SCENE 2

TAKE 1
South Ockendon

SOUTH OCKENDON subnormality hospital in Essex has had its unfair share of bad publicity recently. An allegation of cruelty by a nurse and the manslaughter of one patient by another led to news reports—some of which have been angled to hurt the staff—and, predictably, morale within the hospital has suffered badly.

The outburst of righteous indignation which followed the Ely Hospital Report made both public and politicians briefly aware that all was not well in Britain's subnormality hospitals. The politicians may have known better but the public, unaware of the near-crisis understaffing and overcrowding in many of the hospitals, have been apt to lay blame on the nurses. Nurses from South Ockendon have had to endure taunts like 'Where are your jackboots?' when out in the adjoining village.

Anyone who knows anything about the subnormality hospital service knows how unfair this collective condemnation is. On one afternoon when I was at South Ockendon recently there were 34 nurses looking after 10 female wards with 486 patients and 37 male nurses (9 of them were working overtime) looking after 11 men's wards containing 509 patients.

This was not an exceptional day—it indicates the resources with which William Searle, head of nursing services, has to juggle all the time. He has a work force of 258 nurses (76 fully trained) to spread over two day shifts and a night shift. The spread is ridiculously thin and the total number is regularly whittled down by holidays, courses and sickness. Because nursing has to be concentrated on the most difficult, disturbed wards some of the other wards are manned—if that is the right word—by one sister with an assistant in training coping with 46 patients.

South Ockendon's staffing problems are probably more acute than most because of its geographical position. As the physician superintendent, Dr. Gordon Dutton, said: 'Local industry has the edge on us all along the line.'

There is a concentration of industry in the area. Dagenham and Fords are close by, so are Plessey Electronics and innumerable light industries. Industry offers more fringe benefits and as much money for a five-day week as the hospital can for seven-day-a-week shift work. If a man can earn £27 a week on a bread-round in the area, it is unrealistic to expect him to go on nursing—however much he may be devoted to the job, there comes a point where, given the chance to provide his family with a better living, he literally cannot *afford* to go on nursing.

As one charge nurse put it: 'The old concept of nursing as a vocation still exists as far as the powers that be are concerned, but those days are gone and gone for good.'

Another small, but nonetheless important, factor helping to make the position at South Ockendon exceptional is that the hospital is just one mile outside the area qualifying for a London 'weighting' on staff salaries. Inclusion in the area would mean another £95 a year on a charge nurse's salary and would cost the regional board £26,000 per annum overall.

Over the last year the number of trained staff at the hospital has remained constant, but the number of nursing assistants—the essential 'pair of hands' for the day-to-day care—has fallen from 63 in April 1968 to 47 now. There are also larger than normal numbers of vacancies for maintenance and catering staff.

The nursing establishment is 17 per cent below strength, added to which (more likely, in part at least, *because* of it) there is a very high sickness rate among staff. Of 37 ward staff off sick in one week in April, 10 were fully qualified and 16 state enrolled nurses. If the pressure of work was less perhaps the sick staff members would come back to work when they felt better rather than actually waiting until they were fully recovered. But as it is, as Dr. Dutton says, 'People stay off until they are 100 per cent, knowing that, if they feel under the weather, they won't be able to cope with the overcrowded ward.'

With a catchment area incorporating most of the East End of London, the hospital seems to get a higher proportion of disturbed patients than most. The patients come from a tough environment where children grow up familiar with violence in the streets and in the home.

'The grade of patients has certainly gone down,' said Dr. Dutton. He quoted a break-down for last year's 128 new admissions—83% were severely subnormal, 32% could not walk and 48% had serious behaviour problems. From these figures alone it is obvious that a high proportion

patients need intensive care and this is just what cannot be provided with the existing staff/patient ratio.

An average, worked out on the day I was there, would be one member of nursing staff to 12½ patients (the Ministry's ideal is 1:4), but the figure does not mean much unless related to the job that needs to be done. If the nursing was purely supervisory the ratio would be almost tolerable, but what is needed in fact is much nearer to intensive care. A random day's statistics from the Hospital Activity Analysis give some idea of the demands made upon the staff and show what 'nursing' in this context really means:

There were 1,016 patients in the hospital, of whom 18 were bed-ridden; 141 non-ambulant; 165 poorly ambulant; 440 incontinent of urine; 289 incontinent of faeces; 261 needed feeding; 566 needed dressing; 307 were epileptic; 426 needed special observation; and 289 were subject to unpredictable behaviour.

The situation became so critical in April, during the police inquiries into the manslaughter and while the Press inquisition was in full swing, that Dr. Dutton suspended admissions. Questions were asked in the House—on the crest of the Ely wave —Richard Crossman pronounced the hospital 'overcrowded' and said he intended to syphon off 100 patients into other hospitals to ease the pressure. Baroness Serota, the then recently appointed Minister at the Department of Health and Social Security, visited the hospital to assess the problem. She impressed the staff with her ability to make immediate contact, her background knowledge and her grasp and appreciation of their difficulties.

