ADMISSION OF PATIENTS TO HOSPITAL

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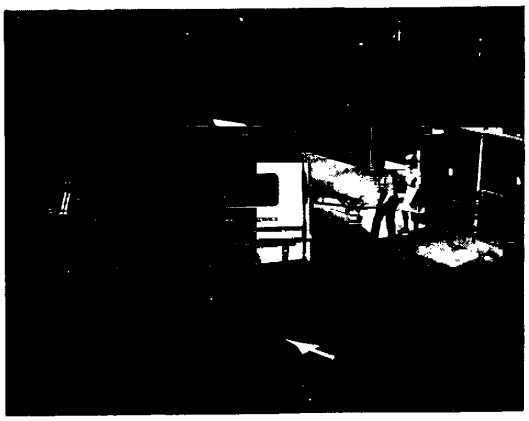

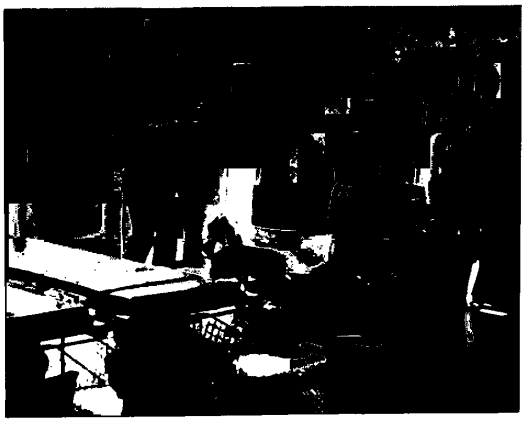

14 Palace Court London W2 4HT
Telephone: 01-727 0581

ADMISSION OF PATIENTS TO HOSPITAL

by Howard Baderman BSc MRCP
Christine Corless BA
M J Fairey
Michael Modell MRCP MRCGP
Yvonne Ramsden SRN SCM

Foreword by Sir Francis Avery Jones CBE MD FRCP

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PARTICIPATING HOSPITALS

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Sir Francis Avery Jones CBE MD FRCP Chairman
consultant physician
Central Middlesex Hospital, London

Howard Baderman BSc MRCP
consultant physician
University College Hospital, London

Christine Corless BA
deputy secretary
Brookwood Hospital, Surrey
(formerly project officer, King's Fund Centre)

M J Fairey
house governor
The London Hospital

M C Hardie MA FHA
director
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Michael Modell MRCP MRCGP
general practitioner in the London Borough of Camden

G A Phalp CBE TD
secretary
King Edward's Hospital Fund for London

Yvonne Ramsden SRN SCM
group principal nursing officer
West Manchester Hospital Management Committee
(formerly principal nursing officer,
North London Group Hospital Management Committee)

Irfon Roberts MA FHA Secretary
assistant director
King's Fund Centre

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As we proceeded with this study we realised that admission to hospital covers a very wide field and the real need for such an investigation became apparent. We are most grateful to the King's Fund for making the study possible, for secretarial and other supporting services provided by the King's Fund Centre, and for the guidance of the steering committee. We would like to express our particular thanks to the chairman, Sir Francis Avery Jones, and to Irfon Roberts, secretary, for their constant support and advice.

We would also like to express our appreciation to the staff of the hospitals who participated so readily in the survey, especially for the cooperation and help given by those hospitals we visited, and to the Emergency Bed Service, London, for their helpful comments.

HB
CC
MJF
MM
YR

CHAIRMAN'S FOREWORD

Hospitals, like big ships, are made up of dozens of units working independently. Ships have the advantage that at least there is one hand on the wheel, unlike hospitals where responsibility is often divided between three or more, even in one unit or one service.

This report's list of contents shows how many facets there are to the arrangements needed for admission of patients to hospital. There is much to be said for nominating one person to take the responsibility for monitoring the arrangements, and the need for regular review of all procedures must be accepted by the administrators, medical records staff, nursing staff and by the doctors. If attention is given to detail in the organisation of each step, there can be considerable improvement in the efficient use of beds and in maintaining the all-important personal touch. The first impression is always such an important one, particularly if the patient is apprehensive.

The report brings together examples of the best practice in a number of hospitals up and down the country. It is hoped that by making review and revision a simpler process, admission procedures will be better organised, leading to better care for patients.

FAJ
London
1973

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INTRODUCTION

The seemingly simple task of finding a bed for a patient in need of specialist treatment and skilled nursing can be anything but a simple one.[11]

The function of hospitals is to treat patients, admitting them when necessary. Most patients are sent to the hospital by their general practitioners, but some arrive direct via the ambulance service. In many hospitals about half the patients are admitted as acute emergencies. Although there is little difficulty about the majority of admissions, sometimes delays and difficulties arise, causing patients and their doctors frustration and discontent. In some cases the patients may even suffer. It is a disturbing fact that between 10 and 20 per cent of all patients referred to the Emergency Bed Service in London by their family doctors, have to be medically refereed into the nearest hospital, which, together with five other hospitals, had previously refused to take the patient.

The administration of admission of patients to hospital is a complex and difficult problem. Maintenance of a correct balance between waiting lists and emergency admissions, the need for flexibility in bed allocation between specialties, and a variety of more local problems, all have an effect upon the standard of service given by the hospital to its patients. While admittedly there are many problems in hospitals, there has been a growing feeling that more could be done to overcome many of the administrative difficulties by examining existing procedures and perhaps attempting to standardise some of them. At the suggestion of Sir Francis Avery Jones, the King's Fund agreed to undertake a survey of the problems and possible solutions in the organisation of efficient and considerate procedures for the admission of patients to hospital. It was decided to concentrate largely on hospitals that were believed to have already established good practice in this field. The purpose of the survey was to produce a report focussing attention on good practice that could be of immediate practical help to hospital and health service authorities. The method was to ask for specific examples of existing procedures and innovations, with some statistical background, rather than conducting a purely statistical study. It was felt that three main areas needed investigation; firstly, the relationship of the general practitioners to the hospital admission department; secondly, the means of ensuring greater flexibility in the use of beds and maintaining the optimum ratio between elective and emergency admissions; and thirdly, the mechanics of the admission procedures necessary to ensure administrative efficiency and at the same time to maintain a personal approach to the patients. The brief was gradually extended to cover several other problems which it was felt impinged directly upon admission procedures. In the event, the final report does not consider these main problems strictly in the above form or the above order, but considers the problems as they affect a patient whose admission must be achieved and who may hail from one of a variety of 'sources', such as a waiting list, or who is an emergency admission. In this way, it was intended to follow sequentially the way the system impinged upon a patient, from his appearance on a waiting list to his discharge from hospital.

The Fund set up a small steering committee, with Sir Francis Avery Jones as chairman. Four members of this committee formed the working party to operate as a team with a full-time project officer. They were Dr Howard Baderman, consultant physician at University College Hospital, London; Mr Michael Fairey, at the time deputy and now house governor at The London Hospital; Dr Michael Modell, a general practitioner at the James Wigg Centre, London, NW1; and Mrs Yvonne Ramsden, at the time principal nursing officer of the North London Group Hospital Management Committee and now group principal nursing officer of West Manchester Hospital Management Committee. Miss Christine Corless was appointed project officer, and is now deputy secretary of Brookwood Hospital, Surrey.

METHOD

Pilot Survey

A draft questionnaire was drawn up and distributed to three hospitals in London. The results showed that the draft was too long and complicated to produce a satisfactory response on a national scale, and the questionnaire was simplified accordingly.*

Distribution of Questionnaire

The survey was initially limited to the 60 general hospitals in the United Kingdom which have over 500 beds and an accident and emergency department as defined in HM(63)40[55] and HM(68)83[56]. The revised questionnaire was distributed to hospital management committees in July 1971 for completion by the appropriate hospital. The questionnaire was also sent to senior administrative medical officers of all regional hospital boards for their comments. It was hoped to gain information about small hospitals from this source, and also from the HMCs already contacted who had smaller units within their groups, which they considered might also be of interest.

Response

Replies were received from 17 of the 20 regional hospital boards (85 per cent), nine of which gave detailed information. Of the 60 questionnaires distributed, 55 (92 per cent) were returned, with one hospital asking to be excused from taking part. Of the 55 hospitals participating, 25 were classified as acute general hospitals, 11 as mainly acute and 19 as teaching. Four hospitals had over 1000 beds and six hospitals, for various reasons, such as reallocation or upgrading, had under 500 staffed beds. The questionnaires were analysed, with special attention to the final question which asked for examples of and opinions on good practice.

Visits

Following up information given in the questionnaire and the comments of the regional hospital boards, members of the working party visited 14 hospitals throughout the country, as well as the Department of Health and Social Security and the Emergency Bed Service in London.

The Report

From these sources, examples of good practice have been selected which could be valuable to hospitals and their local general practitioners who are reviewing their admission procedures. Examples of common problems met, and innovations designed to overcome them, form the larger part of the report. From these have been drawn the recommendations.

*See Appendix A for final questionnaire.

SUMMARY OF MAIN RECOMMENDATIONS

1 Have a flexible system of admission
Hospitals should study their admission systems thoroughly and devise clearly defined policies which will balance conflicting demands on the system, giving maximum flexibility.

2 Keep the patient in the picture
Patients must be treated with great consideration and friendliness at every stage of the admission procedure. The patient should be fully informed on every aspect of his admission, his apprehension allayed and his dignity preserved at all times. Information booklets, a pre-registration system, private interviewing rooms in reception, and well trained reception and escort staff can do much to build up an informal and relaxed atmosphere, as well as save time on arrival at the hospital.

3 Keep the general practitioner informed
The general practitioner should be informed each time any decision is made by the hospital to admit or discharge his patient. He can do much to allay the fears of a patient, if he is fully informed at all stages of the admission procedure. Close cooperation between the hospital and the general practitioner ensures continuity of care of the patient.

4 Give patient and general practitioner some freedom of choice of hospital
In centralising admission arrangements for an area, some freedom of choice of hospital for the patient and the general practitioner should be maintained.

5 Consider the subject of admissions as a whole
Both waiting list and emergency admissions must be regarded and managed as a whole, and not treated as separate, irreconcilable concepts.

6 Revise the procedure regularly and make it known
A clearly defined admission procedure should be regularly reviewed. It should be given to all new members of the medical, nursing and administrative staff and circulated widely to local general practitioners and health authorities.

7 Consult the staff in devising the procedure
Without the full understanding and cooperation of the medical and nursing staff, no admission procedure can possibly succeed. To secure this cooperation, doctors and nurses must be involved in designing the procedures. This is vital in areas such as selection from the waiting list, predicted discharge, and allocation of beds.

8 Ensure that the consultant is personally involved with managing his waiting list
Waiting lists must be well arranged. Senior medical staff should be personally involved in the selection of patients for admission and only they should authorise the removal of a patient's name from a list. Waiting lists should clearly indicate priority and should be regularly reviewed by consultants so that they are **real** waiting lists.

9 Have one person to manage the bed state
One person should be responsible for the management of the bed state with ultimate responsibility for placing any patient in any bed in the hospital. (*See also recommendation 11.*)

10 Have a centralised system with good communications
Admission procedures should be centralised in one administrative area. The current bed state and all waiting lists should be accessible and visible here at all times. The admissions office should be situated to give easy access to medical staff and designed for the efficient transmission of information to and from wards and departments. Close contact with the accident and emergency department is especially important.

11 Have a flexible system of allocating beds
Beds should be allocated flexibly throughout the hospital. If beds are strictly allocated between specialties, closely controlled and limited 'lodging out' of patients can help to make better use of them.

12 Keep the bed state accurate
Every hospital should have an accurate bed state record, continuously updated, in order to make the best use of available beds when admitting patients.

13 Give the general practitioner prompt access to the system
A general practitioner needing to admit a patient as an emergency should have prompt access to the admissions office and to the appropriate person on the hospital medical staff when desired. This officer should be readily available at all times.

14 Give clerical staff authority to accept emergency cases

Prompt acceptance of emergency cases by the clerical staff of the admissions office, provided a bed is available, should be encouraged. This is a qualified acceptance of the patient with a view to admission. The patient should be reassessed on arrival by the hospital medical staff. This reduces the delay initially incurred in having to contact the appropriate doctor for a decision. Only a member of the medical staff should refuse an admission. A record should be kept of all refusals.

15 Have one point of entry for admitting all emergency cases

All emergency admissions should be channelled through one point, on arrival at the hospital. This improves prompt documentation and disposal. Clinical assessment may be carried out in this area and, if necessary, initial treatment begun very early on. The patient is then admitted to the most appropriate bed.

16 Use an admission ward to full advantage

An admission ward can act as a buffer in an admission system, provided it is closely controlled and that patients only stay in the ward for a limited time before being transferred to the correct specialty ward within the hospital, or being discharged.

17 Give close attention to the system of discharging patients

The management of discharges has a profound effect on an admission system. Prediction of discharges can do much to enable waiting list admissions to be scheduled, and prevent the last minute cancellation of patients who have already been given a firm admission date. The advantages of a predicted discharge date to the patient already in hospital are obvious, too.

18 Cooperate with other branches of the health service

Close cooperation with the general practitioner and the local authority can help the hospital to reduce waiting lists and prevent delay in discharge. An early discharge system, and outpatient surgery, increase integration of the hospital with the community it serves.

THE WAITING LIST

If you can wait and not be tired by waiting—Kipling's *If*

Waiting lists are the records of patients who, though needing hospital treatment, must wait because there are no appropriate beds available.[57]

This chapter gives a summary of the ways in which the hospitals covered by the survey try to ensure that their waiting lists are effectively managed, and that a patient on the waiting list is admitted as soon as possible. There are many problems involved, not the least of which is the need to maintain a balance between waiting list, that is 'cold' admissions, and emergency 'hot' admissions, whilst at the same time giving the patient as much notice as possible of admission, ensuring that sufficient beds are available for emergencies and maintaining a high bed occupancy or patient throughput.

The hospital consultant staff decide whether a patient should be admitted or put on the waiting list. This decision is reached after an outpatient consultation at the hospital or after a domiciliary visit by a hospital consultant. In a previous study of hospital waiting lists[30] all hospitals approached stated that the overwhelming majority of patients on their waiting lists were placed there as a result of attendance at a hospital outpatient clinic or, in the case of school children, after a previous attendance at a school clinic; and that, by contrast, the proportion of those placed on the waiting list following private consultation or domiciliary visits was generally very low (1.2 per cent).

Organisation of the Waiting List

The arrangements for placing a patient on the waiting list vary considerably. The survey revealed that some waiting lists are still maintained by individual medical secretaries who, according to one hospital, 'are aware of all the factors relating to the admission of a (particular) patient'. The general trend, however, seems to be towards **centralisation** of the waiting lists of individual consultants in one accessible office. The final question in the questionnaire (Question 13) asked hospitals to state what they considered to be 'the most important aspects of your admission procedure and bed state management, with particular reference to any developments, innovations or good practices' which could be adopted elsewhere. Several hospitals described the advantages of a centralised waiting list.

