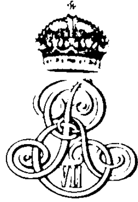

KF REPORT

81/229

The Working Relationship in Day Hospitals

Report of a Conference held at the King's Fund Centre

Christobel Howard Grau

October 1981

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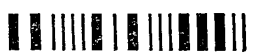

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THE WORKING RELATIONSHIP IN DAY HOSPITALS

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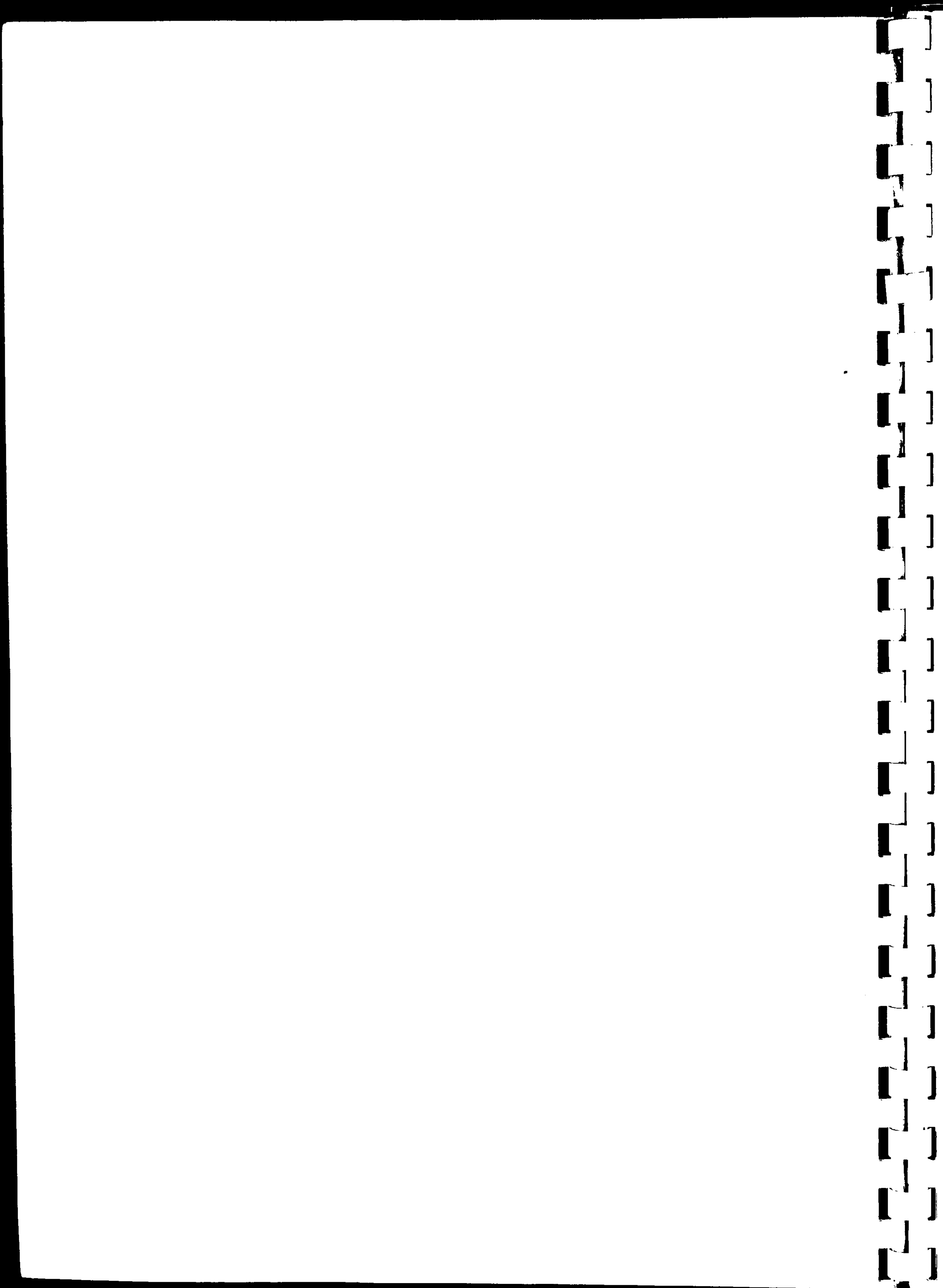


CHAIRMAN'S OPENING REMARKS

The Chairman, Miss Pat Young, Editor of Geriatric Medicine, welcomed delegates to the conference.

Miss Young said that she could do no better than quote a definition by Professor Brocklehurst in a book on the geriatric day hospital published in 1970:

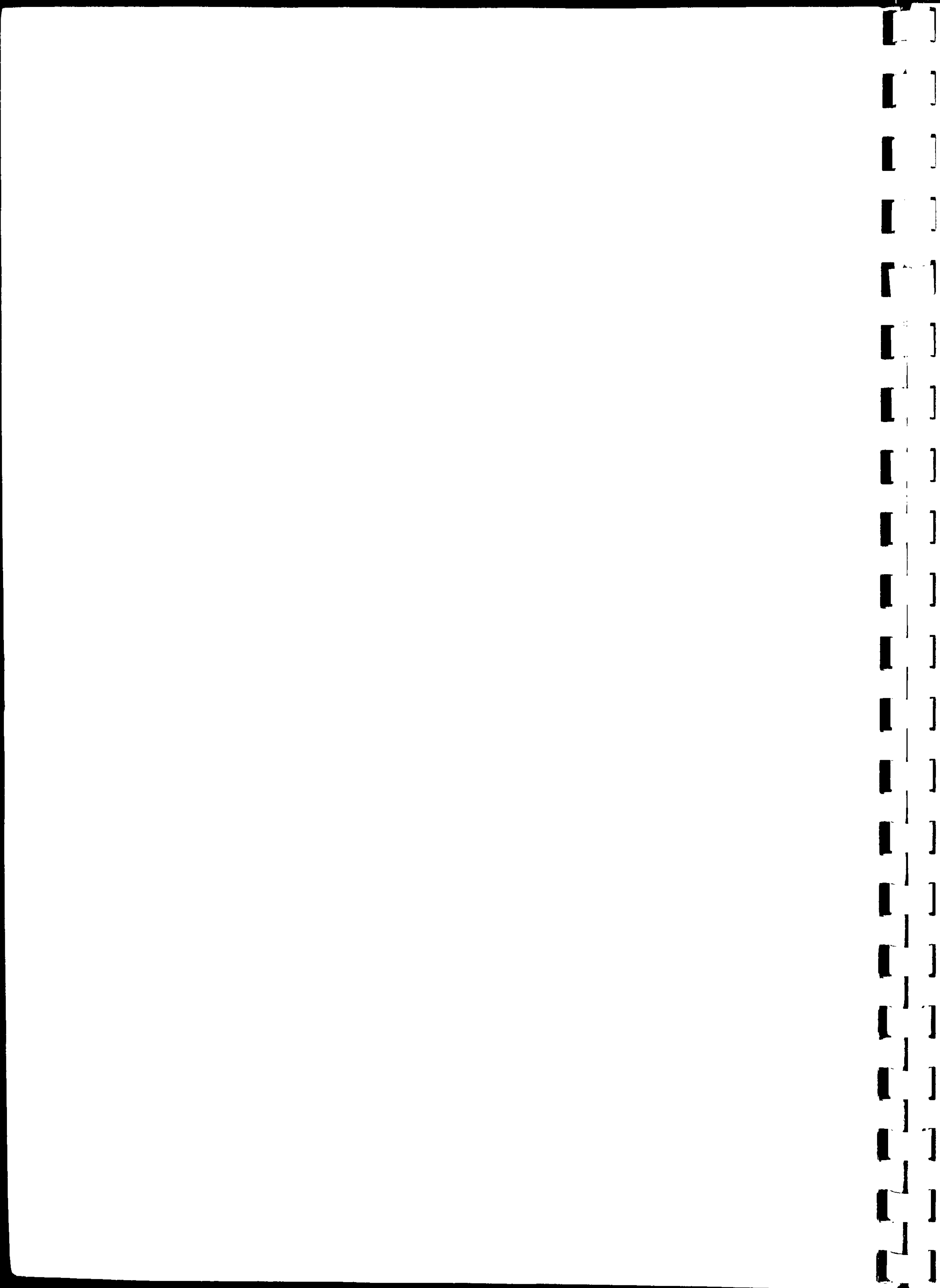
> 'A day hospital is a building to which patients may come or be brought in the morning, where they may spend several hours in therapeutic activity and whence they return subsequently on the same day to their own homes'.

The building was generally, although not always, within an ordinary hospital; it might be no more than a single room specially adapted, or a whole purpose-built structure of varied rooms, and there were many beautiful purpose-built hospitals throughout the country.

Geriatric day hospitals provided facilities for physiotherapy, occupational therapy, medical examinations, nursing treatment, and other activities including investigations, speech therapy, dentistry, chiropody and hairdressing. The building and its facilities might be used entirely for day patients coming from their own homes, or included ward patients who would come over in the morning and return to the ward later in the day. It is at this point that one must draw a distinction between the day hospital and the day centre: the latter provided only social facilities and was usually administered by a local authority or voluntary bodies.

The concept of the day hospital began in the 1940s with psychiatric day hospitals and the first one was the Marlborough Day Hospital in London which was opened in 1946. Geriatric day hospitals began with out-patients attending wards and rehabilitation departments for a day. This was happening all round the country in the 1950s and led to the opening in 1958 of the first purpose-built geriatric day hospital at Cowley Road Hospital in Oxford, which was designed to deal with both physically and psychiatrically disabled patients with emphasis on the latter. Since those days the day hospital concept had developed rapidly and there were now 300 in all parts of the country. They catered mainly for the physically handicapped, or those with physical disorders of one kind or another, while the psychiatric day hospitals operated independently.

Miss Young referred to a most excellent book entitled 'Progress in Geriatric Day Care' by Professor J C Brocklehurst and Dr J S Tucker, recently published by the King's Fund Centre and currently priced at £7.00. This volume comprised a survey of the progress that had been made in geriatric day care from the study of a number of hospitals around the country, and she was sure the delegates would find it extremely informative.



The first objective of the day hospital was rehabilitation, a process which, as Professor Brocklehurst said, 'anticipates recovery', and the second, maintenance, which was supporting the degree of recovery in order that the patient did not lapse and lose the independence which he had achieved. The third, assessment was forming an opinion of the patient's physical, mental and social situation, so that a plan could be devised for the treatment. Lastly for on-going medical, nursing and social care.

To achieve all this there was a fundamental need for a skilled, enthusiastic multidisciplinary team, which consisted of a consultant physician in overall charge, possibly another doctor who had day-to-day responsibility, nursing staff, a physiotherapist, an occupational therapist and social workers, although many other disciplines might well make an important contribution.

One of the most important points was for the multidisciplinary team to work smoothly together, and Miss Young hoped that as the conference was concerned with working relationships within a team, any problems would be aired and solutions found. Nevertheless, without the supporting transport service any skills would be unavailing. Thus speakers at the conference would cover this all-embracing subject of ambulance work.

It was equally necessary to consider the availability of services within the community. They were lucky to have a speaker from the Citizens Advice Bureau a co-ordinator who would give most useful information, which she was sure would be of value to the delegates.

Miss Young then introduced Professor Brocklehurst, who was one of those speakers all Chairmen would say needed no introduction because he was so well known. The founder of the Leonard Day Hospital at Bromley in Kent and indeed one of the pioneers of the day hospital movement in the country today.

2. MULTIDISCIPLINARY APPROACH TO AND THE FUTURE DEVELOPMENT OF DAY HOSPITALS.

Professor Brocklehurst, Department of Geriatric Medicine, University of Manchester, thanked Miss Young for her introduction. He felt that the essence of the successful management of day hospital care really concerned relationships between the staff, communication between staff and patients, and also communication between staff and patients' relatives.

In respect of the present situation of day hospitals in this country, as had already been mentioned, one must distinguish between day hospitals and day centres. There seemed to be no difficulty in distinguishing a geriatric day hospital, which was part of the hospital service, staffed by professionals with a primary therapeutic role, and a social day centre usually run by the local authority social services department, with a different type of staff which did not include nurses, therapists or physicians, and had basically a recreational role, and in both day hospital and day centre was clearly quite complementary.

When Professor Brocklehurst and Dr Tucker were looking at day hospitals during their work on the text of the book already mentioned they asked a number of questions. One concerned new patients attending day hospitals for instance:

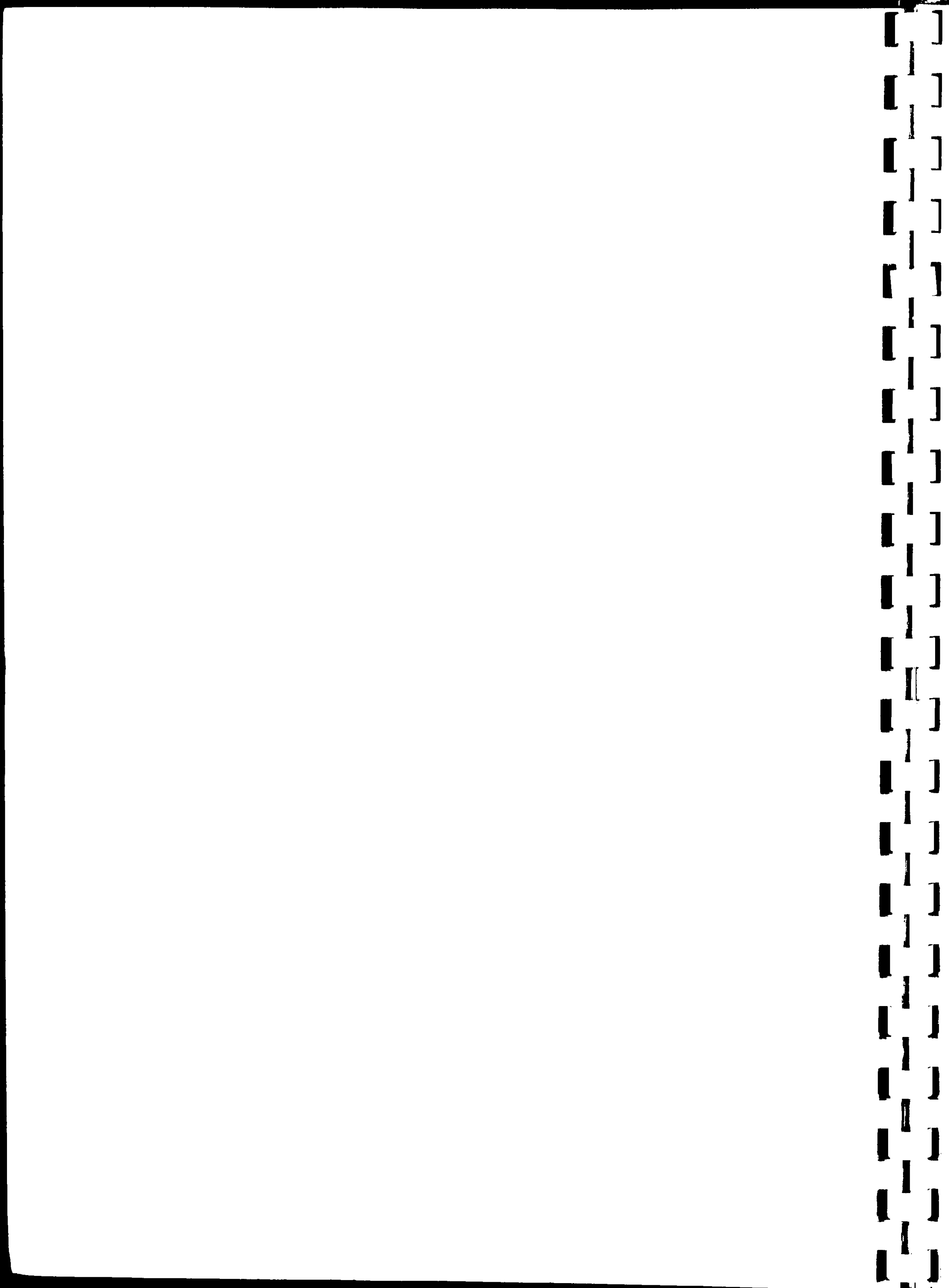
> 'How many of these patients could equally have attended a social day centre'?

The answer was 'about three per cent'. Conversely, when together they visited day hospitals and talked to patients and other people around, they found that over half those attending a day hospital were also going somewhere else during the week, such as church, club or day centre. In fact 13 per cent attending day hospitals were at the same time going to day centres. Delegates should consider this salient point when considering the future of day hospitals; whether there should be an overlapping role somewhere along the line or whether this was simply a reflection of a shortage of resources in one or other field at the present time - debatable conjectures.

There was some overlap within the psycho-geriatric field. This was now developing as a speciality on its own - a branch of psychiatry with approximately 60 consultants and quite a large number of psycho-geriatric day hospitals. It was the current policy of the Department of Health that psycho-geriatric day hospitals should be separate from geriatric day hospitals. There was a separate norm laid down, namely two places per 1,000 people aged 65 and over, which was the same as that for day hospitals. In their survey of about 200 day hospitals, Professor Brocklehurst and Dr Tucker found that in about one-third some separate provision had been made for psycho-geriatric day care. At that time not all were purpose-built or even specially adapted, some were in the big mental hospitals. Nineteen per cent of geriatric day hospitals had a policy of accepting psycho-geriatric patients; for the remaining 45 per cent there was no provision, clearly a very high proportion. Obviously the role of the psycho-geriatric day hospital, although a very different one was tremendously important. It concerned supporting relatives and coping with the enormous problems of dementia in old people at the present time, also the provision of day hospital care for confused old people within the health service.

Only 17 per cent of day hospitals had a waiting list. This could be interpreted as a sign that most were successful. On the other hand a waiting list could be a mark of failure, an indication that the day hospital concerned was not fully meeting its needs, particularly so when considered in the context that day hospitals carried a number of social patients who could quite well attend social day centres.

Referring to the combination of the day hospital and the rehabilitation service for in-patients, Professor Brocklehurst and Dr Tucker had found there was a common function in about one-third of day hospitals. A day hospital with good facilities and equipment provided a splendid opportunity for the therapists to be involved with geriatric in-patients, who might eventually progress to becoming out-patients and thence able to attend from their own homes, even if for a time they returned to the day hospital for maintenance treatment until they felt fully confident.



Referring to the multidisciplinary team - it was one of the most important aspects of a day hospital, which appealed to doctors, therapists, nurses, social workers and other people who were involved. It was also one of the most popular specialities within medicine, where colleagues from various disciplines worked closely together, obtaining maximum job satisfaction from practising in the field of geriatrics.

