

RESPONSIBILITIES OF HOSPITALS AND LOCAL AUTHORITIES FOR ELDERLY PATIENTS

BY

THOMAS MCKEOWN, M.D., Ph.D., D.Phil., F.R.C.P.

AND

K. W. CROSS, Ph.D.

From the Department of Social Medicine, University of Birmingham

For some time it has been evident that a large number of elderly patients are in the wrong place. Some who need hospital care remain at home or in welfare homes; there are others in acute hospitals who no longer need investigation or treatment of acute illness; still others are in geriatric units only because they have no home or welfare home to which they can be discharged. The position is further complicated by the maldistribution of patients between geriatric and psychiatric hospitals and between long stay and acute units.

It might be thought that most of these problems could be solved by enterprising hospital and welfare authorities by a simple exchange of patients between different types of accommodation. Exchanges are sometimes made, for example, on a one to one basis between geriatric units and welfare homes, a ratio which would appear to be favourable to the hospital where duration of stay is in general much shorter than in the homes. Yet the net effect of such measures has been disappointing: for hospitals because their beds are soon filled by new admissions; and for welfare homes because there are apparently unlimited demands on their limited resources.

The difficulties are undoubtedly aggravated by an overall shortage of accommodation but they cannot be attributed solely to this cause. They are due also to the failure of legislation to define unequivocally the respective responsibilities of the two major authorities. For while the obligations of hospitals and local authorities for old people who are either well or acutely ill are clear enough, their roles in relation to patients whose needs are intermediate are less well defined. Local authorities are asked to provide "residential accommodation for persons who by reason of age, infirmity, or any

other circumstances are in need of care and attention which is not otherwise available to them", and they may "provide on the premises on which accommodation is being provided such health services, not being specialist services or services of a kind normally provided only on admission to a hospital, as appear to the authority requisite and as may be specified in the scheme under this Section".* This wording is certainly open to the interpretation that it is the duty of local authorities to accommodate infirm old people, even when their disabilities are such that they require medical and nursing care. A hospital, however, is defined as "any institution for the reception and treatment of persons suffering from illness" and illness is considered to include "mental illness and any injury or disability requiring medical or dental treatment or nursing". This wording can be read to mean that hospitals are responsible for all patients needing institutional medical or nursing care. It is not surprising that elderly patients are misplaced, for neither of the major authorities can be certain of the extent of their responsibilities.

But the ambiguity of the Act has this excuse, that the disabilities of elderly patients are continuously graded, from trivial to serious, and the distinction between hospital and welfare roles has hitherto been difficult to make consistently. For borderline patients it may be impossible to say confidently to which of the two authorities they should be assigned. The problem becomes somewhat more tractable, however, when we consider not the nature of the disability but the kind of attention it requires. Indeed this approach was recommended in a Ministry of Health Circular [HM 65(77)] which

*Section 21 of Part III of the National Assistance Act.

defined elderly patients who may need admission to homes as those "who do not need continuous care by nursing staff".

The present investigation was launched in an attempt to assist the Birmingham Regional Hospital Board and City Welfare Department to determine what should be their respective contributions to the care of elderly patients. More specifically, it had two aims: to examine the basis for division of responsibilities between hospital and welfare authorities; and to estimate on this basis the amount of accommodation of different kinds needed by a defined population.

METHODS

The investigation was concerned with all Birmingham residents aged 65 and over and covered:

(a) Patients (1,210) in geriatric units, whether located in general hospitals or separate "chronic" hospitals;

(b) Those (605) in general or special hospitals;

(c) Residents (1,394) in the City's welfare homes.

It did not include elderly patients in psychiatric hospitals or living at home or on waiting lists for admission to geriatric units (122) and welfare accommodation (260).

A record card was completed during 1965 for each hospital patient or welfare home resident. The data included information concerning the patient's illness and physical and mental condition and an assessment of the type and amount of medical, nursing, and other care required.

The hospital data were recorded by a doctor and a nurse administrator who were fully aware of the aims of the enquiry. They visited each hospital in turn, and completed the records on the wards in consultation with the senior nursing and medical staff concerned with the care of the patients. The survey in welfare homes was made by an experienced member of the field staff of the Department of Social Medicine in consultation with the matrons and wardens of the homes.

CLASSIFICATION OF PATIENTS ACCORDING TO THEIR NEEDS

BASIS OF CLASSIFICATION

We have referred to the ambiguity of legislation which makes it difficult to decide whether patients with intermediate needs should be regarded as a hospital or a welfare responsibility. We suggest

that the decision should turn upon whether they require continuous nursing care by state registered mental, or assistant nurses; if they do they should be assigned to the hospital. This conclusion is based on the belief, amply confirmed by experience, that trained staff cannot be attracted in sufficient numbers to provide a satisfactory standard of care away from the main hospital centres. It therefore seems essential to make the patients' nursing needs the basis of decision concerning his location.

