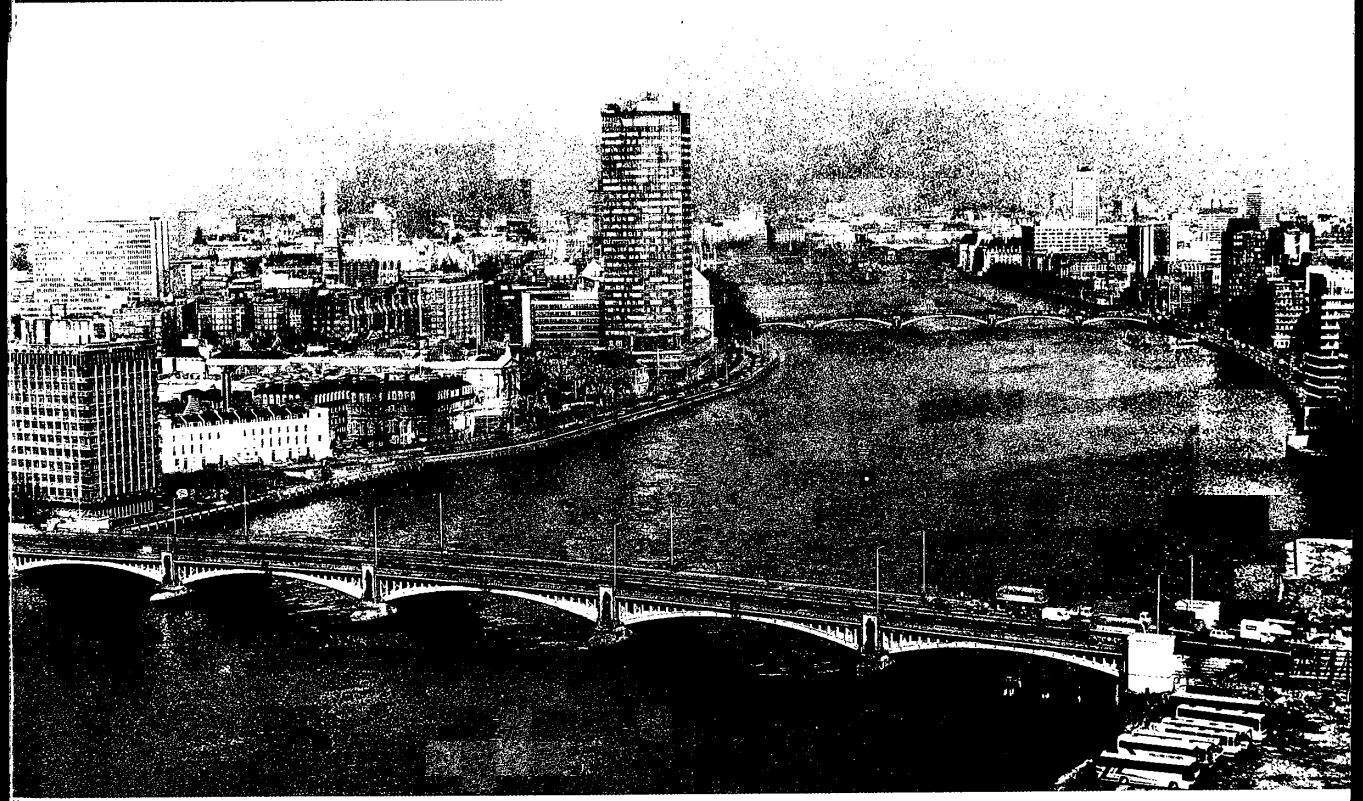
London Views



Three essays on health care in the capital

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Elaine Murphy

for the King's Fund Commission
on the Future of Acute Services in London

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She is also founder editor of the International Journal of Geriatric Psychiatry and UK advisor to the World Health Organisation on the health of elderly people. She has published extensively in her own clinical research fields of depression in old age and the epidemiology of mental disorder in the community and also on community care services. At present she has a particular interest in the quality of care of residential homes for people with dementia.

Acknowledgement

The author would like to thank Dr Philip Brown, Research Registrar, Guy's Hospital, for his assistance with Essay 3.

1 Acute care in London

Current issues and problems

Introduction

This is an unashamedly *personal* view of the current issues based largely on my experience of working in the south east segment of inner London. It is a view informed by impressions gained in working in five different London teaching and postgraduate hospitals and the local communities they serve, also in a variety of smaller general hospitals and large mental hospitals and by being closely associated with a voluntary organisation providing care for elderly and disabled people in inner London whose perspective on health services is very different from that of health service staff. The fine details may vary across inner London and attitudes are beginning to change in some teaching hospitals, but the fundamental problem remains the gap between what London hospitals aspire to provide and what Londoners need. I make no apology for emphasising the problems of London residents, while acknowledging that the London teaching hospitals, especially the postgraduate teaching special health authorities (SHAs), have a legitimate national role in certain fields of medicine and also that day-time commuters and visitors to London make legitimate service demands.

Traditionally, London has received a service from its hospitals and community health services which was undoubtedly better than most other places in simple terms of accessibility and quantity of health care. I think back to the 1960s and early 1970s when well-funded London district hospital services in part compensated for a variable and sometimes frankly bad primary care service. Hospitalisation rates were very high compared with elsewhere. The reasons for this have always been unclear – it was widely thought at that time that it was due to poor primary care and the simple ready availability of local beds, but there are other important reasons. The first is that nursing care provided in hospitals and local authority homes has been used as a substitute for family care that is not available to the same degree in inner London as outside of London. This issue is explored further in Essay 2 on services for elderly people, but the arguments hold true for younger people too. There are far more people living alone, without nearby family support, than elsewhere. The effect of this on clinical services is that hospitals cannot at present be used simply as technical treatment centres. Day surgery, for example, may be very acceptable to a 50-year-old man going home to a competent, observant wife who can give 48 hours of attentive nursing care, but it is quite another matter for a single man

living in lodgings without the support of any close relatives or friends. London hospitals have traditionally provided hotel and personal care to people who elsewhere could have been treated at home.

A further, and surprisingly little explored, reason for high admission rates is the factor that the man in the street might suggest – that there is simply more morbidity of those disorders that demand hospital treatments, a direct result of the social characteristics of the poorest Londoners.

The last reason for high admission rates of local residents to teaching hospitals is their relatively high use of specialist multidistrict services. These services happen to be sufficiently convenient geographically for local GPs to be able to refer with ease and for tertiary referrals from district medical and surgical specialties to be seen quickly by colleagues in the same group of hospitals.

Bed losses

Whatever the reasons for the high use of hospital beds, as a houseman in a London hospital in 1971 I do not remember ever turning away an emergency admission or waiting for more than a few days to admit a moderately urgent case. There was also a wealth of hospitals – small local specialist hospitals for women and children with eye disorders and so on, and large general hospitals with a rather "arm's length" relationship with their local teaching hospitals. Figure 1.1 is a map of the south-east London boroughs of Lambeth, Southwark and Lewisham in 1974; there were 20 hospitals. Figure 1.2 shows the situation now; there are three teaching hospitals – King's, St Thomas', Guy's and their three teaching satellites of Dulwich, South Western and Lewisham, the first two of which are already dying in the drive to centralise services on the teaching hospital site. This makes it very clear how dependent the local population has now become on the large teaching hospitals for their secondary health services. The bed losses since 1974 have been staggering. It is easy to see how these were justified in the early days of bed cuts when it was believed that over-provision merely encouraged excessive admissions. For example, between 1982 and 1989 a quarter of the acute hospital beds were lost from my own district. Unfortunately, bed reductions have taken no account whatever of the social characteristics of the inner London population. There are, of course, still an awful lot of beds left in London compared with other parts of the country but the question arises whether they are really available for the local population.

Availability of existing beds for local use

Guy's is a fairly typical teaching hospital of approximately 850 beds, of which 100 are psychiatric beds. Of the 750 remaining, 150 are used by multidistrict and supraregional specialties, leaving approximately 600 for district acute services. Of these 600, 35 per cent are in use by an influx of patients from other districts, of which about half come from outside London and the other half from neighbouring districts in the region, leaving 390 approximately for local people. Looking more closely at the 390 beds, 90 are permanently occupied by elderly people

