Policies for a Crisis?

Some aspects of DHSS policies for the care of the aged

A COMMENTARY BY
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EDITORIAL NOTE

The new series

Because of the length of essays entailed in providing an adequate presentation, the results of research commissioned by the Trust or in which the Trust has had a major part have on occasion no appropriate publication outlet. This was one of the main reasons for the Trust establishing the 'Problems and Progress' series twenty years ago. Frequently, however, it was evident that some of the freshness of an essay was inevitably lost in the wait for other essays to complete a volume, and sometimes one suspected the immediacy of the thrust of a particular communication had been lost in a volume in which the collection is of disparate nature. It has therefore been decided to experiment with a new series of Occasional Papers, arising from ventures of the Trust concerned with matters of the moment and designed to lead the way to improvement of services.

Policies for a Crisis?

The first of these is *Policies for a Crisis?* a commentary by Sir Ivor Batchelor which raises questions on a major problem of our time which is likely to worsen in the near future, namely the care of the very elderly and frail. The particular problem of the group of the elderly who are mentally ill was specially remarked upon in an earlier publication of the Trust *The Impending Crisis of Old Age* (OUP, 1981) and within the past few days the Office of Population and Census has published figures of the population changes in England and Wales since the 1981 Census which show a 7 per cent increase in the age group 80 and over (Series PP 2, No. 12, HMSO). The implications of this are disturbing and call for an urgent review of what will be required by way of public policy to ensure an adequate state of readiness to deal with what could well in the immediate future be a major crisis in care provision.

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INTRODUCTION

This is a commentary on some aspects of DHSS policies. It would be impertinent to suppose or hope that it might in any respects be definitive: it is neither a comprehensive nor a balanced survey. It has had a more modest objective: to advance the discussion initiated by the Nuffield Provincial Hospitals Trust's publication The Impending Crisis of Old Age(1) and pursued at the seminar held by the Trust in September 1982. Topics which have had considerable attention in these contexts have been neglected. It attempts to supplement the already published material in areas where it has seemed to the author to be inadequate: and to concentrate on aspects of policy and performance where the Department appears to be most vulnerable to criticism. It is a commentary not an account of an in-depth or statistical investigation: the latter would require a different procedure of enquiry, more resources and more time.

I have used mainly the policy papers published and issued by the Department over the past five years: and have supplemented these with interviews and correspondence with officers of the Department. I have not paid visits to areas of good or bad practice because I am reasonably familiar with the clinical problems and good practices have been well reported. I have not reviewed the data about specialised psycho-geriatric services, for two reasons. First, there has been much written on them in psychiatric journals and books, in the Nodder Report, and in the very recent publication of the Health Advisory Service entitled The Rising Tide(2). There has also been a booklet from the Centre for Policy on Ageing, on Mental Illness in Old Age(3). Secondly, there do not seem to be major differences of opinion about how to approach the issues. The difficulties are seen to be rather in making widespread what in many places is already being done well.

I have assumed that, in general, areas and topics which are already the focus of keen professional interest and involvement are unlikely to present the most intractable

problems. I have thought it more useful to concentrate on aspects which have had less attention but which may be hardly less important. It is the more active areas of work which excite doctors: they tend to lose interest in what is long-term or seen to be therapeutically unrewarding, and the latter is of course very commonly characteristic of the illnesses and disabilities of the aged —especially the very old. Also, so numerous are the old and so various their situations and needs, inevitably they engage a range of the health and social services far beyond the bounds of any present or potential medical specialisation designed to support them.

In much of the recent literature, attention has been focused on doctoring, acute treatment, and rehabilitation. The problems which I have concentrated upon are the provision of beds and care for the demented, the structure and deployment of the nursing services, and some of the deficiencies in the medical contribution to primary care. I have not explored the social security aspects, important as these undoubtedly are, and I have not said as much as might have been said about nursing homes, since the Trust is studying this important topic.

In reviewing services devoted to the aged it has not been possible to separate what is generic for that age group from what is more generally characteristic of NHS provision. Deficiencies may be more or less specific to the care of an age group or more widely spread across the age spectrum. If the focus of discussion appears at times in what follows to broaden considerably beyond the area of immediate enquiry, the reason is that its target has inescapably become wider.

I have found the Department's own Report on Community Care(4), in the detail of its coverage and its realism, one of the most valuable publications on the topics under discussion.

As I hope will be obvious, I have not interpreted my role as narrowly that of psychiatrist and, still less, that of psychotherapist.

The facts upon which the following discussion is based were elicited in the early months of 1983: it has not proved possible to have their accuracy re-checked by the Department.

1
Some general observations

1.1 The Department deserves great credit for the way in which it has, over many years, championed the needs of the old and given priority to the services required for them, against indifference or resistance from the medical profession and in most places and at most times, public apathy. Its policy documents, notably A Happier Old Age(5) and the White Paper of 1981, Growing Older(6) have been comprehensive and persuasive.

1.2 The Department has not been assisted in its efforts by much political interest: there have been few questions in Parliament. But public opinion is more volatile than it used to be and rather easily swayed in its sympathies by the excitement of journalists. It could well be that the problems of old age will become much more sensitive politically. They could be highlighted emotionally by such occurrences as 'granny-bashing'; and attention to such a distressing social phenomenon could move easily, logically, and quickly to the circumstances in which it had occurred and which might be held to mitigate the individual offence, viz: the intolerable burden and strain which had been imposed upon the relatives. If this were to happen, the Department could very quickly find itself in the front line of attention and criticism.

1.3 In its policies for the care of the aged the Department has given a lead especially in two directions—towards increased care in the community, and in promoting the medical specialty of geriatrics. The latter is mainly of professional concern. The former presses directly and heavily on the general public. It may be questioned (and it will be, below) whether this policy has not already placed too onerous and sometimes an intolerable burden on relatives, friends, and other

carers. And if this is the case, or if the balance between what is acceptable or to be rejected by the public is already swaying uncertainly, then the situation (if there are no changes in current policies) is very likely to deteriorate over the coming decade. If it does, the Department will be blamed: the policies have been central policies.

1.4 There is another highly important area in which the Department must get the balance right; and that is between central policies and guidance on the one hand, and local initiatives and responsibilities on the other. The Department has amply fulfilled its obligation to establish and propagate the principles involved in caring well for the elderly. But probably it has had, and still has, a greater desire than it should to intervene in the Health Service. This comes not from a lust for power but out of a concern for standards. The Department is an over-anxious mother, reluctant to give her children independence; and not least because it has seen some of them go to the bad and become cause for public scandal. Nevertheless it should be accepted now that enough broad policy statements and more specific guidelines and norms have been issued by the Department; and that the drive henceforward must be to secure relevant and fully effective action locally.

1.5 Departmental intentions are to devolve responsibilities to Regions and Districts. Since January 1982 a system of Regional Accountability Reviews has been instituted, in which the performance of Regions in implementing national policies is scrutinised: but so far (I understand) in about only half the Regions have District reviews been carried through on the basis of plans tailored to local needs and circumstances. NHS Regions should pay far more attention to monitoring the plans and performance of Districts than to issuing or forwarding guidelines to them. From the point of view of the aged, the sooner responsibilities are firmly established at District level the better. Since the inception of the NHS the problem at the periphery of the service has always been that resources and finance for development have got sucked into the acute sector of medical care. The Dis-

tricts should now be held very firmly to their responsibility for preventing this; and it is at District level that provision can best and most quickly be adjusted to the changing needs of the community, and the contributions of the NHS, the Personal Social Services, the private sector, and voluntary organisations can be co-ordinated. Earmarking of funds centrally does nothing to promote the development of strong feelings of responsibility at District level: on the contrary, it fosters the expectation that local neglect will be made good, sooner or later, by a Departmental hand-out. For these reasons the Minister of Health's recent decision to allocate £6m over three years to encourage 'district schemes for the development of comprehensive psychiatric services for elderly people with mental illness' can be greeted only with mixed feelings, even though it is intended more to raise standards by financing 'demonstration services' than to compensate for deficiencies.

