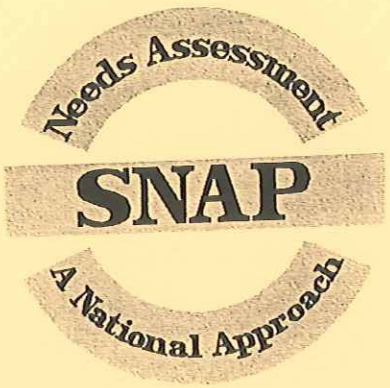
Scottish Needs Assessment Programme



Care of Elderly People

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Scottish Needs Assessment Programme

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February 1997

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ACKNOWLEDGEMENTS

I am grateful to the following people for their help with the compilation of this document: Dr Graeme Simpson of Renfrewshire Healthcare NHS Trust, Dr Marie Laurie, Dr Phil Hanlon of the Department of Public Health, Glasgow University, Dr Cameron Stark of Ayrshire and Arran Health Board, Dr Dorothy Moir of Lanarkshire Health Board and Dr Helene Irvine of Greater Glasgow Health Board.

Further copies of this report are available from Jackie Gregan, SNAP, 69 Oakfield Avenue, Glasgow G12 8QQ, tel. 0141 330 5607.

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Health Needs and Health Promotion in Deprived Areas in Scotland

CONTENTS

EXECUTIVE SUMMARY

Services for elderly people are under great strain because of the increasing numbers of very elderly people, a reduction in family support and other demands. There are also concerns about the lack of home support services, inappropriate admission to nursing home care, about the quality of life in institutional care, about medication and about emphasis on palliative 'care' rather than on encouraging independence: health services must maintain people's independence for as long as possible, otherwise quality of life will decline and the cost of care increase. Unless action is taken to relieve the strain on the system present deficiencies in health and social services can only increase.

A very wide range of professionals is involved in providing care for elderly people, and the relationships between them have evolved over a long period of time. If all the resources currently directed to the care of elderly people were available to plan and establish an entirely new service, it is unlikely that they would be distributed amongst the same professional groups and in the same way as they are at present. It is clearly impractical however to design a radically new service: the most that can be realistically achieved is to identify areas where services are clearly inappropriate or inadequate and to develop new models of care or make other changes which should lead to improvement. Often these models and suggested changes have not been fully evaluated, at least in this country: it is necessary therefore to try these out on a pilot basis to see if they are effective in the circumstances which prevail locally.

PRINCIPLE AREAS OF CONCERN

(1) INSTITUTIONAL CARE

- Appropriateness of admission to nursing homes.
- Adequate assessment of health status and needs both on admission and thereafter.
- Quality of life.
- Encouraging independence rather than dependence.
- Appropriateness of medication.

(2) HOME SUPPORT

- Timeous supply of necessary equipment, adaptations and other environmental modifications.
- Availability of flexible home care services.
- Availability of respite for family carers.
- Lack of information about the range of services available and how to access them.

(3) SPECIALIST HELP IN THE COMMUNITY

- Availability of therapy for people with continence problems.
- Availability of specialist help for people with Parkinson's Disease and for dementia sufferers and their carers.
- Coordination of services and care management for people with stroke.
- Availability of facilities for multidisciplinary assessment, treatment and rehabilitation for conditions which are common in old age (locomotor disorders, sensory dysfunction, CCF etc).

(4) ACUTE HOSPITAL CARE AND POST DISCHARGE MANAGEMENT

- Access to surgery for conditions such as cataract surgery and hip replacement.
- Discharge arrangements after admission to acute hospital wards.

(5) EMPHASIS ON PALLIATIVE CARE RATHER THAN ON REHABILITATION AND ENCOURAGING INDEPENDENCE

- Assessment of environmental factors and conditions intrinsic to the individual which predispose to dependency.
- Lack of emphasis on and availability of effective programmes for rehabilitation.
- Over-emphasis on medication.

THE ORGANISATIONAL RESPONSE

(1) CHANGING THE ETHOS

- Quantifying the 'gap' between people's potential and their current level of physical, mental and social functioning.
- Attempting to minimise this 'gap' by rehabilitation, environmental modification and other measures.
- Ensuring that medication is given only when there are clear indications and that it is taken as directed.

(2) HOSPITAL DEPARTMENTS OF GERIATRIC MEDICINE

- Sessions dedicated to the development and provision of geriatric services in the community.
- Day hospitals as the base for the development of community assessment, rehabilitation and treatment services.
- Multidisciplinary assessment of all patients for whom nursing (and residential) home care is being considered.

(3) THE GENERAL PRACTITIONER

- Providing resources to enable all patients aged 75 years and over to be screened either opportunistically or in a structured home visiting programme with suitable recording, collation and analysis of results.
- Providing resources for the regular surveillance of patients in nursing and residential homes, including medication, and for rehabilitation.

(4) NURSING (? AND RESIDENTIAL) HOMES

- All admissions assessed as appropriate by a consultant geriatrician and multidisciplinary team.
- Measures to improve the quality of life.
- Continuing and holistic reassessment of health needs and of the potential for rehabilitation.
- Satisfactory procedures for the management of pressure sores, incontinence and for preventing falls and other accidents.
- Surveillance procedures to identify problems with hearing, vision, dental or foot care, high blood pressure, other signs of disease, the side effects of medication, and warning signs relating to pressure sores, with appropriate prompt action.

(5) COMMUNITY HEALTH SERVICES

- Health visiting resources in part redeployed from pre-school health to meet the needs of other client groups, for example in the elderly:

* *75+ screening, with recording of needs.*
* *establishing clinical nurse specialists, e.g. for continence therapy, Parkinson's Disease, development and coordination of stroke services, dementia.*
* *establishing (further) liaison nurse/gerontological nurse specialist posts.*
* *Increase in the number of therapists (and aides).*
* *Replacement of cumbersome and unnecessarily detailed systems for recording process with simpler and less time consuming client-based systems.*

(6) INTERPROFESSIONAL WORKING

- Agreement on common assessment procedures and co-ordinated inter-agency assessment for complex cases.
- Avoiding unnecessarily complicated procedures for identifying the relatively simple needs of most clients.
- Avoiding duplication of effort.

(7) OTHER SERVICES IN THE COMMUNITY

- Encouraging a wide range of flexible home support services, including bathing, 'getting up', 'tuck-in', overnight sleep in and respite.
- Fast response to needs for equipment and adaptations.
- Occupational therapists in the community concerned with promoting the physical and mental well-being of the whole person - not almost exclusively with the provision of beds, equipment and adaptations; this is best achieved if they are part of the health care team.
- Planned respite for family carers: both for a few hours (including overnight stays) each week and for a week or two each year.

(8) ACUTE HOSPITALS

- Formulation of and adherence to effective discharge procedures including:
  - *identification of people likely to need help after discharge.*
  - *preparation of care plan, involving patient and relatives.*
  - *monitoring to ensure that discharge is effective.*

(9) DAY HOSPITALS

- To continue as an integral part of the health service for elderly people by providing:
  - *a focus for the development of a comprehensive community rehabilitation service.*
  - *a setting for multidisciplinary geriatric-led placement for nursing and residential home care.*

RESOURCE REQUIREMENTS **(Mostly possible from exiting resources)**

FOR A POPULATION OF 250,000 SAY,

- Consultant geriatrician with half time responsibility for development and monitoring of community health services for elderly people.
- Community physiotherapists/occupational therapists and aides, based at geriatric day hospitals but available for domiciliary work.
- Use of day hospitals for assessment of all patients being considered for nursing (and ? residential) home care.
- General practices provided with resources to provide total coverage for annual 75+ screening, with appropriate recording, including (possibly more detailed) screening of residents of nursing and residential homes.
- Periodic valid measurement of the quality of life of residents of nursing and residential homes.
- Establishing (from the health visitor workforce) clinical nurse specialists and liaison/gerontological nurse specialists.

PREFACE

The increasing numbers of very elderly (and therefore very dependent) people, together with increased expectations of elderly people and their carers, make a comprehensive appraisal of the services for elderly people a necessity. These services are managed by many separate professional groups (for example - even within the health service - by geriatricians, general practitioners, hospital nurses, community nurses, and the various 'paramedical services') and have evolved largely independently of one another. Separation of purchasing from provider functions however provides an opportunity to develop an integrated network of services which meet the real needs of elderly people and their carers.

The perverse financial incentive of DSS funding being available (until April 1993) for nursing home and residential home care but not for domiciliary care, and the very limited responsibilities of geriatricians for care in the community, have led to an emphasis on institutional care which is both expensive and fails to meet the needs or aspirations of most elderly people. Most elderly people, even many who are severely dependent, can be cared for satisfactorily at home. What is needed is the development of an effective 'community health service' to meet the needs of the great majority of elderly people who can be looked after at home, together with the relatively few who need residential or nursing home care. This service would be responsible for health care in its widest sense - embracing specialist and general health services, social care, and education and leisure opportunities. The health components would be fully integrated with the primary health care team.

It is in this age group where the levels of chronic disease and disability are greatest that there is the greatest potential for prevention and reversal of disability. Yet there is current uncertainty and widespread scepticism regarding the effectiveness and cost-effectiveness of rehabilitation techniques among elderly people. There has therefore been a tendency towards less active therapy and more palliative care of older people with disease. The therapeutic approach emphasises the future potential of the individual and the acquisition of new skills, both physical and social, reinstating a patient's autonomy and independence. The prosthetic approach substitutes for lost skills with some other means of providing function: it removes the stimulus for continued activity and, whilst it may restore autonomy, it does not normally restore independence[1]. The deployment of prosthetic services should only occur when all therapeutic options have been adequately explored, otherwise the prevalence of disability will increase.

For most 'needs assessments', for example for acute specialties such as orthopaedic surgery or diabetes care, there is usually fairly clear agreement about what constitutes best practice; what is generally needed is an improvement in the way in which existing services are managed. However, although there may be reasonable agreement about principles, there is no general agreement about the way in which a service for elderly people should be structured and managed. Some important service components (e.g. the availability of personal care at home at times suited to clients' needs) do not yet exist, or are only at an early stage of development. A 'needs assessment' for the care of elderly people cannot therefore be prescriptive: there is a need to maximise the use made of audits of current practice and to experiment with and evaluate carefully innovations in care. As the population ages, better management of the care of elderly people is vital if the health service is to meet the challenge facing it[2].

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CHAPTER 1

SUMMARY OF NEEDS IDENTIFIED (See APPENDIX 1 for full version)

Resources or reorganisation necessary to cope with the increasing numbers of elderly people and increasing levels of disability.

Improved assessment procedures in order to minimise inappropriate admissions to nursing homes.

Homecare support services to be developed sufficiently as a viable alternative to nursing and residential home care.

Reduction in delay in conducting assessments for community care and in finalising placements in nursing and residential homes after assessments.

Reduction in delay in provision of home aids and adaptations; integrating the role of community occupational therapists with those of other members of the assessment and rehabilitation team.

Improved provision of rehabilitation services in the community; extension of the role of the community occupational therapist beyond assessment for aids and appliances to holistic assessment and rehabilitation.

Adequate support services to help elderly people achieve their potential in terms of physical, mental and social function.

Improved supervision of medication, particularly for elderly people living alone.

Minimising over-medication in elderly people, both those living at home and in institutions.

Early identification and provision of appropriate therapeutic and support measures for problems with vision, hearing, teeth, continence, depression, mobility (including access problems), dementia, social isolation and grieving/bereavement.

Improving access to information, providing choice, and involvement in decision-making.

Reduced waiting times for operations necessary to maintain independence - e.g. for cataracts and hip replacement.

Provision of necessary community services promptly on discharge from hospital.

Providing certain community services, particularly bathing and tuck-in, which are at present difficult or impossible to obtain.

Improving quality of life in nursing and residential homes.

Assisting staff to cope with increasingly dependent residents of nursing and residential homes and with the particular demands made of staff in these settings.

Taking into account the 'mix' of nursing and residential home residents, so that in any one home there is not too great a preponderance of people with high dependency due to physical or mental disability.

Providing opportunity for meaningful daytime occupation in nursing and residential homes.

Ensuring that elderly people are not unnecessarily housebound, for example because of depression or access problems.

Providing short and longer term respite for carers.

Improving transport to and from health services, social work and for shopping/recreational purposes.

CHAPTER 2

TRENDS IN DEMOGRAPHY, SUPPORT AND RESOURCE UTILISATION RELATING TO ELDERLY PEOPLE

Demographic trends (Figure 1 and Table 1)

The total number of people in Scotland aged 65+ is expected to increase from 772,000 in 1992 to 805,000 in 2001 and 827,000 in 2006. The largest growth will be in the oldest age groups; in particular, the number of people aged 85+ is expected to increase from 71,000 in 1992 to 93,000 in 2001 and 100,000 in 2006; there will be virtually no change in the number of 65-74 year-olds[1]. This differential growth is important because per capita expenditure on health and social services rises markedly with age (a greater than four-fold difference between those aged 65-74 years and those aged 85 years and over)[2], and is greatest for the group of very elderly people which is growing the most rapidly. Although around only about 5% of elderly people are in publicly-financed long-stay hospitals, nursing home or residential care[3], this group accounts for almost half of total public health and social services expenditure on elderly people[2]. Data from the OPCS Longitudinal Study in England[4] show that factors apart from physical health status appear to be associated with differentials in moves either to institutional care or the households of relatives. These include age, mental status and housing tenure.

Levels of disability

The prevalence of the most severe levels of disability is 133 per 1,000 among people aged 80 years or over, compared with 16 per 1,000 for those in their sixties and 3 per 1,000 for adults under 50[5]. Despite the ageing of the population there has been no increase, in the last decade, in the prevalence of mobility problems among people aged 65 and over living in private households in Great Britain, according to a supplement to the General Household Survey[6]. In all, about one in ten of those aged 65 and over were unable to walk down the road on their own without help; this proportion rose to almost half (44%) of those aged 85 and over.

Public expenditure on elderly people[2]

Expenditure on elderly people now represents nearly half of all public expenditure on health and social services, and spending on this group rose at an average rate of 3.4% a year in real terms between 1979/80 and 1989/90.

Between 1989/90 and 2006 expenditure on health and social services for elderly people is expected to increase at around 3% a year in real terms: by 1.9% for hospital and community health services, 5.8% for general practitioner services and by 3.6% for personal social services and nursing/residential home care. This estimate is based on future demographic trends and continuing past trends in service utilisation and increased cost relative to inflation.

Figure 1 POPULATION PROJECTIONS (1992 BASED) FOR ELDERLY PEOPLE IN SCOTLAND

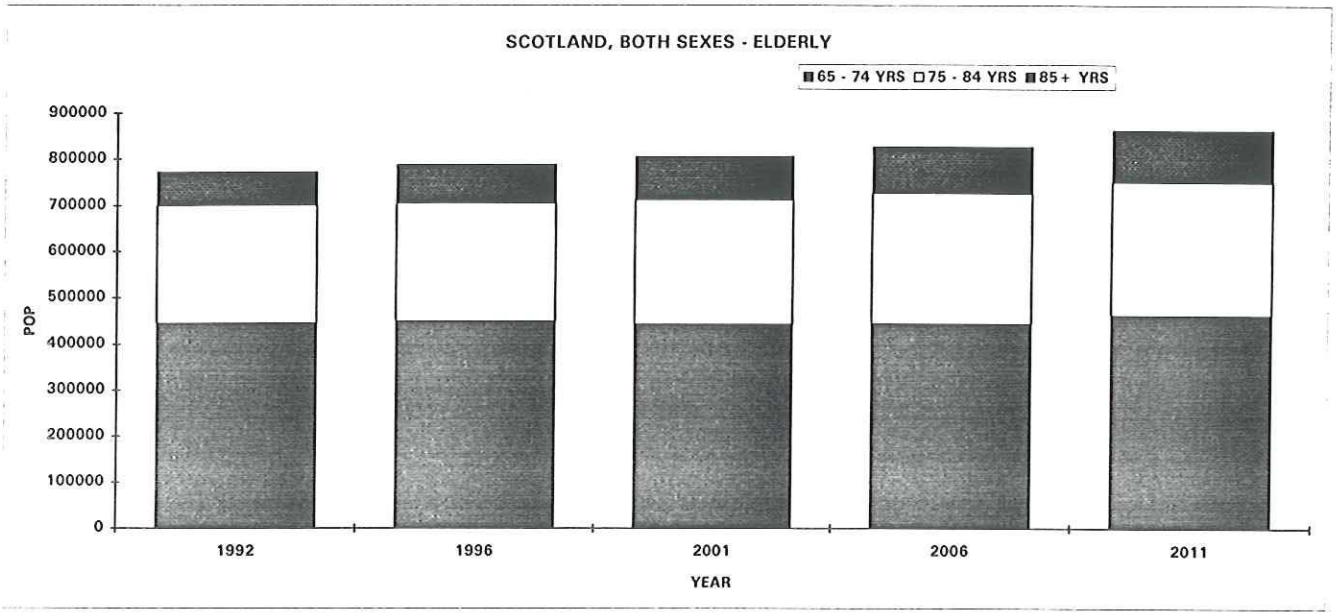

Table 1

AGE GROUP	1992		1996		2001		2006		2011	
	POP	% TOT POP	POP	% TOT POP	POP	% TOT POP	POP	% TOT POP	POP	% TOT POP
65 - 74 YRS	445,100	8.7	448,700	8.7	442,500	8.6	444,200	8.7	463,000	9.1
75 - 84 YRS	255,600	5.0	256,300	5.0	269,400	5.2	282,500	5.5	288,500	5.7
85+	71,000	1.4	82,500	1.6	93,000	1.8	100,100	2.0	111,500	2.2
TOTAL										
65+ YRS	771,700	15.1	787,500	15.3	804,900	15.6	826,800	16.2	863,000	17.0
75+ YRS	326,600	6.4	338,800	6.6	362,400	7.0	382,600	7.5	400,000	7.9
65 - 84 YRS	700,700	13.7	705,000	13.7	711,900	13.8	726,700	14.2	751,500	14.8
TOTAL POP	5,113,000		5,145,900		5,143,300		5,115,000		5,077,000	

The expectation of life without disability[7]

Bebbington[7] showed that if chronic ill-health is defined by measuring 13 key types of disability, each from mild to severe, then men may expect to live in full health for 64 years, or 89% of their lives, while women may expect 67 healthy years, or 86% of their lives. Although women live longer they can expect a longer period of ill-health, especially at the more severe stages of disability.

Over the past 20 years there has been a steady advance in life expectancy of about 3.5 years for males and 2.5 years for females, but there has been no increase in years of healthy active life expectancy[7]: people may expect that these extra years of life to be lived in chronic ill health. Although this broad picture has been confirmed by research in the United States, Canada and Australia[7], the most recent General Household Survey shows that there is no increase in the proportion of feeble, infirm or dependent people in the population[8].

Life expectancy

Table 2
Life table by sex and age, Scotland 1975-93

	Males			Females		
At age	1975	1983	1993	1975	1983	1993
0 years	67.8	69.6	71.4	74.3	75.7	76.9
65 years	11.8	12.5	13.1	15.8	16.2	16.5
75 years	7.1	7.5	7.8	9.4	10.0	10.0
85 years	4.1	4.3	4.4	5.1	5.4	5.4

Availability of support[9]

In 1991, almost four in ten (38%) people aged 65 and over in Great Britain lived alone, compared with one in three (34%) in 1980; a further 39% lived just with a spouse who was also aged 65 or over. The proportion living alone increased with age from a quarter of those in their late 60s to 58% among those age 85 or over. Women were twice as likely as men to be living alone, reflecting their longer life expectancy.

The number of people in the 45-64 age band, which is the peak age for providing informal care, is expected to increase by 22% between 1987 and 2006. This is a bigger increase than for the population aged 75+. Moreover, a higher proportion of elderly people is expected to have a surviving spouse and to have at least one child. The proportions of people in very substandard housing will also decrease, while larger proportions will have resources in the form of residential property and occupational pensions. All these factors will operate in favour of the supply of informal carers. However, substantial proportions of carers are in poor health themselves, with about half of those aged 45 and over (the peak age group for informal caring) reporting a long-standing illness, and this proportion will rise as the average age of carers increases along with the average age of dependent elderly people. Also divorce and women's employment would be expected to restrict family support for older people, although so far the effect of this has been less than might have been expected.

Although the rising participation of married women in the labour force may limit opportunities for the provision of informal care, the higher incomes which result may allow the purchase of private help to assist with caring. Other factors which may influence the level of informal care include rising divorce rates and changes in geographical mobility.

Key messages

- The number of people aged 85+ is expected to increase from 71,000 in 1992 to 93,000 in 2001 and 100,000 in 2006.

- The prevalence of the most severe levels of disability is 133 per 1,000 among people aged 80 years or over, compared with 16 per 1,000 for those in their sixties and 3 per 1,000 for adults under 50 (OPCS, 1988).

- Over the 18 year period 1975 to 1993 life expectancy for men aged 65, 75 and 85 years has increased by 1.3 years, 0.7 years and 0.3 years respectively. The corresponding values for women are 0.7, 0.6 and 0.3 years. It is likely, but not certain, that the increases in life expectancy are associated with longer periods of disability.

- Although women live longer, they can expect a longer period of ill-health, especially at the more severe stages of disability.

- Changes in the likely availability of family and other forms of support are unclear.

- Between 1989/90 and 2006 expenditure on health and social services for elderly people is expected to increase at around 3% a year in real terms: by 1.9% for hospital and community health services 5.8% for general practitioner services and by 3.6% for personal social services and nursing/residential home care.

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CHAPTER 3

CURRENT SERVICES

Care at home

The following options are available. These services are not interchangeable: the absence of one component of an appropriate package may result in the admission or readmission of the patient to an acute bed, or to residential or continuing care[1].

Community Facilities	*Domiciliary Support*
Day Hospitals	Home Care Service
Day Centres	Home helps
Lunch Clubs	Meals on wheels
	Crisis Care Schemes
Carer Support	Community Care Alarm Schemes
	Nursing Services + specialist nursing
Respite Care	Domiciliary Therapy (OT assessment, physio)
Sitting Service	Chiropody
	Continence Advice, pads and Laundry Service
	Night Services

Most of these services are self-explanatory. However, some which are relatively new developments or which may require expansion merit brief discussion.

Crisis Care Schemes

Schemes such as that based in the Royal Infirmary of Edinburgh provide intensive support for a limited period in the community setting, with the object of preventing admissions and supporting newly discharged patients on their return home.

Home nursing services

District nurses provide a domiciliary service on weekdays, with limited evening, night and weekend cover; this includes bathing, catheter care, wound dressing, incontinence laundry. Liaison health visitors arrange discharge and follow-up.

Many acute admissions and readmissions to hospital could be prevented and early discharges facilitated if sufficient concentrated nursing, domestic and personal care were available over the crucial period of acute illness. This could be achieved by providing general practitioners with ready access to a team of people who could give round the clock cover for a few days, or a week or two, perhaps with some specialist guidance. However it is not an economic proposition to provide round the clock nursing care on a permanent basis at home: there are clear economies of scale in providing nursing care in institutions where nurses must be physically present 24-hours per day. Furthermore, there are some emotional and behavioural disorders in dementia which are so emotionally taxing for nurses to care for on a one-to one basis, for example persistent nocturnal wandering, double incontinence, unprovoked

aggressive outbursts, that a supportive working environment of several staff working together may be preferable[2].

Currently, home nursing services are restricted by staffing shortages. Additional nursing staff - often on a more flexible basis[1] - may be available, either from banks or through agencies.

Home care services

Home care assistants are available through homecare or nursing agencies or by private arrangement with individuals. These provide practical support for disabled and frail elderly people, including personal care and household duties; they also attempt to prevent or minimise deterioration by encouraging clients to use their mental and physical faculties to full potential and by the early identification and reporting of changes in functional status. Relatively few people require 24-hour nursing, or even for a nurse to be immediately available at all times. Usually care assistants, with visits from a district nurse as required, will be able to provide all the support that is needed; and care assistants are likely to provide a more suitable form of care except in those cases where skilled nursing is necessary for prolonged periods.

Augmented or comprehensive home care is a flexible and co-ordinated package of care, bringing together a range of health and social care services in order to support people at home who would otherwise have required admission to some form of residential care. Pilot schemes (described in Chapter 13) are being evaluated in Ayrshire & Arran and Greater Glasgow Health Boards.

