King's Fund | Report

Authors: JANICE ROBINSON, PENNY BANKS

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The Business of Caring

KING'S FUND INQUIRY INTO CARE SERVICES FOR OLDER PEOPLE IN LONDON

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JANICE ROBINSON AND PENNY BANKS

The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding. We are a major resource to people working in health, offering leadership and education courses; seminars and workshops; publications; information and library services; and conference and meeting facilities.

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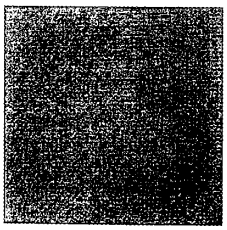
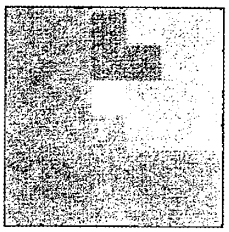


Contents



List of figures and tables

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Foreword

The King's Fund established an Inquiry to examine the way in which care services were provided for older people in London in 2004. In asking us to examine the issues, the trustees of the King's Fund recognised that the environment in which care is provided is changing fast as policy, regulation, funding and investment arrangements are experiencing rapid change.

Our Inquiry has sought to find out how older people needing care and support fare in that environment. We have turned time and again to questions about the way in which care markets work and what this means for older people. How much does the development of a market for services – where commissioning and providing are split – offer choice and flexibility for older people? And if the intention is to maximise choice, what changes need to be made to make that possible? Does the market support innovation? And if not, what are the blocks to that innovation? In a mixed market, with the private, voluntary and statutory sectors offering services, how well served is the older Londoner in search of care? In a system increasingly based on the primacy of individual choice, how can older people become more powerful consumers?

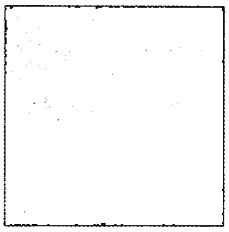
In taking evidence from a wide range of people and organisations, the Inquiry heard of services that are still too inflexible, and that are unable to respond to the changing needs and requirements of older people. We heard of services that are not sufficiently tailored to individual needs, and we heard of situations where, frankly, the promise of choice and control seems very hollow. But we were also told about some extremely positive developments. We heard of increasingly imaginative and intelligent commissioning that supports the development of innovation, and we heard about providers who are extending their services to meet specific needs.

But we also heard evidence of an immature market, in which market signals are hard to read, and many providers are fragile and therefore insufficiently resilient to respond effectively to the needs of the older people they exist to serve. In this market, funding pressures on both local government and the NHS frustrate the growth and development of services that can really focus on the requirements of the user.

The Green Paper, *Independence, Well-being and Choice*, offers the prospects of real choice for older people from a range of suitably responsive services. If its aspirations are to mean anything, the development of strong and confident service providers must be a priority. Making the market work for older people will require attention to their rights and dignity, and the creation of a set of services that can enable older people to live full and productive lives in their own communities. Failure to strengthen the market will result in poor and fragmented services, guided only by the availability of fees, and not by the needs, aspirations and wishes of older Londoners.

I would like to thank all my colleagues on the committee for contributing their extensive experience and expertise to this Inquiry as well as for offering challenging but always constructive discussions. My thanks also go to the King's Fund staff, Janice Robinson, Penny Banks and Sarah Robinson, for the excellent support they provided throughout. Most important, I am most grateful to everyone who generously gave time to share their experiences and perspectives by writing to us, giving evidence to the committee, and taking part in the different studies.

Julia Unwin
Chair, King's Fund Committee of Inquiry into Care Services for Older People in London



Summary

Press headlines proclaiming a 'care crisis' have been commonplace in recent years. As care homes have closed and as hospitals have been unable to discharge patients who no longer need medical treatment but require some form of social care, there have been fears that the care market is failing.

Aware of these concerns, the King's Fund established an Inquiry in 2004 into the way in which care services are provided for older people in London, examining the evidence that might reinforce or refute claims about a care crisis and a failing care market.

The Inquiry was established to find out:

- whether the care system operating in 2004 was meeting the needs and preferences of older Londoners who require care and support because of long-term ill health or disability; *and*
- whether there will be sufficient care services of the right design and quality to meet the needs of older people in London in 20 years.

An independent committee, chaired by Julia Unwin, collected evidence through written submissions, Committee hearings, focus groups and research studies specially commissioned for the Inquiry.

Putting the spotlight on London inevitably means that some of the challenges affecting care services for older people are quite specific to the capital. However, many of the strengths and weaknesses identified in the London care system are echoed across England as a whole. The Inquiry report therefore has national relevance. Its verdict on the poor state of current care and support for older people is also very timely, as the government has launched proposals for modernising social care for adults in its Green Paper *Independence, Well-being and Choice*.

The key finding from our Inquiry is that there are major shortcomings in the current care system that disadvantage older people and their carers. They experience:

- restricted access to care and practical support
- limited choice and control over care services
- being put at risk from untrained and unqualified staff
- hardship caused by inadequate funding and controversy about who pays for long-term care.

The prospects of improvements for the next generation of older people look bleak, as the demand for care will increase and the pressures on private and public resources will intensify.

We call for threee actions to address these shortcomings:

- investment in market development to: strengthen consumer power, support growth and diversity in the market, and create incentives to provide high-quality services

- reform of social policies to ensure equality of opportunity for older people and a culture that focuses on their rights as well as their needs
- mobilisation of more public and private resources for the care of older people and creation of greater transparency and certainty around long-term care finances.

We make our recommendations at a time when issues about services for older people are high on the political agenda and the government is in the process of developing a range of policies to address the challenges of an ageing society. We welcome and support the broad direction set out in the Green Paper, particularly the fact that the government is signalling a significant change in the relationship between older people and services – a change designed to empower them and their carers. However, in our view the proposals will not deliver the radical improvement in services required for the group of older people who need intensive care and support because of failing health and long-term disability. There is a significant risk that older people with substantial care needs will continue to receive care services that are simply not good enough.

Challenges facing care services for older people

A combination of demographic, social, economic and political factors influence the demand for and supply of care services.

Older people's need for care and support

Ageing and deprivation London has proportionately fewer older people than other parts of England. However, a high proportion of older people live in poverty, in poor health, in inadequate housing and with little or no support from family or friends. These high levels of deprivation, particularly in inner London, lead to comparatively high levels of demand for care services. Where older people do have support from family and friends, the carers themselves need help from health and social services.

Ethnic minorities London's older population is made up of many different ethnic groups, including people of Caribbean, African, Asian and Chinese backgrounds. Care services have to be tailored to meet the requirements of an older population with diverse spoken languages, religious beliefs and practices, and customs relating to family relationships and daily life.

Home ownership Half of older Londoners own their own home. High property values in London mean that older people needing a place in a care home have to pay the full costs themselves. Many opt for a care home outside London where places are cheaper, leaving care homes in London with disproportionately high levels of publicly funded residents. Older home owners whose money is tied up in housing equity can face difficulties finding the money for practical support that will enable them to remain at home.

Health and disability Older people's need for care and support can change over time as their health improves or deteriorates. Care services have to be tailored to suit people with short-term and fluctuating needs as well as those who need continuous and increasingly intensive care over many years. The unpredictability of poor health makes it difficult, both for individuals and for local authorities, to plan ahead. Local authorities are also expected to promote the health and well-being of all older people, while at the same time supporting the minority who need care and support.

Expectations Surveys have shown that older people prefer care and support that enables them to stay in their own home, and that they want services that give them choice and control over any assistance given and treat them with respect. Public bodies and independent care providers have to be able to listen to older people and their carers, and to improve those care services that fail to meet expectations.

Care services and the care system

A complex care system Demand for residential, home care and day care services can be affected by rates of treatment and lengths of stay in hospitals and by the availability of suitable housing. Care services therefore have to be seen as part of a wider health, housing and social care system. Local authorities with social care responsibilities are expected to work closely with NHS primary care trusts and housing bodies to commission a wide range of care services, including intermediate care and extra care housing. How well they work together affects the co-ordination of care and support for individuals.

Market conditions Care services operate within distinctive local care markets, where individuals and public bodies buy goods and services from the private, voluntary and statutory organisations that provide them. Local authorities are expected to develop and manage these care markets, with a view to improving value for money and increasing choice through competition. Health and housing services operate within different market. However, all three markets are subject to similar pressures in the labour market and in land and property markets – all of which affect staff recruitment and retention and the level of investment in the renovation or construction of buildings.

Consumer power Older people needing care and support can be highly vulnerable in the face of these market forces, because of their limited knowledge of what is available, their limited capacity to influence the quality of care and their insufficient income to purchase what they require. The public sector intervenes on their behalf by commissioning and regulating care services. How it does that has a fundamental effect on the range, availability and quality of care and support for older people.

The planning system Local and regional government can use their planning powers to influence care and support for older people by offering developers incentives to build supported housing, care homes and other care facilities – alongside other more general housing or commercial developments. London councils and the Greater London Authority (GLA) have to balance the needs of older people with other priorities, such as the shortage of housing for young key workers who are needed to staff essential public services in the capital.

London as a special place

London is similar in many ways to any big city or metropolitan area but there are distinctive features of the London economy and government that create special challenges for the care and support of older people.

Migration patterns London attracts young people from all over the UK and from abroad. However, after the age of 30, more people move out of London than go to live there. Migration in and out of London affects the availability of care workers.

Social problems London has high rates of mental illness, large numbers of deprived families and children in need, and high rates of crime – especially in inner-city areas. These social problems place heavy demands on local authority social services and can put pressure on budgets for older people's services.

High land and property values Care home fees in London are higher than the average for England – reflecting in part high costs of land and property. There is therefore an incentive for individuals and local authorities to buy cheaper places in care homes in other parts of the country. High land values also restrict investment in care homes and in extra care housing.

Labour market London experiences labour shortages in many fields, including public services such as health, education and social care. Employers find themselves competing for staff from the same restricted pools of labour. The London care workforce benefits from staff coming from overseas, but language barriers mean that some of these staff need extra support to acquire the relevant qualifications.

Public expenditure on care services London local authorities spend more on social care for older people than the average for England, but prices are higher in London and inner London authorities have to spend more cash per head to make up for the high numbers of low-income service users, who are less able to pay service charges.

Government and administration There are 33 local authorities in London, all but one of which are co-terminous with primary care trust (PCT) boundaries. Care markets are not confined within borough boundaries, so authorities often compete with each other to buy services for their local populations. This disadvantages local authorities in outer London and in the surrounding counties who are competing with inner London authorities that can pay more.

Strengths and weaknesses of the London care system

There are both strengths and weaknesses in care services for older people in London.

Access to care

Information and advice Some older people and carers have expressed warm appreciation of the information and advice given by staff in social services, the NHS and voluntary organisations. More commonly, the search for information and advice is experienced as a struggle, where the chances of getting the right help at the right time vary according to where people live and who they first approach for help. Older people and carers, particularly those who are funding their own care, would often find it helpful to have someone who could help them understand the system and access appropriate care. Black and minority ethnic older people report particular difficulties in accessing information, and those who cannot speak English have to rely on their families or on community workers to intervene on their behalf. There is a serious lack of financial information and advice – an important consideration given that many older people using care services have to pay for them in part or in full.

Accessing financial support Older people and carers in some parts of London have long waits for an assessment to determine their entitlement to public support. Many older people with low to moderate needs for support are being denied help, as their local council's eligibility criteria give priority to those with the highest levels of need.

Choice and control

Range of services There are new alternatives to residential care – for example, extra care housing, new models of home care, and intermediate care – available to older people. However, these new services are still in short supply. Provision of extra care units, particularly leasehold units, in London, for example, is below the average for England as a whole. Most older people with care needs have limited options, dominated by care homes or conventional home care services.

Preference for care at home Older people in inner London have a better chance of securing help at home than anywhere else in the country, as their local councils commission home care for 44 per cent more clients than the average for England, resulting in a 46 per cent increase in contact hours. There is, however, potential for much greater use of equipment that aids mobility and helps people to feel safe in their homes. The more sophisticated technology is still at an early stage of development and practical application, and health, housing and social care authorities are often reluctant to commit the substantial resources required.

Care home choices A number of issues restrict the choices available to older people.

- **High costs** High land and property prices in London have resulted in the underdevelopment of care homes and insufficient care home places to meet demand. Older Londoners are more likely than anyone else in the country to take up a place in a home outside their borough boundaries and outside London altogether. It is not clear how far the drift from inner to outer London and then to surrounding counties reflects older people's preferences – nor what the emotional and social impact on older people is. There is concern that many older Londoners are being denied the choice of a care home close to family, friends and familiar surroundings because of cost considerations.
- **Loss of small care homes** Care home capacity nationally has been shrinking, but in London a disproportionate number of small care homes have closed, with the result that homes in the capital tend to be larger than average.

Day services Some older people and carers appreciate day centres as they provide company, interesting and enjoyable activities, and respite for carers. Others complain that there is insufficient choice of activity and limited opportunities to pursue interests in community facilities outside the four walls of the day centre.

Control over care services Older people have limited control over the care services they use, in terms of deciding what tasks should be undertaken, when and by whom. Take-up of Direct Payments – which are known to strengthen users' control over care services – is very low in England as a whole and particularly in London.

Groups with less choice than others

Older people with mental health problems There is a serious shortage of services in both community services and residential care for older people with mental health problems, including those with dementia.

Black and minority ethnic older people Voluntary organisations and community groups complain that there are not enough care services catering for the needs of some people from ethnic minorities. In outer London, the proportion of older people from ethnic minorities who receive community care services is lower than the proportion from the overall older population. Only a very small proportion of homes claim to make provision for the religious, dietary and other cultural requirements of black and minority ethnic residents.

Service quality

Home care There is some dissatisfaction with the duration of visits (15–30 minutes) and the way that the tasks undertaken are rigidly specified by care managers. There are also some concerns about the reliability and competence of care staff.
Care homes Although standards have improved since 2002/03, there are many concerns about: poor standards of rooms and facilities; high staff turnover; lack of trained staff (some of whom are seen as uncaring and unable to communicate well with residents); problems with the timing and content of meals; and residents' restricted access to health care.

Integrated social care, health and housing services

Improving co-ordination Some local authorities, with their NHS partners, have begun to make progress in strategic whole-systems planning designed to prevent inappropriate use of hospital services, develop a broader range of alternative care and support in the community and ensure that older people get the right kind of care, at the right time and in the right place. It is common for local authorities and PCTs to work together on the strategic commissioning of services for older people. However, there are wide variations across boroughs in the relationships forged between health, housing and social services partners, and in the extent to which independent care providers or older people and carers feel able to influence strategic planning and commissioning. New integrated community teams, resource centres and intermediate care services are being established, providing better co-ordinated care and support to older people with both health and social care needs. These joint services are still the exception rather than the rule.

Care after leaving hospital By working closely with their NHS partners, local authorities have dramatically reduced the number of delayed discharges from hospital. However, there is widespread concern that people are being discharged too quickly, to their detriment of their health and well-being. Intermediate care services, offering a short period of rehabilitation following a spell in hospital, are less well developed in London than elsewhere.

Market management Local authorities and their NHS partners vary considerably in their understanding of local care markets and in their efforts to manage and re-shape the market to fit modern requirements. Even the most advanced are facing major political and financial pressures that hamper their ability to transform services in the way they wish.

Promoting health and well-being A few local authorities, in co-operation with health and housing partners, have adopted strategies to promote the health and well-being of all older people. Implementation of these preventative programmes is being hampered by the need to concentrate limited resources on care services for vulnerable older people.

Collaboration across boroughs Strategic commissioning across boroughs is rare, although there is interest now in exploring how specialist services for particular groups might be commissioned in this way, and how greater efficiency might be achieved through collaborative commissioning.

Workforce capacity

Skills and qualifications of staff Many care staff are committed to their work, derive great satisfaction from helping people and develop strong rapport with older people and their carers. Increased numbers of care staff are gaining qualifications that demonstrate their competence, but the majority are still unqualified. Staff employed by small care organisations in the independent sector experience particular difficulties in accessing training leading to National Vocational Qualifications (NVQs), as do care staff with English as a second language and those who have poor literacy and numeracy skills. More care service managers than ever before hold or are studying for management qualifications. But many lack the knowledge and skills required to expand or diversify services to meet changing demand. Some commissioners are enthusiastically engaged in the complex task of reshaping the care system, decommissioning services that are no longer needed and developing new ones. But many lack expertise in market management and experience in working in a political environment where there can be great opposition to change.

Recruitment and retention Vacancy rates for care staff in residential care and home care services in London are well above the average for England. Staff turnover is also high. This adversely affects continuity of care for older people and creates problems for employers.

A multicultural workforce Around 60 per cent of care workers in London are from ethnic minorities, the majority describing themselves as black African, black Caribbean or black British and smaller proportions as of Asian or Chinese origins. A large but unknown proportion of care workers come from overseas, some of whom are well qualified in their home countries, most of whom speak English as a second language. There are clear benefits to having a multi-ethnic workforce, but difficulties can also arise in terms of racism experienced by staff and poor communications between staff and service users.

Finances

High expenditure and high costs Considerable resources are spent on care services in London – £1.6 billion in 2003/04 (almost three-quarters of which entailed public sector funding). London local authorities are comparatively big net spenders on care services for older people, spending more per person than the average for England. Expenditure is higher than average, particularly in inner London, because prices are higher than elsewhere and because levels of deprivation restrict local authorities' capacity to raise income from user charges.

Diverting resources from older people's services In the past, local authorities were often found to have underspent on services for older people, spending more instead on children's and families' services. It is not possible to confirm whether that happened in 2004/05 because of changes to central government funding. However, social service directors acknowledge that, in some parts of London, resources for older people continue to be diverted because of pressures on services for children and families.

Capital expenditure on care homes and extra care housing A small number of new nursing homes and extra care units are being built, using public/private partnerships and special housing grants from central government. However, capital

investment in care services is restricted in London as investors in the private and voluntary sectors are less likely to be able to make a reasonable return on their investment through fees, rents and sales because of high land and property values in the capital.

Housing-related support It is not known how much is spent on assistive technology and handyperson schemes undertaking small repair and maintenance jobs around the home. Practical support in the home is available through the Supporting People programme, but older people in outer London are far less likely to receive this support than their counterparts in inner London. Much of the funding is tied up in sheltered housing and local authorities are experiencing difficulties in releasing money to use on floating support workers.

Private resources Individuals spent an estimated total of £265 million on care services in London in 2003/04, two-thirds of which was spent on residential care. However, few older Londoners can afford to fund their own care long term. Many home owners who are cash poor but asset rich are unable to release money to fund care and support in their own home.

Funding pressures Social services directors and London councils report that budgets are under pressure, and there is evidence that they are struggling to meet the needs of all but the most dependent older people.

Views about the financial system Older people and carers have mixed views about paying for services out of their pockets – some being willing provided they are affordable, others being opposed in principle. People who pay for their care regard it as unfair that they should be charged more than their publicly supported counterparts. There is widespread confusion about who is entitled to free NHS continuing care, as opposed to means-tested social care.

Future prospects for care

Demand for care will increase over the next 20 years, and the pressures on the public and private resources needed to respond to those demands will intensify.

Demand for care services can be expected to increase because of:

- a substantial increase in the population aged 85 and over. Numbers will increase by 54 per cent, from 108,000 in 2003 to 166,000 in 2028.
- the ageing of people from black and minority ethnic communities. For instance, by 2008 older people of Asian origin will form 9.8 per cent of the older population compared with 5.6 per cent in 2001.
- poor health among disadvantaged groups, and the particular demands of people with dementia.

Care and support from families Overall, the incidence of informal care is not likely to change dramatically. There may be changes in the patterns of care among some ethnic minority groups, as the number of extended families living together falls and as greater mobility associated with employment reduces the capacity of children to provide intensive care for their parents.

Expectations of care What the next generation of older people wants from care services is very similar to the requirements of older people today. They want services to enable them to lead independent lives, to exercise choice and control

over services and to participate in family and community life. They want services that fit their chosen lifestyles, and some are determined not to put up with standardised, poor-quality services provided for their parents' generation.

The balance of care services Home care services and extra care housing will need to expand substantially, offering an alternative to residential care. More care home places will also be needed to accommodate increasing numbers of older people with complex conditions and to offer older people the choice of a place in London that is close to family, friends and familiar surroundings.

Pressures on service supply More skilled care workers will be needed. But shortages and quality concerns are likely to continue, in the absence of better pay and conditions and enhanced opportunities for education and training. The growth of extra care housing and of care homes will be restricted unless changes are made in housing policy, planning barriers are lowered and shortages of affordable land and property are overcome.

Finances Increases in the very old population, combined with the inflationary impact of the Care Standards Act, will drive up the costs of care. Pressures on public expenditure will increase, as fewer older people will have sufficient income from pensions and savings to pay for their own care. There will be more older home owners with substantial amounts of money tied up in housing equity. The market in housing equity release may grow, enabling older people to draw down part of the value of their homes in order to pay for home improvements and practical support in the home. However, there are few reliable financial products available and many older people wish to leave some inheritance for their children.

Care policy and markets Governments will continue to rely on market mechanisms in the care sector, and public bodies will be responsible primarily for commissioning care services using public money. It is likely that integrated commissioning and market management will become even more complex, as services are purchased by strategic bodies, practitioners and individual service users. The care sector may become dominated by corporate businesses that can keep overheads low and invest in staff training and development. These businesses may be less able to respond to local needs and to the specific requirements of some ethnic groups. It is not clear whether older people can expect to have greater influence on care services – as consumers or as participants in strategic planning. Greater take-up of Direct Payments and individual budgets could increase consumer power in the future.

Understanding the roots of the problem

The problems in the care system in London are related to:

- market failures that restrict older people's choice and control and prevent services responding to what individuals need and want.
- public policies that disadvantage older people, seeing them as dependent, passive recipients of welfare and as lesser citizens than their younger counterparts.
- a financial system that results in restricted access to care and support, confusion and controversy about entitlements to care, and barriers to planning.

Market failures

Older people's weak consumer power Older people do not have the full information required to make informed decisions about their care. The majority of older people lack buying power and have to depend in part or full on public money to buy care, with little or no direct control over how this money is spent. Self-funders, with higher incomes or assets, also find it difficult to obtain appropriate information. Carers are in a similar position, except that their dual role as consumers and providers can lead to them being ignored and left to bear the costs of market weaknesses.

Underinvestment in market capacity and diversity Small care providers lack the resources necessary to expand or diversify their services, and to train and develop their staff to national minimum standards. There is insufficient capital investment in care homes and extra care housing because local authorities and their NHS partners, and self-funders, are unable or unwilling to pay higher prices reflecting full market costs. Care providers do not have a strong incentive to deliver quality care services as commissioners try to get as much service activity as possible for the lowest price.

Public policies

Welfarist approaches emphasise dependency, focus public support on poor people and restrict public expenditure to those older people who have severe care needs.

Ageism Health, social care and housing policies reflect low expectations about the quality of life older people should enjoy. Mental health services for older people, for example, often compare less favourably with those for working-age adults, and welfare benefits are less generous for older people than for younger age groups.

Emphasis on needs rather than rights The care system seems to operate at times with no recognition of older people's human rights. They can be subjected to physical, psychological, financial and sexual abuse by the people charged with their care and can also experience inhumane and degrading treatment.

Financial system

Insufficient public resources Public resources are sufficient for local authorities to respond only to older people with the highest levels of care need. Local authorities strive to keep costs down, which leads to care providers cross-subsidising lower fees from publicly supported clients with higher fees from self-funders. Current resources are insufficient to allow expansion of low level preventive services.

Inadequate private finance Costs of care for those who are denied public support falls on family carers and on individual older people. The majority of older people do not have sufficient income or savings to pay for care and support over a long period. Housing equity release schemes have not so far proved to be an attractive proposition for older home owners needing cash to pay for care.

Lack of transparency There is widespread confusion about the rules governing entitlement to free NHS continuing care and means-tested social care. Many people neither understand nor accept the distinction and therefore regard the funding system as unfair.

Uncertainties A lack of clarity about who will need care, when and for how long makes it hard for individuals and organisations to plan ahead for care in old age. With the virtual collapse of long-term care insurance, there is a dearth of financial products that consumers can use to protect themselves against the risk of needing care. Uncertainties about the future of Supporting People funds also threaten the future availability of housing-related support for older people.

Recommendations

Our recommendations propose specific action we believe is needed now to make the necessary improvements to care services in the immediate future and in the longer term. Our recommendations relate to:

- **reforming policy** so as to ensure equality of opportunity for older people and a culture that focuses on their rights as well as their needs
- **investing in market development** to strengthen older people's consumer power, support growth and diversity in care services, and create incentives to provide high-quality services
- **improving poor services for specific groups**, tackling in particular shortages in services for older people with mental health problems and shortfalls in services to older people from black and minority ethnic communities
- **mobilising more public and private resources** for the care and support of older people.

Reforming policy

Recommendation 1

By the end of 2005 central government should specify a set of indicators to judge progress on delivering its new vision of social care for older people and achieving the outcomes it has identified as important to older people. These outcomes include improved health and quality of life; being able to make a positive contribution; exercising choice and control; freedom from discrimination and harassment; economic well-being; and personal dignity.

Recommendation 2

The Commission for Social Care Inspection (or its successor following the merger with the Healthcare Commission) should monitor the implementation of policy for older people and how far these outcomes are achieved, and report on progress and problems.

Recommendation 3

During the current parliament, central government should introduce new age-equality legislation requiring organisations responsible for care services to demonstrate how they promote equality of opportunity. This legislation should outlaw age discrimination in the benefits system, health, housing and other public services. Either the Commission for Social Care Inspection (or its successor) or the new Commission for Equality and Human Rights should assess progress in promoting age equality through periodic reviews.

Recommendation 4

The new Commission for Equality and Human Rights should use educational campaigns and special investigations to promote and protect older people's human rights and their right to equal treatment. Where necessary it should take legal action to enforce these rights.

Recommendation 5
The Commission for Social Care Inspection should assess progress in promoting older people's human rights in local authorities, and the Healthcare Commission should assess progress in the NHS, through reviews or annual assessments. Where appropriate, reviews should be carried out jointly with the new Commission for Equality and Human Rights.

Investing in market development

Recommendation 6
Central government should fund local authorities to provide information, advice, advocacy and service brokerage. These should be:

- available to all older people. It is no longer acceptable to deny self-funders access to the help and advice available to those eligible for public support.
- developed in partnership with older people and their carers; PCTs; housing; independent providers; and the voluntary, community and business sectors
- based on existing local arrangements and new developments, including initiatives such as the Building Financial Capability project and Link-Age
- accessible and appropriate for older people and their carers from all local communities
- recognised as impartial, transparent and credible by older people and their carers.

The Commission for Social Care Inspection should monitor these services to ensure that these criteria are met.

Recommendation 7
Local government should support information, advice, advocacy and brokerage services by exchanging good practice, evaluating new schemes to ensure that older people are satisfied with them, and monitoring their performance. The Commission for Social Care Inspection, the Social Care Institute for Excellence, the Improvement and Development Agency, and the Care Services Improvement Partnership should work together to spread good practice.

Recommendation 8
Central government should pilot and evaluate individual budgets as proposed in the Green Paper, so as to assess how far these budgets genuinely give older people more control and choice over the services they need and they way they are delivered. Joint individual budgets (funded by local authorities and the NHS) should enable older people to secure as wide a range of services as possible, including health- and housing-related services that older people currently have difficulty accessing.

Recommendation 9
Local authorities and PCTs should establish effective arrangements to involve older people in commissioning services. Education and leadership development agencies should include good practice in involving older people in their education programmes for commissioners working in local authorities and PCTs.

Recommendation 10
The Department of Trade and Industry should support small care organisations to develop the business infrastructure necessary to enter the care market or to expand and diversify their services. Priority should be given to:

- developing more flexible and versatile care and support in people's own homes that can meet their short- and long-term care needs
- providing business support to small voluntary and community organisations working with black and minority ethnic communities to assist them to develop new care services responsive to older people's diverse religious and cultural preferences.

Recommendation 11
The Greater London Authority should give higher priority in its planning guidance to the development of new care homes and extra care housing (both rented and leasehold) in those parts of London where the current supply is insufficient to meet the needs and preferences of older Londoners.

Recommendation 12
Local authorities should make greater use of their planning gain powers to encourage the development of more supported housing and care homes in areas where the current supply is insufficient. In partnership with PCTs, local authorities should create land banks to be used for these developments and form public/private partnerships to lever more capital investment into housing and care services in London.

Recommendation 13
Local authorities and their PCT partners with the Association of London Government should develop capital investment plans on a pan-London and/or a sub-regional basis. This will help to ensure that new care homes and extra care housing are located where the need is rather than where land is cheapest. Planning on this basis is particularly important to ensure the development of specialist services that are not viable within individual boroughs, such as those for people with complex conditions and for specific black and minority ethnic communities.

Recommendation 14
Central government, local authorities and PCTs should jointly fund, on a pan-London basis, education and training programmes aimed at all staff who are involved in commissioning care services.

Recommendation 15
Skills for Care and workforce development departments within strategic health authorities should increase the support they give managers of care organisations to develop their businesses and to expand or diversify to meet current and future demand.

Recommendation 16
By 2007, the Commission for Social Care Inspection should institute systems to rate the performance of local authorities on how far their commissioning is achieving high-quality services and is also ensuring that these services meet equality standards.

Recommendation 17
Strategic commissioners and providers should work together with older people and their organisations to specify the outcomes that services should achieve for service users and carers.

Recommendation 18
Care managers should purchase care and support for an individual on the basis of the outcomes the older person wants. They should not specify in detail how the provider should deliver these outcomes. Care providers should be free to work out, in dialogue with the older person concerned, what this means in practice.

Recommendation 19
Local authority and PCT commissioners should consider paying a quality premium to encourage and reward providers whose services exceed national minimum standards.

Recommendation 20
Training and workforce development partnerships should increase their funding for training care workers. Particular attention should be given to care workers whose first language is not English and to those who lack basic literacy and numeracy skills. Workforce development departments, Learning and Skills Councils, Skills for Care, and health and social care organisations should combine their funds to provide intensive, work-based support to care staff working for small, dispersed care providers.

Improving poor services for specific groups

Recommendation 21
Local authorities and their PCT partners should develop and implement commissioning strategies to care for and support older people with a range of mental health problems and their carers. These strategies should:

- identify key areas for developing new services and redesigning existing ones. In most cases, we envisage that this will involve a radical overhaul of the current patchwork of provision based on a fresh appraisal of the specialist and generalist support required.
- indicate where existing resources could be used more effectively and where additional spending is needed to provide both specialist and generalist support and to upgrade staff education and training.

Recommendation 22
The Care Services Improvement Partnership should give high priority to improving services to older people with mental health problems through a nationwide development programme. The national directors for mental health and older people should regularly report on progress to government and the wider public.

Recommendation 23
We urge all authorities involved in commissioning, providing and regulating social care to improve the range and quality of services offered to people from black and minority ethnic groups. For example:

- Local authority and primary care trust commissioners should take the lead in developing high-quality services for black and minority ethnic older people.
- All local authorities and PCTs should work closely with black and minority ethnic groups and organisations to develop a better understanding of their needs and to address these needs in their plans for service development.
- Commissioners should ensure that private- and voluntary-sector providers demonstrate how they will meet the needs of older people from black and minority ethnic communities and their carers.

- The Audit Commission should ensure that local authority comprehensive performance assessment ratings reflect how well authorities are engaging with and providing for black and minority ethnic communities. This should also apply to the Healthcare Commission in their NHS annual assessment ratings.

Recommendation 24
In consultation with the relevant community groups, the Association of London Government should bring together local authorities, on a pan-London or sub-regional basis, to plan and commission specialist services for black and minority ethnic groups that cannot be met within a single borough.

Recommendation 25
Local authority and PCT commissioners should encourage community and voluntary organisations to enter the care market and develop services responsive to the needs of particular communities. Support should include advice on organisational development and training for managers and care staff. In addition, such services should receive medium-term funding, not the one-year agreements that are the current norm.

Mobilising more public and private resources

Recommendation 26
Central government should review its decision not to increase funding for adult social care and older people in the short term. This Inquiry demonstrates that local authorities and PCTs are struggling to meet all but the highest levels of need. If the government is serious about wishing to develop more preventative services while at the same time providing intensive care and support to a minority of older people, it needs to re-examine funding. We are not convinced that existing funding will be sufficient to implement the ambitious proposals set out in the Green Paper.

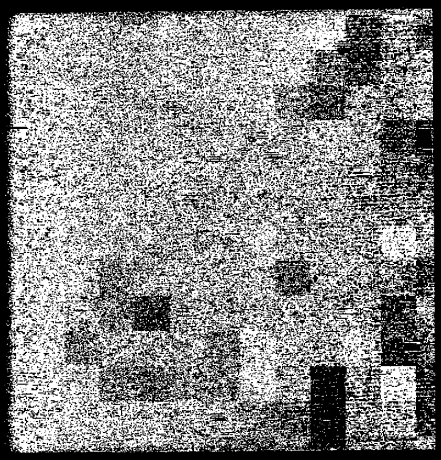
Recommendation 27
Central government should clarify the different circumstances in which older people are entitled to receive means-tested social care and free NHS care. In particular the government should ensure greater local consistency in interpreting the NHS criteria for continuing care. We welcome the government's proposals to establish a single set of national eligibility criteria for NHS continuing care. We also endorse the recommendations of the Health Select Committee that these should be seen as a short-term measure and there should be a more fundamental debate about the distinction between a free health care service and a means-tested social care system. We also welcome the proposal that this should be informed by the King's Fund social care review currently being undertaken by Sir Derek Wanless.

Recommendation 28
Local government and its NHS partners should be more open and accountable for what they spend on care services to older people. As well as fully involving older people and their carers in planning service developments, authorities should report back to the public regularly on how much has been spent on services for older people and on what specific types of care and support.

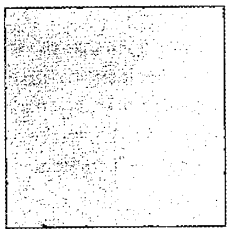
Recommendation 29
Local authorities and PCTs should ensure that they establish systems to enable older people and their organisations and champions to scrutinise local budgets and expenditure and to challenge decisions to divert resources intended for older people.

Recommendation 30

Central government should consider how to make housing equity release schemes more attractive so that older home-owners will be willing to use them to pay for the care and practical support they need to stay in their own homes. This means looking in detail at the tax and benefit anomalies that act as disincentives to using these schemes. Expert advice should be offered to older people on the schemes available.



Introduction



Introduction

Concerns about a care crisis

Press headlines proclaiming a 'care crisis' were commonplace towards the end of the 1990s and in the early years of the 21st century. Public concern mounted as increasing numbers of care homes closed and as hospitals were unable to discharge patients who no longer needed medical treatment but required some form of social care. This led to fears that the care market was failing. Across the country, care services for older people were perceived to be deteriorating, causing hardship to older people and their families, and setting serious challenges for central and local government, the health service, and independent care businesses.

Government responded to these concerns with measures designed to achieve greater stability in the care market and speedier care placements of older people fit to leave hospital. These included forging an agreement between local authorities and independent organisations providing care as to how they would work in partnership to build care service capacity (Department of Health 2001a). Increased funding was also made available through a 'Cash for Change' initiative (Department of Health 2001b), and legislation was introduced to require local authorities to reimburse the NHS for avoidable delayed discharges (Community Care (Delayed Discharges) Act 2003).

While these efforts were acknowledged by the King's Fund, nevertheless it was felt that political responses to the problems unravelling in the care system were essentially reactive and piecemeal, and might in themselves create unintended difficulties in the short term. A longer-term view was needed, for – as the Fund had warned in an earlier report about the care workforce – the problems could only intensify with rising demands for care in an ageing society and with continued doubts about the capacity of care services to meet the needs of the next generation of older people (Henwood 2001).

It was in this context that the King's Fund decided to set up an Inquiry into the way care services are provided for older people, examining the evidence that might reinforce or refute claims about a care crisis and a failing care market.

London focus and national relevance

The Inquiry focused on the operation of the care system in London during 2004 and on the prospects for care services over the next 20 years. This focus on London has several advantages. First, we have been able to take a detailed look at an area of the country where worries about the capacity of care services to cater adequately for the needs of older people are particularly intense. A relatively large number of care homes have closed in London and the south-east of England, and there have been high levels of delayed discharges from hospital. In this context, concerns about the care of people with dementia are particularly poignant, given their high use of residential care and the risks they face of staying in hospital too long when there are insufficient care alternatives.

Second, the London focus acts as a laboratory, allowing us to take the temperature of a care system that is perceived to be ailing, and to gain insights into the way in which successive reforms of community care are actually being played out. In this respect, London proves to be a microcosm of a wider world that has been implementing government policies on care services and care markets.

Putting the spotlight on this local area means that some of the challenges identified are bound to be quite specific to London. For instance, conditions in the London land, property and labour markets are different from those in rural areas, and this affects the supply of care services. Equally, we were keen to find out how care services respond to the needs and preferences of the high numbers of people from a wide range of black and minority ethnic communities who live in London; this preoccupation would probably have been less strong had we focused our attention on a rural area. However, throughout the Inquiry we have been struck by the extent to which many of our findings concerning the strengths and weaknesses of the London care system are echoed across England as a whole. This report therefore has national relevance, commenting as it does on the way social care is experienced by older people.

A ground-breaking Inquiry

So far as we know, this is the first time anyone has taken a close look at care services for older people in the capital and provided a detailed overview of a care system that serves thousands of older people and their carers, employs large numbers of workers, and absorbs millions of pounds of public and private resources. The Inquiry has been a major undertaking, exploring complex relationships between social care, health and housing, and examining the contributions that statutory, private and voluntary organisations, as well as families and communities, make to the care and support of older people.

Most important, the Inquiry has tackled a subject that matters to people. Older people and their families, of course, care deeply whether care services are well or poorly provided – and so do most of the people who work in this area. Interest in the subject goes even wider than that, for the care and support of vulnerable older people can be seen as a touchstone of a civilised society. Our Inquiry has endeavoured to show how far the current care system stands up to that test.

The nature of the Inquiry

The Inquiry was established to find out:

- whether the care system operating in 2004 is meeting the needs and preferences of older Londoners who require care and support because of long-term ill health or disability
- whether there will be sufficient care services of the right design and quality to meet the needs of older people in London in 20 years.

Several lines of inquiry were pursued to answer these key questions. First, we endeavoured to find out how older Londoners and their carers experience the care system – in terms of both seeking help and using care services. We also felt it important to explore what the baby boomer generation (born just after the Second World War and now in their 50s) expect from care services in 20 years when they themselves may start to need care and support.

Second, we examined, in some detail, past, present and future trends in the London care market, identifying and explaining changes taking place in the demand for and supply of care services in the capital.

Third, we looked at how care services operate within a care market where public finances and private incomes are used to purchase a range of residential and home care services run by private-, voluntary- and statutory-sector organisations. And we sought to understand how public bodies can influence care markets for better or worse through their policies, funding, commissioning and regulation.

Fourth, we investigated how local councils, with their health and housing partners, go about commissioning care services in practice. We also assessed how effective they are at managing and shaping the care market to ensure that services meet the needs and preferences of older people.

A changing policy environment

We expected the Inquiry to produce some fascinating insights into the way in which social care, health and housing policies affecting older people are implemented. However, we probably did not realise how far policy would change during the year the Inquiry took to complete. It has been necessary to keep abreast of this fast-changing policy environment, as new policy developments could have a bearing on our findings, our conclusions and our recommendations for change.

For instance, in March 2005 – just as the Inquiry was drawing to a close – the government issued a Green Paper entitled *Independence, Well-being and Choice: Our vision for the future of social care for adults in England* (Department of Health 2005). This acknowledged shortcomings in social care – many of which had been identified by people presenting evidence to the Inquiry. The Green Paper set out proposals for improving opportunities for independence, choice and control by extending the use of Direct Payments, introducing 'individual budgets', and improving assessment and support through care brokers or 'navigators'. Greater emphasis was also placed on preventive services. These issues featured frequently in our considerations of action that should be taken to address the problems we identified. In drafting our final report, we have had to bear in mind that some of what we have to say has already been acknowledged by government and other key bodies who are in a position to bring about real change in care services for older people.

The operation of the Inquiry

The King's Fund set up an independent committee, chaired by Julia Unwin, to undertake the Inquiry during 2004, with support from a secretariat involving staff of the King's Fund. (Committee members are listed in Appendix 1, p 149.) Committee members brought an impressive range of experience and expertise to the Inquiry, including extensive knowledge of social care, health and housing and a long-term interest in the diverse mix of people who need care and support at some time in their life.

The job of the committee was to shape the main lines of inquiry, to commission research, to agree a final report, and to help publicise the work during and after the Inquiry.

Collecting the evidence

A call for evidence (*see* Appendix 2, p 151) was issued in February 2004, with a closing date of 2 April 2004. The Inquiry clearly struck a chord with many people who had something to say about the state of care services for older people in London. More than 100 written responses were received from individual older people and carers, from local authorities, NHS primary care trusts (PCTs), care providers, professional bodies and trades unions, from voluntary organisations working with and for older people and carers, regulatory bodies and the Department of Health. The evidence submitted provided us with a rich source of information and views from many different perspectives. (*See* Appendix 3, p 157, for details of those who submitted written evidence.)

Three focus groups were organised for care workers employed in care homes and in home care services to give them the opportunity to speak about their experiences, both good and bad, and to voice any concerns about care services. Their enthusiastic and frank contributions to the Inquiry gave us very valuable insights into what it is like to work in this area and how provision for older people appears through the eyes of care staff. (*See* Appendix 4, p 159; for focus group participants.)

Authoritative evidence was presented to committee hearings that took place during June, July and September 2004. Thirty people from a wide range of organisations attended the hearings, giving their views about progress and problems in London's care services and answering the committee's questions about current concerns and future prospects. We were especially pleased that Dr Stephen Ladyman, then Parliamentary Under-Secretary of State for Community, participated in the hearings, as well as senior figures in local government, care organisations and the voluntary and community sector. (*See* Appendix 5, p 161; for details of the people who attended the hearings.)

New research

The committee also commissioned four new research studies, and a briefing on housing and care issues, from researchers with extensive experience in this field. Their work provided us with a wealth of detailed information that helped us to drill down on some of the broad issues raised in other evidence presented to the Committee. The research studies have been published as working papers to accompany the Committee's final report. They include the following documents:

- Levenson R, Jeyasingham M and Joule N. *Looking Forward to Care in Old Age – Expectations of the next generation.*
- Netten A, Darton R, Davey V, Kendall J, Knapp M, Williams J, Fernández J L and Forder J. *Understanding Public Services and Care Markets.*
- Laing W. *Trends in the London Care Market 1994–2024.*
- Banks P. *Commissioning Care Services for Older People: Achievements and challenges in London.*

Other working papers are also available, including:

- Levenson R and Joule N. *What Older People Say about Care Services – A literature review.* (Unpublished, available from King's Fund library)
- Banks P. *Commissioning Care Services in London (full study findings).*
- Netten A, Darton R, Davey V, Kendall J, Knapp M, Williams J, Fernández J L and Forder J. *Understanding Public Services and Care Markets.* (Full research report available on PSSRU website)

Interim report

Given how successful the Inquiry was in engaging so many people in this important and controversial topic, the committee felt that it was important to provide an early indication of the findings to all those who had shown such an interest in the work. An interim report was therefore published (Robinson 2004), setting out the emerging key themes and discussing some of the dominant policy dilemmas affecting the development and delivery of care services for older people.

This report received a good deal of press coverage, which suggested that the issues we were examining continued to be of great topical interest. We received very positive feedback from readers of the interim report, who confirmed that the picture we painted of shortcomings in the care system was widely recognised.

Definitions and terminology

Inner and outer London

Throughout this report, we refer to Greater London, to inner and outer London, and to particular London boroughs. The map overleaf shows the area of the capital and its constituent parts. The demarcation of inner and outer London is particularly important to bear in mind for, time and again, we have found that conditions vary quite markedly between inner-city areas and the suburbs.

Furthermore, data describing conditions in London almost always distinguish between inner and outer London. Unfortunately, there are different definitions. In this report we have usually followed the definition used by the Office for National Statistics (ONS) when reporting on census data; this classifies the boroughs of Haringey and Newham as part of inner London; and Greenwich as part of outer London. The Department of Health switches these boroughs in its data relating to expenditure, service activity and so forth. When we use Department of Health data we adjust it to fit the ONS classification.

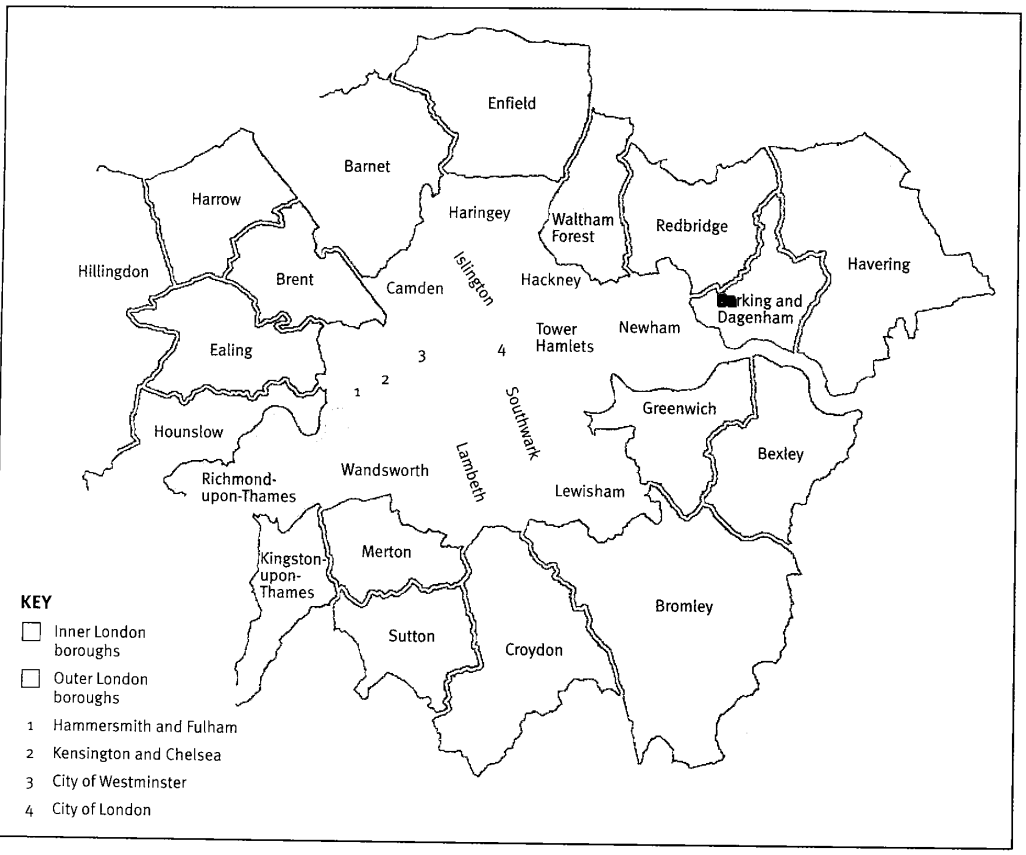
Census data

Throughout this report we have based our population statistics and projections on data from the 2001 census. This provides an important element of consistency and enables useful comparisons to be made. We are, of course, aware of the controversies about the accuracy of the 2001 census and the arguments that, in some parts of London, population figures have been underestimated. We are also aware that population figures have been updated and are under review in some boroughs.

