H.M. (57) 86

NATIONAL HEALTH SERVICE

GERIATRIC SERVICES AND THE CARE OF THE CHRONIC SICK

Summary. This memorandum makes known to hospital authorities the principal general conclusions derived from the recent survey of services provided for old people and the chronic sick and makes some suggestions for their improvement. It defines the functions of the different statutory authorities concerned and illustrates the necessity for practical co-operation between them. Suggestions are made on the organisation of hospital services for out-patients and in-patients. Reference is made to the relevant parts of the Guillebaud Committee's report and a circular addressed to local health and welfare authorities is appended.

The Survey

1. Boards and Committees will be aware that there has recently been completed a nation-wide survey of the hospital and specialist services provided for old people and the chronic sick (other than the mentally ill and mentally defective) and their relation to the services provided by local authorities in both their health and welfare capacities. A detailed report on this is being published, entitled "A Survey of Services available to the Chronic Sick and Elderly in 1954–55", in the series on Public Health and Medical Subjects (No. 98) (H.M.S.O.). The survey has revealed a number of points at which the hospital services in particular areas are defective and the Minister is making suggestions for improvement to the individual Boards concerned. Apart from these, comparisons between the practice of different hospital authorities have enabled the Minister to formulate certain general principles which he thinks should guide the planning of hospital and specialist services, and these are set out below. Most, if not all, of the questions discussed will be familiar to some hospital authorities and the essential purpose of the memorandum is to bring the best practice revealed by the survey to the notice of Boards and Committees whose services for the chronic sick and elderly have so far been less effectively developed. The Minister recognises that both other demands on financial resources and absolute shortages of certain types of staff may make it impossible quickly to reach a high level of achievement everywhere but he fully agrees with the view expressed by the profession in the debate on the Guillebaud Report in the House of Commons, on the 7th May, 1956, that the development of services for the aged is one of the most urgent tasks confronting the National Health Service. In order that Boards and Committees may be aware of the advice given to local health and welfare authorities, a copy of the circular sent to them is appended to this memorandum.

The Main Aim

2. There are three places in which old people who have become too frail or sick to fend for themselves may be looked after: their own homes (including special housing), a "welfare" home provided by a

To: Regional Hospital Boards,
Hospital Management Committees,
Boards of Governors.

local authority or voluntary organisation, and a hospital, where they may be receiving active medical and surgical treatment or little active treatment but a considerable amount of nursing care.

3. The Minister wholeheartedly agrees with the Guillebaud Committee's conclusion (paragraph 647 of their Report) "The first aim should be to make adequate provision wherever possible for the treatment and care of old people in their homes". This is desirable not only on economic grounds but because old people are generally happier and more comfortable in their own homes and prefer to stay there, living their own independent lives, as long as possible. The Minister's policy, therefore, is directed to that end and is based on the development to the full of the preventive services and domiciliary and out-patient care. He recognises, of course, that no matter how much domiciliary care is given there will be many cases where social as well as medical considerations make admission to hospital necessary or desirable. But this should always be treated as a last resort, and everything possible should be done to enable old people to stay at home unless they clearly need treatment of a kind that can only be given in hospital, or the burden on younger members of the household becomes so great as to threaten them with breakdowns.

Division of Responsibility

4. Responsibility for the care of the chronic sick and the elderly is shared by a number of statutory authorities:

(*a*) the hospital authorities, who are responsible for providing out-patient and in-patient hospital and specialist services and, where necessary, consultations with specialists in the patient's own home;

(*b*) the local authorities, who, in their health capacity, provide home nursing, domestic help, health visitors and other domiciliary services; and in their welfare capacity provide residential accommodation and certain domiciliary services under the National Assistance Act; and

(*c*) the Executive Councils, who are responsible for the general practitioner service.

Although the three authorities are administratively and financially independent, the services they provide should be interdependent. The Minister makes no apology for emphasizing once more the need for effective co-operation between the different authorities and their officers. The aim should be to provide what is, in effect, a single service for the aged infirm and sick, to which the survey has shown that the division of statutory responsibility need be no obstacle. Boards and Committees are reminded of the Guillebaud Committee's view that the root cause of problems relating to the care of the aged is the inadequacy of the present services and not their form of organisation (paragraph 642 of their Report). More detailed discussion of this subject, including a detailed definition of the respective responsibilities of hospital and welfare authorities, will be found in later paragraphs.

5. Nor should the essential place of the general practitioner be overlooked. He has the knowledge and experience of treating old people in their own homes, and so long as the patient is being looked after at home primary responsibility for his treatment rests with his general practitioner. Hospital authorities should take, and if necessary create, opportunities to discuss the services to be provided—and particularly their arrangements for the admission and discharge of elderly patients—with representatives of the local general practitioners.

