

What is long term care for the elderly?

# **THE DANISH EXPERIENCE**

## **CONCLUSIONS**

**Report of the final conference  
on  
12 December 1979  
at the  
King's Fund Centre**

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## THE DANISH EXPERIENCE - Flexibility of Care

10 October and 12 December 1979

This is a summary of the final conferences on the care of elderly people based on a study of Danish experience in this field. The subjects for discussion were housing, the need for flexibility in care and the identification of good practices.

Dr Colin Godber described the confusion most frail, elderly people and their families experience in Britain when faced with the different services offering care for old people. The Health Service, the Social Service Department and the Housing Department may each be the responsible agent at different stages in the old person's care. Often it seems they work without reference to each other.

In Denmark this lack of co-ordination is avoided by making the Social Services Department responsible for the whole range of support services from the community, to sheltered housing and into the Nursing Home system. The Danish system is more flexible and is used to better advantage.

The British system is too fragmented and rigid. Instead of a gradual progression based on need from community support to sheltered housing, to full nursing care, the system is haphazard and inefficient. Often elderly people wait so long for sheltered accommodation that they have to be admitted to hospital in crisis having become unable to fend for themselves. They are then turned down for Part III accommodation as being too disabled. At the same time they have jumped the queue for hospital care. This misplacement of people is a major flaw of the present British system.

Britain must move in the direction of the Danish system with one agency taking overall responsibility and placing people according to need. Sheltered housing schemes with greater and more flexible support are needed. Residential care must be improved to allow far more frail and disabled people to be cared for out of long stay hospital beds. This means that staffing levels would have to be increased and buildings modified. In the present economic climate, perhaps local authorities could be persuaded against percentage cuts across the board and in favour of radical pruning of obsolete homes. Thus redeploying staff to make the remaining homes more effective.

Measures could be taken to encourage similar steps in the private sector. If our Part III accommodation could be moved in the direction of the Danish Nursing Homes, (where no one is regarded as too disabled for admission), we might be able to phase out some of the less satisfactory long stay hospitals and to use hospital geriatric and and psycho-geriatric beds to back up the rest of the system.

### Services for the Elderly

Mr R J Lewis (Assistant Director, Social Services), Mr J Jay (Assistant Director of Housing) and Dr J McCann (Community Physician) described in some detail the work the group did in Stockport, to re-think and re-design services for old people. After local government and NHS re-organisation, a thorough examination was made of major areas of expense, and of which were services for the elderly. A survey was undertaken to establish the needs of the over 65's and covered everything from rent rebates to medical services. It was financed jointly by the health authority and the local authority. Its conclusion was that they were providing the wrong care for the wrong people in the wrong place. On the basis of the research paper they drew up their plans for the 1980's.

One of the major issues they faced was that when an elderly person was moved from one place to another it was always because of a crisis and not a planned move to enable them to cope better. The 'break through' came with radio-alarm systems and a new way of providing warden support. A group of mobile wardens was formed and a number of radio alarms (which plug into ordinary three-pin sockets) were installed in old people's own houses and in sheltered housing schemes.

The central control unit is manned 24 hours a day. The alarm units can be used as monitors - buzzing twice daily, if the elderly person does not reply within a minute the alarm signal shows at the control unit. The units can also be fitted with thermostats to warn of the dangers of hypothermia in bedridden people in winter. The wardens have small vans and take seven minutes on average to answer an alarm call. The service now covers 1700 elderly people living in the community.

The Area Health Authority has also bought a number of units which are allocated to elderly people discharged from hospital, who are still at risk. The important thing is that the whole service is managed by one agency, the Social Services.

The radio alarm system has also been introduced into several tower blocks of flats which have a high proportion of elderly tenants. These blocks are popular because of their central position in the town, the nature of the accommodation and the entry-phone system in each block, which seems to give a sense of security. The Housing Department had planned to make some modifications to provide two communal rooms (as has been done in the Manchester area and other places) but this was not approved and the radio alarms were installed instead. A local church building was acquired and now provides the communal facilities which are organised by the elderly tenants themselves.

The use of tower blocks of flats in this way is seen to be an effective use of property which is not suitable for families and is an effective response to a demand from the elderly tenants for this kind of accommodation.

