Report on

SERVICES FOR THE ELDERLY

in the

METROPOLITAN BOROUGH OF LEWISHAM

1964

by

A COMMITTEE SPONSORED

by

KING EDWARD'S HOSPITAL FUND FOR LONDON

54 KING STREET, LONDON, E.C.2

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PREFACE

The problem of finding hospital accommodation for the elderly is one that is constantly in the public mind. It is usually referred to as well nigh insoluble, but on occasion reports appear suggesting that locally it has been contained, if not actually mastered.

If indeed there are areas where it is being effectively tackled, it is most desirable that such success should be publicised. It seemed that this could be the case in Lewisham, but to obtain proof clearly would need much work and expense. To this end, the Fund set up the Committee which prepared this Report. Mr. E. L. Turnbull, a prominent member of the King's Fund well-known for his impartiality, kindly undertook the onerous duty of Chairman. He was assisted by a Committee of local people and by Mr. W. L. Graham as Secretary, who was eminently suited to this post by his long practical knowledge of the problems of the elderly. Together the Committee has produced a Report covering every aspect of the problem and they have provided most valuable information for the use of all who have this problem before them.

It is sad to have to record that very shortly after the Report was completed, Dr. Smithard, the Medical Officer of Health of Lewisham, died suddenly. His untiring work for the Committee was deeply appreciated by all members of the Committee.

McCORQUODALE OF NEWTON
Chairman,
King Edward's Hospital Fund for London.

FOREWORD

Much interest has been shown in our work in Lewisham and we have received many enquiries about it during the four and a half years in which we have been engaged on it. As this report shows, our work was not simply an investigation of the arrangements for old people. We were required to correct any gaps or weaknesses we found if it was in our power to do so. Where we could not ourselves do this we tried to suggest how improvements could be made.

At times it has been necessary to leave our main road for a while and explore byeways in order to discover how certain results were achieved, even when those results were satisfactory. For example, one of our first and chief aims was to discover whether there were elderly patients in Lewisham who were unable to get the hospital treatment they needed. The house-to-house Survey and our questionnaire to general practitioners indicated that there could be few, if any, such patients. A further enquiry was needed to show whether it was the adequacy of accommodation in the Lewisham Hospital Group or help from neighbouring Groups which accounted for this. The discovery that it was the adequacy in Lewisham led to a further enquiry to find whether the Lewisham method was more costly in beds than that of other areas.

We were disappointed that we were unable to reach a unanimous decision on the matter of a geriatric unit. The majority of us are not convinced that the establishment of such a unit in the Lewisham Group would do anything to improve the arrangements for the elderly in that area: there are clearly two schools of thought as to how the needs of the elderly can be met. This has had to be accepted: indeed it may well be that both are right.

E. L. TURNBULL
(*Chairman*)

MEMBERS OF THE COMMITTEE

E. L. Turnbull, *C.B.E.*, *Ll.B.*, Chairman

Miss L. H. Ellis	representing	Lewisham Old People's Welfare Association
Miss J. Holmes, *A.I.M.A.*	,,	Lewisham Hospital Management Committee
G. E. Hutchinson	,,	Lewisham Hospital Management Committee
F. L. Lloyd Jacob	,,	London County Council, Welfare Department
T. V. Mendelsohn, *M.R.C.S.*, *L.R.C.P.*	,,	Ladywell Lodge
R. Ll. Meyrick, *M.B.*, *B.S.* (*Lond.*)	,,	General Practitioners
Ann Mower-White, *M.R.C.S.*, *L.R.C.P.*, *D.P.H.*	,,	London County Council, Health Department
L. V. Roberts, *M.D.*	,,	Lewisham Hospital Management Committee
E. H. R. Smithard, *M.B.E.* *M.D.*, *D.P.H.*	,,	Metropolitan Borough of Lewisham
W. L. Graham, Secretary	,,	King Edward's Hospital Fund for London

CONTENTS

INDEX TO TABLES

REPORT OF THE LEWISHAM CO-ORDINATING COMMITTEE

INTRODUCTION

Origin of the Committee

1. Our Committee was formed in June 1959 on the invitation of King Edward's Hospital Fund for London following a recommendation that was made by one of the Fund's own Committees (hereinafter referred to as the Special Committee) which had studied the provision for the elderly sick in London.

Terms of Reference

2. Our terms of reference were defined broadly. We were asked to try to ensure in Lewisham full co-operation between all services for the elderly, to ascertain what gaps existed and how they could best be filled.

3. We understood that the King's Fund would consider sympathetically any applications for financial help for projects within their purview which we felt were essential to make the area a model one.

4. We agreed to look particularly at the application to Lewisham of three factors which the Special Committee considered might in general be preventing or hindering a satisfactory comprehensive service for old people, namely:—

(a) that often not enough was being done by hospitals to provide active treatment and to make suitable arrangements when improvement in their condition make elderly patients fit for discharge.

(b) that often hospitals were unable to send cases to welfare accommodation, and vice versa.

(c) that hospital beds often cannot be freed because there is no place to which to discharge those patients who only need some nursing.

5. Although pensionable age starts at 60 for women and 65 for men, we decided, for the general purpose of any detailed enquiry, to make the minimum age 65 for both men and women.

the health and welfare facilities available to old people living in private households in Lewisham and finding out how many of the people knew of the existence of the services. Since there is no register of elderly people, the Survey selected a sample of 1 in every 19 rateable units in Lewisham, which gave a total of 3,475 rateable units. The Survey instructed their interviewers to ensure that all persons aged 65 and over living in these units were accounted for, which, in some cases, meant making enquiries of neighbours and shopkeepers. There were no persons of the required age groups in 2,461 of the units selected, the remaining 1,014 addresses containing 1,370 persons aged 65 and over.

16. The main interviewing took place in May/June 1961, when nearly 81% of the sample agreed to co-operate, 16% refused either directly or indirectly through someone else in the household, and 3% were not contacted. Later, further attempts were made to obtain interviews with those who had originally refused as well as with those who had not been contacted and as a result further interviews were obtained, leaving 9 people uncontacted; it was discovered that 3 of these were in hospital, 1 had died soon after the main interviewing period and one was working full-time, was active and not isolated and so no further attempts were made to obtain an interview. Interviews were completed with the remaining 4 but were too late to be included in the analysis.

TABLE I

Proportion of men and women in sample set and sample achieved compared with proportion in England & Wales

	People aged 65 and over in sample set %	People aged 65 and over in sample achieved %	People aged 65 and over in England & Wales %
Male	37·6	36·8	38·4
Female	62·4	63·2	61·6
Number of persons on which based	1,363 = 100%	1,190 = 100%	5,521,000 = 100%

There is little difference in the proportion of men and women in the sample set in this age group and in the proportion of men and women in England and Wales. The proportion in the sample co-operating is also very similar in spite of the slightly higher refusal rate of the men.

TABLE 2

The age distribution of men and women 65 and over in the sample achieved and in England and Wales (the latter based on the Registrar General's Quarterly Return for the third quarter 1961)

Age distribution	MALES			FEMALES			BOTH SEXES		
	Sample achieved No.	Sample achieved %	England & Wales %	Sample achieved No.	Sample achieved %	England & Wales %	Sample achieved No.	Sample achieved %	England & Wales %
65 - 69	168	38·5	39·1	250	33·3	34·3	418	35·2	36·1
70 - 74	130	29·8	28·4	199	26·5	27·6	329	27·7	27·9
75 - 79	70	16·1	18·7	163	21·7	20·3	233	19·6	19·7
80 and over	68	15·6	13·8	139	18·5	17·8	207	17·4	16·3

These distributions are similar and it may therefore be concluded that the sample is representative of the elderly population of Lewisham so far as age and sex are concerned.

TABLE 3

Household Composition. The percentage of co-operating persons in different types of household

Type of household	Percentage co-operating	No. of old people on which percentage is based
Old person living alone	89	313
Couple living alone	85	474
Couple and others	92	182
Women and others	93	296
Men and others	83	78
All types of households	89	1,343

It would thus appear that where a married couple, of whom one or both are 65 or over, are living alone, and where an elderly man lives with others, there is a higher refusal rate.

17. It was stated that 23 of the men who were not interviewed were working and 13 were not working. Since those mentioning work gave this as the reason for not being interviewed, it may be that those

Table | Page

Tables in the Appendix

TABLE 7

Length of time bedfast and housebound people had been thus confined

How long since last got up/out	At time of interview		Total bedfast & housebound	
	Bedfast	Housebound	No.	%
3 months or less ..	4	6	10	8
Over 3 months-1 year ..	9	23	32	25
,, 1 year-3 years ..	4	33	37	29
,, 3 years-7 ,, ..	4	25	29	23
,, 7 years	1	16	17	14
Vague "a long time" ..	—	1	1	1
All bedfast or housebound	22	104(1)	126(1)	100

(1) Excludes 1 not answering.

From these figures it is estimated (2) that in private households in the whole of Lewisham there will be not less than 243 nor more than 447 permanently bedfast elderly people. Similarly, there will not be less than 1,500 nor more than 2,200 permanently housebound.

(2) Calculated using Biometrica Tables for Statisticians, Part I, 1954.

19. When considering the application of the Survey figures quoted in this Report to the whole of Lewisham, some factors must be borne in mind because their "reliability" depends on two things:

(1) the size of the sample
(2) the size of the proportion within the sample.

The sample of full interviews, 1,190, representing 4.3% of the population over 65 years of age, is large in total and so also is the number of people usually able to go out (1,074) and the number permanently housebound (94). All these will give reliable estimates when applied to Lewisham but the sample size for the bedfast is small and, while it is in total adequate, any breakdown of the total could not be considered as a reliable estimate when applied to all elderly people in Lewisham because the results are subject to too wide a margin of error.

20. 54% of the Survey sample have no-one under 65 years of age living within their households, while 46% live in households with at least one person aged less than 65, although this does not necessarily mean that they can depend on younger persons within the household for help. Twenty-five of the housebound or bedfast in the Survey sample have no-one in the household to help them. (See also Appendix, Tables IV, V, VI).

TABLE 8

Those having difficulty in doing their own shopping.

	Bedfast		Housebound		Gets out		All old persons	
	No.	%	No.	%	No.	%	No.	%
No difficulty, no-one helps	—	—	1	1	412	39	413	35
No difficulty, has help ..	—	—	2	2	469	44	471	39
Difficulty, has help ..	22	100	102	97	161	15	285	24
Difficulty, no-one helps ..	—	—	—	—	21	2	21	2
All persons in sample on which percentage is based ..	22	100	105	100	1,063	100	1,190	100

In addition to the 22 bedfast persons assumed to have difficulty doing their own shopping, 102 of the 105 housebound (97% of those housebound) and 182 of the 1,063 who were able to get out at time of interview (17% of this group) say they have, or would have, difficulty doing their own shopping.

21. Four hundred and seventy-one of the 884 elderly people in the sample who said they have, or would have, difficulty in doing their own shopping (53%) nonetheless have help. Of those who have, or would have, difficulty doing their own shopping, all those bedfast and housebound have help with shopping, as do 161 of the 182 who are able to get out but have difficulty shopping.

TABLE 9 (a)

Help with Shopping.

Who helps with shopping	Difficulty in doing own shopping		No dfficulty with shopping		All persons	
	No.	%	No.	%	No.	%
Helped by:—						
Relatives in household	200	70·2	382	81·1	582	77·0
Others in household ..	6	2·1	18	3·8	24	3·2
Relatives not in household	48	16·8	51	10·8	99	13·1
Friends, neighbours ..	37	13·0	26	5·5	63	8·3
Private domestics ..	5	1·8	1	0·2	6	0·8
Welfare services ..	22	7·7	7	1·5	29	3·8
Shopkeeper delivers ..	6	2·1	—	—	6	0·8
All sources of help ..	324	113·7	485	102·9	809	107·0
No. of persons getting help	285	100	471	100	756	100
No. not having help ..	21		413		434	

Area chosen for the Investigation

6. We understood that the Special Committee favoured Lewisham as an area for such an experiment for one special reason: in the Lewisham Group there is no geriatric physician and the only beds specially allotted to the elderly are for rehabilitation. It appeared to the Special Committee that in so far as the hospital service was concerned, elderly people had as much attention and as much chance of getting that attention as they had in areas where there were orthodox geriatric units. It was part of our task to test this.

7. We agreed to take the Metropolitan Borough of Lewisham as the area of our enquiry. This Borough covers an area of 7,015 acres. It had at the 1961 census a total population of 221,753 of whom 27,546 (12.43%) are aged 65 and over. No area of the Borough, classified according to the economic status by using the J-index, is over 6 and the lowest is less than 1. (See also Appendix, page 70). The Borough coincides approximately with the main catchment area of the Lewisham Hospital Management Committee.

8. In Lewisham, according to the 1961 census, there were 15,717 one-person and two-person households containing persons of pensionable age (i.e. males 65 or over, females 60 or over). Of the one-person households, 839 were of males and 5,230 of females. Of the two-person households, of which there were 9,648, 7,702 consisted of a male and a female, 109 of two males and 1,837 of two females of whom 591 were both pensionable. Altogether 20,410 persons of pensionable age were in one and two-person households, 11,024 of these containing one pensionable person and 9,386 containing persons both of whom were pensioned.

9. The basis of the Survey which figures largely in this Report was a little different in that it dealt with all people over 65 years of age. The 1961 census figures show that there were 10,177 men and 17,369 women of this age group in the Borough.

10. By and large, the basic services in Lewisham are much the same as for any other large town in England and Wales but their administration is somewhat different as Lewisham is a metropolitan borough. As a result the London County Council is concerned with welfare work through its welfare department and it is also concerned with several of the health services through its health department. These personal health services include health visitors and home helps.

11. The Metropolitan Borough Council up to recently has been primarily concerned with making grants to old people's organisations and clubs and more particularly the Lewisham Old People's Welfare Association, to which a grant of £16,600 is being made in the financial year 1963/64. Further statutory powers were given to the Metropolitan and other Boroughs in 1962, as a result of which Lewisham has established or is establishing various centres for old people, a workroom for the employment of the elderly and a holiday home. It has also taken over the administration of ordinary holidays for old people.

12. The Lewisham Old People's Welfare Association, which was established in 1947, is a progressive body which, besides carrying out direct work for the elderly, helps to co-ordinate the thirty or more voluntary clubs which are also present in the Borough. In addition the Old People's Welfare Association is responsible for the meals-on-wheels service and has more recently started a boarding-out scheme. Additionally, there is a branch of the Women's Voluntary Service which, besides running several clubs, also helps the Old People's Welfare Association with the distribution of meals-on-wheels.

Other voluntary organisations help in various ways.

Method of Investigation

13. Our investigation included enquiries of general practitioners, district nurses and health visitors, studies of the services and visits by some of us to various schemes both local and elsewhere. We also decided that a survey must be made because this would be the only means by which we could ensure that cases of need were discovered. We commissioned the Government Social Survey to do this for us and the King's Fund undertook to pay the cost of £5,000. This particular part of the investigation is referred to as "the Survey".

14. In order to get some experience as to what questions should be asked in the Survey, we made a small pilot enquiry ourselves, using the Women Health Officers of the Borough Council who kindly undertook to do this for us. In this pilot survey, 204 houses were visited, 79 of which had between them 112 elderly residents; 105 of these were interviewed. From these interviews it was possible to make suggestions to the Survey when the questionnaire was being drawn up.

The Survey

15. The terms of reference of the Survey were to carry out an investigation with the objects of discovering the need for, and use made of,

who did not give "working" as part of the reason for refusal were *not* working. If this assumption is correct, it will be seen from Table 4 that there is a higher refusal rate among men who are known to be working than those not working or not giving working as a reason for refusal.

TABLE 4

Proportion of men who are working who co-operated compared with men not working.

Working status	Co-operating %	No. in sample on which % is based
Working	82	130
Not working or not giving work as reason for refusal	86	348
All males	85	478

However, though these proportions are different, the difference is small.

18. As a large number of elderly people would be visited in the Survey, we considered this a valuable opportunity to find out if any were in need of help, the nature of the help and if it could be provided. The Government Social Survey works in strict confidence and therefore could not pass on any information which would disclose names and addresses without the permission of the people concerned. It was arranged therefore that anyone needing help or advice would be encouraged by the Survey interviewer to send a post card (which was supplied) to the Lewisham Old People's Welfare Association. Cards were completed for, or left with, most of the people with whom there were interviews; a very small number refused them. One hundred and ninety-seven such requests concerning various services were received from 145 people. This number proved too much for the Association to attend to by personal visits and only 69 were seen at home; 23 others were interviewed in the office and 53 were answered by letter and though they were sent a reply paid post card asking again for a representative to call if a visit to the office were not possible, nothing more was heard from 34 of them. A few of those visited had no recollection of ever sending a card in the first place. The principal value of this enquiry is the indication it gives as to which services received the most interest. (The main results are summarised in Appendix, Table II).

