King Edward's Hospital Fund For London

RECOVERY HOMES

A REPORT OF AN INQUIRY INTO THE WORKING OF RECOVERY HOMES AND THEIR VALUE TO THE HOSPITAL SERVICE

King Edward's Hospital Fund For London,
10 Old Jewry, E.C.2

1/- Post Free

March, 1954.

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NEWS AND CO
A REVIEW

Value of Recovery Homes

AT an early stage after the end of the war King Edward's Hospital Fund for London set up their Convalescent Homes Committee, who have undertaken a large programme for assisting the modernisation and re-establishment of convalescent homes. As a result of experience and of a special survey it was recognised that few convalescent homes were capable of accepting patients at an early stage of convalescence. If any advantage in the increase of the turnover of beds in general hospitals by transfer at an earlier stage of recovery was to accrue, another type of institution was required. A special study of recovery homes was then instituted.

This is a subject which has received a good deal of thought by hospital authorities, and it will be recalled that Liverpool Regional Hospital Board and the United Liverpool Hospitals published in 1953 a joint report in which the value of recovery homes as a means of obtaining an improved use of resources was discussed. This report is referred to by Sir Henry Tidy, K.B.E., M.D., F.R.C.P., Chairman of the King's Fund's Convalescent Homes Committee, in his foreword to the Fund's newly issued booklet on Recovery Homes (obtainable from King Edward's Hospital Fund for London, 10, Old Jewry, E.C. price 1s. post free).

straight cost per staffed bed to which we have become accustomed. This work of doubtful value will, it is to be hoped, be discontinued when a departmental costing system is adopted.

Earlier in the month of March, the Department of Health issued S.R.B. 54/13. This circular provides for the transfer of the salaries of clerical staff employed in clinical and allied departments of hospitals to the hospital accounts. Previously these were charged to board of management expenditure and afterwards spread over the hospitals. The effect of the circular is to make the expenditure of board of management refer only to hospital administration proper. This seems wise if erroneous conclusions as to the cost of administration are to be avoided.

In this circular there is a paragraph to the effect that in future advertising is to be charged to board of management and not to the hospital concerned; no great matter.

Recovery Homes

The possible development of recovery homes, to which patients might be transferred once the acute stage of their illness is over in hospital but before they can be termed convalescent, has received increasing attention in recent years. In favour of such development it has been urged that the recovery home offers a means of relieving pressure on acute hospital beds and securing quicker turnover of patients, and at the same time a means also of reducing hospital costs. It has also been urged that by providing the means of retaining patients sufficiently long to ensure that their convalescence is consolidated before their return home, the risk of relapse and need for further hospital care is diminished, and, further, that by combining measures for rehabilitation with purely convalescent treatment patients are able to resume work more quickly after discharge. The possible value of the recovery home in these directions has received striking support in the *Hospital and Community* study reviewed in a preceding article. A further argument for the recovery home is that the change from the tense and anxious atmosphere of the acute hospital to that of the home materially assists the patients' recovery.

Despite, however, the apparent attractions and despite general agreement on the existence of suitable cases for transfer, hospital authorities have for the most part fought shy of developing recovery homes. They have done so largely because of doubts of the kind expressed in the report[1] of the Liverpool hospital boards. These include doubts as to whether savings in maintenance costs at recovery homes would not be counter-balanced by higher costs at the parent hospital, as a result of a higher turnover of more acutely ill patients, and doubts also about other results, notably the effects on nursing resources and those of the technical departments. Would not the concentration in hospitals of only the severe stages of illness place an undue strain on nursing resources and on technical departments, such as the operating theatres, the pathological and radiological departments, and pharmacy? Might not the patient suffer through lack of confidence in the recovery home, regarding it as in the nature of a second grade hospital? Would he not also suffer, and medical standards be lowered, if recovery homes entailed divided medical responsibility, with some doctors confined to recovery home work? Would not, too, the diversion of patients to recovery homes entail considerable modifications in training and teaching arrangements for nurses, and in teaching hospitals for medical students, and could these be made without detriment to professional standards?

[1]The Recovery Home in the Hospital Service. An Inquiry by a Joint Committee of the Liverpool Regional Hospital Board and the Board of Governors of the United Liverpool Hospitals, 1953. See THE HOSPITAL, August, 1953, p. 418.

A forceful answer to doubts and questions of this kind has now been given in a report[2] of an inquiry conducted by the convalescent homes committee of King Edward's Hospital Fund into the working and value of recovery homes. The committee was set on its inquiry as a result of finding that, with few exceptions, existing convalescent homes were not equipped to take patients at an early stage of convalescence and that it was not a practicable proposition to try and adapt them to do so. It concluded that if patients were to be transferred from hospital at an early stage, as was tending to happen, an institution distinct from a convalescent home was needed. It accordingly decided to make a study of recovery homes, using the definition —on the model of the Astley Ainslie Institution, Edinburgh—that a recovery home provides accommodation "for patients in whom the disease has definitely begun to abate, or the risk of complications after operation is only slight, so that with proper care and nursing the patient is likely to progress to recovery".

