KING'S FUND CENTRE

Home from hospital: providing continuing care for elderly people

by

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HOME FROM HOSPITAL: PROVIDING CONTINUING CARE FOR ELDERLY PEOPLE

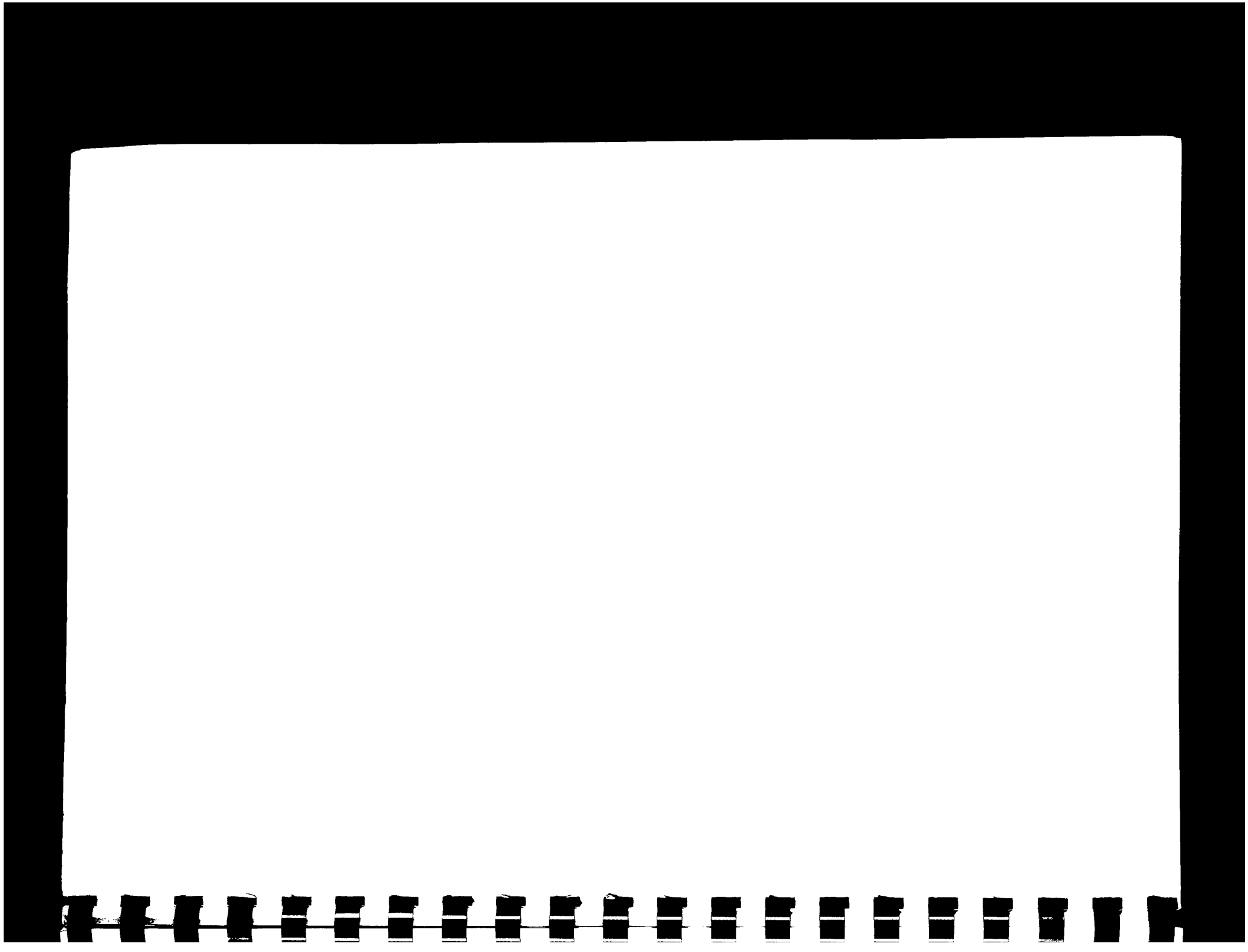
SOME KEY ISSUES AND LEARNING EXPERIENCES FROM THE FIELD

MURIEL SKEET 1982

with additional Appendices and footnotes, 1985

CONTINUING CARE PROJECT

C O N T E N T S



P R E F A C E

Alphonse Karr wrote these memorable words in January 1849, 'Plus ca change, plus c'est la meme chose'.* Muriel Skeet notes in her introduction to this book that the first study of the home care needs of discharged hospital patients was published as long ago as 1970.

I wish to record my appreciation of the support which Muriel Skeet has always given to the Continuing Care Project and for her many years of devoted work in this field. We, as patients and as practitioners, owe her an enormous debt. We are also grateful to Sheila Puckle who generously gave time and expertise in sorting and assembling the original data.

The current study, which describes practices in use in 1982, shows that whilst significant progress has been made in tackling the problems, they have become more serious, mainly because of the current and projected increases in the numbers of elderly people. The Continuing Care Project has added an appendix to this study which deals with further aspects of the work of professionals and volunteers and offers pointers for future action. A few footnotes have been added to the text.

Fortunately, new discharge planning and after care schemes are being introduced and encouraged by the Department of Health and Social Security. These include voluntary organisations' demonstration projects. They will assist patients returning home from hospital. ('Helping the Community to Care', 1985-8). Nevertheless, the need for statutory and voluntary agencies to take new initiatives becomes increasingly urgent when one remembers that today a tiny proportion of elderly people occupy a half of our hospital beds and, in the near future, the numbers of very elderly patients will increase dramatically.

Geraldine M. Amos
Continuing Care Project.

* Alphonse Karr, Les Guepes, 1849

I N T R O D U C T I O N

The Continuing Care Project (CCP) is concerned with improving the quality of the arrangements made for support and care in the community when elderly people are discharged from hospital.

Even when relations and friends are available to help, the days following discharge can be a period of great vulnerability and anxiety, both because the patient is unlikely to have fully recovered his health and strength and because the total care offered in hospital can provide a protection and create a dependence which make returning home a devastating shock.

Several different services and support systems exist in the community and can be called upon to help at this time, but all too often they are not mobilised: either because no one has realised that they are going to be needed, or the providers are not informed early enough, or the patient and his family do not know how, and from whom, to ask for help. The result is that every day there are people returning home from hospital to conditions which cause them and their families unnecessary physical, emotional and mental suffering.

Previous reports

Concern about this problem is not new. It is over a decade since the first study of the home-care needs of discharged hospital patients was undertaken. In 1970 the Dan Mason Nursing Research Sub-Committee of the National Florence Nightingale Memorial Committee of Great Britain and Northern Ireland published the results of that study in a report Home from Hospital. This has been re-printed several times by Macmillan Journals Ltd, the latest edition appearing just over one year ago.

That original publication stimulated further study in the field. In 1973, Care is Rare outlined in more detail the needs of elderly patients discharged from hospitals in the Liverpool area. It disclosed that even when needs were identified, action to meet them was often not taken. For other patients, services were offered too late.

This report was followed two years later by another, Going Home, which analysed some of the organisational and communication problems within hospitals themselves. It recommended that information concerning a patient's possible needs after discharge should be collected before or soon after his admission to hospital. It advocated that such information be recorded systematically and acted upon speedily so that services could be organised some time in advance and brought into operation immediately after the patient's discharge. This report, based on research and test programmes in two Liverpool hospitals, also recommended the appointment of after care coordinators.

All reports aroused, throughout the country, an awareness of, and sometimes an interest in, the subject of hospital discharge. Other surveys and studies were undertaken and, as a result, some hospitals initiated special schemes designed to bridge the gap between ward and home.

In a few instances, because it was realised that the first three to five days after discharge were often the most vulnerable and vital and also represented approximately the length of the time-lag in getting statutory services to operate, emergency programmes were initiated by the voluntary sector.

But over the past three years, data collected by interested organisations, such as Age Concern and the Centre for Policy on Ageing, have presented pictures of very varied circumstances. In some areas, hospital and community staff have planned good innovatory services, but in others, conditions for old people who have gone home from hospital are as bad as they were twelve years ago.

In 1977, the National Continuing Care Project was established by Geraldine Amos and financed by the (then) National Corporation for the Care of Old People (now the Centre for Policy on Ageing). Its aims were

> To promote the coordination of after-care arrangements for effective care of discharged elderly patients.
>
> To develop in all those involved in the care of the elderly patients a perception and an awareness of their continuing care needs.
>
> To encourage the introduction of effective methods and procedures as a means of improving the delivery of after-care to elderly patients.
>
> To develop close links between elderly patients and their families and the statutory and voluntary providers of care.

It was agreed by members of the steering committee that promotional work should be accompanied by a national survey to collect information on after-care arrangements and to discover those effective discharge procedures and innovatory schemes which were already in existence. A summary of the information obtained and discussion of some of the key issues identified were published in 1979 and copies of this publication Organising Aftercare are still available.

The report was not meant to be a definitive statement. Its purpose was

> To raise relevant issues.
>
> To encourage local and national debate on these issues.

To assist health and social services personnel in the examination of their own discharge procedures.

To re-examine in the light of a national survey, some previously identified problems.

Other activities of the Continuing Care Project

In addition to the publishing of reports, other promotional work has been the main activity of the Continuing Care Project. This has included a series of multidisciplinary conferences held in many major towns and cities during the last three years. The first, held at the King's Fund Centre in London, was over-subscribed within two weeks of its announcement and the second, arranged to take the 'over-flow', had a waiting list of 200 potential participants. This initial enthusiasm was indicative of the great interest which subsequently has been shown in the subject all over the country.

Based on information collected at these meetings, more detailed investigations of certain identified discharge procedures and the results of discussions with contacts in the field, a teaching package on discharge procedures for nurses was published for the Continuing Care Project by Macmillan Journals Ltd in 1980. The production of this package was made possible by a generous grant awarded by the Edwina Mountbatten Trust.

Sharing experiences

Other sources of information, including continued informal discussions with staff of hospitals and community services up and down the country, have resulted in the Continuing Care Project acquiring a wealth of information on other people's experiences in discharging elderly people from hospital. It was decided therefore that its next publication should take the form of a selection of these personal reportings.

This, the latest publication to be produced by the project, aims to give a brief summary of the good-practices operating in hospitals and communities which have been reported to us over the past year or so. They are presented here for the information of hospital staff, community services and the general public, in the hope that they may prove adaptable to conditions and circumstances met elsewhere. It is also hoped that their publication will inspire in others the desire to share their own, equally valuable ideas for ensuring the well-being of patients discharged from hospital care.

It must be emphasised that no practice described in this publication has been evaluated by the Continuing Care Project, nor has the project collected the opinions of the patients themselves. The Continuing Care Project has accepted the assessments of the staff operating the schemes who believe that their pattern of discharge procedure works, and have suggested that their experiences may be of help to others.

The Continuing Care Project most gratefully acknowledges the wonderful response it has had to its request for such information. Particularly, it would like to thank those who shared their failures and disappointments as well as their successes and triumphs. Members of the Steering Panel appreciate enormously the time and effort involved in supplying this valuable material, some of which, if not included here, will be used at conferences, meetings and consultations undertaken by the CCP.

Indeed, because information collected is always passed on quickly, some of the good practices described here will already be familiar to those who have attended recent workshops and discussion groups organised by the project. We feel however, that no apology is necessary as the reporting of learning experiences can bear repetition.

Altogether, the material supplied gives impressive evidence of cooperation and collaboration between professionals in hospital and the community services. It also includes reports on the involvement of voluntary services, including some remarkably young volunteers who like to help their elderly friends or neighbours. An increase in instances of formal and informal services working together is a particularly encouraging characteristic of this series of practices. It is not always the younger members of these agencies who give services. Sometimes they are supplied by the very people for whom they were intended - the elderly themselves.

This development surely augurs well for the welfare of future generations and sets a most useful example to those of us who have not reached 'old age', but have the interests of our elderly patients at heart. Certainly, if excellence of care is to be maintained, communication, cooperation and collaboration are vital activities of all members of the hospital and community teams. It is hoped that this presentation will go some way to achieve coordination of services and thereby help to ensure continuation of care for each patient discharged from hospital.

Muriel Skeet.
London, May, 1982

CHAPTER 1

SOME FINDINGS FROM VARIOUS SURVEYS

Since 1970 there have been a number of surveys carried out by various individuals and agencies all aimed to discover the needs of people when they leave hospital, and when these are not being met, why the system is failing. Although these cover more than a decade, the findings are disappointingly similar.

In the main, it is the elderly patients and those who live alone who, when told of their imminent discharge from hospital, voice not only practical problems such as getting in food, but also speak of their apprehension, and even fear. Some who have received care, attention and interest while in hospital, know that they are going home to none. When patients were kept in hospital for some weeks after an acute period of illness or injury there was a gradual weaning, or rehabilitative period, before discharge. Where nothing has replaced this, there is understandable apprehension.

A great lack, identified in all studies, is that of communication. As has already been discussed, patients need information and advice about their illness and convalescence and staff need information about the patients' home conditions and home care needs.

The second lack, stemming from the first, is one of planning. Care must be planned and planned before discharge if it is to be continuous: these surveys show that very little is. The majority of patients who fare well either need no after-care, or have families and friends who rally to their aid. The studies reviewed show that approximately 45 per cent of patients need either practical assistance of one kind or another, or information and advice. On an average just under 20 per cent need the former and are not getting it and between 25/30 per cent need the latter and are not receiving it.

(i) Length of notice given to patients of their discharge dates

With the exception of maternity patients to whom the anticipated length of stay is made known before admission, the majority of patients are given one to three days notice. Except in instances where convalescence is arranged, surgical patients tend to be given shorter notice than medical patients. Interviewers have noted that some elderly patients are agitated by the short notice given, especially if they live alone and have to start thinking about clothes for travel and getting food in at home.

Most patients are left to tell their families or friends about their discharge dates and to make their own arrangements for leaving hospital. Those without a telephone often express their anxiety to interviewers, especially when they are not anticipating having visitors. The short notice gives them hours of worry and fretting until their families visit or are contacted.

(ii) **Transport to discharge address**

The vast majority of patients make their own arrangements regarding transport home. This may include hiring a motor car or taxicab. Some use public transport and some are even allowed to walk home - although in most instances accompanied.

Comments on the mode of transport used refer mainly to travel by ambulance. Complaints are almost equally divided between the long wait for the ambulance to arrive at the hospital, the jolting during the journey and the long route involved in taking home other patients. Frequently elderly people using this form of transport are expected to travel wearing only dressing gowns: this causes not only discomfort, but to some people of this older generation, great embarrassment.

Many have to wait until the evening for their families to collect them, some sitting all day by their already re-occupied hospital bed. Interviewers have noted that by the time they embark upon their journey they are already weary.

(iii) **Knowledge of patients' domestic arrangements**

In the studies under review, of those patients aged 66 years or more, between 20/40 per cent were asked in hospital about their domestic arrangements. Frequently it is a doctor or the ward sister who enquires, but social workers make between 15/25 per cent of the interviews.

(iv) **Hospital services arranged before discharge**

Almost all patients are given a follow-up hospital appointment either for an outpatients clinic or for attendance in another department in the hospital, for example, physiotherapy. Among the elderly patients less than 10 per cent have transport arranged for these appointments and few are asked how they plan to make the journey back to hospital. These sometimes include patients who will be attending day centres on a regular basis. Surprisingly few appear to have aids or appliances lent to them. Of those loaned, the most frequent one noted is the Zimmer walking frame. While measurements for prostheses are usually made before discharge, many elderly patients go home

without them. While this is probably due to the necessary wait until the wound is properly healed, as after a mastectomy, or the limb shaped and ready, following mid-thigh amputation, the anticipation of having to cope with a prosthesis about which little is known, can give rise to considerable anxiety.

(v) **Community services arranged**

It is common to find that when a patient has one community service requested for him (or her) he is offered at least one other, such as meals-on-wheels and home-help services. The majority of requests are made to health visitors, district nurses and general practitioners. Surprisingly few arrangements are made for elderly patients to have a laundry service or the loan of equipment from a voluntary agency. Chiropody is also low on the lists of requests made by hospital staff.

(vi) **Advice given to patients**

The most frequent advice given to patients when they leave hospital is 'Take care of yourself' or 'Don't do too much'. In one study it was discovered that nearly 60 per cent of the patients received no other advice.

Many patients (the percentage ranges from 19/45 per cent) receive no information on the medicines, hormones or antibiotics they are to continue to take at home. Approximately 7 per cent are told how active they may be (this figure was as low as 3 per cent in one survey) and between 2/4 per cent are thought to do their own dressings. More medical patients than surgical patients receive some information about their convalescent period (a ratio of 3:1).

(vii) **Hospital's communications with patients' general practitioners**

Improvement can be reported in the sending of information to general practitioners. Whereas in a 1970 survey it was reported that 60 per cent of the letters were sent out within one week of the patients' discharge dates, this figure has risen to 77 per cent in a 1980 study. This does, however, leave a very vulnerable 23 per cent. For it is found that if the communication is not sent within one week, it is usually a month or more before the general practitioner hears that his patient is home again.

(viii) **Home care needs of discharged elderly patients**

Approximately half the number of patients who leave hospitals in this country need no after-care or receive adequate help from family and friends.

It is interesting to note however that overall the number of community services called upon within two weeks of the discharge dates, are roughly double those arranged by hospital staff. Almost all these are organised by the patients' general practitioners.

(a) the need for information, advice and reassurance

The need for information, advice or reassurance is most frequently recorded and applies to all age-groups.

In relation to activity, many elderly people recuperating from treatment for fractured femurs find walking difficult without the help and encouragement of physiotherapists. Others, feeling 'tired' or 'run-down' wonder whether they are 'overdoing it' and only need general reassurance about their progress. They feel that this aspect of their convalescence is not important enough to warrant a visit to their doctor, but need to know whether the feeling of tiredness is to be expected.

The after-effects of treatment, including surgery, can also cause anxiety: expressed worries include uncomfortable, inflamed or discharging wounds; frequency and urgency following urological surgery; and the effects of radiotherapy. It is frequently found that when patients continue to have treatment such as radiotherapy as an outpatient they fall between the proverbial two stools. The hospital staff expect the side-effects to be dealt with by the patient's general practitioner whilst the latter considers the hospital responsible as long as the patient attends for treatment.

Advice on diets is also required by a number of patients, especially those who are trying to cope with a new colostomy, and diabetic patients who find that what they are expected to eat is often expensive and inconvenient to prepare separately from family meals.

Other patients require advice on prostheses and appliances such as ileostomy belts/bags and on drugs they are taking. Side-effects of the latter give rise to anxiety and while some patients have been warned about side-effects, few have been told whether to continue with the medicine after they have appeared.

Patients who experience pain, such as those with osteo-arthritis or malignant lesions, often need advice. While hospital staff frequently send patients home with a bottle of sedatives - whether these are needed or not - analgesics appear to be in short supply.

While it is probable that many patients do receive the advice and information they need, often the timing of it is wrong. Many patients

speak of being in a state of excitement or apprehension and fear, when told they may go home and consequently are in no state to receive and retain instructions. Older patients also say, 'I forget everything people say to me these days: if only the hospital had written it out for me .....'

(b) the need for help with treatment and mobility

Between one and two-thirds of the number of patients discharged from hospital are reported to be continuing some form of treatment at home. Help needed but not being received includes assistance with dressings: instillations of eye and ear drops, insulin injections and exercises.

The majority of patients who require equipment such as commodes, air-rings or back-rests do not know that these can be borrowed from one of the voluntary organisations. Consequently ill-afforded money is spent on buying them.

Elderly people who would find life much easier by the fitting of ramps, handrails, lavatory seat supports and other aids for disabled people, often do not know how to obtain them. Some are also confined to their houses because they are unaware that wheelchairs can be hired.

More than one study has discovered that hospital staff also are often ignorant of the services available in the community.

(c) the need for help with personal care

A particularly vulnerable group of patients are those who need help with personal care. Patients in the higher age groups, especially surgical and orthopaedic patients, those with long-term illnesses and those living alone, experience the most frustration and the greatest inconvenience. The majority of these rely upon families and friends for care when they return home. Relations who normally live in the same house are most frequently called upon, and this sometimes means loss of money to the family budget.

Friends and neighbours may also rally to help in some instances but elderly people often dislike the resulting feelings of obligation and dependence. Relying upon relatives not living at home can produce anxiety because of the uncertainty involved, and some patients have spoken of having to wait until the evening to be washed, or to have their beds made, because that is the only time their helpers can come. Little help given by voluntary organisations has been recorded.