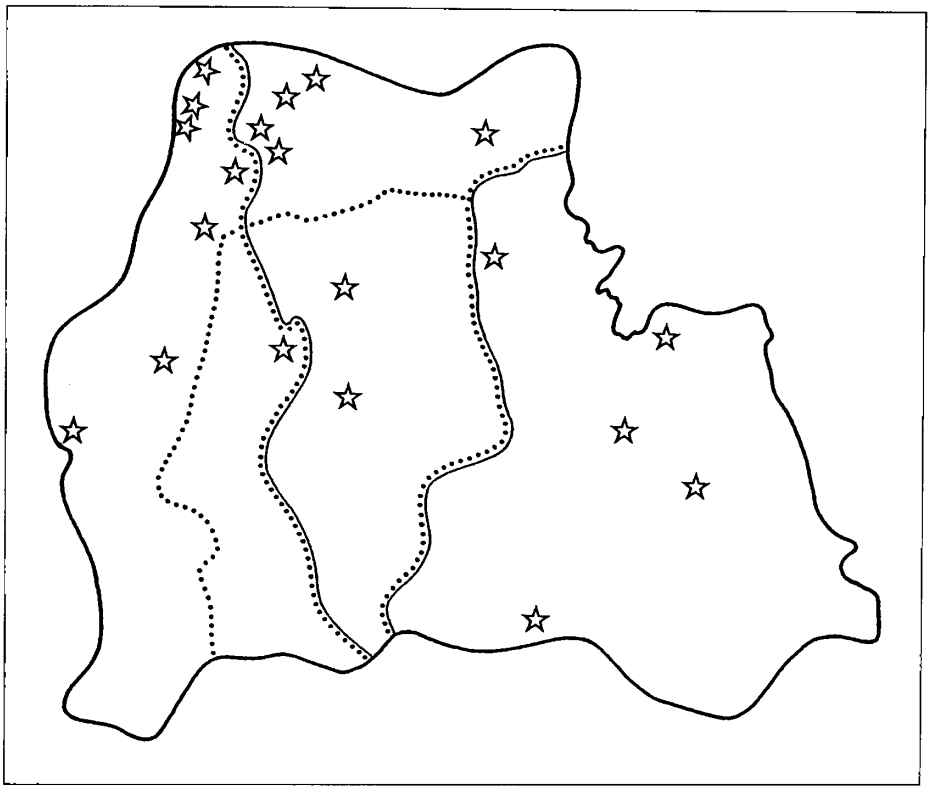


Figure 1.1

"Acute" hospitals in 1974: Lambeth, Southwark and Lewisham

Source: Lewisham and North Southwark Health Authority

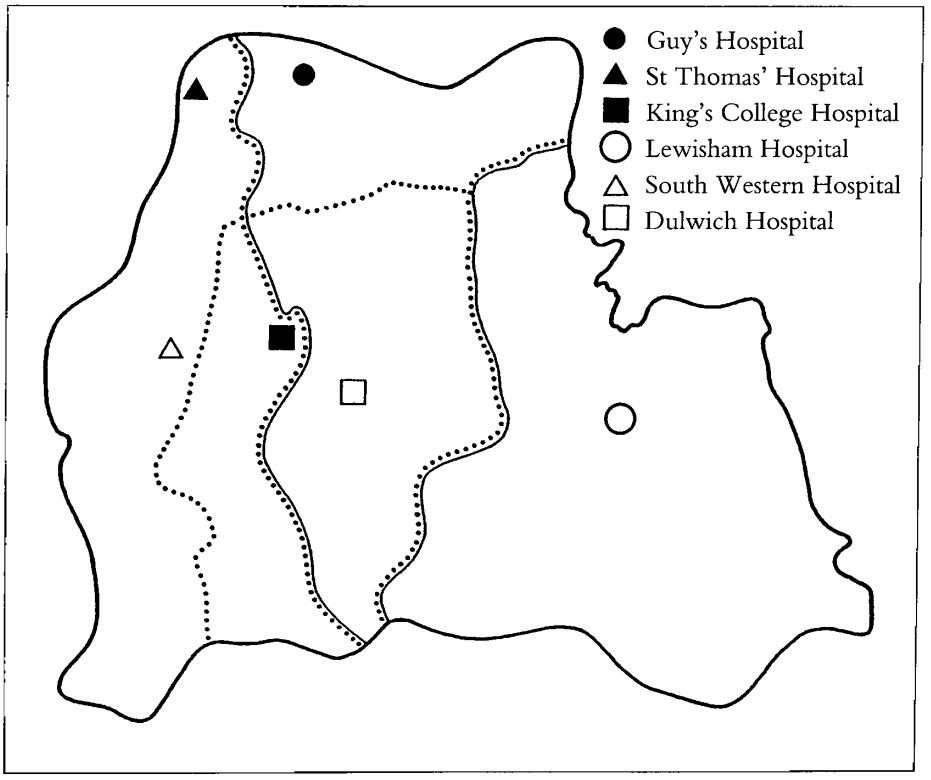


Figure 1.2

"Acute" hospitals in 1991: Lambeth, Southwark and Lewisham

of 65 and over staying longer than 90 days. The reasons for this are fully explored in Essay 2 on services for elderly people.

The proportion of beds occupied long term increased suddenly when the 1985 financial ceiling was imposed on social security benefit funding for individuals entering private residential and nursing care, a factor which left London homes unable to provide adequate care on the level of funding provided. Furthermore, there has been a massive drop in the number of long-stay beds for elderly people which was fuelled by the earlier 1983 decision to make social security funding available to residents of local homes at the going rate charged by local proprietors. This sudden unexpected "bonanza" allowed London hospitals to close long-term nursing beds and change the use of other long-stay beds to provide acute care. For a couple of years between November 1983 and 1985 there was an increasing transfer of long-stay care into the local private sector and, for a while, no bed-blocking in London. During the 1980s local authorities in London decreased the number of residential care places in Part III homes as a result of their own financial problems and the drive to improve quality at the cost of quantity. When the financial ceiling dropped in 1985, bed-blocking began to rise again. These elderly people are waiting for nursing home type care, the majority have severe physical and mental disabilities which require more care than can be provided in an ordinary residential care home. They live a most unsatisfactory life on wards where staff resent their presence and where little is done to improve their quality of life. Their presence brings the number of available beds for district acute work at Guy's down to 300. The situation is more or less the same in every London teaching hospital, with one or two notable exceptions.

The impact of this poor availability of beds on the local population is profound. GPs constantly complain of the difficulties of getting the ordinary sick person into hospital. Community Health Councils (CHCs) know the problems too but hospitals do not collect relevant information. They do not record the number of individuals refused admission on the phone by the registrar on call and, of course, GPs quickly learn when not to bother even trying certain hospitals. The Emergency Bed Service (EBS) provides some telling statistics. The EBS offers assistance to GPs in securing admissions for acutely ill patients. If it is unable to arrange acceptance, it appoints a medical referee who will refer a patient to a hospital as an acute emergency if he or she thinks proper. Between 1974 and 1984 the medical referee rate was 8 per cent. Since then the rate has risen dramatically, up to 20 per cent in 1989 (see Table 1.1).

Applications to EBS have not risen but have declined. This probably reflects GPs' decreasing demand to EBS for admissions of those who would have been admitted in earlier years. They are raising their threshold for demand to include only those for whom no possible alternative care plan can be arranged. On the other hand, the pressure from hospitals on the EBS to keep admissions down has resulted in a larger proportion of referrals being medically refereed. The most likely explanation of these changes is the inadequate supply of local acute

Table 1.1

London EBS caseload statistics

	Total applications	Per cent medically refereed	Per cent refereed in Lewisham and North Southwark
1983	30,237	7.99	(6.1)
1984	29,107	8.08	(7.5)
1985	31,425	12.58	(7.2)
1986	30,859	11.69	(13.3)
1987	30,726	12.02	(19.8)
1988	29,739	15.92	(28.4)
1989	27,686	20.04	(35.0)

beds. My own district, Lewisham and North Southwark, tops the league table of net exporters of patients in London, sending patients to Greenwich, Bromley and even further afield. These patients are often elderly people in need of local support services on discharge, which is far more difficult to arrange at a distance.

The unavailability of beds leads to a defensive attitude to admissions, particularly for elderly people and others with severe disabilities who are judged to be likely bed-blockers. It leads to hurried and inadequate discharges, poor training for staff in good standards of care, a very poor example to students and an ethos of "get them out at all costs". In summary, Guy's has 850 beds but in reality only 300 are genuinely available for local people with ordinary acute conditions, far less than is currently demanded at present while there are few alternatives to admission available.

The use of multidistrict services, however, is quite the reverse. In spite of Lewisham and North Southwark having only 10 per cent of the population of the region, district residents use 20 to 25 per cent of the multidistrict specialty beds and services. In other words, local people have a double or even greater chance of access to cardiothoracic, renal, neurosciences, plastic surgery, radiotherapy and so on, than their neighbours in non-teaching districts. In general, the costs per case in these specialties are higher than in general medicine or surgery. We now have a situation in London where on the one hand large sums of money are expended on a relatively small number of individuals receiving high technology care, some of which has not been subject to rigorous outcome and cost–benefit studies, and, on the other hand, far less care than you would expect for the commoner ailments and routine emergencies. Multidistrict services and other specialist services dominate the picture. In south-east London in 1990 we had four cardiothoracic surgery services within three miles of each other, three renal units, three plastic surgery centres and a three site radiotherapy service. Although no doubt there is some rapid thinking going on right now about the future of these services, essentially all the teaching hospitals do the same thing. Not only do services duplicate and

triplicate equipment and laboratory costs, they do not necessarily communicate with each other over clinical practice protocols or the results of outcome studies.

Finally, a comment must be made about the 35 per cent influx from other districts. Those that come from surrounding London districts merely reflect local patients and GPs' choice and the haphazard nature of EBS placements. However, the half of the inflow that comes from further afield reflects two other phenomena: first, the highly specialised research interests of consultants at teaching hospitals which results in their being sent one type of case from all over the region or from even further afield; secondly, the persistent tendency of some peripheral GPs to send their middle classs patients back to their "Alma Mater" teachers instead of the less prestigious local district general hospital (DGH). This probably affects outpatients more than inpatients but I still have the impression when I visit wards at Guy's that the curious phenomenon of "bunions from Barrow in Furness" is alive and flourishing at my own hospital.

The NHS in London is the wrong shape in other ways

London has a highly mobile population: 15 per cent of the local population changes every year. A significant proportion of transient or temporarily resident people do not register with local GPs. Their attempts to use the hospital as a source of primary care are generally discouraged although they have no realistic alternative available in an emergency.

Homeless people, that is those living in bed and breakfast accommodation with children, single homeless hostel dwellers and those living rough, are also ill served by the traditional GP/hospital division of services.

Services are often unwelcoming and inaccessible for people from ethnic minorities as a result of language and cultural barriers. Few services make positive efforts to reach out to these communities, who may have low expectations and make few demands.

Finally, health authorities currently give very little thought to prevention and invest little in effective health promotion schemes in primary care. Joint working with environmental health departments of local authorities is negligible.

How have we reached this unsatisfactory situation?

The answers, I would suggest, lie in the corporate aims of the London teaching hospitals to be centres of national and international medical excellence aided and abetted by medical schools whose grant funding depends not on the excellence or appropriateness of their undergraduate medical education but on their ability to attract "mega bucks" research money into basic biological sciences and the remoter shores of advances in clinical treatments. The ethos of the London teaching hospitals has changed little over the past 100 years – teaching is still largely focused on a model of achieving a biological diagnosis and specific treatments for individual disorders. This, of course, remains a legitimate and important aspect of medical education but it is not

enough to prepare doctors for the kind of problems they will face in their work. Almost all academic medical developments in the priority care areas have been funded by health authorities; there are no more than a handful of University Funding Council (UFC) funded psychiatrists, geriatricians or rehabilitation specialists across the whole of London. Interest in research in health services or social and community aspects of medicine is in its infancy. Teaching still largely takes place in hospital, and experience in primary care and community settings is minimal.

The NHS should have a keen interest in the training of doctors but has singularly failed to influence the schools to produce doctors better equipped for general practice, for public health medicine or for the kind of hospital practice which puts service to the community first. I suggest that the objective of achieving national and international status on the medical scene is at odds with the objectives of providing an excellent service to the local community, where completely different priorities are voiced by local GPs, the CHC and local authorities who want more of the routine "bread and butter" general medicine and surgery services, better hospital/community links, improved care for chronically sick and disabled people and a less remote, more "user friendly" institution.