As a result of its investigations, which included visits to nine hospitals in different parts of the country which had one or more recovery homes attached to them, the committee considers that there is scope for, and advantage to be gained from, the development of recovery homes as defined by it. Such homes should be attached to a parent hospital and regarded as an integral part of it, both for administration and for medical nursing control, thus ensuring continuity of treatment. In certain circumstances more than one hospital with a common consultant staff may share a home. Experience, it is emphasised, has shown that patients who have reached the stage of "recovery" unquestionably benefit from the atmosphere and quiet of a country house after the irksome noise and disturbance of the acute ward. Recovery homes should therefore be situated in country surroundings or at least in ample grounds, but reasonably accessible to the parent hospital. Patients from surgical, general medical and gynaecological wards are most suitable for transfer and up to about one-third of such patients can, and not more should, be transferred. The ratio of nurses to patients in existing homes is commonly 1 to 4 or 5, about half the nursing staff being fully trained and more or less permanent, and the others student nurses, usually sent for a three months period. Discussing the effects on nursing staff and other departments of the hospital, the report indicates that extra work falling on nursing staff at the parent hospital only becomes severe when the transference of patients exceeds one-third. The training of nurses, as also the teaching of medical students, is not found to be adversely affected, and in fact "a recovery home helps to extend the facilities for nurses' training", since there is more time there for teaching and students have the opportunity to watch the progress of patients, who still require active nursing, to recovery. While there must be some increase of work in operating theatres and technical departments it was not found such as to have attracted any special attention or called for any special measures.

So far as costs are concerned it is noted that the cost of establishing a recovery home will involve the parent hospital in additional expenditure represented by the capital cost of the home and its annual cost of maintenance. The capital cost of purchase and adaptation of a suitable country house is, however, considerably less than building additional hospital wards, while experience shows that the cost of maintaining a patient in a recovery home is usually rather less than half that in the parent hospital. As regards

[2]Recovery Homes. King Edward's Hospital Fund for London, 10, Old Jewry, London, E.C.2. 23 pp. Price 1s. (post free).

Telegraph
12 June 54

Times
12 June 54

HOSPITAL-RUN HOMES CAN REDUCE COSTS

SURVEY BY FUND

"Recovery homes" established as a half-way house between hospital and convalescent home for patients no longer in need of full hospital treatment but not ready for discharge can

Secure a quicker turn-over of beds in busy hospitals;

Reduce hospital waiting lists; and

Reduce maintenance costs per patient by up to two-thirds.

This is the conclusion of an inquiry made by King Edward's Hospital Fund for London. Recovery homes are receiving much attention from hospital authorities at the present time.

Ten hospitals which already possess recovery homes were visited during the inquiry. The report says that "all were enthusiastic as to their value."

Recent developments in antibiotics have made them increasingly important. With the risk of sepsis after operations almost eliminated many patients no longer require full hospital facilities, although still unfit for a convalescent home or to return home.

USE OF COUNTRY HOUSES

Several hospitals expressed the opinion that the converted country house is the most suitable building for a recovery home. It remains under the supervision of the parent hospital. Average stay in homes surveyed was 13.4 days.

Analysing the costs at six hospitals, the report says that the cost of recovery home treatment varies between 37 per cent. and 57 per cent. of the cost of a bed in hospital.

"The capital cost of adaptation of a suitable country house is considerably less than building additional hospital wards."

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VALUE OF RECOVERY HOMES

RESULTS OF HOSPITAL FUND INQUIRY

BY OUR MEDICAL CORRESPONDENT

There has been considerable discussion about the place of recovery homes in relation to the hospital service, and King Edward's Hospital Fund for London has published the results of an inquiry into the matter. Such homes are intended for the transfer of patients from hospital at an early stage before the use of the conventional convalescent home would be feasible. They must supply adequate nursing care and be within reach of the parent hospital so that visits can be made by the consultant staff or their deputies.

The inquiry shows that about a third of the patients in the surgical, medical, and gynaecological wards of a general hospital are, as a rule, suitable for transfer to a recovery home. It is stated that the authorities of hospitals with recovery homes have no doubt as to their value. It is claimed that the extra work thrown on the parent hospital by a quicker turnover of patients in the acute stages of illness is only severe when the transference of patients exceeds the maximum rate indicated in the inquiry. This suggests that the best programme is a stay of about a fortnight in hospital and a similar period in a recovery home.

The report, which makes no recommendations, can be obtained from the offices of the fund, 10, Old Jewry, E.C.2, price 1s.

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THE HOSPITAL, July, 1954

the effect on the maintenance costs of the parent hospital the conclusion is that the effect is too small to be recognisable and cannot be more than slight.

It is the committee's final conclusion that the establishment of recovery homes carries with it important economic and social benefits in increasing the turnover of acute cases, with consequent reduction of the waiting list; affording substantial relief when there is severe and increasing demand for the admission of acute surgical cases; providing an atmosphere which materially assists the patients' recovery; and affording substantial reduction of the total cost per patient. With this report behind them one may hope that more hospital authorities will now be convinced of the possibilities of recovery homes.