Whatever the concern, and however many the good intentions, the basic problem of slow recruitment and too many patients remains at South Ockendon as at many other subnormality hospitals throughout the country. Piecemeal solutions and stop-gap plans may alleviate the immediate problem but the basic one will inevitably recur.

According to Ministry figures, Dr. Dutton has got 483 patients too many. He has a further 250 on the waiting list. The Ministry's recommended size for subnormality hospitals is 'no more than 500 beds'. Therefore, to overcome the overcrowding and cope with the waiting list, Dr. Dutton estimates that another four or five hospitals are needed just in the south Essex area.

Because South Ockendon Hospital is in a state of crisis, and because it is the first hospital on which attention has been focused after the shock of the Ely Report, positive action to improve the situation will probably be taken. But South Ockendon is not unique; it is not a 'special case'; if direct Ministerial intervention does yield results there are likely to be physician superintendents in many parts of the country saying: 'Why not my hospital too?' Dr. Dutton says: 'I'm lucky to have got my shopping list in first.'

Mr. Searle, who tackles the day-to-day problem of keeping the wards of South Ockendon staffed, cannot afford to have elusions about nursing the subnormal. He says the character of the nursing has changed radically now that virtually all the admissions really need hospital care and the essential urgent move is to get the local authorities to provide facilities for patients for whom the hospital staff are acting solely as guardians.

Both he and Dr. Dutton agree that there are about 150 people in South Ockendon who could almost immediately be taken into other forms of care within the community if they existed. Mr. Searle wants local authorities to be made aware

of their responsibilities in this context and favours 'model village' schemes for subnormals not needing intensive care.

Considering the type of care which has to be provided on many of the wards, it is obviously essential to accelerate the development of alternatives to hospital care for 'high grade' patients. In one ward there are 46 severely subnormal children who also have severe physical handicaps. Only 8 can feed themselves, only 8 are not incontinent and about 6 can walk. This leaves about 40 who need constant nursing care and the usual staffing on the ward is the sister plus three nurses. They are very hard-pressed just to keep their 10 patients per head clean and fed, let alone be able to do any attentive therapeutic nursing, but they try.

Mr. Searle wants to develop two streams of nursing intake. One group of selected students, trained to keep pace with the doctor, understand what he is talking about clinically and carry out his treatment instructions. The other intake would be broader based, for mature married women who would bring simple, warm, human feelings as their qualification to undertake the day-to-day care of patients. This category could be employed part-time to fit in with their domestic commitments.

The place of older women with compassion and intelligence in the nursing service was emphasised by Sister Nicholas in the admission and 'physical' ward. She was sure that if recruitment methods made it clear that extensive training was not necessary for about 90% of nursing work, many more women in their 30s and 40s would be attracted into the service. 'But all of us tend to forget what a shock it is when you're first introduced into a ward,' she said. 'A gentle introduction would help enormously but, because of the staff shortage, it is impossible to provide one. So for everyone you get, you probably lose one other because they're thrown in the deep end first and feel they can't cope.'

Mr. Searle is convinced that by building large hospitals for subnormals a social service was done but 'we have let society off the hook'. The community has to be re-educated to understand its responsibilities towards the subnormal. 'Up to now the staff have shared the shame of the subnormal hospital and not told their neighbours where they worked.'

A kind of quiet, desperate inertia has crept into the service. As Mr. Searle puts it: 'The problem has been with us for so long it's like having one leg shorter than the other—you learn to live with the pain. We've been living with the pain for years now.'

Perhaps the saddest facet of the whole problem of overcrowding and understaffing is that the nurses know better than anybody that they are not doing the job properly because it just is not possible. 'You train staff, tell them what they ought to do and then put them in a situation where they can't do it,' said Dr. Dutton. 'The frustration aspect is the worst part of the whole problem.'

In such conditions flashpoints are bound to occur and violence can flare up by the very nature of some of the patients. Between January and February this year 28 staff were injured and needed medical attention and 125 patients were injured by other patients—'directly accountable to overcrowding. It is the only way they have of demonstrating their frustration, to break a window or a locker or worse,' said Mr. Searle.

'We're doing better than we should with what we've got,' he said. 'I'm constantly amazed by the way my staff keep going. After all, if you were 5 men short in industry they just wouldn't set the machine going. Here you can't stop the machine.'

John Payn

Impressions of Hospitals

Diana William

Diana Williams has been variously diagnosed as suffering from anxiety state, temporal lobe epilepsy, schizophrenia and depression. She took part in the Consumers' Panel session at this year's annual conference of the NAMH

THE MAIN building of Hospital A looked ominous from outside, and, though the halls and corridors were usually bright and clean, it seemed that much of the renovation had been done to impress visitors rather than to cheer up the patients, because there was little attempt at attractive décor in the dormitories.

However, the new unit for short-term patients was more inspiring. Its main dormitory was bright and always festooned with flowers. There was a 'normal' atmosphere in the lounge because it was open to both men and women. If you were convalescent you could play the piano in the 'day room' and make a noise there without fear of disturbing those who were in the sleeping quarters