Care for the Elderly

CARE FOR THE ELDERLY

A collection of reports
on a series of twelve conferences
held at the Hospital Centre
between June - December 1970

July 1971

Price 50p

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CARE FOR THE ELDERLY

List of contents

The report on the first conference was prepared by Miss Helen McCarrick, and that on the second by Mrs Shirley Hardy; the reports on the other ten conferences were prepared by Mr David Boorer.

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INTRODUCTION

This publication contains reports on a series of 12 conferences held at the Hospital Centre between June-December 1970 on the subject of services for the elderly in hospital and community.

Statistically, over 12 per cent of the population are now aged 65 and over, and this proportion may rise to about 14 per cent by 1981. On any one day, about 140,000 hospital beds, over one-third of the total, will be occupied by patients over 65, and about the same number of old people will be resident in homes and hostels run by local authorities and voluntary organisations. These are massive numbers, but nearly 95 per cent of old people still live independently in private households in the community.

Of all these people, some may have been 'old' by the time they were 55, whilst others may still be young at 75. It is well recognised that the aim of all services for the elderly should be to enable old people to live full and happy lives in the community for as long as possible, and that support for old people and their relatives in their own homes can do much to reduce the need for admission to hostel or hospital and to expedite return home after admission. The achievement of this aim requires close co-operation and co-ordination of effort between hospitals and local authorities and between statutory and voluntary organisations at all levels. In this series of conferences, speakers were chosen from many different professions and organisations to describe what has already been done to provide a high standard of service for the elderly in many places and to discuss what might be done to improve standards still further.

Many of the conferences were over-subscribed and - to judge from the conference questionnaires returned by many participants - many people did find the conferences useful. These facts seem to indicate that there is a need for more opportunities for the exchange of information and ideas on the care of the elderly. The Hospital Centre is planning to arrange further meetings on the subject and to follow up some of the good ideas that were described during the conferences. But the Centre alone can only reach some of the people some of the time. It is therefore hoped that the success of these conferences may encourage other authorities and organisations to arrange similar activities on a continuing basis at regional or local level.

The conferences were arranged in close co-operation with the North West Metropolitan Regional Hospital Board and about 60 per cent of the places at each conference were reserved for representatives from health and social service authorities and voluntary organisations in the Board's area. The King's Fund would like to place on record its appreciation of the support that was so readily given by the Board and in particular for the assistance given

CARE FOR THE ELDERLY

INTRODUCTION

This publication contains reports of a series of conferences held at the Metropolitan Hospital Centre between June-the October 1979 on the subject of care for the elderly in hospital and community.

Statistically, over 13 per cent of the population of the Metropolitan Region is over 65, and this proportion may rise to about 14 per cent by the year 2000. Over 140,000 hospital beds, over one-third of them in geriatric hospitals, are used by people over 65, and about the same number of beds in hostels run by local authorities and voluntary bodies. A massive number, not nearly all of them elderly, are cared for in private households in the community.

Of all these people, some may need only occasional help, others may still be perfectly able to look after themselves but may require services for the elderly such as meals on wheels, day centres or clubs. Many live in the community for as long as they can, and their relatives or neighbours admission to hospital or hospital-like care. The achievement of this aim requires effort between hospitals and local authorities and voluntary organisations of all kinds. In these conferences were chosen from many different aspects of what has already been done and to discuss how the elderly in many places and to discuss how they can be helped still further.

Many of the conferences were held in the Metropolitan Hospital Centre's conference centre, and the rest in other hospitals. Each conference lasted one day. There was time for more opportunities for the exchange of views between those who work with the elderly. The hospital's geriatric staff took part in all the conferences on the subject and to follow up the discussions during the conferences. But the conferences were open to other people some of the time. It is hoped that conferences may encourage more and more similar activities on a continuing basis.

The conferences were arranged by the Metropolitan Regional Hospital Board and the Metropolitan Hospital Centre. Each conference was reserved for representatives of service authorities and voluntary organisations. King's Fund would like to place on record its appreciation of the help which was so readily given by the speakers and by the chairmen and rapporteurs.

by Miss Joan Bricknell, one of the Board's nursing officers, who was seconded part-time to the Centre to help organise the conferences. Sincere thanks are also due to all the speakers who came from many parts of the country to tell of progress and problems in their own work, and to Mr David Boorer, who prepared the reports on ten of the conferences and edited the whole collection.

These reports have been prepared largely at the request of the conference participants who asked for a record of the conferences to be made available. The detailed programme for each conference has been included for the benefit of those who may wish to consider organising similar conferences in their own region or area. It is hoped that the reports will also be of interest and help to all those who are concerned with introducing or developing good ideas and practices in the care of the elderly in hospital and community.

Miles Hardie
Director
King's Fund Hospital Centre

July 1971

1. INTRODUCTORY CONFERENCE

Conference on Thursday 11 June 1970

Chairman: Miss E Rickards OBE MS FRCS
Vice-Chairman
North West Metropolitan
Regional Hospital Board

12.30 - 1.30 p m	Buffet lunch
1.30 - 2.15 p m	Tour of exhibition
	Conference
2.15 - 2.25 p m	Introduction by Chairman
2.25 - 2.40 p m	Outline of the project Mr M C Hardie
2.40 - 3.00 p m	THE HOSPITAL ADVISORY SERVICE & GERIATRIC CARE Dr A A Baker Director National Health Service Hospital Advisory Service
3.00 - 3.15 p m	A NURSING VIEW Problems and priorities Mrs Fay Rigby Matron In the Ray Nursing Home Maidenhead
3.15 - 3.30 p m	IMPROVING GERIATRIC CARE: The work of the Teesside Geriatric Association i) Dr D M Prinsley Consultant Physician S Teesside and N Teesside Hospitals Chairman Teesside Geriatric Association
3.30 - 3.40 p m	ii) Mrs M G Hill Secretary Teesside Geriatric Association
3.40 - 3.50 p m	Interval
3.50 - 4.30 p m	Questions, discussion and summing up

12.30 - 1.30 p m

1.30 - 2.15 p m

2.15 - 2.25 p m

2.25 - 2.40 p m

2.40 - 3.00 p m

3.00 - 3.15 p m

3.15 - 3.30 p m

3.30 - 3.40 p m

3.40 - 3.50 p m Interval

3.50 - 4.30 p m Questions, discussion

1. INTRODUCTORY CONFERENCE

Under the chairmanship of Miss E Rickards, Vice-Chairman of the North West Metropolitan Regional Hospital Board, the first of a series of twelve conferences on geriatric care was held at the King's Fund Hospital Centre on 11 June.

In an introductory talk, Mr Miles Hardie, director of the Centre, explained the background and purpose of the series and of the exhibition associated with it. He referred to the Centre's policy of trying to relate its activities still more closely to the needs and wishes of health service authorities, particularly in the London metropolitan area. On this basis the programme of activities on geriatric services had been organised in very close co-operation with the North West Metropolitan RHB, and one of the Board's nursing officers, Miss Joan Bricknell, had been seconded part-time to the Centre to help arrange the programme.

Purpose of Programme

The purpose of the conferences was to discuss progress and problems in the development of services for the elderly in hospital and community. An essential feature of the programme was to involve staff of all disciplines from all branches of the health services and from voluntary organisations concerned with the elderly. In preparing material for the conferences and associated exhibition, the Centre had invited statutory and voluntary authorities throughout the country to send in details of good ideas and practices in geriatric care. The response had been encouraging, and many of the replies had been summarised and reproduced in a booklet Improving care for the elderly, which was to be given to all those attending each conference in the series. Through these conferences and the accompanying process of exchange of information and ideas the Centre hoped to be able to help improve still further the services being provided for the elderly.

Hospital Advisory Service

The next speaker, Dr A A Baker, director of the Hospital Advisory Service, gave an account of the service which, he said, apart from reporting on conditions in hospitals to the Secretary of State was also a service to help hospitals improve themselves. Its brief was very wide, and entitled it to comment on any part of the hospital service from the Department of Health down to ward level. Long-stay hospitals were being considered first by the Advisory Service teams, with some priority given to hospitals for the mentally handicapped. Initial emphasis was on the good aspects of hospitals, in order to find out what things hospitals were doing well. After that, the Advisory Service wanted to look at problem areas.

Each team consisted of five people: a consultant in the specialty concerned, a hospital administrator of group secretary level, an administrative nurse, a ward nurse and a social worker. It was not necessary to have a senior clinician; personality traits were of more importance, and the teams wanted to find out from people what they themselves wanted to do and how they thought they could do it, not impose outside ideas of how the team thought things should be done.

The hospital service, said Dr Baker, was full of good ideas, particularly at ward level - the difficulty is to make them materialise. One beneficial result of the Advisory Service was to shorten the time taken to get a good idea off the ground and up to discussion level.

About two weeks was taken to tour a hospital, and usually so many ideas emerged that it was necessary to pick out those which could be implemented. Absolute openness was necessary - there would be no 'secret reports'. Matters of importance were raised at the final meeting before the team left the hospital. In the long run, said Dr Baker, personalities and how people worked together were far more important than the number of toilets or the amount of bed space.

He felt that the team visits had introduced stimulus and a fresh approach, and sometimes questions were asked that should have been asked before. Reports were then written in about two to three weeks and a gap of the same time allowed for them to be considered; follow-up timing was variable. In each hospital at least one meeting was arranged with representatives from local authorities.

It was highly unlikely, said Dr Baker, that anything brand new would be produced that had never been done before, but good ideas were being passed on much more quickly. Those in the teams also learned from their work and would take the knowledge gained back with them to their previous posts. Recruitment to the Advisory Service had all been by secondment, and six months to two years was thought to be a suitable term, to ensure a turnover of fresh staff with fresh ideas.

Dr Baker made four points about the geriatric problem. First, priorities. Thirty per cent of hospital beds, other than those for mental illness, were filled by geriatric patients. Should priority be given here, or to what he called luxury items, such as heart transplants? Secondly, there was a need for clearer definition of what exactly was meant by geriatric services. Thirdly, there was a need for better placement. Some people in hospital could manage quite well outside, some of those at home were in real need of more help than they were getting. A series of facilities of a wide range was required to give a patient just the amount of support he needed without taking away his independence. How many areas had, in fact, planned this?

Continuity of care needed

Lastly, there was a need to organise a service run by one therapeutic team, so that as far as possible the same people followed up and cared for the same patient, to give continuity of personal relationships. This continuity was particularly vital for the old, the mentally handicapped and the psychotic.

Should not the general practitioner and the district nurse, asked Dr Baker, be free to come and go within the hospital that housed their patient, and should not the hospital nurse be free to follow up her patient when he returned to the community? Although this meant a lot of re-thinking of our existing services, existing nurses, Dr Baker thought, should be encouraged to extend their scope rather than to look for fresh services with new types of nurses being introduced.

Problems and Priorities - the nursing view

The nursing view, under the title Problems and Priorities, was put by Mrs Fay Rigby, matron of a home for both old and not-so-old chronic sick at Maidenhead. If anyone had expected Mrs Rigby's priorities to be facilities unattainable either through lack of staff or financial stringency, they were mistaken. She gave five basic priorities for the old, all capable of achievement and all matters of absolute basic nursing: care of the bowels, the bladder, the mind, the back (including general hygiene) and the necessity for a good and complete report when staffs handed over to one another.

Back to Basic Nursing

Her talk amounted to a strong indictment of present-day nursing. She blamed nurses for the constipation that she said led in many elderly patients to mental confusion. No one was quicker to react to a bad-tempered nurse, she said, than a geriatric patient, and she blamed this bad temper on the fact that nurses no longer had to be in early at night. (Were nurses never tired and bad-tempered in times gone by, one wondered, from working long, long hours?)

Care of the back, said Mrs Rigby, began in the kitchen; a well-fed patient became a well patient, and she deplored the fact that some ward sisters no longer served meals and in fact did not even know whether their patients had eaten all their meals or not. False economy on the part of HMCs in accepting low-priced contracts for food supplies came next under the lash; there was far too much cheese-paring on food, she thought, and much food that was unsuitable ended in the pig-bin.

Coming to problems, the ones she cited were not those oft-repeated ones of outdated buildings, overcrowding and lack of staff. First Mrs Rigby put hypersensitivity of patients - those who were fully intact mentally were often spoken to as if they were some kind of idiot.

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Another problem was the way in which the NHS had taken so much responsibility away from relatives, who needed to be closely integrated in the care of the patient. Next of kin should not be regarded as names in a book to be sent for when a patient died. It was also disgraceful, she thought, that hospitals should ever have to buy a patient his or her clothes.

Staff attitudes to patients

Perhaps her most scathing attack was on the ward sister who considered it less important to see her patients' relatives than to accompany the consultant on his rounds, and who made this her excuse for taking her off duty during visiting hours. This provoked a certain amount of audience reaction later on, when battle was joined between Mrs Rigby and Dr G L Mills, in charge of geriatric services at the Central Middlesex Hospital, who was very much opposed to the suggestion that a ward sister should not accompany the consultant.

Mrs Rigby's final attack was on changed attitudes. Junior nurses and doctors today, she said, tended to imagine they were there for themselves alone, and gone was the day when the patient was a welcome guest. Nowadays he was made to feel a complete nuisance. The cause of this, she believed, was to be found in the work of theorists, and she ended by saying she would like to see on the walls of every hospital, regional board and Department of Health itself the slogan 'Danger - Theorists at Work!'

Teesside Geriatric Care Association

After this hard-hitting delivery the next two speakers presented a much more comfortable picture of a successful geriatric association started on Teesside three years ago. Dr D M Prinsley, consultant physician, S and N Teesside Hospitals, said its aims were mainly educational, to improve staff knowledge and morale, and thereby indirectly improve geriatric care, but the social side was also encouraged and developed, and the monthly lectures, which covered a wide range, were preceded by a social gathering. There had been a recent and most successful trip to Rotterdam, for which the Association hired an entire ship with 88 berths, and visited the Dutch equivalent of Part III accommodation.

Mrs M G Hill, secretary of the Association, gave a description of the organisation and membership, which included all grades of medical and nursing staff. Of the 200 members, 150 were from the hospital field (five hospitals were associated in the geriatric department) and the remainder from the local authorities. Membership subscription was 25p per annum and an annual dance showed a small profit.

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Teesside Central Care Agency

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Involvement of relatives

Questions and comment from the audience started around Mrs Rigby's remarks on ward sisters, consultants and relatives; Mrs Rigby, said one delegate, had put the consultant in perspective. Should not relatives be encouraged to visit at the time of the consultant's round? Mrs Rigby and Dr Prinsley were all in favour, but Dr Mills strongly disagreed. The first responsibility of a consultant, he said, who had a big enough retinue already, was diagnosis and treatment of the patient, and relatives should not be there when technicalities were discussed, although 'relatives conferences', such as are held in the geriatric unit at Edgware General Hospital, were quite a different thing.

Dr Baker was asked why his team had no lay member; the answer seemed to be a doubt as to what exactly, in such a team, would be a lay person's role. The chairman, however, also thought it a good idea for the lay point of view to be included, and Dr Baker said he was open to suggestions. He was also asked the inevitable question about shortages of geriatric beds and Part III accommodation, and in reply said there was far too much preoccupation with the 'bed' and the hospital end of the service and insufficient attention given to what could be done outside.

In contrasting the number of consultant geriatricians - about 200 - with the number of general practitioners - about 20,000 - he thought we jumped patients far too quickly from total independence at home to total dependence in hospital. A better way of using our energies than as at present might be in the institution of seven-day day hospitals, opening from morning to evening. This brought forth mention of their high cost - higher than that for an ordinary hospital bed - due to the expense of the ambulance service needed, and this again, Dr Baker suggested, might need a look into alternatives to using ambulances.

Points were made by delegates about the ways that could be used to 'bridge the gap' for patients not well enough to live in Part III accommodation and yet not ill enough for hospital, and the system of 'six weeks in, six weeks out' that could bring hospitals and relatives together as partners in sharing the burden. As Dr Baker had said early in the conference, the ideas are there; in some areas good ideas have materialised into practice and are improving the standards of geriatric care. If by the end of this series of conferences the scope of such improvements is on the way to being widened further, then the objectives of those responsible will be being achieved.

2. OLD AGE - NOT AN ILLNESS
(Voluntary services for the elderly in the community)

Conference on Tuesday 7 July 1970

Chairman: Dr E W Wright
Medical Officer of Health
London Borough of Waltham Forest

10.00 - 10.30 a m	Coffee
10.30 - 10.35 a m	Introduction by Chairman
10.35 - 11.00 a m	GETTING OLDER - opportunities and problems Mr A Sheridan Retirement Officer Kodak Limited
11.00 - 11.25 a m	CIRCUMVENTING THE PROCESS OF AGEING Dr Monnica Stewart Assistant Physician Geriatric Department Edgware General Hospital
11.25 - 11.50 a m	Discussion
11.50 - 12.00 noon	Break
12.00 - 12.45 p m	Syndicates : introduction to projects
12.45 - 2.15 p m	Lunch
2.15 - 3.30 p m	Syndicate projects
3.30 - 3.45 p m	Tea
3.45 - 4.15 p m	Syndicates report back
4.15 - 4.45 p m	General discussion
4.45 p m	Close of conference

Lunch

Syndicate project

Tea

Syndicate report back

General discussion

Close of conference

2. VOLUNTARY SERVICES FOR THE ELDERLY IN THE COMMUNITY

Nurses, social workers and voluntary service organisers attended the second Hospital Centre conference on geriatric services. The theme of this meeting was that old age was not an illness. Rather it was a period of freedom and opportunity which might last as long as a man's working life. Voluntary service could help old people to realise these opportunities and to live healthy and purposeful lives. The chairman was Dr E W Wright, medical officer of health, London Borough of Waltham Forest. He pointed out that even with the paid staff who dealt with old people, it was the voluntary approach which counted. It was what people gave of themselves which made the difference in caring for others.

