KING EDWARD'S HOSPITAL FUND
FOR LONDON

HOSPITAL PERSONAL AID SERVICE FOR THE ELDERLY

REPORT TO 31st DECEMBER 1958

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THE Service undertakes to visit, on behalf of hospitals, elderly people awaiting admission to hospital whose medical condition does not warrant immediate admission to an acute ward.
The main objects are:

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

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

(3) To suggest suitable means for the care of those patients who are not considered by the hospital to need admission on medical grounds.

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

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

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OFFICE

C/O NEW CROSS GENERAL HOSPITAL,
AVONLEY ROAD,
S.E.14.
Telephone: NEW Cross 3635

FOREWORD

THE Hospital Personal Aid Service for the Elderly was established by King Edward's Hospital Fund. It has the co-operation of the four Metropolitan Regional Hospital Boards, each contributing towards the cost, the Fund paying the balance. In 1958 the Service worked for and at the request of fifteen hospital management committees.

It is emphasised that no domiciliary visits are made except at the request of hospitals to whom, of course, the Service is free. The Fund welcomes enquiries about this Service and is always ready to consider requests from hospitals in the metropolitan regions who think the Service could be of help to them.

ZACHARY COPE,
Chairman.

REPORT TO 31st DECEMBER 1958

IN OUR LAST REPORT we made some comments on chronic sick waiting lists. This time we want to discuss them in greater detail as year by year our work has shown that in general they are not the record of patients awaiting hospital vacancies and the arrival of the ambulance as is usually supposed. This statement is based on our investigations, the results of which we give in the following pages. Lest there be some who feel that we are unduly stressing a matter which does not ultimately affect the admission and treatment of patients on the lists who really need and await hospital care, we would say that we do so for two special reasons. First, the lists imply shortage of accommodation and this in turn gives rise to the belief that to provide adequate care for the elderly is a far greater problem than it, in fact, is. Secondly, we believe that at times considerable distress is caused because many people are put on these lists although the hospital does not expect to admit them.

The number of geriatric/chronic sick patients said to be awaiting admission to hospitals in England and Wales on 31st December each year since 1949 has remained fairly constant as the following figures (Ministry of Health) show:

1949	..	7,712	1954	..	9,719
1950	..	9,591	1955	..	9,273
1951	..	8,807	1956	..	9,584
1952	..	9,748	1957	..	10,626
1953	..	9,139	1958	..	9,583

It will be seen that there were no more waiting at the end of 1958 than there were in 1950. It may be inferred that some nine thousand more beds are needed to meet the demands of the geriatric/chronic sick. When an investigation is made of the cases which comprise the lists it is clear that if taken as a guide to the demand they are dangerously misleading.

We have studied the figures relating to ten hospital groups in one Metropolitan Hospital Region. All of them are in or on the borders of Greater London. The total number of patients on their chronic sick waiting lists on 31st December, 1958 was 675.

But we found that 187 of them were, in fact, already in hospital. It seems that quite frequently elderly patients, having been admitted to appropriate wards with an acute condition, are put on the chronic sick waiting list for transfer as soon as treatment of the acute condition has been completed. Others may be in geriatric/chronic sick wards in other hospital groups and want to be transferred to a hospital near the homes of their relatives. Whatever the reason 28% of the number on the waiting list of these ten hospital groups already occupied hospital accommodation. In another area it was 25%. It seems possible therefore that about one quarter of the total number in the country shown as awaiting admission are, in fact, already in hospital beds. Though these may not always be the most suitable beds, they are, at any rate, provided by the hospital service. We made a quick check of the transfer cases in one group and out of the twenty on its list we discovered that all had either died or had been discharged or transferred elsewhere. Another group told us that they seldom give any priority to patients for transfer from acute wards as they have invariably found that when they offer a vacancy the patient who arrives is not one of those on the list. Thus it seems that, not only might a high proportion of those on the waiting lists already occupy hospital beds, but the need for transfer from one ward or hospital to another is often extremely doubtful as is the intention of the hospital to arrange it.

The ten hospital groups also had 34 cases awaiting transfer from welfare authority accommodation and it interested us to notice that four of the groups each showed exactly the same number waiting at the end of 1958 as at the end of 1957. When we enquired into eight of these cases we found that two had died 18 months before, one six months before, three had been admitted to other hospitals and two had recovered.

