



## **Royal Commission on Long Term Care for the Elderly**

### **Continuing Care Conference Submission No 5:**

### **The Interface between Health and Social Care**

#### **Introduction**

The Continuing Care Conference (CCC) welcomes the Royal Commission's invitation to contribute a short paper on issues raised by the interface between health and social care, and how to ensure effective or 'seamless' provision of services. CCC's members, who come from all sectors and offer varying perspectives, have direct, daily experience of these issues and have submitted detailed evidence to the Commission in their own capacity, as have other interested organisations. The Royal Commission will also be aware of other detailed analysis, notably the report by the Audit Commission, *The Coming of Age: Improving Care Services for Older People* (October 1997). We do not propose to cover such ground in depth; rather, our paper outlines key points of concern and offers certain guiding principles.

#### **Critical Failings**

It is our view that the distinction between health care and social care is spurious and there is ample evidence that the present fragmented system of care is not working:

- people do not understand what care they may receive and from whom;
- there are no incentives to provide recuperative and rehabilitative care;
- it is difficult to chart the progress of individuals through 'the system';
- the system creates opportunities for shelving responsibility from agency to agency, and shunting costs likewise, and
- energy is 'wasted' in inter-agency disputes.

We do not deny that good, even excellent, care exists but organisational change is needed to transform a system which is 'good in parts' into one that can guarantee seamless, effective services.

## Building the Framework for Seamless Care

CCC's view is that seamless care services for older people are best delivered within a policy framework that promotes health, well-being and independence rather than one that focuses narrowly on illness, frailty and dependency.

We agree that urgent attention must be given to the most pressing problems arising from the interface between health and social care, and we hope that lessons from the recent winter initiatives, notably concerning hospital discharge, are carried forward in future years. In addition, promoting maximum co-operation with and between housing, transport and other public services provides a valuable opportunity to promote independence or retain minimal dependence for as long as possible. The organisation of some local authorities already reflects such integrated thinking.

The pace of change within the care sector in the past eight years, since the NHS and Community Care Act came into effect, has been fast, and is well documented. There exist side by side: an evolving marketplace; significant – and welcome - advances in care practice; severe resourcing difficulties, and organisational and structural absurdities, notably the boundary between free health care and means tested social care.

It is our view that current funding arrangements are, overall, driving down standards of care, and are wasting valuable resources through lack of clarity.

The principle of free health care, including nursing care, aids and therapy, for instance physiotherapy and occupational therapy, should be a central premise of the system of delivering care. We draw the Royal Commission's attention to proposals from the Rowntree Inquiry and also from the Royal College of Nursing and Age Concern, which are variations on this theme.

- A central question for the Royal Commission is therefore, 'What people can expect to receive free and what is not free?' Whatever the Royal Commission's recommendations, there must be absolute clarity in the arrangements.

### National Eligibility Criteria

CCC has submitted a separate short submission on the importance of consistent national needs assessment and eligibility criteria for access to care. We draw your attention to our submission and also to independent research undertaken by the Personal Social Services Research Unit, University of Manchester (*Eligibility Criteria for Social Services for Older People in England, Research Summary, 1997*), which CCC and Age Concern England sponsored.

- **There must be standard national eligibility criteria, and no variability.**

Concerns have been raised in some quarters that standard national eligibility criteria would deny local flexibility. On the contrary, standard national eligibility criteria *do* allow for differing local circumstances to be taken into account. For instance, one standard criterion might take into account how far a person is from shops and other amenities. The same criterion would be applied in Orkney and in Islington but with very different outcomes.

It is also important to guarantee consistency between NHS continuing care eligibility criteria and local authority criteria for community, or social, care, and to provide opportunities for recuperation and rehabilitation.

Many people are confused about what they are entitled to and from which agency. We would urge that future guidelines are written in plain English and that they are made easily accessible to the public.

### **Pooling of Budgets**

CCC endorses the Government's intention to introduce provision for pooling health and social services budgets for elderly people. We look forward to the proposals likely to be contained within the forthcoming White Paper on social services. However, we are aware that pooled budgets will not be the answer to all ills, and that the exact proposals must be thoroughly scrutinised to ensure that there are no unintended - and detrimental, - consequences for older people, as we are aware some commentators fear.