1.6 At District level the health and local authority services will have to make their own arrangements to maximise their co-operation. Central government should place upon each the responsibility for effective liaison and should encourage this by some shared financial allocations—but central government should keep out of local particulars. Joint financing has generally been a success: but the budget for it is and should be small: these are pump-priming exercises and are particularly useful when they can be fitted into a Research and Developmnent framework. Both the NHS and the local authorities are likely in the foreseeable future to be short of finance for anything like ideal services. This will force a healthy assessment of priorities and an emphasis upon a better balance of services locally. Some elements of the present provision are overdue for critical appraisal of their cost-effectiveness, e.g. on the NHS side, day hospitals for psychogeriatric patients.

1.7 Probably too much emphasis has been placed on structures at Area and District; too little on the importance of the co-operation of professional groups and individuals at the 'grass-roots'. But two aspects of District level structure merit emphasis. It would undoubtedly foster

co-operation and efficiency if the health and local authorities were jointly to finance and staff data-gathering and statistical units to meet health, social services, and housing requirements. Such joint information units about needs would provide the best basis for the rational and economical development of complementary services. The recent Health Advisory Service report points out how necessary it is for the monitoring and evaluation of services to have carefully collected and relevant statistics, and it provides details of what is required(2).

1.8 It will certainly further local co-operation at District level if there are also lively Joint Programme Planning Committees responsible for the planning of services for the aged across the health and local authority boundaries. Such committees do not have executive powers or a budget: but by bringing together the leading professionals from the health and social services and representatives from interested lay bodies to identify problems, propose solutions, and regularly to review progress, much of mutual value can be achieved, and their parent authorities will be better advised.

1.9 While in the NHS the devolution of responsibility downwards and the process of accountability upwards are proceeding, there remains the problem of how to maintain a high degree of sensitivity to the needs and wishes of the local community. Present structures in the NHS do too little to promote, far less guarantee this. The sensitivity of Health Districts to consumer opinion of their performance can be assisted by the Community Health Councils. The CHCs should be aided, not their existence threatened, as it was under the previous government.

1.10 There are those who wonder anxiously if it is necessary or humane, so to differentiate the aged as receivers of services: are they not an integral part of the adult population, and do not they themselves want to belong with the rest and not to be treated as a special problem? But because of their exceptionally heavy demands on health services, their dependency and particularly the increasing incidence of dementia as they grow older, they

do constitute a special problem. There are those also in the community who, going in the opposite direction, continue to hanker after a comprehensive service for the aged, not just crossing administrative boundaries but involving a fundamental restructuring, simplification, and unification of responsibilities and provision. The most logical way of achieving this would be to make health as a whole a local authority responsibility: anything else, which would require the assent of the professions concerned, could only be a tidying operation at the fringes. Such a major restructuring, whether or not desirable, does not look like becoming a political possibility this century. Untidy and unsatisfactory as present arrangements may be, they will have to be made to work as well as possible.

1.11 If there is to be more emphasis on local responsibilities and initiatives, inequality in the amount and level of provision across the country will have to be accepted. It already exists: some health authorities use what they have efficiently, others less so. The inequality could become even more marked. But confidence should be placed in the mechanisms of RAWP and the Accountability Reviews with the health authorities, while the interaction of professional providers and their patients or clients provides a potent, if undiscriminating, stimulus to a rising standard of facilities and performance. The Department is rightly active in identifying and promulgating, in various ways, examples of good practice. As has been noted above, more consumer awareness and influence should be fostered, through the CHCs. What the Department should not do is to attempt, in reaction, more standard-setting from the centre. In so uncertain an economic climate it could not know what standards to set over-all: and if you attempt to set a standard for one or other element of staffing or services, you run a serious risk of upsetting the balance of the whole.

1.12 Much play has been made by critics of the Department in attacking national norms of provision on the grounds that they are wrong or have become seriously out of date. At the Trust's seminar in September 1982, for example, it was claimed that:

> the present NHS norms of provision were outdated and inappropriate and should be revised urgently and be calculated on the basis of the over-75 age group.

There were grounds for this criticism: the bed norms per thousand people aged 65 and over were formulated in 1972 and had not been updated. Since then the Department has accepted that the guidelines require to be adjusted to allow for the increasing number of the very old among the elderly population. But the adjustment suggested is marginal—shifting to the top of the previous guidelines, i.e. from 2.5 to 3, to 3 per thousand.

1.13 There may in certain circumstances be a use for norms, to get some kind of provision off the ground, to promote the development of a cinderella service, or to make sure that a specialty gets a fair share of health service manpower. Norms may be used to fight local battles for resources. But, while they may be a help in situations of serious deprivation, they may equally be constraining, and services which may be no more than adequate can, when measured against them, appear inflated. Norms may not keep pace with changing expectations and they tend to fossilise a certain level of provision, usually rather a low level. They have other deficiencies: norms are rarely based on critical research, are too rigid for the variety of local circumstances, and may pick out rather arbitrarily one only, or a few elements in what should be an integrated package of care, or perpetuate a no longer relevant balance between categories of care.

1.14 Scrutiny of the present norms and guidelines for the numerous elements of the 'care package' for the old, all the kinds of provision and the various categories of staff, reveals a complex and untidy schema. It does not look like the confident and coherent expression of a national strategy, and it does not look now to be of much use to those concerned with the delivery of services. Rather than tinker with it further in revision, it would be better to accept that it had outlasted its usefulness and publicly to abandon it in favour of developing what is needed at local levels.

1.15 There may be some truth in the criticism that health services are sometimes more closely aligned to professional interests than to the needs of patients. What is a more pertinent observation, in the case of the care of the old, is that policies and services have been too doctor-dominated or influenced. The importance of the nursing services in practice has not been reflected in the influence of nurses in the planning process. For example, the whole development of nursing homes in the NHS seems to have been retarded by a felt need to obtain the agreement of geriatricians to it. Too much attention seems to have been paid to the doubts of doctors, and too little to eliciting the willingness and using the undoubted ability of the nursing professions to take further responsibilities. To give another example of the undervaluation of the nursing contribution, decisions must often be made as to whether an old patient should be looked after by the geriatric or the psychogeriatric services; certainly the medical diagnosis is often relevant, but far more often the critical aspects influencing sorting and allocation are those of nursing care and safety. Yet it is the doctors, not the nurses, who usually make these decisions.

1.16 <u>Recommendations</u>

There has been a sufficiency of Departmental general policy documents. Responsibilities for the proper care of the aged should be firmly established at the Health Districts, and plans of action should be formulated at this level.

Co-operation between the health and local authority services would be assisted by joint data-gathering and statistical units, and by joint programme planning committees.

Consumer opinion and influence should be sought and welcomed. The Community Health Councils have an important role.

National norms have outlasted their usefulness and should be abandoned.

2
A note on terminology and euphemisms

2.1 The 'confused elderly' is a widely used and most unsatisfactory term. It is employed to describe three patient populations with different prognoses, viz:

(a) those suffering from an acute confusional state, due to physical illness or toxicity, who are not demented and may be expected to recover, given appropriate treatment;

(b) those who are demented and have in addition a confusional state: they may be expected to respond to a limited degree to treatment;

(c) those who are demented and whose dementia will not respond to treatment.

2.2 It is a term so widely used probably in part because people do not like to face unpleasant facts. By including a number of different conditions it gives a spurious impression of the possibility of cure or substantial alleviation in the huge population of those who are irreversibly mentally damaged.

2.3 'Functional' mental illness in old age, though it may escape recognition and may be inadequately treated (and this in the individual case may be disastrous), is not an overwhelming problem. It is of course highly important to forestall, detect, and treat promptly the causes and symptoms of confusion or depression when they occur. But it is not the confused elderly who are the main problem: it is the demented.

2.4 Another euphemism which has been introduced in recent years to label the demented is the 'elderly severely mentally infirm'. It substitutes four words for

one and it is, as of course most euphemisms are, less precise. No doubt the term has been used because, being just infirmity, it then becomes easier to persuade the social services that it is their responsibility to care for it. But it is not just infirmity which is the core of the problem but a disintegration of all that is most human and individual. Words should not be used to hide the truth of the matter which is that amnesia, disorientation, restlessness, and incontinence may create a condition of the most complete, continuous, and demanding dependency on the care of others.

