King Edward's Hospital Fund for London

CONVALESCENCE
AND
RECUPERATIVE HOLIDAYS

A REPORT OF A SURVEY CARRIED OUT BETWEEN FEBRUARY AND JULY 1950

KING EDWARD'S HOSPITAL FOR LONDON, 10, OLD JEWRY, E.C.2
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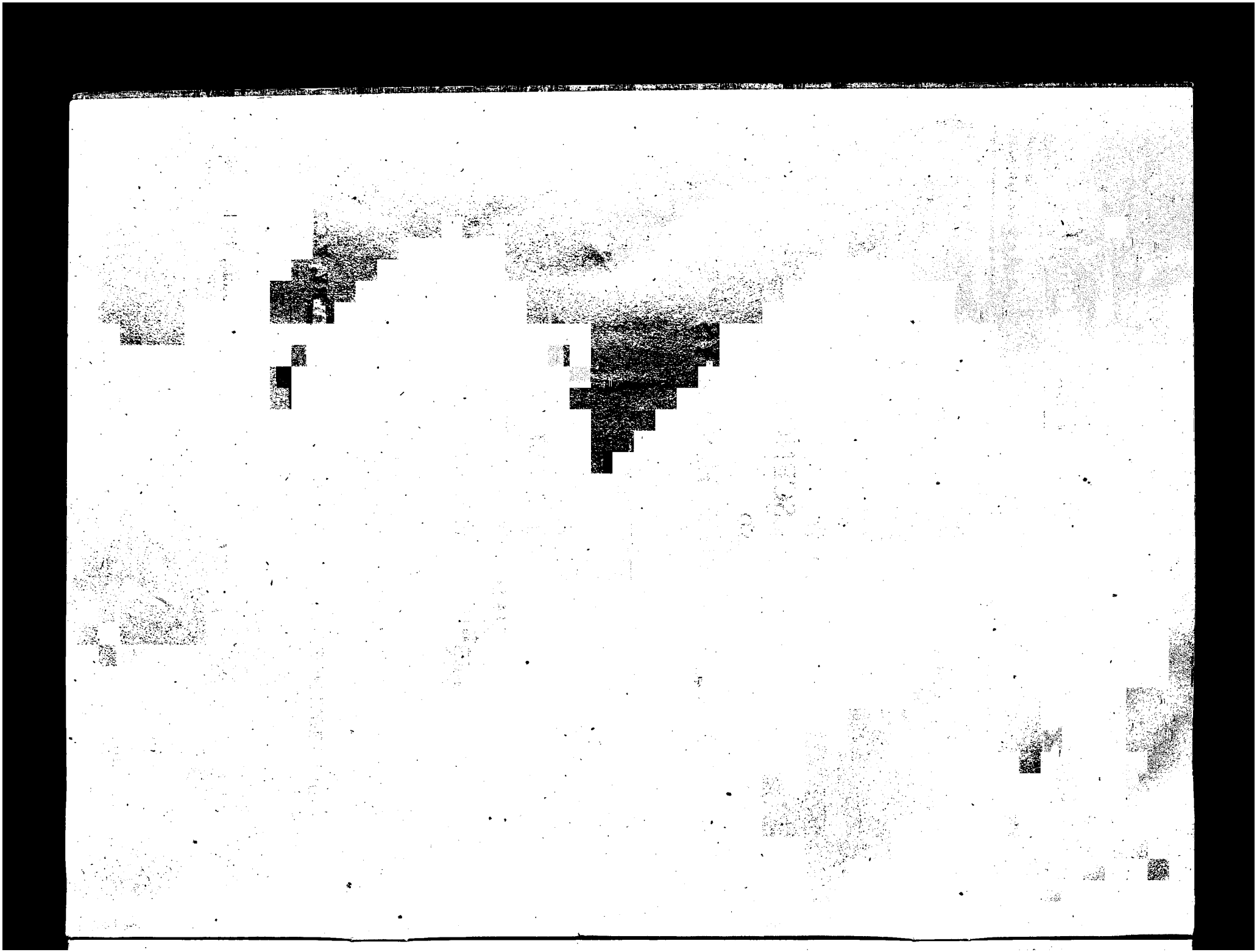

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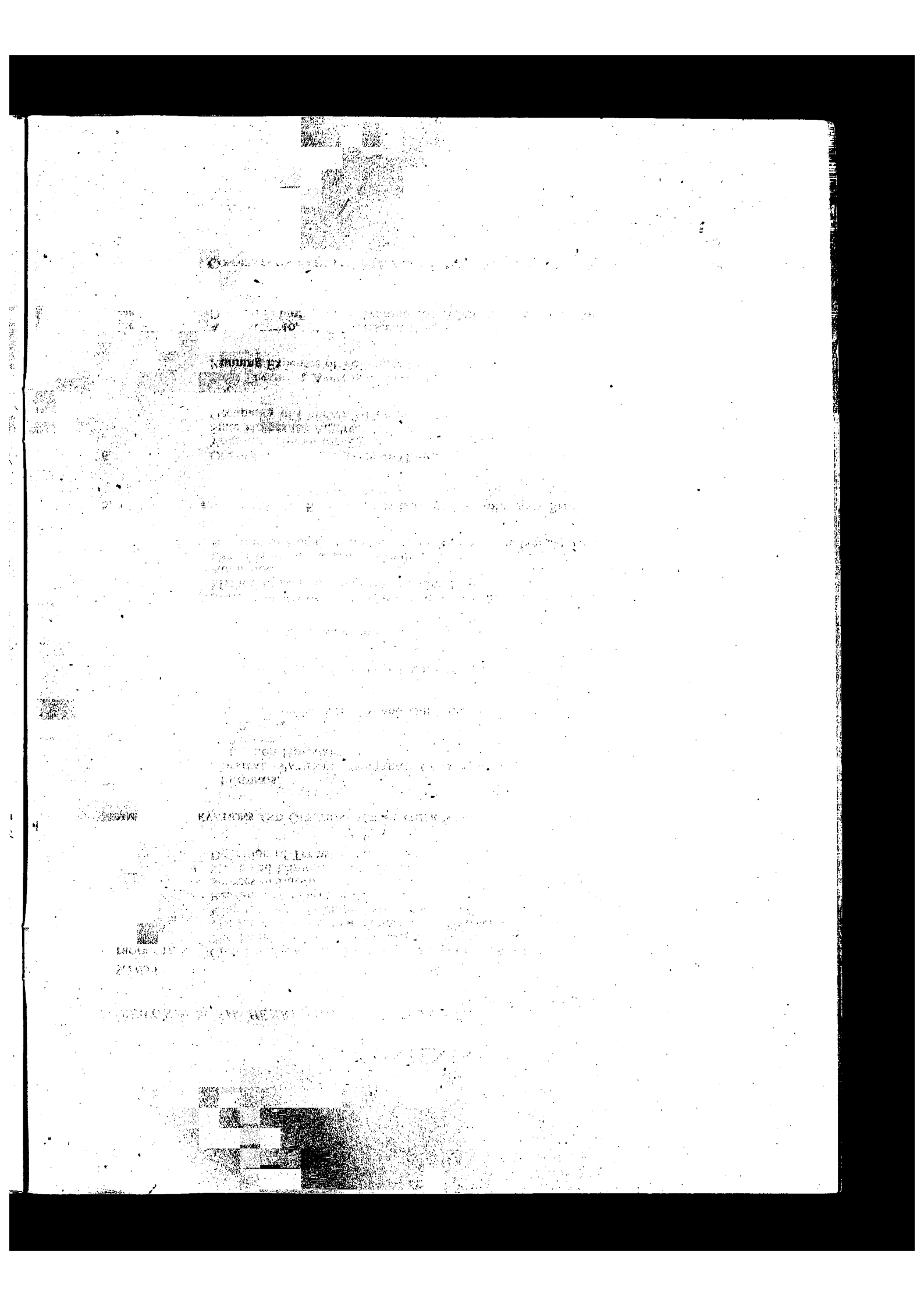

FOREWORD

The decision of the King's Fund to authorise a detailed survey of convalescence as it affects London patients arose as a development of the work of the Fund in the rehabilitation of convalescent homes.

In 1946 it was realised that convalescent homes had been severely affected by the war, many having been obliged to close. Reserve funds were often insufficient to enable them to re-open, and were rarely adequate for the expenditure necessary for modernisation to meet present-day requirements. Consequently, in December 1946 the Fund set up the Convalescent Homes Committee with instructions to assist convalescent homes in their difficulties.

The Committee started with little knowledge of how to carry out their functions. It was here that the help of hospital almoners at once became invaluable. Throughout the activities of the Committee, including the survey here reported, the assistance of almoners, both individually and through their Institute, has been frequently requested and invariably afforded.

The first step was to ascertain what convalescent homes existed which took patients from the London area, and a list was compiled as the result of enquiries in many quarters. This is now issued annually as the Directory of Convalescent Homes serving the Greater London Area.

It was decided that each home should be visited and reported on as to its condition and needs. After some initial difficulties it was found that this duty, to be satisfactory, had to be done by members of the Committee, and each home is now visited annually. The members of the Committee thus acquire personal knowledge of homes and their problems.

The first step was to assist homes to re-open, involving re-decorating and equipping with modern facilities, and in many instances requiring structural alterations.

In the four years 1947 to 1950, £230,000 *were expended for this purpose, much of which could not have been obtained from other sources. The main part of this programme of re-establishment has now been completed.*

In 1948 the Ministry of Health was implementing the National Health Service Act 1946 by transferring to the Ministry convalescent homes which afforded "treatment", as directed by the Act. The Ministry was hampered in this duty by the lack of information about the country's

convalescence services. It was also placed in the difficulty of deciding what constituted "treatment" in a convalescent home.

While the state homes are thus under a different administration to the voluntary homes, there is considerable overlapping of interests. Owing to the general goodwill of the Regional Boards this has involved less difficulty than might have occurred. Nevertheless, as indicated in the survey, the financial interests of the two groups are not identical.

Many requests have been received by the King's Fund as the result of its interest in convalescent homes. Thus it has been asked to provide homes for special types of diseases and patients. It has to be realised that the establishment of a convalescent home is usually quite different from that of a hospital. A single hospital of moderate size can house under one roof wards for males and females, for medical and surgical disabilities, for children and infants, and can provide for diabetic, gastric and other diets.

Convalescent homes, except a few of the largest, are restricted to one or two groups. Convalescents from a hospital thus have to be redistributed to a number of homes, and it may be difficult to find accommodation for a patient belonging to a special group. The number which belong to the group may in fact be small, and the demand not so important as might at first appear.

The delay in finding vacancies at homes, both for in-patients and out-patients, is another matter which often arises. No information has existed as to how frequently this happened, how long was the delay, and whether the difficulty was due to shortage of beds or lengthy formalities for admission.

It became clear that very little information was available about convalescent patients as distinct from convalescent homes. It is important to know what happens to a patient and his application form between the time he is in bed in a ward and the moment he arrives in a home, and equally so for an out-patient or one recommended for convalescence from other sources.

Another problem of a different type is concerned with the low occupancy of voluntary homes in winter. If their winter occupancy is so low that they cannot recoup themselves in summer these homes must close and this may result in insufficient beds to meet the summer demand.

The survey was initiated in the hope of obtaining answers to some at least of these and other questions which have presented themselves to the Convalescent Homes Committee.

While they have not all been answered, much information of value has been obtained.

HENRY TIDY.