TABLE 5

Details of the interviews achieved and not achieved

		%
Contacted (directly or through another member of the household)		
Full interview	1,190	86·8
Full interview, too late for analysis	4	0·3
Incomplete interview	7	0·5
Refusal	164	12·0
Non-contact		
In hospital	3	0·4
Subsequently died	1	
Not seen personally, lives alone	1	
	1,370	100

The random selection of the sample and the high proportion of completed interviews afford some assurance that the Survey gives information reasonably typical of the elderly people in Lewisham.

TABLE 6

The mobility of informants at the time they were interviewed and their usual mobility

		%
Bedfast, permanently	18	1·5
Bedfast temporarily, usually housebound	3	0·3
Bedfast temporarily, usually goes out	1	0·1
Housebound permanently	94	7·9
Housebound temporarily, usually goes out	11	0·9
Usually goes out	1,063	89·3
All persons	1,190	100

80% of those who are usually able to get out said that they have unlimited mobility. See Appendix, Table III.

TABLE 9 (b)

Help with shopping for the bedfast

Who helps where there is or would be difficulty	Difficulty in doing own shopping
Helped by:—	No.
Relatives in household	20
Others in household	—
Relatives not in household	7
Friends, neighbours	3
Private domestics	—
Welfare services	—
All sources of help	30
Number of persons bedfast at time of interview getting help	22

Some 90% of old people in the sample who have help with shopping get assistance from relatives, 77% living in the same household and 13% from relatives living elsewhere. 8% having help get it from friends and neighbours and nearly 4% from "welfare services"; in this case the home help service.

TABLE 10

Difficulty with Housework

Difficulty with and help with housework	Bedfast		House-bound		Gets out		All old people	
	No.	%	No.	%	No.	%	No.	%
No difficulty, no-one helps	—	—	5	5	338	32	342	29
No difficulty, has help	—	—	8	8	438	41	447	38
Difficulty, has help ..	22	100	89	84	227	21	339	28
Difficulty, no-one helps	—	—	3	3	60	6	62	5
All persons in sample on which percentage is based	22	100	105	100	1,063	100	1,190	100

TABLE 11 (a)

Source of Help with Housework

Who helps with housework	Difficulty in doing own housework		No difficulty in doing own housework		All persons	
	No.	%	No.	%	No.	%
Helped by:—						
Relatives in household ..	224	66·3	351	78·9	575	73·3
Others in household	6	1·8	13	2·9	19	2·4
Relatives not in household ..	27	8·0	35	7.8	62	7.9
Friends, neighbours	11	3·3	8	1·8	19	2·4
Private domestics	33	9·8	35	7.8	68	8·7
Home Helps	80	23·7	23	5·1	103	13·1
All sources of help	381	112·9	465	104·3	846	107·8
No. of persons having help on which percentage is based ..	338	100·0	446	100·0	784	100·0
No. of persons *not* having help ..	63		343		406	

TABLE 11 (b)

Source of help with housework for the bedfast

Who helps where there is or would be difficulty	Bedfast at time of interview
	Difficulty in doing own housework No.
Helped by:—	
Relatives in household	19
Others in household	—
Relatives not in household	2
Friends, neighbours	1
Private domestics	—
Home Helps	8
All sources of help	31
Number of persons bedfast at time of interview getting help	22

22. The question of social contact for bedfast and housebound old people is important and the 127 informants who were bedfast or housebound were asked to record people who had called on them during the seven days immediately preceding interview. In the 117 cases where information was obtained 10 of the old people said they had not had any visitors in the seven days preceding interview. This does not, of course, mean that they were completely isolated as they all lived in households containing other people, but that they had no visitors other than members of the household in which they live.

TABLE 12

Visits to Old People

No. of days had visitors in 7 days preceding interview	At time of interview		
	Bedfast No.	Housebound No.	Bedfast & Housebound No.
0	1	9	10
1	2	12	14
2	3	9	12
3	3	17	20
4	2	2	4
5	—	13	13
6	2	3	5
7	8	25	33
Had visitors but number of days not known	—	6	6
All bedfast and housebound in sample giving information	21	96	117

See also Appendix, Table VII.

Thus, just under a third of these bedfast or housebound elderly people saw someone other than the people with whom they lived on at least 6 of the 7 days immediately preceding interview. On the other hand, 10 saw no-one outside their own household during the 7 days preceding interview and 26 had visitors on only 1 or 2 of the 7 days immediately preceding interview. Sixty-one of these elderly people had a visitor on either Saturday or Sunday or on both these days.

Arrangement of the Report

23. Our Report is arranged under headings that indicate the main circumstances in which elderly people may require assistance. In each part we discuss the services that are provided to meet the various circumstances, whether they are adequate, whether they are well known and whether we consider improvements are needed.

PART I—SICKNESS

Section A: Sickness needing Hospital Treatment

Section B: Sickness at Home

General Practitioner Service
Home Nursing
Health Visitors
Women Health Officers
Home Help Service
Meals-on-Wheels
Laundry
Night Attendants
Bathing
Chiropody
Sickroom and other equipment
Hearing
Sight
False Teeth
Knowledge of Services available
Knowledge about existence of Old People's Welfare Association
Health Clinic
Day Care & Good Neighbour Service

Section C: Sickness in Welfare Accommodation

PART II—ACCOMMODATION

Section A: Housing
Section B: Boarding Out Scheme
Section C: Welfare Homes

PART III—OCCUPATION AND RECREATION

PART IV—GENERAL

PART I: SICKNESS

Section A. Sickness needing Hospital Treatment

General Background

24. Before the start of the National Health Service in 1948 it was the policy of voluntary hospitals, with numerous specialist staff as honoraries, to concentrate on the treatment of the acutely ill and to avoid the admission of the chronically sick. This was partly responsible for the concentration of the elderly sick in local authority hospitals.

25. It will be remembered that in those days there was not the same outlook with regard to early ambulation as there is now, nor were antibiotics or steroid drugs in use. Thus, many patients were considered irremediable who would not be so regarded today.

26. After 1948, the segregation of the elderly sick as a separate problem arose out of this situation and in the light of the practice which has been developed in the intervening years at Lewisham, one of our main objects was to consider whether it was in the interests of the elderly that this segregation should be perpetuated. Particularly was this so since, with an ageing population, physicians will in future be dealing with an ever-increasing number of elderly people.

The Local Hospital Service

27. Before the National Health Service, three of the four hospitals which now form the Lewisham Hospital Management Committee Group—Lewisham, Hither Green and Grove Park—belonged to the London County Council; the fourth, St. John's, was a voluntary hospital. As was the L.C.C.'s custom in its large hospitals, several wards in Lewisham were devoted to the care of chronic disease; prior to the last war 300 beds out of a full complement of 800 were so used.

28. In 1948 staff shortage and bomb damage had reduced the number of beds in Lewisham seriously and at the start of the Health Service the shortage was largely responsible for the long waiting list which, by February 1951, reached a peak of 198. In the first instance, therefore, circumstances compelled the hospital to look for an alternative to the allocation of numerous beds for elderly chronic sick.

29. During 1951 the waiting list was reviewed and extra beds were opened, some for a time extra to the normal number for which staff was available, in order to meet the immediate need. By the end of that year the number waiting had fallen to 40. In September 1952 regular domiciliary visiting was arranged for preadmission social assessment and these various measures resulted in still fewer waiting; since 1956 there has been virtually no waiting list except during the winter months when exceptionally it has risen to a maximum of, say, 20, involving a wait of up to two weeks. On the last occasion prior to completion of this Report that the state of the waiting list was checked, namely the 17th December 1963, there were no patients waiting.

30. It is important to bear these changes of circumstances in mind because opinions die hard and some local general practitioners probably remember the difficulties they once had to arrange admission to hospital of their chronically ill patients. We believe that this accounts for the generalisation and somewhat sweeping criticism we received in answer to our two enquiries and for which no supporting facts were given.

31. There is now no specific allocation of beds for the elderly sick in Lewisham and the total number of general medical beds available in the Group is 237 (1) including 50 in two rehabilitation wards, one male and one female, to serve a population of about 220,000. However, the Group benefits from having Grove Park Hospital, with 145 tuberculosis and 145 non-tuberculosis beds, which admits cases which otherwise would have to occupy general medical beds.

(1) Increased to 263 in March 1964. The number of rehabilitation beds is being reduced to 38.

Principles and Procedure Adopted by the Hospital Group

32. At this point it is appropriate to set out the views held at Lewisham Hospital, to which hospital the majority of applications for admission on predominantly social grounds are made.

(a) Elderly people are usually best at home under the care of the family doctor, who is a key figure in this scheme, with such assistance from the domiciliary services as may be required. The family doctor is the person best placed, though not always properly equipped, to assess the needs of an individual elderly person. First, therefore, every possibility of enabling the patient to remain at home is examined in the course of *assessment before admission.* The Group's Medical Officers do not feel that admission to hospital for the acute incident

occurring in an elderly patient is necessarily in that patient's best interests.

Following this principle, a system is in operation for dealing with applications for admission.

These are made to the Admissions office and should be supported by a written medical report; in many cases patients are accepted on a verbal report, later submitted in writing. Patients, if they are not already known to the hospital, are normally visited by the hospital Social Visitor, whose report, together with the medical report, will determine the priority of admission or may suggest a more suitable alternative to admission. If the medical condition seems to warrant it, however, the patient may be seen at out-patients' or by a physician at home. Decisions regarding social visits, priorities and suggestions as to alternatives to admission are all made by the Physician in charge of Social Admissions. We want to emphasize that all social admissions are made by or under the guidance of one physician. The general practitioners in the area have been advised of this procedure.

(b) There are times when it is only possible for relatives to continue caring for an elderly sick person if the patient is admitted to hospital for an agreed period whilst they take a rest or a holiday; otherwise they would bear a great burden and perhaps decide that they could not continue to do so. Lewisham arranges admissions of this kind and there were 125 in 1962. These are the only cases admitted direct into the rehabilitation wards, except in times of very heavy pressure on the acute medical beds.

(c) It is a cardinal principle that where admission is necessary it should be arranged at the earliest possible moment. Delays of a few weeks may seriously reduce or even destroy the chance of rehabilitation.

The procedure adopted has worked so well that, as we have already said, there is virtually no waiting list.

(d) It is beneficial for the elderly to be in wards where there are younger people, many of whom can be seen to be benefiting from treatment, and not segregated at the outset as special medical problems because of age. To be in such wards gives them an incentive not to resign themselves to a state of invalidism and much reduced mobility. As already stated, patients are admitted to the general medical wards and it must be mentioned that the wards at Lewisham are the open type; a modern layout, sub-dividing the bed accommodation to some extent, would be beneficial in these medical wards, as indeed it would

be in most of the other units. It is the experience of Lewisham, and we presume of most hospitals, that a large proportion of patients who, when admitted might well have been regarded as long stay cases, respond to treatment and can be discharged to their own homes. Many such cases are transferred to the rehabilitation wards while others who do not respond and who through circumstances cannot return home, remain in the acute wards until it is possible to arrange discharge to, for example, a nursing home with which the Regional Hospital Board has contractual relations, to a terminal home or to some other appropriate care.

(e) Once admission has been decided upon, it is necessary for the almoner, guided by the medical staff, to begin planning for discharge in consultation with the relatives. This is important because at the outset relatives are advised of the help that is available, if necessary, for the proper care of the patient on return home. If return home is not possible, alternatives must be considered.

The medical staff consider that it is largely through following these procedures that the number of long-stay patients remains small.

33. The Lewisham view may therefore be summarised as follows:—

A person should be in hospital only if and so long as he needs the resources which are provided there and nowhere else; thereafter he is best at home with suitable domiciliary care or, if this is not possible, in a home which is not associated with the disciplines of a hospital and has a more homely environment and atmosphere.

Investigations made by the Committee

34. We concentrated our investigations into the arrangements for the local hospital care of elderly people who were ill but not acutely so. We made no specific exclusions and considered that our enquiries would bring to light any difficulties that might arise over cases of all kinds.

35. We started our enquiries by sending a questionnaire to 118 general practitioners, 34 home nurses, 18 health visitors and 3 women health officers, asking them if they considered the hospital, welfare and domiciliary services for elderly people in Lewisham were adequate. The following replies were received about the hospital service:—

Hospital service considered adequate by:—	Hospital service considered inadequate by:—
9 general practitioners	23 general practitioners
17 district nurses	14 district nurses
7 health visitors	8 health visitors
	3 women health officers

36. The doctors were also asked whether they would, with their patients' permission, send us the names of any who were in any kind of need. We received the names of 29 people, 2 of whom were said to be awaiting hospital admission. Enquiries at the hospital showed that both these patients had in fact been admitted by the time the information reached us. The other 27 cases had pension, housing, or other queries of a similar nature, which the Old People's Welfare Association undertook to investigate. Of these 29 cases that were investigated, no inadequacy in the medical or nursing care could be found; the problems were social.

37. These results did not point to any definite path for us to follow. We felt that the more factual evidence which we obviously needed could best be obtained through a house-to-house enquiry, which we hoped would bring to light any people who appeared to be in unsatisfactory circumstances. It would also indicate to what extent people in need of help failed to get it because they did not know it was available. Such cases as were found could then be investigated by one of the organisations represented on our Committee with qualifications appropriate to the apparent need. Interviewers were therefore specifically told that they should make every effort to report, with the patient's permission, any case of need they came across. In the event we were naturally somewhat handicapped by the necessarily strictly confidential treatment of the information obtained by the Survey. People who wanted help over such matters as pension and housing naturally gave their names and addresses for passing on to us. At the same time, even if we could have been given the names of the bedfast and housebound cases, which we were not, we obviously could have done no more than ask them whether they wished to remain where they were; possibly to ask this would have been undesirable in some cases.

38. The Survey completed interviews with 1,190 people over 65; 18 (1.5%) were permanently bedfast and 97 (8.2%) permanently housebound. We sent a second questionnaire to general practitioners asking them, amongst other questions, if they had any patients over 65, who they felt should be in hospital. Forty-three of the 118 general practitioners to whom this questionnaire was sent, replied. The response was, however, probably better than this suggests as a number undoubtedly replied on behalf of their partners. This produced no cases at all though some doctors indicated that they had an unspecified number of patients they would feel happier about if they were in hospital but that the patients would prefer not to be in hospital. It is assumed that this covers many of the estimated 243-447 permanently bedfast patients in Lewisham. All doctors replied "no" to, or left

unanswered, the question "Have any (patients) been refused admission to hospital in the Lewisham Group?".

39. The final question on the form was "Do you think hospital admission facilities for those over 65 in the Lewisham area are satisfactory?". Twenty-seven doctors said they were and though 6 said that they were not and 2 that there was difficulty if the reasons for admission were mainly social, they had no instances at the time. Eight replied that very few of their patients lived in the Borough. We must emphasize that these questionnaires were not specifically concerned with the bedfast and housebound cases we believed existed. Doctors were at liberty to include any of their patients.

40. These results could be taken not as conclusive proof, because not all doctors answered our questionnaire, but as a reasonable indication that there could be very few patients in their homes whom Lewisham Hospital refused to admit.

41. It was possible, and indeed we had heard the criticism, that the geriatric units of neighbouring groups were asked to, and sometimes did, admit patients from Lewisham Borough because beds were not available locally. We were at pains therefore to discover whether this was so.

Of five neighbouring hospital groups, all of which have geriatric units, three told us that at the time of our enquiry no patients from the Borough of Lewisham were in their wards or on their waiting list.

A fourth hospital group had 30 patients from Lewisham Borough. Twenty-eight of these had been admitted from Ladywell Lodge, the L.C.C.'s large Home in Lewisham. The fifth group had 10 Lewisham residents, all from Ladywell. It is unlikely that all of these were living in Lewisham before they entered Ladywell, possibly none of them had been, but their residence in Ladywell brought them within the Lewisham Hospital Group's catchment area.

42. It seemed at first that here was confirmation of the criticism that neighbouring hospitals were helping the Lewisham Group. But, as we show in paragraph 143, these admissions were made so that Ladywell could accommodate the patients from these hospitals, and we are satisfied with this explanation.

43. We found that of the two Lewisham residents who had not been in Ladywell, one was accepted by a neighbouring hospital because she was a relative of a member of the staff and the other was admitted without any prior reference to Lewisham either by the general practitioner or the hospital. There is therefore no evidence to support

any allegation that neighbouring geriatric units admit Lewisham patients whom local hospitals refuse.

44. A second criticism of the Lewisham Hospital Group arrangements has been that patients are being discharged home when they should not be. The gravamen of this criticism is that because the Lewisham hospitals take all elderly patients into the acute medical wards (on which there is constant pressure) the medical staff are naturally always anxious to discharge these patients as soon as possible. The chronic elderly sick therefore suffer as their pace of recovery or rehabilitation is necessarily slower than that of younger patients.

The hospital authorities realise that this danger exists, particularly among younger staff fresh from a teaching hospital, with little or no experience of the needs of the elderly chronic sick. Being aware of the danger, the senior medical staff do their utmost to counter it and to imbue their juniors with their own readiness to take as much interest in elderly chronic patients as in the others. This also applies to the nursing staff.

