This series of briefings summarises work undertaken by the Centre for Policy on Ageing on

HEALTH AND SOCIAL CARE: Research

IMPROVING THE HEALTH OF OLDER LONDONERS - REVIEWING THE EVIDENCE

Background
Following on from two large research projects for the old Health Education Authority, CPA was commissioned by an NHS Regional Executive to undertake a rapid review of the scope for improving the health of older residents within its health region. Published in 2000, the review:

- identifies key issues to be considered in developing a strategy for improving the health of older people;
- summarises recent evidence on the epidemiology of disease and disability in later life;
- reviews evidence on the effectiveness of different interventions aimed at preventing or postponing ill-health and disability in later life;
- discusses policy options for service providers.

Outcomes
Key issues and key points identified:

- Health improvement in later life is about adding life to years as well as adding years to life. The challenge for the health and social care system is to maintain health and quality of life in an ageing population;
- it is essential to distinguish between (i) a strategy to promote healthy ageing in the population and (ii) a strategy to improve the health of people who are already 'old';
- a strategy for improving the health of older Londoners must take account of the heterogeneity of the older population. There is enormous variation in health status and in social and material circumstances;
- differences in health status should be reflected in the different kinds of health improvement goal that are relevant to different sub-groups of older people. The strategy should consider the scope for 'prevention' in respect of people who are already chronically ill or disabled as well as those who apparently free of chronic disease and without significant functional limitation - for people who are already living in residential or nursing care as well as for those living 'independently in the community';
- the strategy must consider how it is to address the problem of social and ethnic inequalities in health.

Effectiveness and cost-effectiveness
The best evidence of effectiveness (what works) is available for a handful of interventions which have been evaluated in several clinical trials and have been the subject of meta-analyses or systematic reviews:

- influenza vaccination works: during influenza epidemics it reduces mortality, morbidity and hospitalisation among people aged 65 years or more;
- anti-hypertensive medication works in older people;
- multi-factorial behavioural interventions (with or without pharmacological treatment) to
reduce cardiovascular risk work better in high risk populations than in the general population;
C cardiac rehabilitation works: it has measurable survival and quality of life benefits (though the evidence is limited in respect of older cardiac patients);
C multi-disciplinary assessment for falls prevention with appropriate follow-up works: it prevents falls and fall-related injuries in high-risk populations of older people living in the community;
C there is also some evidence from randomised controlled trials for the effectiveness of educational/behavioural interventions targeting older people;
C there is very little UK data on costs and cost-effectiveness of preventive interventions with older people;
C other issues/health problems which demand attention or active consideration as possible strategic priorities are:
- promoting healthy lifestyles among older people
- health and health care for older people from ethnic minorities
- falls prevention
- undetected and/or untreated hearing disability and depression
- access to health care for older people in institutional care
- increase provision of chiropody services.
The report concludes that there is an urgent need for more research into the area of effectiveness.

Publication:

ESTIMATING DEMAND PRESSURES FOR PERSONAL SOCIAL SERVICES FOR OLDER PEOPLE

Background.
CPA, in conjunction with the Centre for Health Economics at the University of York, was commissioned by the Department of Health, to estimate short-term demand pressures arising from the needs of older people for personal social services. The main aim was to investigate how far it was possible to assess the impact of the implementation of the community care reforms under the NHS and Community Care Act 1990, which were intended to reduce the number of older people going into residential care.

Such estimating has its difficulties because of the mismatch between the different sorts of data available. It is also important to distinguish between the contrasting sets of factors which have an influence on what happens in practice - factors such as demographic change within the population of older people may have just as much an impact on admission rates to care homes as the policy goals themselves. Known pressures on uptake of services include:
C living alone;
C onset of dementia;
C recent hospital episode;
C recent bereavement;
C NHS policies.

It is also known that there are a range of factors mitigating demand for services:
C availability of informal care;
C individual resources (to go private);
C onset of acute medical need leading to hospitalisation;
C tight eligibility criteria;
C LA charging policies;
C availability of other services (e.g. respite care).