INTRODUCTION

Convalescent Homes before the National Health Service Act

> "To provide, free of cost to its beneficiaries, establishments in the country or at the seaside for the temporary residence of convalescent or debilitated persons whose restoration to health is impracticable in the Hospital or in their own homes, but may be speedily effected by pure air, rest and nutritious diet which their own means are insufficient to provide."

1. This definition of the objects of a convalescent home, taken from the trust deed of one of the first to be established in this country—the Metropolitan Convalescent Institution, founded in 1840—requires, after over 100 years, virtually no qualification. It still remains true that convalescence, though certainly a medical need, is also a social question. The growth of the convalescent home movement in the last quarter of the 19th century was a reflection not of any sudden realisation of the medical advantages of convalescence but of the gradual awakening of the medical profession to the importance of realising that their patients led an existence both before and after their period in hospital ; that the period before might have an important bearing on the cause of their disease ; and that the period after might vitally affect the speed and completeness of their recovery.

2. As always, it was left at first to a few individuals of greater vision or greater heart to lead the way. The foundation of the Metropolitan Convalescent Institution was the direct result of the initiative of one medical student at St. Bartholomew's Hospital. Seeing a woman in the hospital in great distress he enquired the reason ; apparently she had been told by the physician that medicine could do no more for her, what she needed was a holiday in the fresh air of the countryside. The futility of prescribing the impossible was suddenly borne in upon the student, whose name was Munro, and upon impulse he inserted an appeal in the advertisement columns of the *Record* which led in due course to the formation of a committee and the establishment of a cottage convalescent home at Harrow Weald. The subsequent history and development of the Metropolitan Convalescent Institution would perhaps be out of place here but it is of interest that when its four large homes were taken over by the Minister of Health in 1948 the Chairman was a Miss Munro, a direct descendent of the founder. The fact is illustrative of the general tendency for convalescent homes to be "family concerns", which has been at once their strength and their weakness ; strength because it gave them a continuing tradition of service ; weakness because the natural desire to maintain tradition sometimes militated against progress.

3. By 1890 enough homes had been founded for convalescence to be no longer an unusual recommendation upon discharge from hospital. But there was still no official recognition of the necessity for some organised social care for hospital patients ; and it was not until 1895 that the first Lady Almoner was appointed to the Royal Free Hospital, following the recommendation of a Select Committee of the House of Lords, which three years earlier had investigated the problem of over-crowding in the Out-patient departments of London hospitals. The main function of these Almoners, or hospital social workers, was to discover and endeavour to meet, the social problems of the patients. Inevitably, and properly, the arrangement of convalescence came to be one of their most important duties. No-one knew better than they, who visited

patients in their own homes, which cases were in greatest need of it, and what kind of home would be most suitable—for the choice of a convalescent home, like the choice of a hotel, is essentially a personal thing.

4. With the entry of the Almoner into the hospital scene, the cause of convalescence now had an influential counsel. It was the Almoner who brought pressure to bear upon the authorities to extend and improve facilities for convalescence. Unfortunately, as in the case of the hospitals themselves, there was no means of co-ordinating individual enterprise within an overall policy ; and as a result the 50 years between the appointment of the first Almoner and the passing of the National Health Service Act saw a steady increase in the number of homes without the achievement of a balanced and comprehensive system. In particular, the special needs of certain medical categories of patients tended to be neglected because there were not enough of them from any one hospital to justify the establishment of a special home ; whereas some authority in a position to view the broader picture would have been able to take action. The almost complete lack of basic information about the country's convalescent services was only fully realised when the National Health Service Act was passed and administrators were faced with the task of implementing its provisions as they affected convalescence.

The Transfer of Certain Convalescent Homes to the State in July, 1948

5. In the National Health Service Act, 1946, it is stated in Section 79 that any ''institution for the reception and treatment of persons during convalescence'' was considered to be a ''hospital'' within the meaning of the Act and therefore to be transferable to the Minister. Guidance was given in Ministry circulars, and it would perhaps be pertinent to quote some in order to explain how and why some homes were transferred and others were not. On the point of deciding which came within the Act's definition, Regional Hospital Board Circular (47) 9 stated: ''Of those rejected a large number are convalescent homes which are frequently borderline cases. The broad differentiation is between convalescent homes which give treatment and those which do not. The latter, which are primarily holiday homes, have not been deemed to be hospitals within the meaning of the Act''.

A further Ministry circular dated 1st March, 1949, stated that it would be the duty of Hospital Boards to provide, as part of the Hospital Service, for patients who required convalescent ''treatment'' and that Local Health Authorities had power under Section 28 of the Act to provide for those who required ''little or no more than rest, good food, fresh air and regular hours''. It was stated that it was not easy to define ''treatment'', but it must ''be regarded as being more than these and as including at least regular medical supervision and nursing care''.

The Exclusion of Certain Homes from transfer

6. The Minister's instructions to the Regional Hospital Boards made it clear that any home that did not wish to be transferred should have an opportunity to say so and also that it was his intention only to take over homes that were needed to provide the necessary hospital services. Referring again to Regional Hospital Board Circular (47) 9, we find the following : ''The Minister may disclaim any hospital if it appears to him that its transfer will not be required for the purpose of providing hospital and specialist services. The Governing Body may serve a notice on the Minister stating they wish such hospital to be transferred to him despite his wish

to disclaim. The Minister feels that the mere fact that a hospital has asked for disclaimer must not in itself in any way govern the Board's judgment in direction of disclaimer. The primary consideration should be whether the requirements of the Hospital Service would be better met by the transfer of the hospital to the Minister, or the hospital continuing to function independently''.

7. Questions of disclaimer arose in connection with homes of particular character, and among these were:—

(i) Institutions which did not render services of a kind the Regional Hospital Boards were concerned with.

(ii) Cases where hospital work was only a part of a Society's work.

(iii) Cases in which administration would be particularly difficult, as for example, homes managed by religious communities.

8. Hospital Boards were encouraged to make contractual arrangements with those non-transferred, or voluntary homes that provided regular medical supervision and nursing care. By these arrangements homes were to be asked to accept a number of patients from the Regional Hospital Boards on a payment basis. At the same time, the Minister considered it would be desirable for the voluntary homes to be divided into those that were suitable for Board's patients and those suitable for Local Health Authorities to use under Section 28 of the Act, as it was felt to be undesirable to have both types of patient in the same home. Hospital Boards and Local Health Authorities were invited to investigate this and report a suitable division to the Ministry, but it was found not to be a practical arrangement and in December 1949 a fact finding survey was directed instead. In this the Ministry asked that all voluntary homes should be placed in one of the three following categories:—

(*a*) Those which provide convalescent treatment within the scope of the hospital service, and may therefore be appropriately used by Regional Hospital Boards.

(*b*) Those which provide recuperative facilities of the ''recuperative holiday home'' type and may therefore be appropriately used by Local Health Authorities.

(*c*) Those which are a combination of (*a*) and (*b*).

This survey has not yet been completed.

9. Before the National Health Service came into force, nearly all convalescent and recuperative holiday homes were under voluntary management and in this respect they were unlike hospitals, where more than half were owned and administered by Local Health Authorities. When the State took over, however, the great majority of hospitals were transferred, but only a minority of convalescent homes were incorporated in the Hospital Service. Among the homes omitted from the Hospital Service were all those that provided facilities for recuperative holidays. As it is no part of the Hospital Service to provide recuperative holidays, and Local Health Authorities do not generally own or operate recuperative holiday homes, it has come about that recuperative facilities are provided by voluntary homes.

10. It was realised by the Ministry, however, that it might be desirable to contract with certain non-transferred homes for their services on a payment per patient basis. The contracts thus made between Hospital Boards and certain convalescent homes within their regions provide for the Boards' patients to be sent to the homes at an agreed fee. The homes are not obliged to reserve any particular number of beds for the Board, but accept patients, if of suitable type, when proposed for admission. They are free to use for other patients any beds not required by Hospital Boards' patients. The contracts are not binding on either party, and subsequently a number were terminated by Hospital Boards when economies had to be made.

11. From the foregoing directives to Boards, it appears that the Minister hoped to balance the hospital services within each Hospital Board region, rather than on a National basis. On the whole, however, convalescent homes were built where the climatic conditions are particularly suitable for convalescents, and most of these homes are concentrated in a few of the sea-coast regions, and there are comparatively few in other regions. Convalescent patients prefer not to travel far afield from home, but in practice they may have to travel some distance, from a hospital in one region to a convalescent home in another.

King Edward's Hospital Fund for London

12. Under its Act of Incorporation the Fund is entitled to make grants to hospitals and convalescent homes within the London area, and also to those outside London, serving the needs of London patients. This the Fund has done since its foundation in 1897, although the emphasis of its work has always been on hospitals. However, in 1946 it was realised that the whole convalescent service, which had been severely hit by the war of 1939 to 1945, was in danger of disintegration. Visits were made to all homes that had been on the Fund's list before the war and which could still be traced, and as a result the Convalescent Homes Committee was set up in December 1946 with instructions to assist the convalescent homes in re-establishing themselves.

13. Contact was made with a number of homes, and provided their standards were satisfactory, they were included in the Fund's Directory of Convalescent Homes. The details included in the Directory were designed to be of use to Almoners and others who had the duty of sending patients for convalescence. The publication of the Directory led to the homes becoming more widely and better known and, since the standard is known to be satisfactory, it has led to an increased occupancy. Only homes that were registered charities were eligible for inclusion in the Directory—*i.e.*, non-profit-making—and thus the users were assured that charges were the minimum to make income meet expenditure.

14. New homes have been added to the Directory as they have come to the notice of the Committee and at the present time there are included 146 situated in the four Metropolitan Hospital Board Regions and 41 in other regions. Of this total, 60 homes were transferred to the National Health Service in July 1948 and are now owned by the State, but they are still included in the Directory. In the four Metropolitan Hospital Board Regions, two thirds of the convalescent homes, containing some 3,000 beds, are still under voluntary management, and all are providing valuable services.

15. Having established the Directory, the next important step was to make it possible for those homes that had been obliged to close during the 1939–45 war to re-open and for all to

modernise themselves to meet present-day requirements. Very few had sufficient reserve funds to meet the cost of large-scale modernisation and it was therefore decided that substantial grants were justified from the Fund's resources.

16. Accordingly, in the four years 1947 to 1950 inclusive, sums amounting in all to £230,000 have been made available to the Convalescent Homes Committee for this purpose. It is evident from the knowledge we now have that had not this expenditure been made, a number of homes would have been obliged to close, and nearly all would be giving a much poorer standard of service and comfort to their patients than they are at present able to provide.

17. It is now considered, however, that the main part of the programme of modernisation has been carried out, and large sums are no longer being allocated by the Fund for this purpose. It is now the maintenance and smooth working of these homes that is the chief concern of the Convalescent Homes Committee, and in order to keep in touch with them so that they can advise and assist with grants, a system of annual visits has been arranged.

Reasons and Objects of the Survey

18. The Fund's interest in convalescent homes being known, it was inevitable that bodies interested in the provision of special facilities should ask for help from the Fund. These requests were often for additional homes for special types of patients, and while it was natural that each should plead the greatest consideration for their own particular interest, it was difficult for the Fund to decide where the real need lay.

19. Many and varying opinions were given by responsible people and bodies that were in touch with this type of work, and it was felt that the time had come to make an effort to obtain some authentic statistics and information on which to base our future actions. Furthermore, the interesting survey of convalescent facilities in England and Wales made by the Institute of Almoners in 1947 showed that there were many points that needed further investigation. It was felt that these statistics would make it possible to follow up and further analyse the points made in that survey.