Although the question was not specifically put in the questionnaire, there was no indication in answers from general practitioners to support this criticism nor in the replies obtained by the Survey. Some cases are transferred to nursing homes with which the Regional Hospital Board has contractual relations, but this seems to us to be reasonable. Such accommodation is very limited in this hospital region and when we made a check on 30th November 1962, we found that there were 16 patients from Lewisham hospitals in contractual beds.

45. Whatever may be the different opinions on early discharge, our enquiries have not found patients at home and in need and therefore in Lewisham patients seldom require early re-admission. It is a reasonable corollary that it may well be that early discharge from hospital, like early post-operative mobilisation in other fields, is an unpopular but beneficial part of treatment.

46. We paid particular attention to length of stay in hospital. On two occasions, April and September 1958, there were in the Lewisham Group, 2 and 6 patients respectively whose stay had been more than six months. In comparison with this, there were on 30th September 1958, 2,728 such patients in hospital groups with geriatric units in Greater London; an average of 124 per hospital management committee group.

47. A third criticism we investigated was that it is because Ladywell Lodge admits and keeps more elderly residents of Lewisham Borough than it and other Homes do of other boroughs, that Lewisham Hospital Group have few long stay cases.

The London County Council Welfare Department kindly allowed us the use of their records, from which we extracted the following figures, which represent a 1 in 3 sample, showing the number of former residents of 65 and over of Lewisham and its three neighbouring boroughs who were in welfare accommodation at the end of June 1962:—

Bermondsey	.. ..	48 or 1 in 1,084 of the population
Camberwell	.. ..	665 or 1 in 263 of the population
Greenwich ..	.. ..	125 or 1 in 684 of the population
Lewisham ..	.. ..	430 or 1 in 515 of the population

These figures do not support the criticism that Lewisham Hospital Group is helped by Welfare Homes more than other areas are.

48. We considered it essential to compare statistically the results of Lewisham's methods with those in the three neighbouring boroughs. Is Lewisham using proportionately more or fewer beds and are more or fewer patients being admitted than in the neighbouring boroughs? The South East Metropolitan Regional Hospital Board kindly lent us their Hospital In-Patient Enquiry admission cards for 1959 and 1960, some 6,000 in all. The King's Fund authorised the payment of a fee to International Computers & Tabulators Ltd. to process these cards and throughout this operation we had the guidance of the Regional Hospital Board and the Ministry of Health.

49. The following Table shows the admission and occupied bed rates per 1,000 population over 65 years of age in 1959 and 1960 in Lewisham and three neighbouring boroughs.

TABLE 13

Admission and occupied bed rates per 1,000 population over 65 years of age 1959 and 1960.

Borough	Population	Average number of admissions per 1,000 pop. over 65 years of age	Average number of occupied beds per 1,000 pop. over 65 years of age
Lewisham Met. Borough	222,000	128	10·15
Greenwich Met. Borough	86,000	151	16·45
Camberwell Met. Borough	175,000	144	16·86
Bermondsey Met. Borough	52,000	187	20·15
Mean total Greenwich, Camberwell and Bermondsey		152	17·25

50. From these figures, which show a lower admission rate and a shorter length of stay in Lewisham, the only conclusion that can safely be drawn is that there is a different situation existing in Lewisham which, taken in conjunction with other conclusions of our Committee, make it desirable to test whether there is over-admission to hospitals in other places and whether once admitted patients are kept longer than is necessary.

Ministry of Health Plans

51. During the course of our work the Ministry of Health published "A Hospital Plan for England and Wales", paragraph 24 of which reads as follows:—

> "Each district general hospital will include an active geriatric unit. It is through this unit that elderly people likely to require prolonged treatment will usually be first admitted. Others will be transferred to it from acute wards. Normally some beds for long-stay also will be at the district general hospital; but limitations on the size of the main hospital or its distance from smaller towns which it serves will often justify long-stay annexes on separate sites or geriatric provision at small hospitals."

52. It would appear from this that the Lewisham Hospital Management Committee are failing to carry out what the Ministry of Health envisage.

Certain members of the Committee, having discussed this with representatives of the Ministry of Health, do not believe this would be so even if Lewisham make no changes. Our impression was that the extent to which geriatric units are introduced in existing hospitals would continue to depend much on the careful consideration of the need in the light of particular circumstances, the primary criteria being whether the needs of the elderly are being satisfactorily met.

53. In addition to the foregoing we also considered paragraph 16 of the Hospital Plan in relation to Lewisham:—

> "There are at present considerable divergences between different areas in the provision for geriatric patients within a national average of 10·8 beds per 1,000 persons aged over 65. It appears, however, from studies conducted by the Ministry of Health that in areas where the whole range of services for the elderly inside and outside hospital is well developed, the necessary hospital provision is being achieved with about 10 hospital beds per 1,000 persons aged over 65, which is equivalent to 1·4 beds per 1,000 total population as estimated in 1975. With the further

development of active treatment and rehabilitation and the wider and fuller provision of services for the elderly outside hospital, this ratio (1·4 beds per 1,000 total population) should be adequate or more than adequate generally and should cover the provision required for the elderly confused who do not need treatment in a psychiatric hospital. It has to be applied with due regard to the assessment of the numbers over 65 in the 1975 population of the respective regions."

54. Applying these figures to Lewisham, where in 1961 there were 27,500 people over 65, the number of beds required would be 275 now and about 315 in 1975. Comparison with Lewisham is difficult as there is no specific allocation of beds for the elderly. The total general medical beds is, however, 237, excluding 145 chest beds (non-tuberculosis), so theoretically it would seem that the number available for patients, who in other areas would be classed as geriatric, is considerably below the estimated requirements. This is among the points we discuss in the following paragraphs.

Discussion and Opinion

55. We have considered this apparent deficiency between the number of beds for general medical use in the Lewisham Hospital Group and that required in other areas and the sources from which additional beds might be filled if they were provided as a geriatric unit.

56. We have no evidence that there are patients needing but being refused hospital admission. If there are any there must be very few from this source to occupy additional beds (paragraph 38).

57. There are patients in the medical wards of Lewisham, St. John's and Hither Green Hospitals who could be brought together. These patients already occupy hospital beds so their number does not represent any deficiency in beds. Whether they would benefit from being together is a matter of opinion. The Lewisham Hospital Group's view is that it is beneficial for the elderly to be in wards where there are younger people (paragraph 32 (d)). That the results of Lewisham's method, of which this is a part, are satisfactory is shown by the few patients who need to stay more than six months compared with the number of long-stay cases in many geriatric units (paragraph 46).

58. There are, at any one time, some 80 patients in the sick bay at Ladywell Lodge who, according to the Ministry of Health Memorandum No. HM (57) 86, would appear to be the responsibility of the

hospital authority (paragraph 144). We have commended a review of the existing demarcation between hospital and welfare responsibility to enable patients of this kind to remain in familiar surroundings. We would not therefore support any proposals to transfer patients from this source.

59. We have considered the needs of patients in the terminal stages of illness. Although such cases are not refused admission to Lewisham hospitals, arrangements are at times made for Lewisham Borough residents to be admitted to special Homes in Clapham and Hackney, where they are treated with great humanity and understanding. But, because of the distance involved, this arrangement can cause inconvenience to relatives and friends wishing to visit the patients. We are agreed that accommodation for such cases should be separate from hospital buildings, should have an entirely different character from a general hospital and should admit patients other than those who are dying. We understand that plans are already well advanced for the establishment of a Home under voluntary auspices on the border between Lewisham and Beckenham and this we welcome. The admission of terminal patients to a purpose-built home is, we consider strongly, usually preferable to admission to ordinary geriatric wards.

60. The foregoing reasons satisfy us that there is no source from which any additional beds should be filled in Lewisham and the ratio (1·4 beds per 1,000 of the total population) is more than adequate.

61. We have given much consideration to the question of a geriatric unit. We believe that geriatric units were set up in many areas as a speedy and convenient method of beginning to meet the special needs of elderly patients. But in Lewisham, as we see it, these needs are now being met satisfactorily. Some of us believe that the existence of a geriatric unit might even be a disadvantage. The fact cannot be ignored that at, for instance, 30th September 1961, 3 patients awaited admission to Lewisham compared with an average of 33 in each of the 25 geriatric units in Greater London.

62. There is the fact, too, that as the Report on Hospital In-Patient Enquiry for the year 1960 shows, 42% of patients in general medical wards are over 65 years of age. It might therefore be asked how segregation in the future will be made when more and more patients in medical wards are elderly. The future population of Lewisham, as in the rest of the country, will include an increasing number of elderly people but it is clear that these elderly people are much healthier

than those of a similar age in past decades. The average age of those entering hospital will tend to be higher than at present.

63. There is in geriatric units, we believe, the temptation to unnecessary over-expansion and the danger of relieving general physicians of responsibility. The result may be that the true interests of the elderly patient, especially his need to be restored to a condition in which he can return home, take second place.

64. When a hospital group has a geriatric unit there is only a limited number of allocated beds into which such patients are admitted. It often happens that their admission to acute medical wards when the geriatric unit is under pressure is resisted. Thus, a geriatric or chronic sick waiting list may build up; Lewisham avoids this. We believe that the flexibility of hospital beds, used in the way they are in Lewisham, renders the easier admission of all those who require hospital care. We would emphasize once more that speedy admission of the old is of cardinal importance.

65. More liaison and co-operation between many agencies are needed in connection with the elderly than with any other group of people. The link between hospital and home must be more definite where the elderly are concerned than with, for example, the ordinary surgical patient who on discharge from hospital has no further connection with it apart, perhaps, from a follow-up. We are satisfied that this is achieved in Lewisham within its present system and we dissent from Memorandum H.M. (63) 24 published by the Ministry of Health on 14th March 1963. In paragraph 7, the Memorandum says "It is useful if one or more officers of the local authority are specially designated as responsible for mobilising the Community Services, including the Voluntary Services, for patients on discharge from hospital." This, we suggest, is too impersonal a procedure and we prefer the direct contact of Almoner with the organisers of the local authority or voluntary services that are actually required and the general practitioner. Each patient is a special case and to arrange the right help for him needs the first-hand knowledge of the hospital staff who are at present responsible for his treatment and care.

66. The Special Committee were under the impression that often hospitals are unable to send cases to welfare accommodation. There is a waiting list for admission to welfare accommodation and being an in-patient in hospital does not grant priority to admission to Part III.

67. Another point of the Special Committee was that there is at times, in so far as old people are concerned, not enough active treatment.

We do not think this can be said of Lewisham. We think that there is a danger of this arising in areas where the geriatric unit is not near a general hospital. The various services for active treatment would not therefore be readily available. Lewisham's method of admitting patients to acute wards would enable them to receive any treatment that is necessary.

68. A further impression of the Special Committee was that acute beds may be blocked by long term cases. As we have already reported, Lewisham Hospital Group is successful in transferring to more suitable accommodation patients who would block acute beds for an unreasonable time.

69. The results of our investigations lead us to the definite opinion that the present arrangements for the elderly sick in Lewisham are satisfactory. Our opinion is based on the fact that:—

(a) There is no evidence to show that there are patients at home who need hospital care which is refused them (paragraph 38)

(b) There is no evidence that neighbouring hospital groups are admitting patients whom Lewisham hospitals refuse (paragraphs 41—43)

(c) There is no evidence of premature or unsuitable discharge from Lewisham hospitals (paragraphs 44—45) But we recognise that in individual cases opinions can differ both from the medical as well as the social aspect. Such differences would not be peculiar to Lewisham.

(d) There is no evidence that the London County Council gives more help in Lewisham than in other boroughs (paragraph 47)

(e) As patients seldom have to wait for admission, the present number of beds is adequate for the inclusion of patients who require hospital admission for social reasons. It seems possible that in some areas there is over-admission (paragraphs 36 and 50)

During the four and a half years of the Committee's enquiries no organisation represented among us, nor elsewhere, has found any case which would cast doubt on the efficacy of the hospital procedure in Lewisham.

70. In a field of such growing importance as that of the care of the aged in hospital there is much virtue in experiment. The experiment in Lewisham we have now described seems to us to be proving success-

ful but the hospital authorities in Lewisham would be the last to claim that they alone are responsible. Services are inter-dependent and Lewisham Hospital Group is well supported by other services, which makes its own work easier. The hospital authorities would not deny that improvements could be made in their present methods.

71. We hope it might be possible for an investigation such as ours to be made in the area of an orthodox geriatric unit and, unless that investigation showed that the arrangements in Lewisham fall substantially below the level attained in the other area, we could not commend change in the present system in Lewisham.

GERIATRIC BEDS AND GERIATRIC UNIT

Certain Views of the Minority of the Committee

We disagree with the majority of the Committee on certain matters in Part I, Section A (sickness needing hospital treatment), and especially on the number of hospital beds needed for the elderly, and on the decision against recommending a geriatric unit. The 'geriatric' patient as considered here does not include the acute medical or the ordinary surgical case which of course should be admitted to the ordinary beds of the hospital.

On the number of beds for the elderly required in the area, we think the more reasonable and accurate approach is to take the figures produced by the Ministry as a result of various national surveys and disagree with them, if this can be done, in relation to their application to Lewisham. The majority of the Committee on the other hand think that merely because there is no obvious evidence of a deficiency in beds the number of beds is thereby sufficient.

There have been various official suggestions on the required number of geriatric beds, one of the latest and most authoritative perhaps being contained in the Ministry plan for the reconstruction of the hospital service which was issued in January 1962 (1). Here it is stated that there are considerable divergencies between different areas within a national average of 10·8 beds per thousand persons aged over 65. From studies it appears that in areas where the whole range of services for the elderly inside and outside hospitals will develop, the necessary hospital provision should be about 10 hospital beds per thousand persons aged over 65 or 1·4 beds per thousand total population as estimated for 1975.

Applying these figures to Lewisham, where in the 1961 census there were 27,500 people over 65, the number of geriatric beds required would be 275; on the basis of 1·4 per thousand total population in 1975 (assuming this to be 225,000), the requirements then would be 315 geriatric beds.

The total number of geriatric beds now present is not known because of the combination between geriatrics, general medical and other medical specialties, but since the total number of beds of all these specialties including geriatrics but apart from chest disease, was in 1963 only 237, it is clear that there must theoretically be a considerable deficiency in beds for geriatric purposes. The majority of the Committee think that the need for these additional beds does not exist, but we take the view that the evidence can be regarded as pointing another way. Surrounding areas which have geriatric units have no difficulty in filling their beds. This, the majority say, is due in the main to the supply creating the demand and this they seem to think is wrong. On the other hand some evidence we have had from an earlier investigation indicated that many doctors thought it was so difficult to get patients into hospital here that they had given up putting them on the waiting list. It might in other words be that the "gearing" for easy admission to hospital in Lewisham differs from what it is in other areas where there is a geriatric unit, and over the years this has had a depressing, and perhaps unfortunate, effect on demand.

It would appear likely that there is an immediate deficiency of at least 150 *ad hoc* geriatric beds, and that in fact this deficiency is likely to increase before 1975. If there were the 150 beds now they could be filled by:—

(1) About 60 patients now scattered in the medical wards of Lewisham, St. John's and Hither Green hospitals, who could more appropriately be in geriatric wards.

(2) About 60 patients (less a proportion who are strictly non-Lewisham residents) in the sick bay at Ladywell.

(3) An unknown number of patients (perhaps a dozen) in hostels for the dying, including Hackney and Clapham, but who themselves (and their relatives) might well prefer to be near their homes.

(4) An unknown number of patients (again perhaps a dozen or more) who because of difficulty in securing admission to hospital (the emphasis at present is apparently on keeping borderline cases out rather than bringing them in), are an unreasonable burden on relatives at home. This applies both to the dying and to the chronic sick.

(5) An unknown number of patients at present bedbound in mental hospitals outside the borough but who, because they cannot return home for some special reason, would be better off in long-stay psychiatric wards of the unit, being nearer their relatives. This group would not of course include cases of advanced mental abnormality.

(6) A few patients who now will only agree to going to hospitals outside the borough (e.g. King's) but who would be more likely to welcome hospital treatment in a geriatric unit in the borough, or to be transferred to such a unit from the teaching hospital concerned.

In general, we hold the view that there is ample material in the area for the establishment of a unit, that a unit once established would prove popular with relatives and beneficial to patients, and that the unit would be likely to grow through ordinary reasonable demand as time passed.

