim must be the creation of an integrated service for the old. Regional Health Authorities in England are not in a position to observe and analyse integrated developments in which local government is playing a major role. Examples of procedural objectives which should thus be recommended are the fixing of responsibility within the hospital service for planning and accountability for care of the elderly; and the designation of planning and operational teams responsible for all services within a district. *We most strongly recommend the production of a model partnership agreement to demonstrate on the basis of existing practice how to plan and implement an integrated district service at district and lower levels in which the resources of hospital and domiciliary health*

services, social services, housing services, and voluntary organizations can be combined in joint partnership.

44. We have found widespread, indeed almost total, ignorance of certain excellent local services, which must be as good as any in the world. From the lessons analysed from such development, it should be the duty of central government to work out standards as recommended objectives for all authorities at local level, coupled with an analysis of the staffing and revenue implications. We realize that Government Circulars advocating standards have been ineffective in the past. But such guidance can be made effective if the standards are based upon actual performance and if lack of progress towards the recommendations is closely questioned. Despite the gleams of excellence, the overall standard of service is only moderate and often inadequate. *The significant effect of government guidance on mediocre management should not be surrendered through fear of irritating those who do not need it.*

Professional education

45. A fundamental method for the improvement of care is to improve vocational and continuing education. Ultimately it is the quality of the staff who care and the staff who manage which will decide the quality of service. General professional education is moving in the right direction in all the principal professions concerned but far too slowly. *We must ask each profession whether its official policies on education about care of the old match the challenges facing our society outlined in chapter 1 and restated in paragraph 1 above.*

The communication of good practice

46. Senior staff at the centre and locally, far too often, react to events rather than control them. To approach this problem, there is a need to inspire by example through a higher level of continuing education and communication which at present, certainly for senior staff, are diffuse or inadequate. Although staff themselves are for the most part eager to learn, their needs are not yet met, particularly in respect of 'care groups' such as the old. This problem has been identified in the past (11) and again recently by the Director of the Health Advisory

Service (12), but it has not yet been resolved, and not for lack of physical facilities. The material for an educational campaign concerning care of the old and handicapped already exists, but awaits analysis and presentation. *Because of the professional and political suspicions which might be aroused, we doubt if the DHSS should take the lead which would better come from within the services or from an independent organization. The first step to be taken is a feasibility study of the implications and viability of this proposal for an educational campaign based upon a belief in an integrated service partnership as to be aimed at services which are in practice separated.*

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PART I

The setting of the problem

1 Our elders

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The meaning or lack of meaning that old age takes on in any given society puts that whole society to the test, since it is this that reveals the meaning or lack of meaning of the entirety of life leading to that old age. *Simone de Beauvoir.*

Values in a changing society

The value system adopted by any society includes the way in which it values the elderly as a group and as individuals, and will undoubtedly affect the care accorded to them. Changes which have been taking place in the structure of the prevailing culture have undoubtedly led to major changes in the status of the elderly. Many of the developments in industrial technology and in employment legislation have resulted in the elderly losing power, leadership, and authority, all of which confer high status, and also purpose, which gives meaning to life. The distinction which is accorded to the elders in primitive societies, as the repositories of the culture and wisdom of the community, has been almost entirely rejected in modern industrial societies where so much emphasis is put on the individual as a producer, and where the reverence for the wisdom of old age has been replaced by the attaching of greater merit to the vitality and innovative vigour of youth. Retirement is enforced for the most part at a particular age, regardless of individual ability, and the older retired person is left with no role to perform which is valued by society. It has been observed that

> the standing of old age has been markedly lowered since the notion of experience has been discredited. Modern technocratic society thinks that knowledge does not accumulate with the years but grows out of date. Age brings

> disqualification with it: age is not an advantage. It is the values that are associated with youth that are esteemed (1).

In a few areas of life it may be argued that accumulated experience is still allowed to make a contribution—political life, the law—but even those remaining areas are being eroded.

Rapid social change, which is also a characteristic of modern society, leads to deterioration in the status of the elderly for several reasons:

> it renders some of their skill and knowledge obsolete; not only can they no longer ply their trade, there is no reason for them to teach it to others. In a changing society the young people are nearly always better educated than their elders and thus the latter lose their authority deriving from their superior knowledge. Modern societies have high mobility both geographic and social and both kinds tend to put distance between children and parents, to weaken the bonds of the extended family and to undermine the authority of the elders (1).

Elderly people may never have been major producers but the advent of compulsory retirement unequivocally identifies them as non-producers and as, in some sense, dependent. This view of the elderly as dependent overlooks the reality that, for a high proportion, this is a period of consumption, not of goods and services which are provided by the active members of society, but of those goods for which the elderly have deferred consumption during their own productive years. While it is considered meritorious for individuals to plan their life consumption in this way, state provision is not always viewed in the same light. It is true to say of course that the savings element does not entirely cover the consumption experienced by the elderly; the proportion that is may be expected to grow in future years as occupational pensions become a more prominent feature of personal income.

The status of the elderly then has changed and is changing. This chapter examines in more detail the important changes which have been taking place and reflect on the status of the elderly.

Demographic influence

Not least of the changes which have influenced the position of the elderly in society is the enormous growth in the actual numbers—people aged 65 and over grew from 1·7 million in 1901 to 7·1 million at the 1971 Census in Great Britain (2), and 7·9 million at 1978. The numbers are expected to continue to increase to a peak in 1991 of 8·3 million, and to fall back thereafter to around the present level by the end of the century (table 1). Seen from this perspective, the 'tide of elderly' which is expected to engulf us appears to be almost exhausted.

What is significant in the last quarter of this century, however, is that the elderly will themselves get older: in 1901 29 per cent of those aged 65 and over were aged 75 or more, in 1971 35 per cent (2), and a further rise is expected, to 45 per cent in 2001 (3). The proportion aged 85 and over has risen from 3·3 per cent to 6·7 per cent and will increase further to 10·6 per cent within total numbers which change little, those aged 65–74 are already falling (table 1), the population aged 75–84 will increase to 1986 and then level out, while the oldest group, 85 and over, will increase constantly and dramatically over the next quarter century to a number 60 per cent above the current level. Another 700,000 recruits are expected in the age group 75 and over by 2001, and over 300,000 of these will be aged 85 and more—those most dependent and in need of support.

Another important change is the increasing proportion that

Table 1. Projected population aged 65+ in Great Britain 1978–2001. (1978 = 100).

	65–74	*75–84*	*85+*	*65+*
1978 (Thous.)	*5022*	*2393*	*527*	*7942*
1981	99·6	107·2	105·9	102·3
1986	95·5	116·0	121·4	103·4
1991	95·3	117·3	140·0	104·9
1996	92·9	114·1	154·6	103·4
2001	86·9	115·7	160·7	100·5

Source: OPCS *Population Projections* 1977–2017.

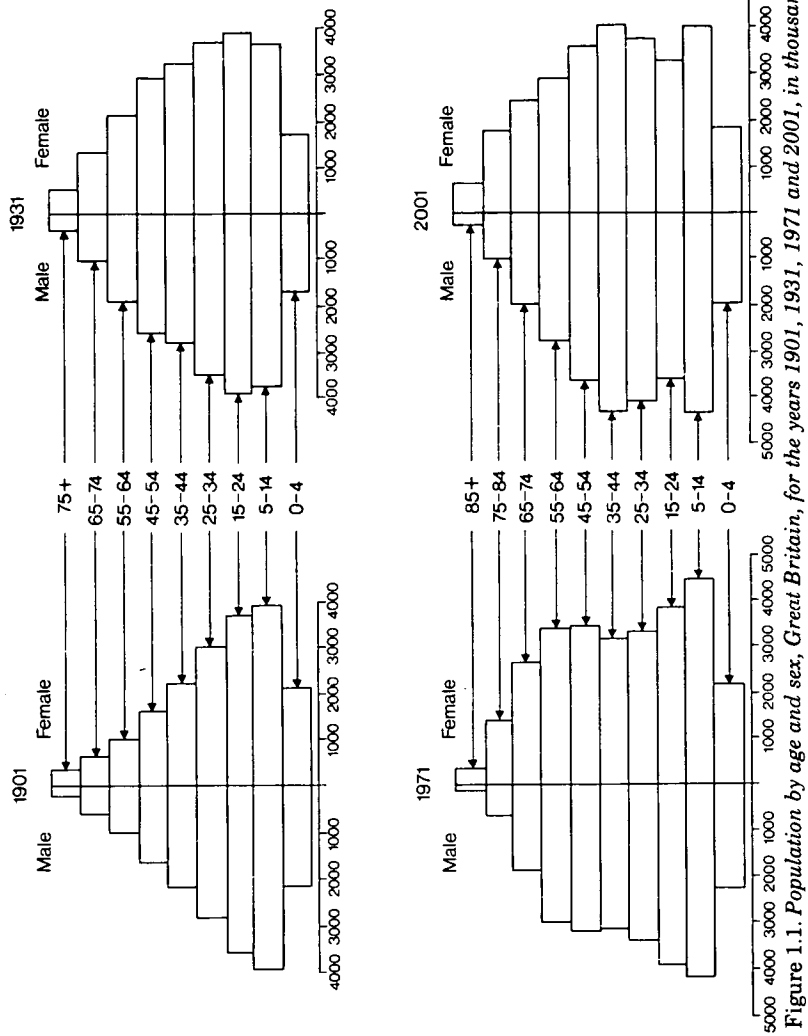

Figure 1.1. *Population by age and sex, Great Britain, for the years 1901, 1931, 1971 and 2001, in thousands.*

the elderly comprise of the total population—from 8·3 per cent in 1901 to 13·8 per cent in 1971, and with a projected figure of 14·3 per cent in 2001. The changes in the age-structure of the

population which can be seen in figure 1.1 are a product of the continuing fall in the birth-rate in this century, and hence of the relative numbers of people in the younger age-groups—the live birth-rate per 1000 total population has fallen from 28·2 in 1901–5, to 11·6 in 1977 (England and Wales) (4)—and to changes in life expectation. Falls in mortality are most evident at younger ages—the gain in life expectation at birth (table 2) has been over 21 years for males in this century and over 23 years for females. The result of this, and the gains at later ages, is that more people survive to old age.

Expectation of life has changed very little for the elderly themselves. For men only 1·7 years have been added to life expectation at age 65 in this century (table 2) while women have gained 4·1 years. The ageing of the elderly population which has been noted can thus be interpreted mainly in terms of the numbers in successive cohorts, rather than to changes in survival in the elderly. Clearly the major demographic influences are the increase in the total population and the reduced mortality at younger ages, resulting in more people surviving to become 65. Life tables show that at 1970–2 rates of mortality 82 per cent of females would survive to age 65, and 70 per cent of males (4), compared to only 47 per cent and 39 per cent at 1901 rates of mortality.

Most of the gains in survival were made in the first half of the century before the advent of antibiotics and high technology medical care, and may largely be attributed to improvements

Table 2. Gain in years of life expected at different ages between 1901–10 and 1975–77.

At Age:	*M*	*F*
0	21·4	23·6
1	14·3	17·7
15	9·1	12·2
45	4·6	7·8
65	1·7	4·1

Source: OPCS *Mortality Statistics* 1977 series DH1 no. 5, table 22.

in hygiene and nutrition and environmental conditions. It has been calculated that if the age specific mortality rates of 1951 had held good over the next quarter century we would still have 95 per cent of our present elderly population (5).

Marital state and health

Marital states have also changed considerably over the century (table 3), for men in particular. For these there has been a consistent increase in the proportion who are married, from 57 per cent in 1901 to 72 per cent in 1971, with a compensating fall in the widowed and divorced, and a slight reduction in those remaining single. The changes are less dramatic for women and there has been little change since 1931 in the proportion married, or widowed and divorced. The differences between men and women, which at first sight appear inconsistent, result from the fact that in general men are married to younger women (including below the age of 65), and that a higher proportion of women are in the older age group; 39 per cent of

Table 3. Marital state of the elderly aged 65 or more in England and Wales, 1901–91.

	1901 %	*1931* %	*1951* .%	*1961* %	*1971* %	*1991* %
Females						
Single	11·1	15·4	15·9	16·1	14·8	8·8
Married	30·7	34·1	35·2	33·8	35·0	35·1
Widowed & Divorced	58·2	50·5	48·9	50·0	50·2	56·1
No = 100% (thous.)	*856·6*	*1690·5*	*2852·8*	*3728·6*	*4403·2*	*4590·0*
Males						
Single	7·4	8·6	8·2	7·9	7·4	8·0
Married	57·4	61·9	66·4	69·5	72·4	72·8
Widowed & Divorced	35·2	29·5	25·3	22·5	20·1	19·6
No = 100% (thous.)	*661·1*	*1272·8*	*1971·9*	*2317·2*	*2736·7*	*3001·0*

Source: *Census* volumes and (1991) Richard Leete: *Changing Marital Composition*, OPCS *Population Trends*, no. 10, 1977, 16–21.

women were aged 75 or more in 1971, compared with 29 per cent of men, and in this age group only 15 per cent of women still remain married. The proportion single rose from 1901 to 1961, reflecting in part the loss of young men in the First World War, and has only recently begun to fall. At ages below 65 the proportion remaining single is falling considerably, for women particularly, for whom fewer than 10 per cent remain unmarried in the age groups from 30–59. The proportion of elderly women who remain single (15 per cent in 1971) is expected to fall to less than 9 per cent by 1991, although little change is expected in the proportion who remain married. The benefit from this is that, more elderly people having been married, fewer are likely to have remained childless.

Marriage is the best insurance against many of the adversities of old age. Death-rates are lowest for the married at all ages, including for the elderly, followed by the single, and then the widowed and divorced, who have the worst experience (table 4). And marriage also protects against the need for services—married people make considerably less use of hospital services and are less likely to be found in residential care: the residence rates for persons aged 65 and over in institutional care from the Census show that being single or widowed or divorced are powerful factors in determining use of these services.

Data on hospital beds used in a year paint a similar though less extreme picture: bed-use rates by the non-married are 2·1 times as high as for the married for males, and 1·65 times greater for females (table 6). These differences are more marked for long-stay than for acute beds.

Table 4. Comparative death rates by marital state for selected ages, England and Wales 1970–72.

At	*Males*				*Females*			
Age	*Married*	*Single*	*Widowed*	*Divorced*	*Married*	*Single*	*Widowed*	*Divorced*
67	100	119	141	139	100	108	117	120
72	100	113	128	132	100	108	112	116
77	100	112	123	124	100	106	114	130

Source: Life Tables 1970–72 First Supplement to the 123rd *Annual Report of the Registrar General for England and Wales* 1977. HMSO 1979.

Table 5. Persons aged 65 and over in institutional care. GB 1971: Rates per 10,000 population by marital state.

	Males	*Females*
All	377	551
Single	1431	1090
Married	153	157
Other	792	666

Source: Census 1971 GB, Non-Private Households.

Table 6. Hospital bed-use rates index, England and Wales, 1973.

	Males		*Females*	
	65–74	*75+*	*65–74*	*75+*
Married	100	100	100	100
Non-married	210	215	165	165
Acute beds				
Married	100	100	100	100
Single	169	135	104	94
Widowed	156	148	115	112
Long-stay beds				
Married	100	100	100	100
Single	297	211	180	134
Widowed	231	170	159	160

Source: Butler, J. R. and Morgan Myfanwy (1977) 'Marital status and hospital use', *Br. J. prev. soc. Med.* **31**, 192–8.

These data for general hospitals do not exhibit the vast excess for single people that can be seen in the Census table, and the reason for this can largely be attributed to care in other types of institution; the excess in the residence rates for single people compared with other marital states is much greater in both psychiatric hospitals and residential homes.

Both morbidity and social factors are likely to play a part in influencing these rates: illness, including mental illness, may well cause the single to remain so; also, as mortality has been shown to be higher in the non-married, we may perhaps infer from this that morbidity is also.

Family support

Social support is clearly more available to the married, and the widowed and divorced are more likely to be able to call on help from the younger generation than are the single.

If the trend is for more elderly people to have been married, and hence to have had the chance of having children, there have also been counteracting trends for such children to be less available to provide support to their parents: increased mobility, changes in household composition, and an increasing tendency for women to work outside the home, all play a part.

It is difficult to document some of these trends but no-one would dispute the increased mobility of younger families which has been apparent in the past 20–30 years. Added to this, improvements in their financial state, and in housing policy, no doubt also make it easier for old people to support themselves in separate households. The result of these influences can be seen in the changes in household composition between the Censuses of 1961 and 1971 (data were not published in this form for earlier Censuses). In this period the proportion of persons (of pensionable age) who were living alone doubled from 17 per cent to 34 per cent (table 7), and the General Household Survey estimates 33 per cent of those aged 65 and over were living alone in 1977–8, with the proportion rising to

Table 7. Household composition of persons of pensionable age, England and Wales.

	1961	*1971*
Total Persons	6 283 740	7 642 250
	%	%
Living Alone	17·2	34·3
two-person families	47·5	52·0
(both pensionable)	(32·1)	(37·7)
both married	34·1	40·7
parent & child	5·9	5·2
(both pensionable age)	(0·43)	(0·58)
other two-person	7·5	6·1
three or more person family	35·2	13·7

Source: *Census* 1961 and 1971 Household Composition Tables.

more than half for women aged 75 or more (6). Those in two-person families rose slightly, while there was a dramatic fall (from 35 per cent to 14 per cent) in those living in households of three or more persons, so that only about one-in-eight old people live in a household of more than two persons.

Of two-person families most are of married couples and there has been an increase in this proportion; and most are households where both persons are of pensionable age.

The proportion of households consisting of one parent and one child has fallen slightly; among these, households where parent and child are both of pensionable age account for only a small proportion, but this proportion is increasing slightly: other data show that households with a parent and son are almost as frequent as those with a daughter.

As the numbers and proportion of very elderly increase, not only will the level of dependency increase but, in the nature of things, those available to care for them will also tend to be older and more frail themselves.

The ability of younger people to care for their parents and elderly relatives is also affected by the increasing tendency for women to engage in paid employment outside the home: in 1951 only 21·7 per cent of all married women were economically active, by 1971 this had risen to 42·2 per cent; for women aged 45–59 the rise was from 22 per cent to 54 per cent. The Department of Employment forecasts that by 1986 55 per cent of all married women will be in paid employment, and 70·5 per cent of those aged 45–59 (7)—i.e. those most likely to be called upon for the care of elderly relatives.

Disability and age

While mortality rates have been falling slowly there are no data to document changes in morbidity over time; it may be surmised that falls in mortality in themselves may lead to a greater degree of chronic illness in the population. Age and disability undoubtedly go hand in hand: fewer than five per cent of those aged under 75 were found to be permanently house-bound or bed-fast in a recent survey of people living in their own homes, compared to nearly 20 per cent of the age group 85 and over (8). Disability is more widespread: 49 per cent of the younger age-group had no difficulties associated

with disability, but only 24 per cent of men and 32 per cent of women aged 85 and over.

Disability brings with it difficulty in carrying out personal or household tasks: 51 per cent of those aged 85 and over were unable to bath themselves compared with only four per cent aged 65–74, and 34 per cent compared with six per cent were unable to sweep floors.

Mental as well as physical incapacity increases with age: organic brain syndrome (dementia) is present in 2·3 per cent of persons aged 65–69 living in the community, rising to 5·5 per cent at 75–77, and shows a steep increase to 22 per cent for those over this age (9). Residence in a psychiatric hospital also increases with age, as can be seen in figure 2.

Consumption of public resources

Increasing disability and incapacity lead to the very elderly being high consumers of all health and social services. In addition to occupying most geriatric beds, the elderly occupy almost 40 per cent of all acute beds, about half the beds for mental illness and over 90 per cent of places in accommodation provided by or on behalf of local authorities. Recent government estimates have put the cost per head for health services as three times as great at 65–74, and six times as great at 75 and over, as at ages 16–64, and for the personal social services the relative expenditure is six and twenty-six times greater (10). Figure 1.2 demonstrates clearly the increase in use of residential care services with increasing age: residence rates rise sharply, two per cent of the population at age 65–74 and 20 per cent of those aged 85 and over being in some form of institutional care.

The extra numbers expected in the older age groups clearly presage a considerable increase in demand on services of this kind, and, given the level of unit costs cited in the government document (10), and that the present pattern of care continues, expenditure on health and personal social services for the elderly must increase. The population peak in 1991 indicates an increase in expenditure of some £300m for the elderly at that time, 11 per cent above the present level, made up of an increase of 21 per cent (£350m) for those aged 75 and more, which is offset to some extent by a fall of some five per cent in

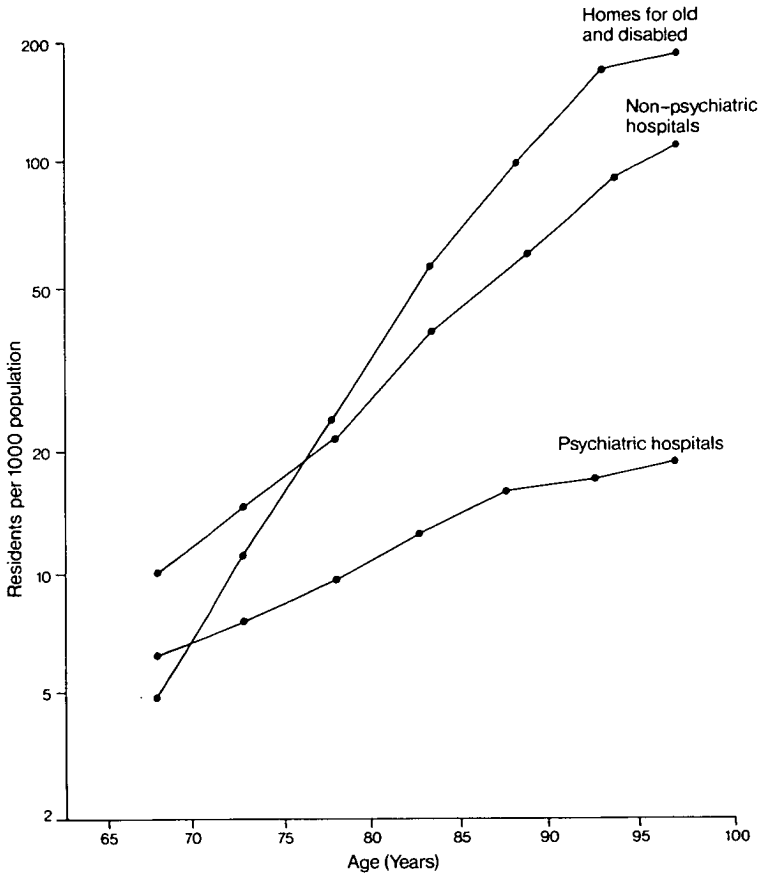

Figure 1.2. *Persons resident in institutions, by age, England and Wales, 1971.*

the population aged 65–74. Projected expenditure will fall back slightly by the year 2000. Future expenditure on the younger age-group (65–74) should fall as the numbers decline and an increasing proportion of expenditure from public services for the elderly will go to those aged 75 and over—the figure increasing from 60 per cent in 1978 to 68 per cent in 2001. There is little prospect of savings to offset these expected increases from people under the age of 65; the numbers in some age groups are projected to fall (5–19, 50–64), but the remainder are expected to rise and, on balance, expenditure for those aged

less than 65 may also be expected to increase, albeit by a lesser percentage of five per cent over-all.

Expectations

Not a great deal is known about attitudes of and to the elderly; one sample survey, however, suggests that they tend to express greater satisfaction with their circumstances than younger persons (11). This was true for housing and the district in which they lived, for their standard of living and financial position, (although these were the two areas of least satisfaction), and leisure; respondents even expressed as much satisfaction with their health as did the age group 45–59, though both of these were less satisfied than adults under 45. However, compared with the younger age groups, fewer elderly expressed positive affect about feelings and achievements. Also compared with younger adults they were slightly more likely to feel lonely but less often to experience troughs of boredom and depression. These findings perhaps go some way to dispelling notions of lack of satisfaction among the elderly generally. Nevertheless, it may be noted that one-fifth of the elderly expressed very low levels of satisfaction not only with 'life as a whole' but also with every one of the life domains studied.

Objectively, the circumstances of the elderly may be seen to be improving. The real value of the state retirement pension for a married couple was two and a half times greater in 1979 than in 1951, and has also increased in relation to average male earnings—from 36 per cent in 1961 to 45 per cent in 1977 (12). However, as a recent review noted 'for most of the 8·5 million people now over pension age, retirement is not financially speaking a bed of roses'; and in 1978 22 per cent of pensioners were also receiving supplementary benefit. This proportion had fallen from the previous year nevertheless due to the growing numbers of younger elderly raised above the poverty line by occupational pensions, and this element of income may be expected progressively to improve the financial position of pensioners—people retiring in 1980 are already receiving some modest benefit from the scheme (13).

Age still carries a disbenefit: the recent OPCS study of the elderly found that the income level declines consistently with increasing age of husband and wife, and that income levels of

non-married persons aged 85 and over are significantly lower than for those aged 65–74 (14).

This enquiry also sounded a hopeful note for the future: the younger elderly were found to be in better material circumstances, largely as a consequence of the improvement in working conditions and the social reforms and fiscal measures which have taken place since the Second World War, and it may be hoped that many of these better features will be carried through into their later years. While improved material circumstances may point in the direction of some enhancement in life style for the elderly, the inevitable ageing of the elderly population and the accompaniments of ill-health and loss of mobility, combined with loss of companions and support, seem bound to remain, and together to present a problem for the caring services.

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2 Retirement

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Nothing reveals more clearly the lack of clear thinking about the difficulties of growing old than the present position concerning retirement. It is, for example, too often regarded as the gateway to old age, yet there is today a considerable difference both in time and in circumstances between being retired and being old. We have made little attempt to dispel the myth that the retirement age is in some way related to the biological changes associated with ageing.

We have allowed retirement to become a sudden compulsory transition from a role with status and respect and for which we spend the first twenty years of our lives in preparation, to a situation which has clearly little status and little respect, a 'roleless role'; for this, apparently no preparation is required.

It was not always so. Well within the life span of the present retired, the customary position was to regard retirement from work as coincidental with a decreasing ability to continue for physical or ill-health reasons. In fact, retirement has become a 'social phenomenon' in a relatively short space of time (1): in 1931, over half of men over 65 years were working; in 1951, the figure dropped to 31 per cent and in 1971 it was 19 per cent. Today, we have the paradoxical situation in which our society allows its leaders in politics, in law, and in the arts, to go on in their occupations until they choose to leave yet applies a compulsory age for leaving employment to the majority of working people.

It is clear that as a social policy, we need to consider retirement with a much greater awareness of its history and of its impact on the lives of an increasing proportion of our population. Fortunately, more information about older workers and retirement has recently become available (2) and this

encourages us to see the process of retirement as being concerned with the behaviour and attitudes of individuals, with the practices and policies of groups and organizations such as employers and trade unions, and with the structure of society as a whole which determines that there shall be such an institution as 'retirement'. Some aspects of the retirement policy, such as the age difference between men and women at which access to the retirement pension is allowed, are difficult anomalies for any government to rectify because of the financial steps necessary. There is however no need to delay a radical review of other aspects, particularly if the results from retirement in respect to the health and general welfare of the elderly seem to be unacceptable.

The significance of retirement

Retirement creates for individuals and sometimes families crucial problems of a social, economic, psychological, and even physical nature. In assessing its importance in influencing the well-being of older people, it is easy to blur the picture and confuse the conclusions by over-simplistic generalizations. It is important therefore to start by acknowledging that for many people, retirement can provide both freedom and opportunity which can in turn bring fulfilment and many years of happy and healthy living.

For the majority, however, it is probably true that the loss of status, income, and companionship pose a risk to mental and physical health for which modern industrial society has not prepared them.

The greatest threat is likely to be psychological. To talk of 'retirement shock' (3) is not going too far for some, for the sudden break in the steady habits of years can bring feelings of despair if not depression, and of boredom if not apathy. An enforced and rapid re-adjustment is required, usually with only one's own strengths to help. Everyone has to make the transition; not all can make it smoothly.

The effects on physical health are not so clear and are difficult to establish scientifically: here, as in every aspect of growing older, so much depends on each individual's previous life and situation. It is likely however that the commonly held belief of sudden physical deterioration as a result of retirement

is really a myth. With the spread of occupational pensions, those suffering from ill-health are likely to have retired before the compulsory age; in fact, the recent survey (2) reflects a gradual decline in the proportion of men and women working in the ten years before pension age, and of men aged 64 years, 20 per cent were already retired. The key factor in enabling and prompting people to retire is the state retirement pension. An interesting finding in the study was that people who retired at the pension age were rather more likely than the rest to say they had looked forward to their retirement and that they were enjoying it.

There appears to be little evidence that retirement by itself produces quick changes in physical well-being. The same however cannot be said about social and economic problems. These are real and demand attention. A recent review of the 'social creation of poverty and dependency in old age' (1) states: 'The retirement age acts as an arbitrary cut-off point, distinguishing the socially and economically useful from the dependent, which is forced on older workers by institutional or customary practice, regardless of their abilities'.

We consistently devalue the skills and the contribution of older people. Thus we are encouraged in our attitudes of thinking of the old and the retired as irrelevant to the maintenance or development of society by productive work and economic growth. Our goals, in social and health policies, are therefore no more than those which simply accept this dependent minority at a level befitting their lowered status, a minority for which the valuable younger groups have to 'care'.

Cohort differences

The social and economic effects of retirement draw attention again to three things which are of fundamental importance in any review of services for the old; the individual differences, the differential impact, and the speed with which change is occurring in our society. The first of these has been referred to before, and is the wide variation in individuals in their personal experience of retirement: so much depends on their previous standards and habits of living, their previous job, their access to occupational pensions. The second factor underlining the need to consider the differences as well as the similarities in

the elderly is the emergence of 'two nations' in old age (4), so that there are in fact greater inequalities to living standards after work than during work. And the different standards become gradually greater between the recently retired and the 'older' old. For example, while 53 per cent of all elderly households have washing machines and 75 per cent have refrigerators, for those over the age of 85 years the figures drop to 33 per cent and 53 per cent respectively (1).

The third underlying general aspect is the speed of changes in our society which can influence adversely the general attitudes to retirement. The explosion in scientific and technical knowledge, the greater requirements for formal education and skills training, the acceptance by society of much higher levels of unemployment at all adult ages—these and other factors will if anything encourage public opinion towards support for even younger retirement ages.

Not all of the changes in our society are likely to prove to be deleterious. The growth of owner-occupation, the improvement in pensions and other aspects of financial support, and the longer periods of formal education could well have benefits which are not yet obvious. However, for the next decade or more, such changes could well simply exaggerate the cohort differences, and emphasize even more the essential need to appreciate the very different expectations which can exist among those who have been retired for varying periods of time.

Retirement therefore is of importance in the social and economic effects it produces, in the attitudes towards ageing it promotes, and in the challenge it presents to everyone's abilities to adjust mentally and emotionally to a very changed way of life. There is a great overlap between these effects and the creation of poverty, isolation, and ill-health in the elderly. What is not yet clear is what should be done to lessen the impact of retirement in creating problems for the old.

The changes required

The first requirement is surely the collection of much more information about the whole subject. There are already enough doubts about the present retirement policy to support most strongly the urgent removal of the age-related compulsory retirement approach and the use instead of a much more

flexible approach. Ideally, everyone should have the degree of choice about retirement which is already the privilege of some.

In the survey already referred to (2), there was considerable support in principle for gradual retirement, and just over half of those already retired said they would have preferred to do so gradually. We believe, with Palmore (5) that compulsory retirement is unfair to the capable older worker, that it can be psychologically and socially damaging, and that it is economically wasteful.

The avoidance of the creation of poverty in old age must be a high priority. This means alterations in the differential access to pensions which has started with the more recent pension schemes and the setting of old age pensions at levels beyond the poverty line. The subsequent effects in terms of the maintenance of health and in producing more constructive attitudes to the elderly groups in the population could well be dramatic.

We need more knowledge on how to help people adjust to the changes involved in disengaging from full-time work. Even if the worst effects of retirement can be abated by removal of the sudden and compulsory age hurdle and by the ending of pension and retirement policies which lead to poverty in so many, there is still a major change to be negotiated whenever the decision is made to stop work. One thing is becoming clear, and that is the relative failure of 'preparation for retirement' classes. Undoubtedly they provide some help for some about to retire. But the central dilemma remains: in order to give time for advice to be accepted and acted upon, preparation has to start at an age when those most at risk will not attend classes.

At present, pre-retirement classes are attended by only a small proportion of older workers, and a disappointing 38 per cent had heard of any courses (2).

In any case, we need to consider the whole subject of leisure and living without work in a much wider context. A big increase in holiday entitlement occurred in the UK between 1951 and 1975 (6) and it looks as though the trend will be to give longer holidays than to introduce a shorter working week. Also, preparation for any career nowadays must include an increasing capacity to accept the need for updating at intervals of a decade or so, and the speed with which knowledge and technol-

ogy is changing suggests that we are already facing the need to accept two or three 'careers' for everyone in a working life-time. It is therefore imperative that an urgent and quite radical re-think is given to two things that will become of increasing importance: firstly, adult education in general as a regular and lively force for good in our society; and secondly, the role of industrial concerns towards the after-work welfare of their employees and their families.

The contribution of adult education

Adult education's contribution will be threefold. First and probably most important will be the encouraging of 'a lifestyle that encompasses much more than doing a job and supporting a home' (3). It will aim at tapping the potential interests and skills latent in everyone; and it will build on a modern educational system which lays greater stress on learning to live as well as learning to earn a living. Imaginative use of facilities often surprisingly under utilized in our communities, such as school and community recreation and sports centres, and the use of voluntary help including those from the recently retired professional teachers, could mean that striking development will not depend on massive amounts of new resources. The possible combination of interest-group excursions abroad with the already flourishing package holiday firms for older people are already providing examples of what can be done with the encouragement of self-help and just a touch of a less protective attitude to the abilities of the elderly to travel and enjoy new situations.

The activities of bodies such as the Pre-Retirement Association and of adult education organizations such as the Workers Educational Association require much more encouragement and support.

The employer and trade unions

There is as much room for experiment and new ideas in the role of industrial concerns to promote well-being in their employees. Unfortunately, the very slow or even non-growth of occupational health schemes suggests that government stimulus and example may be necessary. We are thinking of going well beyond the role of industry in preparing its work force for

retirement. We would like to see the genuine acceptance of a more fluid concept of working contracts, with greater opportunities to move in and out of different occupations; with real choice to retire ahead of the State pension age; and with encouragement wherever possible to choose a phased retirement, or a proliferation of post-retirement work opportunities. Industry and other employers will base their approach on a more realistic understanding of the contributions which the older worker can make, and on the value to their commercial futures in demonstrating a concern for real problems in their community. In this last respect, we should remember the possible involvement of industry in voluntary effort; it is not too trite to say that one's own happiness can often be obtained by making others happy. Industry could re-deploy some of its concern for industrial relations into a liaison with the statutory and established voluntary services so that its workers can participate in one or other local project in which all can have some satisfaction and pride. Sponsorship would thus take on a different and acceptable image if seen to be not entirely based on a desire to advertise and promote particular products.

In addition, we have surely reached the stage where the trade unions could exert an impressive influence on this aspect of the welfare of their members.

It could be pointed out here that the public service which one would expect to be particularly lively and sensitive to these matters, namely the National Health Service, is so far failing miserably to give a lead.

It is clear that we are assuming that health is indivisible from social and mental well-being, and that health in advancing years is equally dependent as in youth to adaptations to changes both within the body and in the environment. We feel there is no need to introduce special 'screening' programmes at retirement age. Most people will continue to be reasonably healthy at the time of discontinuing regular employment. Instead we need an approach to adult health based on concepts of 'at risk' factors, which is already an important plank in the delivery of primary health care. Such an approach would continue to see any major change in the circumstances of vulnerable individuals as an opportunity for the primary care team to be of assistance if necessary; for example, bereavement, retirement,

and sudden illness, may create for an important minority the need for health and environmental support.

Should society expect more from the retired?

We have concentrated so far on what society should do for those who retire from work. But we must also consider what the retired can do for society. The younger retired at any rate may well feel they have life too easy now and would welcome more challenge to their long nurtured skills. We should therefore considerably increase the level of expectation as to the contributions we hope the retired will make to many parts of community life. We have in mind successful ventures such as the 'foster grand parents' programme in the USA and the planned exchange of skills in 'linked opportunity' schemes organized by some voluntary societies. We believe more experiments are now required in this country, such as day-release arrangements in the final year or so of regular employment so that socially useful supportive work can be undertaken. In these and many other ways, we can avoid old age becoming an 'absurd parody of our former life'; we need to go on 'pursuing ends that give our existence a meaning—devotion to individuals, to groups or to causes, social, political, intellectual, or creative work' (7).

Conclusion

We are convinced that a healthy start to that elongating period of life after retirement can rightly follow from attitudes and policies which promote the morale of the people involved and provide support which many will require to adapt to the changes occurring in their lives. Morale will be strong where this period of life is seen to require, as every other stage does, the pursuit of activities which give meaning and satisfaction to being alive. This in turn will be helped by the abolition of poverty as a concomitant to retirement, and on getting rid of an intergenerational myth concerning the potential contribution of the elderly. The support required must be based on ideas of an active and largely independent group of individuals, well able to help themselves and others if the general ethos of society is right.