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good hospital management, closer co-operation between medical, nursing and other staff, keener interest on their part in the efficiency of out-patient arrangements, and a greater concern for the convenience of patients. Boards and Committees, it suggests, can help by the right kind of publicity, aimed at staff as well as patients, by periodical efficiency checks, and by encouragement of effort aimed at improvement.

Under the headings of appointments systems, punctuality of staff, responsibility, reception of patients, and public relations, the circular goes on to list particular points to which, it is suggested, special attention should be given. Stress is very rightly placed on the need for appointments systems not only to be universal but designed to ensure that as far as possible each patient is called for the [illegible] he is

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CONTENTS

FOREWORD

This inquiry was initiated at a time when it was realised that a number of hospital authorities were beginning to think that the addition of recovery homes might assist in the solution of the problem of providing a better hospital service.

The subject has received deep thought in various quarters and the report published in 1953 by the Liverpool Regional Hospital Board and United Liverpool Hospitals examines the pros and cons of recovery homes as a means of obtaining a better economy of resources.

This present report tells of the actual working of certain recovery homes, their functions, possibilities and limitations. It also discusses the effect on the parent hospitals. It is hoped that this information will be useful to hospitals or groups of hospitals which are considering the addition of recovery homes or have already started them.

It would not have been possible to prepare this report without the willing co-operation of the hospitals and recovery homes which were visited. The King's Fund wishes to thank all those who so kindly helped in this way.

HENRY TIDY,
Chairman, Convalescent Homes Committee,
King Edward's Hospital Fund for London.

March, 1954.

INTRODUCTION

The Limitations of Convalescent Homes

1. In 1946 it was brought to the notice of the King's Fund that the Convalescent Homes serving Greater London were in an unsatisfactory condition as the result of the war.

The Fund therefore established a Convalescent Homes' Committee to examine the position.

Members of the Committee have regularly visited a large number of homes and obtained information about all others which could be traced. Many Homes had been used for different purposes during the war and needed extensive repair while others had unavoidably been neglected, and a large programme of modernisation and re-equipment was necessary to bring them again to a satisfactory standard. Funds were placed at the disposal of the Committee, and by 1951 it was considered that the capital requirements of convalescent homes had mainly been met.

2. As the result of the experience gained by the Committee, and from the Survey of Convalescence and Recuperative Holidays published by the King's Fund in 1951, it was recognised that only a small number of homes were capable of accepting patients at an early stage of convalescence. It had also come to the notice of the Committee in the course of their visits to convalescent homes that it happened sometimes that patients, while no longer needing the full service of an acute hospital ward, were transferred at a stage when they still required more care than the normal convalescent home could give, with the resulting risk that relapses and complications might develop. It was then hoped that if the staffing and equipment of certain homes could be brought to a higher standard, patients could be transferred to them at an earlier stage of recovery, thereby assisting in relieving the pressure on acute hospital beds, which was causing anxiety.

It was found, however, that a number of factors militated against this policy. For example, many homes were not structurally adapted for further developments, the necessary nursing staff would be very difficult to obtain, and the costs of maintenance would seriously increase. Further, it was more than doubtful if surgeons and physicians would be willing to transfer patients at an early stage of recovery to surroundings and conditions of which they had little knowledge and over which they had no control. The Convalescent Homes Committee arrived at the conclusion

that if patients were to be transferred from hospital at an early stage, an institution distinct from a convalescent home was necessary.

3. It was therefore decided to make a study of recovery homes.

Enquiries first were made as to the views of a number of hospitals within the London area. Visits were made to a few recovery homes already existing within the Metropolitan Hospital Board Regions.

Information was later received that certain large general hospitals in the provinces had already organised recovery homes, in some instances several years previously, owing to the necessity of relieving pressure on their beds. These hospitals are outside the Metropolitan Regions but the Committee was advised to include them in further inquiries.

Definition of a Recovery Home

4. The term is used in this report with the following meaning :—

A recovery home provides accommodation " for patients in whom the disease has definitely begun to abate, or the risk of complications after operation is only slight, so that with proper care and nursing the patient is likely to progress to recovery." This definition is used for admissions to the Astley Ainslie Institution, Edinburgh.

5. A convalescent home, on the other hand, provides accommodation for patients who require a limited period of rest and recuperation after illness or operation before returning to normal employment.

Other names have been suggested, such as " Pre-Convalescent Home " or " Hospital " or " Post-Operative Home." The title " Recovery Home " has a psychological value and is most descriptive of its functions.

Homes expressly for long-stay orthopædic cases are considered to be outside the present inquiry.

