Evolution of a programme of health services research and development in the health care of elderly people

In 1989, the Research Unit of the Royal College of Physicians initiated work concerned with the quality of health care. In the following year, a programme on the health care of elderly people was started with generous funding from Marks and Spencer plc and the Private Patients Plan Foundation.

Goal of the programme

The goal of the programme is to enhance the health of elderly people by improving the quality of their health care. The three main strategies for accomplishing this goal are translating existing knowledge into day-to-day use, strengthening that knowledge, and integrating research and development activities.

Translating knowledge into practice

Since mere publication of clinical guidelines is unlikely to alter routine practice, an attempt was made from the outset to provide associated practice materials and to devise supporting activities.

Workshops are held at the College to review what is known and done. Informed discussion is promoted through detailed background papers which are circulated beforehand and presented at the workshops. Small group work, consultation and further discussion results in the production of reports which contain the clinical guidelines and good practice materials.

Completed clinical guidelines

Long-term care

The report High quality long-term care for elderly people [1] recommends clinical guidelines based on a number of key indicators (Table 1) to be applied both to the long-term care facility and to the care of the individual residents. The report was supported by good practice materials in the form of an audit system called The CARE (continuous assessment review and evaluation) scheme [2]. Emphasis is placed on the team approach to audit, the primacy of care staff in audit, the need for objectives and the key role of management in moving forward to improve the quality of care. These principles have recently been echoed by the Department of Health in its recent guidance on the development of clinical audit [3]. Supporting activities include a multicentre study of the feasibility and effectiveness of the CARE scheme which has been carried out in both the public and private sectors, and a conference on practical ways of improving the quality of long-term care to be held at the College in November 1994.

Assessment

The introduction of audit posed difficulties for clinicians who were faced with a great array of assessment scales to choose from. A set of scales was recommended in a report entitled Standardised assessment scales for elderly people [4] (Table 2). Three supporting activities have been carried out; a multicentre study of the feasibility of using the scales has now been completed (the SAFE study); a College conference was held for those with practical experience of using the scales; a survey of the use of the recommended scales was carried out in 1992 and is to be repeated this year. In addition, liaison ensured that there was congruence between this report and the advice of the Royal College of General Practitioners with regard to the ‘over-75s checks’ [11]. Overall, the recommended scales are becoming more widely used but there are many challenges still to overcome in the development of a common language of care.

Day hospitals

The controversy about the proper role of geriatric day hospitals (GDHs) as an integral part of comprehensive

| Table 1. Key indicators of the quality of long-term care |
|--------------------------------------------------------|
| • Preservation of autonomy                             |
| • Promotion of urinary and faecal continence           |
| • Prevention of pressure sores                         |
| • Optimising drug use                                  |
| • Managing falls and accidents                         |
| • Optimising the environment, equipment and aids       |
| • The medical role                                     |
health services is fuelled by worries that they might be targeted for closure to cut costs. A workshop resulted in the publication of a report entitled *Geriatric day hospitals: their role and guidelines for good practice* [12]. The good practice resource in this case is the *Clinical audit scheme for geriatric day hospitals* [13]. Supporting activities have included a national survey of practice and provision in relation to goals and a multicentre study of the characteristics of patients attending GDHs. We also contributed to the recent National Audit Office report on day hospitals [14]. A multicentre action development project of the clinical audit scheme is planned.

**Clinical guidelines progress**

*Elderly people who fall*

In response to the Health of the Nation initiative, clinical guidelines for the management of elderly people who fall are being produced. A multidisciplinary workshop has been held at the Royal College of Surgeons in partnership with the British Geriatrics Society and the Medical Commission for Accident Prevention. It involved a wide range of providers (from ambulance services to social workers), consumers, purchasers and policymakers. Accompanying good practice materials will probably include a patients' guide, a model contract, assessment/management cascades for use across sectors of care, and an audit scheme.

### Table 2. Recommended standard assessment scales

- Barthel activities of daily living index [5,6]
- Abbreviated mental test score [7]
- Lambeth communication screening instrument [8]
- Geriatric depression scale [9]
- Philadelphia geriatric center morale scale [10]

**Post-acute care**

The term post-acute care refers to the phase of hospital care between acute interventions and hospital discharge, and is intended to avoid the confusion that can arise when talking about 'rehabilitation' and the narrowness of the discharge planning concept. A workshop has been held to develop clinical guidelines for post-acute care for use throughout the hospital systems to complement the College report on equity in health care for elderly people [15]. Good practice materials are likely to include a patient guide, a model contract for post-acute care, and an audit scheme.

