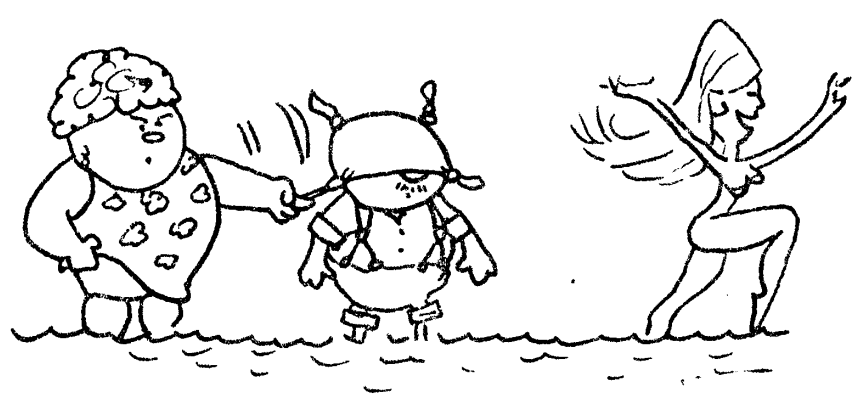
Elderly

HEALTH AND WELFARE OF THE ELDERLY



Gerald Clemence
Cynthia Hiller
Mark Leighton

Kings Fund ADC Course 1979

Terms of Reference: To review services at present available and to make recommendations towards an integrated health care system for the elderly.

Conduct of Study:

(1) A review was undertaken to present a statistical profile of the population and its needs with regard to the health and welfare of the elderly.

(2) A review was also undertaken of present reports and recent literature to establish current organisational trends and developments, and to determine contemporary thoughts concerning future planning.

(3) Interviews were held with medical and para-medical representatives and bodies concerned with the health and welfare of the elderly - eg. Geriatricians; Nursing Staff; Occupational Therapists; Physiotherapists; Social Workers; Health Visitors; General Practitioners; General Surgeons and Physicians; Health Care Planning Teams. Visits were also made to Old People's Homes and accommodation units for the elderly

(4) And finally consideration was also given not only to health education and prevention, but to the preparation of members of society for old age.

INTRODUCTION : THE ADVANCEMENT OF 'OLD AGE'

The government decrees that old age begins at 60 for women and 65 for men. It can last for anything up to a quarter of a century or more, apparently promising a multitude of ills, and ending in inevitable death. However, the strict definition of geriatrics is 'that branch of medicine which treats disorders and diseases associated with old age' and therein lies a greater problem as many of these disorders and diseases can strike the individual long before they reach the retirement age.

It is a fact that after retirement, many elderly people suffer a diminution in status and increasing vulnerability. From being what may be termed a 'fully functioning member of society' it is often as if the shutters are drawn on the involvement in society and they are suddenly faced with the necessary adjustment to an alteration in both their life style and financial situation; a position which every member of society eventually has to come to terms with. They become acutely aware of this when they are unable to look after themselves and more especially when they have to be admitted to hospital, which is often after a long struggle against declining health, adversity and fear of becoming dependent on others. Indeed, one of the big problems which Health Visitors and Social Workers alike have to overcome is the elderly person's reluctance on others if he is to remain in good health; it is a sad fact that this attitude of reluctance is often misinterrupted as 'being obstructive and difficult' which tends to force those who wish to help away from the elderly person. Luckily, however, this is countermanded by the fact that taken as a whole, the community is beginning to recognise their problems as being problems of society as a whole.

The increasing number of elderly people both in the community and more importantly in hospital has not led automatically to an increase in sympathy and concern for their plight; indeed the reverse has often happened. In consequence the quality of the care of the elderly hospital patient is often not all that it might be and improvements in arrangements to safeguard the patient's well-being as an individual have often lagged behind improvements in scientific investigation and treatment. The care of the patient as 'an interesting case' may be there, but the psychology needs of the individual

are often lacking; there is no evidence that emotional sensitivity diminishes with age, rather that attention to emotional needs becomes more important in the face of increasing disability. Indeed, it may sometimes be felt that any patient's well-being can be taken for granted provided that his known illnesses are treated, but this is far from being the case. Good care for the elderly patients needs sophisticated teamwork, planned educational programmes for staff and the observance of an explicit code of practice. The implementation of these principles can greatly improve the quality of care even in wards which are far from ideal and within available resources.

As with any age group in the community, the elderly have certain basic needs; they have health needs - for medical and nursing care, for rehabilitation and assessment services; they have welfare needs - for help in the home, legal and financial advice meals on wheels, etc.; and they also have social needs - for accommodation that is planned as part of the community with access to shops and transport, the social contact, for meaningful occupation, and for dignity and independence. In this paper we have considered the provision for these needs based on services which are and can be provided for the elderly not only in residential and health services accommodation, but also - and more importantly - in their own homes.

Quality of life depends on the ability of the individual to live to his full potential as a human being. It requires the recognitinn of the old person as a unique individual with a need for creative activity, for privacy and fellowship at appropriate times, and with the right to be consulted and to choose in all matters affecting his health and welfare. The Royal College of Nursing has published a handbook of guidelines ('Improving Geriatric Care in Hospital', 1975) for consideration which includes such key areas as the patient's day and personal needs; environment; staff attitudes mobility; independence; social needs; appearance and communication. These areas obviously need to be considered to maintain the quality of life of any individual, and this is no less a case when considering the elderly who unfortunately have been demonstrated to place a big demand on available health resources; a demand which would appear to be steadily increasing.

- o - o - o - o - o - o - o - o -

THE DEMAND ON RESOURCES

In 1971, 16% of the total population of Great Britain was aged 65 or over as compared with 11.8% of the population in 1941 and 6.2% in 1901 and it is anticipated that in 1981, this proportion will increase to 16.8%. The greatest relative increase in population in the last 70 years has been in the 65+ age group, and this significant increase in the proportion of elderly in the population is due mainly to changes in the pattern of mortality; changes which have inevitably lead to a change in the demands made by the elderly on health service resources.

It is well known that health care requirements increase with advancing age, but how much more health care the aged require than their juniors is less commonly appreciated. Swedish estimates suggest that people in their seventies use about twice as much care as they did at age 50, and four times as much as they did at 20. Information published by the Veterans' Administration in the United States confirms this point.

The number of beds occupied by patients aged 65 and over provides some indication of their demand on hospital resources. Patients in this age group, which at present represent about 14% of the total population (as compared with 11.8% in 1941 and 6.2% in 1901, and 10% in the 1960's), constitute about 20% of the total number of hospital inpatients, and occupy about 45% of occupied beds; women over 75, who constitute approximately 4% of the total, occupy 20% of the beds. Also, the rate of hospitalization - ie. the number of hospital discharges and deaths per 10,000 population - of persons over 65 has risen markedly over the past few years. The gradual increase in the percentage of total population over 65, previously referred to, is expected to increase to 16.8% in 1981 (statistics obtained from O.P.C.S. data). An ageing population coupled with rising expectations of medical care is therefore resulting in an increasing pressure on hospital resourcee by the over-65 age group.

