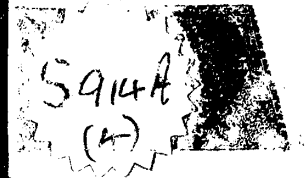
EMERGENCY BED SERVICE

(KING EDWARD'S HOSPITAL FUND FOR LONDON)

REPORT FOR THE YEAR
ENDED 31st MARCH

1957



KING EDWARD'S HOSPITAL FUND FOR LONDON

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EMERGENCY BED SERVICE

19th ANNUAL REPORT

Report for the Year ended 31st March, 1957

INTRODUCTION

During the year the Service received 60,973 applications for admissions to hospital. This is 4,722 less than in the previous year. The decrease was most due to a phenomenally quiet winter (December to March), applications for general acute cases during the remaining months of the year being at a normal level. Applications for infectious cases were considerably fewer than in the previous year until January, when the usual biennial epidemic of measles set in and caused a sharp rise for the remainder of the period.

As regards general cases, only one other winter, that of 1951-52, has been as quiet. In that year the Service received 14,891 applications from January to March inclusive as compared with 15,982 during the same period in 1957.

Despite the small number of applications which should have made admissions easy, it is disturbing to see that the proportion of cases admitted through the operation of the Medical Referee system remained high. The table below shows the situation over the past six winters.

Jan.-March	*Applications*	*Admissions*	*Med. Refs.*	*% admitted via Med. Refs.*
1952	14,891	12,834	705	5.4
1953	21,197	17,642	2,044	11.5
1954	17,309	15,389	1,955	12.7
1955	18,106	16,250	2,002	12.3
1956	19,005	16,993	2,633	15.4
1957	15,982	14,914	1,527	10.2

The following extract from an article by Dr. G. F. Abercrombie, Chairman of the E.B.S. Committee, published in *The Lancet* on 17th November, 1956, is relevant.

"MEDICAL REFEREE PROCEDURE

There are, of course, varying degrees of urgency. The Service works on this principle; if no bed can be found for a case, it may be submitted to the medical referee of the local hospital management committee for immediate admission. This is done through a doctor specially appointed by the Regional Hospital Board and known as the Regional Medical Admissions Officer (R.M.A.O.).

In less urgent cases, when 6, 8 or even 10 hospitals have been approached and have no bed, the R.M.A.O. has a number of choices. He may find by telephone, that the general practitioner is willing to hold the case over and to apply again next day; a domiciliary visit by a consultant may be suggested and accepted; perhaps a hospital will agree to examine a patient in the out-patient department with an undertaking either to admit him or to start treatment, relieving the general practitioner of a responsibility which he feels he should no longer accept. But it is to be firmly stated here that every patient, represented by the R.M.A.O. as in need of urgent treatment which can *only* be obtained in hospital, does in fact go in.

This weapon—it is really the only word for it—was originally designed for use only if the illness seemed likely to be fatal, and was very sparingly used before January 1953: but the proportion of cases then forced in, nearly 14% of all admissions, was almost twice as high as any previous year (Fig. 1, lower graph). Since that time the proportion has remained high, and in February, 1956, reached 19%. We may note that the peak of forced admissions occurs later than the peak of voluntary admissions. Study of the two graphs of Fig. 1 leaves little doubt that the present warning system is unsatisfactory. It is

unthinkable that, except under unpredictable conditions which may swamp the hospitals, there can ever be a return to the days of January 1951, for in any average year the medical referee procedure will keep the admission rate above 85%.

This degree of success, however, was achieved in the first quarter of 1956 only by an amount of refereeing which is simply not acceptable. Fig. 2 shows this quarter in more detail. The three graphs are of moving weekly totals; the upper shows applications, the middle "voluntary" admissions, the lower "forced" admissions. In the week ending February 29th, the hospitals accepted voluntarily 1,176 cases, and 326 more were forced upon them. It is not difficult to see from Fig. 2 what happened. The hospitals gradually filled, and by Christmas they were nearly full; a fine response was made to the additional demands inevitable in January, but the effort was not sustained. Voluntary admissions remained at or near 1,100 a week, although applications varied from 1,400 to 1,700. The deficit was made up largely by forced admissions.

