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Improving Services for Older People

What are the issues for PCGs?

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Executive summary

This paper aims to support primary care groups (PCGs) planning to develop local services for older people and carers. It provides a comprehensive overview of current policy developments (summarised in Chapter 2) and draws on the wider literature to discuss the likely issues and challenges that PCGs will face in reshaping services for their older population. The paper is published as part of the King's Fund's PCGs and Older People project.

- Although there are many examples of innovative models of care for older people in the UK, PCGs need to be aware that health and social services are not always good at addressing the needs of older people and carers, especially those with complex or continuing needs.

- At worst, older people are vulnerable to age-based discrimination and poor standards of care. Such problems are evident across primary, secondary and social care settings. There is little guidance available on tackling ageism but involving older people and carers in service delivery is likely to be a useful strategy.

- Involving older people poses particular challenges. Older people are a large and heterogeneous group and conventional methods may exclude for example, very frail elderly people, who will have a valuable perspective. Some older people and carers will need support to attend meetings, for example, transport or 'helpers'. PCGs should also be aware that older people may be reluctant to criticise health services or have low expectations.

- PCGs are relatively new organisations and the process of involving older people and carers may be daunting initially but evidence suggests that the experience is perceived positively by staff and older people are willing contributors.

- Independence is increasingly recognised as a key outcome for older people with health and social care needs. This has become a key policy goal supported by national funding to develop better preventive and rehabilitative services in the community.

- All PCGs will need to be aware of developments to their local community health and social services. PCGs aiming to reshape services for older people and carers will first need to reach agreement at board level that older people are a priority (reflected in the health improvement programme) and the areas where development is required.

- PCGs will also need to be involved in developing multi-agency strategy (for example the joint investment plan) and be clear about how progress will be measured. Local objectives and outcomes should be consistent with increasing independence.

- However, the lessons from earlier experiments with primary care-led commissioning suggest that achieving strategic change is difficult. Total purchasing pilots for example, were more successful in implementing operational improvements such as practice-based social workers.

- More encouragingly, GP commissioning pilot schemes (the precursor to PCGs) seem to have been better equipped to achieve strategic health improvement goals. Community nurses (often the key contact staff for frail older people and carers in the community) made a notable contribution to several GP commissioning projects.

- Prescribing was a notable focus for development by the GP commissioning pilots. This approach is particularly relevant for older people who are at high risk of adverse consequences through multiple prescribing, mis-prescribing and non-compliance.

- Effective partnership between health and social services (and other relevant partners, for example, local authority housing departments and the voluntary sector) is especially important for community care because of the scope for service fragmentation. However, genuine partnership between primary and social services has proved difficult to sustain, requiring mutual trust, shared ownership, an agreed vision of service development and clear objectives.

- Joint strategies are unlikely to be effective without mechanisms to engage the primary and social care professionals involved in delivering the service. The new statutory duty of partnership and the availability of 'flexibilities' may promote better joint working.

- Strategies to promote internal PCG organisational development are likely to influence PCGs' ability to achieve their objectives, such as improved community care services. However, the level of resources available for PCG development varies and remains a key concern.

- PCGs are under some pressure to demonstrate early progress and may prefer to focus on one or two priorities rather than take a 'global' approach to older people's services. Strategies likely to produce measurable results for older people and carers will vary depending on local circumstances but, for example, might include one or more of the following:

- prescribing review
- a focus on specific chronic health conditions with a care-pathway approach
- preventing emergency admissions and/or delayed discharges of older people
- strategic involvement in the local joint investment plan.

1. Introduction

What does a healthy old age look like? Of course, older people themselves greatly value good physical and mental health. But they also stress the importance of being able to participate in life. They want to be able to maintain independence and dignity in older age, have choice and control and, crucially, feel part of mainstream society.[1,2,3]

While there are many innovative examples of services for older people and carers which support these goals, health and social care services are not always good at helping older people and carers – particularly those with complex or continuing needs – achieve a 'normal' life. Fragmentation and lack of co-ordination between the various health, social and voluntary agencies are frequent criticisms of community care. Traditionally, older people have had little opportunity to influence service delivery. Recent work by the King's Fund highlighted the reservations that staff and managers involved in caring for older people themselves have about the quality of current provision and their concerns for their own old age.[4]

Primary care groups (PCGs) are responsible for improving the health of the population, developing primary and community services and commissioning hospital services. There is considerable expectation that PCGs, with their primary care perspective, can secure real improvements through working in partnership with a range of local health and social agencies and involving the community. This paper aims to support PCGs intending to develop local services for older people and carers and will also be of relevance to other agencies with an interest in community care. It provides a comprehensive overview of current policy developments and draws on the lessons from earlier experiments with primary care led-commissioning and the wider research literature to discuss the likely issues and challenges that PCGs face in reshaping services for older people and carers.

This paper is published as part of the King's Fund's PCGs and Older People project. The project aims to explore the extent to which PCGs can improve services for older people and carers, working closely with five PCG pilot sites across England over a two-year period. The project also supports a wider network for PCGs interested in developing services for older people and carers.

2. Older people as a vulnerable group

2.1 Issues for PCGs

- PCGs need to be aware that older people and carers are a vulnerable group and older people may not feel able to complain about poor standards of care. PCGs seeking to make significant improvements to services for older people and carers will need to consider ways to:

  - promote positive attitudes to older people within the PCG
  - develop a holistic approach to the health of older people including preventive services and health promotion; services that primary care professionals are ideally placed to provide[5]
  - raise professional awareness of the full range of health and social services and voluntary organisations available to support older people and carers in the community
  - ensure that older people and carers have equitable access to primary health care and any other services that the PCG commissions, for example by monitoring and feeding back comparative referral rates.

- Because age discrimination can be so deeply rooted (to the extent that older people themselves sometimes hold ageist views) it is difficult to tackle even when the problem is recognised.

- Probably the single most effective strategy is to involve older people and carers in service planning and delivery with primary and social care professionals. Issues around public involvement are discussed in Chapter 4.

2.2 Background

Despite the fact that one in five adults is over the age of retirement in the UK and the proportion of very old people is set to increase markedly,[6] the needs of older people and their carers are still not well addressed by the health care system,[7] This is partly because services have not adequately responded to the health challenges posed by an ageing society but may also result from age-based discrimination.[8,9] Older people from minority ethnic groups and those with complex disabilities or mental health problems are particularly likely to suffer.[10,11,12] Of course, ageism is not unique to the NHS and social services, and probably reflects negative attitudes towards older people more generally in British society. However, it is especially serious because older people are major consumers of care. In addition, for very frail older people and those with complex needs, their experience of formal services is likely to be an important determinant of quality of life. Older people are vulnerable to various forms of exclusion and discrimination,[13–16] for example:

- at the extreme: abuse, neglect and unnecessary sedation
- marginalisation from decision-making, both individually and collectively
- people aged over 65 are a hugely diverse group, yet individuals may find that once labelled as 'elderly' they are treated in a stereotyped way by health and social care staff. Not only does this result in unsatisfactory interpersonal relationships but individuals' health and social needs may be missed
- lack of awareness of the vulnerability of older people on the part of service providers and managers, however unintentional, effectively excludes or disadvantages older people and their carers.

2.3 Policy context

The Government wants Health and Local Authorities to work together with a range of partners to improve care, support and independence for people with mental health problems and older people.[26]

Guidance for future national priorities for health and social care will be issued... and Primary Care Groups will be required to abide by it.[94]

Recent Government health policy recognises that older people and carers have the right to be treated with the same respect as other patients, that is, as individuals with widely differing and legitimate health needs. More generally the benefits to the wider community of better social inclusion and the barriers faced by older people and carers in participating in their community have received greater formal acknowledgement. Recent national policy initiatives aimed at tackling ageism and targeting older people and carers are given in Box 1.

Box 1: Recent national policy initiatives targeting older people and carers

Better Services for Vulnerable People initiative
Department of Health policy initiative[17,18] highlighting the vulnerability of older people and action to be taken at authority level. Emphasis on the importance of effective joint NHS and social services partnership, improved multidisciplinary assessment and rehabilitation services. The initiative was backed with funding for community care services and introduced the requirement for health and local authorities to develop joint investment plans for community care.

Ministerial group for Older People and Better Government for Older People initiative
Programmes encompass themes of inclusion, access, information, citizenship, partnership and public participation. Under the Better Government for Older People project, 28 pilot schemes are being led by local authorities plus a 'learning network' has been established to disseminate good practice and bring together managers, professionals, voluntary agencies and older people.

Public health and older people

- The White Paper *Saving Lives* includes a national commitment to reduce the overall death rate from accidents by 20% and serious injuries by 10%. Around a third of all accidental deaths result from falls to people aged over 65.[19,20] The Health Education Authority/Department of Trade and Industry resource pack *Avoiding slips, trips and broken hips* aims to raise awareness of accident prevention strategies for older people among health professionals. The pack highlights the importance of home safety, the role of the annual '75+ health check' as a preventive tool and the need for good information for older people on local services and health promotion advice.[21]
- Re-introduction of free eyesight tests for people aged 60 or over.
- Annual winter fuel allowance, recently increased to £150 for pensioners. Additionally, the Government has announced an 'Affordable Warmth Programme' to install energy efficient heating for people on low incomes. The Utilities Bill, currently before Parliament, will require utilities companies to produce 'social action plans' that consider the interests of customers on low incomes.
- Widened influenza immunisation programme.
- The Transport Bill currently before Parliament proposes that all transport authorities take into account the needs of older people and those with mobility problems in their transport and bus strategies. Additionally all authorities must provide a concessionary travel scheme for pensioners reducing fares by half (at least). Entry to these schemes has been set at £5 (at most) per annum.

