KF REPORTS

KFC 82/206

ISSUES FOR LONDON DHAs:

POLICIES FOR THE ELDERLY

Report of a conference held at The King's Fund Centre on 13th May 1982

King's Fund Centre
126 Albert Street
London NW1 7NF
Telephone 01-267 6111

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established is 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings.

King Edward's Hospital Fund for London

ISSUES FOR LONDON DHAs: POLICIES FOR THE ELDERLY

CONTENTS

Ann Foster September 1982

ISSUES FOR LONDON DHAs: POLICIES FOR THE ELDERLY

Report of a Conference held at the King's Fund Centre on 13th May 1982

"Issues for London DHAs: Policies for the Elderly" was the first in a series of one day conferences, each focussing on a different area of service provision and policy development, held at the King's Fund Centre following reorganisation of the NHS April in 1982. The aim of the conference was to introduce members of London District Health Authorities to the particular problems of providing services for elderly people within London. To set the overall context for the discussions, a background paper was circulated in advance to participants, which discussed the development of policies for old people in general and introduced some of the themes to be developed during the day. The background paper is reproduced in this report as Appendix I.

Participants were welcomed to the King's Fund Centre by its Director, Mr Graham Cannon, who then handed over to the chairman for the day, Dr John Dunwoody.

Introduction to the Conference. Dr John Dunwoody, Chairman, Bloomsbury DHA.

In his opening remarks, Dr Dunwoody stressed the need to consider the provision of services for old people in the specific context of London. Despite considerable progress, he said, the quality of provision for old people, both in the community and in hospitals in the Capital contrasted greatly with the excellence of provision available in its acute units. Further, the statutory services for old people in London would be required to meet a considerable increase in needs due to demographic change. As in the country as a whole, the proportion of London's elderly population with the greatest potential needs, those over the age of 75, would be increasing. However, the continuous depopulation of the Capital means that the level of informal support available in other parts of the country would not be available in London so that the statutory sector would be required to compensate or provide for the physical or emotional isolation experienced by old people in London. These issues would be developed in more depth by subsequent speakers. Dr Dunwoody therefore introduced the first of these, Mr Tom Snow.

The Challenge Facing London DHAs. Mr Tom Snow, Divisional Education Officer, NUPE.

"The challenge facing London DHAs" was the title of Mr Snow's presentation. He took as his major themes: the significance of social isolation for London's elderly people and the extent to which statutory agencies had taken account of this characteristic in planning and providing services for the old. These themes are covered in more depth in his publication, "Services for old age: a growing crisis in London".[1] Mr Snow supported many of his arguments by reference to a handout of selected statistics, which is included in this report at Appendix II.

Mr Snow began by pointing out that in London, elderly people make a much greater use of acute inpatient facilities than elsewhere in the country, as the following figures illustrate:

Table 1. Patients aged 65+ discharged from general medical beds per 1,000 population aged 65+

Inner London	71.9
Outer London	51.0
England and Wales	37.7

(Source = LHPC 1981. Year unstated)

The "characteristic planning answer", said Mr Snow, sought an explanation for this phenomenon in the plentiful supply in inner London of acute facilities. The argument being that since demand is insatiable, where facilities exist they will be filled. However, in Mr Snow's opinion this answer ignored the significance of the evidence arising from the "Elderly at home survey",[2] which revealed the importance for old people of help from family networks. In London, however, this support is considerably less than in the country as a whole as the following statistics demonstrate.

Table 2. Percentage of persons aged 65+ having monthly or less contact with relatives

Inner London	35.1
Outer London	22.6
England and Wales	15.5

(Source = Elderly at home survey carried out in 1976)

This comparative isolation from relatives is partly due to outward migration from inner London taking place since the Second World War. However, the low level of car ownership in London makes it difficult even for families living in different boroughs to maintain contact. These important social changes have come about rapidly, in the space of one generation. Research indicates that in the 1950's it was common for working class parents in London to have close contact with their children. In Mr Snow's view, this lack of traditional, informal support provided a more accurate explanation than the "characteristic planning answer" of the heavy use of acute facilities by London's elderly people.

The question then asked was whether the providers of statutory services had appreciated the significance of these social changes and taken account of them in planning services for the elderly. The per capita expenditure of local authority services in inner London was, said Mr Snow, high in comparison with the country as a whole. This might indicate an attempt to compensate for relative social deprivation. However, as the following statistics indicate, the chances of isolated old people receiving social services are still considerably less in London than in the country as a whole.

Table 3. Comparative chances that persons with monthly or less contact with relatives can receive social services.

	Home Help	Meals at Home
Inner London	64	58
Outer London	63	57
England	100	100

(Source = Services for Old Age. Age Concern, 1981)

There was, said Mr Snow, some debate about the extent to which, in establishing local authority Grant Related Expenditure (GRE), the Department of Environment gives weight to the existence of social isolation. The methodology being used was unclear, underlying assumptions and value judgements were not made explicit, and the inference drawn by Mr Snow was that social isolation was regarded as one of a number of marginal, rather than a crucial central issue. Mr Snow used Southwark as an example to indicate the gap which exists between GRE and expenditure in local authorities. In 1981, in this borough, the social services budget was £11½ millions (44%) above GRE. The 1981 Census showed that the GRE calculations had assumed a population of people over 75 in Southwark greater by 22% (2,600) than the actual. Hence the existing "spending gap" would be wider still in the next financial year. Although GRE allocations are not supposed to represent financial targets, Mr Snow said, year by year Central Government controls are forcing local authorities to regard them in this light. Government is not obliged to argue that services are excessive - the onus rather lies on social service departments to demonstrate existing need - a task for which an accurate data base is essential but possibly non-existent. The pressures on social service departments could be seen in the statistics for home helps printed below. They indicate that the growth in home help services is tailing off and that in inner London the number of hours help received by elderly people in receipt of the service is decreasing. These figures are extremely significant since the home help service is crucial in attempting to provide a surrogate for informal non-statutory care.

Table 4. Home Help Cases per 1,000 population aged 65+.

	1977-78	1978-79	1979-80	1980-81
Inner London	147	146	149	150
Outer London	94	99	101	100
England	103	106	105	104

(Source = CIPFA).

Table 5. Home Help hours per case

	1977-78	1978-79	1979-80	1980-81
Inner London	117	127	114	109
Outer London	96	100	97	96
England	115	114	111	111

(Source = CIPFA).

Mr Snow then considered the extent to which social isolation had been taken into consideration in planning health services in London, as follows:

1. Acute hospital beds In 1979, the London Health Planning Consortium published "Acute hospital services in London",[4] which recommended an overall reduction of 5,000 acute beds in London, equivalent to 10% of the total. This would bring provision in the Capital nearer to the national average. The formula for determining the level of acute beds was however modified because it was recognised: a) "changes in the pattern of use in an area cannot be expected to take place quickly"; b) "social and environmental factors, not reflected in the morbidity of an area, may also affect the area's need for inpatient care, relative to other areas". Hence where the projected hospital rates for a particular specialty were lower than the current rate, "the projected age/sex specific rates for that specialty and area were increased to give an overall rate halfway between the current and original projected rates".

This approach was severely criticized by Mr Snow on two counts: Firstly it took no account of social isolation per se as a factor determining a required service level. It was presumably subsumed under "social and environmental factors". This gave no indication of the importance or significance attaching to this attribute. Secondly, the decision to increase rates "halfway" was presented with no logical or scientific justification. It appeared to be a purely arbitrary and subjective measure, totally inadequate in a context of extensive reductions in acute bed numbers.

2. Geriatric beds

The inadequate provision of hospital geriatric beds was noted in the 1981 LHPC paper "Profile of services for the elderly in London".[5] This pointed to the need in inner London for "between 400 and 600 extra geriatric beds over the next decade". However, there was a gap both in time and thinking between this document and the earlier one on acute services. No consideration was given to the need to compensate elderly people previously reliant on acute provision, for inadequacies in other parts of the service. The perceived priority had been the reduction of acute facilities and these cuts were not made contingent upon expansion of geriatric beds. There appeared to be a general assumption that the decrease in acute beds would coincide with an increase in geriatric facilities, an assumption belied by the following statistics.

Table 6. Numbers of Geriatric and General Medical beds in Inner London

	1976	1977	1978	1979	1980	Change 76-80
Geriatric beds	2949	2977	3009	3017	2920	-1%
General medical beds	4016	3858	3684	3385	3214	-20%

(Source = SH3 statistics)

3. Community care

The Acheson Report[6] drew attention to the shortcomings of primary and community care services in London. However, given these inadequacies, in Mr Snow's view, it represented a missed opportunity to ask fundamental questions about a philosophy for the care of the old founded on community-based provision. It could have asked: Is this basic philosophy workable?

To what extent can there be a major switch in resources in London? To what extent is dependence on acute beds irreversible? Evidence for a pessimistic view can be derived from the following statistics relating to community nursing and health visiting services in London - services essential for the development of community based forms of care.

Table 7. Community Nurse and Health visitor cases aged 65+ per 1,000 population aged 65+

	Community Nurse	Health Visitor
Lambeth/Southwark/Lewisham	123	32
England	190	73

(Source = DHSS Form LHS 27/3)

At least part of the explanation for the low levels of use of these services is likely to be the shortage of care available from relatives and others in between the visits of community nurses and health visitors. As long as this remains a possibility, it must cast a serious doubt on policies which place greatly increased reliance on community services .

In the absence of a coherent policy to provide for the elderly, and in view of the absence of a planning body for London, Mr Snow proposed the following two initiatives as the challenges now facing London DHAs.

1. Ensure that better quality information is collected, including an up-to-date profile of the population and its needs, and a profile of the service response to those needs. Use this information to monitor the implementation of policy.

2. Fill the alarming planning vacuum which now exists for London. By joining together and collaborating in planning services for the elderly, said Mr Snow, DHAs might be able to prevent a disastrous situation emerging for London's old people.

Policies for Care of Elderly

Following on from Mr Snow, two speakers from the Department of Health and Social Security gave presentations relating to the development of policies for the care of the elderly. The first speaker was:

Dr Geoffrey Rivett, Principal Medical Officer, DHSS

Dr Rivett focussed particularly on the development of services for the elderly in London, and and in doing so had three particular messages for members of London DHAs.

1. The first concerned the need to distinguish between health service politics and health service planning. The former, he said, was the concern of Ministers and the general public, via the ballot box. Its subject matter was questions of relative resource allocation, both at national level between government departments, and within the NHS, between Regional Health Authorities. District Health Authorities must work within the given framework of these political judgements, and must view their task as being to secure the best possible service within their allocated resources.

2. The second message was the need to develop a strategy which encompassed the requirements of the total population rather than just a particular group. Within this overall strategy, the options for delivering services to specific groups should be considered carefully, weighing up the possible contributions of, and collaboration between, the health, local authority and voluntary services.

3. Thirdly, Dr Rivett considered briefly the particular features affecting health care planning in London as follows:

a) The continuous depopulation of the Capital since the turn of the century, which meant that in absolute terms the numbers of old people would not be increasing although the proportion of very elderly people would rise. The 1981 Census confirmed this overall decrease.

b) The concentration of acute services in the centre with until recently, a reluctance to accept elderly and long-term patients in acute beds. At the same time there are severe shortcomings in primary and community care services in London.

c) The complex links between hospitals and medical schools. The financial problems facing the Universities have created problems for teaching and research.

d) The division of responsibility for London between the four Thames Health Authorities.

