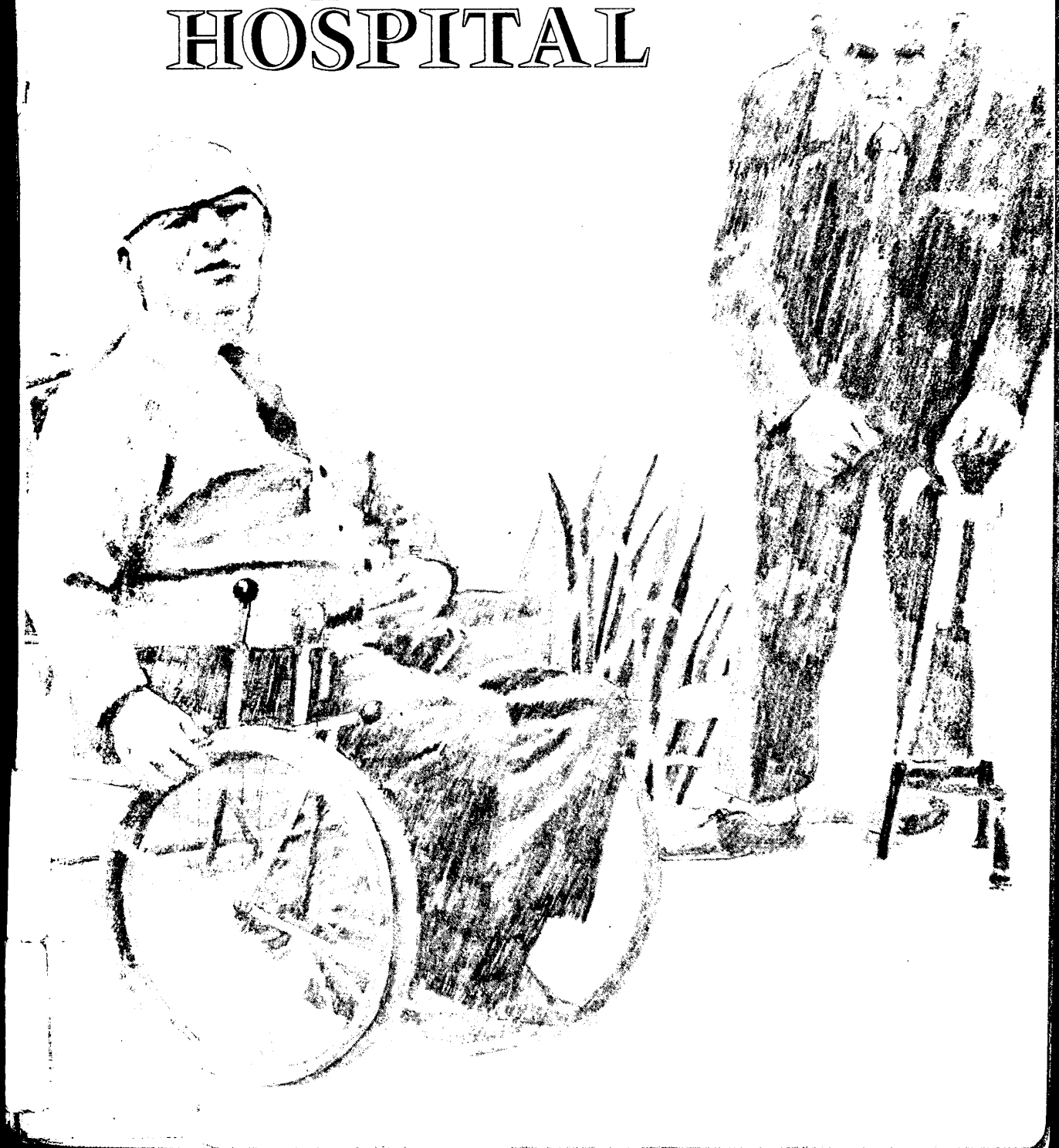
THE GERIATRIC DAY HOSPITAL



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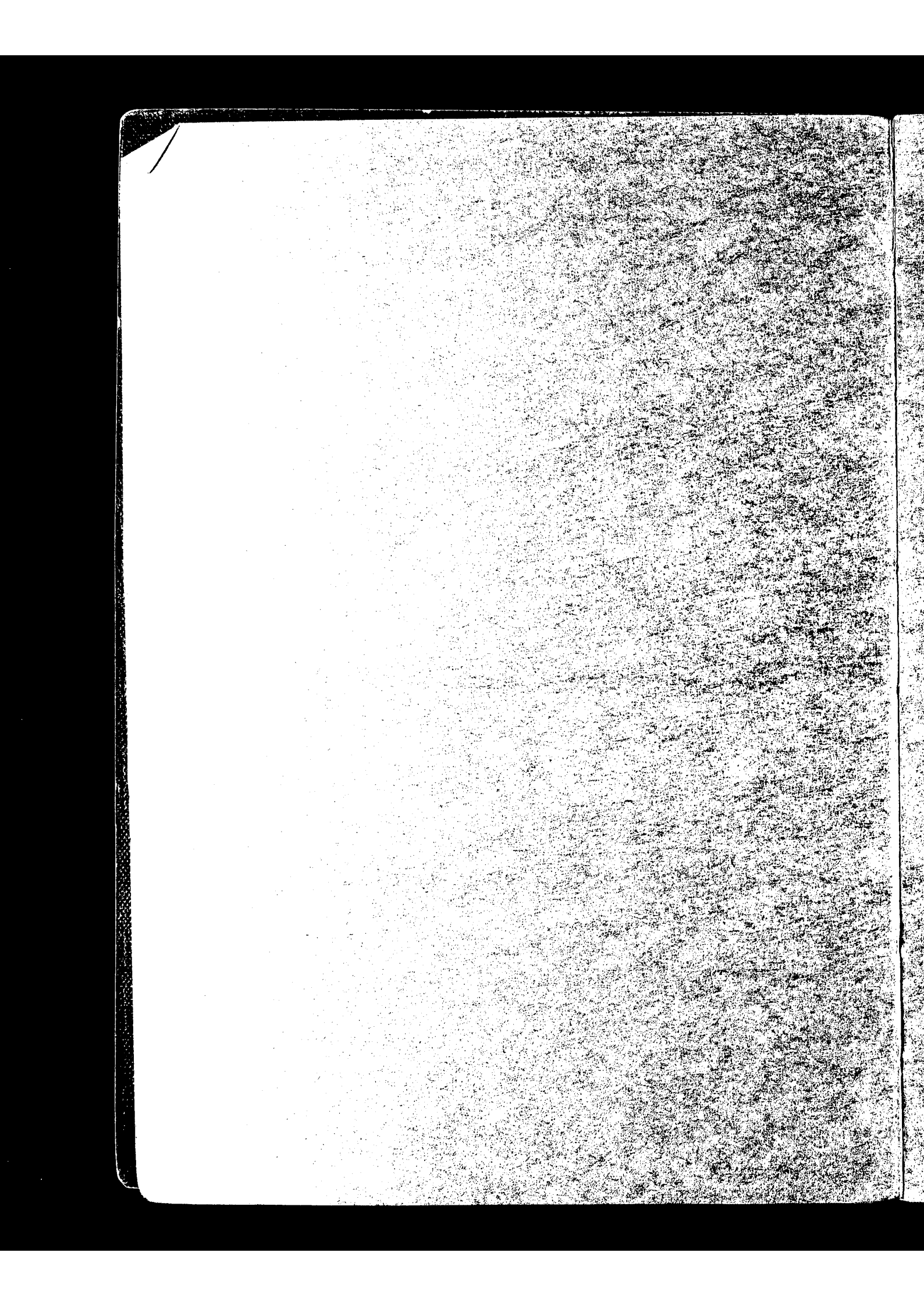
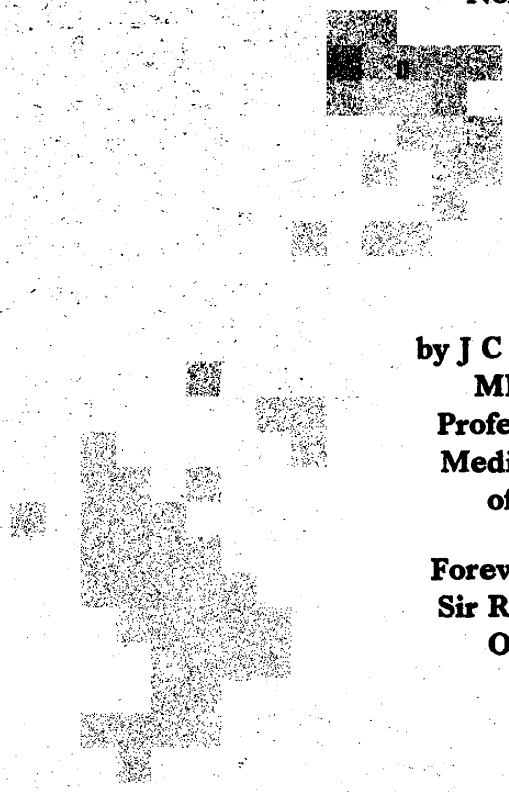


THE GERIATRIC DAY HOSPITAL

A report of three studies of geriatric day hospitals in Great Britain and Northern Ireland



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This book consists of a series of papers on various aspects of the geriatric day hospital as it exists in Great Britain and Northern Ireland in 1970. I must thank many people for their help. The research committee of the South East Metropolitan Regional Hospital Board gave a grant for two surveys, one of five day hospitals and the other a six-year survey of the Lennard Day Hospital; King Edward's Hospital Fund for London gave a grant for a national survey of day hospitals.

The consultant geriatricians who have contributed essays on their own day hospitals, Drs W E R Budd, R O F Hardwick, R E Irvine, J G Pritchard and C W J Ussher, also took part in the survey of the five day hospitals. Their cooperation is gratefully acknowledged. In particular I must thank four people: Mrs S Brocklehurst carried out the six-year survey of the Lennard Day Hospital; Mrs A M Ellerton organised the national postal survey and also prepared the manuscript, Mr G Kalton acted as consultant on statistics, and Dr Stephen Lock gave valuable advice and edited the manuscript for publication.

Finally, thanks are due for their help in various ways to Drs L L Griffiths and R K Chhabra, to the consultant geriatricians throughout the country who completed questionnaires, and the staff of the five day hospitals who helped with the survey.

J C BROCKLEHURST
London 1970

FOREWORD

The three major users of the hospital and health services are those suffering from disorders of the elderly, from mental disease and from the consequence of accidents. In the treatment of all three groups of disorders, rehabilitation plays a prominent role. The day hospital and the day centre were developed because of the special rehabilitation needs of the elderly sick and of those suffering from mental illness. This is well illustrated by the rapidity in the growth of day hospitals for the geriatric services; ten in 1959, over 90 in 1969.

The author stresses that the reason for and the primary role of the day hospital are therapeutic. Despite the varied character and siting of the five day hospitals which have been studied in detail, and the differing nature of the populations served, it is interesting that the major reasons for their use can be classified under three headings, rehabilitation, physical maintenance, social care. For those planning area and district health services, it is valuable that the author clearly differentiates between the functions of the day hospital and the day centre, yet stresses the valuable supportive role of the day centre for the day hospital.

Professor Brocklehurst is to be congratulated upon the timely publication of this report. In planning and thinking towards a fully integrated health service, all concerned with the future services will find this book a most valuable analysis of the problems to be considered in planning day hospitals.

RONALD TUNBRIDGE 1970

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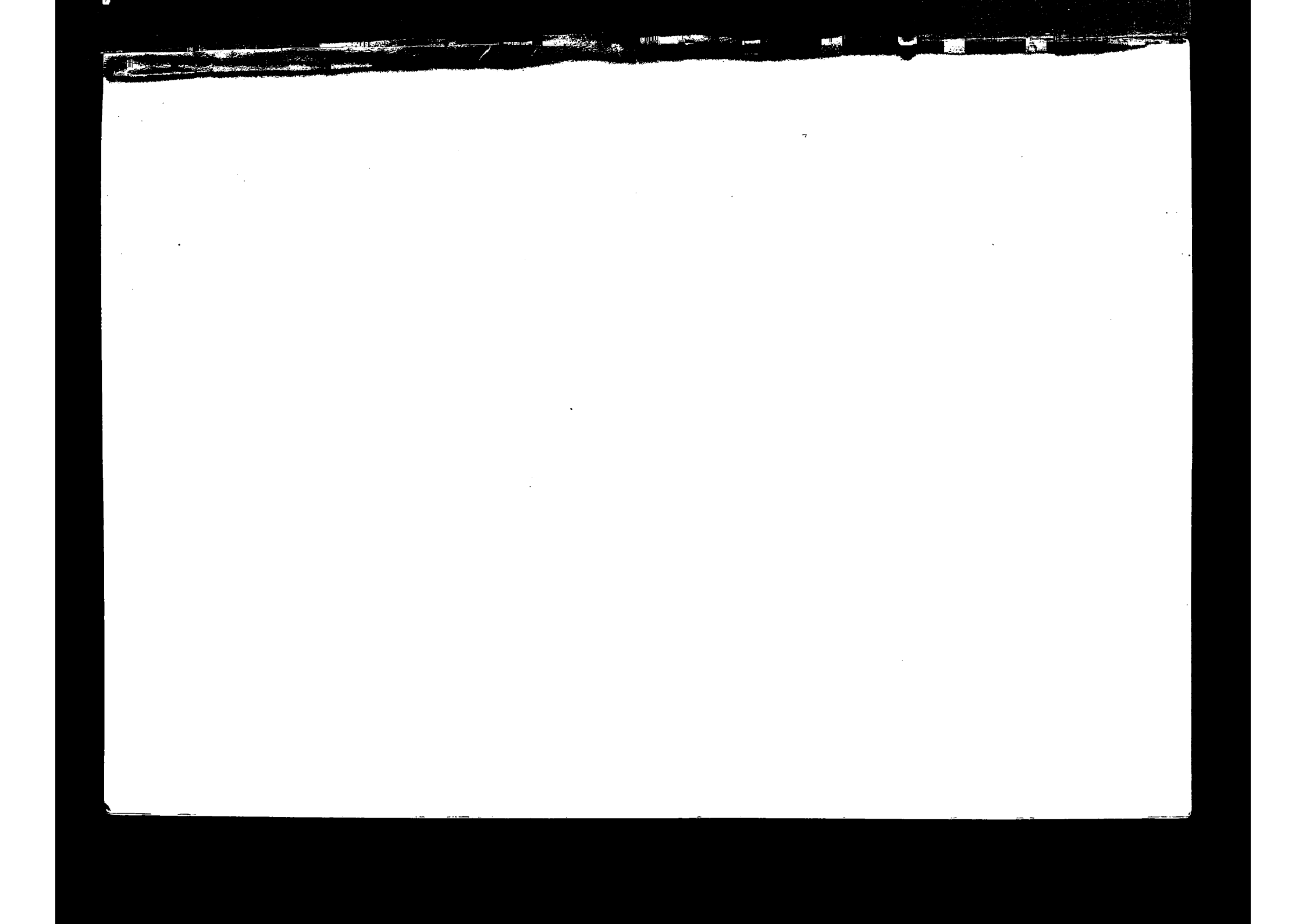


INTRODUCTION

This book must begin with a definition. A day hospital is a building to which patients may come, or be brought, in the morning, where they may spend several hours in therapeutic activity and whence they return subsequently on the same day to their own homes. The building is generally, although not always, within the curtilage of an ordinary hospital. It may be no more than a single room specially adapted, or a whole purpose-built structure of many varied rooms. Geriatric day hospitals provide facilities for physiotherapy and occupational therapy, for medical examination and nursing treatment, and usually for various other activities including investigation, speech therapy, dentistry, chiropody and hairdressing. The building and its facilities may be used entirely for day patients coming from their homes, or it may be used by in-patients as well, who come over from the wards in the morning and return in the afternoon.

Geriatric day patients are almost always brought by special transport and thus make moderate demands on the ambulance service, the cost of which may well be the most expensive element in day hospital treatment. Usually between four and eight hours are spent every day in the day hospital. This long period of time differentiates day patients from those attending for short periods of treatment in physical medicine departments. The prolonged period is necessary for elderly people. Though the pace must be slow, the activity must be as continuous as possible. Everything the patient does – walking along corridors, having lunch, taking part in remedial exercises or in group projects – involves a therapeutic activity designed to improve his health and overcome his disabilities. Geriatric day hospitals may also be used to prevent breakdown in health, both in patients and in their families. In a nutshell the aim is to dissociate the 'hotel' element of hospital care from the therapeutic content, leaving only the latter.

At the outset it is important to distinguish between day centres and geriatric day hospitals. Day centres provide social facilities – company, a cooked meal, possibly a bath and chiropody, but none of the remedial services found in the day hospital. Day centres are usually run by local authorities or voluntary bodies (often both together, coordinating their

work through the old people's welfare committee). Nevertheless, transport is an essential part of both the day centre and the day hospital.

HISTORY

In 1958–9, James Farndale visited 38 psychiatric day hospitals, nine geriatric day hospitals, three day centres for the elderly and a group of rehabilitation centres. His analysis, *The Day Hospital Movement in Great Britain*[6], is the first and only major publication about day hospitals in this country. It conveys a very clear picture of the situation and trends at that time – over ten years ago.

Of geriatric day hospitals, Farndale wrote 'Up to now, day hospitals for old people are small and experimental. They operate on a very limited scale.' In the decade since Farndale's study, there has been an explosion in the development of geriatric day hospitals – in 1969 there were at least 90 day hospitals in the United Kingdom and a further 29 were due to be opened in 1970. During the same time a comparable development of hospital in-patient geriatric services has also occurred. The scale of this development is an achievement of which the British National Health Service may be proud. It has been studied with the greatest interest by most other developed countries in the world and has served as a pattern for many in the creation of their own geriatric services.