Hospital at home

Hospital at home is usually defined as the provision of a service that prevents hospital admission, or facilitates early discharge from hospital. Hospital at home schemes may be community or hospital based. Community based schemes build on existing resources, including district nurses and domiciliary provision of other services such as physiotherapy and occupational therapy. Clinical responsibility is usually assumed by general practitioners. In hospital based schemes, consultants provide clinical responsibility, and services are provided on an outreach basis with varying degrees of integration with community services. In the UK (unlike the USA) the schemes are usually nurse-led and focused on personal rather than technical services.

In a recent survey of 136 health authorities in Britain (76% response), 139 existing and 100 planned hospital at home schemes were reported. Paediatric and mental health services made up 21% and 12% respectively of schemes in operation, and a further 15% and 21% of planned schemes. Only 15% of existing or planned schemes were providing or planning to provide specific technological services. Some schemes are designed to care for specific conditions, such as home ventilation. Others provide specialist services, such as administration of intravenous antibiotics or parenteral nutrition. Much more common are schemes to care for patients discharged early from hospital after surgical, especially orthopaedic, procedures[3].

There is little published research on the relative costs and benefits of different forms of hospital at home in comparison to traditional hospital care. Non-randomised

studies suggest that hospital at home is a safe and acceptable way of delivering care to patients after repair of a fractured femur or hysterectomy, and that hospital at home can be cheaper per bed day than hospital care for patients with a fractured femur.

However, it is still unclear whether hospital at home schemes represent a new, cost effective direction for health service provision or are merely a substitute technology of limited value and lifespan.

Specialist nursing

Specialist nurses are becoming increasingly employed to improve management of care in the community for people with conditions such as continence problems, stroke and Parkinson's disease. They work closely with general practitioners and other members of the primary care team, with hospital specialists and - where appropriate - with voluntary organisations. The Parkinson's Disease Society in England has funded several such posts, and a job description is given in Appendix 7. There are also nurse stroke co-ordinators and continence advisors in several Scottish Trusts.

Domiciliary Therapy

Local authorities are responsible for occupational therapy, and the health service, for all other domiciliary therapy. The range of services includes assessment for aids and appliances, physiotherapy, speech therapy, and chiropody.

Night Services

Elderly people who are confused or unable to cope with toileting during the night may require additional support in the form of sleepover or night sitting services. These may be provided by nurses, or usually more appropriately by care assistants.

Respite for carers

Often a member or members of the family can cope with the great majority of the needs of a disabled or frail elderly person if they can be relieved of their responsibilities for just a few hours each day or even each week. For a relatively small investment in day care (inside and/or outside the home) and/or perhaps one or two nights each week it is often possible to maintain a person at home at less cost and much more satisfactorily than in a nursing or residential home.

Lack of adequate respite may result in the admission or readmission of the patient to hospital, and sometimes, if the carer can no longer cope, this will be on a long stay basis. While some relief for carers can be provided by attendances at day centres and day hospitals, and by sitting services, residential places are also needed. Currently some respite places are available in local authority residential homes, but these do not meet demands; a more flexible use of short term vacancies in such homes would lead to an increase in provision. Geriatric and psycho-geriatric hospitals may also provide respite care, in which case criteria for admissions to NHS continuing care facilities would normally be relaxed to some degree.

Residential care

Elderly people whose level of dependence is such that they cannot cope at home may be transferred to residential accommodation provided by a local authority, the voluntary sector, or the private sector. Residential care was originally intended for fit elderly people, admission criteria excluding those who were unable to walk without support, incontinent people, and those with behavioural problems. Recently, improvements in the services available to people living at home has resulted in residential homes having to accept more dependent patients; however this has not generally been reflected in increases in staffing numbers, or the employment of nursing staff.

Continuing nursing care

Some people require ongoing nursing care. Those requiring continuing specialist medical and nursing supervision will remain the responsibility of the NHS with care being provided in either a long-stay NHS geriatric or a psycho-geriatric bed. In some instances, health boards will place such individuals in private nursing homes, but since they remain under the clinical management of consultants their inpatient care and the associated costs continue to be the responsibility of the NHS.

Where patients are required to enter non-NHS nursing homes, they may either meet the costs themselves or seek state support from local authorities under the new community care arrangements. The local authority would then assess the need for such care and consider whether to fund it.

Table 3 gives the approximate numbers of elderly people (aged 65 years and over) permanently resident in long stay hospitals, nursing homes, residential homes and other types of institutions in Scotland. About 32,000 elderly people living in nursing and residential homes, with the balance between the two being almost equally split but with a trend towards increasing numbers of nursing home places with a decrease in residential homes. About 12,000 elderly people are permanently resident in long stay hospital and this number is steadily diminishing. The range of costs of being in these types of accommodation is also shown in table 5 (from about £200 to £700 or more per week), as is the current level of contribution from the local authority for people who are in receipt of Income Support.

Table 3
Approximate numbers of people in long-term residential care facilities in hospitals, nursing and residential homes in Scotland and associated costs

		Total Cost (per week)	Local Authority contribution
Long stay hospitals	12,000	£400-£700+	-
Nursing homes	16,000	£290-£450+	£290
Residential homes	16,000	£194-£350	£194

Table 4 gives the approximate numbers of individuals in the different groups within the health service per 500,000 population. The large number of nurses contrasts with the very small numbers of occupational therapists and physiotherapists who work in the community.

Table 4
The present distribution of health care professionals (average for Scotland)[4]

For a population of 500,000

Physiotherapists	140 (16)
Occupational therapists (NHS)	75 (60)
Speech therapists	50 (3)
Consultant geriatricians	9
General practitioners	340
District nurses	170
Health visitors	150
Practice nurses	85 (estimate)

Numbers in parenthesis relate to unqualified assistants
Source: Scottish Health Statistics, 1994

Table 5 summarises the different agencies and professional groups involved in the care of elderly people.

Table 5
The different agencies and professional groups responsible for the care of elderly people[3]

Social Work Social Workers Occupational Therapists Home help supervisors Home helps/care assistants Wardens of sheltered housing Day centres Lunch clubs Home care Community alarms Care support - sitting service - respite care	**Community Health Services** District nurses Health visitors Chiropodists (Physiotherapists) (Occupational therapists) Liaison nurses Domiciliary therapy Continent advice Laundry service Night service
Primary Care General practitioners Practice nurses District nurses Health visitors	**Private Sector** Nursing/residential homes Home care assistants Home nurses
Health Board Purchasing commissioner(s) Nursing home inspectorate Public Health Medicine	**Hospital Trusts** Day hospitals Consultant geriatricians Geriatric nurses Liaison nurses Physiotherapists Occupational therapists Auxiliary nurses Respite facilities
Research Institutions Universities (Glasgow, Stirling) Community Care Personal and Social Services Research Unit (Kent)	**Voluntary Organisations** Nursing/residential homes Respite facilities Home care assistants

Table 6 gives a summary of the costs of a variety of residential and non-residential community services.

Table 6
Average costs of a variety of community services[1]

	£
Home	
Day hospital attendance	44.00
Home help (per hour)	4.16
Meals on wheels (per meal)	1.61
Day centre attendance	6.31
Lunch club (per meal)	1.61
Crisis care referral	208.00
Community care alarm	173.00
District nurse (per visit	
RGN	32.00
Enrolled Nurse	20.00
Aids/appliance assessment	16.00
Domiciliary physiotherapy (per 2 hour visit)	65.00
Neural rehabilitation session (2.5 hours)	81.00
Chiropody clinic (per session)	4.00
Domiciliary chiropody (per visit)	32.00
Incontinence pads (per week)	2.00
Incontinence laundry (per week)	6.50
Sleepover or night sitter (per week)	323.00
Respite care	
Geriatric assessment bed (per week)	674.00
Residential home (per week)	200.00
Sitting service (usually from voluntary organisations)	
Residential Care (per week)	
Local authority home	232.00
Private residential home	189.00
Voluntary home	167.00
Continuing Care	
Long stay NHS bed (per week)	527.00

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CHAPTER 4

JOINT PLANNING AND INTEGRATION OF SERVICES

Introduction

The Audit Commission report, "Making a Reality of Community Care" in 1986 indicated that conflicts in policy between Government departments and local bodies and individuals responsible for providing services inhibited the development of effectively targeted community services. Also, the "perverse incentive" of open-ended social security provision for people in private residential and nursing home care encouraged the rapid expansion of institutional care at the expense of improving and extending services to enable people to continue to live in their own homes.

The Government commissioned Sir Roy Griffiths, deputy chairman of Sainsbury's and of the NHS Policy Board, to undertake a complete review of community care policy. He recommended that local authorities should be the single body responsible for organising "social care" for the elderly, people with mental health problems and people with disabilities. Local authorities would fund their new responsibilities with money transferred from the social security budget for care in residential homes and these funds would be specially ear-marked as a specific grant.

The Government launched its White Paper, "Caring for People: community care in the next decade and beyond" over a year later. The key proposals were:

(a) Local authorities to be given the responsibility to assess individual need, design and purchase packages of care and ensure that services are delivered;

(b) Local authorities to publish plans for developing community care services "consistent with the plans of health authorities and other agencies";

(c) Local authorities expected "to make maximum use of the independent sector";

(d) The money spent on income support for residential and nursing homes to be transferred to local authorities to enable them to purchase appropriate care for elderly and disabled people, from a range of providers according to the assessed needs of the individual - with careful monitoring to ensure that care is chosen according to its appropriateness rather than its cost;

(e) Local authorities to establish "arms length" inspection and registration units to check on residential care homes in all sectors.

Scottish Office, NHS in Scotland Management Executive, NHS Responsibility for Continuing Health Care. NHS Circular MEL (1996)22.

The new arrangements were put into effect from 1 April 1994. The main responsibilities of the two main strategic authorities may be summarised as follows[1]:

Social Work Departments

Social work authorities are required:

- in conjunction with health agencies, **to produce, publish and consult on community care plans** for the development of community care services, consistent with the plans of health authorities and other interested parties
- to be responsible, in collaboration with medical, nursing and other interests for **assessing individual need, designing care arrangements, and securing their delivery within available resources**
- to **promote the use of the independent sector**
- to assume responsibility for **public financial support** of people requiring private and voluntary residential care
- to establish **"arms length" inspection units** to monitor standards, initially in residential care in the voluntary, private and public sectors
- to apply a **new specific grant** to promote the development of social care for severely mentally ill people, for people with dementia, and those with head injuries

Health Authorities

The implementation of the NHS reforms following the Act gives the health authority primary responsibility for the following:

- to assess the **health status** of its population and set priorities for improvement of health
- to **promote health** and to work closely with others in the local area to promote healthy lifestyles, environments, workplaces and communities
- to establish **priorities for health care** in consultation with local people and interests
- to **purchase health services** from NHS providers which meet the health care needs of the population
- to **work closely with general practitioners** and other independent community practitioners to develop and improve primary care services
- to **work closely with local authorities** and others to implement the community care forms enshrined in the Act.

A House of Commons committee highlighted the potential conflict explicit in the reforms between attempts to restrict the social care budget (previously there was an open-ended commitment to those claiming income support) and the increasing

demand on services resulting from detailed assessment and identification of patients' needs[2]. Although some local authorities have had budgetary difficulties, most have managed with the resources allocated to them, for example by tightening the criteria used to assess eligibility for community care and by targeting services more cost effectively - but possibly at the price of replacing of one system of institutional care (hospital) with another (residential and nursing homes)[3].

The Scottish Office has recently defined NHS responsibilities for continuing health care, in order to distinguish this from continuing care which is a local authority responsibility[4]. The following extracts are of importance in the context of this report:

- The NHS remains responsible for arranging and funding a range of services that match health care to the needs of people who require continuing health care, whether that care is best provided in a hospital setting or more appropriately in the community.

- Health Boards and local social work authorities should have in place clear agreements on how they will resolve disputes (between themselves as purchasers) about responsibility in individual cases for meeting continuing care needs. These arrangements will be within the context of the overall joint planning agreements.

- Health Boards, local social work or housing authorities or Scottish Homes should not place younger people inappropriately in inpatient, nursing or residential care or supported accommodation intended for older people.

- Hospital and social work staff should ensure that patients, their families and any carers/advocates have the necessary information, in writing, to enable them to take key decisions about continuing care. Written details should be provided of the likely cost to the patient of any option which he or she is asked to consider (including where possible and appropriate the availability of Social Security benefits). These costs will include housing or other accommodation costs additional to care costs. Patients should also receive written details of any continuing care which is arranged for them. This should include a statement of which aspects of care will be arranged and funded by the NHS.

- Within their strategies for continuing care, Health Boards should identify what arrangements are required for securing ambulance and other specialist transport services. These should include, on the basis of the patient's needs as determined by the clinician responsible for their care; transport to and from hospital, hospice or other health care facilities; transport where an emergency admission is being made to or from a residential care or nursing home; non-emergency transport for people in residential care and nursing homes or in their own home to and from health care facilities.

Scottish Office, NHS in Scotland Management Executive. NHS responsibility for Continuing Health Care. NHS Circular MEL (1996)22.

Observations and Concerns of the Medical Profession[5]

- Within the NHS, the primary care services have a lead role in the provision of care in the community. GPs in particular have a round-the-clock responsibility for the medical needs of all those living in the community. Because of their constant availability they are often used as the "first port of call" by those in need of care in the community, whether of a medical or social nature.

- In Scotland guidance has been issued stating that the services of specialist community nurses and other health board employed professionals should be available in nursing/residential homes when requested by a GP.

- Despite the increased choice in services, it is unlikely that the number of private nursing homes will decrease significantly as existing residents will have their income support "ring-fenced" and the NHS will continue its policy of reducing the number of long-stay hospital beds.

- Voluntary organisations have a valuable role to play in providing both practical and emotional support through their local branches; these provide advice and information and organise support groups where people can meet others in a similar situation to themselves.

- Audit Commission estimates have suggested that 25 per cent of elderly people in care homes could be cared for adequately in the community. Although other research suggests a less serious situation, there remains concern about the inappropriate use of these establishments.

- Extra funding should be made available as a matter of priority to deal with the increasing numbers of "older old" people, aged 85 and over. Government guidance should be issued to the population as a whole to enable individuals to plan financially for dependency in old age.

Recommendations[4]

- An intensive infrastructure of services should be provided to enable frail elderly people to remain in their own homes, including fully trained home helps, nursing support, access to other therapists and day-care facilities.

- The statutory authorities and relevant professionals should ensure that older people and their carers are informed fully of their options and their rights in choosing the care that they are to receive.

- Clear arrangements should exist to ensure that residents of nursing and residential care homes have free access to the services of community nurses and other health authority employed personnel.

- There is an urgent need to establish sound communication networks between all agencies concerned with the care of the elderly. These should include the automatic involvement of specialists and the provision of feedback and progress reports to GPs who have referred patients into the care of other sectors.

- Ways of promoting greater collaboration between health and social services are needed. Joint commissioning of health and social care is happening in some areas; managers have linked with general practitioner surgeries and social workers have become attached to practices. These localised initiatives should be evaluated and the results widely disseminated.

- Good relations between health and local authorities and the voluntary sector are necessary to enable people to live independently in the community as long as they can. Medical, nursing and other health and social service professionals, based both in hospitals and the community, should familiarise themselves with these groups so that they are in a position to recommend them to patients.

- Social workers and general practitioners need to make opportunities for more face-to-face meetings: a named contact in social services for each practice and social workers becoming members of the primary health care team are possible ways of achieving greater collaboration. An understanding of each other's culture and methods of working are clearly important and could be promoted by joint education and training, or by social workers and members of primary health care teams being seconded to each others' departments for short periods of time.

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CHAPTER 5

THE BALANCE OF CARE

At any one time elderly people may be living at home, in a nursing or residential home, or in a long-stay hospital bed; alternatively they may be receiving hospital treatment in an acute bed, or assessment and rehabilitation in a geriatric assessment bed.

Of patients aged 75 years and over, about 70% of those in acute beds (60% of those in geriatric assessment units) are discharged home. Most of the other patients die (about 16%) or are transferred to another hospital or specialty. Only 3-4% appear to be discharged to residential or nursing home accommodation[1].

In a survey in Glasgow in 1992 about 9% of medical beds, 2.5% of surgical beds and 20% of geriatric assessment beds were 'blocked'. Approximately 60% of the patients 'blocking' beds were awaiting transfer to continuing or terminal care, 20% transfer to another hospital and 20% to home or residential care[2].

The availability of 'continuing-care' beds

Table 7 overleaf compares nursing homes, residential homes and long term hospital provision in Scotland with that in the UK as a whole. The total provision of continuing care (NHS psychogeriatric and geriatric beds, nursing homes and residential care) for Scotland (134 per 1,000 people aged 75 years and over) is very similar to that for the UK (131 per 1,000). Within this total, the proportion of residential home places in Scotland (40%) is very much lower than the average for England (77%)[3]. There is therefore a marked relative deficiency of low dependency residential home beds and relative over-provision of nursing home beds in Scotland, with nursing homes meeting a shortfall in residential care[4]. However Primrose considers that there is under-provision of high dependency facilities in England for those who require continuing nursing care, and so an appropriate target placements for the proportion of residential homes in Scotland would be somewhere between 40 and 66% - perhaps about half of the total provision of continuing care. With the increasing numbers of very elderly and other factors, the size of institution provision in Scotland will probably require to be near to present levels, but with a greater proportion of low dependency care[4].

The rise in long-stay institutional provision in Scotland from 4% of the 65+ population in 1985 to 6% in 1991 was largely due to the expansion of the nursing home sector; this expansion varied widely between Health Boards, with a disproportionate rise in many rural areas where demand is least. This led to a reduction in blocked beds in geriatric and medical units. This dramatic expansion of institutional provision for the elderly was largely due to the availability of Department of Social Security (DSS) support, and is far greater than would have been expected on the basis of population alone[4].

There are probably adequate numbers of continuing care *geriatric* beds, due to the increase in private nursing home provision; however the private sector has been reluctant to provide continuing *psycho-geriatric* care, leading to difficulties in discharging patients from acute beds to psychiatric accommodation.

Table 7
Number of places in continuing care for elderly people: GGHB, Scotland and Great Britain

Institution type	Scotland 1993	UK 1994*
No of places		
Residential homes	16,019	312,000
Nursing homes	15,436	183,000
NHS		
Long stay	12,525	60,000
Psycho-geriatric	5,354	22,300
Geriatric	7,171**	37,600
TOTAL	**43,980**	**555,000**
Places per 1,000 65+ years		
Residential homes	20.7	34.0
Nursing homes	20.0	20.0
NHS		
Long stay	16.2	6.5
Psycho-geriatric		2.4
Geriatric		4.1
TOTAL	**56.9**	**60.5**
Places per 1,000 75+ years		
Residential homes	49.7	78.0
Nursing homes	47.9	45.7
NHS		
Long stay	38.9	15.0
Psycho-geriatric		
Geriatric		
TOTAL	**136.6**	**138.7**
% of total beds		
Residential homes	36.4	56
Nursing homes	35.1	33
NHS		
Long stay	28.5	11
Psycho-geriatric	12.2	4.0
Geriatric	16.3	6.8

* Lang & Buisson, 1995
**includes NHS/private partnership beds

Misplacement of low dependency people in nursing and residential homes?

Carter et al[5], 1992 found in a survey of 488 residents of private nursing homes and 637 residents of residential homes in Fife, that 24% of nursing home residents and up to 29% of those in residential homes were considered by care staff to be fully independent. The authors suggested providing a more restricted range of long term care for frail elderly people, and concentrating more on providing high quality assessment and rehabilitation facilities.

Thirty percent of elderly residents in three nursing homes in Aberdeen[4] were almost independent in self care, with modified Barthel scores in the range 34-40. The mean Modified Barthel score for 61 nursing home placements in Aberdeen following discharge from hospital was 36.

It was found that during 1993/94 one in five local authority-funded admissions to nursing homes in Aberdeen would more appropriately have been accommodated in residential homes or - in a smaller number of cases - cared for at home (Primrose, personal communication, 1995). It was also shown that of 119 admissions to nursing homes in Aberdeen since 1st April 1994, 77% of the 69 local authority placements were judged to be appropriate (mean Barthel score 10.7) whereas only 56% of the 50 privately funded admissions were in this category (mean Barthel score a less dependent 14.1)[6].

During 1993/94 a survey was conducted of the dependency characteristics of elderly people resident in all the long stay geriatric hospital wards, nursing homes and residential homes within the area served by Greater Glasgow Health Board, using the Barthel Index[7]. In residential homes managed by the Regional Council the Barthel score was derived from characteristics already recorded on computer file. In the other institutions those in charge were asked to arrange for dependency to be measured by themselves or by suitable staff. Scores were obtained for over 4,700 people. Table 8 shows that very few patients in long stay hospitals had Barthel scores of 18 or above (most of these being temporarily 'parked' in these hospitals), but 20% of these in nursing homes and 30-35% of those in residential homes were in this low dependency category.

Table 8

	Barthel Score		
Type of institution	**Number**	**12+ moderate dependency**	**18+ lower dependency**
Hospital long stay	1,268	5%	<1%
Nursing homes	1,231	50%	20%
Residential homes			
Regional council	1,337	70%	30%
Independent	886	75%	35%

The Barthel Index however primarily reflects physical disability, and in general the admission criteria for most residential homes require residents to be physically able; the main reasons for entry often relate to mental impairment, functional distress and absence of an immediate carer (often through bereavement) and Barthel scores are therefore likely to be high in residential homes[8]. Primrose believes therefore that very few - perhaps only 5% - placements in residential homes are inappropriate, compared with possibly around 25% in nursing homes.

Some financial implications of misplacement in nursing and residential homes

If 20% of the 16,000 people accommodated in nursing homes could be more appropriately cared for in residential homes or even at home, there would be a cost saving of £96 per week (difference in local authority contribution between nursing

and residential homes) for 3,200 people - about £300,000 per week or £16 million per year.

For the probably small proportion (perhaps 5%) of the 16,000 people accommodated in residential homes who could possibly be more appropriately cared for at home, the cost of providing support at home including day care might well exceed the current local authority contribution of £194 per week. It may therefore not be possible to achieve cost savings even if it were possible to transfer people from residential facilities to their own homes.

The implications of private admissions to nursing and residential homes

Almost half of privately funded admissions to nursing homes are inappropriate in that they do not need this level of (or sometimes even any) nursing care. Those with independent means may choose to enter a nursing home without any assessment, and in consequence they are fitter than local authority funded people. However in time their resources will diminish, resulting in the local authority having to take over part or all of their funding in due course.

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CHAPTER 6

HEALTH SERVICE INPUT TO NURSING AND RESIDENTIAL HOMES

Some quotations

British Medical Journal, April 1996[1]

"Why, when Britain faces the unprecedented strategic challenge of the long term care of older people, is there increasing evidence of strategic drift? Two issues are of particular concern and may lead to increased costs: they are the poor assessment of eligibility of older people for long term care, and poor quality of care. The difficulties with assessing eligibility and ensuring quality indicate the urgent need for some form of strategic review."

"If the circumstances in South East London area generalisable to the rest of Britain, there is a severe problem with the entry to nursing home care which has long term implications for individuals, organisations, the health of the population, and the national economy. If we continue to adopt what has been described as a "prosthetic" rather than a therapeutic approach to the long term care of older people, the consequences for future generations may well be devastating. There is a need for national strategic development to stop people going too early to the wrong place. Agreeing a better way forward would be appropriate before the international year of older persons in 1999".

"International comparisons may be useful; in Australia no one enters long term care without seeing a geriatric assessment team; in Japan a 10 year "Gold Plan" is being implemented by the ministry of health and welfare to tackle the longevity revolution; in Norway the government's health board is developing a major investment plan in specialist health services for older people."

Medical Research Council, 1994[2]

"It is in elderly people that levels of chronic disease and disability are greatest and there is the greatest potential for prevention and reversal of disability. Yet there is current uncertainty and widespread scepticism regarding the effectiveness and cost-effectiveness of rehabilitation techniques among elderly people. This has resulted in a tendency towards less active therapy and more palliative care of older people with disease or disability. The therapeutic approach emphasises the future potential of the individual and the acquisition of new skills, both physical and social, reinstating a patient's autonomy (the ability of an individual to do what he/she desires), and independence (the ability of the individual to do cope without the help of others). The prosthetic approach substitutes for lost skills with some other means of providing function: it removes the stimulus for continued activity and, whilst it may restore autonomy, it does not normally restore independence.