In the face of these complexities, it was essential for the DHSS to have a strategy for the overall development of health services in London. The task of the London Health Planning Consortium had been, as the 1981 London Advisory Group Report entitled "The development of health services in London"[7] pointed out, "to provide a pan-London perspective of the problems and to assist with local planning".

The overall strategy encompassed a reduction in acute services as outlined in "Acute hospital services in London"[4] and an increase in the number of geriatric beds as outlined in the "Profile of services for the elderly".[5] Despite the complexities of planning health services in London, Dr Rivett reaffirmed the findings of the latter document, that the continuing reduction of the population of inner London confirms "that the scale of extra provision required is not such as to throw doubt on the strategy, agreed by Ministers, of using some of the resources released by reductions in acute services to bolster community and institutional services for the elderly".

The three-fold message for members of London DHAs was therefore:

a) Be clear about your task - planning not politics.
b) Be aware of the complexities.
c) Develop your own comprehensive strategy for the development of all health services in your district within the overall policy and financial framework provided by Government and RHAs.

The second speaker from the Department of Health and Social Security was:

Miss Margaret Edwards, Principal, DHSS

Miss Edwards presented a national perspective on the development of policies for the elderly, highlighting areas where members of District Health Authorities had a particular role to play.

She began by restating the central objective of policy in this area, outlined in "Care in Action"[8] and "Growing Older"[9] as being to enable old people to live independent lives in the community for as long as possible. This, she said, should be a manageable objective for most of the "young elderly", those under the age of 75. After that age the increasing complexity of medical and social problems made the fulfilment of that aim more difficult. A major function of service providers, in relation to those who of necessity enter institutional care, should be to safeguard and enhance the quality of their lives.

Referring to the implementation of this community-based policy of care and support, Miss Edwards pointed out that less than 10% of district budgets were being spent on community-related services for the elderly. This low proportion of resources indicated the need for health authorities to expand provision in this area. Much "community care" was the responsibility of social service departments. District Health Authorities, said Miss Edwards, could play a major part in helping them to forecast need and plan services accordingly.

Miss Edwards then turned to a consideration in more depth of particular forms of care for the old, as follows:

Residential Care Despite the development of domiciliary services and sheltered housing, a significant minority of elderly people continue to need residential care. Such care is now usually only provided on a long-term basis, when it is no longer possible for an elderly person to cope in their own home, with the consequence that new residents are becoming increasingly old and frail.

As a result of this increasing dependency, many local authorities are finding difficulties in meeting residents' nursing needs. Whilst it must be recognised that it is not the function of residential homes to provide health care equivalent to that available in hospitals or nursing homes, there is a need for health and local authorities to work together to improve the nursing support available in residential homes. Apart from providing homes on a permanent basis for old people, residential homes are also used to provide short-term care for elderly people often in order to give some relief to families and informal carers.

Nursing Homes When an elderly person requires continuous nursing care, the aim of policy is to ensure that it is provided in small local units close to family and friends in as "homely" an atmosphere as possible. This, said Miss Edwards, is an ambitious and, given current resource constraints, necessarily long-term aim. However, much can be done to improve existing environments without the need for major capital funds. The Department of Health and Social Security is currently sponsoring three experimental nursing homes which will provide just this sort of care for patients who require more nursing than the community nursing services can supply, but who do not need the full range of hospital services. The nursing homes are being funded and planned jointly by the DHSS and the three health authorities involved, and will be evaluated from the Department's Research Funds. Funds will be available for the evaluation for a period of five years.

Hospital Care The hospital care of elderly people was the subject of the recent DHSS publication, "The respective roles of the general acute and geriatric sectors in care of the elderly hospital patient".[10] Nationally, at any one time, old people occupy nearly half the available hospital beds and since 1970 they have accounted for 90% of the increase in hospital cases. Since only 15% of all beds nationally are designated for geriatric medicine, and as 64% of these are in long-stay hospitals, it is clear that a considerable number of elderly people are being treated in general acute beds. As "The respective roles"[10] study makes clear, despite an increasing number of beds being assigned to geriatric medicine, a major shortfall in suitably qualified medical and nursing staff means that this situation will continue into the forseeable future. In the last ten years the number of consultant geriatricians has increased by 76% but there is little prospect that in the near future sufficient suitable applicants will be available to rectify the current shortfall. There have been various initiatives to increase geriatric medical staffing including increases in the number of doctors in training grades in geriatric medicine and general encouragement for senior registrars in general medicine to include a period of geriatric medicine in their rotational posts. Appointments of consultants with a special responsibility for elderly patients is also another option which has been fairly widely adopted.

The picture is similar in relation to nursing staff. There is a continuing inbalance between qualified and unqualified nursing staff working with elderly patients and improvements both in overall numbers and in the ratio of qualified to unqualified staff will require additional nurse staffing expenditure, as well as more recruits to the specialty.

Whilst there are severe shortages of remedial staff in many departments of geriatric medicine, the outlook for future supply in these professions is more hopeful.

It should not be forgotten however, that major improvements have taken place in recent years and departments of geriatric medicine have made a major contribution to these. The DHSS remains committed to the continued development of these specialist departments. For them to work effectively however, it is essential that adequate acute and assessment beds are available on the DGH site.

Other beds will also need to be provided-active and slower stream rehabilitation, as well as some long stay beds with supporting services and medical and nursing cover as appropriate. Outpatient services also need to be provided in proximity to other specialities and the other necessary investigative facilities. Similar consideration should also be borne in mind when siting day hospitals which are an important part of provision although proximity to other specialties is of lesser importance.

In 1979 the Department issued a package of guidance and learning materials developed jointly with the NHS called "A programme for improving geriatric care in hospital".[11] The aim of this programme was to help all staff working with elderly patients to increase their understanding and awareness of the needs of patients and develop improvements at ward level. The programme is widely in use and seems to have had an effect on attitudes and practices. But the continuing education of all staff working with the elderly remains a priority.

Day Hospitals and Short Term Care Facilities These are important adjuncts to inpatient services. Since 1970, attendances to day hospitals have increased by 165% and now amount to about 1½ million per year. Short stay facilities are valuable both in giving relief to carers and in detecting at an early stage conditions which if neglected might necessitate inpatient admission or long-term care. The DHSS, said Miss Edwards, regards further development in this area as an important policy direction.

Primary Health Care Good primary health care is of crucial importance in preventing disability and dependence among elderly people, in enabling more of them to continue to live at home, and in ensuring that other forms of health and social services provision function as they should. Many GP practices and primary health care teams are addressing themselves to the special needs of their elderly patients and special arrangements include registers of elderly patients at risk, off-peak surgery hours and regular visiting of housebound elderly people. Such work is still limited and one possibility the Department is proposing to explore, said Miss Edwards, is the provision of funds to selected Family Practitioner Committees for the purpose of constructing age/sex registers for GPs who wish to use them.

Voluntary Care The voluntary dimension of provision for elderly people is increasing continuously and taking full account of its existing and potential contribution is an important aspect of service planning and provision. Both local and health authorities can initiate, support and foster voluntary effort at local level. There are very practical ways in which statutory services can help the voluntary sector. Local authorities can provide direct grant aid and rate relief in certain circumstances; both local and health authorities can provide practical assistance such as free loans of accommodation, transport and supplies of various kinds. They can also provide professional back up for voluntary workers. A start has certainly been made, said Miss Edwards, but this is an area in which there is scope for much more collaborative work at local level.

Informal Care All policies in relation to elderly people rest on the recognition that the primary sources of support and care are still informal and voluntary. An immense contribution is made by families, friends and neighbours as well as a wide range of private, voluntary and religious organisations. Support for carers in all these capacities is a very fundamental strand of policies. Much is already being done to help these people by local and health authorities but they still have a major contribution to make. Most directly they can share the burden by designing services to take account of carers' needs.

The summary above, said Miss Edwards, merely skimmed over current policy in relation to the development of services for elderly. However, it should, she hoped have suggested to authority members various areas where they could take the lead in initiating and improving the care and support provided to the elderly in their own districts.

The contributions by the DHSS were followed by the final presentation of the morning which was given by a Director of Social Services. This title was:
Health Care for the Elderly - The View from Social Services
Mr Ken Boyce, Director of Social Services, London Borough of Newham.

Mr Boyce's talk took the form of a "fictional" account of the problems which an old person might face in trying to obtain help from the statutory health services.

He began by imagining an old lady, who without any obvious cause was feeling generally "unwell". Her initial act was to call upon a neighbour, who when she realised the old lady was not improving, decided to call upon more formal assistance. This "fictional" episode took place on a Saturday morning which partially accounts for the distressing sequence of events then charted by Mr Boyce:

1. Neighbour calls GP - GP not available, ansafone gives number for deputising service.

2. Deputising service after considerable delay sends a strange GP who knows nothing of the old lady's medical history but who nonetheless gives a prescription for medication.

3. Some time later, the old lady appears to worsen and the neighbour begins to fear she will have to cope alone.

4. Neighbour therefore telephones 999 and asks for an ambulance.

5. She is quizzed by the ambulance service who say that the old lady does not represent an emergency, therefore they cannot help.

6. Neighbour then asks another neighbour to transport the old lady to the nearest Accident and Emergency Department.

7. Here a harassed junior doctor with no training in geriatrics sees the old lady. He is unable to identify the specific cause for her being "unwell", and is very conscious of his consultant's antipathy towards elderly "bed blockers" or "inappropriate users of acute services". However, he may do one of two things:

   a) Admit the lady to an acute ward where the consultant's attitudes are mirrored by the nursing staff. Since no arrangements are in existence for a geriatrician to see patients on general acute wards, and since the acute specialists are unable to help the old lady, after a distressing and confusing stay in a hostile environment, she would be sent home.

or

   b) Send the lady home.

8. Once home, after a possibly lengthy period without formal support, the statutory services can again be involved. On Monday, the GP may arrange for a domiciliary visit by the geriatrician, and the appropriate health and social services support may then be mobilised.

Mr Boyce acknowledged that this account might not ring true for all districts, but health authority members could ask themselves whether these events might happen in their localities. Some of the problems charted are outside their control - access to general practitioners' services, for example, which the Acheson Report[6] showed to be particularly poor in inner London. However, they could do something about some of the problems. The message Mr Boyce hoped would emerge from his 'fiction' was - do not lose sight of the person. The best way to improve the quality of services is to scrutinize them, not in relation to the whole "client group" but with respect to their effect on a particular individual.

Mr Boyce recognised that the social services have as many shortcomings as the health services - but his brief had been to speak about the latter! Local authority social services could place cruel pressures on old people. For example, when an elderly house-owner is admitted to residential care, the local authority may have first call on his estate to recoup charges, should he die. The elderly person might therefore be deprived of the pride and satisfaction of leaving a bequest to his children.