History and Development of Recovery Homes

6. A few recovery homes were started after the 1914–18 war. This was perhaps before their time for several reasons. Acute surgical cases, even of mild types, were in a stage of possible complications, especially from sepsis and infections, for a longer period than nowadays. Hospitals had only a limited number of senior residents who already had considerable responsi-

bilities, and consultant staffs feared that the amount of visiting which would be required of them might be excessive. Owing to such difficulties more than one of the early recovery homes became reduced to taking cases at the stage of full convalescence. Between the wars, in the thirties, several more recovery homes were established but the system did not develop to any extent. Indeed, few hospitals were financially in a position to undertake further responsibilities.

7. Developments in the last few years, however, have radically altered the position. Among these may be noted :—

(*a*) Antibiotics have almost eliminated the risk of sepsis following surgical operations, and have shortened the critical stages of certain prevalent medical diseases.

(*b*) With this fear of sepsis no longer present, and as the result of other advances, surgeons have found that patients can profitably be allowed to get up within a few days of operations and that certain complications are reduced by this method. These patients no longer need the full facilities of a hospital, while not yet fit for a convalescent home or to return to their own homes.

(*c*) Some hospitals have a considerable body of senior residents who are qualified, if necessary, to undertake the visiting of a recovery home.

(*d*) The changes in treatment make a definite place for recovery homes where patients can be under the most advantageous conditions for future progress.

Advantages of a Recovery Home

8. The King's Fund considered that the following advantages might result from the possession of a recovery home by a hospital :—

(*a*) Quicker turnover of hospital beds in a hard pressed hospital.

(*b*) Reduction of hospital waiting lists.

(*c*) Provision of additional beds at a lower capital cost and at a maintenance cost substantially below that of the hospital.

(*d*) Possible reduction of total cost of treating each patient.

9. The inquiry was planned initially to ascertain how far these suppositions were true, and what objections might exist to the system of a recovery home.

It had not been previously realised that a recovery home also possessed a special value in that the change of atmosphere from the hospital to the home materially assists the patients' recovery.

REPORT ON INQUIRY

Opinions of certain London Hospitals

10. An inquiry designed to elicit the views of hospitals on the merits and demerits of recovery homes was sent to the following Metropolitan hospitals, which include both teaching and non-teaching hospitals :—

Central Middlesex Hospital
Middlesex Hospital
Royal Cancer Hospital
Royal Free Hospital
University College Hospital
West London Hospital, Hammersmith and St. Mark's Hospitals
Bow Hospital Group
Chelsea Hospital Group
Paddington Hospital Group
Sidcup and Swanley Hospital Group
Woolwich Hospital Group

None of these hospitals or groups of hospitals has a recovery home attached, in the sense which complies with the definition given in paragraph 4.

11. Although replies differed to some extent, there was substantial agreement on the following points :—

(i) Hospitals agreed as to the existence of suitable cases for transfer.
(ii) Medical staffs favoured the principle that a recovery home should be attached to a parent hospital in order to ensure continuity of medical and nursing care.
(iii) Administration should be under the control of the parent hospital.
(iv) Hospitals with training schools would be able, as a rule, to supply nursing staff for the home.

Several hospitals expressed the opinion that the converted country house would be the most suitable building. The importance of accessibility was stressed.

No anxiety was felt by the teaching hospitals that the teaching of medical students would be adversely affected.

12. Most hospitals expressed in varying degree anxiety as to the effect of the heavier work in the hospital wards, and the pressure on operating theatres and ancillary services. It was felt that this might necessitate increased nursing staff in the wards and increased staff for the theatres.

13. Several hospitals, while agreeing that the cost of treating a patient in a recovery home would be lower than in hospital, thought that the cost of the increased intake of acute cases would appreciably offset any saving arising from the transfer of patients to a recovery home.

Enquiries at Hospitals with Recovery Homes

14. In order to obtain direct information a number of hospitals and their attached recovery homes were visited. The list is given in Table I.

TABLE I. HOSPITALS VISITED WITH ATTACHED RECOVERY HOMES

Hospital	*Attached Recovery Home*	*Distance Apart*
Hillingdon Hospital, Middx. (705 beds)	Uxbridge County Hospital (63 beds)	4 miles
Leicester Royal Infirmary, Leicester (446 beds)	Zachary Merton Pre-Convalescent Home (100 beds)	9 miles
Nottingham General Hospital, Nottingham (441 beds)	The Cedars, Pre-Convalescent Home (100 beds)	3 miles
	Ruddington Hall, Pre-Convalescent Home (50 beds)	5 miles
Royal Berkshire Hospital, Reading (339 beds)	Blagrave Pre-Convalescent Home (64 beds)	3 miles
Royal Northern Hospital London (287 beds)	Grovelands Pre-Convalescent Hospital (60 beds)	5 miles
Royal Victoria Infirmary, Newcastle-on-Tyne (723 beds)	Castle Hill Recovery Home (100 beds)	12 miles
West Ham Hospital Group, London, S.E. (266 beds)	Hillingdon House, Post-operative Home, Harlow (35 beds)	21 miles
Worthing Hospital, Sussex (221 beds)	Courtlands Recovery Hospital (52 beds)	3 miles
York County Hospital (222 beds)	Deighton Grove Recovery Home (47 beds)	5 miles

15. All the hospitals visited were satisfied with and enthusiastic as to the value of their recovery homes. The general claim was that more recovery beds could be profitably filled. In every instance the fullest information and facilities were provided and replies given to all inquiries. The King's Fund wishes to express its thanks to their administrative and consultant staffs.