Out-patient Services

6. In accordance with his aim of preventing or delaying the need for admission to hospital as far and as long as possible, the Minister urges on Boards and Committees the importance of developing out-patient services for the elderly and the chronic sick. The provision of physiotherapy and other forms of rehabilitation at an early stage can frequently arrest deterioration and eliminate the need to admit some patients to hospital and prevent the deterioration of others after their discharge. Much has already been done: for example, the number of out-patients attending special geriatric clinics rose from 6,988 in 1950 to 18,401 in 1955; and there is little reason to doubt the attendance of elderly patients at ordinary out-patient clinics has also increased. It is by no means universally accepted that separate clinics run by a geriatric physician are preferable to carefully worked-out arrangements for elderly patients to have full access to the general out-patient services and physiotherapy in particular. Special geriatric clinics have, however, been found useful for following up discharged in-patients, in agreement with the general practitioner and for keeping under supervision patients who are having to wait a long time for admission. On the whole, the Minister inclines to the view that, except for these special purposes, elderly patients can best use the ordinary out-patient services, and especially physiotherapy. In any event he asks Boards and Committees to devote special attention to this whole subject. Any major expansion of out-patient services will no doubt mean giving high priority to increased expenditure on those services, but the result will be not only more satisfactory to the patients but cheaper than the alternative of providing additional beds in hospitals or welfare homes.

7. Where for any reason it is impracticable to hold special geriatric clinics these patients might usefully be seen on the wards, without admission, where the lay-out of the hospital permits. In whatever direction out-patient services for old people are developed, care will be needed to secure an adequate appointments system, with special facilities for those least able to endure any waiting that may be inevitable. The system will need to be worked out in consultation with the local authority's ambulance service, on which an extra burden is likely to be thrown. Here again, however, the extra expenditure should prove economic in the long run.

Day Hospitals

8. By way of supplementing out-patient clinic services for elderly patients, some interesting experiments are being made in the development of day hospitals providing physiotherapy and occupational therapy. They can be especially useful for patients with some degree of mental enfeeblement, when an association will need to be established between them and a convenient mental hospital. Patients are brought from and returned to their homes by car or ambulance and may attend for a specified number of half or whole days each week. Here again, as with more conventional out-patient services, arrangements will need to be worked out in consultation with the ambulance authority; but care will be needed to ensure that the ambulance service is not relied upon for this purpose to such an extent as to make the day hospital uneconomic.

9. Day hospitals serve the following purposes:

(i) They enable in-patients to be discharged earlier than usual.

(ii) Some therapy can be started on certain types of patients awaiting admission.

(iii) Patients who have become ambulant and fully rehabilitated after an incident such as a "stroke" frequently deteriorate on return home. Supervision and continuation therapy in day hospitals prevent or delay this deterioration.

(iv) They may do away with the need for admission of certain patients.

(v) By increasing their social contacts, the day hospital improves the mental attitude of lonely elderly chronic sick patients. This applies particularly to those left alone at home all day while younger relatives are out at work.

(vi) They may give relief to relatives while the patient is away from home.

An account of the work of existing day hospitals will be found on pages 125–128 of Part II of the Department's Report for 1955.

Similar objects might be achieved by arrangements for patients to attend regularly occupational therapy and physiotherapy departments for group or individual treatment.

In-patient Services

10. A potential source of confusion in the total service for the aged sick and infirm is the lack of a clear perception by hospital and welfare authorities of their respective responsibilities. The Guillebaud Committee drew attention to this in paragraphs 642–645 of their report and welcomed the definitions set out in the next two paragraphs. These would, they felt, provide a comprehensive service with no gaps between hospital and local authority responsibilities for residential care. In their opinion the solution to the problems did not lie in the provision for the aged of a third type of accommodation between hospital and welfare home. This last conclusion is supported by the survey reports, which show that in general there need be no insuperable difficulty in distinguishing the types of case proper to each type of authority, though there may of course be occasional differences of opinion over individual patients. There is no evidence to suggest that the recognition of a third category of person not the definite responsibility of either authority would be anything but harmful.

11. Apart from the active elderly person who is in need of residential care and who is clearly the responsibility of the welfare authority, the latter's responsibility also extends to the following:

(i) Care of the otherwise active resident in a welfare home during minor illnesses which may involve a short period in bed.

(ii) Care of the infirm (including the senile) who may need help in dressing, toilet, etc., may need to live on the ground floor because they cannot manage stairs and may spend part of the day in bed (or longer periods in bad weather).

(iii) Care of those elderly persons in a welfare home who have to take to bed and are not expected to live more than a few weeks (or exceptionally months) and who would, if in their own homes, stay there because they cannot benefit from treatment or nursing care beyond what can be given at home, and whose removal to hospital away from their familiar surroundings and attendants would be felt to be inhumane.

All these are persons for whom any necessary nursing care would be given by relatives, etc. with the help or advice of the home nurse if they were living in their own homes. In welfare homes that care should be given by attendants, assisted or advised by the visiting home nurse in the small welfare home, or by a small staff with nursing qualifications or experience in the larger homes.

It is not regarded as the responsibility of the welfare authority to give prolonged nursing care to the bedfast (except in those in (iii) above), nor is it desirable that separate "infirmary wards", in which patients from other homes are concentrated, should be created in large homes.

12. Apart from the acute sick and others needing active treatment, who are clearly the responsibility of the hospital authority, the latter's responsibility also extends to the following:

(i) Care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years.

(ii) Convalescent care of the elderly sick who have completed active treatment but are not yet ready for discharge to their own homes or to welfare homes.

