

Health and Social Care Services

Creative Responses to Ageing

Healthy Life Expectancy

There are three broad academic theories regarding the interaction between health and life expectancy (Manton, 1982; Graham et al., 2004; Jagger et al., 2016):

- Compression of morbidity**
 This model argues that healthy life expectancy is rising faster than life expectancy, and people are spending a smaller proportion of their life in poor health. Overall the proportion of the population in good health will remain the same. Raising the state pension age will reflect increasing good health in the older population
- Expansion of morbidity**
 This model argues that health improvements are not keeping pace with rising life expectancy, and people are spending a greater proportion of their life in poor health. Pressure on health and other later life services will rise. Raising the state pension age may be unsustainable as a solution, because while people are living longer, they are not necessarily able to work.
- Dynamic equilibrium**
 This model argues that people are living longer with disease and disability but the overall severity of that disease and disability is decreasing. There

may be a need for structural changes to how services are delivered. Health spending may need to be redistributed away from acute healthcare, towards long-term needs. Workplaces may need to adapt to a higher proportion of older workers with mild or moderate ongoing health needs.

Which model is correct?

There is ongoing debate over which model best represents the current situation. Chatterji et al. (2015) report inconsistency in the results of international studies exploring these different scenarios.

Compression of morbidity is more commonly reported when studies focus upon disability or functional impairment, while expansion of morbidity is more commonly reported with regard to chronic illness.

Within the UK, a recent Government Office for Science (2016) publication suggests that expansion of morbidity is occurring with regard to the discrepancy between healthy life expectancy and life expectancy. However, Jagger et al. (2016) suggest that cognitive impairment and self-reported health are showing compression of morbidity, while later life disability is showing dynamic equilibrium.

KEY POINTS

Life expectancy is rising. At present there is no clear consensus as to whether people are spending a higher or lower proportion of this longer lifespan in good health.

Contradictory research findings may represent differences between geographic areas and different trajectories for different diseases.

'Health' does not have a static definition. As set out overleaf, GPs are actively encouraged to identify risk factors and diagnose conditions early. More accurate scans and blood tests may pick up problems that would previously have gone unnoticed.

One factor in the lack of consensus may be that different health needs follow different trajectories. Different health conditions or disabilities are not necessarily expanding or compressing at the same rates within the same population groups and in the same locations. This may have varying implications for the provision of health and social care (e.g. an expansion in dementia would have a more substantial impact on the residential care sector than an expansion in diabetes). Broad discussions about later life health may tend to mask variations between different aspects of health.

General practice 'demand'

General practice is widely reported to be under pressure. It is frequently suggested that the ageing population will inevitably increase demand.

Older people's usage of general practice is influenced by health policy and developments in healthcare practice. General practice is increasingly encouraged to proactively identify and address health needs. For example, the Quality Outcome Framework (QOF) gives general practitioners a financial incentive to undertake actions such as conducting diabetes checks and diagnosing dementia (NHS Employers, 2016).

Better early diagnosis and preventative care have an impact on general practice usage (e.g. patients may need repeat prescriptions and regular review appointments) (Baird et al., 2016). However, this does not necessarily mean individuals are less healthy in their day to day lives. On the contrary, early detection may mean health needs are better managed.

Starfield and Mangin (2011) express skepticism with regard to whether targets such as the QOF are appropriate in general practice. QOF recommendations are often based on clinical trials that focus on younger patients with a single health condition (Starfield and Mangin, 2011; Buffel du Vaure et

al., 2016). In contrast, many older primary care patients have multiple health conditions, and actions to improve one health problem may worsen another. In addition, prescribing multiple medications for multiple conditions may be hard for the patient to manage and increase the risk of drug interactions (Cantlay et al., 2016). It has also been suggested that ten minute appointment slots may be unsuitable for patients with more complex needs (Baird et al., 2016; Baker and Jeffers, 2016).

Rather than older patients inevitably creating pressure on general practice, general practice may need to adapt to a role focused upon long-term management of multiple ongoing conditions. This may include changes to the skillset in general practice, different length appointments, and better join up with other services.

Wasting the GP's time?