There are many reasons for this extensive development of geriatric day hospitals. Firstly, the development itself is evidence that they fill a need in the geriatric department. Above all is the versatility they offer the geriatrician in treatment and in care. Though, in general, geriatric hospital beds are in limited supply, the day hospital overcomes many limitations imposed by this and allows an immediate service to be offered – which often overcomes the need for subsequent admission.

Secondly, the day hospital adds lustre to the geriatric department and, as Irvine[10] pointed out, is a morale-booster for the whole service. By its outward-looking sense of hope, optimism, and reablement, it provides a therapeutic atmosphere that bubbles over into the rest of the geriatric department. It allows doctors, nurses and therapists to accompany their patients back into the community and see the processes of rehabilitation completed.

The third reason for their development is that day hospitals have become popular because their hours suit the married women on the staff, who can use their highly developed skills with satisfaction and still manage a household of young children. For this reason the adequate staffing of many day hospitals often contrasts strongly with staff shortages in in-patient departments.

The development of geriatric day hospitals was later than that of psychiatric day hospitals. Harris[8] dates the origin of psychiatric day hospitals at 1942 in Russia; Montreal followed, and then Kansas. The first British psychiatric day hospital was started in London as an independent institution – the Marlborough Day Hospital, in 1946.

Geriatric day hospitals began with out-patients attending the wards and rehabilitation departments for the day and being taken home in the late afternoon. Such arrangements were in being in the 1950s in Aylesbury, Tindal General Hospital; Bolton, Bolton District General Hospital; Leeds, St James's Hospital; Liverpool, Newsham General Hospital; London, Langthorne Hospital; Oldham, Oldham and District General Hospital; Oxford, Cowley Road Hospital and Rivermead Hospital; and Rochdale, Birch Hill Hospital and Marland Hospital – and probably elsewhere. The first purpose-built geriatric day hospital opened at Cowley Road Hospital, Oxford, in 1958, designed to deal with both physically and psychiatrically disabled patients, but with emphasis on the latter.

Apart from Farndale's book, early descriptions of day hospitals were given by Cosin[4], Droller[5] and McComb and Powell David.[12] Nuffield House, a day hospital for confused old people in Nottingham, is really a psychiatric day hospital, although the patients resemble those attending geriatric day hospitals. Administered by the local authority, it is intended particularly to provide social relief and prophylaxis against mental and physical deterioration; most of those attending suffer from moderate senile psychosis.[15]

Woodford-Williams and her colleagues[18] and Brocklehurst[1] analysed the patients attending during the first year of two day hospitals, Sunderland and Bromley, respectively. In a trial of day hospital care Woodford-Williams *et al* matched attenders with non-attending control patients. Although in the early months more patients from the treatment group were admitted to hospital than controls, this trend was reversed in the second six months, with an average of five and 9·8 in-patient days in the treatment and control groups, respectively. Brocklehurst assessed the effect on in-patient admission as follows – this was prevented in eight per cent and delayed in 6·7 per cent of those attending the day hospital. Earlier discharge from hospital had been possible in 11·8 per cent of day patients.

Almost all papers written about day hospitals stress the importance of developing complementary social day centres in the community for those whose needs are social rather than medical. Woodford-Williams and Alvarez[17] went further and suggested the need for four complementary day establishments within the geriatric service – a day club, a workshop

for the elderly, a day ward and a day hospital. They based this plan of progressive patient care for day patients on a careful analysis of why a random sample of 100 patients attended, suggesting the following phases in day hospital care:

a treatment – the initial phase for all patients except those in phase b
b relief of strain in the relatives
c improvement – the phase preceding cure – but also preceding the last two phases, e and f
d cure – followed by discharge
e physical dependence
f emotional dependence

Of their patients ten per cent were in the phase of physical dependence and 25 per cent in that of emotional dependence. The latter were largely the anxious, the depressed and the lonely, patients in whom discharge was followed by relapse. They suggested that, while the day hospital should continue to give intensive treatment for those in the phases of treatment and improvement, the day club or workshop would be more appropriate for the emotionally dependent and most of the physically dependent. The day ward would be more appropriate for those 'heavy' patients with physical ailments or confusion, comprising most of phase 'relief of strain in the relatives' and also for some of the physically dependent.

Describing the day hospital in Cardiff, Pathy[14] has analysed the patients who attend. Three alternative forms of day care are available in the Cardiff geriatric service. Firstly, the main day hospital is used for patients requiring detailed or major pathological and radiological investigation, or assistance from other specialties. Dental and chiropody treatment is available as well as physiotherapy and occupational therapy. Patients attend on an average of ten occasions, usually once or twice weekly. The second is a complementary day hospital for more routine nursing, medical or physical treatment. The third is a day annexe, covered by nurses from an adjoining ward and providing more long-term supervision. These three forms at Cardiff would seem to correspond to three establishments described by Woodford-Williams and Alvaréz as the day hospital, the day club or workshop and the day ward respectively.

Irvine[10] prefers the term 'day ward' to day hospital, but does not suggest that more than one establishment is needed. Pathy concludes that there is need for at least one geriatric day hospital place for every 3,000 of the population. In Cardiff three local authority health visitors are seconded to the geriatric department and play an important part in the day hospital service. In addition all patients discharged from the

day hospital after six weeks attendance or longer are assessed at the out-patient clinic – one, three and six months after discharge.

Pathy has also provided one of the few estimates of cost available so far. At the main day hospital the cost per patient per day was 42s (£2.10) compared with 115s (£5.75) for an in-patient per day. The respective figures for the day annexe and long-stay patients were 31s (£1.55) and 65s (£3.25) per day. (Presumably these figures do not include transport, which is often the major cost element in day care.) Farndale[6] claimed that day hospitals for old people were not saving the National Health Service any money. This was because none of the hospitals with a day hospital had been able to reduce its budget (and this may be true). Nevertheless, he added that the day hospital was one economical way of improving the *quality* of medical care to old people.

Fine[7] emphasised the value of a day hospital in treatment of faecal incontinence, often the only reason why admission to hospital is requested. Enemata at the day hospital often obviate this need. Irvine has described another activity which may be incorporated into the day hospital programme, the 'wheelchair clinic'. At the Hastings Day Hospital, this is held once monthly and is attended by the technical officer from the local wheelchair and appliance centre, as well as the hospital rehabilitation staff. This has become a focal point for the supply of wheelchairs used by every department and has greatly reduced the mistakes made in providing chairs.

THE PRESENT STUDY

The main part of this book is concerned with three separate investigations into geriatric day hospital care in Great Britain.

The first investigation, described in Section 1, attempts to define the total geriatric day hospital provision in Great Britain at the end of 1969 and to consider the principal types these day hospitals comprise. It also discusses the views of most geriatricians about day hospitals.

The second (Sections 2 and 3) is a study of five day hospitals in the south-east of England – their history, physical amenities and staffing. It also provides a profile of patients, their social and physical characteristics, the diseases they suffer from, the reason for their attendance and the treatment they receive. Since, in effect, the survey is a frozen section of one period in time, it cannot tell the outcome in each patient's case. Hence this evidence cannot be used to evaluate the day hospital in terms of ultimate outcome.

This latter aspect is considered in the third investigation (Section 4), a review of all patients attending the Lennard Day Hospital in Bromley,

Kent, over six years. It deals with the duration of attendance and the outcome at the end of this period, and of subsequent periods of attendance.

A summary of all three investigations is presented first.

SUMMARY

In a postal survey of all 239 consultant geriatricians in Great Britain and Northern Ireland, replies were received from 94 per cent, representing 196 departments. Of these, 90 had established day hospitals by mid-1969, and a further 29 had day hospitals scheduled to open before the end of 1970. Hence by the end of 1970 there will be at least 119 geriatric day hospitals in this country (page 22, and Appendix I).

In only 77 departments was there no day hospital or none scheduled for 1970. Many of these had day hospitals scheduled for 1971–2; others had one accepted in principle, but had not included it in any programme.

The number of beds provided by the geriatric departments per 1,000 population was:

up to 0·9	34 per cent
1 to 1·4	28 per cent
1·5 and over	38 per cent

In 61 per cent of departments the assessment wards were in a general hospital. In 85 per cent a consultative out-patient clinic was held (page 22). Departments with no day hospitals in existence or planned by the end of 1970 tended to be worse off for beds, and fewer of them held consultative out-patient clinics (page 24).

Social day centres existed in 55 per cent of the areas involved; they were three times more common where there was also a day hospital (page 24).

Of consultants with day hospitals 82 per cent thought them essential – and so did 41 per cent of those without any prospect of having a day hospital before 1971. Only four per cent of all consultants thought day hospitals to be of little or no value (page 24).

The day hospitals themselves were equally distributed between general and geriatric hospitals. In five cases they were entirely independent of any hospitals. Facilities for in-patients and day patients were shared in

87 per cent of day hospitals, especially physiotherapy and occupational therapy (page 26).

One-third of the day hospitals had fewer than 20 places a day. Most (82 per cent) were open five days weekly. In half of the day hospitals all patients travelled by ambulance. In the others, some came by hospital sitting-car, by taxi, or by private transport. Most patients spent five to seven hours at the day hospital on each visit (page 27).

The consultant geriatrician saw patients at the day hospital on at least one day weekly in 80 per cent of the day hospitals. Medical assistants, senior registrars and registrars were responsible for most of the day-to-day care (page 29).

All but 13 of the 90 day hospitals had one or more nurses on the staff – usually at least one SRN. In a quarter of the day hospitals student or pupil nurses did some of their training there (page 29).

Physiotherapists were in 81 per cent of day hospitals, occupational therapists in 78 per cent, and speech therapists in 48 per cent. Untrained aides were equally distributed between physiotherapy and occupational therapy departments (page 29).

The person in charge (under the direction of the consultant) was an SRN in 64 per cent, and the head occupational therapist in 22 per cent, of day hospitals (page 29).

Physical rehabilitation was regarded as the most important function of the day hospital by most consultants; physical maintenance therapy came second. Social care of mentally confused rated lowest in importance (page 31).

In 63 per cent of day hospitals, patients' progress was reviewed at regular case conferences which included doctors, nurses, therapists and social workers. Where case conferences were not held, patients' progress was regularly reviewed at review clinics attended by doctors and nurses (page 33).

Of the 119 departments with day hospitals in existence or due to open by 1970, only 57 per cent had a staff member who was also a member of the local old people's welfare committee; most usually this was the consultant (page 34).

A comparison of five day hospitals in the south-east of England by staffing and patients attending during one week in November 1968, showed that the hospitals provided between 30 and 50 places daily.

Although the average places available daily were 37, only 28 patients usually attended and each day four to five of those sent for did not arrive. One day hospital place to each 4,500 population served seems a reasonable average figure, depending on local circumstances (page 38).

In general there are twice as many occupational therapists as physiotherapists. Aides are frequently employed, their numbers equalling professional workers in both of these departments (page 41).

In the average 30-place day hospital there is an average staff of 5·7 whole-time equivalent ancillary workers, including aides, and 4·2 nursing staff of all grades; in other words, ten staff members other than medical staff. This does not include chiropodist or dentist. Consultant geriatricians spend 2·6 hours weekly, while junior medical staff spend 7·3 hours weekly, spread over five days (page 41).

The patients include twice as many women as men, but the 18 per cent of the patients under 65 include more men than women. The proportion of patients who are married is much the same as in the general elderly population. In three of the areas many of the patients had moved there on retirement – particularly those of social classes 1 and 2 (pages 41–43).

Most patients travelled two to five miles to the day hospital; only one per cent travelled over ten miles. Of the women 40 per cent were alone all day when not at the day hospital, but only 16 per cent of the men. Almost one in six attended a day centre or club, as well as the day hospital (pages 43, 45).

About one-quarter of the patients could walk alone, and 13 per cent were wheelchair patients. Although 20 per cent of the men and eight per cent of the women had some urinary incontinence, this was a major reason for attendance in only two per cent (page 47).

One-third of the patients came from the geriatric wards and ten per cent from other wards. Most of the remainder were seen at out-patient clinics or domiciliary consultations (page 47).

Thirty per cent suffered from stroke, 30 per cent from arthritis, 22 per cent from chronic brain syndrome and 18 per cent from other diseases. The principal reasons for attendance were physical maintenance (42 per cent), rehabilitation (27 per cent), and social reasons (26 per cent). A few, five per cent, came for other reasons, including medical and nursing procedures (page 49).

Fifty-seven per cent attended once weekly, and only five per cent came four or five times weekly, though hospitals varied considerably. Thirty-

seven per cent attended for over one year, particularly in the seaside towns. Sixty-one per cent of the patients received physiotherapy. All but one per cent had some occupational therapy, though only in one-third was this a specific part of rehabilitation (pages 49–51).

A six-year survey of the Lennard Day Hospital showed that between 1963 and 1968, 965 different patients attended. The largest number (44 per cent) were aged 75 to 84, and only three per cent were over 90. Women outnumbered men, except in the age group 65–69, in which the numbers were roughly equal. In the older age groups the proportion of men dropped steeply (pages 67–69).

Patients were referred in equal numbers from home and from hospital; ten per cent came from medical wards, tended to be younger, and male, and attended particularly for treatment of stroke. Those referred from geriatric wards (36 per cent) stayed for a shorter time in hospital than those in a consecutive series of all patients discharged from the same wards (page 69).

In the under-60s, there were two main diagnoses – stroke and multiple sclerosis. Altogether, stroke was the commonest reason for attendance in those under 80. Over that age, chronic brain syndrome and arthritis became more common diagnoses. In general, stroke was more common among men and arthritis among women. More of the patients with stroke attended for longer periods of time than those with other diagnoses (pages 69–71).

Fifteen per cent of the patients discharged themselves – almost half of these in the first two weeks. These tended to be slightly older, and more of them suffered from cardio-vascular or respiratory rather than neurological or locomotor diseases. Of the remainder, equal proportions were discharged by the medical staff as no longer needing treatment, or were discharged either because of admission to hospital, or illness at home, or they had died. The first group contained considerably more stroke patients, and the second contained more patients with chronic brain syndrome (pages 73–77).

Over 20 per cent of the patients had second or subsequent periods of attendance. Usually they attended again for the same reason as on the first occasion. Following the second and subsequent attendances more of the patients were admitted to hospital, became ill at home, or died, than after the first attendance (page 77).

1 NATIONAL SURVEY OF GERIATRIC DAY HOSPITALS

The essence of hospital geriatric practice is an area service based on the hospital beds of the consultant. The service must embrace, firstly, the diagnosis and treatment of the pathological processes which in any individual old person contribute to his disability; secondly, rehabilitation; and, lastly, provision of long-stay care for both physically and mentally disabled patients. The hospital beds on which this service is based are found in a variety of institutions – general hospitals, infectious diseases hospitals, hospitals for chest diseases and infirmary blocks of former workhouses. In future hospital development, the national policy is that geriatric departments should be part of district general hospitals, and this policy is already being put into effect in those hospitals under construction.

Thus, most consultant geriatricians have had to develop a service within a group of heterogeneous and often physically separate hospitals. Since the various wards or hospitals are administered as a unit, it was possible to apply the principles of progressive patient care in geriatric units at an early stage. Assessment and rehabilitation services have been developed in whatever wards and beds were available in general hospitals, while long-stay care may be based in smaller and more peripheral hospitals. One extension of this progressive patient care is the day hospital, and hence these have been developed in a variety of situations. Most logically they have formed an extension of the rehabilitation department; some have been developed wherever a site or an empty ward was available; in a few cases they have been created away from the hospital centre altogether.

The present survey was undertaken to obtain a comprehensive picture of geriatric day hospitals in 1969–70. Questionnaires, sent to all consultant geriatricians in Great Britain and Northern Ireland, were divided into three parts, only one to be answered, depending on whether the consultant's geriatric unit:

a had an existing day hospital in 1969
b had no day hospital but one was planned to open by the end of 1970
c had no day hospital and none was planned to open by the end of 1970

TABLE I GENERAL FINDINGS FROM QUESTIONNAIRES REPRESENTING 196 GERIATRIC DEPARTMENTS

GROUP A — *day hospitals in existence in 1969*	*90*
GROUP B — *no existing day hospital, but one planned to open by end of 1970*	*29*
GROUP C — *no existing day hospital, and none planned to open by end of 1970*	*77*
	196

	A and B	C	total
hospital beds/population served (in thousands)*			
0·9	34	38	34
1–1·4	28	24	28
1·5 and over	38	38	38
assessment unit situated in a general hospital	56	69	61
out-patient consultative clinic held	91	75	85
social day centre (with transport available) present in the area	76	25	55
social day centre (with transport) neither present nor planned	16	27	21
consultant geriatrician regards a day hospital as:			
essential	82	41	66
valuable	16	51	30
of little or no value	2	8	4

* *In only 180 questionnaires was this information given.*

In those departments where two or more consultants worked together in one unit, only one questionnaire was completed. Of the questionnaires posted to 239 consultants – the total number designated as geriatricians by all the regional hospital boards, 196 were returned completed, representing 225 consultants, a response rate of 94 per cent. The replies, therefore, may be regarded as representative of contemporary British geriatric hospital practice.

All three sections of the questionnaire had certain common questions, designed to obtain a general picture.* From the answers, some general points can be made about all geriatric departments, and some comparisons drawn between those with a day hospital either in existence or planned to open in 1970, on the one hand, and those with no day hospital planned by 1970, on the other. The findings are set out in Table I and a full list of geriatric day hospitals, with dates of opening, appears as Appendix I.

