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KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

THE ROLE OF THE GENERAL PRACTITIONER HOSPITAL IN THE CARE OF THE ELDERLY

Report of the conference held at the King's Fund Centre on 6 March 1979.

September 1979

The King's Fund Centre,
126 Albert Street,
London NW1 7NF

THE ROLE OF THE GENERAL PRACTITIONER HOSPITAL IN THE CARE OF THE ELDERLY

PROLOGUE - Mr W G Cannon, MA FHA, Director of the King's Fund Centre. The Conference was convened by the King's Fund and the Association of General Practitioner Hospitals, to promote discussion and debate on the place that English and Welsh GP Hospitals have in providing for the elderly. It was hoped that pointers for further activities, such as workshops, debates and research, would emerge from the day's thoughts.

INTRODUCTION AND EXPOSÉ - Conference Chairman, Dr I S L Loudon, DM FRCGP, Health Centre, Wantage.

Dr Louden told the story of GP Hospitals. In 1858 Dr Albert Napper opened the first Cottage Hospital in Surrey. The growth was such, that by 1895 there were 294 in England and Wales and books had been written on the design and running of the ideal GP Hospital, which was usually rural, open to all General Practitioners, and with patients charged by means test. After 1948, GP Hospitals became anomalous, isolated, and targets for closure. Further threats, by the concept of the District General Hospital in the 1962 Hospital Plan and the Bonham Carter Report in 1969, emphasised the economics of large hospitals. In 1968, the Oxford Regional Hospital Board pioneered the idea of Community Hospitals and Dr Bennett was appointed to evaluate them. In 1972, a joint report 'General Practitioners in the Hospital' was published by the Royal College of Physicians and General Practitioners.

The 1974 DHSS circular on Community Hospitals clarified the comprehension of them. It suggested that:

(a) existing hospitals could be adapted if good and large enough;

(b) some would be purpose built;

(c) very small GP Hospitals would be closed.

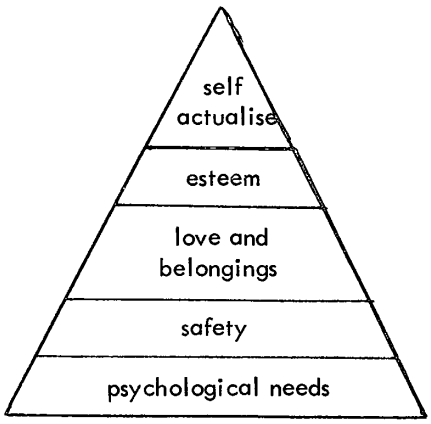
The Report was not well received by General Practitioners, because of the condemnation of included surgery and obstetrics, disagreement with the minimum size of 50 beds, and the blanket plan covering all GP Hospitals was foolish. Their qualities were that they were varied, flexible and met local needs.

Sandy Cavenagh's pioneering research on General Practitioner Hospitals nationally, highlighted the casualty and cold surgery service.

The best and all embracing name is 'GP Hospitals', 'Cottage Hospitals' was an historical term for a 6-8 bed unit. The valuable Oxford concept of Community Hospitals was not relevant everywhere.

THE CONSULTANT'S VIEW OF GERIATRIC PRACTICE - Professor Peter Millard, MB FRCP, St George's Hospital, London.

Professor Millard used lively diagrams. Figure 1 - The Needs of the Individual.



Achievement requires roles to be played. He suggested generating the nurses' pride in running a long-stay ward and not threatening their safety.

The needs of the elderly at home were:

(a) co-ordinated care

(b) diagnostic accuracy

(c) freedom of choice

A plethora of Autonomous Bodies, Voluntary Organisations, and their family, overwhelmed them.

The General Practitioner had five choices of jumping the specialist barrier.

1. lies
2. out-patient reference
3. residential homes
4. psychiatric beds (no hope!)
5. General Practitioner Hospitals (a defensive evasion of the hurdle).

The Cottage Hospital did not have adequate scientific investigation, adequate rehabilitation and could not provide highly specialist, diagnostic knowledge fostered by technical advance. The Cottage Hospital required specialist visits and should be used by General Practitioners for short-stay treatment, which would be done at home otherwise, if there were local facilities. He questioned that such hospitals were used for long-term care. The dilemma was to satisfy the individuals providing the service and the patients treated.

GENERAL PRACTITIONER HOSPITAL ROLE IN THE CARE OF THE ELDERLY PATIENT - Dr F E S Hatfield, MRCS LRCP, Ongar.

Dr Hatfield stressed his view, that small unit GP Hospitals close to home were the place for the long-term care of the elderly.

