TITLE

Client/Patient Need at the Interface between Health and Social Services on Discharge from an Acute General Hospital.

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Thesis submitted to the University of Nottingham
for the Degree of Doctor of Philosophy, August 1997.

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Client/Patient Need at the Interface between Health and Social Services on Discharge from an Acute General Hospital.

ABSTRACT.

One thousand four hundred and twenty two patients in an Acute General Hospital in Mansfield were studied over a one year period, 1989-90, in order to determine their needs for formal and informal care on discharge.

The research method included a screening project for 189 patients on admission, an analysis of 1064 referrals to the Hospital Social Workers, and 169 referrals to the Hospital Discharge Scheme for Volunteer support.

Patient/client needs for formal and informal care were found, and unmet needs after Hospital discharge were identified.

Problems relating to formal care systems and shortage of Public Sector resources were found to cause serious difficulties for patients and Carers. The availability of Carers and lack of family members in informal care structures was a key issue.

The work showed how Volunteers from the Discharge Scheme were able to contribute to the work of formal and informal Carers and ensure that safe Hospital Discharges occurred for very vulnerable people.

PREFACE

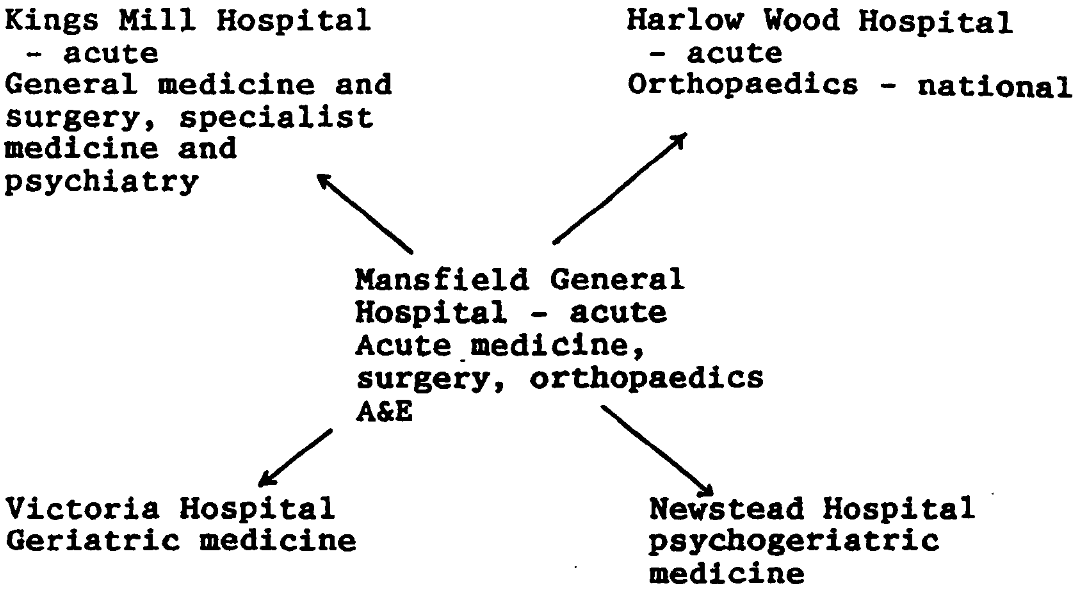
The setting for this research

The research base for this thesis was Mansfield General Hospital, which provided acute services for medicine, surgery, orthopaedics and accidents and emergencies. The patients were mostly adults, since specialist medicine, including paediatrics, was based at other hospitals within the Central Nottinghamshire Health Authority.

The General Hospital was the primary receiver of unplanned admissions for the Health Authority. It had only a total of 250 acute beds, and could not contain and treat all patients who required admission. It operated a week-about intake rota with Kings Mill Acute Hospital. Some patients who needed longer term treatment, from geriatric and psychiatric medicine were transferred to other hospitals within the Health Authority once their acute medical/surgical needs had been met.

Fig 1 shows the hospitals within the Authority, and their functions, by way of explanation.

Fig 1. The hospital group within the Central Nottinghamshire Health Authority



Mansfield General Hospital was the main entrance route for acute hospital patients. These were mostly unplanned admissions through the Accident and Emergency Department.

The Health Authority catchment area was covered by three Social Services Departments which were mostly co-terminous with the Health Authority boundary. Where they were not, patients from Derbyshire and up to seven other Social Services areas were admitted to the hospitals in the group, in much smaller numbers.

The majority of patients came from Mansfield, Ashfield and the surrounding towns and villages. The area was mostly rural, and its main sources of employment were through the mining industry, textiles and ancilliary businesses. At times, unemployment had risen to 19% and many families had become used to periods of poverty as a result.

The total community population serviced by the Health Authority amounted to 210,000 with a small ethnic minority of less than 1%.

Mansfield General Hospital had a patient throughput of some 8,500-9,000 inpatients per year, and average patient stay amounted to 5 days.

The Hospital Social Work Department

The hospital social work department had an allocation of two social work posts, one administrative officer/secretary, and 1/3 of Senior Social Worker time as management.

A Principal Social Worker managed the social workers for all the hospitals in the group, but the staff at each hospital worked as units rather than in teams since they were located at some distance from each other.

In 1986-7 a hospital Discharge Scheme was initiated by the social work unit at Mansfield General. This was innovatory, since the scheme Co-ordinator was actually established as a staff member within the Social Work Unit, unlike most other such schemes which were organised and managed by the voluntary sector and not by the formal Social Services.

The Scheme was a joint funded project, set up for three years in response to the social workers' and hospital staff's perceived need for patient support on discharge from hospital.

In 1988, when the Scheme began, no-one knew how to measure either the volume of patients in need at discharge, or how that need was constructed or characterised.

The Social workers had a basic statistical system of recording their annual referral rate and measured these figures against the hospital's numbers of discharges and deaths. It was clear from these figures that the annual throughput of patients was rising by 5% each year, and the referral rate to social workers increased by the same percentage.

The Social Services management had no interest in these statistics, and social workers were under intense pressure to keep up with increasing workloads. They were very worried about the safety of some patients when they were discharged, fearing that their needs had not been properly assessed. They had no idea about the outcome of their discharge planning processes, except by random information from patients and relatives who rang them post-discharge complaining that services had not arrived, or that relatives could not cope.

Some patients were observed as rapid re-admissions to the hospital, and there were occasionally disputes among staff about their unmet social needs which seemed to be an underlying causative factor.

In professional terms, it was very difficult to make sense of day-to-day practice. This was a common experience among other social workers in the hospital group.

When the opportunity arose for research into client/patient need at the General Hospital, the social workers and the Discharge Scheme Co-ordinator were eager to participate and contribute to the research process.

They felt, in common with their senior social worker who was conducting the research, that a needs baseline for patients who were being discharged from hospital was urgently required in order that a constructive, measurable response could become part of their working situation.

Many hospital staff, especially nurses and geriatricians who referred patients to the social workers had similar concerns. These were framed through their views of risky discharges, and lack of social work support on demand and on time. The hospital staff were therefore supportive, at least in principle, to a research initiative which addressed the whole discharge process.

It is important to indicate, at this early stage of the thesis, that the social work unit was not typical of all such Social Services hospital departments. Its special characteristics were:-

1) That a measuring device for workload and management was in situ (already stated).

2) The social workers, including the senior, were able to see all patients referred unless they were moved from the hospital very quickly or died. Thus all patients who were discharged home or to residential care were assessed. The workers achieved their aims by working unpaid overtime and by doing recording at home. The senior social worker covered caseloads herself when staff were on leave or sick, and caseload handovers were always effected between workers.

3) Working relationships between social work and hospital staff had been built over a period of more than three years. The hospital was quite small, and staff were well known to each other. Most non-medical staff lived in the surrounding area, and there was a great deal of cultural commonality, dialect, use of language and original working class status.

4) The senior social worker was trained both in social work and nursing, and medical terminology, diagnosis and understanding of prognoses was not a problem. Her dual training provided status with other staff.

5) Some staff training with the local School of Nursing helped with good multidisciplinary relationships and at least a preparatory understanding of social problems in the ward setting.

6) The hospital managers were very sociable with the Social Work Department staff. Confidence was built not only by time and good practice, but quite simply because the social workers found answers to many problems and conflicts, especially with patients' relatives, when others failed.

The hospital staff, including managers, came to the social workers for advice, personal support, and information. On occasions, counselling was requested by hospital staff members.

7) The open relationship between the hospital managers and the senior social worker ensured that accountability for problematic situations was shared and owned appropriately on most occasions. This relationship added to a culture of reasonable co-operation and respect among subordinate staff.

Overall, the hospital was a friendly, busy place and very much part of its local community. A high level of trust existed between many members of staff and supportive working relationships were both valued and respected.

Each of the six main wards had a basically similar method of working, although differences in practice, for example recording on patient records, did exist. These differences appeared to be accepted but sometimes created problems with reference to exchange of information and discharge planning.

The Framework for this thesis

This thesis is entitled 'Patient/Client need on Discharge from Hospital'. It aims to address the complex issues which surround a person as a patient who is leaving hospital, as a client or service user in relation to the formal hospital and community-based Social Services, and as an individual who is part of family and neighbourhood systems in a community setting.

Every person, in the course of their lifetime may be admitted to hospital, and unless death intervenes, will experience a hospital discharge. Anyone might become a formal Social Services user for a short or extended period of time, and we all participate in and move among social groups of many kinds during our life experience.

The individual person, as a patient or client is at the centre of concern. The Health Service exists in order to treat patients and cure ill-health. Without patients, there would be no need for hospital or the beds which they occupy during treatment.

Similarly, formal care structures exist in the community to meet the needs of clients or service users to remain in their own homes for as long as possible by maintaining their independence with a quality of life and lifestyle which they prefer.

The voluntary sector occupies an important position in relation to both Health and Social Services through its dual role of lobbying for better care provision, and by providing its own structure of support to community groups and individuals with social needs.

Informal care - provided mostly by family members and to a lesser extent by friends and neighbours, is the main platform on which care needs rest. It is the major source of care for all members of society during their life stages from birth to death. Those individuals who become entirely dislocated from such care may encounter serious social disadvantages and even become members of an underclass which is characterized by personal and social dependency on others (non-family) deviance and social disturbance.

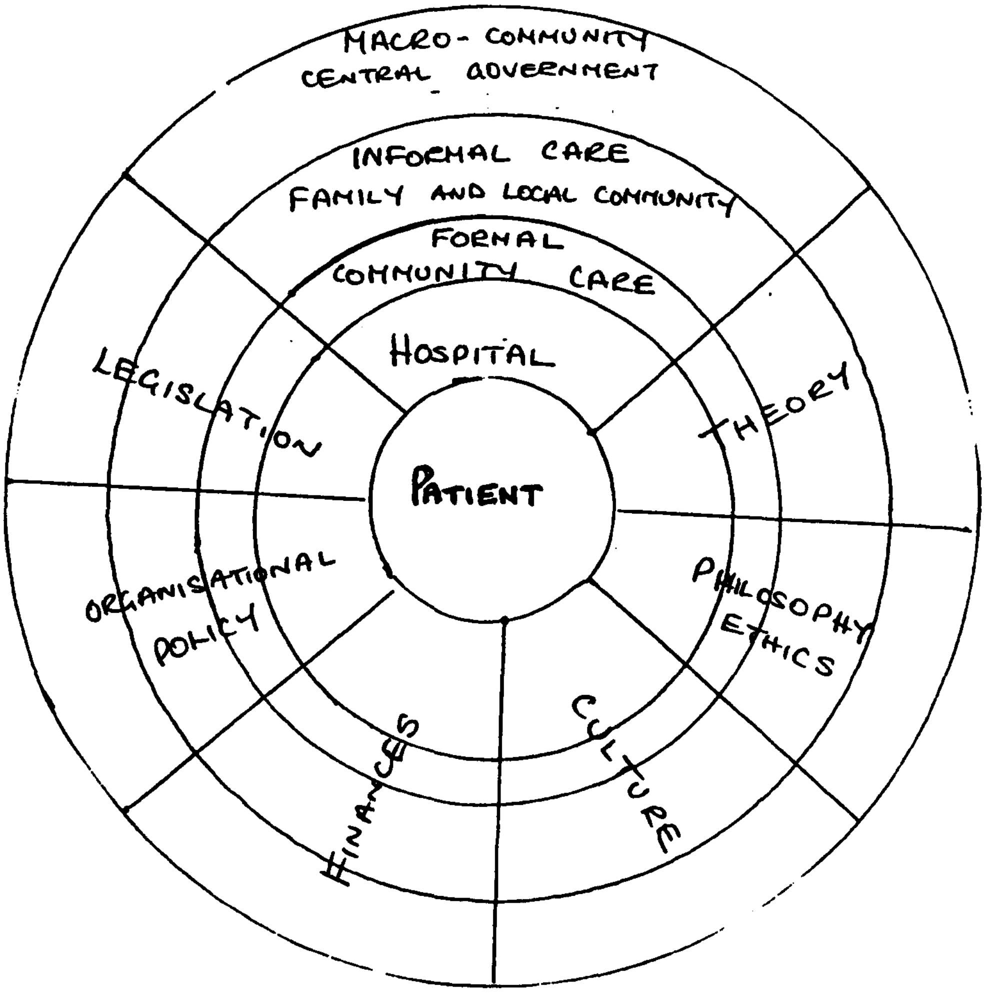
When a person is admitted to hospital, depending on the complexity of health and social needs which s/he has at that time, and increased needs which develop during hospitalization until discharge, some or all of the existing care structures, both formal and informal, may have to be brought together to meet those needs.

The person/patient/client identity is subjected not only to the three major structures of care so far described, but is also embedded in a wide range of policies, practices and theories which are integral to their operations both separately and jointly. A further level of influence also prevails through the interpretation of these by the people who control the systems of care such as doctors, managers and workers with varying levels of skill.

The individual being discharged from a hospital may have little knowledge of these aspects of her/his environment, nevertheless they will determine the success or failure of the transition from hospital to community in the short-term and possibly for an extended period after that.

Figure 2 is used to illustrate the patient in hospital, surrounded by the complex structures which influence the quantity and quality of care required and available.

Fig 2. Diagram to show a patient's position in hospital, in the context of Health and Community Care processes



Although the patient is shown centrally in this diagram, it does not follow that the patient's needs and interests are also at the centre of operations, structures or policies surrounding her/him, or that the various care organisations are adequately linked together to provide a consistent and effective process of care.

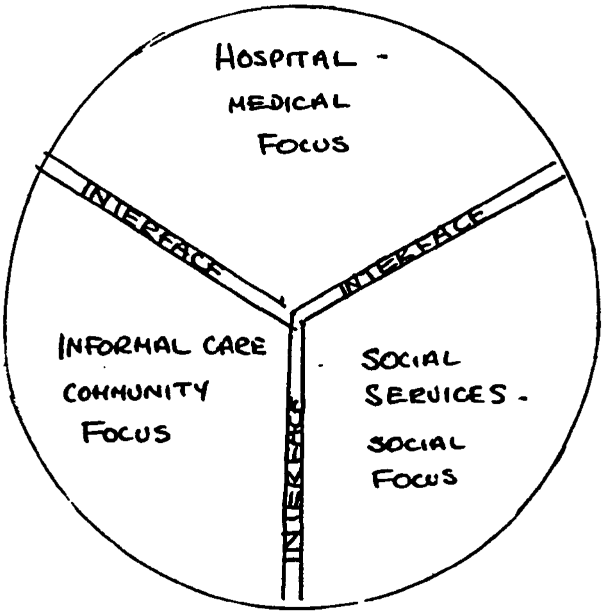
A recent report from the King's Fund Institute (Marks, 1994) states: 'Concerns over the discontinuities of care across hospital and community services has characterized the NHS since its inception, and is reflected in current debates over how best to achieve seamfree - seamless - care'

'Discontinuity of care' is a key issue for this thesis. It is interpreted as unmet or only partially met need, as a person changes status on discharge from hospital. The areas of need may be medical, relating directly to health service responsibility, or social, as in the context of formal social services, the voluntary sector or informal family care.

The point is made already that three care structures exist, and may be brought together to meet needs. It is helpful to use the concept of 'interfacing' to emphasise that each of the structures is confined by boundaries which encompass the limits of their operations and responsibilities, as well as their differences in functions and purpose.

Fig 3 is used to clarify the interfacing boundaries.

Fig 3. Diagram to show the boundaries and interfacing of the three care structures.



It is important for professionals working within the care structures of health and social services to focus principally on the responsibilities of their own areas of care. It is also important for each to understand the support systems for dependent patients or clients which the other provides. This is particularly so when patients/clients are dependent on both for a safe return home from hospital and have to cross the care boundaries in the process. If patients are also dependent on informal carers, then both hospital and social services staff also need to look at this structure of care, its availability and safety, in order to maximise the outcomes of formal care.

Clearly, there are varying degrees of interdependency among the three care structures. If this were a static situation, no doubt, in time everyone would come to know and appreciate the roles and responsibilities belonging to each. But it is not so, because each structure is constantly in a state of change, be that medical or social evolution due to technology, epidemiology or demography.

Monitoring of states of change is not easy. To concurrently monitor all the changes in three care structures simultaneously and to define their influences on each other is probably impossible.

Nevertheless, given the interdependency of formal and informal care structures in a hospital setting, it is necessary to establish an overview at intervals of the joint outcomes of their care processes, and to evaluate the effects of care systems on individuals and groups.

This thesis attempts to provide such an overview, focussing on the person/patient/client as an individual being admitted to hospital, being treated and assessed, and being discharged home or to some other type of care.

Chapter 1, the introduction to this thesis, is entitled 'Health and Social Factors affecting Client/patient Need on Discharge from Hospital'. In this chapter, the context of 'need' is discussed, followed by an examination of the types of patients who constitute an acute hospital population, and who therefore will be discharged. It goes on to look at the caregivers, both formal and informal who meet their needs, and what happens when the interfaces of care structures meet. Finally, the problem of hospital discharges are considered in the light of research and work which has already been undertaken to resolve such problems.

Chapter 2 describes the research methods which have been used in the study of patients who became a 'hospital population' at Mansfield General Hospital for the period of one year.

There are three chapters of data, both qualitative and quantitative which describe patients by age, sex, living accommodation and marital status as a baseline. Each chapter goes on to look at patients from a different perspective, for different reasons, but the overall aim is to cover the situation of need on admission, at discharge, and the aftercare needs of the most vulnerable individuals who were identified. Three separate groups of patients are studied. They were all admitted, and were part of the Mansfield General Hospital population during one year period 1st October 1988 to 30th September 1989.

The first chapter of data, **Chapter** 3 takes a sample of 189 patients at the point of admission to the two medical wards at the hospital. One ward was for women, the other for men. The patients were screened with the following aims:-

- to discover what formal services had been needed before admission
- how the patients were supported informally at home
- which patients would need social work assessment and/or Discharge Scheme support
- whether patients with social needs were being adequately referred by nursing staff
- whether there were areas of unmet need which should be addressed.

The second chapter of data, **Chapter 4**, is an analysis of 1064 patients who were referred to the hospital social workers during the one year period of research. The patients are categorised into specific groups to provide a focus on particular areas of need, for example, those who were abused elderly people, or had attempted self harm.

Patients' needs for formal care are shown quantitatively, their informal care structures are examined, and any involvement with voluntary sector organisations are recorded.

This chapter aims to look at formal care needs for patients leaving hospital, and the environment in which hospital social workers operate. These workers are the means by which patients' formal social care needs are met. They have a key role in ensuring that people return home to a safe care network where formal care supplements and supports informal care structures in the community.

Their role, although it is very important for patient/client safety, is controversial and difficult because it spans the major structural boundaries of the NHS and Social Services. It is subjected to influences from both organisations, and any changes which take place within either or both.

The social work role is discussed at some length in relation to patient/client need.

The third chapter of data, **Chapter 5**, focusses on the referrals made to the Hospital Discharge Scheme. During the one year period 169 patients were referred for volunteer support on discharge, by the social workers. They were considered as people who might be at risk because formal and informal structures did not appear to meet their needs for safety and support following hopitalization.
The Discharge Scheme volunteers became part of their safety network on discharge. They acted as a bridge between the structures of formal and informal care, and were able to provide a flexible support system for variable lengths of time based on actual post-discharge needs.
The volunteers supplied their Co-ordinator with information about the patients and carers whom they helped, this provided an aftercare picture of the person/client/patient reality following hospitalization.

Finally, **Chapter 6** provides a conclusion to the thesis. It discusses the client/patient needs both met and unmet, which emerged during the period of study, and the influences which prevailed to create safe or unsafe hospital discharge. There are also discussions about some ways of improving the systems of care in future in the context of the Community Care Act 1990

To summarise, this thesis aims to address a range of issues and questions, as follows:-

- are patient/client needs identified and met by Health and Social Services professionals?
- are formal and informal care structures linked together effectively to provide a safe and adequate transition from hospital to home
- do informal care structures meet care needs in the community as they are expected to, and is there a valid role and need for volunteers in the existing structures of care, and how should this be developed?
- is a seamless pattern of care possible?

Chapter 1

Health and Social Factors affecting Client/Patient need on Discharge from Hospital.

Chapter 1 is used to discuss four key issues, in the context of practical, political, historical and theoretical perspectives, which affect client/patient need on discharge from hospital. The chapter is in three parts, which are entitled:-

1) The contextual meaning of client/patient need and the Hospital Population.
2) The situation of caregivers who meet client/patient need - what happens at the interfaces of formal and informal care?
3) The problems of achieving seamless care when patients are discharged from hospital.

Part 1 The Contextual meaning of client/patient need and the Hospital Population.

Introduction

Need is a condition of affairs placing one in difficulty or distress: a matter requiring action to be taken (Oxford English Dictionary, 1988).

Client/patient need is both complex and difficult to define, because the people who become patients in an acute hospital such as Mansfield General, are not an homogeneous group. They are men and women of different ages, cultures, religious and social backgrounds. They may live within a relatively small geographical area, but this could be in town or village or even as homeless persons, with or without partners or family members to care for them. Collectively they have varying degrees of independence/dependency in their daily lives, relative to their living conditions, income, personal abilities and social networks. A proportion of the patients will undoubtedly have acquired the label of "client" or "service user", in relation to their need for formal Social Services support, before their admission to hospital, but many others will not have, and probably never will need to ask for help in this way.

Similarly, some patients on admission will be entering the Health Service system for the first time, whilst others will have experienced degrees of ill health, requiring treatment from general practitioners and Community Health staff over variable periods of time. The only common factor which all people share on admission to hospital is that of their health related needs, according to doctors, cannot be met in the community through medical services, by their families or by self-care methods.

At the point of admission they present with a wide range of needs for medical or surgical intervention, depending on their illnesses or traumas, and this is the beginning of an unusual experience in a specialized environment. Hospitalization represents a situation where a person - now a patient- is dissociated from previous sources of social identification, isolated from usual forms of community support and independent decision making, and has most areas of personal power removed as she or he becomes subject to medical processing by hospital staff.

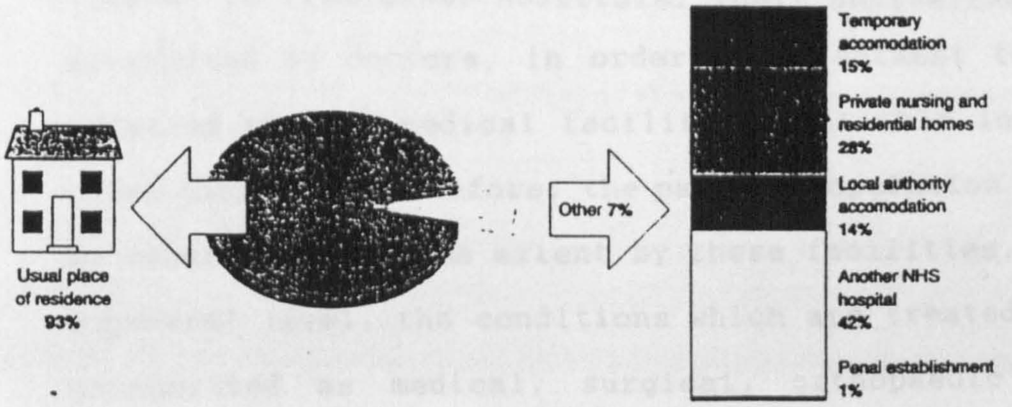
At the end of the process patients wish to be discharged home in an improved state of health, hopefully to enjoy an independent and pain-free lifestyle. This is compatible with the objectives of doctors, nurses and hospital managers who are responsible for their care, and who, through the use of expensive hospital resources aim to treat and cure illness as quickly and effectively as possible.

The outcomes of hospitalization, however, are not the same for all patients. Many are restored to good health on a permanent basis, but others only improve for a short period of time and need re-admission to hospital (Scottish Health Service, 1993; Coppeard, 1990) for further treatment which may or may not be interspersed by health and social care in the community.

According to the Audit Commission Analysis (OPCS, 1991), less than 10% of all surviving patients do not return to their own homes. 93% do go back to their usual place of residence, where they are either self-supporting or need help from others to manage their daily lives.

The 7% who do not go home are made up of those who go on to another hospital for further care and treatment, and those who need to move on - or be moved on - to another residence in the community. A breakdown of their destinations is shown in Fig 4, below.

THE DESTINATION ON DISCHARGE OF GENERAL MEDICAL AND GERIATRIC PATIENTS, ENGLAND (1989-90)
Fewer than ten per cent of patients discharged from hospital do not return to their usual place of residence



Source: Audit Commission analysis of data from Regional Hospital Episode statistics supplied via OPCS (1991)

There is no evidence that these changes of destination are planned in any way as an outcome of hospitalization. The move or transfer to another hospital is based on the need for more specialised care as a rule, and as the result of medical assessment. The other destinations, to residential/nursing home care, temporary accommodation, and penal establishments indicate a need involving social change, be that temporary or permanent, which affects both patients and their families.

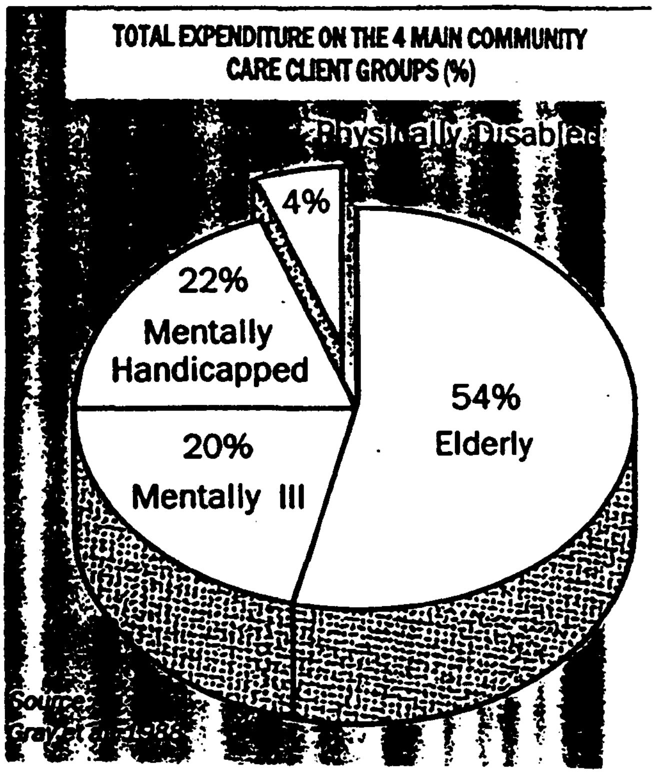
1.1 The hospital population

Patients are admitted to acute hospitals from the community, from all types of residential care and by transfer in from other hospitals. Their admissions are determined by doctors, in order for treatment to be effected through medical facilities available in any given hospital, therefore, the patient population will be determined to some extent by these facilities. At a general level, the conditions which are treated are categorised as medical, surgical, orthopaedic and emergencies.

The population of acute hospitals do not represent a comparative cross section of people in the community, by age, sex or social circumstances, and particular groups of people are much more likely to be admitted than others.

1.2 Older people and Hospital Admissions

The predominant group among all patients consists of people over the age of 65 years. Currently, around 50% of all available hospital beds are occupied at any one time by older people, (Neill and Williams, 1992). Ill-health and functional disability affects people in all age groups, but these are more prevalent among older people, predisposing them to the need for Health and Social Care within hospital and the community. A conference report on Health Care in Old Age (Smith, 1988) showed that around 79% of all people aged over 65 years had some form of contact with the NHS over a 12 month period, and (Gray, 1988) estimated that 54% of District Health Authority budgets were spent on care for elderly people. (See Fig 5)



TOTAL EXPENDITURE ON THE 4 MAIN COMMUNITY CARE CLIENT GROUPS (%)

Figure. 5

PER CAPITA EXPENDITURE FROM ALL SOURCES ON ALL TYPES OF PRIVISION, BY DHA AND CLIENT GROUP (1985–6)

	Elderly £	Mentally Ill £	Mentally Hand/cppd £	Physically Disabled £	All £
District 1	72	14	10	5	100
District 2	71	41	21	7	140
District 3	72	10	17	6	106
District 4	49	61	54	8	172
District 5	63	30	64	4	162
District 6	60	25	23	5	112
6 District Average	66	24	27	5	123

Source: Gray et al., 1988

This does not mean that older people are an homogeneous group, in spite of stereotypical views that they are usually ill or dependent. Although some 80% do have at least one chronic disease or disability, most are living independently and manage their health care without extensive medical or Social Services intervention. (Stone 1986). Research in the United States reveals that it is in fact a small subset of the older population who are heavy users of medical care (Brotman 1982, Roos, Shapiro and Roos

1984), both in hospital and the community. Advanced age is one of the strongest predictors of health care and social needs (Eisdorfer, Mullner and Cohen 1989), as those aged over 75 years have a higher rate of illness, fall more, and are more likely to be mentally confused. (Tinker 1984). This much older group of people, with their health needs, which increase with age, are likely to exert the greatest pressure for use of acute hospital beds.

Two issues affect this situation. The first is that more people need health care as the general population increases, and this includes old and very old people. The second is that people are generally living longer, due to better health care, living environments and employment facilities.

The numbers of people in the population are rising steadily and have been since the seventeenth century. At that time they numbered under 5 million, by 1800 the figures had risen to just over 10 million, to 25 million by 1900, and are set to reach almost 50 million by the year 2000. (McKeown 1976).

The numbers of older people have risen within the population also, and there is a trend of great significance among those aged over 75 years. Table 1 shows that people of 85 plus years will have increased by almost 90% between 1981 and 2001.

Table 1 The Elderly Population 1981-2001.

Great Britain

	1981	1991	2001	1981-2001 % of change
Total population (thousands) aged:				
65-69	2,667	2,718	2,398	-10.1
70-74	2,265	2,233	2,176	- 3.9
75-79	1,601	1,793	1,825	+14.0
80-84	900	1,208	1,210	+34.4
85+	552	843	1,047	+89.7

Source:
OPCS 1983, table 1; 1989 based projection for the home population mid year as in OPCS 1984, appendix table 1.

Whilst the absolute numbers of elderly people have increased, the age structures within the aged section of the population have changed. Between 1901 and 1981 the proportion of men increased by a factor of 2.78, but the proportion of those aged over 75 increased by a factor of 3.37.

Among women aged over 65, the factorial increase was 3.48, and for those aged over 75 it was 5.00. Therefore, both the numbers of old and very old people have increased with women constituting a higher proportion of both. (Parker 1990).

While men and women over the age of 65 enjoy roughly the same number of active years, and they die from fundamentally the same causes, there is striking evidence of women's greater burden from non-fatal disease, and men's from fatal diseases. (Arber and Ginn 1991). An increasingly higher proportion of women become disabled as they age, and the gap widens for those suffering from severe disability. Above the age of 80, twice as many women are likely to be badly disabled as men.

Mental health statistics also show gender differences, with approximately twice the number of all women, compared with men, suffering from depression and anxiety, and more suffering from dementia. The incidence for dementia increases with age to 25% for those over 80 years.

Osteoporosis is a particular problem for older women, affecting one in four women as opposed to one in forty men, because of its acceleration due to oestrogen loss after the menopause. This leads to an increased risk of fractures and associated mortality. Some 25% of older women die as a result of hip fractures, whilst many others never regain their mobility. (Henwood 1990).

Because older people are much more likely to be suffering from chronic illness and disability they are also more likely to be receiving medication which has been prescribed by GPs and in the course of hospitalization.

Older people may suffer serious side effects as a result of the number and combination of drugs which they are prescribed, and older women are more prone to this than men. It has been found that one in ten admissions of older people to geriatric and medical wards is due to disease caused by the effects of medication. (Parrsh et al. 1983). Inappropriate prescriptions and incorrect use of drugs may result in falls and poisoning, and the consequences of the former are particularly serious for older women whose bones are more brittle than men's. Overall, more older women than men are likely to be admitted to acute hospital wards.

Social factors affecting Health among Older People

1.2.1

It is not only health conditions and the physical effects of ageing which predispose older people to the need for hospital admission and community health care. Their needs are compounded by social and environmental factors also, including accommodation, economic situations and care support systems on which they rely, in order to keep their independence at home, and choice of lifestyle.

Living alone

A social factor which affects older people in particular, is the situation of living alone. The number of one person households increased in Great Britain from 12% in 1961, to 26% in 1988. (Social Trends 1990). The majority of these are older people, but more are elderly women. In 1986, 20% of men aged 65 and over lived alone, compared with 48% of women. Table 2 shows the percentages of elderly people and their types of household, including living alone. (GHS 1986)

Table 2 **Elderly people in private households by sex, age and type of household. Great Britain 1986 (percentages)**

Household type	Males						Females					
	All 65+	65-69	70-74	75-79	80-84	85+	All 65+	65-69	70-74	75-79	80-84	85+
With spouse												
and others	11	16	9	6	7	7	5	7	5	2	2	4
no others	62	65	65	65	50	38	33	50	39	28	13	8
Total with spouse	73	81	74	71	57	45	38	57	44	30	15	12
Without spouse but with:												
children/children-in-law	3	2	2	5	4	15	9	5	6	8	16	23
siblings	2	2	1	2	2	3	3	3	3	5	4	2
others	2	2	1	1	3	0	2	2	2	2	2	2
Total without spouse/ with others	7	4	4	8	9	18	14	10	11	15	22	27
Living alone	20	13	21	21	34	37	48	33	45	55	62	61

Source: General Household Survey 1986, table 12.2.

The key reason for the larger proportion of women living alone is that they have a greater longevity than men, and, therefore, outlive their partners during a prolonged period of widowhood. Four fifths of women aged over 70 are widowed compared to only one fifth of men in the same age group. Living alone has become a major problem because of the accompanying circumstances of isolation, loneliness and lack of family support. As a result, there are increased social and mental problems among elderly people, and especially among older women. (Bornat, Phillipson and Ward 1985)

Also relevant to the circumstances of living alone, is the fact that women are more likely than men to have to move into residential care. This increases with age and is largely because more older women are disabled and live alone. (National Women's Commission 1992).