2.5 'Mental impairment' is yet another term which has been used with reference to the state of the elderly demented individual. It is no better than the others; and it has recently been given a quite different, legal definition. Under the Mental Health (Amendment) Act 1982, it is being introduced 'instead of 'subnormality' for the few abnormally aggressive or seriously irresponsible mentally handicapped people who need to be detained'.

3
The most serious clinical problems

3.1 It is the old who are suffering from a moderate or severe degree of dementia who present the most intractable problems. The older the individual, the more likely is it that he or she will be suffering from dementia. Twenty per cent of those over the age of 80 are demented.

3.2 Those who quietly dement can be cared for as increasingly helpless children, who evoke reactions of mothering. But the grosser symptoms of dementia, into which the individual sufferer usually has no insight, are very distressing to others—incontinence, restless insomnia, wandering, falls, forgetfulness leading to losing things, and to dangerous actions such as turning on the gas but failing to light it, repetitive, irritating, and useless actions, suspicion and aggression. Not only are the disturbances of behaviour in themselves difficult to deal with, they are accompanied inevitably by a distortion of personal relationships and by a progressive failure of the ability to communicate with others, which is particularly poignant for relatives. It is an indication of the nature and severity of the stress upon relatives that the assistance which they most appreciate is to be given a break from the burden of caring.

3.3 Dementia of this severity is the result of bodily disease, being due either to neuropathology of the Alzheimer type or to multiple infarcts of the brain. Its management and care are therefore primarily the responsibility of the health, not the social, services. The point is reached in a great many cases, the unskilled carers having done all they can, when the requirements are for high-dependency nursing and a long-stay bed--from which

the old person, as his or her dementia progresses, will not move many yards. It is a nursing home, not rest or residential home, type of care which is then required.

3.4 Both the geriatric and psychiatric services as specialist services (and of course not they alone) look after the demented, in very large numbers. It is frequently by rather arbitrary pathways that the demented individual reaches the service in which he is cared for. If the demented individual's behaviour is markedly disturbed, he is more likely to be found in psychiatric accommodation.

4
Indications of stress and strain in the present provisions

4.1 I should make it clear that I believe that the limits of community care of the mentally ill and demented will be reached more quickly than those which determine the care of the physically ill and disabled: both because of the very different nature of their symptoms, and because of the very different effects of those symptoms upon other people.

4.2 The burden falling on relatives who support demented old people in the community is widely known to be severe. The deteriorated and further deteriorating behaviour of the old person presents many serious practical problems of management and security; while it strains personal relationships, to the degree not infrequently of precipitating mental ill-health in the carer. The high level of stress to which the principal carers and supporters are subject, and the distortion of their daily lives, will be exemplified in the study commissioned by DHSS from Dr Ian Sinclair and Enid Levin at the National Institute for Social Work: their report is being compiled. Another indication of contemporary pressures upon carers in the community is to be found in the Health Advisory Service's most recent report(2):

> Over a long period every Community Health Council interviewed during H.A.S. visits has included the psychogeriatric service as an agenda item for discussion, often top of the list, as of great concern.

4.3 There is plenty of evidence which would tend to suggest that the present staffed-bed provision for the

frail and demented is inadequate. Everywhere one finds elderly individuals more disabled, and more dependent, than the environment can sustain. Those manning the primary care services complain that many old people who should be in institutional care are not. Wardens in sheltered housing report that too many of their residents are incapable of self-care. Those responsible for Residential Homes (Part III Accommodation) provided by the local authorities complain that up to half the populations they look after are too disabled for such accommodation, and need more care, elsewhere.

4.4 Is the present balance between the NHS and local authority provision generally correct? Are the local authority services being overloaded? The Department does not think so: it believes that the personal social services have a considerable 'door-keeping' ability, and can refuse entry to those for whom they cannot adequately provide. It is sensible, of course, if you are pressing a policy on doubtful collaborators, not to say to them 'You've had enough'. You wait to hear from the targets of your policy that they feel the victims of it. But if the Department were to press its policy for community care too far, and thus provoke a reaction of revolt, it could suffer a backlash which would throw an even greater burden upon its strained resources.

4.5 The pressure of the old who need care and treatment is also felt heavily in the acute hospital sector. Already in 1978 over three-quarters of all hospital admissions of people aged 65 or over were to the general hospital specialties, and over 40 per cent of all acute general hospital beds were occupied by the over-65s. So far increases in acute hospital activity have in general apparently more than kept pace with population changes: but the shoe begins to pinch increasingly painfully, and in many parts of the country general hospitals are under severe pressure. The proportion of their facilities and services devoted to the care of the very old is increasing inexorably. There is increasing bed occupancy by the over-75s, and a falling bed occupancy and shorter length of stay in the 15-44 age group. The very old may be get-

ting their fair share of attention, but is this now at the expense of younger people who need acute services and who cannot find them elsewhere? The Department is uncertain:

> What is far from clear on the basis of analyses performed so far is whether or not younger age groups will suffer reduced levels of service as the proportion of over 75s in the population continues to increase as projected(7).

4.6 It appears from this evidence of overload already on the present arrangements for care that, given the demographic projections, the provision for the very elderly infirm will have to be increased and probably very significantly increased. Blockages of the pathways into and through services are widely obvious; and these appear now to be due more to the inadequacy of the total volume of provision than to ineffective use of the resources available. The main shortage is of bed provision for the over 75s. How is the Department in its policies responding to this situation?

5
The Department's solutions, and the apparent need for more beds

5.1 To relieve the mounting pressures on the present position, the Department relies on the following measures and resources:

(a) Increased family and community support;
(b) More active treatment and rehabilitation;
(c) Increased use of Part III Accommodation (Residential Homes);
(d) Community Hospitals;
(e) Nursing Homes.

It does not rely, explicitly, on the mental hospitals. It must be doubted if the Department's confidence in its policies is well founded.

5.2 There is no doubt that housing which is suited to their needs will help old people to remain longer in the community and independent. The implementation of a specific and comprehensive housing policy for the aged is needed therefore to complement the health and social services: improvement grants, private sector building for the elderly, and sheltered housing are all important. But it must be emphasised that none of this can provide for the needs of those who are more than mildly demented and require intensive care by others.

5.3 Can relatives, friends, voluntary bodies, and other helpers do much more than they are at present doing to support old people (particularly those living alone and demented) in the community? There has been no national or large sample survey by OPCS or any other organisation whose findings can be quoted. A greater burden of

domestic care can be carried by the general public at a time of economic recession, when many women with disabled old relatives are out of work. But the demographic trends, both with regard to the aged and to their potential middle-aged supporters in the community, are adverse; and the employment situation may improve. Certainly the availability of even the present number of female carers in the community cannot be guaranteed over the coming decade. Furthermore, they are expected not only to be primary carers for their own relatives, but more generally to man the voluntary effort which it is hoped will fill the gaps in community services: gaps which arise particularly in 'unsocial' hours, at weekends and during holidays.

5.4 The Department sets great store by the use of acute District General Hospital beds for assessment, effective short-term treatment, rehabilitation, and quick turn-over. The throughput in these beds has increased in recent years: the Department believes that it might be improved further. The Department complains of a lack of assessment beds in DGHs for elderly patients with psychiatric disorders. Rightly it wishes to see the specialised skills of the geriatricians and psychogeriatricians employed to the best purpose. This is good medicine. But there is no scientific evidence that the early detection and treatment of physical and mental illness will prevent the onset or delay the march of dementia. The preventive and therapeutic efforts of geriatricians and psychogeriatricians is unlikely therefore to have much influence on the need for long-stay beds (whether in hospitals or Homes) for the severely demented. Similarly, the recruitment of more members of the professions supplementary to medicine, therapists of various kinds, will improve the quality of care, but is unlikely to affect very materially its outcome.

RESIDENTIAL HOMES (PART III ACCOMMODATION)

5.5 Residential homes run by the local authorities play a crucially important part in any strategy for the

care of the old and demented. How large a part can they play?

5.6 The Statistics Branch of DHSS has been investigating the 'State of Dependency and the Age of Admissions to Residential Homes for the Elderly'. It has been doing so since 1981, but it has not yet made even a preliminary report. No doubt it will have been found that there has been a progressive rise in both the age of admission to this form of care and the degree of dependency of the clients. The extent of the rise is likely to compel very soon a reappraisal of the staffing and use of this type of provision.