National Service Framework for Older People (NSF)

The NSF will outline standards of care, effective interventions and models of good practice for services for older people, encompassing formal care provided and commissioned by primary, acute, specialist and social care agencies. The framework should additionally address issues such as tackling race inequalities. The NSF is expected to be published in autumn 2000; and is to be implemented locally from April 2001.

Welfare, benefits and pensions

- The basic state pension remains linked to the retail price index rather than average earnings. However, a 'Minimum Income Guarantee' for those older people (with few savings) dependent on Income Support has been introduced and this should be linked to average earnings in the future.
- Some of the anomalies surrounding benefit payments to residents in local authority homes are to be removed by the Department of Social Security.
- Television licences should be free for all people over 75 from November 2000.

- Informal carers will have a right to unpaid leave from employment under the carers' strategy for family emergencies. Informal carers receiving benefit may qualify for the proposed Second State Pension.

The Department of Social Security is monitoring the pensioner poverty, housing conditions and healthy life expectancy as part of its initiative to combat poverty and exclusion.[22]

Care Standards Bill

Legislation currently before Parliament regulating independent health providers and much social care, including residential care and nursing homes (but not day centres) and, for the first time, personal home care services. In England, a National Care Standards Commission will be created to inspect and regulate services together with a General Social Care Council to regulate the training and conduct of social and care workers. Alongside the legislation, the Government has consulted on a draft set of minimum standards for these services. If the draft standards are confirmed, the Government estimates the closure of 8% of independent nursing homes and 4% of residential homes.

Fair access to care

The 1998 White Paper *Modernising Social Services* heralded a 'fair access to care' initiative aiming to create a more consistent approach to access and eligibility to social services and long-term care both geographically and across health, social services and housing agency boundaries.[23] Guidance is expected in 2000.

The long-term care charter

From June 2000, local authorities (working with health services) will produce 'long-term care charters' for the public making clear what services are available locally, eligibility criteria, charges and complaints procedures in line with this national initiative.[24] Local charters must set clear standards in six areas: information; responding to the needs of carers and users; housing options; supporting independence; getting the right health care; and carers' support.

Age-based discrimination in the workplace

The Department of Education and Employment recently launched its *Age Diversity* media campaign to challenge age-based discrimination in the workplace. Additionally, a proposed European Union directive will, if passed, make age-based discrimination by employers illegal in member states. While workplace policy is clearly aimed at people below the age of retirement, this campaign signals the perceived importance of ageism as an issue.

The National Carers' Strategy and the Carers and Disabled Children Bill

The strategy acknowledges the importance of carers and the need to better support them.[25] Local authorities and health providers should consult and involve carers in service planning and a three-year 'carers' grant' has been allocated to local authorities to expand the provision of short breaks. Under legislation currently before Parliament, local authority powers will be extended to include the provision of services to carers in their own right including direct payments, the right of carers to have their own social services assessment and support for young carers and parent carers. The Department of Health has recently established a carers' web site: www.carers.gov.uk

The Government's modernisation agenda

In line with the Better Services for Older People initiative, the *Modernising Social Services* White Paper reflected the importance of independence as a key outcome for older people (and others) entering the care system.[23] Ring-fenced funds over three years in the form of 'partnership' and 'prevention' grants (described in more detail in Chapter 3) have been allocated to local authorities to support this aim. Indeed, greater independence for older people is a designated national priority.[26] The performance assessment frameworks for the NHS and social services include performance indicators that capture aspects of care for older people and carers.[27,28]

The National Beds Inquiry

The National Beds Inquiry is likely to influence future policy development. The Inquiry found that older people are the major users of hospital beds but their needs (and those of their carers) are not well met due to a lack of community-based and rehabilitation services, inappropriate use of acute beds and delayed discharge.[29] The Government has invited responses on the best way to develop services for older people (the consultation closes in May 2000).

Extension of 'direct payments' schemes to people over 65

Since February 2000, older people have been able to apply to their local authority for a 'direct payment' with which to buy non-residential independent sector services for themselves, rather than leaving social services to arrange this on their behalf. (Older people must have been formally assessed as having a need for services to qualify for the scheme).

2.4 The impact of ageism and low standards of care

The prevalence of ageism or low standards of care in the social and health services received by older people is difficult to quantify, but some of the evidence is alarming.

The charity Action on Elder Abuse recently found that a quarter of calls to their helpline came from older people complaining of maltreatment either in residential care homes or from domiciliary workers and care assistants.

An independent report into acute hospital care in 1998 *Not because they are old*, found evidence of negative attitudes towards older people and inadequacies in care provided on general wards. In some instances, hospitals were failing to meet even basic standards of nutrition or personal hygiene for older patients, causing great distress to these patients and their relatives and leading to adverse outcomes.[30]

While the latter inquiry also found examples of good practice and made recommendations which were endorsed by the Secretary of State for Health (including easing workload pressures, staff training and support, patient involvement in decision-making and so on), these findings are disturbing because of the continuing reliance placed on acute and other types of institutional care for older people.

In the health service, problems often arise because older people and carers have health needs that are often simply not well understood or are ignored. This is especially likely where the emphasis is on treating acute illness or injury. The 1999 National Confidential Enquiry into Perioperative Deaths, *Extremes of Age*,[31] highlighted the excess risk to very frail older people (aged over 90) of undergoing surgery. Although surgical outcomes for this group can be very good, some hospitals seemingly fail to organise their care in a way that is compatible with the needs of these patients (for example, by reducing surgical delays or providing appropriate recovery care) and surgery too often leads to unnecessary complications or death.

Discrimination occurs across the health and social care divide, in primary care, community and hospital settings and at all levels of service delivery. According to a recent report from the Social Services Inspectorate, social services departments are commissioning less effectively for older people than other client groups. It said: 'It

was of concern to find that the traditionally low expectations of older people were matched by those commissioning and providing services to them'.[32]

Quite apart from ethical concerns, ageism and/or a general lack of awareness of older people's needs on the part of primary care groups will have serious consequences for the health and well-being of older people and carers. Issues include:

- Older people are sometimes viewed negatively by general practitioners because they are perceived to generate a disproportionate amount of work through home visits, mandatory screening checks for the over 75s and so on. The general shift from long-stay NHS care to residential and nursing homes has led to increased demand for GP services from an increasingly ill and disabled section of the population.[33] Residents of nursing and residential homes are more likely to have difficulty accessing mainstream primary care for this reason; indeed, the BMA has explicitly advised GPs that these patients are likely to prove a drain on resources.[34]

- Older patients and carers are sensitive to negative attitudes and may be deterred from seeking formal care for 'non-urgent' health problems. There is evidence of widespread unmet health need in the older population.[35]

The general practitioner is frequently the first health professional consulted by older patients and their families. The belief, held by some general practitioners, that frail older people are necessarily destined for care in residential settings precludes investigation and take-up of alternative community-based options.[36]

This same fatalism extends to the lack of health promotion and lifestyle advice offered to older people despite the fact that many older people are unaware (or fatalistic in turn) that their lifestyles might be unhealthy.[37] In fact, the health and social benefits of lifestyle changes (e.g. exercising) can be very considerable for older people.[5]

Certain conditions seem to be invisible in the elderly. Mental health problems in general tend to be misdiagnosed in general practice (and other health settings).[38] For example, up to 16 per cent of older people in the community are estimated to suffer from clinical depression, a proportion which rises to over 40 per cent of older people in residential care settings.[39] However, depression frequently goes untreated despite effective therapies and drugs.[40] Untreated mental health problems can result in serious disability and loss of independence.

There is convincing evidence that older people are being denied access to specialist care for conditions such as cancer and heart disease, even in cases amenable to intervention and treatment.[41,42,43]

Older people have traditionally been excluded from clinical trials and this lack of an evidence base is sometimes cited as a reason for low referral rates to specialist care.[44] However, lack of evidence of benefit to this population group is not in itself, evidence of no benefit.

Although rationing is rarely explicitly age-based, measures designed to control demand or improve efficiency and cost-containment (for example, reduced length of stay and the increasing importance of day case surgery; closure of community hospitals; cuts in district nursing budgets and the trend towards means testing for community-based social care services) have frequently proved to have a disproportionate impact on the older population.[45,46]

3. Maintaining independence

3.1 Issues for PCGs

- PCGs are well placed to act as key players for better integrated primary, community and social care and the Royal Commission for Long Term Care (1999) envisioned PCGs as the logical single point of contact for arranging multidisciplinary assessment of older people and carers. PCG board members should be well aware that promoting independence for older people is national policy. Certainly PCGs are likely to set up systems to monitor levels of acute hospital utilisation by older patients as a priority (although they may be primarily driven to act by local service reconfiguration, budgetary concerns and the fact that emergency admissions and delayed discharges in the older population are key performance indicators). PCGs intending to commission or shape service development for older people and carers will need to establish:

  - a good working knowledge of planned health and social care service developments for older people and carers, for example awareness of the content of the local joint investment plan
  - some consensus at PCG board level and reflected in the health improvement programme (HImP) that older people and carers' health is a primary care priority and those areas where service development is required (for example, carers' support, intermediate care, discharge liaison workers)
  - an action plan: for example, board meeting agenda item, setting up a strategic working group on intermediate care, establishing formal links with social services working groups, mapping current service provision and so on
  - desired objectives and outcomes that will increase independence for older people and carers and clarity about how progress will be measured.