CCC believes that:

- Pooled budgets will result in greater accountability and increased transparency.
- Pooled budgets will result in greater involvement by hospital consultants, occupational therapists, GPs and professionals from other medically-related disciplines, whose skills can promote rehabilitation.
- Pooled budgets may enable 'lifetime' care costs to be assessed, and interventions at different stages of care evaluated. This approach would not only improve the care management of the individual, it could form the basis of much-needed research to assess the effectiveness and cost-effectiveness of various preventative and rehabilitative interventions. This is particularly important in the present climate where there is evidence that, due to funding constraints, many local authorities have had to cut back on preventative measures.

### **Joint Commissioning**

We recommend that the Royal Commission should examine carefully the pilot schemes for joint commissioning in mental health, announced last year.

Some of the closure programmes for long-stay hospitals demonstrate areas of excellent co-operation between health authorities, local authorities and the independent sector. They demonstrate that joint commissioning can work, though clear objectives must be set and mechanisms for measuring performance must be incorporated into any plans.

### **Design of Services: Innovation**

CCC recommends that the design of future organisational and regulatory arrangements should also be sufficiently flexible to encourage costed, innovative approaches to care as well as encompassing current means of delivering effective, seamless care. For instance, some flexibility has already been shown in the use of independent sector facilities to provide intermediate care. Clinical studies have shown the effectiveness of stroke units, but the organisational will to implement such schemes lags some way behind.

### **Access to Services**

CCC is concerned at evidence that older people are being denied access to medical treatment because of their age. Similarly there is evidence, as with NHS chiropody services, that procedural changes may make it more difficult for older people to gain access.

One benefit of pooled budgets, as mentioned above, is that it would be easier to quantify the costs of an individual's care and to track the effectiveness of particular interventions.

We oppose rationing of health care on grounds of age. However, we recognise that resources are not, and never have been, infinite. Consequently, we would urge that any criteria for rationing be made explicit.

## **Regulation**

CCC has submitted a separate submission on Standards of Service, which looks at aspects of regulation. For the purposes of this paper, we would like to emphasise that the regulatory system should reflect the reality of, and the need to provide, a continuum of care. Professor Malcolm Johnson's proposals for a single care home will be known to the Royal Commission. CCC's Care Standards Committee has submitted a paper to the Department of Health on issues relating to the proposed statutory registration of home care service providers, which we welcome. We also contributed to the consultation on *Moving Forward*, which resulted in the Burgner report.

Whatever proposals are recommended, there must be contiguous licensing arrangements which are targeted and stratified. The Cabinet Office-based Better Regulation Task Force will also be reporting on this in the near future. We strongly advocate that regulatory panels are multi-disciplinary.

## **Integrating Policy: Central Government Initiatives**

As well as advocating 'integrated' organisational approaches at local level, it is also relevant to consider the overall development of Government policy and how it affects the well-being of older people.

### **Better Government for Older People**

We await with interest the initial results of the Better Government for Older People initiative and we urge that momentum is not lost as the programme develops. Not only should the Royal Commission be concerned with the 'interface between health and social services', the quality of the interface between the *individual* and these services must also be considered.

CCC welcomes initiatives that include older people within the decision-making process and also improve access to information.

### **Social Exclusion**

CCC looks forward to the results of any initiatives from the Social Exclusion Unit, but regrets that its initial priorities do not appear to focus directly on older people. Nevertheless, much social isolation among older people arises from fear of crime and lack of transport. Isolation is often a precursor of depression, which increases the likelihood of the need for care. Therefore any policies that reduce crime, particularly on problem estates, could have indirect, though unquantifiable,

benefits for vulnerable older people. At a local level, the quality of street and estate lighting and availability of public transport are also relevant. One key policy objective must be to ensure, as far as possible, independence and self-determination.

## **Transitional Arrangements**

In considering the reform of the system of care provision, we must ensure that any financial arrangements are staged to accommodate the 'trapped generation', ie people aged 55 and older who will be unable to make substantial self-arrangements. Policies should be clear, fair and inclusive.

**CCC**  
**May 1998**