



## Choice and responsiveness for older people in the "patient centred" NHS

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or medical intervention. The diagnosis of depressive disorder requires careful assessment. If treatment is indicated several options remain. Psychological treatments, including cognitive behaviour therapy, have been used extensively, and several randomised trials attest to its efficacy in mild or moderately severe depression.<sup>6</sup> Where available, psychological treatments are often used as a first line treatment, particularly in younger adolescents and children. However, little evidence exists to support their use in young people with more severe depression, and here pharmacological treatments may be important.

Fluoxetine remains an option, and it is probably now being used as the first line pharmacological treatment in most patients. It can have problematic adverse effects, including restlessness and agitation. The other selective serotonin reuptake inhibitors may still be used in some circumstances under specialist supervision.

The other main category of antidepressant drugs is the tricyclic drugs. Their use has declined since the introduction of the selective serotonin reuptake inhibitors and particularly since a systematic review in 1995 concluded that they seem to be no more effective than placebo in the treatment of depression in children and adolescents.<sup>7</sup> A more recent Cochrane systematic review showed that they may offer some benefit for adolescents with depression but not for pre-pubertal children.<sup>8</sup> These drugs are associated with clinically important adverse effects, and most are toxic in overdose.

What are the lessons to be learnt from the way in which these events have unfolded? The dramatic issuing of the guidance by the Committee on Safety of Medicines is likely to lead to considerable uncertainty and some difficulty for many patients and doctors. Although the guidance is clear cut, the decisions have been based on relatively few studies. The dearth of research means that a high proportion of the 40 000 children and adolescents taking antidepressants in the United Kingdom are likely to use fluoxetine in the future on the basis of randomised trials involving a few hundred people, the largest of which was funded by the company that makes the drug. The difference in effectiveness between sertraline (subject of the new advice from the Committee on Safety of Medicines<sup>9</sup>) and

fluoxetine<sup>10-12</sup> seems marginal on the basis of the available evidence. Independently funded research into the effectiveness of treatments for depression is needed.

Concerns also remain about the way in which data from trials about serious adverse effects of some antidepressant drugs, held by the pharmaceutical companies concerned, seem not to have been previously released to the Committee on Safety of Medicines. A more robust system, requiring full disclosure of information, is urgently required.

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## Choice and responsiveness for older people in the "patient centred" NHS

*New community care regulations mean that older people may not be able to choose where they are treated*

According to the health secretary, John Reid, a patient centred NHS driven by the principles of choice and competition will improve equitable access to health care in particular for the poor and disadvantaged. The patient, and not the provider, will be king while NHS provision will still be provided on the basis of equal treatment for equal need. But it is difficult to reconcile this vision of choice and equity with the Community Care (Delayed Discharge) Act, which comes into force in January 2004.

From January 2004 local authorities will be fined by the NHS for failing to arrange social care services for patients who are no longer appropriately situated in an acute hospital bed. Under the provisions of the Community Care Act social service departments will have a minimum of two days to assess the needs of a patient and arrange a suitable package of care—whether this be at home or in other forms of accommodation—or face a fine of £100 (\$177; €142) for every day the patient remains in hospital. If on

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Monday at 2 pm an acute trust issues a notification to local social services that they must assess and arrange social services for a patient the services must be in place and the patient discharged by Thursday at 11 am or a £100 fine must be paid.<sup>1</sup>

Not only will local authorities' social services be under pressure to avoid these fines but patients and their families are also unlikely to receive any leniency from NHS acute trusts. From 2006 the new tariffs for acute care episodes will be worked out according to average length of stay.<sup>2</sup> If any patient stays longer than the average length of stay the acute trust will actually be making a loss by continuing to care for patients. Conversely, if the acute trust succeeds in discharging the patient before the patient has experienced an "average length of stay" the trust will make a profit. The new act thus provides acute trusts with a formal mechanism by which they can restrict their exposure to financial risk by transferring costs out of the system and back into the community.

The government has allocated £100m each year to local authorities to pay any "reimbursement" costs (fines) to the NHS as a result of delayed discharges. In theory this should lead to investment in community based services, but only if delayed discharges can be avoided. Yet this underestimates the underfunding and current lack of capacity in the community care sector. The National Beds Inquiry recommended that there should not be further disinvestment from acute services until such time that the investment in "care closer to home" had been made.<sup>3</sup> However, according to the Association of Directors of Social Services, in 2001-2 local authorities were spending 10% more than their budgetary allocations from central government, a pressure which has led to tighter eligibility criteria and a reduction in service provision.<sup>4</sup> As a result the number of households receiving home help or home care dropped from 491 100 in 1996 to 381 200 in 2001.<sup>5</sup> On top of this, capacity within the care home sector is also shrinking—13 400 care home places were closed in the 15 months to April 2003 and an overall contraction of some 13% has occurred since 1996.<sup>6</sup>

The NHS Plan pledged to increase the total number of NHS beds by 7000 from 2000 to 2004. However, the target increase in beds of 2100 general and acute beds and 5000 NHS intermediate care beds by 2004 has not been achieved and the total number of NHS beds in England has continued to fall from 186 091 in 1999-2000 to 183 826 in 2002-3.<sup>7</sup>

The combination of reduced NHS and social services capacity and new financial incentives could see the chronically sick and older patients being forced into accommodation which is inappropriate and does not serve their needs. If their first choice of care home is not available, older patients will be offered an interim placement, which may be far away from their family and local community and inappropriate to their care needs. The tight timescales involved in the discharge process may also make it impossible for the owner of the proposed care home to assess whether the patient can be adequately catered for.<sup>8</sup> According to guidance from the Department of Health, if an individual and their family is unhappy with the interim care package offered by the local authority, "the council is entitled to consider that it has fulfilled its statutory duty to assess and offer services, and may then inform the individual

that they will need to make their own arrangements."<sup>8</sup> Parliament's Joint Committee on Human Rights has already warned that the act "will undoubtedly give an incentive to social services employees, when assessing patients' needs for community care services ... to minimise the services that it will say the patient will require."<sup>9</sup>

The effect of these measures is also likely to undermine one of the most significant pieces of legislation guaranteeing consumer rights. The rights of older patients to choose their care home are enshrined in a 1992 amendment to the 1948 National Assistance Act known as the Direction on Choice,<sup>10</sup> which is intended "to ensure that when councils with social services responsibilities make placements in care homes or care homes providing nursing care, that, within reason, individuals are able to exercise genuine choice over where they live."<sup>11</sup> The exercise of this right has, however, proved problematic. The Department of Health currently attributes 8% of all delayed discharges to patients exercising their right to choose.<sup>12</sup> Choice for older patients is thus now presented as an obstacle to the efficient functioning of the system.

John Reid has stated that his government "will empower patients by giving them genuine individual choices—about where, when, how, and by whom they are treated."<sup>13</sup> It seems that the secretary of state does not have in mind the frail elderly and people with long term illness.

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