Achieving high quality long-term care for elderly people: consumers’ wishes and providers’ responsibilities

The organisation of long-term care for older people has major implications for all hospital and community health services. However, even health professionals have a poor understanding of the structure and purpose of long-term care and national professional bodies are still not giving enough attention to the issues involved. In the wider context, care of disabled older people has received little public debate in the UK despite the ethical, social, and financial issues involved and despite the recent major organisational changes in the health service. The past ten years have seen a huge expansion in private residential and nursing homes with a concomitant fall in NHS long-stay beds. Currently, approximately 500,000 elderly people in the UK are living in some form of long-stay care facility, and many other elderly people with multiple disabilities are being supported at home and should also be included under the umbrella of long-term care. Ensuring appropriate, equitable, and high-quality care is a responsibility not only for health and social services but also for society as a whole. This conference, organised jointly by the Royal College of Physicians, the British Geriatrics Society, and Age Concern England, with support from the Department of Health, was a much-needed and welcomed initiative. Over 200 delegates attended, consisting of doctors (geriatricians, psychiatrists, general practitioners), nurses (public and private sector), social services representatives, Department of Health representatives, managers of nursing homes, and members of charities such as Age Concern and the Relatives Association.

Understanding consumer needs

The first session considered the complex needs of residents in long-term care.

Mr Des Kelly (Director of Social Care Practice, Social Care Association) highlighted the different needs of residents and staff in long-stay units. For example, staff working patterns are often rigid with set times and routines for practical tasks such as washing, dressing, and helping residents to bed. Trying to superimpose a resident-led system, where the emphasis is preservation of identity, with choice and flexibility in living patterns, is potentially conflicting. Residents should be ‘allowed’ to take risks if they so wish and retain control over their environment as far as possible. Managing the resident-staff relationship is a fundamental aspect of high-quality care and requires good leadership. Individualised care plans and effective staffing systems (including training and support) are essential components.

Mrs E M McEwen (Director of Information, Age Concern England) also stressed the importance of individualised care and maintenance of independence and autonomy. She called for nationally agreed guidelines setting out what residential and nursing homes should provide, including residents’ contracts and security of tenure. Greater innovation in the organisation of care, for example group housing and smaller homes, was also thought to be important. In addition, care at home for those with complex needs must be adequately supported and not abandoned when need increases (a theme revisited several times during the day).

Mrs Dorothy White spoke on behalf of the Relatives Association, a charitable organisation recently founded by a group of relatives and close friends of elderly people in homes. In addition to providing a listening ear and practical help for relatives via groups within homes, the Association is working to promote groups or networks able to cooperate with local advisory committees, local authority planning committees, and even to raise issues with government departments. Mrs White stressed the importance of developing non-confrontational partnerships between relatives or friends and staff. Relatives can be a source of considerable practical help not only for individual residents but also for the home generally. Their energies need to be well directed, and joint meetings with staff and involvement in care planning are to be encouraged. The Relatives Association appears to be of extremely useful development, not only providing support but also potentially able to exert pressure both locally and nationally for high standards and good quality care.

Access to appropriate high-quality medical care for those in homes was an issue raised in this and other sessions. There is a general concern that specialist geriatric services are less available to those in long-term care facilities outside NHS hospitals. There is a mistaken belief that nursing homes can provide comprehensive nursing and medical care without the input of specialist services. General practitioner involvement in local nursing homes is patchy, and appropriate structures for obtaining advice, reassessment/admission, and continuing education are not in place. Greater use could be made of day hospitals and hospital long-stay units for these purposes. It is difficult to understand how continued expertise in dealing with such complex patients in the community can be maintained without the central resources of a hospital. Unfortunately, many hospitals have lost long-stay beds and many day hospitals are under threat.

The second session was concerned with ‘Striving for

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quality'. Dr E Dickinson (Research Unit, Royal College of Physicians) gave an introduction to the principles of quality in health care and emphasised that it was largely the calibre of the staff which determined the quality of a service. One way to improve quality of care is to empower staff to recognise and correct deficiencies in procedures, and this needs investment in training.

Mr D Cadbury (Assistant Director, Solihull Social Services Department) described how a departmental social services inspection unit provides an assessment of the quality of care in residential homes. All homes are inspected twice each year, one visit announced, the other unannounced. Care is assessed by an analysis of the facilities provided, for example food and heating, and the opinions of the residents are elicited using structured questionnaires.

Mrs L Kellaher (Director, Centre for Environmental and Social Studies in Ageing, University of North London) described Inside Quality Assurance (IQA)—a quality assurance programme developed for residential settings, with funding and backing from the Department of Health. If a residential care home adopts the IQA system, comments are collected from residents, relatives, and staff to provide the basis for a formal report which is submitted to an independent assessor. If the report meets set criteria for quality, accreditation is granted for two years. If it does not, changes are suggested and the cycle is repeated. During trials of the IQA system it became apparent that frail elderly people were quite able to make well-focused remarks and suggestions for change, and that serious underlying problems could be identified at an early stage.

Professor J Brocklehurst (Research Unit, Royal College of Physicians) explained the theory behind the Royal College of Physicians CARE Scheme (continuous assessment review and evaluation). The Scheme is provider-based and analyses the medical care process through assessment of the home’s facilities and by giving each resident a questionnaire. Mrs L Crutenden (Matron, Gloucester House Nursing Home) described her experience of using the Scheme as part of a national pilot study. The Scheme took much longer to implement than expected, but once established it did improve awareness of problems within the home, together with increased expectations for improvement. She praised the user-friendly format of the Scheme.

