## II. SURVEY METHOD

Data for this study was collected by means of a survey of elderly patients (65 years and over) who were admitted to the Royal Sussex County Hospital in March, 1985. They were interviewed in their own homes after discharge, using a pre-coded questionnaire designed for subsequent data analysis on SPSSX. From the earliest planning stage the project was conducted with the support and encouragement of the Brighton Health Authority and East Sussex Social Services Department. Appendix I lists the series of consultative meetings held in the course of which useful advice was gratefully received by Members of the CHC Ad Hoc Sub-Committee for Primary Health Care from professionals working in the field and familiar with the procedures being used.

### 1. Questionnaire Design

The preliminary draft of the questionnaire was based on earlier survey work in this field, in particular the study conducted by Gay & Pitkeathley[1], but adapted to meet Brighton CHC's special concern over the support provided for elderly discharged patients during the first 48 hours after coming home. Some information was also sought on further assistance provided throughout the first two or three weeks after discharge and on pre-discharge events, but it is accepted that the data collected in both these instances is not comprehensive. There was an over-riding concern not to allow the questionnaire to become so long that an extended interview became necessary, bearing in mind the advanced age and poor health of many of the potential respondents. A selective approach was therefore considered to be appropriate and evidence from the literature, professional advice and members' own experience all suggested that there was a greater likelihood of unmet needs in that immediate post-discharge period.

The questionnaire was designed to be administered in the patients' own home after discharge. the questions were deliberately restricted to simple factual issues whose meaning the respondents would understand. Even so it was accepted that hospitalisation is stressful and that patients' memories might not always be reliable. Provision was therefore made for respondents to answer truthfully that they were not sure of the answers to some of the questions asked and Question 43 (interviewer's assessment of the patient's mental condition) was included as a crude check on the reliability of the information.

Pre-coding was extensively adopted to facilitate subsequent computer analysis and also to ease the task of interviewers and speed up the interviews, although some provision was made for open-ended questions to afford patients an opportunity of expressing in their own words their perception of their needs and the appropriate support required. Piloting demonstrated that the interview could be completed in half an hour although in many cases where there were multiple problems it could take as long as an hour. This was felt to be the limit of acceptability.

The questionnaire was revised several times, largely in response to professional advice received from many quarters and finally piloted in February, 1985, after which experience final amendments were made before the Training Day for interviewers on 25th February, 1985. (See Appendix II for final version of questionnaire.)

### 2. Interviewer Recruitment and Training

Interviewers were drawn from two main sources - CHC Members and friends (19) and undergraduate students on BA(Hons) Social Administration Course at Brighton Polytechnic (12). Many of these, especially amongst those in the first category, had previous experience of interviewing and considerable

knowledge and understanding of the issues being investigated but it was felt that it would be useful to come together and pool expertise before going out into the field. In particular it was considered important that everyone concerned had an opportunity to familiarise themselves with the questionnaire before using it. A Training Day was therefore organised at Brighton Polytechnic (Falmer). The morning session was devoted to a discussion of the circumstances of the elderly population and a review of the local provision of relevant community based services by the BHA, ESCC Social Services and the voluntary sector. In the afternoon the questionnaire was explained, advice on interviewing techniques offered and a role play session allowed prospective interviewers an opportunity to interview one another.

## 3. Sample Design

The aim of the survey was to provide a 'snapshot' picture of what was happening across the District to a representative sample of elderly acute patients at a given point in time. It was decided to focus on acute patients as earlier studies [2] had discovered that problems concerning the adequacy of aftercare arrangements were more likely to occur in this area than among longer stay geriatric patients - a situation thought to arise not only because staff on geriatric wards are more familiar with the needs of elderly patients, but also because the slower throughput provides more opportunity to plan and liaise effectively with community services.

It was therefore decided at an early stage to sample from the acute hospital population of the District. Consultations with the District Medical officer revealed some of the complex procedures that would be necessary in order to secure a sample of patients who had given informed consent to being subsequently contacted by the CHC and as a result it was decided to restrict the survey to one hospital - the Royal Sussex County. On the basis of discharge statistics supplied by the District Medical Officer, it was estimated that up to 400 elderly patients (65 years and over) were likely to be admitted in any one month. For survey purposes a sample of at least 150 was felt to be desirable so the RSCH alone would yield sufficient numbers and logistically it would be much easier to work within a single hospital. This decision was influenced by a late proposal to include Accident & Emergency patients. Professionals from the BHA Community Unit and from East Sussex Social Services Department argued strongly that such patients were often particularly at risk because a shortage of hospital beds inhibited admission in marginal cases, so that elderly patients could often be sent home quickly while still in a state of shock and with little opportunity for anyone to alert community support services. These arguments were persuasive but sampling the large and continuous 24 hour flow of A & E patients seven days a week seemed beyond the capabilities of the CHC. It was therefore proposed and agreed that Social Work staff in the A & E Department inform those elderly patients referred to them of the research project and seek their consent to participation. Social Workers claimed that all elderly patients who gave cause for concern would be referred to them and that about 50 relevant patients might be anticipated in any one month.