1 GENERAL FINDINGS

PROVISION OF HOSPITAL BEDS

The number of geriatric hospital beds per thousand population served was shown in 180 of the 196 replies. The figures given are for beds actually in use at the time of replying. There were up to 0·9 beds per thousand population in 34 per cent of all departments, 1 to 1·4 beds per thousand population in 28 per cent, and 1·5 beds or more per thousand in 38 per cent. The criterion of beds per thousand total population served is not a particularly good one, since the age structure of the population varies considerably in different areas – from eight to 25 per cent aged 65 and over. The provision of geriatric hospital beds must also take some account of the provision of residential (so-called 'Part III') accommodation, and of long-stay mental hospital beds in the area.

Comparisons between departments with day hospitals either in existence (Group A) or planned to open by the end of 1970 (Group B) and those with no day hospitals planned to open by the end of 1970 (Group C), show no difference in the proportion of those with 1·5 beds and over per thousand. But of departments with fewer than 1·5 beds per thousand, those in Group C are worse off than those in A and B. This seems surprising since a day hospital is one method of counter-balancing a relative shortage of beds, and might seem to be of greatest importance where beds are most scarce. Possibly some hospital management committees have made inadequate provision in all geriatric facilities, perhaps reflecting local policy. On the other hand, possibly Group C includes an excess of rural areas, where day hospitals may be of less value and where

* *Copies of the questionnaire are available from the King's Fund Hospital Centre, 24 Nutford Place, London W1H 6AN.*

the proportion of pensioners in the population is low. Information from the questionnaires indicates that 20 per cent are mainly or partly rural.

BASIC FACILITIES

Some guidance about the type of service provided might be given by whether or not the assessment unit is in a general hospital, and whether or not a consultative out-patient clinic is held. A positive answer to the former was given in 61 per cent and to the latter in 85 per cent of the questionnaires. In comparing Groups A and B with Group C, the two questions cancel each other out, for, while more departments in Group C have the assessment unit in a general hospital, fewer hold an out-patient clinic. The latter answer may reflect either the tendency of day hospitals to stimulate the inception of an out-patient clinic, many of which are actually held in the day hospital, or greater difficulties in holding out-patient clinics in the more rural areas in Group C. At all events, out-patient clinics and day hospitals seem to go together.

SOCIAL DAY CENTRES

Social day centres, and supporting transport, were available in the areas of 55 per cent of the departments. In these cases, social day centres and day hospitals seem to have developed together, since social day centres are present in 76 per cent of Groups A and B and in only 25 per cent of Group C. They are essential to the proper functioning of day hospitals, otherwise discharge from the latter may become very difficult.

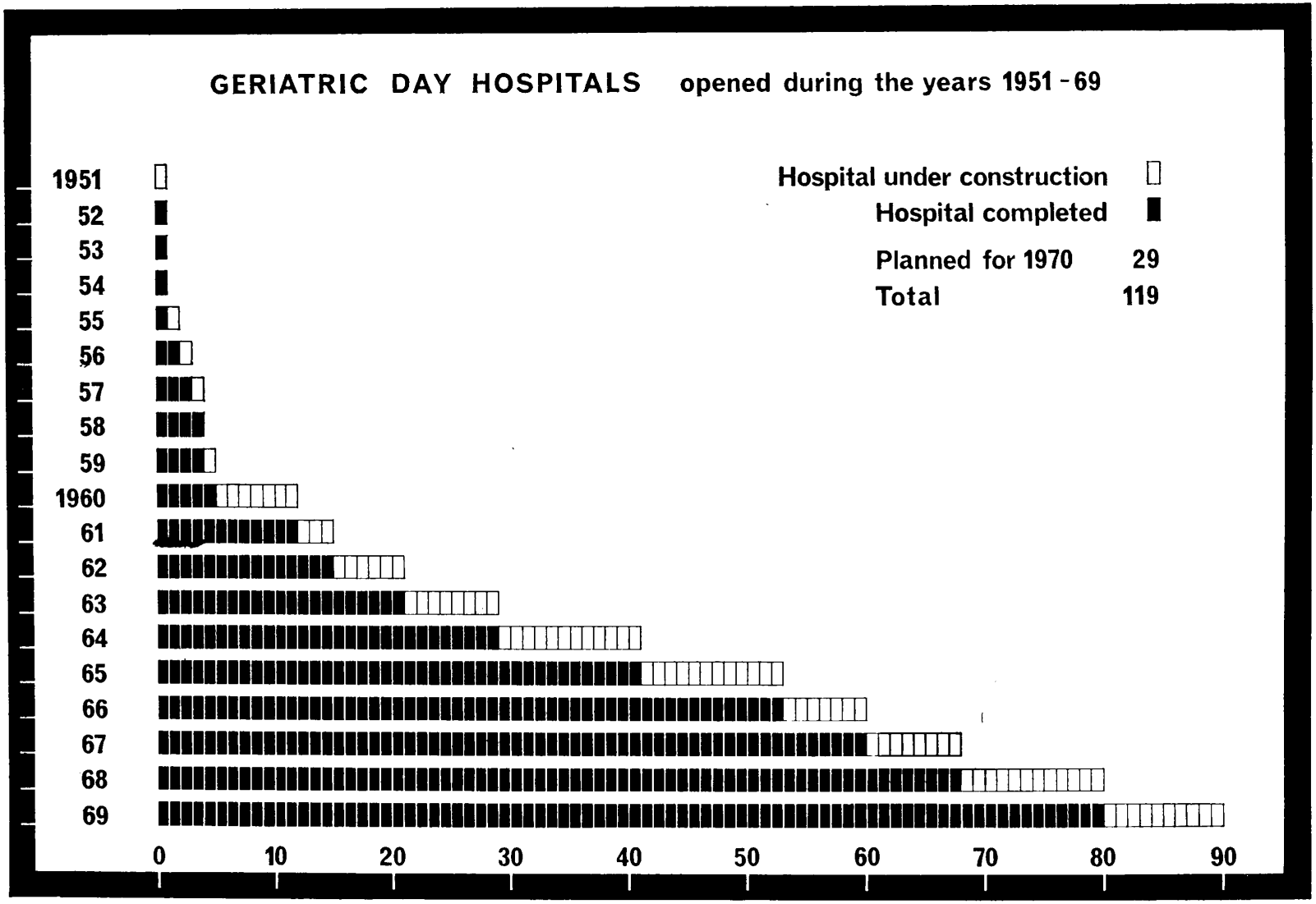
VALUE OF DAY HOSPITALS

Consultants were asked how valuable they felt a day hospital was, or would be, to their own service. Their answers (Table I) hardly require comment, except perhaps to stress that 41 per cent of those without day hospitals regard them as essential to the proper functioning of their own departments.

2 CHARACTERISTICS

The findings discussed in this section relate only to the 90 Group A departments (with existing day hospitals) and 29 Group B departments (with day hospitals planned to open before the end of 1970).

The diagram shows considerable development since 1959–60 and an acceleration of development planned for 1970.


GERIATRIC DAY HOSPITALS opened during the years 1951 - 69
Hospital under construction
Hospital completed
Planned for 1970 29
Total 119
1951
52
53
54
55
56
57
58
59
1960
61
62
63
64
65
66
67
68
69
0
10
20
30
40
50
60
70
80
90

Day hospitals are found:

in general hospitals	61
in geriatric hospitals	63
in both (that is, two day hospitals)	6
elsewhere	9
(mental hospital	3)
(chest hospital	1)
(independent of any hospital	5)

Facilities for day patients and in-patients were shared in 103 (87 per cent) departments. Details of the type of facilities shared in Group A departments are:

physiotherapy and occupational therapy	75
lavatories	40
day rooms	36
dining rooms	36
consulting rooms	23
baths and showers	19

Thus, in most cases the day hospital and the in-patient rehabilitation department are combined. The advantages of such an arrangement are obvious. Not only is it economic in equipment, but it is good for the morale of in-patients to work alongside those who come from their homes. Moreover, patients are happier on discharge from the wards when they know that they can continue in the security of a familiar department and staff, at least for the next few weeks.

Number of places available each day in the 90 day hospitals in Group A are:

1–9	8
10–19	22
20–29	21
30–39	18
40–49	9
50 and over	12

Thus, one-third are small, having fewer than 20 places daily, and only 24 per cent have more than 40 places daily. There is always a discrepancy between the number of places available and the number of patients who actually use them, since some of the old people sent for each day fail to arrive. They may be ill, not feel up to the journey, or perhaps not be out of bed in time. Some day hospitals on which there is considerable pressure, send for more patients than they can take, knowing that some will not arrive.

The difference between places available and the number of patients actually arriving can be shown for day hospitals opened before 1968. In each case the average daily attendance is calculated from the total attending for 1968; this is divided by 50 to find the number attending per week – assuming two weeks for holidays, bad weather and strikes – and further divided by the number of days the day hospital is open each week. The figures are:

places available daily	attendances daily
1–9	6·5
10–19	10·9
20–29	17·5
30–39	27
40–49	31·6
50 and over	49·4

On the whole the figures are in step and suggest that there is no real shortage of places.

The number of days per week the day hospitals are open are:

1 day	2	
2 days	4	
3 days	4	
4 days	5	
5 days	75	(82 per cent)
total	90	

Thus, the great majority are open five days weekly.

THE PATIENTS' DAY

The information discussed here and in subsequent sections also comes from the 90 day hospitals at present in existence. In 43 of them all the patients are transported by ambulance, and in a further 42 most come in this way. In the remaining five many patients come by other means. For example, in a rural community where the day hospital covers a radius of up to 17 miles and where only ten per cent of patients come by ambulance, the remainder come by hospital sitting-car. In another area some day patients come by taxis which carry a full complement and are paid for by the local authority.

Sixty-five patients (72 per cent) spend between five and seven hours daily at the day hospital. In 21 cases (23 per cent) fewer than five hours are spent and in four cases (five per cent) over seven hours. In most cases the first patients arrive between 9 am and 10 am (83 per cent) and the last patients leave between 3 pm and 5 pm (85 per cent).

TABLE II NUMBERS OF DAYS PER WEEK PATIENTS ARE SEEN BY VARIOUS GRADES OF MEDICAL STAFF

	days per week					total
	none	less than 1	1	2	3–5	number
consultant geriatrician	5	15	45	15	20	87*
medical assistant, senior registrar or registrar	—	5	25	16	54	56
clinical assistant, senior house officer or house officer	—	33	10	10	47	37

* *Not answered in three cases.*

TABLE III NURSING AND ANCILLARY STAFF IN 90 DAY HOSPITALS

	sessions per week				some, but number not stated	total number of day hospitals with staff in this grade
	1—4	5—9	10—19	20 and over		
nurses						
SRNs	27	8	47	9	9	64
SENs	27	9	43	12	9	53
student or pupil nurses	—	—	—	—	—	23
nursing auxiliaries	18	16	28	27	11	55
ancillary staff						
physiotherapists	50	20	18	4	8	81
physiotherapy aides	43	22	24	2	9	45
occupational therapists	48	21	12	6	13	78
occupational therapy aides	24	26	26	11	13	47
speech therapists	73	4	—	—	23	48

3 STAFF

The number of days each week on which various grades of medical staff see day patients is shown in Table II. Evidently the main day-to-day care falls on the junior staff, particularly on medical assistants, senior registrars and registrars. Day hospital patients are seen by consultants other than geriatricians in 15 of the day hospitals (psychiatrist in eight, physical medicine specialist in four, general physician in two and orthopaedic surgeon in one).

NURSING AND ANCILLARY STAFF

Table III indicates the number of sessions per week for each grade of nursing and ancillary staff. Thirteen of the 90 day hospitals have no nurse on the staff. In only one case is a nursing auxiliary the only nurse. In 37 day hospitals there are both registered and enrolled nurses on the staff. In 23 day hospitals (26 per cent) student or pupil nurses undertake some of their training in the day hospital. This would certainly be most important if students are to have an all-round view of geriatric nursing.

One day hospital has no ancillary staff and two others have none that are trained. Although slightly fewer in number, occupational therapists have more total sessions than physiotherapists – the figures for less than five sessions a week being 48 per cent and 50 per cent, respectively. Untrained aides are employed in equal numbers in both physiotherapy and occupational therapy departments. In only four hospitals are there physiotherapy aides working without the supervision of a trained physiotherapist (a situation contrary to National Health Service and professional regulations). There are nine occupational therapy aides working without professional supervision by an occupational therapist. Possibly in some cases aides are supervised by a trained worker of the associated profession. More than half the day hospitals have speech therapy sessions, though most of these (73 per cent) are less than one a day.

In all but 18 cases a particular staff member is in overall charge of the day hospital, working under the consultant's direction. The various members of staff in charge are:

SRN	46
SEN	3
occupational therapist	16
physiotherapist	3
other	4
(remedial gymnast	1)
(day hospital mother	1)
(medical secretary	1)
(club organiser	1)

Other staff with regular sessions in the day hospitals are as follows (in each case the number of day hospitals involved is given):

medical social worker	69
chiropodist	57
voluntary helpers	29
health visitors	19
dentist	8

Dental treatment is available in 24 day hospitals but regular sessions are provided only in eight.

4 SERVICE PROVIDED

Basically, geriatric day hospitals may provide four different types of service – physical rehabilitation, physical maintenance, social care, and medical and nursing procedures.

REHABILITATION

This word, so commonly used in geriatric medicine, is not a very exact term for what is intended. 'Reablement' or 'reactivation' may be better words. The intention is to restore to a maximum degree of independence a patient who is disabled by physical, or combined physical and mental disease. The essential principle in 'rehabilitation' is that improvement is looked for. Once improvement ceases, rehabilitation is no longer possible.

Rehabilitation requires the particular skills of physiotherapists and occupational therapists and the use of special apparatus. The degree of disability must be assessed by the occupational therapist in terms of activities of daily living (standing, sitting, getting on and off the bed, dressing, preparing meals and so on) and attempts made to improve all those activities which are deficient. Nevertheless, the whole staff of the day hospital is engaged in rehabilitation, for this embraces all the patient's movements around the day hospital and all his activities during several hours a day.

MAINTENANCE

Generally meaning physical maintenance, this is the process which should follow rehabilitation. Patients attend for maintenance because it is feared that, without this periodic physical treatment, their condition would regress and the degree of independence previously reached would be lost.

SOCIAL CARE

Some patients need social contact to maintain their optimum health and would be isolated if they did not attend the day hospital. Sometimes it is

only by such support that their relatives can maintain them at home. It is implicit in the proper use of a day hospital that such support should not be available from other non-hospital sources. In an appropriate situation, patients attending for social care should be only those so disabled either physically or mentally – or both – that some form of hospital care is needed for their day-time supervision.

MEDICAL OR NURSING PROCEDURES

Some patients will attend for various medical or nursing procedures.

Each consultant with an established day hospital (Group A) was asked to indicate how important he thought each of these functions was in relation to his own day hospital (Table IV). Physical rehabilitation is overwhelmingly thought to be the most important function of a geriatric day hospital, followed by physical maintenance. Medical and nursing procedures come surprisingly low on the list – possibly indicating that relatively few patients can benefit rather than that the service itself is regarded as unimportant. Finally, social care of the mentally confused is little valued as a day hospital service. Though undoubtedly some form of social care for confused old people allows many of them to be maintained in the community – and without this they may impose an intolerable burden on their relatives, so that admission to an institution becomes inevitable – probably most geriatricians do not regard themselves as the proper people to provide such day care. Day care can be provided at a social day centre, though most centres run by volunteers find the responsibility of caring for mentally confused old people too great. Furthermore, psychiatric day centres also do not welcome demented old people. This is an aspect of day care which demands a more positive approach than is apparent at present.

Apart from physical therapy and chiropody, the other main services provided by geriatric day hospitals are:

cooked meals	89
bathing	80
electrocardiography	72
enemata	70
treatment of depression	57
individual speech therapy	50
treatment and care of dementia	43
sternal marrow puncture	37
sigmoidoscopy	32
infusion of blood or iron	31
group speech therapy	24
launderette	18

TABLE IV CONSULTANT GERIATRICIANS' ESTIMATES OF IMPORTANCE OF VARIOUS SERVICES PROVIDED IN THEIR DAY HOSPITALS (question unanswered in one case)

	very important	little or no importance
physical rehabilitation	79 (89)*	3 (3)
physical maintenance	69 (78)	2 (2)
social care of physically disabled	45 (50)	12 (13)
medical or nursing procedures	32 (36)	23 (26)
social care of mentally confused	19 (21)	31 (35)

* *Figures in brackets are percentages*

TABLE V STAFF OF GERIATRIC DEPARTMENTS ON LOCAL OLD PEOPLE'S WELFARE COMMITTEES

	departments with day hospital (A)	departments with plans to open day hospital by 1970 (B)	total
staff on local old people's welfare committee	55 (61)*	13 (45)	68 (57)
consultant geriatrician	42	9	51
medical social worker	15	4	19
other	6	4	10

* *Figures in brackets are percentages.*

Thus, although social care of the confused is not highly valued by geriatricians as a day hospital function, this service is provided in half the day hospitals.

5 REVIEW OF PATIENTS

If the day hospital is to function dynamically, not only must patients obtain the fullest benefit from it, but they must not linger once they no longer require its services. In individual cases, the doctor must make the decision on both issues and regular review of patients is essential. All but one of the 90 day hospitals have such arrangements. In six cases these decisions were regularly made on the doctor's routine visit but not by other means. The remaining 83, however, had a more formal arrangement; either a case conference attended by doctors, nurses, ancillary and social workers, or a regular review clinic run by doctors and nurses only. In 57 day hospitals a regular case conference is held, in 25 a review clinic but not a case conference. In one hospital, which prefers to be called a 'day ward', a daily ward round is held in which the doctor, accompanied by nurses and ancillary workers, sees all the patients attending that day. In 33 of the day hospitals, two or all three of these methods are used for the regular review of patients.