20. In authorising a detailed survey of convalescence, the King's Fund directed that enquiries should, as far as possible, cover the problem as it affected London patients. As far as was known, no previous survey had covered this ground in the detail which was considered necessary. The task was somewhat formidable, covering an extensive field of enquiry, information being sought regarding many aspects of convalescence, of which the following might be indicated as the chief points:—

(i) To ascertain the present demand for convalescent accommodation, and how far it is met. This to be in the widest sense, and to cover as many types of patient and diagnosis as possible.

(ii) To ascertain the occupancy of convalescent homes, and to see if there is any undue wastage of available accommodation.

(iii) To enquire into the systems of admission to convalescent homes and see what delays are being experienced in admissions and the reasons therefor.

(iv) To see what authorities and bodies are bearing the financial responsibility for patients' convalescence, because it is realised that the division of responsibility between Hospital Boards and Local Health Authorities is often difficult to determine.

Sources of Information

21. To obtain the data for this survey it was necessary to collect information from Almoners of Hospitals about the patients they sent, or tried to send, to convalescent homes. This proved to be the major part of the work, and we wish to record our thanks and appreciation of the whole-hearted and enthusiastic help given by the Head Almoners and their staffs in nineteen London and two Provincial hospitals. Without their aid this survey would not have been possible.

22. In order to facilitate the collection of information by Almoners a form was provided which was completed for every patient which the Almoners wished to send for convalescence during a specified period. This form provided information as to the age, sex, diagnosis and convalescent requirement of each patient as well as details of the attempt to find a convalescent home, the time taken in so doing, the success or failure, and the responsibility for payment. No less than 6,000 of these forms were filled in and returned to the Fund and have been used in the compilation of the statistics appearing later in this report.

23. Convalescent homes in the Metropolitan Hospital Board Regions that admitted London patients gave us details of the number and type of cases they accepted, and the arrangements that were made for the payment of fees. In all, 113 homes (78 voluntary and 35 State) were approached, and all but four co-operated. A further five did not send in complete statistics for the whole period of the survey.

24. Valuable information was given us by the following, and we wish to record our thanks and appreciation for the help they have given:—

London County Council,
Invalid Children's Aid Association,
Family Welfare Association,
National Association for the Paralysed,
Hearts of Oak Benefit Society,
National Deposit Friendly Society.

Finally, we take this opportunity of thanking the Middlesex Hospital for most kindly allowing the statistics to be analysed in the Medical Records Department there, and Dr. D. D. Reid, M.D., Ph.D., of the London School of Hygiene and Tropical Medicine, for his invaluable statistical help and advice in preparing the later stages of this survey.

Scope and Limitations of the Survey

25. Owing to the considerable voluntary work which the survey would inevitably impose on our helpers in hospitals and convalescent homes, it was considered that a six months' period

was the longest over which it could be extended. It was decided that the period 1st February to 31st July, 1950, should be taken as a sample covering a fair proportion of winter and summer season. There are, however, various inevitable sources of bias in any period less than a full year, and the following factors should be borne in mind in considering the results of the survey.

(i) The seasonal effect, in early spring, of the epidemic period of upper respiratory tract infections is estimated to affect the proportion of convalescents.

(ii) The demands for convalescence include the requirements of twelve teaching hospitals, and as these may be supposed to include a larger proportion of acute cases than others, the proportion of patients needing convalescence is possibly higher than in non-teaching hospitals. It was necessary to obtain the main portion of our information from teaching hospitals because they had the larger Almoner staffs who would be better able to deal with the volume of work entailed.

(iii) There is a time lag between the admission of a patient to hospital and subsequently to a convalescent home, and consequently the comparable period of admission to hospital is rather earlier in the year, and includes more winter and fewer summer seasonal types of cases.

(iv) Information was only obtained from voluntary and State homes. There are, however, a number of private homes run on a commercial basis about which we have little information, and it was accordingly decided not to approach them. We cannot assess the work of these homes, but it is known that they are sometimes used for Local Health Authority patients as well as by patients who pay for themselves with, or without, assistance from Samaritan Funds.

(v) It is probable there were some patients for whom doctors did not recommend convalescence because the type of case was one for which they knew from past experience it was impossible to provide. Thus, the number of failures to admit for convalescence may be under estimated.

26. Some bounds had to be given to the scope of the enquiry, because it was known that there were various institutions operating under the general heading of convalescent homes whose work varied between the care of quite ill people and the provision of inexpensive seaside holidays for persons who are well but of very moderate means. It was evident that there were three types, *i.e.*, convalescent homes, recuperative holiday homes, and homes that provided inexpensive seaside holidays and change of air for people who could not otherwise afford a holiday, and only the two former have been included in our survey. Both of these types provide resident nursing staff, and generally speaking, the convalescent home provides more staff and treatment than the recuperative holiday home, but this is not invariably the case. In both cases admission is made only on a doctor's recommendation.

27. In this survey the term ''convalescence'' unless specifically stated to the contrary, has been used to denote both convalescence as a continuation of hospital treatment (provided by Regional Hospital Boards) and recuperative holidays for after care and prevention of illness (as provided by Local Authorities under Section 28 of the National Health Service Act).

28. It is understood, however, that persons are sent to convalescence for the following reasons:

(*a*) When there is some physical disability of a temporary nature, requiring, in the opinion of the doctor, a period of convalescence.

(*b*) When social conditions at home are not satisfactory, and in the opinion of the Almoner full health will not be regained after illness unless a period of convalescence is given. A doctor's recommendation is then given on the advice of the Almoner.

29. It therefore follows that all patients with one particular diagnosis will not necessarily require convalescence, and conversely, social conditions irrespective of medical conditions particularly in the case of women, may be indications for convalescence. Recommendations for convalescence are not necessarily only made for hospital patients, but may be for people attending clinics, welfare centres, etc., or after medical treatment, in their own homes. General practitioners do not seem to make use to any great extent of the convalescent facilities that are available for their patients.

Definitions of Terms

30. For those who are not in constant touch with the subjects dealt with in this report, some definitions of the terms that are used may be helpful. Among the more important are:—

Transferred Home: One that was taken over by the Minister of Health under the National Health Service Act as being necessary for the hospital service because it provided the required standard of medical supervision and nursing care. They have since come to be called State Convalescent Homes.

Non-Transferred Home: One that was not taken over by the Minister because it did not provide the requisite medical supervision and nursing care, or because it was administratively undesirable to do so.

Voluntary Home: The name that has been retained by the non-transferred homes since the original division was made by the Ministry of Health. They are sometimes referred to as Independent Homes.

Contractual Arrangements: The arrangements made between a Regional Hospital Board and a Voluntary Convalescent Home within its region for the reception of patients at an agreed fee.

Holiday Home: The Ministry's original term used to signify the homes not taken over because the necessary standard of medical supervision and nursing care was not provided. These homes were intended for the use of Local Health Authority patients.

Recuperative Holiday Home: This is the type of home that was originally termed "Holiday Home" by the Minister, and has since come to be known by this name because they receive Local Health Authority patients.

Recuperative Holidays: The service provided for patients by Local Health Authorities under Section 28 of the National Health Service Act. In the case of children of school age it also designates the service provided by Local Education Authorities under Section 48 (3) of the Education Act, 1944.

Convalescent Homes: Strictly speaking these are the homes that receive Regional Hospital Board patients and are either State Homes or Voluntary Homes with contractual arrangements. The name, however, is often used in reference to both convalescent and recuperative holiday homes.

SUMMARY, OBSERVATIONS AND QUESTIONS FOR FURTHER STUDY

31. Accommodation, with or without treatment, for patients requiring convalescence or recuperative holidays is provided through the services of the Regional Hospital Boards, Local Authorities, Voluntary Bodies, Religious Communities, Friendly Societies, and Trade Associations.

It is desirable for the functioning of the Health Service that all these bodies should play a part. We believe that the application of the National Health Service Act has left several problems unresolved and that better co-ordination in regard to admission of patients and finance is required. (Paras. 8–10, 118.)

32. Statistics collected by 19 London hospitals show that 28 per cent. of in-patients recommended for convalescence waited an average of 8 days in hospital, after being fit to transfer to a convalescent home.

It appears to us to be essential that some way to obviate this delay be devised. (Paras. 42–47.)

33. It is frequently reported that there is difficulty in deciding whether a particular patient on leaving hospital is the responsibility of a Regional Hospital Board (convalescence) or a Local Health Authority (recuperative holiday).

So long as the present arrangements for payment continue, further guidance from the Ministry regarding the interpretation of *convalescence* and *recuperative holidays* is required and improved administrative arrangements between the authorities on whom liability for payment rests. (Paras. 104–107.)

34. The small proportion of patients requiring serious dressings who were admitted to convalescent homes during the period of the survey suggests that post-operative cases had reached a certain stage of convalescence before leaving for the home.

If the staffing and equipment of a selected number of homes capable of providing nursing care were brought up to a higher standard, it may well be that a number of such cases could be discharged from hospital earlier and so release hospital beds which are urgently needed. (Paras. 54, 61, 144.)

35. One of the objects of the Survey was to discover which categories of patients present the greatest difficulty in placing. We have now a certain amount of information on this but we are not even yet in a position to draw any positive conclusions.

We suggest that this matter requires further study. (Paras. 57–62, 64, 67, 73.)

36. We have noted that the provision of convalescence for children presents special problems and requires more careful and overall planning than it has yet received. It reflects to a marked degree the difficulties which arise from the lack of a single administrative authority.

One Local Authority has decided that in providing recuperative holidays for children of school age the period of stay in a home should in principle be limited to two weeks. Experience, however, indicated that there are many of these children not provided for through Regional Hospital Boards who on medical grounds require a stay of four weeks. In the allocation of the sum provided for annually by Local Authorities, the children for whom a stay of four weeks is prescribed should, in our view, have prior claim. (Paras. 80–84.)

37. We have noted the great variety of method which applies to the admission of patients to homes and which occupies a good deal of time and energy on the part of Almoners' departments, Regional Board officers, and the Matron or admitting officer of homes. We feel convinced that a simpler method could be devised through consultation between the parties concerned which would speed up admissions without impairing the free choice of home. (Paras. 90–98, 103.)

38. The need and the provision for convalescence and recuperative holidays changes from time to time. Since the collection of our data the position regarding occupancy in particular has become less satisfactory.

A periodic survey may be required to ascertain the position of homes, in regard to occupancy and maintenance costs, and the medical types of patient most urgently requiring accommodation.

39. Our figures show that certain homes suffer from a low rate of occupancy, particularly during the winter. This is closely related to the question posed in paragraph 32, concerning the difficulties in finding vacancies for patients waiting in hospital. There is, however, a second and even more serious aspect of this question. A low rate of occupancy spells financial disaster to a voluntary home. The ability of most of these homes to keep open depends on whether they can keep their beds occupied all the year round. (Paras. 87–88, 119–122.)

40. It is evident that the needs of a considerable number of patients cannot be met unless these voluntary homes continue to function. We therefore regard the matter of the finance of these homes, in the face of rising costs, as one of the most urgent of the questions arising from the Survey, deserving prompt study and action. (Paras. 119, 134, 135, 137.)