The Victoria Infirmary, Glasgow, has introduced this central control which provides an overall view of the waiting list situation and enables all arranged admissions to be registered in advance: it facilitates the follow-up and replacement of waiting list patients unable to attend for admission and ensures that the selection of a patient from the waiting list is in accordance with a pre-determined set of priorities; for example, medical or social urgency. It also takes account of such factors as theatre list waiting time and arrangements for x-ray and pathology investigations.

'In any development plans we would recommend the establishment of a central admission office from which are controlled bed states, bed bureau, emergencies, waiting lists, reception of patients and admission documentation procedures', replied one hospital secretary. This trend towards centralisation of all admission procedures plays a large part in this survey and is discussed in more detail in a later chapter.

Informing the Waiting List Patient

In the hospitals visited, the patient is either given the appropriate literature concerning his admission in the outpatient department immediately after his appointment, or is sent a confirmatory letter by the admissions office as soon as the information has been sent there by the medical secretary or a member of the consultant's team.

Many hospitals, when confirming that a patient has been placed on the waiting list, ask the patient to supply details which will save time when a definite date for admission has been arranged.* The following extract from a letter distributed by the Royal Infirmary, Manchester, is a typical example.

'You have been recommended for treatment as an inpatient in this hospital. Will you kindly complete and return the enclosed form as soon as possible, as this will save time when you attend for admission. A further notification will be sent to you when a bed is vacant. You will naturally wish to be admitted without delay, but owing to the number of patients awaiting admission, it is impossible to say when there will be a bed available for you. Every effort will be made to admit you as soon as possible, but you should bear in mind that preference must be given to cases of a more urgent nature. If you can give a telephone number it may avoid the need to send a telegram if a bed becomes available for you at short notice.'

Delay in Admission

Another study[9] discussed the possible sources of

*See page 15, Pre-registration.

delay in gaining admission to hospital; some patients were afraid or embarrassed, or were so reluctant to bother their general practitioner that they put off consulting him; in a few cases, the patients felt that the general practitioner had not sent them to hospital soon enough, but once referred to hospital 'two-thirds of the patients were seen at the outpatient department within a fortnight, and 70 per cent were admitted within two months of being seen there. Some patients, however, had a much longer wait'.

Calling a Patient from the Waiting List for Admission

The decision to call in a patient for admission from the waiting list was in every case a medical one.

Question 5: Who decides when a waiting list patient is to be sent for?

Fourteen hospitals merely stated 'medical staff' and did not elaborate further, but 13 hospitals specified that the decision was made by the consultant, and 23 hospitals the consultant or the registrar of the appropriate firm. In five hospitals, the decision was made by the registrar or house officer. Only four of these hospitals indicated that the decision was made in consultation with the staff of the admissions office or medical records department, although it may be that there is more informal consultation in other hospitals also, particularly if the waiting lists are situated in a central admissions office. In two hospitals, the ward sisters take part in the decision. Staff in several hospitals pointed out that confusion can arise if too much responsibility is vested in junior medical staff in arranging waiting list admissions. These doctors may be inexperienced, and their relationship with their consultant such that they are more likely to 'overbook' (that is, call in too many waiting list patients), rather than risk under-utilising their firm's beds. Junior doctors are also less experienced in gauging the length of some operations, and the need for the personal involvement of senior medical staff in selecting patients for admission from the waiting list was emphasised in discussion with hospital staff throughout the survey.

Criteria for Selection

The criteria for selection from the waiting list were similar everywhere. In most hospitals, the relevant information about the patient's condition and home situation is entered on the waiting list, together with an indication of the urgency of the case, usually classified as 'urgent', 'soon' or 'routine'. Any other information, such as holiday dates and whether the patient is prepared to come in at short notice, is also noted. Most hospitals have a system of coloured flashes, or some other indication which shows at a glance which patients require urgent admission from the list. A scheme was developed in Canada where a physician screened every request for hospital admission, using the clinical data given by the doctor who was treating the patient. This classification into categories—elective, urgent, very urgent and emergency—was recorded by the staff of the admissions office and was under continual review.[45] Fifty hospitals in the present survey checked that a bed would be available for a waiting list patient when selecting cases from the waiting list, two 'as far as possible', and three made no check at all.

Notice of Admission

'Patients on the waiting list should, as far as possible, be given adequate notice of an approximate but realistic date for their admission.'[58]

'Admission to hospital is important to the patient, the patient's family, the hospital and others awaiting admission. It is essential to give the patient adequate notification of the impending admission for two reasons:

1 To allow time for making domestic arrangements
2 To allow time to inform the hospital in the event of inability to come into hospital on the specified day.'[39]

As Murray and Ferguson point out[39], the Institute of Hospital Administrators in their study of waiting lists (1963)[30] found methods of notifying patients for elective admission 'inappropriate by present management standards', and highlighted that patients rarely informed the hospital if they could not accept the booking.

Once a patient has been selected from the waiting list, the admissions office generally informs him by post or, if notice is very short, by telephone or telegram. 'The area where improvement is continually being sought is the calling in of the patient', reported one hospital. 'An appreciable number are called in for admission the following day.' 'Our immediate problem is that the high number of emergency admissions means that not more than 24-hours' notice can be given to a waiting list patient and in some cases the patients are asked to telephone the hospital to see if in fact a bed is available', stated another, pinpointing the problem which many hospitals are faced with when calling elective patients for admission. One or two days' notice is clearly insufficient for mothers who have to arrange for the care of their children, and for employees either to inform employers or make alternative arrangements at work. Comments from a patients' satisfaction study[44] emphasised the difficulties experienced by some patients when called in at short notice:

'Told on Wednesday afternoon to report Thursday at 11 am. Live in the country and have a large family'

'Two days not really long enough when there are young children to leave'

'Told on Saturday to come in Sunday; could not inform my employer'

'Arranged to go in and then was put off which was difficult as had arranged for substitute for professional work'.

On the other hand, one patient felt 'If you have a short time (before admission) there is no time to start worrying'.

Patients called in from the waiting list are usually asked to contact the hospital as soon as possible if they are unable to attend. Most hospitals have some patients on the waiting list who are prepared to come in at very short notice and it has been suggested that the offer of an early bed compensates for any inconvenience caused. There is very little time to replace a patient who defaults if the original notice was only one or two days.

In a study carried out by Ferguson and Murray in 1969, a default rate of 22·4 per 100 elective admissions occurred.[17] However, this survey was carried out over a period of two months which included Christmas and New Year and in the present survey the default rate in the hospitals visited was generally much less than this. Ferguson and Murray found that no central point existed for feedback of information by the patient either by letter or telephone. 'In many cases when the patient telephoned, the information was not passed on to the person in control of the admissions for the particular specialty. No provision had been made for utilising the bed in the event of default of admission by the patient. This was an extremely important facet of the problem as some of the specialties had long waiting lists for elective admission.' To improve the situation a notification of admission form was designed, the lower part of the form for completion by the patient if unable to come in on the date specified. The patient was instructed not to telephone, but to return the form to the hospital admission department. This is the necessary feedback to a central point and the information is then passed to the clinician for action; that is, to select another patient from his waiting list.

Some admission clerks will themselves select patients from the waiting list for admission at short notice in the light of their own experience and knowledge.

'When I reached the hospital I was told there was no bed.'[44] The admissions office nightmare is the patient who arrives for admission, only to be told, after making domestic arrangements and perhaps having had very short notice of admission, that there is no bed available. Although this does not happen often, most hospitals under heavy emergency pressure have used beds intended for waiting list patients for urgent admissions. The understandable reaction of the elective patient does nothing to help to raise the morale of the admissions office staff, and such a situation is harrowing for all concerned. Even though infrequent, the effect of such a situation lingers long. In an effort to avoid this, The London Hospital asks all patients to telephone the hospital at approximately 4 pm on the day before admission when, taking into account the current bed state and anticipating the number of overnight emergencies, the patient can be told if a bed is available. If there is still some doubt, the patient is asked to telephone again early on the morning of his scheduled admission for a definite answer.

Several other hospitals have adopted this system, including Southampton General Hospital, where patients for the surgical unit telephone at 9 30 am or at 1 pm for a final decision as to whether a bed is available. Although this does not entirely prevent the occasion when a patient will still arrive without previously having telephoned to confirm his admission, only to find there is no bed for him, the chances of this happening are greatly reduced.

At Dudley Road Hospital, Birmingham, and The London Hospital, if a patient is refused admission at very short notice before arriving at the hospital, this is shown on the waiting list and such a patient is never refused twice.

Defaulters are usually written to and offered another date for admission. The Royal Infirmary, Manchester, writes three times and if no reply is received the consultant is informed and is responsible for deciding what further action to take. Medical records officers who were visited during the course of the survey stressed that their staff cannot remove a patient's name from the waiting list without the consultant's approval. Some hospitals enlist the help of the general practitioner in following up defaulters. In one general practice in North London a social worker or health visitor is then asked by the general practitioner to visit the patient who has defaulted, thus involving the local authority social services.

Pre-admission Routines

Pre-registration

'There was a large queue at reception; had to wait 1½ hours. Could people not complete basic details before coming?' commented one patient taking part in the patients' satisfaction study.[44] Pre-registration has been adopted at Law Hospital, Lanarkshire, where all admission procedures are organised as far as possible before the patient's arrival. This procedure allows the patient to complete personal details in the privacy of his own home and once these details are returned to the hospital, all relevant documentation can be completed, saving much time on admission. Previous case notes can be retrieved and await the patient's arrival.

Pre-admission Investigations

At the North Middlesex Hospital every effort has been made to minimise the patient's stay in hospital. As an example of what can be done, grouping and cross matching of blood is carried out as part of the admission procedure. McEwin[37], writing from experience in Australia, stresses that the nature and extent of investigations and tests required by waiting list patients should be decided before admission, and

as many of these investigations as possible be completed before the patient becomes an inpatient. For those tests that he cannot have done as an outpatient, firm bookings should be made so that they are undertaken promptly after his admission to hospital. The day and time of his admission should be so arranged as to ensure the minimum delay between his arrival and the performance of the first of these tests.

The Royal Infirmary, Manchester, in an effort to reduce length of stay, has introduced a programmed investigation unit (PIU) with 40 beds for patients requiring investigation. The unit is open from Monday to Friday. Each patient has the investigations needed, listed by the specialist concerned, in the outpatient department and the admission date is selected well ahead. Investigations are arranged by the sister-in-charge of the unit, who then informs the inpatient office which patients to call in. Prior notice of admission varies from three days to eight weeks, and a very close liaison is maintained between the unit and the departments carrying out the investigations. McEwin also advocates pre-admission clinics, which delay the definitive admission to hospital, but at the same time ensure adequate pre-operative assessment of patients.[37] The patient is seen by an anaesthetist in the outpatient department, and this, in fact, advances the time at which he sees the patient. He can check on recent illness and any minor hazards to anaesthesia, examine the patient and give any explanation about the current illness and proposed treatment as required, before the patient is admitted.

Information for Patients

Patients need at least four basic kinds of information about the hospital to which they are being admitted. First, they should know about the admission procedure so that they can be safely settled in the hospital with the minimum delay or embarrassment. Second, they need to know about the domestic details of ward life so that there will be no doubts or surprises to unsettle them. Third, they should be informed about the different kinds of staff and services available to help them. Finally, they must know how best to obtain information from, and to communicate with, the hospital staff. In a study in a small general hospital in Edinburgh[21] which had recently introduced a new comprehensive booklet for the use of its patients, it was found that it was helpful to the great majority of patients to receive certain types of information before they were admitted; for example, ward routine and the hierarchy denoted by nurses' uniforms. The study demonstrated the contribution which an information booklet may make to understanding the admission procedure. The information booklet, *So You Are Going Into Hospital*, which was distributed with the February 1969 issue of *The Hospital*, was also designed to allay the fears of the potential patient and inform him of what he may expect in hospital. The King's Fund gave many useful examples of topics mentioned in such booklets in its study, *Information Booklets for Patients*, published in 1962.*

The Royal Infirmary, Manchester, among other hospitals, distributes an information booklet to the patient (or parent) with 'full information about the facilities of the hospital—so phrased and set out as to show that they will receive a kindly reception at the hospital'. East Birmingham Hospital issues a booklet with a similar aim: 'When you come into hospital as a patient for the first time, you may find much that seems strange and difficult to understand. The purpose of this booklet is to tell you something about how things are done here and who does them. We want you to be happy and comfortable during your stay here and we hope that you will settle down and feel at home as soon as possible'.

Informing the General Practitioner

The admission letter to patients from Southmead Hospital, Bristol, contains a form which the patient is asked to take to his general practitioner regarding drugs currently prescribed. This ensures that the general practitioner is automatically made aware of the patient's impending admission. Edgware General Hospital notifies the general practitioner of a patient's admission by printed postcard, giving the appropriate ward. The Middlesex Hospital also informs the general practitioner of the ward to which his patient is admitted. Bulletins are sent from Victoria Infirmary, Glasgow, to general practitioners, giving the average waiting times for an outpatient appointment and for admission to hospital for each consultant, and routine surveys of waiting time are carried out for all outpatient consultative clinics. Some London hospitals and general practitioners also receive statistics of waiting times for outpatient appointments for specialty clinics at all the hospitals in a given area. This allows the hospitals to compare their clinics under pressure with those of neighbouring hospitals and also allows general practitioners to make sensible choices when referring their patients.

The Reality of Waiting Lists

'Hospital authorities should decide how often and by what methods entries on the waiting list should be reviewed and what arrangements should be made for taking action on the facts disclosed by the reviews. The circumstances of each patient on the list should be reviewed at regular intervals; a six-monthly review should be appropriate for most cases. For this review a postal inquiry of the patient or his general practitioner should normally be sufficient. Waiting lists can be inflated as patients may have received treatment elsewhere, or may have died or moved away.'[57]

Some hospitals review waiting lists, although not all at six-monthly intervals. The Royal Infirmary, Manchester, writes to the patient three times and if no answer is

*Collections of information booklets now in use are available for perusal at, or on loan from, the King's Fund Centre, 24 Nutford Place, London W1H 6AN.

obtained, the consultant is informed; he then decides whether or not to remove a name from a waiting list. Airth and Newell believed that the way waiting lists were kept up to date was very important in assessing the demand for beds.[2] Some element of clinical risk has perhaps to be accepted here. A patient who fails to reply to a letter or a reminder is generally assumed to be out of need and his name is removed from the waiting list. This removal is made, however, only when all reasonable attempts to contact the patient, involving his general practitioner, have failed. Excessive anxiety on this point means that no name is ever removed from a waiting list and most experience shows that such a degree of caution is probably not necessary. There should, however, be a system of checking emergency admissions against the waiting lists.