5.7 The latest available discussion of the value and functions of these residential homes is to be found in Chapter 8 of Alison Norman's publication from the Centre for Policy on Ageing(3). Her views seem to be close to those of the Department. She is intelligently and sensitively aware of how the needs of old people should be met in this kind of accommodation and of how standards of care should and can be raised. She is also well aware of how residential homes are now being used for the care of the demented to a degree that is far from what was originally visaged of their functions

> in both the statutory and non-statutory sectors, residential homes are in the position of purporting to do one thing and actually doing something quite different—with the result that staff levels, training, design of buildings, assessment techniques and care and rehabilitation skills are all too often inadequate for the work to be done.

But in two respects she is less than sufficiently critical.

5.8 Norman does not go into any details about the economics of this kind of care, but supports it in part on the grounds that the only practicable alternative is expensive long-term NHS hospital beds. That is an eminently reasonable point of view; local authority provision is to

be preferred because it is cheaper. But she does not leave it at that, and tries to have the best of both worlds. She goes on to plead that it should be recognised that:

> residential work with the elderly is a demanding and skilled task with great potential in the development of community services and that staff should receive training, status and pay appropriate to their work.

If they did so, the economic advantages of this sort of provision would largely disappear.

5.9 She seems also, as do the Department, to expect the residential homes to do even more than they do now in the care of the aged and demented (who in this chapter of her book she chooses to call the 'confused' though she knows that this is a misnomer). She advocates:

> A clear acceptance of responsibility by the residential sector for the care of both mentally and physically disabled people unless they have some characteristic which clearly demands hospital care.

5.10 Enlarging the role of the residential homes in the care of the aged and demented could be achieved either by increasing the number of residential homes or by increasing the percentage of demented people in them, or by doing both of these things. Theoretically no doubt the number of residential homes could be increased: in fact the local authorities cannot find the money to increase them, and their numbers may even be decreasing. Hope then is pinned on increasing the percentage of demented old people in the present residential homes; and it may be a hope with little basis. It seems to be widely agreed, based on practical experience and the research of the Manchester workers (8), that it is manageable to have up to one-third of the population of a residential home who are demented. 'Specialist' homes for the demented have been tried but now have few advocates. Even to maintain, far less increase, such a high percen- tage of the demented in an ordinary residential home is

difficult, and a degree of support from the NHS is required in advice, training of staff, and the actual nursing of these patients.

5.11 It is, I think, not doubted that there is still a need for residential homes which will serve their original functions. But already the nature of residential homes has been widely and drastically altered, and it is doubtful if this process can be taken much further. Increasingly they are providing not homes, but beds for those who would formerly have been in hospitals. One might in those (probably not very many) places where NHS provision for the patient group is in excess, put into the residential homes a greater amount of psychiatric advice and nursing attention: the more you did that, the higher might you raise the percentage of the demented who could be cared for. But it is very unlikely that the limits of the tolerable could be sufficiently raised to make it possible to accommodate in these homes the greatly increasing numbers of the severely demented. Also, of course, the more NHS resources that you put in, in this way, the nearer the residential home comes to being a nursing home.

5.12 Neither the NHS nor the local authorities have a declared policy that the residential homes should become nursing homes. Policies and practice are at variance. That there is not a clear policy for the future of this Part III Accommodation is probably another reason, additional to their cost, why the local authorities are holding back on the construction of further homes.

COMMUNITY HOSPITALS

5.13 Hospitals of between 50 and 150 beds have been called 'Community Hospitals'. Departmental policy since 1975 has conceived of these smallish institutions as providing up to one-quarter of all hospital beds and essential accommodation for many old patients, the locus of some of the geriatric beds of a District, and places

for the care of the 'elderly mentally infirm'. Up to two-thirds of the beds required in these two categories would be provided in the community hospitals, many of which would be in the charge of general practitioners. This policy has been a failure. No agreement has been reached with the two branches of the medical profession most concerned, the GPs and the geriatricians, about what functions these community hospitals should serve and how they should be staffed and conducted.

5.14 In the Department's mind these community hospitals were to be mainly hospitals for the old, but the general practitioners had little desire to look after the demented. They had other ideas: the concept of community hospitals seemed to offer the opportunity of getting their own hospitals, with X-ray and other facilities, where they could practice acute medicine and minor surgery, and treat those who could be cured, or at least rehabilitated. The geriatricians, on the other flank of the disagreements, thought that they should control at least the preliminary assessments and admissions to these units, and expressed apprehension about the level of care and mobilisation which would be achieved for elderly patients under the care of general practitioners.

5.15 The Department evidently got bogged down in argument with these two medical professional groups. And while there has been contention about the national policy and little or no progress in its implementation, these community hospitals have been disappearing. One hundred of them with up to 150 beds each, were closed in the five years prior to 1981 (the latest dates for which figures are available). The facts are given in the table below:

Number of Small Hospitals in England 1976-80

	1976	1977	1978	1979	1980
Under 50 beds	762	793	754	742	727
50--149 beds	675	657	644	623	610

5.16 These closures are bound to have a serious impact on the Department's ability to ensure that sufficient

beds are provided for those old people who need them. They have been made, one supposes, on the grounds that community hospitals are uneconomic: which perhaps has often been a way of saying that the money expended on them would be better spent on the acute services, or that those running the acute services had demanded that.

5.17 A new memorandum of guidance on planning the pattern of hospital services is, I understand, at a late stage of formulation and approval in the Department. I have been told that in considering the future of community hospitals, attitudes will be more flexible: but I doubt if the new policy document will prove to be radical enough. I fear it will seek further compromise between the competing interests of the two sections of the medical profession who have so far bickered over the increasingly bare bones of the old policy, instead of going boldly for the solution which appears to be clearly indicated—namely, identifying nursing as the profession which is primarily concerned, and giving nurses responsibility for the development of many of the small institutions into nursing homes.

NURSING HOMES

5.18 Nursing home type of care can be provided in areas of existing hospitals (geriatric and psychiatric), in separate nursing homes or in residential homes.

5.19 It is difficult to understand why the development of nursing homes for the infirm aged should have been so retarded in the NHS. Such provision has been commonplace in the private sector and on the continent of Europe for many years. Even now there are only three NHS experimental schemes in England and Wales (they follow the Danish model), only one of which has actually started. It may be that too much weight has been placed on the opposition or scepticism of some doctors: geriatricians have expressed the view that in nursing homes, nurses might not rise to the responsibilities placed upon them, that

there might be unacceptably low standards of care, and that public scandals might erupt.

5.20 Commonsense indicates that the provision of nursing homes and their more domestic atmosphere as a viable alternative to other types of institutional care, and their acceptability to patients, relatives, and staff, hardly need to be tested. For the NHS their chief unknown aspect is their cost: but while the experiments being undertaken will include research into their financial aspects, they may not provide the answers needed, since the homes being tried out (of 20 to 35 places) are smaller than the lower limit of what the private sector considers to be profitable. Neither will the present experiments bring any answers soon enough: final reports of their results will not be available for about five years.

5.21 It is essential therefore that while this careful exploration, documentation, and evaluation proceeds, local experimentation at District level with such provision (both for geriatric and psychogeriatric patients) should not be held up. It will be more rough and ready, and mistakes may be made. But the need is urgent.

5.22 The DHSS experiments mentioned above are concerned with patients who might otherwise be in long-stay hospital geriatric beds, not with psychogeriatric patients. If the old person is 'severely mentally infirm' and requires psychogeriatric care, he or she will not be admitted to one of the experimental homes. The Research Liaison Group responsible for mental illness research is discussing a nursing home experiment for the severely mentally infirm, but it is still at the planning stage. It is obviously relevant that, to give an example of which I know personally, since before the Second World War, the Royal Edinburgh Hospital for Mental Disorders (since 1948 a part of the NHS) has run associated nursing homes for psychiatric patients, including those who are suffering from senile disorders. And to be able to deploy staff in nursing homes from a parent mental hospital has clear advantages in flexibility, in back-up resources, and in providing for staff the possibility, if required, of periods of work in less stressful areas.

5.23 A further limitation of the current experiments is that none of these nursing homes is placed in a conurbation. The experimenters could not find a suitable building on an inner city site; and there it would certainly be more difficult to recruit staff.