No generalisations could be made about GP Hospitals, because they adapt to their environment; some which didn't, closed.

In Ongar, the guideline is, that no patient is kept more than three months. They have eleven long and eleven short-stay geriatric beds. Acute work is essential to maintain staff morale.

He thought the ingredients for success in a mixed long-stay and acute GP Hospital were:

1. The attitudes of the medical staff team.
2. Consultant Psychogeriatrician and Geriatrician support to the General Practitioners.
3. The GP support to 'Matron' (or Senior Nurse).
4. Community goodwill; which suffered such a blow, when the hospitals were cut off from their local voluntary support in 1948. It is therapeutic to the community to mobilise their help and charity, for extra facilities and equipment at their local hospital.
5. To balance acute and chronic work, avoiding the use of the hospital as a 'dumping ground'; (some minor operations were done to keep staff interest).
6. The Geriatric Unit or Cottage Hospital should be separate; if attached to a bigger unit, it becomes second class in every respect.
7. To develop good Day Care.
8. Provision of holiday care for the old gives their families a much needed break.

CO-ORDINATED COMMUNITY GERIATRIC CARE FROM A GP HOSPITAL - Dr E E Hewinson, MB ChB, GP Administrator, St Editha Hospital, Tamworth.

Dr Hewinson felt that GP Hospitals were the best places to co-ordinate and rationalise the services for the old.

He described Tamworth, where 23 General Practitioners serve a population of 52,000. The hospital has 68 acute beds and a General Practitioner unit of 112 beds now. The League of Friends provided a Geriatric Day Hospital in 1970, catalysing the request for him to be GP Administrator. The wards then had 144 custodial bed-bound patients, with no privacy. The aim was change to progressive care and the bed state was reduced to 112. Screening and assessment were provided by local funds. Tamworth also has 150 Warden supervised units of accommodation.

Their ideal now is one of total patient care. On admission, the patient is frequently assessed and rehabilitation planned by staff of all disciplines. He defined rehabilitation as - "where every patient is helped to gain mobility, to live the best quality of life and to die in dignity".

There is full integration between a jointly funded hospital based social worker, a Part III Home in the grounds, attached Health Visitors and District Nurses and Housing Officers, forming an efficient team.

Six group practices each appoint a doctor to cover routine care. Initially a social worker and District Nurse visit the home, then the team discusses the case assessment and decides action. Everyone is involved (including auxiliaries who complete the admission forms). Community staff see the patient on the ward pre-discharge and alert the social services. Holiday care is arranged either in hospital or the social service home, and co-ordinated by the community nurse.

The Geriatric Liaison Committee meets monthly, and includes: GP's, nurses, social workers, a physiotherapist, an occupational therapist, voluntary bodies (for funds), and where necessary, the housing officers. The aims of the team are:

1. mobility between forms of care;
2. assessment of Part III clients;
3. co-ordinated transport;
4. increase of community provision;
5. better communication.

The GP Administrator's job was similar to an orchestral conductor.

'THE CONSUMER'S VIEW' - Councillor Mrs W Mitchell, SRN SCM, Greenwich CHC.

Mrs Mitchell was gravely concerned that many GP Hospitals were threatened by closure or were already closed. In their area, patients who had been in both GP Hospital and the District General Hospital were (literally) on the march and lobbying the House of Commons to save their local hospital. She said that the GP Hospital was best, unless the patient needed the sophistication of the District General Hospital. Although these hospitals are part of the NHS, they are helped by local voluntary funds and community affection.

Mrs Mitchell illustrated patients' preferences, with case studies:

1. A lady aged 74 (husband 86) was transferred from a DGH to a GP Hospital, her GP giving general care and the Consultant available if needed. She was acutely aware of the different atmosphere, easy access for visitors, and no guilt at taking up a much needed bed in a big hospital, calm peace, and care by her own GP.

2. An elderly man living at home with his wife, has episodic acute illness treated in the GP Hospital, for those brief periods when nursing care cannot properly be given at home - with little disruption to their lives, and easy access by visitors.

3. A bedridden old lady looked after by her family, admitted to give all a much needed holiday; an impossibility for the DGH.

4. A lady in bed at home with lumbago; not strictly needing admission on clinical grounds, but home care was impossible because of her insecurity and fear, was cared for in the GP Hospital.

GP units are as necessary in urban as in rural areas, to ease visiting; - a major factor in healing. If the illness is serious distance has to be overcome; but if milder, then the services should be local. The economic arguments against GP Hospitals do not take account of the crises they prevent, nor of the quality of human care. We must stop the rot of closures!