- When older people and carers are involved in discussions about service development, they tend to prioritise a broader range of services than traditional health services, for example access to sheltered housing and transport.[47] Any serious attempt by the PCG to develop better primary and community-based services for older people and carers must involve effective collaboration with social services, wider local government and hospital and community trusts. In practice this means agreeing respective roles, responsibilities, funding, action, accountability and monitoring progress. Additionally, PCGs are expected to start developing contacts with users, carers, voluntary organisations and the public.

3.2 Policy context

> *Availability of timely health and social services in the community can make a crucial difference to the ability of older people to maintain or achieve independence and maintain a healthy active life. It enables the spiral of avoidable admissions to hospital, leading to pressure on hospital beds, and ultimately inappropriate admissions to care homes, to be broken.*[57]

Independence has become a key theme in national policy running through a whole series of interrelated policy documents, guidance notes, policy levers and initiatives.

While the much feared 'demographic time bomb' seems unlikely to materialise, Britain remains an ageing society with an increasing proportion of very old people,[48,49,50] the majority of whom would prefer to live independently in their own homes.

For many older people, however, the current pattern of service provision has actually had the opposite result and *increased* dependency: for example, efficiency drives in the acute hospital sector have resulted in greatly restricted opportunities for recuperation and rehabilitation in hospital but have not released resources for community-based alternatives. Long-term institutional care is sometimes the only option open to older people experiencing difficulty coping at home following illness or

injury,[51] yet this may offer few rehabilitative opportunities or actively promote regaining or maintaining independence.

Ever tighter resource constraints have prompted social services departments to direct services towards clients with very urgent needs rather than fund preventive services aimed at sustaining more older people in the community.[32] Yet, preventive services, even 'low level' help with tasks like housework and shopping, seem to be key in maintaining older people and carers' confidence in their ability to live independently, are likely to be highly cost-effective[52] and are often the services older people value most.[53]

Dependence is expensive. Specialist inpatient stays and supported residential care consume large amounts of health and social care resources. For individuals living in long-stay residential or nursing homes (and their families) the costs can be considerable. Up to one third of residents are entirely self-funded, usually from the proceeds of selling their former homes.[54]

The availability of long-term health care services has been distorted by the way the system is funded. In the 1980s, many NHS hospitals were able to reduce their provision of continuing care beds as the private residential and nursing home sector expanded. (This expansion was fuelled in part by the social security system in place at this time. Residents of independently run homes automatically received higher levels of benefit than they would have been entitled to in other settings.) This 'cost-shunting' by the NHS is now passed on to social services (responsible since 1993 for assessing need and means testing) and hence ultimately to individuals and their families through charges. Because of the complexity of the system, residential care placements for older people may be a cheaper option for social services to arrange than community-based alternatives such as intensive home care.

However, a fundamental problem with the long-term care system is that the lines of responsibility between health and social services are not at all clear cut. The result is unfair in that, for example, eligibility for NHS funded long-term care varies across the country. The Government issued continuing health care guidance in 1995[55] in an attempt to clarify certain areas of the health and social care divide and remind the NHS of its role to provide long-term care, but this did not address many of the underlying anomalies and perverse incentives in the system. The Government is currently considering the recommendations of the Royal Commission on long-term care and has announced that a White Paper will be published later in 2000.[48] Meanwhile blurred NHS and local authority responsibilities for continuing care have left authorities open to legal challenge (as in the recent highly publicised case *R v. North and East Devon Health Authority, ex parte Coughlan*[56]).

Better integrated health and social care, intermediate care and home care, respite and crisis schemes can and do enable older people to live in the community while retaining some independence and control over their lives. However, to date, such schemes are frequently 'stand-alone' innovative projects that may not survive beyond a limited funding period regardless of outcome. Integrated community care for older people and carers has yet to become mainstream.

The Government has set out four interrelated objectives in relation to promoting independence:[57]

- reducing 'avoidable' and emergency hospital admissions
- improved availability of recuperation and rehabilitation services
- better preventive services in the community, including respite

- provision of support and services for carers to maintain their health, including the information they need on the health status and medication of the person being cared for.

Reducing 'avoidable' and emergency hospital admissions

The focus on preventing avoidable and emergency admissions among the older population is evident in the winter pressures funding initiatives and expanded 'flu vaccination programmes,[58,59] conditions attached to Partnership and Prevention grants for community care[60,61] and the national performance assessment frameworks for the NHS and social services.[28,62]

Rehabilitation services

The term rehabilitation applies to a wide range of services and therapies (including for example, occupational therapy, specialist stroke units and re-ablement teams working in people's own homes) which aim to restore physical or mental functioning or role.[63] Effective rehabilitation enables older people (and other patients) to make the transition from hospital to home or community care successfully, for example, reducing cases of delayed discharge and reliance on residential and nursing home placements. It can also enable older people to maintain their level of independence no matter the type of setting in which they live.[64] Paradoxically, although improved access to rehabilitation has been an explicit policy goal since the early 1990s, evidence suggests that the availability of rehabilitation to older people may have actually declined over this period.[65,66]

The Better Services for Vulnerable People initiative in 1997[17,18] marked a renewed commitment to improving community care services, specifically better rehabilitation and recuperation services for older people and was backed with funding. More recently, the Partnership Grant (£647m for the period 1999–2002)[23] announced in *Modernising Social Services* White Paper[23] has been allocated to local authorities for community care. (The name of this grant reflects the perception of joint working as a

pre-requisite to effective community care). Partnership Grant is available for all aspects of collaborative community care – including multidisciplinary assessment; preventive services; services for carers; hospital discharge for patients with complex needs and contingency arrangements for the winter months,[67,60] – but rehabilitation and recuperation services (including respite) are consistently cited as a priority for development.

Preventive services

In addition to Partnership Grant, Prevention Grant totalling £100m for the period 1999–2002 is conditionally available to social services departments for preventive services.[23] Under the terms of the grant, preventive services are defined broadly as any service intended to 'delay or prevent loss of independence'.[68] Again, local authorities must show evidence of joint working and additionally produce a prevention strategy to secure continued payment of their grant allocation.[69,67] An analysis of social services' prevention strategies found the difficulty in defining short-term outcomes (especially financial) was a real obstacle to developing preventive services. Authorities with better preventive strategies tended to involve older people and carers in planning, have links to a strong voluntary sector and incorporated aspects of prevention across the range of health and social services. While authorities acknowledged ageism as a problem, their preventive strategies generally failed to tackle discrimination.[70,71]

Carers' support

Despite the importance of informal carers in maintaining the health and independence of very many older people in the community, formal support for carers remains variable and in places inadequate at local level.[72–75] For example, the Carers (Recognition and Services) *Act* 1995 enabled carers providing 'regular and substantial' informal care, the right to request a formal social services assessment of their ability to care, when the person being cared for was themselves formally assessed or reassessed. Social services are required to take into account the results of any such assessment in

the care package provided. However, in practice, the provision of carers' assessments has been generally low and in some authorities very low.

The Government's national strategy for carers *Caring about carers*[25] signals a less reactive attitude to carers' support and an awareness of carers as individuals with health and social needs in their own right. Measures outlined under the strategy include the entitlement to unpaid leave for family emergencies, more and better opportunities for short breaks from caring responsibilities and better information about services. (Clear and accessible information about long-term community care services for older people and carers is also a key component of the long-term care charter.[76]) The strategy emphasises the duty of local authorities and health providers (and other agencies) to involve carers in service planning, a requirement echoed in related health and social policy initiatives (see Chapter 4 below).

Additionally, legislation is proposed under the Carers and Disabled Children Bill to extend local authority provision (including direct payments) to carers themselves following a formal carers' assessment. The Bill extends the right for carers to request a formal assessment of their needs to cover the case where the person being cared for has refused their own assessment. Additionally, it enables local authorities to provide more flexible short breaks for carers (a key theme in *Caring about carers*) through the provision of voucher schemes.

Carers' Grant (£140m over three years) is payable to local authorities to encourage joint working to develop short breaks for carers.[23,67,77] Under the priorities guidance, primary care organisations and social services departments are charged with the task of setting up systems to identify carers as a first step towards implementing better services for carers.[57,23]

Performance monitoring

As part of the Government's modernisation agenda, both the NHS and social services are now subject to joint national priorities guidance[78,26] and national performance monitoring which includes a range of targets and performance indicators intended to capture information relevant to services for older people and carers.[28,62] For example, national targets include:

- a reduction in the overall death rate from accidents by 20 per cent and the rate of serious injury by 10 per cent by 2010[20]
- a reduction in the death rate from cancer in people under 75 by 20 per cent by 2010
- a reduction in the death rate of coronary heart disease and cancer in people under 75 by 40 per cent by 2010
- a reduction in the growth rate in emergency admissions to hospital for people over 75 to 3 per cent by 2002
- every patient with suspected cancer to see a specialist within two weeks of their GP requesting an appointment. To be achieved by 1999 for breast cancer and by 2000 for all cancers
- extension of NHS Direct to cover the whole population in 2000.

