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Social Care Demographics and Pressure Points

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March 2012

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1 Introduction

This short paper summarises a lecture given by Professor Keith Moultrie to a Community Exchange Seminar run by Oxford Brookes University and Oxfordshire Council for Voluntary Associations on 8 March 2012. The paper focuses on the social care of older people in England, and its purpose is to:

- Explore the changing population demographics across the country.
- Consider the potential implications for social care and related health and welfare services.
- Consider the policy response to date and how it might develop further.

The views are those of the author, but draw upon the work of The Institute of Public Care at Oxford Brookes University over the last 25 years.

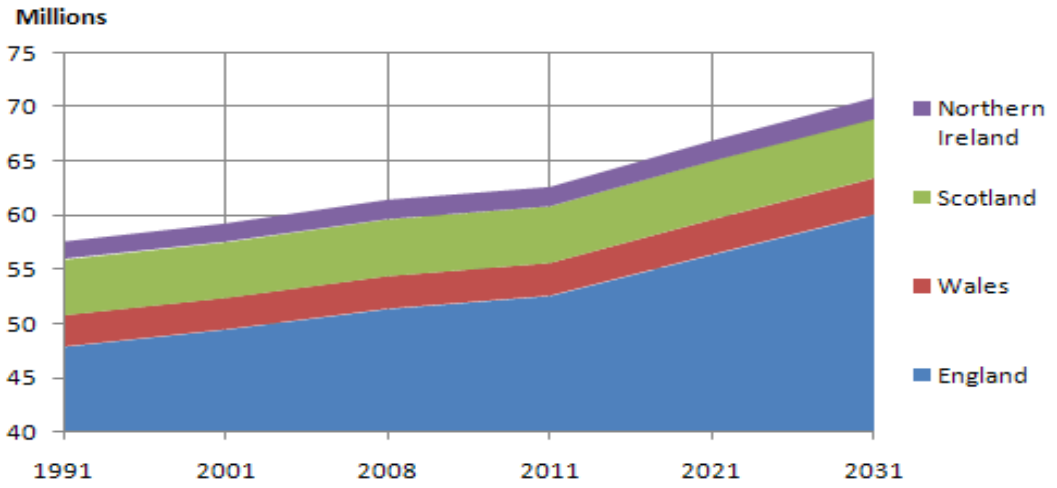
2 Population Change

The structure of the British population is in the middle of significant change. The current total population in England is about 52.5 million people, of whom:

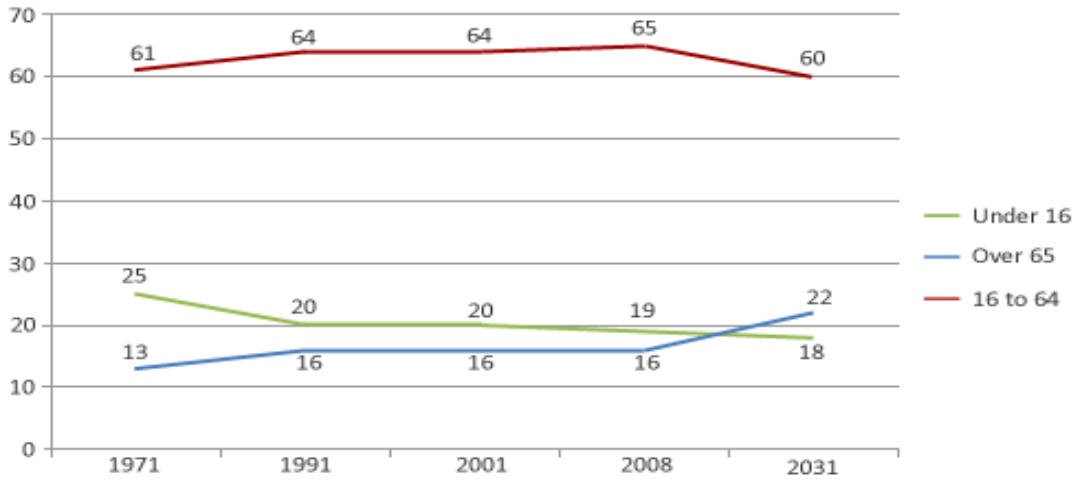
- Over 17.5 million are aged 50 and over (about 34%, or 1 person in 3)
- Over 8.7 million are aged 65 and over (about 16.5%, or 1 person in 6)
- Over 1.2 million are aged 85 and over (about 2.3%, or 1 in 40)[1]

