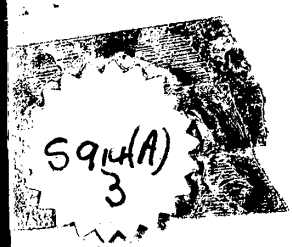
EMERGENCY BED SERVICE

(KING EDWARD'S HOSPITAL FUND FOR LONDON)

REPORT FOR THE YEAR ENDED 31st MARCH

1956



KING EDWARD'S HOSPITAL FUND FOR LONDON

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EMERGENCY BED SERVICE

Report for the Year ended 31st March, 1956

INTRODUCTION

During the year the Service received 65,695 applications for admission to hospital, some 2,000 more than during the previous year. The greater part of this increase was for general cases, though applications for infectious cases were also up on last year, mainly due to the high incidence of poliomyelitis in the late summer and autumn.

The winter started normally with general acute applications rising quickly at the end of November. There was, however, an ominous absence of the usual pre-Christmas decline which is generally evident from about 18th December until after the holiday period. Experience has shown that the absence of such a decline is a warning of an unusually high rate of applications in the New Year, and this was again borne out last winter. After Christmas applications rose rapidly to 1,800 per week by 10th January, and remained between that figure and 1,400 till the end of the first week in March.

The remarkable feature of the winter, however, was not so much the number of applications, which though large was not the largest in the history of the Service, but the exceptional difficulty that was experienced in finding the necessary empty beds. All whom it was

deemed essential to admit were indeed admitted, but the proportion of cases forced into hospital under the medical referee procedure rose to unprecedented heights. Judging from the comments made to the Service by the hospitals, this distressing situation seemed to arise from many causes. For instance, there was a natural unwillingness on the part of the hospitals to clear beds by discharging into the very cold weather those patients who had been suffering from respiratory disease. " Shortage of nurses," sometimes arising from the lack of recruits, but more often from illness, was also given as a reason for refusing admission. In addition it seems possible that the increased number of beds set aside for special purposes has unduly reduced the number available for general emergencies. At the same time the hospitals constant endeavour to maintain a high occupancy must inevitably reduce their ability to take in unexpected emergency cases.

One further difficulty has been the prejudice of certain hospitals against " E.B.S. cases." There is, of course, no such thing as an E.B.S. case as all applications are put forward by general practitioners. Nevertheless the idea persists that cases received via the E.B.S. are more likely to be unsuitable than those offered by the general practitioner in person. There is no truth in this, as has been proved again and again. This is checked from time to time by asking hospitals to give their opinion on all the cases they have received from the Service in a given period. The last check was made in February 1956, when two teaching and two non-teaching hospitals were asked to provide the required information. These four hospitals saw or admitted 264 patients at the request of the Service, of which 10 were, in the opinion of the hospital, not cases justifying admission as emergencies. The illness was not in accordance with the diagnosis in some of the remaining 254 cases, but they were, nevertheless, in the opinion of the hospitals, in need of immediate admission.

Another criticism made against " E.B.S. cases " is that very many of them cannot be discharged to their own homes, for social reasons, after cure is complete. It has not been possible to make an analysis of such cases, but it is inevitable that a considerable number of this

type should be admitted through the Service, because the E.B.S. is the general practitioner's final resource. If, for instance, he offers two patients, one aged 40, the other 80, both suffering from pneumonia, to a hospital, which at that moment has only one empty bed, the former will be admitted and the latter in all probability will be refused. The general practitioner then calls the Service to his aid, and if the condition of the octogenarian is such that admission is essential, he will, if necessary, be admitted on the order of the Regional Medical Admissions Officer. Should any hospital feel that it is receiving an undue number of unsatisfactory cases, the Service will be willing to assist in checking the facts.

MEDICAL REFEREE PROCEDURE

The improvement mentioned in the last report, in the proportion of cases in which it was necessary to invoke the Medical Referee procedure, has unhappily not been maintained. As is well known, these are cases which, the Service having failed to admit by normal application, are considered by the Regional Medical Admissions Officer of the Board to require admission to hospital, and are therefore passed to the medical referee of the Group for admission.

The increasing use of the referee procedure causes the Service grave concern, for it inflicts hardship on the hospitals and impairs good relations between them and the Service. Quite apart from this aspect, the constant demand for beds tends to make the hospitals reluctant to accept cases living outside their immediate locality, and thus defeats one of the objects of the Service, which is to try to spread the load evenly.