One of the basic principles in favour of such a unit is that elderly people in wards of their own are subjected to an emphasis on being up and about, on occupation and on social life, which emphasis cannot be so effective in wards where there are acutely ill people. It is germane to the argument to know (as is pointed out in the main report) that in a booklet issued by the Ministry of Health entitled Services Available to the Aged and Chronic Sick (section 9—hospitals) (2) it is stated that those planning new general hospitals will be urged to include, wherever possible, the admission wards of the geriatric unit within their walls. Here patients will be diagnosed, assessed and given initial treatment and will continue their rehabilitation within other wards of the same unit. A long-stay annexe may be sited in separate wards or even in an adjoining hospital. The booklet states: "It is the tempo rather than the nature of the treatment which distinguishes the geriatric from the general medical wards, and the geriatric physician is concerned with the sociological factors influencing disease in the elderly." We would underline this question of the tempo as we think it is fundamental. A retired person is not in such a hurry as a younger person and the longer he has been retired, the less of a hurry he is likely to be in. A high tempo is inherent in any acute hospital ward and it is only in the calmer, less rushed, atmosphere of a geriatric unit which has a sufficiency of beds, that the correct tempo for the elderly person can be maintained. This applies equally well to the celerity of discharge as it does to the tempo of treatment.

Advice on the composition of a geriatric unit has been brought up to date in the recent Ministry publication on the reconstruction

of the hospital service (already referred to). It is there stated that each district general hospital will include an active geriatric unit. (3). It is through this unit that elderly people likely to require prolonged treatment will usually be first admitted. Others will be transferred to it from acute wards. Normally some beds for long stay also will be at the district general hospital, but site difficulties may justify their being placed elsewhere. The official view shown in the plan is backed by the non-Governmental "Porritt" report (4) issued in October 1962 which states: "Seriously ill old people should be admitted to the acute medical or surgical wards. Those suffering from degenerative diseases should be admitted to special geriatric units attached to general hospitals."

We think that the degenerations of old age are of sufficient importance and sufficiently specific to justify their inclusion, with advantage, in a specialty of geriatrics. It is true that many degenerations of old age start at a much earlier age, but other factors, environmental and otherwise, which affect elderly people make the treatment and management of such people showing degenerative changes a special problem of its own. There are also factors which do not in any event apply to similar degenerative changes in, say, middle age.

A point is made in the main report that it is psychologically better for the elderly themselves to be in wards where there are younger people, many of whom the old person can see are benefiting from treatment. The argument in our view may be specious as the old person is quite as likely to think that it is because the younger person has the advantage of age that he is doing well; it is more probable that if he sees a person of his own age recovering say from a stroke or from urinary incontinence he will think that if it can occur to that person it can occur to him. It is the staff of the unit who can and do provide this stimulating atmosphere.

On the question of a geriatric unit as such as opposed to geriatric patients being scattered through the general wards of various hospitals under the care of several different consultants, the logical conclusion is that there should be one geriatric physician of consultant status in charge. He could then take a panoramic view of all the factors concerned with the welfare of the elderly, whether medical or sociological, and merely through being the one person in charge he is more able to coordinate his work with that of the numerous other authorities in the area concerned with the care of the individual old person—the local health authority, the local welfare authority, the metropolitan borough council, and various voluntary agencies. Of all medical specialties geriatrics is the one which most needs liaison with outside agencies. It is not essential, though highly desirable, that the physician should be concerned only with geriatrics, but he is unlikely to be able

to give the necessary detail to his work if most of his time is spent in other specialties or if geriatric patients are also being dealt with by several other physicians in the hospital.

For a geriatric unit to function well it is necessary to have a specialist who is prepared not only to direct matters in his own hospital and perhaps have his own staff of physiotherapists and other ancillaries, but who is also prepared to work in close liaison with other statutory and voluntary bodies, perhaps being either himself or by his representative on some of the main committees. The statutory bodies will, we are sure, recognise the advantages of this and we are equally sure that some devolution of their sovereignty could be arranged. In other words the consultant would be permitted by himself or through his staff to deal with certain forms such as are required administratively in the home help and other services before support of this nature can be enlisted. This would cut down the amount of work and time required in getting such services into motion, again with benefit to the patient and to the public generally.

ANN MOWER-WHITE
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References

(1) Cmd 1604 HMSO 1962 p5.
(2) Ministry of Health July 1961 pp9 and 10.
(3) Cmd 1604 HMSO 1962 p7.
(4) A Review of Medical Services in Gt. Britain, Social Assay, London, 1962.

PART I: SICKNESS

Section B. Sickness at Home

The General Practitioner Service

72. The general practitioner service is of first importance for patients at home whose illness merits a doctor's attention. The doctor's attendance will depend first on whether the patient or his relatives ask him to call or inform him of the illness and secondly on whether the doctor himself considers it necessary. An enquiry into this was not a matter for our Committee but, in order to get a general impression on the service, the Survey asked respondents whether they see their doctor regularly, how often they see him, when they last saw him and, of the bedfast and housebound, how they get in touch with him if he does not call regularly and they want him. Fifteen of the bedfast said their doctor calls regularly and the remaining 7 that they send for him when they need him. Forty-five of the housebound said he

calls regularly and 60 that they send for him when necessary. Of the 67 bedfast and housebound who send for their doctor when they need him, 44 get a neighbour or a relative to call at the doctor's surgery and 23 telephone him. All said they never have any trouble in getting the doctor to call.

TABLE 14

Visits to Patients by General Practitioners

	Bedfast	Housebound	Bedfast and Housebound	
	No.	No.	No.	%
More than once a week	—	1	1	1·7
Once a week	6	4	10	16·6
Every 2 or 3 weeks	5	16	21	35·0
Once a month	3	24	27	45·0
Less than once a month	1	—	1	1·7
All bedfast and housebound visited regularly by doctor	15	45	60	100·0

It will be seen that nearly 98% of all those bedfast or housebound who are visited regularly are visited at least once a month and over 18% are visited once a week or more often.

73. 23% of those who were able to get out at the time of interview said they saw the doctor regularly. Whether those getting out see a doctor regularly or not appears to be independent of age, although a slightly higher proportion of women see doctors more regularly than do men (25% of women compared with 19% of men).

TABLE 15

Frequency of doctor's consultations by those who can get out, where consultations are regular

Frequency of consultation	People able to get out	
	No.	%
At least once a week	16	7
Every two or three weeks	63	27
Once a month	99	42
Once in 2-3 months	46	20
Less than once in 3 months	10	4
All having regular consultations	234(1)	100

(1) Excludes 3 not answering.

74. Four of the 10 people who see their doctor regularly, but as infrequently as once in 3 months, are aged 65-69, and the other 6 are 70-74. There is, however, no other indication in the original data to suggest that the frequency of doctors' consultations rises in the older age groups where people are able to get out.

Eight hundred and twenty-five people who were able to get out but who said they did not see their doctor regularly were asked the last time they had seen him, their answers being shown in the following table:—

TABLE 16

Last occasion doctor seen by those able to get out who do not see doctor regularly

Last time doctor seen	Able to get out but not seeing doctor regularly	
	No.	%
Within last week	49	6
Within last month	117	15
Over 1 month ago	140	18
Over 3 months ago	139	17
Over 6 months ago	115	14
Over 1 year ago	228	30
All able to get out but not seeing Doctor regularly	788(1)	100

(1) Excludes 37 not answering.

Over 20% of those who can get out but do not see the doctor regularly have consulted him within the last month.

We think this service works well. **Conclusion**

Home Nursing

75. Home Nurses from the Ranyard Nurses (an organisation who receive a grant from the London County Council) may be provided on the application of the patient's doctor. It would seem that whether he applies or not depends on his opinion as to the ability and desire of relatives to give adequate attention. Nine permanently bedfast patients in the Survey were attended by a nurse although each lived with daughters, daughters-in-law or other members of the family, as did the other 9 who had no nurse.

76. So far as we have been able to discover, home nurses are provided without difficulty, but the time a nurse can spend with an elderly patient is limited. It is clear that by herself a nurse will not be able to provide enough care to enable a patient to remain at home instead of being admitted to hospital unless there are relatives in the house able and willing to give sufficient attention.

77. As might be expected, it was found that this service is well-known, particularly amongst those who might be likely to need it. In the Survey all the permanently bedfast patients knew of it and 87% of all respondents.

78. In view of the limited time a nurse can devote to each patient we think that there may well be a useful field here for expansion (see paragraph 103). We know that there are already volunteers and we hope that home nurses will call on such help increasingly. (See Appendix, Tables VIII and IX). **Conclusion**

Health Visitors

79. The Health Visitors' main duties are based on the Ministry of Health Circular 118/47 dated 10th July 1947, which states:—

> "Under Section 24 of the National Health Service Act it becomes the duty of the local health authority to provide a complete health visitor service for the purpose of giving advice as to the care of persons suffering from illness (which by definition in Section 79 includes mental illness and any injury or disability requiring medical or dental treatment or nursing) to expectant and nursing mothers and to mothers and others with the care of young children. She will be concerned with the health of the household as a whole, including the preservation of health and precautions against the spread of infection, and will have an increasingly important part to play in health education. She will work in the closest co-operation with the family doctor."

80. The nature of a health visitor's duties has been explained in the Report of a Working Party on the Field of Work, Training and Recruitment of Health Visitors, of which Sir Wilson Jameson was Chairman. This Report makes it clear that the health visitor should be truly a medico-social worker, playing a full part in both preventive medicine and social action. Her relationship with the general practitioner will be more like that between consultant and almoner in hospital than the relationship of doctor to nurse. She can do much to help the aged, whether or not in need of medical care and, if she has the practitioner's backing, may extend her usefulness without great difficulty to patients who are

bedfast or who are suffering from chronic illnesses of a less disabling order.

81. Much of the health visitor's work must consist of co-operation with the welfare organisations and the welfare department of the local authority. She should be called in wherever there is a health problem with which she can assist or should herself call for the help of the appropriate organisation when, as may often be the case, she is first on the scene. We are aware that there is a considerable shortage of health visitors and therefore it may be difficult, particularly in some areas, for health visitors to attend to all the duties for which they are required. It is essential for them not to be called on to undertake work which is definitely outside their province.

82. In the Survey there was little reference to health visitors. Probably the interviewers did not always specifically mention them when they were asking elderly people where they first heard of the various services, but the only time health visitors are mentioned is in connection with chiropody.

83. We are concerned that, according to the evidence, the health visiting service is not taking more part in the domiciliary care of old people. We hope the Ministry of Health will see their way to giving more precise guidance to local authorities on the relation of this service to elderly people. **Conclusion**

Women Health Officers

84. Women health officers are employed by the Borough Council. They deal primarily with the deteriorating case with a view to prevention of further deterioration down to the compulsory removal stage under Section 47 of the National Assistance Act, 1948.

We think this service works well. **Conclusion**

Home Help Service

85. Local health authorities have the power to make arrangements to provide domestic help in households where it is needed owing to illness, confinement, or the presence of children, old people or mental defectives. This is not one of the free services and authorities are empowered to recover from those assisted such charges as the authorities consider reasonable, having regard to the person's means. A scale of assessment is used but in fact most cases are not charged.

86. In Lewisham, there are two Home Help Organisers, one for the eastern half and the other for the western half of the Borough. Home helps give assistance with essential domestic work including, where

necessary, preparation of meals, light domestic laundry and shopping. It is no part of a home help's duty to give personal attention to a patient. Thus, as with district nurses, a home help alone may not be enough to keep a patient at home who is without relatives.

87. One hundred and four people in the sample (8·8%) said they had a home help. (1) As is to be expected, a higher percentage of those bedfast or housebound had the services of a home help than did those who could get out.

TABLE 17

Use of the Home Help Service

Use of home help service at time of interview	Bedfast		Housebound		Gets out		All degrees of mobility	
	No.	%	No.	%	No.	%	No.	%
Has home help	8	36	27	26	69	6	104	9
Had home help, but not now	3	14	6	6	39	4	48	4
Never had home help ..	11	50	72	68	955	90	1,038	87
Number of people on which percentage is based ..	22	100	105	100	1,063	100	1,190	100

TABLE 18 (a)

Domestic circumstances of those having home help

Mobility	Living alone		Living with others		All types of households	
	No.	%	No.	%	No.	%
Bedfast or housebound:						
Have home help	14	56	21	21	35	28
No home help	11	44	81	79	92	72
All bedfast or housebound	25	100	102	100	127	100
Able to get out:						
Have home help	25	10	44	5	69	6
No home help	230	90	764	95	994	94
All able to get out	255	100	808	100	1,063	100

(1) The proportion of 8·8% of old people in Lewisham having home helps is significantly higher than the proportion calculated for all county boroughs in England (4·3%) and all county councils in England (3·8%). ("The Effects of Population size on Local Authority Services", Myra Woolf, Local Government Commission for England (unpublished)).

TABLE 18 (b)

Domestic circumstances of the bedfast who have home help

Bedfast at time of interview	Living alone No.	Living with others No.	All types of household No.
Have home help ..	1	7	8
No home help ..	1	13	14
All bedfast at time of interview	2	20	22

Hence, 11 of the 22 people bedfast have used the home help service and 8 had the services of a home help at the time of interview. Thirty-three of the 105 housebound people in our sample have used the service, 27 having a home help at the time of interview. Of the 14 bedfast people who had no home help, 13 had families who might reasonably be expected to cope with housework, shopping and cooking. Twenty-four of the 104 informants having home helps said they would like more frequent or longer visits. (See also Appendix, Tables X XI and XII).

88. Those not having home helps were asked if they could get enough help with shopping, meals and housework etc. or whether they needed someone like a home help to come in regularly. Fifty-six of the 1,086 informants not having a home help said they would like someone to come in regularly, although 9 of the 56 said they could not afford to have one.

89. The home help service is well-known. All the permanently bedfast patients in the Survey knew of it and 93% of all respondents. Twenty-three of the 197 services, about which the Old People's Welfare Association received enquiries, were in respect of home helps.

Conclusion

The demand for this vital and well run service is growing but restriction is inevitable because insufficient numbers of suitable people are offering themselves for this kind of employment.

Meals-on-Wheels

90. The provision of hot meals to people in their own homes is undertaken by voluntary associations, but the local authority has concurrent power and may also give financial support to these associations.

91. In Lewisham, the meals-on-wheels service is organised by the Lewisham Old People's Welfare Association, assisted by the W.V.S. and other voluntary bodies. The scheme operates from Monday to Friday and each old person getting meals is visited on two days only. They can, if they so desire, take two meals on each day, saving one for the following day. The charge to the old person is 1s. 1d., the balance of the cost being met by the Borough Council.

92. There are seven luncheon clubs in Lewisham where elderly people who are members of the club can obtain a hot meal. At the time of interview only one of these was a permanent club serving meals each day, Monday to Friday. At the other clubs meals were served one day a week. The charge to old people is 1s. 1d. a meal.

Of those who have or would have difficulty getting meals, all the 22 bedfast, 56 of the 61 housebound and 66 of the 73 who were able to get out, say they have help in getting meals, leaving 5 housebound and 7 able to get out who have difficulty in getting meals and have no-one to help them. There would also appear to be 12 people having difficulty in getting meals, as will be seen from the following table. If all such in the Borough were assisted in this way it would mean an increased demand on this service to old people of about 60%.

TABLE 19

Difficulty in getting meals

Difficulty with and help in getting meals	Bedfast		Housebound		Gets out		All	
	No.	%	No.	%	No.	%	No.	%
No difficulty, no-one helps ..	—	—	23	22	538	51	561	47
No difficulty, has help ..	—	—	21	20	452	42	473	40
Difficulty, has help	22	100	56	53	66	6	144	12
Difficulty, no-one helps ..	—	—	5	5	7	1	12	1
All persons	22	100	105	100	1,063	100	1,190	100

(See also Appendix, Tables XIII and XIV).

94. We are informed that in fact this service is continually undergoing expansion in accordance with the known demand.

Only 7 requests for information about the service were made to the Old People's Welfare Association following the Survey but, although the figures we have quoted are too small to give a reliable estimate, it seems likely that there are upwards of 200 elderly people in Lewisham who have difficulty in getting meals and many of these would have the service if they could. We recommend that those who operate this

Conclusion

service investigate this and also make enquiries as to the local need for meals to be supplied at weekends, as is done in some areas.

Laundry

95. The evidence we received indicated that in the Borough of Lewisham the washing of articles of bedding or clothing of incontinent persons is being done adequately at the Council's Disinfecting Station. The number of new cases for whom washing was done increased each year from 1951 until the demand appeared to be more or less stabilised seven years later. The service is free.

96. It is always difficult to get private laundries to accept work of this nature and it is also difficult for relatives or others to do the washing at home. It was because of the great need for such help that the Borough Council decided to deal with the work, as far as practicable, under Section 122 of the Public Health (London) Act 1936. The Survey felt that old people would be put in an embarrassing position if they were asked directly if they were incontinent, and that the answers would not be reliable as some people are understandably reluctant to admit this condition exists.

97. The investigation was confined on this point to those who were bedfast, and interviewers were instructed to ask the person responsible for looking after the people concerned whether they soiled the bedclothes. The question was asked when the interviewers and the person responsible for looking after the old person were out of sight and hearing of the person concerned. In the 17 cases where the question was put, 8 said the subject did soil bedclothes and 9 said they did not. Asked if this soiling of bedclothes caused any special difficulties, only 1 of the 8 said no, 2 said no because they used the special laundry service and 5 said there were difficulties. Two said the difficulty was a financial one as laundry costs were expensive. Two find the washing difficult as they have no washing machine or copper; one boiling the sheets in a bucket on top of the cooker. One person said that sometimes she feels at the end of her tether through having to wash soiled linen.