4. Primary care and older people and carers

4.1 Issues for PCGs

- The Government's change agenda is wide-ranging and PCGs will have to be selective about which national and local priorities they choose to target and how they go about this. However, given the major spend on prescribing (and the availability of PACT data), it is highly likely that PCGs will want to target prescribing practice. Older people are an obvious target for prescribing review. Some guidance is available to PCGs on prescribing review (*see Box 2*).

Box 2: Guidance on prescribing review

GP Prescribing Support is a National Prescribing Centre/NHS Executive report written for PCGs recommending a range of prescribing support services known to improve prescribing practice.[79] It includes model frameworks and local case studies and discusses medication review; prescribing in nursing and residential homes; disease management clinics; management of information about drugs; audit; educational outreach; prescribing analysis; generic prescribing; formulary development; guidelines and protocols; repeat prescriptions; prescribing software; issues around the primary-secondary care interface; and gives guidance on commissioning a prescribing support service.

- Any focus on chronic conditions or disease management is likely to be of special relevance to older people. This includes cancers and coronary heart disease (current national priorities), diabetes and sensory impairment as prevalence increases with older age. However, the national call-recall cancer screening programmes do not routinely invite women over the age of 65 so early detection may be an issue in older age groups (an evaluation of the impact of expanding the breast screening programme to women aged between 55 and 69 is ongoing[80]).

- All registered patients aged over 75 should be offered health checks annually. although there is some evidence that eligible patients are missed[81] and there is only

limited evidence of their effectiveness.[82] But health checks do seem to result in increased referrals suggesting they have some use as a screening tool.[83] Health checks as they currently exist may be something of a missed opportunity and could perhaps be extended to cover a wider range of social and emotional issues, for example to screen for depression.[84] Health checks may have other uses too – PCGs may want to use them to identify carers or, possibly, as a way of engaging 'hard to reach' older people in planning and feedback.

- Access to primary care is a real problem for many older people and carers, along with:

  Information. While older people and carers' information needs are similar to those of other patients, much of the information available on local health care services often (unwittingly) discriminates against older people, for example information may not be offered to house-bound patients or may only be published in small print.[85]

  Services. The needs of older people and carers have frequently been ignored in service design. For example, reviews of health and social services for people with visual or hearing impairments have criticised health and social services for being inaccessible (for example, hearing awareness training for staff in contact with older people and carers remains rare) even though these conditions are relatively common.[86,87] Culturally appropriate services may also be an issue, especially for older patients who do not speak English.

  Physical access. Obviously all new or refurbished practice premises should be designed and adapted with the needs of all patients, including older and disabled patients in mind. However, a proportion of older patients are too frail physically or have no means of transport to attend their local health surgery and will need to be visited at home by their GP or nurse or out-of-hours primary care service or have transport, provided for example through voluntary community transport schemes.

- Although modernisation funding is available for primary care (£306m in 1999–2000), almost half of this money is not actually extra cash for primary care but came from the now defunct GP fundholding budget.[88] Not surprisingly, financing service improvements (on top of management and administrative costs and prescribing commitments) is a major issue for PCGs and a recent report from the Department of Health suggested that PCGs wishing to make early progress should look to reshape existing services rather than invest money in new developments.[89]

4.2 Background

Older people consult their GP more often than average although not greatly so (*see Table 1*). Good primary care can make a huge difference particularly to those older people (and their carers) who are living with chronic illness and disability and those with complex health and social needs. The local health centre is often the first point of professional contact for older people and carers experiencing difficulties and should be well placed to identify vulnerable patients (for example, experiencing difficulty coping with a period of acute illness) *before* their condition deteriorates.

Table 1: GP consultations by age group in 1996 (Great Britain)

Age group	*Average number of consultations per person in 1996*
0–4	7
5–15	3
16–44	5
45–64	5
65–74	6
75 and over	7

Source: Office for National Statistics. *Living in Britain: Results from the 1996 General Household Survey*. 1998.

Older people are major consumers of prescribed drugs and one consequence is that they are at greater risk from drug-related complications than other patients. In common with other patients, many older patients do not take medication as instructed by their doctor or pharmacist or they keep drugs long beyond their safe shelf-life. Older people with multiple or chronic health problems are more likely to be offered contra-indicated treatments or suffer the effects of different drugs interacting in combination.

Beyond the 'core' medical services offered under the general practitioners' contract the range of primary and community health services available to registered patients varies tremendously. These can include multidisciplinary services and resources such as dietetics, chiropody, domiciliary pharmacy, practice-based social work, discharge liaison, intermediate care, physiotherapy and even alternative therapies. Chiropody is a key treatment in maintaining or restoring mobility (a fact often unrecognised by health professionals and managers) and older people and carers report great benefit from access to practice-based and domiciliary podiatric services.[47]

Primary care is better and more accessible in some areas than others. Inner London, for example, is notorious for having many inaccessible surgery premises. There is no national system in place to allocate primary care services to match local needs although the recent PMS pilot projects have enabled general practitioners and community trusts to expand primary care services (for example, by employing general practitioners) specifically in order to improve access in areas of particular need.[90] Indeed, earlier forms of primary care-led contracting such as fundholding and total purchasing arguably advantaged their own patients at the expense of patients registered with non-fundholding practices, leading to accusations of a 'two-tier NHS'. PCGs which comprise former fundholding and non-fundholding practices will have to address inequities in access to services. Government guidance stresses that PCGs should expand successful services to cover the entire population, that is, by 'levelling-up' rather than 'levelling-down'.

However, some primary care-led commissioning groups had success in reshaping services for older people by, for example, commissioning intermediate care schemes such as hospital at home for their patients. Such success was not a general feature of fundholding or locality commissioning groups, thus providing the impetus for the introduction of pilot primary care commissioning groups by the incoming Labour Government (the precursors to PCGs).

The Government's modernisation programme additionally aims to widen access to primary care through Healthy Living Centres, intended to be one-stop centres for a wide range of social, leisure and health advice and treatment (funded by the National Lottery); NHS Direct; and primary care Walk-in Centres where patients can consult a nurse or doctor without having to book an appointment. Walk-in Centres seem to be primarily aimed at people unable to reach their local surgery conveniently, for example while at work or when travelling. Continuity of care may be threatened by these initiatives and there are some concerns that the traditional primary care role of gate-keeping will be weakened.[91] Early indications are that older people seem to be less likely to use NHS Direct than other patients.[92] This may reflect access problems, for example, rates of telephone ownership are lower among the elderly and older people experience a relatively high incidence of hearing impairment. It may also reflect a preference among older people and carers to consult their own doctor.

Not all primary care services are free of course. People over pension age have long had the right to free prescriptions on the NHS but must pay towards the cost of other community-based NHS health services, such as dental care, unless they are on a very low income. Furthermore, access to NHS services is not always readily available (indeed, improving access to NHS dentistry is now a national priority) and the private sector is an important provider of much community health care, even for older people in significant clinical need. For example, community health trusts sometimes refuse to provide NHS chiropody to frail older people living in private nursing homes (citing this as the responsibility of the nursing home to arrange independently) despite the

specific inclusion of NHS chiropody for nursing home residents in the 1995 continuing care guidance.[55]

The confusing and piecemeal nature of NHS charges and services has led to real fears that older people and carers (who tend to be price sensitive) may be deterred from seeking appropriate health care and the Government recently reintroduced free eyesight tests for people aged over 60 following evidence of increased incidence of eye disease in this population.

4.3 Primary care as a national priority

Primary care is a major national priority area in its own right with ring-fenced funding from the modernisation fund. PCGs will face considerable pressure to demonstrate early progress in addressing issues around quality and access.[89,26] At this stage, however, PCGs are still likely to be agreeing local priorities, developing primary care infrastructure and establishing the PCG as a functioning organisation (*see Box 3, which describes relevant local strategic plans*); an emphasis reflected in the range tasks set out in Department of Health guidance to PCGs.[93,94,95] These include:

- an agreed programme of action with the health authority for 1999–2000 setting out how PCG objectives will be met (in line with national and local priorities)
- contributing to the development of the local health improvement programme
- an annual accountability agreement with the health authority
- primary care investment plans for 1999–2000 to 2001–02 (September 1999)
- developing at least two long-term service agreements (one of which should fall within a national priority area and one within a locally agreed priority area) either alone or in partnership with other agencies

- appointment of senior lead(s) to develop a clinical governance programme
- contributing to the development of the local service and financial framework (March 2000).

Box 3: Plans, strategy documents and agreements

Community care plan. Every local authority is required to produce a publicly available annual plan or update outlining its community care provision and strategy. The plan must be agreed with the relevant health authority and a draft made available for consultation.

Health improvement programme (HImP). Public document outlining plans to improve health of local population in line with local need and national priorities. HImP development led by health authorities but must involve local authorities, PCGs, NHS trusts and other stakeholders.

Primary care investment plan (PCIP). Annually produced three-year rolling plan for primary care investment in general medical services, primary care infrastructure and wider primary care outlining existing services, infrastructure and workforce and proposed new developments. Early PCIPs are likely to focus on transitional issues, e.g. tackling inequities in primary care provision. The PCIP is expected to complement the HImP and be consistent with related national strategies, e.g. on information technology. The PCIP is costed and forms part of the annual accountability agreement with the health authority.