Since 1974, when teaching hospitals came into the mainstream health service system, the hospitals have learned to pay lip service to the notion of local commitment. More recently Trust applications have glowed with heart-warming mission statements about the needs of local people but it remains to be seen whether the declared intention to have two sets of priorities – to develop specialist services of national renown *and* to foster local services – is really feasible. Businesses rarely thrive by setting out in two different directions at once or by giving staff two sets of mutually exclusive messages. Many London hospital managers believe the two aims are not mutually exclusive, but in the past whenever a conflict has arisen between the two aims, the national "market" has generally won out over local needs. In theory, of course, the local purchasing authority can specify the service it wants in the contract – certainly its bargaining position will be a great deal better than before the reforms – but the hospitals will have the final say in what business they really want to be in and will set their own priorities.

Some London hospitals have made attempts to change the pervading culture – St George's springs to mind as the most successful with King's and Barts also acknowledging that a cultural change is needed – but teaching hospitals are indivisibly linked to their medical schools by the clinical staff who are common to both organisations, and medical schools look to the UFC and, in terms of their teaching curriculum, the General Medical Council (GMC), not the NHS, for their future direction. One or two deans are beginning to think seriously about how to shift the culture and this past year there have been a number of speeches from deans who have grasped that the health service reforms will force purchasing authorities to rethink local priorities and that this will have a major impact on local medical education. Some deans have begun to talk about new priorities in medical education which reflects a new public health focus on the

needs of local communities and on achieving improved health status of local populations, but progress is slow and cultural change long overdue.

There have been attempts to rationalise some of the multidistrict and smaller district specialties (especially those where it is feasible for people to travel for treatment) but so far with little success. Medical schools in London have until now insisted that every speciality must be on every hospital site for clinical teaching purposes. There is an understandable reluctance on the part of clinicians to lose from their own hospital a service cherished by colleagues which is conveniently on site for cross-referrals. It is, however, perfectly possible for students to travel for clinical experience – provincial medical schools have always used a wide variety of regional hospitals for clinical teaching. I do understand the practical difficulties and the needs of students for central support, but these are problems which it is possible to solve. The health service changes will drive rationalisation but it remains to be seen whether this opportunity will be grasped with enthusiasm by the schools or whether they will be dragged reluctantly to the inevitable.

Solutions

A vision for London

Left to their own devices and an uncontrolled internal market, the London hospitals will change radically anyway. We can already see hospitals reviewing their service "businesses", making a judgement on what they have to offer in terms of national prestige to give them the edge over their neighbours and other teaching hospitals and planning to abandon the second rate "also-rans" where other hospitals are clearly in the academic and clinical ascendency. The highly publicised "service review" at Guy's – done by a kind of opinion poll of clinical directors – was explicitly designed to identify publicly those specialties that any consultant, senior nurse or local GP would have identified as unlikely to achieve a national reputation for excellence. There will be deals done with other hospitals, agreements reached about which hospitals will focus on which sub-specialty, but if they are allowed to go their own way there will also be long drawn out competitive battles fought for diminishing levels of business, as the provincial and London suburban hospitals develop local expertise in the major high-tech specialties.

These random movements in the shape of clinical services are unlikely to produce improved services for Londoners except by accident. Before coming on to organisational structures which might facilitate sensible strategic planning for London, let me set out my personal vision of what services should look like in central London.

2020 Vision

The teaching hospital as it exists today – a monolithic supermarket of health care services – would disappear. In its place would be perhaps half a dozen high technology hospitals concentrating on specialist

investigation and treatment, each specialising in one or two fields of medicine only. In addition to these hospitals there would be locality hospitals which would also be teaching hospitals but which served a district community for routine treatments which could be only provided in hospitals. These locality hospitals serve as a base for consultants to engage in outreach work in peripheral clinics in health centres in order to give advice to GPs, give support to home nursing initiatives, provide acute crisis nursing services and terminal care nursing teams. There would be some specialties whose work would be conducted almost entirely outside the hospital from resource centres in the community. Mental health care, care of the elderly and most rehabilitation work in neurology and rheumatology could be done outside hospital. Scattered across London, possibly on existing hospital sites, would be specialist clinics for the sub-specialties conducted largely in outpatient and day case work. Far fewer patients would require admission because of the amount of medical, nursing and home care available at home. In addition to spending on health care services, districts would spend perhaps 10 per cent of their total revenue on community health promotion and prevention schemes and on secondary and tertiary prevention schemes to reduce handicap.

What would need to be done to achieve this vision?

- Major rationalisation of supraregional and regional specialties across London.
- A radical review to ascertain which parts of services provided by SHAs are truly "national" or necessary to postgraduate education and which are merely duplication of more general work that could be done by other hospitals.
- Major rationalisation of sub-specialties in which the patients are usually ambulant, for example ophthalmology, ENT, dermatology, oral surgery, which can be provided largely on an outpatient basis and where there is no particular need to be sited within the local neighbourhood. It would be possible to coalesce several existing departments into specialist clinics that could also be teaching centres.
- A decision needs to be made about which services need to be truly local. These would be services where accessibility is known to influence take-up of services. Services for sexually transmitted diseases, mental health services, care of the elderly medicine, community preventive health services for women and children all spring to mind as services where local accessibility is crucial.
- Teaching hospitals should decide whether to be community focused or specialist medicine focused. Some should strengthen their generalist medicine and surgery specialties and provide the main sites in London for undergraduate medical teaching. The most obvious hospitals to play this role are those conveniently situated in their local resident catchment areas such as King's, Charing Cross, St George's and the Royal Free. They could also become centres of service innovation and academic service research to develop models of

inner city health care of relevance to cities throughout the world. The role of such hospitals would naturally move away from being "bed" dominated to becoming much more a central resource institution for both primary and secondary care developments and public health initiatives. Such a vision could only be realised with the support of a medical school which had an alternative vision of medical education to the one currently espoused by the majority of London medical schools. There is scope for uniting medical schools across a spectrum of hospitals providing different styles of care, to ensure that students are exposed to a full range of specialty experience while doing most of their training in community hospitals and services.

- The teaching hospitals which did not become community hospitals could move towards being smaller, high technology specialist investigation and treatment centres providing multidistrict and regional services for a substantial segment of inner London. Clearly, the outer London areas and provinces would increasingly want to develop cheaper alternative services outside London for many of these specialisms but, for the foreseeable future, there will be some services where the concentration of expertise and equipment will remain in London.

Inevitably there will be fewer teaching hospitals able to play this role than currently aspire to it – one, perhaps two, perhaps three of the "supra-centres" could go without the country suffering major loss. The important thing is for the best quality expertise and real excellence not to be lost; exactly where the experts are sited is less important. One fear is that one or more hospitals will close and the good departments will be sacrificed along with the mediocre.

Organisational structures to facilitate change

The current structure of four Thames regions divided into a dozen or so individual districts has not fostered sensible planning across London. At present the only major health service influence that crosses London is the University of London Faculty of Medicine and the group of Metropolitan Deans, a group which has so far not moved for major change, although there are encouraging "straws in the wind". There is a case for having a London region to set general strategic direction although the thought of bureaucratic central planning imposing a grand solution across London is a nightmarish old east European scenario best avoided. I would also be seriously concerned about the power base created by having one London region which might well disadvantage the provincial regions whose services remain relatively underfunded compared with London. But there does need to be a body that can set some general strategic directions, negotiate with the University of London and its constituent schools and work with any future local London government. (All the major political parties are now committed either to a new local London government or to a local government planning body for London.) Detailed planning might possibly be done in two blocks, north and south of the river, or in four

London segments in "mega" health authorities like the one planned for south-east London.

The alternative to old fashioned strategic planning is to create rules for the market which give rather more clout to purchasers than they currently enjoy. The essential characteristic required of a new planning system is that it can reconcile incentives for providers to attract business with London health authorities' priorities. A new incentive-based planning system could perhaps avoid the problems created by autonomous self-governing units and fragmented purchasing but it will need to be flexible, and avoid becoming a heavy central planning bureaucracy. Capital allocations could act as the key incentive. Planning has to coexist with devolved management responsibility of providers at the operational level and any planning system will fail unless it has the commitment of the medical schools to make major changes in the way they use services for teaching.

Finally, for any planning system to work in London, there will need to be far greater central government leadership in setting realistic health targets for socially deprived, multicultural areas, and extensive development work in translating targets into practical indicators. *The Health of the Nation* (Secretary of State for Health, 1991) was a good start but that now needs to be built on to develop specific targets for the residents of the capital.

2 Health services for elderly people in London with special reference to acute hospital services

Current issues and problems

The ageing population

Until the results of the 1991 census are published, many of the available data on the social demography and health of old people in London are derived from the 1981 census and studies carried out in the early 1980s. The key demographic change affecting the UK as a whole is the dramatic rise in the over 85s (see Figure 2.1). It is the over 75s, and especially the over 85s, who place the heaviest demands on health and social services. While the 65–74 year age group will drop slightly in London before the end of the century, the rise in over 75s and over 85s will have a very significant impact on all services.

While the *numbers* of over 85s may not look large on paper, the proportional rise will have a dramatic effect on services for the next 40 years, at least when the post-war baby boom will begin to need services, at which point demand will reach a peak.