More generally, within social service departments, the elderly as a group are not accorded priority. Mr Boyce pointed out that over the last ten years the elderly have received proportionately less of social service budgets, with the major share going towards services for children and families. Even when elderly people do receive the range of services to which they are entitled, the lack of examination of their impact on the individual may lead to undue complacency. Mr Boyce related an anecdote about an elderly disabled couple in his "patch" who on paper received a very impressive range of services. He was therefore shattered when they informed the media that they coped 'virtually alone'. However, when close examination was given to their situation, it became apparent that for 20 hours of the day they were on their own. Mr Boyce therefore pleaded for the providers of services to consider their impact on the individual. "Do not lose sight of the person. Feelings are facts!"

How may progress be made in improving care? In Mr Boyce's "fictional" account, a central figure had been the neighbour - the "informal carer". However, his account also showed the stresses which such unsupported reliance placed upon this individual. These stresses could be relieved if statutory bodies developed more contacts with carers. Where need is of "low" or "medium" intensity and the amount of support provided by inpatient or long-term care is not required, the aim of statutory services should be to bolster and support the work done by family and neighbours - possibly by paying them for their services, but certainly by assuring them of an "on-demand" service from the statutory sector should they no longer feel able to cope alone.

Mr Boyce recognised that this solution might be in potential conflict with the culture of a society in which Trades Union and professional interests are (legitimately) so highly developed. It was a solution possibly more acceptable to Mediterranean societies for example, where rules and lines of demarcation have not been so firmly drawn. Nonetheless, said Mr Boyce, in the interests of the individual - the person, not the client or the patient, such developments might offer the best hope for the future.

The Elderly in Stockport - Policies and Progress

During the afternoon policies for elderly people were considered in a specific context. Participants heard about service developments which had taken place in Stockport, where close collaboration between health and social services have effected significant changes and improvements. The conference heard first from:

Dr Joan McCann, Community Physician (Social Services), Stockport Health Authority

Dr McCann began by giving some background information about Stockport's population and its health care provision for elderly people.
The district: Was a single district area and since April 1982 has been a district health authority with boundaries co-terminous with the local authority.
The population: Total 300,000 of which over 65 = 14%, over 75 = 5.3% (expected to increase by nearly 13% by 1991).
Hospital provision: 387 geriatric beds (18 or more in 1983) on 4 sites; 114 psycho-geriatric beds on 3 sites including 56 bedded unit for the elderly severely mentally infirm on the DGH site.
Medical staff: 3 consultant geriatricians (one a recent appointment) and 5 consultant psychiatrists (one with responsibility for planning psycho-geriatric services).
Strategy: Broad strategy is, in accordance with national guidance, to make good existing deficiences in health service provision and to develop community services in collaboration with the local authority and voluntary bodies. The aim being to allow old people to maintain independent lives in their own homes for as long as possible.

Elaborating on this general strategy, Dr McCann stressed the need to:

1. Provide community residential care to prevent inappropriate "bed-blocking".

2. Ensure good discharge and liaison arrangements between hospital and community.

3. Recognise the probable impact of demographic changes on specialities such as ophthalmology, orthopaedic surgery and general medicine, and plan accordingly.

4. Provide the primary health care team with an effective hospital service.

5. Provide an adequate paramedical community service (especially chiropody and physiotherapy).

6. Provide an effective and supportive psycho-geriatric service with expertise available to doctors, social services, and families in the district.

7. Provide an assessment service which ensures elderly people are accommodated according to their needs.

8. Put some resources into the prevention of morbidity in the elderly by early detection of disease and disability.

These, said Dr McCann, were their aims, but how successful had they been in achieving them? She hoped to show that even in times of little or no growth, some progress can be made. However, if change is to be achieved, some factors are of paramount importance:

1. Good formal and informal links at planning and operational levels between health and local authorities, social services, housing and voluntary bodies. The right climate must exist in which all agencies share a willingness to work together.

2. There must be a broad strategy, accepted by all statutory agencies, developed at joint care planning team level.

3. There must be be an ability to make the best possible use of new and existing resources. For example, when additional beds are provided, the correct balance between acute and rehabilitation beds must be ensured; when additional staff are appointed, their job descriptions must reflect current needs; new schemes must have appropriate operational policies which can be implemented flexibly; reosurces must be used imaginatively to overcome obstacles and create an atmosphere both forward-looking and innovatory.

Dr McCann then proceeded to describe some of the developments in health, and joint health and local authority arrangements, which had taken place in Stockport in recent years, in order to demonstrate how existing and new resources had been used to provide a better service for elderly people.

A. Recent staffing alterations and additions

The district had recently appointed an additional consultant geriatrician, a consultant psychiatrist with particular responsibility for the planning of psycho-geriatric services, and an associate specialist psychiatrist, funded by converting an existing clinical assistant post in psychiatry. Given these resources, the challenge was to deploy them most effectively. The decision on how to do this was made by looking at the changing needs of the elderly and tailoring job descriptions to meet those needs. As a result, in Stockport specialist advice, both geriatric and psychiatric is available to geriatric and psychiatric departments, local authority residential homes for the elderly and homes for the elderly mentally infirm. Consultant input has been assured in the planning and development of the psycho-geriatric unit and community services. The consultant geriatrician provides advice to the psycho-geriatric unit on a regular basis. He visits elderly persons homes regularly and the appointment has enabled the management of 48 extra geriatric beds by the three consultant geriatricians. The associate specialist in psychiatry has a commitment to visit homes for the elderly mentally infirm.

B. Using reallocated beds

The Stockport use of beds again demonstrated a responsiveness to identified local needs. In the new psycho-geriatric unit, half of the available 56 beds were designated for assessment and short-stay, thus providing a source of advice and support to homes for the elderly mentally infirm, social services staff and families. Similarly, 20 of the 48 newly allocated geriatric beds were designated for acute assessment. The operational policies on the Stroke Rehabilitation Ward are designed to ensure that staff work intensively as a team and length of stay is limited to a maximum of 4 months to ensure that transfer from other wards in the DGH will be possible and bed-blocking is prevented. The importance of paramedical services is recognized, not just for their clinical services but as a source of advice and education for other staff. Hence efforts are made to attract these staff by providing good facilities and environments in which to work.

C. Loan equipment service

This service was set up to provide disablement aids for handicapped people of all ages, who are either permanently or temporarily disabled, living in the community. The service operates from a base at the local geriatric hospital and a limited number of items are available on loan for the community services. A storeman/driver makes deliveries and collections. Requests for aids are forwarded by the district nurse, health visitor, general practitioner, social worker, or by self-referral, and channelled through the District Nursing Service. Aids required urgently are issued on request.

Because provision of aids between social services, health services and voluntary bodies seemed so complex, a working party was set up to look at the problems, and provision was rationalized as far as possible. This working party identified how useful it would be if the aids assessment centre were relocated adjacent to the loan equipment service so that advice would be readily available to staff and patients about loan items. An old building was converted and enhanced for this purpose, a spin-off being that accommodation was released in the DGH which allowed the development of a general occupational therapy department. These improvements were secured without large capital funds and they do not have significant revenue consequences. In the future, it is hoped to provide a loan service funded on a shared basis with the Local Authority, so that all patients/clients and all District Health Authority/Local Authority staff have one major source of loan equipment.

D. Improving geriatric care in hospital

Stockport Health Authority is participating in the improving geriatric care in hospital[11] training programme. A 'key team' has been appointed of doctor, administrator and nurse, and regular meetings are held in three main locations with staff from all disciplines.

Guidelines for discussion deal with the following main areas: identity and dignity; high dependency care; mobility; security; independence; pattern of the day; social needs; appearance; prevention of incontinence; communication; and terminal care - all subjects which do not necessarily require financial resources but do require a coherent philosophy and thoughtful approach.

E. Volunteer stroke scheme

This scheme is operated by the Chest, Heart and Stroke Association in collaboration with the Health Authority, which pays the coordinators' salaries. The scheme is designed to involve untrained volunteers in helping stroke patients who have speech and allied problems. It is also to help these people regain their confidence, hopefulness and happiness, without which they are in danger of not attaining their maximum posssible recovery.

The volunteers visit stroke patients at home to stimulate and encourage communication. Patients also attend a weekly club and are involved in as many outings and social functions as possible.

It is very important for officers of the statutory services to maintain contact with the co-ordinators, to provide advice and support as necessary. This is done by holding a quarterly meeting involving the co-ordinators, the consultant geriatrician, Dr McCann and the area speech therapist. It does not require a lot of time but performs a very useful function.

F. Joint high dependency home

This innovatiave scheme arose as a result of recommendations made by the Joint Planning Team. It is funded from joint finance monies and was planned by health and social services staff working in close collaboration. An elderly persons' home (EPH) was adapted to cater for residents who are too highly dependent for EPH but do not require hospital care. Five of the 38 places are for rotating care. Enhanced care staffing levels are maintained and medical, paramedical, nursing and social services staff work as a team. Medical care, treatment and assessment are provided by a GP clinical assistant. A consultant geriatrician is adviser to the home, and the district nurse visits regularly. An occupational therapist and physiotherapist assess and treat residents.

Decisions on admissions are made jointly by medical and social services staff.

G. Residential homes for the elderly: arrangements for health care

In 1978, Dr McCann, together with a nursing colleague, carried out a survey of all 18 residential homes for the elderly, as a result of

which several recommendations were made, most of which have been implemented. Dr McCann mentioned in particular medical involvement in assessment procedures for candidates for EPHs. This recommendation was implemented via the establishment of a part-time clinical medical officer accountable to Dr McCann and the consultant geriatrician. She is based in the outpatients department of the geriatric hospital but works in community clinics, EPHs and on domiciliary visits. She receives referrals from social services staff of elderly persons who are thought not to be able to manage any longer in their own homes. She assesses the person medically with the social worker, liaises with the GP, advises on treatment of remediable conditions and on appropriate placement.

It is considered essential that only those elderly people who cannot manage in the community are admitted to other forms of provision. Full assessment often reveals remediable conditions and situations which can be dealt with by other means, such as provision of suitable aids or alternative housing support. The indications are that between one quarter and a third of those referred are thought able to remain in their own homes. This service is called the 'community geriatric assessment service'.

H. Elderly screening scheme

This is a preventive service which aims to avoid extensive periods of morbidity in old people, and involves interested doctors, nurses and administrators. The scheme is operational in 9 GP practices, (3 centres). Participation in the scheme is offered to 70 year olds in the 9 practices and as many as possible of those over 70. There is no compulsion, and a few have refused, but most welcome the scheme and are appreciative. A health visitor attached to the practice visits the patient by appointment and obtains the necessary social and medical history. Subsequently the patient is examined in the doctor's premises by the consultant geriatrician or a member of his team, assisted by two clinic nurses. Close liaison is maintained with the family doctors. The primary aim is to elicit those medical and social conditions which, if not identified and corrected or ameliorated, would result in disability.

The scheme has only been in operation for six months and is currently being evaluated. It is hoped not only to help the individuals seen, but to provide information which will be useful in planning services. Any extension of the scheme will depend on the interest of the family doctors concerned, consultant geriatrician time available and funding for health visitors and nurses.

After this brief summary of some of the major new initiatives for elderly people in Stockport, Dr McCann considered the prospects for future developments.

The joint planning team for the elderly was meeting to produce a report making recommendations for the health and local authorities. The increase in the number of elderly over the age of 75, would imply a greater impact on all services. The areas of greatest need for health services appeared to be:

* more provision of psycho-geriatric services.
* more short-stay geriatric provision to relieve carers.
* more nurses.
* more acute beds which could be made available by providing continuing care outside hospitals.
* stroke rehabilitation for males - already planned.
* more transport for day patients
* more joint provision of high dependency homes with EPHs equipped with some high dependency beds and sick bay wings for residents when they become ill.