Joint investment plan (JIP). Outlines the action being taken by health and social services to improve continuing and community care services in line with the Better Services for Vulnerable People initiative.

Long-term service agreement (LTSA). A contract for health or social services drawn up between commissioning organisations and providers. Agreements should be long-term in nature (at least three years) and include monitoring information and risk management components. LTSAs are intended to become increasingly client/care pathway based.

Service and financial framework (SAFF). The plan which outlines the levels of NHS service and investment required to deliver the HImP and meet national performance targets. The SAFF should also describe the involvement and contribution of local PCGs and PCTs towards local and national objectives.

5. Public participation

5.1 Issues for PCGs

- PCGs are clearly expected to engage routinely with the public and as a minimum must hold some of their board meetings open to the public. Attendance at meetings is likely to depend on the extent to which they are publicised. Frail older people are unlikely to attend meetings without support. It should be stressed however, that given the opportunity, older people and carers can be enthusiastic participants in consultation initiatives.

- The role of the lay member on the PCG board should be clearly defined – does the lay member present a non-professional view based on representation or on personal experience?

- Where PCGs are planning significant changes to services affecting older people and carers – particularly strategic change – it seems reasonable to expect some form of engagement with potential users. This might take the form of consultation with a network of representatives (e.g. CHC, voluntary groups) or direct involvement with older people and carers themselves.

- PCGs should be aware that other statutory agencies, for example, the local authority are required to involve the local community and users in satisfaction surveys and service planning and may be able to share experience of this process.

Involving older people and carers may feel like a daunting task to PCGs faced with many competing priorities and objectives;[96] nevertheless evidence suggests that the insight older people can bring to service planning and decision-making can be highly valuable.[97]

5.2 Policy context

Typically, older people and carers have had little opportunity to influence service provision despite the fact that older people, as a group, are the major consumers of community care and health care services.

More recently, however, the concept of user and public participation has been legitimised to the extent that it is a consistent and central theme of current policy covering both PCGs and other statutory agencies:

> *Primary Care Groups can play a key role in communicating with local people and ensuring public involvement in decision making about local health services.*
>
> *User and public involvement should be regarded as an integral part of Primary Care Groups' activities. It should not be seen as an add-on, nor as being fulfilled by a one off activity such as an annual public meeting. The aim should be to develop a continuous dialogue with local communities.*[94]

Under the national carers strategy health providers are required to provide support to carers and consult them about these services.

Local government and social services have a duty consult the public and to undertake annual user satisfaction surveys – the first in April 2000.[23]

5.3 Older people's views of primary care

What do we know about older people's views of primary care services? In terms of satisfaction, older people tend to be highly satisfied with primary care services and staff in general,[98,99] although one consistent area of concern is out-of-hours availability.[100] There is some evidence, however, that the amount of time GPs are willing to spend with patients is a more important determinant of satisfaction than other factors such as treatment outcomes.[101]

Views of community services are more variable; it is notable that in some surveys in which older people expressed satisfaction with community services, their expectations of these were very low.[102] Carers (who are often older people themselves) have more mixed experiences of primary care services.[72]

5.4 Engaging older people and carers

Engaging older people and carers in decision-making will pose particular challenges:

- The term 'older people and carers' covers a large and heterogeneous group likely to hold a multiplicity of views. If involvement is to be meaningful it is essential to understand whose views are being sought and why.
- A substantial number of older people (and a high proportion of users of continuing care) are socially isolated and/or frail and may be difficult to reach through conventional consultation methods such as public meetings, postal questionnaires and telephone interviews.[103]
- Carers may have difficulty in attending meetings/panel discussions if there is no alternative provision for the person for whom they care. Carers may have a definite preference for expressing their views with or without the person they care for being present.[103]

- Older people tend to be reluctant to criticise health services and staff.
- Older people and carers may have low expectations of service availability and quality.

The public's ability to contribute will be related to the quality of information available to them about local services and plans, and the quality of the process itself (i.e. facilitation, clearly stated aims and so on). Yet despite the complexities, evidence shows that older people and carers are effective partners in decision-making if given genuine opportunities and support to become involved.[104]

There is considerable recent guidance available for PCGs on public involvement although little of this specifically relates to engaging older people and carers:

- *Involving users: Improving the delivery of local public services* (Cabinet Office)[105]
- *Patient and public involvement in the new NHS* (Department of Health)[106]
- *An introductory guide: How to consult your users* (Cabinet Office)[107]
- *Involving users: Improving the delivery of healthcare* (Cabinet Office)[108]
- *Listen up! Effective community consultation* (Audit Commission)[109]
- *Public engagement toolkit* (NHSE Northern and Yorkshire Office)[110]

6. Ways of working

6.1 Issues for PCGs

- As relatively new and loosely-tied organisations, organisational development remains a key priority for PCGs. PCGs must find ways of engaging both their constituent general practitioners and members of their wider primary care health teams – who may have more limited representation at board level. The level of resources available to PCGs for development remains an issue of concern to many PCGs.

- Community nurses tend to have the most professional contact with older people and carers in the community and are likely to make an important contribution to service development. The Government's strategy for nursing (for example, nurse consultants and nurse-led prescribing) may provide PCGs with opportunities to develop their local services for older people and carers.

- A recent survey of PCGs[111] and previous experiments with primary care-led commissioning suggest that strategic change is difficult to achieve and sustain. Likely barriers to success include:

  - information quality and IT problems
  - difficulties in monitoring progress
  - building effective partnerships with social services and other local authority departments and other stakeholders
  - the scale of the PCG change agenda.

- Effective partnership working will be a key test of PCGs. The statutory *duty* of the NHS to work in partnership with local authorities and new partnership 'flexibilities' may promote better joint working.

- PCGs will not only need to introduce and implement clinical governance systems but in working with local authorities will need to be aware of the implications of the local authority Best Value framework, for example, with its greater focus on benchmarking and being able to demonstrate that services are responsive to user views.

- PCGs moving towards primary care trust (PCT) status will face additional organisational issues. For example:

  - PCTs are governed by a different board structure with lay members in the majority
  - they have much greater responsibility for managing human resources
  - community care providers will face additional regulatory requirements under the Care Standards Bill if this becomes law
  - establishing an effective PCT is likely to mean the merger of several local PCGs. Reconciling different priorities may be an issue for PCGs in this position.

- PCGs are under some pressure to demonstrate early progress and may prefer to focus on one or two priorities rather than take a 'global' approach to older people's services. Strategies likely to produce measurable results for older people and carers will vary depending on local circumstances but, for example, might include one or more of the following:

  - prescribing review
  - a focus on specific chronic health conditions with a care-pathway approach
  - preventing emergency admissions and/or delayed discharges of older people
  - strategic involvement in the local joint investment plan.

6.2 Organisation and management

PCGs became operational little over a year after they were formally announced in the White Paper *The new NHS*,[112] and it is important not to underestimate the size of the challenge faced by PCG boards in establishing a cohesive organisational structure in this time, let alone an organisation capable of driving innovation in health care for older people and carers. Concerns focus on the adequacy of the management allowance and workload demands on PCG members with clinical commitments. Concerns about the impact of resource levels on PCGs' capacity to function effectively are reflected in a recent letter from the Health Minister John Denham urging some health authorities to release more resources to cover PCG management costs.[113] However, there are several more fundamental organisational issues:

- The PCG is a loosely tied organisation: its constituent primary care professionals are not directly employed by the PCG and may be indifferent or even hostile to the new arrangements. PCGs must rapidly learn how to engage, inform, respond to, monitor and develop their primary care 'workforce'. Additionally, key PCG tasks such as systematic performance monitoring have traditionally been undeveloped at practice level and will require sensitive implementation.

- Different practices are likely to have developed different ways of working, this is especially obvious in PCGs containing a mix of former fundholding and non-fundholding practices but, for example, conflicting priorities and variations in service levels may also arise in PCGs comprising PMS pilot and NHS beacon practices.

- For PCGs in areas with little history of partnership working or primary care-led innovation, influencing other key health and social care organisations and achieving a sense of ownership over the local health agenda will be a much harder task.

- The multidisciplinary composition of PCG boards is a deliberate attempt to create shared leadership and ownership of PCGs. While the multidisciplinary nature of PCGs has generally been received with enthusiasm by primary care professionals, there is scope for conflict and confusion. An early example is the disappointment voiced by nurses over the lack of parity in nurse and medic representation at board level.[114] Professions allied to medicine are not formally represented at all.

6.3 Primary care trusts

The first 17 primary care trusts will become operational from April 2000. The expectation is that most PCGs will follow this route in due course.

Governing arrangements for PCTs (primary care trusts) differ from PCGs in that the majority of PCG board members are lay people. Primary care professionals instead will make up the majority of a ten-strong trust executive (also to include public health specialists) which will nominate three of its members to sit on the board to represent professional views. Neither is there any place for a social services representative on the PCT board although it remains possible to co-opt such professionals.

For PCGs keen to shape local service delivery for older people and carers, (level 4) trust status is attractive because it confers the power to employ staff directly and fully integrate primary and community provision.