98. It would appear, therefore, that there is a small but very real need for this service, which collects soiled linen one day and returns it laundered the next day. This may be particularly important as it means the old person can manage with, say, 2 pairs of sheets. However, this service does not appear to be fully used.

Conclusion

We have no recommendations to make but we hope this valuable service will be made known among the various agencies who have cases likely to need it.

Night Attendants

99. At times, attendance on elderly persons is needed at night and it is possible to obtain such an attendant through the Home Help Organisers. The service is primarily to give relatives of the patient a rest from disturbed nights and is limited to not more than two nights a week for each patient.

We understand that the demand is not heavy and can be met by the present resources. **Conclusion**

Bathing

100. Washing and bathing can be a real problem for those who are incapacitated. Only 4 requests were made to the Survey for information about help with bathing but the Survey underlines that it is not so much with the bedfast that difficulties exist, because they usually have the help of home nurses or relatives, and often both, but with the housebound. Many live alone and few merit the attendance of a home nurse and, though they are otherwise fairly independent, they cannot bath themselves.

101. Of the 22 bedfast people in the Survey, only one could get the water to wash herself. Five others could wash themselves but members of the household have to bring them the water. Sixteen of the 22 bedfast people in the Survey could not wash themselves, 9 are washed by the district nurse, 6 by members of the household and 4 by relatives who are not living with them. Three of the 16 not able to wash themselves are helped by both the district nurse and either a member of the household or a relative living outside the household.

102. Thirty-one of the 105 people in the Survey who are usually housebound said they have difficulty washing themselves. Five were paralysed and could not wash themselves at all and 2 could only wash hands and face. Eight could wash themselves but no longer bath, and 16 mentioned difficulties such as reaching back and legs, getting tired and taking a very long time.

103. Eleven of the people in the Survey who were housebound have a district nurse call. Some sort of auxiliary nursing service, or an extension of the home help service, might be useful. In Lewisham a limited service, which provides assistance for cases of this kind, is run by the British Red Cross Society and the St. John Ambulance Brigade. We are under the impression that there may be more infirm people who could benefit from the service if it were more widely known. **Conclusion**

104. The Metropolitan Borough Council provides a domiciliary cleansing service primarily for the severe or advanced case, where all necessary apparatus and materials, including hot water, can be

taken to the house. More recently, this service has been extended to include the use of an attendant to visit homes to help elderly people who are too frail to bath themselves or, in certain cases, to blanket-bath them. Requests for this service must normally come through the district nursing service and the district nurse must be satisfied that the case is one suitable in all the circumstances for help and aid by the unqualified bathing attendant. If blanket baths are necessary, some degree of supervision from the district nurse must continue.

105. Old age pensioners can use the Borough's baths at a fee of 1d. (plus, if needed, 2d. for the cost of soap and 2d. for the towel). Nineteen of the 1,063 people who usually go out use this concession.

Chiropody

106. Elderly people are likely to have foot trouble, partly as a result of degenerative changes which occur in the tissues in old age and partly from the effects of long-continued use of badly fitting shoes. (1)

Seven hundred of the people in the Survey (59%) said they had some foot trouble. Five hundred and seventy-four (48% of the sample) had corns and callouses which bothered them and 83 (7%) had difficulty cutting toenails. Not only do toenails harden with age but elderly people tend to have more difficulty in reaching their toes, and some may have lost power in fingers or have poor eyesight, which add to this difficulty. Forty-three (4%) complained of deformities, ulcers and swelling. It would appear that a higher percentage of housebound elderly people have trouble with their feet (68%) than do either the bedfast or those who can get out, where the percentages having trouble are 55% and 58% respectively.

107. Of these 700 people 136 (nearly 20% of those having foot trouble) had no treatment and did not do anything themselves to alleviate the discomfort.

Two hundred and seventy (39% of those with foot trouble) had treatment from a qualified person (chiropodist, doctor, hospital or nurse), 158 (23%) had "treatment" from an unqualified person and 125 (19%) treated themselves. (11 people did not give details of treatment). Three hundred and fifty-one people in the sample who were troubled with corns and callouses (nearly 60% of this group) are not being treated by a qualified person. Nearly 20% of these people rely on a relative, many of them elderly themselves, with consequent potential danger. (See also Appendix, Tables XV and XVI).

(1) Report Chiropody Survey—A. N. Exton-Smith, M.A., M.D., M.R.C.P. Appendix I—Chiropody for the Elderly (National Corporation for the Care of Old People, 1961).

108. There are in the Borough two London County Council foot clinics providing 49 sessions a week, at which treatment is available free to old age pensioners. Those unable to use public transport can be taken to the clinics by car or ambulance. This is supported by a very limited service provided by the Old People's Welfare Association which has seven sessions a week, and some domiciliary work is also done. More people asked the Old People's Welfare Association for information about chiropody than any other service, 50 out of the 145 wanting details.

109. We consider that great attention should be focused on care of the feet and everything possible should be done to improve, especially for elderly people, the present inadequacy of the service caused by a shortage of qualified chiropodists. Surveys made by the Ministry of Health and others have drawn attention to the inadequacy of the present service and to the possibility that indirectly a strain is imposed on other services as a result. We are glad the Minister of Health has recently removed the embargo on extending this service. **Conclusion**

Sick-room and other equipment

110. While 12 of the 22 bedfast informants are able to get to the W.C. (5 manage on their own and 7 with help), they all use some other equipment. Five use a chamber, 12 use a commode and 5 a bedpan. The local branches of the British Red Cross Society and St. John Ambulance Brigade hire out sick-room equipment (or lend where hardship exists) on recommendation from a doctor. The London County Council also loans certain heavy equipment, from its own storage depots, such as hoists, commodes, ripple beds, on the recommendation of a doctor. A loan deposit of 2s. 6d. is refunded on return of the equipment, except, in cases of hardship, when no deposit is asked for.

111. Asked about the use of equipment such as rubber sheets, air rings and bedpans, 2 of these 22 bedfast old people were being loaned equipment by the local branch of the British Red Cross Society (as was one other who usually gets out) while another was hiring privately. All 3 borrowing sick-room equipment lived with other people under 55 years old.

We think this is working satisfactorily. **Conclusion**

For convenience, we include in this section evidence in relation to hearing, sight and teeth. Much of this evidence was obtained by the Survey and, in addition to the following information, further details will be found in the Appendix.

Hearing

112. It has been found in previous enquiries that people are somewhat reluctant to admit that they are hard of hearing. Information obtained on this subject is not, therefore, always reliable but it can be accepted as some guide to the situation.

113. In the Survey, 362 elderly people admitted being hard of hearing, 55% said their doctors knew they were having difficulty and 21% had a hearing aid. (See Appendix, Tables XVII and XVIII). A much higher proportion of those whose doctors knew about their having difficulties had hearing aids—see Table below. Thus, 36% of those whose doctors knew of their hearing difficulties have aids compared with only 2% where the doctor had not been told and the informant did not think the doctor knew. It would seem that a very small proportion of old people with hearing difficulties refuse to accept a doctor's suggestion that they should get an aid, but a large number of elderly people do not tell their doctors of these difficulties. Nevertheless, where the informant said the doctor knew of their hearing difficulties, nearly two-thirds said he had not suggested they have a hearing aid.

TABLE 20

People having hearing aids, or recommended to have hearing aids, where doctor knows of hearing difficulties

Position re hearing aid	Doctor knows of hearing difficulties		All admitting hearing difficulties
	Yes %	No %	%
Has hearing aid	36	2	21
No hearing aid and Doctor/Hospital suggested having one	3	1	2
Friends/relatives suggested having one	10	10	10
No-one suggested having one	51	87	67
Number of elderly people admitting hearing difficulties	197=100%	163=100%	360=100%(1)

(1) Excludes 2 persons where position re hearing aid not answered.

114. Following the Survey, 4 post cards were sent to the Old People's Welfare Association for information relating to hearing and the necessary advice was sent to them.

Conclusion

This evidence shows that there is a need for educating old people into the advantages of a hearing aid.

Sight

115. It would appear that old people whose only source of income is a retirement pension and who live alone are the most likely groups to delay having their eyes tested. Provision is made in certain circumstances for cost of lenses and frames to be recovered from the National Assistance Board and also for eye-tests to be carried out at home. It seems that these facilities may not be widely known.

116. 96% of elderly people in the sample say they have to wear spectacles, 1% are registered blind and just under 3% say they do not need to wear glasses. A higher proportion of women are blind but this may well be due to the greater number of more aged women (80 and over) in the population and the tendency to blindness increasing with advanced old age.

117. 31% need glasses for reading only, 9% for distance and 56% for both distance and reading. While the proportions of men and women needing glasses for reading are similar, it would appear that a higher proportion of women need glasses for distance than do men (68% of women compared with 59% of men). Of the 1,140 people in the sample who said they needed to have spectacles, 1,090 (96% of this group) actually had spectacles and used them, 39 (3%) had them but did not use them and 11 (1%) did not have spectacles. (See also Appendix, page xi, Table XIX).

False Teeth

118. 84% of the people interviewed by the Survey have false teeth but of these 4% only use them sometimes and 6% not at all. 3% need them but have not got them.

TABLE 21

Possession and use of false teeth by men and women in the sample

Possession and use of false teeth	Men %	Women %	All persons %
Have, and use most of time ..	69	77	74
Have, and use for some purposes only	4	4	4
Have, but do not use	7	6	6
Do not have, but need	4	2	3
Do not have, and do not want ..	16	11	13
Number of people on which % based	438=100%	752=100%	1190=100%

From the various reasons given for not using false teeth—painful, uncomfortable, a nuisance, not liking them—we consider that those who need and wish to have false teeth have no difficulty in obtaining them.

Knowledge of services available

119. In each paragraph we have indicated, so far as available evidence has permitted, to what extent the various services are known. There are indications that some needs are not always being met by existing services. This may be due to:—

(1) The inability of the service to meet the full demand, or

(2) The appropriate authority not knowing about old people who need help.

120. For many of the services, application has to be made directly by the people themselves or on their behalf by others who are not directly concerned with the health or welfare services, and it could well be that these people do not know of the existence of such services. Much of the evidence we have given was obtained by the Survey which made an attempt to collect information about old people's knowledge of the existing services and, where they knew that particular services are available, through what channels they first heard of them. There are several difficulties arising in this operation. Let us consider these:—

(1) We know that when asked "What services do you know about?", some people will not mention particular services although they know about them. It cannot be argued that if they had known about a service and forgotten its existence at the time of interview they would therefore be unlikely to apply for it, since we would expect that, if it were needed, this need would act as a stimulus to the memory.

(2) If one asked about knowledge of a particular service then it is likely some people will claim to have heard of it either because they think they ought to have done so or because they have heard about a similar scheme, or even out of sympathy with the interviewer, feeling they might disappoint the interviewer if they say they have never heard of the service.

(3) Where a service might have already been mentioned during the interview, the informant might well *not* mention it again.

Steps were taken to minimise the effect of these difficulties by adopting the following procedures:—

(a) The interviewer used a standard introduction to this question: "Elderly people can get medical aid and other services if they need them—do you know of any help or services they can get in Lewisham?".

121. Since we are concerned mainly with the services administered by local health and welfare authorities, any reference to National Health provision, such as spectacles, teeth and so on, and to financial provisions such as National Assistance and pensions, were accepted by the interviewer but not recorded. (This acceptance by the interviewer is important, as if she had indicated to the informant that any part of the information given was of no interest it might have resulted in the informant not mentioning other services in case they too were of no interest).

122. The standard probe "Are there other services you have heard about?" was used both to show we wanted to know about every service they had heard about and were not merely asking for one or two examples and also to encourage the informants to go on thinking about the problem.

(b) For each service the informant mentioned spontaneously, additional data was collected as to whether the informant was using, or had ever used, that service.

(c) We did not expect anyone to name spontaneously all the services listed. Interviewers were then instructed to say "There *are* other services which you haven't mentioned but might have heard about. Have you heard that old people in Lewisham can get ..... if they need it?", prompting each of the items not already mentioned.

123. They were reminded that on no account was the word "remember" to be used, e.g., they were not to say "Do you remember hearing about .....?" as this might make the informant feel his memory was faulty and he might claim to have heard of it when in fact he had not.

124. Where an informant had repeatedly to say he had never heard of the services mentioned, interviewing practice was to comment on the lines, "It is just as important to know how many services you have not heard about as well as those you might have heard of", so that the informant does not feel he ought to have heard of them, or, *after* getting a "Never heard of it" to such a service as changing library books, comment casually "Quite a lot of people do not seem to have

heard of that service", so as to reassure the informant that he is not necessarily any less aware than a lot of other old people.

125. However, these procedures are unlikely to have eradicated all the errors and the figures shown of numbers of people knowing of existence of the services are likely to be higher than the actual number. Thirteen services were listed in Question 42 of the questionnaire.

TABLE 22 (a)

The number of services about which elderly people in the sample said they had heard

Number of services listed which elderly people claim to have heard about	Elderly people in sample		
	No.	%	Cumulative %
13 (all services)	18	1·5	1·5
12	27	2·3	3·8
11	64	5·4	9·2
10	91	7·7	16·9
9	111	9·4	26·3
8	171	14·4	40·7
7	173	14·6	55·3
6	184	15·5	70·8
5	156	13·2	84·0
4	110	9·3	93·3
3	41	3·5	96·8
2	23	1·9	98·7
1	11	0·9	99·6
Heard of none	4	0·4	100·0
Number of people on which % is based	1,184(1)	100·0	—

(1) Excludes 6 where full information could not be obtained.

TABLE 22 (b)

Figures relating to the bedfast only.

Number of services listed which bedfast people claim to have heard about	No.
11	1
10	3
9	2
8	2
7	2
6	4
5	1
4	3
Number of people	18

TABLE 23

Services for which a significantly higher proportion of those living alone claimed to have heard compared with those living with others

Service	People claiming to have heard of service		People not having used the service but claiming to have heard of it	
	Living alone %	Living with others %	Living alone %	Living with others %
Meals-on-wheels	96	92	95	91
Chiropody	64	52	57	48
Meal clubs	54	44	44	37
Holidays	67	60	61	56
Number of people on which percentage is based ..	280=100%	910=100%	223=100%	815=100%

126. It will be seen that for the four services where there are the biggest differences between those living alone and those living with others, this difference in having heard of the service is only partly due to the higher proportion of those living alone using the service. However, the original data show that for some of the other less well-known services the difference is in fact due to those living alone tending to use the services more. (See also Appendix, Table XX).

127. Detailed information about the knowledge of each service is given in the following tables. From these it will be seen that the biggest single means of communication as to the availability of every one of the services listed is by personal contact with people who are not connected with welfare or health, such as friends, relatives, neighbours, etc.

128. There are of course people who do not ask for services because they do not know about them. It seems that there is considerable ignorance about the existence of services.

TABLE 24 (a)

Knowledge of services

Service	Using or have used		Said had heard of service				Never heard of it		Number of people on which % is based
			Spontaneously		After prompting				
	No.	%	No.	%	No.	%	No.	%	
Home help	154	13	268	23	687	57	81	7	1,190
Meals-on-wheels	27	2	148	13	930	78	83	7	1,188
District nurse	234	20	93	8	711	59	150	13	1,188
Chiropody	115	9	82	7	468	40	523	44	1,188
Social clubs	143	12	256	22	679	57	112	9	1,190
Clubs for meals	37	3	69	6	442	37	642	54	1,190
Library books	2	—	8	1	259	22	917	77	1,186
Visitors	3	—	14	1	357	30	811	69	1,185
Bath concessions	28	2	6	1	178	15	974	82	1,186
Sick-room equipment	66	6	21	2	415	34	684	58	1,186
Invalid chairs	17	2	27	2	400	33	742	63	1,186
Laundry service	23	2	18	2	165	14	980	82	1,186
Holidays	53	4	42	4	639	53	451	39	1,185

TABLE 24 (b)

Knowledge of Services by the bedfast

Service	Used or have used	Said had heard of service		Never heard of it
		Spontaneously	After prompting	
	No.	No.	No.	No.
Home help	8	3	7	—
Meals-on-wheels	1	4	13	—
District Nurse	13	—	5	—
Chiropody	2	—	7	9
Social clubs	1	1	14	2
Clubs for meals	—	—	7	11
Library books	—	—	2	16
Visitors	—	—	5	13
Bath concessions	—	—	3	15
Sick-room equipment	5	3	3	7
Invalid chairs	2	—	6	10
Laundry service	3	2	2	11
Holidays	—	—	8	10

TABLE 24 (c)

Percentage of interviewees claiming to have heard of each Service

Service	Percentage of sample claiming to have heard of service	Percentage of permanently bedfast claiming to have heard of service
Home help	93·2	100·0
Meals-on-wheels	93·0	100·0
Social clubs	90·6	88·9
District Nurse	87·4	100·0
Holidays	61·7	44·4
Chiropody	56·0	50·0
Clubs for meals	46·0	38·9
Sick-room equipment —	42·3	61·1
Invalid chairs	37·3	44·4
Visitors	31·6	27·8
Changing library books	32·7	11·1
Bath concessions	17·9	16·7
Laundry service	17·3	38·9

129. General practitioners would appear to have been first to tell 22% of those who said they had heard of district nurses, 11% of those who claimed to know about the home helps and 6% of those claiming to know about borrowing sick-room equipment. Comparatively few of the elderly people hearing about other health and welfare services said their G.P. first told them about it. The Old People's Welfare Association is mentioned as the initial source of their knowledge of a service by comparatively few people.

