KING EDWARD'S HOSPITAL FUND
FOR LONDON

HOSPITAL
PERSONAL AID SERVICE
FOR THE ELDERLY

REPORT TO 31st DECEMBER 1960

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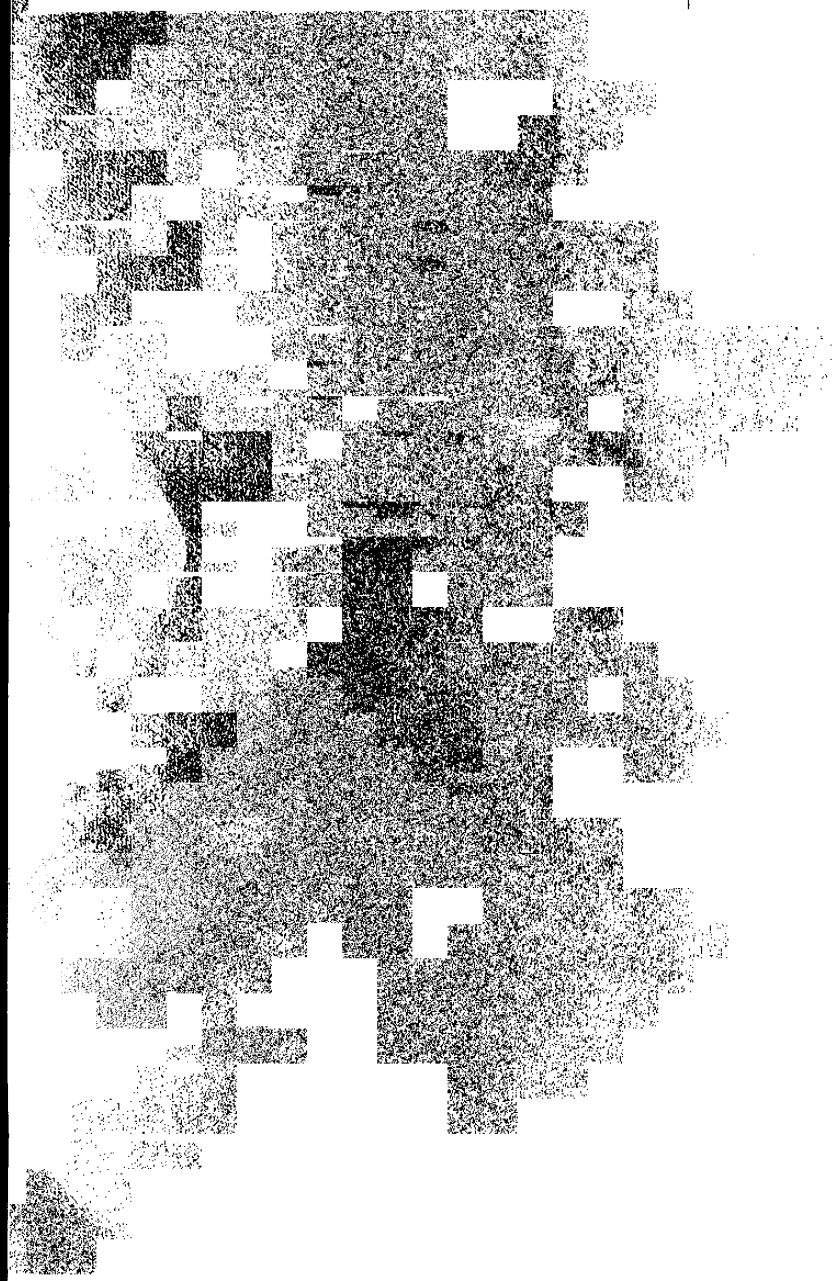

HOSPITAL PERSONAL AID SERVICE FOR THE ELDERLY

THE Service undertakes:

1. To visit, on behalf of hospitals, elderly people awaiting admission to hospital whose medical condition does not warrant immediate admission to an acute ward.

   The main objects are:

   (a) To assess the social circumstances in order to suggest to the hospital the priority, based on social grounds, of those who need admission.

   (b) To inform the hospitals of the home circumstances of the patient both in support of the suggested priority and as a guide when discharge is being considered.