The prospect of having to force in every fourth admission, even for a comparatively brief period in this coming winter, is most disagreeable, and over and over again a hospital is compelled to receive a patient whom it had declined an hour before.

DISCUSSION

The increasing use of the referee procedure causes very grave concern, for it inflicts hardship on the hospitals and impairs good relations between them and the Service. Moreover, the constant demand for beds tends to make hospitals reluctant to accept cases from distant areas, and thus defeats one of the objects of the service, which is to spread the load evenly.

Shortage of nurses, either from lack of recruits or more often from illness, is sometimes given as a reason for refusing admission. The increased number of beds set aside for special purposes may have reduced the number left for general emergencies, and the endeavour to maintain a high occupancy-rate must also reduce the ability to take in the unexpected.

A further difficulty has been the prejudice of certain hospitals against "E.B.S. cases." There is, of course, no such thing as an E.B.S. case, as all applications originate from general practitioners. It must be remembered that E.B.S. is the general practitioner's final resource. If, for instance, he offers two patients, one aged 40, the other 80, both suffering from pneumonia, to a hospital which at that moment has only one empty bed, the younger will be admitted and the older in all probability will be refused. The general practitioner then calls the Service to his aid, and if the condition of the octogenarian is such that admission is essential, he will be admitted on the order of the R.M.A.O. To some extent, therefore, E.B.S. is trying to place patients already rejected, and it may very well be that many of them cannot be discharged to their homes, for social reasons, after recovery is complete. Hence the erroneous idea that cases received through E.B.S. are more likely to be unsuitable than those offered by the general practitioner himself. They are not unsuitable, and the truth of this is confirmed from time to time by various methods. In February 1956, two teaching and two non-teaching hospitals were asked to give their opinion on all cases received from the Service in a given period. These four hospitals saw or admitted 264 patients, of whom only 10 in their opinion did not justify admission as emergencies. The illness was not in accordance with the diagnosis given in some of the remaining 254, but they were, nevertheless, in the opinion of the hospitals receiving them, in need of immediate admission. This is a remarkable confirmation of the clinical judgment of general practitioners."

THE WARNING SYSTEM

During the summer detailed consideration was given to the Warning System with special reference to the experience of the winters 1954-55 and 1955-56, both of which could be considered average. There is little doubt that the system as previously operated has become obsolete. It will be recalled that the system was based on the proportion of applications which were admitted to hospital, and that when this proportion fell to 85% a "White" warning was sent out, and that this was followed by "Yellow" and "Red" warnings at 80% and 75% respectively. The

operation of the Medical Referee procedure now makes it highly unlikely that the proportion of admissions should ever again fall to such levels except under quite unforeseeable circumstances. If the system was to fulfil any useful function it was therefore evident that the whole basis of using warnings must be reconsidered.

At first sight it might be thought that a system based on the total weekly numbers of applications would suffice. Such a yardstick, however, would not alone be satisfactory, since a figure which the hospitals could take in their stride in December might prove a severe burden in February, when many beds are blocked by longstay patients and sickness among the nursing staff is common. Another factor. which to some extent acts as an index to the degree of difficulty experienced by hospitals, is the proportion of cases admitted through the Medical Referee procedure, and it was felt that a system based on these two factors should prove satisfactory.

Past experience seems to show that serious difficulty does not arise until weekly applications exceed about 1,500, and the proportion of refereed admissions rises to about 1 in 8. It was therefore decided that these two figures (both of which would have to be exceeded) should constitute the new warning level, with a proviso that if, when weekly applications reach 1,500 the percentage of cases admitted through the medical referees is rising steeply, a warning may be issued when the referee rate reaches 10% of all admissions.

It was decided to abolish the "White" warning, which had never called for any specific action, and to go straight to a "Yellow" which did. It was further decided not to tie the "Red" warning to any specific set of figures, but to hold it in reserve in the event of the "Yellow" proving ineffective.

