ORGANISATION AND MANAGEMENT OF SERVICES FOR THE PROVISION OF AIDS TO DAILY LIVING

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SUMMARY

1.This study was undertaken with funding from the Nuffield Provincial Hospitals Trust to examine services for the provision of aids and adaptations with a view to improving their efficiency and effectiveness.

2.The data on which the study is based came from specially mounted surveys in contrasting areas of Glasgow. Samples of consecutive referrals for aids and adaptations provide the main data base; these surveys are supplemented by retrospective surveys of equipment use, an assessment of unmet need and a study of professional work practices.

3. Provision of aids and adaptations is split between community nursing services (operated by Health Board) and community occupational therapy services (operated by Local Authority Social Work Departments). This division is confusing to patients/clients and gives rise to duplication and overlap in service provision.

4. In both services patients/clients experience considerable delay in obtaining aids and adaptations. Delays in the occupational therapy service occur at two stages:- between referral and assessment and between assessment and delivery: 1 in 2 clients waiting for more than a month for assessment and just under 1 in 3 experienced a further delay of more than a month before receiving their aids and adaptations. Delays

are shorter and less frequent in the nursing service, yet around 1 in 3 patients waited for more than a week and 1 in 9 more than a month for equipment from the nursing stores.

5. For both services delays were attributable to inefficiencies in the storage and delivery systems. Stores were too small, inadequately staffed and badly organised. Drivers often had other competing duties and were not replaced over holidays and at times of sickness.

6. In the occupational therapy service the limited time OTs spent on assessment contributed to further delay for the client. In the present study OTs spent 30% of their time with clients compared with 48% on clerical duties. OTs felt that approximately one third of their duties could be delegated to assistants and/or clerical workers.

7. Both services are predominately reactive and no concerted effort is made to identify unmet need. The study does not provide first hand evidence of the extent oof unmet need, but data available from a local survey showed that almost 1 in 2 of those found to be disabled were without an appropriate aid/adaptation. Of those with such an unmet need, only 14% were already on the waiting list of the local occupational therapy service.

8. In both services a substantial proportion of equipment, around 15%, remains in patients' homes unused and unavailable for reissue. The potential for recycling is further limited by inadequate facilities for cleaning and repair of returned equipment.

9. Improvements in both services can be achieved by introducing improved forms, changes in staff deployment and upgrading of storage facilities. Specific recommendations are made in relation to these and other proposed changes.

10 Further improvements require a more fundamental restructuring and a move from the present dual service arrangement to an integrated system. Strong arguments are made for a single assessment form and for a single storage and distribution system.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER1

INTRODUCTION

The present research was undertaken to make a critical appraisal of services for the provision of aids to daily living and to formulate proposals for their more efficient use.

Two issues which are fundamental to any review of services for the disabled are, 1) identifying the disabled and 2) establishing what are their needs. This necessitates clarification and definition of the terms disability and need and requires some estimate of the prevalence of disability.

The 1st two sections of this chapter are therefore devoted to looking at definitions of disability and need. In the light of these definitions section three reviews issues relating to prevalence. The fourth section examines the current trend and policy of community care and the importance that the provision of aids to daily living has for the success of this type of care.

1.DISABILITY: There is no universally agreed definition of disability and confusion arises as disability-related concepts are interchanged and used inconsistently.

Traditionally, the term disability has tended to refer to specific handicaps, for example, blindness or the result of trauma eg war or an accident. According to this usage people were easily identified and their

needs catered for. Indeed, much of the early legislation for the disabled was specific to these particular groups.

Over the years, however, there has been a move away from a purely medical model of disability, to a much broader definition which includes the recognition that disability has many causes, and includes those suffering from chronic degenerative conditions normally assosciated with the ageing process.

Many attempts have been made to define what constitutes disability. Duckworth(1983) gives a comprehensive discussion on the use of "disability" terminology and reviews some of the attempts made at definition highlighting the limitations and virtues of each.

The most widely accepted and comprehensive definition, however, is that by Wood(WHO,1980) and adopted by the International Classification of Impairments Disabilities and Handicaps (ICIDH). He argues that impairment, disability, and handicap are all independent concepts that arise as a consequence of disease. It is not the disease itself that is important but the typical response to it. He distinguishes between these concepts as follows:-

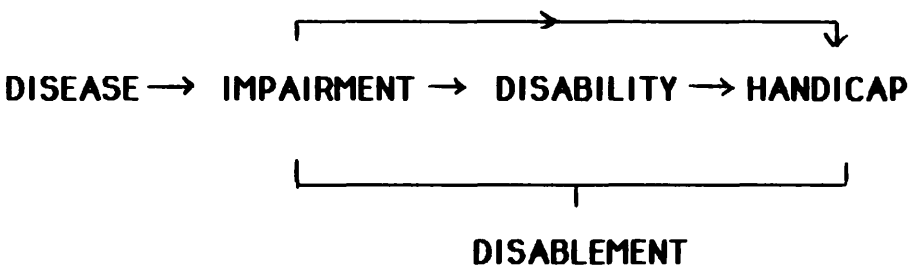
Impairment "Any loss or abnormality of psychological or anatomical structure or function" (ie parts or systems of the body that do not work).

Disability "Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range

considered normal for a human being" (ie things people cannot do).

Handicap "A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role for the individual" (this is in relation to a particular environment and relationships with other people).

The term "disablement" is used as a collective description which refers to any experience identified by these terms. The relationship between these concepts is depicted in the following diagram:-



An impairment may or may not cause disability. Disability always arises from an impairment but a handicap may arise from a disability or directly from an impairment. Tait(1981) provides the example of a man with epilepsy. He has an impairment, but if the epilepsy is well controlled, he will show no reduction in activity (disability), but he may experience considerable disadvantage (handicap) if he lives or works with people with adverse attitudes to his condition. Disability and handicap are, therefore, not gradations of the increasing severity of impairment.

For a lot of purposes, obtaining a definition is just an academic exercise

as almost anyone could be described as disabled in some way, but for entitlement to benefits and services it is of paramount importance. Definitions are only relevant in a particular context and great care has to be used when making comparisons or using data for policy making or service planning.

The present research study operates within the ICIDH definition of disability to include people who have been identified as having a physical disability which restricts their ability to perform various activities and who might benefit from the provision of aids to daily living.

2.NEED : A need must be identified before a demand for a service can exist. Identifying need however, is also hampered by problems of definition and much has been written on the subject. The most comprehensive definition available is one proposed by Bradshaw(1972), who identifies four concepts of need:-

a) felt need is equated with want, ie people are asked whether they feel they need it. This definition is, of course, limited by the individuals knowledge and willingness to confess to lack of independence.

b) expressed need or demand is felt need turned into action, those people who demand a service.

c) normative need is a desireable standard laid down and if an individual or group falls short, they are identified as being in need. This may be tainted with paternalism ie middle class values being imposed. This

definition changes with time both as a result of developments in knowledge and changing values of society.

d) comparitive need is found in studying the characteristics of those in receipt of a service. If people with similar characteristics are not in receipt of a service, they are considered to be in need.

It is not surprising, therefore, that needs are constantly changing. The availability of services on offer influences how needs are defined and ultimately met. In addition, needs may change as clients improve and deteriorate, and as expectations of the individual and society change, with technological advances in the manufacture of equipment. Furthermore what is an acceptable solution to a need in one situation may be totally unacceptable in another. We cannot assume therefore,that because two people are labelled as disabled or elderly and have what appear to be the same needs, that they will receive the same resources or have their need met in the same way. Nor can any assumption be made that one way of meeting a need is better than another.

Finding a uniform definition of need is complex, consequently the present research employs a spectrum of need. This spectrum ranges from no need, through met need, to unmet need.

1. NO NEED:- This group may all have needs in the future and whilst they may be in a similar situation and circumstances to those demanding aids, they do not have a current expressed need.

2. MET NEED:- This group has a need which has been recognised and suitable aids have been provided. While they do not have any other current expressed need for aids, they may do so in the future.

3. UNMET NEED (Identified):- This may be a) Unassessed, where the need is known but not acted upon, or b) Assessed, where the need is recognised and has been assessed, but resources are not immediately available.

4. UNMET NEED (Hidden):- This again takes two forms. First when a need is experienced by a client but not known about by the authorities. And second, when a need is neither recognised by the client nor known about by authorities.

This typology of need provides various categories which are useful for planning and evaluating a service such as the one for the provision of aids. Evaluation of existing services can be undertaken by looking at clients whose needs have been met. However, perhaps more important for planning, is the necessity to look at unmet need. Differentiating between the different categories of unmet need allows for recognition of short falls in the existing system. The existence of long waiting lists may indicate a shortage of staff; assessed unmet need may indicate a shortage of resources, whereas hidden need may indicate the need for information and education programmes and consequently, the mounting of a screening programme.

3.PREVALENCE OF DISABILITY: While a number of studies have been carried out to estimate the size of the disabled and elderly populations, these tend to be studies of identified need, by virtue of the fact that the people studied are already in receipt of a service by eg attending a day centre or receiving home helps. To get a more comprehensive view, studies are required, which are based on large samples of the general public. Unfortunately, because of the expense, time and effort required to mount such studies, few have been undertaken.

In 1988 the Office of Population, Censuses and Surveys (OPCS) published the results of a national survey which they had commissioned to estimate the prevalence of disability in Great Britain. It estimated that there were approximately 6 million adults with one or more disability living in private households. This was double the estimate of just over 3 million made by Harris, in 1971. While this appears to be a massive increase in the number of disabled people, it is important to note that the two studies employed different measures of disability. The more recent OPCS survey concentrated on disability rather than handicap and it also utilised a scale of severity, ranging from very slight to severe. The overall prevalence of disability was therefore, calculated on the number of people found to have disabilities over a certain level of severity. By contrast, the definition used by Harris related handicap to the capacity for self-care. She did not include people whose handicap stemmed from

mental illness nor did she include people at the lower level of severity. The General Household survey, (OPCS,1985) also reveals the discrepancies which can arise from differences in definition; eg it estimated that 21% of adults in private households had a disability, whereas the 1988 study places the estimate at only 14%.

Two inescapable conclusions have emerged from the various disability studies. First, most disabilities are a direct result of impairments that arise as a consequence of the ageing process. The overall rate of disability rises with age, slowly at first and then accelerating after 50years and rising very steeply after about 70years. Almost 70% of disabled adults are aged 60 or over and nearly half are over 70. Second, there are more women (3.6 million) than men (2.5 million) who are disabled (OPCS1988), this is directly explained by the fact that more women survive into old age.

These facts suggest that general population studies can be used for estimating the prevalence of disability. The 1985 based projections included in SHARPEN (1988) (see table1.1) show that more people are living longer, and in particular that more people are surviving to very old age, and that this trend is likely to continue into the next century. While, this obviously has implications for the service providers, it is not just a straight forward equation between more elderly and more services. The heterogeneity of the elderly has been well documented and they have been

shown to have different needs (Wells and Freer,1988).

Table1.1

POPULATION: ESTIMATED AND PROJECTED AGES 65 AND OVER (in thousands)

Age Group	Estimated 1985	1985 based projections 1991	1996	2001	2005
65-74	432	437	440	429	424
75-84	250	263	259	266	276
85+	55	72	86	95	96
Total 65+	737	772	785	790	796

Plank(1977), Wade et al(1982) and many other studies have identified that a mismatch exists between needs and services. In her study of the service needs of the elderly in Manchester, Luker(1987) discovered that elderly people with lay carers were less likely to benefit from statutory services, than those without. It was not clear whether this was a result of rationing by service providers or failure of lay carers to make contact. Matching needs to resources is a major problem. It would appear that many of the elderly and disabled do require more services, but it is not clear who they are, or what is the nature of the services required.

Of local interest is a series of household surveys undertaken by Strathclyde Regional Council Social Work Department, in accordance with section 1 of the Chronic Sick and Disabled Persons Act, to identify both the number and the needs of disabled people. The question was asked, whether there was anyone resident within the the house "whose everyday life is affected by an illness, disability or handicap - either physical or mental - or by problems due to old age". Although the methodology of

these studies can be criticised , in particular it was felt that some of the interviewers may have suggested needs to the disabled, they did provide a lot of useful data and resulted in many disabled people being identified and having their needs met. The surveys reveal that the numbers of disabled people and the degree of unmet need, especially for community occupational therapy (OT), varies a good deal from area to area (see table 1.2) but it is clear that a great deal of unmet need exists and that a lot of this is hidden need. (This will be examined further in chapter 10).

Table1.2

ESTIMATE OF THE DISABLED AND THOSE IN NEED OF OT IN AREAS OF STRATHCLYDE*

AREA	TOTAL POPULATION	% DISABLED	% DISABLED WITH NEED OF OT
CLYDEBANK	51,668	7.4	30
IRVINE	90,814	8.5	30
GLASGOW/SOUTH2	77,934	8.5	24.3
INVERCLYDE	97,443	8.2	21.9
GLASGOW/WEST	121,968	8.9	27.5
GLASGOW/CENTRAL	72,472	7.6	23.5
RENFREW A	99,807	6.3	34
MOTHERWELL	149,105	6.8	36.5
CUMBERNAULD	10,903	5.4	45.9
TOTAL	**772,114**	**7.7**	**28.9**

* Table from Strathclyde Regional Social Work Departments' Chronic Sick and Disabled Persons data.

The foregoing review of prevalence studies and the needs of the disabled has established that the number of people who can be described as disabled is increasing and is likely to continue to do so as the number of elderly people increases. The present policy is for more elderly to be cared for at home, within this policy the provision of aids to daily living is crucial.

4.COMMUNITY CARE: To some community care is anything other than institutional care; to others it is almost the institutional care transported to the community and to yet others it is care by the family. The recent government publications, SHARPEN(1988) and "Caring for People" (1989) have outlined government policy and state quite clearly that the government is firmly committed to a policy of community care which means *"providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives"* this would involve, *" the development of a wide range of services provided in a variety of settings".* ranging from domicilliary support, respite and day care, sheltered housing, group homes and hostels, residential care and nursing homes to long stay hospitals. The government envisages the main components of community care as being to promote the development of domicilliary, day and respite services to enable people to live in their own homes, or *' in homely settings in the community'.*

The importance of suitable housing, is perhaps the most important single factor for ensuring effective community care. In the absence of ideal housing being immediately available, Fontaine and Hutton(1987) suggest, there are two ways of achieving normalisation for people with a physical disability, one is to adapt the environment to enable the disabled person to function as easily as possible, the other is to develop aids for the

disabled so that they can function in an environment which has not been adapted for their needs. It is important therefore, that services for the provision of aids are rationalised and organised in such a way to fulfil their main objectives; to enable people to reach their full potential and to live as independently as posssible as well as providing support and asssistance to their carers.

A great deal of emphasis is placed on the involvement and contribution of family and friends in caring for people in the community and the government stressess the importance of considering the needs of carers when making an assessment. Several studies (Tinker,1980; Abrams,1978; Hunt,1978) have identified the importance of the immediate family in supporting and caring for the elderly at home and indicate that many individuals are caring for a dependent relative unaided by other family members or the statutory services. It is still traditionally, female relatives (Allen,1983) who are the main carers and while there are fears that this source of carers will be greatly reduced as more women are enticed back into the work market, this does not appear to be the current trend.

Much has been written in recent years on the various burdens placed on carers. Koopman-Boyden's (1979) study showed that 66% of main carers had experienced some effect on their health as a direct result of their caring role. Similarly, Sanford(1975) looking at patients admitted to a

geriatric unit, reported that 52% of carers were suffering from depression or anxiety. The financial burden of caring has been well documented (Nissel,1982) both directly from increased heating, diet etc and indirectly by loss of wages decreased promotion etc. The restriction of a normal social life has also, been documented which may contribute to the emotional and psychological costs.