In conclusion, we would stress that it is not the purpose of

this chapter to over-emphasize the health effects or the other problems of retirement. We feel sure that the onset of disabilities, especially those which immobilize, are far more important than retirement in determining the quality of life in people growing old. Nevertheless, the trauma of retirement is very real to many, and the time to tackle this problem has arrived. We have suggested steps which should be taken, such as improvements in the financial support provided to those no longer in paid employment, the removal of the rigidity of compulsory age-related retirement, an adult educational programme which enlightens the increasing leisure periods in life as well as one which prepares for adaptation to change, industry and trade unions which are alert to what they can do, and perhaps most of all, experiments in promoting ways in which we can still make use of and appreciate the contributions of the retired themselves.

If the social policy and public attitudes are modified as indicated above, then retirement will become less of an artificial society-created traumatic experience complicating the difficult enough process of growing older. The health and social services could then concentrate on their double responsibility of promoting for all a capability to adapt to new challenges with use of the individual's own resources and support for those few who will require more specialist help in the face of change.

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PART II

The state of care

3 Support in the home

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The old, alone, and frail at home still present a challenge to the health and social services with which they are not dealing with any confidence. This is not because of a lack of awareness of what should be done, nor is it entirely a question of demand outstripping the services available. The objectives of maintaining independence for as long as possible are clearly established and accepted. The trouble is how to do it; the central dilemma is how to have a personal and careful assessment of needs and then to present in a co-ordinated way the help considered to be right for that person at that time and yet avoid the creation of dependency by limiting the choice to the individual concerned.

We now know much more about the general position of the elderly in the community from both national and local surveys. We know that at any one time, about 90 per cent of old people live at home, and one in three live alone. We expect just over half of those aged 65–74 to have some form of disability and that this could rise to over three-quarters among those over 85 years. We know that of those over 75 years, 17 per cent are appreciably handicapped. Less than half of the 'older' old are able to get out without assistance (1, 2). We no longer need surveys to demonstrate that a considerable problem exists.

The services available

Despite the growth of such facts and figures, we need to understand a great deal better than we do what they actually mean. We should be careful to avoid too rigid a categorization by age-group. Just as individual old people vary considerably in their personal and environmental circumstances, so the problems they face and the range of support required varies considerably. From the start, the services to be provided both

statutory and voluntary, have to remember these vast differences between old people as individuals, the wide variations in the impact of growing old on them, and the rapidly changing social and economic features in the society in which we are all living.

The range of services available is considerable (see table 1). Ideally, these services for the old should be based on a careful assessment of what that particular person requires, bearing in mind what he or she can provide themselves or obtain from their family or community. We lose considerably more than the inefficient use of resources if we generalize our approach too much or fail to build in a maximum degree of flexibility in the delivery of services. Yet the limitations to and the costs of assessment and flexibility encourage the continuation of the present position where the common experience is paradoxically one of overlap and confusion for some in an overall position of considerable shortage.

There is therefore still considerable value in experiments in different ways of meeting the needs of the vast majority of old people who will live out their days in their own homes. In drawing attention to only a few of these in this chapter, we do not want to minimize the encouraging new enthusiasm for pilot schemes which has emanated from the advent of joint financing. It will however be part of the conclusions in this review that the patches of excellence only serve to highlight the greyness over-all, and that more dynamic measures of learning and implementing are now required.

The health/social services partnership

Much of this chapter will be concerned with the need for co-ordination between the services available. It is therefore important to stress first of all that there are important differences between the health and the social services which have to be appreciated if the best use is to be made of both. The National Health Service exists essentially to treat and to rehabilitate those who are ill or disabled; the approach is diagnostic and prescriptive, and the elderly patient and his relatives accept an expectation on them to comply with the advice given. The social services on the other hand provide care and support where the family and the person himself are

unable to cope, and those who wish to encourage the old to do more for themselves often find it difficult due to the expectations of the old, or their relatives, or indeed the local policy-making councillors. Of course, social workers are correctly concerned with a therapeutic approach in the sense of aiming to achieve change in their client's view of their situation or in the attitudes of others. But the 'therapeutic imperative mood' of much of what has to be done by health staff in dealing with disability is noticeably different to what has to be done to overcome any remaining handicap. These differences in approach are reflected in our national fiscal policies for the two services.

The partnership between these two services, on which so much depends, should therefore be viewed against a background of real understanding about the differences as well as similarities in the aims of the services.

The elderly should know the services

Behind the problems and the possible answers lie four general principles which have to be observed if the services are to be comprehensive yet flexibile both in scope and depth. First, the elderly themselves should know the services and how to use them. An independent person will have strengths as well as weaknesses, and therefore the initial requirement is to see that the former are used as much as possible. At the least, this means an advisory service readily accessible to everyone in the community, and backed up with sufficient resources to allow simple handbooks and reference leaflets to be made available. At most, it suggests an adult education and leisure programme within the context of a lively community, so that everyone can maintain a variety of enjoyable and worthwhile relationships with individuals and groups in their vicinity. These activities may have to start off as a deliberate initiative with voluntary societies encouraged to take the lead, but surely they will be regarded in due course as part of the general provision for everyone living in our post-industrial society so that continuing personal fulfillment is possible. In terms of maintaining well-being and preventing early deterioration, the investment required, which is mainly time, must be very acceptable in face of the high cost of the alternatives.

A further and increasingly important part of helping the

elderly to help themselves is the support to be provided for the first line 'carers' in the community. Relatives first and foremost, and friends and neighbours next, deserve much more recognition of their importance. While what may be needed is simply encouragement, much will be gained by the provision of easily understandable advice and guidance on the common day-to-day problems and how to minimize them such as is contained in a recent book, *Take Care of Your Elderly Relative* (3). There is in fact an enormous number of very useful booklets, but they are not making the impact required, nor are they reaching the right people at the right time. Adult education for maintaining health in middle and late years remains pluralistic and generally superficial. There is an urgent need for much greater leadership by for example the Health Education Council, in association with the adult and community education services which we feel are so essential in preparing our society for coping with the flood of the new old.

The combined results likely to be obtained from health education, from continuing contact, and from support given to those helping others make these approaches the vital first planks of the services for the old.

The services should know the elderly

The second general principle to be observed is that the services should know the elderly. This is important in two senses; specifically and obviously, the notification to those in the public services of those elderly people requiring their help; but secondly and more generally, both the professionals within the services and indeed the population as a whole should have a better understanding of what it means to be old. This does not mean simply a greater knowledge of the biology of ageing although this would help, nor does it mean acceptance of the plight of so many old people although this is essential. Instead, it refers to that change in attitude at all levels of the service and in all of us towards avoiding the myths and re-inforcing the stigma of the last of our deserving minority groups to obtain the parity of esteem which we struggle to provide to others. It refers to first recognizing and then eradicating if possible the prejudices of 'ageism' as we now try to deal with

racism and other stereotyped attitudes. We do not have all that long in which to make the change.

The feeling that problems are more easily contained if help is provided as early as possible has naturally led to proposals for reliance on surveys of old people, on registers and on socio-medical screening programmes. Some good work has been done, usually using health visitors to build up an awareness of needs and to draw attention to those at risk amongst the over 75 or even 85-year-olds in the population. However, health visitors remain largely involved with families with young children and may not have the time or indeed the inclination to increase the time they allot to the elderly. There is little doubt that the survey techniques exist and that computer-programmes can be used to build up extensive 'registers' which could then be used to analyse need and to alert the services (4). It may well be that along these lines lie the best approaches for a society to ensure that the dependent elderly are known and the gaps in the services made clear. There is certainly much attraction to the idea that the exposure of a problem is an important first step in getting it resolved.

But there are arguments against such an approach in addition to the obvious ones of cost: these include the sad lessons of experience in screening programmes in other age-groups, and the more general disadvantages from 'packaging' such a large group of very different individuals into a 'register'. To meet these difficulties, we could of course vary the cut-off points; we would then have, for example, a register of 'over-85-year-olds living alone'. As an adjunct to a 'caring' society, this is a sensible development—but more is necessary. A consideration of the points made elsewhere in this study suggests that the best approach is to have a network of good friends and neighbours backed up by an alert and sympathetic primary care team, closely linked to social and other public services. Professional contacts with the old, the attentive family doctor for example, can often by regular visits do more than screening.

To be effective however in meeting the prime objective of maintaining independence as long as possible, a new concept of old age is necessary. There must be an acceptance that life requires challenge, that some anxiety is a useful motivating force, that living means inter-relationship with others and with

one's environment and that this entails some risk. It is therefore essential that both as individuals and as a community we put considerable emphasis on the provision of suitable but not cocooned housing, and on the maintenance of mobility and promotion of meaningful contact so that isolation is avoided. A re-orientation of the services so that priority is given to support and prevention will not be easy. In many ways, it is easier and more re-assuring for staff and also for relatives and neighbours to cope with the needs of neatly labelled and undemanding old people rather than accept the rights of everyone to make decisions which may be more anxiety-creating to others. Nevertheless, a start could be made with in-service training of currently employed staff. By using selected educational approaches, group discussions, role-playing, and video-recording teaching aids we should produce a cadre of professional workers in all disciplines who could then help the community as a whole to see old age and its problems in a very different light. There is here a major challenge to the education and training of all staff (see chapter 11). It is fair to say that doctors, nurses, and the therapeutic professions are just getting round to the importance of education about old age in their curricula.

As well as initial professional training, a massive exercise in in-service training is required. As there are confusions among the different professional groups not only about role but even about who should be able to advise about what, the in-service training should be joint and multi-disciplinary. We would place a responsibility on the Joint Consultative Committees to see that initiatives are taken to establish these joint training sessions with an adequate allocation of priority and resources.

Crisis help

The third general principle regarding support in the home is the greater need for the prevention of crises or the reduction of secondary disabilities. It is perhaps in this field where some of the most interesting experiments have helped to produce a clearer idea of what can be done to provide prompt help in a crisis. There are two requirements to be borne in mind: first, when something goes wrong, the elderly may have little in the way of reserves and so swift and effective help is required;

secondly, the removal of old people from their homes can be so traumatic and the chance of incorrect placement is so high that such a step should be taken only if there is no alternative or if there has been a sound assessment of the sort of help that particular person requires.

There are several ways of trying to provide prompt help in crisis. One of the most developed services is that in Stockport, where a radio-alarm and mobile warden scheme covers grouped housing schemes as well as elderly in aged persons dwellings and individual houses. The scheme provides a 24-hour seven days service in which 16 mobile wardens, provided with equipped vans, answer alarm calls and undertake other visits to old people at risk. A permanently staffed central control has two-way radio contact with the wardens, who can therefore call for immediate help from any of the emergency services once they have answered a call. (For more details, see pp. 235–6). In this way, modern technology is used to call on a prompt statutory service when the person in need presses the button. The costs of such a scheme seem to be comparable to and perhaps cheaper than providing residential wardens in sheltered housing, and there is the added attraction that the alarms can be installed temporarily and in any person's home. In the evaluation of such schemes, their possible effect in interfering with neighbourly feelings and responsibilities should be considered.

The prevention of hasty removal from home requires two types of intensive service, differing according to the nature of the crisis. In this country, the experiments are usually related to 'social' emergencies and the avoidance of admission to an old person's home is the major objective. The essential components of these schemes are 24-hour teams of home-helps and nursing auxiliaries, backed up by social workers and if need be by the primary health care team. The success in terms of maintaining at reasonable cost the elderly person at home until the crisis abates and normal community services can take over, is not yet established but the evaluation of existing schemes such as those in Blakeney and Warrington is eagerly awaited. The gains from not breaking well established links by using 'intervention teams' are likely to make this type of crisis service very attractive. Their use in cases where nursing is required,

relying on already available district nursing services will be of particular importance in supporting the elderly at home.

However, if the emergency is more 'medical', then schemes exist in other countries which may be worth trying, such as the 'hospital at home'. In New Zealand, a doctor provided with a very substantial staff of nurses, physiotherapists, occupational therapists, and social workers, can arrange for extra-hospital care as a complete service as an alternative to hospital admission. It is run by the hospital but about half of the work of the service is arranged by the general practitioner. The service also provides for accelerated discharges from hospital and for the treatment of the terminally ill at home. We urgently need experiments in this country, as the same effects are unlikely to be achieved only from strengthening or expanding the primary care team.

Co-ordination at patient level

The fourth and fundamental general principle is that better use can always be made of the present services by co-ordination and by better understanding of each other's contribution. There is a great variety in the services required. A key element in the home is co-ordination of the help which is available. To the person in need, regardless of age, a multiplication of assistants is confusing and can be alarming. Add into this the demarcation disputes amongst the professions and staff involved and the protective barriers erected, and the problem of the stream of different feet down the garden path is a major one! Many voluntary workers or indeed relatives and good neighbours, are frequently alarmed at the buck-passing between the professions, between the services, between the taxpayer and the ratepayer. It is not surprising therefore that experiments in co-ordination are taking place, but these aim largely at bringing together voluntary help with statutory agencies. Missing so far is a clear questioning of the role of different staff, and even further away are sincere attempts to merge or rationalize the established 'mix' of professional and other staff. There are however encouraging signs, and one or two authorities are beginning to say, for example, that they will not plan again except jointly with the NHS and Housing Authorities fully involved.

It is in the nature of problems in the older person that they are seldom simple; even if the trigger event is clearly social or physical, there is a rapid evolution of a mixed bag of secondary problems. Frequently, the most economical and effective care would be from multi-purpose staff whose skills cross the boundaries between health and social services, and between statutory and voluntary bodies. It is unlikely that the staff groups themselves will be able to consider objectively what is required or initiate the changes necessary as staff organizations depend so much on a clear demarcation of the duties of their members. While much progress can come from the use of joint financing experiments, more extensive action is required and this will involve government intervention and leadership.

The employment of co-ordinators of voluntary services occurs in several places and include the reliable schemes in Blakeney and Leicester (see pp. 223–5). These are surely essential components of any comprehensive service for the support of the elderly at home. We refer later to the fundamental importance of a reliable infra-structure at very local levels, such as the street or village. Without this the services will continue to be patchy and their impact rather by luck than design.

In fulfilling the four principles outlined above, particular attention has to be paid to certain well-known problems in providing services for old people. These can be listed as:

1. The setting of objectives as a joint exercise between the services involved.
2. The importance of *basic* support, in terms of environment (housing, situation), personal factors (nutrition, mobility) and social factors, (contact, meaningful activity).
3. The discontinuity of care, especially at weekends.
4. The particular problems of the isolated elderly.
5. The barriers to good care which come from inter-relationship difficulties between for example, employed voluntary staff.
6. The difficulties of those on the 'margins' of care (5).

The manpower required

In addition, whenever services for the old are discussed, there are sooner or later expressions of anxiety relating to the availability of the resources to meet the demands already being made. In general terms, this question of the priority to be given

to these services is dealt with elsewhere in this report. In the particular case of support in the home, the availability of the manpower required and how it is used is a major consideration. In the health service, the most important group are the nursing staff (see chapter 9). The two aspects of main relevance to this section are: the role of the health visitor, and the amount of their time to be devoted to the elderly; and the effect of the new training scheme for district nurses, and the need for an arrangement in which they have in their control small teams of less qualified staff, home helps or aides, so that they can provide the range of assistance required.

The second group of staff of major importance are the therapeutic professions. It is now widely recognized that physiotherapy, occupational therapy, and speech therapy, are important services in the support of old people at home.

The maintenance of mobility, the re-establishment of speech and the modification of the home and provision of aids to daily living are all examples of the need to provide the primary care team with these skilled staff when required. Although evaluation of their effectiveness is difficult as with many of the health services, we are urgently requiring guidance and reassurance on the best use of the therapeutic professions. But without some clearer support for the contribution which they can give, there will remain an over-all shortage in recruitment and a resultant restriction of their scarce functions to fully equipped hospital units. We have not made progress along the lines indicated in the MacMillan report. We have not made up our minds concerning the use of 'aides'. We are not using volunteers to assist in these fields as already happens in other countries. And we are not looking at the small but perhaps important overlap of role between these staff and community nurses. There is therefore an urgent need for national discussion and new policies so that we can more easily place this valuable group of professions in a comprehensive plan for the support of the old at home.

Two other professions require mention. One of the valuable developments in dietetics since 1974 has been in some areas the deployment of a few dietitians into a community service. As nutrition must be remembered as a vital basic service for the old, this encouraging trend should be supported.

The other profession not yet considered is chiropody. Here we are very close to a national scandal in terms of the failure to clarify our national policy and of willing the means to provide the service which is one which is always emphasized in studies of old people in their own homes. A manpower survey (Association of Chief Chiropody Officers) has shown that the whole time equivalent chiropodists in the NHS is approximately 2000 and there are about 350 vacant posts. In 53·7 per cent of vacancies advertised, no applications were received. Nearly 10 per cent of directly employed staff are already over retirement age, and another 12 per cent of men reach 65 years in the next five years. While figures published in 1978 show that the intake into the chiropody profession increased by an average of 1 per cent p.a. in the previous six years, in 1979 there was an actual decrease in the number of State Registered Chiropodists. The annual wastage rate is 6·3 per cent. There is some national recognition of this worrying manpower position, and at last two new Colleges for chiropody will open in 1980–1. However, it is far from clear how much these will help and there is some support for the gloomy conclusion that they will not make a significant impression on the predicted demand for chiropodists.

What can be done? Assuming the overriding importance of chiropody is maintaining mobility, the first steps must be to use what we have as effectively as possible. A domiciliary service will help 8 to 10 patients in a day, while a transport backed clinic service will treat 16 to 18 patients a day, thus making better use of the professional time of the chiropodist. Another major advantage of a clinic service is that the present and widespread 'perpetual treatment cycle' for the elderly could be replaced by a higher standard of treatment in clinics with good facilities, allowing planned discharges of patients to occur and a larger number of people can be helped instead of the present unwise acceptance of an approach which leads to higher and higher volumes of treatment for small numbers.

In addition, the facilities required for a high standard service should be provided, so that for example a chiropody appliance laboratory is available to all chiropodists to facilitate the care given to patients with severe chronic conditions.

But of fundamental importance is a clear national decision

on the importance of chiropody in the NHS and the standards of service to be provided. In the Report of the Royal Commission, it points out that NHS chiropody is essentially a community service provided for the elderly. Evidence received was that more and better distributed services were needed. The suggestion for more 'foot hygienists' was supported. While we continue to press for the development of chiropody, we must re-emphasize the common knowledge that a simple nail-cutting service frequently makes all the difference between mobility with confidence and being unnecessarily house-bound.

Probably the only way to begin to get the chiropody service up to its correct level is to improve both the status and the salaries offered to chiropodists. A start has been made to the former, but the gap between NHS and private practice income levels is still too great. Once we get the recruitment we require, then the rather obvious need for more colleges of chiropody will surely be recognized. In the meantime, the provision of a simple nail-cutting service, as being pursued by voluntary bodies such as Age Concern, must remain high on any list of services for the elderly at home.

Conclusion

The support for old people in their own homes depends on first of all ensuring that they move into this period of their lives as well protected as possible in the sense of their personal environment, their nutritional state, and their living standards and habits especially in relation to social contact. The prompt provision of aid during crisis will prevent the breaking of links too easily done and yet very difficult to mend. Finally, the steady, co-ordinated assistance in daily living as independence moves in fits and starts towards more dependency will probably ensure that a majority remain at home for most of the time in their final years. The need for institutional care must be seen as a function of the level of disability in the people at home and of the amount of community services available.

There are two major conclusions. The efficiency of care will depend on clear national and local policies about priorities and about co-ordination of the services available. The implementation of a comprehensive service when required will require the resources in numbers and skills and the ability to bring

voluntary and statutory together effectively. But it is no longer acceptable that this is left to happen only where a happy coincidence of devoted and motivated individuals is already there. We need a simple method for ensuring that every community has someone accountable for initiating a co-ordinated service and for highlighting those deficiencies which hold back a minimum service which could deal with the vast majority of the basic needs of older people in their own homes. However much pragmatic support is at present being provided, it is usually only started with benefit of hindsight and after an emergency has occurred. The key for the future must be an approach based on anticipatory alertness and assessment, by the individuals themselves but particularly by the services concerned.

Acknowledgements

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Annex

A checklist of services for support in the home

Service	Provided by
1. Pension	State
2. Age related financial help, tax benefits, special savings plans	State
3. Adult education, leisure programmes	County Council (Education) Universities Voluntary societies Commercial concerns
4. Own home, assistance with maintenance, repairs, adaptations for safety and comfort	County Council (Social Services) Voluntary societies
5. General practitioner and primary care team	National Health Service (District Health Authorities)
6. Cut-price schemes, transport entertainment, hairdressing	District Councils Transport authorities Business and commercial concerns Voluntary societies
7. Clubs for the elderly	Voluntary societies County Council (Social Services)
8. Luncheon clubs	Voluntary societies County Council (Social Services)
9. Health Visitors	NHS District Health Authorities
10. Aged persons dwellings	District Councils (Housing)
11. Street or village wardens schemes	Voluntary societies County Councils (Social Services)
12. Nail-cutting service	Voluntary societies
13. Sheltered housing	District Councils (Housing)
14. Home Helps	County Councils (Social Services)

15. Aids to daily living, occupational therapy	NHS District Health Authorities County Councils (Social Services)
16. Special adaptations to the home	District Councils (Housing) County Councils (Social Services)
17. Nursing auxiliaries	NHS District Health Authorities
18. Meals on wheels	County Councils (Social Services)
19. Telephone	County Councils (Social Services)
20. Domiciliary laundry service	County Councils (Social Services) NHS District Health Authorities
21. Library service for the housebound	County Councils Voluntary Societies
22. Social worker service	County Councils (Social Services)
23. Domiciliary physiotherapy	NHS District Health Authorities
24. District nursing	NHS District Health Authorities
25. Night nurses	NHS District Health Authorities
26. Day centres	County Councils (Social Services) Voluntary Societies

4 Family and other non-statutory care

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It is, sadly, still the case that uninformed commentators decry the part which families play in caring for the elderly. It is not like it was in grandmother's day, it is implied. Indeed it is not, but not in quite the way these commentators have in mind.

In the first place, middle-aged women, upon whom the main family care of the elderly still falls, are relatively fewer. In 1901, for every 100 elderly persons in the general population there were 83 women aged 45–59. By 1971 this ratio had dropped to 49.

Secondly, over half the married women between the ages of 45 and 60 were in paid employment in 1971, compared to less than 10 per cent as late as 1921. Married women in this age-group are more likely to be working than married women in any other age-group, with the result that they have become either increasingly unavailable to care for the family's dependent members or they are finding it necessary to carry out this function as well as work outside the house (1).

Thirdly, as a recent survey of people aged 75 or over in four urban areas shows (2) 30 per cent have never had any children and another 45 per cent have had only one or two. The average number of children per completed family in mid-Victorian times was 5·5 to 6·0, and even those married in 1901 had well over 3·0. Among the many women living alone in 1978 almost 40 per cent had never had any children. Some of those who had had children have outlived them so that at the time of the survey 35 per cent of all respondents had no living offspring. Another survey showed that 5 per cent of elderly people living alone had no living relatives of any sort.

Yet where there are children support is often given. Abrams noted that:

> of all those with a surviving child one in six live in the same dwelling with them and another two in six live very close to them . . . altogether 62 per cent said that at least one child lived either with them or within six miles . . . Almost three-quarters of those with surviving children saw one of them at least once a week during the four weeks before the survey (3).

Where substantial care is needed by the elderly there is evidence that it is often given even to breaking point. A small survey in Islington, for example, asked whether elderly people needed help with self-care activities such as dressing, bathing, going to the toilet, cooking, cleaning, and shopping. Those living with relatives were found to be the less mobile: of these 26 people, six needed help with all these self-care activities: but none received much help from others outside their immediate household. The survey concluded that:

> relatives caring for old people are more likely to bear the sole responsibility for their care. The majority can only leave their relatives unattended for a few hours while shopping. They are usually unwilling to leave their relatives for longer with a minder or else they are unable to find someone to sit with their relatives . . . Our over-all impression is that families and partners caring for elderly continue to do so against the odds receiving very little advice or practical help.

In a study of 850 'good neighbour schemes', Professor Philip Abrams found that 'good neighbours' are rarely neighbours as such—90 per cent of such caring is done by relatives, mostly women.

The 95 per cent of elderly people who live in the community (as opposed to being in an institution of some kind) live in households composed as follows (4):

	% of all aged 65 and over
One elderly person alone	29·6
Couples, of whom one or both are elderly, or elderly siblings	46·9
Elderly person or couple with next generation only	12·5
One or more elderly with others	11·0

It may be seen from this, first that nearly 30 per cent of the elderly live alone. We have seen that many of these have no family to give them help, and as they grow frailer these people particularly will need to look elsewhere than family for it. Secondly, the table shows that nearly half of the elderly live with one other person who is also elderly: they will often be able to give each other considerable support, but may also need additional help from elsewhere. Finally, there are those, nearly a quarter, who live with others who are not elderly: these may be better placed for help from within the household but, as we have seen, those who give it may not be able to manage indefinitely or without a break. In many cases it is not reasonable to expect the family, or the household, to cope with the frailty and infirmity which may arise. To whom else can they look?

It has become common to sub-divide caring support into the informal, the voluntary, the statutory, and the commercial (following the Wolfenden Report 1978). The informal includes the family, whose support we have been examining, and also includes friends and neighbours. It is clear that friends and neighbours have a much more limited role than family. They may perhaps be able to light fires, cook meals occasionally, or collect prescriptions, and these are important and might even enable some who would not otherwise do so to remain independent at home. A survey in the Scottish Borders in 1971 showed that 78 per cent of elderly had visits from friends, and 66 per cent from neighbours: 4·7 per cent of friends visited daily and 33·6 per cent at least once a week; 17·2 per cent of neighbours visited daily and 24·4 per cent at least once a week: though what 'visits' implied is not clear.

One may, in sum, agree with Michael Bayley, who has written:

> . . . the basic, primary, first line care is provided by the informal system of family, friends and neighbours. The other systems need to acknowledge and recognize this in the way they structure and organize themselves. Just one example of the way official thinking fails to acknowledge this can be seen in the description of the GP and the domiciliary nursing staff as 'the primary care team'. They are not. The family and their allies are the primary care team (5).

Family, friends, and neighbours are 'informal' because they spring from no formal organization. Through the chances of birth, or bonds forged in other ways, they are motivated to offer help. Nevertheless the informal can be seen to shade into the formal, for similar duties are undertaken by volunteers organized—albeit very loosely maybe—by community groups; or by a 'Fish' scheme operating on a parish scale; or by an Age Concern organization covering a town. The aim of 'Fish', as of Age Concern, is not to take the place of normal neighbourliness, but rather to stimulate and extend it by providing a link between people who are in need of support through illness, stress or loneliness, and other people who would like to offer help, but do not know where it is required. Age Concern Leicestershire, to take another example, have 81 'Contact schemes', providing neighbourhood contacts who may just make check calls to see that all is well. 'Others', as Age Concern Leicestershire writes in their booklet about the scheme, 'with a little more time to spare, call in for a chat, talk over a problem, pass on useful information, or give practical help by arranging some shopping, collecting a pension or prescription'.

It is difficult to assess what effect the organization of volunteers in these ways has. One person who was responsible for organizing a good neighbour scheme in a Lancashire town observed: 'our impression is that about half the people were already good neighbours, but only identified themselves as such because of the scheme. The rest became good neighbours for the first time'.

Volunteers may of course be recruited by statutory bodies as well as by voluntary organizations. Social service authorities may use them for a variety of activities, and a list prepared for

a study of volunteers in social work departments in Scotland included driving a minibus or car to take clients to day care, shopping, cooking, diversional therapy, staffing lunch clubs, and providing outings or holidays. In Glaven, N. Norfolk, a GP initiated and developed a scheme based on a day-centre in the village: in addition to the facilities in the centre there are now the services of over 200 volunteers dispersed over 12 villages, who supplement the meals on wheels and home-help service, provide reliable nursing cover in the home and the day-centre, and operate a 'drive out shopping service'.

This description of who arranges services for the elderly must at this point however come to a demarcation line. It must go on to discuss one aspect of the organized, formal, services, some statutory, some voluntary, whose aim is to underpin, provide backing and encouragement for, the great primary care 'team' of family, friends, neighbours, and volunteers. Statutory services are described elsewhere in this book. Here I want to assess the contribution of the voluntary organization.

In sheer quantity there can be no doubt of its importance. It was estimated in 1977 that the whole-time equivalent of 267,000 people were engaged in the voluntary personal social services, which compared with 200,000 in statutory services. The elderly attracted one-third of all voluntary help and there is no doubt that the voluntary organization has a full share in the care of the elderly, as in other social welfare.

It is however fashionable to question what is the raison d'être of the voluntary organization in the latter half of the twentieth century. Sneering references to 'do-gooders' abound, as if doing good was at all events to be avoided, or became something better if people are paid to do it, and better still if it is the state that does the paying. Some voluntary bodies have invited such criticism, for 'Lady Bountiful' is not quite dead; and self-perpetuating voluntary groups do not necessarily keep up with the times or with professional practice. Nor is it true, though some of them claim it to be, that they alone have the 'pioneering role'; that they have it at all may justify their existence, but they share it with the statutory. It cannot be denied that they may do certain things in basically the same way as the state does, but there are arguments for their doing so either because they can sometimes do them at less cost, or because if they did

not do them no one would, and total provision would be that amount less; or because there is real value in variety and choice for the client. Finally, there are some things that only the voluntary, independent, organization can suitably be expected to do. All these points may be put forward with respect to certain of the services provided for the elderly by voluntary bodies.

The provision of accommodation for old people epitomizes a number of the virtues of voluntary effort. For forty years—beginning during or even before the Second World War, and well before the 'welfare state' as we know it—residential homes were opened and managed by voluntary organizations. Today they still provide one-sixth of residential care (24,000 places) in England: they offer it in Homes for people who like to live with others of similar faith, or occupation, or interest; for people with special physical needs; for people who want to return to live in a certain locality. By specializing in these ways they can draw upon financial support that would not otherwise be available, and they offer alternatives to the less discriminate residential care offered by the local authority. Some voluntary bodies are turning to providing more nursing care, for those who have grown in need of it whilst in their residential Homes.

In the field of sheltered housing a similar story may be told. The Abbeyfield societies offered a new line in hostels for old people in the early 1950s: housing associations sprang up in quantity in the 1960s and since, and now provide about 30,000 independent units of accommodation with warden and communal facilities, especially for those for whom local authority housing might not, e.g., on grounds of residential qualification, have been available. Again, some of these are now extending their concepts of continuing responsibility by adding units with extra care for those who come to need it.

The provision of accommodation is something which it is good that the voluntary organization undertakes, alongside the state. This is true too of the provision of advice and information, and indeed in some respects this is a role which only the independent organization can suitably undertake. The citizen needing advice wants to be sure that it is unbiassed, and if he needs advice on matters affecting local authorities or government departments he will not be convinced of a lack of bias if

the source of advice is a part of one of those authorities or departments, or if there is any suspicion that it is under their control in any way.

In a valuable report published in 1977 the National Consumer Council reviewed Local Advice Services (6). It concluded that in some of them there was a real place for trained volunteers: because the cost of provision was lower that way; because 'they can quickly see the point of view and sympathize with the layman who walks through the door, because they are so nearly laymen themselves. Also they often have a marked sense of dedication and are prepared to work at inconvenient times'; and because of the independence which has already been referred to.

The report went on to draw 'a simple analogy with the medical profession, those who are ill usually first consult their GP. If he cannot deal with the problem, he refers them to a suitable specialist. The same sort of argument should apply to those in need of advice and assistance.' The NCC sees the Citizen's Advice Bureaux 'as providing the basic local general practitioner service that would be the foundation tier of a properly integrated local advice structure', preferably with more bureaux serving quite small populations, for ease of access. The CAB would call in those with specialist knowledge as required, and this could in the case of the elderly include local Social Service Departments, Age Concern organizations and so on. These proposals seem to be worthy of development, and indicate an important input for the voluntary organization and the volunteer.

So far this paper has been concerned with outlining some of the ways in which voluntary and independent effort can help in meeting the needs of the elderly. It has been made clear that whatever is undertaken by other sectors of care, it is the family, where it exists, which has the prime responsibility and carries by far the major load: others—friends and neighbours, unofficial organizations, the statutory services, are able to provide restricted but selective support which if properly applied may make all the difference, as it were at the margins, to the ability of the family to continue its care. Even though marginal, however, their importance and the scale of the unofficial operation is such that its development cannot be left totally to

chance: the state in some form is expected to take an interest in the quality and quantity and incidence of what is being done. The importance of the relationship between statutory authorities and the voluntary and private sectors is great.

There are a number of aspects to this. In the first place it is essential that there is close collaboration between them, so that best use is made of all facilities. This is not happening as it should. Voluntary organizations providing services with small grants from local authorities are having those grants cut, to save public expenditure at the behest of the government, apparently without adequate thought for the large effects on what they are doing which a comparatively small saving made in this way has upon them. Voluntary residential homes taking old people with small means are unable to continue doing so because social service departments are unwilling to continue to help with the payment of fees, so that such homes must either reduce costs by reducing standards, or raise funds from elsewhere, or take only people who are better off: in other words, they must either change their role drastically or close, and this is forced upon them not by any policy planned by them and the local authority but by the total absence of planning.

Secondly, though the authorities which register private and voluntary homes are responsible for ensuring that standards of care are adequate, this is often very inadequately pursued. In some departments there are designated officers who do a good job of liaison with these homes, and are looked to for advice on many matters. In others, this function is regarded as of low priority and there is no such liaison. Recent examples of abuse of the vulnerability of old people in private homes have highlighted the problem, and the DHSS is considering experimental appointments of inspectors, on the lines of HM Inspectors of Education. In the meantime however there is considerable support being given to non-statutory homes by the Homes Advice service of the Centre for Policy on Ageing, which can readily advise on matters common to all homes and areas, but does not claim to have knowledge which is essentially local. A part could be played by local voluntary bodies like Age Concern if they made a point of getting their visitors into residential homes and taking a systematic interest in what

they saw going on: but there is no sign of any such proposal being promoted.

This leads to a third point, that though voluntary organizations have an important part to play they often cannot do so effectively without some statutory financial 'pump-priming'. This applies to the organization of voluntary workers, whether for visiting or car-driving, providing a meals service or a library service, or running a day-centre: a full-time organizer, almost certainly on a paid basis, is generally required, and to find a salary is not always readily achieved by the voluntary organization otherwise suitably equipped to undertake the responsibility.

The same point applies to a quite different matter, the improvement and modernization of residential homes: the sort of capital sums which are required, for example to put in a lift or create single bedrooms out of rooms shared by 3 or 4 residents, is not easily raised from the public yet cannot be borrowed from statutory sources. This is in contrast to the situation in which voluntary housing associations providing flats or bungalows are placed: there are two sources of statutory funds for them—the Housing Corporation and the District Council. It is an anomaly that where homes for the elderly are concerned such pump-priming funds are available only from limited charitable sources such as the Hayward fund of the Centre for Policy on Ageing.

This chapter has been about a subject which is uppermost in the minds of the present government. For philosophical reasons—a belief in the individual and the entrepreneur (voluntary or private) taking the initiative rather than leaving everything to the state—and for economic reasons—a belief that this is a way of keeping public expenditure and inflation within bounds—the government claims to wish to encourage non-statutory sources of support, for the elderly amongst others, of the kind we have been discussing. That there may be no great reservoir of untapped support within the family seems clear, but if only a small percentage increase was achieved, so great is the part the family plays, this would make a considerable difference. That volunteers and voluntary organizations might add something to their endeavours, with a worthwhile marginal effect, is very likely, but only if statutory support and

encouragement and collaboration is maintained and fostered. That the private sector will increase in certain fields, such as private residential homes for old people, seems likely, but this will require liaison and supervision from the statutory if it is to play a satisfactory part. A positive approach on all sides is required.

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5 Residential accommodation

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For those elderly people whose needs cannot be met in their own homes, with whatever degree of support from relatives, neighbours, friendly voluntary helpers, and statutory home care services, and whose physical and mental condition does not require constant medical and nursing attendance, special residential provision becomes necessary.

Part III of the National Assistance Act 1948 placed a duty upon local authorities to provide such accommodation for those in need of care and attention 'not otherwise available to them'. With the abolition of the last vestiges of the Poor Law—Part I of this same Act states with unequivocal simplicity that the Poor Law shall cease to exist—came the gradual replacement of the large institutions which once housed the aged poor by smaller 'homes' which sought to provide essential care with recognition of the individuality and dignity of the 'residents', no longer institution inmates.

Part IV of the Act required local authorities to register and inspect similar homes provided by private persons and voluntary organizations.

Over these thirty and more years the old people's home has fulfilled the indispensable function of a place of care and safety for old people who would otherwise be at considerable risk in their own homes or unnecessarily occupying geriatric hospital beds for social rather than medical reasons.

Yet, during these decades, there has been considerable change in these homes and in recent years much discussion and debate—if not amongst the public at large, at least within professional circles—about their role and purpose.

The homes have tended to become smaller. The thousand-bed and more institutions of the Poor Law gave way to homes

of a hundred and less and now, typically, of fifty, forty, or thirty places (1).

While this tendency to smaller, therefore homelier, homes, has encouraged increasing attention to the individuality of residents and the expression of personality, a counter-tendency has been provoked by the increasing age and frailty of residents for whom these homes have catered.

The improvements in living standards of elderly people within the community—in health provision, housing, social services and income levels—have given more people than ever a longer life and helped to sustain the great majority in their own homes for the whole of their remaining years. In consequence those admitted to old people's homes have tended to be amongst the eldest, most infirm, and most confused. By now the average age of residents in local authority old people's homes is in the mid-eighties.

The smaller the homes, the older the residents, the more difficult does it become to achieve the design of buildings and the kind of living arrangements which can successfully reconcile the conflicting needs for privacy and individualism on the one hand and the facilities to cater for the special needs of very infirm, sick and confused old people on the other (2).