5.24 There is undoubtedly scope for expansion of the private sector in the care of the aged, particularly in the provision of more nursing homes. This expansion should be fostered in DHSS policies; while keeping in mind that the geographical spread of such accommodation will be far from comprehensive, that standards of care are liable to present a considerable problem, and that there are likely to be weaknesses particularly in psychogeriatric provision. Nursing homes have mushroomed in parts of the country where the tourist trade has declined; and they might wither or become unwilling to carry the heaviest burdens of care, in a different national financial climate.

MENTAL HOSPITALS

5.25 I have found it difficult to judge fairly the position of the mental hospitals in the proposed total pattern of care for the aged. There has been no census of their patient populations since 1971. Of the 73,000 patients in the mental hospitals in England, 39,000 are over the age of 65.

5.26 The patient populations of the mental hospitals in England and Wales have been falling in numbers, for two major reasons (there may be others): these hospitals have been discharging into the community schizophrenic patients the majority of whom are not cured and are in fact incurable, and they have been limiting the admissions of demented old people. These are expressions of a Departmental policy which, capitalising on a too facile dichotomy between cure and care, determines (entirely reasonably) to preserve the NHS's ability to cure and (less convincingly) to devolve a much greater part of the elements of care on the local authorities, the families of patients and the private sector.

5.27 The rightness of this policy as regards schizophrenic patients is arguable. With regard to the needs of the old and demented, there has undoubtedly been an aspect of rejection in the attitude of the mental hospital staffs. Acute medicine has the prestige and the money: they too want to deal predominantly with the treatable and curable. They are encouraged in their rejection by a last-resort definition of their role by the Royal College of Psychiatrists; and they rationalise it with the excuse that if they had more old patients they might lose their status and approval as institutions of medical and nursing training. Of course they would not. The result of their rejection is that large numbers of the elderly and markedly demented are in geriatric accommodation, where they are in the care of nursing staff less well trained to look after them; and in residential homes, where the greater part of the staff have had no training at all.

5.28 The Department expects a fall in this decade in the total number of psychiatric beds needed for patients aged over 65(9). Of the estimated 550,000 patients suffering from moderate or severe dementia in 1991, it expects to house not more than 33,000 in psychiatric beds. The Department does realise that there will be a considerable problem in the mental hospitals in 'seeing that empty beds are made available for elderly patients'. It is of course not the physical presence of beds, but their availability that matters.

5.29 The patient population previously treated in mental hospitals is, it is planned, to be cared for in larger part by families, or in private institutions and nursing homes, in Part III Accommodation or in 'small, local domestic-style psychogeriatric units' which are to be part of the psychiatric services and provide continuing care. These local units do not exist: and there is not a single experiment being carried out by the Department on nursing home care for severely disabled psychogeriatric patients. It should be added that even if accommodation in smaller units were available, it might prove to be less satisfactory than that in the mental

hospitals. In a small unit where the demented were concentrated the atmosphere and working environment could easily become dispirited, and the recruitment and retention of staff difficult. In a larger hospital the circumstances allow more easily of staff rotation to less demanding areas of care, and morale and standards may more easily be maintained. It is impossible to be categorical about this: but to close hospital beds which one has for accommodation which might prove to be no better but more expensive and less satisfactory, is not sensible.

5.30 I think that the Department is too sanguine: and that contrary to its expectations it is very unlikely, in front of 'the rising tide' of the very old and demented who will be non-ambulant and more or less helpless, that present policies for and in the mental hospitals will be much longer sustainable. If they cannot be sustained the period of readjustment will be painful. Demoralised as they have been by the prevalent doubts about their relevance and integrity, the staffs of these hospitals will see an alteration of policy about their admission of old people as yet another attempt to use them as 'rubbish dumps'. It is a revealing phenomenon that, whilst previously English psychiatrists would strongly resent their being referred to as 'bins' ('loony bins'), they now themselves sometimes use the term for their own specialist hospitals.

5.31 To sum up this section, little or nothing has been said here about the quality of provision: the amount of it comes first. If there are sufficient beds now for the considerably and severely demented who are over the age of 75 (and this is by no means evident) there will not be adequate provision over the next ten years as their numbers rise, if present plans are simply continued. A sceptical review reveals that the Department's policies rest too largely for comfort on a series of doubtful assumptions and hopes. To put it in challenging terms, they depend on measures of prevention which cannot prevent; on the willingness of an over-burdened public to shoulder yet heavier burdens; on a greater use of Part III Accommodation for the demented, the growth of which cut-backs in

local authority finance is preventing; on early treatment and rehabilitation by specialists of what is incurable; on NHS nursing homes which do not exist; and on the use of community hospitals which are being closed. At the same time the Department is hopeful of closing more mental hospitals—30 were mentioned in 1980, the majority of whose populations are over the age of 65 and which look after many of the most demented patients. It appears that there is now a conjunction of formidable demographic trends, a system of care under severe strain and inadequate plans for the future. If this critical analysis is correct or even substantially so, a major change of stance and emphasis is required.

5.32 Recommendations

The residential homes (Part III Accommodation) are becoming nursing homes: a critical reassessment of the policy for their use is required.

Most, perhaps nearly all, of the existing mental hospitals should be retained: which will involve some increased expenditure on their repair and maintenance, and a considerable amount of attention to restoring their morale.

Plans should be made to press on urgently with nursing home developments (not just experiments) in the NHS: many of the community hospitals could and should be converted to this use, and their seemingly progressive closure halted.

The private sector should be encouraged strongly to provide similar accommodation.

6
Nursing in the community

6.1 Despite the central importance of nursing in discharging the responsibilities of the Department for the care of the aged who become dependent, the voice of nursing at the highest levels of policy-making seems muted. Nurses have traditionally performed their duties devotedly, filled gaps in services, and done what they were bid. They have been members of a very conservative profession, slow to innovate. Neither in the field nor in the Department do the issues concerning the nursing services and the professional development of nursing get an intellectual appraisal which is sufficiently penetrating. This is reflected in the current uncertainties about how nursing in the community should develop, as well as in deficiencies in the actual services provided.

6.2 District nurses are of first importance in the delivery and development of nursing services in the community. They form a professional group which is at present highly self-conscious and ambitious; they want to be upsides with the health visitors. They have pressed for, and obtained, a statutory qualification which controls the entry of recruits into district nursing practice. They wish the locus of their training to be in institutions of further or higher education. The content of their training now includes attention to issues of health education and promotion. It is evident that, on the one hand, their development is bringing them closer in role to the health visitors, with the probability of over-lapping; and that, on the other, there is some danger of their own distinctiveness from general nurses being exaggerated. There is no technique of nursing which is peculiar to nursing on a district: the distinctiveness from general hospital nursing lies mainly in the degree of unsupported responsibility which the district nurse

may carry and the fact that she may have to improvise in the domestic circumstances of the delivery of personal care. It follows from the above that there is a need to keep the 'philosophy' of district nursing under critical review. There are also several practical problems which have a bearing on the care of the aged.

6.3 Although there are no measures of need for district nurses which can be applied, recruitment to district nursing is almost certainly not rising as fast as it should be to cope with the increasing amount and degree of dependency in frail old people. In fact the Department does not know the annual recruitment to district nursing: it has the figures for the total number employed, but it does not have the figures for intakes and leavers. Taking this work force as a whole (i.e. including not only registered nurses) in England, it rose from 12,649 w.t.e. in 1977, to 14,522 in 1981. It is a field of work which is popular with nurses, and in many places there are waiting lists for entry into it. There appear to have been two blocks to further and faster recruitment: the one financial, the other a shortage of places in the Colleges which provide training for the new statutory qualification.

6.4 There are also deficiencies in the way in which the clinical work of district nurses is developing. District nurses, although apparently not hostile to enrolled nurses and other assistants in the nursing team, are often poor delegators. They want to do things with their own hands in the interests of maintaining (as they see it) clinical care at a high standard. At the same time the nature of their work has been changing, and changing it appears in a way directly contrary to what is required if more old people are to be supported and cared for in their own homes. While the total number of people aged 65 or over attended to by district nurses has increased, the percentage treated by them in their own homes has fallen from 80 in 1972 to 67 in 1981. Instead of treating more old people at home, district nurses are spending a greater part of their time in health centres and in general practitioners' premises, working with

general practitioners. In the latter setting the percentage of old people treated by them has risen from 17 to 29; and they have been caring considerably more for people of middle age.