The number of beds occupied by elderly patients has risen steadily from approximately 65,000 daily in the 1960's to over 85,500 daily in the 1970's;

this represents an increase of 31.4%. Not only do these figures contain more women than men but the rate of increase in bed usage by women has been substantially faster; no one would suggest that medical and social conditions are likely to remain unchanged over the next decade but it is worth noting that a crude straight line projection suggests that if these trends continue the elderly may be occupying something approaching 100,000 non-psychiatric beds daily by 1985. This increased bed usage is not simply the outcome of a rising population, but represents the resultant of a steep and continuous rise in the rate of hospitalization, offset to some extent by a reduction in the average length of stay.

Though most marked in the elderly and in women, rising rates of hospitalization are a feature of all age groups. The reasons are easy to speculate but are hard to quantify. Developments in medical technology, patients' expectations, and social changes probably all play a part. If a pool of unmet need exists - as it probably does - then simply making available facilities will have the affect of increasing the rate of hospitalization. New buildings and increasing the number of medical and other support staff are not the only ways of doing this; reducing the average length of stay will have a similar effect. Average lengths of stay in hospital are falling in all age groups and the elderly are certainly sharing in this trend (Table I). More short-term admissions for purposes such as investigations, coupled with more active treatment with early return to care at home and better ward management, are probably the major factors responsible for this trend.

However, a noticeable point in this trend is that the older group of women have contributed least to this situation. The high ratio of females to males in the earlier part of the century, particularly after the World Wars, meant that many women remained unmarried and are now therefore in the position that they have no immediate family to look after them. Thus, as these women grow older they are likely to impose more demands upon health resources; since the war this sex ratio has moved towards more equal numbers of men and women in the population, and there are therefore less unmarried women in a position to adopt their traditional role of caring for elderly parents. Social factors may well therefore be reasonable for the fact that older women present a longer length of stay; for instance, as pointed out, many of these women are widows lacking family support, so that convalescence or rehabiliation takes longer before they are ready to go home. Indeed, in

TABLE I : AVERAGE LENGTH OF STAY (excluding maternity)

	MALES			FEMALES		
	ALL ages	Under 65	Over 65	ALL ages	Under 65	Over 65
1957	22.0	18.8	36.0	23.6	17.6	47.0
1967	16.4	13.2	28.5	19.5	12.1	43.0
% fall	25.5	29.8	21.0	17.4	31.3	8.5

recent years there has been a marked tendency away from the closely-knit family community with grandparents, parents and children remaining in the home environment, and this has certainly had an effect on the demands made by this group on the health service. A disease category such as arthritis and bronchitis shows clear evidence of this effect for both men and women, when length of stay is often assessed according to marital state.

The distribution of the elderly throughout the departments of hospital in 1975 are summarized in Table II. Although over twenty conditions accounted for nearly 75% of all bed usage by the elderly in the 1970s, of particular interest is that half of these bed-days were for the 'top four' conditions, ie. - stroke, heart disease, cancer and arthritis. The biggest single cause of bed occupancy by the elderly is cerebrovascular disease, which accounts for over 14,000 beds daily at the present time. 'Other diseases of the nervous system', however, accounted for over 4,600 beds daily in 1970, and has been increasing even more rapidly. In 1970 more than 60% of the cases placed in this category were cerebral paralysis of various types, so that in 1970 patients with these two diseases occupied over 18,000 beds daily - ie. 20% of the total beds occupied by patients in this age group and 10% of all occupied beds (excluding maternity and psychiatric). The average hospital stay of stroke cases is approximately 3 months for women, with little evidence of shortening; clearly this common affliction of old age represents a major and continuing burden on health service resources.

Diseases of the heart and arteries also account for a large number of the occupied beds, representing approximately 10,000 daily for heart disease and 4500 for arterial disease. While hospitalization rates for most kinds of heart disease are rising, hypertensive disease shows a marked exception; here the hospitalization rate has fallen noticeably, probably owing to a steady improvement in the drug therapy of essential hypertension. Also when drug-treated hypertensive patients fall ill, they more commonly enter disease categories other than hypertension - eg. cerebrovascular disease, acute myocardial infarction and renal disorders.

TABLE II : DISTRIBUTION OF PATIENTS AGED 65+ (1975)

	Discharges & Deaths as % of total at all ages	Average number of beds used daily as % of total at all ages
Geriatrics	94	88
Chronic sick	89	88
G.P. medical	50	70
Chest diseases	38	38
General medicine	35	46
Radiotherapy	35	39
Ophthalmology	33	43
General Surgery	22	35
Trauma & Orhopaedic	20	35
All departments*	22	47

(*excluding maternity and psychiatric departments)

All forms of malignant disease accounted for over 7,000 beds in 1970, ie. 9% of the total occupied by the over-65 age group. Some 20% of these beds were occupied by cases of neoplasms of the intestine, including the rectum and approximately 14% by cases of neoplasms of the lung and bronchus. The hospitalization rate for 'all cancers' is rising steadily for both men and women, and the rate for cancer of the lung is rising more steeply, clearly reflecing the increasing incidence of this disease. In cancers of other sites it might be suggested that developments in treatment are making admissions for surgery, radiotherapy, or palliative treatment more frequent. An additional factor is the possibility that many admissions for cancer to medical and geriatric wards may be readmissions for assessment. Also, patients go home after initial treatment, but may often return at a later date for terminal care, and there is evidence that social trends may well be making this practice more common. However, on the other hand, in spite of the seriousness of the disease the average length of stay for treatment is falling.

In 1970, the various forms of joint disease accounted for over 5,000 beds occupied daily by the over-65 age group, approximately 85% of them by women. Hospitalization rates for all forms have risen steeply since 1957 and there has been no compensating drop in lengths of stay. As a result of this, the average number of beds used daily more than doubled between 1957 and 1967 and is still on the increase.

The high proportion of occupancy in the ophthalmology departments by the elderly is also worthy of note, being 35% of the cases and 43% of bed occupancy. This is obviously a reflection of an ageing population prone to suffer from disorders such as detachment of the retina, cataract and glaucoma. Despite increases in the amount of resources provided for the elderly in other specialities, these proportions have remained reasonably static during recent years.

A different pattern again is seen in department of chest diseases, where the proportion occupied by the elderly went up from 30% to 38% in 1970.