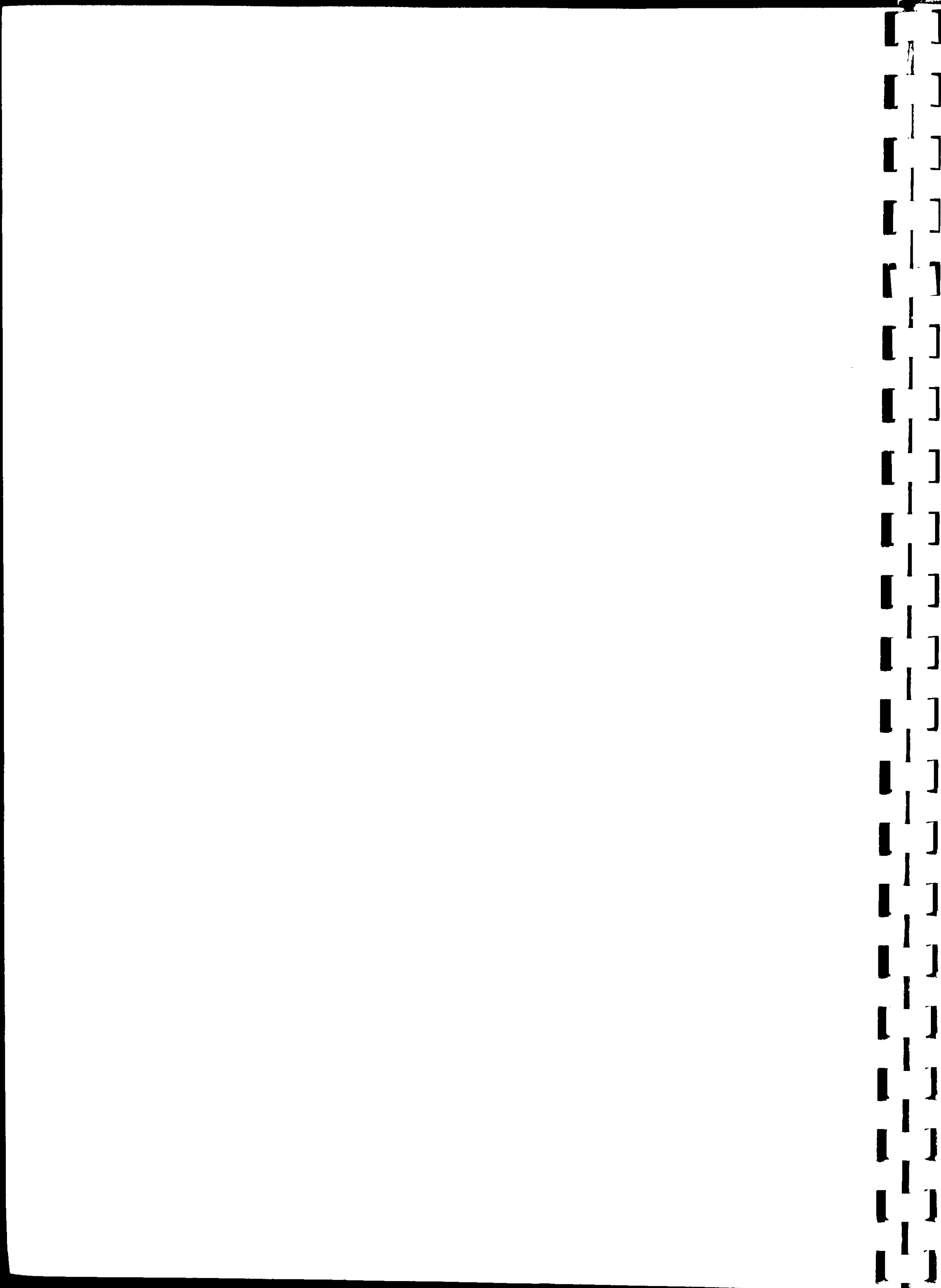
Teamwork within the case conference was important because it motivated the multidisciplinary team to meet regularly and form working relationships - an important source of communication. Speaking in the simplest terms, a case conference involved a number of elements, some of which were the concern of everybody attending, and naturally some concerned individual members of the team. Ideally a case conference should be carried out weekly, although probably only one half or one third of the day hospital patients were reviewed each week. Ten or fifteen people appeared to be a reasonable number at one time. Normally, those attending such a conference would be the consultant concerned, or if not he would delegate a medical assistant, the senior nurse, the head physiotherapist of the hospital and possibly other physiotherapists, the head occupational therapist, and the social worker involved; also a dietician and a speech therapist, should the patient under review be their concern.

It was important for everybody to understand what questions should be asked about each individual patient: firstly:

> Why was the patient attending the day hospital?
>
> What was the primary diagnosis (and just as important) a secondary diagnosis?

He noted that the primary diagnosis of rather less than one-third of patients attending day hospitals was a stroke and the second most common was arthritis. The problems associated with either disease and of others could differ enormously. There could be immobility, incontinence, confusion, falls, social isolation, diarrhoea, a whole host of different problems which prevented the patient from living a full life and who thus came for help and treatment to the day hospital. Professor Brocklehurst considered it important to distinguish what was the problem or problems.

It was all too easy for a day hospital to become simply a recreational facility which was not its purpose. The reason for each patient's attendance should be determined in the correct sequence. As the Chairman had said, there were several different reasons: rehabilitation, assessment, maintenance treatment, medical or nursing procedures, and social reasons such as respite for relatives from their burden or care. Reasons often changed as did persons. For instance a patient might be referred to the day hospital for assessment involving only one or two attendances, when it was found that rehabilitation was needed. Once the patient had received a period of treatment, as Professor Brocklehurst succinctly stated, he might have reached his optimum where no further improvement was anticipated, and rehabilitation would then cease. Having come to this conclusion, what would be the next step?



It was Professor Brocklehurst's opinion that certain patients should continue attending the day hospital for maintenance reasons to prevent deterioration. Maintenance treatment was likely to involve perhaps only one attendance a week. Some day hospitals arranged for the patient to attend for some weeks and then cease attending for a similar period.

Where social reasons were concerned a patient might have reached his zenith and be able to manage at home moderately well, but some patients had an elderly spouse also needing care, so a day spent back at the hospital in order to recoup was often advisable, assuming of course that the patient was not fit enough to be transferred to a social day centre.

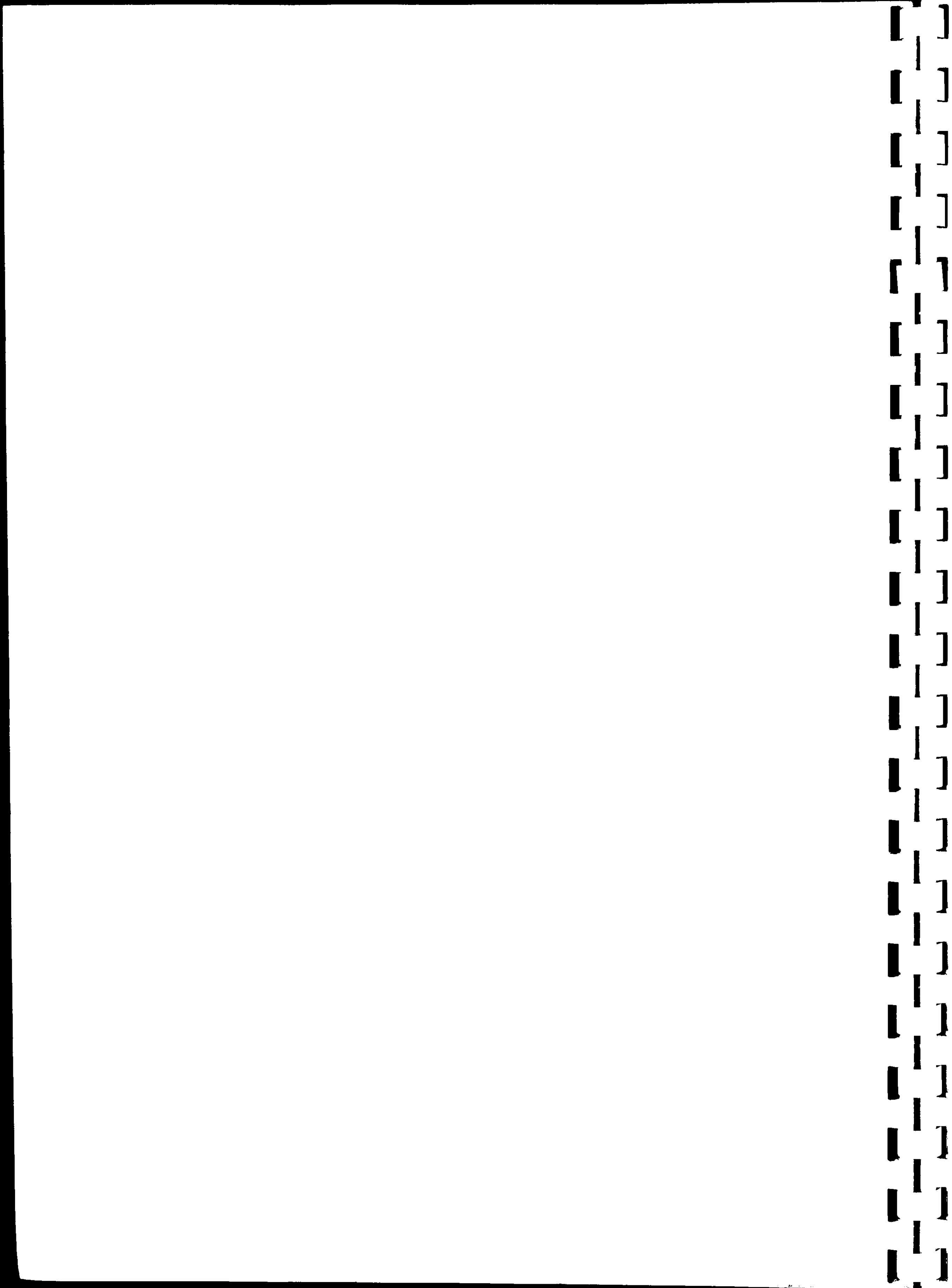
The fist question at a case conference should be 'why was the patient attending?' The doctor present then stating the diagnosis, the problems, the reason for attendance, for how long, and any other difficulties.

The next stage was to assess from other members of the team attending what progress had been made since the case was last reviewed.

The third stage was redefining the objectives. What now in the light of his progress was needed? It was necessary for the team to arrive at some consesus as to what should be the course of management during the next few weeks. At this stage Professor Brocklehurst felt that the patient should be included in the conference if fit enough. The matter could then be decided possibly much more positively.

Naturally good record keeping was essential, notes being the basis of communication. Again, the question often arose as to how they should be kept. Should each department retain their own or should there be one set of notes? Professor Brocklehurst considered it an advantage to have one record which contained reports from each team member, although he appreciated that most members would need to keep some working notes as well in their own paticular department. Although stating perhaps the obvious, he felt it was necessary to stress that the patient's first attendance at a day hospital, or even before he attended, a statement from the referring doctor, who was likely to be a consultant or a senior registrar, as to why he wanted the patient to attend, the objectives, and any information concerning drugs etc. Each hospital should have a referral form giving this information to all members of the multidisciplinary team.

Programming was equally important, particularly if the day hospital accepted both in-patients and day patients. Progress notes were vital. One fact which had emerged during the survey carried out by Professor Brocklehurst and Dr Tucker was communication with relatives. It seemed clear that relatives of a patient attending a day hospital knew little about the objectives, such as why their relative was attending, and what they might be able to do in furthering the hospital's aims and objectives. It was an excellent idea that relatives should be invited to the day hospital and spend some time with the patient and different therapists. There should be better methods of communication with relatives than at the present time.



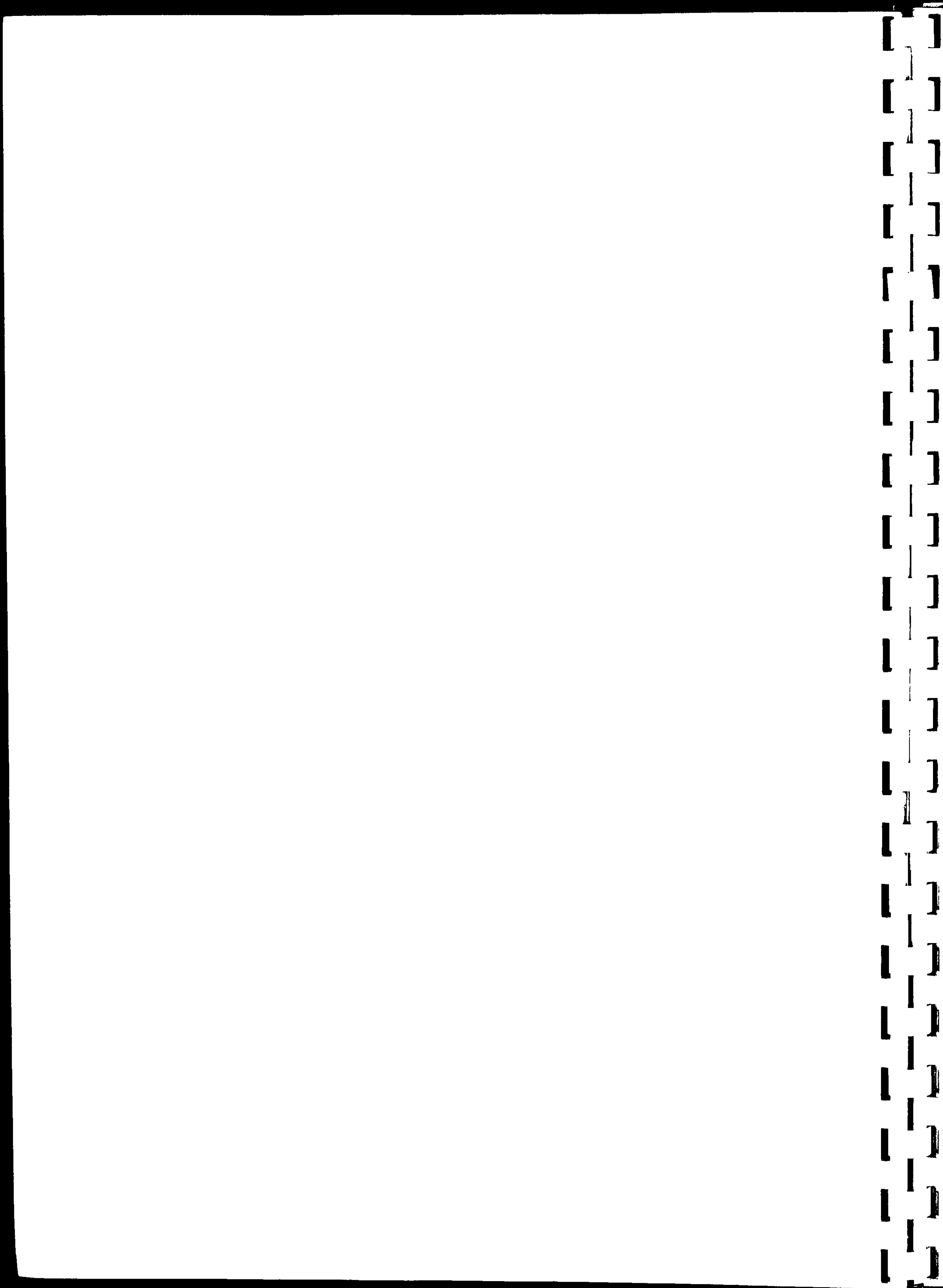
Another interesting question arose. Who was actually in charge of a day hospital? Often there was no clear-cut answer. In the majority of day hospitals the day-to-day administration was in the hands of the senior nurse. A number of hospitals had designated this role to either the senior physiotherapist or occupational therapist, while in some hospitals an administrator had a specific role. However, the overall area of responsibility lay with the consultant to whom the patient had initially been referred. Thus it was he who made the ultimate decision as to each individual's course of treatment.

Professor Brocklehurst considered the future. He said it was very difficult to assess the future needs for geriatric care. It could not be underestimated that the day hospital scheme required to be greatly extended. The proportion of old people throughout the country over 65 years of age would not increase very much more in the present decade. A peak would probebly be reached in the late 1980s and as far as could be judged the proportion of those over 65 years would not increase thereafter. The change occuring as most people knew, was in the growing proportion of the very old - namely over-70s, 75s and 80s. Naturally these age groups made the greatest demands on the geriatric and social services.

It was unfortunate that the age of 65 had been taken as the cut-off for planning norms. These norms should be based on some other figure, either 70 or 75. In a number of regions such as the North-West the authorities had managed to make their norms weighted to the proportion of people aged 75 and over. The figure of two places per 1000 over 65 normally used, was probably correct in a hospital providing both in-patient and out-patient care.

The day hospital was now a permanent feature of health care. The real problem lay in the field of dementia. There would be a huge increase in psycho-geriatric day care, and it was appropriate that this care should be undertaken in seperate premises because the objectives were different and it was not in the best interests of either the psycho-geriatric or geriatric day patients to be in one unit. From his point of view Professor Brocklehurst would prefer to see seperate development of more social day centres, and a clearer definition of the day hospitals' objectives. Day hospitals were very much on the agenda throughout the world. They were a British innovation. Now in the western world and indeed in a number of third world countries, geriatric care of the patient wasdeveloping and day hospitals played an important part. Thus there was the interesting possibility of comparing the way in which day hospitals developed in different countries to meet each particular need.

To talk of the future was difficult commented Professor Brocklehurst. He was sorry he had no very profound statement to make.



3. NURSES IN DAY HOSPITALS.

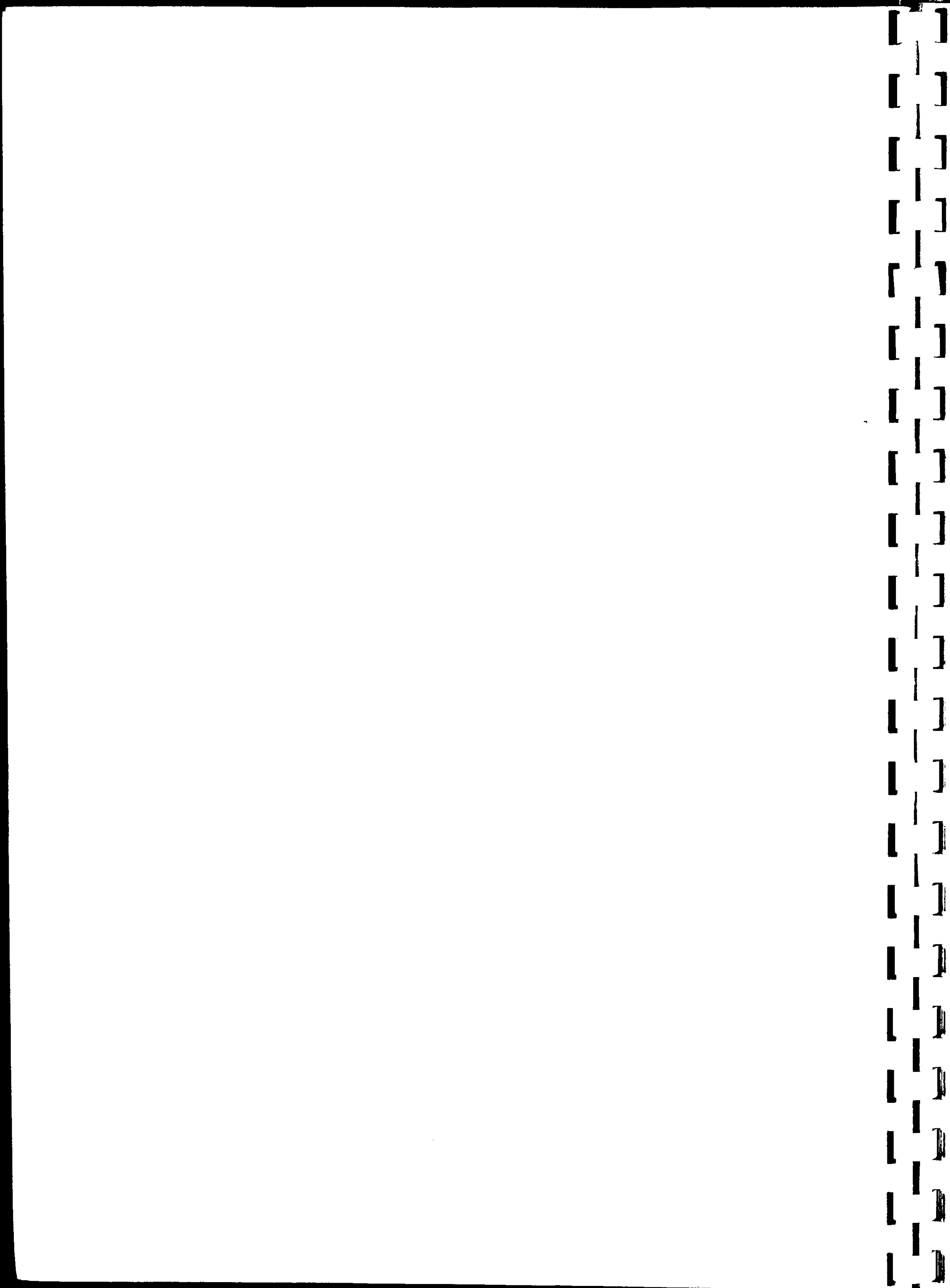
Mrs Pauline Blight, Senior Nursing Officer, Geriatric Section, Southwood Hospital, London.

