Geriatric care in the United Kingdom: aligning services to needs

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Current provision and funding of health and social care for older people in the United Kingdom are undermined by a structural and operational misalignment of primary healthcare teams, acute hospital trusts, community trusts, and social services. The problem has been compounded by the fact that funding originates from at least three sources: the NHS, local social services departments, and personal or insured means. The inevitable result is obfuscation of responsibilities.

The recent report from the Royal Commission on Long Term Care, *With Respect To Old Age*,[1] recommends the establishment of a national care commission to monitor trends, costs, accountability, and the interests of the consumer and to set national benchmarks. This builds logically on policy trends signalled in the government discussion paper *Partnership in Action* and *Modernising Social Services*, which suggest a national regulatory system and standards.[2 3] In this article we outline a possible solution that integrates and aligns health and personal care for elderly people in a practical and incremental manner. To put our strategic proposals in a contemporary perspective we briefly outline some present issues.

Summary points

- Health care tends to focus on acute problems at the expense of managing and preventing exacerbations of chronic illness
- Long term care of elderly people has been shifted from hospital to residential homes
- A partnership is proposed including general practitioners, geriatricians, and social support staff for care of frail elderly people
- Partnership would be encouraged to and responsible for maintaining and improving the health of frail people rather than fire fight acute illness
- Planned, supported, and funded care by general practitioners may improve the health of care home residents and avoid episodes of expensive care

Shift to residential care

The locus of long term care has shifted from hospital long stay wards directed by geriatricians to privately operated community nursing and residential homes, where medical care is provided by general practitioners. The massive expansion of long term care in independent homes, now 70% of total provision, has largely been a consequence of inadequate development of health and social services. Residents of care homes often have multiple diseases and significant physical and mental impairment. Their medical care is entrusted to general practitioners, many of whom have had no special training[4] and for whom there is little incentive under present remuneration to provide appropriate patterns of care. The decreasing commitment of the NHS to chronic care, particularly for frail elderly patients in long term care, has insidiously been accompanied by a tendency to define illness as terminating at the point of hospital discharge. As lengths of hospital stay fall, older people are at real risk of missing rehabilitative opportunities[5] and of inappropriately entering long term care, often on a presumed temporary basis, without a management plan.

The key to managing chronic illness is active surveillance and timely intervention. Research shows that geriatric evaluation and management improves outcomes and saves money.[6–9] Departments of geriatric medicine have traditionally led the management of frail older people in hospitals. Indeed, the specialty grew out of the need to provide medical care for such long stay patients. With the dissolution of long term care in the NHS the specialty has increasingly merged with general medicine, to the extent that geriatricians now constitute the largest medical subspecialty in acute adult medicine.[10] Increasing specialist commitments for many general medical specialties and the inexorable rise in acute medical demands have resulted in many geriatricians becoming firefighters of acute exacerbations of chronic disease. They are unable to lead programmes that encourage maintenance of health and functioning of elderly people. Rising and inappropriate acute hospital admissions[11–13] may partly be a consequence.

Increasing rates of hospital admission have not been related to improved outcomes for very elderly people.[14] Conversely, outcomes of certain illnesses—for example, respiratory infection[15]—may be better when they are managed in nursing homes rather than

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hospital. Uncertainty about health outcome has resulted in reduced investment in geriatric services; insufficient investment has meant that subacute illnesses in older people are increasingly managed as full acute care cases. The resultant increasing workload imposed by nursing home residents on primary care[4] has led to a sporadic evolution of supervisory medical care contracts for nursing homes. These contracts are outside traditional primary or secondary structures[16] and, paradoxically, clinical governance.