In a study of waiting lists in Cardiff[27], a careful postal and personal follow-up was made of over 5000 patients who had been waiting at least three months for admission. It revealed that 76 per cent were admitted as planned, or transferred to another hospital, 5 per cent did not attend when sent for, 11 per cent did not reply to a circular letter and 2 per cent were admitted as emergencies or direct to other hospitals. However, personal visits to 400 patients who did not reply to the circular revealed that 45 per cent of them were still waiting for admission and that the hospitals would have been quite wrong to assume that they no longer needed inpatient care. Airth and Newell felt that perhaps the best solution was that no follow-up letter be written but thought that a reassessment of the patient's need for admission should be made at an outpatient clinic shortly before admission is likely to be arranged. Although this would take up more of the consultant's time in the outpatient clinic, they considered it would save him the waste of resources and time caused by empty beds owing to the failure of patients to arrive when called for admission.[2]

At Frenchay Hospital, Bristol, where the waiting list for plastic surgery is long, a letter is sent about six weeks before the expected date of admission asking whether the patient is still available. This hospital found that six-monthly reviews on waiting lists only irritated the patient if there were no immediate hope of admission. It has recently introduced a review of patients who have been on the waiting list for five years.

A frequent review is in operation at Wexham Park Hospital, Slough. 'It is hoped that you will be admitted to this hospital sometime during the next six weeks. In order to assist us in making the best use of the limited number of beds available, I should be grateful if you would let me know whether or not during the coming six weeks there are dates when you will not be available for admission. It would help us considerably to know if you would be available for admission at 24 hours' notice and if there is a telephone number where you can be contacted during the day.'*

*Letter to patients from the medical records office, Wexham Park Hospital.

Hospital Scrutiny of Waiting Lists

The Institute of Hospital Administrators recommended, in their report on hospital waiting lists, 1963, that waiting lists should be subject to regular medical and administrative review at short intervals.[30] Bradford Royal Infirmary has a quarterly check on waiting lists by the hospital management committee, in which the chairman of the medical executive committee is involved. These figures are presented to the medical executive committee. The Hospital Activity Analysis (HAA)* computerised returns are also subject to scrutiny by the group medical records officer, medical staff and group secretary, and action is taken where appropriate. With the development of a 'Cogwheel'[26] structure of medical management and with the use of HAA, comparative statistics are being presented in some hospitals to medical divisions for discussion and action, although a recent study found that 'with a few exceptions very little imagination seems to be used in the presentation of these statistics to the clinicians'.[20] In practice, it is admitted that few clinicians show much interest in such statistics.

Reduction of the Waiting List

'Lengthy waiting lists usually represent a long waiting time for the patients on them and ought not to be accepted as inevitable. A long waiting list, if it is stationary, normally represents not a deficiency of resources, but a backlog of cases.'[58]

Several hospitals described methods by which they attempt to reduce their waiting lists, using special and temporary measures where necessary. These include the increased use of theatre time for the appropriate specialty within hospital groups and the reallocation of beds among specialties for a short period of time. In an effort to reduce waiting time for admission, the Luton and Dunstable Hospital is transferring patients faced with a long wait on to the waiting lists of some of the large London hospitals; for example, Westminster Hospital, St Charles' Hospital and Whittington Hospital, where they may be admitted rather earlier. A similar scheme was proposed by a consultant surgeon at the Royal London Homoeopathic Hospital, whereby, after six months on a waiting list, a person should have the option of transferring to a list at another hospital.[12]

It is not realistic to accept the waiting list at its face value. A further interesting feature of the Cardiff enquiry[27] was, that of the total number of patients on the waiting list for more than three months, three per cent were there because of duplication of names, 15 per cent had already been treated or died and 15 per cent said they did not intend to seek admission. 'Even where accurate, waiting list figures fail to reveal that part of the demand which is deterred by the length of the queue.'

*Hospital Activity Analysis is an annual national collection of data on a ten per cent sample of patients; the data are processed by the Office of Population Censuses and Surveys for the Department of Health and Social Security.

Booked or Planned Admission

Several hospitals are now using a system of booked admission for some cases as an alternative to the waiting list. At the Royal United Hospital, Bath, general surgeons endeavour to give patients an admission date at the time of the outpatient attendance. This helps to keep the actual waiting list to an absolute minimum and has been found to reduce the frustrations of lengthy waiting times. St James' Hospital, London, is another of the hospitals using a system of planned or booked admission in some specialties. The remaining few waiting lists here are kept by individual consultants.

Although there are great advantages for the waiting list patient who receives adequate notice of admission, there is no provision in such a system for emergency admissions, which can put tremendous pressure on other beds and firms in the hospital, particularly in the medical specialties. The emergency may consequently have to be admitted to an inappropriate bed, if a bed for a waiting list patient is booked too far in advance.

ADMISSION PROCEDURE— ELECTIVE PATIENTS

Reception

The admitting office or reception area is often the first contact patients have with the hospital on admission. Patients tend to remember the trivial things that happen as they enter hospital. One patient reported that at reception he was greeted with 'Oh, no! Not another one!' and commented that this did little to put him at ease.[44] Another patient, however, felt that 'royalty could not have been better treated'. Many hospitals in the present survey stressed that the reception staff play a large part in welcoming the patients and helping them to adjust to their new surroundings. At the Royal Infirmary, Manchester, an inpatient admission unit receives all incoming patients and 'it is accommodated, decorated and furnished and the staff selected and taught to provide an informal and relaxed atmosphere for the patients' reception'. Law Hospital, Lanarkshire, asks the patient to report direct to the ward, explaining that unusually good signposting avoids confusion and that a well-sited enquiry office is available for any patient in difficulties. Most hospitals, however, ask incoming patients to report to a central reception unit, usually situated close to the main entrance. At Ashton-under-Lyne General Hospital, a patients' reception unit has recently been provided through which all admissions are directed. This is manned by administrative staff during normal working hours and at other times cover is provided by porters. The University Hospital Management Committee of South Manchester has provided a similar patients' enquiry office suite where patients are received. The King's Fund check list, *Spotlight on Shop Window Staff*, provides a useful guide to hospitals who wish to ensure that their reception arrangements provide the best and most reassuring service to their patients.[33]

Some patients were faced with congestion in the admissions office, with limited privacy for the documentation which took place there. In order to avoid such congestion, when patients of The London Hospital telephone for confirmation on the afternoon before their expected admission, they are given arrival times spaced at 15 minute intervals. Other hospitals also try to stagger waiting list arrivals as much as possible.

Registration

Pre-registration, either in the outpatient department or before admission, helps to save time on admission as most of the necessary documentation can be completed before the patient arrives. A few details still have to be supplied on arrival and several hospitals emphasised the need for privacy for patients when they complete their documentation. Bristol Royal Infirmary has interviewing rooms leading from the main reception area, in which patients can be interviewed individually. The East Birmingham Hospital has a comfortable waiting area set apart for patients and their relatives and the new admission unit at Bristol Royal Infirmary also provides a pleasantly designed and furnished waiting area.

Escort to the Ward

Porters are available at some hospitals to escort patients to the wards. At the Royal Hampshire County Hospital, Winchester, patients are received in a pleasant room close to the main entrance and members of the Women's Royal Voluntary Service act as escorts. When the formalities have been completed, the WRVS member takes the patients, sometimes singly, sometimes in groups, to the wards to which they are being admitted. St James's Hospital, Leeds, and Frenchay Hospital, Bristol, are among others who have voluntary hostesses to escort patients during certain hours.

ADMISSION PROCEDURE—EMERGENCIES

An emergency case requires admission to hospital promptly. The pressure of emergency cases on the admission system varies considerably from hospital to hospital; in some cases it is as high as 75 per cent of all admissions, in others as low as 14 per cent, although most of the hospitals in our survey received between 45—65 per cent of all admissions as emergencies. The problem facing these hospitals is the need to provide for these unplanned admissions, while giving clinically-serious waiting list cases appropriate priority and sufficient notice of admission. The parallel aim of maintaining a high bed occupancy and throughput must also be considered. Emergency admissions can be classified as 'heralded', that is, any emergency case of which the hospital has prior warning, and 'unheralded', that is, any unexpected emergency.

HERALDED EMERGENCIES

Choice of Hospital for the General Practitioner

Most hospitals now have a defined catchment area and accept ultimate responsibility for admitting patients from their area. The Western Regional Hospital Board, Scotland, have devised a system for the Glasgow hospitals for emergency admissions. In the past general practitioners were told, on occasions, that a hospital could not admit a patient, with the result that the general practitioner and RHB had to approach numerous other hospitals. Dangerous delays could arise. Hospitals are now zoned, so that each group is responsible for admitting acute cases from a defined zone, when the general practitioner requests admission and the hospital doctor agrees that hospital admission is clinically indicated. This arrangement does not preclude the general practitioner from making a personal request for admission to a particular hospital for a special reason, although in such a case the hospital concerned is under less obligation to admit the patient. If such a selected admission is not possible, the general practitioner contacts the designated area hospital.

Several hospitals have a 'take-in' system shared with neighbouring hospitals, which enables participating hospitals to foresee and prepare for their emergency duty days. Southmead Hospital and Frenchay Hospital, Bristol, participate in such a scheme. If these shared schemes are to be successful, general practitioners must be kept informed of the schedule and any subsequent changes. Hull Royal Infirmary, among others, distributes copies of emergency rotas to general practitioners, enabling them to know immediately which hospital to approach for an emergency admission. As part of this arrangement, consultants are also issued with the emergency rota. The Royal Infirmary, Sheffield, for example, is 'on-take' for the admission of heralded emergencies two days each week and every third Sunday.

Ease of Access for the General Practitioner

The admissions office at Whittington Hospital, London, has a direct Post Office telephone line so that any general practitioner requiring his patient to be admitted, can ring this office without going through the hospital switchboard. The Central Middlesex Hospital also has two telephone numbers which general practitioners can use to contact the admissions office during the day. In all hospitals visited, the doctors who might be required to accept a heralded emergency were on constant call, through a 'bleep' system. In practice it was often found that they might not be easily located.

Bed Bureau

The term 'bed bureau' may refer to an office in an individual hospital where information about the bed state is kept. In this report it is used to denote an administrative area where all requests for beds for emergency admissions are received, and from where beds within the hospital or within the group are sought, and, when found, are allocated for particular patients requiring urgent admission. A bed bureau, whether organised by a group or region, can relieve general practitioners of the time-consuming responsibility of finding a bed for an emergency patient.

St James's Hospital, Leeds, organises a bed bureau which serves the Leeds area. This was originally set up so that a general practitioner could, after unsuccessfully attempting to have his patient admitted to the hospital of his first choice, obtain information as to whether accommodation was available in other hospitals in the area. It now deals with medical, surgical, orthopaedic and paediatric admissions by using beds available in Leeds and the surrounding area. The Windsor Group Hospital Management Committee has a bed bureau, which was established

in 1946. This serves six hospitals in the group and maintains a 24-hour service, five days a week, for placing emergencies. The bed states of two of the hospitals are obtained twice a day and the remaining hospitals submit one once daily. The average time for admission to be arranged and accepted through the bed bureau is seven minutes. The clerk tries to place the patient referred by the general practitioner in the nearest appropriate hospital to the patient's home. This bureau is closed at weekends, due to shortage of staff.

Edinburgh is served by an emergency bed bureau, which is located within the headquarters of the South-Eastern Regional Hospital Board. The bureau deals with the emergency admission of patients to hospitals in the Edinburgh area in all clinical categories except mental health. The use of the bureau is not mandatory and the general practitioners are free to negotiate direct with hospitals if they so desire. The bureau is manned 24 hours a day by clerical staff. When a general practitioner wishes to have a patient admitted to hospital as an emergency, he telephones the emergency bed bureau and the details of the patient are recorded. The operator then telephones appropriate hospitals in an endeavour to find a vacant bed. Details of all such telephone calls are also recorded. When admission is secured an ambulance is ordered and the general practitioner is informed to which hospital his patient is to be admitted. If the operator has difficulty in arranging admission for the patient within the time limit stated by the general practitioner as being acceptable, he invokes the aid of one of the RHB's medical officers. One such officer has specific responsibility for the day to day running of the bed bureau and there is medical cover outside normal working hours.

Emergency Bed Service, London

The Emergency Bed Service (EBS) was set up in 1938 by the King's Fund, with the aims of speeding the admission of patients needing emergency treatment in hospital in the London area and, at the same time, making the task of the general practitioner involved with such admissions much easier.

Since the advent of the National Health Service, the EBS has acted as an agent for the four metropolitan regional hospital boards, in order to ensure that however full hospitals in the London area were, a bed was found for any patient requiring immediate admission. Two medical referees were appointed by the boards, one of whom is always 'on call'. These doctors are armed with the authority to insist on the immediate admission of the patient to the hospital group nearest to his current location. If six hospitals to whom the case has been offered have refused to admit the patient, the medical referee can insist on a hospital taking over responsibility for the case. The service provides a 24-hour continuous cover and there is a direct telephone line which enables a general practitioner and hospital doctor to talk to each other if necessary, linked through the EBS. The staff of the EBS feel that it is important for hospitals to keep a record of all refusals, especially since a case may eventually be referred back to the hospital. Many hospitals keep such a record and receive from the EBS regular lists of patients accepted and refused. Such records give a clear picture of pressure on beds in a particular hospital at particular times.

Acceptance of a Heralded Emergency

Thirty-five hospitals said that the firm on-take accepted a heralded emergency for the hospital: the decision was normally taken by the registrar or house officer of that firm. In ten hospitals, medical records staff in the admissions office or bed bureau accepted the case. This was the responsibility of the accident and emergency department staff in six hospitals, and three hospitals had a medical admissions officer to accept emergencies. One hospital merely stated 'medical staff'.

A Doctor-to-doctor discussion

The guide notes laid down by the Western Regional Hospital Board for hospitals in Glasgow state that full discussion between the general practitioner and the receiving doctor of the admitting hospital is essential. All information concerning the patient, particularly the degree of urgency and, where necessary, fitness to travel to another hospital, is exchanged. At the Royal Infirmary, Manchester, a general practitioner seeking a patient's admission is always put in telephone contact with the resident medical officer, or the senior registrar of the surgical 'urgency' unit of the day. The North Middlesex Hospital has a full-time medical admissions officer with delegated authority to admit to vacant medical or surgical beds. Heralded emergency admissions at the Central Middlesex Hospital are dealt with by the admissions officer from 9 am to 5 pm, Monday to Friday, and from 9 am to noon on Saturdays. This admissions officer is a senior hospital medical officer; the registrar in the specialty concerned accepts heralded cases at all other times.

Non-medical Acceptance

In several hospitals there is liaison between medical and clerical staff before acceptance: 'The "inpatient" clerk accepts after medical consultation'; 'Bed bureau accepts when beds are available but on-take firm does so when the beds get short'. But this is not common practice. Some hospitals have instituted a procedure in which a clerk is given the authority to accept all cases offered for urgent admission by general practitioners, either direct or through a bed bureau, unless there is some reason why a particular department on a particular day is unable to accede to all requests.

St James' Hospital, London, has used this system for several years and has found that it expedites the admission acceptance and rarely leads to the arrival of an unsuitable case. If there is a special reason why a clerk cannot accept a case the request must be referred to a doctor authorised to admit patients who can discuss the case with the general practitioner or bed bureau before deciding whether to accept or refuse the

admission.