CASE CONFERENCES

In geriatrics, as in other branches of medicine, case conferences are taking the place of ward rounds in certain situations and the survey shows them to be the most popular way of reviewing patients, being used in 63 per cent of the day hospitals. The doctor cannot assess the progress of patients undergoing rehabilitation unless he has information from the ancillary workers involved – especially the physiotherapist and occupational therapist. Social factors are inexorably bound up with rehabilitation in old age, and information from the social worker is needed in many cases. Such information is best given in person by the workers concerned and, since any data may have a valuable bearing on the patients' progress and future, all of them should be present when decisions are made. It is cumbersome and wearying for a group of five to ten people to move from patient to patient carrying their documents with them; the alternative of sitting round in a group has obvious advantages. The group will include the ward sister. Health visitors, general practitioners and other people concerned with domiciliary care of the patients may also attend. The case conference is an excellent medium for teaching and students of any of the disciplines represented should be included.

In some case conferences, patients are discussed but not seen – although the doctor may visit specific patients afterwards. In others, patients are first discussed and then each brought in to meet the group to discuss progress and the future and to demonstrate what has been achieved.

Since day hospital patients attend for varying numbers of days, the case conference may need to be held on different days in subsequent weeks, or on more than one day weekly.

Our findings were:

once weekly	30
more than once weekly	6
less than once weekly	18
no information given	3
total	57

The chair is taken by the consultant geriatrician in 50 cases, although in nine of these other staff may deputise for him from time to time. In four cases the medical assistant or senior registrar takes the chair, and in two, a nurse. One case conference is informal and has no chairman.

Regular attenders at case conferences in the 57 day hospitals include:

consultant geriatrician	57
other medical staff	48
physiotherapist	47
day hospital sister	44
medical social worker	43
occupational therapist	40
health visitor	15

The local authority welfare officer attends regularly in ten day hospitals, the speech therapist in four, and the home help organiser in one. No general practitioners attend case conferences regularly, but in 18 day hospitals they sometimes attend.

OLD PEOPLE'S WELFARE COMMITTEES

Geriatrics is one of the hospital medical specialties which extends its influence and involvement into the community. The care of old people concerns intimately the local authority and voluntary organisers as well as general practitioners and geriatricians. An effective link between the hospital service, the local authority, and the voluntary agencies is a *sine qua non* of a good geriatric service, and the existence of a day hospital makes this link even more necessary. For this reason, those geriatricians with day hospitals now in existence or planned to open by the end of 1970 (Groups A and B) were asked about their involvement in local old people's welfare committees (Table V). Surprisingly, in only a small majority of cases is someone, usually the consultant, from the geriatric department staff a member of this committee. In some cases more than one member of staff are members of the committee.

6 DISCUSSION

VARIETY OF DAY HOSPITALS

The survey findings emphasise the variety of hospitals and wards available to develop the geriatric services. This applies no less to day hospitals, which vary according to the different local needs and buildings and staff available. Nevertheless, just as in-patient geriatric departments provide a broadly similar service throughout the country, so do geriatric day hospitals.

Of the 90 existing day hospitals reviewed the great majority are in use five days a week, provide over 20 places a day and have a staff of nurses, physiotherapists and occupational therapists. Physical rehabilitation and physical maintenance are regarded as their most important functions – and the progress of patients is reviewed at case conferences chaired by the consultant geriatrician.

A few day hospitals differ considerably from this general pattern. One deals with eight patients brought every day from their homes to the hospital physiotherapy department – but physiotherapy, occupational therapy, group speech therapy, bathing and a meal are all provided. Another is the rehabilitation unit of a general hospital which takes up to ten patients a week. Again, all services, including physical therapy, medical investigation, nursing and social follow-up, are available: also, nursing is provided by a district nurse from the local authority. A few day hospitals consist of similarly small groups of patients coming to day rooms of hospitals and managed by the ward staff. One comprises three-quarters of a converted hospital chapel staffed by an occupational therapist, and accepting up to 25 patients daily. In one or two areas there are several small day hospitals linked with scattered in-patient units.

One day hospital, which the consultant prefers to call a 'day ward' or 'day space', accepts patients as emergencies from general practitioners. These patients may be brought up by ambulance and observed throughout the day before the decision is made to admit them or not at the end of the day.

Some consultants reluctantly accept social care as a major role for their day hospitals. They argue that, while they do not regard this as a proper function of a day hospital, if they do not provide such care, no one else will, and the end result will be the admission of more in-patients. To a small extent many day hospitals have some of these patients who require only social care.

AMBULANCES

The ambulance service is an essential part of day hospital provision.

In only five cases did most patients not come by ambulance. In a few of the questionnaires the consultants commented on ambulances. One mentioned the difficulties in congested city areas, and several gave transport problems as reasons why day hospitals would be difficult to establish in certain country areas. Only two consultants criticised the ambulance service, one saying that it is 'erratic, reluctant and often late (up to noon)', the other saying that ambulances get diverted to accidents.

There can be little doubt that to function efficiently a geriatric day hospital requires special ambulances and crews to be provided by the local authority. Eight or ten-seater vehicles with hydraulic lifts are needed, and, whatever other work they may be required to do, the journey to the day hospital should always be the first in the morning. Special crews are an advantage, for the work has its own particular character which does not appeal to all ambulance men. A sympathetic crew becomes an important part of the day hospital team, both in the understanding help that can be given to elderly disabled passengers, and also in reporting crises or mishaps that arise at home. Whether or not a patient gives up day hospital treatment in the first week or two may largely depend on the quality and understanding of the ambulance crew.

PRESCRIBING DRUGS

The question of prescribing drugs for day hospital patients was commented on by two consultants, one referring to occasional double prescribing. Policy about prescribing should be decided before the day hospital opens, in consultation with the local medical committee. There are advantages in drugs being prescribed only by the general practitioner – who, after all, remains in charge of the patient and may be called to see him at nights or weekends. Even so, the hospital medical staff can suggest to the general practitioner what drugs should be prescribed, and this can be a valuable point of contact between the doctors concerned.

If drugs are to be prescribed by the day hospital staff, the method used in one day hospital may be recommended. Two treatment cards are made out for each patient. One is left in his hospital notes, the other is sent home with him in a strong envelope, to be brought on each attendance. Any changes made by the general practitioner or hospital staff are noted on this card, and so each is aware of the drugs being given.

2 SURVEY OF FIVE DAY HOSPITALS

1 GENERAL FINDINGS

One difficulty in defining the place of day hospital care at the present time is the great variability in its content in different hospitals. The content depends on many factors – the availability of therapists and of welfare facilities in the area, the number of day places compared with the population, the interests of the geriatric department staff, especially the consultant in charge, and others. The best way of obtaining a profile of the work done in a geriatric day hospital is to analyse the types of patient attending and the treatment given over a limited period of time. The survey described here was undertaken for this purpose and also to encompass the variability between different day hospitals. It comprises a survey undertaken simultaneously in five day hospitals in the South East Metropolitan Region during the first week in November 1968.* Data were obtained for all patients who actually attended each of these day hospitals that week.

The general findings indicate correlations and also important differences in practice. Geriatric services are well developed in the region; geriatric departments number 16, each in charge of a consultant geriatrician. Nine have opened day hospitals in the past seven years, and others are planned. The five day hospitals here described are the longest established ones and serve a wide variety of areas.

Bromley	opened 1962 with 40 day places, serving an outer London urban community of 235,000
Margate	opened 1963 with 50 day places, serving a seaside town and rural population of 120,595
Dartford	opened 1964 with 30 day places, serving a Kent industrial borough population of 204,000
Hastings	opened 1965 with 30 day places, serving a seaside town and rural population of 150,000
Maidstone	opened 1967 with 35 day places, serving the county town of Kent, with a population of 125,000

Attendances in the week of the survey, shown in Table VI, make clear that the five day hospitals have enough places for their population and

* *Each day hospital is described by the consultant in charge, see Section 3.*

should have no need for waiting lists. According to the part played by the five day hospitals in the local geriatric service, an average of 37 places for 167,000 people (one place for 4,500) seems adequate. In fact, since the south-east of England has a higher number of pensioners in the population than the country in general – and since this survey included two seaside towns where the number of pensioners is double the national average – this figure probably errs on the generous side. The number of places required depends not only on the population served, but also on the type of work done by the day hospitals. This, in turn, may be influenced by the adequacy of provision of geriatric hospital beds and places in local authority homes, and by the provision of social day centres with adequate transport locally. These five departments are linked with an average of 9·4 geriatric hospital beds per 1,000 pensionable population, while the number of places in local authority welfare homes varies from 11 per 1,000 population over 65 in Bromley to 14 per 1,000 over 65 in Kent. Social day centres with adequate transport are available in only two of the five areas – Bromley and Dartford – and in neither of these are they sufficient to meet the need (interestingly enough, these two areas have the longest established day hospitals). Social day centres are now planned in the other areas. The presence of a day hospital uncovers the need for complementary social day centres – and probably stimulates their provision after an interval of a few years.

2 STAFF

Table VI also shows the average number of sessions worked by staff in post in the week of the survey and indicates the ratio of staff to the average number of patients attending daily in 1968. In some day hospitals, staff look after both day patients and in-patients. Figures in the table represent the proportion of staff actually dealing with day patients.

The types of staff used in the various day hospitals differ considerably. This is, in part, influenced by the consultant's policy when setting up the day hospital – and particularly whether it 'grows' out of the occupational therapy department, in which case it is managed by the occupational therapist, as has happened in several areas. Alternatively, occupational therapy, physiotherapy and nursing may all figure prominently in the work of the department. In this case, general administration and the responsibility for the arrival and departure of patients are likely to fall on the senior nurse. The more detailed descriptions of the five day hospitals in Section 3 show how these duties are shared among staff. In all cases, the consultant geriatrician is ultimately in administrative charge and all major policy decisions are his.

TABLE VI MEAN FIGURES FOR THE FIVE DAY HOSPITALS SHOWING PLACES, ATTENDANCE AND STAFFING*

	places available daily		37
	average daily attendance 1968		28
week of survey	average daily attendance	29·4	34
	average daily called for but did not come	4·6	

mean population served – 166,919

ancillary staff

(sessions per week)†			
	occupational therapist		15·2
	occupational therapy aide		16·8
	physiotherapist		7·8
	physiotherapy aide		9·4
	speech therapist		3
		total	52·2
ratio of ancillary staff sessions per week to average attendance of patients per day in 1968			1·9:1

nursing staff

(sessions per week)†			
	SRN		9·2
	SEN		5·6
	nursing auxiliary		18·4
	student, pupil or cadet		4·2
	voluntary helper		2·2
		total	39·6
ratio of nursing staff sessions per week to average attendance of patients per day in 1968			1·4:1
ratio of total ancillary and nursing staff sessions per week to average attendance of patients per day in 1968			3·3:1

medical staff

(hours per week)			
	consultant		2·6
	medical assistant or registrar		6·9
	senior house officer or house officer		0·4
		total	9·9

* *Figures for individual day hospitals are given in Appendix II.*
† *Whole-time service is equivalent to* 10 *sessions weekly.*

With these considerations in mind, a closer look at the staffing shows more occupational therapists than physiotherapists – on average twice as many. An important factor is the extent to which aides – unqualified assistants – are employed in occupational therapy, physiotherapy and nursing departments. One advantage of a day hospital is that it can attract staff because the hours of work are convenient. Aides working under the direction of trained staff – and thus gradually receiving in-service training – make a big contribution.

Speech therapists usually do a few sessions every week in each day hospital. Their work in the treatment of dysphasia due to stroke is now well established. Moreover, their role extends beyond the actual number of sessions worked since a good speech therapist in the rehabilitation team influences the attitude of all the other members of the team towards dysphasic patients.

The involvement of student and pupil nurses in the day hospital indicates the use of the day hospital in training.

The ratios of the average number of sessions per week of ancillary and nursing staff to that of patients attending daily gives a broad indication of staff levels. In these day hospitals, the ratio is 3·3:1 – that is, 3·3 sessions or 0·33 of a whole-time (ten sessions) worker to each patient attending daily. On this basis, a 30-place day hospital would have ten whole-time staff, including both nurses and ancillary workers. Chiropodists and dentists are not included in this figure.

Medical staffing figures show that the consultant geriatrician spends an average of 2·6 hours per week and other medical staff just over seven hours per week in the day hospital. There is, however, a wide variation between the individual day hospitals. The total number of hours spent weekly varies between seven and 14·5 (mean 9·9).

3 CHARACTERISTICS OF THE PATIENTS

The age, sex, civil state and social class of patients are shown in Table VII a, b and c. Of the 465 patients in the survey 143 (31 per cent) are men and 322 (69 per cent) women. There is a wide age spread from under 65 to 90 years; 18 per cent are under 65 years, comprising twice as many men as women. In general the women are older, 73 per cent are 70 years old or over compared with 57 per cent of the men.

These age trends are, of course, in keeping with those of the general population. The higher proportion of men under 65 is probably associated with the higher incidence of stroke in them. Younger men with stroke may well return home earlier to be cared for by their wives while continuing day hospital rehabilitation. Younger women with

TABLE VII PATIENTS ATTENDING FIVE DAY HOSPITALS

a age distribution (total number 465)

	0—64	65—69	70—74	75—79	80—84	85—90	90+
men	27	16	20	15	18	3	1
women	14	13	16	23	20	11	3
total	18	14	17	20	20	9	2

b civil state (total number 465)

	married	single	widowed	divorced or separated
men	71	5	22	2
women	28	16	55	1
total	40	13	45	2

c social class (total number 458; 7 unclassified)

	1	2	3	4	5
men	8	19	18	42	13
women	3	12	29	40	16
total	5	14	25	41	15

TABLE VIII MOVEMENT TO AREA ON RETIREMENT COMPARED WITH SOCIAL CLASS

social class	men	women	total numbers
1	6 (55)*	4 (36)	22
2	14 (52)	18 (46)	66
3	6 (23)	28 (32)	115
4	12 (20)	16 (13)	186
5	1 (6)	6 (12)	69
			458
			(7 unclassified)

* *Figures in brackets are percentages of each social class in the area.*

stroke, on the other hand, cannot do this so easily since more are unmarried or widowed, or have husbands who go out to work.

Of the men, 71 per cent are married compared with 28 per cent of the women (Table VII b). Direct comparison with the Registrar General's figures is not possible since the figures here include some patients below 65 years. Nevertheless, there is little difference since in 1961 he showed that of those aged 65 and over who were married, 70 per cent were men and 34 per cent were women. The same limitation in comparison with his figures applies in considering social class (Table VII c).

All patients were asked if they came to the area to retire, and 23 per cent answered that they had. Among the five areas the figures were distributed thus:

Bromley	27 per cent
Dartford	13 per cent
Hastings	32 per cent
Margate	31 per cent
Maidstone	11 per cent

and show the expected high proportion in the two seaside towns and that Bromley, a pleasant suburban area, had been chosen by a large number. The proportions for all the areas seem high but no doubt all include some people who move to a different area on retirement to be with or near their families. Over half of the men in social classes 1 and 2 have retired to the area and the proportion declines progressively in the other social classes. The highest proportion of women coming to the area on retirement is drawn from social class 2 (46 per cent). The comparison is shown in Table VIII.

Mileage travelled to the day hospital is as follows:

distance in miles	percentage of patients
0–1	11
2–5	69
5–10	19
10+	1

There is no notable difference between the areas; 20 per cent of the patients travel over five miles, though the time spent in transport is prolonged more by the slowness in picking up individual patients than by the distance travelled.

TABLE IX DOMICILE OF PATIENTS

	alone	relative, same generation	relative, two generations	relative, three generations	non-relative	residential home	nursing home
men	8	68	12	4	2	5	1
women	34	26	21	3	4	7	5
total	26	39	18	3	3	7	4

total number 465

TABLE X PATIENTS' CONTACTS AT HOME (at least once weekly) WHEN NOT ATTENDING DAY HOSPITAL

	nobody	relative or friend	social or voluntary worker or home help
men	27	65	8
women	26	58	16
total	26	61	13

total number 465

TABLE XI INCIDENCE OF URINARY INCONTINENCE

	none	at day hospital	only at home	wears appliance*	catheter in
men	81	4	5	8	2
women	92	2	4	1	1
total	89	3	4	3	1

total number 465

* *4 catheters, 15 other appliances.*

4 SOCIAL CONDITIONS

As would be expected, more of the women (34 per cent) live alone and more of the men (68 per cent) with their wives (Table IX). Eighteen per cent live in two-generation households and three per cent in three-generation households. There are few available figures of the general population to compare these with. Townsend's survey[16] of old people in Bethnal Green shows 31 to 33 per cent in two-generation and ten to 14 per cent in three-generation households, suggesting that day hospital patients are much more isolated from their families than other old people are.

Comparing domicile with civil state the survey shows that married men and women have similar domiciles, 86 per cent with spouse only and nine per cent in two-generation households. Almost the same proportion of widows and widowers also live with their children (36 per cent and 42 per cent, respectively) but 45 per cent of the widows live alone, and nine per cent in residential homes, compared with 26 per cent and 23 per cent, respectively, in the case of widowers.

Forty per cent of the women and 16 per cent of the men are alone all day. Study of the home contacts of the patients on the days they are not attending the day hospital show similar findings for both sexes except that more of the women see only a home help – because more of them live alone (Table X). Twice as many men in social class 1 are without contacts than in all other social classes – though the total is small (11 men in social class 1, six of whom have no visitors except at the day hospital).