The lack of resources allocated to the implementation of community care and the fact that the numbers of people requiring care are likely to increase suggests that the situation of high dependence on the family is unlikely to change. Every effort should be made to provide them with adequate support to help reduce the burden and strain. The provision of appropriate aids and adaptations is one way of encouraging independence and assisting the carers to cope but this is dependent on a service being readily available and an accurate assessment being made.

Aids and/or adaptations can only hope to achieve this if the right piece of equipment is provided at the right time (Keeble1979). An aid will only be of assistance if it is acceptable and either the disabled person or someone on his behalf knows and wants to operate it. A study by Thornely, Chamberlain and Wright,(1977) identified that many aids were unused, some had never been used, and others were no longer used. In a study of 500 elderly and disabled people in receipt of aids Mulley(1989) found that 50% were not in use, and that one third of feeding aids, and one fifth of

bathing and toilet aids had never been used. The fluctuating and progressive nature of rheumatoid arthritis accounts for a particular need to reassess the suitability of aids (Hollings and Haworth 1978). A postal survey carried out by the Committee for Research on Equipment for the Disabled, (SHHD,1988), shows that many disabled people have problems due to inadequate assessment, lack of choice of aids and inadequate instruction in their use which resulted in aids not being used. For many the problems encountered by the disabled, improvements are already comercially available. The study conducted by Ritchie and Cook (1981) revealed that a lot of community staff were lacking in knowledge and information on aids for the disabled, despite this information being readily available from the Disabled Living Foundation and Mary Marlborough Lodge. In a review of several studies Page et al(1980), concluded that the professionals who prescribe and purchase aids need more and better quality information on which to base their judgements because if an aid is not satisfactory it will not be used.

There is a great deal of literature comparing the merits of one piece of equipment with another and while this is useful, the particular aid many disabled people get is governed by financial constraints and what the person prescribing knows to be available. There is no indication that this situation is likely to change. While Caring for People(1989) will oblige Local Authorities to undertake assessment, it is still not clear what

additional funds will be available. Until new funds are released it is likely that staff will continue to experience the dilemma of assessing for need within the constraints of the availability of equipment.

Caring for People(1989) also stresses the importance of promoting choice; but this is also likely to be restricted by lack of finance, with the resultant constraints on the quality and range of aids supplied and on the number of staff employed to prescribe them.

The current shortage of OTs has stimulated much debate on how OTs time should be deployed and whether more untrained personnel could be responsible for poviding aids and adaptaions. This is an issue over which the profession is divided and is discussed in an independent review of the OT service by Blom Cooper(1989). Several studies illustrate that OTs are dissatisfied that they are required to ration service provision (Scrivens 1983) and that compromises have to be made(Sinclair et al 1988).

At present the provision of aids and adaptations is complex and fragmented, aids and adaptations of one sort or another being provided by Social Work Departments, Health Boards, DHSS, Local Authority Housing Departments Voluntary and Chartitable organisations. A multidisciplinary approach to care provision is not without its problems; as Una McLean (1989) has shown in her review of the problems created by a lack of co-ordination between different services and the tendency of the different professional groups to guard their own territory of expertise.

Caring for People(1989) has many implications for service providers; and identifying who is best qualified to carry out assessments is one major issue. The community OT is possibly the person who has most knowledge of what is available to assist the disabled in the community and Bumphrey(1989) argues that it is imperative that OTs are involved in planning and managing community care. A strong argument against the use of OTs, however, is that the current service is unable to meet all demands, as is evident by the existence of long waiting lists in most areas. There are not sufficient trained staff employed and many assessments on the elderly and disabled people are delegated to untrained staff eg social work and occupational therapy assistants (Sinclair et al.,1988).

This reinforces the need for scarce resources, in the form of both equipment and personnel, to be used efficiently and effectively. Before going on to discuss the efficiency and effectiveness of the local system it is important to clarify exactly what services are involved.

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AIDS FOR DAILY LIVING

Nationally, health and social work (social services in England) departments are the main agencies responsible for the provision of equipment, although in some areas, voluntary agencies are the main suppliers. There is no national policy specifying which agency should provide a piece of equipment or pay for an adaptation. Many local arrangements have been reached: the most common criteria for reaching an agreement is either the type of equipment or the length of time it is likely to be required. Even where such agreements exist, problems arise over certain grey areas. For example, if a short term illness becomes long term then equipment may have to come from another source.

Looking at the way services have developed may help to clarify how some of the problems associated with these services have emerged.

The creation of the Welfare state, particularly the National Assistance Act of 1948, marked the beginning of services for the ill and disabled. Welfare Officers were directed to "instruct handicapped persons in methods of overcoming the effects of their disabilities", and although aids were not specifically mentioned in the Act, some welfare officers started to provide them. Many of these original aids were made in prison, hospital or training workshops, often with a specific client in mind. Many were of Heath Robinson design and not aesthetically pleasing. These aids

could only be obtained through the local welfare officer, but since historically, he was still associated in many peoples minds with the Poor Law, many disabled people were reluctant to ask for help.

In a survey conducted by Buckle in 1971, out of 441 people with wheelchairs only 20% possessed a ramp and of these 32% had paid for them themselves. The main reason given was that people claimed they did not know that help could be obtained from local authorities.

The service for the provision of aids did not really start to develop until after the creation of social work departments and the introduction of section 2 of the Chronic Sick and Disabled Persons Act 1970. However, it did not make it a statutory obligation for local authorities to provide aids and adaptations. Consequently, provision became fragmented, with some areas providing a better service than others.

The Disabled Persons (Services, Consultation and Representation) Act 1986 was introduced to remedy the shortcomings of the 1970 Act and imposed an obligation on local authorities to assess the needs of a disabled person (if requested to do so), to provide the necessary services, and to provide information on all services available in their locality. However, in many areas resources are not available in sufficient numbers to cope with the demand, consequently a great deal of disatisfaction and frustration exists.

There has been no great change in the nature of aids requested over the

years; aids for walking, feeding and bathing were the most commonly issued in the 1950s and 1960s and they remain the most commonly issued today. The major change has been in the quality of the equipment. The manufacture of aids is now carried out on a large scale, the Disabled Living Foundation database was known to have 10,200 separate items on record in1988 and this was acknowledged to be incomplete (Chamberlain 1988).

The current situation, therefore, is one where there is a great deal of equipment on the market, an increasing number of retail outlets, an increase in the number of people requiring aids and a failure of government expenditure to keep pace. This trend is similar to the one envisaged by Wolff(1980) who predicted that as more people became disabled as a result of the ageing process they would demand higher standards, more choice and ease of access to aids or 'tools for living' and the establishment of 'Granny-Care' shops.

Several definitions of an aid have emerged over the years. In 1968 a working party on aids for the disabled defined a "personal aid" as a term to describe "small, easily handled items which assist the patient's functional ability". This included such items as bath aids, toilet aids, eating aids, aids to dressing and household gadgets.

George(1986) describes an aid or an item of home loan equipment,

"*as any piece of equipment which attempts to limit, decrease or overcome*

the problems faced by a person with a physical handicap" and using Bowden's (1984) definition it should,

" *restore and maintain the person's independence and normal place in the community within his physical psychological and social limitations. This requires an understanding of disease and disability, a recognition of the person as a whole, his individual needs and the way he functions within his environment"*

In an attempt to define an aid Malone(1980) has looked at the subject in some detail. He argues that a gap exists betweeen human aspirations and the extent to which these aspirations can be achieved or realised in practice. This gap can be closed by improvements in technology. Consequently in Malone's definition an aid is "*a device, generally self applied or managed, which by mimicking, substituting for, amplifying or monitoring a bodily function helps individuals maintain the gap between their aspirations and achievements at an acceptable level in the presence of physical or mental disabilities,particularly those that are socially as well as physically incapacitating".*

Aids which require installation are called adaptations, but these vary from comparitively inexpensive grab rails to such major items of expenditure as stair lifts. Also included as adaptations are major alterations or extensions which may be required to make a property suitable for a disabled person. The difference between minor and major

adaptations is generally decided on the basis of cost.

Traditionally, medical or nursing aids have described equipment which is required for nursing someone in their own homes and aids to daily living generally describes items which enable someone to live independently eg to toilet, move around, transfer eat dress and bathe his/her self.(see appendix 1 for examples).

What constitutes an aid therefore can be seen to encompass a wide variety of items. The main concern of the professional carers is to improve the quality of life, both of the carer and the person being cared for, and to assure that assistance is given at the appropriate time.

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AIMS AND OBJECTIVES

The necessity of having an efficient service for the provision of aids and adaptations has been discussed in the previous chapters and is of paramount importance for the implementation of community care. With this in mind, this research was undertaken to make a critical appraisal of the existing services for the provision of aids and if necessary, to formulate proposals for improving their efficiency and effectiveness.

As a preliminary to the main investigation a small pilot study was undertaken to establish:-

1. Who provides equipment?

2. Do patients/clients experience any problems in obtaining equipment, if so where, and what are they?

PILOT STUDY

The pilot study involved selecting twenty patients from district nurse and health visitor case loads, who had either recently requested or received equipment. This sample was not representative but was chosen because it was easily identified and accessible. The patients selected were all registered with GPs who were based either in Shettleston or Baillieston Health Centres and were all interviewed in their own homes. The interviews took the form of a questionnaire which also gave the patients an opportunity to relate anecdotal experiences. Informal

discussions with community staff and inspection of the various stores also provided information on how the systems for the provision of aids operated. The results of this study are reported below;

The twenty patients in the pilot study had a total of 77 aids and had requested a further 21 items.

The statutory agencies had provided 77%(59) of the 77 aids with the remaining, 23%(18) of items provided from private, voluntary and informal sources. (see table 3.1).

Table 3.1

SOURCE AND USE OF EQUIPMENT OF PATIENTS IN THE PILOT STUDY

SOURCE	IN USE	NOT IN USE	TOTAL	
COMMUNITY OT	16	6	**22**	]
NURSING	20	13	**33**	]- 77%
HOSPITAL	4	-	**4**	]
PRIVATE	5	1	**6**	]
RED CROSS	2	-	**2**	]- 23%
INFORMAL	8	2	**10**	]
	71%(55)	**29%(22)**	**77**	

*N.B. The total percentage in this and subsequent tables may not total 100% because of rounding to the nearest whole number.

The table shows that 71% of the items were used regularly and felt to be satisfactory but 29% of the items were no longer or never had been used but remained in the patients' homes. This suggested a lack of follow up to see if equipment was appropriate and whether it continued to be useful. Patients had various reasons for keeping equipment which they no longer

required. Some of the items were being kept "just in case" a patient's condition deteriorated; others felt that their friends might be able to benefit from equipment without having a lengthy wait for an assessment; (this was also the excuse used by some nurses for allowing patients to retain equipment which they no longer used) and others claimed they did not know where to return equipment.

There was a substantial difference in the experience of patients receiving equipment from the two main sources. Most nursing aids had been delivered within 3 to 10 days, with 3 exceptions; two wheelchairs took between 3-4 weeks to be delivered and one lady waited 10 weeks for a commode, because her referral had been made to the wrong agency. By comparison most patients expressed problems and delays in receiving equipment from the occupational therapy service, reporting delays from 3 months to three years.

Of the 21 items, for which referrals had been made and, which had not been delivered only two were for nursing aids the remaining 19 for OT aids. The 2 patients waiting for nursing aids, both requiring cot sides, had been waiting for approximately three months as the equipment was not available. The clients waiting on OT aids had been waiting for up to two years, some had been assessed and were waiting on equipment others were still waiting to be assessed. Some patients/clients therefore, were found to have equipment which was not in use whereas others were

experiencing delays in having their needs met.

QUESTIONS RAISED BY THE PILOT STUDY

The results of this small study indicated that the statutory agencies were shown to be the major providers of equipment and although the private, voluntary and informal providers accounted for 23% of the equipment, the inability to monitor them or directly implement changes in them results in the main study concentrating on the statutory services. Problems did exist for patients/clients in obtaining equipment in the sample examined and this raised questions which required investigation to establish if these problems were widespread and whether anything could be done to make the existing systems more efficient.

1.The major problem, reported by staff and patients, was delay in getting equipment. Delays were reported at two points; waiting to be seen by the OT staff, and getting equipment once patients/clients had been assessed. The majority of the nursing aids appeared to have been delivered, promptly, but anecdotal evidence suggested that problems did exist, in particular for more expensive or unusual items.

The distribution network appeared to operate efficiently if equipment was in stock and a driver was available. All stores however, indicated that problems did arise, each year, as money to buy equipment tended to run out half way through the year. In order to see if people were experiencing problems and delays in the provision of equipment from the

statutory services, it was decided to look at several areas of the city in greater detail and attempt to isolate where and why they occurred. The main research was designed to establish:-

Whether patients/clients experience delays in aids provision and if so, where and why these delays occur?

The results of this study are reported in chapters 6 and 7.

2. A lack of follow up was identified, the pilot study indicated that 29% of equipment out on loan was no longer or never had been used. In the nursing stores it was assumed assessment had already taken place prior to referral, but the scale of non use suggested that adequate assessment had not taken place. Other instances where equipment was no longer in use raises questions as to the need for reassessment and information on where to return equipment.

Clients were often confused as to where equipment had come from and consequently did not know where to return it. It was felt the whole area of what happened to equipment warranted further investigation as unused equipment could be retrieved and made available for redistribution, especially as budgets did not appear to be adequate. This leads us to ask,

What happens to equipment once it has been out on loan?

A small study was set up to answer this question, the results of which are reported in chapter 8.

3. Referrals to the OT service, assumed that no asssessment had taken

place, with the exception of some hospital discharges. The pilot study suggested that people waited longer for a service from the OTs than from the nursing stores; this finding, coupled with complaints from the occupational therapists who felt they spent too much time doing routine clerical work, led to a study on how staff spent their working day. The results of this study, **How Occupational Therapy staff spend their time?** are reported in chapter 9.

4. Both statutory systems were dependent on patients/ clients knowing where to go for help. The pilot study indicated that problems do exist (eg The lady who made a referral to the wrong agency had a long wait for a commode); some people either did not know of these services or did not want to ask for help and had purchased their own equipment, or had borrowed equipment from friends etc.. This raises the question, **are there many people who do not know where to get help or will not ask for help?** The existence of waiting lists for assessment and for delivery of equipment indicated that an element of unmet need existed. The whole area of hidden and unmet need was felt to be worthy of further investigation and is looked at in greater detail in chapter10.

METHODOLOGY

This research project was designed to examine the existing services for the provision of aids to people in the community. It involved several small studies, as described in this chapter.

LOCATION OF THE STUDIES

Four areas of the city were identified from which to draw the study populations. These are:-

Clydebank which is situated on the bank of the river Clyde has a lot of unemployment because of the decline in ship building and related industries. It has a comprehensive mixture of housing to include low rise and multi-storey flats, semi-detached, sheltered and purpose built housing for the elderly and disabled. There is a large health centre in the town where the majority of the local GPs and community nurses are based and also where the community nursing store for the West of Glasgow is situated. The community occupational therapy service is provided from one of the area team Social Work offices in the town, which also houses their equipment store. No driver or handyman is employed for the OT service.

Castlemilk is a large council housing estate, built in the 1960s with few amenities. It is built on a hill side and consists mainly of high rise flats and tenement type housing with communal staircases, although there are

a few sheltered houses, there is a scarcity of ground floor flats without external steps. Many of the houses are being refurbished, but this does not alleviate the problems of those elderly and disabled whose houses are unsuitable because of their location.

Primary health care is provided by several GP practices, with community nurses, (health visitors and district nurses) group attached but housed in different premises from each other and from the GPs. Requests for community nursing aids are made to a local community nursing store (Florence Street) and delivered from there by a driver.