In total a potential elderly population of over 400 was anticipated from which to sample. As the CHC was most concerned with the circumstances of the oldest patients in their 70s and 80s, or indeed 90s, it was initially proposed to adopt a higher age limit than 65 years but it was later accepted that it would be easier to work within a well recognised classification of elderly if hospital staff were to be asked to help in drawing the sample. It was however felt that the CHC's limited interviewer resources could not be very economically used if spread over the whole area of the Brighton Health District so it was decided that the survey be restricted to elderly

people returning to homes in Brighton, Hove and the coastal strip between Brighton and Newhaven - the majority of patients in the RSCH did in fact come from that area. Other elderly patients would also automatically be excluded by virtue of the fact that they would not be returning to their own homes. Some would remain indefinitely in hospital or be discharged to other long term institutional care, a few could be expected to die while others would leave to stay with friends or relatives, at least for a period of convalescence. There was no clear indication of what proportion of the anticipated 400 these categories might amount to but a quarter to one-third did not seem an unreasonable estimate. Of the remainder a further allowance had to be made for refusals to co-operate so that about 200-250 patients might eventually be eligible for interview. On this basis it was decided not to sample further but to attempt universal coverage of this group of patients.

It was therefore agreed that all elderly (65+) patients admitted to the RSCH during March, 1985, be given an explanatory letter eliciting their co-operation in the survey with a tear-off consent form on the bottom (Appendix III). The Medical Records Manager felt that this procedure could most easily be administered by Ward Clerks at the time of a patient's admission. CHC Members could then collect completed forms at the end of each week. In A & E Social Workers were to hand out letters and collect completed consent forms as previously agreed.

Such a procedure was approved by the Medical Ethics Committee and implemented in a small pilot study in February, 1985, involving the A & E Department and Defflis Ward. The result was disappointing in that over 2 weeks only 5 signed forms were returned from A & E and 3 from Defflis Ward. As a result of these findings the two CHC Members who had undertaken responsibility for the collection of consent forms arranged to attend a meeting of Ward Clerks to explain the nature of the survey and to discuss with them the least onerous method of distributing and collecting the consent forms. It was agreed that the Clerks would hand out the forms but that the CHC Members would be available to help collect them if required, which would also provide an opportunity to explain further the nature of the survey to any patient still in doubt.

## 4. Drawing the Sample

All elderly admissions and A & E referrals from 1.3.85 - 31.3.85 were in theory to be included in the sample. Letters with attached consent forms were delivered to all wards where elderly patients could conceivably be admitted and to A & E on 28.2.85 and during the month two CHC Members made a combined total of more than 20 visits to the Hospital. The final sample was 173 - rather smaller than anticipated, partly because only 6 cases were received from A & E.

We were later informed by the District Medical Officer that there had been 376 discharges of patients aged 65 years and over from the Hospital in March, 1985, and although some patients undoubtedly declined to take part, both the Ward Clerks and the CHC Members concerned are aware that several patients had not been contacted. There is no implied criticism of the Ward Clerks here - they made valiant efforts on busy mornings to add yet one more job to the many they were already hard pressed to complete, but it seems worth detailing the difficulties if only to demonstrate that the method adopted had serious limitations. The major problems identified were:-

(a) pressure of work at the time patients were admitted;
(b) patients being too ill/distressed on admission to give informed consent;
(c) Ward Clerks off sick/on holiday and substitutes being unaware of the survey; and
(d) delays being converted into omissions as patients were discharged before the nature of a patient's response to the request was clarified.

An additional difficulty that became apparent when a few patients who had previously signed consent forms subsequently refused to be interviewed was an evident confusion on the part of some patients as to what was going on. At least one Social Worker in the Hospital became concerned that this confusion could lead to patients actually getting less after-care as she felt that some of them might believe the CHC was going to arrange it and therefore not ask to see a Social Worker. Both CHC Members involved however were very careful to explain to patients that they were not in a position to offer services directly and believe that Ward Clerks emphasised the same point.

If however many patients really did not understand/remember what they had read and agreed to, then the whole cumbersome apparatus of consent procedure would appear to have failed in its objective. A recent edition of Community Health News (January 1985, published by the Association of CHCs for England & Wales)[3] highlights a similar problem encountered by Warrington CHC when they attempted a survey of acute patients, and refers to a willingness in some Health Authorities to release names and addresses (but presumably no further information on the patient) to their local CHC for survey purposes. Patients would still of course retain the right to refuse co-operation when approached for an interview. In view of the official status of the CHC and responsible nature of its activities, together with the difficulties encountered in this survey, the BHA might be prepared to reconsider its position on this issue. Much time and energy has been spent by both Ward Clerks and the CHC Members in trying to compile a sample but unfortunately the numbers are rather smaller than hoped for and, perhaps more importantly, not necessarily representative of the Hospital's elderly population. However much relevant and useful data was collected concerning those patients who were interviewed which should provide an informative commentary on existing policies.

## 5. Interviewing

Signed consent forms, when collected from the Hospital, were sent to the CHC Office, coded and distributed to interviewers. Consent forms included information on preferred times of visit and gave telephone numbers where applicable, which greatly facilitated the making of appointments and avoided, where possible, sending unexpected visitors to elderly people. No interviewer called after dark unless a specific appointment had been made.

25 interviewers eventually participated (11 students and 14 CHC Members and friends) of whom 24 undertook 1 - 8 interviews, while the twentyfifth completed 36.