Clubs or social day centres are attended by 18 per cent of the men and 15 per cent of the women, unmarried women being proportionally the highest club attenders – perhaps a carry-over from younger days. Slightly more of the women are alone all day when not at the day hospital. It is surprising that about one in six of those attending day hospitals are also attending clubs or day centres, most of these being physically independent patients. Although the total number of wheel-chair patients is small, an excess of them are also club attenders. Presumably they are younger chronic sick patients striving for as much social contact as they can get.

TABLE XII SOURCES OF REFERRAL

	out-patient			in-patient		
	geriatric out-patient consultative clinic	domiciliary or assessment visit	direct	geriatric ward	medical ward	other wards
men	27	8	16	34	9	6
women	29	14	17	29	7	4
total	29	13	17	32	7	2

total number 465

TABLE XIII DIAGNOSTIC GROUPS

	arthritis	dementia	depression	fractured femur	stroke	Parkinsonism	cerebral arteriosclerosis	other CNS	incontinence only	other disease
men	15	1	1	4	40	9	6	8	1	15
women	31	3	5	4	25	7	4	7	1	13
total	26	2	4	4	30	7	4	8	1	14

total number 465

5 PHYSICAL STATE

The degree of independence is similar in both sexes:

walks alone	23 per cent
walks with walking aid	58 per cent
walks with human assistance	6 per cent
wheelchair – independent	5 per cent
wheelchair – not independent	8 per cent

Most patients, then, are independent, though they need to use walking aids. Nevertheless, 13 per cent have to use wheelchairs, indicating the need for adequate space in the building. Two notable differences were the high proportion of independent patients in Dartford (61 per cent) and of wheelchair cases in Hastings. The proportion of men who were in wheelchairs and not independent was three times as high as that of women: also, most of them (12 out of 17) lived with their spouses – a high figure compared with the women (4 out of 18). Five of these 12 also attended a social day centre. Presumably the attendances of this small group of men were mainly to allow their wives as much respite as possible.

The incidence of urinary incontinence is shown in Table XI. A comparison of the reasons for attendance of the 52 incontinent patients with all other patients shows no difference (incontinent patients – 26 per cent rehabilitation, 46 per cent maintenance and 26 per cent social: for the whole series, v. infra). However, there are minor differences since, of the 13 incontinent patients attending for rehabilitation, only two are incontinent at the day hospital; of the 23 incontinent patients attending for physical maintenance, only two are incontinent at the day hospital; and of the 13 incontinent patients attending for social reasons, eight are incontinent at the day hospital. Thus, most of those with intractable incontinence by day and night attend for social reasons, probably because of the incontinence (nevertheless, they form under two per cent of all the day hospital patients).

6 SOURCES OF REFERRAL

The sources of referral of all patients are shown in Table XII. Most of those who have not been in-patients were referred from the geriatric out-patient consultative clinic held, in some cases, in the day hospital and in others in the normal out-patient department of the hospital (see Section 3). There is considerable variation between hospitals in the sources of referral. In Bromley and Dartford – areas of general similarity – over a quarter are referred from domiciliary or assessment visits, while in Hastings and Maidstone the proportion is less than five per cent.

TABLE XIV REASONS FOR ATTENDANCE

a general

	rehabilitation	physical maintenance	social reasons	other
men	33	44	19	4
women	25	40	29	6
total	27	42	26	5

total number 465

b compared with number of times per week attending

	once	twice	3—5 times
rehabilitation	40	34	26
maintenance	56	32	12
social	76	18	6

c correlated with duration of attendance

	0—3 months	3—12 months	over 12 months	total numbers
rehabilitation	45	35	20	126
maintenance	26	35	39	193
social	14	34	52	129
				448*

* *17 attended for other reasons.*

7 DIAGNOSES

The diagnostic groups shown in Table XIII comprise the principal diagnoses. Geriatric patients, of course, suffer from multiple ailments and their disability often results from more than one pathological process. These groups may be further amalgamated to bring out the main categories of disability dealt with, as follows:

arthritis or fractured femur	30 per cent
stroke	30 per cent
cerebral arteriosclerosis, dementia, Parkinsonism, other diseases of the central nervous system	22 per cent
depression	4 per cent
other disease	14 per cent

There are several interesting variations in the incidence of different diagnoses among the individual hospitals. Bromley and Hastings both have a large proportion of stroke patients (45 and 39 per cent, respectively); Dartford has 12 of the 19 patients suffering from depression, because of a close psychogeriatric link in that hospital; and Margate has 68 of the 122 patients with arthritis, again because of a close link with the physical medicine department.

8 REASONS FOR FREQUENCY AND DURATION OF ATTENDANCE

The diagnosis itself is not necessarily the reason for the patient's attendance. For instance, a patient with stroke may be coming for rehabilitation, for physical maintenance having completed his rehabilitation, for social reasons because his wife has to work and he is unfit to be left alone, for medical supervision of hypertension, or for nursing supervision of faecal incontinence. In fact, the three principal reasons for attendance are the first three given above. Only five per cent of all the patients come for any other reason – two per cent for treatment of depression, four per cent for nursing or medical supervision, speech therapy only, or occupational therapy assessment. Table XIVa shows the distribution of the principal reasons for attendance. The reason for attendance and frequency of attendance are compared in Table XIVb. Trends are as might be expected – patients coming for rehabilitation are the most frequent attenders, and those for social reasons, the least.

Moreover, few of the latter group come more than once weekly (only four of these 119 patients come five days weekly). In general, they are not coming to allow relatives to go out to work, but rather to give them a break one day a week. Again, 28 per cent of those coming for social

reasons live alone and 15 per cent in a residential home or nursing home. Thus, attendance for 'social reasons' is as much to combat the patient's social isolation as to ease the burden of the relatives.

The proportion attending for social reasons is highest in the two seaside towns (Margate 33 per cent and Hastings 43 per cent) compared with ten per cent for the other areas. Most of those attending for rehabilitation live with their spouses (56 per cent). This indicates that they can be discharged from hospital at an early stage to continue their physical therapy as day patients. Finally, the mileage travelled shows no correlation with the reason for attendance.

FREQUENCY

The numbers of times the patients attend weekly are:

once	57 per cent	
twice	28 per cent	
three times	10 per cent	
four times	2 per cent	5 per cent
five times	3 per cent	

There are several local differences – for instance, Bromley has ten per cent of patients attending four or five days weekly whereas Margate has only one patient attending more than twice weekly, and Hastings has none attending more than three times weekly.

There is no association between the frequency of attendance and the patient being alone all day, or the diagnostic group.

DURATION

The lengths of time during which patients have been attending are:

0–1 month	15 per cent
1–3 months	15 per cent
3–6 months	17 per cent
6–12 months	15 per cent
over 12 months	38 per cent

– with equal distribution between the sexes.

Again, individual hospitals vary considerably. In Dartford, 84 per cent attend up to three months, and only one patient longer than six months. In Margate and Hastings, 51 per cent and 59 per cent, respectively, have attended for over a year. Undoubtedly, these differences relate to the existence of social day centres in Dartford but not in the seaside towns. Moreover, the latter have a more rootless population and so the need for social attendance might be expected to be greater.

This is in keeping with the low frequency of attendance in these towns. Nevertheless, there is no excess of patients living alone, and more of the men live with their wives in these towns than in the other areas. Again, fewer of the patients are alone all day when not at the day hospital in these towns than in the other areas.

A comparison of the duration of attendance with the reasons for attendance shows, as might be expected, that those coming for social reasons attend the longest (Table XIVc).

9 TREATMENT PROVIDED

PHYSIOTHERAPY

During the week of the survey patients had the following types of physiotherapy:

individual	physical 47	61 per cent
	electrical 3	
	both physical and electrical 11	
	group physiotherapy	24 per cent
	none	15 per cent

The 61 per cent receiving individual physiotherapy includes 63 per cent of patients attending for rehabilitation, 53 per cent for maintenance, and 24 per cent for social reasons.

OCCUPATIONAL THERAPY

Ninety-eight per cent of the patients had occupational therapy:

individual rehabilitation	30 per cent
individual diversional	29 per cent
groups	39 per cent

in addition, 13 per cent had an occupational therapist's assessment or reassessment.

OTHER TREATMENT

Eight per cent had speech therapy, 25 per cent chiropody (varying from 7 to 40 per cent), 28 per cent had a bath, and a few had dental treatment. Special nursing treatment was given to 24 per cent of the patients – the most common procedures being injections, dressings, urine testing, recording blood pressure, eye bathing and surveillance of diet. A doctor examined 20 per cent during the week.

10 DISCUSSION

The five day hospitals are a microcosm of geriatric day hospitals, reflecting their variety. Two are purpose-built, two are conversions of existing hospital buildings and one has elements of both. Only one, Westbrook Day Hospital, Margate, is entirely separate from in-patient services; it is five miles from the nearest geriatric hospital. In all the others some mixing of in-patients and out-patients occurs in the day hospital, varying from half-and-half in Bromley, all of them being geriatric patients, to a combination of geriatric, medical and orthopaedic in-patients in Maidstone.

In the two seaside towns, the emphasis is very much on social care. This seems to result from the lack of suitable local day centres rather than from any difference in the condition of the patients themselves, since in these towns there is no excess of patients living alone, or being alone during the day. Margate has a system of periodic reattendance and patients are 'rested' between courses of attendance. When the day hospital attempts to deal adequately with social cases demand for more places increases. Hastings Day Hospital stresses a positive social and preventive role. Both Hastings and Maidstone have developed the 'club' aspect of day care, arranging visits to the local shops and occasional bus trips. At Hastings, the importance of the appearance and morale of the patients is emphasised, and bathing and hairdressing are available to everyone. This policy seems to diminish subsequent long-stay hospital admissions, since only three of all day patients admitted to hospital during three years remain as long-stay patients for over a year. This may be contrasted with Nisbet's findings[13], that a third of the women admitted as long-term patients were still occupying hospital beds three years after.

Apart from social care another important function is the rehabilitation of patients with stroke. Medical and nursing procedures were the principal reasons for attendance of only four per cent of the patients, and the most common reason for attendance of 42 per cent was maintenance of physical independence. Nearly all geriatricians agree that physical maintenance and physical rehabilitation are important day hospital commitments. There are those who argue that social care is no responsibility of the hospital service. On the other hand, if social care is not adequately provided by other agencies, breakdown will occur earlier and in the end hospital beds will be occupied for longer periods. The provision of social care may be seen as an extension of the geriatric hospital service into community and preventive medicine.

Since almost one-sixth of the day patients use wheelchairs, clearly adequate space is an important prerequisite of the day hospital. These

patients include the very disabled social cases – those needing nursing attention during the day, who would therefore not fit into social day centres. Others are learning to live in their wheelchairs. It is important to provide plenty of lavatories suitable for independent use by patients in wheelchairs or using walking aids.

Very few patients attend for assessment or supervision of incontinence. The number of those attending primarily for other reasons who are also incontinent is greater than those attending for incontinence itself. Most patients who are incontinent while at the day hospital are attending for social reasons, a fact that would also make them unacceptable in social day centres.

Only four enemata were given during the week, less than one per day hospital. This contrasts with the policy in Liverpool, where there is an 'enema room' in the day hospital, and some patients attend simply for control of faecal incontinence. Since enemata figure largely in geriatric practice it follows that many patients in the areas surveyed must be receiving enemata from district nurses. Bathing, on the other hand – another service performed by district nurses – is undertaken in these day hospitals for 28 per cent of the patients – an average of 26 baths per day hospital each week.

The day hospitals also vary in the extent to which other activities take place in the same building. At Dartford, both geriatric and psycho-geriatric out-patient consultative clinics are held in the day hospital, and at Margate the variety is even greater – geriatric, physical medicine, orthopaedic and rheumatism out-patient clinics all being held in the day hospital.

The suggested provision of day hospital places of 1 to 4,500 total population served is lower than Pathy's[14] figure of 1 to 3,000. These day hospitals illustrate the variety of staff needed. Nurses, occupational therapists, physiotherapists and speech therapists are required together for a total of at least 3·3 sessions weekly for every patient attending per day, that is, 99 sessions for a day hospital with 30 patients each day – equivalent to ten whole-time workers. The proportion of different types of staff varies a good deal, depending on the function and history of each day hospital. In general, four ancillary workers to three nurses of all grades, including aides, is the mean.

3 DESCRIPTIONS OF THE FIVE DAY HOSPITALS

The geriatricians in charge have contributed descriptions of their day hospitals.

LENNARD DAY HOSPITAL, BROMLEY	**J C Brocklehurst**
DAY HOSPITAL AT JOYCE GREEN HOSPITAL, DARTFORD	**W E R Budd**
WESTBROOK DAY HOSPITAL, MARGATE	**J G Pritchard**
LINTON DAY HOSPITAL, MAIDSTONE	**R O F Hardwick**
HASTINGS DAY HOSPITAL	**R E Irvine and C W J Ussher**

1 LENNARD DAY HOSPITAL, BROMLEY
Bromley Group Hospital Management Committee

Opened in 1962, the Lennard Day Hospital, Bromley, is partly purpose-built and partly an old fever hospital ward block. The new part forms three sides of a square, the old block the fourth, with a courtyard and garden, including a small pond and a waterfall in the centre. A glass-walled corridor surrounds three sides of the garden and is wide enough for two wheelchairs to pass. It is a favourite place for patients to sit and enjoy the garden and chat to passers-by.

The physiotherapy department is a single gymnasium, bright and well equipped. Occupational therapy is spread over three smaller rooms, one being the ADL room (aids to daily living). It would be better if these three rooms were joined. The room for the speech therapist is also used by patients in 'relaxators' for treatment of postural oedema.

Patients meet their visitors in a carpeted lounge, which has a large mural painting along one wall. The lounge, with a lending library for in-patients and out-patients, is generally used for one or other of the occupational therapy group sessions in the afternoons, as well as for case conferences. There are one consulting room and two examination rooms,

with equipment for electrocardiography and various other diagnostic procedures. The day hospital has no x-ray department or pathology laboratory and the assessment wards and out-patient consultative clinic of the Bromley and Sidcup geriatric service are in the large district general hospital at Farnborough about one and a half miles away. The remaining accommodation in the day hospital includes bathroom, lavatories, offices and a dining room which can seat 36 people at a time.

The day hospital includes the rehabilitation unit for the entire Bromley and Sidcup geriatric service. In-patients are transferred from the unit's assessment wards at Farnborough Hospital for active rehabilitation. In-patients and out-patients work together. There are up to 40 places for day patients and, since two sittings of meals allow 72 patients to have lunch, the total complement is fixed at that figure. This allows 32 to 36 in-patients to be accommodated. They come over from the wards at 9 00 am and stay until they have had their tea at 3 30 pm.

The advantages of combining in-patients with day patients are considerable. It is good for the in-patients to get away from the wards during the day and mix with other people coming from home. It allows an easy transition from the in-patient to the out-patient stage at the time of discharge. The patient knows that he will be treated in the same place by the same therapist when he goes home. This continuity is very important for both patients and staff. Often so much team work and preparation are needed before patients can actually go home – frequently including visits to the house by therapists and social workers, sometimes with the patient. To lose the effect of this continuity of relationships when the patient finally goes home – a time when it is most needed – would be unfortunate.

Day patients arrive in four ten-seater ambulances of the Greater London Council ambulance service, each of which has a hydraulic tail lift. This is the first journey of the day for these four ambulances, which are not diverted for emergencies for which, anyway, they are unsuitable. Immediately on arrival, patients go to the dining room, take off their outdoor clothes and have a cup of tea. Receiving patients, serving meals and taking patients to the appropriate therapy department are the responsibility of the nursing sister and her staff. She also arranges schedules of daily attendances which she passes on to a clerk who notifies all concerned, including the ambulance service. She is responsible for all nursing treatment, bathing, supervision of drugs, organisation of clinics and helping the doctors and dentist.

After tea, patients are taken to the various therapists. Mornings tend to be taken up with individual treatments, and afternoons with group treatment. Speech therapy groups for dysphasic patients are cooperate

ventures with both speech therapists and occupational therapists. Occupational therapy groups include some for physical movements and others for mental stimulation or group involvement of depressed or withdrawn patients.

Both pupil and student nurses spend part of their training in the day hospital, and thereby obtain a balanced view of hospital geriatric practice. Unqualified aides take part in the work of all departments and have much to contribute.

All day patients are seen by the geriatric registrar on the first day they attend. He records their history and examines them, or summarises the findings and conclusions reached from previous medical investigations, and requests initial therapy. The geriatric registrar, who attends every day, also sees patients needing continuing medical supervision, and any who may be unwell. He maintains contact with general practitioners – for in some ways his work overlaps theirs. Though occasionally drugs needed for therapeutic trial are ordered from the hospital pharmacy (for one week only), prescribing generally remains the province of the general practitioner, to whom suggestions are made if the hospital medical staff think they are appropriate. The consultant geriatrician holds one clinic a week, when patients attending on that day are reviewed. The clinic is run as a case conference with registrar and departmental heads, sister and medical social worker, when treatments are reviewed and social problems discussed. The aim is to diminish attendance, and finally to discharge patients, whenever feasible.

The primary aims of the day hospital are physical rehabilitation and maintenance. Forty-five per cent of the patients suffer from stroke. The geriatric rehabilitation department and day hospital offer the chief facilities in the area for the rehabilitation of this condition, and tend to receive the most difficult cases.