A common media stereotype is that some older patients contribute to pressure on general practice by using GP appointments inappropriately, for example because they are lonely and 'want a chat'. This draws upon wider stereotypes of older people being isolated and burdening services.

Patients sometimes worry about wasting GP time, and this can deter them from seeking help (Cromme et al., 2016; Llanwarne et al., 2017). It is potentially difficult for a patient to judge whether a concern is serious or not (Llanwarne et al., 2017). Also, many health campaigns encourage patients to seek early GP advice. This is especially with regard to mental health problems such as depression, where there can be stigma about seeking help

(see for example: Time to Change, 2018). Society therefore provides mixed messages as to whether and when patients should approach general practice about concerns.

'Avoidable' general practice appointments often relate to wider system issues. The Primary Care Foundation reported that while 27% of GP appointments they sampled could potentially have been avoided, the majority of these were not cases where a patient could have used other services or practiced self-care (Clay and Stern, 2015). Many avoidable GP appointments either related to how appointments were allocated within the practice (e.g. the patient could potentially have seen a nurse rather than a doctor) or to problematic connections with other

services (e.g. the patient was following up an issue with hospital care, or needed a doctor's letter in order to make a benefits claim). Tackling these kinds of issues may be more to do with changing how public services work, rather than expecting patients to behave differently.

Using general practice to seek help for social problems should be considered within a broader context. Real-terms funding for social care has decreased, and GPs report increasing difficulty in assisting their patients to access mental health or social care support (National Audit Office, 2014; Baird et al., 2016). If older people have genuine needs which are not being met elsewhere, it is perhaps unsurprising that they turn to their GP for help.



'Bed blocking'?

Another commonly cited concern about the effect of the ageing population on health care is so-called 'bed-blocking' within hospitals.

The term 'bed-blocking' places the blame on older patients, overlooking the fact that they do not cause the problem, and that delays in being discharged to appropriate care places them at risk. Delayed discharge does not affect the majority of older patients, but rather affects patients who have particular needs such as cognitive impairment or a high level of dependence (Challis et al., 2014). Delayed discharge is associated with higher mortality, increased risk of medical complications, reduced ability to undertake day-

to-day activities, and has a negative impact on emotional wellbeing (Green et al., 2017; Rojas-García et al., 2018)

Delayed discharge is primarily a structural and organizational problem, associated with delays in carrying out assessments, arranging care packages or non-acute healthcare. There is substantial variation between hospital trusts with regard to rates of delayed discharge (Humphries, 2017). Problems such as failure to effectively plan for discharges, poor communication and lack of capacity in other services have been repeatedly identified in the literature, but continue to contribute to delays



(National Audit Office, 2016; Edwards, 2017; Gaughan et al., 2017; Landeiro et al., 2017).

Delayed transfers of care should be considered in conjunction with premature discharges from hospital. A YouGov survey for Healthwatch England (2015) found that 12% of people discharged from hospital felt unable to cope at home, while 24% felt a friend or relative was unable to cope following hospital discharge.

Contribution of older people to healthcare

Around 3 million people in the UK volunteer with the health and disability sector (Naylor et al., 2013). Volunteers take on a wide variety of roles, including non-emergency patient transportation, hospital and hospice visiting, community signposting, acting as patient representatives and community first response roles.

Volunteering has a positive effect on both healthcare users and volunteers, and can help provide additional capacity and resilience within health services (Boyle et al., 2017). In 2008, it was estimated that health volunteering was worth around £700,000 to each hospital trust, and £250,000 to each primary

care trust (Teasdale, 2008, cited in Naylor et al., 2013).

Due to the breadth and diversity of volunteer activities, there is limited data on the demographics of volunteers across the health sector. However, traditionally a significant proportion of healthcare volunteering has been undertaken by adults who have retired or are approaching retirement (Boyle et al., 2017). Retired volunteers tend to commit more time, and take on more regular volunteering commitments (Nazroo and Matthews, 2012; Naylor et al., 2013; Office for National Statistics, 2017).

Beyond formal volunteering activities, 1.2 million people over the age of 65 reported undertaking

care activities in the 2011 census, and the number of older carers is projected to continue to increase (Carers UK and Age UK, 2015). A third of carers over 65 report providing more than 50 hours of care a week (Carers UK and Age UK, 2015). Older adults are also likely to engage in occasional ad hoc health activities that are not necessarily captured in survey data, for example driving someone to a health appointment, or offering advice on self-care to friends.