   (c) To suggest suitable means for the care of those patients who are not considered by the hospital to need admission on medical grounds.

   (d) To ensure that the waiting list is kept accurate by informing the hospital of any case which, through any change of circumstances, can be removed from the list.

   No patient is visited and no action is taken except at the request of the hospital staff who are consulted at every stage.

2. To provide a centre where hospital and other authorities can obtain information about the services for, and assistance with, the problems of the elderly and chronically ill.

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REPORT TO 31st December 1960

In presenting this Report on the work of the Service during 1960 we are pleased that we are able to show improvements in the hospital service which, we are convinced, are leading to greater benefits to patients themselves.

In dealing with chronically ill patients, particularly those up to middle age, it is not difficult to allow the wish to provide ample comfortable and pleasant accommodation to assume greater importance than facilities for diagnosis, treatment and rehabilitation. We believe that unless extreme care is taken, some patients may be admitted to long term accommodation when they should have been admitted elsewhere for treatment from which they might have benefited.

Our work shows that indifferent administration and organisation often cloud the true position, making it appear much more formidable than it really is. The following details of a recent experience will explain what we mean.

During a survey of waiting lists which we made in March 1960, a hospital group suggested to the hospital board that they need not be included as they maintained a fairly extensive visiting scheme which kept them in touch with patients before they were admitted and informed them of any changes. We did however make the survey and, of the 62 patients on the list, 9 had already been admitted, 14 had recovered or refused admission, 2 had died and 7 had left the district or could not be traced. Eleven patients from this list were admitted during the course of the survey, which lasted a month. Thus the actual number still waiting and needing admission at the end of that time was 19.

By the end of 1960 an agreement was made with the board and the hospital management committee for us to undertake regular domiciliary assessment for this hospital group. By then there were 56 patients on the waiting list and, after visiting them all, we suggested that 26 could be removed and asked if 8 others could be considered for out-patient treatment. Five months later none of the 26 had been removed from the list but when we

drew attention to this all the names were taken off. No arrangements were ever made for out-patient treatment for any of the 8, although the suggestion had originally been well received, and eventually all became in-patients.

Applications for admission in the group are made in two ways. Most general practitioners are directed to the medical records department but some insist on speaking to the medical registrar personally. We visit the medical records department cases but, however urgent we consider any to be, none has priority over the registrar's cases which no one has visited. Obviously all cases must have equal scrutiny by hospital medical staff and we are sure that in due course a better system than the present one will be introduced.

This situation is not unique and supports our contention that there are many administrative improvements still to be made within the hospital service.

DOMICILIARY SOCIAL ASSESSMENT

The Service has continued to visit patients whose doctors have applied for their admission to hospital. The purpose of these visits is to make an assessment of the social needs of the case to ensure that those with the greatest need are given priority and to suggest, and if necessary arrange, any appropriate alternative care that may be agreed on.

Two thousand and seventy four patients were visited for assessment. This is 346 less than in 1959 and is due to work being discontinued in three areas outside the metropolis. If the figures for 1959 in these three areas are disregarded there was an increase of 142 patients in the twelve remaining management committee groups.

Table I gives a statistical summary of the results of the domiciliary visits compared with those of 1959 and the totals since the Service began its work in 1951.

TABLE I

Statistical Summary of Patients Visited for Social Assessment

	1951-58	1959	1960	%	Totals 1951-1960	Totals %
Patients visited	11,513	2,420	2,074		16,007	
1. *Removal from Waiting List*						
(a) Died or already admitted	1,337	119	96		1,552	
(b) Withdrawn	2,880	440	398		3,718	
(c) Other arrangements ..	1,614	561	522		2,697	
	5,831	1,120	1,016	48.99	7,967	49.77
2. *Admission to Hospital*						
(a) Priority I (Urgent) ..	626	49	25		700	
(b) Priority II (Less Urgent)	1,459	247	265		1,971	
(c) Priority III (Not Urgent)	1,101	321	273		1,695	
(d) After observation ..	1,587	528	407		2,522	
	4,773	1,145	970	46.77	6,888	43.03
3. *Died before Admission* ..	336	30	14	0.68	380	2.38
4. *Still Awaiting Admission*						
(a) Priority I	—	—	—			
(b) Priority II	—	—	2	0.09	2	
(c) Priority III	—	—	6	0.29	6	0.05
5. *Still Under Observation* ..	—	—	7	0.34	7	0.04
6. *Died While Under Observation*	573	125	59	2.84	757	4.73

The figures show that the usual pattern is being followed and the number of cases found not to need hospital admission is approximately the same as the number who do. Many of the figures may need explanation.