Table 3 shows the percentages of women and men in residential care.

Table 3 PERCENTAGE OF WOMEN AND MEN RESIDENT IN COMMUNAL ESTABLISHMENTS BY AGE

Age groups	Women	Men	Sex ratio (F/M)
65-69	1.02	1.19	0.86
70-74	1.85	1.64	1.13
75-79	4.01	2.85	1.41
80-84	8.69	5.54	1.57
85+	20.27	12.20	1.66
All 65+	4.58	2.47	1.85

Source: S Arber and J Ginn and Later Life, a sociological analysis of resources and constraints, 1991

Derived from OPCS, 1983

Home Occupancy and Tenure

Some 95% of older people live in their own homes, and nationally around 56% are home-owners. In 1951. 4 million people in Britain owned their own homes, and this rose 14 million in 1985. (Social Trends, 1987); with a proportional reduction in the stock of public sector housing available for rent. This has resulted in a concentration of older people in council-owned accommodation, which is often the least desirable.

Older people who own their homes are not necessarily better off than others, because of the struggle to pay for maintenance and repairs. Older women in particular are most likely to live in substandard housing, and lack financial resources to either make improvements, or move.

Recent research concluded that successive English House Condition Surveys by the Department of the Environment (1983:1988) have shown that older people live in properties which lack basic amenities, are unfit, or are in disrepair. This is particularly true of owner occupied property and private rented accommodation. Given the number of older women living alone within both these types of property, this statement causes alarm. (Peace 1993).

With regard to men and health, housing tenure proves to be a powerful tool for determining life chances. The mortality of male home-owners is substantially below that of those who rent their homes, and this is so within each of the social classes from 1-5. (OPCS 1982)

Appropriate housing facilities, or lack of them in many instances are fundamental to both the health and social welfare of older people, and relative to needs regarding care.

Poverty and Social Deprivation

A number of studies have consistently shown that there are correlations between ageing, disability and health care needs, and poverty. (Disability Alliance 1975). Severely disabled people are more likely to live in poverty, with low incomes, likely to have little or no savings, and to suffer more from social isolation.

Henwood and Wicks (1984) found that there was a strong association between advanced years and poverty, particularly among working class elderly people and especially women. Their community living circumstances - referring back to the previous section of this chapter - were worsened by poor housing and inadequate heating. These in turn exacerbated deteriorating health and degrees of disability. Qureshi and Walker (1989) showed in their study of families and older people in Sheffield that more than five times as many people aged 85 and over were classified as severely disabled, compared with those aged 75-79. Because of the age distribution of disability, women were more likely than men to suffer from disablement, especially severe disablement.

Their living conditions were relative to their ability to pay for adequate heating and food, which in turn related to problems of dependency on low incomes, and state pensions. The fact that older people have to struggle to afford the costs of adequate heating has been an issue of great concern for some time, in the context of health and social care needs. The fuel problems of older people are different from those of other low income groups. They rarely suffer from fuel debt, and are rarely disconnected. They are much more likely to put money by, and/or cut down on fuel consumption in order to avoid receiving a bill they cannot pay, and this has some disturbing results. (Help the Aged 1984-5). On average, pensioners spend less on fuel in winter than other households in the summer, and single pensioners, the majority of whom are women, spend up to 30% less on fuel than the average household.

The outcome of inadequate heating is that risks to health are increased in the form of chest infections, added pain and stiffness among people with orthopaedic conditions, anxiety and depression, and hypothermia. Around 55% of pensioner households have been found to have living room temperatures below 16°C in the morning (the minimum temperature at which people in employment can refuse to work), around half do not heat their bedrooms at all, and up to 10% can be considered at risk of hypothermia. As a consequence, especially in harsh winters, the number of people at risk remain high - probably around 850,000 elderly people. (Bornat, Phillipson and Ward, 1985)

The problems of low income extends into other areas of life in the form of cheap diets and poor nutrition, the difficulty of affording dentures and spectacles for older people with low occupational pensions, the cost of clothing and replacement of household items - and difficulty in affording a reasonable involvement in leisure activities.

This concentration of economic disadvantage can often be traced back to an earlier lack of access to well paid jobs, difficulties in building up pension rights, inadequate health care, unemployment, especially among working class people, and discrimination. An inadequate income in old age results in a life lacking in quality, choice and independence. (CAP 1987).

Once again, women are affected in more instances than men. Only 17% of women retire on full, basic state pension, and a average women's retirement income is much lower than men's. (EOC 1992). Lone, elderly women are the poorest, with 49% having incomes just above the poverty line compared with 36% of lone elderly men. (GHS 1988).

All of these social and economic factors provide indications for the population of patients in Acute Hospitals. There are likely to be more women than men, with a predominance of women among the old and very old. They are more likely to present not only with health problems which are associated with age and disability, but to also be poorer, to have financial difficulties including access to state benefits, to have housing difficulties, high levels of need for support in their own homes, and to experience loneliness and isolation. People of working class status are likely to be over represented with all types of socially constructed difficulties, which in turn affect their health, life chances and general well-being.

This section of Chapter One has concentrated on older people, attempting to illustrate the inequalities of health and social conditions which affect them. It relates mainly to white people, but also to the minority of black and Asian people who are also aged, and growing in number.

Issues for People of other Cultures

It is very important to consider people from other cultures, not only in the context of being old, and subject to ageist attitudes, but also in the context of attitudes to race, and the comparative outcome of their old age. They can be seen to suffer the effects of double discrimination (Dowd and Bengston, 1978)

Statistics show that black and Asian older people are more likely than other pensioners to depend on supplementary benefits as a prime source of income. A significant number who came to Britain as dependents are not eligible for any state support, and are totally reliant on the goodwill of family relatives. Even for those with relatives, the quality of life may be very limited, and some suffer from feelings of cultural isolation and loneliness (Hill 1991). One study in Birmingham (1981) found that a substantial number of elderly Asian people had no close relatives in Britain, and they were extremely vulnerable.

The Women's National Commission states that Local Authorities rarely have any means of meeting the needs of ethnic minority older women. In London this has led to the establishment of the Asian Sheltered Residential Association which has expertise in meeting the particular needs of different cultures, (Smith 1988), but this type of resource is rarely available, especially outside large city areas.

Hill (1992) commented that African Caribbean and Asian elders in particular are disadvantaged in income, housing, health and access to services, relative to their white counterparts. As members of a minority group they also experience the particular disadvantage of racial discrimination, and their existence is often unrecognised even within their own communities.

Class and gender, as well as race and age, are important dimensions of inequality. Black groups recently have identified the need for an emphasis on "simultaneous oppression", as this avoids the marginalization of their identities and focuses more clearly on the fact that the inequalities faced by black disabled people are shaped by racist, disablest and patriarchal structures at the same time. (Begum 1992: Stuart 1992).

Qualitative research was carried out in the Swindon Health District (1993) to ascertain the views of local ethnic minority populations on the services they received from, and their access to, local health services. The researchers found frustration, even anger among many respondents. They stressed the need for urgent action, which included equal opportunities policies, race awareness training, advocacy, the availability of female doctors, language diversity, consideration of cultural issues and the low take-up of services.

1.3 Non-elderly Acute Hospital Patients

Patients who are aged between 16 and 65 years make up the other half of Acute Hospital populations. Whilst a number of these are admitted to Hospital with the same long-standing chronic illness complaints as their older counterparts, their health conditions are also affected by life situations and environmental/social factors which are more specific to younger age groups.

Main Causes of Death

The BMA Guide to Living with Risk (1990) shows that overall, 85% of people die from three causes, which are, heart disease (48% of all deaths), cancer (25%), and respiratory diseases (11%). Social lifestyle is a significant factor in relation to these illnesses. The first concerns the hazard of smoking, which is the single most self-imposed risk to health. The Royal College of Physicians has estimated that out of 1,000 young men who smoke, 250 will die early because of tobacco consumption. (Gann 1991). Although women have a lower death rate due to smoking related causes, as the number of female smokers increases, their early death rate is also rising.

Smoking is associated with a range of respiratory illness, including bronchitis, asthma, emphysema and chronic obstructive airways disease, not necessarily as the primary cause, but as an aggravating factor which accelerates premature death. As the illnesses progress, and become chronic long before old age, treatment in the community and in hospital is needed, and creates problems relating to employment, family incomes and overall quality of family life, since all family members are affected by the chronic illness of one adult.

Smoking is also related to heart disease and cancer, both of which effect more younger men than women. Lung cancer, and malignancy in other organs, coronary artery disease, myocardial infarcts and strokes emerge as the main causes of death in men from the age of 45 years onwards, and many of those who do not die suddenly are subsequently disabled and prevented from continuing their normal lifestyles.

Diet is the second most important factor in the context of heart disease and cancer. Consumption of high-fat foods, highly processed and refined sugars and carbohydrates, and excessive alcohol are all associated with dangerous levels of cholesterol which cause high blood pressure and arteriosclerosis, and weight gain. The BMA Guide recommends that individuals should take more care of their own health, and in order to minimise any predisposition to heart disease and cancer, that they should stop smoking, reduce alcohol intake, reduce consumption of fats, sugar and salt, take regular exercise and learn to relax, and to eat plenty of fibre.

This advice applies to men, women and children. Poor dietary intake among children at the age of 11 years has been found to cause alarmingly high levels of cholesterol, and indicates that heart disease and its disabling consequences might be set to increase significantly among even younger people.

The major causes of death from cancer among women show a different profile. They are due to cervical and breast cancers, with half of deaths for cervical cancer and 40% of those with breast cancer, occurring among women under the age of 65. In both cases among women aged over 65 years, the early stages of cancer are likely to have begun before the age of 65, and many of the women concerned have not been medically screened, or received smear testing. The Women's Nationwide Cancer Control Campaign recommends that both cervical smear testing and breast screening should be extended to all women aged 50 years and over, in combination with an awareness programme for older women and their GPs. (Women's National Commission 1992).

Patients who are Dying

The populations of Acute Hospitals, for those people under the age of 65, are dominated by patients suffering from heart disease, respiratory disease and cancers. Although more than 80% of their last year of life, when they are actually dying, is spent at home, the majority still die in hospital. (For non-hospital deaths, nursing homes have overtaken own homes as the place of death. (Seale and Cartwright 1994). During the last year of life, repeated readmissions to hospital are needed for treatment, pain control and the relief of distressing symptoms.

Since the 1970's there has been an increase in the number of specialist services for people who are dying from cancer. Initially the concentration was on in-patient care, but now, in addition to 3110 specialist beds in voluntary and NHS settings, and 240 support teams in hospitals, there are 370 home care teams, and more than 200 day hospices supporting people at home. (Hospice Information Service, 1994). More than 200 specialist social workers work alongside health care colleagues.

However, as resources of all kinds have flooded into the care processes of dying cancer patients, there has been increasing concern about those people dying from other conditions - such as heart disease, strokes, Alzheimer's disease and AIDS, who could also benefit from the principles and practice developed from palliative cancer care. The other patients in most instances, have to rely on routinized formal services, informal carers, and voluntary groups, who do not usually have appropriate training to deal with death and dying. The change required is largely in attitude and confidence, but an understanding of common responses to loss and bereavement is important. Speed of response to need is essential when people are dying, and for their carers. They need aids, adaptions and welfare benefits to arrive before - not after the death.

Although death rates in hospital are not publicly available - local CNHA sources show that each year some 500 patients are dead on arrival at Accident and Emergency, and around 6% of all patients admitted actually die in hospital. It is not possible to ascertain how many patients die shortly after discharge, but the Manitoba longitudinal study found that a substantial proportion of older persen's admissions could be attributed to individuals who were about to die, and those amounted to some 35% of all hospital admissions of elderly people. (Ory and Bond, 1989).

Death and dying is, therefore, a very important aspect of hospital care, before admission and after discharge.

The 1992 Government report (HMSO 1992), in recognition of the need of all dying patients, now requires district health authorities to plan for and purchase appropriate care for all their residents, but little evidence of change in service and care availability has so far emerged in most districts.

1.3.1 Suicide and self-harm

The numbers of people who die as a result of suicide has been increasing since the last war, and in many parts of Britain, deliberate self poisoning (attempted suicide) has become the most common reason why women are admitted as emergencies to general hospitals, and the second most common reason (after ischaemic heart disease) for admissions of men. (Hawton and Catalan, 1982). in addition, a survey of general practitioners (Kennedy and Kreitman, 1973) indicated that they might be seeing as many as 30% more cases than those referred to hospital.

The majority of suicides are among males, and have been so since 1901, but over the last few decades the gap in numbers of men and women who have killed themselves has narrowed, and in some English cities, females have been in the majority. (Stengal 1975).

No one single cause or group of causes can be found to account for the level of suicide rates. Many factors are influential at the same time, and positive correlations have been found with a number of personal and social characteristics, which are: male sex: increasing age: widowhood: being single or divorced: childlessness: high density of population: unemployment: social class: economic crisis: alcohol and addictive drug consumption: a broken home in childhood: mental disorder: physical illness.

The average age overall of people who succeed in killing themselves is 55 years, and many are physically ill.

Social class, expressed by grouping of occupations has been found to be an important factor in the UK and elsewhere. The highest suicide rates for people aged 20-64 years has been among professionals, managerial and business occupations (Class 1 and II), classes III and IV have low suicide rates, and the mortality rate for class V is as high as class II. In the USA, the highest suicide rate is found in class V and is related to unemployment and the threat of loss of work among the unskilled working class. (Stengal 1975).

Attempted suicide occurs most often among younger people, and the highest rates for females are found in the age group 15-19 years. As many as 1:100 females of this age in the general population are likely to be referred to General Hospitals each year after taking overdoses or injuring themselves. The highest rates for males occur in the age group 25-29, and amount to 1:200, who may be referred to hospital during any one year. In both sexes, the rates decline substantially in middle age, and are extremely low after the age of 60. (Hawton, and Catalan, 1982).

Far higher rates of attempted suicide occur among those of lower, rather than higher social-economic status, and many people who make attempts, especially men, are unemployed. (Holding, Buglass, Duffy and Krietman 1977).

Approximately 9 out of 10 cases of attempted suicide referred to Acute Hospitals involve self-poisoning, the rest being self-poisoning and self-injury combined. Very often, alcohol is also associated with attempted suicide, and is used more by men than women.

A major problem of attempted suicide is that many people repeat the behaviour, and factors found to characterize such patients are problems in the use of alcohol, personality disorder, a history of previous in-patient or out-patient psychiatric treatment, previous attempts resulting in admission to hospital, and not living with relatives. (Buglass and Horton 1974).

Patients who repeat suicide attempts pose very difficult problems for medical, nursing and psychiatric services in general hospitals. Apart from the expenditure of medical time and resources, the recurrence of patients for the same reasons may antagonise the staff involved in their care, who are likely to feel that their therapeutic efforts have been wasted. At the same time, such patients have an increased risk of suicide, and usually experience serious personal and social problems.

Most people who actually kill themselves are suffering from a psychiatric illness, but this applies only to a minority of those who attempt suicide. However, most instances of self-poisoning or self-injury are preceded by stressful events. Payhel (1975) found in his study that attempted suicide patients had on average experienced four times as many such life events as their general population controls. In particular, they had more serious arguments with their partners; had a new person in their home; serious illness of a family member; serious personal physical illness, and had had to appear in court for an offence.

Sometimes, loss of a partner or rejecting behaviour by a partner or relative, and in some cases, acts of infidelity had occurred.

In addition to stressful life-events, people who attempt suicide are likely to experience chronic problems of some complexity with their marital relationships, boyfriend/girlfriend relationships, sexual relationships, difficulties with their children, financial problems, at work, after an accident or operation, and through alcohol. (Bancroft, Skimshire, Casson, Harvard-Watts and Reynolds, 1977).
Some patients with marital problems were found to have separated shortly before their attempts, and may had experienced some form of recent loss.

Hawton and Catalan found in their Oxford study, that poor physical health and recent general hospital admissions were significant for 22.5% of men and 34% of women. Almost 1 in 5 of the women had recently had accidents, or undergone surgery. There was an association between epilepsy and attempted suicide, with sufferers between 5 and 7 times more commonly represented. Patients with epilepsy were more likely to repeat their attempts.

A different range of chronic problems affected adolescents. The most common was relationship with their parents, especially their fathers; 36% were living with only one parent, and 12% with neither parent. In addition, 12% had been "in care" with Social Services at some time, more than half had problems at school, including both with their school work and in relationships with their teachers. Employment difficulties, including unemployment, were common among those who had left school. Half had difficulties with their girl or boyfriends, and several were socially isolated due to lack of friends.

It is apparent, when considering this group of patients in particular, that whilst medical treatment is the first essential intervention that they need on presentation at hospital, their accompanying needs are equally important in the context of personal, psychological and social support.

1.3.2 Accidental Death and Injuries

Deaths among young people are largely due to accidents. Seventy per cent of deaths in 25 year old men are caused by accidents and violence, in particular accidents on the road, and many are associated with alcohol. All of those involved in accidents - whatever the cause, do not die. A proportion survive, increasingly so as medical technology and improved intensive care facilities in hospitals are available. But some of those people who survive, especially after serious accidents, are disabled for life with varying degrees of severity, from loss of one limb or other organ, to a state of vegetative total dependency on other people's care. Accidentally injured persons are treated in the first instance in Acute Hospitals, some on acute medical and surgical wards and later, in Young Disabled Units or other rehabilitation units with specialist functions, such as Spinal Units or Brain Injury centres.

The outcome for the families of those who are severely disabled following accidents, is serious, it involves a total change from ordinary family life and expectations of achievement and independence, to one of centring on the needs of one disabled person, with dependency on state benefits for income and a changed home environment, parenting responsibilities and loss of life-chances.

In the context of accidents, it is important to include the effects of major disasters, such as motorway pile-ups, fires, floods, bombings and air crashes. These types of disasters are increasingly becoming a focus of concern for all public sector services, and any hospital with an Accident and Emergency Department will from time-to-time receive the victims of such events.

Special contingency plans are needed for the initial crisis, followed by longer-term support structures to enable those involved, their families and members of the community, to cope and recover. (Egan 1990)(Parad 1978). It is important to highlight the longer-term effects of major disasters, in the context of Post Traumatic Stress disorders.

In the 1970's and 1980's, studies were undertaken in the USA and Australia following both natural and technological disasters, to discover what the long-term psychological effects were on bereaved people and survivors. (Tichener, 1988). These studies indicated that from 40-70% of those directly involved experienced psychological stress and impairment during the first month following the disaster, and after one year this dropped to 25-40%. Even after 2 years, 15-20% experienced chronic levels of anxiety. (Raphael, 1986).

The results of post traumatic stress have implications for both general and mental health. Physical reactions include difficulty in sleeping, fatigue, headaches, nausea and above average susceptibility to illness, including admission to hospital.

Psychological reactions include anxiety, phobias, depression, irritability and anger, which in combination lead to difficulties in working, increased dependency on alcohol or drugs, and problems in maintaining normal relationships within families.

It is noted in the supplement to the Nottinghamshire

County Council's Major Emergency Plan (1994), that levels of stress/distress vary with the severity of the disaster, the directness of the experience of the individuals involved and their previous stressful life events. Some groups are particularly vulnerable: people with sensory impairment, with learning difficulties, children, older people, those with physical disabilities and/or psychiatric disorders, those who have been multiply bereaved, and especially those who see themselves as responsible for the disaster. The chronic effects of technological (man-made) disasters are consistently higher than those of natural disasters. Certain physical injuries, particularly burns which are disfiguring or disabling, have negative emotional and psychological effects of considerable durations.

The outcomes of major disasters can be seen overall as very complex, and relative to both health and social needs. For those who survive, and for their families, there are needs for ongoing support from a range of organizations, not just in the short-term, but for a much longer period whilst they recover after the initial crises have been dealt with.

A thorough understanding of the principles and benefits of crisis intervention is required from those professionals who provide services, in order that a baseline of restoration is established, in conjunction with the careful planning of ongoing multi-disciplinary care processes.

1.3.3. Younger people with Severe and Chronic Disabilities

The last group of patients to be discussed in this section of Chapter 1 are those who are younger, chronically sick and severely disabled. Their numbers are small in relation to older disabled people, as shown by the OPCS survey - The Prevalence of Disability among Adults. (HMSO 1988). There are possibly 613,000 adults among all age groups who are severely and very severely disabled, (in severity categories 6-10), living in the community. Approximately one third of these are aged between 16 and 60 years.

The size of this group is increasing, brought about by advances in medical technology, treatment and rehabilitation which have increased the life expectancy for those who previously would not have survived. It is estimated that their numbers could double within the next 20 years. (Zarb 1992).

In the Central Nottinghamshire Health Authority District, a conservative estimate of 905 people who were severely chronically sick and physically disabled was drawn from a survey (1989) conducted by nursing staff in the community. All were current users of health and social services, some were in hospital (Acute and Young Disabled Unit), and all had used the Hospital Service within the previous year. A great deal of concern was expressed about this group of patients because they presented problems in the Acute Hospitals, including Mansfield General, due to bed-blocking and length of stay. Some patients in the Young Disabled Unit, which was funded as part of the

Acute service, had been there for several years. This applied particularly to people with severe head injuries and advanced multiple sclerosis. Clearly a strategy to define and meet their care needs was urgently required, and the survey identified a number of issues that would have to be addressed.

The first was that people in this care group (16-64) had vastly different needs, some of which depended on the nature of the underlying "disabling" conditions, others upon the age of onset and the rapidity of progress of the disease, disorder or injury.

The patients fell into three groups:-

1) Those with congenital and/or birth injuries, such as spina-bifida, hydrocephalus and cerebral palsy.
2) Those with conditions of sudden onset, including strokes with subsequent brain-damage, accidents to the brain and spinal cord causing loss of a limb and severe infections, such as meningitis or encephalitis which damage the central nervous system.

3) Those with progressive conditions affecting the muscles or nervous system, such as muscular dystrophy/atrophy, multiple sclerosis, motor neurone disease, Parkinson's disease, Huntingdon's Chorea and severe epilepsy.

The second issue was that continuity of care was lacking, with inadequately organized multidisciplinary planning and follow-up to treatment. Long term rehabilitation and support was often not available, Early counselling and support for family members was essential but not co-ordinated or available from either Health or Social Services.

These problems were found to be common in other Health Authorities (Owens 1987) and the experiences of severely disabled people in Acute Hospitals (Zarb and Oliver 1993) were described as stressful, frustrating, depressing and painful. Carers needs were not assessed, nursing staff did not have adequate knowledge or skills to deal with patients' needs, and discharge plans were fraught with problems, including inappropriate placements into residential and nursing home care.

The CNHA survey referred to a report by the Royal College of Physicians (1986), as follows:-
"This report is critical of health authorities in general and presents a picture of fragmented services with little continuity of care, omissions and duplications of services, delays in obtaining help, etc. Usually inadequate information is given to the disabled person about the nature and expected course of the underlying condition, about the treatment plan and management of ensuing disabilities, and about the opportunities, services and help that are available". (page 6).

It also mentioned the Kings Fund Institute research paper (1988), "Last on the List", which stressed the need for the involvement of disabled people themselves in service design and management of future progress, and referred most importantly to Circular HN (88)26.

The key aims of the Circular included a greater emphasis on the prevention of disability, improvement in collaboration for planning and co-ordinating services, relieving pressure on carers, provision of information about local services, and the involvement of disabled people in identifying the services they needed. In fact it set out the principles for a social model of care, and put the person at the centre of its concern, not service led provision. .

As a result of their commissioned survey, and examination of local services, which were described as outdated, too thinly spread and in need of a complete restructuring, the managers for the CNHA set out a range of aims and objectives to meet the requirements of Circular HN (88)26 and the needs of their chronically sick and severely disabled patients. These included establishments of preventative services; specialized services and the formation of new multidisciplinary teams relating to mini Young Disabled Units on three hospital sites; specialist disability consultant cover; a Disability Living Centre in the community, and community rehabilitating services. Training and education for staff on Acute Wards was planned, and this included nurse managers.

To date, the Health Authority has only been able to improve it s services by costing and providing a Community Health Care input as part of home care packages, based on an assessment and review of individual patient/carer need. This has reduced the cost of keeping patients for long periods in hospital by around £40,000 per year per patient. Otherwise the situations of need with respect to care, most aspects of rehabilitation and the training needs of staff remain unaddressed. No new services have been established some six years on.

The severely chronically sick and disabled patients have become labelled as a group of people with "complex needs", but the Health Authority planning and operational staff have not been able to give a definition of "complexity" or to structure policy responses to such needs.

This situation is not uncommon. At the Conference for Young Disabled Units (Norwich 1994) many representatives of Health Authorities and different Social Services Departments reported that progress in developing services for this patient group was slow, and piecemeal. Different responses in different parts of the UK indicated that although severely chronically sick and disabled people are among those with the highest amounts and greatest range of care needs, that serious difficulties persist in both attitudes and abilities among service providers, to plan and implement adequate responses.

With regard to the needs of severely disabled people who return to, or live in the community, there is evidence that they are marginalized in a number of ways.

Zarb and Oliver (1993) have considered this issue in the context of enforced dependency through a lack of appropriate and acceptable supportive services. They found that many disabled people felt that their needs, and even their existence, had been overlooked. Many were anxious, and considered that their own independence was threatened because their needs were not understood with regard to <u>long-term</u> disability in the organization of service provision. They felt that there was a lack of understanding about the medical and physical consequences of chronic illness and disability, there was a lack of suitable or acceptable living options, and that all of these problems were compounded by inadequate benefit and pension provision, and lack of the recognition that extra financial costs are associated with ageing with disabilities.

Many people felt frustrated because they could not get advice or information about resources they might need. Often they did not know where to go for information, or sources did not exist. They found that in some areas, professionals acted as gatekeepers to information, and were either unwilling or unable to provide the advice required.

As a result, some disabled people had not claimed benefits for which they were eligible, could not make responsible choices about their own health, or moves into residential or nursing home care. They could not find appropriate transport facilities or join social and leisure groups, they could not choose appropriate equipment to enable them to cope more independently with their disabilities and certainly could not have holidays of their choice.

In fact, Zarb and Oliver state "The history of relations between disabled people and statutory support agencies has been characterized by distrust and disillusionment. This report has also given examples of people who clearly feel that they have been badly let down by doctors, social workers, community nurses and others. Given this climate of lowered expectations and mistrust, it is likely that care managers (ref. to the NHS and Community Care Act 1990) drawn from the statutory agencies will still be perceived as being more closely aligned to the interests of purchasing (and providing) agencies rather than the needs of users. Indeed, the Department of Health's implementation guidance on assessment and care management clearly indicates that the final decision on individual support packages will be based on cost and availability of resources. (Dept. of Health 1991). Disabled people could be forgiven, therefore, if they see their needs as coming a poor third in the assessment equation". (p.112-3)

The central issue, which the circumstances of people with disabilities shows particularly well, concerns models of care which have been used by health and social work professionals - To TREAT the person as if they were the illness or disability, instead of

ENABLING the person with the disability to attain maximum independence in an environment which is accessible.

Illness and disability do not exist independently of each other, even though the services for each appear to be split - with the NHS dealing with the former, and community based Social Services dealing with the latter.

Indeed, the OPCS survey (1988) shows that there is a continuation of relationship between identifiable illnesses of all types, and the disabling conditions which result from them. The survey, using 16 categories of illness which were coded from the International Classification of Diseases, identified 13 categories of disability which occur singly and in clusters in conjunction with all types of illness complaints. Furthermore, disabilities were divided into degrees of severity and showed that the older the person, the more likely they were to suffer from more than one complaint, and more than one disability.

1.3.4 Other patients who become part of the Hospital Population

This chapter, so far, has been concentrated on important specific groups of patients, who make up the Hospital Population.

There are many others, who,in much smaller numbers arrive at hospital for treatment, and are subsequently found to have a variety of needs which are relative to their social, psychological and overall life situations.

Itinerant Patients

There are itinerant persons, for example, mostly male who happen to be travelling through the Health

Authority catchment area and become ill. Their needs and circumstances pose particular difficulties for medical and social work staff alike.

Their solitary lifestyles, lack of anyone to provide care after treatment and frequent non-compliance with health/social advice, create situations which negate ordinary support systems. Alcoholism, substance abuse, mental illness and anti-social behaviour commonly accompany itinerancy, with evidence of personal self-neglect and health risks.

The non-compliance attitudes and behaviour with which workers are presented create special difficulties if itinerant patients need temporary accommodation. A hostel and money to travel may offer a possible solution, but with no guarantee that the patient will arrive there. An older itinerant person may be in need of temporary residential care, but unwilling to accept, preferring to resume his or her previous lifestyle. If such accommodation is the only possible answer, the placement itself is likely to cause friction and discontent. Solitary independent, itinerant individuals are probably the least likely of all to adapt to, and comply with institutional group living situations, and also the least likely to be tolerated comfortably by fellow residents or staff.

Residential care is structurally antipathetic to itinerancy and unlikely to be a satisfactory measure from the individual's own personal perspective.

Family Violence and Abuse

A small number of patients who are victims of family violence or abuse arrive in Casualty Departments and wards each year. They may be children in need of protection, women who have been assaulted by their partners, and sometimes men who have perpetrated the abuse and are legally prohibited from returning to their family homes.

This small group are separate from others who are suffering from peer violence, or as a result of attacks by strangers, because of the safety issues involved after their discharge from hospital, the legal implications for protection of children and their parent carers, and quite often, the need for temporary accommodation.

In all cases, the need for temporary accommodation is a critical one, requiring Social Workers to have the knowledge of a range of community resources and means of access to them. Hostels and Women's Refuges are thinly spread in the community, and at best only provide short-term measures to resolve the situation. For women and children who need to be accommodated in such crises, emotional, psychological, legal and practical needs have to be met initially and in the longer term, they require ongoing support and intervention.

Whilst Hospital Social Workers can provide help with the initial crisis of family violence or abuse, a clearly defined procedure for their role, and the linking process with area Social Work teams who will continue to work with the families concerned, is essential both to offset risk to children and to enable their carers to live in safety.

Social work support for male abusers usually amounts to provision of advice about hostel accommodation and a small sum of money to enable them to travel. If probation officers are involved, they may be contacted for help, but this is particularly difficult when a man is not in his home area.

The responsibilities of formal agencies with respect to the needs of male abusers are very unclear, apart from medical intervention for treatment whilst in hospital, and the duties of police departments relevant to criminal behaviour. Formal strategies for personal and emotional support appear to be absent or unclear, and left to the individual initiatives of Social Workers when such referrals are received.

1.4 Inequality in Health and Health Care Provision.

This brief overview of Acute Hospital populations, which has attempted to illustrate how they are made up of different groups of people, and who is affected in specific illness areas, is by no means comprehensive. Nevertheless, it does provide indication of need for services and support by health and social services, and makes the point that an episode of hospital treatment, even if people are discharged quickly, is not the end of the health/social care needs story by any means.

All of the groups identified had not just physical needs for healthy adjustment and treatment, but psychological, social, emotional and practical needs as well, which in many cases existed before admission, and continued after discharge.

This complexity of need indicates that people in hospital each require an holistic overveiw as individual people, and that professionals who care for them should have a comprehensive range of knowledge and understanding of race, culture, lifestyles, the effect of ageing and disability, and of social and personal oppression which is threaded through soceity's attitudes. Also as earlier parts of the chapter have shown, patients as people are subjected to living conditions and other socio-economic factors which influence health and life chances within their social groups, and as individuals.

Inequality in health.

There are around 6 million patient admissions to acute General Hospitals each year, but all patients do not receive the same quality or quantity of health care provision. Inequality is part of the whole spectrum of health care service, both in hospital and in the community. The overall distribution of medical services in response to need for medical care indicates a great mismatch between resources and disease, mismatch in age, seriouness of disease and social class, and uneveness of health care funding. (Melzer 1989). (DHSS 1981).

Stern (1981) argues that inequalities in mortality rates between socio-economic groups reflects a process of social mobility whereby healthy individuals move upwards in the social hierarchy, whilst those with poorer health move downwards. This means that social classes I - III are likely to gain healthier people to replace their unhealthier members, and that social classes IV and V will conversely acquire those unhealthier members who cannot retain their wealth because of their poor health status. The outcome of this social migration is reinforcement of health inequality between richer and poorer social groups, with a depressed average health status in social classes IV and V,, and apparently improved health status among social classes I - III.

Overall, the risk of death is systematically related to social class, and inequalities are found at birth, in childhood and adolescence and throughout adult . life.

The OPCS Longitudinal Surveys (1988) show that inequality is also affected by education, region of residence, employment status, gender, occupation and housing tenure. The fact that there is a substantial difference in death rates between houseowners and council tenants has already been mentioned.

Male death rates are almost double those of females in every occupational class, and the sex differential tends to increase with age. Hart (1985) found that morbidity (the experience of sickness and ill-health) was an important factor here, since women, whilst they live longer than men, experience more ill-health and make more frequent use of medical services. He suggests that stress, depression and somatization increase individual vulnerability to illness and that these are all linked to life events which cause low selfesteem and feelings of hopelessness. In this context, black people and working class women experience more illness because of relative social and economic deprivation.

Another enduring potential for stress, is that working class life is predisposed to long-term difficulties, such as unemployment, which is concentrated among semi-and unskilled workers, accidents at work, caring for chronically sick family members, because of inability to pay privately for care support, and loss of life partners. Loss events are likely to constitute stress and crises among all social classes of course, but since there is a higher probability of premature death in social classes IV and V, bereavement events are clearly significant.

The research of sociologists, like Brown and Harris (1978) makes it clear that personal vulnerability to, and the distribution of resources for coping with loss events are highly class related.

In the context of loss, it is important to mention the study by Rees and Lutkins (1967) on the effects of widowhood. They found that in the year following the death of their wives, widowers were subject to an increased risk of dying themselves. Newly widowed men were 40% more likely to die due to a number of causes, the most frequent being heart disease.

This increased risk factor was noticed more than eighty years ago by Durkheim (1952), who pointed out that suicide rates were linked to social variables like religion and marital status. He considered that the lives of married people were more subject to normal social integration, and as such their will to survive was strengthened.

The information from Occupational Mortality statistics (1988) show that death rates are higher among widowed, and single people, than among those who are married. These facts suggest, that the risks of premature death are closely related with having a partner - which enhances survival prospects, and that being without one exposes people to risks of all kinds.

Thus, many aspects of illness are not to do with bodily organs wearing out, and can be seen as socially constructed and subject to society's whole infrastructures of opportunity and circumstantial life events.

Inequality in Health Care Provision.

Whilst inequalities exist with respect to health and illness in the general population, and these can be seen in the context of socio-economic constructs of ageing, disability, class and gender, it is also the case that Health Care Provision is not equally provided for all who need it, due to the uneven distribution of Health Care resources in different regions of the country.