To give a recent example of rising demand, in 1981 in Lewisham and North Southwark there were 3600 people of 85+ years resident in the district and 700 admissions of that age group to acute hospital beds. By 1987 there were 5700 people of 85+ years and 1140 admissions. These figures do not indicate that 20 per cent of all over 85s are admitted during the course of a year but rather that a minority

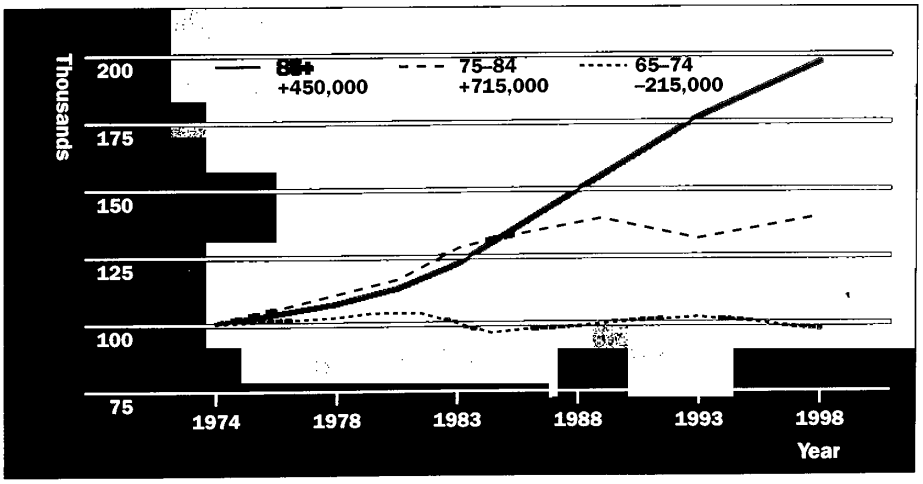


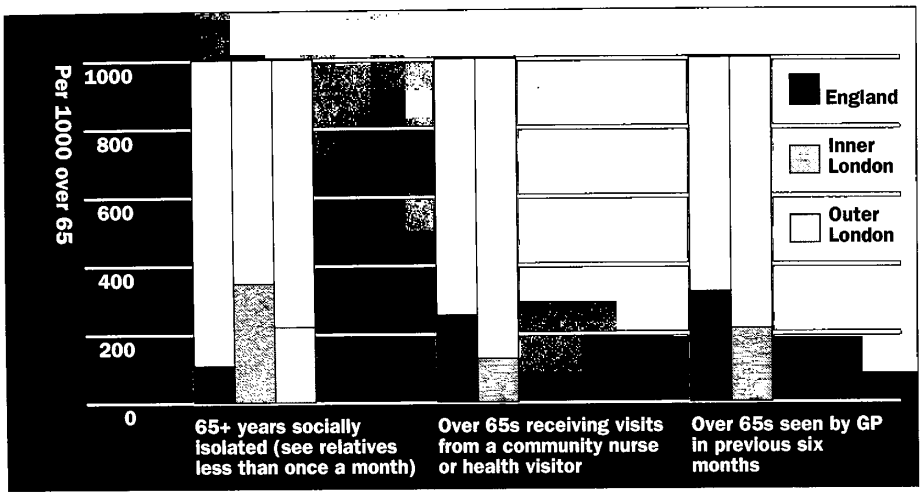
Figure 2.1

Population trends 1974–98 England and Wales

Source: OPCS figures to 1984 and Government Actuary's Department 1983 based forecasts

Figure 2.2

Demands made by older people in inner London on GPs and community nursing services



Source: Snow, 1981

– probably 10 per cent or less – are regularly readmitted for recurrences of illness on a "revolving" door basis.

A second example is the demand for long-term care. Currently 11 per cent of those aged 85 years or more are in permanent residential care in homes and hospitals in London. This rate has remained steady for the past 10 years and is not remarkably different from the rates for over the past 30 years. These very old people have displaced the "young old" and "middle old" from residential care places. The demand for continuing care, whether provided at home or in residential accommodation, will continue to rise inexorably.

By comparison with the country as a whole, the pattern of help currently given to older people in inner London is markedly different. They are more likely to live alone, especially the over 75s, to be more socially isolated, to receive much less help from relatives, friends, neighbours, community health services and general practitioners and to be more reliant on social services and hospital beds (Snow, 1981). It is significant that the services which can substitute for the absence of the family are those most heavily used in inner London – hospitals, old people's homes, meals on wheels and home helps (Snow, 1981), but it is also true that older people in inner London make heavier demands on their GPs and community nursing services (see Figure 2.2). The relative isolation of old people in inner London is in part a consequence of the exodus out of London of young families in the 1960s. Social isolation is made worse by a lack of personal transport, lack of money – many depend on DSS benefits – fear of crime (which may or may not be justified) and the architectural design of the council estate and private run down terrace housing environments in which many Londoners live.

Acute health care

The problems of the acute hospitals and the problems of providing care for elderly people are closely intertwined. Elderly people use all parts of the NHS more than younger people; in particular they are very

heavy users of acute beds. Even in Lewisham and North Southwark – which has a relatively poor provision of specialist medical beds for elderly people compared with other inner London districts – *in 1986–87, 22.5 per cent of all hospital admissions were of people over 65 and nearly 40 per cent of all beds were occupied by elderly people. This includes 42 per cent of surgical bed-days and 60 per cent of all medical bed-days*. The vast majority of admissions are for chronic obstructive airways disease, ischaemic heart disease and other vascular diseases, neoplasms, fractures and cerebral organic disease, but 5 per cent of admissions are classified as "housing, household and economic circumstances". In the author's experience, this last category is a catch-all classification of elderly people with a mild or moderate degree of dementia and a motley collection of physical disorders which could be treated at home if mental frailty were not also present.

Cerebral organic disease: dementia

The rising tide of dementia in advanced old age is the main reason for the increasing need for long-term care in both institutions and the community. As a rule of thumb, using the most recent survey data from inner London (Lindesay, Briggs and Murphy, 1989), 10 per cent of the over 75s and 20 per cent of the over 85s have significant mental impairment which interferes with their capacity to perform activities of daily life. Two-thirds of elderly people in residential care and approximately 80 per cent of elderly people in long-stay hospital beds and nursing homes are suffering from dementia (Bond, Atkinson and Gregson, 1989; Donnelly *et al.*, 1989). It is important to realise that there are far more dementia sufferers being cared for in ordinary residential care homes, nursing homes and general hospital beds than are cared for by specialist psychogeriatric beds or Elderly Mental Illness (EMI) homes. It is possible for a profoundly physically disabled old person to remain cared for at home alone if that person is mentally alert and wishes to remain independent, whereas only a moderate degree of dementia may make it difficult for an old person to remain at home.

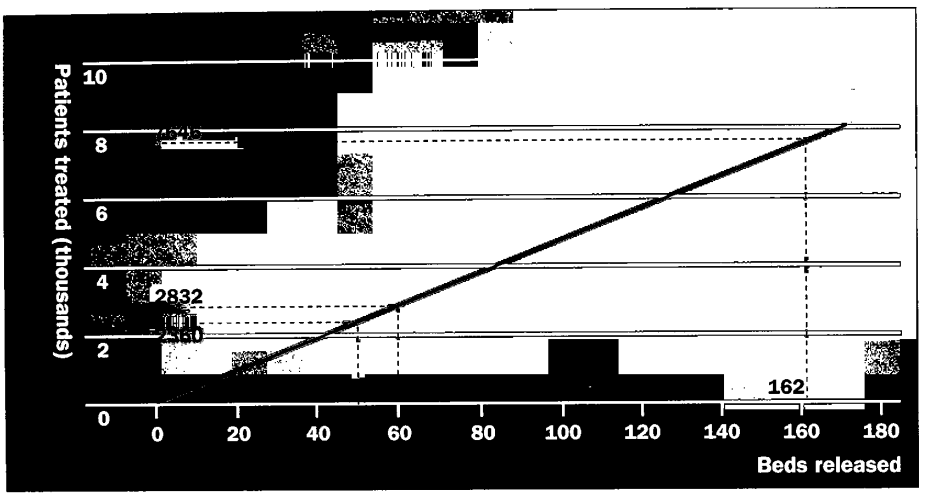
Inappropriate use of acute beds

In many London districts acute beds are occupied by elderly people with chronic severe physical and mental disabilities staying for many months and who require long-term nursing. There have been two (unpublished) censuses in Lewisham and North Southwark in the 1980s. In 1984, while 19 per cent of acute beds were "occupied inappropriately because of delayed discharge", only 7 per cent of the acute beds were occupied by people waiting for long-stay nursing home care and not all of these were elderly. By 1988, *25 per cent* of medical and orthopaedic beds were occupied by "delayed discharges" and of these the vast majority *(20 per cent of the total beds)* were elderly people waiting for long-term nursing care (Cooper and Murphy, 1988). The situation in acute geriatric wards was much worse – 45 per cent were "blocked" with elderly people staying over 90 days waiting for a nursing home or long-stay bed.

The situation described above exists to a greater or lesser degree

Figure 2.3

The potential number of patients who could be treated if acute beds "unblocked"



Source: LNSHA caseload data 1988

in all London hospitals, but the size of the problem varies from district to district, depending on the rate of loss of acute beds over the past 10 years and the local borough's approach to residential care.

The impact of blocked beds on the efficient use of acute beds is self-evident. One way of demonstrating the problem of blocked beds is to look at the number of people who could be treated in these beds if they were not inappropriately occupied. This exercise was carried out in Lewisham and North Southwark using 1986–87 figures. There were 162 acute beds occupied by long stayers. However, the average current caseload figure for *all* acute specialties (excluding obstetrics) was 47.2 patients per bed per annum. If the average caseload figure had applied to the 162 blocked beds, an additional 7646 could have been treated (see Figure 2.3). Since the caseload figure reflected the poor turnover in blocked beds, this figure may well be an underestimate of the potential use of these beds. It might well be pointed out that even if these beds were released, the funds would not necessarily be available to treat this number of extra cases and perhaps this exercise is a rather spurious one. Nevertheless, it is a graphic illustration of the impact of inappropriate use of beds in London.

It is worth noting that acute elderly admissions in London are local London residents. The catchment area system in care of the elderly medicine grew up specifically to ensure that people did not get rejected as "undesirable" patients and that one or more named consultants had specific responsibility for services to a geographical area. This has not been as successful in London as elsewhere but one result of this policy is that in marked contrast to the residential origin of younger patients, which in some specialties is up to 60–70 per cent from outside the district, well over 80 per cent of people aged over 75 admitted to London hospitals are from the local district (or a specific identified neighbourhood catchment area). Elderly people admitted to hospitals other than in their own district have arrived there by placement by the Emergency Bed Service (EBS) or, rarely, by being away from home when the emergency arose. Any GP will tell you that the chances of

being able to choose a hospital for an old person in need of admission outside the locality are so low as not to be worth bothering to try.

Why is there a bed problem?

The rising number of very old people

The rising number of very old people is the main reason, but the social characteristics of the elderly population in London are important too. Over 50 per cent of the over 75s live alone and 12 per cent of them do not have sole use of basic sanitation facilities. Many live in older terraced properties on two or more floors with no indoor WC and no fixed bath or living accommodation. Rehabilitation after a fractured femur, for example, is much more difficult if staff are preparing an old person to go home alone to a damp, cold, terraced house with the bedroom on the first floor, the WC "out the back", gas fires and ovens which are difficult to control safely, unsafe threadbare rugs and lighting provided by single 40 watt bulbs. Elderly people stay in hospital longer than necessary after an acute illness while equipment is ordered, the house is made safe and the social services are organised.

Loss of long-stay beds

The proportion of beds for elderly people allocated to long-stay care has gradually diminished as the total pool of acute beds has dropped. Partly this has been a deliberate shift in the use of specialist care of the elderly beds towards more acute and short-term rehabilitation work and away from long-term care.