There can be no under-estimating the problems facing the most enlightened home manager seeking to establish 'homeliness' whilst coping with severe incontinence, senility, and all the toil of physical coping with washing, dressing, feeding, and caring for perhaps 40, 50 or more, octogenarians and nonogenarians day after day, night after night, as a permanent way of life. The high level of infirmity with accompanying physical and mental ailments dictates a correspondingly high level of nursing care. The dividing line between old people's home and nursing home becomes increasingly thin and difficult to maintain (3).

In such unpromising circumstances, wonders are frequently performed, with numerous examples of excellence both in physical provisions, standards of care, and promotion of opportunity for individual self-expression and development.

The style and quality of living in an old people's home is obviously governed by many factors, including the environment, structure, organization and management of the home,

but most fundamentally of all by the nature of the relationship between the caring staff and the residents. This relationship is what mostly matters, not only in general terms between staff as a group and residents as a group, but in the particular sense of the relationship between person and person—care assistant and individual resident.

If staff are indeed the key factor, not just the Officers in charge but all the staff, then it is a matter of the greatest concern that they should be carefully selected and then given maximum help and support through training, discussion, and constant ready back-up.

The old people's home provides for its residents a total living experience, not a treatment centre from which the patient goes home at the end of a session or upon discharge, nor a private self-contained home where others visit to give service and depart. This home is a place for living and a place for working—residents and staff sharing every experience in the closest proximity. How well or how badly residents and care staff communicate and inter-relate determines whether the home is a place which can satisfy the needs and hopes of those for whom it is home (4).

It is said that voluntary organizations succeed better than public authorities in providing the atmosphere and opportunities for individuality and personality to flourish. The voluntary organizations are likely to have less rigidity, less conformity to externally imposed rules, and thus the better chance to adapt the home to the people within it. The local authority is more obviously accountable and therefore sensitive to criticism, with a resultant caution and reluctance to extend individual freedom lest it means taking risks and making mistakes.

Though there may be some truth to such generalizations, it is more true that each home—whether local authority, voluntary, or private—is different and there are examples of good, bad, and indifferent in each type of establishment. Some generally different characteristics may be accountable, however, to the variations in clientele for whom the various homes cater. Voluntary organizations may be more selective in allocating places, private homes obviously need to satisfy commercial as well as welfare interests, while local authorities must

meet the whole range of needs presented to them which are not otherwise met.

Despite the differences, there are compelling reasons why there should be pressure to uplift standards by eliminating outdated ideas which restrict residents' freedom of choice within the homes. As new generations of elderly people come in need of residential accommodation, their expectations are based upon their own previous experience of higher living standards, better education, and less acquiescence in what others order for them (5).

There are, or will surely be, expectations of single rooms, private washing and toilet facilities, personal furniture, and opportunity for continuing social interests. The problem is that inherited building design usually frustrates such development so the challenge will be for maximum flexibility and adaptation in both structural and human terms to the changing needs of our old people.

These general arguments and considerations cannot hide some of the difficult particular concerns which must be seriously examined and for which specific answers need to be found. Amongst these is the question of how best to meet the needs of those old people whose mental state is such that they must have a high degree of personal care and whose behaviour is extremely distressing for those other old people with whom they share a home.

This is a controversial area because of a natural desire on the one hand not to segregate people, while on the other hand there may be a limit to the tolerance which can reasonably be expected from old people who must share their daily lives with others they find much too hard to cope with (6).

Sensible grouping within homes may often be helpful, but in the end there seems no better alternative but to provide specially designed and specially staffed homes for those elderly mentally infirm people. Furthermore such homes can play a positive role in providing short-term care for hard pressed relatives as well as rehabilitative care and treatment for old people then able to live in the ordinary homes.

The question of suitability and compatability within the home is no easy matter to resolve, particularly for the local authority. If old people are not to be shunted from home to

home, as they get older, change, and deteriorate, then initial allocation is critical on the basis of skilled assessment and, after admission, continuous regular progress reviews (7).

The residential worker's task is a highly skilled one in recognizing, supporting and enhancing individuality within the group setting. That the group consists of very old and infirm people makes this task harder but no less necessary. Understanding and coping with physical and emotional conditions and problems requires knowledge, skill, and a high level of commitment to serve a group of people of advanced age, with the probability of failing sight, hearing and mobility, and short life expectancy (8).

These staff need every help to support the old people in dealing with loneliness and apathy, incontinence, sexual relationships, death and bereavement, and in finding ways for residents to share in the management of their own lives, whilst preserving the privacy and dignity of the individual. A new need is now emerging to cater for the distinctive needs of elderly people from ethnic minority groups (9).

Much of the positive thinking about the present and future role of old people's homes within the general context of the care of the elderly is bedevilled by the increasing pressure upon those homes to relieve urgent problems elsewhere, whether to reduce the occupation of hospital beds to enable other admissions to take place, or to provide a safe haven in an emergency within the community. Such pressures may well override planned policies for individual homes and may set aside the social priorities within the long waiting lists which local authorities have to bear (10).

It is unrealistic therefore to ignore the quantitative level of provision of places in old people's homes while considering the role, purpose and quality of the home in providing care as part of the general health and social residential accommodation. There is an inevitable compulsion to find some place somewhere, whether well chosen or not, to provide a place of safety to meet desperate need.

Not only does such shortage create pressure and reduce the standard of care, but it removes from old people themselves, and their families, the freedom of choice which should lie at the heart of planning for the elderly person's future welfare. Even

at the maximum, choice cannot be asbolutely free, meaning by that unlimited freedom. Freedom of choice means the right to choose within the limits of suitability, given the individual's condition and capability. Choice of area, of type of home, of particular establishments, of companions; choosing by reference to informed advice, to reliable opinion, to reputation, to trying out; these are some of the ingredients of free choice. For most old people, however, in these days, and for their families, desperate needs dictate immediate acceptance (11).

It must be said, however, that in the last few years of financial stringency in public expenditure there has been little progress in making good these shortages, and the present indications of central government policy for the years ahead give no hope of improvement for the foreseeable future.

With this pessimistic forecast it can be said that the old people's home as a positive feature in the context of the general welfare of the elderly is under threat. If past pressures of demand persist, or even increase, from amongst the ageing community, then the chances for improved standards for a rising generation of elderly people with enhanced expectations can only diminish.

If the gap in residential provision cannot be made good by the local authorities, then is this the opportunity for voluntary organizations to meet the needs? It must be said, however, that these bodies are by no means exempt from the financial problems with which the public services are confronted. Or can ways be found whereby private commercial enterprise can provide the necessary services whilst better systems are introduced to safeguard standards and ensure care is not subordinated to profit?

Or can support in the home be yet further developed with extensive home care services embracing the whole width of practical help schemes and good neighbour links within the community? Or can new answers be found in adapting the concepts of sheltered housing schemes to provide for more of those who need substantially more care than has generally been the case hitherto?

Perhaps these are not a list of alternative options but rather indicative examples of the comprehensiveness of an effective

care and support programme for the elderly within which the old people's home is but a part, albeit a crucial one.

Towards partnership

The conceptual link between old people's home and sheltered housing scheme is close. Housing and social care are provided by both and the difference is in the degree and balance between these elements.

The changing social scene amongst the elderly people in our nation requires readiness to move from rigid provision of services, patterned more often by the statutory structures or traditional philosophies of the providing authorities than by the needs of people.

The differing needs of elderly people require differing responses with as varied and extended a gradation of residential provision as possible, not in order to move elderly people along a downward escalator, but rather to offer choice and better alternatives by which to sustain individual capability with helpful support.

This argues for variety in the range and types of old people's homes, capable in design and staffing of meeting a range of needs from the physical problems of mentally alert retired people to fairly severe conditions of senility. Similarly there is scope for considerable variation in sheltered housing with degrees of care provision from minimal visiting services to intensive residential care provided by trained assistant staff.

Between the polarized extremes of old people's home and sheltered housing scheme every possibility exists to bring together the best features of each. The old people's home with its linked housing scheme; the 'mother home' with dispersed housing units; the sheltered housing scheme with adjoining residential care unit; housing schemes with visiting or resident warden services plus care assistants and a range of home-care workers. These and other possibilities provide housing plus care in a variety of ways which break down the barriers of health, housing, and social services authority structures.

Such inter-agency arrangements serve people but they create administrative problems, including financial anomalies. Comparing the statutory financial conditions for residents of old people's homes with the rent schemes for tenants of sheltered

housing schemes, and the financial exemptions for health services reveals anomaly enough, but if services are to be provided across the administrative boards, the financial complexities are alarming. If these are obstacles, however, to meeting real needs in ways which are fitting, then they are obstacles which should be overcome. Once again, the voluntary organizations are well placed to achieve housing care schemes unhindered by some of the constraints placed upon or assumed by statutory bodies.

Alliances between housing associations and voluntary welfare agencies can be fruitful in introducing more new schemes with variety of provision and management. It should also not be impossible to extend such voluntary schemes into partnership arrangements with local authorities and health authorities, possibly with the aid of joint financing arrangements, so that yet more comprehensive schemes can be developed.

The whole residential sector, in all its varied forms and possibilities for the welfare of old people, is not a world apart from the private lives of old people in their own homes, with their own families, or in their own familiar neighbourhoods. Residential care is part of community care, that is linked within the geography and social context of the neighbourhood. Moving into residential accommodation must not mean moving out of the life once known.

To the extent that residential services, no matter by whom provided, offer choice to old people fitting to their current and changing needs, without surrender of personal freedom and dignity, but with the sense of security and support which their condition may require, then will a proper response be available to old age in a caring community.

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6 Sheltered housing

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The earliest sheltered housing schemes were built in the west country soon after the end of the Second World War and subsequent expansion, particularly in the last 10 years, has been rapid. In 1963 it was estimated there were approximately 36,000 elderly people residing in sheltered housing schemes; Audrey Hunt (1) in 1976 estimated that the figure had increased to 300,000 persons. These statistics have been further up-dated by the recent research conducted by Oxford Polytechnic (2) which indicates an overall total provision of warden assisted dwellings in Great Britain of 492,000. This is equivalent to nearly 7 per cent of the 65 and over elderly population.

It is apparent therefore that this particular development in the care of the elderly is popular and successful and encourages housing authorities to continue building accommodation of this type. By comparison, other forms of residential care for the elderly have lagged behind in the wake of what Derek Fox, previous Housing Advisor to the Department of the Environment, described as 'The Great Local Authority Success Story of the Last Decade'.

In addition to sheltered housing schemes, local housing authorities have always attempted to provide suitable accommodation for the elderly. The recent Leeds Study (3) showed that between 1945 and 1960 just over 202,000 small flats were provided for rent and also between 1966 and 1971 a further 380,000 similar units were added. The total accommodation thus provided amounted to 27·3 per cent of the then total housing authority house building programme.

These figures represent the comprehensive view taken by the local housing authorities of housing responsibilities which include the housing needs of the elderly, and therefore the

building of adequate and comfortable accommodation in which elderly persons can live out their retirement in happy surroundings. The social services and the health service also have similar aims in providing residential accommodation for the elderly and it is here that we begin to see the necessity of close co-operation and planning between the three statutory authorities to ensure that the total residential care needs of the elderly can be met in the best possible way within existing resources.

One of the reasons for the success of sheltered accommodation compared to other types of provision relates to the preferential financial funding that it receives. Initially, sheltered housing was encouraged by County Council subsidies to District Councils towards the management and running costs of schemes. They provided support for the welfare aspects which usually included the employment of a warden, suitable intercommunication system, communal room, and other similar facilities. Accommodation was therefore provided for those elderly persons who otherwise would not be able to retain their independence and would have had to be taken into Part III residential accommodation. This latter solution was considered to be an expensive and inferior solution. It is a feature of sheltered housing schemes that they allow elderly persons the facility of a legal tenancy which is carefully preserved by the local authority. In this way they retain their independence, although it is becoming more apparent today that some of the residents reach the stage that, even with the assistance of a warden acting as a 'good neighbour', they are no longer able to care for themselves and the need can arise for their transfer into Part III residential accommodation or hospital.

The 1972 Housing Finance Act removed the necessity for County Councils to continue their subsidy towards sheltered accommodation which instead attracts along with other forms of local authority housing provision, a 66 per cent capital cost subsidy. Up to the recent housing expenditure cutbacks, the only significant constraints upon a local authority to build this type of accommodation was site availability and planning considerations, providing that the political will was there to provide schemes. Sheltered housing accommodation has proved popular with elderly people themselves and also with the

elected members of local authorities concerned with the house building programme. These factors alone account for its proliferation since the Second World War and the situation contrasts starkly with the constraints upon the provision of other forms of residential care of the elderly. For example, loan sanction to provide Part III residential accommodation has, over the years, proved difficult to obtain.

There is also an anomalous situation with voluntary residential care in that voluntary groups involved with this type of provision cannot get capital finance from any statutory source.

It could be argued therefore that the proliferation of sheltered housing is partly due to the comparatively easy way it can be financed and provided, compared to other forms of provision. The situation is also paralleled by Housing Associations who receive in effect 100 per cent subsidy towards the cost of providing sheltered housing schemes.

We have to be certain, therefore, that the growth of sheltered housing does not arise solely from its comparatively easy access to finance but that its popularity is due to a natural demand arising from the way it solves many of the housing and care problems of elderly persons.

Sheltered housing schemes assist with the problem of elderly people living on their own who cannot otherwise manage and need the facility of a warden who can respond in an emergency. They also assist with other aspects of the general housing problem. For example, a significant number of family houses in both the private and public sector housing are occupied by elderly persons over the age of 65. Circular 76/77 'Better Use of Vacant and Under-Occupied Housing' stated:

> We need to develop a more versatile range of dwelling types which can be organized to cater for the growing demands for small households and large families. There is an over-supply of three bedroom dwellings in both the public and private sectors.

If elderly people move to smaller dwellings then family type dwellings are released onto the housing market which lessens the pressures in both the public and private housing building sectors to provide new family homes. In this way better use can be made of our total housing stock.

Sheltered housing is therefore known to be attractive and to provide the incentive for elderly people to move and so often achieve the release of a family house. This trend runs counter to some of the views expressed by the Department of the Environment that provisions should be made through the supportive services to assist the elderly to remain in their original homes. It would seem, however, that there is room for both approaches in providing a choice of alternative forms of care to the elderly.

Another benefit from the provision of sheltered accommodation is that through the communal facilities and the encouragement of social activities by the warden, the problems of loneliness can, to a large extent, be overcome. It has always been assumed that loneliness is one of the major problems of old age although recent research carried out by Stockport Metropolitan Borough has indicated this is not universally the case. Nevertheless, the evidence from a number of sheltered schemes indicates that many residents appreciate the extensive social contact that they have with other residents within the scheme.

Perhaps the most important aspect of sheltered housing is the degree of independence that is enjoyed by the residents and it is this factor which can provide a therapeutic benefit quite apart from its attractiveness on ethical grounds.

Having established that sheltered housing has a significant part to play in the residential care of the elderly, then it is important to consider which is the best authority to manage this type of accommodation.

The resident of sheltered accommodation is in a different legal position to that of a resident in a Part III residential home—the former for instance cannot be permanently transferred to hospital without formal agreement, the latter in practice can. This is one reason underlying the debatable issue of whether housing or social service departments should manage the tenancies. The principal argument against responsibility being with housing departments is that the normal Council housing allocation scheme is often the basis for the granting of tenancies and is unsatisfactory in the case of the elderly as some of these schemes undervalue social factors compared to position on the waiting list. On the other hand it

may be better for the older person not to be classified as a 'social problem' as is the probable assumption if responsibility lies with the social services department. It is also argued that the independence of elderly residents will be more readily preserved by the management of separate tenancies allocated and managed by housing departments. The resolution of this debate is not unconnected with argument as to the division of responsibility between the social services and the health services for admission to residential homes. Close inter-working between all three departments in the allocation of tenancies, management and planning is the best immediate answer.

Our elderly population is increasing disproportionately to the remainder, notably in the 75+ age-group. Already long standing existing sheltered schemes comprise mainly frail, very elderly residents which cause special management problems. Many of the earlier sheltered housing schemes and even some in recent years are designed and managed with no deep thought about their long-term objective and future use. For example, some do not have adequate warden relief or a proper inter-communication system. This situation has to be seen against the background of reduced provision of residential care and a concept of the hospital/community relationship which will place an even greater burden upon sheltered schemes. Symptoms are therefore emerging of the problems of dealing with the very elderly in sheltered schemes. Wardens are in fact complaining that, due to the ever increasing age of the residents, much more is now expected of them than a good neighbour relationship. Qualifications, experience, and training will become increasingly more important if they are to provide for the changed situation. Schemes increasingly need 24-hour cover which will require the employment of relief wardens. Modern inter-communication must replace obsolete systems. Future options could include facilities for nursing care as a sort of half-way house between the concept of sheltered schemes and Part III residential accommodation. Communal facilities could also be used as luncheon clubs on a local basis.

The problem of the ageing population within sheltered housing is not the sole reason for the problems which are now confronting managers of these schemes. The provision of residential Part III homes is dropping behind demand due to

the lack of finance and also a change in attitude on the part of the Health and Social Services which concentrates more upon treating elderly patients with a view to them remaining in their own homes except for temporary transfer if needed to more intensive care. The effect of these policies is a greater dependence on the part of the community services upon sheltered housing schemes to provide accommodation for an ever increasing number of the frail elderly. Much more is demanded of the warden and the frequency of residents' emergency calls is increasing.

Not infrequently, general practitioners expect wardens of sheltered housing schemes to provide nursing care and sometimes they are also expected to provide meals and medication. For all these reasons it is becoming increasingly clear that the wardens no longer can act only as a good neighbour; and sometimes their job becomes almost intolerable with a 24-hour commitment to their residents which could end in a breakdown of the warden's health. One attempt to resolve this problem often taken by the managers of sheltered schemes is to instruct their wardens not to indulge in these additional duties: but this is difficult for the supportive services to understand and very often wardens feel that they have a moral commitment to their residents.

One of the original concepts of sheltered housing was to provide a social mix of residents to include younger fit elderly who would be able to assist with organizing social events and generally stimulate interest in fellow residents. This type of approach, valuable as it is, is becoming difficult to adopt as the number of frail elderly residents increase. The argument has been advanced (4) that as the original cohort of tenants ages and a definite loading of the balance against their moving into Part III accommodation develops, the load upon the wardens of the sheltered housing scheme is inevitably increasing. Consequently Housing Departments which are understandably reluctant to extend their caring roles by increasing staffing levels, select only fitter candidates for vacant tenancies. And accordingly the whole problem is exacerbated by increasing pressure on Part III homes.

This argument does not take into account those housing authorities who consult fully with Social and Health Services

upon the letting of tenancies in sheltered housing schemes and therefore often permit a greater influx of frail elderly into sheltered accommodation.

The future

In view of these developments in the role of sheltered housing it becomes increasingly important that local authorities should examine thoroughly how much sheltered accommodation should be provided in relation to their total housing strategy and what form it should take. There are problems of existing schemes where the demands upon the warden are increasing, of how much should be built in the future, and of whether a proportion of this should contain greater care facilities. There does seem to be a need for more central research and planning to try and ensure that the various provisions for residential accommodation for the elderly are complementary to each other and do not compete for existing resources.

The Leeds University Study (3) states that it seems unlikely there is a planning relationship between the different types of provision for the elderly despite the real impact each has on the other. It is still usually treated in a piecemeal fashion despite a few attempts on the part of housing and social services departments and Health Authorities to co-operate. The statistics and observations that are being produced by the Leeds University Study and the Oxford Polytechnic will undoubtedly assist central and local government to start to plan ahead for meeting in the best possible way the residential care of the elderly. This is the approach recommended in *Housing for Old People* issued in April 1976 by the Department of the Environment.

Perhaps one desirable feature emerging alongside the problems of residential care of an increasing elderly population is the apparent movement towards coalescence between housing and social services departments as to the manner in which they seek to overcome their difficulties. For example, evidence has been examined of the way in which some sheltered housing schemes are now providing medical support and meals for the residents. Similarly, some residential homes managed by social services departments provide for residents to have individual rooms where they can do a limited amount of preparing their

own meals, e.g. breakfast and supper. Several local authorities are introducing sheltered housing schemes which are a joint venture between housing, social services, and the Health Authority to take account of the special needs of the frail elderly. For instance, Kinloss Court at Southampton (Part IV) comprises 58 one-bed flats served by a warden with two assistant wardens and a domiciliary aid. Nurses are seconded to the complex by general practitioners who also arrange for Health Visitors to call as necessary. Social Services provide social work support. The objective of the Scheme is to provide sheltered accommodation giving a greater than usual intensity of care directed towards tenants with a greater than average disability and who otherwise may have required admission to Part III residential accommodation or hospital care.

Another example is Stockport Metropolitan Borough who have recognized the increasing problem of frail elderly in sheltered schemes and have introduced the concept of care assistants which enable tenants to receive short periods of care for about ten minutes in the morning, ten minutes at lunch-time and twenty minutes in the evening. This approach, it is maintained, is appreciated by the residents, helps them to retain their independence and relieves the burden upon the warden. However, the main central approach to the problem of the residential care of elderly in Stockport is the introduction of a radio communication system linked to peripatetic wardens who can be contacted by an elderly person equipped with a transmitter/receiver. This system enables the frail elderly to remain in their own homes in the comforting knowledge that they can quickly summon assistance in an emergency. Stockport Metropolitan Borough have therefore questioned whether to provide more shelter accommodation rather than build small flats which can be linked into the radio control system. Although this approach is innovatory and brings forward another option in the way in which society cares for its elderly, it obviously does not meet all the needs and it is apparent that there is still a role for the provision of standard sheltered accommodation. For instance, it does not answer the problem of unsatisfactory housing, loneliness, and under-occupation. The mere presence of a warden who is close at hand and can be seen, is a comfort to the elderly. Also much use is made of the

communal facilities within sheltered schemes. Nevertheless, the provision of perpatetic wardens with radio communication is another option providing greater freedom of choice and should be seriously considered.

It does seem therefore that there is a trend to provide a service for the elderly which is something more than the normal concept of sheltered accommodation but falls short of Part III residential homes and similar homes provided by voluntary organizations. Normal sheltered housing will still have its part to play but to relieve some of the pressures upon wardens there is a need for more intensive care schemes. New proposals should take account of this increased provision and existing schemes could be examined to see if they are capable of accommodating greater care facilities.

The discussion document ('A Happier Old Age') asks how co-ordination and collaboration between Health, personal social services and housing departments can be achieved. In commenting upon this a Medical Care Research Unit report from the University of Newcastle-Upon-Tyne (5) finds that many more links should be made between the decision makers at the operational level in the Departments concerned so that by future joint planning, under provision and overlap of care may be prevented.

With greater collaboration and planning at local levels the development of sheltered accommodation can be adapted to the consumers' needs so as to include something between that normally provided by Part III residential homes and normal sheltered accommodation. But joint approaches to the problem need to be monitored and published: and there is a need for further and much more sophisticated research to identify the special problems of those elderly people who occupy the margins between one form of care and another.

Current thinking within the Department of the Environment indicates that sheltered housing attracts supportive services whereas Housing Departments, as previously emphasized in this paper, complain that wardens are over burdened. Obviously, if sheltered accommodation is now catering for a greater number of frail elderly due to lack of places in Part III residential homes, then this situation is bound to happen. At one sheltered scheme in a major city which contains a large

proportion of frail elderly and disabled, the warden complains she is receiving approximately 100 emergency calls a month. Many are not, in the true sense of the word, emergency but indicate that the resident needs some sort of attention. Apart from an over-burdened warden, supportive services will be heavily in demand. This type of situation is frequently experienced by wardens and it is apparent that sheltered schemes with greater care facilities would assist with accommodating frail elderly in existing schemes and allow wardens to revert to their original role and deal 'normally' with the other tenants. This type of approach would at the same time allow the frail elderly to retain their independence, moving only as a last resort to Part III residential homes or hospitals.

It is abundantly clear that at the local planning level there is an urgent need for collaboration between all the relevant services to determine the extent and demand for sheltered accommodation and the form it should take. Where additional facilities are needed, frequently described as 'Category 2½' Schemes, then the possibility of joint funding between the authorities should be explored. It is suggested that this could be done through a strengthening of existing collaborative arrangements within the National Health Service, thus involving County Joint Committees and Health Care planning teams with appropriate representation from Housing Departments.

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7 Care of the elderly mentally ill

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Introduction

The term psycho-geriatric is often used to describe that group of elderly people who have developed some form of mental illness. Unfortunately this term psycho-geriatric is also used as a synonym for dementia and hence can and does cause confusion when it is used. Dementia is a term used to describe the consequences of progressive irreversible physical deterioration of the brain, manifest in a failing memory, dis-orientation in time and place, a deterioration in the ability to reason and often emotional lability.

There are arguments in favour of developing special facilities for old people with dementia but the experience of most psychiatrists with a special interest in the elderly, strongly suggests that while there is a need for special services for the elderly mentally ill, these services should and must encompass all types of mental disorder. The major reason for this is that diagnosis in the elderly can be difficult and it is of great importance that depression and other functional mental disorders are differentiated from dementia and treated appropriately. The establishment of units for dementia alone means that others who may not be experienced in mental disorders of the elderly have to make diagnostic decisions before the special dementia unit becomes involved in the old person's treatment and care. Thus, services for the elderly mentally ill should encompass all types of mental illness in this age-group: but it is best that they are not described as psycho-geriatric services since this term is so often used to describe dementia.

The prevalence of dementia in old people should not obscure the fact that the same range of mental illnesses that afflict the young can also attack the elderly, with a tendency for depres-

sion, in its various guises, to be more common in the elderly than any other age-group.

Elderly people are also often described as being confused, with the inference that this is the same as being demented. Confusion is used to mean a number of different things, ranging from the abnormal conversation of someone with delusions to the forgetfulness and dis-orientation of dementia. In fact the word confusion should be confined to acute and sub-acute toxic confusional states. These are fairly clear clinical pictures, described fully in most medical textbooks and are the same as 'delirium'. Acute and sub-acute confusion is inevitably due to physical illness and in the elderly almost any physical disorder can produce 'confusion'. Most of these conditions are treatable, with the resulting disappearance of the confusion; the problem is one of diagnosis and treatment by a competent physician.

Hospital services for the elderly mentally ill

In the past old people with mental illness have tended to be either treated by the general psychiatric services, or the geriatric facility. Psychiatric care tended to be centred on the large mental hospital, with the majority of old people being admitted and never discharged again. This kind of inpatient facility, while having treatment and rehabilitation facilities to a greater or lesser degree, still consists of large numbers of long-stay beds, occupied by many long-stay patients. Some of these have entered hospital in old age; many have grown old within the psychiatric institution.

For the past twenty years, however, special services for the elderly mentally ill have been developed in some parts of the country and this movement is rapidly spreading. The majority of these services are still based on the psychiatric hospital, but tend to be community orientated, with the provision of day-hospital care and a philosophy of maintaining as many old people in the community as possible. Some of these units for the elderly mentally ill have been developed within the general hospital complex and at least one of them is solely contained within the general hospital. When this happens co-operation between the psychiatric service for the elderly and the geriatric service is much easier and more effective, compared to the situation that exists when psychiatric provision is in the distant

psychiatric hospital miles away from the department of geriatric medicine.

There is strong evidence to support the view that both the department of geriatric medicine and the department of geriatric psychiatry should be sited in the district general hospital. When one or both are hidden away from the centre of medical practice in a district, facilities tend to be inadequate, staff isolated, standards low, and therapeutic efficacy seriously impaired.

There are various ways of providing medium and long-stay care, including the use of psychiatric hospital wards and general hospital facilities. In one unit all types of care are provided on each ward. There are two wards with mixed sex facilities and each one provides treatment, rehabilitation, and medium and long-stay care. Experience of this unit does seem to show that the quality of life for all patients is significantly improved, staff morale is better and patients who would have been sent to long-stay wards in a traditional unit sometimes improve sufficiently to be discharged. This is an experimental system, which hopefully will be evaluated in the future. All the evidence available certainly points to the disadvantages of using psychiatric hospitals as long-stay facilities. Most of these hospitals are a long way from the population served so that old people admitted there are rarely visited and since most of their visitors are elderly they soon become lost and forgotten waiters for death. The Royal Commission on the National Health Service did a great disservice to psychiatry and the psychiatry of the elderly with its recommendation that mental hospitals should continue to play an important part in providing psychiatric help.

The hospital service as well as providing inpatient facilities should be concerned with the development of day hospitals and a community psychiatric nursing service. All staff members of the special unit for the elderly mentally ill should be community orientated and be willing and allowed to involve themselves in community work. For example, the psychiatrist should do home visits, as well as paid for domiciliary visits, while occupational therapists and nurses should be able to go out and make home assessments for patients and provide help using their expertise when this is necessary. In the care of the elderly there is no

place for hospital staff who hide behind the walls of their hospital.

One solution to the problem of long-stay patients, apart from the experimental method already mentioned, is to establish health service nursing homes sited in the community providing accommodation for say fifteen to twenty long-stay patients, with some accommodation for short-term holiday relief and day-hospital facilities for a further ten to fifteen patients who would come from the immediate neighbourhood of the nursing home.

Another solution is to develop boarding-out schemes, in which homes are found for elderly people with ordinary families, or in small rest homes and the latter are best run by voluntary organizations, which may be national ones or a specific group of hospital staff and friends of the hospital interested in helping old people.

One of the serious problems afflicting special units for the elderly mentally ill, particularly when they are sited in the psychiatric hospital, is that they start off with all wards fully occupied. This obviously makes it extremely difficult to provide a service to the community and many individuals who attempt to provide a service become demoralized and hopeless in their approach to the problem of old people. In these cases it is essential that a day-hospital is established and serious attempts made to start boarding out schemes and group-homes so that beds become available and a real service can then start to function.

Department of Health and Social Security recommendations

In October 1972, the Department of Health and Social Security issued a document entitled 'Services for Mental Illness Related to Old Age'. This contained guidelines for hospital services for mental illness related to old age, which are reproduced in the Annex to this chapter, page 113.

These guidelines are still used but may have many disadvantages. For example functional mental illness is separated from dementia. Many units for the elderly mentally ill contain a large number of old people, who have grown old within the

mental hospital and yet norms are used that do not take this into consideration. Hospital norms should be dependent upon community facilities, since some hospitals cope with many fewer beds than recommended, while others cannot manage with bed numbers above these norms.

Patterns of care that have evolved

A number of different patterns of care have developed throughout the country, ranging from nothing as far as special provisions are concerned all the way through to highly developed special units closely related to both geriatric medicine and community services.

Day-care is today looked upon as an essential part of any service for the elderly mentally ill and most special units have at least one day-hospital which can provide the whole range of psychiatric treatment and do everything an inpatient unit does, apart from providing night accommodation. Yet it is doubtful if any district has adequate day-hospital facilities and many have only minimal provision.

Although a day-hospital, or rather day-hospitals, can significantly reduce the need for inpatient accommodation, a number of problems may arise which defeat this objective. Transport is all important, since the majority of patients attending a day-hospital need to be brought there and taken home again by the Ambulance Service. This is necessary not only because of disabilities of the patients but the shortcomings of public transport. Some districts experience little difficulty in obtaining adequate help from the Ambulance Service, while others particularly those in large metropolitan areas, such as London, have serious difficulties. Over-stretched Ambulance Services tend to place a low priority on transporting patients to and from day-hospitals and may limit the number they are willing to accept and even cancel the service completely on days of particular shortage often without any prior notice. This significantly reduces the contribution the day-hospital can make, since patients at risk cannot safely be treated in the day-hospital and even those not at risk at home cannot be adequately treated because of the uncertainty of their regular attendance.

Another problem with day-hospital care is that patients may

fail to attend. When the individual is clearly at risk at home, this can be serious. The establishment of a community psychiatric nursing service with one or more nurses working from the unit in the community significantly decreases this danger of the non-attender, since the nurse can visit and deal with problems that may have occurred.

The establishment of *combined assessment units* has been recommended and some services have such units to which both the geriatrician and the psychiatrist can admit and then carry out a combined assessment of the patient. The reason such units are recommended is that old people suffer from a number of different pathologies and it is occasionally difficult to decide whether an individual in trouble is suffering from a psychiatric, organic, or social problem. The first combined assessment unit was established in Nottingham, where not only did the psychiatrist and geriatrician have access and involvement but the local Social Service Department was also involved and could admit patients if necessary. Various types of combined assessment are now being used and some workers no longer favour a special combined assessment unit but prefer to run a co-ordinated service, with combined assessment available in both the geriatric and psychiatric departments, including the combined assessment of out-patients and day-patients. It does appear where the department of geriatric psychiatry and the department of geriatric medicine are sited close together and there are close links between staff of the two units, specific combined assessment units are completely unnecessary.

Many departments of geriatric medicine are troubled by patients with mental illness whose behaviour causes problems for both staff and other patients. When there is a department of geriatric psychiatry, linked to the department of geriatric medicine, these problems do not occur because there is both expert advice to hand and ease of transfer when this is necessary.

Another reason for positive action is that one of the most difficult areas to attract nursing staff to is the care of the elderly mentally infirm. The establishment of an active unit for the assessment rehabilitation or long-stay care of the elderly mentally infirm is a pressing need in many Health Districts. There are far too few established active psycho-geriatric assess-

ment units and the long-term care of such persons is extremely patchy. There are a few places of excellence where the appointment of a psycho-geriatrician has led to the development of an active service. Where these units have been established and under the leadership of a psycho-geriatrician it has been very much easier to attract trained nurses. The needs of the elderly mentally infirm have lacked the support and interest of the statutory training authorities as far as nurses are concerned. The general nurse has little or no experience in this type of care while the Registered Mental nurse's experience, usually in a large psychiatric hospital, portrays only the custodial routine of basic nursing care. Of all areas of the so-called cinderella services the psycho-geriatric patient appears to be the most neglected. It is therefore of the utmost importance that Health Districts develop active services where the interest of the pyschiatrist and/or the geriatrician injects enthusiasm and hope. Without the active interest and support of other professionals, nurses become disenchanted and the possibility of improving these services whether in the institutions or community diminished.

As well as close co-operation between psychiatry and geriatric medicine there is also a need for an equally *close relationship with social service departments*, local social security offices, local authority housing departments, and the voluntary organizations involved with the elderly that may operate in a district. One or more social workers are essential members of any psychiatric team, be it dealing with the elderly or any other age-group. Provided the service for the elderly mentally ill has a social worker, or social workers, liaison with the social service department can occur through them. Since the reorganization of the NHS, social workers are employed by social service departments even when they work in hospitals. This should mean that they are in close touch with their social service department as well as the hospital service with whom they work. Liaison with other agencies is slightly more difficult, since it would be both unreasonable and impossible to have representatives of these agencies working with the psychiatric team. The team approach will be considered later, but it can be said here that if a good team approach has been developed this appears to almost inevitably result in close relationships

developing between the psychiatric service and the various agencies previously mentioned. There are fairly obvious reasons why the service should relate to voluntary organizations involved with the elderly.

Perhaps it is not so obvious why liaison is necessary with *housing departments* and social security offices. Very many old people live in council accommodation, which may range from normal council houses and flats by way of special flats and bungalows for the elderly to warden supervised flatlets. Many residents of special housing are disabled and this disability may be 'psychiatric'. One of the major reasons why people of all ages with psychiatric disorders remain in hospital longer than is needed or necessary is the absence of a place to go. Thus, housing departments need to have easy access to psychiatric help and psychiatric facilities need help and assistance from housing departments.

As far as *social security* is concerned, many old people particularly those with mental disorders do not receive all the benefits to which they are entitled and because of this may actually deteriorate to such a degree that long-term care becomes inevitable. Other elderly people in psychiatric hospitals would be able to leave if suitable accommodation in the community was found for them and money to pay for the accommodation was available. Experience in placing old people back into the community including the operation of boarding-out schemes and the establishment of group homes has clearly shown that a good relationship with the social security department facilitates the provision of appropriate financial help and removes the delays and confusions that so often occur when such a relationship does not exist.

An examination of the various patterns of care that are developing therefore shows that success is very dependent upon coordination and cooperation.

Other specific services

In the patient's home, the *family doctor* service is obviously vital and it is clearly necessary for family doctors and their teams to have a good knowledge and understanding of the problems of elderly people, their emotions, their fears, and their illnesses. *Home-helps* play one of the most important

roles in supporting the old at home and a lack of home-helps can and does result in elderly people being unnecessarily taken in to either old people's homes, or admitted to hospital. *Meals-on-wheels* also help, but unfortunately the quality of such meals often defeats their usefulness, with many old people giving the food to the cat or dog, as distinct from eating it themselves. However, nutrition is very important and any effort made in the community to provide food for old people must be encouraged, provided the encouragement is coupled to concern with quality and quantity.

Old people's clubs, *dining-clubs and day-centres* combat loneliness, improve nutrition when meals are provided, and contribute to both the prevention of mental illness in the elderly and the support of those with mental problems. Special day-centres for the elderly mentally ill are as yet an uncommon phenomenon, but there is a clear need to develop and expand this type of service. In one health district, which has a disproportionate number of elderly people, a service has been developed which uses very few hospital beds and is able to do this because of a variety of community facilities, including a local authority day-centre for the elderly mentally infirm. Day-centres can of course be run by both local authorities and voluntary organizations and this pattern should be encouraged, since it provides choice and sometimes healthy competition.

The NHS as well as providing a family doctor service also provides home nurses, health visitors, *community psychiatric nurses* and to a greater or lesser degree a *chiropody service*, a *physiotherapy service* and an *occupational therapy service* to the community. Unfortunately the latter three provisions are scarce and often totally absent.