> *We are delighted by the opportunities available to us in the new NHS. We believe that a Primary Care Trust, as a single local organisation, will give an unrivalled opportunity for local doctors, nurses, other health workers, and above all local people, to shape services and provide better health care.*[156]

Such enthusiasm is not universal although the main concerns have been directed more at the speed of change than opposition to the principle of trust status. An early concern has been the capacity of PCTs to manage human resources, especially given patchy employment conditions for practice nurses.[115] The medical profession has voiced unease about the risk of dispute between PCGs in the course of transition to trust status. Additionally the viability of independent contractor status for GPs might be threatened in the longer term particularly since PMS pilots have encouraged the development of salaried GPs and nurse-led primary care.[116] PCTs could face a conflict of interest, for example, a PCT may find itself responsible for allocating resources to its constituent primary care practices while acting as a primary care provider in its own right (through a PMS pilot). Health authorities have the responsibility of safeguarding the wider public interest in such circumstances.[117]

As new and untested organisations, concerns have naturally been raised about PCTs' capacity to integrate and manage community health services effectively. This remains an open question, but the challenges for PCTs will be considerable, for example, in achieving new regulated standards for domiciliary services (under the proposed Care Standards Bill).

6.4 The future of community nursing

The impact of the Government's strategy *Making a Difference* will be far reaching in primary care. The strategy recommended that the community nursing service should be organised around teams of nurses and workers led by health visitors. The roles of practice and district nurses is currently under review. The strategy also introduced the new consultant nursing posts. All nurses whatever their grade will be on structured pay scales. Community nurses are often the key contact for frail older people and carers in the community and PCGs may want to take advantage of new roles and nursing grades, such as nurse practitioners, nurse consultants, nurse-led prescribing and primary health care assistants, in developing community health services.[119]

6.5 Building on past experience

PCGs have their roots in earlier experiments with primary care-led commissioning such as fundholding, multifunds and other forms of locality commissioning and purchasing. Total purchasing (TP) is one of the closest forerunners with many TP pilots specifically attempting to improve local services for older people and carers. TP has been evaluated in depth (*see Box 4*). Although many TPs clearly aimed to improve care for older people, in general they displayed a limited strategic approach and instead concentrating on developing practice-based services. In terms of their organisational characteristics, PCGs are similar to the more innovative and strategic-thinking TPs, so it might be expected that PCGs will be better able to develop a *vision* of services for older people and carers.

Box 4: The experience of total purchasing pilots

What was total purchasing?

Under the total purchasing scheme, participating practices were delegated a budget by their health authority with which to purchase some or all hospital and community health services for their population. TP sites comprised single fundholding practices or groups of practices with an average practice population of around 33,000. They were given discretion to set strategic priorities and objectives and purchase services, although in practice the health authority retained accountability for devolved budgets. Fifty three first-wave pilot sites went 'live' in 1996–97, while a further 35 sites followed in 1997–98. The scheme officially ended in early 1998.

By the end of the scheme, 11% of the first-wave sites had dropped out of TP altogether while a further 19% did not respond to requests to participate in the national evaluation.[120] Although the numbers are small and the evidence is indirect, this does suggest that commitment and enthusiasm for total purchasing at practice level was difficult to maintain over a period of considerable policy change.

Results in year one

In their first year of total purchasing, first-wave sites identified a wide range of priority areas and objectives including ambitious plans for managing emergency admissions, purchasing community and continuing care and early discharge schemes. However, levels of achievement in these areas were very mixed. Almost two-thirds of the stated

objectives relating to early discharge were achieved. But this fell to just half for community care and the majority of the stated objectives for emergency admissions were *not* achieved.

Results in year two

In the second year, the overall scale of ambition was notably reduced and not surprisingly the level of achievement rose; although it is important to note that those TPs that did focus on more complex areas were now also highly likely to be successful. Community and continuing care became the single most common priority area in the second year with two-thirds of TP sites citing this as one of their four main purchasing objectives in 1997–98. In both years, TP objectives were primarily addressed through primary care development rather than commissioning.

The impact of TPs on community care

Case study analysis of five TP sites purchasing community and continuing care[121] suggests that TP priority setting was primarily based on primary care professionals' perceptions and experiences. As a result, the case study TPs were more likely to focus on objectives such as improving practice-level contact with social workers rather than invest in innovative services such as preventive care. In general:

- there was little meaningful user involvement in service planning and delivery
- *practice* level links with social services improved notably as result of TP
- the case study TPs did not appear to be aware of policy developments in community and long-term care.

Characteristics associated with TP achievement

TPs were generally more likely to achieve their stated objectives if they:

- were larger
- spent more money on their priority areas
- had a positive relationship with their health authority.

That PCGs may be well equipped to take a strategic commissioning role is also suggested from an evaluation of GP commissioning. In 1997 the Government announced forty pilot GP commissioning sites in England. The sites which went 'live' in April 1998 varied in their scale, objectives and structure but shared the following features:

- a cash-limited prescribing budget
- the involvement of community nurses in both at strategic and operational levels
- patient involvement
- a requirement to contribute to joint commissioning activities between health authorities and social services.

Prescribing was a key issue for many of the pilot projects, forming the focus for peer review, information gathering and in some cases a good 'climate of trust' was established among participating practices. Achievements depended crucially on the relationship with the parent health authority and the ability of the project manager to develop good relations with external and internal stakeholders. Barriers to progress included non-standardised information systems across practices, the time commitment required of practising clinicians and nurses and a lack of strategic engagement with local authority and trust stakeholders. Patient involvement remained an aspiration rather than a reality because of a lack of experience and guidance. In contrast, community nurses tended to play an important role in projects where they were given real influence. The evaluation concluded that the GP commissioning pilots were able, to a greater extent than earlier fundholding, to focus on priorities for health improvement.

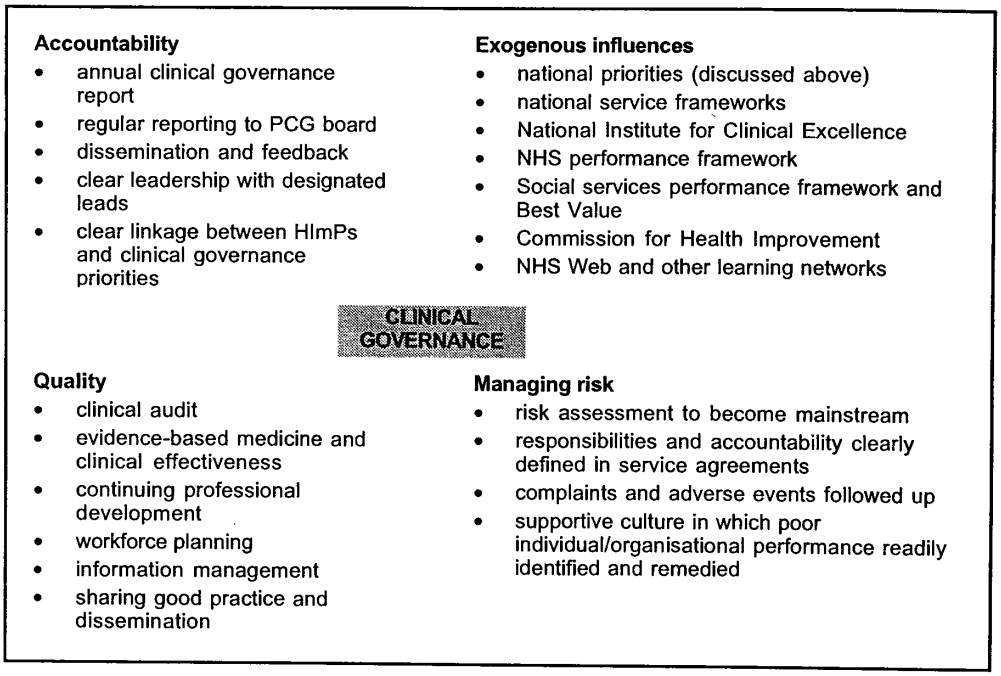
Finally, there is a danger that in the process of wholesale reform, existing local innovation and achievement may be lost or abandoned or 'reinvented' at some later date. Service reviews would be helpful to minimise this risk.

6.6 Clinical governance

Quality improvement initiatives in primary care are nothing new, but formal accountability for quality of care across the PCG represents something of a culture shift for primary care professionals more used to a model of professional accountability. Figure 1 shows the clinical governance framework for the NHS as outlined by the Government.[122] PCGs are expected to focus their efforts in one or two clinical or managerial areas initially and achieve four main tasks relating to clinical governance in their first year:[123]

- appoint lead person(s) and implement accountability and working arrangements
- baseline assessment of capacity/activity
- agreed action plan
- annual report on clinical governance with first to be produced in 2000.

Figure 1: Clinical governance: the framework for PCGs



Research to date has shown that clinical governance is generally viewed positively by primary care professionals but there are perceived barriers to implementation, notably resource levels and the scale of cultural change required of GPs.[124,125]

There has been some concern too that PCGs will not involve the public or users in their clinical governance programme although this is a clear requirement.[126] An early survey of PCGs' clinical governance activity in London found that very few PCGs had chosen care of older people and carers as a priority for clinical governance, the majority preferring instead to focus on coronary heart disease and stroke, diabetes or mental health. However, it may be that taking a condition-specific approach in these areas will actually result in more rapid measurable progress for older people (who are more likely to suffer from, for example, stroke) than a more holistic approach could achieve.[125] The survey highlights the inexperience of many PCG clinical governance leads for this role and a widely-reported lack of support from external sources such as health authorities.