This might appear to be a daunting 'shopping list'. However, Dr McCann hoped that her summary of developments so far had shown that much could be achieved without major resources if health and social services are willing to work closely together and cooperate to achieve maximum benefit from resources already in existence.

Dr McCann's presentation was followed by another on the same theme - developments for the elderly in Stockport - but this time from the social services viewpoint, by:

Mr R Lewis, Assistant Director of Social Services, Stockport Metropolitan Borough.

Mr Lewis began by describing the approach to service development adopted in Stockport, the essence of which is the avoidance of incrementalism - "We built x number of old people's homes last year, let's build x more this year!" - in favour of a continual reassessment of existing needs and accordingly a redefinition of the required pattern of services. This approach was used in the borough's first planning document on the elderly, produced in 1975. It involved the use of a dependency scale which was, in Mr Lewis's words, a "rough and amateurish way" of getting away from broad statistics in order to build a picture of the actual needs of elderly people in Stockport. One of the recommendations resulting from this 1975 review was the bridging of the gap between hospital and local authority provision for the elderly, the genesis of the "joint high dependency home", already briefly described by Dr McCann. Mr Lewis described how this scheme was brought to fruition as follows:

Joint high dependency home

An existing home which was physically suitable for very frail elderly people - that is, it did not have stairs in the middle of the corridors, and already had a reasonable sized lift - and was geographically close to where the geriatricians worked, was designated for this purpose. The staffing requirements were determined, not by reference to any prescribed national formulae, but by asking "What will these residents need?"

As a result, a care staff ratio of 1:2.4 was decided upon; regular district nursing input was arranged; a physiotherapist and occupational therapy staff are available; and without interfering with the right of each resident to have his or her own general practitioner, a designated medical officer contracted to the health authority, is required by his terms of service to visit the home daily and generally oversee the health of the residents. As a further example of the close cooperation between health and social services in this venture, the latter waived their right to allocate places in this home, and admissions are agreed by a joint health and social services panel, on which the geriatrician has final say. Mr Lewis felt that this initiative showed that it is possible to care for very frail and elderly people in a local authority establishment, provided that it is operated jointly with the health authority, and provided that truly "collaboral" relationships exist between the two authorities.

Good relationships, both formal and informal, such as had been built up between officers of health and social services in Stockport over the years were, said Mr Lewis, vital in generating the understanding and trust necessary to initiate many joint ventures. It had thus been possible in Stockport to develop:

Consultant geriatrician support to elderly persons' homes

One geriatrician has particular responsibility to advise officers in charge on problems of management. Obviously care must be taken not to override another consultant's clinical responsibility or interfere with the resident's relationship with his or her general practitioner. However, in an atmosphere of trust, such organisational arrangements can work.

Another example where such relationships are necessary is the: Community geriatric assessment service, already described by Dr McCann.

Mr Lewis then went on to consider significant developments in the community. He referred to the development of:

Functional rating forms and social assessment documentation

Traditionally, many elderly people are admitted to residential homes without adequate information about their background and level of function. In the last 5 years, a number of different styles of functional rating forms have been developed and these now reflect forms used in the Health Authority. Methods of completing the form vary from establishment to establishment, but basically they are designed for easy completion using colour code systems. A new social assessment form was introduced for completion by social service officers and social workers prior to a client being considered for admission to an EPH. All residents are formally reviewed 6 weeks after admission with the resident and his or her relatives/friends participating in the decision as to whether the placement should be permanent.

Mobile warden service

Nearly 2,000 people are now linked to the mobile warden service using radio alarm equipment. This is the largest scheme in this country and was the first major scheme using this type of equipment. Participants are provided with a simple call system - although this can, and is, adapted on occasions to involve pressure pads, pocket transmitters and temperature control units - and on activation a mobile warden operating from a radio controlled vehicle can be with the caller within a matter of minutes. As a result of this service many old people have been able to remain living in their own homes and maintain their links with the communities they have known for many years.

Some of the units are paid for by the health authority, so that if a consultant wishes to discharge someone, but feels there is an element of risk, one of these units may be installed.

Joint working takes place in Stockport not just between the health and social services, but between branches of the local authority particularly housing and social services, as shown by the arrangements for:

Sheltered housing

Alongside the provision of the mobile warden service, the availability of sheltered housing has continued to be developed in Stockport in the last 5 years. However, allocation of tenancies in all sheltered housing schemes is now undertaken jointly between housing and social services departments; in certain of the schemes, care staff are provided in addition to home helps.

In Stockport, the traditional way of providing home help services has been abandoned and instead there have been established:

Domiciliary care teams

The recent Barclay Report[12] discussed the concept of "patch systems". In Stockport, it has for some time been considered necessary to provide services for elderly people on a smaller geographical area and more closely aligned to the work of primary health care teams. For the past 3 years, 5 group practices have had social workers specifically attached to them to try to bridge the gap between primary health care services and social work support services. However, in relation to the delivery of domiciliary services, traditionally many individuals would have been involved in one old person's home - home help organisers, therapists, social workers, meals-on-wheels organisers, and so on. In Stockport domiciliary care teams have been developed based on smaller patches. They are headed by senior social workers, who visit elderly people, undertake initial assessment, and can call upon and allocate a full range of resources including the provision of home helps, minor aids and adaptions, meals-on-wheels, laundry servcices and, where appropriate, professional social work support. Home help organisers are more concerned with the logistical organisation of the home help service and with staff management.

The final initiative developed in Stockport which Mr Lewis discussed in his selective account of progress made there, was in relation to:

Tackling loneliness

One of the major problems for old people is lack of mobility with consequent loneliness. In Stockport a new door-to-door on demand transport system has recently been introduced called 'Easygo'. At present, vehicles are used which are suitable for wheelchair access but it is hoped to extend the service by buying vehicles for pedestrian access also. Easygo also operates a luxury coach, purchased by the Council's lottery panel which enables organisations for the elderly and disabled to take people to seaside resorts and on day trips in comfort. And, said Mr Lewis, to the approval of conference participants, "without the stigma of having 'Stockport Social Services' emblazoned on the side".

In conclusion, said Mr Lewis, he could not claim that Stockport had a pattern of services which was meeting all needs. There was much to be done and there was no room for complacency about recent developments. Services should be continually reassessed in the light of current needs, and changes made, ignoring as far as possible the traditional modes of service delivery and the source of finance. However, underlining all this, said Mr Lewis, was the importance of having made secure relationships between health and social services, so that mutual criticism was accepted in good faith and each felt able to influence the actions of the other.

The last formal contributions of the day came from three senior NHS professionals working in London who had been asked to respond to the contributions made to the conference so far, and to consider, from their own professional viewpoints, the problems and issues surrounding the development of services for the elderly in London. The first to speak was:

Dr Jane Jackson, District Medical Officer, Newham Health Authority

Dr Jackson began by describing some of the particular problems to be addressed in London. First of all, she pointed out, "inner London" is a label covering very different populations and social and environmental circumstances. The needs and hence the required service responses could change dramatically over very small distances. In Newham, where Dr Jackson had recently been appointed as DMO, the population was, for London, relatively settled, predominantly working-class, and with about 30% of house holders New Commonwealth citizens; most of the health authority staff live outside the District. Secondly, all authorities were facing financial problems and London had some particular difficulties. Thirdly, there was the problem of the closure of acute beds to which Tom Snow had referred. Although Dr Jackson felt that in Newham there had been too many acute beds and many had been used in the wrong way, there were tremendous problems in trying to reduce the numbers and free the resources tied in with them, while at the same time attempting to achieve a change in emphasis within the service.

The problems of primary care in inner London made a shift from hospital towards community-based forms of care particularly difficult. These were the problems, but there were also positive aspects. Financial constraints necessitate a fundamental rethink of the way services are provided and this can be beneficial. In Newham, Dr Jackson also saw the benefits of a constructive Community Health Council, a supportive local authority, an excellent social services department, a Chairman and Leader of the Council both interested in joint planning, and co-terminous health and local authority boundaries. There was thus sufficient support and impetus for health and local authorities to consider jointly what resources exist in Newham and how they could be used most effectively, sensibly and sensitively.

Referring to the description of developments in Stockport, Dr Jackson admitted to being "absolutely Stockport obsessed". She identified four particular aspects of their work which she thought had relevance for Newham. The first was the "Stockport approach" itself - the corporate consideration of population needs and the joint consideration by health and social services of possible service responses. She felt it was very important to consider which tasks particular agencies were particularly good at, and which were better left to another body. These sorts of issues could be discussed corporately and demarcation lines between services redrawn if appropriate.

The second point was the need to design services for people "between two stools", the people who are not fit enough for local authority Part III accommodation but who do not need hospital facilities. Dr Jackson particularly commended the Stockport development of the joint high dependency home to solve this problem. There were, she thought, other innovative solutions which could be tried, for example: by providing individuals with money and a choice of facilities and letting <u>them</u> decide how they should be cared for; by using a hospital ward as a pre-discharge rehabilitation centre with general practitioners, remedial therapists, social workers and others all involved.

The third "Stockport initiative" which particularly impressed her in view of the tremendous difficulties with public transport in London was the 'Easygo' system. She was unsure how it might operate in London - "problems with voluntary drivers" were often cited - but there was a need to do something to help old people who had to be up and dressed at dawn to be taken to out-patients and then had to wait for hours after their appointments to be taken home by ambulance.

The development about which she was particularly enthusiastic however, was the home warden alarm scheme because it allowed so many people who are fragile to live independent lives in their own homes. Dr Jackson was currently involved in a study of very old people living in Bethnal Green, many of whom were very frail and disabled, but who were nonetheless coping. Their main anxiety was that they might fall over and lie injured and undetected for many hours. For them the home warden alarm scheme would be a tremendous source of security.

Dr Jackson then turned to a consideration of what the general thrust of policies in relation to the elderly should be. She mentioned in particular:

The promotion of good health. Educating people about the right sorts of foods; encouraging and helping them to take exercise; stimulating their minds by the provision of further education classes if they would like them; and maintaining their status by allowing them to continue to contribute their knowledge and skills to the community.

Keeping people out of hospital. This meant making primary care as good as possible. Here Dr Jackson warned about the danger of labelling a general practitioner service as poor because the GP concerned was old and worked single-handedly without an appointment system. He might well be providing the kind of service old people liked and not the somewhat uncompromising and depersonalised appointments systems found in some practices and health centres. Health authorities should consider whether they were doing all they could to help general practitioners provide a service. Health authorities should support the local authority and voluntary bodies who were also engaged in work which might keep old people out of hospitals.

Sharing services. Mr Boyce had pointed out the priority given to children in social services departments. Dr Jackson commented that in all parts of London there had been a tremendous historical impetus towards the development of child health services. Whilst not suggesting that resources should be shifted from that area, she felt that services developed for one group could be shared with another. Thus, in Haringey for example, the hearing surveillance services designed for children were now also being used by adults.