(d) the need for help in the house and garden

Help with domestic work features largely amongst the unmet needs in all studies. It is a need expressed more frequently than any other and is greatest among the old people. Often with the spouse unwell the husband or wife who is left to do all becomes very tired and after a few weeks there are often signs of lowering standards in both housekeeping and personal care. Several patients speak of the need for a 'nicely-served meal' to tempt them to eat.

Although in only one survey was a specific question asked relating to the need for help with gardening, many elderly people expressed the view that the sight of weeds, long grass and rose suckers flourishing, is positively painful when they can do nothing about them.

(e) the need for company

One survey found that two-thirds of the older patients interviewed commented that they were 'very lonely', 'would like someone to chat to' or 'just sad'.

The number of older people living alone and without a telephone is high in the country as a whole, although it differs considerably by geographical area. In addition to not having a telephone in their house of flat, many old people do not have access to a domestic telephone and live streets away from a public call box.

Other elderly patients who have been rehoused in large modern housing estates live in comparative physical comfort, but in isolation. They have been moved away from friends they have known for years and sit at home, lonely, bored and sometimes in despair. Going to the shops by public transport is expensive and even getting prescriptions to the chemist can become a major problem for them.

(f) financial needs

Convalescence in old age is often complicated by financial worries. Information concerning income is sometimes volunteered when patients are worried about the cost of home helps, diets, late arrival of social security benefits or when a member of the family is losing money to look after them. Frequently they are unaware of the benefits to which they are entitled.

(ix) **The needs of six selected patients**

Because approximate percentages mean little, a few thumb-nail sketches

of the plight of six selected patients from one survey are presented here. It is emphasised that these are miniatures of the greatest needs discovered during the period of the study. They are reported, not as a representative sample of post-hospital experience, but of the worst instances of hardship encountered.

Mrs. A., aged 92 years, widow. Untreated carcinoma of rectum. Blind. Discharged to live alone at own home with home help and district nursing services arranged, and daughter living nearby. After one week home help's time was cut to two mornings per week, so Mrs. A. moved in to live with her widowed daughter. Immediately the home help was taken away altogether. A district nurse had visited three times in two weeks. Three times she had made tea and once 'sponged down' Mrs. A. Daughter as breadwinner was out at work from 7.30 am to 5 pm. Although on piece-work she took an extra half-hour for lunch to come home to give mother food and drink. She did housework, washing and shopping in the evenings. Both mother and daughter had asked for the return of a home help but had been told that they could have one only if they paid for her. This they could not afford to do. The daughter's job was in jeopardy because she had taken so much extra time off. Unable to get to the WC or even to pour water for herself, Mrs. A. sitting in bed or on the commode all day was 'waiting for the end to come'.

Mr. B., aged 87 years, widower. Untreated carcinoma of prostrate with metastases. Doubly incontinent. Confused. Sent home to daughter over sixty years old. No community services arranged by hospital. Fitted with a urinal to wear. Unable to keep this in position, Mr. B. sat padded with towels. At the time of the first interview a district nurse asked for by the GP had visited once to give him a blanket bath. A health visitor had called once. Two months later the district nurse was visiting once daily except at weekends. Mr. B. was more confused, wandering about and falling if not watched constantly. His daughter had to call on her neighbour to help her lift her father but 'disliked doing so because of the smell, and father's bad language and repulsive habits'. Son-in-law had had day off work to enable his wife to do some Christmas shopping. At the time of the second home interview the daughter, having little rest day or night, felt she 'couldn't stand another day'.

Mrs. C., aged 70 years, married. Parkinson's disease. Diabetes mellitus. Senile dementia. Sent home to live with husband and son. No community services arranged by hospital. Patient was obstreperous and tearing off her clothes on arrival home. Her general practitioner stopped 'the tablets' and the patient had been quieter. The doctor had also asked for a district nurse to call daily to help Mr. C. The nurse came three times a week to wash the patient but said she couldn't come more often because Mrs. C. had a family. The family consisted of the husband who had angina pectoris and a middle-aged bachelor son at work all day. He felt he couldn't wash and change his mother, but was able to lift her when he was at home in the evenings.

For the rest of the day Mr. C. aged 74 coped alone. The district nurse had said that Mrs. C. should be in a mental hospital, but her husband who loved her very much was determined to keep her at home if he possibly could. He was sure he could manage if only he could have a district nurse once a day and a night sitter occasionally.

Mrs. D., aged 70 years, widow. Congestive cardiac failure. Sent home by ambulance to live alone. District nursing service arranged by hospital (by telephone). Patient was put on her bed by ambulance men and was unable to get off again. A neighbour saw the ambulance arrive, so called in. She found that the only food in the house was some eggs and bread bought before Mrs. D.'s admission to hospital, and that Mrs. D. 'needed everything done for her'. After ten days the neighbour felt she could not continue to give all the care which was needed. She had sent for the patient's GP who had her re-admitted to hospital. The district nurse did not materialise.

Mrs. L., aged 87 years, widow. Fractured femur. Blind. Sent home to live alone. Bath attendant, meals-on-wheels and physiotherapy requested by hospital medical social worker. Two weeks after her discharge no one from any service had called on Mrs. L. She was paying her neighbour to do the shopping and the laundry. She needed help with dressing and bathing but was receiving none. There were two unemptied chamber pots in her room at the time of interviewing. She tried to cook for herself but found it 'difficult'. She was afraid that she might take wrong dosage of drugs because all bottles were the same size and felt alike. Two months later a neighbour had called Mrs. L.'s doctor who had readmitted her to hospital.

Mr. S., aged 72 years. Enlarged prostrate. Retropubic prostatectomy. Congestive cardiac failure. Incontinent of urine. Sent home to live in caravan with wife. Two weeks after discharge Mr. S. was padded with towels and changing his clothes three times a day. Caravan full of washing. Two months later he had been taken to the hospital out-patient department and been fitted with a urinal. This was 'inefficient' and Mrs. S. had bought sheets of plastic to protect her husband's clothing. She was still washing and drying incontinence pads she had made from towels. Both were depressed by constant smell of urine and Mr. S.'s lack of progress, and felt 'desperate for advice'.

Recent reportings also describe, in less detail but very similarly, horrifying vignettes of patients and their families and friends' experiences after discharge from hospital. As was the case a decade ago, the numbers of patients with needs may not be large, but where need does exist it is often great - and frequently unnecessary.

CHAPTER 2

DISCHARGE PROCEDURES: SOME KEY ISSUES IDENTIFIED

Communication of information between hospital and community

Effective planning for a patient's discharge depends upon the correct information being collected and used efficiently. Those involved in making the decision to discharge a patient used to build up a picture of the person in his normal or day-to-day environment - social, psychological and domestic - and use such information early on in the hospital stay in order to identify potential gaps and needs as well as likely strengths and potential abilities.

A patient is often known to a wide range of hospital and community staff, statutory and voluntary organisations, individuals, relatives, neighbours and friends. If no attempt is made to collate information about his daily living activities, a false picture can be drawn up having regard only to his ability or dependence in the hospital ward.

It is the experience of the Continuing Care Project that this flow of information from those in the community who already know the 'new patient' is very limited. In a situation where time and resources are scarce it is vital to look at information already available and to encourage those who hold it to share it. The need for confidentiality is sometimes given as an excuse rather than as a reason for withholding information from colleagues. Information shared is often seen as power shared. Of course, the confidentiality of a patient's records is a vital right to be preserved at all costs, but it is equally important that certain basic information about home circumstances, the support available and services already received or likely to be required should be shared among those involved in his care. If a question of confidentiality does arise, the patient's permission to share the information should be obtained. It is our experience that usually this is happily and readily given.

Needs identified by one person, if not strictly relevant to his own field may not be passed on to the person who should know about them. A junior nurse for example may learn facts about a patient's home circumstances while carrying out a nursing procedure in the ward, but the ward sister and hospital social worker may never discover them and so the patient's burst of confidence is wasted. It is important therefore that such information, including likely or potential needs on discharge, is written down and made available to those who should be concerned. This information should be constantly reviewed, as circumstances can change quickly and frequently.

Patients with social needs must be identified at the earliest opportunity - if possible when first seen in the clinic or the outpatient department - and accurate predictions made regarding those whose discharges are likely to be delayed. Also, if the total range of information held by staff, family, and the patient himself is to be brought together routinely and automatically, a 'referring officer' must be identified and used by all. It is fully realised that for some patients there is often delay between the time they are listed for hospital admission and the day they actually enter the hospital ward. During that period circumstances can change.

It is also appreciated that there is often a reluctance on the part of some patients to admit that they are likely to have problems. Others may not even recognise that their circumstances give rise to them.

Many patients - and this applies particularly to elderly people - will interpret questioning about their home circumstances as prying or will feel pressurised by it. They may also be reluctant to accept any help even when aware that they need it. They will all be 'away from home-ground', under some stress, anxious and even fearful. Questioning, therefore, should be sensitive and gentle and emphasis placed not on the patient's weaknesses and disabilities but upon his strengths and abilities. Relatives and friends should be brought into the picture from the outset in order that they may be supported and not supplanted in the continuing care programme.

All those concerned with developing arrangements for continuing care must agree upon its components and decide how far they should go in describing modifications demanded by age, emotional state, intellectual and physical capacity, the social-cultural-economic status of the patient and the setting in which the after-care is to be continued.

While the community may have difficulty in passing on information to the hospital when a patient is admitted, there are equally severe difficulties in communication between the hospital and the community when a patient is discharged. One notorious subject of complaint is delay in notifying the general practitioner (GP) that the patient has gone home. This delay can be anything from several days to over a month and yet it is often assumed that the GP is responsible for after-care. When he does hear from the hospital he is often provided with only the sparsest of information and may not visit his patient unless actually requested to. Many patients are told to inform their GPs themselves when they arrive home from hospital, but they often feel too tired to go out or 'don't want to worry him'. Research carried out in Birmingham showed that:

elderly patients showed a high level of anxiety about their health after discharge from hospital and were markedly reassured by a visit from their own doctor;

only 50 per cent of patients had been visited by their GP or a nurse by the 14th day after discharge;

many GPs thought that the hospital was responsible for patients after discharge if they continue to attend an outpatient clinic. Yet many hospitals purposely suggested that the patient should be given the responsibility of contacting his GP. Studies have shown that many doctors react more often and more quickly to a personal request to visit rather than to a note from a member of the hospital staff.

A frequently met difficulty is that GPs are not always in a position to advise about medications. Either they do not have the required knowledge about the drug itself or they have inadequate information from the hospital about the drug in relation to the patient.

Many geriatric hospitals do maintain a continuing responsibility for discharged patients through day centres, day hospitals or by liaison with community staff who report back at case conferences. In the majority of acute hospitals, however, there is little or no feedback to hospital staff and this is regretted by many health workers.

Just as staff are urged to help patients to use their abilities, so the community to which they are to be discharged should be encouraged to use its own local resources and to develop self-reliance.

Communications between hospital staff and patients and their relatives

The success of continuing care depends in the end upon the abilities of the patients themselves and their relatives (or others) who care for them. Hospital treatment and other assistance can all be wasted if those who are to provide care on discharge are not well informed and supported. The nature and timing of information passed to patients and families, and their comprehension of it are factors which influence recovery and future cooperation. The nurse is well placed to teach relatives how to look after a sick member at home, but often the opportunity is lost. Hospital staff may speak of uncaring relatives but their apparent apathy may be due to fear and lack of knowledge. Appropriate skills must be taught and relevant knowledge made available to them.

Hospital admission and hospital visiting can be overwhelming experiences and a ward atmosphere is not always conducive to the imparting of worries or anxieties. Ward staff sometimes assume that,

providing an elderly person does not live alone, his care will be continued adequately. But many studies have found that this is not always so. Many elderly patients have spouses of the same age or older. Even if the husband or wife is well, the ageing process frequently affects the quantity and quality of continued care they are able to give. Often with the spouse unwell the husband or wife left to do all becomes very tired and the living standards of both fall rapidly.

Some relatives and friends may misunderstand the nature of a hospital admission for an old person. It may be seen as a long-term solution to all their problems and occasionally houses may be sold or re-let because of the lack of appreciation of the short-term nature of much of modern geriatric hospital care.

It is common for consultants to use ward rounds for communicating with patients. But these clinical processions can be ordeals for elderly patients. Confronted by a vast array of staff and students they are naturally inhibited and frequently confused. This kind of situation is worse on teaching rounds and because of their lack of intelligent response patients are often thought to be apathetic; as one recent report has stated, 'this state of apathy is often attributed to senility rather than to emotional distress caused by the illness or by the failure of staff to respond to the patient's needs'.

It is known that the greatest need for advice concerns activity and reassurance. Patients need information about the effects of treatment, on diet, drugs, control of pain and the use of appliances and prostheses. As one elderly patient said in relation to learning to use a walking frame, 'What seems easy in hospital, proves difficult at home'.

It has been suggested by a few that written instructions which could be kept would be more helpful than verbal ones which can be forgotten. However, some district nursing officers have reported that many patients - not only the older ones - lose written instructions and they have suggested that a triplicate book should be used. The top copy of the instructions would be given to the patient, the second to the 'community contact' and the third put into the patients notes for review at the first outpatient appointment. This still does not prevent the loss of the patient's own copy, however.

The contrast between hospital and home is particularly marked with regard to the taking of medicaments. Patients are suddenly expected to be responsible for their own medicines when they go home, having been totally dependent upon ward staff until that time. It has been suggested that ward staff could examine how patients might be helped to be safely responsible for their own medicines before discharge,

learning their possible side effects, how long the medication should continue and where to obtain further supplies. Other problems associated with drugs which have frequently been reported include the difficulty in opening packages and bottles with arthritic fingers, the unclear labelling for those with diminishing sight, and remembering whether a dose has been taken.

TEAMWORK IN PRACTICE

'Teamwork' or the 'multi-disciplinary approach' are phrases which have been with us for more than a decade, but sometimes it would appear that only lip service is paid to them.

It has to be remembered that there is a competitive as well as a collaborative element in team work. Not everyone is able to work as a team member. Bringing people together geographically is certainly not all that is required to make a team. In fact, it has been said that when people of individual disciplines try to fit in with others, they do not act with confidence and assurance. This surely affects the quality of their work, and one is left with the question - 'is the multi-disciplinary approach the correct one'?

As far as continuing care for old people is concerned, it would appear that many of their needs are the result of a combination of physical, social and psychological difficulties or problems. No one person in the health or social services has the answer, because in this age of specialisation, no one person has the knowledge and information required. Consequently, today many professionals make up 'the team'.

Some of the Team Members

Hospital social workers

The presence of social workers in hospitals is well established and discussion of their role and location has been widespread, both before and after responsibility for hospital social work was transferred to local authority social service departments. One of objectives of this change was to provide a consistent social work service both in hospitals and the community. It also meant that hospital-based social workers would have more immediate access to resources provided by social services departments. It was hoped that this would provide a continuous service for clients between community and hospital. Additionally, it was anticipated that the social work presence within hospitals would be strengthened by making it part of a larger organisation.

During some of the more detailed investigations undertaken by the CCP throughout the country its researchers became involved in discussions with hospital social workers on a variety of issues relevant to the continuing care of elderly patients after discharge. These included their perception of their own role and their ability to live up to it; their relationships with other hospital staff and how to improve them; conflict between their role in relation to the elderly and other work; conflict between confidentiality and teamwork; and how best to discover those patients who need them most.

The amount of casework undertaken with the elderly by social workers is limited and the practical problems of trying to arrange for discharge are considerable. The current shortage of staff means that in a busy hospital the social worker's involvement often begins when discharge is imminent or a case has become an urgent problem. In some social services departments hospital social workers believe that they are seen only as 'fixers and arrangers' of certain services provided by outside agencies.

Social workers in geriatric units

The multi-disciplinary team approach common in geriatric departments, with its emphasis on rehabilitation, is incomplete without the active involvement of a social worker. With the comparatively longer length of stay in geriatric departments there is greater opportunity for the development of relationships with patients, and social workers can initiate these either at the time of admission, or at the first ward round. Many social workers prefer to interview new patients privately at first, and may see all new admissions (unlike the practice on general acute units where this is now exceptional).

The social worker can also have a key educational role to play with regard to other staff, making use of any opportunity to increase their perception of the overall needs of elderly people. This applies equally to all types of unit, but social workers in geriatric units are likely to have the advantage that others already have some understanding of their potential contribution.

Social workers on general acute units

Where a social work department waits to receive referrals from ward staff (the most commonly cited practice), these tend to be received after it has been decided to discharge the patient. The social worker then has to respond to urgent demands for service, and there is insufficient time for adequate planning for discharge. One report found that most 'indicators' for referral used by ward staff are unsatisfactory, and the pressure to vacate beds swiftly is considerable.

The CCP has learnt of a number of methods employed by social workers to ensure that they are providing services for priority patients:

(a) They interview all patients aged 65 and over.

(b) They interview all patients aged 75 and over.

(c) They go through the nursing Kardex with the ward sister, daily, weekly or twice weekly.

(d) They hold regular meetings with medical and nursing staff to help them understand and appreciate patients' social problems.

(e) They pay regular ward visits to identify new admissions, and those patients who are potentially 'at risk' on discharge.

(f) The social work assistants/aides interview all patients aged 65 or 75 and over.

(g) Admission slips which identify patients who live alone or are of the above age are sent to social work departments.

It is recognised that there are situations in which the practice of seeing every patient is unrealistic, and there is also the valid argument that this is not the best way for social workers to organise their time. It may be more important that the staff who have direct contact with the patient should be aware of those who need a social worker. This increases the need for the social worker to ensure that other staff are aware of his/her role and function.

While the majority of respondents consider it to be a matter of great importance that those elderly patients who require it should receive, on discharge, continuity of care from the social services department, it is apparent that this does not always happen. Some hospital social workers try to follow up their clients into the community, but many say that they do not have the time. For others the travelling distances may be unrealistic, while some community services are so overstretched that the handover at the time of discharge is inevitably delayed.

Home help organisers

Despite its scarce resources, the home help service is one which has recognised the need for prompt action at the time of discharge, and many hospital staff now realise the potential role of home help organisers. In more than one district home help organisers pass information about their patients and their home circumstances to the hospital. Consequently, in many instances home help organisers are

being increasingly involved in case conferences and other informal discussions with health and social service personnel.

In day hospitals also the home help organiser frequently attends case conferences because she can provide much basic information about how the elderly patient is managing at home, while in some districts home help organisers are located in hospitals or spend part of their day in the hospital. This allows the hospital staff to get to know the organiser's problems and she, in turn, is able to allocate resources for specific elderly patients or have more advance notice of their discharge dates and so allocate home helps where they are most needed. Unfortunately, however, this is more the exception than the rule and at best the home help is made to feel the Cinderella member of the caring team.

The nursing team

The nursing team of the hospital, in particular the ward sisters, play a central role in the care of hospital patients and therefore in organising after-care for elderly patients. Nurses are also responsible for creating the atmosphere in wards in which patients do, or do not, feel at their ease and therefore able to talk about their problems.

According to replies sent to the Continuing Care Project, ward sisters are often involved in the identification of patients' needs on discharge, as well as with making arrangements to meet these needs. This is true of both general acute and geriatric units, although the responsibility is often seen as one to be shared with a variety of people. There is a tendency, however, for 'arranging services' to mean making arrangements for district nursing only.

Ward sisters may learn much about the patient that is not necessarily passed on to a person who is in a position to take action. The criteria used by some ward staff to determine whether a patient has needs are known to be unreliable, and their knowledge of community services is often limited. The commonest indicator used is 'lives alone', yet those living with others can also have great difficulties; they may be responsible for looking after that someone else. Using an appearance of poverty (not always easy to detect particularly in hospital) as an indicator may mean that patients are missed when they have severe emotional problems which are hampering their recovery and which a social worker might be able to resolve. Using extreme age as an indicator may mean that the problems of an individual 'younger' old patient are overlooked. The ward sister is often too busy to perceive social and psychological problems, particularly in a surgical ward where all her skills and time are rightly occupied in organising nursing for her patients.

One CCP report included the following statement: 'processes for passing information between hospital departments are unreliable and depend to a great degree upon the personality of individuals concerned. This places the patients who have no choice but to rely on them, in a very vulnerable position. We found that information that was passed on was often inaccurate, insufficient or too late'. Unfortunately, the national picture does not appear to be different.

When hospital nurses speak of aftercare, they very often mean visits by a district nurse. This visiting can be used as a way of checking up to see that the patient is all right after arriving home. More often, however, it is to undertake certain specified procedures including bathing, attending to dressings, taking out stitches, or giving drugs. The majority of patients are visited only if they require one or other of these practical procedures, rarely because of other problems. The conventional procedure for organising district nurse visiting has been for the ward sister to ring the nursing officer (community) or the district nurse herself, on the day of, or the day before, discharge. The district nursing service usually responds promptly and does not, it would appear, require more notice than this. However, it has meant that the information given to district nurses is frequently inadequate.

