

The Changing Face Of Day Hospitals For Older People With Mental Illness. Consensual Development Of Functions And Standards



**A Report by
the Day Hospital Network
Faculty of Old Age Psychiatry
Royal College of Psychiatrists**



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With the support of Dr M Hussain



August 2008

Acknowledgements

The Day Hospital Steering Committee and Expert Panel

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Administrative Support: Caroline Walsh

Supporting Organizations

Cheshire and Wirral Partnership NHS Trust
University of Liverpool

Workshops and Focus Groups

Function development

Leeds Workshop: Millside Day Hospital, Linden House Day Unit, Asket Croft Day Hospital, Towngate Day Hospital, Aire Court Day Hospital.

Derby Workshop: Erawash Day Centre, Dovedale Day Hospital, Quarnmill Day Hospital

Ipswich Workshop: Violet Hill Day Hospital, Minsmere Day Hospital, Kesgrave Day Hospital, Whitwell Day Hospital.

Cumbria Workshop: Bethay House Group, Windemere Day Hospital, Bethden Day Care.

Bromley Workshop; Bridges Day Hospital, Memorial Day Hospital, Upton day Hospital, Greenwich Day Therapy Service, Bexley Day Hospital.

Southwest Yorkshire Workshop: Functional Day Therapy centre, Priestley Day Unit, North Kirklees Day Unit, Kershaw Grange Day Unit, Calderdale Day Unit, Savile Close Day Unit.

In addition there were members of community mental health teams, in-patient facilities, day care services and other health organisations included in the workshops.

Day Hospitals/Facilities

Standard Setting

Cheshire and Wirral Partnership NHS Trust
St Mary's Hospital
Dewsbury NHS Trust
Humber Mental Health Teaching Trust
Norfolk and Waveney Mental Health Partnership
Leeds Mental Health Trust
Birmingham and Solihull Mental Health Trust
Nottingham Healthcare NHS Trust
Plymouth; Plympton Hospital.

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Summary

Day hospital services are rapidly evolving as a consequence of change in configuration of other related services and shifting needs of patients. In the context of increasing diversity of service provision, this report is predicated on the assumption that the traditional definition of a day hospital is becoming redundant. This review defines the main functions frequently undertaken by 'day hospitals' in England with the understanding that different organizations will provide differing combinations and numbers of these functions. A subsequent review of the literature and associated validation through an adapted Delphi technique has generated the related clinical standards by which such functions can be audited. It is anticipated that as day hospitals and related facilities evolve there will be a need for these and new standards to reflect development in functions and service profile

This document is intended as a guide for local services developing standards that can be subject to audit and used for internal quality control and to evaluate performance against objectives. It is not intended to define any preference of day hospital model. Services may adapt standards to best suit the day hospital model in use. It is not the purpose of this document to either condemn or condone the existence of day hospitals.

The standards are presented under the following domains: Domain 1; consisting of Organisational Standards which include standards relating to the establishment, organisation, access and physical environment of a day hospital. It is strongly recommended that all day hospitals adopt these common standards. In Domain 2 we include standards relating to specific clinical functions frequently adopted by day hospitals. Surveys have demonstrated that day hospitals vary in the degree to which they provide these functions. Not all day hospitals will deliver all functions. Adoption and prioritisation will depend on a variety of issues, including local service configuration and the service priorities of commissioners.

Domain 1; Organizational standards.

Organisational standards relate to the general principles underpinning the design and appropriate functioning of day hospitals. They should be adopted in the context of Trust policy and planning process. They draw attention to three critically important issues in developing services:

1. An explicit description of the roles and functions of the day hospital/facility
2. The need for collaborative planning of the service, including close working agreements with social care agencies, related inpatient units and other mental health community services.
3. The importance of a needs led organisation of services catering for the different needs of patients with organic and dementing disorders and those with other types of mental illness.
4. Standards relating to the physical and situational environment of the day hospital/facility. Accessibility and transport related standards are included in this domain. Attempts have been made to avoid replication through the exclusion of standards

and related criterion that are common to other health facilities. Consequently, the list of standards is far from exhaustive and should be utilised in the context of standards relating to health and safety, building design and access.

Domain 2: Standards relating to clinical functions

This domain includes standards relating to potential functions of day hospitals. These include; intensive multidisciplinary management; patient support and involvement, acute and crisis care; rehabilitation and early discharge; longer term management and psychotherapeutic interventions. Of these functions, intensive multidisciplinary management and patient involvement and support are considered common to all day hospitals. Prioritization of the other clinical functions will vary between day hospitals.

Definitions and Terminology

Context

Day Hospital Standards have been developed by drawing on published standards, consensus and review. The extensive consensus process has included professional groups and patients. The Standards are endorsed by the Faculty of Old Age Psychiatry; Royal College of Psychiatrists.

The Standards have been developed to be consistent and work in conjunction with 'National Standards, Local Action. Health and Social Care Standards and Planning Framework 2005/06-2007/08, Standards for Better Health . Department of Health 2005'.

Terminology

Day Hospitals: Day hospitals vary in their design, purpose, function, staffing and profile of patients. Consequently, a standardised definition is impossible and of limited utility. In the context of these standards; the term 'Day Hospital' refers to a facility that is managed by an NHS trust. In part, this differentiates day hospitals from 'day care' facilities usually managed by voluntary agencies or local authorities. Day hospital facilities prioritise therapeutic assessment and management whereas day care facilities prioritise quality of life, socialisation and support. In the context of combined social and health care trusts these roles may become blurred, hence the importance in defining function with relationship to all day facilities.

A day hospital does not usually have direct management responsibilities for inpatient care. However some day hospitals may have direct access to inpatient beds and facilities and may prioritise crisis intervention with 'bed access' control. Likewise some day hospitals will have out-reach teams and a blurred role in relationship to other community care organisations. Again, this emphasises the importance in clearly defining role and function in relationship to these sister organisations.

These Standards have been designed to cater for day hospitals specialising in the assessment and management of older people with mental health problems. Some day hospitals will also cater for younger people. The Royal College of Psychiatrist's guidelines relating to the care of younger people with dementia should also be considered if the target patient population crosses age ranges. Some day hospitals will be joint day hospitals with physicians specialising in older people. In such cases these Standards should be applied in association with the Guidelines published by the British Geriatrics Society. Further confusion is generated by many day hospitals working on a sessional basis, in that they do not routinely provide a 'whole' day service. Hence the term 'partial hospitalisation' is used in some parts of the USA to describe the function of day hospitals. Lastly, some day hospitals have adopted a 'travelling' day hospital system. In such cases day hospitals move from one locality to another, dependent on the day of week or conduct out-reach into other localities on a regular basis.

Standards and Criteria

Use of standards

The Standards and related criteria are designed to provide a standardised measurement by which the quality of day hospital organisation and service provision can be assessed. The Standards should be considered as 'good practice' standards. Each standard is associated with criteria that generate scores enabling managers and clinician to assess to what degree the facility meets each standard.

The Standards in Domain '1' should be considered as best practice for all day hospitals. They relate to the general organisation and establishment of a day hospital and to the physical environment and access (specifically relevant to day hospitals). The Standards in domain '2' relate to specific functions of day hospitals. As it is anticipated that day hospitals will vary in the functions that they provide, only two functions are recommended as mandatory. Consequently not all Standards will apply to all day hospitals. It is appreciated that as day hospitals evolve, so will their functions and related standards.

Each Standard should be scored by the criteria and a total score generated so as to enable comparison with potential maximum score, enabling future service development and audit.

Domain 1: Standards Relating to Day Hospital Organisation

The Standards in domain 1 are recognised as being of critical importance in the development and delivery of a day hospital service. They relate to the general principles underpinning the design and appropriate functioning a day hospital. They should be adopted in the context of Trust policy and planning process. They draw attention to three important issues in developing day hospital services:

1. An explicit description of the functions of the day hospital
2. The need for collaborative planning of the service, including close working agreements with social care agencies, related inpatient units and other mental health community services.
3. The importance of a needs led organisation of services catering for the different needs of patients with organic and dementing disorders and those with other types of mental illness.
4. The physical environment and access to the day hospital facility. Notably we have excluded a range of physical and environmental standards which are common to Health and Safety legislation and common NHS Trust standard operating procedures within the UK.

Standard A

Each day hospital unit should have an agreed, written philosophy/mission statement and demonstrate the role of users and carers in planning and designing service delivery.

Criteria

The philosophy mission statement should include the following

1. Two mandatory functions
 - i. Multidisciplinary assessment/treatment (score 1)
 - ii. Provision of education/support for carers and families (score 1)

The inclusion of other functions will be determined by consultation and planning processes.

2. A description of the patient groups targeted by the day hospital. This should include age range, psychiatric conditions (commonly targeted patient populations are identified on page 30 of the document) (score '1')
3. An agreed percentage of patients attending for greater than one year. (score 1)
4. Information on the degree of expected user, family and carer involvement. This includes evidence of pre-planned regular meetings with user groups in reviewing service delivery and process, patient involvement in planning and development of the service. (score 1).
Planned family/carer user groups and support and education.(score 1)
5. There is an established on-going audit programme relating to the functions and associated standards of the unit. (score 1)

Potential total score; 7

Standard B.