Mrs Blight said that originally it had been suggested she should talk on 'The Role of the Nurse in the Day Hospitals'. Quite frankly, she herself, could not tell her audience what this role was, because the role of a nurse in a day hospital had not been clearly defined. Thus, the object of the Conference was to provide ideas and guidelines.

Mrs Blight considered her own definition of a day hospital. When she started nursing in 1973 the main objectives were obviously treatment; both nursing and remedial treatment although no remedial staff were then available; also follow-up care for those who had been in-patients, not necessarily from the geriatric ward, but from some other wards in the hospital; to give relatives some rest, and to save hospital beds. Day patients were given the same consideration as if they had been in-patients but went home at night and at weekends. When Mrs Blight first set up a pilot day hospital, out-patients were the first consideration. It was vital to recruit nurses and being able to offer them the hours of 9 a.m. to 5 p.m. in a day hospital proved more successful than the unsocial working hours on the wards. This objective might still be important in some areas but one preferred to think that caring for elderly people and making it possible for them to live in their own homes came first.

During the last few years the aims of the day hospital had been reassessed although the main objectives were still maintenance of health, rehabilitation involving social care, remedial, medical and nursing treatment; while the saving of hospital beds was incidential and not a priority.

Having agreed that admission to the day hospital replaced in-patient treatment in a geriatric unit, it would be 'simplistic' to state that the role of the nurse in a day hospital was similar to that of a nurse working on a ward. The majority of day hospitals were under the care of a geriatrician, with a visit at least once a week, involving a multidisciplinary meeting. The remaining medical cover came from clinical assistants and junior medical staff, thus the nurse in the day hospital had to be responsible and to take the lead for many decisions. Though referrals could come from many sources, patients usually arrived via the department of Geriatric Medicine. Some consultants, however, did encourage referrals direct to the sister in the day hospital. This was much easier as she could then decide about the availability of places, how the patient could be accommodated, and often assess him. The sister could co-ordinate attendances thus avoiding a large number of patients on one day and a few on the next. The sister was also responsible for records of the patient's progress, and usually kept a card index system or other similar method.



How did one prepare the nurse for the day hospital role? A nurse needed a sympathetic approach coupled with the ability to work in a multidisciplinary team. She needed to know the underlying principles of assessment and rehabilitation, and this often meant that a nurse had to re-think her attitude towards patients. The basic nurse training and very often the motivation to become a nurse caused her to look upon patients as dependants. In caring for the elderly and certainly in a day hospital, the nurse must alter her attitude and cease to regard them in that light. Flexibility was very important.
In the area of Islington they had geriatric nurse visitors who were trained to undertake assessment. A continuing problem was that patients frequently failed to attend the day hospital and often were not fit enough to do so. This was where liaison with the visiting nurse and day hospital nurse was essential.

> Who should run the day hospital?
> What staff would be needed, assuming a sister was to be in charge?

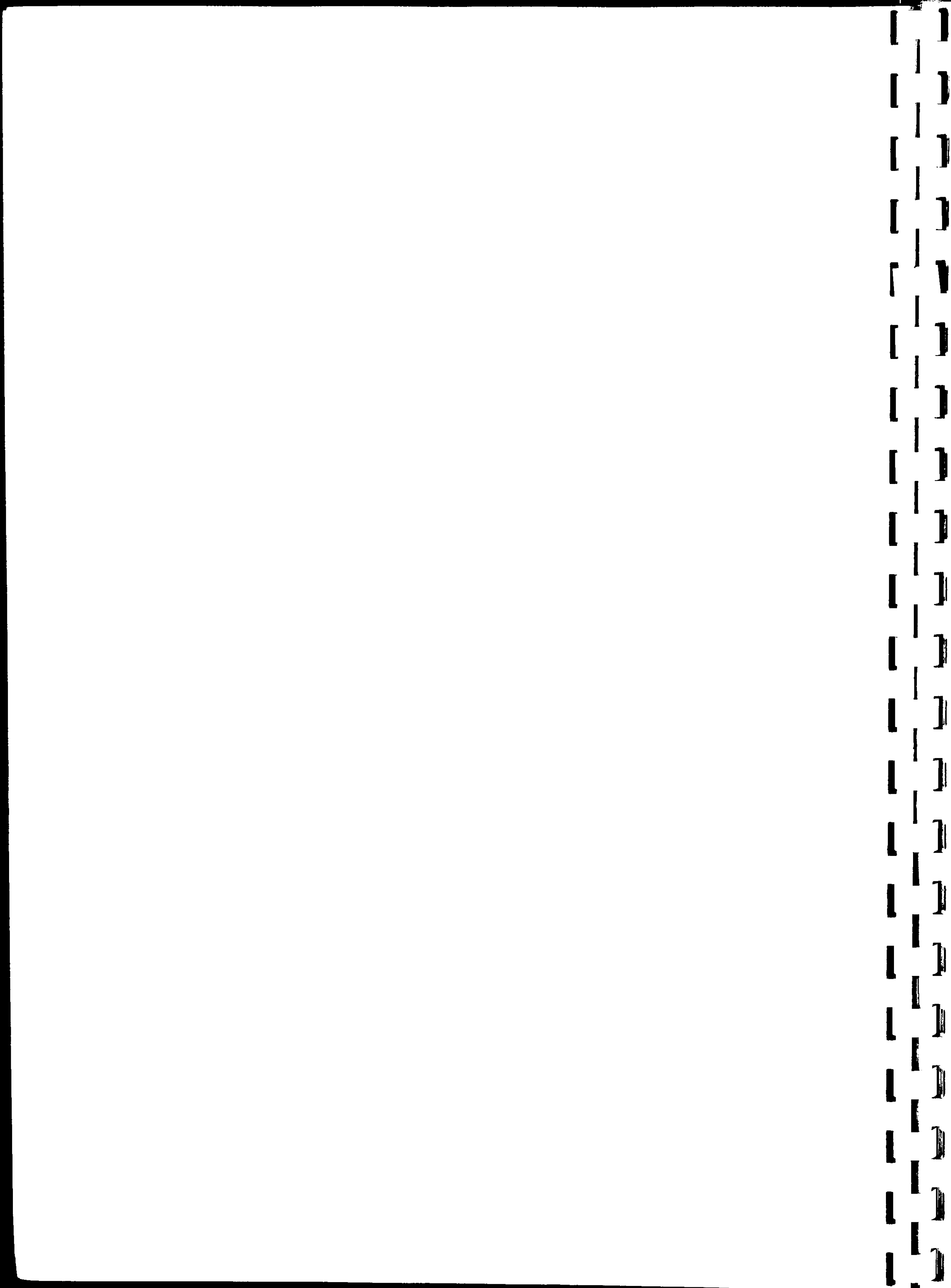
Firstly, a deputy would be needed, preferably a staff nurse, or senior state enrolled nurse (SSEN), who could take her place on the multidisciplinary team with confidence. Obviously the number of nursing staff would depend on the workload, but adequate back-up staff would be required, particularly clerical, to deal with transport and other administrative matters.

Mrs Blight said she had been involved in starting two day hospitals in totally different districts. The first one the original pilot scheme was run by a staff nurse, who was then succeeded by a SSEN. Her experience and personality had contributed to the hospital's success. Regarding the start of the second day hospital, Mrs Blight had suggested that the senior nurse's post should go to a ward sister who because of her experience and also her pleasant personality clearly understood the nursing input required in the multidisciplinary team and the aims of the day hospital.

The only preparation passed on to those nurses was to arrange for them to visit existing day hospitals, and read what was at that time the small amount of literature available. Also support within the multidisciplinary team in the first weeks.

Although the aims and objectives of day hospitals inevitably had to be flexible, a standard post-basic training, as well as experience in care of the elderly was essential. A number of staff members took a Shortened Course on Care of the Elderly which was not really appropriate for them, but it was the only form of instruction available.

There was a great need to educate <u>all</u> nursing staff in the running of a day hospital so that when a patient was referred to a day hospital they would know how it operated.



4. THE ROLE OF THE PHYSIOTHERAPIST

1)Miss Rowena Kinsman, Superintendent Physiotherapist
Barnet General Hospital, Barnet Health District.

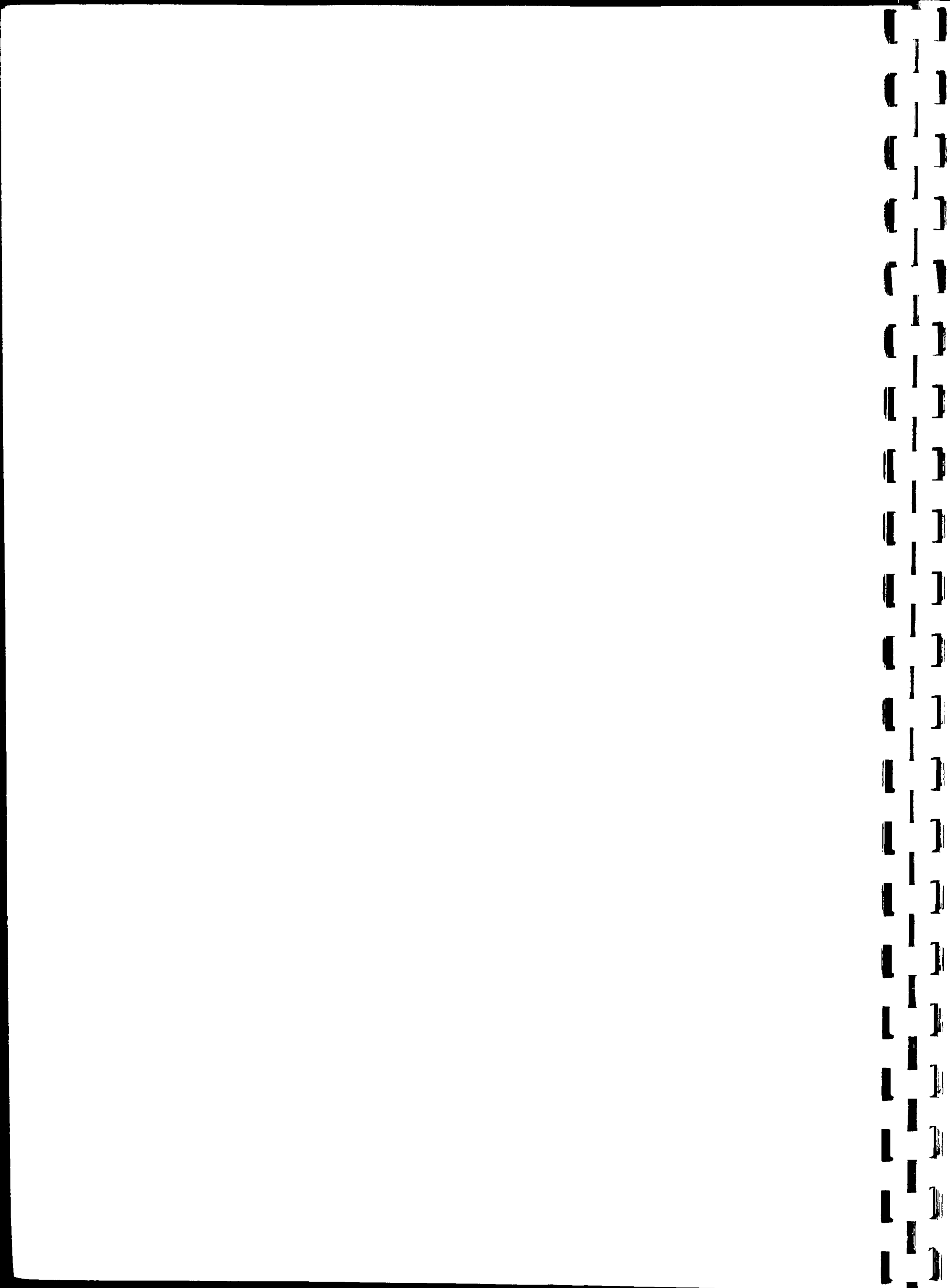
Miss Kinsman said there was no easy demarcation between an occupational therapist and a physiotherapist working in a geriatric day hospital, but 'as a rule of thumb' she would suggest that the role was that of educator, able to assess and identify the needs of the patient, to provide physiotherapeutic treatment and to work as a member of the multidisciplinary team.

Physiotherapists had an understanding of movement in its widest sense and knew how to facilitate movements so that a patient might once more lead an independent life. This skill only became useful when it was shared with other staff and understood by the patient. In order to do this the physiotherapist must be able to teach both staff and patient.

The first objective was to gain a complete understanding of the patient's ability, range of movement and exercise tolerance. The findings should be recorded on an assessment form and a realistic programme of treatment drawn up. It was important that if the patient had more than one problem, these were also recorded, and the most important, identified. The assessment form should then be made available to the staff involved with the patient's case and the physiotherapist would ensure that they understood how the patient 'moved'.

As an example when a patient is getting in and out of a chair, this appears a simple movement taken for granted, but it had to be appreciated that the person needed to shift his weight from one hip to the other and then hitch the free hip forwards, and in order to do this he had to place both feet on the floor prior to standing. A slide showing a hemiplegic patient with the foot on the affected side forwards so that she could tell that when the patient stood up, he was in a position to take a step forwards without going into associated patterns. Unless this information was shared with the rest of the staff it was impossible for them to follow the physiotherapist's method when, for example, helping a patient up from a chair. If all the points were observed as to how a patient moved it soon became easy to help him and he would probably only need assistance from one person; also, more independence for that patient was achieved.

In addition to showing various members of the team how patients could be taught to manage for themselves, physiotherapists should be aware of the research carried out which suggested that elderly persons could regain muscle power which would in turn bring about increased ability and restore confidence. It was therefore important that where appropriate, individual treatments were given. The physiotherapist should carefully monitor these treatments to prevent a situation developing whereby treatment was being continued after the patient had reached the maximum potential. If the treatment continued it should be for maintenance purposes only.



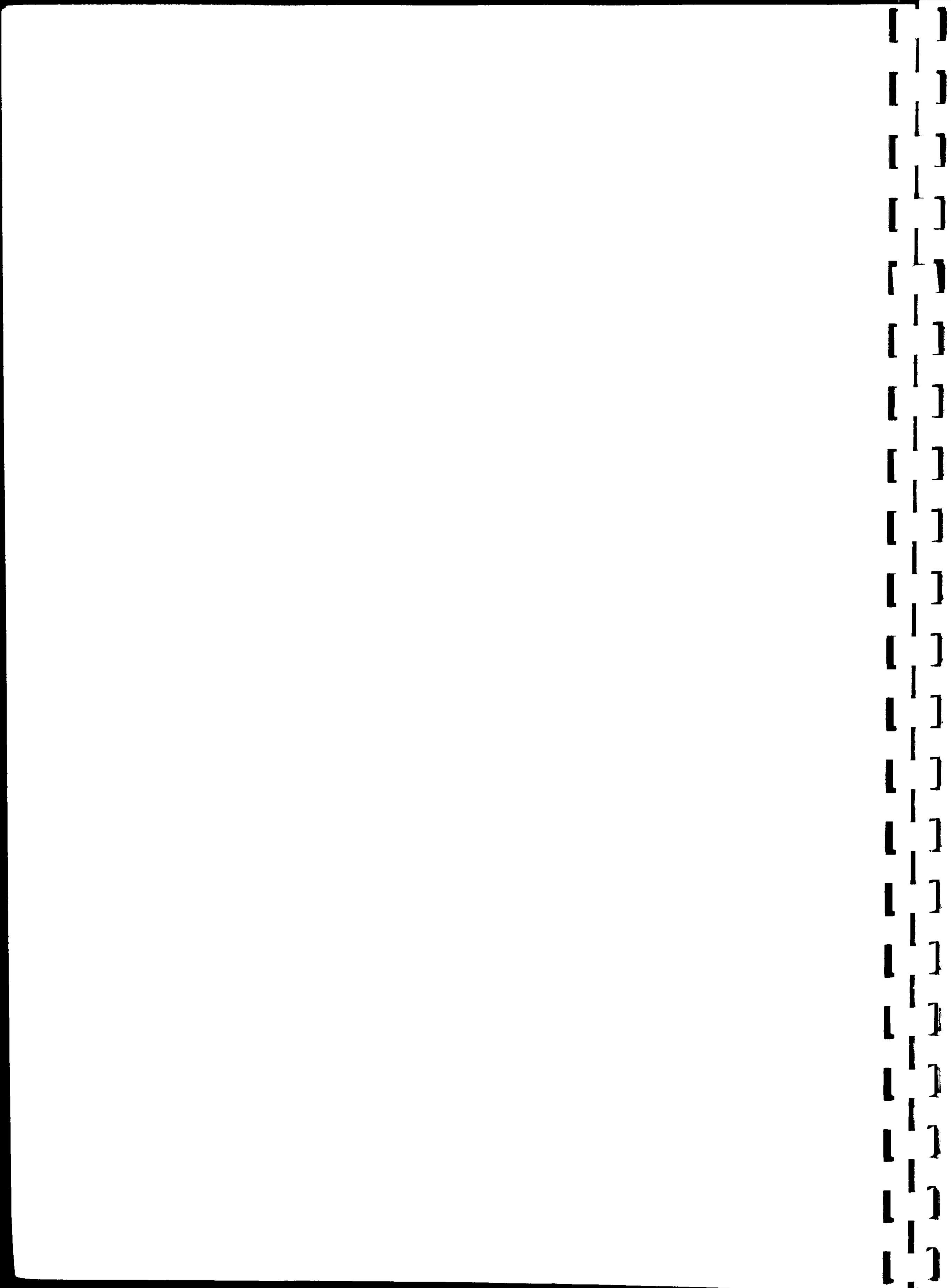
Miss Kinsman had been recently involved in a day census and survey of 281 patients attending a day hospital, and she thought the delegates would be interested to know that most of them attended for about six months; however some received physiotherapy treatment one and a half years after they had attended initially.

At all times during treatment the physiotherapist must recognise that patients were motivated by success and that the programme of treatment must allow for this. It would obviously involve close liaison with other staff because all must recognize this fact. It involved speaking at case conferences, saying clearly and realistically what a particular patient had achieved or could achieve. This might also involve the physiotherapists in the admission and discharge policy concerning a patient.

Another area involving physiotherapists working in geriatric day hospitals was in the care of the staff backs. They should instruct all staff in how to care for their backs especially when lifting patients, and it was important this aspect of their role should be realized. The Australian lift taught in the wards was not often used in day hospitals because it was thought that most members of the team knew how to lift correctly. Nevertheless, it was important to ensure all staff in the day hospital had this knowledge. There was also the procedure of how to get a patient off the floor after a fall. One of the normal methods was to make use of a piece of furniture. It was important that physiotherapists should ensure a patient was calm while awaiting help, or confident enough to raise himself by this method. The physiotherapist should also show staff and relatives how this could be done.

As a physiotherapist, she was concerned about their role in a day hospital. In this connection she had undertaken a small survey to ascertain the physiotherapists' views on whether day hospitals were being used for treatment purposes and the extent in which physiotherapists were involved. In 72 per cent of the answers physiotherapists were involved with the design of a day hospital, yet only 40 per cent were satisfied with the completed building. Miss Kinsman and her colleagues wondered if this was because they were not trained to contribute fully within the design team or that their recommendations were not adopted. The comments indicated that the open plan of many departments meant there was a high level of noise, making it difficult to carry out assessments or to work on programmes requiring a quiet area. Many also commented on the lack of meeting-room space and of storage space both for equipment and for wheelchairs. There were frequent comments that handrails were omitted, or at unsuitable heights, and they were interested to find that 48 per cent of day hospitals in the survey were unable to cope with the number of places for which they had been designated. The survey also showed that a member of the nursing profession was predominantly responsible for day-to-day organization of the day hospital.