The entire residential care policy has been re-examined. A communal referral system has been introduced to get the right people to the right level of care. This has led to the development of a joint 'high dependency' home with improved bathing and washing facilities, variable height beds a good alarm system, adequate medical cover, which allows elderly people with considerable disabilities to be cared for out of hospital.

Domiciliary services have also been re-examined. Housing policy has changed. There will be no more blocks of 'specialty housing' but the emphasis will be on 'mobility housing' - access for wheelchairs in council housing.

Several themes run through Stockports re-development of its services.

1. You take services to the people rather than bring people to the services
2. More active co-operation between the health authority, social services and the housing authority.
3. Variety of provision of care.
4. Flexibility in transferring clients from one level of provision of care to another.
5. Joint local authority and health authority assessment of need.

#### Problems of Housing Needs for the Elderly

Mr F H Gregory (Director of Housing and Works, Thurrock) gave a brief history of the development of local authority housing for retired people.

One of the main points was the change of emphasis which has taken place in the post-war years. Most local authorities are now concentrating on the provision of old-age pensioners accommodation because -

- a) there is increased demand
- b) it helps to reduce the number of under-occupied properties and to free larger accommodation for families.

Elderly tenants are often glad to move to specially built sheltered accommodation if it is within a short distance of their original home and enabled them therefore to maintain contact with their neighbourhood. There are two types of sheltered accommodation - category 1, consisting of self-contained flats with separate access and category 2, consisting of self-contained flats within one building with enclosed corridor access and special slow lifts. In both cases tenants have the benefit of warden services and communal facilities.

It is not easy to find sites for sheltered housing within existing estates but in Essex they have found that much of the pre-war old-peoples housing apart from being inconvenient, had large gardens. By moving tenants out temporarily, and bulldozing the existing premises, they were able to build sheltered housing on the land this made available. Until the last two or three years transfer of aging, frail tenants to Part III accommodation has been relatively straightforward. Cut backs in expenditure, however, have meant no new Part III accommodation and therefore less vacancies with the result that sheltered housing is being left with more infirm people. Wardens who were never intended as full-time attendants are having to carry more responsibilities. Housing Associations too are increasing the number of OAP dwellings on their sites and rent and rate rebates are available for elderly people who may not be able to afford an economic rent.

### Changes of Care in the Voluntary Sector

Mr Christopher Bourne (Chairman of the Policy Committee, Linen and Woolen Drapers, Cottage Homes) gave a history of the Cottage Homes.

The cottage homes were started in 1898 to 'provide homes for the aged, poor and infirm of the Trade'. By 1900 the houses at Mill Hill consisted of 26 cottages and a central block of communal facilities. In 1929 a nursing cottage with seven beds was added and the concept of total care from the date of entering on retirement, has been fundamental ever since.

There are now three sites (Mill Hill, Derby, Glasgow) with a total of 245 cottages, 25 flats with separate bathrooms, 81 bed-sitting rooms, 58 rest home rooms and 55 nursing wing beds. Residents pay a maintenance charge and rent.

The proportion of places in the nursing wing and in Part III accommodation has to be kept under review. A high standard of care in the nursing wing is essential if the 'total care' policy is to be effective, although people who became too ill or frail to care for themselves may be given the choice of going into the nursing wing or into the care of the NHS.

The Cottage Homes demonstrate that in the voluntary sector of Britain a system of flexible total care exists which is similar to the Danish nursing homes. One important point is that each person is surrounded by his own possessions and has his or her 'personal space' clearly identified.

Dr Margery Kuck from the Department of Health and Social Security said that a small number of experimental NHS nursing homes were to be set up in Britain. They would have fifty places in homely, single units and residents would be encouraged to bring their own furniture. The Consultant Geriatrician would take overall responsibility and there would be a nurse in charge.

Rehabilitation would be important. At least one home would be in an inner city area with poor GP services. Money would be provided for four years and results and costs would be monitored and compared with a long-stay ward on which the same amount of interest was being devoted.

In five years decisions would be made on whether a change of policy was needed.

Mr Roger Burton (Senior Social Worker, St George's Hospital) spoke of the positive as well as the negative side of institutionalisation. Each of us is shaped by his or her upbringing and training but at the same time each person has the opportunity to influence the pattern for the future.

Institutionalisation by and large provides a frame of reference and support for the majority in society but sometimes patterns are imposed and serve only to harm individuals. This is the negative side of institutions as described by Goffman who listed the four main characteristics of the closed institution:

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1. authoritarian
2. life in groups or herds
3. regimentation
4. moral enforcement of activity

This negative institutionalisation is only too familiar in residential homes and long-stay wards.