There should be evidence of collaborative planning and working between day care services provided by the Local Authority or voluntary agencies and the day hospital provided by the NHS

Criteria

1. The philosophy/mission statement and functioning of the unit has been agreed and planned with other stake holders. Stake holders may include; inpatient units, community mental health teams, day care units, patient groups (score 1 if informal discussions, score '2' if stake holders are formally engaged with documented evidence)
2. Evidence is required that specified and agreed (with referring and accepting agencies) referral and access procedures are in place. This criteria includes evidence of
An agreed procedure by which patients are referred, including the agencies that may refer them (score 1)
An agreed time-frame by which patients will undergo preliminary assessment and acceptance. (score 1)

- Agreed procedures for refusal of referred patients. (score 1)
3. Evidence that there is agreement with agencies (primary care, day care, community mental health teams etc. regarding discharge protocols (score '1' if informally agreed, '2' if formally documented)
 4. There should be written agreements with day care services, relating to transfer of patients, cross-organisational support and assessment, enabling a seamless delivery of services (score '1' if general arrangements in place, only score '2' if arrangements with each of the appropriate services are documented).
 5. Regular, documented contact is maintained with other community services and inpatient facilities relating to inter-face procedures between organisations and reviews of patients attending more than one organisation. (score '1' if evidence relating to joint discussions concerning care plans, score '2' if evidence of regular, documented joint management meetings and reviews of patients).
 6. Out-reach provide services in other venues including outpatients services, GP clinics, social care facilities etc. (score '1' if evidence of group or individual work taking place in other venues, score '2' if regular and programmed)

Potential total score; 13.

Standard C

If the day hospital provides services for both functional and organic patient groups then separate, need-based arrangements should be made for each group.

Criteria

1. Patients with established functional or organic syndromes do not mix in terms of assessment and management. (score '1' if separated for assessment and therapeutic work but mixing in other situations eg. transport, meal times, score '2' if completely separate by session/day or venue)
2. Transport provision is separate for patients with functional and organic syndromes.(score 1)
3. Day hospital assessment and treatment programmes should reflect the specific needs of individuals and groups attending at any specific time. This criterion addresses the need to promote specific assessments, activities and interventions tailored to individual or diagnostic group needs of differing patients. Examples include memory clinics, orientation groups and cognitive stimulation therapy for people with dementia and depression education, bereavement and psychotherapy groups for people with depression. There should be a list of planned non medical activities including types of individual or group work, OT activities and other related activities, which is subjected to regular review. (score 1)
 If there is evidence that less than half of these activities are related to specific patient diagnostic groups or types of patients then score 1. If the majority of programmes/activities are specifically designed for individual or differing needs of diagnostic groups, score 2.
4. Services should be flexible, enabling infrequent or sessional attendance. (A session is defined as a limited period of time, usually half a day or less in which

specific activities are pre-planned to cater for the specific needs of the patient or group attending. It is usual that the patient will only attend for specific, pre-planned sessions.) (score '1' if some or most attendees attend on a daily basis, score '2' if all service a mixed sessional/day-based model, score '3' if the day hospital only provides sessional placements).

Total potential score: 9

Standard D

The day hospital should be readily accessible to the population that it serves (transport and geographical location)

Criteria: transport

1. Transport arrangements should be flexible, utilising ambulances, NHS minibuses, taxis, private vehicles, public transport, enabling individualised transport arrangements. (score '1' if some flexibility but main transport is 'round-robin' pick-up/drop off, score '2' if documented and funded transport policy facilitates transport flexibility, catering for the patients' needs)
2. Cost of transport should not be a disincentive for patients to attend the facility .(score '1' if facility provides free and appropriate transport)
3. Each patient is not expected to travel for more than an hour between home and the day hospital. (score 1)
4. There is flexibility in pick-up and drop-off times of patients. (score '1' if some flexibility, score '2' if service is flexible enough to cater for the great majority of patients' needs)

Total potential transport score; 6

Criteria: Geographic location

- 5 Facilities are available during the evening, night and weekends. (score '1' if open between 9-5 working week score '2' if open at other times as well)
- 6 The location of the facility is planned (relating to accessibility) in relationship to the rest of the services and target population:
 - a. Is the facility easily accessible (public transport, well signposted, easy for physical disabilities or dependent patients) (score '1' if significant difficulties; score '2' if access is generally good.)
 - b. Is the facility co-located with or readily accessible by other care providing services such as professionals, community services (i.e. parking access, ambulance access, access by MH inpatients, other hospital specialities) (score '1' if some problems, score '2' if no problems.)

Total potential access score: 6

Total potential physical and environment score; 12

Domain 2; Standards Relating to Clinical Functions

Function 1. (Recommended as a mandatory function) Intensive multidisciplinary management (broken up into general, assessment and therapeutic)

Multidisciplinary management is characterised by the following

General issues: The day hospital provides an opportunity for a person-centred approach to care in the context of ready access to many different mental health professionals who meet frequently, providing a comprehensive and well co-ordinated complex care plan in a fairly efficient manner.

Intensity: The assessment and management can be of an intense nature, conducted over prolonged face-face contact and observation. The nature of the day hospital means that patients can be continually monitored in a variety of social and physical environments.

Assessment and therapeutic procedures: The day hospital MDT can offer a very detailed assessment in complicated cases which may be difficult to assess and manage as outpatients or in the community, yet maintain the relative independence of the patient.

Specialty access: The day hospital should be able to provide fairly immediate access to individual specialists in the mental health team. However, patients should also have relatively easy access to other hospital specialists including physicians and laboratory support (X-rays, Scans ECGs etc)

Standard E.

Day hospitals should provide intensive multi-disciplinary assessment and intervention. A multidisciplinary team should include medical staff, nursing staff, physiotherapists, occupational therapists social workers and psychologists. Additional staff may include speech therapists, art and music therapists and other practicing therapists.

Criteria

1. Documented evidence of multi-professional staff working at or with specific responsibility for the day hospital

This should include a minimum of

Qualified mental health nursing staff (score 1)

Qualified psychiatric medical staff (score 1)

Occupational Therapist (score 1)

Psychologist (score 1)

Other(s) (score maximum of 1)

2. There is evidence of multidisciplinary health care assessment (including risk assessment) and management recorded in documentation and care plans (: incomplete documentation score 1; evidence of MDT input in each case; listed participants; score 2)
3. There is access to specialist input.

Specialist input is defined as

Specialists other than mental health specialists at the day hospital (e.g geriatric medicine, physical health assessment and treatment, other acute hospital specialists) (score 1)

Access is defined as

Speed of access that would not be available to the patient if they were not attending the day hospital (e.g. through outpatient services). (score 1)

Total potential MDT score: 9

Standard F

Admission procedures should be expeditious, patient and family/carer friendly and consist of full psycho-social and physical assessment identifying patients' specific needs that inform a care plan.

Criteria

1. Recorded evidence that patients are introduced. This includes
 - a. Orientation around the unit (score 1)
 - b. Introduction to key staff and allocation to an identified key worker (score 1)
 - c. Introduction to other patients (score 1)
 - d. Explanation regarding process and procedures (score 1)
 - e. Provision of written material supporting the induction process. (score 1)
2. Assessments are initiated within 24 hours of attendance. (score 1)
3. Assessment process involves a needs and risk assessment which inform care planning (documented evidence) (score 1 for partial documentation, score '2' if complete and full documentation in each case)

Total potential score; 8

Standard G

Discharge procedures should be formalised early in the patient's care. They should be planned, include elements of education concerning relapse, recurrence and subsequent management of the condition, orientation, building independence, appropriate referral and working with carers and families.

Criteria

1. Discharge plans are discussed by all staff, patient and family/carers (score '1' if only discussed with patient or not recorded; '2' if always discussed with all appropriate patients and recorded)
2. Documented evidence that patients are provided with literature and appropriate advice regarding
 - a. The nature of the experienced problems (score '1')
 - b. The possibility of relapse (score '1')
 - c. Drug management (score '1')
 - d. Arrangements for transfer, follow-up or discharge from service (score '1')
 - e. Offer of copies of discharge correspondence given to the patient (where appropriate) (score '1')

- f. Provision of written information relating to other organisations that can provide additional support and advice (score 1)
- 3. Evidence that correspondence relating to transfer to other services (including discharge letters to primary care) are delivered within 5 working days. (score '0' if not evidence that they are sent, '1' if evidence recorded, '2' if evidence of audit or feedback from recipients)

Total potential score; 10

Function 2. Acute and crisis care,

Day hospitals are generally expected to support (in collaboration with other community services) patients that are in crisis or undergoing relapse of their condition, so preventing hospital admission or deterioration. In the majority of cases, assessment and discharge procedures should be expeditious, co-ordinated and planned so as to reduce patient dependency and enhance recovery. Contact with the patient should be time-limited and goal orientated. Some day hospitals have developed crisis intervention as a major function with view to decreasing the use of inpatient facilities and mirroring crisis care team development in other age specific services.

Standard H

The majority of day hospital assessments and treatments should be time-limited, goal, orientated and focused.

Criteria:

Maintaining throughput, turnover and avoiding institutionalisation of patients.