Robertson (1997) argues that there is a need to recognize interdependence within society. Older people cannot be characterized simply as dependent users of health services. Rather, they are participants in complex social networks, within which they both provide and receive support and care.

Personalisation

Public policy has recently emphasised personalisation, in the form of individual choice about care. For example, the Department of Health (2008) outlined a personalisation agenda, defined as meaning that “every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings.” The Care Act (2014) set out national standards for local authorities carrying out care assessments, including a duty to promote individual wellbeing, and incorporating control by the individual within day-to-day life. A 2013 speech by the Health Secretary suggested that part of the response to an ageing society was to “treat the person not the condition” (Hunt, 2013).

The Department of Health (2008) explicitly associated the personalisation agenda with a move towards early intervention and preventative care, assuming that given the opportunity, individuals will take rational decisions that both promote their own health, and reduce the cost of state services. However, critics have argued that rational choice models tend to be inaccurate, because they do not give sufficient weight to factors such as social context, habit and emotion (Pescosolido, 1992; Diaz, 2000; Burke et al., 2009). It may therefore be incorrect to assume that facilitating individual choice will inevitably promote the interests of public policy: suppose people have preferences that do not align with health policy? Discussions of personalisation in health and social care policy can

tend to discuss choice either as an abstract positive principle, without necessarily considering specific details of older people’s actual preferences and how far those may or may not align with statutory sector priorities.

Financial constraint is one obvious area of potential conflict between personalisation and the broader context of services. Statutory services are based around economies of scale and have legal duties to maintain a balanced budget. The personalisation agenda has been adopted at a time of financial austerity, and since 2008 there has been a substantial drop in both real-term spending on social care for over 65 year-olds, and in the number of older adults receiving such care (National Audit Office, 2014). Reviews of personalisation initiatives such as individual budgeting have suggested that while such initiatives can have positive outcomes, the context of financial austerity ultimately imposes limitations on personalisation (Netten et al., 2012; Kendall and Cameron, 2014; Lloyd et al., 2014). Making funding available for individual budgets may mean that existing community services become less viable (Kendall and Cameron, 2014; Lloyd et al., 2014; Needham, 2014). Personal choice also tends to require that individuals choose between options that are already available, and hence may be less effective for recognising where existing services are not meeting needs, and coming up with viable solutions to improve join-up between services, or to develop new services (Newman et al., 2008; Kendall and Cameron, 2014; Powell and Halsall, 2015).

CO-PRODUCTION

The National Development Team for Inclusion (undated) set out 7 principles for achieving personalisation through co-designing services with older people:

- Involve older people throughout the process
- Ensure older people feel safe to speak up and be listened to
- Work on the issues that are important to older people
- Be clear about how decisions are made
- Use older people’s skills and experiences when making changes
- Ensure meetings, venues and materials are accessible
- Evaluate the process by focusing on actual changes in older people’s lives

Some commentators raise conceptual challenges to the emphasis on personalisation as individual choice. Feminist concepts of care consider care to be an interpersonal relationship between individuals in society (Mol, 2008; Glendinning et al., 2009; Lloyd, 2010; Barnes, 2011). From this perspective, emphasising individual choice overlooks the importance of networks of care within a community, and does not recognise the importance of community development (Lloyd et al., 2014). An additional difficulty is that for some older people, independent choice may not be a desirable basis for designing a care plan, either because they are experiencing a crisis and are not well-placed to make long-term decisions, or because they are unlikely to regain capacity to make choices.