It was stressed by several hospitals that if a case is accepted by non-medical staff it must be **only with a view to admission,** with a bed held available, if admission should be necessary once the patient has been seen at the hospital. If the hospital doctor decides after seeing the patient that admission is not necessary, the general practitioner can be contacted and the hospital doctor is able to discuss the case with him and, when agreement is reached, to send the patient home with arrangements for further treatment or an outpatient attendance.

At East Birmingham Hospital, the staff of the admissions office play an important part in relieving medical staff of many of the clerical arrangements concerning admission, although the admission of patients is, of course, ultimately a medical responsibility. They offer a continuity of service with knowledge of the hospital's admission procedure, local general practitioners and catchment areas for patients. Ninety-five per cent of telephone and other requests for admission are handled through this office. If a general practitioner or other caller specifically requests to speak to a medical officer by name or designation, he may do so, but otherwise the general practitioner arranges the admission of a patient with the clerical staff. Only requests for infectious disease admissions are always directed to a member of the hospital medical staff. If a medical officer refuses to admit a patient or requires further information, he must speak personally to the general practitioner or the person requesting admission. Under no circumstances may a member of the clerical staff refuse an admission; this can only be done by the medical officer concerned. When admissions are handled through the admissions office, details are recorded by the clerks who then contact the appropriate medical officers. The general practitioner is asked to send a letter with the patient and the admitting ward is notified. When an admitting doctor accepts an admission direct from an outside source he informs the admissions office so that the ward can be notified and the bed information board can be amended.

A similar procedure operates at the Whittington Hospital, London. In 1962, it was noted that a number of complaints were being received from general practitioners regarding delays in getting through to the hospital for admission and that further delays occurred when, having succeeded in getting through, the doctor found that his request for admission was referred to one, and sometimes two, hospital doctors. The complaints were investigated and, amongst other things, it was noted that the hospital doctors to whom these requests were referred were usually of junior status and that, in the end, about 93 per cent of the cases were admitted. As a result, the medical staff discussed whether a request for admission by a general practitioner had to be approved by a hospital doctor.

It was agreed that, except in times of pressure on accommodation, or when the general practitioner specifically asked to speak to a hospital doctor, non-medical staff could admit cases without reference to a hospital doctor. The only yardstick was the vacant bed state. As at East Birmingham Hospital, the rule was made that clerical staff could not refuse a case and that this responsibility rested with the medical staff. The hospital reorganised admission arrangements and the admissions and doctors inquiry service (ADIS) was introduced. When the general practitioner telephones this office on one of the 'clearway' extensions, the assistant records the patient's particulars and enters them on the basic record. If the vacant bed state indicates that the patient can be accepted, the doctor is informed accordingly and, at the same time, he is asked to state whether he will be arranging for an ambulance. If he leaves this to the ADIS office, the hospital transport office is informed. If the case cannot be accepted at once, the doctor is informed and his telephone number is taken. The responsible medical officer is contacted and he decides on the action to be taken. The general practitioner is then telephoned and if he wishes to speak to the resident medical officer, this is arranged. The majority of cases are accepted and arranged within five minutes and only about five per cent of the cases offered by general practitioners are referred to the RMO, usually because of a shortage of appropriate beds. In the London area about 65 per cent of cases offered by the EBS are accepted by the clerical staff.

Transport

If a patient is accepted for admission but requires transport to the hospital, this can be arranged either by the general practitioner concerned or by the receiving hospital. At St James's Hospital, Leeds, transport facilities are arranged by the bed bureau. The London EBS also arranges transport as the general practitioner does not know initially which hospital has agreed to see the patient. Hospitals in Glasgow are instructed that the ambulance should normally be ordered by the general practitioner concerned. If, however, it has not been possible to tell him the name of the hospital to which his patient is to be admitted, this must be done either by the receiving hospital or by the admission department of the hospital first contacted when its assistance in finding another bed has been sought. The request for transport falls into one of two categories; either 'immediate' or, if the condition of the patient does not warrant this classification, the general practitioner must specify an acceptable period within which admission must be arranged.

Re-admissions

There are clinical problems associated with the re-admission of a patient who may have attended the hospital on a previous occasion. Several hospitals visited during the survey reported that they always

accept a request for emergency admission if the patient has been an inpatient for an associated illness within a specified time. The problem is that of deciding whether or not the emergency is related to a previous hospital stay. If so, some hospitals have difficulty in agreeing whether the patient should be admitted as a patient of the consultant who treated him previously or accepted as an entirely new patient. These factors complicate admission procedures.

At Lewisham Hospital extremely urgent patients who have previously attended the hospital are always accepted for emergency admission, even if this entails the erection of temporary beds. St James's Hospital, Leeds, and neighbouring hospitals served by the bed bureau endeavour to accept their own re-admissions if the patient has previously attended the hospital either as an inpatient or as an outpatient for the same or similar condition within the previous two years. Re-admissions are admitted to extra beds if necessary and are admitted under the consultant previously concerned, even if this means sending a case to a hospital not on its take-in day.

Allocating a Bed

In 26 hospitals the responsibility for allocating a bed once a heralded emergency has been accepted rests with the firm on-take, usually with the registrar or the house officer.

Question 8: Who is responsible for allocating a bed once a heralded emergency has been accepted?

Nine hospitals merely stated 'medical staff', and in 11 hospitals the medical records staff in the admissions office or the bed bureau found the bed. The staff of the accident and emergency department were responsible for this in four hospitals and the medical admissions officer in three.

In one hospital an appropriate bed was found for a heralded emergency by a medical superintendent in the hospital, aided by the nursing staff. Several hospitals expanded their answers. At the Royal Infirmary of Edinburgh, only clinicians of registrar grade or above have the authority to deny admission to any patient presenting at the accident and emergency department. It is then the responsibility of the medical superintendent or his deputy to ensure that beds are made available. Another hospital explained that when a bed is not available in the required specialty, the matron or the hospital secretary allocates a bed. In the four hospitals where the accident and emergency department allocates a bed, the patient is initially received in this department.

UNHERALDED EMERGENCIES

'Unheralded' emergencies, by definition, arrive at any time without prior warning. The firm on-take is again responsible in 22 hospitals for arranging a vacant bed for an unheralded admission.

Question 9: Who arranges a vacant bed for unheralded emergencies requiring admission?

We found that in 18 hospitals accident and emergency staff arrange for a bed, and in nine the medical records staff in the admissions office or bed bureau are responsible. In two hospitals the medical admissions officer allocates a bed, and this is done by unspecified medical staff in three others. In one hospital the nursing staff allocates a bed according to a principle laid down by the medical staff committee and admissions officer. Several hospitals emphasised the cooperation between the duty firm and the senior casualty officer in arranging a vacant bed: 'casualty officer in cooperation with the receiving surgeon or physician', 'cooperation between the admissions office and medical staff', 'admitting medical officer liaising with the bed bureau clerk'.

The University Hospital Management Committee of South Manchester has a consultant admitting officer who, although seldom called upon, has authority to override his consultant colleagues in the placing of emergency admissions. At St James' Hospital, London, the senior casualty officer, who is the EBS referee in the hospital, makes decisions about emergency admissions. Any decisions to close wards or postpone planned admissions, as in the event of a yellow or a red warning from the EBS, are made by the medical administrator.

Allocation of Beds for All Emergencies

Twenty-four hospitals in the survey normally reserve a certain number of beds for emergency admissions and 31 do not.

Question 10: Do you normally allocate a certain number of beds for emergency admissions? If so, please give brief details.

A great proportion of the answers to this question included provisos such as 'in theory', 'attempt' or 'try', and it seems that the allocation is, in practice, frequently less than intended. 'Every effort', said one hospital, 'is made to keep some beds open for emergencies and each ward on-take attempts to allocate a minimum of four beds for the emergency admissions'. One hospital which does not normally reserve beds stressed that not doing so causes 'a great deal of difficulty and results in waiting list patients being cancelled at short notice'. In Hull each hospital in the area has designated take-in days for medical and surgical admissions and if the beds become full the patient is admitted to the hospital next due on-take. At Hull Royal Infirmary and at Bradford Royal Infirmary, two wards are specifically used for accident cases.

Birmingham Regional Hospital Board Emergency Bed

Service provides a reasonably accurate forecast of the numbers of emergency admissions, by sex and major specialty, to be expected daily, and also gives five days' advance information of probable emergency intakes for Birmingham. The overall forecast is then broken down into quotas for each group and communicated to them. The system was introduced after an operational research survey was carried out in 1969 by the management services division of the Birmingham Regional Hospital Board with the object of improving the distribution of emergency admissions to the Birmingham hospitals. The hospitals were faced with a heavy demand for emergency beds in the Birmingham area at certain times of the year, particularly during the winter months, and this was complicated by the fact that these admissions were not evenly distributed among the hospitals. While some were working under extreme pressure, others might be relatively quiet. An examination was made of the effect of the catchment area on emergency admissions to the hospitals of the Dudley Road, Selly Oak, East Birmingham and United Birmingham groups. Admissions arranged direct by general practitioners, the service provided by the Central Ambulance Bed Bureau, and the criteria on which the regional board's red and yellow warning systems operated, were investigated. Only emergencies arising in the specialties of general medicine, general surgery and gynaecology were included in the study, as these admissions formed the majority of emergencies. It was found that the source of most admissions fell into one of three categories. The general practitioner either contacted the hospital direct, or requested the bed bureau, operated by Birmingham Fire and Ambulance Service, to find a bed. Some admissions also arrived via the accident and emergency department. The study concentrated on the first two sources of admission where delays were most frequent.

Under the new system each participant hospital supplies the Central Information Bureau (CIB), situated at the East Birmingham Hospital, with the actual number of emergencies admitted in the five specialties during the previous admissions day, which runs from 9 am to 9 am. The CIB calculates the expected load likely to occur in each specialty that day in the Birmingham area. The total is allocated to each participant group in proportion to the number of beds per hospital in each specialty. The group is then informed in advance of the number of emergency patients it can expect by sex and specialty, that is, its 'quota'. The information supplied to the CIB must be given as soon after 9 am as possible so that the quotas can be returned before 10 am on the day to which they apply. The accuracy of the data supplied by each hospital is of prime importance as gross discrepancies will result in both the forecasts and quotas being inaccurate, not only for one day but for a number of subsequent days. Quotas are also given to each hospital for five, four, three and two days in advance. As the forecasts approach the day to which they apply, the more accurate they become.

During the greater part of the admissions day, when a group is filling up to its allocated quota level, its emergency admissions are directed to the group either by ambulance control or by direct request from a general practitioner to the hospital. These patients come mainly from the existing catchment area. If a patient is a re-admission, or is directed in from the outpatient department, or presents himself in casualty, the hospital has little alternative but to admit. It has been accepted that a re-admission emergency must return to where he was originally treated.

When a hospital has admitted a certain number of emergencies on one day, usually about two-thirds of the quota for that day, 'allocation point' has been reached and emergencies are then diverted to other participating hospitals until they have all reached allocation point, when admissions are again accepted in rotation. This ensures an even distribution of emergencies among the hospitals so that one hospital does not receive its complete quota within a very short time. If any hospital exceeds the given quota for the one specialty by four or more emergencies, the CIB reduces the following day's quota for that hospital. This system has been found to be helpful in the Birmingham area. However, individual hospitals' predicted quotas show much fluctuation. This has caused difficulties in attempting to reserve beds for these emergencies.

Reception

At Dudley Road Hospital, Birmingham, all emergency admissions other than obstetrics go through the accident and emergency department. Emergency admissions at St James' Hospital, London, also come through this department where the bed board is maintained. The central admissions office at the Royal Victoria Infirmary, Newcastle, is located in the accident department and all patients pass through this office on admission. Unheralded emergencies are seen at the accident and emergency unit at the Royal Infirmary, Manchester, where a decision whether to admit or not, is made. At the Royal Infirmary, Sheffield, however, emergencies are admitted direct to the ward and the relevant information is passed to the admissions office by ward assistants, while Hope Hospital, Salford, has a 'coronary ambulance' which admits patients direct to a coronary care unit. Those hospitals with 24-hour clerical cover are able to register admissions received through the accident and emergency department and ensure full documentation and continuity. Voluntary help is available in some accident and emergency departments to accompany patients through the department and to provide necessary reassurance.

As a very substantial proportion of emergency admissions enter the hospital through the accident and emergency department, it was felt, both by the project team and the staff concerned, that in many of the hospitals visited the presence of a senior doctor

of consultant status in the department would improve the admission procedures in this area. This doctor would also be able to play a large part in reviewing and organising the major accident procedures for the hospital. It is, in fact, the current policy of the Department of Health and Social Security to encourage the appointment of consultants specifically in charge of large accident and emergency units to supervise the clinical and administrative work of these departments.

BED STATE MANAGEMENT

Every hospital is faced with the problem of reducing the waiting list as much as possible and yet must reconcile this with the provision of beds for emergency cases which may arrive at any time. The pressure of emergency admissions on some hospitals in the survey is very great and accounts for 75 per cent of the total number of admissions in two hospitals. The constant pressure places a great strain on resources. This strain is often attributed to a shortage of hospital beds, but widespread discussion at the moment as to the optimum number of beds required has led to a general feeling that the provision of more hospital beds would not relieve the pressure on resources and might well increase the problem. This chapter is concerned with how hospitals manage their bed state and admission procedure in order to make the most efficient and yet considerate use of their existing resources.

Who is Responsible?

The hospitals were asked who was charged with the management of the bed state (Question 12). This question gave rise to some confusion and several queries, which some of the answers reflect. It was hoped to find out who was **responsible** for the management of the bed state. In seven hospitals, no one person apparently has any overall responsibility. The varied replies to this question perhaps highlight the need in many hospitals for an investigation into admission procedures, so that at least a dispute over admission can be speedily resolved by reference to one person. In 12 hospitals an administrator, for example, the house governor, patients' service officer, or hospital secretary, held overall responsibility; in another 12, the medical records officer; and nine vested this responsibility in the admissions officer or bed bureau staff. In nine hospitals the medical superintendent or director managed the bed state, but in a further nine this was the responsibility of individual consultants or departments. The consultant in charge of the accident and emergency department in one hospital, and the nursing officer in charge of the department in another, held this responsiblity. Two hospitals gave no clear indication as to who was charged with management of the bed state. 'The medical records officer records the daily bed state at midnight, but is not charged with its management.'

Of the nine hospitals whose bed state management was fragmented, two gave details of who held overall responsibility. At the North Middlesex Hospital 'day to day management is in the hands of individual consultants but in an emergency, such as a red warning, a medical referee is available'. The University Hospital Management Committee of South Manchester reported 'day to day management is the responsibility of the admitting medical officer of the day in each specialty. Ultimate overall responsibility for the management of emergency admissions is vested in the chairman of the medical staff committee who is designated consultant admitting officer and has overriding authority to place a patient anywhere in the hospital'. At Chase Farm Hospital, Enfield, the subgroup medical emergency admissions officer, of consultant status, is ultimately responsible for the management of the bed state assisted by the medical records officer and the admissions officer. St James' Hospital, London, has a consultant designated as 'medical referee' who is empowered to place a patient in any ward in the hospital in the event of a dispute over admission. The East Birmingham Hospital has a bed wardens' committee, comprising the hospital secretary with two consultants, which meets weekly to review the use of beds.