1 (a) The number of patients who have died or who have already been admitted when the visit to their home is made is decreasing and stands now at about 4% compared with 9% for the total since 1951. This figure partly reflects the manner in which hospital records are kept or, more accurately, used to be kept, because it was not uncommon for our visitors to be asked to call

on patients who were already in the hospitals concerned. Now these are mostly cases where the general practitioner has failed to inform the hospital that the patient has been admitted elsewhere or has died.

1 (b) Unless other arrangements are known to have been made patients removed from the waiting list are shown under this heading. They include those who refuse admission, have recovered and do not need admission and others whose applications the general practitioners cancel.

1 (c) "Other arrangements" include admissions made to welfare homes and to private homes or other accommodation outside geriatric units, the provision of domiciliary services and other appropriate ways of assistance.

About 20% of the patients visited are kept under observation, which means that for some reason a definite decision is deferred. It may be that the patient is to be seen in the out-patients department or, at the time of the domiciliary visit, was too ill to be moved. In such cases delay in admission is intended or death expected and for these reasons the patients are classified separately and appear eventually in either 2 (d), 5 or 6.

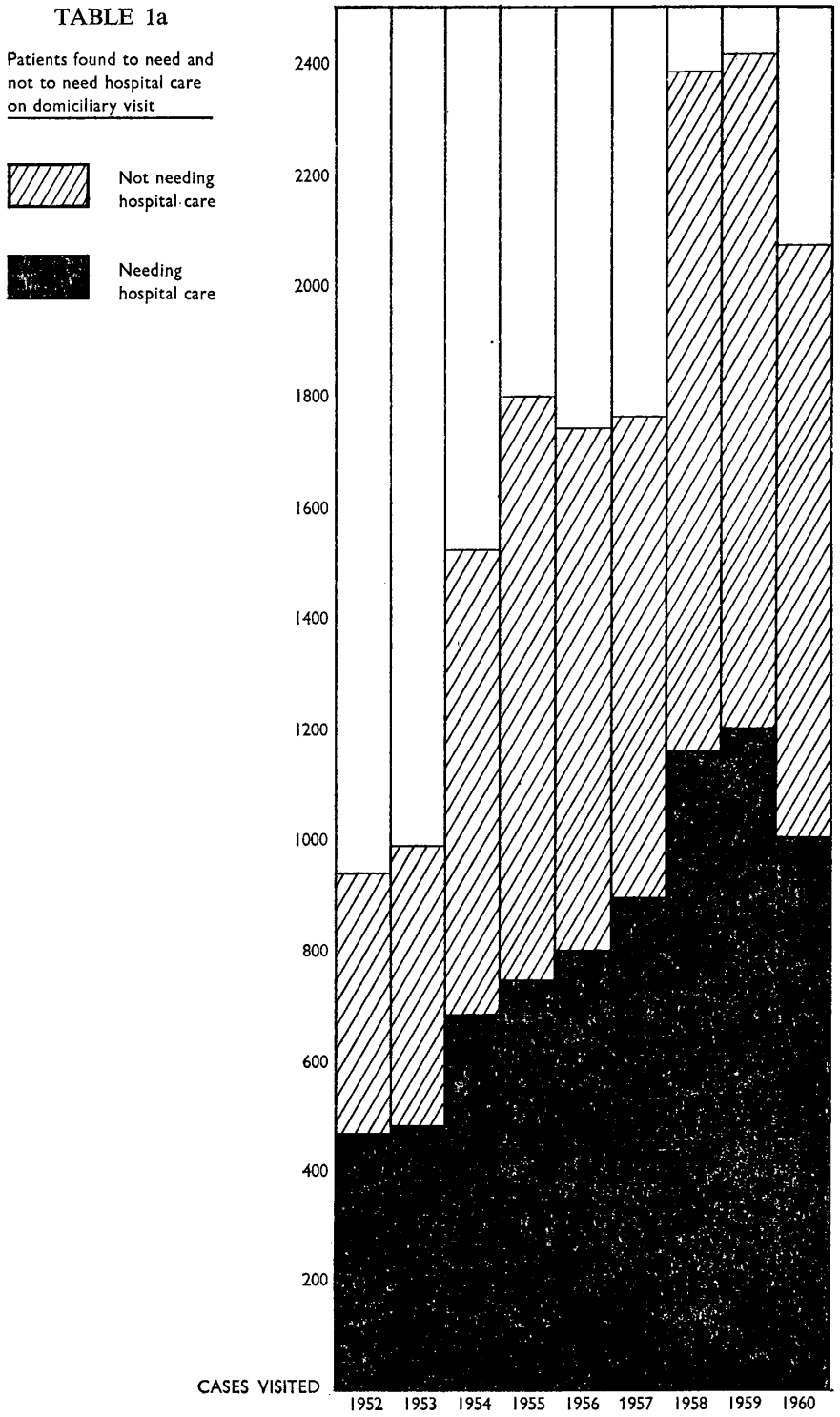
3. Patients under this heading "Died before Admission" have been assessed as needing hospital care but die before admission is arranged.