130. It should be remembered that we have attempted to find out how the informant first got to hear of the service and *not* who was responsible for obtaining the service for those in need. Informants first hearing about, say, the home help service from a neighbour might then approach their G.P. or the Old People's Welfare Association for more information, asking them to obtain the service on their behalf. We should, therefore, consider how many informants knew there was an Association which could give them help and advice on services.

(NOTE: It was thought desirable to make some detailed enquiries as to where the person interviewed had first heard of the various services. Tables in relation to this information covering home helps, meals-on-wheels, district nurses, chiropody, social clubs, clubs serving meals, library books, social visitors, bath concessions, loan of sick-room equipment, loan of invalid chairs, laundry services and arranging holidays are available for consultation by anyone particularly interested in the statistics involved. Application should be made to King Edward's Hospital Fund for London, 34 King Street, London, E.C.2.)

Knowledge about existence of Old People's Welfare Association

131. Four hundred and twenty-one of the 1,190 old people in the sample (35%) said they had heard of the Lewisham Old People's Welfare Association. Not all these people knew of it by title—many did not recognise the name of the Association until "run by Miss Ellis" was added.

132. A higher proportion of women appear to have heard of the Old People's Welfare Association than of men; 38% of all the women in our sample having heard of the Association compared with 31% of men. A smaller proportion of both men and women aged 65-69 (27% of men and 29% of women in this age group) had heard of the Association, the proportions rising for women in each successive 5-year age group to 51% of women 80-84 knowing of the Association then dropping slightly for women 85 and over. For men, 37% aged 70-74 had heard of the Association, and the proportion drops for successive 5-year age groups to 28% of those 80 and over. A very much higher proportion of old people living alone (56% of this group) had heard of the Old People's Welfare Association than of old people living with others (29%). A slightly higher proportion of those in the sample who were bedfast or housebound had heard of the Old People's Welfare Association (41% of those in this group) than of those who could get out (35%). (See also Appendix, Table XXI). Knowledge of the Old People's Welfare Association appears to be independent of social class.

133. Arrangements have been made in London whereby a standard leaflet on local welfare services is issued to old people by the Ministry of Pensions and National Insurance. The leaflet is sent with the notice of the award of the State Retirement Pension. This scheme came into force on the 1st February 1961 and covers all the Metropolitan Boroughs, the City of London and the Middlesex Boroughs of Acton and Willesden. The leaflets include an addressed card (in Lewisham's case to the local Old People's Welfare Association) asking for further information or for a visit to be made.

Health Clinics

134. In view of the establishment of health clinics for elderly people in other areas, the matter was brought before the Committee. It was however pointed out that the whole question had been gone into at some length by the London Local Medical Committee, who were firmly opposed to their establishment. Their opinion had been

endorsed by the Health Committee of the London County Council in May 1962. No further consideration was therefore given to the matter by this Committee.

Day Care and Good Neighbour Service

135. However good local services may be there are people who do not wish to, or do not need to, enter hospital or welfare home and who need more care than the statutory or voluntary domiciliary services usually provide.

136. We were at first under the impression that if any elderly person's problem was not solved, it was probably due to ignorance of the existence of certain services rather than the lack of an appropriate service. This seemed to indicate the need for information centres, or better advertising of those that did exist. To guide us as to what was needed, we arranged, with the co-operation of the Hospital Personal Aid Service, for 24 Lewisham general practitioners to refer cases for whom there was difficulty. During 12 months, thirteen cases were referred.

137. While we were making this very limited survey an experiment was started in the Metropolitan Borough of St. Pancras, on which a Report was published by the National Council of Social Service during the summer of 1963. This scheme was, to quote from the Introduction to the Report, "based on a belief that there was a substantial number of elderly people who because of mild confusion, forgetfulness, sickness or physical disability, were unfit to be left alone for long periods, who did not wish to or could not go into a Home, who could not be improved by treatment in hospital—and if admitted might block a bed for a long time for somebody who could respond to treatment—and whose needs were more than could be provided for by the existing domiciliary services, statutory or voluntary."

138. The old people and their problems, who were the concern of the St. Pancras experiment, are obviously similar to those about whom we were anxious. St. Pancras found success in their scheme which was called "Day Care Service for the Aged and Infirm". It provided 'good neighbours', carefully selected and briefed, to give special care to old people and not to duplicate any of the existing services. During the 15 months (the period covered by the Report) 243 old people were referred and 107 of them were helped. This confirms the impression our own small enquiry gave us that the number of cases of this kind arising in the area of the size of a metropolitan borough would not be large. Each case can, however, be complex and time-consuming.

139. While there is no evidence to suggest the need for an increase in hospital accommodation for the elderly in Lewisham, a gap does exist which should be filled. The Report of the St. Pancras scheme suggests that an extension of it in the Lewisham area would be of considerable benefit to elderly people for whom the present services are inadequate or unsuitable. We are glad to know that the Metropolitan Borough Council are proposing to make arrangements with Lewisham Old People's Welfare Association to start such a scheme in 1964.

140. We would also like to emphasise that a service of this kind should not cut across or duplicate any of the existing domiciliary services for the aged nor tap the same sources of recruitment.

PART I: SICKNESS

Section C. Sickness in Welfare Accommodation

141. We discuss this separately because the enquiries we made into the transfer of residents from welfare accommodation to hospital showed that such transfers raise important issues.

142. The Visiting Medical Officer of Ladywell Lodge, the large welfare authority residential home in Lewisham, told us that he has no difficulty in transferring residents to hospital when they require attention they cannot be given in the Home. Most of these would be transferred directly from the residential quarters but a few would already be in the sick bay, where there are 120 beds, 60 male and 60 female.

143. In 1960, 166 residents were transferred to hospital; 50 of them to special hospitals or those to which they were already known, 46 to Lewisham Hospital and 70 to two neighbouring geriatric units. We were told by the Visiting Medical Officer that transfers to the two geriatric units are on an exchange basis and the majority are initiated by the units themselves on the grounds that the patients have become suitable for welfare accommodation. To accommodate them the Visiting Medical Officer selects, for exchange, residents whom he considers might benefit from physiotherapy or other treatment, very heavy nursing cases or those for whom visiting by relatives and friends would be made easier.

144. The definition of the hospital authority's responsibility, as given in the Ministry of Health Memorandum HM (57) 86 (paragraph 12), is as follows:—

(i) Care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years.

(ii) Convalescent care of the elderly sick who have completed active treatment but are not yet ready for discharge to their own homes or to welfare homes.

(iii) Care of the senile confused or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home.

There are at any one time some 80 "patients" in the sick bay at Ladywell Lodge who, according to this memorandum, are the hospital authority's responsibility.

145. The remaining 40 beds are occupied by those suffering from acute and minor illnesses which can adequately be nursed at Ladywell; a number of exacerbations of existing chronic disease; and those elderly residents who have to take to bed and are not expected to live more than a few weeks or, exceptionally, months and who would if in their own homes stay there because they cannot benefit from treatment or nursing care beyond what can be given at home and whose removal to hospital, away from their familiar surroundings and attendants, would be felt to be inhumane.

146. We were informed by the Visiting Medical Officer of the Home that the 80 or so residents who were clearly the hospital authority's responsibility could be looked after as well in Ladywell Lodge as in hospital. Many had received treatment in hospital in the previous year or two and had later relapsed; others came direct from hospital as no further treatment of any value could be offered. In the view of the Committee it would be undesirable to the health and happiness of many of them if they were transferred from their familiar surroundings to hospital. In some cases it would also create difficulties in visiting by their relatives and friends.

147. There seems to be no need whatever for the full panoply of hospital resources to be made available for the residual care of the aged even when they are bedfast. Nor indeed is it appropriate to incorporate the more disciplined domestic hospital administration into arrangements for the care of old people in the evening of their lives.

It seems to us that the restful, homely and easy-going atmosphere which we noted with approval at Ladywell Lodge is more desirable. Another aspect is, of course, the financial one; there is a separate expertise in providing for the institutional needs of the aged, particularly as to food and accommodation and in round figures we would expect the overall weekly cost of maintenance of a resident of a welfare home to be about one-third of the cost of a patient in a local hospital.

148. As we have mentioned, the sort of system we outline above operates in the special relationship between Ladywell Lodge and all neighbouring hospitals and is clearly reducing the demand upon the hospital beds, though no more in Lewisham than in other parts of the London County Council administrative area. For these reasons we would commend a review of the existing demarcation between hospital and welfare responsibility for the aged chronic sick, with appropriate financial adjustments, and the transfer of suitable hospital premises to welfare accommodation for this purpose. **Conclusion**

149. We have discussed whether there are elderly residents in welfare accommodation who would benefit from a physiotherapy service if it were provided there but we have been informed that such a service would be impracticable. The welfare authority has been given no power to provide such a service and physiotherapy would have to be provided as a Health Service function. We should however like physiotherapy to be available to residents of welfare homes as well as to people in their own homes. **Conclusion**

PART II: ACCOMMODATION

Section A. Housing

150. The majority of elderly prople wish to live in independence. We believe that many may be forced to accept admission to some form of communal home because frailty and infirmity have made it no longer possible for the old person to continue to live in a house which is too large and inconvenient. We obtained information on the number of dwellings provided and planned for elderly people by the housing authorities and others. We did not feel, however, that this information was exhaustive as there must be many other dwellings occupied by elderly people which it would be impossible for us to discover. We are sure, however, that there is a great need for suitably equipped flatlets to which elderly people can move when their homes become **Conclusion**

unsuitable. We are not able to suggest how much accommodation of this kind would be required but we urge the authorities concerned to consider including even more flatlet accommodation suitable for elderly people in their housing schemes. Where possible, flatlets for the more infirm should have a resident warden or should be adjacent to a communal home as has been provided by the London County Council in Hackney, and is being provided elsewhere, where the residents of flatlets are under the unobtrusive watch of the matron of the home.

151. The ideal development which we contemplate for the future for those old people in need of care and attention would be for welfare authorities, under their National Assistance Act 1948 powers, to build not only the communal residential type of small home but also the warden/caretaker flatlets for old people so that old people seeking welfare accommodation could be offered the choice of whichever of these two forms of care they most desired.

152. During the course of our work the Lewisham Borough Council, under their Housing Act Powers, decided to build additional accommodation for old people, and in the summer and autumn of 1963 there were opened three two-storey groups of flatlets, each group with a resident warden and accommodating 88 old people in all. Other such schemes are in progress, besides which the Borough Council has purchased various houses which have been converted into bed-sitting room flatlets for the elderly. We were pleased to hear about this additional accommodation, especially the supervised accommodation.

PART II: ACCOMMODATION

Section B. Boarding Out Scheme

153. Many elderly people may suffer from loneliness when living in their own homes but would be unwilling to accept admission to a communal home. We believe that this gap is well filled by the boarding out scheme which has been operating successfully in a number of areas. We consider that boarding out has a double value. First, it enables elderly people to be in private homes and members of a family and, secondly, though schemes of this nature may be limited in scope, anything that helps to improve the housing situation must ease considerable anxiety and distress caused to old people who often may

wait for prolonged periods before arrangements for their future are made. We are glad that before we finished our work the Old People's Welfare Association had appointed an organiser for the local boarding out scheme, which scheme began at the end of 1961.

PART II: ACCOMMODATION

Section C. Welfare Homes

154. The time may come to many elderly people when they require admission to a welfare home. We have noted that fewer active old people now seek admission and that the average age on admission and of those in residence is increasing. In 1947 the average age of all residents of welfare homes in London was 72 and in 1962 it was 78. The distribution of beds for the active and infirm has changed from 38% and 62% respectively in 1952 to 27% and 73% in 1962. For these reasons the pattern of care and attention is changing.

155. London County Council welfare homes vary in size, from those accommodating about 25 residents to the large establishments housing several hundreds. One of the large homes, Ladywell Lodge, is in the Borough of Lewisham and has traditional ties with Lewisham Hospital. There is accommodation there for 690 elderly people, including sick wards for 120. The County Council also has five smaller homes in the Borough accommodating between them 311 people, and one more, to accommodate 91 people, is under construction. Two more are in the planning stage. We agree with the policy not to have very large homes. None of these homes is intended only for residents of Lewisham. In fact, all will have people from other parts of London, just as homes situated in other boroughs may have residents who formerly lived in Lewisham.

156. Local authorities have power to place elderly people in homes run by voluntary organisations and to pay for their maintenance where this course is advisable. There is one such home in the Borough of Lewisham to which the County Council admits cases.

157. We were told that on the 12th November 1960 there were 70 residents of Lewisham awaiting admission to residential homes. Fifty-five were in their own homes, 4 in private nursing homes and 11 in local hospitals. Twenty-two had waited less than 2 months, 36

less than 6 months and 12 over 6 months. The majority of those waiting for more than 6 months wished to go to a particular home of their own choice and would not accept interim alternative arrangements.

158. In our circular to general practitioners, district nurses, health visitors and women health officers, we asked whether welfare accommodation was considered to be adequate. Thirteen doctors said they thought it was or answered with a qualified yes, 23 said that it was not adequate and 5 felt that they were too new to the district or had too few patients to be able to answer. Only 1 district nurse considered the accommodation was adequate, 39 nurses and health visitors said that it was inadequate.

159. With regard to the transfer of patients from hospital to Part III, we were informed that at the time we discussed the matter (September 1959) no patients awaited transfer from Lewisham hospitals to Part III. We checked to see whether this was a normal situation and found that of 20 cases transferred from hospital to Part III during 1961:—

14 cases	.. ..	involved no delay
2 cases	.. ..	waited 2 months
1 case	.. ..	waited 3 months
1 case	.. ..	waited 5 months
1 case	.. ..	waited 8 months
1 case	.. ..	waited 9 months

The hospital did not consider that any anxiety or difficulty was caused them on this point.

Conclusion

Subject to this, and apart from the acknowledged need for more beds because there is a long-standing waiting list, we are satisfied with the standard of residential accommodation for old people.

PART III: OCCUPATION AND RECREATION

160. We believe that old people's clubs can provide an opportunity, particularly for those living alone, to enjoy social intercourse. At the same time it must be recognised that there are many elderly people who have no wish to join clubs, particularly those for old people. The Survey found that less than 10% of those able to go out went to clubs. The majority of those not belonging to clubs said simply that they had no time or were not interested.

TABLE 25

Reasons for not using Clubs

Reasons for not using Clubs	Elderly people able to get out No.	%
Have friends/family/visitors—so not interested ..	119	12
No time—working, housework, etc.	217	22
Have other social activities	69	7
Have other individual interests	113	12
Shy, self-conscious, no-one to go with	39	4
Do not like old people's clubs	132	14
Do not like mixing/keep self to self	113	12
Prevented by physical troubles, illness	77	8
Not interested (no details given)	168	17
Fares too expensive	6	—(1)
Don't know where they are/never heard of them ..	13	1
Language difficulties/don't speak English	5	—(1)
Miscellaneous reasons	5	—(1)
Total number of reasons given	1,076	
Number of elderly people on which percentage is based	972	= 100

(1) Just over 0·5%.

161. Those who are at present providing clubs for elderly people are in a position to know if or when more clubs are needed. We would, however, like consideration given to the needs of the housebound in this matter in view of the success of a club in the neighbouring Borough of Camberwell. The King George VI Memorial Club in Camberwell has a membership of 250 people. All, through old age or infirmity, are normally confined to their houses but because the London County Council transports them in specially equipped coaches, each is able to have one weekly outing to the Club. There, apart from social activities, are special arrangements for baths, chiropody, hairdressing and occupational therapy.

162. We were of the opinion that consideration should be given to the setting up of a similar club in Lewisham but during the summer of 1962 the Metropolitan Borough Council, which owns premises in Lewisham High Street which are primarily used for old people, was able to start sessions there for the normally housebound old people. The layout and size of the premises limit the number of facilities available but within this limitation it is proposed to increase the number of sessions for the normally housebound as soon as additional transport is available. In September 1963 sessions for the handicapped were also started at the borough's Old People's Centre at Burnt Ash.

163. We have fully considered the occupation of people who have retired from their regular work. There are some who have hobbies and interests which keep them occupied but there are also some who, either from a desire for companionship or occupation or a need to augment their pension, would welcome a scheme which would provide what they need.