Population weighting

Statistics relating to care service activity and expenditure in this report refer to a 'weighted population'. Unless otherwise stated, this refers to adjustments that are made to absolute numbers in order to take account of different levels of need among different populations. The principal adjustments relate to age (the proportion of people aged over 65 and over 85 in the population) and to deprivation (the proportions of people on income support, on Attendance Allowance or Disability Living Allowance, with a limiting long-term illness, living alone, and living in rented accommodation). *Trends in the London Care Market 1994–2024*, one of the research reports commissioned for this Inquiry (*see* opposite), reproduces data relating to both the weighted and the unweighted population.

MAP OF THE LONDON BOROUGHS



Source: Office for National Statistics 2003

Part one
The challenges for older people and care markets

In Part 1, we examine the challenges involved in providing care and support for older people in London. We examine the characteristics of the older population, the care system, the economy and local and regional government. We also discuss how these factors affect demand for and supply of care services.

Introduction

Our Inquiry into London care services has to be seen in the context of the challenges faced both by older people when they need care and support and by statutory, private and voluntary organisations as they respond to older people's needs. Those challenges are derived from distinctive patterns of demand for and supply of care services in the capital, and a complex care system that spans health, social care and housing markets.

We begin by examining the factors that influence care service demand and supply, highlighting the implications for older people and organisations responsible for care services. We also consider some of the dilemmas that arise for individuals and organisations as they make decisions and take action.

Our analysis includes:

- the extent and nature of need among older Londoners, the risk factors associated with the use of care services, and what older people expect from care services
- the characteristics of care services and the care system in London, including the operation of care markets and the influence public bodies exert on those markets
- special features of London's population, economy and government that create unique pressures on the care and support of older people.

We conclude that, while the policy regarding care services may look relatively straightforward, in practice, getting care services right for older people is fraught with difficulty. Decisions affecting care services can also be controversial, raising all kinds of questions about competing demands for help, the best use of limited resources, and effective ways of attracting and keeping skilled staff capable of delivering good care services to vulnerable older people.

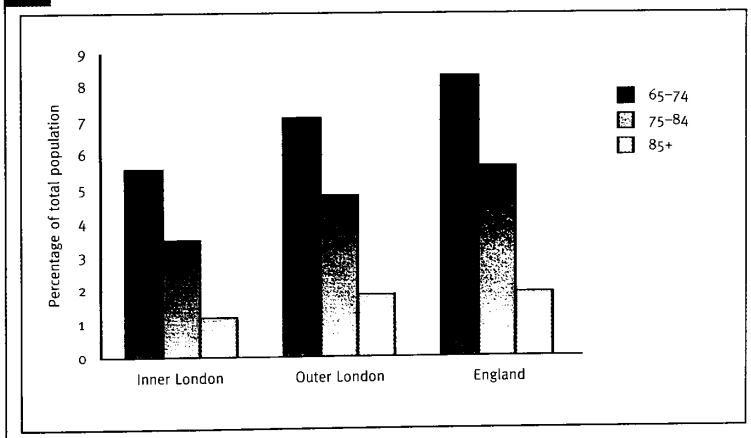
1 Older people needing care and support

A minority in a young city

Just over 7.3 million people lived in London in 2001, making it the largest city in the European Union. Almost 900,000 people were aged 65 or over, while almost 113,000 were aged 85 or over (Office for National Statistics 2003).

The potential demand by older people for care services would appear to be markedly lower in London than in England as a whole. This is because London is a relatively young city. People aged 65 and over represent only 12.4 per cent of the total population, compared with 15.9 per cent in England as a whole. The contrast between inner London and England is even more striking – only 10.3 per cent of people in inner London are 65 or over. This under-representation also applies to the 75–84 age group, who make up 4.3 per cent of Greater London's population, compared with 5.6 per cent in England as a whole. However, when it comes to very old people (aged 85 and over), there is not a marked difference between the population in London and in England as a whole (*see* Figure 1).

1 AGE PROFILE OF OLDER PEOPLE IN LONDON AND ENGLAND, 2001



Source: Laing 2005, data from 2001 census

London's age profile might suggest that the pressures to provide care services for older people who need them are less intense in the capital than in seaside retirement areas, for instance. However, a number of other factors, which we discuss below, reduce this relative advantage.

In the future London's age profile will look rather different. Although the increase in London will still be less than for England as a whole, the size of the older population will grow substantially over the next 20 years (Laing 2005). This suggests that, all other things being equal, demand for care services is likely to increase. We look at patterns of future demand for care services in Section (*see* pp 109–119).

Older people from ethnic minorities are heavily concentrated in London and other metropolitan areas of England; few live in the shire counties

Ethnicity

Older people from ethnic minorities are heavily concentrated in London and other metropolitan areas of England; few live in the shire counties. While 93.4 per cent of older people (aged 65 and over) in England define themselves as white British, only 78.3 per cent do so in Greater London. As Table 1 shows, black and minority ethnic groups make up a higher proportion of the older population in inner London than in outer London; the exception is older people of Indian origin, who are concentrated in the west and north-west outer London boroughs. The diversity of the older population suggests that there is a much greater demand in London than elsewhere for services that are responsive to specific cultural needs and preferences. This responsiveness includes: staff being able to communicate in languages other than English; services that enable people to maintain their religious observance and adherence to dietary and hygiene customs; and services that facilitate social contact with people from the same cultural background who may have shared memories and interests.

TABLE 1: PERCENTAGE OF POPULATION AGED 65+ BY ETHNIC GROUP, 2001

	Inner London	Outer London	Greater London	England
White:				
British	69.6	82.4	78.3	93.4
Irish	6.9	4.1	5.0	2.0
Other	7.0	3.7	4.7	1.7
Total	83.5	90.2	88	97.1
Mixed:				
White and black Caribbean	0.4	0.1	0.2	0.1
White and black African	0.1	0.0	0.1	0.0
White and Asian	0.3	0.3	0.3	0.1
Other	0.3	0.2	0.2	0.1
Total	1.1	0.6	0.8	0.3
Asian or Asian British:				
Indian	2.2	4.3	3.6	0.9
Pakistani	0.6	0.6	0.6	0.4
Bangladeshi	1.5	0.1	0.6	0.1
Other	0.7	0.8	0.8	0.2
Total	5.0	5.8	5.6	1.6
Black or black British:				
Black Caribbean	7.2	2.1	3.7	0.8
Black African	1.6	0.5	0.8	0.1
Other	0.3	0.1	0.2	0.0
Total	9.1	2.7	4.7	0.9
Chinese or other ethnic groups:				
Chinese	0.7	0.4	0.5	0.1
Other	0.7	0.3	0.4	0.1
Total	1.4	0.7	0.9	0.2

Source: Laing 2005, data from 2001 census

The number of black and minority ethnic older people is set to increase. The Greater London Authority plans to publish more detailed projections based on census data in summer 2005. The 2001 census shows that the proportion of black and minority ethnic people among 50–64-year-olds is higher than among older people. In 20 years these now middle-aged people will have become part of the older population – which means that it will become even more important for care

services to cater for the specific requirements of different ethnic groups. Whether the needs and expectations of older people from black and minority ethnic groups will be different in 20 years' time remains to be seen; we examine what middle-aged people expect in Section 9 (*see* pp 103–113).

Health and disability

Older people need care services only when illness and disability prevent them looking after themselves without help. Older Londoners are not markedly more or less likely to need care services as a consequence of ill health than older people in England generally. However, in inner London the proportion of older people reporting limiting long-term illness is slightly higher (24 per cent) than in England as a whole (21 per cent) (*see* Table 2).

TABLE 2: PERCENTAGE OF OLDER PEOPLE WHO WERE NOT IN GOOD HEALTH *AND* HAD A LIMITING LONG-TERM ILLNESS, 2001

Age	Inner London	Outer London	Greater London	England
65–74	21	16	18	17
75–84	26	23	24	24
85+	33	31	32	32
All 65+	24	20	21	21

Source: Laing 2005, data from 2001 census

Some minority ethnic groups are more likely to experience ill health and disability than the white population. For instance, late-onset diabetes is more prevalent among South Asian and Caribbean groups, while African and Caribbean groups experience high rates of stroke (Bardsley and Lowdell 1999). Some of these health inequalities can be attributed to poverty and associated lifestyle differences, such as diet. In addition, in some minority ethnic groups individuals are more likely to see themselves as 'old' and in need of care and support in their 50s. Such premature ageing and ill health have been attributed to deprivation in younger life, the traumas associated with migration (particularly among refugees and asylum seekers), and poor living conditions (London Health Observatory 2003). This suggests that the demand for care services among black and minority ethnic elders may be higher than among the older population as a whole.

Variations in the type, duration and consequences of ill health affect the demand for care services in a number of ways. How and when care services are needed depends largely on the extent to which older people develop acute and/or chronic conditions that run their course in very different ways over time. For example, some people experience many years of good health as they age, followed by a brief period of acute ill health leading to death. Others experience chronic ill health resulting in a steady and unremitting deterioration in their physical or mental capacity over a number of years; people with Alzheimer's disease or Parkinson's disease, for instance, fall into this group. Yet other older people may have one or more chronic conditions such as arthritis or diabetes; their health may be stable for much of the time, with dramatic deteriorations or crises occurring as a result of infection, injuries from falls and so forth.

These patterns of ill health and disability indicate that the need for care services is not static and that it is not always long-term care that is required. This suggests that individuals' needs for care and support should be reviewed periodically to ensure that appropriate provision is made to suit changing circumstances. Furthermore, care services should be tailored to suit people with short-term and fluctuating

There are extremes of wealth and poverty in London's population. More than 40 per cent of single pensioners, and 13 per cent of pensioner couples, have a weekly income of under £200 per week

needs as well as those who need continuous and increasingly intensive care over many years.

Although the incidence of self-reported ill health among older people is relatively easy to chart, it is much more difficult for individuals to predict whether they will need care services and when. People also tend to avoid thinking about their potential future care needs; if they think about it all, people seem to hope that either their family or the state will come to their rescue. These difficulties make it hard for individuals to plan ahead and make arrangements for their own care in old age should they need it. Such reluctance is perhaps understandable given that only one in three women and one in five men are going to need long-term care at some time in their lives (Royal Commission on Long Term Care 1999), and therefore the chances of needing such help seem relatively low. Even so, since most older people who need care and support are expected to pay part or all of the costs of their care, the question arises of how to encourage individuals to plan ahead and to protect themselves from having to sell their home in order to pay for their care. We consider this topic in more detail in Section 10 (*see* pp 115–138).

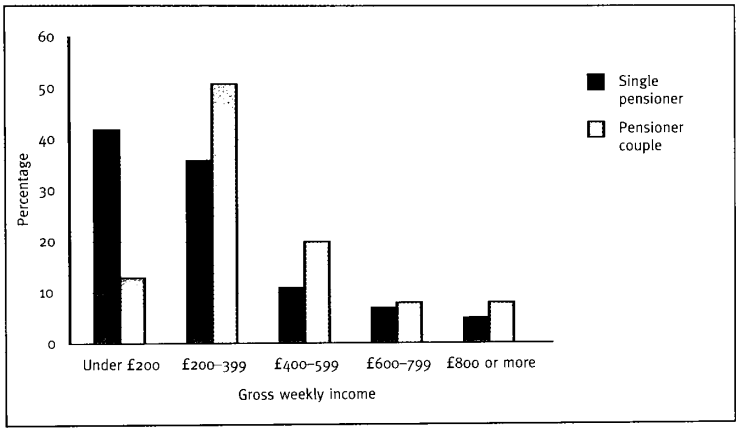
The unpredictability of future ill health also makes it difficult for local authorities, and their health and housing partners, to plan to meet the demand for care services. It cannot be assumed that the health patterns of London's older population – and therefore the demand for care – will be the same in 2025 as it is in 2005. Public health measures and advances in medical science may reduce disease, disability and premature death; in 20 years' time, more older people may well be healthier for longer than they are now (Wanless 2002). That said, it is clear that, in the absence of a cure for Alzheimer's disease, the incidence of dementia is much more predictable and can only increase as London's older population increases. Uncertainties about future demand for care make it all the more important for health and social care planning authorities to monitor trends and to share intelligence about demographic changes taking place across London. We look at what local authorities and the NHS are doing to improve the health of older people and at how London authorities are tackling future care service planning in Section 6 (*see* pp 69–76).

Affluence and poverty

There are extremes of wealth and poverty in London's population. More than 40 per cent of single pensioners, and 13 per cent of pensioner couples, have a weekly income of under £200 per week (*see* Figure 2 opposite). Savings are also low; half of single pensioners and a third of pensioner couples have no savings at all or less than £1,500 (*see* Figure 3 opposite). Pensioner poverty is concentrated in parts of east and north-east London, particularly in the boroughs of Hackney, Haringey, Islington, Newham and Tower Hamlets (Social Disadvantage Research Centre 2003). These are also areas with large black and minority ethnic communities, who are known to experience disproportionate levels of poverty.

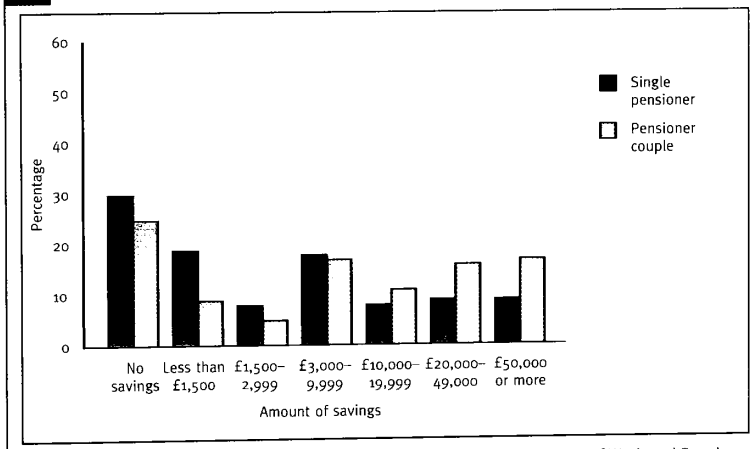
After taking housing costs into account, 36 per cent of older people in inner London are living in poverty, compared with 21 per cent in outer London and 25 per cent in England as a whole (Greater London Authority 2002). Demand for care services from poorer people tends to be higher than from more affluent groups, since poorer people experience higher rates of ill health and disability. At the same time, low-income groups are much more likely to turn for help to their local social services rather than buy the care they need in the open market.

2 INCOMES OF PENSIONER HOUSEHOLDS IN LONDON, 2002/03



Source: Laing 2005, data from *Family Resources Survey 2002/03*, Department of Work and Pensions

3 SAVINGS OF PENSIONER HOUSEHOLDS IN LONDON, 2002/03

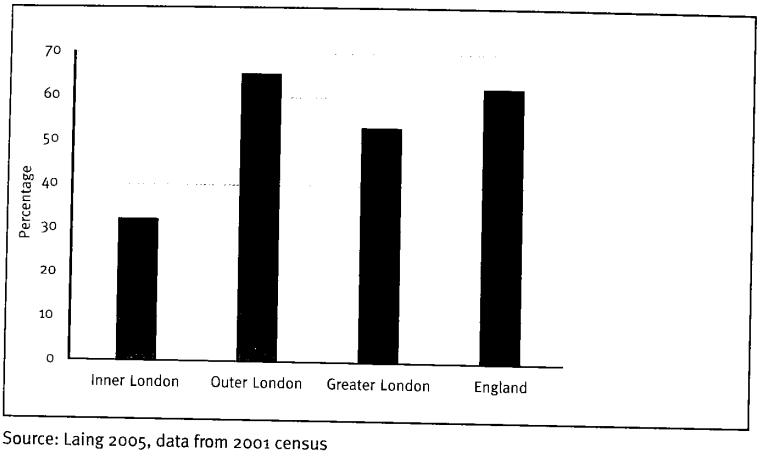


Source: Laing 2005, data from *Family Resources Survey 2002/03*, Department of Work and Pensions

Many older Londoners live in housing that lacks basic amenities (ONS 2003); for example, almost 3,000 older Londoners living alone do not have sole use of a bath or shower and toilet, while more than 54,000 single pensioner households do not have central heating. Older people in poor housing conditions are concentrated in inner London boroughs such as Camden, Wandsworth and Westminster. They experience higher health risks than their better-housed counterparts and are far less likely to be able to stay in their own homes when they need care and support because of ill health.

Just over half (53 per cent) of older Londoners own their own home. However, home ownership among older people in inner London (32 per cent) is markedly lower than in England as a whole (62 per cent); in outer London (65 per cent) it is slightly higher than in England as a whole (*see* Figure 4 overleaf).

4 HOME OWNERSHIP: PERCENTAGE OF OLDER (65+) OWNER-OCCUPIED HOUSEHOLDS WITH OR WITHOUT A MORTGAGE, 2001



Source: Laing 2005, data from 2001 census

Rates of home ownership impact on the way central government allocates resources to local authority social services departments. The assumption that home owners will pay privately for a place in a care home is reflected in the Formula Spending Share, the formula the Department of Health uses to calculate the funding allocation to local authorities for social care for adults; this is based on a variety of factors including deprivation, age and the local cost of services.

Of course, not all home owners are wealthy; indeed many who occupy valuable homes are on low incomes (Burrows and Wilcox 2000). This means that they are less able to keep their houses in good repair. Nor are they able to buy the equipment and home adaptations they require to remain living at home when they need care and support.

The wealth or poverty of older Londoners has major implications for their access to care services. Unlike the NHS, whose services are free at the point of delivery, social care services are means tested. Poorer people rely on public bodies to purchase services on their behalf or to improve their housing conditions through grants or loans. How more affluent people fare depends upon the size of their income and assets, their consumer power, and the extent to which the care market responds to their requirements.

The value of housing assets is taken into account in assessing whether an individual should receive public funding to meet the costs of a place in a care home. If someone has capital of £20,000 or more, they have to pay the full cost of the care themselves. This bites particularly hard in London, where property values are so high that all home-owners find themselves above the means-tested threshold that determines access to public support (Molyneux and Leather 2005).

Similarly, older people are charged for home care and other community services, according to their means. More affluent older people can, in principle and often in practice, buy the care services they need directly from the open market, without any recourse to local authority social services. About a quarter of all home care provided by the independent sector in London is privately funded (approximately the same as in England as a whole). It is more difficult to quantify the number of

More older people receive care and support from family and friends than they do from formal care services. Indeed, many older people are themselves carers, looking after their spouse. Without the contribution of these informal carers, demand for formal, paid care services would be much higher

older Londoners who pay for residential care, because the statistics tell us only who pays for care home places (not whether they are Londoners or not), so we do not know how many residents of care homes outside London used to live in the capital. That said, we do know that almost a third (31.9 per cent) of residents in London care homes fund their own care; the proportion is markedly lower in inner London (20.9 per cent), because fewer older people own their own homes in inner city areas than in outer London (38.9 per cent) and in England as a whole (47.7 per cent) (Laing 2005). (For the reasons given above, these figures understate the level of self-funding among Londoners.) The low level of self-funding for residential care in London in turn places a higher burden on councils to pay for care.

It might be expected that more affluent older people, paying for their care out of their own pockets, would have more choice and control over the services they buy than their poorer counterparts, who rely on local authorities to purchase care on their behalf. There is some evidence that this is not always so; self-funders can find themselves having to pay higher fees and charges for the same services used by rich and poor alike (Office of Fair Trading 2005). The main reason is that self-funders' consumer power is relatively weak compared to that of local authority social services departments, who are able to drive down prices (Netten *et al* 2005). This raises questions about fair trading – fees paid appear to vary according to income and not according to the cost of providing a service. It also raises political questions about the redistribution of wealth; while some people may think it perfectly reasonable for the better-off to pay more for their goods and services, this does not apply in any other market sector. In social policy, income tax is more usually used to 'subsidise' the less well off, and this is generally seen as a fairer and more transparent means of redistributing income. We consider how Londoners paying for their own care manage in Section 4 (*see* pp 43–47).

The relative wealth of some older Londoners poses dilemmas for older people and care organisations alike. With large numbers of older Londoners owning substantial amounts of housing equity but not possessing large incomes, questions arise about whether and how all or part of that equity might be mobilised to enable home-owners to fund their own care at home. This issue is particularly pressing for older people whose care needs are not regarded as sufficiently high to warrant public support and for local authorities, who claim that they do not have sufficient resources to help everyone in need. Some observers consider that more effective release and use of housing equity are the solution to social care finances in the future, in the absence of increased public funding. However, there is some public resistance to equity release schemes, both in principle and in practice, as many older people want to pass on their property to their children when they die. There has also been a general lack of confidence in such schemes. We examine changing attitudes to using housing equity to fund care services for older people and the potential contribution this might make in Section 10 (*see* pp 121–144).

Family and social networks

More older people receive care and support from family and friends than they do from formal care services. Indeed, many older people are themselves carers, looking after their spouse. Without the contribution of these informal carers, demand for formal, paid care services would be much higher. Intuitively, it might be expected that older Londoners would have proportionately less help from unpaid carers, since many Londoners move out of the city when they are young or

middle aged (*see* p 31). If true, this would suggest that demand for formal care services is higher in London than elsewhere.

It is not possible to confirm this using the data available. That said, more than 600,000 people in Greater London provide unpaid care. While the proportion of informal carers is smaller in inner London than in outer London or in England, and some of London's carers are caring for people living outside London, none the less it is clear that a substantial number of Londoners care for relatives and friends (Office for National Statistics 2003). The number of older Londoners receiving care is not known. However, it can be assumed that most care is provided for older Londoners by spouses, particularly where long hours of care (more than 50 hours per week) are involved; carers need to live either with or close to the older people concerned in order to provide care of that duration. This suggests that, generally speaking, family networks in London are strong and are not markedly weaker than in England as a whole. However, the picture is mixed since, as in other parts of the country, some older people clearly enjoy the benefits of strong links with families, friends and neighbours, while others may be isolated and enjoy little social support.

The presence of these support networks in London creates dilemmas both for older people and for local authorities seeking care home places. Many older Londoners use care homes located outside the borough they live in and even outside London altogether. Sometimes this is because older people wish to be nearer relatives who have moved away. Another important reason is that the higher price of residential and nursing care in London provides an incentive for older people to look for, or be placed in, cheaper places far from where they live. For some years London local authorities have placed a far higher proportion of their older residents in care homes outside their borough boundaries than other (even other metropolitan) authorities in England. This raises the question of whether older Londoners are being denied the option of entering a local care home and are being forced to use a care home far from family and friends and their familiar local neighbourhood. We examine the extent and the impact of this 'exporting' policy in Section 5 (*see* pp 46–67).

The extent of informal caring in London also affects the amount and type of support that local authorities, and their health and housing partners, provide to carers. When caring relationships break down because of the intolerable burdens carers experience, the demand for formal care services increases. It is in the interests of local authorities and the NHS to support carers – for the sake of their own health and well-being and to encourage them to keep caring for longer. We look at how far carers in London are supported in Part two of this report.

The desire for an ordinary life

Older people who need care and support because of ill health and disability want to live as full a life as possible. The authorities responsible for public services do not always recognise this. They tend to respond to this group of older people principally in terms of their care needs rather than their roles, rights and responsibilities as citizens in local communities. While care services are important in providing older people with essential help with their day-to-day living, they are not sufficient to enhance people's quality of life. Like everyone else, older people require universal public services – transport, leisure and learning opportunities – that enable them to get out and about and to participate as much as they want to in family and community life. These public services can also reduce the risks of

When it comes to quality of life, older people want the same things as everyone else. They want to feel safe, to have a decent income and a decent home, social contact, control over their lives and opportunities to contribute to family and community life

mental and physical deterioration, social isolation and social exclusion, thereby decreasing the demand for care services.

Our Inquiry did not set out to examine older Londoners' access to and use of a broad range of public services. However, we have been interested to find out how care services link with wider public services and how far they facilitate older people's use of such services.

Some local authorities, working with their NHS partners, have been pursuing corporate strategies designed to promote the health and well-being of all older people, including the minority who need care and support. The Association of Directors of Social Services and the Local Government Association have promoted this approach, urging local councils to pay more attention to extending universal services to all older people rather than just concentrating on the care and support of those with acute care needs (Association of Directors of Social Services 2003a). There are likely to be financial implications for councils who pursue health and well-being policies targeted at older people. At the moment a large proportion of council budgets is focused on social services that support a minority of older people with high care needs. There appears to be little scope for realigning budgets to expand preventive services without reducing the resources committed to intensive care and support. This raises questions about where the increased resources required will come from. We examine what local authorities are doing to promote older people's health and well-being in Sections 5 and 6 (*see* pp 46–67 and 69–76).

What older people want from care services

There is no shortage of information about older Londoners' requirements of care services. Over the last five years, numerous consultations, surveys and research studies have been undertaken to find out what older people want from care services and how satisfied they are with the way in which they are treated when they seek help and use services (Levenson and Joule 2005).

It is clear that what older people require of care services is closely linked to what they want their lives to be like. When it comes to quality of life, older people want the same things as everyone else. They want to feel safe, to have a decent income and a decent home, social contact, control over their lives and opportunities to contribute to family and community life. They want to be independent, which they interpret not as being able to do everything for themselves but as being able to exercise choice and control over how they live their lives. They do not want to be seen as a burden, nor as wholly dependent on others. They appreciate the notion of interdependence, with mutual help and support within networks of friends, neighbours and family (Levenson and Joule 2005).

Older people have indicated time and time again that they value services that support independent living and a good quality of life. This applies to all public services that enable them to have a comfortable, accessible home, a safe neighbourhood, leisure and learning opportunities, adequate transport, a decent income, and access to health and care services – all of which combine to enhance their health and well-being (Levenson and Joule 2005).

With regard to care services, older people prefer care and support that enables them to stay in their own home. That can include both intensive support on a daily basis as well as 'lower-level' (but no less important) assistance such as periodic

When it comes to paying for care services, older people have mixed views about what people should pay for and whether they should pay anything at all

help with domestic chores, shopping and gardening. Whether they live in their own home or a care home, they want to be treated with respect and to feel valued. They want support to fit with their lifestyle and living circumstances, including their family life and their cultural and religious preferences. As a priority, older people want control over any assistance provided – in other words they want to determine who does what for them and when. They also require easy access to information that enables them to make decisions about their lives, particularly at times of change. Having to adapt to unpredictable and difficult transitions (such as failing health, loss of loved ones, moving to more suitable accommodation) is often a major feature of older people's lives; at these times they value advice from someone who can tell them about the options and help them obtain the assistance they require. Older people also value services that enable them to return to independent living after illness or injury. Everything that older people say about their requirements of care services indicates that they want services that meet their needs as a whole person rather than services that merely address their disease, health condition or disability (Levenson and Joule 2005).

When it comes to paying for care services, older people have mixed views about what people should pay for and whether they should pay anything at all. Some feel it is appropriate to pay for services, providing they are affordable and the charges set do not cause anyone to go without the help they need. Others feel that means-tested charges for services are unfair. Many older people are opposed in principle to home-owners having to sell their homes in order to pay the costs of their care in a care home. Others are merely worried by the prospect (Levenson and Joule 2005).

Older people also express strong views about equality of access to care services. Many believe that access to services should depend on need and not on people's age, sex, ethnicity or sexual orientation or on where they live.

When asked what they think about the care services they are using, older Londoners and their carers express satisfaction and praise as well as a range of concerns, complaints and worries about shortcomings. The literature review commissioned for this Inquiry shows that, since about 2000, older people in the capital have indicated where services are not living up to their expectations (Levenson and Joule 2005). It is not known how far these criticisms have led to improvements in the range of services provided or in the way that they are provided. Certainly those working in older people's organisations, including black and minority ethnic communities, sometimes complain about being 'consulted to death' and are weary of repeated consultations organised by public bodies who, they claim, never seem to do anything about the concerns they voice.

Listening to older people and their carers and responding to what they say about the care services they use is a constant challenge for social care, health and housing bodies in London. We examine how far the care services provided in 2004 met older people's requirements in Part Two of this report.

What the baby boomers will want

It is often claimed that people who are now in their 50s will not behave like their parents when they grow old and need care and support. The baby boomer generation, born after the Second World War, grew up at a time of increasing consumerism and declining deference to authority and has enjoyed the benefits of the welfare state. This, it is argued, means that the next generation of older people

will have very different expectations of their life in old age and of care services. They will demand more and be more demanding.

What the next generation requires of care services clearly has a bearing on the future development of care and support for older people. Politicians at central, regional and local level ought to have an interest in this (assuming they take the long view), as should staff responsible for planning sustainable services for the future. It remains to be seen, of course, whether baby boomers grown old will in fact have different attitudes and behaviour. We examine what the baby boomer generation says about its future expectations of care in Section 9 (*see* pp 103–113).

Key points

- **A minority in a young city** London has proportionately fewer older people than other parts of England, and demand for care services might seem less intense than elsewhere. However, there are concentrations of older people living in poverty, in poor health, in inadequate housing and with little or no support from family or friends. These high levels of deprivation, particularly in inner London, lead to increased demand for care services.

- **Ethnic minorities** London's older population is made up of many different ethnic groups, including people of Caribbean, African, Asian and Chinese backgrounds. More than one in nine older people identify themselves as belonging to specific black and minority ethnic groups. Care services have to be tailored to meet the requirements of an older population with diverse spoken languages, religious beliefs and practices, and customs relating to family relationships and daily life.

- **Health patterns** Older people's need for care and support can change over time as their health improves or deteriorates. This means that care services have to be tailored to suit people with short term and fluctuating needs as well as those who need continuous and increasingly intensive care over many years.

- **Home ownership** Half of older Londoners own their own home. This is important because the value of housing assets is taken into account when local authorities assess whether an individual should receive public funding to meet the costs of a place in a care home. Because of high property values in London, all home owners needing a place in a care home have to pay the full costs themselves. Many opt for a care home outside London, where places are cheaper, leaving care homes in London with disproportionately high levels of publicly supported residents. Housing equity release schemes are available that enable people to stay living at home but use part of the value of their home to fund their care. But take-up of these schemes is low.

- **Planning for care in old age** It is hard to predict who will need care in their old age and this makes it difficult for individuals to plan ahead. Local authorities, with their health and housing partners, are also uncertain about the future demand for care services. This makes it all the more important for authorities to work together, monitoring trends and sharing intelligence about demographic changes taking place across London.

- **Social support networks** As elsewhere, many older people receive care and support from family and friends, while some are isolated and have little social

support. The contribution of carers reduces demands on formal care services, but it is clear that carers themselves need support from health and social services to carry on caring. Problems can occur for older people when they are placed in care homes far away from their support networks – an important consideration given that so many older Londoners take up places in care homes outside their borough and outside London altogether.

- **Care plus health and well-being** Older people, like everyone else, require universal public services that enable them to get out and about and to participate as much as they want to in family and community life. To achieve this, local authorities have to pay more attention to promoting the health and well-being of all older people, while at the same time supporting the minority who need care and support. Councils can find it difficult to adopt this preventive approach within current resources.

- **Expectations and experiences of care** Older people are clear about what they want from care services. Surveys have shown that they prefer care and support that enables them to stay in their own home, and they want services that give them choice and control over any assistance given and that treat them with respect. When asked to rate care services in London, they have expressed praise as well as criticisms of service shortcomings. Local authorities and their NHS partners do not always find it easy to listen to older people and their carers, nor to improve those care services that fail to meet expectations.

2 Care services and the care system

A health, social care and housing economy

The care services at the centre of our Inquiry are residential and nursing care homes, home care, and day care. These are the three most dominant service models in the social care sector. However, new types of care services have emerged recently; these include health and social care hybrids, such as intermediate care, and housing and social care hybrids, such as extra care housing.

Social care, health and housing services do not operate in isolation from each other. Within the social care sector, demand for care homes can be reduced by increasing the availability of intensive home care services. Equally, activity across health, housing and social care has knock-on effects on the demand for and supply of care services. For example, increased rates of hospital treatment and faster discharges can increase the demand for all types of social care services from older people, who continue to need support following surgery or other treatment. At the same time, access to health care can be restricted when hospital beds are occupied by people who cannot be discharged because social care services are not available to help them. Similarly, home care services can be provided only to people whose homes are suitable for them to continue living there. If houses are in poor repair, restricting mobility and daily living, older people who need care and support may have no alternative but to take up a place in a care home.

It is therefore more appropriate to see 'care services' as part of a whole care system. Public bodies, such as local councils and the NHS, are part of this system as they are responsible for planning, commissioning and providing health, social care and housing services. This complex system has long been characterised as fragmented, with duplication and gaps in services, and liable to blockages that hinder older people obtaining the right kind of care at the right time. Successive governments have introduced measures to integrate the care system and to prevent blockages occurring. Since 1997, the driving force for greater health and social care integration has been the government's commitment to increase the NHS's capacity and so treat more people more quickly.

Whether older people receive appropriate and timely combinations of care and support therefore depends very much on the way local authorities and the NHS work together to plan, fund, develop and deliver services. A dilemma for local councils and the NHS arises when dominant health policy drivers – such as the push to meet hospital waiting time targets – distort the way that the system as a whole operates and increase the risk of older people being discharged too quickly from hospital with insufficient attention paid to their care needs and preferences. We look at the efforts being made to reduce delayed discharges in London – and the impact on older people – in Section 4 (*see* pp 43–47).

Market conditions in inner London are different from those in the suburbs and different again from those in the counties around the capital

Market relationships

Care services operate within distinctive local and highly developed care markets, where many different individuals and organisations buy goods and services from the businesses, charities and public bodies that provide them. The home care and care home markets are more highly developed than markets in day care, equipment services and meals services. Market conditions in inner London are different from those in the suburbs and different again from those in the counties around the capital such as Essex and Kent.

Since the NHS and Community Care Act (1990), government policy has been to encourage and provide incentives for local authorities to develop and manage markets in social care, in order to improve value for money and increase choice through competition. Social care markets have a number of key characteristics:

- Local authorities do not run the majority of care homes or home care services. Most home care services are provided by small independent for-profit and not-for-profit businesses; most care home services are provided by larger businesses.
- Local authorities are the dominant purchaser of social care services. This gives the public sector substantial power and influence on prices and on the overall shape and balance of care services. London authorities fund 73 per cent of care home residents in the capital and purchase 75 per cent of home care hours provided by the independent sector.
- Individual users of social care services have relatively weak consumer power. They often have to make decisions about care at very stressful times in their lives; many lack the knowledge they need to make informed choices; some have some form of mental impairment; and many find themselves unwilling or involuntary users of services that they find difficult to influence or leave when they are unhappy with the quality of service.
- The charges consumers of publicly funded care services pay are not directly related to the cost of the services but are levied on a means-tested basis.
- In the past the barriers to care providers entering the care market were relatively low. This is now changing as care regulators require providers to meet recently introduced national care standards relating to the quality of buildings and care staff and the quality of the care given. It is relatively easy for care service providers to quit the market (as many have recently). Closing a care home means that its residents lose their home, and all the friendships and associations that go with home, and have to be found, and settled into, alternative places.

Health and housing services operate within very different markets. The health market is largely internal. Its key characteristics are:

- One part of the NHS (PCTs) commissions and funds hospital and community health services provided by another part of the NHS (acute and community trusts).
- Most health care services, whether in hospitals or the community, are provided by the NHS. For example, in 1997/98, only 15 per cent of all hospital admissions were private (Keen *et al* 2001). This is beginning to change as NHS commissioners increasingly fund private sector health services to carry out non-emergency surgery. Even so, new Diagnostic and Treatment Centres – established in the private sector to carry out non-emergency operations – have contracts to cover treatment for 250,000 patients a year, representing only 5 per cent of a total of approximately 5 million such operations carried out in England in 2004 (Kings Fund 2005).

- Service users are not charged directly for their care, as the NHS is free at the point of delivery. Although there is some private payment for health care, for example, dentistry, physiotherapy and over-the-counter medicines, health services are still largely funded through taxation.
- Consumer power is relatively weak despite policies aimed at increasing patient and public involvement in planning services, enabling patients to choose their hospital, and helping individuals who are dissatisfied with the care received to complain and seek redress.
- The barriers impeding entry to the health market are much higher than those operating in the social care market. This is because of the high levels of training and qualifications required of medical and nursing staff and the high capital investment needed for hospitals, clinics and so on.
- In the London health care market, large and prestigious teaching hospitals exercise considerable power over the way in which resources are allocated. This makes it especially hard for PCTs to shift resources away from the acute hospital sector towards primary and community health services. Historically, patients – including older people – have been admitted to teaching hospitals from different parts of London and from outside the capital. This can make arrangements for social care following a stay in hospital particularly challenging.

The housing market is different again, with different markets for home ownership and for private or social rented housing. Key characteristics of this market are:

- The public sector is a minor player as both purchaser and provider of housing.
- Local authorities are important gatekeepers to social housing, including sheltered housing. As gatekeepers they control access to council housing and hold nomination rights to homes built by housing associations. Local authorities also fund home improvements through grants and loans provided via major government programmes, including regeneration programmes.
- Consumer rights vary according to whether individuals are home owners or tenants. However, both are protected in law from losing their homes – so long as you pay your mortgage or your rent you cannot be evicted from your home. A resident of a care home has no such rights; should the owner decide to close the home, the residents can be evicted even though they have paid their fees.
- People rarely change their housing status by moving from owning a home to becoming a tenant of rented accommodation. This can lead to rigidities in supported housing markets, where the supply of extra care accommodation for sale is insufficient to meet the needs and preferences of older home owners.

All three markets are subject to similar pressures in the labour market and in land and property markets. These pressures affect the recruitment and retention of staff and the level of investment in building renovation or construction.

Older people needing care and support can be highly vulnerable in the face of these market forces. This is because they have limited knowledge of what is available, limited capacity to influence the quality of care, and insufficient income to purchase what they require. The restricted consumer power of older people means that the markets cannot be guaranteed to provide goods and services of the quality and at the price they require. This is why local authorities, with their health partners, act on their behalf to commission care services. How those public bodies manage and influence social care, health and housing markets has a fundamental effect on the range, availability and quality of care and support for older people. We examine how effective London local authorities, and their NHS partners, are in shaping and managing local care markets in Section 4 (*see* pp 38–43).

Integrated commissioning

The Health Act 1999 required local authorities and the NHS to co-operate, and now it is very common for local authorities to work closely with PCTs and housing bodies to commission a wide range of care services, including intermediate care services and extra care housing. Co-operation in commissioning can involve partners creating a pooled budget and agreeing that one partner will act as the lead commissioner, and establishing joint management arrangements for staff teams.

While drafting this report, we checked the latest information on joint schemes on the Department of Health's website, which showed that local authorities and primary care trusts had notified the Department of 417 joint schemes concerning services for older people and for younger adults with mental health problems, learning disabilities or physical/sensory impairments. The budgets for these schemes totals £3.4 billion. Most of this money goes to schemes benefiting adults of working age rather than older people. These formal notifications understate the amount of joint work taking place, as local authorities and PCTs are not obliged to notify the Department of Health, and many do not.

As health, housing and social care organisations co-operate to develop and implement commissioning strategies, they have to work within and across the three very different markets described above. This makes their task a complex one, requiring a shared vision of what modern services should look like, sophisticated knowledge and skills to influence and manage local markets, and a strategic commitment to joint working. Given that commissioning and market management are relatively new functions for public bodies, that local authorities have been working in this way for longer than the NHS, and that market conditions can fluctuate relatively rapidly, it is clear that integrated commissioning is very challenging.

The implication of these developments for our Inquiry is that we have looked not only at how well London's local authorities commission care services for older people but also at how effectively they work with health and housing partners. Contemporary commissioning of care services requires the NHS and local authorities to collaborate at least to some extent. How far these bodies actually work together differs across the country – poor working relationships can develop and ambitious joint arrangements can fracture because of financial, political and other pressures (Banks 2002). We examine progress being made on integrated commissioning in London in Section 4 (*see* pp 39–43).

Markets and the planning system

Its planning functions give local and regional government a strong influence on the shape and operation of the housing market, and enable it to determine what sort of and how much housing for different social groups goes where. Planning authorities are also able to offer developers incentives to build schools, nursing homes, sheltered housing etc in addition to other more general housing or commercial developments. In London, both the Greater London Authority (GLA) and the 33 London boroughs have planning powers and responsibilities. In his London Plan (2004), the Mayor of London gave high priority to housing key workers needed to staff essential public services in the capital.

Other groups such as older Londoners, who find it difficult to obtain a place in a care home or in sheltered/extra care housing, could be given higher priority – providing,

The dilemma for planning authorities in London, given the major shortage of housing for the key workers the London economy needs and also the relatively high levels of homelessness, is how to realign planning priorities to give higher priority on the housing needs of older people

that is, both these types of accommodation are recognised as an integral part of housing provision for older people. As it is, neither the GLA nor most borough councils choose to look at housing with care services in this way (Age Concern London 2003). Nor have they tended to negotiate 'planning gain' deals with developers that benefit older people with care needs (Molyneux and Leather 2005).

The dilemma for planning authorities in London, given the major shortage of housing for the key workers the London economy needs and also the relatively high levels of homelessness, is how to realign planning priorities to give higher priority to the housing needs of older people. Ageist attitudes may also be leading London planning authorities to neglect the supported housing needs of older people and to rely on many moving out of London when they need that sort of accommodation. In addition, there may be a general lack of understanding of the place of older people in the housing market. We consider what more planning authorities could do to stimulate the development of new supported housing options in Section 5 (*see* pp 45–67).

Regulation and care markets

Markets cannot be guaranteed to produce high-quality, safe care services because the vulnerability of the people who use these services puts them at risk of neglect and abuse. Care markets offer consumers limited choice (particularly when they want to exit an unsatisfactory service), and consumers have insufficient information to make informed choices as well as weak purchasing power. Regulation is therefore needed to protect older people.

The state offers protection and national minimum standards of care through regulation. Since the Labour government came to power in 1997, the regulatory system governing social care has changed dramatically. The Commission for Social Care Inspection is now responsible for inspecting both residential and home care services to ensure that standards are being met; in 2008 this responsibility will pass to a new body, following the government's decision to merge the two regulatory agencies dealing with health and social care.

Regulation affects both the demand for and the supply of care services. Individuals buying their own care and local councils purchasing care services will tend to use only registered care providers who have demonstrated that they meet minimum care standards. Those services that do not meet the minimum standards will close and go out of business. At the same time, care providers who feel unable to meet the costs involved in achieving the national care standards can decide to quit the market, thus reducing the supply of care services. There is evidence that many small care homes across England have closed, partly for this reason (Netten *et al* 2005).

Care regulators face a dilemma when they encounter poor-quality care services. Putting those services out of business means depriving older people of services that they have come to rely on and that may, in the case of residential care, constitute their home. In London between 2002 and 2004 the regulator did not close any care homes, even though a number caused considerable concern (Sa'id *et al* 2004). It is also unclear whether the regulator or another public body can decide to bring in another organisation to run a failing care business, rather than close it. This contrasts with arrangements in other sectors such as social housing.

The main challenge for regulatory bodies is how to regulate the care market in a way that delivers what matters most to older people and their families while at the same time maintaining a reliable supply of services

How far older people themselves have confidence in the way social care regulation works is also open to question. The regulatory system does not operate in a way that drives up standards and recognises high-quality services. Inspectors judge a service by whether minimum standards are achieved. In addition, they are criticised for concentrating on checking paper policies and procedures rather than talking to service users and their carers and listening to their experiences and views of the services they receive. The result is that consumers cannot judge whether an organisation offers a basic one-star service, a two-star or a premium three-star service. The main challenge for regulatory bodies is how to regulate the care market in a way that delivers what matters most to older people and their families while at the same time maintaining a reliable supply of services. During our Inquiry, the Commission for Social Care Inspection acknowledged shortcomings in the way in which care services were being inspected and regulated and put forward for consultation proposals for modernising the system (Commission for Social Care Inspection 2004a). We discuss the impact of regulation on London care services in Section 4 (*see* pp 39–43) and consider plans for changing the regulatory system in Section 10 (*see* pp 115–138).

Key points

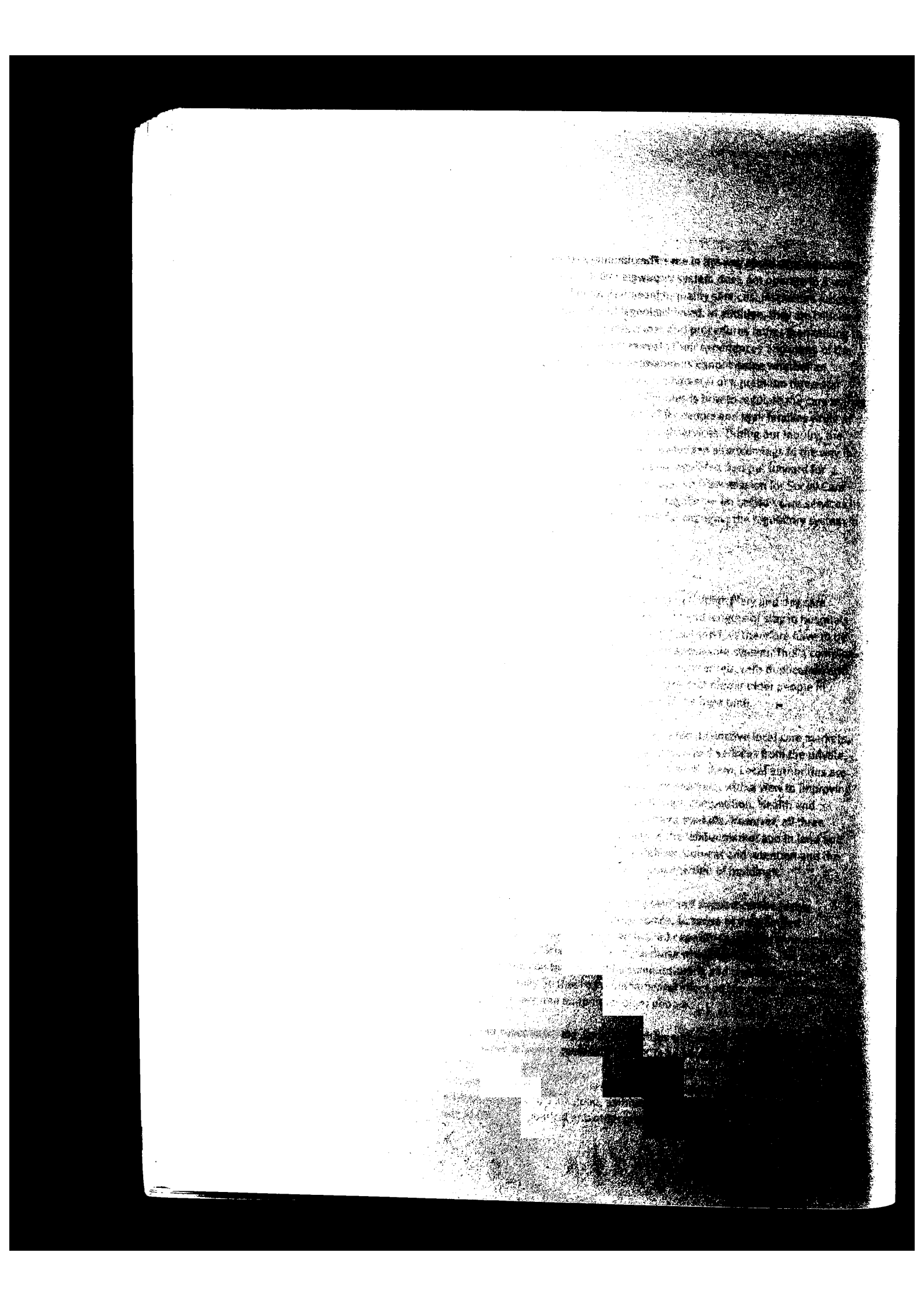
- **A complex care system** Demand for residential, domiciliary and day care services can be affected by rates of treatment and lengths of stay in hospitals and by the availability of suitable housing. Care services therefore have to be seen as part of a wider health, housing and social care system. This a complex system that has long been characterised as fragmented, with duplication and gaps in services, and liable to have blockages that hinder older people in obtaining the right care, in the right place, at the right time.