Prosthetic interventions may be provided when therapeutic interventions would be more appropriate, and of greater long-term benefit both to the patient and to the health and/or social services. Someone with osteoarthritis hip could be offered a therapeutic hip replacement or a prosthetic home-help. In this case, the short-term costs of the therapeutic option might be higher, but in the longer-term, the costs falling on the social services would be greater as they would be ongoing and even increasing as the woman's dependence also rose. **The deployment of prosthetic**

services should only occur when all therapeutic options have been adequately explored, otherwise the prevalence of disability will increase.[2]

The type of intervention which a patient receives is likely to be dependent on the first point of contact by the patient for help; for example, the GP might offer a therapeutic intervention and the social worker a prosthetic one. Social workers may operate in this way because of a lack of training to appreciate or assess where therapeutic interventions might be appropriate"[2].

The Rowntree Foundation, 1996[3]
"The goal of long-term care for elderly people is to maintain as high a quality of life as possible in the presence of chronic physical, cognitive and social disabilities, which commonly deteriorate over time. Older people's lives are also frequently punctuated with episodes of acute problems which may be medical, cognitive, behavioural or social. **Hence, assessment is important not only at the point of entry to continuing care, but on regular occasions thereafter"[3].**

Dept of Geriatric Medicine, St Georges Hospital, 1995[4]
"Accurate diagnosis with an optimistic therapeutic approach is the key to the optimum use of resources. Rehabilitating even a small number of potential long-stay older people will reap long-term financial benefits, quite apart from the benefits to the patient in terms of morale and health gain".

Introduction

Residential homes managed by the local authority provide assessment, rehabilitation and short term care as well as long stay accommodation. They also provide respite care for elderly people in order to provide relief for carers. Residential homes managed by private providers and voluntary organisation however are usually concerned mainly or exclusively with the provision of accommodation; because there is usually insistence on independence in mobility and dressing and a reasonable degree of continence, these homes are probably best suited to patients with early dementia who cannot be supported in the community.

Some former residential homes offer short-term rehabilitation for users who are determined to return to their own homes, but who need time and support to regain their skills and confidence. The setting is residential, but physiotherapy and occupational therapy are key parts of the care provided. Admissions are for a set period (usually up to six weeks), and a target date for going home is identified at the outset[5].

Most nursing homes are owned privately (usually by large organisations), although some are owned by voluntary organisations. Most nursing homes are independent of the NHS (apart from the need to satisfy the registration criteria of the local health authority), although increasing numbers are contracted by the health authority to provide accommodation, nursing and ancillary services with continuing medical supervision from hospital consultant geriatricians and junior staff. The main advantage of such contractual arrangements is the provision of 'hotel' services in a more attractive and purpose-built environment at considerably less cost than is possible in usually out-dated NHS continuing care facilities.

- Residents of nursing homes and people receiving social care and community health services support in residential care homes, supported housing, or in their own homes may still require access to specialist medical, nursing or other community health services. This access may include occasional continuing specialist medical advice or treatment, specialist palliative care, specialist nursing care or community health services such as physiotherapy, speech and language therapy and chiropody. It may also include specialist medical or nursing equipment normally only available through hospitals. Basic equipment such as incontinence supplies if prescribed by the General Practitioner will be provided through the NHS at no charge[6].

- Access to specialist medical and nursing services should be available on exactly the same basis for those people receiving social care and community health services support in residential care homes, supported housing, or in their own homes. Community health services are a crucial part of the provision of continuing care for people at home or in residential care. Health Boards should work closely with users, local social work and housing authorities. Community Health Councils, Scottish Homes, GPs, hospital and community provider units and the voluntary and independent sector should agree the likely demand for continuing community health services support[6].

- For those in residential care homes, Health Boards should arrange for specialist palliative health care as for people living at home. For those in nursing homes, Boards should arrange for the provision of any necessary additional specialist palliative care in addition to the general nursing already provided[6].

- In many areas, although the residents of private nursing homes are registered with a GP, other members of the primary health care team who are employed by the health authority, e.g. district nurses, are not allowed to provide services for them. Even in homes where access is allowed, actual levels of provision are poor[7].

- The ongoing cost of nursing home care should be thought of and the long term view taken. What may seem more costly short term may in fact be more cost effective long term.

- The reasons why complex home care packages are not always being put in place should be looked at: is it cost or social worker time, is there an unspoken or written ruling about the 'ceiling' of the cost of a home care package, or is it due to lack of training; "experience" or knowledge of services from the person designing the package?

The medical and nursing members of the GGHB nursing home inspection team have made a number of observations about the quality of life and care in nursing homes and these, together with some others, are as follows:

Criteria for medical supervision

- The criteria for admission for ongoing medical supervision in long-term care are not well defined and there is very considerable variability both in the quality and quantity of medical input to nursing and residential homes.

- Responsibilities for medical care in residential and nursing homes are often poorly defined, and general practitioners are being expected to take on even more treatment, monitoring, and advocacy in these settings in future[8].

Group dynamics

- Many long stay facilities have moved little from the former models of care set up by the NHS. Residents are assessed in the abstract with only a few good homes giving any thought to the collective dynamic in a home and how the admission might influence that.

- Few nursing homes refuse admissions on the basis of inability to meet needs. This is despite the fact that some homes accommodate thirty or more people with moderate to severe dementia who are unable to influence their own environment. In homes with large numbers of demented people, communal care is inevitable.

- Because in most institutions little or no attention is paid to group dynamics, the opportunity is lost of the less dependent residents meeting some of the needs of the more dependent so that care assistants can concentrate on the needs of the few most dependent people.

Availability of community services

- Many nursing home residents are deprived of the community services which would be freely available to them at home[7]. There is no routine monitoring of this group either by physiotherapists or occupational therapists and therefore unmet needs, unless recognised by care staff, remain unmet or are compensated for by increased nursing 'support'.

- There is likely to be considerable potential for functional improvement among disabled adults resident in nursing homes. It is important that these residents are provided not only with a congenial environment, adequate nutrition and personal care but also receive the necessary support and stimulation to retain and if possible enhance the use of all their faculties, thus enhancing their well-being and quality of life.

Too much emphasis on nursing care?

- The need for nursing care is emphasised when care becomes communal and systemised. Very few patients require 24 hour nursing care, and such care is likely to create symptoms and may bring about an iatrogenic need for more care.

- The need for care is not synonymous with the need for nursing, and nursing is not a pre-requisite for good care. Nor even is coping with deteriorating mental or physical functioning a nursing responsibility.

The importance of establishing the best forms of communal living

- Communal living is not the cultural norm, although some people do make this choice. We should therefore be reluctant to promote it in long-term care to frail and disabled people except where this is appropriate from the point of view of the patient and/or financial considerations.

- The main reason for communal care is financial. Although this is acceptable in view of limited resources, it is a compromise, and we should research the best possible communal care setting with attention to size, resident group dynamics and dependency mix.

The natural and artificial models of care

- Family and 'instinctively' caring persons work to a natural model, where the overwhelming need is to preserve patients' dignity and autonomy and the various elements of good care, including the necessary skills, fall into place unconsciously. There is no need for rhetorical statements about dignity and preserving residents' space because these values are inherent to the attitude of the carer. Patients are more likely to co-operate with natural care, there are fewer problems with compliance and there is much less need for interventions such as sedation.

- Many institutions however work to an artificial model of care; this is much less effective because people respond less well to instructions and protocols than to suggestions delivered with tenderness and so there are more problems with behaviour, attitude and compliance. The model is also inefficient in that conscious effort has to be made to pursue protocols for the achievement of each desired outcome, whereas in natural care the same or often better outcomes can be achieved unconsciously and more quickly.

Medication or stimulation?

- Residents of nursing homes are given more drugs than the rest of the elderly population, and they are commonly given excessive amounts of psychoactive drugs. "Incoherency or constant repetition of inappropriate requests may require increased tolerance from staff members rather than sedation", and "excessive, restless activity may be signalling a need for a lower and not a higher dose of an antipsychotic drug"[9].

- In a study in Glasgow, 217 of 909 (24%) nursing home residents were taking a neuroleptic drug. According to American guidelines the prescription would have been appropriate in only 27 (12%) of cases. The 190 others had been prescribed the drug for reasons such as mild aggression and agitation, wandering, uncooperativeness and insomnia[10]. In a study of 1,888 residents of residential

homes the proportion of elderly people being prescribed hypnotic drugs varied between 3.5% and 60% in different homes[11].

The importance of the configuration of the building

- The size, structure and layout of the building are important in that these may reinforce attitudes that the space belongs to the staff rather than to the residents. Perhaps the most important determinant of quality of life in an institution may be whether the institution functions in accordance with staff needs and perceptions or whether it is orientated primarily towards the individual and collective needs of the residents.

- In some nursing homes, each resident has his or her own 'living area', which includes a bed, and their own pictures, ornaments and other expressions of themselves; the staff knock before they are admitted to this space. In many, however, residents spend almost all day in the communal 'day area' which is unattractive and in which residents have no identity: Although staff may say they are 'promoting dignity', the living space is controlled by them and residents are not allowed to move out of it or even within it without permission. The way that staff talk to and treat the residents is quite different: in the one, residents are treated with tenderness and respect; in the other they are instructed and coerced.

- Location is a relatively minor determinant of the quality of life in an institution. A 'good' location may ensure that some residents receive more visitors and are able to go out to the shops. However a change in location with little or no reference to what takes place within the building is likely to result in little benefit: it is still possible to be confined to or bound within the four walls of a care facility despite an ideal location. Being *located in* the community is not synonymous with being *integrated with* the community.

The special skills and attitudes required by nursing and other staff in nursing homes

The "nursing" care of old people living in an institution requires very different skills, attitudes and knowledge from those usually required in nursing. Most importantly, what is often required is encouragement to maintain or improve functional status rather than more traditional nursing care. This means that the more usual acceptance of a client's dependent state requires reorientation towards encouraging independence as far as is possible. Some nursing home residents do require lesser or greater amounts of nursing care; however others - and quite possibly the majority - require rehabilitation or habilitation rather than 'nursing' care which may actually encourage dependency. This important philosophical shift, together with other special features peculiar to the working environment of a nursing home, imposes unusual demands and stresses on nurses and other staff. Some of the implications of this are as follows:

- Nurses and other staff in nursing homes require new skills and considerable attitudinal changes, as well as some new knowledge. Specialist training would be required to achieve these changes, not merely attendance at seminars.

- A new type of professional may be required in nursing homes, possibly akin to an occupational therapist, whose prime objective is to encourage independence and minimise deterioration of physical, mental and social functioning. This would enable a smaller number of nurses to concentrate on more traditional nursing functions.

- Continuity of nursing and other staff is crucial in order to encourage a sense of responsibility for residents and so that changes in residents' condition can be detected as soon as possible and appropriate action taken.

- One of the most important nursing responsibilities is to know the indications for all the medications given, to know their possible side effects (including the signs of under- and over-dosage) and to work in partnership with the general practitioner (and, where appropriate with other therapists, the patient and relatives) to establish the most suitable therapeutic regime for each patient.

- The responsibilities of nursing staff are considerable and stressful, with the danger of 'burn-out' after a prolonged period. This problem is possibly even greater for care assistants who work in nursing homes: their job is very hard, the 'shifts' are often difficult and the wages usually very poor.

Recommendations

General principles[4, 12]

- Comprehensive multi-disciplinary assessments before a client is admitted to any form of long stay care is essential, including the involvement of a consultant geriatrician and experienced occupational therapist.

- There should be a thorough assessment of each resident's medical condition at least annually, including testing of visual and auditory function by the appropriate professionals.

- There should be adequate levels of physiotherapy and occupational therapy input to all nursing homes.

- There should be expert geriatric advice and input to homes.

- Psychosocial and spiritual needs, likes and dislikes, activities and interests are in general of more importance to residents than health care. These factors should be prominent in the assessment of quality of continuing care, should be demonstrated in case records and should be recognised in the care plan.

- The views of residents and their relatives should be sought in periodic validated surveys.

- Routines (e.g. meal times) should be formulated in response to residents' needs rather than the requirements of contracts.

- There is a strong case for integrating the registration and inspection of residential and nursing homes, especially as the health advisory service seems to have

experienced a reduction in its inspectorial role and now comes into health authority areas only by invitation. This should help resolve the problem of misplacement in both types of establishment, and allow residents to graduate to higher levels of care as their dependency increases. It would also deal with mismatches in levels of provision of nursing and residential home places within individual localities. In addition, the remit of the inspection units should be extended to cover the increasing number of private-run domiciliary care services to ensure that standards do not pose a threat to vulnerable elderly and disabled people living in their own homes[6].

- Residents should be encouraged where possible to accept the power role rather than be expected to be controlled. To achieve this, staff must relate to residents on an individual and personal basis.

- Each resident should have a 'home environment', with his or her own space, possessions and privacy. The staff must not have governance over the use of private rooms or public day areas.

- There is a need for meaningful day time activity and adequate physical, mental and social stimulation in nursing and residential homes.

- A more suitable configuration is needed for nursing and residential homes, possibly by limiting the size of homes to a maximum of probably eight residents in order to create a familial type of grouping. This encourages residents and staff to conform to culturally normal behaviour patterns.

  People who initially fund themselves in nursing and residential homes do not require any formal assessment. When their funds become depleted it is likely that the local authority will have to pay for their care despite the fact that they are still fairly fit and would not meet the assessment criteria. Also their dependency may have increased unnecessarily simply due to institutionalisation.

- All information regarding the patient's physical or mental condition should be available to the person(s) assessing suitability for placement in a particular home.

Nursing homes

- Criteria for ongoing medical supervision require clearer definition. Community services available to people living at home should also be available to those in nursing and residential homes - particularly occupational therapy and physiotherapy.

- Nurses and other staff working in nursing homes require special training. Nurses need to be particularly knowledgeable about the medications prescribed for each patient and potential problems in their use.

- The emphasis on nursing care and task-orientation should be reduced, with a corresponding increase in encouragement of elderly people to do things for themselves (and others) even if this involves some slight risk. This would require input from some other professionals - for example occupational therapy.

- There should be a mix of dependency levels so that the least dependent residents can help and support those who are more dependent. Residents therefore need to be 'selected' for admission after taking account of the characteristics and needs of those already in the home.

- The art of natural care must be fostered, with plans, procedure and protocols used to enhance natural care rather than replace it.

- A more satisfactory way is needed of monitoring the quality of care and ensuring a better quality of life. This will require development of more sensitive procedure, including some which would be administered by a lay person. Check-list based systems are usually ineffective in differentiating good from what are clearly poor quality establishments.

Residential homes

- The health care needs of residents are the responsibility of primary care teams. The increase in residents' dependency levels places additional demands on these teams, and this should be recognised, and GPs consulted, when homes are registered.

- There should be regular staff training.

- The effectiveness of residential care could be improved by the following:

    * Higher staffing levels to cope with increased dependency, which may prove cost-effective by preventing admissions to hospital.

    * "Sick bays", providing more intensive care for short periods to prevent admission to hospital and to permit earlier discharges.

    * Small group living, with the segregation of small groups of patients with similar needs in domestic settings, affording them a more flexible life style.

    * Better utilisation of places, with more flexibility in holding temporarily vacant places and speedier placements from hospital.

    * More respite places to allow carer relief.

    * Residential homes operating as resource centres, providing services in the community to patients discharged from them (familiar staff in a different setting).

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CHAPTER 7

TRENDS IN THE USE OF ACUTE BEDS BY ELDERLY PEOPLE

Hospital utilisation

(a) Increase in emergency admission between 1981-85 and 1988-92[1]

Table 9

Age Group	% increase
0-14	11.3
15-44	27.0
45-64	16.8
65-84	32.7
85+	12.2

Table 9 shows for different age groups the increase in emergency admissions to acute hospitals which has taken place over the seven year interval between the two time periods 1981/85 and 1988/92. There have been substantial increases for all age groups, but the increase has been particularly high for the 65-84 year age groups. Figures 2a and 2b show this in graphical form. However, average lengths of stay in acute specialties for patients for all age groups have fallen markedly since 1978 - by about 45% in men and over 50% in women.

The diagnoses contributing most to the increase in emergency admissions in the 65-84 year age group were angina, cardiac disrhythmias, chest/respiratory symptoms, chronic airways obstruction and heart failure; for the age group 85 years and over the diagnoses contributing most to the increase were fracture of neck of femur, acute myocardial infarction, cerebrovascular disease, heart failure and chronic airways obstruction.

(b) Use of acute hospital beds by people aged 65 years and over

Figure 3a shows that in terms of the numbers of patients treated for most acute specialties, over 30% are aged 65 years and over; this age groups however comprises only 16% of the population. For ophthalmology the proportion of discharges for people aged 65 years and over is over 50%. However, because older people on average have considerably longer stays in hospital for each episode of care the proportion of bed-days utilised by people in this age group is 52% for the average of all specialties, and 50% or greater for general surgery and ophthalmology and greater than 60% for orthopaedic surgery, urology and general medicine (Fig 3b). This means that at any one time in the major specialties of general medicine and orthopaedic surgery over 60% of beds will be occupied by people aged 65 years and over.

Multiple medical and social problems are common in older people, and their care requires full assessment and a comprehensive approach which addresses all of their problems. The involvement of physicians specialising in the care of the elderly is therefore desirable for older people who are admitted to acute hospital wards.

Working arrangements which involve physicians specialising in the care of the elderly are needed throughout the hospital. The need for a programme of rehabilitation is common to most older people who have suffered a major illness[2].

The trend to increase in hospitalisation rates (both in-patients and day cases) is likely to continue. The increase in the number of elderly people in the population however has made only a very small contribution to this increase, the main factors being[3]:

- medical advance, extending the range of treatable condition.

- a possible increase in levels of morbidity (the General Household Survey shows an increase in levels of chronic sickness (all ages) for both males and females between 1980 and 1988, but these data must be interpreted with caution).

- differences in the threshold levels at which referrals are made to hospital, which may reflect rising public expectations, especially as regards the elderly.

A further increase of around 10% in in-patient activity has been predicted for the period 1990-91 to 2000-01, and this is likely to be accompanied by a reduction in acute beds of up to 30% in the same period. Greater efficiency in the use of available facilities will be essential if the growing demands of elderly patients are to be met. The following action has therefore been proposed[3]:

- an increase in day case surgery.
- further reductions in lengths of stay.
- a reduction in bed blocking.
- improvements in community services to support earlier discharge of patients and more use of day surgery.