Shift working can also mean that the nurse who collects information from the patient and family may not be the one consulted regarding his discharge. This emphasised the importance of comprehensive and up-dated record-keeping.

In recent years more and more hospitals have employed nurse liaison officers (the title varies) to coordinate all requests for district nursing and to maintain contact with the staff of community services. Although the object of these appointments is to improve communciation, hoighten perception and provide more information, it has sometimes been found that the presence of this intermediary has restricted the information provided.

A more systematic approach to nursing and the individual patient is currently being developed in some areas. The first stage is the identification of all patient needs including those relating to aftercare after discharge from hospital. In this 'nursing process' a plan for each patient is developed on admission, with goals for treatment. The patient's progress is recorded in a way which allows for changes in goals and activities. The detailed recorded assessment of each patient includes building up a picture of the whole person from the physical, social and psychological points of view.

Physiotherapists and occupational therapists

The Continuing Care Project's survey and detailed investigations show that the roles of physiotherapists and occupational therapists vary widely. Their involvement in planning for after-care is considerable in some places, and negligible in others. The following table is of interest and represents replies from 166 hospitals, when asked:

(a) Who identifies problems of elderly patients?

(b) Who arranges aftercare?

	Physio-therapists	Occupational therapists
Acute hospitals		
involved in identifying	23%	2%
involved in arranging	15%	2%
Orthopaedic hospitals		
involved in identifying	55%	45%
involved in arranging	36%	27%
Geriatric hospitals		
involved in identifying	53%	62%
involved in arranging	13%	22%

Clearly both physio and occupational therapists are more likely to be involved on orthopaedic and geriatric units than on acute units. Indeed, the involvement of occupational therapists on acute units is negligible (even though many of these units contain orthopaedic wards). On geriatric units, however, both disciplines are seen as having a vital part to play in the work of the team and their role in rehabilitation can be very significant. The whole ethos of getting people back on their feet and preventing dependency and institutionalisation relies for its success very largely on the skills of these two professions. Their skills flourish in situations where the other staff, in particular the consultant, value their contribution and involve them fully in assessment and treatment. However, in most geriatric settings, and where therapists are involved in the other kinds of units, the therapists wait until their services are requested by the consultant. Therapists do not in general take initiatives to discover needs. Either they wait to be asked, or their contribution is built into the system of treatment prescribed by the doctor.

Often other staff in hospitals hold misconceptions about the contribution of therapy staff. Inter-disciplinary meetings can overcome this and enable therapists to feel members of a team, instead of 'ancillary staff' with a subservient role. Even occasional meetings can be of immense value. It is important that patients also understand what the work of therapists is; one group of hospitals has produced an information booklet for its elderly patients and their relatives, which includes a description of the roles of physiotherapists and occupational therapists. This makes it very clear that rehabilitation is the mutually shared aim. It explains that the therapists are trying to help their patients to achieve independence, and this may include not only exercises, but teaching them the best way to dress or to prepare a meal although suffering from partial handicap.

Sometimes elderly patients who have surgery become bedbound and dependent, and then become a 'social problem', whereas timely, effective intervention by physio and occupational therapists could have prevented this, and facilitated home discharge. One way of bringing the type of rehabilitation which is specifically geared to elderly patients' needs into acute wards is by the establishment of a relationship between the acute team and the geriatric team, the latter including physio and occupational therapists.

The shortage of domiciliary and community-based therapy services in this country is common knowledge. Hospital-based occupational therapy staff can help to bridge the gap by making domiciliary assessment visits before or during a patient's admission or by accompanying the patient on a trial visit home. During such a visit the hazards and difficulties of that particular house can be identified and plans made to overcome them. It has been pointed out that many occupational therapy kitchens in hospitals are poor preparation for the reality of most old people's kitchens. Where domiciliary visits are not possible, hospital based therapists can look at other ways of obtaining information. This may mean working closely with other professional groups, such as district nurses or home helps who have been visiting the home. It could involve more informal means of communciation, possibly following the example of the home help organiser who sends the hospital a form containing information about patients' home circumstances. Conversely, therapists often hold information which is of value to others, in particular on the detailed assessment forms which are in common use. The case notes are the obvious place to collect together all this information. The problem remains of how to motivate people to read them.

The hospital administrator and his staff

Only very rarely in CCP surveys were administrative staff mentioned as having a role to play in the identification of patients' needs and in making arrangements for discharge, or even in ensuring that either

is done. They appear to be seen only as performing specified tasks such as taking care of pension books. However, Improving Geriatric Care in Hospital states: 'The Administrator has the opportunity and the ability to influence in other ways the care provided to elderly patients. He can bring direct pressure to bear on members of the District Management Team to effect a change in attitude towards the elderly'.

The role of doctors

The role of hospital doctors in ensuring continuing care for the elderly is implicit. The need for good communications between doctors, patients and their relatives has often been noted. It has been seen that although a patient's actual treatment is central, this cannot be properly carried out without due regard to that person's social and emotional context, and therefore not without a sound knowledge of the patient's home circumstances. This knowledge is more likely to be available on geriatric units, but the need is just as great on general acute units. Lack of adequate planning for after-care following, for example, major surgery can lead to re-admission and a waste of resources. Here, of course, the hospital doctor is not without assistance and the ways in which all those involved can best communicate for the good of the patient is one of the central themes of many previous reports of the Continuing Care Project.

It has been seen that an approach to the patient in his total environment is more common in geriatric units where there is an emphasis on rehabilitation in the patient's own home. This kind of care for the elderly is said to be fostered by the multi-disciplinary team approach, and one of the vehicles for this is often a case conference in which doctors usually play a part. However, the style of these conferences varies, particularly in the following respects:

the extent to which the participants can contribute their own information and views;

the extent to which decisions are taken jointly or taken by one person. In the latter instance it is usually the consultant geriatrician.

Here there is the obvious danger that when the case conference is dominated by one individual who does not have knowledge of all fields and of all services required, the patient does not receive the best continuing care which can be provided.

It is appreciated that good collaboration with other services providing aftercare for the elderly, and good communication between all workers

concerned, is more difficult to achieve on busy general acute units, where there is less time and an understandable desire to concentrate on the treatment of a specified medical condition. Junior hospital doctors taking a patient's history on admission often miss the opportunity to collect social information and to pinpoint potential problems. One survey found that although this 'clerking in' is meant to include a full family history, in practice notes vary considerably. Some did provide a full picture; many simply stated whether the patient drank or smoked.

The role of volunteers and voluntary agencies in the care of elderly patients discharged from hospital

Despite increasing national interest in the role of voluntary workers, the CCP surveys have brought little information about the part played by them in relation to the continuing care of elderly people. While there is a long tradition of voluntary help in this country, and people helping people has been the backbone of British social life for centuries, there has recently been widespread questioning of the volunteer's role in the health and social services. Some organisations have made moves to get their volunteers involved in discharge procedures, escorting patients from hospital and settling them in their homes, but not all are able to recruit assistance for the hours these are most needed.

Research undertaken by Jill Pitkeathly and Pat Gay and reported in a publication entitled When I Went Home examined the demand for volunteer services at home as experienced by the 'consumer'. They carried out a series of detailed interviews and concluded that volunteers were an important additional resource in the care of discharged patients. The authors stated: 'Volunteers are generally undervalued by the statutory services and may be seen as the last resort. Volunteers are not a panacea: they have their faults and certainly cannot be the answer to all our problems. However, the voluntary sector is an important additional resource waiting to be tapped, not as a quasi-professional service, nor as a cheap alternative (but) to provide an informal network of care for patients who do not already have this provided by their family, friends or neighbours'. The authors also pointed out that any method of organisation must take account of local conditions and therefore will vary from district to district.

The CCP sees this as the direction in which voluntary help is moving and has suggested that it can be encouraged by the appointment of coordinators or volunteer-organisers. A variety of models exist for the coordination of volunteers, but a deep level of involvement in the hospital and good communication with professional staff are vital. A coordinator or organiser needs sufficient authority to not only support the volunteers themselves, but also to convince staff of the formal services of the value and purposes of volunteer help. Each must work out the most effective way of organising referrals and of making accurate assessments. Above all, it must be borne in mind by

everyone that the contribution of a volunteer is quite different from that of any professional worker and that volunteers are not there to fill gaps in the statutory services.

Setting up voluntary schemes is by no means an easy task. The consultations that are required to initiate a scheme in the health service can dampen the drive of the most motivated negotiators. Some professional workers have unrealistic expectations of volunteers and anticipate the instant success of innovatory schemes. If the voluntary sector does not respond as swiftly as the health or social services departments wish this is not always the fault of the volunteers or the voluntary agency. Foresight is required and requests for help at the time of, or after discharge, are unfair demands. In order to be efficient and effective, volunteer schemes must be involved in the planning process and at the earliest possible stage.

CHAPTER 3

VOLUNTEERS AND VOLUNTARY AGENCIES: A Brief Discussion of Some of the Main Issues

Because of what is reported as 'successful deployment of volunteers' in some schemes, which include volunteers or voluntary agencies, it is considered worthwhile to discuss their potential role and, in particular, the attitude of professionals towards them and the kind of work they could do.

There are many definitions of the word 'role', but a generally accepted one is that it constitutes the behaviour expected of an individual by virtue of his occupying a specified position in a social situation.

Role expectations exist in the mind of an individual and in the minds of those with whom he associates in carrying out his work. But these expectations do not remain in the mind. They tend to become communicated as direct instructions or less directly; for instance, when admiration or disappointment in some performance or behaviour is expressed by a colleague. Low congruence in perceptions among group members in regard to their roles may not only be disfunctional for the provision of a service, but may mean that the individual feels his identity is not being respected and recognised by those with whom he works.

Defining 'volunteer' is more difficult for there is more than one category of such person. The working party on the Place of the Voluntary Service in After Care - **2**, appointed by the Home Office, under the chairmanship of the late Dowager Marchioness of Reading, in its second report distinguished between associates - that is to say volunteers 'who can provide support for a considerable period by a personal relationship' - and other volunteers 'whose contribution is more likely to be of a short duration in the way of a simple practical task or advice on a technical problem not requiring personal involvement'. The working party drew attention to the fact that 'there will always be truly independent persons and organisations who do not want any official contact or recognition and yet wish to offer a service'. Ten years later, another study designed to discover the role of the volunteer in the reorganised health service confirmed that statement - **3.**

One of the recommendations from that study was: 'Volunteers in the health field working in the community should form part of the

Primary Health Care Team and a member of that team should be responsible for their in-service training, their supervision, their follow-up assessments and for giving them continuous encouragement and support. Similarly, those working in hospitals should come under the supervision of a senior member of the nursing staff to whom they should be responsible and accountable'. Integration as a member of the team is difficult if not impossible if the volunteer is responsible to a lay organiser whilst all other members are responsible to a senior member of one of the professions. A task should only be delegated to a volunteer and accepted by him if he is safe in carrying out the procedure. An expert in that particular field must be the judge.

It follows that accountability is something which must be given very careful consideration as the personal responsibility of each individual professional member of the team must be borne in mind. For this reason, every member of the team - whether professional or amateur - must be fully informed of the others' roles, duties, specialised skills, interests, responsibilities and limits of competence.

The characteristics which occur with the greatest frequency in the literature on teamwork, and which are considered to be most important in its development, have been set out by the authors of The Work of the Nursing Team in General Practice -1.

These are:

(1) Members of the team share a common purpose which binds them together and guides their actions.

(2) Each member of the team has a clear understanding of his own functions; appreciates and understands the contributions of the other (professions) represented on the team and recognises the skills and interests they have in common.

(3) The team does the practising by pooling knowledge, skills and resources and that all members share responsibility for the total outcome of their decisions.

(4) The effectiveness of the team is related both to its capabilities to carry out its work and its abilities to manage itself as an independent group of people. Leadership only becomes a problem when there is a lack of mutual respect and trust.

The report of the Panel on Primary Health Care Teams (British Medical Association, 1974) stated, 'As the team is composed of members from a number of complementary disciplines, it is essential to define the objective of all its members so that there is a clear definition of their roles' - **4.**

To learn a professional role, one goes through a specific educational programme designed to teach those skills and give that knowledge essential to carrying out the work within that role. Training is also a means of introducing a newcomer to the expectations of other members of the team and of providing them with the opportunity to identify with it. Surely this must apply to the amateur in the health or social services team, as well as to its professional members.

However, in order to integrate the volunteer (who is not always an amateur, we must remember), it is necessary to have the acceptance and the cooperation of three parties - the volunteers themselves, the professionals and the patients.

With more people living longer, the plight of old people, especially those recently discharged from the security, warmth and servicing of hospitals and Homes, occupies the attention and the conscience of many a social worker. The burden also falls squarely on the shoulders of the nursing members of the primary health care team. We have known the curing role of the medical profession; that medical intervention is frequently dramatic and puts doctors in the team-leader position. But we are moving to new and expanding roles for other professions, because the people we keep alive longer - rightly or wrongly - give nursing intervention an important place. This applies not only to the phenomenon of longevity. We also have disabled, and drug and machine dependent patients living in the community who, a few decades ago, would have been dead.

Among the services which have been recommended to receive urgent attention are:

(a) Care in half-way houses to provide accommodation and necessary services for old people,

(b) door-to-door transport services for ill and elderly patients discharged from hospital or undergoing regular treatment as outpatients,

(c) home-help and meals-on-wheels service operating daily; the lay staff receiving support and encouragement from professional members of the primary health care team,

(d) night-sitter service to relieve the families and friends of patients who are ill or dying at home,

(e) organisation of voluntary helpers of all ages to cook, serve meals, garden, shop, launder, do housework and to provide company, interest, and encouragement for those in special need, particularly the old and the lonely. - **5**

Most of these services do not need to be delivered by someone with a professional training - many needs could be met by a well-prepared and, in some cases, an adequately trained volunteer.

But many patients and their families do not know about the services already existing, and they do not know how to set about creating a demand for those not available. And when they have a vague idea that something of the kind exists, they do not know where to go for it. - **5**

Another problem which has been highlighted in rural areas is the patient's resentment of any intrusion into his privacy by a neighbour. It is for this reason that some street-warden schemes which have been initiated in various areas have failed. The patient or his family do not want neighbours seeing inside the home, finding out that the linoleum is torn or that the sheets are darned. Pride can be a mixed blessing.

Sadly, studies have also made another discovery - the services needed are not always those which volunteers wish to provide. Some services are more popular with the providers than with others and this explains, to some extent, the duplication of voluntary services which exist. Unfortunately, some organisations provide a service which they consider necessary rather than finding out by local surveys what is actually needed in their area. Others just direct patients to statutory services. Unfortunately this practice, without contributing to solutions, adds to the professional's load instead of helping to ease it. - **3**

Recruitment is also a major problem for some voluntary agencies. They report that requests for help frequently have to be turned down because of lack of staff. The earlier discharge of patients from hospital has in some areas brought more demands than their members can possibly cope with. Preparation of homes for patients returning from hospital is considered an important service, and one for which more helpers are needed. A good source of supply for this particular activity is known to be retired nurses who, having been left on the scrap-heap in their late fifties and sixties, are delighted to find that they can be useful again.

Experience has proved that telling people about a particular need in their own community usually stimulates offers of help. People rarely offer help in a vacuum, they need to be aware that their help is needed. Just as they want to know how their money is going to be used before giving it to a charity, so they will want to know how their time will be spent before offering it to a voluntary organisation. Many will also need assurance that preparation for the job will be forthcoming.

By involving the community in discovering the needs on its own doorstep, members of the voluntary organisations will often proffer ideas on how to meet them. They will also help to implement plans and, finally, help in their evaluation. On-going assessments of their work and services are sadly absent from the plans of most voluntary organisations. Some have become introspective and continue their traditional forms of service without question or judgment - others dabble in so many activities that they provide no one excellent service. Instead of searching for solutions to today's problems, many opt for palliative measures. Often they are seen as 'not doing very much' - a state not likely to attract new recruits. If voluntary agencies are to make their mark and obtain publicity, they must earn it by providing services which are needed.

Sometimes the service offered may be the right one, but is given under the wrong circumstances. As one patient with a progressive disease said, 'The voluntary organisations will provide transport to attend their own clubs and outings, but I don't necessarily want to be with people with whom a physical disability is the only thing I have in common. I would like to visit my own friends for a meal, but transport to enable me to do so is just not there'. - **5**

The time a service is available is also important. One of the greatest gaps in the statutory services is caused by the closure of departments at weekends and over Bank Holidays. Yet many voluntary organisations close at the same time. As many elderly patients are discharged on Fridays, medical equipment for loan is often needed at weekends, but in many areas the depots of both statutory and voluntary agencies close down from Friday afternoon to Monday morning. In many parts of the country, the statutory meals-on-wheels service is also discontinued for four or five days over Easter and Christmas, as is that of voluntary organisations. Too often volunteers and voluntary organisations are providing the services they want to provide and at the time they want to provide them, rather than those which patients or clients need at the time they are required.

It has been made clear during group and individual discussions that greater coordination, collaboration, communication and cooperation are vitally needed not only between statutory and voluntary sectors of our welfare state, but also between the voluntary organisations and volunteers themselves.

Individual characteristics should be preserved, but to save the professionals' time and also to be able to meet the need quickly, the voluntary organisations should, perhaps, consider Seebohm's one-door principle. Not only would this provide one telephone point where all requests for voluntary help could be made, but it would also provide one recruiting point and a centre for the deployment of volunteers. Jack Ashley's comments on associations for the deaf have wider implications. 'There are too many fragmented organisations, each dealing with its own specialised aspect of the problem and in many cases with specialised groups of people. At present, despite some attempts to coordinate their activities, deaf organisations leave themselves vulnerable to petty jealousies and parochial conflicts'. These petty jealousies and parochial conflicts result not only in a waste of resources, but also contribute to people's general confusion and ignorance regarding voluntary organisations.

During CCP fieldwork, the following statement from the Report of the Committee on Local Authority and Allied Personal Social Services (Seebohm Report 1968) has been underlined time and time again, 'The ways in which existing resources are organised and deployed are inefficient. Much more ought to be done in the fields of prevention, community involvement, the guidance of voluntary workers and in making fuller use of the voluntary organisations' - **6.** At the present time there appear to be minimal results from the many services voluntary workers offer. The low awareness of agencies and volunteers is indicative of this. Whilst there is an enormous investment of devotion, there is a deplorable lack of return.

The whole subject of preparation and training of volunteers working in the welfare state requires more study. However, it is believed that all training should include the three elements of knowledge, skill and understanding. Obviously, preparation or training for a job depends on the job to be done. But any amateur working with a patient or client requires at the very least, briefing on matters such as confidentiality.

The Aves Committee (1969) thought that 'volunteers who will be involved in close personal relationships, whether their work is the befriending of a lonely person or is concerned with helping people who have complex problems, will need, above all, to know

something about human reactions and behaviour. They may need help in understanding the feeling and attitudes of clients and in realising that the relationship has to be one of mutual acceptance. They need to learn something of the arts of communications and establishing relationships, of how to give and receive information and respect confidences'. - **7** It is important too that they should be able to judge how far they can go in dealing with a difficult situation and when and where to turn to for advice and help.

In planning training it is necessary to bear in mind not only the demands which the work will make on the volunteer, but also his own experience, capacity and attitudes and the resources which are available for training and continuing guidance or support. The amount of information, skill or awareness which volunteers may need to acquire will depend on these factors and will vary greatly, but it is essential that each volunteer should be helped to see how his learning can be applied to his work. Any training scheme which fails to enable him to apply his knowledge can achieve little and may even defeat its aim by confusing him or undermining his confidence.

It would seem logical that the professionals should train or prepare today's volunteers to be their assistants. But do the professionals want that task? Do they want volunteers who will help them in their work? What about their reputation of being unreliable? What about trade union repercussions and the possibility of litigation?

Certainly it would appear that there is an urgent need for professional staff working for the welfare state to be prepared for working with volunteers. They must see them as assistants to themselves, working under their supervision: volunteers are not, and must never be seen as alternatives to professionals. Even in times of emergency they must always be supervised by qualified staff. But in order that they may be effective and competent at those times, they must be given opportunities to practise in real-life situations.

Professional members of the health and welfare teams should also be provided with information concerning voluntary organisations, their work and the services they provide. Such preparation should be included in their training programmes. It is not the exclusive right of the so-called caring professions to help people. Today we have a caring community. Health by the People is not only for third world countries. - **8** Now, as never before, there is the need - and the opportunity - for professional staff members of the welfare state to work with, as well as for, the community.