The National Health Service in Britain was founded to provide a comprehensive system of health care for all, with free access to everyone irrespective of their ability to pay. Despite these intentions, distribution in the NHS has been unequal (DOH 1980), because of a tendency to incrementalization - which is to allocate resources on the basis of what already exists, rather than on the basis of need in a fundamental sense. The principle reason for extra funding to the richest parts of the country, at the expense of the poorest, has been due to the siting of the most prestigious teaching hospitals which have absorbed a large and generally unquestioned share of available funding.

As a result, people at greater health risk in heavily industrialised parts of the country have had worse medical facilities than their fellow citizens in London and the home counties.

In practice, this means that poorer working class communities have tended to have the shabbiest and most over crowded facilities in the NHS.

In 1990, the Audit Commission became responsible for external audit of the National Health Service, with duties for reviewing the financial accounts, economy, efficiency and effectiveness of health authorities use of resources.

In 1992 the Commission published Report No.5, entitled 'Lying in Wait: the Use of Medical Beds in Acute Hospitals'. (Audit Commission, 1992).

The findings of the Report were based an analysis of National, regional and local data for hospital in-patient activity and bed useage, a survey of over 100 acute Hospital Units in England and Wales, and visits to ten Hospitals. They showed wide variations in availability of hospital bed numbers in different Health Service Districts, significant variations in the likelihood of being admitted or not to hospital, variations in lengths of hospital stay for similar groups of patients, an uneven distribution of medical officers in different hospitals, and a considerable variation in the numbers of emergency admissions to hospitals across the Districts.

The Report focussed on practical measures which could be used to improve hospital services, but acknowledged that 'Historical inequalities have been perpetrated, leaving some districts with too few beds in relation of the population they service while others are relatively well off '. (p.2)

A package of solutions was recommended in order to remove the inequality and inefficiencies which exsisted in Hospital Care Provision. These included improved admission procedures, with monitoring of referrals from general practices, appropriate patient placement on hospital wards, regular examinations of profiles of average lengths of inpatient stay for common conditions for individual consultants, procedures to ensure prompt and efficient hospital discharges, for all types of patient, and co-ordinated bed - management at hospital level.

These management actions were to take place within an environment in which the availability of hospital beds was closely matched to the expected patient workload, (p.2). But the report made it clear that appropriate activity by G.Ps before hospital admission, and after patients were discharged would be essential as part of the package of solutions.

Communication between G.Ps and hospitals was a significant problem, and in a number of cases G.Ps did not know when patients had been discharged. Furthermore, it was evident that G.Ps had used emergency hospital admissions to get round the unavailability of appropriate ward facilities when they were needed, and that on some occasions patients would not have needed hospital admission at all if an urgent second medical opinion had been available at the time. The report stated 'There needs to be more dialogue between hospital staff and G.Ps about their respective roles and responsibilities'. (p.30)

At the level of GP/Patient consultation, studies of consulting room behaviour show that doctors spend more time with middle class patients even within the same practice. (Cartwright 1967). The average time spent with a middle class patient took 6.2 minutes, with a working class equivalent of 4.7 minutes. This time difference helped to explain another finding - which was that middle class patients get more information from their doctors, ask more questions and prove less easily satisfied with advice or treatment. Even though the working class patients had been with their doctors for an average of 4 years or longer, they were less well known.

Cartwright's study concluded that treatment for the middle classes appears to be more patient-centred, and focused on the needs of the consulter, while for working class people, it tends to be more doctor centred and geared to the needs of the doctor.

The class related issue also has to do with the patients themselves. People who have cultural backgrounds that teach the value of promptly seeking professional health care, and whose social group supports this opinion, go to the doctor sooner than do people from cultures with different values. (Feist and Brannon 1988).

Even so, common disorders that are well understood medically are not widely understood by patients, and common concepts of illness can be relatively primitive. This is a particular problem for black and Asian people - where translation and terminology may provide a total barrier to understanding between doctor and patient. (Lan and Hartman, 1983)

One good example of a very common health problem - hypertension - was only understood with any accuracy by 12% of patients interviewed. (Meyer, Leventhal and Gutman, 1985).

Faulder points out that communicating specialised knowledge to someone who is untutored in the subject is a problem in any field. Expertise generates its own jargon, and no where more so than in medicine. Doctors have the advantage of their skills and their clinical experience which they bring to their decision making. Patients on the other hand are usually ignorant about the basic medical facts relating to their illness and they are further handicapped by their emotionally vulnerable state.

A seriously ill person is certain to be deeply worried and fearful, and is usually is no condition to absorb difficult technical information. (Faulder, 1985)

Common ground in understanding, not only of the illness, but also the attribution of causes of the illness are of equal importance, since this is a platform for coping with the process and management of the illness and its consequences. (Taylor 1983).

Some of these studies are quite old, but they make the point that clear and adequate communication is a basic need, and essential for satisfactory health care practice.

The Report by the Audit Commission (1993) which addresses communication between Hospitals and Patients shows that major problems still exist in this area, and require changes in practice at all levels to enable patients to maximize the potentials of Health Service provision. Knowledge is power, (Lukes 1974) and inadequate communication is a sure means of disempowering patients and securing an unequal relationship between doctors and those whom they treat. The Audit Commission recognised this, and stated 'Communication lies at the heart of health care delivery. To be effective it must be a two-way process: the service must give patients the information they want and need, and it must do this, as far as possible, in a way that is tailored to the individual's experience of health problems and to his or her unique blend of beliefs, understanding, expectations and ability to communicate.

The organization as a whole must create optimum conditions for good communication, and that necessarily entails clarifying responsibilities and establishing accountability.... Poor communication, with barriers between patients and the people they need to talk to, muddled and contradictory messages and missing information, creates avoidable anxiety and distress. It is, at least in part, in response to concerns about communication in the NHS services, that the Department of Health has published The Patient's Charter.' (page 3).

This document - The Patient's Charter (DOH 1991) - establishes from a political point of view at least, that the needs for proper information, and adequate communication should in future be a baseline for the delivery of Health Care.

The most significant inequality in health care - whatever policies prevail, or however statements about equality describe desired principles and practices, is that of private medicine. Private health care has enabled those who can afford it to avoid the difficulties of the NHS, its waiting lists, shortage of beds and specialist services. (Doyal 1987)

PART 2.

The Situations of Caregivers who meet Client/Patient need at the Interface between Formal and Informal Care.

2 The situations of Caregivers who meet Client/Patient need - what happens at the interface of formal and informal care?

Care in the community is going on all the time, involving family, friends and neighbours as informal carers for those in need. Formal care services from Health and Social Services are provided in a highly structured way, and the voluntary sector is continually developing its responses to need according to perceived deficits within the formal agencies and new care needs which arise as family structures change.

Community care processes can be seen as evolutionary and progressive. As needs change, for all sorts of reasons, different responses and types of service emerge and legislation is changed to ensure responsibility and accountability by public sector providers. Threaded through political initiatives about public sector provision are statements that all types of organisations should work together so that they are complementary, and overall, can ensure that good standards of health, social conditions and general public welfare are available to support people in need.

2.1 Care in the Community - Family Care and the State

"The basic ties of the family at the heart of our society are the very nursery of civic virtue. It is on the family that we in the government build our own policies for welfare, education and care, ...The Welfare State is designed to be a springboard and not a sofa". (Margaret Thatcher PM to the General Assembly of the Church of Scotland. Observer 22 May 1988 in Finch 1989).

Margaret Thatcher's remarks are an assertion that family ties are the foundation of our whole society and should be accorded a primacy above all others, underpinning the political view that Care in the Community is Care by the Community and care by the family. Who should provide care lies at the centre of current debates about the development of modern society and the future of the welfare state.

As the population ages, the issue of provision of care, and assistance to growing numbers of elderly and disabled people in need is confronting more and more families - and in particular - women.

Since the family is, and always has been the main provider of care, there is an uneasy relationship between it and the state. As long as public provision for those in need has existed, there have been political concerns that the family might abandon its responsibilities and moral obligations to dependent relatives. (Qureshi and Walker 1989).

Townsend (1963) addressed this concern in his book "The Family Life of Old People", and Moroney (1976) found that in the opinion of many civil servants and social welfare practitioners in England, Wales, West Germany and Denmark, families were less willing to care.

Successive Secretaries of State for Social Services in the 1980's have expressed fears about increasing dependency on public welfare, (Qureshi and Walker 1989) and hence for the future of the welfare state and the costs of public services.

Both in welfare policies and in the enforcement of law, there has always been a considerable reluctance to make provision from state resources for people who "ought" to be relying on support for their relatives, especially where this is underpinned by a legal obligation. (Smart 1984).

However, a number of research studies have shown that these apprehensions are misplaced (Townsend 1965, Qureshi and Walker 1989, Finch 1989, Braithwaite 1990, Wright 1986). Families do accept their caring role responsibilities (particularly females) and some are forced into caring roles which are emotionally, psychologically and physically damaging to both carers and those being cared for.

The burden of caregiving is an aspect of caring which Braithwaite examines in the context of two community care programmes, involving 144 caregivers in Canberra.

The central focus of her work is "that the quality of life of caregivers is an outcome worthy of equal attention in any evaluation of community care programmes, and that there is no social justice in a system which ignores this issue and indeed worsens the problem. Community care continues to function as a system in which the needs of one powerless group, the aged, are being met by sacrificing the needs of another powerless group, caregivers, predominantly women, the demands for whose unpaid labour drives them out of the remunerative workforce". (Braithwaite 1990).

A specific type of caring situation, in which elderly disabled people were living at home with their married children, was the purpose of a study undertaken by Nissel and Bonnerjea, (1982). Using time-diaries and taped interviews they assessed the cost of care to those who gave it, and the value of care to those who received it. For most of the carers, their experience was joyless, but they felt guilt about considering the possible use of residential care for their dependents. In many cases the families were near to breakdown and their relatives were certainly dependent enough to qualify for some form of residential care. All would have appreciated better information about help that was available in the community, and needed the opportunity to talk their situation through with someone else.

Cherill Hicks (1988) concentrated on the carers of physically disabled and elderly people, finding that they wanted a system from the state that genuinely encouraged their dependents to lead independent lives in the community. She commented - "Instead, the already inadequate system of services and benefits is, if anything, being eroded by cash cutbacks, by the family-orientated approach of present government policy ... the danger is that, as support to disabled and elderly people is reduced, their potential for an independent life will be eroded, and the burden of looking after them will fall even more heavily on their families".

Wenger (1984) found that age, sex and the marital status of both carers and cared for, were the end products of important social processes. These processes involved material factors, ideology about sex, gender, obligation to kin, and kinship network negotiation. Furthermore, the affective state between carer and dependent was influenced by their personal and family histories.

Qureshi and Walker (1989) studied the situation of older people and their carers in Sheffield. They found no evidence of unwillingness, or weakening of the will among families, and women in particular, to provide care for elderly relatives. Four out of five elderly people with principal helpers were receiving help from within the family. Over half the principal helpers were daughters. An assessment was made that most of those needing care and attention were receiving it, and severely disabled people were all receiving informal care where it was available, and formal care when it was not. The long term trend towards elderly people living alone was matched by the growth of the local extended family and high levels of contact were sustained between the elderly and their children.

A sample of 32 carers in Canterbury presented a complexity of issues. (Ungerson 1987). All her carers felt that general kinship formed the basis for a general system of morality, but they varied in their views of family obligations and who should care. They understood that the quality of state intervention was a "major determinant for the basis of private morality, and many also understood that they were acted upon, even to the extent of being moral victims". (p 142). Most of the carers felt trapped by their duty to their dependent. Only a few women, and even fewer men, enjoyed their role.

Ungerson observed that psychologists and social policy analysts, address different aspects of caring. "Psychologists look to its affective components and its peculiar affinity with femininity, while social policy analysts look to the function of family care within capitalism and patriarchy". (p 148).

All of the studies provided insights into the process of caring and being cared for, addressed policy issues, social trends and the various aspects of the feminist concern for the position of women and their needs.

Gillian Dalley (1988), takes these issues further, arguing that collectivist principles of sharing, altruism and co-operation offer a viable means of redefining the politics of community care, and an opportunity for moral responsibility to be translated into a practical responsibility in relation to equal rights and opportunities for everyone. "The feminist alternative is of a society ... which values the activity of caring and recognises the worth of those cared for and those doing the caring ... choice and freedom of action are ensured". She makes the point the "unpaid", "voluntary" or "informal" care would not be given a higher moral value than care provided by the collectivity - "such care too often is the outcome of compulsory altruism and is exploitive of giver and receiver".

A point of criticism might be that hardly any of this literature ever falls into the hands of carers, and its language would be unintelligible to most working class women, and women from other cultures. Its message must be translated for and carried to those who really need to hear and understand. The likelihood that many carers are able to obtain even a basic publication such as "Helping to Care - a handbook for carers at home and in hospital" (Kershaw, Wright and Hammonds, 1989), is very remote indeed. The information about all sources of help is most effective when personally presented and explained to a carer or a person who needs care.

Part of the community interface with the formal services is occupied by the voluntary and charitable organisations. They have produced information packs and literature about specific illnesses, disabilities and how to obtain the formal support which should be available. The Carers' National Association produces a regular newsletter "The Carer" which is circulated nationally to its affiliated groups and individual members. In many instances the carers groups have been initiated by Social Services and Health Service workers, but it is difficult for the National Organisation to access isolated older carers whose own cultural experiences has not included any group involvement or politically oriented action. Rural carers are particularly isolated and geographical distance prohibits group participation

Furthermore, after a long caring grind, many carers find themselves socially deskilled, worn out and resigned to coping alone until the death of their dependent.

It has been the experience of support workers in voluntary and statutory sectors that many carers are too tired and exhausted to have any motivation to join groups, and cannot find the time to do so. They need the support of sitting services so that they can leave their caring task, even for a few hours, and would prefer the service in order to go shopping or just to have some respite time for themselves.

2.2 Family structures and Capacity to Care

The picture emerges, as one considers the studies which examine different perspective of caring and caregivers, that the "why" of caring is complex, and tied into family role/gender/dynamics, and that the "how" of caring is being responsibly undertaken by Britain's 6 million known family/informal caregivers (Green 1988), whose numbers are rapidly approaching 7 million (Carers National Association 1995).

No doubt there is a small minority of family members and other people who choose not to care, and even wilfully neglect or abuse dependent people. Clear evidence about who they might be, how many there are and why this behaviour occurs is hard to find, except perhaps in part from the growing literature concerning abuse of older people. Otherwise, situations of neglect are seen through sensational media reports, and tend to focus on the failure of Social Services to protect and support vulnerable people who have died in particularly awful circumstances.

A more appropriate way of considering family care and why it is not always able to contain the needs of dependent members, is to look at evidence from research on family structures, their cultural needs, the effects that caring brings to bear on them, and how the need for formal care provision arises.

In 1957 Townsend's classic description of family life described informal care structures which were set in a matriarchal society, where reciprocal caring was carried out by women - vertically between generations and horizontally between kin. "The system was chiefly organised around female relatives.. at its focal point was the grandmother ... usually she managed the home, be it with increasing assistance from her daughters and other relatives ... the last refuge was the family". Even so, some old people, whose families had died, moved away, suffered severe physical or mental handicap, or chronic sickness, experienced not a family as their last refuge, but an institution. (Townsend 1957),

Townsend's study of elderly people who were admitted to residential care looked in some depth at their social situations prior to admission. It found that with advancing age the proportions of persons admitted rose steeply: for both sexes the proportion of unmarried was greater than the proportion of those widowed and divorced, and many times greater than those who were married; similarly it increased for those who were childless, or whose children had died. A tenth were unable to name the whereabouts of surviving relatives (p 292), "The facts about family structure and status (were) clearly important in explaining social insecurity. Men and women alike seemed to recognise that the ability to go on living in a normal community was weakened in old age if there were no relatives of succeeding generations to replace the loss by death or illness of relatives of the same or succeeding generations. Family relationships extended into and merged with the whole community of the widows (and widowers) left desolate. The comparative paucity of substitute sources of help was noticeable". Clearly, the need for support from the state had taken over the need for care by the family, and it was only when that care was fragmented and absent that institutional care had been substituted. This did not mean that families had not tried other ways of coping. The study goes on to say that some of the old people, when their principal close family carer was no longer available, tried living first with one person, then another. But family resources were sometimes limited or close relationships with a new household could not be established and SPELLS OF ILL HEALTH added to the difficulties.

Problems of illness and strain on carers, friction in the household, hostility and incompatibility were found among 27% of those elderly persons who had lived with others in their families. The physical health of carers also had an effect. (p 306). "In one instance after another we became aware (of the effect) ... of abnormal physical defect or infirmity on personal relationships". 36% of those admitted had been living with relatives who were themselves ill, infirm or of advanced age. The absence of subsidiary or secondary sources of help by other relatives, friends or social services was a common characteristic. Townsend also describes "abnormality of family history or structure" as a cause of admission. By this he meant the situation of common-law marriages, husbands and wives who had been deserted by their spouses, the presence of step-children, and parents affected by alcoholism and imprisonment. In these families, the expectation that care would be available through duty, obligation or love could not be sustained.

Townsend's later work (1962) illustrated how bleak and cruel life could be in residential institutions. Most old people had really wanted to remain in their own homes - only a small number had referred themselves for admission to residential care and some were assessed to be functionally quite able, and, perhaps could have been supported in the community if more resources had been available for them.

Quite clearly, even four decades ago most people did not <u>want</u> to be dependent on the state and avoided it for as long as possible. Although the standards of quality in residential/nursing home care have changed since then, and have improved in many ways by comparison with the old state asylums, public attitudes remain very consistent.

The views of older people with regard to the need for residential care have been researched more recently (Allen 1992,).
Just over a third in Allen's study felt that

entering some kind of residential/nursing home care would be acceptable if they became ill and were unable to care for themselves. 55% said they would not consider such care, and 12% were not sure.

When the carers' opinions were sought on the same issue, around 25% thought it would be a good idea because their elderly relative would be cared for and not be lonely. But their responses were also influenced by the costs of private care and guilt about ceasing to care. None of the carers who were elderly spouses found the idea acceptable.

Although some older people thought that this type of care would be a positive choice, it was not so for younger severely disabled people. A number of participants in a project, which focused on ageing with a disability (Oliver and Zarb, 1993) stated that they would prefer to take the option of suicide or euthanasia rather than relying on support services or moving into institutional care.

A key issue for both groups, the older people and the young people with severe disabilities, was whether informal carers could continue to care for them indefinitely. They were concerned that if their carers reached a stage of not being able to cope with levels of intense dependency - especially if they themselves became ill or their carers' own health broke down, then the prospect of having to be admitted to institutional care would become a real possibility.

Formal systems of care would be the only avenue of support left, because informal care capacity from family and friends was exhausted.

2.3 Who are the Carers?

In the early 1980's, the Department of Health and Social Security commissioned the Office of Population and Census surveys to include questions about informal care and carers in the General Household Survey. These were included in the 1985 Survey, and a report was published in 1988 (Green 1988).

All adults who were interviewed were asked if they cared for, or gave help to anyone who was sick, handicapped or elderly living in the same household, or if they provided some "regular service or help" to anyone similarly in need who lived in a different household.

The published report showed that one in seven adults (14%) in Great Britain were providing care, and that one in five households contained a carer. In total there were approximately 6 million carers in Great Britain, 2.5 million of whom were men, 3.5 million were women. Around 1.7 million were providing care for someone in the same home, and one fifth of carers were looking after more than one person.

Four out of five carers were looking after a relative, two in five were caring for one or both parents, and an equally large proportion were caring for their spouse.

The report highlighted the fact that the likelihood of being a carer increased with age, especially for women, and the peak age for caring was between 45 and 65 years where women carers outnumbered men at 25% to 16% respectively. Unsurprisingly, three quarters of carers were looking after a person aged over 65 years, and about half were caring for someone over 75.

Overall, the statistics show that family members are the major source of care for people who are sick, disabled and elderly, and the report points out that the time spent in caring for them varies from a few hours a week, to well over 50 hours in some cases.

A number of other studies (Qureshi and Simons, 1987; Henwood and Wicks 1985; Ungerson 1987) suggest that within the whole spectrum of caring that there are four main principles which determine who offers personal care, and that this can be shown as a hierarchy of obligations - as follows:-

1) The marriage relationship takes primacy, so that one's spouse becomes the first source of support for married people. This is shown in detail in Wenger's study (1984) of elderly people living in rural North Wales.

2) Second in importance is the parent-child relationship, with adult children being the major source of support for elderly parents, and

parents being the major source of care for adult disabled children. The pattern of support here is much more gender specific, with mothers and daughters being carers more commonly than sons and fathers. (Glendinning 1983).

3) People who are members of the same household are also the main providers of care, with an adult child who shares a home with a parent being much more likely to be giving personal care than their siblings. This also applies to more distant relatives who sometimes share a household.

4) The fourth and most important principle of personal care provision, is gender. Women are more likely to be carers. When there is a choice between female or male relatives, mothers, daughters and daughter-in-law will take precedence over fathers, sons and male-in-laws.

The pattern of caring principles and responses virtually guarantees care for men as long as women are available. This may not be the case for women, and Shanas (1979) noted that women were two or three times more likely to say that no one helped them during a period of illness. Maybe women do cope more independently than men - they are presumed to do so (Wenger 1984), even if they are physically disabled. As a result, when they are either ill or handicapped they are less likely to receive support from either informal carers or formal support systems. (Charlesworth, Wilkin and Durie, 1984).

One important point which emerges throughout all the literature on caring, is that time and again care is found to fall and rest principally on the shoulders of one primary carer, even when others could help. It seems that caring tasks and responsibilities are not shared out on the basis of a logical, socially just system of distribution. Who gets the job is not to do with merit - but more with availability, a conscience about obligations and duty, and attitudes of others to confer such obligations in the context of socially determined rights and roles and affective influences. One very important issue is about <u>who</u> really knows and feels that they have a right to say no? Clearly, perspectives on this issue are different for men and women, and as women's attitudes change may have a significant effect on sources of care for the future.

2.4 What do Carers do?

Carers spend a lot of time caring for other people. The OPCS Survey (1985) mentions time periods of less than ten hours, ... and more than 50 hours ... but examples from many individual cases in all of the literature so far referred to shows that much more time is often spent than this. Some carers are virtually undertaking a full-time caring job, unpaid, often experiencing interrupted sleep at night, and a relentless grind of physical work which goes on and on, seven days per week.

The Carers Survey shows that the basic tasks of caring generally involve personal care, such as washing, dressing and using the toilet. About half of all carers are involved in this way. The other half are involved in providing nursing care - such as giving medicines, feeding - sometimes by tube, bed-bathing etc., and also in giving physical help such as with walking, using stairs, getting in and out of bed and taking someone out of the house by whatever means -

car or wheelchair.

Over 80% of carers underpin these basic tasks by providing practical help at home with housework and cooking, gardening and shopping. Women are much more likely to be involved with intimate and physical help, while men more frequently undertake practical tasks such as shopping and taking someone out.

Around a quarter of all carers manage single handedly, 30% get some help from other family members and only a tenth have a joint main carer who genuinely shares the work. Male carers are more likely to receive help with caring from another member of their household.

Caring tasks are very like those expected of servants who were in service to wealthy upper middle class families in the past. Poorer people have always been expected to look after their elderly and sick dependents until death do them part, and for a pittance until sometime after the Second World War, were expected to clean, scrub and skivvy for others with more powerful social status.

This analogy brings to mind very strongly the oppressive nature of caring tasks and powerlessness of those who take on the heavy burden of care. Carers, because of their own love, duty, obligation, reciprocation and guilt - whatever motivations, can be ignored and, therefore, marginalized by professional workers - especially hospital and social work staff. They are more subtly oppressed by their family members and peers who do not pro-actively take on and share both the task and the responsibility.

2.5 The need for Formal Service provision when patients are discharged from Hospital

Informal carers provide the main source of post-discharge support to both elderly and non-elderly people when they leave hospital, and in addition, statutory services form an important part of their community care structures. (Victor and Vetter 1985).

Some patients - especially those who are chronically sick, elderly and severely disabled, receive a range of statutory services, singly and in combination before admission, which are delivered by Home Care Services, Occupational Therapists, Meals-on-Wheels, District Nurses and Health Visitors, and from GPs.

On discharge from hospital their needs for such services may be at the same level but research shows that a significant number of people either become service users for the first time at this point, or need an increase in service levels. (Russell 1989). When Victor and Vetter (1985) surveyed a sample of elderly people three month after discharge, they found that the 17% who needed Home Help Services and 12% who needed District Nurses before admission had increased to 25% and 37% respectively.

Another study by Jones, West and Lester (1992) showed that the percentages of patients receiving formal services after discharge were - District Nurse or Health Visitor - 32%, chiropodist - 16%, Day Hospital - 6%, physiotherapist - 5%, Occupational therapy - 2%, and speech therapy 1%. The social services received were home help/care aide - 27%, social worker - 13%, Meals-on-Wheels - 11%, and day centre - 5%.

A much smaller number received support from the voluntary sector, with Age Concern at 2%, and volunteer help with shopping, self-help, counselling and others also at 2%.

In theory, when patients - especially those who are elderly and more likely to be living alone - are discharged and need continuing care, the concept of good discharge planning would indicate that services should be arranged prior to discharge. The first three days, extending in some instances to three weeks, are critical for frail and older people in terms of settling back at home. During this period they may continue to feel pains and be generally unwell, wounds may not be fully healed, and the effects of both physical and psychological trauma may not be resolved. Sleep and eating patterns need readjustment time, and family carers also need adjustment time to fit extra care tasks into their daily routines. (Continuing Care Project 1975 Age Concern) (Neill and Williams 1992).

However, research has shown that in practice it is not uncommon for people to find that required services have not been arranged, and perhaps not even discussed, either with patients or carers. Where services have been arranged there are sometimes delays between discharge times and community services coming on stream. (Skeet 1982).

The study already referred to by Jones (1992) found that 38% of patients had not discussed their aftercare needs with anyone in hospital. The most recent research in Nottinghamshire on hospital discharges (Project Team, NCC 1995) found that high proportions of service users and almost 50% of their carers, did not have information on contacts for the statutory services available, and there were reported deficits also in information with regard to the use of drugs, illness management and actual discharge arrangements. Confusion was observed in a small number of cases about transport, time and date of discharge, and discharge destinations. Written information confirming discharge arrangements had only been received by 5% of all patients surveyed.

Patient and carer dissatisfaction concerning discharge arrangements and service provision was significantly focused on Home Care requirements, whilst satisfaction with community nursing services was at a high level.

Overall, recent and past studies on Hospital Discharge arrangements indicate that around 85% of patients are satisfied with the formal services provision which they need. The remaining 15% seem to experience a persistent gap in care provision between Health and Social Services which is characterised by communication and co-ordination difficulties. The 15%, furthermore is a variable proportion among different Health Authorities and Social Services

Departments.

One service area that is noted in all research available, and is constantly reiterated in literature on caring and informal carers' experiences is that of communication between General Practitioners and Hospital staff. The problem appears to stem from the delay in discharge notification to GPs. When this occurs, patients who need either or both GP and District Nurse follow-up, do not receive it for some time, if at all.

The South Glamorgan Hospital Discharge Service (Russell 1989) found that 37% of elderly people had definitely not received a GP visit within 2 weeks, and for a further 20% there was uncertainty as to whether or not a visit had occurred; in Harding's sample (1987) of discharged patients only 28% of hospital communications had arrived at the GPs' surgeries within a week of discharge, and the Continuing Care Project (1979) found that only 50% of elderly people in their study had been visited by a GP some 2 weeks after discharge.

GP involvement with discharged patients is clearly important from a health-care perspective, but the Griffiths Report on community care (1988) also proposes that it should be part of the GP's formal contact to inform services of a patient's community care needs, and suggests that: "The GP should also be able to satisfy himself that the Social Services authority has considered the case. The Social Services authority should, therefore, confirm that it has received the referral from the GP, and tell him what action it has decided to take". (Griffiths 1988, 6:14).

This report also reminds GPs that their present contract gives them a responsibility for advice to enable their patients to take advantage of the local authority social services provisions.

2.6 The relevance of hospitalization to Social Care needs on Discharge.

Around 10% of the general population become Hospital patients in any year, including 18% of severely disabled and 36% of very severely disabled people.

(OPCS 1989). There are no definite means of predicting how many patients will need formal services on discharge, but studies undertaken during the last 2½ decades have shown that hospitalization is a consistent and key factor leading to a Social Services referral. (Allen, Hogg and Peace 1992; Townsend 1988; Williamson 1985, Victor nd; Amos 1973; Skeet 1970). In two north London social services teams it was found that one fifth of referrals for home help were made from hospitals. (Sinclair, Crosby, O'Connor and Vickery 1988).

In Nottinghamshire in 1991/92, the Annual Statistical Report for Adult Services showed that between a quarter and a third of all adult care referrals originated from Hospital based teams - the majority of these being for Home Care/Meals-on-Wheels services. Overall, 92.6% of these referrals were for people aged 65 years+, with the majority aged over 75 years.

There are two key reports concerning Social Work in Hospitals (Connor and Tibbett 1988, SSI 1992). Although the referrals for Home Care services are not specifically quantified, both reports illustrate that among adult care referrals, the majority of clients are aged 75+, and that Hospital Social Work activities are centred on Discharge planning and arranging practical services to enable people to return home safely.

An earlier report from the Hammersmith and Fulham London Hospitals (Murray and Mitchell 1985) produced similar findings, with some 45% of all patients referred aged over 75 years, and a majority needing referral on to the area Social Services for Home Help and other practical support at home.

The Mansfield General Hospital Social Workers had a variety of views about the need for Home Care support, based on their own experiences. The most important view was that this need indicated a degree of risk, not necessarily for readmission to hospital, or admission to residential care, but to personal safety at home, both immediately on discharge and during the two weeks which followed. They considered that practical care at this time was needed because older people in particular, were not fully recovered from their illness or operation, and that many felt a loss of confidence in their own ability to cope. This was more likely of they were living alone, and if their family members lived some distance away.

The other view that the Social Workers held, was that frequency of Home Care services prior to admission served as an indicator of both wish and need. Anyone who had previously received the service three times a week or more was regarded as potentially in need of more intensive services - and possibly some short term care or day care - on discharge. This level of frequency was often found among older people with some degree of mental health difficulty, those who had experienced repeated hospital admissions, and those whose informal care networks were absent, fragmented or breaking down.

The frequency of Home Care indicated to the Social Workers that a patient's need for the service on discharge would be intensified, and should be co-ordinated to restart immediately at the date of discharge. As Home Care services were not always available at Bank Holidays and weekends, Friday discharges represented a serious risk, and this fact was constantly emphasised to Hospital staff, who just as constantly seemed to forget it. Arranging Home Care Services for these patients required some days notice with area staff, because their rota routines needed time adjustments to accommodate increased frequency, and to ensure availability of Home Care Aides on particular days. The Social Workers felt, therefore, that the significance of Home Care service needs should be formally recognised by ward staff in the context of person-safety and appropriate professional assessment and practice.

Other members of the Social Work team based in other Hospitals, considered that the need for Home Care Services was the greatest and most important of all. Although meeting this need could become a monotonous task they felt that it should be seen as a priority area of work underpinned by policy for service standards, response times by Areas, and ongoing monitoring.

The process of meeting Home Care needs for Hospital patients appears to be variable in different Social Service authorities. In Nottinghamshire the response of the service providers are routine, but uneven, and dependent on area budgets and availability of staff. In contrast, the service in Staffordshire provides a Hospital Aftercare service for immediate assessment post discharge, which is geared to Hospital Discharges and can provide intensive support on a time-limited basis.

Variability of service, response and reliability were found among the authorities contacted by Neill and Williams (1992), and in many cases the services were too thinly stretched to be effective. They found, too, that Home Helps needed simple guidelines for assessment to enable them to understand the process of discharge and recovery, so that they could participate in ongoing assessment and review rather than being task-centred and possibly not cost effective.

The issue of increasing numbers of older people living in the community has been referred to several times already, and it follows, that as these older people are the majority users of Home Care Services, the size of the service needs to increase also. In Nottinghamshire, like a number of other Social Services departments, this has not been the case. No increase in the Home Care budgets has been made for the last eleven years, and service provision becomes operationally more difficult.

2.7 The Social Services Inspection of Home Care in Nottinghamshire

In March 1994 the Social Services Inspectorate compiled a report on the Nottingham Home Care Services, as part of a national programme of inspections. The officers found that although staff demonstrated a positive commitment to operation and development of their service, problems were caused by lack of strategic management, and operational coherence in prioritizing services and deploying the workforce. There was an issue about provision of "cleaning" services, recognition of the therapeutic value of cleaning, and the balance of this service alongside other intensive needs for more personal support.

The inspectors commented that carers needs did not appear to influence the outcome of service assessment, reviews of the service were rarely undertaken, and that many service users were unclear about the role of their Community Care Assistants. Limitations of the service to the hours of 7.30am-7.30pm were a real concern, and the training for staff was not supported by an adequate training programme.

With regard to hospital discharges, and the needs of patients returning home, the report stated that cross boundary issues between Health and Social Services were still not being resolved to effect appropriate service delivery. A Home Care project which was being operated to review services did not have a representative for the Hospital Social Work Teams. The Inspectors recommended that such representation was needed in order to gain informal views on the impact of Hospital Discharges and the provision of Home Care Services.

They also considered that a formula for determining service provision in future should include not only the population of people aged 75 years+, but also the numbers of people in each district with limiting long-term illnesses.

The last point is very significant with regard to the Districts in the Health Authority catchment area covered by the Hospitals in North Nottinghamshire, since Mansfield and Ashfield have the highest percentages per head of population, and also the highest percentage of households with one or more persons with limiting long-term illness, in the county.

Table 4 illustrates these facts.

Table 4

Percentage of Population with Limiting Long-Term Illness;And Percentage of Households with One or more People with Limiting Long-Term Illness, by District Council Area

District	Percentage of Population with a Limiting Long-Term Illness	Percentage of Households with One or more Person(s) with Limiting Long-Term Illness
Ashfield	15.1%	29.0%
Bassetlaw	14.6%	27.5%
Broxtowe	12.0%	23.0%
Gedling	12.0%	22.9%
Mansfield	16.3%	30.8%
Newark & Sherwood	13.2%	25.3%
Nottingham	14.9%	27.1%
Rushcliffe	11.1%	20.5%
County	13.9%	26.0%

Source: OPCS County Monitor: 1991 Census Nottinghamshire

The SSI report commented on links between Home Care and other services, highlighting liaison with Occupational Therapists and District nurses. Although operational links with OTs were good, their increasing workloads and subsequent waiting lists for assessment for aids and adaptations meant that delays in service provision, and the absence of rehabilitation work in people's homes, were actually adding pressure to the Home Care Teams and affecting their service delivery.

Operational boundaries between Home Care and District Nursing Care had never been clarified. There were instances where responsibilities for bathing, nail cutting and handling of medicines were unclear. One health authority provider highlighted the lack of agreement about the personal care/cleaning divide between the two services, and claimed that the new community care processes were inflexible and bureaucratic.