SECTION 1

REPORT OF SURVEY FINDINGS

Hospital Patients requiring Convalescence. Statistics from nineteen London Hospitals

41. It will be seen from the following statistics in this section that the difficulty of obtaining convalescent beds for London patients is reflected more in the time that has to be spent waiting for admission than in the number who altogether fail to obtain it. A serious aspect of this is the large number of days spent in hospital by patients who were ready to go to convalescence but were unable to obtain immediate admission to a convalescent home.

These statistics are presented in three sections, "In-patients", "Out-patients" and "In-patients and Out-patients Combined".

In-patients

42. Of a total of 4,436 recommendations for admission to convalescent homes, 196 or 4·4 per cent. failed to gain admission ; 1,450 or 34·2 per cent. of the successful admissions experienced no delay and went direct from the hospital ward to a convalescent home. The other 2,790 or 65·8 per cent. of admissions had to wait, either in hospital or at home, and sometimes part of the wait was spent at each place. In all instances it was ascertained that application was made in ample time, and no wait was due to a late application for convalescence. Applications were usually initiated 10 to 14 days before the patient was expected to be ready to leave the ward. Nevertheless, the average wait after that date experienced by these 2,790 patients was 12½ days.

43. The waiting periods in hospital, home or at both places, was divided as follows:—

(1) 838 patients waited in hospital, and then went to a convalescent home.

(2) 420 patients waited first in hospital, and then at their own homes before obtaining admission to a convalescent home.

(3) 1,532 patients were sent straight from hospital to their own homes to await admission to a convalescent home.

The first two groups occupied 1,258 hospital beds that could have been released if convalescent beds had been available. They spent waiting periods in hospital as shown in Table I.

TABLE I—IN-PATIENTS—PERIODS OF WAITING IN HOSPITAL:

	Waiting time in days (inclusive)					
	1–2	3–7	8–14	15–28	29–60	Over 60
Number of patients	201	605	279	131	41	1

44. The average wait in hospital of these 1,258 patients was 8 days, which represents a loss of 11,140 hospital-bed-days, spread over 19 London hospitals during a six months period. Had these patients been sent to convalescent homes without delay, their total cost to the Health Service would have been less by the difference between the cost of their maintenance in a convalescent home and in hospital for the period they were delayed. The number of patient-days thus wasted would accommodate 620 patients from the waiting list if it can be assumed that the pre-war average stay in hospital of 18 days still holds good. Although this experience may not necessarily be typical of all London hospitals, the total wastage of beds in the Metropolitan Regions for this reason must be considerable.

45. It may be argued that so many patients (1,258) should not be retained in hospital, but should be sent back to their own homes to await convalescence. A review of almoners' opinions suggests that the reason for this retention is chiefly a social one. With the present shortage of houses, a number of patients are living in unsuitable home conditions, and it is not possible or desirable for them to return home after hospital treatment. This is particularly the case with women, who, if they return home will take up their household duties without assistance and the whole burden of running a home falls on their shoulders, thus retarding recovery or causing a relapse to occur.

46. To complete the picture as far as in-patients are concerned, we must see what happened to those who had to wait at home till a vacancy could be found for them at a convalescent home. These consisted of the 420 who had already had to wait some time in hospital, and another 1,532 who were sent home direct from hospital, making a total of 1,952, or 46 per cent. of admissions to convalescent homes. For these patients the average wait was $12\frac{1}{4}$ days. The fact that such a large proportion of in-patients had to wait at home for admission to a convalescent home shows a particularly unsatisfactory state of affairs. If convalescence is to give its full benefit, it should follow immediately after the patient has left the hospital ward. Looked at from an economic standpoint, it is obviously desirable to reduce the time away from work to a minimum, and in these cases the period has been lengthened because the patients were not ready to start work again until convalescence was completed. The result of patients having to wait at home is reflected in the figure of those who did not obtain admission to convalescent homes, where 50 per cent. of the failures were caused by their giving up the idea of convalescing because no bed could be found within a reasonable time. In this connection it was noted that there were a number of instances where patients had told almoners they were unable to stay away from work the necessary time to wait for admission to a convalescent home without losing their jobs, and they accordingly gave up the idea of convalescing away from home. They therefore returned to their work because they felt just well enough to do so, but we feel that in all probability they were not really fit, and consequently their health and work may both have suffered.

47. The position among in-patients referred for convalescence is summarised as in Table II.

TABLE II—IN-PATIENTS—RESULTS OF APPLICATIONS FOR CONVALESCENCE:

	Number		Percentages	
Failures		196		4·4
Admitted with no delay		1,450		32·7
Waited for admission:—				
(i) In hospital only	838		19·0	
(ii) In hospital and then at home	420	2,790	9·5	62·9
(iii) At home only	1,532		34·4	
Total applications		4,436		100

Out-patients

48. These are necessarily dealt with separately because their waiting time is in rather different circumstances to that of the in-patients.

49. Of a total of 1,621 applications for admission to convalescent homes, 92, or 5·6 per cent., failed to obtain admission and 158, or 10·5 per cent., of successful admissions experienced no delay. The remaining 1,371, or 89·5 per cent., of those admitted had to wait at their own homes until admission could be arranged. The distribution of their waiting periods is shown in Table III.

TABLE III—OUT-PATIENTS—DISTRIBUTION OF WAITING PERIODS:

	Waiting time in days (inclusive)					
	1–2	3–7	8–14	15–28	29–60	Over 60
Number of patients	12	106	237	472	390	154

50. A minimum estimate of the average waiting time of 29 days is given by assuming that all who waited more than 60 days had in fact waited exactly that period, though in practice many had waited much longer. Experience suggests that it takes seven days to arrange for the convalescence of out-patients and therefore the effective average waiting time can be said to be 22 days. As among in-patients, half of those who failed to obtain admission declared that they were unable or unwilling to spare the time to wait for a vacancy in a convalescent home.

51. The position among out-patients referred for convalescence is summarised in Table IV.

TABLE IV—OUT-PATIENTS—RESULTS OF APPLICATIONS FOR CONVALESCENCE:

	Number	Percentage
Failures	92	5·6
Admitted with no delay ..	158	9·7
Admitted with delay	1,371	84·7
Total applications	1,621	100

Combined Statistics for In- and Out-patients

52. Altogether we have analysed 6,057 cases of applications for admission to convalescent homes. Details of the in-patients and out-patients have been given in the previous sections, and the following remarks apply to the combination of the two.

Grouping of patients' needs

53. We hoped to find out what type of service the convalescent homes were called on to provide, and almoners were accordingly asked to state in each instance what was the general convalescent need of the patient as seen by doctor and almoner. These have been grouped in the following table, showing the numbers and proportions of the whole ; they include men, women and children.

TABLE V—COMBINED IN AND OUT-PATIENTS—SUMMARY OF CONVALESCENCE NEEDS:

	Simple Convalescence	Diabetic diet	Gastric diet	Simple dressings	Serious dressings	Ground floor room	Other needs	Total
Number of patients ..	4,267	154	413	162	41	310	710	6,057
Percentage ..	70·8	2·5	6·8	2·6	0·6	5·1	11·6	100

54. The "Simple Convalescence" group includes a wide range of medical cases and also a substantial proportion of the post-operative cases as well. In view of the large number of major operations carried out in the hospitals concerned, the fact that only 0·6 per cent. of all patients sent for convalescence needed serious dressings would seem to indicate that major surgical cases are seldom, if ever, discharged to convalescence until serious dressings are no longer required. Furthermore, the fact that only 2·6 per cent. of the admissions were patients requiring even simple dressings suggests that post-operative cases as a group do not leave hospital at all early.

Length of stay in convalescent homes

Patients were recommended to stay at convalescent homes for the periods shown in Table VI.

TABLE VI—COMBINED IN- AND OUT-PATIENTS—RECOMMENDED LENGTH OF CONVALESCENCE:

Length of stay in weeks	1	2	3	4	5	6	Over 6
Number of patients recommended ..	16	1,348	3,006	876	86	478	247

These recommendations include those for children (962) and a number of these will appear in the "over 6 weeks" group as applicants for entry into long stay special schools for delicate children.

Grouping of medical categories

56. A further grouping was made of the applications by dividing patients into 16 medical categories, as shown in Table VII. For each of these medical categories are given the number of patients, the percentage each category forms of the whole and the number and proportion of failures in each. The categories where the failure rate is above the general average are marked with an asterisk.

TABLE VII—COMBINED IN- AND OUT-PATIENTS—RESULT OF APPLICATIONS, SHOWING FREQUENCIES AND ADMISSION FAILURE RATES IN MEDICAL CATEGORIES:

Medical category	Number of applications	Percentage of whole	Number of failures	Percentage of group failed
Asthma	71	1·1	8	11*
Bronchiectasis	60	1·0	6	10*
Bronchitis and chest conditions	451	7·4	12	2·6
Cancer	359	5·9	13	3·6
Chorea	21	0·3	0	0
Coeliac	11	0·2	6	54*
Gastric conditions	448	7·4	11	2·4
General medical	1,460	24·3	59	4·0
General surgical	2,105	35·0	80	3·8
Heart conditions	279	4·6	32	11·5*
Nervous diseases	240	3·8	10	4·2
Orthopædic	194	3·2	6	3·2
Rheumatic diseases	175	2·8	18	10·2*
Skin diseases	68	1·1	11	17·5*
Tuberculosis (pulmonary)	35	0·6	10	28·0*
Tuberculosis (other)	80	1·3	6	7·5*
TOTALS	6,057	100·0	288	4·75

57. From Table VII it is clear that the admission failure rate among patients suffering from skin diseases and heart conditions is appreciably above the overall rate of 4·75 per cent. Although the number of patients with pulmonary tuberculosis was small, failure to secure admission is significantly above the average. It seems probable that the condition of these patients was not severe enough to justify their admission to sanatoria while at the same time they were not considered suitable for admission to a convalescent home. The admission failure rates for asthma, bronchiectasis and rheumatic diseases are also suggestively above this average; while for the few patients with coeliac disease, admission could not be arranged for half of them. Excluding children, a good deal of the difficulty associated with, say, heart and rheumatic patients may arise simply because these illnesses are usually found among the elderly who require a standard of nursing care unlikely to be found in convalescent homes. It is essential therefore to inspect failure rates in the different age and sex groups of those recommended for admission. These are given in Table VIII. It should be noted that whilst we asked that all patients needing convalescence should be reported to us, we are not altogether satisfied that this always happened. There are occasionally patients who require special nursing facilities, but experience has shown that these can so very seldom be placed in convalescent homes that no one now thinks of suggesting they should be recommended for admission. These cases may have escaped the returns from which these statistics were compiled.

Admissions and failures to admit in age groups

58. The following table shows the number of admissions in each sex and age group, the number, and the percentage in each group who failed to obtain admission.

TABLE VIII—COMBINED IN- AND OUT-PATIENTS.
RESULT OF APPLICATIONS, SHOWING FAILURES TO ADMIT IN SEX AND AGE GROUPS:

Patient's age in years (inclusive)	MALES			FEMALES			Combined % failures
	Number admitted	Number not admitted	% failures	Number admitted	Number not admitted	% failures	
0–2	83	7	7·8	64	7	9·9	8·7
3–5	111	6	5·2	130	6	4·4	4·6
6–12	234	23	9·0	224	13	5·5	7·3
13–16	54	4	6·9	61	1	1·6	4·2
17–59	1,126	48	4·1	2,562	101	3·8	3·9
60–70	322	18	5·3	566	27	4·6	4·8
Over 70	75	14	15·7	157	13	7·7	10·5

59. The failure rate of all groups combined was 4·75 per cent. of the applications for convalescence. There seems no reason to suppose that the fact that applications for women are more than double those for men is an abnormal state of affairs as there are a number of obvious reasons why women convalescents outnumber men. Despite this, except for the youngest age group, the failure rate for males is consistently greater than the corresponding rate for females. For men over 70, the failure rate rises to 15·7 per cent., but in both sexes the difficulties in admission appear to be greatest for the patients at the two extremes of the age scale. To this general rule the only exception is the age group 6-12 years among boys, which confirms the report from the Invalid Children's Aid Association which appears in a later section of this survey.