They were also interested in the frequency of patient attendance for physiotherapy: once a week, twice a week, three times a week and even five times a week. It was argued that physiotherapy for the elderly was only successful if it was often and little. In their survey they found that this was not the case. The



role of physiotherapist and of many other members of staff in a day hospital was to teach patients to manage for themselves to the best of their ability. Whatever the pathology, the patients needed to be re-taught how to do tasks which had previously been no problem.

2) Miss Anne Dummett, Occupational Therapist, Whittington Hospital, London.

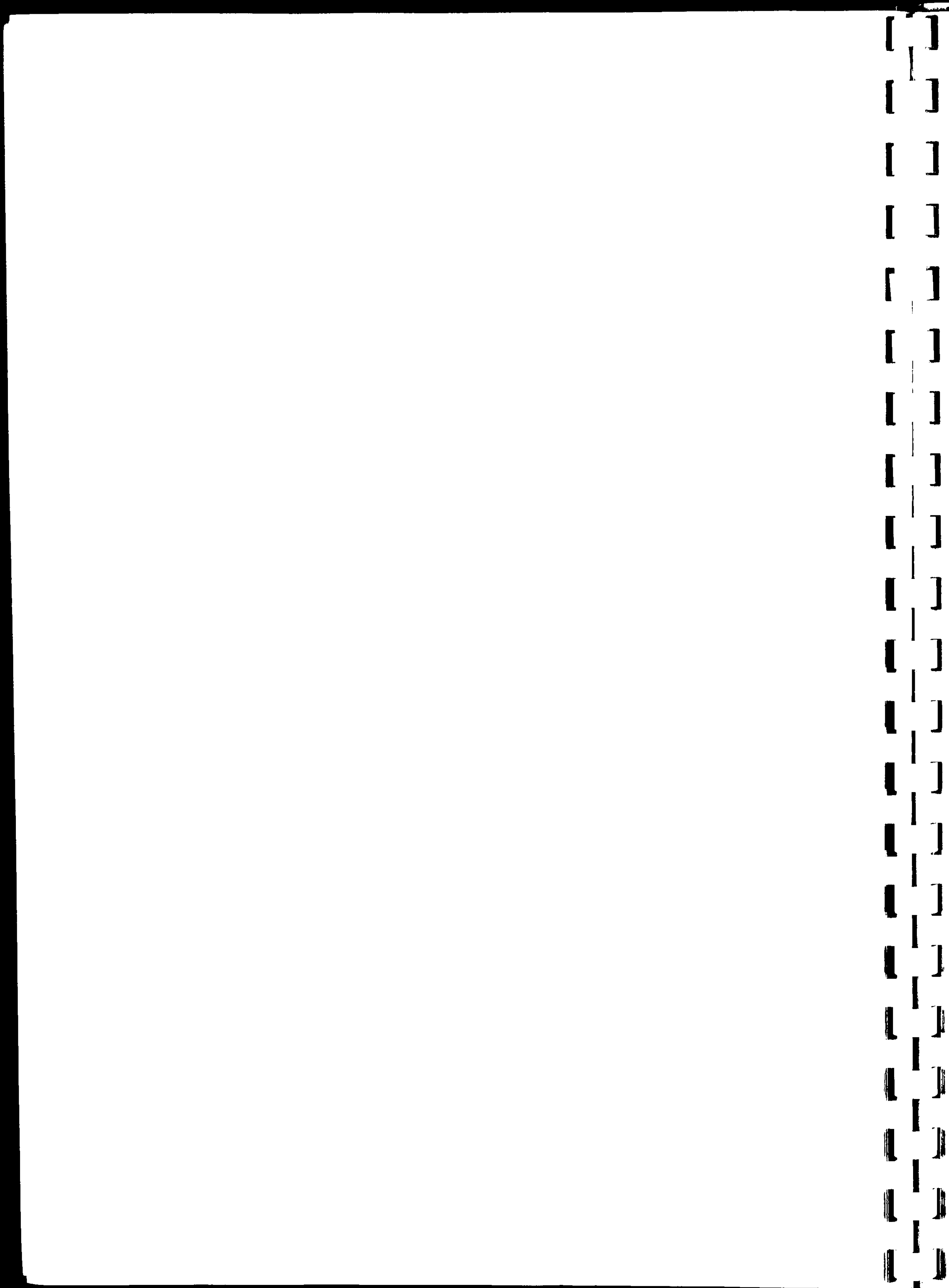
Miss Dummett said what had just been outlined to the delegates, the role of physiotherapist was one of initial assessment; movement facilitation, teaching of staff/patients/relatives, and other personnel; with the emphasis on education. Similarly, occupational therapists performed all of these functions but most important of all were unable to carry out an effective treatment programme without the initial and essential work of the nursing staff, and physiotherapists, and by being a member of the multidisciplinary team. There was inevitably overlap in many areas but one discipline could not work in isolation if day hospitals as they were emphasizing at the conference, were primarily for education and treatment, not merely for social activity. Just as physiotherapy had developed beyond 'heat and massage', so occupational therapy had developed beyond 'baskets and pink bunnies'.

The role of the occupational therapist was seen to be one of:
(a) training the patient in activities of daily living
(b) assessment of the patient's home environment including type of access to home, internal lay-out, proximity to shops, clubs and transport
(c) organizing group activities
(d) specific testing, such as a cerebral function test or perceptional psychological testing
(e) wheelchair assessment and training in how to use the aid. For instance, it was essential to lift up the footrest and put on the brakes before getting out of a wheelchair.

A home visit was important to make sure the doorways were wide enough to allow the chair through and that there were no flights of stairs; and no lift. Such matters were often overlooked if the wheelchair was ordered without referral to the occupational therapist or some other person with suitable knowledge, or it would prove an aid to disablement rather than to independence.

(f) therapeutic recreational activities such as hand function and dexterity, in addition to socialization and interaction in groups.

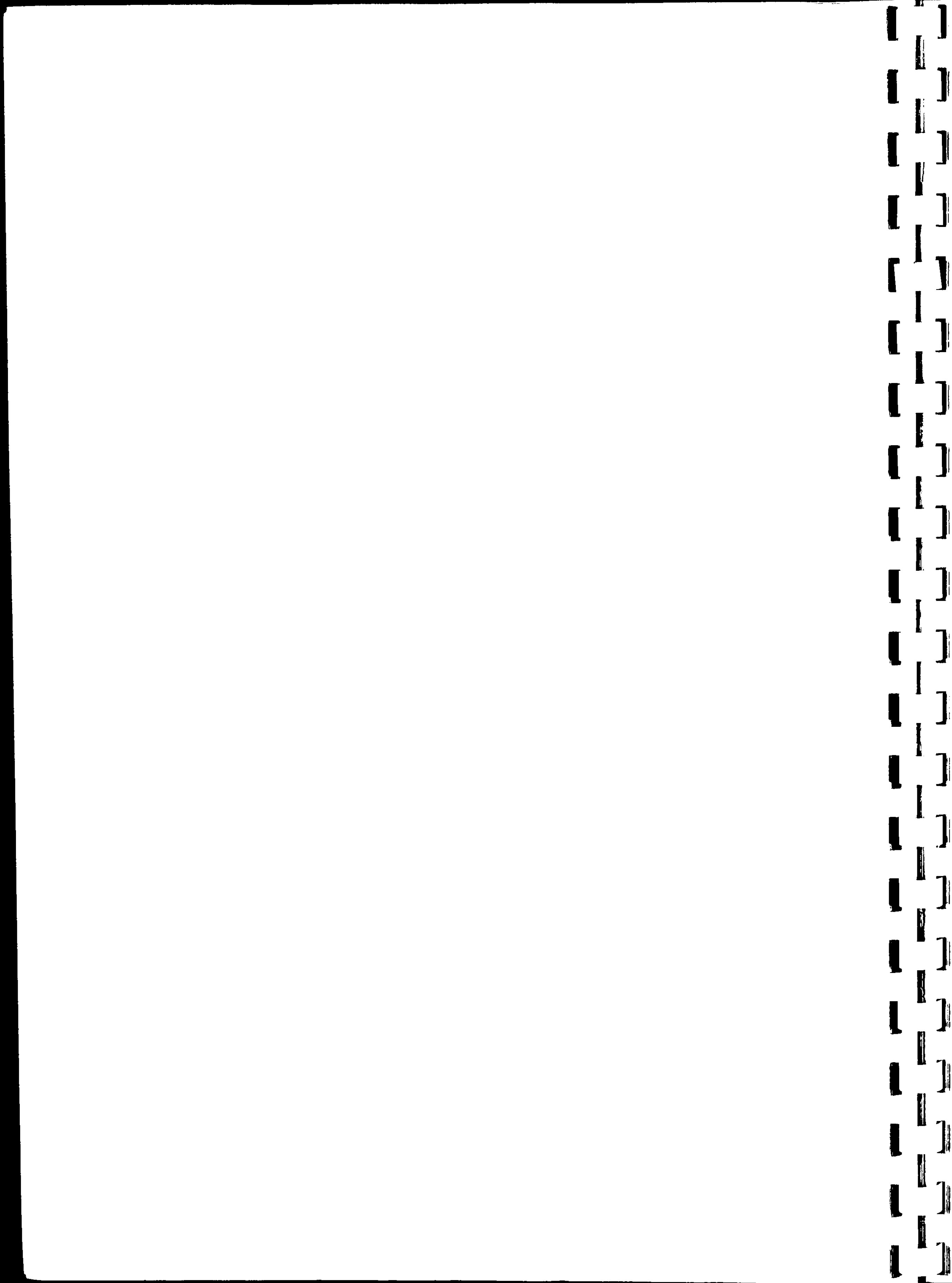
There was, however, a danger as had happened in America that physiotherapists and occupational therapists became too involved with assessment to concentrate on their real roles in the day hospital setting, which were to enable the individuals attending the hospital for treatment to live at home and remain there with dignity and independence.



Physiotherapists and occupational therapists had an all-embracing role striving to achieve that end, and must concentrate on re-teaching and reinforcing well-known activities such as cookery, handling of money, even of road safety. There was also the need to ensure that the patient would be able to transfer from bed to chair or commode during the night. In addition to all this individual activity, group sessions should comprise reality-orientation activities, culinary programmes and how to cope with life/society groups. It was possible to help to link reality-orientation closely with cookery by relating the recipe chosen to seasonal dishes, for example, jam in summer, apple pies in winter. Bread making was another example, useful in bad weather or even during bread strikes'. These activities stimulated associated senses such as smell, sight and touch. Group activities also encouraged balance and co-ordination, besides teaching new skills. In group activities patients helped one another, showed interest in each other's past and present lives. Mixed group involvement developed participation and enabled individuals to project their experiences, particularly important to those living alone or who suffered from deafness. Miss Dummett then showed a type of deaf aid, a machine which amplified speech through earphones as used with record players. It stimulated conversation and gave any teaching help the patient might need.

The social worker was another essential member of the team who would be able to give the members the full social history of a patient and act in close liaison with social services departments and community homes, linking information with that gained by physiotherapists and occupational therapists on a home visit. It was taken for granted that home visiting by an occupational therapist was beneficial, but she believed other members of the team should also participate. If carried out jointly by those members of the multidisciplinary team whose field involved a particular patient, it avoided delays in providing aids, adaptations and facilitated correlation. The furtherance of community links through teaching of relatives or joint visiting led to integrated treatment of the patient concerned. Thus through teaching and reinforcement of skills in a day hospital environment, the elderly should have freedom of choice and quality not quantity of rehabilitation.

Miss Dummett concluded on a warning note by stating that she and her colleagues should not forget to question their competence to dictate a life-style.



5. HELP FROM THE CITIZENS ADVICE BUREAU (CAB)

Mrs Mary Hitchin, Co-ordinator,
Citizens Advice Bureau, Camden Council of Social Services.

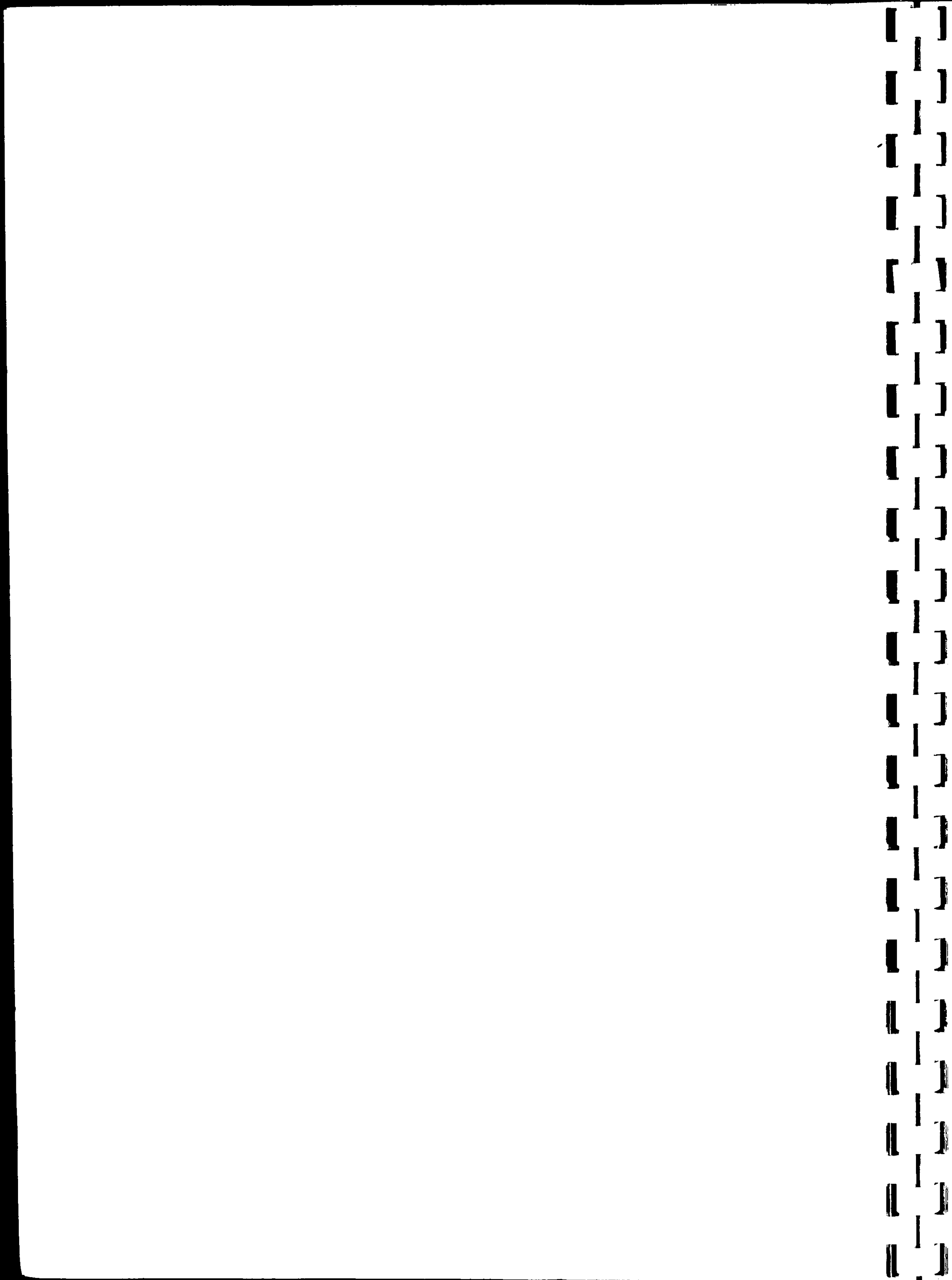
Mrs Hitchin referred to an observation made by an earlier speaker when she said day hospitals were for the maintenance of the elderly in the community and in their own home. Mrs Hitchin said that Citizens Advice Bureaux were not only of use when the patient returned from rehabilitation, but also during the period of treatment.

Everyone present was aware that problems, financial or otherwise could impede recovery and reduce the benefit of medical and other treatments. Patients attending day hospital invariably took their problems with them, and at the end of the day and at weekends they were once again ordinary citizens. Even the able-bodied found it difficult to cope with various types of legislation and for the less able there could be disastrous results. It was important for those dealing with elderly people in a day hospital to 'listen out' for problems and the Citizens Advice Bureau was there to offer help.

Legislation involved endless form filling and even those working in the Citizens Advice Bureaux had difficulty in understanding some of the forms that appeared. In an application for supplementary benefit there were 40 different means tested benefits to be studied, but the Citizens Advice Bureau was there to deal with such matters when people busy in other disciplines just had not the time to spare, nor possibly, the knowledge.

The Citizens Advice Bureaux had started as a war-time emergency, helping people with government legislation about rationing, how to send parcels to prisoners-of-war, evacuation details, and so on. It was thought that after the war Citizens Advice Bureaux would no longer be required, but almost immediately major pieces of legislation came into being. One was the National Health Service Act, and another the National Insurance Act. Legislation had been pouring out ever since so the Citizens Advice Bureaux became more and more necessary.

Close liaison between hospital staff and Citizens Advice Bureaux was beneficial to both, not only for patients, but also for members of staff. Mrs Hitchin held sessions at various hospitals for student nurses and others, helping them to learn what pitfalls they should look out for when renting their own flats or independent living accommodation. Mistakes could mean loss of money and difficulties over Rent Act legislation. Also income maintenance for the elderly and certain other advantages such as bus passes, and as she had mentioned earlier, supplementary benefit.

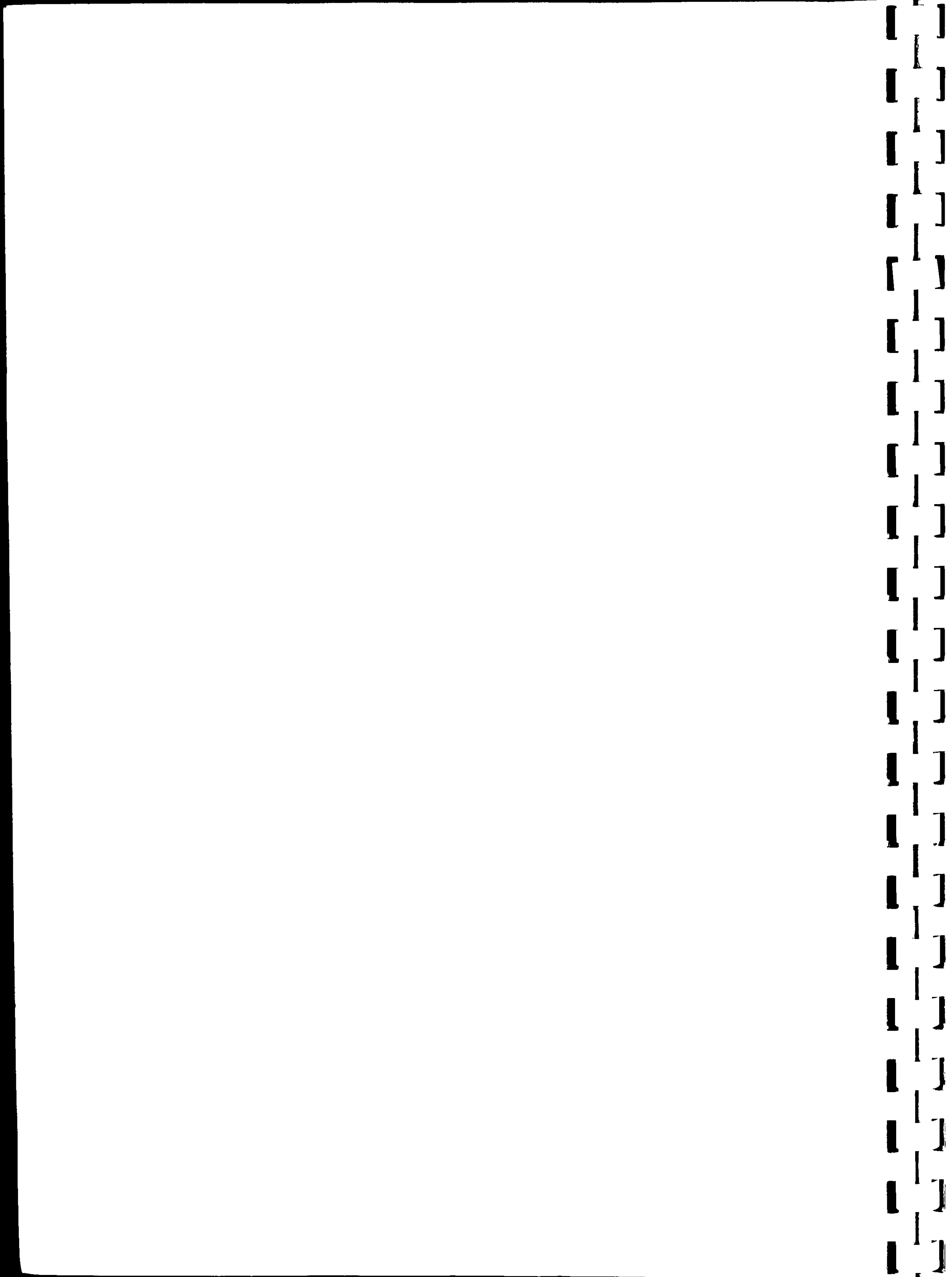


There were no environmental boundaries for the Citizens Advice Bureaux. One case had been that of an elderly lady attending a day hospital who had come to the point when she felt unable to write to her daughter in Zimbabwe. After writing frequently and receiving no reply, the worried daughter went for advice to the Citizens Advice Bureau in Zimbabwe. They gave her the address of a Citizens Advice Bureau in London and the daughter's fears were quickly eased. It was arranged that a volunteer should visit the patient once a month to write to the daughter at her mother's dictation, and to read any letters that arrived from Zimbabwe. That was communication and it meant a great deal to mother and daughter.

