The range of local authority services in this country

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As I see it, local authority services fall into five main groups, the first being special housing; second, financial help, not direct to old people themselves but to voluntary agencies; third, the provision of community services; fourth, supervision of facilities for old people and fifth, the provision of residential accommodation.

Housing

In county boroughs there is only one local authority involved, although there may be several different departments. In the county areas, and I speak from one in Kent which is the third largest local authority in the United Kingdom, with a population of 1,330,000, the situation is different because the housing authorities are the separate district councils. Whilst we make contributions towards their welfare services in old people's housing, we are dealing with 48 different local authorities in the county and our relations with them vary, according to their ideas, allocation of housing, the state of their aged population, numbers and so on. Our annual health and welfare budget is about £5,000,000, of which probably between 35 and 40 per cent is spent on community and residential services for the aged by the county authority.

Housing for old people ranges from normal accommodation tailored to the needs of old people, through special facilities, flats or small houses with warden services on a travelling basis, to the provision of special accommodation in buildings or flats with a resident warden. This type of housing development is a variation of the old medieval alms house for the care of the aged. It is sometimes argued that a more extensive provision of special housing for old people with effective welfare services would reduce the demand for beds in old people's homes and hospitals by obviating or delaying the changes of senescence, but I know of no clinical evidence to prove this. With a very large waiting list, you take the most urgent cases; it is very difficult to look back and say—had there been some other form of social service available this might have been avoided. At the moment I am encouraging the county council to subsidize this type of housing on the grounds that it is the right thing to do, and not that they will eventually get a financial reward. I hope they will get such a reward, but I cannot see it yet.

Support of voluntary agencies

Following the introduction in 1948 of one of the most, if not the most, comprehensive systems of social security in the world, we saw an astonishing proliferation of voluntary bodies devoted to assisting broadly identifiable groups—the spastics, those with migraine, spina bifida, and among these social agencies we must put first, the growth in voluntary agencies for the welfare of the aged. They were in being before 1948, but they have shown a very large and welcome increase since that time. We subsidize these voluntary agencies with grants to cover visiting, clubs, day centres, meals, finding lodgings, and so on. These are admirable activities that all of us would wish to encourage but it seems that as economic stringency grows, local authorities must consider closely the amounts of grant they are asked to give, and there may be economic need making more people take up paid employment, leaving fewer for voluntary work.

Community services

The field services that local authorities provide are broadly the same throughout the United Kingdom although individual and departmental arrangements may vary. In

some authorities as in Kent, health and welfare are combined in one department under a medical man. In others there may be a combined health and welfare committee with separate committees or departments. With separate health and welfare staff in the field there is obviously a danger of overlap. In Kent where there is one department, all field services are under one common directorate. It is open to argument whether in the provision of domiciliary services we should have specialist staff trained and experienced to deal solely with the aged.

The district nursing and domestic-help services will be dealt with later and I propose only briefly to refer to things like nursing aids which we are using more and more. We have extensive services available for things like hoists, walking frames, ripple beds, and about half a million pads a year for incontinent patients. These pads are made in our training centres by the mentally subnormal. This is a useful provision that has added tremendously to the comfort of incontinent old people being nursed at home.

For the welfare of the aged there are the chiropody services, introduced only a few years ago. I do not think that health visitors should be used for routine visits to the aged, though many of my colleagues would disagree with me. Health visitors' training is long and specialized; I cannot see that in routine visiting their nursing and midwifery experience is being properly used. When we are so short of specialized staff, we should surely not use those trained for as long as four, five and six years for the less specialized routine welfare visiting of the aged. If general practitioners want specialized visiting of ill, old people then I believe this should be more a function of the district nurse than of health visitors. So far as possible we are subsidizing local old people's welfare committees to appoint paid organizers to co-ordinate voluntary effort.

The ambulance service costs are increasing because of the demands of day hospitals. Out of our budget of £5,000,000, £860,000 goes to the ambulance service, and over the last few years the increase has been mainly in connection with day and geriatric hospitals for old people. This work is one of the least liked tasks of ambulance drivers.

Public control

We register homes for the physically disabled, nursing homes for old people and nursing homes for the mentally disordered. In Kent we have 92 registered private and voluntary homes where old people are looked after. We may not fix the financial terms under which old people are received, but we hold the ring, as it were, between the payer and the receiver; we ensure by registration that minimum standards are observed and that the residents get all that they pay for. We are responsible for seeing that the conditions under which old people are looked after are right, that their diets are reasonable, that their standard of accommodation does not fall below certain specified levels and that the staff is adequate. All this we must be able to enforce in a court of law, because if we refuse registration the aggrieved person can take us to court to show reason for our refusal.

There has been a steady growth in homes for old people run for profit. They fulfil a manifest need, and whilst not every old person in them would come within our ambit as a statutory authority there is no doubt that a substantial number of them do, so that homes being run for profit make a valuable contribution to residential care of old people.

Residential accommodation

The changes in medicine, social needs and population structure over the last 20 years seem to me to have had their greatest impact on the arrangements we are called upon to make (either on our own or by subsidising voluntary bodies) to provide for the residential care of the aged. Ever-increasing hospital costs and growing specialization mean that the functions of hospitals are not only being defined more closely today, but they must be examined even more closely in the future to ensure that these specialized

resources are used only for the people who need them, and for the shortest possible time. As is usual in the social services things are arranged so that the local authorities always get the dirty end of the stick. The more closely defined the functions of the hospital service, the greater the duties thrown on us to provide residential care. The requirement has changed from the old type of mixed poor law establishment to specialized establishments providing for various needs. Broadly we differentiate three main groups. Forty beds to a home seems to be about the right number to provide for old people who whilst capable of a considerable measure of self care are in need of some help. We then distinguish two other types of home. One for people showing the physical infirmities of age, many of them in wheel chairs, incontinent, or using walking aids. And the other type mainly for people whose mental changes prevent them from being assimilated into ordinary homes. At present we are providing about 2,500 beds for old people, directly or indirectly, of which about 230 will be for those old people whose mental changes require us to make special provision. These beds we think are best disposed of in units of about sixty. The Ministry, which sometimes lives in a world of its own, would like to see rather smaller units, but site and building costs are high and what we are now doing is accepted by the Ministry as a reasonable compromise.