One point which seemed to stand out in discussions with hospital staffs visited, was that all members of a hospital's staff who are involved with bed allocation, from the admissions clerk constantly receiving requests for admission to the administrator with overall responsibility, must have a clear indication of the current bed situation in the hospital. Some form of continuously updated record of the bed situation would seem to be essential.

Bed Board and Bed States

The questionnaire asked hospitals for details of their bed state record.

Question 4: Is there a single **running** record for the whole hospital, eg, a bed board showing the bed state of all wards? If **no,** what records are kept?

Twenty-two hospitals had a single running record which took various forms and which showed the bed state of all wards. Most frequently, a bed board was situated in a central admissions office, but there was some variety in the displayed information. The East Birmingham Hospital has a simple board which can be seen from a distance by an admissions clerk who may be speaking on the telephone. 'A large bed board with

coloured discs is used to indicate empty/extra beds on individual wards. Using this system the bed state of the hospital can be seen at a glance and decisions affecting the allocation of beds can be made speedily. This information is also used at the regular weekly review of the use of beds.'

Other hospitals indicated every bed in the hospital, using coloured discs or flashes. The London Hospital has a system in which coloured tags for a particular bed indicate when a patient is due to be discharged the following day, and also show a bed reserved for a waiting list patient. Other bed boards, such as that at Bristol Royal Infirmary, give the name of the patient, and indicate whether he was admitted as an emergency or not.

Those hospitals with bed boards in use seemed satisfied with them, although several had reservations about the accuracy of the information received and exhibited. One hospital had experimented with a bed board for a trial period of three months but had found that insufficient use was made of the board by the medical staff. This was perhaps in part explained by the admitted difficulty in obtaining the correct information from the wards.

The survey highlighted several ways of gathering information for a bed board. Some hospitals rely on the ward to send down the information whenever necessary. With this in mind, the medical records officer at the East Birmingham Hospital holds induction courses for all grades of nursing staff, during which she tries to impress upon them the importance of the accurate and rapid transmission of all relevant information to the admissions office. At The London Hospital, the ward clerks are responsible during the day for the bed checks and either bring in the information personally or telephone the admissions officer. A tape recorder records this information if no one is available to answer the telephone immediately. At other hospitals the admissions officer or one of his staff telephones the wards at certain specified times during the day, more frequently if the pressure for beds is very great, and adjusts the bed board. The stumbling block appears to be the flow of information from the wards to the admissions office. In order to be effective, a bed board must be accurate, and this is impossible without full cooperation from the medical and nursing staff. It appears from the survey that a bed board on its own, suddenly introduced into an admissions system, can have only a limited success. It will be effective if it is fully supported by the medical and nursing staff who must willingly provide a steady flow of information on transfers, deaths and possible discharges. Once the staff are confident that the board presents an accurate picture of the bed state, they will rely on it not only when allocating beds for emergencies but also when planning future waiting list admissions. Ideally, one person should be responsible for controlling the bed board.

Of the 33 hospitals having no single **running** record showing the bed state of all wards, 21 rely on the daily bed state return, usually taken at midnight, for information on the bed state. Seven hospitals were found to rely on this bed state, augmented by other checks made with the wards during the day. 'A list of vacant beds by wards is kept in a note book, which is compiled from the daily 8 am ward returns. This is revised at 4 pm by a telephone call to each ward.' 'A copy of the previous midnight bed return is available for the admitting officer and a further check is made at 11 am daily.' Five hospitals had other arrangements. 'Bed boards showing bed state of wards on reception for the day.' 'The firm on duty to take emergencies makes its own arrangements.'

Central Admissions Office

Many hospitals mentioned, in answer to Question 13 on innovations and good practices, that they had just set up, or were considering setting up, a centralised admissions office, concentrating in one area all data about admissions and the bed state.

St Thomas' Hospital, London, is developing an admissions office to allow all such information as admission, inter-ward transfer, transfer to other hospitals, discharges and deaths, to be coordinated in one office. This is the centre for 'present and future information on the bed occupancy position of the hospital'.*

A surgical unit at Southampton General Hospital has an experimental information room, serving four wards, being evaluated in conjunction with the 120-bed nursing areas envisaged in any new unit in the Wessex region. Waiting lists and the bed states are kept in this room and the staff also relieve nurses of such 'non-nursing' duties as relatives' enquiries and certain medical record activities associated with the unit.

An information room has also been set up at Walsgrave Hospital, Coventry, and plays an active part in the management of the hospital, although it has yet to expand into all the roles which are foreseen for it. This information room has three primary objectives: to act as the collection centre for all information in the hospital to do with the management and use of hospital beds; to collate and use the information collected; and to carry out some medical records procedures for the hospital.

The concept of an information room associated with a central admissions unit is now often considered when new units or procedures are being designed. Such single or paired areas may well be efficient in centralising functions previously carried out in different parts of the hospital by several different types of hospital staff. Their value to patients, relatives, general

*St Thomas' Hospital, Group Admissions Policy, booklet produced for use in the hospital group.

practitioners and hospital medical, nursing and administrative staff has yet to be fully proved, but the benefits seem very promising. Initially, they may prove expensive to set up in terms of accommodation and staff. Siting them near the main hospital entrance or near the accident and emergency department may enhance their efficiency and minimise their cost by avoiding duplication of functions and, therefore, of staff.

Twenty-four Hour Cover

Several larger hospitals which have developed a central admissions office are now providing clerical cover in this office 24 hours a day, seven days a week. Poole General Hospital is aiming at this for the future to substantially relieve the nursing staff of the responsibility of completing admission orders and to enable all medical records documents to be prepared at the time of admission. Darlington Memorial Hospital and St James's Hospital, Leeds, are among other hospitals who have introduced a 24-hour clerical service.

Admissions Officer

Most hospitals with a central admissions office have appointed an admissions officer to coordinate the functions of the office. This officer is usually a member of the administrative staff and is responsible to the hospital secretary for organising the admission of patients to hospital and for all the work of the admissions office. The admissions officer at St Thomas' Hospital, London, is responsible for the maintenance of the bed state board and the allocation of beds for emergency admissions. He has to take into consideration 'cold' admissions already booked, the bed state of the firm whose bed is to be occupied when that firm is next on-take, and availability of convalescent patients for transfer to other wards or hospitals in the group.

The admissions officer works closely with the medical staff and the ward sisters. It was stressed on several occasions during the course of the survey how important it is to have an admissions officer sufficiently senior and of sufficient calibre to supervise effectively the bed state of the hospital. He must have both the staff and the status to work with ease with the medical staff in this crucial area.

Medical Staff Involvement

'The growing pressure on the acute beds will mean that during the next two years it will be necessary to introduce a more sophisticated system of admissions and bed state management, with medical staff involvement', stated the hospital secretary at Doncaster Royal Infirmary. Some hospitals, including Guy's Hospital, have encouraged more senior medical staff to become involved in the selection of patients from the waiting list in order that less experienced junior doctors do not call in patients and possibly overbook the beds. Both St James's Hospital, Leeds, and St Thomas' Hospital, London, have operational manuals for junior medical and administrative staff describing their admission procedures. Although there is no assurance that these are read when received on appointment to a post, junior medical staff can, and do, refer to them when necessary and this system does encourage a more uniform admission practice. The Northern General Hospital, Sheffield, is among hospitals who hold an induction evening for newly appointed house officers at which they are given a brief description of admission procedures and policy. The Central Middlesex Hospital also holds an induction course for junior medical staff on their first morning in post. Two of the hospitals visited specified that they are now using the information gained from Hospital Activity Analysis* to interest and involve the medical staff in the management of the bed state, by presenting them with regular information on, and comparisons of, waiting time for admission, length of stay and so on, for discussion and action where necessary.

Bed Allocation

The principle of whether beds should be allocated to specialties or firms has been widely discussed and hotly disputed. Traditionally, consultants tend to guard their beds because the number of these beds represents a tangible sign of their work and even of their status in the hospital. There is also the feeling that independent control of his own beds appears to the consultant to relate to the vital clinical independence that he must exercise on behalf of patients for whom he has assumed responsibility. An over zealous defence of beds, however, can lead to overall inefficiency and waste in their utilisation. At worst, patients are even kept in longer than necessary to 'block' beds so that they are not available for an emergency admission or other 'unsuitable' patient. Opportunities are also lost to even out seasonal and other fluctuations in the use of beds. The problem is one of reconciling the long held proprietary attitudes of some medical and nursing staff who look to only a limited stretch of the hospital horizon, with a more flexible approach, taking the broader view of the needs of the community as a whole. Forty-two hospitals reported that all their beds were allocated to individual specialties. However, the answers to Question 11 were sometimes ambiguous, perhaps because the question itself was not clear.

Question 11: Are all the beds in your hospital allocated to individual specialties? If so, please give brief details.

Confusion also arose over the position of intensive care and accident and emergency beds: for example, 'an intensive care unit where beds are not classified', and 'except where it is used for emergency admissions'. With the intensive care and emergency beds, specialist units, such as paediatric, respiratory and coronary investigation units, account for most of the unallocated

*See page 17.

beds. Several hospitals with a rigid allocation of beds have patients lodged out in beds belonging to other firms, as the appropriate bed on the correct ward is not available. 'There is widespread bed borrowing even to the extent of inter-ward transfers to other beds'. A survey at The London Hospital[14,15,16] revealed that staff felt that not only can lodging out affect the patient's morale, but also that he may not be looked after as well as a patient in the right bed. The medical staff who have to visit patients in scattered wards, and the nursing staff who have the patients of several different firms on the ward, are also subject to additional pressures of work. There are, however, advantages to be gained from a **controlled** policy of lodging out which can prove a valuable method of increasing bed usage.

'Pool' Beds

To overcome this problem of lodging out, Guy's Hospital hopes to have a proportion of beds on eight surgical wards set aside as 'pool' beds. The remaining beds are designated to either a particular firm or specialty. The admission study at St Thomas' Hospital, London, suggests that about one in five beds should be taken from each firm to form a common pool, and the remainder will be under the absolute jurisdiction of the firms concerned. The pool beds could be allocated flexibly by an administrator or administrative committee, according to changing needs.[6]

Reducing the Waiting List

Emergency Admission Ward

Medical opinion is divided as to whether a patient is best served by admission to a specialty ward, or to an emergency ward with a relatively high level of nursing and medical care. The arrival of an emergency admission in a general ward at any hour can disturb other patients during the night and disrupt the ward routine during the day. This disturbance can be prevented by receiving all emergency patients in an emergency admission ward.

The admission ward is generally accepted as a reasonably efficient way of providing for emergencies. It acts as a buffer and provides time to plan the appropriate accommodation of all admissions. At University College Hospital there is an accident and emergency admission ward to take all emergencies for the first 48-72 hours with the exception of paediatric, obstetric, and psychiatric cases, and to retain those which can be predicted as short-stay emergencies, such as minor head injuries and cases of self-poisoning. Emergency admissions are thus concentrated here and patients on general wards are much less disturbed, especially at night. An inpatient requiring transfer to one of the main wards in the hospital is transferred from the accident and emergency ward as early as possible on the day following his admission. St James' Hospital, London, has one ward which is used for emergency admissions during the winter months. In summer, it houses patients from other wards which are being decorated or upgraded.

Observation Wards

Walton Hospital, Liverpool, has an observation ward which admits short-stay and almost all self-poisoning cases, thus reducing the load on the remaining inpatient beds. The London Hospital has a similar ward to which patients are admitted overnight for observation. These patients are discharged or admitted to another bed in the hospital by 11 am at the latest, the following day.

Day Wards

'Outpatient treatment of varicose veins has reversed the rapidly increasing admission rate for this cause and a more critical approach to tonsillectomy has reduced the number of these operations by a third. These two changes alone have probably released half a million inpatient days for other patients without any loss of efficiency in patient care . . . waiting lists could and should be reduced by such means.'[24]

The Royal Infirmary, Sheffield, has a small day ward for surgical cases, and Walton Hospital, Liverpool, has a day ward for almost all day surgery including some sizable operations.

Day wards can also reduce the load on inpatient beds and help to reduce the waiting list, as a scheme in Edinburgh has shown.[46] In December 1969, the Western General Hospital, Edinburgh, initiated a programme of outpatient surgery for patients suffering from conditions which are traditionally treated on an inpatient basis, for example, inguinal herniorrhaphy and 'routine' operation for varicose veins. This system was developed in close cooperation with both the Queen's Institute of District Nursing and the local general practitioners. The initial scheme has now been much expanded, serving from 350 to 400 patients per month, in the fields of urology, gastroenterology, gynaecology, haematology, radiology and neurophysiology. The first step in selecting the patients from the waiting list for day surgery was an enquiry of the general practitioner about the patient's clinical suitability. Once the general practitioner had agreed to supervise the post-operative course, the patient was asked whether he was prepared to accept treatment on this basis. At this stage, pre-operative assessment of the patient's home circumstances by the district nurse proved to be of great value. She was able to assess the suitability of the home and to reassure the patient and relatives on any aspects of the scheme about which they may have had qualms. At the start of the project the source of the patients was the surgical waiting list, but now patients are assessed for their suitability on their first referral to the outpatient department and general practitioners refer patients with the recommendation that they be considered for outpatient surgery. The patient, the general practitioner and the district nurse are notified of the date of the operation several weeks in advance. With this

notification is sent a summary of possible post-operative complications and notes for guidance. The patient attends the hospital at 8 am in readiness for general anaesthesia. Before the operation the surgeon re-examines the patient and confirms the arrangements for discharge home. On completion of the operation, the surgeon telephones the general practitioner and district nursing headquarters to confirm these arrangements. A record of the operation is dictated immediately so that a typed copy reaches the general practitioner within 24 hours. The patient arrives home by ambulance between 3 and 5 pm to be seen on or shortly after arrival by the district nurse who visits daily thereafter, until stitches are removed. The nurse on duty in the evening also visits on the day of the operation and on the two succeeding evenings. So far there has been enthusiastic participation in this scheme by patients, general practitioners and district nurses alike.

This is one way of improving cooperation between the hospital and the community, which is greatly encouraged when each has a definite role to play in the management of the patient. There are, however, important repercussions on hospital care which should not be overlooked.[3] When minor surgical cases are treated in the outpatient area, or when the fitter patients are discharged after 48 hours, several things happen. The average age of the ward patient rises. The ward population soon consists of patients who are seriously ill or in some way more dependent and the work load on the entire nursing and surgical team increases accordingly.

Five-day Wards

The West Middlesex Hospital has had a five-day ward since 1961 and this form of clinical management has also been used by other hospitals. Staff and services are not required at weekends and this allows for improved recruitment of nursing staff, particularly those who are married. It is necessary to limit the cases treated to certain well defined groups whose clinical course can be confidently predicted and controlled. Guy's Hospital has introduced such a ward to treat any surgical case whose length of stay is unlikely to extend beyond a Friday afternoon. Programmed investigations can also be carried out in a five-day ward. The staff on a similar ward at the Royal Infirmary, Manchester, stress that patients must be carefully selected in order that their stay is at the most five days. One vulnerable feature of such a ward is the patient who is not ready for discharge on Friday, who then has to be found another bed in the hospital at short notice.