To summarize:—

A "Yellow" warning will be issued when applications reach 1,500 per week *and* the proportion of cases admitted through the referees exceeds 12½% of all admissions.

If both graphs are rising steeply with weekly applications at 1,500 or over, a referee rate of 10% will call for a "Yellow" warning.

A "Red" warning will be issued if the "Yellow" proves ineffective, or the situation continues to deteriorate.

Warnings will be cancelled when the situation allows, but will in any case be removed when applications *and* the proportion of cases admitted through the referees fall below the warning level.

As has already been mentioned in the introduction the past winter has been a phenomenally quiet one for the Service, and it was never necessary to operate the new system.

CONCLUSION

It must be remembered that the medically refereed cases are only a small proportion of the total work of the Service. The great majority of all cases are admitted smoothly and efficiently, and we are confident that the general practitioners and the hospitals are satisfied with the work of the Service. The Service's relations with the hospitals remain, as always, very friendly, and we constantly receive from general practitioners indications of their great appreciation of our work.

The Service would like to thank the hospitals for their great co-operation and for the help they have given in times of difficulty, particularly in the winter. We are very grateful also to general practitioners for their patience and kindness when the Service is dealing with some of the more difficult cases which are accepted on their behalf.

APPENDIX 1

GENERAL ACUTE CASES

	Applications	Admissions	Cases not admitted		
			Failures to admit		
			G.P. Cases	Hospital Transfer	Cases withdrawn by applicants
1956					
April	4312 (4403)	4049 (4130)	136 (140)	35 (31)	92 (102)
May	4259 (3916)	4016 (3716)	131 (76)	38 (37)	74 (87)
June	3821 (3663)	3644 (3489)	72 (75)	25 (31)	80 (68)
July	3491 (3466)	3357 (3347)	32 (34)	27 (22)	75 (63)
August	3374 (3494)	3263 (3374)	37 (36)	11 (19)	64 (65)
September	3695 (3679)	3544 (3510)	60 (43)	36 (32)	55 (94)
October	4340 (4279)	4128 (4083)	96 (77)	45 (48)	71 (71)
November	4719 (4548)	4458 (4278)	141 (125)	39 (50)	81 (95)
December	4979 (5632)	4771 (5277)	100 (193)	16 (48)	92 (114)
1957					
January	5597 (6884)	5238 (6102)	207 (539)	45 (54)	107 (189)
February	4870 (6516)	4539 (5734)	165 (539)	59 (49)	107 (194)
March	5515 (5605)	5137 (5157)	130 (265)	47 (39)	201 (144)
TOTAL	52,972 (56,085)	50,143 (52,197)	1307 (2142)	423 (460)	1099 (1286)

Figures for the corresponding month of previous year are shown in brackets.

APPENDIX 2

INFECTIOUS CASES

	Total Applications	Total Admissions
1956		
April	568 (1056)	561 (1028)
May	732 (823)	722 (817)
June	663 (770)	658 (765)
July	668 (788)	665 (781)
August	530 (810)	527 (789)
September	550 (952)	540 (903)
October	548 (715)	546 (704)
November	602 (610)	595 (602)
December	633 (659)	629 (645)
1957		
January	683 (597)	676 (583)
February	833 (568)	806 (556)
March	781 (689)	763 (672)
TOTAL	7791 (9037)	7688 (8845)

Figures for the corresponding month of the previous year are shown in brackets.

CHRONICS

Placed on Waiting List ...	210
Cancelled	10

APPENDIX 3

GENERAL PRACTITIONERS' ACUTE CASES
ANALYSIS OF AGE GROUPS

October 28th, 1956 — February 16th, 1957

Age Groups	Cases Offered	Percentages Admitted	Increase or Decrease compared with corresponding period in 1955-1956
Birth—20	3522 (3720)	100.0 (99.9)	+0.1
21—30	2041 (2030)	99.4 (99.0)	+0.4
31—40	1543 (1619)	98.9 (98.4)	+0.5
41—50	1635 (1799)	98.7 (97.7)	+1.0
51—60	2376 (2787)	98.1 (95.6)	+2.5
61—70	3068 (3975)	95.6 (93.1)	+2.5
71—80	3138 (3832)	93.9 (89.6)	+4.3
Over 80	1219 (1454)	90.8 (89.6)	+1.2
Total offered	18,542 (21,216)		

Figures for the corresponding month of the previous year are shown in brackets.

