KING EDWARD'S HOSPITAL FUND
FOR LONDON

HOSPITAL PERSONAL AID SERVICE FOR THE ELDERLY

REPORT TO 31st DECEMBER, 1955

HOSPITAL PERSONAL AID SERVICE FOR THE ELDERLY

THE Service undertakes to visit, on behalf of hospitals, elderly patients awaiting admission whose medical condition does not involve immediate admission to acute wards.
The main objects are:

(1) To suggest to the hospital the priority, based on social grounds, of those who need admission.

(2) To inform the hospital of the home circumstances in support of the suggested priority and as a guide when discharge is considered.

(3) To suggest suitable alternatives to admission wherever possible in cases where the hospital decides it is unnecessary to admit.

(4) To ensure that the waiting list is a "live" one by informing the hospital of any case which, through any change of circumstances, can be removed from the list.

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

COMMITTEE

Sir Zachary Cope, M.S., F.R.C.S. (*Chairman*)
The Hon. Mrs. John Mulholland
Dr. G. F. Abercrombie, V.R.D., M.D.
Dr. H. L. Glyn Hughes, C.B.E., D.S.O., M.C., Q.H.P.
Dr. J. A. Scott, O.B.E., M.D., F.R.C.P.
C. S. B. Wentworth-Stanley, Esq.

Secretary

Mr. W. L. Graham

Assistant

Miss Joceline Owen

Case Workers

Miss P. M. Mitchell (S.W. Region)
Mrs. F. Lindley (S.E. Region)
Miss J. F. Forshaw (N.E. and N.W. Region)
Miss D. Norton, S.R.N., B.T.A.(Hons.) (N.W. Region)

OFFICE

c/o New Cross General Hospital,
Avonley Road,
S.E.14

Telephone: NEW Cross 3635

FOREWORD

THIS is a report of the work, not of one particular hospital or geriatric unit, but of a Service for elderly people whose doctors have applied for their admission to hospital. It grew from a modest attempt to put in order the chaotic conditions in respect of elderly patients which prevailed at the beginning of the National Health Service.

The Service is first and foremost a hospital one as it is concerned only with those cases which are on hospital waiting lists and acts on the instructions of hospital doctors. A very close liaison is however kept with statutory bodies because it is possible for an aged person to come within the scope of two or more authorities or to appear at first to be the responsibility of one authority but to prove on investigation to be that of another. Close touch is also maintained with the many voluntary organisations which are doing such valuable work in this sphere.

Although the Service is not actively concerned with cases after they have entered hospital, except from time to time to assist with discharges, a yearly survey is made, with the help of the hospitals, of each case we have visited. It is thus possible to show in this report what has happened to each patient.

The Service does not claim to be unique except perhaps that it covers many areas. Expansion of the work into new areas has been rapid during the last two years, which indicates that there is still a need now as there was five years ago. If other groups feel that the Service could be of use to them in any way we should be pleased to help.

ZACHARY COPE,

Chairman.

REPORT TO 31st DECEMBER 1955

INTRODUCTION

A STUDY of the work of the Emergency Bed Service during the early months of the National Health Service showed how serious was the situation of elderly patients. Beds for the younger acutely ill cases could usually be found without serious delay but when the admission of an elderly person was sought even a prolonged search often failed to find a hospital able to accept him. General Practitioners were then in a desperate plight and the Hospital Personal Aid Service for the Elderly, as it is now known, began in a small way to examine the position to see how it could be improved. It is as well to recall briefly the conditions which existed at that time.

Hospitals had to contend with long waiting lists of patients thought, often wrongly, to be in need of long-term care. Few Hospital Groups had geriatric physicians and as almoners could seldom be spared to make domiciliary visits, the names of applicants were often put on these lists with but scant record of their medical and social circumstances and with little assessment of their real needs. In fact the need and the value of domiciliary visiting were not recognised as they are now. Thus when hospital vacancies occurred it was often the practice to admit in chronological order rather than on the needs of the patients.

