KING EDWARD'S HOSPITAL FUND
FOR LONDON

HOSPITAL PERSONAL AID SERVICE FOR THE ELDERLY

REPORT TO 31st DECEMBER 1959

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THE Service undertakes:

1. To visit, on behalf of hospitals, elderly people awaiting admission to hospital whose medical condition does not warrant immediate admission to an acute ward.
   The main objects are:
   (a) To assess the social circumstances in order to suggest to the hospital the priority, based on social grounds, of those who need admission.
   (b) To inform the hospital of the home circumstances of the patient both in support of the suggested priority and as a guide when discharge is being considered.
   (c) To suggest suitable means for the care of those patients who are not considered by the hospital to need admission on medical grounds.
   (d) To ensure that the waiting list is kept accurate by informing the hospital of any case which, through any change of circumstances, can be removed from the list.

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

2. To provide a Centre where hospital and other authorities can obtain information about the Services for, and assistance with the problems of, the elderly and chronically ill.

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FOREWORD

THE Hospital Personal Aid Service for the Elderly was established by King Edward's Hospital Fund. It has the co-operation of the four Metropolitan Regional Hospital Boards, each contributing towards the cost, the Fund paying the balance.

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

ZACHARY COPE,
Chairman.

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THE Hospital Personal Aid Service for the Elderly started its work ten years ago although it did not actually receive its name until 1955. It is perhaps an appropriate time to review briefly its work and development during this period.

Its main activities can now be classified under three headings, namely (a) domiciliary social assessment of elderly and chronically sick patients awaiting admission to hospital, (b) information and advisory service, and (c) young long-stay patients. The Service was not, however, originally designed specifically for any of them but the need for them was discovered as the early enquiries were being made.

Those who were concerned with the admission to hospital of patients who were not acutely ill will remember how extremely difficult it often was to arrange such admissions during the early years of the National Health Service. The length of waiting lists made it seem most unlikely that the hospital service could ever provide enough beds to meet this very heavy demand. Enquiries were made and the situation and its causes studied. It seemed that as a first step it might be helpful to arrange meetings of representatives of organizations concerned both officially and voluntarily with the health and welfare of elderly and disabled people. They might find ways of co-ordinating their efforts and helping each other and those they were trying to serve. With the permission, help and encouragement of the South-East Metropolitan Regional Hospital Board, co-ordinating committees – as they were called – were set up in ten hospital groups in that Region. Each was composed of representatives of the local hospital management committee, local authority health and welfare departments, general practitioners, the National Assistance Board and a number of voluntary societies. These committees provided an opportunity for each organization to learn something of the others' activities but, as they were seldom able to find definite solutions to the many problems with which they were confronted, it may have been thought that they did not serve any really useful purpose. To the Fund, however, a most important fact emerged; it seemed that the hospitals had little

knowledge of the needs of the patients on their waiting lists. The lists were only of names – often with no clear diagnosis (it was not uncommon to find the reason for admission to be "tottery" or "unable to use her legs") – and, in the few cases where social details were given, they were extremely brief. A large number of the applications had been received by the hospitals as much as two years before and no checks had been made as to whether admission was still necessary.

Here then was a clear course of action for the Fund to take; to bring waiting lists up to date, for it seemed that the hospitals themselves had no staff available to do this. Accordingly, with the approval of the Regional Hospital Board and the hospital management committees concerned, visits were made during the next few months to nearly 400 patients who were on the waiting lists of five hospital groups. It was not the subsequent discovery that a quarter of them had died or had already been admitted that was really important, for it was expected that the lists would be out of date, but that a large number of patients refused admission or seemed suitable for some other care. With the permission of the hospitals and general practitioners concerned, other services were approached on behalf of these patients with the result that other provision was made for 127 of them and their names could be taken off the hospital waiting lists.

Before this review of waiting lists started an attempt had been made to help hospitals to obtain appropriate alternative care for some of their patients by providing them with forms listing the various other services and amenities. The hospitals were invited to mark what was needed for individual cases as they arose and to return the forms to the Fund who would try to arrange the necessary service. However, the scheme was not successful as, for one reason or another, hospitals did not find it easy to mark and return the forms.