16. Each home visited contained at least 30 beds and was attached to a large general hospital. The Committee has no experience of small homes with 15 or 20 beds which may be attached to hospitals with 100 beds or less.

Relations of a Recovery Home to a Transferring or Parent Hospital

17. In all places which were visited the recovery home had been established by a general hospital for the express purpose of taking its own cases. From its inception, therefore, the recovery home had been attached to a parent hospital for its administration and for its medical and nursing services.

18. All authorities agree that it is essential that a recovery home should be attached and should be regarded as an integral part of the parent hospital. The hospital supplies stores, food, and drugs, and provides general services as required, but it is advisable that separate accounts should be kept.

19. It must be borne in mind that the patients transferred have not reached the stage of convalescence and they still need the same basic medical and nursing treatment as they were receiving in hospital. Such continuity of treatment can only be ensured if it is directly under the control of the staff of the transferring hospital. Indeed consultants would be unwilling for their patients to be removed out of their care at this stage.

The home should be visited regularly at convenient intervals by members of the consulting staff or by senior residents who are familiar with the patients and may at times act for the consultants but not to their exclusion. A resident doctor at the recovery home is unnecessary and is regarded as inadvisable. If the home is more than 12 miles from the hospital arrangements are usually made with a local general practitioner to be available in the event of an emergency.

20. The nursing staff must be under the control and supervision of the matron of the parent hospital and supplied from the hospital. An assistant matron or senior member of the nursing staff is locally in charge. It is important to note that in the homes visited there

is ample time and opportunity for teaching and training student nurses. The nurses are contented and the work is not monotonous, and, although there are no acute cases, the rapid turnover maintains interest.

21. The ratio of nurses to patients varies considerably, but is commonly 1 to 4 or 1 to 5. About half the nursing staff are fully trained and more or less permanent; the others are student nurses. Varying numbers of pre-student nurses as may be available are used for minor services in the wards.

The staff at a 47-bed recovery home was as follows :—

1 Sister in Charge
3 Sisters S.R.N.
2 Staff Nurses S.R.N.
5 Student Nurses.

22. In some cases two hospitals in the same group, of which one hospital has a recovery home attached, have the same consultant staff. In a few such instances, a small number of patients are being transferred from the second hospital.

Within this framework, a recovery home may be attached either to a teaching hospital or to the principal hospital of a group.

23. The parent hospital and the recovery home both have duties in maintaining the character of the home. If it is to continue to fulfil the functions for which it was established, the cases transferred must conform to the definition given in paragraph 4.

The home is not equipped with nursing or medical staff to deal with patients in an early acute stage, and, if these are admitted, the nurses become overworked and are disturbed when the necessity arises to return patients to the hospital. If, on the other hand, the hospital transfers too many long stay orthopædic or geriatric cases, the beds in the recovery home rapidly become blocked.

The homes which work most smoothly and satisfactorily are those which adhere most closely to the definition which has been given. Mixture with patients of other types or grades of severity seems rapidly to impair the standard and its value as a recovery home. It is essential that the home should not be used to take cases merely because they are an inconvenience to the hospital.

Localities and Buildings suitable for Recovery Homes

24. Hospital authorities are emphatic that a patient who has reached the stage which is defined as " recovery " particularly benefits from the atmosphere and quiet of a country house after the noise and disturbance of an acute ward have become irksome, and consequently that a recovery home should be in country surroundings or at least in ample grounds.

The distance from the parent hospital depends initially on this requirement. In a provincial city a house which complies with these conditions may well be found within 5 miles of the hospital and the centre of the town. For London it might have to be 20 to 25 miles distant.

Within these limits, conveyance of patients by ambulance involves no risk or discomfort.

25. Accessibility is an important factor since the hospital consultants must be able to make sufficient visits to keep the patient under observation. The home must be easily reached by patients' relatives, and public transport to and from a local centre must be available for the staff.

26. The homes visited were with one exception converted private houses standing in their own grounds. Some of the houses had been given to hospitals but in several cases a hospital had deliberately decided to purchase a country house as being most suitable for the purpose.

The accommodation in these homes varied between 35 and 100 beds equally divided between the two sexes. A convenient size is between 35 or 40 and 60 beds, 60 being about the maximum a large country house can provide without extensive building, which tends to diminish its simplicity. Nevertheless in more than one instance pleasantly constructed wards, making a total of 100 beds, have been successfully added to the original structure.

While country houses are especially convenient for conversion this does not exclude the possibility of adapting other types of buildings.