Getting older - opportunities and problems

The role of industry in helping old people face the problems and opportunities of retirement was described by Mr A Sheridan, retirement officer, Kodak Ltd. He pointed out that the employment situation worked against tailing people off from work slowly, and that many people had suddenly to face up to the problems of retirement. These fell into four main groups: money, work, routine and companionship. The old person's happiness depended more on his mental adjustment to retirement than on his income, as long as he had enough money to get by. A man missed his work because it had provided him with status and with a sense of purpose. The absence of routine might lead to aimlessness and slipshod habits. Above all, the pensioner missed the companionship of workmates who were isolated from his home situation but who could act as a safety valve for domestic difficulties or share in family joys.

Industry had a great role to play in preparing its employees for retirement. Such preparation need not start fifteen years before employees were due to leave, but it was no use at all attempting to prepare a man for retirement three months before his retirement date. Some happy medium between these two, according to the circumstances prevailing in the situation, was the best that could be offered. This varies from two to ten years before retirement date. It was, on the other hand, no solution to avoid this by keeping men in employment until they dropped, although some men might prefer this. Prolonged employment did not solve the community or individual problem of preparation for old age, nor was it applicable in an age of automation and reducing job opportunities. The old person's greatest resource in preparing for retirement was his experience and his knowledge of himself. No outsider could tell someone else how to spend his leisure time or retirement years. The pre-retirement courses held at Kodak were for 25 - 30 employees at a time and were taken by speakers from outside the company. After a lifetime of being directed by his employer, a man did not want the firm to tell him how to spend his retirement. The talks were aimed at preparing people to live within their pension income, to keep in good health and to find a sense of purpose and companionship. If a man achieved this, he could hope to live his retirement life and not just wait to die.

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Achieving effective living

The idea of purposeful and healthy retirement was taken up strongly by the second speaker, Dr M Stewart, assistant physician, geriatric department, Edgware General Hospital. She pointed out that there was no way of circumventing the process of ageing but that this need not mean that old age was a twilight of living death. Effective living could be achieved but this depended on individual attitudes and whether or not disability was allowed to become a handicap. Old age could be an opportunity if a person was able, or was helped, to know himself.

Grinding poverty had been eradicated, but the life of the elderly often lacked quality rather than quantity. A combination of small events in an old person's life such as a fall, the end of tradesmen's deliveries, and so on could lead to isolation and to loss of the will to live. Doctors often found it easier to concentrate on technicalities of care rather than the quality of a person's life; yet if life ceased to be meaningful, medical care was not enough to keep an old person alive. New dwellings, public transport and shops were not being conceived with the needs of an ageing community in mind.

It was not enough to offer an old person loving care; the old person also had to be able to give to others and to feel that he was still needed. It was never too late for any person to achieve a sense of purpose or to realise that 'tomorrow is the first day of the beginning of the rest of my life'.

Voluntary work and the newly retired

In discussion, this problem of meaningful activity and interests for the elderly was put in the wider context of educating all age groups to use the increasing leisure time available to them, and the extent to which this type of education would make the transition to retirement easier. Life had to be seen as a continuing learning experience which might include retraining for a second job or for part-time work or voluntary interests after retirement.

Voluntary workers could provide a valuable service by running employment bureaux for old people. Volunteers visited local firms to look for jobs suitable for old people and then allocated them. This had been working well in some areas but the Selective Employment Tax had discouraged most employers from taking on part-timers.

The development of commuting, and the number of people who lived in one community and worked in another, was felt to add to retirement problems. These people often had no home community involvement and were lost when they came to retirement. Many old people did not want to join Old People's Clubs, and Dr Stewart and other members of the audience clearly sympathised with this viewpoint. This 'loner' type of person might, however, welcome a regular visitor or join in a scheme to help others. Pre-retirement courses in industry were, for example, making some 60 - 65 year olds think about what they could do for their workmates who had retired some 10 - 15 years before and were possibly becoming frail and isolated.

Achieving effective living

Voluntary work and the needy

There were many suggestions as to how old people could be kept active and involved, which pointed up the speakers' two main points: that each old person was a unique individual, and that each was entitled to the retirement pattern which suited him best. Both statutory and voluntary workers had an obligation to help the old person to 'choose life' for himself, and not to decide it for him. It was an arrogance to tell other people what to do with their leisure. This was not to say there was nothing to do. There was a need for an improvement in the leisure facilities available. There was a need for more up-to-date song books and suitable sketches and plays for use in Old People's Clubs. There should be more books in large print and more adult education classes in premises which were attractive and comfortable for the elderly. There should be modern leisure facilities with meals available on the premises.

Voluntary Service by the old for the old

Voluntary service by old people for other old, or even younger, people might fulfil a need after retirement. It could replace the status and sense of purpose which had been provided by work. One speaker pointed out that elderly people were now being pushed out of positions of responsibility in many voluntary organisations to make way for younger members at just the point at which they could give, and needed to give, their full attention to the organisation. It was important not to let old people fall down on their voluntary service because the needs of the client had to be put first. Careful selection and placement, however, should ensure that every volunteer found a niche where he could give as well as receive. This applied to any volunteer who worked for the elderly. They also had to be able to sustain any task which they took on, because routine was very important to old people and clients needed to know what they could expect of a volunteer.

Statutory officers, present at the meeting, pointed out that it was not an admission of failure for a voluntary body to hand a client over to a statutory body. There should be a pattern of partnership like that described in the Gospels, when the Good Samaritan handed the traveller over to the paid care of the innkeeper. There was a need for better communications with voluntary bodies so that both the statutory authorities and the old people themselves knew where to find voluntary help. The first channel of communication could be improved by the appointment of one person in each organisation to undertake liaison, and the second by the publication of a booklet to go out with all new pension books, giving details of all statutory and voluntary services in a local authority area. Local welfare clinics might act as clearing houses for this kind of information and an increase in the number of health visitors would allow for more routine geriatric visiting. A number of people felt that the many voluntary bodies should amalgamate and define their areas of activity, but others felt that this might lead to gaps in the net of care that those in need might fall through.

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3. PREPARATION FOR RETIREMENT & EMPLOYMENT OF THE ELDERLY

Conference on Wednesday 15 July 1970

Chairman: Dr F A Binks
Consultant Physician
Edgware General Hospital

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Mr M C Hardie
10.35 - 10.40 a m	Introduction by the Chairman
10.40 - 11.00 a m	PREPARATION FOR RETIREMENT Miss L M Hubbard Secretary Pre-Retirement Association
11.00 - 11.15 a m	PRE-RETIREMENT PREPARATION IN THE HEALTH SERVICE Dr A Gatherer Medical Officer of Health Reading County Borough
11.15 - 11.30 a m	PRE-RETIREMENT EDUCATION Dr Arthur Dalzell-Ward Director Field Services The Health Education Council
11.30 - 11.45 a m	THE ROLE OF THE LOCAL EDUCATION AUTHORITY Mrs E M Errington Mander College, Bedford
11.45 - 11.55 a m	Interval
11.55 - 12.45 p m	Questions and discussion opened by Miss M Davis Regional Nursing Officer Oxford Regional Hospital Board
12.45 - 2.15 p m	Buffet lunch and tour of exhibition
2.15 - 2.30 p m	EMPLOYMENT OF THE ELDERLY Mr R V MacKay Department of Employment and Productivity
2.30 - 2.45 p m	PENSIONERS IN SEARCH OF A JOB Mr F Le Gros Clark
2.45 - 3.00 p m	FOSTERING DEVELOPMENT OF HOBBIES (Fircone Groups) Mr Wilfrid Nicholson Birmingham Pre-Retirement Council
3.00 - 3.15 p m	WORKSHOPS FOR THE ELDERLY Dr Margaret A Glass The Employment Fellowship
3.15 - 3.25 p m	Interval
3.25 - 4.15 p m	Questions, discussion and summing up

3. PREPARATION FOR RETIREMENT

Conference

Chairman:

10.00 - 10.30 a m

10.30 - 10.35 a m

10.35 - 10.40 a m

10.40 - 11.00 a m

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12.45 - 2.15 p m

2.15 - 2.30 p m

2.30 - 2.45 p m

2.45 - 3.00 p m

Mr Wilmot

3.00 - 3.15 p m WORKSHOPS FOR

Dr Margaret A

The Employment

3.15 - 3.25 p m Interval

3.25 - 4.15 p m Questions, discussion and

3. PREPARATION FOR RETIREMENT AND EMPLOYMENT OF THE ELDERLY

Preparation for retirement is probably the most important of all the 'preventive' measures which can be taken to ease the problems posed by caring for the elderly. But it should be remembered that not all old people want to retire at the usual age of 65. Many want to go on working. This is an aspect of the old age problem which merits attention. Both preparation for retirement and employment for old people were dealt with in the third conference on geriatric services, under the chairmanship of Dr F A Binks, consultant physician to the geriatric service at the Hendon Group of Hospitals.

The Pre-Retirement Association

Miss L M Hubbard, secretary of the Pre-Retirement Association, an organisation which exists largely to promote an awareness of the need for people to prepare for their retirement with the same care they devote to planning their careers, spoke of the association's work, much of which is delegated to local associations. The association plays a very large part in planning syllabuses for pre-retirement courses, compiling reading lists and speakers' notes. The growth in local associations - there was only one in 1951, now there are branches all over the country - is an indication of the PRA's success.

That there is a need for advice and help cannot be doubted. As Miss Hubbard pointed out, most people need to substitute for the excitement and activity of a full-time job. There is, she said, great need to prepare for the phase of life following retirement; a period which can occupy from 10 - 15 years. The pre-retirement problem will grow no smaller. By 1980 one-sixth of the population will be pensionable but only 20 per cent of these people will be fully occupied and have no problems. Many of the rest will need help and encouragement to be able to face their retirement 'with purpose and enjoyment'.

By far the worst hit, of course, are executives who find it difficult to give up responsibility at a comparatively early age. This, too, is a problem unlikely to diminish.

The role of the NHS

The Health Service itself may have a part to play in preparing people for retirement. This was suggested by Dr A Gatherer, medical officer of health, Reading. This concern should also, he said, be extended to the Health Service's own employees. Dr Gatherer stressed the responsibility of the NHS for providing information and guidance on this period of life for its employees. In his view, the service displayed 'an abysmal lack of concern' in not providing an occupational health service for its staff. Good management, he said, should promote a staff welfare service which would include pre-retirement education. (Perhaps some of the hospital occupational health departments now being set up in hospitals in various parts of the country will take on this task.)

3. PREPARATION FOR RETIREMENT

Perhaps research is the most important need of all. We know little about the pre-retirement period and we know little about the retraining of older workers. Dr Gatherer referred to the research now being done at Cambridge by Belbin and Le Gros Clark - research based on the 1961 and 1966 census figures. It is, perhaps, useful here to point out that research for the geriatric exhibition threw up some interesting examples of employing people past retirement age. Nearly all the firms which employed older workers were satisfied with their performance and above all with their reliability which offset their slower working rates. In one or two cases older skilled workers were used to carry out 'one-off' jobs - repairs on assembly line products, for example, which would otherwise have been too costly a service to offer customers. One firm deliberately employed a number of pensioners as telephonists and trained them for the job with excellent results for all concerned.

Education and preparation

Dr A Dalzell-Ward, director, Field Services, Health Education Council, touched upon a subject dealt with in detail during a previous series of Hospital Centre conferences (New Ways Towards Learning, THC Reprint No. 448), namely education. He spoke of the need for continuing education and the fact that, for every phase of life, we need preparation. This is, of course, vitally important in helping people to cope with what is often 'the trauma of retirement'. Such preparation could, he suggested, be related to health education. Group psychotherapy, discussions and films are excellent ways of overcoming the rigidity of mind which often settles upon people in retirement. There is a need to offer new interests in place of the old.

Mrs E M Errington is a member of the teaching staff at Mander College, Bedford and is now tutor to the college's pre-retirement courses. This came about as the result of an initiative from Bedford Pre-Retirement Association to form a viewing and discussion group around the BBC's series 'Forward to Retirement'. This was attended by 20 people of ages ranging from 61 to 82 and proved so successful and stimulating that the college was asked to take over the running of pre-retirement courses in Bedford. They agreed to do so because preparation for retirement was considered to be a valid part of adult education. In addition, they had the facilities and the experience needed to create an atmosphere "in which even the shyest, most inarticulate member of a class can gradually be drawn into effective participation." Bedford's courses have proved an immense success.

Subjects covered, apart from the basic pre-retirement course, include woodwork (for the retired) and plans are afoot to run a 'cookery for the retired' course. Course members have also taken up painting and Mrs Errington feels sure that many will find their way to the wide range of other courses offered by the college, and also to those held in Further Education Centres in both the Borough and County. One ex-engine driver, who went along somewhat diffidently to the nearest evening class in art, has now begun to sell some of his own work.

But equally important is the fact that people who have never entered any institute of further education are now inside one and are enjoying it. People who attend the pre-retirement courses always make comments like, "This has been an eye-opener; everyone ought to know about it" or "I should like to go on coming to Mander College for the rest of my life." Their morale has received a boost because people are now interested in their opinions and they learn more, almost, from each other than is actually being taught. "In retirement," said Mrs Errington, "they recognise that what unites them will be more important than what divides them. Many go on together to join the Bedford Retirement Club, the success of which is clearly seen in leaflets on that topic."

Educational facilities available

In the discussion that followed the morning's talks, one of the most useful and important contributions was made by a local authority education officer, who pointed out that if a group of people numbering about 15 or more wish to have a pre-retirement course (or any other course, for that matter) they should address their enquiry to the director of education of the local borough or county, asking whether some provision could be made.

The matter will then be referred to the appropriate education officer - for further education or adult education, who will make all necessary arrangements with the local college. The education authorities will provide lecturers and teaching accommodation. The members attending such a course will be required to pay the usual fee applicable to all those who enter adult courses of further education.

Employing the older person - the role of the DEP

Employing, rather than occupying, the older person is far more difficult, and the afternoon session was devoted to that topic. First to speak was Mr R V MacKay of the Department of Employment and Productivity. The DEP is keen to persuade employers to allow workers to continue their jobs past retirement age if they so wish. Many employers are quite happy to do so. But they are not usually so keen to take on older men as new employees. The DEP does its best, where it feels an upper age limit has been added to a job specification unnecessarily, to persuade the employer to change his mind. The reason for the Department's keenness to get the older worker into employment is based on more than sympathy. It is based on economic and manpower problems which began to be evident during the last war and which became generally recognised in 1951. This policy of persuading employers to retain and employ older workers takes on a new urgency when it is realised that by 1981 people of retiring age will equal 25 per cent of the working population.

The DEP has no upper age limit for assisting people to find jobs but most of its experience, naturally enough, is with those under 65. Experience with the 60-65 age group has shown that the problems of placement are complicated by three factors:

But equally important is the fact that [illegible]
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three factors:

-- the area in which the worker lives
-- the type of work he requires
-- the hours he is prepared to work.

The area of residence is an overriding factor. Prospects, apparently, are best in London and diminish as one moves outward. Coastal towns are particularly difficult because there is intense competition for the few jobs available to older workers.

Type of work is also a problem. Manual workers have the least difficulty, executives the most. Clerical staff come somewhere in between with the jobs available to them being mostly routine. As there is no general tradition of part-time work for men (as there is for women) this, too, can pose problems. Mr MacKay said the short working day is the most difficult to arrange and that although men do succeed, sometimes, in finding part-time jobs, these are most likely to be of the short working week or seasonal variety.

This final point about the difficulty of getting part-time work was underlined by Mr F Le Gros Clark, a member of the Industrial Training Research Unit, Cambridge. The earnings rule is the major limiting factor. It means, quite simply, that if a retired person earns more than a certain sum each week, over and above his state pension, he loses a proportion of that pension. The limit at present is £7.10.0. (£7.50) a week. Because of this he needs part-time work and as Mr MacKay has shown, this is not easy to come by. And, as Mr Le Gros Clark said, "If part-time work were easy to find, we should not need to discuss it. But the market is a very restricted one for men of any age."

Employing the older person - the role of the voluntary agency

Despite its willingness to help, the DEP is not the best organisation to find work for those past retiring age, said Mr Le Gros Clark. In areas where there is a pool of unemployed, those most in need of jobs are men in the 55 to 64 age group. It is for this reason that local DEPs are glad when some form of voluntary agency takes on the burden of finding work for older men.

Over the years a number of such agencies have taken on the task and the work of eight of them in the South and the Midlands has been analysed. At the time of analysis they covered 786 men. The breakdown of jobs offered and the percentage of pensioners who accepted them is given in the following table:

Handymen, cleaners and the like	50.0
Clerical jobs	15.3
Gardening etc.	12.4
Van driving and chauffeuring	5.5
Garages, petrol pumps and parking sites	4.1
Miscellaneous jobs	12.7

This shows that when a retired man does get a job, there is an even chance it will be that of cleaner or handyman. The place of work may be a small factory, an office building, a block of flats, a catering establishment or a private household. A breakdown of prospective employers showed that 40 per cent of

-- the area in which the [illegible]
-- the type of work he is seeking
-- the hours he is prepared to work

The area of residence is an overriding [illegible]
best in London and diminish as one moves [illegible]
particularly difficult because there is [illegible]
available to older workers.

Type of work is also [illegible]
executives the most [illegible]
available to them being [illegible]
part-time work for men [illegible]
Mr Mackay said the short [illegible]
although men do succeed [illegible]
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This final point about the [illegible]
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Mr Le Gros Clark said. [illegible]
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Employing the older person

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percentage of pensioners who accepted them to give to the [illegible]

Handymen, cleaners and the like	[illegible]
Clerical jobs	[illegible]
Gardening etc.	[illegible]
Van driving and chauffeuring	[illegible]
Garages, petrol pumps and parking [illegible]	[illegible]
Miscellaneous jobs	2

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all enquiries came from private households, 9 per cent from retail shops, public houses and restaurants. Only about 15 per cent were for men possessing specific skills and industrial experience.

"It is evident," said Mr Le Gros Clark, "that part-time work lies along the by-ways of employment. We must realise that more than 80 per cent of the jobs offered fell within the 'service' class of employment." Needs of pensioners, as he pointed out, are best met in this direction by voluntary agencies. In his view, one of the most useful services any industry or local authority could do for its pensioners would be to make it known "that a modest subsidy would be available for any bona fide agency established in the area prepared to seek avenues of suitable employment for those in retirement."