From Office for National Statistics data it is apparent that the overall population will continue to grow in the next 20 years[2]:

[1] Data downloaded from The IPC Projecting Older People Population System www.poppi.org.uk on 2 March 2012
[2] Source: Office for National Statistics Mid-year estimates for 1971 to 2008, 2008-based projections for 2031

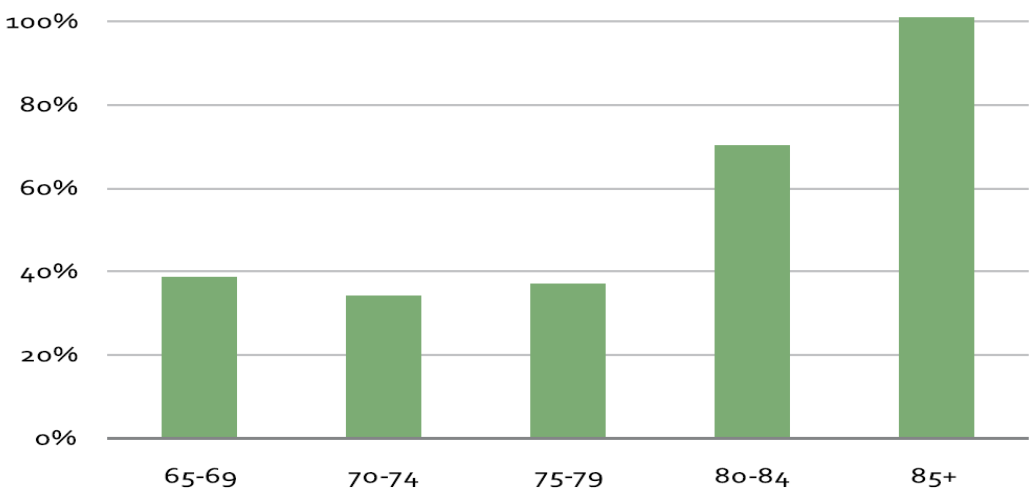


The distribution of ages in the population is also changing, and is projected to alter significantly over the next few years, with reductions in the proportion of children and working age adults, but an increase in the proportion of older people[3]:



The increase in the number of older people is significant, particularly with regard to those aged eighty and over. In its final report in July 2011, The Commission on Funding of Care and Support, chaired by Andrew Dilnot, summarised the projected increase in older people in England between 2010 and 2030 as follows[4]:

[3] ibid
[4] Commission on Funding of Care and Support (2011) Farer Care Funding, p17



This increase in numbers and proportions of older people, (including a doubling of the number of over 85s) is certainly a significant factor which health and social care policy makers, service commissioners and planners need to take into account. However, it is by no means the inevitable crisis that our politicians and media sometimes like to portray[5].

3 The Policy and Planning Challenge

Policy makers, commissioners and planners cannot afford to have the same knee-jerk reactions as the press. They need to try and understand the range of factors, in addition to population change, which can affect the likely demand for state funded care and support, and aim to develop services to address these factors, good and bad.