It is obvious that if the tasks and responsibilities of service providers are not clearly defined and understood, firstly by the providers in each service which they operate, and secondly by providers of other complementary services, that there will be either overlapping of tasks with duplication and confusion, or gaps in services which providers do not see, and which create areas of unmet need, and risks for service users. According to recent studies and reports, this seems to be the case in the context of care needs at home.

PART 3

The Problems of Achieving Seamless Care When Patients are Discharged from Hospital.

3. The Problems of Achieving Seamless Care when Patients are Discharged from Hospital

Sections 1 and 2 in this Chapter have so far attempted to illustrate the wide variety of people who are admitted to hospital, how certain groups are predisposed more than others to particular types of illness, and that inividually and collectively people have a wide range of needs both simple and complex when they are discharged. Their care situations at home have been discussed in the light of research undertaken on issues affecting formal and informal care, and the information in Section 2 shows that formal service provision does not always guarantee that needs are met even when they are known to exist.

Many thousands of people each year interact through situations of hospital discharges. The largest part of the care/needs meeting task is undertaken by informal social network members, followed by the statutory sector and in much smaller numbers by private and voluntary agencies.

The complexity and volume of interactions between so many people among hospital and community NHS staff, social services workers, patients, family members and others are bound to contain gaps and flaws in communication which are everyday experiences between individuals in ordinary life. (Arglye 1972). In addition to this potential for miscommunication is the problem of not understanding specific medical information and Social Services terminology which both in their turn can and do lead to misinterpretation and confusion. Therefore, communication is likely to continue to present ongoing obstacles ot the reality of seamless care. (Audit Commission, 1993)

Another problem is created by the organisation of service provision and distribution of Health and Social Services care which is not structured upon the knowledge of absolute numbers of people in need, but is rather more focussed on what existing services already provide, budget constraints and political influences (Davies and Challis, 1986). Differences in the medical and social models of care which operate within the two organisations, professional roles, systems and cultures also determine the ways in which care needs are identified, assessed and met, or not, as the case may be.

Part 3 of Chapter 1 seeks to address the difficulties of providing 'seamless care' - interpreted as meeting patient/client need effectively, safely, and appropriately, by exploring:

1) Theoretical perspectives of human need, understanding need and responses to need

and

2) Theoretical perspectives on roles and systems within organisations.

3.1 Theoretical Perspectives of Human Need, Understanding of Need and Responses to Need.

The concept of seamless care, whereby all client/patient needs are met effectively, safely and appropriately on discharge from hospital has not been realised in practice. This fact is shown repeatedly through research studies, some of which have been described in Part 2 of this Chapter. Accounts of unmet needs causing difficulties for patients and carers, and unsafe hospital discharges have persisted in spite of attempts to address the situation through pilot discharge schemes, health and social policy statements and Government Circulars (HC(89)5 and LAC(89)7).

The question of why this is so does not have a satisfactory answer, even though the outcomes of the Age Concern Continuing Care Project (Age Concern, 1975), the study of patients being discharged from hospital by Pitkeathley (Pitkeathley, 1979), the South Glamorgan Hospital Discharge Service (Russell, 1989) and Neill and Williams extensive work on After Care Schemes for elderly people leaving hospital (Neill and Williams, 1992), illustrate that successful outcomes can be achieved.

As a result of Neill and Williams' work, a Hospital Workbook (DOH, 1994) was collated and published for planners, managers and practitioners in Health and Social Services. It gives a step by step guide for professions who are involved in assessing and arranging patient discharges. The work 'need' is found frequently in the Hospital Workbook, as in *'health and social care needs', 'complex needs', 'particular needs', 'someone needs ...', 'issues which need to be addressed', 'managers will need ...', 'comprehensive needs assessment', 'reduce the need for procedures..', 'a named nurse will need ...', 'needs of the service user', 'procedures will need champions', 'crucially need a clear allocation'*.
The verb 'to need' links many pieces of text together, and given the number of times it is used in different contexts, the impression emerges that the interplay of needs among people, whether patients or staff, is a crucial issue.

Good quality, safe and appropriate discharges have come to mean that assessment of patients needs has been effectively undertaken, that those needs have been met and dealt with, or satisfied, and that hospital beds are not wastefully occupied when medical care is completed.
Since so many difficulties present themselves as people leave hospital, the questions arise as to what is

actually done during assessment, and what is meant by needs?

The assessment process clearly involves a number of people. This thesis puts patients at its centre of concern, and they must play some part by at least being able to say what they need. Nurses, doctors, occupational therapists, social workers and carers are also involved, and presumably some kind of consensus agreement has to be arrived at during the assessment about how patient needs are to be met.

Two of the critical issues in assessment of need are determining how need is to be defined, and who is to identify that it exists. A basic difficulty in understanding any definition of need is the value orientated basis of human and social needs. This emerges in the diverse ways in which need is employed in everyday language. (Doyal and Gough, 1991)

'I need' is used by individuals about themselves,
and interchangeably with 'I want'. People are described as needing (something) with the implication that 'something ought to be done because ..', 'They need to' precedes statements offering quick solutions to problems of small and greater dimensions. Statements of need are riddled with judgements and different perceptions which

really are a reflection of our own individual experiences. (Glampson, Scott and Thomas, 1975)

Moral values affect the way people see each other as being in need or not, underpinned by concepts of what is 'good' and 'bad' for them, and what they deserve to have.

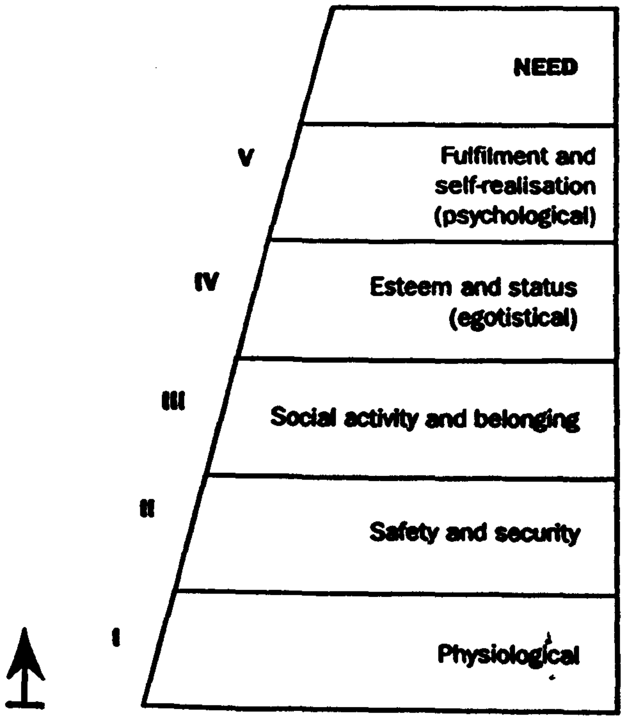
Legislation, which sets boundaries on what people are entitled to in the meeting of social needs rarely defines with any precision what those needs are. For example, the Seebohm Report (1968) saw the personal social services as large scale experiments in ways of helping those in need, but did not succeed in defining need. Similarly, the Jay Report (1979), the Cumberledge Report (1986), the Government Paper on collaboration between the NHS, local government and voluntary organisations (DHSS, 1986), and the 1990 NHS and Community Care Act all refer to meeting needs for different groups of people and call for services to be responsive to needs, to assess needs and to meet them as comprehensively as possible. It is consequentially left to professional managers and practitioners to interpret the need of individuals and groups through whatever assessment formulae are available and approved.

However, given that assessment of needs is not value free, some flexibility may be desirable so that definitions of need can change and develop over time, according to variations of areas of need, funding available to provide services, and political pressures and considerations. Even so, there will be differences in the way that individuals and families experience need, and what they expect in the way of help. (Glampson, Scott and Thomas, 1975).

Maslow's Hierarchy of Human Needs.

Human needs have been theoretically defined by a number of people. Maslow (1943) constructed a theory which proposes that there is a hierarchy of human needs, which are instinctively driven by internal motivation to survive, procreate and protect the human species, to function as a social member of groups, and to eventually achieve a positive state of fulfilment and individual self realisation. Figure 6 shows how this hierarchy of human need is organised.

Fig 6: Maslow's Hierarchy of Human Need.



Maslow suggests that within this hierarchy the lower order needs have to be satisfied before time and energy can be devoted to pursuing higher order needs. If someone is hungry, for example, the physiological drive to obtain food will be most powerful, and must be satisfied first. When this has been achieved the next drive - to secure a safe and protective environment - will emerge, and this too can be dealt with.

The person can then move on to satisfy his needs for social activity, in family groups, at work and in purposeful activities with other people.

The attainment of social satisfactions provides a platform for which to pursue more individualistic needs for status and self esteem, and finally, the ultimately integrated and desirable state of personal fulfilment and self-realisation emerges. The person is happy, able to take care of herself and others, and is in good shape physically, mentally, emotionally, psychologically and socially.

In conditions of adversity, basic needs emerge once more, and the process begins again.

The potential exists, theoretically, for each one of us to achieve our maximum potential as a human being, but this depends on following the hierarchy. Maslow allows for human variation by acknowledging that needs can be driven from anywhere in the hierarchy, at the expense of lower order needs, and with the consequence that the person will be harmed.

For example, the need to take drugs, to over-work to satisfy ambition, or stealing to acquire material possessions may result in higher order needs being met at the time, with the subsequent results of ill-health, stress and psychological damage, and loss of social status.

Maslow's hierarchy of needs is useful insofar that it shows the scope of human needs, and covers the physical, social, psychological and emotional needs that we would all generally reckon to have, certainly at an individual level. It appears to fit quite well with a medical model of care/intervention, particularly at level 1 and in some circustances level 2, since medicine and surgery are focussed on bodily care and restoration of health, including proper nutrition and functional abilities, and mental health.

However, the needs 111 to 1V, higher up the hierarchy are not so much the centre of concern for medical staff, but that is not to say that they would ignore them or deny that these needs exist.

It seems fair to say that some doctors and nurses in hospital probably would see difficulties in the meeting of higher level needs - particularly if they apply OUTSIDE the hospital, as concerns which belong to the patients themselves, their carers and professional social care workers. After all, ranges of professional responsibility are given boundaries by the funding which is provided by the State, professional activities are defined within these boundaries, and workers are given job-descriptions which tell them what they *should* do. After that, other areas of concern are left to the individual workers' own judgement or perception, and the extent to which they are prepared or able to *give of themselves* in addressing such needs. People say 'I'm here to do my job, not yours'.

Maslow's theory, then, can be seen to give us indications of different needs which human beings have, and this is helpful, particularly in seeing people in a desirable and optimum state of health, and social and personal wellbeing. But the theory does not go far enough to be of more practical use in assessment of patient/client need in a hospital environment.

Bradshaw's Taxonomy of Social Need.

Bradshaw (1972) constructed a theory of human social need, which is intended to be of practical value when undertaking the tasks of need assessments, and service delivery. This theoretical approach enables service providers to make and rationalise public policies, and to deliver services through a professional assessment format which also involves the service user.

The taxonomy of social need has four classified definitions, which are:

- **normative needs**
- **felt needs**
- **expressed needs**
- **comparative needs.**

Normative needs are defined according to an agreed set of social standards. A desired standard is determined by relevant professional experts, and this is measured against a standard which already exists. If a particular group, or an individual, falls short of the desired standard, these are persons who are deemed to be 'in need'. Therefore they will, at least in principle, be eligible for some type of service provision.

The difficulty with this theory, in operation, is that the desirable standard may not be compatible with other definitions of need, and other professionals may have conflicting standards of their own to work to.

For example, standards of housing and modern utilities might be relatively easy to agree upon, in principle, but high-rise dwellings have been a cause of major disagreements between architects and social planners Also, the variable standards of home improvements funded by Local Councils show that agreements are not absolute. In some instances, because of residency rules, people in urgent need of indoor toilets have not been eligible for grants. The existence of standards, however they are agreed, does not mean that all people's needs will definitely be met.

Even more difficulty arises when less tangible issues such as family size, nutritional standards or domestic cleanliness are the subjects of standard setting. What might be seen as a public health issue, say by a health visitor who finds an elderly person living amongst accumulated rubbish, may not be given the same significance by a Housing Officer or care worker. Differences in opinion can be extreme in such cases, amounting to morally based accusations of professional neglect.

A possible solution to this dilemma is to be found by involving those people who are service users in the identification of their needs, that is to say, asking them what they feel they need. In this way, Bradshaw proposes that felt needs will assist the relationship between providers and users in construction of services, and appropriateness of standards.

The difficulty with asking people what they feel is that they may identify what they think they need, when really this is what they want. In everyday language, people use 'I want' or 'I need' interchangeably without clear rationalisation, and on the basis of 'feeling'. They may express a desire for something which they think they ought to have, because their neighbour has whatever it is, and they too should be entitled to have it. This does not necessarily mean that they need it.

On the other hand, people with an obvious need for service may not be willing to say so, because some social stigma is attached by being seen to be in receipt of that service, or because public sector workers are seen to be nosey or intrusive. Social work support or intervention with families who have childcare needs is a case in point. People with varying degrees of mental illness may not have insight into their needs, and therefore not be able to say what they are, or make rational choices.

Nevertheless, what people feel they need is important. **Felt need** lead to **expressed need,** both individually and collectively, thus creating a demand for services, and standards of service. Expressed needs as demands can be publicly measured as waiting lists especially for NHS services or housing, and in the end will influence political action and organisational policy.

Bradshaw's fourth definition is **comparative need.**
The comparison of need here is made between groups of people receiving services and those who are not.
Significant characteristics of service users are taken as indicators of need, and therefore when these characteristics are found among non-service users, they too are identified as being 'in need'.

The problems posed by using significant characteristics is in how to decide what they are, and how important they might be. Again, different professionals will identify different features of community groups, and tend to be guided by the outcomes of research. These will become evident according to the methods used in any given piece of research.
As Bradshaw pointed out, there is a perpetual dilemma facing research into needs. If professional prescriptions and subjective user preferences are both flawed by

imprecision when used as a means of deciding what needs are and how they can be measured, then who is to decide on appropriate social indicators, and how?

Choices about who is in need, and which services are to be provided when resources are scarce, will continue to be influenced by factors such as the availability of skills to determine felt and comparative needs, and the views of policy makers on priorities that can be given to meeting normative and expressed need.

Doyal and Gough's Theory of Human Need.

Doyal and Gough (1991) agree, in accordance with other theorists, that subjective individual feelings do not provide reliable determinations for meeting human need. They propose that a theoretical specification is required which demonstrates both objectivity and universality, independent of subjective preferences.

They find that basic human needs are linked to the avoidance of serious harm, which poses fundamental threats to survival and social participation, and interferes directly or indirectly with activities that are essential to a person's plan of life.

Thus basic human needs are defined as physical health and autonomy, and as such, must be met as a pre-condition for human action and interaction and achievement of goals.

Physical health is necessary for all living creatures in order to stay alive. All human beings are at risk sometime of becoming ill, and in the process their potential for functioning or even surviving is compromised.

Doyal and Gough propose that we should all have access to means for survival to the degree that we are capable of it. We therefore should also have access to health care provision which is available.

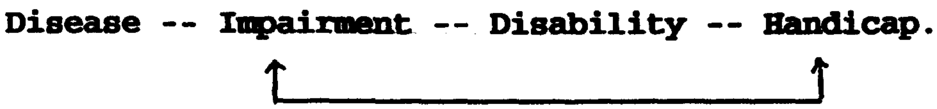
They make the point that measures of mortality rates and life expectancy are used as relevant indicators of deprivation, and are invaluable indicators of a wide range of health and social conditions. Indeed, UNICEF (1987) uses infant mortality rates as a key indicator of social progress when comparing nations, and levels of life expectancy can be regarded as the best overall measure of basic need-satisfaction.

Illness and death do not provide a complete picture of the need for physical health. Disease and trauma are not all completely cured by medicine and surgical interventions. This has been noted before in discussion about chronic and terminal illness. Therefore, some means has to found of measuring poor physical health, given the importance of human competence to partipate fully within any given style of life.

Doyal and Gough propose that the most direct method for measuring poor health is to measure functional or structural disability, without using medical categories. They refer to the WHO International Classification of Impairments, Disabilities and Handicaps (1980), which can be used to inform assessment of:

abnormality or loss of psychological, physiological or anatomical structure or function - defined as **impairment**; restriction or lack of ability to perform an activity in the manner or within the range considered to be normal for a human being - defined as **disability**; and the social consequence of disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex, social and cultural factors - defined as **handicap**.

They show the relationship of definitions as follows,



Disease -- Impairment -- Disability -- Handicap.

Doyal and Gough go on to refer to the OPCS Report (1988) which showed the prevalence of disability among adults in Great Britain, and which distinguished ten main areas where disability could be experienced. This Report too, provides a means of assessment for degrees of disability, and for determining the consequent needs which disabled individuals might have. This form of assessment, as with the previous WHO classifications, could be used for different people anywhere in the world.

Autonomy as a basic human need is to have the ability to make informed choices about what should be done and how to go about doing it.' Our aims and beliefs, that is, our own reasons, are what connect us logically to our own actions.' (Doyal and Gough 1991, p.53)

The theory goes on to demonstate that three key variables affect our levels of individual autonomy, which are the understanding that a person has of herself and other people, the psychological capacity which she has to create and structure options for herself, and the objective opportunities which enable her to use them.

The element of understanding depends on what a person is taught, both formally and informally by others. Psychogical capacity includes cognitive and emotional abilities, and ultimately a person's mental health, whereby she is able to act in practical, rational and responsible ways which are socially and culturally relevant and appropriate.

The third variable is the range of opportunities for new and significant action which are available to people through their life roles, and whatever is regarded as meaningful in terms of improvement to a person's lifestyle.

Each person as a member of a social group, anywhere in the world, is potentially a participant in some form of cultural life. This means, in praçtice, that people 'must have the physical, intellectual and emotional capacity to interact with fellow actors over sustained periods in ways which are valued and reinforced in some way. Loss of health or autonomy entails disablement in this respect and an inability to create or share in the good things of life, however they may be defined.' (Doyal and Gough 1991 p.69)

So far this theory has provided clear and useful insights about basic human need, in terms of physical health and autonomy, but the next issue of concern is whether or not these needs are likely to be met.

This depends on the presence of societal preconditions which exist in any particular culture, and which provide a satisfactory living environment for its individual members.

There are four societal preconditions which are required universally , which are defined as production, reproduction, cultural transmission and authority.

In all cultures there has to be production of material goods in order to establish an economic base on which the distribution of wealth, resources, labour and public welfare will depend. This is subject to relative market influences, of course, but in the end, production is the means whereby food, shelter, clothing, leisure facilities and benefits for poorer people can be provided.
The production of, and trading with material goods is essentially a social process, needing rules and regulations for distribution and entitlement. These may vary among different social groups, but they must allow at least, for a basic means of survival. This does not mean that all who need will get, or that all will work who want to. Equality or inequality will be decided according to the agreed systems for distribution, collectively held cultural beliefs and the principles of moral justice which underpin them.

Reproduction has to protected in order for a society to survive. This means that care of women during pregnancy, childbirth, post-natal care and child-rearing are basic precedents to shaping the development of individuals within a culture and hence the type of adults that they are desired to become.

An essential factor in child-rearing is family or kinship structure, insofar as roles and family responsibilities are assigned to parents, particularly women. In societies where women's roles are identified specifically and primarily with biological reproduction and child-rearing, their contribution in terms of production is likely to be compromised and undervalued. This reinforces sexist stereotypes, and assigns a 'natural' right to men to control the processes of production, material wealth and the rules which they choose to apply.

However a society determines its family values, and however these may be oppressive to women, its ultimate success will depend on the processes of reproduction and the socialisation of its offspring.

Cultural transmission is the means whereby the existing values, norms, rites, rules and traditions of any given society are passed among its members, horizontally and laterally between generations. Patterns of communication must be established which will conform to and reinforce dominant normative patterns, and which people can

understand in terms of their own life experience.
Doyal and Gough propose that this is essential in a practical sense and for learning how to deal with productive and reproductive tasks.
Individuals also need to be able to understand rules which legitimate acquisition, and must know and accept what goods they are entitled to in return for their work.

Social structures and cultures can ensure that their most successful values, collective beliefs and methods are passed on by cultural transmission. In this way they can learn from their mistakes and build on their strengths with a minimum of conflict. They may not have all the best results or methods when compared with others whose basic need-satisfaction appears to be higher than theirs, but low levels of conflict within a cultural group, even if there are poor levels of need-satisfaction among its members, indicates that they have internalised and accepted their own principles and rules of distribution.

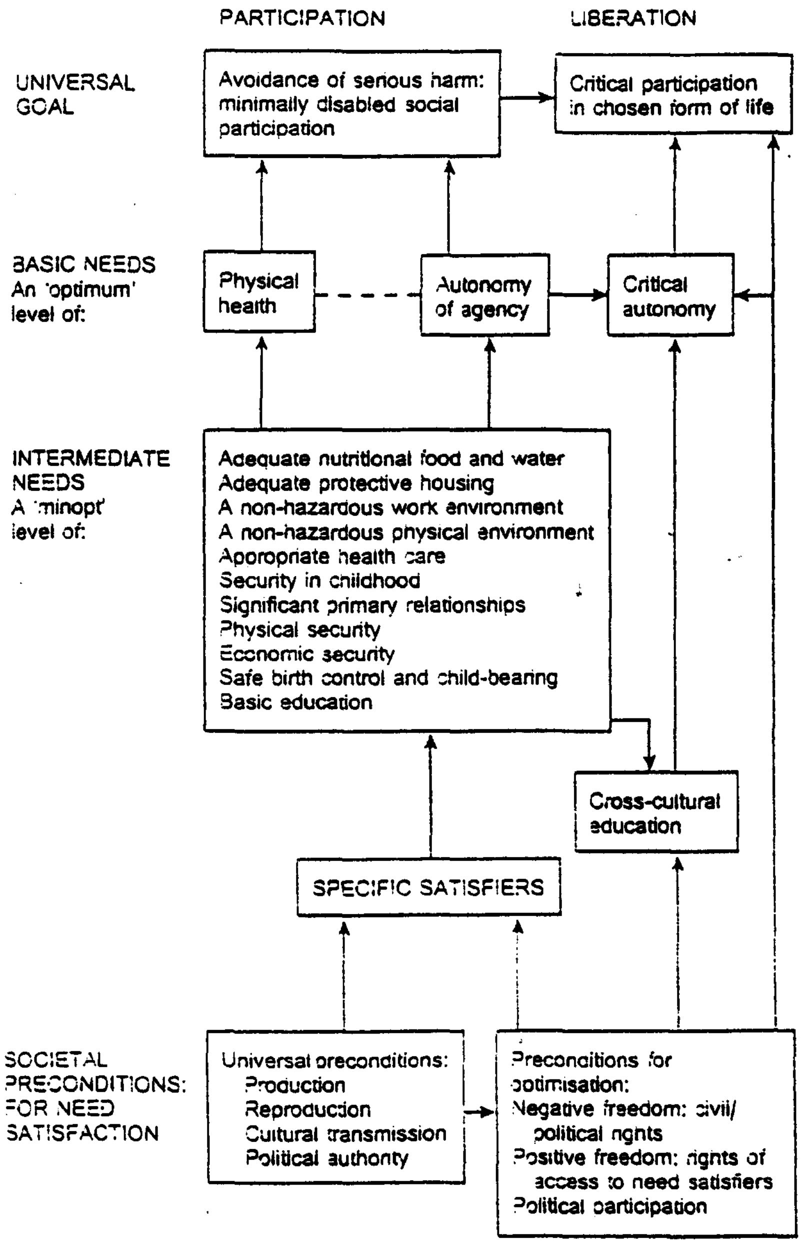
The fourth societal precondition that applies universally is that of authority. This, in fact means political authority with power to hold the rules and normative

structure of a culture or society together. Each must have some kind of government, whith systems for establishing justice and thereby a means of law enforcement.
Individuals within cultures may be inclined to break the rules in order to pursue self interest at someone else's expense or even to cause harm to them. This situation requires a method of applying sanctions which will protect the victim. On the other hand, rules may become unfair, outdated or impossible to apply because values, guided by progressive insights, have changed. Political authority is a means of legitimately changing the rules, and establishing freedom or constraint in a collectively more acceptable way.

The four societal preconditions to meeting human need may appear to be somewhat abstract in the context of this thesis, but Doyal and Gough's theory shows that these are essential for meeting what they term as **intermediate** needs. There are eleven intermediate needs, which are identified in Figure 7 , which illustates the whole theory with all its component parts.

Figure 7.

The Outline of Doyal and Gough's Theory of Human Need.



The theory in outline

The intermediate needs shown in Figure 7 are readily recognisable in terms of European cultural expectations, but apply in other cultural contexts as well, in that to avoid becoming physically ill, all people need a healthy living environment with adequate food, shelter and so on. In fact, we all need a range of environmental inputs which have a material base and which can be identified within the terms biomedical understanding.

In order to survive and maintain a minimum level of physical health we need at least a minimum satisfaction of intermediate needs as they are defined. In order to survive and enjoy our lives, and thereby provide a fair,progressive and supportive environment for and with our cultural fellows, Doyal and Gough come to the conclusion that we should actually aspire to an optimum level of satisfaction of such needs, and should regard this as our civil and moral right to do so.

This conclusion is supported by the United Nations Declaration of Human Rights 1948, the 1963 European Convention on Human Rights, the 1959 Declaration of Rights of the Child, the 1975 declaration on the Rights of Disabled Persons, and the 1979 Convention on the Elimination of all Forms of Discrimination Against Women.

Optimum levels of need satisfaction involve removal of discrimination towards others simply because they are different, in race, religion, sex or sexual orientation, ability or age. This is confirmed in the context of Civil Liberties, but not so in statute. Political oppression exists in many countries, individuals are persecuted because of their beliefs, and people with disabilities are denied access to life experiences which are generally taken for granted by able-bodied contemporaries.
Until guarantees that discrimination and oppression can be eliminated, in all their forms, autonomy as a basic human need is constantly threatened. Furthermore, whilst autonomy is not accepted as both a need and a human right, physical health, the other basic element of human need is also undermined.

Statements of civil rights, which encompass guarantees of equal freedom, protection against unfair state controls and abuses, of legal rights, personal rights, equal rights for women, ethnic and minority groups, and the right to political participation serve as a precondition for optimum need-satisfaction. An index of infringements has been drawn up which can be used to measure the extent to which civil rights are upheld in practice in different countries across the world. (Humana 1996).

(The detail of how this index works in practice is not discussed here, but Doyal and Gough (1991) do show how it can be applied to chart comparative need-satisfaction in First, Second and Third World Countries.)

However, statements and declarations of civil rights and liberties are not enough. In order for societies and cultural groups to progress their development and to be empowered to effect changes which lead to optimum need-satisfaction, their individual members must be given the right to political participation.
Through political participation they are given the opportunity to influence State Policy , policy making processes, and the content of specific policies.
Open debate and the best available sources of expertise are crucial in the process of political participation and decision making - achieving thereby a state of democracy.

In other words, this means a form of government where power resides in the people, and is exercised directly by them or through officers democratically elected by them. The ideal outcome is a social state in which all have equal rights, where there is least possible interference with cultural and individual liberty, and all members experience positive freedom.

Political participation then, is also an essential component for meeting human need. It facilitates the possibility of cross-cultural education within societies, and the satisfaction of intermediate needs which in their turn will ensure that the basic needs of physical health and autonomy are met.

One final point has to be drawn from Doyal and Gough's theory, and that concerns the issues of **reciprocity and altruism**.

A theme is apparent throughout their discourse on human needs, which is that individuals must interact with others in ways that reinforce their collective values, and which are necessarily oriented towards their social relationships. Personal development for each person is based within the context of social relationships with family, friends, education, work and leisure.

Through these relationships common concerns and goals are linked to moral codes and rules which provide the basis for bonding individuals into a concensus of entitlement and responsibility.

This in turn becomes a value base for the ways in which we care for each other and what we are prepared to do for each other. We can, with choice to do so, exercise social morality through reciprocity in a variety of ways. This

can be demonstrated for example, by mutially sharing material goods, time, energy and skills with others, and with a fair expectation that they will do the same for us if we need them to.
This does not involve receiving formal rewards, such as wages for work.

We can go one step further in response to meeting needs of other people by choosing to give of ourselves umconditionally without any expectation of benefit for self at all. This means, in its broadest sense that we can act altruistically and make personal contributions to the vision of common good as it is culturally perceived.

It is essential to draw upon this point because it relates to the activity of volunteering, which is an important issue for this research.
Doyal and Gough's theory of human need validates both reciprocity and altruism in the context of our concern, ability and action which we employ in order to contribute to meeting basic human need for other people who are informal in relationship with us.
In fact, we can pursue altruism for the benefit of those within our own culture and also for THOSE WHO ARE NOT.

Altruism, volunteering or giving to those whose basic needs are not being met is a source of some controversy. Political feminists have argued that it is a means of exploiting women in their caring roles, and others think that it may absolve the State from providing care through mechanisms of welfare provision.

Socoibiologists have debated its possibility as a genetic trait, and Midgley writes, 'The problem of 'altruism' keeps on recurring...as the central insight of sociobiology so usefully shows, behaviour that benefits others does not prevent it (*gene promotion*), providing that those others usually share one's genes... It can make it extremely adaptive to be nice to others... in human beings, the complexities of culture can give them a much wider range of channels (*for their motivations*) than is possible for other species. Virtue is as real a fact as vice is, and the variety of genuine human motives is also real.' (Midgley 1985, pp 122-127).

At the end of the day, altruism exists as part of our capacity to meet human need, and why, if we are free to exercise choices about what we do as part of our own autonomy, should others disallow us to do so? The contention remains because of the inherent risk of exploitation by those in power who can use it to their own selfish advantage, or indeed through ignorance of their own duties.

All of the theories of human need which have been discussed provide insights in different ways which can inform and progress understanding of, and therefore research into human need.
Information about the scope of human need, ways of meeting human need and a construct of human need have all been issues drawn from these three theoretical perspectives. As far as possible, all three will be employed in this work and the research methodology which is applied to it, and will be related to the assessment of needs of patients who are being discharged from hospital.

3.2

Policy and Organisation Issues - Collaboration between Health and Social Services.

The key issues for the provision of safe care on discharge from hospital are that a process for assessment of need for all patients is clearly established, and that both Health and Social Services are structurally organised to provide an appropriate response to need in all cases, thus meeting medical and social needs together in order to satisfy a wide variety of situations.

The sections of this chapter which look at the different people who are likely to become patients, the diversity of their pre-disposing circumstances and subsequent needs show how important these issues are.

The current organisational reality, which has existed since the inception of the Health service and organisation of Local Authorities in 1948, is that two very different agencies have to strive together to meet client\patient need whatever those differences might entail.

Historical Perspectives.

Prior to 1948 there were considerations and debate about the possibility of integrating Health and Social Services into one single organisation. However, proposals that a unified Health Service based on Local Government should be established to replace the systems of Poor Law Care were rejected. The Medical profession opposed the idea because of the need for National funding rather than by Local Authorities which were too small to provide adequate finance, and Politicians were dependent on the dominant Medical profession for their co-operation in actually getting the Health Service to run at all.

Finally a need was politically recognized and accepted that there should be a tripartite structure for Health, consisting of Hospital and specialist services, a community based General Practitioner service, and Local Authority Health Services for the community.

This meant in practice that Medical Social Work, including the original Almoners were to be retained in hospitals and employed by the Health Service, and that District Nursing was controlled and funded by the individual Local Authorities.

Meanwhile, in the Local Authorities, the main services were also divided into a tripartite structure for Children, Mental Health and Welfare which covered Older people and those with Disabilities.

Political hopes, based on the new structures which were enshrined by the National Health Service Act and the National Assistance Act of 1948, were that efficient Health and Social Care service provision for the Nation would lead to a more healthy work-able society overall, eventually leading to a reduction in public spending.

This never became a reality, and after 1948 the costs of both

Health and Welfare provision rose steadily. Also, the new tri-partite structures in the NHS and Local Authorities proved to be cumbersome, inefficient and costly to run. Difficulties arose very quickly due to the arrangement of responsibilities and duties of each organisation where boundaries overlapped or did not meet.

As Loxley comments,

> 'In both Health and Welfare in the 1960's concern grew about the costs of duplication and the failure of fragmented services to meet people's needs. Economic fears combined with political pressure and changing management philosophies to produce a search for equity and efficiency through re-organisation. Social Services was the first to move towards a more integrated organisation in 1970, after the Seebohm Report of 1968 recommended a generic service with a 'one door' policy. The NHS followed in 1974. The idea which influenced the re-organisations not only of the NHS and Welfare services but also of local authorities generally was that of corporate rationalism, which sought through planning management and budgeting to meet needs in the public sector both equitably and efficiently. The structures set up were bureaucratic,stratified and hierarchical and the mechanisms used were central accountability, the separation of strategic from operational planning and financial control through, in the case of the NHS, cash limits.' (Loxley 1997 pp12-13)

At the time of the local Government and Health Service re-organisations in 1971-74 the aim remained to provide demand led services,at least in principle. The means by which these aims were to be achieved were through Co-operation, Collaboration and Communication, which should be the foundation for future working practice within and without the services.

In 1972 Sir Keith Joseph, then Secretary of State for Social Services, stated that Central Government would concentrate on ensuring that that 'two parallel authorities - one local, one health - within their separate statutory responsibilities shall work together in ownership for the Health and Social Care of the population.' (Alsopp 1984)

One year later, the Report of the Working Party on Collaboration between the NHS and Local Government (1972) acknowledged that 'Health and Social needs interact, therefore services interrelate', underpinning the concept that a close partnership and working relationship must be realised between the two.

This report was followed by the Report of the Working Party - Social Work for the Health Service. (DHSS 1973). The first chapter was entitled 'The Realities of Collaboration', and pointed out that collaboration would not be easy for Health and Social Services, and that in fact the success of the two organisations working together depended a great deal on the good will of the professionals directly involved in patient care.

In hospitals where doctors, nurses, paramedical and social work staff actually interfaced with each other to provide patient/client care and to meet their needs as they were being discharged, this statement about 'goodwill' was particularly significant.

Hospital Social Workers.

The reorganisation of the NHS and Local Authority Social Services had altered the managerial and funding responsibilities for two key groups of workers. District Nurses were now part of the

Health Service provision instead of Local Authority and both the original hospital Almoners and Medical Social Workers were moved from Health into the new generic framework of Social Services.

Both professional groups experienced difficulties. District nurses suffered from a lack of direction and planning until the Cumberledge Report in 1986 gave their role in multi-disciplinary working a new status and significance.

Hospital social workers were left in very vulnerable situation for some years to come. From a training perspective, they now had to qualify through the Certificate of Qualification in Social Work. Previously their training had been with Health, and the old Institute of Almoners , which had required one years training with Medical Officers, no longer existed.