The problem remains of determining nursing needs in borderline cases. Experience of the present enquiry suggests that the following criteria can be used to identify the various classes of hospital patients fairly confidently from those who should be in welfare homes:

(a) Patients needing hospital investigation or medical treatment. These are the patients regarded as suitable for admission to acute hospitals, although many of them are now treated in geriatric units. They are readily identified, and apart from the confusion of the roles of acute and geriatric hospitals (to which we shall refer later) they present no problem concerning their location. They should clearly be in hospital.

(b) Patients confused or disturbed to a degree which requires continuous mental nursing. These have to be identified from the substantial number of patients who are mildly confused, but do not need the attention of a trained mental nurse. This distinction is admittedly subjective, but it is usually made readily by doctors or nurses, or indeed by the staffs of the welfare homes who can quickly identify residents whose mental condition makes it undesirable for them to remain in the homes.

(c) Patients who are incontinent, immobile, or in need of rehabilitation. Persistent incontinence is widely, and we believe justifiably, regarded as a disability which makes it desirable for a patient to be under the care of a nurse and in hospital. The same is true of immobility, although here it is important to limit the term to patients who are confined to bed or to a chair at the side of the bed. Patients so restricted need nursing care and should be in hospital. This is not true of the much larger number of elderly people with limited mobility who usually require little personal attention and none by a trained nurse. Need for rehabilitation is an obvious reason for retaining a person in hospital but it usually arises at the end of an acute illness and is not a source of confusion concerning the location of patients between hospitals and welfare homes.

Table I shows the results obtained by applying these criteria to the Birmingham residents in welfare homes, geriatric units, and acute hospitals. It will be desirable to consider briefly the classification of patients within each institution before discussing the larger issue of their respective roles in the care of the elderly.

WELFARE HOMES

Residents are classified according to their usual state of health, minor acute illnesses being ignored. On the basis of the criteria outlined above, 117 (8.4 per cent.) of the 1,394 Birmingham residents in the homes had disabilities of a kind which would admit them to hospital. 56 of them were confused or disturbed to a degree which made it desirable for them to have mental nursing; the other 61 were regularly incontinent. Some of these patients had lived in the homes for a considerable time and transfer to hospital might have been difficult for them and unwelcome. It is therefore essential that the staff of the homes should have discretion in judging the desirability of a move, which cannot always be determined solely by the patient's physical or mental condition.

The 1,277 residents considered suitable for the homes are divided in Table I into three classes. 733 had no significant disability and required no personal assistance. 304 had some limitation of mobility and needed ground floor accommodation or the use of a lift but no personal assistance. The remaining 240 needed personal assistance, but of a

kind which could be provided by untrained staff and was often given by other residents.

It is the distinction between these 240 residents and the 117 considered more suitable for hospital care, with the corresponding distinction between patients in geriatric units (see Table I), that has been the main source of difficulty in determining the limits of responsibility of hospital and welfare authorities for the care of the elderly. Yet the distinction can usually be made quite confidently on the basis of the three criteria of mental state, continence, and mobility. (For residents of the homes the need for rehabilitation is rarely an issue). The 240 residents in the welfare homes who needed some personal assistance were all continent and at least partially mobile. The attention they required consisted essentially of help in washing or dressing or in going to toilet, although a very few patients (8) also needed some assistance with feeding. These services do not require trained nurses and are fully within the competence of the staff of the homes who accept them as part of their normal duties.

GERIATRIC UNITS

There were 1,210 patients in geriatric hospitals or in geriatric units attached to general hospitals. 203 (16.8 per cent.) had no disabilities or only minor disabilities which required no more than simple personal attention from untrained staff. On the criteria previously discussed these patients were suitable for admission to welfare homes.

The remaining 1,007 patients needed hospital care. 78 of them required investigation or hospital

TABLE I
CLASSIFICATION OF ELDERLY PATIENTS IN BIRMINGHAM ACCORDING TO THEIR NEEDS FOR CARE

Disability	Type of Care Required	No. of Birmingham Residents			
		In Welfare Homes	In Geriatric Units	In Acute Hospitals	On Waiting Lists
None requiring special accommodation or personal attention	Welfare home only	733	203	32	260*
Limited mobility; not requiring personal attention	Welfare home with ground floor accommodation or lifts	304			
Infirm; requiring personal attention	Welfare home with personal assistance from untrained staff	240			
Incontinent, immobile, or needing rehabilitation	Basic nursing and/or rehabilitation	61	712	97	122†
Confused or disturbed to a degree which requires mental nursing	Mental nursing	56	217	—	
Illness requiring hospital investigation and treatment	Investigation or treatment of acute illness	—	78	478	
Total		1,394	1,210	607	382

*People living at home who were on welfare home waiting lists.