The community Occupational Therapy service is based in the local area Social Work team office; which has no storage facilities. A local store was based in neighbouring Govanhill, but following boundary changes it has recently moved to the main South East District Headquarters store.

Rutherglen:- was formerly an old borough, and has a wide variety of private and council owned housing; including old tenement flats, and purpose built housing for the elderly and the disabled. GPs are based in the local health centre, which also accomodates the community nurses. Nursing aids come from a local store (Florence Street).

The OT service for these clients is based either in Cambuslang or Castlemilk, depending on where they live, with equipment coming from the district store based in the grounds of Belvidere hospital. Castlemilk and Cambuslang OT deparments share the services of a driver/ handyman.

Milngavie is a professional residential area. There is a high proportion of private housing, and the mixture of housing types includes purpose built flats and sheltered housing complexes. There are only a few traditional council houses. GP surgeries are spread through out the area with community nurses attached to particular practices but based in separate clinic buildings. The nurses in the clinics have used charitable donations to purchase items of equipment, however, the majority of nursing aids come from the store at Clydebank.

The occupational therapy service is based in the area team in Milngavie, and equipment is provided from a district store in the city which employs a storeman and a driver /handyman.

1.STUDY OF DELAYS AND PROBLEMS IN THE PROVISION OF AIDS

The data for this study were obtained through the analysis of a large cohort of consecutive referrals to community nursing stores and community occupational therapy departments. All referrals made during June and July 1988 were followed up to see if patients/clients were experiencing any difficulties. A further cohort of referrals from the nursing stores was obtained during January and February 1989 to provide a larger sample size.

All the patients requesting nursing aids during June and July 1988 were interviewed, and while this provided a lot of anecdotal material, it was decided that it was too time consuming to pursue all the referrals to the

occupational therapists and the requests for nursing aids during January and February 1989. Details of the outcome of referrals for these patients/clients was therefore, obtained from case records, delivery slips and from the various staff involved.

The results of this study are reported in chapters 6 and 7.

2 RETROSPECTIVE SURVEYS OF EQUIPMENT USE

Patients/ clients who had previously borrowed equipment were identified and every effort was made to interview them to establish what happens to equipment once it is borrowed. The patients and clients (or their families) were all asked if they still had the equipment? If so, they were asked if they were still using it and if they had any further contact with the services, either to borrow more equipment or return it. If they were not using the equipment, they were asked why use had discontinued and what had happened to the equipment. The samples yielding this information came from two independent surveys:-

A)The Nursing Store

Nursing records permitted the identification of patients who had borrowed equipment more than a year previously and who were still registered as having it. 225 such patients were identified from records at Florence Street. Only those who could be contacted by telephone were followed up as it was felt that it might be distressing to turn up on the doorstep of a patient's family asking about equipment which had already

been returned, especially if the patient had died. Where a telephone number was unavailable, the electoral roll was checked to see if the occupants of the house had changed. Where the occupancy had changed, new occupants were contacted, but when none of them knew what had happened to the previous occupants it was felt unprofitable to pursue the search. It should also be reported, 130 patients could not be contacted, and it wass impossible to determine what had happened to their equipment. Of the 95 patients contacted, 34 had equipment which had been out on loan for more than 18 months; 16 had equipment which had been on loan for between 15- 18 months, the remaining 45 had equipment which had been on loan for 12-15 months.

B) OT Service

The sample consisted of all clients living in Rutherglen and Clydebank who were registered as having requested an occupational therapy service between August 1985 and January 1986. This did not include referrals made for adaptations, "orange badges", holidays or information, neither did it include a large number of clients who had subsequently died or moved out of the area. Of the 132 clients identified: 32 could not be contacted, 100 were contacted either by telephone or a house visit.

The results of this study are reported in chapter 8.

3.PROSPECTIVE WORK RECORDS

Semi-structured prospective record sheets(see appendix 2) were given to

OTs and untrained occupational therapy assistants(OTAs) in the four area offices in which the main study was carried out. They were instructed to estimate how much of their time was spent doing clerical duties and how much was spent assessing and treating clients. They were also asked to complete questions pertaining to status, length of time in post, job satisfaction and duties they felt could be delegated. The results of this study are reported in chapter 9.

4. STUDY EXAMINING THE EXTENT OF UNMET NEED.

Little is known either about the type or extent of unmet need for aids. Not having the resources to mount a survey for this purpose; data gathered by the Chronic Sick and Disabled Persons Project(CSDPP) for Strathclyde Regional Council were used. The CSDPP data for Cumbernauld were gathered in July/August 1988 and indicated that there was substantial unmet need. All referrals made to the OT service were examined to discover the eventual outcome. This was done by examining client records, and interviews with occupational therapy staff; clients were not contacted as it was felt it might raise false expectations if their needs had not been met following the survey.

The results of this study are reported in chapter 10.

CHAPTER 5

THE STRUCTURE AND FUNCTIONING OF SYSTEMS FOR THE DISTRIBUTION OF AIDS AND ADAPTATIONS

Four main sources of equipment were identified in the pilot study; these were, the statutory agencies, the private sector, the voluntary/charitable organisations, and an informal or casual network. These all operate independently and the remit and organisation of each is examined in turn:-

(A) STATUTORY AGENCIES

Two statutory bodies provide equipment, in Glasgow; the community nursing division of the Greater Glasgow Health Board and the occupational therapy department of Strathclyde Social Work Department. These operate independently with their own finances, management and organisation.

The division of responsibility for the provision of aids, is regulated by guidelines laid down by the Scottish Home and Health Department (Circular No. 1976(Gen)90,). The Glasgow Division of the Regional Social Work Department and the Greater Glasgow Health Board agreed that the deciding factor should be the type of equipment.

Broadly, the Health Board is responsible for provision of aids where:-

a)" *they are directly related to the management of an illness,especially to facilitate the patients domiciliary nursing care or to facilitate the rehabilitation of a patient from hospital*"

or

b)" *The skills of a particular discipline within the health service are more appropriate to the prescription and use of aids required on medical or*

nursing grounds,"

The Social Work Department is responsible where.-

" the aids or equipment are required to help the disabled person achieve a greater independence within his own home and are predominately of a domestic character,".

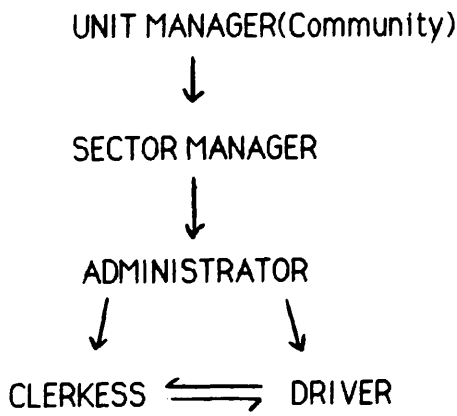
Appendix 1 lists the types of aids available from each of these sources.

In general these guidelines are helpful, but confusion can arise; for example, when staff or clients have moved from parts of the country where different guidelines have been used or when equipment is returned to the wrong agency and it is then reissued rather than returned to its proper source.

(1)HEALTH BOARD COMMUNITY NURSING STORES

The Greater Glasgow Health Board has three community nursing stores. Day to day management is performed by community administrators who delegate the running of the service to clerical and ancilliary staff (see fig.5.1).

Fig.5.1 **MANAGEMENT STRUCTURE OF NURSING STORES**



Ordering of equipment is done by the sector manager, without consulting nursing or physiotherapy staff, although occasionally requests for specific items of equipment are made. It is only recently that the service was given its own budget, previously, home nursing aids came out of a general budget which included office equipment.

Two nursing stores serve the areas chosen for the main study:-

1)Florence Street provides equipment for patients in the South of Glasgow. It is located up a flight of stairs, in an old clinic building, which means that the driver has to carry all the equipment up and down stairs.

2)Clydebank provides equipment for all of the West of Glasgow. It is located in the Health Centre at ground floor level to the rear of the building with good vehicular access.

HOW THE NURSING STORES OPERATE

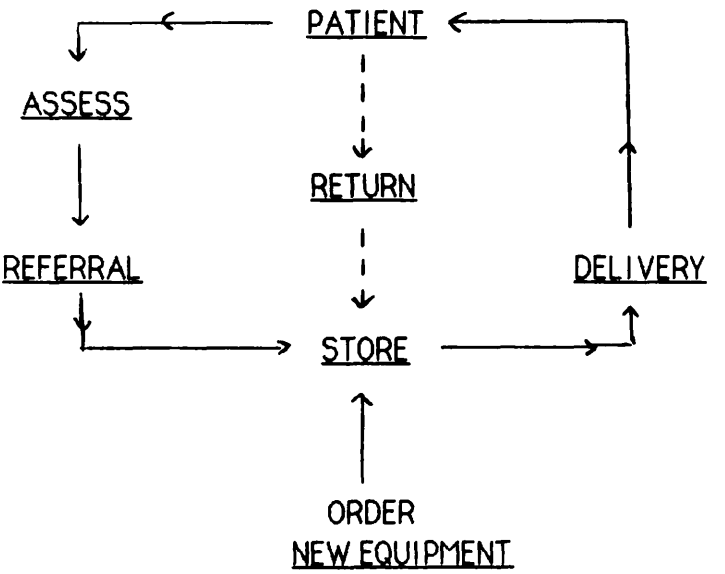
Both stores are run by clerical and ancilliary staff who have no specialist knowledge of equipment and all have other unrelated duties to perform. These often take precedence over the delivery and uplift of equipment. While there are differences in the facilities and day to day running of the two stores, they share a common referral pathway (see fig.5.2)

Patients are assessed by a health worker who sends a request to the nearest community nursing store for the appropriate piece of equipment. These requests are made to a clerkess who in turn passes them to the

driver who is responsible for going to the store to collect the equipment and delivering it to the patient. A signed delivery slip is then returned to the clerkess for filing. Equipment is returned to the store, by three routes: by the driver following a request from a patient, by the patient themselves and it is collected from clinics and health centres where it has previously been returned.

Fig.5.2

REFERRAL PATHWAY THROUGH NURSING STORES



There are no set guidelines which operate if equipment is not immediately available. he drivers either hold the request awaiting the return of equipment or they give it back to the clerkess who, in turn, either holds onto it or passes it on to the administrator for ordering.

The driver is an important person in the system as he ultimately determines what to deliver, to whom and in what order; he is also responsible for determining which equipment requires cleaning or

repairing and for informing the clerkess when stocks are low.

The clerkess is another key figure. She is responsible for all referrals for equipment and all requests for uplift, which she passes onto the driver. She is also responsible for keeping any official waiting list, maintaining records and informing the administrator if more equipment requires to be ordered. However, she in turn is dependent on the drivers keeping her informed and returning all the referral slips for equipment which has and has not been delivered. Record cards are kept of individual requests to borrow equipment but they are not arranged in such a way to facilitate an estimate of the total amount of equipment borrowed. In addition, when equipment is recorded as returned these records are destroyed.

Having concentrated on the common features of the stores, it is important to acknowledge a number of differences in recording and monitoring.

a) In Florence Street all referrals are made by telephone to a clerkess who is subject to constant interruption. In Clydebank all but emergency referrals are made via a card system to the clerkess. Staff within the Health centre deliver the cards by hand, those in outlying clinics send them by a courier system or by post.

b) In Florence Street the referrals are initially recorded in notebooks (one for deliveries and one for uplifts), and are subsequently typed onto delivery slips by a typist, before being returned to the clerkess for

collection by the driver.

c) Patients receiving equipment from Florence Street sign for it in duplicate, one copy is left with the patient asking them to return the equipment when no longer required, the other copy is retained by the driver to be returned to the clerkess for filing. In Clydebank patients only sign the referral card which they return to the driver, consequently they do not retain any record of where to return equipment.

d)In both stores the signed delivery slips are meant to be returned to the clerkess for filing but they are often lost. When this happens in Clydebank all record of the referral is lost; in Florence Street the information is retained in the notebooks but delivery slips are not checked to see that all are returned. In both stores it is therefore, difficult to check if deliveries have been made or not.

There are also minor differences in the remit of the stores.

e)In the South East of the city all requests for walking aids are referred to the community physiotherapist who visits, assesses and delivers the appropriate aid to the patients. In Clydebank,requests for walking aids are not treated separately.

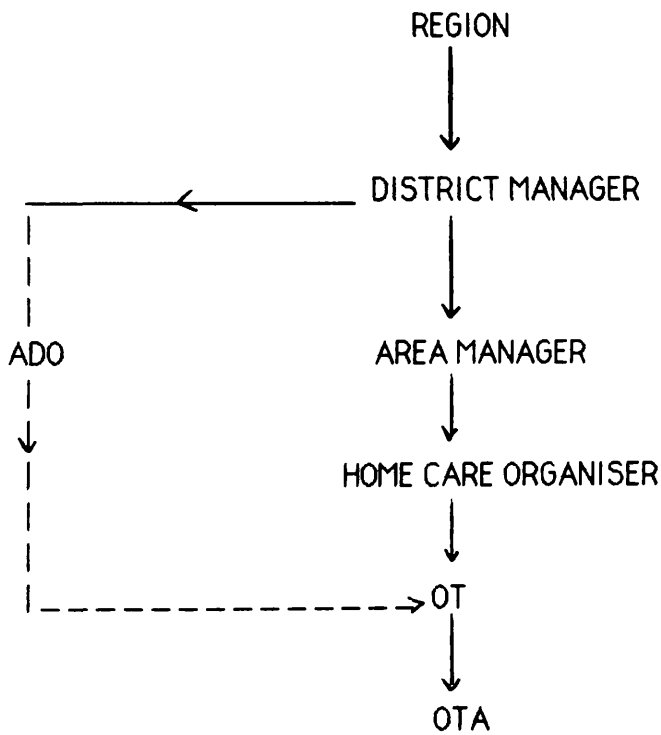
f)The Clydebank store does not use the driver to deliver urinals and bedpans. Instead, a small stock of these items are kept in clinics around the area to be distributed by the nurses.

(2).COMMUNITY OCCUPATIONAL THERAPY SERVICE

In Strathclyde, the community occupational therapy service is provided by qualified occupational therapists (OTs) and their untrained occupational therapy assistants (OTAs), based in an area team. The line of management extends from the Home Care Organiser(HCO) to the district manager; but professional supervision comes from outwith, generally from an Assistant District Officer (ADO) at district level(see fig.5.3).

Fig.5.3

MANAGEMENT STRUCTURE OF COMMUNITY OT SERVICE



Budget is allocated at regional level but responsibility is effectively devolved to district level. There are separate budgets for aids and adaptations. The aids budget is further broken down; a proportion is retained at Region to contribute to the purchase of large items, a

proportion is allocated to a central draw for basic stock items bought under contract tenders, the remainder goes to district headquarters for the purchase of non stock items.

The adaptation budget is similarly split. A portion is retained at regional headquarters for those more expensive adaptations which require regional permission, the remainder is controlled at district level.