For example, it might be argued that this generation of older people is; wealthier, healthier and in a position to contribute even more significantly to the wellbeing of the community as a whole than any previous generation. Certainly older people now hold a huge proportion of overall income and capital[6] in England:

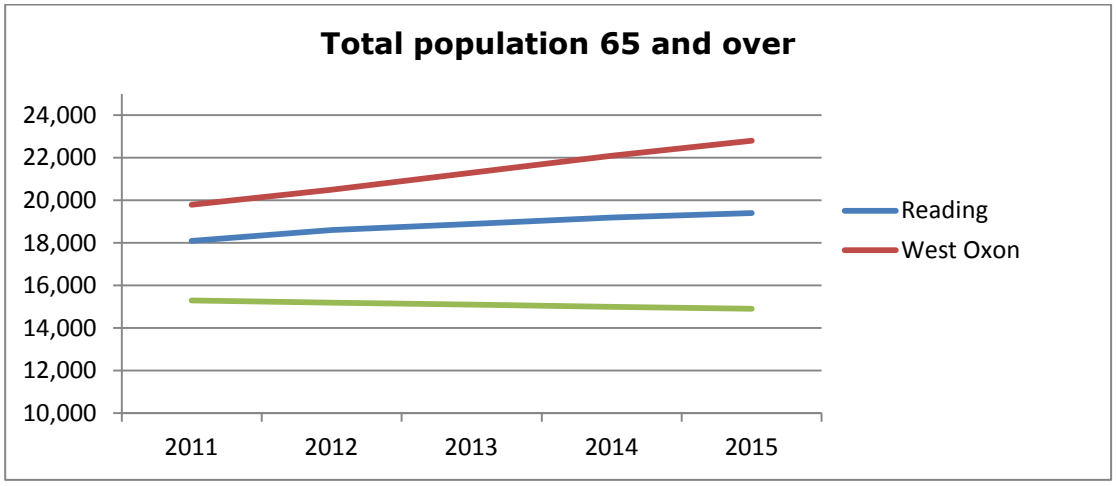
Age	Mean Income (taxpayers)	Total Capital	Average Capital
20 -44yo	£26,700	£90.04bn	£30,136
45-65yo	£38,900	£127.7bn	£96,086
Over 65	£22,600	£105.1bn	£120,209

[5] The Independent on 23 February 2012 for example suggested that *"Ministers fear that the National Health Service could require an emergency cash bailout before the next general election to enable it to cope with the escalating demands of an ageing population"*

[6] Extrapolated from http://www.hmrc.gov.uk/stats, Distribution of Income and Tax by Age and Gender 2008-09, and Identified Personal Wealth 2005-07, downloaded 2 March 2012

This has been an extremely fortunate recently retired generation, free of world war in their working lives and living through a period of unparalleled growth with the support of an extensive welfare state and pension system. Not surprisingly, during this recent economic downturn, many policy makers are now asking whether, because there will be proportionately fewer working age adults to pay for welfare services through taxes in coming years, then more of this accumulated wealth held by the retired population should go towards meeting the cost of their welfare support.

It is also worth noting that, while the overall population trends are clear, this hides significant variation between different parts of the country which planners and commissioners need to understand if they are to respond effectively to local need. For example, the overall numbers of older people in West Oxfordshire are projected to rise considerably in the next 3 years, while Reading is expecting a smaller rise and Tower Hamlets will actually see fewer older people.[7]



In understanding likely future demand policy makers, commissioners and planners will also need to take account of the changing wishes of the older population. Services acceptable to people of 80 plus today are not likely to be desired by the current pre-retirement generation in 15 - 20 years time. For example, as part of a project for The DH Care Services Improvement Partnership in 2009, IPC undertook interviews with focus groups of people of 55-65 years, and compared their views with other evidence about the wishes of the current 80 plus generation[8]. In general today's 55-65 year olds were looking for:

[7] Data downloaded from The IPC Projecting Older People Population System www.poppi.org.uk on 2 March 2012

[8] DH Care Services Improvement Partnership (2009) Key Activities in Social Care Commissioning

Health and Wellbeing	Community Social Care	Accommodation
More recognise the importance of being able to socialise and enjoy company outside the home. More see the 'preventative' value of keeping the mind active and challenged, whether through formal learning or hobbies. They want to address health problems quick to avoid deterioration. They see the health value of being able to continue, or develop, work based or civic roles and responsibilities.	More people do not want care to be restricted to their home, but to have support to do things themselves. Consistency of carer is usually identified as the most important element of a quality service. People look for reliability of visits, people arriving when expected, but that the actual care given can be flexible.	More people want to stay in their own homes. More accept that a move into housing with care appropriate if they acquire disabilities in older age. Sufficient space for family or friends to stay is seen as important. More are positive about equipment and assistive technology and see this as offering real opportunities for them to stay in their own homes comfortably and safely. People do not want to move into a care home.