Training

It does appear essential that special psychiatric services for the elderly mentally ill are developed. One problem with developing such services is the absence of trained personnel, interested, and capable of developing such services. There are short-term and long-term solutions to this problem. Part of the long-term solution is to introduce more teaching about the care of the elderly into medical, nursing, and remedial training. The immediate method of dealing with this is to allow and encour-

age every unit for elderly mentally ill to establish training appointments for doctors, nurses, and other appropriate staff. Many people in the caring professions believe that they have no interest in the elderly, but when exposed to work in a unit for the elderly discover that it can be an interesting and rewarding way of spending their professional lives. Obviously the quality of the unit is important since a demoralized non-functioning annexe to the mortuary must have the opposite affect, except that such units occasionally stimulate people into wanting to do something about what they see.

The proportion of old people in the community is going to increase and since this is one of the few certainties of the future there can be no excuse for not making every effort to ensure that appropriately trained people, who are well motivated, are made available to deal with the crisis to come.

Joint planning and action

It has been emphasized that elderly people with mental illness need a whole range of services which are provided by various agencies. Planning of services for the elderly must be a joint exercise. As far as official organizations are concerned planning must be co-ordinated between the hospital service and local authorities. Failure to do this will only lead to disaster.

There are a number of ventures which can and should be jointly funded. For example, hospitals run day-hospitals, while local authorities run day-centres. It seems reasonable to combine both the day-hospital and the day-centre on the same site, using communal services and allowing and encouraging interchange of clients which can be controlled. This idea has been described as desegregated segregation and the principle can be applied to residential accommodation as well as day-hospital and day-centre facilities. A geriatric day-hospital, a day-hospital for the elderly mentally ill and a local authority day-centre could in fact all be combined on the same site, with communal use of general services and the option of the various patients and clients mixing or segregating themselves, depending upon their own desires and the welfare of others. In a residential establishment the same could apply, with one part being an old people's home while the other catered for the

elderly mentally ill. Here again residents could mix, but could separate themselves if they wished.

The segregation of the elderly mentally ill does produce damaging effects upon the individual, since it means that those who have psychiatric problems cannot learn to relate to a 'normal society'. When large numbers of old people with dementia are herded together they tend to deteriorate more rapidly than is the case if they are able to live in the community. On the other hand, many elderly people with physical disabilities, or other 'non-psychiatric problems' find the mentally ill disturbing and sometimes frightening. The concept of de-segregated segregation gets around both these problems by allowing mixing, but at the same time, allows individuals to escape from each other. In fact a system that allows this has advantages for any group of people regardless of whether they have mental illness or not.

Conclusions

The Department of Health and Social Security's guidelines on services for the elderly mentally ill have already been mentioned and briefly discussed. There are claims that the norms mentioned are too low, while others consider they are too high. Some services in the country are unable to cope with the maximum number of beds recommended, while others successfully provide a service with no more than 0·5 beds-per-thousand population over the age of 65. There are many reasons for these differences, including the problem of the long-stay psychiatric patient already mentioned, lack of community orientation on the part of the staff providing the service and deficiencies in local authority provision for the elderly.

What is important is that services are carefully co-ordinated and appropriately expanded, with the object in mind of supporting as many elderly people in the community as possible. When this happens the number of in-patient beds almost become irrelevant, except that too many does tend to result in patients being admitted unnecessarily and kept in hospital longer than they should be.

When considering the number of beds it is important to remember that simply reducing the number without providing the necessary day-hospital and community services that cater

for the elderly results in old people either being neglected or admitted to inappropriate facilities, such as general medical and general surgical wards. Too many beds have serious disadvantages, but simply removing them does not solve any problems and usually creates many more.

Special psychiatric services for the elderly mentally ill should therefore be established in every health district. These services should be community orientated, with an emphasis on day-hospital care and community treatment. Every service should have an adequate number of community psychiatric nurses as well as social workers and doctors. The role of remedial staff must also be emphasized.

The special unit for the elderly mentally ill may have to be established in a mental hospital in the first place, but plans should be made to establish the unit within the general hospital complex as soon as possible. Preferably the unit should be sited close to the geriatric unit and close links developed between the two services, regardless of their relative positions.

The possibility of establishing health service nursing homes should be investigated and the present methods of dealing with the elderly mentally ill examined, monitored, and assessed. The idea of caring for all types of patient on the same ward is worthy of examination.

Services for the elderly mentally ill require joint planning between the hospital service and local authority services, with voluntary organizations being encouraged to also involve themselves in these planning manoeuvres.

Methods of re-establishing old people in the community need to be explored and boarding out and group home schemes encouraged and expanded.

Training is of considerable importance and training in the care and problems of the elderly should be provided for all professional groups who are involved in providing treatment, support, and care. Special efforts should be made to establish training appointments in units for the elderly mentally ill so that staff can be trained and be available to develop and man existing and new units for this age group.

To state the obvious, mentally ill old people are just people like the rest of us and hence require all the things man needs, but provided occasionally in a special way.

Annex

DHSS Guidelines (1972)

Category	*Guidelines*
1. Elderly patients who have grown old in hospitals for the mentally ill.	Number diminishing. New accommodation not needed, but improved conditions.
2. Elderly patients with functional mental illness.	Service requirements contained within the guideline provision of 0·5 beds and 0·65 day-places per 1000 total population suggested for adult mental illness in HM(71)97.
3. Elderly persons with mild dementia but not suffering from other significant physical disease or illness.	It is envisaged that persons in this group will be cared for at home or in local authority residential accommodation.
4. Elderly patients with severe dementia but not suffering from other significant physical disease or illness.	2·5–3 beds plus 2–3 day-places per 1000 population aged 65 and over. This is additional to the scale of provision suggested for adult mental illness in HM(71)97.
5. Elderly patients with dementia whether mild or severe, and also suffering from other significantly physical disease or illness.	Service requirements contained within the recommended planning guidelines of 10 beds and 2 day-places per 1000 population aged 65 and over for geriatric services.
6. Elderly patients requiring joint geriatric/psychiatric assessment.	10–20 beds per quarter-million total population as suggested in HM(70)11. Normally to be sited in the geriatric department of the district general hospital.

8 Primary care

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THE PROBLEM

The primary care physician has the same aim in the management of the elderly as other professionals—to retain the maximum number of people living independently in their own homes. Equally, the ability to fulfil this objective depends on a number of variables, which include the degree of organization within individual general practices, the state of co-ordination between the local nursing and social services, and to a very large extent the absolute numbers involved and conditions of housing. Though involvement is already high, contacts between the doctor and very elderly patients could double by 1993. Apart from the growing numbers of elderly people in the community, there is an increased awareness of the sheer complexity of the problems they present. An additional problem is that there is considerable variation throughout the UK, in which the most difficult areas are 'retirement' areas and inner-city areas, which produce conditions quite different from the average practice, with 15 per cent of listed patients over the age of 65.

State of the art

Primary care has undergone a number of reactive changes in recent times.

A new style of general practitioner has emerged as the result of altered financial arrangements, reimbursement of ancillary help, and attachment schemes which enable the GP to come into partnership with those working in the other health care professions. This has had significant effects in many aspects of

primary care, except for the care of the elderly, where ambivalent feelings persist.

As a result primary care teams have been developed, in purpose built premises, with the aim of effecting programmes of preventive medicine for all age-groups. There are many demonstrations of the effectiveness of such teams in paediatrics, both in providing high levels of immunization, and in monitoring development, while adequate antenatal supervision is almost universal.

It must be noted here that GPs receive item of service payments in respect of antenatal care, the immunization of infants, and for cervical cytology as a means of screening for cancer.

Attitudes to the elderly

The preventive measures just mentioned are undertaken on a far wider scale, and with much more general sense of purpose, than are shown in the care of the elderly. Some of the reasons for this are clear. In the first place, few older doctors over the age of 45 have had any undergraduate exposure to teaching on the problems of old age. There has been, on the other hand, a considerable amount of postgraduate education on the clinical aspects of the subject, but less on organizational approaches to solutions.

Within the newer type of general practice, with its appointment systems, and access to doctors via receptionists, old people need to be made welcome. However, it is true to say that old people with complex physical, social, and mental problems will not fit comfortably into a five minute slot during a busy consulting session.

Apart from this, they are heavy consumers of drugs, and these are usually prescribed by a variable method of repeat prescribing in which the patient may not be seen for several months.

An effect of modern practice reorganization has been a marked reduction in the number of home visits paid to patients in their own homes, at least by doctors. In certain cases, reliance can be made on visits paid by geriatric visitors, health visitors, or district nurses, although a small proportion of general practitioners is assiduous in paying regular visits to

the elderly. It may be questioned, however, how far these visits are social calls, rather than having a medical function.

The view still remains, among many, that work with elderly patients is uninteresting and unrewarding. Such views are reinforced by calls for crisis intervention, when there are no arrangements to be made other than summary disposal. These views are particularly prevalent among older single-handed doctors, in inner-city areas, who have been by-passed by further medical education, and advances in practice organization.

Relationships with hospital, and other institutions

There is nothing that improves the morale of the primary care team more than good back-up and co-operation from the hospital team. The relationship with the hospital consultant, both as an assessor and teacher, is vital.

Problems arise where the geriatric unit is not located within the district general hospital, and is lacking in prestige locally. This is often the case where it is housed in old buildings, and the staff exhibit low morale. The degree of skill in diagnosis and assessment generally, so much more demanding in the elderly than in younger groups with better social support and single pathologies, should be demonstrated in at least one centre in every district.

The role of Liaison Nurse between hospital and community has been established in many Health Districts throughout the country. This as yet developing role has proved to be extremely valuable in co-ordinating discharge and admission procedures between the hospital and the community. The choice as to whether the liaison person is a Health Visitor or District Nursing Sister has been left to individual preferences and varies in many of the establishments. The Liaison Nurse is often called upon to assess the dependence and nursing requirements of an elderly person at home, and advises the District Nurse, the GP or the Consultant Geriatrician as to the best possible solution to the difficulties that have been encountered. On discharge from hospital the reverse applies: the Liaison Nurse is in touch with agencies that can supply the right kind of support within the home and will continue to visit on a regular basis to see that this support is forthcoming.

Community hospitals provide excellent opportunities (where

they exist) for general practitioners to continue to care for elderly patients showing a moderate degree of dependency. They have been shown to be popular with both GPs and the public, for short-term, long-term, and terminal-care. In all these aspects it is desirable that they should provide part of the total beds under the control of the consultant, who would be available when required for joint consultation.

It is increasingly mentioned that Part III accommodation now provides for a much older patient, but lacks resources for skilled nursing which might make it into a treatment resource. The transfer of residents when they are ill is not always easy, and the documentation of new patients on arrival is often deficient. There is enough wrong in all these situations at present to discourage primary care physicians from adopting fresh approaches to the problems of the elderly population. In this they are assisted by the elderly themselves, who as a group are uncomplaining and poor reporters of illness, often attributing the symptoms of their illness to old-age. Where low morale exists, doctor/patient contact is infrequent. Reliance has been placed on the traditional situation of the active patient and the passive doctor. Where the doctor responds only to symptom-orientated demand, particularly in the elderly, there cannot be the same effective answer to the problem of this group as has been demonstrated in the more structured preventive care shown to mothers and babies.

THE WAY FORWARD

It is clear that solutions to the threat posed by a 'geriatric explosion' demand quite revolutionary changes in a number of functions, together with rewards and incentives attached to restructuring. The see-saw effect produced by a decline in the birth-rate, and unprecedented increases in the numbers of the very old, will demand broadening and restructuring of the traditional base of primary care.

Preventive care

Doctors and the primary care team must be encouraged to conduct a preventive programme, which will involve an integration not only of work, but of recording. In primary care this

may be done in two ways. Preparation for old-age should begin as early in life as possible, so that health education should be a function of all consultations, even from early childhood. A clearer idea of functional capacity can be arrived at in middle-age, when health education programmes should be intensified if diseases are to be prevented or delayed.

The value of screening is debatable, and it is not intended to try and resolve the matter here. The early health screening programmes which took place in the 1950s could clearly be shown to be productive of early diagnoses which it was assumed could be treated so as to prevent disability advancing, and keep patients out of hospital by providing adequate treatment and rehabilitation. They were taken up by enthusiasts. Today further evidence shows that screening the elderly is expensive of time and money, and unproductive of unknown serious disease which might be reversed.

Nevertheless, case-finding programmes enable doctors to get to know their old patients better, and, should examinations show them to be well, patients derive much encouragement from that knowledge. The danger is that, without a health screening programme, doctors will not be granted the opportunity of effective contact, since old people do not fit in to the rather superficial five-minute encounter which has come to form the basis of modern consultation.

Record keeping

In the compilation of a complete record, time has to be spent at the initial visit. For team requirement the record must contain information relevant to each discipline. This is easier to introduce and maintain where there is computer storage, and this is increasingly likely to become the method of record keeping in primary care. The basic tool for the identification of patients, and for undertaking any audit, is the Age/Sex Register, without which monitoring, recall, and research are not possible in any complete sense. But beyond an obligation to keep records as part of his Terms of Service, there is no requirement for a doctor to keep them to any standard. The majority of records are still kept in envelopes E.C.5/6, developed in the time of Lloyd George; others have graduated to the more practical A.4 type, while a small minority of enthusiasts have

micro-computers for record storage, visual display, at risk registration, recall and follow-up. There should be some incentive to encourage doctors to structure the notes of all patients who have lived through to seven decades, to facilitate the recall of information, and to transmit it when the patient is admitted to hospital or other care.

Good record keeping is of extreme importance in health-care, and the transfer of this information when patients move to new areas, or when they enter hospital may be vital. This information is of particular importance in old-age when there are accumulated pathologies, some of which have led to surgical procedures, about which the memory of the patient may be poor. Furthermore, it is at primary-care level that information concerning past occupation, education, housing, finance, mood, and mental performance are best obtained, so that an old person's record should be structured specially, and differ from other age-groups. Since patients grow old with their doctors, the death or retirement of older doctors removes a great store of important information which is not recorded in manual systems. Screening procedures would therefore, apart from the detection of occult disease, afford an ideal opportunity for integrating and structuring the patient's profile and problem list.

Growth of the team concept

The primary health-care team, consisting of a nucleus of professional workers, is led by the general practitioner, who is the co-ordinator of activities. Such teams, as already noted, function well in purpose built premises, with rooms for nursing, health visiting, and social work dimensions, having good means of internal communication, a common recording system and a policy for case-finding, assessment, and follow-up. Such co-ordinated teams exist, but few are orientated towards the care of the elderly. Alternatively some practices employ a system where the health visitor, or practice nurse, visits the elderly group at home, reporting back health needs to the doctor, and social needs to the social worker.

To resolve the issues raised in the promotion of different types of teamwork, and co-ordination between professionals, and between professionals and the paraprofessionals who work

alongside them, it is surely right to experiment with alternative patterns of inter-service collaboration. A reduction in the barriers to teamwork resulting from perceptions of the balance of power which exists between one profession and another (1), could be achieved by joint training programmes for doctors, nurses, and social workers. Attention could also be paid to factors affecting the operation and success of attachment schemes to general practice (2), such as a room for interviewing and the use of a telephone on the premises to encourage good working relationships within members of the primary health-care team. The organization of the practice itself is also an important factor, especially the degree of commitment by members of the primary-care team, and the attitudes of the doctors. That social work attachments to health-centres can be particularly effective in providing good partnerships between general practitioners and social workers has been demonstrated (3).

Good working relationships are however not the ultimate goal unless they lead to what is perceived as a good quality service from the patient's point of view. Old people do not always react favourably to entry into their home of a series of experts, however well co-ordinated. The role of the general practitioner as a co-ordinator of services therefore remains an essential one.

Primary-care should set itself the objectives of better case-finding, closer integration of the primary health care team, improved compliance with treatment, patient education, more rational prescribing, follow-up audit, and recall accuracy. There is also within general practice a huge source of untapped opportunity for clinical research.

There can be little doubt that the NHS offers opportunities and means of delivering care to an elderly population which are not likely to be bettered elsewhere in the world, particularly in the field of doctor-initiated consultation. Nevertheless, the situation at present falls far short of what is required and is likely to prove deficient in the face of increased demands. During the last fifteen years, primary-care has shown itself capable in some fields of being increasingly productive by modernization and reorganization, rather than by expansion;

(a). In antenatal care it is customary to use a co-operation

card upon which are recorded important data both at visits to the general practitioner, and in hospital. This card remains in the care of the patient who may present it when travelling within the ambit of the NHS. This card is compiled for the specific purpose of a pregnancy.

(b). Primary routine vaccinations are carried out by general practitioners and their staff, for which special documentation is required.

(c). Since the introduction of item of service fees for cervical cytology, this preventive measure has been adopted as a routine procedure throughout general practice.

These developments have been assisted by the attachment of trained health visitors and nurses to practices, and the use of recording systems introduced for the purpose, and often shared with the local authority services. It seems logical to assume that primary-care would be rapidly orientated towards the care of the elderly if it were also to attract item of service payments. It is true that there is at present an across-the-board payment made in the form of higher capitation fees for those aged between 65 and 74, and a still higher fee for those aged 75 and over. This is administratively easy, and is intended to reflect the higher work load imposed by these older age-groups. Many observers are, however, unconvinced that these fees are justified by actual performance, and since in the great generality of cases general practitioners do not operate age/sex registers, they may in fact be offering less rather than more service to the elderly than in the past. Everything seems to point to the desirability of rewarding effort made rather than blanket payments given out in anticipation of their being earned, particularly as many old people are prescribed for on repeat prescription lists which effectively enable them to receive treatment without seeing the doctor at all.

Payments for restructure of records

There would appear to be two areas in which items of service might be introduced. In the first place an incentive should be given to reconstruct the patient's record card on reaching the age of 70. In most manual recording systems the sheer bulk of accumulated information prevents recall of important information, particularly during crisis intervention. Furthermore,

much of it has been rendered obsolete, while further information is required at this age. If doctors, and their co-workers are to have an adequate record card, with appropriate data, and active problem lists, leading to planned programmes of care, a doctor should receive a fee for this reconstruction, for this is something only he can do. Since older people are those best served by a full physical examination, including some routine testing, in view of insidious disease processes, and unusual presenting features, this type of encounter with the doctor would be additionally beneficial. Apart from the opportunities afforded to detect unreported illness, such examinations increase the skills of doctors, and reassure patients when pronounced fit.

The skills of doctors

It is contended here that the medical care of old people demands high skills and the modern knowledge gained through continuing education in geriatric medicine. These are complex cases, and traditional attitudes and methods no longer apply. To continue with them brings frustration to doctor and patient alike, and a lowering of morale on both sides. This is no spirit in which to approach the next decade.

The advances made in the last 25 years in geriatric medicine have shown that greater, rather than lesser, skills are needed in the interpretation and gathering of data in old people. It seems only appropriate, therefore, that doctors should be encouraged to acquire these skills and experience in order to undertake this, just as those offering maternity services need to be inscribed in an Obstetric List. The Court Report has made similar recommendations to encourage higher skills in the field of paediatrics, although it might be pointed out that most cases in primary-care present less in the way of clinical difficulty. Higher skills, however, are normally subjected to assessment by examination, or gained by periods spent in approved units of a speciality. Following the precedent of the Obstetric List, which is entered either by having the Diploma of the Royal College of Obstetrics and Gynaecology, or six months of approved experience in hospital, either of which entitles a doctor carrying out maternity services to a higher item of service fee, it would seem to follow that special skills and

experience should be rewarded when relevant to assessment of the elderly. It is in this area particularly that a Diploma of Geriatric Medicine would be appropriate and germane to the content of general practice; far more so, in fact, than the Diploma in Child Health which is more specialized.

Satisfaction through work in primary-care should thus be encouraged by incentives to achieve higher educational standards, and to adapt methods of practice to real medical need. Higher qualifications to practice special branches, such as paediatrics and maternity, have brought prestige and attracted doctors into fields with special opportunities. Despite great advances in knowledge in geriatric medicine, there is as yet no acknowledgement of its importance as an academic discipline, nor any concerted attempt to make special arrangements for its practice.

It will take a long time for these examples to influence the main body. Item of service payments can act as an immediate catalyst in providing a widespread service, as for instance in screening for cervical cancer. Fiscal factors are vital in determining what doctors do and how they do it (4). The way forward in the longer term appears to lead along the avenues of higher education, better record-keeping, integration of primary-care teams, and altered patterns of practice. Primary-care has a key role to play in crisis intervention, diagnosis, and assessment, and in intermediate and long-stay care. It should be encouraged to develop an interface with hospital-care through a partnership between primary-care physicians who are capable of caring for hospital patients, and geriatric physicians who bring their experience out into the community.

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9 The case for small nursing units

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Introduction

In cases of severe disability where the person is bed-ridden, unable to dress, wash, or feed, or in some other way permanently dependent and where active rehabilitation offers no prospect of success, prolonged nursing care is inevitable.

This kind of care is probably best provided in long-stay hospitals and nursing homes. Patients with such disabilities are, however, to be found in many residential homes and of course in private homes, and if the period is very prolonged, the burden is often too great for those providing the care.

There are strong arguments for encouraging an increase in the provision of *nursing homes* for such patients rather than increasing the number of beds in long-stay hospitals. The arguments against long-stay hospitals are substantial. They often isolate the patient by their distance from the family; they are sometimes difficult to staff; moreover they are comparatively expensive because of the often unnecessarily high level of medical cover available and a degree of support services which is wasteful. The larger long-stay hospital tends to be less cost-conscious than the small nursing home since accountability is diffused. It is also more difficult to avoid the depersonalization of patients which can be a feature in large institutions for the chronic sick.

The importance of voluntary and private nursing homes

Facilities for the type of care which characterizes the best kind of small nursing home do not ordinarily exist in the NHS, although some general practitioners use the beds in GP hospitals for long-term care. This has been a matter of deliberate

policy generally on the grounds that they are uneconomical. There is of course a significant relaxation in this general policy, in as much as there are numerous voluntary and private sector units registered and under some supervision of the NHS and with which the NHS has contracted arrangements for beds. About half of these are probably of a high standard.

As a general rule, morale is high in both GP hospitals and in the better independent nursing homes because they tend to be easy to staff and are often well managed. The main criticism of the well-organized and efficient units is that they are occasionally inclined to regiment their patients over-zealously in ward-like conditions, sometimes lack sufficient medical guidance, and rarely aim at rehabilitation, even in appropriate cases. Nevertheless, though these criticisms can be made, the claim is valid that they could become, within an overall policy embracing appropriate guidance, providers of economical, high quality care, close to the patients' homes, and accessible to family and volunteer participation.

The projections for the future are such that it has to be assumed that there will be an acceptance of NHS responsibility for an increasing number of very dependent elderly. The thin line of respective responsibility makes it likely there will be a realization eventually of the need for joint development of homes run in partnership between the NHS and the local authority. Alternatively the only other way to meet the likely demand will be to contract out more cases to authorized voluntary or private homes. A further extension of the policy of contracting out would be for the government to encourage the development of private and voluntary nursing homes by extending and improving the system of attendance allowances on which many private patients already depend for part-payment of their fees. Providing there is sufficient professional supervision of untrained assistants the well-organized nursing home specializing in the care of the elderly does not require the high level of trained nurse staffing ratios of the institutions providing acute care.

It cannot of course be denied that because of the age of the clientele in the private sector, there is some risk of abuse and scandal through neglect of care, overcharging or misappropriation of property or funds. The present system of supervision by

the NHS is admittedly inadequate and it would have to be improved substantially if a policy of increased contracting out was followed. The introduction of a self-disciplinary system and rules of conduct are also very desirable.

Any change in this direction should be part of a 'package'. Thus, most health districts in this country have well-developed in-service training departments, which among other activities, run courses for untrained staff, teaching basic nursing skills. The possibility of extending this facility to nursing home staff who could, with advantage, participate in these training programmes, would help to increase the co-operation between the private and voluntary sector and the NHS. At the same time such a policy could contribute to increasing the degree of supervision that is statutorily undertaken by Health Authorities.

Though otherwise private nursing homes receive no assistance from the community services, it is fairly usual for general practitioners to visit voluntary and private homes and prescribe NHS drugs for their patients. This is in the general interest, bearing in mind how heavily dependent the NHS is, in many areas, upon the provision made in the private sector. It is, however, unsatisfactory that little by way of remedial services such as occupational therapy or physiotherapy is available in the same way.

The public sector

The success of the good small nursing home is undeniable. While it has hitherto not been policy to do so, the development of small public sector nursing units in the community should be seriously considered as an alternative to the further development of long-stay geriatric wards or hospitals, and of contracting out to independent institutions. Properly constituted and managed, such units could provide better care than that currently available in many of the NHS hospitals. Joint action by social service departments and the NHS authorities to provide nursing home types of facility are likely to be very attractive to nursing staff if they were offered an opportunity to take full management responsibility for the Home on a day-to-day basis, in the same way as Nursing Officers in charge of small GP hospitals do, at present. This would not cut across the

responsibility of the geriatrician for the development of local policy about admission and assessment, but the unfettered authority of the supervisors to manage their Homes within such an agreed policy about assessment, periodic re-assessment and the objectives of care, would be attractive to many nurses. The point cannot be too strongly made that nursing homes, GP hospitals and, with suitable reform, long-stay hospitals, offer an opportunity to the nursing profession to exercise initiative and leadership. Although such a policy would demand a considerable change in the outlook of many medical men, it would offer an opportunity for a better use of skilled and suitably trained staff. There would also be an important role for interested general practitioners in providing medical cover, and as partners with the nurses-in-charge, in maintaining co-operation with other official and voluntary services.

Organizing for the problem

Although the concept 'small is beautiful' has much to recommend it, it is recognized that there are dangers in the argument that because nursing staff work in situations of responsibility, the end-result will be a comfortable homely atmosphere, where caring takes precedence over curing.

Regimes inflicted on many of our elderly stem from the initial training of nursing staff who may, with good intention, nurse a person to a degree of dependency. Expressions of concern over physical failure involving fundamental dignities are often met with 'never mind dear, won't take a minute to clear up', or countered by catheter control for incontinence, or baby bibs for those with shaky hands and no teeth. Because wet and dirty beds cause more work and food dropped in the lap and on the floor is messy and inconvenient, nursing aids are often used by staff to help them rather than the person they are used upon.

Although many would say that developments over the past ten years have enlightened our understanding of an individual's need to retain independence and dignity, a fine balance has to be attained between over-activating the seemingly inactive and allowing a complete state of apathy to exist. Inappropriate games and outings where everyone must join in are in their way as soul-destroying as 'all chairs face the centre of the room'.

The philosophy and theory of care of the elderly is being steadily advanced. Putting this into practice requires more attention to the training of the staff who will be responsible for implementing theory.

Developments for the future

There are already in existence numerous voluntary schemes offering a range of accommodation for the elderly. The general objective is clear. Provision should be made for the particular needs of the elderly person from minimal care and supervision in sheltered accommodation through to constant nursing attention. The nursing units in the best of such schemes are usually small and provide care for those whose physical or mental state renders them very dependent. This particular group of elderly are those whose general condition, due mainly to the ageing process, places them in a situation where they are not acutely ill enough to require the attentions and facilities of a hospital but are too dependent on constant assistance and attention for the care staff of a social services Home. In general, however, there is urgent need to develop accommodation that would meet the needs of this particular group in society as a whole. Close co-operation between health and social services is essential if the concepts and requirements of total 'care' of these elderly people are to be met. The attitude of medicine and nursing towards treatment and care of patients on one extreme is as inappropriate as the social services provision of accommodation and shelter with minimum supervision on the other.

The idea of small nursing units is attractive whether they exist as an entity of their own or are attached to sheltered or residential accommodation. Experimentation in some areas in the country has proved that difficulties only exist in the imagination of those in authority. Yet the responsibility for managing and running such units remains open to debate. Further experimentation should take place in a variety of ways to establish a care pattern. Those areas of the country that have gone forward crossing the boundaries of responsibilities should be carefully examined. Patterns have varied a great deal: these should be studied with care and the most successful should be adopted as models by those who teach and those who plan for the future.

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10 Hospital care for the elderly

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A fundamental aim of the health and social services for the elderly is to enable old people suffering from physical or mental disability to live where they would wish to live if they were not disabled. For the great majority of old people this means living in a private house with no undue sense either of being insecure or of being a burden to others. For this reason official planning for the elderly in recent years has quite properly laid emphasis on domiciliary and other community services rather than on institutional care. There have been criticisms that the commitment to community care has been less than wholehearted (1) and the provisions less than adequate (2) but no-one has seriously questioned non-institutional life as the desirable objective for most elderly people.

We should view hospital facilities for the elderly primarily as serving this same objective, and it is for this reason that in the last decade the pre-occupation of geriatric medicine has shifted from the supervision of long-stay wards to the provision of those services which prevent hospital admission or minimize length of hospital stay. Such services are acute hospital units, out-patient clinics, day-hospitals, home visiting and liaison with community and primary care services. This change of emphasis has brought geriatric medicine into competition with more traditional specialities for the resources necessary to provide a service aimed at treatment and rehabilitation rather than at institutional care. Government proposals formally to favour the development of hospital services for the elderly (3) provoke predictable outrage among those specialties which have traditionally enjoyed a privileged claim on resources.

This response has amounted on occasion to a call for the

abolition of separately identifiable, and therefore separately fundable, services for the elderly (4). This suggestion may well originate from those who stand to gain from the maintenance of traditional patterns of resource allocation but it can be argued that those services for the elderly which are at present separately identifiable and fundable are not necessarily those which are in most urgent need of development. This dilemma epitomizes a basic shortcoming in the British health and social services that management is restricted by a structure that has grown by historical accretion rather than in response to defined objectives. The structure has come to embody all the inertia of professional expectations and administrative precedent and is incapable of rapid adjustment to changing needs. Even the reorganizations of 1974 apparently owed more to political considerations such as the balance of power and privilege between professional groups and to the relative burden on central and local taxation than to any clear perception of how the health and social services actually work or what they are required to achieve. Certainly, in perpetuating and widening the administrative gulf between hospital and social services the 1974 reorganizations exacerbated what had always been one of the most intractable problems in care of the elderly.

Taking a functional point of view some of the salient features of illness in the elderly which need to be provided for in hospital facilities are:

1. Multiple pathology.
2. Non-specific or atypical presentation of disease.
3. Rapid deterioration of illness if untreated.
4. High incidence of secondary complications.
5. Prolonged recovery phase.
6. Importance of environmental factors—housing, income, social support, etc.

These features place practical requirements on a hospital service for the elderly. First there must be capability for immediate admission when necessary; second the full range of modern diagnostic facilities appropriate to a District General Hospital (DGH) must be immediately available; third supervision by doctors and nurses of appropriate generalist expertise is essential and fourth the facilities for aftercare need to be available and appropriately deployed.

There can be no question about the desirability of immediate access to hospital admission when necessary but the importance of DGH beds in hospital services for the elderly is widely misunderstood and under-estimated. Many administrators and other professionals assume that the call for DGH geriatric beds is essentially a window-dressing exercise aimed at improving the image of geriatric medicine but without any significance in functional terms. This attitude stems from the assumption that geriatric beds today will contain only the long-stay patients who would have occupied them 25 years ago. To a specialist working in some other under-endowed service and ignorant of the wider issues of medical care a DGH geriatric unit may therefore appear as something of a cuckoo in the nest (5). However, experience of providing medical services for the elderly supports the crucial role of DGH beds in practice as well as in theory. Three geriatric services which claim to be successful in providing immediate admission without waiting lists or bed blocking in other specialties and with the generation of minimal numbers of long-stay hospital patients have been described from Sunderland, Oldham, and Hull. These three services are run on different management policies which partition the medical care of elderly patients between geriatric and other medical services in different ways and which result in wide differences of overall admission rates. Analysis of the medical resources, both geriatric and non-geriatric, used by these three services shows that they have a much higher number of DGH medical beds available to the elderly than is to be found in the general run of hospital services (6). It seems reasonable to postulate that the success of these services is primarily due to uncommonly good facilities, in which they are similar, than to management policies, in which they differ.

In these three services the higher availability of DGH beds is due to a large number of DGH beds in geriatric wards. It is appropriate to ask whether it is necessary for these beds to be in the 'geriatric' rather than the 'general medical' allocation or indeed whether it is necessary to separate these allocations at all. We have suggested above on theoretical grounds that old people in hospital will do better if they come under the supervision of doctors and nurses with appropriate expertise. Again there is practical experience to support this concept. An

Edinburgh study (7) has produced evidence that the attachment of consultant geriatricians to medical units reduces the length of stay of elderly patients, independently of transfer to geriatric beds. Studies of so-called 'bed-blocking' elderly people reveal that some of these are being inadequately managed (8). Even if there is *a priori* no reason why general medical units should not be able to manage elderly patients adequately it seems that at least in a proportion of cases they do not. Again, on theoretical grounds, one would anticipate that services for patients who cannot be discharged directly from admission units back into the community but need to go to rehabilitation or long-stay hospital care will be better off if the doctors who provide the acute care are also responsible for the subsequent care. It is only by providing continuity of responsibility in this way that the pattern of care in the acute units can be integrated with that in the rehabilitation and long-stay areas. This integration is necessary to ensure that orientation of treatment is similar throughout the service and that the attitudes of patients and relatives are managed consistently. Integration is also necessary for doctors and nurses to be appropriately apprised of the medium and long-term outcome of their management. It benefits neither patients nor professions for doctors and nurses to be able to allocate their mistakes and failures to someone else's responsibility. Clearly the conventional view of geriatric departments as units of secondary referral taking patients mainly from other hospital departments, either directly or by rejection of general practitioner referrals is not appropriate although it is still implicit in the thinking of many medical and administrative groups.

A further cogent reason for insisting on DGH units for the geriatric service lies with the training of junior medical staff. Many junior doctors recognize the desirability of obtaining some geriatric expertise during their training whatever their ultimate specialization is likely to be, but they are unwilling to apply for geriatric posts or to be rotated to them if work in geriatric departments is away from the DGH and its educational activities.

This reasoning suggests two alternative models of hospital medical care for the elderly. Both require the continued provision of consultants with specialist interest and training in

the management of elderly patients and with particular responsibilities in the management of resources for elderly patients. The first model is to take a defined age as separating the responsibilities of geriatric and non-geriatric units. Conventionally either 65 or 75 has been taken as the dividing age. The former will require a higher resource allocation to the geriatric service but the latter will probably necessitate higher over-all medical allocation of resources because of less direct access by patients aged 65 and 74 to specialist rehabilitation services (6).

The second possible model for hospital medical care for the elderly is based on the fact that at least to the end of the century the elderly will be numerically the most important group of patients requiring such care. It therefore proposes that rather than developing separate and parallel services for patients on either side of an arbitrary age, the organization and responsibilities of general medical units should be adapted to accommodate the needs of the increasingly elderly population. In addition to some changes in the training and attitudes of the medical and nursing staff this model requires that the consultants with special responsibility for the elderly should have their admission beds on the general units and be involved in determining unit policy for training and organization. These same consultants should be responsible for the rehabilitation, long-stay and day-hospital facilities integrated with the units. This approach has been adopted as policy in one or two areas (9) and is facilitated by some of the provisions of the Royal College of Physicians Working Party on 'Medical Care for the Elderly' (10) and some recent DHSS policy (11) but is not yet of demonstrated efficacy. Among the suggested advantages of the arrangement are the increased efficiency in the use of resources compared with running two parallel age-defined medical services and the provision of a more attractive career in geriatric medicine. A third advantage is that it provides postgraduate experience in the care of the elderly under specialist supervision for junior doctors and nurses who may go on to careers which require considerable expertise in the management of elderly patients but for whom no provision is made in post-graduate training for the acquisition of relevant skills (e.g. orthopaedic surgery). There is no reason why this advantage could not be embodied in the age-defined geriatric unit if rotation of *all*

junior staff between non-geriatric and geriatric wards could be insisted upon. Potential disadvantages of the integrated approach are that because of traditional professional attitudes the role of the specialist geriatrician on admission units may be less than appropriate and continuity of care may be less than is possible in age-defined units. The balance of advantages and disadvantages of the two models may vary between different districts but clearly what is required is that each district should make an explicit decision as to which model of care it is to pursue and then adopt short and long-term planning appropriate to that end.

For the majority of districts in England and Wales either model would be likely to require the provision of more DGH resources for the geriatric service. For some years official norms for England and Wales have required that a geriatric service should have at least five DGH beds per 1000 persons aged 65 and over. Problems of definition and unavailability of data make it difficult to assess how close we are to this aim on a National scale. A postal survey of consultant physicians in geriatric medicine in England was carried out in an attempt to answer this question. Respondents were asked what proportion of their geriatric beds had resident junior medical staff, daily availability of laboratory facilities with same-day return of results, and on-site daily availability of radiographic services including barium studies. These three criteria were chosen as a minimal basis for DGH facilities. 141 replies were received indicating that on average 35 per cent of geriatric beds had such facilities. If this is an accurate estimate of the National situation it corresponds to approximately 2·9 beds per 1000 persons aged 65 and over. Of the responding districts apparently 13·5 per cent had no beds with DGH facilities in the geriatric service. This is a serious shortfall and many districts have developed plans for remedying the deficiency in the long-term. Unhappily, if as seems probable, present government thinking is favouring small hospitals and is therefore unlikely to sanction expansion of District General Hospitals, the building of geriatric units on DGH sites upon which so many under-endowed geriatric services have set their hopes will presumably be prevented. This would not of itself necessarily prevent the provision of DGH beds for geriatric services since in many

districts strict adherence to planning norms would permit reallocation of beds to geriatric services from over-endowed specialties. Furthermore, if the need for immediate access to a full range of modern diagnostic facilities is the criterion for placement in a DGH there are services traditionally provided there which are more rational choices than geriatric medicine for deployment into smaller peripheral specialist hospitals. There seems no reason why a case that a physician or surgeon would be prepared to treat as a private patient in an average nursing home should not be treated as a National Health Service patient in a peripheral specialist hospital. Or are we to assume that private patients are commonly offered second-rate care?