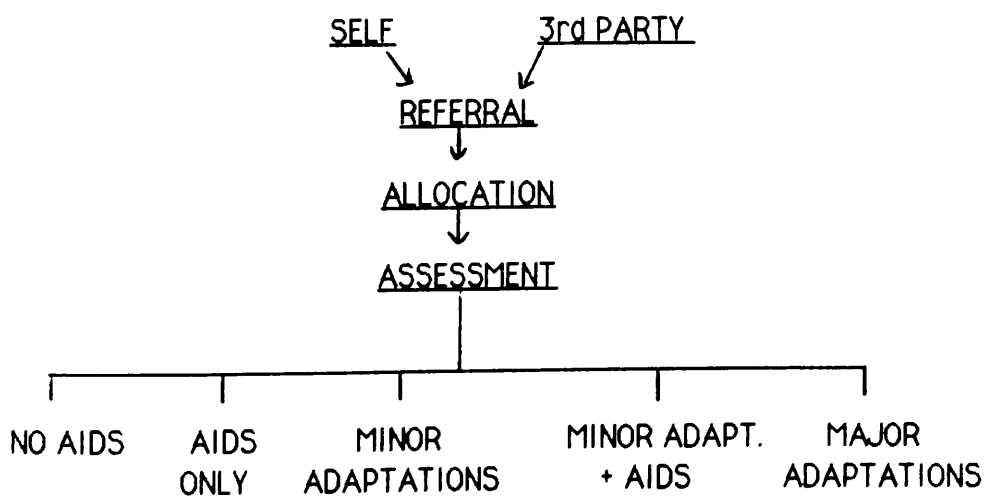
In none of the four areas studied is clerical help employed for the OT staff. In Milngavie, Rutherglen and Castlemilk there is access to drivers and handymen but Clydebank is dependent on drivers from the general transport pool and has no access to a handyman.

HOW THE OT SERVICE OPERATES

There are individual variations in the way different offices operate but there is a basic common referral pathway through the Community OT service (see fig.5.4).

Fig.5.4

REFERRAL PATHWAY THROUGH COMMUNITY OT SERVICE



The OT service operates an open referral system and although official referral forms exist, they are rarely completed. Referrals accepted by the occupational therapy staff are given a registration number and an acknowledgement letter of receipt is sent to the client. Prioritisation of referrals is mainly done by the HCOs. Clients are allocated either to the OT or OTA, who place them on a waiting list. Clients with low priority tend to be allocated to an OTA, which ocassionally results in their being seen before clients who are regarded as high priority and required to be assessed by the OT. Most clients are visited and assessed in their own homes and there are five outcomes to the assessment: namely,

a) aids to daily living,

b) a minor adaptation

c)a major adaptation

d) a combination of (a) (b) and(c)

e) no aids or adaptations.

Aids may be delivered by the occupational therapy staff at the time of assessment or at a later date by a driver or handyman. Routine folow up visits or telephone calls are usually made to check that all equipment or adaptations have been installed and that they are satisfactory. Further follow up visits are not generally made unless a client makes another referral to the occupational therapy department.

Records are kept by the individual staff members but these vary

considerably in accuracy and legibility so that it is often difficult to determine what equipment or adaptation a client has been given.

Variations occur between the different departments;

a) In the absence of clerical help, Clydebank and Rutherglen OT staff "man" the offices each morning to receive referrals either by telephone or from callers. In Castlemilk and Milngavie (also without clerical staff) there is no such routine deployment of staff. When OT staff are unavailable a telephonist takes the clients name and number and gets the OT to telephone back later to accept the referral.

b) In Milngavie the OT prioritises and allocates her own work, in the other departments this is done by a Home Care Organiser. (Although many of the OTs claimed to be unhappy because HCOs allocate the work, in practice they found it useful to use them as scapegoats if clients complained about the length of time they had to wait for a service.)

c)The registration of referrals varies between the offices. In Castlemilk and Rutherglen the referrals are received in the office. Originally these were sent to district headquarters for registration, but because of lack of clerical staff at headquarters, this practice was stopped during the study. The OTs estimated that sometimes referrals disappeared for months during which time the OT had no access to the referral and found it difficult to answer any queries concerning them. Registration of referrals and allocation of a Social Work department number is now done

by the OT staff themselves.

d)The South East District, which includes both Rutherglen and Castlemilk, has recently opened a Disabled Resource Centre (DRC), and as part of this service they offer certain clients the opportunity to go to the centre and be assessed for equipment by an OT.

THE OTHER STATUTORY PROVIDERS

Patients being discharged from hospital may be given inexpensive items of equipment on a non returnable basis by the hospital occupational therapist (eg bath mats, dressing aids, feeding aids etc). Other more expensive aids may be given on short term loan of up to two months to enable patients to be discharged home while awaiting supply of equipment from the community occupational therapy service. The alternative solution for patients requiring long term equipment is for the hospital to supply it and then obtain reimbursment from the community occupational therapy department. In practice, most patients being discharged from hospital requested their equipment directly from the community occupational therapy service. Hospital physiotherapy departments also give out equipment, generally walking aids which the patient has been using in hospital and are not expected to be returned.

Local authority housing departments also have a responsibility for the provision of minor adaptations to their property, in conjunction with recommendations from the community OT.

Provision of specialist equipment, such as hearing aids, elastic stockings, communication aids, special footwear etc., which require the patient to be seen by a hospital consultant, were not included as these were not considered to be within the remit of the study, nor was the provision of wheelchairs from DHSS disablement service centres.

B) VOLUNTARY/CHARITABLE ORGANISATIONS

The Red Cross is the largest voluntary provider of equipment in Glasgow. Although it was not a major provider in the pilot study (2%), it is worth mentioning the contribution it makes as it both complements and supplements the statutory sector.

There is one central store which supplies all of Glasgow and three small independent stores, in Clydebank, Milngavie and Bearsden which supply their immediate vicinity. The Red Cross is run on a purely voluntary basis and is dependent on donations from the general public and from borrowers, ie the disabled, their friends and their carers. Records are kept of what is issued to whom and when it is returned, recall slips are sent out every 2-3 months and most equipment is returned or its location known. Clients are encouraged to collect and return equipment as the Red Cross is dependent on voluntary drivers.

Most referrals come from private individuals but those from health workers are thought to be on the increase. No charge or deposit is made but in the Clydebank store the organiser asks for a £5 deposit for

wheelchairs because of many being returned in a poor state of repair.

By far the largest number of referrals are for temporary wheelchairs accounting for 74%(340) of equipment borrowed from the Glasgow store and 63% overall (see table 5.1).

Table 5.1

EQUIPMENT BORROWED DURING 1988 FROM THE RED CROSS

	GLASGOW	MILNGAVIE	BEARSDEN	CLYDEBANK	TOTAL
WHEELCHAIRS	340	46	60	40	486(63%)
COMMODES	46	30	24	14	114(15%)
WALKING AIDS	24	24	12	11	71(9%)
BATH AIDS	10	-	9	3	22(3%)
BED CAGES	6	-	4	4	14(2%)
URINALS/BEDPANS	4	-	4	4	12(2%)
RINGS/CUSHIONS	6	-	2	-	8(1%)
OTHER ITEMS	24	-	2	13	39(5%)
	460	**100**	**117**	**89**	**766**

There were 367 borrowers for 460 items of equipment in Glasgow. The multiple borrowers being predominately loans of wheelchairs to societies and clubs for day trips and shopping expeditions. This was reflected in the pattern of borrowing, which showed peaks in demand during the summer months and December.

Other charitable suppliers include the Multiple Sclerosis society which gives gifts to its own members. These usually take the form of extra 'luxury' items, which would not normally be provided by the statutory agencies eg special powered chairs. These societies tend not to keep records of individual purchases only that a certain amount of money was spent on gifts of equipment to its members.

Local charitable groups and individuals also make ocassional donations of

equipment to health centres and clinics.

C)THE PRIVATE SECTOR

A few patients reported going out and buying equipment from chemist shops, and while they probably represent the tip of an iceberg, it is not possible to estimate the full extent of such private sector use in Glasgow.

Although the numbers in the pilot study were small the increasing number of specialist shops, selling aids to daily living and mail order catalogues advertising in local papers indicate a growing demand for the private purchase of equipment. Private sector suppliers were unable to differentiate between disabled people buying for their own use and those buying for private nursing homes. The rapid increase in the number of private nursing homes for the elderly undoubtably accounts for a large proportion of the growing private market but is unlikely to account for all of it.

Those respondents in the pilot study who purchased equipment gave several reasons: some had heard that there were long waits to get equipment, others had not thought of doing anything else. More generally the fact that people choose to purchase their own equipment may be a consequence of the stigma associated with contact with the social work department. Sophisticated advertising and education campaigns have also increased public awareness of what is available, and this greater

awareness, plus the long waiting times for the statutory agencies to provide equipment may also have had an effect.

The growth in the sale of second hand equipment was also noted. This gives cause for concern because without appropriate assessment there must be doubts about the safety of such equipment.

D) AN INFORMAL OR CASUAL NETWORK

The provision of equipment through an informal or casual network was also found to be in evidence with clients receiving items which were no longer required by friends and neighbours. Nurses were also found to take part in this informal network by allowing patients to retain equipment which they no longer required and then giving it to other patients without informing the appropriate stores.

The very nature of this network ensures that it has no formal structure but it was thought to be more prevalent among the patients/clients in traditional working class areas where people tended to know everyone in the street. The size of this source of supply is impossible to quantify. It is officially discouraged and staff were unwilling to reveal or to attempt to record how often informal transfers occurred, although all were prepared to admit it went on (if not by themselves certainly by their colleagues). Discussions with patients/clients also revealed that these informal transfers occurred.

SYSTEM DELAYS

The pilot study revealed that many people experienced long delays in receiving equipment, with reports of some clients dying or being hospitalised before having their needs met. In order to examine this issue further, it was decided to look at a large cohort of consecutive referrals to the nursing and OT services and to follow their progress through the two systems to identify where the delays occur.

At the outset it has to be emphasised that there is a basic difference between the two services. For nursing aids, an assessment is assumed to have been undertaken by a Health worker prior to referral, and this requires an efficient distribution service. By contrast, referrals to the occupational therapy services can be made by anyone, thus, in most instances assessment has not taken place prior to the referral. What is required here is an efficient system of assessment as well as a distribution service. Consequently, exact comparison of the two agencies is not possible but there are sufficient similarities to allow some comparisons to be made.

NURSING STORES

The majority of people requiring nursing aids do so because of illness, therefore long delays are unacceptable. The time for delivery of equipment from the nursing stores is shown in table 6.1.

Table 6.1

TIME FOR DELIVERY OF EQUIPMENT FROM NURSING STORES

within	Florence St	Clydebank	**TOTAL**		
24hours	21%	26%	**24%(139)**	]	
4 days	26%	36%	**32%(183)**	]-	**71%**
7 days	13%	16%	**15%(85)**	]	
7- 28 days	18%	13%	**15%(84)**	]	**19%**
28+ days	5%	4%	**4%(23)**	]	
not deliv.	17%	5%	**10%(56)**		**10%**
Total	**229**	**341**	**570**		

It can be seen that 71% of the items of equipment were delivered within 1 week of the referral; 19% of the items took longer than 7 days to be delivered and 10% were not delivered at all. There are however, variations in the length of time taken to deliver equipment from the two stores; patients requesting equipment from the Florence Street store appear to be consistently worse off than those served by the Clydebank store. It can be seen that 60% of Florence Street equipment was delivered within 7 days whereas 78% of Clydebank equipment was delivered in the same period. Similarly,17% of items requested from Florence Street were not delivered at all as opposed to just 5% from the Clydebank store. Overall, Florence Street accounts for 70% of the equipment which was not delivered at all. Reasons for non delivery are varied. Of the 56 patients who failed to receive:- 30 had died, 10 were hospitalised, 1 no longer required the item, 1 had bought the equipment and 4 patients still waiting for equipment were assumed no longer to require it. 2 patients could not be traced and 8 patients had had their

requests cancelled without any reason (possibly most of these had also died).

It is apparent that the majority of these items were required for terminally ill patients or those who subsequently required hospitalisation. While it is unlikely that the equipment would have prevented hospitalisation or death, there is little doubt that the quality of life of the terminally ill and their carers could have been improved if the equipment had been made available.

OT SERVICE

The clients who made referrals to the OT departments experienced initial delays in waiting to be seen and further delays in having their needs met following assessment.

Table 6.2

TIME FROM REFERRAL UNTIL CASE OPENED BY OCCUPATIONAL THERAPY STAFF

WITHIN	CLYDEBANK	CASTLEMILK	RUTHERGLEN	MILNGAVIE	TOTAL	
2 WEEKS	11%	40%	28%	31%	**22%**	]
4 WEEKS	10%	15%	7%	36%	**14%**	]- **51%**
8 WEEKS	18%	2%	5%	31%	**15%**	]
12 WEEKS	23%	10%	2%	-	**12%**	]
16 WEEKS	7%	5%	9%	-	**6%**	]- **28%**
20 WEEKS	11%	-	2%	-	**5%**	]
24 WEEKS	8%	5%	-	-	**5%**	]
>24 WEEKS	8%	15%	46%	-	**17%**	
NOT OPENED	4%	8%	3%	2%	**4%**	
No. of items	**119**	**40**	**58**	**42**	**259**	

Table 6.2 shows that while 51% of all clients had been seen within two months a disturbingly large proportion(28%) are not seen within six months. There are wide variations between individual OT departments.

Milngavie did not have a long waiting list and consequently 98% of referrals had been or were being dealt with within 2 months whereas only 40% of those in Rutherglen, 39% in Clydebank and 57% in Castlemilk had been seen in the same period. These huge variations require comment. Castlemilk and Rutherglen operate a system of self assessment for clients requesting external rails and this accounts for the high proportion of referrals opened in the first two weeks in these areas. At the other extreme, after 24 weeks, 8% of referrals were still waiting to be seen in Clydebank, 15% in Castlemilk and 46% in Rutherglen. These substantial variations are mainly explained by the numbers of clients waiting to be assessed but there are other factors which influence the delays and which will be examined later in the chapter.

There are several aspects of both services which explain some of the reasons for these delays. Each service will be examined in turn.

NURSING STORES

THE MODE OF REFERRAL:

In Clydebank, referrals are made via a card system, but there are different modes of delivery of these. Patients registered with GPs in the Health Centre, have their referrals hand delivered, whereas those served by outlying clinics and isolated GP surgeries have their referrals delivered by the post or via the courier system .

Table 6.3 indicates that patients registered with GPs in Clydebank Health

Centre are more likely to receive equipment within 24 hours, 39% as opposed to only16% being delivered to patients served by clinics. However, by 4 days there is no real difference between patients in the health centre and those in outlying clinics and at the end of 7 days patients in the health centre are more likely to be waiting on equipment than those in the outlying clinics.

Table 6.3

DELIVERY TIMES FOR PATIENTS FROM THE HEALTH CENTRE AND OUTLYING CLINICS

within	HEALTH CENTRE	CLINICS	Total
24hours	39%	16%	26%
4 days	23%	47%	36%
7 days	12%	19%	16%
7- 28 days	15%	11%	13%
28+ days	6%	2%	4%
not delivered	5%	5%	5%
No. of items	**155**	**186**	**341**

From table 6.4, it can be seen that the major reason for delays in delivery to patients served by clinics is the time for the referrals to reach the clerkess in the store. 88% of health centre referrals were received within 24 hours in comparison with only 52% from the clinics.

Table 6.4

TIME FOR REFERRALS TO REACH CLERKESS FROM CLYDEBANK HEALTH CENTRE AND CLINICS JANUARY/FEBRUARY 1989

	HEALTH CENTRE	CLINICS
24hours	88%	52%
4days	12%	38%
7days	-	3%
[1]D/K	-	7%
TOTAL	**74**	**166**

Note:- 1. D/K =don't know;11 requests were not dated.

While the mode of referral influences the ability to respond immediately

in Clydebank, it does not explain why patients in Florence Street wait longer to get equipment or why 38% of Clydebank patients' were still waiting for equipment after 4 days. Other factors have to be considered.

THE TYPE OF EQUIPMENT:

The majority of the referrals are for small relatively inexpensive items.