With the degree of choice and control available in the future, through their accumulated capital and income, and as a result of national policy supporting personal budgets and direct payments, this generation will be in a much stronger position than previously to secure the kind of services they really want.

Policy makers, commissioners and planners also need to question whether age itself is an inevitable determinant of illness, disability and demand for services. For example, in an influential analysis in a policy briefing by the World Health Organisation in 2009, it was argued that a longer life does not inevitably mean greater health care demand: it argues that

'There is a growing consensus that ageing does not have to be an inevitable drain on health care resources.' [9]

and points to commentators who suggest that future demand will be influenced more by what is termed 'compression morbidity' (where the average age at which illness and disability strike is delayed to a greater extent than the average age at death) than by other scenarios. Although prediction is an inexact science here, policy makers are recognising that

[9] World Health Organisation Policy Brief 10: B Rechel etc (2009) How Can Health Systems Respond to Population Ageing?

increased age in the population does not inevitably mean increased demand for health care – indeed the WHO report suggests that

'The impact of increases in the older old population with disabilities will fall predominantly on the long-term care sector rather than the acute health sector.' It also suggests that *'.. although population ageing will bring some additional costs, these can be reduced by the application of appropriate and well coordinated health and social policies that slow the rate of health decline associated with ageing and thus the amount of health care services required.'*

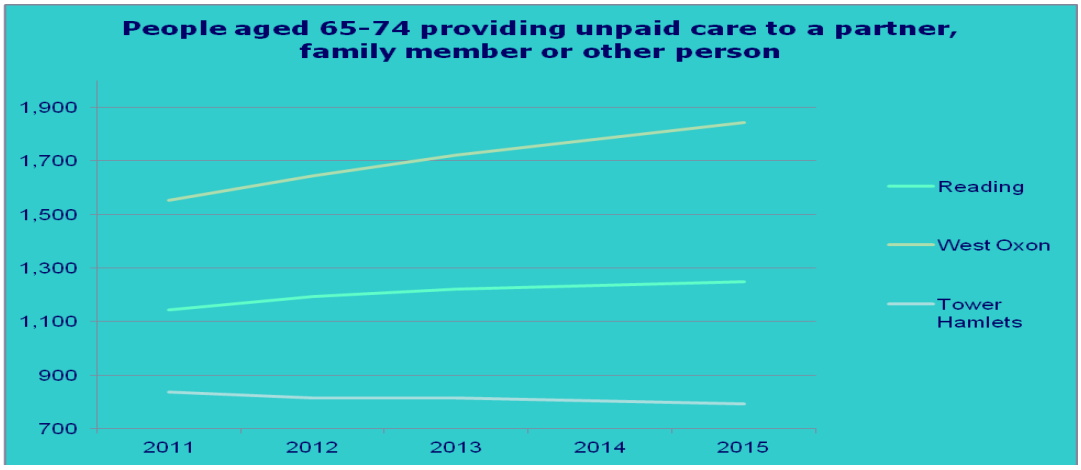
So, we have an aging population overall (with local variations), a comparatively wealthy older age group with changing attitudes towards their health and care as they enter old age, and the need to design services which will promote health and wellbeing and reduce the demand for acute care in the future. However, in designing services, policy makers, commissioners and planners also need to consider what resources and services are available, what impact they have, and whether they need to be improved. So how well are our services doing?