"AUDIT AND THE RESOURCE PERSON" - Dr M Lee-Jones, GP, Wallingford.

Two separate functions of audit were:

1. Clinical: investigation, maintenance and improvement of nursing and medical standards.
2. Management: effective use of facilities.

The key was adequate information circulated before audit meetings on every patient in the review period by the multi-disciplinary team (GP's occupational therapists, physiotherapists, nurses, and social workers). It is sterilised educationally if loners did the audit solitarily.

At Wallingford there is an acute ward, 38 beds for long-stay patients, and 25 supporting Day Care places which do not revivify always.

The main principles of the Audit are care objectives. Carers, and the patient have the same specific temporal goals, e.g. to walk x number of steps and climb x steps, within a given period.

A 'Resource Person' is really a source or possibility of help. Locally it is the Consultant Geriatrician. Each patient is assessed by a Consultant (not always the Geriatrician) for admission; but is cared for by the GP afterwards, with Consultant advice.

In the Day Care Unit, the 'Resource Person' is a GP/Rheumatologist Clinical Assistant offering relevant advice.

The Consultant who suits GP's is one who can share his skills, not the type who thinks his special knowledge carries mystique. The 'Resource Person' is part of the Audit Team and is audited too!

THE NURSES' CASE - Mrs Zena Reade, SRN SCM, Nursing Officer, Aldeburgh Hospital (17 beds and out-patient facilities for casualty and minor surgery; the medical staff are all GP's).

The special advantages of GP Hospitals from a nurse's point of view are:

1. Close involvement by the doctors with the local community.
2. Easy adaption to real local needs.
3. Definite advantages to the patient (all highly valued):
   (a) Easy access for visiting.
   (b) Flexible admission and discharge arrangements.
   (c) Patients know the medical and nursing staff.
   (d) Continued medical care from their GP's.

The value of GP Hospitals is sure, but the relationship to the District General Hospital and their role in the NHS is particularly important.

1. GP Hospitals provide for short spell admissions, not needing scarce and complex resources of the DGH.
2. They cannot cope with all the patients the DGH wishes to pass on, as there are difficulties with admission to long-stay geriatric beds.
3. They cannot always discharge patients due to poor home support. Home services must offer seven day cover - in case voluntary and family help are unreliable.

   More district nursing aides are needed.

An answer to difficulties in finance is to question how much money is mis-spent occupying beds for weeks on end for social reasons. She suggested that a small accommodation charge could be made to support GP Hospitals.

Humanity demands that the increasing class of chronically sick should be treated as near home as possible, for the reasons given.

ALLOCATING RESOURCES - Dr A Withnell, BSc MDMB ChB FFCM, Area Medical Officer for Gloucestershire.

The resources for the NHS are, and will always be, insufficient to meet demands. There are five: land, money, skills, buildings and equipment. Money and skills constrain the NHS; given those the other three usually follow.

Finance

1. Capital: While the community identifies with voluntary funding, this often reduces public funding in the periphery. The health authority should combine local and Exchequer money, perhaps on a £ to £ basis, initiating projects with Exchequer money, to ensure early starts and avoid inflation costs.

2. Revenue: Treatment costs less in a GP Hospital c.f. DGH. Suitable patients were those, because of home circumstances need hospital care, but not the resources of the DGH (which may also generate convalescent cases).

Two advantages of GP's as the skilled resource were knowledge of the patient and stability of medical staffing, enhanced by the introduction of the Hospital Practitioner grade. The size of practice lists should acknowledge hospital commitment. GP's provide 24-hour cover for less than one SHO's annual salary.

Consultant Geriatricians could contribute at out-patient clinics at the GP Hospital, bringing a better understanding with the GP's, adding variety to his programme and better for the patients. Non medical ancillary qualified skills were in short supply near hospitals. Part-time work at the local hospital with less travelling is attractive. Ambulance and transport costs are saved if local occupational and physio therapy is available.

Allocation of more resources to GP Hospitals may result in a better use and an increased availability of essential skills and scarce funds.

SOCIAL SERVICES AND THE CARE OF THE ELDERLY SICK - Miss E Turner-Smith, Principal Social Services Officer for Hertfordshire.

The organisation of the Hospital Social Work after the major changes of 1974 (When the Local Authority provided the hospital social workers for the first time) aimed at:

(a) relevant concentration of skills

(b) the development of those professional skills

(c) optimum deployment of scarce professional resources

(d) a good career for social workers in the health setting

(e) a co-ordinated and comprehensive approach to the public.