(iii) Care of the senile confused or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home.

It is not regarded as the responsibility of the hospital authority to give all medical or nursing care needed by an old person, however minor the illness or however short the stay in bed; nor to admit all those who need nursing care because they are entering upon the last stage of their lives.

13. In England and Wales as a whole just over 1·2 beds per 1,000 population have been allocated in National Health Service hospitals for the treatment of chronic sick patients other than the mentally ill and mentally defective. It is, in the Minister's view, quite impossible to devise any generally applicable standard of hospital accommodation required for these patients, expressed in terms of beds per 1,000 population: requirements will vary widely according to many local factors—for example, the proportion of old people in the general population, which varies significantly from region to region; the standard of housing in the area; the extent to which employment is available for women who might otherwise be looking after elderly relatives at home; and, above all, the extent to which out-patient and ancillary services have been developed within the hospital and the hospital is supported by domiciliary and welfare services outside. The most that can be said is that—so far as can be judged from the survey—in areas where there are a fully effective geriatric service and adequate domiciliary and welfare services, and the age distribution of the population is normal, a ratio of 1·2 beds per 1,000 population will give a reasonable hospital service with no evidence of undue strain. In other words, the need generally is for a better use of existing beds, supplemented by better domiciliary and welfare services, rather than for more beds, although in some areas there is a definite shortage of beds also. It would, of course, be quite wrong to reduce the number of beds allocated to the chronic sick because the ratio in a particular area was substantially higher than 1·2 per 1,000, unless experience had shown the provision to be excessive.

14. As has already been stated, the Guillebaud Committee, in considering the future pattern of services for the aged, suggested that the first aim should be to make adequate provision wherever possible for the treatment and care of old people in their own homes. With regard to the hospital service they referred particularly to the need to provide sufficient geriatric units where old people referred for treatment could be sorted into two main categories—first those needing prolonged hospital treatment and secondly those who could be rehabilitated and returned either to their own homes or to welfare accommodation (paragraph 648). The survey has demonstrated the soundness of this recommendation.

15. It is sometimes argued that the development of geriatrics as a separate specialty and the widespread establishment of special geriatric departments is not in the best interest of elderly patients, either acute or chronic. The view is advanced that the elderly acute sick are best treated in general medical wards under the care of general physicians, and it must be recognised that even in general hospitals containing well-developed geriatric departments the proportion of patients over 60 in the acute medical wards may already be over 50 per cent. and is likely to increase. It is further argued that even wards specially allocated to the elderly sick should be in the charge of a general physician having other responsibilities rather than of a specialist geriatric physician.

16. At the time of the survey, geriatric physicians of consultant or S.H.M.O. rank had been appointed in only one-third of the hospital groups which had beds specifically allocated to the chronic sick; and there is, of course, no question that a great deal of valuable and successful work is being done by general physicians for the elderly and chronic sick. But it is clear that their problems are essentially different from those of younger patients. To begin with, the speed with which they can be restored to health, however active the treatment provided for them, is necessarily less than with younger patients and it is doubtful whether the tempo of a busy medical ward can provide the most comfortable and effective environment for their recovery. Experience shows that there are practical difficulties in accommodating more elderly patients with younger patients; the very elderly may be noisy or incontinent, their dietary needs are different and furniture and equipment need to be specially designed for their uses. More important, their problems are often as much social as medical and not many general physicians will, in practice, have time to acquire the necessary special experience to deal with these. The survey suggests, at least, that in too many cases where large departments for the elderly sick are in the charge of general physicians whose main responsibilities lie elsewhere, much of the work has perforce to be left to juniors and that such departments are in fact usually less successful than those in the charge of a specialist geriatric physician.

17. The Minister recognises that there are not at present enough candidates with appropriate experience in general medicine applied to the care of old people to fill consultant appointments on a large scale. While there is no doubt that specialised staff and services should be available in this branch of hospital work, there is no reason why it should not be organised, on the lines suggested in succeeding paragraphs, under the charge of a general physician who is interested and experienced in it and is able and willing to devote to it the necessary amount of his time. Difficulty in filling specialist geriatric

appointments should not deter Boards from setting about improving the services they provide.

18. It is not to be thought, however, that the geriatric department—whether it is run by a specialist geriatric physician or by a general physician who has other work as well—should have the monopoly of treating elderly patients, to the detriment of the irremediable chronic sick. The suggestions made in the following parts of this memorandum should be read in the light of the observations in this and the preceding paragraph.

19. The Minister considers that hospital authorities should give high priority in the allocation of their resources to the establishment in every hospital centre of a geriatric department under the charge of a specialist physician, whether a general physician with a special interest in the subject or a physician working only in this field, and with full supporting services. In either case the physician must be prepared to give his full attention to the social factors which so often influence the onset and course of illness in old people. The department would have two rather different functions. First, an attempt should be made to admit to it those elderly patients from the immediately surrounding area who require in-patient treatment, whose illness is influenced by social factors and who do not require the special services available only in the other hospital departments. A careful medical and social assessment can then be made and a decision taken to retain the patient for treatment, to transfer him to long-stay hospital accommodation or to seek his admission to an old people's home provided by the local authority or a voluntary body. The extent to which this function can be centralised must vary according to the size and nature of the area served by the hospital centre: it may be necessary to establish subsidiary geriatric departments in associated hospitals but it is desirable that these should be under the direct control of the physician at the main centre. He should be appointed to the staff of the other hospitals and he or his juniors should pay frequent visits to them.