The neighbourhood has three social day centres with their own transport, and more are planned. Their use is limited largely by insufficient transport, and at present not everyone who would be suitable can be transferred to a social day centre. Some have to be discharged without the immediate opportunity of such continuing care; others leaving the day hospital do not appreciate the facilities offered by day centres, sometimes finding a degree of inertia which they compare unfavourably with the activity of the day hospital. This is particularly so when they have been taken as day-guests at local residential homes. No doubt a busy programme of activities in social day centres is needed. A day centre recently started in the area, for elderly confused patients, should help to deal with several different problems.

2 DAY HOSPITAL AT JOYCE GREEN HOSPITAL, DARTFORD

Dartford Hospital Management Committee and Medway and Gravesend Hospital Management Committee

The geriatric day hospital at Joyce Green, once a fever hospital, opened on 3 May 1965. It was formed by modifying the ground floor of one of the ward blocks which measures 160 ft × 29 ft overall. The existing dividing partition was retained, and at the end nearer the main entrance a small suite of offices was provided. The day hospital contains the headquarters of the geriatric service for the Dartford group of hospitals and the western end of the Medway and Gravesend group of hospitals. Office accommodation has been provided for the nurse-in-charge of the geriatric nursing staff at Joyce Green Hospital, where there are 164 geriatric beds, for the social worker and her assistant, and for the clerk who arranges patients' transport. The consultant and his secretary each have an office on the floor above, where there is a 20-bed psycho-geriatric ward for men. Two consulting rooms and a treatment room are provided, and the former ward kitchen is adapted as a servery. There is no space for a dining room, so patients sit at card tables for their midday meal. The card tables are stacked in a corner afterwards.

Physiotherapists work in the first main space. There are parallel bars permanently in position; also an electric hoist, in which a heavy patient can be hoisted to his feet supported in a sling somewhat like a breeches buoy and, supported by the hoist, can walk the length of the department. The motor of the hoist follows him, running in a track secured to the ceiling. This piece of apparatus has not proved as useful as we had hoped.

The occupational therapy department has the customary apparatus for remedial and craft work and also a model bathroom, lavatory and kitchen where patients can be assessed and trained in the activities of daily living. There is another bathroom with a special invalid bath, a lavatory and shower-bath. The provision of more sanitary rooms is a pressing necessity. We have only four lavatories for up to 50 patients.

The day hospital staff consists of a sister-in-charge, three auxiliary nurses (two women and one man), physiotherapists (one and a half whole-time equivalent, with one whole-time helper), occupational therapists (one and a half whole-time equivalent, with one whole-time helper). Nursing cadets from the Dartford school of nursing also work

in the day hospital.

We had hoped to accommodate 40 patients per day, but experience showed that we did not have room for so many, and the average daily attendance is nearer 20. The day hospital is close to the geriatric wards and in-patients from the rehabilitation wards attend for one to two hours, half a day or a full day. The number of patients about the day hospital at any one time is thus around 35.

A somewhat ruthless policy of discharging patients as soon as useful therapy is completed has been the rule since the day hospital opened. We are fortunate in having several social day centres run by the old people's welfare committees in our area to which we can refer some of our patients on discharge. A return to isolation and inactivity is thus avoided, but despite this we find some patients no longer requiring active therapy who, if not attending the day hospital once a week, put themselves to bed at once on return home. Sometimes they have to be admitted as in-patients, later to be mobilised. We have, therefore, to keep this group of perhaps 20 patients attending at least once a week. They tend to get in the way of patients undergoing active therapy, and additional space where they can be accommodated and kept occupied is badly needed.

By arrangement with the ambulance services of the GLC and Kent County Council, we do not bring day patients from a greater distance than 12 miles except in very unusual circumstances. A geriatric out-patient clinic is held once a week in the day hospital, and a psycho-geriatric clinic, at which the consultant psychiatrist and geriatrician see patients together, is held once a fortnight. Its work is increasing. Because of it, however, there are always depressed and mildly demented patients about who tend to get in the way of the others and who may wander off. On the other hand, we have found that mixing with other patients and taking part in simple group activities have improved the behaviour of many of our elderly patients suffering from organic dementia to the point where they are reaccepted in their family circles. Thus, their admission for custodial care has been prevented, or at least postponed. These patients account for the high percentage of physically independent persons attending our day hospital.

It is very easy for an individual patient to be overlooked and to continue attending week after week quite happily, long after his or her therapeutic needs have been met. To avoid this, regular case conferences are held on all the day patients currently attending and, where appropriate, the patient's relatives are invited to join.

3 WESTBROOK DAY HOSPITAL, MARGATE
Isle of Thanet Hospital Management Committee

Westbrook Day Hospital was opened on 1 October 1963 after adaptations to the building and considerable re-equipping. The hospital is administratively linked to Hill House Hospital, Minster-in-Thanet, and functions as the administrative centre of the Isle of Thanet geriatric service, controlling admissions to the acute unit in Ramsgate Wing of the Isle of Thanet District Hospital (eight beds, shortly to be increased to 23), Hill House Hospital (190 rehabilitation and long-stay beds) and Haine Hospital (26 beds). The day hospital, however, is physically quite separate from these geriatric hospitals, each of which is about five miles away. An out-patient clinic will be opened shortly at the Margate Wing, Isle of Thanet District Hospital. The main clinics at present are held at the day hospital and comprise the main admission and review clinic (all day Wednesday), a joint clinic held with the consultant in physical medicine (monthly on Wednesday), a rheumatic clinic on Thursday and an orthopaedic-geriatric clinic linked with the consultant orthopaedic surgeon of the Royal Sea Bathing Hospital, Margate, on Friday. Rounds are conducted daily by visiting general practitioners.

The population served is indeterminate owing to the massive seasonal fluctuation but on 1 April 1968 was 120,595, of which 25,619 (21·2 per cent) were over 65 years of age. Westbrook Day Hospital has 50 places daily, Monday to Friday, and since we have found that six to eight patients are normally absent, 54 to 58 are called. Over the last five years attendance has averaged 47 to 48 per day. The figures fall in exceptionally bad weather and also before and after Christmas and at other Bank Holidays. A complete list of patients who will attend is distributed to all heads of departments. Coordination is achieved, clinically and administratively, by a regular staff meeting on Wednesday and by the deputy hospital secretary of Hill House Hospital and Westbrook Day Hospital also acting as the geriatric admissions officer. The medical social worker and the consultant's medical secretary are based at the day hospital.

Services comprise physiotherapy, occupational therapy (including assessment of daily living and home adaptation service as well as a craft department which offers remedial wood and metal work), speech therapy (about 18 cases a day), chiropody on two days per week (about 24 cases a week), hairdressing on one day per week (about 14 hair-cuts and two shaves). Wheelchairs, electric hoists and other appliances are prescribed and the splint maker attends regularly. There is a laundry service including spin dryer, electric drying cabinet and ironing.

All patients discharged from beds in the geriatric department are also followed up at Westbrook. We are also developing links with the Churchill Day Centre and the psychiatric day hospital at Princess Mary's Rehabilitation Hospital, both of which are at Margate.

The work demands considerable nursing time and the establishment is: assistant matron, sister, staff nurse, SEN, nursing auxiliaries (four women and one man) and two cadet nurses. The nurses work an 84-hour fortnight, covering the hospital from 8 00 am to 6 00 pm, Monday to Friday, and also 8 00 am to 11 30 am on Saturday when the day hospital is open for administrative purposes but no patients attend. All routine nursing work, investigations and treatments are available.

Westbrook has a crêche for children between one and five years of age of the staff of this and other hospitals. This enables many women with children to continue nursing and medical work.

Currently, 216 patients are attending once, twice and three times a week. Demand is beginning to exceed capacity and we have put forward plans for an extension to enable 75 patients to attend daily.

Because of the excessive numbers a new mode of patient care was developed, similar to de Largy's 'six weeks in – six weeks out' scheme for in-patients.[11] Patients are 'rested' from attendance when they have reached a peak, but some responsibility is still held by the hospital for their care. Even so, by this method saturation point was reached in 1966, and subsequently fewer cases could be accepted. It is now necessary to have a strict discharge policy. The total patient complement passing through Westbrook Day Hospital has been 1,037, with an average of about 14,000 attendances every year.

Actual attendances have decreased, whereas the number of attendances arranged is fairly stable, because heavier cases are now being taken at an earlier stage of treatment and thus there is some absenteeism due to illness. This has prevented many from attending who would have benefited from the social contact, particularly as retirement to this part of Kent often separates the aged from their children. Nevertheless, an active therapeutic approach is the correct policy for Westbrook Day Hospital. The statutory and voluntary agencies must develop day centres and clubs in the area to cope with the demands of healthy, but socially isolated, elderly persons.

4 LINTON DAY HOSPITAL, MAIDSTONE
Central Kent Hospital Management Committee

This unit, opened in 1967, is in the precincts of Linton Hospital, which is mainly geriatric (292 beds) but also contains some 18 medical and 36 orthopaedic beds. The day hospital is next to the physiotherapy department and the two run together, providing day hospital care for the elderly and rehabilitation for orthopaedic and medical patients. An out-patient physiotherapy service is provided by the same unit.

Throughout, the accent is on active therapy and rehabilitation. Inevitably a fair amount of maintenance therapy is required for the older patients, who attend usually once or twice a week for supportive therapy to enable them to continue at home. Some patients also come up once or twice weekly to give their relatives some relief from continual care. One patient attends daily to enable her husband to continue in his job. Some of these social cases could be discharged if there were suitable day centres in the town.

The consultant physician attends on three days a week, on one of these running a consultative out-patient clinic from the day hospital. A clinical assistant attends daily. Overall administration is the responsibility of the sister-in-charge in close collaboration with the chief occupational therapist and superintendent physiotherapist.

Apart from day hospital patients the unit is used by the occupational therapists to assess old people living alone, especially how they perform the daily tasks of living and manage in the kitchen. In-patients from the assessment and long-stay wards attend for the final stages of their rehabilitation before discharge. The step from the 'hotel' life of an in-patient to life at home is eased by frequent day hospital attendances immediately after discharge which can often be cut down quite quickly in the weeks that follow. The most useful facilities offered, apart from direct therapy, are bathing, chiropody, a personal laundry service and hairdressing. The cost per patient per day for the year ending 31 March 1968 was £2 9s 2d (£2.46).

One factor leading to breakdown of old people at home is their gradual withdrawal from society. The day hospital staff makes continual effort to encourage them to re-enter society by, for example, supervising shopping expeditions in the local village high street and the use of public transport. An occasional outing is also laid on. Our aim throughout is to treat and improve patients' disabilities as far as possible, then to teach them to live with their remaining disabilities and to become able to maintain independence outside.

5 HASTINGS DAY HOSPITAL
Hastings Group Hospital Management Committee

A day hospital for the Hastings geriatric unit was opened in 1965, modelled on Cosin's pioneer unit at Oxford[4], with its emphasis on occupational therapy and rehabilitation. Our unit, like his, grew out of an occupational therapy department which had been taking a few patients for day care for about a year before the day hospital opened.

Hastings is a popular area for retirement. People over 65 make up 25 per cent of the population, twice the national average. The disproportion of those over 75 is even more marked. Indeed, Hastings has more people over 75 than Dartford has people over 65. Our geriatric problem is exceptionally severe. As the survey shows, Hastings Day Hospital has more patients dependent on wheelchairs than the other day hospitals. Our aim is to support the patient in the community and we concentrate particularly on short-term rehabilitation. Nevertheless, these patients are a comparatively small proportion of those who come to the day hospital in any one week. Many more come for maintenance and for purely social reasons. The last reason is an indication of the need, at present not catered for, for a day centre run by the local authority. Were day care not available many of these people would need in-patient or residential care, probably for long periods.

We have found that the greatest value of the day hospital is its contribution to morale – of the patients, the relatives and, indeed, of the hospital itself. The occupational therapists enable even the frailest old person to do something useful, for example, light industrial work, counting and packing screws. This can be done in the 'heat box' to help mobilise painful fingers. Patients who are dim or confused are encouraged to cut up foam for stuffing toys or cushions. A special effort is made to welcome new patients and to integrate them into the group. One of the best ways to achieve this is when one patient finds that he can do something useful for another, even if it is only pushing round the tea trolley.

Pride in appearance is a sign of self-respect easily lost in old age. We think it important to give every patient the chance of a bath, a hair-do and a manicure. Our launderette, originally installed to deal with the problem of incontinence, has proved to have a more important use in that patients can do their personal laundry. Shopping expeditions, outings and coach trips give an opportunity to get back into society and to sustain morale and self-respect. The value of such activities lies as much in the planning and preparation, and the discussion afterwards, as in the events themselves.

Hastings has the highest occupational therapy staffing of any day hospital in the region, and we could not work without them. On the other hand, we manage with fewer nurses. Our two SENs do not wear uniform. We want to create as homely an atmosphere as possible.

We hold one clinic a week to assess new patients referred for day care, to review with the occupational therapists the progress of those currently attending, and to decide who can be discharged. At present the clinic is held in the out-patient department at considerable inconvenience. However, the extension to be built will enable us to conduct all the activities of the day hospital in one building.

We do no regular rounds, feeling it important not to usurp the role of the patient's own general practitioner. However, our offices and the headquarters of the geriatric unit itself are in the day hospital building and this makes communication with the occupational therapists and nurses easier to maintain.

In four years over 500 new patients have passed through the day hospital. About a quarter of these have died or been admitted to the wards. Of the latter, only three patients have needed in-patient care for twelve months or more. That so few patients have needed long-stay care in hospital is probably the most outstanding benefit accruing to the hospital service from its investment in the day hospital.

4 SIX YEAR SURVEY OF LENNARD DAY HOSPITAL

The survey reviews all patients who attended in the years 1963–8 inclusive. The information has been obtained by retrospective search of case records, each of which includes day hospital attendances in addition to basic data of age, sex and address, showing the date of first attendance and number of times weekly at first attendance, the dates on which frequency of attendance has been altered, the date of discharge, the occurrence of improvement or deterioration, and similar information about subsequent day hospital attendances.

Altogether 965 different patients attended during the six-year period and 17 per cent of these (159 patients) re-attended for second, third or subsequent periods of treatment during that time. The mean annual attendance was 252 different patients.

Most of the detailed information discussed in this section relates to the patients' first period of attendance. It does not necessarily follow that findings in a first period will be similar to those in subsequent periods, when pathology may well have become more complex, and social circumstances more difficult. A smaller survey of the second period of attendance of the 159 reattenders has, therefore, been added. No detailed information about third or subsequent attendances (32 patients) has been obtained, other than the eventual outcome by the end of the six-year period.

Over two-thirds of the patients are women. The age-spread of the 965 patients and the proportion of men and women in each age group is shown in Table XV-a. It will be noted that the proportion of men to women becomes lower as age advances. Men figure prominently in the lower age group – 41 per cent of those under 60 and 43 per cent of those 60 to 69, compared with 31 per cent of the whole series. These figures are compared in Table XV-b with the pensionable population of England and Wales (Registrar General's figures for 1966) and 100 patients consecutively discharged from the geriatric wards in the same departments as this day hospital. This group reported in an earlier paper[2] are referred to in this survey as the 'previous series'. As would be expected the day hospital patients are much older than the general

TABLE XV-a AGE AND SEX IN PRESENT SERIES

age	percentage of total series	percentage of sex incidence in the age group	
		men	women
–59	5	41	59
60–64	8	29	71
65–69	11	52	48
70–74	15	36	64
75–79	22	27	73
80–84	22	26	74
85–89	14	25	75
90+	3	18	82
	100	31	69

TABLE XV-b COMPARISON OF AGE-SPREAD BETWEEN PRESENT SERIES, PREVIOUS SERIES AND PENSIONABLE POPULATION OF ENGLAND AND WALES

age	present series	series of 100 consecutive discharges	total popultaion (RG 1966)
65–74	30	27	64
75–84	51	48	30
85+	19	25	6

TABLE XV-c SOURCES OF REFERRAL IN PRESENT SERIES

general practitioner	out-patient consultation	14	
	domiciliary consultation	33	
	direct	5	52
hospital doctor	geriatric ward	35	
	medical ward	10	
	other wards	3	48

TABLE XV-d COMPARISON OF LENGTH OF STAY BETWEEN PRESENT AND PREVIOUS SERIES

The differences are significant: $X^2 = 6{\cdot}743$: $P = 0{\cdot}03$

	length of stay	
	341 patients in present series, all of whom were referred to the day hospital	100 patients in previous series, 34 of whom were referred to the day hospital
0–1 month	49	38
1–3 months	38	41
over 3 months	13	21

population. The 100 consecutively discharged patients from the geriatric department include 34 who attended the day hospital. In general, patients attending the day hospital after discharge from the wards are younger than patients leaving geriatric wards, but the differences are not very great.

1 SOURCES OF REFERRAL

In the present series almost exactly half the patients referred to the geriatric day hospital came from each of the two main sources – general practitioners or hospital doctors (Table XV-c). General practitioners may refer patients through an out-patient consultative clinic, by a domiciliary consultation, or directly by telephone or letter. Hospital doctors may refer patients from geriatric, medical or other wards. Of those referred from general practitioners the proportion coming through domiciliary consultation does not increase with increasing age. Of those coming from hospital, the proportion coming from medical wards is much higher in the under-75s (63 per cent compared with 33 per cent) and also includes a higher proportion of men than those from the geriatric wards (43 per cent compared with 35 per cent). Fifty-five per cent of patients coming from medical wards suffer from stroke, compared with 36 per cent of those from geriatric wards, and also 36 per cent of the whole series. Thus, patients referred from medical wards are slightly younger, more of them are men, and more are stroke cases. Fifteen patients had been referred from the orthopaedic ward, 13 of whom had fractured femurs.

Of the 341 in-patients who had come from the geriatric wards, almost half had been in for less than one month, 13 per cent for over three months and only two patients for over one year (Table XV-d). Comparison with the length of stay of patients in the previous series shows that those subsequently attending the day hospital spent a shorter time as in-patients. This is some indication of the value of the day hospital in diminishing in-patient stay.