Voluntary organisations, with their unique pioneering function, can implement innovative programmes without waiting for committees to be convened or for questions to go up the scale and answers to slowly come down again. It is for this reason that voluntary organisations must stamp on any sign of bureaucracy if it appears in their midst and it is for this reason that they must never allow themselves to be totally state financed. Their independence is their strength. They can, if their leaders are imaginative and courageous, provide a service when, where and for whom it is needed.

Can we afford not to use volunteers in the welfare state? Studies have shown that in Britain we are deploying community nursing personnel inefficiently. - **9** We have expensively trained staff with high qualifications and great experience, who are sometimes used ineffectively. How can we conserve our resources? The cost of the National Health Service for 55 million people in the United Kingdom is 75 times the annual budget of the World Health Organization. This cost has increased explosively during the past 15 years. Administrative changes were brought about in 1974 to help organise services in a more economical way. And now another reorganisation has just taken place. It may be that health care can be better and more economically achieved by different combinations of disciplines, professionals and auxiliaries. We have an obligation to save skilled time which is a most expensive commodity. Yet health professionals in particular have this inbuilt resistance to auxiliary help. In a recent global study of the subject, it was shown time and time again that resentment at the deployment of auxiliaries came from doctors and nurses. - **11**

Neither are social workers exempt from this inbuilt resistance to the use of volunteers. The Aves Report observed: 'It is unlikely that all professional staff in the social services, social workers and others, will be immediately convinced of the value of voluntary work'.- **11** The Barclay Report also stated, 'to date the evidence from such bodies as the Volunteer Centre clearly suggests that professional services have not been renowned for their skilled use of volunteers'. It went on to acknowledge that, 'the volunteer cannot be stereotyped as untrained, inexperienced and unreliable. On the contrary, with unemployment so high and retirement occurring earlier in people's lives, volunteers could be highly trained and experienced. Sometimes, therefore, volunteers will be able to deal with more complex situations than a particular social worker'. - **12**
Giving service is an open-ended commitment and more can always be done given the material and human resources. Have the professions the right - and the conscience - to limit those human resources?

The health professions are notoriously conservative, and understandably so, as they undertake onerous responsibilities and part of their personal defences against self-doubt arise from the established certainties within their professions and sciences. But we must not think only of medicine and its allied services. Education, social security payments, housing assistance and support of food supplies, all represent continuity of care. In France the Social Budget covers all these, yet the health service takes nearly a quarter of the GNP. - **10** Who can affirm that it should take more at the expense of others?

Surely the key to the future of our welfare state is a sensible partnership between the professions, within individual professions and with the community itself. Only in this way can our common aim - the health and welfare of all people, including a continuity of care - be achieved.

The contribution of volunteer groups throughout Europe

The voluntary contribution in Europe is in varying stages of development. Culture and tradition play a large part. In some countries voluntary service has been a widely accepted form of public service for generations, in others it has never existed.

In those countries where volunteering is well established there is an increasing awareness of the importance of improving the quality of life for elderly people; the need to help them to remain active and to be stimulated mentally.

One recent trend is volunteering by the elderly themselves, and some services have been taken over by the very people for whom the service was first intended. These include meals-on-wheels, recreational activities, home help service, staffing of day centres and manning telephone exchanges for special help agencies. The main aim is 'desegregation' of old people and it is believed that the rapprochement which was established between generations during the 'Year of the Child' is being maintained. Some older people are going into schools to speak about the history they have lived through, their interesting memories and about professions and trades now extinct or quickly disappearing.

For the very old, or those with no choice but to go into an institution, it can be of comfort and help to find volunteers there of an age near to their own. Volunteer groups participate in daily events, open up the old people's curiosity about the outside world and organise games which require imagination, memory

and observation. One Red Cross society is training elderly people to become comperes for shows for old people, recognising, as the Red Cross has always done, that some relevant preparation is necessary if volunteers are to do good work.

The families of elderly people often have ideas about what volunteers could do - they can discuss their own needs and thus new services are conceived and developed. Certainly those who are looking after very old or incapacitated people for most of the year will appreciate the chance of a holiday if temporary accommodation or other relief care is made available while they are away.

Voluntary work must be a dynamic process, responding sensitively and swiftly to new needs. The needs of elderly people are now the concern of many volunteer groups throughout the world. Volunteers can help to meet their needs by working not in competition but in cooperation with professionals. Both groups still have much to learn about working with each other.

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CHAPTER 4

DISCHARGE PROCEDURES:
Some Practical Experiences Reported from the Field

Among the various practices discussed with members of the CCP, the following have been chosen as being of interest. Although the basic ideas of some schemes - such as the appointment of liaison officers - are already being put into operation in a number of places, the selection briefly described here are believed to have one or more innovative components. It is hoped that these will serve as the basis for initiating ever-widening ripples of planned continuing care.

The appointment of liaison officers to provide continuity of nursing care

District A has initiated an after-care scheme based wholly on the use of community nurses and health visitors. This provides a liaison service between all five hospitals in the district and community nurses. Daily visits to hospital wards are undertaken by the liaison officers, who then collect discharge forms and inform the practice-based community nurses of the services required.

Post: Hospital/community liaison sister or charge nurse

Qualifications:

State registered nurse or registered general nurse (Scotland). District nursing certificate preferred but this is not essential, as opportunities are given to take appropriate training after appointment.

Grade: Sister or charge nurse, Grade II.

Responsible to: Senior nursing officer (community)

Reports to: Divisional nursing officer

Aims of post:

(1) To provide a liaison service between the hospital and the community in order to maintain continuity of care for discharged hospital patients.

(2) To promote good relationships and liaise with nursing colleagues, medical practitioners, social workers and members of all other caring professions, working in the community and in the hospitals of the districts.

Duties and responsibilities

(1) Professional

(a) To collect and to process daily, details of all hospital discharges requiring home nursing care.

(b) To ensure that medical and nursing instructions given to patients in hospital are understood by them.

(c) To inform the appropriate hospital staff of problems associated with a patient which may affect his recovery.

(d) To relay details of hospital discharges to the relevant surgeries or health centres.

(e) To advise wards and departments on the proposed discharges with regard to home circumstances and to organise, prior to the patients' discharge dates, supplies of any needed aids or equipment.

(f) To attend case conferences as requested.

(g) To complete a monthly workload return.

(h) To participate in research programmes as required.

(2) Administrative or managerial

(a) To keep accurate records.

(b) To write and submit reports as and when required to appropriate agency through line management.

(c) To attend and participate in staff meetings.

(d) To report staff requirements through line management.

(e) To act for nursing officer as requested.

(3) Educational

(a) To participate in the induction of newly appointed staff.

(b) To participate in orientation programmes of nursing staff and observation programmes for professional visitors as required.

(c) To participate in community programmes for student nurses.

(d) To participate in health education programmes as required.

(4) Personnel

(a) To be aware of the Health and Safety at Work Act 1974, and to ensure that the legislation is followed strictly in relation to colleagues, self and visitors.

(5) Any other duties

(a) Any other duties as specified by the senior nursing officer in accordance with training, experience and other discussion with the post-holder.

The job description is reviewed periodically and amended as necessary after consultation.

District B (see Annex A) initiated a system because of the increasing numbers of early discharges. It is a community liaison service designed to provide continuity of nursing care, with smooth transition of patients from hospital to their own homes. The sphere of activity is concerned mainly with nursing, but good contact with other individuals such as social workers, and with relevant services forms an integral part in order to ensure comprehensive patient care.

Although the office is based in a hospital, the staff are responsible to the community nursing officer. Two full-time nursing sisters and two part-time clerks are employed in the scheme. Full coverage is given:

Monday to Friday	9 am to 5 pm
Saturday and Sunday	1 pm to 5 pm

At all other times an Ansafone service is used.

Over Bank Holidays a community sister goes into the office between 4/5 pm to transfer information about any discharges which has been recorded on the Ansafone to the appropriate community agencies.

Post: Community liaison sister

Qualifications: State registered nurse with appropriate post-registration experience

Responsible to: Divisional nursing officer

Reports to: Community nursing officer

Aims of Post:

(1) To ensure continuing of care for the patient from hospital to community.

(2) To develop and maintain an effective communciations system.

Functions:

(1) To act as liaison between ward sister and community nursing sister or health visitor in order to coordinate ongoing treatment and to ensure, prior to discharge, that services are available.

(2) To assess the needs of the patient through consultation with personnel involved, patient and relatives.

(3) To refer discharge of patient, according to need, to the appropriate district nursing sister or health visitor.

(4) To liaise with the community nursing sister or health visitor to assess the patient's home conditions prior to his discharge.

(5) To liaise with the social services department and relevant voluntary agencies concerning the needs of the patient at home and to inform the community staff involved.

(6) To be responsible for maintaining, as a means of ensuring good communication with community staff, the following records:

staff lists

holiday lists

off-duty rotas

This system has been recommended by District B, particularly for early discharges. Information concerning it has been disseminated in the following form:

POST-DISCHARGE SUPPORT
A SYSTEM FOR EARLY DISCHARGES

Due to pressure on the availability of surgical beds, there is a growing trend towards early discharges. This makes it increasingly difficult to arrange adequate support facilities before the patient is sent home.

Detailed below is a system which could greatly help to eradicate this problem. This system has been formulated following preliminary discussions with the District Management Team, the District Committee of General Practitioners, Senior Nursing Staff, the Area Pharmacist, the District Medical Records Officer and the Sector One Administrator of B Health District.

Basis of Proposed System

For admission purposes, patients can be classified into two broad categories:

(a) Planned admission

(b) Emergency admissions

In the B Health District, the percentages of planned and emergency admissions are roughly 55% and 45% respectively. Whilst little or no opportunity arises to make advance assessment of emergency admissions, significant improvements could be made for assessing the needs of planned admissions. The basis of such a system would be as follows:

Before Admission

(i) A policy of giving (where possible) two weeks instead of one week's notice when selecting patients to come into hospital. This would probably mean a minimum notification of about one week, which would enhance the opportunity of getting home assessments made.

(ii) Patients likely to have post-discharge problems being assessed by their General Practitioner (GP) or having assessments made by the Community Nursing Service (CNS) prior to admission to hospital.

Upon Discharge

(iii) Notifying the GP and CNS regarding those services required and indicating those services contacted.

(iv) Informing the GP about the diagnosis, treatment required and details of any drugs dispensed on discharge.

(v) A discharge letter from the consultant to the GP giving relevant details about the patient's case.

In emergency admissions, or for other non-assessed patients, information will have to be obtained on the ward. It is hoped that in most cases the GP or relatives could give information which would help in assessing the patients' needs.

Operation of the System

(a) Patient Pre-Admission Enquiry (Appendix)

Completion of Part A

Medical records staff complete the box containing the patient's personal details. An indication is also made (from the surgeon's admissions list) whether or not an early discharge might be possible. The form is then sent to the patient together with the admission date. The standard admission letter could be slightly amended to ask the patient to take the Pre-Admission Enquiry to their GP as soon as possible.

The patient takes the Pre-Admission Enquiry form to his/her GP who completes the Drug History Information on the back of Part A.

Completion of Part B

By consulting the patient, the GP could ascertain whether post-discharge support is required. This can be simply indicated by deleting the appropriate Yes or No. If support is required, details could be given in the space provided. The GP could possibly enlist the help of the CNS in obtaining this information.

Where support is required, but an early discharge has not been indicated, the complete form can be given back to the patient to take into hospital. In cases where support is required, and a possible early discharge is indicated, then the GP or CNS would complete the patient's name and address in Section B (3) and detach Part B along the perforated line, giving Part A back to the patient to take into hospital.

If the GP feels that further information is required, then the CNS could be asked to make a home assessment (Reverse side of Part B).

The GP or CNS would send Part B by first class post directly to the Community Liaison Sister, who would be able to arrange the necessary services prior to the patient coming into hospital. This would enhance the opportunity of giving such patients satisfactory planned early discharges, and may help to improve the availability of beds. At this point, careful consideration should also be given to any possible convalescence needs, since the maximum advance notification should be given, due to the limited resources available.

Use of the Form

The patient brings Part A (or the complete form if an early discharge is not anticipated, or no support is required) into hospital with them.

Part A is now available for the anaesthetist's use, whilst information on Part B is ready for the Community Liaison Sister (CLS) or Social Worker to act upon. In the case of an early discharge, Part B will have already been received by the CLS and the necessary services arranged.

Emergency Admissions

Relevant information could be obtained from the patient and his/her relatives, or from the GP (by telephone).

(b) Post-Discharge Support Notification (formerly District Nurse/Health Visitor Form)

Completion of Form

When the patient is ready for discharge, the four-part NCR form is completed by the ward staff (only for those patients requiring support). Any confidential or other 'delicate' informaiton may be omitted from the top (white) copy of the form. The form is signed by the Ward Sister and despatched as follows upon the patient's discharge.

1st copy (white) given to patient for the Community Nursing Sister

2nd copy (pink) forwarded to the Community Liaison Sister

3rd copy (blue) forwarded to the Community Liaison Sister

4th copy (yellow) retained in the patient's case notes

Use of the Form

The patient gives the CNS the first copy when she visits the home. The second copy, containing any additional nursing requirements, will be posted first class by the CLS to the CNS. The CNS could then pass on the second copy to the GP if requested (keeping the first copy for her reference). Urgent information may be transmitted by telephone if necessary. A third copy will be received by the Community Liaison Sister for her file. The fourth copy is held in the patient's case notes as a record.

(c) Discharge Note (Revised) (Appendix)

Completion of Form

The form has been redesigned to incorporate two additional features:

(i) Detailed information about any drugs which the patient received on discharge, and

(ii) an indication as to whether or not a follow-up appointment will be required.

When the patient is ready to be discharged, the Houseman completes the three-part NCR form. If the patient requires drugs to take home, the prescription is written in the appropriate section and the complete form is forwarded to the Pharmacy where details of the drugs dispensed are entered on the form. The Pharmacist retains the third copy for his reference, and returns the top two copies with the drugs to the ward. When the patient is discharged, the Houseman sends the top copy by first class post to the GP, keeping the second copy for the case notes.

This method relieves the Houseman of having to write out details of drugs dispensed twice, i.e. on the present prescription form, and on the present discharge note. This would mean that discharge medication would be dispensed by the use of this form only.

If no drugs are required, the two copies of the form are filed in the case notes.

Use of the Form

The GP receives a confidential and fairly detailed report regarding the condition of the patient upon discharge. An indication is also made concerning future appointments, and any other additional reports which may follow.

This system, if adopted (or adapted), should help to improve the coordination of services for post-discharge support. It must be remembered, however, that the success of any system is dependent upon adequate understanding of its aims by those who are expected to work it. It may well be that adopting or adapting this system would require changes in the present responsibilities of some members of staff. If this is the case, then those areas must be made the subject of consultation with the staff groups affected, in order to come to some alternative arrangement, bearing in mind that the ultimate objective is to help the patient.

One geriatric unit has appointed a higher clerical officer as a focal point for communication between hospital and community. She combines this work with general secretarial work for the geriatrician. This arrangement also recognises that medical staff often work in a number of wards, units and departments and in more than one hospital. It provides general practitioners and others with a single telephone number to ring for help with any problems of geriatric medicine. This liaison officer/secretary collects and records information on the home circumstances of each patient and this is included in the ward notes.

Using the multi-disciplinary team approach

Apart from the 'nursing only' after-care procedure, the majority of discharge schemes reported to the CCP as 'working well' are based upon the team approach; sometimes the team includes community staff at the hospital stage and sometimes it does not. Many such programmes centre around case conferences in the ward. In all instances the medical or surgical consultant 'takes the chair', although CCP observers have frequently commented that it is the ward sisters present who lead the discussion and are most knowledgeable about the patients who are being assessed for discharge. However, whoever or whichever professional it may be, it is apparent that if the discharge procedure is to be successful one person must take responsibility for the coordination of all activities and services. Where this does not exist the result can be duplication of effort at best and at worst real needs remaining unidentified.

(i) Assessment on admission

One outstanding example of this was given by geriatric unit Z. Here both social work assistants and the admitting nurses 'screen' all elderly patients. Each discipline uses a form which gives their respective senior member (social worker or ward sister), an initial collection of facts from which to assess the need for further conversation and enquiry. The member of each discipline gathers information regarding the services already received at home before the admission to hospital. The social work assistants also question each patient about family and friends, accommodation and financial position, while the nurse assesses physical and mental abilities and requests information on housing, pets, family and friends. While it was clear to the research officers of the CCP that use was made of the information collected by the social work assistant, the use to which the social data collected by the nurse was put, remained unclear. Many of the nurses themselves had no idea why they were required to ask patients to provide social details and some declared that they considered it was 'the social worker's job, not ours'. Also on this unit, although it was considered by the medical staff that a multi-disciplinary approach was being used, the social workers reported that hospital doctors 'ordered' Part III accommodation, disregarding the patients' and the social workers' opinions.

The community nursing staff sometimes even triplicated the questioning when they visited patients on the wards before discharge, but then 'all the known facts about home circumstances can be just ignored if the hospital bed is needed'.

In geriatric unit Y, although the assessment was said to be 'multi-disciplinary', it was usually so by referral only. Most potential patients were visited at home before admission by one of the medical staff. If he or she considered it to be necessary, the social worker also paid a home call to assess the situation and identify any potential difficulties likely to be experienced after discharge. Every patient was discussed at weekly meetings attended by occupational and physio therapists, hospital and community social workers, hospital and community nurses, medical staff and home help organiser. The health worker absent from all weekly case conferences reported to the CCP was the general practitioner.

This absence of members from one or more disciplines was a characteristic of case conferences held on surgical ward Z. Although a regular weekly meeting was held between junior medical staff, ward sisters and occupational and physio therapists in order to plan for their patients' discharges, social workers were contacted only if it was decided that such a referral was required. No consultant was ever present and the ultimate responsibility for continuing care was in the hands of the ward sister.

In homoeopathic hospital A a weekly meeting was held to discuss those patients with difficulties. Selection of these was undertaken by the senior house officer and medical students attended the meetings. Here the consultants were very much involved and aware of their total responsibility for the patient. Both they and the social workers were keen to take medical and nursing students on domiciliary visits to increase their awareness of the 'dynamics of personal relationships in relation to implications for recovery and dependency'.

The staff of this hospital identified patients with needs through the 'development of their relationships with them'. They considered that screening every patient resulted in time being wasted on those with no needs, to the detriment of those who required help. It was also stated by the social workers that screening undertaken by unqualified people often meant that key signals were either not recognised or ignored: people needed to be able to trust their social workers and know that the information they gave would be acted upon.

Once more it was stressed that the education of staff and helpers was of paramount importance. 'Recording systems do not make people work better'.

In geriatric unit X the social worker played the leading role in assessing and interviewing, although other disciplines were involved in the discharge planning and implementation. The outstanding feature of this particular unit was the position of authority held by the social worker; no elderly patient was discharged until she gave the go-ahead. It was she who contacted the geriatric liaison officer, the general practitioner, the wardens of sheltered housing (where necessary) as well as the social services. The CCP observers considered that this scheme depended upon the personality of the social worker and the trust and respect she engendered in all her colleagues, as well as patients and their families and friends. These two examples also emphasise once again the advantages of small units: taking the services as a whole, such intensity of work on the part of social worker and home help organiser is just not feasible.

While recognising that it is often on acute units that systems for identifying after-care needs and arranging services are less well developed, and that it is from these wards that problems with discharge procedures very often occur, the CCP realises that it is quite unrealistic to expect all surgical and medical ward sisters to arrange weekly case conferences; indeed with so many short-stay patients and early discharges, many patients with needs could be in and out between such meetings. Neither is the holding of case conferences always the best use of manpower resources.

It has been emphasised earlier that information is available from people in the community who already know the patient. With nursing particularly in mind, the following examples may be of interest.

On ward A a form is completed by a nurse when the patient is admitted. This gives details not only of mental, emotional and physical condition of the patient, but also of support available at home and the community services already involved. In addition, it has a section headed 'Services to be asked to advise'. On the basis of information collected in the first part, the ward sister may decide to bring in the social worker, health visitor or therapist from the very beginning. This system means that the nurse is the key person to initiate the identification of needs. It is, of course, part of the assessment component of the nursing process and is one which is being increasingly used throughout the nursing world.

In general practice A the district nurse or health visitor attached to the practice fills in a form as soon as it is known that one of their patients has been admitted (or even better, sometimes when they know one of their patients is going to be admitted) to hospital. On this form they give details of the family members and friends seen as potential helpers, the medical treatment which has been given up to the date of admission and the nursing and social services which the patient has received at home. This is attached to the patient's hospital notes when he is admitted.