164. Under Section 31 of the National Assistance Act, 1948, local authorities may make contributions to the funds of any voluntary organisations whose activities include the provision of recreation or meals for old people. Under a 1962 amendment, workrooms for old people may also be provided either by the local authority itself, by grants to a voluntary organisation, or by a combination of the two. This should give fresh impetus to local authorities.

165. A visit was paid by two of us to the old people's workshop at High Wycombe and there were many aspects there that interested us. Those who applied for work when the workshop first opened seemed more interested in the companionship and occupation than in the payment and were in fact paid only 3d. an hour initially. The hours are 6 daily from Monday to Friday.

166. The Survey found that of 1,075 people able to get out 175 were interested in working. Seventy-four of these qualified their answers commenting to the effect that the work would have to be light, not too far away or done sitting down. Asked what type of work, 36 men said any light work, 8 did not know, 41 specified office or clerical, 20 listed skilled or semi-skilled work such as carpentry, woodwork or house-painting and 11 general handy work. Of the women, 30 were interested in household work such as cleaning, cooking, mothers' help or vegetable preparation for schools and hospitals, 16 in knitting, sewing and needlework and 14 in light manufacturing work and assembly. For the 154 who were prepared to give an estimate, the average number of hours per week they were prepared to work was 16·6.

167. Following the Survey, 14 people (8 men and 6 women) asked the Old People's Welfare Association for information about employment. All of them were interested in light or part-time work. At the time of the Survey, when this employment was sought, the Association was not able to do anything. The question was, however, taken up and six local firms were written to but only two replied. Neither of these was in all respects satisfactory. It has not therefore been possible to develop the finding of employment.

TABLE 26

Sex and age distribution of those already in employment and whether interested in working or not

Sex of old people in sample able to get out and whether working or interested in working	Age Group				All ages
	65—69	70—74	75—79	80 or over	
	%	%	%	%	%
Males—able to get out					
Working already	40	22	19	4	26
Unable or unwilling to work	30	53	63	87	50(1)
Interested in working	30	25	18	9	24
Number of men in sample on which percentage is based	164	127	65	56	415
Females—able to get out					
Working already	10	7	5	3	7
Unable or unwilling to work	73	82	87	91	81(1)
Interested in working	17	11	8	6	12
Number of women in sample on which percentage is based	233	190	138	98	660
All old people in sample able to get out					
Working already	23	13	9	3	15
Unable or unwilling to work	55	81	80	90	69(1)
Interested in working	22	16	11	7	16
Number of old people in sample able to get out on which percentage is based	397	317	203	155	1,075

(1) Seven men and 11 women who did not know whether they were interested in working have been included in the group "unable or unwilling to work".

168. The Survey enquiries show that about 16% of the elderly people in Lewisham who are reasonably active would be interested in light or part-time work.

TABLE 27

Length of time people over 65 were prepared to work

Number of hours per day	Number of people aged 65 and over willing to work				All willing to work
	Days per week				
	2	3	4	5	
2 or 3	13	22	12	24	71
4 or 5	8	11	8	32	59
6, 7, 8	2	2	1	19	24
All willing to work	23	35	21	75	154

169. To provide these people with suitable work might not be easy but we were glad to be informed, during consideration of the draft of this Report, that the Metropolitan Borough Council had decided in the summer of 1962 to open a workroom for the elderly in addition to other facilities for the elderly at a centre at Burnt Ash Hill. This workroom was opened in the autumn of 1962.

PART IV: GENERAL

170. There are many provisions, services and schemes, both statutory and voluntary, which we have not so far mentioned. Many are able in their own way, either directly or indirectly, to bring relief or happiness or to act as preventives of deterioration of mind or body.

171. All people interviewed in the Survey were asked if there was anything that could be done for old people in Lewisham to help them or make them happier. Nearly two-thirds of those interviewed thought that all that could be done was already being done but by the time this question was reached all informants had been questioned or told about all the welfare services available and therefore not a great deal of importance should be attached to this.

TABLE 28

Suggestions old people made as to what could be done to help them or make them happier

Suggestions made	Elderly people No.	%
Financial help		
Increased income/pensions/National Assistance	64	5·6
Reductions or concessions in prices	76	6·6
Control rent	13	1·1
Provide work	19	1·6
More help in the house	43	3·7
Social		
More visitors (social)	90	7·8
Other social amenities/entertainment	47	4·1
Improve housing	55	4·8
Provide outdoor amenities	32	2·8
Publicize existing services	10	1·0
Miscellaneous answers	16	1·5
Nothing more can be done/don't know of anything	753	65·0
Total things mentioned	465	
Number of persons answering on which percentage is based	1,152(1)	100

(1) Excludes 38 not answering.

172. During the pilot study for the Survey, people interviewed were asked "What do you think are the worst things about growing old?". Interviewers found, however, that this question caused a great deal of distress to some of the informants who were trying to avoid having to admit their fears and emotions or even to think about some of the conditions in which they might find themselves. The Committee agreed that while this is an important aspect of any enquiry into the conditions of old people, it would not be justifiable to cause distress to elderly people in order to quantify data on conditions we already know exist.

TABLE 29

Worst things about growing old mentioned by old people in the pilot enquiry

Worst things about growing old	Elderly people	
	No.	%
Loneliness	31	26·0
Isolation—cut off from family/world of young	7	5·9
Feel unwanted/neglected	9	7·6
Ill health	27	22·7
Not being able to get about	19	16·0
Deterioration of eyesight/hearing	4	3·7
Loss of intellectual capacity	4	3·7
Loss of interest	10	8·4
Loss of energy	19	16·0
Dependence on others	16	13·4
Being poor	9	7·6
Regret not having done better in youth	2	1·6
Sensitivity to noise	1	0·8
Don't think about it, contented, accept old age	13	10·9
Number of things mentioned	171	
Number of people on which percentage is based	119	100

173. Many old people feel lonely and not having satisfactory social contact is one of the main factors.

If the sample is divided into two groups, one being those bedfast or housebound and the other those able to get out, some indication of social contact can be obtained by considering, for those who can get out, the use made of social clubs and, for those bedfast or housebound, the sort of people visiting them and the number of days they have visitors. The use made of the wireless and television media of communication should also be considered for those who cannot get out.

Use made of wireless sets

174. Eleven of the 117 bedfast or housebound older people who gave details of the number of days on which they had visitors did not have a wireless set. All ten of those who had no visitors did have a radio but 4 of these 10 said they did not listen in regularly.

Six of the 46 who had no visitors on at least 4 of the 7 days immediately preceding interview had no radio and 15 had a wireless set but did not listen regularly.

60% of those bedfast or housebound listen to the wireless regularly compared with 74% of those who get out listening regularly.

Use made of television sets

175. Thirty-six of these 117 older people did not have a television set. Five of the 10 who had no visitors did not have a television set though 4 of the 5 with sets view regularly.

Thirteen of the 46 who had no visitors on at least 4 of the 7 days immediately preceding interview had no set and 7 had a set but did not view regularly.

55% of those bedfast or housebound look at television regularly compared with 60% of those who get out who view regularly.

Financial Help

176. One hundred and forty-nine old people (13% of those answering the question) thought that more should be done either to increase incomes or to make old people's incomes go further. Sixty-four said pensions should be increased or income increased by such measures as not taxing old age pensioners' earnings or abating pensions when working. Eight people asked the Survey to obtain information for them in connection with pension or similar problems and some of those enquiring about part-time employment clearly had remuneration in mind.

177. We know how sympathetically the National Assistance Board consider the applications they receive but we are sure that some elderly people who would be eligible for some allowance do not apply for reasons of pride. This applies particularly to the non-contributory pensioner who hesitates to seek assistance and rather than do so may cut down on meals in order to try to make income meet expenses. In time, when there are no longer any non-contributory pensioners, this situation will no longer exist.

178. There are a number of social services and activities which are organised by voluntary societies and which form an important part of the whole welfare structure. In Lewisham the Old People's Welfare Association organises or can give information on most of the local activities for elderly people—clubs, friendly visits, holidays, outings, besides the particularly important meals-on-wheels service, chiropody and boarding out, to which reference has already been made. After the Survey 57 requests were made to the Old People's Welfare Association for details of social activities, particularly holidays and friendly visits. The Association publishes a leaflet giving information about the welfare services and one of these was left by the Survey team with each interviewee.

Holidays

179. Holidays for the able-bodied elderly are arranged by the Metropolitan Borough Council. The handicapped or convalescent elderly can have holidays arranged through the County Council or through the Old People's Welfare Association or other voluntary associations.

General Practitioners' Guide to Services for Elderly People

180. Soon after our Committee was formed we became convinced that often family doctors, particularly if they were new to the area, were insufficiently aware of what services existed or how they could be obtained. We therefore prepared a guide, copies of which were sent to all general practitioners practising in the Borough of Lewisham, in which we gave information on all services which might be used for elderly people. A guide of this kind can we find soon be out of date. We hope the Metropolitan Borough Council will in future publish and keep up to date booklets similar to ours.

Conclusion

We recognise, however, that a written guide of this kind is of limited value. General practitioners, for whom the guide is intended, would not always find it easy to suit the services listed to individual cases.

Register of Elderly People

181. We have considered whether a worthwhile improvement in the service for old people would flow from adopting the suggestion which has been mooted from time to time of compiling and maintaining a register of all people in the state retirement age ranges. It is true that such people are a clearly discernible section of the community

although if the suggestion were to be adopted there is room for argument whether the present state retirement ages (60 years for women and 65 years for men) are the appropriate minima for this purpose; a higher minimum age level might well be more suitable. It needs to be said also that the community would not be prepared to accept the proposition of compulsory registration of old people with its attendant intrusion into the private lives of this large section of the population.

182. However, nothing emerged in the course of our enquiry—in particular from our house-to-house Survey—to warrant any conclusion that just because people are elderly they are ex hypothesi in need of medical or welfare services, and we conclude that the task of compiling such a register and more particularly keeping it up to date, would not be justified by results.

Summary of Conclusions

(Figures in parenthesis relate to paragraphs in the Report)

1. Additional beds	There is no source from which any additional beds should be filled in Lewisham and the ratio (1·4 beds per 1,000 of the total population) is more than adequate. (60. See also view of minority on page 38 (a)).
2. Elderly patients in wards with younger ones	Lewisham medical staff's view that elderly patients benefit from being in wards where there are younger patients seems to be justified by results. (57. See also view of minority on page 38 (a)).
3. Hospital and Welfare Authority responsibility	We commend a review of the existing demarcation between hospital and welfare authority. (58 and 148).
4. Terminal cases	Accommodation for terminal cases should be separate from hospital buildings. (59).

5.	Geriatric Unit	We do not consider the formation of a geriatric unit necessary in Lewisham. (61-68. See also view of minority on page 38 (a)).
6.	General Practitioner Service	We think this service works well. (72-74).
7.	Home Nursing	We think there may well be a useful field for expansion (using volunteers for such attention as bathing). (78 and 103).
8.	Health Visitors	We are concerned that according to evidence the health visiting service is not taking more part in the domiciliary care of old people. We hope the Ministry of Health will see their way to giving more precise guidance to local authorities on the relation of this service to elderly people (83).
9.	Women Health Officers	We think this service works well. (84).
10.	Home Help Service	The demand for this vital and well run service is growing but restriction is inevitable because insufficient numbers of suitable people are offering themselves for this kind of employment. (89)
11.	Meals-on-wheels	We recommend that those who operate this service investigate the apparent need for its expansion and also for meals to be supplied at weekends. (94).
12.	Laundry	We hope this valuable service will be made known among the various agencies who have cases likely to need it. (98).

13.	Night Attendants	We understand that the demand is not heavy and can be met by the present resources. (99).
14.	Bathing	See 7. Home Nursing.
15.	Chiropody	We consider that great attention should be focused on care of the feet and everything possible should be done to improve, especially for elderly people, the present inadequacy of the service caused by a shortage of qualified chiropodists. (109).
16.	Sickroom and other Equipment	We think this service is working satisfactorily. (111).
17.	Hearing	There is a need for educating old people into the advantages of a hearing aid. (114).
18.	Sight	It seems that certain facilities in connection with the cost of lenses and frames and for eye-tests to be carried out at home may not be widely known. (115)
19.	False Teeth	We consider that those who need and wish to have false teeth have no difficulty in obtaining them. (118).
20.	Physiotherapy in Welfare Homes	It would be a convenience if a physiotherapist were available from the hospital for residents in welfare homes. (149).
21.	Housing	We urge the authorities concerned to consider including even more flatlet accommodation for elderly people in their housing schemes. (150).

22.	Welfare Homes	Need for more beds but we are satisfied with the standard of residential accommodation for old people. (159).
23.	General Practitioners' Guide for elderly people	We hope the Metropolitan Borough Council will in future publish and keep up to date booklets similar to one prepared by the Committee. (180).
24.	Bedfast and housebound in Lewisham	It is estimated from the figures produced in the house-to-house survey that in private households in the whole of Lewisham there will be not less than 243 nor more than 447 permanently bedfast elderly people. Similarly, there will not be less than 1,500 nor more than 2,200 permanently housebound. (Table 7, paragraph 18).

The three factors which the Special Committee considered might, in general, be preventing or hindering a satisfactory comprehensive service for old people were closely examined in so far as Lewisham Hospital Group is concerned.

(a) We are satisfied that in the Lewisham method there is provision for active treatment for any patients irrespective of age. We are satisfied that suitable arrangements are made for the discharge of patients when improvement in their condition make them fit for it.

(b) We are satisfied that transfer of patients to hospital from Ladywell Lodge and to Ladywell Lodge from hospital is satisfactorily arranged.

(c) We are satisfied that beds are seldom occupied for unnecessarily long periods by patients who are not in need of hospital care.

APPENDIX

The economic status is based on the J-index, of which the following is an explanation:—

It has been shown (1) that the number of jurors in a district is closely related to other indices which are used for measuring the economic status of an area, such as income and non-industrial rateable value per head. All jurors are distinguished in the Electoral Rolls by the letter "J" and an index has been compiled showing the percentage of jurors in the electorate, thus enabling the classification of all administrative districts, parliamentary constituencies, and in some cases wards within constituencies, for economic status.

If we look at the J-index for Urban Administrative districts, we find it ranges between 0·02 (Glyncorrwg U.D., Glamorganshire), (Brandon & Byshottles U.D., Durham and Fishguard & Goodwick U.D., Pembroke having the next lowest value of 0·06) and 20·64 (Banstead U.D.) at the top end.

If we consider the 28 Metropolitan Boroughs we find that the J-index ranges between 0·29 (Poplar) and 8·57 (St. Marylebone). Lewisham, with a J-index of 2·72 has 18 M.B.s with a higher J-index and 9 M.B.s with a lower J-index, although three of the eighteen higher values are within 0·12 of the value for Lewisham and would for most purposes be considered as having the same economic status.

(1) The proportion of Jurors as an Index of the Economic Status of a District: P. G. Gray, T. Corlett & P. Jones, C.O.I., 1951.

TABLE I: Proportions co-operating in areas of different economic status

Economic status (2)	% co-operating	Number on which % is based
6	76	59
4 but less than 6	87	331
3 but less than 4	93	90
2 but less than 3	85	514
1 but less than 2	92	158
Less than 1	89	218
All areas	87	1,370

(2) See J-index above.

TABLE II: Summary of services requested

Chiropody	45
Home help or extra help	22
Holidays	19
Employment	14
Eye testing and spectacles	12
Friendly visitors, lonely social contacts	8
Financial items	8
Hearing aids	6
Accommodation	4
Laundry service	4
Meals-on-wheels	4
Miscellaneous (18 different requests)	27
	173

TABLE III: Conditions said by old people to limit their mobility

Reason for limited mobility	Bedfast	House-bound	Bedfast and housebound		Able to go out	
	No.	No.	No.	%	No.	%
Unlimited mobility	—	—	—	—	858	80·0
Blind/bad eyesight	1	9	10	8·0	7	0·7
Crippled, paralysed	4	16	20	16·0	11	1·0
Cardiac conditions	3	20	23	18·4	40	3·7
Rheumatic conditions	6	36	42	33·6	49	4·6
Pulmonary conditions	2	12	14	11·2	60	5·6
Nervous conditions (so described)	—	9	9	7·2	8	0·7
Old age/infirmity	4	10	14	11·2	10	0·9
Other physical disabilities	7	12	19	15·2	51	4·8
All reasons for	27(1)	124(1)	151(1)	120·8	236(1)	22·0
Number of persons	22	103(2)	125(2) =	100·0	1,075 =	100·0

(1) Some people gave more than one reason.
(2) Excludes 1 not answering.

TABLE IV: Number of elderly people in sample living in households with younger people

Age composition of household	No. of persons	%
Persons 65 and over only	645	54·2
At least one person 65 with younger people	545	45·8
	1,190	100·0
Persons 65 and over only	645	54·2
At least one person 65, and person(s) 55-64	186	15·6
" " " " " " " 35-54	319	26·8
" " " " " " " 25-34	100	8·4
" " " " " " " 15-24	78	6·6
" " " " " " " and young children only	4	0·3
All age groups	1,332(1)	111·9
Number of persons in sample	1,190	=100%

(1) Some informants lived in households containing persons in more than one age group.