Interviewing took longer than anticipated as many elderly patients admitted to Hospital in March were not discharged home for some weeks. It was therefore decided to extend interviewing for two whole months after the last patient in the sample was admitted, i.e. to the end of May, 1985, by which time patients who had not returned to their own homes could reasonably be excluded. Eventually 138 elderly patients were successfully interviewed; 11 refused and 24 could not be interviewed for a variety of reasons, including death (6), return to or continuous residence in hospital (6), illness and/or mental confusion (7) and giving up their own home (5).

"Tracking down" these elderly people proved much more difficult than anticipated. Some chronic sick were repeatedly in and out of hospital while others found it difficult to hear the doorbell or answer the door. Some definite information as to the condition and/or whereabouts was however eventually obtained in all but three cases.

As far as possible all the interviews took place between 2 and 3 weeks after discharge but there were unavoidable delays in contacting some people so that a proportion of the interviews took place up to 5 or even 6 weeks later. Patients however tried very hard to remember the information required and most interviews were successfully completed. Where there were instances of less than total recall "not known" answers were appropriately recorded. Ten questionnaires did unfortunately have to be excluded when the interviewees were found to be too young, i.e. under 65 years!

## 6. Analysis

After interviewing was finally completed at the end of May all questionnaires were edited and open-ended questions coded on the basis of responses received. Much additional information was written in the appropriate space on the final page which was sufficient to permit two extra questions to be formulated and answered (see Appendix II for amended version of the questionnaire). 128 edited questionnaires were then delivered to the Computing Centre, Brighton Polytechnic, so that the data could be entered onto the computer prior to analysis via SPSSX.

Subsequent statistical analysis carried out during July and August, 1985, consisted of a series of frequency distributions and cross tabulations, controlling for age (under 75 years and over 75 years) and area of domicile (Brighton, Hove and the coastal strip from Brighton to Newhaven). Bearing in mind the relatively small sample, it was not felt to be appropriate to submit the data to more sophisticated analysis or to apply tests of significance. The results, therefore, need to be seen as indicative of potential relationships rather than as offering any substantive proof, but the fact that many of the findings support evidence from other studies lends credence to their validity.

The majority of the 128 questionnaires were satisfactorily completed and most of the analysis is based on the total sample size, but in some instances information was not available in full for all respondents. In particular, age was only specified in 126 cases. Where the overall total is less than 128, this is clearly indicated and all relevant percentages are calculated on the basis of the total number of cases for which information is available.

## REFERENCES


1. Gay, P. & Pitkeathley, J: When I went Home - Kings Fund, 1979.
2. Continuing Care Conference Papers, 1979, esp. those by Slack & Gibbon Victor, C.R. - A Survey of the Elderly After Discharge from Hospitals in Wales.
3. Community Health News, January 1985 - Association of CHCs for England & Wales.

   "Warrington CHC has carried out a patients' opinion survey on the Acute Wards at the District General under some difficulty. The Hospital refused a list of discharged patients to enable the CHC to contact them - Warrington points out that Hull CHC was provided with a list of 500 by its DGH when carrying out a similar survey - and the two alternatives followed were unsatisfactory. Letters to patients while in hospital elicited a dismal response and asking staff to hand questionnaires to patients when they left, with a letter from the CHC, did not work very well either. 'Whether all patients during the survey period were given questionnaires to complete is open to question.'

## III. SURVEY FINDINGS

### INTRODUCTION

The main concern of this study was to investigate the support received by a sample of elderly patients after hospital discharge, especially during the first 48 hours, but to put this information into context it was necessary to enquire into social circumstances and into hospital discharge procedures. The questionnaire therefore fell into three sections:-

1. Background information,
2. Recent hospitalisation and discharge, and
3. Aftercare, which included information on the help provided within the first 48 hours and during subsequent weeks.

In the report and discussion of the findings it has been found useful to retain this categorisation in the first instance, although of course much of the analysis concerns the inter-relationship between factors in different sections. The quantitative data from the computer analysis will be considered first, but in subsequent discussion and interpretation considerable use will be made of the wealth of additional comment that interviewers were invited to add to the final page of the questionnaires. Much of this material provides illuminating additional detail to some of the precoded answers or extra information on home background. Finally findings will be compared and contrasted with evidence from other studies in an attempt to elucidate further their significance, remembering that research 'is not merely a machine for providing facts. Its task is to clarify and critically examine both the ideas and the reality of social care'.[1]

One important point that needs to be emphasised at the outset is the underlying bias of the exercise. The CHC is interested in, and committed to, the consumers' perception of the NHS. The information sought and recorded is therefore (with the exception of the two or three final questions headed 'Interviewers' Comments') very much in the nature of the patients' perception of events and their own subjective reaction to them. We make no apologies for taking this line as we feel that too little attention has been paid in the past to the consumer's expectations and wishes vis à vis the NHS with the result that services have not always been as effective as they might have been. In the current survey we have found evidence that the help elderly patients are offered is frequently not what they want, and that many have been frustrated by lack of opportunities for communication and by misunderstandings. Amos[2], referring to the Continuing Care Project, claims to have learned that 'on the spot surveys of patients in their homes give a different impression from discussion with hospital staff about what they think they have provided'.