PCGs will need to establish mechanisms to ensure that national priorities, standards and the recommendations from the national service frameworks and the National Institute of Clinical Excellence (NICE) are incorporated into practice. Box 5, below, lists a range of resources available to support PCGs' clinical governance activity.

The national service framework (NSF) for older people is due to be published later in 2000 and must be implemented from April 2001. Health and local authorities are expected to undertake a multidisciplinary mapping of services currently provided to older people and carers in preparation.[26]

NICE is investigating a wide range of treatments and therapies many of which are especially relevant to older people. For example, topics being investigated in 1999–2000 include:

- wound care
- hearing aids
- hip prostheses
- specified drugs or treatments for diabetes (type II), Alzheimer's disease and rheumatoid arthritis.

Box 5: Selected resources for clinical governance in primary care

National guidance

- *A first class service: Quality in the new NHS*[122]
- *Clinical governance: Quality in the new NHS*[123]
- *Supporting doctors, protecting patients: A consultation paper on preventing, recognising and dealing with poor clinical performance*[127]

NHSE regional offices have published a range of resources relevant to PCGs:

- *A discussion paper: success criteria in clinical governance*[128]
- *Clinical governance in primary care – getting started*[129]
- *Clinical governance development needs in health service staff*[130]

National Primary Care Research and Development Centre guidelines

Quality assessment for general practice: supporting clinical governance in primary care[131] describes quality assessment methodologies in some detail but also lists many other resources including:

- a wide range of Internet resources to support PCGs from general networks sharing good practice to more specific sites such as evidence-based general practice;
- related references on continuing medical education and professional development in general practice
- national voluntary external inspection and accreditation schemes for general practice
- remedial schemes to support GPs who are under-performing.

The NHS Web

Includes pages devoted to clinical governance and sharing good practice. Only available to those practices with a computer link to the Internet.

Royal College of General Practitioners guidelines

Clinical governance: practical advice for primary care in England and Wales.[132]

University of Sheffield Wisdom Centre

A comprehensive Internet resource on clinical governance citing policy documents, research reports, relevant organisations. Incorporates links to other related Internet sites.[133]

6.7 Managing information

Under the national strategy for information, *Information for Health,* PCGs are required to appoint a lead person for information, contribute and agree to the health authority-led district information strategy and are answerable for their part in its implementation.[134,135,136] National objectives outlined for primary care include computerising and linking all GP practices to NHSnet and £20m funding to improve practice IT systems. The long-term goal is to develop integrated electronic health records ('located' in primary care) which can be viewed and updated remotely, for example, during a spell of hospital treatment. These records are expected to underpin

much better quality data for service planning and monitoring health improvement. However, in the short-term, primary care groups face several problems:

Quality

Practice-based data is potentially highly useful for monitoring health improvement because it is population-based, but data quality is a major concern. A verification study of the *Mediplus* general practice database suggested that only 65 per cent of referrals were actually recorded in the database.[137] And data quality among the 200 practices contributing data to *Mediplus* is likely be better than the average. Nevertheless GPs themselves rate practice-based information above data from health authorities and trusts. The evaluation of total purchasing found that in 5–20 per cent of cases, data from other agencies conflicted with that recorded on the general practice system.[138] Table 2, below, highlights potential sources of primary care activity data.

Table 2: Primary care activity data

Information	*Possible source*
Comparative prescribing data	GP practices; PACT
GMS activity	GP practices; health authority
Demography and population health	Health authority public health department
Community services	PHCT; community trusts; social services
Acute services	Liaison staff; acute trusts; health authorities
Other practice-based, e.g. counselling	Participating practices
Waiting list information	Provider trusts

PCGs will have to balance the desire for high quality information with the need to take action to achieve objectives.

Consistency

There are a plethora of practice systems operating and some practices are still not computerised at all. Different systems measure different pieces of information and in different ways. Data is not necessarily transferable between different packages. Furthermore the use that GPs make of computers will vary within and between practices. PCGs will need to have some way of reconciling local variation.[139]

Access

Inability to access information held by provider trusts and the health authority was a frequent frustration for fundholding GPs and total purchasing. This is likely to be less problematic for the PCG since lines of communication should have been established in the local information implementation strategy. But it remains the case that some agencies, for example A&E departments, small community trusts and social care agencies may not currently record information in sufficient detail to be useful for PCGs and vice versa.

Within primary care, access is also an issue as systems need to be integrated and accessible to the whole primary care team, not just GPs. Furthermore, practice-based systems have been primarily developed as aids to day-to-day practice and some have very limited interrogation and analytical facilities, so it may not be easy to contrast older people and carers' utilisation of health care across the PCG and against national norms for example.

Comprehensiveness

Traditionally information tends to be collected around activity while health outcomes, (important for implementing clinical governance and assessing PCG effectiveness in improving health), is currently much more limited, a fact also reflected in the paucity of primary care indicators in the current national performance assessment framework.

In conclusion, the experience of total purchasing highlighted lack of adequate information as a real barrier to progress and also revealed that participating TP pilots initially underestimated their information needs.[138] Although the national strategy for information is a step forward, PCGs are similarly likely to experience difficulties in monitoring and measuring their progress, especially in the short-term.

6.8 Partnership working

Partnership has almost become a mantra in health and social care policy circles (although this renewed emphasis builds on a notion of 'seamless care' which has been a consistent policy goal for the past twenty years or more). Wholesale integration of health and social services remains politically unthinkable in the immediate future in mainland Britain[140] and instead the Government's solution has been to impose a *duty* of partnership working on local government and the NHS, and enacted legislation to allow partner organisations greater flexibility to integrate particular services (*see Box 6*). The importance assigned to partnership working at the primary care level can be seen in the attempt to incorporate multidisciplinary working into the organisational structure of PCGs.

Box 6: New partnership 'flexibilities'

New 'flexibilities' to facilitate joint working between health and social services have been incorporated into the Health Act (1999). Accompanying guidance argues that joint working should become 'core' not marginal activity. The main levers for change are:

- pooled budgets (pooled money will lose its original NHS or social services 'identity')
- lead commissioning (i.e. where one partner takes the lead in commissioning both health and social care)
- more scope for fully integrated provision of social and health care by single providers.

There will be expanded powers for authorities to transfer funds between health and social sectors and the health authorities' *joint finance* allocations will now be integrated into mainstream allocations. Monitoring and accountability requirements are discussed. Further draft guidance was issued for consultation in September 1999.

For many frail older people and carers there is no simple distinction between their health and social needs. Decisions over statutory responsibility for funding and providing care are, however, often open to local interpretation. There is much evidence that poor collaboration between the various community care providers (including primary care) has worked to disadvantage older people, resulting in poorer health outcomes and loss of independence.[51,4,3] Box 7 describes the organisation of the UK community care system.

Box 7: A divided community care system

	Health	Social services
Funding	Central taxation. The expense of funding long-term care means there is an incentive for health authorities to shift responsibility as far as possible to social services. Assessment criteria setting out health and social service responsibilities for meeting long term care needs are determined locally leading to wide geographical variation. Traditionally, primary care professionals only indirectly affected by financial implications of treatment decisions but this has changed with devolved cash-limited budget held by PCGs.	Central and local taxation allocated between competing local authority departments. Social services departments must raise 9% of their total expenditure through charges. Real cuts to social services budgets have increased pressure on statutory services reducing range of services and focusing support on clients in severe need.
Access	GPs gatekeepers to specialist care. Primary health care team provides primary & community health care. Community nurses key health professionals for older people/carers with complex needs. Care generally free at the point of delivery with rationing by waiting list.	Social workers gatekeepers to community care. Under NHS Community Care Act (1990), social services responsible for multidisciplinary assessment & organisation of health & social care package to meet each individual's community care needs. Social care subject to means testing & charges. Voluntary and private sector are main providers of much social care.
Stand-ards	Traditionally health care services have been regulated through professional peer review. The Commission for Health Improvement (CHI) marks a more regulated approach. Independent providers and community health services will also be subject to further regulation and standards if the Care Standards Bill becomes law.	Social services activity is open to inspection by the Social Services Inspectorate. However, the Care Standards Bill (currently before Parliament) will bring in much greater regulation at service level. The Bill covers residential and nursing homes and, for the first time, domiciliary services.
Culture	'Professional model' dominates medical care. Clinical governance may limit scope for individual discretion.	'Bureaucratic model' i.e. formalised lines of accountability and decision-making and less professional autonomy.
Organis-ation	NHS and local government have different organisational structures with separate planning cycles, performance monitoring and accountability arrangements and in past, restricted opportunities to integrate and share resources etc. New legislation is being enacted to facilitate partnership. The limited scope for primary care and social care professionals to train/work alongside each other has led to poor understanding of roles and stereotyping.[141]	

Of course, primary and social services joint working has been encouraged before. Under the community care reforms in the early 1990s, health and social care agencies were expected to plan and develop community care services jointly. But the community care reforms failed to achieve widespread collaboration between primary health and social services in practice. Published research has explored the forms of partnership that were sustainable and analysed factors inhibiting effective joint working. Primary and social care partnerships can be divided into those with a strategic focus (e.g. joint commissioning of services for older people) and those aimed simply at improving current practice through better integration (e.g. co-locating primary and social workers).