SECTION II

ADMISSION PROBLEMS OF SPECIAL GROUPS

60. On first inspection, therefore, both age and diagnostic groups seem to be important factors in determining the ease of admission. As we have said, however, these two factors are frequently related and tables were accordingly prepared to show the distribution of the length of wait in days in each age and sex group within each diagnostic category. Table IX summarises these tabulations for some of the numerically important diseases.

TABLE IX—FREQUENCY OF DELAYED ADMISSION IN CERTAIN MEDICAL CATEGORIES OF CONVALESCENT PATIENTS:

Age group in years	Chest diseases				Gastric conditions				Cancer			
	Males		Females		Males		Females		Males		Females	
	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %
0–16	37	57	36	69	3	66	3	0	0	0	1	0
17–59	62	32	64	34	238	37	57	18	43	33	111	23
60+	31	55	28	25	45	53	29	20	39	21	93	30

TABLE XI—CONTINUED.

Age group in years	General medical				General surgical				Hearts			
	Males		Females		Males		Females		Males		Females	
	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %	No.	Wait over week %
0–16	86	52	91	58	67	40	59	49	3	66	11	45
17–59	123	40	330	32	281	32	1,184	26	58	52	59	41
60+	46	50	67	52	99	29	228	27	32	56	32	44

61. In this table are set out in their age and sex groups the numbers of patients recommended for convalescence while in-patients at London hospitals taking part in the survey. Against the total in each sub-division is noted the percentage who had to wait more than seven days for admission to a convalescent home. Although the individual differences, *e.g.*, between the percentage for males and females aged 17–59 suffering from chest diseases, may be small, some broad trends are evident. Generally speaking, the previously noted disparity between the age groups is maintained even among patients of the same sex suffering from the same type of disability—viz., least delay is experienced by adults between 17 and 59 years of age, the elderly have appreciably greater difficulty, while children seem to experience the greatest frequency of delay in admission. Again, even within these age and diagnostic groups it is clear that men tend to fare worse than women, even though fewer men are being recommended for convalescence. Conversely, within each sex and age group there are consistent trends which are of interest. Among children, patients with chest diseases tend to wait over a week for admission more often than those with medical or surgical conditions. Among adults of all ages and both sexes patients suffering from heart disorders are clearly the most difficult to place in suitable homes. On the other hand, patients in the general surgical category are, irrespective of sex and age, usually admitted without much delay compared with other cases.

Adolescents

62. These range between 13 and 16 years of age and there are few suitable homes for them. There were applications for convalescence for 120 of these patients, of which 5 were not placed and 22 waited more than 30 days for admission. The waiting lists and unplaced cases show a variety of medical needs, but no particular one predominates. In the case of boys, the home should be under the charge of a man who must be able to handle boys, while the matron must be responsible for their health. Any home that does not have such an arrangement is bound to experience difficulties because boys of this age need indoor and outdoor occupations almost more than anything else, and their convalescence will not give full benefits unless they are happily employed and the home is running smoothly.

63. It is equally important to keep girls happily occupied, and when their state of health allows, such activities as Girl Guides and acting have been tried at certain homes. This work usually falls upon the matron because homes cannot afford an assistant, though in some instances voluntary workers have come in to help.

Asthma

64. About 1 per cent. of the applications were for asthma sufferers, and though the numbers involved were too small for any firm conclusion to be drawn, the failure of 11 per cent. is suggestively above the average. Almoners have reported difficulty in placing short stay cases of children of the 6–12 year age group. Our figures have shown that there were proportionately more in this group than any other and that a substantial proportion had to wait between one and three months for admission. It appears that there is a shortage of convalescent beds for these children.

65. There were a number of instances where almoners had difficulty in placing women patients, usually because there was no suitable home in the desired locality. The majority, however, waited less than a fortnight for admission and men waited roughly the same time.

Colostomies

66. There were applications for 42 of these patients, and only in one instance was it not possible to arrange admission.

Diabetic patients

67. There were very many more women than men in this group. There are a number of homes that will accept these convalescents, and there is evidently more demand from women patients. We noted 25 instances, all except two being women, when almoners reported that the patients had waits ranging between 3 and 16 weeks before obtaining admission.

Epileptics

68. There were 31 cases of epileptic patients who required convalescence and only two were unable to obtain admission to a home. We have been informed by the National Association for Mental Health that they have been unable to keep both their homes for epileptic convalescents filled and are proposing to close one.

Gastric diets

69. The homes and hospitals that supplied information both showed that the proportion of men convalescents was more than twice the number of women. There were a number of instances of men having to wait a long time for admission and very few for women. Patients requiring gastric diets were 6·8 per cent. of the total applicants.

Mothers and babies

70. These patients are always difficult for the almoner to place because either or both of the patients may be ill and there are often other children in the family to be provided for before the mother and baby can go away. It is for this type of case that the recuperative holiday home

is so valuable because it is possible for the mother to be admitted with her other children, if necessary. The State homes can normally accept an unwell mother with a new baby, but if it is only the baby that is ill it might be necessary to board out the mother at her own expense, and there could be no question of accepting the other children of the family as lodgers.

71. We have been given some information on this subject by the Medical Officer of Health for the L.C.C., who informs us that at present his department is unable to find suitable accommodation for recuperative holidays for all these patients, though strenuous efforts have been made to solve the difficulty. At one time, as an experiment, accommodation was taken in private hotels and boarding houses, but this was not entirely satisfactory because often the facilities for washing and drying clothes were inadequate, and it was not possible to arrange for the children to be properly cared for when the mothers wanted to rest.

72. From the statistics provided by the London hospitals, there were, in the six month period of the survey, 73 applications for these patients to be admitted to convalescent homes and all were admitted except seven. All were cases where the mother and baby required convalescence, and in no instances were accompanying small children sent to the home as well. Almoners reported that in a number of cases arrangements had to be made for the other children in the family to be sent elsewhere and often considerable difficulty was experienced.

73. The L.C.C. waiting list of these cases, which included mothers and babies with accompanying toddlers, increased from 10 in February to 94 in July, though they were being placed in homes at the rate of about 30 a month, and it is evident that this class of patient is insufficiently provided for. The Fund has interested itself in the welfare of certain homes that provide recuperative holidays for these patients and there are also other authorities who are doing good work in this field. The Soldiers', Sailors' and Airmen's Families Association, Salvation Army, and Church Army, are all helping to place the children from the L.C.C. areas, and we have also been told by the Family Welfare Association that about one-third of the patients they referred for recuperative holidays in the period February–July were mothers with children. It is evident that the combined efforts and resources of the interested authorities are still unable to meet this apparently growing commitment.

Paralysed patients

74. It was not expected that the information supplied by almoners would include many instances of paralysed patients being referred for convalescence, and the results of the survey have confirmed this.

75. We are indebted to the National Association for the Paralysed for information on this subject as they have recently undertaken a survey of paralysed people in England, with the object of discovering how many of these are in need of convalescence or recuperative holidays.

76. With between 3,000 and 4,000 names on their register it was estimated from their pilot survey that between 150 and 200 people had been recommended for recuperative holiday or convalescence by their doctors. Many had been unable to have any sort of change of air after illness because their disabilities were such as to make it difficult for them to be accepted by a recuperative holiday home. Their survey also showed that the largest proportion of these patients were men in the age group 22–45 years and that the majority needed some assistance from an attendant. There are very few convalescent or recuperative holiday homes that can accept them because of their special needs and the Association is hoping, if ways and means can be found, to start a special convalescent home for these patients. On the whole, ex-service men are better provided for than others and it is these others who are the Association's chief concern at present.

Skin diseases

77. The numbers involved in this group were small, being only 1 per cent. of all applications, and the failure rate of the group shown as 17·5 per cent. may be accepted with some reserve. It is evident, however, that many homes are unwilling to accept these patients and almoners have reported great difficulty in arranging convalescence for them.

SECTION 3

CHILDREN'S CONVALESCENCE

78. In considering convalescent homes for children, there is a particular requirement in that the patients have to be kept in close age groups because of the necessity to keep the various groups apart for reasons of treatment and education, and each needs a different type of staff. In small homes it is generally the practice to keep to one age group, but in larger homes it is possible to have several groups and keep them separate.

79. Originally each home was built to deal with the needs of some special community, hospital or society, but now that all are working for one Health Service, some planning seems desirable to ensure that each age group has the same facilities.

80. Enquiries have been made at a number of homes to see if there was any one age or diagnosis group with needs more pressing than others. We found that, except in winter, all homes were as full as circumstances allowed, but that infection caused considerable wastage of beds. It was also found that the position is complicated by the fact that there are now two admission waiting lists for each age group, according to whether treatment for the particular diagnosis is to be the responsibility of the Regional Hospital Board or the Local Authority. This situation affects particularly children below school age, and we found, for example, that there were babies in the 0 to 2 year age group waiting for recuperative holidays, while available convalescent beds for that age group remained vacant. We also found cases of babies suffering from the same illness, some of which were on the Hospital Boards' convalescent list whilst others were on the Local Health Authority's recuperative holiday list.

81. The actual waiting lists at individual homes did not give much guide as to the various needs of each age group, because it is the usual practice of homes to list only the bookings for admission for the ensuing four weeks, and to refuse altogether those applications for which no vacancy can be seen within a reasonable time.

82. We are indebted to the Invalid Children's Aid Association for our information about waiting lists, as in their capacity of placing agent for the L.C.C., they operate central waiting lists for a large number of children of all age groups. During the six month period of the survey they arranged, on behalf of the L.C.C., for the admission of 1,794 children to recuperative holiday homes, 94 to residential special schools for delicate children and 51 to Regional Hospital Board convalescent homes. At the end of the period covered by the survey, the 31st July, 1950, the waiting lists showed a total of 815 children, which included 61 applicants for residential special schools and 35 for Regional Hospital Board beds. Table X shows the distribution among age and sex groups of the children waiting on July 31st, 1950.

TABLE X—INVALID CHILDREN'S AID ASSOCIATION—WAITING LIST ON 31ST JULY, 1950, OF CHILDREN FROM L.C.C. AREA:

Age group in years	Boys	Girls	Babies and Toddlers
0– 1	—	—	5
1– 2	—	—	66
3– 4	—	—	110
5– 6	70	186	—
7–12	228	—	
12–14	52	98	—
Totals	350	284	181

83. It was expected that these children would have to wait from 4 to 6 weeks before vacancies in recuperative holiday homes were available, but in cases where medical considerations make it desirable that the child should go away early, the Association can give priority on the waiting list.

84. We were informed by the Invalid Children's Aid Association that they found the waiting period for boys between 6 and 12 years is above the average, also for babies under 2 years of age. In Table X the boys in the 7–12 group show the largest waiting group. The lack of beds for boys of the adolescent age group was severe last year, but since the I.C.A.A. opened a home for this group, the situation has improved.

