Governance and autonomy in alternatives to hospital care

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Abstract

Older people with complex illness and disability should have the same equitable opportunities and safeguards for treatment and care as do younger people. These should be based on needs, likely health gain and personal preference. Comprehensive assessment and goal setting, with monitoring of progress and outcomes, should be an integral feature of alternatives to hospital care, wherever they are provided. To satisfy the principles of clinical governance the development of innovative intermediate rehabilitative and long-term care programmes may require more time and expertise than small purchasing groups can reasonably provide. Pooling health and care budgets managed in partnership by larger providers may offer a solution. There is an urgent need for pilot projects to inform development.

Governance and autonomy in alternatives to hospital care

Tension exists between personal autonomy and service governance in many aspects of health and care, particularly in later life. Rights, individual responsibility and risk-taking have to be carefully balanced with opportunities afforded by new treatments and technology, finite resources and rising expectations. New alternatives to hospital care for older people may be greeted with scepticism from health care professionals, mindful of the medical dis-establishment of long-term care in Britain, lack of systematic research evidence for community hospitals [1] and the often hard-won access to a full range of investigation and treatments for older people in acute hospitals. Alternatives to existing practices carry the risk of becoming cost-driven substitutes rather than outcome-driven innovations.

Many of the concepts of need of older people are grounded in outdated perceptions of social vulnerability and inadequate support that traditionally characterized the ‘geriatric hard core’ [2]. Improving living conditions and health maintenance have and continue to reduce the previously common privations of ageing that typically presented, for example as malnutrition or hypothermia. Contemporary disability in ageing is increasingly defined by evolving patterns of underlying clinical diagnoses. Older, vulnerable patients frequently have complex multiple pathologies. Those with diminished mental capacity need clinical advocacy that establishes reasonable goals and provides the means to achieve them within a whole system [3]. Disjointed, multi-specialty, multi-agency episodes of care may work for consumer-led aspects of health care but for vulnerable people they are inadequate. The course of one patient illustrates the pitfalls of contemporary health care.

Case report

An 84-year-old patient with diabetes mellitus was considered by his GP and consultant physician to be approaching institutional care, as a consequence of an escalating burden of irretrievable multiple pathology. He was admitted acutely for a minor infection, which was complicated by immobility and urinary retention. Following initial medical treatment, a urologist recommended transurethral prostatectomy after ‘convalescence’. After three weeks on a medical ward, the patient was transferred to a hospital-purchased nursing home interim care bed. Here his condition did not improve. After 4 weeks, he underwent preoperative anaesthetic assessment and was found to be unfit for surgery for several reasons, including the development of a heal pressure sore. Demoralized, he was readmitted to a medical bed, this time under the care of the consultant familiar with his case. The patient’s health further declined with death occurring in hospital 11 weeks after the initial acute admission.

In isolation, each management step this patient received was reasonable, including the use of an alternative to a hospital bed. However, comprehensive
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geriatric assessment [4] subsequently linked to treatment would have avoided the futile procession of health care episodes and would have used the acute illness as a trigger event for long-term care. Acute illness or new disability is seldom simply reconciled by isolated interventions in older people burdened with co-morbidity. Indeed, such approaches engender the hollow spectacle of ‘treatment success, outcome failure’ with typical patients often passing from one specialist service to another until their problems are declared as beyond medical remedy and a rapid discharge characterised by a poorly structured care plan lacking outcome expectations.

Clinical governance

Governance is a key component of health service modernization in the UK. To date, governance has been applied principally to high technology and costly areas of medicine, where information systems are well developed. Governance should provide a potent force for improving health and care services for older people. Currently, health policy in the UK [5] features increasing responsibilities for health service commissioning by primary care. This is accompanied by: (i) Responsibilities outlined in the NHS quality framework [6] (Figure 1) and (ii) demanding standards of corporate governance [7] (Table 1).

Impetus for developing health and care services for older people comes from: (i) The audit commission’s findings [8] of poor co-ordination of hospital discharge and the consequent ‘reversing door’ of recurrent hospital admissions stemming from failure to address all patients’ needs—especially their rehabilitation potential. (ii) The findings of the National Bed survey, which highlights the opportunities for a range of Intermediate Care Services [9].

Satisfying governance will prove demanding for established services for older people, particularly so for innovative, alternative, approaches to care that lack suitable benchmarks. Currently, many medical sub-specialities use age-related disease epidemiological data for service planning and resource justification. Using age as a denominator for health service development is flawed, indeed it may be considered to perpetuate ageism, for older people whose needs are often similar to younger people. Logically, governance of medical and surgical specialties should incorporate outcomes appropriate to later life. These might include institutionalization rates for treatable conditions (such as arthritis) and those awaiting joint replacement, and conditions such as Parkinson’s disease or diabetes mellitus. Dependency and loss of autonomy concerns many older people far more than the spectre of death.

Evidence of reduced dependency and crisis admissions (effectiveness) and cost savings (efficiency) rather than simple treatment rates and mounting care costs should drive investment in services for older people. Indeed, not only is this likely to be better than the ‘fire fighting’ now commonplace, it is likely that older people, having increased awareness of health in later life will increasingly demand such development.

Older people may be divided into two broad groups, those with capacity and circumstances to exercise choice (who often fall into the speciality-related patterns of governance outlined above) and those who are compromised to the extent that their autonomy is dependant on the overall construct of their health and personal care. Governance is embryonic for many aspects of social services personal care [10]. In particular, outcomes for personal care are less developed than health care. Many older people require relatively small inputs of care to compensate for various impairments, but those with complex needs are often entirely interdependent on both health and personal care services. For this population, integrated health and personal care makes practical sense and makes care standards much more accessible for meaningful governance.