- **Market conditions** Care services operate within distinctive local care markets, where individuals and public bodies buy goods and services from the private, voluntary and statutory organisations that provide them. Local authorities are expected to develop and manage these care markets, with a view to improving value for money and increasing choice through competition. Health and housing services operate within very different markets. However, all three markets are subject to similar pressures in the labour market and in land and property markets – all of which affect staff recruitment and retention and the level of investment in the renovation or construction of buildings.

- **Consumer power** Older people needing care and support can be highly vulnerable in the face of these market forces, because of their limited knowledge of what is available, their limited capacity to influence the quality of care and their insufficient income to purchase what they require. The public sector intervenes on their behalf by commissioning and regulating care services. How they do that has a fundamental effect on the range, availability and quality of care and support for older people.

- **Integrated commissioning** Local authorities with social care responsibilities are expected to work closely with NHS PCTs and housing bodies to commission a wide range of care services, including intermediate care and extra care housing. How well they work together varies across London. Even where working relationships are good, ambitious joint arrangements can break down due to financial, political and other pressures.

- **The planning system** Local and regional government can use their planning powers to influence care and support for older people by offering developers incentives to build supported housing, care homes and other care facilities – alongside other more general housing or commercial developments. London councils and the Greater London Authority have to balance the needs of older people with other priorities, such as the shortage of housing for young key workers who are needed to staff essential public services in the capital.



3 A special place

In many respects, living and working in London is similar to life in any big city or metropolitan area. However, there are distinctive features of London that have consequences for the demand for and supply of care services for older people. These differences derive from the nature of London's economy and its government.

Population migration

As the principal centre of government, business, financial services and the arts, London attracts young adults from all over the UK who want to take advantage of these employment opportunities. As they grow older and form families, and as the relative attractions of the capital diminish, they tend to move out. In recent decades, there has been a net migration of people of all ages over 30 from London. At younger ages, Londoners from inner city areas tend to drift to the outer London suburbs, while Londoners in general drift out of the capital, mostly to destinations in east and south-east England (London Development Agency *et al* 2003).

Around retirement age, some people move out of London to the country or the coast; in addition, a relatively insignificant number move abroad. However, retirement moves are not numerous enough to form a sudden surge in outward migration. Much of this outward migration involves older people (often couples) in the higher socio-economic groups who own their own home and therefore have greater opportunities to move and to maximise their assets (Crosby 2004). The older people remaining in the capital are therefore more likely to be poor in terms of income and assets. For the reasons discussed in Section 1, this in turn increases the demand for health, social care and housing services.

People also move to London from abroad. London experiences a net inward migration from abroad of all age groups, including people aged 65 and over. In 2001, more than 102,000 people aged between 18 and 59 living in London reported that they had been living outside the UK in the previous year (ONS 2003). Many of them will have been foreign nationals, attracted by the capital's educational and employment opportunities.

The inward and outward migration of younger adults from London has consequences for the capital's care workforce, since it affects both staff turnover and continuity of care. While it is not clear how far the outward migration of care workers affects staff turnover, it can safely be assumed that care workers coming from abroad, who plan to stay for a short while and then return home, will increase turnover.

Social problems

London experiences a range of social problems related to social deprivation and to conflicts around the world. Rates of mental illness are high (Levenson *et al* 2003). Some parts of London have large numbers of deprived families with children in need

or at risk (Department for Education and Skills 2004). Crime and disorder are major problems throughout the capital, and especially in inner city areas that have high rates of illegal use of drugs, theft and violence (Simmons and Dodd 2003). In addition, large numbers of people from minority ethnic groups experience racism and social exclusion. Many of these people are British citizens who have lived in London all their lives. Some have migrated to the UK and have lived and worked in London ever since they arrived in the country; others have recently arrived as refugees or asylum seekers (Coker 2001).

These social problems place heavy demands on local authority social services, which have responsibilities for children and families, people with mental health problems, and young offenders. Budgets for older people's care services can come under severe pressure as other demands with higher political risks are given higher priority. We examine how local authorities experience and react to those pressures in Section 8 (*see* pp 93–103).

Land and property values

Land in London, especially inner London, costs more than anywhere else in England. House values are also comparatively high. This means that it is expensive to build new care homes or supported housing in London. It is also harder for the public sector to raise the capital for new buildings, and the private sector has to charge commensurately high fees, rents or sale prices to stand any chance of making a decent return on its investment. Typical care home fees in London are 20–30 per cent higher than the average for England; in 2004 they averaged £600 per week for nursing care and £450 per week for residential care. These averages mask the real range of fees charged, since care homes in the most expensive parts of London, such as Kensington and Chelsea, may charge as much as £950 per week (Laing 2005).

The underdevelopment of the care home sector is one result of high land and property costs in London. Neither councils nor self-funding residents are able or willing to pay fees that are considerably higher than outside London. As discussed in Section 5, this is one of the reasons why so many older Londoners choose a care home, or are placed by their council in a care home, outside the borough they live in or outside London altogether.

Supported housing is underdeveloped in London for the same reason. Outer London is better off than inner London in this respect. Even so, much of the available supported housing is for rent rather than for sale, reflecting the reluctance of private developers to enter the London housing market. This suggests that older Londoners who are home-owners are likely to find it more difficult to buy extra care housing than their counterparts in the rest of the country.

The labour market

Overall, London has virtually full employment and a strong economy based on service industries; however, this favourable picture does mask wide variations in unemployment rates between different boroughs. There are also labour shortages in many fields, including public services such as health, education, social care and the police. Employers find themselves competing for staff from the same restricted pools of labour. This is particularly evident in health and social care, where non-professionally qualified staff are required for care, administrative and ancillary roles.

Public- and private-sector employers of care workers in London face many challenges to recruiting and retaining good-calibre staff capable of delivering a high quality of care to vulnerable older people

At the same time, care work – with its low pay and demanding responsibilities – can seem unattractive alongside jobs in the retail and leisure sectors. This results in staff recruitment and retention difficulties for care service employers (Henwood 2001). While these difficulties are not restricted to London, there is some evidence that care service employers in areas of high unemployment experience fewer problems of this nature (Joseph Rowntree Foundation 2004 p 171).

As mentioned above, London benefits from people coming from abroad to study or work. With serious labour shortages in the NHS, particularly of nurses, some employers have recruited people from the European Union, Africa, South East Asia and Australasia as nurses or care workers (Buchan *et al* 2004). Some foreign nurses are known to be working as care assistants in care homes and home care services while they wait for their nursing qualifications to be cleared.

All the people who have come from abroad and taken up jobs in care services are clearly willing to do the low-paid work that Londoners do not want. No doubt this reflects the more restricted opportunities available to migrants to London. Nevertheless, the fact that they are able to fill vacancies so readily reflects the relatively low barriers to entering the care workforce, which, unlike the nursing workforce, does not require long training and specific qualifications as a condition of entry.

The recruitment of care staff from abroad has many advantages. People from overseas are undertaking work that many British people do not wish to do; some may be well educated and experienced in caring for others. The downside is that many may not have a good command of English or be familiar with a culture where the expectations of older people and their families may be very different from those in their own country. This suggests that the education and training of care workers should take account of their different cultural backgrounds, languages and communications skills.

Regardless of whether they are British nationals or workers from overseas, people from black and minority ethnic communities experience more restricted employment opportunities than their white/British counterparts. This results in black and minority ethnic workers on the whole being disproportionately unemployed or employed in low-paid jobs with poor career prospects (Office for National Statistics 2004). It is therefore perhaps not surprising that black and minority ethnic staff make up over 40 per cent of the London care workforce. Since most older Londoners who use care services are white, black staff can encounter racial prejudice and racial abuse from a minority of clients who hold racist views. This has implications for employers who need to protect their staff from such abuse and tackle persistent offenders who refuse to change their behaviour.

Public- and private-sector employers of care workers in London face many challenges to recruiting and retaining good-calibre staff capable of delivering a high quality of care to vulnerable older people. The difficulties discussed above suggest that they need to develop sophisticated human resource policies and practices that will attract and reward good care workers. Their dilemma is how to implement these strategies with a workforce that continues to be viewed as cheap and replaceable labour, with all that that means in terms of attracting resources for education and training and for pay. We look in more detail at the experience of care workers in London and of their employers in Section 7 (*see* pp 81–91).

It is clear that London – or, more accurately, inner London – has a comparatively high level of expenditure on care services. It is another question whether there are sufficient resources to ensure that every older Londoner receives the help they need

Public expenditure on care services

Care services in London are big business, accounting for an estimated £1.6 billion in 2003/04. Not all of this is public expenditure, since many people pay privately for their care or contribute towards the cost of their care through means-tested charges. Nevertheless, London authorities spend more on social care for older people than the average for England. Of course, prices are higher in London than elsewhere – Laing & Buisson (Laing 2005) estimate that price differentials add between 20 and 25 per cent to the costs of care in London. Also, inner London boroughs spend more cash per person because of the high number of low-income service users, who are less able to pay charges. After allowing for both cost and income factors, it is not clear whether London councils spend appreciably more on the social care of older people than local authorities elsewhere in England. We examine patterns of expenditure on care services within and across London in more detail in Section 8 (*see* pp 89–99).

While most care market analysts credit local authorities with achieving value for money when purchasing services from private- and voluntary-sector care providers (Netten *et al* 2005), others question whether the money spent on care services is being spent efficiently. A recent review of public-sector efficiency carried out for the Treasury by Sir Peter Gershon indicated that goods and services could be procured more efficiently by reducing the procurement and transaction costs incurred through multiple contracts with the independent sector (Gershon 2004).

Local authorities in London began to look at the scope for achieving efficiencies during our Inquiry (Association of London Government 2004). In his 2005/06 budget, the Chancellor of the Exchequer required local authorities to make 2.5 per cent efficiency savings in social services. Social services directors have argued that the scope for such savings is limited. The individualised and local nature of social care leads to a large number of expensive individual contracts, while a move to cheaper block contracts would dilute the personal approach commissioners are trying to achieve. Collaborative contracting on a regional or sub-regional basis would be likely to favour large corporate providers to the detriment of small care businesses, who would be unable to meet the specifications of large-scale contracts. It remains to be seen how far London authorities can spend more efficiently and what impact such savings will have on the care services older people need and use. We look at the pressures and at progress and outcomes in more detail in Section 8 (*see* pp 89–99).

It is clear that London – or, more accurately, inner London – has a comparatively high level of expenditure on care services. It is another question whether there are sufficient resources in the social care system to ensure that every older Londoner who needs care and who cannot afford to buy it themselves receives the help they need. Large numbers of older Londoners fail to meet the eligibility criteria for public support and have to rely on their own resources to obtain care and support. In recent years, many different bodies have maintained that, nationally, social care is underfunded (Social Policy Ageing Information Network 2001; Rankin 2004; Henwood 2001). In Section 8 (*see* pp 89–99), we consider the funding pressures being experienced by London local authorities and their NHS partners, and we assess the evidence about the adequacy of resources.

Government and administration

Thirty-three local authorities in the capital are responsible for assessing the care needs of older people and arranging services for those who need care and support. Borough boundaries are the same as those of primary care trusts (PCTs), which should aid joint working and integrated commissioning. However, care markets extend into neighbouring boroughs and beyond into the counties around London. This means that the different authorities purchasing care services compete with each other for services. Outer London authorities can find themselves unable to match the care home fees that inner London authorities are willing to pay. Similarly, county councils such as Essex and Kent compete for local care home places with both inner and outer London authorities.

Care service providers operating across all or some of London's boroughs have to negotiate separate contracts with all the councils trying to buy their services. This can make life difficult – negotiating and dealing with the very different contracting requirements set by different councils takes a substantial amount of time. Both care providers and commissioners pay the price of high transaction costs, which, as mentioned above, are currently being questioned. We look briefly at the efforts being made to achieve greater efficiency in care service commissioning in Section 8 (*see* pp 89–99).

Earlier in this report, we mentioned the difficulties in planning future care services caused by the unpredictability of illness and disability among older people and their migration within and out of the London area around retirement. Health and migration patterns affecting the demand for care services make it all the more important for local authorities to share intelligence about the needs of their local populations. This suggests the need for a London-wide mechanism for planning care services across London boroughs. Although the GLA has some pan-London planning responsibilities, they do not extend to health care or social care services. This means that planning on a regional or sub-regional basis, and also the commissioning of specialist care services serving small populations across London, depends upon collaboration between many different councils and PCTs. Until now there has been little collaboration of this sort. This is partly because of the tensions between politically independent local councils that want to respond to the care needs of their local community in their own way and do not wish to make the compromises required to reach regional or sub-regional agreements. We look at how local councils are working together in Section 6 (*see* pp 69–76).

Key points

Living and working in London is similar to life in any big city or metropolitan area but distinctive features of the London economy and of London government create special challenges for the care and support of older people.

- **Migration patterns** London attracts young people from all over the UK and from abroad, who want to take advantage of employment and education opportunities in the capital. However, after the age of 30, more people move out of London than go to live there. Migration in and out of London affects the recruitment and turnover of care workers, and can have an adverse impact on the continuity of care for older people.

- **Social problems** London has high rates of mental illness, large numbers of deprived families and children in need, and high rates of crime – especially in

inner city areas. These social problems place heavy demands on local authority social services. Budgets for older people's services can come under pressure, with higher priority being given to services for other groups.

- **High land and property values** Care home fees in London are higher than the average for England – reflecting in part high costs of land and property. There is therefore an incentive for individuals and local authorities to buy cheaper places in care homes in other parts of the country. High land values also restrict investment in care homes and in extra care housing.

- **Labour market** London experiences labour shortages in many fields, including public services such as health, education and social care. Employers find themselves competing for staff from the same restricted pools of labour. It can also be difficult to recruit care workers when opportunities in the retail and leisure sectors can seem more attractive. The London care workforce benefits from staff coming from overseas, but language barriers mean that some of these staff need extra support to acquire the relevant qualifications because of language barriers. Many care workers, both British and foreign nationals, experience racial prejudice and abuse from a minority of clients who hold racist views. Employers have to protect staff and tackle unacceptable behaviour among service users.

- **Public expenditure on care services** London local authorities spend more on social care for older people than the average for England but prices are higher in London and inner London authorities have to spend more cash per head to make up for the high numbers of low-income service users, who are less able to pay service charges. Although a comparatively high level of resource is devoted to care services, funding pressures lead local authorities to concentrate those resources only on older people with high levels of need – leaving others with more modest needs to rely on their own resources to obtain the help they require. Questions arise as to whether current resources could be spent more efficiently and whether there are sufficient resources in the care system to ensure that *all* those needing care and support receive it.

- **Government and administration** There are 33 local authorities in London, all but one of which are co-terminous with PCT boundaries. As care markets are not confined within borough boundaries, authorities often compete with each other to buy services for their local populations. Authorities in outer London and the surrounding counties are disadvantaged, being unable to match the fees inner London authorities are willing to pay. Care providers spend a lot of time negotiating contracts with all these different authorities. At the moment, there is little collaboration between the boroughs on planning or procuring care services for older people.

Part two
Strengths and weaknesses of London's care services

In Part 2, we draw on evidence given to the Inquiry to present our findings about the strengths and weaknesses of the care system in London. Individual chapters discuss access to care; the care options available to older people; how social care, health and housing organisations are working together to integrate care and support; workforce capacity; and finances.

Introduction

In this part of the report, we examine how far the care system in London is delivering what older people and their carers require. We conclude that care services in the capital serve some older people and their carers well. However, the care system has major shortcomings and fails to meet the needs of many older people who need care and support.

In forming our judgement we have drawn on evidence submitted in writing to the Inquiry, on oral evidence given at Committee hearings and on research studies specially commissioned for the Inquiry. We have organised the evidence according to key issues that are known to matter a great deal to older people and their carers, drawing on a literature review conducted for the Inquiry (Levenson and Joule 2005). These issues include:

- being easily able to find and obtain the assistance they require
- having a choice of appropriate local services, with different options as to what is provided, where, by whom and when
- using local care services that they value; where they are able to determine what service is given, when and by whom and where services offered make them feel safe and secure, treat them with respect and are responsive to their individual needs and circumstances
- being treated as a whole person with a range of needs, with services organised and co-ordinated in ways that address their situation as a whole
- being able to afford the care and support they need
- being treated fairly, having the same opportunities for care and support whatever their age, sex, disability or medical condition, ethnicity, religion or sexual preference and regardless of where they live or their personal income and assets.

Bearing in mind these key requirements of older people and their carers, we assess care services in London, looking in particular at:

- access to care, including information, advice and brokerage, and access to financial support
- care options, including the range, volume and quality of services and the choices available for disadvantaged groups
- the integration of health, housing and social care services, including strategic commissioning, the provision of new integrated services and collaboration across boroughs
- workforce capacity, including characteristics of care staff, training and qualifications, recruitment and retention, and the performance of managers in care organisations and commissioners
- finances, including public and private expenditure, funding pressures and views about the funding of long-term care.

4 Access to care

Information and advice

The older people and carers who gave evidence to our Inquiry reported very mixed experiences of trying to find the help they needed. In some cases, they spoke warmly about the information and advice they had received from GPs, social workers, district nurses and the 'hospital' or 'health centre'. They also mentioned help from voluntary organisations that run advice services, such as Age Concern, the Alzheimer's Society, Contact a Family, Counsel and Care and the Elderly Accommodation Counsel. Others mentioned friends and family as important sources of information. Some carers praised the information and support their local carers' centre or carer support worker had provided.

In other cases, the experience was a struggle. There were accounts of council staff not answering the telephone; of staff being difficult to understand or being rude and unhelpful; of being passed to four or five people before reaching the 'right person'; of having to wait a long time before any help was forthcoming. Carers who had looked for a care home for their relative complained about the lack of help from social services and claimed that the local authority 'simply is not interested [in helping] self-funders'.

Voluntary organisations working with older people strongly endorsed these comments. They reported that the chances of an older person getting the right help depend entirely on whom they approached first: it feels like a lottery – you hit the jackpot if you approach a health or social care professional who knows about local services or can refer you on to someone in the care system who can help. Even so, older people wanting information about support services not offered by the local authority, such as help with housework or gardening, do not usually know where to go and are unclear about the reliability of the people offering such services.

Older people from black and minority ethnic communities reported particular difficulties in seeking help. Many older people who cannot speak English find themselves relying on their family or on community workers and specialist advice workers to intervene on their behalf. However, acting as advocates and translators for their parents is a strain for some family members; it was stressed that even the most articulate relatives can find dealing with officialdom taxing. Equally, community workers and community centres are not available everywhere, and even the best can find it difficult to respond with any urgency.

Several recent studies involving older Londoners have revealed similar evidence of inadequate information and independent advice about the availability of care services, supported housing options and financial help, and have shown that the lack of this information prevents older people making informed choices (Levenson and Joule 2005). In one such study undertaken in Camden, 25 per cent of older people in residential care said that they had not received any information to help them with their choice of care home (Dalley and Hadley 2000).

There is little scope for private sector organisations to fill the gaps in the information and advice older people and their carers require. All the signs are that older people are neither able nor willing to pay for information and advice

Access to the right information at the right time is a long-standing problem affecting older people with care needs. Some London local authorities have tried to improve the situation by creating integrated resource centres offering information and advice alongside other services such as day care. Many local authorities also fund community centres and information/advice services run by voluntary organisations. Older people and their families often find these helpful, but the concept of a 'one-stop shop' providing advice and support has proved impossible to put into practice. This is particularly frustrating at a time of crisis when quick decisions about care options have to be made. Furthermore, voluntary organisations – especially those working with black and minority ethnic communities – complain that short-term funding restricts the development, scope and continuity of the information, advice and advocacy services they wish to offer.

There is little scope for private sector organisations to fill the gaps in the information and advice older people and their carers require. All the signs are that older people are neither able nor willing to pay for information and advice. This was brought home to us when we heard about the business developed by an organisation called 'bettercaring'. This company compiles real-time information about care homes – their facilities, prices and vacancies – and publishes it online as a subscription service for social service authorities, who can access it when they need to find a care home place for a client. In theory, this service could be made available directly to older people and their families. However, bettercaring indicated that this would not be commercially viable. This means that the public sector must continue to hold responsibility for providing information, advice and advocacy or for funding independent organisations to carry out these functions.

We know that the government is aware of the need to improve information and advice for older people. The Link-Age initiative launched in December 2004 aims to ensure that, when multidisciplinary teams assess an older person's needs, they will also provide information and advice on such things as services and sources of funding from welfare benefits (Department for Work and Pensions 2004). It is too early to say what impact this new initiative is having.

Accessing financial support

Older people requiring a care service and needing public money to finance that care in part or in full have to be assessed by their local authority. Since the Carers (Recognition and Services) Act 1995, carers too have been entitled to have their own needs assessed.

Voluntary organisations working with older people reported long waits for an assessment in some parts of London and much faster responses elsewhere in the capital. The Commission for Social Care Inspection confirmed these variations (Sa'id *el al* 2004). While London as a whole is comparatively slow at starting assessments – only just over half of all assessments were begun within 48 hours of the person first contacting social services – inner London authorities perform consistently better than those in outer London. When it comes to completing assessments within four weeks, delivering services and conducting reviews, London's overall performance is in line with national averages and is deemed to be 'moderately good'. Again, inner London performs better than outer London.

Voluntary organisations working with carers who gave evidence to the Inquiry acknowledge that more London carers receive an assessment now than five years

ago. That said, the Commission for Social Care Inspection reports that London as a whole undertakes fewer carers' assessments than other regions. This is worrying given that carers play such a vital role in supporting older people at home (Commission for Social Care Inspection 2004a).

During an assessment, local authority staff consider whether an individual's needs are sufficient to warrant public expenditure on various care services. In line with guidance from the Department of Health, local authorities set eligibility criteria that describe the seriousness of risk to independence and other consequences if needs are not addressed (Department of Health 2003a). There are four bands of risk: critical, substantial, moderate and low needs. Risks can include:

- threat to life
- the development of significant health problems
- little or no choice or control over the immediate environment
- serious abuse or neglect
- inability to carry out personal care or domestic routines
- inability to sustain involvement in work or education/training
- the loss or breakdown of social support systems or relationships
- inability to undertake family or other social roles.

People assessed as having 'critical needs' score on most of these criteria. People with 'moderate needs' might just have difficulties with some personal care or domestic routines, with some aspects of social support and relationships, and with undertaking several family or other social roles.

Users, commissioners and service providers participating in a study of commissioning in six London boroughs were concerned about the way eligibility criteria were being applied, suspecting that substantial numbers of older people with considerable needs were being excluded from public support (Banks 2005). In three of the six boroughs (Hillingdon, Lewisham and Newham), councils had a policy of restricting public support to people assessed as having critical or substantial needs.

Across London, 27 out of 33 local authorities have information on their websites about their policies for eligibility for adult social care. The majority (18 out of 27) only meet the needs of people assessed as falling into the top two categories of need. Six of these are in inner London, 12 in outer London. Of the nine local authorities committed to addressing needs in the top three categories, four are in inner London, five in outer London.

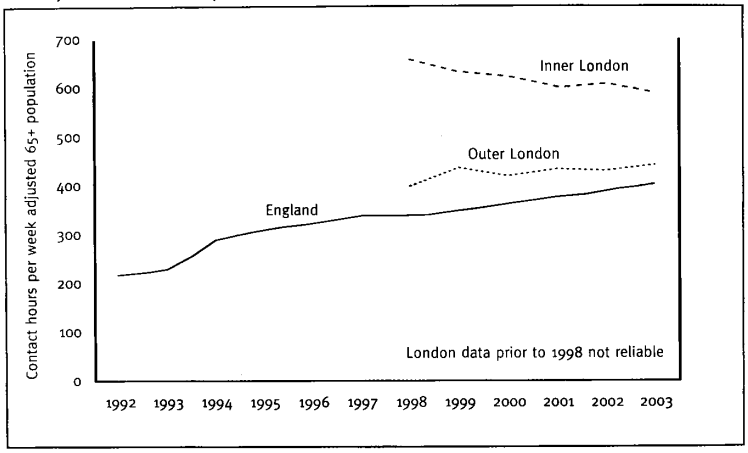
This website information may have been out of date when we found it in January 2005, and policies may have changed since then. However, it does confirm that across much of the capital public support is restricted to Londoners assessed as having the highest categories of need. As one older person participating in the Inquiry put it: 'You have to be in a pretty bad way to get any help from social services these days.'

Trends in the amount of home care provided for older Londoners demonstrate that eligibility criteria are being tightened. Data for home care shows that, while the number of hours of home care commissioned in London has remained relatively static since the mid-1990s, the numbers of households receiving home care services has dropped dramatically (*see* Figures 5 and 6 overleaf). Councils explain that financial pressures have caused this tightening – they have no alternative but to

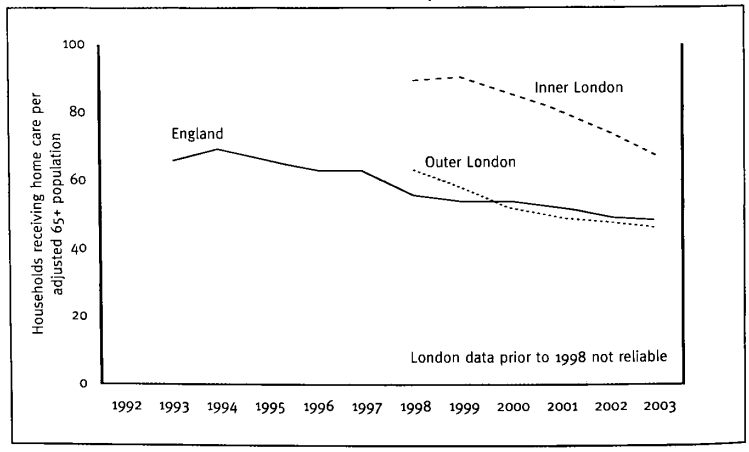
Both policy and practice result in large numbers of Londoners being prevented from obtaining any public support and having to pay for it out of their own pockets

concentrate resources on the fewer people with the highest needs. Whatever the reason, both policy and practice result in large numbers of Londoners – some of whom need help because they can no longer carry out one or more of the tasks of daily living or because their informal care is under strain – being prevented from obtaining any public support and having to seek help themselves and pay for it out of their own pockets.

5 WEEKLY TOTALS OF HOURS OF HOME CARE COMMISSIONED BY LOCAL AUTHORITIES PER 1,000 OLDER PEOPLE (WEIGHTED POPULATION)



6 NUMBER OF HOUSEHOLDS RECEIVING HOME CARE SERVICES EACH WEEK COMMISSIONED BY LOCAL AUTHORITIES PER 1.000 OLDER PEOPLE (WEIGHTED POPULATION)



Source: Laing 2005, data from Department of Health HH1 returns

There is also evidence that the dependency levels of people in care homes have been rising (Darton *et al* 2003). This is perhaps less controversial than the trend in home care, as most people would agree that it is inappropriate to provide residential care for older people with low to moderate care needs.

Key points

Information and advice

- Some older people and carers have expressed warm appreciation of staff in social services, the NHS and in voluntary organisations who have provided them with information and advice that has helped them make decisions about their care.

- More commonly, the search for information and advice about available care services and supported housing is experienced as a struggle, where the chances of getting the right help at the right time vary according to where people live and whom they approach first for help. It is also often difficult for older people and carers to find someone who can help them steer their way through the complex care system and secure the services they need. This is a particular problem for people funding their own care who complain that they receive little or no help of this kind from social services.

- Black and minority ethnic older people report particular difficulties, and those who cannot speak English have to rely on their families or on community workers to intervene on their behalf.

- There is a serious lack of financial information and advice – an important consideration given that many older people using care services have to pay for them in part or in full.

Accessing financial support

- Older people and carers in some parts of London have long waits for an assessment that will determine their entitlement to public support. Many older people with low to moderate needs for support are being denied help, as their local council's eligibility criteria give priority only to people with substantial needs for assistance with personal care and other basic activities of daily living.

5 Care options

Home care services and care homes have traditionally dominated care services. Other services, such as day care, meals on wheels, equipment and housing adaptations, have always been less important in terms of total expenditure. This is as true for London as it is for England as a whole. However, the historic development of residential and home care services in London and in England has differed markedly – in the capital the care home market is underdeveloped because of the high cost of land and property. This means that Londoners have a different choice of care options. For this reason, new care services, such as extra care housing and housing-based dementia care, that elsewhere are starting to offer an alternative to traditional residential care, are lagging behind in London and are only just beginning to extend choice for older Londoners.

Home care services

Most older people with care needs prefer to stay living in their own homes. Older Londoners have a better chance of receiving help at home than elsewhere. This applies particularly to those living in inner London. As Table 3 below shows, inner London boroughs commissioned 46 per cent more home care contact hours per person (weighted population) for 44 per cent more clients in 2003 than English councils as a whole. Outer London differed little from the metropolitan boroughs or from England as a whole in terms of the numbers of home care clients. However, outer London local authorities commissioned proportionally more home care contact hours than the average for England.

More older Londoners supported by their local authority receive home care services from independent-sector agencies than from their council's in-house home care service. In outer London 79 per cent of contact hours were outsourced to the independent sector, compared with 74 per cent in inner London and only 66 per cent in England as a whole (*see* Table 3).

TABLE 3: HOME CARE COMMISSIONED BY LOCAL AUTHORITIES PER 1,000 PEOPLE AGED 65 AND OVER (WEIGHTED POPULATION), SEPTEMBER 2003

	Inner London	Outer London	Greater London	Metropolitan boroughs	England
Number of clients	69	47	56	51	48
Number of contact hours per week	586	433	493	437	401
	Percentage of contact hours outsourced to independent sector				
	74	79	76	N/A	66

Source: Laing 2005, data from HH1 returns to the Department of Health

Since the early 1990s, local authorities throughout the country have been expanding home care services by commissioning more contact hours. At the same time, however, they have been reducing the number of people who receive these services and prioritising those with the highest needs. In their use of home care services, inner London boroughs have been leading the way for others to follow.

However, the gap is closing, as Figures 5 and 6 (*see* p 42) in Section 4 show, with councils across England overtaking outer London. Inner London is also losing ground, though it still remains well ahead in both clients and contact hours.

As we indicated in Section 4 (*see* pp 39–43), both in London and elsewhere, publicly supported home care is more likely to be available for people with critical and substantial care needs. Home care services are not provided to any great extent for older people who are becoming frailer and needing help with daily living tasks such as housework, shopping and gardening.

New types of care at home

Homesharing and adult placement schemes are two new models of home care that have emerged in recent years. Both are still in their infancy and occupy a very small share of the market.

Homesharing offers an alternative to older people who want to stay in their own home but who need practical support. Older people open up their home to young people aged 23 and over, who are very often students or young single workers needing accommodation. In return for rent-free accommodation, they provide companionship and practical support (usually help with domestic tasks rather than personal care). This option is likely to appeal to only a relatively small number of older people and, even then, only those who do not require intensive care and support. The government is supporting homesharing through grants designed to extend choice to older people. So far there are only 700 homeshare arrangements in England, of which about 100 are in London (Homeshare website).

Adult placement schemes offer opportunities for older people and other people in need to live in someone else's home or to spend the day there, receiving care and support as required. Ordinary people offering their homes and their time in this way become approved adult placement carers. In this respect, adult placement is rather similar to fostering. The number of older Londoners using these schemes is not known. However, it is very low in comparison with conventional home care or residential care. For example, in 2004, only 1,765 people (of all ages) were supported by their council to live in 'unstaffed registered care homes' in London, a category of care service that includes adult placements (Department of Health and Office for National Statistics 2004).

Care homes

Numbers of places

Older Londoners wanting a place in a local care home are less likely to secure one than older people living elsewhere. In 2004, the supply of care home places in London was one-third below that for England as a whole: at 31.9 places per 1,000 older people (weighted population) compared with 47.7 per 1,000 in England. The supply in inner London is smaller still: 20.9 places per 1,000 older people, less than half that for England. In outer London, there were 38.9 places per 1,000 older people (weighted population). These figures reflect the high cost of land in London, which pushes up the cost of care home places.

There is a noticeable 'commissioning drift' away from the most expensive areas of London. Inner London councils commission care home places in outer London and

the surrounding counties, where places are cheaper; outer London councils also purchase places outside London. Even so, as Table 4 shows, London councils make less use of care homes for their residents compared with the metropolitan councils and with councils across England as a whole. In London, local authorities support 23 care home residents aged 65 or over per 1,000 older people (weighted population); the equivalent figures are 28 per 1,000 in metropolitan council areas and 27 per 1,000 in England as a whole.

TABLE 4: CARE HOME RESIDENTS AGED 65 OR OVER PER 1,000 OF THE POPULATION (WEIGHTED POPULATION), MARCH 2004

	Inner London	Outer London	Greater London	Metropolitan boroughs	England
Nursing care	9	8	9	9	9
Residential care	14	14	14	19	19
Nursing and residential care	24	22	23	28	27

Source: Laing 2005, data from Department of Health, *Community Care Statistics: Supported residents (adults)*

These figures relating to the overall supply of care home places mask differences between residential care homes and nursing homes. London local authorities support the same proportion of people in nursing homes as councils across England. However, there is a marked difference in the use of residential care homes. London local authorities support a quarter fewer residents in these homes than the average for England. This statistic appears to confirm the view that London has successfully substituted intensive home care services for residential care for people who are not so dependent that they need nursing care. In fact, this substitution effect can be true only of inner London as the volume of home care commissioned by local authorities does not differ substantially from England as a whole (*see* above).

Out-of-borough placements

London councils also place a much higher proportion of the residents they support in care homes outside their borough boundaries. London authorities place 38 per cent of their residents in homes outside their boundaries, compared with 14 per cent in England as a whole. The contrast between inner and outer London is striking. In inner London nearly half (49 per cent) of all supported care home residents live in homes beyond their borough boundaries, compared with 31 per cent in outer London (*see* Table 5).

TABLE 5: CARE HOME RESIDENTS PLACED IN HOMES OUTSIDE THEIR LOCAL AUTHORITY'S BOUNDARIES

	Inner London	Outer London	Greater London	Metropolitan boroughs	England
	Elderly and physically/sensorily disabled residents of residential and nursing homes placed outside local authority boundaries as a percentage of all placements of that client group				
1994 residential	26	19	22	6	7
1994 nursing	68	48	57	19	14
1994 residential + nursing	33	23	27	9	9
	All residents placed outside local authority boundaries (other than those with mental health problems and learning disabilities) as a percentage of all placements of people aged 65+				
2004	49	31	38	14	14

Source: Laing 2005, data from Department of Health *Community Care Statistics: Supported residents (adults)*

The pattern of out-of-borough placements was the focus of some concern and controversy during our Inquiry. Several witnesses, including people working for voluntary organisations and managing independent-sector care businesses, criticised the 'export policies' of local authorities. They argued that most older people do not want to be – and should not be – moved away from their community at a time when they are ill and vulnerable.

There is evidence to suggest that large numbers of self-payers move into care homes outside their borough and outside London altogether

It was difficult to find out what was happening and why. Local authority commissioning managers explained that some out-of-borough placements reflect older people's desire to move to a care home nearer to relatives living elsewhere in London or outside the capital. Managers in Redbridge and Waltham Forest, for instance, reported that 'a large number of people' request placements in Essex because their families have moved there in order to take advantage of cheaper housing. In these cases, out-of-borough placements could be said to bring families closer together rather than disrupting family ties.

Commissioning managers also suggested that some placements are in homes in neighbouring boroughs, and that, because London boroughs cover such a small area, these placements can in fact be considered to be 'local'. For instance, Westminster has block contracts with nursing homes in Lambeth and Wandsworth, boroughs that lie immediately south of Westminster across the Thames. Westminster's contracts manager explained that service users who go to these south London homes tend to come from the south of Westminster and 'have more affinity' with south London than with the north of Westminster, 'where the borough's own PFI home is situated'. A similar story was told for outer London. In Sutton, over half of the out-of-borough placements are in adjoining authorities such as Kingston-upon-Thames, Merton and Surrey.

However, these moves within London boroughs and the adjoining counties do not tell the whole story. Witnesses to the Inquiry explained that the drift from inner to outer London and to the counties beyond is caused by the availability of cheaper care home places. Indeed, some witnesses from outer London complained that places in their area have been taken up by people from inner London, thus 'displacing' their own residents. In addition, some local authorities, aware that they have insufficient care home places for their residents, have been building new care homes (often funded by the Private Finance Initiative).

We do not know how many older Londoners who pay for their own care live in care homes outside the borough where they used to live. This is because statistics on care home residents do not reveal where they were living previously. However, there is evidence to suggest that large numbers of self-payers do move into care homes outside their borough and outside London altogether. First, we know that most care home places in London are occupied by publicly funded clients. As Table 6 opposite shows, private payers make up a smaller proportion of residents than they do in other parts of England. The very low self-pay proportion of 20 per cent in inner London is understandable in view of the low level of home ownership in inner London boroughs (*see* page 49). Because they do not have a home to sell, most older inner Londoners qualify for means-tested local authority support. Outer London's estimated self-pay rate of 30 per cent (just under the England average of 32 per cent) is more surprising. High rates of owner occupation (*see* Figure 4, p 16) and high property prices in outer London would suggest that self-pay rates in outer London ought to be well above the average for England, as they are in other affluent areas of the south-east such as Berkshire, north Hampshire, south Oxfordshire and Surrey, where self-pay rates rise to 50 per cent or even higher. The likely explanation is that self-payers living in inner London move to care homes in outer London and beyond, and that many outer London self-payers choose to enter care homes outside London in order to take advantage of the lower prices they charge.

TABLE 6: SELF-PAYERS AS PROPORTION OF RESIDENTS OF INDEPENDENT-SECTOR CARE HOMES, 2002

	Inner London	Outer London	Greater London	England
All independent-sector care homes	20	30	27	32

Source: Estimated from *December 2002 Census of Residents of Care Homes Receiving Nursing Care in England*, Department of Health. Figures include residents in residential care homes and in nursing homes.

Without studying people living in care homes in greater depth, it is impossible to know which factors influence their decision to move into a care home some way away from where they were living. We also do not know about the social and emotional consequences of such a move. However, the worry remains that the relatively high cost of care in the capital may be denying many older people in London the choice of entering a care home close to family, friends and familiar surroundings.

Extra care housing

During our Inquiry, the Department of Health was promoting extra care housing as an important extension of choice for older people in need of care and support. Dr Stephen Ladyman, at that time Minister for Community, enthusiastically supported the development of more extra care housing. He said: 'A residential home is not the inevitable direction of travel as we get old. ... Extra Care can offer a very real alternative' (Ladyman 2004). The government's Extra Care Housing Fund is making £87 million available between 2004 and 2006 to enable local authorities to develop more extra care provision. Several London authorities submitted successful bids, including Ealing, Enfield and Havering. In 2004 the government announced that a further £60 million would be made available for extra care housing between 2006 and 2008.

Extra care housing is a distinct form of supported housing. Residents have tenancy rights to an apartment or bungalow; can use dedicated care services, usually available 24 hours per day, that form an integral part of the development; can have meals in an on-site restaurant; and can join in a range of social and recreational facilities and programmes. Provision for residents is thus more sophisticated than in ordinary sheltered housing, which generally has just a communal lounge and a part-time scheme manager.

The extra care sector in England as a whole is still very small, with just over 34,000 units for rent or sale. (By way of contrast, 440,000 people live in residential or nursing care homes, and 700,000 people receive home care.) The supply of extra care accommodation in London (978 units in all) is low compared with England (just over 34,000 units). As Table 7 overleaf shows, the shortage applies equally to the social rented sector, where units are developed and operated by housing associations in collaboration with local authorities, and to the private sector, where most units are sold leasehold, with the remainder rented at market rates. The lowest rates of both types of provision are in inner London. Here there are only 23.7 social rented extra care units per 1,000 older people (weighted population), just under 70 per cent of the average for England; and private provision is less than a quarter of availability in England as a whole.

One reason why extra care provision is particularly low in inner London is the lack of suitable sites for development. Some of the extra care housing elsewhere has been built on the sites of redundant local authority care homes, but these are in relatively short supply in London. Some London authorities have created new extra care units

TABLE 7: SUPPLY OF EXTRA CARE HOUSING PER 1,000 PEOPLE AGED 65 AND OVER (WEIGHTED POPULATION), 2004

	Inner London	Outer London	Greater London	England
Extra care units	Extra care units of accommodation			
For rent by local authority or registered social landlord	896	1,902	2,798	26,600 est
Leasehold or private rent	82	402	484	7,600 est
	Extra care units per 1,000 people aged 65 and over (weighted population)			
For rent by local authority or registered social landlord	23.7	32.3	28.9	34.3
Leasehold or private rent	2.2	6.8	5.0	9.8

Source: Laing 2005, data from Elderly Accommodation Council database of sheltered and retirement housing, as at December 2004

by converting care homes, while others have remodelled sheltered housing. Some new units have also been built.

Three of the six boroughs that took part in our study of commissioning were either in the process of remodelling sheltered housing or were considering doing so; one was also converting a block of high-rise flats (Banks 2005). It is not clear whether these developments include all the services and facilities that conform to the criteria set out in guidance for commissioners (Appleton and Porteus 2003). Some may in fact be 'enhanced sheltered housing', a category of housing between extra care and sheltered (Molyneux and Leather 2005).

The scope for conversions of this kind varies across the capital, reflecting the uneven distribution of sheltered housing. In outer London in 2004 there were almost 30,000 rented sheltered housing units; the numbers of units available in individual boroughs varied widely from a low of 808 units in Merton to a high of 2,721 in Bexley. In inner London, there were just over 23,000 units, with a low of 920 in Islington and a high of over 3,000 in Lewisham. There were far fewer sheltered housing units available for leasehold sale. In outer London, these amounted to just over 9,000 units, with a low of 106 in Barking and Dagenham and a high of 1,075 in Bromley. In inner London, there were only 558 leasehold units in total, with a low of 47 in Camden and a high of 148 in Lewisham (data from Elderly Accommodation Counsel in Molyneux and Leather 2005).

A number of factors crowd specialised housing for older groups out of the priorities of private developers and local authority planning departments. These include the low level of home ownership among older people in inner London; the high cost of land throughout London; and the high demand for ordinary housing.

All this means that, while extra care housing is an option for some older Londoners, as yet relatively few people can take advantage of it. The opportunities for home owners who would like to sell up and buy a more suitable home with care and support on tap in London are especially restricted.

Other forms of supported housing

Housing-based dementia care

Supported housing has not generally been considered suitable for older people with dementia. Traditionally, spouses have been relied on to care for a partner with dementia in their own home, with or without home or day care to relieve them of some of their caring responsibilities. When these arrangements break down, the person with dementia is almost always transferred to a care home.

No retirement villages have yet been built in London. So older Londoners wishing to live in a care village need to look outside the capital

New models of housing-based provision have begun to emerge in which the carer and the person they are caring for continue to live together. This can be in either a bungalow or a flat within a supported housing development, or in a small group living scheme. Schemes that seek to maximise independent living for people with dementia within extra care housing offer special design features (for example, special wings, safe spaces to wander in) and assistive technology and motion detectors. The number of these units is not known, but, as with extra care housing in general, this form of housing is still embryonic.

At the moment, older people in advanced stages of dementia are unlikely to be able to choose this option. Extra care housing is considered to be more suitable for people in the early stages, since they are more likely to be accepted by other residents. Good practice suggests that it is better for the older person themselves to adapt to new surroundings and develop new relationships – this way they are more likely to be able to live there, with support, for life (Molyneux and Leather 2005).

EXTRA CARE HOUSING FOR OLDER PEOPLE WITH DEMENTIA, WESTMINSTER

The City of Westminster redeveloped the site of a former residential care home in partnership with Notting Hill Housing Group to provide a housing with extra care scheme. People with dementia are included throughout the service. The scheme, which opened in November 2004, provides 41 one-bedroom flats, 2 two-bedroom flats, and 2 four-bedroom flats for people in the moderate to later stages of dementia. The development includes some assistive technology, such as rising lights in bathrooms and bedside passive infra-red alerts, which can be used to support people living in their own home. Facilities for tenants include an optional restaurant service and other shared spaces, some of which are also used by local community groups. The care service provides 24-hour support based on the site and has close links with other local health and social care services.

Retirement villages

A number of retirement villages – sometimes also known as care villages – have grown up across the country in recent years; most offer extra care services on site. Retirement villages typically consist of a mixture of ordinary and sheltered housing, including bungalows and apartments, clustered around a central complex of communal amenities, including a café or restaurant, rooms for leisure activities, a library and a shop. Various types of care are also available, including extra care services and residential care accommodation. Hartrigg Oaks in Yorkshire, owned by the Joseph Rowntree Housing Trust, is a famous example.