- 1. The turn-over index is equal to or less than that agreed in the philosophy/mission statement

The turn-over index is calculated by:

Number of patients discharged at end of audit period (1 year) X 100%

Number of patients at beginning of audit period

(score 1 if less than or the same as that agreed in mission philosophy statement)

- 2. There is recorded evidence of pre-planned review dates relating to finished periods of assessment or intervention (score1 if incorporated in care plan)
- 3. There is recorded evidence that an explanation regarding purpose and proposed length of stay at the day hospital is given to patients and carers within or at the end of the initial assessment period. (score1 if recorded and '2' if evidence of patient and/or carer acknowledging plan)
- 4. There are therapeutic strategies in place to facilitate the discharge of institutionalised patients/patients from the day hospital. (e.g. leavers groups, graded discharge procedures, introduction to alternative community resources) (score1 if evidence of planned interventions designed to facilitate discharge,

score '2' if evidence of effectiveness of such interventions as demonstrated by case examples)

Total potential score relating to maintaining turn over and avoidance of institutionalisation: 6

Managing crisis

5. There is evidence that the day hospital has crisis intervention and management as a defined function within the philosophy/mission statement. (score 1)
6. If the day hospital is prioritizing this role then appropriate staffing levels and grades have been provided and funded. (score 5)
7. Flexible out-reach arrangements have been made so that staff can support patients in community settings if required. (score1)
8. There are recorded operating procedures relating to management of patients in their own homes, defining the relationship with community mental health teams. These should include documented arrangements of referral, key worker arrangements and case management and support provided by CMHTs (score1)
9. There is appropriate recorded and auditable supervision of staff working in community settings (score1)
10. In some situations the day hospital may have control over access to inpatient beds. If this is the case then there needs to be agreed written operational policies relating to this. (score 1)
11. Reviews should be undertaken of cases in which despite provision of crisis intervention, the patient has been admitted into inpatient care with view to identifying unmet needs and improving the service. (score 1)

Total potential score relating to crisis management: 11

Function 3. Rehabilitation and early discharge from inpatient units

Early engagement with inpatients may facilitate the recovery process and rehabilitation of people with severe mental illness. There are a number of functions by which inpatient bed usage may be reduced. This includes the promotion of early discharge through joint management of inpatients, enhancing dependency and recovery in non inpatient settings and the promotion of rehabilitation and recovery of patients that may have been in hospital for long periods of time. Both in-reach and out-reach services may play an important role in providing a bridge between the community, the day hospital and inpatient services.

Standard I

Rehabilitation of inpatients.

Rehabilitation is based on the following principles (Royal College of Psychiatrists)

- Enhancing the strengths and resilience of patients (patients, carers and families).
- Maintaining optimism for individual growth and recovery.
- Treating disability with respect and acceptance.
- Improving the holistic quality of life for those with the most severe disabilities.
- Reducing stigma and promoting social inclusion.
- Therapeutic risk-taking to promote personal responsibility.

Criteria

Inpatient liaison

1. There is an agreed (inpatient and day hospital) policy relating to the joint management of inpatients attending the day hospital. (score 1 if clearly defined and recorded, score '2' if evidenced by successful case examples)
2. Inpatient and day hospital staff attend joint case reviews of inpatients using day hospital facilities (score 1 if occasional, score 2 if frequent and routine; at least once a week).
3. Specific sessions/interventions are in place for patients who are either at risk of institutionalisation or are institutionalised. (examples include specific groups, activities and progress reviews) (score 1)

Outreach services

1. There are agreed, documented protocols relating to duration, purpose and review of interventions undertaken by the outreach team (score 1)
2. Care plans clearly specify care co-coordinator and supervision responsibilities, particularly in relationship to interfaces with CMHTs (score 1)

Total potential score; 7

Function 4. Longer term management

Long term attendance is associated with institutionalisation, dependency, and social and psychological dependency. Long term care (as a consequence of lack of more appropriate community service provision) should be avoided and appropriate strategies developed, including out-reach support groups held in alternative venues or progressive or incremental reduction in attendance. Unless specifically defined as a major function of day hospitals, long term attendance is usually reserved for small, well defined, specific groups of very complicated, unstable and complex cases. The philosophy/mission statement of the day hospital should reflect the proportion of patients expected to attend for greater than one year (see standard D).

Standard J.

Long term care (greater than one year) should be provided to patients that would otherwise require admission into institutions and for which other community based facilities are either inappropriate or not provided.

Criteria

1. There is specific identification and active management of long term patients (LTSU) (score '1' for evidence of specific list of long term attendees).
2. Each LTSU should have an individual needs assessment and regular 3 monthly (at least) reviews with view to exploring potential for developing independence and recovery and promoting discharge to alternative community facilities (score 1 if evidence of regular review, score '2' if three monthly reviews recorded and demonstrably influencing care plan).
3. Each LTSU should have a care plan which specifies the therapeutic need to attend for greater than one year. This includes:

- i. Evidence of lack of alternative services/facilities (score 1 if deficit clearly identified)
 - ii. Social dysfunction/isolation, lack of support, preventing the patient from being rehabilitated (score 1 if clearly described in care planning)
 - iii. Medical or psychiatric instability and unacceptable risk if discharged (score 1 if clearly documented)
 - 4. Each LTSU should have an individualised care plan that identifies therapeutic and goal orientated treatment, activities and management, driven by needs assessment. (score 1 if individualised care plan has been constructed, score '2' if specifically related to needs and risk assessment)
- Total potential score: 8

Additional quantitative evidence supporting rehabilitative process of LTSU patients can be developed:

Across an audit period (usually of one year):

Proportions of LTSU patients:

- Discharged from the day hospital back into main stream mental health services
- Discharged into day care or voluntary/ social services organisations
- Discharged from mental health services.
- Re-admissions to the day hospital
- Admissions to inpatient care

Function 5. Psychotherapeutic and Psychosocial interventions (including individual, family and group interventions)

Psychotherapeutic/social work can be loosely classified into three:

1. Formal psychotherapy groups characterised by:

- Being undertaken by specifically trained staff
- Usually taking the form of individual or 'closed' or family groups
- Regular supervision of therapist and therapeutic process
- Undertaken in the context of manualised or formal conceptual frame-work
- Usually time limited, sequence of interviews or group meetings
- Goal orientated
- Evidence based

2. Informal/open/social therapy usually undertaken by mental health staff without specific, formal training. This type of group or individual work is frequently employed within day hospitals and may fulfil a wide range of purposes including:

- Patient peer support
- Physical activity
- Social awareness and rehabilitation
- Skill training
- Education
- Assessment in group settings
- Behavioural and social monitoring

3. Provision of general supportive milieu. This is informally provided through a supportive environment enabling patients to express themselves in a safe and comfortable environment. This is of particular importance within a day hospital setting as it provides an appropriate environment in which sensitive assessments and interventions flourish. However, unless monitored and controlled, such an environment can be detrimental through enhancing dependency and institutionalisation.

Standard K

The unit may provide facilities for group and individual psychotherapy.

Criteria;

1. Staff have demonstrable skills/experience in undertaking the relevant psychotherapeutic/social intervention (formal training for formal psychotherapy and informal training for informal psychotherapy) (score 1 if evidence of informal training, score '2' if evidence of formal training (through specific validated and recognised courses))
2. Documented evidence demonstrating that both formal and informal psychotherapeutic/social intervention is pre-planned and reviewed through supervision (score 1 if recorded evidence of therapeutic work and '2' if formally reviewed through supervision with recorded feedback to therapist).
3. Formal and informal psychotherapeutic/social involvement of individual patients is needs driven and included within care plans (score '1' if evidence of specific need for therapy is identified in assessment and care plan, score '2' if evidence of specific psychotherapy goals are met).
4. Evidence that there is feedback from patients and staff recorded on a regular basis in care notes (score 1)

Total potential score; 7

Function 6. (Recommended as a mandatory function) **Carer, patient and family support and involvement,**

It is generally accepted that day hospitals play an important role in working with patients, carers and families in terms of education, health promotion, support and skill sharing.

Standard L

The unit should promote close working relationships with families and carers of patients through support and education.

Criteria

1. Evidence of good communication links between patients, family members and carers day hospital staff (where appropriate) (score '1' if informal access, score '2' if evidence of recorded access)
2. Documented evidence that family and carers are encouraged to participate in the patients' management (where appropriate) (score '1' if engaged, score '2' if it is specifically recognised as part of the care plan.)
3. Each carer is offered a carer assessment and appropriate support (score '1' if carer assessment undertaken and '2' if evidence of care plan being undertaken.)

4. The day hospital carries out home visits so as to assess the home environment and facilitate care and coping skills of families and carers (score 1)
5. Evidence that patients, carers and families are included in developing/improving the day hospital services (score '1' if evidence of involvement, score '2' if evidence of feedback resulting in change)
6. Evidence that the day hospital runs regular group meetings or educational/information meetings for families and carers (score 1)

Total potential score: 10

Development of the Standards

Introduction

The Day Hospital Network was established by the Faculty of Old Age Psychiatry as a consequence of the National Survey of Day Hospitals undertaken in 2001. Four hundred and forty day hospitals were included in the survey. The survey identified a number of issues needing further consideration.