4 Health, Wellbeing and Social Care Services – A Summary

The largest group providing health and care support to older people are carers. There are estimated to be over 6 million carers in the UK, providing day-to-day support for a friend or relative. Many people over the age of 50 years provide some form of care – for example Mooney et al found almost half of employees in their fifties and sixties had some degree of caring responsibility, and with nearly as many men as women reported providing care, although women's care giving was more intensive.[10] It is estimated that almost 980,000 carers are over 65 years, and that this will increase by more than 100,000 in the next five years with considerable variation across the country[11] :

[10] Ann Mooney and June Statham with Antonia Simon (Policy Press) The pivot generation: informal care and work after fifty

[11] Data downloaded from The IPC Projecting Older People Population System www.poppi.org.uk on 2 March 2012



The voluntary and community sectors are also hugely important in supporting a community infrastructure which promotes wellbeing. There are an estimated 600,000 community groups with no formal registration in UK, and 170,000 registered charities, 20% of which are classified as working in welfare, wellbeing and social care, which have a combined income from all sources of around £8.3 billion[12]. However, there are concerns that these services while very much appreciated, sometimes have limited impact on demand for health and social care. For example, the DH 'Use of Resources'[13] noted in 2009 that

"Well-being services are very popular with the public and there is growing evidence of their ability to improve people's mental health and general well-being. It is difficult, however, to track directly whether people are being prevented from needing social care support in the future."

It is almost impossible to calculate the number of people using the voluntary and community sectors but numbers using formal health and social care services are more easily obtained. An estimated 1.78 million clients were receiving social care services in 2008-09, of whom 1.22 million (68%) were aged 65 and over. This total is about a quarter of the overall 65+ population. About 85% of clients received community based services, 15% received residential or nursing care.[14]

A total of 340,000 beds were used in care homes in 2009 according to an analysis of national data by IPC[15]. The NHS Information Service calculate 77% of care home places are used by over 65s, a total of 262,000 beds. At any one time therefore, about 3% of the over 65 population would be residing in a care home bed. Extrapolating the use of these beds across the year, this produces a total of approximately 95 million bed-days in a full year. About half of all care home places are self funded, and the care home market for older people in England is estimated to be worth £4.9 billion.

[12] House of Parliament Standard Note: SN/SG/5428 (2011) Voluntary Sector Statistics
[13] Department of Health (2009) Use of Resources in Adult Social Care: A guide for local authorities
[14] NHS Information Centre (2008-09) Community Care Statistics
[15] IPC for the Think Local Act Personal Consortium (2011) 'Review of Self Funders in England

About 200 million contact hours of home care were provided through local authorities in 2008-09 according to the NHS information Centre[16], which is equivalent to 8.3 million 24-hour 'home care days' per year. It is estimated that self funders buy about half of the amount of local authorities across the country, or some estimated 4.15 million 'care days'. Total home care provision is therefore about 12.45 million care days in the year. The home care market has grown from £510 million in 2002-2003 to £652 million in 2010.[17]

Turning to acute health care, according to the NHS Information Centre there were approximately 94 million inpatient bed days in 2010 -11, and people on average stayed for 5.5 days. This comprised:

0-14yo	15-59yo	60-74yo	75+ yo
10.5 million days	41.25 million days	20.9 million days	22 million days
12% of total	44% of total	22% of total	24% of total

In other words over 60s make up about 20% of the population and use 46% of beds, and over 75s make up about 7% of the population and use 24% of beds. It is worth noting that older people spend about twice as much time in residential beds across the country as in hospital.[18] Health care spending has increased more than any other major area of national expenditure over the last 20 years. According to the Institute of Fiscal Studies

'*Spending on social security, education and the NHS has grown faster over the past five decades than have total public spending, current spending and national income. These three areas have therefore increased their respective shares of public spending and national income. The NHS in particular has experienced substantial growth, with average annualised real increases of 3.2 per cent under the Conservative governments from 1979 to 1997, and 6.3 per cent under Labour from 1997 to 2008.*'[19]