There are no retirement villages in London because it would be difficult to acquire a large enough site and land values are too high. It has been argued that 'virtual villages' could be developed in the capital: a series of small joint-venture housing schemes across a designated geographical area that would offer both specialist and ordinary housing. The grouping of small schemes would provide the economies of scale needed to support adequate care staffing. A wide range of leisure and other facilities would be available for use by residents of the schemes and by people from the wider neighbourhood (Molyneux and Leather 2005). It is not clear whether 'virtual villages' would be as popular with older people as provincial retirement villages appear to be. In any event, no retirement villages have yet been built in London. So older Londoners wishing to live in a care village need to look outside the capital.

By and large, day services are located in day centres catering for older people with high levels of care needs

Day services

We collected very little evidence about day services during our Inquiry. This was largely because we decided to concentrate on the larger home care and residential care markets; the questions we asked when we called for evidence reflected these priorities.

Most day services in London, as elsewhere, are run by local authorities or by voluntary organisations and community groups; many of these receive grants or other funds from the local authority to carry out their work. By and large, day services are located in day centres catering for older people with high levels of care needs. The day care can be a key component of care packages consisting of home care, respite care, night sitting services and so forth; all these combine to enable older people with high care needs to remain living at home and provide relief for carers.

Until relatively recently, many lunch clubs were run across London; these provided a hot meal and company and activities across the middle of the day. Voluntary organisations presenting evidence to the Inquiry reported that many lunch clubs have either closed recently or are threatened with closure, generally because local authorities have withdrawn their funding in order to concentrate scarce resources on those most in need.

Older people and carers participating in the Inquiry spoke highly of the day services they or their relatives use. These services are seen as providing company and interesting and enjoyable activities during the day. Some older people reported that they felt 'stimulated' or 'more lively' on the days they went to the day centre. One 66-year-old man said: 'At the Asian Day Centre, I can communicate in my own language and I feel well looked after.' A 73-year-old woman, undergoing regular haemo-dialysis, who also supported her husband with dementia, said about his day centre: 'They are also supportive of me, and I feel he gets good care and stimulation there. I can't speak too highly of them.' An 84-year-old woman said: 'I especially welcome the company I have from attending the day centre. I feel much better and more lively on the days I have attended.'

There were three main criticisms of day centres. First, there are not enough day services for some black and minority ethnic groups, particularly Muslim elders; often there is only one centre in a particular area for Asian elders. Second, older people in general have little choice about which day centre they attend; people are often just placed there by a local authority care manager, who does not indicate that there might be a choice. The third criticism was of the limited range of activities day centres offer. One man said: 'I would like to learn to use computers and to learn English but that is not possible here.' Other comments concerned the poor standard of food served and the small number of outings.

In contrast with recent developments in day services for younger people with learning difficulties, there is little evidence that innovative services for older people are being developed. The emphasis in services for younger people with learning difficulties is moving away from day centres, where social interaction and activities are confined within four walls. Efforts are being made to offer people with learning difficulties 'day opportunities' that enable them to pursue their interests in ordinary community facilities such as leisure centres, pubs and cafés or colleges of further or adult education (McIntosh and Whittaker 1998). Our impression is that

the thinking around day centres for older people lags behind day services for other groups, and that this might indicate ageist attitudes. Day centre managers are less ambitious about the activities provided on and off the site for older people than for younger people with learning disabilities. This may be because they have lower expectations about older people's quality of life. However, a more detailed study is needed to provide evidence for that impression.

Housing-related support

Equipment

A wide range of equipment is available to support people at home, ranging from mobility equipment to technology that helps people to feel safe in their own homes. Some of this is very simple (for example, a gadget for unscrewing jam jar lids). However, high-tech developments, such as 'smart houses' and robots, have also been progressing. Our Inquiry collected very little information about how far older Londoners use assistive technology; this reflects the fact that such technology is still at the early stages of development and practical application.

Care lines

Most of the information we have relates to community alarm services across the capital. These alarms are usually contained in pendants that older people wear; when they are in any kind of trouble they can contact an emergency service. Local authorities provide most of these 'care lines', although one or two have recently out-sourced their care line to a private-sector company. There are about 150,000 households in London that subscribe to a care line; the proportion of connections to private homes and group-living settings (for example, sheltered housing and care homes) varies widely between boroughs (London Boroughs Care Lines Group 2004). About two-thirds of 'dispersed connections' (in other words connections to individual homes) are to people living in rented social housing; the remaining third are to private renters or to owner occupiers. The preponderance of alarms in social housing is probably explained by the fact that some local authorities, until recently, supplied alarms only to council tenants.

Some local care lines services, such as the one in Merton, have been developing a package that includes pendant alarms, fall detectors, natural gas and carbon monoxide detectors, security locks, and even a handyman to carry out minor repairs and installations. These developments are clearly helpful to frail older people in London who are likely to be frightened of crime, at risk of accidents in the home and (for people with memory loss) liable to put themselves in danger by forgetting to turn off the gas.

Assistive technology

There is potential for greater use of more sophisticated assistive technology. This includes CCTV-type equipment that monitors movements within the home and raises the alarm when someone wanders into the street at night or fails to move at all, and tele-medicine technology that monitors changes in health conditions in people with heart and respiratory problems. However, all the evidence suggests that older people in London and elsewhere have very limited access to this assistive technology. Some commentators have suggested that this is largely because funding authorities are reluctant to commit the substantial resources required,

Although an increasing range of care options is available, most older people are faced with a rather restricted menu dominated by traditional forms of residential and home care

and because of the difficulties of bringing together the different funding streams in health, housing and social care (Metz and Underwood 2004). There is also some evidence that older people do not always find this kind of technology acceptable in a domestic setting.

Choice and control in practice

Although an increasing range of care options is available, most older people are faced with a rather restricted menu dominated by traditional forms of residential and home care. It is true that older people in inner London who prefer to have help at home rather than go into a care home have a greater chance of being able to choose that option; this is because their council is more likely to have commissioned proportionately more home care than local authorities elsewhere. However, as we have seen, older people with moderate to mild care needs find it harder to get the help they want when they are unable to meet local authority eligibility criteria. Those people who would prefer to use a care home or extra care housing relatively near where they are currently living also have a restricted choice, given the distribution of such services in the capital and the incidence of out-of-borough placements by local authorities.

Evidence presented to the Inquiry also suggests that older people have very little control over community services, in terms of the activities that are undertaken, the time of day they are carried out, and the people who provide the assistance. This is largely because local authority care managers prescribe quite tightly the tasks that are to be done, and leave little flexibility for care workers to vary their work according to the service user's preferences.

The government introduced Direct Payments in the belief that they strengthen older people's control over the care services they use. (Direct Payments are payments made by the local authority following a needs assessment to the individual concerned; they use the money to buy the help they want.) Evaluation of Direct Payments used by young disabled people indicates that they do hand real control to the individual. In England as a whole, only 1,899 older people received Direct Payments in 2003, out of a total 12,585 recipients, including younger people with physical disabilities, learning difficulties and so on. That suggests that the number in London is very low (Commission for Social Care Inspection 2004b).

Does London have enough care services?

Home care services

There is no evidence of insufficient capacity to meet the demand for home care services in London, whether these are paid for by local authorities or privately. London is well provided with registered home care agencies: there were 1,517 registered agencies on 31 March 2004, and a further 2,388 agencies were in the process of applying for registration (Sa'id *et al* 2004). (In 2003, home care agencies were for the first time required to register with the regulator; successful registration depended on their meeting national minimum standards introduced by the Care Standards Act 2000.) And, as we reported earlier, London local authorities fund proportionately more home care than elsewhere.

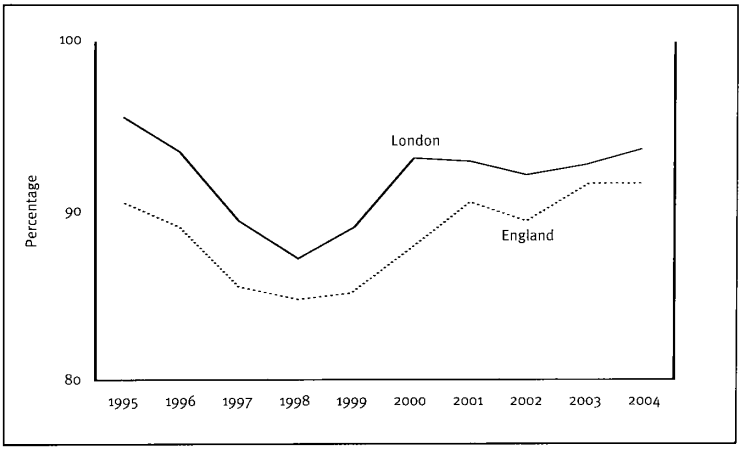
Demand, not supply, is the main problem with access to home care services in London. As we have seen, local authorities are unwilling to commission home care

for older people with less serious needs. And, as far as we can tell, older people on low or modest incomes who are not eligible for services are not always able to buy the help they need.

Care homes

There are insufficient care home places within London to meet demand. The widespread use of care homes outside London is evidence for this. Health and social services staff working in some areas of outer London report that it can be difficult to find places for older people leaving hospital who are unable to return home (Banks 2005). The shortage of places is revealed by the occupancy rates in London care homes, which are typically two to three percentage points higher than the average for England as a whole (*see* Figure 7).

7 OCCUPANCY RATES, CARE HOMES FOR OLDER PEOPLE IN LONDON, 1995–2004



Source: Laing 2005, data from Laing & Buisson database

To a limited extent, the current shortage of care home places can be attributed to the closure of care homes. London had a net loss of 3,200 care beds between 2000 and 2004, as Table 8 overleaf shows. Although some new homes did open during that time, the new registrations were insufficient to offset the closures.

The shrinking of care home capacity reflects a national trend. However, as Figures 8 and 9 overleaf show, care home capacity started to decline later in London than in England as a whole, in other words, after 2000 rather than after 1997; in addition the rate of decline has been rather slower in London. The so-called care home 'crisis' experienced in some parts of the south of England has therefore had less impact across London as a whole. This general picture nevertheless masks some dramatic changes in particular London boroughs. Camden, Islington, Kensington and Chelsea, and Tower Hamlets all lost more than half their care home capacity between 1991 and 2001 (Haynes *et al* 2005).

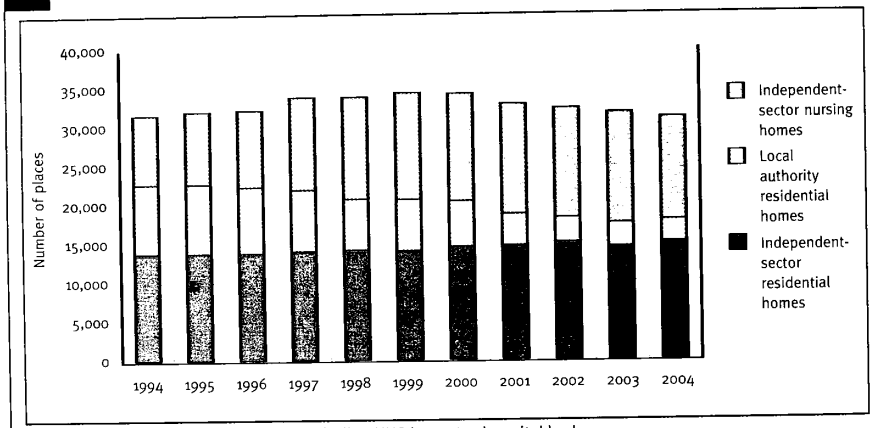
The closures in London between 2000 and 2004 involved disproportionately more small care homes. The result is that there are now fewer small care homes than in 2000. Because some of the new care homes that opened between 2000 and 2004 are large (that is 60 beds or more), the average home size in London is slightly

TABLE 8: CLOSURES, OPENINGS AND OTHER CHANGES TO CARE HOMES FOR OLDER AND PHYSICALLY DISABLED PEOPLE, 2000–04[1]

	Greater London	England	Greater London	England
Capacity at April 2000	1,059	14,335	34,369	420,743
Less closures	−171	−2,515	−4,336	−52,899
Plus openings	+46	+450	+2,024	+15,527
Other changes[2]	−17	−222	−886	−6,079
Capacity at April 2004	917	12,048	31,171	377,292

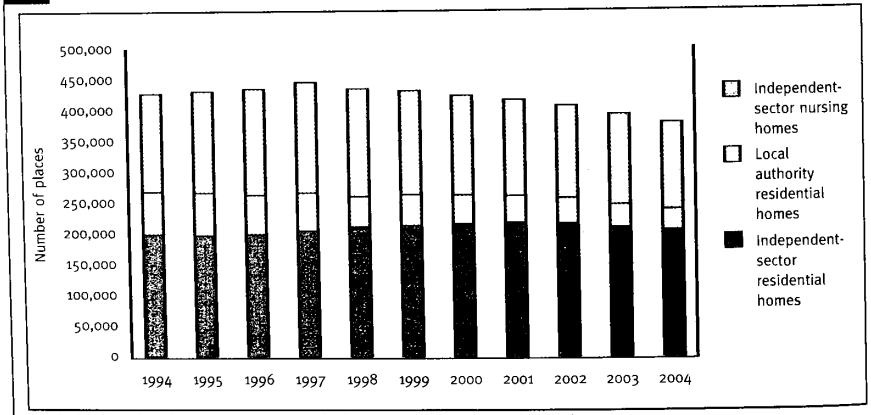
[1] including local authority homes but excluding NHS long-stay hospital beds
[2] (expansions, reductions, repositioning to other client groups or registration types, and so on)
Source: Laing 2005, data from Laing & Buisson database.

8 PLACES IN CARE HOMES FOR OLDER AND PHYSICALLY DISABLED PEOPLE, LONDON, 1994–2004[1]



[1] including local authority homes but excluding NHS long-stay hospital beds
Source: Laing 2005, data from Laing & Buisson. Care of Elderly People Market Survey, various years

9 PLACES IN CARE HOMES FOR OLDER AND PHYSICALLY DISABLED PEOPLE, ENGLAND, 1994–2004[1]



[1] including local authority homes but excluding NHS long-stay hospital beds
Source: Laing, 2005, data from Laing & Buisson. Care of Elderly People Market Survey, various years.

Commissioners, providers and older people and carers interviewed all expressed unease at the speed of some discharges and voiced their suspicions that some older people were being treated inappropriately so that local authorities could avoid having to reimburse the NHS for delays

larger in London than in England as a whole. As a consequence, older people who prefer smaller, more homely care homes now have less choice and are more likely to have to live in much larger developments, some of which may have a more institutional feel.

As we discussed earlier in this report, the shortage of care home places in inner London causes councils there to secure places in outer London or beyond. In this respect, most boroughs are able to secure places, paying higher fees than outer London boroughs in the process. The problem now is that local authorities in some parts of outer London report difficulties in finding care home places at a price they are willing to pay. This inability or unwillingness to pay the fees demanded has led some care home proprietors to restrict access to publicly funded clients and to give priority to self funders (Netten *et al* 2005). Several care providers taking part in a consultation for the Inquiry convened by the English Community Care Association (King's Fund 2004) made this point. This situation makes life difficult for commissioning managers in some authorities as they try to find places for their residents. For example, commissioning staff in two of the six boroughs participating in the Inquiry's commissioning study reported that their care home placements would be on a knife edge if any more of the homes they generally used either closed down or refused to take publicly supported clients (Banks 2005).

Delayed discharges

The relatively high rates of delayed discharges of older people from London hospitals in recent years might suggest that there are insufficient care home or home care services available. Certainly, London was experiencing very high levels of delayed discharges in October 2003, when the inner London rate was almost twice that of England as a whole. However, this has changed since the introduction of a reimbursement policy, which requires local authorities to pay 'fines' to the relevant NHS hospital if a patient has been delayed in hospital solely because of a lack of supporting community care arrangements (Community Care (Delayed Discharges) Act 2003). London authorities have drastically reduced the number of reimbursable days, which fell from 2,000 in October 2003 to less than 500 in July 2004 (Sa'id *et al* 2004). This improvement cannot be attributed to the development of new long-term care services. Local councils seem to have started to work more closely with their health partners to streamline the admissions and discharge processes and to develop more intermediate care services providing short-term rehabilitation for people who might otherwise have been placed in a care home. Where there were delays, and the reason given was 'waiting for a care home placement', it might be that the older person was taking a long time to make the life-changing decision to go into a care home and to find the home of their choice.

It is worth noting that the progress in reducing delayed discharges is sometimes at the expense of giving older people sufficient time to make these decisions and choices. Commissioners, providers and older people and carers interviewed in the Inquiry's commissioning study all expressed unease at the speed of some discharges and voiced their suspicions that some older people were being treated inappropriately so that local authorities could avoid having to reimburse the NHS for delays (Banks 2005). During our Inquiry, the Commission for Social Care Inspection reported on its study of delayed discharges; this concluded that nationally some older people were indeed being discharged too quickly to the detriment of their health and well-being (Commission for Social Care Inspection 2004c).

London's development and funding of intermediate care services (both residential and non-residential) to prevent hospital admission and to facilitate timely hospital discharge has been less impressive than elsewhere. Nationally, intermediate care beds funded by local authorities increased by 20 per cent in 2003/04. London authorities performed less well and also started from a very low base. Similarly, non-residential intermediate care is underdeveloped in London. Although the data on intermediate care is problematic because of definitional difficulties that lead to inconsistencies in what is being counted, questions do arise about the volume and the quality of intermediate care services in the capital.

Community health services

Questions also arose during the Inquiry about the adequacy and availability of a range of community health services. The Greater London Forum for the Elderly expressed concerns about the difficulties many older Londoners were experiencing in accessing NHS chiropody, dentistry, optical care and physiotherapy. Older people and carers taking part in the commissioning study undertaken for the Inquiry echoed these concerns, indicating that some had also experienced problems securing continence services and help with hearing aids. Care providers, too, sometimes found it difficult to access these kinds of health care for their clients (Banks 2005).

Community health services have a clear link with social care services. Older people's mobility and quality of life can be impaired if they cannot get the proper treatment and appropriate therapy. They become more dependent than they need be and are then more likely to require some form of social care.

Are some groups better off than others?

Older people with mental health problems

There is a serious shortage of services for older people with mental health problems, including dementia. This includes:

- people with a history of mental health problems, who often, on reaching 60 or 65, are moved from services for working age adults to older people's services, which do not always provide the same specialist care or quality of support
- people who develop depression and anxiety in old age, whose difficulties health and social care professionals do not recognise or address
- older people with different forms of dementia. They in particular are often provided with outdated and inadequate support and care from both community services (such as home and day care) and residential care.

All the boroughs in our commissioning study (Banks 2005) identified major shortfalls in this area of provision. One submission to the Inquiry argued that it is 'a national disgrace that services for people with dementia have changed so little over the last ten to twenty years' (Richardson 2004). In its evidence, the Greater London Association of Directors of Social Services referred to 'an emerging crisis for this group' and blamed historic underinvestment by local authorities and the NHS in both community services and residential care (Reilly 2004).

Many people who gave evidence to the Inquiry believed that the problem is getting worse. Care providers who previously accepted people with dementia are now less inclined to do so because they are unable to meet the regulators' more exacting

Much of the evidence submitted to the Inquiry claimed that not enough care services are responsive to the specific requirements of older people from black and minority ethnic backgrounds

standards. It was impossible to verify these claims since the new care standards were only introduced in April 2002. Staff from strategic health authorities, who tend to have a good overview of what is happening in the different boroughs within their boundaries, suggested that it would be unwise to rely too much on this explanation: they claimed that inspectors vary in the way they judge whether the higher standards required for dementia care are being met.

London was no worse off for care homes registered to care for people with dementia in 2004 than anywhere else: 13.4 per cent of care homes in London provide this service, compared with 12.5 per cent in England. On the other hand, London has fewer independent-sector home care providers who claim to provide specific services for people with dementia: 4 per cent of all home care providers offer these services, compared with 6 per cent across England (Laing 2005). But these differences are small. Much more telling is the low proportion of both care homes and home care services that provide specialist care for people with dementia.

Awareness of the shortage of provision for this group is high in London. During our Inquiry, the London Development Centre for Mental Health and the South West London Strategic Health Authority (which leads on services for older people) ran several conferences drawing attention to the problems and to good practice that could be extended more widely. The good practice includes memory clinics; combinations of home, day and respite care to keep people at home; and the inclusion of people with dementia in extra care housing. A network of commissioners and providers was established to highlight any shortfalls and to encourage the development of better services by identifying common concerns and sharing good practice. The London Development Centre has also been working with a number of older people's services locally through its service improvement programme helping them to increase their efficiency and effectiveness. The efforts of the London Development Centre for Mental Health were backed by the National Directors for Mental Health and Older People (Lois Appleby and Ian Philp), who began to work together to promote better responses for this group during 2004 (Department of Health 2004b). Part of this promotion has involved visits to strategic health authorities to highlight the importance of focusing on the mental health of older people and eradicating age discrimination. Age Concern and the Mental Health Foundation were leading a three-year, UK-wide Inquiry into Mental Health and Well-Being in Later Life at the same time as our Inquiry. The Inquiry into Mental Health is intended to raise awareness, empower older people, and create an evidence base to influence policy and improve services.

Other groups

Service shortages were reported for people with complex needs who require continuing NHS care. There were also reports of insufficient services for older men with a history of homelessness and hard drinking. This applies particularly in some parts of inner London, which for many years has attracted migrant labour from all over the United Kingdom.

Black and minority ethnic elders

Much of the evidence submitted to the Inquiry claimed that not enough care services are responsive to the specific requirements of older people from black and minority ethnic backgrounds. Information gathered by Laing and Buisson for this Inquiry appeared to support that view. A small survey of independent-sector care

homes revealed that only a very small proportion of homes (16 per cent) in London claim to make any special provision for the religious, dietary and other cultural requirements of black and minority ethnic residents. As Table 9 below shows, London care homes (particularly those in the voluntary sector) are more likely to make this provision than homes in other metropolitan areas such as Birmingham and Manchester. Even so, the low proportion of homes that claim to tailor their services specifically for black and minority ethnic residents is striking – in a city where more than 21 per cent of the population aged 65 and over is of non-white British origin (30 per cent in inner London and 17 per cent in outer London).

TABLE 9: INDEPENDENT-SECTOR CARE HOMES FOR OLDER PEOPLE THAT CLAIM TO OFFER SERVICES TAILORED TO THE CULTURAL NEEDS OF BLACK AND MINORITY ETHNIC GROUPS

	London	Birmingham	Greater Manchester	Shire counties	Total
Homes surveyed	532	488	355	530	1,905
Responses	131	90	65	125	411
Specific services[1]	21	1	1	2	25
Non-specific services	40	27	21	30	118
Percentage of respondents offering specific services as percentage of all respondents	16	1	1	2	6

Source: Laing 2005, data from inspection of care home brochures requested by Laing & Buisson, September 2004
[1]Examples include catering for dietary and religious preferences. Claims that are too wide to be meaningful are classed as 'non-specific services'.

This does not mean that black and minority ethnic elders do not use care services. On the contrary, as Table 10 opposite shows, older people from Caribbean and African backgrounds are more likely to live in a care home than any other ethnic group. This may reflect the poorer housing conditions in which they live and a lack of informal support among those groups.

Black and minority ethnic organisations participating in our Inquiry were concerned about the lack of care services (both residential care and home care) for older people from Bangladeshi, Indian and Pakistani backgrounds, for older people of Chinese origin, and for older Muslims whose country of origin is not in the Indian sub-continent. Certainly these groups are under-represented in care home places, as Table 10 shows. The position regarding community services such as home care is more complicated. There is no data on the numbers of clients receiving community care packages by ethnic group and age. Performance indicators used in the Department of Health's Performance Assessment Framework (*see* p 62–63) for social services do provide some insight into patterns of referrals, assessments and packages of care arranged. These show that black and minority ethnic elders in inner London are more likely than their white peers to receive an assessment but less likely to receive a service following assessment; why this happens is not clear. From this, it seems to follow that the proportion of older people from black and minority ethnic groups in inner London who were actually receiving services in March 2004 was approximately in line with the average for inner London's older population (unweighted) as a whole. In outer London, however, the Performance Assessment Framework statistics suggest that the proportion of older people from black and minority ethnic groups receiving services is lower than the average for outer London's older population as a whole (Sa'id *et al* 2004).

A number of organisations providing specialist care services to particular black and minority ethnic communities gave evidence to the Inquiry. They included organisations running home and day care services and care homes for a variety of groups including Greek and Turkish Cypriots, Jewish people, and people of Asian,

TABLE 10: LIKELIHOOD OF BEING RESIDENT IN A CARE HOME BY ETHNIC GROUP

	Percentage share of London's population aged 65 and over	INDEX of care home usage London	INDEX of care home usage England and Wales
White:			
British	69.6	73	99
Irish	6.9	102	110
Other	7.0	96	112
Mixed:			
White and black Caribbean	0.4	177	200
White and black African	0.1	155	266
White and Asian	0.3	96	127
Other	0.3	130	138
Asian or Asian British:			
Indian	2.2	56	101
Pakistani	0.6	55	41
Bangladeshi	1.5	22	53
Other	0.7	93	128
Black or black British:			
Black Caribbean	7.2	134	148
Black African	1.6	158	245
Other	0.3	125	139
Chinese or other ethnic groups:			
Chinese	0.7	57	121
Other	0.7	218	602
ALL ETHNIC GROUPS	100	77	100

Source: Laing 2005, data from 2001 census

Note: The relative likelihood of being resident in a care home by ethnic group has been calculated by combining 2001 census data with data on care home populations independently derived by Laing & Buisson. Black and mixed race black ethnic elders have a much higher risk of being in a care home than the population as a whole, whether calculated for London or England and Wales. In contrast, Pakistani and Bangladeshi elders are very under-represented in care homes. Indian elders have a low propensity to be in care homes in London, but an average propensity in England and Wales as a whole. It should be noted that these index numbers are calculated on the basis of populations unadjusted for factors that may predispose to entry into care homes such as deprivation, living alone or absence of informal care.

Chinese, African and Caribbean origin. Some of their services are faith-based; often they employ care staff who speak the same languages as service users; and some offer what service managers described as a 'holistic service', in which assistance ranges from social work services and practical help in the home to more general help with finances, immigration matters and family difficulties. All the community services reported that they were oversubscribed but were finding it difficult to expand. One reason for this was that some local authorities were starting to question their higher than average unit costs and asking whether these were because of inefficiency or because they represented the real costs of specialist services.

In the case of residential services, organisations running care homes for black and minority ethnic elders reported that vacancies had been filled by people from the Midlands (ASRA Greater London Housing Association) and that they recognise that they need to reduce the amount of residential care they provide and develop more community services to enable more people to stay at home (Jewish Care).

Home care services were criticised from all quarters, including service users and home care staff and employers themselves

HOME CARE IN WANDSWORTH

Mushkil Aasaan started in 1993 as a small self-help group serving the Muslim community in Wandsworth. Having received support from the local authority to develop more formal services, it now offers a home care service that employs about 70 people and sees 150 people per week. Staff and volunteers speak the same language as clients and are aware of their customs and cultural preferences regarding food, personal hygiene and religious practices. A social work service is also provided, helping clients to sort out a range of problems.

While these specialist services serve some older people from black and minority ethnic groups very well, not everyone wants to use separate services. Successive studies have shown that some prefer to use mainstream services where they mix with people from a variety of backgrounds (Levenson and Joule 2005). It is important that people should have a choice and that mainstream services ensure that they respond to the diverse needs of older people. We look at how satisfied older people from black and minority ethnic groups are with the services they use in the next section.

Are services good enough?

Older people and their carers told us of their appreciation of a wide range of care services, including home care, day centres, care homes and extra care housing. A 91-year-old woman said: 'My GP was very helpful and gave advice. The district nurses were also always there, and the social services department gave help and support to me.... I was very happy with the help my husband received, both from the borough service and especially the Alzheimer's Society.' However, there were also many concerns about the quality of home care and residential care services.

Home care

Home care services were criticised from all quarters, including service users and home care staff and employers themselves. Complaints focused on the amount of time allocated to a home care visit (half- and quarter-hour visits), the rigid set of tasks to be completed in the time, and the timing of visits to get people up or put them to bed. There were also concerns about staff not turning up on time or at all; staff staying for less time than the client was charged for; and staff being incompetent or uncaring.

Other evidence confirms that there are major concerns about the quality of home care in London. First, as Table 11 opposite shows, Department of Health Performance Assessment Framework indicators reveal that users of home care services in outer London are less satisfied with them than users in inner London and in England as a whole. The Department of Health's commentary notes that users from black and minority ethnic groups in outer London are much less satisfied than their white counterparts (Department of Health 2003b).

Second, a survey carried out by the UK Home Care Association (UKHCA) in 2003 confirmed that throughout the country local authorities commission very short home care visits. Of visits commissioned by local authorities, 58 per cent made by independent providers, and 43 per cent made by services run by local authorities, lasted half an hour or less (Matthew 2004). Home care workers participating in the Inquiry's focus groups were very critical of this trend. They felt under pressure to

TABLE 11: SATISFACTION LEVELS AMONG USERS OF HOME CARE SERVICES IN ENGLAND AGED 65+, 2002/03

Question	Inner London	Outer London	Greater London	Metropolitan boroughs	England
Q1 'Do your care workers come at times that suit you?' Percentage saying 'Always' or 'Usually'	86	86	86	90	89
Q2 'If you asked for changes in help you are given, are those changes made?' Percentage saying 'Always'	65	58	61	65	65
Q3 'Does anyone contact you from Social Services to check that you are satisfied with your home care?' Percentage saying 'Yes'	56	50	53	52	55
Q4 'Overall, how satisfied are you with the help from Social Services that you receive in your own home?' Percentage saying 'Extremely satisfied' or 'Very satisfied'.	55	51	53	58	57

Source: Laing 2005, data from Department of Health. *Personal Social Services Survey of Home Care in England aged 65 or over: 2002/03*

undertake the work as quickly as possible. This leaves them with little time to sit and talk to the older person about day-to-day matters and no time at all to help them do things for themselves – it is much quicker to do things to or for them. In 2004, organisations providing care at home services were required to register with the Commission for Social Care Inspection and to demonstrate how far they meet national minimum standards. In its evidence to the Inquiry, the Commission for Social Care Inspection reported a number of concerns about home care in London, and told us that approximately 86 per cent of home care organisations in London registering have conditions attached to their registration requiring them to make an improvement or provide better evidence that a standard is being met.

Care homes

The quality of care homes in the capital has been changing in recent years. In its evidence to the Inquiry, the Greater London Association of Directors of Social Services reported that some have become outdated and are no longer considered fit for purpose. Some that used to be run by local authorities have been decommissioned, taken over by independent sector providers and refurbished to a higher standard. As mentioned earlier, some new care homes have been built in London; others have closed, sometimes because their owners did not wish to spend the money needed to upgrade them.

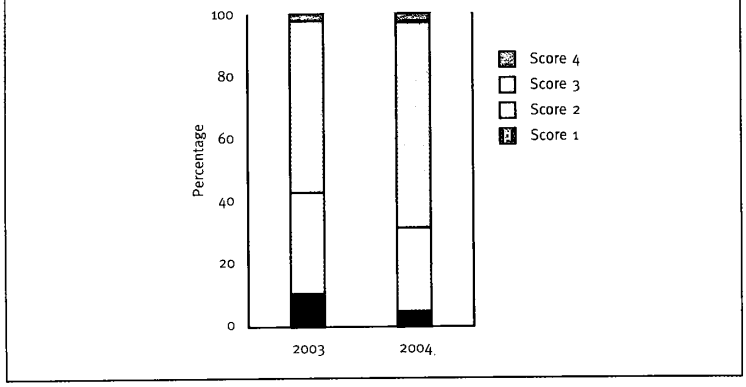
During our Inquiry, we heard a good deal of criticism of care homes: the standards of their rooms and facilities, the poor quality of the staff who work there, and restrictions on access to health care for residents. These criticisms came from carers, from voluntary organisations working with and for older people, from health professionals, and from commissioners in local authorities and primary care trusts (PCTs).

Some older people and carers who had visited care homes where friends or relatives were living had concerns. These focused on insufficient staff, poor-quality food, and poor relationships between staff and residents, either because of high staff turnover or because of communication difficulties among staff whose first language was not English. Care providers and others were concerned about the large number of older people in care homes who exhibit signs of dementia but receive little or no specialist help.

Inspections carried out between 2002 and 2004 confirm that there are quality shortcomings in some of London's care homes (Sa'id *et al* 2004). The Commission for Social Care Inspection reported a considerable improvement in homes' performance against the national standards between 2002/03 and 2003/04.

London homes scored poorly on having suitably qualified and experienced staff who can deliver care to the required standards

10 OVERALL QUALITY STANDARDS OF CARE HOMES IN LONDON 2002/03 AND 2003/04



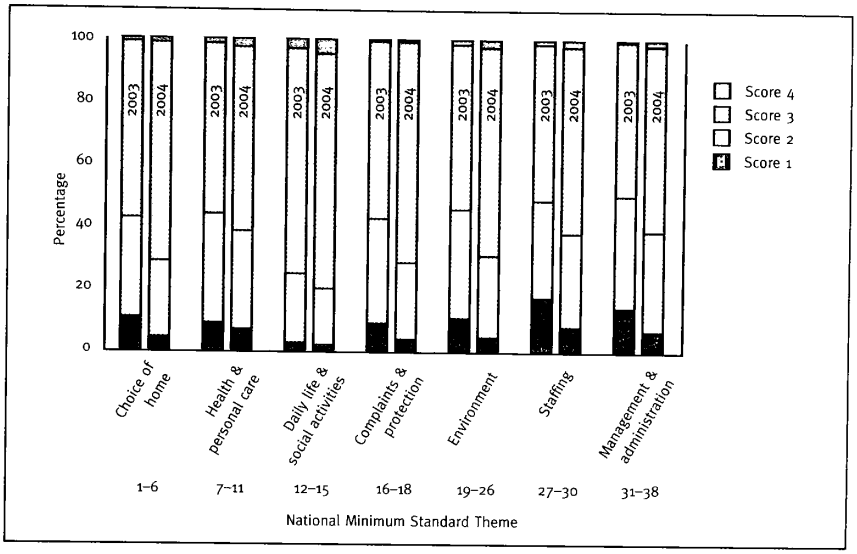
Key: Performance in relation to National Minimum Standards (NMS)
Score 4: exceeded NMS
Score 3: met NMS
Score 2: minor shortfalls
Score 1: major shortfalls

Source: Sa'id 2004

However, it also noted that very few care homes in London had exceeded the national minimum standards. While most met the standards, over 40 per cent were judged to have either minor or major quality shortfalls. Inspections confirmed that, on the basis of assessments against the national minimum standards, London care homes perform less well than the national average on delivering day-to-day health and personal care, respecting service users, and supporting them individually. Homes also did not perform well on the standards relating to safe medication procedures and meals and mealtimes, which were also a frequent complaint in evidence to the Inquiry. Things London homes did do well included daily life and activities, where a good proportion of homes exceeded the standard.

There were also major shortfalls in the way homes respond to complaints and related protection issues. Although environmental standards vary across London care homes, scores for this standard generally compare favourably with those in other regions. London homes scored poorly on having suitably qualified and experienced staff who can deliver care to the required standards. London also performed less well on standards of management and administration, particularly in relation to financial procedures and safe working practices. Homes run by voluntary-sector bodies consistently performed better than homes in the private sector (Commission for Social Care Inspection 2004a).

11 SPECIFIC QUALITY MINIMUM STANDARDS IN CARE HOMES IN LONDON, 2002/03 AND 2003/04



Key: Performance in relation to National Minimum Standards (NMS)
Score 4: exceeded NMS
Score 3: met NMS
Score 2: minor shortfalls
Score 1: major shortfalls

Source: Sa'id 2004

IMPROVING SUPPORT FOR CARE HOMES – SOUTHWARK CARE HOMES SUPPORT TEAM

Southwark Primary Care Trust hosts a Care Homes Support Team, jointly funded by Lambeth, Southwark and Lewisham Primary Care Trusts. The team was set up to strengthen NHS medical and nursing support of the 40 local independent-sector care homes with nursing in Lambeth, Southwark and Lewisham to enable them to achieve higher standards in the care of older people. The multidisciplinary core team has a mix of experience and expertise, including six older people's specialist nurses, a mental health lead nurse, project pharmacist, and consultants in old age psychiatry and medicine. The core team, which works with a range of other practitioners and specialist clinicians, provides specialist advice and offers training to care homes with nursing . The team is also responsible for undertaking assessments and reviews of both NHS-funded nursing care and continuing care for care home residents, as well as older people who are receiving NHS-funded continuing care in their own homes.

Key points

Choice and control

- **Range of services** There is a wider range of services coming on stream, including extra care housing, new models of home care, and intermediate care, all of which offer alternatives to residential care. Some of the new home care services have been developed for specific ethnic minority groups, where staff speak the same language and understand the customs of older service users. These new services are still in short supply. Most older people with care needs

are faced with a restricted menu of care options dominated by care homes or conventional home care services.

- **Preference for care at home** Older people in inner London have a better chance of securing help at home than anywhere else in the country, as their local councils commission home care for 44 per cent more clients than the average for England resulting in a 46 per cent increase in contact hours.

- **Care home choices**
  - **High costs restrict choice** High land and property prices in London have resulted in the underdevelopment of care homes and insufficient care home places to meet demand. Older Londoners are more likely than older people anywhere else in the country to take up a place in a home outside their borough boundaries and outside London altogether. It is not clear how far the drift from inner to outer London and then to surrounding counties reflects older people's preferences – nor what the emotional and social impact on older people is. But there is widespread concern that many older Londoners are being denied the choice of a care home close to family, friends and familiar surroundings because of cost considerations.
  - **Loss of small care homes** Care home capacity in London has been shrinking, following a national trend. Closures have involved disproportionately more small care homes, with the result that the homes in the capital tend to be larger than average. This gives less choice to older people who prefer more homely settings, disliking the institutional feel of some larger homes.

- **Choosing extra care housing** Provision throughout England is still very small. But the supply of extra care units in London is well below the average for England; rented extra care is one-third below the England average while, in inner London, leasehold units are more than two-thirds below the England average. The latter severely restricts the choices of home owners who would like to sell up and buy a more suitable home with care and support on site.

- **Day services** Some older people and carers are appreciative of day centres as they provide company, interesting and enjoyable activities, and respite for carers during the day. Others complain that there is insufficient choice of activity and limited opportunities to pursue interests and use ordinary community facilities outside the four walls of the day centre.

- **Assistive technology** There is potential for much greater use of equipment that aids mobility and helps people to feel safe in their homes. The more sophisticated technology is still at an early stage of development and practical application. Health, housing and social care authorities are often reluctant to commit the substantial resources required, which can put vital equipment and adaptations to the home beyond the reach of many older people.

- **Control over care services** Older people have limited control over the care services they use, in terms of deciding what tasks should be undertaken, when and by whom. Take up of Direct Payments – which are known to strengthen users' control over care services – is low in England as a whole. London local authorities perform less well on this than the national average.

Groups with less choice than others

- **Older people with mental health problems** There is a serious shortage of services for this group, including those with dementia. Shortfalls are evident in both community services and in residential care. Very few care homes and home care services offer specialist care for people with dementia.

- **Black and minority ethnic older people** In inner London, black and minority ethnic older people are just as likely to be receiving care services as the older population as a whole. This is not true in outer London, where the proportion of black and minority ethnic older people receiving services is lower than the average for outer London's older population as a whole. Voluntary organisations and community groups complain that there are not enough care services catering for the needs of people from Bangladeshi, Indian, Pakistani and Chinese backgrounds, nor for Muslims who have not come from the Indian sub continent. Older people of African-Caribbean origin are more likely than any other ethnic group to be resident in a care home. Only a very small proportion of homes claim to make provision for the religious, dietary and other cultural requirements of black and minority ethnic residents.

Service quality

- **Home care** Dissatisfaction with home care services arises from the very brief visits (15–30 minutes) that care staff make; the way that the tasks they undertake are rigidly specified by care managers; and concerns about the reliability and competence of care staff.

- **Care homes** Although standards have improved since 2002–03, there are many concerns about poor standards of rooms and facilities; high staff turnover; lack of trained staff (some of whom are seen as uncaring and unable to communicate well with residents); the timing and content of meals served; and residents' restricted access to health care.

6 Integrated social care, health and housing services

As described in Section 2 (*see* pp 25–31), local authorities are now working more closely than ever before with NHS bodies such as PCTs in order to achieve better co-ordinated services and integrated care for older people. Within local authorities, collaboration between social services and housing departments has advanced in recent years, in some cases by merging departments. Much of the collaboration between social services, health and housing takes place in commissioning care services, either at the strategic level for populations or at the level of the individual.

Our Inquiry focused particularly on how councils and primary care trusts in London are working together on strategic commissioning (Banks 2005). It is this process that has the potential to transform the shape, volume and quality of care services so that they better meet the changing needs and preferences of older Londoners. Strategic commissioning is a cyclical process that includes:

- understanding and forecasting supply and demand factors within the market to meet the current and future needs of older people
- aligning partners in the system to agree a shared vision and what needs to be done to achieve the agreed goals
- planning joint strategies to meet these goals
- applying resources to achieve strategic goals
- reviewing and evaluating to adjust to changing needs (Department of Health 2003d).

There is also an important relationship between commissioning at a personal level, where services are arranged and purchased for the individual – micro-commissioning – and strategic commissioning. Strategic commissioning should ensure that there are appropriate local services to meet an individual needs-led assessment; information about needs derived from micro-commissioning should inform local strategic plans.

Commissioning to transform services

During the Inquiry, we found both strengths and weaknesses in integrated commissioning among London authorities and PCTs. There were wide variations in strategic commissioning practice, and overall performance in the six boroughs we studied can be summarised as 'work in progress' to transform services (Banks 2005). We heard about many examples of innovative developments where PCTs, social services and housing are collaborating to redesign existing services, introduce new integrated services, and reconfigure the whole system in local health and care economies.

Redesigned existing services include new integrated resource centres offering a range of education and leisure opportunities alongside health, care, information and advice services. These centres are replacing traditional day centres.

New integrated services include:

- specialist community-based services for people with mental health problems commissioned and delivered jointly by PCTs and local authorities
- new extra care housing units designed for people with dementia, with accommodation developed using the latest technology
- new local provision designed to prevent older people having to make a further move to NHS continuing care provision, developed collaboratively by boroughs and PCTs
- outreach teams to offer flexible support to older people in new housing developments
- integrated health and social care teams linked to general practices to offer more co-ordinated care to older people
- joint work to train staff and introduce new single assessment procedures that will integrate different professional inputs and so ensure a holistic approach to older people's needs.

INTEGRATED HEALTH AND SOCIAL CARE TEAMS – KINGSTON-UPON-THAMES

Kingston-upon-Thames' integrated health and social care teams are based in four localities and linked to primary care practices. These co-located multidisciplinary teams assess and provide services to older people in the community. They include social workers, district nurses, occupational therapists and home care assessor staff. Where appropriate, older people have a full holistic assessment of their needs (single assessment). The district nurse, occupational therapist or social worker co-ordinates and commissions the care and support services needed for the individual. In developing these new integrated arrangements, priority has been given to team building and training in person-centred assessments, care management skills and financial assessments.

Steps to reconfigure the service system include:

- strategic development of intermediate care services to prevent inappropriate use of acute health services, support people's return home, and help the whole system function more effectively.

Local authorities and PCTs have succeeded in reducing delayed discharges from hospital but, as we noted in Section 5, there are fears that the speed of discharges may have been to the detriment of some older people and their carers.

In some parts of London, the commissioning and development of care services are linked to wider corporate work to improve the local environment and opportunities for all local older people. Action to ensure safe neighbourhoods, provide community support teams, handyman services and other practical support make access to adult education easier, and promote initiatives run by older people – all this is designed to enhance the quality of life for all older citizens. Health promotion and prevention activities are also being developed to prevent or delay the need for care services. Keep-fit classes, initiatives to prevent falls and emerging work to manage proactively the care of people with long-term conditions are all progressing the prevention agenda.

All these are examples of changes brought about by collaborative commissioning designed to improve the quality of life for all older people and transform care services for those who need support. However, much of this work is at an early stage. The evidence discussed in earlier sections of problems in accessing services,

A partnership approach to commissioning was common, but the strength of partnerships between health and social services depends heavily on the local history of joint working and on strong and stable leadership

AGEING WELL STRATEGY – LEWISHAM

Lewisham has a three-year, multi-agency strategy for older people: *Ageing Well in Lewisham 2002–2005*. The strategy was developed in partnership with older people, those reaching retirement in 10 to 15 years, policy makers and professionals across the borough. The Health Partnership Board is responsible for implementing the strategy's action plan, and older people have a key role in monitoring progress. The action plan details the responsibilities of different agencies and groups for meeting the key objectives of:

- valuing older people's contribution to the community
- enhancing the financial security of all older people
- keeping people as independent as possible by improving preventive services and providing high quality acute health and support services
- enhancing safety and security within the home and outside
- ensuring access to lifelong learning
- supporting relationships, addressing loneliness and isolation, and challenging age discrimination.

A review of progress in 2004 highlighted some of the challenges in maintaining momentum on this proactive agenda to promote independence and well-being. Recent national policies are supporting this focus.

limited care options and poor-quality services indicates some of the difficulties in commissioning effective care services. Furthermore, some of the boroughs studied had no clear shared strategy for taking forward this broader agenda to improve the quality of life of older people. And, despite their commitment, both local authorities and PCTs reported problems in adequately funding much of this work.

Commissioning practice

The Inquiry saw both strengths and weaknesses in the way local authorities, NHS, housing and other partners undertake commissioning to transform care services.

Partnership working

A partnership approach to commissioning was common, but the strength of partnerships between health and social services depends heavily on the local history of joint working and on strong and stable leadership. Partnerships are also being extended to include housing and housing-related support in strategic work between local authorities and PCTs. These partnerships are exploring a wider range of options for integrated and community approaches to services to older people. (*See* pp 72–73 for more on housing strategies across London.)

However, partnerships with independent providers are very varied. In some places providers talked of feeling 'a bit like Cinderella not invited to the ball'; they feel that they are involved primarily in contractual relationships rather than strategic planning, and expressed frustration at their dealings with the council at every level. In contrast, in some boroughs independent providers appreciate good communications with the local authority and the professionalism of officers.

Relationships with the voluntary sector are also mixed, and many voluntary bodies feel on the outside of strategic discussions. Some authorities have adopted an

Although clear values underpin work on older people's services and some service specific strategies are evident, there is not always clarity about an overall strategy to redesign and commission services

explicit developmental model of commissioning to support and help build capacity in the voluntary sector, particularly among black and minority ethnic groups. Longer-term funding agreements, training opportunities and special fees are being employed to build capacity. However, many voluntary organisations do not feel that they are real partners around the strategic planning table and feel under pressure to accept spot contracts or one-year service agreements. They are frequently the first sector to face cuts when there are funding pressures – although they are the very sector that provides much of the community support and low-level help at home that older people so value.