20. The geriatric department's second function is itself to provide active rehabilitative treatment for all its patients who it is expected can be restored to health and returned to their homes or to welfare accommodation within a reasonably short time. This function requires a fairly extensive supporting staff, discussed in paragraphs 26–28 below, and the time cannot be foreseen—indeed may never come—when it can be decentralised to more than a limited extent. Patients who are found in the associated hospitals to be capable of benefiting from active geriatric treatment of the kind envisaged will usually, therefore, need to be transferred for the purpose to the main hospital centre. Where, however, it is found practicable to provide full geriatric services in the subsidiary departments it is again essential that they should be under constant and effective supervision by the physician in charge of the central department.

21. "Hospital centre" is used in the two preceding paragraphs, as in RHB (48) 1, to describe a group of hospitals which together provide all the normal consultant services for a natural aggregation of population. It is not suggested that geriatric services should be further centralised as a general rule, and in the small centres they can and should be the responsibility of a general physician with special experience and giving a substantial part of his time to the work.

22. It has been found that more effective use can often be made of the beds in an acute geriatric department if it is supported by a unit providing for convalescents. The final stages of clinical rehabilitation and social readjustment before discharge do not always need the full services of a hospital and a convalescent unit can free more expensive beds in the acute department for more urgent cases.

23. There are, of course, many patients who cannot benefit from active treatment but who require a higher standard of nursing than can in fact be provided in their own homes or can properly be provided in local authority accommodation—the genuine chronic sick. Again, it may be found that the setting aside of special accommodation for this category of patient contributes to the more effective use of beds in the acute geriatric unit. The survey has shown the deficiencies of much of the accommodation provided for these patients, even in the most elementary amenities, but of this Boards and Committees are only too well aware. The Minister welcomes the improvements made even by such simple means as the imaginative use of paint and relies on Boards and Committees to do what they can in this direction. The value of dayrooms, at both geriatric and chronic sick units, as a means of encouraging ambulation should be borne in mind when improvements are considered. He also gratefully recognises the value of visits by voluntary workers to those cared for in these surroundings. The other important point on chronic sick units which emerges very clearly from the survey is that they must be under effective supervision by the physician responsible for the geriatric service in their area, and that patients should be freely transferable from such accommodation to the acute geriatric unit and vice versa as their condition requires. Few patients should be admitted direct to long-stay accommodation for the chronic sick without a full assessment in an acute geriatric ward.

24. The survey has revealed the great value of a short stay in hospital for chronic sick patients nursed at home to give the relatives looking after them a rest or holiday and to enable the patient's condition to be re-assessed. The Minister hopes that those hospital authorities who do not already have such schemes will consider starting them. Local health authorities, from their knowledge of home conditions, may be able to supplement the information available from general practitioners when patients are being selected. Experience shows that these schemes are greatly appreciated and may prevent complete breakdown of home care arrangements and consequent long-term hospital care. Where accommodation permits it may be possible to consider regular re-admission of suitable patients who are proving a heavy burden to their relatives at home.

25. If the hospital and welfare services for the elderly sick and infirm are to be properly integrated, one essential is machinery which will secure a smooth and continuous flow of patients between hospital and Part III accommodation. Old people inevitably fluctuate to and fro across the line between infirmity and sickness and there ought to be no difficulty, except in areas where there is a real shortage of hospital or Part III beds, about the temporary (or permanent) admission to hospital of old people in welfare homes when their health deteriorates and, conversely, the transfer of hospital patients whose condition improves but who are not fit enough to resume an independent life and cannot be discharged to the care of relatives or friends. It is difficult to imagine a good reason why, in the same area and within the same sex, there should be old people in hospital

who are medically fit for transfer to welfare homes and, at the same time, in welfare homes to which these people could suitably be transferred, others waiting for admission to hospital. The solution might be for the hospital geriatric physician to hold a joint appointment with the Regional Board and the local authority. He would then be able to control admissions to hospital and to facilitate transfers between hospitals and Part III accommodation. He would also be able to give the local authority advice as required through the Medical Officer of Health on the medical aspects of applications for admission to Part III accommodation from persons living in their own homes. In any event, continuous contact between hospital and local authority staffs is needed to avoid indefensible anomalies.

Ancillary Services

26. If a geriatric service is to be effective the physician must be supported by adequate ancillary staff such as physiotherapists, occupational therapists, chiropodists and almoners. The ancillary services should be available (though not necessarily all of them full-time) at all hospitals where there are active geriatric beds or beds for the chronic sick.