†Patients at home who were on hospital waiting lists.

treatment of acute illness and were thus similar in their needs to the large numbers of elderly patients admitted to the wards of general hospitals. 217 patients were confused or disturbed to such a degree that they needed mental nursing and should logically have been assigned to the hospital psychiatric service. Only the remaining 712 patients (59.0 per cent.) fall into the class commonly and regrettably referred to as "long stay". Of these patients, 510 were immobile (confined to bed or to a chair at the side of the bed), 124 were mobile but incontinent, and the other 78 needed rehabilitation.

ACUTE HOSPITALS

There were 607 patients over age 65 in Birmingham general and special hospitals; a further 61 in convalescent units are not included. 478 were, or had recently been, under investigation or treatment of acute illness and were of a type generally considered suitable for the wards of general hospitals. The remaining 129 patients, however, had passed beyond this stage and could, more appropriately, have been transferred to other accommodation; 32 of them no longer required hospital care and were retained only because they had no home or their home was, for one reason or another, not ready to receive them. The other 97 patients needed prolonged care, with basic nursing and rehabilitation services: 56 were immobile; ten were mobile but incontinent; 31 required rehabilitation after completion of treatment of their acute illness.

WAITING LISTS

Although the needs of patients on waiting lists were not assessed they should be considered briefly. At the time of investigation 260 people living at home were seeking admission to welfare homes and 122 to geriatric units. Although psychogeriatric assessment would probably have shown that some of the latter needed mental nursing and should have been admitted to a psychiatric unit, the majority undoubtedly required basic nursing because of infirmity or physical illness. This is the assumption we shall make later in estimating the amount of accommodation of different types needed by a defined population.

ROLE OF HOSPITAL AND WELFARE AUTHORITIES

If some proposals for improvement of medical services—for example, the establishment of the large and truly comprehensive hospital—are to be implemented, it will be necessary to define the limits

of medical responsibility much more clearly than in the past. This need arises particularly in the case of the mentally ill, the mentally sub-normal, and the aged sick, of whom the last have been the subject of the present investigation. The results leave no doubt about the confusion of roles which now exists between hospital and welfare authorities, as well as between the various classes of hospitals.

We have suggested that the line between the work of hospitals and welfare homes should be drawn according to the type of care needed by patients, and that the most significant consideration is nursing care. If patients need prolonged attention from nurses—whether of the state registered, mental, or assistant type—they should be assigned to hospitals, the only institutions able to attract trained staff in sufficient numbers to provide a satisfactory standard of care. If this basis is accepted, the following criteria can be used to distinguish hospital patients from those who should be admitted to welfare homes:

- (a) Patients needing hospital investigation or medical treatment;
- (b) Patients confused or disturbed to a degree which requires mental nursing;
- (c) Patients who are incontinent or immobile or in need of rehabilitation.

In practice, hospital and welfare home patients can almost always be identified from information concerning mobility, continence, and mental state.

The results obtained by applying these criteria to the Birmingham population are given in Table I. They show the considerable overlap of functions of the various institutions: 8.4 per cent. of welfare home residents had disabilities which would have admitted them to hospital, while 16.8 and 5.3 per cent. of patients in geriatric units and acute hospitals respectively had no disabilities which made it necessary for them to stay in hospital. They remained because their homes were, for one reason or another, unable to receive them or, more often, because they had no home.

Even more conspicuous is the confusion of the work of the different classes of hospitals in the care of the elderly. Only 59 per cent. of the patients in geriatric units were of the type commonly referred to as "long-stay": the remainder needed psychiatric care (18 per cent.), or investigation and treatment of acute illness (6 per cent.), or did not need to be in hospital at all (17 per cent.). At the same time 21 per cent. of those over 65 in acute hospitals did not require their services, and could have been

cared for more appropriately in a facility providing basic nursing and rehabilitation, or in a welfare home.

It is this overlap of functions of geriatric and other hospitals which makes the figures currently quoted for the bed requirements of the aged sick almost meaningless. They are based upon experience of geriatric units, the contemporary analogue of the Poor Law Hospital, and ignore the large numbers of elderly patients in general and psychiatric hospitals with identical medical and nursing needs.

In Table II we have attempted to estimate bed requirements, taking account of all persons aged 65 and over in public institutions or on waiting lists for admission. The first column of figures, based on the analysis in Table I, shows the number of persons considered to need care in welfare homes or in hospital. Patients in psychiatric hospitals were not covered in the present investigation, but they were examined in an earlier (1958) survey and those over 65 are included in the figures given in brackets. These data have been used to estimate the numbers of beds needed per 100,000 population and per 1,000 persons aged 65 and over.