FAST FACTS

6.4%

fall in real-terms spending on local authority organised adult social care between 2009-10 and 2015-16 (Luchinskaya et al., 2017)



60%

of the demographic pressure on local authority social care services comes from increasing need for social care from working age adults. (Harris, 2017)



73%

of older people with a qualifying need under the Care Act are not having their needs fully met by formal care (Blake et al., 2017)



10%

of people can expect to spend more than £100,000 on social care after the age of 65 – but it is difficult to predict who, and there are few precautions individuals can take (Dilnot, 2011)



Funding social care

Luchinskaya et al. (2017) compare the 6.4% fall in adult social care funding to a 15.6% rise in the number of adults over 65. This is potentially a rather crude comparison. The vast majority – around 90% - of people over the population over 65 do not access local authority social care (Office for National Statistics, 2013b; National Audit Office, 2014). Health inequalities have an impact on needs: a 65 year-old woman in Richmond-on-Thames can on average expect to spend another 16 years in good health, compared to only another 5.4 years for a man from Newham (Office for National Statistics, 2016b). Debates about the compression or expansion of morbidity (see Page 1) are also relevant here. If morbidity is compressing, a rise in the population over 65 does not necessarily translate to a rise in social care demand, whereas if it is expanding, demand may rise faster than the rate of population ageing.

Population ageing is only one of many factors increasing strain on adult social care. The ADASS suggest that increasing demand from working age adults is a larger source of demographic pressure than for older adults. (Harris, 2017). Other pressures include rises in minimum pay for care home staff, increased deprivation of liberty safeguarding applications, closure of the Independent Living Fund, and rulings with regard to the pay status of 'sleep ins' (Cromarty, 2017; Harris, 2017). A further possible source of pressure is that 7% of the adult social care workforce are EU citizens, and it is uncertain what effect leaving the EU will have (Davison and Polzin, 2016).

REFORM OF SOCIAL CARE FUNDING?

The Dilnot Commission looked into how later life care could be more sustainably funded. It found that current arrangements are opaque and make it difficult to plan ahead. There are limited options for people to take precautions against very high costs. Dilnot recommended:

- A lifetime cap on care costs at £35,000
- Increased means testing threshold
- National eligibility criteria (Dilnot, 2011)

In 2015, implementing these recommendations was a manifesto commitment by the Conservative party. However, implementation was first postponed and then, in December 2017, formally dropped.

The 2017 Conservative manifesto suggested increasing the means testing threshold but including the individual's home, even if they were still living in it, meaning some people receiving domiciliary care would lose eligibility. This proposal was dubbed the 'dementia tax', and suggested to be one factor in the loss of the Conservative majority

The government has now said a green paper on later life care will be published by Summer 2018.

Much of the discussion about services for older age focuses on the provision of formal social care. However, the National Audit Office (2014) highlights that the informal care sector is estimated to be at least 4 times larger than care provided by local authorities.

The majority of informal care is provided by people aged over 50, and the rates of informal care provided by older populations is rising (Carers UK and Age UK, 2015; Office for National Statistics, 2016a). People aged 50-64 are most likely to be unpaid carers, but people aged over 65 spend more hours providing care (Office for National Statistics, 2013a). More than half of carers over 85 spend 50 or more hours caring each week (Carers UK and Age UK, 2015).

Caring for others

The Carers' Trust (2016) identified key issues affecting older carers:

- Care co-ordination
- Managing their own health needs
- Transport, especially in rural areas
- Lack of information about benefits and allowances
- Feeling obliged or pressured to care for someone
- Financial management
- Feeling unable to take a break
- Problems around planning for the future
- Housing suitability
- Availability of support

FAST FACTS

There are

1.2 million

carers over the age of 65 in the UK (Carers UK and Age UK, 2015)



59%

Of carers over 85 are men. This is in contrast to other age groups, where the majority of carers are women (Carers UK and Age UK, 2015)

Conceptualising informal care

There has been recent recognition that informal caring is often underrecognised. One response has been to value informal care through working out the cost if this care were to be provided by a paid carer (see for example: Buckner and Yeandle, 2007). This approach can be valuable for highlighting the contribution of older people who care for others, and counters assumptions that older people are economically unproductive.

However, quantifying the value of informal care in this way raises some problems. In first place, it assumes that the kind of care provided by a spouse, relative or friend is comparable to care provided by a paid carer, and that one can be directly substituted for the other. In practice, older people often have individual preferences as to who should provide which

types of care: strangers coming into the house may be seen as intrusive, but on the other hand, individuals may not want problems such as pain or incontinence to be observed by relatives (Gott et al., 2004; de São José et al., 2016). Different relationships have an impact on informal care: for example, does the carer cohabit with the care recipient, and what is their prior relationship like? (Pinquart and Sörensen, 2011). Informal networks are also potentially less expert and less accountable (van Dijk et al., 2013). Attempting to measure and value informal care using measures designed for formal care may overlook elements that are specific to care being provided within an existing relationship.