Pre-discharge Wards

Newell suggested a pre-discharge ward as an alternative to an admission ward on the grounds that it is better to admit patients initially to their correct specialty wards.[41] More beds on specialty wards are made available by transferring patients almost fit to go home to a pre-discharge ward with nursing of lower intensity, thus making better use of beds and nurses throughout the hospital.

The one disadvantage may be that many patients will require early and perhaps hasty transfer. However, in practice this disadvantage has not been found to be great. Such an urgent transfer from an acute ward is often anticipated by the ward sister, and the patients are usually forewarned. Indeed, these patients' morale is often high, sustained by moving to a ward of high quality with a good standard of amenities and, most precious of all, peace at night. The length of stay of patients on the Nuffield Ward at Dryburn Hospital, Durham, is usually predetermined and a good turnover achieved. Continuity of consultant cover is maintained throughout the patient's stay. Early discharge from this ward is sometimes required and is arranged by the relevant junior medical staff and the ward sister. In this particular instance the increased supply of beds for emergency admissions facilitated by this pre-discharge ward is much welcomed by the nursing staff on the acute wards. Newell has written that most patients did not resent this form of intra-hospital transfer, but in another study[6] the pre-discharge ward was not recommended as an alternative to surgical admission wards.

Newell described the experiment at Dryburn Hospital, Durham, which has a pre-discharge ward of 22 beds serving the 300 beds of the hospital.[40] One consultant has administrative charge of the ward. Should the pre-discharge ward become full, it contains a pool of the fittest patients in the hospital from whom the consultant in charge can select those most suitable to be discharged home. Other patients in the main wards nearing the end of their stay can then be transferred to the pre-discharge ward, freeing more beds in the main wards for the new admissions. If all beds become full, Newell argues that the effect on a patient of the lack of a bed is transferred from the first day of the patient's stay when his dependency is high, to the end of another patient's stay when the risk incurred by not being in a hospital bed is at its lowest. The disadvantage of such a system is that it can involve the simultaneous transfer of several patients in the hospital, if beds are in great demand. A patient's morale can be lowered by sudden transfer to a different ward even towards the end of his hospital stay. This system can also result in a very heavy extra burden for the nursing staff on the acute wards from which patients are transferred. The beds in these wards become filled repeatedly with patients needing more acute nursing. These advantages and disadvantages require very careful assessment.

Pre-convalescent beds

Bradford Royal Infirmary and Bristol Royal Infirmary are among several hospitals with pre-convalescent beds available to them which, as in the case of pre-discharge beds, enable them to make more use of their acute beds. Patients well on the way to recovery, but still in

need of rest and some nursing care, are offered pre-convalescent beds, often away from the main hospital site, if it is thought that this will further their recovery or where home circumstances are unsuitable for this rest and supervision.

DISCHARGE OF PATIENTS

The discharge of patients is very closely related to admission procedures. Delay or, more often, unpredictability in discharge, holds up and complicates the admission of other patients. It is therefore essential for the smooth running of the admissions office, and for the sake of patients waiting to come into hospital, that as much accurate information as possible about the discharge of an inpatient is given and passed on by the medical and ward staff.

Notice to Patient

Several hospitals stress that ward sisters and doctors try to give the patient adequate notice of discharge. Without this, difficulties arise in arranging transport home and assistance from relatives and the local authority. Inadequate notice of discharge leads to patients occupying beds unnecessarily, while arrangements are made for care at home.

Predicted Discharge

In order to overcome this problem, some hospitals have developed a system of predicted discharge. Before the right number of waiting list patients can be scheduled for admission some estimate has to be made of the number of beds that will be available for them. This depends directly on the number of discharges about to take place. Prediction of discharges on a day to day basis can make a valuable contribution to the control of bed occupancy. The London Hospital has developed a system in which information about predicted discharges is included on bed state returns and the staff are instructed to inform the admissions office as soon as they know of a discharge date. These predictions are reviewed daily and are also indicated on the bed board as an aid to the admissions office staff in allocating patients from the waiting list to the appropriate beds. This system has been found to play a very significant part in controlling the number of patients who are lodged out on inappropriate wards. Guy's Hospital has a similar system where the registrar, in consultation with the ward sister, is asked to predict daily the discharge date for those patients who are likely to be discharged within the next seven days. This information is passed to the admissions office and entered on the bed state board. University College Hospital plans to appoint a discharge secretary as a member of the admissions office team, thus underlining the importance of discharge data in the management of an admission system.

St Joseph's Hospital, Victoria, BC, Canada, has introduced a system of 'instant bed review' known as the 'Maui System', as it originated in Hawaii.[48] The predicted discharge date is entered on a chart at the time of the patient's admission and altered if the condition of the patient changes. The admission card is filed under the predicted discharge date and is then reviewed by a member of the medical staff the morning after the designated date. The reviewer, who is a member of the senior medical staff on a rota basis, obtains a list each morning of 'overdue' patients from the admitting department. He collects information about these patients from medical and nursing staff and may suggest a new discharge date, if this has not already been given by the patient's clinician. This review takes place six times a week and allows medical staff on a rotating basis to gain experience in the management of admissions and discharges for the hospital as a whole.

Early Discharge

The planned early discharge of suitable surgical patients has been developed by the West Suffolk Hospital Group. The three branches of the health service have collaborated closely in this scheme. Patients are selected for early discharge at the first outpatient appointment and their agreement to participate is sought at this time. A health visitor visits the patient at home prior to admission to assess home conditions and explain to the patient and his family exactly what the scheme entails. The health visitor visits the wards and is able to arrange the early discharge of emergency unbooked cases, where appropriate. In surgical cases, the decision on the discharge of the patient is made by the consultant usually on the first or second post-operative day. A pro forma letter is completed by the surgeon and one copy is sent to the family doctor and one is given to the patient to give to the district nurse. As a safeguard, the information is also telephoned to the health visitor and passed on to the appropriate district nurse so that she is able to visit the patient soon after discharge. The scheme has proved so successful that it now involves general surgical, orthopaedic, ophthalmic, paediatric medical, obstetric and gynaecological cases. The scheme has resulted in a quicker turnover of hospital beds and a reduction in waiting lists, as well as increased job satisfaction for the district nurse.

The Western General Hospital, Edinburgh, also has a

scheme of early post-operative discharge. This was started in October 1967, at the instigation of the Queen's Institute of District Nursing. The direct link with the hospital is made by a district nursing sister who visits each surgical ward three times a week. She is informed of patients who are to be discharged and their requirements for dressings, suture removal, psychological support, assistance with appliances, and so on, and she may meet the patients before they leave the wards. The patient is visited at home by a district nurse on the day of discharge, and daily or as often as is required thereafter. Thus, there is no loss of continuity of nursing care at the time of discharge and the patients have great confidence in the scheme. The patient is returned to his home and family sooner than he would otherwise have been. In less than three years considerably more than 2000 bed days have been saved. A conservative estimate indicates a saving of a minimum of three hospital days per patient. No change in the allocation of district nursing staff has been required and nurses in the district have welcomed with enthusiasm the variety that this type of work brings.

RECOMMENDATIONS

The numerous problems which confuse and complicate admission systems have been highlighted during this survey. The tendency to regard waiting list and emergency admissions as entirely separate and irreconcilable concepts is heightened if no one person is responsible for the overall management of both. The lack of a well defined policy and procedure for admissions results in an admission system which does not make the best use of costly resources such as available beds, medical and nursing manpower and theatre sessions. Some patients feel that there is a lack of information and explanation from the hospital on all aspects of admission and discharge. It is disturbingly common practice that too much responsibility is vested in junior medical staff, who are often left to select admissions, while most senior staff are involved mainly in decisions on discharges. Many nurses consider that a lack of involvement in admission procedures and a lack of influence on their own work load lead to a lack of interest on their part and to limited cooperation between the ward staff and the admissions office.

The demands on an admission system invariably conflict. There is great pressure for admission from the waiting lists from medical and administrative staff within the hospital. General practitioners and the public as a whole are also anxious to reduce waiting lists as much as possible. The rapid admission of 'cold' cases can be prevented by the pressure of emergency admissions, which in some hospitals can be as high as 75 per cent of total admissions. Pressure from this source involves not only patients and their general practitioners but the emergency bed services and other coordinating agencies, and the accident and emergency department within the hospital. Administrative pressure demands the maximum utilisation of resources by waiting list and emergency admissions, in order to produce an economically efficient hospital service.

If the first two demands on an admission system, pressure of 'hot' and 'cold' admissions, are balanced, the third, economic, demand is met. It therefore follows that a hospital admission **policy** must be designed to balance and reconcile these conflicting demands so that the hospital makes the most humane and efficient use of its resources for the community which it serves.

An admission **procedure,** the practical implementation of an admission policy, should therefore cover waiting list and emergency admissions, management of the bed state and the discharge of patients, making the best use of the nursing and medical manpower available.

Waiting List 'Cold' Admissions

Procedure for Supplementary Investigations
Any supplementary investigations required after an outpatient appointment should be carefully arranged to avoid further journeys back to the hospital, particularly in the case of elderly patients or mothers with young families. An escort to the appointments office or appropriate department can help to avoid confusion.

Reporting Back to the General Practitioner
The medical staff should inform the general practitioner quickly of the outcome whenever a patient attends the clinic for the first time. If the patient is placed on the waiting list, it is helpful if the general practitioner is informed of the likely waiting time for admission, the estimated length of stay of the patient and any interim treatment advised. Only then can the general practitioner answer the patient's questions fully.

Procedure for Placement on the Waiting List
Medical secretaries should inform the admissions officer immediately a patient is to be placed on a waiting list, with all relevant details. The patient should be sent confirmation that he is now on the waiting list, for many patients simply do not understand what is said to them in busy clinics. Waiting lists should be sited centrally, with ease of access for medical staff, rather than remaining with individual secretaries. A closer liaison between the admissions officer and the medical staff is thus achieved.

Assessment of Priorities on the Waiting List
The consultant should assess priority on both clinical and social grounds and the degree of urgency should be clearly indicated on the waiting list. It should also be noted whether the patient is free to come in at short notice, has any special home circumstances, or requires pre-admission booking of special investigations.

Management of the Waiting List
The apparent length of waiting lists can be distorted,

as patients frequently attend another hospital, decide not to have further treatment, leave the district, or sometimes die. A systematic review of the waiting list, contacting those patients who have been on the list for more than three or six months, will clarify the picture and produce a real **waiting** list. Patients should be written to tactfully, asked if they still require admission, and given their approximate position on the waiting list. If the patient does not reply to such a letter after, at most, three efforts to contact him have been made, the general practitioner should be informed. No non-medical member of staff should remove the name of a patient from the waiting list. The consultant should be informed when such a step is contemplated and he should decide the action to be taken; for example, further contact with the general practitioner, a further outpatient appointment or a home visit by a member of the local authority social services department. It can be argued that a frequent review may give patients false hopes of admission, particularly in specialties with long waiting lists, but it is felt that this review lets the patient know that he has not been forgotten and prevents calling in patients who no longer require admission, thus saving time, avoiding frustration and making better use of all resources.

Selection from the Waiting List
Patients should be selected for admission by a senior member of the medical staff—consultant or registrar—rather than by a house officer, who lacks the necessary experience. Junior staff are more likely to overbook patients rather than risk leaving the firm's beds empty and the chief's operating list too bare. The admissions office staff should point out any factors that they feel the medical staff might take into account before calling in patients, such as take-in days, pressure of emergencies, ward closures and so on. Patients should be given as much notice as possible of admission, and arrangements should be made to contact those who are willing to come in at short notice, if a selected patient defaults. In hospitals with a high occupancy and/or many emergency admissions, a check should be made the evening before or the day of admission, that a bed is still available for a waiting list patient. By asking the patient to telephone the admissions office in advance, it is possible to avoid the unfortunate situation where a patient arrives to find no bed available.

Preparation of Patient
Information sent to patients and relatives about admission should be as comprehensive and reassuring as possible. A booklet explaining ward procedure, nurses' ranks and uniforms, trolley shop services, postal arrangements, transport, visiting hours and so on can do much to allay the apprehension felt by patients when given a definite admission date. Special information for parents and simple 'story book' booklets for children are also of great value.

Notification of Admission to General Practitioner
The practice of informing a general practitioner of his patient's admission date and ward by sending him a postcard should also include an invitation to visit. A form accompanying this notification, asking for details of drugs currently prescribed for the patient, is very important.

Alternative to the Waiting List—the Planned Admission
Some hospitals have a system of planned, or booked, admission which obviates the need for waiting lists. The consultant keeps a diary in his clinic and when he sees a patient requiring admission he offers him a date which suits the patient and himself. This system gives patients adequate notice of admission and they are less likely to be refused a bed because of an emergency admission. There is much to recommend this system, but it must be controlled by the consultant and it must take account of a predictable number of unheralded emergency admissions. It will only be effective if the waiting list is not long, if there is a good system of bed control in the hospital and, above all, if the admissions office is kept informed of all admissions booked in this way.

Reception of Elective Patients
Most patients are anxious and tense on admission and every effort should be made to put both them and their relatives at ease. The admission suite should be well signposted, as near the entrance to the hospital as possible and comfortably furnished, and the receptionists should be chosen and trained to provide an informal and relaxed atmosphere. Volunteers can play a useful part in this area.

Pre-registration
A pre-registration system in which details required for their admission are obtained from patients at their outpatient appointment, or from them at home and then passed to the admissions office, saves time on arrival. The folder and registration documents are prepared in advance. This encourages an informal atmosphere on admission and avoids a long wait by patients and relatives. If any details have to be taken on arrival there should be as much privacy as possible.

Escort to Ward
Voluntary hostesses or a porter should always be available to escort patients and relatives to the ward and should be positively encouraged to adopt a friendly attitude towards the new patient on this first short journey within the hospital.

Reception on Ward
It is helpful if the admissions office telephones the ward to let the sister know of a patient's arrival. Nursing staff are then available to welcome the patient and his family and to explain ward routine.

Facilities for Personal Property
Patients may need to be advised, in the booklet sent

to them about their admission, to bring to the hospital little of value. However, the practice of asking relatives to take the patient's clothes home, once he has been admitted, may well have a depressing, isolating effect on the patient already made anxious by his admission to hospital. Patients are much happier wearing their own clothes and this may well encourage earlier discharge.

Emergency Admissions

Choice of Hospital for General Practitioner and Patient
Local emergency take-in arrangements should be flexible. Patients or general practitioners should not have to approach a hospital against their specific wish if this can be avoided. Some freedom of choice should remain, although, with the reorganisation of the National Health Service planned for 1974, this choice is likely to diminish in an increasing number of specialties.