Ninety per cent of the patients came to the day hospital from their own homes, ten per cent from residential or nursing homes. There was no relationship between domicile and age but slightly more women than men came from residential or nursing homes.

2 DIAGNOSES

The principal diagnostic groups of the 965 patients are shown in Table XV-e. Stroke is by far the most common reason for attendance. The table relates diagnostic categories to age groups and emphasises the high incidence of stroke among the younger patients (under 80 years), and that in the over-80s it is equalled by arthritis. The principal diagnosis in the 53 patients under 60 is stroke followed by diseases of the central

TABLE XV-e RELATION BETWEEN DIAGNOSIS AND AGE

age	stroke	chronic brain syndrome	other CNS	OA* RA	fractured femur	other	total number of patients
–59	53	6	26	4	0	11	53
60–69	46	15	8	15	2	14	183
70–79	46	16	4	14	3	17	353
80+	18	21	6	19	8	28	375
total	36	17	7	16	4	20	964†

TABLE XV-f RELATION BETWEEN DIAGNOSIS AND REASON FOR ATTENDANCE

	stroke	OA* RA	chronic brain syndrome	all patients
rehabilitation	63	26	29	41
maintenance	17	38	35	29
social	4	3	9	6
other reasons	16	33	27	24

* *Osteo-arthritis and rheumatoid arthritis.*
† *One patient mis-classified.*

nervous system (CNS) in 26 per cent – mainly multiple sclerosis. Apart from the increasing incidence of arthritis and of 'chronic brain syndrome'* among the older patients, there is no other correlation. Stroke is more common among the men attending (41 per cent of the men to 33 per cent of the women) and arthritis among the women (19 per cent to 9 per cent of the men). Incontinence of urine was the main diagnosis in 38 patients (3·9 per cent) of the series, and was more than twice as common in men as in women.

Of the four principal reasons for attending a geriatric day hospital (Table XV-f), 41 per cent attended initially for rehabilitation, 29 per cent for physical maintenance and six per cent for social reasons – the remaining 24 per cent for medical or nursing reasons. The reason for attendance is not related to sex. Maintenance is a more common reason for attendance in the under-60s (34 per cent) and over-90s (37 per cent) – although the total number in each of these groups is small. More than the average number of patients came from medical wards for rehabilitation (55 per cent), from geriatric wards for maintenance (40 per cent), and by direct arrangement for social reasons (18 per cent).

Table XV-f also relates the reason for first attendance and diagnosis. The larger number of stroke patients are coming for rehabilitation, and arthritic or chronic brain syndrome patients for maintenance. More of those coming for social reasons suffer from chronic brain syndrome than from the other diagnostic categories.

3 FREQUENCY AND DURATION OF ATTENDANCE

Patients may come from one to five days weekly, the frequency being decided by the consultant geriatrician when the patient is first accepted. Among the 965 patients, frequency on first attendance is as follows:

once a week	27 per cent
twice a week	28 per cent
three times a week	25 per cent
four times a week	8 per cent
five times a week	12 per cent

Since those who come four or five times weekly form a minority (20 per cent) it is worth considering their particular characteristics. The largest proportion comprises the youngest age group, under 59 years (Table XV-g). This may be because the younger disabled patients have working spouses and cannot be left alone at home. Men form a higher proportion of this group and of the group 60 to 69 years than they do in the series

**A composite diagnosis describing patients suffering from cerebral arteriosclerosis, Parkinsonism, mental confusion and incontinence.*

TABLE XV-g PATIENTS COMING FOUR OR FIVE TIMES WEEKLY ON FIRST ATTENDANCE

		—59 years	60—69 years	70—79 years	80+ years	
total number attending four or five times		18	40	59	74	
proportion of age group attending		34	22	17	20	
sex distribution of those attending	men	44	55	32	24	
	women	56	45	68	76	
					total number	191

TABLE XV-h FREQUENCY OF ATTENDANCE COMPARED WITH REASON FOR ATTENDANCE

frequency of attendance per week	reasons for attendance: rehabilitation	maintenance	social	medical or nursing	total numbers
once	12	46	7	35	265
twice	36	34	6	24	263
three times	54	20	3	23	246
four times	79	12	4	5	76
five times	67	9	8	16	115
					965

TABLE XV-i RELATION BETWEEN DURATION OF ATTENDANCE AND DIAGNOSTIC CATEGORY

	0—2 weeks	2—4 weeks	1—3 months	3—6 months	6—12 months	over 12 months	total
stroke	24	35	34	37	40	47	36
chronic brain syndrome	18	23	17	18	15	12	17
rheumatoid or osteo-arthritis	18	16	13	13	19	17	16
all others	40	26	36	32	26	24	31
total numbers	149	106	249	187	150	123	964

as a whole. Thus, 52 per cent of men under 70 come four or five times weekly, compared with 30 per cent of that age group in the total series. Most of those attending three to five times weekly are coming for rehabilitation, whereas those attending once weekly come principally for maintenance or medical or nursing reasons (Table XV-h). There is no relation between frequency of attendance and distance travelled.

The lengths of time patients attended during the first course of treatment are as follows:

0 to 2 weeks	15 per cent
2 to 4 weeks	11 per cent
1 to 3 months	26 per cent
3 to 12 months	35 per cent
over 12 months	13 per cent

Most patients (61 per cent) attend for periods of one to 12 months. The 15 per cent attending up to two weeks may include a few coming for special medical or nursing procedures – but mainly comprises those discharging themselves. Altogether, 136 patients discharged themselves (15 per cent), 60 (44 per cent) in the first two weeks of attendance. The reasons for this are discussed below. The 13 per cent of patients who attended for over a year includes 3·6 per cent (35 patients) who attended for over two years.

There is no sex difference in the duration of attendance. Age is related, however. More of the younger patients attend for long periods of over 12 months and more of the older patients for short periods of up to two weeks. Short attendance (up to two weeks) is also related to the distance travelled – for instance, only 13 per cent of patients from Bromley and Beckenham (one to five miles) gave up within two weeks, compared with 23 per cent of those from Sidcup (five to ten miles). This is statistically significant, $x^2=5{\cdot}624$: $P<0{\cdot}02$.

The relation between diagnostic group and duration of attendance is of interest (Table XV-i). Patients with stroke are the longest attenders; those with chronic brain syndrome form a progressively smaller proportion of attenders after four weeks. The proportion of arthritic patients attending for the various lengths of time shows little variation.

4 WHAT HAPPENS TO THE PATIENT

From Table XV-j, showing the manner of discharge, it will be seen that 15 per cent of the patients discharged themselves. A quarter of them were aged 85 or over, compared with 19 per cent of the whole series – a significant difference, $x^2=9{\cdot}824$: $P<0{\cdot}01$. More women than men discharged themselves (16 compared with 10 per cent). There is no

TABLE XV-j MANNER OF DISCHARGE

died, admitted to hospital or ill at home	44
discharged by medical staff	38
discharged by self	15
moved away	3
	total number 898

TABLE XV-k RELATION BETWEEN CERTAIN DIAGNOSTIC GROUPS AND SELF-DISCHARGES (numbers)

diagnosis	self-discharge	medical discharge	
fractured femur	10	28	$X^2=4{\cdot}022$
all other patients	126	811	$P<0{\cdot}05$
other diseases	36	160	$X^2<3{\cdot}281$
all other patients	100	669	$P<0{\cdot}05$

TABLE XV-l MAIN DIAGNOSTIC GROUPS COMPARED WITH OUTCOME AT END OF FIRST COURSE OF TREATMENT (excluding self-discharges and those moving from the district)

outcome at end of first course of treatment	stroke	OA* RA	chronic brain syndrome	significance
died, admitted to hospital, ill at home	123†	63	83	$X^2=26{\cdot}382$
discharged by medical staff	141	51	44	$P<0{\cdot}01$
improved	131	6	45	$X^2=25{\cdot}840$
no change	79	26	45	4DF
deteriorated	101	10	62	$P<0{\cdot}01$

* *Osteo-arthritis and rheumatoid arthritis.*
† *Figures express numbers.*

statistically significant relationship between distance travelled and self-discharge. On the other hand, two diagnostic groups were particularly related to self-discharges (Table XV-k), more fractured femurs than might have been expected and more cardio-vascular or respiratory, rather than neurological or locomotor diseases. The reason for the first group is not clear, but in the latter probably the treatment was less specific and the reason for arranging attendance less precise. Thus, the patients may have been less satisfied with their treatment at the day hospital.

When the patients who deteriorated are compared with those who were discharged by the medical staff – an indication usually of improvement – in each of the three main diagnostic categories (stroke, chronic brain syndrome and arthritis), one finds that the highest rate of discharge was in the first category and lowest in the second. This finding is confirmed by the assessment made at the time of discharge (Table XV-1). In short, these findings show that patients with stroke tend to improve, those with chronic brain syndrome and arthritis, to deteriorate.

Table XV-m indicates the varying pattern in method of discharge in subsequent years (this refers only to first attendance). The drop in total number discharged in later years is due to the increasing numbers attending for second or subsequent times; these are not considered in this table. It is also due to those still attending in later years. The proportion of patients discharged by the medical staff increases in the later years.

These are the patients who have improved or who appear to be deriving no further benefit from attendance. The proportion admitted to hospital, becoming ill at home, or dying, diminishes in later years and so does the proportion discharging themselves. Perhaps the changes may be most easily appreciated by comparing the outcome in the first three-year period with that in the second period. From 1963–5, 49 per cent became ill, were admitted to hospital or died, compared with 42 per cent in the second three years. Similarly, 33 per cent were discharged by medical staff in 1963-5 compared with 46 per cent in 1966–8, and 18 per cent discharged themselves compared with 12 per cent in the second three years. These figures indicate better selection of patients and earlier discharge when experience had been gained in running the day hospital.

Altogether, 313 patients (31 per cent) were admitted to hospital during the six years: 210 (67 per cent) to geriatric wards, 46 (14 per cent) to medical wards and 57 (18 per cent) to other wards.

Of the 210 admitted to the geriatric wards, 94 per cent had come to the day hospital through the geriatric department (in-patient, out-patient,

TABLE XV-m METHOD OF DISCHARGE AT END OF FIRST ATTENDANCE (excluding those who have moved from the district)

	1963	1964	1965	1966	1967	1968
admitted to hospital, died or ill at home	50	48	47	39	46	39
discharged by medical staff	32	33	36	49	43	48
discharged self	18	19	17	12	11	13
total number	183	153	169	141	149	69

TABLE XV-n METHOD OF DISCHARGE FOR FIRST, SECOND AND SUBSEQUENT PERIODS OF ATTENDANCE (omitting patients who moved out of area)

	first period	second period	third or subsequent periods
admitted to hospital, died or ill at home	46	64	70
discharged by medical staff	39	25	17
discharged self	15	11	13
total number	864	127	30

domiciliary visit or direct). Of the 46 admitted to the medical wards, 76 per cent had similarly come to the day hospital through the geriatric department.

SECOND PERIOD OF ATTENDANCE

Altogether, 159 patients (17 per cent) attended for a second period. The times between stopping the first course and starting the second were as follows:

1 to 3 months	49 per cent
3 to 6 months	17 per cent
6 to 12 months	21 per cent
over 1 year	13 per cent

Of those who restarted within three months most (86 per cent) had been previously discharged either because of illness at home or admission to hospital. On the other hand, the larger number (64 per cent) of those either discharging themselves or being discharged by medical staff and who had a second course of treatment, did not return until after six months. The main diagnosis on second attendance was the same as on the first attendance in 123 patients (77 per cent).

The frequency of attendance to begin with on the second occasion was about the same as the first time, and the principal diagnosis was also almost the same. Nevertheless, the method of discharge the second time was, as might be expected, rather different from the first time (Table XV-n). Thus, fewer discharged themselves or were discharged by the medical staff – while more were admitted to hospitals, became ill or died, compared with the first attendance.

Thirty-two patients (three per cent) attended for three or more courses of treatment, and most of these (66 per cent) were finally admitted to hospital, became ill at home, or died.

5 DISCUSSION

During the six years of this survey, the Lennard Day Hospital served several different purposes. Firstly – and perhaps most prominently – it has been a stroke rehabilitation unit. In this it has reflected practice in the geriatric rehabilitation wards. Patients with stroke, admitted to both the rehabilitation wards and the day hospital, came from the geriatric assessment wards and general medical wards. Patients coming from the latter tended to be younger, and more of them were men. Stroke rehabilitation has become an important function of geriatric departments, and in many areas these are the main units for treating the more difficult cases. Patients in this group attend for longer periods than those with other diagnoses; they are also the patients who most

often improve and are discharged by the medical staff as needing no further treatment.

A second use of the day hospital emphasised by this survey is the prevention of disability (or of increasing disability) in patients suffering from arthritis, both rheumatoid and degenerative. These patients predominate among the older age groups (particularly the over-80s). They usually come once weekly for a full day's programme of individual and group treatment.

A third important use is in managing patients with chronic brain syndrome. These patients predominate among the small group who come for social reasons – that is, to afford some relief to their relatives. As a group they tend to remain static but, compared with other patients, their course of attendance most frequently terminates by their becoming ill or being admitted to hospital.

Another group of patients who attend to relieve the relatives comprises younger patients with various neurological disorders, especially multiple sclerosis. They are severely disabled, require nursing while at the day hospital, and would not be suitable to attend ordinary social day centres. Some of the patients with chronic brain syndrome attending for social reasons might attend special day centres for the confused elderly if enough of these were provided.

Comparison between the length of stay in hospital of those patients subsequently attending the day hospital with all patients being discharged, shows that the day hospital does allow earlier discharge from the geriatric wards. Another emergent factor is the gradually changing pattern of care over the years. Although no consistent change is seen in the reasons for attendance in subsequent years, the proportion who are discharged by the staff increases and the proportion discharging themselves decreases, indicating that the selection of patients is better.

It is just as important not to have an excess of places as it is to have enough. If too many places are available, the stimulus to discharge patients is diminished. The longer patients have been attending, the more difficult discharge becomes.

CONCLUSION

The three surveys described provide a comprehensive statement about geriatric day hospitals in Great Britain and Northern Ireland at the present time. We conclude with the highlights which the surveys bring out.

In 1960 there were twelve geriatric day hospitals in the country. By the end of 1970 there will be at least 120. Almost two-thirds of geriatric departments will then include a day hospital, a reflection of the value placed on them by consultant geriatricians. Two-thirds of all consultants regard a day hospital as an essential part of a geriatric service. Only four per cent regard it as of little or no importance.

The opening of a geriatric day hospital stimulates further development in the local facilities for old people. The need for social day centres becomes at once apparent, and their provision seems to follow a year or two after opening a day hospital. If day centres are not developed then the day hospital tends to accumulate a larger number of patients coming for social reasons only. This may be open to criticism on two counts – firstly, that it is not the function of the hospital service to provide care for social reasons; secondly, that too many people in a day hospital who are not undergoing a programme of treatment tend to 'get in the way', and make it more difficult for the staff to pick out those who need treatment.

Social day centres are provided and staffed either by voluntary bodies or local authorities, or by both working together. A strong link between all bodies involved is needed if provision of both types of day care for elderly people is to be adequate. The local old people's welfare committee may be the best forum for this coordination, and it would seem important that consultant geriatricians should belong to these committees. In fact, 57 per cent of geriatric departments in hospitals in the country are represented on them at the present time.

Day hospitals create an appetite among old people for companionship and purposeful activity. It has been suggested that this is a form of emotional dependence, which perhaps is unfortunate, but which

physicians must accept. On the contrary, the importance to positive health of companionship and purpose in old age must be recognised and the community must provide for these needs by establishing social day centres.

Often the main difficulty is transport. Without it, social day centres simply become luncheon clubs for the able-bodied which, while their value is undoubted, exclude those in greatest need.

Day hospitals also stimulate the development of out-patient consultative clinics in geriatric departments which are necessary for a balanced service. The day hospital's evolution is influenced by subsequent developments in the local community. Selection of patients improves; fewer discharge themselves, more come for positive therapeutic reasons.

It is the general rule for day patients and in-patients to share facilities, particularly in rehabilitation departments. This is not only an economic use of staff and facilities, but also gives elderly patients an added confidence at the time of their discharge from hospital – often a time of great anxiety. To know that they will return perhaps several days a week to the department and staff they have come to know and respect, makes the patients' first few weeks of resettlement at home much easier, and less subject to breakdown. It also diminishes the time spent as in-patients.

The survey of five day hospitals in south-east England suggests that one place is needed for 4,500 total population. Pathy[14] suggests one place to 3,000 total population. These suggestions indicate the range – local circumstances dictating the local need.

Evidence suggests that day hospitals with 20 or fewer places are overfilled; patients attend in excess of places available. Over 20 places allows for those old people who are called for but for various reasons do not come. The most popular size, 20 to 40 places a day, would serve a population of 60,000 to 180,000 of average age structure. An excess of places probably discourages discharge and may interfere with the proper function of the day hospital.

Most patients come by ambulance and special arrangements are essential to ensure that the ambulances will not get directed to accidents. This will not happen if eight or ten-seater ambulances are used. The journey to the day hospital should be the first in the morning, otherwise patients may not arrive until noon and the work of the day hospital is impeded. There is also advantage in having regular ambulance crews for this work. They get to know the patients and can provide useful information when things go wrong. In some areas, taxis and hospital

sitting-cars bring patients. In general, very few patients travel more than five miles.