Improving the quality of care on acute wards. There was a need to educate and train staff looking after the elderly on acute wards. Changing attitudes towards the old and overcoming negative views about old people's potential for recovery represented a major challenge. Geriatricians could play a major role in this area, and there was a need to ensure that all medical students gained some familiarity with rehabilitation and long-term care as well as acute geriatric medicine.
Finally, said Dr Jackson, there was a need for:

Improving the quality of long-stay care in the NHS. If a person had to be admitted to a long-stay bed, the care he or she received should be the best possible. Even if the institution was a hospital, it should be regarded as the patient's home and they should be fully aware of their rights. The aim should be to enhance, not continually diminish the individual.

In concluding, Dr Jackson recognised that it was easy to identify problems and issue broad prescriptive statements but that the reality and pressures facing the providers of statutory services made the fulfillment of these laudable objectives very difficult. To tackle some of these issues effectively, it would be necessary to depart from entrenched positions and be prepared to be innovative and experimental. Shifting ideas and sharing resources represented the only way progress could be made.

The second "professional response" came from:

Miss Christine Hancock, Chief Nursing Officer, Bloomsbury Health Authority

Miss Hancock considered the development of policies for the elderly in London in relation to nursing services, both in the community and in hospitals.

Examining first issues relating to community nursing services, Miss Hancock echoed Dr Jackson's observations about the great differences in population and environment in various parts of inner London, differences which make it essential that community workers really "understand their patch". Living in the patch is the best way of acquiring an understanding of that population's needs, the amount of support available from informal networks, and the potential and limitations for community care. However, in inner London, because of the high cost and scarcity of housing, very few community nurses are able to live amongst the population they serve. There is also a considerable problem in retaining experienced and knowledgeable nurses. This lack of knowledge and experience means that it is extremely difficult in London to exploit to the full the potential of the community nursing service to function as a source of expert advice to other community workers and hospital staff, and to monitor the effectiveness of care in the community from all sources.

Another problem Miss Hancock mentioned was the marked degree to which GPs' practice catchment areas overlap in the inner city, a fact which presents great problems for developing patch-working and encouraging the concept of primary health care teams. A survey in Islington had revealed that one council estate was served by 41 different GPs, said Miss Hancock. She questioned the extent to which it was possible for health visitors to play a greater part in preventative work with elderly people. Health visitors in London have very small caseloads, but these include families with children in very difficult situations. It would be unrealistic and unfair to expect health visitors in these circumstances to decrease the time available to such families in favour of devoting more time to the elderly. Thought should be given instead to the possibility of developing the concept of geriatric visitors, already in existence in Camden. Alternatively, it was possible that as a result of the new training programme, district nurses could take on more preventative and screening work and thereby also end the confusing distinction between nurses who treat and nurses who do not. Another major hindrance to the development of preventative work in London is the absence of access to age/sex registers to identify at-risk people.

Caution should also be exercised, said Miss Hancock, in deciding who is to be involved in caring in the community. There was a tendency, she felt, to assume that almost anyone whether trained or not could be a "carer". However, good community nursing care required skilled personnel, which was not equivalent to dishing out a series of tasks to untrained people.

On a more positive note, Miss Hancock felt that the "misfortune" of the absence of large psychiatric hospitals in inner London had resulted in the development in the Capital of community-orientated psychiatric nursing services from which the rest of the country could learn. However, the facilities available to community nurses either from geriatricians or psycho-geriatricians for the admission of patients for short-term hospitalisation were very poor.

The final point which Miss Hancock made in relation to the development of community services, was the need to lend more support to local authority and private homes for elderly people, so that nursing care could be provided to old people without the stigma of transferring them to institutions labelled for example "for the mentally confused".

Miss Hancock then considered elderly patients within hospitals, of particular relevance to London, as Tom Snow had pointed out, becuase of the high level of contact old people in London have with acute hospitals. She said that the opportunity was being lost to use Accident and Emergency Departments as mechanisms to screen and prevent morbidity in the old. For example, old people presenting with injuries from falls should be assessed to establish the cause of the fall rather than just having their bruises treated. Hospitalisation of old people should be prevented at all costs, and innovative schemes which helped achieve this end, such as the use of observation wards as assessment wards for old people as developed at Whipps Cross Hospital, were to be commended. The establishment of geriatric and combined geriatric and psycho-geriatric assessment units also helped fulfil this aim, with the further benefit that they provided a base for the concentration of skills appropriate for the care of old people - nursing, medical, paramedical, social work - rarely achievable in a large hospital.

Nursing staff could play a more positive role in helping relatives and friends maintain involvement with old people undergoing a period of hospitalisation. Too often the people who had cared for an old person before the particular episode requiring admission, were excluded by professionals from continuing that care. As a result, they found other uses for their time and energies and were reluctant to accept responsibility for the old person again when they were judged fit for discharge.

Considering the treatment of elderly people in general acute wards, Miss Hancock made several points. Firstly, teaching hospitals tended to recruit staff from outside London who therefore lacked any local knowledge. It was essential that these staff were made fully aware of the importance of a satisfactory environment before an elderly person is discharged and that they therefore took steps to find out about elderly patients' home circumstances. Quite detailed enquiries might be necessary in order to establish the appropriate degree of rehabilitation necessary for any individual. It would be, for example, unnecessary to ensure that an old person could cope with a flight of steep stairs, if he or she lived in a ground floor flat.

There could be advantages for old people on general acute wards, for example being with younger people. However, too often they were regarded as illegitimate competitors for acute resources and came off second best as rivals for the attention of busy nursing and medical staff trying to cope with their needs as well as those of younger, acutely ill patients.

The value of involving the geriatric team in the care of old people on acute wards was stressed. Miss Hancock mentioned the experience in Edinburgh[13] where, by attaching geriatric staff to acute medical wards, dramatic reductions in length of stay were achieved as well as an increase in the skilll and confidence of acute hospital staff in dealing with older patients. Similar benefits are achievable if geriatric units are established within acute hospitals, and the special skills of those departments disseminated throughout the institution, in particular in ensuring that adequate attention is given to discharge arrangements for elderly patients. There is still, however, a reluctance in teaching hospitals to allocate beds for geriatric medicine. The existence of departments of geriatric medicine has done much to improve the image of caring for the elderly and there was evidence now that many nurses were turning to geriatric nursing as a positive career choice.

Referring to her own district Miss Hancock noted that there were many famous specialties and institutions of direct relevance to elderly people but which were not providing specific local services. There was now an opportunity to call upon this specialised expertise in developing district services.

In relation to long-stay care, Miss Hancock commended the booklet on improving geriatric care in hospitals[11] referred to in Dr McCann's presentation. By giving attention to attitudes and basic features of the environment much could be done to improve dramatically the quality of long-stay care.

Finally, Miss Hancock touched on two issues relating to central policy for the development of services for the elderly. The first was the intention to increase the number of geriatric beds in London contained in the LHPC document[5] mentioned by Dr Rivett. She pointed out that that document gave no indication of how such beds would be staffed. There are, she said, currently over two thousand funded vacancies for trained nurses in inner London and although geriatric nursing is increasing in popularity there would not be enough applicants to staff the scale of bed provision envisaged. Nursing auxiliaries, even where they are appropriate, are also difficult to recruit in London. The second was in relation to the nursing home concept being piloted by the DHSS in collaboration with three district health authorities. It was, said Miss Hancock, unfortunate that the Department had chosen not to base one of these experiments in London because it might have demonstrated the impact of the Capital's demographic, social and environmental features and their effect on the feasibility of implementing such a scheme in London.

The final contribution came from:

Professor Peter Millard, Professor of Geriatric Medicine, St Geoge's Hospital Medical School

Professor Millard's presentation took the form of a series of messages for members of health authorities, concerning the determination of policies for the elderly. They are summarised below:

1. Recognise the extent and sources of existing knowledge, and familiarise yourselves with it.

Knowledge relevant to the development of policies for old age could be derived from a number of disciplines, for example, medicine, sociology, psychology, nursing and management theory. Not only modern sources were pertinent, said Professor Millard, - "If you want to read common sense about the care of the elderly, read Hippocrates".

2. Be committed, not to the extent of rigid adherence to a particular line of policy development, but sufficiently so to be critical of any Central directives which are at variance with an accepted philosophy of care. For example, said Professor Millard, the current Departmental espousal of the nursing homes concept represented a denial of the geriatrician's responsibility for long-stay patients. Long-stay care had been transferred to the NHS from local authorities as a result of evidence of mismanagement of long-stay patients during the 1939-45 war. Under the leadership of geriatricians tremendous improvements and advances had been made. Now the need for this leadership was being denied and there was an abundance of evidence, in particular from America, which demonstrated the detrimental effects of lack of such leadership.

3. Know where good practice exists and learn from it.

This might mean looking beyond the statutory services. For instance, the Jewish Welfare Board, The Drapers etc. can supply good examples of sheltered housing, nursing homes and integrated old people's homes.

4. Be aware of the relevance of other services.

Recognise for example, the potentialities of sheltered housing but also its weaknesses and limitations, and the work others have done to attempt to overcome them (for example in Stockport and Southampton).

5. Question the professionals.

Find out, for example, about medical management of waiting lists and the measures being taken to improve them. Check that medical policies are geared to preventing future long-stay problems - for example, are sufficient hip replacements being undertaken, are there arrangements for elderly people to be screened and assessed in Casualty? Ask management about the training of staff - what measures are taken to affect attitudes?

6. Support the professionals.

Recognise the progress which has been made - the reductions in length of stay, the commitment and calibre of staff now working with the old. Ask questions of the professionals but congratulate them on their achievements and support them in their endeavours to secure further improvements. Encourage them to be innovative and experimental.

7. Consult the professionals.

Take into account their experience and knowledge when proposing change. Unless policy decisions take account of professional experience and opinion, conflict will ensue.

8. Recognise the need for departments of geriatric medicine.

Professor Millard felt that since 1974, the commitment to departments of geriatric medicine with firm bases in district general hospitals and full supporting long-stay facilities, had waned. There appeared to be a belief that a general physician could fulful the role of the geriatrician. Not only did this fail to recognise the special skills and expertise of the geriatrician, it ignored the fact that a geriatric service entails a commitment to the rehabilitation of long-stay patients, a commitment which general physicians do not share. Without geriatricians the number of long-stay patients would increase, and not only would the quality of care of old people deteriorate but the NHS as a whole would suffer as more and more beds would be needed to accommodate long-stay patients.

Geriatric units in general hospital provided foci from which workers specialising in the care of the old could disseminate knowledge and influence the work of others - in the hospital, in other institutions and in the community. They also provided bases for these workers, from which they could consolidate and expand on their knowledge.

This then said Professor Peter Millard, is the formidable task which confronts health authority members: the identification of sources of knowledge for self-education; applying this knowledge to question and encourage the professionals; and with the professionals, developing a coherent philosophy of care within which experimentation and innovation are encouraged in the search to improve continually the quality and effectiveness of care for the elderly.

Chairman's Summary

In drawing the conference to a close, Dr Dunwoody commented briefly on the ideas and views expressd during the day.

An important point which he felt those involved in the provision of services for elderly people should bear in mind, was the need to avoid being authoritarian - to avoid assuming they alone know what is "best" for old people. Many of the improvments in society in the last decades had been secured by the labours of today's "elderly" people.