One can scarcely imagine that central or local administration will have the radical courage to pursue these options on a wide scale. Indeed a major uncertainty about the future is where the initiative for the improvement of hospital services for the elderly is to come from. One advantage of a nationalized system of health and social services ought to be the ability of central government to impose by persuasion or sanction at least minimal standards on a nationwide basis. In practice enlightened DHSS policy aimed at improving geriatric services has been consistently blocked or attenuated peripherally and the fact that there is no administrative machinery to prevent this suggests that central administration is more concerned with devolving responsibility than with improving standards. The fashionable trend towards what passes as 'local democracy' lends a rationale to this preference as the worsening economic climate and prospect of crisis and scandal provide motive. Clearly initiatives will need to be seized at local level but it is highly doubtful whether Health Authorities as presently constituted will respond appropriately to the needs of the community they serve.

In the longer-term, recruitment of doctors into hospital care of the elderly is a crucial problem. At present consultants in general medicine have an average of around 30 beds under their care while for consultants in geriatric medicine the number is about 180 and the additional commitments of outpatients, day-hospitals, community, and management work are at least as great as in other medical specialties. Although only

15 per cent of all consultants in England and Wales were born outside the British Isles the corresponding proportion of consultant physicians in geriatric medicine is 40 per cent (17). It is doubtful if the specialty could have survived in its present form and with its present deficiencies without this influx of foreign graduates. More recently the lack of competition for consultant appointments in geriatric medicine has raised inevitable fears that candidates of inadequate calibre may be appointed. In addition to clinical responsibilities a consultant in geriatric medicine needs to have considerable administrative and management expertise in order to deploy the resources under his control to the best advantage of the community. Nothing that we have said earlier about the need for resources in geriatric services should be taken to imply that these resources will run themselves. The ability to apply a consistent clinical policy, to enlist the co-operation of colleagues in other disciplines, to create and pursue realistic plans for future developments, all form part of the necessary stock-in-trade of the consultant with responsibility for the elderly.

A major impediment to the recruitment of high quality British graduates into the specialty is undoubtedly the poor working conditions and inadequate resources provided for most geriatric services. Doctors are presumably motivated by the desire for money and social status as much as any other professional group but no doctor who desired only money would opt for a career in the British hospital services while the pickings are potentially so much greater and easier abroad or in general practice. An important element in the motivation of hospital doctors is craftsmanship, the reward in providing a good and progressive service to patients individually and collectively. In only a minority of geriatric consultant posts in Britain are resources sufficient to realize this objective.

Inextricably associated with the problem of resource allocation is the problem of the low status of the specialty in the eyes of the medical profession as a whole. Furthermore, professional status is translated into financial terms through the Distinction Award system and a study of the distribution of Distinction Awards by specialty raises the strong suspicion that a physician opting for a career in geriatric medicine will be heavily penalized in terms of his chances of receiving an award,

particularly an award above the lowest grade. The recently modified rules for Distinction Awards state that outstanding service contributions should be grounds for an Award and this may improve the outlook for some geriatricians. However, the ability to produce a good service depends on having good resources, so to be truly equitable, Awards offered under the new rubric should be for effort rather than achievement (and it may be that this already occurs to some extent). Alternative ways of compensating geriatricians for their poorer Distinction Award prospects are sometimes proposed including a specialty salary lead or such special pension privileges as those still enjoyed by psychiatrists in recognition of the unpleasant nature of their work in days gone by.

The situation is complex however since although the chances of the average geriatrician receiving a Distinction Award is low compared with most other specialties his income from domiciliary visits is likely to be higher. The average annual number of domiciliary visits by consultant geriatricians is reported to be as much as four or five times higher than the average for all specialties (17). Moreover, positive discrimination in the form of salary leads for geriatricians, however well intentioned, would probably be counter-productive. It would be unlikely to attract physicians of appropriate ideals, might be taken to justify the continuation of unpleasant working conditions and would certainly delay the acceptance of geriatric medicine on an equal footing with other specialties. There are also serious doubts about the salary lead paid to nurses in geriatric departments. There is no convincing evidence that it has improved recruitment to the specialty and it does not accurately reflect differences in work-loads between departments. Most importantly it presents a serious barrier to the integration of geriatric departments with the rest of the hospital service and therefore hinders innovation and efficient use of resources.

The function of the hospital service for the elderly is crucially dependent on the other services with which it works. The need for adequate domiciliary services to permit early discharge from hospital and maintenance of disabled people at home is obvious enough. Domiciliary services which are adequate in quantity may not be adequate in availability and in too many

districts old people may have to stay in hospital longer than necessary because of delays in organizing services needed on discharge. The inter-action with psychiatric services is also crucial. There seems little doubt that future planned provision for the psychiatric services for the elderly is set at too low a level (12). By applying a ruthless discharge policy to elderly patients with dementia it is perfectly possible to run a psycho-geriatric department with very few beds. This merely means, however, that some other service, probably less appropriate to the task, will be forced to provide care for the casualties of such a policy. Often it is the social services department but a demented old person maintained too long in the community will inevitably become a non-psychiatric hospital problem through injury, self-neglect, or over-medication. Once admitted to a non-psychiatric hospital bed more appropriate placement may prove as impracticable as discharge back to the community would be inhumane. Anti-social behaviour by a restless noisy demented patient can disrupt the progress of an entire ward of patients in a geriatric unit so misplacement may be more than a trivial anomaly of professional responsibilities. This unhappy chain of events has been recorded in the literature (12, 13) but it is not clear that the need for psycho-geriatric, geriatrics, and social services departments to co-ordinate their activities is sufficiently translated into practice.

We have emphasized the important role of the assessment and active rehabilitation facilities of geriatric services. What of the fate of those patients who cannot respond to such treatment and for whom life in their own homes is an unrealistic objective? At present planning is based on the concept of community hospitals which will contain up to half the geriatric beds of a district. The community hospital is envisaged as a small unit placed near the community it serves, a highly appropriate concept since the family and social contacts of long-stay elderly patients fall off as a function of the distance visitors have to travel (15). Unfortunately, the concept of a community hospital has become confused with that of a general practitioner hospital although the DHSS has made it clear that any beds in the community hospital will only count towards the geriatric allocation if they are directly controlled by a consultant geriatrician (16). This is an important principle since it would

be highly inequitable for a consultant to be given responsibility for a service to the community but not given executive control of resources necessary to discharge that responsibility. It is desirable that there should be general practitioner beds in community hospitals but these must come out of the acute bed allocation and not the geriatric. Community Hospitals are an attractive idea, and not merely for the care of the elderly, but the prospect of their being built in significant numbers under present economic conditions remains remote.

In searching for alternatives, one approach arises from the problem we have alluded to earlier in the essential discontinuity in both administration and facilities between local authority residential homes and hospitals. Because of non-correspondence of criteria between the two services there is a group of disabled people, particularly those afflicted by incontinence, who are apparently ineligible for placement in either institution—even though the strategic concept of the health and social services is of a graded spectrum of facilities for increasingly dependent patients from sheltered housing through residential care to hospital care. The ageing of the population and the improvement of housing standards make it doubtful whether the function of residential homes as envisaged in the early legislation of the welfare state is any longer appropriate. On the one hand we hear that increasing numbers of inmates in residential homes are so dependent that they need the nursing care appropriate to a hospital while it is simultaneously claimed that a significant proportion of inmates are so little disabled that they could manage in sheltered housing (1). Has the time come to agree that only the significantly disabled should qualify for placement in residential homes and that the nursing care and other facilities such sufferers require should be provided there? Observation suggests that in some areas this may already be occurring. Certainly there are wide local variations in the function social services departments see for their residential homes. Such variations probably have an important effect in determining the success or failure of the associated hospital services for the elderly but there does not appear to have been any systematic study of this subject. It seems timely to consider whether some of the facilities destined for the Community Hospitals we shall

probably never be able to afford to build could be provided by formally recognizing a changed role for residential homes.

A new source of confusion in the present uncertainty about the care of the irremediable patient is the call for NHS 'nursing homes'. Unfortunately, 'nursing home' means different things to different people. To nurses resenting domination by the medical profession, and lacking the skill of a Florence Nightingale to manipulate it to their own ends, the nursing home is seen as an institution run administratively and clinically by nurses. For the reasons set out above in discussing community hospitals, admissions to and discharges from any beds contributing to the geriatric service must remain in the control of the physician in geriatric medicine responsible for the total service. All other matters may well be appropriately deployed to nurses—as indeed already happens in practice in most long-stay geriatric hospitals. The only difference would be presumably, that the nurse and not the doctor would be personally responsible for anything that went wrong.

An alternative concept of a nursing home is as a means of providing care for a much wider range of dependency than the present statutory institutions—to comprise, in effect, the conventional functions of residential home and long-stay hospital. This concept is attractive to geriatricians constantly under pressure to transfer elderly people to and fro between residential home and hospital as their condition fluctuates around the conventional and increasingly inappropriate dividing line between the responsibilities of local and health authorities. There is clearly no reason why this concept of a nursing home and that set out in the previous paragraph should not be combined, and precedents both good and bad can already be found in the voluntary and private sectors.

Underlying much of what has been said in this chapter is the concept of responsibility. It is the problem of allocating responsibility for medical care of the elderly that determines the future of geriatric medicine as a specialty. If general medical services were to accept responsibility for all medical or social referrals of elderly people to hospital and extend that responsibility to include the phases of rehabilitation and continued care together with day-hospital and home-care liaison, the future of a separate specialty of geriatric medicine

might be called in question. In a few, mainly rural areas general physicians have accepted such responsibilities and provide excellent services but for the great majority of the country the extinction of geriatric medicine would require a fundamental redefinition of the responsibilities of general medical services.

The physician in charge of geriatric facilities recognizes a responsibility to provide a service to a defined community. He also retains traditional clinical responsibility to individual patients. These two responsibilities may come into conflict when resources are scarce and create ethical dilemmas that are not easily solved. It seems important on both practical and humanitarian grounds to preserve these traditions of personal responsibility in hospital services for the elderly. However, the administration of a geriatric service by clinicians actively involved in providing personal patient care is quite at variance with the way that other professions engaged in the care of the elderly organize themselves. In terms of patient care physicians are in teams with social workers but in terms of executive power and field of responsibility they compare with Directors of Social Services. The non-correspondence of the medical and social work hierarchies is inadequately recognized in the statutory structure for liaison between local and health authorities so that opportunities for constructive co-operation and practical planning are often lost.

In the total pattern of care for the elderly no one service can claim self-sufficiency or absolute priority for new resources. Nonetheless, institution-based care, and particularly the hospital geriatric service, provides a crucial underpinning to the community services. If relatives or others looking after old people at home cannot have complete confidence that institutional care would be available immediately if it becomes necessary, morale is lost and the familiar vicious circle of unnecessary referral and resistance to discharge of old people from hospitals becomes established. An efficient geriatric service is a *sine qua non* for the whole system of care for the elderly in a district. It is clear from the experience already quoted that given a definable adequacy of resources such an efficient service can be provided; the fear that geriatric services are a bottomless pit into which any amount of resources could

be sunk without material improvement in output is totally unjustified. Nor will the elderly simply go away if they are ignored; they are the products of demographic trends at the beginning of the twentieth century and not, as many seem to think, of the medical advances of the last twenty-five years. They will not conveniently die off from some nineteenth-century disease or other if care is withheld from them. The threat of major scandal grows yearly, and enlightened self-interest, if no nobler motive, should persuade health service administrators to grasp some urgent nettles.

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PART III

The structure of care

11 Aspects of quality: management, research and education

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The quality of care has been demonstrated to be a subtle mosaic in which the quantity and allocation of resources, the experience and personal skills of those who provide care, and the reactions of the client all have an essential place (1). The attainment of the objectives set within each of these divisions is finally dependent on human motivation, not least on compassion for the sick or pride in personal achievement, on curiosity for the discovery of truth and on political ambition. Chapters 7 and 13 of *A Question of Quality?* (1) gave a vivid illustration of the high importance of personality and motivation in organizing and in caring. But since most human action falls short of the ideal, chapter 7 also demonstrated how effective organization not only clears the path for extraordinary initiatives but raises the standards of care of ordinary staff and ordinary institutions. Much that has been said in this Report on the care provided to patients in their homes and in institutions has therefore hinged upon the general state of the art in each particular sector of the structure of care—for instance, in the processing of information, as discussed in chapter 12, or in the skills of management, the progress of research and the effectiveness of education as discussed in this chapter. Whilst the present work is not the right occasion to dissect the complex field of quality, it is necessary to make the point that in selecting for mention three aspects of quality, which are indeed often neglected, it has to be assumed that attention will be given elsewhere to other equally important matters, such as sufficiency of resources, professional self-assessment, and patient satisfaction (24)

MANAGEMENT

Management is exercised by those who control an organization's human, financial, physical, and informational resources and in addition have authority over the structure of the organization itself.

The NHS has no headquarters organization other than the DHSS. In these circumstances Ministers and Civil Servants are inevitably part of the management which then extends outwards through the Health Authorities to the 'managers' on the 'shopfloor', the doctors, nurses, and other professionals. Management of the social services is based more firmly in local authorities where, despite some sharing of responsibility with central government, accountability to the people and responsibility for the execution of policy are mainly vested.

Effective resource management at all levels including manpower deployment is of crucial importance to quality of care, since other than by extraordinary individual initiative there is no other means for the implementation of policy and the exploitation of human experience. The role therefore assigned to, or assumed by, the manager, whether in planning or operating services, is an important factor in good management, especially in dealing with the elderly where the quality of care is so dependent on the manager's success in working jointly with the managers of other services.

In addition, however, to the execution of policy, managers bear a responsibility for monitoring the performance of health staff and institutions and in this role lies the most obvious connection with the quality of care. It is evident that management failure occurs every time there is a justified public outcry over patient maltreatment in the health and personal social services. This is in fact a symptom of the distance between centralized bureaucracy and the clientele since the practice, if it was observed, of Authority members and officers visiting every institution to observe standards and support the staff, would prevent most of the notorious scandals which have occurred. Many believe that the Hospital House Committees which existed before 1974 under the old Hospital Management Group system provided, through their volunteer spirit, a closer link with NHS clientele than is the practice today. Such

management failures are also attributable to a failure in technique. It can be shown that a mechanical monitoring of indicators, such as duration of stay and staff sickness rates (2), will give advance warning of a progressive failure of standards of care.

The efficiency of managers in these various tasks will mainly depend on their own educational attainment (3) which is discussed on a following page; and also upon the planning and information systems described in chapter 12 and the presentation, analysis, and dissemination of research.

The Health Advisory Service

The Hospital Advisory Service was set up in 1969 following a series of scandals in psychiatric hospitals. Today, renamed the Health Advisory Service, it is responsible for monitoring both psychiatric and geriatric care. Its objective and procedures have been publicly recorded (1, 4). Its existence is an admission of the previous failure of management at all levels to monitor care and also to win the confidence of those who work at the 'sharp end' with individuals in distress.

The role of the HAS, as it has developed, is principally to stimulate change for the better by comparison, discussion, and description of good practice. It has been stated (5) that it has nowhere found the ideal comprehensive service but it has identified the component parts. It has listed as 'good', twenty geriatric units and fifteen services for the psychiatry of old-age. Despite progress achieved by visiting, reporting, criticizing, and advising, the HAS has, however, not yet found a certain method which leads to a general improvement in services.

The experience of this Working Group is very similar in that a number of excellent but partial services have been discovered. This has led us to consider why good practice is not exploited and disseminated before it sometimes withers due to lack of encouragement or the loss of some key staff. There is an imperative need to record, analyse, and present lessons of successful innovation: but nobody should misjudge the difficulty of carrying through these tasks at the requisite level of quality.

Supervision of voluntary and private institutions

Management is also by statute (6) responsible for the registration and supervision of private nursing homes (NHS) and of independent residential homes (the social services). Although the present system is better than nothing, it is generally acknowledged that control is difficult to enforce. The solution to this problem is certainly not easy, bearing in mind the need to avoid bureaucratic hectoring, to be economical in supervisory manpower, and also to endeavour to sweep within the supervising net unregistered homes and guest-houses which are essentially carrying out the same function as those registered, but it may be at a dangerously low standard. If, however, progress is to be made, a first step should be to make the inspectors independent of those public authorities, in the NHS or local government, which are put under strain by closure decisions. It would seem that one option requiring investigation is the extension of the HAS's responsibility into this field.

RESEARCH

The discovery of new truths, their analysis and the implementation of the implied new directions of action is self-evidently linked to the quality of care. For without 'research and development' and 'research intelligence', as these activities are usually termed, any system of care is likely to become fossilized and that which is bad in it will be permanently preserved. In the course of this study, some gaps in current research have been identified. Systematic study is lacking of the dependency of old people in their own homes, in residential homes and in long-stay hospital wards in relation to quality and cost of care. A short-term reconnaissance was therefore commissioned (7) which demonstrated the fact of overlapping care in these three situations and confirmed the need of a thorough investigation. Although such knowledge is central to any thinking about the overall pattern of care, there has so far been no effective national investigation, though a few progressive authorities have carried out local studies (8). A second pressing need is for properly conducted cohort studies. Another instance of ignorance unrelieved by research concerns the present state of

accommodation in Part III homes. We do not know the extent to which bedrooms and toilet facilities are shared nor whether there is a significant trend of change.

The point has already been made that because of a lack of study the values of much progressive experiment such as is summarized in Part IV, will probably go unexploited. This situation arises almost wholly because of a lack of technique and capacity in the research field.

It is therefore necessary to refer briefly to the state of research of which official details are available on request (9). Judgment upon the output of research must be based on either systematic analysis or on public exposure and debate—or, ideally, on a combination of both. Use has been made in this Report of certain studies which have been published and the value of which has so come to be generally recognized (10, 11). But there is no known analysis of the value and meaning of other research projects relevant to the elderly, although their number is considerable. The great majority of these have been commissioned by the DHSS under the Research Liaison Group system and amount to fifteen completed and nineteen ongoing research projects. In addition, there are of course the relevant studies commissioned by other sections of the DHSS and other Departments.

Since 1973 (12) there has been no known attempt, other than the bald and insubstantial *Annual Reports* series (13) to account for this research expenditure by analysis and synthesis of the results. It has been left to an independent foundation, the Centre for Policy on Ageing, to publish a detailed register of research in this field and to maintain a library of social gerontology (14). With the exception, therefore, of studies such as those mentioned, it is difficult to distinguish which have had a useful outcome.

As to the second pathway to judgment, public exposure and debate, there does not seem to exist a recognized policy for publication of the results from projects commissioned in this field by government. It is true that investigations into biomedical problems, such as hypothermia, stroke, and dementia, are published and scrutinized under the traditional and extensive exposure provided by the medical and even the lay press. But there is no such coverage for subjects such as comparative

studies of varying patterns of institutional and personal care. Probably nobody knows the quantity and quality of work put into this field. The quantity is likely to be considerable since most new local innovations commence today with some inbuilt commitment to evaluation. But quality is likely to be lacking for want of scientific support. These deficiencies, both of analysis and of technique, may be explained by the history of health care research (15), as a result of which there has been little progress in conceptualizing and developing the skills required for the comparative assessment of models of care. The first priority therefore, in the particular field of research for the care of the elderly, is the general task of creating an intellectual framework for health care research, of strengthening research bases and of sharpening a publications policy.

EDUCATION

Of the many and various aspects of quality of care, professional education is conceivably the most important because it should provide the distillation of policy, practical experience, and advanced thinking which will be hard for the ordinary professional person to come by in his working career.

The attitudes of a profession as a whole towards work within one of its specialties with one particular group of clients are determined to a large degree by the opportunities given during professional training to see the work involved (16). Secondly, attitudes are also conditioned by the advice proffered by teachers to their students. If there is no exposure to a particular specialty, it is almost a corollary that there will be no teachers who are themselves knowledgeable about it and likely to advise students favourably about its attractions. Once the student has progressed to be a qualified professional and is committed to another and more 'popular' specialty, he or she will be unlikely to switch allegiance, whatever the intrinsic merits of other specialties. It is therefore highly significant that until recently three of the major professions involved with care of the elderly, the medical, nursing, and social work professions, in their individual ways created a bias during professional training which discouraged a commitment to caring for the elderly.

Medicine

There has already been reference to the need in medicine for the rotation of all junior staff in training between geriatric and non-geriatric wards in order to present a balanced picture of health care challenges. Where this is already practised, it has been found that some young doctors develop a natural commitment to caring for the old. The more usual position however is as described in chapter 10, with poor competition for medical appointments associated with care of the old and an 'unpopular' image in the minds of a majority of doctors of such a career.

Until recently the GMC and the Joint Committee on Higher Medical Training, whilst recommending the educational pathway for the small minority who at present opt for a career in geriatrics, made no reference to the need for all undergraduate and postgraduate students to have an objective exposure to both the practice and the challenge of such a career. As a recent article in the *BMJ* shows (17), this failure is now coming to be recognized.

The Education Committee of the General Medical Council has recently issued new recommendations (18) the relevant sections of which merit quotation:

> *B(3): The undergraduate curriculum analysed by subjects*
> (A) The Study of Human Structure and Function, and Human Behaviour, Paras 42–6,
> 45 . . . The principles of demography should also be taught, including the effects upon society and upon medical practice of the increasing numbers of elderly people in the population . . .
>
> (C) Clinical Studies, Paras 50–65
> 50. The term 'clinical studies' is used to embrace Medicine and Surgery and their many sub-disciplines, Obstetrics and Gynaecology. Child Health and Paediatrics, Psychiatry, Social and Preventive Medicine, General Practice, and Ethics and Legal or Forensic Medicine. During the study of these subjects the attention of the student should be constantly directed to the importance of the interrelationship of the physical, psychological and social aspects of disease and the growing importance of the

problems posed by disability and disease in an increasing elderly population. The teaching of clinical subjects should also provide opportunities to ensure that due attention is paid to health education and to bring out the importance of rehabilitation.

58. Psychiatry: Students should be introduced to the care of the chronic and the elderly psychiatric sick . . .

59. The Elderly: The student should receive instruction in the special problems of diagnosis and treatment of illness in the elderly and in maintaining mental and physical health in old age. He should be introduced to the range of domiciliary and institutional services available for the care of the elderly.

Though this move is very hesitant, it is to be welcomed as an advance. There should now surely be a Department of Medicine concerned with care of the old in all medical schools. It is also significant that an American report under the auspices of the Institute of Medicine (19) has also found that 'substantial improvements in teaching about the process of ageing and the problems of the aged are required at all levels of medical education'.

The psychiatry of old-age

Undergraduate and postgraduate education in the psychiatry of old-age has lagged in most respects behind even the hesitant steps forward made by the medical specialty. There is very little exposure of the student to the problem and there are very few postgraduate training posts in existence.

The first signs of improvement have recently appeared. A section for Psychiatry of Old Age has been created within the Royal College of Psychiatry and a member of the sub-specialty is entitled to sit on the Council of the College. At Nottingham, Dr Arie, a leading member of the sub-specialty, has for some time been Professor of Health Care of the Elderly.

General practice

The Royal College of General Practitioners jointly with the British Geriatrics Society has issued for study a Paper on training general practitioners in geriatric medicine (20). This

recognizes a stark contrast with training in paediatric medicine in the degree to which in the case of geriatrics out-dated attitudes are still taught. The Paper recommends that training in geriatric medicine should begin at the undergraduate level and be reinforced throughout the postgraduate career.

Nursing

Educational developments in nursing have some similarity to those in medicine, except that they are rather more advanced.

Until recently student nurses had no obligatory training in the care of the elderly. In 1979 the implementation of the EEC Directives ensured for the first time that all student nurses should undertake a minimum of eight weeks training in the geriatric department and it is hoped that, as with junior doctors, this will stimulate sufficient numbers to a permanent commitment in this field.

The Joint Board of Clinical Nursing Studies has also approved post-basic courses in the Care of the Elderly. Course 297 is entitled 'Care of the Elderly and Geriatric Nursing for Registered and Enrolled Nurses'. The length of the course is 24–27 weeks and it is designed to train nurses in all aspects of the specialty including the physical, social, psychological, and psychiatric aspects of the care of the elderly in the community, the general hospital and the psychiatric hospital. The course is suitable for both hospital and primary health care nursing staff and is available at fifteen centres in the United Kingdom. The second course, no 940, is a short course entitled 'Care of the Elderly and Principles of Geriatric Nursing for Registered and Enrolled Nurses'. This course is 10–15 days and is designed for nurses working in hospital or in the field of primary health-care whose work is wholly or partly concerned with the care of the elderly. This course is available on a day-release basis at forty-two different centres in the United Kingdom.

These approved Joint Board of Clinical Nursing Studies Courses are certificated on completion.

Social work

The Central Council for Education and Training in Social Work recognizes a responsibility for ensuring that social work courses include teaching and practice learning opportunities in the

field of work with older people. The Council is aware of some apparent lack of enthusiasm amongst students for such work which may be due to their misconception that observable progress should always be the outcome of professional intervention, and also to the unsatisfactory quality of supervision students get on practice placements.

A number of changes have recently been introduced. A Certificate in Social Service has, as a standard option, one option on the elderly which is now taken by substantial numbers of students. However, there is more difficulty over staff interest in a part-time programme of post-qualifying studies. Short courses on teaching about work with the ageing are, however, over subscribed.

The remedial professions

Both the Chartered Society of Physiotherapists and the British Association of Occupational Therapists have developed over the last two years Special Interest Groups in Care for the Elderly, the objects of which are basically similar, to help new members and those who have previously lacked help by the arrangement of regular lectures and exhibitions: and also to develop post registration education in geriatric medicine.

Wardens and care assistants

There are an unknown number of wardens (of 'homes' and sheltered accommodation) and of care assistants who need training in duties such as care of the incontinent, the administration of medicines, and application of dressings, hygiene, and the use and fitting of equipment and appliances. The training requirement each year will be considerable and is increased if the needs of 'home-helps' are added. Taking into account the large private and voluntary sector, the total of such staff might run as high as 100,000. Some local authorities have reacted by providing short in-service training. In addition courses in caring services have been started by certain Polytechnics and are of a comparatively advanced content, leading to a Certificate in Caring Service. The Local Government Training Board is also involved.

Managers

A very powerful case can be argued for planning and financing a campaign for the continued education of all senior 'managers' as previously defined. This major gap in our training system has been debated for a number of years (21, 22). The Director of the Health Advisory Service is at present arguing (23) that in the limited field of mental illness in old-age there should be an educational campaign aimed at health-care planning teams or psychiatric services management teams based upon structured material prepared by acknowledged leaders in the field.

It can be argued that our plans should be more ambitious than that. Education about the policy problems and innovative solutions over the whole field of care of the old could be pioneered as an experiment in the continued education of senior staff. There are admittedly difficulties to be foreseen in carrying through such a project. It needs to be based not only upon experience of acknowledged quality but also upon a fundamental belief in integrated service to the individual person, crossing over administrative boundaries as outlined in chapter 5. Such a campaign should be doubly valuable because of its stimulative effect upon thinking previously hedged within the confines of a single profession. However, its creation could not fall neatly within existing single service procedures. A feasibility study of the implications of such a campaign would be necessary before further action could be commenced.

CONCLUSION

The remarkable features of the over-all situation are firstly, the belated but significant trend towards recognition that care of the old is one essential part of all health and social care and must therefore be included in the professional educational syllabus; and secondly, the isolation of each profession despite the fact that the core training is necessarily similar.

There exists at present no recognized mechanism for the comprehensive discussion of educational issues affecting the health and personal social services. In particular, no single body is responsible for training and supply in any one profession, nor is there any one body taking an overview across all

the professions. It has for instance become a matter of principle that the DHSS and General Medical Council should act within separated zones of responsibility.

Research which potentially might become a balancing influence upon the unilateral thrusts of professional and educational self-interest, is as yet no more than an aggregate of tactical advances, each separately inspired by short-term and ephemeral objectives. The obvious deficiencies in the supply of staff for the care of the elderly can therefore be no surprise, and the consequent problems should be approached without illusions about the prospect of finding a simple or easily popular solution.

Against the pluralistic background to education development which has been described, it is not surprising that there are information gaps and that advances are being made piecemeal. If our report has made out a case for greater deliberation and determination in action across the whole field of care, a part of this must be in respect of setting standards of training. In England the RCP, the RCGP, the Joint Board of Clinical Nursing Studies, the Central Council for Education and Training in Social Work and the British Geriatric Society, are some of the many institutions already closely involved. The time is right to enquire whether these initiatives should be pressed more vigorously and if there is a case for a national institute to weave together the very varied strands of interest.

There is also a powerful case for experiments at local level to discover how far a joint in-service training syllabus could be introduced for those who deliver day-to-day care, whether they work in the NHS or social services and whether in the public or the private sector.

Both those who provide care for the old and those who organize it are ill-prepared by our educational institutions for the coming crisis, described in chapter 1, when the number of those aged 85 and over increases to 60 per cent above the current level. *The independence of the Professions bears with it the burden of responsibility for reacting decisively to the threat by a major re-orientation of the direction of professional education.* The responsibility for preparing 'managers' is more difficult to determine because of the manner in which the DHSS is both divorced from the NHS and wedded to political authority. Before any final decisions on this have to be reached *we could*

take the first step, a study of the feasibility of launching an educational campaign aimed jointly at senior staff in both the health and personal social services. That could be within the capacity of the NHS or of an independent foundation.

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12 Information for planning and policy making

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INTRODUCTION

A necessary feature of a successful service is the availability of adequate information both for the day-to-day management of services and for the derivation of longer term policies. The term 'information' however lacks clear definition and several different (though inter-related) aspects can be distinguished. For example, there is the information which doctors or social workers require to provide care to individual patients or clients. There is the information which administrators require to manage particular services. Another kind of information is required by individuals in need of some form of care who are seeking an appropriate service. Finally policy makers and planners need yet a different set of information. All these kinds of information (and others) are essential if services sensitive to the real needs of the elderly population are to be provided and used efficiently, and except for the last category have been discussed in other chapters. In this chapter, therefore, only the role of information in the context of the policy maker and planner will be considered.

The adequacy of information is often criticized, though paradoxically there appears to be an abundance of data—some would say too much data. It follows, therefore, that the first step in an enquiry on information must be to review the content of those sources which currently exist. An appraisal of their content and availability for analysis will point to a number of shortcomings. Frequently criticism is made of the accuracy and timeliness of information, and often routine data sources are not analysed except as the result of persistent request. This

strongly suggests that it is the processing of data which constitutes a weak link in the chain of providing adequate information. This is not a new revelation. Indeed the failings in this respect have been pointed to on a number of occasions in the past (1, 2), and apparently ignored. The information requirements for planning comprehensively for the elderly exemplify the need for an 'information broker' who has the skill to comprehend the requirements of the policy maker and to use the different information systems to extract data and to analyse and interpret them appropriately.

Having reviewed, in brief, existing sources, an analysis will be presented to illustrate the potential and the limitations of existing data. Chapter 10 has pointed to the important position of hospital services in the comprehensive pattern of care. An examination of current levels of usage and provision of hospital services throughout the NHS points to large geographic variations which cannot easily be explained. Following on from this, an analysis of the demand and usage of hospital in-patient facilities in one Regional Health Authority and the projection of this into the future, indicates that available resources are probably adequate to cater for the effects of demographic changes, provided efficient use is made of beds and that a responsive balance between specialties is ensured. The relevance of such an analysis is highlighted in the evidence emerging from the current round of strategic planning in the NHS, which indicates that simple approaches are being adopted which ignore known facts which could be accounted for by using existing information. Failure to analyse adequately the future pattern of demands could have significant implications. This suggests that much more use could be made of existing data and that the skills of the information processor are in short supply.

A REVIEW OF EXISTING SOURCES

It is first necessary to consider in brief the main tasks for which information might be required in order to assess the adequacy of existing data sources. Descriptions of some of the main sources referred to are included in an appendix to this chapter.

Socio-demographic data, and needs

The ultimate objective of planning and policy making must be to provide a comprehensive range of services which are sensitive to the real needs of the elderly population. It follows, therefore, that the starting point must be the consideration of the size and structure of the elderly population for a defined area and the way that it is changing in the future. Definitive data on the characteristics of the population are only available once each decade from the national census. Based on these data, and using data collected continuously on births, deaths, and migration, the Office of Populations Censuses and Surveys (OPCS) produce mid-year estimates for each intervening year as well as projections for future decades. In the event, when past projections can be assessed against census data, the predictions of future populations have often been characterized by large errors. These result in the main, from the difficulties of predicting future birth-rates. For the elderly, however, the projections should be much more reliable since projecting for these age-groups involves the progressing of known cohorts from the census using death-rates which are more stable (in relation to birth-rates). Thus, for example, projections can be obtained for the populations resident within each Area Health Authority's boundary with data shown by sex in two age-groups: 65–74, and 75 plus. Data for the United Kingdom reveal a decline in the population aged 65–74 up to the next century, but increase in the population aged over 75 up to the year 1991, after which the level remains constant. (The implications of these trends are considered in chapter 1.) Some local authorities produce forecasts of their own future populations which take account of additional factors such as planned housing developments which are thought will affect future populations. Data on the social characteristics of populations or other factors which might influence their need for services and care are more difficult to come by for other but the census year. At the national level, surveys such as the General Household Survey undertaken annually, and the detailed one-off survey The Elderly at Home provide some guides. At the local level, registers of handicapped and disabled, payments of disability allowances, and the General Morbidity Survey, pro-

vide some insight, though all these sources may be challenged about their completeness and representativeness. Some local and health authorities, and voluntary bodies, have undertaken special surveys on particular aspects. Though these data provide a general descriptive picture, the translation of such factors into assessments of the need for particular forms of care or services is difficult and involves an element of subjectivity, since exact knowledge cannot exist. The only unequivocal measure of morbidity is the certification of death.

Data on services provided

The policy maker will need data on the services currently provided and the use being made of them. A number of sources exist, and there are some notable gaps. A fundamental problem is that different services are the responsibility of different administrative authorities located at different geographic levels. There is no single body responsible for policy at the 'local' level or for planning the comprehensive range of services. Of immediate concern are policies on health, social services, and housing. The latter two areas may be administered by different levels of local government, under different political principles; when personal social services and housing fall within the same local authority there can still be no guarantee that a comprehensive approach will be taken. (The problems in this respect are considered in chapter 13.) Consequently, there is no focus for providing a common information base. Even if the need for providing a comprehensive set of data for a defined geographic area was perceived, the logistics of bringing together the disparate data from different authorities and agencies would be exceedingly difficult, though the very few 'shining examples' (3) point to what might be done. Not only is there no focus, and the data incompatible, but the data are frequently locked within individual bureaucracies and access is for all practical purposes not possible. The need for a focus of responsibility for deriving comprehensive policy for the elderly is a recurrent theme in other chapters; implicit in this is the need to provide comprehensive information for defined geographic areas and to overcome the incompatibilities in existing sources. The need to integrate data from different sources is widely acknowledged, particularly with regards to medical

information; this has provided the stimulus for the Oxford Record Linkage Study, the Scottish record linkage facility and the OPCS one per cent national cohort. In addition there are a few examples of health and local authorities perceiving the need to provide a comprehensive information base. These are only isolated examples and the absence of an integrated information service elsewhere is an absolute obstacle to the policy and planning process.

Health services

An extensive range of data is collected on particular services and forms of care as shown in the Appendix. Thus, on health services, Hospital Activity Analysis, the Hospital Inpatient Enquiry and the Mental Health Enquiry offer a range of patient-based data, though not without certain limitations. The SH3 return shows certain data on institutions and their work-load in particular recognized specialties. One notable gap in these systems is the absence of data on 'psycho-geriatric' services, though in this respect problems of definition are inherent. *Staffing* returns indicate levels of manpower resources, but these returns were designed primarily to provide counts of staff in different grades and it is difficult to relate these to the service they actually provide. Returns indicate levels of particular community care services. Existing *costing returns* do not allow the direct calculation of the cost of the elderly, though unpublished data held in the DHSS indicates a steep gradient of rising costs with age (for all health and personal social services estimated costs per person, per year are: 0–4, £160; 5–64, £85; 65–74, £250; 75+ £635). A major gap is the absence of data on *primary-care*, and in particular on the services provided by the general practitioner. It has been pointed out in a previous chapter that GPs receive higher *per capita* payments for the elderly on their lists though there is no information on the assumed higher levels of service provided for the elderly. The records held by the Family Practitioner Committees (FPCs), because of the need to calculate the *per capita* payments, would allow the automatic maintenance of age/sex registers for GPs if the card-files currently maintained manually by each FPC (one card per patient, approaching half-a-million records in some FPCs) could be transferred to a

processible medium. Only a minority of GPs currently have age/sex registers. The Trent Regional Health Authority has been developing a computerized FPC system; to date it is understood that four FPCs have their records computerized. One FPC has estimated that the cost of computerizing its records will be more than off-set by eliminating the excess *per capita* payments to GPs which are inevitable because of duplication in the manual records.

An important problem with most NHS data services relating to the elderly is the use of the terms 'geriatric' and 'acute' without appropriate qualification. Such terms are often used for planning and resource allocation purposes and they spuriously imply homogeneity within the two respective groups. An improved classification system which reflects operational practice is required as a matter of some urgency.