The new CQSW training paid sparse attention to any Health related work, and in the early stages did not address the needs of older people to any great extent. The focus of training was on families, child care and mental health, and this was reflected in the priorities and status given to work in the Local Authority based Social Services.

The effect for the Hospital Social Workers was that their work practice and skills dropped to the lowest point of significance in professional terms. Their professional identity was invalidated, and as people they suffered severe demoralisation.

Their new managers in Social services, in some cases did not know what to do with them, in others expressed radical views about whether their work was actually necessary or not.

Some were moved to Area based offices, where pressures were put on them to undertake work which fitted with the new managers' priorities. Others were left in their Hospital bases to get on with their work as best they could.

* In general, these workers were subjected to a discriminatory attitude by their new peers and managers who devalued them and the work which they were trying to do. This had no professional base since most Local Authority managers did not know or appreciate the needs of patients in or leaving hospital, and there was no doubt that this attitude was a reflection of the acrimonious relationship which existed between Doctors and Social Services managers at most levels in the organisation.

Furthermore, Hospital Social Work was seen by other workers as a 'soft option', and an area of work which was professionally risky and deskilling.

Overall, Hospital Social Workers were viewed as little more than Doctors' handmaidens who wore white coats and were a redundant breed. Their expertise did not have relevance to the new Social Services genericism of the 1970s. (Author's note: These views are drawn from my own experience as a CQSW Hospital Social Worker).

At a senior management level in Health, considerable resentment was caused by the placement of Hospital Social Workers with the new Social Services Departments. Doctors felt that their services to patients would be curtailed or disappear, and that hospital beds would become blocked even more than they already were, as a result. This concern was valid, since Social Workers had already objected to operating as 'bed clearers', and different views existed within their own ranks about the nature and priorities of their own task.

This time was one of uncertainty, professional confusion and personal struggle for those at the hospital interface level of practice.

Phoebe Hall wrote in 1976 that another issue

> 'concerns the problems of implementing a community care policy for discharges hospital patients. The Hospitals return their patients to the community and the Local Authority is responsible for their subsequent care. Health Authorities complain that Social Services do not provide adequate community support once a patient is discharged, Social Services criticize the hospitals for failing to notify them of people at risk. The Local Authority Medical Social Workers are caught between the two. It is to be hoped that the newly created Joint Consultative Committee, consisting of health authority and local authority personnel, will iron out some of these difficulties.' (Hall 1976)

The new genericism of Social Work in the 1970's placed many Social Workers and their managers in a state of confusion. Some felt deskilled as they tried to provide services to all client groups, particularly those who had worked previously with adults who were disabled or elderly, and had had no previous child-care training.

In time genericism overall, through service delivery, practice and Social work training, began to be scrutinised as public and media demands gathered pace for more adequate responses to child-care needs and child abuse, care for psychiatric patients and those discharged to the community, and in a few cases for older people who had been abused, neglected and left to die alone.

Gradually, Social Workers began to return to to a specialist focus within their generic teams. By the early 1980's this was formalised with a managerial and resource preference given to child and family work, and specialist training and qualification for some workers in Mental Health.

The focus on child-care and Mental Health left work with older people in the community and Hospital Social Workers in particular, as a second or third rate service. As the more elite groups of workers attracted attention and their demands were seen in the context of media reports, they received resources in the form of staffing and funding whilst the others remained static.

The majority of qualified workers gravitated to child-care and mental health teams, leaving a pool of unqualified workers and social work assistants alongside the mostly unqualified residential and home care staff.

Those workers who moved into Hospital Social Work teams, as the Almomers and older Medical Social Workers retired, found themselves in a world of medically focussed health care staff with language, expectations and attitudes which were unknown to them. Whatever professional identity they may have held whilst working in the Social Service Area teams, or had believed was theirs once they had qualified, appeared to have little credibility in a health care setting.

Their training did not fit with the Health Service professionals' expectation that discharge of patients was a priority. They were criticised as they spent time making application to panels for Part 111 beds. Control over resources they needed from Social Services for patient discharges was held and gate-kept by Area managers and there was no access to private nursing home care unless patients could fund themselves. Furthermore, different social work departments and Areas defined their responses to client need in their own ways, and the hospital social workers had to comply with a range of different attitudes and local rules about service delivery.

Hospital social workers found themselves working in Geriatric Hospitals where beds were blocked by long-stay patients who had never been assessed for their personal, social and long-term care needs, and who were a legacy from the time when institutional care in Health was the only option. They were expected to accompany Consultants on their ward rounds and to behave as their predecessors had before re-organisation.

In Acute Hospitals and Day hospitals the throughput of patients was increasing as the NHS used new treatments and technology, but there were few increases in Social Work staffing resources to match the increased demands on their time.

Until 1976 the only official recommendation to be found for the numbers of staff required in health Care settings was in the Cope Report of 1951, which did not relate to the needs of patients over twenty years later.

In 1976, when the Social Workers in Scotland were transferred to the Local Authorities from Health, the Mitchell Report alerted agencies to the difficulties that would arise. It focussed on the uneven nature of the Hospital Social Work Services and drew attention to the fact that there was very little research which clarified the work situation in hospitals, or the resources which would be needed in different kinds of Hospital settings. (Mitchell Report, 1976)

The Report recommended that Local Authorities should make enquiries into the Social work tasks in the Health Service with a view to producing staffing guide-lines, and that the Scottish Office should promote studies to analyse the tasks, role and function of the Social Workers in these settings.

The response by the Scottish Office some ten years later was a report entitled 'Social Workers and Health Care in hospitals' (SWSG 1988) which examined the Hospital Social Work task. It concluded that patient choice, quality of care and more appropriately organised hospital discharges were effected when Social Work services were provided. It detailed the work which needed to be undertaken with patients and families, and found that increases in numbers of staff were needed in all the hospitals included in the Report. It also showed that Hospital

Social Work Services were more efficient when the workers were based in Hospitals and that patient stay was reduced in many instances through Social Work intervention.
However, the issue of patient/client need in a research context remained unaddressed, and Stevenson (1988) commented that there was a dearth of literature on this subject since the early 1970s.

Given the low professional status which the organisational changes created for Hospital Social Workers, the loss of skilled workers, and the gaps in knowledge and experience of new workers moving into the Health Care settings this absence of information and analysis is no surprise. Previous expertise had been swept on one side, and new workers were having to make sense of their environment and role whilst learning about it on the job.
The new CQSW training did not include a Health Care component, and the new Social Services managers in Hospitals tended to be drawn from Area Social Work settings in preference to the existing Medical Social Workers. They too had learn what the task entailed.

There were two pieces of work which provided information about hospital social work. The first was a study using time diaries (Law, 1981) which looked at patterns of working. The second was a dictionary of client problems which was compiled through analysis of hospital social work referrals. (Murray and Mitchell, 1985). These two stand alone as historical evidence of the work which was undertaken at the practice working interface between Health and Social Services in hospitals.

In 1981 a change in the rules of DHSS funding for people entering private nursing home care enabled hospital social workers to offer a choice of different accommodation for some long stay older hospital patients. Those who did not have private funds were able to claim for benefits to meet a minimal cost for funding their care. As a result, until 1993 when the NHS and Community Care Act 1990 was implemented, increasing numbers of elderly people moved from the previous long stay hospital beds into private nursing homes.

Whether they were enabled to do this or not through social work services depended on the prevailing political attitudes of different local authorities. Labour controlled local authority managers openly resisted the moves of privatisation and openly disapproved of the placements. Others, who held Conservative right wing views, and of course the medial officers whose beds were blocked by elderly long stay patients, endorsed the option and helped or persuaded patients and their families to make the choice to move on from hospital.

In all cases, from 1971 until 1993, any services that patients required when they were discharged from hospital were acquired on the basis of worker's professional or unprofessional judgement, and the way that they interpreted client/patient need. Formal assessment documentation was rare. Services were provided on the basis of request, availability and on exchange of information between hospital and area workers. Requests for placements in Part III residential care had to be supported by formal, written application to panels, and until 1983 an exchange system of hospital beds for Part III beds as patients became ill or recovered was also operated in most local authorities.

No formal policies were constituted for either Health or Social Services with specific rules or directions for the discharge of hospital patients.

A Department of Health circular (DOH LAC(89)7) was sent to all local authorities in February 1989, which set out the responsibilities of health authorities for the discharge of patients from hospital, it asked them to review their existing procedures, and to make sure that patients did not leave the hospital without adequate arrangements being made for their support in the community.

Senior and middle managers were found generally to have not established policies for these most important aspects of service provision, even though they would relate directly to costs and the most effective use of scarce resources.

The two decades following reorganisation were a period of time when service delivery for patients leaving hospital should have been improved, more carefully structured and delivered. Collaboration was intended, and projects were studied by the Personal Social Services Research Unit at the University of Kent, and Bristol University's School of Advanced Urban Studies (Smith, 1993). Action research into collaboration between five different agencies involved with the care of elderly mentally frail people was undertaken by Dartington (1986).

The issues which were identified were the need for allocated finance, clarity of accountability, the need for mutual trust, agreement on leadership and authority, training in skills and knowledge, continuity of relationships, shared locations and adequate time. Loxley (1997) comments as follows on the issues of collaboration:

> 'The philosophy of collaboration as it threads through the public policies implicitly weaves together assumptions of an encompassing model of health, comprehensive and integrated care, the meeting of individual and community needs, and mutual interest for agencies and professionals. But little of this is made explicit, and the common assumption seems to be that the separation of health and social services gives rise to wasteful duplication, costly gaps and undeveloped potential, all of which apparently undesirable results collaboration in intended to overcome .... Collaboration itself has not been much examined either as a concept or as a practice' (Loxley, 1997 p 22-23)

Difficulties of organisation and collaboration for Health and Social Services

The reorganisations of health and social services in the 1970's were the beginning of major shifts in direction for public welfare for decades to come. Political influences were brought to bear on both organisations which were intended to reshape welfare responses to public need, because the then Labour government had to introduce measures to curb the increasing demand for public spending against the economic problems of rising inflation, unemployment and slow economic growth.

At this time, there was a structural gap between state expenditure and government revenues (Walker, 1984). The solution for the Keynesian economic policy makers was to use public borrowing to fill the gap in the economy, and encourage reflation.

This failed and the resulting economic crisis necessitated a change from the Keynesian era of demand management, to the monetarist system of control over the money supply and public sector borrowing, which before 1976 had not been under the direct control the government.

The Labour Government aimed for a strategy that would bring about a steady and substantial reduction in the financial resourcing of the public sector.

In 1979, the election of the Conservative government led to a fuller monetarist strategy with tighter Treasury control over public sector borrowing and expenditure, and institutionalised the subordination of social policy and planning to economic policy making.

Public sector provision therefore became **cost-oriented** rather than **needs oriented.** The powers of local authorities and socialist planners were now explicitly threatened in terms of managerial authority and budgets, and by the growth of corporate power through capitalism.

This all led to a change in relationship between central and local government authorities, and the Health Service. The former became dependent on central government because of its controls on their budgets, and the model of welfare provision which was politically envisaged as a market economy. The NHS, which continued to be funded centrally by the State, also had to re-jig its organisational planning to fit a business orientation which demonstrated cost efficiency and value for money, but also in the context of reduced funding.

Whilst the public sector was forced to follow the rules of the market, and to adopt the terminology of private sector business, it was not the same as private enterprise. Unlike the private sector it could not generate profits which would enable growth and thereby meet the costs, demands and needs of the public - now it's 'customers' - for health and social care services. In fact, health and public sector services became a psuedo-market, framed by business marketing methods, target setting and quality initiatives. But unlike the free market which could compete and grow by improved production and efficiency, the public sector was unnaturally constrained by funding controls, and had to *reduce* its budgets on an annual basis, whilst still responding to community needs. In fact, the changes of political direction and control radically changed the direction of welfare provision from what Room (1979) describes as an institutional to a residual model of welfare distribution. Figure 8 shows the basic outline of three models of welfare provision, which are, working from right to left in the figure, the **institutional model, the market liberal model, and the residual model.**

Figure 8. Three Models of Welfare Provision.

The Models of Welfare Provision

	Residual	Market Liberal	Institutional
Economic Theories	Neo-classical economic theory displaying strong belief in the market system as the most rational basis for social organisation.	Economists of the neo-classical tradition who have moved away from the rigid dictates of laissez faire and are concerned with the functional requirements of advanced societies.	Theories in the socialist tradition concerned with equality and highly critical of the ability of the market system to abolish poverty and promote equality.
Basic Assumptions/ Value Positions	Market mechanism is the best means of distributing life chances. Strong belief in individual self help. Concern that all social institutions would not undermine the work ethic and market incentives.	A belief in the market as an important distributor of life chances. Concern not to undermine the incentives of the market. Also a belief in the need to make social provision for the periodic dislocations in the economy as a functional prerequisite.	Rejection of economic status as a determinant of access to life chances. Emphasises equality and fellowship as the basic elements of the social system.
Role of the State	Role of the State limited to a few specified areas. Provider of minimum subsistence standard of living for those in need.	Sees a broader role for the State as a regulator of the economy and in ensuring full employment. Advocates selective social policies providing reasonable standard of living for those in need. However adequate levels of provision depend on economic growth.	Sees a central role for the State in all areas particularly in the promotion of equality and redistribution.
Nature of Welfare Provision	Through the market by individuals purchasing of privately produced services. State provision is limited to a minimum.	A "mixed" economy of welfare provision through the market and a public sector which provides services on a selective basis usually on the criteria of a means test.	Collective State provision of conveniently available services provided by criteria of need by the State. Social Services seen as a major method of redistribution.
Role of Welfare in Social Integration	Minimal role. Social integration follows from the market system whereby individual self-interest and the common good coincide.	Optimistic theories of growth whereby increasing affluence will be provided for all. By this means social integration will be promoted.	Great emphasis on the vital role of collective welfare provision as a major mechanism for promoting equality and social integration.

As Fig. 8 shows, the institutional model of welfare provision is strongly aligned to socialist theories, and originally emerged at the turn of the century among Fabian socialists. The advocates of this model, who framed their theories in the context of the Poor Law, attacked the free market system of distribution on the grounds that it facilitates the pursuit of self interest to the exclusion of collective goals. The result of the free market system was that western societies became characterised by social problems due to poverty, pocket of public squalor and uneven work opportunities. The market system was viewed as being basically unjust, because rewards and resources are distributed with no clear principles other than individual profit maximisation.

Using this critique of the market system, advocates of the institutional model propose the replacement of an economic free market focus with a different redistribution system as the basis for a new social order.

In the new system, social policies group and treat individuals according to their needs, rather than their economic power. Individual freedom is no longer the primary social value. **Social rights** are publicly defined, and **guaranteed rights** for citizens ensure equal access to a wide range of social experiences which influence their life choices, distributed through contemporary social service, health, education, housing and so on. In fact, social rights involve a guarantee of the individual's free access through social policies, to a share of society's resources (Room, 1979). This model of welfare provision has strong echoes of the theory of human need by Doyal and Gough (1991)

The **market liberal** model shares many of the basic assumptions of the previous one, but seeks to include market incentives into the equation as an important factor in determining life chances and opportunities. It shows an awareness of change towards industrial and societal improvement through the economic growth and places the responsibility on the State to ensure full employment and to provide a reasonable standard of living. Public sector services are viewed as mechanisms which will respond to certain objective social needs, for example to provide economic respite times of market dislocations, to protect the labour force from periodic difficulties such as peaks and troughs in market processes, and to deal with dissatisfaction and unrest among the working classes.

There is a clear concern in the market liberal model to limit State support to helping individuals who are in need. While the model advocates a reasonable standard of living for those who are dependent on the State, it clearly allows the individual's social position to be determined by wages which can be earned within the market, and the wealth which he acquires. There is a significant emphasis on the fact that expenditure on public services must be conditional upon economic growth. Provision for poorer people therefore depends on a larger national income, rather than changing the distribution of wealth. In the context of this model, the market is the key to better societal and industrial environments overall, and market competition is not constrained. The mixed economy of welfare provision involves a commitment to include the voluntary, public and private sectors.

The third model, that is the **residual model** of welfare provision, exphasises that market mechanisms are the fairest and most efficient means of determining standards of living and opportunities. Opportunities for distribution of income, wealth, education and medical services depend on where people are placed relative to the market economy. In ordinary circumstances, they are expected to provide for themselves in times of sickness, unemployment, old age and other situations of dependency which might occur. They should do this through the institutionalised arrangements within the free market, that is by private medical and disability insurance, pension schemes and a range of other financial investment opportunities.

Within the residual model of welfare provision, it is proper for the State to have minimal involvement with social welfare services, and with social policy which will influence market opportunities. A central concern is that social policies which separate life chances from the labour market rewards tend to reduce work incentives, and hence prosperity. For example, why work when unemployment benefit pays more? An additional concern is not to constrain or reduce wage earners (usually male in the context of this theory) responsibilities for supporting their families and dependents.

The market and the family are seen as appropriate channels for meeting needs. Social policies which advocate that the State should take on public responsibilities therefore undermine the capacity of both, creating dependency. They consequently pose a threat to the very foundation of social integration.

Extensive social policies involve high levels of taxation, these too discourage work effort, create problems of economic control (the fiscal system), and act as a hindrance to both.

Residual state support means only providing a bare minimum to those who really need it, and social policies have to support the integration of the market society accordingly.

It is apparent that this model fits with right-wing Conservative government thinking, and that it does not either pay much heed to equality or the roles of women. Family values are likely to be positively centred on heterosexual nuclear family units for financial efficiency. Single parent situations will be cost inefficient and undesirable - a problem, in fact, which will have to be put right.

The three models of welfare provision, and the economy in relation to social need, serve as an indicator to the wide ranging changes that would have to be dealt with at all levels of society when shifts occur in Central Government. Whilst governments issue their statements of intent about the direction of economic policy, it will take some time for these to be integrated into and through all levels of marketing, industry and the organisations.

On the basis of current experience, during§ the time from 1979 to 1997, when the Conservative government was in power and recently lost it to Labour, it seems that two decades is probably the length of time needed. As political influences take effect, public tolerance is guided by collective experiences of these effects, and in the end will determine the shift in government. The economy, and how public welfare provision is structured and constrained or supported has has to shift with the government. Different measures of effectiveness of outcomes have to be used, and clearly, *management of change*

will need to be implemented to facilitate the continuing function of both in meantime.

Since human need is affected by government power for all members of society, it is necessary to look at the sociology of organisations, and to consider how their structures might be also be affected, and what the outcomes might be for workers and non-workers within organisations.

The issue of co-operation, collaboration and communication is of great importance here, as this work has already indicated. Also, collaboration which is intended is not necessarily achievable because it has been expressed in political ideological statements.

The sociology of organisations.

Goals and ideology

The acute general hospital is focussed upon here as the organisation in question.

As an organisation, it is a social unit which has been established in order to meet a primary goal, which is the provision of health care to a given population of people who live outside its physical boundaries.

The operational work of actually providing its health care service takes place within its physical boundaries, and multiple goals, which are intended to be complementary, give direction to its operation and systems which hold it together.

Smith (1975) point out that multiple goals, even when complementary, also produce conflict because different decision making structures may be employed for different goals. Activities relating to different goals may require different skills, resources and more or less autonomy of task.

The overall aim of the organisation may be to achieve all of its goals, but constraints occur and prioritisation of important and less important goals may have to be ordered by those people who have power within the hierarchy of organisation authority to do so.

Acute hospitals thus will function with a complexity of goals, which will be shown in their formal written statements. These have to be operationalized by worker members, through their individual and collective perceptions, and Smith states, invariably disagree in their perceptions of these goals.

Goals within the organisations are often subject to change. Goal displacement occurs when a minor goal replaces the existing dominant goal, and this happens most often when the procedures for administering goals become a goal in their own right. This phenomenon is usually associated with bureaucratic organisations, where administrative processes actually impede operations which are intended to achieve formally stated goals.

As organisations develop and achieve their goals or refine their operations, some goals will become outdated and will need to be replaced by new ones. The process of change then gives rise to a succession of goals. In the hospital setting, changes occur all the time because techniques and technology change, certain specialist facilities may become available or moved to other hospital. Worker skills required as a result will also change, and the organisation will have to modify and change its statements of goals accordingly. In the process, worker perceptions will also change, but in they may not change at the same rate. Unless their understanding about new goals is clear, confusion is possible and they can potentially find themselves in states of conflict about what they are doing, or trying to do.

Smith (1979) says

> 'To understand the real goals we have to understand the organisational conflicts, for the the operative goals of the organisation depend upon which is the dominant group at any particular time' (p8)

Thus the issue of who has sufficient power to be seen as dominant is one of central importance, and this will be discussed later.

It is necessary to return to the significance of worker perception about goals at this point, and to consider groups of workers and the relevance of their perceptions. In order to progress the analysis, different group perceptions are referred to as 'professional ideologies' (p9), as they are held by doctors, nurses or any member of another professional group.

(An ideology is defined as a 'configuration of relatively abstract ideas and attitudes which are used to symbolize an absolute state in which the elements are bound together by a relatively high degree of inter-relatedness or functional inter-dependence' (Smith, 1977).)

Ideologies can be used to distinguish the views of different groups and about the ways that hospitals, and other establishments are organised and actually funtion, whatever the officially stated goals might be.

The concept of ideologies serves to raise an important question about the relationship between ideology (ie the perceptions held by specific groups) and organisational practice.

Geertz (1964) point out that ideologies may function in one of two ways, in the context of interest theory and strain theory. In the interest theory, ideological declarations are seen as part of a universal struggle for advantage, or power, and in the strain theory as part of a chronic effort to correct socio-phychological disequilibrium, or professional insecurity and anxiety.

In theory, then, ideologies may serve as absolute statements of ideal objectives and goals, and the organisation can be seen as the outcome of conflicts between groups, each pursuing different objectives whilst attempting to present **their** goals as **the** goals of the organisation.

Even if ideologies conflict, organisations need solidarity at some point in order to function. As ideologies can conflict, so they can create solidarity which is the other alternative. They can funtion as a subjective means of control, or provide opportunities for rationalizing the organisation's function by pooling and sharing perspectives.

In the context of an actual organisation, such as the General Hospital in question, the importance or power base of any ideology rests in the end with an ultimate source of power or control. If that source is the State, it can ascribe power and resources to serve the interests of any particular ideology, if it can be seen to be meeting the State's goal for the organisation.

When the previous Labour government was in power, medical ideology was extremely important in the context of improving the National Health. As long as the government had economic facilities to fund an institutional model of welfare provision there was no significant conflict.

When economic constraints had to be applied, the power base of medical ideology had to be rationalised by management through the effective use of resources.

Later, when the Conservative§ government came to power and moved towards a residual model of welfare provision, the balance of power between medical and management ideology was moved again as political goals changed.

The ideology of any particular profession or group therefore can serve a range of purposes, depending on its relativity to overarching external goals and inter-organisational goals and functions. From this theoretical perspective, organisational outcomes are the end product not only of stated goals, but the interplay of ideologies that are embedded within the structures and functions.

Compliance and power.

Organisations consist of people working together as a single group, or in the case of a general hospital, a collection of groups which each have specific areas of responsibility in which their tasks are located. All formal work groups depend on some form of order and control for work regulation, working conditions, formal directions or rules, and for the maintenance of their formal rights of contract. Their managers are the people appointed to hold these responsibilities, and who also have formal power designated to them through the organisation's hierarchical power structure.

Workers in groups are required to comply with their contracts for work, and also with their managers' authority in order to be seen to carry out their work tasks effectively.

Etzioni (1961) describes compliance as 'a relationship consisting of the power employed by superiors to control subordinates and the orientation of the subordinate to this power' (p15). He explains that power can be exercised in different ways, to control those who are subordinate, lower order participants in the organisation. Etzioni defines nine different types of power, and the following three are of the most relevance.

Coercive power is exercised by means of threats or physical force, but this is only likely to be used in a hospital setting when specific and extreme behaviour has to be exercised to protect others from harm.

Remunerative power is based on material rewards of goods and money, and normative power rests on the allocation of symbolic rewards, such as status symbols and marks of esteem and prestige.
Etzioni argues that though the elites of organisations can and do use all three kinds of power, they tend to use one more specifically that others to obtain results they require.

For power to be effective, workers responses to power are as important as the type of power which is exerted. Etzioni defines the compliance involvement as the 'cathectic-evaluative orientation of an actor to an object, characterised in terms of intensity and direction' (p9). This means that workers who are lower in the organisation's hierarchy may be indifferent about the way in which power is exercised, or they may feel strongly about it. They may also disapprove or approve, and based on these feelings, exercise **alienative involvement** by strong disapproval, **calculative involvement** by relative indifference, depending on the remunerative rewards obtained, and **moral involvement** by strong approval.
Etzioni suggests that one type of compliance tends to predominate, but I would consider that in a hospital setting, calculative/remunerative and moral/normative typologies apply with regularity. Smith (1979) suggests that there is some confusion as a result of the power/compliance typologies which

Etzioni defines, because of the existence of formal ideology and operative policy. 'Effectiveness' is similarly confusing when the typologies are applied.

Etzioni's theory applies particularly well to simple dyadic relationships, but organisations of complex groupings and operation, such as the General Hospital, have several hierarchies working alongside each other all the time. Therefore, relationships of power and compliance will have to be considered within major groups in the organisational hierarchy.
Power relationships in a General Hospital setting are very complex. The involvement of so many participants, where worker groups at all levels in the hierarchy are interdependent to a greater or lesser extent operationally, means that professionally-based, socially co-operative and collaborative senior management relationships are likely most effective in maintaining the direction of the organisation, and ideologically achieving its goals. This does not mean that the organisation will be ultimately effective in terms of formally measured targets, but that those people in operational working relationships will have a better chance of work satisfaction (Handy, 1982).

The other possibility is that senior managers or professional group leaders may compete for power and influence. The question is, whether this type of competition is harmful or productive?

Handy (1982) suggests that there are three conditions embedded in the situation.

First, whether or not the competition is open, and whether the pool of power is unlimited needs to be clarified. Usually, resources and position power are restricted. Only a few people can head up the power pyramid and control its resources. Expert and professional power, however, are often available to all. It is therefore an option for everyone to increase their personal prestige or professionalism, and thereby add to the pool of power within the organisation. Only if this deprives others of their power would this situation become win-lose, and therefore a closed competition.

Weber's (Weber, 1947) view is that authority relations in bureaucratic structures are limited in scope, and power is not transferred from one social realm to another. A systematic division of labour, rights and power is essential for rational organisation. Not only must each participant know his job and have the means ot carry it out, which first of all includes the ability to command others, but he must know the limits of his job, rights, and power so as not to overstep the boundaries between his role and those of others, and thus undermine the whole structure.

Handy's second condition concerns the important variables which are being controlled by the participants. At the beginning of the managerial arrangements, they usually are, and the aim of competition is to get more variables under one's control. In this condition only nepotistic versions of power culture apply as a rule, and specific people such as friends or relatives may have an initial advantage. This is not particularly relevant to a hospital setting.

The third condition is about power differentials, in situations where there is some degree of power equality. This is only important where role boundaries overlap, and territorial prerogatives need to be resolved. The aim in this case must be to rationalize the power differentials to avoid confusion.
Generally, power competition is not seen to be directly helpful to the tasks of the organisation.
However, power politics are a reality and a feature of organisations. From senior managers downwards, individuals and groups can exert pressure in pursuing their own interests, and there are others who will block them. The successful manager, both in personal and organisational terms is the person who is best able to reconcile divergent interests, that is the differences between individuals and between groups.
In the event that economic resources have to be constrained, or cut back because of central government policies which take away Health Service funding, competition for scarcer resources is inevitably going to be intensified among those who are most powerful within a hospital organisation. After all, their

professionalism in terms of the quality and amount of service they work to provide is under threat. The curtailment of funds means that less is available, jobs and services have to be reduced, and the way that services are delivered is affected.

The 'cost effectiveness' of resources becomes a central focus, and if this means shedding work activities, the threat of loss becomes real for all worker groups. Whose services are most important - as expressed through ideologies - will be an element of the competition.

If an organisation tries to deal with the same volume of work with fewer resources, standards which were possible with more funding will have to suffer when there is less. But within health care, Standard Charters say that they must be maintained to prove that quality services are being provided, and as the tension grows between what is expected and what is possible, all worker groups in the organisation become subjected to organisational stress. This means that the goals of the organisation can always be compromised by external threats, which are expressed by internal organisational dysfunctions.

The most powerful operants internally can usually preserve their rights, and loss is projected downwards through the hierarchies of worker groups. Each has to struggle to survive, and individuals find that they are expected to try to give more of themselves to cover the work demanded of them.

In hospitals and Social Services, which are both affected in the same way by Government constraints, the majority of people with hands-on caring roles are women. The situation is the same then, in terms of women and caring. They are the majority of workers who will bear the stress and whose own economic rights and roles will be at risk.

The Patients

So far, the focus of issues about power has been on senior managers and professional staff in hospital, but power is located throughout organisational hierarchies. Generally people at the top are seen to have the most, and those at the bottom have least. This does not mean that there are predictable decreasing proportions of power from top to bottom, or that a hospital is oligarchical in an absolute sense.

Power is also located where workers are in control of their environment for a greater period of time, in the sense that they may not have designed it, but maintain it with professional skills, decisions, order and are responsible for it by delegated authority. Wards are an example and described theoretically as first line units (Smith, 1979) operating with a degree of autonomy, but in conjunction with others from different worker groups in the process.

Whilst the medical profession is seen as most powerful and dominant, their presence on wards has to be co-operative overall because doctors and nursing staff are interdependent professionally to achieve their organisational goals.

Different professional groups are reconciled within the hospital in their working practice, even though they are accorded different professional status, and in this sense carry with them varying degrees of prestige. A hierarchy exists in this respect, alongside the official hierarchy which is bureaucratically determined, and follows the order of professional, senior professional and non-professional workers groups.

Social workers in hospital are different, because their true locus of control exists outside the hospital, with Social Services. Their prestige is derived from two sources, and as such creates a duality of role. Prior to the 1990 NHS and Community Care Act, and before their role was officially reinforced, their prestige and respect in hospitals was hard won. It depended on how other Health Service workers perceived them in terms of their usefulness through their hospital based activities. They were in reality regarded on a continuum of competence or 'usefulness' , from being essential to useless, and this made their role vulnerable in both a professional and a practice context. Clear role definition and expectation then, also establishes organisational validity and security.
Bywaters (1989) drew attention to the position of hospital social workers, and their status compared with nursing staff. He found that they shared common problems arising from the power of doctors, and their own needs to acquire more security through

professional knowledge and training.

He makes two very important points in his analysis, first that the definition of a 'social model of health' remains imprecise. The common language which is currently being used to disguise a variety of different understandings of what makes for 'health' creates a psuedo-consensus, which in turn masks a failure of the existence in practice to confront factors which maintain profound inequalities in health experience and health care provision.

Secondly, he addresses the issue of gender. Both nursing and social work employ women in the majority to carry out the 'caring' tasks through their professions. Definitions of nursing involve examining the relations between the role of nurse and the general position of women. Both occupations involve doing work which is *low status* because of the values of caring and coping, and define both the identity and activity of women in Western society (Graham, 1983). Men by comparison were advantaged by the introduction of managerialism through the organisational developments in the NHS following the Salmon Report, with the result that there are greatly increased numbers of men amongst nursing and senior hospital managers.

So, if status in the hospital hierarchy is attained by professional expertise, and governed by the division of labour with caring tied to a subordinate and less powerful position, what of the patients who are those needing care and treatment? Once they enter the hospital they become subjects of its rules, regulations and objective treatments. As such, they are stripped of their ordinary life roles and whatever autonomy they had at home, and have already acquired vulnerability because of their impaired physical health.

Patients are dependent on the ways in which workers treat them, apply medical procedures, and the attitudes of workers to them as people. They are the subjects of other people's power, and in terms of the hierarchy are at the bottom in a state of disempowerment. For the period of time that people are in hospital, Smith (1979) concludes that hospital procedures do in effect function to re-define the patients' self image and significant others. Family, relatives and other carers are now in roles which are subordinated by the person's hospitalisation, and dependent on staff to give them information. The difficulties which they are potentially going to experience have already been explored, but it is important to add here, that hospitalization involves inherent risks to people, because of the fear of what will happen to them, and the possibility that their new life controllers might get it wrong.

People obtain much of their health oriented knowledge from outside the hospital, especially through women's information sharing, through literature, mother-daughter caring experiences, and also via the media. What they already know may or may not come to pass, and trusting the doctors and nurses might be a precarious business.

The hospital is a site of public tension, getting in can be difficult, what happens inside creates a life change, and getting out can actually increase life problems.

The effectiveness of the hospital organisation, with its systems of profesionalism, bureaucracy and power depend in the end on the people who are part of it, their collaboration, communication and co-operation with each other and the way they treat their patients - or customers.

3. Theoretical Perspectives on Roles and Systems.

The final part of Chapter 1, section 3. aims to show how roles and systems affect client/patient need as it is addressed by Health and Social Services in the Hospital setting, and as patients are discharged from Hospital care.

Theoretical perspectives are drawn from the work of Goldstein (1973) and Woodhouse and Pengally (1991).

Goldstein discusses the ways in which systems are structured, and how workers/practitioners function within those structures.

Woodhouse and Pengally focus on the interactive processes in any complex of systems, in which clients, patients, practitioners, professionals and agencies each play a salient part.

In particular, the latter address the effects of role related anxiety and the ways in workers are affected, boundary issues for practice, and the dynamics of collaboration with other agencies.

Patient/Client Discharge in relation to Health and Social Service Systems.

Patients are part of a primary system, that of the Hospital setting. The Hospital environment, with all its processes and functions, can be seen as a change system (Goldstein 1973) whose purpose is to restore people to a condition of good health in order that they can move out of that system and return to the community to rejoin their usual and familiar systems of life and care. Whilst in Hospital, patients are subjects of their prevailing environment, in terms of its structural properties and the assigned roles and values of its worker-members.

When they are referred to Hospital Social Workers or Discharge Scheme workers, they are, in effect, handed over to the operants of a secondary system of formal or semi-formal care.

The secondary systems have a key aim which is compatible with that of the primary system, in their intentions to enable patients - now clients - to leave hospital and resume life in the community.

Although Social Workers operate as a secondary system within the hospital setting, they are, in fact, a part of another primary system, which is the community based Social Services. This system, like the hospital system has structural properties, assigned roles and values, but these are not the same for each organisation.

Each system also assigns an identity for its worker-members, which is structured and ordered in the context of its primary functions and environment. Hospital Social Workers are usually removed in an environmental sense from their primary setting in the community.

Since these workers, like patients/clients are also subject to their prevailing environment, there is the possibility that their professional identity may be threatened or compromised in a number of ways. Because of their proximity to a secondary setting, their use of unfamiliar terminology derived from Health care practice or their focus on patient need within the hospital, they may be perceived by their community based colleagues as having too much loyalty to the secondary health care system, or as 'others' who are making demands on primary system functions which challenge routine practice and cannot be met. In this way, the workers can threaten the adequacy of performance and response of colleague workers within their own primary system.