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Figure 2a

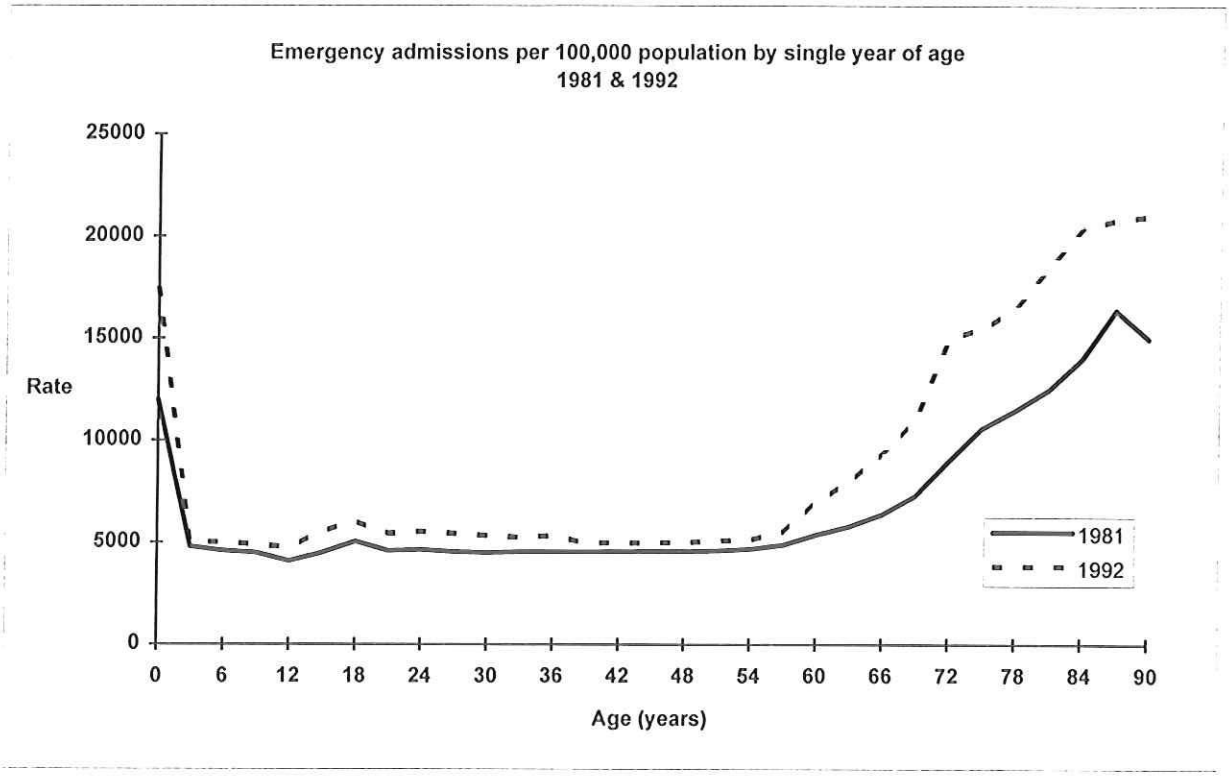


Figure 2b

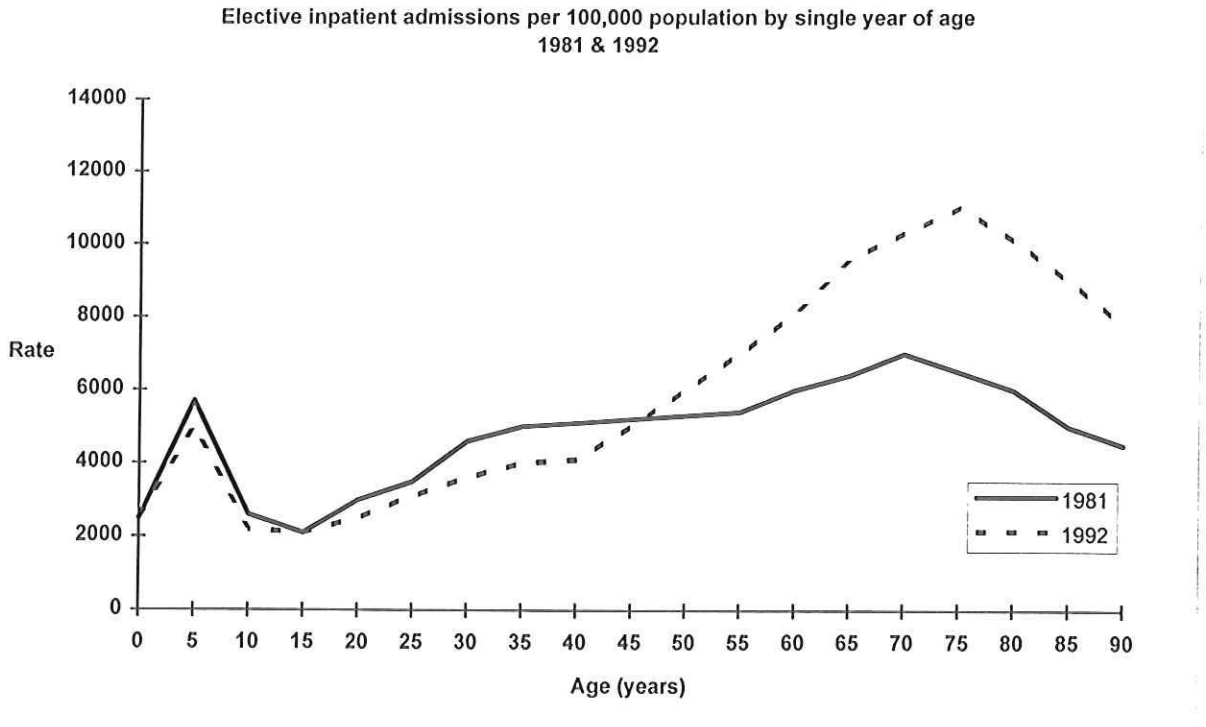


Figure 3a

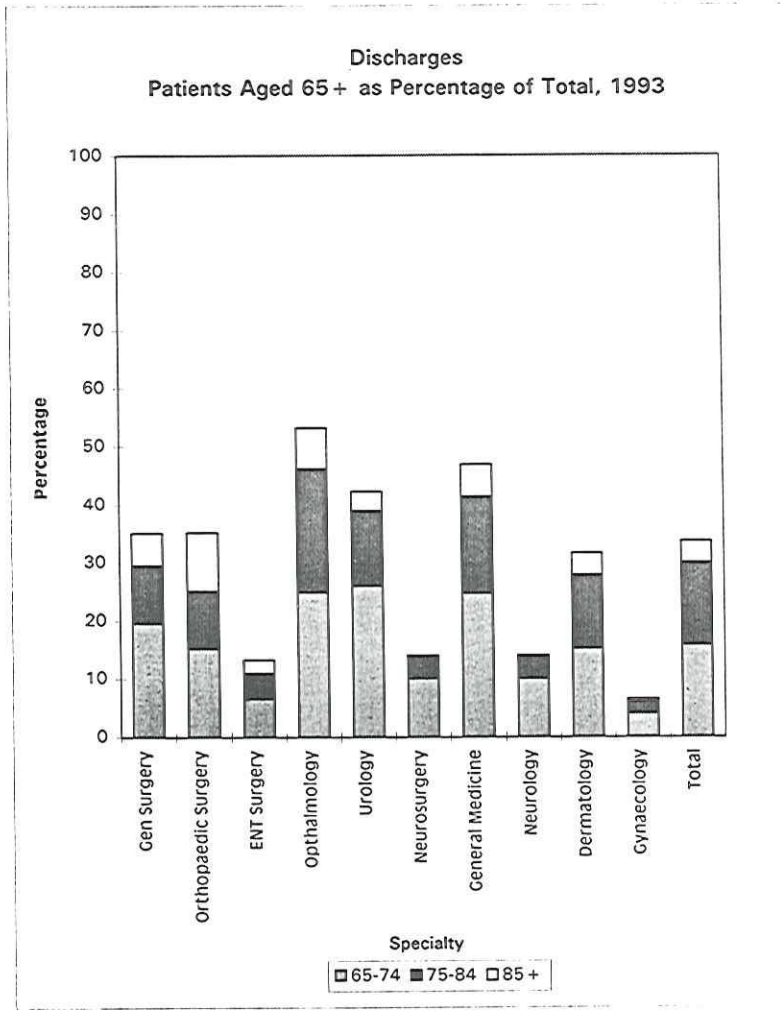
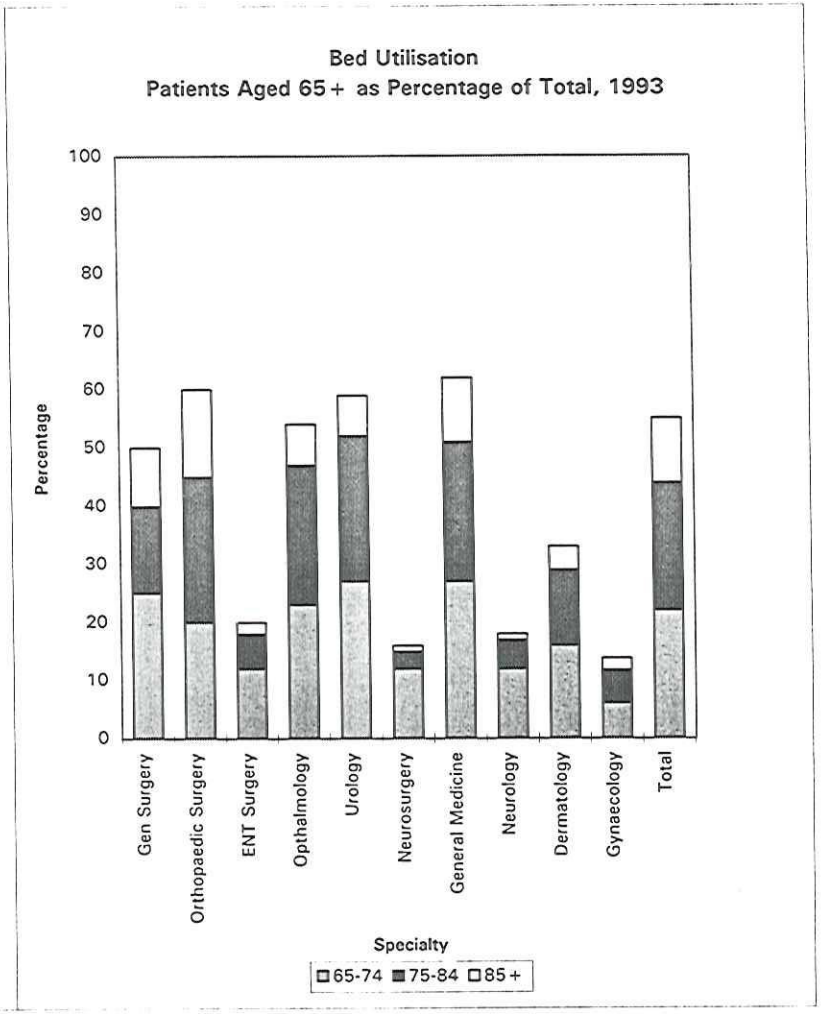


Figure 3b



CHAPTER 8

DAY HOSPITALS

Outpatient clinics are intended for medical investigation and treatment by a specialist geriatric service whereas day hospitals are for medical investigation and multi-disciplinary management (which includes OT, PT, chiropody, speech therapy and dietetics). There has been much recent debate about the usefulness and cost-effectiveness of day hospitals, including tendencies to underoccupancy, cost-inefficiency, high non-attendance rates, and difficulty in evaluation. However, day hospitals can facilitate earlier discharges and prevent admissions to hospital: they provide a full range of medical, nursing and therapy services without overnight stay and are therefore a less expensive option.

Day hospitals can also be utilised as the setting for multi-disciplinary geriatrician-led assessments for long term placements, including nursing home and residential care. This provides GPs and hospital consultants with relatively rapid access to a high quality placement process for both community- and hospital-based patients.

Martin et al[1] have analysed activity in a busy urban geriatric day hospital with 30 places sited adjacent to geriatric assessment and rehabilitation wards. During 1991 there were 731 new referrals, accounting for 5,780 attendances (median 7 attendances per patient with an average period of attendance of 3 weeks). 38% of patients were unscreened general practitioner referrals, 33% consultant referrals, 12% from geriatric wards, 7% from out-patients and 8% from other hospital departments. The main medical reasons for attendance were stroke and heart disease. There were usually two or more reasons for referral - the most common being physical rehabilitation (66%), medical/functional assessment (60%), assessment for confusional state (14%), medication problems (9%) and incontinence assessment/management (8%). General practitioners felt that at least 25% of their referrals would otherwise have required hospital admission. 18% of attenders required in-patient care, the remainder having planned discharged arrangements. The liaison health visitor made 337 home visits to day hospital patients - during or shortly after the period of day hospital attendance.

The average time spent at day hospital was 5 hours 23 minutes, with an additional 90 minutes per patient for ambulance transport. Excluding meal times, the average treatment time available was 4 hours 30 minutes. Active treatment time however was on average 164 minutes for new patients and 93 minutes for return patients. 95% of patients received medical treatment, 82% physiotherapy, 76% nursing care, 66% occupational therapy and 6% speech therapy. Only 5% received medical treatment alone - suggesting that the day hospital was not duplicating the function of an out-patient clinic.

The authors concluded that a properly functioning day hospital is an essential part of a geriatric service, the emphasis being on assessment and rehabilitation, with patients discharged as soon as they have met realistic targets, or when attendance becomes for social benefit only. Much of the blame for confusing the function of the day hospitals and social work day centres was attributed to "consultant geriatricians who do not make proper use of the resource", although it was acknowledged that in rural areas - where day centre places may not be accessible - it may be necessary to accommodate a number of social or respite attenders.

In a study in a day hospital in Fife[2] referrers felt that 94% of patients requiring physiotherapy and 70% of those requiring occupational therapy need not have attended the day hospital had adequate domiciliary services been available. However the services requested by referrers were consistently fewer than those actually provided for patients by the day hospital. The author suggested the establishment of a day-hospital based multi-disciplinary community rehabilitation service for frail elderly people, providing both clinic and community based services and with clearly stated service definitions, aims and objectives. There is an example of this type of service in Cornwall where a Community Assessment, Rehabilitation and Treatment (CART) Project has been established[3] to offer skilled multidisciplinary assessments of health and social care needs for elderly people, particularly for those verging on the threshold of institutional care. Two teams of physiotherapy and occupational therapy staff and a specialist nurse, with referral to a consultant elderly care physician as needed, achieved significant improvements in patients' Barthel scores compared with a control group, and there were fewer admissions to institutional care.

Services provided by day hospitals could be improved by more flexible ambulance transport, weekend opening (as in the St Bernard's Club, Stockingbridge House, Edinburgh) and the provision of step-down facilities for chronic attenders[4].

Conclusions

- A properly functioning day hospital is an essential part of a geriatric service, the emphasis being on assessment and rehabilitation, with patients discharged as soon as they have met realistic targets.
- The geriatric day hospital should be the focus for development of a comprehensive community rehabilitation service.
- Day hospitals should be utilised as the setting for multidisciplinary geriatrician-led placements for nursing and residential home care.
- Half day attendance may be more appropriate because occupational therapy, physiotherapy and medical treatment can normally all be completed in that time and the visit is likely to be felt more necessary and worthwhile.

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CHAPTER 9

THE ROLE OF GENERAL PRACTITIONERS AND PRIMARY CARE TEAMS

Screening patients aged 75 years and over

Screening programmes for the elderly have demonstrated that it is possible to identify unmet need and increase service uptake but have not demonstrated significant improvements in functional status. There are some improvements in morale in the elderly, and possible decreases in mortality rates. However, screening also raises expectations about health and social provision which may not be fulfilled.

A practice of 10,000 patients might be expected to have 680 patients aged 75 or over. As a functional assessment and follow up will probably take a minimum of one hour with travelling time, case analysis and management, it might be estimated that a practice of 10,000 would need at least 1 whole-time equivalent practice nurse (or other trained person) to routinely assess all those over 75 years on an annual basis

The alternative strategy would be an opportunistic approach. About 90% of elderly people visit the general practitioner in the course of a year and many see members of the primary health care team in their own homes. A functional assessment could therefore be included as a component of routine care, although it is difficult to estimate how much time this would take.

Most general practitioners delegate surveillance to a member of the primary health care team such as the health visitor or practice nurse. This raises several questions. Should Health Authorities provide staff to do this work or allow community staff to help do assessments on elderly patients, or will general practitioners be expected to employ their own staff, or even use Health Authority staff on a sessional basis? Should the Health Authorities be attempting to supplement GP schemes if there is evidence that these services are not comprehensively provided[1]?

The British Medical Association has requested[2] that "The requirement for GPs to offer annual 'health checks' to patients on their lists aged 75 years and over should be removed". On the other hand in some general practices practice nurses and/or health visitors conduct a thorough domiciliary assessment of all patients aged 75 years and over, and publish annual reports of the benefits achieved. (See Chapter 13, example I).

Recommendations[1]

- General practitioners should adopt an opportunistic approach to screening of the over 75's.

- Patients over 75 years who are not seen opportunistically during a year should either be invited to attend the doctor's surgery or be offered a home visit by the general practitioner or other trained member of the primary health care team within their home.

- A standard form listing areas of assessment should be developed and completed annually and retained in the patient's medical records for those over 75.

- A method for collecting and analysing the screening data from the general practitioners for planning services should be established.

Responsibilities for care in nursing and residential homes[2]

The unplanned growth in the number of private residential and nursing homes has created uncertainty for the medical profession. Patients in these establishments are generally regarded as "being in their own home" and it has been assumed that general practitioners will therefore provide any care that is needed within their contract for general medical services. This is increasingly challenged by the profession. Not only do many patients in nursing homes require a level of and frequency of care beyond that generally provided by GPs, but some are placed there as an alternative to long-stay NHS hospital beds and remain officially under consultant care. Many GPs in the former situation feel inadequately recompensed for the level of work required. In the latter case, GPs should be funded by the district health authority for providing care which continues to be the responsibility of the secondary care sector.

The lack of consideration given to the provision of general medical services when private homes are set up is of grave concern. Under current regulations, health authorities cannot oppose the registration of private nursing homes on the basis of need; only if the facilities provided do not meet required standards. There is also no provision for general practitioners to be consulted, and as the number of homes increases the already limited access to the services of other health authority employed primary health care personnel is restricted even further.

Responsibilities in relation to social care[3]

General practitioners and other doctors are most likely to develop shared systems of community care if they enter into discussions with local community and social care staff; evaluate and meet their own needs for specific training; and participate in schemes to make care more local. There is no clear evidence, however, that general practitioners have the skills to purchase social care services, even with the help of care managers. The attachment of care managers to practices has been popular in the few instances in which it has occurred, and it is reasonable to expect that bringing primary social and health care together could improve communication and delivery of services. But the availability of care management to improve outcomes for patients outside the settings of special research projects is not yet established.

Another potentially expanded role for general practitioners is greater support for informal carers, for whom family doctors might seem to be natural allies. But a recent project by the King's Fund, an independent health care think tank, suggested that such alliances were rare. Carers expressed needs for more information, for the identification of carers in general practices' information systems, and to be viewed as co-workers with their own needs for support. But general practitioners cannot be expected to take on much more work, and, even with special facilitators, the King's Fund's project found difficulties in changing practice. Although there is some information that only a general practitioner can impart, much can be done by other members of the primary health care and by mental health teams and by social workers. Well produced pamphlets, videos, and other material for carers are available but are not always easy to find.

Recommendations[2]

- The role of the general practitioner in nursing homes (excluding those contracted to the NHS) requires to be defined.
- People living in residential homes should receive community nursing, physiotherapy, occupational therapy, chiropody and other community services in the same way as for people living in their own homes.
- Residents of nursing homes should also receive these services; although a community nursing service would not usually be required, input from specialist nurses might well be necessary.
- Consider establishing a new type of professional, probably general practice based, whose prime objective would be to encourage independence and minimise deterioration of function (see Chapter 6).
- The widespread attachment of community psychiatric nurses and social workers to GP practices should be encouraged[3].
- Increase the support provided to carers and their organisations.

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CHAPTER 10

ASSESSING NEED AT THE POINT OF DISCHARGE

The NHS & Community Care Act 1990 requires all units to have in place arrangements for the safe discharge of people from hospital, and this depends on close co-operation between health boards and local authority social work departments.

Hospital discharge should be seen as a way of bringing all other actions within the hospital to a satisfactory conclusion, but appears at present to be poorly co-ordinated in some hospitals. A properly resourced early discharge scheme is one way of making sure that rehabilitation is tailored to individual needs. It also helps to ensure a smooth handover between hospital and community staff, improving working relationships in the process. It may help to avoid discharges to residential or nursing homes which, even as temporary arrangements, can lead to long term dependency[1].

On discharge from hospital some patients may need intensive support including the possibility of continuing NHS inpatient care, nursing home or residential care or where practical and possible an intensive package of support at home including supported housing. Decisions about whether to discharge patients from NHS care and on how their continuing care needs might best be met should be taken following an appropriate multi-disciplinary assessment of the patient's health, social care and housing needs in consultation with the patient's relatives/carers and involving the relevant housing agency where appropriate. In many cases this arrangement will involve referral to a consultant with specialist responsibility for continuing care along with the other specialist staff. Such consultants, working with other specialist staff, will also normally be responsible for assessing patients referred directly from the community who may require NHS continuing care[2].

Continuing NHS care, rehabilitation, nursing/residential home or domiciliary care?[2]

Ultimately the question whether or not to discharge a patient from the care of a consultant is a clinical matter. Where a consultant (or a GP working in a community hospital) considers that a patient can be discharged from the care of the NHS, the fact that he or she will not be eligible, on discharge, for benefits is not a reason for keeping a patient in hospital. Although this needs to be applied with great sensitivity, it is an important principle which should govern the approach taken by Health Board.

Taking account of the results of the assessment and the patient/carer view the consultant (or GP in some community hospitals) in consultation with the multi-disciplinary team, and in particular with nursing staff will decide whether:

1. The patient needs continuing inpatient care arranged and funded by the NHS because:

   either he or she needs ongoing and regular specialist clinical supervision on account of; the complexity, nature or intensity of his or her health needs, i.e. medical, nursing and other clinical needs taken together; or the need for frequent not easily predictable clinical interventions; or where he or she requires routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or where he or she has a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.

   or after acute treatment or inpatient palliative care in hospital or hospice his or her prognosis is such that he or she is likely to die in the very near future and discharge from NHS care would be inappropriate, including supported housing.

2. The patient needs a period of rehabilitation or recovery arranged by the NHS to prevent discharge arrangements breaking down;

3. The patient can be appropriately discharged from NHS inpatient care, (in which case) social work authorities will co-ordinate an assessment of needs which will determine whether the person should be offered:

   * either a place in a nursing home or residential care home arranged and funded by the social work authority and/or by the patient and his or her family (paragraph 26 refers);

   * or a package of social and health care support to allow the patient to return to his or her own home or to alternatively arranged accommodation.

Health purchasers should ensure that hospitals have in place mechanisms for routinely monitoring rates and causes of re-admission (in particular amongst older people) and the outcomes of hospital discharge. Monitoring should be shared with housing and social work partners and performance should also be reviewed through clinical audit. Local policies should include explicit protocols and eligibility criteria for rehabilitation. Health Boards should agree with the relevant local authorities the need for any additional housing, social or educational support which may be required as part of an agreed package of rehabilitation.

Research over nearly thirty years clearly demonstrates the inadequacies of discharge practice, particularly for vulnerable groups such as the elderly. These guidelines and research findings have led to a move towards more formalised and structured discharge planning, with many hospitals and Trusts developing their own guidelines for routine use by staff [3]. A useful diagramatic representation of the process of discharge planning, of the responsibilities of the main groups of staff and also a checklist of items to be taken into consideration in discharge planning has been published[4]. Discharge planning is now being actively developed in many but not all wards; however application of the guidelines and principles which have been developed is often limited.

Research data stresses the need for a multidisciplinary approach, improved communication between community and hospital staff, accurate assessment and recording of patients social circumstances and functional ability, and involvement of patients and carers. The importance of a designated co-ordinator to oversee and check all discharge arrangements is also emphasised. However research also indicates that all too often in practice this is not the case.

Problems with discharge procedures[1]

In a study of discharge procedures of hip fracture patients in nine hospitals by the Audit Commission[1], patient records were examined for evidence of discharge planning. The results were poor at all hospitals. Patients' views of discharge were often negative. Many said they were given conflicting information, and carers were critical of the lack of planning and consultation. Written information for patients was rarely, and even when available was usually not routinely, provided. Factors which contributed to this poor performance included:

- lack of awareness of the hospital discharge policy. Ward sisters were often unable to provide a copy of the policy, or to give a clear description of its contents.

- few formal planning meetings. Multi-disciplinary meetings may only take place during ward rounds, which are often inconvenient for staff based elsewhere, such as social workers or therapists. Some wards do not have meetings at all.

- a lack of training for nurses and social workers. Most hospitals rely on cascade training for nurses, with little or no direct training. Although most social workers received some training when community care responsibilities were introduced, many said the focus was on how to complete forms.

- poor monitoring of discharge, with unclear responsibilities and poor information. Re-admissions are rarely monitored.

All hospitals visited had policies, but staff rarely referred to them. In some hospitals, social workers were unfamiliar with the standards and triggers for referral to social services. Social workers did not routinely attend ward round meetings at any of the hospitals visited during the study, although most did attend multidisciplinary meetings on elderly care wards. All too often no-one was responsible for coordination, resulting in fragmented and disjointed care with adverse effects on the outcome for patients.

Discharge liaison nurses often provide a link between hospital and community, attending discharge planning meetings and getting to know the needs of individual patients. However, this role can introduce its own problems. **A single discharge liaison nurse may be unable to cover a whole hospital effectively;** in one study hospital the discharge liaison nurse works mainly on elderly care wards, and only visits the orthopaedic wards if invited. **The presence of a discharge liaison nurse may mean that ward nurses do not take responsibility for discharge planning and fail to learn about local services. A more useful role for liaison nurses would be to establish frameworks for liaison between services and help ward and community staff to develop their own arrangements.**

Patients do not feel sufficiently involved in decisions about their care; they do not know what decisions had been taken, or why, in relation to key issues such as rehabilitation, discharge and support at home. The involvement of patients and their carers and relatives is crucial if they are to return home safely and successfully.

Communication with the Primary Care Team[4]

At the time of discharge, good communication with the primary care team is essential in providing continuing of care to the patient and support and reassurance to the carer. However, in some cases letters take over a week to arrive, and as the patient is given only seven days' drugs on discharge confusion about medication may result. It is recommended that on discharge the immediate discharge letter, **fully completed**, and the discharge checklist, should either be given to the patient for delivery hand, faxed, or posted immediately to the GP. In complicated cases, the GP should be telephoned before the patient's discharge. The **full discharge letter** should be sent or faxed to the GP within ten working days of discharge.

If community nurses are to be involved in follow-up, contact should be made with the district nurse or health visitor before discharge and any on-going treatment discussed. Community nurses should be provided with copies of discharge plans where relevant. Where district liaison charge nurses are available, they can make a valuable contribution at this stage.

Social work provision[4]

Social workers involved in assessment are faced with the dilemma caused by an increasing turnover in NHS beds accompanied by an obligation to ensure that patients' preferences are taken in to account in finding placements. This can result in patients blocking beds even although suitable residential places are available. Earlier referrals to social work would enable the assessment to be undertaken well before the patient is due to be discharged, and would increase the possibility of an acceptable place becoming available. It is likely that hospital-based social workers provide a more efficient service to inpatients than their community-based colleagues.

Delays in discharge may arise in some areas from inadequacies in the provision of home helps, the lack of places in residential or nursing homes supplemented by local authorities, and complicated financial assessments.

The lack of residential and nursing home places has financial implications: the relative costs of residential care per week in June 1993 were: local authority home, £232; private residential home, £189; voluntary home, £167 compared with up to £1,750 for a week in an NHS acute bed. The cost of an extra day in hospital ranges from "250 per day in a large acute teaching hospital to £85 in a geriatric assessment unit.

Delays, inadequate provision of support, or an unsatisfactory environment for the discharged patient also result from the lack of day centres and lunch clubs in some places, and inadequate funding for aids and appliances. In some areas discharges are delayed by a lack of adequate numbers of day hospital places in the specialties of medicine and psychiatry of old age, or by difficulties with transport.

Medication[5]

Adverse drug reactions may cause up to 10% of hospitalisations among elderly people and can contribute to severe cognitive impairment. Such reactions may result from unnecessary or over-medication; medication continued for prolonged periods without reassessment of need; serious complications or side effects (e.g. anaemia); or lack of compliance.

Elderly patients are often taking several drugs on prescription, but compliance tends to be poor. People sometimes take a drug or drugs for several months or even years without reappraisal of the need for them. For these reasons patients admitted to a geriatric unit have their medication closely scrutinised and often revised. It is obviously essential that the general practitioner should be made aware of any changes if the patient is to benefit. However, five to ten days after discharge from a geriatric assessment unit 27% of patients in one local study were found to have had no new prescription issued, and of these for whom prescriptions have been dispensed since discharge there were changes in 24% (11% addictions, 13% omissions); most of these 'changes' were probably the result of the old prescriptions being issued through the 'repeat prescription' procedure. Contrary to hospital advice, 47% of medications were issued in childproof containers.

Recommendations[1,4]

Professionals and managers should work together to develop a formal multidisciplinary team approach, with clear lines of communication and joint goals for patients. A named individual (probably a primary nurse) should take overall responsibility for planning and reviewing the progress of each individual from day to day, keeping them and their carers fully informed of developments at all stages[1].