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Figure 1. The quality framework and patient care.

Table 1.

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Rehabilitation

In spite of widespread support, rehabilitation remains at risk in the NHS [11]. Stroke and hip fracture rightly receive much attention because of their incidence. For both diagnoses, primary and secondary prevention and fast track management have become foci for action, monitored through measurable process audits. This clarity of purpose eludes much rehabilitation of the large proportion of older people, with multiple and sometimes uncertain diagnoses. In stroke care, the relationship between severity, co-ordination and intensity of rehabilitation and outcomes [12] will increasingly inform the appropriateness of alternatives to full hospital rehabilitation. Some cases of hip fracture may be so extensively burdened by co-morbidity and disability that, thorough assessment may predict that outcomes may not be improved through intensive rehabilitation [13]. For a few older people, a fractured hip could potentially be positively identified as a pre-terminal event for which the appropriate management would be palliation. Acceptance that withholding effectively futile treatment may be possible, signals new levels of responsibility and obligation for co-ordinated and informed care. It also challenges the current vogue for care pathways. Simplistic production-line approaches risk exclusion or treatment misadventures for patients failing to conform to the entry criteria of pathways. Clinical governance should be inclusive in principle and practice. This suggests a need for broad professionally-determined patient flows that comprise:

- the formulation of a diagnosis and likely prognosis.
- an interdisciplinary assessment of functional and social needs.
- a management plan with a provisional outcome goal and planned review.

Within this inclusive model, specialist and individualised streams (such as those for stroke care) can be accommodated. Historians of geriatric medicine may consider this a return to progressive patient care—it is not. It signals a focused approach to specific disease and disability groupings based on evidence and expected outcomes. Medical opinion and leadership should set goals and explore a range of rehabilitative options, including alternatives to traditional hospital models. Finally, modern information technology is capable of tracking individual case progress providing that measurement is undertaken in a standardized, sensitive and meaningful way [14].

Long-term care

Long-term care remains contentious and unresolved in the UK. There is continued uncertainty following the report of the Royal Commission on long-term care [15]. Integrated partnerships of health and social services together with various providers of care are generally desirable [16] for services to frail and vulnerable people. In long-term care they are quite fundamental. Development and institution of a mandatory threshold assessment that binds assessment and commissioning processes is long overdue [17]. Assessed needs should provide the foundations for subsequent care [4] and an individual benchmark for governance. The construct of care should be interdisciplinary and cohesive rather than uncoordinated multidisciplinary, multi-agency care. A capitated care scheme has been proposed that features pooled health and care budgets and may provide a practical solution [18]. Such approaches could enable and encourage health and care teams to manage some patients with sub-acute and acute illness in situ as an alternative to hospital transfer as well as provide pro-active routine care. There is evidence for good programmes of managed care being associated with improved outcomes [19]. Pro-active approaches may encourage preventative health care programmes targeted to the long-term population, for example investment in hip protectors [20] and the use of Vitamin D and Calcium [21]. These interventions may reduce hip fracture rates, thus freeing orthopaedic resources and potentially increasing hip replacements in those patients requiring social support awaiting surgery, a virtuous cycle indeed. Providing evidence for such approaches may find little enthusiasm for commissioning in competition with other demands, but within a comprehensive funding approach for those in long-term care, the reduction in overall dependency may bring a net cost saving and thus become an attractive component of care.

In general improvement or adaptation is the goal of rehabilitation. In long-term care, rehabilitative intervention may slow decline and reduce dependency. Indeed, persuasive evidence for exercise programmes exists [22]. The effective organization of exercise initiatives requires a whole-population approach.

Systematic care

Individual primary care groups may lack the range of resources to develop and manage comprehensive, radical, wide-ranging programmes. These could at least blur and at best wholly integrate health and care services. Both rehabilitation and long-term care are high volume, costly, but relatively low tech health and care activities. Franchised systems of care could emerge led by community trusts, health authorities or providers of good standing, co-ordinating and evolving existing resources within localities. Reservations that this collectivist approach may harm individuals [23] may appear compelling until the alternative of concealed, sub-optimal, inappropriate or even missed treatment opportunities are considered [24].

Precedents in the UK for such a collective development may be observed in the establishment of large
mental health trusts, that include several previous services and the amalgamation of general hospitals to improve service effectiveness and efficiency.

Conclusion
Older people need continua of interdisciplinny services, much of which may be enhanced by the addition of integrated innovatory options to traditional hospital care. Innovative, alternatives to hospital care for older vulnerable people, undergoing rehabilitation or long-term care provide pose particular challenges to clinical governance. Potential solutions of systems of care ‘franchised’ to local services may bring consistency and facilitate governance. A ‘franchisor’ may provide an organizational structure as well as an auditing function monitoring outcomes. It is important that alternatives to hospital care demonstrate maintained, preferably improved outcomes which satisfy the clinical governance requirement that individual patients experience the best possible health. Only then can they exercise personal autonomy most fully. Vulnerable elderly patients have a special dependence on such comprehensive approaches to health and care, which have common aims and clear responsibilities.

Key points
- Systematic organization of rehabilitation and long-term care is necessary to satisfy the demands of governance and autonomy.
- Reduced dependency and avoidable crises are more appropriate outcomes than treatment episodes for many older people.
- Effective programmes may be developed through pooled health and care resources with captitated approaches to long-term care.
- Opportunities for innovation need to be counterbalanced by the complexity of establishing and managing innovation.
- Alternatives to hospital care may be best developed using franchised systems that provide efficient integrated local care amenable to governance.

References