User-focused commissioning

Service users and carers have some involvement in the different processes of the commissioning cycle. However, this does not happen systematically everywhere, and their influence on service developments is often very limited. Commissioning at the individual level frequently amounts to purchasing standardised care packages that specify a rigid set of tasks to be carried out in a fixed time. This is at odds with the strategic vision of flexible services tailored to individual need to which many authorities aspire. Most important, it is not what older people or their carers want.

Understanding the market

There are different levels of understanding of local needs and supply. Some authorities are grappling with inadequate information and data collation systems; one commissioner described these as 'a shanty town of databases'. All authorities are trying to take a whole-system approach that recognises the interdependencies of services and aims to anticipate the consequences of action taken in one part of the system for other parts. However, commissioners find that predicting the impact that new service developments will have on the system as a whole presents considerable challenges; one example is the impact of new extra care housing developments on the demand for residential care.

Managing the market

All authorities are taking steps to manage the market through different types of contracts, such as block contracts, to give greater security to providers, and, where possible, to raise the fees paid to them. They are also supporting different training initiatives, for example to support home care providers in training their staff to gain National Vocational Qualifications (NVQs).

Although clear values underpin work on older people's services and some service specific strategies are evident, there is not always clarity about an overall strategy to redesign and commission services. Indeed, there is some debate about the vision for services and the most appropriate balance of services between residential care and care at home.

Integrated housing strategies

All authorities are encouraged to develop and implement older persons' housing strategies, detailing plans for generalist and specialist housing together with care and support for residents. However, a telephone survey carried out for our Inquiry in January 2005 showed that only a minority of authorities have developed and

published their strategies and are in the process of implementing them (Molyneux and Leather 2005).

The majority of the six boroughs taking part in our commissioning study had developed joint housing strategies in consultation with older people and other stakeholders. These appear to be exploring a much wider range of options for integrated and community services to older people than some traditional care services. Plans include expanding community alarm, telecare and other supportive services to assist people in their own homes, as well as developing schemes offering information, advice, and other resources to local older people.

Evidence to the Inquiry presented by the Commission for Social Care Inspection (drawing on Joint Reviews of social services carried out by the Audit Commission and the Social Services Inspectorate) came to similar conclusions to our study on commissioning practice in London. The Commission found that councils across London are making a concerted effort to improve commissioning strategies for older people's services. But they also observed that, with notable exceptions, performance in market management is poor, and noted that some councils are 'locked' into contracts with the independent sector for services that may no longer be appropriate.

Challenges for commissioners

In some local authorities, commissioning has been acknowledged as a key role since only about 2000, and senior commissioning posts are relatively new. Some authorities find it difficult to appoint and retain senior people with the necessary skills and experience. PCTs are also relatively new organisations; although all those interviewed in our study defined commissioning as a process that extends beyond contracting and procurement to service development, many acknowledge that they are new to this role. Their limited experience of partnership working, and the very wide brief on which they have to deliver (commissioning primary and community health services, hospital services, and (with local authorities) care services) makes it difficult for them to undertake all the important components of care services commissioning such as needs analysis and relationship building.

Organisational arrangements to support the multi-faceted commissioning process are also being developed. Some authorities have a well-led and managed team of people with clear roles and responsibilities within the social services department and in relation to other agencies; in others the integrated commissioner posts are integrated in name only and their responsibilities focus on the employing organisation; in other authorities the integrated commissioners act as a focal point for older people's services, working across numerous boundaries in a roving role with a very wide brief.

Many social services operational managers carry a mix of responsibilities for in-house and external services and have differing relationships with strategic commissioners. Some managers argue that the mix of strategic and operational responsibilities works well as it links commissioning at the frontline for individuals with an overview of needs and supply for planning purposes. Others, who are moving towards integrated commissioning, argue for a clear distinction between commissioners and providers so that in-house services are commissioned on the same basis as external providers.

Some collaboration is taking place across boroughs and pan-London to develop a more coherent approach in which authorities can work together to maximise their influence on care markets

However skilled and experienced they are, all commissioners face complex tasks. These include the challenges of forecasting when it is difficult to predict the aspirations of future generations; planning ahead when there may be no consistent patterns of service usage; planning for transient populations; and accommodating unknown factors such as medical advances. In addition, commissioners engage in whole-systems working, which they describe as requiring the capacity 'to work on all of it all the time', and in bringing together health and social care cultures where people 'think and operate differently'. At the same time, commissioners have to deal with pluralistic and fragmented markets in order to develop choice and diversity for local people.

All these activities call for time-consuming attention to communication within (both up and down) and across organisations. Commissioners deal with numerous cross-boundary issues; new services can take a considerable time to bring into operation where they are hosted across several boroughs. Equally, decommissioning services may be particularly sensitive. Decommissioning can involve negotiating a solution with a range of competing local and political interests while ensuring that the older people who use the service concerned receive proper alternative provision and support.

There are also pressures to commission in the most cost-effective way at the same time as managing demand and increased public expectations of services. Higher local service charges and government promotion of choice in public services have fuelled public expectations. Commissioners concerned with developing local high-quality responsive services highlight the importance of an in-depth knowledge of local needs and strong links with micro-commissioning (commissioning for the individual), and of developing a shared vision for local services between the PCT and social services. This tends to run counter to proposals for more cost-effective regional commissioning (*see* below).

Our study suggests that current commissioning practice scores reasonably well in terms of several indicators of cost-effectiveness. Prices for care services have not been allowed to escalate out of control; a mix of services is being commissioned, and where possible expensive options are being dropped; contracting processes are being streamlined; and the number of contracts with local providers is being rationalised. However, there is still much to be learned about the most cost-effective processes to achieve diverse markets that offer genuine choice and appropriate services to older people from all communities.

Cross-borough and pan-London collaboration

Some collaboration is taking place across boroughs and pan-London to develop a more coherent approach in which authorities can work together to maximise their influence on care markets and to share best practice in commissioning and developing integrated services. These developments include an Association of London Government Learning Improvement Network supported by the National Health and Social Care Change Agent Team and the creation of the Greater London Association of Directors of Social Services sub-committee on older people's services and a network of London assistant directors of community care services. A London Centre of Procurement Excellence has been set up, sponsored by the Association of London Government (ALG) and the boroughs of Westminster and Hammersmith and Fulham. It is examining how the procurement of care services might be undertaken more efficiently. The ALG is supporting the development of joint

commissioning arrangements in health and social care services. The Association of London Government is also working with the NHS Modernisation Agency PCT Improvement Programme (London Region) to consult on the development of a joint commissioning strategy for London.

In its evidence to our Inquiry, the Greater London Association of Directors of Social Services supported the development of a London-wide strategy and acknowledged that the barriers to joint commissioning across boroughs are similar to those affecting progress in pooling budgets and joint commissioning with local PCTs. It argued that, if progress is to be made, a consensus needs to be established on the vision and objectives for different models of care services and on joint governance and risk-sharing.

A London-wide Supporting People strategy is also being developed by the Association of London Government. This is focusing on specific client groups with cross-authority needs. These include older people with needs relating to alcohol abuse and homelessness and older people unsuitably housed with families or other people.

The impact of these different initiatives is not yet clear. But all of them aim to improve understanding of the care markets, market management and strategic planning across health, social care and housing. This is important given the significant market, policy and financial pressures on commissioning activity.

It is clear that commissioners are working in a very challenging environment. Cost pressures in the market, competing priorities and other restrictions mean that authorities are having to suppress demand through very tight eligibility criteria. These funding difficulties work against the aspirations to offer choice for older people and to support an innovative market. A shifting workforce, reliance on temporary and poorly skilled staff, and a lack of stable leadership hinder the effective implementation of local commissioning strategies. Commissioning is also thwarted by the cost of new buildings where land and property are scarce and expensive.

National policy has provided some positive support to improving services through, for example, the National Service Framework for Older People. However, unresolved issues, including the funding of long-term care and problems around NHS continuing care, present further challenges to progress. Although the government has pushed to drive up quality, relationships with regulators and inspectors have not yet been fully worked out. In addition, threading through much of this is a deep-rooted ageism that local communities in some areas are only just beginning to challenge and that confronts commissioners seeking to change planning priorities.

Our verdict is that integrated commissioning within London boroughs is still at an early stage, and we are only just beginning to see the results of better integrated services on the ground. Some social care, health and housing partnerships are more advanced than others. But all areas experience shortages in skilled and experienced staff and find that major political and financial pressures hamper their ability to transform services in the way they wish.

Key points

- **Transforming the care system** Some local authorities, with their NHS partners, have begun to make progress in strategic whole-systems planning that is designed to prevent inappropriate use of hospital services, develop a broader range of alternative care and support in the community, and ensure that older people get the right kind of care, at the right time and in the right place. This work is still in its early stages.

- **Working in partnership** It is common for local authorities and PCTs to work together on the strategic commissioning of services for older people. There are wide variations across boroughs in the relationships forged between health, housing and social services partners, and in the extent to which independent care providers, older people and carers feel able to influence strategic planning and commissioning.

- **Care after leaving hospital** By working closely with their NHS partners, local authorities dramatically reduced the number of delayed discharges from hospital between October 2003 and July 2004. However, there is widespread concern that people are being discharged too quickly, to the detriment of their health and well-being. Intermediate care services, offering a short period of rehabilitation following a spell in hospital, are less well developed in London than elsewhere.

- **Better co-ordinated services** New integrated community teams, resource centres and intermediate care services are being established, providing better co-ordinated care and support to older people with both health and social care needs. These joint services are still the exception rather than the rule.

- **Market management** Local authorities and their NHS partners vary considerably in their understanding of local care markets and in their efforts to manage and reshape the market to fit modern requirements. Even the most advanced are facing major political and financial pressures that hamper their ability to transform services in the way they wish.

- **Promoting health and well-being** A few local authorities, in co-operation with health and housing partners, have adopted strategies to promote the health and well-being of all older people. This involves making use of a wider range of public services to improve safety and security, practical support in the home, education and leisure opportunities and increasing health promotion activities. Implementation of these preventative programmes is being hampered by the need to concentrate limited resources on care services for vulnerable older people.

- **Collaboration across boroughs** Strategic commissioning on a pan-London or sub-regional level is rare. There is increased interest in exploring how specialist services for particular groups might be commissioned in this way, and how greater efficiency might be achieved through collaborative commissioning.

7 Workforce capacity

The workforce involved in care services for older people includes:

- care workers, who provide the bulk of hands-on care
- managers or owners of care businesses in the statutory, private and voluntary sectors
- commissioners in local authorities and/or NHS PCTs, who purchase care services at a strategic or individual level on behalf of older people needing care and support.

Of course, many other workers are involved in caring for older people; these include NHS staff (for example, doctors, nurses and therapists) and housing-related support workers. But we concentrate our attention here on staff employed in residential, home or day care (whether in practitioner or managerial positions) and on staff who perform a commissioning function. In particular we look at their capacity to develop and deliver care and support that meet the needs of older Londoners.

The care workforce

Older people and carers participating in the Inquiry presented a mixed picture of their experience of care workers. Some reported that they or their relative had received excellent care from care staff, or had found particular staff to be kind, caring and professional. One or two talked about how some of their care workers had 'become real friends'. Where they had criticisms, these related to continuity, competence, and education and training. Comments included: 'I find it disorienting when the regulars are replaced' (older person); ' We have had very variable service from different home care agencies' (daughter of an older person receiving home care); 'The last carer was not safe. I worry who is going into my mother's house' (carer); 'The staff are not well educated' (older person); 'I think the staff need more understanding of what it means to work with elderly, frail people' (older person); and 'The staff need to be better trained' (older person). Several older people noted that care workers are on low pay and are not recognised for the work they do.

The strengths and weaknesses of the care workforce become apparent when we look at the changing nature of care work; pay and conditions; the characteristics of the London care workforce, training and qualifications; and recruitment and retention.

The changing nature of care work

The demands on care staff have changed over the last decade as more older people using care services have high levels of dependency associated with serious physical or mental impairments. Much of the work of care staff involves personal care, including help with feeding, bathing, dressing and personal hygiene, and they give rather less attention to domestic tasks such as cleaning or shopping. The work is necessarily of an intimate and potentially intrusive nature; it has also come

to resemble work that nurses would have undertaken in the past. Care workers taking part in Inquiry focus groups spoke about how their work often involves catheter care, colostomy care, assistance with medication, and PEG feeding (for people who find it difficult to suck or swallow).

Describing their typical day, home care workers in the focus groups talked about constant time pressures to get through the work required and having to move quickly between clients, often spending no more than 15–30 minutes with each person. Residential care workers felt that they were always running between clients at peak times during the day, for example, getting people up and ready for the day or helping them prepare for bed. Workers in care homes and residential care workers commented that the pressures intensified if other staff were sick or on leave, or if vacancies were hard to fill, as employers appear to have very little slack to cover these eventualities.

Pay and conditions

Nationally, most care workers are on low pay rates. In 2004, the median gross pay of female care workers was £6.40 per hour. Pay ranged from £4.80 per hour or less (for the bottom 10 per cent of workers) to over £8.30 per hour (for the top 10 per cent). This means that the wages of the bottom 10 per cent are at or below the national minimum wage. Care workers in the public and voluntary sector earned on average 22 per cent more than those in the private sector (Eborall 2005).

Pay rates in London are higher than elsewhere because of the capital's higher living costs and the competition for labour in a low-unemployment economy. However, the average gross weekly pay of care workers in inner London is only 8 per cent higher than the average for England, although it is rather higher in outer London (18 per cent higher). It is not clear why the average difference in pay is relatively small (unlike the difference in care home fees). It may be that higher rates of unemployment in some inner London boroughs, combined with the ready supply of staff from overseas, serve to keep down wages (Eborall 2005).

Most care staff work part time, and many are able to fit their work around family commitments, study or other jobs. Home care workers' hours can include what used to be called 'unsocial hours' (early morning and late evening, through the night, and weekends) as well as time in the 'ordinary' working day. These hours are essential to respond to the requirements of severely disabled older people living at home. Being able to choose these times also suits some care workers. People in our focus groups described how their working hours fit their child care arrangements (for example, they go out to work when their partners come home) or their studies at college. Residential care workers have always had to cover different shifts, but it is now common for home care workers to do the same, in contrast with the home helps of a previous era who tended to work between 9am and 4pm.

The number of care workers entitled to an occupational pension and to sick and holiday pay varies widely. Some have a contract specifying a guaranteed minimum number of hours, with the option of doing more if the demand is there. Some home care workers report that they are contracted to work for very few hours; when a client goes into hospital or dies, those hours are not necessarily replaced, leaving them in financial difficulties. Given its relatively poor pay and conditions, it is perhaps not surprising that the care sector is dogged with staff recruitment and retention difficulties, as discussed on pp 84–88.

As in the rest of England, most care workers are female. But London's care workforce contains many more people from black and minority ethnic backgrounds than elsewhere

Characteristics of the London care workforce

As in the rest of England, most care workers are female. But London's care workforce contains many more people from black and minority ethnic backgrounds than elsewhere. A survey carried out by the United Kingdom Home Care Association and Topss England (now Skills for Care) in 2004 found that 60 per cent of home care workers in London described themselves as being from an ethnic minority; the majority were black African or Caribbean or black British. In all other regions, the proportion was lower than 10 per cent (McClimont and Grove 2004). A similar proportion of care home staff are from ethnic minorities. In 2003/04, the Association of London Government's Care Home Information Network found that 42 per cent of care home staff were black or black British, 40 per cent were white (including 6 per cent who described themselves as Irish), almost 11 per cent were Asian or Asian British, about 6 per cent were mixed, and 2 per cent were Chinese or other (Association of London Government 2004).

The majority of care service users are white and come from a generation that grew up in a less diverse society than we have now. While black and minority ethnic care workers in our focus groups talked of enjoying good, friendly relationships with most services users, some had experienced racist behaviour by a small minority of older people and their families. Most staff claimed to understand and tolerate racist abuse coming from older people in the advanced stages of dementia. But in any other circumstances they wanted their employers to demand an end to racist behaviour and to withdraw services from people who failed to comply.

A large but unknown proportion of London's care workers come from abroad to work in the capital. In a training initiative in north-east London involving over 100 residential care workers from different care homes, training assessors noted that the 'vast majority' of staff had recently arrived from overseas (Meehan 2004). Most had English as their second language, and many lacked basic literacy and numeracy skills. However, some overseas staff are well qualified in their home countries. For instance, several participants in our focus groups were qualified nurses from Africa; they were hoping to work for the NHS and were working in the care sector while waiting for their UK nurse registration to be cleared.

Training and qualifications

In 1990, barely 3.5 per cent of the care workforce in England had any relevant qualification whatsoever, and most of those were social workers. The situation hardly changed during the 1990s, as the Kings Fund's inquiry into the care workforce revealed (Henwood 2001). However, following the Care Standards Act 2000, the number of care staff gaining qualifications has increased rapidly, as employers have set out with some urgency to meet a target that requires at least 50 per cent of care workers to have an NVQ in care at Level 2 by 2005. In 2004, 28 per cent of home care staff were estimated to have attained Level 2 or to be studying for it; 22 per cent of independent sector care homes had met the target, but in half of all such homes fewer than 20 per cent of staff were qualified (Eborall 2005).

This trend was apparent in London during our Inquiry. Quite rightly, care organisations and staff present this as good news, reporting the great pride felt by care workers who achieve these qualifications despite very poor experiences of schooling. This is clearly very encouraging, but nevertheless large numbers of care workers still hold no qualification that confirms they have the competencies required

for the work. Furthermore, as Skills for Care pointed out in its annual report in 2005, it does not look likely that the qualifications target will be achieved.

Some care workers find it hard to obtain the relevant NVQs. Staff working in small care organisations can be disadvantaged; these organisations report difficulties in accessing funds for training their staff and in releasing staff for training when there is no one to cover for their absence. Changing patterns of working hours can make it more challenging to organise work-based training for staff. Care workers speaking English as a second language or lacking basic skills also face difficulties, as the extra support they need is not always forthcoming.

Workforce development departments within strategic health authorities have a crucial role to play in developing the capacity of the health and social care workforce. We were impressed by the extensive programme to develop the social care workforce initiated by the North East London Strategic Health Authority (NELSHA), working with partners such as the Learning and Skills Council, Skills for Care, NHS bodies and local authorities, and City University. One particular initiative, the Care Homes Training Collaborative, has demonstrated what can be achieved when small care homes and their staff are supported (Meehan 2004).

Recruitment and retention

For some years, the care workforce in London has suffered problems of high staff vacancy rates and high staff turnover (Douglas 2002). These difficulties, which were reported by commissioners and providers operating in the London area, continued throughout the year of the Inquiry.

CARE HOMES TRAINING COLLABORATIVE – BARKING AND DAGENHAM, HAVERING AND REDBRIDGE

During 2003/04, 330 care staff from 45 small care homes in the boroughs of Barking and Dagenham, Havering and Redbridge were recruited into a work-based learning programme leading to NVQ Level 2 qualifications for care workers and NVQ Level 4 qualifications for managers. These care homes were experiencing high staff turnover and a low skills base among care staff. Training facilitators were funded to support care homes and care staff participating in the programme.

Almost half the care workers achieved NVQ Levels 2 or 3, and almost all the managers achieved Level 4. Many care staff struggled to participate in the learning programme while working long hours, speaking English as their second language and facing numeracy and literacy difficulties. A quarter withdrew within the first two months; some did so because they had underestimated the work involved or thought they could not do it, but more left because the course led them to realise that they did not wish to continue working in the care sector. Others withdrew later because of poor health, maternity leave or extended absence relating to their families abroad. However, many won through, with the one-to-one support of the training facilitators; the added value they provided was appreciated by both employers and care staff.

A network of care homes has now been established to make it easier to obtain training for staff and to access funding.

Vacancy rates among care staff employed by local authorities in London are well above the average for England

Recruiting people to social care work

Vacancy rates among care staff employed by local authorities in London are well above the average for England. As Figure 12 shows, the vacancy rate among care staff in residential homes in Greater London was 22.2 per cent in 2003, compared with 9.2 per cent in the rest of England. Among local authority home care staff the vacancy rate was 16.5 per cent, compared with 11.2 per cent in England. On the other hand, staff turnover, while high, was not appreciably worse in London than elsewhere, and fewer social services departments in London report recruitment difficulties than their counterparts elsewhere. No doubt these figures for the whole of London mask significant difficulties experienced in some parts of the capital. The Inquiry received reports of problems in more affluent outer London areas, where the supply of local labour for the care sector is more restricted than in parts of inner London.

Most care service staff work in the independent sector. Here the trends are less clear, as workforce surveys are not carried out annually as they are in the statutory sector. The latest available figures, for 2001, indicate that both vacancy and turnover rates among care staff employed in independent care homes in London are better than elsewhere in England, substantially so in the case of the turnover rate (*see* Figure 13, p 83). However, the London rates for managers and supervisors are higher.

This limited information about the London independent sector care workforce shows that, while there certainly are recruitment and retention problems, they may be no worse than across England as a whole. Nevertheless, half the independent sector employers in London rate their experiences of trying to recruit care workers as either difficult or very difficult.

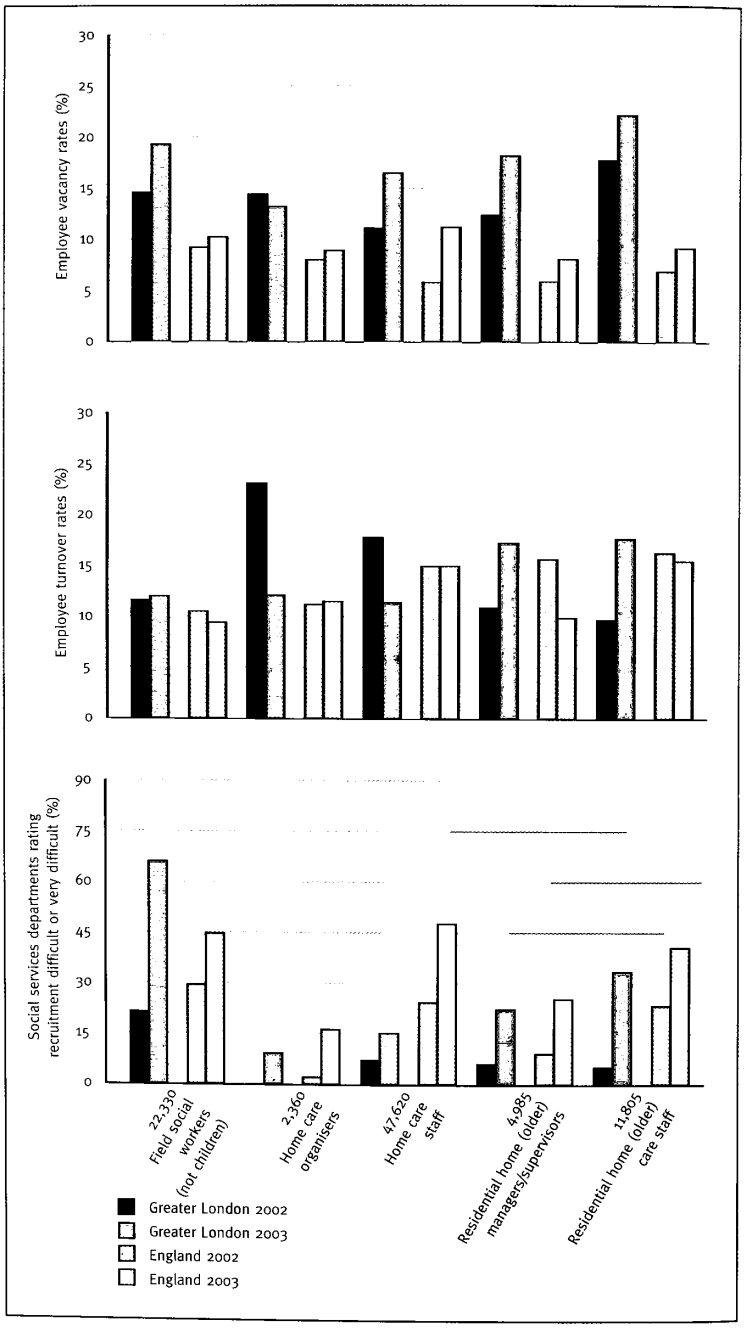
Motivating social care workers to stay

Why do some London employers appear to have fewer recruitment difficulties than others? This question has preoccupied local authorities and others concerned with developing strategies to attract people into social care generally (including social work) and to encourage them to stay. Some insight can be gained from listening to care workers describing the attractions of the work and the features of a good employer.

Care workers taking part in our Inquiry reported that they derived job satisfaction from being able to help older people, from receiving smiles of recognition and words of appreciation and praise from their clients, and from getting to know people and becoming part of their lives.

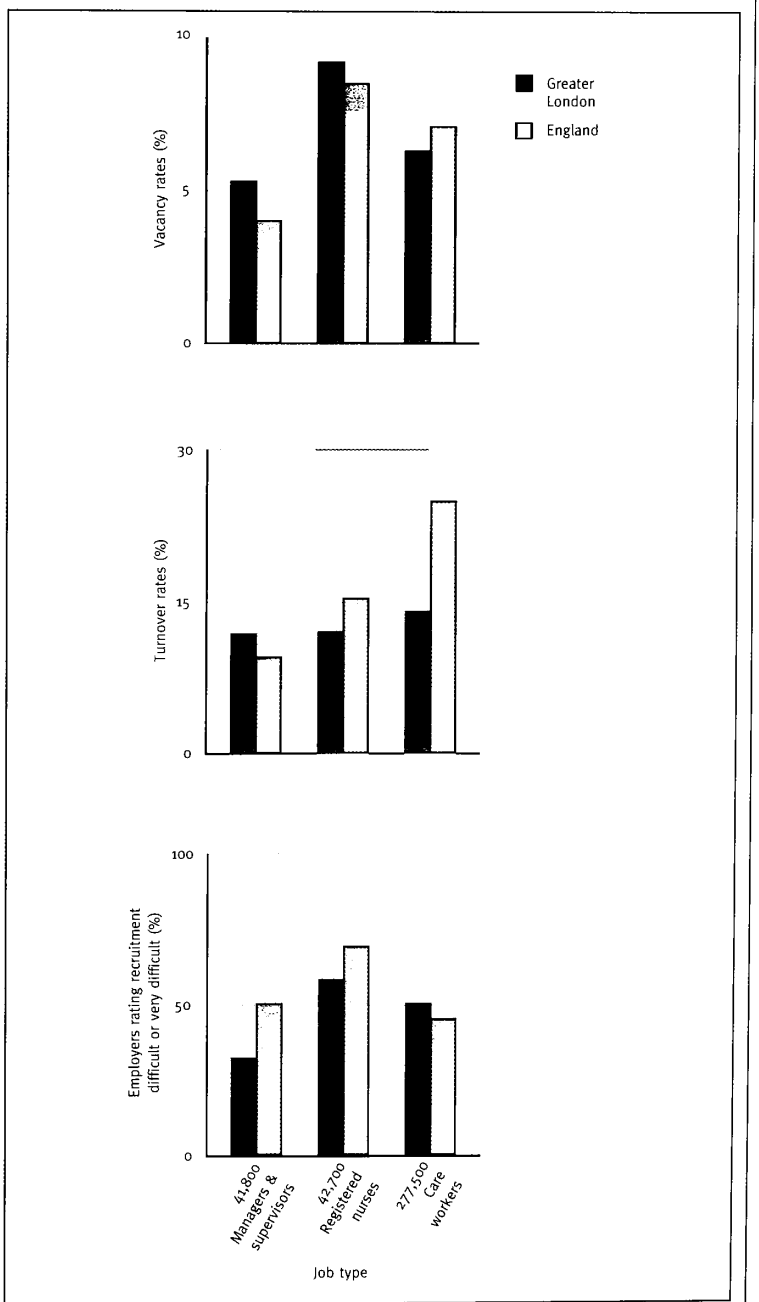
One home care worker described how she enjoyed working with an African–Caribbean client: 'I cook for her and she likes proper Caribbean cooking. Also – I'm a single parent and so is she – so we have something in common.' Another said: 'One of my clients has a stair lift but if I'm there and he is up for it, I get him to walk up the stairs – he likes to do it. You can motivate them.' Similar feelings were evident among residential care workers recruited to take part in the Care Homes Training Collaborative mentioned above; they attach importance to the value of older people's lives and to caring for 'the sick and frail' (Meehan 2004). There is some evidence that screening people on their motivations for care work, combined with regular supervision, can help to 'weed out' workers unlikely to stay in the sector, and thereby reduce turnover (Matthew 2004).

12 INDICATORS OF CARE WORKFORCE STABILITY, STATUTORY SECTOR, 2002 AND 2003



Source: Laing 2005, data from Laing & Buisson. Care of Elderly People Market Survey, various years.

13 **INDICATORS OF CARE WORKFORCE STABILITY, INDEPENDENT SECTOR CARE HOMES, 2001**



Source: Laing & Buisson. Care of Elderly People Market Survey, various years.

Care staff in our focus groups described good employers as those who enable staff to fit their work around other aspects of their life (family or study); who provide support in difficult situations; and who find ways to acknowledge and reward good performance and a 'job well done'. Care staff claimed that they are more likely to stay with this kind of employer. Not surprisingly, pay and conditions are also a factor, although by no means the only or predominant one. Practically everyone thought that wages should be higher to reflect the demanding nature of the work. Workers employed by local authorities (some of whom had been care workers for more than ten years) expressed concern and some surprise at the lower wages some of their colleagues in the independent sector were being paid. Regardless of the sector they work in, most home care workers are highly critical of employers who do not pay them for travel time or travel costs as they move between clients.

Other evidence suggests that good management can reduce staff turnover rates. In a study of home care commissioning, managers reporting low staff turnover explained that it was important to 'allow staff the hours that suit them, provide good support from management, and a sense of working as a team'. One voluntary-sector manager who recruited primarily from the local community and had very low staff turnover gave workers:

- pay of £7 per hour (with no enhancements for weekends)
- guaranteed hours
- mileage payment for travel
- team working in a locality with one supervisor per 12 workers, resulting in continuity of care
- close management support in case of difficulties
- spare time in the rota to deal with sickness (Matthew 2004).

There are no simple solutions to the problems of recruitment and retention in London's care workforce. However, part of the answer may lie in strategies that commissioners can deploy as they specify and fund care services and in the way providers deploy, manage and support their staff. Commissioners, for instance, need to stop squeezing providers by, for example, expecting home care staff to do quarter-hour slots, which reduces work satisfaction, and not paying enough to cover the real costs of employing and training staff. And providers themselves need to adopt flexible employment practices to suit the needs of their workforce.

Senior managers of care organisations

In the experience of this Inquiry, the management of care services receives rather less attention than the problems of recruiting and training lower-grade staff in the care workforce. 'Managers' were mentioned in the evidence submitted to the Inquiry only in the context of the problems experienced in recruiting managers with nursing backgrounds to nursing homes. Shortages of these managers with nursing backgrounds were reported to have deterred some care providers from investing in new homes in London. Other research conducted by the King's Fund has confirmed serious difficulties with nurse vacancy and turnover rates in the capital (Hutt and Buchan 2005) and reported on the impact and implications of overseas recruitment drives (Buchan, Jobanputra *et al* 2004).

More care service managers than ever before are obtaining relevant qualifications, such as NVQ Level 4 in management and care. Nationally, in 2003 36 per cent of managers in local authority care homes held an NVQ Level 4 Registered Managers Award or were studying for it (Skills for Care 2005). One-third held other

The changing nature of the care market means that successful senior managers (or proprietors) of care organisations need to acquire entrepreneurial skills in order to develop their services

management qualifications, and 37 per cent had professional social work qualifications. There were no reliable figures about managers in independent care homes. This increase in managers' qualifications reflects a target set by the government following the introduction of the Care Standards Act 2000, whereby all registered managers are expected to hold an NVQ 4 or equivalent qualification by 2005. Given the demanding nature of the task of running care services and managing care staff, this trend in education and training must be welcomed.

However, the changing nature of the care market means that successful senior managers (or proprietors) of care organisations also need to acquire entrepreneurial skills in order to develop their services. This might mean expanding provision, diversifying into new community services that enable older people to live at home, or reducing or re-configuring residential services for which demand has fallen. More opportunities for managers to develop their business knowledge and skills are clearly needed; in the absence of such personal development among care providers, it is hard to see how the capacity and diversity of care services can change.

Filling this gap in management development will not, in our view, be a simple matter of managers taking generic business courses or receiving help and advice from consultants who know about business planning, marketing and so on. Any business development support must take account of the fact that most care service managers are experienced in running small care businesses; many have a nursing or social services background and have 'public-sector values'. The experience of the workforce development department of NELSHA indicates that, while some care service managers are interested in developing their business skills, they benefit from having a tutor or mentor who can help them interpret business development issues in the distinctive context of the changing policies and market conditions affecting health and social care.

Commissioners of care services

A study carried out for the Inquiry revealed that commissioning practice varies across the six London boroughs studied (Banks 2005). This reflects the different experience and expertise of the staff engaged in commissioning. In some local authorities, commissioning has been recognised as a key role only in the last few years and senior posts are relatively new. Some local authorities are finding it difficult to appoint and keep senior people with the necessary skills and experience.

PCTs are still relatively new organisations, and many acknowledge that staff are often new to commissioning (as opposed to contracting and procurement) and are sometimes inexperienced in working in partnership with local authorities. Health commissioners also hold a very wide brief relating to modernising the NHS, which often makes it difficult for them to undertake all the key components of effective care services commissioning.

Considerable experience and expertise are required to commission care services effectively. Staff need to be skilled in market management and to tune into a political environment where there can be great opposition to change as some services are decommissioned and new ones are developed. The role is even more complex and demanding where the NHS and local authorities have established integrated commissioning. As discussed in Section 6 (*see* pp 69–76), this requires

Commissioning staff report that they are more likely to be effective when working in a well-led and well-managed team of people with clear roles and responsibilities within social services departments and primary care trusts

a sophisticated understanding of how the whole health, social care and housing economy works and an ability to work across organisational boundaries, and cultures and political priorities. When staff with these aptitudes are in short supply, it is hard to see how efforts to transform the care system can be successful.

The ability of even the most skilled and experienced commissioning staff to make a difference can be impaired by organisational arrangements that hamper their efforts. As we saw in Section 6 (*see* pp 69–76), changes have been taking place in the way local authorities and PCTs work in partnership to commission care services for older people. Unfortunately, both only embarked on integrated commissioning comparatively recently, and as a result the roles and responsibilities of commissioning staff are not always clear. At times, staff can find themselves involved in commissioning that is 'integrated' in name only, as they essentially work to one of the organisations in the partnership. Commissioning staff themselves report that they are more likely to be effective when working in a well-led and well-managed team of people with clear roles and responsibilities within social services departments and PCTs (Banks 2005).

We conclude that increased opportunities are required for commissioners to develop their knowledge and skills so that they can be more effective in bringing about change. Both central and local government recognise the importance of developing commissioning practice. During this Inquiry, the Department of Health's Change Agent Team, in co-operation with the Association of London Government, ran a series of master classes and other learning opportunities for commissioners in the London area. It is not clear what impact these courses had, or whether they might be continued and developed.

Better education and training for individual staff will not be sufficient. The evidence suggests that further thought needs to be given to the way the commissioning process is organised and to how staff work within and across two separate organisations. Authorities can gain much by learning from each other about good practice and new ways of working.

Key points

- **Committed and caring staff** Many care staff are committed to their work, derive great satisfaction from helping people and develop strong rapport with older people and their carers.

- **Skills and qualifications** Increased numbers of care staff are gaining qualifications that demonstrate their competence, but the majority are still unqualified. Staff employed by small care organisations in the independent sector experience particular difficulties in accessing training leading to NVQ qualifications, as do care staff with English as a second language and those who have poor literacy and numeracy.

- **Recruitment and retention** Vacancy rates for care staff in residential care and home care services in London are well above the average for England. Staff turnover is also high. This adversely affects continuity of care for older people. It also creates problems for employers, the majority of whom report that they are finding it difficult or very difficult to recruit care staff. The problem appears to be more acute in the affluent suburbs.

- **A multi-cultural workforce** Around 60 per cent of care workers in London are from ethnic minorities, most describing themselves as black African, black Caribbean or black British and smaller proportions as of Asian or Chinese origins. A large but unknown proportion of care workers come from overseas, some of whom are well qualified in their home countries, most of whom speak English as a second language. There are clear benefits to having a multi-ethnic workforce, but difficulties can also arise in terms of racism experienced by staff and poor communications between staff and service users.

- **Managers' business skills** More care service managers than ever before hold or are studying for management qualifications. But many lack the knowledge and skills required to expand or diversify services to meet changing demand.

- **Commissioning skills** Some commissioners are enthusiastically engaged in the complex task of reshaping the care system, decommissioning services that are no longer needed and developing new ones. But many lack expertise in market management and experience in working in a political environment where there can be great opposition to change.

8 Finances

What is spent on caring for and supporting older Londoners?

Expenditure on care services for older people is big business, amounting to an estimated £1.6 billion in London in 2003/04. As Table 12 below shows, most of this (almost £1.2 billion, 73 per cent) consisted of spending by local authorities, that is, public spending. Purely private spending (excluding an unknown amount spent on aids and adaptations and so on) is estimated at £265 million (16 per cent). However, if user charges for local authority funded services (£196 million) are added, the local authority share reduces to 60.5 per cent and the private share increases to 29 per cent. NHS expenditure on continuing care and on free nursing care in care homes amounts to £176 million (11 per cent).

TABLE 12: ESTIMATED PUBLIC AND PRIVATE EXPENDITURE ON CARE SERVICES FOR OLDER PEOPLE IN LONDON, 2004

	Gross spend £ million	of which, user charges £ million
Local authorities[1]		
– care homes	567	157
– home care	275	24
– other	331	15
Total local authority	1,173	196
NHS[2]		
– continuing care in NHS hospitals and care homes	120	0
– free nursing payments to care homes	56	0
Total NHS	176	0
Private[3]		
– care homes (net of NHS free nursing)	175	
– home care/home help	90	
– other (aids and equipment, etc)	NA	
Total private	265	
GRAND TOTAL	1,614	

[1] Department of Health archive of local authority PSS expenditure 2003/04.
[2] Estimates 2004/05.
[3] Estimates 2004/05 from Laing & Buisson database.

Comparative spending in London and England

London local authorities spend proportionally more on care services for older people than their counterparts in the rest of England. As Table 13 overleaf shows, inner London authorities were the highest net spenders on personal social services for older people in 2003/04, spending £1,063 per person aged 65 and over

(deprivation adjusted). Outer London authorities spent £852 per person, while the all-England average was £727 per person. This means that on average inner London authorities spent 46 per cent more per person than the England average, and outer London authorities 17 per cent more; the all-London average spending was 28 per cent more per person.

TABLE 13: NET TOTAL COST PER PERSON AGED 65+ (WEIGHTED POPULATION) OF OLDER PEOPLE'S SERVICES TO LOCAL AUTHORITIES, 2003/04

	Inner London	Outer London	Greater London	Metropolitan boroughs	England
Assessment and care management	£175	£137	£152	£80	£95
Nursing care placements	£159	£137	£145	£116	£115
Residential care placements	£257	£237	£245	£251	£260
Supported accommodation	£9	£6	£7	£4	£3
Direct payments	£3	£5	£4	£2	£3
Home care	£295	£223	£251	£180	£176
Day care	£84	£51	£64	£41	£39
Equipment and adaptations	£12	£9	£10	£10	£10
Meals	£21	£14	£17	£6	£7
Other services	£48	£33	£39	£11	£20
TOTAL	£1,063	£852	£934	£702	£727

Source: Laing 2005, data from Department of Health archive on local authority personal social services expenditure.

Initially, it would appear that care services for older people in London are better resourced than elsewhere. However, further analysis is required to take account of specific London circumstances.

For a fair comparison, net spending per person needs to be adjusted further to take account of two factors: price differences, and the prevalence of low incomes in London, which impact on the extent to which service users can pay charges. The question is: does higher spending by London boroughs on personal social services for older people reasonably reflect higher prices and the lower income generated from user charges? There is no clear answer.

On the one hand, multiplying the 2004/05 Formula Spending Share (FSS) weightings (*see* pp 91–92) for prices (Area Cost Allowance) and income (Low Income Top-up) indicates that inner London's cash requirement per person aged 65 and over (weighted population) during that year would have been 56 per cent higher than the average for England. However, actual spending in 2003/04 was 46 per cent higher. The corresponding figures for outer London are 31 per cent additional cash requirement compared with 17 per cent higher spending. On the face of it, therefore, these comparisons suggest that London boroughs may be 'underspending' on older people's services in comparison with England as a whole.

On the other hand, there is a case that the allowance for prices in the FSS (*see* pp 91–92) is too high. The FSS Area Cost Allowance for most inner London boroughs was set at 29 per cent above the England average in 2004/05. However, Laing & Buisson's view is that the care home cost premium should be about 20–25 per cent. Furthermore, a significant proportion of care home placements are outside London, where prices tend to be lower. In addition, the price premium actually paid by inner London boroughs for home care appears to be substantially lower than the FSS Area Cost Allowance. According to Performance Assessment Framework (PAF) data for 2003/04, the average gross cost for home help and home care in inner

London was £13.50 per hour, just 5 per cent higher than the England average of £12.90. One reason for this relatively small differential may be that more home care is outsourced in London: 76 per cent in contrast with 66 per cent in England (*see* also Table 3).

Net expenditure by local authorities on care services for older people increased year on year between 1997/98 and 2003/04 across England. But expenditure in London rose more slowly. The disparity was particularly high in 2002/03; net current expenditure in England rose by 12.9 per cent, but by only 5.7 per cent in Greater London. The increased costs of care home places were the main reason for this spending explosion; the net bill for nursing care placements rose by 22 per cent (but by 11 per cent in London), and for residential care placements by 17 per cent (London 6 per cent). About half the increase in England was caused by the transfer of preserved rights' residents (in other words, people funded by income support when the Community Care reforms were introduced in the early 1990s) to local authority budgets from April 2002, for which the Department of Health provided additional grants. The other half can be attributed to the rising cost of care home places. Local authorities began to pay higher fees as care homes closed, shortages of local beds increased, and there were fears about the stability of the care home market. London authorities were less exposed to these forces because fewer London residents are placed in care homes and because they were already paying higher fees for care home places.

However, changes in the cost of care homes do not fully explain the disparities in the rate of increase of net expenditure. English local authorities pushed up their net spending on home care services by 7 per cent in 2002/03, compared with just 3 per cent in London.

All this suggests that England as a whole has caught up slightly with London's expenditure on services for older people in recent years. This is not to say that London is falling behind, since the capital still spends more per person, as discussed above.

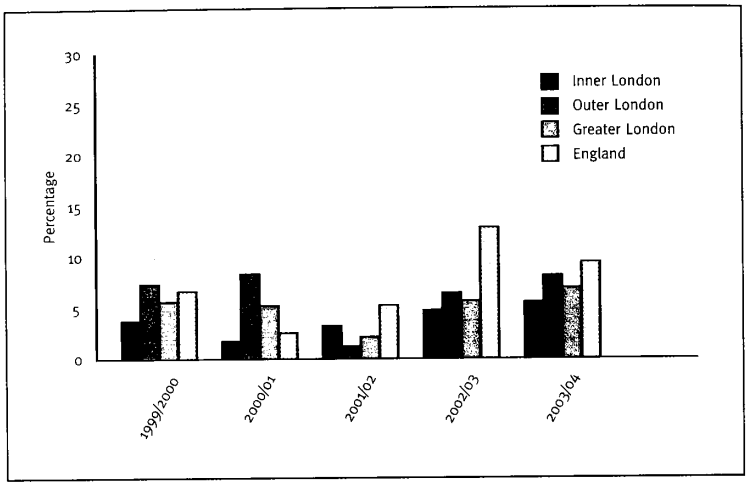
Spending in London

In its Comprehensive Spending Review in 2002, the government increased its allocations to personal social services by 9 per cent per annum in cash terms for three years beginning in 2003/04. However, in 2003/04, when this increase should have started to flow through the accounts, actual expenditure on services for older people in London did not increase at that rate. As Figure 14 overleaf shows, spending increases that year were significantly lower in the inner London boroughs (5.6 per cent on average) than in English authorities as a whole (9.5 per cent); the outer London boroughs were not far behind, with an average 8.2 per cent increase.

What explains the relatively low growth in inner London? Can it be attributed to a relatively low increase in central government grants or to decisions by individual boroughs not to prioritise older people's care services and to use the increased funding for other forms of social care? Unfortunately, changes in the government's method of distributing grants make this question difficult to answer. In 2003/04, Standard Spending Assessment (SSA) formulae were replaced by Formula Spending Share (FSS). At the same time, indicative allocations to personal social services were increased by £1.1 billion in order to re-base them at the level of historical spending. This had run significantly above SSA because of 'overspending' on

Capital expenditure on care homes and extra care housing by local authorities is relatively low because private and voluntary sector investors raise most of the capital required

14 PERCENTAGE INCREASES IN CURRENT EXPENDITURE BY LOCAL AUTHORITIES ON PERSONAL SOCIAL SERVICES FOR OLDER PEOPLE, 1999/2000 TO 2003/04



Source: Laing 2005, data from Department of Health archive on local authority personal social services expenditure.

children's services, while local authorities had historically 'underspent' on services for older people. There were also significant changes in local authority functions at the time. All these factors combine to complicate analysis of year-on-year changes in grants and spending. Such indicators of relative change as can be extracted point to differing conclusions. Thus London's FSS grants in 2003/04 for all personal social services, compared with the SSA for 2002/03, rose by 3 percentage points more than England's. On the other hand, London's FSS grants in 2003/04 for all older people's services, compared with the SSA for 2002/03, fell by 2 percentage points more than England's (the overall fall was a result of re-basing).

Therefore the best that we can say is that there is no good evidence that London underspends compared with elsewhere.

Local authorities can set high levels of charges for home care and other community services and offset these against their expenditure. There is little evidence that this happens in inner London. As Table 14 opposite shows, inner London councils in 2003/04 recouped a relatively small proportion of their gross spending on older people's community-based social services from charges to users. For instance, income from home care charges – the largest non-residential expenditure head – was only 6 per cent of gross expenditure in inner London, compared with 11 per cent in outer London and in England as a whole. This is to be expected given the high levels of deprivation in inner city areas.