Landlord and tenant problems were another area which affected elderly tenants, particularly those in the private sector. A great many were known as controlled tenants, paying unrealistic rents, for example, one tenant was paying £1-14p per week inclusive for a small house. Since November 1980 those controlled rents formed under the Rent Act of 1957 had become 'decontrolled' which meant that the landlord was now able to fix a fair rent. Rates were also involved, the arrears of which the elderly tenant was unable to pay. Fortunately, friends of that particular tenant got in touch with a Citizens Advice Bureau and the bureau staff were able to negotiate repayment of the rates to relieve the tenant's anxiety.

Another problem was fuel bills. The householder might be at the day hospital when the meter reader man called, and this might happen on several occasions so that an alarming 'estimated' fuel bill would finally reach the elderly person. The Citizens Advice Bureaux did a lot of work with fuel boards negotiating payment of accounts, obtaining help from charities and other sources and advising the consumer himself how to budget for the fuel accounts.

Finally there was the case of an elderly couple who wished to marry. The lady however confided to a member of the staff at a Citizens Advice Bureau that she had at one time been married, had no idea whether her husband was alive or dead, and in addition she had changed her name, but not through deed-poll. The Citizens Advice Bureau member was able to reassure her that this was not necessary provided she did not apply for such benefits as social security under two surnames. The Bureau would also be able to help in tracing her husband and to petition for divorce as she had not seen him for five years.



The delegates were probably wondering where all the information was obtained. The government provided a substantial grant to the National Association of Citizens Advice Bureau headquarters, and twice a month, every Bureau in the country was sent a batch of information containing updated legislation, and a copy of every relevant leaflet. The most important piece of information provided was an orange sheet, which gave the updated legislation that had taken place even in the two weeks since the previous batch of leaflets.

In response to a query from a delegate, Mrs Hitchin assured her audience that the staff of the Citizens Advice Bureaux would handle telephone queries and also pay home visits where necessary.

Mrs Hitchin said that after the conference she proposed getting in touch with her national headquarters so that organizers in local bureaux throughout the country were made aware of the work being done by day hospitals, and hopefully either the delegates or the organizers would get together concerning the help Citizens Advice Bureaux could offer.

6. TRANSPORT ARRANGEMENTS

The sixth and seventh speakers wished to give a combined talk.

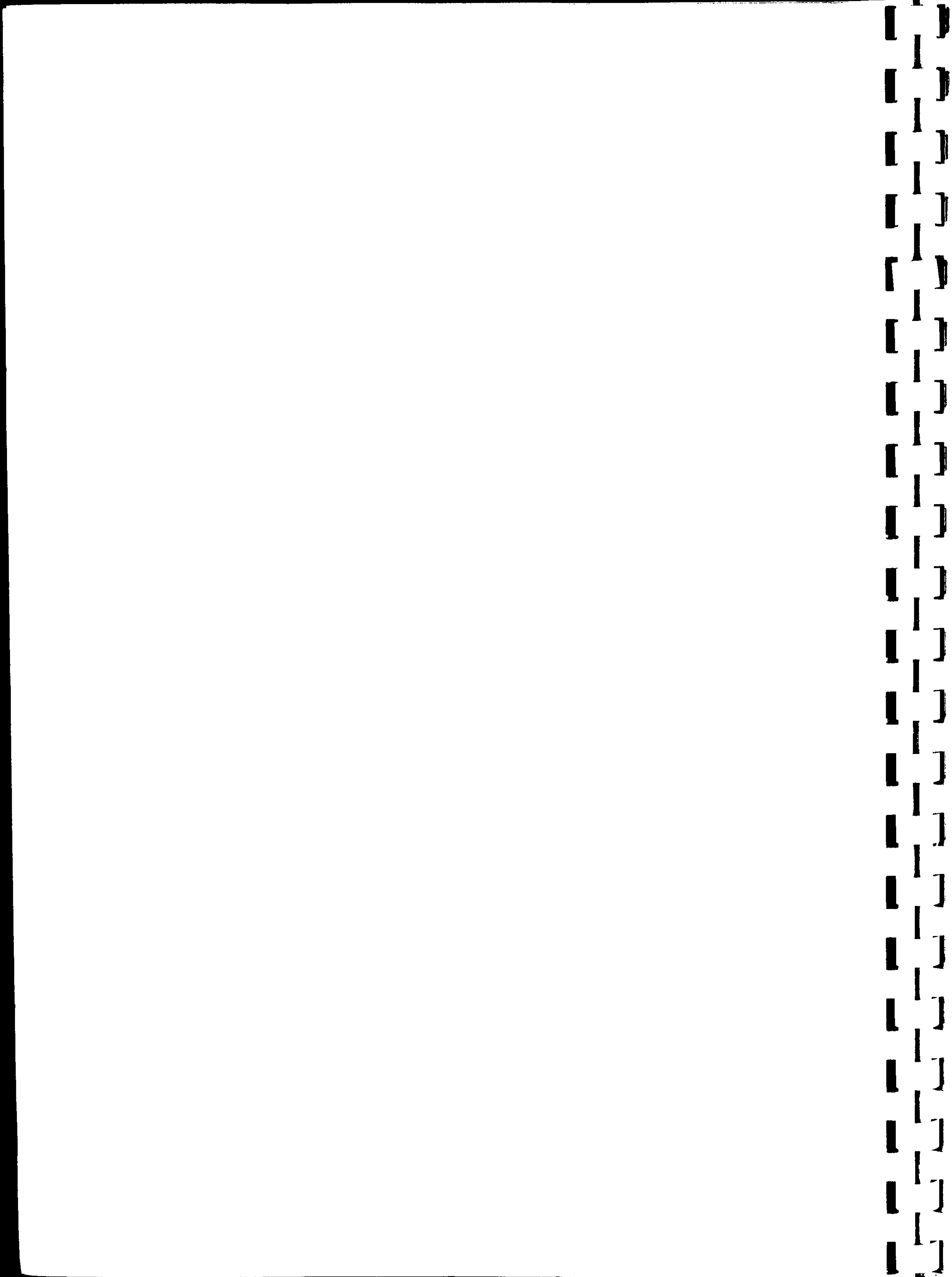
1)Mr J McCafferty, Chief Ambulance Officer, Lincoln HA.

Mr McCafferty said that the delegates would have noticed the subject under discussion was 'Transport Arrangements' and that of course, referred to transport concerning patients to and from day hospitals.

The definition of transport was 'to be carried from one place to another' and that was the theme he and Alan Hargreaves would be pursuing in their talk that morning and in syndicate discussion in the afternoon.

The aim of their presentation would be to look very closely at the best methods of transport and that such an important aspect of day hospital care should be considered before a unit opened. The question arose as to whether or not transport to a day hospital should consist of trained staff and special vehicles.

Leaving aside the after duty hours emergency situation, the basic duty of providing an ambulance service had been little affected by re-organization. The extent of this service depended, however, on the interpretation of such expressions as 'where necessary' and 'reasonable requirements' when ordering ambulance transport.



Mr McCafferty quoted from a paper presented to the 1973 Conference of Chief Ambulance Officers and still in 1981 they were encountering the same problem. 'I remind you of the importance of clearly defining the statement 'to meet all reasonable requirements' and in illustrating how difficult this can be, I quote from the 3rd report headed 'Extent of the duty of Local Health Authorities to supply Ambulances issued by the Association of Municipal Corporations, the County Councils Association and the London County Council Conference on the Ambulance Service'.

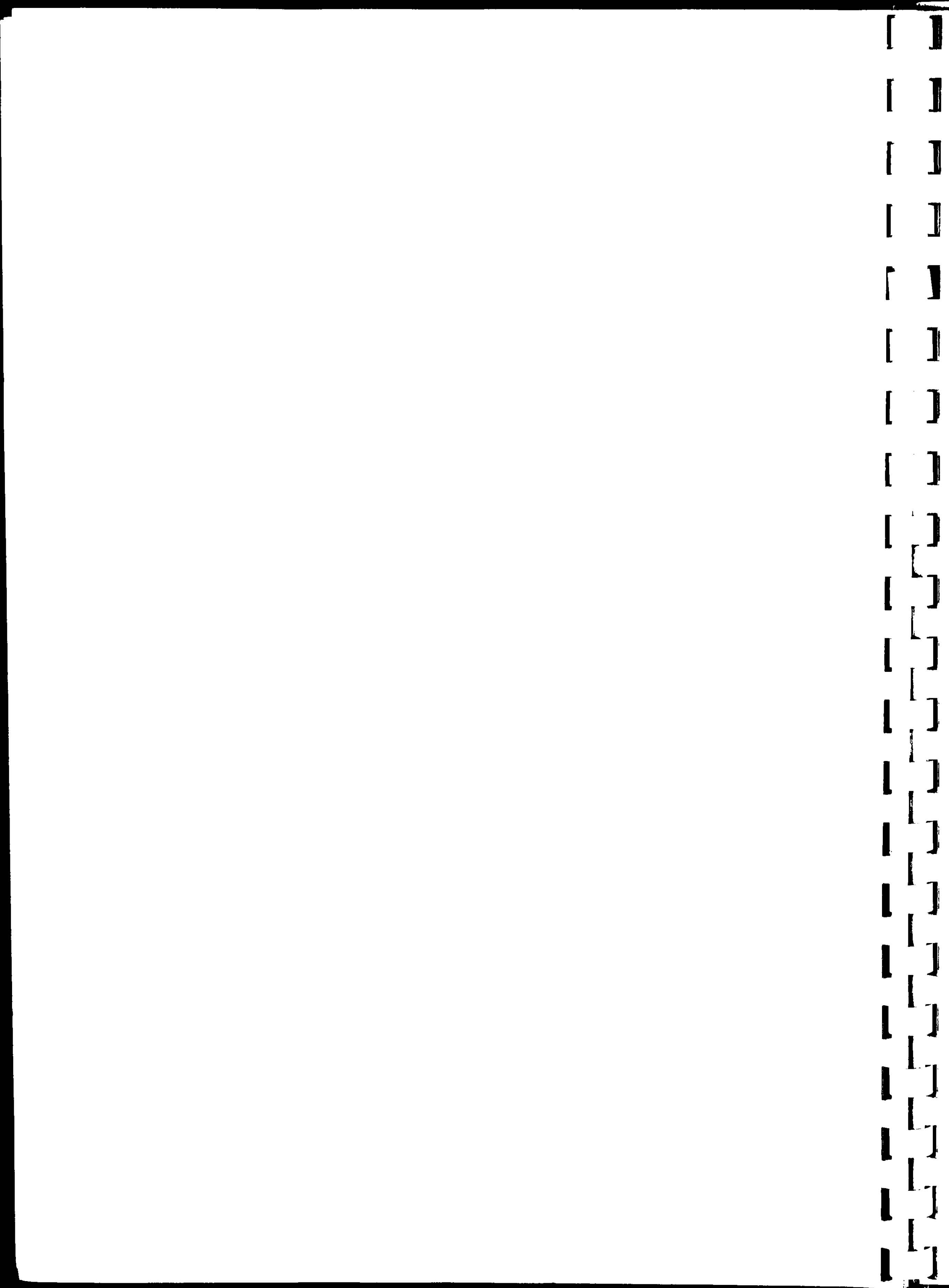
Doubt had arisen whether the words 'where necessary' in Section 27 of the Act of 1946 meant 'where necessary on medical grounds'. The cases that caused difficulty were those for whom an ambulance was not necessary on medical grounds but it had been found expedient to order one because public transport to and from the patient's home was either infrequent ot non-existent. The ambulance officer concerned would not want the patient to be denied treatment and would thus be obliged to supply a fully manned and equipped vehicle, even though the condition of that particular patient might not warrant such transport.

It was also necessary to consider the financial effect on the ambulance service with increased out-patient diagnostic day care and treatment facilities. The doctor or authorizing person was responsible only for ensuring that the patient was conveyed to and from the day hospital for treatment, not the means by which that patient was transported.

The ambulance service had been expanding since 1948 and increased day attendances at out-patient clinics, psychiatric and geriatric day hospitals had brought the cost up to astronomical proportions. Even without increasing the daily out-patient workload, the problems were sufficiently serious, and had been discussed by the Patients Transport Services working party of which Mr McCafferty and Mr Hargreaves had been members. As a result of the working party's deliberations, in the interest of those with real medical needs and to assist those with the task of authorizing transport, a more positive definition of eligibility was desirable. It recommended that unless patients made their own arrangements suitable transport free of charge should be made available for:-

(a) patients requiring transportation to hospital as a result of an accident, emergency or serious illness.

(b) patients who suffered from a physical or mental illness, disability or condition, which in the opinion of a doctor or any other authorized health care professional would thereby be precluded from making their own way to or from necessary treatment or diagnosis centres without such transport.



The rules of the use of the ambulance service as set out by the Lincolnshire Health Authority which were posted in every hostel and out-patient department throughout the county which stated clearly: 'Only those persons who are designated by qualified medical staff as by reason of health or impediment unable to use either public or alternative forms of transport are entitled to ambulance transport'.

In deciding transport arrangements for a geriatric day unit, and assuming a senior ambulance officer was part of a unit planning team, there were a number of points to be considered. He would value the opinion of the delegates as to: What the catchment area should be 5, 10, 15 or 20 miles?

The classification of patients.

(a) would they be unable to walk unaided ?

(b) be able to walk assisted by one person ?

(c) be able to walk assisted by two persons but need to be lifted into the vehicle ?

It was necessary to know the number of patients to be transported daily and how to reduce travelling times by zoning patients after their initial assessment, thus enabling the shortest route to be taken. This method would prove disappointing to the patients, who enjoyed being taken outside their four walls to see a little of the town or countryside on the way to the day hospital'.

The next query raised, concerned the type of vehicle and staffing required:-

(a) was it desirable for a unit to have its own vehicles and staff?

(b) was it more economical to contract out to a mini-coach firm or?

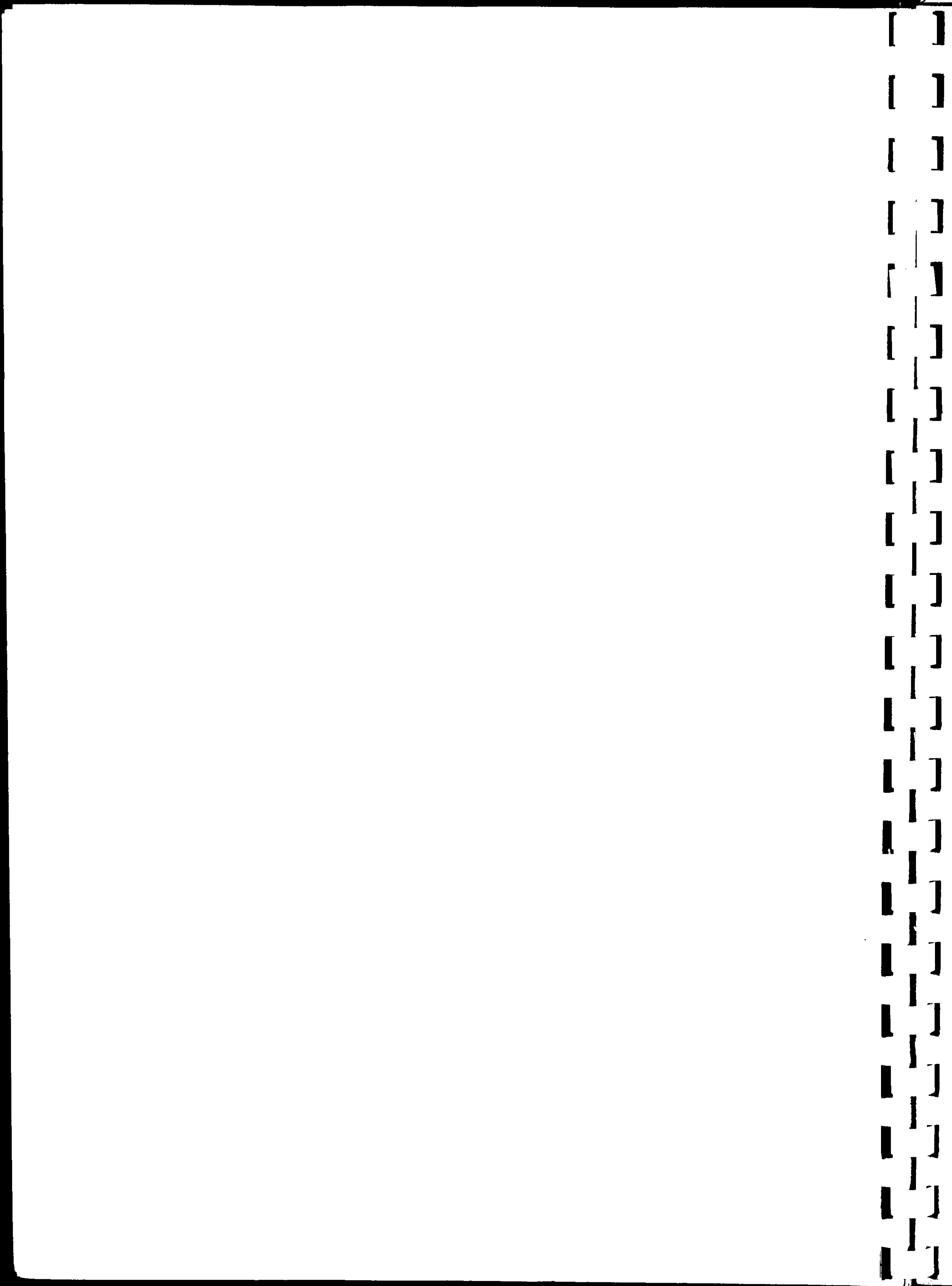
(c) was it preferable that the ambulance service should provide specially designed vehicles and skilled staff?

It had to be pointed out that districts had to fund any additional vehicles and staff and if (c) was accepted there were three alternative vehicles to be considered:-

(1) a Basic Ford Transit 12-seater sitting case bus, currently costing approximately £5,200.

(2) a Ford Transit van converted to national specifications and currently costing approximately £9,000 or

(3) a Ford Transit 10-seater sitting cas ambulance built to national specifications and currently costing £11,000.



Regarding staff, the present day cost to the district of two qualified members of ambulance staff would be £12,000 per annum (£6,000 each person). Mr McCafferty also asked for the delegates' opinion on the need for ambulance staff to be 'unit trained' in addition to their ambulance skills, so that care could be continued between home and unit.