On the other hand, Health care workers may experience the responses of Hospital Social Workers as too slow when patients are to be discharged, or not responding in the way that is expected by the hospital medical staff, and in effect creating obstacles for the effective running of the hospital system.

The outcome may well be that the Hospital staff form a negative view of their functions and identity, even if the system constraints are not their fault.

However well the Hospital Social Workers perform in their secondary setting, they are not Health Service owned professionals, and therefore cannot assume full system identity or integrity within their daily work practice in hospital.

Their role is in fact a sub-system to that of hospital care. Their position in terms of their own primary Social Services system carries the risk that they may also become a sub-system within their parent organisation, and therefore of secondary importance and value to that organisation.

This systems perspective explains the views which Hospital Social Workers have expressed, especially since the 1974 Local Government re-organisation of services, with regard to feeling devalued in their professional identity and task, and somehow existing in a 'no-man's land' between Health and Social Services. Discharge Scheme workers may find themselves in a similar situation. If they are actually employed by Social Services, they are technically part of the same parent system organisation. However, since their functions are different to professionally trained workers, and especially as they work with volunteers whose primary environment is informal and community home based and therefore not subject to the same rules, their identity within Social Services potentially carries even more threat and risk of marginalisation and devaluation.

If they are employed by a different agency, a positive view of their effectiveness will depend on how compatible their functions are seen to be by either Health or Social Services in terms of hospital discharges and safe care in the community. As a sub-system acting between the two, they are also at risk of being exploited by one or the other or both, in order for either to speed up the return of patients to the community or to act in the absence of formal service availability.

Goldstein (1973) proposes that the requirements of any system take precedence over the expectations and concepts of specific roles. A systems sensitive practitioner adjusts her/his activities to the demands of the system itself, and ultimately establishes an equilibrium with respect to the system's variables. Through the identification of the system processes an increased measure of responsiveness and control is made possible.

The difficulty presented to Hospital Social Workers, and to Discharge Scheme workers here is that they are functional links between two different primary systems which are not the same in structure. Any differences within those systems, which create dysfunction and impediments to the requirements of one to the other, are likely to create serious difficulties in both equilibrium, responsiveness and control. Thus the workers are disempowered and at times, rendered ineffective.

The Properties of Systems.

Goldstein proposes that there are two systemic properties in change agency settings, which are inter-systems or more external factors, and intra-systems or internal factors which influence the administration and implementation of practice.
External factors include the way in which the setting's programme is carried out. This needs to be considered in relation to where the specific setting fits into a network of other relevant organisations within the social welfare system. In particular, do the systems operate on a co-operative or competitive terms?
Are there established modes and channels of communication, with the opportunity for exchange of ideas and information?

On the issue of communication alone, at an interface worker level, Robinson's research into Hospital Discharge Planning for Older People (Robinson C. 1994) showed that even within the Health Service there were differences in record keeping, and the

ways in which health service professionals communicated and shared information with each other and Social Workers, even within the same Hospital. Her conclusions and those of the staff involved were that these were problem areas which created difficulties in planning safe discharges where patients' needs would be properly addressed, and in collaborative working which, as it stood, could not provide the seamless pattern of care envisaged in the NHS and Community Care Act 1990.
Furthermore, the problems of communication were found to extend into management thinking and planning, and the overall vision of the services for older people.

Goldstein identified that there could be critical external factor difficulties lodged within systems in terms of problem definition, analysis and planning, with the resultant division or delegation of responsibility concerning how, and by whom the problem would be treated.
On this point alone, whether various organisations and services coincide or conflict, how they define the problem and how priorities are assigned, governs the degree to which practitioners find themselves struggling in an isolated realm of practice apart from other resources and programmes, or in consonance with other endeavours.
In theory therefore, in order for workers to be enabled to function effectively between two primary systems whose aims are in accord, a joint organisational definition of any particular

problem would be necessary, in conjunction with clarity of responsibility and role.

The intra-structural properties of a system are the physical setting, or environment, formal policies, regulations and protocol. These are identified theoretically as regulatory norms by which the organisation's aims are achieved, and include a selection process which determines which people will become users of the service.
Selectivity is an area which presents problems within the Hospital setting at times, because it is the Health Service workers who select the patients who potentially need a Social Work service. Social Workers can then only respond in a re-active way to the Health Service discretion or demands. Their effectiveness is dependent on the Health workers' perception of their role in relation to social care needs. This means that the NHS staff, usually nurses, should have a clear understanding of social needs and the appropriate functions of the Social Work service. In order to obtain this understanding, they would need to have considerable input, preferably during the course of formal training, with regard to social need and the ways in which Social Services are able to respond. Generally, this is not the case. Nurses tend to learn about social needs from their colleagues, by trial and error experience, from exposure to the practice of Hospital based Social Workers, or may be guided simply by their own assumptions.

This method of referral, or selection of clients is precarious. Some people may be missed or even deemed to not be eligible for service because they do not deserve it. Thus a gap in services is likely to occur for individuals and maybe groups of patients, especially if there is no formal guideline for workers to use when decisions are difficult to make.

Direct selection by the Social Workers themselves would be very time consuming and costly because of the sheer numbers of patients admitted to Hospital. It would involve a total screening process by a small number of workers, and as Davies and Challis (1986) observed, screening processes have been tried but are not usually employed as a rule because of cost and worker time.

On a less definitive level than the system's regulatory norms there are also guiding theories and beliefs, which are explicit and implicit philosophies to which the setting addresses itself, with notions about what is 'good' and 'bad' for people. The precepts and values which have existed within a system over a period of time set a guiding culture in which it's properties are embedded.

Its valued theories govern how problems falling within its remit are defined, and the proper means of treating them.

The assigned roles and related norms of the setting's members are bound to its structural properties, and their concepts of responsibility and behaviour bear directly on service delivery. All these conditions not only comprise the structure of the change environment, but create a culture as well.

Over time, these entities fuse into a set of beliefs and behaviour generally shared by members of the change environment. They may or may not expressed at a conscious level by individuals, but a culture is formed which is sensed by outsiders in terms of functionality, informality, freedom or restriction. Cultural norms become tacitly understood and shared regulatory mechanisms which are evident in attitudes, the way people communicate, in jargon that is used and in other styles of performance.

These set the boundaries and conditions for service, and consequently influence the nature of practice.

Goldstein's theory illustrates how complex the properties of systems are both in construction and operation. The behaviour norming process of workers, which becomes a culture, is a powerful means of operational response and control within the system. If it is shared on such an integral basis as the theory suggests, then any intended major changes which need to made will not be able to be effected simply by the introduction of a new piece of written policy, or by a new formal regulation. Change in a system will also involve changing the attitudes and beliefs of staff members. In a hospital or Social Services department this will inevitably involve considerable numbers of people, many of whom might feel threatened by the intended change.

Therefore, as Goldstein notes, changes in institutional practice are notoriously difficult to achieve.

Woodhouse and Pengally (1991) considered the effects of stress and conflict in terms of the dynamics of working relationships within systems. They referred to the work of Menzies Lyth (1970), who studied stress evidenced by hospital nurses, and their consequential and compulsive need to adher to administrative and technical procedures, established attitudes and role relationships.

The theoretical conclusions of this work, which extended the thinking of Jaques (1951), were that professional workers develop socially organised defences against conflict and anxiety which is engendered by their tasks within the organisation. In so doing, they externalised and gave substance in objective reality to their own personal psychic defence mechanisms.

Their defences strengthen entrenched attitudes and agency boundaries in order to resist further stress and conflict, and this in turn actually hinders collaboration and co-operation between workers, which might make their tasks easier. In some instances, their defences give rise to interprofessional dysfunction and conflict which is both projected and sustained.

Woodhouse found too, that administrative and procedural decisions, as well as conflicts and efforts to resolve them, are as much bound up with work related anxiety as they are with rational attempts to define and distribute roles effectively and to promote the staff's performance.

Stress and conflict which affects system workers therefore results in the strengthening of established roles and attitudes, and renders the possibilities of creativity and change very difficult to achieve at any level within the system.

The researchers found too, that the externalisation process, or creation of objective reality which workers develop to cope with stress and conflict at work, also give rise to labelling of other people , either system users or professionals, as causators of their difficulties. Thus patients or clients, or other workers become objectified as 'the problem'.

The process of labelling the atypical ar resistant user simplistically places the onus on them and relieves the setting and system practitioner of responsiblity. Projection of responsibility on to another worker achieves the same end and relieves role strain.

Having once identified others as the problem, workers then do not need to look further for a solution to the anxiety provoking circumstances, and action to resolve them is not taken.

If this theory and thinking is translated into a hospital situation, where anxiety is generated about getting patients discharged in order to achieve a key aim of the system, it is possible to understand how patients who are non-compliant or who resist discharge in some way are seen as problems by medical and nursing staff,with worker associated anxiety and conflict.

Likewise, if Hospital Social Workers do not respond as expected in facilitating discharges as the Hospital needs them to, they also will be labelled along with the patients they are trying to support.

The inherent risk to the 'problem' patients is that they might be discharged before safe care community packages are in place, or worse, that having experienced the problem once the hospital workers deselect patients with some types of social need by not referring them to Social Workers, and discharge them anyway.

These situations seem likely to occur where specific types of patients, or their care needs are not clearly defined as the responsibility of either agency, Health or Social Services, or where the agencies are not in agreement about whose responsibility they are. In such situations the interface workers from both systems will be struggling to provide a care system for which formal structures are not in place, and will inevitably experience stress and conflict as a result.

This brief exploration of systems theory shows that the provision of seamless care between Health and Social Services is complex at many levels, and affects all staff involved in the patient/client needs meeting process.

The external and internal environments to the Hospital system, its history and culture as well as formal policies and regulations, all interact in a dynamic process which does not always have the patient/client with her or his needs at the centre of concern.

Once within a system, each individual is subject to a range of pressures, priorities, attitudes, technology and professions, all of which contribute to the final outcome, which may not be the one desired or anticipated at the outset by any single system participant.

CHAPTER 2

Design and Implementation of the Research Methods

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Design and Implementation of the Research Methods.

Introduction.

The preface to this thesis explained that an Acute General Hospital was to be used as an area for research into Client/Patient need at the interface between Health and Social Services. It described the Hospital population and setting, the Social Work Department and the Hospital Discharge Scheme with Volunteers, which had just begun to operate.

The aims of the research were to construct a view of the Hospital patients over a one year period in terms of their needs for care, in order to show:

- whether patient/client needs were identified and met by Health and Social care professionals,
- which patients needed formal care services before hospitalisation and what those services were,
- if formal and informal care processes were linked together effectively to provide a safe transition from hospital to home,
- whether informal carers could meet care needs in the community as they were expected to,
- and if there was a need and valid role for volunteer support from the Discharge Scheme.

2.1 The Research Proposal and Ethical Issues

In order that this research was accepted and allowed to be conducted in the setting of Mansfield General Hospital, a research proposal was compiled before work actually began. This was submitted for approval to the Board of Medical Ethics, Central Nottinghamshire Health Authority, and to the Director of Nottinghamshire Social Services for consideration by the Directorate of service managers.

Permission was needed from both organisations as confidential records generated by Health and Social Services were to be used in the research process, and patient/client identity had to be protected (Maykut and Morehouse, 1994).

Similarly, the identity of workers had to remain confidential whether they were employed by Health or Social Services. Also, because volunteers were to be participants as workers in the Discharge Scheme, assurances had to be given that they too would be subject to the rules of confidentiality.

The research proposal was accepted and confirmed in writing by the Chair of the Medical Ethics Committee, with the proviso that at any time the research documentation would be made available for inspection. A request was included in the reply that information from the research findings might be considered by the Ethics Committee to help in their future shaping of Health Service provision, if that information was considered to be useful in the context of service improvement.

The proposal was also accepted in writing by the Director of Social Services, on the condition that as a research worker, I would make a link with the newly formed Community Care working group, and advise the group of any findings from the research which would be relevant to their thinking about service provision in relation to the forthcoming NHS and Community Care Act 1990.

The Principal Training Officer, Nottinghamshire Social Services Department, arranged an interview with myself on behalf of the Director, to discuss the research proposal, and to offer support form the Training Section if it was required. He also examined the scope of the proposed research and discussed the implications for the work of the Social Work Unit staff at Mansfield General Hospital.

Preparation for the Research

Once the research proposal had been accepted and permission was granted to proceed, a cascade of consultation and information sharing was set up to brief the Health and Social Services staff whose co-operation and support would be needed during the research period. The following diagram shows the process of preparation which was undertaken prior to the commencement of research.

Figure 9 Diagram of the preparation process for the research.

1. Discussion about the need for research,
   - interface Health and Social Services workers at Mansfield General Hospital, including the Hospital Manager and Group Principal Social Worker

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2. Drawing up of research proposal with title
   - shared with staff and managers at the hospital
   - submitted to the Board of Medical Ethics and Services Directorate.

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3. Research proposal accepted, and permission granted to proceed
   - shared with interface staff, managers and doctors at the hospital
   - research team identified as the Social Work Unit staff

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4. Briefings to staff and volunteers about
   - the scope of the research
   - patient/client confidentiality

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   - access to and use of confidential Health and Social Services records
   - assurances that responsibility for the research information would be held by the Senior Social Worker
   - assurances that normal working practice would not be disrupted

2.2 The research team

The research team consisted of myself, as Senior Social Worker for Mansfield General Hospital, the two social workers who staffed the Social Work Unit, and the newly appointed Discharge Scheme Co-ordinator.

My role, as the research lead officer, was to take overall responsibility for: the research; effective communication with mult-disciplinary staff; the research design and methods; confidentiality with regard to patient/client identity and records used by Health and Social Services; management issues which might arise in the course of the research process; data checking and collation; and the analysis and writing up of the research findings.

My role as Senior Social Worker

In everyday working practice my position as Senior Social Worker and manager carried considerable power and influence with respect to the social work staff and the effectiveness and quality of their work within the hospital. The social workers rarely came into contact with my own line manager, the Group principal Hospital Social Worker, as he was based at another hospital site and much of his own work was focussed toward senior management tasks which took him out of the hospital group catchment area.

Therefore I had almost complete autonomy to conduct my tasks and responsibilities as I chose, and simply had to report to line management at fairly regular intervals about the way the social work unit was being run. As long as the working practices were seen to be problem free, the Group Principal was content with this situation.

At Mansfield General Hospital, and two other hospital sites where I managed social work units, I was a formal member of the hospital Group Management meetings. Operational problems were openly addressed, policy issues, organisational issues, organisational changes and constraints were shared, and the outcomes of this shared forum were a basis for a co-operative working relationship. The effects of negotiation and respectful relations between the managers were reflected in everyday working practice, and proved to be very useful when inter-organisational difficulties arose. Over time, I came to feel that there was a shared value base about working standards and constant monitoring of patient/client care, even though mistakes and miscommunication occurred. At least the platform of trust and respect left doors open for discussion and resolution, rather than blame and labelling which could easily have happened.

I was able to relate to the medical terminology, hospital systems and culture quite easily, due to my previous nursing background. This in turn gave me credibility among nursing staff and managers, and also the social work staff.

Overall, I found that my professional position, management relationships and participatory management style facilitated a congenial working environment where research could be undertaken.

My position within the hospital was a relatively powerful one, where I could influence a range of staff through multi-diciplinary interaction at a number of levels. I considered carefully what effects this might have on the process and outcomes of a research study. There was a risk that I could upset working relationships by demanding too much from social work staff (this is explained more fully later), or even interfere with the process of ward staff referrals for social work support if I appeared to be exploiting a ward operation to serve my own interests. A research project would involve scrutiny of some aspects of working (Somekh, 1994), whether this was to be patient or organisation focussed.

Therefore any hospital research could only be conducted with agreement about the aims of such work, and with positive agreement and co-operation from all the professionals involved. This meant that careful planning and information sharing would have to be part of the research process, not only at the outset of work, but during the course of the work so that everyone knew what was happening. It was important to establish how much control colleagues would have over the ways their work would be reported (Somekh, 1994). Otherwise, I concluded that my professional position and power would not affect the daily flow of work to the social work department which would provide research data in the context of client/patient need, since I was not directly involved in the volume or type of work at the point of generation. I was interested in the **outcomes** of what was an existing, established, reactive organisational process to patient needs on discharge from hospital, and intended to collect data which was already generated by the consequences of ordinary everyday practice from the ward environment.

The Social Workers.

The two social workers, as individuals, were very different people, with different views about social work, and life generally. One was female, with seventeen years of working experience at Mansfield

General Hospital. She was an unqualified worker, from a working class background, and had much in common socially with the nursing staff. She had worked hard to gain a professional understanding and approach to her work, had also accumulated a great deal of medical knowledge, and had undertaken small research projects of her own. The ward staff respected her, and found her reliable and patient-centred, effective when working with patients' families, and most important, she was assertive and confident in interaction with the doctors. The second social worker was male and had recently qualified in England. He had previously worked in Canada with child care and mental health for a number of years. He came from a middle class background, and tended to make social alliances with medical rather than ward staff. Because he was a new social worker, nurses regarded him with some apprehension, and he had to work hard at building trust in the ward situations. He had not been employed in a general hospital setting before, and was treated quite respectfully, as a newcomer who would have to conform to the hospital culture and learn the ropes.

The Discharge Scheme Co-ordinator

The fourth member of the research team was the

Discharge Scheme Co-ordinator. She, like the female social worker, lived locally, and had a working class background. She had worked in both Health and Social Services for many years and had trained as a Registered General Nurse in the late 1960's at Mansfield General Hospital. Her nursing background provided her with credibility in her relations with the medical and nursing staff, and she was very confident about using medical terminology and understanding the organisational systems within the hospital.

Implications for the research team and the research process

This brief account of the four team members shows that as a working unit or group, we had a range of skills and experiences which we could bring to the research process, and to the analysis and interpretation of client/patient need.

As individuals we also had differences in our social backgrounds and professional training. Both of these were important factors because in terms of our own value bases, whereby our differences were integrated and expressed, we each saw and experienced situations differently. Our own prejudices or preferences would, therefore be reflected in the ways that we worked. Likewise, the ways in which we interacted with and our working relationships with other professionals were qualitatively and experientially different. Our own differences, and our working practice and relationships were part of the whole hospital organisation, and we were interactive participants (Maykut and Moorhouse, 1994) in the whole organisation context, just as our work colleagues, patients and their carers were.

We accepted that we would have what Hammersley (1993) describes as a conscious partiality, or partial identification with our research objects, in the context of methodological guide-lines for feminist research. Hammersley says , of conscious partiality, that

> 'it is the opposite of the so-called spectator knowledge (Maslow, 1966:50) which is achieved by showing an indifferent, disinterested, alienated attitude towards the 'research objects' .... Conscious partiality is different from mere subjectivism or simple empathy. On the basis of a limited identification it creates a critical and dialectic distance between the researcher and his 'objects'. It enables the conection of distortions of perception on both sides and widens the consciousness of both the researcher and the researched' (p68).

A strength of the research team was its potential for theoretical sensitivity, through literature that we had read and had available, through our professional experience and implicit and explicit understanding of the hospital, its working members and patients (Strauss and Corbin, 1990). On the one hand, our professional experiences and insights provided a rich base of knowledge about our research environment, but on the other, the same factors could potentially block us from seeing things that had become routine or so obvious that we had ceased to think of this as significant. We had to endeavour to keep our eyes open to what was no longer consciously apparent to us by using techniques of questioning, analysing words and phrases, by using comparison of data, by turning assumptions upside down, and by 'waving the red flag', that is using words or phrases which would prompt us to take a closer look (Strauss and Corbin, 1990).

A particular issue for myself, as the lead research worker, was to be aware of my own power position in relation to my co-researchers, who were also subordinate to my formal authority.

The social workers were under pressure because of high caseloads, and the research project had the potential to add to unit stress. I felt responsible towards them by being aware of this, and asked them at the outset to share feelings of stress and conflicts that the research process might cause, as we went along. I also made an undertaking to them to share a proportion of their work personally, in my own time if pressure became really difficult.

Lomax (1995), in her discussion about action research pointed out that

> 'one way of ensuring collective action is to establish colleagues as co-researchers ... Asking others for information is problematic in action research and is to be approached with care. It might be feedback about one's own practice, or information about outcomes associated with one's own practice. There is a fine line between getting feedback to inform one's own practice, and making judgements about the practice of others ... Persuading others to become co-action researchers is the great art of action research, demanding high level interpersonal skills and strong personal commitment to shared practice on the part of the action researcher' (p53).

I had the power to be supportive in this way, or authoritative by demanding that the work would have to be their total responsibility. I chose the former, and in the end event we all worked overtime without payment to achieve the ends of work completion and the research requirements.

I acknowledged that we would need to use both quantitative and qualitative methods in conducting this research, and that each worker would perform differently because of their implicit and explicit knowledge and working methods. Also, if they were under pressure, their priority had to be to complete their formal work first. I did not think that they would each and always be able to collect complete and accurate data, with regard to all patient/client needs, therefore the data at the end would not be absolutely accurate or complete.

Within my own role, I had the authority to supervise the workers. We agreed that this would be used as a tool for discussion and decision making about complex situations where 'need' was difficult to understand, and where our views could be shared and respected.

A difficulty that can be encountered in the course of action research is the possibility that a co-worker could lose incentive or change her views with regard its aims or even decide to opt out of her role. In this event, the research process could be threatened, and might need to have a change of direction.

Research methodology therefore has to have a means of dealing with this event, which is the discipline of reviewing cycles of action. In cyclical review, the difficulties, threats and opportunities for change are explored, and another direction may have to be considered. We discussed this openly at the outset of the research, and agreed to use the monthly Unit meeting for cyclic reviewing of our process.

2.3 The research methodology

The aims of this research, the environment in which it was set and the means by which it could be achieved, were founded in Action Research methodology. In her paper on action research, Pamela Lomax (1995) describes this method as 'an interaction in practice of being about improvement'. **How** the research is done is important, but so too is **why** it is done.

Action research takes the researcher beyond the aims of finding solutions by means of orthodox quantitative techniques, and objectification of those things and/or people who are being researched. Its form of enquiry involves the researcher herself, in achieving a deeper understanding of values that underpin her own and others' practice, and how these related to the research outcomes.

Action research methodology bridges the divide between research and practice, and starts with questions which practitioners 'feel' they need to find answers to, arising from concerns within their work setting (Somekh, 1994). The actual research takes place there, and no constraints or controls are exerted to change the setting for research purposes.

This methodology applies to the research into client/patient need at Mansfield General Hospital. I had no intention of changing the work context in order to research the situation, but to draw from it the understanding of what was actually happening to the people who had health related and other needs when they became patients within the hospital system, and what happened with regard to their needs when they exited the system.

Lomax (1993) summarises the principles which she found to govern action research, through her own experience, and which governed this research also. They are

1. Action research is about seeking improvement by intervention
2. Action research involves the researcher as the main focus of the research
3. Action research is participatory and involves others as co-researchers rather than informants
4. Action research is a rigourous form of enquiry that leads to the generation of theory from practice
5. Action research needs continuous validation by 'educated' witnesses from the context it serves
6. Action research is a public form of enquiry (p51)

The overarching principle which was applied to research of client/patient needs, and explicitly stated to all who were involved, was that the research work in itself was intended in every way possible to EMPOWER those who participated. Also, the the empowerment which we might establish through the research work would be applied in future for the benefit of other people, patients, carers and colleagues who we did not know.

The Research Design

The research design was crucially important, and had to encompass both the aims of defining client/patient need, and to maximise the opportunities to to do so within the hospital setting, and without disrupting the environment as it already existed.

The focus of the design had to be on areas of need about which information was not readily available, and what was not known, as well as that which was known already.

These areas were:

1) the kinds of need patients had when they were admitted to hospital, and whether they potential needs on discharge could be readily identified **on admission**. The indications about this area were that nurses were expected to apply their understanding and assessment of need at the point of admission, and in the process make referrals to other professionals whose tasks were intended to meet those needs. The nurses and medical staff were responsible for generating referrals ot specialist health care workers, for example in psychiatry, psychology, medicine and surgery where these existed **outside** the general hospital resources. They were also responsible for making referrals to physiotherapists, speech therapists and occupational

therapists for therapeutic treatments and resources to complete the overall care of patients and to meet their functional needs. These resources existed within the hospital.

They also were the case finders for, and referral agents to the social workers, whose tasks it was to ensure that patients' social needs were met and that their social circumstances were appropriate for them to leave hospital.

It has already been stated that the social workers had previous experience of referral not being made for patients in need, and some clarification was to be sought through the research process for the reasons why. The research design was intended to enlighten this situation, and to measure and identify the need as it existed at the point of admission.

2. the second area of enquiry was focussed on the needs for patients as they became clients, and in the process of their change of status required assistance from the social workers.

There was no **formal** system of measuring the numbers of patients who were referred, although the Social Work Unit kept its own informal statistics year by year. As they stood, those statistics had no formal status either for Health or Social Services. It was known that the same number of workers were expected to respond to the increasing numbers of referrals as they reacted to the demands of the increased hospital patient throughput. My view about this was that the social workers were exploited due to lack of formal recognition of their workloads, and subject to work overload and stress as a result. I was told to **prioritize** work when there were too many referrals, but this meant making judgements about not meeting needs for some people. I felt that in doing so I was being required to exercise my professional power and authority in a negative way, to treat patients unequally and actively reduce their legitimate right to a safe hospital discharge.

The social workers had no means of clarifying or categorising the patients' needs which emerged during assessment and care planning. If we were to rationalise our tasks and be effective and properly skilled to meet these needs, there was a real need for us to be professionally prepared to do so, and to advocate for patients, on their behalf, for their needs to be met holistically.

The usual process of dealing with needs-related difficult resolutions was on a one at a time basis, as and when they arose. The same problems kept on recurring, and we were not able to make a rational or effective analysis of how often, why and what needs were actually involved.

3. The third area was with regard to patient/client need and whether or not it was found to have been met once patients were discharged from hospital.
Other hospital aftercare schemes repeatedly reported that needs were unmet after discharge, and there was no monitoring of unmet need for Mansfield General Hospital post-discharge patients. Other reports demonstrated that unmet needs left people at risk, increased probabilities for readmission, and the both patients and their carers were disadvantaged as a result.
This was a most important area, but one which was hidden from both Health and Social Services. The patients and carers themselves were disempowered because of the hidden situation.

There were opportunities to address these areas of enquiry within the working environment of the Social Work Unit, and whatever resources it contained. The action research framework was therefore structured within this context, and Fig 10 shows how it addressed the areas of enquiry, and also spread the research activities among the workers and resources available.

Fig 10. Diagram to illustrate the research framework

*Enquiry area 1 ---> patient/client need on admission to hospital

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Action research activity — Screening project for selected groups of patients on selected wards

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To be undertaken by Discharge Scheme Co-ordinator — Hollins and Abbott Screening project, using interview schedule - **Patient Group 1**

↓

Senior Social Worker **Quantitative and qualitative Analysis of need on admission**

*Enquiry area 2 ---> Needs found during assessment and met in preparation for safe hospital discharge

↓

Action research ---> Social work referrals, action and care plans
activity

↓

To be undertaken---> All referrals to social workers
by social workers using interview schedule, existing referral forms and case records - **Patient Group 2**

↓

Senior Social Worker - **qualitative and quantitative analysis of needs of patients referred prior to discharge**

*Enquiry Area 3 ---> Patient/client needs after discharge to the community

↓

Action research---> Discharge Scheme records in
activity conjunction with social work records

↓

To be undertaken---> All referrals to the Discharge
by Discharge Scheme Scheme using interim schedule
Co-ordinator and additional records generated by volunteer feedback
Patient Group 3

↓

Senior Social Worker - **qualitative and quantitative analysis of need after hospital discharge**

When the three areas of enquiry had been addressed by the workers through their research activity, the final analyses and collection of records became my responsibility, as Senior Social Worker and lead research officer.

The areas of research enquiry necessitated the selection of three separate patient/client group, and these were given the distinctive titles of

Group 1 - the Hollins and Abbott Ward Screening Project
Group 2 - Patients who were referred to the social workers
Group 3 - Patients who were referred to the Discharge Scheme

The details about the selection of the three groups, and how the research activity was conducted with the follows in Section 2.4 of the chapter.

2.4. Research activity with the three selected patient/client groups

The Patient Sample

A total of 1422 patients were involved in this research study. Three different groups were selected, for particular and comparative purposes. The three groups were entitled -

Group 1 - the Hollins and Abbott Ward screening project
Group 2 - Patients referred to the Social Workers
Group 3 - Patients referred to the Discharge Scheme

The three groups represented patients at different stages of their hospital in-patient stay.

Reasons for selection of the three patient groups

Group 1. The Hollins and Abbot Ward Screening Project.
Group 1 was a sample of the raw hospital population - specifically used to investigate a possibility that some patients with a need for help or advice from the Social Workers were being missed by the usual reactive method of referral from the nursing staff.
During the previous four years of work, Social Workers had found that patient needs for referral were sometimes overlooked. Also, a one year screening project of patients aged over 65 years in the Accident and Emergency Department was completed in March 1988 (unpublished report to the Elderly Persons Division, Nottinghamshire Social Services), which showed that when patients were given direct access to a Social Work referral route, the proportion of referrals increased from 9% to 21%. None of the extra referrals were life-threatening,but they indicated that lower levels of need for advice, information about formal and informal services and DSS benefits in particular, were being missed. Not having enough, or appropriate information, was a common feature of a patient's hospital experience, in both a medical and social

context. A report from a survey of patients at the University Hospital, Nottingham (Huehns 1988) illustrated that 75% of elderly patients felt that they had not been given enough information about their condition, and 52% did not understand the treatment they had received.

The method of research applied to Group 1 was to screen every male and female patient admitted to the Hollins and Abbott medical wards over a 28 day period, within 24 hours of admission. A total of 169 patients were screened. It would have been more satisfactory to screen a larger number of the raw population (Hedges 1979) which included male and female surgical wards also, but the time factor, person power and cost involved did not permit.

If it had been possible to include the surgical wards with the medical wards in the screening project, then the aim of discriminate sampling (Strauss and Corbin, 1990) would have been fulfilled. Screening data from surgical wards would have maximised the opportunity for data comparison between the types of ward, and enabled the discovery of similarities/differences about numbers of patients in need of help, and the different needs they might have had.

The screening project was undertaken by the Discharge

Scheme Co-ordinator, using a personal interview technique in conjunction with an interview schedule entitled Form 1 (See Appendix A). The personal interviews with each of the screened patients were guided by Form 1, which had been drawn up in the planning phase of the research project. The general procedure for developing a research schedule was followed (Maykut and Moorhouse, 1994) and resulted in a Form 1 which focussed on areas of patient/client need which the social work staff team, including the Discharge Scheme Co-ordinator, were already familiar with.

When screening began the Discharge Scheme Co-ordinator introduced herself personally to each patient, explained that she was part of a research project and its purpose, gave a statement of confidentiality, and asked for permission to conduct the interview. She also explained that she needed to make notes and to complete Form 1 in order to collect the research data. Patients were given an undertaking that any problems/needs they talked about would be addressed through the social workers, if they so wished. They were shown their own completed Form 1 at the end of the interview, and checked it for accuracy. She approached patient/cliet need in an interactive way which focussed on how families, friends and neighbours as well as formal care services would be available and able to give support discharge from hospital.

In the context of this research component, that is the screening project, the Co-ordinator was very much more engaged at the patient's own level and reality of need than as a researcher whose only focus was to acquire positivist and quantitative data. The screening project was considered therefore to be empowering for the patients, who after all were very disempowered by their hospitalization and patient status.

Oakley (1990) suggests that disengagement from interviewees in research is exploitative, disempowering and discourages rapport. In fact, the people being researched are objectified and depersonalised. The screening project interviews were intended to encourage rapport, give patients the opportunity to think and discuss, make choices and add to information later on. In this way the process of researching was qualitative. Information about equipment, family networks and opinions about formal services were gathered alongside the quantitative data collection guided by Form 1.The Co-ordinator was briefed to provide each patient with a range of information, during screening, about social and voluntary groups, basic DSS benefits, access routes to formal services, and about health queries by reference to the nursing staff.

Group 2 - Referral to the Social Workers.

The second group totalled 1064 patients who were referred to the Social Workers in the usual way, by the nursing staff, and occasionally by the doctor or occupational therapists. This was done by completing a Social Work Request Form with patient details, problem area 1 to 7, degree of urgency and referrer's signature and status (See Appendix B)
This form, called' Mansfield General Hospital - Request for Social Work' (See Appendix B) is self-explanatory. The referral tick box area, containing seven choices, only gives a broad idea to the receiving social worker of what the assessment and subsequent intervention might entail. In the unit based Social Work response system, this information was usually quite adequate. The Social Workers had tried other documents and requests for more patient details, but this always involved checking again with the ward staff, who might not be the same shift as the referrer, and might or might not be aware of the detail of the referral.

Generally, more specific information requests had been found to create more complications than answers.

The nursing staff were not trained as Social Workers, or in methods of social assessment, and to ask them to extend the process of clarifying the Social Work task had proved to be a most uncertain proposition.
The seven tick box areas of patient need on the Social Work Request Form, as broad as they were, did enable nursing staff to make referrals on the the basis of easily perceived concern - if not accurate information - about areas of patient need. Boxes 1 and 7 provided two convenient catchall areas for the referrers to notify a general or unusual problem, without having to agonise on the degree of appropriateness of the referral. Having made the referral, the nursing staff could get on with their own medically focussed role, and wait for the Social Worker to come to them before or after an assessment, if details were needed about a patient's physical condition.

The fact that a referral had been made to the Social Worker should have been recorded in the patient's nursing notes, or in a diary record book on the ward. Sometimes this was not done, and two referrals would arrive for the same patient, made by two nurses on different shifts. The ward staff were made aware that duplication had occurred, and the two referrals were treated by the Social Workers as one. Duplications were always noticed and checked out by the Social Work secretary who collected the referrals from the wards each day. This was important because sometimes, although referrals were apparently duplicated, they occasionally reflected a rapid re-admission to hospital for a patient who had been referred, discharged and returned to the hospital within 24 hours.

Once the Social Work Request Forms had been collected, the secretary recorded them in a Referral Book, and transferred the details to the standard Social Services Department Referral Forms. These were numbered, and any previous case records already existing were stapled to them. The secretary attached a Form 1 - Referral to the Discharge Scheme (Appendix A) to the new referrals, and passed the set of documents to the hospital Social Worker.

The new referrals were received by the Social Workers within four hours of being collected, and the assessment was begun within the next 24 hours.

Referrals from the Accident and Emergency Department were treated as a priority. These were often taken by telephone call direct to the Social Worker, who went to interview the patient within half an hour (longer by negotiation with the A and E sister if the patient needed to be X-rayed or put in plaster). Screening Form 1 was completed at interview by the Social Worker.

The information collected by the Social Workers was used in their care planning process for each patient, and proved to be a very useful way for identifying gaps in services before admission, as well as for drawing up a rota of services on discharge.