Care partnerships

One option for dealing with the increased community workload would be to commission general practitioners (or primary healthcare trusts) to form a structured partnership with geriatricians and other relevant specialists. This would provide comprehensive medical care including health promotion, management of chronic disease, enhanced nursing home care, and "watchful waiting."[17] American experience of proactive care for residents in capitated care systems suggests a reduced use of hospital resources.[18] These potential partnerships would allow the development of gerontological nurses, care pathways, and improved individual care through the earlier detection of problems and home management whenever possible.[19]

We propose a more comprehensive partnership solution in which geriatric care consortiums have an overall responsibility for the care of frail elderly patients. Models from the United States could inform the development of such programmes.[20 21] Consortiums could be established from a primary care group or trust,[22] a community trust, hospital care of the elderly department, social services department, or even an independent provider organisation. Capitation payments based on the average expected health and social care costs of patients would be pooled from health and social care sources. Consortiums would be required to manage health proactively and could be responsible for all the medical care of enrolled patients, wherever it occurred. Threshold entry criteria would be based on either an individual's history or contemporary assessment indicating higher risk for above average costs—for example, admittance to institutional care.

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Long term care of elderly people has been shifted to residential homes

Pooling of medical funds alone would create incentives to reduce hospital costs by improving primary medical care but leave the current schism between medical and social goals. Social goals tend to be more compensatory, with successful care being considered that which meets clients' needs while avoiding any adverse events. Ideally, both groups would adopt a more therapeutic set of goals to improve or at least maintain individuals' functioning. In the case of long term care, one measure of success might be simply slowing the rate of decline.

The idea of pooling social and medical funds that support frail elderly people may generate anxieties that social concerns will be discounted. However, the risks of ignoring potentially correctable problems, including iatrogenic ones,[23] are too real to neglect. Pooled funding promises more informed quality management than present systems, which are based on process regulation.[24] The system could identify and reward organisations achieving better than expected outcomes; conversely, poorly performing groups could expect a punitive review. The adoption of a standardised assessment tool[25] would enable outcome to be monitored and provide the proposed care commission[1] with consistent information from which it could report trends.[25 26]

Although the potential of the consortium approach has attractions for both institutional and community care more widely,[9] its development should be incremental to allow testing and refining of systems. The initial threshold for entry into the consortium service should be transition to nursing home care. Once experience has been gained from nursing home cases, the most expensive end of the health and care spectrum, the threshold could possibly be lowered to include people with defined impairments of activities of daily living or specific health and care needs. Integrated care and the case management approach have already been shown to reduce personal dependency and dependence on care.[8] Meta-analysis has supported comprehensive geriatric assessments,[6] and a prospective trial over three years applied to people over the age of 75 concluded that comprehensive geriatric assessment can delay the development of disability and permanent admission to nursing home care.[27]

The fundamental goal of integrating and aligning services encourages all stakeholders to do the right thing to best meet individual's care needs. Undesirable perverse incentives to shunt funding and general responsibility for an individual between agencies would anachronistic. Alignment of health and social care to serve frail elderly people could be furthered through incentives to vigorously assess, treat, and rehabilitate patients rather than enter them into a geriatric consortium, with the resultant erosion of individual health and social care budgets. Geriatric consortiums could encourage rehabilitation by providing incentives for re-establishing enrolled patients in the community. In addition, recognition of the extra requirements of patients with complex needs would promote health maintenance. Dissidents need to consider the evidence for positive approaches[28] and the paucity of evidence supporting neglect.

How would consortiums work?

The consortium model can be illustrated by considering the catchment of a large primary care group and a combined acute and community trust. The consortium has 1300 nursing home beds and a local audit has indicated that improved care of nursing home residents could release 15 hospital beds, potentially liberating over £1 million a year.[29] General practitioners could be paid for clinical sessional time to manage residential home patients. Remuneration could exceed the present general medical service's capitation payment by perhaps £200 a year. Emergency out of hours care would be provided by a local general practice consortium.

