Looking After the Elderly

(A presentation for STEM PBL without *any* cut and paste!)

Around one in two women and one in three men who turn 65 will require intensive long-term care in their late old age. And if we think it's tough now, a huge time-bomb awaits the NHS / Social Services;

Year \ Population	Over 65	Over 85
2002	9.4m	1.1m
2051 (govt. projection)	17.6m	4.2m

This last figure alone should reassure us that there will always be an increased and increasing need for Emergency Physicians – (and probably for all doctors) – so even though the jobs are drying up at the moment, we shouldn't despair. Of course, by the time it happens, those of us still alive will be part of the 4.2 million…

Around 4 per cent of people aged 65 and over in the UK, and 12 per cent of those aged 80 or more, live in residential, nursing home or long-stay hospital care. At Wythenshawe, 75% of all admissions to MAU are over 65; 25% over 85. Do the sums!

Another 20 per cent of those living at home receive domiciliary services, including home care, day care, meals, community nursing and private domestic help. Those over age 85 are more likely to receive all formal services than the 'younger' old, and this is particularly true of residential care.

While the majority of care home residents are eligible only for means tested social services funding, a minority are eligible for full NHS funding without a means test. How this care is to be funded is an important issue, which continues to provoke lively debate. The essence of the debate is about how far people should fund their own care and how far they should be publicly funded. (With controversy enough about who's going to pay our pensions; who's going to pay for our healthcare?!?!)

Not only is this a barrier to long term development of social care policy, but also a practical barrier on a case by case basis in arranging care packages. Along with people's independent spirit ("I'm only leaving my house in a coffin") the issue of who's going to pay is the major factor.

This may not seem directly relevant to A&E, but indirectly, the knock-on effect of the increasing number of people who need care packages, who use up the limited resources available in the community, impacts upon what can and cannot be offered to our patients.

So what *do* we offer…?

Using South Manchester as the example…

Any elderly person (OAP) who needs an increase in social care gets put on the CDU Social Care pathway. They need to be independently mobile, else they get admitted under medics.

Page 1 is demographics.
Page 2 is clinical governance; lying / standing BP, routine bloods, ECG and baseline observations. A good thing; about 7-10% end up being admitted as a result of these findings.
Having 'passed' these tests, a referral is then made to the Rapid Response Referral Team.
So any person who needs a step-up in home based care will be assessed by Joyce and her team, as well as Occupational Therapy and Physio. The resulting efforts can lead to anything from 1 visit a week to the 'full monty' - 4 carers a day, meals on wheels, home appliances etc.

The relationship between this team and CDU/A&E is excellent. Both teams are proactive in making the system work; (the RRR team come round looking for work in the morning.) If felt appropriate, intermediate care can be arranged at Buccleigh Lodge (Elizabeth Slinger Rd, by Withington Hospital, opposite the cop shop). It must be clear that the OAP will most likely be going home afterwards. This is all entirely PCT funded.

This process happens between 8-4, so usually leads to an overnight stay on CDU - but very few OAPs *on this pathway* stay longer than 1 night, and many are sorted the same day.

If these steps are felt to be inadequate, then a Social Work referral is made. Again, the RRR team and SW team work very closely together. They can offer Respite Care or definitive Residential / Nursing Home placement. Funding here is controversial and means-tested, but for the first week after hospital admission it is free.

In 2004, on any given day, around 3,500 older people remained in hospital in England after they had been declared fit to leave because arrangements had not been made for them to move on. ("bed-blocking"). From January 2004, any patient referred to Social Services who was not discharged within 48 hours leads to a £120 per day fine to SS… This means that now, on the whole very few patients end up waiting longer than this. On the wards it can take a little longer.

Most local hospitals have developed similar structures. Although controversial at the time, the bed-blocking fines have been a prime mover in this. So another (admittedly rare) example of a random government target that has actually ended up improving patients' care.

However….

If you get admitted to Wythenshawe, **don't** live in Trafford or Stockport. I haven't been able to find anyone who can explain why it occurs, but the individual social work teams might as well be in Iraq, Zimbabwe and Venezuela. In some cases patients end up staying 10 days on CDU purely because they live in WA14 or SK8 rather than M22. This also occurs reciprocally, and must surely be surmountable?