For research purposes, the information was collated to show needs for services, to identify changes in service needs, and to identify the different characteristics which applied to patients who needed them. The total number of referrals to the Social Workers was used to make statistical estimates of patients likely to need services within a given hospital population in future. I have already noted that the social workers had agreed that their supervision records should be used for reference and analysis of patient/client need. These proved invaluable, because each time a patient was referred whose needs were very challenging and ways could not be found to meet them, the social workers discussed the situations in supervision. The supervision records then became a rich source of information about need, and the dilemmas that occurred, when, for example, resources were not available, no policy or guidance existed to guide the social workers, or ethical conflicts left the worker disempowered and unable to help.

Group 3 - Patients referred to the Discharge Scheme.

The third group consisted of 169 patients who were referred to the Discharge Scheme Co-ordinator by the Social Workers. They had been assessed to have special needs which the formal services could not meet appropriately.These patients were facing various difficulties which would put them at risk on discharge, and might end up with a readmission to hospital.

Referrals were made by the Social Workers handing a completed FORM 1 to the Discharge Scheme Co-ordinator. They discussed and clarified their information together, and regular updating continued after the referral stage to co-plan the patient's final care package. The Co-Ordinator visited the patient on the ward, and made her assessment by completing FORM 2 - Discharge Screening, with the patient, and carers if they were available. (See Appendix E - FORM 2).

FORM 2 defined a range of tasks with which the patient needed help BEFORE admission, then, given her change of health and circumstances what help she would need on discharge.

Informal carers were identified , and recorded on a matrix of weekdays to show when they called on the patient to give help. The main carer was identified, next of kin, and location of the patient's door-key.(The unknown whereabouts of a key had previously delayed a discharge for up to two days.) A check through available Health Service aids helped the patient to think about any need for equipment at home. Similarly, a check on the patient's functional ability from her point of view ensured that O.T.aids would be available when needed. Reasons for retirement, and personal disabilities regarding diet, sight, hearing, and mobility were recorded.

A further check was made in case there were any outstanding needs concerning housing or welfare rights. If the patient had any communication or emotional difficulties, or had been diagnosed as suffering from mental illness, this was also recorded. When the information was complete, the Co-ordinator was able to match a volunteer to the patient's needs on discharge.

The screening process enabled patient and professional to work through physical, environmental, psycho-social and emotional needs together, thereby agreeing what sort of help was perceived and felt to be appropriate to that individual person.(Stevenson 1989)

At all times during the assessment, the patient's carer(s) and any difficulties they might have in giving support were included. Occasionally, when Form 2 had been completed, the patient and Co-ordinator found that care supports were adequate, so the scheme was not needed. In a very few cases, the actual assessment process helped people to decide that they could cope without a volunteer. These patents were given the option to contact the Co-ordinator after discharge, if something went wrong.

Sometimes, after the care plan had been made, a patient became very ill, needed to be transferred to another hospital or even died. Then the plan had to be abandoned, but wherever possible, information about the patient was relayed to the new ward staff on transfer. A few patients who needed the Scheme had relatives who lived a long way from the Mansfield area. If distant family appeared, they could be included in the care plan at very short notice.

All patients who agreed to use the Discharge Scheme signed a consent form which was retained in the Co-ordinator's case file. (See Appendix C). They were asked if they would give permission for their information to be used as part of the research process, to show how formal care systems succeeded or failed to meet their needs. They were assured of full personal confidentiality and anonymity, and informed that the research was being undertaken to improve the hospital and social care processes

Once the patient had been discharged with a full care package and volunteer support, the Co-ordinator took on the dual role of manager and supporter to the volunteer. A check on the situation was made after 24 hours, and the volunteer then supplied regular progress reports. If the social worker was still engaged with the client, her information was linked to the volunteer's. In the case of a patient who was dying at home, the social worker would become part of the volunteer's support system with the Co-ordinator. When the case was finished, by agreement between the client, volunteer and Co-ordinator, FORM 3 'Volunteer Report' (See Appendix D), was completed, and the volunteer withdrew.

The volunteer report contained a list of fifteen possible tasks which were most likely to be performed. The volunteer noted these and time spent helping the client, for each day of the week, and recorded her number of visits.

The volunteer tasks were categorised as follows:

1. Visiting and social.
2. Practical and domestic help.
3. Transport.
4. Nursing and personal care.
5. Welfare rights.
6. Terminal illness support.
7. Service monitoring.

The volunteers were invited to respond to a choice of eleven questions about the use of the scheme, the clients attitude and response, client satisfaction with formal services, and suggestions for general improvement. It was recognised by the planning group, before the Scheme was in operation, that a precise definition of the volunteer role would be impossible. It was very important to have the situations of clients at home described in the volunteer's own words, because of their intimate, unprofessionalized perceptions of needs and circumstances in a person's own home. Therefore the volunteers were asked to provide a report either by writing on their Volunteer Reports, or verbally to the Co-ordinator, who kept her own case record for each person referred.

The Volunteering situations usually went on for periods of between 2 days to 2 weeks. In the planning stage it was decided that flexibility in response to need was a key issue, and providing that volunteers expressed a wish to continue to meet someone's needs in very difficult or uncompromising circumstances, they would be supported in their task. However, periods exceeding 2 weeks were to be very exceptional. When the volunteers reported their progress, these records became stories in their own right.

The clients' records were used along with the empirical data to complete a very full picture of the needs of the most vulnerable people who were referred for help. They showed the struggles which they went through with the volunteers to resolve their needs, and make their choices, against severe odds of poor health and social deprivation.

The themes which emerged in the records were used to draw out information about patients' and carers' needs, and to inform some clearer understanding of how they felt about their situations.

A most important point to make is that the client records, or stories, were written as expressed in some cases by themselves, but mostly by the volunteers. The volunteers were not professional workers, and not part of the hospital environment. They were part of the patient/client's own world in community, and sympathetic to how they perceived and interpreted need. As such they were not indoctrinated by the mores and traditions of the hospital, nor were they constrained by time and shortages of resources. As lay-people, they were alongside the patient/clients in a more equal and subjective context than professional workers. The volunteers were all fully briefed about the research processes, and consented for their views and comments to be included in the context of needs and their volunteering work. They were assured of confidentiality and anonymity for their own identity.

3.Data Collection - the interview schedule Form 1

Form 1 - Referral to the Discharge Scheme

Form 1 was the key assessment document for both the Social Workers and the Discharge Scheme Co-ordinator. Its format is straightforward as a data profile for any patient, beginning with age, sex and marital status, and followed by reason for admission to hospital. The primary illness, and secondary illnesses or disabilities, whether the patient was living alone, or who she lived with were recorded next. Informal carers ie. close family members - were specified, and anyone else was termed 'other'. These included brothers, sisters, aunts, nephews, in fact all extended kin, friends, neighbours, landladies and lodgers. The person assessing identified their relationship and status.

The next area of information was called 'Existing formal care'. This was a matrix of days of the week with boxes to record the frequency usage of nine different services before admission. The duration in time of each instance was not recorded, but this fact was relevant in structuring formal care support on discharge, and was dealt with by the Social Worker and other formal agent. If the Social Worker, found out from the patient that NHS services had been insufficient, a referral was passed to the nursing staff, who were responsible for negotiating increase or change of NHS services as necessary. They rarely had time or opportunity to feed details back to the Social Worker, because of fast patient turnover and changes in nursing shifts. Therefore this consequential part of the Discharge package remained an unknown quantity. The completion of the 'existing formal care' data matrix informed the assessor whether care was spread out through the week, or whether all services arrived on one day. When services were re-started on discharge, it was possible to have the SSD attendance days rearranged, especially if regular out-patient attendances were to follow. The Social Worker communicated this need to the appropriate social services agency.

This area was very important when service provision needed to be increased, or spread through the week to maximise effectiveness. It could be related to the patient's involvement in social organisations - for the few who were attending any, and to supplement any private help that the patient had independently employed. New needs about NHS community care services were referred to the ward staff.

The next data area recorded details of house ownership, type of accommodation, residential care, and warden facilities. In the final data analysis this was used to consider appropriateness of housing, housing problems, and for identification of different housing circumstances. For example, the fact that there was a housing warden available prompted an enquiry about the type of service that the warden provided, whether she was on call 24 hours daily, only during the day, or only on call from a central telephone contact base away from the accommodation. The provision of a warden meant many different levels of support.

The data collation areas for heating, bathroom, toilet and bed, enabled the assessor to talk through any areas of need concerning a patient's living environment, and to assess whether these areas were going to present functional or safety problems when the patient went home.

This was a key information area, which when related to the patient's illness and degree of disability, indicated various needs for help. Coal fires without exception proved to be a difficulty, and some even existed in warden aided accommodation.

If beds were upstairs, they might need to be brought downstairs by someone prior to discharge, and this fact related to both illness eg. heart attacks, and functional problems with mobility, and quite importantly, whether there was a carer to get the bed down, or incapacitated and not able to do so. When no-one else was available, the hospital Social Worker and Occupational Therapist had to do it. The area based Social Services could not enter a property unless the patient was present. If there was only a toilet upstairs or outside, the Social Worker might refer to them for provision of a commode, and later would have to determine the date of patient discharge so that it would be delivered in time.

Bathrooms upstairs caused problems for some patients, and sometimes they needed alternative facilities for personal hygiene. In a few cases an upstairs bathroom generated a referral to the hospital OT who referred on the area OT for provision of a shower downstairs. If one had been ordered previously, and installation had been delayed, sometimes for months,due to budget shortages, the urgency of need had to be communicated to the Area Office.

The overall assessment of housing and living accommodation facilities served as an indicator for whether a home visit would be needed with the Social Worker, OT and patient. The visit might also involve the patient's carers, area OT, and Domiciliary Services Officer.

The last data collection/assessment area on Form 1 was entitled 'Social Work Tasks'. Having worked through the other assessment areas, the Social Worker used the tasks boxes to identify the tasks which needed to be undertaken before discharge. At this point the question of welfare rights was raised and checked through, to ensure that the patient was claiming all necessary benefits. If not, application forms, DSS leaflets and help to complete them was provided. If the patient was unable to do this, a carer was approached to do it with the Social Worker instead. This area included enquiries about pension books, levels of benefit and any problem that the patient described concerning state benefits.
'New' indicated the provision of a new service not received before hospital admission, 'rein' indicated the need to reinstate services already received and '+' indicated a need for a service increase on discharge. In the case of domiciliary services, a request for increase had to be assessed by the Domiciliary Services

Officer before it would commence. In some areas, the same rule applied to Meals on Wheels, in others the amount of increase requested by the hospital Social Worker resulted in an immediate supply on discharge.

'OT aids' were often discovered as a need by the Social Worker, rather than the OT. This was because the nursing staff had not assessed patients' need for OT aids, nor checked whether they had appropriate aids and adaptations at home. This data area was included to show how many patients received an OT aid/OT assessment as a result of the Social Worker's involvement, whether that meant making a referral to the OT, finding funds for an aid that was not available, fetching or delivering aids for a patient, jointly working with the OT on provision of aids, fetching beds downstairs or taking the patient home to try equipment.

'Housing' referred back to the assessment area of housing, indicating that there was a housing difficulty which needed resolution before the patient was discharged, or soon after. This included rehousing applications, acquiring medical letters of recommendation for a patient to gain housing points, structural problems with homes needing repairs that could not be afforded, a home damaged by fire, or anything else that occurred.

'Family problems' indicated family disputes about who should care for the patient, money, whether the patient should or should not go into residential care, refusal to care, exploitation or abuse of the patient. 'Help with a dependent' meant exactly that, and included occasions when carer and dependent had both been admitted to hospital together.

'Residential care' indicated that some information about, or assessment for residential care was needed. The Social Workers had a very limited role concerning private care arrangements, but they acted as an advocate or alter-ego for those incapacitated patients without a carer if they chose to go into private care.

The Local Authority provided long stay and short stay residential care, which meant that the Social Worker had a choice of five different methods to use for admission , because the hospital catchment area covered five Social Service areas (one in another county) .

4. Data Collection Methods

Quantitative data

Data finding and recording for the three patient groups was undertaken by professional workers and volunteers in the course of their daily routines. The completion of FORM 1 did add a task for the Social Workers, which they were motivated to undertake for several reasons. It encouraged them to look closely at their assessment methods, and to consider 'need' in a fresh way. It did not displace or shortcut any of their skills, but helped them to think about the forthcoming 1990 NHS and Community Care Act, assessment and Care Management roles in the hospital setting.

The Social Workers had taken part in the structuring of the Discharge Scheme, and were testing their own ideas to some extent. They were also engaged in proving their own statements about patient\client need by actively taking part in the research process.

NB At the time when this research was undertaken, there was no formal social work assessment documentation which could have perhaps been used instead of the interview schedule. The schedule - entitled Form 1 - was an early form of an assessment document, and all that was available.

At the end of each week during the one year period of research - October 1st 1988 - September 30th 1989, the Senior Social Worker closed the completed Social Work cases on the the unit, and checked the completed data FORMs 1 with the running records and referral documents. If there was any doubt, the Social Worker who had completed the form was consulted. This system gave a high degree of accuracy to the empirical data. The data FORMs 1 and 2, and records from the Discharge Scheme referrals were handed to the Senior Social Worker when the Co-ordinator had closed each case. These were also subjected to record checking for accuracy.

The data FORMs 1 were entered into six computer spreadsheet programmes on Ability Plus and SPSSX software, to be used as a multiple measuring device (Smith 1975) by the Senior Social Worker. The methods of research were both qualitative and quantitative. This part of the data collection was the quantitative element of the research work. Basic statistical measurements were made which could be compared with the other orthodox empirical data and research findings, in order to compare and contrast the patient groups with others which showed similar characteristics.
The quantitative data served to provide an overview of the patients in hospital with others in the community,

and to demonstrate properties of people in different contexts.

Qualitative Data

The qualitative elements of data collection raised a number of challenges and questions which had to be resolved and satisfied before such data could be used. From an ethical perspective, where personal information, comments and views were to be included, it was essential that the people whose social circumstances were being represented had given prior informed consent. Permission was sought from those patients who were part of the screening project, and those using the Discharge Scheme. They were also fully informed about the aims of the research, and assured that they would not identified.

The same ethical rules applied to the volunteers and social workers, with regard to their records and verbal contributions.

The patients who were part of Group 2, who were referred to the social workers, were the largest research group, and their personal views were not part of the data collection, except in the most generalist sense which did not identify them individually. The records about this group, which were generated internally by the social workers, and included medical information taken from ward records, were the property of the hospital and Social Services Department. The ethical rule for use of this data was that such records, whilst they could be used to represent patient/client need must not facilitate any personal identification of any patient, or particular ward or worker.

The patients themselves were therefore not required to give permission for the departmental records to be used, but the Medical Ethics Committee and Social Services Committee were. This condition was satisfied when the Committees gave written agreement for the use of the records.

The qualitative element of research was essential to capture themes within the written records which could not be quantitatively pre-determined, because I did not know what they would be. The records contained information which was yet to be discovered (Maykut and Morehouse, 1994) and until they were to hand I had no idea of the contextual existence of possible sub-groups, or specific individual circumstances which might be crucially important. In fact. the themes which did emerge were the most important of all, because they revealed patients one at a time at first, who then become parts of larger or smaller groups. For example, these were people with learning disabilities, mental health needs and people who were abused.

By allowing these specific themes to emerge, it became possible to see the whole hospital population in a different way, and to think about needs differently.

The qualitative approach to research in the hospital allowed the research team to express themselves in a way that could be stated, given relevance and be used to influence a process of change. For patients and their carers, it provided a means of expression for the silent voices of the least powerful and most vulnerable participants in the organisation.

I believe that the actual 'insider-researcher' position facilitated more equality and access to parts of the patients' worlds that were not deemed to be relevant in the usual organisational hierarchy of power and control.

The themes in the data which I refer to did not emerge until the period of one year given to the research until it was well under way. The quantitative data was easy to collate and check. The qualitative analysis of the information in the records was not, and needed hours of cataloguing, identifying and re-checking to find some sort of order to represent those patients whose needs were intense, complex and life-threatening. As a result, the focus of the research moved towards these groups, but the aims of the research remained as they had been originally laid down.

CHAPTERS 3, 4 AND 5.

Research Analysis - the needs for formal and informal care

Introduction

The Patient Population

During the period of this research study the total patient discharges and deaths at Mansfield General Hospital were 8014. 1233 (15%) of the patients were referred to the Social Workers, and 169 (14%) of these became client referrals to the Discharge Scheme. (These referrals amounted to 2% of the total patient population).

Table 5. Referral figures for the research period

Time period	Discharge/ death	S.W. referrals	D.S. referrals
1988 Oct-Dec	1924	14% 271 (214)	57
1989 Jan-Mar	1971	17% 328 (282)	46
1989 Apr-Jun	2031	15% 313 (280)	33
1989 Jul-Sep	2088	15% 321 (288)	33
TOTALS	**100% 8014**	**15% 1233 (1064)**	**2% 169**

Table 5 shows that the Social Work referrals increased proportionately to patient discharges and deaths and that during the winter months a seasonal rise occurred ie January - March, when the referrals came to 17%. This was due to the higher number of elderly people who fell ill and had more accidents at that time of the year. This is a national trend. (OPCS 1991) (Ford K. 1992). The social work referrals in Table 5 show firstly the total referrals, and then, in brackets, are the number of referrals which were *not* referred to the Discharge Scheme.

The data analysis is based on three groups of patients, as follows:
Group 1 [Chapter 3] the Hollins and Abbott ward screening project, represents a sample of the raw hospital population ie 189 patients drawn from the total of 8014.

Group 2 [Chapter 4] shows the number of patients who received social worker intervention only - 1064

Group 3 [Chapter 5] shows the 169 social work clients referred to the Discharge Scheme, after social work assessment.

Each of the groups is analysed separately, and later in this work they are compared, to look at differences and similarities that the data about them reveal.

CHAPTER 3.

The Hollins and Abbott Wards screening project

Hollins and Abbott wards were male and female medical wards respectively at Mansfield General Hospital. Patients who were admitted on each ward were screened by using the data collection Form 1 - referral to Discharge Scheme, for a period of one month. The screening was undertaken by the Discharge Scheme Co-ordinator, and aimed to look at a sample of the patients population as a whole, before assessments had been started by any other medical, paramedical or social work professional who would be planning their discharge. In the course of the usual process of referral to the Social Workers, only 15% of patients were referred by the hospital staff, which left 85% of the in-patients who would not see a social worker. This meant that they would not be referred to the Discharge Scheme for support either, since the social workers were responsible for generating such referrals after they had made their assessments of patients referred to them.

The aims of screening a section of the raw hospital patient population were, therefore, to discover if patients who needed social work or Discharge Scheme support were being missed.

The medical wards were chosen because of their consistent patient population. The surgical wards, particularly where older people with fractures were sent on for rehabilitation to another specialist ward, were under much closer scrutiny by the paramedical staff and Social Workers, and subsequently, by the Discharge Scheme. At the outset of this research, it was intended that the surgical wards should be screened. However, time did not allow for this, because of the daily pressure of work on the Social Work Unit, and the Discharge Scheme Co-ordinator.

The patients screened on Hollins and Abbott wards were not representative of all people admitted throughout the Central Nottinghamshire Hospital Group. There were no specialist areas of treatment which would have included younger men, women or children, such as psychiatry, maternity or paediatrics, for example.

Admissions to medical wards in an acute hospital setting relate much more closely to the health care needs of elderly people, covering conditions such as cardio-vascular disease, respiratory illness and malignancy. The four main causes of death after the age of 45 years (at which time it is mostly men who begin to die from coronary artery disease) (OPCS 1985), are coronary thrombosis, strokes, respiratory

disease and malignant growths of all sorts. Men are more likely to be affected by cancer of the bronchi. The peak death rate in the United Kingdom at present is around 80 years, with natural mortality tailing off at a maximum of 110 years (Lodge, 1981)
Over 55% of general medical beds are occupied by people over the age of 65 years, even though they amount to only 15% of the general population. Almost two thirds of all patients admitted to combined medical and geriatric specialties in the UK (OPCS 1991) are aged over 65.

Once in hospital, elderly patients tend to remain longer than average. In 1967 the length of stay for a person aged under 65 was 8 days, compared with 13 days for someone aged over 65. By 1986, the average stay over all for younger patients was reduced to 6.5 days (now the current target for length of stay for specialist orthopaedic patients in the Central Nottinghamshire Health Authority), and to 8 days for those age 65 plus.
Predictably there are complaints that older patients are being discharged from hospital 'quicker and sicker' (Neill and Williams, 1992), with a long term negative impact on the older patient, and a substantially increased burden on families who have to give their time and energy to care for them. It is possible that over time readmission and critical

care for these patients may continue to drive costs higher (Abrams, 1987).

At Mansfield General Hospital the nursing staff often commented on the readmission rate of elderly patients, and the frequent reappearance of some in the Accident and Emergency Department. The concept arose that they were becoming 'revolving door' patients. A typical example was that of an elderly woman appearing first with pain in her hip, who was diagnosed as having nothing wrong physically. However, her mobility caused great difficulties for her family carers who felt that she could not be safely left alone. She was discharged home with a referral for Domiciliary care, only to reappear within the next few days completely unable to walk. Again she was sent home, and the next time the Social Worker saw her, she was on an acute orthopaedic ward with a pathological fracture of the hip. There was a dilemma at her first appearance as to whether the presenting problem was medical or social. At her second appearance it was definitely seen as social because of her need for care at home. Her health need was only confirmed when she actually had a fracture.

Another example was that of an elderly man who presented in the Accident and Emergency Department. This patient had been admitted to hospital several times, and eventually had been discharged to a nursing home after referral to the

Social Workers. On appearance at Casualty he was referred to them again by the consultant in charge of the department. The problem concerned a blocked catheter, which should have been dealt with by a community physician, but a locum standing in for the regular GP had simply told the nursing home staff to send him to hospital without seeing him in the community. The consultant did not know about the Health Authority's responsibility to deal with medical care for nursing home patients and expected the Social Worker to intervene and to resolve what was in effect a Health Service problem. Even when she contacted the appropriate officer no-one knew how to handle the difficulty. Several similar situations occurred causing great frustration .

Patient admissions and readmissions also took place regularly throughout the group of hospitals. Mansfield General Hospital had an alternating system of patient intake with King's Mill Hospital. Patients in some cases, were also transferred to other hospitals for specialist care. It was possible during the screening project to record how many patients were discharged and where they went to, whether that was to their own home, residential care or another hospital.

Data Categories in the Screening Project

The screening process provided a broad data base which illustrated the patients in both medical and social perspectives, and the the data areas are shown in the following order:

(1) Age and marital status

(2) People who lived alone, and their carers.

(3) People who did not live alone, and their carers

(4) Those who had local supportive kin

(5) Housing and heating

(6) Those who were users of Social Services before admission

(7) Occupational Therapy and Health Service Aids before admission

(8) Women's mobility

(9) Social activity before admission

(10) Primary and secondary illness

(11) Patients who were referred to the hospital social workers

(12) Patients who were referred to the Discharge Scheme

(13) Patient destination on discharge

(14) Summary of client/patient needs during the screening project

Throughout the screening project data analysis (wherever it is appropriate) reference is made to other available data such as Hunt's social survey of 'The Elderly at Home' (Hunt, 1978), thereby comparing the patient group with their peers in the community. Hunt's survey has been chosen because it is the only existing single piece of research which covers many of the data areas contained in this research project. It precedes this work by one decade, nevertheless its data has proved vauluable in terms of comparison, showing similarities and differences with regard to patient/client needs and the consequences of reorganisation in community service provision.

All patients were screened within 24 hours of admission, unless they were too ill, very confused or actually dying. The total number screened was 189, ie 111 men and 78 women.

Hollins and Abbott ward screening project - Data analysis

1. Age and Marital Status of Patients

Table 6 - Table to show the age and marital status of the men and women screened

Total patients - 189 111 men = 100% 78 women = 100%

Age group	Married		Single		Widowed		Divorced		Total
	M	F	M	F	M	F	M	F	
-65	36	28	8	6	3	4	5	3	93
65-69	16	5	-	1	3	2	-	-	27
70-74	9	7	1	-	5	6	-	-	28
75-79	12	3	-	-	3	4	-	-	22
80-84	2	1	-	-	6	3	-	-	12
85-89	-	1	-	-	1	4	-	-	6
90+	-	-	-	-	1	-	-	-	1
TOTALS n=	75	45	9	7	22	23	5	3	189
%	68	58	8	9	20	29	4	4	100

52 men and 42 women were aged under 65 years. Overall, half of the patients were in this age group, women being proportionally younger than men. 96 patients were aged over 65 years.

More men were married than women even though the women were younger overall.

Fewer men than women were widowed and equal proportions of men and women were single and divorced.

Table 7 - Comparison of the patients aged 65+ with those in the General Household Survey - Hunt A. 1978

Age	65+	75+	85+
Men % GHS	72	25	4
Hollins Ward %	57	39	3
Women % GHS	63	30	7
Abbott Ward %	57	30	14

* (Percentages are rounded upwards)

Table 7 shows that proportionally the male patients were fewer in the age group 65+ than in the General Household Survey, much more likely to be aged 75+, and almost equally represented in the 85+ age group.

The situation for women was different. There were fewer women aged 65+, equal proportions aged 75+, and twice as many aged 85+.

It appeared that for both men and women, the nearer they were to their potential age for death, the more likely they were to be hospitalised on a medical ward.

Table 8 - Comparison of the same group of patients aged 65+ for marital status

Marital status	Married	Widowed	Single	Divorced
Men % GHS 1978	75	19	4	<2
Hollins Ward %	66	32	<2	-
Women % GHS 1978	38	50	10	>2
Abbott Ward %	46	51	<3	-

This comparison shows that men who were medical patients were less likely to be married and almost twice as likely to be widowed than those in the GHS. They were also less likely to be single or divorced.

Women patients were more likely to be married and equally likely to be widowed, and very much less likely than the men to be single.

2. Men and women who lived alone, and their carers

Table 9 - Table to show men and women who were living alone

Age	-65	65-69	70-74	75-79	80-84	85-89	90+	Total
Men	5	3	5	2	4	-	1	20
Women	5	2	5	4	2	1	-	19
Total	**10**	**5**	**10**	**6**	**6**	**1**	**1**	**39**
%	26	13	26	15	15	3	3	100

Twenty men were living alone, 75% were aged over 65 years. Five reported that they had no carer in the community who could look after them on discharge from hospital, ie 13% of men who lived alone.

19 women lived alone, and 74% of them were aged over 65 years. None said that they were without an informal carer. The informal carers for those men and women who lived alone were mainly kin.

15 men and 12 women were cared for by sons, daughters and other younger family members, one woman was cared for by her sister, and the remaining five men and six women depended on friends and neighbours to look after them. Eleven patients, that is 6% of the total number screened, were therefore totally dependent on people who were not related to them.

The General Household Survey (Hunt, 1978) showed that 30% of people aged over 65 years lived alone. 39% were women, compared with 16% of men.

41% of the screened patients aged over 65 years lived alone, they represented 38% of the women, and 25% of the men.

3. People who did not live alone, and their carers

Table 10 - Table to show who the patients lived with

150 patients (79%) did not live alone. 189=100%

	Men	Women	Total	%
Living with a spouse	75	45	120	63
Living with other relative - son, daughter or other	13	8	21	11
Living with a person dependent on them for care	3	4	7	4
Living in residential care	-	2	2	1

Family Carers

Overall, 68% of men were living with their wives, compared with 58% of women who were living with their husbands, but this proportion changed among older patients. After the age of 65 years the percentage of men had fallen to 66% living with their wives, and to 46% of women who were living with their husbands. All but four patients with spouses named them as their carers. More men than women were living with adult children or other kin.

Patients in residential care

Five per cent of women aged over 65 years had been in residential care before they were admitted to hospital.

Patients who were carers

Seven patients (4%), that is three men and four women, were carers themselves, and had left someone in the community who was dependent on them.

One man lived with a physically frail wife, the second with his mother who suffered from senile dementia.
The third man lived near to his daughter who was suffering from a mental illness. He had enlisted the help of a friend to look after her whilst he was in hospital.

Three women lived with dependent spouses, and a fourth with her mentally disabled son. All the women had been able to call in extended family members who took over their carers roles whilst they were in hospital.

Every patient had someone who could at least be called upon to help out in a crisis that concerned themselves, or their dependent.

However, it was clear from the screening information that 78% of the patients were depending primarily on one carer to look after them when they were discharged from hospital. In the main that carer was their spouse (63%) followed by a son, daughter, or other kin (11%) and finally a mixture of friends and neighbours (4%).

Secondary Carers

The patients were asked if they had a secondary carer to fall back on if, for some reason, their primary carer could not help. Half of the women, and two fifths of the men said that they had. In addition to their informal carers, half of the older patients who were living in warden aided accommodation said that their wardens would possibly become a secondary carer. The wardens views on this were not known.

Health of carers

A quarter of the patients reported that their carers at home had health problems which in particular were of a chronic nature, such as heart disease (involving recent heart surgery in two cases), arthritis, diabetes and chest conditions, ie chronic obstructive airways disease and cancer. It was apparent that as each of these carers and dependents had moved in and out of health crises their care for each other had been reciprocal, and it was difficult to differentiate between who was the carer and who was the dependent.

The patients overall had varying degrees of dependency and§ care needs, which ranged from personal functional help at home for a temporary period, to long-term care because of chronic and sometimes deteriorating illness and physically disabling conditions.

4. Patients who had local supportive kin

81% of the screened patients had family members living locally who would offer some support if necessary.

Table 11 - Table to show which patients had local supportive kin

Age	Screened men	Men with family locally	%	Screened women	Women with family locally	%
-65	52	46	88	41	37	90
66-69	19	16	84	8	5	63
70-74	15	10	66	13	10	77
75-79	15	12	80	7	5	71
80-84	8	6	75	4	3	75
85-89	1	1	100	5	3	60
90+	1	0	-			

There were 20 men (18%) who had no family in the area relied totally on their spouse, if they were married. If widowed or single, they relied on friends, neighbours, formal service from care assistants, meals on wheels and in some cases, a housing warden.

Thirteen women who were without local family all relied on friends, neighbours and formal care in the same way as the men.

Family support appeared to be fairly consistent over all the age groups, until the patients in some cases had outlived his or her family, or they had moved too far away.

5. Housing and heating

The patients were screened for information about their housing situation, and what type of heating they used. Table 12 shows what type of tenure they had.

Table 12 - Table to show tenure of dwelling

Tenure	Men	%	Women	%	All patients
Owner occupier	70	63	36	46	56%
Council tenant	36	32	36	46	38%
Private tenant	5	4	4	5	5%
Private residential care	-		2	3	1%

Men=111 Women=78 All patients=189

A third of the men lived on one level with all facilities, either in a bungalow or flat. Three lived in an upstairs flat and thought that the stairs would become a problem in the near future because of worsening mobility. Slightly more women also lived in a flat or bungalow.

Two thirds of the men lived in a house, but of these 14% had their beds downstairs because of failing health.

Two thirds of the women lived in houses, and 10% had their bed downstairs for the same reason. A further three women were anxious about coping with stairs on discharge.

Table 12 shows that considerably more men than women lived in houses which they owned, fewer men were living in council property, and almost equal proportions were renting as private tenants.

These figures include both younger and elderly patients, and it is not possible therefore to make an accurate comparison with Hunt's findings in the General Household Survey. Her figures are over 10 years old, but even so, when compared in Table 13 shows a similar trend to this study except for privately rented accommodation.

Table 13 - Table of comparison between General Household Survey and all screened patients

	Home owners	Council tenants	Privately rented
GHS 1978	54%	30%	13.5%
All screened patients	56%	38%	5%

The general reduction in available privately rented properties since 1978 probably accounts for the low number represented in this research study.

The fact that 66% of the screened patients lived in a whole house corresponds closely with Hunt's figure for the overall population at 63%, and also for those living with amenities all on one level, whether in a flat, bungalow or maisonette - Hunt 37%, screened patients 35%.

Warden aided accommodation

18 patients lived in warden aided accommodation, all aged over 65 years. There were seven men, and 11 women. The services provided by wardens varied, some were resident within the elderly person's housing complex, on call 24 hours for emergencies and made daily calls to those residents who were frail or ill. Some wardens did not live on site, but paid regular visits to the residents during the day, and were on call from a central telephone point in the area.

Other wardens were only on call when needed and shared their duties with others to several housing complexes.

On the whole, patients were very positive about their warden accommodation, and felt that they would be helped in an emergency. Their comments and criticisms were very similar to those in the Anchor Housing Scheme Report (1984). A few felt that the warden services were not much use to them, particularly if they had fallen out of reach of pull-chords, and could not contact the warden as a result.

Heating

Table 14 - Table to show the types of heating that patients used at home

	Men %	Women %	All pts %
Coal	40	49	45
Gas	52	44	48
Electricity	4	3	4
Communal heating	4	4	4

There was a difference in the percentages of men and women aged over 65 years who used coal. The largest proportion of patients in any group using coal were 70% of women under 65 years, compared with 42% of the men.

All those using coal fires were, or had been, connected with the coal mining industry locally, and they either received a coal supply or some allowance from the Coal Board.
With both sexes, coal fires became a problem after the age of 65, and more so with increasing age when they became dependent on family, friends and formal services to help light their fires. Eight per cent more men than women had gas heating in their homes, and equal numbers of men and women benefitted from electric and communal heating facilities.

No patients were without some form of heating. Hunt's survey in 1978 showed that 28% of elderly people used solid fuel. The higher percentage of patients in Central Nottinghamshire using coal reflects the influence that local industry has on this particular form of heating. Since the 1978 survey, technology and fuel costs for electricity and gas have obviously changed the amount and types of fuel consumption. In 1978 almost equal proportions of elderly people used gas and electricity, in 1989, as the screening data shows, the use of electricity as a sole means of heating is very much reduced, and gas, which has been a cheaper option for fifteen years, especially with the change to North Sea Gas, is a much more popular option.

6. Formal services used by patients before admission

Table 15 - Ages of patients using formal services

	Men % of age group	Women % of age group
-65	9 (17%)	1 (2%)
65-69	6 (32%)	3 (37%)
70-74	6 (40%)	6 (46%)
75-79	4 (27%)	5 (71%)
80-84	5 (62%)	2 (50%)
85-89	-	2 (40%)
90+	-	-
Total	30=27% of all men	19=24% of all w'men

Total patients = 49 Men = 30 Women = 19

Table 15 shows that more men under 65 years were users of formal services than women. After 65 years there was an increase of usage with age, and a noticeable difference in amounts of use between men and women aged 75 - 79. Most men in this age group were still married, whilst most women were widowed. Overall, slightly more men than women used formal services, and they tended to be younger.

Domiciliary Service Users

Table 16 illustrates the percentage of men and women as users of seven types of formal services.