We are of course open to the allegation that the memory of sick elderly people is not entirely reliable. Anticipating such an accusation, we have made several efforts to get around the problem. In the first place we have restricted ourselves to simple straight forward questions and we have endeavoured to interview patients within 2/3 weeks of discharge from hospital. 62 (48.4%) were in fact interviewed within 14 days but unfortunately owing to interviewer problems over the Easter vacation, 22 (17.2%) were not seen until 6 weeks or more after discharge. Secondly, we trained our interviewers to be patient and helpful without being directive, and we asked them to make a layman's judgement of the patient's lucidity after completing the interview. The results of this question were as follows:

Table 1 Did the Patient Appear Confused? (Q.43)

| | |
|---|---|
| Very confused | 6 (4.7%) |
| Occasionally confused | 22 (17.2%) |
| Completely lucid | 98 (76.6%) |

n - 128

The low level of reported mental confusion would seem to support the supposition that severely confused elderly people are less likely to be discharged to their own homes and more likely to go into long-term residental care. Several examples of this happening occurred within our original sample of 173. The vast majority of those interviewed therefore had a very clear understanding of what had happened and was still happening to them - or not happening, as the case may be. It would be quite wrong - an example of ageism at its most blatant - to discount their evidence because of their age. Because for many their lives were relatively uneventful, small details acquired considerable importance and the answers we received were very comprehensive.

Whether or not these answers reflected unrealistic aspirations is of course another matter. On the whole, however, the finding was that the elderly patients concerned were remarkably easily satisfied - grateful for the medical care received in hospital and expecting little in the way of support afterwards. This is perhaps the result of a lifetime of lower living standards for some and a too ready acceptance by others of the notion 'they don't really bother with you when you are old'. Our results will show a surprising degree of acceptance of very difficult circumstances which should perhaps encourage us to take those complaints that are made more seriously.

## A. SOCIAL CIRCUMSTANCES

### 1. ANALYSIS OF FINDINGS

The first area to be investigated was the background social circumstances of the patients. This refers to a set of socio-economic factors which, while being beyond the control of the NHS, greatly influence the need for community health and social services. They underline the obvious point emphasised by the Black Report[3] among others that many ostensible health problems are in fact basically issues of social inequality and poverty, and that, just as the causes reach beyond the confines of the NHS, so must the remedies.

(a) Age and Sex: Of the 128 elderly patients interviewed, there were 90 women and 38 men. This sexual imbalance is to be expected in an elderly population and it became more pronounced with increasing age as the following Table demonstrates:

Table 2 Age of Patients by Sex (Q.12 and Q.13)

| Sex | Age in Years | | | | | TOTAL |
|---|---|---|---|---|---|---|
| | 65-69 | 70-74 | 75-79 | 80-84 | 85+ | |
| Female | 19 (21.6%) | 21 (23.9%) | 23 (26.1%) | 15 (17.0%) | 10 (17.4%) | 88 (100%) |
| Male | 11 (28.9%) | 15 (39.5%) | 5 (13.2%) | 5 (13.2%) | 2 (5.3%) | 38 (100%) |

n = 126

Because a higher proportion of the older patients were women, age and sex variables became confused in subsequent analysis and it was not considered practical to use sex as an independent variable. Age was however seen as a factor of key importance and a separate set of frequency distributions was subsequently computed with reference to those under 75 years and those 75 years and over - conforming to the generally accepted categorisation of 'young' elderly and 'old' elderly. It will be noted from the Table above that despite the expected weighting towards the younger end of the age range, the sample included 32 (25.4%) over 80 years. The oldest was in fact 92.

(b) Household Formation: While age was identified as one potentially important factor relating to the need for aftercare support, another was considered to be the extent to which patients were living alone or with other elderly or handicapped people only. In the event 55 (43%) usually lived alone. the remaining 73 lived with a variety of others as indicated below:-

Table 3 Who Lives in the Same Household with You? (Q.46)

| | | |
|---|---|---|
| Lived with a spouse | 54 | (74%) |
| Lived with child/children | 20 | (27.4%) |
| Lived with other relatives | 9 | (12.3%) |
| Lived with non-relatives | 4 | (5.5%) |

n = 73 (NB. Categories are not exclusive)

The majority of those who did not live alone, however, lived with someone else who was also elderly (43 or 58.9%) and in 38 of these cases the second elderly person was the only other person in the household, so that in fact 91 out of the original 128 (71.1%) were either normally living alone or with another elderly person only. The numbers living with a handicapped person were much smaller (14) but in 10 cases the handicapped person was the only other person in the household, and in 7 was also elderly. Out of the 53 who normally lived alone, 12 did in fact have someone living with them on a temporary basis when they first returned from hospital, and in 8 of these cases the person involved was a child or children.

Analysis by age showed that a higher percentage of 'older' elderly were living alone, 29 (48.3%). Not unnaturally they were less likely to be living with their spouse, 19 (31.7%) as opposed to 35 (85.4%) of the younger elderly, but more likely to be living with other relatives, 16 (26.7%) as opposed to 13 (19.7%). Of those not living alone, 22 (33.3%) of the younger elderly were living with another elderly person only and 15 (25%) of the 'older' category.