Since there are considerable variations in age distribution, even among urban populations in England and Wales, the estimates per 1,000 persons aged 65 and over is for most purposes the more useful. For welfare home accommodation this figure is 15.3, and it is not increased very much (to 17.2) by the addition of patients in psychiatric hospitals. Inclusion of the latter does of course raise substantially the estimate of beds needed for patients who require mental nursing (from 2.4 to 9.3) and, to a lesser extent, for those who require basic nursing and rehabilitation (from 8.6 to 10.8). The number of acute beds per 1,000 aged

65 and over is increased slightly (from 4.8 to 5.4).

In view of the time which has passed since the assessment of the medical and nursing needs of Birmingham patients in psychiatric hospitals, it would be unwise to put too fine a point on the interpretation of these figures. Some rounding off seems essential and we suggest that, allowing a modest margin for error, if elderly patients were cared for in the type of facility most suited to their needs, contemporary bed requirements per 1,000 persons aged 65 and over would be approximately: seventeen welfare beds; nine beds in hospitals with psychiatric nursing; eleven beds in hospitals providing basic nursing and rehabilitation; and five beds in acute units (including short-term psychiatric units). It should be recognized on the one hand that these figures take no account of patients at home unless they were on waiting lists, and it is possible that if sufficient accommodation were available the demand would be higher than is suggested by our figures. On the other hand the estimate of beds in hospitals providing psychiatric nursing (nine per 1,000) is nearly 10 years out of date and future requirements may be lower.

The maldistribution of patients between hospitals is likely to prove difficult to correct. Psychogeriatric assessment may help, but patients' needs change and, so long as geriatric, psychiatric, and acute beds are on separate sites and separately staffed and administered, continued misplacement of patients seems inevitable. However, it should not be too difficult to eliminate the overlap of functions between welfare homes and hospitals, by providing a modest increase in welfare beds and by using information concerning mobility, continence, and mental state as the basis of a simple mechanism for ensuring that patients are cared for in the right place.

TABLE II
ESTIMATE OF BED NEEDS FOR PATIENTS AGED 65 YEARS AND OVER

Type of Care Required		No. of Persons*	No. per 100,000 Total Population†	No. per 1,000 Persons Aged 65 and Over
Welfare Home		1,772 (1,985)	166 (186)	15.3 (17.2)
Hospital with	Mental nursing	273 (1,073)	26 (101)	2.4 (9.3)
	Basic nursing and rehabilitation	992 (1,242)	93 (117)	8.6 (10.8)
	Investigation or treatment of acute illness	556 (626)	52 (59)	4.8 (5.4)

*Figures in brackets include an estimate (from a previous Birmingham survey) of patients over 65 in psychiatric hospitals who were not covered in the present investigation.

†Figures in this column are given to the nearest whole number.

SUMMARY

The medical, nursing, and other needs of all Birmingham residents aged 65 and over in welfare homes, geriatric units, and general and special hospitals were assessed during 1965. It is considered that patients needing the continuous attention of trained nurses should be cared for in hospital, and this principle is used to define the respective responsibilities of hospital and welfare authorities for different types of patients. In practice the distinction between hospital and welfare patients can almost always be made consistently from information concerning mobility, continence, and mental state.

The results (Table I) show the substantial overlap of functions between hospitals and homes and between the various classes of hospitals. Only 59 per cent. of patients in geriatric units were of the type referred to as "long-term"; the remainder needed psychiatric nursing, or investigation and treatment of acute illness, or did not need to be in hospital at all. 21 per cent. of patients in acute hospitals could have been cared for more appropriately in a facility providing basic nursing and rehabilitation or in a welfare home.

The figures are used to estimate the amount of accommodation of different kinds which would be required by elderly patients if they were correctly placed. Including the results of an earlier assessment of the needs of patients in psychiatric hospitals (not covered in the present enquiry), the numbers of beds (per 1,000 persons aged 65 and over) were approximately: in welfare homes, seventeen; in hospitals with psychiatric nursing, nine; in hospitals providing basic nursing and rehabilitation, eleven; and in acute units, five.

The data from hospitals were collected by Dr Lindsay Gordon and Miss I. Chandler. We are indebted to them, and also to Dr L. Nagley and Dr R. Cape, for helpful comments in the interpretation of the results. Mr D. Nappy, Chief Welfare Officer for Birmingham, provided valuable advice about the organization of the survey of welfare homes where the data were collected by Miss Ida Giles. We are grateful to the staffs of the Birmingham hospitals and to the Wardens of welfare homes for their collaboration in the assessment of patients' needs. The data were analysed with the help of Miss Ida Giles and Mrs Betty Mann. The costs of the field work were met by a grant from the Birmingham Regional Hospital Board.