**Incontinence**

A report on incontinence services is being produced and is intended to cover all ages, but links will be made with the clinical guidelines portfolio for elderly people.

**Future plans**

Further developments for devising clinical guidelines, in consultation with the specialty of geriatric medicine, are in hand.

- Initial workshops were dominated by doctors. We now seek to include other interested parties such as providers (all disciplines and sectors of care), purchasers, patients and policymakers in all workshops. As the number of participants is generally limited to 30 people, we require workshop members to wear two (or preferably three) hats to ‘earn’ their place around the table.
- A portfolio approach has now been adopted for the development of clinical guidelines, using four categories (Table 3). Work on services is well under way as described above, work on syndromes is commencing, and work on special topics and on strategic diseases is in the planning stages.
- Thus far, all workshops have been held in partnership with the British Geriatrics Society. We intend to maintain this key link and strengthen it with other partnerships. For example, the falls workshop was held in conjunction with the Medical Commission on Accident Prevention and the long-term care conference is being held in association with Age Concern and the Department of Health.

- In consultation with the specialty of geriatric medicine, we are devising a new framework for developing clinical guidelines because such guidelines are now being written at all levels in the Health Service—in units, districts, regions and at the national level—and a tension has emerged between the advantages and disadvantages of producing clinical guidelines at national and local levels (Table 4). The new framework seeks to combine activities at local and regional levels with the expertise, imprimatur and publishing capability of
the College. There would be a national priority list of topics for clinical guidelines. Groups participating in the scheme (be they units, districts or regions) would indicate that they were developing clinical guidelines on a particular topic, and this information would be advertised widely to avoid duplication of effort. Participants will be offered help with the production of high quality guidelines and will be encouraged to submit them for national endorsement and publication by the College. We hope that this approach will enable the portfolio of clinical guidelines to be built up rapidly without damaging appropriate national or local development.

- All clinical guidelines projects are now managed according to a tight timetable to shorten the long intervals that have developed in the past between workshop and publication. However, the need for participative drafting and consultation means that it is difficult to complete most clinical guidelines projects in less than nine months.
- Increasing energies are being devoted to dissemination and implementation. Various channels of distribution are being opened up and the required mailing databases to alert colleagues to reports are being prepared by the publications department. The scope of good practice materials is being expanded and the role of purchasing in the quality of care is being explored.

**Strengthening the knowledge base**

We are aware of the need to develop a more focused strategic role in fostering research. Consultant geriatricians have expressed their overwhelming support for a national research and development network on various topics. The goals of the network are to facilitate projects that would otherwise not be done, particularly multicentre studies. A twice yearly newsletter, *Linker*, has been launched, research taskforces have been created and contact has been made with key funding bodies and the NHS R&D initiative.

**Age profiles in care**

There is some evidence of different rates of access and intervention for people of different ages. A taskforce has been formed to examine the feasibility of carrying out some basic research into age profiles in aspects of cardiovascular care.

**National chronic wound audit**

The current goal is to clarify areas of commonality between the existing five national sets of clinical guidelines and numerous local ones, in order to define key areas of agreement for required standards of care. Funding is being sought to carry out a multicentre community based audit.

**Table 4. Advantages and disadvantages of national and local level clinical guidelines development**

|                       | National guidelines |                       | Local guidelines |
|-----------------------|---------------------|-----------------------|------------------|
| **Advantages**        | Avoids duplication  | Efficient use of time and resources | Ownership through participation |
|                       |                     | Best use of experts  | Better chance of implementation |
|                       |                     | Endorsed by national bodies | Local solutions |
| **Disadvantages**     | Distant             | Unrealistic           | Time consuming   |
|                       | Poor dissemination  | Slow                  | Disparate        |
|                       |                     |                       | Duplicative      |
|                       |                     |                       | Local expertise may not exist |
|                       |                     |                       | Lack of credibility with purchasers |

**Organisation of geriatric medicine**

Little is known about how different local geriatric medicine services operate, so a national survey is planned for the autumn of 1994. Results will be used as a baseline for monitoring service development, to identify areas of innovative practice and to characterise local services for comparative research.

**Parkinson’s disease**

A multicentre study of the aetiology and natural history of Parkinsonism is being set up, involving the appropriate specialties and relevant national organisations.