In return, the least they should be able to expect is to be involved in decisions about how they should live in future. They were entitled to exercise choice even if this entailed taking risks. After all, said Dr Dunwoody, in some years "they", the elderly, would be "us" and will we not expect this level of independence?

An issue which had received only brief consideration during the day was the involvement of members of the geriatric team in Accident and Emergency Departments. Such involvement was important, said Dr Dunwoody, both in ensuring the provision of the most appropriate care at the earliest possible stage in an inpatient episode, and in preventing avoidable future problems.

Finally, Dr Dunwoody encouraged the audience to seek to influence the way services are provided and secure changes if they seem necessary. From his own experience as a Health Authority Chairman for five years, he was sure this was not a vain endeavour. If there were to be changes in the way services are provided for old people in London, it would largely be due to the actions of people attending the study day or of people in similar positions. And that, he said, was a fitting note on which to end the day!

Appendix I

ISSUES FOR LONDON DHAs: POLICIES FOR THE ELDERLY

Background Paper for Conference on 13th May 1982

Preface

This paper is addressed to members of London District Health Authorities attending the King's Fund Centre Conference on 13th May 1982 on "Policies for the Elderly". Since participants will have varying degrees of knowledge about the subject of the conference, the purpose of this paper is to provide some basic background information and introduce some of the themes which will be developed during the day. It is intended after the conference to produce a report of the day's proceedings which may incorporate this paper. Comments or suggestions on additions or amendments to be bourne in mind when producing this composite document would be very welcome.

1. RECENT GOVERNMENT GUIDANCE RELATING TO POLICIES FOR THE ELDERLY

1976 saw the issue of "Priorities for health and personal social services in England"[14] which was the "first time an attempt has been made to establish rational and systematic priorities throughout the health and personal social services". In this document, the elderly were identified as a group requiring special attention because of their increasing numbers and because of concern over standards of care for them.

Special attention to the needs of the elderly has been advocated in subsequent policy statements. However whereas the 1976 document stated that "There must be a deliberate decision to give them (the elderly) priority over the development of the general and acute hospital services", "The way forward"[15] issued in 1977 reflected the general concern to which this aspect of policy had given rise and pointed to the importance of maintaining the acute services to meet the demands from the elderly. "The requirement to restrain the growth of expenditure on acute servcies nonetheless remains. But the Government recognise the importance of the acute sector in meeting the needs of priority groups, particularly elderly people".

"Care in action"[8] issued in 1981 reaffirmed the elderly as a priority group and emphasised the need to involve the entire community in providing support and care for elderly people. The objectives for health authorities and local government outlined in this latest document are reproduced below.

Objectives for health authorities and local government in relation to the elderly

Source: "Care in action" para. 5.4.

a) Strengthen the primary and community care services, together with neighbourhood and voluntary support, to enable elderly people to live at home. Some elderly people may need the additional support and cover of sheltered accommodation in which voluntary organisations are taking an increasing interest, but this form of housing provision will be available only to relatively few.

b) Encourage an active approach to treatment and rehabilitation to enable elderly people to return to the community from hospital wherever possible. The development of acute geriatric units in district general hospitals enables acutely ill elderly people, who require the special expertise available in departments of geriatric medicine, to be cared for by a consultant in that specialty. Guidance and training aids are available to help staff improve standards of care and quality of life for in-patients in departments of geriatric medicine. These departments are centres of expertise for others involved in the care of elderly people in the hospital service and in the community.

c) Maintain capacity in the general acute sector to deal with the increasing number of elderly patients. Two-thirds of all non-psychiatric hospital in-patients aged 75 and over are currently treated in general acute beds. It is in this age group that numbers are expected to increase considerably, and in which treatment needs are generally more complex - because there may be several conditions which need treatment at the same time - and rehabilitation is more difficult than for other age groups.

d) Maintain an adequate provision for the minority of elderly people requiring long-term care in hospital or residential homes.

Of particular significance to District Health Authorities is the espousal of the philosophy of devolution of responsibility to district health authorities heralded in "Patients first"[16] and restated in "Care in action"[8]. As a result this document states "In the recommendations on priorities which follow, it should be recognised that, while governments have regularly identified services or groups as requiring priority nationally, there may be locally one particular group or service within the priority field which requires most attention. There are, too, other groups and services which authorities should not ignore and which in some local circumstances may have prior claim on resources". Hence it is for District Health Authorities to determine what priority should be given to services for the elderly in their own districts.

Two documents which deal solely with policies for the elderly have also been issued in recent years. The consultative document ""A happier old age"[17]" was issued in 1978 and, after taking account of responses to this document, the White Paper "Growing older"[9] was issued in 1981.

"Growing older"[9] drew attention once more to the significance of demographic changes, pointing out that in the last twenty years the proportion of people over the age of 65 had risen by one-third so that currently they accounted for 15% of the total population. Within this percentage the numbers of very elderly, those over the age of 75, were increasing sharply and since this group made the greatest demand on statutory services, the problem of how to meet their needs was particularly acute.

The aim of Government policies was defined as being "to enable elderly people to live independent lives in their own homes wherever possible". The document then reviewed all the elements of State provision which helped fulfil this aim pointing to the importance of adequate income and housing policies for old age. The primary role of public services was described as enabling people to care for themselves and supporting family and community networks.

The messages for policy makers arising from "Growing older"[9] are that statutory services should not be planned without reference, firstly to existing private and voluntary support, or secondly without reference to other elements of existing statutory provision. All the services available to meet the demands of the elderly and their supporting networks should be viewed as complementary so that collaboration between the branches of the statutory services and between the statutory and private and voluntary services is essential.

The thrust of Government guidance on policies for the care of the elderly has thus been to promote, as far as possible, community based forms of care.

2. COMMUNITY CARE

It is worth commenting here that the concept of "community care" is not without ambiguity and as the DHSS policy study document issued late in 1981 entitled "Community care"[3] points out, it has descriptive uses (e.g. community care is those services provided outside of institutions) or may serve as a statement of objectives (e.g. community care for the mentally ill is minimising disruption of ordinary living).

The study, after identifying various definitions within both of these categories of use, concludes that the concept of community care will continue to elude a definitive statement and that aspects of various definitions will be given prominence at different times. It is important however for policy makers to be clear about the way in which they are using the term at any particular time.

One possible definition of "community care", for example, has been that it is that form of care which provides the most cost-effective package of services given the needs and wishes of the person being helped. The attraction of this form of care has been therefore that it allows a resolution of what Macintyre[18] described as the humanitarian and organisational perspectives in the provision of care for the elderly. The humanitarian perspective seeks primarily to ameliorate the suffering which may accompany the ageing processes; the organisational, to ameliorate the burden of dependency placed by the aged on society as a whole.

The "Community care"[3] study expressed some concern about this conception of community care and reviewing relevant research studies concluded:

" i Community-based packages of care may not always be a less expensive or more effective alternative to hospital or residential provision, particularly for those living alone;

ii The 'cost-effectiveness' of these packages often depends on not putting a financial value on the contribution of informal carers who may in fact shoulder considerable financial, social and emotional burdens;

iii Health and social services authorities need to consider <u>all</u> the public expenditure costs involved in determining patterns of service for particular groups although their decisions are likely to be particularly influenced by consideration of those resources for which they are themselves responsible;

iv Few studies have compared <u>both</u> the cost <u>and</u> the effectiveness of different packages of care. More research is needed in this area but it would be a mistake to underestimate the methodological difficulties".

Hence other questions arise for the consideration of District Health Authority members - What are our objectives in providing services for the elderly? How far do we wish to improve the quality of life for the elderly and how far reduce the "burden" on the rest of society? Depending on the answers to these questions, different forms of care would be appropriate.

3. INTERDEPENDENCE OF SERVICES FOR THE ELDERLY

In Section 1, the point was made that since all services for the elderly should be viewed as complementary, it is essential for policy makers to consider the totality of available provision. This section elaborates on this interdependency.

The specialty of geriatric medicine is relatively new. The first appointments of physicians specialising in geriatric medicne were made around 1950. Brocklehurst[19] and Anderson[20] are sources for clear accounts of the origins and development of this branch of medicine.

The successes of pioneers in the specialty, like Marjorie Warren, in applying a dynamic and curative approach to the diseases of old age, based on careful and accurate diagnosis and supported by an active rehabilitation programme, meant that many people who had been regarded as bedfast for the rest of their lives could be restored to independence. Hence the need for long-stay institutional places was reduced. The formulation in the 1962 "Hospital plan"[21] of a norm of 10 beds per 1,000 population over the age of 65 thus represented a policy to decrease the number of institutional places for the elderly. It was based however on the assumption that the new model of progressive geriatric care would continue to be developed and it assumed also the existence of adequate supporting domiciliary and welfare services. This norm is also dependent on a good proportion of geriatric beds being located in the district general hospital where elderly patients will have access to acute diagnostic and treatment facilities. The 1981 "Respective roles"[10] study reaffirms this guidance as follows:

> "An effective geriatric service can be achieved with 3 beds per 1,000 population aged 65 and over in the main DGH for assessment and acute treatment, and a further 2 per 1,000 for active rehabilitation, preferably in the DGH but otherwise in a general hospital with other acute beds and appropriate facilities, such as the medium size hospitals which it is proposed to retain under the new hospitals policy. Up to 5 longer-stay geriatric beds per 1,000 elderly may be needed depending on local circumstances, provided in small local hospitals where patients can be cared for as near as possible to their homes, families and friends".

If the effectiveness of a geriatric service is dependent on the balance between acute, medium and long-stay facilities, it is also, as Arie[22] has recently pointed out, dependent on the availability of other forms of residential care provided by local authorities.

> "One cannot legitimately speculate on sufficiency of beds without considering complementary provision. No geriatric service can cope if the total local "pool" of places falls too low as a result of deficiencies in the residential sector. Of course, there is plenty of scope for debate as to the best balance of care between the NHS and local authorities; but this is a separate issue that does not affect the combined total of places needed".

The provision of long-term care for the elderly reflects what Arie has called "one of the self-inflicted wounds of our Welfare State". This wound was inflicted as Millard[23] points out when the decision was taken to give the responsibility for the long-term care of chronic sick to the NHS whilst leaving with local authorities the responsibility for the elderly who by reason of age or infirmity were unable to care for themselves. Currently there is a tri-partite structure for the provision of long-term care which has led to a lack of coordination in planning and development of services.

The forms of provision and their associated problems are, in Millard's words:

"Sheltered Housing

Run by local authority housing departments or by voluntary organisations these bring together in one building elderly people living in self-furnished flatlets where they are expected to cook for themselves. The warden's role is to be on call at times of crisis. Too many calls not surprisingly lead to rejection by the warden who has had no training, yet is expected by many to cope. Institutional drift is now occurring in these units, the young old are slowly growing older and frailer and within our society we have developed a new problem - a new challenge which requires a new solution.

Residential Homes

Run by the local authority social service department or voluntary organisations these units provided for the basic physiological needs of food, water and warmth. Life is usually in small groups - 4 to 6 people sharing a room - although more modern homes have some single rooms. Private toilet and bathing accommodation is not available.

The accommodation is paid for according to individual means and there is a six months residential qualification prior to admission. The current tendency is not to staff these units with nurses. Inevitably, firstly, because of lack of pre-admission medical examination and, secondly, because of illness, people require nursing and medical care. The care staff are usually housewives employed on the manual labourer scale and have no training. It is not therefore surprising that now many of these homes have recreated the infirmary wards with severely disabled people being mismanaged.