27. At Reading a single-storey hospital, originally designed for orthopædic patients, has been converted into a recovery home. This is a beautiful building in country surroundings, which was erected shortly before the 1939–45 war and would now be very costly. It is very effective as a recovery home, though not more so than some converted private houses.

28. Conversion of a building into a recovery home entails altering rooms into small wards, which is often easily performed, and provision of extra sanitary annexes. A day room is essential as well as amenities for patients who may be ambulant for a few days before returning home. Accommodation is also necessary for nursing and domestic staff.

29. Equipment should be as simple as possible, consistent with the work to be performed. An operating theatre is unnecessary, and if an operation is indicated, the patient should be returned to the parent hospital. Ancillary services, such as X-rays, laboratory facilities, dispensary and services of a physiotherapist are supplied, when needed, by the parent hospital.

The cost of purchase and conversion of a building will necessarily vary with local and other factors. York General Hospital bought a house in 1947 for £10,000 and converted it at a cost of £12,000, a total expenditure of £22,000 for 47 beds, being an average of £470 a bed. This was a very successful conversion. At Worthing a bomb-damaged house was purchased in 1946 for £18,000 and repaired, converted and equipped for £32,000 : deducting £10,000 repaid for War Damage, the net cost was £40,000 for 52 beds, about £800 a bed.

30. The Committee has no experience of conversion of other types of buildings or of specially built homes.

A small country hospital might be convenient and easily adapted. Certain convalescent homes for children are not being used at present to their full capacity, and there is some evidence that the demand for such accommodation may diminish in the future. Conversion of these institutions into adult recovery homes should present little difficulty.

In no place visited has a hospital built on conventional lines been converted and authorities possessing recovery homes are strongly of opinion that they might be unsuitable.

31. It has been suggested that a hospital which has " unstaffed wards " might use them for recovery beds. On first thoughts this idea may appear simple and attractive. But such wards are commonly in old hospitals in city surroundings, and are usually unstaffed because there is no nursing staff available for them. Their adaptation would have little in common with the country recovery home.

Some fever hospitals in country surroundings are no longer required but with few exceptions they tend to be institutional and

uncongenial though they often have the advantage of standing in their own grounds.

Categories of Patients and Proportion Suitable for Transfer

32. Patients are suitable for a recovery home who conform with the definition given in paragraph 4. Such patients, while not yet convalescent need only nursing and simple general treatment, together with regular observation by the consultant staff of the parent hospital.

33. Hospital authorities are agreed that patients from surgical, general medical and gynæcological wards are most suitable for transfer. In most instances these wards supply sufficient cases to fill the available beds, and hospitals have given little thought to special departments, but it is generally believed that the number of cases from E.N.T., skin and eye wards would be small.

34. The question of transferring children does not appear to have been generally considered by hospital authorities since the existing homes can be filled without them, but no definite reason has been advanced for their exclusion, provided there is accommodation. One home takes some children and finds them quite satisfactory.

35. Maternity cases fall into a separate category, since they require as careful treatment after confinement as before it. In one home maternity cases form 60 per cent. of the admissions, and the home is specially equipped to deal with them and does so successfully. This is in effect the provision of additional beds to the parent hospital and differs from the general conception of a recovery home. Other homes do not admit maternity cases.

36. Firmness should be exercised in resisting pressure to take orthopædic and geriatric patients since these commonly prove to be long stay, and geriatric patients are often difficult to discharge. Nevertheless most homes have been unable to avoid admitting a few orthopædic cases, and it may be mentioned that one general hospital is in process of establishing a separate home for orthopædic patients.

37. The proportions of transfers attributable to the various medical categories in six of the recovery homes that were visited are given in Table II.

TABLE II. PROPORTIONS OF TRANSFERS ATTRIBUTABLE TO VARIOUS MEDICAL CATEGORIES.

Medical Categories	*Recovery Homes*					
	A	B	C	D	E	F
Surgical	78%	50%	57%	54%	48%	30%
Medical	12%	—	14%	46%	22%	10%
Gynæcological ...	6%	23%	16%	—	21%	—
Orthopædic	4%	27%	13%	—	3%	—
Pædiatric	—	—	—	—	6%	—
Maternity	—	—	—	—	—	60%
	100	100	100	100	100	100

It is important to know the proportion of cases which are transferred or are regarded as transferable in order to ascertain the maximum number of recovery beds which a hospital could fill with suitable cases.

38. In most instances the hospital was in fact limited by the number of recovery beds available, which was insufficient to take all the suitable cases. These hospitals therefore could only supply figures for those actually transferred, and express an opinion as to what further number of beds could be used.

The number of patients transferred in different hospitals rises regularly with the proportion of available recovery beds to the number of hospital beds in the wards for surgery, general medicine and gynæcology. The highest proportion transferred by a hospital is 30 per cent. from these wards, and its recovery home has this ratio of beds.

From the information available it would appear that a parent hospital is supplied with a sufficient number of recovery beds when these total one third of the number of beds in the surgical, general medical and gynæcological wards. Up to this ratio a parent hospital still has some suitable cases which it is unable to transfer. The corollary is probably correct : viz., if cases are transferred in excess of this ratio, the home is receiving unsuitable patients.