85. Experience shows that a number of the slighter cases waiting for a recuperative holiday are cancelled in September, as they have sufficiently improved in health during their normal summer holidays.

86. More beds are available from October to March because various Societies that provide summer holidays for their children, place beds at the disposal of recuperative holiday patients in winter. This factor, combined with the smaller demand for recuperative holidays in winter accounts for the waiting lists being very much smaller at that season.

Low occupancy of Recuperative Holiday Homes (at a time subsequent to the period covered by the survey)

87. Although the following does not come within the period of the survey, we feel it is important to report that at the beginning of 1951 a number of recuperative holiday homes in the Thanet area were very short of children. This is thought to be due to:—

(1) Reluctance of parents to allow children to be sent away in the winter months.

(2) The cold weather usually prevailing in that part of the country in the winter.

(3) District medical officers having already granted recuperative holidays to the full limit of their finances for the current year.

88. Whatever the reasons, these voluntary homes are placed in a difficult position during the winter, as their overhead expenses continue while the income falls sharply owing to low occupancy. With the return of the summer their services are again in demand and it is evident their weekly charges will have to be increased unless the winter occupancy improves.

89. If some satisfactory arrangements can be made for the winter occupancy—perhaps through the Children's Officers of the Local Authority—the position of these homes may be maintained, but otherwise their future appears to be anxious and uncertain.

SECTION 4

SYSTEMS OF ADMISSION TO CONVALESCENT HOMES

90. With a shortage of convalescent beds, there is inevitably difficulty in finding suitable accommodation for patients and it is therefore necessary that the admission system should be as quick and efficient as possible. It is evident that the present methods for obtaining a convalescent bed, to which the hospital almoner has to conform, are far from satisfactory and there is no uniformity of practice.

91. The channels of approach through which an almoner has to steer an application for a patient to obtain a convalescent bed are as follows :—

(1) For admission to a State Convalescent Home	Apply to the Regional Hospital Board, or the secretary of the appropriate Hospital Management Committee, or direct to the Matron of the Home, according to the practice in the region in which the Home is situated.

(2) For admission to a Home that has contractual arrangements with a Regional Hospital Board for the use of a number of beds	Apply to the Regional Hospital Board, leaving the Board to select the particular Home; or apply direct to the selected Home; or apply to both Board and Home simultaneously, according to the regulations of the Board and/or the practice of the Home.
(3) For admission to a Voluntary Home, or a Home with no "contract bed" vacant at the time required	Apply direct to the Home and raise the money for the fees from the patient and/or charitable sources.
(4) For admission to a Recuperative Holiday bed either in a Home solely for such cases or in one that takes both recuperative holiday and convalescent cases	Apply to the Local Authority and leave them to select the Home, or apply to the Home and Local Authority simultaneously, according to the regulations of the Local Authority of the area in which the patient lives.

92. As the admission arrangements are such an important aspect of the survey, a number of enquiries were made, and the views of the Almoner's staffs of 15 hospitals were obtained. We were informed that they consider it is most important that convalescence should be dealt with as a personal affair, and the patient should be sent to a home where he will enjoy the surroundings, meet congenial people and receive the necessary degree of nursing care and attention. Without these factors he will not make full use of the convalescence, and a complete and satisfactory recovery will be retarded. It is in this respect that convalescence differs somewhat from hospital treatment. Almoners are unanimous that they must be able to choose the convalescent home they consider will best meet the personal needs of the patient, and in this context it is usually only the almoner who knows both the patient and the home.

Admissions arranged by application through Regional Hospital Boards

93. These admissions are dealt with through a centralised system that applies only to the State or "Contractual" homes within that particular region. It is not a universal system and some Regional Boards have different arrangements, all of which must, of course, be known to the almoners.

The advantages and disadvantages of this system are considered to be:—

Advantages	*Disadvantages*
(1) A central waiting list for the whole Region	(1) Almoners are unable to discuss their cases direct with the Matron of the Convalescent Home before admission has been arranged.
(2) The Regional Hospital Board knows where there are vacant beds, as all are allocated by them.	(2) Almoners are unable to choose the convalescent home.
	(3) The Regional Hospital Board may refuse convalescence on inspection of the application form only.

94. Another point, which is no doubt an advantage to Hospital Boards but may be a disadvantage to patients and almoners, is the tendency for Hospital Boards to insist that State homes are filled before "contractual" beds are used. From a financial point of view, it is understandable that the Hospital Boards should make this ruling, but it often means that a patient is sent to a home that the almoner considers is unsuitable for the patient, and the best results are not obtained. Furthermore, there seems to be some tendency to maintain a waiting list for State homes to ensure full occupancy, even though there are suitable vacant beds in voluntary "contractual" homes.

95. The existence of a central waiting list and bed state at the Regional Hospital Board office is neat and businesslike, but its value is much reduced when there is no choice of homes in which vacant beds are immediately available. A waiting list tends to ignore the priorities of different patients, and the machinery for booking a bed takes longer because the application must be handled at the Regional Hospital Board before it reaches the home. This does not mean that some kind of central Convalescent Information Office is not desirable, but such an office would have to know of all vacant beds in every type of home, and be able to tell almoners where there was a suitable bed, or if there was a vacancy in the home of her choice. Admissions could not be made direct by such an office because nearly all homes require almoners to furnish written details of application on a form which has to be considered by the home's matron and medical officer before admission is granted. It is the exception for a home to agree to admit a patient direct after a single telephone conversation, as can often be done in the case of hospitals. A central information office would be possible if all convalescent homes and Hospital Boards would agree to co-operate but a central admission office does not appear to be practicable.

Admissions Arranged by Application Direct to Homes

96. The advantages and disadvantages of this system are:—

Advantages	*Disadvantages*
(1) The almoner has personal contact with the home before admission is decided.	(1) Applications may have to be made to a number of homes, as there is no means of knowing where the vacant beds are. This may take time and trouble, which could be avoided by the use of a Central Information Office.
(2) The almoner and patient have freedom of choice and can select the home where the patient's individual needs can best be met.	

97. Almoners were unanimous in considering that the advantages of direct approach to convalescent homes far outweigh the disadvantages. Admissions made in this way save time and trouble because there is only one authority to deal with, and it is also easier to deal with any last minute changes. In practice certain large hospitals tend to concentrate on particular homes, and provided this is not at the expense of the smaller hospitals, it seems an admirable arrangement as the personal contact between matrons and almoners is maintained.

98. Our survey has shown instances of a Board refusing to admit patients to a "contractual" home selected by the almoner, and diverting them to a State home instead. There have been cases where a patient has had to wait a considerable time for a bed in a State home, whereas he could

have been admitted to a "contractual" bed at once. Our attention has been called to instances where a patient has been refused admission to a home because all "contractual" beds are full, but is at the same time offered immediate admission in the same home if he will pay the fees himself.

Method of Keeping Admission Waiting Lists

99. The best method of dealing with applications for admissions to short-stay homes appears to be for the homes to accept and book, about a fortnight in advance, only beds which are certain to be available for the patients. It is not a good plan to give an uncertain vacancy then or even later, because almoners may find the patient still on their hands when the convalescence should have started.

If no firm vacancy can be promised within a reasonably short time, should not the patient be refused, promptly, so that the almoner can try elsewhere ?

100. Some of the smaller homes, that are bound by the terms of their Trusts to accept only certain social classes of patients, have arrangements whereby the applications have to be examined by the Management Committee of the home. This procedure tends to cause delay in authorising admission.

Admission Forms

101. Nearly every convalescent home has a different form on which application for admission has to be made. Some of these are long and tedious, and require references and signatures of referees, etc. Almoners have to keep a stock of forms for each home, which is rather inconvenient, and it seems obvious that there is a case for the adoption of a standard admission form. The introduction of such a form is not as simple as it would appear, because some homes are tied by the terms of their foundation trusts to accept only certain social classes of people, or those of certain limited incomes.

Use of Hospital Samaritan Funds

102. It often happens that a patient urgently needs to be sent to a convalescent home but there is no bed available in a State or contractual home to which the patient can be sent at the State's expense. In these cases it is the practice for a contribution to be made from the hospital's Samaritan Fund, the patient paying the rest.

103. Patients naturally prefer to take their convalescence at the public expense in a State or contractual home, and consequently it usually takes longer to obtain a bed in these homes than in others where patients are required to pay the fees, or at any rate a portion of them themselves. Admissions made outside State facilities are usually more rapid and offer a wider variety of home, but Samaritan Funds are limited and the number of these admissions was no more than 6 per cent of the total admissions during the period of survey. It was noted, however, that at one hospital nearly one third of the convalescent patients had their convalescence assisted by the Samaritan Fund, and it may be significant that the waiting periods and failure rates were less than at any other hospital. It is evident that Samaritan Funds are invaluable in certain cases where convalescence cannot be obtained by other means, or immediate admission is essential.

Selection of Home—Convalescent or Recuperative Holiday Home

104. Convalescent and recuperative holiday homes offer a wide range from which the almoner can select the most suitable for the patients' needs. The nursing staff in many recuperative holiday homes is similar to that found in convalescent homes with contracts with the Regional Hospital Boards, and adequate attention is usually available for patients recently out of hospital, though serious dressings cannot be undertaken. Generally speaking, there is little difference between the two types of home.

105. Before the almoner can arrange the admission of a patient, she has to ascertain from the doctor whether "nursing care and attention" is required after the patient leaves hospital. If this is the case, the patient is eligible for admission to a convalescent home as a Regional Hospital Board patient, and an application for admission is initiated in the manner previously described. If no "nursing care and attention" is required, the patient is only eligible for admission to a recuperative holiday home as a Local Health Authority patient. An application is then made to the Divisional Medical Officer of the Local Health Authority for permission to arrange admission. At the same time, the almoner has to decide which home will be most satisfactory for the patient and where he is likely to derive most benefit from his convalescence.

106. Since it is often almost impossible to draw a dividing line between the types of patient, and a number may be equally suitable for admission to either type of home, the choice for the almoner lies between the various individual homes at which accommodation is available. The responsibilities of Hospital Boards and Local Health Authorities in the matter of convalescence are not well defined, and there have been instances of patients having their convalescence delayed while these two bodies were unable to decide which should bear the financial responsibility. In such circumstances it is not surprising that anomalies arise. There have been instances where two patients have had exactly the same complaint, and needed similar treatment, but one has gone to a convalescent home as a Regional Hospital Board patient, while the other has been sent to a recuperative holiday home as a Local Health Authority charge.

107. The arbitrary division of homes into two categories, combined with the fact that a patient may change from a "convalescent" to a "recuperative holiday" candidate while waiting for admission, has absurdly complicated the almoner's task in this important branch of hospital social work.

CONVALESCENT SERVICES PROVIDED BY FRIENDLY AND BENEFIT SOCIETIES AND TRADE ASSOCIATIONS

108. A survey of the provisions for convalescence cannot be complete without reference to the work of Friendly Societies, and the Committee has been greatly assisted in this matter by the Hearts of Oak Benefit Society and the National Deposit Friendly Society.

109. In the early part of 1950, Friendly Societies owned nine convalescent homes situated within the Metropolitan Hospital Board Regions, though all were not in operation. There were, however, some 350 beds available. These homes are primarily for members of Friendly Societies,

but other patients are accepted if there are vacant beds, and conversely, if there are no vacancies available for members of the Societies, arrangements are made for them to be sent to other voluntary homes.