6.5 It is Departmental policy that district nurses should care not only for old people in their own homes but provide also nursing assistance to the frail elderly (when they need it) in residential homes and in private sector homes, where the patients are in the care of their general practitioners. The number of district nurses thus employed is increasing. This is sensible: if these patients do not get help, pressure for their admission to hospital is inevitable.

6.6 In England there are still only about 3000 enrolled nurses and 3700 nursing auxiliaries working in the community. In other words since the mid 1960s the build-up of community nursing teams has been very slow and hesitant. The attitude of the fully qualified (registered) nurses has been alluded to above, an attitude of doubt about the abilities of less well trained and of untrained helpers. Also, if funds have been available for nursing, they have tended to be spent on the employment of trained nurses. Colleges of Nursing Education have not been geared to train enrolled nurses for work in the community, the necessary clinical placements have not been available.

6.7 Untrained home helps (untrained, that is, except by life experiences) working in the social services, are seen to play a vital role in supporting old people: any halt in the expansion, far more a contraction, of the home help services due to limitations on local authority expenditure, would cause the Health Department great concern. Untrained nursing auxiliaries, working in the NHS, are viewed quite differently, and their numbers have been kept artificially low. Yet they are derived from the same section of the working population and their work with patients may be indistinguishable. The financial implications of having a substantial element of the work force untrained are of course considerable: and I know no evi-

dence which would suggest that the NHS could not very properly employ in its community nursing services many more nursing auxiliaries.

6.8 Here is an aspect of nursing in which the Department, if it is to be successful in promoting change, will have to give a determined lead. It will have to put to the nursing professions that it has a viewpoint and a policy which is to some extent inevitably in conflict with their own. It will of course have to get the professions' agreement, since it is the qualified nurses who will have to provide (closely or rather less closely) the necessary supervision in practice: but it will have to insist that in the community, as in the hospital services, there is a large place both for those who are less fully trained (the enrolled category) and those who have not been trained at all in any professional sense. It would be inordinately expensive and extravagant to depend mainly or entirely on a fully qualified nursing staff in the community. Professional ambitions run directly counter to this. The United Kingdom Central Council for Nursing, Midwifery, and Health Visiting has issued a discussion paper on nursing education which supports the concept of an all-registered nursing profession. It was a document which ignored the financial implications, the demographic constraints, and largely the nature of the work which this sophisticated work force would be employed to do.

6.9 There are other problems in community nursing which affect the care of the aged. The health visitors are a highly trained, and expensive, work force. They have settled down after a troubled period in which they were undecided as to whether they were more allied to nurses or to social workers. Looking at their situation theoretically, it appears that they are in a very good position to assess, advise upon, and set in motion the services which an old person may need; and there are increasing numbers of old people who require such assistance. Traditionally the main focus of the health visitors' attention has been on children and young mothers: but they have recently had fewer children to look after,

physical health in childhood has generally improved, and why should their concept of the family remain so narrow? Furthermore, published research has seemed to demonstrate the value of their contribution to measures designed to prevent more serious breakdown in old age.

6.10 But despite the claims of the old for attention and the extent of their needs, and despite the fact that their training includes care of the aged, the health visitors have made no move to re-orientate their practice and in fact are now doing not more but less than they were doing 10 years ago, to help them. Of the persons visited at home by health visitors in 1981 only 6.8 per cent were aged 65 and over.

6.11 The role of the health visitors certainly appears to merit scrutiny, not only in this respect but because of the increasing overlap in functions between them and the district nurses. The district nurse delivering clinical care is often in a position to give advice which is relevant to prevention and health promotion, and to give such advice at a time often when the client is most receptive to it. But, though these aspects have been introduced into her syllabus of training, they are not distinctively part of her role, they belong to the health visitor.

6.12 In a follow-up after the publication of Growing Older(6) in 1981 the Department discussed informally with representatives of the district nurses and the health visitors whether a joint seminar should be held to discuss their respective roles and the possibility of some joint initiative being taken. Apparently no enthusiasm for this was expressed by the professionals, and the Department did not push them further. But it seems obvious that the problems will not go away; and what may be required is not an adjustment at the margins of the roles of district nurses and health visitors, but the creation of a new kind of community nurse who would embrace the roles of both.

6.13 In the community the number of practice nurses

(i.e. nurses working directly with and employed by general practitioners) has been increasing; and there are considerable, unresolved problems connected with this increase. These practice nurses, employed in about one-quarter of the general practices in England and Wales, who seem generally to be happy in their work and to be glad to be independent of a nursing hierarchy which tends to tell them what not to do, are looked upon by many of their colleagues in the rest of the nursing profession as blacklegs. They are seen to be the doctors' handmaidens, doing what the doctors do not want themselves to do instead of being nurses in their own right.

6.14 We are concerned here, not so much with the general pros and cons of this development, but specifically with its effects upon the care of the aged. It probably has some adverse effects. It diminishes (though perhaps only to a slight extent) the total amount of resources available to nursing, since the practice nurse may do receptionist duties on the one hand or on the other perform functions which would fall otherwise to the doctor. Also, the practice nurse tends to be surgery or clinic bound, rather than deployed treating people in their own homes. Thirdly, there is a danger that, as a product of the hostility of the wider nursing profession, the number of nurses from the NHS attached to general practices may fall.

6.15 These are issues which one way or another affect the well-being of the primary care team upon whose integrity and efficiency so much of the care of the elderly depends. It would be more logical, and it might lead to a better deployment of nursing services in the community, if the nurses required in general practice were provided by the health authorities. But the Department, unable (were practice nurses to be withdrawn) to guarantee a substitution of staff from the resources of the health authorities, and unwilling to upset part of the arrangements of the general practitioners' 'charter', cannot call a halt to the recruitment of these practice nurses.

6.16 Apart from short update/refresher-type courses in

geriatric nursing, the Joint Board of Clinical Nursing Studies has six-month courses which lead to the award of a qualifying certificate in the specialty. Seventeen centres provide such courses. One would have hoped that in face of the rapidly increasing need for staff who can provide nursing expertise at a high level and inspire their teams, recruitment to these courses would be flourishing. It is not: 117 certificates were awarded in 1982; only 15 more than 3 years previously, and in the intervening years there had been no advance.

6.17 Psychiatric nurses working in the community are a valuable resource: they should be used mainly in support of others, as advisers and trainers. There are very few of them and it is improbable that there will be many. The shortage in numbers and quality of trained staff in the psychiatric hospitals, higher patient-dependency in these hospitals, the difficulty of finding suitable training areas, as well as financial constraints, are likely to make the build-up of this specialist category a very slow business.

6.18 Uncertainty about how nursing in the community should best develop, progressive over-lapping of the roles of district nurses and health visitors, manifest under-employment of less trained and untrained staff, apparent withdrawal of nursing support in the home, the anachronism of practice nurses, all confirm the need for further examination and review. They are important topics which were not dealt with adequately in the report on _The Primary Health Care Team_(10). In fact, only one of them, practice nurses, was discussed at all. There is no locus for this enquiry outside the department, no professional body which might be relied upon to try to resolve the issues. On the contrary, the nursing profession shows increasing signs (e.g. in the Royal College of Nursing and in the United Kingdom Central Council) of fragmentation in its groupings and sympathies. The recently formed UKCC has institutionalised the internal divisions of the larger nursing profession: health visitors and district nurses are sharply divided there.

6.19 Within the Department, despite the dominant em-

phasis on the importance of increasing community care, responsibility for its development appears in some respects disjointed. There appears to be no continuing mechanism for discussion within the Department, far less secure framework for joint planning, between the Divisions responsible respectively for nursing and the primary care (medical) services. In some ways the nursing services delivered by the district nurses and health visitors seem to lie between the health and social services, rather than to belong intrinsically to the NHS, while the general practitioner services tend to be isolated from both. In the strong, persistent emphasis on the responsibilities of the local authorities to provide care in the community, there has perhaps been an encouragement to forget that the NHS itself has large responsibilities in the community, many of which fall outside the remit of general practitioners.