Social services

Surprisingly extensive data, on *residential accommodation*, are requested by the DHSS from social service departments. Unfortunately, however, this does not extend to any detail about grades of accommodation. The RA1-4 returns include data on potentially all unit provision (including voluntary and private homes, though it appears the data are not always returned), as well as on the residents accommodated within that provision. In contrast with other sources, data are recorded on where individuals were admitted from and discharged to, thus providing one aspect of an otherwise undiscernible picture of the flow patterns between different forms of care. If properly analysed this could be a valuable source, and it is interesting to note that the returns themselves are designed as 'punching documents' in order that the data might be transferred to a computer processible medium. Presumably this is a task undertaken in the DHSS which issues reports (which do not seem to exploit the full potential of the data) about two years after the data have been returned. Other data returned to the DHSS provide statistics on services such as meals on wheels, home helps, etc.

The Chartered Institute of Public Finance and Accountancy (CIPFA) produce a range of statistical publications which draw together a variety of data on local authority services. The booklet *Personal Social Service Statistics*, produced annually,

gives a concise picture of personal social services in all authorities including sections specific to the elderly. These data reveal substantial variations in the levels of services between different authorities (cf. the variations in hospital provision considered in detail in later paragraphs). There is the need to relate these variations to other factors such as socio-demographic variables. An absence of any quantifiable association between different aspects of social service provision and other health services indicates the absence of an identifiable and comprehensive strategy.

Housing

The Department of Environment requests remarkably little data on *housing provision*, in contrast with the extent of the data requested by the DHSS on residential accommodation for the elderly. As a consequence of the inadequacy of available data, a study on sheltered housing for the elderly has been recently commissioned by the Department of Environment from the Oxford Polytechnic (4). It would be useful to have available data describing the criteria which different housing authorities use to allocate tenancies to the elderly. This constitutes one important aspect in a complex picture of the flow patterns between different services. For obvious reasons data describing the 'twilight zone' of hotels and boarding-houses for the elderly do not exist and it is not possible to estimate the extent to which these forms of provision exist, only occasionally do they come to light.

Given these (and other) data sources, the problem for the policy maker is then to analyse these and produce plans, and there are indications that more might be done in this respect. It has been argued that there are organizational and logistical obstacles to be overcome. Yet there is evidence which indicates that within particular services when these problems should present no real difficulties, full use is not made of existing data. The following example indicates that the consequences of such shortcomings might be significant.

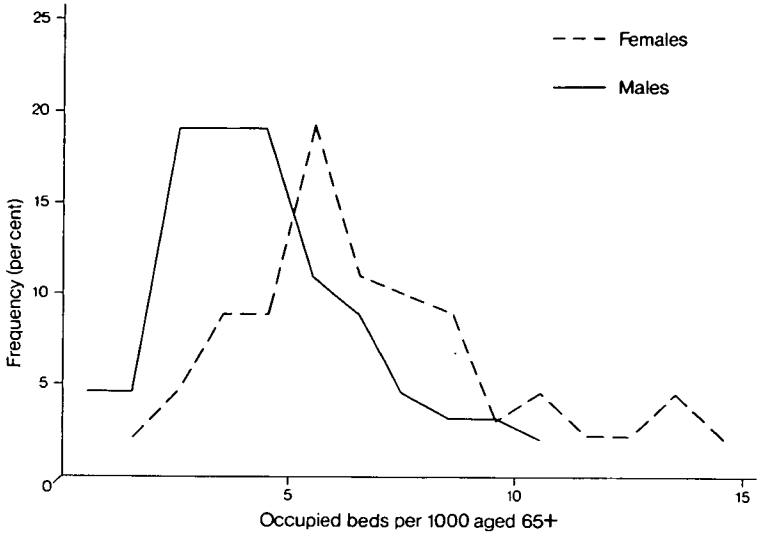

Figure 12.1. *Distribution of sex specific rates of geriatric bed usage by patients aged 65+ for Area Health Authorities in England.*

ILLUSTRATIONS OF INFORMATION PROCESSING

Previous chapters have established the important position in the complex of services which is occupied by the hospital. Data were abstracted from the 1975 HIPE aggregated to give the total numbers of beds used by patients resident in each Area Health Authority aged over 65, by sex, in 'geriatric' and in all other 'acute' specialties. These figures were divided by the corresponding OPCS mid-year estimate of population to give age/sex specific rates of bed usage for each AHA. Figure 12.1 shows rates of geriatric bed usage for males and females expressed as frequency distributions. It can be seen that women on average use almost twice as many beds *per capita* than men (the mean rates of usage are 8·6 beds per thousand for women aged sixty-five and above, as opposed to 4·6 beds per thousand for men aged sixty-five and above). Figure 12.2 shows similar frequency distributions of acute bed usage. It can be seen that men use marginally more beds than women (the mean rates of usage are 7·3 beds per thousand men aged sixty-five and above as opposed to 6·3 beds per thousand women aged over sixty-

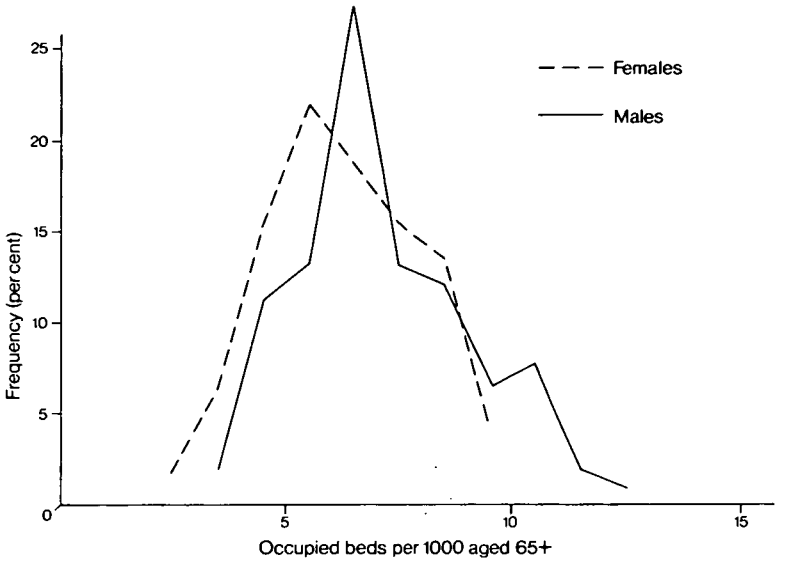

Figure 12.2. *Distribution of sex specific rates of acute bed usage by patients aged 65+ for Area Health Authorities in England.*

five). It should be noted from these results that almost as many acute beds as geriatric beds are being used by the elderly.

It is interesting to note the wide range of variation in the rates of usage between different Area Health Authorities; the coefficients of variation (a statistical measure of variation, i.e. the standard deviation divided by the mean expressed as a percentage) for all four distributions are about 50 per cent. Some differences are to be expected since Areas and their residents are undoubtedly heterogeneous in terms of social and other characteristics (urban versus rural, industrial versus agricultural, etc.). Also, the rates of usage are a product of different mixes of admission-rates and corresponding lengths of stay and are likely to be influenced by the availability of beds. It could be that in some instances beds classified as 'acute' are in fact no different from 'geriatric' beds. If acute beds were 'substituting' for geriatric beds (or vice versa) on a consistent basis, then this would be evident in terms of reduced variation in the distribution of total (i.e. geriatric plus acute) bed-usage-rates and in terms of statistical correlation between acute and

geriatric bed-usage-rates. No evidence of any such quantifiable association was found in the data.

Routine data describing other hospital services are less comprehensive than for in-patient care, the main source being the SH3 return. The data are aggregated by place of treatment rather than residence and, therefore, expression of rates in terms of resident population may be misleading—though there is no alternative. For the elderly aggregated to AHA level, the extent of any error should be minimal, but this is an assumption which cannot readily be tested. Since the data are also presented by specialty, no insight into usage by the elderly in any specialty other than geriatrics is possible.

Table 1 shows the mean rates of provision together with their respective coefficients of variation. Little by way of quantitative

Table 1. Mean rates of provision with coefficients of variation for various forms of service. Correlated with geriatric bed-usage-rates for Area Health Authorities in England.

Form of service	*Mean rate (per 1000 65+)*	*Coefficient of variation (%)*	*Correlation coefficient between total geriatric bed-usage-rate and rate of provision of service*
Number of new regular day-patients	5·8	72	0·22
Number of total regular day-patients	171·7	82	0·16
Number of new out-patients	5·9	85	0·17
Number of total out-patients	37·6	84	0·11
Number of out-patient sessions	3·8	103	0·10

Source: 1975 SH3 data. 1975 OPCS mid-year estimates. 1975 HIPE data.
Table 1 shows the extent of the correlation between total geriatric bed usage rates and the other forms of provision. It is not immediately obvious what the sign of the correlation coefficients should be (negative indicating substitution between services, or positive indicating both services increase or decrease correspondingly), but as is shown in table 1, the values are in general positive but not very significant statistically.

criteria for providing these services has been established, but the respective coefficients of variation give some guide to the wide range of provision between different AHAs. Intuitively, some statistical association between the levels of in-patient and out-patient and day-patient services might be expected, but none is really evident in the data.

The over-all picture is one of large variations between different AHAs. Given sufficient data, attempts could be made to 'explain' these variations statistically, for example in terms of differences in socio-demographic characteristics. If a significant amount of the variation could be explained then this would have important implications for national resource allocation policies. If variations could not be explained, then this would indicate that the data were inadequate, or more likely that the differences were a result of historic deployments of resources unrelated to the present population characteristics, and that a policy to correct this position was required.

Within this over-all picture it is possible to obtain a more detailed picture for particular areas from existing data. Table 2 shows data obtained from the Oxford Record Linkage Study for 1977. The data show the usage of beds and rates of admission by sex and age for broad groups of diseases. The data are from Oxfordshire and West Berkshire, a mixed urban and rural area with a population at risk of about 900,000. All hospital in-patient admissions and most day-cases are included, but day-patients are not included (which represent a sizeable group in mental illness). The purpose of this table is to show the highly variable pattern of admission rates between age and sex groups for different types of diseases; in addition, to show the high numbers of beds occupied by these different groups. Should fine detail be required of specific conditions within the broad disease groups shown, then this could be readily obtained from the basic data. If the data were re-analysed by specialty rather than disease group then an equally variable pattern would be apparent, with the elderly making significant demands on most acute specialties in addition to the geriatric specialty.

The results shown in table 2 reveal that in the cases of diseases of the circulatory system, diseases of the respiratory system, mental illness, accidents and poisonings, and the residual group, the rates of admission increase markedly with

Table 2. Condition specific usage of beds, and rates of admission by age and sex.

		Males			*Females*			*Total*		
		65–74	*75–84*	*85+*	*65–74*	*75–84*	*85+*	*65–74*	*75–84*	*85+*
Neoplasms	*beds+*	35·5	19·9	3·2	23·6	18·0	7·2	28·8	18·8	5·4
	*rate**	40·5	52·8	35·4	25·6	25·3	20·9	32·2	34·1	24·6
Diseases of	*beds*	25·5	32·6	9·6	21·0	35·9	28·5	22·8	34·6	21·1
Circulatory system	*rate*	32·8	56·8	83·0	20·3	40·4	63·8	25·8	45·8	68·8
Diseases of	*beds*	23·6	24·4	11·1	20·9	22·4	27·9	22·3	23·4	19·6
Respiratory system	*rate*	14·4	31·9	54·3	6·6	14·2	27·2	10·0	20·1	34·1
Mental°	*beds*	13·1	7·5	3·4	17·9	19·3	10·2	15·7	13·8	7·0
illness	*rate*	4·8	9·7	25·9	4·3	10·9	13·7	4·5	10·5	16·8
Nervous	*beds*	22·5	25·2	3·8	20·8	32·7	21·0	21·4	29·9	14·6
System	*rate*	9·6	18·8	16·0	9·7	16·3	16·8	9·6	17·1	16·6
Diseases of	*beds*	18·2	16·0	2·5	17·6	20·2	7·3	17·9	18·1	4·8
Digestive system	*rate*	21·2	25·3	27·8	13·2	16·9	16·6	16·7	19·7	19·5
Diseases of Genito-	*beds*	24·0	21·8	2·0	8·7	8·3	2·7	14·5	13·4	2·4
Urinary system	*rate*	14·1	19·7	17·5	7·0	6·0	6·2	10·2	10·6	9·1
Diseases of Musculo-	*beds*	19·6	7·8	2·0	23·0	25·5	12·6	21·8	19·5	9·0
Skeletal system	*rate*	9·4	9·8	8·0	13·1	13·6	13·7	11·4	12·3	12·2
Accidents and	*beds*	10·5	7·5	2·6	15·2	29·1	24·9	13·1	19·7	15·2
Poisonings	*rate*	9·0	12·7	23·1	10·7	26·0	54·9	9·9	21·5	46·7
All Other	*beds*	20·6	17·2	7·4	12·6	19·7	12·1	15·4	18·9	10·5
Conditions	*rate*	51·2	87·9	185·4	37·4	85·7	178·3	43·5	86·4	180·1

+ Beds occupied by a specific age-group as a percentage of all beds occupied by its respective sex.
* Sex, age, and diagnostic specific rates of admission per 1000 community population at risk.
° Long stay patients (those admitted before 1977) not included
Source. *Oxford Record Linkage Study Data 1977.*

age for both sexes. This trend is apparent also for diseases of the nervous system and diseases of the musculo-skeletal system in females, and for diseases of the digestive system in males. For the remaining groups (with the exception of diseases of the genito-urinary system in females) rates of admission increase up to the age of eighty-five, but then show a tendency to level off or decrease slightly. The case of diseases of the genito-urinary system in females is the one exception where the rate of admission is higher in the 65–74 age group than in the 75–84 group. For the majority of disease groups, rates of admission for men are higher than the corresponding rates for women; in the cases of diseases of the musculo-skeletal system and of accidents and poisonings the reverse is true. Table 2 also shows the result of translating these admission rates into the corresponding beds used. In this table, for each broad disease group the numbers of beds occupied are expressed as a percentage of the total beds occupied by all ages within each sex. (Thus, for example, it can be seen that for neoplasms, males aged 65–75 occupy 35 per cent of all the beds occupied by males of any age for that condition.) The proportion of beds occupied tends to decrease with age because of the reducing numbers of the population at risk in the older age-groups. For the majority of conditions it can be seen that the population aged over sixty-five occupies in excess of half the beds of all those used, in accordance with the more general picture described previously for all AHAs.

Simple analyses, such as the one outlined, could be performed throughout the NHS based on the data collected under the Hospital Activity Analysis (HAA) system. This would undoubtedly confirm the results obtained for Oxfordshire and West Berkshire—that rates of admission vary considerably with age, sex, and condition, and that it is therefore inaccurate to consider the population aged over sixty-five as homogeneous in terms of their need for medical care. This may seem to be no more than an observation based on common sense. It is surprising, however, to observe that many Regional and Area Health Authorities have adopted simple planning 'norms' for calculating future bed requirements which ignore these facts. Ten Regions have to date produced the strategic plans originally requested by the DHSS for 31 January 1979. All Regions

calculate separately 'geriatric' and 'acute' bed requirements. To calculate 'geriatric' bed provision, half the Regions use the DHSS recommended norm of 10 beds per 1000 population aged over sixty-five, which dates back to the 1962 Hospital Plan when population structures were very different; three Regions use separate norms for the age (not sex differentiated) groups 65–74 and 75+; only two Regions use age and sex specific norms, though one of these includes the Standardized Mortality Ratios (SMRs) as an additional factor. To calculate 'acute' bed requirements, half the Regions use a norm undifferentiated by age, sex, or even specialty; one Region applies a norm undifferentiated by specialty to a population weighted for age and sex differences; the remaining Regions use age, sex, and specialty specific norms; though again one Region chooses to include SMRs in its calculation. There is no known yardstick by which these different forms of calculation might be assessed. Yet, given the probable reliability of the forecasts of the changing population structure, and given the evidence that current patterns of demand are highly age and sex specific, the calculation procedures which fail to acknowledge these facts would *appear to be inadequate*, and fall short of what is practicable.

Analysis in one Region (5) has indicated that, if current and past trends in demand and usage of hospital in-patient services are projected forward with the changing patterns of population structure, then existing *bed provision is probably adequate*. For this to be the case, however, re-deployments of resources between certain specialties are required. (Though such an analysis indicates that the capacity exists, inevitably capital expenditure would be required, for example to up-grade and re-equip wards.) Analysis of HAA data for the Region and OPCS mid-year estimates of population, allowed the calculation of age and sex specific rates of treated demand and bed usage by specialty for one Area within the Region. As has already been demonstrated in table 2 with an analysis by broad diagnostic category, these rates are highly age, sex, and specialty dependent. Analysis by specialty rather than condition was preferred since the former has more meaning in physical planning terms. When these rates were applied to the future population structure of the Area, estimates of the demand and corresponding

bed usage were calculated based on the assumption that current rates were maintained. From SH3 data however, historical trends were apparent and these were projected forward and used to modify the constant rate calculations. (Trends had to be estimated from SH3 data since the HAA system had not been in operation for a sufficient number of years to enable calculations to be based on that source.) Analysis of SH3 data also revealed that substantial improvements in lengths of stay and turnover intervals were possible based on practice then being achieved in other parts of the Region. When improvements in these factors were used to modify the projections obtained thus far, it was evident that the existing bed stock appeared adequate to accommodate the demographic changes even when allowance was made for historical trends (largely increasing) in demand rates. This analysis was confirmed by the Region's own analysis along similar lines which resulted in proposals issued for consultation to amend the bed norms used for planning (6). It was stated:

> The current overall (acute) norm of 2·5 beds/1000 population has been accepted by the Trent region since June 1975 and followed from a meeting of the Sheffield RHB in September 1971. The split of this norm between specialties was also agreed, for guidance only, at the 1971 meeting based on the latest information then available regarding bed usage. The purpose of calculating new-norms is therefore threefold:
>
> (i) to take account of known changes in medical practice, as reflected by demand rates and lengths of stay over the last seven years;
>
> (ii) to anticipate likely changes in these factors over the near future in so far as these are indicated by trends over the past few years;
>
> (iii) to allow explicitly for different bed requirements for populations with different structures.

Thus, using HAA, SH3, and population data, calculations were performed along the lines described which resulted in changes in proposed bed requirements for the population of the Region. In total terms the over-all bed requirements were

anticipated to rise by about three per cent, but between specialty groups more significant changes were proposed. These are summarized in table 3.

There is no reason to doubt that these principles apply to other Regions and the implications of not evaluating the consequences of demographic change along these lines are self-evident from the results of such analysis.

COMMENT

This chapter has been concerned with the availability and use of information for planning and policy making. A review of the main data sources reveals notable gaps. This is not surprising since the several sources were never conceived as parts of a comprehensive system; rather they have grown as a result of a perceived need for data on specific aspects of particular services. From this review a number of general comments may be made.

First, socio-demographic data do exist for particular localities derived initially from the census and often augmented with forecasts produced by individual local authorities. At present, however, the knowledge required to translate these descriptive factors into specific statements of the levels of different forms

Table 3. Bed norms (expressed as beds per 1000 total population). Calculated by the Trent Region.

Specialty group	*Current norm*	*Proposed Norm**	*Per cent change*
Medical	0·79	0·88	11·4
Paediatrics	0·15	0·10	−33·3
General Surgical	0·66	0·69	4·5
ENT	0·12	0·06	−50·0
Trauma and Orthopaedic	0·44	0·55	25·0
Ophthalmology	0·09	0·06	−33·3
Gynaecology	0·25	0·24	−4·0
Total	2·50	2·58	3·2

Source: Consultative paper distributed within Region, 24 January 1979.

* Taking account of demographic changes and advances in medical practice (as measured by trends in rates of demand and length of stay).

of provision required to provide a balanced and comprehensive service for the elderly, which must be the ultimate purpose of planning and policy making, does not exist. This is a comment on the state of the art generally in social welfare planning.

Second, it is evident that there is a lack of balance of data collection between particular services. For example, the extent of the data collected by the DHSS on residential accommodation can be contrasted with the paucity of data on sheltered housing collected by the Department of Environment. As a consequence of the pattern and content of data currently collected, it is not possible to formulate a picture describing the movements between different forms of service. This would seem to be crucial information for deriving policy and evaluating the wider effects of any proposed changes in a particular service, as well as monitoring the consequences of current patterns of service in particular localities. In this respect, potentially more use could be made of Hospital Activity Analysis data, the Mental Health Enquiry and the data collected on residential accommodation, which record data on source of admission and disposal.

Third, it is also evident that there is no focus at national, nor as a general rule at local level, which draws together comprehensive information on client groups such as the elderly. Rather the data are dispersed between different authorities and agencies at different administrative levels. This position simply mirrors the absence of a focus for formulating policy. In practice, if it were felt to be desirable to bring together existing sources to form a comprehensive whole, the extent of the available data would require considerable expertise and the availability of data processing aids, such as a computer. Such resources should be available at most Regional Health Authorities or local authorities, and such a collaborative endeavour would surely constitute a justified claim on joint financing monies. There would also appear to be much scope at the national level to provide comprehensive information either in the DHSS or the Department of Environment, or by the OPCS on behalf of these Departments of State, though to be of use locally the time taken to process and return information would need to be reduced significantly. If attempts were made to draw together and use existing data for formulating comprehensive

policy, then this would surely lead to efforts aimed at ensuring compatability and a proper balance between the different data sources. Such efforts, however, will only result from a better understanding of the value of 'intelligence' and the consequent need for good information.

Many of the issues pointed to in the context of the elderly are of course relevant to the subject of information for planning and policy making generally. If the value of intelligence and the need for comprehensive information analysis become generally accepted, and the administrative and logistical problems resolved, it would make more sense to have an information strategy across the board with information on the elderly constituting one part of the whole. Such a holistic approach may seem daunting, but attacking the problems in a piecemeal fashion may require disproportionate efforts and make benefits difficult to achieve. There is no reason, however, why effort should not be directed towards an identifiable problem such as the elderly in the first instance, as part of a complete strategy on information.

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5. Butts M. S. and Ashford J. R. (1977). 'A framework for planning hospital services', in McLachlan, G. (ed.) *Framework and Design for Planning*. (Oxford University Press for the Nuffield Provincial Hospitals Trust.)
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Appendix

Sources of data

The number of potential sources of data on the elderly is large. It is not possible to produce a comprehensive bibliography of all routine and non-routine sources, ad hoc surveys, or local information systems which particular bodies collect for their own purposes, nor would it be particularly productive. Instead, some of the more important sources are briefly considered. For each source the form of data collected is indicated. Reference is also made to the availability of the data for subsequent analysis. The various forms of analysis published for the several sources are not considered in detail; those interested in a particular type of information are best advised to contact the body or agency which collects the data to see what form of analysis is (or could be) produced. Not all data sources listed in this appendix are of equal extent, content, or availability; the criterion for inclusion was whether the source was useful in adding to the comprehensiveness of the picture which might be drawn from the data available on the elderly.

DEMOGRAPHY AND DATA ON GENERAL MORBIDITY

The Census

The decennial census is the definitive source of socio-demographic data. The next census is due in Spring 1981 and with the exception of 1941 there has been a census every tenth year since 1801. During this period the content has increased significantly in association with the capability of processing increasing volumes of data by mechanical means. A wide range of analyses are produced by the Office of Populations Censuses and Surveys (OPCS) and published by HMSO; in addition, a

large body of analysis is not published and can be made available for analysis by research workers and other interested bodies.

Proposals for the 1981 census have been set out in a Government White Paper (Command 7146). A wide range of personal data are to be collected which are relevant to the elderly. General population information will include: name, address, whereabouts on the census night, sex, date of birth, and marital status. Extensive data will be recorded on the amenities within each household including: the number of rooms, whether sharing the availability of certain amenities, such as bath or shower, inside or outside toilet. The design and definition of enumeration districts constitutes the basic building blocks for the aggregation of data describing the different patterns of administrative boundaries. Thus, for most administrative boundaries (from enumeration district, through the various levels of local government, to a national aggregate), an extensive range of descriptive analyses are produced from the basic data. The first analyses usually become available about two years after the completion of the census.

The General Household Survey

The General Household Survey (GHS) introduced in 1971 is a survey based on a sample of the population in about 15,000 private households undertaken by the OPCS. It aims to provide a continuous assessment of a wide number of important socio-demographic variables. The sample is designed so that the data are representative of Great Britain; analysis and estimates are not produced below the national level. The analysis of the data for each year is published two to three years later.

The Elderly at Home

The Elderly at Home was a one-off survey carried out in 1976 by the OPCS on behalf of the DHSS to examine the social circumstance of the elderly living in private accommodation. The report was published in 1978 by HMSO. Extensive data were obtained by interview at 1987 households containing 2622 elderly (over 65 years old) persons. The estimates obtained from the sample were used to draw a national picture of the

circumstances of the elderly at home; a number of analyses are shown of the Regional variations in particular factors.

Deaths

Death certificates are returned routinely and continuously to the OPCS. Each year these data are analysed by age, sex, and cause of death (ICD classification) aggregated initially to the local authority district level. The results are returned in computer print-out form (the SD25 tabulations).

Population projections and forecasts

Each year the OPCS produce mid-year estimates of the size of the population resident within certain administrative boundaries; the data are tabulated within sex and age groupings. Periodically the OPCS also produce future projections of population size and structure. These projections are based on historical trends of birth and death rates, and migration patterns derived from various sources. A number of alternative assumptions (high, medium, and low) about these factors enables the calculation of a range of 'plausible' projections. The business of projecting population size and structure has always involved a large element of uncertainty, particularly with regard to assumptions in future birth-rates, though for the elderly the figures should be more reliable. Uncertainty increases with the distance of the projection from the basic census data.

Some local authorities use the projections to produce forecasts for their own purposes. Allowance can be made for factors such as planned housing developments which are thought will influence the size or structure of the resident population, in addition to the projection of known trends. The difference between such forecasts and the OPCS projections is sometimes a source of confusion which has some significance since population size and structure is a primary basis for determining cash allocations to both health and local authorities.

National Morbidity Survey

The 1970/71 national morbidity survey was undertaken by the Royal College of General Practitioners, the OPCS and the DHSS. Diagnostic data on individual patients were recorded in

volunteer practices initially chosen so as to be representative of the country as a whole. An extensive range of analyses were published in 1974: *Morbidity Statistics in General Practice, Second National Study 1970–71*, HMSO. These data have been criticized on the grounds that the volunteer practices participating in the study might have been atypical of the population of GPs as a whole, thus giving a biased picture of the kind of patients presenting themselves. Nevertheless, it is the most recent extensive source of morbidity (presented to the GP) in the population.

Registers of handicapped and disabled

SSDA 902 returns completed by Local Authority Social Service Departments for each year ending 31 March, give counts of those registered as blind or partially sighted, and with other handicaps, by age (65–74, 75+) and sex.

SSDA 901 returns give counts of those registered as handicapped by age, sex, and form of disability.

The coverage and completeness of both returns is open to question since it depends on the perception and willingness to be registered on the part of individuals.

USAGE AND PROVISION OF NHS SERVICES

Hospital Activity Analysis (HAA)

Throughout England and Wales data on almost all discharges and day-patients except in psychiatry and maternity are recorded on the HMR1 form. There are certain exceptions with particular hospitals, some of which have their own computer system which produces HAA data as an automatic by-product. A minority of hospitals do not return the data. The data are usually accumulated and processed at the Regional Health Authority level on computer. Arrangements for analysing the data vary between Regions; it was usual to provide a 'batch' service but increasingly arrangements are being made for users to access the data via 'remote' terminals in 'real-time' mode. In some Regions access to the data is difficult. The data are collected continuously, though it is usual to group the data into

calendar years or quarters and access to any one year's data is generally possible some time during the following year.

The data recorded for each in-patient spell include: hospital of treatment, name, sex, date of birth, area of residence, place of birth, admission and discharge details, diagnostic conditions (ICD code), and details of any operation. Thus, analysis is possible for any age grouping and it is possible to aggregate individual records to give a picture of particular geographic and administrative areas. For the elderly, however, there is an important problem in that data are only completed on discharge, and sometimes the medical data are subject to delays. Thus, analysis could fail to identify chronic long-stay patients and could give a mis-leading picture of factors such as length of stay. The design and completion of the form in three parts (administrative details on admission, administrative details on discharge, and eventually medical details) offers the potential of identifying individual patients who have been admitted but not discharged. Thus, long-stay patients ('bed-blockers') could be identified.

Hospital In-patient Enquiry (HIPE) Data

HIPE is about a ten per cent national sample of all in-patient discharges derived from HAA or from manual completion of HMR1 Forms. It is accumulated and processed by the OPCS and analyses are published with upwards of a two year delay. OPCS also hold unpublished analyses and special analyses can sometimes be produced on request. There has been some criticism concerning the statistical basis upon which the HIPE sample is formed.

Mental Health Enquiry

A PSYCH(I/P) form is completed for each psychiatric in-patient. The form is in two parts: part one records a range of personal and diagnostic data; part two contains data on 'outcome' when discharged. The data are forwarded to the DHSS and processed by computer. A range of analyses can be produced, as announced in health notice HN(79)67, and each Region's data is returned to the Region on magnetic tape for subsequent analysis, if required. One problem of interpretation concerns determining

the area of residence of patients, thus making analyses for defined geographic areas difficult.

SH3 Return

At the end of each calendar year all hospitals complete an SH3 form. For each of about 40 recognized specialties data are recorded on the numbers of: available and occupied beds, discharges and deaths, day-cases, new and total out-patient attendances, out-patient sessions, and the size of the waiting list. Data are also recorded on numbers of new and total day-patient attendances by specialty, and on numbers of attendances in certain support departments (e.g. radiotherapy). Certain other data are also recorded on workloads in support departments (such as physiotherapy and x-ray) but these are not differentiated by age or even specialty. The forms are collected by each Area Health Authority and forwarded to the Regional Health Authority and to the DHSS, where the data are now being transferred to computer for analysis. Some Regions have, in addition to the SH3, a system for collecting data more frequently (at quarterly or even monthly intervals). Analysis takes place at all levels with increasing delay towards the centre. These returns constitute the only source of data on numbers of beds available (as opposed to those used, which can be derived from HAA) and on out-patients. It is not possible to discern from the data the total usage of in-patient, out-patient, or day facilities by the elderly since the data are recorded by specialty.

Staffing Returns

SBH57(1) computer analyses for medical staff at senior registrar level and above are returned to Regions and teaching Areas annually on 30 September from the DHSS based on changes notified during the year. The analysis shows the number of clinicians by grade and number of sessions.

SBH115 returns completed by each hospital for the year ending 31 March and returned to the DHSS, record the numbers of whole-time, part-time and whole-time equivalent nurses with the 'geriatric lead'.

NHS Community Services

LHS27/3 returns completed by Area Health Authorities for the year ending 31 December and returned to the DHSS record: the number of cases aged over 65 seen by health visitors, by source of request (GP or hospital); and the number of persons aged over 65 treated by home nurses, by place of first treatment (home, health-centre, GP surgery, hospital, residential home).

SBL618 returns completed by Area Health Authorities for the year ending 31 December and returned to the DHSS record the number of treatments for those aged over 65.

USAGE AND PROVISION OF SOCIAL SERVICES FOR THE ELDERLY

Residential accommodation

In March 1976 the RA1, 2, 3 and 4 annual returns (year ending 31 March) were introduced by the DHSS. These replaced the SSDA 101, 102, 103 (part) and 105 returns, and request data on all residential accommodation provided under Part III of the National Assistance Act 1948, and all accommodation provided by voluntary organizations, private bodies, and individuals for the same purpose. Most voluntary and private homes being registered under sections 37–40 of the Act are known to the social service department in whose area they are situated. The RA1 form is completed by the social service department and it summarizes the provision in terms of number of homes administered by the department and the corresponding number of residents. Form RA2 and RA4 are completed by the matron or secretary of each of the authority's homes and forms RA3 and RA4 similarly for each voluntary or private home in the area. RA2 and RA3 returns include specific data describing the home as well as a count by age-group and sex of the number of permanent and short-stay residents. For permanent residents detailed personal data are collected on all individuals discharged or admitted during the year, including: sex, date of birth, date of admission/discharge, and source of admission/discharge. For each unit within a home an RA4 form is completed which includes descriptive data about the unit as well as about the numbers of residents.

These forms are designed as 'punching documents' and presumably the data are held in computer processible form within the DHSS. Analyses are produced and distributed to social service departments after about a two year interval. It appears that data on voluntary and private homes is sometimes not complete. Despite this drawback, these returns constitute an extensive and potentially valuable data source.

Community services provided by Local Authority Social Service Departments

A number of annual returns (year ended 31 March) are completed by Social Service Departments and returned to the DHSS. These include:

SSDA302 recording number of meals-on-wheels served for the elderly and/or physically handicapped, classified by place of serving (e.g. Salvation Army, WRVS, etc.);

SSDA303 recording number of visits made by home help for those aged 65–74 and 75+;

SSDA305 recording number of households provided with aids and adaptations classified by type of household (single person aged 65–74, 75+, or two or more occupants of which one is aged 65–74, 75+) and type of adaptation (e.g. installation of telephone or television, payment of license.

HOUSING PROVISION FOR THE ELDERLY

The Department of Environment request little by way of data from Local Authority Housing Departments on sheltered accommodation for the elderly. The only data returned are recorded as at 31 April annually by Housing Departments on the HIP1 forms. The data include a statement of sheltered dwellings for the elderly classified by: Local Authority, Housing Association (Local Authority financed, or from other sources), other public sector, private sector. The net change envisaged over the next five-year period is also recorded. Also recorded are the number of elderly persons in sheltered dwellings, and the number not in sheltered dwellings but judged to be in 'need'.

13 Collaboration to meet the needs of the elderly

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Separation by integration: the setting of the problem

The health-care of the elderly is inseparable from their social-care and accommodation. A health problem presents itself as a social problem: a social problem as a health problem. In the tasks of prevention, caring, curing, and rehabilitation, health facilities, social provision, and mode of accommodation are interdependent and there are wide, grey areas where it is hardly possible to distinguish one from the other. It follows that the provision of health and social services and special accommodation must be closely inter-related if the results are to reach expectation. Government decisions however have tended to divide responsibility sharply between strongly contrasting and independent systems. The criterion of organization has been not the complexity of the needs to be met but the grouping of kindred disciplines and professions. Within each professional grouping, needs of the elderly have to compete with the demands of other groups of patients and clients and their priority is determined fragmentarily and according to different sets of criteria and political and administrative considerations. Professional separatism is re-inforced by the division of those responsible for planning provision between and within central government departments. There is no ministry for the elderly, but departments and sub-departments for separate services. Only in the Cabinet is there a common (but ineffectual) point of responsibility. The result is that, despite the attempts at inter-departmental liaison, there is no policy for the elderly, only isolated policies without rational inter-relationships.

Apart from the general social security system, there are five main service groupings concerned: general practice, other community health services, hospitals, personal social services and public housing. Each has a history of changing role and scope and of changing patterns of control, as more effective organization was sought in the face of the medical profession's objections to local government administration on the one hand and local government's case for the grouping of services under elected councils on the other.

The scene was first set in the 1940s with the attempt to establish comprehensive services. Government sacrificed proposals to unify provisions under local authorities and, in 1946, provided for the nationalization of the hospitals and organization of general practice under local executive councils, while other aspects of health-care and the provision of social support and accommodation stayed with the public health authorities, the county and the county borough councils. In 1948 these councils became welfare authorities with the duty to 'provide residential accommodation for persons who by reason of age, infirmity or any other circumstance are in need of care and attendance which is not otherwise available to them' (1). Housing remained a separate local government service which, outside the county boroughs, was administered by the local borough and district councils.

The welfare committees appointed in accordance with the requirements of the National Assistance Act 1948, were often looked upon as a continuance of the 1930 Poor Law Act's public assistance committees, with their guardians' committees. They inherited the stigma of the Poor Law along with a large proportion of the former workhouses as a major part of their residential accommodation. They also inherited many Poor Law officers and institutional staff upon whom the new welfare departments were dependent. They lacked comprehensive definition of responsibility and even power or duty to provide and implement a comprehensive plan of action. It was a long and difficult task for them to establish a new and enlightened reputation, although by the 1960s a great deal had been achieved in renewing approaches and institutions and there were examples of excellent practice. In some cases welfare authorities kept welfare services together with public health

services under their medical officer of health. It was inevitable that they tended to be seen as the poor relations of the children's departments, which were set up under statutory children's committees and statutory chief officers under another act of 1948 (2). Unlike the welfare service, the children's service provided a new and attractive career in a department with its own special professional autonomy.

A major shift in the approach to social services and in their organization followed the recommendations of the Seebohm Committee in 1968 (3). The Committee accepted the need for a comprehensive social service for the family and the whole community, involving the unification of the childrens' welfare and mental health social work staffs, and the training of staff as generic social workers to serve not just a particular 'client-group' such as children, the elderly, or the handicapped, but the family and community as a whole. It seems generally agreed that the merging of staffs led to a loss of concentration on the problems of the elderly and handicapped. The ex-child welfare officers, with their higher status and longer training, took most of the more influential jobs in the new personal social services departments. The focus of publicity on mistakes in judgement and the following of formal procedures in children's cases created a situation where work for the elderly and handicapped was liable not to be given the attention that the weight of the problems appeared to demand. Many of the direct links with medical specialists—between psychiatric social workers and psychiatrists and between welfare workers concerned with the needs of the handicapped and the appropriate hospital staff—appear to have been lost. The generic approach, however justified on other grounds, accentuated the problems of communication between social and medical workers and set back the collaboration that was agreed to be essential (4).