Birmingham Retirement Council and FIR-Cone Groups

One voluntary organisation doing sterling work is the Birmingham Retirement Council (BRC), set up in 1961. Its work was described by a member of its Executive, Mr W Nicholson. A special feature of the work of the BRC, and one for which Mr Nicholson has special responsibility, is FIR-Cone (Friends-In-Retirement) Groups.

The formation of these groups was inspired by the help and advice sought from the BRC by retired men and women who wished to make the fullest use of their new life of leisure. "Dimly distant recollections of their school days" discouraged many of them from utilising the resources offered by the local education authority. Was there any demand for groups to pursue some subject or hobby together? The BRC decided to make a trial, and in March 1966 some 150 retired men and women met to discuss such a project. Their enthusiasm was evident and a first group interested in woodwork was started almost immediately. From this nucleus FIR-Cone has developed steadily, and the initial pattern has been followed with suitable modifications. An instructor with experience in the subject is sought within the group; they are happy to pass on their knowledge and improve their own techniques. Where qualified skill is essential, for example in dressmaking, fitness exercises, the help of the local education authority is requested; other volunteers generously give of their time. Each group manages its own internal affairs with a leader acting as secretary and liaison with BRC - they also keep in touch with members unable to attend through illness and arrange hospital visits where necessary. A monthly meeting of leaders determines FIR-Cone policy as a whole, and joint projects are planned involving all members.

FIR-Cone groups were offered as an opportunity for joint occupation - they have proved to fulfil the urgent needs felt by many retired men and women for social contacts and a niche in the community - members are indeed Friends-In-Retirement. The groups now number over 50 with a wide range of subjects and some 1,500 members. The demand is increasing as some 1,700 men and women wait to join groups when instructors or premises become available. Little publicity has been possible: the press is kind to us, but the majority of people join through personal contacts.

The BRC is a success, running both pre-retirement courses and post-retirement groups; and its executive and staff are mainly retired. But it is worth stressing what Mr Nicholson said. The success would not be possible without the support received from all sectors of the community; from the Lord Mayor, the City Council, board of directors, local government and personnel officers, and trade union officials.

Workshops for the elderly

Dr Margaret Glass, from the Employment Fellowship, described the establishment of workshops for the elderly. The first was founded in Finsbury in 1951 and people came to work for about two hours each day. (Workshops have improved, as visitors to the geriatric exhibition and readers of the booklet, Improving Care for the Elderly will realise, a great deal since then.) But the greatest need remains the same - that of keeping old people not only housed but happily occupied. For this, said Dr Glass, the help of employers and local authorities is needed with buildings, money and so on.

And to make a case for this really demands many more facts. As Dr Kidd, chief medical officer, Northern Ireland Hospitals Authority said during discussion, "No one has identified the problem - the size of the problem and the statistics."

4. SCREENING AND ADVISORY SERVICES

Conference on Thursday 30 July 1970

Chairman: Dr C A Boucher OBE
Medical Adviser
British Red Cross Society

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Mr M C Hardie
10.35 - 10.40 a m	Introduction by the Chairman
10.40 - 11.10 a m	ASSESSING THE NEED FOR GERIATRIC SERVICES Professor W Ferguson Anderson Department of Geriatric Medicine Stobhill General Hospital, Glasgow
11.10 - 11.40 a m	THE HEALTH CHECK AND THE GENERAL PRACTITIONER Dr John D Harte General Practitioner Bedford
11.40 - 12.00 noon	THE ESSEX COUNTY COUNCIL SURVEY Mr W E Boyce OBE County Welfare Officer Essex County Council
12.00 - 12.10 p m	Interval
12.10 - 12.45 p m	Questions and discussion
12.45 - 2.15 p m	Buffet lunch and tour of exhibition
2.15 - 2.30 p m	GERIATRIC ADVISORY SERVICES Dr C Burns Director of Public Health London Borough of Islington
2.30 - 2.45 p m	THE REDBRIDGE SCHEME Dr T B Dunn Consultant Physician Chadwell Heath Hospital
2.45 - 3.00 p m	GERIATRIC COMMUNITY CARE Dr Charles Hodes General Practitioner Boreham Wood
3.00 - 3.15 p m	MEETING THE NEED Miss H Smith Health Visitor attached to group practice London Borough of Islington
3.15 - 3.25 p m	Interval
3.25 - 4.00 p m	Questions, discussion and summing up

4. SCREENING, ASSESSMENT OF NEED AND ADVISORY SERVICES

Screening and advisory services, used scientifically, are most useful tools for dealing with the geriatric problem. This became clear during the fourth conference in the series on geriatric services. The theme of the conference, as Dr Boucher, medical adviser to the British Red Cross Society, pointed out, should concern itself with "a more realistic and rewarding approach."

Few people know as much about the geriatric problem as Professor W A Ferguson Anderson, professor of geriatric medicine at Glasgow University. Professor Anderson, after reviewing the past development of geriatric services - a development that really got into its stride with the foundation of the NHS, which concentrated initially on beds and homes for the elderly and in which demand for services "has been without parallel" - then went on to describe the pattern of service needed for the future.

Future patterns of service

The problem for the future is to discover unmet need, bring care and treatment to bear and do everything possible to enable each old person to remain in the community for as long as possible. Screening, to discover those at risk, assessment, to bring the most effective form of treatment to bear, all carried out by a geriatric team based on a community health centre or group practice and using a team of general practitioner, health visitor, district nurse and other specialists, is the method for the future. This service should be part of an area geriatric service based, where possible, on a district general hospital and including continuing treatment units, long-stay beds, provision for the mentally frail, day hospitals and out-patient facilities. "This kind of comprehensive service," said Professor Anderson, "seems necessary for old people."

What is needed, said the professor, is a comprehensive service which will provide assessment and community services, which will recognise the value of protected housing and which will have provision for the physically and mentally frail. Such a service must be used economically and this demands both medical and social assessment. As he pointed out, it is very costly to provide an old person with a home help, if the pernicious anaemia from which that old person may be suffering and which made the provision of a home help necessary in the first place, remains untreated. By its very existence, such a service can have a 'spin-off'. In Glasgow the social conditions are recorded at the assessment pre-admission visits by the physician in geriatric medicine, and when comparison is made between these conditions at the start of the geriatric service and now it is noted that there is increased provision of baths, a reduction in the number of outside toilets and a general improvement in the standards of cleanliness among old people.

ASSESSMENT OF NEED AND ADVISORY SERVICES

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The need at the moment is for more academic appointments so that career prospects in work with geriatrics can be seen to be recognised as important. "Let the people in authority," he said, "give recognition to geriatrics." It is also important, as Dr Brotherston has pointed out "... to come to terms with the fact that the aged are here to stay and in increasing numbers."

Health checks and the GP

Professor Anderson had set the scene. Others looked at the details. Dr John Harte, a general practitioner from Bedford, talked about the health check and the GP. Unlike many of his colleagues, Dr Harte is convinced of the value of the social medical health check for many reasons, one of the most important being to overcome the kind of service 'on demand' which imposes such burdens on the services available and which leaves so much need untouched. Basically, Dr Harte is trying to identify problems before they reach the point of breakdown. He is looking at groups of people in order to identify their individual priorities and as a result of conducting his own survey has discovered areas of need and gaps in the service he was providing which he had no idea existed. He was able to discover potential vulnerable groups and he can now plan to meet their needs. He would like to extend the survey to the 30 to 50 age group because these people hardly ever visit the GP's surgery and because they should be offered health checks. In this way the GP could build up a health profile of all his patients and by making use of the unique doctor/patient relationship could encourage patients to undergo the treatment or changes in their way of life needed to avoid future illnesses. Such a health profile would avoid much of the crisis management which is so common a feature of general practice and would allow for the development of a good on-going doctor/patient relationship without the stress of the crisis relationship.

Not all GPs feel they can undertake this kind of study and it is initially a time-consuming business, but once completed can conserve time. But much more can be done with the information the GP already has: with the list of patients, the NHS identification number and the creation and maintenance of an age and sex register. The register is also time-consuming, but perhaps time could be saved if it could be maintained by the local executive council using a computer. Certainly a great deal of the initial investigation, follow-up and support can be undertaken by attached health visitors and district nurses working directly from the GP lists and essential priorities of need can then be met.

Needs of the old people - a survey

Even financial stringency can have its blessings. "Essex County Council, as part of a general review of services, carried out a survey into the needs of old people to make sure that the limited financial resources available were being put to the best possible use." In co-operation with the local executive council and with voluntary organisations it surveyed old people over 75 in six selected areas. The findings of this very detailed survey, described by

Mr W E Boyce, county welfare officer, are now being put through a computer and a full report is to be published in collaboration with the Department of Health and Social Security. An initial study of the information coming from the surveys has enabled Essex to identify some major areas of need and action is already being taken to develop in the following four main areas:

- a personal contact service for old people at risk in the community
- further development of housing suited to the special needs of old people
- the improvement of deficiencies in the present domiciliary services both statutory and voluntary (although these have proved less formidable than was at first feared)
- the extension of existing social and recreational facilities for old people.

Apart from these concrete findings, the survey itself proved valuable in many ways. It showed, for example, that there were variations in need and demand from area to area. This proves the fatuity of applying general solutions to particular areas and underlines the need for local research before action is taken. The survey also showed that a large number of old people entitled to statutory help, such as the physically handicapped, were not aware of the services to which they were entitled - in one area, 50 per cent of handicapped old people had not registered with the local health authority.

But even more interesting were some of the side effects of the exercise. A great deal of press publicity was given to the survey and it was found that there was a direct correlation between amount of publicity given and the response received. And in terms of 'spin off' those areas which had not been selected for survey were rather cross about it and decided to do their own, using voluntary organisations. Most important of all, from Essex's point of view, was the experience gained in working with voluntary organisations on this kind of exercise. "We have," said Mr Boyce, "realised limitations on both sides."

Geriatric Advisory Service

Some people pin great hopes on geriatric advisory services. But they may not work so well in practice, and one example of this was given by Dr C Burns, director of public health, London Borough of Islington. In Islington the advisory service really falls into two parts - a service for clinical examination and assessment carried out by a local authority medical officer, and a service for health education and social contact. The medical assessment service, which has been running now for four years, relies on personal request for examination from old people or on referral from geriatric visitors and other sources. Over four years it has dealt with 407 people out of a total over-65 population in the borough of 28,000. The scheme, therefore, only makes a small impact. In fact the service is declining. Initially, and in

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response to widespread publicity, the response was good, but in the first half of this year only 20 people have been seen. Medical staff involved wonder if they were reaching the right people. Perhaps, said Dr Burns, a service of this kind would be better organised by a GP and his team of attached local authority staff. Initial screening, limited to handicapping conditions which were capable of relief, would be carried out by a geriatric health visitor who would refer persons requiring further examination or investigation to the general practitioner, or where he was too hard-pressed, to a local authority doctor.

Much more successful are the health education sessions. Held two or three times a week in various parts of the borough, these get regular attendances of 40 to 50 old people. Programmes vary from the social to the educational and include films, group physiotherapy and so on. All are run in close conjunction with the borough's health education staff.

Screening - with limited resources

The Redbridge scheme is basically an attempt to carry out screening as thoroughly as possible within limited resources. It was described by Dr T B Dunn, consultant physician, Chadwell Heath Hospital. Nine GPs undertake screening on a rota basis, two GPs at a time, on behalf of the eighteen GPs at present in the scheme. GPs advise their patients to take part and of those invited about 40 per cent attend.

In addition to a questionnaire and a medical examination, they have blood taken for routine tests and are advised to have a chest X-ray. A copy of the examination report with the results of the blood tests and the recommendations of the examining doctor are sent to the patient's GP. Up to the end of 1969, 565 patients had been examined and 360 abnormalities of sufficient note to bring to the attention of the GP have been found. The scheme is considered sufficiently successful to continue development to see if it can continue on a larger scale. Consideration is also being given to the optimum age for initial examinations. At present one screening centre calls patients for examination at 65, while at the other they are called at 72.

Dr Dunn also described a survey conducted in Redbridge with the help of the GLC Intelligence Unit. The findings, similar to those reported by Mr Boyce, showed that the majority of the old people surveyed were fit and reasonably contented. Only 5 per cent considered themselves to be lonely and only 12 per cent wanted contacts outside their own families. However, the survey did show, "a clear need for improving the publicity to the elderly about their rights and about the services available."

response to widespread publicity. The response
of this year only 20 people have been
they were reaching the right people.
this kind would be better organised by
authority staff. Initial screening
were capable of relief, would be
would refer persons requiring
general practitioner or
doctor.

Much more successful are the health education
times a week in various parts of the
40 to 50 old people. Programmes
include films, group physiotherapy
with the borough's health education

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Prevention

Dr Charles Hodes of Boreham Wood is a general practitioner who has turned firmly towards preventive medicine. Now that he has health visitors attached to his practice he is able to screen patients from 35 onwards and provide a sickness service. His screening is carried out by district nurses and the follow-up by health visitors. Patients are called for screening by the computer which holds the files and patients are placed into categories. According to these categories, patients may be placed on a routine visiting rota, sent to hospital or residential care. The team approach works well in Dr Hodes' practice. Health visitors run obesity clinics and because they are all trained in psychotherapy are able to deal with patients' more fundamental needs. District nurses carry out a wide range of treatment clinics. An innovation that could well be followed up by other practices is the 'grief visit'. It is practice policy for a health visitor to visit every family which has had a death and to provide them with support and help where needed.

The practice team does not confine itself to work within the practice. They also follow up patients when they are placed in residential care and in the future Dr Hodes hopes to have small groups consisting of residential patients and day-care patients, which will be run by trained voluntary workers.

Miss Smith is a health visitor attached to a group practice in Islington. A significant part of her work is running a geriatric advisory clinic. This, she said, has three aims: prevention, to encourage old people to assist each other and to give them the opportunity for regular health checks with their own doctor. Miss Smith's role is organiser, educator, helper and friend.

She organises a three-month programme which includes films on health education and general topics, outside speakers, discussions, quizzes, physiotherapy and cookery demonstrations. She is also involved in a great deal of counselling because many of her old people, living as they do in a re-housing area, are anxious about their future. Miss Smith does what she can to sort out immediate problems and turns those of a long-term nature over to the borough's geriatric visitors. This enables her to bring a wide range of services to bear and avoids duplication of effort.

Discussion threw up many points. It emphasised the need for housing authorities to be closely tied in with planning for old people. It stressed the need to involve local ministers of religion, a topic very dear to Professor Anderson's heart, who said, "I would like to see a place for them in the health centre." Concern was expressed about a national retirement policy which stopped people working at a fixed age and which penalised them financially if they went on doing so.

The role of the day centre also came under scrutiny. One group thought the emphasis should be on providing a full range of services for old people; another considered that the day hospital's main role was to relieve hard-pressed relatives. Professor Anderson also considered that the present old people's home was outmoded. He would like to see it transformed into a place

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where the old person could gain a far greater measure of independence, say some of his own cooking, for example, and not to be thoroughly shielded from life. Some homes, he felt, should be turned into homes for the mentally frail.

The whole subject of screening was called into question. There are those who see it as the complete answer and those who have their doubts. Several questions need answering. Does screening have dangerous side effects? Have we the resources? As Dr Hodes pointed out, at this stage we simply do not know. "We have to find out whether screening is a good thing - we have to discover what's in it for the patient." Screening may have side effects. It may produce anxieties, or it may give the patient a feeling that all is well and will remain so.

Old people are still people

Obviously a great deal more research is needed. Dr Monnica Stewart of Edgware General Hospital was concerned with wider issues. She wondered if we were putting people into lots of slots and forgetting that they are, first and foremost, people. "Are we," she said, "going to help people to become people?"

In his summing up, Dr Boucher recognised and agreed with Dr Stewart's anxiety. He said, "We do the greatest dis-service to old people by referring to them in such terms. It is undesirable to regard all people aged 65 years or more as old, and psychologically it is harmful. It would be better to recognise that some of us at all ages may depend on support. We stress too much that people of retirement age are an isolated group and thereby we accentuate their isolation."

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5. PSYCHOGERIATRIC SERVICES

Conference on Wednesday 9 September 1970

Chairman: Professor Martin Roth
Department of Psychological Medicine
Royal Victoria Infirmary & University of Newcastle-upon-Tyne

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Mr M C Hardie
10.35 - 10.40 a m	Introduction by Chairman
10.40 - 11.10 a m	THE WELFARE OF PSYCHOGERIATRIC PATIENTS Dr J A Whitehead Consultant Psychiatrist St Francis Hospital, Haywards Heath
11.10 - 11.25 a m	BOARD-OUT SCHEMES AND THE COMMUNITY'S CONTRIBUTION Mrs J V Graham Social Worker, Psychogeriatric Unit Severalls Hospital, Colchester
11.25 - 11.40 a m	DAY CARE AND EMERGENCY SERVICE Mrs M Garrod Ward Sister, Severalls Hospital, Colchester
11.40 - 11.55 a m	THE ROLE OF THE GENERAL PRACTITIONER Dr Peter Chapman General Practitioner, Colchester
11.55 - 12.05 p m	Interval
12.05 - 12.45 p m	Questions and discussion
12.45 - 2.15 p m	Buffet lunch and tour of exhibition
2.15 - 2.35 p m	INTEGRATED SERVICES FOR THE ELDERLY Dr R W Parnell Consultant Physician in Geriatrics Highcroft Hospital, Birmingham
2.35 - 2.55 p m	THE GOODMAYES PSYCHOGERIATRIC SERVICE Dr T H D Arie Consultant Psychiatrist Goodmayes Hospital, Ilford
2.55 - 3.15 p m	THE FUTURE OF PSYCHOGERIATRIC SERVICES Dr T S Wilson Consultant Geriatrician Barncoose Hospital, Redruth, Cornwall
3.15 - 3.20 p m	Interval
3.20 - 4.00 p m	Questions, discussion and summing up
4.00 p m	Tea

5. PSYCHOGERIATRIC SERVICES

[illegible]ference on Wednesday 7 September 1970

[illegible]ot Martin Nash
[illegible]ment of Psychological Medicine
[illegible]Victoria Infirmary [illegible]

[illegible]Notice of meeting

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[illegible]Mr M C [illegible]

[illegible]Introductions [illegible]

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[illegible]Speech [illegible]

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5. PSYCHOGERIATRIC SERVICES

The problem of providing treatment and care for mentally frail old people - psychogeriatrics - is one of the most difficult facing the NHS today. It is an indication of the concern surrounding this problem that this conference was the most heavily over-subscribed yet.