One of our duties is to get people out of hospital and relieve pressure on hospital beds, but like many other things in life it is easier said than done. Faced with long waiting lists, faced with frequent demands from many quarters, from members of parliament downwards, to meet immediate cases of urgency, it is not always easy to use vacant beds in our homes to relieve demands on hospitals. In fact half the admissions to our homes come from people in the community who have never been on our waiting lists at all, their need being presented within a matter of days in circumstances where we have to meet it. So far we have not suffered from restrictions in capital spending on old people's homes, but the indications are that we are not going to be able to continue at our present rate. We have been building between three and four new homes a year involving a capital outlay of about £500,000 and I find it difficult to see how we can continue to do this. Indeed, we can hardly provide all our field services and still keep within the government's requirement that in the year 1969/70 we shall increase our spending by only three per cent.

Spending in fields like mental health has risen by 22 per cent this year and the figures next year will be 20 per cent more. On our other welfare services, national assistance, care of the aged, spending ought to increase at the rate of about 11½ per cent. I cannot see how we can shrink some of our essential services with all the uproar that would create, but we cannot continue our full expansion of services within the government's three per cent limit.

One of the weaknesses of modern society is that we are apt to spend time planning and talking about planning instead of doing. The Ministry of Health 'circular' mill at the Elephant and Castle goes on grinding out exhortations as to what we should do, what we ought to plan for, and the staff we ought to have, forgetting that our expenditure is limited by the government. As you know the government have said that their object is to restrict expansion of the Civil Service in 1969/70. Many of us would agree that would be an admirable thing; but the government also say that the restriction of three per cent on increased spending should also result in a like restriction of our staff. On the one hand we are being exhorted to keep spending, to have a ten-year plan updated from year to year to retain impetus, and on the other we are expected to comply with exhortations to economize.

A striking commentary is provided by the number of old people in care. In 1930 when we took over the poor law institutions there were 2,300. That number dropped in 1948 to 920. (It is interesting to reflect why that change took place.) Since 1948, however, the situation has entirely reversed. With a slightly smaller local population of 1,300,000 we now have nearly 2,400 old people in residential care, and our waiting list

is 659. I cannot see that list being abolished in the near future.

Future arrangements of local authority health and welfare services should bring general practitioners and local health authority staffs together. The conditions of general practice are changing, and we have to change with them. It is not always easy because there are not as many nurses and health visitors as there are general practitioners. On the proposals for area health boards, I doubt whether they are going to result in the release of any new amounts of money for specialized man-power for the social services. I am not against change but our trouble is that in postulating escape from difficult circumstances we do not want to admit that administrative change will not suddenly unlock some hitherto hidden and undisclosed resources in money and man-power.

In management, and I am after all a manager of a large scale health and welfare service, we need to define our objectives and determine the resources in money and man-power that we can command to fulfil those objectives. The task of management is to see how these things can best be brought together. Therefore the question arises as to how we ought to proceed. What I would like to know from you is, are we using the money that the government allows us to spend, in the right ways and at the right time?

Mr W. E. Allison (*residential services officer*)

First and foremost is the question of who should and—probably even more important—who should not be in an old people's home. The Act says 'Local authorities shall not provide services of a kind normally only provided by admission to a hospital'. That wording was settled well before 1948, when there was no National Health Service, and the great changes since then, in what is normally provided in hospitals have changed the rôle of old people's homes. One simple example is the development of warning systems, which have progressed from one of the residents banging on matron's door with a walking stick to the employment of night attendants supported by electronic devices and internal telephones. Cost has also progressed. For Kent County Council homes the percentage of total running costs paid to staff has risen from 44 per cent in 1953 to 60 per cent in 1967. The current division of responsibility between local welfare authorities and hospitals is laid down in a Ministry of Health memorandum dated 15 September 1965. Paragraph 5 reads:

> The elderly people whom local authorities may need to admit or retain in homes can broadly be defined as, those who are found after careful assessment of their medical and social needs to be unable to maintain themselves in their own homes, even with full support from outside, but who do not need continuous care by nursing staff. They include (1) people so incapacitated that they need help with dressing, toilet and meals but who are able to get about with a walking aid or with the help of a wheel chair; (2) people using appliances that they can manage themselves or without nursing assistance; (3) people with temporary or continuous confusion of mind but who do not need psychiatric nursing care. They also include residents who fall ill whether for short or long periods whose needs are no greater than could be met in their own homes by relatives with the aid of the local health services. Where the illness is expected to be terminal, transfer to hospital should be avoided unless continuous medical or nursing care is necessary. Some incontinent residents other than those with intractible incontinence and other disabilities may also be manageable in a residential home.

It is necessary to stress one simple but vital fact. The whole can be greater than the sum of its parts; for instance, if the condition of one dependent person is tested against the standards of responsibility and found to be just within the compass of an old people's home—then a second and third and so on. The pressure on the staff force which can be employed at an acceptable cost can build up so that the facilities become saturated well below the total number of places in the home unless there is a fair proportion of relatively capable residents. At the ordinary type of home such as we have in Kent for about 40 people, experience is that just about one quarter of the total number of residents can have extensive physical infirmity provided there is not