Decreasing provision of residential care by local authorities

Institutionalisation rates for the over 65s have traditionally been high in inner London but over the last 10 years there has been a dramatic loss of "Part III" places provided by the local authority. Approximately 20 per cent of the places have gone in the last 10 years (DoH PSS LA statistics, 1989) and the trend is for more places to go in the near future with the drive to improve standards of residential care and also the determination of councils to improve the quality of domiciliary care to old people who are still living in their own homes. Those residential homes that remain open are caring for a much more seriously disabled group than formerly. *Local authorities in London now care for people with severe levels of disability, the kinds of people who used to be in NHS long-stay beds.*

Lack of private provision

Government policy since 1983 has encouraged private sector and joint initiatives in residential and nursing home care. While inner London has had some growth in this area, it is minimal compared with elsewhere in the UK; furthermore, the growth has largely been in registered residential *care* homes, not in *nursing* homes. Nationally, the loss of geriatric beds and local authority places has been balanced by a dramatic growth in private registered care homes and private nursing homes. In London there are some private care homes, but they do not take seriously dependent old people, and there are very few private nursing homes. Nationally, there was growth of 74,000 private nursing

home places between 1982 and 1989 but only a few hundred places were established in inner London. The capital costs and employment costs in London make it impossible for proprietors to fund the investment debt from social security benefit levels and provide a reasonable standard of care to those who are heavily dependent. Nationally, 50 per cent of old people in residential care pay for their own care out of their personal resources. In inner London very few indeed have the resources to do so.

Nursing homes outside London

As a consequence of the lack of nursing home places there has been pressure to transfer old people in need of long-term nursing care out of acute hospital beds in London to cheap nursing homes in the suburbs or further out of town, particularly to the south coast. On a visit to a newly opened private EMI home in Yorkshire last year, the author was surprised to note that 12 of the 25 residents had been placed there by inner London health authorities, as official policy not by sleight of hand of a clinical team. Similarly, a home in East Sussex, which was closed in 1988 as an emergency because of the poor standard of care, was three-quarters occupied by elderly people placed from *two* geriatric medical units in London.

However, families in inner London rightly protest about the practice of distant placement and often will not collaborate with clinical teams who practise it. In many boroughs social workers will not participate in distant placements either, again for very good reasons. This undesirable practice may well cease altogether when the new community care funding regulations come into force in April 1993, since no placements using social security benefits will be made without the involvement and support of the local authority. Distant placement is a partial and highly unsatisfactory solution; it has not prevented the rise of bed-blocking.

Quality of care for elderly people in hospital

The vast majority of elderly people admitted to hospital are diagnosed, treated and discharged in exactly the same way as everyone else. A consultant physician in care of the elderly medicine in London has an average caseload per year of between 700 and 900 discharges and deaths, with patients staying between 9 and 12 days for 67–74-year-olds and 14 to 15 days for 75+-year-olds (Yates, 1987). This compares with the average for consultants outside London of a day or two shorter, although the differences are not striking. However, the lack of long-stay provision has a serious impact on the quality of acute services for elderly people.

Seriously disabled old people in need of continuing care remain in limbo on acute wards without adequate access to rehabilitation, in an impoverished social environment adapted to the needs of acute patients. The quality of their lives in terms of privacy, choice, autonomy and daily regime is extremely low.

Anxiety about future placement of disabled elderly people and potential bed-blocking acts as a serious barrier to admission of an old

person during an acute illness. Defensive attitudes on the part of medical staff have a seriously negative effect on teaching and training staff in care of the elderly. The spin-off in terms of staff recruitment for professionals of all kinds to work with elderly people and the shaping of attitudes of a future generation of students is seriously worrying.

Precipitate discharge of elderly people who can be discharged back home is the inevitable consequence of a diminished pool of functioning acute beds.

Many seriously disabled elderly people remain in inadequately staffed local authority homes where staff are not trained to handle such levels of disability.

The pressure on district nurses and home care services from the local authority is such that even targeting their efforts on the most seriously disabled has led to many old people in great need getting inadequate input.

Clinical leadership in medicine for care of the elderly

In spite of 30 years of pioneering development work in Britain, geriatric medicine remains a poor relation in many London hospitals and, as a consequence, some hospitals have failed to attract into the specialty those who are interested in service development. There are many distinguished gerontological medicine experts in London hospitals but many have not perceived their role as giving clinical leadership in service development. These criticisms are not warranted in all districts. There are a few London departments which are nationally and internationally renowned for their excellence and breadth of vision. It is, however, a salutary exercise to visit Nottingham, Bristol, Oxford, Manchester and indeed many districts in suburban London such as Bexley and as far afield as Cornwall to see how far behind most London services have slipped in terms of innovation and developments in community orientated services.

The services in London have mostly remained firmly wedded to the acute hospital model of care, with many physicians playing a role in acute general medicine alongside their responsibilities to develop a service for elderly people. For the past 20 years geriatricians have debated whether a specialist, age-related approach, that is creating a separate specialist service for all elderly people over a certain age, is preferable to an integrationist approach in which physicians in care of the elderly work alongside general physicians. The arguments for this latter model are that elderly people use a high proportion of all services and everyone must in practice be a geriatrician. The role of the specialist is to focus developments and be a source of specialist help to colleagues. There are excellent models of both styles of service around the country and it is clear that both models, if followed through into a comprehensive service framework, can work well. In London there are too many models of *partial* integration which are patently failing to deliver a service which is in any significant way distinguishable from acute general medicine.

This is, of course, the author's personal view which may well be refuted by those who are practising care of the elderly medicine. My

colleagues may well point to the day hospitals, the liaison nurses linking with community services, the willingness of consultants to do domiciliary assessments and so on. But the day hospitals are under-used and sometimes indistinguishable from local authority day centres; specialist advice services to local authority establishments are often rudimentary and there are few extensive outreach links from the hospitals into primary care. This may seem like a sweeping generalisation and it is true that many clinicians have encouraged the development of small early discharge schemes and a few are working with GPs in health centres but the sum total of community and primary care links is small.

The division between care of the elderly medicine and care of the elderly psychiatry

This is a serious problem for GPs and for the services themselves. Mental health services for old people were established as a direct response to the rising numbers of dementia sufferers in need of a service although it is worth noting that half of the referrals are for "ordinary" psychiatric disorders in mentally alert people. But dementia and other confusional states often occur in the setting of a mixture of physical disorders: for example, the problems of cerebrovascular disease, Parkinson's disease, drug induced and other toxic confusional states do not fall happily into one specialty's expertise rather than the other; multiple pathology is the norm over the age of 75 years. GPs constantly complain that they are confused about the artificial division, the lack of collaboration between the two services and the difficulties in deciding which specialist to refer to when a patient becomes acutely confused from an unknown cause. There are also demarcation disputes about the long-term care of poorly mobile dementia sufferers.

A national conference in the late 1980s organised by the Royal College of Psychiatrists (RCPsych) and the British Geriatrics Society (BGS), referred to in its planning stages somewhat optimistically as "Affairs between Geriatricians and Psychiatrists", heard survey results suggesting that most services had the most tenuous links between them: consultants in these services were often working to totally different philosophies about health services, presumably arising from their differing physician and psychiatrist training. This is a nationwide problem, much explored by the RCPsych and the BGS, who published jointly a short set of rules for joint working and cooperation, but very little progress has been made in getting the two services to work together in ways that are meaningful to GPs. Any strategy for health services for old people in London would need to address this issue. An opportunity to weld the services more closely together could arise as services shift their focus away from the hospital.

Solutions

It would not be sensible to attempt major rationalisations of services across London for care of the elderly. Services need to be local, neighbourhood focused on smaller areas of the community. If the services are to be accessible they must be within easy reach by public

transport or on foot. The major change that is required is to move the focus of the services away from the hospital and into primary care and domiciliary support services, to lessen the need for hospital admission, to reduce lengths of stay further and to address seriously the real need for institutional care of the most seriously disabled. In addition to this there are now new opportunities of case finding and secondary and tertiary prevention strategies, as a result of the new GP contract. During the transitional phase of promoting action in primary care, some reorganisation of the management of medicine and psychiatry of old age would be necessary to promote an integrated community and hospital approach.

Long-term care

There are now numerous studies of home care support services for severely disabled people using case (or care) management principles which aim to provide an alternative to long stay residential care. The evidence is that for the same costs, or less, it is possible to sustain at home old people with moderate degrees of mental disability or severe degrees of physical disability, as a substitute for Part III residential care – that provided in registered *care* homes – but that *these schemes do not reduce the need for long-term 24 hour nursing care* (Davies and Challis, 1980; Murphy, 1988). This may seem at odds with the evidence that acute care could be provided at home as an alternative to hospital (see page 30). In the acute case, recovery or partial recovery is expected to take place in days or weeks, whereas in those who are permanently very seriously dependent on nursing care for most daily tasks of life, usually because of dementia, it is rarely considered to be an economic proposition to provide nursing care round the clock on a permanent basis at home. There are clear economies of scale in providing nursing care in institutions in those situations where one or more nurses must be physically present round the clock on a permanent basis. Furthermore, there are some emotional and behavioural disorders in dementia which are so emotionally taxing for nurses to care for on a one-to-one basis, for example persistent noctural wandering, double incontinence, unprovoked aggressive outbursts, that a supportive working environment of several staff working together may be preferable.

There is no evidence at all that by increasing community health services in the form of traditional district nursing or home care services the demand for long-term nursing care in institutions will diminish. The freeing up of acute beds will depend crucially on forming a joint strategy with the local authority for the use of existing long-stay care places in local authority and independent sector homes and in agreeing joint development. Without a working agreement with the local authority, access to social security funds will cease completely in April 1993. There is no doubt that the future of London teaching hospitals and London purchasing authorities who can negotiate a satisfactory partnership with their local authority will be much more secure than those who, for one reason or another, cannot. The alternative, which is to close existing acute beds and provide the full revenue costs of continuing nursing care, is clearly going to be a lot more expensive than

a joint strategy. The options for low capital cost solutions using existing local authority buildings are much greater with a joint strategy. Without a joint strategy, the health service will have to use whatever type of institution provides the best value for the least costs – sometimes this will be joint venture partnerships with voluntary organisations, housing associations, the private sector, sometimes an adapted long-stay hospital ward. The availability of capital will largely determine the solution.