As vacancies in hospitals fell far short of the demand, waiting lists grew at an alarming rate. These were seldom properly reviewed and soon became a most unreliable guide to the number of patients really needing admission.

King Edward's Hospital Fund had supported the early enquiries into the situation and in August, 1951, under an arrangement with the South East Metropolitan Regional Hospital Board, it provided financial aid to enable a small staff to be engaged solely for the purpose of furthering these enquiries in an improved and more detailed way.

Waiting lists of a few hospital groups were reviewed in turn and by the end of the year the homes of 357 patients had been visited. Full details are given in a later paragraph and we need only mention here that 238 (67%) were removed from the lists for various reasons leaving 119 (33%) needing admission. The necessity of investigations of this kind had thus been proved, and hospital groups asked if the enquiries could be extended to include new applicants so as to guide them on priorities and to assist those patients who were found to need help in some other way. Thus the review, and the enquiries became continuous and in August, 1955, the Fund decided to make the scheme available to groups in all the Metropolitan Regions. Under this expansion the Service now operates in eight hospital groups in addition to seven in the original South-East Area.

THE SERVICE'S METHOD

GENERAL practitioners apply direct to the hospital for the admission of their patients. In many cases the need for admission arises as much from social circumstances as from medical. There are seldom immediate vacancies to meet the applications that are being received from many different doctors. It is clearly helpful if the hospital has the guidance of one visitor who is able to see all the cases awaiting admission. Hospitals, therefore, give the Service the names of the patients to be visited, having first informed the general practitioners that this will be done.

Our case-worker for the area concerned calls at the patient's home and submits a report on each visit. No fixed questionnaire is used but the report is divided into two parts – "physical" and "social". Under "physical" the case-worker notes any changes in the patient's condition which may have occurred since the doctor last called or any other information she is given by the patient or a relative which she considers the hospital would wish to know. The "social" report gives a complete picture of the home circumstances and of the home itself; the ability of the relatives to care for, and their feelings towards, the patient; the suitability of the house in relation to the particular disabilities of the patient. These and all other relevant details are reported and it is also borne in mind that information given now may be needed when the question of discharge is considered. Each report ends with a recommendation. If admission seems to be essential or unavoidable a priority is suggested. If on the other hand it seems feasible for the patient to be maintained out of hospital the possible ways and means of doing so are given. No further action is taken, after the report has been given to the hospital, without instructions. The Service has always insisted on working through a hospital doctor for it is he who must decide whether a patient is to be admitted or not. The Service does not normally discuss cases with general practitioners. It considers that this too is a matter for the hospital doctor.

There is variation in the system of visiting depending on the wishes of each geriatric physician. Some visit all cases first and ask the Service to investigate those whose problems appear to be mainly social; others prefer to have the Service's reports before they themselves see the patients. In one group the physician visits with the case worker of the Service. There is variation too in the way in which subsequent action is taken for those patients who need not be admitted: sometimes it is the almoner who sees to this and sometimes the Service.

RESULTS

THE accompanying summary shows what happens to each of the 5,668 patients visited by the Service from 1st August, 1951 to 31st December, 1955. For the sake of clarity the following notes are given.

Removals from Waiting Lists

Out of 5,668 patients visited the names of 2,929 were removed. 29% of these had died or had been admitted to hospital, although their names were still on the waiting lists and given to the Service for visiting. This shows how seriously out of date lists often are.

The highest proportion of removals is of those who are withdrawn (51%). These patients either refused admission or had recovered and did not need admission or were found not to be in need of hospital care and refused any other form of help. Of these in this last category it may be mentioned that it is not uncommon to find people ready to be admitted to a "hospital" but not to an "institution", "union" or "workhouse". Withdrawals are only made after the hospital has discussed the case with the general practitioner.

