Some general practitioners make arrangements for clinics in their surgeries, at which the nurses attend to give injections and apply dressings to certain patients by appointment. Because of existing legislation these arrangements are quite unofficial at present, and on a trial basis, but those we have tried have proved most successful. When the National Health Service and Public Health Bill now before Parliament becomes law these arrangements will be extended. There are difficulties about group attachment where a number of individual general practitioners cover a relatively small area. This can result in two or three nurses visiting the same road or even the same house. There is no doubt that practice attachments both increase the work and the amount of travelling the nurse has to do. And of course the more time she spends on the road the less time she has left for nursing. In Kent there are over 700 general practitioners, while we have only 162 district nurses and 110 nurse midwives, making a total of 272. We have to do our best to allocate them fairly. It is difficult, too, to make these arrangements when some doctors want attachments and some prefer to work on their own. However, there is no doubt that a nurse can give better service when working with a group practice in close co-operation with the general practitioner. While carrying out routine practical care she can help the aged patient to live through the sixth and seventh ages of man in such a way and with such a degree of self respect that he is far removed from Shakespeare's 'lean and slippered pantaloon' who declined speedily into second childhood and mere oblivion.

Domestic help service

Mrs G. Richardson (*area domestic help service organizer*)

I am sure you are all quite aware of the service that operates in your particular district or area, but whenever doctors telephone me they always say "Well, Mrs Richardson, what can you do about it?" after they have presented their particular problem. I should like to give you a short history of the service. Prior to the introduction of the War Obligation Act of 1918, domestic help services were in the main organized and run by voluntary bodies. This Act first permitted a local authority to provide a measure of assistance to nursing and expectant mothers. These groups are also included in the wider categories provided for under section 29 of the National Health Service Act of 1946, but the service has become very largely one for the care of the aged. National figures of 1966 revealed that of 418,966 households provided with domestic help, 78 per cent of the recipients were over the age of 65. When the Act became operative in 1948 the arrangements were placed on an organized basis by making them part of the National Health Service and the larger authorities appointed organizers. The Act, however, is a permissive one, with the result that no set pattern has emerged after nearly 20 years, some authorities are continuing to operate domestic help services only, whilst others like Kent have progressed beyond this stage to include other domiciliary services. The Institute of Home Help Organizers, set up in 1954, has done much to overcome the drawbacks of a permissive service by enabling members to interchange ideas and study related problems. Week-end schools held annually at centres throughout Britain help in this direction, and the Institute has also introduced a training course covering local authority administration, social services and specialized aspects of administrative and practical work in the domestic help service. In the county of Kent, which has a population of 1,300,000, the overall domestic help service is supervised by a county domestic help

organizer and for administrative purposes the county is divided into six areas and subdivided into districts. Each district organizer works under the guidance of an area organizer, approximately 5,000 households receive domestic help weekly, 76 per cent of the recipients being over 65 years of age. Nine-hundred home helps are employed and the average cost of providing service to a household for the year 1966–67 was nearly £32. Householders who cannot afford the standard charge of 6/2 per hour are asked to contribute towards the cost of the service in accordance with their financial circumstances, there is a minimum charge of 5/- weekly regardless of the number of hours service provided. Domiciliary services provided under the Act are as follows:

1. Domestic help service
2. Evening service
3. Night attendant service
4. Family care service
5. Family welfare service.

1. *The domestic help service* undertakes the essential duties of the household, help may be provided once weekly to clean floors etc., and can be increased as the patient's mobility declines. Daily help is often necessary for the totally housebound or bedridden patient, on occasions it is necessary to provide split duty service, early morning to light fires, get breakfast and tidy through; mid-day to prepare, cook and serve the mid-day meal and perform household duties, prepare bedside trolleys with food in suitable containers, thermos flasks are also used as a means of feeding patients over long periods. Diets prescribed by the medical profession are strictly adhered to but when special diets are not required arrangements can often be made for the provision of meals-on-wheels from the Women's Royal Voluntary Service. When split duty service is provided the home help is asked to perform general duties between these visits in the homes of ambulant patients. It is obvious that the home help who wants full-time employment must attend some households in the afternoon, which often creates annoyance, but nevertheless an organizer must make the most of available labour and give priority to the bedridden and the housebound patient. It is preferable to start helping the infirm patient before the home has suffered too much deterioration.