(c) Accommodation: The 128 patients were accommodated as follows:-

Table 4 What Kind of Accommodation have you got here? (Q.7)

| | | |
|---|---|---|
| House | 56 | (43.8%) |
| Bungalow | 20 | (15.6%) |
| Flat (ground floor or with lift) | 24 | (18.8%) |
| Flat (not ground floor & without lift) | 19 | (14.8%) |
| Room | 1 | (0.8%) |
| Sheltered Accommodation | 6 | (4.7%) |
| Maisonette | 2 | (1.6%) |

n = 128

The most common situation was living in a house and house and bungalow together account for 59.4% of the sample. It is likely that this group have adequate space but may well face problems of heating, cleaning

and general maintenance, plus difficulties in the upkeep of gardens. Only 1 person claimed to live in a single room although some of the flats/flatlets were in reality little more. Potentially problematic situations existed for the 19 patients living in a flat not on the ground floor and without a lift.

An age breakdown rather surprisingly shows little difference in the position of the 'young' and 'old' elderly. There were virtually the same proportions overall in houses and bungalows but slightly more 'old' elderly in bungalows, 18.3% compared with 13.6%, and a slightly higher proportion of the older category were in ground floor flats or those with lifts. This still left 8 people of 75 years or older however in non-ground floor flats without lifts. It was noted that 4 out of the 6 people in sheltered accommodation were in the 'older' category.

The questionnaires also asked about how the accommodation was heated and how often the various forms of heating were used. Responses to the latter question did not prove very useful as the interviewing period (mid-March to the end of May) straddled the winter/summer divide, which is a pity as worry about fuel bills was a fairly frequently mentioned anxiety. It seems likely that there may well be problems in this area.

Table 5 What Kind of Heating to you Possess? (Q.8)

| | | |
|---|---|---|
| Full Central Heating | 60 | (46.9%) |
| Partial Central Heating | 9 | (7%) |
| Night Storage Heaters | 9 | (7%) |
| Gas Fires | 54 | (42.6%) |
| Electric Fires | 77 | (60.2%) |
| Paraffin stoves | 8 | (6.3%) |
| Coal fires | 19 | (14.8%) |
| Other | 2 | (1.6%) |

n = 128

(NB. Categories are not exclusive)

From the Table above it will be seen that full central heating was available to less than half the total sample, and further analysis showed that amongst the 'old' elderly only 21 (35%) possessed full central heating. Electric fires were often used as a back-up form of provision for short-term heating of bedrooms in particular. Coal fires remained the main form of heating for several, including 9 of the 'old' elderly, and tended to be a form of heating to which its users had a strong emotional attachment. The majority of patients did possess a telephone (83.6%) but this still leaves a worrying 21 without, including 13 'old' elderly.

(d) Social Contacts: Whereas age and housing conditions might be expected to influence the need for support, questions concerning social contacts were designed to elicit potential for support. Questions were asked concerning length of time that patients had been established in the District, numbers of relatives living locally and the extent of regular visits from health and welfare professionals prior to their recent hospitalisation.

The rationale behind the residence question was the hypothesis that the more long-term residents might be expected to be more 'rooted' in the community and therefore more able to draw on the informal networks of support from friends and neighbours. Patients were therefore asked how long they had lived at their present address and how long they had lived within the district defined as within 30 miles of there.

Table 6 How Many Years Have You Lived at this Address/in this District? (Q.3 & 1

| No. of Years | Place of Residence | | | |
|---|---|---|---|---|
| | Current Address | | Brighton District | |
| Less than 1 year | 4 | (3.1%) | 2 | (1.6%) |
| 1 - 4 years | 23 | (18%) | 7 | (5.5%) |
| 5 - 9 years | 15 | (11.7%) | 6 | (4.7%) |
| 10 - 19 years | 35 | (27.3%) | 19 | (14.8%) |
| 20 - 29 years | 20 | (15.6%) | 28 | (21.9%) |
| 30 - 39 years | 14 | (10.9%) | 16 | (12.5%) |
| 40 - 50 years | 10 | (7.8%) | 15 | (11.7%) |
| 50+ years | 7 | (5.5%) | 35 | (27.3%) |

n = 128

Table 6 shows that relatively few have recently moved house, let alone moved into the district, and that 31 (24.2%) have been over 30 years at the same address and 66 (51.6%) over 30 years in the same neighbourhood. On the other hand, whereas only 15 had moved into the district within the last 10 years, 42 had moved house, suggesting a possible change of address on retirement. A consideration of the age dimension as might be expected showed more of the 'old' elderly as really long-term residents of 40 years or more, both within the district and at the same address. As regards recent mobility in the last five years, there appeared to be little observ able difference between the age groups.

Respondents were asked to identify numbers of adult relatives not living in the same household but living approximately within a radius of 1 mile, between 1 and 10 miles and between 10 and 30 miles. No precise definition of relative was given and it seems likely that this was variably interpreted. However with regard to identifying a potential for support perhaps a subjective definition is most valid. Table 7 shows that 29 (22.7%) had no adult relatives living near according to any of the categories used, whereas 89 (69.5%) had none within a mile. It is also noticeable that to have a large number of adult relatives available was comparatively rare. Although 10 claimed to have more than 10 relatives within 30 miles, 84 (65.6%) claimed 2 or less. 12 of those without any relatives near were also living on their own.

Table 7 Numbers of Patients with Relatives Living Near By Total Number of Relatives (Q.10)

| No. of Relatives | Distance in miles | | | |
|---|---|---|---|---|
| | Less than 1 | 1 - 9 | 10 - 30 | Within 30 miles |
| 0 | 89 | 63 | 78 | 29 |
| 1 | 16 | 26 | 18 | 30 |
| 2 | 10 | 24 | 19 | 25 |
| More than 2 | 13 | 15 | 13 | 44 |

n = 128

An age breakdown did not reveal any marked differences between 'older' and 'younger' elderly - 12 (20%) of the former had no relatives compared to 17% (25.8%) of the latter.