TABLE 6.5

ITEMS WHICH WERE NOT DELIVERED OR DELAYED

TOTAL REQUESTED	AIDS REQUESTED	NOT DELIVERED	DELAY MORE 7 DAYS	% OF ITEM NOT DELIV /DELAY
18	WALKING AIDS	-	5	28%
73	ZIMMERS	2	7	12%
13	WHEELCHAIRS	3	2	38%
53	URINALS/BEDPANS	7	9	30%
215	COMMODES	18	24	19%
1	RAISED TOILET SEAT	-	-	-
1	INFLATABLE TOILET SEAT	1	-	100%
10	BEDS	4	4	80%
1	MATTRESS	-	-	-
7	COT SIDES	4	3	100%
3	BED ELEVATORS	2	-	67%
32	BACK RESTS	1	6	22%
28	BED CAGES	-	5	18%
10	RIPPLE MATTRESS	-	-	-
44	SPENCO MATTRESS	11	28	89%
1	CUSHION	-	-	-
45	RINGS	-	9	20%
5	HOISTS	1	1	40%
10	MONKEY POLES	2	4	60%
570		**56**	**107**	**29%**

Table 6.5 indicates that there are proportionately more delays for more expensive items and that they are also most frequently not delivered at all. For example all of the patients who requested cot sides experienced delays in excess of 7 days and 4 patients did not receive them at all. Similarly, most of the patients ordering spenco pressure care mattresses

either experienced delays or did not receive them at all. The main reason for this is that waiting lists are allowed to develop and reordering is delayed. There are no guidelines as to how long patients should wait prior to orders being placed nor is there any attempt made to recall equipment. The reasons for the non availability of regular stock items can primarily be attributed to a shortage of equipment and, in turn, to low stock levels and the non availability of a driver.

DRIVER DELAY: The driver plays an important role in the eventual outcome of referrals to the Nursing Stores. Several delays are directly related to the driver being on holiday or off sick and no replacement being provided. If the regular driver is not available priority is given to deliveries, uplifts of unused equipment are often ignored and equipment shortages result. Reordering of basic items are also delayed if the driver fails to notify the clerkess that stocks are low. The Florence Street store did not have any urinals for over 4 weeks because of delay in ordering. Four requests for beds were left unanswered, not because there were none available, but because the driver delayed delivering them for several weeks, until they were no longer required. There were also instances of referral slips being misplaced and equipment not being delivered until re-referrals were made.

DELIVERY DELAY ATTRIBUTABLE TO OTHER PROFESSIONALS:

Other professionals regularly delivered items of equipment(see table 6.6)

Table 6.6

EQUIPMENT DELIVERED FROM NURSING STORES IN JUNE/JULY

	CLYDEBANK	FLORENCE ST.
Driver	72%	67%
Physio	-	33%
Nurse	24%	-
Other	4%	-

There are several reasons for this:

1. Preference of Health Professionals

a)The community physiotherapist in S.E. district assesses all clients referred for walking aids and provides them with the appropriate equipment at the time of assessment.

b)District nurses based in the health centre at Clydebank, chose to deliver equipment to patients for several reasons; they knew, 1) that no equipment would be delivered over a weekend; 2) that terminally ill patients would get equipment sooner if they made the delivery; 3) that the driver was on holiday and no replacement was available and 4) to ensure that equipment was delivered to patients whose original referral had been lost.

2.Not cost effective

The Clydebank store does not deliver urinals and bed pans by van as it is not considered cost effective to do so, therefore stocks are kept in nursing clinics throughout the area and distributed by nurses as required, these are then replaced by the driver when he is delivering.

3.Collected by relatives.

This is not encouraged by the clerkesses as they have to leave their other

duties to open the store and distribute the equipment.

4 By-passing the system

Nurses deliver to patients who are waiting on items from the stores from equipment which has been returned to clinics/surgeries.

This highlights the fact that nurses in Clydebank Health centre are at an advantage. Equipment is more readily accessible (despite restricted access to the store), they know when the driver is not available and consequently they can arrange to take it out to patients. The failure to reorder, collect and deliver are the main reason for delays and for the differences between the two stores.

OT SERVICE

It is impossible to record exactly how long OT referrals took to reach the various departments because of the great diversity in the way they are made:- by 'phone; in person at the office, by letter and some by completion of an official referral form, (mainly from hospital discharges and community nursing staff). However, as was evident from table 6.2, the mode of referral is irrelevant and the major reason for delay is the initial wait to be seen. The obvious conclusion is that there are not sufficient staff employed but perhaps this is an over simplification and other reasons may contribute to delays. The OT service differs from the nursing stores in that assessments do not take place prior to referral.

Table 6.7

THE OUTCOME OF 259 REFERRALS

NO AIDS OR ADAPTATIONS	24%(61)
EQUIPMENT ONLY	35%(90)
MINOR ADAPTATIONS	16%(41)
MINOR&EQUIPMENT	20%(52)
MAJOR ADAPTATIONS	5%(13)
OTHER	(2)
TOTAL No.	**259**

NOTE: The 2 other are cases which would be classed as minor adaptations but which are regarded as such low priority that no outcome has been finally decided.

Thus, 24% received neither aids nor adaptations, 35% received equipment only, 16% a minor adaptation only and a further 20% received equipment in addition to other minor adaptations.

Delay in being assessed and changing needs were the major reasons clients did not receive any aids or adaptations (62%). By contrast, the number of inappropriate referrals were insignificant.

Table 6.8 shows that 34% of the clients who received equipment had it delivered by the OT or OTA.

Table 6.8

EQUIPMENT DELIVERED TO OT CLIENTS

OT/OTA	34%
DRIVER	41%
COMBINATION	20%
OTHER	5%
TOTAL No.	**142**

Drivers delivered aids to 41% of the clients, with a further 20% receiving small items from OTs and OTAs but also having larger items delivered by a driver. Staff in Clydebank deliver most equipment themselves because they have unlimited access to the store and also because they do not have a regular driver. The 5% 'other' were delivered by the Home Care

Organiser in Clydebank who uses her estate car to deliver some of the larger items because of the non-availability of a regular driver.

Of those clients who experienced delays in excess of 1 month (see table 6.9) 26% were attributable to a driver not being available. Other reasons for delays were primarily to do with non availability.

Table 6.9

REASONS FOR DELAYS OF MORE THAN 1 MONTH	
DRIVER NOT AVAILABLE	26%(13)
EQUIPMENT NOT AVAILABLE	36%(18)
ORDERING	12% (6)
COMBINATION	26%(13)
TOTAL No.	**50**

Equipment is recycled if it is returned to the stores in good condition but since no attempt is made to recall it, recycling appears to be fairly rare (no records are kept). The majority of equipment distributed wasnew and therefore, delays in delivery were because of delays in the ordering of non stock items; delays in supply from the manufacturers; the lack of finances to buy new equipment or a combination of these factors.

The district stores operate on a first come first served basis, and OTs often have no idea what is in the store. This means that if an OT requests an item which is not immediately available they do not know if there is an alternative piece of equipment in the store which would suffice.

Clients also experienced delays in having minor adaptations carried out. As shown in table 6.7; 36% required to have minor adaptations carried out, mainly fitting of grab and hand rails. This work was executed by a

mixture of workmen from the private sector, direct works, and the occupational therapy departments own handymen.

Just over 1 in 2 clients requiring minor adaptations had a further delay in excess of 1 month. Table 6.10 shows the reasons for this delay. Most prominent was waiting for permission (21%)from housing departments to erect rails, despite the fact this was almost regarded as being a "rubber stamping exercise" and was rarely not approved. The time taken to place orders also contributed to delays in some areas. The other major delay (21%) was when work was contracted to direct works, OTs had no control over when the work was carried out. Pressure of work meant that in some instances OT staff tended to 'forget' about these clients, after they had contracted the work out until the bills came in for payment. In general private contractors did the work without any delay.

Table 6.10

REASONS FOR DELAYS IN EXCESS OF 1 MONTH	
PERMISSION	21%(10)
ORDERING	19% (9)
DIRECT WORKS	21%(10)
PRIVATE	6% (3)
COMBINATION	25%(12)
HANDYMAN/TECHNICIAN	8% (4)
TOTAL No.	**48**

MAJOR ADAPTATIONS

5% of the clients (see table 6.7) were assessed to require major adaptations and all experienced lengthy delays in excess of 6 months. These delays can mainly be attributed to bureaucracy. Delays within the OT service were often experienced in obtaining authorisation to provide

finance. Delays were experienced at each stage of the process in obtaining planning permission and building warrants, having plans drawn, grant applications approved, obtaining estimates etc. Most of these delays are outwith the OTs power and require legislative change. It is unfortunate that the most disabled are often the group who experience the longest delays.

REASONS FOR DELAYS

The single most important reason for delays in the OT service is the long waiting time for an initial assessment. Various factors are thought to contribute to the size of waiting lists and these will be discussed in the next chapter.

In the nursing stores, the driver is the single most important reason for patients experiencing delays. He is responsible for the delivering, uplifting and ordering of equipment and if he is not available then shortages of equipment result. The driver also contributes to delays in the OT service, particularly in Clydebank, where the OT service has shared access to a driver.

The type of equipment requested also contributes to delays in both services. Delays are particularly common for large and more expensive items since new orders are not placed immediately even when money is available. Budgets are never adequate to finance new equipment for everyone; therefore both services are dependent on the return of

equipment for recycling. This is not done efficiently as will be shown in a subsequent chapter.

In both services, those areas where staff have easy access to the stores, experience shorter delays as the staff are able to deliver small items of equipment in their own cars.

The mode of referral has been shown to have an effect on the amount of equipment which is delivered immediately from the nursing stores but it cannot explain long delays or non delivery. However, the mode of referral does not directly contribute to delays in the OT service.

Inefficient monitoring is apparent in both services. In the nursing stores, "lost" referral cards resulted in several patients experiencing lengthy delays. In the OT service, clients waiting for minor adaptations often experienced long delays because staff 'forgot' about work that was contracted out unless the client complained or until bills came in to be paid. The direct works department of Local Authority seemed immune to OT's requests to carry out work quickly, whereas private contractors were more eager to please. Obtaining permission from other agencies, in particular housing, also contributed to delays.

Ignorance/belligerence of staff also contributed to delays. For example, it was reported that some drivers were reluctant to deliver unusual aids, claiming not to know what was requested and failing to enquire until complaints had been received for non delivery. One driver showed great

reluctance to deliver beds as this involved hunting in the store for all the component parts.

Strathclyde Regional Social Work Department have recognised that delay in obtaining a service from the community OT is a major problem and they have introduced two innovative schemes in parts of the city.

Disabled Resource Centres (DRCs) have been opened to which clients are invited to attend for assesment by an OT. They also act as information centres and meeting places for the disabled. Clients are generally collected in Social Work Department minibuses and returned home again following assessment. The appropriate equipment is delivered and fitted the following day by an OTA. While the DRCs provide a fast efficient service they are more likely to be attended by the less disabled. As a consequence the more disabled have to wait longer and may also find the budget has run out by the time they are assessed. The operation of the DRCs is also restricted by finance, many cannot work to full capacity because of lack of budget. Poor utilisation of staff is compounded by the fact that OTs often have to wait for clients who frequently do not turn up.

More important for job satisfaction is the fact that staff do not get an opportunity to know the clients since they are not involved in follow up visits. This lack of client contact means that staff are not able to develop many of their professional skills. Thorough assesssment often does not

take place as clients are tense and likely to forget or be unable to give all relevant information. Alternatively, they are tempted by equipment they see on display and often make a good case for obtaining it, irrespective of whether they need it or not.

As an alternative way of providing a quick service OT staff, in one area, load up a vehicle with equipment and do a"blitz" on a particular locality. This approach has the advantage that a lot of clients are seen within a fairly short space of time and assessed in their own homes. However, this type of service can only be offered to simple assessments of the less disabled.

Delays were obviously the aspect of the service which most affected the patients/clients, but the research revealed other problems, some of these are highlighted and discussed in the next chapter.

CHAPTER 7

OTHER FORMS OF INEFFICIENCY

The previous chapter discussed delays in service provision and some of the reasons for them. There are, however, other factors which detract from the efficient operation of services. These include:-

1. Inadequate referral forms.

Insufficient information is given on referral forms to enable prioritisation to take place. Referrals for equipment to the nursing stores give only the basic information: name and address of the patient, the equipment requested, the patient's GP, the person making the referral and the date. Equipment is normally distributed in strict rota but prioritisation cannot take place if there is not sufficient information.

In the OT service there are also vast differences in the amount and type of information available since an open referral system operates. All OT departments attempt to prioritise and allocate on the basis of the available information. The highest priority is given to clients requiring aids to enable them to be discharged from hospital and those unable to perform basic functions eg toiletting and feeding. The young chronic sick, children and those requesting major adaptations are generally allocated to the OT whereas requests made for the elderly eg for bath aids are given to the OTAs. In reality, clients who were deemed as lower priority and allocated to the OTAs were often seen quicker than clients allocated to

the OTs. Overall, prioritising tends to be done on the basis of what is requested rather than on the needs of the client.

2.Staff Deployment

The study suggests that staff are not deployed in the most efficient manner.

In the nursing stores, both clerical staff and drivers have other totally unrelated duties, which often take priority over the provision of aids. The lack of clear procedures and guidelines result in referrals being misplaced and orders not made. The volume of demands placed on the clerkess ensure that she does not have time to keep accurate records or to check that the driver has made all the deliveries.

Qualified OTs are asked to do routine clerical duties, answering telephone calls, filing and registering referrals at a time when they are known to have long lists of clients waiting to be assessed. This was recognised as a major problem,which merited further investigation and is discussed in chapter 9.

3.Inadequate storage

Both services suffer from inadequate storage facilities. In general, there is insufficient space, stores are badly organised with no inventory kept of what is in stock and what has been returned. Facilities for cleaning, repairing, and servicing equipment are either missing or inadequate. Equipment is often discarded because there is no one available to clean or

repair it. Many stores do not employ a storeman which means that drivers have to identify equipment before making deliveries. Restricted opening of stores also means that patients/clients cannot obtain equipment during holidays, weekends and evenings.

4.Assessment

Accurate assessment is regarded as essential for the efficient running of any community care service and should include some follow up or reappraisal.

Assessment is assumed to have taken place prior to referrals being made to the the nursing stores but individual incidents indicate that this is not always done accurately. There is evidence of two separate incidents where hospital beds were requested and an attempt made to deliver them but there was insufficient space to accomodate them in the patients homes. Other incidents were identified where spenco mattresses were delivered but found to be inappropriate as insufficient space was left in the bed for the patients spouse and no alternative sleeping accomodation was available for them. Patients found equipment unacceptable in a number of instances as they hadn't known what to expect. Visits made to patients who had borrowed nursing aids revealed several instances where the professional who had made the referral had not been back to check that it was appropriate. Several patients were identified who had been given back rests and bed cages which they didnt know how to assemble

and Zimmer walking frames which were being used incorrectly. The evidence suggests that although the majority of referrals are appropriate more care should be taken in assessment particularly when requesting larger items such as beds which require additional time and manpower to deliver.

All referrals to the OT service are assumed to require an assessment, but in the present study of the 259 referals made, 30% did not receive a formal assessment(see table 7.1).

Table 7.1

THE OUTCOME OF REFERRALS AND WHETHER ASSESSED OR NOT

		NOT ASSESSED	ASSESSED
61(24%)	NO EQUIPMENT	62%	38%
90(35%)	EQUIPMENT ONLY	16%	84%
41(16%)	MINOR ADAPTATIONS	39%	61%
52(20%)	MINOR + EQUIPMENT	21%	79%
13 (5%)	MAJOR ADAPTATIONS	-	100%
2	OTHER	-	100%
259		**79(30%)**	**180(70%)**

There are various reasons for this, some clients had died or their need had changed while waiting; some were previously known to the OTs and received help without another assessment being made and there is another group who undertook self assessment. In Castlemilk and Rutherglen, clients who request external rails are automatically sent a form for them to state their requirements without any formal assessment being made. These clients therefore, bypass the waiting lists, and if they are subsequently found to require other help following a check visit, then it is also given priority. This is regarded as being particularly unfair, as

the budget is never adequate to last the whole year, and clients with fewer needs may get priority over those with a greater need, eg the disabled housebound.