Long Term Care in the Hospital Service

The National Health Service discharged its responsibility towards the chronic sick by warehousing the elderly in the unwanted hospitals of the health service - poor law hospitals, the sanatoria, infectious diseases hospitals and small voluntary hospitals that were seen as unsuitable to develop as acute hospitals.

In parts of the country these hospitals were, and still are, the dowry of many a consultant in geriatric medicine and in like manner the back wards of a mental hospital are given to the consultant in psycho-geriatrics. There has been some improvement in the care of those who remain permanently, but for the majority, life is still lived out in large groups in dormitory wards for 16 - 30 patients sometimes even without a day room. Staff have attempted to develop social activities, such as music and art, and even patient committees have been formed."

Experiments are currently being conducted in three locations in England with the nursing home concept. These are based on Scandinavian forms of long-term care for the elderly and will aim to provide continuous nursing care in a domestic environment with sufficient stimulus for rehabilitation. They would aim to overcome the problems described above by trying to promote individuality, personal choice and patient participation.

Surveys of the levels of dependency of residents in local residential homes have revealed high levels of disability. For example, Millard in 1979 studied with the research department of the London Borough of Merton the disability levels in the 7 residential homes serving the Borough. There were 244 permanent residents. 34% needed more than supervision in walking, dressing and washing, feeding and the management of excretion. In particular, 23% were incontinent of urine and 11% faecally incontinent. 12% led a bed-to-chair existence and 5% needed spoon-feeding.

In many ways the needs of elderly people are difficult to describe in terms of either NHS or local authority social services responsibility. A point Dr McCann will be making is that it is less helpful to think of the elderly as either "patients" or "clients" but rather as "people with needs". Planning to meet these needs should therefore proceed jointly by health and local authority services. This sort of approach is reflected in the applications of the Balance of Care Model which is being pioneered in various parts of the country. Old people are classified according to their levels of need and "packages of care" are devised to meet those needs. An example is given below of possible packages for one category of elderly person.

Table 1 - Possible Packages of Care for one Category of Elderly Person

Resource	Unit of Provision	Packages of Care				
		1	2	3	4	5
Hospital bed	days per week	7				
Residential home	days per week		7			
Own home	days per week			7	7	7
Day hospital	days per week			1½		
Day centre	days per week				4	
Home nurse	visits per week			2½	1½	3
Home help	hours per week			12	6½	16
Meals on wheels	number per week			1½		3

Package 1 is solely a health service resource and package 2 is solely a local authority social services resource. The other three packages all assume the patient could live in his/her own home, with various combinations of services provided either in the community and at the patient's home (packages 3 and 4), or solely in the patient's home (package 5). The resource usages shown in the example, and those fed in to the BOC Model, are "ideal" standards; they are what the care providers believe is necessary, ignoring any constraints on resource availability. BOC allows the policy-maker to vary the extent to which these standards can be met: it is possible with BOC to explore the trade-off between providing a high standard of service to fewer people and a lower standard of service to a greater number of people, with a given set of resource levels.

So far the need for the various branches of statutory services to plan jointly has been emphasised. Obviously, within a philosophy of community care, the types of services devised must depend on the level of informal and voluntary support available which the statutory services will aim to complement. Ms Edwards will be drawing attention to this in her presentation. Various experiments have been conducted in different parts of the country to devise community care schemes which support the informal and voluntary sectors. These are described in the "Community care"[3] study.

Turning now from a general consideration of policies for the elderly, it will be appropriate to consider some aspects of London's aged population and existing service provision, which have a bearing on future developments in this area.

4. LONDON'S ELDERLY POPULATION

(i) Numbers

The London Health Planning Consortium and London Advisory Group have recently produced three studies which concern the provision of services for elderly people in London. As the table below, which is reproduced from the "Profile of Services for the Elderly in London" shows, the number of elderly people in inner London is not expected to increase significantly during the 1980's even in the 75+ age group; and the numbers in the 65 - 74 age group are expected to fall by some 20%. Those in the older age group do, of course, make much higher demands on services, but even after allowing for this, it is clear that inner London does not face an increasing problem in terms of the elderly population it has to provide for. The position in outer London is, however, different: the 65 - 74 population is expected to fall by 15% but the population in the 75+ age group is projected to increase by over 20%. And in the rest of the Thames Regions the 75+ age group is again expected to increase by 20% but with no appreciable fall in the 65 - 74 age group.

Table 2 - Present and projected population by age

(figures in thousands)

	ALL AGE	65-74	75+
1971			
Inner London	3,016.5	255.8	148.7
Outer London	4,425.1	374.6	211.5
London Total	7,441.6	630.4	360.2
Rest of Thames Regions	6,442.4	573.0	351.3
England	46,130.0	3,948.1	2,202.1
1978			
Inner London	2,696.6	268.4	164.6
Outer London	4,221.4	419.7	244.3
London Total	6,918.0	688.1	408.9
Rest of Thames Regions	6,607.9	625.2	388.7
England	46,349.4	4,304.1	2,519.8
1988			
Inner London	2,379.8	211.7	168.4
Outer London	3,992.1	353.0	295.0
London Total	6,371.9	564.7	463.4
Rest of Thames Regions	8,814.2	615.6	471.0
England	46,628.5	4,125.3	3,000.1

Thus it might appear that inner London will have fewer problems in providing for the needs of its elderly than outer London. However, these statistics do not reveal the greater social isolation of elderly people living in inner London.

(ii) Social Isolation

The acute services document[4] showed that inner London has the highest proportions of elderly people living alone, and of poor housing, in the country. For instance, the 5 local authorities with the highest proportions of pensioners living alone are all in inner London. The movement of younger people away from central London and the changes in community structures also make it less likely that pensioners living alone will have relatives nearby who can help in looking after them when they are ill. These facts obviously have some significance for a philosophy based on care in the community. However, interpretations of their significance vary. Tom Snow[1] has argued that the failure of resource distribution mechanisms to take account of the relationship between the supply of services and the availability of other forms of help has serious implications for old people in London.

5. PRIMARY CARE AND COMMUNITY SERVICES

Another feature of London's services which has implications for a community based service are the shortcomings in primary care and community services to which the Acheson Report[6] drew attention.

The report noted however (Section 7.14)

> "Although there are particular problems in London because of the high proportion of elderly people living alone and the breakdown of family and community supports, we do not believe that any fundamentally different approach to their care is required. The stress laid by the London Advisory Group and Ministers on the need to build up local services - and this applies both to geriatrics and psycho-geriatrics - is welcome. Such services, if they work closely with local people, would do much to reduce the need for institutional care. But they can only operate effectively if the primary care services are able to provide the necessary support.
>
> The main requirement is for the development of primary care teams - which many of our recommendations elsewhere are designed to achieve - and their integration and co-operation with the district's geriatric and psycho-geriatric services. We believe, however, that this integration and the effectiveness of the services can be improved in two particular ways - by more active screening and preventive care of the elderly; and by the greater involvement of general practitioners in the care of their patients in hospital".

Referring to the balance of health service expenditure in London, the report points out (Section 13.9)

> "In inner London expenditure in community services has been a smaller proportion of total expenditure by health authorities than elsewhere. We have therefore recommended that the voice of the community services should be strengthened and be given a more effective hearing in the structure of management than heretofore. However, bearing in mind the past lack of progress in the face of clear guidance from Ministers, we believe that DHSS and health authorities may need to seek more effective means of achieving the necessary shift of resources".

One area that the report identified as warranting further expenditure was community nursing services. Although health visitor and district nurse staffing levels in London are above the national average, the report argues:

> "In inner London the guidelines for establishments should be 20% more than existing standards in recognition both of high turnover and heavier workload and also in recognition of the fact that staff are young and inexperienced and therefore less familiar with problems they encounter".
>
> (Recommendation 6.2)

6. HOSPITAL AND INSTITUTIONAL PROVISION

The Acheson Report[6] also drew attention to the problems of hospital and institutional care in inner London as follows (Section 7.13):

> "Although, in absolute terms, the use of hospital and other insitutional care by the elderly in inner London may be above levels in other parts of the country, the type of care available is often not appropriate to their needs. Geriatric services are poorly provided in many parts of London and as a result, elderly patients are admitted more often to general acute beds often for social rather than purely medical reasons. Moreover, the dependence of inner London on large remote mental illness hospitals means that the confused or senile elderly are more likely to have to be removed from contact with their community even for assessment and may never be able to return".

The LHPC profile of services for the elderly[5] examines this issue in more depth and concludes (paras 22 and 23):

> "In broad terms, inner London will need between 400 and 600 extra geriatric beds over the next decade. As discussed above, most of the extra provision will be needed for short stay patients and should therefore be in DGH units. At present there are some 850 geriatric beds in DGHs in inner London out of a total of 3,200. To meet the guideline of 3 beds per 1,000 over 65s in DGHs, a total of some 1,150 beds should be available; an increase of 300 over current provision. The need for additional DGH beds varies between Districts but is not the purpose of this Profile to suggest where additional provision is most needed.
>
> In outer London the shortfall in geriatric beds will be of the order of 1,500. At present there are 1,350 geriatric beds in DGHs in outer London and, under the norm of 3 beds per 1,000 over 65s, a minimum of 600 extra DGH beds would be needed. In addition some 900 beds will need to be provided or made available in hospitals no longer required for acute services".

The LHPC documents[4,5] and the Acheson Report[6] together indicate that although the numbers of elderly people in inner London are not likely to cause existing problems to deteriorate quickly there are nevertheless substantial problems already in existence which need to be tackled.

The population changes in outer London per se imply increasing problems for service providers.

7. CONCLUSION

It is beyond the scope of this brief and selective description of policies and problems relating to the provision of services for the elderly, to be prescriptive or supply answers. It may serve however to highlight some of the questions with which Distict Health Authorities are faced. For example:

1. What priority should we give to developing services for the elderly as opposed to other client groups?

2. What specific objectives are we pursuing in providing services for the elderly?

3. What are the strengths and weaknesses of existing forms of provision - health, social service, other local authority, private, voluntary and informal?

4. Do we know enough about these other sources of care?

5. What should be our major emphasis in developing future services? - Building up health service provision? Redirecting resources within the health sector? Directing resources from health to social services?

6. Do we know enough about initiatives being taken elsewhere from which we might learn?

7. How effective are out collaborative and liaison mechanisms with other providers of services for the elderly - both statutory and voluntary?

Doubtless participants can think of many more, equally pertinent. The conference on 13th May will provide an opportunity for these questions to be aired and possibly indicate where their solutions lie.

HANDOUT RELATING TO MR SNOW'S PRESENTATION
"The Challenge Facing London DHAs"

1. Patients aged 65+ discharged from General Medical beds per 1,000 population aged 65+ (Source: LHPC 1981. Year unstated).

Inner London	71.9
Outer London	51.0
England and Wales	37.7

2. Percentage of persons aged 65+ having monthly or less contact with relatives (Source: Elderly at Home survey carried out in 1976).

Inner London	35.1
Outer London	22.6
England	15.5

3. Comparative chances that persons with monthly or less contact with relatives can receive social services (1976) (Source: Services for Old Age. Age Concern 1981).