Counterbalancing - but unstable and often unpredictable - factors had to be built into the forecasting process. The study was able to estimate a broad band of demand, ranging
between minimum and maximum need, based on the type of limited data currently available but called for more data collection particularly on the extent of domiciliary care (received from all sources) in order to make more accurate forecasts in the future.

**Publication:**
Carr-Hill, R (Centre for Health Economics, University of York) and Dalley, G (Centre for Policy on Ageing) (1999) Estimating Demand Pressures Arising from Need for Social Services for Older People. £7.50. Available from Publications Centre, Centre for Health Economics, University of York YO1 5DD.

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**PATIENT SATISFACTION: THE DISCHARGE OF OLDER PEOPLE FROM HOSPITAL**

**Background**
CPA was commissioned by a London health authority to conduct a survey of older patients' satisfaction with hospital discharge procedures as part of its quality programme. Semi-structured interviews were conducted to learn about patient experiences of discharge and the subsequent period at home after discharge. The research team interviewed 211 older people with particular reference to whether they felt they had been kept well enough informed, whether arrangements for going home had worked well and whether they were satisfied with community based services put in place on their return home.

**Outcomes**
- Most people said they had been kept informed about what was happening while they were in hospital and most said they had been asked about their home circumstances but over a quarter felt this had not been the case.
- Most people said they felt ready to leave hospital but over half said they had been given very little notice of when this would happen (24 hours or less).
- Around a fifth, mostly those living alone, had no-one at home to settle them in, make up a bed and get food in;
- Poor communication between different members of staff was reported;
- Some were critical of the lack of services on returning home;
- A small number spoke very warmly of the quality of care and services they had received throughout the whole process of being in hospital and subsequently when they were discharged.

The report made a number of recommendations:
- The need for strong management leadership to make improvements.
- Regular review of how the discharge process is handled by all members of staff involved;
- Regular audits to ensure all discharged patients receive a discharge letter in line with service specifications;
- Regular audit of the effectiveness of inter-agency liaison and collaboration to ensure individual patients do not 'fall through the net' on their return home.

**Publication:**
A MODEL FOR ALLOCATION OF THE STG BUDGET FOR THE PURCHASE OF RESIDENTIAL AND NURSING HOME CARE

Background
CPA, in conjunction with the Centre for Health Economics at the University of York, was commissioned by a large metropolitan borough, to review the then current methods of allocating the Special Transitional Grant for the purchase of residential and nursing home care for older people and to create a model which would reflect current needs more accurately. The project analysed census data, locally gathered data on the current uptake of residential and nursing home care and the findings of locally commissioned research. It also examined a sample of case records of recent allocation decisions to assess how far they had been made in line with current policy and eligibility criteria. A number of face-to-face interviews and group discussions with social services staff about their allocating decisions were conducted.

Outcomes
A report and proposed resource allocation model to ensure resources were more accurately matched to actual ‘needs’ were generated to enable the resources available to be distributed as equitably as possible between the constituent wards of the metropolitan authority. Results indicated a complex inter-play of salient factors and evidence that some re-allocation of resources in favour of a number of the inner city wards was identified. The qualitative study to identify the presence of any systematic variation revealed in patterns of decision-making at a local level found none. In particular, no evidence of increased cost driven decision-making at the expense of identified need and expressed choices around support services was revealed.

NB. This report is not available for distribution.

HEALTH SERVICE NEEDS OF MEMBERS OF MINORITY ETHNIC COMMUNITIES

Background
CPA was commissioned by a Community Health Care NHS Trust, who recognised that the community health service needs of its black and minority ethnic older population were not being adequately met. The task was to identify the service needs concerned and to make recommendations about how services could be targeted or developed to meet these needs more effectively. A six-point strategy, which included using rapid appraisal and other qualitative research methods, was adopted.