TABLE V: Number of elderly people living in households with younger people and relationship to informants

Relationship of younger person to informant	No. of persons	%
One old person alone	280	23·5
Elderly couple only	402	33·8
Old person household, daughter not working ..	64	5·4
Old person household, other female not working ..	86	7·2
Old person household, daughter/female working ..	127	10·7
Old person household, employee (maid/housekeeper)	50	4·2
Old person in other types of household	13	1·1
Couple and daughter not working	16	1·3
Couple and other female not working	8	0·7
Couple and daughter/female working	81	6·8
Couple in other types of households	63	5·3
All types of households	1,190	100·0

TABLE VI: Elderly people living alone or with others

Living alone or with others	Bed-fast	House-bound	Bedfast and Housebound		Usually gets out	
	No.	No.	No.	%	No.	%
Elderly person living alone ..	2	23	25	20	255	24
Elderly person living with spouse only	3	29	32	25	370	35
Elderly person living with others	14	45	59	46	281	26
Elderly person living with spouse and others	3	8	11	9	157	15
All old people	22	105	127	100	1,063	100

TABLE VII: Who visited bedfast or housebound elderly people in 7 days preceding interview

Who visited in 7 days preceding interview	At time of interview			
	Bedfast	Housebound	Bedfast and Housebound	
	No.	No.	No.	%
No-one	1	9	10	9
Home help	6	26	32	27
Doctor	11	20	31	26
District nurse	10	10	20	17
Church or religious bodies	2	4	6	5
Daughters	5	32	37	32
Sons	5	26	31	26
Grandchildren/great-grandchildren ..	1	19	20	17
Other relatives	5	27	32	27
Friends, neighbours	9	50	59	50
"Welfare personnel"	—	2	2	2
Paid domestic help	—	1	1	1
Tradesmen, etc.	—	5	5	4
No. of different types of visitors ..	55	231	286	243
No. of elderly people giving information	21	96	117	100

TABLE VIII: Those having visits from a district nurse

Mobility at time of interview	Having district nurse No.		Having district nurse %		All elderly people in sample on which % is based
Bedfast permanently	9	13	50	59	18
Bedfast temporarily	4		100		4
Housebound permanently	9	11	10	12	94
Housebound, usually gets out	2		18		11
Able to get out	27		3		1,063
All states of mobility	51		4		1,190

TABLE IX: Frequency of district nurses' visits

Frequency of visit	Number of people		
	Bed-fast	House-bound	Get out
Everyday (or every day except Sunday)	7	2	2
At least once a week	3	6	10
Once a fortnight	1	2	1
Once a month	—	—	2
Less than once a month	—	—	7
Other answers	1	—	1
No answer to frequency	1	1	4
All visited by district nurse	13	11	27

TABLE X: Age composition of informants' households using home help service, those who have used it and those never using it

Use of home help service at time of interview	Age composition of household					
	People 65 years and over only		At least one person 65 and over and at least one 55-64 years only		and other under 55 years	
	No.	%	No.	%	No.	%
Has home help	78	12	5	4	21	5
Had home help, but not now	25	4	5	4	18	4
Never had home help	542	84	121	92	375	91
Number of elderly people on which percentage is based	645	100	131	100	414	100

TABLE XI: Whether those having home helps, and those who have had them, live alone or with others

Use of home help service at time of interview	Elderly person living alone		Couple living alone		Couple living with others		Elderly person living with others	
	No.	%	No.	%	No.	%	No.	%
Has home help	39	14	28	7	7	4	30	9
Had home help, but not now	18	6	8	2	8	5	14	4
Never had home help ..	223	80	366	91	153	91	296	87
No. of elderly people on which % is based	280	100	402	100	168	100	340	100

TABLE XII: Number of days a week the home help comes and how long she stays

Number of days per week the home help calls	Number of informants the home help visited				All lengths of visit
	Hours per visit				
	1	1½	2	3	No.
1	1	—	13	1	15
2	—	5	49	2	56
3	1	3	18	—	22
4	—	1	1	—	2
5	3	3	2	—	8
6	—	—	—	1	1
All visits by home help	5	12	83	4	104

TABLE XIII: Who helps to get meals for elderly people

Who helps in getting meals	Difficulty in getting own meals		No difficulty in getting own meals		All persons	
	No.	%	No.	%	No.	%
Helped by:—						
Relatives in household	119	82·7	426	90·0	545	88·3
Others in household	5	3·5	17	3·6	22	3·6
Relatives not in household	14	9·7	18	3·8	32	5·2
Friends, neighbours	5	3·5	5	1·1	10	1·6
Private domestics	2	1·4	4	0·8	6	1·0
Welfare services	4	2·8	3	0·6	7	1·1
Eat out	5	3·5	3	0·6	8	1·3
All sources of help	154	107·1	476	100·5	630	102·1
No. of persons getting help on which % based	144	100	473	100	617	100
No. of persons *not* having help..	12		561		573	

TABLE XIV: Who helps to get meals for the bedfast

Who helps where there is difficulty	Bedfast at time of interview No.
Helped by:—	
Relatives in household	20
Others in household	—
Relatives not in household	4
Friends, neighbours	1
Private domestics	1
Welfare services	1
All sources of help	27
No. of persons bedfast at time of interview getting help	22

TABLE XV: Proportions of men and women in various age groups who have trouble with their feet

Age Group	Having trouble with feet					
	Men		Women		Both sexes	
	%	No.	%	No.	%	No.
65 — 69 ..	38	168	64	250	53	418
70 — 74 ..	46	130	66	199	58	329
75 — 79 ..	44	70	74	163	65	233
80 and over ..	51	68	71	139	64	207
All ages ..	43	436(1)	68	751(1)	59	1,187(1)

(1) Excludes 2 men and 1 woman not answering.

TABLE XVI: Sources of treatment for different types of foot trouble

Source of treatment	Corns callouses etc.		Cutting toenails		Deformities ulcers etc.		All types of foot trouble	
	No.	%	No.	%	No.	%	No.	%
Professional treatment	223	39	32	39	15	35	270	39
Non-professional "treatment":								
Relative uses sharp instrument ..	112	20	26	31	—	—	138	19
Relative uses abrasives	20	3	—	—	—	—	20	3
Self treatment:								
Corn caps/plasters/solvents	29	5	—	—	—	—	29	4
Corn pads/soaks/oils	84	15	2	2	10	23	96	15
Too vague to classify..	8	1	1	1	2	5	11	1
No treatment or help	98	17	22	27	16	37	136	19
Number of people with foot trouble ..	574	100	83	100	43	100	700	100

TABLE XVII: Proportions of elderly people having hearing difficulties in different age groups

Age Group	Hearing difficulties			Number of people on which % is based
	With difficulty %	None admitted but hard of hearing %	No difficulties %	
65 — 69	24	—	76	418 =100%
70 — 74	28	—	72	329 =100%
75 — 79	33	3	64	233 =100%
80 — 84	43	2	55	134 =100%
85 and over	49	8	43	73 =100%
All ages	30	2	68	1,187(1)=100%

(1) Excludes 3 persons who did not give age.

TABLE XVIII: Things elderly people have difficulty in hearing

Difficulty in hearing	Those admitting difficulty %	All elderly people in the sample %
No difficulty admitted	—	70
Difficulty in hearing everything	11	3
Difficulty in hearing direct speech	42	13
Difficulty in hearing general conversation	13	4
Difficulty in hearing radio or T.V.	11	3
Difficulty in hearing door bell, telephone bell	8	2
Difficulty in hearing voices on telephone	3	1
Unspecified difficulties	23	7
All conditions of hearing	111(1)	103(1)
Number of people on which percentage is based	362=100%	1,190=100%

(1) Percentages add up to more than 100 as some people had difficulty in hearing more than one sort of thing.

TABLE XIX: Time since last eye test by qualified person

Last eye test	Permanently Bed-fast	Permanently House-bound	House-bound or bedfast		Normally go out		All needing spectacles	
	No.	No.	No.	%	No.	%	No.	%
Within last 3 years	4	47	51	51	640	61	691	60
3 — 5 years	2	12	14	14	174	17	188	17
Over 5 years ago	5	23	28	28	191	18	219	19
Doesn't remember	—	3	3	3	26	3	29	3
Never had test	4	—	4	4	12	1	16	1
All tests	15	85	100	100	1,043(1)	100	1,143(1)	100

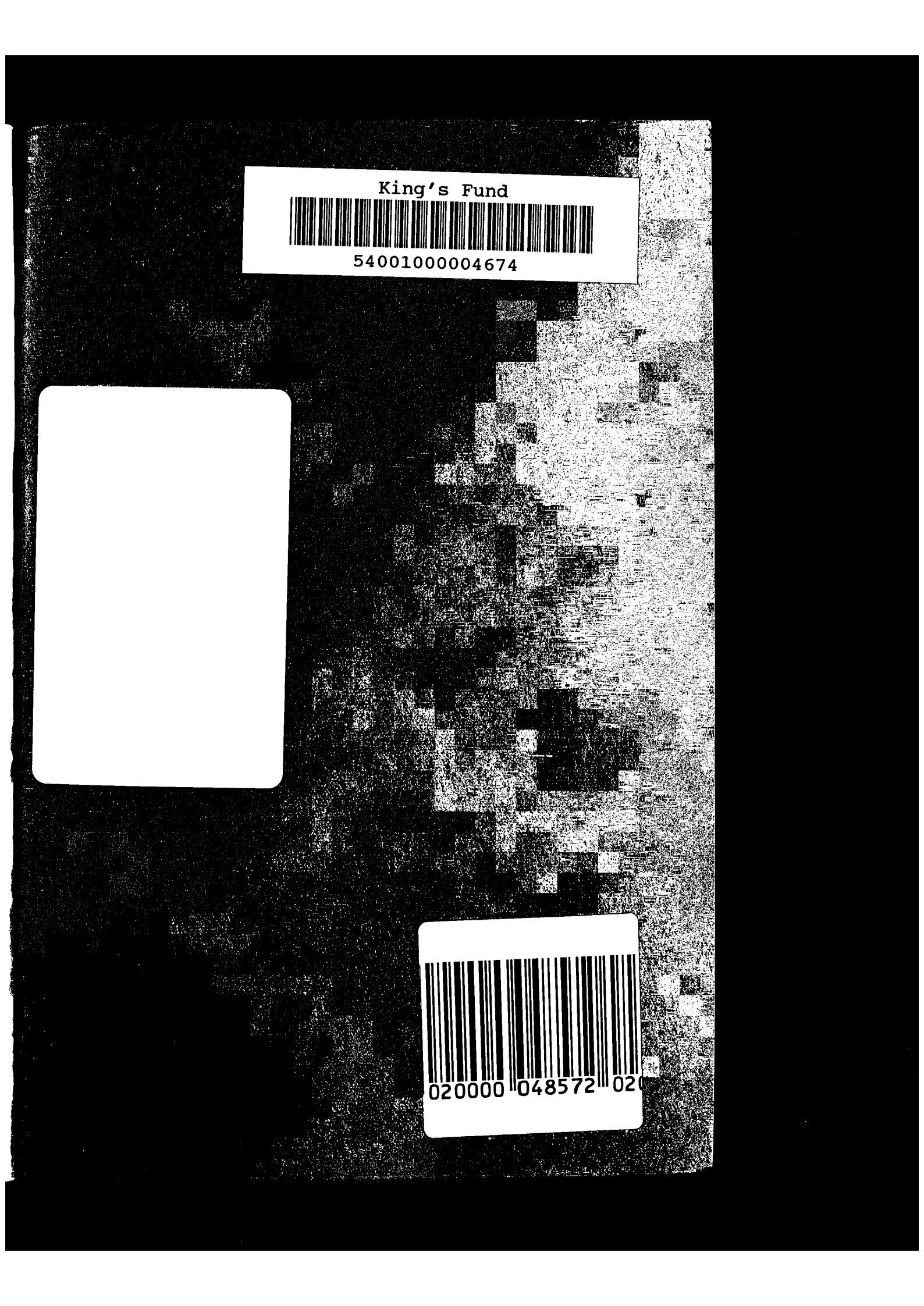
(1) Excludes 2 not answering.

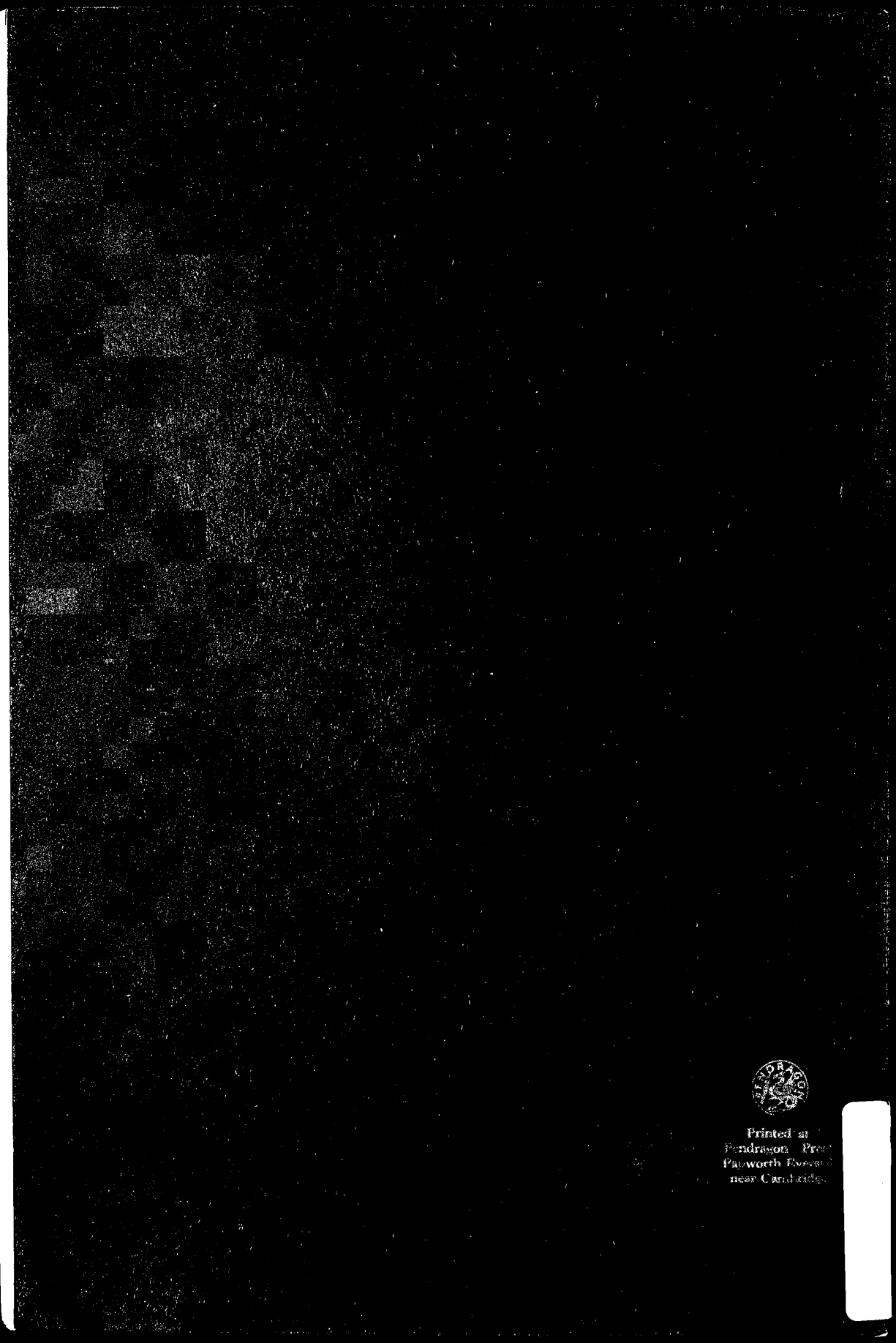
TABLE XX: Source of income of those who have used or heard of particular services

Service heard of or used	Retirement or O.A.P. only		National Assistance		Other sources	
	No.	%	No.	%	No.	%
Home Help	192	92	278	95	639	93
Meals-on-wheels	193	92	281	96	633	92
Chiropody	120	57	188	64	359	52
Social clubs	187	89	274	93	617	90
Number of people having various sources of income on which % is based ..	209	100	294	100	687	100

TABLE XXI: How long informants have lived in Lewisham and whether they have heard of Old People's Welfare Association

Length of time lived in Lewisham	Heard of O.P.W.A.				Number of elderly people on which % is based	
	Yes		No			
	No.	%	No.	%	No.	%
Up to 2 years	38	29	93	71	131	100
Over 2—5 years	43	39	67	61	110	100
Over 5—10 years	47	39	72	61	119	100
Over 10—20 years	78	33	156	67	234	100
Over 20 years	210	36	374	64	584	100
All elderly people giving information ..	416	35	762	65	1,178	100





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