The acute service for care of the elderly

While alternatives to long-term nursing care have proved disappointing, there is evidence that many acute admissions could be prevented and early discharges facilitated if sufficient concentrated nursing, domestic and personal care is available over a crucial period of acute illness. GPs know that they could avoid many admissions if they had instant access to a team of people who could give round the clock cover for a few days, or a week or two, perhaps with the support of some specialist guidance of a minimal kind. Early discharge schemes where concentrated but diminishing input is provided over the course of several days/weeks after discharge are very popular but they tend at present to operate as small local projects and as *outreach services from the hospitals or community health services* and not from GP practices. There needs to be a major growth in these schemes. Unless the scheme is comprehensive and district-wide there is unlikely to be a demonstrable drop in the use of beds.

There also needs to be a change in the management and organisation of these support services if they are to be perceived as useful by GPs. A review of the current services provided by community nursing and local authority home care would highlight fruitful areas for targeting current resources more effectively. Community nurses are keen to use their professional training to the full and are enthusiastic about this work. One well-researched scheme which has been shown to be economical as well as popular is the Peterborough Hospital at Home scheme (Parker and Pryor, 1991).

Home support for people with moderate disabilities

The case or care management, home support schemes mentioned above (page 29) are important for three main reasons.

- First because they enable moderately disabled old people to retain their independence at home, as long as possible, which is largely what they wish.
- Second, they enable the local authority to reduce the number of care home places required and free-up valuable buildings for sale or use by more seriously disabled people, increasing the potential for joint developments with the NHS.
- Third, the schemes enable many old people with chronic disabilities, who are at risk of "social admission" in a crisis, to remain at home, out of hospital beds altogether.

Home support schemes involve the employment of skilled case worker care managers managing a budget to buy in an appropriate mix of personal and domestic services for each individual. To work effectively, care managers need good access to both GP and specialist services. While care management developments are largely the responsibility of the local authority, they can transform the work of health professionals working with elderly people, simply by providing the back-up personal care to enable people to stay at home.

The structural organisation of services for care of elderly people

The arguments for having a fully integrated service, in which general medicine and geriatric medicine are run together as one single management unit, are seductive. Protagonists point to the fact that elderly people make up the bulk of the work of the general medical services and that all medical specialists must therefore become "gerontologists". A further argument often heard is that it is difficult to attract high fliers into geriatric medicine, therefore we must give doctors some of the "acute" younger work as an incentive to do the less attractive care for the elderly.

Looking around the country, however, it is clear that the integration model works only where there is a charismatic and highly respected gerontological physician who is able through the personal influence of his or her department to alter significantly the style of service and commitment to the elderly of the rest of his or her generalist colleagues. Such individuals are rare and the model fails if general physicians are uninfluenced by their geriatrician colleagues.

When a service to a particular care group is in a rudimentary state of development, it is usually easier to promote developments with a defined, ring-fenced specialist service, with a clearly defined population of patients and a separate allocated budget. The *majority* of services for care of the elderly nationally known for their excellence are managed as separate departments, and the most successful of these run joint departments of health care of the elderly which encompass both medicine and psychiatry of old age – a teaching example is Nottingham, a non-teaching example is Crewe.

There are dangers in a separate ageist approach. For example, there is little choice for patients if everyone over a certain age is referred to a separate department, so there must be a degree of flexibility for local GPs. But, in general terms, age-related services (which care for all referrals of patients over a certain age) provide diverse teaching opportunities and an enjoyable working mix for the clinical team. This system also reduces resentments about the service being lumbered with the least attractive patients.

The reason why separate age-related services have been resisted in some parts of London is the problem of there being too few designated geriatric medicine posts and too many specialist physicians chasing too few general medicine beds. The situation will remain unchanged unless incentives are provided for high quality geriatric physicians to work in London who can rival in quality the specialist

general physicians they should be replacing. Incentives means having a good quality environment to work in, good community services and, of course, good pay. Geriatricians in teaching hospitals have not figured prominently in distinction awards lists – the sheer size of the competition from other clinicians in their hospitals in getting on the 'C' award ladder places them at a disadvantage compared with their colleagues in non-teaching districts. Moreover, the opportunities for private practice are negligible. If the care of elderly people is to be improved, consultant staff leaders must be rewarded more effectively.

Community innovations

The community geriatrician does not yet exist in this country (although he does in parts of Australia). There could be specialists whose job is to help develop primary care expertise in the field of health care of the elderly, to work with GPs and their teams, especially those providing services to local authority and private residential and nursing homes. In New South Wales, publicly funded nursing home care is available only after a full medical and social assessment has been carried out in the community by a geriatrician-led community team. These teams also receive acute referrals for assessment of people at home. This is one model which might be considered further here in Britain. On the other hand, perhaps having more specialists of a different kind is not the answer. The same function might be performed by an existing consultant taking on this work as part of the current job but having sessions freed up to do it.

The new contract

One activity such a consultant might participate in is assisting GPs in developing the "75+ screen". The new GP contract encourages GPs to screen elderly people of 75 years and over. Most GPs rightly think this exercise is *potentially* a waste of time, but it could be turned into an extremely helpful case-finding exercise, especially for the over 85s, if both health and *social care needs* are looked for simultaneously.

If properly carried out, screening data could be aggregated and analysed for the purposes of local planning. But neither GPs nor family health service authorities (FHSAs) are currently in a position to do this very effectively. Specialist health services for elderly people could play a helpful role in developing the assessment instrument and could participate in local preventive service planning in conjunction with the local authority and voluntary organisations. Most of the "need" picked up in screening will be *social* need for personal care, domestic care and financial assistance rather than health care needs narrowly defined. A pure health care approach to the over 75s screen is likely to reveal little that is not already known to GPs.

The over 75s screen has provided a potential "gro-bag" for generating and nurturing new ideas for services but at the moment few districts in London have really grasped its potential. For example, the aggregated and analysed data from elderly people within one or more practices could be used to generate an annual public health report on the current needs of the elderly people in the locality. This could be

used by locality planning groups, comprising representatives of health service, local authority, voluntary organisations and community, as the basis on which social support and primary health care development plans are based. Clearly, data from individuals must be confidential but aggregate data should be available for planning purposes. The extent and nature of the need for personal care services, sitting services, respite care, and support for family carers and neighbours, could emerge in detailed local colour if this screening was taken seriously.

Other community options

Across the country, numerous new service ideas have emerged to meet specific local problems. Usually the initiative has been taken by a voluntary organisation or by joint working of statutory and voluntary sectors. The majority of these schemes provide community options for care of chronically disabled people and their families. A truly comprehensive spectrum of service options would include residential respite care, day care of a variety of kinds, sitting services, fostering schemes, "boarding-out", carers' groups and so on. All these can have a positive effect on the use of acute hospital beds by providing families with the confidence that there is a range of back-up services available to enable early discharge and support in between episodes of acute illness.

Conclusions

Solutions that work for health services in Lewisham or Lambeth may very well not work in Brent or Camden. The London boroughs differ widely in their political commitment to services for old people and the historical level of the quality and quantity of their provision. The boroughs also differ considerably in the range of voluntary organisations willing and able to take on a major providing role. Health service plans must therefore be devised locally, at least until there is a London-wide local government planning body.

In summary, for elderly people with severe dependency as a result of chronic illness, the local authority holds the key to a comprehensive strategy. But to improve services for elderly people with acute illness London's health services should back up the GPs by giving them easier access to specialist help, more control over the way current health service resources are used to support old people with acute illnesses at home and real alternatives to acute hospital admission. Families cannot provide the same level of support in London that is available elsewhere, but those many families that do provide support need maximum help from statutory services to continue their caring work. If we do not want hospitals to return to their original medieval function of providing nursing care for the poor and chronic sick, then we must provide realistic alternatives in people's own homes or in as nearly homelike conditions as we can.

3 Acute psychiatric services in London

Current issues and problems

Introduction

This paper focuses on acute psychiatric services, which fall within the King's Fund current review. The problems of people with long-term severe mental disorder are touched on here, since they affect the provision of acute services, but are not covered in depth. Readers seeking a fuller account of long-term problems are referred to *After the Asylums* (Murphy, 1991).

Acute psychiatric practice in London is characterised by hospital-based clinicians operating a "first aid" rapid treatment, rapid discharge policy for severely disturbed patients in wards which overall are dismal, crowded and poorly maintained. Forty per cent or more of admissions are patients admitted compulsorily under sections of the Mental Health Act. On some wards this proportion is 80–90 per cent. The Mental Health Act Commission (MHAC) attends inquests of patients who die while "on section" or on leave from a hospital while on section. The MHAC has repeatedly complained to inner London health authorities that "sectioned" patients are sent on leave too early when they are still at risk of harming themselves or others and are discharged without adequate follow-up. Moreover, these patients are often discharged to bed and breakfast hostels in distant boroughs in another part of London, for example Lambeth has used hostel places in Pimlico and Paddington.

Many acute psychiatric wards operate on the basis of over 120 per cent occupancy on paper, with patients on leave liable to be recalled in an emergency, in which event the next least ill person is hurriedly discharged at a few hours' notice. Section 117 of the Mental Health Act, which lays a responsibility jointly on the health authority and local authority to provide aftercare for patients discharged from compulsory treatment orders, simply does not operate in any meaningful way in many London districts. This frantic clinical activity is a result of the pressure on acute beds, which in turn is a result of the high morbidity levels of the inner city population, a lack of alternatives to admission, problems of homelessness, the demands of the "new long stay", and extremely poor community services.

Increased psychiatric morbidity in inner London

The prevalence of mental disorder nationwide is vast, representing over one-quarter of the GP caseload; and one in six people will seek professional help at some point in their lives. Well over 90 per cent of psychiatric morbidity is dealt with by GPs, and of course by families and

friends. However, the prevalence of major psychiatric disorders, especially the schizophrenias, has long been known to be exceptionally high in inner city areas of high social deprivation, a transient population, especially those areas of multiple occupancy dwellings with many people living alone and unsupported. The classic studies of Faris and Dunham (1939) in Chicago and other studies in the 1950s in Massachusetts and Bristol, UK, have been borne out by more recent research in Nottingham (Giggs and Cooper, 1987). The prevalence of the major psychoses is closely linked to environmental and social factors – employment, housing, migration, family structure – and also to cultural and racial characteristics.

Afro-Caribbean patients in particular are more likely to be diagnosed as having schizophrenia, although the reasons for this are far from clear, and also more likely to have caused a public disturbance and to have been admitted via the police (Dean *et al.,* 1981; Ineichen, Harrison and Morgan, 1984). Compulsory patients tend to have been in London only a short time, to be living in temporary accommodation, alone, have few contacts with relatives and to have low occupational status (Szmukler, Bird and Button, 1981).