Outcomes
C a high level of commitment to the aims behind the project amongst Community Health Care NHS Trust staff, community organisations and individual older people;
C a large capacity for development of service provision to black and minority ethnic communities;
C the ‘problem’ of the diversity of the Trust’s ethnic communities sometimes seems to have slowed progress on service development;
C black and minority ethnic older people want better access to appropriate, sensitive mainstream services, rather than specific services for their communities;
C links need to be improved between the Trust and local community or voluntary groups and networks;
C there needs to be a clearer link with those local agencies doing similar development work, and a clarification about responsibilities for consultation;
C there need to be better links with GPs and health/statutory organisations or forums for services to develop more effectively;
C information about the Trust’s services requires a more complex and imaginative approach than simply producing leaflets in English or other languages;
Main recommendations
C training for ethnic awareness and monitoring among Trust staff;
C improved sharing of ideas, contacts and initiatives among Trust staff;
C improved networking with other organisations, particularly Health Agency
development workers, GPs and community groups;
C more creativity needs to be introduced around the formats and dissemination of
information about services to users, taking into account language and literacy.

NB. This report is not available for distribution.

BEST VALUE? SERVICE USERS’ VIEWS OF COUNCIL SERVICES FOR OLDER PEOPLE

Background.
CPA was commissioned to undertake this study of service users’ views as part of a London
borough council’s Best Value review of older people’s services. It involved the sampling of the
views of residents in a number of local authority residential care homes and service users
living in the community.

For those in residential care homes the purpose was to explore:
- what the individuals thought about the process of admission (in terms of information
  provision, consultation and choice);
- what they liked about their current living arrangements;
- what could be improved.

The views of staff were sought to complement those of the residents.

Outcomes - residential care residents
- many had made a positive choice to go into residential care;
- the decision to go into residential care was due to a range of factors such as: illness,
  frailty/mobility problems, need for companionship, loneliness and bereavement, anti-
  social environment, need for security and safety;
- many had made decisions on their own but others had done so with the help and support
  of family, friends, doctors - only a tiny minority felt they had had no say;
- respondents were evenly divided between those who felt they had received enough
  information and those that had not;
- most had expected comfort, being looked after, companionship and/or safety on going
  into care - only one person mentioned losing independence;
- some regretted having to leave their home and familiar surroundings;
- almost all had a single room; one person said she did not mind sharing, the only other
  person sharing was worried about who might share with her next;
- almost all ate their meals together - there was a sense that that was what the homes
  expected (unless a resident was ill);
- most felt that the benefits of living in residential care were company and companionship,
  helpful caring staff, good food, care and comfort, safety and security, being looked after
  and cleanliness and quality of environment;
- most people had visitors regularly and kept in touch with the outside world - however a
  number said they received no visitors;
- only one person had a telephone - others complained about lack of access to a
  telephone;
- most people were satisfied with arrangements for seeing their doctor.

Staff questioned contributed almost wholly positive views about the care residents received.
They were proud of their own role in this while at the same time wishing they could do more in
respect of providing more individual ‘quality time’. The difficulties which they perceived related
mostly to their own experiences (impact of agency staff, pressure of work, constraints of
location and building) and it appears they worked hard to ensure that this was not passed on to affect residents themselves.

*Residents living in the community (includes sheltered housing)*

Similar questions were asked of a sample of older people living in the community (including some living in sheltered housing). Responses varied:

- the views of people living in their own homes were mixed - especially about the quality of care received;
- there were examples of indifference and the very casual treatment of some vulnerable and frail people often linked to services provided by outside agencies;
- there were some instances of poor information about the circumstances of community-based clients and improved reliability of information and communication systems relating to community care services was required;
- sheltered housing residents were generally pleased with living in sheltered housing because it meet their needs and they valued the security and friendship it offered;
- most of them felt well supported by family and friends and neighbours;
- they all felt that the housing managers (wardens)did a good job;
- whatever particular arrangement for contact with the housing manager was (telephone, visit, buzzer) on the scheme in question, the residents seemed to find it satisfactory;
- most residents felt the charges were fair;
- there were mixed views however about the quality of services going into them and, like the community based service users, their criticisms seemed to be levelled at agency staff.

**Conclusions**

A useful picture emerged of what older residents think about the services laid on for them by the Council. Contrary to much received wisdom, many people enjoyed living in residential care and some made a positive choice to do so. Any dissatisfaction lay in the lack of time staff have to spend with residents, the failure take note of individual needs and preferences and, in a very few instances, poor care and attention.

NB. This report is not available for distribution.

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