5 Do Services Meet Needs?

Sadly, the idea that this huge array of services across these sectors is perfectly configured to promote a healthy old age, to intervene quickly and effectively when there are problems and to help people return to the community when they are recovered are not borne out by recent reports. Some examples of recent findings on the impact of health and social care services shows the limitations of current arrangements:

[16] NHS Information Centre Community Care Statistics
[17] IPC for the Think Local Act Personal Consortium (2011) 'Review of Self Funders in England
[18] NHS Information Centre (2011) Activity in English NHS Hospitals
[19] Institute of Fiscal Studies (2009) A Survey of Public Spending in the UK

5.1 Continence[20]

The great majority of continence services are poorly integrated across acute, medical, surgical, primary, care home and community settings. "Although 55-80% of services report themselves as integrated across healthcare settings, only four services across the country fulfil all of the requirements set out in the DH guide "Good Practice in Continence Services". There has been a gradual upward trend in the documentation of the likely cause or type of urinary tract infection. However, a third of people still have no diagnosis written down.

The majority of policies regarding the provision of containment products, eg, pads, include a statement that provision is according to clinical need. However, 66% of primary care sites impose a limit on provision of 4 or less pads per day.

Quality of care (assessment, diagnosis and treatment) is worse in older people, but people of all ages, and vulnerable groups in particular (frail older people, younger people with learning disability) continue to suffer unnecessarily and often in silence, with a 'life sentence' of bladder and/or bowel incontinence.

5.2 Stroke[21]

In England, fewer than 40% of trusts are achieving the minimum standard on stroke care. Even the best region is only just over half and the worst, East of England, only 29% of trusts achieved the required standard. The national standard is to admit all patients to stroke units. However,

"Almost half of hospitals report the need to admit patients to non-specialist beds. On the day of the (RCP) audit 36% of patients who were in one of these beds had been there for more than 24 hours".

More than 1 in 10 units that provide stroke care for patients beyond 72 hours exclude patients on the basis of 'no rehabilitation potential'.

"It is impossible to judge whether a patient has 'rehabilitation potential' at such an early stage and policies to exclude stroke patients from a stroke unit are indefensible".

Less than a third of hyperacute units have specialist stroke ward rounds 7 days a week. Only a third of stroke units meet all five of the basic criteria used in the SUTC (Stroke Unit Trialists' Collaboration) key characteristics to define quality.

[20] Taken from Royal College of Physicians Report on Continence Care 2010
[21] Based on National Sentinel Stroke Organisational Audit, Royal College of Physicians, 2010 and Supporting Life After Stroke – A review of Services for people who have had a stroke and their carers, Care Quality Commission, 2011

"All services should be striving for excellence. Few can be said to have achieved it."

5.3 Dementia[22]

Over a third of people with dementia who go into hospital from their own homes are discharged to a care home setting. Just 19% of hospitals had a system to ensure ward staff were aware that a person had dementia and how it affected them. Although it was policy in 96% of the hospitals that all patients with dementia have an assessment made of their nutritional status, the audit found that this did not happen for 30% of the patients. 69% of hospitals were not able to identify people with dementia within reported information on in-hospital falls and their causes. 77% of hospital staff said that antipsychotic drugs were used always or sometimes to treat people with dementia in hospital, although in a quarter of cases they estimated this was not necessary. 47% of carers said that being in hospital had a significant negative effect on the general physical health of the person with dementia, which wasn't a direct result of the medical condition. 77% of hospitals do not have a training strategy identifying key skills for working with people with dementia. Only 31% of GPs believe they have sufficient training to diagnose and manage dementia, a decrease since the Forget Me Not report eight years ago.

5.4 Falls[23]

Injurious falls are the leading cause of accident-related mortality in older people. The most common serious consequence of falling is hip fracture. This occurs in approximately 76,000 people per year in the UK. Half of all older people suffering a hip fracture never return to their previous level of independence. About 10% die within a month and approximately 20% enter a care home. Patients with first fractures are not flagged up for secondary prevention. Only around half of A&E and MIU routinely screen people who have had a fall for risk of future falls. Less than half of falls admissions are screened for osteoporosis risk. Only 52% of fallers who attend ED or MIU are screened for future risk of falling and a mere 15% for osteoporosis. This has not improved significantly since 2008.