Capital expenditure

Capital expenditure on care homes and extra care housing by local authorities is relatively low because private and voluntary sector investors raise most of the capital required. All London authorities have divested themselves of most of the care home stock they used to own. However, some London local authorities have recently increased their investment in nursing homes through partnerships with private investors, recognising that local provision is insufficient and that the private

TABLE 14: CLIENT CONTRIBUTIONS AS A PERCENTAGE OF GROSS TOTAL OF LOCAL AUTHORITY EXPENDITURE ON OLDER PEOPLE'S SERVICES, 2003/04

Expenditure head[1]	Inner London	Outer London	Greater London	Metropolitan boroughs	England
Assessment and care management	0%	0%	0%	0%	0%
Nursing care placements	28%	28%	28%	32%	31%
Residential care placements	24%	30%	28%	28%	31%
Supported accommodation	1%	6%	4%	7%	6%
Direct payments	2%	2%	2%	2%	3%
Home care	6%	11%	9%	9%	11%
Day care	2%	5%	3%	5%	5%
Equipment and adaptations	9%	6%	7%	13%	5%
Meals	29%	41%	36%	31%	41%
Other services	1%	3%	2%	35%	10%
TOTAL OLDER PEOPLE[2]	14%	19%	17%	21%	22%

Source: Laing 2005, data from Department of Health archive on local authority personal social services expenditure.
[1] includes SMSS costs (overheads) allocated to service lines on a pro-rata basis.
[2] excluding Supporting People.

sector will not invest in high-cost parts of London without some incentive. There are examples of Private Finance Initiative nursing home developments in Greenwich, Richmond-upon-Thames and Westminster.

Spending on housing-related services

Public expenditure on supported housing is also relatively low – unsurprising given the low numbers of units in London as a whole. However, some London local authorities were allocated funds by the Department of Health and the Office of the Deputy Prime Minister to develop more extra care housing in 2003/04 and 2004/05.

It is not possible to quantify the amount local authorities and their health partners spend on housing-related support such as equipment and other assistive technology. The Integrated Community Equipment Services Support Team, established in 2001 by the Department of Health to encourage PCTs and local authorities to co-ordinate the delivery of equipment in the community, has collected information about expenditure on community equipment within local authorities. However, Molyneux and Leather (2005) do not place great faith in the data – returns are said to be inconsistently calculated and many are incomplete – and 2004's figures are considered unreliable. In 2005 the government announced that £80 million would be made available for assistive technology from April 2006; it is estimated that £200,000 of this will be allocated to each London borough (Department of Health 2004a).

No information is available on the total expenditure in London, or in England as a whole, on 'handyperson schemes'. In a survey it conducted in 1995, the Joseph Rowntree Foundation found 63 such schemes operating in England. It has been estimated that there has been a threefold increase in the number of these schemes since then, as home improvement agencies have focused less on small repair and maintenance jobs around the home and more on larger-scale, grant-aided renovation and refurbishment work (Molyneux and Leather 2005).

The national Supporting People budget in 2003/04 was £1.8 billion. Some £340 million of this was allocated to supporting older people, and some of this was used

Evidence from social services directors indicates that pressures on services for children and families can lead to resources intended for older people being diverted to other purposes

to fund extra care schemes. The proportion of households receiving Supporting People services in inner London was similar to England as a whole: 111 and 119 households per 1,000 people aged 65 and over (deprivation weighted). But, as Table 15 below shows, the proportion of outer London households (58 per cent) receiving this support was only a little more than half the English level. Inner London authorities allocated over twice as much Supporting People funds per household in the 65-plus population (deprivation weighted) as the average for authorities throughout England (£88 and £40). By contrast, outer London authorities spent roughly the same as authorities in the rest of England, even though prices are higher in London. In 2004, the government reduced the funds available for Supporting People. At the same time London authorities are trying to shift expenditure from sheltered housing towards providing extra care housing and floating support workers to support people wherever they live, in other words in ordinary or sheltered housing.

TABLE 15: SUPPORTING PEOPLE: GRANT ALLOCATIONS BY CLIENT GROUP, 2003/04

	Inner London	Outer London	Greater London	England
	Household units in receipt of Supporting People funding per 1,000 weighted 65+ population[2]			
Older people with support needs	111	69	85	119
Frail elderly	12	4	7	4
Older people with mental health problems	0.2	0.1	0.2	0.2
	Allocations of Supporting People funding per 1,000 weighted 65+ population[2]			
Older people with support needs	£88	£37	£57	£40
Frail elderly	£9	£3	£6	£3
Older people with mental health problems	£1	£0	£1	£1

Source: Laing 2005, data from Office of the Deputy Prime Minister. www.spkweb.org.uk

[1] Estimated population aged 65 and over in 2005/06, unadjusted for age or deprivation.

[2] Weighted population relates to population aged 65 and over weighted for age and deprivation (but not service costs, ability to pay user charges or 'sparsity') as in the 2005/6 FSS older people's formula and scaled to the England population.

How does spending compare with need?

It is difficult to assess the relationship between spending and need. But actual expenditure by local authorities can be compared with the financial allocations from central government, which are made according to a formula that reflects needs. Until 2003/04, comparing the government's allocations based on SSAs with expenditure by local authorities frequently showed that councils across the country were underspending on social services for older people. SSAs have now been discontinued, and it is no longer possible to make those comparisons.

However, comparing the new funding allocations based on FSS with social services budgets for older people shows that most authorities in England and in inner and outer London as a whole set budgets for 2004/05 that closely matched FSS and other grants (*see* Table 16 opposite). However, the 2004/05 budgets of some individual London authorities suggested that they were planning to spend well below what central government assessed them as needing to spend; for example, Lambeth budgeted to spend just 73 per cent of its central government allocation on older people's social services. Evidence from social services directors to the Inquiry indicates that pressures on services for children and families can lead to

TABLE 16: CENTRAL GOVERNMENT'S GRANT ALLOCATIONS WITH LOCAL AUTHORITY BUDGETS FOR EXPENDITURE ON OLDER PEOPLE'S SOCIAL SERVICES, 2004/05

	Inner London	Outer London	Greater London	Metropolitan boroughs	England
	£ million 2004–05				
A) Personal social services FSS for older people plus major grants predominantly for older people*	433	571	1,004	1,601	6,459
B) Budgeted net current expenditure by CSSRs on older people's personal social services	415	546	962	1,540	6,251
Ratio: B) divided by A)	0.96	0.96	0.96	0.96	0.97

Source: Laing 2005.
* Major grants predominantly for older people include Preserved Rights Grant (England = £458m), Access and Systems Capacity Grant (England = £457m), Carers' Grant (England = £125m) and Delayed Discharges Grant (England = £100m).

resources intended for older people being diverted to other purposes. The budgets in a few other London boroughs (such as Ealing and Richmond-upon-Thames) indicated plans to spend more than the FSS allocation plus other grants.

Budgets and actual expenditure are, of course, entirely different things. At the time of writing, there was no information about the out-turn expenditure for 2004/05. However, it is entirely possible that, as in previous years, some London authorities will spend less than their FSS allocation on older people's care services and less than they intended to when they set their budgets at the start of the financial year.

Could public money be spent more efficiently?

Following the Gershon review of public-sector efficiency (HM Treasury 2004, *see* p 34), the government took the view that local government (including social services) could spend money more efficiently, particularly in the way it procured services from the independent sector. It required councils to achieve 2.5 per cent efficiency savings in their social services budgets for 2004/05. London authorities are taking seriously the need to demonstrate their efficiency and, under the auspices of the London Centre for Procurement Excellence, are examining the scope for savings in 'back office' costs, largely by reducing transaction costs associated with large numbers of spot contracts with independent care providers. It remains to be seen what savings might be made.

Even if savings are possible, there is no reason to think that overall expenditure on adult social care will be reduced, given the funding pressures currently being experienced by London local authorities.

Funding pressures

In their evidence to the Inquiry, both the Greater London Association of Directors of Social Services and the Association of London Government referred to funding pressures on social services and to the intense competition for limited resources to meet the cost of responding to children and families in need, high levels of mental ill health, and the need for safe neighbourhoods for all. They report that capping has restricted councils' ability to raise more funds through the council tax, and that local government funding formulae have left 'many boroughs at the floor in the allocation of government grant'. They claim that a combination of factors have created 'a position where the needs of our elderly population continue to be greater than the available resources'.

We do not know precisely how much older Londoners spend on care services from their own pockets. But Laing & Buisson have estimated that it amounted to £461 million in 2003/4

Several organisations taking part in the Inquiry argued that, even though large sums of public money are used for older people's care services, the base line is too low to meet needs adequately. This was the view of the Association of London Government and also of a large number of voluntary organisations. Others have argued elsewhere that substantial increases in social care funding are required, in line with the historically high increases awarded to the NHS in 2001 (Henwood 2001).

Opinion is divided about whether there are sufficient funds to meet the care needs of older people in London. Certainly, Dr Stephen Ladyman, who was the Parliamentary under Secretary of State for Community during our Inquiry, did not think so when he spoke at one of the Inquiry's hearings. He stressed that social care must deliver within the budget set by the comprehensive spending review (CSR). However, he also stressed that dialogue between departments was important for maximising the use of resources on services for older people.

Given the evidence in this report of shortcomings in the volume and quality of local care services in London, we take the view that, at the very least, London authorities are struggling to make best use of the resources they have. We are not able to say how much more money is required. However, we do note that the Commission for Social Care Inspection has suggested that, on a national scale, local authorities are facing financial pressures that indicate that an additional £729 million will be needed for older people's services in 2006/07, rising to £1.2 billion in 2007/08 (Commission for Social Care Inspection 2005).

There have been intense debates about levels of funding for social care. Many organisations have called for a review like that undertaken by Derek Wanless on NHS funding in 2000. We welcome the fact that Wanless began a review in 2005 for the King's Fund. However, he will not be assessing the adequacy of current funding but will be examining the level of resource needed to meet demand in 20 years.

In the absence of substantial increases in public funding for older people's services in the near future, attention inevitably focuses on private funding and on whether more might be mobilised to ease the difficulties that individuals and public authorities are experiencing.

Private expenditure

Because the relevant data are not routinely collected, we do not know precisely how much older Londoners spend on care services from their own pockets. But Laing & Buisson (2005) have estimated that it amounted to £461 million (including user charges) in 2003/4. Although substantial private expenditure on community-based care services, care homes and rented extra care housing is much lower than public expenditure (*see* Table 13).

It is impossible to say how much Londoners pay privately for home improvements, or for assistive technology. Community alarms are the only exception; more than 150,000 people in London pay an average £4.50 per week for the services of a care line (London Boroughs Care Lines Group 2004, Douglas Miles, personal communication).

Few older Londoners have the resources to pay care home fees, or for substantial packages of care at home, out of their ordinary income. More than two in every five (42 per cent) of single pensioner households in London had a gross income of less

than £200 per week, and 64 per cent of pensioner couple households had a gross income of less than £400 per week. Furthermore, few have any substantial savings – only 18 per cent of single pensioners and 33 per cent of pensioner couples have savings of £20,000 or more (*see* also Figures 2 and 3, p 15).

The incomes of older people with care needs can be boosted by welfare benefits, such as Attendance Allowance. But it is worth noting that, unlike younger adults with disabilities, older people are not entitled to a Disability Living Allowance, which includes money to help with mobility costs. Harding (2005) argues that this amounts to age discrimination and results in keeping incomes of older people below what is needed to compensate for the costs of ill health and disability.

However, many Londoners do have substantial amounts of money tied up in their owner-occupied home. Older outer Londoners are particularly well placed, since they enjoy slightly higher rates of home ownership than the average for England, as well as significantly more valuable properties (£223,000 on average in 2004 – *see* Table 17, below). Older home-owners owned £39 billion of property at 2004 prices in outer London and a further £13 billion in inner London. Ninety per cent of this property was unmortgaged (Laing 2005).

TABLE 17: PROPERTY PRICES, LONDON, 2003

Inner London	Outer London	Greater London	England
	Mean property prices 2003[2]		
£301,000	£223,000	£252,000	£159,000
	Median property prices 2003		
£225,000	£190,000	£200,000	£132,500

Source: Laing 2005, data from Land Registry.

A small but growing market in housing equity release schemes is being used to fund a range of goods and services. Nationally, the value of annual sales of equity release mortgages rose from £127 million in 1998 to £1,161 million in 2003. In 2004, some 25,000 people in England used cash released from housing equity to purchase a range of goods and services (Key Retirement Solutions 2004). Much of this was spent on home improvements; the rest was allocated to holidays, a new car and so on. How much of the 'home improvements' goes on stair lifts and other equipment or adaptations to aid the mobility of disabled people is not known. But it seems that very little – if any – of this money is used to fund care and support services.

At the moment at least, housing equity release does not appear to be being taken up by significant numbers of older home-owners with modest care and support needs but who do not meet local authority eligibility criteria for public support, and do not have sufficient income to allow them to pay for the care they need.

Views about the funding of care services

Some older people participating in this Inquiry made it clear that they are perfectly willing to pay for services, providing they are affordable. This point of view has been borne out in other studies and surveys of older people in London (Levenson and Joule 2005). However, some older people and carers, together with voluntary organisations working with older people, expressed their opposition in principle. They regard it as unfair that people with ill health and disability – through no fault

Who is entitled to free NHS continuing care (as opposed to means-tested social care) is not always clear either to older people and their families or to staff responsible for assessing eligibility

of their own – should have to pay for or towards the cost of their care. At the same time, a large minority of the older people who submitted evidence to the Inquiry made it clear that they are worried about their ability to pay for residential care should they or their spouse need it. This controversial subject was raised time and time again during the Inquiry.

The funding system is also felt to be very confusing. Who is entitled to free NHS continuing care (as opposed to means-tested social care) is not always clear either to older people and their families or to staff responsible for assessing eligibility. During the Inquiry, PCTs were reviewing funding decisions that had been made some years earlier, following a ruling by the Health Ombudsman, who found that some older people had been wrongly charged for their care when it should have been provided free by the NHS. Staff of PCTs taking part in the Inquiry's commissioning study (Banks 2005) complained about the huge amount of work involved and the fact that the system was 'in a mess'.

Key points

- **High expenditure and high costs** Considerable resources are spent on care services in London – £ 1.6 billion in 2003/04 (almost three-quarters of which entailed public sector funding). London local authorities are comparatively big net spenders on care services for older people, spending more per person than the average for England. Expenditure is higher than average, particularly in inner London, because prices are higher than elsewhere and because levels of deprivation restrict local authorities' capacity to raise income from user charges.

- **Diverting resources from older people's services** In the past, local authorities were often found to have underspent on services for older people, spending more instead on children and families services. It is not clear whether that continues to happen or on what scale. In most cases, budgets for 2004/05 were in line with or above central government allocations. Looking at actual expenditure for that year, it is impossible to tell one way or the other, as central government simultaneously increased funding for social care and changed the allocation formula, which led to some London authorities having their central grants reduced. Social service directors nevertheless acknowledge that, in some parts of London, resources for older people continue to be diverted because of pressures on services for children and families.

- **Capital expenditure on care homes and extra care housing** A small number of new nursing homes and extra care units are coming on stream, using public/private partnerships and special housing grants from central government. However, capital investment in care services is restricted in London as investors in the private and voluntary sectors are less likely to be able to make a reasonable return on their investment through fees, rents and sales because of high land and property values in the capital.

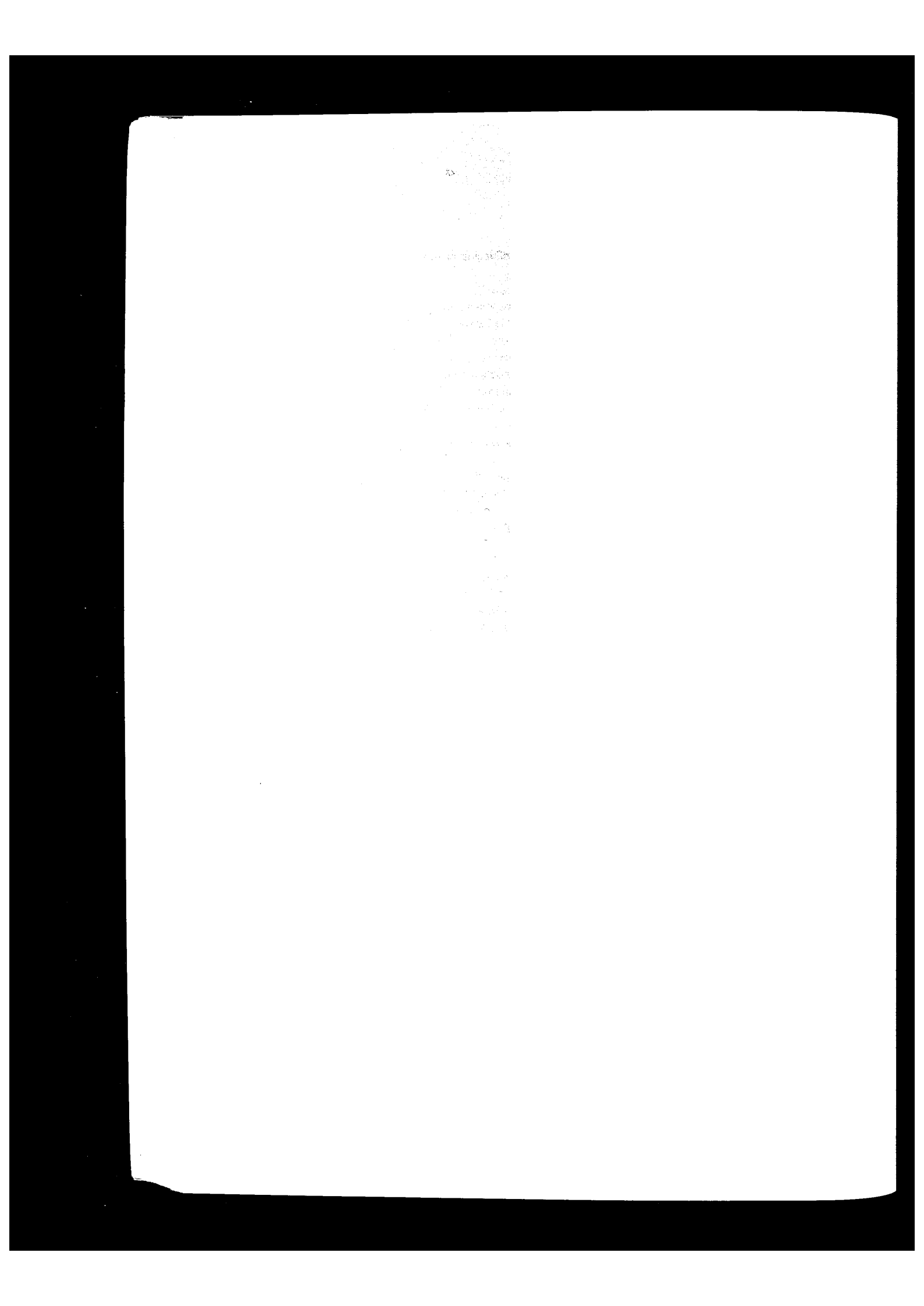
- **Housing-related support** It is not known how much is spent on assistive technology and handyperson schemes undertaking small repair and maintenance jobs around the home. Practical support in the home is available through the Supporting People programme, but older people in outer London are far less likely to receive this support than their counterparts in inner London. Much of the funding is tied up in sheltered housing and local

authorities are experiencing difficulties in releasing money to use on floating support workers.

- **Private resources** Individuals spent an estimated total (excluding user charges) £265 million on care services in London in 2003/04, two-thirds of which was spent on residential care. However, few older Londoners have incomes that would allow them to pay for care services out of their own pockets for any length of time. This applies to many home owners who are cash poor but asset rich. Very few of them have opted for housing equity release schemes that would enable them to use part of the value of their homes to pay for care and support.

- **Funding pressures** Social services directors and London councils report that budgets are under pressure, and there is evidence that they are struggling to meet the needs of all but the most dependent older people. Many organisations claim that there are insufficient resources in the care system as a whole. Some local authorities are exploring whether and how resources could be used more efficiently by reducing 'back office' and contract transaction costs.

- **Views about the funding of long-term care** Older people and carers have mixed views about paying for services out of their pockets – some being willing provided they are affordable, others being opposed in principle. There is widespread confusion about who is entitled to free NHS continuing care, as opposed to means-tested social care.



Part three
Facing the future

In Part 3, we look to the future, considering the prospects for the care of older people in 20 years. We examine the options for improving the current care system and make recommendations for action in the short and the longer term.

Introduction

This report has presented a picture of a flawed care system that fails to meet the needs of many older people in London. In this section of the report, we look ahead and consider what changes may occur in the immediate and longer term future.

We begin by considering whether care services can be expected to improve or deteriorate over the next 20 years, examining factors that will affect demand for and supply of care and support for older people. Our analysis includes:

- changes in the age, health, and ethnicity of the older population in London
- expectations of care among people who are in their fifties now and who may start to need care and support in 20 years' time
- shifts in the balance between residential care and home care services
- the availability of private resources to pay for care that is means tested
- financial pressures in social care and supported housing.

We conclude that future prospects for the care of older people in London look extremely challenging. Demand for care is mounting, and the pressures on public and private resources needed to respond to those demands are increasing. While the current position of care services in London is a matter of grave concern, the future looks even worse.

Next, we explore what should be done in the immediate future to improve care services for the current generation of older people and for those who will come after them. First, we analyse the causes of the problems afflicting care services, identifying:

- failures in the care market
- public policies that disadvantage older people
- public and private funding of care services that is insufficient, uncertain and lacking in transparency.

We then consider options for tackling these problems and end with 30 specific recommendations for action by central, regional and local government, the NHS, regulatory bodies, private and voluntary sector organisations and agencies responsible for education and training.

9 Future prospects for the care of older people in London

Having spent a good deal of time examining what was happening to care services in 2004, the Inquiry was keen to look ahead and see whether older Londoners can expect care services to improve or deteriorate over the next 20 years. It is notoriously difficult to predict the future in five years' time – let alone over the next two decades. Nevertheless, we have examined the evidence available and taken a view about what is more, or less, likely to happen.

All the signs are that more people will need care and support and that more money and services will be required in order to deliver the same level of care as now.

Will more people need care and support?

Looking at the future population of London, there is no reason to suppose that current patterns of inward and outward migration will change very much in the next 20 years. London's demographic profile is therefore projected to remain relatively young.

However, the number of older Londoners may increase substantially during that time. By 2028 there will probably be almost 1.1 million people in London aged 65 and over, out of a total population of about 8.5 million (*see* Table 18 overleaf); this represents an increase of 300,000 (34 per cent) over 2003. The number aged 85 and over will grow by 65 per cent, from 108,000 in 2003 to 166,000 in 2028.

The proportion of black and minority ethnic elders in London's older population is also expected to increase as those currently aged 50 to 64, who form a larger proportion of their age group, grow older. For example, in 2001, 5.6 per cent of the older (65 and over) population in London was of Asian origin (Indian, Bangladeshi, Pakistani or other), while 9.8 per cent of the 50–64 age group was of Asian origin.

It is impossible to be certain about the future age profile of London's population, and these projections need to be treated with caution. Projections made in 1996 envisaged virtually no increase at all in inner London's older population over the next 20 years. Much depends on the assumptions built into the calculations. But, in the absence of any other projection from a reliable source, we are inclined to accept that offered by the Office for National Statistics.

On the basis of these population projections, Laing & Buisson (Laing 2005) have suggested that the volume of demand for care services will increase by 31 per cent in London between 2004 and 2024 (23 per cent in inner London and 35 per cent in outer London). This is illustrated in Figure 15 overleaf, where current age-specific usage rates have been applied to projected future populations.

This picture could be markedly different if the risks associated with the need for care were to change substantially. For instance, the health of the older population may be better in 2024 than it is now, as the generation born during and just after the

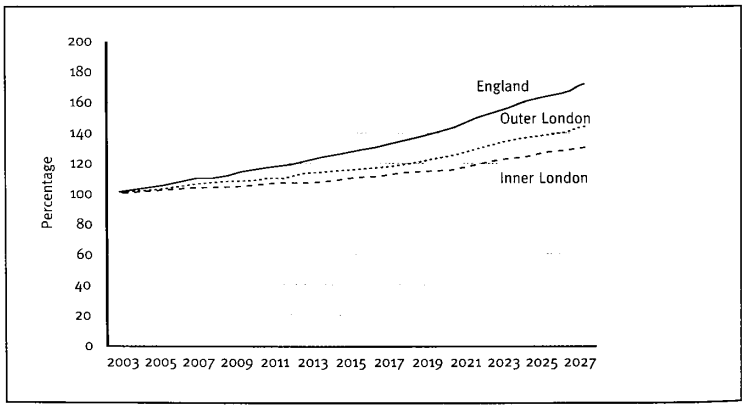
Most of the baby boomers who took part in our focus groups believed that they will enjoy good health for longer in old age than their parents did

TABLE 18: PROJECTED DEMOGRAPHIC PROFILE OF LONDON AND ENGLAND, 2003–28

		2003 (thousands)	2008 (thousands)	2013 (thousands)	2018 (thousands)	2023 (thousands)	2028 (thousands)
England	<65	41,909	42,633	42,759	43,101	43,430	43,344
	65–74	4,159	4,304	5,020	5,471	5,431	5,902
	75–84	2,852	2,873	3,037	3,274	3,924	4,293
	85+	936	1,114	1,244	1,404	1,618	1,858
	All ages	49,856	50,923	52,059	53,249	54,403	55,397
Greater London	<65	6,489	6,720	6,908	7,095	7,245	7,318
	65–74	467	457	500	541	560	633
	75–84	316	307	313	321	361	393
	85+	108	120	127	137	152	166
	All ages	7,380	7,604	7,847	8,094	8,319	8,510
Inner London	<65	2,612	2,735	2,848	2,951	3,029	3,070
	65–74	153	148	155	164	173	201
	75–84	99	95	95	97	105	112
	85+	32	35	37	39	43	46
	All ages	2,896	3,013	3,134	3,251	3,350	3,430
Outer London	<65	3,877	3,986	4,060	4,144	4,217	4,248
	65–74	313	309	345	377	387	433
	75–84	217	213	218	224	256	281
	85+	76	84	90	98	109	120
	All ages	4,483	4,592	4,713	4,843	4,969	5,081

Source: ONS. Principal, 2003-based sub national population projections.

15 PROJECTED[1] VOLUME OF DEMAND FOR CARE (INDEX, 2003 = 100)



[1] Projected by applying 2004 age-specific usage rates for care homes for older people to projected future populations.

Second World War reaches its 70s and 80s – the age when care needs usually start to increase. These baby boomers may enjoy longer periods of good health in old age, having benefited from higher standards of living than those experienced by pre-war generations. Certainly, most of the baby boomers who took part in our focus groups (Levenson *et al* 2005) believed that they will enjoy good health for longer in old age than their parents did. This belief was particularly strong among

TABLE 19: PERCENTAGE OF RESIDENT POPULATION AGED 50–64 BY ETHNIC GROUP, 2001

	Inner London	Outer London	Greater London	England
White:				
British	58.3	71.6	67.2	91.0
Irish	6.6	4.8	5.4	2.0
Other	10.3	5.3	7.0 2.1	
Total	75.2	81.7	79.6	95.1
Mixed:				
White and black Caribbean	0.3	0.2	0.2	0.1
White and black African	0.3	0.1	0.2	0.0
White and Asian	0.4	0.4	0.4	0.1
Other	0.5	0.3	0.4	0.1
Total	1.5	1.0	1.2	0.3
Asian or Asian British:				
Indian	3.0	7.2	5.8	1.5
Pakistani	1.2	1.5	1.4	0.6
Bangladeshi	2.3	0.3	1.0	0.2
Other	1.3	1.8	1.6	0.3
Total	7.6	10.8	9.8	2.6
Black or black British:				
Black Caribbean	7.2	3.0	4.4	0.9
Black African	4.5	1.4	2.5	0.4
Other	0.4	0.2	0.3	0.1
Total	12.1	4.6	7.2	1.4
Chinese or other ethnic groups:				
Chinese	1.2	0.8	1.0	0.3
Other	2.2	1.1	1.4	0.3
Total	3.4	1.9	2.4	0.6

Source: 2001 census.

second-generation black and minority ethnic groups; the exception was people of Bangladeshi origin, who felt that their lives in this country were much harder than they had been for their parents in the 'old country'. If these expectations become reality, overall future demand for long-term care services would fall.

The evidence to support this scenario is not very strong, particularly given the current incidence of health inequalities among younger generations. These suggest that some (poorer) sections of tomorrow's older generation will experience various forms of chronic ill health. The healthy living initiatives currently being implemented may make a difference. But such measures are more likely to make a dramatic impact on the health of the population when they are targeted at young people rather than at middle-aged or older people.

New breakthroughs in medical technology may prevent or cure conditions such as Alzheimer's disease and other dementias. Given the time it takes to discover new treatments and to test them for safety before they are made available to the public, it seems unlikely that the prevalence of dementia among older people will have declined markedly in 20 years. On the contrary, we can expect dementia to continue to take its toll on the older population. By 2024, we can expect more older Londoners to experience this condition. Currently, dementia affects 1 in 20 people over the age of 65 and 1 in 5 over the age of 80 (Alzheimer's Society 2005).

Most middle-aged participants in our study wanted to be able to receive care and support in their own home – although some appreciate that circumstances might make residential care a safer, more practical option

All in all, it is likely that demographic pressures will increase the demand for care in the future.

Will the next generation of older people have different expectations of care services?

It is often assumed that, when they become old and start to need care and support, the baby boomer generation will think and act very differently from their parents. Research commissioned for this Inquiry suggests that assumptions of different expectations can be overstated (Levenson *et al* 2005).

Middle-aged Londoners taking part in our study were clear about how they wanted to live their lives in advanced old age and what they expected of care services, should they need them. Overall, their views and aspirations were very similar to those of today's older people. They want to live independent lives, and to determine what happens in their life; to have close and regular contact with family and friends (but not to depend on them); and to continue to learn and engage in social and educational activities. They were very explicit about wanting care services that facilitate their autonomy and their participation in family and community life. These broad requirements are very similar to what older people up and down the country have been saying over the last five years and more (Levenson *et al* 2005).

When thinking more specifically about care services that might be needed in the future, middle-aged people placed much emphasis on the different lifestyles they lead compared with their parents. They saw themselves as enjoying different kinds of food and taking part in a different range of leisure and cultural pursuits. They thought it would be very important for care services to treat them as individuals and enable them to maintain their lifestyle. They also expected to be able to exercise choices much as they already do as users of commercial (and more recently public) services. While some thought that they would not want to put up with the standardised, poor-quality services provided for their parents' generation, some recognised that failing health and low income could restrict their choices and their capacity to demand something better.

In terms of choosing where to live, most middle-aged participants in our study wanted to be able to receive care and support in their own home – although some appreciate that circumstances might make residential care a safer, more practical option. There were also mixed views about giving up their current home and trading down to a smaller house or a flat; some of those owning their own home were already contemplating that possibility. Equally, there were different expectations about continuing to live in London (which some regarded as an exciting, vibrant place) or moving out on retirement.

It is difficult to know how much credibility to give to what people say they will want in 20 years' time. After all, this kind of research is asking people to express views about something they have not experienced and about which they may know very little. Comparing the views of different generations is also fraught with difficulties. Baby boomers and the current older generation may hold very similar aspirations about how they want their lives to be in old age and how care services should accommodate these expectations. But the baby boomers may live in a different time when their capacity to get what they want is enhanced or diminished.

The baby boomer generation may well turn out to make different demands of care services and to be more assertive in voicing those demands. Much will depend on their power and influence in the care market at a time when failing health may have dented their self-confidence, when their knowledge about care options may be seriously limited, and when their buying power may make them more or less dependent on public bodies acting on their behalf.

Will more care services be needed?

Most older people needing care and support are helped by their families and friends. Far fewer older people use formal care services that employ paid care workers. Demand for these care services would increase dramatically if family carers stopped caring for their spouse, parents or other relatives. There are no signs that that is about to happen. However, there could be less informal care in the future if women become less willing to take on that role, and if better employment opportunities make it more difficult for them to provide intensive care and support for family members. Feelings of duty and obligation towards older relatives could also diminish as divorce and re-marriage loosen familial ties. And smaller family sizes, combined with greater labour mobility, could mean that there will simply be fewer relatives living nearby to offer care and support.

The only evidence the Inquiry collected on these issues came from what middle-aged Londoners taking part in our study said about their expectations of care from their families when they grow older. They stressed that they do not want to have to rely on their adult children's support and, more to the point, most made it clear that they believe that their children will be less willing and able to take on intensive caring responsibilities. Some black and minority ethnic participants pointed out that a further fall in the number of extended families living together and greater mobility associated with employment opportunities are likely to reduce their children's capacity to care for them in older age (Levenson *et al* 2005).

Of course, what people believe will happen and what actually happens are two quite different things. Others who have looked in detail at informal caring projections do not anticipate a collapse in informal care. For instance, the report of the Royal Commission on Long Term Care (1999) was more optimistic, while conceding that there is a 'funnel of doubt'. We too think that we are unlikely to see any dramatic falling away of informal care over the next 20 years, assuming that no catastrophic events (such as war or natural disaster) take place. It can therefore be expected that care services will need to continue to support family carers in the future, in order to help them to continue caring and to prevent their own health and well-being deteriorating unavoidably.

Will the balance of services be the same?

It is possible that all the care services that are so familiar to us today – residential, home and day care – will expand at the same rate to meet increased demand. This could happen as a result of inertia or lack of imagination on the part of local authorities and private payers. In other words, people may continue to buy what they have always bought. If this is so, services in 20 years will not look very different from today's. Nor will the balance of care in London between care homes and home care have changed very much.

However, if the thrust of policy on the social care of adults continues in the same direction as in recent years, we would expect to see increased opportunities for older people to receive help in their own home instead of going into residential care. For that to happen, there will need to be more home care services and more extra care housing. The home care workforce will have to expand. That looks entirely possible providing new sources of labour come into the care market. For instance, workers from the European Union accession countries could increase the number of foreign nationals already employed in London's care workforce; and relatives, friends and neighbours of older people receiving Direct Payments might be encouraged to work in this area. However, in the absence of better pay and conditions, and also of enhanced investment in education and training, questions about the quality of the home care workforce would remain. And shortages of skilled workers needed to support people with complex needs would continue to bedevil the provision of care.

There are also limits on how far home care services can expand. While it is possible to provide care and support at home for older people with high dependency needs, until now the cost of doing so on a 24-hour basis has been regarded as prohibitive. This suggests that there will still be a place for care homes.

Although the number of care home places may have fallen across England, there is an argument that there is a need for more places in London, particularly in nursing homes, to accommodate the increasing number of older people with complex needs and also to reverse the practice of placing older people in homes outside the capital. However, it is hard to see how expansion can happen in view of the shortage of reasonably priced land and property. In addition, there seems no end to the staffing problems that currently afflict the care home sector.

It is reasonable to expect more social extra care housing to be available for rent in the future. This assumes that government will continue actively to promote such developments and that local authorities will continue to recognise the merits of this form of supported housing as an alternative to traditional care homes. However, it is hard to see how the stock can increase dramatically in London unless the housing priorities of central and regional government change, planning barriers are lowered or removed, and shortages of affordable land and property are overcome.

There are also barriers to the development of leasehold extra care housing in London. Buying is not feasible for most older people living in inner London; only 20 per cent own their own home, which they could sell to pay for a leasehold extra care unit. Even in outer London, where home ownership is above the national average and suitable land is cheaper than in central London, only a small minority of older people are likely to be able to afford to buy extra care housing and to pay the service charges.

This lack of affordability derives from the value of the property older Londoners own and from their average income. As Laing & Buisson point out (Laing 2005), the typical service charge for a leasehold extra care unit is about £5,000 per annum – a sum that would 'absorb a substantial, often unaffordable, share of older households' income'. The majority of older people cannot afford these service charges. As Figure 2 (*see* p 17) shows, more than three-quarters of single pensioner households have a gross weekly income of less than £400, as do two out of three households with a pensioner couple.

Some older people are expected to have substantial savings and investment income; but these are likely to be a very small minority

When purchasing sheltered housing, older people usually 'trade down' from a larger property. However, Land Registry records show that there are proportionally fewer sales of detached and semi-detached houses in London than in the rest of England. Most properties in London are flats or terraced houses whose value may not be much more than a new extra care housing unit. For instance, the small number of extra care flats on sale in outer London in 2003 cost about £210,000 for a one-bedroom unit and £275,000 for a two-bedroom unit. The mean value of all residential property that changed hands in outer London that year was £223,000; the median value was £190,000. This suggests that few older homeowners in London can hope to sell their home and buy extra care housing within the capital. Most would have to move to a cheaper area outside London.

Will more resources be needed to pay for care?

We anticipate that the pressures on public expenditure will increase, driven by the demographic factors discussed above and by the inflationary impact of the Care Standards Act on the costs of staff and buildings. These pressures will be even greater if local government decides to increase capital investment in nursing homes and/or extra care housing.

A dramatic increase in older people's ability to pay for their own care would diminish these demographic and other pressures. However, there seems little prospect of older people receiving better pensions. On the contrary, the Pensions Commission (Turner 2004) concluded that in 20 years' time many people will face 'inadequate' pensions in retirement as occupational pensions become less generous and funded pension saving continues to fall. Some older people are expected to have substantial savings and investment income; but these are likely to be a very small minority. Overall, older people may well have lower income and savings in 20 years than they do now (*see* Figures 2 and 3, p 15).

Supporting People funds could be used to enable older people to pay for small amounts of low-level support at home, in the form of 'floating support workers' or equipment and other assistive technology. However, most Supporting People funds are currently tied up in sheltered housing, and will have to be freed if they are to be used for floating support schemes in an individual's own home. That may well happen over the next few years. However the longer-term future is decidedly less clear, since the government may not continue the Supporting People programme.

While the prospects for older people's income and savings are not particularly encouraging, the future does look more hopeful in one respect: the substantial sums of money that many older people will have tied up in their home. By 2030, about three-quarters of all people aged 45 and over are expected to own their own home (Turner 2004). However, this high rate of home ownership is unlikely to happen in inner London; it would be wise to assume that the owner occupation rate there will remain about half the national average.

These property-related assets could have two effects. First, if a greater proportion of older people entering residential care own their own house, local authorities' expenditure on care home places will decrease commensurately, as home owners will be ineligible for public support. Unfortunately, this is not likely to benefit inner London local authorities as much as councils elsewhere. In any case self-payers in inner and outer London are likely, as they do now, to move to a cheaper care home

outside the capital. This in turn means that London authorities (particularly in inner London) will have to meet the care needs of proportionally more older people with low incomes and assets.

Second, housing equity could be realised, through housing equity release schemes, and the proceeds used to pay for care and support (or indeed other goods and services required in retirement). A lot of hopes for the future funding of care and support services are resting on housing equity. Though the current market is relatively small, the value of equity release mortgages has risen substantially since the late 1990s: from £127 million in 1998 to £1,161 million in 2003. It has been predicted that new business will double to £2 billion in 2010 and quadruple to £4 billion in 2031 (Equity Release Working Party 2005). New regulatory arrangements under the Financial Services Act 2000 and the move to 'no negative equity guarantees' may also increase public confidence in equity release products. So far, however, there is little evidence that equity release is being used to fund care; the latest figures show that most is spent on home improvements, holidays and new cars (Key Retirement Solutions 2004).

The prospects of equity release increasing substantially to finance care are not promising. The Pensions Commission was downbeat about the terms and conditions involved and argued that equity release may 'remain trapped in a small, high price, sub sector of the market'. It also pointed out that many older people resist housing equity release because they want to bequeath their housing assets to their children. The Commission recognised that many younger people rely on inheriting their parents' housing assets to bolster less than adequate pensions and have sufficient income in their own retirement (Turner 2004). Others, such as the Rowntree Foundation, are more optimistic about how far older people in the future might use housing equity to fund their own expenditure in retirement (Rowlings 2005). The Rowntree Foundation points to new research showing that bequeathing property is becoming less important to newer generations of older people.

There are intense debates about releasing housing equity to fund care. On balance, in the absence of major changes around housing equity, it seems to us safe to assume that strong pressures on public expenditure on care services will continue. We cannot say precisely how much more public money will be needed. But it seems likely that year-on-year inflation-only increases are unlikely to be sufficient, given the historically high levels of investment in the NHS and the fact that local authorities now appear to be struggling to meet the needs of older people in their communities. Further modelling is required to achieve a better picture of the future resources needed; we are pleased that Sir Derek Wanless will be doing this in his review of social care funding for the King's Fund in 2005/06.

Will care policy be different?

It is entirely possible that social care, health and housing policies affecting older people will have changed in some way or other over the next five years and that this will have an impact on the care and support they need. Looking forward to 2024 is almost impossible. However, in the absence of any radical welfare reforms, it is probably safe to assume that care policies will still be underpinned by a commitment to market mechanisms and that public bodies will still be primarily responsible for commissioning care services. It is certainly hard to envisage any wholesale return to the public sector as provider of social care services, even if adult social care were merged with the NHS. Indeed the pressure to keep costs

Future prospects for the care of older people are extremely challenging. Demand for care is mounting, and the pressures on public and private resources to respond to these demands is increasing

down and to obtain value for money suggests that more use will be made of the private and voluntary sectors as care providers than happens now.

With the public sector continuing to be responsible for the strategic commissioning of care services for local populations, it is reasonable to expect the commissioner workforce to develop greater knowledge and skills – if only because the role of commissioner will be a more established career. Whether there will continue to be so many commissioners working at local level is unclear. We may see a concentration of expertise (and leverage with providers) at regional or sub-regional levels. Such concentration would work against the trend in the NHS, where commissioning is set to become more fragmented as practice-based commissioning is introduced. In any event, integrated commissioning will become much more complex, and the management of markets even more challenging, especially if older people make greater use of individual budgets (as proposed in the government's 2005 Green Paper) and this leads to care markets diversifying and fragmenting further. (A person with an individual budget is informed about the amount of resources they have been allocated following an assessment of their needs, and is then involved in decisions about how those resources should be used to purchase services on their behalf.)

However, other drivers are likely to lead to greater market consolidation. On the provider side, it seems almost inevitable that there will be fewer small-scale businesses; the cottage industry that dominates the care sector will give way to corporate businesses, which can keep overheads low and invest in staff training and development. As the market consolidates, small local concerns capable of responding to local needs will be driven out of business, and new organisations, such as those offering specific services for black and minority ethnic communities, will be prevented from entering the market. The result may be less variety and innovation and therefore fewer options for older people.

Whether older people can expect to have greater influence on care services – either as consumers or as participants in planning – remains to be seen. In its Green Paper, the government proposed a new vision for social care for adults and indicated that extending Direct Payments and introducing 'individual budgets' for older people will be at the heart of its reforms. We cannot yet judge whether the ideas put forward constitute radical change. What is clear is that, without radical reforms, older people's choice and control over care services will not increase.

Our conclusions are that future prospects for the care of older people are extremely challenging. Demand for care is mounting, and the pressures on public and private resources to respond to these demands is increasing. While the current position of care services in London is a matter of grave concern, the future looks even worse, and real change is not in sight.

Key points

Future prospects for the care of older people in London are extremely challenging. Demand for care is mounting, and the pressures on public and private resources needed to respond to those demands are increasing. While the current position of care services in London is a matter of grave concern, the future looks even worse.

- **Demand for care services** can be expected to increase because of:
  - a substantial increase in the population aged 85 and over. Numbers will increase by 54 per cent, from 108,000 in 2003 to 166,000 in 2028.
  - the ageing of people from black and ethnic minority communities. For instance, by 2028 older people of Asian origin will form 9.8 per cent of the older population.
  - poor health among disadvantaged groups and the particular demands of people with dementia.

- **Care and support from families** Overall, the incidence of informal care is not likely to change dramatically, despite divorce rates and women's continued participation in employment. There is likely to be less support from 'live-in carers' among some ethnic minority groups, as the number of extended families living together falls and as greater mobility associated with employment reduces the capacity of children to provide intensive care for their parents.

- **Expectations of care** What the next generation of older people wants from care services is very similar to the requirements of older people today. They want services to enable them to lead independent lives, to exercise choice and control over services, and to participate in family and community life. They want services that fit their chosen life-styles and some are determined not to put up with the standardised, poor-quality services provided for their parents' generation. They believe they will be more assertive than their parents.

- **The balance of care services** Home care services and extra care housing will need to expand substantially, offering an alternative to residential care. More care home places will also be needed to accommodate increasing numbers of older people with complex conditions and to offer older people the choice of a place in London that is close to family, friends and familiar surroundings.

- **Pressures on service supply**
  - More skilled care workers will be needed. But shortages and quality concerns are likely to continue, in the absence of better pay and conditions and enhanced opportunities for education and training.
  - The growth of extra care housing and of care homes will be restricted unless changes are made in housing policy, planning barriers are lowered and shortages of affordable land and property are overcome.

- **Finances**
  - Demographic factors and the inflationary impact of the Care Standards Act will drive up the costs of care.
  - Pressures on public expenditure will increase, as fewer older people than now will have sufficient income from pensions and savings to pay for their own care.
  - There will be more older home owners with substantial amounts of money tied up in housing equity. This will not lead to any substantial decrease in local authority expenditure on care homes, as home owners needing residential care will continue to opt for cheaper places outside London. Home ownership in inner London is likely to remain at around half that of the rest of the country.
  - The current market in housing equity release may grow, enabling older people to draw down part of the value of their homes in order to pay for

home improvements and practical support in the home. But, unless attitudes to inheritance change, together with the terms and conditions of financial products available, there is no prospect of substantial increases in private resources coming into London care services.

- **Care policy and markets**
  - Governments will continue to rely on market mechanisms in the care sector, and public bodies will be responsible primarily for commissioning care services using public money. It is likely that integrated commissioning and market management will become even more complex, as services are purchased by strategic bodies, practitioners and individual service users.
  - The cottage industry that dominates the current care sector will give way to corporate businesses that can keep overheads low and invest in staff training and development. The latter may be less able to respond to local needs and to specific ethnic groups.
  - It is not clear whether older people can expect to have greater influence on care services – as consumers or as participants in strategic planning. Greater take up of Direct Payments and individual budgets could increase consumer power in the future.

10 Pressing problems and options for change

In the preceding chapters, we identified major shortcomings in current care services for older people and argued that these problems are likely to intensify over the next five to twenty years. The questions are: why are these problems occurring and – given that most of what we have found will come as no surprise to people working in this field – why are they such a long-standing feature of care services for older people?

As we examined the way the care system in London works, we were struck by how far the problems we observed are related to:

- **Market failures** that restrict capacity and diversity in local care services; that limit older people's choice and control over the care services they use; that provide no incentives for care providers to offer quality services that older people value highly; and that treat carers as a free resource, with little recognition of the costs they bear when providing care and support to older people.
- **Public policies that disadvantage older people**, seeing them as dependent, as passive recipients of welfare, and as lesser citizens than their younger counterparts. These policies lead to low expectations of older people's quality of life and of the care and other public services that can enhance their opportunities to lead a full life. Ageism is also reflected in policies and practices that discriminate against older people and that fail to uphold their human rights and to recognise how communities need to be shaped to accommodate an ageing population.
- **Insufficient public and private finances in the care system** to meet the needs of older people requiring care and support, and a funding system that lacks transparency and certainty. These result in restricted access to care and support, confusion and controversy about entitlements to care, and barriers to planning ahead for care in old age.