Although immense, the problem is not insoluble. This emerged clearly during the day and the scene was well set by the chairman, Professor Martin Roth of the department of Psychological Medicine, Royal Victoria Infirmary and University of Newcastle-upon-Tyne. A great deal is being done, but a great deal more needs to be done. As he said, the major ingredients of a solution have been with us for some time. We know the problem is vast, we know also that we need care in the community (because that is what old people want), we know also that we must have facilities.

But we have gone a long way. The geriatric wards have lost their "drab, workhouse-like appearance" in most cases. But, said Professor Roth, "the spirit of the workhouse is not yet dead." If we are honest, we must see that the progress made so far has been dwarfed by the immensity of the problem that remains.

The solution to this problem demands family involvement and responsibility, and a balance between what is Utopian and what is possible. "Above all," he said, "we must measure the quality of life." Not until then can one judge whether a realistic solution to provide geriatric services without long-term beds is possible. But, he concluded, advances of the past twenty years have shown that a lot of so-called degenerative changes are in fact due to disorder that can be alleviated or cured by attention to medical, emotional, social and environmental factors.

Dr J A Whitehead, now a consultant psychiatrist at St Francis Hospital, Haywards Heath, is best known for his work with the elderly at Severalls Hospital, Colchester. This work, which has been fully described elsewhere, includes close links between hospital and the community, boarding-out schemes and emergency services.

General hospital psychiatry - the dangers

But Dr Whitehead was most concerned to point out some of the dangers inherent in current policy towards the development of general hospital psychiatry. In his view the trend towards developing psychiatric units in district general hospitals could mean an eventual run-down in the quality of care offered by large psychiatric hospitals. This, he felt, would come about because an increase in general hospital units would mean that large psychiatric hospitals would cease to play an active part in psychiatric care. Their staff will be depleted and they will come to contain mainly old people and those unfortunates who have been rejected by the general hospital psychiatrist. General hospital

PSYCHOGERIATRIC SERVICES

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psychiatric units with a beddage of 0.5 per 1,000 population "cannot and will not deal with very old people." In Dr Whitehead's view this would mean that "the standard of care they (the psychiatric hospitals) provide will deteriorate until it could reach a level worse than anything that has been known in the past 100 years." Part of the answer, according to Dr Whitehead, is either for psychiatric hospitals to "be run down, closed and demolished so that there will be no temptation to use them as dustbins for those who are difficult to treat and help, or take on and maintain some active function." But before this can happen, each area will need a comprehensive general hospital psychiatric unit and the geriatric services will need to expand and develop. Once these changes have occurred, geriatricians could take over all hospital-based services for the old. The reasons for this, he said, are that old people present similar problems regardless of their illness and that the majority of psychiatrists are not particularly interested in the old. Geriatricians do have an interest and tend to be more aware of the special needs of the old. Geriatricians should also become more involved in the selection and care of old people (in welfare homes) and should, in fact, generally mastermind the service for the old. For this to happen, the geriatric services, including personnel and facilities, will need to be considerably expanded. The general practitioner should also play a key part.

Board-out schemes, day care and emergency services

Two more descriptions of the work at Severalls followed. One given by Mrs J V Graham, social worker in the hospital's psychogeriatric unit, was on boarding-out schemes, and the other given by Mrs M Garrod, a ward sister, was about day care and emergency services. Boarding-out is only one of a number of imaginative schemes run by Severalls. It is planned and carried out with care and skill, begins in the hospital with the preparation of the patient, allows informal contact with the hostess-to-be, includes a trial period and very careful follow-up. Finances are also carefully considered and constant support is provided for patients, relatives and hostesses. In addition to boarding-out, Severalls runs holiday schemes, guest houses, group homes (a joint project between hospital and local authority which has now reached the status of a charity) and close involvement with people in the community generally.

Day hospital care is also vital. Described by Mrs Garrod, the services at Severalls day hospital (which has a daily attendance of between 110 and 120 patients) effectively prevents hospital admission in 65 per cent of all patients referred. Among other advantages, day care gives relatives a break during the day. Facilities offered at the day hospital including bathing, chiropody, hairdressing, physiotherapy and medical and clinical needs, with particular attention being paid to ears, eyes, feet and bowels. Patients also enjoy a wide range of occupation and social activity. Experience, said Mrs Garrod, has shown that the day hospital helps to keep people in the community.

She also described the Severalls 'Flying Squad' which was started in 1966. The squad was ready at all times of the day and night to turn out to help old people in need. It was equipped to meet any emergency and was prepared to

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help with chores such as cooking, cleaning and repairs. The squad was made up of a doctor, nurse and social worker. The Flying Squad enabled a patient's immediate needs to be met, allowed time for an adequate assessment of needs and gave a breathing space in which further action could be taken. Although the squad as such has now been disbanded (the wide range of services provided by Severalls and in the community have rendered it almost obsolete) the equipment is still available and an emergency service, in which a social worker will go out when called, still exists.

Links with GPs

The link with the general practitioner in the Severalls area are good. The way in which this worked was described by Dr P Chapman, a GP in Colchester. His role has two main aspects: one is to make a decision once an elderly patient has been brought to his notice whether to admit the patient to hospital or not (can the family cope? Usually they can), and the other is to mobilise all the services needed on the patient's behalf. In this role the GP not only ensures that the patient receives the services needed but can also avoid intrusions on the patient's privacy and dignity. Responsibility taken by the GP, said Dr Chapman, will also help relatives to cope with their guilt feelings. If, on the other hand, admission is needed, it is the GP's task, on discharge, to ensure that supporting services are alerted if the hospital has not already done this.

Old people need a 'customer-orientated service'. This was said by Dr R W Parnell, consultant physician in geriatrics at the North Birmingham District Hospital. To achieve this demands integration of services, the abolition of waiting lists in order to give the GP free choice of placement, and extensive use of the day hospital. Dr Parnell is responsible for geriatric patients in both Good Hope General Hospital and Highcroft Hospital, which is a psychiatric hospital. In this arrangement, the selection of the type of treatment - geriatric or psychogeriatric - is left to the GP. 75 per cent of the admissions to Highcroft Hospital come under the geriatrician, the rest under psychiatrists. At Good Hope Hospital, consideration is being given to the allocation of a proportion of wards in Sheldon units for surgeons and physicians to continue to be responsible for the long-term care of their own patients. "It is good for them to understand long-term care," said Dr Parnell.

Waiting lists

This overall plan would not work, he said, if waiting lists were a factor. Waiting lists would limit a GP's choice of care. They must be abolished. How? By reducing the time spent by each patient in hospital and thus achieving a more equitable use of beds. Such a scheme can only work if it is supported by adequate community facilities, of which the day hospital is the key. According to Dr Parnell, there is a positive correlation between day patient facilities and patient turnover in psychiatric hospitals. The day hospital is valuable in getting patients discharged. In addition it exerts great influence on postponing admission. "You are," Dr Parnell concluded, "reducing in-patient stay at both ends."

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A new service

The service for old people at Goodmayes Hospital, Essex, was described by Dr T H D Arie, consultant psychiatrist, as "a new service for old people." It was started in its present form when he joined the hospital staff two years ago. The basic ideas behind it were to improve the quality of geriatric care and to prove to the staff that work with the old could be exciting and professionally rewarding. Dr Arie had few preconceived ideas about what such a service should offer, but he believed that the service should be available to all who needed it, that crises should be met with the minimum of fuss, that any solution, no matter how unorthodox, should be tried, that all work should be based on assessment, that communication should be open, easy and effective. "The situation should not collapse for want of the right hand knowing what the left was doing." Finally, Dr Arie and his staff were prepared to take responsibility for all that they did. There was to be no buck-passing.

At Goodmayes the service has developed to the happy point of good co-operation with local authorities, a steady flow of patients to local authority accommodation and to a most heartening change of attitudes on the part of matrons of residential homes when faced with the prospect of having ex-psychiatric patients.

Medical staffing

But perhaps the most exciting development has been with medical staffing. Dr Arie's unit is staffed almost entirely with young part-time married women training to be psychiatrists. Despite some initial problems with the regional board the scheme has been a success and the impact of these personable young women on old people, especially on the men, has been no mean one.

Over the past two years results are as follows: admissions are up by 22 per cent, discharges by 75 per cent, deaths down by 25 per cent. Deaths within a month of admission were 6.5 per cent compared with a rate for England and Wales of (1967 figures) 8.5 per cent.

But the lesson to be learned from Dr Arie lies not only with statistics. It lies with attitudes. He and his team are prepared to try the new and unconventional - to think again. As he said in conclusion, "The care of the old cannot wait upon Utopias, for many of them will be dead long before then."

Assessment

Psychogeriatric services for the future was the theme of Dr T S Wilson, consultant geriatrician, Barncoose Hospital, Cornwall. He spoke mainly on the pattern of care which has emerged in Cornwall over the last few years and dwelt particularly upon the value of assessment. Psychogeriatric problems are basically those of extreme old age, but even so a comparison of the results with patients admitted to a psychiatric hospital compared with those admitted to an assessment unit show up favourably for the latter.

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Psychiatric Hospital

Admissions	100
Deaths	45.6 per cent
Discharges	26.6 per cent
Remaining	29 per cent

Assessment Unit

Admissions	221
Deaths	43.6 per cent
Discharges	42.2 per cent
Remaining at end of 6 months	13.6 per cent

Obviously the patient admitted to the assessment unit has a significantly better chance of being discharged. Even so, such a unit must be backed up by a full range of other services. These must include special residential homes for the mentally frail, dispersed so that the resident is not cut off from home and families, and the assessment unit also needs close working relationships between those responsible for geriatric, psychogeriatric and welfare accommodation.

Looking to the future, as Dr Wilson did, is not easy. It is hard, for example, to predict need. Cornwall has tried and their yardstick is 300 psychogeriatric beds for each 50,000 of the population. But the most important thing, as Dr Wilson emphasised, is "cohesive working between all authorities involved."

The value of this conference, as in all conferences, lay as much in discussion as it did with the formal presentations by speakers. The problem of transport, for example, which was thrown up during a discussion on the problems of the priorities of the ambulance service, led on to a debate on the reliability (or otherwise) of voluntary help. Two suggestions emerged from this. One was for the appointment of a paid organiser of voluntary service wherever possible, and the other was for careful consultation with voluntary organisations about the problems involved in providing a service.

Taking responsibility

And, of course, much was said about Dr Whitehead's suggestion that geriatricians should take responsibility for care of all old people. Some suggestions were made for training a new breed of medical man - the specialist in psychogeriatrics. According to one of the proposers, "this would overcome the present situation where there were two streams of doctors, one interested in mind, one in body - both dabbling." Professor Roth recognised the logic in the suggestion but thought the idea "not capable of realisation tomorrow - but an idea for an experiment." He felt that geriatric psychiatry (a better term than psychogeriatrics, perhaps?) had urgent need of both disciplines and of other disciplines that are co-operating.

Psychiatric Hospital

Admissions	100
Deaths	45.6 per cent
Discharges	26.6 per cent
Remaining	29 per cent

Assessment Unit

Admissions	271
Deaths	45.6 per cent
Discharges	72.7 per cent
Remaining at	
end of 6 months	13.6 per cent

Obviously the patient admitted to the assessment unit has a high chance of being discharged. Even so, such a unit needs to have a range of other services. These must include specialist residential, mentally frail, dispersed so that the resident is not far from family, and the assessment unit also needs close working relationship between those responsible for geriatric psychogeriatric and accommodation.

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The conference, he said, had learned that many interesting ideas for developing care of the old had come from psychiatric hospitals, together with the interesting paradox that many suggestions for community care were hospital-based. He warned about the danger of expecting too much from the growth of district general hospital psychiatry. New specialties, he said, would have a low priority. He also was concerned about the proposed reduction in bed ratios, at the suggested figure of 0.5 per 1,000. This could lead to increased demands on geriatric services which were already hard-pressed for staff and could mean that places which had done important work over the last 30 years would feel the pinch. "I hope," he said, "we can preserve what is good in the existing service."

The conference, he said, had learned that ... ideas for developing ... care of the old had come from ... with the ... interesting paradox that many ... more hospital- based. He warned about the danger ... the growth of district general hospital psychiatry. ... would have a low priority. He also was concerned ... in bed ratios, at the suggested figure of 0.5 per ... required demands on geriatric services which ... would mean that places which had been ... would feel the pinch. "I hope ... nursing services."

6. THE HOSPITAL GERIATRIC UNIT

Conference on Tuesday 29 September 1970

Chairman: Dr J N Agate
Consultant in Geriatrics
Ipswich & East Suffolk Hospitals

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre - Mr M C Hardie
10.35 - 10.40 a m	Introduction by Chairman
10.40 - 11.00 a m	THE PLACE OF THE HOSPITAL IN THE PATTERN OF GERIATRIC CARE Dr M R P Hall (now Professor Consultant Physician in Geriatric Medicine Newcastle General Hospital University of Southampton)
	DEVELOPMENT OF NEW GERIATRIC UNITS
11.00 - 11.30 a m	i) Sheffield Region Dr J F McGarity, PASMO; Mr E E Stentiford, Architect; Miss M G Stephenson, Asst Nursing Officer Sheffield Regional Hospital Board
11.30 - 12.00 noon	ii) Scotland Dr W T Thom, Medical Officer; Miss E K McNaught, Nursing Officer; Miss D Norton, Nursing Officer Scottish Home and Health Department
12.00 - 12.10 p m	Interval
12.10 - 1.00 p m	Questions and discussion
1.00 - 2.30 p m	Buffet lunch and tour of exhibition
2.30 - 3.00 p m	UPGRADING - PRINCIPLES AND PROBLEMS Miss E K McNaught, Nursing Officer, Scottish Home & Health Dept Dr A M Anderson, Medical Officer, Scottish Hospital Centre
3.00 - 3.30 p m	UPGRADING OF SANITARY ACCOMMODATION Dr J P Stewart Consultant in Physical Medicine Princess Margaret Hospital, Swindon
3.30 - 3.35 p m	Interval
3.35 - 4.15 p m	Questions, discussion and summing up
4.15 p m	Tea

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6. THE HOSPITAL GERIATRIC UNIT

Planning, based on detailed research, is essential when providing new geriatric units in hospitals. It is equally important when existing departments are being upgraded. All too often, however, it is as the chairman, Dr J N Agate, consultant in geriatrics, Ipswich and East Suffolk Hospitals, said, "Planners sometimes disregard medical and nursing opinion. They say, 'What do these people know about designing hospitals?'" Just how much they know became evident during the day.

The place of the hospital in planning

Before any planning decision can be taken, people must be clear about the place of the hospital in the pattern of geriatric care. This was the theme for Dr M R P Hall, consultant physician, Newcastle General Hospital and soon to be Professor of Geriatric Medicine, Southampton University. In Dr Hall's view, the hospital has a vital multi-disciplinary role in the total care of the elderly, a role which ranges from admission to discharge and which also takes in out-patient services. Everyone in the hospital should be involved because, as Dr Hall said, "The only thing that makes geriatric patients different is that they have lost their independence." Dr Hall would like to see the physician in geriatric medicine become part of the general medical team, taking a share of all acute admissions, and a part in the management of all elderly patients on the general medical wards. Hence in constant touch with his medical colleagues and thus regarded "as a clinical expert rather than as a disposal expert." In addition, physicians in geriatric medicine would have wards for assessment, re-enablement and continuing care. Under such an arrangement, elderly patients could be treated in the optimum setting to achieve success and those who need the support of the geriatric services would receive them earlier than they might have otherwise. Such a flexible approach would allow for any permutation of care for 'in and out' admissions, holiday relief schemes, comprehensive day and out-patient services, follow-up clinics and flexible psychogeriatric services. In Newcastle, both general and mental hospitals have psychogeriatric wards.

The hospital, said Dr Hall, also has an important part to play in research, both clinical and operational, into problems of ageing and patterns of care. It also has a responsibility to teach the principles of geriatric care to anyone likely to come into contact with the problems of ageing.

Developing new units - Sheffield

The development of new geriatric units was dealt with by two teams. The first, from the Sheffield Region, consisted of Dr J F McGarity, principal assistant senior medical officer, Mr E E Stentiford, architect and Miss M G Stephenson, assistant nursing officer, all from Sheffield Regional Hospital Board. What

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Sheffield has done is to modify the Bristol acute ward to suit the needs for new accommodation at Sherwood Hospital, Nottingham, and for the geriatric ward development now taking place at Leicester General Hospital. The adaptation of the Bristol ward in both these hospitals was an expedient to provide a flexible design to meet a changing situation. It is a tribute to those who designed the Bristol ward that the Sheffield team found it necessary only to make the absolute minimum of alterations in order for the ward design to be suitable for geriatric patients. The Bristol design, they thought, although not ideal, was flexible enough to be used - with some modifications - as an acute admission ward for geriatrics and ultimately for long-stay patients.

The wards now provide accommodation for 30 patients. They are arranged well enough for nurses to observe the very ill patients adequately, and flexible enough to allow recovering patients to progress from quiet areas of the ward to parts which are rather more lively. Patients can be alone if they wish, the ward can accommodate couples and relatives, and there is a seminar and demonstration room which can double for physiotherapy. This enables patients to work at their own pace. Perhaps most important is the liberal provision of well-sited sanitary facilities, so arranged that neither nurse nor patient has far to travel.

Developing new units - Scotland

The Scottish team based much of their planning on an existing ward plan, the Falkirk ward, and went into the problem in even more depth, basing their final conclusions on some very detailed research and some careful study of the needs of the nurse. This work was described by Dr W T Thom, medical officer, Miss E K McNaught, nursing officer and Miss D Norton, nursing officer, all from the Scottish Home and Health Department.