No single model is likely to be successful and each hospital must develop its own method of working, perhaps with regular team meetings. The main point is that there should be a recognition that some formal arrangement is required and that it is made to work. A successful system is likely to include the following:

- someone to take overall responsibility, supported by appropriate tools to help coordination proceed smoothly.

- identification of people who are likely to need help after discharge, and the type and extent of help they are likely to need. People living on their own with limited mobility or with some confusion can be identified if the assessment process is effective. Such information needs to be recorded clearly on the notes and even included in some form of monitoring system, so that all are aware of a likely need for future action.

- early specification of a likely target date for discharge, and involvement of all who need to plan care after discharge. Once such a date has been specified, it should be recorded in the notes and those responsible for organising post-discharge care alerted.

- full assessment as the target date approaches (including home visits where appropriate) and planning of support during and after discharge.

- organisation of the support required, ensuring that patients and their relatives are fully involved throughout the process.

- monitoring patients' progress towards discharge and the causes for delays, and subsequent monitoring to ensure that discharge is effective.

- training to ensure that all the professionals involved know the procedures and how to apply them, joint training between health and social services staff being preferable.

For care to be effective, each element must be provided as part of a co-ordinated package supervised by a named person and with clear lines of communication. Purchasers could take a lead by specifying contracts for care by condition. Following this plan does not mean involving the whole multidisciplinary team in the care of each patient. If a patient has less complex needs, the assessment and care planning process will be relatively straightforward. Full multidisciplinary care and treatment should be reserved for those with the most complex needs. However, to ensure that no one falls through the net, everyone should receive a comprehensive assessment.

- Adopt discharge planning procedures recommended by The Working Group on Acute Beds and the Elderly (Discharge Planning)[4].

- Appoint a key-person in each ward or specialty to co-ordinate and oversee discharge arrangements.

- Draw up and agree guidelines with ward staff to ensure uniformity of handling discharge documentation.

- Standardised and validated instruments should be used to ensure that information is accurate.

- Ensure that patients and carers are involved to a satisfactory level and do not feel inhibited discussions should be conducted in a private and non threatening way.

- Surveys should be conducted at intervals to establish how well wards staff understand and put into effect discharge planning policy.

- Ensure that patients receive their correct medication after discharge from hospital by sending a discharge summary to the general practitioner by first class post on the day of discharge, by a general practitioner visit within 5 days of discharge and by issuing child-proof containers only when the patient can cope with these.

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CHAPTER 11

MEDICATION IN ELDERLY PEOPLE

Extracted from DRUG THERAPY[1] by Rochon P A, Gurwitz J H, Lancet 1995; 346; 32-36 and other sources [2,3,4]

Because elderly people often need a number of different drugs they are more prone to interactions and side effects. Also poor memory may lead to missing doses or taking multiple doses, possibly leading to overdose. Up to 10% of hospital admissions in elderly people are due to drug side effects; and these may contribute to severe and avoidable cognitive impairment in those who are not admitted to hospital[2].

Older people take about three times as many prescription medications as younger individuals do, mainly because of their increased prevalence of chronic medical conditions. However, taking several drugs together substantially increases the risk of drug interactions, unwanted effects, and adverse reactions. For some drugs, an increase in the volume of distribution (e.g. diazepam) or a reduction in drug clearance (e.g. digoxin) may lead to higher plasma concentrations in older than in younger patients, and pharmacodynamic changes with ageing may result in an increased sensitivity to the effects of certain drugs (e.g. opioids). People sometimes take a drug or drugs for several months or even years without reappraisal of need. For these reasons patients admitted to a geriatric unit should have their medication closely scrutinised and often revised.

In 1990, a US consensus panel of experts in geriatric medicine, geriatric psychiatry, and pharmacology developed a list of medications considered inappropriate for older patients, either because they are ineffective or because they pose a high risk of adverse effects. The list included long-elimination half-life benzodiazepines (e.g. diazepam), oral hypoglycaemics (e.g. chlorpropamide),antidepressants with strong anticholinergic properties (e.g. amitriptyline), and dementia treatments (e.g. cyclandelate). It was estimated that in the late 1980s almost one-quarter of old people in the community in the US were taking at least one drug from this list of contraindicated medications. Further guidelines for medications considered "appropriate" generally but which are prescribed for the wrong indications, in the wrong dosages, or for too long or too short a time (e.g. for hypnotics, analgesics, acid-peptic disease treatments, and antibiotics) were advocated.

Adverse Drug Effects

Avoidable adverse drug effects are the most serious consequences of inappropriate drug prescribing in the elderly. In addition, misinterpretation of an adverse reaction as another medical condition may lead to the prescription of additional medications with their own potential to cause side-effects. For example, a patient started on a high potency antipsychotic medication such as haloperidol may develop extrapyramidal side-effects. These may be misdiagnosed as a new medical condition (Parkinson's disease) so that the patient is inappropriately put on antiparkinsonian medication. He or she is also now susceptible to the adverse effects of the new tablets. Similar examples include prescribing antihypertensive therapy for raised blood pressure resulting from NSAID therapy, and chronic laxative use to counteract reduced gut motility resulting from the use of anticholinergenic antidepressants.

Reviewing Medication

Periodic evaluation of the drugs a patient is taking should be an essential component of the medical care of elderly people. This may indicate the need for changes - discontinuation of a therapy prescribed for an indication that no longer exists, substitution of a required therapy with a potentially safer agent, or reduction in dosage of a drug that the patient still needs to take, or an increase in dose or even addition of a new medication. Information in medical records or provided by the patient will often be inaccurate or incomplete and the physician may have to ask patients to display all the bottles of pills that they are using. Over-the-counter products that the patient may not consider the domain of the physician should be included, as should skin products, vitamins, and all ophthalmic preparations.

Benefits of discontinuing medication

Epidemiological studies have demonstrated associations between the use of chronic antipsychotic therapy, used for example to address behaviour problems in patients with dementia, and major morbidity such as falls and hip fractures.

Avorn et al examined the effects of a comprehensive educational outreach programme, directed at physicians, nurses, and nurses' aides, on the use of antipsychotics in the long-term care setting. The intervention emphasised the benefits of a trial of gradual withdrawal of antipsychotic medications from non-psychotic patients receiving them and the use of non-pharmacological means of handling behavioural issues. In facilities receiving the programme about twice as many patients on antipsychotic drugs had them discontinued, and this reduction in medication use was associated with some improvement in cognitive function and functional ability.

Similarly Ray et al reported that when staff were educated on the appropriate use of antipsychotic medications their use fell substantially without an increase in other psychoactive medications, the use of restraints, or reports of behavioural problems.

One of the main objectives of the US federal regulations for nursing homes implemented in 1990 was to reduce inappropriate use of antipsychotic drugs. The indication for treatment now has to be documented, non-pharmacological approaches must be tried first, and a record of gradual reduction of therapy has to be on file after six months of treatment. As a result, antipsychotic drug use in nursing homes decreased by 27% with no compensatory increase in use of other psychoactive medications.

Improving safety through therapeutic substitution

Often when drug therapy is vital to the patient a safer alternative to the current regimen is available. For example, if a patient is taking a long elimination half-life benzodiazepine such as diazepam and continued therapy is required, a shorter half-life agent may be preferable (e.g. oxazepam).

Tricyclic antidepressants are used for a variety of indications in elderly patients from depression to the relief of chronic pain. The tertiary amine antidepressants (e.g. amitriptyline) tend to have especially strong anticholinergic properties with the

potential for side-effects including confusion, constipation, urinary retention, and dry mouth. When a patient is experiencing such effects and a tricycic is required, a secondary amine antidepressant (e.g. desipramine) which produces less severe anticholinergic effects may be safer.

Reducing dose to reduce risk

The risk of adverse effects of NSAIDs, even at lower doses, means that non-pharmacological approaches should always be considered first and continued along with pharmacological therapies. For example, when a weight-bearing joint is affected by osteoarthritis, weight loss, a planned exercise programme, and walking aids may provide relief. Otherwise give the lowest dose required to achieve the desired therapeutic effect.

Educating elderly people[3]

Elderly people requiring medication should be reassured of what is normal with increasing age (e.g. that eight hours of sleep and a bowel movement every day is not mandatory). An explanation of possible side effects due to medication is essential. Taking this extra time talking to the elderly patient will increase compliance and this discussion will ascertain more definitively if the drug in question is really necessary.

Patients should be encouraged to think before they ask the doctor for a prescription, or the chemist for a medicine.

* There is not a pill for every ill.
* Every pill incurs a risk and the possibility of side effects.
* The benefits may not outweigh the side effects.
* There may be a risk of interaction with alcohol.

Doctors should take time to discuss these issues with patients where the indications for a drug are not absolute. The patients and/or carer should be active participants in establishing the therapeutic regime.

Educating health care professionals[3]

All health care professionals in direct contact with elderly people, including the district nurse, should review their patients' medication regularly. Asking oneself the question, 'is this drug really necessary' on every visit is helpful.

Encouragement should be given to the practice now usual in geriatric assessment units of critical appraisal of all medications on each admission of an elderly patient to hospital with a view to discontinuing or reducing the dosage of drugs wherever appropriate.

Compliance is often poor, and many strategies have been suggested to improve compliance. These include simplifying medication regimens, providing written and

verbal information, and more appropriate packaging of drugs. Self medication in hospital has also been suggested as a way of improving compliance on discharge[4].

When general practitioners are surveyed they describe high levels of demand, but objective evidence consistently suggests that doctors overestimate patients' expectations. Reanalysis of published data shows that about a fifth of patients leave general practice consultations with prescriptions they did not expect. If doctors' perceptions do not correspond with patients' preferences poor or inappropriate prescribing, wastage of drugs, and unsatisfactory doctor-patient relationships may result[5].

Examples of medications which are often overprescribed in elderly people[3]

Diuretics
Non-steroidal anti-inflammatory drugs (NSAIDS)
Hypnotics and anxiolytics
Antidepressants
Laxatives
Antibiotics
Beta-blockers
Analgesics
Peripheral Vasodilators
Omeprazole (usually could be replaced with cheaper alternatives such as cimetidine or nizatidine).

Minimising adverse drug reactions (ADRs) and interactions[2]

ADRs in elderly people may be minimised by adopting the following simple prescribing practices:

- seek a precise diagnosis and avoid giving a drug for each symptom;
- keep drug regimes simple, avoiding polypharmacy wherever possible;
- know a few drugs well; develop a practice formulary;
- know when a reduced dose is indicated because of age related changes;
- review the need for chronic therapy e.g. inappropriate dosage or duration of treatment using antidepressants;
- take tme to explain the treatment.

Recommendations[1,2,3,]

- Periodically review the medication regimen of all elderly patients.
- Discontinue medications when there is no ongoing need for treatment.
- Consider adverse drug effects as a potential cause for any new symptoms or signs.

- Always consider non-pharmacological approaches first.
- Select carefully within a drug class to reduce the risk of adverse effects.
- Use the lowest feasible dose to achieve the desired therapeutic effect.
- Advanced patient age, in and of itself, should never be considered a contraindication to potentially beneficial drug therapy (e.g. thrombolytic therapy for acute myocardial infarction.
- There should be a partnership between physician and patient in therapeutic decision making.

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CHAPTER 12

ECONOMIC ISSUES

PROJECTIONS OF PUBLIC EXPENDITURE ON HEALTH AND SOCIAL SERVICES FOR ELDERLY PEOPLE IN 1989 TO 2006 (TABLE 10)

Demand for Care

(i) Taking account of demographic change alone

Over the 17 year period 1989-2006, total expenditure on health and social services for elderly people would need to grow by 12 per cent (0.7% per year) to keep up with solely demographic pressures, on the basis that age, utilisation of services and unit costs remain constant. Over the whole period, the rate of growth would need to be fastest for PSS (including publicly funded nursing home and residential care) at about 1.1% a year; less for hospital and community health care at about 0.6% a year; and slowest for family health services at around 0.3% a year.

(ii) Taking account of trends in service utilisation as well as demographic change

Bebbington suggests that although the at birth expectation of life without disability changed little between 1976 and 1985, amongst elderly people there was a significant improvement. Lower levels of age-specific disability among elderly people should mean lower age-specific demand for long term care, such as long-stay hospital, nursing home and residential care. However, the effect on acute health care and rehabilitation services is less clear: if lower age-specific disability is achieved through improved health care, it could imply higher age-specific demand for acute rehabilitation services, but if it results from other factors, such as improved living standards, lower age-specific demand for these services would be expected.

Change in the proportion of elderly people living alone will also affect demand, as this group tends to be more reliant on the statutory services than those living with others. The proportion of elderly people living alone increased from 22% in 1962 to 37% in 1988, and some further increase can be expected, though probably at a slower rate. The age-specific utilisation of services may also be influenced by advances in medical technology. For example, improvements in surgical techniques may increasingly allow successful operations to be carried out, even on patients of very advanced age.

If changes over the 1980s in age-specific service utilisation rates are projected forwards and incorporated in the pure demographic effects, with unit costs rising at the same rate (relative to inflation) as in the past again assumed, total expenditure would increase by nearly 22 per cent between 1989/90 and 2006, an average annual increase of 1.2%. This is almost double the growth rate resulting from demographic change alone. Both personal social services and family health services would grow at a rate of 2.7% a year, but the growth rate of hospital and community health service expenditure would be zero, mainly reflecting the lower utilisation of long-stay hospital care.

(iii) Taking account of real costs as well as changes in demography and service utilisation

If the assumption of constant real unit costs is relaxed by assuming that the costs of labour and other inputs used in the provision of health and social services continue to rise at the same rate, relative to general inflation, as in the past the impact of all three factors can be considered. On this basis total expenditure on health and social services for elderly people would increase at around 3% a year in real terms: 1.9% for hospital and community health services, 5.8% for family health services and by 3.6% for personal social services and nursing/residential home care.

Supply of care (see also Chapter 2)

The 1985 General Household Survey found that there were around six million carers in Great Britain, of whom 3.4 million carried the main caring responsibility and 1.4 million devoted at least 20 hours a week to caring. Substantially more household care is provided by informal carers than by formal community health and personal social services. People involved in substantial levels of caring activity are often quite elderly themselves and are most likely to be caring for relatives in the same household.

The number of people in the 45-64 age band, which is the peak age for providing informal care, is expected to increase by 22 per cent between 1987 and 2006. This is a bigger increase than for the population aged 65+, or even the population aged 75+. Moreover, a higher proportion of elderly people is expected to have a surviving spouse and to have at least one child. For example, it has been estimated that the proportion of women aged 75+ having one or more living children will increase from 75% in 1986-1991 to 82% in 2001-06.

Table 10
Projections of health and social services expenditure on elderly people allowing for demographic, service-utilisation and unit cost trends: 1989/90 to 2006 (England)

Trend	Hospital & community health services	Family health services	Personal social services and nursing home and residential care	All services
	(£)	(£)	(£)	(£)
Demographic	0.6	0.3	1.1	0.7
Demographic and service utilisation	0.0	2.7	2.7	1.2
Demographic and service utilisation and unit cost	1.9	5.8	3.6	3.0

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CHAPTER 13

EXAMPLES OF GOOD PRACTICE IN SCOTLAND

I Surveillance of elderly people in a general practice in Glasgow (Dr Ken O'Neill and Sister Isaacs, Midlock Medical Centre, G51 1SL)

For almost 10 years a structured programme of health surveillance has been conducted in a general practice (5,200 patients: 360 aged 75-84 years and 166 aged 85 years and over) in a deprived part of South Glasgow. Each person aged 75 years and over is visited at home - those aged between 75 and 84 years by a practice nurse (who is employed about half time in the practice exclusively for this work) and those aged 85 years and over by the Health Visitor (who spends about 25% of her full time commitment to the practice in the care of elderly people). Almost all patients agree to be visited, and during a 60 to 90 minute conversation the patients 'open up' to the nurse and discuss issues which they feel unable or inappropriate to raise with the doctor. During the time spent with the patient an assessment checklist is completed, including a mini mental state questionnaire; blood pressure is checked, and samples (of urine and, where it is felt appropriate, blood) taken for analysis. Particular attention is paid to identifying possible side effects of medication and problems with compliance. Referrals are made directly for example to the general practitioner, continence adviser, keyworker for people with dementia, chiropodist, home care organiser, occupational therapist, befriending scheme and housing department; referrals through the general practitioner are made to hospital out patient departments, particularly the hearing aid clinic, diabetic clinic and department of urology. Return visits are made to syringe ears, provide influenza vaccination and for follow up purposes.

Records are kept of all interventions and referrals and of their outcome and these are analysed to provide aggregate data for an annual report. The programme ensures that almost all elderly people in the practice are screened in a relaxed atmosphere at home once per year, that remediable problems are identified and effective action taken.

II) Edinburgh Crisis Care (Lothian Health Board/Social Work Department)

Crisis care is a short term crisis intervention service to people living in the Edinburgh area who are over the age of 16 years, and

- who otherwise might have to be admitted as an emergency to hospital or residential care, or

- whose ability to cope is affected by sudden illness, or whose discharge from hospital presents particular difficulties, or there are unforeseen changes in their circumstances, such as the normal carer becoming ill or being admitted to hospital. Currently, Crisis Care has no remit to work with people with HIV/AIDS.

It is based at the Royal Infirmary of Edinburgh, and the team consists of one co-ordinator and five full time crisis care workers, accessible 24 hours per day. It complements existing service such as home help and community nursing in time of crisis. The service is provided for a maximum of 2 weeks in any one period. A

maximum of 3 nights overnight service may be given. It offers personal care: toileting, washing, dressing, assisting with bed/toilet/chair transfers, bathing, lifting, incontinence management, stoma care and catheter management, supervision of medication, dietary needs.

(III) Comprehensive home care for frail elderly people in Glasgow (Greater Glasgow Health Board/Social Work Department)

Pilot schemes providing comprehensive home care for frail elderly people are being introduced in four areas of Glasgow. These are being evaluated by a team from Greater Glasgow Health Board and Strathclyde Regional Council Social Work Department and the results will be used to inform decisions on the further development of the schemes in Glasgow. Clients will be referred to the schemes from March 1996 and the evaluation will last for at least 12 months from that date.

Operation of the schemes

Each project will have a project leader from the Social Work Department, employed and sessional home care workers from the Social Work Department and community nurses. The home care worker role is a new post and staff have a remit to carry out personal care tasks, extended home care tasks and practical tasks. All project staff will be geographically based in one central location. In addition to the project staff, each scheme will have attached occupational therapy, physiotherapy and chiropody staff. They have been resourced to allow access to additional sitter services, day care and respite care.

Referrals

Criteria for referral will be kept fairly unstructured initially and largely at the discretion of the consultant or GP caring for the patient, following a number of guidelines:

- in the absence of comprehensive home care, admission to some sort of institutional care is a likely outcome for the elderly person;
- it is unlikely that the scheme will be suitable for elderly people with severe dementia who live alone;
- the GP agrees that the elderly person is suitable for comprehensive home care;
- the elderly person's medical needs could be met in the community;
- the elderly person's housing conditions are conducive to receiving comprehensive home care;
- the elderly person and his/her carer (if appropriate) agree to receiving support from the project.

Evaluation

The evaluation will address the following questions:

1. What is the impact on the user's health and well-being?
2. What is the impact on informal carers?
3. What is the impact on the primary care team?
4. What happens to the users in terms of residential admissions?
5. Is this service acceptable to users, carers and staff?

6. What are the costs incurred to all groups?
7. Is it feasible to establish this level of inter-agency working in Glasgow?
8. Who are the appropriate group(s) of elderly people to refer to this service?

The main methods being used in the evaluation are (i) a descriptive study of the pilot schemes, (ii) a full costing study, (iii) monitoring the health status, well being and morale of all consenting users and carers who are included in the pilot schemes and (iv) comparing the costs and outcomes with groups of similar people admitted to residential or nursing homes, for whom comprehensive home care was not an option available. The latter will include a before and after comparison and a comparison with people resident in areas of the city where comprehensive home care is not provided.

The evaluation will use standardised instruments to assess health status, well being and morale and face to face interviews to assess user, carer and staff acceptability. Case notes will be reviewed to obtain information on any residential admissions. A daily diary of activity has been developed and this will be kept in each user's home. All staff will be asked to complete an entry whenever they go into the home. The purpose of the diary is to monitor activity, for costing purposes and as a means of communicating with other staff and informal carers.

(IV) Augmented Care at Home (Ayrshire and Arran Health Board/Social Work Department)

Augmented Care at Home is a partnership project between Ayrshire and Arran Health Board and Strathclyde Regional Council Social Work Department, established through the joint planning mechanism. The pilot was set up for two years with funding from Ayrshire and Arran Health Board through resource transfer. The pilot projects were established to provide "intensive and flexible home care services, with primary focus on physically frail older people who would otherwise be in continuing care beds in hospital. The aims and objectives were to be implemented by two Augmented Care at Home teams who were to "provide a range of personal, practical, emotional, social and health care support following assessment.

Home care support workers are a new type of hybrid worker who combine the functions of community nursing assistant and home help. Home care support workers undergo a two week induction training provided by the college of nursing and midwifery.

All referrals to Augmented Care at Home are made through consultants in geriatric medicine. A potential user of Augmented Care at Home may be referred either from a hospital or community setting. If the patient is in hospital (continuing care or acute) the consultant geriatrician will assess the patient in hospital. Offer the option of Augmented Care at home and my have a preliminary discussion with the user and any family. If the patient is living in the community the general practitioner may refer the patient to the geriatrician who will make a domiciliary visit to assess if necessary.

The care needs of users of the Augmented Care at Home are assessed by the Home Care Support Organiser who visits the potential users as soon as possible, whether that be in home or in hospital, to ascertain their wishes and needs. The Home Care Support Organiser liaises with as many as possible of those involved in

the care of the person involved in order to build up an assessment of his or her social needs.

An important part of the organisation of care for an individual by the home care support organiser is matching the user's needs to the individual home care support workers who will provide that care. Establishing a care plan is a process of negotiation with the user. There are formal reviews of the care plan and, in addition, the assessment of need is an ongoing process and care plan are adjusted accordingly.

Flexible care is provided during the evening, at weekends and at night, if required. Users report high levels of satisfaction in being able to exercise their choice to be at home. Carers and other professionals involved with the care of these users consider that the well-being of users is being promoted by the service because users feel secure and have company as well as care. Communication with community nurses and other agencies is reported to be good and other professionals were satisfied with the skills and roles of the home care support workers.

(V) The clinical, social and economic outcomes of a community based service for urinary incontinence (Greater Glasgow Health Board)

Urinary continence is a problem which has a major effect on quality of life, often leading to social isolation and inducing much stress in both sufferers and carers. In a recent MORI poll, 6.6% of 1883 men and 14.0% of 2124 women interviewed in their homes throughout Great Britain reported some degree of involuntary or inappropriate loss of urine. In the three age groups 30-49 years, 50-59 years and 60 years and over, the rates for men were 2.0%; 5.4% and 13.3% whereas for women they were 10.9%; 15.4% and 16.8%.

Management of the condition is sometimes inappropriate, with lack of investigation of the cause and the prescription of incontinence aids rather than referral for more detailed investigation and treatment. Failure to seek help is also a problem either through lack of awareness of the services available or embarrassment.

The open access Continence Resource Centre at the Southern General Hospital has proved a successful innovation. This service offers advice, simple screening and management, and is based on self-referral. In 1994, the centre had 270 new referrals for assessment, of whom 202 (75%) were resident within Glasgow. Also, the information service at the resource centre has been utilised by NHS and non-NHS staff and carers from within Glasgow and beyond.

A study with a Glasgow nursing home population of more active management and more appropriate use of produces resulted in improved levels of continence for a number of patients and savings in use of supplies (O'Neill, personal communication). Translated to the city, savings of over £100,000 per annum in supplies to nursing homes could be realised. In addition, a proactive community approach would aim to improve the continence service for individuals living at home, which at the same time would make more effective use of resources.

GGHB made available funding for a community continence nurse in each of five of the 11 localities within the Greater Glasgow Health Board area, and a physiotherapist.