4. Only eight patients needing hospital care awaited admission at the end of the year. None of these was urgent and in fact the applications had only been made during December.

Table Ia gives, as a graph, the proportions needing and not needing hospital care. There are 7 cases excluded from this graph in 1960 as they were still under consideration by the hospitals at the end of the year.

TABLE 1a

Patients found to need and not to need hospital care on domiciliary visit



Length of Wait for Admission

The Service has noticed the very marked improvement in the time patients wait for admission. Nine years ago only about 30% of the urgent and less urgent hospital cases were admitted within a week of the domiciliary visit. Now 74% enter hospital within a week.

TABLE II

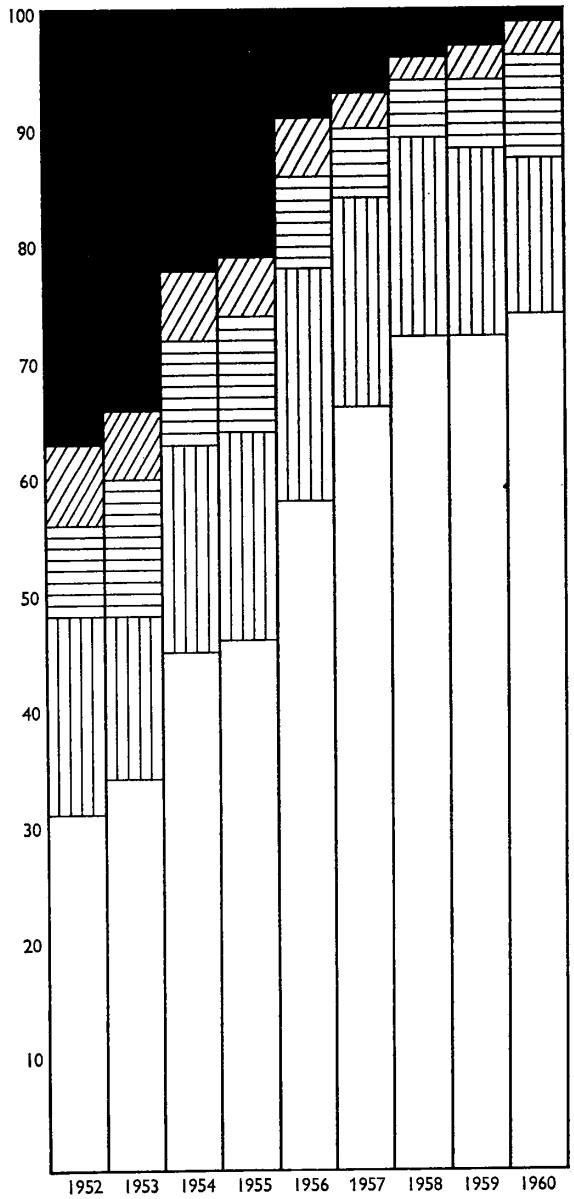
Length of Wait for Admission

	1954	1955	1956	1957	1958	1959	1960
CASES ADMITTED	348	219	219	228	353	296	290
On day of visit ..	10	13	18	27	24	21	29
1 day after visit	43	29	30	48	67	48	49
2 days after visit	35	25	24	25	42	32	42
3 days after visit	20	12	17	15	41	42	43
4 days after visit	16	5	16	13	32	18	26
5 days after visit	15	9	11	7	19	21	18
6 days after visit	19	8	12	14	28	33	9
i.e. within 1 week	158 45%	101 46%	128 58%	149 66%	253 72%	215 72%	216 74%
During 2nd week	63 18%	40 18%	43 20%	41 18%	60 17%	47 16%	37 13%
During 3rd week	31 9%	22 10%	18 8%	13 6%	19 5%	17 6%	25 9%
During 4th week	20 6%	11 5%	11 5%	7 3%	7 2%	10 3%	8 3%
During 2nd month ..	37 11%	23 11%	10 5%	12 5%	8 2%	5 2%	3 1%
Over 2 months	39 11%	22 10%	9 4%	5 2%	6 2%	2 1%	1 —

Table IIa shows clearly the steady increase in the numbers admitted after only a short wait and the reduction of the number of those waiting longest.

TABLE IIa

LENGTH OF WAIT FOR ADMISSION PER 100 CASES



Length of Stay in Hospital