The social worker may work flexibly with the community hospital as:

1. hospital based, but responsible to a specialist Social Services Officer;
2. hospital based and accountable to the Team Leader;
3. within the Area Social Services Team, accountable to the Leader;
4. Group Practice attachment continuing their care of the patient if admitted to the hospital.

The nature of work with elderly people can be extremely complex, and the 1976 memorandum of the British Geriatric Society states that the clinical picture is usually influenced by these factors:

1. multiple medical problems;
2. ageing is a complication;
3. residual disabilities are common;
4. relevant social and environmental factors;

5. patients may have serious fears about their roles and future.

The community hospital offers opportunities to the health care team to assess the elderly continuously with a range of skills and for each member to contibute. Mutual advice is important; social workers cannot work in a vacuum and need comprehensive team support.

Implications of the increasing pace of medicine were:

1. Treatment plans may fail if too fast for the patient, and may lead to withdrawal and depression.
2. The elderly sick need time to regain the 'skills of living'. There may be a need for stimulating convalescence provided close to home.

The potential of the community hospital for the elderly and their families is that the 'slogan' of 'the bigger the better' may need to change to 'small is beautiful'. Factors include (i) the feeling of security in a small unit nearer home; (ii) community hospitals must remain active and have full access to all the specialist skills, and (iii) elderly in-patients need contact with reality and emotional support.

The potential for families and the community includes:

1. involvement of close relatives in shared care in the local hospital;
2. flexible use of beds;
3. bereavement counselling;
4. easy follow-up;
5. personal voluntary help in the local hospital continuing after discharge.

The GP Hospital should become a focus of Health Care with the GP Practice; perhaps with a walk-in health advisory centre. Close relationships are needed between the local hospital, the Social Service Day Centres and residential homes.

DOMICILLARY SUPPORT SERVICES - Mrs J McGregor, MECI, Founder of 'Country Cousins' and 'Emergency Mother's Bureau'.

The audience was asked three questions -

Can you walk without a 'Zimmer frame'?

Can you get out of bed without falling?

Can you look after yourself unaided?

and asked them to imagine their attitude if the answer had been 'no'.

Her agencies provide temporary non-nursing help with a rota of 3-4 weeks, but cannot cover night and day care. There are two distinct needs; short-term care after illness, and long-term chronic illness.

Accurate placement and success of her helps is aided if:

1. doctors and social workers give full details;
2. many patients are ignorant of available facilities, e.g. for incontinence or district nurse visits;
3. it is understood that only housekeeping is covered;
4. there were more agencies (their own can only help with about 50-60% of requests);
5. observers look beyond superficial appearances; patient and family often put on their best for the visit;
6. the innovation 'Emergency Plus' would be additional to any other helpers in the home.

Contrary to popular belief, the service was used not just by the middle and upper classes, but by charities,and people struggling to afford it.

The second part of the Conference ran as five syndicates with different topics; reporting back to Conference.

A How should admissions and discharges of old people be controlled? How should day-to-day care be organised?

Two themes ran through the discussion: carers must communicate freely; fixed rules are foolish because of the variability of GP Hospitals.

1. Admissions

The syndicate felt that facilities, rather than skills, determine service.
Some thought there was better care than in the District General Hospital, but all agreed that first-class care was needed. X-ray facilities, adequate physiotherapy and occupational therapy were essential.

Appropriate cases were - terminal illness, social and holiday care, acute medical, surgical and convalescent; whatever objective applied it would be 'policed' in practice by the senior nursing staff.

2. Discharges

Discharge should be planned by the team before selective admission, and involve all the ancillary services (e.g. District Nurse to visit the patient in hospital); maybe with a short home trial first.

Inflexible staging between Part III homes and hospital should be relieved; pâcé a moral observation that Part III accommodation is intended as the patient's secure home.

3. Day-to-Day Care

Specific clear action, with clinical objectives should be noted using problem orientated medical records. Soundly financed, regular consultant advice is needed for visits, so that requests are not inhibited. Rigid policies generally fail.

B Suggest ways the barriers which exist between the Health Service and the Social Services can be broken down when old people are cared for.

The difficulties of allegiance experienced by Medical Social Workers since 1974 was discussed, and it was resolved that the patient came first.

The team approach was favoured, but was not always successful. Social workers had to have many relationships. Some GP's disliked 'teams', so establishing common criteria between social workers and GP's is difficult.

Philosophy and practice differ, ie Part III accommodation was intended as 'hotel care', whereas about 30% of residents need a long-stay hospital. Philosophy not material is the barrier.

Some felt that the Health Services were more dynamic and Social Services more static and parochial. The different functions of the Social Services Day Centres and the Day Hospital are fundamental, but too rigidly applied.