The role of the nurse is to:

a) i) assess residents in residential/nursing homes and propose future management of incontinence for them;
   ii) to work closely with staff in homes to promote continence and to improve the management of incontinence for residents;

b) provide assessment clinics in their locality for referrals with urinary incontinence;

c) act as a local information and advice resource for staff and carers in the locality.

As a result of this study, information will be obtained on: the cost effectiveness of continence nurses working in nursing and residential homes; the effect on the community nursing service of having continence support staff working in the community; whether the service results in an increase in the number of people presenting with incontinence in the community, and the clinical, social and economic benefits to people who attend community clinics held by continence support nurses.

(VI) Early supported discharge scheme for hip fracture patients, Edinburgh Royal Infirmary.

The aim of this scheme is to enable fitter hip fracture patients to be discharged directly home from acute orthopaedic care, with rehabilitation and reliable post-discharge support. A liaison occupational therapist and a liaison sister work with the orthopaedic nursing and rehabilitation staff and an early care doctor. The team promotes and monitors early rehabilitation, carries out pre-discharge assessment and home visits, liaises with community health and social services, and monitors progress after the patient has gone home. The proportion of hip fracture patients going straight home from acute care has risen, and satisfaction is high among patients, their carers, GPs and community health and social services staff. Economic evaluation has shown that the scheme has brought considerable savings by reducing lengths of stay.

(VII) The CARD Project (Co-ordination of Assessment and Resources for Dementia; Dr Ken O'Neill, Midlock Medical Centre, Glasgow G51 1SL)

Aims and Objectives

CARD is a multi-disciplinary, collaborative approach to case identification, assessment and service co-ordination for dementia sufferers and their carers. It makes service planning and provision less fragmented and more appropriate to individual needs. It is based on the development of open and effective channels of communication between Primary Care and Social Work. Duplication of assessments by professionals within the community setting often lead to fragmentation of care and confusion for the client. The need to share a common multidisciplinary assessment and to allocate the role of assessor to one individual - the Key Worker - is central to the project.

The objectives are:

- To identify and assess those individuals with dementia referred by general practitioners within the South West Sector of Glasgow.
- To perform a comprehensive needs assessment of each patient.
- To facilitate inter agency co-operation by employing a key worker to assess individuals and liaise with those responsible for resource allocation.
- To collate data which will facilitate appropriate provision of resources/services, whether existing or innovative.
- To examine the economic implications of "Care in the community".
- To monitor and evaluate the service.

Methodology

The CARD Project is based at Midlock Medical Centre which is an inner city general practice that services part of Glasgow's South West sector. During its first year, the Project only accepted referrals of patients registered with the practice. Patients with memory or cognitive impairment were identified during annual over-75 assessments which are performed by the practice nurse at home.

The Key Worker (in the home) assesses cognitive function using the Mini Mental State Exam and mood using the Geriatric Depression Score. A blood test is obtained to identify any potentially reversible causes of cognitive impairment. Once cases are identified using this screening process, a behavioural assessment is carried out using the Clifton Assessment Procedures for the Elderly. A functional assessment of need is also performed for which information is obtained from both the patient and carer. During this assessment, attitudes towards receiving help are explored and the individual's wishes and those of the carer documented. A financial assessment is carried out, and in complex cases advice is sought from local benefits advice agencies. Carers are interviewed separately using the Relative Stress Scale and a needs assessment made.

The assessment information is shared at bimonthly meetings with the general practitioner and members of the social work team; appropriate action is discussed and a package of care to meet unmet needs is planned. It is then the responsibility of the Key Worker to access and co-ordinate relevant resources. Actions taken are recorded and relayed to the referring practitioner. Patients and carers are updated regarding these meetings to ensure appropriate service provision where indicated. Advice and information is also offered to carers informally in one to one counselling sessions with the Key Worker or corporately at one of the Carer Education Courses offered by the Project.

Results

Liaison with local social work departments has led to the provision of services such as day-care, respite, home help, home support and so on. Specialist services for dementia sufferers and their carers exist within the area and several patients are now using and enjoying these services. Community mental health and nursing resources are frequently provided in response to requests made on behalf of patients. The Project has also become involved in local dementia support groups and carers are encouraged to attend.

Many alliances have been made between local (and national) voluntary and charity organisations as well as private initiatives. Likewise information regarding the Project is readily shared with interested or involved parties. Information about resources for dementia sufferers and carers is being organised into a local directory of services which will be available from the Project.

Evaluation

Benefits from the service include:

- Patients and carers with unmet needs benefit from comprehensive assessment and resource allocation, including a variety of financial benefits.
- Patient and carer involvement in needs assessment allows delivery of a package of community care tailored to individual need.
- The Key Worker assessment and service co-ordination encourages continuity of care, minimises time delays and avoids duplicate assessments.
- Information and expertise is shared amongst all professionals, clients and carers leading to holistic care of high quality.
- Development of relationships between Primary Care, Social work and Voluntary Agencies provides an effective framework for Joint Community Care.
  Aggregation of data relating to dementia in a defined general practice population provides valuable information for the assessment of needs of the client group as a whole.

Reassessment of functional status at five monthly intervals is used to assess the adequacy of service provision and reduction in carer stress and their reliability of case identification. A referral system has been devised whereby General Practitioners from other Practices within the South West sector who suspect dementia can refer patients to the Project for assessment and service co-ordination; it is expected that most patients will again be identified during their annual over-75 years health screening checks.

CHAPTER 14

SOME INNOVATIONS, TO BE EVALUATED

(1) Consultant physicians with a special interest in community geriatric medicine[1]

In this country virtually all consultant geriatricians have responsibility for hospital in-patients over the full spectrum of acute care through assessment and rehabilitation to long term care and a few have additional commitments to acute general medical receiving. Most consultants also have some community responsibilities - for example assessment for residential /nursing home care.

A new type of post, the consultant physician in community geriatric medicine, has been proposed. The physician would have full access and inpatient responsibility for hospital beds but also a range of duties in community settings. The consultant would be a full member of the hospital based department of geriatric medicine; may have responsibility for acute care of older patients in hospitals; would have responsibility for rehabilitation and continuing care in hospital and community settings; and would promote liaison with primary health care and provide a medical service to the social services department. The establishment of consultant physicians in community geriatric medicine would extend the expertise of consultants trained in geriatric medicine beyond the hospital setting to benefit the health of older people at home and improve standards of care in residential and nursing homes.

There is an increasing need for advice and support to general practitioners as they become responsible for more severely dependent older people both in residential care and their own homes but especially in nursing homes. New avenues of community involvement could include liaison clinics with GPs in health centres with Elderly Care Consultants/Geriatric Visitors and the establishment of local community teams with nursing and social services staff leading to the identification of at-risk individuals. They should also be involved in assessment as part of community care.

A summary of the possible roles and responsibilities of the Consultant Physician in Community Geriatric Medicine is provided as Annex 1 at the end of this chapter.

(2) Liaison Nurses and Gerontological Nurse Practitioners

Liaison nurses are responsible for planning the pre and post discharge care of elderly and chronically disabled people. By liaising with medical and ward nursing staff, physiotherapists, OTs, community nurses and social workers, they are able to formulate discharge plans and to arrange for the supply of services and materials in order to expedite discharge from hospital. They are also able to provide ward staff with valuable information about patients' home circumstances. At their post discharge visit, liaison nurses monitor patients' well-being and safety, medication (including compliance), and the provision and use of support services and any necessary equipment.

The liaison nurse is also able to determine the need for, and to negotiate respite admission for geriatric care; to respond rapidly to any problems; to avoid expensive readmission to hospital and potential disasters; to ensure that social, environmental

and financial needs as well as medical and nursing needs are addressed; and to contribute to the education and training of nursing, medical and paramedical staff, and social workers. Liaison nurses also carry out health promotion for both patients and carers; keep statistics and participate in audit; refer to other agencies; and provide information to patients and carers about benefits, allowances and other sources of help.

Consideration might be given to extending the role of liaison nurses to include the follow-up of discharges to residential and homes; to giving advice to these institutions; and to ensure that all elderly people in residential, nursing homes and geriatric hospital care, participate in appropriate surveillance programmes (e.g. for hearing, vision and other remedial problems).

In the USA there are more numerous and formally trained Gerontologic Nurse Practitioners (GNPs) who take on a wider range of tasks, including:

- Recognising and counselling older drivers at risk of motor vehicle accidents;
- Improving and maintaining quality standards, delivering primary care, and reducing unnecessary prescribing in nursing homes;
- Intervening in indirect self-destructive (or suicidal) behaviours amongst community-based elderly people, including non-compliance;
- Proactive screening and on-going regular health and social surveillance/support of at-risk elderly people, and visiting elderly people in home care schemes;
- Health promotion for elderly people;
- Assessing falls in elderly people.

There exists an extensive literature on the subject of GNPs ranging from studies of cost-effectiveness[2] to the improvement of long-term nursing care and discharge outcomes[3] as a result of the proactive and regular input of GNPs in nursing homes. It has been argued that a GNP in every nursing home is a necessary expenditure to ensure an adequate quality of care and quality of life[4]. Incentive payments to and accreditation of nursing homes may also be based on quality of care outcomes that are audited by GNPs[5]. Some GNP training is conducted in what are called 'teaching nursing home programs' based in accredited teaching nursing homes[6].

(3) Community Nurse Specialists for Illnesses Common in Elderly People

People with long-term disabling conditions such as stroke, multiple sclerosis, Parkinson's disease and some rarer conditions such as the ataxias have always been seriously disadvantaged by, amongst other things, a lack of expert help from professionals working in the community. The inadequacies of care in the community for elderly people with these conditions are often in sharp contrast to the quality of care provided in hospital.

As a result, disabled elderly people and their carers are often:

- unaware of sources of help, including financial benefits, location of victim support groups and voluntary organisations (e.g. Chest, Heart and Stroke Society, Parkinson's Disease Society)

- lacking essential information about the nature and aetiology of their condition, the need for certain types of medication and the side effects of these medications, for example in Parkinson's Disease

- becoming unnecessarily housebound and/or depressed, for example after suffering a stroke[7].

- at risk of becoming more dependent or deteriorating more rapidly.

There is a need, therefore, to provide more ready access in the community to professionals who have this type of expertise. One way would be to introduce specialisation into community nursing, into health visiting in particular. Community Nurse Specialists work closely with a particular hospital department and relevant voluntary organisations in order to become expert in the assessment and care of patients with a particular problem or disability (e.g. stroke or multiple sclerosis) or group of diseases (e.g. non-stroke neurological conditions). They also work with community staff to provide practical skills, support, and teaching; in some cases they arrange speedy hospital admission for patients. The aim is for specialist knowledge and attitudes to 'cascade' from hospital specialists, voluntary organisations and other experts through the specialist nurse to each community nurse who has a client with that particular condition on her caseload. Conversely, insight gained from experience working in the community is transferred to hospital staff to help them better understand the needs of the client group and, for instance, the importance of adequate discharge planning[7].

This type of nurse specialist has responsibility for all patients with a specified condition who are resident within all or part of a health authority. They assist in establishing protocols of good practice, in setting policy for patients, and they provide clinical advice. They are used as a resource not only for the other community nurses, but for social work staff and voluntary sector.

In order to provide the Community Nurse Specialist with a manageable span of responsibility it is necessary to have intermediate persons or 'co-ordinators' for each specialist activity (e.g. for stroke, Parkinson's disease, other neurological conditions and arthritis) - for example one in each health centre. This co-ordinating function could be established by encouraging each community nurse to develop a special interest in and to take responsible for people with a specific problem or condition. Co-ordinators would also have responsibility to liaise with appropriate voluntary agencies. The relationships between the specialist community nurse, the co-ordinators and the body of community nurses are illustrated in Figure 4 in Chapter 15 for the condition of stroke for which such a specialist community nursing role has already been found in the GGHB area. Job specifications for a nurse specialist in Parkinson's Disease and for a stroke care co-ordinator are given in Appendix 7.

(4) Keyworkers and the need for information

Service users often are unable to identify anyone willing to discuss their problems and put them in contact with sources of help. Key workers should be available to act as a contact point for patients requiring advice or help, to identify shortfalls in services and encourage the development of new services, and to keep clients informed of progress and likely outcomes.

One way in which these new health service professionals might relate to existing professionals and voluntary organisations with responsibility for care of elderly people is illustrated as Figure 4 in Chapter 15.

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Annex 1

Role of the Geriatrician in the community
(According to the revised document on Community Geriatrics, BGS, April 12 1994).

1. Developing procedures and practices to maximize the effectiveness of specialist geriatric care and to support general practitioners in their primary responsibilities to care for frail elderly people in the community.

2. Involvement with the local authority, general practitioner, community health service and mental health services in assessment, care management and the setting of standards.

3. Involvement in multidisciplinary assessments through local resource allocation groups, organised by the local authority.

4. Drawing up, in co-operation with the local authority and community health services within the multidisciplinary setting, hospital to community discharge plans with arrangements for post discharge liaison.

5. Use of care of the elderly hospital, (or day hospital, or enhanced health centre), facilities for more detailed assessment of elderly persons requiring care packages in the community.

6. Co-operation with local authority and district health authority to draw up admission criteria for residential and nursing homes.

7. Providing expertise in the inspection of private and voluntary residential and nursing homes.

8. Establishing, with the local authority, co-operation and co-ordination between paramedical disciplines such as physiotherapy and occupational therapy.

9. Promoting within the community and in association with the local authority the single door approach to community care, leading to co-ordinated home care provision of nursing and caring services.

10. Assisting the local authority in assessing needs of carers and helping, where appropriate, to supply these needs.

11. Health care planning and needs assessment for health and local authorities as purchasers.

12. Providing expertise to the local authority in training residential care workers in local authority residential homes and to provide advice on appropriate packages of training.

13. Establishing, with the joint registration group, a procedure to assess the level of training available for care assistants in private and voluntary residential and nursing homes, and making adequate training a condition for registration.

14. Assessing and helping to meet, with the co-operation of local authority, the training needs of care managers in the problems of elderly care. This is likely to have a major resource implication.

15. Offering advice through local contact with general practitioners on problems arising from over 75 assessments.

16. Encourage good liaison between geriatricians and general practitioners and planning joint educational initiatives.

17. Encouraging the continuing inclusion of experience in care of the elderly in vocational training for general practitioners.

18. Encouraging general practitioners in training to undertake examination in the Diploma of Geriatric Medicine.

19. Re-examining the geriatricians' in put to continuing care of elderly people. While this remains at quite a high level in some areas there is a danger in others that geriatricians become more distanced from this type of care. Local health authorities in co-operation with local social work departments should be encouraged to establish a network of overall geriatrician supervision of continuing care in the community.

CHAPTER 15

POSSIBLE SOLUTIONS

Over the 17 year period 1989-2006, total expenditure on health and social services for elderly people would need to grow by 12 per cent (0.7% per year) to keep up with solely demographic pressures. However if recent changes in age-specific service utilisation rates are projected forwards and incorporated in the pure demographic effects, with unit costs rising at the same rate (relative to inflation) as in the past, total expenditure would increase by nearly 22 per cent between 1989/90 and 2006 - an average annual increase of 1.2%. If in addition, it is assumed that the costs of labour and other inputs used in the provision of health and social services continue to rise at the same rate, relative to general inflation, as in the past, then total expenditure on health and social services for elderly people would increase at around 3% a year in real terms: 1.9% for hospital and community health services, 5.8% for family health services and by 3.6% for personal social services and nursing/residential home care.

There are only three ways of addressing this problem of continued increasing demand. The first is to make the necessary substantial increasing investment required to provide services as they exist at present for an increasing population of dependent elderly people. The second is to make little or no additional investment and to allow existing services to cope as best they can: this is the current position and will probably have seriously deleterious consequences. The third alternative is to put into effect changes which make much better use of existing resources and which should allow improvement in service delivery at no greater ongoing cost; this - obviously the preferred alternative - will, however, require significant initial investment and probably for a longer period than a single financial year. This report suggests that consideration should be given to the following changes:

Improving the assessment process for admission to nursing/residential home care and for provision of community care services

a) the assessment and placement process requires to be speeded up and - for straightforward cases - simplified.

b) clear criteria are needed for admission to nursing and residential homes, and these must be adhered to.

c) assessments require to be objective and skilled. Complex assessments - including all those for nursing and residential home care - should include assessment by a specialist geriatrician.

Making home care a viable alternative to nursing/residential home care

a) home care services require to be more fully developed to provide sufficient flexibility and choice, including night cover, 'paramedical' services, respite and transport.

b) where adequate homecare services are available, health and social work professionals should positively promote home care as a feasible and desirable option.

c) 'packages' of homecare services are much more complicated to set up than delivery of services through a nursing or residential home; social work professionals must be encouraged to spend the time required to set up and monitor such homecare packages.

d) the role of the home care assistant should be developed in order to create a workforce of multi-purpose providers, acting as a channel through which different professionals link to individual elderly people; this will have training and supervisory implications.

Improving the speed and range of provision of community services

a) simplify and speed up the procedures for assessing the need for and providing aids and appliances - for example by entrusting community nurses or occupational therapist aides with this responsibility except when the needs are complex.

b) remove the communication, administrative and budgetary barriers between community occupational therapists and other therapists (e.g. nurses, physiotherapists, chiropodists) working in the community by making occupational therapists responsible to the same authority; this would improve communication, reduce delays and would facilitate development of a common philosophy (OTs at present being responsible to social workers who often have an entirely different philosophy).

c) the skills of occupational therapists are necessary for the holistic assessment of people with complex health and social care needs. At present community occupational therapists are largely employed in making assessments for aids and appliances in relatively simple cases and this is a waste of a scarce and valuable resource.

d) encourage providers to develop a wider range of more flexible services, particularly bathing, 'tuck-in' and other home care services.

Improving hospital discharge procedures

a) adopt discharge planning procedures recommended by The Working Group on Acute Beds and the Elderly (Discharge Planning), including checklist.

b) appointed a key-person in each ward or specialty to co-ordinate and oversee discharge arrangements; draw up and agree guidelines with ward staff to ensure uniformity of handling discharge documentation.

c) conduct surveys at intervals to establish how well wards staff understand and put into effect discharge planning policy.

d) ensure that patients receive their correct medication after discharge from hospital by sending a discharge summary to the general practitioner by first

class post on the day of discharge, by a general practitioner visit within 5 days of discharge and by issuing child-proof containers only when the patient can cope with these.

Improving quality of life in (some) nursing and residential homes

a) identify a more discriminating and otherwise satisfactory process for monitoring the adequacy of care and quality of life in nursing and residential homes; consider the protocols developed by the Royal College of Physicians and British Geriatric Society (1992) for use as part of this process.

b) more clearly define the criteria for ongoing medical supervision.

c) shift the emphasis, where appropriate, from nursing to processes which encourage independence and minimise deterioration of physical, mental and social functioning; this may require input from a new type of professional.

d) ensure that residents of nursing and residential care homes have access to the services of community nurses and other health authority employed personnel in the same way as the people living at home.

e) provide acceptable levels of rehabilitation input and meaningful daytime activity in nursing and residential homes, and provide a structured rehabilitation service.

f) try to ensure a reasonable 'mix' of residents, with a spectrum of dependency levels and abilities/disabilities.

g) enable staff in nursing homes to acquire new knowledge, skills and attitudinal change.

h) the optimum configuration for nursing homes, in terms of size and layout, requires to be determined and new homes built to this (probably smaller size) specification; the trend towards institutional care outside hospital being increasingly provided by larger corporate institutions contradicts the aim of community care being in domestic settings.

i) there is a strong case for integrating the registration and inspection of residential and nursing homes.

Early identification and effective management of possibly remediable health problems which threaten independence (e.g. vision, hearing, mobility, access, continence, depression, dentition, dementia, social isolation, bereavement)

a) encourage general practitioners and other members of the primary team to identify and actively manage such problems during opportunistic (annual) 'health checks' on elderly people living at home or in residential care.

b) ensure that elderly people living in nursing homes or NHS continuing care are screened for these conditions, and appropriate action taken, as part of a multidisciplinary assessment at least twice per year.

Helping elderly people to achieve their potential in terms of physical, mental and social function

a) shift the emphasis in nursing homes from the passive provision of care to encouraging residents to do things for themselves (?and for other residents) as far as is possible.

b) ensure that residents of nursing and residential homes and that older people In other settings have adequate opportunity to engage in meaningful daytime activity.

c) establish an acceptable level for occupational therapy and physiotherapy input to nursing homes, and ensure that this is provided.

d) establish more effective assessment and rehabilitation services for elderly people living at home and in residential homes; one possibility would be to develop this as an outreach service from day hospitals.

Clarifying the role of the general practitioner

a) the responsibilities of the general practitioner in nursing homes (excluding those contracted to the NHS) require to be more clearly defined; the development of a role for other member(s) of the primary care team - for example a nurse specialist, physiotherapist or occupational therapist should be considered.

b) the general practice 75+ screening is a contractual requirement, but its effectiveness is unproven and there is no proven best approach to it. For most general practitioners the best approach may be opportunistic; patients who are not seen opportunistically during a year should either be invited to attend the doctors surgery or be offered a home visit by the general practitioner or other trained member of the primary health care team within their home. Some general practitioners however find that there are very real benefits in all their elderly patients being visited at home by the practice nurse or health visitor, and an example of good practice which has worked well for several years is given in Chapter 13, example I.

c) general practitioners should have access to specialist help for the care and support of patients whose management is often difficult and time consuming; examples would include specialist nurses for stroke, Parkinson's disease and continence problems.

d) a standard form listing areas of assessment for those over 75 years of age should be developed and completed annually and a method for collecting this data for planning services should be established.

Reducing over-medication

a) professionals should take time to explain the action of drugs and possible side effects; and older people discouraged from expecting a medicine for every ailment.

b) medication should be kept to the minimum required to maintain the necessary effect; critical appraisal of all medications should be made on each admission of an elderly person to hospital and say at least 6-monthly intervals during long-term NHS, nursing or residential home care.

c) the development of hospital and general practice prescribing formularies should be continued and adherence to these encouraged; departments of geriatric medicine should be involved in this process.

d) ways of 'supervising' the medication of elderly people at home, particularly of those living alone, should be explored.

e) it is important to ensure that general practitioners are promptly made aware of advice about medication given to patients whilst in hospital.

Reducing waiting times for operations necessary to maintain independence, e.g. for cataracts and hip replacement

These waiting times are monitored by each health authority; where they are excessive appropriate action is clearly needed.

Providing adequate practical support and respite for carers

a) provide more practical help for carers - e.g. respite for short periods each weeks and for occasional longer breaks.

b) ensure ready access to information and advice about possible sources of support.

Provision of information, involvement in decision making and choice

a) shift the emphasis from collection of information to dissemination.

b) ensure that older people and their carers are informed fully of their options and their rights in choosing the care that they are to receive.

c) offer advice about benefits and other forms of support to all those who may be eligible.

d) provide information and advice for patients with long-term medical conditions which are difficult to manage.

Improving communication and coordination

a) improve communication networks between all agencies concerned with the care of the elderly.

b) ways of promoting greater collaboration between health and social services are needed. One possibility would be to align social work and primary health care teams (i.e., groups of general practitioners) at a locality level. Localised initiatives should be evaluated and the results widely disseminated.

c) medical, nursing and other health and social service professionals, based both in hospitals and the community, should familiarise themselves with relevant voluntary organisations so that they are in a position to recommend them to patients.

d) a named contact in social services for each practice and social workers becoming members of the primary health care team are possible ways of achieving greater collaboration. Joint education and training and the secondment of social workers and members of primary health care teams to each others' departments for short periods of time, would help in the understanding of each other's culture.

Conduct pilot evaluations of innovative services, for example

a) make maximum use of published work, audit activity and evaluations - both local and those conducted elsewhere in Scotland.

b) provision of additional sessions in geriatric medicine to allow for one or two consultants to take on as part of their commitment the responsibilities of consultant physicians in community geriatric medicine, including the development of a more cohesive community geriatric service.

c) the development of community assessment and rehabilitation teams as a geriatric day hospital outreach facility.