What the Scots did was to carry on with the study of ward units where the Nuffield architectural team left off. Their first step was to define the basic functions of any ward unit irrespective of specialty or the age or sex of the patients. They then recognised and accepted that the design of a ward and the relationships of rooms within it directly affected the work of nurses. Following a series of studies of the nurses' work over continuous 24-hour periods a pattern of nursing work emerged. This was:

1. An instruction was given or read.
2. Equipment was prepared.
3. A procedure was carried out.
4. Used items were deposited for collection.
5. The procedure was recorded.

From this cycle of activity the nurse working rooms were defined and their relationships to bed areas established. As a result of this work an experimental ward unit was planned and built at Falkirk Royal Infirmary. After the unit had been functioning for a year it was evaluated to assess the validity of the recommended principles and found successful.

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It was from this point that the Scottish geriatric ward study started. The basic principles of the Falkirk plan were accepted. The team had to decide on the difference between the needs of the acutely ill young, the acutely ill old and the chronic elderly patient. Basically the needs of the old differed from the young in that they required reduced intensive care areas, increased day and rehabilitation space, increased and strategically sited sanitary facilities. It was shown as a result of investigation that the average elderly patient has only one and a half to two minutes from comprehension of a full bladder to the involuntary relaxation of the sphincter, and that this meant that patients must be within 30 to 40 feet of the WC at all times.

Space at the bedside, for rehabilitation to start as soon as possible, and space for occupational therapy, physiotherapy and activities of daily living must also be included. All these areas must be placed so that they reduce the walking distance for patients from a marathon to something reasonable, and thus enable old people to walk to and from these areas as a therapeutic exercise. As Miss Norton pointed out "planning needs to be based on more than opinion." Scots certainly believe in facts.

And, it must be stressed, the Scots are planning for the future. It is not enough to plan on a basis of today's needs. All areas must be planned with future problems in mind. One of these problems is an increasing incidence of incontinence and studies at the Scottish Hospital Centre have led to the development of an area which will allow the nurse to cope with the maximum ease and flexibility with this problem. Adequate bathing facilities equipped to allow a nurse to use the method of cleansing necessary to the patient including bidet, shower (handrail) and ample room for wheelchairs are basic factors that the Scottish team emphasised.

Calculations can also be brought to bear on the number and dimensions of WCs. Scotland would recommend a WC area of not less than 30 sq ft on a 5' x 6' module, a size and shape which allows for the 'wide turning circle' needed by old people. There should be enough to go round. Something which produced gasps of amazement from the audience, accustomed no doubt to making do with less generous provision, was the statement that including WCs in the bathing areas and single rooms a total of 14 should be available in the 30 bed ward. This figure could be varied with design, but as Miss Norton pointed out, "this is a case where the WC really earns the title of convenience."

Upgrading

The same kind of detailed investigation and factual analysis can be used when it comes to upgrading existing accommodation. Miss McNaught, during the afternoon session, outlined Scottish yardsticks for upgrading wards, again based on the most careful studies by a team which included a quantity surveyor. Upgrading is a term used with more glibness than precision and can apply to almost everything from a complete rebuilding job to mere redecoration. In Scotland the term is applied only to functional improvement. The Scots based their study on the work of the nurse and the relationship that room siting has

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to that work. Part of the study included a 24-hour, minute-by-minute analysis of the nurses' working day and the production of many string diagrams. As a result, and after matching each set of observations against established requirements, the team was able to produce trial upgrading schemes to three levels of sophistication and three levels of cost. Costs range from £500 to £1,000 to a bed. They also isolated general factors which had to be considered in relation to each scheme - the type of ward, its size and the money available. As a general rule they consider no building worth upgrading unless it has 10 to 15 years of life ahead of it. Other points that people considering upgrading should bear in mind are the fact that it is almost always necessary to lose at least one bed, in order to provide adequate working areas, and that hospital supporting facilities are, or can be, available. Existing ward organisation and function must be examined critically and out-dated practices must be eliminated.

Priorities in upgrading

As with all else, upgrading involves an assessment of priorities and in the Scots' view the priorities are these:

(i) Grouping of the most ill patients to facilitate nursing observation with ready access to nurse and working areas

(ii) The concentration of supply and disposal in adjacent areas located for nurses treating ill patients

(iii) Improving the level of patient privacy with screens and by removing noisy areas

(iv) The provision of acceptable sanitary and washing facilities for both ambulant and wheelchair patients.

All these recommendations have been tested. The team was offered a ward in a general hospital and they chose to upgrade it at a cost of £800 a bed. Results shown on slides portrayed partitioning between bed areas, built-in clothing storage between partitioning and a dramatic improvement in patients' washing facilities which, although sacrificing two out of three washbasins, ended up by providing a completely enclosed and private washing compartment where none had existed before. Satisfactory supply and disposal facilities were also provided.

Dr A M Anderson, medical officer, Scottish Hospital Centre described a detailed study of a ward containing 39 female psychogeriatric patients. The study, carried out by a team from the Scottish Hospital Centre, showed up deficiencies in accommodation and pattern of nursing care all too familiar to the majority of psychiatric nurses. An attempt was made to assess nurse dependency of the patients by defining certain characteristics. The number of beds in the ward was excessive and the dormitories were overcrowded. The ward design was not suited to the type of patient accommodated and supervision at night was not easy. Items and activities which should have been centralised

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in closely related nurse working rooms were scattered about a number of areas remote from the point of use, inadequate or inappropriate, yet three of the rooms in the ward were not fully used. Washroom, bathroom and toilet facilities were contained in a single room also used as a disposal room and sluice. None of the four WCs could take a wheelchair or attendant. While the two baths could be used with an ambulift, there was no curtain or partition between them and no hand shower for hair washing. No shower was available and there were no facilities other than the baths for cleaning incontinent patients. The level of patient privacy and amenity was low.

Members of the team were impressed by the cheerfulness and patience shown by the nursing staff caring for these often difficult patients despite the inadequate ward accommodation. The study demonstrated clearly the improvements necessary in the accommodation for this group of patients and as such was a useful precursor to any upgrading scheme.

Sanitary accommodation

The provision and upgrading of adequate sanitary accommodation is essential to geriatric wards or departments. This topic was dealt with by Dr J B Stewart, consultant in physical medicine, Princess Margaret Hospital, Swindon, who was a member of a working party set up by Oxford Regional Hospital Board in 1967 to look at ancillary accommodation with special reference to sanitary accommodation. Dr Stewart echoed much of what the Scottish team had said, stressing the need for the proper placement of sanitary facilities in order to help nurses. He also felt that the toileting of patients was made easier if the WC, bath, shower and so forth were all sited in one area which should also include space for a floor-standing lifting device.

Dr Stewart felt that three types of sanitary accommodation were needed in each ward area. These were:

Type A	bath, WC, handbasin, hoist, wheelchair, cupboard space and soiled clothing receptacle
Type B	WC and handbasin
Type C	shower and drying area, the shower to have tip-up seat.

Types A and C could cope with 1 to 15 beds and Type B with 1 to 5 beds. He also stressed the importance of correct temperatures and moisture control for shower cubicles. 21°C was about right. But he had found great variation in the bathroom temperatures regarded as suitable, ranging from a "jolly sharp" 35.6°C in a mental subnormality hospital, to 40.6°C in a geriatric ward. The correct temperature, he said, was 37.8°C.

Other points stressed by Dr Stewart included the need for toilet areas to be adjacent to nursing areas; the importance of "really high and wide doors" for wheelchairs and hoists and the usefulness of adhesive strips attached to the inside of baths. These, he felt, were better than rubber bath mats which could be forgotten.

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With the aid of slides Dr Stewart outlined the many improvements which ingenuity could make to bathing old people, many of which were quite within the competence of the average do-it-yourself enthusiast. Finally, he strongly recommended the inclusion of a bidet, the Clos-o-Mat for choice, although he realised that its cost could be a prohibitive factor.

Plan for the future

Discussion ranged very wide and gave the Scottish team one or two chances to show how carefully they had thought out their plans. In answer to one question, which raised the wisdom of equipping geriatric wards on a scale equal to that of an acute ward, Miss McNaught stressed again the need to plan for the future. A ward which is comprehensively equipped can cope with a wide range of different patients, and planning must take account of future changes in patterns of care. But there was a danger of over-equipping a ward. If, for example, every bed had piped gases, it would prove almost impossible to reduce bed numbers if this was thought necessary. And what about cubicalisation and the conflicting demands of patient privacy and nursing observation? This is difficult, but a ward designed around the work cycle of the nurse makes her job easier and this enables her to carry out her observation more efficiently.

7. RESIDENTIAL ACCOMMODATION FOR THE ELDERLY
(Special housing and hostel accommodation)

Conference on Thursday 8 October 1970

Chairman: Surgeon Rear Admiral J M Holford
Senior Medical Officer
Department of Health & Social Security

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Mr M C Hardie
10.35 - 10.40 a m	Introduction by the Chairman
10.40 - 11.00 a m	THE HOUSING NEEDS OF THE ELDERLY Mr George Meredith Chief Welfare Officer (Now Director of Social Services City & County of Norwich City & County of Norwich)
11.00 - 11.30 a m	PLANNING ACCOMMODATION FOR THE ELDERLY Dr A L Bussey Senior Medical Officer West Sussex County Council
11.30 - 11.50 a m	THE CONTRIBUTION OF THE HOUSING ASSOCIATIONS Miss K J Bartlett Hon Secretary Servite House, London S W 10
11.50 - 12.00 noon	Interval
12.00 - 12.45 p m	Questions and discussion
12.45 - 2.15 p m	Buffet lunch and tour of the exhibition
2.15 - 2.55 p m	THE LILLINGTON SCHEME Mr Geoffrey Darke Architect Darbourne & Darke Mrs M Rees Matron Charlwood House Old People's Home
2.55 - 3.15 p m	THE LAWRENCE HALL PROJECT The Reverend James Froud Durning Hall Forest Gate, London E 7
3.15 - 3.35 p m	TRENDS IN DESIGNING FOR THE DISABLED ELDERLY Mr R G Worthington Architect Wycliffe Noble & Partners
3.35 - 3.40 p m	Interval
3.40 - 4.15 p m	Questions, discussion and summing up

3.40 - 4.15 p m

7. RESIDENTIAL ACCOMMODATION FOR THE ELDERLY

(Special housing and hostel accommodation)

Keeping old people out of hospital is really the key to many of the problems surrounding geriatric care. This can even be taken a stage further. Perhaps the emphasis should shift from Part III accommodation to sheltered housing, from design for old people to design for living, in which anyone, young, old, disabled or fit, can live. This was the theme underlying the conference held under the chairmanship of Surgeon Rear Admiral Holford, Senior Medical Officer at the Department of Health & Social Security.

Sheltered housing

Some local authorities, it seems, are definitely moving away from the traditional concept of the old people's home. Mr George Meredith, who is chief welfare officer for the City and County of Norwich (and now Director of Social Services), believes that too much planning for old people is based on the past; that the yardstick which is too often used is, "it's better than the workhouse." No doubt it is, but is it good enough? Is much of the current accommodation for the elderly really planned for those who use it? Or should we be thinking of types of accommodation in which old people - as they really are and not as we imagine them to be - could live out their lives? It seems that we should. Norwich (and some other local authorities) are basing their plans for the future on sheltered housing with warden services. In accommodation like this, the majority of old people can live and die without ever entering Part III accommodation. With such housing, believes Mr Meredith, "If we move forward fast enough, we will catch up with the work done by some charities."

Planning is as important when deciding on accommodation for the elderly as it is with anything else. Dr A L Bussey, senior medical officer, West Sussex County Council, described a review his authority has recently carried out into the needs of the frail sick elderly with special reference to their accommodation. The methods used related population estimates to planned accommodation identifying areas of need (especially senile dementia) and highlighting present and future shortages within the local authority and the hospitals of the regional hospital board.

Problem-centred management

One approach suggested by Dr Bussey is to replace the present department-centred management by "problem-centred management." This would provide a service which would follow the patient right across the board, regardless of the boundaries which exist between hospitals and local authorities. This is not new. The maternity services operate in this way and a service for old people would only have to cross one additional boundary - that of the social services department.

In the long term a more flexible approach to planning, geared to local conditions, is needed. Dr Bussey suggested that regional hospital boards appear to give priority to the provision of acute beds which then often become blocked by long-stay patients. Higher priority for geriatric beds would relieve this pressure and enable more intensive use to be made of existing acute facilities. Because population structures vary across the country, flexibility is essential. As he said, "Worthing is not Wigan or West Bromwich; as the problems differ, so must the solutions."

Residential accommodation and voluntary organisations

Mr Meredith had referred to the advanced work being done by some charities. Just how advanced some voluntary organisations are was shown by Miss K J Bartlett, honorary secretary, Servite House, London. After reviewing the history of organisations such as hers (which had almost all been founded to relieve poverty and its problems) she described the close links her society has with statutory bodies and some of the experiments her organisation is carrying out. One example is a unit where young and old live together and where the contributions of one to the other have proved to be very successful. Another is a £370,000 building scheme consisting of two blocks, one of which is normal accommodation and the other sheltered accommodation. Both schemes bear out Miss Bartlett's belief that everything should be related to normal life. In other words, "We should keep our tenants and have normal relationships with hospitals."

Miss Bartlett was also strongly in favour of day hospitals "to ease the terrible anguish of young people who have to go out to work and leave old people behind." She was not at all in favour of high-rise housing which, she said, "is not acceptable to old people" and also deplored "the hopeless inadequacy of the home help service."

The Lillington Scheme - theory ...

The Lillington Scheme is basically part of a housing development built by Westminster Council. Part of it is Charlwood House, which is a combined scheme for sheltered accommodation and a residential home. It was designed by Darbourne and Darke, architects, and the thinking behind the scheme was described by Mr Geoffrey Darke.

Because this kind of scheme was new to Westminster, Mr Darke had to produce his own brief. After widespread research and consultation and after many visits to homes in other areas, he decided to plan accommodation that would be pleasant to live in, that would provide privacy, but would also bridge the "dreadful step from independence to dependence." The design was based on the bedroom. There are single and double rooms, grouped together in a lobby, each with its own toilet facilities. There are spaces for people to sit and chat and there are small sitting rooms for each group of bedrooms. The external design is such that each room has a view, without giving the resident the feeling

to the long term a more flexible approach to planning, particularly to local conditions
is needed. Dr Bussey suggested that regional hospital boards appear to have
paid little to the provision of acute beds which have often been flooded by long-
stay patients. Higher priority for geriatric beds would relieve the pressure
and enable more innovative use to be made of existing acute facilities. Certain
population structures vary across the country. Flexibility is essential. As he
said, "Worthington's one Wigan or West Bromwich in the provinces after all,
must the solutions."

[illegible] assessment and community operations

that he is perched on the edge of a vertical cliff. Materials used were selected to create an atmosphere of cosiness. Much use was made of warm red brick and natural wood.

... and practice

How this works in practice was described by Mrs M Rees, matron of Charlwood House Old People's Home. The home accommodates 76 residents in 44 single rooms and 16 double rooms, and occupies the ground, first and second floors of the block. The third, fourth, fifth and sixth floors have 48 flatlets for old people. People who live in the flatlets can have lunch in the home at a daily charge of 5p. This not only ensures that they get at least one hot meal a day, it also enables the staff to keep an eye on them. Basically Mrs Rees had no complaints (although Mr Darke later said she was being too kind and admitted to some design errors). Living on a housing estate, as Charlwood residents do, said Mrs Rees, has pros and cons. The pros include the interest and kindness of neighbours, often sparked off by their children, and the cons include the behaviour of some children. From the residents' point of view the close proximity of two pubs, both reachable without crossing any roads, must also count as an advantage.

It is not easy to look after two distinct sets of residents, but Mrs Rees has a good relationship with GPs in her area and with the local geriatrician. Mrs Rees hoped for more sheltered housing schemes in the future but left architects and planners with this message, "Please seek advice from the people who have to run these establishments. The snags one comes up against in caring for the very elderly infirm, mentally confused, doubly incontinent residents now being admitted are worth knowing about."

Lawrence Hall Project

Another charitable endeavour which is something of a pace-setter is the Lawrence Hall Project. This was described by the Reverend James Froud, who works for the Astor Charity Trust. Apart from the wide range of activities which the Trust promotes (which run the whole gamut of social, religious, cultural and sporting pursuits), there is now the Lawrence Hall Project. The planning for this began when Mr Froud discovered that young people were leaving the area and the old were living on their own in large, nearly empty houses. The Trust said he could spend up to £300,000 and the upshot is a building with 42 flatlets containing little more than four walls and a kitchen, in which the residents provide the rest. But what makes Lawrence Hall unusual is the fact that the flats were built according to the ideas of those who were to live in them and not according to 'expert' opinion. Such opinion was sought but was tested against what the residents-to-be considered necessary and was modified accordingly.

In addition to the flatlets Lawrence Hall provides a large hall for social gatherings, a dining room and 12 other rooms which are used for a variety of purposes, chiropody, a Citizen's Advice Bureau and medical screening among

them. Apart from the residents, some 500 to 600 people use Lawrence Hall during the day and local participation is such that residents actually provide much of the manpower to keep the place running. An ex-seaman, for example, runs the boiler house. "Out of this," said Mr Froud, "had come a tremendous feeling of sharing the common problems of life."

Design for living

A detailed description of the ideal in design for old people was given by Mr R G Worthington, of Wycliffe, Noble and Partners, architects. Mr Worthington believes that there should be no distinction between designing housing for the fit, and disabled or the elderly. "I look forward to the time when housing is designed for people of all kinds to live in."

There are many factors to bear in mind when designing for the elderly. There is a tremendous need for storage space to house pieces of bric-a-brac and other treasured possessions. Recesses off main rooms can accommodate this. Equipment and finishes pose other problems. Floor finishes may appear adequate, but may be stained and damaged by battery acid from the motors of wheelchairs. The need is for "finishes which will stand up to unfair wear and tear."