The results of our work in 1958 which are given in the following pages add support in other ways to our contention that in general waiting lists are misleading. But statistical summaries do not show the distress which is caused to elderly people and often to their relatives by the use that is made of the lists.

Many hospitals have said that they have patients on their lists whom they do not expect to admit unless there is some

definite change in the medical or social condition. What help is arranged for these patients instead? Often, we find, none, nor does it seem that the patient or the relatives are always aware of the true intention. For nineteen months a daughter had been expecting the admission of her 91 year old mother as she hoped it would save her own marriage which the patient's presence was straining. The hospital had not recorded any diagnosis and apparently considered that the old lady's extreme infirmity justified the entry of her name on the waiting list but not her admission to hospital. Meanwhile the daughter continued to hope. Another patient had waited twenty months because, we were told, the hospital saw no medical reason for admission and the social circumstances were reasonably satisfactory for one who was active enough to care for himself while alone all day. Chronic sick or geriatric units will be familiar with such cases and we need not quote more, but it does seem to us that one and a half years is a long time in which to remain in doubt about the future. It seems that at times it is easier to accept a name on a waiting list and excuse the prolonged delay on shortage of accommodation than to declare that the patient does not need hospital care and to seek or suggest alternative assistance for him. Such alternative arrangements as we have made have always met with the general practitioners' approval and in fact many general practitioners look for such help for their patients as often as they expect admission for them.

We are aware that much of our criticism has been made after enquiry into but a small number of cases and hospital groups. Nevertheless we feel that there is enough evidence to cause serious misgivings and if every hospital group were to make similar investigations into the cases on their waiting list, not only would the number of patients really awaiting vacancies be far less than that published by the Ministry but many elderly people would have more practical help than they have at present. There has been so much improvement in the general care of and provision for elderly people that it seems a pity that it should be obscured by misleading statistics.

DOMICILIARY WORK IN 1958

DURING the year 2,396 patients on hospital waiting lists were visited for social assessment. This is an increase of 688 on the number visited in 1957 and is due to an increase in the number of cases in most groups rather than to the Service working in more groups.

Table I gives a statistical summary of the results of the domiciliary visits with, for comparison, those in 1957, those since the Service started in 1951 until the end of 1956 and the totals.

TABLE I

Statistical Summary of Domiciliary Visits

	1951-56	*1957*	*1958*	*Totals*	*% of Total*
Patients visited	7,409	1,708	2,396	11,513	
Removal from waiting list					
Died or already admitted	1,037	134	166	1,337	11.6
Withdrawn	1,962	377	518	2,857	24.8
Other arrangements ..	825	316	465	1,606	14.0
	3,824	827	1,149	5,800	50.4
Admission to Hospital					
Priority I (Urgent) ..	556	40	30	626	19.8
Priority II (Less urgent)	948	188	323	1,459	
Priority III (Not urgent)	611	199	286	1,096	
After observation ..	829	320	423	1,572	
	2,944	747	1,062	4,753	41.3
Died before admission ..	290	22	23	335	2.9
Still awaiting admission..	—	5	57	62	0.5
Died while under observation	351	107	105	563	4.9
	7,409	1,708	2,396	11,513	

It will be seen how little the pattern changes year by year; about half those visited are removed from the waiting lists while rather less than half are admitted; some are recommended for admission but die before vacancies are found.

In the first place it will be seen that 11.6% have died or have already been admitted by the time the domiciliary visit is made. Considering this visit is usually within a day or two of the application being received by the hospital, the proportion in groups which

do not keep their waiting lists under constant review must be very high indeed. A still greater number of removals (24.8%) are those who recover and do not need admission or refuse it and their names are consequently withdrawn by their doctors.

We would like to draw particular attention to the numbers removed from the waiting list when other arrangements have been made. These represent patients whose doctors, though they applied for hospital admission, agreed to the arrangement for some alternative care which the Service suggested. This number is rising gradually and in 1958 was 19% of the total number of patients visited. It will not be denied that this is a very appreciable saving of hospital beds as it is assumed that had the visit not been made the patients would have been admitted and their stay might have been prolonged. What is of more importance is that something has definitely been arranged for these patients instead of leaving them like many others only "on the waiting list".