General Practitioner Ease of Access
A general practitioner needing to admit a patient should have prompt access to the admissions office and to an appropriate medical officer when desired. A direct special telephone line to the admissions office is one point here; a readily available, nominated, medical officer is another. Together, these two features do much to remove a serious weakness in many admission procedures.

Informed Initial Response
As promptly as possible, the general practitioner should be given a definite decision as to whether the hospital will see his patient with a view to admission. Long delays and indecision on the telephone at this first stage are frustrating and time consuming. It should not be a part of any admission system that a general practitioner has to wait for an answer until a house officer or registrar is contacted in the operating theatre or outpatient department, or on a ward round.

Bed Allocation
When accepting a patient with a view to admission, the admissions officer must be aware of the bed state, making sure that a bed is available should hospital examination confirm that the patient requires admission. Emergency teams on-take must be aware of the current bed state and of all aspects of the emergency take-in arrangements at the hospital. Take-in arrangements in the neighbouring hospitals should also be well known to the medical staff, to allow for forward planning of the bed state.

Bed Bureau
A bed bureau can relieve general practitioners of the time consuming responsibility of finding a bed for a patient requiring emergency admission. From our study, it appears that general practitioners have no objection to dealing with a clerical officer for the majority of their cases, as long as they have ready access to the appropriate member of the medical staff when they need it. A clerk receiving details of the case from the general practitioner should be authorised to accept a patient for hospital assessment provided a bed is available, and he should be able to contact the appropriate hospital doctor rapidly, when necessary. The working party felt that only a member of the medical staff should refuse an admission to a general practitioner and that a record should be kept of these refusals in the admissions office. A bed bureau serving a group of hospitals not only saves the general practitioner from making a number of telephone calls but will spread the pressure of emergency admissions more evenly throughout the group. In hospitals with a large number of admissions, a 24-hour admission service will give continuity to the management of the bed state and will also relieve nursing staff of these administrative duties, outside normal office hours.

Transport
The admission system must include clear recognition of the responsibility of either the general practitioner or the hospital for arranging transport for the patient.

Informed Final Decision
The general practitioner must be promptly informed by the hospital of its decision, once he has referred the emergency case. He must know if the patient is to be admitted, to which ward, with what provisional diagnosis, and for what proposed treatment. If the patient is not to be admitted, it is even more important that the general practitioner is informed of this decision and the reason for it. This last information must be given by a medical member of the hospital staff.

Reception of Patients
There must be well organised arrangements for the reception of the emergency patient on his arrival at the hospital. Ideally, there is a good case for channelling all emergency admissions through one point, preferably the accident and emergency department, for many of these patients may require urgent treatment on arrival and it is wasteful to duplicate treatment and resuscitative facilities and staff in an admission suite. The patient may be assessed by the staff of the accident and emergency department or by the medical officer on duty for emergency cases for that day. This prompt clinical appraisal ensures that admission is really necessary, **before** the patient is admitted to a ward, and that the appropriate bed is allocated. It can be argued that a heralded emergency should be admitted straight to the ward, for the diagnosis is on most occasions clear, but this procedure can lead to delays before the patient is seen by a doctor and investigations and treatment started. The admissions office may not be informed of such a patient's arrival if he is admitted straight to the ward. In some hospitals, the distance of the wards from the accident and emergency department may make it impractical for all cases to be admitted through this one area.

Facilities for Relatives
Every effort should be made to provide adequate facilities for relatives of emergency patients who may often be anxious or distressed. A relatives' room close by the main accident and emergency department, with voluntary workers to reassure and provide refreshment, is much appreciated.

Bed State Management

Procedure for Bed Allocation
The allocation of beds should be as flexible as possible so that they may be easily reallocated among clinicians and specialties if pressure is great in one area and less in another. A more rigid form of bed allocation, coupled with limited and well controlled lodging procedures in other wards, also gives good utilisation of beds but may make difficult the supervision of widely distributed patients by a single clinical firm.

Surveys of Bed Occupancy, Turnover Interval, Length of Stay, HAA
These facts should be skilfully, that is, simply, presented and should be fully used by the medical staff and administration to manage the bed allocation. This can stimulate interest in the general problems involved in the management of the bed state, as well as highlight areas of special difficulty.

Bed State Record
Any record of the bed state, whether by bed board or bed return, should provide a continuous record seven days a week. The record should be brought up to date either by contact with each ward at frequent intervals throughout the day, or as each admission and discharge occurs.

One person in the admissions office should be responsible for keeping the record up to date. Nursing staff or ward clerks must inform the admissions office of deaths, discharges or transfers as and when they occur. This ensures that patients are allocated to the most appropriate beds, the nursing work load is shared, and the bed state of the hospital is immediately available whenever needed. The need to update the record is particularly important in hospitals with large numbers of emergency admissions and/or a very high bed occupancy.

The record must be **reliable** and present as accurate a picture as possible. Only if this is so will it inspire confidence among medical and nursing staff and assist the admissions office staff to achieve maximum use of available beds.

Responsibility for Management of the Bed State
One officer in the hospital must have ultimate responsibility for the management of the bed state vested in him by the medical and general administration of the hospital. In the event of a dispute over admission, this officer should have overriding authority to place a patient promptly anywhere in the hospital. Rearrangements of bed allocations or changes in procedure may be made by a small subcommittee led or assisted by this officer.

Discharge of Patients

Notice of Discharge
As much notice as possible of discharge should be given to the patient and ward staff in order that the patient and his family shall be well prepared, transport arranged if necessary, valuables returned and arrangements made with the local authority for domiciliary help, if this is required. Any delay while these matters are being arranged will cause the patient to be detained in hospital unnecessarily, waste beds and other resources, disrupt the bed state and even make it necessary to cancel at the last minute the admission of new patients already called in from the waiting list.

Discharge Prediction
Medical and nursing staff should develop the practice of predicting a probable date of discharge for every patient, to aid admissions office and medical staff in scheduling the selection of waiting list patients for admission and controlling bed occupancy. Information about predicted dates for discharge can be included on bed state returns and should be reviewed daily. This information should be readily available to the staff in the admissions office to aid them in allocating patients from the waiting list to the appropriate beds. It is essential that the ward staff keep the admissions office informed of any changes in this prediction.

Early Discharge
A planned early discharge system, with the cooperation of the local authority and general practitioner, should be introduced wherever possible in order to make better use of beds and reduce waiting lists. This system improves cooperation and liaison between the hospital and the community which it serves.

Notification of Discharge to the General Practitioner
The general practitioner should be notified on the day of discharge of his patient with brief details of the clinical course and of drugs prescribed, of information given to the patient, arrangements made with the local authority for domiciliary care, and of any arrangements for the follow-up of the patient by the hospital.

CONCLUSION

'The surprising variety in the different methods in use at the hospitals we visited and the fact that they were themselves rarely satisfied that they had the final answer, underline the complications of the subject and show that no easy solution is available', concluded a report, *Some Observations on Hospital Admissions and Records*, prepared by officers participating in a course arranged by the King's Fund in July 1948. Nearly a quarter of a century later the same statement is just as valid a conclusion. Several hospitals taking part in this present survey were anxious to revise their admission arrangements and readily outlined problems and possible solutions. It is hoped that this report will be of immediate practical help to those hospitals who are planning changes in admission procedure and that by highlighting good practice and suggesting points which should be considered when revising an admission system, hospitals will be encouraged to look afresh at existing arrangements. Several trends have become apparent: an increasing emphasis on the centralisation and continuous supervision of admission procedures, the need for management of the admission system as a whole and the greater use of bed state information to predict future events. Medical and nursing staff involvement and interest in the management of admission of patients to hospital are growing and it is hoped that this close cooperation both within the hospital and with other health service authorities, will give rise to admission procedures which are increasingly efficient and, above all, humane.

APPENDICES

APPENDIX A

Questionnaire

Name of hospital

Question	Answer
1 Type of hospital	**a)** acute **b)** mainly acute **c)** teaching
2 Number of staffed beds	
3 Statistics for the year	
a) Total number of deaths and discharges	**a)**
b) Average length of stay	**b)**
c) Number of admissions	**c)**
i) emergency	**i)**
ii) non-emergency, (that is, planned)	**ii)**
4 Is there a single **running** record for the whole hospital, for example, a bed board showing the bed state of all wards? If **no,** what records are kept?	**YES** **NO**
5 Who decides when a **waiting list** patient is to be sent for?	
6 Is a check made that a bed will be available?	**YES** **NO**
7 Who accepts a **heralded emergency** (that is, any emergency case of which the hospital has prior warning) for the hospital?	
8 Who is responsible for allocating a bed once a **heralded emergency** has been accepted?	
9 Who arranges a vacant bed for an **unheralded emergency** requiring admission?	
10 Do you normally allocate a certain number of beds for emergency admissions? If so, please give brief details.	**YES** **NO**
11 Are all the beds in your hospital allocated to individual specialties? If **no,** please give brief details.	**YES** **NO**
12 Who is charged with the management of the bed state?	

13 What do you consider to be the most important aspects of your admission procedure and bed state management, with particular reference to any developments, innovations or good practices which you think might usefully be introduced on a wider scale throughout the country?

Some of the topics in which we are interested are listed below, and there are doubtless many others which could be included.

1 Outpatients
Waiting time for appointment
Waiting in clinic
Procedure for supplementary examinations
Reporting back to general practitioner

2 Patients on the Waiting List
Procedure for placement on waiting list
Assessment of priorities on waiting list
Waiting time for admission
Notification of position on waiting list **(a)** to general practitioner **(b)** to patient
Review of waiting list
Procedure for calling patient for admission, and notification to general practitioner
Preparation of patient (for example, booklets)
Liaison with general practitioner and local health authority for home arrangements whilst in hospital
Notification of drugs prescribed by doctor
Alternatives to waiting list

3 Admission Procedure—Elective Patients
Transport
Admission suite
Reception
Registration
Escort to ward
Facilities for patients' relatives, etc
Reception on ward
Facilities for personal property
Explanatory leaflets (additional to booklet)
Social services

4 Admission Procedure—Emergency Patients
Bed bureaux
Transport
Reception and admission
Facilities for relatives and police
Notification to general practitioner

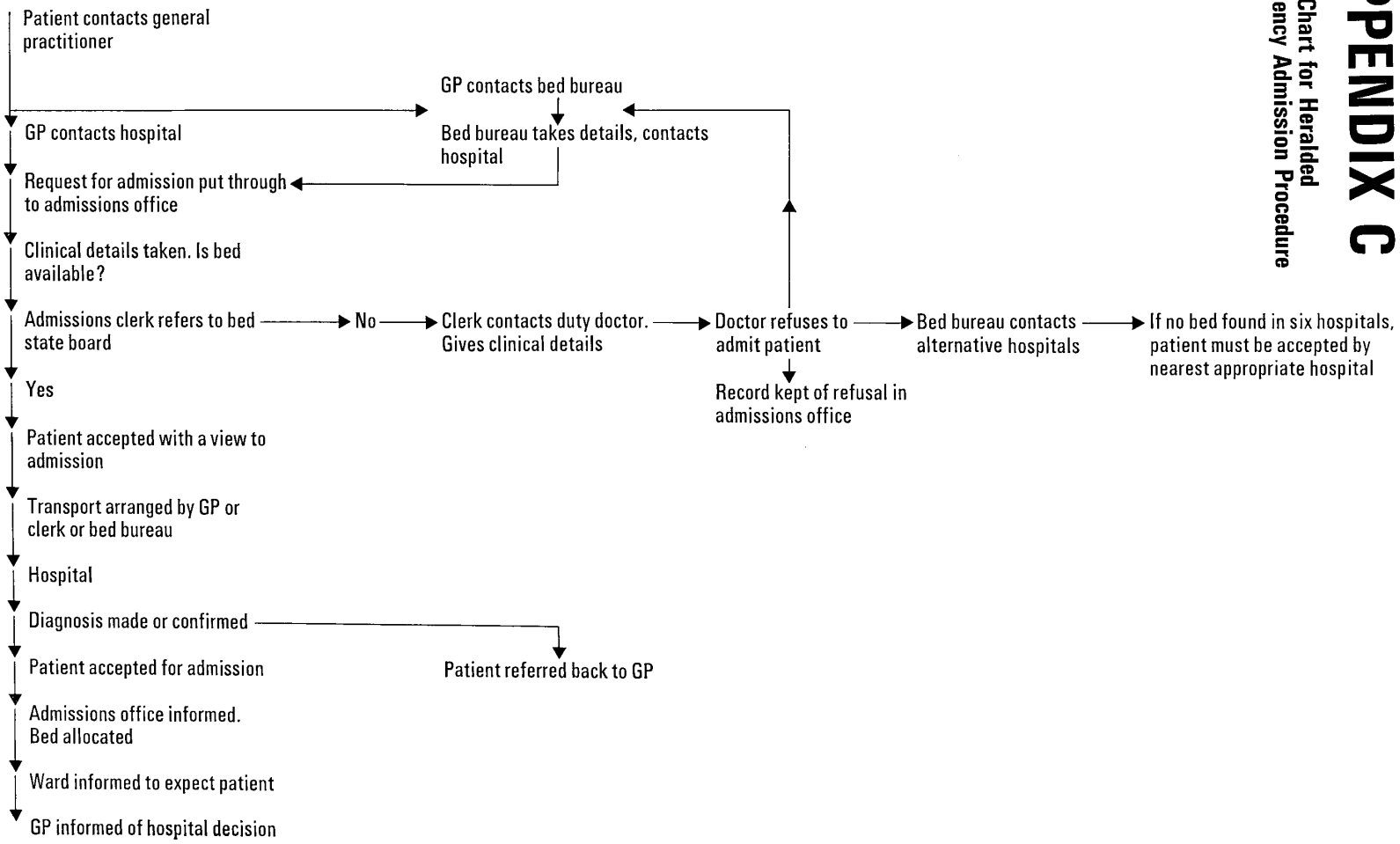
5 Clearing the Waiting List
Admission and doctors' inquiry service
Admission wards
Day wards
Short-stay and five-day wards
Convalescent wards
Pre-discharge wards
Hostel wards
Progressive patient care
Procedure for bed allocation
Procedure for use of operating theatre time
Procedure for patients' discharge
Surveys of occupancy, turnover interval, length of stay, Hospital Activity Analysis
General practitioner's participation in hospital care
Liaison with general practitioner and local health authority for domiciliary care

APPENDIX B

Flow Chart for Waiting List Admission Procedure
(See under flap opposite)