Equipment must be right. Where possible and where it can be afforded the Clos-o-Mat bidet should be specified. At £300 or so, this is not cheap but Mr Worthington stressed that this piece of equipment is invaluable, particularly for the incontinent and at least one should be included in any scheme.

He then showed some examples of design for the disabled which included wire-bottomed shelves so that disabled people can see their contents from beneath, ovens adjustable for height and sinks with insulated bases so that women working sitting down in wheelchairs would not have their legs scalded.

Sheltered housing and Part III accommodation

Much of the discussion centred around Mr Meredith's contention that sheltered accommodation should not be integrated with Part III accommodation. Those in favour cited the advantages of having expert help on tap, the advantages of dining facilities and of general supervision. Those against felt that friction between Part III residents and those in sheltered accommodation might occur. People in homes might resent people from flatlets commandeering favourite armchairs. They might also feel that people living in sheltered accommodation were better off. Integration might create a kind of 'old people's ghetto'. But others felt that the two kinds of resident could and did mix. It took time but could work well.

And one plea which found a sympathetic echo was a suggestion that we should study the provision made for their old age by those who could afford to choose. Some buy or rent flats, some bungalows. We should, said the speaker, ask today's 50-year olds what they want, because we are planning now for the next 10 to 20 years.

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8. IMPROVING CARE FOR THE ELDERLY

Conference on Tuesday 20 October 1970 at West Middlesex Hospital

Chairman: Mr M C Hardie
Director
The Hospital Centre

10.15 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Hospital Miss M M Veale Chief Nursing Officer West Middlesex Group
10.35 - 10.45 a m	Introduction by the Chairman
10.45 - 11.00 a m	THE NURSING ADMINISTRATION OF THE GERIATRIC SERVICE Miss M Bunyan Assistant Matron in charge of the Geriatric Service
11.00 - 11.05 a m	INTRODUCTION TO WARD VISITS Dr James Andrews Consultant Physician to the Geriatric Service South Middlesex Hospital Group
11.05 - 12.20 p m	VISIT TO UPGRADED GERIATRIC WARDS
12.20 - 1.30 p m	Lunch
1.30 - 2.00 p m	THE FUNCTION OF THE DAY WARD Dr James Andrews
2.00 - 2.45 p m	DISCUSSION AND DEMONSTRATION OF EQUIPMENT WITH DAY WARD STAFF
2.45 p m	Depart by coach for South Middlesex Hospital
3.00 - 3.30 p m	VISIT TO LONG STAY WARD Management of the incontinent patient Mrs P Paddon Sister-in-Charge
3.30 p m	Return by coach to West Middlesex Hospital
3.40 - 4.00 p m	Questions, discussion and summing up
4.00 - 4.15 p m	Tea

8. IMPROVING CARE FOR THE ELDERLY

People can share ideas about improving care for the elderly no matter where they meet but actually to see new ideas being practised and to discuss them with the people responsible in the working situation is perhaps the best learning situation of all. It was with this in mind that the eighth in the series of geriatric conferences was held at the West Middlesex Hospital under the chairmanship of Mr Miles Hardie, Director of the Hospital Centre.

The work of the hospital's geriatric unit was described by Miss M Bunyan, assistant matron in charge of the unit. It has four wards for men and women, a total of 113 beds, a day hospital, out-patient clinic and half-way house. There are also long-stay wards in the group and beds in local cottage hospitals for which the West Middlesex has admission rights. The pattern of care is basically one of rehabilitation, with emphasis upon the diagnosis and treatment of acute diseases of the elderly and anaemia. The policy of the unit is of course progressive in the sense that patients are prepared for discharge, but it also deals with long-term cases.

Day Hospital staffing and organisation

Bridging the gap between out-patient care and in-patient care is the day hospital - an upgraded Nightingale ward catering for 30 patients. It is a unit which is easy to staff because of its five-day working week. Staffing in the unit generally is not too bad, mainly because of its "regular band of part-timers" but there are also trained staff employed on a full-time basis. Domestic services are managed by a domestic manager and a forewoman.

In addition to nursing and domestic staff there are physiotherapists and occupational therapists with whom nurses work closely on the rehabilitation of the patients. And although there is no voluntary service as such, a "faithful band" help out and many women volunteers have started bringing their husbands with them.

Dr J Andrews is consultant physician to the geriatric services in the hospital and introduced conference members to the programme of ward visits planned for them. Staffing on the geriatric unit of the West Middlesex is very much a multi-disciplinary arrangement in which nurses, physiotherapists and occupational therapists pool their knowledge and experience for the benefit of their patients and thus demarcation disputes are eliminated. At the West Middlesex it is not always nurses ministering to patients, but rather OT's and physio's encouraging self-reliance. The team approach is best seen in the wide variety of equipment available and in the way its purpose is explained to the staff. This explanation and understanding, said Dr Andrews, is essential, otherwise the equipment is underused.

Equipment - a wide variety

Space in which to work is absolutely essential. In Dr Andrews' view good conditions are the first priority and within these conditions, a variety of equipment. It is no use, for example, buying 30 identical beds for 30 patients because "patients don't come in standard sizes." Different types of beds, different kinds of hoists, different types of baths and chairs are all needed. They certainly practise what they preach at the West Middlesex, using both the Mecanaid ambulift, the Steel-nurse hoists, a variety of beds and chairs, the Medic bath, the Vogue bath and the Ladywell bath.

Dr Andrews was a little dubious about the sense in separating acute and rehabilitation wards because, as he pointed out, patients undergoing a rehabilitation programme also have many medical problems. But progressive patient care in the sense of having separate long-stay wards can, he said, have advantages.

Following Dr Andrews' introduction the conference then toured geriatric wards at the West Middlesex Hospital, seeing for themselves much of what had been described and talking to nurses, physiotherapists, occupational therapists and patients. Certainly the West Middlesex staff believe in variety and certainly this variety enables them to tailor their equipment to the individual needs of each patient.

The next part of the programme was concerned with the day ward and again the visit was introduced by Dr Andrews. In his view a day ward for geriatric patients is "an ordinary ward where we don't give bed and breakfast." It is a ward with the emphasis on rehabilitation, run where possible in conjunction with Day Centres provided by the local authority. In the day ward, psychological stimulation for the patients and rest for relatives are only incidental. This demands a pretty clear-cut admission and treatment policy and at the West Middlesex patients only stay on the day wards books if they are improving and have not yet reached an optimum standard. The majority of patients stay for under three months, but a very few for a year.

Rehabilitation

Again the emphasis is on rehabilitation and the multi-disciplinary approach. Activities include group therapy and activities of daily living. There is an OT bathroom where staff can teach patients to look after themselves (such equipment should be properly plumbed, said Dr Andrews) and beds for medical examination, the treatment of pressure sores and for OT and physiotherapy.

In the day ward, the major problem lies with a shortage of OTs and physios, something which is slowing up the ward's throughput. But for a department that was merely a 'tarted-up' old pre-war hut, the day ward at the West Middlesex appears to be a cheerful and dynamic place.

Equipment : a wide variety

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The same principles, of careful upgrading and a large variety of equipment, were apparent during the last visit to a long-stay ward at the South Middlesex Hospital. Here again there was a variety of beds and, most impressive, a Clos-o-Mat bidet.

The final discussion centred mainly around incontinence and the use of volunteers. One member of the audience questioned the idea of using nappies for old people, something done by Sister P Paddon of the long-stay ward. This, said the speaker, was undignified. Sister Paddon took the opposite view. The use of drawsheets and incontinence pads formed into a nappy kept patients warm and comfortable and saved bed linen. Provided they were used in conjunction with a bed-pan every four hours and not left in situ too long, patients came to appreciate them.

Volunteers

Earlier in the day Dr Andrews had criticised the practicality of volunteers, something which, he said, had been tried and found wanting. He described the idea of volunteers taking over large aspects of a hospital's work as a "political gimmick" and considered it unrealistic to think that hordes of volunteers could come in to do the work. Mr Hardie disagreed with this view and pointed out that volunteers could be a great help in geriatric care provided they were well organised. They should not, however, be considered as substitutes for paid staff. Their proper role was one of improving the quality of life for the patients and of helping to involve the community in the life of the hospital.

Unfortunately no one present had experience of volunteers in an organised scheme although several spoke highly of the work of leagues of friends and one or two people recognised the wide variety of tasks volunteers could carry out. But as far as the West Middlesex is concerned, it is the lack of continuity in voluntary service which has created the problems.

The final topic concerned the role of the hospital and local authority in the care of the elderly. Dr Andrews' view is that if each does the job properly there will be few problems. Certainly he feels that there are no difficulties in the area of responsibilities between the hospital service and the local authorities, but it was not the problem of either in a hard-pressed area to carry out the other person's work.

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9. INCONTINENCE IN THE ELDERLY

Conference on Thursday 12 November 1970

Chairman: Dr Monnica Stewart
Assistant Physician in Geriatrics
Edgware General Hospital

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Miss J B Craig Assistant Director
10.35 - 10.40 a m	Introduction by Chairman
10.40 - 11.00 a m	THE EMOTIONAL ASPECTS OF INCONTINENCE IN THE ELDERLY Dr S S Sutherland Consultant Psychiatrist Woodilee Hospital, Lenzie, Glasgow
11.00 - 11.05 a m	Questions
11.05 - 11.25 a m	MANAGEMENT ASPECTS Miss E F S Blencowe Matron, Loughborough General Hospital
11.25 - 11.30 a m	Questions
11.30 - 11.50 a m	PREVENTION - A SUCCESSFUL RETRAINING PROGRAMME Mrs N H Allcorn Assistant Matron, Claybury Hospital
11.50 - 11.55 a m	Questions
11.55 - 12.00 noon	DOMICILIARY CARE Mrs J Meers Geriatric Liaison Health Visitor Bedfordshire County Council
12.00 - 12.15 p m	Interval
12.15 - 1.00 p m	Questions and discussion, with panel of all speakers
1.00 - 2.30 p m	Buffet lunch and tour of the exhibition
2.30 - 3.30 p m	Syndicates
3.30 - 4.30 p m	Reporting back and discussion
4.30 p m	Tea

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4.30 p m	Tea

9. INCONTINENCE IN THE ELDERLY

Incontinence is the biggest single problem facing the elderly and those who care for them. It is also a problem which sometimes leads people to despair: to accept incontinence as something for which nothing can be done. This conference showed what can be done and above all that incontinence is not the hopeless problem that many people appear to think it is. The chairman for the day was Dr Monnica Stewart, Assistant Physician in Geriatrics at Edgware General Hospital.

Emotional aspects of incontinence

It is important, for example, for people to understand the emotional aspects of the problem and these were set out by Dr S S Sutherland, consultant psychiatrist, Woodilee Hospital, Glasgow. There has been a vogue, since the 1959 Mental Health Act, for people to call psychiatrists in to deal with the emotional aspects of incontinence, but Dr Sutherland warned against this. Referral to a psychiatrist, even worse, admission to a mental hospital, could produce 'ego damage' in the old people so treated. Many of the emotional aspects of incontinence could be adequately treated by the patients' own 'caretakers' with the support and advice of the psychiatrist.

It is important, first of all, to appreciate that psychodynamic factors apply to all old people suffering from incontinence, whether the cause of that incontinence is organic (brain syndromes, confusional states) or due to psychodynamic causes (regression in the face of stress, retreat from reality or rebellion against the situation in which the old person finds himself). Incontinence may be caused by any or a combination of these factors, which may be created by the fear of death, by making old people feel unwanted, by a lack of stimulation. What is vital is that the caretakers should be aware of the effects of incontinence upon old people and that they should act and behave accordingly.

Old people, in the main, do not accept incontinence as a fact of life. They suffer feelings of guilt and shame, are aware of being a trouble and a burden. They are afraid that their incontinence will alienate them from any remaining relationships they may have. If this does occur, the resulting increase in isolation can lead to further regression.

All these symptoms can be reinforced by the care patients receive. As a general axiom one could say, as Dr Sutherland did, "the better the nursing, the more the patient is encouraged to regress" because many nursing procedures appear to be designed to assist childish behaviour on the part of the patient. There is a tendency to put patients to bed, to undress them and to feed them. Well-intentioned but inadequate nursing management can also lead patients to retreat from reality. Everyone needs stimulation from the environment, even those with robust mental health. And again the axiom would seem to be "the better the nursing staff, the greater the sensory deprivation."

9. INCONTINENCE IN THE ELDERLY

Incontinence is the biggest single problem facing the elderly and those who care for them. It is also a problem which everyone has to learn to accept incontinence as something for which nothing can be done. This conference showed what can be done and about one hopeless problem that many people suffer from. The day was Dr Monica Swart, Consultant Geriatrician at the General Hospital.

Emotional aspects of incontinence

It is important, for example, for people to understand the problem and these were set out by Dr Swart at Woodlee Hospital. Clarence. There was the Health Act, for people to call psychiatrist, even worse, the psychiatrist, even worse, the damage' in the old people to incontinence could be so much the support and advice of the

It is important, first of all, to appreciate that all old people suffering from incontinence have an organic (brain syndrome) cause (depression in the

So what should the 'caretakers' do? First of all they must recognise that the old person has feelings and emotional problems. Secondly they must be honest with themselves and admit that they, too, find incontinence unpleasant. This is not easy for doctors and nurses, because to them it is often unacceptable to dislike a patient or a symptom, but this awareness is half the battle. They must also be aware of the need never to promote guilt in the patient's mind. In effect they must say to the incontinent patient, "Your incontinence does not worry me - so don't be afraid that you will lose my friendship." At the same time they must avoid implying an acceptance of the situation. They must accept the patient and combat the symptoms. In essence, said Dr Sutherland, the approach to incontinent patients must be personal. "We must try to treat an old lady who wets and soils herself and can't help it - and this will need all the sensitivity and understanding we can muster."

Management aspects of incontinence

Much of what Dr Sutherland had said was underlined and reinforced by Miss E F S Blencowe, matron at Loughborough General Hospital, who spoke on the management aspects of incontinence. Most important, of course, is the attitude of the staff concerned who must try to understand the feelings of the patient, who must try never to rebuke "because it destroys the patient and adds to the suffering." Nurses must learn to listen to their patients, even, said Miss Blencowe, to the extent of considering the patient's own rituals and enabling them to follow such rituals. Together with this must go factors like warm lavatories, ample time to go to them, and the consideration of toilet facilities during trips taken away from the hospital.

But basically, as Miss Blencowe said, incontinence is not a hopeless problem. "We can use the situation to challenge the skills and ingenuity of the staff involved." The treatment of incontinence is a team effort, demands involvement from doctors, nurses and from senior nursing officers. There are still nurses who, despite cries of amazement from some of the audience, regard work in a geriatric ward as a punishment. Above all, the treatment of incontinence is a question of attitudes.

Reducing incontinence

What can be achieved when attitudes are right and when the skills of the ward staff are allowed full play was described by Mrs N H Allcorn, assistant matron, Claybury Hospital. Mrs Allcorn had been in charge of a ward of 48 long-stay patients, aged between 60 and 90, of whom 36 were incontinent. When she left it, there were only 10 cases of incontinence by night and 8 by day.

This was achieved by what can only be described as a major team effort with nurses in the forefront of the campaign. Mrs Allcorn observed the ward for a long time before she took action, then held a series of staff meetings. The staff worked out a plan of action which included rehabilitation, extra commodes, toilet identification, a reduction in sedation, a longer day for the patients and

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a rearrangement of the ward furniture. They encouraged patients to take a greater interest in their personal appearance, gave them personal clothing, got them to help with bedmaking and ward dusting, and had them fitted with shoes to replace slippers. The occupational therapist gave them simple exercises, and also helped the patients to cut out pictures of lavatories to stick on the ward toilet doors, for identification purposes. These doors eventually became plastered with such pictures. The furniture was rearranged from its traditional 'around the walls' pattern into more intimate groupings with avenues left to allow and encourage movement towards the lavatories.

Extra commodes were acquired and placed at the entrances to the toilets and to encourage patients to use toilets rather than commodes, one more patient than there were commodes available was always taken to the toilet area. The idea behind this was the hope that "the patient would become impatient and pop into the toilet." Walking aids were provided and consultation with the night nurse and the doctor led to a drastic cut in night sedation. Patients were encouraged to leave the ward on shopping trips, relatives were contacted and began to visit once again and music to movement sessions were held. The whole idea being, as Mrs Allcorn said, "to get the patients moving, moving, moving."

Incontinence at home

Ways in which incontinence at home can be dealt with were described by Mrs J Meers, geriatric liaison health visitor, Bedfordshire County Council. In essence her talk was about an individual approach to each problem. She stressed the need to recognise the small beginnings of incontinence, such as arthritis, and the reduction of mobility, the need to introduce commodes, raised lavatory seats, walking aids, chairs out of which old people can climb without difficulty. She also mentioned apparent incontinence - caused by things like the WC at the end of the garden - which may be a deterrent to its use. Cold lavatories are also a factor.

But with a shortage of home nursing staff, efforts must be made to assist and support relatives with coping with incontinence and a wide range of services are needed. Equipment must also be provided. Basically it is a question of teamwork and of education of patients and relatives with the co-operation of hospitals and local authorities. Good communications between members of the team is the basis of success.

Incontinence - some solutions

Syndicates brought many suggestions for solving the problems of incontinence. The most common ones were, naturally, more money and staff, but groups also stressed the need for incontinence to be taught as a specific subject in nursing and medical schools; for an improvement in attitudes about the whole subject; for greater emphasis upon health education ("if you can put up posters on VD, why not ones on incontinence?") and underlined the importance of support for nurses from doctors. Education for young doctors on incontinence and its

problems was another suggestion which was coupled with a suggestion for a "course for Deans of medical schools" and attachment to GPs of qualified staff. Communications at all levels could be improved and a great deal more research into causes of incontinence, the reduction of the nurses' load and into electronic stimulation of the pelvic floor would, it was thought, be useful.

One suggestion which was made was for investigation into old-fashioned ideas for promoting bowel action - the use of bread pudding and rhubarb - and a suggestion, in the realm of clothing for the incontinent, for the return of 'the old-fashioned divided drawers'.