**Doctors in management**

Many geriatricians are now involved in health service management, yet they may be ill-equipped for this role in terms of experience, skills and resources. A taskforce is being formed with the British Association of Health Service Managers, the Institute of Health Services Management and a business school with health service expertise, to examine this issue.

**Outcomes**

We have formed an outcomes appraisal group which aims to facilitate the development of appropriate outcomes for elderly people by making key links between
leading researchers and consumers, and to develop a research capability for evaluating putative measures.

**Integrating research and development**

Information gaps in research and development are seen to lead to duplication, 'reinvention of wheels' and a failure for patients to benefit from available knowledge. In response, a national information and dissemination centre is proposed by the NHS R&D initiative. We seek to develop a complementary system which concentrates on the care of elderly people and the needs of practitioners and researchers in this field. Work with Age Concern and the Age Concern Institute of Gerontology has resulted in the publication of a directory of guidelines for care, entitled *Gold standards*, which is now in its second edition [16]. A further need is for advice on harmonising methods in health services research so that results can be reliably compared, and we intend to establish a register of research activities and interests. There is a wide commitment to cooperate within geriatric medicine, and links have been established with many other bodies. Where possible, a contribution is made to national projects such as the Clinical Terms project. The unit has also taken the lead in the formation of a national umbrella forum concerned with the care of elderly people; it is hoped that this will include consumers, carers, nurses, physiotherapists, occupational therapists, speech therapists, social workers, managers, general practitioners and hospital specialists drawn from national groups. The purpose will be to act as a reference group for service development and as an exchange for ideas, activities and products.

**Conclusion**

Although this programme is in its infancy, the most important lesson has been recognising the implications of the rapid pace of change in the NHS. This means that projects need to be completed in 'real time'—otherwise enthusiasm may be lost. Also, more attention needs to be given to the implementation of clinical guidelines. Little is known about how to make changes in clinical behaviour. We aim to use a revised strategy, based on existing resources (such as audit, contracting and continuing medical education), which involves the key stakeholders and produces a range of products. Our most important role is in coordination and facilitation to allow the rapid spread of new ideas, to eliminate duplication of effort and 'reinvention of wheels', and to facilitate research that would otherwise not be done.

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**References**

1. Report of the Royal College of Physicians and the British Geriatrics Society. High quality long-term care for elderly people: guidelines and audit measures. London: RCP, 1992.
2. Report of the Research Unit of the Royal College of Physicians. The CARE scheme (continuous assessment review and evaluation): clinical audit of long-term care of elderly people. London: RCP, 1992.
3. Department of Health. The evolution of clinical audit. London: DoH, 1994.
4. Report of joint workshops of the Research Unit of the Royal College of Physicians and the British Geriatrics Society. Standardised assessment scales for elderly people. London: RCP, 1992.
5. Mahoney FL, Barthel DW. Functional evaluation: the Barthel ADL index. *Maryland State Med J* 1965;14:61–5.
6. Collin C, Wade DT, Davies S, Horne V. The Barthel ADL index: a reliability study. *Int Disabil Stud* 1988;10:61–3.
7. Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age Ageing* 1972;1:233–8.
8. Peach H, Green S, Locker D, et al. Evaluation of a postal screening questionnaire to identify the physically disabled. *Int Rehabil Med* 1980;2:189–93.
9. Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: preliminary report. *J Psychiatr Res* 1983;17:37–49.
10. Davies B, Challis D. Matching resources to community care. Canterbury: Personal Social Services Research Unit of University of Kent, 1986.
11. Wallace P, Williams EL. Health checks for people of 75 and over. (Occasional paper 59). London: Royal College of General Practitioners, 1993.
12. Report of the Research Unit of the Royal College of Physicians and the British Geriatrics Society. Geriatric Day Hospitals: their role and guidelines for good practice. London: RCP, 1994.
13. Report of the Research Unit of the Royal College of Physicians, Clinical audit scheme for geriatric day hospitals. London: RCP, 1994.
14. Report of the National Audit Office. *National Health Service day hospitals for elderly people in England*. London: National Audit Office, 1994.
15. Report of the Royal College of Physicians. Ensuring equity and quality of care for elderly people: the interface between geriatric medicine and general internal medicine. London: RCP, 1994.
16. Report of Age Concern. *Gold standards*. London: Age Concern, 1994.

The reports mentioned in this paper are available from the Publications Office of the Royal College of Physicians.

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