When joint funding was involved then there was co-operation and enthusiasm, as the pay was better.

C What are the best ways of keeping old people out of hospital? How is Day Care best used?

The word 'old' was rejected and 'problem elderly people' substituted. They were usually over 70, poor, deteriorating mentally and living alone. The problem depends on the local services - urban and rural communities differ. In rural areas the home is identifiable and neighbourly. All patients, however, depend on goodwill and the voluntary services.

It was felt the GP might screen using the age-sex register prior to deterioration. Holiday care in local authority homes helps enormously to avert crises.

The tangled 'hotch potch' in the care of the elderly, i.e. Local Authority Homes, Part III, Day Care, Long-Stay Hospitals, Housing, Social Services, would be solved by interchange under one roof.

Day Care

Day Hospital care under permanent Consultant cover near a Geriatric Unit, and the Day Care Centre under GP's and attached to the GP Hospital was distinct and the latter was analysed for the optimum, viz.

1. Out-patient Consultant - physical and pathological diagnoses.
2. Physiotherapy - for minor strokes, rheumatoids, etc.
3. Social and diversionary occupational therapy.
4. 'Daily Living'.
5. Family support and relief.

D How can you maintain the morale of nurses, whose work is with the chronic elderly sick in GP Hospitals?

It was felt that if the general morale was high, then the nurses' morale was too. Adequate staffing was essential with part-timers to keep staff levels up, particularly in rural areas. In acute wards, the higher the rate of bed turnover the faster the beds fill with long-stay cases; nurses on acute wards then resent the pay that long-stay staff earn.

In the cities the young wish to work in the District General Hospital and the more mature staff in smaller units. Perhaps young nurses might gain insight with rotational training, including small active units. A deep vocational sense is found in some geriatric nurses; but those who do not opt for geriatrics primarily do get down-hearted. Mixed cases rather than entirely acute or long-stay were mostly favoured.

Staff exchange was suggested to avoid professional isolation. 'Adopt a granny' schemes and mixed sex wards were popular - the old ladies stopped grizzling and the men watched their manners.

E What action should arise from this Conference and how should its effectiveness be assessed?

Dr Cavenagh reported back the trenchant view that - "matters must not be left there". Possible action included:

1. More of nearly everything for the next 20 years.
2. More hospital beds for the elderly.
3. More flexibility.
4. More education of families in home care of the elderly.
5. Adequate circulation of the Conference proceedings.
6. To discuss the Conference back at work.
7. To persuade the DHSS of the views of the Conference.
8. Solid fact is needed to convince the DHSS. A study standing statistical criticism, sampling costs and quality of care in a GP Hospital compared to a DGH or elsewhere.
9. To search the current literature. This was thought beyond any individual at the Conference, but might be done by the OHE or the Association of GP Hospitals.
10. To prepare a 'Manifesto of Intent' by the Association of GP Hospitals in terms of the elderly in hospital: perhaps another document like the 'Cottage to Community' 1977.
11. A deadline for review of the day's effects and to regather at the King's Fund Centre, after an agreed time.

EPILOGUE - Dr Loudon, Chairman.

Dr Louden made a number of summary points:

1. We must persuade the Regions to allocate funds, rather than the DHSS.

2. Seventeen members of the Conference expressed a wish to have a follow-up.

3. If, as the Conference seemed to agree, the best place for the elderly sick was at GP Hospitals, then most of them should be treated there. This would constitute a major change in national policy. Not all members of the Conference agreed with the logical extension of the first point. The GP Hospitals should not just treat the elderly.

4. Ways of designating beds:

   (a) Long-stay under a Consultant with the GP as his 'house physician' was not acceptable to GP's.

(b) Geriatric beds under the GP and payment for regular Consultant advisory visits was accepted.

(c) Long-stay geriatric beds under the GP with Consultant advice on request, was also accepted.

5. Dr Loudon asked the Conference members to assess their relationships between GP's and Consultant Geriatrician as:

Excellent or good	50%
Moderate	22%
Poor or Absent	28%

6. There was general agreement that where relationships between GP Hospitals and Social Services were good and 'willing', they were often ineffective, due to lack of resources, such as inadequate Part III accommodation.

7. The Chairman felt that the Conference had demonstrated the liveliness and variability of GP Hospitals and that the very broad level of activity was a great source of strength to their future. They were not in favour of blanket recommendations for roles or activities.

8. Liaison Committees were generally thought to be a poor substitute for common administration. The present fragmentation was thought to be a crazy way of providing continuous and co-ordinated care for the elderly.