Enhancing general medical service payments would require around £260 000, which would leave substantial sums for improved consultant medical, specialist nursing, and various paramedical supports. A recent survey indicated that prescribing costs for nursing home residents are more than double those for community controls,[30] and poor prescribing[31] in nursing homes indicates scope for improved treatment as well as more efficient prescribing. Social service funding would require little change, but the ability to vary funding according to the dependency of the patient would keep funding aligned with need.

Organisational change

British nursing homes are presently configured to provide long term care but are increasingly being used for various forms of intermediate or subacute care. Such forms of care need to be developed to enable homes to cope with patients whose acute medical needs have been satisfied but who require convalescence or simple rehabilitation.[32] Nursing homes, if properly supported, could meet some of these needs more efficiently than hospitals. The predictable profile of individuals likely to benefit from such schemes points to further opportunities for the geriatric consortiums described.[33]

The development of a register of nursing homes may facilitate a systematic review of the role of professional nurses. Such a review is pressing because of the increasing shortage of fully trained nurses.[34] Staffing notices for nursing homes demand that a registered nurse is present at all times, irrespective of residents' actual needs. Introduction of gerontological nurses[35] could relieve general practitioners from some of their routine tasks and bring a much needed consistency to assessment and planning of care as well as specialist care management. This coordination of care may allow more constructive use of medical time and a greater yet more clearly defined range of duties for care assistants.

Focusing on maintaining health and prevention of exacerbations in chronic disease and disability is more likely to relieve current pressures on the health service than the current approach of injecting money to deal with seasonal pressures in acute services and for waiting list initiatives. The approaches outlined here could enable a care commission,[1] and help resolve the continuing practical and political difficulties of health and personal care funding.