1. There is a wide diversity in terms of character, role and utilisation of day hospitals with little evidence of common clinical or operational standards.
2. There is considerable overlap between day care facilities and day hospital facilities with associated lack of clarity, blurring of roles prolonged and default attendance of patients.
3. There are deficits in terms of close working relationships with social services and other community and health organisations.
4. There is lack of information relating to evidence based interventions, activities and outcome measures.
5. There is often under-representation of staff with appropriate skills, including psychologists and social workers. Nursing staff are often multi-rolled and involved in providing domestic and administrative duties due to inappropriate staff establishment.
6. There are pervasive problems with transport arrangements for patients.

The Faculty of Old Age Psychiatry was advised to set up a day hospital network in order to address these issues. The main aim of the network is to promote quality of care in day hospitals catering for older people with mental illness and develop a response to the rapidly changing profile of day hospital service in the UK. A variety of initiatives were adopted to achieve these aims including regular national day hospital conferences, sharing examples of good practice between day hospitals and establishing standards that would be open to audit and review.

In the context of a rapidly changing profile of day hospital care, the aims of this report are:

1. To present a consensual review of the functions carried out by day hospitals.
2. To provide a consensually derived set of standards relating to these functions.

Background

The evidence

There is a rich literature relating to the arguments both for and against day hospitals for older people with mental illness. Generally speaking national documentation tends to support the existence of day hospitals (WHO 1997, Audit Commission 2000, HAS 2000, NSF 2001). However, it is evident that these reports are based on the consensus process or examples of 'good' practice, rather than any specific, peer reviewed, scientific evidence relating to efficacy. It is this lack of evidence that feeds the controversy regarding the utility of day hospitals, their 'effectiveness' and their relative benefit in terms of cost. In the absence of direct evidence relating to comparative efficacy of day hospitals for older people with mental illness we are forced to draw on three lines of enquiry. In the first instance we can draw on evidence relating to similar organisations providing care for other age or diagnostic groups.

Marshall et al (2003) have undertaken two Cochrane reviews relating to the efficacy of day hospitals for working age adults. In comparing day hospitals to inpatient care, the author summarises: Day hospitals are a less restrictive alternative to inpatient admission for people who are acutely and severely mentally ill. At least one in five patients currently admitted to inpatient care could feasibly be cared for in an acute day hospital. The psychiatric symptoms of inpatients deemed suitable for acute day care appeared to improve more quickly than if the person had been cared for as an inpatient. Day hospital care was also less expensive than inpatient care. In comparing day hospital care to outpatient services (Marshall et al 2001); day hospitals offer care that is less restrictive than in-patient care but more intense than out-patient care. They can be used to provide more intense/ specialized care to treatment-resistant out-patients (day treatment programmes) or to long-term patients (day care centres).

They can also bridge the gap between in-patient and out-patient care (transitional day hospitals). However, there was insufficient evidence to determine whether any of the three types of day hospital care had substantial advantages over out-patient care. In older patients with physical illness and handicap a Cochrane review (Forster et al 1999) summarized the findings of a meta analysis of 11 trials in saying; when resource use was examined the day hospital group showed trends towards reductions in hospital bed use and placement of survivors in institutional care. Nine studies comparing treatment costs indicated that day hospital attendance was a more expensive option, although only two analyses took into account long-term care costs. Medical day hospital care for the elderly appears to be more effective than no intervention but may have no clear advantage over other forms of comprehensive elderly medical services.

The second line of enquiry that informs the evidence base draws on studies undertaken within day hospital settings, relating to the effectiveness of individual services or procedures. Obviously this line of enquiry does not attempt to compare the efficacy of day hospitals with other organizations but does draw attention to methods by which efficiency and outcomes can be potentially improved. The following studies are examples of some of the better, well designed studies.

Ashaye et al (2003) employed a standardized assessment tool (the Camberwell Assessment of Need for the Elderly) in the context of a randomized controlled trial in two day hospitals and demonstrated its utility in identifying patient needs and showing that the day hospitals met over two thirds of the unmet needs of patients. However, these findings vary across studies, with the proportion of unmet needs in long term attendees seemingly greater (Hoe et al 2004). Bramesfield's study (2001), examining the effectiveness of day hospitals in the treatment of older depressed people had mixed results, with evidence of good outcome in some but with over half demonstrating no improvement. Other large studies tend to support the effectiveness of day hospitals in improving depressive symptoms in older attendees (Soref & DeVries 2005).

In the context of dementia care a number of studies have shown that both day care (Wimo et al 1993) and day hospitals (Ashaye et al 2003) can enhance patient health through providing appropriate assessment, meeting unmet needs and potentially delaying institutionalization. These studies illustrate the potential effectiveness of various aspects of day hospital care, such as assessment or treatments of specific patient groups. It is important to emphasize that they do not validate the concept of a 'day hospital' but merely show that day hospitals can deliver these services effectively.

The ambiguous relationship between day hospitals for older people with mental illness and day care is seminal to much of the discussion.. In this respect 'day care' is the provision of social care delivered through non NHS organisations and is often 'means tested' or open to charging. A number of researchers have draw attention to similarities between the nature of patients and the benefits gained through attendance at both types of facilities (Currie et al 1995, Warrington and Eagles 1996, Eagles and Warrington 2002), arguing that NHS resources could be better targeted.

On the other side of the argument, a number of authors have demonstrated differences between the patients attending both types of establishment (Furness et al 2000, Collier & Baldwin 1999).

A more recent study has compared standards of care in day hospitals and day centres, catering for older people suffering from dementia. Day hospitals were shown to offer greater degrees of systematic assessment, scored higher in terms of rehabilitation potential, aspects of carer involvement, better physical environment, but proved poorer in terms of transport arrangements. 'Person centre care' seemed to be similar in both types of establishments (Reilly et al 2006). Drawing on a number of documents, the authors developed a questionnaire of 55 questions, orientated around structural features of the service, care processes, service content and service quality.

The different findings of these studies may reflect differing methodology but equally, if not more likely, reflect the diversity found in day hospitals and their relationship with other community services. This would be consistent with the findings of the National Survey mentioned above and does have significant implications regarding the generalisation of research findings based on local definitions and character of day hospitals.

Despite day hospitals being originally developed to provide three main functions; assessment, treatment and rehabilitation (Aire 1986) and primarily focused on the management of dementia, the lack of standardisation and supporting evidence regarding efficacy has made them vulnerable to disestablishment or change. This is often in the context of development of other related services which may fulfil one or more of the traditional roles of a generic day hospital catering for older people with mental illness. The introduction of community mental health teams posed a substantial challenge (Murphy 1994). More recent developments including the demand for equitable services for older people (and compared to those for working age adults) poses potential challenges through the development of crisis intervention and related services (Age Concern 2007). Some of these functions are potentially carried out by day hospitals and related out-reach teams (Richman & Wilson 1994). It is clear that day hospitals have to evolve. The introduction of sessional attendance, specialisation of function and changing skill sets promote diversity and development to the extent that the traditional 'day hospital' concept is becoming progressively redundant.

This introduction does not attempt to provide an exhaustive review of the relevant literature. Its main aim is to illustrate the potential sources of evidence relating to the clinical efficacy of day hospitals for older people with mental illness and provide an overview of rapidly changing service provision. It is obvious that the evidence base is sparse with a notable absence of definitive randomised controlled trials. This weak evidence base has fed on-going arguments concerning day hospital efficacy. One major issue confounds potential research in this area. In essence this relates to problems and this defining of a day hospital of a day hospital.

It is evident from surveys that the 'day hospital' concept is poorly defined in terms of function, patient and patient characteristics, organisation, service provision and delivery. This diversity is easily illustrated through the day hospital network which has cited examples of good practice including day hospitals that specialise in long term management of personality disorders, those that entirely specialise in either dementia care or functional illness. There are day hospitals that are amalgamated with geriatric medical day hospitals, day hospitals that are isolated in rural areas and travel between sites, day hospitals that predominantly provide day care facilities in the absence of appropriate social provision and those that operate as gate-ways to inpatient services with outreach to the homes of patients, catering for the severely ill.

Some day hospitals do not provide daily attendance but operate through planned sessional attendance. Some day hospitals are closely working with day care facilities, providing a seamless service. This diversity maybe a reflection of default design, dependent of 'filling' gaps in community services, may reflect innovative and improved ways of delivering services and may reflect related changes in associated services. Irrespective of the underlying causes, it is evident that extreme caution should be taken in generalising findings from research conducted on a small number of day hospitals. Likewise the assumption that generic 'outcomes' such as reducing inpatient admission are always relevant in determining the efficacy of a day hospital should be challenged.

Research and audit outcomes should be informed by pre-defined design, purpose and functions of each unit.

It is evident that the traditional concept has evolved to the extent that the generic term 'day hospital' is almost impossible to define and that further evolution is inevitable. This document presents the findings of a series of projects designed to characterise contemporary functions of current day hospital facilities and review and develop clinical standards associated with these functions. We anticipate that this will provide a flexible model, open to further evolution and development by which the function and standard of care provided by day hospitals or related facilities can be measured.

Published Day Hospital Standards

There are a variety of sources that inform the development of standards for day hospitals for older people with mental illness. Most of these were used to inform a questionnaire, designed to compare standards in day hospitals and day centres (Reilly et al 2006).