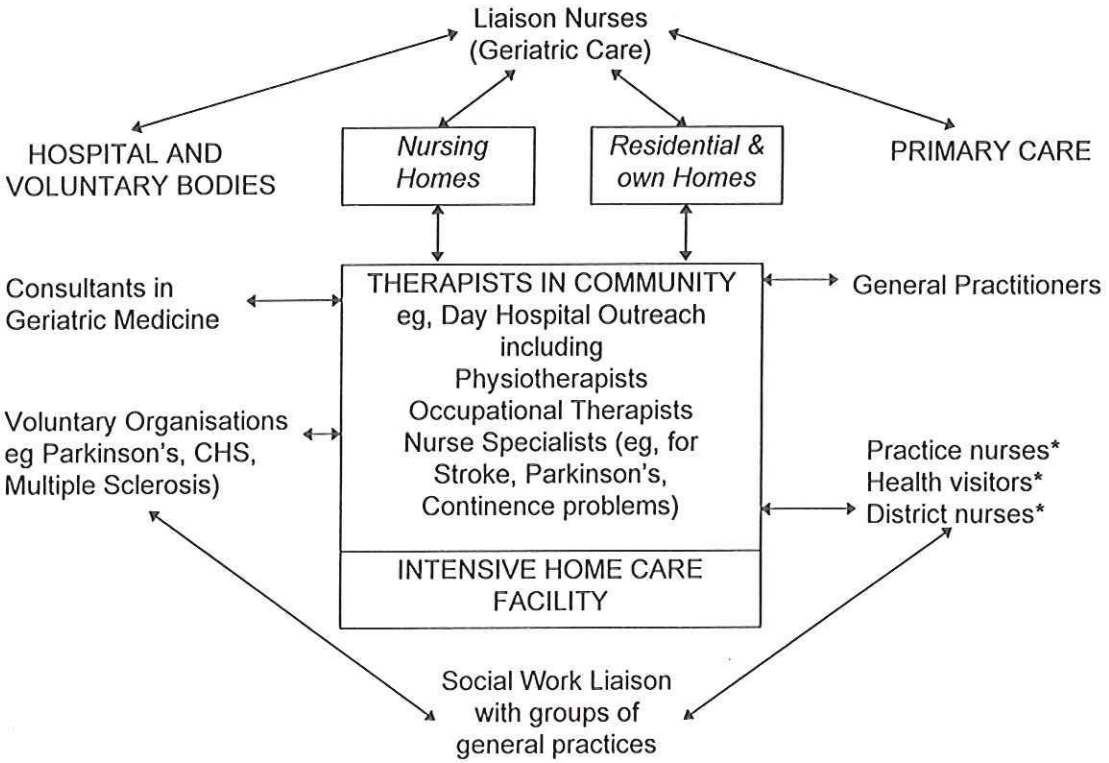
d) appointment of gerontological nurse specialists, for example from the existing workforce of community nurses.

e) development of a cadre of community care specialists for a variety of specific conditions (such as stroke, incontinence and Parkinson's disease) who would be responsible for training and supporting practice nurses, community nurses and other members of the primary care team who have direct responsibility for patients with these conditions. These posts could be established from the health visitor workforce.

f) appointment of local coordinators for the care of people with these specific disabling conditions: This coordination could be a part time (say one session per week) responsibility of community nurses - each nurse for example having special responsibility for one particular condition; this would require no additional funding.

g) intensive home care as a means of expediting hospital discharge and possibly preventing the need for hospitalisation.

Figure 4
Suggested interprofessional relationships and responsibilities



*encourage these to develop special interests/resposibilities, eg in stroke, multiple sclerosis, Parkinson's disease, continence problems

Possible organisational framework for a geriatric service

For many of the above suggestions to be put into effect it will be necessary to clearly define the responsibilities of different professional groups and their relationships to one another. For example,

- The general practitioner and other members of the primary care team require ready access to additional support and advice for the care of their elderly patients; this should include physiotherapists, occupational therapists and nurse specialists who would work in nursing and residential homes as well as in patients' own homes, and a short term intensive home care facility. These services could possible be run on an outreach basis from geriatric day hospitals, with input from relevant voluntary organisations; pilot trials of such services should be initiated and carefully evaluated.

- The involvement of social workers with geriatric day hospitals and/or groups of general practices should also be evaluated.

- The role of 'geriatric liaison nurses' in facilitating arrangements for discharge from acute hospitals (including geriatric assessment and rehabilitation units) requires more precise definition.

- The relationship between community assessment rehabilitation and treatment services provided for elderly people (possibly from geriatric day hospitals) and similar services for younger physically disabled adults requires to be explored.

- There will be implications for recruitment and training - with a possible shift from surveillance and palliative care (provided mainly by nurses) to rehabilitation and therapy (provided mainly by physiotherapists and occupational therapists).

CHAPTER 16

SOME OTHER CONSIDERATIONS

PROMOTE GOOD HEALTH AND PREVENT DISEASE AND DISABILITY

Disease prevention and the promotion of good health in the elderly population should have greater priority. For example,

Accident prevention

On average 230 adults aged 65 years and over are killed each year in accidents. The major causes are falls (54%), pedestrian road traffic accidents (18%) and house fires (9%). There are about 3,000 admissions to hospital each year in this age groups, and 26% of these accidents occur in the home.

General practitioners can help reduce falls by taking particular note of contributory factors arising from problems with eyesight or the feet and from medications or clinical disorders that cause unsteadiness; they and other members of the primary care team are also well placed to suggest alterations in the home environment which may be advisable in the interests of safety. Safety should also be a high priority among planners, architects and safety.

Stroke prevention

This is a major source of disability in the elderly, and the clinical trials published on both systolic and diastolic hypertension in the elderly strongly support the detection and drug treatment of hypertension at least up to age 80 years. All patients should have their blood pressure checked regularly (at last every three years) and blood pressure should be measured as part of the annual 75 year and over health check, at least until aged 85 years.

Influenza immunisation

Modern vaccines are highly effective against influenza, an unpleasant infectious disease with a high mortality in the elderly during epidemics. There is acknowledged to be relatively low take up of influenza vaccine in the UK compared with for example the USA; with adequate publicity and education this could be improved.

Osteoporosis prevention

Hormone replacement therapy is likely to have an appreciable impact on the public health problem of hip fracture only if it is continued indefinitely after the menopause. At present it appears more worthwhile to concentrate on encouraging scrupulous management of drug therapy for other conditions and minimisation of external hazards in the immediate environment as well as health promotion programmes to decrease smoking and encourage exercise.

Physical exercise

Elderly people should be encouraged to take exercise in order to improve their general well-being and cardiovascular status. For example exercise programmes could be established at lunch clubs, health centres and perhaps even geriatric hospitals.

Vision, hearing, dental and foot care

There is evidence that people who require tests of visual acuity are not receiving them because they cannot afford, or are reluctant to pay, the prescribed fee. Audiometric testing is available free of charge as a hospital out-patient facility on referral by a general practitioner; the service appears to meet with current demand but not everyone who might benefit is referred. Chiropody is available both as a clinic and domiciliary service, and the demand for it is almost limitless. As with eye testing, elderly people are often unwilling to ask for dental assessments and treatment, except in an emergency, because of reluctance or inability to pay.

Diet

Diet plays an important part in the prevention of coronary heart disease, hypertension and stroke, and also obesity and its complications such as diabetes. Several cancers may also have a dietary causation. However little attention has been paid to the importance of a healthy life style in elderly people, living in institutions or at home.

Elderly people suffer the maximum impact from cardiovascular disease, diabetes, cancers, osteoporosis, arthritis and dental tooth decay. Inactivity leads to low food intake and inadequate fibre intake results in constipation. In a UK survey in the late 1960s 6% of men and 5% of women aged 65-79, and 12% of men and 8% of women aged 80 years, were 'undernourished'. There is therefore a risk of deficiency disease, particularly where vegetable and fruit intake is low. Elderly people need to participate fully in the recommended national change in patterns of both physical activity and diet.

The (Age Concern) 'Age-Well' Initiative

AgeWell is a campaign developed by the Health Education Authority and Age Concern England. The intention is to promote positive views of health in old age and to counter the commonly held belief that advancing years necessarily meant deteriorating health.

The views which inspired AgeWell may be summed up like this:

- some decline in health and stamina is inevitable as people age; however it is likely that physical and mental activity and a fulfilling life will reduce ill-health and postpone disability and death. It is therefore to the advantage of individuals and society as a whole that as many people as possible live an active, healthy and fulfilled life.

- older people can be assisted to increase control over their own health, and this can both improve their health and postpone the onset of dependency.

- many professional workers accept that passivity, dependency and declining health are normal in old age and that this means prescribing medicines and providing services. Such views can be countered and replaced by a more positive view of health in old age in which older people can be encouraged to cooperate actively in maintaining their own health.

- older people should be consulted about their own health needs, and their views taken into account. They can have a continuing role in developing an appropriate programme of action.

- existing examples of imaginative health promotion work with older people should be encouraged and publicised.

- a variety of agencies, statutory and voluntary, local and national, can be mobilised in support of action along these lines and collaboration between them is one of the keys to success.

IMPROVE ATTITUDES TO ELDERLY PEOPLE - BOTH OF THE PUBLIC AND OF ELDERLY PEOPLE THEMSELVES

- Assist older people to cooperate actively in maintaining their own health since this is likely both to improve their health and postpone the onset of dependency.

- Consult older people about their own needs, including the need for medication, and take their views into account; when possible ensure that they have a continuing involvement in the management of their own care.

- Discourage professionals from accepting that passivity, dependency and declining health are normal in old age, and encourage them to explore all opportunities for rehabilitation and promoting health before prescribing medicines and passive forms of support.

- Attempt to convince elderly people that their health and well-being is as much the concern of the NHS as that of any other age group.

- Combat the tendency of elderly people merely to accept certain remediable disabilities as the inevitable consequence of ageing.

PROVIDE ADEQUATE PRACTICAL SUPPORT AND RESPITE FOR CARERS

Health purchasers are required to address the needs of:

- people who have complex or intense health care needs and will require specialist medical or nursing supervision or assessment during a period of respite care;

- people who during a period of short term health care require or could benefit from active rehabilitation;

- people who require day hospice care;

- people who are receiving a package of palliative care in their own homes;

- people with challenging behaviour.

Provide practical help for carers

- Consult with carers in order to better recognise their needs and formulate strategies to meet these needs

- Provide (a) short term breaks as part of a planned programme of support for the user or carer rather than as a crisis reaction; (b) longer breaks - which may be organised by providing care in the home or in a residential facility.

- Develop flexible respite provision between agencies which is tailored to individual carers needs.

- Ensure that carers are given opportunities to continue/recommence employment.

Ensure ready access to information and advice

- Develop an information strategy in consultation with voluntary organisations (including the Carers National Association) and other statutory agencies.

- Nominate a specialist co-ordinator in each health board as the main contact for carers with responsibility for providing information on all services and help available to carers.

Ensure that all relevant professionals are aware of support available both locally and nationally, and of good practice elsewhere

- Encourage good communication between health service staff to minimise delays in providing services.

- In conjunction with voluntary organisations establish a training programme for health service workers so that they can:
  - offer clear explanations of medical problems
  - offer counselling
  - provide information on how to access welfare benefits and advice
  - be aware of carers' emotional needs, including reassurance that their needs are understood.

ENABLE THOSE ELDERLY PEOPLE WHO WOULD PREFER IT TO DIE COMFORTABLY IN THEIR OWN HOMES

There is little objective information about the need for terminal care in the community, and about the extent to which this is met. This information is essential before the changes necessary to establish an adequate support system for terminal care can be identified. Meanwhile the following actions could usefully be taken:

- Ensure that hospitals have and adhere to clear policy guidelines for managing terminally ill people, including advising and providing for patients to die at home if so desired.

- Ensure that all dying patients and their relatives are aware of their right to die at home.

- Incorporate specific training on dealing with terminally ill people in the postgraduate training of general and geriatric medical registrars and senior registrars.

- Increase the number of community nurses trained in palliative care.

- Provide additional support to and encourage collaboration with relevant agencies and self help organisations in the voluntary sector, for example Cruse, Tak Tent, the Macmillan nursing organisation.

- Compile and disseminate information about services for terminally ill people - for example by producing a directory of services for distribution to general practitioners and others, and developing and extending telephone information services.

ENSURE EQUITY OF PROVISION AND SAFEGUARD AGAINST AGEISM IN THE ACCESS OF ELDERLY PEOPLE TO SECONDARY AND TERTIARY CARE

Ensure that older people are not discriminated against on the grounds of age alone

- Monitor rates for certain operations (e.g. cataract, hip replacement, hernia repair, prostatectomy, renal transplantation, CABG) and other procedures (e.g. hearing aid provision) both in terms of comparison with other health authorities and of variation by gender, age, socio-economic groups and by place of residence.

- Encourage specialist units such as the CCU and ITU to publish a breakdown by age groups of the proportion of patients admitted so as to ensure that elderly people are not prevented from getting the best medical care simply because of their age (Royal College of Physicians, London 1994).

- Acute units should have a clearly defined, written operational policy and a strategy for the development of acute emergency care for old people.

Ensure that racial and other minority groups are able to access services to the same extent as the majority of the population

- Develop systems for monitoring problems such as social isolation and abandonment by relatives of elderly people from ethnic minority groups.

- Be particularly sensitive to the preference for support in the home rather than institutional care for many people from ethnic minority groups.

- Explore opportunities for the provision of alternative forms of Chinese and Asian health care.

- Encourage community nurses to take a specific interest in the needs of elderly people from ethnic minority groups and in collaborative work with relevant voluntary organisations.

APPENDIX 1

Health Care Needs in Later Life: Consumer Views: *A literature review focusing on the unmet health needs and the untreated health problems identified by older people and their carers, by Philip Hadridge, Research Associate, East Anglia Regional Health Authority, March 1993.*

General considerations

- **terms such as 'the elderly' and 'geriatric' are disliked** by older people for they imply an unwarranted homogeneity and have negative connotations.

- older people are more likely to see health in terms of **the ability to function on their own.** Mobility is particularly important in determining judgements of health and 'the quality of life'.

- the need for **more and better information** about the types, purpose, source and level of all sorts of service available to older people and their carers is a continual theme. Various methods of distributing information are suggested, including: improving the ability of workers to pass on information; integrating health and social information sources and making it available from one well advertised source; and ease of telephone access to service staff.

- **choice** is important to people of all age groups; older people want to **participate in decisions** over where they die, cardiopulmonary resuscitation and the type and location of continuing care. Choice, however, presupposes information and that there is more than one option from which to choose.

Specific health problems

- **many older people do not have their vision tested regularly** despite the known increase in eye problems with age. This may be for a number of reasons such as cost concerns, low expectations (ascribing eye problems to age), and further access difficulties due to the lack of transport and lack of knowledge about the availability of domiciliary care.

- studies indicate that over 40% of older people have a hearing impairment. Whilst the free nature of the NHS service is appreciated, the way that some local NHS services are structured is frequently criticised by older people and their organisations. Waiting times and difficult physical access, due to the centralisation of services in Ear, Nose and Throat departments in many health authorities, are disliked. **Organisational models that allow GPs to directly refer to audiologists are preferred. Other issues of concern include** the lack of routine retesting in many authorities, **the need for some GPs to take hearing loss more seriously,** the health/social divide in the supply of aids and equipment, **and the need for greater support to those older people adjusting to hearing loss and their new aid.**

- **the majority of older people have not been to the dentist in the past five years.** A number of factors are implicated including: the low level of perceived need for dental care among older people, the majority of whom have dentures; cost concern; and difficulties with mobility that are not overcome in surgery design or the level of availability of transport and home care.

- **services for people experiencing difficulties with continence are particularly appreciated,** as are community schemes that support people following episodic in-patient care (e.g. hospital at home).

- depending on the age of the respondents, various studies report about three quarters of older people have feet problems that make self-care difficult.

Provision of equipment

- **the level of supply of aids, equipment and advice** in relation to activities of daily living (including continence and occupational therapy services) **is of concern.** The quality of the provision of special footwear is increasingly criticised.

In-patient care

- **the importance of care and treatment for older people being based on their wishes and their ability to benefit, and not purely on their age, is particularly important in in-patient acute care.**

- **waiting lists for treatments that are helpful in aiding independent living** - such as joint replacement and cataract surgery - **are particularly resented by older people.**

Community services

- a particular concern is the delay that may be experienced before community services respond to the discharge of someone. **The information and care 'vacuum' experienced by some people on return home from hospital is particularly disliked.**

- older people and their carers appear to be more concerned by non-acute care, although waiting lists, prompt admission, discharge policies and informed choice are important in acute areas. **A few issues appear to be of greater importance including: information, hearing services, carer support, foot care, continuing care, non-emergency transport, continence services and the supply of personal care (e.g. bathing) in the home.** Older people and their carers tend to be appreciative of what they receive from the NHS, but often want more of it. In services that are on the borderline with social services (e.g. bathing, continuing care) older people appear to prefer NHS provision.

- **depression is a problem many older people - especially women - experience,** probably due to the increasing loss of roles, income, health, friends and relatives. Health services could respond better in helping older people adapt to these life changes, by providing counselling and a greater understanding from all workers.

Carers

- **carers want information on services and practical help - including relief care, advice and responsive (fast and flexible) services.** They also want to be recognised and listened to. A major problem for some carers is that effective services may not be known and that they may be under-provided.

Transport

- **the lack of organised transport (including non-emergency ambulance, dedicated vehicles and volunteer drivers) for those unable to travel independently due to disability or cost constraints is a major concern** to older people. Those living in rural areas and living alone are the most affected in relation to the time and effort it takes to access NHS hospital care. Those receiving NHS transport tend not to be particularly satisfied with it due to unspecific pick up times, prolonged journeys and poor co-ordination with clinical care. The perceived trend to ascribe some people's need for transport to NHS care as a social need is not understood or appreciated by older people and their carers.

- poor, single, older people resident in rural areas tend to experience worse access to quality services. GP and emergency services and in-patient treatment in hospital tends to be the least difficult for older people to access. Dental, optical, and services for carers are more problematic. For access to be improved information to raise expectations, transport and home visits may be needed.

Elderly people and what they need: Irvine H. *A postal survey of the opinions of a variety of professionals regarding services for elderly people with particular reference to health gain and cost effectiveness: responses from six consultant geriatricians, four geriatric liaison nurses, six physiotherapists and five health service occupational therapists. Greater Glasgow Health Board, 1995 (unpublished).*

Views of Consultant Geriatricians

I Problems discharging or transferring elderly patients

"There is a major difficulty in placement in residential or private nursing home care from hospital, with current delays of 6 months or more from the time of referral."

"Significant delays occur in the transfer of patients from hospital rehabilitation and assessment beds to residential/nursing care when all parties have already agreed that this is the solution."

"There is an urgent need to solve the "bed blocking" problems caused by delays in community care assessments for elderly patients in hospital beds, especially geriatric assessment and rehabilitation beds."

"Lack of social work availability with two months to case allocation and a further month to first contact results in patients either being discharged without planning or referrals not being made in the first place. Because of this, patients simply revolve between hospital and community becoming more frail and dispirited."

"Blocked beds in hospital cause misery to those who have been rehabilitated, and because of boredom waiting for placement they deteriorate making the original assessment and placement out of date and a further assessment needed."

II Community care services

"Home-support services are often inadequate for elderly people's needs. There is a tendency to offer services which are readily available rather than to tailor a home-support package to an elderly person's needs. Some services such as bathing and supervision of medications are not available for the vast majority of elderly people who require them."

"The lack of services such as bathing service and tuck-down service impair our ability to provide a tailored package of needs for elderly people on discharge from hospital."

"The supervision of medication administration for elderly confused patients living alone requires attention."

III Rehabilitation

"In hospital, many elderly patients outwith geriatric medical units have unmet rehabilitation needs. It is essential that there is optimal use of existing rehabilitation resources, and that deficiency in hospital based rehabilitation staff numbers are remedied."

"With the drive towards evermore efficient use of surgical beds, more thought should be given to the rehabilitation support which will be necessary. The benefits of geriatric orthopaedic rehabilitation units are now recognised but there is more potential for this type of liaison e.g. vascular surgery."

IV Staffing and skill mix

"The appropriate skill-mix of carers for elderly people in various forms of long-term care (including residential homes, private nursing home, and NHS geriatric medical long-term care) is often lacking. The skills and specialisms required should be formally identified and mandatory programmes of training instituted to bring staff up to required standards."

"Hospital staff require more information on the existing case mix of nursing homes prior to discharge of elderly patients. Increasingly, we are discharging highly dependent frail elderly patients to nursing homes where there is already a high concentration of highly physically dependent patients."

"There is now a need to increase staffing levels and improve skill mix when the patient dependency levels increase. Systems such as RUGS should be introduced to determine nurse staffing levels according to dependency levels."

V Prevention

"There is now good evidence that anticoagulating patients with atrial fibrillation reduces stroke. The benefit is greatest in elderly patients with co-existing heart disease but this is the most difficult group to anticoagulate safely given the way the anticoagulant services are largely hospital based. Consideration should be given to providing a user-friendly community based anticoagulant service for patients with atrial fibrillation who are at increased risk of stroke"

VI The need for geriatricians to contribute to assessment and monitoring procedures

"Geriatricians should be involved in the selection process by the social work departments for nursing home and residential care."

"Patients referred for continuing care in hospital and nursing homes should have a multidisciplinary assessment of their needs including potential for improvement led by a consultant geriatrician.

Community nurse specialists in geriatric care, physiotherapists and occupational therapists (Included only if additional to above)

The need to encourage independence

- "There is a large gap between patients' mental and physical capabilities and their levels of achievement; this gap could be narrowed by encouraging more group socialisation and mental and physical stimulation."

- "If the elderly could be kept mobile for longer periods of time, their 'continence state' would improve because they can actually get to the toilet and would thus result in them requiring fewer incontinence garments and pads. The cost of provision for incontinence supplies to the Health Board/Trusts is enormous."

- "Good quality, regular and appropriate activity/exercise has been shown to be of definite benefit to elderly residents of old people homes. Unfortunately these benefits are not yet widely understood and therefore resources are not often made available to introduce this kind of activity more generally."

- "Better follow up programmes are required, designed to keep the elderly mobile and independent are required after discharge from hospital. This programme could also be applied to the elderly who have problems with mobility and are in nursing homes."

- "Physiotherapy input into nursing homes should expand to allow regular sessional input, rather than being on a medical referral basis only. There should be more physiotherapy input to home, day centres and nursing homes."

Reducing social isolation

- "Loneliness and depression are very common in the elderly due to poor mobility; transport to clubs and so on cannot be provided many areas."

- "A number of elderly patients are housebound because of living upstairs. Although keen to go shopping or to social clubs and other activities, they are unable to use the stairs. These individuals need care assistants to assist them downstairs and transport them to their chosen destination. More sitting services are needed to give relief to carers."

- "Elderly people at home often lack visits from anyone, are unable to go out, and have insufficient access to day centres; their physical and social needs are therefore unmet.

- "The use of Ward Hostesses could be increased within the wards in an effort to increase the stimulation to the patients."

Difficulties with community care

- "Patients in hospital frequently wait for long periods to have community care assessments and placement in residential/nursing home care. This leads to blocking of assessment and rehabilitation beds and to patients becoming stressed, bored and frustrated at the lack of knowledge about progress regarding their future care."

- "Ideally, every elderly patient should be seen by a health care professional within 24-48 hours of discharge as this is the time when most problems occur. This cannot always be achieved and help promised prior to discharge can often fail to materialise."

- "Problems encountered on discharge include community nursing staff not being made aware of the patient being at home; home helps not being aware of the need for increase in their visits and other requirements, e.g. food preparation; inappropriate or no occupational therapy and physiotherapy aids in the house, although requested prior to discharge; poor drug compliance; a 'vicious circle' of admission to hospital - home - readmission due to a breakdown in continuity of care; home helps not providing services such as window cleaning, washing stairways, cleaning cupboards."

- "There are protracted waiting times for assessment for placement in sheltered housing, residential or nursing homes."

- "When the assessment has been completed and a decision made as to the most appropriate placement, often there is no place available. This means further blocking of hospital rehabilitation beds. Better communication between OTs, the housing department and hospitals is needed to improve/speed up housing adaptations needed for elderly patients to return home."

- "Day care facilities are required within the community where health care professionals can assess and treat patients. These centres could meet both the physical and social needs of the patient."