Duration of Patients' Stay in a Recovery Home

39. It was originally expected that the principal function of a recovery home would be to take short stay cases, for example, patients who have spent two or three days in bed and need only

a further two or three days before being fit to return to normal life. It has, however, been found that it is uneconomical to transfer such patients and that the beds can be used more profitably for a severer type. Ambulant patients are rarely transferred.

Many of the cases now transferred are of medium severity, who spend some 12 to 15 days in hospital and a similar period in the recovery home. Such cases before transfer would have already reached the stage where the risk of complications is slight and steady progress to recovery can be anticipated. The average duration of stay, where details have been available, is 13·9 days in hospital and 13·4 in the home, a total of 27·3 days. Many of the figures were affected by the presence in the home of a small number of long-stay orthopædic cases. If these long-stay cases are omitted, the average duration for the majority would be definitely reduced. Data are incomplete, but in one home the duration was 10 days excluding orthopædic patients, following 14 days in hospital. The average total duration of a stay in hospital and home, excluding orthopædic cases, would thus be about 24 days. Even this duration may be longer than an average stay in a general hospital, but it is longer because of the severity of the case and not because of transference to a recovery home. Most homes are full to capacity summer and winter. Admissions are made at short intervals, often daily.

40. Patients, with few exceptions, are discharged direct to their own homes. A few patients are transferred to convalescent homes, but it is the general opinion that the second transfer should be avoided if possible.

Effect on Nursing Staff and Other Departments of Parent Hospital

41. It is obvious that the quicker turnover of acute cases must react on the volume of work of ward nurses and also, to some degree, on other departments of a parent hospital. The question of the extra work entailed caused some anxiety in certain of the hospitals originally consulted and doubts have been raised on these grounds as to the value and desirability of a recovery home. It is important consequently to obtain some measure of the extent to which the work is affected.

42. With regard to nursing staff, specific enquiries on two points were made from a number of hospitals with recovery homes. First whether the training of student nurses was interfered with and secondly whether the nursing staff of a ward was overworked,

a larger allocation of nurses becoming necessary. With the permission of hospital authorities, the opinion of matrons was obtained on these questions.

43. Matrons of some hospitals with recovery homes attached state that representations are received from ward sisters that they have insufficient time for teaching the student nurses, but they say that this cannot be ascribed entirely to the recovery home as other factors contribute, such as shortage of staff. These matrons think that teaching in the transferring wards is probably affected to some extent, though close co-operation of the sister tutor with the ward sisters is helpful. Not all matrons, however, agree with these views.

Somewhat unexpectedly, a recovery home helps to extend the facilities for nurses' training. It is customary to send student nurses to the recovery home for periods of three months, and in these wards there is ample time for teaching. Patients still require active nursing and students have the opportunity to watch their progress to recovery. It is the general opinion that this training is valuable and evidence shows that examination results have not deteriorated.

44. It is important to note that the effect of a recovery home on the work of a parent hospital can easily be exaggerated and is often over-stated.

A general hospital of 700 beds which has a recovery home of 100 beds may be taken as an example. The recovery home will be supplied from about 550 beds, which gives a proportion of 1 recovery bed to 5·5 beds in transferring wards. Thus the effect on a ward of 28 beds can be represented approximately by saying that 23 beds will be discharging normally and 5 beds will be transferring to the recovery home. Such a proportion is unlikely to cause any serious disturbance. Those in charge of administration and of nursing in the hospital in question find in fact that they receive no reports of overwork from the ward staffs or of difficulties in teaching nor is there any call for extra staff in other departments of the hospital.

45. Pressure of work of course, will vary with the rapidity of the turnover depending on the percentage of transfers to the home. As previously indicated, the maximum percentage of suitable cases for transfer may be taken as 30 per cent. In a 28 bed ward, this would correspond to 19 discharging normally and 9 transferring to a recovery home. Matrons find that in these circumstances the work is heavy for a normal allocation of nurses, although the nursing staff do not complain. It is probable that when transfers

reach or approach this proportion, some relief to the nursing staff is called for.

46. It has not proved possible to obtain a reliable comparison of the intensity of work in wards with and without a recovery home, since many factors are involved.

The opinion has been expressed that with high pressure the difference can be represented as one extra nurse to a ward. Matrons who have had to deal with this position find that the deficiency can be met by the employment of ancillary staff. Ward orderlies relieve nurses of many non-nursing duties, and an acute transferring ward has employment for full-time orderlies. Use can also be made of part-time nurses. With such resources, no increase may be necessary in the number of trained nurses.

Matrons consulted have no doubt as to the value of a recovery home especially from the point of view of the treatment of patients, and consider that the nursing problems can be made to fit in.

47. There must be some increase in the work of the operating theatres, probably of similar dimensions to the increased work in the wards. Such increase does not appear to have attracted any special attention or called for any special measures. No report was received of additional staff being required either for the operating theatres or for other departments.

