Clinical Topics

Brendoncare: an initiative in the care of the elderly

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Last month Professor Michael Hall, professor of geriatrics at Southampton University, and Sir Ronald Gibson, former chairman of council of the BMA launched an appeal for £1 million for the Brendoncare Foundation, a charity for the provision of caring homes for the elderly. Their joint statement said in part: "The general treatment of the frail elderly by the state is a scandal. We make no criticism of the dedicated and willing members of the NHS or the quality of care they give, but the system that so ill serves the most vulnerable members of our community is a disgrace. Lack of money and bureaucratic confusion has left a legacy from the Victorian era with the state looking backwards, remodelling ancient buildings and patching up a system of care which is fragmentary, pitifully inadequate, and increasingly inappropriate to the elderly age group.

"The effect is to create institutions which are profoundly depressing for visitors and staff—and the residents who hover in a limbo between life and death—in many cases having little desire to go on existing. They are deprived of privacy, dignity, and security at a time in their lives when they have a right to expect all those things in equal measure. The problem is compounded by the disturbing lack of understanding between the health and social services. This separation is particularly damaging in the geriatric field. The hapless victim is a patient to one and a client to another. The two authorities argue and often disagree."

No one would quarrel with that assessment. One of the most consistently awful features of British society is its indifference to the old—and especially to those who are old and poor. While we no longer, like our Victorian ancestors, condemn "elderly paupers" to the humiliation of the workhouse many old people dread the approach of physical or mental frailty. They know that the institutional care provided by the state for the elderly is often overcrowded and unappealing. Many long stay hospitals and homes are, indeed, horrifying; their physical features are bleak and sometimes frankly squalid while the patients or residents spend their days in futile inactivity waiting for death. Furthermore, waiting lists are so long at all levels—sheltered housing, part III accommodation, local authority homes, and long stay hospital—that old people often spend months or years at an inappropriate level. Doctors know all too well how many families struggle on, caring for an elderly invalid who would be in an institution if there were a place in one close at hand—and if the institutional care provided was attractive.

Foreign contrasts

British doctors who have travelled to other countries to look at their systems of care for the elderly return here angry and depressed. My own response to visits to Denmark, the Netherlands,

and Australia has been to ask why other countries no richer than Britain can provide care which is so very much superior. The institutions I visited in these countries were bright and cheerful, with obviously high morale in both staff and residents.

So when Sir Ronald Gibson told me that the same standards could be achieved in Britain I willingly agreed to visit the Brendoncare Foundation in Winchester to see what had been done.

What Sir Ronald and his team have achieved is an integrated unit for care of the elderly which follows the principles that have been shown to be important in pioneering countries such as Denmark—and which has achieved the same high standards.

Brendoncare provides old people with a residential home which has on the same site a nursing wing for the care of those who develop physical or mental disabilities. Each resident and each patient has his or her own room with a bed, furniture, and possessions brought from their own home. As a result even the nursing wing manages to avoid the institutional atmosphere found so often in places for the elderly. There are sitting rooms and day areas, and a dining room in the residential wing; but residents are free to take meals in their own rooms if they wish. The residents I saw were cheerful and intellectually lively; most were in their 80s or early 90s and some had been living at Brendon for many years. Of those in the nursing wing some had come from hospital after, for example, orthopaedic surgery for a fractured femur; others had been admitted from home with progressive degenerative vascular disease, while still others had been transferred from the residential unit. One room is reserved in each part of Brendoncare for short stay, respite admissions. Some patients are accepted short term on a day basis. The core philosophy, however, is that residents should choose to come into the home at what they believe to be the right time—and should be able to stay there until they die, no matter how dependent they may become.

How is this care financed? The salaries of the nursing and domestic staff and all other revenue costs are met from the fees paid by the residents—which range from £140 to £220 per week, depend-

FIG 1—The original house with the connecting wing to the nursing home.

ing on the size and facilities of the room provided (some have their own shower cubicles, for example) and on the resident's income. But the crucial feature of the system is that the rates currently paid to residential homes by the DHSS are enough to balance the books: nine of the 45 residents at Brendoncare have their fees paid by the NHS. The system may give the impression of being yet another example of the middle classes looking after their own—but in reality it is classless and could be transplanted to any part of the country.