It was considered important to enquire about regular visitors as it was hypothesised that those already in contact with health and welfare services before hospitalisation would be more likely to get prompt attention on discharge, being already 'on the books'. A regular caller was defined as someone calling at least once a week.

Table 8 Which of the Following Were Calling Regularly Before you Went into Hospital? (Q.6)

| Regular Callers | 'Young' Elderly | 'Old' Elderly | Total |
|---|---|---|---|
| G.P. | 6 | 3 | 9 |
| District Nurse | 3 | 8 | 13 |
| Health Visitor | 2 | 4 | 6 |
| Social Worker | 1 | 4 | 5 |
| Home Help | 2 | 14 | 17 |
| Meals on Wheels | 0 | 3 | 4 |
| WRVS | 0 | 1 | 1 |
| Other voluntary visitor | 3 | 3 | 6 |
| | n = 126 | | n = 128 |

It is immediately obvious that few of the sample were receiving any such regular visits. The Home Helps were the most common callers, followed by District Nurses, but 90 respondents were getting no regular professional visitors and only 7 were receiving more than 1. 36 of those with no visitors were living alone. In this case an analysis by age was instructive as it showed quite clearly that both regular visits by District Nurses and by Home Helps were concentrated among the 'old' elderly.

(e) Area Variations: The 128 elderly people in the sample were drawn from three areas of Brighton Health District - Brighton, Hove and the coastal strip from Brighton to Newhaven. The main objective of the tripartite analysis is to compare and contrast provision of aftercare support in these three zones, but the validity of this exercise depends on some awareness of the similarities and dissimilarities in social background. A comparative analysis was therefore undertaken of social conditions between patients from each of the three zones; there were 55 (43%) from Brighton, 47 (36.7%) from Hove and 26 (20.3%) from the coastal strip. On the whole the similarities were more apparent than the differences. Age/sex characteristics were similar in all three although there were more really old people (i.e. 80 years and older) from Hove, 17 (36.2%) as opposed to only 7 (13.2%)* in Brighton and 8 (30.8%) along the coastal strip. This is not a feature that shows up clearly in a crude distinction of younger and older elderly based on a division at 75 years and points to the arbitrary nature of this or any other cut-off point. It may well be, however,given the need for some kind of categorisation,

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* 2 observations missing, therefore n = 53

that a division at 80 years may be more useful. The more conventional division at 75 is nonetheless retained in this Report to facilitate comparisons with the findings from other studies.

As regards living alone, there is again a basic similarity, with the proportion in Hove being slightly higher than the average, i.e. 22 (46.8%) compared to 23 (41.8%) in Brighton and 10 (38.5%) along the coastal strip, nor are the proportions living only with other elderly people very different.

Accommodation shows more variation as indicated in the Table below. Living in flats with or without lifts is more common in Hove, whilst living in bungalows is more prevalent along the coastal strip.

Table 9 Accommodation by District (Q.7 and District Code)

| Nature of Accommodation | Brighton | Hove | Coastal Strip |
|---|---|---|---|
| House | 28 | 16 | 12 |
| Bungalow | 5 | 4 | 11 |
| Flat (ground floor or lift) | 9 | 15 | 0 |
| Flat (not ground floor or lift) | 7 | 12 | 0 |
| Room | 1 | 0 | 0 |
| Sheltered Accommodation | 3 | 0 | 3 |
| Maisonette | 2 | 0 | 0 |

n = 128

Possession of heating facilities was more closely comparable except that central heating was slightly more common along the coastal strip and gas fires considerably less in evidence, possibly because piped gas was not always available. Virtually all, i.e. 25 out of 26, of those along the coastal strip had a telephone, but only 81.8% of those in Brighton and 78.7% of those in Hove. It begins to appear that although differences are generally slight and numbers are of course small, the social conditions of the patients from Hove tend to be less advantageous than average.

Turning to evidence of potential support, those from the coastal strip are unlikely to have lived in the district for really long periods of 30 years or more and more likely to be recent immigrants - 5 of the 9 respondents who had moved into the district in the last 5 years came from this area.

As regards having relatives locally, a higher proportion of those in Hove were totally without - 15 (31.9%) compared to 23.1% along the coastal strip and 14.5% in Brighton - and proportionately fewer people claimed to have more than 2 relatives, i.e. 10 (21.3% in Hove compared to 24 (45.3%) in Brighton and 10 (44.2%) along the coastal strip.

Table 10 Regular Callers by Area (Q.6 and District Codes)

| Regular Caller | Brighton | Hove | Coastal Strip |
|---|---|---|---|
| G.P. | 5 | 4 | 0 |
| District Nurse | 3 | 7 | 3 |
| Health Visitor | 2 | 4 | 0 |
| Social Worker | 3 | 1 | 1 |
| Home Help | 7 | 4 | 6 |
| Meals on Wheels | 3 | 0 | 1 |
| WRVS | 1 | 6 | 0 |
| Other Voluntary Worker | 6 | 0 | 0 |

n = 128

Table 10 summarises the numbers of regular 'professional' callers in each of the areas and although numbers are small, certain differences are indicated. The Home Help service was proportionately more used by those along the coastal strip and particularly under-used in Hove, where proportionately more people were receiving District Nurse visits - perhaps reflecting the higher proportions of very elderly in the sample there.