The Seebohm Committee stated that:

> they had arrived at the firm conclusion that a family service cannot be fully effective until the social service department and the housing, education and health departments are the individual responsibility of the same local authority. This conclusion is based on the many practical examples of the difficulties which arise in areas where

> these functions are divided between different authorities which have been given to us in both written and oral evidence and during visits we have made to a wide range of local authorities in different parts of the country. (para. 676).

The Green Paper on the National Health Service in the same year proposed a single authority for medical and related services in each area (5):

> The principal aim would be to give it comprehensive scope for co-ordinating the policy and operation of a wide range of services; for planning the efficient use of complementary resources; and for striking the right balance between care in the community and hospital care (para. 21).
>
> The aim should be to reduce the problem of co-ordination of different services to the smallest practicable dimensions, and to arrange that the geographical areas of administration of the health service, if not the same as, co-incide as far as possible with any new local government areas (para. 24).
>
> The effective development of comprehensive services for the long-term sick, including disabled persons requiring medical and nursing care, and of the elderly and mentally disordered, requires that all aspects of health care should be the responsibility of a single authority . . . (para. 28).

The problems of relating health and social services were acknowledged but consideration was deferred pending the report of the Royal Commission on Local Government. It was, however, stated that the medical and related services and the social work services need to be planned and operated in close association with each other.

The following year the Royal Commission (6) argued for integration of the personal services under one authority but laid down that if separation of health was necessary, health and local authorities should be responsible for the same areas, 'looking together at their needs and dealing in partnership with situations that call for common action' (para. 366). In this case, the:

> nature of a proper relationship between health boards and

> local authorities demands that both should be responsible for the same areas, looking together at their needs and dealing in partnership with situations that call for co-ordinated action. The operational arrangements necessary to ensure this close co-operation would be far too complicated if board boundaries cut across those of the new local authorities (para. 367).

Thus the desirability of integration was re-iterated but political realities determined that the control of the services had to be split. The line of cleavage was determined by the boundaries between the professions. The new government of 1970 quickly launched a health service reorganization which transferred community health services from local authorities to new health authorities with the objective of integrating medical services. At the same time hospital social workers were transferred to local government—to the new non-metropolitan county, metropolitan district and London borough social services departments. Under the Local Government Act 1972 public housing services remained with local government although, outside the metropolitan areas, at a different level of authority. The division of responsibilities according to type of problem (for example, mental illness or physical handicap) and according to groups within the community (such as children and the elderly) was lost in the new structure, and grouping according to professional interest predominated. Thus the elderly, in a few years, had lost the focus of attention of a particular local government committee and department and the influences towards collaborative relationships between health and social workers which arose from common membership of the same authority.

In face of the much stressed need for close working between health and social services despite this organizational separation, and to solve the problem of the important grey areas of care for which mutual responsibilities were unclear, the government sought to arrange coterminosity between health and social services authority areas. Indeed this consideration largely determined the areas of the health authorities, which were defined by the new local authority boundaries. But organization of the health service for operational purposes

followed quite a different principle. Health districts for basic planning and implementation were defined principally according to location of hospital complexes and their catchment areas. This separation of administrative responsibilities within the new health service between an area level, mainly for planning purposes, and a district level, for 'operational planning' and implementation, raised many problems, since the district teams were not subordinate to area teams. They tended to take independent lines and it became quickly obvious that collaboration between local authorities and area multi-district health authorities was difficult, slow to develop and no substitute for planning collaboration between local authority departments and health district management teams if the desired integration in planning, programming, and implementation was to be achieved. In 1979 the Royal Commission on the National Health Service gave expression to a general condemnation of the complexities and frustrations of the multi-tier service and the government is now moving towards a simplification which will, in many cases, eliminate the area level, which was designed to achieve co-terminosity of policy planning, in favour of an integration of health planning and operational responsibilities at a closer level to the public. This recommendation has been quickly taken up by the government and steps towards implementation are proceeding. Some implications of this move are considered below. Here it may be observed that the rejection of any concept of common boundaries, together with the accompanying proposal to reduce local authority membership on health authorities from a third to a quarter, marks a final and almost ultimate step in the organizational severance of health and local authority services described above (7).

Attempts at a solution

It seems important at this juncture to attempt to learn from the history of the attempts to establish the degree of inter-authority collaboration that was generally agreed to be essential, and to develop new proposals for overcoming existing problems and the fresh difficulties that may be expected to arise from the government's current reorganization of the health authorities.

The National Health Service Reorganization Act 1973, in

accordance with the recommendations of a special inter-departmental and inter-governmental Working Party on Collaboration (8), imposed a statutory duty on authorities to 'co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales' (Section 10(1)). It required the setting up of joint consultative committees to advise area health authorities and 'the local authorities wholly or partly within their areas on the performance of their duties under the preceding sub-section and on the planning and operation of services of common concern to those authorities' (Section 10(2)). Such joint consultative committees (JCCs) were established slowly and unenthusiastically from 1973 onwards. They have generally proved difficult and unsatisfactory administrative animals for a number of reasons. The attitudes of members differ fundamentally according to whether their responsibilities lie with the health service or with local authorities. Their meetings have rarely proved satisfactory because of their size and variety of membership, their infrequency, the complexity of their business, problems of representation and differences in attitude and in expectations (9).

In 1973 the Working Party on Collaboration drew up a list of measures to overcome the operational problems arising from the separation of the services. It is remarkable that five out of the six main recommendations have been commonly neglected. These are the co-option of AHA members or officers, to local authority committees, joint attention to the collection and publication of information about comparative performance in joint working, the setting up of area joint working parties to ensure the best joint use of supplies and ancillary services, the setting up of joint intelligence teams to develop collaboration on statistics, and collaboration between the NHS and local authorities in training activities with the JCCs serving as focal points for coordination and provision at area level.

Of more fundamental importance, joint planning has proved a difficult and elusive concept. Effective planning requires commitment of resources. Both health and local authorities have been under great and increasing difficulties in maintaining their existing services and have not been prepared to allow a joint body to extend a direct influence on their allocation of priorities. The most that the more successful JCCs have done

is to authorize the setting up of joint studies on particular problem areas to assemble data and advance suggestions. The joint finance scheme has given the JCCs an important role in decision-making regarding the allocation of the funds designated for this purpose: this should not however be confused with the wider concepts of joint planning for the use of the wide band of resources—finance, manpower, buildings, and materials—which the authorities concerned have at their disposal to meet the needs of the elderly and other groups for whom they are jointly concerned.

It has always been clear that collaboration between elected and appointed authorities would depend largely upon the relationships between their officers and the quality of joint staff work. DHSS circulars stressed the need for joint working groups of senior officers to meet regularly to ensure that the day-to-day operation of the services worked smoothly, that plans for development in areas of mutual concern were properly examined and processed before submission to JCCs and that early action was taken when the Committee had considered and made decisions on them. The unpublished research available indicates that little was achieved to fulfil such expectations in the aftermath of reorganization. Indeed the lack of ability by the JCCs to take planning decisions of the kind that appeared to be envisaged in the Circular of 1973 undermined confidence in the effectiveness of joint staff work, while the hectic nature of the problems of re-organization left little time to explore the possibilities of joint work.

Since 1976 at least, when the joint finance scheme required closer inter-authority consultation, the formal machinery for collaboration at staff levels has been based mainly on the concept of joint care planning teams at health area and social services authority level, supplemented by more specialized planning teams and working groups. Specialists in community medicine (SCMs) with special responsibilities for liaison were given membership of social services department, management teams and health services liaison officers have in most cases been appointed in social services departments and have been invited to join health service planning teams. However the distance of these specialists and liaison officers, upon whom principal responsibilities for presenting the needs of vulnerable

social groups in the policy formation process have rested, from the health district operational levels in two-tier administrations, and sometimes their lack of day-to-day knowledge of policy developments and opportunity to influence decisions in their own authorities, are problems that have not often been overcome.

It has been at the Health District level that the closest joint working has been possible—despite, in the multi-district areas, the lack of co-terminosity of areas with social services and housing authorities, and the lack of formal joint machinery for collaboration. In accordance with the recommendations of the report 'Management Arrangements for the Reorganised National Health Service', better known as 'the Grey Book' (10) the health district, as the operational base for local hospital and community health services, became the focus for the multi-disciplinary examination of local needs. Multi-professional health care planning teams (HCPTs) were set up in most districts to assess the needs and changes required for priority groups, amongst whom the elderly were prominent. Representatives of local government services—particularly social services, although education and housing officers were also sometimes included, were invited to participate. A typical HCPT for the elderly might include the district community physician, an administrator, a geriatrician, a psychiatrist specializing in the elderly, a GP, a nurse, a social worker and, less commonly, an occupational or physio-therapist, a district council housing officer, and a representative of voluntary agencies. In some cases, a specialist in community medicine from the health area administration was included and provided a bridge to policy thinking at that level. Assessment of HCPTs' success has been very variable. They were handicapped by confusion of role: they generally lacked the means for the systematic planning of services, although they usually incorporated the wide knowledge and expertise necessary for evaluation of services and the development of new approaches. Much was dependent upon the accident of good chairmanship and leadership and the extent to which they were taken seriously by the district management team. The main value that was emphasized by participants in interviews carried out by the Institute of Local Government Studies during a research

project commissioned by the Nuffield Provincial Hospitals Trust was their contribution to establishing a network for local inter-agency and inter-professional understanding.

DHSS advice accompanying the joint care planning circulars in 1976 and 1977 (11) proposed the somewhat different concept of district planning teams (DPTs) to evaluate existing guidelines, develop and make specific proposals for changes and priorities for three-year programmes and advise on rationalization and re-deployment. CHC representation was encouraged. In many cases HCPTs simply continued to operate; in others they were re-formed into DPTs and in some cases the advice was used as support to abolish local HCPTs and find a new local formula for a joint appreciation of needs and possibilities.

The rapport and success in the development of new ideas has been impressive in the case of at least some planning teams at district level that have brought together specialists from the five main areas of activity on which the elderly with complex health and social needs depend—general practice, hospital, community health, social services, and housing services. Means have been found to overcome the problems of non-coterminosity, assemble and analyse key information and exercise mutual influence on policy and operations.

Special opportunities arose from 1976 through the provision of allocations of joint finance, through which social services expenditure which helped to relieve pressure on the health services could be financed from health service sources. The possibility of engaging in exploration and evaluation of joint operational possibilities has given a sense of purpose and motivation. Perhaps the major and so far unresolved obstacle to joint finance has been the insistence upon eventual transfer to local government of financial responsibility for all revenue expenditure incurred by new joint projects. This has in some authorities led to resistance to projects involving long-term commitments and a tendency to regard the source as a stop-gap to revive or continue services that would otherwise have been cut for the sake of financial economy. Consequently joint finance has in practice not been the spur to initiative and innovation that might have been hoped. Joint finance has in fact been an expedient to overcome underspending by local

government in matters that were having a detrimental effect upon the health service, but has not led to a genuine sharing of financial responsibility in these key areas in which financial responsibilities overlap. There is no acceptance of permanent joint responsibility, no truly joint finances and therefore no basis for joint planning.

The need for joint planning for the elderly and other vulnerable groups has been much stressed in official reports and circulars, but in practice a satisfactory organizational basis has been lacking. Apart from the joint finance allocations, joint care planning teams have lacked the necessary resources for forward planning. Finance and man-power are constrained by strong political and professional pressures at other levels, where the elderly may have no strong advocates. The problems of collaboration on services for the elderly are formidable, given the separateness and quite different patterns of management and accountability of the services, their highly dissimilar procedures for planning, decision-making, and budgeting, the strength of self-interest and competing demands within each authority exacerbated by growing financial stringency, scarcity of manpower to meet demand in other areas where there is strong public pressure, heavy workload, lack of mutual knowledge of each other's systems and the conceptual gulf resulting from the extent to which ideas in each service have been moulded by contrasting academic disciples and professional training. Moreover the separate and often apparently unrelated approaches to policy-making and financial support at national level have raised obstacles to a joint approach to planning. If there is no integrated view at national level of the respective roles of the hospital, primary health care teams, community health services, social services, and housing services in meeting the rapidly growing combined needs of the very elderly, and if the financial instruments to support these services mostly operate independently and without any logical relationships, the motivation and ingenuity required locally to create some sort of rational pattern of provision has to be great indeed.

The new pattern of health service organization put forward in the consultative paper 'Patients First' (12), and to which the government appears committed, will raise a new set of problems for joint working in many parts of the country. The statements

of principle that the needs of patients must be paramount and that as many decisions should be taken at local level close to the community as possible are unexceptionable. But the rejection of the need for common administrative boundaries for the principal services concerned and the consequent replacement of area health authorities by district authorities whose boundaries may not correspond to those of social services and housing authorities will undoubtedly disrupt many of the administrative relationships that now exist and will require a conscious and determined effort by the parties involved if local policies are to be integrated in the interest of patients and clients. Confirmation has been given by regional administrators, as well as by county council representatives, that the destruction of area planning in multi-district areas threatens the welfare of the old and handicapped.

The consultative paper states that, 'The Government intends that new authorities should feel themselves to be more clearly responsible for local needs' and by inference uses this intention as justification for limiting local authority representation on each district health authority to four members (13). While the role of councillors on health authorities has undoubtedly been ambiguous, there can be no doubt that the reduction of representation will narrow further the already tenuous channels of communication between those who control local health services and those who control local social, education and housing services. On the other hand, the proposed maximum delegation of responsibility to hospital and community services level, with direct responsibility (except for medical staff) to professional heads at district management team levels, would appear to strengthen professional control and influence (para. 12). Professional responsibility for reflecting community need as a whole rather than professional predilections and self-interest becomes of so much greater importance. If there is a failure in this respect it is likely to be the disadvantaged groups—of whom the elderly form a major portion—who will suffer most. 'Patients First' already signals a danger by ignoring the special problems relating to staff work for adult priority groups in its discussion of the use of NHS community medicine manpower (annex, 'Links with Local Government'). The need for an adequate means of focusing on the interests of these

groups at the local level, of assembling and analysing evidence of their needs and monitoring the effect of current services, of planning, innovating, and programming to ensure that their welfare is given the priority which in principle it is generally agreed it should have, and of ensuring that operational decisions are weighted appropriately and implemented—all these needs require bold and firm organizational measures. Maximum delegation with a 'cosmetic' JCC at health district level may substantially weaken the possibility of inter-authority collaboration and the attention given to work for the elderly unless the means are created to bring together those working for their interest to create an effective and influential force.

Suggestions for future action

There are dangers and costs in prescribing one organizational solution to this problem for all health authorities. The best current practice shows that district care planning teams can function well on a multi-disciplinary, multi-authority basis. Every health district authority should be required to ensure that the conditions are set up to enable such teams to work effectively. The following suggestions are made to help to define such conditions. The arrangements should be worked out jointly with the local authorities concerned.

1. There should be a focal inter-professional and inter-authority staff group responsible for reporting on the needs of the elderly, the policies and plans desirable to meet them and the means for implementation. Policy-making, planning, and implementation cannot be effectively considered in isolation from each other: the staff group should have a general responsibility to represent and report on needs in its areas of concern. Whether it should also be concerned with other and overlapping priority groups (such as the mentally ill and handicapped and the physically handicapped) would be a matter for local decision, but it is important that the group should not be too large and its concerns not too diffuse. The group should include consultants, nurses, GPs, social services and housing officers, administrators and representation of voluntary organizations.

2. Such a group should consult and report to both the district health authority and the district management team. In agreement with these bodies it should also be able to put advisory

reports before social services and housing authorities. The linkages with these latter authorities should be carefully worked out so that elected members and local authority officers can be kept informed of the progress of policies for the elderly and have a full opportunity to consider and make their influence felt in these matters. It is important that the local authority chief officers concerned should be asked to give their co-operation in providing evidence of need and of effectiveness of services as well as suggestions on action that is desirable.

3. Adequate administrative and research support for such care planning groups is essential. An administrative officer should be designated to ensure that a group receives the information and draft papers it requires to function effectively. Counterparts within the social services and housing departments concerned should also be designated with whom close informal cooperation would be expected.

4. It appears that 'non-co-terminosity' must be accepted as a condition under which arrangements for collaboration will have to be devised in most areas in future. There is no standard formula under which the problems entailed can be resolved. It is a challenge that can only be met given determination and ingenuity to ensure that the necessary channels of communication are created and kept open. The best practice in the past has shown that this is possible provided that authorities are prepared to allow and encourage diversity and a degree of autonomy within the resources available, in local areas.

Such diversity and devolution of decision-making to local areas is justified not only as a specific response to the problems of non-co-terminosity but also on the grounds of the local flexibility of approach, which we strongly advocate in this report. Needs differ, existing provision differs, institutions bearing the same names differ, perceptions of the necessary remedies differ from locality to locality, as do many other factors. Moreover, these factors change over time—sometimes quite rapidly. Response has to be localized to cope with local variety and complexity.

This point is of general validity but it has particular implications in the case of social service authorities with large populations and wide-spread boundaries which will have the task of relating to more than one district health authority. The

information they have available with a bearing on local policies needs to be collected and presented in a way which will be relevant to the care planning teams concerned. Their staff structure and pattern of district organization and delegation of responsibility should facilitate collaboration for the purpose of plans for the priority groups based on health service districts. Social services area organization for fieldwork and for local planning purposes can be flexible in a way that is not possible for the health service with its massive fixed investment in hospital complexes that define their own catchment areas, and local government must accept this fact and fit in with the reality in order to fulfil *its* responsibility to the priority groups concerned.

5. No mention has been made of community health councils, partly because their role differs greatly according to local attitudes and partly because of uncertainty about their future. Clearly the means of involving the public in criticism and support of policies and in the development of innovative initiatives is of importance and the means must be found to make this possible. This remains an area for local experimentation, whatever form new legislation may take. But an essential basis for valuable contribution by the public lies in collaboration in the implementation of services. This collaboration needs to happen at a more local level than the health district *viz.* an integrated neighbourhood level of action, able to respond as freely as possible to local circumstances.

Finally, it may be remarked that the failure which has been described above to develop joint planning along the lines envisaged in 1973 should in no way discourage authorities from establishing a joint approach to comprehensive programming to meet the needs of the elderly. There is no possibility under the present administrative structure of the fusion of the main planning processes of health and local authorities, but given a committed and realistic approach by the main parties concerned, much can be achieved within current constraints. Cases quoted in chapter 15 show how, where higher authorities are ready to allow, encourage, and support collaborative planning and initiatives at a district or more local level and to ensure that the priority to vulnerable groups that is part of general policy is reflected in resource allocation, much can be

achieved. Obviously there must be a local will to collaborate and to involve those concerned with the operational management of services to the elderly in all phases of detailed planning and implementation. A joint appreciation is required of the needs to be met within the district, using whatever information and means of research can be made available. A thorough exploration of the resources that can be tapped from statutory and voluntary bodies and within the community and of the means to make the best use of them should be undertaken at the same time. The development of an approach that ensures that existing facilities are put to the best use, that unused resources are brought into use and under-used resources are developed and that innovations are designed to fill gaps and improve on current provision is a creative phase of planning that requires mutual perception of implications and multi-disciplinary insights. It needs mobilization and testing of the availability of identified resources. Joint projects require definition and clarification of objectives to avoid confusion in implementation. Implementation of new schemes must to a large extent be experimental and require reviews at suitable intervals. Monitoring and re-planning are an aspect of implementation.

Additional resources will be necessary but the exploitation of what resources exist in all public and private sectors and their most effective use is a challenge that must have as much priority as pressure to ensure that the elderly have a just proportion of whatever new resources can be made available. This demands a new commitment to joint working and to the setting up of more effective collaborative arrangements, with the objective of seeing that there is adequate representation of the needs of the elderly at the key levels of decision-making in all the authorities responsible.

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14 Value for money

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Not only in these times of restrictions on public sector borrowing, but at any time, it is of first importance to establish whether the present system of welfare for the old obtains the best output from the resources available. In answering this question we need to be constantly alert to the fact that each particular part of the system is linked with the rest and therefore if the output from any part varies, either for the better or worse, the effect is felt throughout. If an increase in cash benefits helped more people to care for themselves or others at home there would be a decreased demand on hospital resources but if domiciliary services were cut hospitals would soon feel the strain and demand more funds. In any final analysis the resources available have to be conceived as one whole. For reasons given in this, and other chapters, we are of the opinion that major improvements in care could be achieved for the current population within the sum total of public funds currently available.

The network of financial charges built into the total system of care is a major factor in the rate of consumption of services. Local authorities are expected to impose charges for social services because of the original philosophy that there should be 'no element of charity' involved. In residential care, for example, a person could be charged up to £58 per week, although this varies between areas. In the NHS, however, although most of the state pension is confiscated for long-stay elderly patients, health services are otherwise without an economic barrier at any point. Such an inconsistent framework of charges undoubtedly shapes the system of care in a way that was never

deliberately intended. Whilst the position on charges is the dominating factor, the whole system has grown up as a mish-mash of cash benefits, of which many are subject to complicated conditions, and of services, of which some are free and others subject to charges varying according to the decision of each local authority. The output of such a system is perforce marred by gross variability, society having placed a higher priority on the principle of local decision making.

Since the more important issue for us is the cost and effectiveness of public welfare, the status of private care is not discussed in any detail. It has nevertheless been already noted that it occupies a significant section of the whole system. Whilst at the top end of the charges scale, the independent sector is of significance only to the few really wealthy old people, there is a section where because of voluntary contribution or public subsidy, the range of charges is moderate. The competition so offered must be beneficial to the welfare services.

CASH BENEFITS

Benefits available to the old, sometimes only conditionally, include the old-age pension, supplementary benefit, attendance and other allowances, and concessions or exemptions on various charges. (A list is included in the Annex.) Cash benefits offer freedom of choice and are less paternalistic than services. One supremely important effect is that they stimulate the joint use of public and private funds, and therefore attract private resources towards a service for which the state might otherwise have had to foot the total bill.

It is well-known that many of these benefits are not claimed and public expenditure estimates often assume only a 60 per cent take-up. One cause may be the complexity and inaccessibility of the written rules. In part, however, it will also be due to the fact that those with incomes above the base level at which supplementary benefit is payable must apply separately for each particular benefit. People of this kind, if they lack persistence or help, end up worse off than those with lower incomes and fall into a poverty trap, all the worse because they are also likely to get less than their share of social services. Rough estimates based on the last census put 37 per cent of

retired households with low incomes at the supplementary benefit level, 13 per cent with high incomes and 50 per cent with moderate incomes.

Because of a cash limit on budget programmes, central and local authorities are often inhibited from advertising entitlement to cash benefits for fear of attracting more than the estimated number of claimants. Such frustration of policy must stem from indecisive management and may very likely lead to additional calls upon expensive services. Therefore we recommend a continuous effort to simplify instructions and the encouragement of local information posts in neighbourhoods. The initial results of the Kent Community Care Scheme (chapter 15, pp. 229–31) where case-workers have funds to maintain a person at home, suggest that untied cash deployed to assist individual cases can be highly cost effective.

We single out for special mention the fact that mobility allowances are not paid to the elderly, although there are unsystematic concessions on public transport, arranged holiday excursions, and transport to hospitals and other institutions. Voluntary effort has to fill the remaining gap.

Whilst most public services (whether in the health, social services, or housing fields) are free or very highly subsidized, it is necessary to mention here the scheme for equity-sharing in sheltered accommodation built by housing associations. Under present arrangements a government grant of 30 per cent is paid towards capital cost. Since the public subsidy is much less than for comparable housing for rent, more housing can be developed at a much lower cost to the taxpayer. Just as important, these arrangements, just as other cash benefits, may enable elderly people of very modest assets to exercise choice.

SERVICES

Expenditure on services is very approximately one-third of that on cash benefits (see figure 14.1): but since perhaps only 10 per cent of the elderly—the severely handicapped—are in receipt of services, the relative importance of services cannot be assessed by the resources used.

In considering the level of output from the services in relation

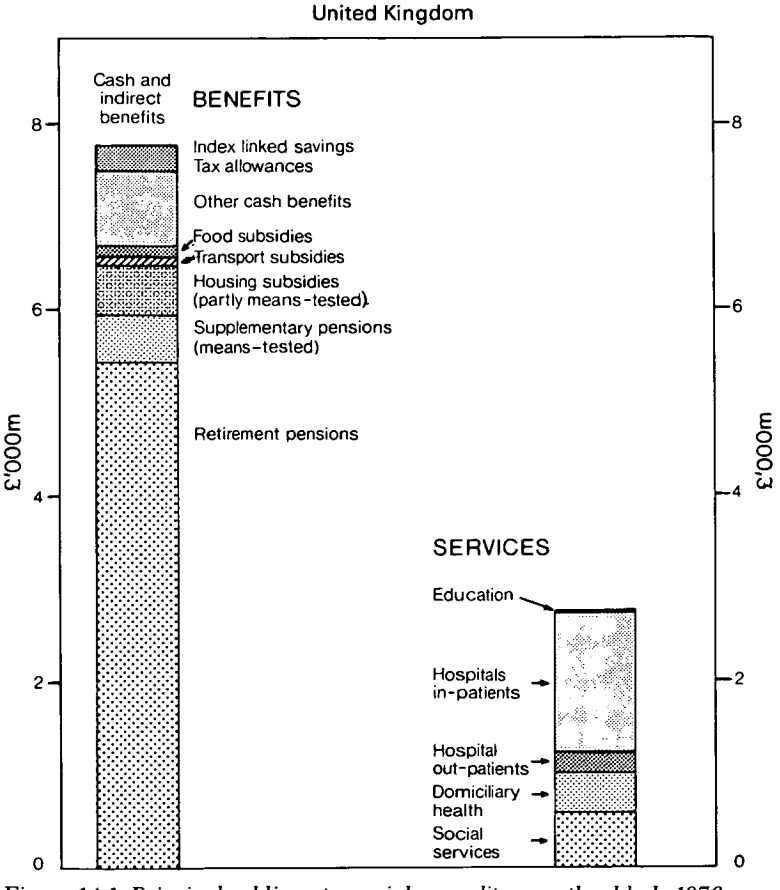

Figure 14.1. *Principal public sector social expenditure on the elderly 1976.* Source: Central Statistical Office.

to resources used we must look separately at each piece of the system of care before attempting any general analysis.

Domiciliary

It seems probable, though hard to demonstrate scientifically, that statutory services, such as home-helps, meals-on-wheels and lunch-clubs, day-centres, chiropody, telephones, and special equipment, are effective up to a point as preventive measures in proportion to costs. The full time use of professional

staff, such as nurses, to give emergency cover is more open to question.

Sheltered accommodation

The value of sheltered accommodation has been instinctively acknowledged by its popularity both with management and client. Its net capital cost, because it often releases a more valuable, larger house for family use is negligible or negative. Residents requiring statutory domiciliary services are likely, where housing is grouped, to be more accessible and therefore marginally less expensive. As we have seen, there is in practice a considerable saving from a shortfall in the delivery of services, partly because of the warden's existence.

Residential accommodation

At present, the average cost per resident is £80 per week. This is lower than hospital in-patient care, but more expensive than voluntary residential care, the cost of which is very variable, possibly averaging about £50 per week. (These costs compare with a range of charges in private nursing and residential homes of from £60–£150 plus.) There is still some argument as to why the small residential home or nursing home is undoubtedly cheaper per resident than the hospital ward. One explanation bases itself on the cost of drugs, which is often not accounted for in 'homes' because prescribed by GPs. However, the costs of nursing homes and Part III homes include a servicing charge on the capital cost (which is not included in NHS accounting). Almost certainly the principal explanation of the difference in costs is that the overhead costs (such as maintenance, porterage, grounds) are lower in the small units in which, being self-accountable, there is much stricter financial control. Another reason for the difference is the cost of medical cover as discussed below.

In-patient care

The average cost of in-patient care in the South East Health Region per week is £290 for acute care, and £105 for geriatric care. These costs include medical and nursing cover, equipment and drugs, physiotherapy, occupational therapy, food, and other overheads. They do not include capital servicing which

might add some 7·5 per cent making the total £312 and £112 respectively. (These costs compare with a range of charges in private hospitals of from £270–£1400).

During the present decade there have been significant reductions in almost every specialty in the average length of stay. If this trend continued, it might be reasonable to look for a stable level of performance in the future despite the fact that the NHS is at risk as a labour-intensive service in an inflationary age. But the pessimists argue that a law of diminishing therapeutic returns is operating and as a result duration of stay will not continue to decline in future.

There is, however, evidence that improvement is still possible in care of the elderly in acute beds by an active policy of diagnosis and rehabilitation. There is little indication of diminishing returns in this sector, and therefore the redistribution of resources to it will be effective in proportion to the costs involved. Although the cost of an acute bed is much more than that of a long-stay bed, this is discounted if the patient's length of stay is much reduced.

Policy in regard to long-stay beds is more debatable. There is no argument over those patients for whom there is a hope of rehabilitation. But for those patients whose condition is irremediable, it is possible to raise questions about the level of medical, nursing, and other cover. For such patients there may be unnecessary surveillance and attention, which incur unnecessary cost and impose a type of care dictated more by professional roles than patients' interests. For instance, in large units, the nursing staff may insist upon a high level of staffing regardless of the category of patient. For these patients the small independent nursing unit is more comfortable as well as less expensive.

Co-ordination of policies

Apart from its general shortage, the major problem of finance is caused by the multiplicity of organizations, and consequently budgets, which allow for 'cost-shunting' or 'buck-passing' between them all. Hence, arise continued complaints about 'bed-blocking' or 'misplaced' people in institutional care, the growth of the private sector to fill the gap left by the failure of

the public sector and the increasing reliance on relatives with whom the 'buck' usually rests.

There is no doubt that there has to be some debate about responsibility for the care of the elderly. Is it to be the major responsibility of the family or is it to be a State responsibility? If the former, how are services to be used to relieve strain or provide skilled care where necessary? If the latter, how is responsibility to be shared between the various agencies concerned?

In the meantime, some flexibility in budgetary arrangements would be useful. Joint finance is a good example of the way in which one agency can help another to provide services to the benefit of both. However, this may lack the flexibility in the use of resources which is necessary if community care is to be a feasible alternative to institutional care. Moreover, this flexibility cannot be achieved cheaply, since the use of more community care resources is a net increase in expenditure, in the short-run, although it might well be the least-cost alternative in the long-run if it does prevent the expansion of institutional care. More testing of alternative ways of delivering intensive community care is urgently needed.

In the short-term the situation is likely to be dominated by the present restrictions in the expansion of services. This implies continuing reliance on the informal caring system and the use of private and voluntary nursing homes. It is possible that this period of public expenditure restrictions could be used to test out the acceptability of different forms of care. Further experiments might be encouraged in deploying community workers to organize the informal and voluntary care system and co-ordinate it with the statutory services. An extension of the Kent study to other areas could usefully be part of this. Thirdly, the appraisal of the development of nursing units in both the private and public sector would be valuable to future policy planning for the care of the dependent elderly.

Finally, one body which could help with the present tangle of different organizations and budgets is the health-care planning team. This is an important local focus of interest. Of course, it has no budget, but it is in a position to see across the whole system of care, identify specific problems and test out alternative solutions. With the right spirit of co-operation, it should be

possible to surmount some of the present obstacles to a co-ordinated system of care. However, in the end it may be necessary to extend the joint financing scheme to cover the build-up of new services or the expansion of existing ones, to test innovations and to provide the necessary impetus to moving the whole care system towards its identified objectives. At the moment joint financing is seen as a 'back door' method of transferring responsibility for services from the national exchequer to the local rates. More permanent methods would encourage more local initiative.

Value for money?

In coming to any over-all judgement about value for money, the first and major question is how far the paternalism of services—benefits in kind—is closer to the interests of the individual than freedom of choice encouraged by cash benefit. Against services, it can be said that they are offered on a take or leave it basis, the individual being expected to conform to the service; against cash benefits, that some individuals, when elderly and infirm, do not benefit from being forced to choose and manage their own affairs. There can be no general answer when so much depends on the circumstances of each specific case. *But where the arguments seem evenly balanced, either on general principle or particular application, the decision should fall in favour of greater individual freedom.*

Looking at the system of benefits and services as a whole in the light of the resources used and the output seemingly achieved, certain areas merit particular attention.

Cash benefits

Amongst cash benefits, attendance allowance is likely significantly to increase freedom of choice, and it could be improved by complementing it with the more flexible use of monies assigned to case-workers. Careful study is required of these strategies from both philosophic and economic aspects. The negative aspects of rules on mobility allowance could be included in any such study.

The use of a means test to exclude those of modest means from cash benefits and subsidized services imposes a poverty or

rather 'disability' trap, which is the worse in that it discourages the take-up of benefits by eligible people. There is a need to investigate the working of means tests and other rules in the same category.

The complexity of published material on eligibility and of the actual working procedures may be a bar on the effective use of benefit and services. Study is needed to establish how far this is so.

More study is needed on income maintenance policies for the elderly in general, given the new national pensions and the development of occupational pension schemes.

Attracting private resources

There are two parts of the system where public funds are attracting private resources:

1. Equity sharing schemes, in the area of sheltered accommodation provided by housing associations, are of importance. Whether the principle might be extended into residential accommodation, also merits examination.
2. Support of independent institutions from public funds by contracting out or placements is very important.

It is surprising that there has been little or no study of the effect in these sectors of the welding of public and private funds. It is possible that there are benefits to the individual in freedom of choice and to the state in financial savings, and that therefore there should be a far higher level of encouragement given by government.

Long-term care

There are two other sectors where an enquiry into national policy is required to support local planning and decision-making. In the one, there is doubt that the long-stay hospital is the most effective way of caring for the chronically dependent elderly. In the other, local authority residential care, there is a worry that the population will become too dependent for adequate care to be given within existing resources and organization. There is a major need for a study of the outcome and cost of different methods of care for the very dependent elderly, including the introduction of nursing units to the public sector.

The implication of the previous observations taken together is that there is an irrefutable case for the creation of a comprehensive financial strategy as between Departments of State which would place no bar, other than the level of national wealth, upon local initiative and freedom of choice.

Annex

Services and benefits for the elderly

From booklet FB1 published by the Department of Health and Social Security.

A. Pensions and allowances (Administered by DHSS)

Benefit	*Eligibility*
1. Retirement pension.	Payable to men aged 65 or over and to women aged 60 or over provided that they satisfy contribution conditions and have retired from regular work. There is an age addition for people aged 80 or over.
2. Non-contributory retirement pension.	Payable to anyone 80 or over not in receipt of normal retirement pension or its equivalent.
3. Supplementary pension.	Anyone over retirement age whose 'requirements' exceed his/her 'resources'.
4. Graduated pension.	Increased allowance to retirement pension payable in accordance with previous contributions. Graduated contributions ceased in April, 1975.
5. Earnings related pension.	Earnings related (1/80th) addition to retirement pension. Scheme introduced in April, 1978.
6. Widow's pension.	Payable according to age at husband's death and dependent upon own and husband's contributions.
7. War pensions.	Payable to disabled persons or their dependants as a result of war service or service in the Armed Forces since 1945.

8. Attendance allowance.	Payable to people who need a lot of looking after for at least 6 months, either by day or by night. A lower rate is paid for people who require attendance by night only or by day only.
9. Invalid care allowance.	Payable to people of working age who cannot work because they have to stay at home to care for a severely disabled relative. Married women do not generally qualify for this allowance.

B. Rates, concessionary schemes and exemption from charges

Benefit	*Eligibility*
1. Rate rebates (local authority).	People not in receipt of supplementary benefit can claim a rebate on rates. The rebate depends upon gross weekly income.
2. Rent rebates (local authority).	Rent rebates can be paid to tenants of council and privately let houses provided they are not in receipt of supplementary benefit. Rebate depends on gross income and family size.
3. Exemption from prescription charges (DHSS).	People over retirement age are exempt from prescription charges.
4. Exemption from charges for dental treatment (DHSS).	People in receipt of supplementary benefit are exempt from dental charges.
5. Exemption from payments for spectacles (DHSS).	People in receipt of supplementary benefit are exempt from most optical charges.
6. Hospital fares for patients (DHSS).	People on supplementary benefit may claim a refund for fares spent travelling to attend out-patients or on admission or discharge.
7. Hospital fares for visitors (DHSS).	Occasionally refunds of fares are given to people visiting a close relative in hospital.

8. Concessionary fares (local authority).	Some local authorities provide concessionary fare schemes for people of retirement age. Schemes vary enormously from one locality to another.
9. Concessionary access to local authority facilities (local authority).	People of retirement age can obtain free or reduced price admission to recreation and educational facilities. Schemes vary from one locality to another.
10. Concessionary access to other facilities (various).	Various government, voluntary and private organizations allow reduced prices for use of services (e.g. historical monuments, national trust properties, cinemas, hairdressers, etc.)
11. Fuel allowances.	People in receipt of supplementary benefit are helped with fuel bills.

C. Access to health and personal social services

Access to health service facilities is free except, as already stated for long-stay elderly patients. The major social services for which charges are made are:

Benefit	*Eligibility*
1. Residential care.	Charges are made according to the resident's income and wealth.
2. Home-help.	Charges are made according to income in some areas of the country.
3. Meals-on-wheels and luncheon-clubs.	Charges are made as a contribution towards the cost of the meal. This contribution varies from one area to another.
4. Day-care.	Charges are made in some authorities towards the cost of meals.
5. Aids and adaptations.	Contributions towards major adaptations are collected by some authorities. Improvement grants may also be used. Policies vary from one authority to another.