It may be argued that many of these cases would not have died or that they might have recovered more quickly if they had been visited and admitted when the application was first made. This may be true but it must be remembered that the Service is attempting to overcome difficulties. It is often presented with lists which have not been reviewed for many months, and its first object is to bring these up to date. The following two instances show the importance of this. One list contained the names of 110 patients and it had not fallen below this figure for a long

time. After enquiries had been completed only five patients needed admission and this was arranged for all of them within a fortnight. In another group out of 32 cases only six needed admission, and beds were found for them within a week.

The removals for "Other Arrangements" account for 20%. These patients either went to Local Authority Homes or were able to be maintained at home with the help of Local Authority Services, or could be satisfactorily treated in out-patient departments or entered private nursing homes.

Admissions to Hospital

It must be emphasised that many patients are admitted to hospital without the Service being asked to visit them. The figures we give therefore only represent a proportion of the total number admitted. The priorities given by the Service are based on the social circumstances and may well be altered by the geriatric physician for medical reasons. However, most of the cases thought by the Service to be urgent are so treated by the hospital. Changes in priorities are more likely to arise when the social circumstances do not indicate any urgency but the physician decides on quick admission for clinical reasons after consultation with the general practitioner.

The patients admitted "After Observation" are those who did not need any immediate action when first seen but owing to uncertain medical or social circumstances were kept under observation. Only a proportion of such cases are admitted. Some die and some become suitable for Part III Homes.

Died before Admission

The figures show the number of cases who died after they were visited and before a bed could be made available for them. Figures under this heading show an improvement; in both 1951 and 1952 16% died before admission, in 1954 it was 11%, and in 1955 less than 4%. There were, however, 61 patients still awaiting admission in 1955 when the present enquiry was made, and though for most of them application was only made during the last week or so of the year, it is possible that a few may die before they are admitted to hospital.

SUMMARY

	1951	*1952*	*1953*	*1954*	*1955*	*Totals*
PATIENTS VISITED	357	955	994	1,557	1,805	5,668
REMOVALS FROM WAITING LIST						
Died and already admitted ..	97	146	93	260	257	
Withdrawn	95	240	236	421	494	
Other arrangements	32	78	103	151	226	
	— 224	— 464	— 432	— 832	— 977	2,929
ADMISSIONS TO HOSPITAL						
Priority I (Urgent)	36	154	163	89	65	
Priority II (Less urgent)	31	162	171	259	151	
Priority III (Not urgent) ..	25	75	43	123	162	
After observation	8	1	60	127	259	
	— 100	— 392	— 437	— 598	— 637	2,164
DIED BEFORE ADMISSION	19	74	84	73	26	276
STILL AWAITING ADMISSION	—	—	—	—	61	61
DIED WHILE UNDER OBSERVATION ..	14	25	41	54	104	238
	357	955	994	1,557	1,805	5,668

In addition to the 5,668 patients included in the summary, the Service visited 555 others which have been excluded for the following reasons:

14 could not be traced in the hospital records.

125 were discharged patients visited in the course of a survey.

416 were visited only to assist a hospital to revise its records.

Length of Wait

The following table shows the wait from the date of our visit to the date of admission of Priority I and II cases only. Omitting 1951, when comparatively few visits were made, there is a definite improvement year by year. More cases are being admitted after shorter waits and fewer cases wait a seriously long time.

	1951	*1952*	*1953*	*1954*	*1955*
CASES ADMITTED ..	67	316	334	348	216
On day of visit ..	7	9	12	10	13
1 day after visit ..	11	42	35	43	29
2 days after visit ..	2	16	19	35	25
3 days after visit ..	4	9	13	20	12
4 days after visit ..	1	10	12	16	5
5 days after visit ..	2	4	14	15	9
6 days after visit ..	—	9	8	19	8
i.e. within 1 week..	27 40%	99 31%	113 34%	158 45%	101 47%
Within 2 weeks ..	7	52 17%	47 14%	63 18%	40 18%
Within 3 weeks ..	9	26 8%	39 12%	31 9%	22 10%
Within 4 weeks ..	1	23 7%	19 6%	20 6%	11 5%
Within 2 months ..	10	44 14%	51 15%	37 11%	23 11%
Over 2 months ..	13	72 23%	65 19%	39 11%	19 9%