APPENDIX C

Flow Chart for Heralded Emergency Admission Procedure




GP gives letter of referral to patient. In some cases sends direct to consultant
Patient contacts hospital to make appointment
Appointment made by outpatient desk
Clinic list raised the day before clinic
Are there previous case notes?
Yes
Old notes retrieved by records staff
No
OP clerk heads new notes (and combines old)
Discharge patient. Letter to GP
Consultation
Patient to continue as outpatient. Time for return visit given. Letter to GP
Doctor decides to admit
Doctor decides if case is emergency
Yes
Arrange for immediate admission
Determine degree of priority
Explain to patient
Patient placed on waiting list (priority)
Pre-registration details taken in OPD
Information sent to admissions office by medical secretaries
Placed on visible strip waiting list trays in admissions office
Confirmatory letter sent to patient
Explanatory letter to GP
Patient selected from waiting list by medical staff in liaison with admissions officer
Patient notified of admission date
GP informed of admission date, asked for details of drugs and invited to visit
Replaced on waiting list or
Completes pre-registration details if not already given
Sent information booklet
P informed
Removed from waiting list (if appropriate)
No
Patient contacts hospital to confirm or decline admission
No reply from patient
GP informed
Yes
New patient contacted at short notice by telephone or telegram
Notes retrieved from files, folders made up
Ward informed of patient's admission date
GP informed
Patient phones admissions office day before scheduled admission
Patient informed. Put back on waiting list with higher priority
No
Is bed available?
Yes
Patient arrives at reception for admission
Registration details completed in privacy
Patient and relatives escorted to ward
Admissions office informs ward to expect patient


GP gives letter of referral to patient. In some cases sends direct to consultant
Patient contacts hospital to make appointment
Appointment made by outpatient desk
Clinic list raised the day before clinic
Are there previous case notes?
Yes
Old notes retrieved by records staff
No
OP clerk heads new notes (and combines old)
Discharge patient. Letter to GP
Consultation
Patient to continue as outpatient. Time for return visit given. Letter to GP
Doctor decides to admit
Doctor decides if case is emergency
Yes
Arrange for immediate admission
Determine degree of priority
Explain to patient
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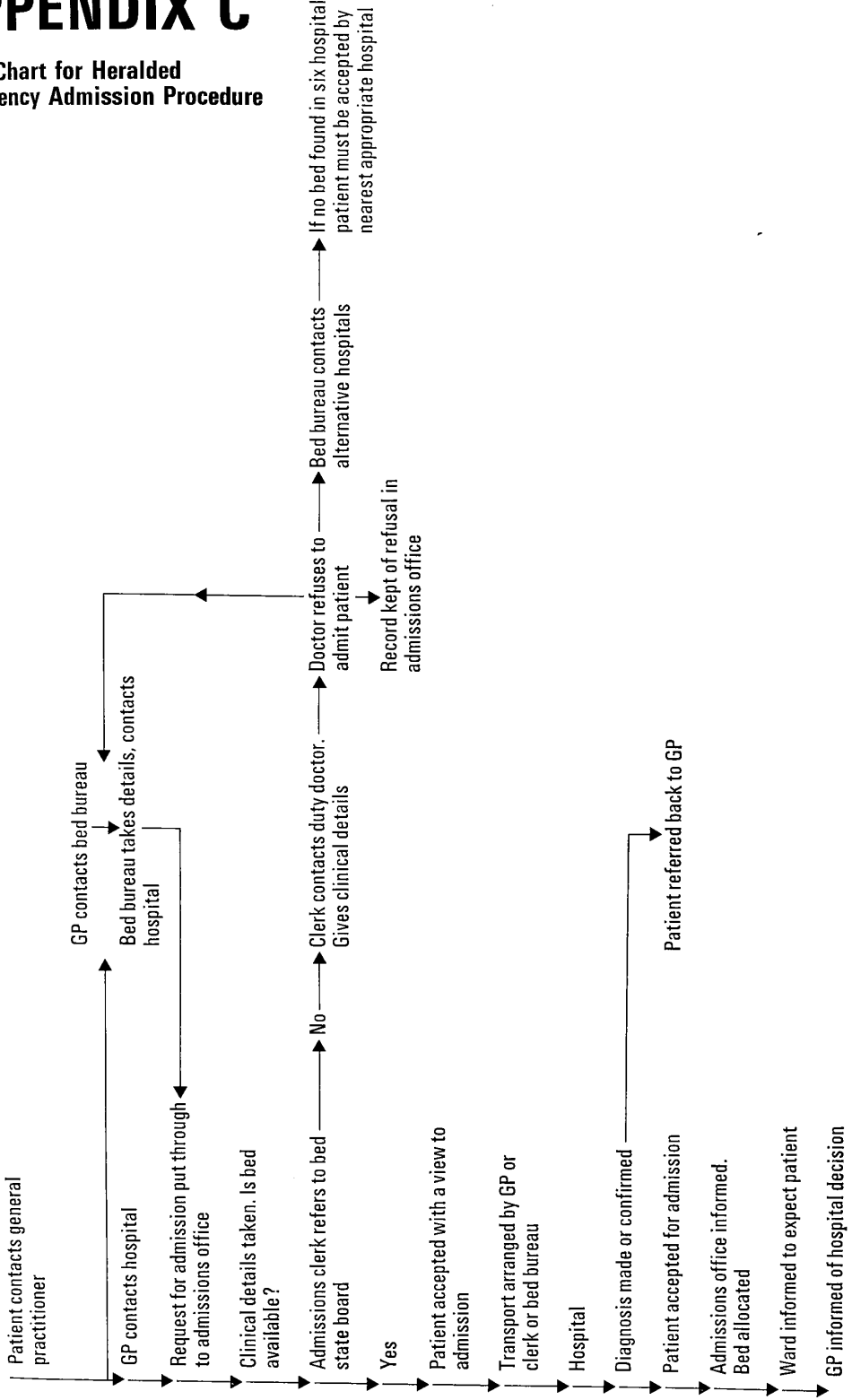
Patient notified of admission date
GP informed of admission date, asked for details of drugs and invited to visit
Replaced on waiting list or
Completes pre-registration details if not already given
Sent information booklet
P informed
Removed from waiting list (if appropriate)
No
Patient contacts hospital to confirm or decline admission
No reply from patient
GP informed
Yes
New patient contacted at short notice by telephone or telegram
Notes retrieved from files, folders made up
Ward informed of patient's admission date
GP informed
Patient phones admissions office day before scheduled admission
Patient informed. Put back on waiting list with higher priority
No
Is bed available?
Yes
Patient arrives at reception for admission
Registration details completed in privacy
Patient and relatives escorted to ward
Admissions office informs ward to expect patient

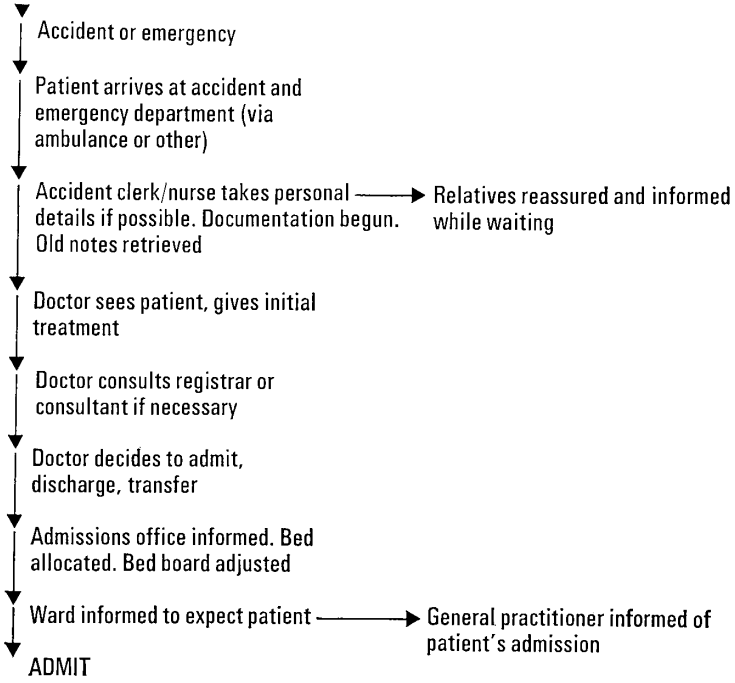
APPENDIX C

Flow Chart for Heralded Emergency Admission Procedure



APPENDIX D

Flow Chart for Unheralded Emergency Admission Procedure



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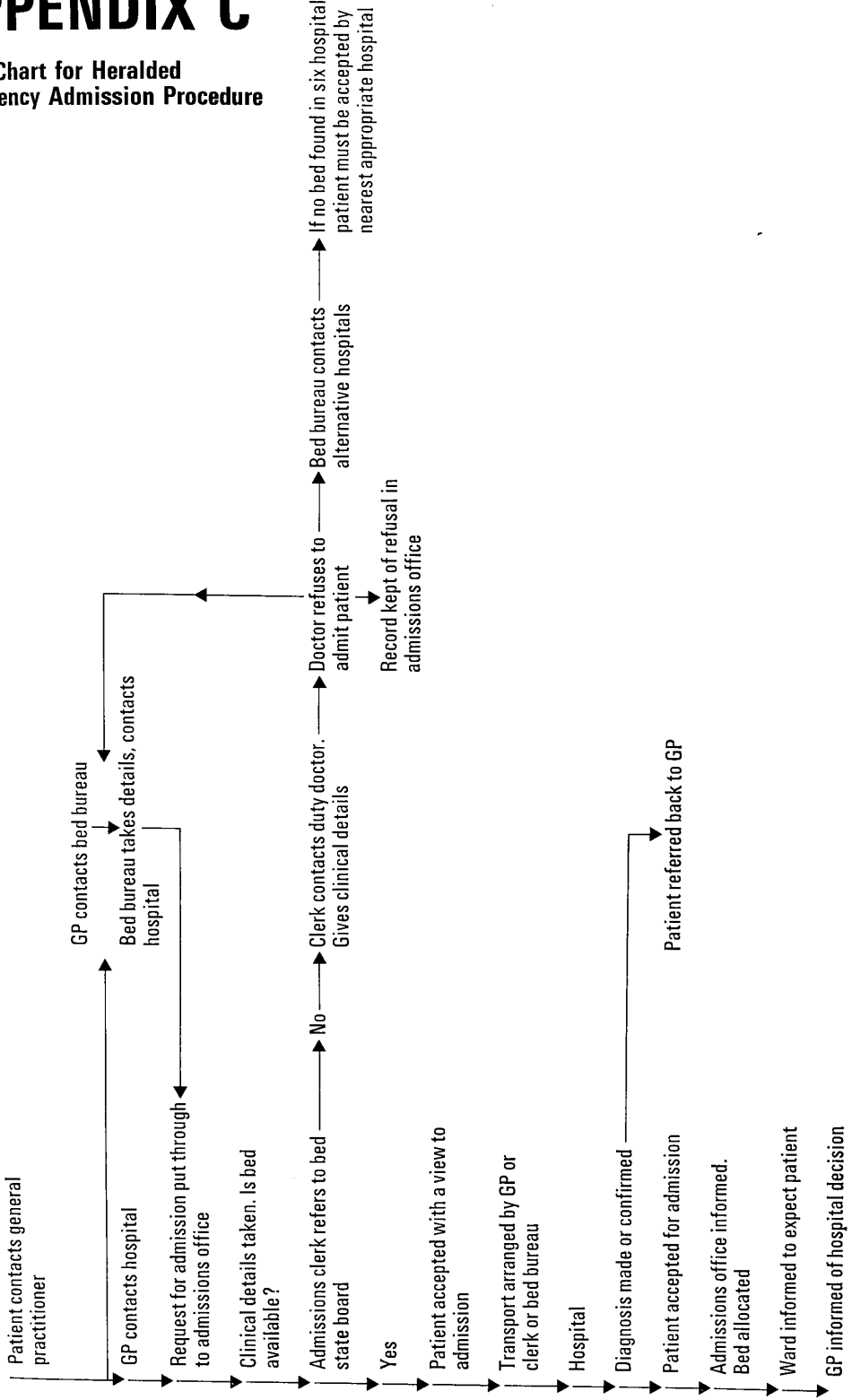
Flow Chart for Heralded Emergency Admission Procedure



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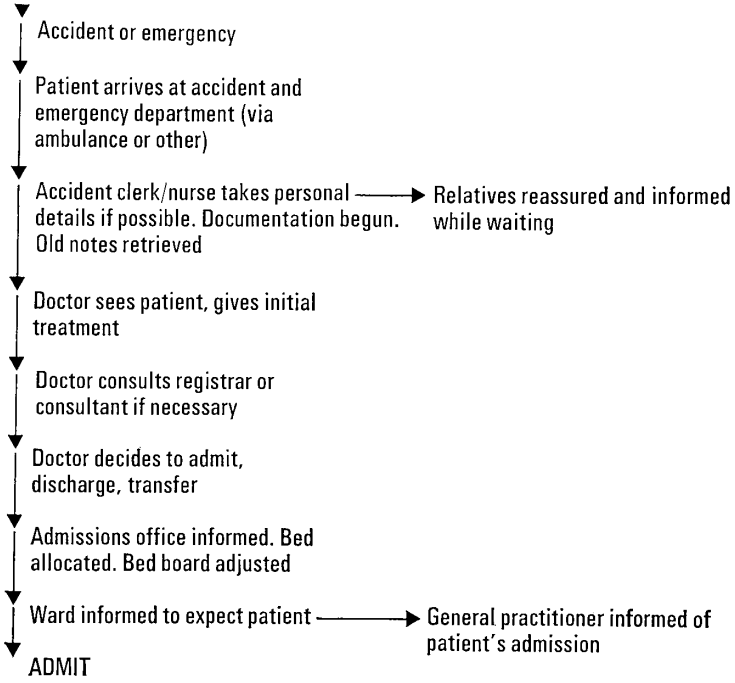
Flow Chart for Unheralded Emergency Admission Procedure



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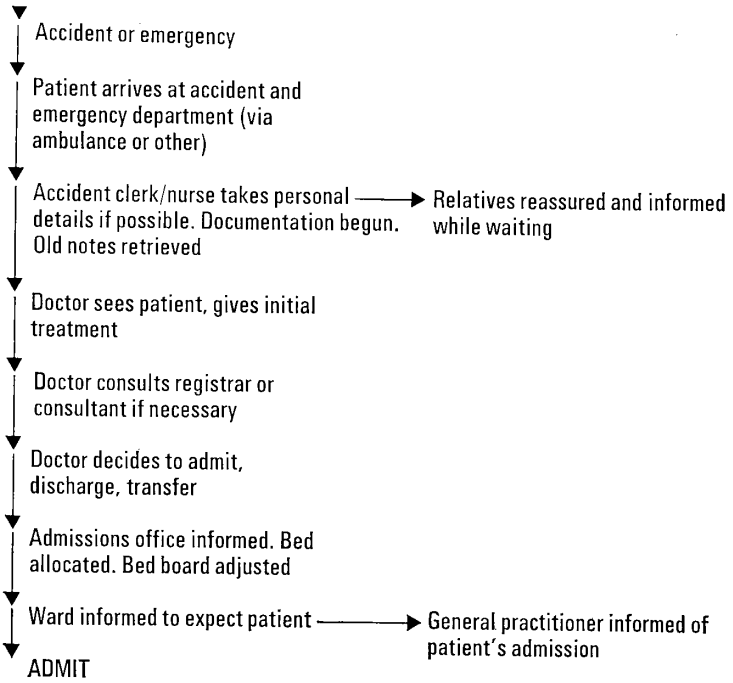
Flow Chart for Unheralded Emergency Admission Procedure



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