Out of a total of 16,007 patients visited and assessed since 1951, 6,888 have been admitted to hospital. Table III shows their length of stay. It is well known that the greatest number of deaths and discharges occur during the first four weeks in hospital but it is interesting to see that patients may still be discharged after a stay of two years or more; one patient went home after six years.

TABLE III

Length of stay in Hospital

Days	*Deaths*	*Discharges*	*Still In*
0 — 28	1,347	1,219	39
29 — 56	477	736	15
57 — 84	260	413	5
85 — 112	160	227	4
113 — 140	115	129	13
141 — 168	92	102	9
169 — 196	63	73	7
(6 months)			
197 — 224	67	50	7
225 — 252	61	38	5
253 — 280	49	32	2
281 — 308	46	31	7
309 — 336	52	18	4
337 — 364	28	13	7
(1 year)			
365 — 392	36	21	6
393 — 420	37	13	12
421 — 448	29	14	3
449 — 476	28	10	5
477 — 504	24	7	7
505 — 532	27	9	6
533 — 560	24	8	6
561 — 588	14	5	11
589 — 616	13	4	7
617 — 644	13	2	5
645 — 672	18	4	10
673 — 700	12	3	6
701 — 728	17	4	4
(2 years)			
3rd year	111	27	37
4th year	68	6	22
5th year	38	4	14
6 years and over	26	1	28
	3,352	3,223	313
		6,888	

Table IIIa shows how many patients in every 100 admitted to hospital, die or are discharged. It will be seen that the proportion now being discharged is becoming increasingly greater than those dying, and the position eight years ago is now reversed.

The increase in the number of patients still in hospital from 1958 compared with previous years is due to the Service having visited 600 more cases in 1958 and to the admission of 315 more patients that year. This increase has been maintained.

TABLE IIIa

Deaths and Discharges in Hospital per 100 *patients*

	Deaths	*Discharges*	*Still In*
1952	59	38	3
1953	60	38	2
1954	56	41	3
1955	57	37	6
1956	52	40	6
1957	48	45	7
1958	33	46	21
1959	34	48	18
1960	33	55	12

SURVEY OF WAITING LISTS

In the regular domiciliary assessment of patients which the Service makes every year, as reported in the preceding paragraph, something like fifty per cent of the patients are, for various reasons, not in need of hospital care; some are already receiving it although, in fact, their names remain on the waiting list.