There is little doubt among geriatricians that the prime use of the day hospital is the physical rehabilitation of disabled old people. For this reason staff numbers need to be fairly high. The survey in south-east England suggested a total of ten whole-time equivalents of staff for a day hospital with an average daily attendance of 30 patients. The number comprises occupational therapists, physiotherapists, speech therapists, and aides to these three groups, also SRNs, SENs and nursing auxiliaries. It does not include domestic staff, chiropodists, dentists or medical staff. The average day hospital of 35 places requires one session of consultant's time and two of junior medical staff's time per week.

In 68 per cent of day hospitals a nurse is in overall charge; in 22 per cent it is the head occupational therapist. The essence of a geriatric day hospital is teamwork and it is possible for all departmental heads to work together with none being in charge other than the consultant taking overall medical responsibility. The responsibilities of the sister or charge nurse comprise reception of patients, provision of meals, supervision at bath and toilet, medication, dressings, injections and other procedures, organisation of clinics, and assisting doctors and dentists. A clerk is always needed on the premises to receive telephone calls, type and deliver attendance schedules and make out case notes.

Apart from physical rehabilitation, the next most important function of the geriatric day hospital is physical maintenance of old people who are likely to deteriorate following discharge from hospital or cessation of treatment. These patients include some with stroke – but more prominently those with arthritis.

Third in importance is social care, which may be needed for patients with physical or mental disability, including many who use wheelchairs and some who are incontinent. Most of these will be patients with chronic brain syndrome and, to a lesser extent, younger patients with chronic neurological disorders. Many such patients could not be managed at social day centres.

About one-third of patients under 60 who attend do so four or five days a week, presumably to allow their relatives to work. The remainder come once weekly for the therapeutic advantages which they themselves gain.

Social care of mentally confused old people is rated as the least important function of a geriatric day hospital by a majority of consultants. Nevertheless, there is a great need within the community for such care –

and there seems no doubt that mixing demented patients with others in a therapeutic environment improves the social behaviour of the demented, and eases the situation at home. It would seem that further discussions and experiments are needed to decide whether mentally confused patients can best be cared for in geriatric or psychiatric day hospitals, or in social day centres.

There is also a small place in the day hospital for treatment of depression in old age. This is practised successfully at Joyce Green Day Hospital. It is equally a function of psychiatric day hospitals.

A whole range of medical procedures, including electrocardiography, sternal marrow puncture, sigmoidoscopy, infusion of blood and iron are available at most day hospitals. Similarly, nursing care includes bathing, enemata, catheter changes, dressings and injections, and a variety of clinical tests.

In one or two day hospitals there is great emphasis on receiving and evaluating emergency cases referred by general practitioners. Such patients may be brought to the day hospital at once on the day of referral, or the following day, and a decision on admission taken after a few hours observation. If, as is so often the case, a social crisis is the underlying problem, the health visitor or social worker attached to the day hospital may spend the day restoring social equilibrium.

Pathy[14] has described such a department in Cardiff and advocates the use of two or three separate day hospitals, each with its own particular function. Woodford-Williams and Alvarez[17] have also suggested this. Thus, one day hospital, or part of it, is closely associated with the out-patient department and is primarily used for observation and medical or nursing procedures. A second may provide recreational therapy for the confused and emotionally dependent, while a third may provide for the heavy nursing of physically disabled day patients.

While it may be useful to consider variations of day hospital care in these categories, and perhaps to develop separate areas of the day hospital especially for them, it would seem contrary to the basic spirit of a day hospital not to have them housed in the same building.

The majority of patients attending are aged 74–85 years, and 90 per cent of all patients come from their own homes. Referrals from hospital and from general practitioners are equal in number.

Since 13 per cent of patients are in wheelchairs, and a further 59 per cent use walking aids, due allowance must be made in constructing hospital buildings. Corridors should be wide, access to lavatories should

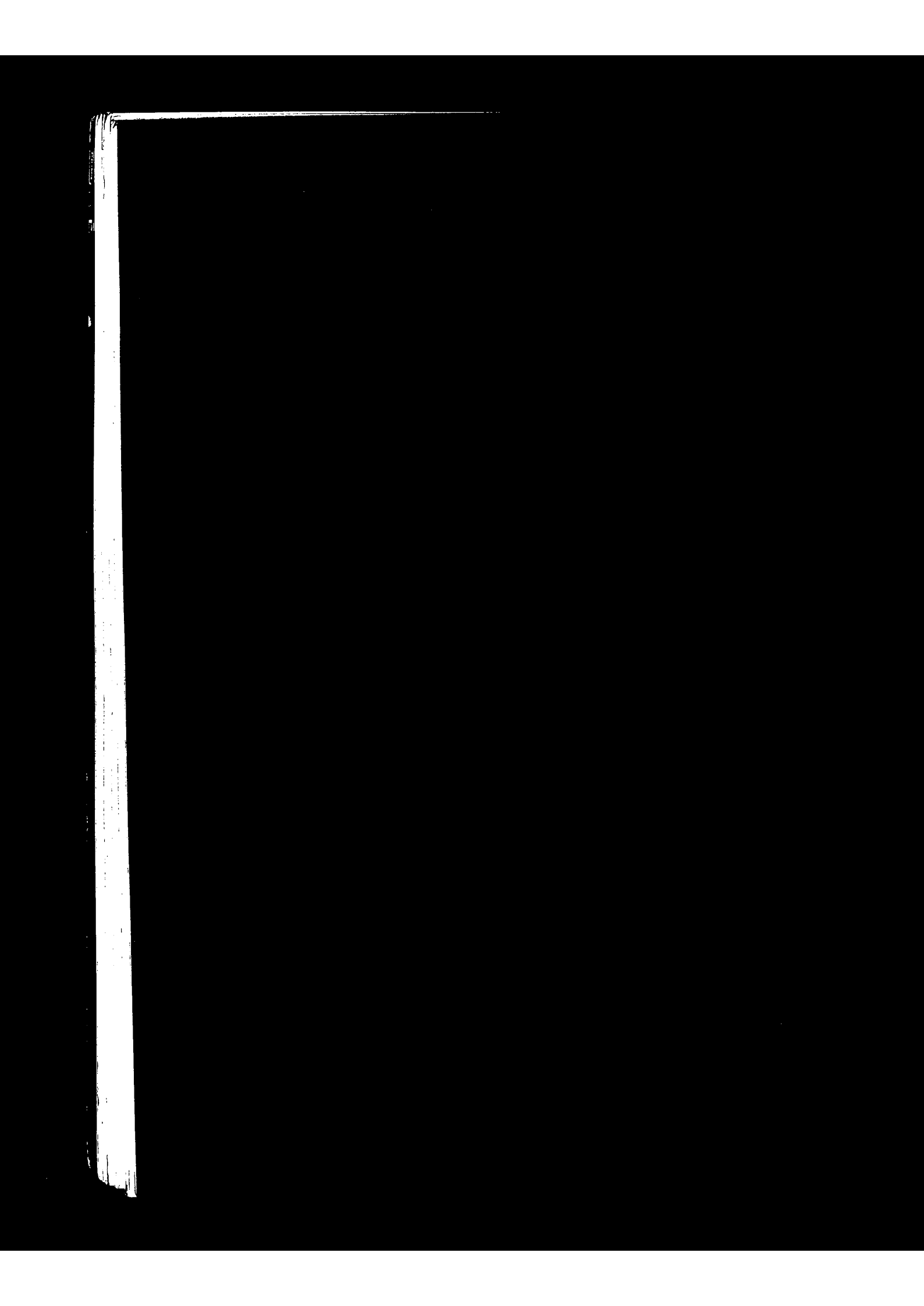
be around baffle walls and not through doors which have to be opened.

Stroke accounts for 30 per cent, and arthritis or fractured femur account for a further 30 per cent of the attendance. Stroke is the diagnosis of the majority of patients referred from general medical wards and of patients attending initially for rehabilitation. Patients with stroke are also the longest attenders. The geriatric day hospital may be seen as the most important centre for stroke rehabilitation in many areas, and is well adapted for this purpose.

Close medical control at all stages of day hospital care is essential. If day hospitals are to be further developed for medical procedures and immediate patient referrals by general practitioners, then the medical staffing levels suggested above will need to be augmented.

The day hospital has an important staff educational function. Regular case conferences to review patients' progress afford an opportunity to exchange ideas among the geriatric rehabilitation team, and a teaching opportunity for students of all the disciplines to develop insight into the complex processes of geriatric rehabilitation.

Finally, the effect on morale – not the least important aspect. The day hospital acts as a window through which the staff of the whole geriatric department can see the fruits of their labours as their elderly patients are re-settled and maintained in the community.



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APPENDIX I

GERIATRIC DAY HOSPITALS IN GREAT BRITAIN 1970

ENGLAND, NORTHERN IRELAND and WALES

regional hospital board	hospital management committee	date opened	total attend-ance 1968	days open per week
BIRMINGHAM	Coventry	1970	—	—
	Dudley Road	1960	5,120	5
	Dudley Road	1964	—	5
	East Birmingham	1967	4,224	5
	Herefordshire	1969	—	1
	North Staffordshire	1960	1,311	5
	South Birmingham	1966	16,605	5
	South Warwickshire	1964	1,744	5
EAST ANGLIAN	King's Lynn Area	1963	2,861	5
	Peterborough and Stamford	1965	3,454	5
	Peterborough and Stamford	1969	—	5
	West Suffolk	1964	3,852	5
LEEDS	Halifax	1970	—	—
	Huddersfield	1965	3,762	5
	Hull (A)	1963	8,768	5
	Leeds (A)	1955	5,928	4
	Leeds (A)	1970	—	—
	York (A)	1962	683	—
	Wharfedale	1960	3,968	4
	Wharfedale	1966	6,210	5

LIVERPOOL	East Liverpool	1961	13,114	5
MANCHESTER	Barrow and Furness	1965	2,974	4
	Blackburn and District	1962	4,583	5
	Bolton and District	1957	11,490	5
	Burnley and District	?	1,068	5
	Bury and Rossendale	1965	1,396	5
	North Lancashire and South Westmorland	1966	7,987	5
	North Lancashire and South Westmorland	1966	3,395	5
	North Manchester	1970	—	—
	Oldham and District	1966	12,044	5
	Salford	1964	9,838	5
	South Manchester	1958	4,797	5
	Stockport and Buxton	1967	3,826	5
NEWCASTLE	Durham	1960	5,650	5
	Hexham and District	1964	4,894	5
	Newcastle upon Tyne	1968	—	5
	North Teesside	1963	—	5
	South Shields	1963	614	2
	South Teesside	1961	12,871	5
	South Teesside	1964	3,833	5
	Sunderland	1960	10,085	5
	West Cumberland	1965	3,790	5
NORTHERN IRELAND HOSPITALS AUTHORITY	Belfast	1970	—	—
	Londonderry	1970	—	—
NORTH EAST METRO-POLITAN	East London	1965	590	1
	Enfield Group	1970	—	—
	Ilford and District	1966	3,000	5
	Romford Group	1969	—	5
	St Helena Group	1962	3,000	5
	Southend-on-Sea	1970	—	—

NORTH WEST METRO-POLITAN	Central Middlesex Group	1964	3,551	5
	Luton and Hitchin	1964	640	5
	South West Middlesex	1962	3,784	5
	West Herts	1970	—	—
OXFORD	Banbury and District	1965	11,271	5
	High Wycombe and District	1967	3,286	5
	High Wycombe and District	1970	—	—
	Kettering and District	1969	4,204	5
	Kettering and District	1970	—	—
	Northampton and District	1965	6,235	5
	Northampton and District	1970	—	—
	Reading and District	1970	—	—
	Royal Buckingham-shire and Associated Hospitals	1970	—	—
	Swindon, Cirencester and District	1970	—	—
SHEFFIELD	Barnsley	1968	5,292	5
	Derby Area No 1	1965	4,783	5
	Grimsby	1970	—	—
	Leicester No 2	1970	—	—
	Mansfield	1970	—	—
	Nottingham No 2	1969	—	5
	Sheffield No 1	1967	4,125	5
	Sheffield No 1	1967	5,566	5

SOUTH EAST METRO-POLITAN	Bromley Group	1962	7,999	5
	Brighton and Lewes	?	538	3
	Canterbury Group	1967	11,650	5
	Central Kent	1967	7,607	5
	Cray Valley and Sevenoaks	1968	2,127	5
	Dartford	1964	9,328	5
	Greenwich and Deptford	1970	—	—
	Hastings Group	1965	9,264	5
	Isle of Thanet	1963	11,634	5
	Lewisham Group	1968	—	2
	Medway and Gravesend	1962	6,325	5
	South-East Kent	1968	2,986	5
SOUTH WESTERN	Cheltenham	1965	384	5
	Exeter and Mid-Devon	1970	—	—
	Frenchay	1968	1,608	5
	Plymouth and District	1969	—	5
	Torquay District	?	2,000	5
	West Cornwall	1968	3,812	5
SOUTH WEST METRO-POLITAN	Croydon and Warlingham Park Group	1970	—	—
	Kingston and Long Grove	1968	—	5
	St Helier Group	1965	6,075	5

WELSH	Caernarvon and Anglesey	1963	2,150	3
	Cardiff and District	1959	6,869	5
	Cardiff and District	1964	12,995	5
	Merthyr and Aberdare	1968	—	5
	Newport and East Monmouthshire	1968	—	4
	Pontypridd and Rhondda	1963	2,783	5
	South West Wales	1969	—	5
	Wrexham, Powys and Mawddach	1970	—	—
WESSEX	Bournemouth and East Dorset	1970	—	—
	Southampton Group	1970	—	—
	Winchester Group	1970	—	—

SCOTLAND

regional hospital board	**board of management**	**date opened**	**total attendance 1968**	**days open per week**
EASTERN	County and City of Perth General Hospitals	1956	3,500	3
	Dundee General Hospital	1968	950	3
SOUTH-EASTERN	Edinburgh Northern Hospitals	1960	6,305	4
	Edinburgh Southern Hospitals	1964	5,493	5

WESTERN	Coatbridge, Airdrie and District Hospitals	1969	—	5
	Dunbartonshire Hospitals	1960	3,044	5
	Glasgow, Western and Gartnavel Hospitals	1966	600	2
	Southern Ayrshire Hospitals	1970	—	—

TEACHING HOSPITALS

Charing Cross Hospital	1963	2,592	5
Guy's Hospital	1970	—	—
King's College Hospital	1963	8,748	5
St George's Hospital	1970	—	—
St Thomas' Hospital	1970	—	—
The United Cambridge Hospitals	1961	2,533	5
The United Oxford Hospitals	1961	20,000	5

APPENDIX II

STAFF/PATIENT RATIOS IN FIVE DAY HOSPITALS, WITH IN-PATIENT PLACES PER POPULATION IN THE FIVE AREAS SERVED

	Bromley	Dartford	Hastings	Margate	Maidstone	mean
places/day	40	30	30	50	35	37
called for but did not come (daily average)	6	3	5	8	1	4·6
average daily attendance (week of survey)	37	17	21	46	26	29·4
average daily attendance in 1968*	32	16	23	46	23	28
ancillary staff	**sessions**	**sessions**	**sessions**	**sessions**	**sessions**	
occupational therapist	11	8	30	15	12	15·2
occupational therapy aide	8	10	30	20	16	16·8
physiotherapist	8	5	8	10	8	7·8
physiotherapy aide	8	5	8	10	16	9·4
speech therapist	2	5	3	3	2	3
total	37	33	79	58	54	52·2
ratio ancillary staff sessions/average attendance of patients	1·2:1	2:1	3·4:1	1·3:1	2·4:1	1·9:1

nursing staff	**sessions**	**sessions**	**sessions**	**sessions**	**sessions**	
SRN	13	5	0	20	8	9·2
SEN	0	0	8	10	8	5·6
nursing auxiliary	18	10	8	40	16	18·4
voluntary helper	1	0	0	10	0	2·2
pupil or cadet	5	6	0	10	0	4·2
total	37	21	16	90	32	39·6
ratio of nursing staff sessions/average attendance of patients in 1968	1·2:1	1·3:1	0·7:1	2:1	1·4:1	1·4:1
ratio of nursing and auxiliary staff sessions/average attendance of patients in 1968	2·3:1	3·4:1	4·1:1	3·2:1	3·7:1	3·3:1
medical staff	**hours**	**hours**	**hours**	**hours**	**hours**	
consultant	1½	3	1½	5	2	2·6
medical assistant or registrar	7	7	6	9	5	6·9
senior hospital officer or house officer	0	0	2	0	0	0·4
total	8½	10	9½	14½	7	9·9
patients, attendances in 1966	8,321	6,091	5,695	12,042	—	
1967	8,484	5,743	6,141	11,955	4,950	
1968	7,999	4,112	5,743	11,634	5,787	
population served	235,000	204,000	150,000	120,595	125,000	166·919 Average mean population per day hospital place is 4,511.
in-patient beds per 1,000 population over 65 years	7·7	7·4	21·2	11·2	7·9	9·4

* *Assuming day hospital is open five days weekly for 50 weeks in the year (allowing for Bank Holidays and days of non-attendance due to exceptional weather or ambulance strikes).*

INDEX

This book describes three separate investigations into geriatric day hospital care in Great Britain.

The first investigation, described in Section 1, attempts to define the total provision of geriatric day hospitals at the end of 1969 and to consider the principal types these day hospitals comprise. It also discusses the views of most geriatricians about day hospitals.

The second (Sections 2 and 3) is a study of five day hospitals in the south-east of England – their history, physical amenities and staffing. It also provides a profile of patients, their social and physical characteristics, their diseases, the reason for their attendance and the treatment they receive.

The third investigation (Section 4), a review of all patients attending the Lennard Day Hospital in Bromley, Kent, over six years, deals with the duration of attendance and the outcome.