What is needed is a change in attitudes, a willingness to take the risks of establishing better patterns of community care which will support old people and allow them as much freedom and independence as possible rather than create patterns which lead to apathy and misery.

Mr John Holt (Assistant Director of Housing, Southampton) described an experiment in Southampton to provide a form of sheltered housing, half-way between category II (ie groups of flatlets with communal services and wardens) and Part III accommodation. He called it the 2½ stage. The Southampton scheme originated with the HCPT for the elderly.

A group of 32 flatlets with communal facilities was set aside to be used for those more frail than usual in sheltered housing. The aim was to support them in their own homes for as long as possible. Four full-time staff were employed (rather than the two and a half under 'normal' sheltered housing). The difference in salaries was met by Social Services and the Health Authority, who have worked closely with the Housing Department throughout the project. Home helps, Meals on Wheels and other support services are provided by Social Services and there is a guarantee that, when necessary, residents would be found a place in Part III accommodation or in hospital. This guarantee has been seldom used, but has been very successful when needed. The wardens seem able and willing to support frail residents as long as possible rather than the usual situation of trying to get them transferred early because of the difficulties of getting places in hospital or Part III.

Tenants were originally selected by a panel made up from three authorities. Vacancies were few and are now handled by the housing department in consultation with the health authority and social services department.

Staff provide a 24 hour service but otherwise their responsibilities are not very different from other wardens. Nursing is done by the community nurses. At the weekends meals are provided from a freezer of pre-cooked dishes for those unable to provide for themselves. About two-thirds of the residents receive Meals on Wheels during the week. A liaison officer is appointed from the local Social Services Department who acts as a trouble-shooter when necessary.

The scheme has now been running for three years and is judged a success. Perhaps the best achievement has been the excellent relations between the departments of Housing, Health and Social Services, without which it would have been impossible.

Dr Picton-Williams (South Western Hospital, St Thomas' District) described the shared day care provision in Lambeth. He made the clear distinction between the functions of the day hospital, which provides a central diagnostic and treatment service for people who do not need a hospital bed, and the day centre, which has a social function. By running two together as a joint venture between the health service and the local authority they have achieved a flexible, integrated service. The hospital geriatric team works well with the community. Responsibility is shared and administrative barriers have been overcome.

The scheme has succeeded in its aims of:

- a) allowing earlier discharge from hospital
- b) preventing crisis admissions
- c) encouraging collaboration between hospital and local authority staff.

Neville Marston (Northamptonshire Social Services) spoke of the problems of the future in terms of:

- a) increasing population of old people by the year 2000 with three times as many people over the age of 85 and twice as many over the age of 75
- b) cutbacks in the provision of local authority residential care and in hospital beds
- c) fewer children to care for elderly relatives
- d) fewer volunteers in the community - eg WRVS
- e) more single elderly people needing residential care because of present high divorce rate.

Residential care is an expensive service and Mr Marston did not think the community would be willing to pay for it at the level which would be required. The only solution would be to concentrate resources on supporting elderly people at home.

Three areas in particular would need to be developed:

- 1. Methods of teaching elderly confused people to overcome the problems caused by confusional state.
- 2. An active home rehabilitative service, making full use of technological developments in equipment and adaptations.
- 3. Further developments of the tower block schemes - a massive increase in sheltered housing systems where services can be provided in a centre.



A number of themes emerged from the meetings as being worthy of further discussion:

- i Most elderly people will live in their own homes throughout their lives. Much more thought must be given to adapting private housing as needs change.
- ii How many old people are in homes because they need to be there and how many are there because of lack of community support?
- iii Segregation of old people - does the warden become an 'institutionalised good neighbour'?  
What are our expectations of the community and the family?
- iv Costs - is it cheaper to warehouse people in poorly staffed old hospitals than in new sheltered housing with community support?  
What are the implications?
- v The importance of a flexible policy in which Housing Departments, the social services and Health Authorities work closely together.
- vi The problem of 'institutional drift' in state provision;  
the belief that people in an institution will inevitably decline.
- vii The need to publicise good practices.
- viii The training needs of wardens.
- ix The elderly person as a consumer - what does he or she want?