This intense pressure occurs in the first three months of every year with unfailing regularity; the degree of intensity alone varies. The only way in which this situation can be eased seems to be for some definite procedure to be adopted by the hospitals during this period. Such a procedure must presumably take the form of a reduction of the waiting list admissions so as to allow for the increase in emergency cases. To a certain degree earlier discharge of patients to their homes or to convalescent homes may be possible, but this is unlikely to pro-

vide more than a portion of the number of beds required. Discussions are now taking place between the Ministry of Health, the Regional Hospital Boards, Boards of Governors and the Service in an endeavour to see whether some procedure can be devised which will enable the normal increase of applications, during the first two or three months of the year, to be met without an undue load being thrown on hospital staff.

THE WARNING SYSTEM

'White' warnings were in force from 6th to 16th January, from 9th to 14th February and from 22nd February to 6th March. The first of these warnings seems to have been moderately effective since the proportion of admissions to applications ceased falling although applications were still increasing. The two later warnings did not seem to be as effective.

In addition to these E.B.S. warnings, local warnings were issued by some Regional Boards, but the response to these seems to have been patchy.

A detailed examination of the whole warning system is now being undertaken with a view to improving it before next winter.

INFECTIOUS CASES

No great difficulty was experienced in admitting infectious cases except for a period in August and September when the high incidence of poliomyelitis made fever hospitals unwilling to accept too many minor fevers. A total of 745 cases of poliomyelitis were dealt with by the Service during August, September and October.

CHRONIC SICK CASES

The decline in the number of chronic cases dealt with by the Service and mentioned in the last report has continued. 573 cases were referred to the chronic sick waiting list this year as compared with 880 in the year 1954/55. It is now generally known to general practitioners that the Service cannot deal with non-acute cases, and the reduction mentioned above is a reflection of this knowledge. It does not of course mean that there are fewer chronic sick in London.

APPENDIX 1

CASES DEALT WITH 1st APRIL, 1955—31st MARCH, 1956

GENERAL ACUTE CASES

	Applications	Admissions	Cases not admitted		
			Failures to admit		
			G.P. Cases	Hospital Transfers	Cases withdrawn by applicant
1955					
April	4403 (4232)	4130 (3992)	140 (106)	31 (45)	102 (89)
May	3916 (4592)	3716 (4272)	76 (155)	37 (71)	87 (94)
June	3663 (3658)	3489 (3488)	75 (53)	31 (45)	68 (72)
July	3466 (3653)	3347 (3481)	34 (59)	22 (39)	63 (74)
August	3494 (3306)	3374 (3167)	36 (50)	19 (25)	65 (64)
September	3679 (3500)	3510 (3348)	43 (40)	32 (46)	94 (66)
October	4279 (4408)	4083 (4136)	77 (102)	48 (75)	71 (95)
November	4548 (4072)	4278 (3903)	125 (64)	50 (43)	95 (62)
December	5632 (4817)	5277 (4596)	193 (102)	48 (41)	114 (78)
1956					
January	6884 (6855)	6102 (6103)	539 (480)	54 (82)	189 (190)
February	6516 (5413)	5734 (4948)	539 (302)	49 (26)	194 (137)
March	5605 (5838)	5157 (5199)	265 (411)	39 (38)	144 (190)
TOTAL	56,085 (54,344)	52,197 (50,633)	2142 (1924)	460 (576)	1286 (1211)

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

APPENDIX 2

INFECTIOUS CASES

	Total Applications	Total Admissions
1955		
April	1056 (753)	1028 (738)
May	823 (626)	817 (620)
June	770 (612)	765 (609)
July	788 (629)	781 (625)
August	810 (576)	789 (573)
September	952 (480)	903 (479)
October	715 (570)	704 (568)
November	610 (578)	602 (577)
December	659 (675)	645 (670)
1956		
January	597 (895)	583 (855)
February	568 (926)	556 (897)
March	689 (1247)	672 (1197)
TOTAL	9037 (8567)	8845 (8408)

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

APPENDIX 3

GENERAL PRACTITIONER'S GENERAL ACUTE CASES ANALYSIS BY AGE GROUPS

October 30th, 1955—February 18th, 1956 (16 weeks)

Age Groups	Cases Offered	Percentages Admitted	Increase or Decrease compared with corresponding period in 1954-1955
Birth—20	3720 (3936)	99.9 (99.9)	—
21—30	2030 (2019)	99.0 (99.5)	- 0.5
31—40	1619 (1618)	98.4 (98.9)	- 0.5
41—50	1799 (1732)	97.7 (98.4)	- 0.7
51—60	2787 (2558)	95.6 (95.9)	- 0.3
61—70	3975 (3319)	93.1 (94.5)	- 1.4
71—80	3832 (3119)	89.6 (92.2)	- 2.6
Over 80	1454 (1275)	87.0 (89.6)	- 2.6
Total offered	21,216 (19,576)		

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

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