How it happened

The origins of Brendoncare date back to 1954, when the late Mrs Phoebe Bacon converted her house, Brendon, into a home for elderly people in which residents had their own rooms and their own furniture. In 1974 a 14 room nursing wing was built at the end of the garden—achieving the essential principle that once admitted to the home residents would not have to be moved off the site when they became frail or sick. In 1981 a national appeal was launched, which has now topped £209 000 and part of the original house was modified to provide facilities for residents who needed extra care. In 1982-3 five rooms were added to the main house and a further wing of 15 rooms built in the garden.

FIG 2—The nursing home with its day room on the left.

In total, therefore, £600 000 has been spent on the buildings at Brendoncare—none of it coming from central or local government funds. It is because the capital has been raised from charitable sources that the 45 room institution can balance its books with fees within the range provided by the DHSS.

Repeating the pattern

The governors of the Brendoncare Foundation are convinced that they have developed a formula which can be repeated in other parts of the country by communities that have the energy and initiative to follow the example. Plans are under way for similar homes to be established at Otterbourne (Hampshire), Henley on Thames, Froxfield (Wiltshire), and Burley (New Forest). The advisory services of the foundation's honorary consultant architect, surveyors, and accountants are being provided free to these new units.

The principles that Brendoncare believes essential are:

- (1) That the home should be a caring home, not a nursing home or hospital.
- (2) That the inmates will be residents not patients.
- (3) That each resident should have a separate room with his or her own furniture if that is what is wanted.

(4) That medical care when needed will be provided by residents' own general practitioners, with the help of the nursing staff of the home.

(5) That no distinction will be made between NHS and private patients; but necessarily a means test will have to be applied to determine the contribution made by each individual.

(6) That each home will be a charity, not seeking to make money out of the elderly or the state.

Contrast with the private sector

The *BMJ* has recently criticised the growth of private "sunset homes" in Britain. In the past year or two many entrepreneurs have converted former small hotels, large private houses, and other buildings into homes for the elderly infirm. The impetus for this growth came from the government decision in 1983 allowing local authority social services departments to pay the fees for residents of private sector homes. Some of these homes provide their residents with a caring atmosphere but others do not: and very few have the staff or the facilities to care for their residents when they become ill. Where Brendoncare scores is that the fees it collects do not have to contribute to capital costs, interest, or profit margins; instead the whole income is used for revenue costs and so it can achieve good staff/patient ratios in an environment that can be well maintained.

Non-profit institutions

Several of our European neighbours provide care for their elderly populations by allowing non-profit charitable institutions to set up residential/nursing homes with residents' fees paid from the health insurance system. Here in Britain such institutions are unusual, but Brendoncare has shown that they can be established and that (given current scales of payment from the DHSS) they can operate on a sound financial basis.

The essential element, however, is that Brendoncare's capital came from charitable sources. Is it reasonable to expect that enough capital can be raised in this way to finance the thousands of homes that are needed?

The answer from Sir Ronald Gibson and his team is that each community must make its own efforts. My own belief is that in present economic circumstances some combination of charitable and state resources seems the only way that our care for the elderly will be improved. The prevailing mood among health professionals working with the elderly is profoundly gloomy, with the demographic tide rising relentlessly. So the Brendoncare initiative is one of the few recent developments that gives any grounds for optimism. But the postscript must sound a note of pessimism: Brendoncare has a waiting list of 100. Britain needs to double its number of places for the elderly infirm before there can be any prospect of such waiting lists being substantially cut.

References

- 1 Smith T. Denmark: the elderly living in style. *Br Med J* 1983;287:1053-5.
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- 3 Smith T. Old age in the sun. *Br Med J* 1984;288:1515-7.
- 4 Godber C. Private rest homes: answers needed. *Br Med J* 1984;288:1473-4.

Correction

Preliminary experience with a hospital blood pressure follow up clinic with nurse practitioner assessment and microprocessor based data retrieval

We regret that an error occurred in this paper by Dr P C Rubin and others (1 September 1984, pp 537-9). The values for diastolic pressure in the left hand column of the table should have read ≤ 90 , -110 , and >110 , reading downwards, not ≤ 150 , -180 , and >180 .