A Slovenian model of integrated care for older people can offer solutions for NHS services

Services need to adapt to meet the needs of our ageing population. A model of care from Slovenia provides an innovative approach to caring for older people

INTRODUCTION

Britain is experiencing a demographic transition as the post war baby boomers reach retirement age (Age Concern, 2008). The number of people aged 85 and over is projected to more than double over the next 25 years, from 1.3 million in 2008 to 3.3 million by 2033 (Office for National Statistics, 2009). With significant increases predicted in the number of over 65s with dementia, coronary heart disease and osteoporosis by 2025 (Telegraph.co.uk, 2009), those providing care for older people face a major challenge.

The National Service Framework for Older People (Department of Health, 2001) encouraged the eradication of age discrimination and promoted the importance of supporting person centred care within newly integrated services, with particular focus on integrated mental health services. Translating these nationally supported standards into local delivery presents challenges for the NHS, as the present model of care segregates social and nursing care when older people begin to need assistance with activities of daily living.

In November 2006, the DH launched a Dignity in Care campaign, which initially focused on dignity for older people. In August 2007, it was extended to mental health services where it covered tackling stigma, the therapeutic environment, safety and privacy, extending rights to advocacy and older people’s mental health.

The visit to the University of Maribor in Slovenia was funded by an Erasmus (European Region Action Scheme for the Mobility of University Students) grant. University staff were welcoming and we were able to share significant insights into the similarities and differences in the delivery of student nurse training, despite the language barrier.

The visit included an appointment at an elderly care facility where the model of care promoted was innovative and creative. It was also financially prudent and provided integrated holistic care for residents. We believe the NHS should consider adopting this approach to respond to the recommendations of the National Service Framework for Older People (DH, 2001) and the NHS next stage review interim report (DH, 2007a), both of which promoted delivery of care in the community.

The launch of the “whole system demonstrators” approach to integrated health and social care (DH, 2008; 2007b) further encouraged healthcare providers to shift care from hospital by supporting people

LESSONS FROM ABROAD

Britain is not alone in facing this burden of care and much can be learnt from other European countries running initiatives mirroring those of the NHS. This article describes a visit to Slovenia to investigate a seamless model of care that caters for people from when they require only minimal assistance through to high dependency needs and eventually end of life care.

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PRACTICE POINTS

- The ageing population is having, and will continue to have, a big impact on nursing care.
- Nurses need to consider how they can provide appropriate and individualised care.
- The profession needs to promote dignity in care, particularly for vulnerable older people and clients with mental health needs.
- Greater thought should be given to the integration of social and nursing care.
so they could retain their independence in the community. These proposed integrated approaches to care can be seen in the Slovenian model.

**SUNNY DALE**

Sunny Dale (translated title) is a concrete tower block, which, we were told, had been used as offices during Tito’s communist regime. However, about a decade ago it was converted into an elderly care facility for private and state funded residents.

The overarching philosophy at Sunny Dale fits with the *National Service Framework for Older People* (DH, 2006b; 2001), which aims to ensure that older people receive appropriate and timely care packages that meet individual needs regardless of health and social service boundaries.

The set up of the home ensured that residents needing health and social care were able to remain in one place throughout their lives, with their varying care needs being met under one roof. If their care needs changed they could still be met at Sunny Dale.

This flexibility is evident in the structure of the care facility (Box 1).

**Layout of the facility**

The layout in Box 1 illustrates the range of health and social care provided at the home. The top floor contained single rooms catering for fee paying residents who have varying degrees of physical disability but do not need a high level of nursing care.

We visited one woman on this floor who was a wheelchair user. She needed assistance with mobility but had a range of aids to help her to remain relatively independent. The seventh floor was similar, although residents on this floor share rooms and are funded by the state.

Floors 5 and 6 were devoted to the care of residents with mental health problems, particularly those with dementia and difficulties in cognitive functioning. These levels were staffed 24 hours a day by healthcare assistants. They were accessed by lifts requiring a code to operate, providing a higher level of security for residents.

Floors 3 and 4 were devoted to providing high levels of nursing to people with severely reduced mobility and acute care needs. The majority of patients on these floors were confined to bed and care was provided again by healthcare assistants with the support of a qualified member of staff.

The first and second floors offered sheltered housing style accommodation, with assisted living for residents. They had their own rooms with en suite bathrooms and cooking facilities. This fits with the NHS Modernisation Agency’s (2009) commitment to promoting self care in the management of long term conditions.

The ground floor had clinical facilities where nurses and doctors could conduct clinics and provide treatment. Residents could be given communal healthcare such as flu vaccinations, to prevent the spread of infection. This is an important element of community living, to ensure disease prevention and health promotion (Gaughran et al, 2007).

The basement contained a social space where residents meet, as well as restaurant facilities providing meals for those who needed them. Green et al (2008) emphasised the importance of providing stimulation for patients and clients. In Sunny Dale, the occupational health service organised three sessions a week for residents to enjoy a range of activities based around arts and crafts. The sessions were arranged by floor so that residents with mental health problems who needed more supervision were catered for on a different day to those needing less help.

In total, there were 160 residents, cared for by three qualified nurses, 15 healthcare assistants and one social worker who linked...
with community social workers. There were also three doctor sessions per week. Staffing levels depended on the nature of care provided on each floor and needs assessment. Although levels appeared to be minimal, there was no evidence of staff being under strain and the atmosphere was relaxed, friendly and competent.

The home also organised social outings for the independent living residents and had its own singing group, which gave regular performances to other residents. This is, we were told, an important part of Slovenian culture for the older generation. Residents’ intellectual and spiritual needs were met through a fully stocked library and chapel offering weekly services.

Sunny Dale was partly state funded, with additional private income generation. Interestingly, charges for medications varied; some were provided by the state but residents or their relatives were required to pay for some of the more expensive drugs.

**COMPARISON WITH NHS**

The integrated care provided at Sunny Dale has similarities with the definitions of care outlined by the NHS Modernisation Agency (2009) but with the unusual feature of being provided in one facility.

As stated by the Modernisation Agency, most people (70–80%) with long term conditions can care for themselves with minimum input from health and social services (Fig 1, page 11). They represent the bottom floors of the Sunny Dale model – that is, those who would probably live in sheltered housing.

The middle layer includes high risk patients who need more active disease and care management from professionals. This would correspond to the people with mental health problems and those on the two upper floors at Sunny Dale who needed assistance. Finally, in the top level of the pyramid are patients with highly complex needs. These are usually aged over 65, and represent a small proportion of the population. This category can also be identified in the care provided at the home as those requiring a high level of nursing care and those reaching the end of life.

**CONCLUSION**

Sunny Dale provides an inspirational approach to the care of older people needing varying levels of support. The home is a community that provides autonomy for those capable of caring for themselves but can also respond to their needs if and when they change or their health deteriorates.

The Sunny Dale model appears to offer solutions that meet the NHS agenda for care of older people. If nurses are to embrace the fundamental principle that “the practice of caring is central to nursing” (Watson, 1979) we need to acknowledge that this type of seamless approach is a valid one.

This model should be explored as a possible way to meet the new priorities in delivering care for older people and should be viewed as an opportunity to blur the existing boundaries between health and social care. ♦

**REFERENCES**


Telegraph.co.uk (2009) Number of Dementia and Heart Disease Sufferers to Stretch NHS to Breaking Point. Telegraph.co.uk. tinyurl.com/nhs-older-illness