TABLE III : AVERAGE NUMBER OF BEDS USED DAILY 65+ (1965- 70)

Year	Medical	Surgical	Geriatric and Chronic
1965	19,329	17,992	44,445
1966	19,729	18,350	45,395
1967	19,189	18,436	45,507
1968	19,323	18,771	47,533
1969	19,106	18,921	49,227
1970	18,679	19,358	48,564

TABLE IV

HOSPITAL RETURN - FORM SH3

REGIONAL COMPARISONS

MEAN STAY IN DAYS BY SPECIALTY

1977

Specialty \ Health Region (RHAs and B. of G.s	Northern	Yorkshire	Trent	E. Anglia	N.W. Thames	N.E. Thames	S.E. Thames	S.W. Thames	Wessex	Oxford	S. Western	W. Midlands	Mersey	N. Western	Preserved Boards of Governors	All England
Gen. Med.	10.1	11.5	9.5	11.1	13.0	13.6	13.6	12.4	10.6	9.7	10.3	10.9	14.6	11.6	-	11.8
Paediatrics	5.8	6.9	5.5	5.0	4.9	5.5	6.2	5.0	6.0	5.1	5.1	6.0	7.3	6.0	9.5	5.9
Infectious Dis.	14.3	9.7	10.2	12.0	12.3	10.9	8.8	6.2	9.9	8.6	11.8	9.9	16.1	9.7	-	10.4
Chest Dis.	18.9	17.9	19.7	16.8	21.0	21.0	21.1	26.2	16.3	16.5	18.5	23.2	28.4	23.9	12.5	19.9
Dermatology	16.8	19.2	21.4	19.0	22.2	24.3	25.0	24.4	23.2	28.1	19.0	21.7	26.3	22.0	15.7	21.4
Neurology	10.1	20.1	13.3	11.5	15.6	36.8	17.4	10.9	12.1	30.5	13.8	11.9	15.0	12.7	16.2	17.1
Cardiology	10.6	9.3	8.2	10.3	9.9	12.3	10.6	12.5	8.6	-	7.7	9.3	14.2	9.3	9.8	10.0
Rehabilitation (Physical Medicine)	27.8	46.3	32.6	26.6	27.0	31.2	21.9	31.2	24.9	24.8	51.6	25.6	76.8	81.8	-	28.9
S.T.D.	-	7.3	9.1	-	3.7	13.9	10.8	18.2		-	7.6	10.4	22.7	-	-	11.4
Rheumatology	19.5	23.4	22.6	21.2	18.6	27.0	21.5	23.5	26.2	22.7	14.5	21.5	28.7	28.5	-	22.5
Geriatrics	77.4	73.5	74.2	70.1	99.4	103.9	79.8	86.3	104.7	57.6	86.2	97.0	94.1	79.9	-	83.7
Units for Yngr. Disabled	295.0	135.4	170.1	176.4	445.1	214.7	269.5	60.6	86.2	87.2	385.6	465.9	212.8	64.9	-	186.6
Gen. Surg.	8.7	8.9	7.4	7.8	9.0	9.2	8.4	8.4	7.4	7.3	7.8	8.6	9.1	8.0	9.9	8.4
E.N.T.	3.8	3.8	4.0	3.4	4.7	4.7	4.5	4.0	4.5	3.5	4.4	4.4	4.2	4.2	5.0	4.2
Trau & Orth	14.6	13.6	13.4	13.5	13.5	16.7	13.8	13.7	11.1	10.3	13.6	13.0	17.6	14.4	16.8	13.7

Specialty \ Health Region (RHAs and B. of G.s	Northern	Yorkshire	Trent	E. Anglia	N.W. Thames	N.E. Thames	S.E. Thames	S.W. Thames	Wessex	Oxford	S. Western	W. Midlands	Mersey	N. Western	Preserved Boards of Governors	All England
Ophthalmology	7.6	8.1	7.4	5.9	7.4	8.3	7.7	6.9	6.3	5.8	6.6	7.3	7.9	7.1	5.7	7.1
Radiotherapy	11.7	11.9	10.5	12.1	10.9	12.2	16.8	10.6	12.4	11.1	10.7	8.4	15.2	13.3	-	11.6
Urology	8.0	8.3	7.1	6.9	8.8	9.0	8.4	6.9	7.2	6.1	8.5	8.1	9.1	7.9	6.8	8.0
Plastic Surg.	8.7	7.9	7.6	8.6	8.0	9.3	9.5	8.9	8.4	9.4	11.7	9.8	12.3	13.0	8.6	9.4
Thoracic Surg.	13.6	13.6	13.0	10.0	13.9	14.6	13.7	17.8	9.1	9.0	13.6	11.4	11.9	10.1	16.5	12.6
Dental Surg.	2.6	2.3	2.3	2.3	2.7	2.6	2.7	3.3	2.5	2.2	2.4	2.6	3.4	2.8	2.2	2.6
Orthodontics	-		1.6		-	3.2	3.0	2.6			2.1	-	35.0	14.9	-	6.5
Neurosurgery	11.7	12.1	11.0	13.3	17.4	21.5	11.4	9.7	12.2	7.8	9.5	11.9	24.2	14.4	12.8	13.1
Gynaecology	5.2	5.6	5.3	4.6	5.3	5.4	5.3	5.6	4.9	4.4	5.0	5.5	6.0	5.4	5.5	5.3
Obstetrics	7.0	7.2	6.5	6.3	7.5	7.2	7.3	7.4	6.5	5.9	6.5	7.1	6.5	6.9	7.7	6.9
S.C. Baby Unit	7.7	7.9	7.8	5.9	7.8	8.8	7.8	7.3	7.9	7.8	9.8	8.1	7.5	8.3	10.3	8.0
G.P. Maternity	5.9	5.5	4.6	4.8	4.5	4.7	6.7	5.5	5.2	4.2	5.3	4.4	4.6	4.8	-	4.9
G.P. Other	22.4	16.9	18.8	17.1	18.6	21.2	19.2	25.7	17.4	19.3	18.2	16.7	24.9	20.4	-	19.3
G.P. Dental	0.0	0.0	2.9		-	0.0	1.6	1.8	1.5	-	2.2	1.3	0.0	-	-	1.7
Pre-conval	16.6	24.1	19.9	15.3	13.8	34.2	10.7	20.1	21.6	17.5	16.1	17.7	18.6	21.6	8.2	18.6
Convalescent	21.8	14.0	15.1	12.6	11.9	-	13.1	-	30.0	-	8.1	12.8	13.2	-	13.1	14.4
Staff Wards	5.6	4.2	3.7	3.2	5.9	5.2	6.3	4.8	5.5	6.1	5.6	8.4	5.6	3.8	4.1	5.6
O.S.U.	9.3	7.0	6.6	8.1	18.0	8.2	11.4	8.4	7.1	19.7	27.4	25.8	10.0	8.3	9.9	10.1

Source: DHSS SH3 Summaries - 1977

MJ/Oct 1978

TABLE V

HOSPITAL RETURN - FORM SH3

IN-PATIENT TURNOVER INTERVAL

BY SPECIALTY OR DEPARTMENT

ENGLAND

1977

	TURNOVER INTERVAL IN DAYS
Total: all departments	4.8
Total: all depts. excluding psychiatric	3.7
Total: all medical departments	4.2
Total: all medical departments excluding chest diseases	3.9
General medicine	2.1
Paediatrics	4.8
Infectious diseases	11.2
Chest diseases	10.3
Dermatology	9.3
Neurology	5.2
Cardiology	2.1
Rehabilitation (Physical Med.)	12.5
S.T.D.	30.0
Rheumatology	7.5
Total: all geriatrics and units for younger disabled	6.9
Geriatrics	6.6
Units for younger disabled	31.6
Total: all surgical departments	2.9
General surgery	2.4
E.N.T.	3.3
Trau. & Orth.	3.3
Ophthalmology	4.5
Radiotherapy	3.2
Urology	2.1
Plastic surgery	4.3
Thoracic surgery	5.1
Dental surgery	2.2
Orthodontics	4.1
Neurosurgery	2.7
Gynaecology	2.3
Total: obstetrics and G.P. maternity	3.8
Obstetrics	3.1
Special Care Baby Units	6.3

	TURNOVER INTERVAL IN DAYS
Total: all psychiatric departments	31.5
Psychiatry children	46.0
Mental handicap	81.1
Mental illness	25.7
Adolescent psychiatry units	68.3
G.P. maternity	7.3
G.P. other	6.8
G.P. dental	0.4
Pre-convalescent	8.1
Convalescent	5.9
Staff wards	19.2
Other specialist units	3.7

Note

To calculate the annual turnover interval in days:

$$\text{Turnpver interval} = 365 \times \frac{\text{(Avg. Daily Avail. Beds - Avg. Daily Occup. Beds)}}{\text{Total Annual Discharges and Deaths}}$$

i.e. the turnover interval is the average number of days a bed is empty after the discharge of one patient and the admission of the next.