110. A number of industrial firms have arrangements for sending their employees away at the expense of the firm for recuperative holidays or rest-breaks when they are in need of a rest and change of air. These patients are sent on a doctor's recommendation, but do not normally require medical supervision and nursing care when they are admitted to a home. Simply by having a rest, change of air and good food they are able to build up their strength and return fit to carry on with their work.

111. Certain large Industrial Firms and Trade Associations have their own convalescent homes in which facilities are provided for their employees and members, and it is the usual practice to accept outside people whenever there are vacant beds. To keep these homes full is the constant aim of their Management Committees, because a fluctuating occupancy and continual rise in the maintenance costs may easily produce an unsatisfactory state of affairs.

112. There can be no doubt that these facilities are most desirable, and the service can perhaps best be described as preventive and recuperative. Without it many workers would pass from a "run down" condition to a state of actual illness, involving absence from work and possibly admission to hospital where they would further increase the already acute shortage of hospital beds.

OCCUPANCY OF CONVALESCENT HOMES

113. The information given to us by the almoners of London hospitals, which has been analysed in previous sections, gives some indication of what happens to convalescent patients when they leave hospital. We have also obtained information from a number of convalescent homes relating to their admissions, treatments and occupancy, which is analysed in the succeeding tables. The great majority of the 5,769 patients who were sent to convalescent homes from the London Hospitals taking part in this survey, were in fact admitted to the homes that we have questioned. We cannot, however, follow the course of each individual patient and thereby establish exactly what happened, because during the period of the survey these homes admitted a total of 24,576 patients as against 5,769 sent for convalescence from the selected hospitals. We have therefore examined the problem by looking at it first from the hospitals' end and then from that of the convalescent homes'.

114. With a view to ascertaining if there was any wastage of bed accommodation we asked the convalescent homes for details of their occupancy. The following tables regarding occupancy are arranged to show the occupancy over three two-month periods.

115. The figures of occupancy in these tables show the average daily occupancy of the staffed beds. In these, we have included those beds vacated because of infection, short term closure for house decorations, and isolation rooms. Excluded are beds which have been unstaffed for long periods and beds closed because of major alterations to the buildings.

Overall Occupancy of Convalescent Homes for Adults

TABLE XI—VOLUNTARY HOMES (ADULTS):

Period	Number of homes giving information	Staffed beds	Average overall occupancy
February—March ..	35	1,223	68·7%
April—May	38	1,439	81·5%
June—July	37	1,502	85·0%

116. The above figures include homes with Regional Hospital Board contracts and recuperative holiday homes. The figures relating to these two groups separately are shown in Tables XII. and XIII.

TABLE XII—VOLUNTARY HOMES (ADULTS) WITH HOSPITAL BOARD CONTRACTS FOR A PROPORTION OF BEDS:

Period	Number of homes giving information	Staffed beds	Average overall occupancy
February—March ..	14	615	78%
April—May	13	582	87%
June—July	12	618	95·5%

TABLE XIII—VOLUNTARY HOMES (ADULTS) WITHOUT HOSPITAL BOARD CONTRACTS (RECUPERATIVE HOLIDAY HOMES):

Period	Number of homes giving information	Staffed beds	Average overall occupancy
February—March ..	21	608	59·7%
April—May	25	857	77·5%
June—July	25	884	80%

117. It will be seen that there is a rise in occupancy in the summer months both at the homes with Hospital Board contracts and at those without, and that it is more marked in the latter. The rise in both cases is due to the increase in the number of recuperative holiday patients. At homes with contracts, the proportion of Regional Hospital Board patients was in fact slightly

less in the later than the earlier part of the period. Homes with contractual arrangements are in a sounder position than the others because they can rely on a steady flow of Boards' patients all the year round and to these can be added the recuperative holiday patients, which enables them to show a very satisfactory occupancy in the summer.

118. It has been mentioned earlier in this report that the Minister of Health has had under consideration the designation of certain voluntary homes for the exclusive use of Hospital Boards, leaving the remainder for the use of Local Health Authorities, Friendly Societies and the public generally. It is believed that one reason for this division is that it would bring to an end the present circumstances under which Local Health Authority patients, who are obliged to contribute towards the cost of their recuperative holiday, find themselves in the same home as Regional Hospital Board patients, who receive their convalescence free of charge. Under Section 28 of the National Health Service Act, the Local Health Authorities are entitled to recover part of the fee from the patient, having regard to his means. The proportion recovered varies according to the practice of the particular Local Authority. Consequently, in addition to the Boards' patients there may be in the same home a number of different Local Health Authorities' patients all contributing different amounts, though their means may be identical.

119. If the Minister were to decide that a certain home was to be used exclusively by a Regional Hospital Board, this might under the contractual arrangements as they at present exist, have important financial consequences. If the beds were not fully occupied by the Board and the home was not allowed to take patients from other sources, it would have to raise the fees charged to the Board to a level which would cover all the costs of the home including the unoccupied beds. The fewer patients the higher the cost per bed. The outcome might be that the Board might be called upon to pay all the costs of the home, the whole year round, regardless of the number of beds occupied. Bearing in mind the desirability of preserving the voluntary character of the homes, the financial implications should be seriously considered before deciding that the use of particular homes shall be the monopoly of the Regional Hospital Boards. Under present arrangements it is necessary that a voluntary home is as full as possible, otherwise the cost per patient may rise to a figure that Hospital Boards and Local Health Authorities are unwilling to pay, and it may be forced into financial difficulties which may oblige it to close.

120. The comparison of occupancy of convalescent homes and recuperative holiday homes in Tables XII and XIII shows the latter at some disadvantage, but this is partly accounted for by the fact that included in their number are 5 homes that are tied by the terms of their Trusts to accept only certain occupational groups of patients. These homes may accept respectively only ex-service patients, merchant seamen, or nurses and because of their limited scope, show a lower rate of occupancy. Another reason for low occupancy arises from the fact that some patients like to be away from their own kind when convalescing and prefer a home where they will meet people in other walks of life. In cases where the Trust Deeds can be interpreted to allow a wider definition of eligibility for admission it is obvious that occupancy can be improved, as has occurred in certain homes for ex-service men who now admit women who have been members of the Women's Services.

121. These 5 homes with limited admission show the following results:—

TABLE XIV—VOLUNTARY HOMES RESTRICTED TO PATIENTS OF OCCUPATIONAL GROUPS:

Period	Number of homes	Staffed beds	Overall occupancy
February—March ..	5	180	44·5%
April—May	5	180	57·7%
June—July	5	180	67%

The position in the remaining recuperative holiday homes, having deducted those five shown in Table XIV is given in Table XV.

TABLE XV—VOLUNTARY RECUPERATIVE HOLIDAY HOMES OTHER THAN THOSE SHOWN IN TABLE XIV.

Period	Number of homes	Staffed beds	Overall occupancy
February—March ..	16	428	66%
April—May	20	677	83%
June—July	20	704	83·5%

122. The conclusion to be drawn appears to be that the recuperative holiday homes are not permanently working at full pressure, though in August and September they may be expected to be rather fuller than at other times, as these patients' demands are very seasonable. The reason for the lower occupancy is partly explained by patients cancelling their admissions at short notice and partly because Local Health Authorities appear unwilling to assume financial responsibility for any more patients. This latter reason may also explain why there are patients waiting at the same time as there are empty beds.

123. We were also able to obtain similar figures from 21 State convalescent homes, which are given in Table XVI.

TABLE XVI—STATE CONVALESCENT HOMES FOR ADULTS:

Period	Number of homes	Staffed beds	Overall occupancy
February—March ..	21	1,268	80·2%
April—May	21	1,287	84·5%
June—July	21	1,277	85·2%

These show a much steadier level of occupancy, with a 5 per cent. rise over the whole period. This compares very closely with the contract homes where the Regional Hospital Board admissions increased slightly though their proportion of the total occupancies dropped a little.

Occupancy of Children's Homes

124. Similar statistics were obtained from two types of Voluntary homes for children. These were (*a*) Boarding Special Schools for Delicate and Physically Handicapped Pupils which admit children for periods ranging from three months to a year or more and (*b*) recuperative holiday homes where children are admitted for periods of two to six weeks. The former are recognised for maintenance grants by the Ministry of Education and at these the patients' fees are the financial responsibility of the Local Education Authorities. At the latter the patients' fees are paid by the Local Health Authorities.

TABLE XVII—VOLUNTARY HOMES FOR CHILDREN (ALL CATEGORIES):

Period	Number of homes giving information	Staffed beds	Overall occupancy
February—March ..	32	1,634	84%
April—May	35	1,703	90·5%
June—July	32	1,653	95%

The above can be divided into:—

A. Long stay homes which provide education (special schools).

B. Short stay homes which do not provide education.

TABLE XVIII—(A) BOARDING SPECIAL SCHOOLS FOR DELICATE AND PHYSICALLY HANDICAPPED PUPILS:

Period	Number of homes giving information	Staffed beds	Overall occupancy
February—March ..	17	1,070	96%
April—May	17	1,096	94%
June—July	16	1,070	98%

125. The Boarding Special Schools for Delicate and Physically Handicapped Children, for which figures are shown in Table XVIII (A), have a high and even rate of occupancy. This is considered to be due to the fact that children remain there for many months and there is very little wastage due to turnover of beds.

TABLE XIX—(B) VOLUNTARY SHORT STAY RECUPERATIVE HOLIDAY HOMES FOR CHILDREN:

Period	Number of homes giving information	Staffed beds	Overall occupancy
February—March ..	15	564	61%
April—May	17	607	86·5%
June—July	15	583	88·5%

126. In the February—March group of Table XIX are included two homes that had only reopened at the beginning of the year, and had consequently been unable to fill up by the time the survey started. Had they been excluded from that group the average occupancy figure would have been 68 per cent. (instead of 61 per cent.). Also in the short-stay homes are included five with Regional Hospital Board contracts, but as the number of the Board's patients was only 3·3 per cent. of the total admissions, this factor is not considered materially to affect the situation.

127. Figures were also obtained from a number of children's convalescent homes administered by Regional Hospital Boards, and these are given in Table XX.

TABLE XX—STATE CHILDREN'S CONVALESCENT HOMES:

Period	Number of homes giving information	Staffed beds	Overall occupancy
February—March ..	14	661	74%
April—May	14	667	79%
June—July	13	642	76%

These homes show a rather lower rate of occupancy than the voluntary homes for which, however, we are unable to suggest any explanation, particularly as the Invalid Children's Aid Association maintains a waiting list, at certain times of the year, of children requiring admission.

SECTION 7

SOME FINANCIAL ASPECTS OF CONVALESCENT TREATMENT

Patients Sent from Hospitals to Convalescent Homes

128. We have ascertained what proportion of patients sent from hospital to convalescent homes had their convalescence or recuperative holiday paid for by various bodies.

129. The 5,769 patients admitted to convalescent homes from the 19 London hospitals taking part in the survey had their fees paid in the following proportions:—

Paying Authority	*Proportion*	
State Home	53·5%	
Contractual arrangements	14·1%	
Local Authorities	16·7%	
Friendly Societies	0·4%	
Trade Welfare Associations	0·8%	
Charitable Bodies	1·5%	Charitable sources 9·6%
Samaritan Funds	6·1%	
Other Funds	2·0%	
Patients paid	4·9%	
TOTAL	100%	

The Local Health Authorities' proportion represented 28 per cent. of the Out-patients' and and 12·6 per cent. of the In-patients' applications.