(ii) Assessment for discharge

Geriatric unit V encourages patients and relatives to attend evening meetings, both during the hospital stay and following discharge home. This gives them chances to meet a wide range of hospital staff and offers opportunities for the latter to monitor progress and deal with any specific problems which arise.

A number of units - both general and geriatric - are experimenting with discharge 'check lists'.

Although not a worthy substitute for effective forward planning, this practice does help to ascertain that all routine procedures have been undertaken, relevant people notified and the patient prepared as much as possible for the discharge.

Record-keeping in nursing is vitally important and is another activity which requires urgent attention. Once again, it is one of the components of the nursing process, being especially crucial in the planning, implementation and evaluation of the patient's care and also in handing over to colleagues either in hospital or in the community.

In one pilot scheme, all patients discharged from hospital M over a period of 16 weeks were visited by district nurses who, amongst other things, recorded whether the visit and follow-up had been necessary. Half were not. Now all discharges are notified to the central nursing office which acts as a clearing house. But not all patients are visited and of those who are, many require and receive visits from a member of another profession as necessary.

(iii) Interprofessional collaboration

Time and time again, conference participants have emphasised the importance of educating trained staff, as well as students and learners, about the need for planned discharge. One stressed that 'Communication with the patient must be given top priority. And convincing staff of the benefit of continuing care is just as important as the mechanics and paper work on which so much time is spent'.

The importance of collaboration between all disciplines has been stressed frequently in CCP discussions and workshops. For example, elderly patients on acute wards are often sent home without adequate notice just before the weekend. This 'Friday afternoon syndrome' as it is called by some health workers is a common one and causes much stress to patients, families and to nursing staff when the medical staff are allowed to get away with instant discharge. It is also asking the impossible of the home help service. After a home help organiser is informed that a need exists, it is necessary for her to contact a home help (possibly in writing if the telephone is not available), to ensure that she transfers her service from an existing client to the patient being discharged. Services can be arranged at the point of discharge, but only if sufficient notice is given to the organisers.

One community liaison sister has reported, 'I collaborate with the social worker and occupational therapist to put up a united front to persuade the doctor to delay discharge until all services are laid on. This usually works!' Perhaps the answer lies in that word 'persuade'. Writing about hospital care for the elderly, Grimley-Evans accuses nurses of resenting domination by the medical profession and of 'lacking the skill of a Florence Nightingale to manipulate it to their own ends'. - 1
Certainly, it would appear that many members of health and social service professions still have much to learn about team membership.

A difficulty which has been solved by collaboration is one concerning the assessment of mobility and independence. Ward

nurses' opinions about an old person's capabilities can vary, so sometimes an arrangement is made whereby they assess the patient and then seek an opinion on their assessments from physio and occupational therapists.

Good inter-professional relationships such as these help to ensure that more accurate assessments take place before discharge. If there is any doubt about a patient's ability to cope at home, the occupational therapist can become more deeply involved including, if necessary, undertaking a visit home with the patient for a few hours or even overnight.

Many people have stressed the importance of each representative of a discipline knowing and keeping to his or her area of responsibility. But can this be carried too far? In geriatric unit R, the social worker provides, for the weekly case conference, a social report on every patient. This includes the state of the patient's house, his family and the services he already receives. Likely problems are then discussed by nursing, medical and therapy members of the staff and their individual responsibilities identified and listed. It was reported, however, that the service to the patient can break down either due to lack of coordination or, sometimes, total dependence being placed upon inadequate social reports.

(iv) Professional cooperation

The importance of trust and respect among all health and social services staff involved has been emphasised time and again - community and ward nurses, for instance, need to respect each other's skills. The tact required in dealing with members of other professions should not disappear when communicating with colleagues of the same discipline. For example, a request for 'weekly bath' could be changed to 'Assess for care please. Perhaps help from your bathing auxiliary'.

Some ward sisters have initiated integrated study days as a direct result of a nursing workshop organised jointly by the CCP and the Nursing Times. Exchange visits between trained hospital and community nurses have also been arranged in some districts. This brings the district nurses up-to-date with new hospital procedures and also gives ward staff some insight into the nursing work which is done outside the hospital.

(v) Knowledge of each other's work

One lack which the CCP has perceived and one to which it is hoped all professions will address themselves is knowledge of what each other does. Many doctors and nurses, for instance, have only a hazy idea of the work of the social worker, her area of competence

and responsibility and even less of an appreciation of the importance of the physio, speech and occupational therapists in helping old people to regain or maintain independence. Likewise, many of the latter professionals are unaware of the proper role of the practice or community nurse and even less of the health visitor. Often elderly patients are denied the much needed expertise and assistance of one or more of these health workers for no other reason than the existence of widespread ignorance about their work. Attempts should be made by all team members to use all existing resources and this includes the community, the family and the patient himself.

Finally, an idea has been put forward by one liaison officer, for visits by volunteers to patients who, on discharge, do not need nursing care or home help, but who could benefit from just seeing someone during the first 48 hours after leaving hospital. This could be organised through each general practice where there would be a chief volunteer with helpers. They would, of course, report any problem they perceived to a particular professional at the surgery, and would thus become important links for the multi-professional team.

(vi) The use of forms

Form-filling, of course, must never be an end in itself, but it can be a useful tool and many examples have been collected by the CCP. Often, however, the designers of forms have reported difficulty in getting colleagues to adopt them. Sometimes this is because there is no one to lead in consolidating policy relating to their use. Many people resent yet another form to fill in; others are concerned about confidentiality, while some staff just simply state that they 'haven't the time'. There are also deficiencies in both internal and external postal systems. Frequently the liaison officer role is seen only as a completer of discharge forms. One such employee reported that at first she was 'not seen as an agent for planning discharges in order to improve continuity of care - being a paper-pusher was seen as being a bit of a sinecure', but by achieving a good deal, she had demonstrated her worth. She had speeded up the completion of discharge forms so that up-to-date information was sent swiftly to the district nurse at her surgery the day before discharge. In addition, she had succeeded in tightening up telephone contact; it had changed to direct nurse-to-nurse talk and messages were no longer being left with a third party to be misinterpreted or forgotten.

In geriatric unit W a form which is completed by geriatric health visitors before the old person is admitted to hospital is included in the patient's notes immediately after admission and is thus made available to all staff members involved in the treatment and care of the patient. This system is made possible because the local health authority has developed a system of geriatric registers and

regular visiting is undertaken by health visitors or state registered nurses to all elderly people registered with general practitioners in the town. Those who appear to be coping well at the time of the first visit are visited only (on an average) twice a year, but information on all is recorded and up-dated at intervals, and it is this which is made available to the hospital immediately the old person is admitted. On his discharge, the health visitor or nurse is notified by the ward sister and she then visits him. A geriatric liaison health visitor based in the hospital runs the scheme and is in regualr contact with all general practices. A great advantage of this system is that elderly patients admitted to general wards are able to be 'slotted in' immediately. It is hoped to involve other acute hospitals in the district in the near future.

Other 'good practices' reported in relation to the communication of information from hospital to community include the giving of a completed form in an unsealed envelope to patients or their relatives/friends on the day of discharge to remind them of the arrangements made for continued care at home. (Annex B) A copy of this form is sent to the GP and the community nursing service. This keeps the patient fully informed of his treatment (including medication) and provides the practice staff with much more information than is usually contained in the traditional 'GP note'. One acute hospital has designed a form which is completed at the time of discharge for any patient over the age of 65 years. It gives details of his mental, physical and social states, and any services required or to be arranged, as well as those which have been requested. Copies of this form are sent to every professional involved in the patient's continuing care and they are asked to report back to the hospital if they find any unmet need when they visit.

Several geriatric units have provided booklets for the use of patients and friends before admission. These provide information on preparing for admission to hospital, the involvement of families and friends, the work of various therapists, social workers and volunteers and services available upon discharge, including day hospital, day centre, laundry service. There is a separate section to be filled in by the patient himself, regarding arrangements for his discharge, including the names of the consultant, ward sister and social worker. The aims of the treatment and rehabilitation he is receiving are also made clear and entered for his reference. A similar booklet is provided for patients who attend the day hospital or day centre.

One of the several reasons given for the poor use of continuity of care plans has been that, of necessity, they are complex. It is said that a single universally acceptable form has yet to be developed and that it is hard to imagine anything which requires

more insight, knowledge, skill and cooperative effort on the part of the sick person, his family and health and social services workers.

Certainly, when several workers are responsible for planning and giving care, it would seem that a means of coordination is vital for success. Their combined efforts must be directed towards a common goal. They must also be informed and appreciative of each other's contribution.

(vii) Consumer participation and the right to know

In some wards and units a regular time is set aside for discussing the care and progress of all patients. It has been suggested that 'consumer participation' in these could be extended to the development of medical records. As reported earlier, many professionals have doubts about making their own records available to colleagues. Would they think it desirable to allow the majority of patients to contribute to, and keep in their possession on discharge, a record of their own care plan? Weed states:

> 'There are those who fear the patient will panic if he owns and understands his own records. But what of the confusion, bad medicine and suffering that result directly from the present practice of keeping source oriented records unavailable to patients and families just when they need them most. It may be the most effective weapon we have against over-utilisation of medical care ... If you want to protect yourself against bad health practices and develop a mature and helpful philosophy about maintaining your health, you need to understand the means by which clinical judgments are made and tested'. - 2

At centres such as the Medical Center Hospital of Vermont, Burlington, USA, a guide for patient instruction at the time of discharge is stored in a computer and the nurse selects appropriate information which the computer prints out for the patient and his family to take home.

The Royal Marsden Hospital in this country, while not yet using a computer for the purpose, also gives patients detailed discharge forms with descriptions of treatment and general advice. It also gives them diagnoses. But instructing patients and relatives is not always enough; if treatments have to be continued at home, teaching sessions in hospital are also needed. Only in this way

can lay people contribute to the care plan and also be expected to carry out competently those tasks they will need to perform after discharge.

The involvement of lay people - neighbours and volunteers as well as family and friends - is an important aspect of continuity of care. Especially at this time, when the main social goal of the World Health Organization and its member states is 'Health for All by the Year 2000' and all governments have agreed in the Alma-Ata Declaration that the key to achieving this goal is primary health care, with full community participation. - 3

Volunteer Schemes

Can lay people be counted as members of the multi-disciplinary team?

As reported earlier in the CCP national study, only four respondents mentioned actual volunteer schemes which were in operation. These were:

(a) A voluntary service organiser working with a team of British Red Cross Society (BRCS) volunteers who provide an escort service for patients and can serve an 'emergency pack' of food. Advice to them is given by a duty nurse at the local hospital from which they operate.

(b) An Age Concern scheme working closely with the hospital social worker to provide 'a comprehensive service for discharged elderly patients'.

(c) One hospital with an 'active and dedicated community care group' of about 40 volunteers who provide cover for practical tasks and companionship.

(d) The use of a form by one geriatric unit to refer patients to an appropriate local agency for necessary 'support' which they believed that organisation could provide.

Six additional hospitals mentioned specific voluntary organisations with whom they were in touch and to whom certain referrals could be made. These included support groups such as Alcoholics Anonymous and Gamblers Anonymous.

In recent discussions and correspondence, four additional 'lay' schemes have been identified. One involves the Women's Royal Voluntary Service (WRVS), two others Age Concern, and the last, Job Creation Scheme 'employees'.

(i) WRVS 'Home from Hospital' scheme

The aim of this scheme is 'to provide a service at the point of discharge from hospital to those patients who live alone and are without a support network. It is intended to provide help for the unsupported at a time which is stressful and which is not covered by existing provisions'.

The procedure is for the WRVS offices to receive referrals from hospital or community-based social workers during certain specified office hours (Monday-Friday). Details given include the patient's name, address, age, GP, hospital and ward number, probable date of discharge and the social worker's own name and place for contact. A local volunteer is then contacted who arranges with the social worker to visit the patient in hospital. During that visit the social worker introduces the volunteer to the patient and the volunteer signs a form of identity. This is witnessed by the social worker. An initial visit is made to the patient's home in order to assess what is required. Volunteers will tidy, wash dishes, warm the house, air the beds and shop. If major cleaning work is needed, the hospital social worker is informed.

When the date of discharge has been confirmed, the volunteer arranges to be at the patient's home and to settle him in. If requested, and it can be arranged, the volunteer may escort the patient from hospital to home. It remains the social worker's responsibility to ensure that other support services such as district nursing, general practitioner visiting and home helps are arranged. The volunteer's visits - for which expenses can be claimed - are limited to:

visit to hospital to meet patient (through the social worker;

visit to home to assess what is required;

visit to home to clean and prepare for patient's return;

visit to home to receive patient.

Usually the last two are combined.

(ii) Age Concern group providing coordinators for continuing care (Annex C)

This is a contact scheme to help elderly patients on discharge from hospital. It is an extension of an already existing Neighbourhood Care Scheme using volunteers from churches, the WRVS and the BRCS as well as from Age Concern. There is a full-time organiser (paid by a joint-financed grant and Age Concern)

and requests for support are directed through the local Age Concern office. The overall aim of the project is to develop a relief service for relatives who are providing care and a family service for older people who have no families (or none who live nearby). In particular, the volunteer group seeks to provide home preparation for elderly people returning from hospital, including a pre-discharge shopping service. Members may give on-going support for periods of two-four weeks. During this time they may provide basic support in the form of collecting pensions and prescriptions and undertaking shopping; a sitting-in service for one or two hours in the afternoon or evening; or an emergency service until the necessary statutory services are mobilised.

The organiser has reported to the CCP, 'Even if community resources are adequate to cope, they are entirely dependent upon an efficient referral system. The first two weeks have been identified as being the most crucial period in the patient's recovery: services provided late often miss this time of crisis, and so prove useless. The hospital to home scheme deals with the entire process of identifying patient needs, planning after care and providing services. The term implies a continuity of service, and care: a continuity that is often lacking at present'.

(iii) After care scheme carried out by Age Concern

In spite of difficulties in financing the cost of a full-time administrator, this after care scheme is carried out by volunteers in areas J and K. These contain three general hospitals, two of which have geriatric departments.

Volunteers have been recruited from a variety of backgrounds. Some are qualified nurses, some are nurses who have retired to have a family, while others have reached normal retirement age. Many of the volunteers bring skills of a more domestic nature.

No basic time commitment is set down for participants; details are taken of when they will be available and these are fitted in with the demands that arise. For example, a volunteer may state that he has most Wednesday afternoons free, but may be called upon only once every few weeks.

Before becoming a part of the service, volunteers are interviewed in their own homes and have to provide the names of two character references. If these are satisfactory, they are supplied with an appropriate identity card to enable them to be recognised as genuine volunteers.

Training

The scheme runs its own training programme, in addition to the Red Cross Home Nursing Course. After being involved in some practical work, and arising from this, volunteers were asked to suggest any additional knowledge that they thought would be useful to them.

As a result of their comments, a number of special training sessions were arranged. These have included subjects such as the physical process of ageing and a visit to an Aids Centre for the Disabled.

Volunteer meetings are held at regular intervals, during which literature on relevant subjects such as diet and hypothermia is distributed. These also provide opportunities for the organisers to up-date volunteers on new developments and for volunteers to express their own feelings and views about the work they are doing.

Insurance

At present, volunteers are insured through the Age Concern (England) Special Insurance Scheme. This policy covers both personal accident (e.g. if the volunteers should fall, or injure themselves whilst lifting a patient) and public liability (e.g. claims for negligence from the patient or his family).

The largest element of risk arises from the nursing or personal attention services undertaken by volunteers; however, these form only a small proportion of the scheme's work.

Running the scheme

The model of practice used in coping with each elderly patient is an extremely intensive one and is reported as follows:

(a) The Age Concern after care workers monitor the admission of patients aged 65 and over to the three general hospitals. (This practice relates only to patients of the general practices participating in the scheme). This is made possible by frequent telephone contact with admission clerks in each of the three hospitals concerned.

(b) When an elderly patient from one of the practices is admitted, an Age Concern after care service handout is attached to their documentation. Once this reaches the ward, the ward sister will approach the patient to give them the handout and find out if they will agree to see an after care worker.

(c) If the patient agrees to be seen, then arrangements are made for an interview on the ward. This is carried out informally; a detailed form recording relevant information is filled out later by the after care worker. At the same time, the patient also fills in a consent form, giving permission to the after care service to contact his GP.

(d) If the patient is too ill to be seen, the relatives are contacted with the ward sister acting as an intermediary. If the relatives agree to cooperate, the after care worker will try to obtain from them all relevant information.

(e) Contact is then made with the hospital social worker to obtain any advice required. When this is not required, the hospital social worker is just informed that contact has been made with the patient.

(f) A number of contacts are then made outside the hospital:

(1) The patient's GP

(2) Health visitor)
(3) District nurse) Especially if patient mentions any contact he has had with them.
(4) The social services)

(g) The after care worker then arranges for a suitable volunteer to be matched with the patient if it is believed he will need help. The volunteer then visits the patient on the ward and makes any necessary arrangements with him.

(h) A second series of checks and referrals are made just before the patient's likely date of discharge. At this stage alterations in after care arrangements may be necessary, as specific needs become clearer.

(i) Following discharge, even where no volunteer has been assigned, two check visits are made to the patient's home to monitor his progress. The first visit is made within two days of discharge. As a result of this visit, the after care worker may find it necessary to contact statutory services about the non-arrival of services such as meals-on-wheels or home help or to provide a volunteer.

(j) Where a volunteer has been assigned, they may be withdrawn when statutory services arrive, if this is all that the patient requires.

While this is the basic model upon which the service operates, Age Concern reports that it is not always possible to accomplish every item in each case.

Where after care services are provided, volunteers perform tasks under the following headings:

1. **Visiting and social**

   for example, visiting in hospital
   welcoming patient home
   brief-check calls to ensure all is well
   'sitting-in' to relieve relatives.

2. **Practical and domestic**

   for example, shopping, collecting pensions and prescriptions
   cooking light meals
   carry out routine domestic chores whilst patient is in hospital
   prepare house for patient's return by lighting fires, airing beds, etc.
   cleaning, laundry.

3. **Transport**

   for example, transporting patient home from hospital
   collecting aids from hospital
   taking patient to doctor's surgery
   taking spouse or relative to visit patient in hospital.

4. **Home nursing and personal care**

   for example, help with dressing and washing
   personal care under the supervision of the district nurse, e.g. medication, dressing wounds, bathing
   sitting-in during the day or evening.

The great majority of help given falls into the first three categories; nursing care is given only occasionally.

Although as stressed in the introduction, no scheme described in this publication has been evaluated by the CCP, one observer has suggested that volunteer organisers being involved in the identification of patients' needs in hospital is a cause of some concern to many social workers. It could also represent a fair amount of duplication and unnecessary interviewing of ill, elderly people. Certainly one check-list received (of 9 pages in 3 parts) appears to be somewhat formidable in its detailed quest for information, and underlines what can happen when collaboration between statutory and voluntary services is missing.

Using young people in the government's Job Creation Scheme (Annex F)

This service has been made possible because of the government's Job Creation Scheme. Hospital group G reports that a welfare cadet was offered to them for a period of six months. It was decided to ask her to screen all elderly patients admitted to the five geriatric wards in the group as it was believed that 'this would be a worthwhile contribution to the therapeutic team approach employed by the two geriatricians and would also provide the best help for the social work team. The form being used at that time by social workers was revised and the redesigned check-list was used for the screening programme'.

After only three months, a review of the hospital's social services programme showed that as a result of the screening, social workers had been able to give more time to other categories of patients and provide some social service to specialties previously left uncovered. Because of this, when the opportunity arose to use a community service volunteer, he was asked to screen the elderly patients admitted to wards specialising in orthopaedic surgery, gynaecology, general surgery, respiratory diseases and thoracic surgery. The number of patients screened thus doubled in a very short time. The recording form used was redesigned and indeed is reported to be under constant revision.

Although both young people used for this service were only 17 years old, it is reported by the social workers concerned that the success of the programme was due in no small part to their intelligence and personalities. Since then, other young people of the same age group and with similar backgrounds have been used to undertake similar work. The logistics of the service are reported as follows:

During the morning the screener visits the wards and finds out from the ward sister about the admission of any elderly patients and also ascertains that they are fit enough to be interviewed. The screener then obtains personal and medical information from the medical notes, to which he has free access. On return to the office the screener checks the social work department records for evidence of any previous involvement with the elderly person.