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1 Royal Commission on Long Term Care. *With respect to old age*. London: Stationery Office, 1999. (Cm 4192-1.)
2 Department of Health. *Partnership in action: new opportunities for joint working between health and social services*. London: Stationery Office, 1998.
3 Department of Health. *Modernising social services: promoting independence, improving protection, raising standards*. London: Stationery Office, 1998. (Cm 4169.)
4 Turrel AR, Castleton CM, Freestone B. Long stay care and the NHS discontinuities between policy and practice. *BMJ* 1998;317:942-4.
5 Young J, Robinson J, Dickinson E. Rehabilitation for older people at risk in the new NHS. *BMJ* 1998;316:1108-9.
6 Stuck AE, Siu AL, Wieland GD, Adams J, Rubenstein LZ. Comprehensive geriatric assessment: a meta-analysis of controlled trials. *Lancet* 1993;342:1032-6.
7 Rubenstein L, Wieland D, et al. *Geriatric assessment technology: the state of the art*. Milan: Eidtrice Kurtis, 1995.
8 Bernabei R, Landi F, Gambassi G, Sgadari A, Zuccala G, Mor V, et al. Randomised trial of impact of model of integrated care and case management for older people living in the community. *BMJ* 1998;316:148-51.
9 Wagner SL, Davis EHC, Gouthous L, Wallace J, LoGerfo M, Kent D. Preventing disability and managing chronic illness in frail older adults: a randomized trial of a community-based partnership with primary care. *J Am Ger Soc* 1998;46:1191-8.
10 Royal College of Physicians of London. *Manpower census of physicians*. London: RCP, 1997.
11 Abercrombie M, Murdoch PST. Development of guidelines for admission from nursing homes to a district general hospital. *Age Ageing* 1995;25 (suppl 1):12.
12 Snape J, Santharam MG. Inappropriate acute admissions from nursing and residential homes. *Age Ageing* 1997;26:320-1.
13 Audit Commission. *The coming of age—improving care services for older people*. London: Audit Commission, 1997.
14 Wasson JH, Thomas TA, Bubiz JL, Teno J. Can we afford comprehensive, supportive care for the very old? *J Am Ger Soc* 1998;46:829-32.
15 Fried TF, Gillick MR, Lipsitz LA. Short-term functional outcomes of long-term care residents with pneumonia treated with and without hospital transfer. *J Am Ger Soc* 1997;45:302-6.
16 Black D, Bowman C. Community institutional care for frail elderly—time to structure professional responsibility. *BMJ* 1997;315:441-2.
17 Robinson R, Steiner A. *Managed health care: US evidence and lessons for the National Health Service*. Milton Keynes: Open University Press, 1998.
18 Burl JB, Bonner A, Rao M, Khan AM. Geriatric nurse practitioners in long-term care: demonstration of effectiveness in managed care. *J Am Ger Soc* 1998;46:506-10.
19 Kane RL. Managed care as a vehicle for delivering more effective chronic care for older persons. *J Am Ger Soc* 1998;46:1034-9.
20 Eng PJ, Eleazer P, McCann R, Fox N. Program of all inclusive care for the elderly (PACE): an innovative model of integrated geriatric care and financing. *J Am Ger Soc* 1997;45:223-32.
21 Williams TF. PACE: a continuing evolving success. *J Am Ger Soc* 1997;45:244.
22 Secretary of State for Health. *The new NHS*. London: Stationery Office, 1997. (Cmnd 3807.)
23 Pearson J, Challis L, Bowman CE. Problems of care in a private nursing home. *BMJ* 1990;301:371.
24 Kane RL, Bowman C. Using outcomes to redefine long-term care: beyond a regulatory model. *J Ir Coll Phys Surg* 1998;27:25-8.
25 Challis D, Carpenter I, Traske K. *Assessment in continuing care homes: towards a national standard instrument*. Canterbury: Personal Social Services Research Unit, University of Kent, 1996.
26 Bowman C. Clinical geratology—evidence based multidisciplinary integrated geriatric care. *Rev Clin Geratol* 1998;8:275-7.
27 Stuck AE, Aaron H, Steiner A, Alessi C, Bula CJ, Gold M, et al. A trial of annual in-home comprehensive geriatric assessments for elderly people living in the community. *N Engl J Med* 1995;333:1184-9.
28 Fiatarone MA. Fitness and function at the end of life. *J Am Ger Soc* 1995;43:1439-40.
29 Bowman C, Caine S, Elford J. *Acute hospital admissions from nursing homes, some may be avoidable*. Weston super Mare: Audit Department, Weston Area Health Trust, 1994.
30 Avery T, Boot D, Groom L, Thornhill K, O'Neill C, Jones R, et al. *The impact of nursing home patients on general practitioners' workload and prescribing costs—a report for Nottingham Health*. Nottingham: Division of General Practice, University of Nottingham, 1998.
31 Pearson J, Challis L, Bowman CE. Problems of care in a private nursing home. *BMJ* 1990;301:371.
32 Steiner A. *Intermediate care: a conceptual framework and review of the literature*. London: King's Fund, 1977.
33 Kane RL, Finch M, Blewett L, Qing C, Burns R, Moskowitz M. Use of post hospital care by Medicare patients. *J Am Ger Soc* 1996;44:251-7.
34 Smith G, Seccombe I. *Changing times: a survey of registered nurses in 1998*. London: Institute for Employment Studies, 1998.
35 Johnson M, Hoyes L. *Regulating long term care: proposals for a single registered care home. A paper prepared for the Joseph Rowntree Foundation*. Bristol: School for Policy Studies, University of Bristol, 1996.

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Commentary: current system could be made to work

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In focusing on the complex issues raised by the undebated and undemocratic expansion of the private nursing home sector and contraction within public provision, Clive Bowman and colleagues have struck at the heart of a malaise within geriatric medicine. Like the Pied Piper of Hamelin they create a hopeful pathway, but are there any geriatricians left to follow their call and is it the right path?