Source: DHSS SH3 Summaries - 1977

MJ/Oct 1978

TABLE VI -

PERSONAL SOCIAL SERVICES PROVIDED BY LOCAL AUTHORITIES

ENGLAND AND WALES

1977 - '78 ACTUALS

Service	Counties England (39)	Counties Wales (8)	Total (47)	London Boroughs (31)	Metropolitan Districts (35)	All Authoriti (113)
	£	£	£	£	£	£
RESIDENTIAL CARE						
Children (net cost per child week excl. capital charges):-						
1. Hostels and other Community Homes	67.21	70.81	67.53	95.78	65.14	72.54
2. Observation and Assessment Centres	118.08	141.80	120.47	158.10	98.99	120.58
3. Residential Nurseries	100.67	102.99	101.15	132.05	103.43	109.41
4. Community Schools	105.53	96.28	104.60	180.27	100.49	107.26
Elderly (net cost per resident week excl. of capital charges):-						
1. Homes	42.83	46.38	43.20	51.80	46.71	45.54
Younger Physically Handicapped (net cost per resident week excl. of capital charges):-						
1. Homes	72.72	84.76	73.94	71.70	67.34	69.38
Mentally Handicapped (net cost per resident week excl. of capital charges):						
1. Homes (Children)	91.79	86.85	91.39	134.48	105.72	101.28
2. Homes (Adults)	47.40	49.04	47.51	62.97	45.26	48.42
Mentally Ill (net cost per resident week excl. of capital charges):-						
1. Homes	50.76	18.64	42.78	51.17	45.57	45.67
DAY CARE						
Day Nurseries (net cost per child day)	5.76	6.64	5.77	7.29	5.48	6.14
Adult Training Centres (net cost per trainee day)	4.44	5.73	4.55	6.00	4.39	4.67
COMMUNITY CARE						
Home Help (net cost per hour of service)	1.47	1.35	1.46	1.89	1.43	1.51
Meals provided (gross cost per meal)	0.39	0.41	0.39	0.93	0.71	0.67

Source: Personal Social Services Statistics 1977-78 Actuals, The Chartered Institute of Public Finance and Accountancy, 1979.

MJ/March 1979

TABLE VII

OUT-PATIENT STATISTICS
BY TYPE OF HOSPITAL
ENGLAND
YEAR ENDED 31ST MARCH 1976

Type of Hospital	No of Attend-ances	No of New O/P	Ratio Att: New O/P	Cost per	
				Attendance	New O/P
				£	£
Acute over 100 beds	17,355,870	4,208,531	4.1	9.22	38.04
Acute 51-100 beds	983,481	292,157	3.4	7.02	23.64
Acute 1-50 beds	993,000	353,190	2.8	5.75	16.18
Mainly acute	5,033,491	1,195,885	4.2	9.02	37.95
Partly acute	1,175,068	256,764	4.6	8.28	37.89
Mainly long stay	336,214	72,684	4.6	8.55	39.56
Long stay	146,720	29,199	5.0	10.04	50.45
Rehabilitation	44,298	2,553	17.4	3.67	63.60
Maternity	840,666	181,910	4.6	5.61	25.91
Psychiatric - mental illness	461,019	48,154	9.6	9.73	93.19
Psychiatric - Mental handicap	51,733	3,226	16.0	7.96	127.62
Orthopaedic	187,322	37,057	5.0	9.47	47.87
Tuberculosis and chest	38,275	5,921	6.5	10.66	68.88
Childrens acute	479,040	108,121	4.4	10.77	47.73
Eye	423,880	85,601	4.9	6.01	29.77
Geriatric	236,499	45,869	5.2	7.25	37.39

1. The number of out-patient attendances are those at consultative clinics together with the number of attendances of day patients, where the latter does not exceed 5,000 attendances per annum.

2. The number of new out-patients are those at consultative clinics together with the number of new day patients at hospitals included in this table under the definition set out in paragraph 1.

Source: DHSS, Health Services Costing Returns year ended 31st March 1976, HMSO 197 .

MJ/Jan 78

Finally, it is worth drawing attention to the changes which occurred between 1965 and 1970 in the numbers of beds used by the elderly according to departments (Table III); the use of medical beds fell slightly by about 100 beds a year. At the same time there was a distinctly greater use of surgical beds, probably of the order of 200 a year. The largest growth area, however, was geriatrics and chronic sick, where an expansion of the order of 800 beds a year occurred, some of which no doubt was associated with the redesignation of medical beds as geriatrics. Thus the evidence is that departments of surgery as well as department of geriatrics are showing signs of pressure arising from the riding population of elderly and are devoting an increasing proportion of their bed capacity to these patients.

Other relevant statistiaal information has previously been published by the Kings Fund and is shown in Tables IV - VII. Recommended norms and standards (DHSS and other) for services for the elderly have also been published by the Kings Fund and are shown in Appendix A.

- o - o - o - o - o - o - o - o -

HOSPITAL CARE

As we grow older we are more likely to need hospital care. Before 65 we are likely to be admitted only once in every ten years compared with more than once every five years when we are over 75. Because old people are slower to recover from operations and illnesses, they therefore naturally stay in hospital longer than someone who is younger. It has been reported ('A Happier Old Age', HN(78)81) that although only about 2½% of old people are in hospital at any one time, they occupy more than half of all the beds; those over 75 taking up nearly one third. Nearly all hospital departments will be affected by the increase in the numbers of very old people but particular pressure will fall on the Department of Geriatric Medicine where about ¾ of the beds are now occupied by patients over 75. Likewise, mental illness hospitals where over ¼ of the 80,000 occupied by patients over 75 - some 16,000 of them by old people who have been diagnosed as suffering from

mental infirmity directly connected with ageing.

Old people suffer from the same physical and mental disorders as the middle aged and can mostly be treated in the same way but over the age of 75 years the range of problems becomes increasingly evident. Many patients are likely to suffer from more than one condition and to show a complex reaction between their physical state and mental condition. Confusinn may arise from physical illness and mental disturbance may complicate and prolong physical illness so that diagnosis presents a particular difficulty. Social circumstances and the particular problems of coming to terms with old age (previously discussed), physical infirmity, bereavement and loneliness along with mental deterioration, which becomes more common with increasing age means,that old people have distinctive medical, nursing and social needs. Current policy reflecting both modern medical practice and the wish of most elderly people to be in their own home is to promote an active approach to treatment and rehabilitation, but this can only be satisfactorily achieved in a general hospital where the full range of diagnostic and therapeutic facilities and advice from consultants in other specialties are readily available.