Maintenance Costs of a Recovery Home

48. Figures for maintenance costs of seven recovery homes and their parent hospitals are given in Table III. These results show that the cost of maintaining a patient in a recovery home is usually rather less than half that in the parent hospital.

TABLE III. COST PER PATIENT WEEK AT RECOVERY HOMES AND AT PARENT HOSPITALS

	Cost per patient week		*Cost at recovery home expressed as a percentage of cost at parent hospital*
	At Recovery Home	*At Parent Hospital*	
	£ s. d.	£ s. d.	
A.	5 15 7	15 10 4	37%
B.	8 10 11	21 0 0	41%
C.	9 7 6	20 14 10	45%
D.	8 5 11	18 2 5	46%
E.	7 8 5	15 10 4	48%
F.	8 6 10	16 9 0	51%
G.	9 19 6	16 18 11	57%

Maintenance costs of Parent Hospital

49. Fears have been expressed that the rise in costs of a parent hospital due to increased work resulting from a recovery home will appreciably reduce any saving effected by the lower costs of a home. Maintenance costs of a hospital must necessarily bear some relation to the amount of work performed, although the relationship will not be strictly proportional to every change.

It has already been shown that the impact of a recovery home on a parent hospital does not produce the severe changes which might have been anticipated and it will have little effect on overhead charges. It must be borne in mind that hospitals which now have recovery beds would in any event be working with a high bed-occupancy.

50. Owing to the number of factors involved, it has proved impossible to obtain a satisfactory comparison of the costs between a hospital with a recovery home and a hospital not too far away of similar size and conditions, but without recovery beds. In one instance, the Royal Berkshire Hospital, with a recovery home, was compared with the Derbyshire Royal Infirmary, and apart from small variations in cost of different departments, there was virtually no difference in the published patient-week costs. On comparing the Nottingham General Hospital, which has two recovery homes, with the Derbyshire Royal Infirmary, the cost at Derby was somewhat the greater of the two. Such comparisons must not be pressed too closely, but there are no available data which indicate that there is any recognizable increase in the maintenance costs of a parent hospital as the result of a recovery home.

The general conclusion appears to be justified that the effect of a recovery home on the maintenance costs of a parent hospital is too small to be recognisable and cannot be more than slight.

51. At the same time it will be realized that the establishment of a recovery home will involve the parent hospital in the additional expenditure represented by the Capital cost of the recovery home and the annual cost of its maintenance.

Effect on total Cost per Patient

52. The financial value of a recovery home is demonstrated by the reduction of the cost per patient. Instead of the patient spending the whole period in the expensive wards of the hospital, half the period is passed in the much cheaper recovery beds.

An important benefit resulting from the establishment of a recovery home is to be found in the economic and social value of a reduction of the hospital waiting list.

CONCLUSIONS

53. Recent advances in treatment, especially the control of sepsis and infections by antibiotics, have rendered it possible and advantageous to transfer from hospital a number of patients at an early stage of recovery to a simpler institution, which may be referred to as a " recovery home."

54. A recovery home may be defined as one suitable " for patients in whom the disease has definitely begun to abate or the risk of complications after operation is only slight, so that with proper care and nursing the patient is likely to progress to recovery." Other types of cases should not be admitted.

55. A recovery home must be attached to a parent hospital for administration and for medical and nursing control in order to ensure the continuity of treatment which is essential. In certain circumstances more than one hospital with a common consultant staff may share a recovery home.

56. A recovery home should be situated in country surroundings reasonably accessible from the parent hospital. The benefit to the patient of transference to the homely atmosphere of a recovery home with continuity of treatment, is now fully recognized although this was not the primary object of its establishment.

57. One third of the patients in the surgical, general medical and gynæcological wards of a general hospital are, as a general rule, suitable for transfer to a recovery home.

58. Hospital authorities who have experience of recovery homes have no doubts as to their value. Others without this experience have expressed the view that the extra work thrown on the parent hospital would necessitate an appreciable increase of the nursing staff and some increase in other departments. Experience shows, however, that the extra work falling on the nursing staff is severe only when the transference of patients exceeds the maximum rate that has been indicated in this report.

59. The teaching of medical students and training of student nurses are not adversely affected by a recovery home.

60. The cost of establishing a recovery home will involve the parent hospital in additional expenditure represented by the capital cost of the recovery home and the annual cost of its maintenance. The capital cost of purchase and adaptation of a suitable country house is however considerably less than building additional hospital wards.

61. The maintenance costs of a parent hospital are not increased by the addition of a recovery home by any amount recognisable in existing data.

62. A recovery home can provide the following results :—

(i) Increase in the turnover of acute cases at the parent hospital and resulting reduction of the waiting list.

(ii) Substantial relief when there is severe and increasing demand for the admission of acute surgical cases.

(iii) An atmosphere which materially assists the patients' recovery.

(iv) Substantial reduction of the total cost per patient.

JLB

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