The inner city also acts as a magnet for mentally disordered people from elsewhere in the country seeking the relative anonymity afforded by hostels and cheap lodgings. A further factor that promotes "drift" is that mental disorder pushes people down the social scale as work opportunities are lost, social supports break down and individuals seek a cheap way of life.

This high psychiatric morbidity is little recognised in official planning guidance. Many regions grasped optimistically at figures calculated in Wessex in the 1970s which suggested only 0.3 beds per 1000 population were required for acute psychiatry, a figure which represents between one-half and three-quarters of the acute beds in use in inner London districts at present.

It is not only the *quantity* of severe mental disorder which is a problem in London, it is the *quality* of the illnesses seen. Over the last 10 years, the levels of disturbance, particularly violence among the admission population, have increased. Inner city areas also have more than their fair share of mentally abnormal offenders sent for treatment from the courts and prisons. Coid (1991) looked at the characteristics of patients from North East Thames placed in specialist private sector care, mostly for disruptive and aggressive behaviours and those requiring security. Of the total, 63 per cent came from City and Hackney, 17 per cent from Tower Hamlets, 13 per cent from Barking, Havering, Brentwood and 3 per cent from Newham. Of the total placed in private care, 53 per cent were Afro-Caribbean, 33 per cent non-British born. Disturbed patients placed in private care represent the unmanageable fringe; most disturbed patients are being managed in NHS beds in teaching and associated hospitals. A similar over-use by inner London districts can be demonstrated in the regional forensic psychiatry services and multidistrict intensive care units for non-forensic patients.

Acute admission wards in London are stressful places to work, especially for nursing staff but also for junior doctors. Recruitment and

retention of staff for this kind of work is exceptionally difficult, particularly now that community work is perceived as more glamorous and the style of working of the future. Building a cohesive multidisciplinary team sharing common values is taxing work for nurse managers and consultants.

Bed usage by this highly disturbed group of patients is heavy. Turner, in a letter to the *British Medical Journal* on 24 August 1991, described the situation in Hackney. "The 20 bed acute psychiatric ward for which I am responsible has 14 patients under Mental Health Act orders of whom 6 are under Section 37 (transferred form courts, usually via prison). At least three others await transfer." He went on to complain about similar pressures in Wandsworth and Islington.

Availability of beds

Availability of beds for new admissions is significantly reduced by a proportion of beds being occupied by long stayers. In 1990 in Lewisham and North Southwark, for 80 per cent of the time 20 per cent of acute psychiatric beds were occupied by patients staying over six months; for 50 per cent of the time, one-quarter of beds were occupied by long stayers and for two or three months at a time over 30 to 40 per cent of beds were occupied. Studies of the long stayers (e.g. Parikh, 1990, in Springfield Hospital, Tooting) highlight the lack of accommodation (5 per cent of admissions are totally homeless or of no fixed abode) and the problem of patients losing accommodation as a result of psychiatric disturbance, and also the needs of people with mental disorder of a severity requiring rehabilitation over a number of years. These latter "new long stay" do poorly on acute admission wards which are not geared up to long-term rehabilitation. These patients are mostly suffering from severe psychoses, brain damage, substance abuse or all three.

The need for supported housing for people with mental disorder is many times higher in inner London than in more prosperous areas. It has been estimated, for example, that the need for supported housing in Hackney is 1.6 places per 1000 general population – approximately three times the number estimated as required in a country town such as Kidderminster (Murphy, 1991).

Lack of community alternatives to admission

Rigorous studies of community alternatives to hospitalisation are few and alternative schemes have generated considerable debate about their effectiveness. There seems little doubt that the majority of people who would have been admitted to hospital 20 or 15 years ago in London can now be treated by domiciliary services. Domiciliary care is provided by community mental health teams of professionals working from a community base; many districts now have such teams in action or planned. The Royal College of Psychiatrists' working party on bed requirements (Hirsh, 1988) found that overall bed usage was significantly correlated with the amount of resources and staff working in the community.

The problem in inner London is that to care satisfactorily for

patients with severe levels of disorder through an acute phase of disturbance, staff must be available to provide "hands on" care round the clock, if necessary over several hours or days. Most early intervention crisis teams developed in London have not been able to provide that kind of support to people in their own homes on a non-residential basis. The Lewisham crisis team has not been shown to reduce emergency admissions (Bouras *et al.*, 1986) and it is unlikely that the similar Parkside service will do so (Onyett *et al.*, 1990). The only inner city service currently operating which claims to use less than Wessex bed norms operates in the predominantly Asian Sparkbrook area of Birmingham (Dean and Gadd, 1989). The service has a special team of home nurses and nursing assistants who can stay with a family through a period of crisis to supervise medication and give general support. This style of work can only be done if the patient lives in a place which can be used as a base for treatment. In London a significant number of people do not. Similarly, family support may not be as readily available in some London districts as it is in a predominantly Asian area. It is not clear whether this style of service could be replicated in inner London but it is likely that it could, given the right staff, in many areas. Further research is needed to look at the economics and acceptability to users and their families of this style of service in communities in London.

The evidence from the USA (e.g. Stein and Test, 1980) is that the outcome of acute psychiatric treatment in the community produces superior outcomes in measures of symptomatology, subsequent independent living and employment status.

Consultant style

Many London services still operate an acute hospital-based model of care which allows little time for acute community work. Doctors in particular remain fixed to hospitals. In many parts of London social services departments complain to the Mental Health Act Commission about the reluctance of consultant psychiatrists to do Section 12 assessments for a section. While there are other bad pockets across the country, nowhere is this problem quite so bad as in parts of inner London. Attitudes are changing but many teaching hospital psychiatrists are based *in* the teaching hospital and rarely move from it except for domiciliary visit requests.

Lack of community support for people with long-term mental disorders

This problem is well known, often highlighted in the media and obvious now to anyone who walks around the streets of London. Suffice it to say that a desperate lack of supported accommodation, inadequate day care and work opportunities, insufficient help with acquiring the appropriate welfare benefits, serious lack of personal social support to improve social relationships, all create an extremely poor service for people with long-term mental disorder. A depressing picture is well described in a recent article about the plight of former patients in West Lambeth and Lewisham (Melzer *et al.*, 1991). Individuals with long-term disorders swell the numbers coming in to

hospital on the "revolving door" process. Health authorities have gradually grasped that the current situation is disastrous in terms of the quality of life many of these individuals have and many districts have developed long-term community support teams, case management initiatives and so on. Case registers of those in need of support and special services for those already homeless and out of contact with ordinary services, are slowly developing.

These new services go some way to tackling the problem but the success of these projects depends crucially on collaborative efforts with local authorities to develop housing and work opportunities. The specific grant for mental illness is targeted at this group but the need is so great and the sums so small it is unlikely to make a major dent in London's problems.

Lack of services for people with disabling non-psychotic emotional and behavioural disorders

Outside inner London and other inner city areas, psychiatric services provide treatment for people with significant emotional and personal difficulties, moderate severities of depression and other lesser degrees of morbidity which nevertheless may be disabling and can be very distressing. In London these people simply do not get a service unless they can afford what the private sector can offer. The evidence suggests many people can be helped by short-term behavioural and psychotherapeutic interventions in primary care but GPs need training and specialist advice if they are to take on this role. Craig (1991) points out the current conflict of the needs of those with severe major psychoses and patients with these lesser severities of disorder who nevertheless are in the greater numbers.

Ideological differences

Since the 1960s when the antipsychiatry movement emerged as part of the more widespread popular movement to promote civil liberties and the rights of individuals, there has been an uneasy tension between the professional view of what a mental health service should consist of, and what voluntary organisations such as MIND, user groups, advocacy groups and particularly the Afro-Caribbean and Asian communities feel a mental health service should consist of. Nowhere in Britain are these tensions so palpable as in London.

Public consultation meetings about services generate a good deal of anger about the current style of services – the medically dominated, drug-orientated acute services are extremely unpopular with the very sections of the community which the services are supposed to serve. Partly this rejection of existing services is inevitable – the stigma of mental disorder tends to stick to those who work with mentally ill people as well as to sufferers themselves. But it is a sad reflection on the development of psychiatry as a medical speciality over the last 40 years that this alienation is as strong as ever.

Since mental health services joined general hospital services in the new NHS in 1948 rather than remaining separate under local council management, psychiatry has become increasingly just another medical

specialty and a rather downmarket specialty at that. Some psychiatrists have measured their success in terms of teaching hospital beds or hospital facilities which rivalled their physician colleagues. The growth of academic psychiatric departments in London in the 1960s and 1970s did little to move the services away from the medical model of care – rather these departments consolidated the approach.

The medical profession is often puzzled and hurt by the accusation that the medical model is solely biological in approach since psychiatrists are well aware of the social and cultural background factors which influence the onset, course and outcome of mental disorder. But the reality is that acute psychiatry offers only treatment that is most quickly effective in the short term for very severe disorders, that is drug treatment. In the current scheme of services there is simply no time to offer anything else.

Attitudes are changing and there is a keen interest now in community service development and alternative approaches which were largely invisible in London 10 years ago, but there is along way to go before inner London communities can feel confident that the aims and objectives of the mental health services have the interests of the users at heart. The Afro-Caribbean community in particular feels disadvantaged by the current system; many users feel uncomfortable with the treatment and care they are offered by a mostly white and culturally narrow service. Moodley (1987) found that many young Caribbeans would prefer not to receive treatment than to use existing statutory services. Again there are services making attempts to understand the needs of ethnic groups within their districts but progress is slow across London.

Problems of commitment to developing mental health services by local authorities

Those boroughs which have committed themselves to developing mental health services, and spend a realistic proportion of their social services budget on services, are in the minority although it has to be acknowledged that some – Kensington and Chelsea, Westminster, City of London, Islington, and more recently Lewisham – have acknowledged the problem and been prepared to consider mental health needs seriously. The specific grant has nudged other boroughs in the right direction but there is still overall a lack of understanding of the needs of mentally ill people. Services which enhance people's capacity to live a normal life involve not only social services but also, crucially, the commitment of local departments of housing, leisure services, education and business development/employment. Serious mental disorder affects the capacity of individuals to participate in the normal activities of daily life, sometimes for a short time but often for years or for the remaining years of their life.

Solutions

In suggesting some solutions, the author has assumed that there will be no more resources available for mental health services in the near future

than at present. However, the proportions of revenue spent on mental health vary significantly across inner London health authorities and there are some districts that need to review whether their current allocation to these services is realistic compared with their spending on other services.