With the agreement of the Ministry of Health, certain regional hospital boards and management committees, the Service undertook to survey the chronic sick waiting lists of a number of hospital groups in the metropolitan hospital regions. The survey has not yet been completed and it would be unwise to draw any definite conclusions at this stage. In April a total of 286 cases awaiting admission in nine hospital groups was reduced to 171. In October, 117 waiting in two groups was reduced to 66 and, in November, 51 in a further two groups was reduced to

34. The final total of 271, to which the lists of these thirteen groups was reduced, includes 110 patients already occupying hospital beds but awaiting transfer to other wards and hospitals. Thus, the actual number of hospital beds needed to accommodate the waiting cases was 161 and not 454 as at first seemed to be the case.

It is intended to report fully when all the surveys have been completed.

INFORMATION AND ADVISORY SERVICE

Requests for information and advice on elderly and chronically ill people's problems and on the services and accommodation for them are being made to the Service in increasing numbers.

A small innovation in this branch of the Service's work has been the publication, quarterly, of comparative statistical information relating to geriatric and chronic sick units in London. The idea suggested itself because some geriatric physicians had asked, from time to time, how their situation and results compared with those of others. At present, 29 hospital groups send figures of their beds, admissions, deaths, discharges, etc. to the Service where the statement is compiled.

It is hoped that these statements may lead to more accuracy in the statistical information that is provided for official publication and will encourage a wider interest in the work and development of geriatric units. A number of hospital groups ask for several copies of the statement for their Committees and we have been able to find various differences in interpretation and record keeping. For instance, in some groups every application is put on the waiting list and remains there until admission or some alternative is arranged. In other groups only when a patient has been assessed as being in need of hospital care is his name put on the waiting list. Thus it is possible for one hospital group to have, say, 25 cases assessed and 25 applications awaiting assessment and to show a waiting list of 50 while another hospital group would, in similar circumstances, say that the number awaiting admission was only the 25 cases who had been assessed.

Figures are compiled and used by hospital management committees, regional hospital boards and the Ministry of Health but would appear often to be unreliable because of inaccuracies and lack of uniformity.

YOUNG CHRONIC SICK

In our last Annual Report brief reference was made to the complexities which obscure the finding of a satisfactory solution to the problem of young chronically ill patients. Surveys and enquiries have indicated that to consider providing only long-term accommodation could in itself be harmful; care must be taken not to create dumping grounds. While there is certainly general agreement that young patients should not be in wards with the elderly and senile, there is not unity of opinion that young long-stay patients should all be together.

Towards the end of the year, as a result of further discussions, it was decided to make intensive enquiries in certain areas which, it is hoped, will show more clearly what accommodation is needed and for what kinds and ages of patients, and how and where it might best be provided. We have the ready co-operation of the authorities—hospital, health and welfare—all of whom are responsible for the care, in some form, of young sick and disabled people, and progress has already been made in the preliminary stages of the enquiry. This must necessarily be somewhat prolonged as it involves obtaining details of individual patients from many different sources. It is believed however that the information which is obtained will enable definite plans to be made.

LEWISHAM SCHEME

The Special Committee, under Lady Clitheroe's chairmanship, which investigated the provision for the elderly sick, made three recommendations. One of these was that a model scheme be established in two or more hospital group areas with a view to seeing what can be accomplished with full co-operation between all services for the elderly and to ascertain whether any gaps exist and how best to fill them.

The first area to be chosen was the Borough of Lewisham which is approximately the catchment area of the Lewisham Hospital Management Committee. The scheme is in the hands of a Committee which meets monthly under an independent

chairman nominated by the Fund and is composed of representatives of the London County Council Health and Welfare Departments, Lewisham Hospital Management Committee, Lewisham Borough Council, General Practitioners and Old People's Welfare Association.

The Committee has studied the local services closely and has also explored the possibilities of services which have proved successful in other areas being started locally. Steps have also been taken to find whether there are people in need, what those needs are and to what extent they cause or might indirectly cause hospital admission.

The Fund has approved a payment of £5,000 for a house-to-house survey by the Government Social Survey, which the Committee decided was essential. It is expected that the Report on this will be in the Committee's hands by the end of 1961.

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