(f) The Inter-relationship of Social Factors: As well as analysis by age and area it was also considered useful to cross-tabulate a selection of social factors in order to identify any possible inter-relationships. Much of the exploration was non-productive but some of the tabulations involving the variable 'usually live alone' are of interest. Those living alone were less likely to have been living in a house, 17 (30.9%) compared with 39 (53.4%) or in a bungalow, 4 (7.3%) compared to 16 (21.9%), but more likely to be in a flat, 28 (50.9%) compared with 15 (27.3%). There was little difference as to the number of relatives living locally or to the number of professional callers. Numbers were small in all categories but it does seem that voluntary visitors, including the WRVS, were more likely to be visiting those not living alone. It is also perhaps worth noting that 7 of those living alone were without a telephone.

(g) Further Analysis by Age: In view of the doubts raised concerning the usefulness of the conventional age categorisation at 75 years, further analysis by age was conducted using a quinquennial categorisation as shown in Table 11.

Table 11 Age of Patient by Living Alone (Q.12 and Q.4(a))

| Household Structure | Age 65-69 | 70-74 | 75-79 | 80-84 | 85+ |
|---|---|---|---|---|---|
| Living Alone | 10 (33.3%) | 15 (41.7%) | 9 (32.1%) | 12 (60%) | 9 (75%) |
| Living with Others | 20 (66.7%) | 21 (58.3%) | 19 (67.9%) | 8 (40%) | 3 (25%) |

n = 126

This Table is interesting in that it does seem to suggest a large proportionate increase in numbers living alone after the age of 80 years. A comparison of this age categorisation and nature of accommodation indicates a steady shift from living in houses to living in flats

with age. These were not necessarily more convenient, however. 5 people aged 80 or over were living in flats not on the ground floor and without lifts. We have already seen that regular professional callers were uncommon but although numbers in each category were small, there is clear evidence that home nursing visits were concentrated in the 80+ groups as 8 out of the 32 in the older age groups were being visited compared to a mere 5 out of the remaining 9 recipients.

## 2. INTERPRETATION OF FINDINGS

In interpreting the data it has been found useful to draw on the extra quantitative material appended to the questionnaires and to relate findings to other studies of elderly populations.

(a) Case Study Material: Statistics tell a partial story although they give no indications of how people feel about their situation, but comments on the questionnaires fleshed out many of the observations made. Living alone, for example, was interpreted in terms of loneliness on many different occasions - 'very lonely old lady', and 'socially isolated old lady', 'very lonely and unhappy' and 'obsessed with the death of her sister two years ago' are just some examples which go some way to conveying the bleakness and desperation felt by some of the people interviewed. For most their loneliness was a problem prior to their hospitalisation but could only be aggravated by it. Not in itself a medical issue, loneliness, as opposed to merely living alone, is a frame of mind that must affect convalescence. CHC interviewers were received with pathetic gratitude on numerous occasions as welcome company - 'come any time', and 'when would you like to come, I am always at home'. One memorable lady, when thanked for sparing the time to answer our questions, replied 'I have all the time in the world, you are the one who is busy. Thank you for sparing me the time'.

Nor should it be supposed that only those living alone are lonely; several of those living with relatives were in fact in the house all day alone while the relative was at work. One elderly lady alone while her daughter was at work was too deaf to hear the door bell so could not respond to visitors if they did come. The CHC interviewer only got in by going down the road and telephoning. Another, alone while her son was at work, lived in an upstairs maisonette and could not get down to the front door.

Length of residence did not seem to ensure the neighbourly contact hypothesised, according to one old man who had lived 24 years in the same road but was only on nodding terms with his neighbours, or the elderly woman who had lived 38 years in the same house but felt lonely and isolated. As another man explained, 'we have been here since the house was built but the others have moved away and it's all young couples now'. Those living with their spouse would seem to be better off but, as we have seen, these were often elderly too and there were several examples of elderly spouses who were frail or ill themselves with a variety of problems including heart trouble, flu and shingles. Other supporting relatives could also be elderly. In one instance an 85 year old lady was living alternately with one or other of her two sisters, both in their 80s.

These examples can of course be compared with others, such as the old man of 82 who, having raised a family of five children single-handed after his wife's early death, lived happily on his own doing all his

own housework in a spic and span flat full of flowering plants, or the Brighton patient with 7 married children all living locally, or yet again the old lady in a 'grubby but warm and cheerful' house who was cared for by her lodger of many years standing. By no means all the respondents were lonely or uncared for but several of them were. The important point is that there were no easily identifiable characteristics by which to distinguish those who were, so careful appraisal of individual circumstances is obviously necessary.

Another important feature to emerge from the concluding comments was the extent of basic housing problems. These tended to be of two kinds, problems of accommodation per se and problems of siting. In the first category was the cold damp basement in Kemp Town, the cold upstairs mews flat in Hove and the overcrowded family accommodation where granny was occupying a much needed bedroom. Also mentioned on several occasions, however, by those whose housing per se was quite acceptable to them was the difficulty of being sited at the top or bottom of a steep hill. This is perhaps a problem peculiar to Brighton. In these cases hospitalisation merely aggravated a problem that they had for the most part already identified. It is perhaps also worth mentioning that two of those living in sheltered accommodation for whom one imagines there would be few problems were in a state of considerable nervous agitation when interviewed owing to a spate of burglaries which had recently taken place in both their widely separated developments.