27. The physiotherapy department should, if at all possible, be readily accessible to the geriatric and chronic sick wards and physiotherapy appliances should be kept in the wards for those patients who are not yet able to visit the physiotherapy department. It is particularly desirable for the elderly patients that facilities should be available for group remedial exercises. Occupational therapy for chronic sick patients is valuable because of its effect on mental rehabilitation as well as on physical recovery; it also has the special value of keeping the fingers supple. Chiropody, too, is useful in assisting the rehabilitation of bed-ridden patients. The employment of an almoner or social worker has been found to improve contacts with patients' relatives and local authorities: this results in a close appraisal of the social factors in the situation and thus an improved discharge rate—indeed it is no exaggeration to say that the geriatric department cannot function adequately without such an officer on its staff. Every effort should be made to seek and maintain the co-operation of relatives, who should be kept informed of the patient's progress and assisted to make arrangements for his return home.

28. Satisfactory ancillary services are reported from less than a third of the hospital groups with beds specially allocated for old people. No doubt this is partly due to shortages of trained staff but there is equally no doubt that without their support the medical work will inevitably be more or less frustrated. The Minister therefore asks Boards and Committees to pay especial attention to improvement in this part of the field.

Admission arrangements and waiting lists

29. Many admissions are arranged as emergencies because of some acute incident or exacerbation of a chronic condition, but most can be arranged rather more deliberately. It is essential to ensure that proper attention is given to the assessment of medical and social priority of patients whose general practitioners have applied for their admission. In some areas this is achieved by the domiciliary visiting of those who are unfit to come to see him as out-patients by the geriatric physician himself, either alone or with a social worker from the hospital or local authority. The Minister commends this arrangement wherever there are enough medical staff to carry it out

and believes that it is possible to operate it without detracting from the general practitioner's sense of responsibility for his patient. Such visits should, of course, always be made in agreement with the general practitioner, who may often wish to be present and should always be informed of the outcome. It has been found in practice that the arrangement results not only in a fair assessment of need, but also in the identification of those who can be helped in other ways and, with the help of the general practitioner, in the mobilisation of appropriate services, e.g., home nursing, home help or admission to a welfare home, thus contributing incidentally to a reduced demand on hospital beds. Where the geriatric physician cannot make a domiciliary visit to a patient on the waiting list, the aim should be for a non-medical visitor qualified to assess and to report on social conditions to visit every elderly patient in his home before he is put on a waiting list.

30. When the patient has been put on the waiting list further visits should be made periodically under the authority of the general practitioner to determine with him what changes, if any, have taken place in the need for admission. This work is best carried out by health visitors, social workers or other suitable officers of the local authority. Co-operation between hospital and local health authority will usually be maintained by the health visitor who will keep in touch with patients on the waiting list and ensure that all possible help in the home is provided for those who need hospital treatment but cannot immediately receive it. She should have a close liaison with the geriatric department and with the general practitioner so that changes in the circumstances of patients awaiting admission may be known to all. It has been found in some areas that the best working arrangement between hospital and local authority is achieved if contact with the geriatric department is made the responsibility of one health visitor who would then naturally work in co-operation with any existing hospital social worker. In a few instances the health visitor has been attached part-time to the geriatric department—an arrangement which appears to the Minister to have much to commend it.

31. In every group with waiting lists of old people, standing arrangements should be made for the regular review of waiting lists to ensure that all patients whose names are included on them are known to need admission to a hospital bed and are in the right, up-to-date order of priority. The survey shows that there is considerable variety in the organisation of waiting lists and that in many areas they are quite unrealistic, including people who have died or recovered, and so are useless as a picture of the real need and as a basis for planning the deployment of hospital and specialist services.

Discharge

32. The Minister has on many occasions drawn attention to the importance of notifying general practitioners when their patients are discharged. In the case of elderly or chronic patients the hospital should make sure (with the consent of the patient) that the Medical Officer of Health also is promptly notified, if the patient lives alone or is for any other reason likely to need domiciliary services after discharge.

Mentally disturbed patients

33. As has already been indicated, the survey did not cover mental illness and mental defect but during its course an enquiry was made into the number and mental state of aged patients in mental hospitals in the county of London. It is clear that there is a need for much closer co-operation between the mental hospitals on the one hand and the welfare authorities and the chronic sick and geriatric departments in each area on the other. In particular, the choice between the various types of accommodation available for elderly people who have become mentally impaired needs to be made in consultation between the different authorities responsible and the arrangements at the time when they are ready for discharge need greater co-ordination than is often found now.

34. Boards and Committees are reminded of the recommendation in R.H.B. (50)26/H.M.C. (50)25/B.G. (50)22 on the establishment of (*a*) short-stay psychiatric units as parts of geriatric departments and (*b*) long-stay annexes associated with general, chronic sick or mental hospitals. Patients can be admitted to (*a*) for diagnosis and short term treatment and to (*b*) if their requirements exceed the resources of welfare accommodation but fall short of what is provided in a mental or chronic sick hospital.

The Younger Chronic Sick

35. Boards and Committees will be aware of the specially difficult problem of caring for the younger patient suffering from some serious chronic condition who has reached the stage when he can no longer be nursed at home. On the one hand, it is wholly unsatisfactory for such patients to be nursed for, perhaps, the greater part of a lifetime in the company of older patients in all stages of terminal illnesses or of much greater age: on the other hand, to gather them together into reasonable-sized groups where they can be looked after on their own may, except in very large centres of population, make it difficult to preserve the necessary contact with their own families.