Despite 94% of sites stating they use a tool or proforma that includes standardised gait, balance and mobility assessment only 34% of non hip fracture patients and 72% of hip fracture patients receive an assessment. 86% of services report that they provide supervised strength and balance exercise training yet only 19% of non-hip fracture patients had participated in any form of exercise for falls prevention within 12 weeks of the fracture.

[22] Based on; Counting the cost: Caring for people with dementia on hospital wards, Alzheimers Society 2009, Improving services and support for people with dementia, National Audit Office, 2007 and National Audit of Dementia (Care in General Hospitals), Royal College of Psychiatrists, December 2010

[23] Based on Falling Standards, Broken Promises, Report of the national audit of falls and bone health in older people 2010, Royal College of Physicians 2011

Many of the exercise programmes being provided are not evidence based. Care home residents are a high-risk population for falls fractures, but often have less access to preventative services than community-dwelling older people. In the clinical audit, care homes were the usual place of residence in 10% of non-hip fractures and 22% of hip fractures, although they only make up 4.5% of the population.

5.5 Dignity and Nutrition

In 2011 CQC undertook 100 unannounced inspections of NHS acute hospitals to look at the quality of care in 2 specific areas – promotion of dignity and nutrition for older people. The findings were that around half of the hospitals needed to do more to ensure that they were meeting people's needs – with 20 of the hospitals visited failing to meet essential standards required by law. Only 45 hospitals were compliant – fully meeting the essential standards relating to both dignity and nutrition. 35 partially met both standards but still needed to make improvements in one or both.

5.6 Social care

In social care it is well recognised that a "*thriving social care market with a range of providers*" is needed[24]. However there are concerns about how this will be achieved[25]. With 79% of councils having frozen or reduced fees in 2011-12[26], how services are best delivered within the limited resources available continues to be a cause for concern. Wages are low for many direct care staff,[27] and some residential services struggle to meet quality standards. The collapse of Southern Cross and abuse of residents within services run by Castlebeck Ltd in 2011[28] are just two examples of serious concerns about the capacity of the market to meet demand and deliver sustainable quality residential services.

This concern has been matched by concern about the quality of home care services from the Equality and Human Rights Commission[29] which found that

[24] David Behan "Questions and answers from webchat with David Behan and Imelda Redmond, 18 October 2011: Caring for our future" last accessed 16th November 2011 at http://davidbehan.dh.gov.uk/files/2011/11/Q-and-A-from-webchat-with-David-Behan-and-Imelda-Redmond_F%E2%80%A6.pdf

[25] Wilkins Kennedy (2011) Press release: Number of care homes going bust doubles over last year note that the number of care home companies increased from 35 in 2009/10 to 73 in 2010/11. Last accessed on 16th November 2011 at http://www.wilkinskennedy.com/news-and-press/press-releases/number-of-care-homes-going-bust-doubles-over-last-year

[26] ADASS (2011) ADASS Budget Survey 2011

[27] Low Pay Commission (2011) Low Pay Commission Report on National Minimum Wage 2011. Last accessed 21 November 2011 at http://www.lowpay.gov.uk/lowpay/report/pdf/Revised_Report_PDF_with_April_date.PDF

[28] Most notably at Winterbourne View in South Gloucestershire in 2011

[29] Equality and Human Rights Commission (2011) Close to Home

"for too many this care delivered behind closed doors is not supporting the dignity, autonomy and family life which their human rights should guarantee".