Syndicate groups met to discuss the following questions:

1. What type of housing should we be planning for the elderly for the next decade? Do we need special buildings - separate areas for dependent sick people?
2. What levels should there be communication and interaction between professionals and Wardens, Community Nurses, Home Helps and Housing Departments and Hospitals.
3. What should the role of the staff of sheltered housing be? What are their training needs? Who are responsible for the training of staff for the role they are expected to play?
4. How much must, and can, attitudes be changed to preserve the identity and self-determination of dependent elderly persons? What policies would you as caring professionals like to see implemented? How would you start implementing good practices?
5. How can a service for elderly people needing support in the community be assessed and administered? How much of a caseload should be carried by one helper? How can a back-up service be supplied by the different departments? Should there be one officer for liaison between all departments?
6. How much help and support should be expected from good neighbours and Voluntary Associations in helping to implement the help needed by elderly dependent people? How would this be co-ordinated?
7. What practical solutions do you know of, or can suggest, to solve the difficulties arising from the increasing dependency of residents in sheltered housing?
8. Should we follow the example of voluntary organisations of providing for the progression from sheltered housing to residential accommodation to nursing homes, rather than changing the responsibilities between Social Services - Health Authorities.

Syndicate Group A discussed

- a. the type of housing needed for the next decade
- b. the levels of communication among professionals.

The following points were made:

Question a

- i Elderly people should be helped to live in their own homes until they die. When the house is too large every effort should be made to adapt or renovate to allow the old person to remain in his or her surroundings and use the excess accommodation for others. Little progress has been made about this.
- ii Elderly people should be encouraged to enter sheltered accommodation before their need is acute.
- iii A whole range of provision is needed including cottage hospitals and blocks of flats with full back-up services ie entry phones and alarm systems.
- iv Part III accommodation should be used as a back-up when people at home became too sick to be cared for by the primary health care team but there must be an emphasis on rehabilitation.

Question b

- i Face to face contact with one's opposite number is one of the best ways to achieve good communication.
- ii Boundary problems between services hinder good communications.
- iii Where there are no wardens, relatives could be encouraged to form rotas to care for each others elderly and to be on call for emergencies.

Syndicate Group B discussed

- a. the role of staff in sheltered housing and their training needs
- b. how to preserve the self-determination of a dependent elderly person

Question a

- i A distinction had to be made between the training needs of those caring for confused elderly people and for physically disabled people. Training courses should be encouraged and arranged by Social Services Departments.

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Question b

- i The importance of allowing people to take risks in deciding how to run their own lives; this is so often missing from the lives old people are expected to live. A less custodial role by senior staff with a more responsible back up service for staff concerned with the daily needs of old people could be encouraged.
- ii The Poor Law concept of 'non-deserving poor' still seems to apply to elderly people who are seen as second-class citizens to be 'put in homes'.

Syndicate Group C

- a. consider how a service for elderly people in the community could be assessed and administered
- b. consider how much help should be expected from good neighbours and voluntary groups

Question a

- i The important thing was to assess the needs of the old person rather than the services. To achieve this an assessment panel covering all the appropriate services would be necessary.
- ii Rather than having one liaison officer to co-ordinate all services it was felt that each area should have an 'advocate for the elderly'.

Question b

- i The value of voluntary groups varied a great deal. The professional had to be alive to the dangers of institutionalising voluntary effort.

Syndicate Group D

- a. consider practical solutions to the problems of increasing dependency of residents in sheltered housing
- b. the desirability of one authority assuming a policy of total care rather than the present division of responsibilities between Social Services and Health Authorities.

Question a

- i A 24-hour warden service; better communication between management and caring staff.
- ii Better training for wardens to enable them to take more responsibility.
- iii Efficient communication systems between residents and wardens as in Stockport.
- iv Efforts to maintain family support, eg relatives associations.

Question b.

- i The important factor was that residents understood the policies of a home.
- ii How long they might stay there.
- iii What would happen if their dependency increased.

Although all the topics for discussion were not dealt with by the groups, much reflection and thought for future action for the care of the elderly in the future was apparent.

In his summing up of the day, the Chairman urged delegates to understand the real facts of ageing, as against the myths, and to have clear ideas of the type of housing that is right for the individual, remembering that flexibility at all stages is important.

If the community accept more responsibility for its elderly, then efficient back-up services are needed to prevent a crisis occurring and the blocking of beds in hospital wards.

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