6.20 It is the stance of the Civil Service that if problems or disputes are identified as being professional, their resolution should be left to the professions themselves: a Department of Government should act maybe as mediator or harmoniser, it should not attempt to provide the answers. This is a sound attitude normally, and Central Departments have subtle ways of making their influence felt. But in the case of the unresolved issues affecting nursing in the community, I do not believe that the Department can any longer afford to stand so far back. I have the impression that in recent years the Nursing Division of DHSS has not had a very distinctive identity in its views and policies, but has been content largely to reflect the attitudes of the profession outside. In the community field it now mirrors its divisions and uncertainties. The Standing Nursing and Midwifery Committee does not have a Sub-committee for Community Nursing: it should have, and if there is to be progress, someone must give, or be encouraged to give, a strong and constructive lead. It should proceed from a rigorous analysis of the present situation; both independence of judgment and vision will be required. The welfare of many old people will depend on whether a new initiative of this kind can be taken and carried through successfully.

6.21 Recommendations

Nurses should play a part in central policy making commensurate with the importance of their contribution to the care of the old.

Enrolled and auxiliary nurses should undertake a much greater share of the delivery of community care.

The Department should make a critical review of nursing in the community, which should involve other Divisions of the Department as well as the Nursing Division.

7
General practice

7.1 The vast majority of elderly people (over 95 per cent of them) live in their own homes; and it is national policy that, despite increasing frailty and disability, they should be encouraged and helped to do so. This is the most essential single element in the policy of community care for the elderly, and its successful implementation depends critically on the quality of the primary care services provided by the NHS. More specifically, it depends on the quality of general medical practice, though by no means entirely so, of course. In the case of very old and severely infirm old people, it is not an expansion in the number of general practitioners that is required as the aged age and multiply, but a parallel development of the nursing and other practical caring services. But if there was to be a halt or diminution of these supporting services, a greater load of work would certainly be thrown on to general practitioners.

7.2 It is widely accepted that certain developments in general medical practice will provide more effective and humane care for the elderly in the community. These include the establishment of multi-disciplinary clinical teams for the comprehensive care and treatment of the sick; and the setting-up and maintenance of an age/sex register in each practice.

7.3 The importance of the Primary Care Team, of doctor, nurse, health visitor, and social worker, for the care of the aged is undoubted; it can be further strengthened by advice from a specialist geriatrician (or psychogeriatrician). It is this team which can provide a balanced assessment of need, agree upon strategy, decide who should do what, and co-ordinate the bringing of help in order to maintain the independence of the patient in the community. Otherwise help tends to be unfocussed and resources may be

dissipated. Action may be taken in a particular direction by one professional group, which could have been avoided by the action of others. For example, a patient may be admitted to a residential home without referral for assessment to a doctor or nurse.

7.4 But such teams have not yet been sufficiently widely and effectively established, particularly in the conurbations where the need is greatest. There has been no general resolution of the conflict between health visitors and district nurses who want to work in a defined 'patch', and general practitioners who insist on taking their patients from a wider area. The alliance of health visitors to general practice has not been assured: many health visitors see their natural colleagues to be not the general practitioners but the community physicians. The professional ambitions and rivalries of the two great health professions of medicine and nursing are tending to keep them apart, in a field where they should work very closely together.

7.5 In relation to mental disability in old age, there is considerable scope for preventive action in general practice, and it is not sufficiently being exploited. To identify those at risk because of increasing age requires the setting up and maintenance of an age/sex register: yet many general practices are without one, and it is known that general practitioners commonly identify a minority, sometimes only a small minority, of the cases of dementia on their practice lists. On the basis of an age/sex register arrangements for screening and assessment can be made; 'well-elderly clinics' may be experimented with; home visits can be paid to those most at risk who, though disabled, through frailty or ignorance or inertia are not making use of the services which could help them. It has been said correctly (by a general practitioner) of contemporary general practice: 'Old people do not fit into the rather superficial five-minute encounter which has come to form the basis of modern consultation' (Thompson, 1981)(1). It appears too (e.g. from the work of Professor J. H. Barber and his colleagues, 1976-82)(11) that in general practice a system of preventive geriatric care, a

screening and assessment system for patients over the age of 75, is both practicable and useful. In preventive programmes of this kind health visitors are key personnel.

7.6 Despite the centrality of its importance in the care of the aged, the Health Departments have very little influence over general medical practice and its development. Administratively, it is largely out of their control. It is staffed by doctors who are individual contractors, with open budgets. It is protected by the Family Practitioner Committees (FPCs) who have been a law unto themselves, keeping at a distance the Health Departments on the one hand and the public on the other.

7.7 Not only do the Health Departments lack control or even effective influence, DHSS has little information about what goes on in general practice. It is the opinion of senior members of the Department that in the past 10-15 years there has been a great improvement in the standards of general practice. This is probably correct and so far as it is correct, one need be less concerned about mechanisms of control and influence. But it is equally certain that there are wide differences in the quality of practice, that some of it is very bad, and that a Health Department should be able, not just impressionistically, to assess change and its nature and speed, and be in a position to determine where action towards improvement can best be taken.

7.8 General practitioners provide more services for the elderly than for the younger members of the population; and this is reflected in what they are paid in specially loaded capitation fees. But there are few details available centrally and routinely about their activities: there is no national statistical profile of general practice. Neither is the Department in a position to make sample surveys from time to time, as measures of general practitioner activity for this (or another) age group. It is dependent for such limited evaluations on initiatives by the medical profession itself, made usually by the Royal College of General Practitioners. The Department does not know, for example, what percentage of practices have age/

sex registers; it does not know accurately the percentages of practices which have attached nurses(12), health visitors and social workers; it does not know therefore whether fully developed multi-disciplinary teams are increasing, stationary, or decreasing in number (it may be the last); and it does not know whether home visits to the elderly by general practitioners are being maintained or not. In general, the Department is fully aware only of those services which attract for the general practitioner specific items of payment(13). And in this very important area of fact-finding and appraisal of the adequacy of services and of trends, the Department has had very little help from the FPCs. The 1974 reorganisation of the NHS failed to integrate general practice with the rest of the NHS; and there has been little or no improvement since then. To the question: can the Department use the present FPCs to help to implement their policies for the care of the aged, the answer is probably—not at all.

7.9 The nodal points of general practice, where individual practitioners/contractors come together for some purpose, are of considerable significance. The relative isolation of general practice from the rest of the NHS, and the isolation in their work of many individual prac-practitioners, have been points of weakness. The number of single-handed general practitioners has been diminishing, and this trend should be strongly encouraged: some of the worst practices have been those of single-handed general practitioners in inner cities, and the grouping of professionals aids the communication of expertise and the maintenance of standards. But the FPCs which should have developed as an area of strength in general practice, have not done so. Since 1974 they have had a responsibility for developing primary care services; but many of them have failed to carry out that responsibility well. Bad practice premises have been overlooked; and the FPCs have been prone to measure the quality of services provided by general practitioners by the number of complaints made against them--through a procedure which, for old people particularly, and without legal representation, is both complex and daunting. The FPCs, while policing those general practitioners who fall grossly below accepted

standards, have generally apparently not conceived it to be their responsibility to seek to improve the quality of services. They have not determinedly set about collecting information relevant to monitoring the quality of services, and they have since 1974 made little progress in computerising their records. They have not been obliged to give the Department an account of their stewardship in the form of annual reports: some only of them have done so. It is therefore not an exaggeration to say that the FPCs have been far too independent, antiquated in many of their attitudes and methods, with huge budgets and practically no accountability.

7.10 The position of the FPCs has been given some critical attention here, because of the importance of their role, the inadequacy to date of their carrying it out, and the proposed new legislation which will change their status (Health and Social Services and Social Security Adjudications Bill, 1982). If the FPCs are to be confirmed in a free-standing status as health authorities, they must be made more efficient and more accountable. There is otherwise no prospect, in the short- or medium-term of integrating general practice more closely into the rest of the work of the NHS. (There is, parenthetically, no prospect of persuading significant numbers of general practitioners to become salaried employees of the NHS.)

