Community care of older people: policies, problems and practice

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What do older people and their caregivers really want from community care?

A focus on functional disability means that the wider aim of community care – enabling older people to enjoy life – is often overlooked. The ideal would be a world where older people are highly valued, have lives that are richer, and voices that are heard.

When older people are consulted about the care they receive, it is found that they often have specific views on how their services should be run:

- **personal care** should be a readily available, reliable and comprehensive service, with a chance to build up a relationship with an individual carer;
- The ideal of **domestic care** is often described as 'low level, high impact'. Domestic care can involve help with general household tasks, gardening and maintenance, and is usually a supplement to personal care;
- **respite care** needs to be reliable, affordable and flexible;
- **day care** should be accessible, catered to individual needs and stimulating – older people are often lonely, and it is important that day care provides an interesting contrast to their normal routine;
- **residential care** should be high quality and allow the older person to have a choice; and,
- **transport** should be safe, accessible, reliable and affordable.

Community care for the elderly can be improved by an increased political commitment to the range of care needs and more stratregic planning at national, regional and local levels. New approaches to, and ways of thinking about, meeting need must be developed, placing older people at the centre and allowing them to 'live well'. The emphasis on meeting targets, or 'ticking boxes', is misplaced.

What community services are available?

Hospital avoidance schemes and early discharge schemes (ie intermediate care) are two important resources for policy-makers looking to maintain older people in the community, prevent adverse health, psychological or social events and facilitate rewarding, active, independent and supported lives.

Examples of hospital avoidance schemes include falls programmes, an increased paramedic role (allowing older people to avoid immediate diversion to A&E) and emergency access to social care and occupational therapy. The National Service Framework for Older People has encouraged the growth of a broader range of intermediate care. Intermediate care should encompass everything from convalescence to enablement to rehabilitation, and it is important that the latter should not be subsumed within the other two. A problem is that hospital avoidance schemes and intermediate care are often isolated schemes with short-term funding; a strategic, holistic service is necessary.

Other resources which help to keep older people out of hospital include day hospitals, day centres (eg dementia support), visiting schemes, adult education, leisure services, fitness centres and various voluntary services. The range of services has been improved of late, as has communication and understanding between the various agencies involved and the services' integration into the community. Challenges remain, however; we need to ensure that the right services are targeted at the right people, that rehabilitation is not watered down and that the balance of costs is not simply shifted towards older people and their carers. Most importantly, though, it is necessary to make the service work as a whole.

What is the best place of care for older people?

Professor Stuart Parker of the Sheffield Institute for Studies on Ageing discussed the best place of care for older people with acute illness, after acute care and in need of rehabilitation.

Geriatric medicine was developed around the concept of the 'geriatric process', whereby patients are, first, assessed in terms of health, function and resources. The objectives of care are then agreed, the management plan specified, and a process of regular review begun.

The results of a systematic review[1] looking at alternatives to acute admission, evaluative literature, impact on key outcomes and research methodologies were discussed. Professor Parker concluded that there is evidence to support the use of interventions based on the principles of geriatric assessment and that comprehensive care can be successfully delivered in both community and inpatient settings. Mortality and length of stay appear relatively unaffected by community-based alternatives to inpatient hospital care, while outcomes in terms of things such as hospital admission rates and institutionalisation appear to be improved.

There are, however, a number of caveats to these conclusions. The number of patients studied for specific interventions is relatively small. Much of the evidence has been gathered in other countries and other health systems. Finally, little high quality evaluative research has so far considered cost, client preference and health outcomes.

Which older people can be successfully managed outside hospital?

Hospitals provide a range of benefits to older patients, including easy access to investigations, specialty opinions, cardiac arrest teams, urgent operations, intensive and coronary care, and specialist equipment. The patient, however, may experience or risk hospital-acquired infection, accident, over-investigation or treatment, and loss of privacy. Hospitals also provide a poor environment for rehabilitation and entail a lack of flexibility in provision (eg poor choice with regard to catering). It is estimated that adverse events seriously affect up to 58% of patients.[2]

Care outside hospitals offers a more homely environment, appropriate to rehabilitation, and an increased flexibility of service provision. It is, however, unsuitable for the very sick and those requiring many investigations or likely to undergo cardiac arrest.

How can we improve care in nursing homes?

The tabloid perception of nursing home care is that it combines a high cost with inadequate funding and staffing, that over-medication and poor nutrition are commonplace and that it depersonalises the older person and leaves them open to abuse. The National Service Framework for Older People envisions a process whereby an individual needing care passes through a proactive process of chronic disease management and is provided with a 'personal care solution'. In reality, patients are more likely to be perceived as 'bed blockers', and to go through a process of reactive 'crisis management', where the transfer of responsibilty is a high priority and the end result is not always the most appropriate discharge placement.

The RCP's report *The health and care of older people in care homes*[3] provides an important series of recommendations for improving care. It suggests that;

- an agreed comprehensive assessment tool is adopted;
- care planning is tailored to the needs of the individual;
- a population-based approach should be used for the planning and provision of services;
- a specialist gerontological nurse is employed as the lead clinical practitioner;
- the roles and responsibilities of general practitioners in care homes are more sharply defined;
- specialist geriatric medicine and old-age psychiatry are re-engaged to the care home population;
- the management of medication and the role of the pharmacist are enhanced through an institutional approach;
- the care from professions allied to medicine is provided through core institutional-based care rather than individual contracting;
- there is a major investment in training, learning and development; and,
- more research into measures which may improve care is undertaken.

In summary, a person-centred, needs-based organisation of care with an emphasis on proactive management and underpinned by surveillance of outcomes is required.

Combining health and social services – lessons from Northern Ireland

Mr John Richards, Chief Executive of Independent Health and Care Providers in Northern Ireland, discussed the close integration of health and social services in the province. The integra-

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tion was on three levels; strategic, where planning of service provision is undertaken in tandem; operational, where the attempt is made to create an holistic, interfaced service; and individual, where representatives of each discipline work together to best address the needs of an individual. There are many lessons to be learnt on the mainland from this model of practice.

The politics of intermediate care

In 1998, Tony Blair described the 'third way' as '[moving] decisively beyond an Old Left preoccupied by state control, high taxation and producer interests; and a New Right treating public investment and often the very notions of society and collective endeavour as evils to be undone'.[4] In terms of health care, the third way 'is neither the old centralised command and control systems of the 1970s' nor 'the divisive internal market system of the 1990s', but rather a system 'based on partnership and driven by performance'.[5] The third way is defined by what it is not, and is based, at best, on a simplified view of the health service in the 1970s and 1990s.

Intermediate care can be seen as an archetypal New Labour policy because it exemplifies notions of 'joined-up government' and inter-agency collaboration, seeks social justice via public funding of both private and public provision and tries to drive performance via a combination of targets, regulation, incentives and innovative relaxations of old rules. It is also a response to traditionally problematic areas of policy which include the demographic shift towards older people, waiting lists, the reduction in NHS beds and the need to co-ordinate but distinguish between health and social services.

There are several aspects of intermediate care which are, at the moment, unsettled. These include:

- the problem of providing evidence to support intermediate care when the concept is so amorphous;
- the feasibility of providing a consistent and 'seamless' service when the stability of local private provider markets, and nursing home access to NHS medical and nursing care, are uncertain;
- the implications of inter-agency politics, particularly the impact of cross-charging and the problem of a clear system of responsibility and blame.

The Government's willingness to use the distinction between health and social services as a rationing criterion has resulted, and will continue to result in, the necessity of constantly reviewing and adapting the way we provide care.

References

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