These systemic problems require action by governments. Saying this does not deny that many of the problems we have identified can be laid at the feet of individual workers or organisations that have failed to do a good job. On the contrary, we have presented in this report abundant evidence of the limitations of the care workforce, and also of provider and commissioning organisations. However, we maintain that the day-to-day operation of care services must be seen in the context of policies and resources that determine what can be achieved on the ground.

We examine here each of these systemic problems in turn and consider some of the options for overcoming them.

Market failures

Our critique of care markets should not be interpreted as a wholesale rejection of market relationships within the care system. On the contrary, we agree with Netten *et al* (2005) that in the past the market has proved to be very responsive to

demand, resulting in a rapid expansion of care homes in the 1980s and of home care services in the 1990s and a shift from institutional care to community services over the last decade. Competition between multiple care providers and better targeting have also enabled local authorities to achieve value for money in purchasing services provided by private and voluntary sector organisations.

However, the market is characterised by a number of weaknesses. These restrict older people's choice and control over care services and prevent services responding to what individuals need and want. These market weaknesses include:

- older people's weak consumer power
- underinvestment in market capacity and diversity
- a lack of incentives for care providers to deliver quality services.

Older people's weak consumer power

Older people occupy a weak position in the care market for three reasons.

First, they do not have the full information they need to make informed decisions about their care. They need to know what is available to help them; what they are entitled to; and how they might best use their personal resources (financial and social support) to secure the help they need. Limited mental capacity or crisis circumstances may prevent some older people identifying and articulating what would make their lives better. They have to rely on intermediaries to provide that information and to advise on the pros and cons of various options. As we discussed earlier, their access to the full range of information and advice they need is restricted.

Second, the majority of older people lack buying power. Most have a low income and could not hope to pay the real costs of care over a long period. That is why the majority of older people who use care services are funded in part or in full by public money.

This brings us to the third reason why older people have weak consumer power. They do not have any direct control over how these public funds are used to pay for care services. Local authorities buy on their behalf, and instruct care providers what they should do for the money they are paid.

We take the view that the public sector should intervene to strengthen older people's position in the market by:

- improving access to independent needs assessment, service brokerage, financial advice and advocacy
- giving older people greater control over the public money allocated to them following an assessment, so that they can choose how to spend it; what they ask care providers to do; and when, and whether, to switch to another service if their current one is unsatisfactory.

Access to information and advice

At the moment, a variety of specialist and generic information products and services, plus assistance from 'service brokers' or 'navigators' who guide them through the maze and obtain services on their behalf, help some older people become better informed about their options. However, as we have seen so often in this Inquiry, this sort of provision is partial and fragmented. There are major gaps

The ambiguous situation of carers tends to make their position in the care market fragile, if not invisible. Yet it is carers who are left to cope with market failings

in, for instance, financial advice that is readily available to all older people who need it. There are also very limited opportunities for older people to have one-to-one discussions with workers who can give them the information they need about care options, advise on their entitlements, help them decide how best to use their personal resources, and help to organise or buy the care and support they choose. In theory, social workers should act as brokers or navigators for people receiving public support. In practice, however, more often they act as rationers, not as brokers. Self-funders also have very limited access to good service brokerage. Furthermore, where social services have provided this kind of help, service users have not always been confident about the independence of the information, advice and service brokerage offered.

Many of these problems also apply to carers. (Between one-third and half of all unpaid care for older people is provided by carers living in the same household, the vast majority of whom are spouses (Milne *et al* 2001). Carers do not have adequate information about where to find help; they are often on a low income, particularly when they have supported a spouse or other relative over a considerable period; and they do not have any control over how public funds are used to pay for care services. Indeed, many of these carers are older people themselves.

The ambiguous situation of carers tends to make their position in the care market fragile, if not invisible. On the one hand, they are consumers or users of services. These may be services specially provided for them, such as carer centres; or services such as home care that are provided for the older person but also indirectly support them as the carer. On the other hand, carers are seen as a resource and an 'informal provider' within the care system. This dual position can mean that carers' own needs are ignored – they are viewed neither as the prime consumer nor as a formal provider. Yet it is carers who are left to cope with market failures.

We recognise that the government has already set up new initiatives to alleviate these market failures. The Department for Work and Pensions' Link-Age programme will offer older people on low incomes information and advice about their financial situation, including pensions, pension credits, and welfare benefits related to disability. Multidisciplinary teams from The Pension Service and local authorities will help older people claim all the monies they are entitled to and at the same time carry out financial assessments for care services. This will help older people to maximise their income and will also prevent them having to provide the same personal information twice.

Another initiative supported by the Department for Work and Pensions focuses on planning ahead for retirement. The Financial Services Authority's Building Financial Capability Project will pilot new information products (for example, a 'beginners' guide' to retirement planning) and face-to-face impartial advice. Information targeted at people in their 50s could explain financial products such as long-term care insurance and equity release schemes. Generic advice would be given (for example, key questions you need to ask about the pros and cons of particular products), not recommendations of specific courses of action. The Financial Services Authority is also developing a new service offering a 'financial health check' for people at different stages in their lives.

These developments are helpful. But much more needs to be done to ensure that all older people – whatever their financial circumstances – have access to the full range of timely, appropriate and good-quality information and advice they require,

especially when they know they are going to need some kind of care and support. This is equally important for older people on low incomes and for those who do not require income support. We are concerned that a relatively large group of older people, who do not meet the eligibility criteria for publicly supported care services, will continue to find it difficult to access information and advice. These are people with a low to moderate income; they may have a small occupational pension and own their own home, and they are expected to fund their own care. In this respect they need just as much support as their poorer counterparts: personal income and assets do not make it any easier to acquire the right information and advice to decide about care and support and to obtain the services that suit specific personal circumstances.

Increasing choice and control

We believe that encouraging older people to opt for Direct Payments will increase their control over the public money allocated to pay for their services. However, they will also need appropriate support services to help them find and employ personal assistants and other forms of help in the home.

That said, we do not believe that all older people will want or be able to use Direct Payments. So we support other arrangements, such as 'individual budgets', that should extend greater control to older people without the burden of employing care staff. Their success will largely depend on how easy it is for older people to use them and on what the allocated budget can buy. For example: can the budget only be used to 'buy' home care assistants, or can it be used for a range of social care, health care or housing-related support? We favour any arrangement that maximises the choice and control older people with care needs have, and we therefore support the more ambitious model of individual budgets.

There is much to be learned from the UK and abroad about how such budgets could give greater choice and control to older people and to their carers. Giving individuals a budget to control does not automatically push up expenditure. On the contrary, all the evidence suggests that older people may spend less than the budget allows, but on services that they want and value. However, there are real challenges in setting individual budgets. In Germany and Japan, for instance, funding entitlements are based on the individual's capacity to perform activities of daily living (Geraedts *et al* 2000; Creighton, Campbell and Ikegami 2003). Adopting that system here could significantly change the pattern of who gets resources and who does not, since entitlements refer to levels of (mainly) physical functioning and are based on a 'medical model' that tends to minimise mental impairments and does not consider social risks.

We note that the government proposes to extend Direct Payments and individual budgets to all adults needing social care (Department of Health 2005). At the time of writing, it is consulting on these proposals and on other ideas about improving access to information, advice and service brokerage. It remains to be seen how the government's new vision for social care will be taken forward.

Options for change

It is tempting to think about setting up new organisations and creating new workers to provide independent information, advice and brokerage for older people. We do not consider this to be either feasible or necessary. It would be better to build the

London care markets fail to deliver an adequate quantity and variety of care services because demand from both the public sector and self-payers is insufficient to stimulate investment in an adequate supply of services

functions (rather than the institutions) that need to be expanded and extended to older people into a network of existing organisations. Designated workers should exercise a brokerage role, helping older people to navigate their way to the appropriate source of specialist information and advice; then, if required, they should secure and co-ordinate the combination of goods and services that the older person has decided they want.

Whether these service functions are located in the public, private or voluntary sectors is less important than their funding and governance arrangements. The market cannot ensure that care service users are better informed. We therefore believe that public money should be used to fund information, advice and brokerage services and so strengthen the position of older people as informed consumers of care. The workers involved should be seen to be independent and impartial and to be acting in the interests of older people alone, with nothing to gain for themselves (either directly or indirectly) from the information and advice they provide.

Some observers claim that such impartiality is possible only if information and brokerage services are located outside the authorities responsible for determining who should have access to public funds. This argument does not entirely convince us. It is perfectly possible for statutory authorities to build 'Chinese walls' around certain functions in order to minimise conflicts of interest. Equally, service brokers must have the authority and leverage they need to negotiate effectively in the care system. In the past, service brokers operating in the voluntary sector have sometimes lacked the leverage necessary to negotiate care packages for individuals. We do not opt for any particular organisational arrangement. However, we do recommend that any new proposals for service brokerage should be judged on how far they meet the principles of impartiality, transparency and credibility. Where impartiality is in doubt, the provision of independent advocacy should be considered.

Under-investment in market capacity and diversity

London care markets fail to deliver an adequate quantity and variety of care services to meet the diverse needs of older Londoners. The market is not responsive because demand from both the public sector and self-payers is insufficient to stimulate investment in an adequate supply of services.

In these circumstances, we argue for more public investment. Revenue funding should be used to help new small care enterprises start up, expand or diversify into new care services; more investment is also required in training and development for care workers, managers of care services and commissioners. Capital investment should be used to fund new care homes and extra care housing in or near the communities where people live.

Investment in care businesses

Increased investment is needed to develop a wider variety of care services that will enable more older people requiring care and support to remain in their own homes. Services are particularly needed for people from black and minority ethnic communities and people with specialist needs such as dementia or complex physical needs that require nursing care. More home care and day services are needed, combined with support for carers. Some of these services should be

We believe that the Department for Trade and Industry, possibly in co-operation with the Office of the Deputy Prime Minister, should set up a care business development service

specialist, serving particular groups and requiring staff with different types of skill and expertise. Others would be generalist, mainstream services that serve particular localities or neighbourhoods, or operate across wider areas than one borough, depending on the numbers and concentrations of people needing care and support.

Many of the independent organisations that currently provide home and day care are small cottage industries employing fewer than 25 staff, many of whom work part time (Matthew 2004). In contrast with the relatively few large corporate care providers operating in this field, many of the smaller organisations lack the resources they need to expand, diversify and market their services and to train and develop their staff even to national minimum standards. Following the introduction of new national minimum standards for care services, it is now even harder for new businesses to start up and to develop new care services for particular niche markets.

In the care home sector, larger organisations supply over half of London's care home capacity, although there are still a large number of proprietors who own and run one or two small care homes. These proprietors, especially those approaching pension age, have featured disproportionately in recent home closures. Those who remain in business may wish to expand or diversify their services or to specialise in a niche market, but often they, and the managers they often employ to run their care homes, lack the knowledge and skills they need to do this.

Options for change

Partnerships between the public and the private and voluntary sectors will increase care service capacity. This is primarily an issue for strategic regional, sub-regional and local commissioning. Commissioning bodies need to work with care providers, signalling the kind of services they wish to see developed and negotiating terms that share financial risks and offer some security to providers in the longer term. Also important is practical support for small businesses so that they can develop the infrastructure needed for service and staff development.

Some local authorities and primary care trusts (PCTs) offer this kind of support to small voluntary organisations willing to develop home care services for particular minority ethnic groups. However, this has been on a relatively small scale and, in some cases, short-lived as the authorities concerned changed their policies. Local authorities could use regeneration programmes to support the growth of small care businesses. So far, initiatives of this sort are limited in number, as local authorities in deprived areas of London prefer to support the development of high-value/high-skill businesses.

We believe that the Department for Trade and Industry, possibly in co-operation with the Office of the Deputy Prime Minister, should set up a care business development service. This would offer grants or loans, plus practical advice and support, to small care businesses wishing to expand or diversify their services in areas where there is a clear demand. This targeted extension of the Department of Trade and Industry's small business development function would form part of a wider programme to modernise the welfare state, and would also link with the Office of the Deputy Prime Minister's efforts to encourage local authorities to build new businesses in local communities.

Any public money committed in this way should be used to drive innovation, not merely to buy 'more of the same' kinds of community services operating within separate silos. This means stimulating a more flexible and versatile range of home care services, offering short and long term care, specialist services for particular groups, live-in and night-time rehabilitative and rapid response services, delivered by combined health and social care teams. In addition, the money should provide incentives for care staff to work in new ways to deliver better integrated care for older people.

Capital investment

The priority is to stimulate the growth of community services that will enable older people with care needs to stay in their own homes. However, some older Londoners will still need residential and nursing care homes, and others will want to move to some form of supported housing, such as extra care housing.

As we discussed earlier in this report, there are insufficient care home places and extra care housing units in the areas where older Londoners who need care and support live. These shortages disadvantage older people all over London. People with severe mental health problems and those with complex needs requiring 24-hour care are particularly affected. They (and their families) are compelled to look further afield in places where land and property values are lower than in London.

Increased capital funding is required to develop more local building-based care services for older Londoners who, because of their care needs or living conditions, cannot remain living in their current home. This investment is unlikely to be committed by private developers alone, as they will not get enough return on their investment in the form of fees, rents or leasehold sales. That might change if local authorities and their NHS partners (or self-funders) become willing to pay higher prices reflecting full market costs. Until now, there has been no sign of this. A level of public subsidy is clearly required to encourage increased development.

Options for change

New public and private partnerships have already begun in London to develop nursing homes and resource centres through the Private Finance Initiative. Other forms of partnership could 'subsidise' capital investment in care services. Public-sector land banks would use the sites of closing care homes or redundant health and community facilities (or trade them for other sites) to build new care homes or extra care housing financed by private developers or by providers of not-for-profit housing with care. A second possibility is to extend Local Improvement Finance Trusts (which involve partnerships between PCTs and property developers) to local authorities to develop nursing homes or health and social care centres offering a range of primary, community and residential services. Public planning authorities in London could also make greater use of planning gain agreements with developers, who might incorporate specialist supported housing for older people in their plans for general housing and/or commercial developments.

These partnerships would go some way to compensate for market failures. The risks involved would have to be evenly distributed between the public and private sectors, and they would have to demonstrate value for money. As with revenue support for the development of care businesses, public monies for capital investment would have to drive innovation, creating buildings-based services that

We believe that there is a case for increasing public funding for training care staff, channelling the money through workforce development departments in strategic health authorities

integrate health, social care and housing services for older people. Local authorities would also have to be willing to engage in these partnerships on a London-wide or a sub-regional basis to ensure that new developments are distributed according to local needs rather than local land prices. The prospects look encouraging, as both the Greater London Association of Directors of Social Services and the Association of London Government told our Inquiry that they favour exploring these options.

The alternative to these public/private partnerships is for local authorities, with their NHS partners, to raise the capital needed and to run the relevant services as 'in-house', publicly owned provision. While some authorities might prefer this, central government restrictions on capital expenditure in public services would limit their scope.

Investment in staff training and development

Additional public investment is also needed to build a competent care workforce able to meet the diverse needs of older Londoners. As we have seen, the care workforce in London relies heavily on large numbers of workers coming from overseas, for most of whom English is a second language. Many care workers, from both home and abroad, lack basic literacy and numeracy skills. These care workers need extra support to undergo training and achieve the qualifications care standards regulations require. However, small care businesses do not usually have the resources necessary to provide or pay for extra language and basic skills support.

Managers of care businesses also need more opportunities to develop the knowledge and skills they require to expand, diversify and market their services. This is essential if care market capacity and diversity are to be transformed to better meet the needs of older Londoners.

It would be short-sighted to focus staff development solely on the people who provide care services. Commissioners of care services in the capital often lack expertise in mapping demand and supply for care in their area, and in managing the market so as to transform the volume, range and quality of care services available for their local communities.

Options for change

The government has already made funds available for the training of social care staff in England through its Training Support Programme (TSP), which received grants of £57.5 million in 2002/03 and £56.5 million in 2003/04. While these funds were not intended solely for training care staff working with older people, Skills for Care and the Learning and Skills Council used some of the money to pilot schemes targeted at people with language and basic skills needs that maximise collaboration between small care businesses. We believe that there is a case for increasing public funding for training care staff, channelling the money through workforce development departments in strategic health authorities, which are responsible for developing both the health and the social care workforce in their areas. It would also make sense for these departments to sponsor training programmes aimed at integrated health and social care teams, in which care workers adopt an enhanced role beyond that of a basic 'care assistant'.

It is important to remember that many managers come from a nursing or social services background and find it hard to apply general advice on business development to the specific demands of the care sector. Business development advisers and trainers will need to combine their understanding of generic business skills with expertise in health and social care. As with social care workers, resources should be channelled through Skills for Care and workforce development departments in strategic health authorities.

New staff development opportunities, under the auspices of the Change Agent Team and the Association of London Government, for people involved in commissioning are encouraging. We believe that these voluntary, one-off master classes and courses should be translated into extensive education and training opportunities for commissioners in the health, social care and housing sectors.

We have discussed above increased public investment in buildings-based care, in care business development, and in workforce education and training. We recognise that this investment will need to be made through robust partnerships between public bodies and private and voluntary sector organisations running care businesses. These partnerships must be based on long-standing relationships of trust and confidence, where both partners deal openly and transparently with each other and share risks. These working relationships have already been agreed in the Building Capacity Concordat developed in 2001 (Department of Health 2001a); examples of good practice have also been promoted by the working group involving statutory, private and voluntary interests (Association of Directors of Social Services 2003b). This provides a strong foundation on which to develop greater capacity and diversity in London's care services.

We acknowledge that our proposals for more public investment in care services may be objected to on the grounds that the private sector could make large profits from that investment. These objections overlook the fact that many care businesses are run on a not-for-profit basis. Even so, the real argument is that increased public investment in private and voluntary sector care businesses would benefit the public good. First, increased capital investment would limit the damage done to older people whose social networks are ruptured when they are compelled to use care homes or extra care housing far away from relatives and friends. Second, both capital and revenue funding will create a wider range of care options to meet the diverse needs of older Londoners and fund a competent and safe care workforce. Third, investment is needed to prevent the care market in London collapsing, and to maintain a mix of small and large businesses capable of responding to the specialist and general needs of older Londoners.

This does not mean that we wish care services to be provided solely by the independent sector. On the contrary, we recognise the merits of a care system comprising services provided by statutory, voluntary and private organisations. However, given the mixed economy of care that has developed over the last decade, the priority now is to make the best of that system and to use public monies to tackle weaknesses in demand and supply that cannot be left to the market.

There are no financial incentives for care providers to offer the better-quality services that older people value. The fact is that services promoting independent living require more resources

Lack of incentives for care providers to deliver quality care services

In any market, two main levers ensure high-quality services. One is finance capable of covering the real costs of any service. The other is regulation, which requires services to meet certain standards or achieve certain results. In the case of care services, neither seems to be working very well.

Commissioners driving down cost at the expense of quality

We have identified a number of concerns about the quality of home care services and care homes older Londoners use. The root of the problem lies in the way local authorities and their NHS partners commission services from care providers. This usually involves specifying in some detail the activities that care staff will undertake over time. The focus is on outputs and activities, rather than on outcomes that indicate what services are expected to achieve in terms of the individual's choice, their control over their life, being assisted by competent and caring staff to carry out activities that matter to them, and feeling safe and secure. Commissioners use their dominant market position to keep the costs of outputs down, and are under pressure to show that they are using public money efficiently and are achieving Best Value. This is measured by comparing unit costs of services (home care contact hours, care home places), which to the purchaser are the same as prices.

We can see the result of this downward pressure on prices most starkly in home care services. Commissioners pay care providers to visit older people for very short periods of time to carry out personal care tasks. Older people and their carers express strong dissatisfaction with the service provided.

Options for change

A move to outcome-based contracting would improve service quality. This would involve commissioners providing funding to meet identified needs. However, the provider would have the flexibility to negotiate with the older person about what assistance to give and when. This would mean older people having a greater say in the care and support provided. Care workers would be required to work with older people rather than just do things to and for them. Commissioners would check that care providers were delivering the quality outcomes that older people value. In order to keep in business, care providers would have to operate in a way that promotes older people's independence and enables them to exercise choice and control and to pursue the lifestyle they choose.

There are no financial incentives for care providers to offer the better quality services that older people value. The fact is that services promoting independent living require more resources, mainly because it takes more time to help people do things for themselves and to negotiate what the care worker is to do on any given day. So far, few local authorities are engaged in outcome commissioning. Nor do they enhance the fees they pay with quality premiums that reflect care providers' proven success in delivering what older people expect and value.

These more flexible contracts would cost more. But the higher costs would be offset by greater staff stability, which would reduce the cost of high staff vacancy and turnover rates. To spend less on recruitment, hiring temporary agency workers and training new recruits, providers need to be able to hire staff who are attracted to

care work and who will stay longer with an employer who supports them in providing a quality service. The care staff who presented evidence to our Inquiry said that they would derive greater job satisfaction from work that maximises older people's independence and improves their quality of life – rather than just feeding or washing them and 'wiping bottoms'. They also said that how much they felt they were doing some good is one of the most important factors influencing their decision to stay in the care workforce.

A stronger focus on outcomes for older people can be achieved only through enduring, trust-based partnerships between commissioners and providers. Given that so many providers are relative newcomers to the care business, it may take some time before commissioners can be fully confident that care services will be delivered in this flexible, user-centred way. However, it is clear that mutual trust between commissioner and provider would be greatly enhanced if providers were offered longer-term contracts and paid fees that cover the real costs of good-quality care.

The carrot and stick of regulation

The Commission for Social Care Inspection could use its powers more proactively to encourage commissioners and providers to develop better quality services. So far, the Commission (and its predecessor, the National Care Standards Commission) has inspected services against national minimum standards that are more concerned with the built environment and with staff competence as indicated by educational qualifications than with the outcomes experienced by people using services. A greater focus on outcome-based standards would help to identify those services that really are delivering what older people want as well as those that are not and may need to be de-registered or closed down. This would require inspectors to spend much more time listening to older service users and their carers about their experiences and their views about how satisfactory services are.

Towards the end of our Inquiry, the Commission for Social Care Inspection made proposals for modernising the regulation of social care. It conceded that it has not focused enough on the experience of those receiving care and on whether services achieve good results (Commission for Social Care Inspection 2004a). At the time of writing, it was consulting on plans to change the way it works, so that it pays much more attention to finding out how far services meet service users' requirements. Whether the Commission will succeed in implementing its plans remains to be seen, as the organisation will merge with the Healthcare Commission in 2008. As with all restructuring, there is a risk that staff may be distracted by uncertainties about their future.

Public policies that disadvantage older people

We acknowledge the advances that social policies affecting older people have made in recent years. These include:

- The National Service Framework for Older People (Department of Health 2001c), which sets out standards for health and social care services currently being implemented in the NHS and social services.
- The Strategy for Housing Older People in England (Housing Corporation 2003), which sets out a broad approach to housing and services for older people in England, involving partnerships with social services, health and other

The Inquiry discovered a level of service for older people with care and support needs that would not be acceptable for almost any other section of the population

agencies; tackling age discrimination; listening to older people; promoting choice; addressing diversity; and developing new specialised housing.
- Quality and Choice for Older People's Housing: A Strategic Framework, developed by the Office of the Deputy Prime Minister and the Department of Health in 2002, which sets out five policy areas for development: diversity and choice, information and advice, flexible service provision, quality, and joint working.
- Preparing Older People's Strategies, which links housing to health, social care and other local strategies (Department of Health 2003c).

We also note the increased attention government is giving to issues concerning older people; these range from pensions and welfare benefits to transport, law and order, and leisure and lifelong learning opportunities. We welcome the cross-departmental co-ordination of policy affecting older people led by the Department for Work and Pensions (Department for Work and Pensions 2005).

At the very least, all these developments reveal a greater acceptance by government of the need to plan for an ageing society and to meet the wide-ranging challenges to the way older people have been treated in the UK.

However, the Inquiry discovered a level of service for older people with care and support needs that would not be acceptable for almost any other section of the population. We conclude that policies governing care services for older people continue to be based on low expectations of the quality of life people should be able to enjoy in their old age. These low expectations are revealed in the type and quality of care services currently funded from the public purse. Furthermore, failures to confront and combat ageism inherent in both social care policy and practice lead to older people being denied their rights as equal citizens.

The welfarist approach

Ever since the National Assistance Act of 1948, social care has been provided for a relatively small group of older people deemed to be dependent and deserving of public support. Community care policies emphasise dependency; they see older people in terms of the things they can no longer do because of failing health rather than the positive contributions that they have made and wish to continue to make to family and community life. Care services are designed to compensate for the impact of physical or mental impairment by providing staff or equipment to assist with daily living activities that the older person can no longer undertake by themselves. In this respect, the intentions – to assist those in need through no fault of their own – are benevolent.

But other components of the welfare approach have had adverse effects. What Andrew Cozens, past president of the Association of Directors of Social Services, has referred to as the 'long shadow of the Poor Law' hangs over social care, bringing with it means testing designed to sort out the 'deserving' (those who are ill or have disabilities) from the 'undeserving' (Cozens 2003). In practice, this means that publicly funded social care is mainly provided for the poor and for those without family willing or able to care for them. Given this focus on the welfare of dependent and poor older people, it is not surprising that care services do not aspire to high-quality standards or to the excellence that is a common goal of universal health care services.

The welfarist approach also constrains public expenditure, which is more and more directed at the most 'deserving', that is, those with the severest care needs and the least income or assets. Categorising those meriting help as in some way different from the rest of the population also compounds the social exclusion of older people who need care and support. It is considered appropriate to remove older people from their homes and communities and to place them in separate, congregate settings such as care homes and day centres. And, while living in a care home, even the poorest resident is left with very little money of their own to buy the things the rest of us take for granted: new clothes, outings, presents for grandchildren (Department of Health 2005). All this demonstrates that older people with care needs are not expected to enjoy the same life opportunities as other citizens.

It is true that more progressive, inclusive attitudes were evident in the Community Care Act 1990, which emphasised reducing institutional care and increasing opportunities for older people to remain in their own homes, supported by an array of community services. However, the resources needed to make that a reality for people with varying levels of care need have not been forthcoming.

Challenges to welfarism

We acknowledge that the direction of social care policies for older people may be about to change. Welfarist approaches are being challenged from two different perspectives.

First, a series of recent reports by the Association of Directors of Social Services, the Association of London Government and the Audit Commission have promoted an approach concerned not with the welfare of a few people with care needs but with the well-being of all older people (Joseph Rowntree Foundation 2004; Kendall and Harker 2002; Association of Directors of Social Services 2003a; Audit Commission and Better Government for Older People 2004). These reports have proposed developing universal public services that would prevent dependency and exclusion and enable all older people to lead full lives in their communities. These ideas effectively reposition social care within a network of mainstream services stretching across local government responsibilities: housing, transport, leisure and lifelong learning, safe communities. They also aim to integrate consideration of the needs and entitlements of all older people, including those with care needs, into mainstream policy areas.

Second, social care policy is being pulled in another direction to sit alongside health care. Ever since the NHS Plan 2000 (Department of Health 2000), the government has increased its efforts to integrate social care with primary and community health services; this has led to fears that social care would be taken over by the NHS. More recently, health policy, having been primarily concerned with acute care in hospitals, has increasingly focused on the management of long-term conditions in the community. New initiatives have been launched to identify people at risk of having to use hospital services, provide intensive case management for people with complex conditions, and encourage people to manage their chronic ill health more effectively. Many of the older people targeted for this kind of help are the same people who receive or are eligible for social care services. There are similar overlaps between staff working in the NHS and in social services, since social services care managers also assess needs and co-ordinate care services for individuals. This raises questions about the necessity for two kinds

of care management working alongside each other. Perhaps more important, the thinking underlying the management of long-term conditions, with its emphasis on managing particular diseases and health conditions, sits uncomfortably with social care values concerned with the person as a whole.

We do not consider that this tension can be resolved by either strengthening links between health and social care or developing better public services for all older people. Any new vision for social care requires both. We would like to see strong health, social care and housing partnerships that enable older people with care needs to lead independent, fulfilling lives. These should be linked to wider public services that build and sustain communities where older people live alongside people of all ages.

In its Green Paper concerned with the social care of adults, the government acknowledged that it is 'not realistic to plan to deliver care in the way we have in the past'. It put forward proposals for care packages that make more use of universal services provided by local authorities. It also indicated that more needs to be done to strengthen joint working between health and social care services. However, it does not spell out in detail how social care will have to be changed to deliver that vision.

Ageism in health, social care and housing policies

During our Inquiry, we saw that care and support for older people are often more limited than for younger groups. The specialist services for older people with mental health problems do not compare favourably with mental health services for younger adults. Equally, care packages for older people living at home concentrate on personal care and day centre activities. This contrasts with provision for some younger adults with physical or learning disabilities, whose care and support workers assist them to get out and about, use local leisure facilities, and take advantage of education and employment opportunities. In addition, expenditure per head on care packages for older people is often lower than for younger people, reflecting past policies that set lower cost ceilings for older people's services (King's Fund 2000).

Ageist thinking can underpin the design and location of supported housing. It is often assumed that older people live alone and that family or friends who visit them will not want to stay overnight. Thus one-bedroom houses are common. Supported housing may be also be located or managed in a way that makes it difficult for residents to engage with the wider community (Housing Corporation 2003).

There is abundant evidence of age discrimination in health and social care services (Robinson 2003). We acknowledge that the government has taken steps to combat such discrimination. The National Service Framework for Older People, launched in 2001, requires 'NHS services to be provided, regardless of age, on the basis of clinical need alone. Social services will not use age in their eligibility criteria or policies, to restrict access to available services' (Department of Health 2001c). It also requires NHS bodies and local authority social services to audit all policies and practices, to identify any age discrimination, and to take action to stamp it out. The National Service Framework marks an important step – government recognition of age discrimination in public services. That said, the National Service Framework is a relatively weak instrument for combating such discrimination, since it relies on promoting good practice and on joint reviews by the Healthcare Commission and the Commission for Social Care Inspection.

Serious consideration should be given to new legislation compelling organisations responsible for care services to demonstrate how their services positively promote equal opportunities

Age discrimination is not illegal – except, from 2006 onwards, in employment. Older people with care needs cannot challenge age discrimination in a court of law and seek redress. All they can do is rely on complaining to the organisation responsible for the alleged discrimination in the first place. It is well known that older people seeking or using care services find it very difficult to make a complaint; this can be a complicated and drawn-out process, and some people fear reprisals. And of course, the organisation concerned may not uphold the complaint or act on it.

Older people and/or their families can complain about care services to the Commission for Social Care Inspection if they do not want to approach the care provider or local authority direct or if they are dissatisfied with the way the care provider or council has dealt with their complaint. The Commission is then supposed to follow up the complaint on their behalf. But this process is not very satisfactory. The Commission admits that it spends 'so much time carrying out routine inspection visits that we do not have enough time to follow up complaints and concerns that people raise with us'. However, this may change as it is planning to alter the way it works, reducing the number of annual inspections and making more resources available to follow up complaints more speedily (Commission for Social Care Inspection 2005).

A culture emphasising needs not rights

Organisations such as Help the Aged, Age Concern England, ippr and the King's Fund (Harding 2004; Age Concern 2003; Spencer Fredman 2003; Robinson 2003) have been calling for government to introduce age equality legislation. They argue that such legislation would protect anyone who suffers discrimination on the grounds of age and should require public authorities to promote age equality in the design and delivery of services.

Serious consideration should be given to new legislation compelling organisations responsible for care services to demonstrate how their services positively promote equal opportunities for older people to exercise their autonomy and to participate in family and community life. Such legislation would enable the new Commission for Equality and Human Rights, which will start work in 2006, to tackle unlawful age discrimination alongside its work on race, sex and disability issues.

Although the law does not protect older people from discrimination on age grounds, like all other citizens they do have rights under the Human Rights Act 1998. They also have rights protected by criminal law. Unfortunately, the whole care system seems to operate as if older people have no such rights. During our Inquiry we saw that the standards of some care services put older people's rights at risk. This happens on those occasions when they are subjected to physical, psychological, financial or sexual abuse by those charged with their care. It happens when inhumane and degrading treatment becomes part of the culture of care homes or hospital wards, so that older people's requests are ignored, they are left wet or soiled for long periods, their medical needs are neglected, and incompetent or uncaring staff put their lives at risk. And it happens when insufficient consideration is given to the impact on older people of closing a care home that has become their real and only home.

The Human Rights Act makes it unlawful for public bodies to act in a way that is incompatible with the rights established by the Human Rights Convention. It also

lays a positive duty on the state to secure the effective protection and promotion of human rights for all its citizens. However, public bodies do not proactively protect and promote older people's human rights. On the contrary, a review by the Audit Commission in 2003 found that the Human Rights Act had had no impact at all on public services (Audit Commission 2003).

Of course, older people can take their complaints to the courts if they believe that their rights have been infringed. But it is not realistic to expect that to happen, given that litigation can be slow and expensive, and that the most vulnerable individuals are hardly in a position to resort to legal action. Advocates could challenge public services that appear to violate older people's rights. However, this avenue appears to be blocked for care services provided by voluntary or private organisations. Following a case brought against the Leonard Cheshire Foundation, the Court of Appeal ruled in 2002 that activities carried out by an independent care provider do not constitute 'public functions' and that therefore people in independent care homes (regardless of whether they are self-paying or are funded by a local authority) are not covered by the Human Rights Act. This legal loophole has left unprotected the majority of older people who use care services (whether care homes or home care); however, the loophole is likely to be closed sooner rather than later.

Options for change

We believe that the public sector should intervene more proactively to protect and promote the rights of older people with care needs. It has been argued that the Commission for Equality and Human Rights and the Commission for Social Care Inspection should lead new measures designed to make the Human Rights Act more meaningful for older people.

Harding argues that, when it is established, the Commission for Equality and Human Rights should use its powers to raise awareness of older people's rights through education, advice and guidance to organisations responsible for running care and support services. It should also enforce the law, either through mediation or by legal action in support of or on behalf of people whose rights have been violated. The Commission should also be given the power to undertake special investigations into aspects of care services that are causing concern, and to make recommendations to government.

The Commission for Social Care Inspection should also promote older people's human rights more assertively during its inspections and special reviews of care services. The current review of national care standards could usefully develop standards that demonstrate a commitment to fundamental human rights such as dignity and respect for older people and freedom from harm and from inhuman and degrading treatment. In its special reviews of social care services, the Commission could audit the systems local authorities and PCTs have set up to protect and promote the human rights of older people in the services they commission.

We found that there is not enough private funding in the London care system. Most older people lack the income required to pay for regular long-term care and support

Insufficient public and private finances in the care system

Adequacy of funding

The amount of public money in the current care system is only sufficient to allow local authorities to respond to older people with the severest care needs. The costs of caring for those denied public support fall on informal carers and on individual older people themselves, who are expected to pay for care with their own money. In addition, local authorities strive to keep costs down, sometimes to the detriment of service quality. This same downward pressure on costs compels some care providers to subsidise their work with publicly supported clients from the higher fees and charges paid by self-funders.

We recognise that public funding for social care is lower than it would be if services were free at the point of delivery, as most health care services are in the NHS. The funding of social care is based on the expectation that, if people have the means to pay for their own care, they should do so. However, we found that there is not enough private funding in the London care system. Most older people lack the income required to pay for regular long-term care and support, either in their own home or in a care home. It is true that many older Londoners own their own home and use the equity to pay for a place in a care home. But because so many use care homes outside London, a smaller proportion of these private resources goes into London care homes than might be expected.

The question is: how might more funding be mobilised for the care and support of older Londoners? We accept that some Supporting People money currently locked up in various forms of sheltered housing could be redirected to 'floating support' offering practical help to older people living in ordinary housing. Unfortunately, it will be some years before these funds can be 'loosened up'; even then, the funds for older people will be in great competition with those required for homeless people, young people leaving care, and so forth.

Older people who own their home could be encouraged to use housing equity release schemes to finance the care, support, equipment and adaptations they need to remain living at home. But equity release will need to be made more attractive. A recent decision to regulate equity-release products is a helpful first step in giving more protection to borrowers and more confidence in this market. However, more needs to be done. No doubt take-up could be increased by increasing awareness of equity release (and its potential to reduce inheritance tax liability), cutting the cost and lowering the minimum amount of money made available. Equity release might also become more popular if the government sorted out the tax and benefit anomalies that act as disincentives to older people drawing down and spending part of the value of their homes on care.

Nevertheless, unless the government is willing to make it more worthwhile for older people to use equity release, it would be unrealistic to expect, at least in the short and medium term, substantial increases in the private resources available to fund care and support for older people in their own homes. Thus it is very unlikely that increased private funding will provide adequate resources for people who need social care now and in the next few years.

The alternative is to consider substantial increases in public funding. We have no reason to believe that London alone requires more funding. If funding levels are insufficient to meet the care needs of older people in London, social care throughout the country must be similarly underfunded.

We recognise that there are major political barriers to be overcome before government will agree any substantial increases in public funding. The first barrier is the way governments think about the costs of social care. Unlike health care, social care for adults is not seen as needing highly skilled practitioners or expensive technologies. On the contrary, it tends to be regarded as an extension of the 'tender loving care' that families provide. This perception is inaccurate: one need only look at the amount of care highly skilled staff give to support people who have serious and multiple long-term health conditions and who are considered suitable for 'social' rather than 'health' care. However, this is not to say that cost pressures in social care are the same as they are in health care, which will always cost more than relatively low-tech social care.

The relationship between health and social care is critically important when considering how much additional public funding social care needs. As Sir Derek Wanless noted in his review of NHS funding in 2000, the two sectors are inextricably linked: both serve people experiencing ill health (acute and chronic), and the supply of services on one side of the divide affects demand on the other (Wanless 2002). Successive governments have begun to recognise these links, as is evident in the funds made available for intermediate care and for developing more long-term care services that enable older people to leave hospital as soon as they are fit enough. However, there has been a reluctance to accept the full implications of this relationship, and as a consequence funding for social care has been given a lower priority than funding for the NHS.

This reluctance also reflects a lack of understanding about the competing pressures within social care to meet the needs not only of older people but also of children and families, young people at risk, and working-age adults with learning difficulties, mental health problems and physical and/or sensory impairments. These pressures – frequently political in nature – often result in local authorities using part of the budgets earmarked for older people's services to fund provision for other groups.

Options for change

We are unable to quantify the funding shortfalls in the current care system. That would require a detailed study outside the remit of this Inquiry. We therefore support the review of social care funding being undertaken by Sir Derek Wanless for the King's Fund, which will estimate the levels of funding required for older people who need social care. It will examine current and future demand and supply factors and explore in some detail the complex relationship between the NHS and the mixed economy of social care.

In advance of that review, we believe there is a case for the government to reconsider its decision to rely on existing funds to implement the changes proposed in its Green Paper. We are not convinced that the current resources allocated to social care are enough to expand low-level, preventive services and also to meet the demands for intensive care. At the very least, the government

Health and social services staff do not always understand the different circumstances in which people are entitled to means-tested social care or free NHS continuing care

should examine the financial implications of extending a wider range of support to more older people.

In the meantime, local authorities could be more open about and accountable for the way in which they allocate resources to services for older people. This will require scrutiny of budgets and expenditure, and comparisons with how similar authorities use their resources. Older people's organisations, including the older people's forums and other consultative, advisory and lobbying groups that are growing up all over the country, are already starting to take on that scrutiny role. But for public pressure for change to grow, local authorities and their health and housing partners must engage with older people more effectively, and older people themselves must demonstrate an interest in what is happening and voice their concerns to the authorities responsible for funding care services.

Transparency of funding

Several different funding streams resource care services for older people. These include: means-tested funding from local authorities; NHS funding for continuing care, which is free at the point of delivery; and the incomes and assets of individuals. As we have seen, there is considerable confusion about who pays for what and when.

In Section 8 (*see* pp 89–99), we noted the wide variations in the way the NHS, in co-operation with local authorities, sets and interprets the criteria that govern access to NHS continuing care for people who require both care and some medical or nursing supervision. We also saw that challenges by the Health Service Ombudsman have led to thousands of cases being reviewed where older people had paid for care that should have been provided free by the NHS. PCTs involved in this Inquiry expressed their frustration at having to divert staff from other work to deal with these reviews and with appeals against decisions. Even though strategic health authorities have tried to reduce variations in criteria among authorities, the government has concluded that a national framework for continuing care criteria is needed. In its report on NHS continuing care published in April 2005, the House of Commons Select Committee on Health acknowledged that 'current arrangements for funding long term care are beset with complexity' and that a single set of national eligibility criteria for continuing care is needed to end the current 'postcode lottery' (House of Commons Health Committee 2005).

Health and social services staff do not always understand the different circumstances in which people are entitled to means-tested social care or free NHS continuing care. It is even more apparent that many older people and their families find the funding rules very confusing. Moreover, many neither understand nor accept the explanation the government gives for distinguishing between their eligibility for health and social care funding. They do not see the logic of the distinction and therefore regard the funding system as unfair (Robinson 2001; Deeming 2001).

This lack of transparency bedevils the system at all levels. It means that commissioners and care providers have to try to achieve better integrated care and support in a challenging financial environment. It also leads to much anger and distress among older people and their families, some of whom resort to the courts to challenge decisions.

The failure of individuals to arrange for care in old age can largely be explained by their unwillingness to think about the eventuality. Nevertheless, current means-test thresholds suggest that increasing numbers of older people will be expected to pay for their own care

As the Office of Fair Trading has pointed out, greater transparency is also needed in the contracts that self-funded residents have with their care homes. Two-thirds of contracts have fee-related terms that are unfair or unclear. One in five care homes charge self-funded residents more than publicly funded residents for a similar room and similar care (Office of Fair Trading 2005),

Options for change

The Health Select Committee has recommended the establishment of a single set of national criteria for continuing care and a national standard assessment methodology as an interim step to solving the problems around funding long-term care (House of Commons Health Committee 2005).

We are prepared to believe that such a measure is likely to help to reduce confusion. However, we do not expect much improvement, since applying the criteria to individuals' circumstances requires a professional judgement that will always be open to interpretation and challenge. We agree with the Health Select Committee that there are more fundamental problems to be addressed, arising from a funding system for long-term care based on free health care and on means-tested personal care.

We are also aware that in his review of social care funding for the King's Fund Sir Derek Wanless will examine not only the level of funding required now and in the future but also who should pay for what. This review should help government to revisit questions about the funding of long-term care that linger long after the Royal Commission made its recommendations for change in 1999. In any event, government will need to clarify people's entitlements to different types of public funding and to persuade older people, and the public at large, that these entitlements are fair and equitable.

Financial uncertainties

One reason why it is difficult to calculate how much funding is required for care services is that individuals and organisations do not know who will need care, when and for how long. This makes it hard to plan ahead and to cover the risks involved.

In the health services, these uncertainties are managed by sharing the risks and pooling resources so as to ensure universal protection for everyone who falls ill. As we have seen, that is not how it works in social care.

In other areas of life, people take out insurance to protect themselves (and others) against the consequences of car accidents, fire, theft and so on. Long-term care insurance is available to protect people against the costs of care in their old age. However, following the exit from the market of all but one of the providers of pre-funded long-term care insurance, consumers now have very few options available. We see little prospect of this market reviving. The cost of funding care for many years means that these insurance products are always likely to be relatively expensive; given the fairly low chance that they will need long-term care, most people are likely to regard the price as too high.

The failure of individuals to arrange for care in old age can largely be explained by their unwillingness to think about the eventuality. This is perhaps understandable, given that most of us do not want to contemplate the prospect of needing care.

Nevertheless, current means-test thresholds suggest that increasing numbers of older people will be expected to pay for their own care. Can more be done to plan ahead for that eventuality, and can government offer greater incentives to people to protect themselves against the risk of having to pay for care in their old age?

In addition to uncertainty about the need for and time span of long-term care, there are also uncertainties about whether various types of public funding will continue. For instance, it is not clear how long Supporting People funds might be available to finance housing-related support for older people. At the moment, these funds can be used to part-fund the service charges of extra care housing paid by residents who receive income support. Such uncertainty hampers the development and take-up of extra care housing.

Options for change

The government could reduce uncertainty and help people to protect themselves against the risks of having to pay for care in their old age. First, some form of capping could be introduced. This would limit the time for which older people have to pay for their care; after that the state would meet the cost. Second, in a top-up approach the state would pay for basic care provision, and individuals could supplement this from insurance benefits. Third, uncertainties about the future of Supporting People funds could be resolved by transferring to pension credits the funding of services charges for extra care housing paid by people on income support.

However, we are not convinced that older people will think that any of these options offer them a substantially better deal than they get at present. We therefore argue that government must intervene to cover the risks in part or in full and to compensate older people for the failure of the financial markets to protect them.

Key points

Problems in the care system in London are caused by:

- **Market failures** that restrict older people's choice and control and prevent services responding to what individuals need and want. These failures include:
  - **Older people's weak consumer power** They do not have the full information required to make informed decisions about their care. The majority of older people lack buying power and have to depend in part or in full on public money to buy care. They have little or no direct control over how these public funds are used to pay for care services. Even self-funders, with higher incomes or assets, find it difficult to access the help they need and to obtain advice on how best to use their personal resources. Carers are in a similar position, except that their dual role as consumers and providers can lead to them being ignored and left to bear the costs of market weaknesses.
  - **Under-investment in market capacity and diversity** Small care providers lack the resources necessary to expand or diversify their services, and to train and develop their staff to national minimum standards. There is insufficient capital investment in care homes and extra care housing because local authorities and their NHS partners, and self-funders, are unable or unwilling to pay higher prices reflecting full market costs. Care providers do not have a strong incentive to deliver quality care services as commissioners try to get as much service activity as possible for the lowest price.

- **Public policies that disadvantage older people**, seeing them as dependent, passive recipients of welfare and as lesser citizens than their younger counterparts. These policies entail:
  - Welfarist approaches that emphasise dependency, focus public support on the poor and restrict public expenditure to those older people who have severe care needs. This approach compounds the social exclusion of older people, as it leads to older people being removed from their homes and communities and being placed in separate, congregate settings such as care homes and day centres.
  - Ageism in health, social care and housing policies, revealed in low expectations about the quality of life older people should enjoy. This results in more restricted care packages focusing solely on personal care and day centre activities – in contrast to greater opportunities for younger disabled people to get out of the house and take advantage of ordinary community facilities and services. Mental health services for older people often compare less favourably with those for working age adults. The design of sheltered housing can also reveal assumptions about restricted lives in old age. And welfare benefits are less generous for older people than for younger age groups.
  - A culture emphasising needs not rights. Older people, like everyone else, have rights under the Human Rights Act, but standards of some care services put older people's rights at risk. They can be subjected to physical, psychological, financial and sexual abuse by the people charged with their care. They can also experience inhumane and degrading treatment that has become part of the culture of some care homes and hospital wards.