7.11 If the new legislation gets the Royal Assent and is implemented, it will give considerable powers to the Secretary of State, not least in the appointments he can make. It should be used forcefully to secure a major change in the attitudes and practice of the FPCs towards greater sensitivity and responsiveness to the needs of the consumer (and to helping him); towards collecting relevant data (and their computerisation) and monitoring the quality of services provided; to providing general practitioners with age/sex registers (to be widely effective, this would have to be done without charge to the recipients); and to reporting annually in a way which will allow the Health Departments to assess and influence change in general practice. Though the FPCs do not have, and will not have, any specific responsibilities for the

care of the aged, all this could have a very considerable beneficial effect on their care.

7.12 There is probably a widespread attitude amongst general practitioners that they are paid only for what they have been doing; that this payment does not cover the improvement of services, and that any measures of improvement should be bought by additional remuneration. This is not an attitude which gains significant expression in the hospital service, whose employees are basically salaried and who see a drive towards the enhancement of services as an obligation of their aspiring professionalism and as a buttress of the privilege of their clinical independence. It may be that the contrasting attitude of general practitioners will become attenuated as the quality of entry into general practice continues to improve and as post-graduate education of its cadres develops strongly. But it is at present to some extent an obstruction to the improvement of primary care services.

7.13 This can be illustrated in the chapter by Keith Thompson on 'Primary Care' in the Trust's publication <u>The Impending Crisis of Old Age</u>(1). He is much concerned with rewards and incentives:

> Item of service payments can act as an immediate catalyst in providing a widespread service.... Fiscal factors are vital in determing what doctors do and how they do it.... It seems logical to assume that primary care would be rapidly orientated towards the care of the elderly if it were to attract item of service payments.

In other words, since there are already higher capitation fees for the care of the old, general practitioners should be paid twice for looking after them. While there may possibly be a case for item of service payments for such preventive measures as the immunisation of children, no plausible case has been made out for their introduction into the general practitioner care of the old.

7.14 There is a further area where general practitioner pressures to increase their remuneration and so make services necessary for the elderly more costly, should be resisted. This is the staffing of nursing homes; and it will become a significant issue if the number of nursing homes under NHS aegis expands considerably. That an old person, for whom he is receiving a higher capitation fee, is being cared for by the staff in a nursing home will usually lighten the burden on the general practitioner. But it is being suggested by some general practitioners, there is need also for a general practitioner to be appointed on a retainer basis to the nursing home itself, to ensure that its general standards are in all health aspects adequate and maintained. He would then be paid, it seems, at the Clinical Assistant rate. The case being presented does not hold water. The person responsible for the care of patients, management, and general standards of a nursing home is the nurse-in-charge of that establishment; and in this she is answerable to her nursing superiors and to the monitoring authority.

7.15 It is changes of attitude which are required in general practice, not further financial incentives: indeed, further financial incentives might inhibit attitudinal change. Professional education is usually looked upon as the most potent method of effecting such change. Here the Health Departments are in a position to exert considerable influence (more than they do), since they are strongly represented on the Councils for Postgraduate Medical Education and provide most of their finance. In postgraduate education much more attention should be paid to the care of the old, and in particular to more intelligent prescribing of drugs for sick old people. Postgraduate educators should also, in association with Clinical Divisions of General Practice or other functional groupings of local general practitioners, assist the development of systems of clinical medical audit in general practice. Unhappily, those general practitioners who need continuing education most commonly make little or no use of what is available; and it seems that neither Health Departments nor profession can reach and make sure of influencing them. The often undiscriminating way in

which drugs (frequently several drugs concomitantly) may be prescribed, the bland or naive assumption that the old person will take the drugs as prescribed, the failure carefully to observe the effect of these drugs in a patient population whose powers of metabolism and excretion are known to be very often impaired, and the consequent and common iatrogenic precipitation of confusional reactions which are disabling and may be fatal, are discreditable aspects of some contemporary general practice.

7.16 Recommendations

The Health and Social Services and Social Security Adjudications legislation should be used determinedly to bring general practice more effectively within the NHS, and to provide data for the monitoring of the quality of the services which are contracted for.

Item of service payments for the care of the old by general practitioners should not be introduced.

Changes of attitude cannot exactly be recommended, but they are nevertheless required in general practice.

The postgraduate education of general practitioners should be improved, particularly with respect to the prescription of drugs for old people.

8
Geriatrics and psychogeriatrics as medical specialties

8.1 The issues of specialisation in geriatrics and psychogeriatrics have a disproportionate amount of attention (e.g. at the Trust's September 1982 seminar) because they are medical issues, of interest to doctors.

8.2 It is the Department, not the medical profession, which has promoted the specialty of geriatrics and expanded it at the fastest possible rate. It is not now worth arguing whether or not geriatrics should be a medical specialty. It has established its expertise and has had notable success in developing and raising the standards of services for the old. But geriatricians cannot expect to cope on their own with the enormous numbers of sick and enfeebled old people. This is a task which they must continue to share with physicians, surgeons, psychiatrists, and of course general practitioners. Geriatricians should concentrate now on teaching their expertise to others, not on expanding their empire. Whether it is integrated, more or less, with the general medical hospital services should be a matter for local choice and experiment: much depends on the personalities involved. Whatever the structure of the services, general physicians, psychiatrists, and geriatricians must work in close accord if the patient is to benefit properly.

8.3 Despite its successes the specialty of geriatrics has not gained high professional status. Its weaknesses are obvious. It attracts few of the intellectually most gifted members of the medical profession. Its contribution to research has been undistinguished. Far too many of those who man the geriatric services have had their basic medical training overseas; this is not their preferred

career, their motivation is uncertain, and they have difficulties with the language and the culture. These have been persistent weaknesses: and if they are allowed to continue to characterise geriatric medicine, they will do it great harm. Until it can be strengthened by a more talented intake into the training grades, it would be unwise to expand this specialty. This would involve a halt in present Departmental policy.

8.4 The intense debate as to whether specialists in geriatrics should be whole-time or part-time (the 'special interest' category) is largely a sterile one: both are required. The debate has been fuelled by the empire-building of some prominent geriatricians and the snobbery of physicians, who have viewed the geriatrician as more often than not a failed physician or at best a physician manqué. The professional ladder of promotion and prestige to which the late Lord Moran(14) so proprietorially referred in discussing general practitioners remains in position, if not now so prominently as in the earlier days of the NHS, still more distinctly than Jacob's.

8.5 Psychogeriatrics is on the way to becoming a specialised aspect of adult psychiatry. Its practitioners have got off to a good start, without prejudice or hostility, and this is probably for several reasons: the initiatives have come largely from the profession itself, its leaders are young and able and they have not split away from the parent discipline. The policy of having in each District a psychiatrist whose main responsibility is for the development of comprehensive psychiatric services for the geriatric population is a sound one. He need not be full-time and it will be advantageous if psychogeriatrics continues to keep close links with general psychiatry. Psychogeriatrics, which has its own 'head of steam' as a specialty, will be best left to develop in its professional context without much Departmental urging. What is just as important is that trainees in adult psychiatry should get sufficient training and experience in this field, and under the influence of the Royal College of Psychiatrists, this is happening.

8.6 It should be made clear by the Department that specialisation in geriatrics and psychogeriatrics will be supported, not in order that these specialties should themselves provide comprehensive medical services for the old, but so that they may lead, innovate, develop, and research into the services necessary, and establish and teach exemplary high standards of caring and treatment.

8.7 Recommendation

There should be no further expansion of the specialty of geriatrics until the quality of medical recruitment to it has considerably improved.

NOTES AND REFERENCES

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6. DHSS (1981). Growing Older: White Paper (London: HMSO).

7. DHSS (1981). Report of a Study of the Acute Hospital Sector: para. 4.5.

8. Wilkins, et al., Health Trends, November 1982, page 98.

9. The Department has informed me (April 1983) that the number of people aged 75 and over admitted to mental illness hospitals and units rose over the years 1978-80.

10. DHSS (May 1981). The Primary Health Care Team (The Harding Report.

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12. In 1981 80 per cent of nurses of all types working in the community were attached to general practices, some to more than one practice (OPCS Survey).

13. But the forms for night visits, which attract remuneration, do not record the age of the patients visited.

14. Connoisseurs of medical hubris will recall how his Lordship referred to GPs as those who had 'fallen off' the professional ladder, into that area of outer darkness.