Table 16 - Type of Service they used

	Men		Women		All pts
Domicilliary Services	10	17%	15	41%	29%
Meals on Wheels	5	8%	5	14%	11%
Day Centre	5	8%	3	8%	8%
Respite Care	1	2%	3	8%	5%
Area Social Worker	7	12%	2	5%	9%
District Nurse	6	10%	10	27%	19%
Bath Attendant	6	10%	4	11%	11%

12 of the men used a combination of services, and 18 used only one service.

21 of the women were dependent on a combination of services, and 9 were users of only one service.

In addition to the use of formal services, four men aged over 65 years employed private help to do their laundry and other household tasks, the reason being that it was cheaper and more reliable. Two women also used private help for the same tasks and reasons, one was aged under 65 years, the other was aged between 70-74.

(Two women aged over 85 were in private residential care before admission).

Both men and women patients used the Social Services provision far more frequently than the average person over 65 years in the community, women in particular. The average provision of domiciliary service community care assistance in Nottinghamshire in 1989 was to 11% of the population aged over 65 years. In this study, 17% of male patients having domiciliary services and 41% of women shows a higher concentration of users of this type of service among those elderly people who have an acute medical illness.

People receiving Meals on Wheels

A larger proportion of the patients (11%) both male and female received meals on wheels than those in the general population. The Nottinghamshire Social Services statistics do not show this figure clearly, but based on the provision of numbers of meals per 1,000 head of population in 1989, 5% is a generous estimate.

More women (14%) than men (8%) received meals on wheels. Hunt's survey showed that only 2.6% of people over 65 years in 1978 used this service.

Day Centres and Respite Care

Equal proportions of male and female patients had been attending a day centre prior to admission. There are no local figures to compare these data with, and Hunt's survey does not differentiate between formal and voluntary types of day centre, so this information is very difficult to isolate.

The usage of residential respite care by elderly people is not statistically recorded locally, but the 5% of patients who needed to use respite care, in the context of short-term care or residential care, would probably be about average.

Area Social Worker

12% of the men and 5% of the women were receiving visits from an area social worker before admission to hospital. When this was the case, patients continued to be part of the area Social Services workload, and the hospital social worker acted in a liaison capacity between hospital and area. These patients tended to be multiple users of services, and were usually on the verge of being admitted to residential care if an area social worker was involved with them. Their health and social care needs were inextricably linked.

Hunt's survey showed that 3.9% of elderly people had been visited by a Council welfare officer - the equivalent then of a social worker, and that percentages were appreciably higher for people aged 85+, bedfast or housebound, or living alone. This is much lower than the 9% of patients who were receiving social work help before admission.

District Nurse and Bath Attendant

Equal percentages of men and women received the service of bath attendant (10%) and district nurse (10%). Hunt's survey found that 7.8% of elderly people had received a visit from a district nurse during the previous six months, and more aged people, especially those over 85 years were greater users of the service.

Hunt's survey did not include bath attendants but 10% of the men and 18% of the women who were surveyed were unable to bath themselves without help. Their inability to bath independently increased with age.

7. Occupational Therapy and Health Service Aids

Table 17 - Table to show men and women, and the aids that they used before admission to hospital

* Some patients had several aids

Type of aid	Men	Women
Stick	43	17
Commode	9	12
Wheelchair	12	12
Stair lift	2	1
Bath/shower aids	8	15
Rails (internal and external)	8	5
Dressing aids	2	1
Toilet seat/rail	2	3
Zimmer frame	5	7
Gate	1	-
Urinal	1	-
Ramps	3	3
3 wheel car	1	-
Bed	1	-
Sheets/pillows	2	-
Hoist	1	1
Telephone adapted	1	-
Stencil	1	-
Arm crutches	1	1
Back rest	2	2
Shower	1	-
Chair	-	1
Sheepskin	-	1
Specially adapted house	1	-

Almost half of the patients had been supplied with aids to daily living at home.

Overall, more men had been supplied with more aids - particularly walking sticks. Three men said they had inherited their aids from a spouse who had died.

In Nottinghamshire, Occupational Therapy aids are supplied to approximately 2% of the elderly population. The proportion of screened patients who had such aids were highly concentrated on the medical wards, demonstrating the close association between health care needs and help with disability in the community. This was particularly the case with men, who had been supplied with almost double the number of aids compared to women.

Hunt's survey (Hunt, 1978, p54) found that elderly women are more likely than men to be suffering from some infirmity and therefore more likely to have physical difficulties. More women in her group of people with physical difficulties at home were supplied with aids, except for walking sticks which were used equally by men and women. Only 2.5% of households had a wheelchair user, which contrasts sharply with the proportion of wheelchair users among the screened patients. More women than men used bath/shower aids, commodes and zimmer frames. Even though more men than women had been supplied with aids overall on the medical wards, the largest difference was with walking sticks, 43 men to 17 women. The use of walking sticks relates obviously to a lesser degree of disability than use of a zimmer frame or wheelchair. The conclusion that can be drawn from the differences in types of aids that men and women used, is that the female patients were individually more disabled than the men. This corresponds with Hunt's findings, and also relates to severity of disability with increased age.

Hunt also found that the extent of use of aids was greater when elderly people lived alone, and that elderly Council tenants were more likely to have almost every type of aid. This corresponds with the circumstances of the screened patients, where women were more likely to be living alone, and very much more likely to be Council tenants.

8. Women's Mobility

The female patients were asked to rate their level of mobility in terms of good, fair or poor. 'Good' meant being able to walk about independently both inside and outside their home; 'fair' meant being able to walk about inside their home, but only for very short distances outside; 'poor' meant having difficulty inside their home and being totally unable to get about outside.

Table 18 - Table to show women patients' state of mobility, by age

Age group	100%	Good		Fair		Poor	
		No	%	No	%	No	%
under 65	41	23	56	5	12	13	32
65-69	8	2	25	2	25	4	50
70-74	13	4	31	4	31	5	38
75-79	7	-		3	43	4	57
80-84	4	-		-		4	100
85-89	5	-		2	40	3	60
	78	29		16		33	

This table - although it relates to women who were patients on a medical ward and not an orthopaedic one where falls and fractures cause problems with mobility - shows clearly how poor mobility is directly linked with ill-health and age.

In fact, where patients were over the age of 65 years only six out of a possible 37 said that their mobility was good. Only just over half of the under 65's said the same.

After the age of 75 years, more patients had poor mobility and in this context, it meant that they were housebound.

Mobility over all the age groups was:

Good - 37%
Fair - 21%
Poor - 42%

The 42% of patients with poor mobility related directly to the percentage who used occupational therapy aids (41%), and also to those needing services from formal agencies.

Hunt's survey found that 10.8% of elderly women were unable to go outside their home without help, compared with 3.5% of men in 1978.

9. Social Activity before admission

The patients were asked if they had any social outlets that took them away from their home environment, such as social clubs, the pub, voluntary work, community centres, or special groups such as a stroke club.

42 men said that they had some form of social outlet. Over

half of these were aged under 65, and they engaged in either hobbies or sports. Twelve said they went to the pub regularly. There were 59 men aged over 65. Only a third had some social activity outside their home, and a fifth enjoyed going out for a drink, especially if they lived alone. It was their only means of keeping in touch with the outside world. A further seven had hobbies such as gardening, or bowls, and two said that going to church was their social activity.

Overall, less than half the male patients had a social outlet. Even if they were under 65 years, only half enjoyed a social activity, and even fewer if they were older.

The picture for women was slightly different. Less than half had a social outlet away from home. Only 17 were aged under 65, seven were aged between 65-69 years, seven were between 70-74, two were aged between 85-89 years, and another aged between 85-89 years still managed to go out socially.

More women overall than men were pursuing a social activity outside their home. It appeared that the younger more mobile women were either working or were involved with their families, and therefore less inclined to follow a leisure pursuit than those who were less mobile or living alone. Older women were more involved in some social activity than older men. Townsend (1957, p64) commented that 'age creates many social problems and imposes strict limits on their ability to maintain social activities' The older the person, the less likely they were to be engaged in social activities.

Formal Day Centres

Five men aged over 65 years, and three older women attended a Social Services Day Centre or Day Hospital. Their number accounted for 4% of the patients overall, and 8% of those aged over 65 years. The national provision of day centre/day hospital places is three to four places per 1,000 people in the population aged over 65 (Tester S. 1989), that is 0.35% of the elderly population. Therefore, the medical patients showed a high concentration of users on the two wards. Interestingly, the highest proportion of attendance nationally at day centres/hospitals is by women, but men and women in this part of the current research shows them to be equally represented. Hunt's survey showed that 15% of elderly men attended some form of social centre for the elderly, and 30% attended some other type of social centre, at least monthly. Women were similarly represented. When the G.H.S. data are compared with those of the screened patients, the social centre attendance of both groups are quite similar in spite of the degree of illness and disability among the latter.

10. Primary and Secondary Illness

The medical conditions from which the patients suffered were divided into thirteen categories, covering the whole range of medical and surgical conditions. No specialist medicine was represented. If patients were found to be needing such treatment, they were referred on to another hospital after their general medical needs had been met. Patients are shown in two ways,in the following table in Fig. 14, firstly by their primary presenting illness, and then by any secondary illness which they also suffered from or had a history of.

Table 20 - Patients with Primary and Secondary Illness

Illness Category	Men				Women			
	Primary		Secondary		Primary		Secondary	
	No	%	No	%	No	%	No	%
1. Orthopaedic			6	5			19	24
2. Cardio/vascular	67	61	25	23	46	59	48	61
3. Respiratory	19	17	3	<3	6	8	7	9
4. Neurology			4	<4	1	1	6	7
5. Digestive tract	6	5	5	<5	4	5	2	3
6. Endoctrine	5	4	4	<4	2	3	12	15
7. Genitio-urinary	2	2			1	1	3	4
8. Accident/injury			2	<2				
9. Self harm	4	4	1	<1	4	5	1	1
10.Psychiatric			1	<1			4	5
11.Cancer	2	2			2	3	2	3
12.Other*	6	5	2	<2	12	15	6	8
13.Sensory impairment			6	5			5	6
	111	100	59	53	78	100	114	146

Men = 111 Women = 78 Total = 189

NB *Other - included indeterminate diagnoses such as 'collapse', pyrexia and investigations etc *Secondary illness - this does not relate to primary illness in the same patient.

These data show some important features about the health of men and women, and it is useful to point out their similarities first. Equal proportions of men and women were suffering from cardiac/vascular disease, and this category included heart attacks and strokes. This was the largest single cause of admission to the medical wards for both sexes.

In very much smaller numbers, men and women had illness of the digestive tract, neurological, endoctrine and genito-urinary systems, had attempted self-harm, had cancer, or conditions that are categorised as 'other'.

The largest single difference in illness suffered by men and women was that of the respiratory tract, which affected more than twice the proportion of men. As a secondary illness however, more women had a history of respiratory tract problems.

Endocrine conditions, usually diabetes, affected more men than women as a primary illness, but three times the proportion of women had suffered from it previously.

25% of women had histories of orthopaedic problems, compared with 5% of the men. This fact links with the problems of middle-aged and older women who suffer more from osteoporosis, arthritis and subsequent fractures.

Only 23% of men compared with 61% of women had a history of cardiac/vascular illness, and this is probably associated with the fact that men are much more likely to die from first heart attacks at an earlier age.

Overall, more women had been treated for more illness than men, but continued to survive longer in spite of this. The amount of secondary illness that was recorded for women confirms the fact that older women tend to have poorer health and a greater degree of disability.

As Table 20 shows, the primary and secondary illnesses that present among patients on the medical wards were mostly of a chronic nature. After hospitalisation the majority had been treated for a health crisis, but were not 'cured'. Each episode of acute illness in the course of a chronic condition was likely to leave a patient somewhat frailer, especially in the immediate post-hospital discharge period of days, or even weeks. For women, frailty and loss of mobility, or degree of disability combined with their previous poor state of health, added to the likelihood that they would need more personal care and help at home, be less independently mobile, and much more likely to need another hospital admission in due course.

Hunt's survey (Hunt, 1978 :71) showed elderly people with illness categories in two groups, (a) those who were bedfast or housebound, and (b) the more elderly mobile. There are some points of similarity between her data and that of the screened patients, even though the patients would be more representative as a mixture of Hunt's groups, rather than one or the other.

For expediency, the relevant data area is taken from Group (b) (p71). Hunt found arthritis and rheumatism among 23% of women, this is very close to the 24% of female patients with a secondary orthopaedic illness. Strokes, cardiac and circulatory illnesses were present among 20% of Hunt's men, and 17% of women. The screened patients showed a much higher incidence at 61% and 59% respectively. This may have been due in part to the type of ward that they were treated on, of course, but the figures may also, to some extent, reflect the increase in heart and circulatory diseases in both sexes during the last two decades.

The patients showed similar proportions suffering from respiratory disease, men 17%, and women 8% to Hunt's figures for pulmonary illness at 14% and 6%. The higher figures for the patients are most likely to relate to the industrial conditions in a mining area and the high number of smokers in this working class area.

If the patient illness categories of self-harm and psychiatric illness can be correlated with Hunt's 'nervous conditions' then male patients were proportionally more than those in the general population (GHS 1978) - 6% to 1.9%. Hunt's women amounted to 2.8% compared with 11% of the female patients who were suffering from or had a history of self-harm and psychiatric illness.

Percentages of patients with sensory impairment, usually blindness or partial sight, correlated closely with Hunt's figures at 5% to 5-8% men, and 8% to 6.9% of women.

11. Patients who were referred to the Hospital Social Workers

During the one month period of screening on Hollins and Abbott ward, some of the patients needed to be referred to the Hospital Social Workers before they were discharged.

The figures for admissions of men and women to the two wards for the previous year were checked and the population of the wards was found to be consistent within one or two percent for numbers and age ranges. The figures for male referrals to the social workers at that time were eight patients ie.7% of admissions, but on Abbott ward, the referral rate for women was 21%. During screening the number of male referrals rose to 28, that is a quarter of patients admitted. The referral rate for females remained the same. (As a means of reference, the increased rate of referral to Social workers of 21% overall was similar to results of the screening project in the Accident and Emergency department, referred to previously, which increased from 9 to 21%).

These facts illustrate the point that some patients who needed either information or support from social workers, were missed when the medical and paramedical professionals determined patients' personal and socially related needs.

Table 21 - Table to show numbers and ages of men and women referred to the social workers during the screening project

Age	Men	Women
-65	8	3
65-69	4	3
70-74	5	5
75-79	4	6
80-84	5	3
85-89	1	3
90+	1	-
n=	28 (21% of 136 admissions)	23 (21% of 108 admissions)

This table illustrates that patients referred to the social workers were mostly elderly, the largest number for both sexes were aged between 70 and 85 years.

Table 22 - Table to show whether the referred patients were living alone, with a carer or a dependent

	Men	Women
Living alone	12	10
Living with a carer	14	12
Living with a dependent	2	1
Total 51=100%	28=55%	23=45%

Table 23 - Table to show informal carers for patients living in their own home

Men = 24 (100%)	Primary carer		Secondary carer	
	Spouse	10	Niece	1
	Daughter	4	Friend	2
	Son	2	Neighbour	2
	Sister	1	Warden	5
	Sister-in-law	1		
	Friend	1		
	Neighbour	3		
	Total	22		10
	None	2	None	14
	Total	24		24
Women = 22 (100%)				
	Spouse	10	Daughter	6
	Daughter	5	Son	2
	Son	1	Neighbour	2
	Son-in-law	1	Friend	1
	Friend	2		
	Neighbour	1		
	Total	20		11
	None	2	None	11
	Total	22		22

These data show that 92% of men living in their own home had a main carer, but only 42% had a secondary carer to fall back on. 86% of the women had a main carer, and 50% had a secondary carer to fall back on, if the primary carer support failed.

Some men and women had other family members living locally, but did not see them as possible sources of care, should they need it, because those relatives were either working, rearing their own families, because of family illness, or in a few cases, because family disputes in the past had caused their relationships to break down.

Five men described their housing warden as a secondary carer, but the warden's views about this were unknown. With both sexes, a patient's spouse was the main source of primary care.

The social work tasks that were assessed in the context of 'need' for the patients who were referred, fell into the following categories:

Welfare rights: formal service assessment/reinstatement: residential care for a dependent: residential care for the patient: housing problems: OT aids: Day Centre: advice and support for carers: counselling - self harm: counselling - bereavement: services for the deaf.

Some patients' needs involved more than one task.

Needs for information

In addition to those patients needing to be referred to the social workers, some screened patients also had needs for information which could be provided by the Discharge Scheme Co-ordinator. They were as follows:-

Table 24 - Patients who needed information.

Attendance Allowance	8
Pension	1
Social Services	4
Domiciliary Services	2
Meals on Wheels	1
Referral for OT aids (self)	8
Referral for OT aids (dependent)	1
Housing	4
Volunteer for gardening	1
Prescription	1

A total of 13 women and 16 men were in need of this information, which was given during screening with no social work involvement or follow-up.

In section (6) of this chapter it was found that seven men (6%) and two women (3%) had been receiving area based social work support before admission.

When these were added to the new patients needing referral to the hospital social workers, the total men became 35, and women 24, which was 32% of male admissions, and 31% of female admissions respectively.

If the patients needing information - which by content would be appropriately provided by social workers at that time because no-one else was in possession of such details, then the total patient referrals were considerably increased, to men 48 (43%) and women 40 (51%). These percentages provide a powerful argument for the need for greater involvement by the Hospital Social Workers with medical patients during a period of acute hospitalisation and a need for a development of their role as an active part of the ward based team.

At the time of Hunt's survey (Hunt, 1978), DHSS officers made domiciliary visits to elderly people in the course of assessments and benefits queries. More elderly people - 6% had received a visit from the Social Security/ Supplementary Benefits visiting officer, than other professional officers. The percentages were 85+ - 10.5%, divorced and separated 12.9%, bedfast and housebound 15.5%, Greater London 10.4%, and those living alone - 9%.

Since 1978, the changes in Department of Health and Social Security have led to the removal of visiting officers. The need for Welfare Rights information and advice now usually requires a visit to an Information Centre, or a difficult telephone dialogue with the local benefits office.
The need for DSS benefits assessment and provision of information is essential in any health related setting, but this appears to have no priority in either Health or Social Services policy.

12. Discharge Scheme referrals.

Two male and one female patient were assessed to have a need for use of the Discharge Scheme as a result of the ward screening projects.

The circumstances of the male patients were:-

1) This man was a widower, aged 95 who lived alone. He relied on an elderly female neighbour who was reluctant to continue her support. His nearest relative was a nephew living in Bradford who could not come to help. After his assessment, unfortunately, this man's mental state deteriorated and he was transferred to the geriatric hospital. The Scheme was not used.

2) The patient was a married man aged 64. On this occasion his wife asked for help. She had to work to support them both, and due to his illness had already taken three weeks off work because the hospital could not give a definite date for her husband's discharge. Her husband was disabled, and needed to be cared for at home when he came out of hospital. The wife felt under pressure to return to work because she risked losing her job if she was absent any longer. She asked for an escort to take her husband home, and settle him in while she was at work. The patient was transferred to King's Mill Hospital from Hollins Ward, but the Discharge Scheme Co-ordinator followed his progress. Even though the ward staff in both hospitals knew about the patient's wife

and her work situation, he was discharged from King's Mill Hospital with one hour's notice, and his wife was expected to come and fetch him. A Discharge Scheme volunteer provided transport, escorted the patient home and settled him in as originally arranged, and averted a crisis for his wife.

The one female patient referred was a married woman aged 79, whose husband was frail. Her supportive family who had been caring for him whilst she was in hospital, were going on holiday shortly after her discharge. A volunteer monitored both husband and wife during the period that the family were away, visited them regularly and did their shopping.

Patients 1 and 3 also needed some social work support, but the second male patient did not. He would not have been referred by the ward staff, and therefore the process of referral to the scheme by the social workers would have failed him.

13. Patient Destination on discharge from hospital

There were 136 admissions to Hollins Ward during the project, and 111 men were screened.

The average length of stay in hospital for men was five days with patients aged 65-79 years taking up beds for the longest period of time (27%) - for 10-25 days.

On Abbott ward, 108 patients were admitted and 78 women were screened.

Their average stay was four days, and those staying for the longest period of time (10%) were aged between 65-74 years, who were in hospital for 10-20 days.

Ultimately, patients were either discharged home, went to residential care, were transferred to another hospital or ward, or died.

The outcome was as follows:

Table 25 - Table to show the ages and discharge arrangements for men and women

Men = 136 Women = 108

Age Group	Returned home		NH/Part 111		Transferred		Died	
	M	F	M	F	M	F	M	F
-65	55	45	1	-	13	9	-	2
65-69	15	8	-	-	4	2	2	1
70-74	12	10	1	-	3	5	2	2
75-79	13	5	1	-	3	4	-	1
80-84	7	2	-	-	1	2	1	1
85-89	1	2	-	2	-	4	-	-
90+	-	-	-	1	1	-	-	-
Total	103	72	3	3	25	26	5	7

	Men	Women	All pts
Returned home	103 (76%)	72 (67%)	71.5%
Nursing home/Part 111	3 (2%)	3 (3%)	2.5%
Transferred	25 (18%)	26 (24%)	21.0%
Died	5 (4%)	7 (6%)	5.0%
Total	136	108	224= 100%

These data show that men were more likely to be discharged home after their acute hospitalisation, almost equal proportions of men and women needed to go into residential care, but more women than men needed to go on to another hospital for specialist treatment or rehabilitation, and slightly more women died.

The men who went to another hospital were much younger overall than the women. They were aged between under 65 and up to 79 years, whilst the women were mostly aged between 70-89 years. The oldest patients were sent to the local geriatric hospital for longer term medical care or slow stream rehabilitation. This might have been as short as one week, some however would not ever go home again. This knowledge was responsible at least in part for the frequent reluctance of old people to go to what they still called 'the workhouse'. Some had had relatives in past years, who went there 'to die', and saw this as their fate too when the Victoria hospital was suggested. Occasionally both patients and relatives refused the transfer, preferring to try to manage at home if at all possible.

It was also known that some of the transferred patients were discharged from the geriatric hospital into nursing home care. Therefore, for those patients who did survive their discharge from that hospital, the cumulative number of patients who went into residential homes would be more than the 3% shown on discharge from the acute wards.

The picture of destinations on discharge from the medical wards at Mansfield General matches the national discharge situation quite closely. The Audit Commission (1991) of Regional hospital episode statistics shows that 93% of discharged patients go home to their usual place of residence, and 3-4% are admitted to some form of residential care.

14. Summary of Client-Patient Needs during the Screening§ Project

The data in this section of Chapter 4 provided an information base which was independent of the nursing and medical staff's perceptions and reference frameworks to the Social Work Department.

Screening

Screening was not a generally used method for fact finding, analysis or structural component within the hospital's systems and not at all as part of Social Work systems. As a case finding activity (Davies and Challis, 1986) it was likely to increase workloads for Health and Social Services staff and therefore to create serious tensions for overstretched and under-resourced workers. In this instance both sets of staff were prepared to accommodate the increased workload for the sake of achieving a more accurate picture of client/patient need on the two wards.

Unmet client/patient need

The first and most important fact that the project data clarified was that unmet client/patient need existed. The numbers of patients who needed to be referred to the social workers rose from 7% to 21% for male patients who were admitted.

Directly linked to the need for more social work intervention was the need for information which patients expressed during their interviews with the Discharge Scheme Co-ordinator. The personal context in checking for areas of personal need, which was the basis for screening, facilitated the patients ability to seek information for themselves and became a means of self help once they had acquired the information. This outcome was similar to finding of Tester and Meredith's study (1987) of ways of giving information to elderly people, relating to their health and wellbeing. They found that personal contact enabled elderly people to understand, retain and act upon information, whereas printed and circulated information was usually thrown away and only used by a very small number. (Tester and Meredith, 1987). The need for information about welfare rights and benefits was particularly noticeable. The presence of a Welfare Rights officer in the acute wards would have met this need adequately.

The need for use of the Discharge Scheme as a result of screening, was low. Three patients were assessed to need the scheme - which represented 6% of the 51 social work referrals. One male patient could certainly have been missed if he had depended on the ward staff, since he was not referred to the social workers, and the very difficult plight of his wife as sole carer had been completely ignored by two sets of hospital staff in spite of her communication with them on several occasions.

Needs for formal services

Identification of patients needs for formal services was made in two ways. Firstly, if patients had been using services before admission these services had to be restarted on discharge - with an assessment of whether there was a need for increase in frequency of provision and duration of sessions. Secondly, patients who had not received services before admission were asked if they or their carers or families would need the support of formal services as a result of the period of hospitalisation and physical ill-health, whether for a short or longer period of time. Just over a quarter of all men and women screened had been using formal services before admission.

On average, the men were younger than the women, and more likely to be users of a single service. The need for a combination of more services increased with age.

The outcome of 51 new referrals to the social workers for domiciliary services and meals on wheels was not recorded, therefore the actual take-up of new services remained unknown.

Private help at home

Very few people (four men and two women) employed private helpers at home. There was only one private community care agency in the Mansfield/Ashfield area, and social workers were not expected to refer people to it, mainly for political reasons. Some patients had asked, during screening, if they would have to pay for the Home Help Service, expressing reluctance to do so, had there been a charge.

Patients who had a social worker before admission

Nine percent of the patients (12% of men and 5% of women) had needed social worker support in the community before admission, and continued to need that support whilst in hospital and after they were discharged.

Day Centre and Day Hospital Care

Five men and three women had attended a Social Services Day Centre or Day Hospital, and needed to resume their attendance on discharge. The nursing staff were responsible for re-referral to the Day Hospital, and the social workers did not learn whether this had been done.

Residential Care

On admission, two elderly women were found to have been living in residential care, representing 1% of admissions in the screening project. On discharge the number of patients needing residential care was increased to 6. Three men aged under 80 years, and three women aged over 80 years needed admission to either a nursing home or Part 111 accommodation. They represented 3% of all patients screened.

District Nurses and Bath Attendants

It was possible to identify the numbers of patients who had needed district nurses at home (10%) and those who had help from a bath attendant (10%). It was not possible to record those who were referred for these services on discharge because the ward staff, who were responsible for restarting or initiating these services could not find a reliable means of informing the social worker when they did so.

Occupational Therapy Aids

The need for provision of occupational therapy aids and equipment on discharge was impossible to define. However, almost half of patients had already received aids and equipment prior to admission, and some of their equipment had been inherited from relatives who had died.

Length of hospital stay

The average length of stay in an acute hospital bed was 5 days. Those patients who were referred to hospital social workers needed a longer period of hospital stay - ie two days more on average, and those patients who were transferred to another hospital, 25 men and 26 women, needed hospitalization for a very much longer period. Their length of stay was measured by numbers of days in Mansfield General Hospital for the purposes of the screening project, but they all occupied a geriatric bed in another hospital for at least an average of 15 days more.

Discharge from the acute hospital

To summarise the discharge/transfer situation, 71.5% of patients returned home from the acute hospital, 5% died, 3% needed residential care and 21% needed further hospitalization and ongoing medical care. It was likely that at lest a quarter of those transferred would need residential care also, and the actual number and proportion who would not be discharged home could not be estimated during the period of the project.

We can safely say therefore, that admission to an acute medical word will not simply be an experience of treatment and cure for at least 28% of patients, particularly if they are aged over 65 years, and more so if they are female. In this project only 67% of women returned home compared with 75% of men.

Carers at home in the community

The screening data showed that most patients were depending on informal carers to provide support at home, and expected that support to be available when they were discharged. Almost two thirds were married, and living with their spouses whom they named as carers. Although many partners were fit and well, the issue of carers' health was clearly a concern for some 25%, because of chronic disability or illness. The Co-ordinator noted that interdependence between patients and carers who were equally frail and moving in and out of health crises, indicated a potential for breakdown in the adequacy of informal carer support. The older the patients, the greater the risk of this breakdown seemed to be. As Cheryl Hicks observed (Hicks, 1988 p77) 'Most wives caring for handicapped husbands are middle aged or elderly women whose partners have been disabled by the major illnesses common to their age group: stroke, dementia and Parkinson's Disease ...'. she also found, among the male carers whom she interviewed, that most of them had given up work to care, and in most ways seemed to bear the same burdens and the same restriction on their lives as women carers. (p161). She commented too, that many older women caring for invalid husbands were chronically ill themselves, and it was hard to distinguish between the carer and the cared for.

The National Carers Survey (1985) showed that ill-health among carers for very dependent relatives, ie.those devoting at least 20 hours per week to caring, increased with the age of the carer. Overall, 32% had a limiting longstanding illness, 44% had a long-standing illness, and 21% reported that their health over the previous twelve months had not been good. Jones, Victor and Vetter (1983) found that 60% of carers experience health problems.

It was clear from the screening project that most patients had access to close and extended family, and considered that care would be available. Over 80% reported that families lived locally and were in contact. This figure reflects the finding of the 1986 General Household Survey (1989) that 84% of all those aged 65 and over saw relatives and friends at least once a week, and 33% every or nearly every day. Another similar factor between the Hollins and Abbott patients and the general population was that 11% aged over 65 years were living with relatives compared to 12% nationally (Social Trends 1987)

A conclusion that can be drawn therefore was that most of the screened patients had informal care available to them from families and there was no evidence to suggest that family support was being withheld, or that any significant disintegration of family care was occurring. More patients over 65 years at 51% than the national average at 36% lived alone, but those who had families living locally were supported by them regularly.

Patients without family carers

Eleven patients had no family available at all to care for them. They cited friends and neighbours as their informal carers, who as Cantor and Johnson (1978) observed, were mobilized in the absence of family caregivers as supplemental sources of assistance.

This screening project did not attempt to define informal carers' roles and functions in any detail, but it was obvious that there were many variations in meanings among the replies that patients gave about the identity, quality and reality of actual support that they received. Those patients who said that their friends and neighbours were informal carers were regarded as vulnerable, because, as Bulmer (1987) noted, 'friends and neighbours (are) only available in a crisis or to carry out limited good deeds' Although neighbours can be extrordinarily helpful, going to the shops, cooking meals and making fires, they do not expect, nor are they expected to undertake continuous service. (Townsend, 1965)

There were no women screened who did not have an informal carer to help, in some way, when they went home. Five men who lived alone reported that no-one was available to care for them on discharge. They represented 5% of the male patients, and 13% of those who lived alone.

These men had no-one to perform the domestic daily tasks at home, or to carry out any nursing functions that would be expected of relatives, especially female relative, no-one to give emotional support to them, or even to call for help in a crisis if they were unable to do so themselves. This was a similar finding to Wright's study of people without carers. (Wright, 1983)

Comparison of patients with people in the general population

Although the sample of patients screened in this project was small, they were admitted from all parts of the Central Nottinghamshire catchment area. All had been resident there a number of years. On the basis that they represented a good random mix of people who needed to be admitted for health problems to an acute medical hospital bed, a comparison of their social characteristics with that of the general population was made to clarify any significant similarities or differences which might be relevant.

Those characteristics already discussed were found to be similar, ie. that 80% had contact and support from family living locally; that 11% were living with relatives rather than in their own home, and that 25% of their carers overall were found to have health difficulties themselves. Fig 20 compares the patients for marital status and living alone with statistics from the general Household Survey 1987

Table 26: Screened patients compared with GHS 1987 by marital status and living alone

	Screened patients %	GHS %
Married aged 65+	58	52
widowed	25	32
divorced under 65	9	6
single aged 30+	8	10
living alone aged 65+	36	30

All patients screened: 189=100%
over 65 : 96=100%

(Social Trends No 17 (1987) HMSO: London Table 2:8)

The higher percentage of married patients is strongly influenced by the fact that 66% of men aged 65+ were married compared to 46% of women.

Home ownership and heating

A comparison of home ownership by patients with the GHS 1987 shows an interesting difference. In 1987, 63% of all home in great Britain were owner occupied. Only 56% of the patients owned their homes, and this figure is much closer to Hunt's findings (1978). This fact reflects the general view that the Central Nottinghamshire area had fallen behind in economic affluence, and was affected by higher levels of poverty than other areas. At times the unemployment rate had risen to 19%.

The larger number of patients aged 65+ affected the owner occupancy percentage. The GHS (1987) also showed that for people aged 60-69 years, 57% were home owners, those aged 70-79 the percentage fell to 52%, and dropped again to 46% for people aged 80+ years (Table 8.25)

The heating arrangements in patients' homes also deserves some comment. 55% were using coal fired heating, and many more simply had gas fires at home. It would be a generous estimate that 45% had the benefit of central heating. Nationally, in 1987, 66% of all homes were centrally heated. (Social Trends 1990, Table 8.10)

Health

Finally, some observations need to be made with regard to the illness/health state of the patients from Hollins and Abbott wards.

The data collated about women's mobility showed clearly how problematic walking and getting about independently had become among the very old. Even though the women were on a medical ward and had not been admitted for orthopaedic treatment, very many more than would be found in the general population were affected (46% nationally and 69% of screened women)

Men's mobility was not examined, but Table 20, showing men's and women's primary and secondary illnesses, demonstrates that 5% reported orthopaedic disability.

Generally, people do not die because of orthopaedic illnesses, but deaths are recorded as a result of falls. In December 1988(Social Trends 1989) 17.1 thousand people died in this way. Falls are the major cause of home accidents treated in hospital by age and sex among all age groups. The incidence of falls increases noticeably among men and women after the age of 65 years, as follows:

Social Trends 1989 Table 7.19

Presenting accidents	Men	Women
Aged 65-74	40.2%	59.9%
75+	67 %	75.8%

Orthopaedic illness/disability rated as the second most frequent problem for both men and women who were screened, with an incidence of 5% for men and 24% for women (all age groups)

The two medical wards admitted patients mostly on an unplanned basis. They came via the Accident and Emergency Department or by GP emergency with a range of illnesses and life threatening conditions. Cardiac and vascular illnesses were the most frequent causes for 61% of men and 59% of women. Both men and women were found to have these as their most predominant secondary illness also. The 1989 OPCS survey of Population Trends showed that these conditions were the major cause of death for men and women, and the local patients reflected the national trend very closely. The second most frequent illness for men was respiratory. 17% presented with a variety of respiratory conditions, compared with only 8% of the women. Again, this was a reflection of the national incidence for deaths, but the female patients were fewer than could have been expected.

The third most frequent illness for men, and fourth for women was for conditions of the digestive tract. Many of the patients were likely to have had cancer, or to have been treated for cancer previously, but this was not disclosed during the screening process. It was at the doctor's discretion that a patient knew whether or not s/he was suffering from a malignant condition, as a result some patients did not know. National statistics showed that cancer of the stomach and intestines is the third major cause of death over all for men and women.

The remaining illness categories in frequency by admission continued to follow the national trends for causes of death including self harm and suicide among men. The incidence among women patients in this study was twice a high, equalling that of men at 4.5%. (Population Trends 56 Summer

1989 HMSO)

The data in the Screening Project overall, showed a picture of the male and female patients on acute medical wards in Central Nottinghamshire, which reflected the national picture of people receiving such health care in the context of age, gender, illness, disability and informal care.