- **Funding that is neither sufficient nor transparent and certain**, resulting in restricted access to care and support, confusion and controversy about entitlements to care, and barriers to planning ahead for care in old age.
  - Public money in the care system is sufficient only to allow local authorities to respond to older people with the highest levels of care need. Local authorities strive to keep costs down, which leads to care providers cross-subsidising lower fees from publicly supported clients with higher fees from self-funders. Current resources are insufficient to allow expansion of low-level preventive services.
  - Costs of care for those who are denied public support falls on family carers and on individual older people who are expected to pay for the help they need. The majority of older people do not have sufficient income or savings to pay for care and support over a long period. Housing equity release schemes have not so far proved to be an attractive proposition for older home owners.
  - There is widespread confusion among the public and staff about the rules governing entitlement to free NHS continuing care and means-tested social care. Many neither understand nor accept the distinction and therefore regard the funding system as unfair. Many care home contracts have fee-related terms that are either unclear or unfair.
  - Uncertainties about who will need care, when and for how long, make it hard for individuals and organisations to plan ahead for care in old age. With the virtual collapse of long-term care insurance, consumers have few options to protect themselves against the risk of needing care. Uncertainties about the future of Supporting People funds also threaten the future availability of housing related support for older people.

These are systemic problems requiring action by governments and the public sector. Options for change include action to:

- **Strengthen older people's position in the care market** by
  - Improving access to independent information, advice and service brokerage. This is equally important for older people on low incomes and for those with personal income and assets that can be used to pay for care. Public money should be used to fund information, advice and brokerage services. Services must be seen to be impartial and should have the necessary authority to negotiate care packages for individuals.
  - Increasing choice and control through the use of Direct Payments, together with the support required to help older people find and employ personal assistants and other practical help around the home. Individual budgets should also extend greater control to older people, without the burden of employing staff.

- **Increase investment in the market** through
  - Practical support for small businesses so that they can develop the infrastructure needed for service and staff development. This developmental support can be provided by local authorities, linked with regeneration programmes, and by the DTI's small business support service. Public money used in this way should be used to drive innovation and to achieve better integrated care for older people.
  - Public/private partnerships to build new care homes and extra care housing, where the financial risks would have to be evenly distributed and capable of demonstrating value for money. Public sector land banks should be created, using the sites of closing care homes or redundant health and community facilities. Public planning authorities should also make greater use of planning gain agreements with developers, who might incorporate supported housing for older people in their plans for general housing or commercial developments.
  - Investment in staff training and development. Increased public funding should be available for care workers, targeting resources particularly on small care organisations and on staff for whom English is a second language or who lack basic literacy and numeracy skills. Managers of care organisations should also have opportunities to develop their business skills, with support from business development advisers who also have an understanding of health and social care markets. More extensive educational programmes are required for commissioners in the health, housing and social care sectors.
  - Incentives to improve service quality. A move to outcomes-based commissioning would ensure that services delivered results that older people and carers want. Fees with added quality premiums should be made available for providers who consistently deliver services that older people value. Inspection of care services by the Commission for Social Care Inspection should take account of the experiences and views of older people using services, and of the extent to which services enable independence, choice and control, and social participation.
- **Reform public policies** by
  - Adopting policies aimed at improving the health and well-being of all older people. This would help prevent dependency and social exclusion and enable older people – including those with care needs – to lead full lives. Social care would be located within a network of universal public services

stretching across local government responsibilities, such as housing, transport, leisure and lifelong learning and safe communities.

- Strengthening support for people with long term conditions, enabling them to manage their own care more effectively and providing intensive case management for those with complex conditions. This preventive approach will require health and social care to work together to ensure co-ordinated support for the whole person.
- Introducing age equality legislation that would outlaw age discrimination by social care, health and housing organisations and require them to demonstrate what they are doing to ensure that older people have equal opportunities for independence and social participation. Older people and carers could challenge age discrimination and seek redress in a court of law.
- More proactive promotion and protection of the rights of older people. The new Commission for Equality and Human Rights, together with the Commission for Social Care Inspection, should use their powers to enforce the law, to raise awareness of older people's rights through educational campaigns, and to undertake special investigations of care services that are causing concern.

- **Mobilise more resources for the care and support of older people** by
  - Reviewing social care funding. Sir Derek Wanless is investigating, for the King's Fund, the levels of funding required in the future and who should pay. His review will be published in early 2006. The government should review its decision to make no more resources available for the implementation of its Green Paper on social care for adults.
  - Greater clarification of the criteria used for NHS continuing care might help to achieve greater consistency in decisions about eligibility.
  - Government considering the merits of reducing uncertainty by capping the amount of time people are expected to pay for their own care or funding a basic level of provision that could be increased with top ups from individuals. Neither may prove attractive, in which case further thought is needed on how government can cover the risks in part or in full and compensate people for the failure of financial markets to protect them.

11 Recommendations

We make our recommendations at a time when issues about services for older people are high on the political agenda and the government is in the process of developing a range of policies to address the challenges of an ageing society. It has resolved to make all public services address the needs of older people, whether or not they have care needs. For example, *Opportunity Age: Meeting the challenges of ageing in the 21st century* (Department for Work and Pensions 2005) sets out the government's aim to embed the values of active independence, quality and choice in all policies directed towards older people. The strategy developed by the Social Exclusion Unit in *Excluded Older People* (Office of the Deputy Prime Minister 2005) emphasises the importance of preventive and low-level services and a positive approach to ageing.

In addition, proposals for major changes in social care for adults were outlined in *Independence, Well-being and Choice: Our vision for the future of social care for adults in England* (Department of Health 2005), the Green Paper published in March 2005. The Green Paper emphasises the role of services in helping to maintain the independence of the individual by giving them greater choice and control over the way in which their needs are met. Proposals to achieve this include extending the use of direct payments; piloting 'individual budgets'; and improving assessment and support for individuals through care brokers or navigators. There is also a greater focus on preventive services and a re-emphasis on partnership working between local authorities, the NHS, and the voluntary and community sectors.

We welcome and support the broad direction set out in the Green Paper, particularly the fact that the government is signalling a significant change in the relationship between older people and services – a change designed to empower them and their carers. However, in our view the proposals will not deliver the radical improvement in services required for the group of older people who need intensive care and support because of failing health and long-term disability. There is a significant risk that older people with substantial care needs will continue to receive care services that are simply not good enough.

We therefore propose specific action needed now to make the necessary improvements to care services in the immediate future and in the longer term. Our recommendations relate to:

- **reforming policy** so as to ensure equality of opportunity for older people and a culture that focuses on their rights as well as their needs
- **investing in market development** that can be addressed only by public-sector intervention
- **improving poor services for specific groups**, tackling in particular shortages in services for older people with mental health problems and shortfalls in services to older people from black and minority ethnic communities
- **mobilising more public and private resources** for the care and support of older people.

These recommendations concentrate on London. But we believe that they also apply to England as a whole on virtually every count. We note specific challenges for London relating to its population, care market conditions, and complex local and regional governance arrangements. But, time and again, our findings about the shortcomings in London are reinforced by evidence relating to England as a whole.

Reforming policy

We note the government's proposals to reform social care and its consultation on plans to introduce service brokerage and individual budgets. We endorse these broad objectives and particularly welcome the renewed emphasis on early intervention and prevention and also on the need to empower older people and change their relationship with the services they use. However, as the government itself would acknowledge, more detail is required about the legislative, organisational and financial changes required to translate these ambitions into reality.

Social care policy

Recommendation 1

By the end of 2005 central government should specify a set of indicators to judge progress on delivering its new vision of social care for older people and achieving the outcomes it has identified as important to older people. These outcomes include improved health and quality of life; being able to make a positive contribution; exercising choice and control; freedom from discrimination and harassment; economic well-being; and personal dignity.

Recommendation 2

The Commission for Social Care Inspection (or its successor following the merger with the Healthcare Commission) should monitor the implementation of policy for older people and how far these outcomes are achieved, and report on progress and problems.

Age equality legislation

Recommendation 3

During the current Parliament, central government should introduce new age equality legislation requiring organisations responsible for care services to demonstrate how they promote equality of opportunity. This legislation should outlaw age discrimination in the benefits system, health, housing and other public services. Either the Commission for Social Care Inspection (or its successor) or the new Commission for Equality and Human Rights should assess progress in promoting age equality through periodic reviews.

Promoting the rights of older people

Recommendation 4

The new Commission for Equality and Human Rights should use educational campaigns and special investigations to promote and protect older people's human rights and their right to equal treatment. Where necessary it should take legal action to enforce these rights.

Recommendation 5
The Commission for Social Care Inspection should assess progress in local authorities, and the Healthcare Commission should assess progress in the NHS, through reviews or annual assessments. Where appropriate, reviews should be carried out jointly with the new Commission for Equality and Human Rights.

Investing in market development

Throughout this report we acknowledge the strengths of the market system. We also point to fundamental weaknesses that only intervention by the public sector can overcome. Such intervention should involve strengthening the consumer power of older people, investing in market capacity and diversity, and creating the right incentives to produce quality services. To rectify current failings, all three must be addressed.

Strengthening older people's consumer power

We endorse government proposals to ensure that older people have access to information, advice and service brokerage as well as receiving either direct payments or individual budgets. These measures will strengthen older people's position in care markets. We also want older people to have a more meaningful involvement in commissioning to enable them to influence care markets so that these actually reflect the priorities of older people.

Better information and advice for older people

Recommendation 6
Central government should fund local authorities to provide information, advice, advocacy and service brokerage. These should be:

- available to all older people; it is no longer acceptable to deny self-funders access to the help and advice available to those eligible for public support
- developed in partnership with older people and their carers, PCTs, housing services, independent providers, and the voluntary, community and business sectors
- based on existing local arrangements and new developments, including initiatives such as the Building Financial Capability project and Link-Age
- accessible and appropriate for older people and their carers from all local communities
- recognised as impartial, transparent and credible by older people and their carers.

The Commission for Social Care Inspection should monitor these services to ensure that these criteria are met.

Recommendation 7
Local government should support information, advice, advocacy and brokerage services by exchanging good practice, evaluating new schemes to ensure that older people are satisfied with them, and monitoring their performance. The Commission for Social Care Inspection, the Social Care Institute for Excellence, the Improvement and Development Agency, and the Care Services Improvement Partnership should work together to spread good practice.

More choice and control for older people

We endorse central government's intention to extend Direct Payments and pilot individual budgets. We also want older people to have a more meaningful involvement in commissioning to enable them to influence care markets so that these actually reflect the priorities of older people.

Recommendation 8

Central government should pilot and evaluate individual budgets so as to assess how far these budgets genuinely give older people more control and choice over the services they need and they way they are delivered. Joint individual budgets (funded by local authorities and the NHS) should enable older people to secure as wide a range of services as possible, including health- and housing-related services that older people currently have difficulty accessing.

Recommendation 9

Local authorities and PCTs should establish effective arrangements to involve older people in commissioning services. Education and leadership development agencies should include good practice in involving older people in their education programmes for commissioners working in local authorities and PCTs.

Investing in market capacity and diversity

More investment in market capacity and diversity is needed. This includes providing business support to small care organisations as well as incentives for private- and voluntary-sector providers to develop more supported housing to encourage them to invest in London despite the high cost of land and property there. Pan-London capital investment, planning and training programmes to develop the knowledge and skills of commissioners and managers of care organisations are also crucial to building market capacity.

Building the capacity of small care businesses

Recommendation 10

By the end of 2005, the Department of Trade and Industry should support small care organisations to develop the business infrastructure necessary to enter the care market or to expand and diversify their services. Priority should be given to:

- developing more flexible and versatile care and support in people's own homes that can meet their short- and long-term care needs
- providing business support to small voluntary and community organisations working with black and minority ethnic communities to assist them to develop new care services responsive to older people's diverse religious and cultural preferences.

Capital investment

Recommendation 11

The Greater London Authority should give higher priority in its planning guidance to the development of new care homes and extra care housing (both rented and leasehold) in those parts of London where the current supply is insufficient to meet the needs and preferences of older Londoners.

Recommendation 12
Local authorities should make greater use of their planning gain powers to encourage the development of more supported housing and care homes in areas where the current supply is insufficient. In partnership with PCTs, local authorities should create land banks to be used for these developments and form public/private partnerships to lever more capital investment into housing and care services in London.

Recommendation 13
Local authorities and their PCT partners with the ALG should develop capital investment plans on a pan-London and/or a sub-regional basis. This will help to ensure that new care homes and extra care housing are located where the need is rather than where land is cheapest. Planning on this basis is particularly important to ensure the development of specialist services that are not viable within individual boroughs, such as those for people with complex conditions and for specific black and minority ethnic communities.

Developing expertise in commissioning

Recommendation 14
Central government, local authorities and PCTs should jointly fund, on a pan-London basis, education and training programmes aimed at all staff who are involved in commissioning care services.

Developing business skills among managers of care organisations

Recommendation 15
Skills for Care and workforce development departments within strategic health authorities should increase the support they give managers of care organisations to develop their businesses and to expand or diversify to meet current and future demand.

Driving up the quality of care services

We support the Commission for Social Care Inspection's plans to be more proactive in identifying how far care services achieve the results that older people want. This will require inspectors to take more time to listen to the views of older people and their carers and find out whether they are satisfied with the quality of the services they receive. We also urge the Commission to include equality considerations in its quality assessments. We note the forthcoming merger with the Healthcare Commission and hope that it will not deflect the Commission for Social Care Inspection from its tasks.

Commissioning for quality

Recommendation 16
By 2007, the Commission for Social Care Inspection should institute systems to rate the performance of local authorities on how far their commissioning is achieving high-quality services and is also ensuring that these services meet equality standards.

Outcome-based commissioning

Recommendation 17
Strategic commissioners and providers should work together with older people and their organisations to specify the outcomes that services should achieve for service users and carers.

Recommendation 18
Care managers should purchase care and support for an individual on the basis of the outcomes the older person wants. They should not specify in detail how the provider should deliver these outcomes. Care providers should be free to work out, in dialogue with the older person concerned, what this means in practice.

Rewarding quality

Recommendation 19
Local authority and PCT commissioners should consider paying a quality premium to encourage and reward providers whose services exceed national minimum standards.

Improving care workers' access to training

Recommendation 20
Training and workforce development partnerships should increase their funding for training care workers. Particular attention should be given to care workers whose first language is not English and to those who lack basic literacy and numeracy skills. Workforce development departments, Learning and Skills Councils, Skills for Care, and health and social care organisations should combine their funds to provide intensive, work-based support to care staff working for small, dispersed care providers.

Improving poor services for specific groups

Some groups of older people have particularly poor experiences of care services. During this Inquiry we focused on two groups who for very different reasons experience double discrimination and disadvantage in the care market.

Older people with mental health problems

Many older people with mental health problems are not getting the type or quality of service they are entitled to expect. This includes people with rather different needs:

- Those with a history of mental health problems who, on reaching 60 or 65, can be arbitrarily moved from services intended for working-age adults to those reserved for older people. These older people's services often do not provide either the specialist care or the quality of support offered by adult mental health services.
- Those who develop depression and anxiety in old age, whose difficulties health and social care professionals often fail to recognise and address.
- Those with different forms of dementia who receive outdated and inadequate support and care.

Better services for older people with mental health problems

Recommendation 21

Local authorities and their PCT partners should develop and implement commissioning strategies to care for and support older people with a range of mental health problems and their carers. These strategies should:

- Identify key areas for developing new services and re-designing existing ones. In most cases, we envisage that this will involve a radical overhaul of the current patchwork of provision based on a fresh appraisal of the specialist and generalist support required.
- Indicate where existing resources could be used more effectively and where additional spending is needed to provide both specialist and generalist support and to upgrade staff education and training.

Recommendation 22

The Care Services Improvement Partnership should give high priority to improving services to older people with mental health problems through a nationwide development programme. The national directors for mental health and older people should regularly report on progress to government and the wider public.

Older people from black and minority ethnic groups

Every issue discussed by this Inquiry, and each of its recommendations, relates to older people from all communities. However, the specific needs of older people from diverse local communities require special attention.

More responsive services for black and minority ethnic older people

Recommendation 23

We urge all authorities involved in commissioning, providing and regulating social care to improve the range and quality of services offered to people from black and minority ethnic groups. For example:

- Local authority and PCT commissioners should take the lead in developing high-quality services for black and minority ethnic older people.
- All local authorities and PCTs should work closely with black and minority ethnic groups and organisations to develop a better understanding of their needs and to address these needs in their plans for service development.
- Commissioners should ensure that private- and voluntary-sector providers demonstrate how they will meet the needs of older people from black and minority ethnic communities and their carers.
- The Audit Commission should ensure that local authority comprehensive performance assessment ratings reflect how well authorities are engaging with, and providing services for, black and minority ethnic communities. This should also apply to the Healthcare Commission in their NHS annual assessment ratings.

Recommendation 24

In consultation with the relevant community groups, the Association of London Government should bring together local authorities, on a pan-London or sub-regional basis, to plan and commission specialist services for black and minority ethnic groups that cannot be met within a single borough.

Recommendation 25
Local authority and PCT commissioners should encourage community and voluntary organisations to enter the care market and develop services responsive to the needs of particular communities. Support should include advice on organisational development and training for managers and care staff. In addition, such services should receive medium-term funding, not the one-year agreements that are the current norm.

Mobilising more public and private resources

The current care system in London urgently requires additional funding to help meet the needs of today's older people. We are unable to quantify how much more funding is required at this stage. We welcome the Social Care Review that Sir Derek Wanless is undertaking for the King's Fund, which will report in spring 2006. This is examining what financial and other resources will be required over the next 20 years to provide high-quality care that reflects the preferences of older people and how such social care might be funded.

Reviewing funding for social care

Recommendation 26
Central government should review its decision not to increase funding for adult social care and older people in the short term. This Inquiry demonstrates that local authorities and PCTs are struggling to meet all but the highest levels of need. If the government is serious about wishing to develop more preventive services while at the same time providing intensive care and support to a minority of older people, it needs to re-examine funding. We are not convinced that existing funding will be sufficient to implement the ambitious proposals set out in the Green Paper.

Clarifying entitlement to health and social care

Recommendation 27
Central government should clarify the different circumstances in which older people are entitled to receive means-tested social care and free NHS care. In particular the government should ensure greater local consistency in interpreting the NHS criteria for continuing care. We welcome the government's proposals to establish a single set of national eligibility criteria for NHS continuing care. We also endorse the recommendations of the Health Select Committee that these should be seen as a short-term measure and there should be a more fundamental debate about the distinction between a free health care service and a means-tested social care system. We also welcome the proposal that this should be informed by the King's Fund social care review being undertaken by Sir Derek Wanless.

Reporting on how public money is spent on services to older people

Recommendation 28
Local government and its NHS partners should be more open and accountable for what they spend on care services to older people. As well as fully involving older people and their carers in planning service developments, authorities should report back to the public regularly on how much has been spent on services for older people and on what specific things.

Public challenges on expenditure for older people

Recommendation 29

Local authorities and PCTs should ensure that they establish systems to enable older people and their organisations and champions to scrutinise local budgets and expenditure and to challenge decisions to divert resources intended for older people.

Removing barriers to housing equity release

Recommendation 30

Central government should consider how to make housing equity release schemes more attractive so that older home-owners will be willing to use them to pay for the care and practical support they need to stay in their own homes. This means looking in detail at the tax and benefit anomalies that act as disincentives to using these schemes. Expert advice should be offered to older people on the schemes available.

Appendix 1
Committee members

Chair: Julia Unwin OBE
Julia Unwin is a Senior Associate at the King's Fund. She is the Deputy Chair of the Food Standards Agency, the Independent Adjudicator for the Audit Commission, a member of the Committee of Reference for Friends Provident and a Board member of the National Consumer Council. She is also an independent Board member of the Department of Trade and Industry. She has been a Charity Commissioner, Board member of the Housing Corporation and Chair of the Refugee Council. She has also been an adviser to grant making trusts and to companies and has researched and published on the funding of the voluntary sector.

Ratna Dutt OBE
Ratna Dutt is Director of REU, a black voluntary organisation providing race equality training, consultancy, research and development in social care. She is a social worker by profession, with over 20 years' experience in social work. Ratna has written extensively on social care issues. She is a trustee of the Social Care Institute for Excellence (SCIE). Ratna received an OBE for her work in race equality in 2000.

Peter Fletcher
Peter Fletcher is Director of Peter Fletcher Associates (PFA), an independent research and consultancy organisation that focuses on whole system strategy, commissioning and partnership working across health, social services, housing and regeneration for older people and other adult groups. He is also Chairman of the Board of Housing 21. He was previously a Director at Anchor Trust and NACRO, and a member of the Department of Health's Community Care Support Force.

Howard Glennerster
Howard Glennerster is Professor Emeritus of Social Policy at the London School of Economics. He is an expert on the economics of social welfare and author of academic studies on the finance and delivery of services for elderly people. His most recent book was *Understanding the Finance of Welfare*.

Tessa Harding MBE
Tessa Harding is Senior Policy Adviser at Help the Aged, focusing on age equality and human rights. Her background is in health and social care, and she previously worked at the National Institute for Social Work, the National Council for Voluntary Organisations and for three local authorities.

William Laing
William Laing has been the driving force behind Laing & Buisson since its foundation in 1986, during which time he has made some major contributions to the debate on long term care funding. He was the author of *Financing Long Term Care: The crucial debate* (Age Concern 1994), which first proposed the separation of long term care costs into the 'care' and 'hotel' costs. The concept was subsequently

adopted by both the Joseph Rowntree Committee of Inquiry, on which William served, and the Royal Commission on Long Term Care.

Leslie Marks
Leslie Marks is chair of the Bromley Council on Ageing (a voluntary sector forum) and Bromley Mind and a co-opted member of London Borough of Bromley's Social Care, Housing and Health Scrutiny Committee. Leslie is also a National Service Framework Champion. She has retired after some 40 years in the voluntary sector as a chief officer and latterly as a charity consultant.

Loraine Martins
Loraine Martins has worked in the public sector for 20 years in local, pan-London and national organisations. Loraine has been involved in commissioning and developing social care services for adults and older people in London and is currently Head of Diversity at the Audit Commission.

Jo Moriarty
Jo Moriarty is a Research Fellow in the Social Care Workforce Research Unit based at King's College London. Her current work centres around the social care workforce. She has previously undertaken research into community care services for people with dementia and their carers and quality of life and social support among people from different ethnic groups.

Peter Smallridge CBE
Having spent 17 years as a Director of Social Services, Peter chaired a Health Authority and now chairs a primary care trust in Kent. He is also involved with Initiatives in Care Ltd, a social care consultancy through which he has worked on services for older people across London. He is a Trustee of two major voluntary organisations.

Peter Westland CBE
Peter Westland is a commissioner of the Commission for Social Care Inspection and is a former Chair of Action on Elder Abuse, a national voluntary organisation. Now retired, his career in social services included being Director of Social Services for the London Borough of Hammersmith and Fulham and working for the Association of Metropolitan Authorities.

Peter Williams
Peter Williams is Deputy Director General of the Council of Mortgage Lenders, the trade body for the mortgage lending industry in the UK. He was previously Professor of Housing Management at the University of Wales, Cardiff and a Board Member of the Housing Corporation and Tai Cymru/Housing for Wales.

Appendix 2
Call for evidence

The King's Fund Inquiry

The King's Fund has set up an independent Inquiry to look at the problems arising in care services for older people in London. Concerns about shortcomings in both residential and home care services have led to warnings about a looming crisis in care and to claims that the care market in the capital is failing to deliver sufficient care services of the right quality to meet the needs of London's diverse older population.

We are aware of efforts being made to improve the situation by central government, by local government and their NHS partners, and by the many private and voluntary sector organisations who run the bulk of care services. However, it is too early to tell whether those efforts will succeed. The future for older Londoners needing care and support remains uncertain.

An independent Committee of Inquiry will be examining how the care market works in London, considering:

- the impact that care services are having on the lives of older people and their carers now
- strengths and weaknesses in the way care services are financed, commissioned, developed and delivered
- whether older Londoners and their carers can expect any improvements in care services in the near or longer term future.

Your views about care services

The Committee wants to hear what people living and working in London think about care services in the capital. We appreciate that people's experience of care services will vary across the capital and we want to hear what is happening in the part of London you know best. The Committee is also keen to hear from people who are able to give an overview of the situation in London as a whole.

Care services include:

Care homes, home care, day services, extra care accommodation (or very sheltered housing) and intermediate care. Other support includes befriending, and practical help around the house and in the wider community.

We would like to hear from:

- older people and carers about their experiences as individuals in seeking and using care services in the capital
- people working in organisations that are responsible for commissioning, providing or regulating care services in London, and from organisations and groups representing the interests of older people and their carers.

SECTION 1

Questions for older people and carers

We don't expect you to answer all of these questions – unless you want to. Feel free to pick and choose, just giving your views on those issues where you have something to say.

Your need for help	What changes in your health caused you to seek help from care and support services? What kinds of help have you needed and why?
Finding the help you need	How easy has it been to obtain information and advice about care services available in your area? Who has been most or least helpful in guiding you to the services you need? What has been your experience of approaching services directly to ask for help?
Having a choice	How far were you able to choose the service that suited you best? Did you have any choice about who helped you, what kind of help they would give, and when and where they would provide that help? In your experience, are some care services harder to get than others?
The cost of care	Are you paying for care services out of your own pocket? How do you feel about that? Are the fees or charges reasonable? Can you afford to pay them?
Quality of care	How far have the care services you have used made you feel safe from harm? Do the staff always treat you with respect? Do the staff have the right knowledge and skills to do their jobs properly? Do they understand how to work with older people and their families? If you have stayed in a care home or spent time in a day centre, what do you think about the building (size, facilities, décor etc)?
Likes and dislikes	What do you like most about the care services you use? Which aspects of services do you think could be improved?
Hopes and fears for the future	Do you think care services for older people in London are likely to get better or worse in the next few years? Do you have any particular worries about the care and support that will be available for you or your family and friends in the future?

Giving us your views

We will treat everything you tell us in confidence, and will not repeat it to anyone using your name, without your permission.

Please send your responses in a short note and attach the form Cover Sheet 1 on page 3. Send to Sarah Robinson at the address on the form by 2nd April.

We regret that we cannot deal with individual cases, nor take up complaints about care services.

SECTION 2

Questions for organisations and groups concerned with care services

HOW IS THE CARE MARKET WORKING IN LONDON?

On each of the five issues set out below, the Committee would like to hear about:

- your **experiences** of care services in London
- your **views** about the causes of some of the difficulties arising
- your **ideas** for bringing about improvements in the future. We are particularly keen to hear about action already being taken to tackle difficulties arising that seem to be working.

SPECIFICALLY, THE COMMITTEE WOULD LIKE TO HEAR ABOUT:

Changes in demand for care services	**Needs of older people and carers** Are numbers of people identified as needing care and support increasing? Are there changes in the numbers of older people who have multiple health problems and complex needs? Are the numbers of older people with dementia and other mental health problems presenting particular challenges for care services? To what extent are older people from black and minority ethnic communities coming forward to seek care and support? **Access to services** How easy or difficult is it for older people to seek and obtain help, either in their own home or in a residential or nursing home? What are the barriers restricting access to care services? **User satisfaction and choice** How far are older people able to choose the care services they prefer? Do some groups have greater choice than others? Which care services currently available are known to be especially valued by and popular with older people? Which services attract most criticism and complaint? Is there any evidence that older people now expect more from care services than they did in the past? **Reducing demand** What is being done to prevent or delay the need for long term care among older people? What impact are these measures having on the lives of older people and on the rates of admission to hospitals and care homes?
Changes in the supply of services	**Shortages** Are some types of care services in short supply? What are these and why are the shortages occurring? What is the impact on older people and their families of these shortfalls in provision? What is the impact on hospitals' ability to discharge older patients who no longer need hospital care?

Mix of care services
How, in recent years, has the balance changed between care provided in people's own homes and in residential settings? Some parts of London have relatively high levels of home care (compared with residential care). Why is that, and is the trend sustainable in the long term?

Quality standards
What impact are care standards regulations having on care businesses entry into and exit from the care market? Is the drive to meet new care standards having any effect on the cost of care? To what extent can older people feel more confident that they are protected from potential abuse, neglect and low standards of care?

New developments
What are the factors that have encouraged or hindered the development of new care and support services, such as extra care accommodation or social and practical support that enables older people to lead full lives at home? How far is it envisaged that new models of care (such as extra care accommodation) will eventually replace longer established care services (such as residential care homes)?

Financial trends

Costs in London
How far are high costs in London encouraging councils and older people themselves to seek places in care homes outside their borough and/or outside the capital? Are policies regarding out of borough placements sustainable in the future? How easy is it to raise money for the development of new buildings for care services or for the refurbishment of existing ones? How has the return on capital in London affected decisions to invest in new buildings (for care homes, very sheltered housing, etc)?

Public funding
How far has increased funding for social care from central government helped local authorities and their PCT partners to meet the care needs of older people in their area? What changes are taking place in the level of fees local authorities are paying to organisations providing care services? Is their sufficient funding in the system to meet the demand for good quality care for older people?

Older people paying for their own care
What changes are taking place in the proportion of older people receiving no public funding (other then free nursing care) for a place in a care home? How do the fees they pay compare with fees charged for publicly funded residents? What impact do 'self-funders' have on the care market, in terms of the availability of both home care and residential care places for publicly funded service users? What progress is being made in allocating Direct Payments and/or funds

	from 'Supporting People' initiatives to older people so that they can buy care and support services directly? What evidence is there that older people have greater control and choice over their care when using Direct Payments?
Staffing concerns	**Shortages** To what extent are shortages of care staff hampering the development and delivery of care services in London? What is causing the shortages? What is being done to improve recruitment and retention of care staff ? How successful are these measures proving to be? **Staff skills** What progress is being made in training the care workforce to meet the standards required in recently introduced care regulations? What steps have been taken to enable care staff working in small care businesses to benefit from education and training? What is being done to support staff with special needs, for example, those needing help with basic skills, those whose first language is not English?
Future of the care market in London	Do you agree with claims that the care market in London is not working very well? If so, what are the most important measures that need to be taken to address current failings in the market? In your view, is sufficient being done by central and local government and by independent care providers to ensure that there are sufficient care services of the right type to meet the needs of London's diverse older population in the future?

Submissions

All submissions to the Inquiry will be acknowledged in the Committee's final report. Where appropriate, information provided in submissions may be cited in the final report.

Please send your responses in a short note and attach the form Cover Sheet 2 on page 7 by 2nd April. Send to Sarah Robinson at the address on the form.

The Committee will be conducting oral hearings in the summer of 2004 and will invite a selection of organisations and individuals to attend the hearings, where particular issues will be discussed in greater depth.

We regret that the Committee cannot deal with individual cases, nor take up complaints about care services.

Appendix 3
Organisations and individuals who submitted written evidence

Older people and their carers

More than 50 people submitted evidence to the Inquiry, including the following:

Jeanette Bardell
Joanna Bornat
Mrs Doris Bradshaw
Mrs Janet Day
Norma Haemmerle
Annabell Henry
Mary Herriot
Mrs Launchbury
Bridget Maloney
Barbara May
Sheila Millington
P Mulligan
Clara Pinto
Janet Rolin
Mrs Susan Short
M Sinfield OBE
Christine Spence
Sylvia Upton

Organisations

Age Concern London
Alzheimer's Society Sutton Branch
Association for Psychoanlytic Psychotherapy in the NHS
Association of London Government
Audit Commission
Better Government London Borough of Hammersmith & Fulham
Bettercaring Ltd
British Geriatrics Society
Bromley Alzheimer's Society
Bromley Council on Ageing
Bromley Older People's Panel
Centre for Ageing and Public Health, London School of Hygiene and Tropical Medicine
Chinese Carers Support Group, Carers London
College of Occupational Therapists
Craegmoor Healthcare
Department of Health
Dulwich Helpline
English Community Care Association
Federation of Voluntary Sector Providers
Gap Research for Bromley Council on Ageing
General Social Care Council
Greater London Association of Directors of Social Services
Greek and Cypriot Community of Enfield
Help the Aged
Hillingdon Carers
Hounslow Crossroads Care Scheme Ltd
Housing 21 Care Options

Jewish Care
London Borough of Bromley Social Services and Housing Department
London Borough of Richmond
London Borough of Wandsworth
London Care Connections
Mental Health Foundation
National Homecare Council
North East London SHA
Pensioner's Voice, Colindale and Burnk Oak Branch
Policy Research Institute on Ageing and Ethnicity
Primary Care Nursing Research Unit, University College
Rethink
Royal College of Psychiatrists
Social Services & Housing, London Borough of Bromley
Social Services Inspectorate
Southwark Irish Pensioners Project
St Mungo's
Stroke Association
Tower Hamlets PCT
UNISON
Winged Fellowship Trust

Health and social care professionals

David Griffiths, Mayday Healthcare NHS Trust
Dr Kevin Kelleher, Queen Mary's NHS Trust
Rosemary Jones, Community Worker
Jacqueline Morris, Royal Free Hospital.

Appendix 4
Care workers participating in focus groups

Pamela Daniel
Angela Elsayed
Veronica Ewan
William Gale
Michelle Heaney-Doyle
Michelle Hewston
Shahadat Hossain
Mayon John
Christine Oculi
Helen Faith Omoragbon
Leigh Prudente
Veronica Reid
Sue Shead
Grenville Sobers
Sansia Wilson

Appendix 5
Witnesses to the inquiry

Voluntary organisations

Mubeen Bhutta, Policy and Communications Officer, Policy and Research Institute on Ageing and Ethnicity (PRIAE)
Jonathan Ellis, Policy Officer, Policy Manager, Health & Social Care, Help the Aged
Kulbir Gill, Alzheimer's Concern Ealing
Jeanette Heider, Interim Manager, Carers London
Aisha Khan, Chair, Brent Muslim Health and Social Care Forum
Barbara Meredith, Consultant to Age Concern London
Sonia Richardson, Head of Mental Health in Later Life, Mental Health Foundation
Lynn Strother, Director, Greater London Forum of the Elderly
Pauline Thompson, Policy Officer, Community Care Finance, Age Concern England
Peter Tihanyi, Operations Manager, Princess Royal Trust for Carers
Cecilia Tsang, Advice and Representation Officer, Carers UK London
Jacqui Wharrad, London Regional Manager, Alzheimer's Society London Region

Care providers

Naseem Abubaher, Director of Mushkil Aasaan
John Belcher, Chief Executive, Anchor Trust
Stephen Booty, Chief Executive, Nestor plc
David Greaves, Director, Tooting Neighbourhood Centre
Tony Hosking, Management Director, Residential Care Services, Care UK
Leon Smith, Director, Nightingale House and member of the National Association of Jewish Care Homes
Nigel Walker, Director of Care, Housing 21
Litsa Worral, Projects Manager, Greek and Greek Cypriot Community Care in Enfield

Commissioners

Terry Bamford, Chair, Kensington and Chelsea Primary Care Trust
Stephen Burke, Chair, Health and Social Care Committee, Association of London Government
Jeff Jerome, Director of Social Services, London Borough of Richmond-upon-Thames, representing Greater London Association of Directors of Social Services (GLADSS)
Samih Kalakeche, Deputy Director of Joint Commissioning, Brent Primary Care Trust
James Reilly, Director of Social Services, London Borough of Hammersmith and Fulham, representing GLADSS
Julia Ross, Director of Social Services, London Borough of Barking and Dagenham, and chair of GLADSS

Central government regulators

Dr Stephen Ladyman, Parliamentary Under-Secretary of State for Community
David Walden, Director of Strategy, Commission for Social Care Inspection (CSCI)
Mike Rourke, London Regional Director, CSCI
Rob Hayhurst, Performance and Information Manager, CSCI

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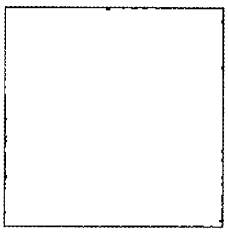
Index



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Penny Banks
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Ros Levenson
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ISBN 1 85717 472 0 Feb 2003 70pp £15.00

Future Imperfect: Report of the King's Fund Care and Support Inquiry
Melanie Henwood
Across the UK, some one million people – many of them women – provide care and support services. Their work is critical to the health, well-being and quality of life of the growing numbers of people who rely on their help, including older people with disabilities and mental health needs. This report, based on a far-reaching investigation into the care sector, paints an alarming picture of a service faced with growing demands as the numbers of people needing help grows, and the complexity of their needs increases.

ISBN 1 85717 450 X Jun 2001 236pp £14.99

Old Habits Die Hard: Tackling Age Discrimination in Health and Social Care
Emilie Roberts, Janice Robinson and Linda Seymour
Based on a telephone survey of 75 senior managers in hospitals, primary care groups, community trusts and social services departments, this report shows that managers in the NHS and social care organisations support new moves to combat age discrimination in health and social care, but lack the tools they need for the job. It provides guidance on practical ways to implement policies designed to prevent age discrimination.

ISBN 1 85717 462 3 Jan 2002 42pp £6.99

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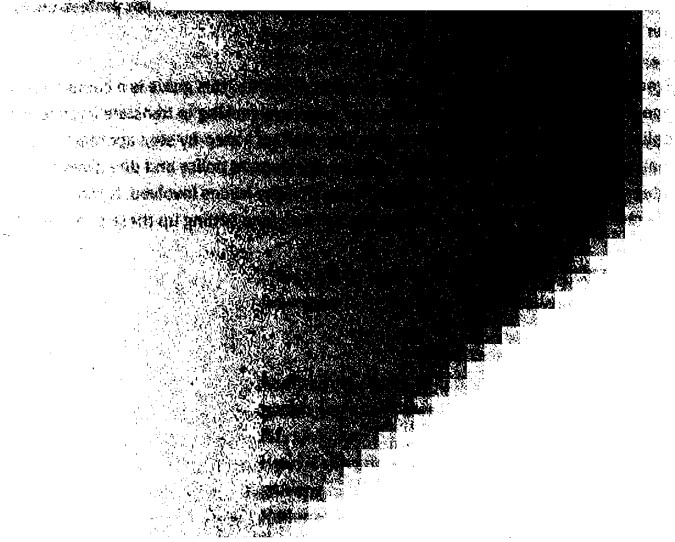
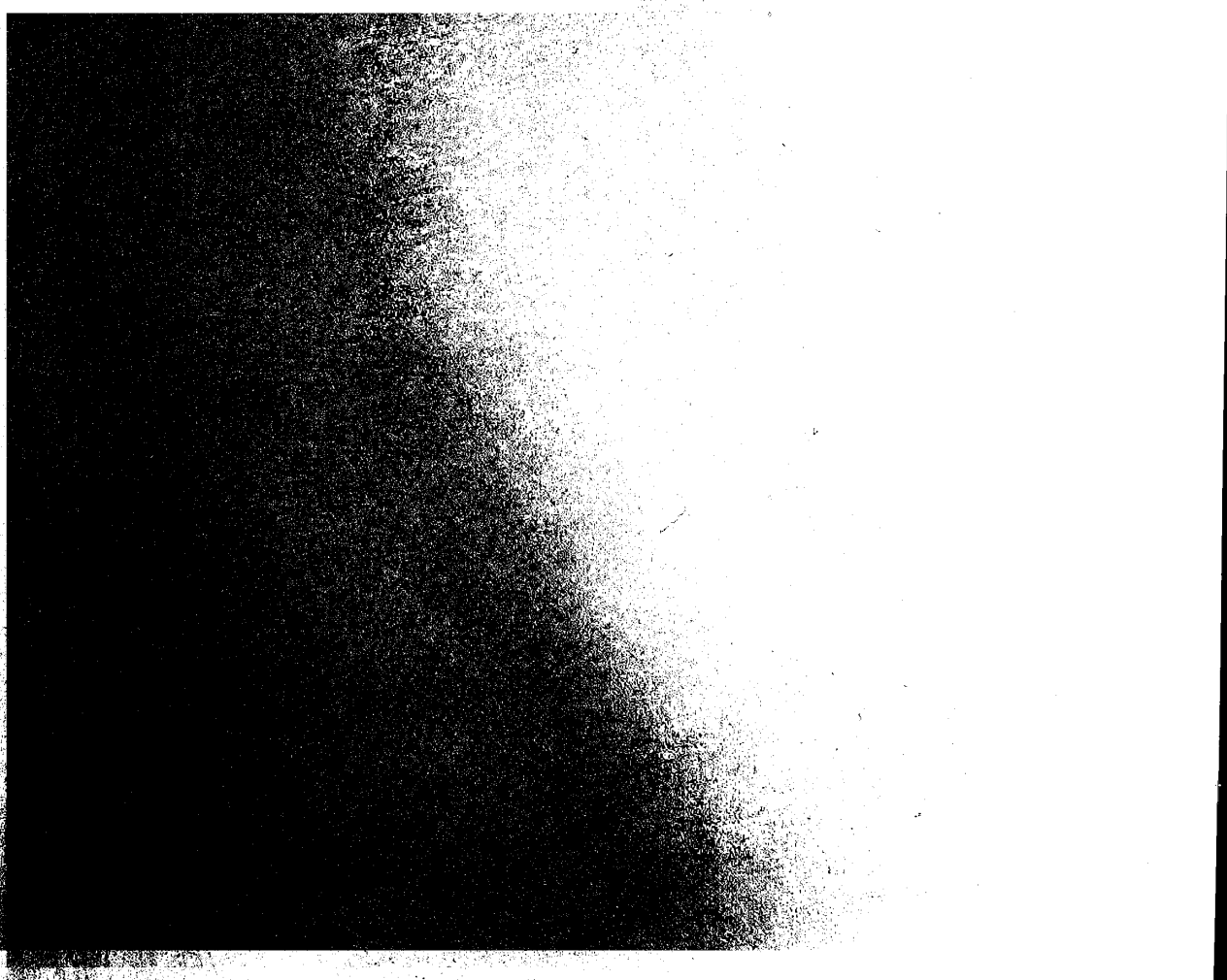
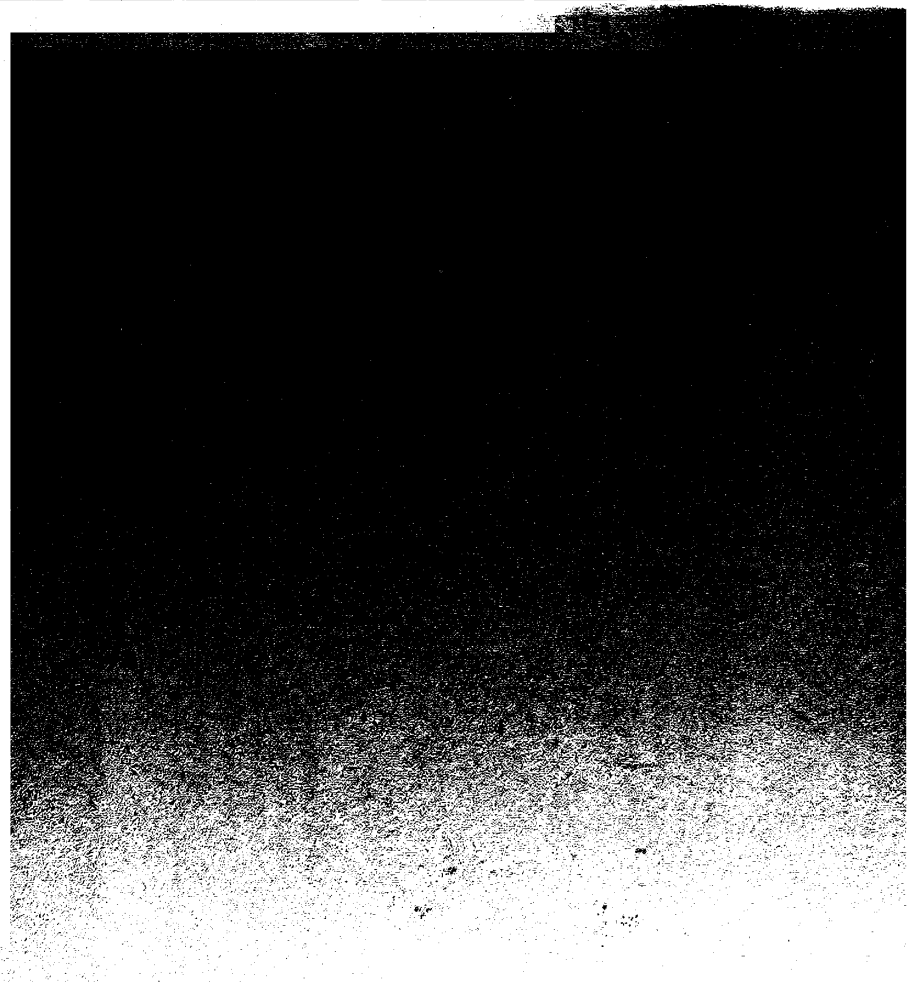
Jan Stevenson and Linda Spencer

Produced with the support of the Department of Health, this guide is a comprehensive one-stop resource for commissioners and providers seeking to translate intermediate care policy into a workable set of linked services. It offers a step-by-step approach to planning, managing and evaluating services, unpicks government policy and directives relating to intermediate care, and reviews the evidence and the issues involved. It contains a wealth of practical case studies and examples to help anyone setting up these services.

ISBN 1 85717 466 6 Oct 2002 134pp £18.00







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The King's Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding. We are a major resource to people working in health, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

In recent years, there has been mounting concern about what many see as a collective failure to provide decent care services for older people.

Press headlines proclaiming a 'care crisis' have become common, alongside fears that the 'care market' – the complex set of systems by which individuals and local councils buy care services, and public, voluntary and private sector providers supply them – is failing.

In London, there are particular challenges in ensuring that older people can access the kinds of care services they want and need. Public anxiety has grown as care homes have closed, and hospitals have been unable to discharge patients who no longer need medical treatment, but require some form of social care.

The Business of Caring **presents the findings of a one-year King's Fund Inquiry – involving the extensive collection of evidence from older people and their carers, care staff and managers, regulators, and local authority and NHS commissioners, plus special research studies – into the state of care services for older people in London.**

The report's key message is that there are major shortcomings in current arrangements for the support of older Londoners and their carers. Older people find it difficult to obtain the care and support they need, and lack choice and control over services. They are also at risk from untrained and unqualified staff, and experience hardship resulting from the inadequate funding available for care services.

It calls for:

- **investment in market development – to strengthen consumer power, encourage service growth and diversity, and create incentives for high-quality services**
- **reform of social policies – to ensure equality of opportunity for older people, and foster a culture that focuses on their rights as well as their needs**
- **mobilisation of public and private finances – to increase overall levels of resources in older people's care.**

It also identifies the urgent need to improve services for specific groups of older people, including those from black and ethnic minority backgrounds, and those with dementia.

Published alongside government commitments to develop a range of new policies to address the challenges of an ageing society, this report will prove essential reading for all those involved in the business of caring, including older people and those who support them; those who provide care, and those who commission it.

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