It has for many years been a policy of the DHSS to encourage the inclusion of acute geriatric units in the same building as all the other acute hospital specialties, into which elderly patients can, where appropriate, be admitted direcetly under the care of a Consultant Physician in Geriatric Medicine. Planning Guidelines recently sent to Health Authorities stress the importance of the Department of Geriatric Medicine becoming firmly established in general hospitals where the expertise of the multidisciplinary team trained in geriatric care can be readily available to advise and support staff caring for elderly patients in other parts of the hospital. Most acutely ill elderly patients are able to return home after active treatment and rehabilitation but in some cases their stay in hospital can be shorter - and sometimes avoided - if treatment at a Day Hospital is available and the care offerred in such an establishment is discussed in a later section.

It is important that hospitals providing continuing care contain adequate residential facilities and staff for these patients who however slow their progress can expect to be discharged, and occupatinnal therapy for those unlikely to do so. It is also important that the surroundings and general atmosphere in the hospital are conducive to maintaining the morale of both patients and staff and especially in order to provide a reasonable quality of life for those patients unable to be discharged. One suggestion currently being considered, particularly for the latter, is the development of a Nursing Home type provision within the National Health Service which might also care for the more heavily dependent residents increasingly found in Old Peoples' Homes.

Hospital care for elderly people who are mentally ill or infirm is provided by the psychiatric services and a more indepth study to the of psycho-geriatric services has previously been reported by another Health Service Studies Group.

- o - o - o - o - o - o - o - o -

THE PATIENT CARE TEAM AND THE SUPPORTING SERVICES

Old people may suffer from a variety of illnesses: physical, psychological and social at one and the same time. Therefore professional staff of different knowledge and skills can be involved in diagnosis, treatment and care. They are concerned, along with the patient's relatives, in working towards the best possible outcome. Consideration and understanding of the patiant as a unique individual with particular needs are vital to the progress. Objectives , different for each individual and vary from time to time for the acutely ill, for those undergoing rehabilitation and for those receiving continuing care, must be decided and listed by the ward team. Indeed, success can be achieved only if all work closely together, share information and expertise and evaluate the many courses of actinn which are possible at each stage of the patient's progress. In no field of health care is the multi-disciplinary approach used so extensively as in the care of the elderly. By working as a team, staff and relatives help old people to gain their optimum level of independence; each member of the team having a specific role and although there is some overlap, the approach, method and skill of each

contributes to the drawing up of a therapeutic programme.

A more detailed description of the functions of each member of this team have previously been reported ('Improving Geriatric Care in Hospitals', RCN, 1975). The direct patient care team consists of a chaplain, a chiropodist, the doctor, the nurse, remedial therapists and the social worker, and supporting services include - the administrator, catering officer, the dietitian, the finance officer, housekeeping and domestic services, laundry and linen services, portering services, secretarial and clerical services, the supplies officers, and the voluntary workers.

It is vital to remember always that, after the patient, his relatives are the most important members of the team for they have a unique place in the care of the elderly; they are clients of the service and they also play a valuable part in the treatment and care of the patient. Relatives have every right to be concerned in what happens to the patient but it needs to be recognised that they may have their own problems in connection to care. They will benefit if they can see that their problems are understood by the hospital team. To understand the needs of the relatives and communicate them to the other members of the team is one of the most important functions of the social worker, although the nurses generally meet the relatives first and gain useful information from them,it is always necessary for the ward nurse to listen to the relatives and take account of what they say because they know the patient better than anyone else, being in direct contact with them on a day-to-day basis. The relatives in turn are usually very ready to acknowledge the professional responsibilities of the hospital staff but they are prepared to take some part in the patient's care and rehabilitation. They may need opportunities to learn how to use aids such as hoists or the best way to help the patient to dress and walk. As a rule their involvement in the care of the patient is not difficult to achieve.

At the same time staff learn, often from the social worker, that not every person has easy relationships with relatives and that they too may be having their own problems in coming to terms with them. A contribution which each relative can therefore make to each individual patient is often very different. One of the best ways to improve relationships with relatives has been reported to be open-visiting, so that they feel at home and as far as possible involved with the life of the ward. In addition a booklet is necessary

to explain how the Geriatric Unit works, how the relatives can assist the patient and what facilities are available to help them

- o - o - o - o - o - o - o - o -

DAY CENTRES AND DAY HOSPITALS

One of the most interesting features in the development of geriatric care in this country over the past 25 years has been the realisation of the important part that geriatric day hospitals have to play in medical services for the old. The first purpose-built day hospital was open in Oxford in 1958, and at the beginning of this decade there were at least 120 day hospitals attached to different departements of geriatric medicines, and there is obvious realization that the presence of a day hospita adds immeasurably to the spectrum of care which can be offered to elderly people.

Geriatric day hospitals must be clearly distinguished from day centres. The day hospital is entirely a hospital in that it offers medical, nursing and medical ancillary services, and it is because of the need of one or more of these that patients attend. Day centres, on the other hand, are social in their content, their purpose being to provide companionship, communal meal and personal facilities (such as laundry and bathing). Both day hospitals and day centres are complementary to each other. Two things they have in common are that each provides a midday meal and occupies the major part of an old person's day, and secondly that each requires the provision of special transport for the majority of those who attend; a requirement which very often strengths ambulance authorities to their limit. It is perhaps a sad fact that if any cut-backs are necessary in an ambulance transport service, one of the first areas of needs to cut is the geriatric day centre/ hospital.

The services provided by the day hospitals have previously been reported (J.C. Brocklehurst, 1970) but summarized are - physical rehabilitation such as in the case of strokes, osteoarthritis, etc.; physical maintenance for physical disabilities which are not by their nature curable; the social care of physically disabled people; medical and nursing procedures. Table VIII

TABLE VIII : PROPORTION OF PATIENTS ATTENDING DAY HOSPITALS FOR PRIMARY REASONS (465 patients)

	%
Physical rehabilitation	27
Physical maintenance	41
Social care of physically disabled	26
Medical or nursing procedure	6

TABLE IX : MODE OF REFERRAL (465 people)

	%
Geriatric Ward	32
Geriatric O.P.D.	29
Direct (telephone or letter)	17
Domiciliary or assessment visit	13
Medical Wards	7
Other Wards	2

shows the proportion of patients attending five day hospitals in S.E. England who attended for these various reasons. Patients attending the day hospital may have been referred with or without previous inpatient admission, and Table IX summarizes the mode of referral of patients attending the five day hospitals previously referred to.

There is unfortunately no record of the number of social day centres now existing in the country, and in fact the variation in which might be called a social day centre is likely to be so considerable from one area to another that any such estimate would be difficult. A number of social day centres have grown up from morning or afternoon clubs for elderly people, but the essential difference between club and day centre is that the latter provides transport for the majority of those who attend, and also provides a midday meal. Both of these are extremely important since it is particularly the frail and slightly physically disabled person who is likely to be isolated, and who is unable to come on foot or by public transport to a day centre.

