

# HOSPITAL ADVISORY SERVICE

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## Community Care

I think I must interpret the phrase community care as meaning care of those in need outside the hospital setting. This seems to be the general understanding of the phrase, although I hope the time is coming when we will consider the hospital as part of the community and merely adapt the resources to the needs.

This is a subject which is interesting the whole world at the moment and I would like to tell you of the ideas being bandied about in the United Kingdom and perhaps mention a few developments which I know are occurring in other parts of the world. Perhaps this may form the basis of later discussion as to how services could develop in South Africa where there is a unique mixture of highly sophisticated and simple living standards.

Very largely because of the difficulties in implementing the westernised systems which have been geared for many years to the dominance of hospital based care for the sick and injured, new thoughts have been stimulated by the methods developing in the Third World. Much more importance is being attached to the primary health care teams and use of auxiliary workers.

The National Health Service in Britain started from the premise that everyone has a right to a comprehensive and coherent service to meet their needs. In health care, all are entitled to benefits, including physiotherapy. In fact, because demands are insatiable, this ideal has been impossible to implement, but that is another story, for another talk and discussion.

In 1971 Amelia Harris undertook a survey to estimate the number of disabled in Britain. Those classified as "very severely", "severely" or "appreciably" handicapped totalled 1,128,000, ie 3% of the population. Of these, more than two-thirds were women and more than two-thirds were over the age of 65. This number more than doubles and rises to 3 million over 16 if all disability is counted. Of these five-sixths are over 65.

One of the most striking demographic changes in Britain is the steady rise in number of the elderly with a dramatic increase of those in their eighth, ninth and tenth decades. So much so that it is estimated that between 1973 and 1993 there will be 4% overall increase in the population, but an increase of 5,6% over 60, 26,5% over 75 and 42,2% over 85.

Whilst considering this vast number of elderly it is significant that a present 1,8% over 65 are in hospitals and nursing homes, 1% in psychiatric hospitals and 1,7% in residential homes. This totals 4,5% so that 95,5% over 65 are at home in the community. There is also evidence that those in dependent age groups will increase. People are staying at school longer and at the end of their working life are retiring earlier.

Surely this must indicate the pattern of the future demand. Along with this statistical warning goes a steady rise in the expectations of care for all ages. The function and role of the remedial professions must be influenced by these facts. What we must think about is what sort of physiotherapy is relevant and where it should be given.

In the past it has been the policy of the Department

of Health and Social Security in Britain to restrict the physiotherapy service to hospitals on the grounds that this was the best way to utilise the time of the therapists. In fact, I understand this was worked out on the numbers of patients a physiotherapist could treat if she had 3 cubicles under her control. I do not need to elaborate on all the fallacies of that thinking to this audience.

Another factor which may have influenced thinking is the type of work sometimes being undertaken by organisations such as the Mobile Physiotherapy Service, which is a voluntary organisation which sponsors mobile units and tends to be equated with "here comes my friendly physiotherapist with a smile and a heat lamp". This may be an outmoded image but it is one which lingers with those responsible at the Department of Health for changes in policy.

The tight control of physiotherapists in hospitals must deny very large numbers the benefit of help from us, particularly in the early stages of disability. We must also remember that most people prefer to "live" at home rather than be "cared for" in institutions. Many physiotherapists have been aware of and disturbed by the needs of people outside hospital and a few sporadic and unco-ordinated efforts are being made up and down the country to provide a service.

Let us think about the advantages and benefits of a community physiotherapy service.

- (1) Patients would be treated earlier if the therapist were used as a member of the primary health care team, e.g. if an elderly person who falls but does no major damage, apart from losing confidence, could be seen early one may be able to prevent the too common sequence of events which results in immobility, incontinence, mental confusion and hospital admission.
- (2) Relatives could be instructed and the patients taught to adapt to their disabilities in their own surroundings. In the past there have been far too many self-satisfied pronouncements about patients being independent because they can get in and out of a hospital bed or climb the hospital stairs. Treatment in hospital has been unrealistic and therefore largely purposeless.
- (3) The exhausting journeys to hospital by ambulance would be avoided. These journeys are incidentally becoming intolerably expensive.
- (4) Hospital admissions may be avoided or delayed and adequate follow-up after essential hospital care could be instituted. How often is independence lost because the stimulus and encouragement is taken abruptly away from patients on discharge.
- (5) Opportunity is provided for the contact with other community services, which is so often lacking, yet is so essential.
- (6) The opportunities for preventive advice and treatment are endless and this is a field where our skills are virtually undemanded and unused.
- (7) Certainly in Britain, and this must be true elsewhere, there are increasing numbers of physiotherapists