36. A few experiments have, however, been made in establishing small groups of younger chronic sick, which are proving very successful. Regional Boards are asked, therefore, to find out in each of the areas for which they are responsible, how many younger chronic sick patients there are and in which hospitals, and to consider at once whether it would not be practicable to group them together in one or more hospitals. It is preferable not to include children in these groups but the upper age limit can be elastic, depending more on the patients' mental attitude than their age in years. The crucial factor may be the existence of suitable accommodation or the possibility of providing it by adaptation: wards are required which are big enough to constitute an independent unit and provide a social milieu for the patients and at the same time not so big that they can be kept full only by drawing patients from too far afield. Given accommodation of the right kind the grouping could be effected by way of exchanges of patients with little or probably no additional expenditure. The Minister considers that this is a development which should, wherever possible, be introduced as a matter of urgency.

MINISTRY OF HEALTH,
SAVILE ROW,
LONDON, W.1.

7th October, 1957.

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(85632) Wt. 8055—1817 10,900 10/57 D.L./372

therefore urges authorities to consider whether in many areas the time is not ripe for renewed contact between themselves and voluntary bodies working in the area with a view to further encouragement of voluntary help and efforts on the lines laid down in Circular 11/50.

18. As the Council know, the Minister of Housing and Local Government has issued a circular (No. 18/57 dated 18th March, 1957) reminding housing authorities of the importance of making adequate provision for the special requirements of old people. The Minister is sure that local health authorities for their part will be quick to appreciate the valuable work which good domiciliary services supplied through them can do as a support to action taken by the housing authorities in this direction.

19. The Minister will be grateful if local authorities will as opportunity serves review their services in the light of the observations he has offered to make sure, as he knows would be their wish, that they are making the maximum possible contribution towards meeting the needs of the chronic sick and infirm.

20. A copy of this circular is enclosed for the Council's Chief Welfare Officer. A copy has been sent separately to the Medical Officer of Health.

21. Correspondence from authorities in Wales and Monmouthshire in regard to this Circular should be addressed to The Chairman, Welsh Board of Health, Cathays Park, Cardiff.

I am Sir,

Your obedient Servant,

J. W. Williams

(85692r) Wt. 8055—1817 8700 10/57 D.L./372

Chief Clerk

Circular 14/57

TELEGRAMS—" HEALTHMIN. PICCY. LONDON ".
TELEPHONE—REGENT 8444.

To County Councils
County Borough Councils
in England and Wales.

MINISTRY OF HEALTH,
SAVILE ROW,
LONDON, W.1.
7th October, 1957.

SIR,

LOCAL AUTHORITY SERVICES FOR THE CHRONIC SICK AND INFIRM

1. I am directed by the Minister of Health to write to you about the survey which, as the Council will know, he has conducted through his officers of the facilities available to the chronic sick, particularly the aged chronic sick and infirm. This survey covered both the hospital services and the services provided by local authorities either as local health authority or as the authority responsible for the residential service for those in need of care and attention under Part III of the National Assistance Act. The Minister wishes to express his appreciation of the help given to his officers in the course of the survey, and to offer for the Council's consideration some observations arising out of his consideration of the information obtained from it. He is communicating also with hospital authorities and a copy of the memorandum which has been sent to them is attached. A Report (No. 98) is being published simultaneously in the series on Public Health and Medical subjects entitled " A Survey of Services available to the Chronic Sick and Elderly in 1954–55 ".

2. For the purpose of the survey the definition set out below of the division of responsibility between the hospital authorities and local authorities under Part III of the National Assistance Act was adopted.

Welfare Authorities

Apart from the active elderly person who is in need of residential care and who is clearly the responsibility of the welfare authority, the latter's responsibility also extends to the following:—

(i) Care of the otherwise active resident in a welfare home during minor illnesses which may well involve a short period in bed.

(ii) Care of the infirm (including the senile) who may need help in dressing, toilet, etc., and may need to live on the ground floor because they cannot manage stairs, and may spend part of the day in bed (or longer periods in bad weather).

(iii) Care of those elderly persons in a welfare home who have to take to bed and are not expected to live more than a few weeks (or exceptionally months) and who would, if in their own homes, stay there because they cannot benefit from treatment or nursing care beyond what can be given at home, and whose removal to hospital away from their familiar surroundings and attendants would be felt to be inhumane.

The Clerk of the County Council.
The Town Clerk.
94150/53/4/2.

All these are persons for whom any necessary nursing care would be given by relatives, etc., with the help or advice of the home nurse if they were living in their own homes. In welfare homes that care should be given by attendants, assisted or advised by the visiting home nurse in the small welfare home, or by a small staff with nursing qualifications or experience in the larger homes.

It is not regarded as the responsibility of the welfare authority to give prolonged nursing care to the bedfast (except those in (iii) above), nor as desirable that separate "infirmary wards" should be created in large homes in which patients from other homes are concentrated.

Hospital Authorities

Apart from the acute sick and others needing active treatment, who are clearly the responsibility of the hospital authority, the latter's responsibility also extends to the following:—

(i) Care of the chronic bedfast who may need little or no medical treatment but do require prolonged nursing care over months or years.