5.7 Summary

So, we have a picture of huge investment in health over the last decades, not necessarily resulting in improvements in health care practice or outcomes for older people. Social care services meanwhile have had some investment, but rather less than the NHS, and both have experienced significant additional demand due to demographic changes. The services provided by the voluntary and community sectors, while much appreciated, often have a limited evidence base, are piecemeal and do not always focus on supporting people who would otherwise need health or social care. Although many older people obviously do get a very good level of care and support, and many professionals provide a valuable and much appreciated service, it would nevertheless appear clear from the above that there is some way to go before our health and care services can be said to be entirely successful in helping people to recover effectively from illness and to live well to their community.

The result is greater demand for acute and substitute care services. Given the recent end to the huge increases in health and social care spending over the last decade, and the likely ongoing reduction in resources to the public sector in the next few years, perhaps it is time to ask again whether the configuration of current services and the distribution of resources is really going to promote a healthy old age and the avoidance of hospital, or whether the balance of services needs to shift further towards preventing illness and ill health in the community. Without this shift then it seems likely that acute health service demand will continue to grow, further undermining the ability of that sector to respond effectively to those with greatest needs.

Any changes would need to be evidence-based and carefully implemented. Attempts in the past to deliver a significant reduction in acute sector demand through community based early intervention services have been well intentioned but ultimately have had limited impact. For example the Department of Health's three year Partnerships for Older People Programme, whilst initially reporting success[30] has subsequently been shown not to have delivered the health benefits it was strongly suggested could be achieved[31].

There has also often been an assumption that prevention is an 'add on' or an 'additional service'. Consequently, developing preventative services can often be seen to increase costs rather than diminish them as they run

[30] PSSRU (2009) National Evaluation of Partnerships for Older People Projects Final Report
[31] Adam Steventon, Martin Bardsley, John Billings, Theo Georghiou and Geraint Lewis, Nuffield Trust (2011) An evaluation of the impact of community-based interventions on hospital use: A case study of eight Partnership for Older People Projects (POPP)

alongside the interventions they are supposed to replace. As a result preventative interventions get developed as pilots or experiments rather than as main stream provision, have limited impact and are eventually abandoned as

6 What is Needed?

Reconfiguring services across the health, social care and wellbeing system requires a whole perspective and a willingness to address service boundaries and professional interests which have built up over many years. Policy makers, planners and commissioners will need to redesign services locally, working with and for a population of older people who will be more demanding and who will have more direct control than their parents before them. The Association of Directors of Adult Social Services (ADASS) recognised this in 2012 when they produced 'The Case for Tomorrow', their policy discussion document about the future of services for older people. They summarise the combined agenda as comprising 8 key elements[32]:

Effective prevention in supportive communities which promote good health, wellbeing and involvement.	**Community health and care services working together** to aid recovery and provide ongoing support to reduce the need for acute care.	**A range of different types of housing** which allows people to remain at home as long as they wish.
Good quality information and advice and straightforward access to health, care and support services.	**The Case for Tomorrow**	**Better recognition and support** for carers, particularly for older carers.
Safe, good quality services from reliable and skilled people.	**Real choice and control** over services which are fairly priced and affordable.	**Services which are effective, efficient and accessible** when and where needed.

This seems a pretty comprehensive summary of the agenda facing all agencies concerned with the health, social care and wellbeing of older people, and one which policy makers, planners and commissioners will need to take a serious look at in years to come. ADASS also suggests that

[32] ADASS (2012) The Case for Tomorrow, A discussion document on the future of services for older people

the Government needs to facilitate this agenda through a series of measures which include:

- Revising the current legal framework
- Reviewing the personal budgets mechanism for social care for older people
- Creating local innovation funds to support community-based prevention services
- Reducing barriers to integration of services
- Invest more in social care as recommended by the Dilnot Commission

ADASS believes there is a great deal which can be done to address some of the potential demand for services which the changes in demographics might trigger over the next few years. Without this whole system perspective, and changes which actually do focus on working with older people to promote their health and wellbeing, make best use of their resources and minimise their need for acute and substitute health and care services, then the demands on health and care services are likely to continue growing in a way which will make them ultimately unsustainable.

Keith Moultrie
March 2012