The shift in responsibility for care of old and physically frail people from NHS hospital long stay to private nursing home care was more than an ideological swap of bricks and mortar. Intentionally or otherwise it helped in the formation of a new consultant group, the "physician with an interest." Unfortunately for older people the interest is rarely in chronic illness, rehabilitation, or prevention of disability. The specialty has embraced the medical model with great zeal, extolling its virtues (for example, equal access to acute services through an appropriate setting) but remaining silent on the drawbacks (faster discharge with poor planning[1]; increased readmission rates; deskilling of specialist registrars; and the abrogation of responsibility to unprepared and unwilling general practitioners.) This unholy mess threatens the survival of the specialty.

Using current structures

I don't disagree with the problem, I differ in the pathway to a solution. The structured partnership between geriatricians and general practitioners might seem attractive, but we already have a system that can be made to work for the benefit of elderly people. NHS geriatric units have teams that carry out assessment and evaluation before making decisions about residential and nursing home placement, practice rehabilitation in its broadest sense, and have expertise concerning the basics of chronic disease management (prevention of pressure ulcers, continence care, etc). Multidisciplinary teams have developed flexible ways of working using day hospitals, outpatient clinics, outreach, specialist (such as stroke or wound care) programmes, and domiciliary services. Geriatric medicine is now being rediscovered in residential and nursing homes, but the bureaucratic minefield that separates the public and private sectors effectively deprives residents of appropriate expertise.

Primary care groups could help clear that minefield. They are structured to draw family and community health practitioners and social services together in two important ways: firstly, through funding the full range of services for elderly people and, secondly, by cooperating in delivering those services. Primary care groups bear the same responsibility for quality and partnership as other parts of the health and social care system[2] and will have a national service framework to help them develop, with other providers in both public and private sectors, those service agreements. Why create a separate system when the current one has not been allowed to respond effectively? Consortiums were developed in the United States because they lacked an established geriatric subspecialty and comprehensive primary care base.

The savings that Bowman et al suggest for their model may not be as great in reality, and short term costs (redundancy and redeployment costs, plus the need to close sufficient beds and lose staff) might defer any benefit. In addition, costs in general practice may increase if proactive management translates into standardised assessments, training protocols, appraisal, and cost-benefit review. Will the private sector willingly contribute to these increased costs? And will the different cultures, accountabilities, and histories of the key players reform in the context of a consortium within any reasonable period? We should look at similar efforts to create funding and delivery consortiums for mental health services[3 4] for guidance on these and related issues.

Changing the culture

One question remains which neither Bowman and colleagues nor I have addressed. Do geriatricians still want to work with chronically frail elderly people? They divested this clinical responsibility surprisingly easily, and we now have a cohort of consultants with apparently little incentive to risk losing the mantle of medical respectability and become involved in chronic care. What of general practitioners? Financial inducement has never produced sustained changes in management and care programmes when applied to only one of the care providers. Clinical and political will is needed to redirect the focus of attention within geriatric services away from acute models of care. The framework of partnership proposed by Bowman et al would perhaps best be directed at removing the barriers to making geriatric expertise available to people in residential and nursing homes. It seems sensible to suggest that entry criteria based on standardised assessments should routinely involve departments of geriatric medicine. Nursing homes could be formally linked to the NHS, allowing innovations such as staff exchanges and rotations, cross benchmarking, dual audit, and joint risk management projects. We could then let clinical governance do its job in a care sector created outside the NHS yet connected to it. To many this issue is the past; in reality it is the future.

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1 Report of Clinical Standard Advisory Group Committee. *Community health care for elderly people.* London: Stationery Office, 1998.
2 Secretary of State for Health. *The new NHS.* London: Stationery Office, 1997. (Cmnd 3807.)
3 Department of Health. *Partnership in action: new opportunities for joint working between health and social services.* London: Stationery Office, 1998.
4 Department of Health. *Modernising social services: promoting independence, improving protection, raising standards.* London: Stationery Office, 1998. (Cm 4169.)

Endpiece

A doctor's reputation

A doctor's reputation is made by the number of eminent men who die under his care.

Sir George Bernard Shaw