In 1997 the World Health Organisation published the 'Quality Assurance in Health Care' which incorporates a fairly exhaustive section on day hospitals for older people with mental illness. It is divided into two, leading with a glossary that provides an illustration of each item. This is followed by more specific criterion and instruction for each rating. Each section is divided into domains: Physical environment, administrative arrangements, care process, interaction with families and community agencies and discharge and follow-up. There are 66 items; each item is given a rating of 0-2.

In 1999 the Health Advisory Service published Standards for Mental Health for Older People (Finch & Orrell 1999). The document provides a section on day care/community treatment facilities which includes the following standards:

- Personal home care services choice and flexibility to meet the assessed individuals need
- Day care is appropriate, flexible and responsive with a range of facilities for both dementia and functional disorder.
- Community assessment and treatment facilities, including day hospitals, focus on assessment and treatment, are able to respond to acute referrals and other intensive packages of care.
- Facilities are appropriate and informal, being safe, non threatening and with adequate amenities.

Each of these standards are associated with a number of qualifying criteria. The document does not provide a grading system.

The Audit Commission published the 'Forget-me-not' report in the year 2000. This provided a number of potentially measurable standards including

- Functional and dementia services should be provided separately (either separate days or separate buildings)
- Day services should be planned collaboratively between health and social services
- Day care provision should be driven by user's needs including appropriate mix of staff, rather than the type of care depending on the agency providing the care.
- Health and social services should ensure equitable access to care and that charging policies should reflect this.
- Long term care for people with functional and organic disorders should be provided in all areas
- Day Hospitals should be used for time limited assessment and treatment .
- Transport performance should be monitored and flexible approaches encouraged if requires (e.g. taxis)

In 2001 the Department of Health published the National Service Framework for older people. This publication provides some statements that could inform the development of related standards.

Day Hospitals should offer:

- Intensive assessment and treatment to people with functional disorders and dementia
- Aftercare following in-patient admissions
- Rehabilitation and support for older people with long term mental illness.

In 2005 the Department of Health published 'Everybody's Business'. This document provides statements relating to day hospital services for older people with mental illness. These include:

- Intensive multidisciplinary assessment and treatment for older people with complex mental health needs
- Should aim at reducing admission
- Focus on rehabilitation
- Sessional based treatment and home based treatment
- Interventions are time limited
- Comprehensive extended multidisciplinary mental health assessment and risk assessment
- Individual and group psychological interventions (counseling, CBT, AMT, coping strategies, coping with loss)
- Education and advice to carers
- Monitor treatment with mental health medication
- Support care staff in mainstream services in order to maintain people at home
- Flexible combination of day care and day hospital treatment models enabling seamless delivery of services.

Lastly, the Department of Health published National Standards, Local Action (2006-7/8) and its related document Standards for Better Health. In addition to providing a reference regarding definitions, this useful document provides a framework against which specific service related standards may be developed. It identifies seven domains which include

- Safety
- Clinical and Cost effectiveness
- Governance
- Patient focus
- Accessible and responsive care
- Care environment and amenities
- Public Health

Each domain has 'Core Standards' and 'Developmental Standards'. By their very nature, they are fairly generalised so as to be applicable to all health and social care systems. It is however self evident that any standards relating to NHS health care systems should relate to this important document.

In addition to these influential documents there are a variety of documents and publications relating to good practice that can also inform the development of standards however, many of these have not been subjected to systematic review, field testing or are difficult to translate into measurable standards. Other authors provide various systems by which process and performance of day hospitals can be quantified. Wimo et al (1993) identified nine potential assessments that can be used to quantify productivity and process. These include:

- The participation quotient; measuring the level of participation during a specific period of time;

Real participation X 100% (number of visits undertaken)

Prognosticated participation (number of visits deemed suitable for each patient each week)

- The registration quotient: measuring over or under capacity

Prognosticated participation X 100%

Attendance capacity (number of visits judged possible)

- Capacity quotient; measuring the level of capacity utilisation

Real participation

Attendance capacity

- Turnover quotient: measuring turn over of patients during a defined period

Number of patients discharged

Number of patients included in the study period

Other quantifiable data includes:

- Average number of visits per patient per week
- Rate of institutionalisation during the study period
- Mortality rates

- Misjudgement quotient: quantifying the number of patients that prematurely left the day hospital for reasons other than somatic illness or and death

Number of patients self discharging per month

Number of patients at inclusion

- Discharge analysis
 - Death
 - Disturbing behavior
 - Refusal
 - Relatives refusal
 - Physical deterioration
 - Mental deterioration
 - Breakdown of care at home leading to institutionalization.
 - Transport problems

Characterising functions of day hospitals in England

Introduction

In developing standards that are of potential utility to day hospitals it is important to characterise what day hospitals are. This process has to accommodate the diversity of day hospital provision and potential developments in the day hospital evolution. This is fairly difficult and it is accepted that any functions and related standards developed will have to be subjected to on-going review. In the absence of definitions of 'day hospitals', we have adopted a consensual approach to define the optimal functions of day hospitals. This was done by identification of the functions and secondly; identifying potential groups of patient and carers best targeted by these functions.

Aims:

1. To identify functions that day hospitals can preferentially provide from the perspective of health service and related staff.
2. To identify the nature of the patient population that would best benefit from these functions.

Method

Employment of focus groups

Focus groups have been used to inform planning and the setting of goals throughout many organizations. They are acknowledged as providing a forum to provide qualitative data through focused discussions, enabling a clear understanding of the topic of interest (Kreuger & Casey 2000). In particular, focus groups have been used for idea generation, attitude studies and habit and usage studies (Greenbaum 1998).

Building the questions/discussion points and reporting systems

A series of six pilot focus groups were undertaken with the following objectives:

1. Design a series of open ended, neutral and sequenced questions to be adopted as Key questions for focus groups to consider. (ASA 1998)
2. To develop an efficient and manageable system through which responses could be recorded and provide material for analysis.

The pilot process developed two key questions:

Question 1:

What can a day hospital do best in terms of assessment and management compared to other services? It is important to remember that participants were asked to express the relative strengths of day hospitals compared to other local service provision.

Question 2:

Considering these strengths, which user groups should be targeted by day hospitals compared to other services?

Each focus group received the second question on completion of the first, after approximately one hour of discussion. Focus groups were encouraged to explore each

question, recoding as many observations and answers as they wished for each question.

Selection of participants

In planning the focus group it is necessary to identify information rich participants with varying access and experience of day hospital services. We primarily focused on recruiting NHS and Local Authority and voluntary agency staff all with experience of working within or collaboratively with day hospitals. It was emphasized that the participants of each focus group did not work in the same day hospital and preferentially represented a mix of professions, organizations and experiences (Kreuger & Casey 2000) so that each focus group would provide multi-professional/organization consensual responses to each question/discussion point.

Focus group organisation and process

The Day Hospital Network was used to identify day hospitals prepared to host the workshops. Seven different mental health and care trusts were engaged in the project. One of the trusts (extending over a very large rural geographic area) hosted two workshops. Each workshop lasted half a day. Instructions were given to the collective participants. They were then divided into focus groups. Each focus group had between five and ten participants. Each focus group elected a facilitator and a scribe. The facilitator encouraged focus group members to engage in discussion.

The role of the moderator

The moderator's role is recognized as an expert in the area of day hospitals (Krueger & Casey 2000). The job is to facilitate each group in maintaining focus on the two questions and to facilitate group process. The moderator then conducted the feedback session to all the participating focus groups.

Recording and reporting

Group selected scribes were asked to summarize group observations on small pieces of paper ('post-it' papers), with each observation confined to individual pieces. This had the advantage of encouraging each focus group to define and differentiate between each observation.

Clarification of the observations

On completion of the focus group tasks all participants were asked to re-assemble collectively. Focus groups were numbered. The scribe of the first focus group was asked to present a response to the first question. All other focus groups were asked to identify similar or associated responses and submit each on a 'post it' response paper. These were collected, with each response being discussed in open forum with view to clarifying definition and meaning. Each focus group was then asked to submit responses in turn and the same procedure undertaken until all responses had been submitted.

Data Synthesis

Guidelines for conducting the analysis were taken from Krueger and Casey (2000), employing a systematic and verifiable system. An adapted form of note based data collection was adopted, promoting summary comments as responses to the key questions. A 'long-table' strategy was used to collate the summary statements, using micro-soft software.

Each statement was subjected scrutinized against the following points (Krueger and Casey 2000);

1. Did the participating group address one of the key questions?
2. Which key question does it address?
3. Does the summary point say something important about the topic?
4. Is it similar to other summary points?

Subsequent analysis is divided into three sequential components relating to each question posed to the focus groups, undertaken by two independent researchers.

All responses are listed (responses to both questions are kept separate and analyzed separately).

Stage 1. Thematic grouping by comment and word content

- Each researcher grouped statements by theme as determined by their word or comment content.
- Each response (irrespective of replication) was grouped individually.
- Each response could be grouped in more than one grouping.
- Responses that do not readily associate with other responses into 'thematic groups' are termed 'orphan responses' and grouped separately.