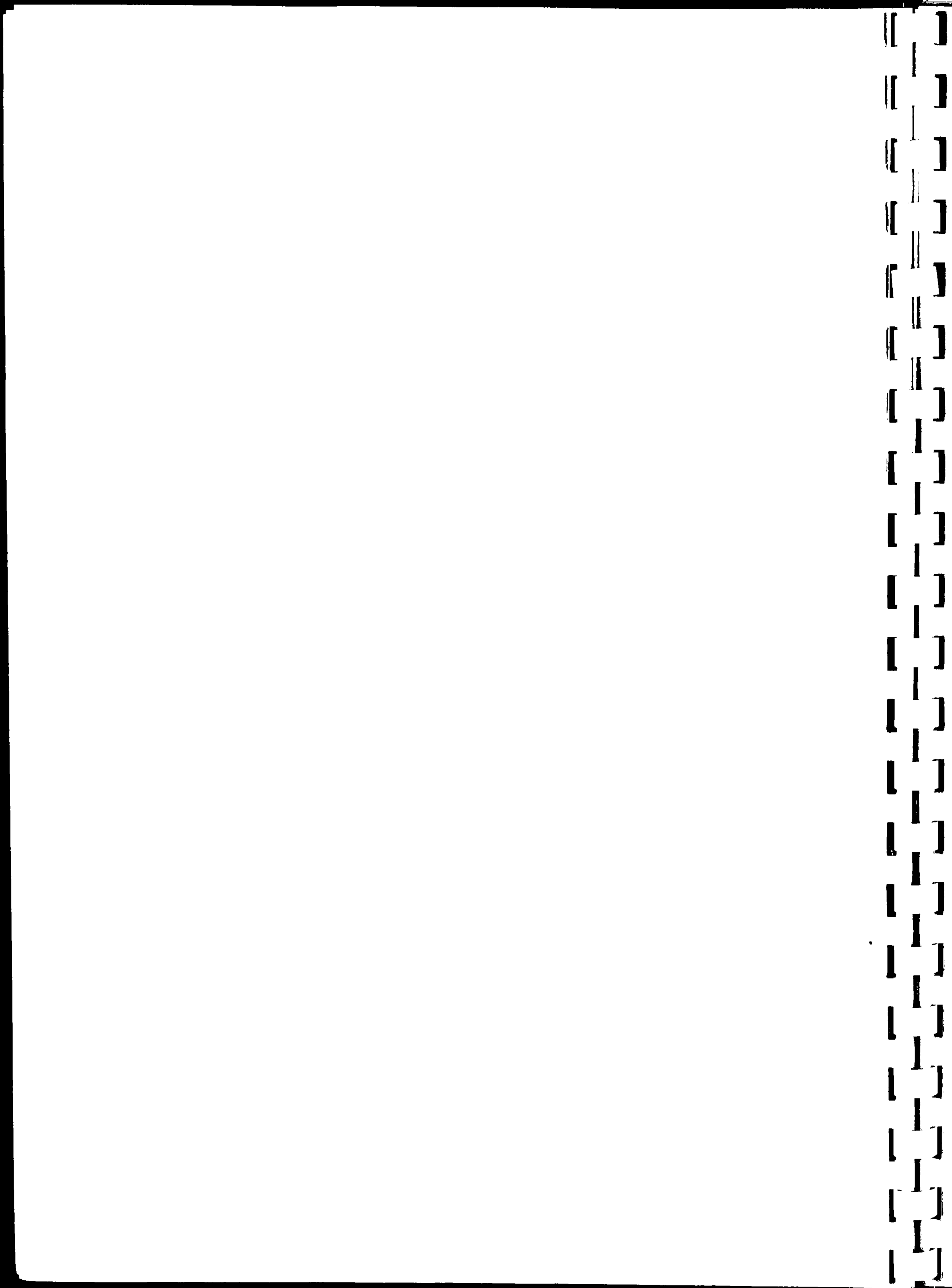
Finally there was the unforeseen shortage of ambulance staff, for example, due to illness. Each district might draw up a list of priorities renal, cancer, etc. and if this was done where on the list would the delegates place day hospital patients? These were some of the problems one had to consider well in advance of a new unit opening, and his fellow-speaker, Alan Hargreaves, would be high-lighting others.

2) Mr E A Hargreaves, District Nursing Officer, Bradford Health District.

Mr Hargreaves said he was responsible for four day hospitals in a very large urban district, present population 360,000 and a large increase in the age range 75 years and over was expected which would add considerably to the demand for services. He had been involved in the planning of hospitals and day-care facilities, but more recently, with Mr McCafferty had served as a member of a working party set up to examine and report on the arrangements for Patients' Transport Services.

Mr Hargreaves had seen during the last 15 months how problems which faced the ambulance service, reduced the effectiveness of the service provided for the patient who needed day treatment. Increased hospital activity had resulted in a heavier demand for ambulance services, and the attendance at day units had risen by almost 100 per cent, psychiatric day units by 60 per cent, and by 1977 day patients constituted about one third of patients carried by the ambulance service. There had been, however, only a 7.9 per cent increase in the total number of patient journeys, which indicated that the ambulance service was coping with increased pressure by the application of stricter criteria for ordering ambulance transport.

A day hospital must have adequate and reliable transport for a large majority of its patients, and in the recent study referred to by Professor Brocklehurst, although patients and relatives seemed to have few complaints about transport, only 15 per cent of ambulance staff were entirely satisfied.

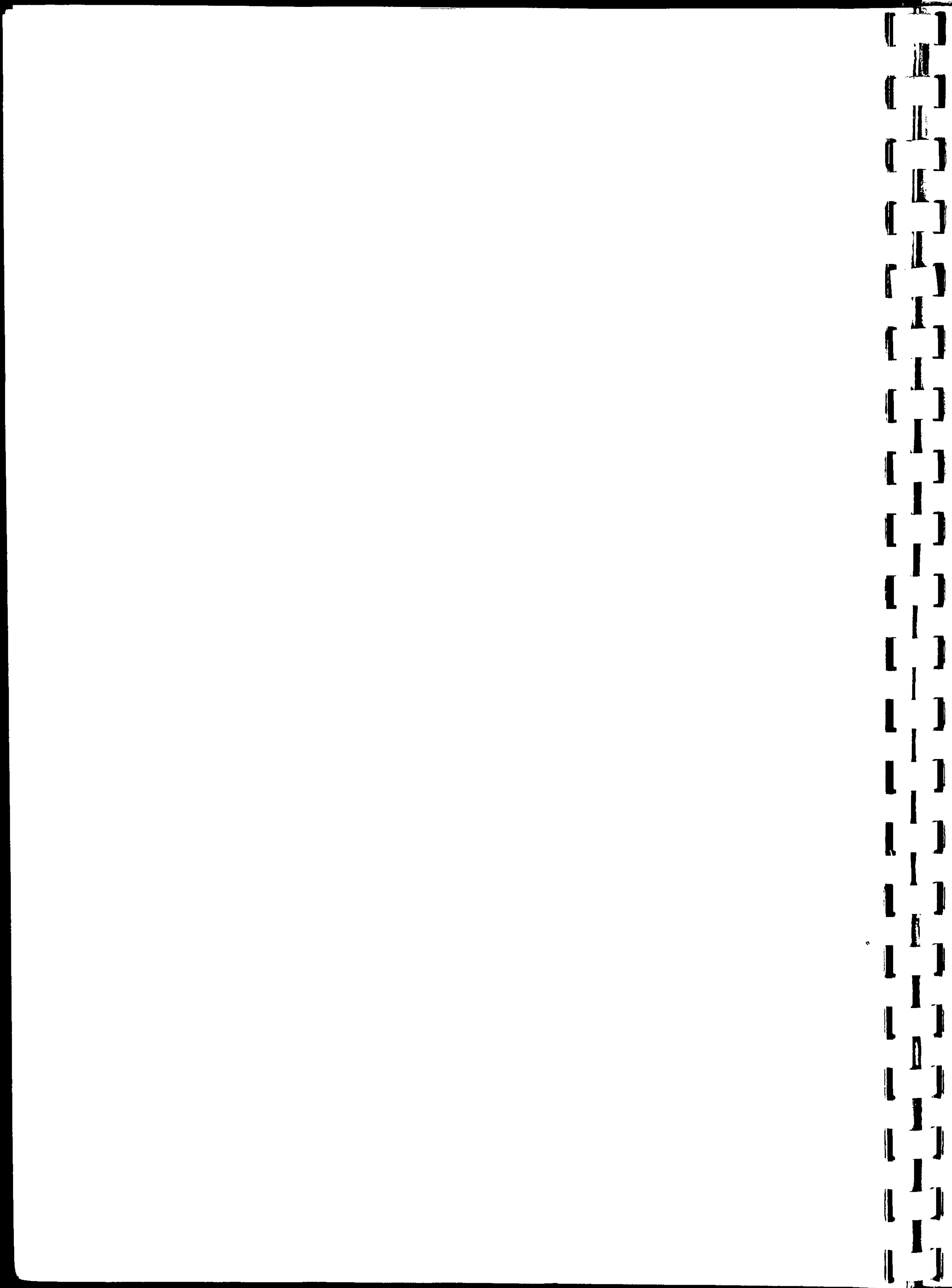


An earlier study by Martin and Millard in 1978 was critical of the way transport was organized and the time involved in conveying patients to and from the day hospital. Arrival and departure times were uncertain, low priority was given to the day hospital patients, and vehicles used were often inadequate. Professor Brocklehurst's study had shown that 70 per cent of patients were brought for treatment in multi-purpose vehicles which were unsuitable, and the British Geriatric Society told the working party that arrangements for the transport of day hospital patients seemed too rigid both in the way transport was allocated and in the variety of vehicles.

There were three main types of day hospital whose patients had varying needs. In speaking to the conference Mr Hargreaves said he would confine his observations to the geriatric patient, where there appeared to be a general consensus that almost all the patients needed transport. There seemed to be from evidence given to him a general agreement that the preferred vehicle was one suitably adapted with a crew of two ambulance staff who had received some form of special medical training. The problems to summarize, were late arrival and early departure which had been the cause of complaints from doctors and nurses in the day hospitals.

With Mr McCafferty he had undertaken a study for the working party of 13 day hospital units, and without exception they were told about problems of unpunctuality of arrival and departure, thus inhibiting the time patients could spend in the Unit. However, they had visited one day hospital in West Yorkshire where the ambulance and hospital authorities had come together at a very early stage in planning, to discuss how they could best meet the transport needs of the patients. Briefly, they had planned in sufficient time to procure two vehicles for the ambulance service which were going to be allocated wholetime to the day hospital. Two special crews had been recruited to man those vehicles, and had been given special training and attachment to the work full time. The ambulance training officer had also planned a course which was related to the movement of non-emergency patients and included a week's experience in the hospital as members of the multidisciplinary team before becoming attached with their vehicles to that hospital.

Mr Hargreaves warned that this sort of planning needed at least two to three years to make funds available to procure vehicles and staff, but if the ambulance and day hospital services were to achieve their common objective of providing the best possible care of patients in the most effective way, that was what must be done. It was necessary to plan ahead and plan together.



SYNDICATE QUESTIONS

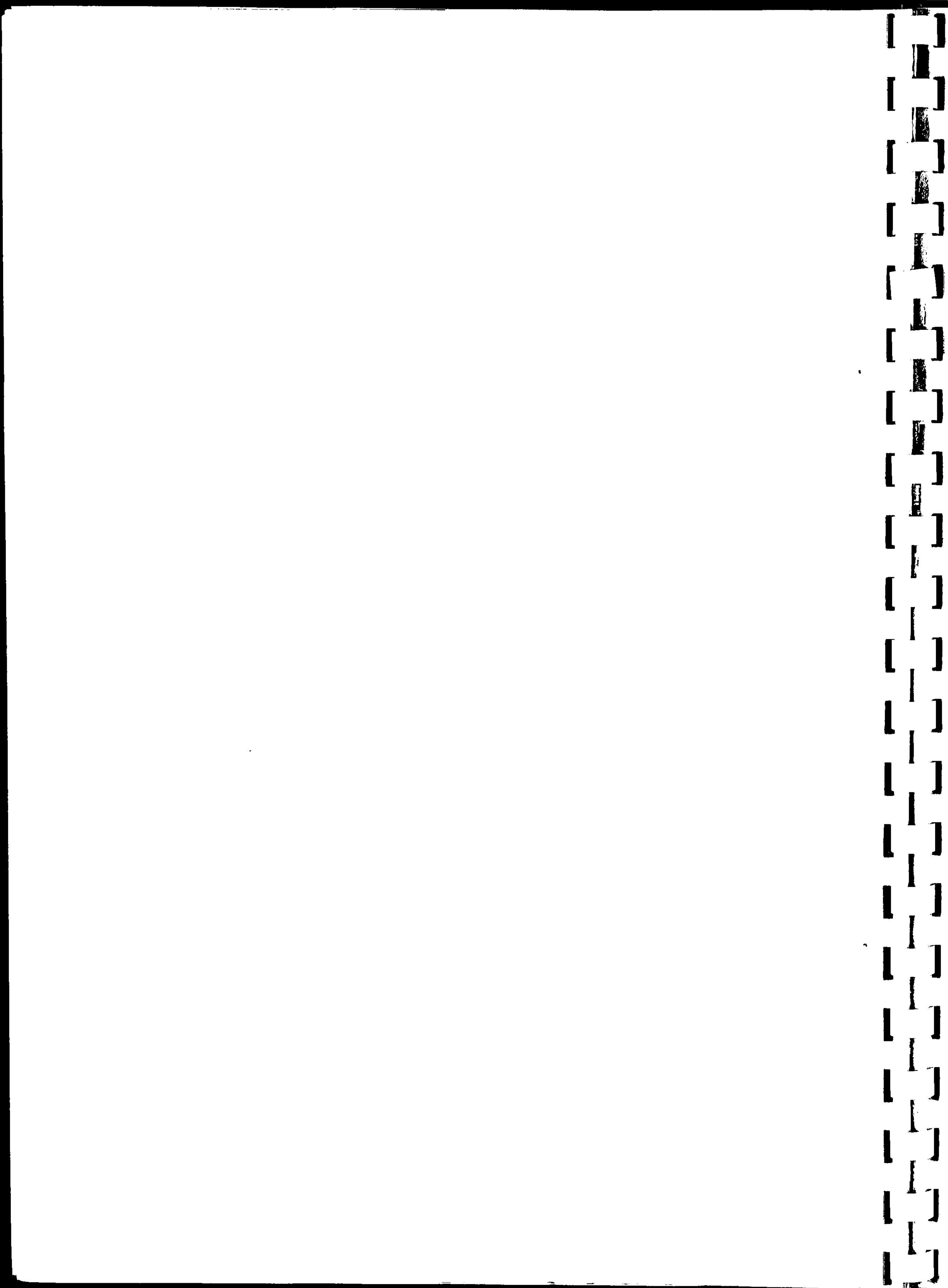
GROUP A (headed by Mrs Pauline Blight)

1. Does the use of day hospital facilities need to be re-defined in the light of present service provision? Should new guidelines for utilization of premises, staff and resources be developed to provide greater benefit?

The group agreed that the use of day hospital facilities had yet to be defined even in the light of present service provision, and that guidelines could be provided to greater benefit. They felt that the day hospital often fulfilled the role of a day centre and were against this practice. Much depended on the particular needs of a population and the resources available. They considered that operational policies should be reviewed. Assessment procedures in accepting voluntary workers, their training, and that of professional staff could be further developed, but the common denominator appeared to be the cost. Premises could possibly be utilized when not in use by youth clubs, stroke clubs or other social groups, but again, much depended on location, insurance and other domestic arrangements being satisfactory with those who might wish to share the premises.

2. Recently retired persons are encouraged to enjoy their retirement. Does this group feel it can utilize this part of the population to help in the care of elderly people on a voluntary basis?

The group decided that it was easier to obtain voluntary help in hospitals, where there seemed to be a more stimulating atmosphere and where a programme of training could be carried out. It was also, conversely, far easier from the point of view of supervision, which often proved difficult in a community setting. In a hospital environment the voluntary worker co-ordinator could assess the work more easily. Loneliness was a recognized common factor in the community and often the bereaved or recently retired person was only too willing to help on a voluntary basis. The group felt that whatever voluntary people were considered, a co-ordinator was needed, not only to 'vet' applicants, assess work etc., but to train them in such aspects as ethics and confidentiality. The achievement of voluntary aid to raise the necessary finance to open four day centres in Bexhill (Sussex) on a voluntary basis, was cited as an exemplary example of what could be done in an area of great need with a high population of elderly people.



GROUP B (headed by Miss Anne Dummett)

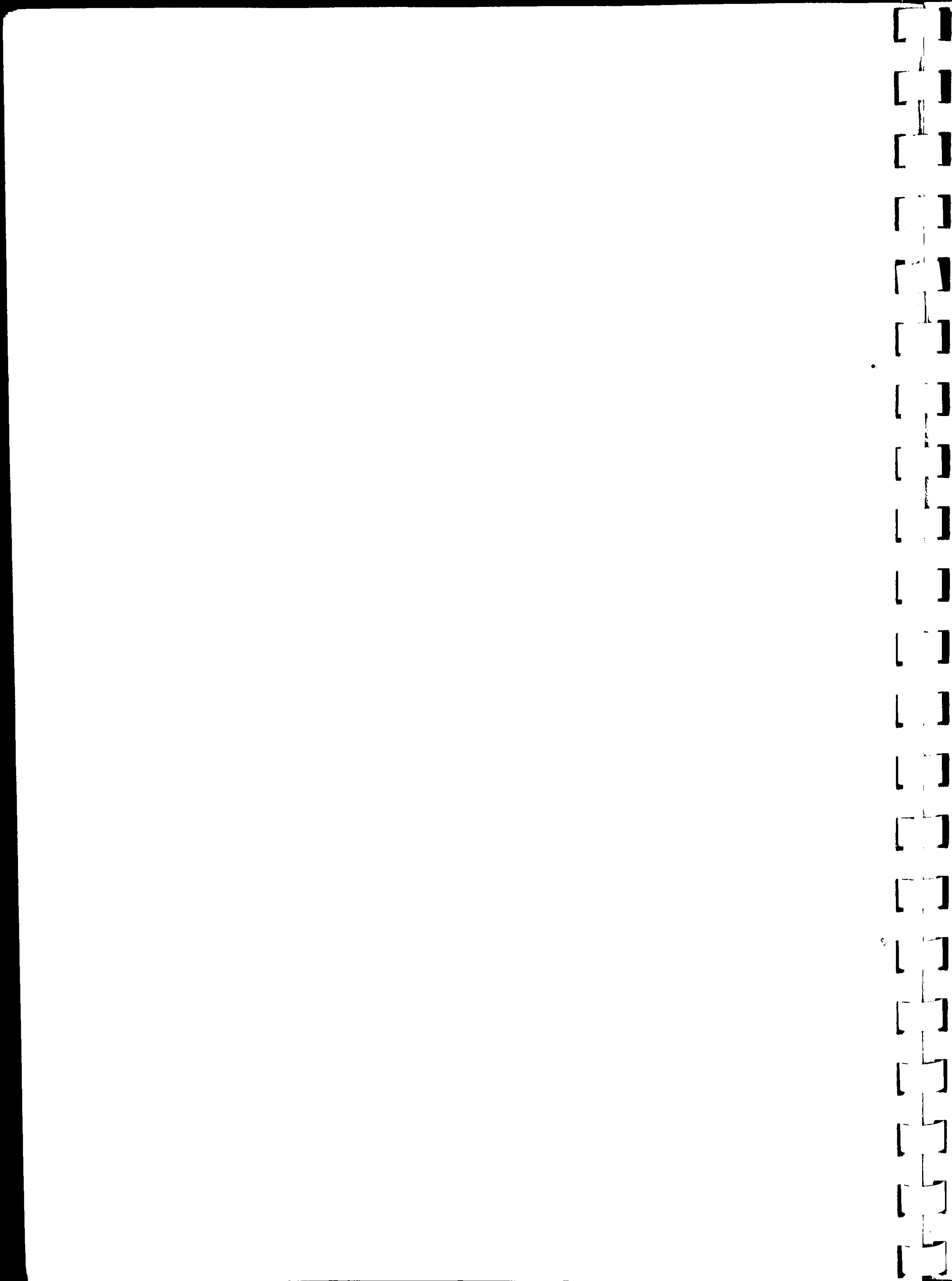
1. In the summary of Progress in Geriatric Day Care page 182 headed 'Staffing', reference is made to the day to day management of the day hospital, and states that the nurse-in-charge appears to be the person in the best position to co-ordinate the smooth running of the day hospital. Can this be justified in terms of the best use of professional qualifications and expertise, especially when related to an earlier nursing view of their work as a 'Jack of all trades'.