130. The patients (4·9 per cent.) who paid for their own convalescence were those who paid the whole fees with no assistance from any other source. Patients (9·6 per cent.) usually contribute towards the fees when assistance is given from charitable funds ; when the Local Authority (16·7 per cent.) sponsors convalescence the patient contributes toward the cost according to his means. These three groups together show that about 31 per cent. of the patients made some kind of contribution towards the cost of their convalescence.

Patients Admitted to Voluntary Convalescent Homes from All Sources

131. We made further enquiries to find out where the financial responsibility lay for the patients in the voluntary homes we approached. Figures were given by the homes showing the patients admitted between 1st February and 31st July, 1950. These, however, do not give a complete picture of the position because we were not able to approach all the homes in the Metropolitan Regions, neither have we consulted any private homes, many of which take patients from Local Health Authorities, or direct from hospitals.

132. Of the 69 homes which gave statistics, 18 had contracts with their Regional Hospital Boards for a number of beds, 17 were special schools for delicate children, and the remaining 34 are classified as recuperative holiday homes.

133. Admissions were made to them in the following proportions:—

Paying Authority	*Proportion*
Regional Hospital Boards (contract beds) ..	20·0%
Local Authorities	34·0%
Friendly Societies, Trade Associations and Welfare Departments	21·7%
Patients paid	14·3%
Other sources	10·0%
TOTAL ..	100%

It is mostly these voluntary homes that provide the recuperative holidays, and during the period under review there were 13,190 admissions, of which 2,703 were Hospital Board's patients 9,282 recuperative holiday patients and 1,205 were delicate children admitted to special schools.

Running Expenses of Voluntary Convalescent Homes

134. The continued rise in the cost of living during the past year has made it difficult for voluntary homes to avoid a deficit on the year's working, because the current charges had, of necessity, to be based on the previous year's costs. This has often resulted in accumulated debts which cannot be liquidated by an adjustment of fees, as public authorities cannot reimburse the homes retrospectively.

135. Most of the voluntary homes included in our survey have some invested funds or, still enjoy voluntary contributions, and may thus be able to meet their deficits from capital assets, but these sources of income are diminishing.

136. To illustrate this, statistics were obtained from 45 voluntary convalescent homes for the year ending 31st March, 1950, and the following position was disclosed.

137. It was found that an average annual loss of £22 had been incurred in respect of each occupied bed, due to the fees being too low in face of the rise in the cost of living. In other words, the average weekly charge per bed was eight shillings and six pence too low to meet the actual expenses.

138. The voluntary contributions and income from investments provided, on average, an annual sum of £45 towards the maintenance cost of each occupied bed. Thus the users of these homes obtained convalescence for their patients approximately 17/4d. per week cheaper than would have been the case had these charitable funds not been available.

TABLE XXI—ADMISSIONS TO CONVALESCENT HOMES—FEBRUARY TO JULY INCLUSIVE.

(Figures supplied by 104 homes, consisting of 69 Voluntary and 35 State Homes.)

		Simple Convalescence	Simple dressings	Serious dressings	Diabetic diets	Gastric diets	Coeliac diets	Ground floor rooms	Colostomies	Bronchiectasis	Non-Pul. T.B.	Others	Total
MEN	Over 60	1,103	83	5	7	297	21	266	19	11	1	23	1,836
	Under 60	3,522	489	24	8	1,183	39	308	48	61	84	119	5,886
WOMEN	Over 60	1,328	213	38	192	142	55	394	37	9	6	108	2,522
	Under 60	5,260	705	217	165	467	148	515	42	45	104	1,060	8,728
BOYS	12–16	223	45	—	4	—	—	7	—	13	21	41	354
	5–12	1,573	93	1	10	—	3	16	—	55	58	97	1,930
GIRLS	12–16	294	7	4	14	2	2	3	1	7	13	55	403
	5–12	1,497	79	—	11	—	4	8	1	50	42	97	1,789
TODDLERS	2– 5	584	9	—	3	—	6	—	1	9	41	35	774
BABIES	0– 5	370	4	—	—	—	1	—	—	—	3	62	440
	TOTAL	15,754	1,727	289	418	2,091	279	1,517	146	260	373	1,723	24,576
Percentages of whole		64	7·1	1·2	1·7	8·6	1·1	6·1	0·6	1·1	1·5	7·0	100
Comparable figures supplied by hospitals		70·8	2·6	0·6	2·5	6·8	0·2	5·1	0·7	1·0	0·6	9·7	100

TABLE XXII—DISTRIBUTION OF PERIODS WAITING FOR ADMISSION, ACCORDING TO MODE OF PAYMENT—FOR IN-PATIENTS FROM 19 LONDON HOSPITALS.

Paying Authority	Total No. of patients	Length of waiting period in days (inclusive)							Percentage with no wait	Mean wait in days	Percentage waited over one month
		0	1–2	3–7	8–14	15–28	29–60	60+			
(1) State Homes	2,392	830	138	627	418	267	103	9	35%	7·9	4·7%
(2) Contractual arrangements	622	164	32	142	137	109	35	3	26%	10·2	6·1%
(3) Local Authorities ..	536	165	35	118	95	67	50	6	31%	10·7	10·3%
(4) All others	690	293	43	182	104	50	18	Nil	43%	5·8	2·6%

NOTES.—1. The mean wait in days includes patients who did not need to wait.

2. Group 4 is made up as follows:— Charitable sources, including Samaritan Funds, 60%; private payment by patients, 31%; Friendly Societies and Trade Welfare Associations, 9%.

3. Since patients in Groups 1 and 2 are both Hospital Boards' responsibility, they have been combined in the following table and are shown in comparison with other groups:—

Payment Group	Percentage with no wait	Mean wait in days	Percentage waited more than one month
(4) All others	43%	5·8	2·6
(1) and (2) Hospital Boards ..	33%	8·4	5·0%
(3) Local Authorities	31%	10·7	10·3%

APPENDIX

COMMENTS ON A PATIENT'S NEEDS IN A CONVALESCENT HOME

Florence Nightingale wrote the following in her "Notes on Hospitals":—

> "It is a rule without exception, that no patient ought ever to stay a day longer in hospital than is absolutely necessary for medical or surgical treatment. What then is to be done with those who are not yet fit for a work-a-day life? Every hospital should have its convalescent branch, and every county its convalescent home".

139. If it can be assumed that the above is as true in principle today as it was when first written, the convalescent homes call for increasing thought and attention. The patient, who has had an acute illness and not yet regained full health, is in need of care and personal attention. From those responsible for his wellbeing at the convalescent home he needs kindness and a warm welcome, which will inculcate a personal liking for the staff at the home.

140. We understand from some matrons of homes that often the less educated type of patient arrives at a convalescent home in a state of some apprehension, afraid that it is an institution run on severe lines. This type of patient is, of course, the exception and needs a particularly soothing and welcoming reception on arrival.

141. In all communities it is necessary that some rules should be observed for the common good and certain instructions must be given to the newcomer. In convalescent homes this should be done in the kindest and most tactful way. Our experience indicates that a good way of doing this is to send the patient an "information" sheet with the admission papers. This should tell the patient what clothing etc. should be brought, how to get to the home, and include a message of welcome. It should avoid the use of the word "regulations" and the word "rules" should be restricted as much as possible. On no account should a list of rules and regulations, perhaps somewhat abruptly phrased, be sent to patients before they arrive. In their state of weakness such things upset convalescents and it is not unknown for a patient to have refused admittance on seeing such a form.

142. If kindness is the foremost need, then comfort for the patient comes next. This should be more marked at the beginning of the stay than at the end because convalescence is a period of rehabilitation for normal life and some slight "hardening off" should be done towards the end of the visit.

143. Breakfast in bed for the first few days might be arranged, but if staff shortage does not permit, it might be possible to arrange breakfast in two sessions so that the newcomers could attend the later one. An alternative might be to take breakfast in bed only to the more seriously ill patients. This is a somewhat important point of adjustment after hospital life and should be arranged if it is at all possible. In all cases, of course, a good understanding by matron of the patient's illness is important, but above all, those in charge of convalescent homes should cultivate the personal rather than the impersonal, way of dealing with their patients.

Staffing Problems

144. At the present time many homes are short of nursing and domestic staff and have difficulty in recruiting adequate staff. The possible exception may be the home attached to a teaching hospital which is able to draw on the nursing staff of the parent hospital. All the evidence we have collected points to the desirability of homes upgrading the standard and scope of their services so that patients can be received from hospital at a rather earlier stage to relieve the pressure of demand for hospital beds. This would involve more trained staff and higher cost per patient, which would be a charge to the Health Service. The extra cost, however, would be comparatively slight and justified in that the list of patients awaiting admission to hospital would be substantially reduced.

Diets

145. The importance of good and nutritious food for convalescent patients has constantly been stressed by the Fund and most convalescent homes are giving increased attention to this matter. In many instances they have been assisted financially by the Fund in introducing improvements to their kitchens, sculleries and equipment. Advice on all matters connected with catering, dietetics and kitchen equipment is available to any home that asks the Fund for help, and in all cases this is given without charge. This has led to better catering in the homes, but there are still not enough homes that will provide gastric and other special diets, this being mainly due to the shortage of competent kitchen staff.

Size of Convalescent Homes

146. In the Metropolitan Hospital Board Regions there are at present convalescent homes ranging in size from 200 to a dozen beds. Most of these were built in more prosperous times and those that are very large have had to be modernized as far as finances and the original plans allow. Even so, it is difficult to get rid of the rather institutional atmosphere that is inherent in the older and larger convalescent homes. The advantage of the large home is, however, that there is usually space available for physiotherapy and other treatment to be given on the spot and the extra cost is not prohibitive if spread over a large number of patients.

147. The medium sized home consisting of 30 to 40 beds is considered by many to be economically the most desirable size. In these the patients are able to enjoy a more homely atmosphere and can probably more easily choose their own friends. A desirable feature of a convalescent home is that the bedrooms should not be overcrowded, the beds being limited to 3 or 4 with as little of the hospital atmosphere as possible. The bedrooms should be bright and comfortable, with a fitted hot and cold water handbasin in each, together with adequate wardrobe or hanging space for their clothes. This latter point is sometimes overlooked, and there can be nothing more irritating for the tidy person than to have no suitable bedside locker or wardrobe for stowing their belongings.

148. The smaller type of home usually has about a dozen beds, and they are very suitable for more discriminating people and the elderly. These homes usually have single bedrooms, comfortably furnished, with fitted basins and gas or electric fires. Some of them were founded some 60 years ago and the terms of their Trusts limit admissions to specified categories (e.g. ladies

of the professional classes with small incomes). It has been found that the rules for admission to these homes are rather tiresome under present day conditions as the patient has to be recommended by one or more referees, but in many cases this difficulty has been got over by simply accepting the almoners' recommendation. It is necessary that in homes of this sort, where the conditions approximate to those of a private house, that the patients should get on well together as with the limitations of space they are bound to see a good deal of each other. Without congenial surroundings, the patients will not get the full benefit of their convalescence. These homes are providing a valuable service and the need for their continuance is stressed by nearly all the almoners who have been consulted.

149. On conclusion of this report, we wish to make particular mention of the many people who are taking part in the management of voluntary homes. At the present time this entails much hard work and often some degree of anxiety as well. This burden is often borne by busy professional people, and their reward lies in the satisfaction they get from helping the sick. High praise is due to them for their valuable work in keeping alive the spirit of voluntary service, the preservation of which is so essential, and which hitherto has always been the special pride of the English people.

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