Not infrequently the other arrangements we make enable the patients to remain at home. We are fully aware that there are some in authority who hold the view that young people should not be burdened with their elderly relatives. In our experience the majority of elderly people wish to be at home and most young people dislike "putting them away". Therefore, we think that the aim of all those concerned with such situations should be to remove the causes that make the old person a burden rather than to remove the patient unless it is obviously necessary or desirable to do so. A simple example of what can be done is the case of the very infirm and very heavy old lady whose nephew and niece found it impossible to keep at home because she could only be lifted when the nephew was there. None wanted the admission which their doctor felt was the only solution. The provision of a hoist, however, changed the whole situation and enabled the niece to give the patient attention at home.

We have already said a great deal about waiting lists but we would draw attention to the fact that five patients we visited in 1957 were still waiting at the end of 1958. It did not seem, at the time of the visit, that admission was necessary on social grounds and one must assume that there cannot have been any great

medical need. Of those the Service visited in 1958 who were still waiting at the end of the year, at least forty-five were not in need of admission on social grounds.

LENGTH OF WAIT FOR ADMISSION

THE steady improvement in the waiting time of those considered to need admission urgently or fairly urgently can be seen from the figures given in Table II. Every year a greater proportion enter hospital within a week of being visited and a smaller number wait an unreasonably long time.

TABLE II

Length of wait for admission

	1952	1953	1954	1955	1956	1957	1958
CASES ADMITTED ..	316	334	348	219	219	228	353
On day of visit ..	9	12	10	13	18	27	24
1 day after visit ..	42	35	43	29	30	48	67
2 days after visit ..	16	19	35	25	24	25	42
3 days after visit ..	9	13	20	12	17	15	41
4 days after visit ..	10	12	16	5	16	13	32
5 days after visit ..	4	14	15	9	11	7	19
6 days after visit ..	9	8	19	8	12	14	28
i.e. within 1 week ..	99 31%	113 34%	158 45%	101 46%	128 58%	149 66%	253 72%
During 2nd week ..	52 17%	47 14%	63 18%	40 18%	43 20%	41 18%	60 17%
During 3rd week ..	26 8%	39 12%	31 9%	22 10%	18 8%	13 6%	19 5%
During 4th week ..	23 7%	19 6%	20 6%	11 5%	11 5%	7 3%	7 2%
During 2nd month ..	44 14%	51 15%	37 11%	23 11%	10 5%	12 5%	8 2%
Over 2 months ..	72 23%	65 19%	39 11%	22 10%	9 4%	5 2%	6 2%

LENGTH OF STAY IN HOSPITAL

IN Table III we show the number of patients who have died since admission, the number discharged and those still in hospital and the length of stay of each. It is not always realised what a high proportion of patients leave hospital or die within a few weeks of admission; as our figures show over 61% die or are discharged within three months. It will also be seen that 25 patients were discharged after they had been two years in hospital; the stay of two of them had been over four years.

TABLE III

Days	*Deaths*	*Discharges*	*Still In*
0 – 28	957	699	57
29 – 56	353	454	41
57 – 84	183	275	10
85 – 112	109	150	6
113 – 140	82	77	17
141 – 168	67	71	12
169 – 196	48	48	6
(6 months)			
197 – 224	51	28	15
225 – 252	46	27	17
253 – 280	37	22	11
281 – 308	30	19	12
309 – 336	37	11	7
337 – 364	19	6	8
(1 year)			
365 – 392	26	10	6
393 – 420	30	7	6
421 – 448	20	9	3
449 – 476	15	7	4
477 – 504	20	5	6
505 – 532	23	8	6
533 – 560	20	4	5
561 – 588	11	5	1
589 – 616	9	4	4
617 – 644	9	1	7
645 – 672	13	2	4
673 – 700	7	3	4
701 – 728	13	2	2
(2 years)			
3rd year	76	21	59
4th year	39	2	36
5th year	17	2	13
6th year	3	—	19
	2,370	1,979	404
		4,753	

We have in the past made special reference to the need to improve the rate of discharge in order to give those awaiting hospital care the treatment they need. Many groups show a higher discharge rate than death rate but in total it will be seen that deaths exceed discharges by approximately 400. However, of the patients visited and admitted in 1958, we have noticed, for the first time, more were discharged than died.

It seems that there may be a more general need for quick assessment of the needs of the applicants for chronic sick/geriatric beds than there is at present. We suggest that hospital beds are primarily for patients who need, or are likely to respond to, hospital treatment and those needing such care as can only reasonably be given in hospital. Patients not in these categories should only be in hospital when all alternatives have failed. We wonder whether it is sometimes easier to use the waiting list and even at times a hospital bed than to seek the alternative.

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