   The group agreed that a full-time nurse was the best person to co-ordinate the smooth running of the day hospital (occupational therapists, physiotherapists and other disciplines connected with the team so often being on a part-time basis) and that before taking up her duties she should receive additional training in the specific role of co-ordinator. It was also thought advisable that more than one nurse, preferably six, should be trained to act as co-ordinator to be called upon if need be. In addition, clerical help would be required as a back-up. Records were an important feature, and the cardex system as mentioned by Professor Brocklehurst and used most successfully in Canada, should be instituted.

   The group felt it important that patients should not attend the day hospital for an indefinite period and that their length of attendance should be subject to assessment in a case conference. It was also agreed that patients should not be confined to one discipline but given care in such disciplines as would benefit them. Thus, they progressed to discharge and subsequent follow-up, with reassessment from time to time. In this way, facilities at the day hospital would be utilized to the full.

2. If day hospitals are established to give care to patients with special needs do you consider that ambulance staff should have training at the day hospital in addition to their basic ambulance training, so that they can provide continuity of care between home and hospital?

   The group members agreed that ambulance staff should receive training within the day hospital, provided those members undergoing such training would regularly man the transport. In essence they would form part of the team in continuing the rehabilitation process of the patient when fetching and returning them to their homes. However, problems would arise in the length and time of the journey, when patients might suffer from travel sickness, incontinence etc., thus impeding the work of rehabilitation. Time was a basic factor. Use of voluntary aid in bringing patients to the day hospital was considered, but no concrete conclusions were reached.



GROUP C (headed by Alan Hargreaves)

1. Does this group recognise the priority need of the elderly to use transport services? If so, how does the group propose to use transport in the current financial climate.

   What special features do you feel are required in a vehicle used to bring patients to a geriatric day hospital?

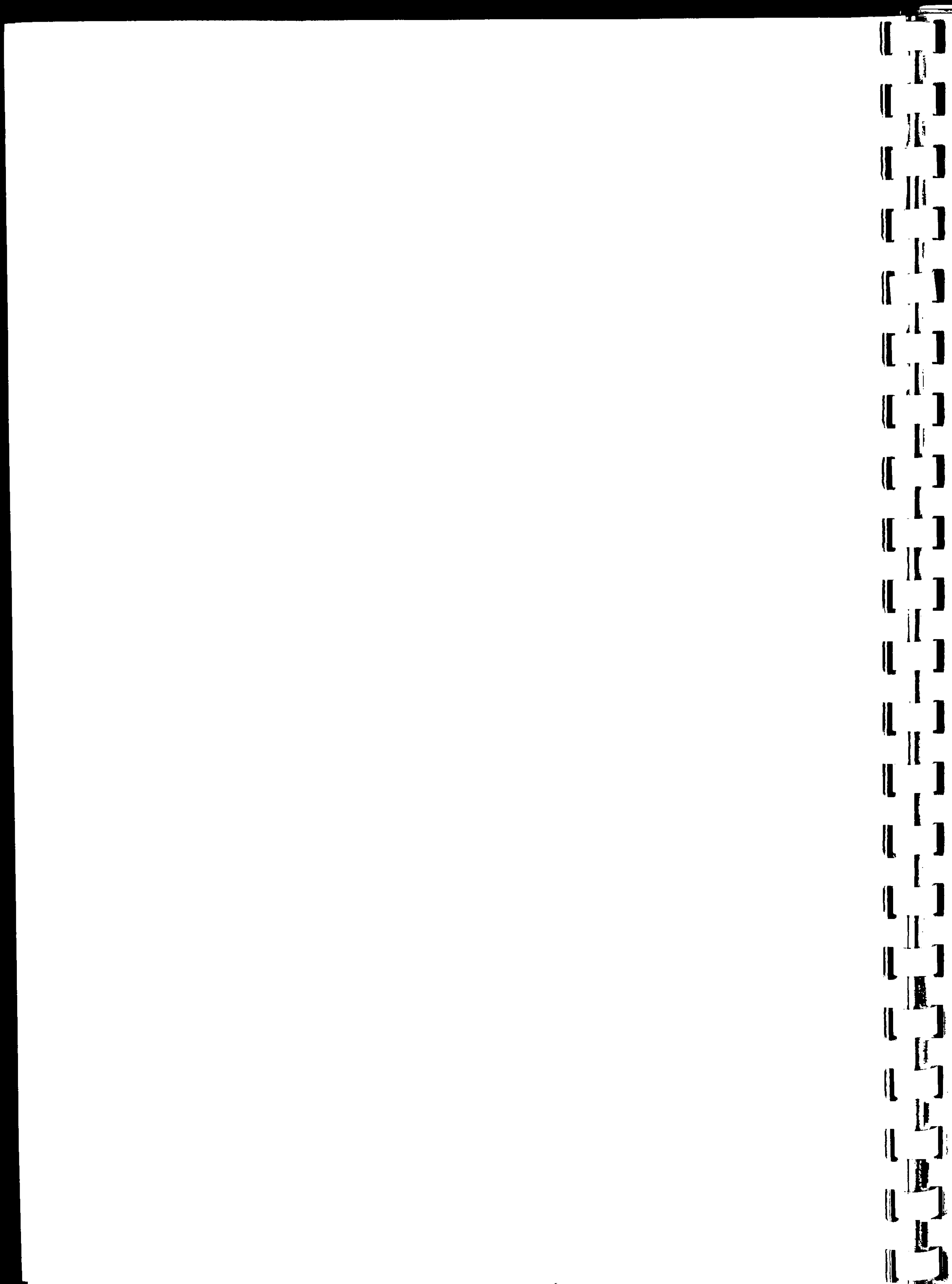
   The group recognized the priority need for the elderly to use transport services, and if the existing ambulance complement was unable to meet the demand it might be possible to include volunteers. While not having the extra training of the ambulance staff, they would at least be able to convey more able patients to and from their homes. An ambulance co-ordinator would be required to organize voluntary helpers.

   In view of financial stringency, it might be possible to restrict the number of patients attending the day hospital on a regular basis.

   Special features required in a vehicle used to bring patients to a geriatric day hospital were: heating of vehicle; high roof (say 6 ft clear) to ensure staff mobility; tail lift; forward facing seats - easy access angle seats to guard against car sickness; clear glass in windows preferable; seat belts; and external lighting for rural areas, for example, garden paths.

2. Are nurses properly prepared or trained for their role in day hospitals? If not, identify areas where basic training or post registration experience has not fitted the individual nurse to work with confidence and in equal partnership with staff of other disciplines.

   The group agreed that existing nursing staff in day hospitals were often inadequately prepared or trained for their role. They needed a greater knowledge of the commitments of other members of the team experienced in community care. The group felt that induction programmes which explained the objectives of the unit would be a good idea. For instance, in the grey areas of mild psycho-geriatric disorders which the nurses might not have had experience in dealing with, the occupational therapist's pattern of training would prove of greater benefit. It was agreed that staff members should be selected before a unit opened so that training could be started and inter-discipline knowledge shared.



GROUP D (headed by Jim McCafferty)

1. In deciding transport arrangements for the geriatric day unit and assuming a Senior Ambulance Officer is part of the unit planning team the following must be considered:

What size will the catchment area be: 5 - 10 - 15 - 20 miles.

What will the classification of patients be: Will they be:
a) able to walk unaided, b) able to walk assisted by one person or c) able to walk assisted by two persons and need to be lifted into the vehicle?

To reduce travelling times can patients be zoned after assessment?

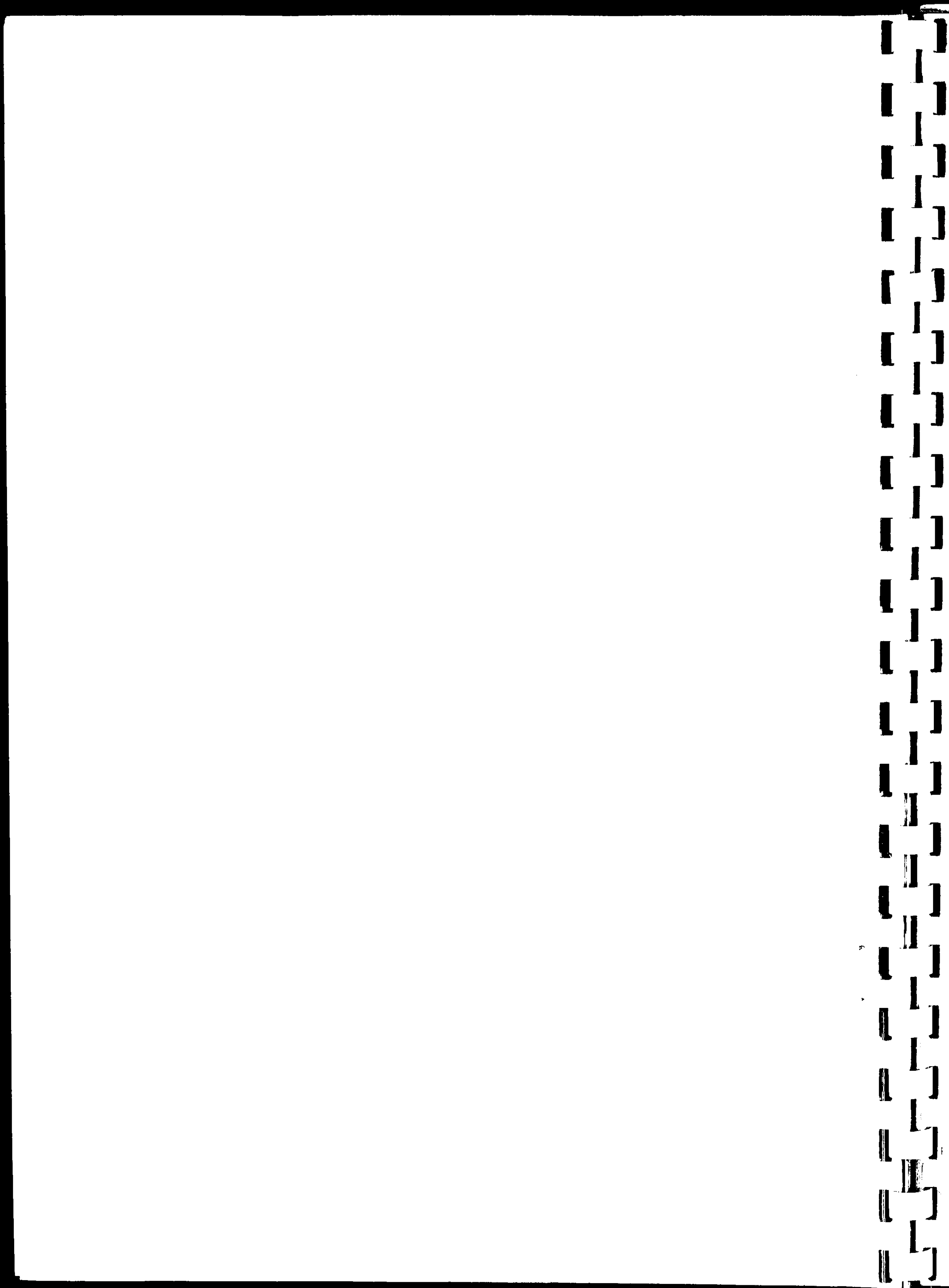
How does this group utilize a multidisciplinary team in these times of limited resources to avoid duplication, enhance overlap areas and build up a comprehensive service for the care of the elderly.

There was a consensus of opinion that the catchment area should ideally be 10 miles, however, this was very difficult to define, especially in urban areas where heavy traffic, high-rise flats, etc. made journey time upredictable. These difficulties were not so apparent in rural areas, and the ten mile catchment area was much easier to contain.

The group agreed that classification of patients should be a) able to walk unaided, b) able to walk assisted by one person, c) able to walk assisted by two persons and need to be lifted into the vehicle.

The question of zoning patients after assessment in order to reduce travelling times was approved in principle by the group, but it was felt that in practice this would be difficult to achieve. It depended upon liaison between the ambulance service and unit team.

The group suggested that a multidisciplinary team should include an occupational therapist, a physiotherapist, a medical assistant, nursing assistants, social workers, clinical assistants, and any other disciplines involved in care of the elderly, including the ambulance liaison officer. The group felt that a short daily conference held by team members in liaison with ambulance staff would be the most expedient way of running the unit.



2. Who is responsible for identifying and taking steps to deal with a patient's non-medical problem?

The group felt that patients' non-medical problems were the responsibility of the team and once identified should be referred to the co-ordinator.

GROUP E (headed by Miss Rowena Kinsman)

1. It is commonly stated that groups/committees asked to make a decision which either exhibits risk or caution. Does the group believe that multidisciplinary teams are on the cautious side? Can over-cautious visit reports and day-to-day reports be responsible for this? Can the group suggest how this may be overcome?

The group had difficulty in forming an opinion but finally agreed that one member of the team working in an outside capacity would have advantage over the rest of the team during discussions and that caution should be exercised in compiling home visit and day-to-day reports.

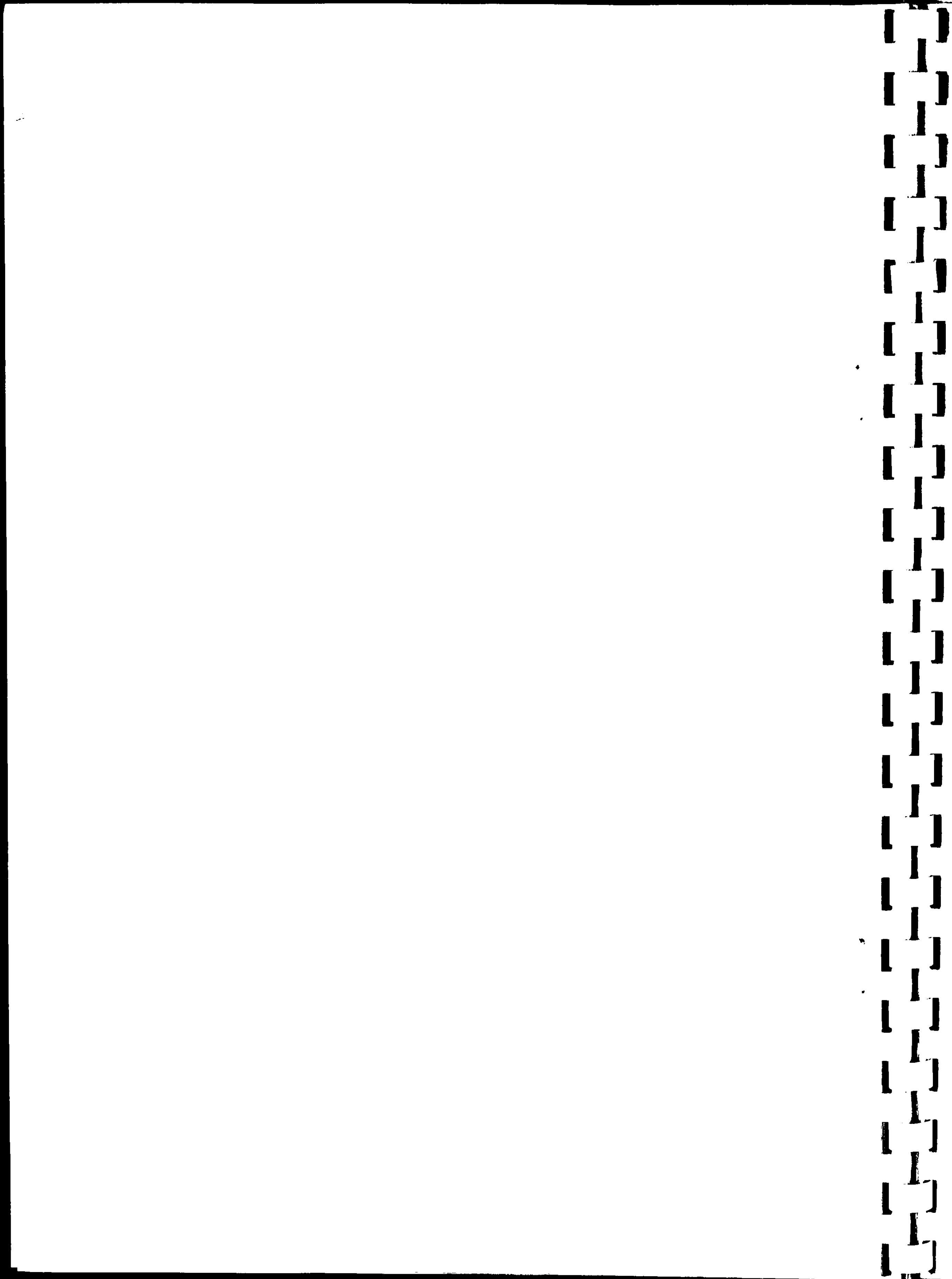
2. Is it desirable for the unit to have its own vehicle/s and staff?

Is it more economical to contract out to mini-coach firms?

Is it preferable that the Ambulance Service provides specially designed vehicles and skilled staff?

It was felt desirable for a unit to have its own vehicle/s and regular crew. In this way patients and crew would be able to develop a good relationship, and the ambulance staff would be able to make decisions. For instance, if a patient's condition worsened during the journey, they would contact the patient's GP for any action he might consider necessary. There was some discussion on the subject of contracting out to partially-trained car drivers who might not be sufficiently experienced to cope with an emergency and were obliged to call the red alert system.

The group decided that it would not be more economical to contract out to mini-coach firms.



The group agreed that it was preferable the Ambulance Service should provide specially designed vehicles and skilled staff. Patients who might find it difficult to get into a car would be more easily accommodated in a specially adapted vehicle, and it was deemed advisable that skilled staff should be on hand to cope with any emergency that might arise during the journey.

