indefinite hospital stay is free for the patient, but at the expense of the hospital.^{6,8,9} There is potential for disagreement between local authorities and health authorities if the issues remain unresolved.

The Community Care Act is meant to be a beginning of an evolving process. High on the agenda for the local authorities is the development of care management. In the scheme, funds are devolved to care managers who will coordinate the assessment process, provide advice on possible services, arrange and if appropriate, pay for services as necessary, monitor its effectiveness and keep it under review. Care managers should be able to buy services from other agencies, creating opportunities for new initiatives. Increasingly local authorities have to separate

their role in providing care from their role in purchasing care. Care managers will become more independent and have more influence on the pattern of care provided.¹⁰

The Community Care Act provides a new framework to delivering care services and opportunities for innovations. Its success depends on the cooperation of the authorities and practitioners involved, and ultimately community care has to be judged by the people who use it.

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Geriatric day hospitals – the future?

The need for rigorous evaluation of geriatric day hospitals is well recognised.¹ In 1981 the white paper '*Growing Older*' advised health authorities in the UK to review the functions of geriatric day hospitals.² Prior to this, Martin and Millard, in 1978 had reviewed all day hospitals (both geriatric and psychiatric) in the South West Thames Region and subsequently made recommendations for future developments.³ They observed that the day hospitals had become established without a common policy for operation and that a minority of geriatric day hospitals fulfilled a predominantly social role. They attributed this to size (number of places), staffing levels (nursing and therapy) and to the lack of places for new patient attendances. This could be problematic for patients requiring short-term rehabilitative therapy. They recognised that adequate staffing levels of therapists were needed to run a geriatric day hospital with a predominantly therapeutic function. They suggested smaller units (12-20 places) to provide a mainly rehabilitative function and larger units (20-30 places) for the more disabled, where they would gain benefit from all aspects of regular attendance associated with general nursing therapy and medical supervision. It was felt that these latter units need not be sited in the district general hospital because activities were mainly diversional.

So what has changed since 1978? The number of geriatric day hospitals has continued to grow and they have become firmly established as part of the geriatric service, for the present. In 1987 a further comprehensive study of all geriatric day hospitals was carried out in the same region, essentially to collect basic data and ultimately to evaluate geriatric day hospital intervention against outcome and to compare with alternative approaches to similar problems.⁴ This study found that only 34% of geriatric day hospitals had a written operational policy. Eighty per cent of geriatricians considered that rehabilitation was the most important function, but 20% were below establishment with respect to nursing staff and therapists. Operational

costs were unknown. Medical and nursing intervention was low despite the medical function being considered important by 40% of the geriatricians. Thirty-five per cent, however, ran integral out-patient clinics to which elderly patients not attending the geriatric day hospital could be referred. There was a moderate amount of occupational and physiotherapy provided, but little evidence of multidisciplinary treatment. Remedial and nursing staff felt that patients with deteriorating mobility were not referred early enough and that general practitioners remained confused about the differences between geriatric day hospitals and day centres. As in most earlier studies, transport remained a common problem, except in mainly rural areas with less traffic and more volunteer input. Whilst informal time-flexibility occurred, no formal changes such as regular half-day sessions were in operation.

Recommendations were made for continuous monitoring of the geriatric day hospital process using Korner data to establish performance indicators and develop outcome measures. A written policy was advised, especially because of cost implications, staffing requirements, and the trend towards community care. Individually tailored patient programmes were suggested and appropriately referred patients should require two or more types of intervention to benefit from the multi-disciplinary team services.

Geriatric day hospitals – the future

- geriatric day hospitals should continue to be an integral part of a geriatric service but their role needs to be clearly defined
- the clear advantage is the ease of access to the range of medical, paramedical, and therapist skills
- patients attending need regular review and should require the skills of two or more disciplines
- problems include the requirement of a special environment, high staffing costs, transportation difficulties, and long periods of inactivity

This study produced no evidence of any particular activity that was apparently an alternative to traditional in-patient, out-patient, and domiciliary services, provided by the geriatric day hospital. Fortunately the organisational problems of providing medical care, nursing care, physiotherapy, occupational therapy, speech therapy, social assessment, chiropody, and dental services together in an out-patient setting were recognised.

Seven years on, what has changed? Perhaps another survey is due. It has become evidence that the mainstay of the geriatric day hospital is the multi-disciplinary team approach. Many geriatric day hospitals now require a detailed referral with aims and specific areas for treatment identified so that inappropriate referrals can be channelled to another service. Some have assessed staffing levels related to the service offered and, following audit, have altered therapist/nurse staffing ratios. Several have attempted to estimate cost and effectiveness and Donaldson and colleagues have proposed ways of determining whether geriatric day hospitals were a better investment than alternative modes of care.⁵

Outcome measures have been developed assessing such procedures as occupancy and activity, based on new patient referrals and time of inactivity, via time-samplings.^{6,7} Others have measured improvement in dependency, clinical, social, and psychological functioning.⁸ Clearly, clinical audit is underway.

Should physiotherapists be in charge of the day-to-day running of the geriatric day hospital now there is increasing emphasis on rehabilitation? With the loss of long-stay beds and the Community Care Act, rehabilitation provides the

key to discharge. The geriatric day hospital provides support following early discharge to the community, particularly in stroke patients.

What of the medical input? Consultant-led geriatric day hospitals perform more effectively with respect to length of attendance.⁹ For the geriatric day hospital to flourish it needs to be part of an active and swiftly responding comprehensive geriatric service. Senior doctors need to be able to attend frequently.¹⁰ It is an ideal setting for geriatric out-patient clinics and for specialist clinics such as incontinence or diabetic clinics. The concept of the geriatric day hospital is too valuable to allow it to be removed by purchasers. It is therefore up to the geriatricians to ensure their medical supervision is immaculate.

Where are we going? In 1973 Professor Brocklehurst stated that the geriatric day hospital is a logical extension of the progression through the acute and rehabilitation wards and forms a bridge between the hospital and the community.¹¹ Twenty years on, with increasing numbers of the very old, and such emphasis on community care, we need to manage this resource with the same commitment as the acute service. If not, it is possible that alternatives such as mobile multi-disciplinary rehabilitation teams and community-based therapists will detract from this facility.

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