Review of use of inpatient beds

Beds should be used to treat those in need of short-term security or who present major behavioural problems in the community – those from the courts, prisons and police should take priority since those are the patients most likely to end up in inappropriate custody in the criminal justice system. Schemes which are designed to provide early treatment and care to courts should develop further. But hospital facilities need upgrading and replacing to provide a suitable environment for caring for highly disturbed people. These patients should *not* have to be carted off to distant mental hospitals during their acute illness as currently happens in many inner city districts at the moment.

Do beds need to be in district general hospitals or teaching hospitals?

There are persuasive arguments in favour of basing most short-term treatment in district general hospitals (DGHs). Advocates of general hospital units point out their superiority to small, localised centres specifically for people with mental health problems. The general hospital is usually quite conveniently situated with good public transport. It is open 24 hours a day and is familiar and unthreatening to the local population. It is possible to walk in and out without being identified as a mental patient. Furthermore, many patients find it reassuring and comforting to be "ill" rather than "mad" or "having a breakdown".

General hospital psychiatric units are close to on-site facilities for other physical specialties which encourages better liaison with other services. Furthermore, psychiatric advice is also available for patients in other specialties and for people coming into the casualty department in a state of mental distress.

The presence of a psychiatric unit in a general hospital or teaching hospital encourages junior doctors to train in psychiatry and provides new trainees with an experience which is not dissimilar to other specialties. Recruitment of junior doctors to psychiatric training has improved immeasurably as a result of medically oriented psychiatric training and the emphasis on general hospital work. Furthermore, the investigative facilities of a general hospital, such as a good X-ray department, are increasingly important with the rise in the proportion of elderly people needing treatment, because of the close links which exist in old age between physical illness, disability and mental disorder.

Such reasons are sound and important, but there has been a heavy price to pay for the move to DGHs from mental hospitals. Highly disturbed patients need *space*, an expensive commodity in London, and sometimes security. A busy general hospital is not the ideal place to test

out early "trial leave" of seriously disturbed patients. Furthermore, many patients do *not* regard themselves as ill and would be more willing to be admitted to a unit with a less clinical ambience, such as a converted house or hostel.

The author's *personal* view is that for most acutely disturbed patients, a DGH setting is not essential for acute psychiatric beds. Acute care could be provided equally well away from the hospital site in hostels and houses as long as they are *spacious*. But the revenue costs of having small local units for highly disturbed people would need careful evaluation and the capital costs in London might be prohibitive. The one group for which a DGH site is the preferred option is elderly people with psychiatric disorders who are highly likely to require other specialist services if they are sufficiently ill to require admission. We need some pilot projects in London to evaluate the provision of acute care outside the hospital. There are under-used local authority hostels in London which adventurous boroughs could make available for pilot schemes. Having an acute unit outside a DGH has been done with moderate success in Banbury, Oxford and more successfully in Cornwall and some other predominantly rural areas where local accessibility to a central hospital presented practical problems.

A shift to community-based treatments

If psychiatric beds are to cope with the seriously dependent people described above, then the majority of people who are currently admitted must be treated at home. This means moving consultants and clinical teams out of their hospital bases and into community catchment area bases. Since community mental health (CMH) teams and CMH centres have a tendency to move upmarket towards serving a less severely ill client group (Sayce, Craig and Boardman, 1991), it is important that their work is monitored, that they are readily available for all GP, social services and police referrals and that they are able to provide "hands on" personal and nursing care over an extended period of hours, days or, if necessary, several weeks. It may be possible to use temporary "asylum" care in ordinary houses converted for this kind of work, but this is likely to prove as expensive as hospital care. It would be preferable to use patients' existing accommodation where possible, and work with local authority and social services departments to develop existing hostel accommodation as a short-term care facility where asylum is required on a temporary basis.

Criteria for an effective system

A workable set of principles for a community-based service was described by the National Institute of Mental Health in the United States in 1980 and these are equally applicable in London today. A service system comprises a network of professionals and/or volunteers covering a geographical location, who accept responsibility for providing assistance to mentally disordered people to meet their individual needs and develop their potential, without their being unnecessarily isolated or excluded from the community. The 10 criteria for an effective system are itemised below.

- There must be mechanism for *identifying persons in need* and for reaching out to those willing to participate; it may also at times be necessary to reach out to those who do not wish to participate but are at risk of harm to themselves or others.
- The system must offer service users assistance in applying for and obtaining *financial entitlements* in the form of income support and disability allowances.
- It must offer *24 hour crisis assistance* so that individuals are not left untreated or unsupported during an acute episode of illness, no matter at what time of the day or night a crisis arises.
- It must provide opportunities for *social rehabilitation.*
- Services must be provided *indefinitely* and be available for an individual's lifetime if necessary.
- Services must provide adequate *medical and psychiatric treatment* on a continuing basis.
- Services must provide *back-up support for family, friends and members of the local community* in order to minimise the burden of care which falls on other people's shoulders.
- The system must engage voluntary groups, community organisations and other members of the *local community* to maximise involvement in normal community activities.
- The system must operate so as to protect *patients' rights* and ensure their *civil liberties* are not denied them.
- Finally, the system must provide for the co-ordination, integration and binding together of services so that they function as one *seamless service,* providing all the elements which one individual requires.

Having established service criteria, it is necessary to assess every individual who needs services along two dimensions: first, in terms of the *ordinary needs* of every citizen; and, second, the *special needs* generated by mental disorder.

Ordinary needs include adequate income, shelter, food and clothing, plus protection from physical harm, a means of daily occupation and the opportunity for emotional, spiritual and social fulfilment. The *special needs* of a mentally disordered person are for specific medical and psychological treatments and procedures. Acute services in London or elsewhere have tended to stress the latter at the expense of ordinary social needs.

Review staff skills

There needs to be a radical review of the skill mix of the existing staff working in the community. At the moment there are too many skilled community psychiatric nurses working within a very restricted framework of professional activity. This also applies to other professional groups such as psychologists and occupational therapists. What is required is a problem-orientated approach which demands a variety of

professional skills – welfare rights advice, housing help, assessment for work and work placement, in addition to specific medical and nursing interventions. One mental health team of "generic workers" in Hackney spends a quarter of their time on welfare benefits negotiations and a very small proportion of their time on direct nursing tasks.

Review the balance of health care and social care

In reviewing skill mix and the balance of professionals against vocationally trained unskilled staff, there must be an explicit decision about the balance of resources to be spent on health care and social care. As beds in peripheral psychiatric hospitals have closed and the focus of the service has shifted to DGHs and teaching hospitals, the balance of NHS spending has shifted away from social care services (then provided in hospitals) to acute health care intervention services. Money transferred from large hospitals has been spent on more consultants, the growth of community psychiatric nurse (CPN) services, increasing the staffing of acute wards and so on. All these improvements were desirable but the growth in social care provision for both short-term and long-term patients has been negligible.

Joint planning

A review of the balance of care will only be useful if done in conjunction with the local authority. Some health authorities are still a long way from real joint working with local authorities. They have been driven together to agree plans for the specific mental health grant but this temporary respite from mutual sniping is reminiscent of Christmas football in no-man's land in 1914. There must be real incentives for both health and local authorities to work together in London if there are to be real improvements in standards of care. Health care planning should move away from the artificial boundaries of current health authorities towards using the boroughs as the geographical area of coterminous planning with the local authority.

Primary care

Most mental health problems are dealt with by GPs and they need access to specialist help from psychiatrists, psychologists, CPNs and perhaps most importantly, people with counselling and psychotherapy skills. The dilemma for psychiatric services at present is how to develop this area of work in the face of the demand from acutely severely ill patients. This is one reason why a review of professional skills across the whole service is so urgently needed, to see if some professionals, for example psychologists, might work better from a primary care base using their skills to train, supervise, advise and take on some of the more disturbed patients who nevertheless do not need to see a psychiatrist.

Setting service targets

Mental health targets have been widely considered as difficult to frame and impossible to measure. *The Health of the Nation* (Secretary of State for Health, 1991) claimed it was unrealistic to set targets. Nevertheless, Thornicroft and Strathdee (1991) proposed a comprehensive set of

national targets and indicators for mental health that could readily be adopted by London districts and any future strategic planning body for London.

Financial resources

The standard weighted capitation formula will greatly disadvantage inner London districts in providing the level of psychiatric service required for this needy population. Some regions have grasped this fact and added a social deprivation weighting to their allocations, other regions have not. All regional health authorities (RHAs) should be encouraged to review their mechanisms for allocating resources to inner London districts in the light of the very high morbidity levels in parts of London.

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King's Fund London Initiative

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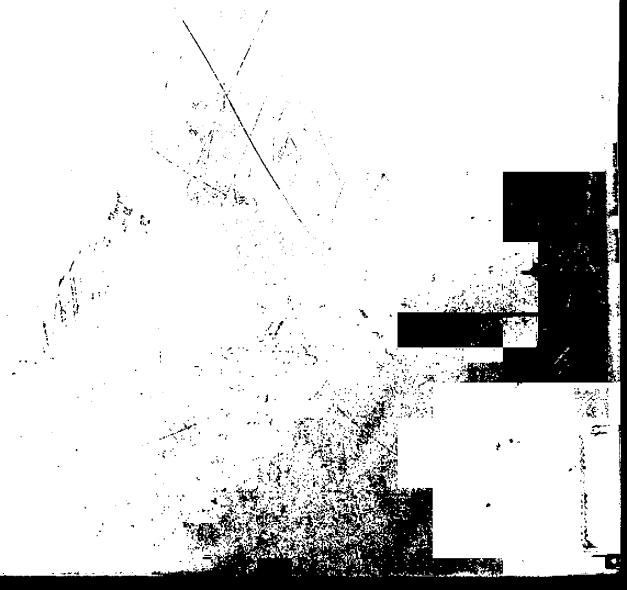
London Views: Three essays on health care in the capital was prepared to inform the work of the King's Fund Commission on the Future of Acute Services in London. It is being published in advance of the Commission's strategy for London in order to inform debate about the future of health care in the capital. This paper should not, however, be interpreted as in any way anticipating the recommendations of the Commission's final report.

The King's Fund Commission on the Future of London's Acute Health Services' terms of reference require it to "develop a broad vision of the pattern of acute services that would make sense for London in the coming decade and the early years of the next century". With this in mind, the Fund's London Acute Services Initiative has undertaken a wide-ranging programme of research and information gathering on the Commission's behalf, of which this working paper represents one part.



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