Discussion at the end of this session began with a comparison of the IQA and CARE schemes; Dr Y Chather from Southampton asked if the two systems should be integrated. Professor Brocklehurst said the schemes used different outcome measures, with CARE being more medically orientated; if they were amalgamated, the product would be unwieldy. He suggested that homes might be encouraged to use the schemes alternately.

Asked whether audit of long-term care should be compulsory, all speakers agreed that it should. However, it should be borne in mind that visits to homes by inspectors of any kind can be disruptive to residents, especially when they are made out of hours. Dr K Mundy from Frimley Park Hospital raised the issues of the pre-admission assessment. Professor Brocklehurst responded that this is best accomplished by a multi-disciplinary team; a medical contribution is essential in order to define the underlying medical problems clearly and ensure treatment of any reversible process before decisions on long-term care are formalised.

The session ended with a brief discussion of the need for a long-term care ombudsman to help resolve difficult issues of the quality of care.

The role of training in long-term care

Mr C Payne (Consultant, National Institute for Social Work) suggested that it was the training in *attitudes* of staff rather than their skills that was more important when addressing the needs of elderly people. Important examples include understanding the needs of older people, communicating with the elderly, and methods of dealing with challenging behaviour. At present, the only formal recognition of training in this area is provided by the examination leading to the National Vocational Qualification (NVQ).

Mr I Turner (Marketing Chairman, Registered Nursing Homes Association) described training in the private sector. He considered that the first step is to prove competence, which can be provided by the NVQ, and then to ensure that competence is maintained.

Professor Brocklehurst opened the discussion by asking the panel how training might be evaluated. The response was generally negative, with Mr Payne commenting that it would be a difficult task and Mr Turner saying that resources are insufficient. The value of training was emphasised by Dr A Homer from Edgware General Hospital, who described a study that showed a 20% reduction in stress experienced by carers after they had undergone appropriate training in long-term care. This effect was apparently lost, however, when the residents were replaced, emphasising the need for a continuing training programme. In the experience of Dr G Greveson (Newcastle General Hospital), many homes have no dedication to training; should training therefore be obligatory? Mr Payne responded that this was indeed becoming the case and gave an example from the Midlands where contracts between the social work department and residential homes include a requirement for a certain minimum number of staff to hold NVQs. Mr Turner was against regulation for training on the grounds that the costs of training can be very variable.

Responsibilities of purchasers

The final session, addressed the challenges involved in purchasing long-term care.
Professor M Knapp (Deputy Director, Personal Social Services Research Unit, University of Kent) discussed the economic imperative of balancing quality and cost. He felt that an understanding of costs could provide an opportunity to improve quality; the economic perspective being important for accountability, policy-making, product development, organisation of practice and research. The current strategic policies for community care require changes in our approach to costs. A needs-led service, operating in a mixed economy with a large community emphasis, needs to be viewed differently from the old system which was essentially supply-led, publicly funded, and institutionally based. Professor Knapp listed four useful principles for assessing cost information. First, the information should be comprehensive; that is, to include costs to all services involved—hospital and community, voluntary and private, users and carers. Second, one should beware ‘average costs’, as these may be misleading if there is wide interindividual variation in need. Third, any cost comparisons need to be truly of like with like. Finally, costs need to be integrated with outcomes and set in the framework of the entire service.

Mr M Shreeve (Director of Social Services, Wolverhampton Borough Council) discussed the challenges of purchasing high-quality care. Social services have held the main purchasing role for the past two years. Mr Shreeve presented a balanced and constructive viewpoint. There is little doubt that reforms to the service were needed. However, the speed of change, the chosen new model of care, and level of financial support remain issues of concern. In theory the new system should increase autonomy, choice and independence, and there is some evidence that this is occurring in practice. Interestingly, Wolverhampton, like many other areas, has seen a huge increase in number of complex home-care packages required to support frail elderly people with multiple needs in the community. This aspect of community care has increased faster than any other system in social services and community health and provides the biggest challenge. No one questions the aim of maintaining elderly people in their own homes, particularly if it is their choice, but the community must be equipped and funded to accommodate this. The rapid expansion in residential and nursing-home care in the 1980s deflected attention and investment from community services—a costly mistake now evident in the ‘community-orientated’ 1990s.

Multidisciplinary assessment has always been pivotal to good geriatric medicine and although this is gradually being embraced by purchasers of long-term care, it often fails to take place for those entering long-term care via routes other than departments of geriatric medicine. This is worrying since inappropriate placement of an elderly person is not only costly to the entire service but also has huge emotional and financial implications for the person and family concerned. Professor Peter Millard had also raised this issue earlier in the day and even called for statutory multidisciplinary assessment of all potential long-term care users.

Mr Shreeve highlighted areas of conflict between professionals in the new system. Fund-holding general practitioners and social services purchasing authorities may view hospital assessment of older people differently. Similarly, some hospital physicians may view the acute admission and assessment of dependent elderly people less positively than others.

The future

The conference ended with a talk entitled ‘The future’ given by Mr Alan Langlands (Chief Executive, NHS Executive, Department of Health). Although this was a very general view with no clear commitment to tackling specific issues in elderly care, it was at least encouraging to hear the Department of Health publicly supporting the goal of providing equitable, accessible, and high quality care to people irrespective of their age.

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