Stage 2: Developing functions from themes

A function refers to a description of a theme group, encompassing the meanings inherent to each of the responses within the theme group.

- Each theme group generated from stage 1 was examined and a 'function' derived from the content.
- Functions derived from each theme group could be related but should be distinct from one another.

Stage 3: allocating 'orphan' responses to functions

- Each orphan response was considered in terms of the developed functions. Orphan responses were included in relevant functions if its meaning approximated closely enough to the description.
- Where orphan responses failed to be included within established themes they remain separate.

Stage 4. Consensus review and definition of functions

- Both researchers returned a list of functions and related responses.

- Individual functions from each researcher were compared and common functions (and associated responses) identified.
- Functions not common were reviewed through consensus. With one of two outcomes:
 1. The generation of additional functions based on consensus
 2. The disestablishment of an outstanding functions and re-allocation of responses to other established functions

Findings

Seven Mental Health Trusts/Care Trusts contributed to the project. Each Trust provided at least two day hospitals, (ranging from two to five). The day hospitals serviced rural/urban and semi-rural communities. A variety of day hospitals were selected including those co-located with acute psychiatric inpatient facilities and those located at a significant distance from inpatient services. Community mental health teams were frequently co-located with day hospitals and a minority was geographically in close proximity to local authority day care facilities.

Data was collected through thirty three focus groups involving 224 participants. **(appendix 1).**

Focus group findings

Question 1 generated 398 responses (appendix 2) from which six functional activities were generated. These have been summarized below, drawing on the content of individual summary statements.

Description of identified functional themes

Function 1. Intensive multidisciplinary management (broken up into general, assessment and therapeutic)

Multidisciplinary (MDT) management is characterised by the following

General issues: The day hospital provides an opportunity for a person-centred approach to care in the context of ready access to many different mental health professionals who meet frequently, providing a comprehensive and well co-ordinated complex care plan in a relatively efficient manner. Both assessment and discharge procedures should reflect MDT contribution.

Intensity: Assessment and management can be intense, conducted over prolonged face-face contact and observation. The nature of the day hospital means that patients can be continually monitored in a variety of social and physical environments.

Assessment and therapeutic procedures: The day hospital MDT can offer a very detailed assessment in complicated cases which would be more difficult in outpatients or in the community yet maintain the relative independence of the patients.

Specialty access: The day hospital should be able to provide fairly immediate access to individual specialists in the mental health team. However, patients should also have relatively easy access to other hospital specialists including physicians and laboratory support (X-rays, Scans ECGs etc)

Function 2. Acute and crisis care

Day hospitals are generally expected to support (in collaboration with other community services) patients that are in crisis or undergoing relapse of their condition, so preventing hospital admission or deterioration. In this context the day hospital may play an important role in preventing admissions which could otherwise be managed in the community. In the majority of cases, contact with the patient should be time limited and goal orientated.

Function 3. Rehabilitation and early discharge of inpatients

Reducing the use of inpatient services is frequently cited as one of the main roles of a day hospital and what little evidence there is suggests that they may have a role, however, efficacy remains unproven. Day hospitals play an important role in the promotion of early discharge through joint management of in-patients, enhancing dependency and recovery in non inpatient settings and facilitating rehabilitation and recovery of patients that have recently experienced a mental illness. Both in-reach and out-reach services may facilitate these and other related functions.

Function 4. Longer term management

Long term attendance is associated with institutionalisation, dependency, and social and psychological handicap if not carefully managed. Long term patients require considerable resource and may adversely influence the therapeutic milieu of the day hospital with impact on other patients unless appropriately managed. Default long term care (as a consequence of lack of a more appropriate community service provision) should be avoided and strategies developed, including out-reach support groups held in alternative venues or progressive or incremental reduction in attendance. Unless specifically defined as a major function of day hospitals, long term attendance is usually reserved for small, well defined, specific group of very complicated or unstable patients. The philosophy/mission statement of the day hospital should reflect the proportion of patients expected to attend for greater than one year.

Function 5. Psychotherapeutic interventions

The day hospital venue may offer appropriate setting for both individual and group work. Psychotherapeutic work can be loosely classified into three:

1. Formal psychotherapy groups characterised by:

- Being undertaken by specifically trained staff
- Usually taking the form of individual, 'closed' or family groups
- Regular supervision of therapist and therapeutic process
- Undertaken in the context of manualised or formal conceptual frame-work
- Usually time limited, sequence of interviews or group meetings and goal orientated
- Usually evidence based

2. Informal/open/social groups usually undertaken by mental health staff without specific, formal training. This type of group or individual work is frequently employed within day hospitals and may fulfil a wide range of purposes including:

- Patient peer support
- Physical activity
- Social awareness and rehabilitation
- Skill training
- Education
- Assessment in group settings
- Behavioural and social monitoring

Groups or individual sessions may be stand alone or in sequence.

3. Provision of general supportive milieu. This is informally provided through a supportive environment enabling patients to express themselves in a safe and comfortable environment. This is of particular importance within a day hospital setting as it provides an appropriate environment in which sensitive assessments and interventions flourish. However, such an environment can be detrimental through enhancing dependency and institutionalisation.

Function 6. Carer, patient and family involvement,

It is generally accepted that day hospitals play an important role in working with patients, carers and families in terms of education, health promotion, support and skill sharing.

Description of Patients

Question 2 generated 196 responses (appendix 3) which in turn generated nine descriptive themes relating to patients that may potentially benefit from the identified functions of a day hospital.

All focus groups identified that day hospitals should target patients, carers and families suffering from functional and/or organic illnesses including patients aged under 65, suffering from organic illness (where appropriate). Such patient groups are characterized by one or more of the following:

1. People with severe mental illness

Patients with severe levels of mental illness: This includes people who have suicidal ideation, unstable and lacking insight, tending to require more intense services than can be provided by CMHTs.

2. Challenging/disinhibited behavior

Patients with challenging, disinhibitive, high risk or antisocial behaviors that cannot be tolerated in local authority or voluntary day care centers. This group includes patients that require specialist assessment and management of such behaviors.

3. People at high risk

This group includes patients that are of high risk of relapse, requiring intensive or long-term monitoring and relapse prevention strategies. It also includes patients that are community residents that are recognised as having a high risk of self-neglect, self-harm or harm to others as a consequence of their mental illness. The group also includes people that have a severity of illness that needs more intensive care than community mental health teams can offer. However such patients may be held in the community through the day hospital. It is anticipated that without such intensive care they may require inpatient admission. Such patients are described as requiring urgent assessment, intensive care/monitoring, refusing admission, undergoing crisis, suffering from acute stages of their illnesses.

4. People with complex needs

This group includes patients with diagnostic/assessment difficulties that may require more intensive investigations and access to the MDT. Patients with complicated psycho-social and physical needs that require intensive or long-term multidisciplinary engagement are also included. Those with treatment-resistant conditions, co-morbidity, psycho-social complications and adversity that require on-going intensive community management may also benefit and fall within this group. This group also includes people requiring access to other specialists (hospital or community-based) or regular medical (psychiatric) monitoring.

5. People with mental illness in crisis

Patients that are defined as in crisis, requiring assessment, suffering from acute symptoms, distressed and requiring immediate assessment/intervention.

6. In-patients

This group includes patients requiring rehabilitation into the community from in-patient settings. In this sense the day hospital is described as providing transitional care, step-down care, in-reach, progressive discharge planning or staged discharge or rehabilitation.

7. People requiring psychological therapies

This group includes people who benefit from social/non-specific supportive aspects of the day hospital, including patients with mental illness who have difficulty socializing, the lonely, the vulnerable and those with little support. The group also includes people that have been identified as warranting formal psychotherapeutic interventions, including CBT, anxiety management, behavioral therapies, psychological assessment, psycho-education and patients that may benefit from group therapies, family therapies and other forms of structured group intervention.

8. People with long-standing mental health problems

People which have enduring or severe symptoms and living in the community needing regular psychiatric input and too ill for non-medical facilities to provide day care. This group also includes patients that require fairly intensive drug compliance monitoring and drug changes/titration.

9. Carers and families of people with mental health problems

This group includes the families and carers of people attending the day hospital, requiring inclusion in the management of the patient, advice, support and respite.

Summary of day hospital function and potential patient groups.

The focus group process has characterized the functions that day hospitals best provide when compared to other community based mental health services. A number of issues are self evident. Firstly; it is apparent that day hospitals have a number of closely related functions which are amenable to standard setting and audit. Secondly, the number and combination of functions undertaken by any particular establishment will vary, with some units being highly specialized in terms of function and others providing a more generic service.

The functions of each day hospital will inform the staffing, design and productivity of each unit and should be reflected in terms of audit and outcome parameters. The consensus process has also provided a characterization of the people best thought to benefit from the functions that a day hospital may deliver. In general, it is evident that day hospitals are best employed in the management of patients who need additional support to that provided by community teams. However, they also have the potential to provide in-reach to facilitate rehabilitation and discharge and provide a useful environment for patients requiring more intensive assessment and treatments than are usually provided in the community.

Clinical Standard Development

Terminology

A standard is defined as 'An objective with guidance for its achievement given in the form of criteria sets which specify required resources, activities and predicted outcomes' (Royal College of Nursing 1990).