Quantification of caring often also focuses on time spent caring, and groups together a large number of

disparate activities (Martin-Matthews, 2000). Again, this can result in reductive comparisons: is accompanying someone to the shops for 2 hours meaningfully equivalent to 2 hours assisting someone with bathing?

Research with informal carers in a wide variety of contexts suggests they often perceive activities classified by researchers as 'care' to be simply part of the friendship or family relationship (Martin-Matthews, 2000; Muraco and Fredriksen-Goldsen, 2011; Ipsos Mori, 2014). Caring in later life can be mutual - for example, spouses who both have health needs assisting each other in managing those needs, or neighbours who check on each other (Lingler et al., 2008; van Dijk et al., 2013; Torgé, 2014). Even where there is a care recipient with very significant needs, care relationships may still be located in elements of shared meaning, rather than a functional focus on one person undertaking tasks for the other (Graham and Bassett, 2006).

Creative solutions

Health and social care is located within a network of statutory, voluntary and informal activities. Often, problems occur around the join-up between different systems: for example patient uncertainty over which service to use, or ineffective information sharing. A number of schemes have aimed to help health, social care and voluntary sector services work together more efficiently and put in place early interventions.

Practice Integrated Care

Practice Integrated Care Teams (PICTs) have been set up in Manchester. The team includes a GP, practice nurse, social worker and other community health practitioners. They identify high risk patients, and with patient agreement, assign a key worker and draw up a care plan. Team meetings are held monthly, which offers an opportunity to discuss cases and also to develop a better understanding of different roles and services. There have been challenges around how to evaluate the effectiveness of integrated working, but the team reports reduced emergency admissions, improved patient satisfaction and a commitment to continue to develop the partnership (Beacon, 2015).

Hospital to Home

Nottingham City Homes and Nottingham City Care Partnership set up a partnership to address the problem of older people living in homes that were exacerbating their health problems or that they could not safely return to after a hospital stay. Through appointing housing and health co-ordinators, they were able to support older people with their housing options, including being able to rapidly allocate

specialist independent living accommodation already owned by the housing association. This resulted in substantial savings on healthcare costs (Skills for Care and Chartered Institute for Housing, 2017).

Identifying problems in advance

GP practices in Stafford send patients a birthday card on their 75th birthday, which includes an easy-to-complete assessment form. The forms are reviewed by an eldercare facilitator, who identifies people who may need extra help (especially with regard to memory), and arranges a visit. The facilitator then acts as an ongoing point of contact. A GP carries out a full assessment and draws up a care plan, in a format designed to be attached to the fridge (and also available online). Phone support is made available for carers. (Greaves, 2013; Greaves et al., 2015)

Home from Hospital

Manchester Care and Repair offer a 'home from hospital' for people over 60 being discharged from hospital. The service can help warm the house, shop for immediate essentials and get in contact with friends or relatives. The service can also offer minor handyman repairs and support with benefit claims (NHS Providers, 2015; Manchester Care & Repair, 2018)

POTENTIAL CHALLENGES

There is broad consensus that health, social care and communities should work more closely together. However, this is often easier said than done. Good practice interventions that have worked well in one place do not always translate well to other settings. The National Audit Office (2017) concluded that the national Better Care Fund programme was largely not meeting its targets in terms of integrating health and social care

Cameron et al. (2014) systematically review the literature and suggest that the following factors are important for supporting joint working between health and social care organisations (and conversely, that problems in these areas often hinder joint working):

- Organisational factors: clear understanding of objectives and roles; effective communication and information sharing; strong management support
- Culture and professional factors: regular joint events to share information and develop an understanding of different roles
- Contextual factors: taking into account the local area, local population and existing services.

They also note that evaluations of joint working often did not consider service user perspectives in depth, nor address whether joint working met the needs of minority populations

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Author:	Michael Toze
Publisher:	University of Lincoln
Funded by	Lincolnshire County Council
Publication Date	March 2018
Further copies available from	Lincoln University Repository