SUBSEQUENT HISTORIES OF PATIENTS ADMITTED TO HOSPITAL

OUT of a total of 5,668 patients visited 2,164 were admitted. The accompanying figures show that the greatest number of deaths and discharges, 677 (31%), occur within the first four weeks after admission. After twelve weeks 1,213 (56%) had left hospital. It will be noticed that nine patients were discharged during their third year in hospital.

LENGTH OF STAY IN HOSPITAL

Days	*Deaths*	*Discharges*	*Still In**	
1–28	432	245	72	
29–56	147	198	18	
57–84	80	111	22	
85–112	54	62	7	
113–140	43	32	6	
141–168	37	27	13	
169–196 (6 months) ..	24	20	11	
197–224	26	13	16	
225–252	23	10	10	
253–280	23	12	13	
281–308	22	7	10	
309–336	10	5	9	
337–364 (1 year) ..	8	2	7	
365–392	15	3	6	
393–420	14	1	9	
421–448	6	5	8	
449–476	6	2	3	
477–504	7	2	3	
505–532	9	3	10	
533–560	5	3	6	
561–588	5	1	5	
589–616	3	2	10	
617–644	3	0	2	
645–672	2	0	6	
673–700	2	1	4	
701–728 (2 years) ..	4	1	2	
3 years	25	9	29	
4 years	9	0	23	
5 years	1	0	2	
	1,045	777	342	2,164

*i.e. Patients who were still in hospital at the time this survey was made.

GENERAL

It is not uncommon now to find that general practitioners, when placing patients on waiting lists, ask if a social domiciliary visit can be made. It seems that the doctor is at times anxious about the circumstances at home rather than the medical condition and he feels there might be some solution which does not involve using a hospital bed. From the results of the Service's visits it will be seen that, in a very large number of cases, general practitioners have agreed to some other action being taken. Had hospital beds been readily available at the time and had domiciliary visits not been made, the majority of these patients would presumably have been admitted. Thus, in the event, they would have occupied accommodation unnecessarily.

We have not remarked in the foregoing pages on the proportions of deaths in and discharges from hospital because, as many other cases have been admitted without any reference to the Service, our figures might not show a true picture. We do, however, notice a great variation between groups in so far as the proportion of deaths to discharges is concerned. In one group, for instance, in one year 406 patients were discharged and 300 died. In another 39 were discharged and 90 died. There is an indication that sometimes discharges are not made because the circumstances at home are not as satisfactory as they might be. Patients still awaiting admission are often in far worse circumstances and we feel that discharges should be made whenever there is a reasonable chance of their being satisfactory. It is possible that discharged patients may return to hospital but while they are at home others can have the treatment they need. The proper place for old people unless they are ill or neglected is surely their own homes, and it is generally there that they would choose to be.

Our figures indicate that hospital beds are actually needed for less than half the number of patients on the waiting lists. It seems therefore that the lists are more accurately "application" than "waiting" lists. This being the case the report that there are 9,000 chronically ill patients awaiting admission in England and

Wales is likely to be inaccurate. Have all these cases been investigated or are many of them unchecked applications as seems likely? Are those which have been investigated kept under constant review?

We appreciate that there is room for argument in these remarks but our point is that so long as waiting lists include more than those actually awaiting vacancies and unless discharges are made whenever there is a reasonable chance of their proving satisfactory at least for a time, the provision of accommodation for elderly patients will continue to seem an insoluble problem. Was the Health Service designed to remove all responsibility from relations? This is a question which has been asked before and it bears repetition.

Printed by Crystalate (Printing) Ltd.,
Tonbridge, Kent