(ii) Convalescent care of the elderly sick who have completed active treatment but are not yet ready for discharge to their own homes or to welfare homes.

(iii) Care of the senile confused or disturbed patient who is, owing to his mental condition, unfit to live a normal community life in a welfare home.

It is not regarded as the responsibility of the hospital authority to give all medical or nursing care needed by an old person, however minor the illness or however short the stay in bed; nor to admit all those who need nursing care because they are entering on the last stage of their lives.

3. This definition was brought to the notice of the Committee of Inquiry into the Cost of the National Health Service (Guillebaud Committee) who endorsed it as making clear beyond doubt that there are circumstances in which old people may properly be given nursing care in welfare homes, as guarding against the reappearance of the old "infirmary wards" in local authority residential accommodation, and as providing a comprehensive service with no gaps between the hospital and local authority responsibilities. The Minister now commends the definition to local authorities as a working guide. In relation to the responsibility of welfare authorities it requires in one particular slight modification in that further experience since its adoption suggests that it may sometimes be necessary to have in a small welfare home one or two staff with nursing experience where care is being undertaken of persons already in the home who have become bedfast and are not expected to live long. In such cases the help which can be given to the regular staff by the visiting home nurse may not always be sufficient to avoid undue strain on them.

4. No definition can hope to cover every set of circumstances that may occur but the survey reports show that while a question occasionally arises in an individual case as to where the responsibility lies, local authorities and hospital authorities do not in general have much difficulty in differentiating the types of case proper to each. The Minister has no doubt that provided it is recognized by local

authorities and hospital authorities alike that one or other of them must accept responsibility and that the paramount consideration in deciding this must be the interest of the person requiring a service, they will be able between them to settle the occasional case of difficulty.

5. The Council will observe from the memorandum sent to hospital authorities that the Minister is urging that high priority in the allocation of their resources is given to the establishment of further geriatric departments both for assessment of cases and for active treatment, and that attention is also drawn to the value of units providing convalescence for the care of those who no longer require full scale hospital services but have not reached a stage at which they can be discharged home, or, if they have no home, to accommodation for those in need of care and attention. Apart from these special requirements it is not thought that there is a general shortage of chronic sick and geriatric beds (although in some areas particularly London there is a definite shortage) but that the problem is rather to ensure the best use of existing beds.

6. On the Part III side, despite the substantial increase in residential accommodation provided since 1949, it appears from the survey that there is still a shortage of accommodation generally, particularly on the ground floor, for the more infirm. The Minister has no doubt that local authorities will continue, as in the past, to devote to the expansion of this service the maximum resources which the economic situation permits.

7. It is also clear from the survey that there are substantial numbers of persons occupying hospital beds who do not require more attention than Part III homes can provide. At the same time, there is a considerable, though on the whole smaller, number of persons in Part III accommodation who should more properly be in hospital though here too the situation is not uniform throughout the country.

8. The three foregoing paragraphs bring out the importance of maintaining close and constant liaison between the two authorities so that there may be the greatest possible interchange of cases, that all available accommodation can be used to the greatest advantage and that the maximum use is made of out-patient facilities. It is not, of course, suggested that such liaison can in itself effect a complete solution of existing deficiencies and as the Guillebaud Committee recognised in paragraph 652 of their report the problems of both the hospital and local authorities in providing more accommodation for the aged sick or infirm, and the necessary staff to man it, can only be resolved over a considerable period of time. These problems can only be considered area by area and the Minister is confident that hospital boards and local authorities will realise the need to keep in touch, not merely on transfers but on their wider plans to provide additional accommodation or services. In some places it has been found helpful for the hospital geriatric physician also to hold a joint appointment with the local authority in which he acts, where necessary, as their medical assessor on applications for admission to Part III homes and can facilitate transfers as desirable between the residential homes and the hospitals in the area.

9. The ambulance service will play an essential part in moving old people between home and hospital and hospital authorities have in particular been asked to consult with local health authorities when making their plans for extended out-patient or day-hospital facilities.

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10. It will be appreciated that the importance which has been attached in preceding remarks to good liaison between hospital and local authorities and to free interchange of cases does not in any way imply that all admissions to Part III accommodation should be via the geriatric units or medically controlled. Many, perhaps the majority of, admissions to care and attention accommodation will be governed by social reasons. A medical assessment should, however, be obtained where this seems to offer a possibility of effecting some improvement in an elderly person's condition. Local authorities will scarcely need to be reminded of the importance of keeping in touch, by regular visiting, with all old people on the waiting list for admission to homes so that their needs can be reviewed at frequent intervals.

11. The survey brought out the great value, for chronically ill or infirm old people, of a short stay in hospital or Part III accommodation as appropriate, as a means of giving the relatives with whom they normally reside a rest or holiday break and the old people themselves a change of environment and routine. The Minister hopes that both hospital authorities and local authorities will extend their arrangements in this direction as freely as their commitments allow. Experience in areas in which they have been tried shows that they are greatly appreciated and that they may prevent a complete breakdown of the arrangements for looking after the old people at home, which would result in their needing long term care.