2. *Evening service.* This is provided where possible to assist a handicapped person into bed, fill a hot-water bottle, prepare and serve a warm drink, and if necessary a light evening meal. A home help, usually someone who lives fairly closely at hand, attends before 8.00 p.m. Usually half an hour is sufficient to undertake these duties but one hour can be provided where there may be an elderly couple to assist. Many patients who receive this service are being provided with split-duty domestic help service and help is required so that they are left safely for the night.

3. *Night attendance service.* This service is provided from 10.00 p.m. to 6.00 a.m. to any person over or under 65 years of age, who is acutely ill, living alone, awaiting admission to hospital or a terminal case; this service is provided when necessary for a period of three weeks, in special circumstances approval can be given by the county medical officer for the service to be extended for a further period. Evening and night attendant service whilst most desirable are not as extensive as we would wish by reason of staff shortages.

4. *Family care service.* This is provided during the temporary absence of the mother and permits children to stay in their own homes.

5. *Family welfare service* is a training service provided for families with particular problems, organizers visit each household and assess the need, periodic calls are made to ensure a satisfactory service is being maintained. There is no doubt, however, that by expending considerable time and effort it is possible to look after people at home, just as appendicectomies can be cared for in domiciliary practice. But there are cases when it is cheaper and better for residential care to be provided, in other words the doctrine,

so assiduously propagated, that everyone should be kept at home for as long as possible irrespective of the circumstances, should not be carried beyond the dictates of commonsense. As recruitment of home helps is becoming increasingly difficult the good management and maximum efficiency are vital. Training of home helps is becoming more widespread but a national training scheme has not, as yet, emerged. In my county the home helps have a course of training undertaken through further education, and this necessitates their attending an evening college twice weekly for two terms. The course consists of 48-hours practical and 38-hours theoretical training, and deals with the problems arising with the expectant mother, home confinements, care of babies and children, adolescence, menopause, severe illness, old age and family life. The course costs £2 15s. which is paid for by the county council and people living out of the district are paid travelling expenses. At the end of the course an examination is held, three-hours written work followed by a practical session for half an hour. Those who qualify receive a certificate. This training is excellent in giving the home help confidence in dealing with problems which arise in the course of her work, and enables her to carry out her duty in each household in a thorough and most efficient manner.

From that you can see that everything possible is done to provide a home help where necessary, but of course I have not elaborated on the problems. For instance, the amorous elderly gentleman who lives alone, and has very young ideas; the cantankerous and difficult old lady who complains that the home help has either knocked too loudly or not loud enough. Home helps have a difficult if not unrewarding task; they have to be prepared to enter all types of homes where there may be the most modern and up-to-date equipment or nothing more than an old pair of dad's underpants and a broom with only three bristles.

Nevertheless, this is where training of home helps is most necessary and I am very grateful to my medical officer for starting a training scheme for home helps in Kent.

Not only do we provide home helps in homes, but also on boats. No problems arise when the tide is down, but you can imagine what it is like walking the gangplank when the tide is in. I remember having a brief case in one hand and a handbag in the other as I crawled up the gangplank and fell over the side in a most undignified manner. But the real problem was coming back down again, I was told afterwards by a collection of workmen who stood on shore that they hadn't seen anything like it since 'D' day.

Discussion

Dr Haire (*Haywards Heath*): As the symptomatology and rehabilitation of all 'senile vascular casualties' is similar, should not geriatric, psychogeriatric and Part III units all be amalgamated?

Dr Irvine: I think there is a great deal to be said for this idea. It has certainly been proved many times over that an elderly patient with a little mental impairment goes where a bed is available rather than according to his or her precise clinical needs. The answer may lie in the concept of psychogeriatric assessment units. There is a need for a common portal of entry into the geriatric services and this ought to begin with proper medical, psychiatric and social assessment. The trouble is that we have to work with the facilities that we have got. In my own hospital, for example, if we could get one more ward, we could provide this service in consultation with the welfare and the psychiatric services but we cannot get another ward.

Dr Ashley: We have a combined assessment unit of 20 beds for emergency situations where