who cannot or do not wish to work in hospitals because of distances or the rigidity of hospital hours. One could consider linking the services of private practitioners with hospital practitioners' work. Physiotherapists are marrying younger, spinsters are becoming fewer, and the service may well have to depend much more in the future on part-timers.

A physiotherapy service outside hospital can be of value in homes, factories, schools, even prisons, in fact wherever the need is.

**Problems of Organisation**

1. There are different methods of managing the physiotherapy service and these are being discussed. It seems that it would be wrong to have rigid schemes. There must be flexibility in the way they are organised. Many people favour the attachment of a physiotherapist to group practices of general practitioners, some work being done at their surgeries or health centres, and some in patients' homes.
2. Others think a community service should be based at the local hospital. This has many advantages from an administrative angle but care must be taken to consider the many who would benefit but never come near a hospital.
3. Others consider that any suitable staffed centre could act as a headquarters for the staff and equipment which may be needed. The essential is to have a 24-hour telephone service and an efficient co-ordinator. It should be possible to group people of different disciplines and employers to avoid overlap and improve communication between them. The greatest deficiency outside hospital is the absence of a comprehensive programme for patients.

**From Whom Would Referrals Come?**

They could come from anyone appropriate and general practitioners, consultants, nurses, social workers, teachers and other health care colleagues might wish to refer people as potential patients. These would be essentially referrals for assessment purposes. Naturally if any treatment in the traditional sense is considered appropriate, then the general practitioner must be contacted and the problem discussed.

**To Whom Would a Service Be of Most Value?**

For pre-school and school children, guidance can be given on handling, basic exercises, equipment, play materials and as links between hospital and community services. Advice can be given to teachers and parents and post-surgical treatment can be given to avoid missing school.

**Adults**

Following cerebrovascular accidents treatment can be started early; patients can be followed-up from hospital. Advice can be given on handling and lifting to those coping with deteriorating neurological conditions and the elderly with multiple handicaps.

Relatives can be taught transfers and lifts. Advice can be given about graded activity. Many patients may be helped to combat stress incontinence. Sufferers from chronic chest conditions can be taught how to manage. Orthopaedic problems can be treated at home; advice can be given to those with rheumatic conditions. The list is endless.

In nursing and residential homes and day centres, lay staff can be taught simple manoeuvres. Preventive work can include advice on safety programmes. Exercises can be given to help combat the threat of immobility in aging.

**Health Education**

Talks can be given to nurses, doctors, health visitors; in fact to any one who asks for guidance.

**What Sort of Physiotherapy**

Only minimal equipment would be needed, such as splints and walking aids since it is not envisaged that the "treatment" at home would or should equate with that traditionally given in a hospital. Obviously anyone needing intensive and specialised therapy would have to go to centres where this would be available.

It is extremely important that adequate records are kept. There must be conscientious treatment planning following initial assessment and then careful notation of progress and responses. The physiotherapist must be able to communicate so that all can understand what is being related. She must function as a member of a multi-disciplinary health team, aware of the patient's social and emotional environment.

She would need to be a senior member of the profession and suitable retraining should be made available if necessary. The community physiotherapist should have access to and be integrated with her colleagues elsewhere in the district and she should have the advantages of post-registration education on equal terms with those in hospital.

What sort of person can fulfil this role? The modern therapist is predominantly useful in training patients to help themselves in overcoming disability. In the community the work will be primarily, but not entirely, advisory and educational. She must work closely with relatives and nurses in the continuing process of rehabilitation and be prepared to delegate less skilled work to anyone appropriate. For too long we have clung to sanctimonious claptrap phrases like "maintenance of standards" when we do not really know what we mean. Delegation of appropriate work to supervise helpers enhances rather than dilutes professional standards and status.