A very interesting innovation has been the development of a mobile day centre (Kaim-Caudle, 1978) providing at most 14 places, which was established in the Metropolitan Borough of Sunderland in June, 1976. The Centre, a purpose-built vehicle rather like a caravan, was provided by Help the Aged and is staffed by volunteer helpers recruited by and responsible to the Old People's Council; the operation costs are met partly by the social services department and partly by Age Concern with a grant from the department. The centre provides companionship and recreation for frail and mildly disabled people, most of whom can walk the short distance from their homes to the centre. The users without exception are reported to greatly enjoy their weekly visit to the centre where they get a good lunch and chat, knit and play games with people of their own kind in a relaxed and congenial atmosphere. The current and capital cost (not allowing for the fact that neither the centre nor the towing vehicle was bought out of public funds) per user per day is less than £2.

There is also the establishment of a Day Assessment Centre in the London Borough of Hammersmith. This centre is staffed by a team of geriatricians, health visitors, occupational therapist, physiotherapist, speech therapist, chiropodist, social worker and helper. The aim of the centre is primarily to assess the individual's need and future requirements regarding such services as sheltered housing, day centre, Old People's Home and other health services. An important factor which the centre plays is the diagnosis of deafness in old age, a handicap which is reported to be often overlooked; in addition a certain amount of rehabilitation is carried out at the centre. As with the Day Hospital, transport is available for patients.

- o - o - o - o - o - o - o - o -

RESIDENTIAL HOMES AND HOUSING

Ten years ago it was reported that local authorities were devoting more than a quarter of their own house building to one bedroom dwellings. With the steady increase in the proportion of old people it is inevitable that many of these dwellings will be occupied by them and they should therefore be designed with the needs of old people in mind, for there can be little doubt that properly designed housing is the most important single factor in the preservation of independence in old people. Such housing, compared with other types, needs less effort to run and keep clean; hence frailer people can continue to cope. Moreover, when help is eventually needed, supportive action by home help, home nurse or other, is easier, and can continue longer.

Sheltered housing, in which a small community of old people is gathered together under the supervision of a warden, has taken various forms. These include blocks of flatlets with a 'house mother' who has telephone or at least bell communication with each resident, self-contained bungalows grouped round a communal social centre which houses the warden, and blocks of bed-sitting rooms with varying degrees of centralised service. There is obviously room for all these types, according to local circumstances. All can be expected to be successful provided that the principle of designing

for easy management and maintenance by people who are old and handicapped is kept paramount.

Guidance issued to local authorities some ten years ago (Ministry of Health, 1965, Care of the elderly in hospitals and residential homes) stated 'The elderly people whom local authorities may need to admit to or to retain in homes can be broadly defined as those who are found, after careful assessment of their medical and social needs, to be unable to maintain themselves in their own homes, even with full support from outside, but who do not need continuous care by nursing staff.' This definition clearly allows great breadth of interpretation, and the types of people one finds in homes reflect the differing kinds of pressure on local authorities. Eg. in an area with much slum property from which active young people tend to move out the old are left solitary and badly housed. There is then a likelihood that admission to a home will be sought at a relatively early age; though, regrettably, in reality this often means admission to the waiting list rather than to an actual home. In a favoured retirement area, on the other hand, the old people are usually better housed.

Because of the social and demographic changes now taking place there is a general tendency for new admissions to be older and frailer than in the past. In so far as this reflects greater success in maintaining people in their own homes perhaps this tendency is to be welcomed. However, one also needs to consider its implications for the design and staffing of homes.

There are also a number of elderly people who suffer from mild confusion and varying degrees of loss of intellectual capacity; such cases possibly border on the area of psycho-geriatric services (which have been considered by another Health Service Studies Group). They need supervision and sufficient restraint to prevent wandering but neither need nor can benefit from the full therapeutic and nursing resources of a mental illness hospital. With the general increase in the older age groups these also are growing in number. Many such are, of course, already accommodated in residential homes, and some are, regrettably, confined to long-stay wards in geriatric or mental illness hospitals because there is simply nowhere else for them to go. There is, however, a growing body of opinion that this group of the

elderly is best cared for in homes specially designed for them, and it has been reported (J.M. Holford, 1970) that several local authorities have now started homes for the mentally frail and their example seems likely to be widely followed.

- o - o - o - o - o - o - o - o -

PREPARATION FOR RETIREMENT

Ageing is a very variable process both in the way it affects individuals and in the speed with which it does so. Throughout our lives we are constantly having to come to terms with the changes it brings about and to alter our life-style accordingly. Usually the process is gradual, but for many people, a dramatic change of life-style occurs at the time of retirement and this has previously been discussed. Our society seems to assume that a major aspect of a fulfilled life is employment, but many people live for 20 years or more after retirement and may remain active for much of that time. People therefore needs interests and activities during retirement, and there is clearly much value in proper preparation. A number of employers and local education authorities offer courses to help those nearing retirement. Certain voluntary organisations are also active in this sphere, but there are many people who do not receive such help.

It can be argued that such courses possibly come too late. True preparation for retirement may often require adjustments in attitudes and life-style throughout the last decade of paid employment and may also depend on financial decisions taken many years earlier. There are important roles for employers, trades unions, local education authorities, and indeed families and the community to play in helping people to adjust to retirement. Many helpful publications have been produced for the elderly (eg. 'Services for the Elderly in Camden'), as well as the preparation for retirement publications (eg. 'In The Pink', H.B. Wright, 1979).

Retirement offers opportunities for people to use their time in many satisfying ways. Community affairs and work in voluntary organisations occupy some; others find fulfilment in voluntary service without being committed to a formal structure. However it is generally felt that the scale on which older

people participate in community activities is not as great as it should or could be. Elderly people can also make good use of the facilities for continuing and broadening their education and recreational activity and indeed it has been suggested that insufficient account is taken of the recreational needs of elderly people, especially in the planning and design of new indoor sports facilities. Elderly people may not be able to take part in the more active forms of sport, but for many, exercise of some kind may well be important in keeping fit.

Some people wish to continue in employment after normal retirement age although the current high rate of unemployment highlights questions about the relative importance of work for different age groups and limits the scope for otherwise desirable developments. However a number of employers provide facilities for their older workers to continue in employment by working shorter hours in a new setting. Other less formalised work schemes also provide the opportunity for some to develop latent skills; voluntary bodies are especially active in this sphere.

Family links can assume increasing importance in old age and many elderly people get great pleasure from visiting their relatives and looking after grand or great grandchildren. Such links can be beneficial to all concerned - not least the children who might otherwise grow up without the experience of companionship with the older generation in their early years. The Good Neighbour Campaign originally launched by the Secretary of State for Social Services in November 1976 was designed to stimulate the development of community support for the elderly. 'Just as retired people have much to contribute to the community, so there is much the community can do in return - for example help with shopping, minor household jobs, gardening, etc. But there is a larger dimension to community support. Although we have previously pointed out that the elderly represent 14% of the total population, many of them find difficulty in their relations with commercial organisations and public authorities. In some public libraries, for instance, efforts are made to ensure that it is not difficult for elderly people to reach a good selection of books. But the same cannot always be said for modern supermarkets where elderly people sometimes cannot always reach what they require. Some items of food are sold in larger packs than they need; clothing and shoes may not always be suitable in style or price; etc.

Maintenance of good health in old age is also particularly important. The White Paper 'Prevention and Health' issued in December, 1977 included a section which set out the Government's policy on this matter. In essence this is the encouragement of physical, social and mental activity, and of measures designed to help prevent the development or worsening of handicapping conditions and cope with disability.