A criterion is defined as 'An item or variable which enables the achievement of a standard and the evaluation of whether it has been achieved or not' (Royal College of Nursing 1990). Valid criteria should be based on evidence, related to important aspects of care and measurable.

In developing the clinical standards for day hospitals we have adopted the following principals (Finch & Orrell 2000):

1. The standards should have face validity and content validity.
2. The standards and associated criteria should be informed by previously published standards and literature so as not to promote duplication
3. The provenance of each standard should be cited
4. The standards should be developed through a process of consensus and consultation with appropriate groups
5. The standards should be measurable (through associated criteria)

Method

Having established the functions of day hospitals and the characteristics of the patients best served by day hospitals we adopted a step-wise consensus process by which standards and related criteria were developed.

1. Search of current literature informing standards in day hospitals for older people with mental illness

A search of health policy literature was undertaken with view to identifying statements, specific standards and guidelines relating to the establishment and management of day hospitals for older people with mental illness. A list of general statements, usually based on consensus or the views of expert panels, referring to good practice, guidelines and standards was generated from the source documents. The master list was reviewed with view to identifying standards relating to the day hospital functions and excluding standards that were considered to be primarily covered by Health and Safety regulations and other generic NHS policy documents referring to mental health and other services. This process informed the development of a list of 12 possible standards relating to the functional domains already identified and an additional standards relating to physical amenities and environment (Appendix 3).

2. Consensus review of standards

1. The putative list of standards was circulated to an expert committee consisting of Psychiatrists, Psychologists, Mental Health Nurses, Occupational Therapists, Physiotherapists, Social Workers and representatives from Age Concern and the Alzheimer's Society. Further modifications were made.

2. Development of rating instruments: An adapted version of the Delphi technique was employed, working with eight day hospitals, each with a review group consisting of a patient/carer, doctor, nurse, manager and one other professional. An instrument was developed to enable the rating of the standards. The instrument was designed thematically so as to rate issues with regard to content and relevance/applicability of each standard. The content domains were generated from National Standards; Standards for Better Health (2005) and included rating each of the day hospital standards in terms of safety, cost and clinical effectiveness, governance, patient focus, accessible and responsive care and public health. As the standards were applicable to predefined operational functions of the day hospital the Standards for Better Health domain of 'Care and environmental amenities, was excluded from the ratings. The relevance/applicability of each standard was rated by items drawn from a list of desirable characteristics of standards and review criteria (Hearnshaw, Harker et al 2001). These included the following domains: Clarity, measurability, ambiguity, practicality, acceptability and minimization of demands incurred upon staff and patients (appendix 5). Each domain consisted of a number of items against which each standard was rated.
3. Each standard was rated against each item using a semantic scale:
 - Very strongly, Strongly, Moderately, Poorly, Very poorly

Data Synthesis

The semantic scale was subsequently translated into a score of 1-5 in order to enable numerical comparison and ranking. Scores were derived for each rating and the sum of scores was generated for each domain. These scores were then reconverted into a semantic scale by dividing the highest possible score achievable in each domain by five.

Findings

Standards for Better Health Domains

Rating of each standard against each domain generated from 'Standards for Better Health' (2005)

Standard	Safety	Governance	Patient Focus	Accessible And Responsive Care	Clinical And Cost Effectiveness	Public Health
1	moderately	Very strongly	Very strongly	moderately	Very strongly	strongly
2	moderately	Very strongly	strongly	Very strongly	Very strongly	strongly
3	strongly	strongly	moderately	poorly	Very strongly	moderately
4	strongly	strongly	strongly	strongly	Very strongly	strongly
5	moderately	Very strongly	strongly	strongly	Very strongly	strongly
6	moderately	strongly	strongly	strongly	Very strongly	strongly
7	moderately	strongly	strongly	strongly	Very strongly	strongly
8	moderately	strongly	Very strongly	strongly	Very strongly	strongly
9	moderately	Very strongly	strongly	Very strongly	Very strongly	strongly
10	moderately	Very strongly	Very strongly	Very strongly	Very strongly	moderately
11	moderately	Very strongly	strongly	strongly	Very strongly	strongly
12	moderately	strongly	Very strongly	strongly	Very strongly	strongly

Hearnshaw et al (2001) domains

Rating of each standard against domains generated from Hearnshaw et al (2001)

standard	Clarity of instructions	Clarity of definitions	Unambiguous	practical	Audit acceptable to staff	Audit acceptable to patients	Audit: low demands on patients	Audit; Low demands on staff
1	moderate	moderate	moderate	strong	very strong	very strong	moderate	poor
2	strong	moderate	strong	strong	very strong	very strong	strong	moderate
3	strong	moderate	very strong	strong	very strong	very strong	strong	strong
4	strong	moderate	strong	strong	very strong	very strong	strong	strong
5	strong	moderate	very strong	strong	very strong	very strong	strong	strong
6	very strong	strong	very strong	strong	very strong	very strong	strong	moderate
7	strong	strong	strong	strong	very strong	very strong	strong	strong
8	very strong	strong	strong	strong	very strong	very strong	strong	moderate
9	strong	strong	very strong	very strong	very strong	very strong	strong	moderate
10	very strong	strong	very strong	very strong	very strong	very strong	strong	moderate
11	very strong	strong	very strong	strong	very strong	very strong	moderate	moderate
12	strong	strong	very strong	strong	very strong	strong	moderate	moderate

Standards relating to Physical environment (appendix 4)

The standards that have been established through the consensus procedure primarily refer to the functional processes undertaken by day hospitals. When rated against the core standards presented in Standards for Better Health (2005) it is evident that they do not address the sixth domain; 'Care environment and amenities'. The domain outcome is defined as;

'Care is provided in environments that promote patient and staff well being and respect for patients needs and preferences in that they are designed for the effective and safe delivery of treatment, care or specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.'

In developing the day hospital standards particular care has been taken in avoiding replication of generic standards that apply across all health care facilities. It was anticipated that there are required standards (relating to health and safety, cleanliness

and access) that encompass many of the issues relating to this particular domain. Hence such standards were not included in the consensus project. A review of the aforementioned literature has identified some of these standards that are of particular relevance to day hospitals for older people with mental illness and a reference list is provided, to be used in conjunction with other relevant, generic standards relating to the physical environment and amenities.

- The day hospital has enough rooms and space to cater for the differing functions

This refers to places reserved for communal activities, recreational activities, dining rooms, waiting rooms, and toilets, administrative and administrative functions.

- The day hospital has enough rooms and space to cater for the number of patients attending at any one time.
- . There are opportunities to separate people with functional and organic disorders.

This refers to types of procedures undertaken by the facility, including medical assessments and treatments, occupational therapy, group work, other activities

- The layout, architectural conception, the décor and the furnishing of the facility have been designed to cater for the needs of older adults with physical handicaps and cognitive deficits.

This standard will be informed by the functions and characteristics of patient groups but should usually include facilities for both functional and dementia disorders. The principal issues include;

- Furniture and decor that promote homely, non institutional perspective
- Appropriate use of colour schemes to facilitate special orientation
- The use of calendars, clocks and signing to promote temporal orientation
- Appropriate auditory aids to help the hard of hearing
- Rooms specially decorated to enable relaxation (e.g. rooms)
- Furniture designed for older people with transfer difficulties
- Flooring is non slip and non shining

Criteria by which Standards are measured (appendix 4)

Having established clinical standards relating to the functions of day hospitals and general areas relating potential criteria relating to each standard, a review of published standards was undertaken with specific purpose of establishing relevant measurable criteria. A scoring system has been developed so as to facilitate:

1. degree to which each standard is met
2. measure of change in meeting standards
3. comparison between day hospitals in terms of meeting standards

For those criteria for which there are no published source references, criteria have been developed from general clinical standards and literature.

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Appendix 1

Functional Consensus

Participants

33 focus groups
224 participants

35 day hospital managers,
34 Occupational therapists of which three were day hospital managers.
16 social workers (2 manager and 1 commissioner of services, including those working with CMHTs))
22 doctors (staff grades, SHOs, SpRs and Consultants)
40 day hospital RMN
15 Health care support workers from day hospitals
1 dietician
5 nurses from in-patient units
26 nurses and health care assistants from community mental health care teams
7 psychologists and 1 CMHT councilor
5 patients/carers
12 day centre reps (social service/voluntary and other voluntary organizations)
2 medical reps
1 admiral nurse
1 Early onset dementia nurse
1 driver
1 secretary

Appendix 2

Summary returns of focus groups relating to question 1, categorised by theme

Function 1. Intensive multidisciplinary management (broken up into general, assessment and therapeutic)

General

Person-centered

Safer working support of other team members

Access to more clients

Inter-agency communication

Multi-disciplinary system

Multi-disciplinary

Day Hospital more flexible than CMHT and IP – i.e. greater range of responses (could be a weakness!)