Many will say that the general practitioner will take advantage of such a service and ask for inappropriate treatment. Much will devolve on the general practitioner who must be taught modern concepts of physiotherapy by the therapists. Provided there is mutual respect between the doctor and therapist and acceptance of each other's responsibilities, difficulties should be few. My enquiries around Britain have shown that this bogey of abuse of the therapy service is grossly exaggerated and great strides have been made in mutual understanding between members of the health team.

The therapist outside hospital has a different outlook. She needs to be socially minded and scornful of demarcation lines. The patient's standard of living must be accepted and she must be ingenious about working without equipment. The therapist will need clinical proficiency and competence to teach, supervise and administrate. She must be good at inter-personal relationships.

This may all need a broader preparation than traditional professional education has given until now, but certainly responsibilities in community care and public service must be accepted. At present practice is not biased towards health maintenance and prevention, but the physiotherapist has the knowledge and skills needed to promote these concepts.

There is no clear policy from the Department of Health and Social Security at present which can guide the development of community services so that they are regrettably proliferating in a haphazard manner. To help clarify the situation a working party to establish the role and function of the therapists in the community was established by the Chartered Society of Physiotherapy in conjunction with the British Association of Occupational Therapists. It has just reported and its recom-

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mendations include:

- (1) An urgent survey of current practice.
- (2) A regional programme of education to teach other members of the health care team the value of remedial therapy.
- (3) A change in student training to appreciate the value of prophylaxis.
- (4) Training of therapists in the extraction of relevant information from various sources and in writing reports.
- (5) Research into the needs of handicapped adolescents.
- (6) A reassessment by the remedial professions of their priorities, with particular regard to adequate provision for the elderly.
- (7) More emphasis during training on teaching methods.
- (8) Consideration of the use of flying squads or peripatetic teams, particularly in rural areas or where therapists are very scarce.
- (9) Efforts should be made to promote better understanding of the potential and needs of the young disabled, the mentally handicapped and psychiatric patients.
- (10) Increased post-registration activities should be encouraged in several areas, including paediatrics.
- (11) Existing services should be evaluated and thoroughly reassessed in view of changing needs.
- (12) Appropriate professional structures should be formulated to avoid isolation of those working outside hospital.

#### Finland

In Finland there has recently been a complete re-appraisal of education of all health personnel, including that of doctors. Their health services have been similarly reassessed.

One result is that there will be some hospital beds for primary medical care, but the main proportion of services are in the community. Much more use is to be made of people who can contribute without an expensive and lengthy training.

Approximately half the physiotherapists are now allocated for more traditional treatments, whilst the rest undertake indirect, preventive, maintenance and educative

services. Since 1973, a one-year postgraduate course in community health and administration has been available to physiotherapists and many have taken advantage of it.

#### Australia

In this country a number of experiments on the use of physiotherapy outside the hospital have been initiated. Some are hospital based, some use peripatetic teams of therapists and social workers. All agree that it is essential to have a co-ordinator.

#### New Zealand

Here they are experimenting with the concept of the hospital at home, rather on the lines of pilot schemes which have been undertaken in Paris. In Britain this scheme has many supporters and may finally be the most economic and efficient use of staff and money available.

#### Scotland

In Scotland the development has been inconsistent and the organisation arbitrary. The wording of their National Health Service Regulations has been interpreted more liberally than south of the border in England and Wales. Sometimes there is a structure for the therapists but often there are no official channels of communication.

In 1973, 98 physiotherapists worked in the community in Scotland, an equivalent of 80 whole time workers. They had 12,785 new patients and carried out 190,189 treatments, an average of 14,875 per person. Most referrals were from general practitioners and all ages were treated in different situations.

#### Summary

So, things are on the move. Certain factors must be accepted if we are to provide the necessary service. Firstly, it must be recognised that community care depends on a caring community. Secondly, we must always be aware that "Inside the hospital, the status and livelihood of a large body of employees requires the patients' presence. It could indeed be that the hospitals need of the patient transcends the patients' need of the hospital".