	Home Help	Meals at Home
Inner London	64	58
Outer London	63	57
England	100	100

4. Home Help cases per 1,000 population aged 65+ (Source: CIPFA).

	1977-78	1978-79	1979-80	1980-81
Inner London	147	146	149	150
Outer London	94	99	101	100
England	103	106	105	104

5. Home Help hours per case (Source: CIPFA)

	1977-78	1978-79	1979-80	1980-81
Inner London	117	127	114	109
Outer London	96	100	97	96
England	115	114	111	111

6. Community Nurse and Health Visitor cases aged 65+ per 1,000 population aged 65+ (1979) (Source: DHSS form LHS 27/3).

	Community Nurse	Health Visitor
Lambeth/Southwark/Lewisham	123	32
England	190	73

7. Numbers of Geriatric and General Medical beds in Inner London (Source: SH3 statistics).

	1976	1977	1978	1979	1980	Change 76-80
Geriatric beds	2949	2977	3009	3017	2920	-1%
Gen. Med. beds	4016	3858	3684	3385	3214	-20%

T.S. 12.5.82.

REFERENCES

Note: This appendix is a composite list of references to literature sources mentioned in the main body of this report and in Appendix I.

1. SNOW, TOM. Services for old age: a growing crisis in London. Age Concern, 1981.

2. HUNT, AUDREY. The elderly at home. London, H.M.S.O., 1978.

3. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Community Care. D.H.S.S., 1981.

4. LONDON HEALTH PLANNING CONSORTIUM. Acute hospital services in London. H.M.S.O., 1979.

5. LONDON HEALTH PLANNING CONSORTIUM. Profile of services for the elderly in London. D.H.S.S., 1981.

6. LONDON HEALTH PLANNING CONSORTIUM. Primary health care in inner London: report of a study group. (The Acheson Report). D.H.S.S., 1981.

7. LONDON ADVISORY GROUP. The development of health services in London. D.H.S.S., 1981.

8. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Care in action. H.M.S.O., 1980.

9. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Growing older. H.M.S.O., 1981.

10. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. The respective roles of the general acute and geriatric sectors in care of the elderly hospital patient. D.H.S.S., 1981.

11. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Improving geriatric care in hospital. D.H.S.S., 1979.

12. BARCLAY, PETER, M. chairman. Social workers: their role and tasks. Bedford Square Press for the National Institute of Social Work, 1982.

13. BURLEY, LINDSAY, E. and others. Contribution from geriatric medicine within acute medical wards. British Medical Journal, Vol. 2, 1979, pp 90-92.

14. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Priorities for health and personal social services in England and Wales. H.M.S.O., 1976.

15. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. The way forward. H.M.S.O., 1977.

16. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. "Patients first". H.M.S.O., 1979.

17. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. "A happier old age". H.M.S.O., 1978.

18. MACINTYRE, SALLY. Old age as a social problem. Dingwall, R, and others. editors. Health care and health knowledge. Croom Helm, 1977.

19. BROCKLEHURST, J. C., editor. Geriatric care in advanced societies. M.T.P., 1975.

20. ANDERSON, SIR FERGUSON. The evolution of services in the United Kingdom. Kinnaird, J. and others. editors. The provision of care for the elderly. Churchill Livingstone, 1981.

21. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. Hospital plan for England and Wales Cmnd., 1604. H.M.S.O., 1962.

22. ARIE, TOM and GRUNDY, EMILY. Falling rate of provision of residential care for the elderly. British Medical Journal, Vol. 184, 1982, pp 799-802.

23. MILLARD, PETER H. Notes of a talk given at Brighton on 14 January 1982 (unpublished).

Appendix IV

LIST OF PARTICIPANTS

Dr J Andrews	Consultant Geriatrician	West Middlesex Hospial
Miss Mary Armstrong	District Nursing Officer	Newham DHA
Mrs W Arnett-Rayson	Nursing Officer	King's Fund Centre
Mr F A Barrett	Member	Lewisham North and Southwark DHA
Mr Dennis Bashforth	Divisional Nursing Officer	St James' Hospital, Balham
Mrs Charmian Beech	Div. Nursing Officer Community	Ealing DHA
Mrs M Belson	Member	Victoria DHA
Mr D Berriman	Chairman	Lewisham and North Southwark DHA
Dr A Berson	Chairman	South Camden CHC
Dr G P J Beynon	Consultant Geriatrician	The Middlesex Hospital, London
Mrs D M Biggs	Member	Hounslow CHC
Mrs P D Blight	Senior Nursing Officer	Islington DHA
Mrs L C Boardman	Member	Barnet/Finchley CHC
Ms R Borley	Assistant Secretary	Wandsworth CHC
*Mr K Boyce	Director of Social Services	London Borough of Newham
Dr H A Bracken	Member-District Management Team	Lewisham and North Southwark DHA
Mrs J A Broome	Member	Lewisham and North Southwark DHA
Dr Sandra Buchanan	Research Officer	Newham Social Services
Mrs Ruth Bucky	Member	Haringey DHA
Dr Burns	Member	Victoria DHA
Mr W G Cannon	Director	King's Fund Centre
Mrs Margaret Crispin	Senior Nursing Officer	Tower Hamlets DHA
Miss R N Clayton	Senior Nursing Officer	Hammersmith Special HA
Mr R P Cleasby	Senior Executive Officer	DHSS
Mr Nigel Coleman	Unit Administrator	St George's Hospital, Hornchurch
Mrs Toff Collie	Member	Richmond, Twickenham and Roehampton DHA
Mrs P Cooper	Member	Camberwell DHA
Mr R J Cooper	Member	Hillingdon DHA
Mr L D Cowan	Chairman	West Lambeth DHA
Mr Tim Dartington	Community Care Field Worker	London Voluntary Services Council
Ms J de Havilland	Member	Paddington and North Kensington CHC
Mrs Louise De Pascalis	Clinical Teacher	Orpington Hospital, Kent
Mrs Rachel Dickson	Member	Richmond, Twickenham and Roehampton DHA
Mrs Dredagh Dodge	Member	Harrow CHC
Mr Tim Dowdell	Development Officer	Age Concern
Mrs J Dunne	Member	Waltham Forest CHC
*Dr J Dunwoody	Chairman	Bloomsbury DHA
*Miss M R Edwards	Principal	DHSS
Ms A Foster	Project Officer - Plannning	King's Fund Centre
Miss J Fiske	Research Asst. Geriatric Dentistry	Royal Eye Hospital, London
Miss Fraser Gamble	Honorary Secretary	Association of Nurse Administrators
Ms L Gillies	Secretary	Haringey CHC
Mrs R C Glanville	Architect	West Lambeth DHA
Mrs Vera T Goupille	Patient Services Officer	Bromley Hospital, Kent
Dr J M Graham	Senior Medical Officer	DHSS
Dr M H Greenwood	Consultant Psychiatrist	Middlesex Hospital, London
Mr P A Griffiths	District Administrator	Lewisham and North Southwark DHA
Dr H N C Gunther	Consultant Geriatrician	Ashford Hospital, Middlesex
Ms Judy Hague	Secretary	K. C. & W. (South) CHC
Mr P Hain	Member	Richmond, Twickenham and Roehampton DHA
Mr Rex Haliwell	Social Work Services Officer	DHSS
Mr S Halpern	News Editor	Health and Social Services Journal
Mr D M Hands	Assistant Director	King's Fund Centre
*Miss C Hancock	District Nursing Officer	Bloomsbury DHA

Mr Miles Hardie	Director General	International Hospital Federation
Mrs N S Hawkins	Member	Lewisham and North Southwark DHA
Mrs Y Herbert	Member	Lewisham and North Southwark DHA
Mrs C M S Hewood	Member	Bromley DHA
Mrs M E Heyward	Member	Ealing DHA
Mr D Higton	Consultant Surgeon	Farnborough Hospital
Dr J P Horder	President	Royal College of General Practitioners
Ms Jane Hughes	Project Officer - London	King's Fund Centre
Miss Elizabeth Hyde	Clinical Teacher	East Birmingham School of Nursing
*Dr J Jackson	District Medical Officer	Newham Health Authority
Dr Hilary James	Member	Lewisham and North Southwark DHA
Miss Valerie Jones	Senior Nursing Officer	St Charles Hospital, London
Ms Susan Kerrison	Member	Brent CHC
Mrs M Kidd	Member	West Lambeth CHC
Mrs D M Kulikowska	Centre Organiser	British Red Cross
Ms C Langridge	Secretary	Wandsworth CHC
*Mr R Lewis	Assistant Director Social Services	Metropolitan Borough of Stockport
*Dr J McCann	Community Physician	Stockport DHA
Dr H J McKee	Consultant	Banstead Hospital, Sutton, Surrey
Mrs Annabelle Mark	SAA Dvlpmt & Service Planning	Victoria DHA
Miss P D Meek	Area Nurse	Lewisham and North Southwark DHA
*Prof Peter Millard	Professor of Geriatric Medicine	St George's Hospital Medical School
Mrs Laurie Millward	Secretary	Edgware/Hendon CHC
Mrs M M O'Brien	Senior Nursing Officer	Willesden General Hospital, London
Mr L A Patrick	Member	Camberwell DHA
Dr D W Payne	Member	Hillingdon DHA
Mr Michael Perry	Social Work Services Officer	DHSS
Mrs B A Pike	Centre Organiser	British Red Cross
Dr Mary Piper	Consultant Geriatrician	Northwick Park Hospital, Harrow
Ms Sue Prior	Nursing Officer	Maudsley Hospital, London
Mrs V R Prudden	Divisional Nursing Officer	Chase Farm Hospital, Enfield
Mr S W Quenault	Member	West Lambeth HA
Dr H B Raeburn	Specialist in Community Medicine	St George's Hospital, London
Dr Sally Redfern	Lecturer in Nursing Studies	Chelsea College, London
Dr C Reisner	Consultant in Geriatric Medicine	The London Hospital
*Dr G Rivett	Principal Medical Officer	DHSS
Mr G T Ruston	Administrator	Islsington Community Health Services
Miss A Seelig	Nursing Officer	DHSS
Mr A J Sharp	Project Coordinator	Brixton Circle Project
Dr G C Siegruhn	District Medical Officer	Redbridge DHA
Dr C P Silver	Consultant Geriatrician	The London Hospital
Mr Eric J Sims	Senior Nursing Officer	Maudsley Hospital, London
Mr P C S Smith	Member	Lambeth and North Southwark DHA
*Mr Tom Snow	Divisional Education Officer	NUPE
Mrs Gwynne Somerville	Officer	West Lambeth CHC
Mrs R Stallard	Member	Redbridge DHA
Mrs M Stern	Member	Ealing DHA
Mrs Jean Symons	Former Chairman	Soho and Marylebone CHC
Mr S E Thorpe-Tracey	Assistant Secretary	DHSS
Mr J Walker	Member	Croydon DHA
Miss S Wellbeluff	Divisional Nursing Officer	Lewisham Hospital, London
Mrs P West	Senior Nursing Officer	Queens Hospital, Croydon
Mrs Frances Williams	Hospital Administrator	Bolingbroke Hospital, London
Miss Gwyneth Williams	Member	Hampstead DHA

*denotes speakers.