Later in the day when the patient is most likely to have visitors the screener interviews the patient. This is a task that is said to be much easier and more productive if a member of the family or close friend is visiting, because statements such as, 'my daughter will look after me', or, 'my wife can cope very well', can be confirmed if the 70 year old daughter or the 94 year old wife is present.

It has been found that the patient's visitors, far from considering this to be an intrusion or a waste of their visiting time, welcome the opportunity to discuss, even with a very young person, the problems and needs of their elderly relative or friend.

When the screener has obtained the information, further action is determined.

The screening forms of patients in non-geriatric wards are passed direct to the senior social worker for perusal and indication of what further action is required from the screener: application for supplementary benefit; request for domiciliary services on discharge; application for other financial benefits; preparation of an Initial Contact Form for the social worker's use.

The screening forms of all patients on geriatric wards are processed by first having an Initial Contact Form (ICF) prepared; this is because of the therapeutic team approach of the geriatricians and the consequent 'need to know' by the social worker member of the team.

At this stage, a check is made with the social services office in the area from which the patient comes, to find out whether that patient has a social worker and to let that social worker know that her client is in hospital. This procedure is followed for all referrals to the hospital's social work team and enables the area-based social worker to continue to work with her client through the time of crisis. It also relieves the hospital social worker who then acts only in a liaison role.

Where there is no area social worker involved a card index is prepared and duplicated for the Divisional Central Index.

All screening forms are seen by the senior social worker who indicates on the ICF to work required from the social worker or screener. For example, social workers may be asked to obtain a Home Circumstances Report because the combination of diagnosis and information gives rise to doubts as to the ability of the patient to manage on returning home. The Home Circumstances Report contains a recommendation by the social worker for the guidance of the geriatrician when he considers discharging the patient. The screener may be asked to advise the patient of his/her financial rights or to arrange domiciliary services on his/her discharge.

The major disadvantage that has dogged the scheme has been lack of adequate financial support. This has resulted in a lack of continuity of screening personnel and a stop/go policy operating in the non-geriatric wards.

Another difficulty concerns the training of these young people. It is time consuming and falls to the senior social worker, who must advise on interview techniques, and also pick up communication failures from the completed screening forms. The screeners' lack of knowledge and experience is also a disadvantage. Nevertheless, in spite of these problems it is considered that the employment of people of the right calibre as social work assistants would greatly enhance the value of the screening programme.

It is reported that the scheme has had the immense benefit of enjoying extremely good relationships with all medical, nursing and para-medical staff. This, obviously, was not achieved overnight and has been due, largely, to the standard and value of the information provided by the social workers to the therapeutic team. Because of these good relationships, it has been possible to obtain agreement that elderly patients requiring domiciliary care will not be discharged without at least four days prior notice and that patients awaiting Part III accommodation will remain in hospital until a suitable place becomes available for them.

A similar scheme operates in hospital group P. Here, every person of pensionable age is screened upon admission by one of three young people. * One, called a Community Service Volunteer (CSV) covers all wards and uses initial contact forms as a check-list to discover details of the patients' home and financial circumstances. The former includes information on the mobility and ability of the spouse or friend and the latter, information enough to determine which benefits and services can be provided. All forms are then passed to the senior hospital social worker who allocates those patients who have been assessed as being in need to one of the three social workers. (It had been found that the allocation of all geriatric patients to one social worker only was a very demanding and unfair way of working).

While it is recognised that this initial screening saves much time for the social workers, it was seen by the CCP project officer as having several unsolved difficulties. The CSV saw herself as a listener only and did not (and had not the knowledge to) answer patients' questions. Yet it was her perception of needs which determined further intervention.

* each funded by a different agency

As there was no reporting back and she did not follow up patients herself, she never learnt how accurate her assessments were. Neither was the information she collected shared with members of other disciplines. Surprisingly, it was reported that the majority of elderly people were happy to talk about their financial position to a twenty-year old, and in fact liked to do so.

While this scheme obviously has some potential, its present practice requires careful evaluation and amendment.

The value and use of home help organisers

In city D a 'Nightingale' service has developed from the initiative of home help organisers.

Some time ago, for a trial period, home help organisers (HHO) were based in hospitals one day a week. This was very successful, but unfortunately had to be discontinued because it took up too much of the organisers' time. Among the advantages reported were earlier and more satisfactory referrals and, on the patient's side, fewer unrealistic promises from ward staff. It has also helped to improve relationships, particularly between the home help organisers and doctors. It is said that the latter, on the whole, had previously held a low opinion not only of the value, but also of the intelligence of the former! The experiment, therefore, has proved to be of lasting benefit. The central district manager of home helps in city D expresses little sympathy for those HHOs who complain of being given inadequate information, maintaining that it is a question of personal contact and also of asking. Because of the trust and respect which HHOs now enjoy in this city, elderly patients may be re-admitted to hospital on their request alone: their judgment is accepted by the staff of all local hospitals.

The mobile service they run consists of driver-home-helps providing an emergency service at short notice. There is no fixed programme of work, but the home helps call into the area office each day to collect details of calls to be made. Many of these may be one-off visits. After visiting the home help prepares and submits a brief report saying whether further visiting or some other support is required.

The 'night-watch' service has developed because of the needs perceived during emergency and other visiting.

The service covers the whole city and the participants provide a ten hour relief service for families, or care for someone who is alone and needs care for a similar period. The average weekly duty is three nights per week per patient and most night watchers work from 9 pm to 7 am. Many have had hospital experience and all have some experience in caring for the sick or elderly, although in fact they are not expected to provide nursing care. What is considered to be of prime importance is that applicants have a genuine desire to serve the community. They must also be healthy, reliable and able to use their own initiative. Care is taken of them individually and support is available when they require it. A lack regretted by the organisers is supervision on-the-job. The scheme is financed by joint funding.

The majority of people who use this service are elderly people just discharged from hospital, who require 48 hours or so 'to just reorientate themselves'. Another important group of patients for whom this service is available are those awaiting admission to hospital. Usually the service is provided the day it is requested, and a full assessment is made the following day.

The scheme is impressive because it is one which has arisen out of local demand; individual judgments are trusted; the service is provided as an emergency and investigations or assessments take place later; it is flexible and it is built on the basis of excellent relationships between lay and professional workers.

Providing continuing care until death

Voluntary Service Council P launched a project to find out what could be done to help someone gravely ill at home and, afterwards, if they should die, so that:

- they might stay at home for as long as possible;
- heavy family burdens are lightened;
- what is too often a dark period of a family's life is transformed into something that is splendid and can be remembered with pride.

The project organiser was an experienced medical social worker and began by:

finding out what was already happening along these lines in the rest of the country;

working with people in parts of the country who were already giving extra help to the very ill, and to their family for friends;

learning what extra help was most needed - day or night 'sitting-in', practical information or advice, looking after other members of the family, cooking meals, doing laundry, shopping, counselling, helping the people who were bearing the brunt of the burden to get a break and so on.

Meetings were then arranged to increase awareness of the need, and also of how people could help. These took the form of discussions and courses and consisted of already formed groups of volunteers as well as social workers, members of the primary health care team, local church members, voluntary agency representatives, family doctors and all other interested organisations and individuals. It was financed by the county council social services committee (in the first place for two years), in order to provide wherever possible 'on-going care in the community to avoid admission to hospital for people who were terminally ill'. Each individual agency or organisation concentrates on its own special service but the whole project is one of collaboration and is coordinated by the project officer.

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CHAPTER 5

HOW SOME SPECIALTIES PROVIDE CONTINUING CARE

It is often said that some of those specialties which are concerned with 'cold' surgery are more efficient in providing after care. Certainly it is known that the many months notice which is given to the staff of maternity units helps them to plan well ahead and often very effectively. But in the latter instance, one is dealing with women of childbearing age and events which usually bring happiness. Hip replacements and cataract operations may eventually become such but there the similarity ends.

Orthopaedic unit G (Annex E) is concerned with orthopaedic surgery for elderly and aged people. Each person representing a planned admission, for example for hip replacement or other surgery for osteo-arthritis, attends a pre-admission clinic some three to eight weeks before becoming an in-patient. An assessment form is completed after the prospective patient has seen the 'practice manager', who asks each person about his post-discharge plans and explains the pre-convalescence bed scheme which is sometimes used. The patient is asked questions about the house to which he will be discharged - the presence of stairs or steps, adequate heating and so on. The old person is given the chance to ask his own questions - about the operation, the likelihood of pain post-operatively, the likely length of any period of immobility and also the number of days to be spent in hospital. This two-way exchange of information takes approximately twenty-five minutes.

At this same visit the physiotherapist assesses the patient's physical capabilities and, if necessary, supplies aids or appliances to improve these. Again the patient is given information on what to expect after surgery and is also told of some of the usual post-operative 'milestones' so that he has incentives and can look forward to improvements in his strengths and abilities. He is told by the surgeon that his admission to hospital is for treatment and not for nursing: that he is expected to get up the day after the operation, then undertake exercises and make progress immediately.

The occupational therapist also assesses both the patient and his home circumstances. The whole plan for his treatment and recovery is then master-minded by the manager.

During the patient's time in hospital a ward round is undertaken weekly by the consultants. As this also includes a geriatrician, a rheumatologist, registrars and housemen (in both geriatric medicine and orthopaedics), nurses, physio and occupational therapists and social workers, the retinue can be overwhelming for inarticulate, sometimes confused, elderly people. Interventions on behalf of patients are therefore often made by social workers or nurses.

This scheme operates without health visitor or nurse liaison systems, the ward sister communicating directly with the nurses attached to the old person's general practice. The concept of overall responsibility by one person, in this instance called a 'manager' appears to be working well. The scheme is based on perception of the patient's needs, difficulties and problems and the aim is to strengthen his capabilities and also those of the people who care for him. This is achieved by efficient and sensitive handling which includes discussions prior to admission and the careful use of the knowledge and skills available in the patient's own home and community as well as those of all the professionals working in the unit. In addition, the manager has two other important responsibilities. Firstly, to ensure communication of all relevant information between the unit and the community and secondly, to monitor the effectiveness of the care given. This is undertaken by following up the patient at home and collecting information from the community staff based in the general practice. Case conferences are called only to discuss specific problems, if and when they occur.

The unit has become a centre for the demonstration of techniques in the treatment of old or enfeebled patients with particular emphasis on joint replacements and other methods of maintaining (or restoring) the independence of patients. For this purpsoe the total care centre 'investigates all aspects and conditions of each patient'. Emphasis is placed on the involvement of disciplines for which combined clinics are organised.

Duties of the manager of the total care centre are given as follows:

(1) The manager of the total care centre will have overall responsibility for administering the centre and will cooperate with the orthopaedic secretaries in the running of the orthopaedic department.

(2) The manager shall have an accurate knowledge of orthopaedic and medical terms.

(3) The manager shall have shorthand and typing to high secretarial standards.

(4) The job will entail a deep understanding of orthopaedic principles and timing of patients for their in-patient and out-patient hospital treatment and rehabilitation.

(5) The manager will personally interview patients before admission to hospital and must therefore understand the clinicians' notes and terminology and must be able to arrange the necessary investigations and consultations with other disciplines as a routine.

(6) The manager will ensure that all letters and other communications between hospital, doctor and patient, etc. are dealt with expeditiously and will be expected to obtain such letters from the medical staff as or when necessary.

(7) The manager will also have to liaise with the patient's general practitioner, the social services and the district nursing services in regard to any particular patient.

(8) The manager will be expected to start an evaluation of a scheme of total care, such as:

(a) before admission, patients will have a clinical evaluation by the consultants but the manager will also be expected to interview the patient and to assess home conditions and to make sure that the patient has the necessary routine and other special tests for the condition under consideration and also to routinely arrange anaesthetic consultations or geriatric or other opinions at combined or ordinary clinics;

(b) the geriatric problems of the aged patient will be noted carefully, including the requirements before the patient is able to go home. Possible problems are living alone, the type of home, the amount of help there would be, the assistance of relatives, financial security or embarrassment; also how the assistance of the social services could help, how easily a district nurse would be available for home treatment, and finally, how the general practitioner could help towards early discharge of the patient;

(c) the manager will be required to prepare planned admissions so that a continuous steady flow of hip and other joint replacements, balanced according to the work-load, flow into the wards geared to the discharges so that on no occasion is a bed left empty. Should the patient's planned discharge not appear to be forthcoming on the correct date, the manager will have to enquire and initiate a case report as to why such delay is occurring. At the time of the planned discharge the manager will send all the necessary clinical or other information to the patient's doctor and to the welfare or social services as may be necessary; if the patient's planned discharge is through some

other form of care, such as a convalescent hospital, a nursing home or the geriatric orthopaedic unit, a similar course will be initiated;

(d) the manager will obtain a planned programme for all other orthopaedic patients admitted to the wards so that she may plan admissions from the total care centre relative to all orthopaedic and emergency admissions so that no bed is left unnecessarily empty.

(9) The manager must have a clear understanding of all medical terminology and especially that used in geriatric and orthopaedic practice, so that she may ensure the continuity of treatment of all patients.

(10) After the patient has left hospital those patients admitted to the total care centre will be followed up and it will be the manager's duty to ensure this follow-up is accurate and is maintained.

(11) The manager will be responsible for organising visits of teams from other hospitals and local professionals so that the greatest value is obtained from each demonstration.

Opthalmology (Annex D)

In hospital F (an eye hospital), pre-admission assessments are also made, but in this instance by nurses and the patients themselves. All patients who are to be admitted and are over the age of 65 are visited by a health visitor prior to admission and again after discharge.

The scheme was initiated some years ago from the community side, by health visitors who had found many elderly patients 'depressed and even suicidal' after discharge from hospital. Now three part-time district nurses are based in the hospital and work a five day week. Altogether, they provide liaison with forty-eight hospital departments and visit thirty of these daily to collect the names and addresses of the patients to be discharged. They then telephone the relevant general practices. The scheme is not without problems: the calibre and conscientiousness of practice receptionists vary greatly, and information is not always passed on. Whenever possible therefore contact is made with one of the professional staff members of the practice.

Features of this scheme are the responsibility put on to the patient and his family or friends to 'forecast' the help and support they believe they will need after the surgery has been done, and the true continuity of care in the form of the same

community nurse making the pre-admission assessment and giving the post-discharge care. Although it may not as yet have achieved an ideal, these notions appear to contain the seeds of effective and efficient continuity of care.

Oncology

What appears to the CCP staff as a good example of community liaison system is in operation at a large London hospital specialising in the treatment of cancer. Both liaison officers responsible for the scheme are experienced ward sisters and are based in the hospital building. Because patients come from all over the country (and often from other countries), follow up in the form of continuity of care is not always easily attained.

Initial contact with community based staff is made by telephone long before discharge and this is followed up either by letter or by a completed form giving appropriate and comprehensive information. Once contact is made it is usually sustained on a regular basis because of the regular follow-up appointments that cancer patients keep as a matter of routine.

Support to community staff is given to a lesser or greater degree depending upon how well they appear to be coping with preparations for the imminent discharge of a patient. Sometimes it may mean persuading a housing authority several hundred miles away of the patient's need. Generally, little difficulty is experienced and mention is made by the hospital's liaison officer of the advantages of dealing with a district nurse at the other end of the line who combines the roles of health visitor and liaison officer.

Communication between staff and patients in the hospital is also good. One reason given is the philosophy held by many of the professionals who are working there. This is summed up by a ward sister who remarked, 'One half-hour spent talking with a patient will aid his recovery and his ability to face the future more than many of the conventional nursing techniques or procedures'.

Patients are referred by ward sisters to the liaison officers: although sometimes positive efforts have to be made by the latter to ensure this is done. Another difficulty which remained unsolved at the time of the CCP visit was also reported. The nursing staff had designed individualised 'nursing process' case notes which it was hoped would be used by all team members involved in the care of a particular patient, but cooperation in this venture

was not always forthcoming from other professional workers. It is a feature of the hospital that little documentation is used for referrals or requests for help: the staff use personal contacts (either by telephone or face-to-face conversations) and this could explain the reluctance on the part of some to alter the practice - which certainly appears to be one which works well. Check-lists are used only for sequential treatments such as medication and radiotherapy. Information from hospital to the community is mainly by telephone with written confirmation. Just before discharge, the ward sister together with the patient writes up details about himself and any continuing care and treatment he is going to need. He takes this with him so that he can show it to anyone who is involved in providing him with help or assistance at home. He can also use it for discussion purposes with community staff if he forgets the reasons for certain procedures or needs reminding about certain aspects of his life-style. For those to whom no further treatment can be given, the hospital also has a continuing care ward to which in or out-patients may be referred when treatment has ceased and nursing care only is required. Relatives may stay with these patients and/or may take them home for any period, knowing that the hospital will re-admit immediately if and when necessary. This unit is also used for re-admissions in order to give relatives and friends a break from caring for the patient at home. This may just be for a weekend or for a holiday of a few weeks. The important point is that contact and care continue until death.

Psychiatry: Multiple short-term admissions with continuity of care

There has been a steadily increasing trend in the setting up of special psychiatric services for the over 65s. With the support of the Royal College of Psychiatrists and the British Geriatric Society, certain psychiatrists in each district are making elderly people their special concern. This usually involves a team approach to providing help to patients and families. A special section for the psychiatry of old age has been established by the Royal College of Psychiatrists. From its membership of hundreds between fifty and one hundred psychiatrists now state that the psychiatry of elderly people is their main professional commitment.

Many of the services fostered closer links with departments of geriatric medicine and social services departments to produce more coherent treatment and acute hospital provision for elderly people with organic brain disease. Encouragement of earlier referral, better assessment in the community and the facility for acute hospital admission has led to a shift from predominantly long-term in-patient care to short-term day care and in-patient crisis intervention and rehabilitation. This is helping to reduce the volume of disability carried by the community and to sift out the most severely disabled patients for whom long-term institutional

care is appropriate. Such units have also tended to take a more positive approach towards the functional psychiatric illnesses of old age with encouraging success rates. In turn, this has promoted a more optimistic attitude to their diagnosis and treatment by the primary care team.

Support for caring relatives

A great deal of the burden of mental disability in the elderly is carried by relatives and often by spouses of similar age. It is in their interest and that of the other services that they should be adequately supported in continuing that care. In the case of dementia, such relatives have a 24 hour job, seven days a week. Their ability to carry on can be greatly enhanced if this load ispunctuated with spells of relief, such as:

(a) Day care - in the form of luncheon clubs, day centres, and day hospitals;

(b) 'granny-sitting' services - ranging from a few hours respite during the day to professional night sitters or home helps relieving for periods such as a weekend;

(c) relief admissions to old people's homes or hospital - such as regular two week breaks at closer intervals as the dementia advances. These should be booked ahead to enable the relatives to make their own plans.

Other methods of supporting caring relatives include:

(a) Surveillance and help from community psychogeriatric nurses who work closely with the primary care service, as well as the hospital unit. They counsel, give practical advice on behaviour management and alert the hospital staff to the need for extra relief, changes in medication, etc.

(b) Relatives'support groups.

(c) Short-term admissions (over and above the relief periods) when necessary to cope with crises.

Provisions for disabled elderly living alone

Elderly people with progressive mental disability require increasingly frequent supervision, and adapt poorly to new environments.

Apart from residential care the emphasis must be, therefore, on providing extra supervision in the person's own home. Once dementia is well established, changes of home should be avoided. Although sheltered housing has been an important development in the UK, because of the frequent sparcity of warden coverage its value for people with dementia has been questioned. A recent development has been 'very sheltered housing' in which there is a greater degree of cooperation between housing, social services and health authorities. In some cases, social services departments are meeting the cost of additional warden cover, and in others they are contracting to provide meals, laundry and home help services.

In town Q a housing scheme has been operating for the last five years with three wardens for the tenants of 32 flats. Their duties include helping the tenants with medication, shopping and preparation of food and with extra help through periods of illness. This unit has maintained some very frail people, many with mental disabilities who would otherwise have needed residential care.

In town R the development of a peripatetic warden service available to any house by a standard electronic device, potentially offers very close cover and avoids the move to a special sheltered housing unit. This use of electronic communications systems in various forms also exists in other areas, providing a regular and reliable contact with a central monitoring unit.

Provision of extra care in the home

Apart from the standard home help and meals-on-wheels services, some areas have developed more extensive networks of voluntary neighbourhood schemes as support for elderly people living alone.

In county Z, the social services department has introduced a scheme whereby social workers may contract with people in the neighbourhood to provide specific services and supervision, up to a certain financial cost. These contracts are made on the basis that they have been shown to postpone or even avoid altogether the more expensive option of residential care. Similarly, there have been a few instances of the 'hospital-at-home' approach to the short-term care of elderly people for whom hospital admission would otherwise have been necessary.