DOMICILIARY SOCIAL ASSESSMENT

THE discovery that hospital waiting lists included so many patients who were not in need of hospital care resulted in the hospital groups, for whom the reviews had been made, asking

whether the Fund would continue to make a domiciliary assessment of all new cases. An agreement between the Fund and the South East Metropolitan Regional Hospital Board enabled the necessary staff to be engaged so that this could be done in an improved and more detailed way; thus the domiciliary social assessment part of the Service became established.

It has been our custom to report annually on the results of these visits and in this Report details of the work done in 1959 and in the years since 1951 will be found.

Table I gives a statistical summary of all the patients visited and of the outcome. When it is remembered that of the 400 patients the Service originally visited about half were taken off the waiting lists for one reason or another, it will be seen that there has been little change over the years; the number removed in 1959 amounted to 45% of the total visited.

TABLE I

Statistical Summary of Domiciliary Visits

	1951–57	1958	1959	*Totals*	*% of Total*
Patients visited	9,117	2,396	2,420	13,933	
Removal from Waiting List					
Died or already admitted	1,171	166	119	1,456	10.5
Withdrawn	2,342	538	427	3,307	23.7
Other arrangements ..	1,141	473	558	2,172	15.6
	4,654	1,177	1,104	6,935	49.8
Admission to Hospital					
Priority I (Urgent) ..	596	30	49	675	
Priority II (Less urgent	1,136	323	247	1,706	17.1
Priority III (Not urgent)	810	291	318	1,419	
After observation ..	1,150	437	528	2,115	
	3,692	1,081	1,142	5,915	42.4
Died before admission ..	313	23	30	366	2.7
Still awaiting admission ..					
Priority I	—	—	—	—	
Priority II	—	—	—	—	
Priority III	—	—	9	9	—
Still under observation	—	—	17	17	0.1
Died while under observation	458	115	118	691	5.0
	9.117	2,396	2,420	13,933	

A figure of particular interest is the 558 patients for whom other arrangements were made with the approval of their doctors. The gradual rise in this figure – on which we commented in our last Report – and which in 1958 was 19%, rose to 23% in 1959.

LENGTH OF WAIT FOR ADMISSION

OBVIOUSLY it is of great importance for patients who need treatment in hospital to start it as soon as possible. The difference between full or partial recovery may depend on this and certainly the length of stay in hospital is likely to be prolonged if treatment is not started while the medical condition is in its early stages. It is the experience of the Service that year by year more patients are being admitted to hospital quickly and fewer wait a long time. In 1952, 31% entered hospital within a week of the domiciliary visit compared with 72% in 1959.

In 1952, 23% waited over two months but this had fallen to only 1% in 1959.

TABLE II

Length of wait for admission

	1953	1954	1955	1956	1957	1958	1959
CASES ADMITTED	334	348	219	219	228	353	296
On day of visit	12	10	13	18	27	24	21
1 day after visit	35	43	29	30	48	67	48
2 days after visit	19	35	25	24	25	42	32
3 days after visit	13	20	12	17	15	41	42
4 days after visit	12	16	5	16	13	32	18
5 days after visit	14	15	9	11	7	19	21
6 days after visit	8	19	8	12	14	28	33
i.e. within 1 week	113 34%	158 45%	101 46%	128 58%	149 66%	253 72%	215 72%
During 2nd week	47 14%	63 18%	40 18%	43 20%	41 18%	60 17%	47 16%
During 3rd week	39 12%	31 9%	22 10%	18 8%	13 6%	19 5%	17 6%
During 4th week	19 6%	20 6%	11 5%	11 5%	7 3%	7 2%	10 3%
During 2nd month	51 15%	37 11%	23 11%	10 5%	12 5%	8 2%	5 2%
Over 2 months	65 19%	39 11%	22 10%	9 4%	5 2%	6 2%	2 1%

LENGTH OF STAY IN HOSPITAL

An interesting trend is apparent in the subsequent history of patients admitted to hospital, although in view of the comments made in the preceding paragraph it is not unexpected. At the end of 1955 we checked with the hospitals concerned what had happened to the 2,164 patients who had been visited by the Service and admitted to hospital. A similar check has been made of the 5,915 patients admitted up to the 31st December 1959, and the following comparative figures are of interest:

	At 31st December 1955	*At 31st December 1959 (including figs. up to 1955)*
Patients admitted	2,164	5,915
Deaths	1,045 (48%)	2,895 (50%)
Discharges ..	777 (36%)	2,617 (44%)
Still in hospital ..	342 (16%)	403 (6%)

It will be seen that the fall of 10% in the number of patients remaining in hospital is almost fully taken up by a greater proportion being discharged; the proportion of deaths increasing by only 2%.