- "A support network for carers is required 24 hours a day, 7 days per week. This would help carers to cope better and hopefully eliminate crisis intervention."

- "More community support is required following hospital stay in order to prevent readmission, support carers and ensure appropriate use of resources."

- "Improve communication between social work and health care workers, e.g. joint working groups to agree methods of work affecting the patients."

- "Increase resources in the community to maintain an increasingly disabled population who choose to remain at home."

The need to improve occupational therapy services

- "Overlap in the role of the physiotherapist and the occupational therapist should be examined to see if there might be a way of pulling these roles together."

- "Low staffing levels (in occupational therapy) result in difficulty in reaching professional standards of assessment and treatment. This can lead to prevention of discharge, bed blocking and inappropriately prolonged hospital stay."

- "Resources within OT departments are inadequate, including treatment facilities, portering and secretarial services."

- "There is duplication of roles between hospital and community OTs. Often assessments are repeated or not acted upon."

- "Develop/increase hospital based community OT services including community occupational therapy liaison to provide treatment in the home post discharge, prevent admission and readmission."

APPENDIX 2

QUALITY OF LIFE IN INSTITUTIONAL CARE

High quality Long-Term Care for Elderly People: Guidelines and audit measures: A report of the Royal College of Physicians of London (1992).

The quality of care in institutions may be considered under the following headings:

Promotion of good health
The early detection and proper management of chronic disease and disability; residents encouraged to use their physical and metal facilities to the full; opportunities provided for rehabilitation wherever there is a possibility of success; accident and disease prevention; promotion of continence.

Respect for the dignity of the client:
For example in relation to age, culture, lifestyle, privacy, method of addressing, confidentiality, handling personal finances.

Optimising drug use:
For example monitoring proportion of patients taking specified drugs (e.g. analgesics, hypnotics, tranquillisers, antidepressants, vitamins, diuretics, antibiotics) or more than say 4 drugs regularly, checks for side effects and regular assessment of need; failure of compliance.

Preserving autonomy:
For example residents contribute to their 'care plan', have named a keyworker or contract person, are able to articulate and exercise choice (e.g. over bed times, clothing, activities, food), and have adequate assessments, treatment and rehabilitation prior to admission.

Environmental requirements:
For example residents able to choose their own room, whether they share it and with whom, availability and convenience of facilities (e.g. power socket, adjustable lighting, wash-basin, toilet, call system, telephone); availability of screens; available space; availability and use of garden; availability of separate room for dining, sitting, quietness, hobbies, TV, preparing food, privacy in bathrooms; availability of communal telephones, post-box, mirrors, hairdressing facilities, commodes (wheeled and static) etc. Attempted rehabilitation before admission; adequacy and frequency of assessment and documentation of physical and mental functioning.

Promotion of continence:
For example quality of assessments of residents with continence problems; measures taken to promote continence; management plans instituted and monitored; adequacy of involvement of residents in the use of incontinence devices; frequency of changes of urinary catheters and sheaths, workers should be able to cope with a range of diverse needs.

Preventive measures:
For example frequency of falls, planned for prevention of falls and other accidents; adequacy of investigation of accidents; measuring trends in the proportion of residents with various grades of pressure sores; adequacy of preventive treatment measures.

This increase in the numbers of nursing home places appears to be continuing - partly because of the slow development of home support services as a satisfactory alternative and partly because of professional and public perception that there is no alternative. People in those nursing homes which operate under contract to a health authority to provide continuing care receive medical services from hospital departments of geriatric/psychogeriatric medicine. The great majority of nursing homes and all residential homes however rely on the general practitioner to provide general medical services; but - except in relatively rare instances where a general practitioner has been identified as having overall responsibility for all or most residents of a particular institution the general practitioner, health visitor or practice nurse will usually only visit patients on request, and not as part of a surveillance programme. Paradoxically therefore residents of these institutions may have their health care needs less adequately assessed and attended to than patients at home who should (if aged 75 years and over) receive an annual 'health check'. There is therefore a risk that some patients in nursing and residential homes with threatening health problems will not have these recognised until it is too late to initiate effective intervention. It is important to determine what is the most appropriate input to nursing and residential homes from members of the primary care teams and the community services - particularly from occupational therapists, pharmacists or planning advisers and physiotherapists.

APPENDIX 3

DAY CASE SURGERY IN ELDERLY PEOPLE[2]

Because of increasing demands on in-patient facilities, and demographic change, more elderly patients will in future have to be considered for day case surgery.

Elderly patients should not be excluded from day case surgery on age grounds, but their suitability determined in accordance with their biological, rather than their chronological, age.

The patient should not live alone; be confused; have to travel unaccompanied to and from hospital; be without telephone access; live too far from the hospital unless hotel accommodation is available.

In the design of day case unit, particular attention should be given to the provision of facilities of importance to the elderly.

Some elderly patients, who live alone and therefore fail to meet the selection criteria for day case surgery, could be treated as day patients if hotels were provided.

The following conditions and procedures were considered suitable for day case surgery. It is generally accepted that only procedures lasting less than one hour are appropriate.

Inguinal hernia	Carpal tunnel
Breast lump	Arthroscopy
Anal fissure	Ganglion
Varicose veins	Cataract
Cystoscopy	Excision/biopsy of skin lesion
Dupuytrens	Minor dental procedures

Selection protocols should be agreed on a local or specialty basis by surgical, anaesthetic and hospital nursing staff in association with local GPs. Such protocols enable decisions about individual patients to be taken by nursing staff and minimise numbers of queries referred to doctors. Assessment for day case survey and arrangements for admission should be combined with the patient's outpatient appointment. Pre-admission anaesthetic clinics should not be necessary.

The marginal cost of an overnight stay in hospital for an in-patient (i.e. excluding treatment costs) is between £60 and £100. The use of day case surgery would achieve a gross revenue saving of £120-£200 if it avoids an in-patient stay of two days, and £180-£300 if an in-patient stay of three days is avoided.

THE INTERFACE BETWEEN GERIATRIC MEDICINE AND GENERAL MEDICINE[3]

Numbers of acute admissions of elderly patients will continue to grow over the next ten years, making increasing demands on hospital services.

The effective management of elderly patients with acute illness depends on appropriate initial placement, early assessment, rehabilitation and discharge planning.

All units should prepare and disseminate clear operational guidelines on the admission of elderly acutely ill patients.

Better care is likely to be provided where there are geriatric assessment and rehabilitation facilities on the DHG site.

Closer collaboration between the specialties of geriatric and general medicine is likely to lead to significant improvements in the management of the elderly acutely ill patient, by facilitating appropriate initial placement, early assessment and timeous discharge planning. Several ways of achieving this were suggested.

While geriatricians are also experienced in the management of acute illness, specialist procedures such as endoscopy and the insertion of pacemakers should remain the province of the general physician with the appropriate interest. A sensible division of responsibilities promotes a more efficient and effective service to patients.

General practitioners must have adequate information about the organisation of services for the care of the elderly in their area, and easy access to hospital and community staff, in order to ensure appropriate placement of patients on admission and relevant post-discharge support. This should be acknowledged in the prompt provision of information about patients at the time of discharge, the accessibility of hospital and community staff, and the content of vocational training programmes.

THE INTERFACE BETWEEN GERIATRIC MEDICINE AND ORTHOPAEDIC SURGERY[4]

Orthopaedic and elderly care directorates should jointly develop the necessary procedures, protocols, communication and liaison mechanisms to ensure that care is systematically planned and co-ordinated. People's chances of going back to their own homes after their stay in hospital are enhanced by effective joint working between care of the elderly doctors and orthopaedic surgeons. Both rehabilitation and discharge are easier to plan if good assessments are available from the start[5]. Some hospitals have established special units for elderly orthopaedic patients, with care provided by both orthopaedic surgeons and elderly care doctors. These offer the benefits of good orthogeriatric liaison, but there is some evidence that the additional costs produce outcomes that are no better than cheaper alternatives.

The early phase of rehabilitation

The early phase of rehabilitation, whilst the patient is in the ortho-trauma ward, should be completed within 7 to 10 days for most patients and orthopaedic/trauma ward, and should be combined with the start of the discharge planning process. It involves the orthopaedic surgeons, nurses and physiotherapists who are concerned with the patients' post-operative management, and the geriatricians, occupational therapists, social workers and primary care workers who are concerned with assessing the likely rehabilitation needs of the patient.

The intermediate phase of rehabilitation

Intermediate rehabilitation should be carried out under the direct supervision of the geriatrician, in collaboration with regular input from the orthopaedic surgeon. The beds should be in a geriatric assessment or geriatric orthopaedic rehabilitation unit (GORU). Collaboration is also needed between the geriatrician and a range of other professionals, notably the patient's GP and social workers.

This phase comprises:

1. intensive rehabilitation of the patient by nursing, physiotherapy and occupational therapy staff to maximise the interdependence of the patient.

2. assessment of the patient's likely final level of independence and destination on discharge.

3. in the case of those who are being discharged home, assessment of the patient's home circumstances and need for community support.

The aim is to help patients to achieve their maximum independence, and prevent re-admissions. A lack of such facilities can hinder rehabilitation and lead to blocked beds in orthopaedic wards. In view of the increasing demand for assessment and rehabilitation in respect of emergency orthopaedic admissions, there is a strong case for identifying geriatric beds specifically allocated for the rehabilitation of orthopaedic patients.

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APPENDIX 4

THE HEALTH OF THE UK'S ELDERLY PEOPLE

MRC Topic Review. The Health of the UK's Elderly People. London: Medical Research Council, 1994

The therapeutic approach emphasises the future potential of the individual and the acquisition of new skills, both physical and social, reinstating a patient's autonomy (the ability of an individual to do what he/she desires), and independence (the ability of the individual to cope without the help of others). The prosthetic approach substitutes for lost skills with some other means of providing function. By implication, this approach removes the stimulus for continued activity and, whilst it may restore autonomy, it does not normally restore independence.

Prosthetic interventions may be provided when therapeutic interventions would be more appropriate, and of greater long-term benefit both to the patient and to the health and/or social services. The woman with an osteoarthritic hip could be offered a therapeutic hip replacement or a prosthetic home-help to carry out the tasks that she would otherwise do. In this case, the short-term costs of the therapeutic option might be higher, but in the longer-term, the costs falling on the social services would be greater as they would be ongoing and even increasing as the woman's dependence also rose. **The deployment of prosthetic services should only occur when all therapeutic options have been adequately explored, otherwise the prevalence of disability will increase.**

The type of intervention which a patient receives is likely to be dependent on the first point of contact by the patient for help; for example, the GP might offer a therapeutic intervention and the social worker a prosthetic one. Social workers may operate in this way because of a lack of training to appreciate or assess where therapeutic interventions might be appropriate.

There is a paucity of information which demonstrates specifically the effects of particular interventions in this age group as a result of the exclusion of older people from most trials of treatment and prevention strategies.

It is in this age group where the levels of chronic disease and disability are greatest that there is the greatest potential for prevention and reversal of disability. Yet there is current uncertainty and widespread scepticism regarding the effectiveness and cost-effectiveness of rehabilitation techniques among elderly people, which has led to barriers in access to this type of care. Consequently there is little guidance at present which can be provided to purchasers and providers regarding the best approaches to rehabilitation.

Only 20% to 30% of those with impairment thought to justify a hearing aid have one. This is partly due to poor provision, but also due to poor information, uptake and compliance. Screening in middle age could minimise years of disability and reduce the number of frail elderly people whose deafness would otherwise cause dependence. The relative costs and benefits require formal evaluation and means of improving the hearing aid service should be pursued.

There is a need to shift the balance now to evaluative research in all aspects of community care. Studies of costs and effectiveness should take priority and should adopt a more systemic approach than a single service focus.

APPENDIX 5

"Findings"; Towards a national system for continuing assessment in care homes.
Joseph Rowntree Foundation, March 1996.

The goal of long-term care for elderly people is to maintain as high a quality of life as possible in the presence of chronic physical, cognitive and social disabilities, which commonly deteriorate over time. Older people's lives are also frequently punctuated with episodes of acute problems which may be medical, cognitive, behavioural or social. **Hence, assessment is important not only at the point of entry to continuing care, but on regular occasions thereafter.**

The study's review of the literature found that assessment prior to admission to institutional care can identify problems which can then sometimes be resolved, making admission unnecessary; it can also reduce deaths and highlight the needs of carers. However, despite their desirability, true multi-disciplinary approaches to assessment are relatively rare.

A detailed evaluation of assessments from 50 local authorities found they varied greatly in the extent to which information was structured. Also,

- There was a lack of integration of health and social services assessment information in the documents used. Only 24 per cent of forms were used jointly by health and social services, the remainder by social services departments only. The review revealed a wide variation in content and quality of information and no clear linkage between identifying problems and formulating a proper response.

- Very few documents were designed for assessing or reviewing the needs of elderly people once they were living in residential or nursing homes and there was a very variable coverage of care needs, depression/anxiety, problems of cognitive impairment and behavioural patterns.

- Assessment of quality in residential settings currently focuses to a large extent on measuring standards, staff quality and casemix using information at *home* level. There is very little individual care plan or resident focus to quality assurance, using *resident* assessment information.

Although, assessment needs to begin at the level of the individual, this information may be subsequently aggregated to give indicators of needs for care and the quality of processes and outcomes relative to costs for a whole home.

The requirement for the UK is a single system which can be used for at least six different tasks: individual care planning, management, supervision, assessing the implications of individuals' mixed needs within one home 'casemix', cost and quality assurance. A common basis is required for agreeing levels of care across organisations and localities which is acceptable to both health and social services staff, focused upon the personal needs of the resident and able to be readily incorporated into a computer software package. The American Minimum Data Set/Resident Assessment Instrument (referred to as the Instrument) appears to have the greatest potential for use in the United Kingdom.

This instrument covers a wide range of subjects, including detailed assessment of physical function, mood, cognitive function and psychosocial factors. Identified

problems trigger assessment protocols which guide the assessor through best practice towards developing a care plan. The protocols do not stipulate the content of the care plan but rather prompt the assessor to address which areas should be considered. In this way, care plans remain tailored to individual needs. It includes the variables required for a system that predicts resource requirements at the level of the individual which can then be aggregated to the level of the institution.

Use of the instrument in the United States has led to a remarkable improvement in a number of areas. There were significant reductions in the prevalence of pressure sores, use of restraints and catheters, improvements in quality of life and reduction in the rate of transfer from long-term to acute care settings, with no increase in mortality. The accuracy and completeness of nursing records also improved.

Bennet M, Smith E, Millard PH. The right person? The right place? The right time? An audit of the appropriateness of nursing home placements post Community Care Act. London: Department of Geriatric Medicine, St George's Hospital Medical School, 1995.

The brief of this audit, commissioned by South East London Health Commissioning Agency, was to look at the admission of clients from Lambeth, Lewisham and Southwark to 13 nursing homes since April 1993 with particular reference to systems of assessment, methods of placement and outcomes of this decision. This included assessing dependency levels and care needs of individual residents, scrutiny of documentation from the referring agencies and a measure of the quality of care provided in each institution.

Principal findings

Accurate diagnosis with an optimistic therapeutic approach is the key to the optimum use of resources. Rehabilitating even a small number of potential long-stay older people will reap long-term financial benefits, quite apart from the benefits to the patient in terms of morale and health gain.

About half of the homes had a specific Visiting Medical Officer (VMO). Others had arrangements with local General Practitioners. Only five of the 13 homes assessed had a formal review system for residents. The rest operated a policy of the doctor seeing new admissions and intercurrent problems as they occurred. Most homes dealing with
very complex nursing requirements (e.g., people who had suffered a stroke rendering them unable to speak or swallow requiring a feeding tube inserted into the abdominal wall to provide nutrition) had some sort of liaison with a local dietician. However, none were having any specific specialist medical input from a physician or geriatrician, and some of these patients due to their care needs seemed to be isolated in their rooms. **There may be a need for specialist geriatric input into the management of such residents.**

A substantial number (35%) of the residents had lesser care needs and the reasons for their admission to a nursing home were often not obvious, either to the audit team or to the care staff at the home. These residents were, at most, requiring residential care, or could have been managed in the community. **Comprehensive multi-disciplinary assessments before a client is admitted to any form of long stay care is essential** if such misplacements are to be avoided. Pressure on acute

hospital beds or acute crises in the community should not cause any client to "bypass" such a system. Short term gains have enormous long term costs!

There was a disturbing level of inappropriate placement, even after poor documentation was allowed for; only 11% of nursing home residents were definitely appropriate for nursing home care, and 54% possibly appropriate; the rest were probably more suitable for home or residential care. **The estimated lifetime cost was £42,250 per misplaced resident.**

If we assume that our sample was approximately 20% of the total nursing home placements between the three boroughs and that a figure of one third inappropriate placements would be repeated across the board then the total figure which would be available to be spent in other ways is £8,928,833.

The degree of interest by staff in the residents themselves and their family/carer was often a good indicator of the level of interaction in the home. In some homes Activity Co-ordinators had been employed with great success.

Documentation was poor, with the result that the knowledge base of the multidisciplinary team in health care of older people is not being properly deployed. There was no medical information in 40% of cases, no social information in 70%, no nursing information in 35%, no occupational therapy information in 93%, and no physiotherapy information in 90%.

There was a serious lack of documentation in the files at homes from the referring agencies. Information in this documentation, if sent to the home, would be useful for providing continuity of care, not only from a clinical perspective but also giving social details which would help the care staff in the homes understand the resident better and more quickly, particularly in cases where the resident was experiencing difficulties in settling. With the ability to appeal against the decision to place in a nursing home by the individual there will also be a need for better documentation. The matrons of the homes where the GPs kept their records on site were much happier with this system.

The recommendations of the study are included in Chapter 6

APPENDIX 6

INFORMATION NEEDS

There is a need for much more information about clients (e.g. dependency, disability and diagnosis), their needs and the outcome of care before the appropriateness of and need for different services for elderly people can be determined. Most recording systems currently in use provide little or no information about clients, their needs or the purpose of care, and are consequently of little use for the purpose of evaluation. For example community 'information systems' tend to be designed for the purpose of monitoring the activity of professionals, and there are no routine recording systems for people resident in nursing or residential homes or for people attending day hospitals.

Without more useful routine information it is impossible to evaluate services and thus to develop the most appropriate mix of services for the care of elderly people. There has however been a number of recent developments, for example:

- core community data set (with some enhancements, for example to enable assessment of met and unmet needs).
- dependency measures (Scottish Health Resource Utilisation Groups or SHRUGS).
- Royal Colleges of General Practitioners (RCGP) and Physicians (RCP) 3-tier schedules for assessment of elderly people.
- RCGP/RCP package for assessing the quality of care (as a whole and for individuals) in all forms of institutional care.
- SMR (Long-stay) record of the characteristics of people in all forms of institutional care.
- information recorded at formal needs assessments of individuals.

General practitioner health checks

The General Practice contract requires General Practitioners to invite people of 75 years and over to have an annual health 'check', but at present these are unsatisfactory because the procedures are unstandardised and no feedback of information available to the health authorities. The Royal College of General Practitioners has proposed the concept of a triple cascade of assessments of increasing detail as a model for assessment. Level one of the cascade consists of brief 'activating enquiries'. Level two consists of more detailed 'standardised assessments' for particular problem areas for those in whom the 'activating enquiry' has revealed one or more problems. Level three consists of more comprehensive assessments, for example by multi-disciplinary teams.

Standardised assessment scales for use in geriatric care

The Royal College of Physicians and the British Geriatrics Society have recommended a set of scales for assessment of function in elderly people, as "a prerequisite for establishing some degree of uniformity in clinical assessment" and which it is hoped will "become part of standard clinical practice in recording the

current health status of elderly people". It was suggested that the scales be used in determining priorities in the allocation of resources, and in ensuring equitable provision for established need. The scales could also enhance communication between those who care for elderly people in different settings, encourage the development of a common clinical language and descriptions of disability, and would have educational value and enhance the training of professionals. The domains covered by the recommended system comprise activities of daily living, mental and physical health, psychological functioning, and social, economic and environmental resources.

APPENDIX 7

Job description for Parkinson's Disease nurse specialist

Job Summary

The Parkinson's Disease Nurse Specialist is responsible for initiating services in the FHSAs to which they are attached in order to enhance the knowledge, care and management of people with Parkinson's Disease and to work closely with general practitioners, consultants, therapists, and social workers in general practices, hospitals and elsewhere. Education, study days and workshops will be arranged to enhance the understanding of Parkinson's Disease.

Key work areas

To develop services already established; to initiate new specialist clinics within general practices and local hospitals; to receive direct referrals from general practitioners, hospital consultants, other community and hospital based medical services, patients and carers, local branches of the Parkinson's Disease Society, social services; to maintain methods of monitoring, interviewing and record keeping as agreed with the managers and researchers.

Service Development

To identify other opportunities for treating PD patients and assist with development; to develop effective integration with local services, both NHS, Local Authority and Charity; to participate in the evaluation of the service.

Quality

To ensure setting of standards of work within each FHSA area; compliance with UKCC regulations and individual performance review.

Human Resources

To provide leadership to NHS and other staff utilising knowledge of Parkinson's Disease.

Nurse Specialist Responsibilities

To act in an advisory role and, where necessary, participate in directed activity;
to take direct responsibility for assessing needs for neurological/medical review and change of treatment and, if needed, arrange this as soon as possible, indicating the nature and urgency of the problem to the general practitioner or consultant concerned;
to take direct responsibility for informing patients and carers regarding Parkinson's Disease - specific aspects of care, drug efficiency and side effects, physical complications of disability; to monitor each patient's response to treatment by regular contact. Early detection of side effects from medication; to counsel patients, carer(s), family and, where appropriate, patient's work colleagues; to participate in educational services to health care professionals; to work closely with local branches of the Parkinson's Disease Society.

Self Development

To maintain knowledge of Parkinson's Disease - therapy and other educational areas pertinent to the role through seminars, conferences and recognised courses.

Chest Heart and Stroke Scotland Stroke Services Pilot: Proposal for a pilot stroke care service.

Chest Heart and Stroke Scotland is the only major Scottish voluntary organisation which is an active provider of support in the community for people who have had a stroke.

The first phase would involve the appointment of a Stroke Care Coordinator who would review the number of stroke patients in the area and identify existing resources.

The second phase would introduce a Volunteer Stroke Service to the area. The Volunteer Stroke Service (VSS) is a service for those who have had a stroke and who have language and communication problems. The VSS aims to:

- encourage those who have had a stroke and who have language and communication problems to regain maximum independence in the community.
- enhance their quality of life, build up confidence and widen social horizons in the community.
- encourage and support the families and carers of those who have had a stroke.

This phase would also include a review of the existing general stroke groups in the area.

The third phase would be the extension of the project to the wider Health Board area and the inclusion of a health promotion, secondary prevention and education service promoting the awareness of risk factors of stroke.

The Stroke Care Coordinator (SCC) will be the key person within this pilot project, and will act as a liaison person between hospital, community and families. The SCC should be based within the community, possible within a major Health Centre and would maintain close contact with the hospital to ensure that patients and their relatives have access to optimal community or hospital care from the earliest stage of their illness.

The Stroke Care Coordinator would:

- visit all patients admitted to hospital wards to reassure and inform and be available to meet relatives of patients to provide early advice, information and support.
- introduce a rolling programme of advice and information sessions aimed at relatives, friends and carers.

- collate a membership pack for the patients and families to be given at the initial meeting and which gives access to basic information about a stroke and stroke services.

- be a member of the team responsible for planning the discharge of stroke patients and following their progress in the community.

- set up a 24 hour contact point via a telephone line and answering machine.

- establish a directory of local resources suitable for stroke patients and update it assisted by Chest Heart and Stroke Scotland. This would be made available to Health Centres.

- liaise with the Volunteer Stroke Service and General Stroke Clubs and be involved with the training of Organisers and Volunteers.

- develop a Carers Support Group with the assistance of the VSS Organiser.

- be recognised as the local contact for stroke for voluntary organisations, statutory agencies and for health care services.

- be involved in the education of student nurses, post registration nurses and paramedic students.

- assist in the delivery of "seamless" care to patients on discharge from hospital, by liaising with community nurses, social workers and voluntary agencies and fostering more positive attitudes to care among these workers.

Scottish Needs Assessment Programme
Report on Acute Stroke