It is interesting to note that 38% received neither an aid or an adaptation following assessment. The initial conclusion to draw is that these referrals were inappropriate but on closer inspection this was not found to be the case, it was rather a case that clients needs had changed. Assessment is complex and it is apparent that needs do change with time and follow up visits should be done routinely on all clients.

Of the 70% of clients who received formal assessment; 40% of these assessments were by OTs and 60% by OTAs. This again raises the question of the extent to which staff are appropriately deployed; to be discussed further in chapter 9.

Both OTs and OTAs assessed fewer clients than had been allocated to them and there were also variations in the percentage of assessments made in each area; 80% were formally assessed in Clydebank, 45% in Castlemilk, 60% in Rutherglen and 74% in Milngavie. These variations can be explained by the number of self assessments in Castlemilk, the long waiting time to be seen in Rutherglen and the number of clients previously known to the service in Milngavie. It was difficult to determine how many clients received follow up visits from the OT service. A note was often put in the records to say that everything was

satisfactory or the case had been closed or the client may have been 'phoned but the important point to note is that follow up visits are not made unless a further referral comes in. The research also identified individual cases where clients had been assessed for a particular problem by the OT department and given equipment but they continued to have problems in another area of daily living eg one lady had been given bath aids but she was unable to get up out of any chair in her house without assistance.

5.Monitoring

In order to obtain a coordinated and efficient service it is essential that adequate records are kept. A large amount of paper work and administration is involved in all areas of the referral network.

In the nursing stores there is no way to check that deliveries are made and little attention is payed to record keeping. Records are not kept in such a way that it can be established how much equipment has been borrowed throughout a year, how much is still on loan and how much has been returned.

The OT staff are themselves responsible for all record keeping since no clerical staff are employed; however, pressure of work prevents them giving sufficient attention to accurate record keeping. Clarity of handwriting and ablility to decipher it also renders it difficult to determine what equipment a client has received.

Overall the research revealed that neither the nursing store nor the OT service makes any consistent attempt to recall equipment and neither service knows what happens to equipment once it has been borrowed. The issue of more efficient use of existing equipment is discussed in chapter 8.

6.Ordering

In the nursing stores there is no set procedure or guide lines, if a piece of equipment is not in stock, the driver may either hold onto the request or he may give it back to the clerkess who in turn may either hold onto it or give it to the administrator to place an order. Ordering is done by the administrator when stocks were low. The benefits of bulk ordering are not realised because there are inadequate storage facilities. Orders were often inappropriate (eg commodes which were too narrow,) and without any regard to waiting lists. Generally there appeared to be a need for more control over what is ordered.

The OT system for ordering equipment changed during the study period; regular stock items now purchased through a Regional tender contract whereas previously individual stores ordered their own stock. Although this system has had a few teething problems and some stock has been inappropriately ordered, it allows items to be purchased more cheaply. However, ordering of non stock items remains cumbersome; orders having to be made out in triplicate and counter signed by several people before it

is eventually placed.

7.Delivery and Return of Equipment

Deficiencies in the distribution and retrieval systems have been shown to contribute to delays in patients/clients receiving a service but these delays can also result in equipment being lost.

From the nursing stores most equipment is delivered and uplifted by the driver in the order he decides, which may be governed by his other duties as well as by his preferences. Deliveries from OT departments, are either with a dedicated driver or one allocated from the transport department. In both systems community staff experience difficulties coordinating times with relatives when equipment will be delivered or uplifted. In some instances where relatives were clearing out a deceased persons house and no driver was available,the equipment was discarded.

8.Staff morale

The lack of career structure and the apparent isolation of the OT service within some Social Work area teams contribute to low staff morale which can only act to the detriment of an efficient service.

9.Budget Management

Nursing stores operate a policy of buying as required and no planning or estimating of need occurs. Statistics are not kept of how much equipment is borrowed or returned to any of the stores but an examination of all referrals made to Florence Street over the last few years showed

that there are peaks in demand but no consistent pattern.

In the OT service separate aids and adaptations budget can result in items being available in one but not in the other, eg grab rails, which come out of the aids budget, are available, but there is no money in the adaptations budget to pay for fitting them. Difficulties also arise in the district store policy of "first come, first served". The budget is not shared equally. If there are staff vacancies in an area, it may not get its full share. Similarly, the policy of approving all requests for particular items(eg external rails) often leads to the budget running out half way through the year. A better use of existing resources would enable the budget to last longer (eg.retrieving and recycling of equipment). This is an issue which warrants further examination and is discussed in the next chapter.

CHAPTER 8

EQUIPMENT USE AND MISUSE

As previously identified shortage of equipment contributes to the delays which clients experience in getting their needs met. The occupational therapists and the staff in the community nursing stores both indicated that there are always problems of supply and demand at some stage through out the year; budgets tend to run out fairly early, and thereafter, equipment has to be provided from what remains in the store or from items being recycled. Neither the occupational therapists nor community nurses operate a recall system and pressure of work on both does not allow them to do routine follow up visits. The pilot study indicated that unused equipment remains in patients' homes and that neither the O.T nor the nursing service knows what happens to equipment once it has been given out on loan and no attempt is made to estimate or record how much is recycled.

This information gap necessitated the mounting of a further two small studies.

1.FOLLOW UP OF EQUIPMENT FROM NURSING STORES

This study involved the follow-up of equipment borrowed, more than a year previously, from Florence Street community nursing store. 225 patients were identified as still having major items of equipment out on loan, but only 95 could be contacted by telephone.

Table 8.1

OUTCOME OF EQUIPMENT REGISTERED AS BEING OUT ON LOAN

BORROWED	No	RETURNED NOT RECORDED	STILL IN USE	NOT IN USE	OTHER
COMMODE	84	21	48	12	3
WHEELCHAIR	4	2	1	1	-
BED	2	1	1	-	-
LIFT	1	-	1	-	-
BACK REST	3	1	2	-	-
RIPPLE MATTRESS	5	4	-	1	-
BED CAGE	3	1	1	1	-
ZIMMER	3	-	1	2	-
SPENCO CUSHION	2	-	2	-	-
MONKEY POLE	1	-	1	-	-
BED ELEVATOR	2	1	1	-	-
TOTAL	**110**	**31(28%)**	**59(54%)**	**17(15%)**	**3(3%)**

NOTE:-3 "other" requires explanation:1lady had given a commode to an old peoples home,after her mothers death, another said that the nurse had moved it to another patient who she was unable to get a commode for, and the other lady was so confused that it was difficult to determine what had happened to her commode.

Of the 110 pieces of equipment, borrowed by these 95 patients, it was claimed that 54% were still in use by the orriginal borrowers and 28% had been returned. Some of these patients who claimed to have returned equipment, but are still registered as having it, may have returned it to their G.P.s surgery, health centre or to the social work department. This equipment may have found its way back to the store and/or it may have been recycled without records being amended.

15.% of items were not being used and had not been used for at least 6 months, but were not available for recycling. Eleven of these were not expected to be required again; the remaining six items, were being kept by patients "just in case they became unwell again", or for relatives who had been admitted to homes or long term hospital care, again "just in case

they got sent home". Two clients spontaneously mentioned that when their relative had died several acquaintances had contacted them to ask if they could have the commodes. The client who gave the commode to an old peoples home thought she was doing a good turn by saying she was sure someone there would be able to use it .

2.FOLLOW UP OF EQUIPMENT BORROWED FROM OT DEPARTMENTS:-

100 clients, who had borrowed equipment from the Occupational Therapy service approximately three years ago were identified. Contact was made by telephone with 77 clients or their families and a further 20 were visited, information about a further three clients was obtained from neighbours who were looking after houses where the occupant was in hospital.

Of the 225 items of equipment borrowed by these 100 clients, 60% were still in use. Of those not in use, only 6% were recorded as having been returned. 13% items were claimed to have been returned but there was no record to substantiate these claims. 16% of items remained unused in clients homes. Overall 40% of the equipment was not being used by the original borrower.

Table 8.2

OUTCOME OF EQUIPMENT RECORDED AS BORROWED BY THE CLIENTS

BORROWED	No	RETURNED NOT RECORDED	RETURNED RECORDED	STILL IN USE	NOT IN USE	OTHER
SHOWER SETS	7	1	-	4	2	-
CHAIRS	41	8	2	26	3	2
KITCHEN GADGETS	20	2	1	11	6	-
DRESSING GADGETS	12	2	-	6	3	1
GENERAL GADGETS	19	3	-	11	5	-
BATH AIDS	74	5	9	42	14	4
MANGAR LIFTS	7	1	-	6	-	-
RAISED TOILET SEAT	12	3	-	5	3	1
TOILET FRAME	8	1	-	7	-	-
TROLLEY	4	-	-	3	-	1
LEG REST	5	1	1	3	-	-
ENTRY PHONE	2	-	-	2	-	-
MONKEY POLE	1	1	-	-	-	-
ROPE LADDER	1	-	-	1	-	-
OVER TABLE	4	-	-	2	1	1
BED RAIL	2	2	-	-	-	-
AUTO LIFT	3	-	-	3	-	-
FLASHING BELL	1	-	-	1	-	-
RAISED SOCKET	2	-	-	2	-	-
	225	30(13%)	13(6%)	135(60%)	37(16%)	10(4%)

NOTES:- clients are only recorded once if they have more than one gadget in any particular category as records often just state eg. kitchen gadgets given.

The "Other" column requires some explanation:-

2 clients had been given bath aids but were too confused to remember what had happened to these but they were no longer in the houses.

1 client had been given a chair and bath aids along with other equipment claimed he did not know what had happened to these although he still had the other items.

1 client claimed to have thrown out a chair on the death of her mother.

2 clients denied having been given equipment, although it was recorded as being given in their notes.

1 client claimed the nurse had taken away a trolley

1 client claimed to have returned equipment to the hospital.

The importance of this small study, is that until it was conducted it has not been possible to know what happens to borrowed equipment and from existing records there is no way of accurately finding out. The group of clients that we managed to contact provided some interesting insights, although they cannot be regarded as being a representative group. They excluded those who were no longer living at their original address and they may have been a more interesting group to follow up because they would

have made some conscious decision about their equipment when they moved house.

In both studies, we can only speculate as to what happened to the equipment borrowed by the group of clients who could not be contacted, ie the 130 from the nursing stores and the 32 from the OT service. Some may still be in use by the original recipient at a different address, some may have been returned and not recorded, some may be lying unused, some may have been redistributed by staff or clients/patients without any record and some may have been discarded or sold.

The single most important observation made from these small studies is a need for MONITORING. This was apparent in several important areas:-

1. A need for follow up visits which could benefit both the supply of equipment and the original borrowers :-

a)16% of items supplied by the OT service and 15% of items supplied from the nursing stores remained in clients/patients homes but were not being used. Recycling of all equipment may not always be practicable, desireable or cost effective but some had clearly not been used and would have been eminently suitable for recycling.

b)60% of OT and 54% of nursing equipment was still being used. This raises questions as to the safety and state of the equipment. Advances in design may mean that more suitable equipment is now available and those clients would benefit from reassessment. Furthermore, needs may have

changed and further equipment be required. Some clients/patients volunteered that they would have liked further assistance,(no attempt was made to assess how many clients would like such a review visit). Only,25% of the clients who had borrowed equipment from the community occupational therapist had, any further contact with the department (the same calculation could not be done for equipment from the nursing stores because the records had been destroyed).

2.A need for better record keeping was identified:-

a) Records were found to be inaccurate; 13% of items of equipment returned to the OTs and 28% of items returned to nursing stores had not been recorded as having been returned. Clients also frequently claimed to have been given more equipment than recorded in their notes.

b) No record was kept as to whether equipment issued was new or recycled, therefore no attempt could be made at estimating the life expectancy of a piece of equipment or when it should be examined for renewal purposes.

3.A need for more precise information to be given to patients/clients:

The patients who retained equipment for which they had no use, seemed un-concerned that it could be of use to others, because not enough emphasis is placed on returning equipment which is no longer in use. Some patients/ clients seemed to be unaware that the equipment was on loan and those who claimed to have returned equipment but were not recorded

as having done so, had returned it to the wrong place (health centres, clinics etc) did not know where it had come from in the first place.

CONCLUSION This part of the study identified a need for closer monitoring to improve the efficiency of both the occupational therapy and community nursing services. For both services, a review of patients/clients needs and a recall system, is likely to improve the service to existing clients allowing more equipment to be recycled and thereby help to reduce waiting times for equipment.

The long waiting lists for initial assessment by the occupational therapists, may indicate that staff do not have the time to do routine follow up visits. This led to an investigation of how OTs spend their time; which will be looked at in the next chapter.

CHAPTER 9

THE USE AND MISUSE OF STAFF TIME

There are long waiting lists for occupational therapy in most areas of the country. In Strathclyde region in March 1989 the number on the waiting lists ranged (in some districts) from 90 to in excess of 2000. There are two obvious reasons for these waiting lists: insufficient and/or inappropriately deployed OTs.

It is widely recognised that there is a national shortage of OTs because of difficulties in recruiting and retaining staff. The present study is, confined to looking at how existing staff are currently deployed and whether they are being utilised appropriately.

During the course of the research, many OTs expressed concern that they spent too much time doing clerical duties and not enough time treating and assessing clients. In an attempt to assess their claims, all OTs and all OTAs in the study areas were asked to complete work diaries over one working week during April 1989.

THE DIARIES

The work diaries gave a crude breakdown of the types of activities in which the staff were likely to be engaged and were divided into mornings and afternoons for each activity. While some difficulties were encountered in accounting for all the time, particularly in the office it is felt they give an accurate account of time spent with clients out of the

office, and at meetings. 5 OTS and 5 OTAS completed the work diaries summarised in tables 9.1 and 9.2 respectively.

Table 9.1

THE 5 OCCUPATIONAL THERAPISTS USE OF TIME (in hours)

	A	B	C	D*	E	%MEAN
HOURS WORKED	35	35	20	(35)24	24	TIME
VISITS	23% (8)	29% (10)	31%(6.25)	33%(7.9)	34%(8.25)	**29%**
TRAVEL	12%(4.2)	14% (4.9)	4%(0.75)	6%(1.4)	18%(4.25)	**11%**
MEETINGS	22%(7.8)	16% (5.8)	5% (1)	8%(2)	-	**12%**
CLERICAL	43% (15)	41%(14.3)	60%(12)	53%(12.7)	48%(11.5)	**48%**

Table 9.2

THE 5 OCCUPATIONAL THERAPY ASSISTANTS USE OF TIME (in hours)

	F	G	H	I	J	%MEAN
HOURS WORKED	35	16	35	20	27	TIME
VISITS	29%(10)	25%(4)	31%(11)	24%(4.8)	57%(15.4)	**34%**
TRAVEL	4%(1.5)	6%(1)	10%(3.5)	13%(2.6)	12%(3.25)	**9%**
MEETINGS	-	-	10%(3.4)	14.5%(2.9)	-	**5%**
CLERICAL	67%(23.5)	69%(11)	49% (17.1)	48.5%(9.7)	30.5%(8.25)	**52%**

FOOTNOTE:-* This OT was employed full time but at the time of the research was only working for 24 hours because she was taking a course for which she had been granted study leave.

It is clear from tables 9.1 &9.2 that the untrained assistants spent a greater proportion of their time in direct client contact than the trained staff. The OTs spent a mean of 29% of their time on visits to clients, either doing assessments, follow up visits or delivering and demonstrating equipment; OTAs spent a mean of 34% of their time visiting clients.