In fact, successful strategic partnerships involving primary care have been comparatively rare.[142,143,144] This is because planning and commissioning tended to occur at district level with no straightforward mechanism for involving autonomous general practices and practitioners. Examples of innovative area-based primary, health and social care partnerships depended to a large degree on senior managers within health or local authorities keen to 'champion' the cause of primary care involvement.[143]

Joint finance, fundholding and to a greater extent total purchasing gave practices and groups of practices more leverage to shape service development for their own patients at least. Rummery and Glendinning[143] cite several examples of highly successful practice-based commissioning for older people in which social services and the primary health care team (PCHT) worked together to develop services. Typically the aim was to meet primary care concerns about hospital admission and discharge for older people, for example by purchasing social care, intermediate care beds or respite care. However, simply controlling a budget is not a sufficient condition for meaningful collaboration.

Examples of smaller-scale operational partnerships between primary care and social services are more widespread.[144,142] A common model is co-location of social

workers/care managers with primary care staff. Benefits include improved access to and reduced duplication of assessment and a one-stop shop for patients who may find accessing social services via primary care less stigmatising. A further obvious benefit has been to improve mutual trust and understanding of respective primary care and social work roles, especially where time and resources have been available for 'team building'. There are many models of shared working; other examples include delegation of the care assessment function to trained members of the PHCT and various forms of collaboration between community nurses and social care providers, such as domiciliary care workers.

What are the implications for PCGs?

Partnership working between primary and social services at a level sufficient to bring about meaningful service change for older people and carers will be difficult.

It is a long-term process requiring mutual trust, shared ownership and an agreed vision of service development with clear objectives and outcomes.[142,146] Furthermore joint strategies must be reflected in mechanisms to engage the primary and social care professionals involved in delivering the service (for example, joint training for multidisciplinary practitioner groups[145]). Involving service users and the voluntary sector also seems to be important.[146] The Social Services Inspectorate recently published advice to PCG boards on developing links with social services following a series of inspections.

Despite these difficulties, we might expect PCGs to have greater success in establishing effective partnerships with social services than earlier primary care players. PCGs have legitimacy as drivers for service change and to some extent institutionalise partnership working. The now statutory duty of partnership to collaborate, for example, in the production of health improvement programmes and joint investment plans may also help to develop relationships with partner organisations. Encouragingly, surveys have found that PCGs and social services departments are positive about the benefits of partnership working, although this view may change as problems are encountered in practice.[147,141]

PCGs will need to consider working with local government more widely to fulfil their objective of health improvement. For example, 'joined up' commissioning for older people and carers might mean forging links with housing and transport departments.

Local authority housing departments are required to consult health and social services over supported and sheltered housing for older people and other vulnerable groups[157] and almost half of housing departments responding to an early postal survey wished to have some form of representation on PCG boards.[147] However, some PCGs seem to be relying on their social services board member to make the links with other local authority departments which may be an unrealistic expectation.

There is evidence that in some PCGs, the social services representative's responsibilities to his or her employing department are not well understood by other members of the board, leading to tensions.[89]

PCGs falling within unitary local authorities which are relatively small are more likely to secure very senior social services representation (that is, director-level). Social services representatives from unitary authorities also seem better able to develop links with other local government departments.[147,89]

The Government's 'modernisation' programme for local government (i.e. the move to 'cabinet style' working supported by area-based committees) may provide a further complication for PCGs where these 'areas' do not coincide easily with PCG catchment populations.[89] There may be benefits for PCGs too, however, for example they may wish to share results or experience arising from local government public consultation exercises or attain wider access to area-based resources such as Partnership Grant or Single Regeneration Budget.

PCGs are expected to make use of the new flexibilities outlined in *Partnership in Action*.[89] Past experience suggests that primary care practices often found it difficult to

identify *any* additional resource to fund social care initiatives or other joint working and this lack of resource was an obstacle to primary care involvement.[148] PCGs with their greater scope to commission services should find the ability to pool budgets with social services partners valuable.[149] In practice interest may depend on the ease with which these flexibilities can be arranged. At present PCGs must apply in conjunction with their health authorities. The potential partners must satisfy their local NHSE regional office that accountability arrangements have been fully considered, which may deter take-up for smaller-scale projects.[150,151]

Working with other partners

PCGs must work with other organisations too, most obviously their health authority. There appears to be some tension in this relationship, with some health authorities reluctant to give PCGs the autonomy they desire while still remaining formally accountable for much PCG activity. Health authorities and local authorities may be more concerned than individual PCGs about equity of access to care across the district as a whole.[89]

In some areas partnerships are already very well established but these may or may not be inclusive of PCGs – for example, some PCGs have complained of having little influence over locally agreed priorities for partnership grant – while in others, PCGs are faced with developing partnerships largely 'from scratch'.[89]

Finally, many PCGs are also developing links with their acute and community trusts, the latter especially likely where PCGs are interested in moving to primary care trust status or considering care pathways as a tool for service development for particular conditions or groups of patients such as older people.

6.9 Best Value

The Government wishes to see best value principles applied to all those working with local authorities whether in partnership or alongside them.[158]

Best Value is a new performance framework for local government (applying to all local authorities and councils with a budget of £500,000 or more) and some other public services (not NHS) aiming to drive continuous efficiency and quality improvement in service delivery. The initiative was initially piloted in selected authorities[152] and will be rolled out nationally from April 2000. The main features are:

Best Value performance plans

Best Value requires the publication of an annual performance plan, with the first plan to be ready by 31 March 2000. The content of these plans looks likely to be strictly prescribed and will include the authority's aims, past performance, its Best Value reviews programme and future performance targets.[153] The plans are clearly intended to strengthen public accountability.

Best Value reviews

Over a five-year cycle, authorities and councils must review *all* the services they deliver. For each service review, draft guidance[153] instructs authorities to:

- question the rationale for provision
- identify the strengths and weaknesses of the service
- investigate how it could be better delivered (considering efficiency, competition and quality improvement)
- set measurable outcomes and time scale for improvement.

Public consultation

Additionally, authorities must be able to demonstrate that services are responsive to public priorities and opinion. (The Audit Commission has published guidance on community consultation for Best Value.[109]) Performance will be monitored through:

- External departmental inspection and audit. The Audit Commission and Social Services Inspectorate will continue to inspect social services departments but, in future, inspections will be timed to coordinate with local Best Value reviews.

- Performance indicators (PIs). A raft of national performance indicators for 2000–01 has been developed to monitor Best Value performance covering 'corporate health' and service specific indicators.[154] For social services, a national indicator set has already been developed under the national performance framework[28] and a subset of these indicators together with a set developed by the Audit Commission have been proposed to reflect progress with Best Value. Note these are still the subject of consultation. Authorities and departments are also encouraged to develop local indicators.[154]

- Benchmarking. Authorities and departments are expected to make comparative assessments of performance both against previous years and relative to other authorities. They must ensure that their quality targets are consistent with the best 25 per cent performing authorities.

- National efficiency targets. Overall authority efficiency improvements must be line to meet the Government's target of 2 per cent improvement per annum for local government and consistent with the best 25 per cent performing authorities over five years.

Best Value presents a real challenge for local government because the emphasis on continuous quality improvement is (culturally) very different from earlier ways of

working (for example, compulsory competitive tendering); furthermore it will require considerable work and resources to implement and progress will be open to Government and public scrutiny.

Given the prominence of the strategy, Best Value is likely to have an impact on PCGs attempting to work with social services departments. This is potentially problematic because Best Value feels rather different to the NHS clinical governance programme which PCGs will be working to implement. For example, PCGs jointly commissioning health and social care for older people may find the requirement to demonstrate how the service is responding to older people's and carers' expectations or attain benchmarked targets relating to independence difficult.[155]

The Government clearly expects partner organisations to sign up to Best Value to the extent that it foresees PCGs and social services departments integrating their quality programmes.[89] It remains unclear how far this can be achieved while the NHS operates to a parallel and more autonomous quality agenda.

7. Conclusion

Services for older people and carers are still in need of improvement. Fragmentation, lack of alternatives to hospital care and negative attitudes towards older people are just some of the issues highlighted in this paper. But it is also clear, given the current policy climate and earlier experiments with primary care commissioning, that PCGs may now have the opportunity to make a real difference to the health and well-being of older people and carers if they can generate the enthusiasm, ambition and local influence to drive strategic change.

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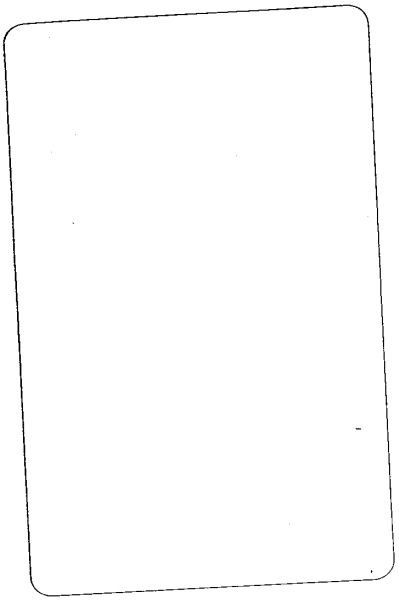

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