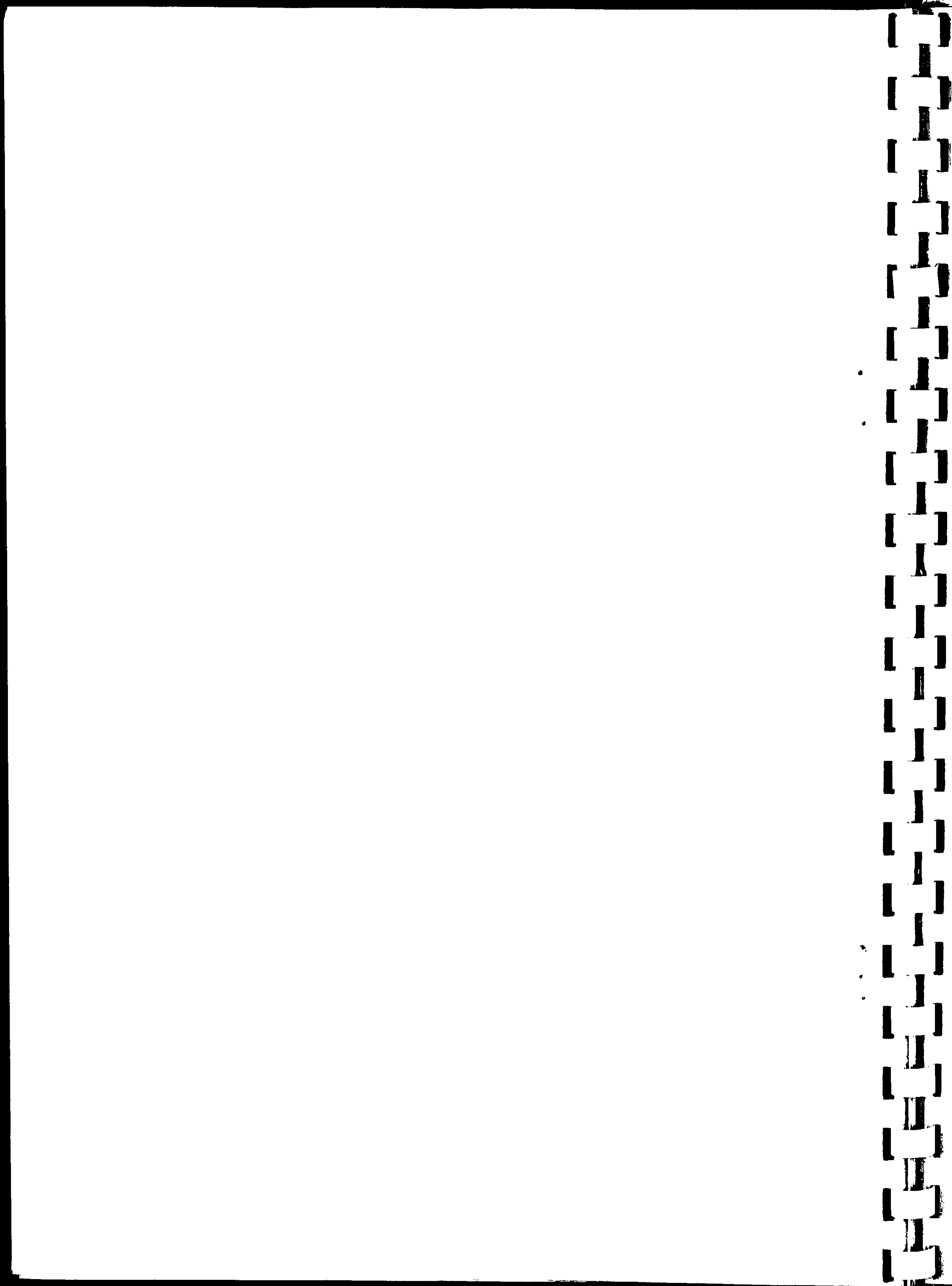
Footnote

The group discussed other topics which did not actually appear on their question sheet. Two speakers interposed from the floor, the first observed that Mr McCafferty's team must know each other well, and Dr Hatterton of Whipps Cross Hospital commented that the social worker 'did everything', that it was difficult to define the role of the social worker, but it was extremely important that this role should be understood.

SUMMING UP BY CHAIRMAN

In her summing up Miss Young emphasized Professor Brocklehurst's statement that the day hospital 'was here to stay'. She went on to elaborate his point that 'Geriatrics is teamwork' and to verify the importance of the case conference as a 'getting together' of each team member's contribution. In this way the patient's prognosis could be reviewed systematically and his future treatment programme planned as a team effort. She emphasised the importance of the need to communicate well; to talk to the patient and his relatives who could help in the rehabilitative scheme of things and for the patient to be present at the case conference say once a month . The maintenance of good case notes preferably one set readily accessible to all concerned in the care of the patient was, according to Professor Brocklehurst, vital. As for elucidating who was in day-to-day charge, it was felt that there was no clear-cut answer. On the whole it was thought the sister, but equally well it could be the member of one of the other professions within the team - often the most dominant personality. In order to work as a successful integrated team there was a need to accept the authority of the person in charge, thereby creating a successful working team relationship. Future needs would be great, particularly in the field of psychogeriatrics and it was extremely pertinent to be planning ahead in order to be able to meet this contingency. An element of controversy entered when Professor Brocklehurst mentioned that some day hospitals were not utilized to full capacity.

Mrs Pauline Blight considered that nurses of all grades needed some preparation and training for their particular role. In addition, they needed to learn how to change their own attitudes in 'letting go' of the patients when the time came for them to be independent of her care. This aspect might be foreign to their natural instincts but a very necessary discipline to be acquired. Mrs Blight then went on to consider how such a course of training could be devised. Many questions came to mind such as who should administer it? For instance, should it be part of the JBCNS courses in Geriatric Nursing, or should it be considered a



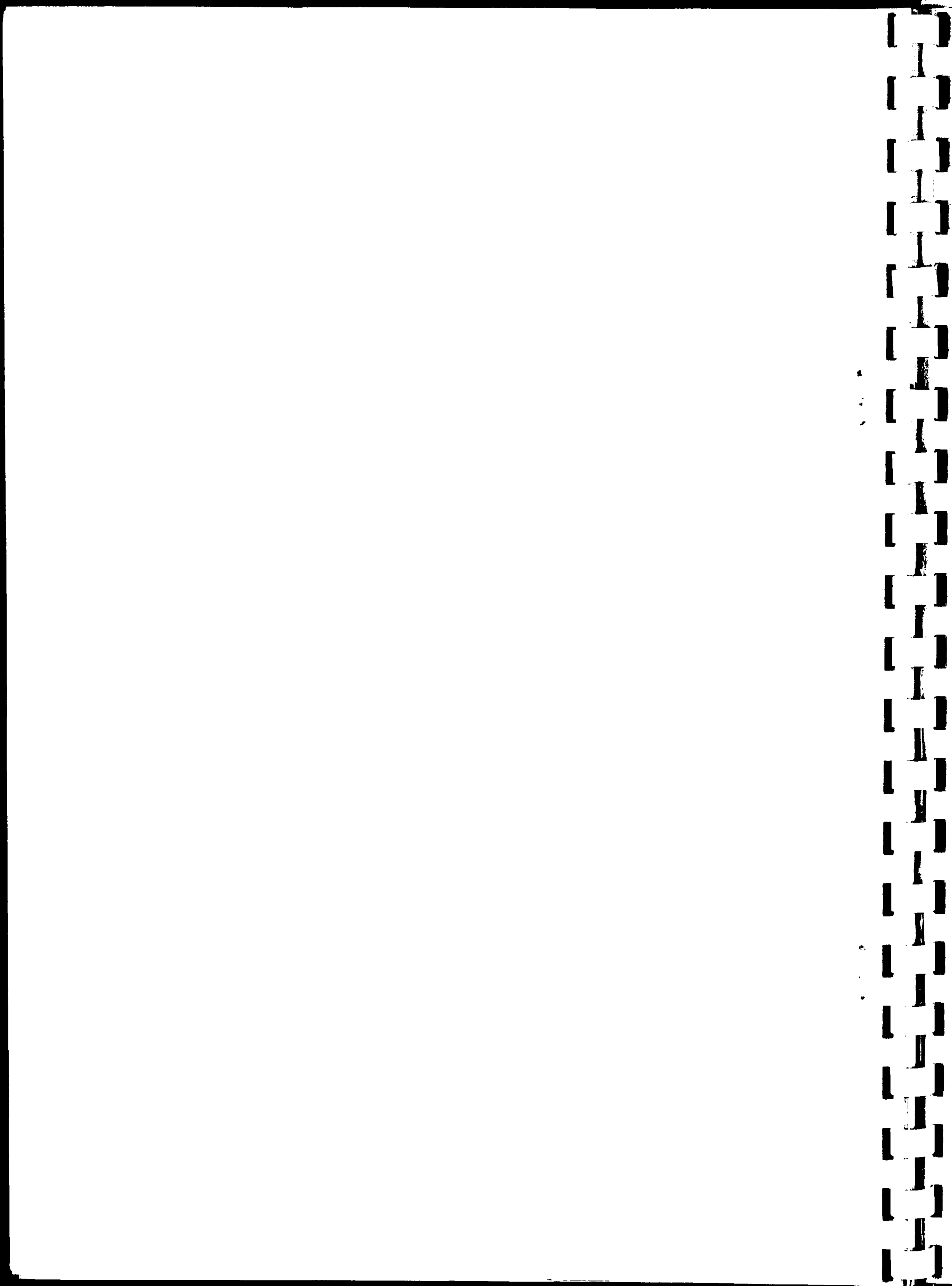
separate entity? What should be the length of the course with the necessary component of community nursing in it? For nurses who were leaders of the teams with the responsibility of being in charge the question was, how could they be given the authority that matched the responsibility?

Miss Rowena Kinsman stressed the problem of encouraging other physiotherapists to collaborate successfully with their colleagues, avoiding the quite dreadful demarcation which was so dispiriting, at the same time giving helpful practical instruction in, for example, lifting patients - back pain being a constant problem. She continued that physiotherapists should be encouraged to make a logical approach to treatment and assessment which was shown in her excellent record cards. She furthered the idea of physiotherapy process taking the same logical and analytical approach to patient care as the nursing process.

Miss Anne Dummett's igenuity and practicality shone through as a model for other O.T.s and was equally applicable to those members of other professions. She demonstrated a rapport between colleagues, patients and their relatives which presented a most constructive approach to helping patients to lead independent lives at home. A sad note which marred an otherwise positive happy approach to the future was the sign of the times - that the elderly have now to be taught the art of self-defence in a violent world.

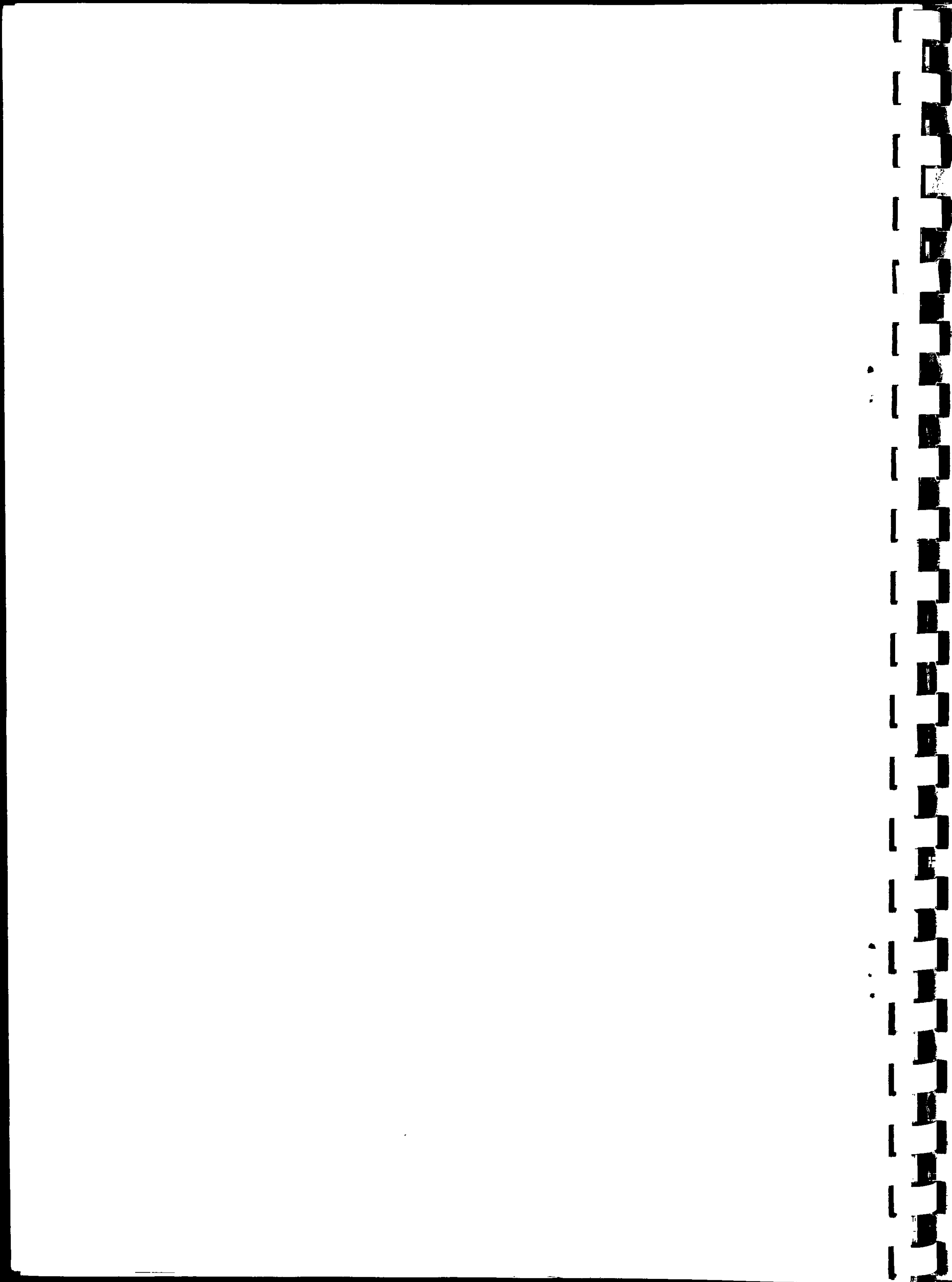
Mary Hitchin gave an eye-opening description of the type of service which the Citizens Advice Bureaux gave. An invaluable aid to elderly patients who had to manage the bewildering problems of daily living which became even more complex each day. It was often overlooked that the elderly could become deeply concerned about what might be regarded as trivia to others. Indeed, anxiety and stress could severely hinder recovery. She stressed that all staff could learn about the service and then pass on information to their patients. She felt that there could be some overlap with social workers in this field, but that should present no problem if openly discussed at case conferences. It would be useful if other voluntary bodies could be encouraged to help and in this way improve the patients' quality of life. Surely here was scope for development.

Mr McCafferty and Mr Hargreaves gave a strong message for the need for closer consultation between the transport service and those who ran the day hospital and ordered the transport. They felt that priorities must be selected in the light of needs clearly perceived and defined. Obviously the transport service must be run both economically and realistically. This service was not a luxury but a necessity. The way it operated should be understood by all those who used it so that it was utilized to maximum effect and capacity. A closer liaison should be encouraged, but how to achieve this was still in the process of being considered by the working party. At this juncture, it could be a useful exercise to consider the report Patient Transport Services, published by Trent Health Authority for practical and down-to-earth thinking.



Lastly, Miss Young returned to Professor Brocklehurst's statement 'Geriatrics is teamwork'. She emphasized that nowhere was this more true than in a day hospital.

Teamwork could be defined as a means of understanding one another's problems with a fundamental willingness to work together, placing one's own personal interests aside if necessary, with one common goal: a better quality of life for the patient.



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King Edward's Hospital Fund for London

King's Fund Centre
126 Albert Street London NW1 7NF

THE WORKING RELATIONSHIP IN DAY HOSPITALS

Friday 16 October 1981

PROGRAMME

Chairman - Miss P Young

10.00am	Registration and Coffee
10.30	Chairmans Opening Remarks
10.40	Multidisciplinary Approach to and the Future Development of Day Hospitals. Professor J Brocklehurst, Department of Geriatric Medicine, University of Manchester.
11.15	Nurses in Day Hospitals. Pauline Blight, Senior Nursing Officer, Geriatric Section, Southwood Hospital, London.
	The Role of the Physiotherapist Rowena Kinsman, District Physiotherapist, Barnet Health District.
	The Role of the Occupational Therapist Anne Dummett, District Occupational Therapist Whittington Hospital, London.
12.00pm	Help From the Citizens Advice Bureau Mary Hitchin, Coordinator, Citizens Advice Bureau Camden Council of Social Services.
12.20	Transport Arrangements Mr J McCafferty, Chief Ambulance Officer, Lincoln AHA and Mr E A Hargreaves, District Nursing Officer, Bradford Health District.
12.45	LUNCH
1.45	Syndicate Discussions
3.00	Panel Reports and Questions and Discussion.
3.50	Summing up by Chairman
4.00	Tea and Disperse.

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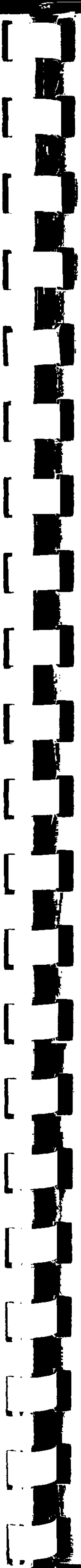

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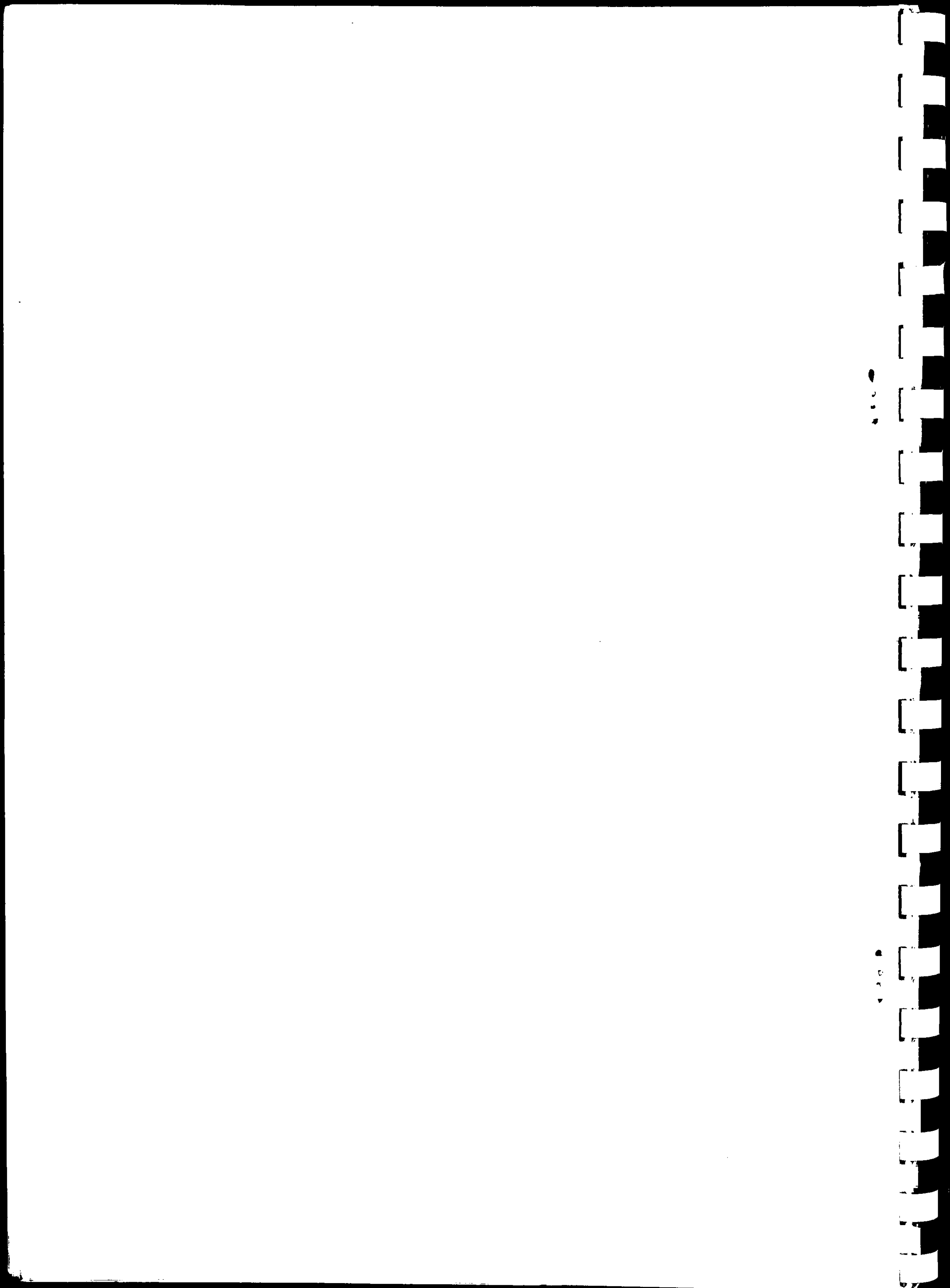

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