Travel accounted on average, for11% of OTs time and 9% of OTAs time; those staff who were dependent on public transport spent the longest time travelling. Time spent at meetings accounts for 12% of trained

staff's time whereas only 5% of their untrained assistants. The content of meetings was not scrutinised but attendance at them was generally on the recommendation of their managers and outwith individual choice.

Clerical duties account for the largest proportion of both groups' working week, accounting for 48% of OTs' time, (with one OT spending as much as 60% of her working week on clerical duties) and 52% of OTAs'time (with one OTA spending as much as 69% of her time doing clerical work).

The high proportion of time spent doing clerical duties was partly explained by the content of the work. In all area offices, with the exception of Milngavie, both trained and untrained staff had to spend an alloted amount of time doing "telephone duty". This meant they had to spend a morning in the office to receive calls from clients. Staff attempted to utilise this time to complete record cards and reports and to arrange visits but constant telephone enquiries meant that they found it difficult to utilise this time efficiently. One OT remarked that the number of 'phone calls was greatly reduced when the waiting list was short as clients were not continually on the 'phone complaining.

Staff felt that approximately one third of their time was on duties which could be delegated. (36% and 40% for OTs and OTAs respectively; see tables 9.3 &9.4). These were predominately clerical duties; in particular 'phone duty, acknowledgment letters, statistical returns, filing, etc, but also included cleaning equipment and tidying store rooms.

Table 9.3

THE PROPORTIONS OF OTs TIME WHICH COULD/COULDNOT BE DELEGATED

	A	B	C	D*	E	%MEAN
HOURS WORKED	35	35	20	35(24)	24	TOTAL
NON DELEGATE	71% (25)	75%(26.2)	50%(9.9)	52%(12.4)	62.5%(15)	**64%**
DELEGATE	29% (10)	25%(8.8)	50%(9.8)	48% (11.6)	37.5%(9)	**36%**

Table 9.4

THE PROPORTION OF OTAs TIME WHICH COULD/ COULDNOT BE DELEGATED

	F	G	H	I	J	% MEAN
HOURS WORKED	35	16	35	20	27	TOTAL
NON DELEGATE	33%(11.5)	60%(9.6)	73%(25.4)	72%(14.3)	69%(18.7)	**60%**
DELEGATE	67% (23.5)	40%(6.4)	27%(9.6))	28%(5.7)	31%(8.3)	**40%**

FOOT NOTE:
When deciding which duties could be delegated and those which the O.T/OTA should do her self Certain assumptions were made: it was assumed that it was necessary for the OTs to attend all the meetings and that letter and record writing also could not be delegated. Some of the duties which I have included as non delegatable includes delivery of equipment which could be done by ancilliary staff but since the OT was also demonstrating the use of the equipment I felt this was justified. I have therefore assumed that all visits to clients homes cannot be delegated.
The large number of hours spent doing delegatable clerical duties by OTA (F) can partly be explained by the fact she was doing 'phone duty for a colleague who had been off work for several weeks.

In response to direct questions various activities were identified which staff felt, were rewarding and they should do more of, and those which were not rewarding and they could delegate.

All staff claimed that activities involving patient contact were the most rewarding part of their work. They felt they would like to do more home visits, to do more follow up visits on former clients and to devote more time to provide a counselling and advice service, particularly to the young chronic sick. Other comments indicated that they would like more time for "professional development" and "liaison with other health colleagues". Clerical duties predominated in the activities which staff found least

rewarding and which they wished to do less of. These included registration of cases, indexing, filing, photcopying, stockkeeping, collating statistical returns, checking on the progress of contractors, "orange badges", ordering and paying accounts, answering 'phones, taking referrals, and making appointments. Many of the staff also identified these as duties which could be delegated to clerical staff.

The other main grievances expressed resulted from financial restrictions and the inability to provide what was required.

This study can only be regarded as providing a crude breakdown of how OT staff spend a working week but to obtain more accurate information would have involved either more detailed work diaries; which the staff expressed a reluctance to complete, or a time and motion study, which was not possible with the resources available. The comments made by trained OTs and their assistants clearly indicate that most job satisfaction is obtained from client contact and that too much time is spent on routine clerical duties. While it can be argued that the questions were biased in favour of this reply, the results of the work diaries substantiated the claims made by the staff (see tables9.1and 9.2).

The nature of the OTs work is such that assessment forms, reports etc have to be completed but the OTs clerical work load could be greatly reduced by employing clerical staff to carry out routine clerical duties, thus freeing more time for client contact. Within the limitations of this

study it seems appropriate to conclude that scarce staff are not being deployed appropriately, and in fact, in some areas, trained OTs have less client contact than their untrained assistants. Reallocation of duties, to free trained staff from routine 'phone duty would seem sensible, particularly at a time when long waiting lists exist, and there is a recognised shortage of trained staff.

Both OTs and OTAs emphasised the importance of having their own clerical staff, since experience had shown that where departments "shared" clerical staff, their work was not given priority and they often had to wait weeks to have a letter typed. It was felt that having clerical help based in the occupational therapy section would provide for continuity and improve efficiency.

The shortage of equipment was regarded by some staff as a disincentive to do more assessments since there was little point in doing them if there was no money to fund any equipment which might be indicated.

Currently, within the OT profession, there is debate about the utilisation of occupational therapy staff: some advocating that more trained OTs are required, others claiming that staff are overtrained for what they are doing and that more assistants would help solve the problem. The Blom-Cooper report and the College of Occupational Therapists have both looked at these arguments and have concluded that there is a place for both qualified and unqualified staff. However, they also observe that care

should be taken to ensure that OTAs are not left to do work for which they are not properly trained and that trained staff do not undertake work which could be undertaken by less highly trained staff.

As the numbers of people receiving care in the community increases, the demands on the occupational therapy service are also likely to increase. The situation is particularly urgent because even current demand is not being met. There are long waiting lists and it is widely recognised that an element of concealed needs exists. An attempt was made to estimate the extent of this unmet need, which will be described in the next chapter.

UNMET NEED

The overall aim of an effective service is to reduce the numbers of people for whom a service cannot be provided, either because the resources are not available or because the authorities do not know of the need. The existence of long waiting lists and delays in obtaining equipment are evidence that identified unmet need exists but little is known of the extent of concealed need. Since it would be a major undertaking to mount a study to identify concealed needs it was decided to examine data gathered from the CSDPP screening study in an area of Cumbernauld.[1] A population of 10,903 were screened and a total of 590 (5.4%) people identified themselves as having an illness or disability which affected their everyday lives. (This figure is lower than most of the national surveys but is possibly a reflection of the fact that Cumbernauld is a new town with a large proportion of younger people.)

The spectrum of need identified in chapter1 has been used to categorise the 590 clients identified. (see fig. 10.1)

1) NO NEED: 33%(197) of the people who described themselves as having a disability which affected their daily lives declared that they had no need, and have never had a need of aids and or adaptaions.

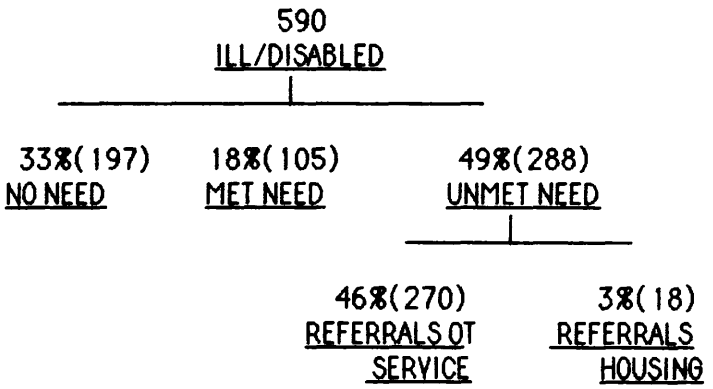
FOOTNOTE : 1. A door to door survey was carried out as a result of Chronic Sick and Disabled Persons Act (1970), with manpower services funding, to identify the numbers and needs of the disabled in certain areas of Strathclyde.

2.MET NEED: 18%(105) clients claimed to have had their needs met and had no further need at present. Most of these clients had more than one aid or adaptation and they had obtained them from various sources:-15% had purchased all their aids; 13% had obtained them from informal sources; 62% had received all their aids from statutory sources and 10% of clients had purchased some and been given others from the statutory agencies.

3. UNMET NEED 49% (288) clients claimed to have an unmet need. Of these 3%(18) were considered to be outwith the remit of the OT service and had been passed on to housing department. This left a staggering 46%(270) who were considered to have an unmet need for OT service. It is on this group of 270 people that the rest of this section will concentrate.

Figure10. 1

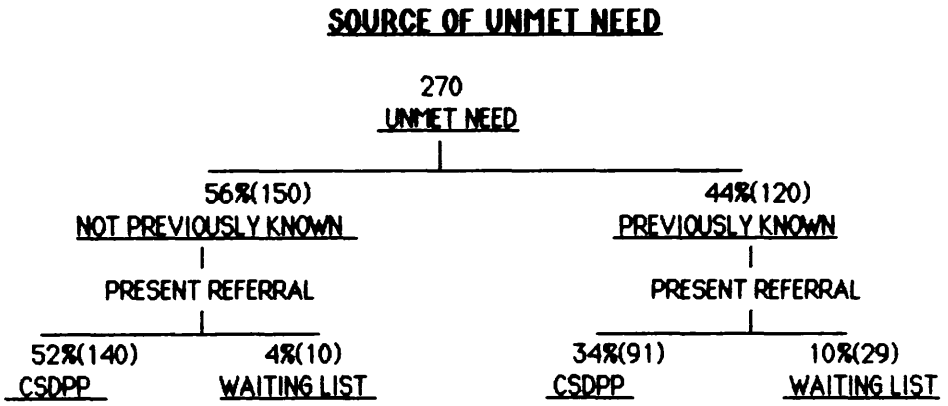
THE NEEDS OF THE 590 PEOPLE IDENTIFIED AS DISABLED



The group of 270 with an unmet need can be further broken down into those with an identified need, that is those already on mainline waiting lists and those with a hidden need, that is those brought to the attention of the service providers only as a direct result of the screening survey.

As can be seen from figure 10.2, although 44% of this group were known to the service from previous referrals to the OT service in the past, only 14% of the total number of people with an unmet need were already on the mainline waiting list for their present unmet need, the remaining 86% were recognised as having a need only as a result of the CSDPP project, that is they had a hidden need. The implication is that the incidence of unmet need could be substantially reduced if those clients who had previously had contact with the OT department had been offerred routine reassessment.

Figure 10.2



The eventual outcome of all clients who claimed to have an unmet need was considered to ascertain if their self identified need was also recognised by the occupational therapy staff. There are three outcomes for these referrals which indicate that a) 75% of clients received aids or adaptations; (ie the authorities also feel they have an unmet need); b) 23% did not receive any aids or adaptations (ie the authorities do not feel they have an unmet need or the clients need has changed); c) 3% of clients

records were missing, therefore the outcome is unknown.

Table 10.1

THE OUTCOME OF THE 270 REFERRALS TO THE OT SERVICE

	PREV KNOWN	NOT KNOWN
A EQUIPMENT	35%(95)	40%(107)
B NO EQUIPMENT	9%(23)	14%(37)
C DO NOT KNOW	1%(2)	2%(6)

The results of this small study must be regarded with caution, and although 46% of the disabled population in Cumbernauld were shown to have an unmet need(fig.10.1), no national estimate of unmet and in particular concealed need can be made.

Previous contact with the OT department does not ensure that people will automatically come back to ask for more help which highlights another deficiency in the existing service which routine follow up visits would help alleviate.

CONCLUSIONS AND RECOMMENDATIONS

The data presented in the preceding chapters highlight delays as the major problem patients/clients experience in obtaining aids and adaptations from the community nursing and occupational therapy services. Existing services are unable to cope with present demand and they cannot even attempt to identify hidden needs. A range of additional problems have been identified. In this final chapter they will be summarised and recommendations will be made for improving the existing services:-

STAFFING

Findings

1.Staff are not always deployed appropriately eg trained OT staff are often required to do routine clerical duties such as being available to answer the telephone, filing etc.

2.Staff (the drivers in particular) have other unrelated duties to perform which often take precedence over the supply of equipment.

3.There appears to be high dependence on the drivers, particularly, in the nursing stores and the system does not function when the drivers are on holiday.

4. Many areas do not have access to a technician to fit simple aids and are therefore dependent on employing private contractors.

5 Difficulties are encoutered in organising deliveries and uplifts because of uncertainty about the availability of drivers.

6. Pressure of work ensures that staff are unable to use all the skills they are trained for as the majority of their time is involved with providing aids and adaptaions.

Recommendations

1.Ancilliary and clerical staff should be employed for recording and monitoring referrals, so as to free practitioners, (OTs in particular), to carry out the duties for which they have been trained and to enable them develop their professional skills.

2. Clerical and ancilliary personnel are required to run the stores and to undertake responsiblity for stock keeping, ordering, inspecting, cleaning and repairing equipment.

3. Drivers should be relieved of the above duties and be employed only for the delivery and uplift of equipment. They might also be given training and responsiblity for fitting minor adaptations such as grab rails and bath aids in patients/clients homes.

REFERRAL/ ASSESSMENT

Findings

1. Referral forms are not always completed, and when they are, they often contain inadequate information to enable prioritisation.

2.Asssessment does not always take place, and when it is done, it is not

always done accurately. In both services there were examples of assessments having been made but inappropriate equipment provided.

4. Routine follow up is lacking.

Recommendations

1. The introduction of a more comprehensive referral form, with a self referral section, would benefit both services and should be completed for all referrals. A comprehensive form would enable prioritisation of referrals and would have the additional benefit of allowing the practitioner to assess the clients/patients or carers insight into their condition.

2. The introduction into assessment and follow up of some indication of how long a client/patient is likely to require an item would facilitate the introduction of a recall system.

STORAGE

Findings

1. Stores are not all easily accessible, eg equipment has to be carried up and downstairs.

2. Neither system has adequate storage facilities and although there are exceptions, both the nursing and OT stores tend to be cramped, badly organised, often without any shelving.

2. Many stores have no storeman and no inventory or stock lists are kept, with the result that no one knows what equipment is in stock.

3. Stores are often without adequate facilities for cleaning, maintaining and repairing equipment, with the result that a lot of equipment is discarded.

4. Access is restricted with stores not open at weekends, evenings or bank holidays.

Recommendations

1.Storage facilities should be improved; larger stores are required to allow for more equipment to be stored in an orderly fashion.

2. Good vehicular access is required

3. Facilities are required for the cleaning, maintenance and repair of equipment.

4. The introduction of small satellite stores would provide practitioners with unrestricted access to small easily delivered items and equipment required for emergency situations at weekends and holidays. These stores should be stocked and controlled by the central store.

EQUIPMENT

Findings

1. Returned equipment is not always checked before reallocation eg.several incidents were reported of faulty Zimmers being delivered.

2. A lot of equipment is discarded because it is broken and repair facilities are not available.

3.Equipment is not always returned to the stores when no longer required

Recommendations

1. Equipment should be routinely inspected on arrival at the store for safety and feasibility of recycling.

2. Equipment should be clearly labelled, that it is on loan and the return address prominently displayed so that clients know to where it should be returned.

ORDERING

Findings

1.In the OT service there has been some rationalisation, with regional contracts drawn up with manufacturers, but for items of equipment not in stock, the process is cumbersome, time consuming and inefficient.

2.In the nursing stores, ordering takes place in an unplanned fashion. If there is money, it is spent on what is thought to be required and new equipment is only ordered when there is none in stock or when supplies are very low.

3.Ordering is often done without reference to practitioners.