12. It is often necessary for the hospital (geriatric) almoner, in association with the geriatric physician, to obtain an assessment of the social need for admission of a patient to hospital. In some areas domiciliary visitors of the local authority (e.g. a health visitor or a social worker) are used to provide reports on the home circumstances on which this assessment is based. These officers in many cases have previous experience and knowledge of the person concerned, and it appears to the Minister that the local authority domiciliary services can when they are used in this way make a valuable contribution towards getting elderly persons who need hospital treatment admitted in the right order of priority. He strongly recommends arrangements on these lines to the consideration of other local authorities, in conjunction with the hospitals concerned and the doctors in general practice in the area. In a few areas one of the authority's health visitors has been specifically attached part-time to a hospital geriatric department for the purpose of providing this social assessment of applicants for admission, an arrangement which appears to the Minister to have much to commend it. Whether general or specialised local authority visiting officers are engaged in this work it is clearly essential that there should be close co-operation and understanding between them and the local general practitioner.

13. Another point which was brought out by the survey and to which the attention of hospitals has been drawn is the importance of their notifying (with the consent of the patient) medical officers of health in good time before discharging patients, particularly those living alone who will require help if they are to carry on satisfactorily on first returning home, so that any requisite domiciliary services may be laid on at once. In areas in which one of the local authority's health visitors has been specially associated with the hospital, it has been found convenient for her to act also as the liaison officer for this purpose.

14. As regards the domiciliary health services, the survey indicates that in most areas they are adequate though, in general, under heavy pressure but that in some areas they are too thinly spread to provide an adequate standard of service. The Minister hopes that, as financial and other circumstances permit, deficiencies will be made good where they exist. It must be borne in mind that these services prevent a heavier burden being thrown on more expensive residential services. In this connection the Minister would invite the attention of local authorities to the analysis of the hospital population on a night in 1951 as set out in paragraph 84 of Part I of the Guillebaud Report, and in particular to the statements that "For all types of hospital and in relation to their numbers in the total adult population, the single, widowed and divorced make about double the demand on hospital accommodation compared with married people" and "about two-thirds of all the hospital beds in the country occupied by those over 65 are taken by the single, widowed and divorced". The significance of these statements as an indication of the need for strengthening the domiciliary services for the elderly, particularly those who are solitary, will not be lost. Authorities will no doubt wish to consider how far they can through these services prevent or delay the onset of infirmities by arranging for aging persons to be visited and given suitable advice.

15. As authorities will know there has been in the last few years a great increase in the proportion of the time devoted by the home help service to the care of the aged, as the value of the contribution which this service can make to help them to continue to live in their own homes has been increasingly recognised. As the experience of progressive authorities has shown, the value of this service can be still further enhanced if it is imaginatively planned, with due regard, for example, to the times at which the old person most needs assistance (maybe evening attendance) and to the type of help most required which may extend beyond purely domestic help with cleaning and the preparation of meals to such things as friendly guidance in personal matters and, in some cases to help with the toilet and in hygiene. A point which emerges from the survey is the importance of avoiding in the case of the elderly frequent changes of home helps or any interruption in the continuity of the service.

16. The survey reinforced one point which has long been recognised, the great importance of complete co-ordination and integration of all the local authority domiciliary services. In a number of areas the degree of co-ordination achieved still leaves much to be desired. The Minister hopes that local authorities will continue to address themselves to this problem which experience in many areas has shown can be successfully solved where there is willingness to find the right solution. It is frequently a matter of securing right departmental and personal relationships, no more and no less.

17. The survey did not touch directly on voluntary services but one conclusion to be drawn from it is the need to use to the full all available voluntary effort. Only if such resources are properly utilised to supplement the work done through official channels can all old people requiring help be provided with a service which it would be beyond the capacity of statutory officers, whether health visitors or welfare officers, alone to provide. In particular, experience has confirmed the great importance of an effective voluntary home visiting service as a contribution to the well-being of old people. The Minister

therefore urges authorities to consider whether in many areas the time is not ripe for renewed contact between themselves and voluntary bodies working in the area with a view to further encouragement of voluntary help and efforts on the lines laid down in Circular 11/50.

18. As the Council know, the Minister of Housing and Local Government has issued a circular (No. 18/57 dated 18th March, 1957) reminding housing authorities of the importance of making adequate provision for the special requirements of old people. The Minister is sure that local health authorities for their part will be quick to appreciate the valuable work which good domiciliary services supplied through them can do as a support to action taken by the housing authorities in this direction.

19. The Minister will be grateful if local authorities will as opportunity serves review their services in the light of the observations he has offered to make sure, as he knows would be their wish, that they are making the maximum possible contribution towards meeting the needs of the chronic sick and infirm.

20. A copy of this circular is enclosed for the Council's Chief Welfare Officer. A copy has been sent separately to the Medical Officer of Health.

21. Correspondence from authorities in Wales and Monmouthshire in regard to this Circular should be addressed to The Chairman, Welsh Board of Health, Cathays Park, Cardiff.

I am Sir,

Your obedient Servant,

J. W. Williams

(85692r) Wt. 8055—1817 8700 10/57 D.L./372