PART IV

The forerunners

15 The forerunners

INTRODUCTION

In this Part are set out descriptive notes of innovative developments referred to in this Report. They range over statutory and voluntary services, and from hospital through to home. They all have as common objective the provision of integrated care to the individual. Taken together, these notes are believed to indicate both the shape and practicability of a model service.

SECTION 1

Voluntary services

AGE CONCERN WIGSTON DAY-CENTRE AND VOLUNTEER SCHEME

Background

Wigston and Oadby are a rural/suburban community having a tightly-knit population of 52,000 including 7000 elderly people.

In 1964 Wigston Old People's Welfare Association was founded through the influence of Councillors on the Urban District Council and in 1967 it was registered as a charity. In 1969 a Neighbourly Help Scheme was set up, to operate through street wardens, but it was not fully successful as co-ordination became an increasing problem for a wholly voluntary service. However, a policy was then adopted of creating a day-centre with ancillary 'drop-in' centres as self-help spring-boards and information rooms. The first drop-in centre was launched in 1971 and a first lunch-club, run by volunteers, was opened in 1973 serving 25 meals each Saturday. In 1972 the Welfare Association renamed itself Age Concern Wigston.

The volunteer scheme

In 1975 the District Council approved a grant for the appointment of a Neighbourly Help Officer with the task of recruiting and organizing street wardens. Funds were then found for the construction of the day-centre at a cost of nearly £45,000 including equipment and furniture. The sources were:

Help the Aged	£12,000
Leicester City Council	£7,500
Trent Area Health Authority	£6,500
Local subscription	£19,000

Oadby and Wigston Borough Council provided the site at a peppercorn rent.

The Neighbourly Help Officer finds volunteers to support elderly people who are at risk and without family support. The services given include visits, shopping, pension collection, dealing with financial problems, and a 'welcome home' service for those discharged from hospital (bed airing, fire lighting, and stocking food). Meals are also arranged whilst a supporting family are away on holiday. Some 350 street wardens are maintained, with in addition approximately 200 casual helpers, some only keeping contact, others carrying out a more active role within the Borough.

The day-centre

The accommodation includes a dining-room, workshop, and shop; and it is planned to extend it with a television room and a hair-dressing/chiropody room. A part-time manager has now been appointed with locally raised funds. Her duties include ordering food and co-ordinating the work of volunteers in the kitchen where due to increasing demand for meals a part-time cook has been engaged. Financially the day-centre is self-supporting.

GLAVEN DISTRICT CARING SCHEME

Glaven District in North Norfolk has a population of about 4000 (of whom 700 are aged 65+) dispersed over 12 villages. The Caring Scheme was organized in 1974 as self-help to meet

needs in home-help, nursing, meals, and other health and social services insufficiently provided in a remote rural community.

The setting is a warden supervised grouped housing scheme of 18 bungalows provided by the District Council close to a GP surgery.

To this base has been added at a cost of £18,000 a day-centre/hospital where bathing, physiotherapy, and occupational therapy are provided once a week, and a lunch-club twice a week. The centre is also the base of 224 volunteers of whom 61 per cent have been with the Scheme for four or more years, including 30 nurses (not all qualified). Their task is to supplement the meals-on-wheels and home-help service, provide reliable nursing cover in the home and the day-centre/hospital and operate a drive out shopping service.

An analysis shows that where there is a high level of need this is met equally by the social services and the Caring Scheme: but for the considerable volume of lesser need almost all of the demand is met by the Caring Scheme.

Administration is through a 12-member executive committee and a part-time caring co-ordinator whose salary was met for the first three years by the Nuffield Provincial Hospitals Trust. This has operated so successfully that these costs are now to be met from local subscription.

The GP personally accepted responsibility for initiating and developing the scheme. Since the scheme began over £40,000 has been raised, some £20,000 of this locally, 270 helpers have been enlisted and 200 clients were served during the year 1978–9. In each of the villages there is a 'representative' whose role is to bring the customer into the scheme.

Future plans look to extending activity by providing cover for patients on discharge from hospitals and supporting the warden of the group housing scheme.

KENT COMMUNITY CARE PROJECT

Background

The project sprang from the initiative of the Director of Social Services for Kent, and was designed by the Director of the

Personal Social Services Research Unit at the University of Kent, Canterbury, and others, particularly the then Senior Research Officer of the Social Services Department. Work in the field began in May 1977 and in January 1978 the full complement of one Principal Social Worker and two Senior Social Workers were engaged.

The project is being conducted in a seaside town in East Kent which has a high proportion of retired elderly people. The town is covered by one social services team who refer cases to the project team. Clients referred are those assessed by the area team to be sufficiently at risk to make them eligible for admission to residential care.

The essence of the scheme lies in the provision of opportunity and incentives for social workers to organize more cost-effective social support for vulnerable elderly clients who would otherwise be likely to be admitted to residential or hospital care. They do so by mobilizing or, indeed, generating extra help in the community.

Objectives

Two aims of the project have been formally defined. One is to improve service to clients by providing a range of individually tailored, community-provided support services at a level between currently available support services and full residential care, to enable the client to remain living in the community where this is considered more satisfactory from his or her point of view than residential care. The second is to secure a more economic use of resources by, in many cases, postponing, and in some cases avoiding, the need for admission to residential care.

Method

A key feature of the scheme is that the workers possess a budget with which they are able to buy in services, whatever their provider—statutory, private, or voluntary—in order to meet the needs of clients.

In making decisions about the relative appropriateness of different means of helping their clients, they are able to use knowledge of the unit cost of existing departmental services as a decision making framework.

The principles of the scheme permitted the project workers

to undertake a wide range of activities in order to improve the quality of life of their elderly clients. Locally based helpers have been recruited to perform tasks for clients, usually for relatively small payments. The provision of help by local people has enabled the project workers to combine the provision of practical services with a degree of personal contact to reduce social isolation.

Helpers have been recruited in the main by advertisement in the local press; although as the scheme has developed a number have come forward by more informal means such as word of mouth or the extension of a relative's activities to other clients. Potential helpers are interviewed carefully by the project workers and references are obtained prior to their introduction to clients. There is considerable variation in the kind of person offering help ranging from those with previous caring experiences, such as retired nurses, to young housewives with time to spare.

Tasks undertaken

The kind of tasks undertaken by helpers are illustrated in the following Table:

Table 1. Tasks undertaken by helpers.

Tasks detailed in each helper's first contract (or contracts)	*No.*
1. Basic personal care (toileting, dressing, washing, meeting security needs)	30
2. Everyday household care (providing meals, lighting fires, making drinks, etc.)	38
3. Irregular household care (shopping, cleaning, laundry, garden, etc.)	20
4. Companionship (social visits, raising morale)	30
5. Other ('one offs', e.g. visiting optician)	2
	120

Note: Based on first contract of 64 helpers. Often more than one task specified.

Inevitably a description in terms of task performance is a focus upon activities and less upon the more subjective content of the help such as raising morale. Such descriptions may make the scheme appear to be merely an extension of the pattern of

response associated with the home-help service. There are, however, important features which distinguish it. Principally, the scheme enables workers in close touch with clients to deploy flexibly resources to meet variations in need, thereby becoming 'case-co-ordinators'. The span of control which a home help organizer covers, with large numbers of home-helps and clients, makes this an impossible activity for them, however willing, and a considerable amount of time is spent in 'traditional' social work tasks, such as helping people to cope with bereavement and enabling them to accept help.

A typical scheme of help for a particular client might take the following shape:

> Mrs A, a woman of 68, has been crippled with arthritis for a number of years. Following a fall when she broke her left leg, she is virtually immobile without help, being confined to her chair during the day. Her home is an inconvenient terraced cottage with outside toilet, steps up to the front door and different floor levels between front room and kitchen, which reduces the prospect for mobility. The package of care provided for her has rendered it possible for her to remain at home despite her high level of dependence:
>
> *Early Morning.* CCP helper gets her up, dresses her and gives her breakfast; different helper Saturday and Sunday.
>
> *Morning.* District nurse visits and assists with washing and dressing her leg.
>
> *Lunchtime.* Home help provides meal and does other houshold jobs Monday to Friday; CCP on Saturday and Sunday.
>
> *During day.* CCP helper provides tea, social visits and shopping as required on a flexible basis.
>
> *During day.* Mrs A has a network of friends and neighbours who visit and provide support at various times.
>
> *Night-time.* About 10 pm, CCP helper assists Mrs A to bed.

Finance

An arbitrary limit to the weekly expenditure per client has been set, so that the total weekly cost of all services for the client is no more than two-thirds of the marginal cost of a place in a residential home. Within this constraint, the social workers enjoy more freedom than would otherwise have been the case to make decisions about how best to enhance the well-being of their clients.

However, despite the decentralization of the budget in terms of allocation, it did not prove possible also to decentralize its distribution. Hence a considerable amount of time has been consumed in continuing negotiations with the Central Office Treasurer's Department over the administration of contract payments. It would seem that in the long-term, organizational problems of this kind could perhaps be more effectively tackled by a decentralization of the distribution of the budget to the area level, whilst still retaining the requirements of accountability.

As to the payment of helpers, the principle is that the helper's commitment is primarily to the helping activity and payment is a secondary factor albeit very necessary to a number of people. The helpers offer their services for a wide variety of reasons and for some of them monetary reward may constitute a form of recognition of the value of their contribution. Indeed, the payments alone are probably not at a level sufficient to be rewarding in themselves and can thus be thought of as rather 'removing disincentives to caring than as a primary incentive, and also having a symbolic value sealing an agreement to provide the services and confirm the expectations from both sides'. A valuable additional function of payment therefore has been the role it has played in sealing an agreement, making a commitment both explicit and regular, clarified by the contract the helper receives specifying the tasks to be performed for each client. There are clear advantages for the elderly person in the reliability and regularity of such arrangements.

Early results

The experiences of clients admitted to the experimental group have been compared with those of a comparable control group

receiving normal attention. It was found that for the most highly dependent clients, the high disability group, the average weekly cost in 1977 prices to the SSD per client for service provision in the experimental group was substantially less (£15) than for their counterparts receiving conventional provision (£19). The contract costs to helpers constituted only £4 of the outlay for the experimental group. For the appreciable disability group, unsurprisingly, costs were lower in both areas, although the experimental group cost less (£11) than the control group (£16). The contract costs to helpers were only £3 out of the £11. The cost differences between the two groups can be explained by the lower rate of admission to residential care of the experimental group.

As to the outcome of care, a preliminary evaluation is based on a comparison of consecutive referrals of 35 clients to the experimental and control groups.

One key criterion of success is whether the experiment maintains clients in their own homes. Table 2 describes the eventual outcome of the first 35 clients in each group. As can be seen, whereas only four clients from the experimental group entered residential care, 12 from the control group required this form of treatment. Furthermore, as can be seen, this difference was not due to a greater rate of hospitalization. In addition improvements in the quality of life were noted for many of the clients receiving the experimental service.

Table 2. The location of seventy cases after 12 months.

	Experimental group	*Control group*
In community	24	15
Elderly persons' home	4	12
Hospital	2	4
Moved away	2	2
Died	3	2
	35	35

These different outcomes are particularly interesting in view of the characteristics of the elderly persons in the two groups. If the sample is divided into two groups, a very high disability group and an appreciable disability group, similar to

the criteria used in the Glasgow study (Isaacs and Neville), then whereas 49 per cent of the experimental group suffered high disability, only 37 per cent of the control group fell into this category. This difference was also evident within the categories. For example, in the experimental high disability group six people were either bed-ridden or chair-bound, whereas this was true of only three of the control group.

Epilogue

These results have induced two other local authorities to replicate the system with their own funds except for assessment which is being financed by independent Trust money. An inner city authority is commencing the scheme and another actively considering it.

If the final judgement for such schemes is favourable, the question arising will be the desirability of making payments to volunteers for such services, when in other projects they are given.

SECTION 2

Towards single service partnership

HOSPITAL AND SOCIAL SERVICES IN HALTON DISTRICT, CHESHIRE

The contribution of planning

Halton District is partly rural, partly urban, with a population of 144,000, of whom 15,900 are over 65. The District includes the old industrial community of Widnes and the new town of Runcorn.

In 1979 the local authorities and the Area Health Authority in Cheshire issued a Report on Old People in Cheshire prepared by a Joint Standing Group whose membership derived from the County Secretariat (in the chair), the Area Health Authority, County Council Social Services Planning, and Central Policy and Research staff, a representative of the District Council Chief Executives, and the Cheshire Community Council.

Amongst the many conclusions of the Report, were the following points:

1. The projected growth in resources for the elderly over the next few years will not be sufficient to enable any major increase in the levels of service for this group. Secondly, the information so far collected could be greatly improved as a basis on which to formulate detailed and comprehensive policies. And thirdly, the multiple split of responsibilities for services for the elderly makes the implementation of a comprehensive and agreed package of policies difficult to achieve.

2. It is therefore desirable to adopt overall objectives for the general development of services; and small-scale pilot schemes, actions, or reviews that could test out some ideas for improving the effectiveness of caring for the elderly.

3. In particular, action might include the possible use of 'joint financing' funds in the provision of sheltered housing. (But this recommendation was blocked by the DHSS).

4. Admission criteria for Elderly Persons' Homes, sheltered housing and geriatric hospital provision should be more fully co-ordinated at first on a pilot basis in a selected district.

At the same time that this study and report was in preparation, a Working Party was set up to carry out a joint local study in Halton Health District, members being drawn from the AHA and Borough Council with a Chairman from Halton Health District. This local group complemented at local operational level the central body's strategic work, and there was liaison between the two.

It had already been agreed at County/Area level to use NHS joint financing funds for the construction of the projected elderly persons' home at Helsby to be run under joint admission arrangements. This was a ready-designed scheme which had been frozen by local government spending constraints, and as it was in a locality of under-provision, was an ideal scheme to provide a quick impetus when joint financing was first introduced.

In a report recently issued by the Cheshire Joint Care Planning Team, it was recognized that the joint financing programme had become a catalyst for a high degree of co-operation at all levels between social services and Health Authority staff. Helsby Elderly Persons' Home is a good

example of how the operational co-operation already existing between fieldworkers could be backed by joint planning and joint provision to provide a much more integrated service.

Hospital services

The Halton Hospital Services are under the charge of one general physician 'with special interest in the elderly'. A second is now taking up post. Their facilities have been built up to include:

22 acute beds in Warrington District General Hospital
20 sub-acute beds in Phase I of Halton General Hospital
99 medium and long stay beds in smaller local hospitals
50 places in Halton day-hospital (with X-ray, rehabilitation, and out-patient facilities).

The sub-acute beds at Halton were converted from a day-surgery ward which could not be used until the hospital has 24-hour resident medical care, while the 22 acute beds at Warrington were upgraded with Halton resources. The remaining beds are in other hospitals and were formerly peripheral facilities to other DGHs; they have now been drawn together to form an integral part of the Halton geriatric service.

There is a multi-disciplinary team working with the Consultant, the members of which are:

Sister in charge of the ward or day hospital
Senior occupational therapist
Senior physiotherapist
District Nursing Liaison Officer
Social Worker (from medico-social related health team).

The team also has a good relationship with social services, to obtain access where appropriate to their resources. In addition to community support staff, these facilities consist of:

The Helsby Elderly Persons' Home (24 residents) constructed with joint financing funds and run by the County Council. The officer-in-charge has a SRN qualification; the consultant physician maintains a close link. Fifteen of the first admissions were from hospitals and future admissions will be on the basis of joint assessment (NHS/Social Services), and there is a special relationship with the hospital service because of the jointly financed origins of this home.

Six other pre-existing Elderly Persons' Homes provide a total

of 185 places. One of these homes was extended using Joint Financing monies. Some have linked flats in addition. Access to these is via the Health Related Social Work team.

It is also significant that the Halton Health Related Social Work Team (four posts) was established through joint financing, and one of its prime tasks has been to support the Halton day-hospitals (psychiatry and geriatrics) and the geriatric service.

Epilogue

The story so far in Halton District seems to demonstrate how joint planning at the County/Area level coupled with enthusiasm at the Clinical level can produce from limited resources an excellent quality of care.

THE STOCKPORT MODEL

When the Metropolitan Borough of Stockport was created in 1974, the opportunity was taken to reassess policy in respect of both child-care and care of the old. An 'in-house' research project was accordingly launched in 1975 to assess the needs of the elderly on the basis of enquiries put to the elderly themselves and to local and health authorities' staff. A crucial element in this process of strategic planning was the establishment of a Joint Intelligence Unit which also served the needs of Stockport Area Health Authority, the AHA having commissioned the Borough in 1975 to assist in the newly introduced NHS planning procedures. Excellent co-operation between officials of the two authorities facilitated the introduction of a joint planning system which is still operating today in care group planning, and in serving the information needs of the joint chief officers' panel. The consequent Policy Report issued in March 1976 analysed the needs of the elderly in Stockport and concluded that the major need was to strengthen domiciliary rather than residential services; and that the further development of services along traditional (and poorly co-ordinated) lines would be impracticable financially and of doubtful benefit to the elderly themselves.

As a result of decisions taken on the recommendations of the

Report, the direction of development was changed so as to encompass:

> The creation of Social Services Officers responsible on their particular 'patch' for co-ordinating all forms of care for each individual client
> The development of a Radio Alarm and Mobile Warden Service

and, additional to the established sheltered and residential accommodation, in a joint operation with the NHS:

> Experiments with high-dependency sheltered homes
> Experiments with high-dependency residential homes.

Social Services Officers

These officers though better paid than social work assistants are not required to have full social work training. Working to a Senior Social Worker, they are intended to enable other care practitioners to know them as the one officer responsible for a particular individual.

Radio Alarm and Mobile Warden Service

This service, introduced in 1978, is based on small non-speech radio transmitters, plugged into the mains and working on a special Home Office allocated frequency. If the alarm button is pressed, Central Control which covers calls 24 hours a day and 7 days a week, contacts mobile Wardens by two-way radio to direct them to the location of the emergency. There is an automatic device for registering breakdown and disconnection of individual transmitters.

There are 20 mobile Wardens and 6 radio-equipped vans. They answer approximately 10 calls a day within an average time of 10 minutes; but only a proportion are real emergency calls. The Wardens can call an ambulance or a doctor with their walkie-talkie radio, if on assessment the situation so requires.

Resident Wardens' posts in some grouped dwelling schemes have been abolished, freeing 30 dwellings. The new service has thus been provided at no extra cost. At first the personal contact provided by some Wardens was missed: but the service has now

become widely accepted as providing a more reliable facility for help in an emergency at any time.

The service now covers 1600 clients, mainly elderly. It is under the responsibility of the Housing Department. There are indications that the new service, by providing a reliable alarm system, will encourage some elderly people to remain independent for a longer time and will enable the Council to adopt a new approach to specialist housing by providing it anywhere without the restriction of having to find space for a whole estate.

The alarm service is also provided, through Area Health Authority, to people discharged from hospital when there is a risk of relapse.

High dependency sheltered accommodation

At Queens Court, Marple, care assistants have been introduced to sheltered accommodation to provide short periods of care three times a day and so enable very frail elderly people to survive independently and more happily than in the best run elderly persons' home. This accommodation links 12 residential places, 20 flats and a lunch-club. Two of the flats are reserved for joint NHS/Social Services assessment of the handicapped. Day-care is also provided for 10 outside clients.

The experiment has been judged successful enough to be replicated shortly with another similar scheme.

High dependency residential home

To go some way to meet the problem of maintaining at risk elderly people in the community, either after discharge from hospital or otherwise, an enhanced staff ratio had been introduced for the Reinbek elderly persons' home so as to achieve a standard of care comparable to a continuing care ward except for full medical back-up (instead of which an appointed GP does three sessions a week). Physiotherapy and OT services are provided by the NHS. The District Nurse visits regularly to carry out injections and dressings and provide advice and supervision if required. The social services care staff are at nearly double the ratio per resident of the traditional residential home.

Admissions are under the supervision of the Area Social

Services Officer in consultation with the Consultant Geriatrician and the Officer in Charge of Reinbek. Of the first 12 admissions, nine were persons discharged from hospital.

The home has 30 beds of which five are reserved for short stay rehabilitation and assessment and one for emergency cases. It is not intended to transfer any of the 'old' residents but to replace them gradually with new admissions. It has been found that the short-stay population mixes well with the permanent residents and provides a useful balance.

This experiment is remarkable not only for the degree of NHS staff involvement but also for the amount of financial support from the NHS through joint funding. Total costs p.a. of £154,660 gross and £127,660 net are being met as to 67 per cent in 1979–80 by joint finance and for the following three years this contribution is expected to rise to 100 per cent. (Staff £119,840: Running Expenses £32,100: Debt Charges £2,720. The cost per resident bed is £78 per week).

Epilogue

The Stockport model of services is a break-away from traditional official guidelines, as so far put out by the DHSS, towards a system closer to individual needs. The costs are comparable, it can be argued, to those of the services replaced.

EAST SUSSEX JOINT CARE

Background

In East Sussex, District Joint Care Co-ordinating Groups, the product of the Joint Care Planning Team and convened by District Council Chief Executives, unite operational planning covering health, housing, education and social services in each District. The Joint Care Planning Team performs the same function for the County, and the East Sussex Area Health Authority and County Council have recently jointly committed resources for the creation of a statistical planning model.

Strategic objectives adopted include an increase in healthcare provision for those needing nursing care in the community rather than continuing care in hospital. A campaign has also

been undertaken to influence the granting of supplementary benefit to enable old people to pay for domestic help.

Specific schemes are being planned and operated jointly between the social services, health and housing sides with a commitment of funds from the NHS. Immediate aims include additional nursing help to elderly peoples' homes, additional intensive home-care services and a scheme on the social services side for centres to provide rehabilitative and day-care. Details of two of these schemes are summarized below.

Turkey Road Linked Scheme

The County Council has included in its Capital Programme the cost of constructing a complex to include 16 residential places, and a 20-place day-centre with ancillary facilities for dining, hair-dressing, chiropody, and staff. The Area Health Authority has agreed to meet 60 per cent of the cost under joint financing arrangements and the Rother District Council will add the housing element of 14 sheltered flats.

All three elements of the complex will be integrated and managed by a single officer-in-charge assisted by residential care officers, care assistants, kitchen, and domestic staff. Community nursing staff will be made available as required from general practice attachments.

Facilities are provided as required to both residents and the local community and include meals, bathing, hair-dressing, and chiropody. A major objective of the residential accommodation is rehabilitative care and short-term admissions, thus preventing long-term care in either Part III homes or long-stay hospital beds.

Polegate

This project has been jointly planned from the outset by Wealden District Council, the Area Health Authority, Eastbourne Health District, East Sussex County Social Services Department and the Polegate community.

Facilities

Seventy grouped units to include treatment rooms, consultation and information rooms, community room, store and office.

Forty-place residential home (under construction).

Four short-stay beds and a short-stay flat are included in the home in order to provide a halfway stopover between hospital and home, or emergency cover for those suddenly unable to cope at home.

Proposed Management Group

Housing Manager, Wealden District Council; Divisional Nursing Officer, Eastbourne Health District; Social Services Manager, South Wealden.

Staff

Volunteers for transport and contact, Warden and Deputy for group dwellings, Officer-in-charge for residential home, Community Warden to co-ordinate all services and cover community links and needs assessment, Occupational Therapist, and part-time Clerk/Typist.

Finance

Capital costs are met by bringing together the normal programmes of the County and District Councils.
Revenue costs including the Community Warden, occupational therapist and clerk/typist are met by the NHS from joint finance for the initial 2–4 years of the scheme.

The future

It is believed the policy of jointly planning from the outset health, sheltered housing, and Part III care will become normal practice in the future in East Sussex. In this way appropriate health-care, principally nursing-care, can be organized to make its maximum and essential contribution.

KINLOSS COURT

Introduction

The concept behind this project was first raised in a Health Care Planning Group within a Health District and was subsequently reinforced by detailed proposals prepared by the consultant psycho-geriatrician.

In July 1975 the Director of Housing, City of Southampton,

proposed to a sub-group of the Geriatric Health Care Working Group Southampton and South West Hampshire Health District that Kinloss Court, a sheltered housing project for the elderly due to be completed in April 1976, be used as a pilot scheme to provide specialized sheltered accommodation. It was proposed that there should be increased staffing at Kinloss Court to be made possible by funds provided by the Area Health Authority and the Social Services Committee of Hampshire County Council.

Kinloss Court is situated in the north-western outskirts of Southampton, four miles from the City centre. It contains 16 one-bedroomed flats and 16 bed-sitting room flats (all linked by an inter-communicating call system to the warden's accommodation), a communal lounge with kitchen, quiet room, laundry room, and a furnished guest bedroom. Grouped bathroom and shower facilities are provided for the bed-sitter tenants.

The dwellings are arranged in two wings, both with separate entrances, and are connected by internal corridors to the central lounge, warden's office and other amenities.

Cardington Court and Cranwell Court are also under the supervision of the staff at Kinloss Court and are situated some 300 yards distant. These two blocks together contain 58 one-bedroomed flats all of which are connected to the warden's call system.

Background

The Council's first sheltered housing scheme for the elderly was built in 1952. There are now 20 schemes, including Kinloss Court, providing 1454 units of accommodation and three more are planned to meet the continuing need for this type of housing.

Over the years the increasing demands made on sheltered housing by the increasing age and frailty of residents has not merely added to the burdens of wardens but has fundamentally changed their role. The population is continuing to age and all the forecasts are that more provision for the elderly will be required. There is also increasingly a desire to move away from institutionalized care to community based facilities which enable people to maintain independent lives for as long as possible.

The strategy therefore is to make the best use of existing facilities in a period of financial stringency and at the same

time to provide the best possible environment for the elderly. The experiment at Kinloss Court, which was opened in August 1976, is an attempt to harness resources to this end. It is also an exercise in active co-operation between a District Council, a County Council and the Area Health Authority.

Objective

The overall objective of the scheme is to support in sheltered housing a clientele of greater average disability than has previously been covered by the Housing Department's policy, by deploying extra support to the tenants in their homes. To avoid overloading of staff which is prone to occur in this sort of situation, it is also accepted that in those cases where the tenant's needs become acutely or chronically too great to be catered for in that setting, prompt transfers will be arranged, on a short or long-term basis, to a residential home or hospital.

The tenants

Criteria for the selection of the first tenants included the usual basis of housing need and qualification but the needs for medical, nursing, and social support were also given high priority. Residents at the outset had to be mobile without assistance, continent, able to dress and prepare simple meals, and sufficiently alert mentally to orientate themselves in their new surroundings. Whilst assured of the privacy and freedom from intrusion that is the right of any council tenant, the staff in some cases had a particular brief to supervise the regular consumption of medication and ensure that attention to diet and basic self-care was maintained. Tenants and families at the outset were made familiar with the objectives and limitations of the support offered.

The first group of tenants for Kinloss Court were selected from cases put forward from health, housing, and social services sources by a multi-disciplinary allocation group consisting of a Senior Medical Officer for geriatrics (DCP's Department), the Assistant Director of Housing, the Senior Adviser (Elderly and Disabled) Social Services Department and a representative of local general medical practitioners. It was agreed that future placements would be handled by the Housing Department without the aid of an allocation group but the applications for

flats made on a form identical to that used in social services for Part III admission, which includes questions regarding a person's physical and mental state and is supported by a medical assessment. The candidates are often further assessed by the Senior Medical Officer.

Duties of the wardens and assistants

In addition to the normal duties the warden is expected to encourage social contact amongst the tenants, and to monitor their state of health and use of medication. The warden is also expected to arrange meals if required in co-operation with the meals on wheels and home help services.

There are two assistant wardens and a domiciliary aide in immediate support.

Support services

Community nursing services. Nurses are seconded to Kinloss Court by general practitioners. They provide the home nursing service to the tenants and arrange for health assistants to visit as appropriate.

General practitioners. The general practitioner on the Steering Committee does, in fact, look after a majority of tenants, though it has been accepted that a number may already have other local doctors whom they would wish to retain.

Social Services Department. The home help supervisors work closely with the warden in assessing the needs for domiciliary support of the individual residents. A particular social worker from the local area office is responsible for liaison with Kinloss Court and is a member of the Steering Committee.

Hospital services. Tenants have access to surgical and other specialist services in the normal way. The geriatric and psycho-geriatric services, however, also undertake to provide prompt support to clients from Kinloss Court. This particulary applies to the question of hospital admission and it has been accepted that tenants who break down to a point where the domiciliary supports are over-stretched will be offered immediate admission to geriatric or psycho-geriatric beds if necessary, such admission usually being preceded by a home assessment. Where there are doubts as to the likelihood of return, the Senior Medical Officer may become involved. Tenants for whom a

return to Kinloss Court would be inappropriate and whose needs are for permanent Part III placement are given the same top priority by the Part III panel as applies to tenants in situ, which gives an incentive to the geriatric or psycho-geriatric services to take on even 'poor risk' cases from Kinloss Court for rehabilitation. The tenancy is not given up until such a final decision is made.

Early results

Analyses of the situation after the first two years have showed the age range of residents to be similar to that of a Part III home (approximately three-quarters are over 75). The dependency of the residents was significantly greater than in other sheltered housing and comparable to that in a Part III home. About one-third were on the books of the psycho-geriatric service. During the first two years there was some overall deterioration although there also occurred an unusual number of cases of improvement. Almost as many improved as deteriorated.

The social help provided (meals-on-wheels, home-help and day-centre) was substantial, and the community nursing service built up to a 60 per cent coverage of residents.

The objective of supporting in sheltered housing a clientele of greater average disability was fulfilled. The fact that 60 per cent of the residents showed some deterioration indicates a degree of frailty which without extra support services would have required admissions to Part III homes. The residents are being enabled to maintain their independence for a longer period of time.

A success of another order has been the development of close collaboration between the various departments involved. A steering group has emerged consisting of an assistant director of housing (chairman), a senior residential care advisor (social services) from district level, a senior medical officer (community medicine), a divisional nursing officer, a general practitioner and a psycho-geriatric consultant (speaking also for geriatrics).

The future

The Housing Department is developing a further, larger, purpose built scheme along the same lines as Kinloss Court. It

is also currently reviewing the work loads of wardens in its various schemes and discussions have taken place in the Health Care Planning Team as to how staffing levels might be improved.

The adjacent housing departments have each explored the possibility of schemes similar to Kinloss Court, and the New Forest District and Hampshire Social Services Department are building a joint Part III/sheltered housing complex with shared staffing at levels which will support frailer than usual tenants. Within the Health Care Planning Team there are continuing discussions on selection criteria for permanent residents in sheltered housing, Part III homes and hospital to be exercised by an inter-departmental monitoring panel; and there has been a recent trial of geriatric or psycho-geriatric specialist vetting of Part III candidates nearing the point of admission.

SECTION 3

Pioneering in the mental handicap service

The case histories already cited represent a significant advance in the direction of integrated care for the elderly. However certain projects and proposals for services to the mentally handicapped have also been particularly noted by the working group because of the precedents they set for even more rapid and whole hearted organization of integrated services for particular care groups.

NIMROD

Outline

Nimrod is the name given to a project for a community based service for mentally handicapped people and their families in an area of West Cardiff. The population covered is 60,000 and the South Glamorgan County Council, South Glamorgan Area Health Authority, Cardiff City Council, the Welsh Office and Mental Handicap in Wales have all been jointly involved in planning and launching the project. There are four communi-

ties covered, and services in the first are scheduled to start in April 1981. Coverage should be complete by 1983.

The idea of such a joint project was originally conceived as a scheme for the care of the elderly: but later converted into its present form.

Objectives

The service is to provide access to the full range of existing* health, social and other services (including voluntary agencies and parent groups). It will include individual programme plans and training schemes, fostering and lodgings, planned residential care in six 'staffed' houses and four 'group' houses, short-term care, sitting-in services and an advice, information and resource centre.

Planning

The project was planned by a Joint Working Party appointed by the four statutory authorities involved. Its aim was to reduce the obstacles to rapid development presented by a centralized hospital service through creating in a defined area a working model of a comprehensive service.

Joint organization

The Management is headed by a Project Co-ordinator (graded Assistant Director Social Services) assisted by four Community Care Managers (graded Band 3 Social Worker). *These appointments and all other staff are open to applicants from all services and can be held by staff on secondment.* The Project Management are under the guidance of a Joint Steering Group.

The total staff to be involved are:

Project Co-ordinator	1
Administrative Assistant	1
Personal Secretary	1
Senior Social Worker	1
Senior Psychologist	1
Community Care Managers	4

* Existing services to which clients and their families will be referred are: all medical and dental services, genetic counselling, occupational therapy, physiotherapy, speech therapy, social work, schools, further education, job-finding services, social security, housing department, home-helps, community nursing (mental handicap and general), health visiting, laundry services.

Senior Care Assistants	6
Care Assistants	45
Domiciliary Care Assistants	8

The project co-ordinator is accountable to a steering group representing the participating authorities together with the Welsh Office and the research unit. The steering group reports to the Nimrod Management Group which has plenary powers and is made up of, as County Council members, the Chairman and another member of the Social Services Committee, the Chairman of Personnel Committee, and the Chairman of the appropriate Sub-Committee; two representives of the Area Health Authority; and a member of the Cardiff City Council. This Management Group of seven was set up to aid quick decision making on the project. Only matters of establishing posts and finance have to be ratified by the County Council. The Management of the project has to be formally based within the County Council so that clients accommodated in domestic living units are eligible for Supplementary Benefit. To this extent the innovation is constrained by legislation.

Finance

It has been estimated that the cost of maintaining clients in domestic living will be significantly less than the cost per patient in Ely Hospital.

The annual cost of the project is estimated to reach £400,000 at present prices as soon as it is fully operational. Responsibility for meeting the budget expenses will be divided:

	County Council	*Health Authority*	*Welsh Office*
Years 1–3	nil	10%	90%*
Year 4	30%	10%	60%
Year 5	40%	10%	50%
Year 6	50%	10%	40%
Year 7	70%	10%	20%

* Approximately equal to the amount of all other joint financing in Wales.

Comment

The Working Group has noted the project as a significant example of a joint service under joint management and jointly financed.

KENT SINGLE SERVICE PARTNERSHIP

The Joint Planning Support Group (Mental Handicap) was set up in March 1977 by the Kent Area Health Authority and Kent County Council. Its membership is derived from the Area Health Authority, the Health Districts, the County Council and voluntary organizations. The Working Party has submitted a long list of recommendations for an improved service within existing revenue expenditure and in the spirit of a 'single service'. *But it does not believe that a true single service can be established without a major national initiative.*

The Working Party calls for policies jointly agreed, for joint reviews of progress and for joint operational working.

The estimated financial commitment by 1988 has been summarized:

	Recurring Expenditure	*Capital*
	£m	*£m*
A.H.A.	8·1	6·7
K.C.C.	6·4	3·6
Total	14·5	10·3

It is proposed that this jointly conceived budget shall be met by authorities independently; but that joint financing monies be used to meet certain non-recurring training and capital costs incurred by the Kent County Council.

Comment

The Kent programme is more conventional than the NIMROD project and closer in concept to some of the innovations already outlined in this Part of the Report, such as for instance the Stockport Model. It is indicative of one method of progress towards a single service partnership.

DARENTH PARK PROJECT

An approach to inter-Authority collaboration

Although this project (for the planned closure of Darenth Park hospital at Dartford, Kent and its replacement with com-

munity-based health and local authority services) is concerned with mentally handicapped people, there may well be lessons for those concerned with the elderly.

This project is seeking to achieve the closure of a 1000-bed subnormality hospital, built for a different age and for a different philosophy of hospital care for the mentally handicapped and serving a catchment area covering parts of Kent and South-East London from Bexley to Lambeth.

Collaboration involves inter-authority planning within and between the NHS and a number of local authorities. Involved are no fewer than: one Regional Health Authority, four Area Health Authorities, eight Health Districts and seven local authorities. The problems and needs cover bodies responsible for health, social services, housing and education, as well as voluntary organizations and, of course, patients and families themselves.

A Steering Group representative of the various public authorities has co-ordinated the planning and implementation of this enterprise, against a background of pressing need for better services within the community and severe financial restriction.

This project is now under way, having completed a multi-disciplinary assessment of patients on a sample basis to assist the planning process and is now initiating area and district based projects to provide local facilities in place of Darenth beds.

The new provisions called for range from, at the one extreme, small special units which will provide a secure environment for the care of highly disturbed and difficult patients to, at the other extreme, 'group homes' to which fairly capable patients can be discharged to live near-normal lives with a minimum of practical assistance. In between these extremes, there are plans for a variety of provisions, including small hospital units, hostels catering for differing degrees of dependency, old people's homes, all requiring some form of day care facilities, social work and other community support.

The emphasis of joint planning has been to devise appropriate forms of community based care, irrespective of which statutory authority has ultimate responsibility. The question has been what do these patients need? What kind of building, what kinds of staff, what kind of environment? not, what kind of

management body? The value of this approach is that it does actually put 'patients first', and organization last.

The philosophy behind the project is now to be put to the test in practice and the response of the responsible authorities will determine the future shape of services for mentally handicapped people. Will it be possible for authorities to mount joint projects? Will they be able to pool resources so as to maximize the contributions each can separately make?

For example, can one local authority make a site available upon which the NHS can construct a hospital unit? Can one health authority build a hostel for the local authority to manage on completion? Can a health authority pay for the running costs of a hostel until such time as the local authority is able to take over the financial commitment? Can joint financing schemes be used on a year-by-year basis to ease financial pressures on an authority so as to assist the transition from hospital to community care?

These are some of the possibilities which the Darenth Project presents. If this kind of flexibility can overcome structural barriers and give better prospects for mentally handicapped people, can similar collaborative responses from public authorities give a better chance for old people in the future?