4. The benefits of bulk ordering are not always realised.

Recommendations

1.Ordering of equipment should be rationalised with more items purchased by prearranged contracts to enable full advantage to be gained from bulk ordering.

2.The ordering procedure for special or expensive items should be

simplified to reduce delays to the patients/clients and to enable staff to easily check if the equipment has been delivered.

3. Practitioners should be consulted regularly about the ordering of stock items.

MONITORING

Findings

1.There is a lack of adequate monitoring, in both services there were instances of referrals getting lost prior to delivery.

2. Full records are not kept of equipment borrowed, no one knows how much equipment is on loan, in stock, lost, recycled or new.

3. No attempt is made to recall equipment or to check that it is still useful to patients/clients.

Recommendations

1. A computer based monitoring system should be introduced which would enable staff to know how much equipment is in the stores, how much is on loan, how much is likely to be required etc.

2. Recall of equipment should be encouraged although it is not desireable to recycle all returned equiment.

INFORMATION

Findings

1. Many patients/ clients did not know where to obtain and return equipment

Recommendations

1. All equipment which is suitable for recycling should be clearly labelled as being on loan.

2. Education programmes and media publicity should be utilised to distribute information. The use of the media and advertising would ensure a higher public profile and is likely to result in more equipment being returned.

THE WAY FORWARD

Implementing these recommendations would certainly lead to some improvement in each of the existing statutory services but duplication and inefficient use of resources would continue. Each service would require improved storage facilities, storemen, drivers, clerical and ancilliary staff. What is required is a more fundamental reshaping of the service.

The first essential element of an efficient service is that people know the service exists and know where and how to get it. The service should, therefore, have a high public profile to ensure that everyone knows what help is available and from whom. This could be achieved through mounting publicity campaigns and education packages.

The second essential element is that patients/clients can communicate their need for help without being hampered by physical or bureaucratic barriers. Referrals should be accepted from anyone and from a variety of

sources eg health centres, social work departments, clinics etc. They should be processed through a central computer network to a service coordinator for allocation. A comprehensive referral form should be completed to facilitate prioritising and allocation of cases.

The third essential element is an efficient and effective delivery service. Equipment has to be delivered to the client without undue delay.

The fourth and final element is that routine follow up visits should be made to ensure that equipment continues to be useful.

The overall effectiveness and efficiency of any service is determined by how each of these essential elements is managed. At present the Social Work Department and the Health Board each provide aids and adaptations and each has its own assessment procedures and distribution network. This is not the most efficient use of existing resources. Instead of the service being split between these two organisations it is suggested that a split should be made on the basis of separate functions. From a functional perspective the fundamental split is between assessment/ follow up and storage/ delivery and fitting.

ASSESSMENT and FOLLOW UP

To ensure that patients/clients have multiple access points to the service there is no alternative but to continue to have both health and social work staff involved in making assessments. Existing expertise has to be used but to reduce overlap and duplication there should be a move

towards the use of a common assessment tool. Guidelines should be drawn up to ensure that specialists are called in for clients with special needs and there should also be routine follow-up.

STORAGE, DISTRIBUTION and FITTING

The existing system with both the Health Board and Social Work Department responsible for their own storage and distribution networks has been shown to result in duplication of staff and resources. A more cost effective and efficient system involves the move towards a central storage and distribution centre for both services with several locally based computer-linked satellite stores. This would reduce a lot of the duplication of facilities and resources which exist at present. A single integrated storage/distribution system would require fewer vehicles, staff could be deployed more efficiently, they would be able to specialise on delivery/retrieval functions, more accurate monitoring could be undertaken, full benefits of bulk ordering could be secured and clients would be more likely to know where to return equipment. Another major advantage of forming a joint store is that such a measure would be likely to give the service a higher public profile and increase managerial interest.

PRIVATISATION/ FINANCING

It is considered essential that assessment remains within the remit of the statutory services to ensure that it is carried out independently.

Privatisation could result in problems of access to the service and would be more likely to favour the wealthy. The concerns are whether accurate assessments would be carried out and whether patients/clients might be pressurised into buying more expensive or non essential items of equipment.

It is considered that a common storage/distribution/fitting service could either be run by the statutory agencies or be put out to private tender. If run by the statutory agencies, agreement on funding and operation would have to be reached by the Health Board and Social Work Department and it would be essential that all staff were employed by the same agency because of inter-service pay differentials.

However the system is operated it is likely an alternative way of financing is required. There are substantial numbers of people able and willing to purchase equipment and would gladly do so, if they knew what to purchase. The introduction of a voucher system similar to that used by opticians would seem to have a number of merits. Those who did not wish to purchase could use their vouchers to hire equipment which could be returned when no longer required.

IN CONCLUSION

The overall aim must be to establish a service which will provide an efficient and effective service without long delays and where the maximum number of clients/patients get the best available help.

In order to achieve this practitioners must be freed to undertake assessment and routine administrative duties be performed by clerical and ancilliary staff. Assessments must remain freely available to all. The distribution and storage of equipment for both services should be centralised to avoid duplication but also encompass local distribution points for emergency and weekend needs. These stores could either be joint funded by Health Board and Social Work department or run as a private enterprise with patients/clients given the option to purchase. The possibility of a voucher system should be examined.

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APPENDIX 1

NURSING AIDS

Aids and equipment required on medical and nursing grounds

Pressure Relief Aids:- eg. air ring cushions and anti-pressure cushions, special mattresses (eg ripple, spenco etc)

Bed Aids:- eg. back rests, bed cradles, bed tables, bed blocks, bed rails, cot sides, beds

Toilet Aids:- eg. bed pans, urinals, commodes

Lifting Aids:- eg. mobile hoists, lifting poles

Walking Aids:- eg. crutches, walking frames and walking sticks

OCCUPATIONAL THERAPY AIDS

Aids and equipment required to facilitate personal care

Toilet Aids:- eg. raised toilet seats, toilet support rails.

Bath Aids:- eg. bath rails, seats, boards, mats, bath tap fitting shower.

Bed Aids:-eg. over bed tables,rope ladders,monkey poles

Sitting Aids:- eg. special chairs, foot stools, spring cushions

Dressing Aids:- eg. stocking aids, long handled shoe horn,

Feeding Aids:- eg.special cutlery, tableware, plate guards ,non slip mats.

Kitchen Aids:- eg.jar openers, tin openers, tea pot tippers

General Personal Aids: eg.helping Hand.

Lifting Aids:- eg. bath hoists

APPENDIX 2

WORK DIARIES(sample)

INTRODUCTION

I want to estimate how much of an Occupational Therapists/Assistants time is devoted to clerical duties, either answering the 'phone, writing letters or order sheets etc.and how much time is spent assessing and treating clients.

Please use this booklet to keep a record of your work pattern for five consecutive days.

DAY DATE

start recording on

---

and continue until

(inclusive)

Please complete the following by deleting as necessary:-

1. I am an Occupational Therapist/ OT Assistant.

2. I work Full Time /Part Time.

3. I have worked in this post for:-

Less than 1 year/ 1-3 years / 3-5 years/ more than 5 years.

4. Do you think you spend too much of your time doing clerical duties YES/NO

5. Which aspect of your work do you find most rewarding? _ _ _ _ _ _ _ _ _ _

6. Which aspect of your work do you find least rewarding? _ _ _ _ _ _ _ _ _ _ _

7. Which activities do you think you should do more of ? _ _ _ _ _ _ _ _ _ _ _ _

8. Which activities do you think you should do less of? _ _ _ _ _ _ _ _ _ _ _ _ _

9. Are there any duties which you think should be delegated to clerical staff, if so which? _ _ _

INSTRUCTIONS

Please insert the day and date on each page. If not working any day, please indicate the reason, eg. sickness, part time, study day etc. Try to estimate how much of your time each day is spent doing the various activities.

DAY 1:-_____

NATURE OF WORK	AM	PM	TOTAL TIME
(A) OFFICE DUTIES			
Answering the 'phone			
Making 'phone calls			
Making appointments			
Writing letters			
Writing records			
Completing order slips			
Other (please specify)			
(B) VISITS			
Assessment visit			
Delivering Equipment			
Follow up visit			
Joint visit for estimate			
Joint visit with another professional			
Other (please specify)			
(C)TRAVEL			
(D) OTHER DUTIES (please specify)			

Thank you for taking the time to complete this form, please feel free to make any comments.

APPENDIX 3

THE STUDY POPULATION

Table APX/1

PATIENTS WHO HAD REFERRALS FOR NURSING AIDS JUNE/JULY 1988

	CLYDEBANK		CASTLEMILK		RUTHERGLEN		MILNGAVIE		TOTAL		
AGE	M	F	M	F	M	F	M	F	M	F	%
1NON PENSION	3	5	2	1	1	-	1	1	7	7	12%
PENSION	27	33	3	5	9	14	4	10	43	62	88%
TOTAL	**30**	**38**	**5**	**6**	**10**	**14**	**5**	**11**	**50**	**69**	
									(42%)	(58%)	

Note:- 1. Non Pension is below 60 years for women and 65 years for men.

There were 119 patients in the study areas, who aids were requested for during June and July 1988 (The patients age was not requested on the referral forms, therefore, was not available for the requests made during January and February 1989) from the community nursing stores.

Table APX/2

AGE & SEX OF CLIENTS WHO REQUESTED O.T. SERVICE

	CLYDEBANK		CASTLEMILK		RUTHERGLEN		MILNGAVIE		TOTAL		
AGE	M	F	M	F	M	F	M	F	M	F	%
0-16	-	1	-	-	-	-	1	2	1	3	1%
17-39	-	1	-	1	-	-	-	1	-	3	1%
40-64	5	11	2	4	2	7	1	1	10	23	13%
65-74	12	24	6	7	7	14	2	8	27	53	31%
75+	15	50	5	14	8	19	3	23	31	106	53%
Don't know	-	-	-	1	1	-	-	-	1	1	1%
TOTAL	**32**	**87**	**13**	**27**	**18**	**40**	**7**	**35**	**70**	**189**	**259**
									(27 %)	(73%)	

Table APX/2 indicates that a total of 259 referrals were made from the study population during June/July 1988 with 73% of them for women and 27% for men. 15% of the OT referrals were for those below the age of 65years with 85% aged 65 years old or more, and 53% of them aged 75 years or more.

APPENDIX 4

BACKGROUND TO STRATHCLYDE REGIONAL COUNCIL DISABLED PERSONS PROJECT

As a direct result of section 1 of the Chronic Sick and Disabled Persons Act 1970, Strathclyde Regional Council Social work Department, in conjunction with the Manpower Services Comission Community Programme, mounted a series of independent studies to try and estimate the number and needs of the disabled people in the region.

These studies involved employing young people under the terms of the Manpower Services Commission and giving them a basic training prior to carrying out a door to door survey within a defined geographical area. The main aims of the project were, to identify disabled people within the project areas and where requested refer them for assessment to appropriate agencies, and also to identify volunteers willing to work with the disabled. The other major aim was to provide work experience for long term unemployed by participating in the project.

Two questionnaires were used by the project to provide the information. The first questionnaire was used at every door to identify whether there were a) any disabled persons at the address, b) any adapted homes not currently being used by the disabled, c) any unused medical or occupational therapy aids and d) any possible volunteers willing to work with the disabled. The second questionnaire was used in houses where a disabled person was identified and contained questions relating to the provision of and need for, a whole range of statutory and voluntary services.

The project was dependent on a person's self assessment of their disability and only those who wished were officially registered as disabled, or had referrals made on their behalf to the appropriate agency.

A large amount of data was collected and resulted in many disabled people being identified and helped. The results of most of these studies were published in a series entitled 'Action on Handicap' by Strathclyde Regional Social Work Department. The project in Cumbernauld was the last to be undertaken in July 1988 but was not completed because of lack of funding and therefore was not written up. Referrals were however made to the appropriate agencies and it was all those made to the Community Occupational Therapy Department which were scrutinised in this research project in an attempt to estimate the extent of unmet need.

APPENDIX 5

INTERVIEW SCHEDULES USED FOR COLLECTION OF DATA ON REFERRALS MADE TO NURSING STORES AND OT DEPARTMENTS

PROVISION OF AIDS TO DAILY LIVING

Patient no.: : : : :

Referral From;-.....

Name:- ..... Marital Status;-.....

Address:-..... Age/DoB;-.....

..... Sex;-.....

Tel.No:-.....

G.P.;-.....

Address:-.....

PatientHistory.....

.....

Home circumstances;-.....

.....

Any Communication Problem:-.....

AID REQUESTED	FROM WHOM	DATE OF REQUEST	DATE OF ASSESSMENT	DATE OF PROVISION	TOTAL TIME

PROVISION OF AIDS TO DAILY LIVING

Patient No. : : : :

1. NAME; -..... 4. MARITAL STATUS; -.....

2. ADDRESS; -..... 5. DATE OF BIRTH; -.....

..... 6. AGE; -.....

3. TEL. No.; -.....

7. Type of accomodation: -.....

Any special problems (eg. stairs, location of toilet).....

.....

8. Who Owns this house- District council / S.S.H.A./ Privately Owned /

Development Corporation / Private Landlord other.....

9. Do you live alone: - YES/NO

If NO Who else lives in house.....

10 Do you have any friends, neighbours, family, who call in regularly

.....

11. Who would you call on for help in an emergency?.....

.....

12. Do you have difficulty moving about the house? YES/NO

With / Without Walking aid.....

If yes reasons.....

13. Do you manage to go out YES / NO

Explain.....

How often.....

14. How do you spend your day.....

.....

15. Who does;

(a)SHOPPING.....

(b)COOKING.....

(c)DRESSING.....

(d)CLEANING.....

16. Do you manage

(a)TOILET (alone/with help).....

(b)WASH DOWN (alone/ with help).....

(c)BATH/SHOWER (alone/ with help).....

SERVICES:-

17. Do you presently have :-

(a) Home Help Yes/No How often.....

(b) Meals on Wheels Yes/No How often.....

(c) District Nurse Yes/No How often.....

(d) Health Visitor Yes/No How often.....

(e) Chiropodist Yes/No How often.....

(f) Occupational Ther. Yes/No How often.....

(g) Physiotherapist Yes/No How often.....

(h) Day Hospital Yes/No How often.....

(i) Day Centre Yes/No How often.....

(j) Outpatients Yes/No How often.....

(k) Voluntary Groups Yes/No How often.....

(l) Others Yes/No State.....

18. Have you ever had any of these services.....

.....

19. Does your G.P. call on request/ regularly .....

20. AIDS

Do you have any existing aids? Yes/No

EXISTING AID	HOW LONG HAD IT	WHERE FROM	DO YOU USE IT	ANY PROBLEMS WITH IT	COMMENT

21. Do you think the aid(s) have improved your quality of life?.....

.....

22. Do you know where to return aids when you no longer require them..

O.T. REFERRALS

Name:- ..... Age..... Sex.....

Address:- .....

Type of house:- Private Council S.E.H.A. Other.....

Do they live alone.....

Housebound.....Ambulant.....

Previously known.....

Referral from:- ..... Date:- .....

Request for:- .....

.....

Background:- .....

.....

ACTION TAKEN

(a) Acknowledgement letter sent:- .....

(b) Referred to other agency:- .....

(c) Asked to attend aids centre:- .....

(d) Equipment sent without visit:- .....

(e) Date first visit:- .....

.....

.....

(f) Visited by assistant O.T.:- .....

.....

.....

.....

.....

.....

.....

.....

.....

Case closed:- .....

REASONS FOR DELAYS

(1) waiting initial visit.....

(2) waiting for driver.....

(3) waiting for technician.....

(4) waiting for equipment.....

(5) waiting on permission.....

(6) waiting on tradesmen.....

(7) delay in ordering.....

(8) client induced.....

(9) other.....