(b) Comparative Analysis: These survey findings suggest a not atypical elderly population although with a slightly higher proportion of the 'older' elderly than is present in the population at large, i.e. 47.6% compared to 38.7%, while 43% as compared to a national average of 30% were living alone.[3] It was particularly noticeable that over 60% of those 80 years or older were living alone and that there was a concentration of this age group in Hove. Living alone has been identified as a major factor[4] in lowering the morale of the elderly and is therefore quite a critical variable vis à vis aftercare. The frailty of some spouses emphasised in the case study material is also referred to in other studies of the elderly.[5] We would appear to have therefore a fairly high level of potential vulnerability in our sample.

As regards accommodation, the sample appears to be fairly well provided for. We did not ask questions concerning tenure or provision of standard amenities which makes direct comparisons with other studies of the elderly difficult, but 39.1% were in bungalows, ground floor flats or those with lifts or in sheltered accommodation, all of which might be considered accommodation particularly suitable for the elderly, and with some notable exceptions the general impression was of a reasonable standard, a finding similar to that of Skeet.[6] There were however difficulties in some cases with stairs and with too much space which was difficult to heat, findings also similar to those of Skeet. Only 35% had full central heating and several expressed concern with fuel bills. There was also a problem peculiar to Brighton of situational difficulties in that an elderly person in well adapted accommodation could be virtually housebound because of the sharp gradient of the road outside. Several mentioned having applied for sheltered accommodation, often prior to recent hospitalisation, but most had not received an encouraging response as demand was so great locally. One elderly woman with an ulcerated leg was told that she would be unlikely to become eligible unless the leg was actually amputated! Happily the majority - 83% - were provided with telephones, but as regards such amenities as telephones and central heating, the population of Hove seemed to be at a slight disadvantage which was a worrying factor in that this was the oldest group and something to be borne in mind vis à vis analysis of aftercare provision.

Although the South Coast is an acknowledged retirement area, only 26.6% had moved into the district during the last 20 years while 66 (51.6%) had in fact been here over 30 years. Several of those who had moved in on retirement volunteered the information that they had friends/relatives or other previous connections with the area. On the whole, therefore, the respondents were socially established - further evidence to belie the myth of an indiscriminate lemming-like rush to the seaside from all points north. Being socially established, however, presupposes the existence of a community into which to integrate, and individual comments suggest that this does not always exist. The survey did not provide enough evidence either way to make any significant contribution to the debate on whether or not natural caring communities still exist, but it does indicate a sufficient degree of uncertainty to caution against basing local community care policies on any glib assumptions that they do.

Research evidence generally has established relatives as the main source of care and support for the elderly in the community and most of the respondents to this survey did have relatives potentially available to care in that they were living locally. 71 (55.5%) lived in households containing one or more members of their family and 99 (77.3%) had non-resident relatives living within 30 miles. As other studies[7] have also indicated, however, this did leave a minority without family support who can perhaps be identified as particularly vulnerable in the aftercare situation. Some of these, again confirming the findings of other studies[8], do seem to have made substitute arrangements with non-relatives - one old lady already referred to was dependant on her lodger and another old man received daily visits from a lady friend of long standing.

Regular contacts with professional caring services before recent hospitalisation were relatively sparse, 70.3% having no contact with any of the services specified, which confirms Philippson's[9] findings. Numbers were obviously small, but it does seem to have been the case that the most elderly were more likely to have been in receipt of services at least in the case of District Nurses and Home Helps. It was a considerable surprise to note the virtual absence of voluntary organisations as several are known to be active in the care and support of the elderly in Brighton Health District. This finding raises questions about the feasability of the proposed extension of co-operation with the voluntary services which features in the BHA Strategic Plan.

To summarise - we have in our survey a sample of elderly people living in the community, many of whom were in vulnerable situations prior to hospitalisation but few of whom were receiving regular statutory support. The comments made by many of them to CHC interviewers suggest that their main problems were social, i.e. loneliness as much as medical, a finding also reported by Skeet.[10] However it is now generally accepted that the two cannot be treated in isolation. It is important in studies of aftercare to appreciate the base from which provision is made. It is unlikely with the best will in the world that effective aftercare can be provided unless longer term issues of support for the elderly in the community are also tackled. Without financial security, appropriate accommodation, professional surveillance and social support from family or friends, elderly people will have difficulty in coping with the variety of inevitable losses accompanying ageing, whether this is the loss of physical or intellectual capacity or of social

contacts left behind on retirement or bereavement. The crisis in the provision of hospital aftercare will merely exacerbate a difficult situation and one which will be impossible to resolve on an instantaneous basis. On the other hand, in a more positive light the aftercare crisis does afford an opportunity of identifying old people in long term difficulties and could be the start of ongoing support strategies. What effective aftercare cannot be is a quick 'in and out' affair lasting for a few days or at best weeks and bearing little relationship to events and circumstances existing before and after. Fergusonll claimed long ago in 1961 that a benevolent home background often makes all the difference between progress and relapse and warned of the danger that without it 'a large fraction of inpatient care can only be merest palliative patchwork'.

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