Education at an early age was stressed and staffing problems could perhaps be relieved by encouraging relatives to help by teaching them how to manage incontinence. And, of course, there is the need to involve the elderly in the management of their own incontinence problems.

In summing up, Dr Stewart said, "We always come back to a plea for more integration of the various disciplines in training and more communication with each other, with relatives and with our own patients."

"We need to get at our own authorities for a reassessment of priorities to get the sort of hardware we need. One thing the astronauts complained about furiously - despite all those millions of pounds which are spent on the space programme - was that they could not urinate or defecate in comfort."

But, said Dr Stewart, quoting Dr Binks's article in Modern British Geriatric Care, "the problems we are up against are conceptual and not technical, scientific or administrative, and this is why it is so difficult to get the obvious across. Much of this lack of perception is due to our persistent preoccupation with the hardware of scientific technology, our obsession with its power, and our hopelessness and fatalism when there is no technical treatment. The idea that the software of meaningful and civilised living is exceedingly powerful, often far more so than the hardware, rarely dawns."

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10. VOLUNTARY SERVICES FOR THE ELDERLY IN HOSPITALS AND RESIDENTIAL HOMES

Conference on Thursday 26 November 1970

Chairman: Mr M C Hardie
Director, Hospital Centre

10.00 - 10.30 a m	Coffee
10.30 - 10.35 a m	Welcome to the Centre by Chairman
10.35 - 10.40 a m	Introduction to day's work by Chairman
10.40 - 11.05 a m	HOSPITAL WORK Not treatment but a way of life Dr J De Largy lately Consultant Geriatrician Langthorne Hospital
11.05 - 11.30 a m	LOCAL AUTHORITY PROVISION What residential homes aim to provide Mr R W Hall Chief Welfare Officer London Borough of Redbridge
11.30 - 11.40 a m	Break
11.40 - 12.30 p m	Discussion
12.30 - 12.45 p m	Briefing for syndicate sessions
12.45 - 2.00 p m	Lunch
2.00 - 3.00 p m	Syndicate discussions
3.00 - 3.30 p m	Syndicates reporting back
3.30 - 3.45 p m	Tea
3.45 - 4.30 p m	Discussion
4.30 - 4.45 p m	Summing up
4.45 p m	Close of conference

10. VOLUNTARY SERVICES FOR THE ELDERLY IN HOSPITALS AND RESIDENTIAL HOMES

No volunteer could have attended this conference and gone away feeling useless. The problems of caring for the elderly are not easy and volunteers have a vital part to play in ensuring that old people remain individuals even though admitted to hospital or Part III accommodation. There is no doubt at all that in a service upon which increasing demands are being made the volunteer will, with help and some training, do a great deal to ease the burden upon staff and patients.

The scene for the conference was set by Mr M C Hardie, director of the Hospital Centre and chairman for the day. Briefly the idea behind the conference was to see whether "the conditions of life provided for the elderly in residential care either in hospital wards or by local authority provision, do in fact enable elderly folk to function as individual human beings at the highest possible level of which they are capable." "We hope," he said, "that today we will consider both what helps us to create conditions in which the older people in our care can live as full lives as possible within the various handicaps that old age sometimes brings with it, and what hinders us in achieving this."

Communications are the major problem. This was said by Dr John De Largy, lately consultant geriatrician, Langthorne Hospital, who referred to Revans's work and to the work done in 1961 by Mrs McGhee on patients' attitudes to nursing care. The major complaint, expressed by two out of every three patients, was lack of information. "Nobody told them anything - and they were frightened to ask."

Needs of the elderly

The elderly have five main needs: they need a home, they need occupation, they need to be needed, they need affection and they need communication. And perhaps the most important of these, from which all else stems, is communication. If we talk to and understand the elderly, if we understand their needs, we can overcome their fears about admission - and as Dr De Largy pointed out, old people <u>are</u> afraid of admission, regarding it as the end of the road, associating hospitals with death and dying - but once they have been admitted, good communication can keep them 'in tune' with the treatment programme.

They also need emotional comfort. Florence Nightingale said, "The nursing of the ward by Sister is just as important as nursing the patient." She also said, "Flowers, of course, are often more pleasurable than the visit of the doctor." Dr De Largy would agree with this. He regards flowers as the botanical barometer. Why? Because, he said, nothing is so pleasing to the patient. Flowers are a good topic of conversation and can lead to a happy discussion about the family. "The patient's face lights up - this is more important than knowing her blood sugar."

But what has this to do with volunteers? "The art of medicine," said Dr De Largy, "is the art of time and this is an art that is rapidly being lost as science takes over. Science does not take account of emotions. And it is to fill this gap that volunteers are needed. They have a key role - that of good listening."

Volunteers - and time to talk

Volunteers with formal briefing in the art of talking to old people - not always easy - can help patients to accept the fact of admission, can maintain their friendship with them once admission has taken place and can help and support them on their return home. They can help relatives (and, as Dr De Largy said, we hear a great deal about battered babies, but what about battered relatives?) and they can help to solve many of the problems likely to face the service in the future.

Dr De Largy should know. When he was at Langthorne Hospital he started a WRVS therapy centre which was set up to "wean patients from hospital." It has a canteen and a shop, where patients are encouraged to buy their own things and helps old people to avoid getting dependent on the ward or ward staff. But setting it up was not easy. Dr De Largy had to sell the idea to ward staff and achieved this by a series of meetings between ward sisters and the volunteers concerned. "I succeeded most effectively at a gin party."

Homes - or institutions?

What are homes for old people really like? Mr Hall, chief welfare officer in the London Borough of Redbridge, often yearns for the old institution which, he said, in 1948 suddenly became a "hell-hole" and which is rapidly being replaced by homes which are often glorified institutions - where people sit in rows and rows and exist under an authoritarian regime. Mr Hall really wants a complete re-think of the kind of care we give old people in residential homes. He questioned the assumption often made that old people need care and attention. We have assumed that this means total care, something which leaves the patient nothing to worry about. "We are," he said, "providing 100 per cent care and producing some of the most beautiful cabbages available ..." He would like to see a home run by residents, "some could run the place better than matron but are not allowed to."

In fact Mr Hall's talk was ruthlessly realistic about the problems of Part III accommodation. Many old people are as frightened of going into a home as they are of admission to hospital. Homes mean to them what hospital often means - "they see it as terminal care - as the end," he said.

Nor did he think that residential homes could be any kind of genuine substitute for a real home. At best they will be small hotels providing a reasonable standard of care and accommodation. We must compensate for this by providing other things. We should involve residents in the running of the

homes and we should get other people coming into homes as if they were visiting relatives and friends in their own homes. This could happen if homes provided kettles in rooms for residents to make tea for guests and if there were lots of small sitting spaces for privacy.

But such an approach demands a new way of thinking about the aged and Mr Hall reiterated something said by a doctor at a Hospital Centre conference several years ago. "We must stop worrying about 'dangerous things' like steps, cooking and lifting. We have to stop worrying about old people and let them live their lives to the full."

Volunteers should play a key part in all this. They should be the visitors for whom the residents make the tea, they should participate fully with the staff and they could, perhaps, treat the residents like genuine relatives and tell them all their troubles.

People at conferences like this often speak for the people in receipt of care. At this conference they were able to speak for themselves. Four residents from Pegram House, a residential home in Mr Hall's authority, were present and not only took a very active part in syndicate discussions but also had some things to say during the general debate.

Syndicates were asked to comment on two main questions each divided into two parts. The questions were:

1. What do you consider to be the priorities of needs for old people in
   (a) geriatric wards in hospitals?
   (b) local authorities' old people's homes?

2. What part can voluntary help play in meeting these needs in
   (a) geriatric wards in hospitals?
   (b) local authorities' old people's homes?

Most syndicates preferred Dr De Largy's definition of needs to the one given to the syndicates (cash, companionship, routine and work) and many stressed the importance of considering the elderly not as a 'different kind of animal' but as people with needs very much like any other age group. All were agreed on the need to treat old people as individuals, all recognised the value of sensible occupation and every group recognised the important part that volunteers could play.

Priorities, naturally, differed according to the groups. More money came high on almost every list whether for people in hospitals or residential homes. Another common factor was for attention to be paid to the problems of transport. Staffing and the need to define 'non-nursing duties' was also mentioned and, of course, those magic words co-ordination and co-operation.

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Paid organisers of voluntary services

A hearteningly common factor was the stress laid upon the need for a paid organiser of voluntary services, again considered important in both hospital and local authorities. Other priorities included day care and treatment facilities, careful selection and assessment of residents and the training of volunteers, which, in one group, was given top priority. But perhaps the most important list of priorities came from the group which contained two residents from Pegram House. Residents of homes probably know what they want better than anyone else and this is the list, in order of importance, that they drafted: doctors' visits, the security of knowing that near relatives could be sent for quickly, attitudes of staff (whether dictatorial or friendly), visits from medical social workers, material possessions, treatment of illness, a chance to develop the mind while in hospital, and taking part in ward chores but the right to drop them at will. A worry expressed by people in this group centred around the posting of letters - in many cases this appears to be dependent upon the goodwill of a nurse or visitor. The old people said, "it would be nice to feel you could post your own letters in a GPO box."

Volunteers - a vital role

And the role of volunteers in all this? Dr De Largy had already summed up much of what was subsequently said when he stressed their value and mentioned their contribution in assisting with the preparation of patients before admission, their friendship while in hospital and their subsequent support after discharge. Others thought that volunteers could meet the old person's need for affection; could encourage the old person to become a 'granny replacement'. Volunteers could also read and write letters, do the flowers, assist with group activities and outings. They must not, however, take jobs away from the old people themselves. Perhaps the most important thing they could give would be time.

The general discussion centred around many aspects of the detailed use of volunteers and it is interesting to record that no dissenting voice as to their use was raised. It was necessary, once again, to clarify the role of the volunteer, to stress the fact that volunteers should not be used to fill gaps left by staff shortage (though doubtless they sometimes are) but to enhance the quality of life for the patients. The need to tread carefully when setting up schemes of voluntary help, to avoid confrontations with health service trade unions, who are rather touchy on this subject, especially if not consulted, was also stressed.

Volunteers, it appears from this conference, have a vital part to play in the overall care of the elderly and must be allowed to play it if the service is to provide the standard of care it should, if it is to meet the current and future demands that the 'geriatric problem' will make upon it and, above all, if old people in receipt of care are to be enabled to lead a full, active and worthwhile life.

Paid organizers vs. volunteers

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11. DAY CARE AND REHABILITATION

Conference on Tuesday 1 December 1970

Chairman: Dr C Burns
Director of Public Health and
Medical Officer of Health
London Borough of Islington

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Mr M C Hardie
10.35 - 10.40 a m	Introduction by the Chairman
10.40 - 11.00 a m	DAY CARE FOR THE ELDERLY IN THE COMMUNITY Miss J Hubbard Deputy Superintendent Health Visitor City of Birmingham
11.00 - 11.20 a m	EXPANDING THE SERVICES FOR THE ELDERLY Dr E Woodford Williams Consultant i/c Geriatric Department Sunderland Area HMC
11.20 - 11.40 a m	DAY CARE IN A PRE-DISCHARGE WARD Mr J C Best Superintendent of Nurses Wharfedale General Hospital
11.40 - 12.00 noon	THE REABLIST'S CONTRIBUTION TO CARING FOR THE ELDERLY Mrs M Hawker Senior Physiotherapist Edgware General Hospital
12.00 - 12.10 p m	Interval
12.10 - 1.00 p m	Questions and discussion
1.00 - 2.30 p m	Buffet lunch
2.30 - 3.30 p m	Syndicate discussion
3.30 - 4.30 p m	Reporting back and discussion
4.30 p m	Tea

11. DAY CARE AND REHABILITATION

The fact that the majority of old people live in the community makes the need for even greater development of comprehensive community care a matter of vital importance. What can be done to keep people out of hospital, to provide them with work, interests and support, to expand the services available and to help them towards discharge from hospital was made clear at this conference, under the chairmanship of Dr C Burns, Director of Public Health and Medical Officer of Health in the London Borough of Islington.

Services in Birmingham

Services available for old people in Birmingham are among the best in the country. Miss J Hubbard, the city's deputy superintendent health visitor, described the efforts being made in that city to provide its old people with a full life and with opportunities for rehabilitation and education. In this, voluntary organisations are the key. In Birmingham they are spearheaded by an active pre-retirement council which runs a wide range of courses. Because some follow-up for those who had attended such courses was considered necessary, Birmingham also set up its Fircone Groups (Fircone meaning second growth as well as Friends-In-Retirement - an apt name) which currently have 1,500 members with another 1,700 on the waiting list. Fircone groups offer courses in a wide variety of subjects: woodwork; foreign languages and English literature among them. There is an entrance fee of $12\frac{1}{2}$p and each member pays 5p at each attendance.

Practical services such as shopping, dog-walking, minor repairs, redecoration and just friendly visiting are provided by a 1,200-strong panel of volunteers (including many young people) who make up the city's Voluntary Visiting Service for the elderly. Between them they visit about 4,400 old people on a regular basis. Co-ordination is achieved by 'fraternal meetings' of people from statutory and voluntary organisations and these ensure that people know what is going on and that volunteers know what to do and who to call on if need be. Birmingham also has lunch clubs run by the WRVS and exercises-for-the-elderly classes. They are experimenting with a system of day care for old people under which relatives can take old people to a centre in the morning and take them home again in the evening. Birmingham has had a register of old people since 1966.

Despite all this, as Miss Hubbard pointed out, the total services offered are not enough to meet the needs of the city's 128,000 people who are over 65 years old. But nevertheless the emphasis upon the integration of voluntary and statutory organisations and the underlying principle of "adding life to years," rather than merely prolonging life, is surely the right one.

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vital importance. What can be done
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help them towards fuller life in
Officer of Health in the London Borough

Services in Birmingham

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Community care - expansion needed

The fact that 94% of old people live in the community demands an expansion of the services available to care for them. Such an expansion must take into account the needs of individuals so that the correct treatment, for which a wide range of services is already available, can be applied early. The key to the best use of the services is held by the GP. This was said by Dr E Woodford Williams, consultant in charge of the geriatric department, Sunderland Area HMC.

A focal point for providing a better service is the day hospital, which should be a part of progressive patient care from hospital to the community. Day hospitals, said Dr Woodford Williams, provide a therapeutic regime, improve the quality of life for the handicapped by allowing them to remain at home, economise on the use of hospital beds and are of value in the supervision and care of vulnerable groups: of those, for example, who are over 80; the bereaved; those with physical and mental handicap, and cases in which there is a strain on relatives. In addition the day hospital is a valuable centre for teaching community care, an excellent focal point for research into all aspects of community care and for creating and maintaining a register of the elderly.

Progressive patient care

"As part of the process of progressive patient care and also to 'wean' old people away from the day hospital and emotional dependence upon it, a chain of day centres and luncheon clubs is needed in order to extend the service into the community. In Sunderland these services have been developed through the Sunderland Old People's Welfare Committee in liaison with the Local Council of Churches and Community Associations. Within the county borough fifteen day clubs and three luncheon clubs have been established. The premises and helpers in five have been provided by Community Associations, and in the remainder by the churches. These centres provide similar facilities to the day hospital, apart from medical services. The clubs are visited by the health visitor for the area and by a doctor from the day hospital. There is good feed-back through these statutory services and the liaison of the club leaders with the secretary of the Sunderland Old People's Welfare Committee." Staffing, as Dr Woodford Williams said, is of paramount importance. "We need people," she said, "with above all a love of people."

The need to wean people away from emotional dependence upon an institution applies also to hospitals. How this has been achieved at Wharfedale General Hospital was described by Mr J C Best, superintendent of nurses. Faced with a pressing need to accommodate patients who could not be immediately discharged, although their medical and nursing care was finished, the hospital had created a minimal care, do-it-yourself ward out of an old hutment ward. There is a central lounge, fully carpeted, on either side of which are placed two-, three- and four-bed rooms. Both men and women live in the ward.

Community care – expansion needed

The fact that 94% of old people live in the community [illegible] demands an [illegible] of the services available to care for them. [illegible] must take into account the needs of individuals so that [illegible] treatment. [illegible] range of services is already available [illegible]. [illegible] best use of the services [illegible] the [illegible] Williams, consultant in charge of the [illegible] (DMC).

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Progressive patient care

"As part of the process of [illegible] people were [illegible] and much [illegible] community. In [illegible] Sunderland [illegible] Williams [illegible] and Community [illegible] day [illegible] and [illegible] family [illegible] help [illegible] live [illegible] considered by [illegible] very [illegible] under [illegible] when [illegible] much [illegible] the [illegible] of the [illegible] as Dr [illegible] Williams [illegible] she said [illegible]

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The work of the staff is mainly that of supervision. They help patients to see that they can do a chore - about which many old people are anxious and in which they often need a great deal of help - and they do not mind if it takes a long time for a patient to dress or to make a bed. The nurses need patience and tact, in order, for example, to encourage a patient to improve his personal appearance and in order to ensure that jobs allocated are given out fairly. The daily programme is a full and active one, but geared to old people, slow-paced and with plenty of time for relaxation and recreation.

Since the unit opened in June 1969 it has accommodated 216 patients of whom 175 have gone home, 8 have gone to Part III accommodation, 13 to other accommodation, 5 to private accommodation and 11 have been found unsuitable for Part III.

Nursing staff in the ward is largely part time and includes a state-enrolled nurse who works for 32 hours a week, one full-time nursing auxiliary and one part-time nursing auxiliary. There is no night staff as such, the ward being overseen by the night sister from another block but there is a bell warning system which has proved effective. Medical cover is provided by housemen from the specialities under which the patient was originally admitted.

Reablists at Edgware

If the object of a geriatric department in a hospital is to help a patient to achieve the maximum possible independence, then the professional staff obviously need help. At Edgware General Hospital they employ a grade of paid staff who are known as reablists, people paid as occupational therapy or physiotherapy assistants.