Measures which can be taken to reduce mental disability

(a) **Medical**

The diagnosis and treatment of remediable elements of mental disability: the use of hypnotics and tranquillizers to render behaviour compatible with management in the home (including depot neuroleptics for aggressions, restlessness and paranoid symptoms in demented patients).

(b) **Psychological**

(i)
Reality orientation - This has usefulness in residential and hospital settings and has also emphasised that recent memory and the capacity to learn are not entirely lost in dementia.

(ii)
Reminiscence - This is the use of older memories in order to focus interest and interaction among groups of disabled elderly people.

(iii)
Behaviour modification - in the form of detailed programmes or as a general approach to management of disability - well established in the field of mental handicap, but shown also to have applications for disability in the elderly.

(iv)
Psychotherapy - group therapy; marital therapy; limited and supportive psychotherapy - All require a different approach when used in relation to elderly people. Often the approach needs to be directive and supportive and with emphasis on the themes of dependency and loss.

Provision of services on a daily basis: day hospitals

The aim of a day hospital is to provide a service on a daily basis for elderly people which will enable them to live at home. Usually the people who attend a day hospital are incapacitated people of advanced age with multiple pathology. The day hospital can provide medical treatment and nursing, diagnostic tests, a full range of assessments as well as active rehabilitation. The maximisation of the patient's independent functions is the primary objective. There is frequent liaison with relevant staff members of the hospital, community and social services and close links with family doctors, domiciliary nurses, day centres, sheltered accommodation and a number of voluntary agencies in the district. The network should make the maximum use of all available resources, thus enabling patients to be cared for at home.

Staffing of day hospitals varies greatly. Day hospital A has a team consisting of three nurses, two occupational therapists, one occupational therapist helper and clerical and domestic support. A full-time social worker is attached to the day hospital. This team is headed by one of the occupational therapists. The medical team includes two consultants in geriatric medicine and other medical staff who serve the district.

When a referral for day hospital attendance is made (usually by a family doctor) a member of the hospital medical team carries out a home visit. The referral form used gives a comprehensive assessment and lists the treatment required. The team then plan together how best to manage the patient's rehabilitation. Initially each patient has a thorough medical check up, followed by any nursing, occupational, physiotherapy, speech therapy or chiropody as required. A complete dental overhaul is made (especially of any dentures) and sight and hearing are tested. Glasses and hearing aids are prescribed or charged as necessary. Weekly case conferences are held between all members of the staff where patient's progress and future are discussed and planned. This duration of both treatment and day hospital attendance is flexible and dependent on the patients' progress.

Factors which are considered important to the success of the day hospitals are reported to include the following:

the development of positive attitudes by all staff members towards patients and their families;

a total approach to the planning and implementation of treatment;

a careful use of, and coordination with, other departments in the hospital so that the widest possible spectrum of treatment is offered;

a comprehensive programme offering not only medical treatment and nursing care, but also a variety of social activities;

an active policy of welcoming families, friends and community organisations to visit, thus encouraging local goodwill, funding and involvement in the day hospitals;

involvement of the patients themselves in their treatment whcih brings general endorsement and therefore support of the programme offered.

Occupational therapy has recently been defined as 'The treatment of physical and psychiatric conditions through specific selected activities in order to help people reach their maximum level of function and independence in all aspects'. This is also the rationale of day hospitals and it would seem appropriate therefore for occupational therapists to play a major part in their management and organisation.

Accidents and emergencies

One very vulnerable group of elderly people are those who attend a casualty or accident and emergency department and are sent straight home, for example, after an exhausting or frightening X-ray or after having a plaster put on a broken limb. They will not, of course, be picked up by any scheme which arranges help for patients discharged from hospital wards. The elderly and frail, especially those living alone or with an elderly spouse, may need help and support quite as much as, if not more than, those who have been in-patients.

Sometimes arrangements are made with local volunteers (such as Councils for Voluntary Service and Age Concern groups) to form a pool of escorts who will be on call to take these patients home. Again this is seen as an idea or suggestion which professional health workers can take to local volunteers when requested to give guidance and information on services needed in their district.

The two check-lists which are included in the Annex have been reported as helping to make those professionals who work in accident and emergency departments aware of their wider responsibilities.

CHAPTER 6

LEARNING FROM OTHER COUNTRIES: A WIDER PERSPECTIVE

Innovatory schemes are not necessarily always good ones, but enthusiasm and quests for improvement should always be encouraged. There is therefore considerable value in experimentation with new ideas and schemes 'in embryo'.

Home care in country A

In this country 'home care', administered by the social service system, is defined as 'a blend of health and social services provided to individuals and families in their places of residence for the purpose of promoting, maintaining or restoring health, or of minimising the effects of illness and disability'.

Because it has been found that many elderly people, especially those just home from hospital, have an increased need for nursing services during the latter part of the day and at night, existing home services in two municipalities in country A have been organised to provide care round-the-clock and at two levels:

- the first level consists of maintenance home care. This offers personal care and social services to persons whose conditions are stable but who require either routine or occasional visits from someone who does not need to be professionally qualified;

- the second level offers intermediate care. This means personal care and social services delivered and coordinated by professional workers. It is offered to those patients whose condition is not expected to fluctuate widely during a period either of rehabilitation or of accommodation to a progressive disease.

This evening shift team consists of two nurses and either two home helpers or two practical assistants. The night team has one of each category of worker. Each team receives a report from the previous shift and then motors to the patient's home. Each motor-car has radio control contact with the central point. This enables staff to receive up to date information and emergency calls and also provides some measure of security for them.

During 1978/1979 (the latest year for which figures are available) 82 per cent of routine visits were made in the evenings. Reasons for emergency visiting were: to change dressings; to make observations and to carry out some other basic nursing care. 75 per cent of the patients visited were over 65 years old and 29 per cent were aged 80 or more.

Patients pay for this service and, while it is likely that it is no less expensive than nursing-home fees, the great advantage is that patients are able to stay in their own homes. The scheme, however, has not yet been evaluated.

It is hoped to extend the service in the future, in order to provide a third level of help in the form of intensive home care. This would be concentrated and coordinated nursing for those patients with a serious illness but who do not require hospital expertise or equipment. A prerequisite to establishing such a service, however, would be that there should be easy access as and when required.

Further experimentation is also planned to extend the service to help people who are looking after dying relatives and friends. This would be more complicated to arrange as it would also involve the payment by municipal authorities of financial compensation for the relatives' lost hours of work.

Innovative approaches in care and nurse-training in country B

In this country it is recognised that doctors and nurses at the primary health care level can play an important part in the prevention of premature ageing, morbidity and dependence, and therefore of admission to hospital. Records are kept of all old people living within a certain catchment area. These include facts about their state of health, the social position of their family and their own status both within and outside the family. Those with an impairment, difficulty, handicap or disease are visited by a geriatric nurse who, in collaboration with staff from the local social services, arranges for their basic needs - including house cleaning - to be met.

Recently, student nurses have also been participating in this service. Sometimes nursing students care voluntarily for old people in their spare time, and this represents a positive step to introducing such practical experience into their training programme. Some have been awarded certificates of special appreciation from local authorities for their contribution in this field, but most of all they are appreciated by the old people themselves.

Special establishments recently set up by local social services provide accommodation for a whole day or week. Nurses working in these units have received specific training during training courses and seminars. Old people's clubs, whilst aiming to mitigate feelings of loneliness by contributing to social and recreational activities, are also slanting such activities towards health education. This gives the old people a sense of endeavour in keeping their self-reliance for as long as possible. Short-stay homes, with helpers, are also made available and provide the elderly person with alternative accommodation while his house is being cleaned or his regular helper is taking a holiday.

During their training nurses who are going to work in old people's homes and sanatoria are taught to derive pleasure from even minor improvements in their patients. They are also helped to develop a moral awareness, a highly humane approach and an appreciation of the medical ethics involved in care of aged people.

Student nurses are taught the fundamentals of rehabilitation and aesthetic education. More recently a new subject, 'occupation of sick persons', has been introduced to help nurses initiate activities for bedridden patients. Post-basic courses in nursing care of the elderly are also available: all are in response to needs identified by interpretation of national demographic and morbidity data.

Medical social workers in country C

The hospital setting is a medical framework and often a highly technical institution. It is because of this some social workers suggest, that while doctors and nurses may feel important and confident in such an environment, they tend to view social work in that setting as a second-class skill. Consequently, medical social workers are often called upon only in times of an emergency, for example, to arrange an immediate discharge. The majority work 'under' ward medical or nursing staff and therefore are restricted to working with referred patients. Because of manpower shortages they may even have to reject some of these, preferring to give a high standard of service to a few rather than a low standard to many.

The value of social workers as members of the ward team, although recognised by some doctors and nurses, is still not fully appreciated. There is an urgent need for clarification of their function. Because this is often lacking, the majority of health workers have little knowledge of social workers' subject area and level of competence.

In relation to the care of the elderly this ignorance is of great concern because disease, even when present and known, is not necessarily seen by old people as the most important factor in their lives. Many of their msot pressing problems are of a socio-economic nature and can be fully discussed and solved only when each member of a multi-professional team contributes his specific skills and knowledge. While some overlapping of activities is inevitable, and in some instances, even desirable, clear lineations have to be set and everyone allocated tasks according to professional experience and competence.

Often the social worker is the link between the patient and his own environment. Because of this, country C has thought it desirable to have some medical social workers based in the community and able to follow their patients into hospital. This, it is hoped, will result in a more efficient and continuing plan of care for patients after discharge from hospital, as well as giving them a sense of security and of 'belonging' when admitted into acute care, thus reducing that state of confusion which often results from such a move. It could also cut down on the liaison work for ward staff.

This suggestion obviously has implications for curricula-planning, including practical community experiences in educational syllabuses. It could well represent a core content for multi-disciplinary educational programmes.

Undertaking appropriate studies and providing relevant education: some questions for the future:

In a study undertaken in country D, it was found that among those old people to whom loneliness was a major problem, there was a high demand for medical attention and drugs. During the five year observation period of the project it was found that they were, in fact, not suffering from definite diseases to any greater extent than other old people. Cognitive functions were also tested and again no difference was found between those complaining of loneliness and the control group. The conclusion was reached, therefore, that elderly people who sit alone doing nothing for a large part of the day are creating for themselves physical problems such as constipation, sleep disturbances, anxiety and depression. The latter sometimes leading to hospital admission.

Because the problem of social isolation is one of the most difficult to solve, it is a frequently discussed topic. Like alienation, poverty and other poor environmental conditions, it can lead to stress commonly manifested as physical symptoms.

The danger is that medical therapy may be prescribed, especially psychotropic drugs which not only do not help the primary condition, but also draw attention away from the underlying cause and may expose the old person to all the hazards associated with drug usage.

In order to create a society in whatever country in which such needs of the elderly have a good chance of being met more appropriately, a determined educational drive is required, aimed at ensuring a better understanding of the process of ageing, of the needs of the elderly and of the most effective and relevant ways of supporting them. Such an educational effort is now, for many nations, a matter of urgency.

Help within families and communities has been a natural occurrence for centuries and perhaps we should consider just what we are doing by talking about it as though we are establishing something new. Secondly, what is the first priority cited by old people themselves? The Age Concern Manifesto * which offers a definition of the overall needs and aspirations of all elderly people has important implications for both educational and service programmes:

> 'The elderly need to have sufficient income to meet their needs for social, physical and emotional well-being; accommodation which ensures their right to privacy and the retention of their own material possessions; and the freedom to exercise those preferences and prejudices which express their individuality and sense of the past. They need easy access to transport to enable them to supply many of their own needs and to pursue their personal inclinations. They need the security of knowing that in the event of an emergency, they will not be put at risk through the failure of essential domestic supplies or the shortage of basic foodstuffs.
>
> Whether living in residential institutions or their own homes they need the kind of health care and domiciliary support which will help them to obtain the maximum degree of independent living in spite of increasing infirmities or disabilities'.

In terms of educational programmes, this raises many questions. Should appropriate theory and practice be included in all basic education? If so, what should be the focus? What clinical experience should be offered? How can we ensure that comprehensive assessments are made, without violating the individual's privacy?

* Age Concern Manifesto, UK, 1975

How can we develop in students an appreciation of the importance of the protection of individual liberty so that each old person is able to retain maximum control and choice over his own lifestyle and over his own dying?

How can we enable the practice of the principles of rehabilitation in order to obtain that original aim - to maintain optimum physical, social and mental function in each elderly individual?

Lastly, how should teachers, managers and researchers be prepared for this field?

Discharge from hospital is not, and should not be regarded as, an isolated procedure. The answer to these and other vital questions concerning elderly people will affect not only continuity of care but also the quality of that care. International exchanges of ideas, programmes, experiences and schemes could help provide some solutions.

CHAPTER 7

THE FUTURE AND LONGER TERM PERSPECTIVE

In order to undertake long-term planning, it is necessary to consider the demographic trends which are likely to influence the type of service that will be required in the future.

The distinguishing general demographic characteristic of the older population in the coming 25 years or so will be the new 'very old'. Despite the number of surveys undertaken and the increased knowledge we have of such facts, often little notice is taken of them; rarely are they interpreted and used. Certainly a rigid categorisation of needs by age grouping should always be avoided for, just as individual old people vary in their personal and environmental circumstances, so the problems they face and the range of support they require also vary considerably. Providers of services - both statutory and otherwise - have to remember the vast differences between old people as individuals, the wide variations in the impact of growing old and, in addition, the rapidly changing social and economic features of today's society. The latter can and do present difficulties enough for younger people; it is little wonder that old people sometimes feel bewildered, inferior and 'left behind'.

It is obvious that there are many problem areas and constraints to good practice. First the lack of communciation, collaboration, cooperation and therefore of coordination. This appears to exist not only between the health and social services and between formal and informal help, but also between the levels of the health system itself and between different, and even the same, disciplines.

Adequate communication and coordination is also often lacking in connection with other sectors, such as housing, transport, environment and education. Consequently, policies adopted by these sectors are not always helpful or even in accord with the implementation of policies of the health sector.

Attitudes towards old people often contribute to the low priority afforded to programmes for health care of the elderly. This, in turn, has led to staffing problems in the field and also to the disinterest in the subject of a number of health and socially orientated voluntary agencies.

Primary health teams often cannot or do not follow up the old person as he is transferred between levels of care. This immobility on the part of his carers can contribute to a lack of smooth continuity of help. Many members of the primary health team do not give - or are unable to give - sufficient time to counselling; to just listening when it is most needed, such as after redundancy, retirement or bereavement. A person made redundant needs mental stimulation and cultural activities if psychiatric problems in later years are to be avoided. High risk groups are not only those with physical impairment, and we need to bear in mind in this connection that today's unemployed young people are tomorrow's elderly population.

Loneliness has been recognised as a problem for many old people. It has to be remembered, however, that loneliness is not synonymous with being alone. Many old people who live alone are rarely, if ever, lonely, whilst others, although living with families, friends or other residents in homes, experience feelings of great loneliness. It has been suggested that there are four main factors which contribute to loneliness; these are poverty, poor health, having little interest in other people and the world around (very often all through life) and the death of the person with whom one has been living or who has been a close companion. Implications for prevention are to a large extent in the hands of the individual; health and social workers can help only in assisting the elderly person to keep active, interested and well; to take notice and action when difficulties or impairments develop, to concentrate on his strengths and abilities rather than on his weaknesses and disabilities; and to give practical and psychological help at crisis points. This may mean stimulating neighbours to give assistance as well as acting and giving aid directly.

Helping the family

For those who are already old and lonely, specific services may be required. Transport, for example, is often a two-way impediment to the meeting of relatives and friends and the holding of other social occasions. Homes and hospitals may be situated a long distance from public transport, making it difficult for friends and relatives of old people to visit them regularly. Some voluntary organisations and agencies run a transport service to take elderly, frail or infirm old people to clubs and on special expeditions or outings. Thought must be given, however, to the obvious preferment of some people to have transport to visit their own families and friends rather than be transported to people with whom they have little in common other than age, a handicap or a disability. So services supplied should - as always - reflect needs of the people and not represent what volunteers and others wish to do or provide.

In relation to all activities for an individual, it is important to achieve a compromise for him between privacy and isolation. Privacy is highly valued by the majority of people and regard must be paid to this. Also, all people need to be alone some times. This is one reason why one of the best objectives of a social policy or service is to help not only the family but the individual to help himself.

Attention must be paid to the preservation and strengthening of family and social bonds and traditions. Care should be taken also to ensure that whatever is done in the name of 'progress' - such as re-housing elderly people - does not imperil existing and cultural patterns of care and support for old people. Environmental conditions are extremely important in old age and there is no doubt that rapid processes of urbanisation can produce great stresses. The corner shop or the village post office which were once good meeting points, have now disappeared and few cashiers in supermarkets have time to chat to their customers.

The size and nature of future demands

In Britain, the tide of increase of those elderly who are least dependent and most able to help others (that is to say, those aged 65/74) is already past its flood. However, the number of those between 75/85 will not reach its peak until 1990, while the number of those over 85 years will not peak until the end of the century. At their greatest the number of persons in these age groups will be respectively, 400,000 and 300,000 more than today's figures. In other words, there will be by the end of the century an increase in the number of people in England and Wales over the age of 75 greater than the present population of Liverpool. It should be borne in mind, also, that as many as one in twenty of the population will suffer from incontinence. In parallel with these increases other demographic and social changes are occurring, the effect of which will be to diminish the number of able-bodied relatives available to share in the continuing care of the elderly.

As Donald Acheson states in his introduction to The Impending Crisis of Old Age - 1, the trends are truly a cause for alarm and attention, not only because of their scale, but also because of the enormous penalties associated with them in terms of human suffering and financial costs. Michael Butts also points out in the same publication that as the prevalence of pathology and dependency of almost every kind increases steeply with age, if current rates of disability and dependency continue, by the end of the century at least half of the additional 300,000 elderly over 85 may need assistance with bathing and a fifth of those living in their homes may be bedfast or at least home-bound.

The startling growth in the numbers of the very old poses a challenge to society which is likely to reach its peak by the end of the next decade and to continue with us for at least another ten years. By the year 2001 it is believed that the number of the over-85s will be 60 per cent above present levels, reaching a maximum in Great Britain of 880,000 or 1.6 per cent of the whole population.* This dramatic increase will be in the age group which today suffers from the severest forms of physical and mental disabilities and which requires six times more resources from the health services and twenty-six times more resources from the personal social services than the average for the rest of the adult population. Other characteristics of this older section of the population will be the domination of women in the sex ration - two-thirds of those over 80 years of age will be women - and, if present trends continue, they will be either single or widowed, live in one-person accommodation, suffer from a chronic illness or condition and in many instances, from multiple pathology. If this predestined tide is disregarded there will be great personal distress - both physical and mental - and an increased demand for continuity of care.

The importance of attitudes

Perhaps the most serious feature of all in this context has been the deterioration in society's attitude to the aged, which appears to have occurred in parallel with their increase in numbers. Rapid development of technology has had the effect of depriving the skills of the middle-aged and the elderly of their relevance. Far from being the valued repository of experience, the elderly person is now often seen as an obsolete relic of bygone times. In the past, the very rarity of survival to old age contributed to its veneration. Now, the term 'geriatric' has become derogatory and indicates the current valuation of the elderly frail to society.

* **cf.** a more recent statement by Mark Abrams on changes in age distribution of the population 1961-2001 which reinforces the need for prompt and drastic improvements in continuing care. 'The numbers of people aged 65 or over have grown by over two million since 1961 but are not expected to increase much more up to the end of the century. Within the broad over 65 age band, the balance of different age groups is expected to change. The 65-74 age group is projected to make up 53 per cent of the 65 or over age group in 2001 (62 per cent in 1981). The most dramatic change is projected amongst the 85 or over group which will make up 12 per cent of the elderly in 2001 (7 per cent in 1981)'.

  'Changes in Life Styles of the Elderly' in Social Trends 14, 1984, p 191.

Thus we are encouraged in our attitude of thinking of the old and even the newly retired as irrelevant to the maintenance or development of our society and unable to do productive work or contribute to economic growth: our goals reflect this acceptance of the older person's lowered status and we speak of him, not as an individual but as one of a homogenous mass. He is not. Old people vary in their personal circumstances and personalities as much as any of us: in many instances, very much more. The problems they face and the range of support they require to remain as independent as possible also vary considerably. Not only are there vast differences between old people as individuals, there are also the wide variations in the impact of growing old, and in the effect of today's social and economic features. Ideally therefore the services offered should be based upon a careful assessment of what each particular person requires, bearing in mind what he can do and provide for himself and what can be provided by family, friends and neighbourhood. Considerably more than efficient use of resources is lost if a generalised approach is used or the maximum possible degree of flexibility is not built into the system.