Table III shows the number of those who died, were discharged or who remained in hospital as at the 31st December 1959, and the length of stay of each patient.

TABLE III

Length of Stay in Hospital

Days	*Deaths*	*Discharges*	*Still in*
0 – 28	1,174	966	47
29 – 56	423	587	21
57 – 84	227	356	11
85 – 112	134	194	14
113 – 140	100	102	13
141 – 168	84	90	13
169 – 196	56	56	12
(6 months)			
197 – 224	61	37	15
225 – 252	56	32	21
253 – 280	45	27	12
281 – 308	40	26	17
309 – 336	42	14	15
337 – 364	24	9	9
(1 year)			
365 – 392	30	18	9
393 – 420	33	9	12
421 – 448	24	10	5
449 – 476	19	8	1
477 – 504	21	6	6
505 – 532	24	9	2
533 – 560	22	6	2
561 – 588	12	5	7
589 – 616	9	4	9
617 – 644	11	2	6
645 – 672	15	3	8
673 – 700	8	3	1
701 – 728	14	4	—
(2 years)			
3rd year	93	25	36
4th year	54	4	36
5th year	28	3	20
6 – 9 years	12	—	23
	2,895	2,617	403
		5,915	

Total admissions for 9 years.

INFORMATION AND ADVISORY SERVICE

A thorough knowledge of services and activities for old people both locally and nationally is essential for a proper social assessment of patients' needs. The Service is anxious that the experience and knowledge it has gained over the years shall be available to doctors, hospital almoners and any other representatives of official bodies. Already a large number of enquiries are received annually (in 1959 more than 1,000 were dealt with). These range from the comparatively simple requests for details of private nursing homes to more complex problems involving those for whom no service seems adequate. It will be appreciated by those engaged in work for the elderly and chronic sick that immediate solutions are not always easy but the Service will give all the help and advice it can.

For some years the Service has intermittently published comparative figures relating to geriatric/chronic sick units. The demand for these statements increased; many units saying that they provided their only opportunity to compare their position with that of others. Recently the statement was redesigned and is now sent quarterly to almost all hospital groups in Greater London.

These are some of the ways in which the Service is playing its part in the hospital work for the elderly. It is convinced that there is still much to be done to achieve what should be the first aim of hospitals, namely the accurate diagnosis and treatment of patients of no matter what age. These facilities must be made available to all those needing them and for this it is not necessarily a question of new buildings. It is clear that there is often room for improvement in the use that is made of the accommodation now available.

YOUNG LONG-STAY PATIENTS

MOST hospitals have no accommodation, other than their geriatric wards, to which they can admit younger chronically ill patients. The Service is frequently confronted, therefore, with the problems which arise, for many of these patients are on the ordinary chronic sick waiting lists. The Service is also approached from time to time by almoners and others who are anxious to find something

more suitable than the chronic sick wards where young people would be surrounded by the old and often senile.

The Service was able to study the subject closely when in 1953-54 a survey was made from its office on behalf of the Leverhulme Research Awards and the South East Metropolitan Regional Hospital Board.

Those acquainted with this particular problem know that it is small numerically but great in complexity. According to the present general interpretation "young" applies to patients of any age from about sixteen to statutory pension age. Some patients are, of course, boys or men and some girls or women; some are in an advanced stage of a progressive disease while others are permanently disabled to a degree which may be mild by comparison. In the normal area covered by one hospital group there may not even be two patients who could suitably be accommodated together. For reasons such as these a solution to the whole general problem is difficult but the Service seeks ways in which the young long-stay patient can clearly best be served.

Printed by Crystalate (Printing) Limited, Tonbridge, Kent