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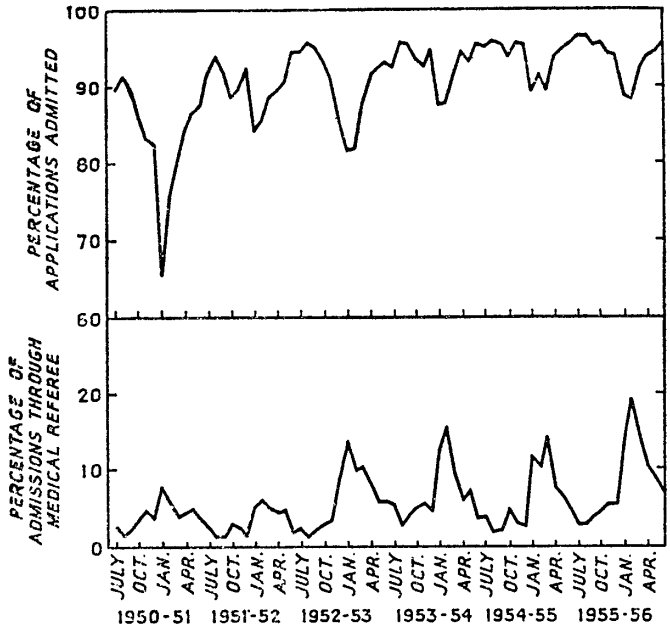

Fig. 1—General acute cases.

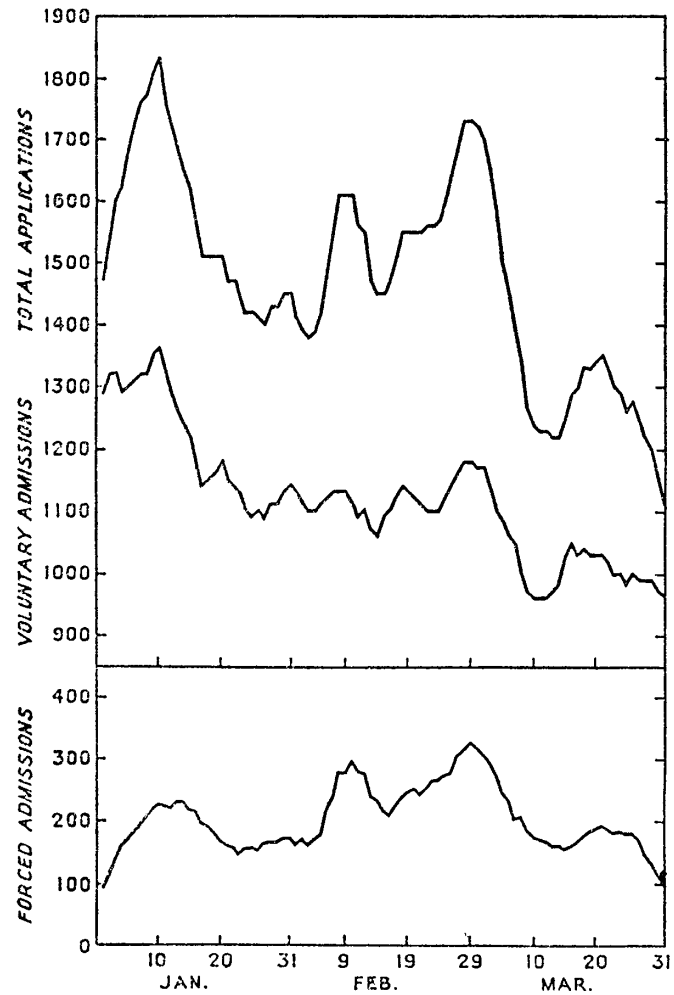

Fig. 2—Weekly totals of general acute cases in 1956.