The 1982 reorganisation of the National Health Service largely abolished the coterminous boundaries agreed in 1974, and will thus bring about the final rupture of the relationship between health and social services. Although it is recognised by the co-authors of The Impending Crisis of Old Age that no one can be certain until the matter is put to the test, it is their considered opinion that 'a vast improvement can be achieved by a radical readjustment of existing resources within the whole field of health and social services and by a strongly defined partnership with voluntary effort'.

Certainly, it is obvious that resources are wasted within the present system, and largely through inefficiencies. The 'blocking' of acute hospital beds, the misuse of many long-stay beds, the lack of preventive action, the poor linkage of resources in the public residential sector (housing, food, care and social contact) are but a few examples. There is also a failure to exploit to the full many private resources and time is wasted in passing the buck between taxpayer and rate payer or between hospital and domiciliary services. As to voluntary work, it is suggested that the size of this army could be greatly increased if 'accepted by management as essential partners'. Voluntary agencies themselves need to form a united front at local level in order to participate in planning the use of resources.

An integrated service

The considerable overlaps in services provided to severely handicapped old people have been reported more than once. While it is necessary to preserve freedom of choice for the individual, the degree of overlap which exists in some areas of long-stay beds, nursing homes and private homes, has been created and maintained more in the interest of the professions than of anyone else. It is a serious waste of resources. The 'blocked' acute beds occupied by patients on sufferance and the inefficient discharge procedures are only two of a long list of effects of the present disjointed system of care. In addition, there are at present inconsistent criteria for admission and re-admission to hospital and residential or sheltered accommodation. This fact has a considerable effect on the planning of discharge from hospital. In some parts of the country a stigma is still attached to Part III homes, while only a few areas run efficient and effective procedures for preventing and dealing with medical and social crises in the home.

The remedies for present defects consist, firstly, in each service setting its own house in order; secondly, and this may be the easiest approach to the first, in moving towards an integrated service operated by the various authorities working in partnership. It is to be hoped that the NHS reorganisation will force appraisals which prove to be creative. Necessary processes may occur in the head, but they are first conceived in the heart and by the values society formulates. It is now a question of political will, swiftly married to administrative action. Otherwise it will be too late.

Reference for Chapter 7

1 The Impending Crisis of Old Age: A Challenge to Ingenuity, A report and Essays edited by R F A Shegog, Oxford, Oxford University Press, for the Nuffield Provincial Hospitals Trust, 1981.

A N N E X E S

Some Examples of Good Practices

A	Administrative
B	Voluntary
C	Medical
D	Nursing
E	Social Services
F	Social Work

When you leave hospital

When you no longer require the constant supervision and care of the nursing and medical staff, the time will be approaching when you will be going home. It is usually possible to tell patients a day or so in advance of discharge but this is not always possible. If you are not well enough to travel home by public transport, arrangements will be made for an ambulance to take you home. If the doctor wishes to see you as an out-patient after you have been discharged, the ward sister will make an appointment for you before you leave hospital. Medicines and tablets that you may need after discharge will be given to you when you leave the hospital. If dressings need to be changed once you are home, arrangements will be made for this to be done.

You may find, however, particularly if you live alone, that you will need help in looking after yourself. This may be in the form of a home help, meals on wheels, nursing care or home aids, e.g. a commode. If you live alone, you may need someone to prepare your home for your return and make sure that you have what you need in the house.

Social Services

(For home help, meals on wheels or general welfare problems).

01-478 3020 (ask for duty social worker)	Office Hours
01-554 4488	All Other Times

District Nursing and Health Visiting Service

North Redbridge
01-554 6419 (Newbury Park Health Centre)

South East Redbridge
01-597 0922 (Seven Kings Health Centre) — Office Hours

South West Redbridge
01-590 0942 (South Park Clinic)

01-882 6441
Ask for 'Bleep' 385 and leave your telephone number — All Other Times

Extract from Hospital Patients' Information Booklet, published by King George V Hospital, Ilford, Essex.

The Management of Geriatric Orthopaedic Patients -

Mrs. P. Marston

Mrs. Marston described her work as Clinical Manager of the Orthopaedic Demonstration Centre at Hastings, and the system of total care developed at the centre for patients requiring joint replacement surgery.

The patient makes regular visits to a Total Care Clinic while on the waiting list for surgery, until a final Assessment Clinic 4-6 weeks before admission. These clinics enable the patient to find out exactly what will happen and to express any anxieties. Unit staff have the opportunity to assess the medical and social situation of the patient, all with the object of planning his or her progress through the unit and back into the community.

The clinical manager correlates all the information obtained and plans the admissions accordingly. She also acts as the link between hospital and community staff, to ensure the smooth rehabilitation of the patient.

From: Home from Hospital - to what?
Continuing Care Project, 1980.

ANNEX B: Voluntary

Age Concern, Leicestershire

Age Concern, Leicestershire, have a highly developed scheme for providing voluntary assistance to discharged hospital patients. Most of their referrals (about six a week currently) come from non-geriatric units in a general hospital, and the organiser can lay on visiting and a variety of services throughout the country, for a flexible short period. She trains and supervises a team of volunteers and also works with local contacts, in extremely close cooperation with the hospital staff, particularly sisters and social workers, who are all aware of the service. Specially trained volunteers are now visiting wards regularly to chat to all old people, and discover those in need of the service.

From: Home from Hospital - to What?
Continuing Care Project, 1980.

ANNEX C: Medical

A Contribution from Geriatric Medicine Within Acute Medical Wards -

Dr. Lindsay Burley

Dr. Burley described a scheme at present in operation in Edinburgh Royal Infirmary. Specialist geriatric staff are attached to acute medical wards and elderly patients can be referred to these teams at a very early stage after admission. Assessments of the patients are made by medical staff, physio and occupational therapists, while the medical social worker obtains relevant information about home support. Weekly case conferences attended by the whole team record the progress of the patient and emphasis is placed on planning effective aftercare.

A study was made of two comparable periods, one before the attachment of the geriatric teams and the other during it. This showed a reduction in median lengths of stay of elderly patients, an increase in the proportion staying two weeks or less and an increase in the proportion discharged home in the second study period.

Factors attributable to the presence of the geriatric medicine team which are important in bringing about these improvements include:

(1) Obtaining a prompt and complete social report.

(2) Multi-disciplinary assessment.

(3) Interest and experience in the psychiatry of old age.

(4) Early planning of arrangements to facilitate return to the community.

(5) Familiarity with local community resources and how to mobilise them.

(6) The ability to arrange directly for geriatric aftercare or negotiate it with other regional geriatric teams.

(7) The ability to decide when it is safe and suitable for an elderly patient to be returned home once a certain degree of independence has been achieved.

(8) The weekly review of each elderly patient, even those who seem to be 'stuck'.

From: Home from Hospital - to what?
Continuing Care Project, 1980.
Based on a paper with the same title by Dr. Burley and three joint authors, University Department of Geriatric Medicine, City Hospital, Edinburgh, 1979.

ANNEX D: Nursing

Hospital and Community Nurses - Planning Patients' Admission to and Discharge from Hospital

Pre-admission reports on elderly patients who are to have cataracts removed, etc. are provided by health visitors. These, together with forms completed by the patients themselves enable the 'matron' of the Eye Hospital concerned to make sure that after care is arranged before admission, so that the operating theatre and the hospital beds are used most effectively. This procedure ensures that the hospital has no blocked beds or delayed discharges of patients.

Williams, E M Paper - Workshop on Practical Achievement of Appropriate Continuing Care for Discharged Hospital Patients.
St. George's House, Windsor,
27/8 November, 1980.

ANNEX E: Social Services

Home Aide Scheme for the Elderly

'A pilot home aide scheme for the elderly was started in Avon in May 1978. A home aide organiser and ten full-time home aides were appointed to provide short term intensive support and practical help to clients within their own homes. The help provided was to be more intensive than that offered by the home help service under normal circumstances. Costs were being met by joint financing.

A major aim of the service was to rehabilitate clients in their own homes so that conventional services could take over after a short period of intensive help. The two main categories of clients intended to be helped were firstly those ready for discharge from hospital but needing help to re-establish themselves at home, and secondly, clients who needed a period of professional assessment to determine the most appropriate form of care.

It was decided that at the time of referral there should be a strong likelihood that after six weeks the service could be withdrawn and replaced, if necessary, by other services. The level of support received by the client from family and friends was expected to continue. Home aides were provided free of charge, thus avoiding any discrepancy between the hours required and the hours that the client felt able to afford.

The home aide organiser and clerk were accommodated in their own office near the social work department in a hospital within the county. The home aides, who were appointed for their previous experience in one of the caring professions, regarded the hospital as their base and worked a five-day rota system over a seven-day week, providing cover to clients up to 24 hours a day. Upon appointment they received two weeks' intensive training in both health and social services authorities, including work on the wards of the hospital. This was followed at intervals by client care training.

Referrals to the home aide service were received by the organiser and a plan of care was arranged in consultation with all interested services. Where the client was awaiting hospital discharge, part of the plan entailed the home aide spending some time in the hospital to observe the programme of physio-therapy or occupational therapy, to talk to the ward sister regarding medication or to acquaint herself with the patient. The home aide was required to keep a written daily record of the client's condition to facilitate ongoing assessment.

The initial success of the scheme led to the creation of three further teams with a total of 50 home aides throughout the county. Analysis of the 513 clients who received a service in 1981 showed that the average weekly number of hours allocated to each client was 23½, although 22% received 30 hours or more. Nearly 10% of the clients received help at night. About two-thirds lived alone and, in the overwhelming number of cases, the home aide spent more time with the client than anyone from outside the household. Two-thirds of the clients were house-bound and over 40% had problems with incontinence.'

M Dexter, Home Help Service as a resource in somatic outpatient care, Avon County Council, 1981
Reprinted in M Dexter and W Harbert, The Home Help Service, Tavistock, 1983.

ANNEX F: Social Work

Hospital social workers assisted by young people who 'screen' patients for possible after care needs

A senior hospital social worker involves four young people, who are funded by various agencies, in screening elderly patients soon after admission. They identify social problems which the patients might meet on their return home from hospital.

The senior social worker reads these forms and determines what further action should be taken. This action might include referral to a social worker or arrangements for supporting services, re-housing, financial help, walking and other aids or respite for the carers, etc.

Social workers found that this scheme allowed them to give more time to other categories of patients, such as psycho-geriatric and long-stay patients.

Ricketts, R, 'Screening the Old' Community Care, 20 September, 1978, p 23.

A P P E N D I X

PROFESSIONALS, VOLUNTEERS AND PRIORITIES

A feature of our modern society is the ferment of ideas which affects all our activities. As this study indicates, the provision of continuing care for the elderly is affected by this ferment. This appendix supplements the study by commenting briefly on professional values and on inter-professional conflicts, followed by suggestions on how volunteer systems might become more credible and reliable. Finally, a few pointers for action have been provided.

One of the results of increased specialisation in the training of hospital professionals is that they become insular and resent other groups when their work requires cooperation.

As W B Harbert points out in his paper, 'The Statutory Sector' (printed in 'Home from Hospital - to What'), 'Professional groups still largely train in isolation. It takes experience and maturity for professionals to come to terms with multi-disciplinary working. In the early years following training they consolidate their skills, and it is normally only after a number of years' practice that they are ready to appreciate the skills and abilities of other professional groups'.

Mr. Harbert suggests that a more multi-disciplinary approach to training would alleviate this problem. It is necessary for the welfare of the patients that the professionals are able to work together as a coherent team who are fully aware of each member's role and who use their imagination to provide a flexible approach to care.

The problem of inter-professional conflict in hospitals stems largely from a basic lack of knowledge about the function of each profession. Doctors and therapists are concerned primarily with care; social workers with social welfare. An awareness of the joint importance of both social and medical aspects of care is an essential part of the improvement in cooperation between the professions.

Another problem which needs to be overcome is the prevailing attitude that management skills are alien to the duties of a hospital professional. W B Harbert remarks,

> 'Management as a concept is unpopular; it raises issues of authority, power and leadership which are often thought to be the antithesis of professionalism'.

Such attitudes are exacerbated by the trend towards specialisation, and they need to be modified in order to create an atmosphere of professional collaboration which is the basis for a comprehensive system of patient care.

Previous Continuing Care Project reports have stressed the lack of communciation and understanding of roles as perhaps the major obstacle to a more effective provision of after care. This is true of some professionals' attitudes to volunteers. Stereotyped views of volunteers as being 'unreliable' with few skills to offer are unjustified in view of the diversity of voluntary agencies and of their functions.

The very 'amateurism' for which they are so often criticised can be a major strength, their lack of institutional bureaucracy can lend a greater freedom and adaptability to meet new situations. It is also true, unfortunately, that schemes which are set up to fill a gap in services may be sucked into the morass of bureaucracy they were designed to combat. Whilst self-help schemes are a source of hope for future change, the problems facing them should not be ignored, nor indeed is amateurism always desirable.

There is firm evidence of resistance by paid staff to the greater involvement of volunteers in both the health and social services. This is an important issue and relatively small progress has been made in tackling the problem since its recognition some years ago. It is considered here from two view points, that of the professional employee and that of the trade union.

Professional employees' resistance to the introduction of volunteers into hospitals and elsewhere is understandable in the light of their own considerable training and experience gained through many hours of hard work. The introduction of volunteers may be seen as a threat to an existing set of established procedures, an upset of an existing way of life. Another problem is that professionals may feel themselves unable to relax; to show any signs of 'unprofessionalism' in front of outsiders. Some may also resent the volunteers' freedom and the time they have to develop closer relationships with patients. Volunteers may often be considered unacceptable then, unless relegated to relatively menial tasks. Recommendations to avoid this situation will be discussed later.

Volunteers <u>are</u> agents of change. One voluntary services coordinator remarked, 'For heaven's sake, don't tell anyone - just let it happen'.

Undoubtedly, the biggest obstacle to trade union acceptance of volunteers is the suspicion that they are being put forward as a cheap, alternative labour force, undermining existing services and thereby threatening jobs. Government ministers in 1979 stated that there was considerable scope for volunteers to perform functions now carried out by social services departments. These statements increased suspicion at a time when jobs were being lost and local authorities were required to reduce expenditure.

In 1980 the Prime Minister said the voluntary movement could do things which the government could not do, or could do them better. Since then there has been evidence of government willingness to help some voluntary organisations fulfil their tasks.

More progress might be made if the government extended its help to innovative schemes, to back up its promises for the capacity of volunteers and voluntary organisations to solve the country's ills.

The following suggestions may help overcome union resistance and make the volunteer system more credible and reliable.

(a) Preliminary consultations with all professional bodies before the introduction of volunteers to see where they are needed and what their duties should be. As the Volunteer Centre guidelines make clear, volunteers should not replace existing staff, unless agreed, but should complement existing services. At one hospital, an agreement had been reached that no volunteers would be used to transport patients. But, in response to the inability of occupational therapists to always provide a service and the delay often involved in waiting for an ambulance, it was agreed that volunteer drivers could be used and their expenses would be met by the hospital.

(b) Machinery for resolving problems which might arise between unions and volunteers should be set up.

(c) Paid voluntary services coordinators should be affiliated to a union.

(d) In the event of industrial action, the Volunteer Centre guidelines stress that volunteers should do no more than their normal duties. The Voluntary Services Coordinator too should not take on extra duties and should only offer extra help (if at all) as a private individual.

The Volunteer Centre report advocates a 'one door policy', that is a central volunteer centre, to which enquiries could be made, volunteers recruited and from which they can be deployed. This would facilitate communication with statutory services and the community, who are often unaware of the amount of help available.

Proper training should be given when applicable. Where a visiting service is being provided for discharged patients, often enthusiasm and time are the main requirements. However, careful matching of visitor and patient must be made. It would also be worthwhile to describe to volunteers possible needs they might usefully discover and in this context the Society of St. Vincent de Paul's visitors' guidelines are recommended.

Finally, volunteers in a hospital should be part of a team, with status and should be responsible to a senior member of (nursing) staff or administrator. Professionals' training and outlook should incorporate an understanding of the voluntary sector, a realisation that professionals do not have a monopoly of skills or care, and that their very 'professionalism' can isolate them from those they are supposed to help.

When discussing work outside hospitals, the report criticises the failings of voluntary bodies and puts forward a number of recommendations. In addition, Barbara Shenfield and Isobel Allen's The Organisation of Voluntary Service recommends that there should be two systems of calls, one to be a brief check and the other a more regular closer call:

(1)
A localisation and decentralisation of services: a group of about 30 street wardens ought to be able to make check calls on about 1,500 old people in their immediate vicinity. On a different basis, 30/40 visitors should be able to provide a closer contact for about 70/80 people in their district.

(2)
Conversely, a comprehensive visiting service in any sizeable area (100,000/150,000 population upwards) needs at least one full-time paid organiser with an office and some clerical assistance to organise only one service. In addition, depending on the size of the area, local group leaders will be needed to whom some responsibilities can be delegated.

(3)
A centralised and systematic record of elderly clients (perhaps with the cooperation of companies maintaining contact with their pensioned former employees) might be kept up-to-date with feedback

from voluntary visitors. This would prevent the keeping of open files for dead clients or for others who do not want visitors. Some smaller voluntary groups do not keep records, instead, information may be kept in the organiser's head, which is both fallible and disastrous should they leave.

(4)
Once again there should be a Voluntary Services Coordinator to whom volunteers are responsible. Any problems or queries could be brought up at regular group meetings where information and ideas could also be exchanged among volunteers.

(5)
It is crucial that there should be an independent assessment of old people by the voluntary organisation, since information from GPs and others is often poor or non-existent.

(6)
A number of model visiting schemes should be set up and monitored in different types of areas to determine - what is available, the work load and what is the most appropriate system of communication and record keeping.

(7)
Voluntary organisations should attract a broader cross section of the population, perhaps with some reimbursements for expenses incurred and duties should be clearly defined.

(8)
Finally and importantly, realism about the finance to support voluntary organisations is vital. Some money is essential and where volunteers are giving a visiting service which would otherwise have to be provided by public authorities, grant aid should be awarded for transport, telephone, postage and other essential expenses. Also, whilst standards should be maintained, independent management must be preserved.

In the present situation of declining resources and the increasing number of unemployed, greater use of volunteers and the voluntary organisations is a necessity. But there has to be a greater willingness on the part of the professionals to accept volunteers as partners in the caring process, to involve them in decision making and to realise that they do not have a monopoly on skills or dedication. As Jonathan Barker suggests, with support from other observers, a revision in the training of doctors, sisters, and other professionals is needed, with more time given to geriatric medicine and the development of a socio-medical approach to elderly patients. To this end training for volunteers should be instituted where appropriate. Visiting the elderly at home

need only demand time and enthusiasm initially, although the guidelines set out in the Society of St. Vincent de Paul's publication would prove a useful introduction. To quote from Care is Rare, 'The contention that the blame for inadequate services lies largely with the scarcity of resources and that little can be done about it is, we believe, overstated and defeatist'.

Ignorance about community facilities for discharged elderly patients and poor communications were established in the Continuing Care Project's Going Home as the causes of 14 per cent of long stay patients at one hospital being unnecessarily kept in hospital. In Who Goes Home an overall 22 per cent of patients were regarded as not needing hospital care at all, and a further 39 per cent were deemed suitable for transfer to sub-acute care.

With better organisation of existing facilities, and greater use of the voluntary sector, resources could be freed to cater for the increasing numbers of the elderly and the very elderly. There is, however, a serious shortage of old people's homes and this has been seen to have led to patients who could otherwise be discharged being kept in hospital, and hence denying others the medical care they need. This situation urgently requires the attention and, most importantly, the appropriate action of central government. In addition, it is recommended that:

(i) More emphasis be placed on resources that allow informal networks of care to flourish. This requires appropriate planning and housing allocation policies, cheap transport and telephones.

(ii) Progress with community hospitals, which are often serviced by a GP and are less costly than general hospitals in capital equipment and specialist labour. They will be nearer to the community and more capable of coping with flexible visiting patterns.

(iii) The introduction of more 'foster homes' schemes, where the carers of the elderly at home can take a break and the elderly person can stay for a few weeks with a family who are paid by the social services. Continuing Care Project surveys have shown that carers placed under the stress of giving constant attention may often be old or incapacitated themselves, and not infrequently will soon need hospital attention if unsupported. 'Drop in' centres or a 'granny sitting' service, as introduced in Northamptonshire and elsewhere (New Age, 1982), where carers can come to discuss problems with specialists and those in a similar position, or simply to have a chat, are other options.

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