The DHSS circular 'A Happier Old Age' previously referred to poses several questions for discussion and these have been itemised in Appendix B

- o - o - o - o - o - o - o - o -

REFERENCES

ABRAMS, Mark (1978). Beyond three-score and ten. A first report on a survey of the elderly.
Mitcham, Age Concern

AGE CONCERN (1977), Profiles of the elderly Volumes 1 and 2
Mitcham, Age Concern

BROCKLEHURST, J.C.(1970) Day Centres and Day Hospitals
Moder British Geriatric Care (Hospital Management) Sept/Oct pp 428 -430

EXTON-SMITH, A.N., GRIMLEY EVANS, J. (1977), Care of the elderly - meeting the challenge of dependency.
London, Academic Press

HOLFORD, J.M. (1970) Geriatric Care in the Seventies
Modern British Geriatric Care (Hospital Management) Sept/Oct pp 410 - 413.

HUNT, Audrey, O.P.C.S. (1978) The elderly at home
A study of people aged sixty five and over living in the community in England in 1976
London, H.M.S.O.

HUNT, L.B. (1973) The Elderly in Hospital: Recent Trends in Use of Medical Resources
B.M.J., 3556, pp 83 - 85

ISSACS, Bernard, (1978) Recent advances in geriatric medicine
Number one
Churchill Livingstone

KAIM-CAUDLE (1978) The chat-shop on wheels
Health and Social Service Journal, 6.1.78, p.11

PLANK, David, Greater London Council (1977), Caring for the elderly; report of a study of various means of caring for dependent elderly people in eight London boroughs.
G.L.C.

ROYAL COLLEGE OF PHYSICIANS OF LONDON (1977), Working Party on Medical Care of the Elderly, London, Royal College of Physicians

ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE (1978), The Working of the National Health Service, Research Paper Number 1
London, H.M.S.O.

WORTHING DISTRICT COMMUNITY HEALTH COUNCIL (1977), Survey 'Concern for the Elderly'.

A Happier Old Age - A discussion document on elderly people in our society
HN(78)81

British Geriatric Society and Royal College of Nursing
1. Improving Geriatric Care in Hospitals
2. A Handbook of Guidelines HC(76)32

Residential Homes for the Elderly Arrangements for Health Care
A Memorandum of Guidance
HC(77)25

APPENDIX A

RECOMMENDED NORMS AND STANDARDS FOR SERVICES FOR THE ELDERLY

(DHSS and other)

I Source: HM(70)11

A. Psycho-Geriatric Assessment Unit Beds

1. Unit of 10 - 20 beds per 250,000 population sited in the District General Hospital, but usually included in in-patient assessment standards.

II Source: DS 329/71

A. Hospital In-Patient Beds

1.	Assessment and immediate treatment)	at least 5 beds/
2.	Rehabilitation (part))	1000 population aged 65+, sited in the D.G.H.
2.	Rehabilitation (part))	
3.	Longer term treatment)	at most 5 beds/ 1000 population aged 65+ sited
4.	Short term care)	elsewhere

B. Day Hospital Services

1. Geriatric Day Hospital Places

a) 2/1000 population aged 65+
or
2/10 beds on site

b) Optimum provision in any one place:
20 - 50 day places

III Source: DS 95/72

A. Medical Staff

1.. 1 consultant physician in geriatric medicine for each district in the Region, a 'district' for this purpose being the area served or to be served by a D.G.H. (or group of hospitals functioning as a D.G.H.) plus supporting medical staff.

B. Nursing Staff

1. 1/1.9 in-patients in wards with 30 or more available beds.

2. Up to 2 more staff than provided by this ratio.

would be needed in smaller wards. This includes administrative and tutorial nursing staff and makes allowance for sickness and annual leave, for post-registration, post-enrollment training, study time of students and pupils and in-service training of nursing auxiliaries.

C. Chiropodists

1. 1 attendance/patient/every 6 weeks.

D. Domestic Staff (basic grades only)

1. 2.75 hours/in-patient/week

E. Kitchen Staff (excluding catering officer or other person in administrative control)

1. For hospitals consisting wholly or mainly of Geriatric beds:

a) Hospitals under 100 beds: 1/15 persons fed

b) Hospitals with 100 - 300 beds: 1/25 persons fed

c) Hospitals with over 300 beds: 1/35 persons fed

2. Of these approximately 40% should be in the cook and assistant cook grades and 20% in supervisory grades (assistant head cook and above).

F. Ward Areas

1. Night space - 60 square feet/bed.

2. Day space - 10 square feet/patient.

3. Curtains or other means of giving all patients some degree of privacy.

4. All patients to have personal cupboard space, usually at the bed side.

IV Source: "Care of the Elderly", Volumes 1 - 3, Wessex RHB, 1972
(Note: all population Norms based on 1000 population aged 65+ unless otherwise stated)

A. Medical Staffing

1. Physician in Geriatric medicine 0.04/1000 population.

2. Psychiatrist 0.02/1000 population.

3. G.P.s 0.5/1000 population.

B. Nurse Staffing

1. 1/1.25 assessment and rehabilitation beds.

2. 1/1.5 long-stay beds.

3. 1/6 day hospital places.

4. Home Nurses and assistants: 1.6/1000 population

C. Social Workers

1. 1/1000 population.

2. 2/250 beds of all types.

3. 1/50 day hospital places.

D. Home Helps

1. 8+/1000 population

E. Health Visitors

1. 0.5/1000 population.

F. Chiropodists (community based)

1. 0.26/1000 population.

G. Social Work Clerks

1. 2/250 beds of all types.

H. Physiotherapists

1. 4/250 beds of all types.

2. 2/30 day hospital places (maximum of 3).

3. 1/250 psycho-geriatric beds of all types.

I. Occupational Therapists

1. 4/250 beds of all types.

2. 2/30 day hospital places (maximum of 3).

J. Therapy Aides

1. 12/250 beds of all types.

2. 4/30 day hospital places.

K. Accomodation

1. 22/1000 population Part III Residential Homes

2. 11/1000 population sheltered housing.

3. 3/1000 population hostels for elderly mentally infirmed.

4. 30/1000 population day centres.

L. Beds

1. Geriatric

a) D.G.H.: 3 assessment beds, 2 short-term rehabilitation beds.

b) Community Hospital: 3 long-stay beds, 2 long-term rehabilitation beds.

c) 2 hospital places (20 - 50 places/Day Hospital).

2. Psycho-geriatric

a) D.G.H.: $\frac{1}{3}$ assessment beds.

b) Community Hospital: 3 beds

c) 2 - 3 Day Hospital places.

M. Secretarial and Administative Staff

1. Secretary to Department (Higher Clerical Officer): 1/250 beds of all types.

2. Secretary to Consultant (Personal Secretary): 1/250 beds of all types.

3. Clerk/Shorthand Typist

a) 1/250 beds of all types.

b) 1/30 Day Hospital places.

V Source: Local Authority Social Services Ten Year Plans, August, 1972

A. Meals Services

1. 200 meals/1000 elderly poulation/week

B. Day Places for the elderly

1. 50/100,000 population.