This idea, described by Mrs M Hawker, senior physiotherapist, Edgware General Hospital, began in 1964 when the hospital advertised for help. They asked only for people with commonsense and a liking for others. They received 36 replies. Today the reablists at Edgware General - mostly married women - carry out a wide variety of tasks. They help and encourage old people to get out of bed, to use the commode, to go to the lavatory. They take old people out and help occupational therapy staff to provide a richer ward programme. Their most valuable contribution, said Mrs Hawker, is the fact that "reablists have the time to make contact at a different level. They have time to talk without rush."

This is not, she stressed, a substitute service; it is an additional service. Reablists are untrained (in the strict professional sense, although on-the-job training is given) but in Mrs Hawker's view, the word 'untrained' is not a denigratory term. All it means is that reablists can add to the work of the professionals and, having had no professional training, can bring a fresh approach to the patients and the hospital. "They provide a bridge to reality," she said.

The work of the Council is carried out by a number of committees and boards. Each of these committees and boards has a specific area of responsibility. Some of the committees and boards are required by law to exist, while others are established by the Council to help it carry out its work. The Council appoints members to each committee and board. Most of the members are citizens who volunteer their time to serve on these committees and boards. They are not paid for their service. They do receive reimbursement for expenses they incur while doing their work. The Council also appoints a staff person to each committee and board. This staff person is responsible for providing support to the committee or board and for keeping records of its meetings.

The Council has the power to create new committees and boards, to change the responsibilities of existing committees and boards, and to abolish committees and boards. The Council also has the power to remove members from committees and boards. The Council usually does not exercise this power unless a member has failed to attend meetings or has acted in a way that is harmful to the committee or board.

The Council is required by law to have a Planning Commission. The Planning Commission is responsible for preparing and updating the city's general plan. The general plan is a document that describes the city's goals for future development. The Planning Commission also reviews proposals for new development and makes recommendations to the Council about whether these proposals should be approved.

The Council is required by law to have a Board of Zoning Adjustment. The Board of Zoning Adjustment is responsible for hearing appeals from decisions made by the Planning Commission. The Board of Zoning Adjustment also has the power to grant variances from the zoning ordinance. A variance is a permission to do something that is not normally allowed by the zoning ordinance.

The Council is required by law to have a Parks and Recreation Commission. The Parks and Recreation Commission is responsible for advising the Council about the city's parks and recreation programs. The Parks and Recreation Commission also reviews proposals for new parks and recreation facilities and makes recommendations to the Council about whether these proposals should be approved.

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The Council has the power to create other committees and boards as it sees fit. For example, the Council has created committees and boards to advise it about the city's airport, the city's golf courses, the city's historic preservation program, and the city's human relations program.

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In Mrs Hawker's view the employment of reablists (a term coined by Dr Monnica Stewart) raises two questions: do we need so much emphasis on professional staffing? and do we need much closer links with the community generally? Society, said Mrs Hawker, only needs to be shown how. A brief film on the reablists at work showed two things: it showed the wide variety of jobs they do and their acceptance by the old people they were helping but more important it showed how fully they are accepted and consulted by professional staff.

Improvements to current services

Many essential improvements to current geriatric services were suggested by syndicates. Among them was the 'essential role' of sheltered housing, the need for early detection of illness, greater co-ordination between statutory and voluntary bodies, the need for more transport and for research into its use, the appointment of paid organisers of voluntary services, the potential value of a reablist service as one form of improvement in geriatric care, improvements in the suitability and accessibility of toilets together with greater use of chemical toilets in the home, the inclusion of relatives in the treatment programme and a change in staff attitudes towards voluntary help. Obstacles to these improvements included, of course, money and manpower, but one syndicate blamed unsympathetic HMCs, who preferred, it said, to spend money on acute beds, while another considered that "we ourselves are the main obstacles."

The problem of care at weekends, an admitted weakness in many services, was raised during the general discussion. Some authorities are designing hostels with special provision for day care and evening facilities and at least one authority has extended its day care scheme until 11 p m. This allows relatives to go out in the evenings. Perhaps, as Dr Woodford Williams said, there should be a night hospital attached to each day hospital.

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12. CONCLUDING CONFERENCE

Conference on Wednesday 9 December 1970

Chairman: Miss E Rickards
Vice Chairman
North West Metropolitan
Regional Hospital Board

10.00 - 10.30 a m	Coffee on arrival
10.30 - 10.35 a m	Welcome to the Centre Mr M C Hardie
10.35 - 10.40 a m	Introduction by Chairman
10.40 - 11.30 a m	RETROSPECT & PROSPECT - PRIORITIES IN GERIATRIC CARE 1. Dr K V Robinson Consultant Geriatrician Hillingdon Hospital 2. Mr T Clay Chief Nursing Officer North London Group HMC 3. Mr D C U Swain Chief Welfare Officer London Borough of Islington
11.30 - 11.45 a m	THE COMMUNITY INNOVATIONS REGISTER Mr Richard Luce Director Community Innovations Register
11.45 - 12.00 noon	FOLLOW-UP IN 1971 Mr M C Hardie
12.00 - 12.10 p m	Interval
12.10 - 12.45 p m	Questions and discussion
12.45 - 2.00 p m	Buffet lunch and tour of exhibition
2.00 - 3.15 p m	Syndicates
3.15 p m	Tea
3.30 - 4.30 p m	Syndicate reports, discussion and summing up

10.00 - 10.30 a m

10.30 - 10.35 a m

10.35 - 10.40 a m

10.40 - 11.30 a m

12. CONCLUDING CONFERENCE

In this, the concluding conference, an attempt was made to draw together the threads of the previous conferences and to suggest priorities and lines of action for the future.

Taking the chair for this conference, as she had done for the first in the series, was Miss E Rickards, vice chairman, North West Metropolitan RHB. Miss Rickards reminded those attending the conference of the kind of people with whom they are dealing - people who had worked hard all their lives, who had small opportunities for leisure, who needed encouragement in order to make the best use of the leisure that retirement had brought them. Today's old people, she said, are essentially modest people. They were not brought up in a permissive society, they have great reserve and "are not used to exposing their bodies, being bathed or nursed or having intimate things done to them with an audience or by members of the opposite sex. They are modest and old-fashioned, but you are dealing with an old-fashioned generation. You must remember that." In Miss Rickards's view the most valuable service that people involved in the care of the old can offer is "to enable people to live life to the utmost."

Priorities - psychogeriatrics

Under the general theme of 'Retrospect and Prospect - Priorities in Geriatric Care' Dr K V Robinson, consultant geriatrician, Hillingdon Hospital, considered that psychogeriatrics was the major problem for the 1970s. The bulk of this problem is at present being dealt with by psychiatric hospitals and geriatric units working in an 'uneasy partnership'. He did not believe that the forecasted run-down of psychiatric beds (based on figures which had already "been debunked") to 1.9 per 1,000 of the general population, would be realistic. A figure of about 3.3 per 1,000 would appear more likely. In any event, Dr Robinson believed the main task is to quantify the size of the geriatric problem "and urge our planners to take more adequate steps for their care in the future."

Priorities - design

In terms of personal priorities, Dr Robinson would like to see more attention paid to the design of toilet annexes, greater interest shown in new designs such as the Clos-o-Mat and more interest in the design of showers for geriatric patients. He also expressed words of warning about day hospitals and day centres. Although Dr Robinson approves of these and values the work they do, he warned against worshipping them too much because "they do not replace beds" and because of the inherent transport problems faced by all such units. Finally, although it was not within the context of the conference, Dr Robinson described North West Metropolitan RHB working party plans for the setting up of special units for the care of the young chronic sick. Each unit should have

about 35 beds and be in the grounds of a district general hospital although apart from it. There would probably be one such unit for each hospital group. It is hoped, he said, that three units may be produced in the next six to seven years.

Priorities - nursing staff

A major priority in geriatric care is nursing staff. This was stated by Mr T Clay, chief nursing officer, North London Group HMC, who referred to the fact that "ward sisters as we know them are a dying race. We are," he said, "going to miss them very much indeed." This is something to be concerned about. Single women are not being replaced. We recruit 60 per cent of nursing staff from overseas and they will return to their own countries in due course. Because of this and because many student nurses still regard acute work as the most interesting, the study of manpower resources is a first priority; nurses must think about what they are there for.

With this shortage in mind and with no immediate prospect of a solution, Mr Clay made a plea for greater attention to be paid to staff welfare, for more study to be made on the use of trained staff resources. In other words he was asking the nursing profession to put its own house in order and for other professions to take more notice of nursing opinion and advice when planning was being undertaken.

Priorities - research, planning and communications

The priorities, according to Mr D C U Swain, chief welfare officer, London Borough of Islington, centred mainly around increased research to discover the real extent of need, for better communications between disciplines, better housing and planning of such housing, increased old age pensions and additional resources, including the increased use of volunteers.

As he pointed out, "if every pensioner looked after someone older than themselves, there would be less need for services because we would know the need earlier."

He was also keen on an increased use, with safeguards, of private homes for old people, for far more sheltered housing, for some kind of means test to allocate services more realistically, for more staff training and for improved health services which should concentrate upon prevention by screening the middle-aged and by teaching people to avoid the dangers of obesity, stress and smoking. And he returned to the theme of involving people more fully in service, "if we can draw these people out to give service while they're young, we probably won't have to give them so much service when they're old."

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Community Innovations Register

Communication, or rather lack of it, is a major and self-confessed weakness of the health service generally - a point which had been made at several of the conferences in this series. Mr Richard Luce, director of the National Suggestions Centre (now known as the National Innovations Centre), plans to help overcome this by setting up the Community Innovations Register (CIR) which will take in the information already available in the Hospital Centre booklet Improving Care for the Elderly. That there is a need for such a service cannot be doubted. Many new ideas are being tried, many have succeeded, many have failed, but the knowledge and experience thus gained is confined to a few people at local level. Under the system set up by the CIR, information on such ideas will be sent out on a regular basis to those interested in learning from others.

But before such information can be sent out, it must be sent in to CIR and as Richard Luce pointed out, "the success of the whole venture depends upon your help and upon the two-way flow of information between users and providers of this information." CIR will be more than just a clearing house for information. It will also seek to identify the areas of greatest need and to assess trends that need strengthening and expressing. The National Innovations Centre has already sponsored an experiment into the free provision of telephones for lonely old people in Hull, has run a campaign to provide small-portion meals for the elderly and has asked local milkmen to provide information to local authorities about any social problems they may notice on their rounds.

The final speaker was Mr M C Hardie, director of the Hospital Centre, who expressed his thanks for the help received with the exhibition and conferences from the North West Metropolitan RHB and from their nursing officer, Miss Joan Bricknell. He looked at the future action under four main headings: information services; research and developments; exhibitions; and conferences.

Richard Luce, he said, had covered most of the ground about information services and he repeated the plea for support and for the provision of information about new developments.

King's Fund plans

Under research and development, the King's Fund has set aside funds for research projects in the field of planning and management for the elderly (but not for purely clinical research) and the Fund would welcome applications from hospitals and health service authorities, especially in the North West Metropolitan area. Mr Hardie also pointed out that funds for research were available from the Board and from the Department of Health and Social Security.

The Hospital Centre would not mount another geriatric exhibition during 1971, but an approach for help - including financial help - in mounting regional or local exhibitions would also be welcomed.

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King's Fund plans

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The conferences, he thought, had proved valuable - perhaps most of all in bringing together staff from all disciplines to hear each other's points of view. One of the most useful meetings was that held at the South West Middlesex HMC "which had all the advantages of a multi-disciplinary gathering plus the opportunity of seeing a geriatric service in action and talking with those on the spot." He offered the Hospital Centre's support in co-operating with statutory and voluntary organisations in arranging both large and small specific local conferences. "We shall welcome," he said, "ideas and suggestions."

Planning and action for the future - syndicate reports

Syndicates, naturally enough, were asked to concentrate mainly upon planning and action for the future and dealt with the following topics: the use of multi-disciplinary meetings; priorities for research and development; follow-up activities in 1971; the development of the Community Innovations Register.

Syndicate A, incredibly, had no experience of multi-disciplinary meetings and deplored the fact. They went on to suggest that there was a need for a working party to study "who are the people actually in Part III accommodation?" They felt there was a need for a new category of accommodation - Part IV - to provide custodial care for psychiatric patients and nursing homes for those with physical disabilities. The initiative for new activities, they felt, should come from the new directors of social services, working with medical officers of health and under the direction of the Department of Health and Social Security.

Syndicate B, looking at the use of funds for research and development, felt that a great deal of money had already been spent on this. What was needed now were funds for pilot schemes to develop the results of research. They also felt that there was a need to develop psychogeriatric assessment units; to promote new housing schemes; to conduct research into the best methods of training home helps; to provide cash for paying organisers of voluntary services - and money for refreshments for multi-disciplinary meetings: the latter, they considered, would improve communications and would be "money well spent."

Syndicate C, looking at the work of the Hospital Centre in the field of geriatric care, praised its efforts and felt that follow-up action should look at ways of preparing old people for admission to residential care. Basically they felt that the Hospital Centre should continue the work it is doing with the emphasis upon improving communications at all levels.

Syndicate D discussed the Community Innovations Register and considered it should concentrate initially on information and advisory services; screening and assessment; housing; co-ordination of services; employment and retirement activities; and incontinence, laundry and clothing, each of which they felt was a separate subject. They also stressed the importance of feeding and nutrition in caring for the elderly.

Syndicate E had had experience of work with multi-disciplinary discussion groups, of which they felt the geriatric liaison committee was an excellent

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Planning and action for the future - syndicate reports

Syndicate A, [illegible] and [illegible] deplored the fact. They [illegible] part in many [illegible] felt there was a need [illegible] cultural [illegible] disabilities. The [illegible] now directors of social [illegible] under the direction [illegible]

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example. They stressed the need to cross boundaries and to involve both statutory and voluntary organisations. They also cited case conferences as another example of useful multi-disciplinary meetings.

Activities to be followed up included the development of work centres, a close look at transport problems, a need "to look at the needs of patients and to develop services for them," and the need to encourage early preparation for retirement. All such developments need more cash, but something which could, they felt, be developed without any additional financial outlay was a national building programme of multi-purpose housing.

Syndicate F confined itself to considering the introduction of non-professional people - both volunteers and paid workers - into the service. The problems, they felt, were the organisation of the non-professional role and the reception of the non-professional into the home.

Syndicate G also looked at the Hospital Centre contribution and suggested a series of locally-based geriatric conferences to which medical students should be invited and for which the lead should come from the Hospital Centre. For 1971 and 1972, they would like to see the Hospital Centre sponsor conferences on mental handicap and safety in the home and the BBC to run a series on facilities for the elderly. Conferences for the active elderly, they felt, could take place in bingo halls.

Syndicate H, looking at the CIR, felt that it should concentrate on screening and assessment, with information and advisory services and co-ordination following as close second. CIR, they felt, could be most useful in identifying problems and in giving information, but the syndicate expressed anxiety about the CIR getting involved in technical problems. They hoped that the information which was sent in to it would be "sifted by experts."

Syndicate I, looking at topic 1 and multi-disciplinary meetings, said that in one area general practitioners had been invited out to lunch ("Who paid?" asked someone in the back of the hall) but said that most of the syndicate members had thought that staff numbers were too great for an informal discussion. They recommended "an interchange between hospital nurses and district nurses." They expressed concern about entertainment for old people in homes and were worried about the provision of services at weekends. They suggested that works organisations might be approached. "Each service," they said, "should have to go but the local authority should take the final responsibility."

Syndicate J thought that the CIR should concentrate upon preventing the hospitalisation of old people but they also asked for its help with employment and retirement activities. Major problems, they thought, were transport for day care and rehabilitation, the training of the public in nutrition, and the need for research into the care of geriatric patients in the community. "The CIR," they said, "should tell people the most economic way of finding these things out." They also felt that there was a need for the education of elderly - especially in decimalisation.

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Much of the discussion centred around the work of the CIR and the pros and cons of the telephone experiment in Hull. People were inclined to prejudge it and Mr Luce could obviously not say anything very helpful because its results have yet to be evaluated. The question of who should sift the information supplied to the CIR was answered, however. Mr Hardie said that a multi-disciplinary panel, representative of hospital and local authorities, had already been set up for this purpose.

Conclusion

In winding up the conference, Miss Rickards thanked the speakers for their contributions and the Centre for its initiative in arranging the whole series of conferences. These had focussed attention upon the problems of geriatric care, and had illustrated many practical ways in which the services for the elderly could be improved. She was glad that the Centre was not proposing to forget about geriatrics with the end of the last conference in the series, and she hoped that some useful ideas for follow-up action would be put into practice in 1971.

CONCLUSION

These twelve meetings were attended by over 1,000 people representing many different disciplines from all branches of the health and social services. Many of the conferences were over-subscribed and - to judge from the questionnaires returned by many participants - many people did find the conferences useful. These facts seem to indicate that there is a need for more opportunities for the exchange of information and ideas on the care of the elderly. The Hospital Centre is planning to arrange further meetings on the subject and to follow up some of the good ideas that were described during the conferences. But the Centre alone can only reach some of the people some of the time. It is therefore hoped that the success of these conferences may encourage other authorities and organisations to arrange similar activities on a continuing basis at regional or local level.

Forthcoming legislation for the integration of health services should in many ways make it easier to provide better co-ordination and better care for the elderly. At the same time, the separate organisation and financing of social services brings with it the danger of new divisions amongst those responsible for providing this care. For the elderly, as for the mentally ill and the mentally handicapped, the borderlines of need and provision between health and social services, and between statutory authority and voluntary organisation, are often hard to define. These are borderlines that the client - the patient - must be enabled to cross and re-cross without undue difficulty whenever the need arises. This will be easier said than done. Amongst other things, these conferences had the aim of promoting dialogue and bridging the gaps between health and social services and between statutory and voluntary organisations. This is a pattern that surely needs to be repeated and developed much further at regional and local level if a really effective system of co-ordinated care is to be achieved.

Those attending the conferences heard many examples of good practice in the care of the elderly in hospital and community; they heard many new ideas about ways in which this care could be improved still further. They also heard of gaps and deficiencies in the services, so that no one can have left any of the conferences with any feeling of complacency. There is much that needs to be done before Britain can really be proud of the way it looks after its old.