C. Residential Places for the elderly

1. 25/1000 elderly population.

VI Source: "Management Information to Aid the Care of the Elderly" - Report of a Research Study for the Hastings Health District - Sponsored by the Nuffield Provincial Hospitals Trust in collaboration with the South East Thames Regional Health Authority, June, 1975 (Note: all population figures are based on 1000 population aged 65+ unless otherwise stated).

A. Beds - Geriatric

1. 10/1000 population.

B. Day Places - Geriatric

1. 2/1000 population.

C. Beds - Psycho-geriatric

1. Functional mental disorders: 0.5/1000 population.

2. Severe dementia only: 2.5 - 3.0/1000 population.

3. Severe dementia/physical illness - (included in geriatric provision above).

D. Day Places - Psycho-geriatric

1. Functional mental disorders: 0.65/1000 population.

2. Severe dementia only: 2.0 - 3.0/1000 population.

3. Severe Dementia/Physical illness: (included in geriatric provision above).

E. Medical Staffing

1. For every 250 beds: 2 Consultants, 8 Registrars or Senior House Officers.

2. For acute/emergency cases: 2 pre-registrar House officers.

3. For a day hospital, for each 30 places: Consultant-1 session, Senior House Officer (or other officer)-4 sessions.

F. Nursing Staff

1. Assessment wards - 1 nurse/1.25 beds.

2. Rehabilitation wards - 1 nurse/1,25 beds.

3. Long-stay wards - 1 nurse/1.50 beds.

4. For Day Hospitals for each 30 places: 1 full time sister, 1 full time staff or enrolled nurse, 2 nursing auxilliaries.

(It should be noted that these norms were set when nurses worked a 42 hour week and had a 4 week holiday. They now work a 40 hour week and have a 6 week holiday and this should therefore be taken into account when calculating standards of care).

G. Other Hospital Staff

1. a 250 bed geriatric department with 2 consultants requires:

a) 2 social workers plus 2 clerks.

b) 5 (W.T.E.) Physiotherapists.

c) 6 (W.T.E.) Occupational Therapists.

d) 11 (W.T.E.) Aides to either department.

e) 1 Departmental secretary.

f) 1 Consultant's secretary.

g) 1 clerk.

2. A Day Hospital requires in addition for each 30 places:

a) 2 (W.T.E.) Physiotherapists.

b) 2 (W.T.E.) Occupational Therapists.

c) 4 Aides.

d) 1 Speech Therapist for 5 sessions.

e) 1 clerk.

H. Social Workers

1. 50 - 60/100,000 <u>total</u> population.

I. Home Helps

1. 12/1000 population.

J. Mobile meals

1. 200/1000 population.

K. Day Centres

1. 50 places/100,000 <u>total</u> population.

L. Residential Homes

1. 25 places/1000 population.

M. Sheltered Housing

1. 25 places/1000 population.

VII Source: "Better Services for theMentally Ill", Cmnd. 6233, HMSO, October,1975

A. Elderly Assessment Units

1. 10 - 20 beds/total population of 250,000 and patients should not normally remain in the unit for more than about 4 weeks.

B. Elderly Severely Mentally Infirmed.

1. 2.5 - 3.0 beds/1000 poulation aged 65+.

2. 2.0 - 3.0 day places/1000 population aged 65+.

HL/MJ/January 1976

VIII Source: Memorandum on provision of Geriatric Services, Report of a British Geriatric Society Working Party, February 1977.

A. Hospital Geriatric Service (within England and Wales)

1. 10 beds/1000 population aged 65+.

2. minimum of 50% of beds for acute admission, assessment and rehabilitation based in DGH or absolute equivalent.

3. Day hospital facilities of at least 2 places/1000 population aged 65+ at DGH or Main Hospital site.

B. Staff for hospital based geriatric service

1. Minimum nurse/patient ratio of 1:1.25.

2. Rehabilitation facilities:

a) Physiotherapists

5 trained plus 5 helpers/200 beds
1 trained plus 1 helper/20 day hospital places

b) Occupational Therapists

5 trained plus 5 helpers/200 beds.
1 trained and 1 helper/20 day hospital places.

c) Social workers

hospital based and 3 trained/200 beds plus
1 trained /40 day hospital places.

d) Speech therapists

2/200 beds plus 40 day hospital places.

e) Dieticians

1/200 beds plus 40 day hospital places.

f) Dentists

at least 4 sessions per week/200 beds
and 1 session/40 day hospital places.

g) Chiropodists

6 sessions per week/200 beds + 40 day hospital places.

h) Health Visitors

2/200 beds plus 40 day hospital places.

i) Audiometry

1 session per week/200 beds and 40 day hospital places

j) Hairdressing

10 sessions per week/200 beds and 40 day hospital places.

k) Hospital voluntary services co-ordinator.

C. Medical Staff

1. 2 consultant physicians in geriatric medicine/district, minimum.

2. No consultant should provide a service for more than 100 beds and 20 day hospital places.

3. 2 registrars, 3 S.H.O. (or 2 S.H.O. and 1 pre-registration H.O.)/200 beds.

D. Administration for the Hospital based geriatric service

1. 1 higher clerical officer, 3 personal secretaries, 1 filing clerk/200 beds.

2. 1 W.T.E. secretary for 40 place day hospital, more if day hospital is seperate.

3. ward clerk available on each active ward.

E. Domiciliary Facilities

1. Residential accomodation

a) 25 places/1000 population aged 65+ for physically disabled.

2. Sheltered housing

a) minimum of 25 units/1000 population aged 65+, more recent work suggests 50 units is more realistic.

3. Day hospital facilities

a) 4 places/1000 population 65+, with transport.

4. Lunch clubs

a) English circular 35/72 and Welsh Circular 195/72 recommend 50 places/100,000 total population to cover 3) and 4).

F. Domiciliary Services (Priorities for Health and Social Services in England , DHSS 1976)

1. Nursing services - day care and night care. 1/2500 total population of all ages with additional bath attendants.

2. Health visitors - 1/4000 total population of all ages.

3. 12 W.T.E. Home Helps/1000 population aged 65+.

4. 200 meals on wheels per week/1000 population aged 65+. 7 day availability.

MJ/Nov 78

APPENDIX B

'A HAPPIER OLD AGE' - HN'78)81

THE ELDERLY IN OUR SOCIETY : QUESTIONS FOR CONSIDERATION

What kind of help and advice is needed to assist people in making this important change in their lives and in developing the right mental attitude to retirement? How can families be helped to prepare for the changes and new opportunities - and in most cases the fall in income - that follow the retirement of a breadwinner?

How can opportunities for community service be extended, and older people encouraged to take them up?

What can be done to improve the range of educational and recreational provision for elderly people?

What encouragement should be given to the extension of opportunities for work after retirement?

Are there ways in which family links can be strengthened and the exchange of help and support between elderly people and their relatives encouraged? Also, more generally, what else can be done to bring the young and the old into greater contact to the benefit of both?

How can this kind of community support be provided on a wider scale? (eg Good Neighbour Campaign)

How serious are these difficulties and what action is needed? (Library facilities, supermarket considerations, clothing problems, economic discrimination - eg. buying on credit)

How might these aims best be pursued? ('Prevention and Health')