More physical/social model than elsewhere in the service

Patient's notes available – psych/medical

Central point control – Multidisciplinary team (MDT) function – Resource centre

Day Hospital better at team working than CMHT (CMHT members tend to carry own caseload in isolation)

Unique knowledge of mental health team to monitor and identify risks

Good skills mix in teams

Shared experience. Seeing people who are more unwell as well as those who are getting better

Multi-disciplinary

Access to multidisciplinary team

Staff support. Having others available to balance ideas off. Skills and experience sharing

Holistic approach to care

Peer group support

Easier to provide 'holistic' care, identify needs. Get a truer picture of someone's difficulties

Increased communication

Main issues a re multidisciplinary work, based on one site, enabling the patient to be seen by all appropriate people at one session and enabling MDT conferencing.

More responsive and flexible than ward or community due to resources, time available, i.e. transport

Intensity

High quality (multidisciplinary and intensive)

Multidisciplinary teamwork Multi-professional, multidisciplinary (rapid response)

More immediate access to the MDT

Access to a skilled MDT

Multi faceted service on one site MDT

Longer period for assessment – over full day

Longer assessment/intervention

More intense monitoring

Unique opportunity to observe behavior at dinner table and appetite etc

Day Hospital setting is less “acute” than the wards – leads to better relationship with patients and carers over time

Assessment – time to assess over the day – holistic assessment according to skill mix

Monitoring of mental state over longer period of the day

Assessment over several hours/days at stretch

How do people function day to day

How do people function over a number of hours

Assessment

Assess and manage physical and mental health

Holistic assessment – e.g. physical assessment/screening

Comprehensive holistic assessment

Comprehensive assessment

More opportunity to carry out comprehensive reviews

Day Hospital better for assessment of patients than CMHT or OPD (see more of the patient easier to organize Px)

Assessing how people adapt to new social situations

Multi-professional medical assessment (more intensive)

Multi disciplinary team – very important assessment in an autonomous setting

Reviews are always attended by full MDT as well as family and voluntary services

Comprehensive assessment “under one roof” in relatively short period of time

Comprehensive nature of assessment is far less intrusive and disruptive for client. Not subjected to multiple assessments by many staff over many MDT – Regular reviews – regular contact with each other

Many people can be seen by professionals simultaneously and benefit from social interventions/contact Better at assessment than others i) visiting CPN may not get full picture (social front can be put on) CPN may not be able to get in ii) more time than Dr in outpatients iii) more knowledge in depth across the day available on each client

Access to patient notes

Multi-disciplinary assessment

Assessing carers needs from multi-disciplinary angle

Skill mix available on one site Multi-disciplinary review

Facilitates a multi-disciplinary assessment of mental health in one location

Can do comparative assessment if people have been assessed at home, we can take them out of that environment and may get a different picture

One-stop shop – single point of assessment

Provide full assessment of needs and sign posting to relevant agencies

Assess and manage physical and mental health

Physical examination combined with mental health assessment

Therapeutic

Variety of therapeutic interventions – medical/nursing/psychological behaviour/social

More intensive support from all disciplines involved in DH

Range of therapeutic interventions due to offering service to a large locality

Identifying person centered – care pathway
MDT interventions
Holistic engagement of the individual across time
Multi disciplinary team reviews
More practical for therapeutic groups
Day Hospital much better than DC for CPA (also probably better than CMHT and IP)

Access to medical and specialist services

Intensive medication management
Enhanced medical involvement
Access to physicians and general hospital
Access to other 2nd level care is more easily facilitated
Access to physical health experts
Efficient assessment: physical
Physical examination combined with mental health assessment
Day hospital integrated with wider service
Diagnostics in complex cases
Rapid access to hospital services e.g. X-ray, C.T. scan, physiotherapy, speech therapy, and psychology to aid diagnosis
Closer links with consultants
Concentrated professional expertise
Access to dedicated health personnel
Can offer a comprehensive range of specialist interventions not available elsewhere
Access to other resources/links/joint interventions
Access to all disciplines/skills
Specialist intensive interventions
Specialist medical management of behavioral disorders
Specifically highly trained staff
Provides hospital treatment
Part of a wider health network, links to in patient units, CMHT (access to information)
Knowledge skills experience of the staff (specialist)
Knowledge skills experience of the staff (specialist)
Specialist skills in assessing and managing functional illness
A more professionalized service
Easy and quick access to diagnostic assessment procedures – particular of physical health but also mental health
Liaison and collaboration of professionals
Joint working with variety of organizations

Function 2. Acute care

Relapse prevention

Relapse management – flexible attendance – when relapse apparent triggers short/sharp assessment and boost to skills to keep people out of hospital
Can prevent relapse better than others i) more mental health expertise than Day Centre
ii) get full knowledge across a day compared with CPN or Dr popping in to assess
iii) can see how responding to every day challenges

Stabilization of treatment

Crisis management

The service provides intensive support through an acute phase of their illness while allowing them to stay at home

Prevents crises through early interventions

Behavioral/management crises intervention

Crisis intervention/outreach

Flexibility of response – rapid

Crisis management

Fast tracking, responding to acute situations

“Crisis resolution” function

Able to provide support immediately in times of crisis – able to provide more time – take people out of home situation

Crisis intervention relieving carer distress

Crisis respite. Continuing to assess, monitor and treat whilst taking pressure of carers in order to avoid admission

Reduces admission

Stops inappropriate admissions

Avoids or reduces need for inpatient treatment

Admission prevention

Preventing admission

Avoidance of inpatient admission

Delaying admission (decreasing bed occupancy)

Prevents admission

Avoidance of I.P. admission

Preventing and reducing length of admission/re-admission through more intensive interventions than CMHTs

Better at support to prevent admission because i) more time available than CPNs and more flexibility ii) does not interrupt everyday life like admission would iii) less stigma than old iv) more mental health experience than Day Centre v) people feel “normal” and get peer support

Can help to prevent in patient admissions

Management of risk to prevent hospital admission

Day Hospital offers a more acceptable, less threatening place for treatment than in-patient

Preventing admission to hospital and facilitating earlier discharge

Alternative to admission – prevention of relapse

May prevent hospital admission

Function 3. Reduction of inpatient occupancy

Early discharge

Early discharges patients from wards to continue recovery

Early discharge facilitation

Care planning and discharge co-ordination (from inpatient services)

Support provided to inpatient services

Close links with inpatient team

Pre/early discharge from in-patient – psych, medical geriatric
Can provide a “stepping stone” between in-patient and CMHT (in either direction) / link between other parts of the service
Links with inpatients transition from ward to home
Facilitating early discharge
Expedite discharge by offering intensive support pre discharge to both patient and ward staff
Aids discharge process
Outreach/in-reach
Rehabilitation (half way house in discharge)
Integration of people from ward to facilitate discharge and continuity of care
Day Hospital better at rehab than IP (i.e. offer a transitional role from IP to home)
Post discharge support
Learn networking skills can transfer to use after discharge – social inclusion
Stepping stone from inpatient to home (rehab)

Promoting rehabilitation and recovery

Rehabilitation

Rehabilitation

Supportive re-introduction to social activities

Able to work with people around recovery model – closer to home/discharge/real life

Rehabilitation and recovery

Enabling integration into the community

Activity planning

Function 4. Longer term management

Day Hospitals better at maintaining people with complex needs over the long term

Monitoring medication

Management of difficult behavior

Monitoring behavior in difficult or unstable patients)

People requiring continuity of environment

On-going period of assessment

On-going outcome monitoring by the team (process of rehabilitation)

Deliver ongoing care

Function 5. Psychotherapeutic interventions

Psychotherapeutic group work

Social skills

Confidence building

Group therapy

Group therapy for functional mentally ill

Group treatment

Assess and develop social skills

Therapeutic groups e.g. CBT, memory group, language group/word confidence “anxiety management” (sorry!)

Day Hospitals are best at socializing people to therapy; there are strengths in the group work that is done especially clients helping each other within the group, also identifying clients who need one to one work
Better placed for group work
The opportunity to help others
Sessional groups for people with functional mental health needs
Ability to offer broad range of groups due to broad range of staff skills and dedicated time for groups
Choice in therapeutic group activity
Day Hospital better than CMHT at group work (skill mix and facilities)
Day Hospital better at psychological therapy than in-patient service
Day Hospital better than Day Centre for therapy (psychological, medical, OT, etc)
Appropriate group work – therapeutic – education – individual work
Gain greater insight (daily)
Access to therapy services
Offers group treatment options
Assessment in groups gives client experience of being with others
Day hospitals are able to prevent cliques happening in order to enable therapy process to happen
Day hospital enable to skill people to return groups (outreach)
A better environment in which to work psychotherapeutically
Being able to run therapeutic program intensity of input
Memory support groups for people with dementia
Deliver evidence based short-term group therapies – brief therapy, anxiety management, goal setting
Provision of a socially supportive environment
More variety of groups available with specific aims, evidence base and evaluation.
Regularly reviewed
Well placed to do group work
Better environment to run groups/more resources to access
Therapeutic milieu (good environment) positive and therapeutic

Function 6. Carer, patient and family involvement,

Educational role
Carer support and education
Peer support and education
Mental health promotion for older adults
Carer support groups information centre
Empower, educate – find new ways to deal with illness – create ‘expert patient’
Education of carers in recognition of relapse
Training and education
Education and health promotion advice centre
Education
Education
Outside specialists: training/education
Sharing skills: best practice and avoid duplication for patients

Appendix 3

Question 2

Considering these strengths, which user groups should be targeted by day hospitals compared to other services?

Demographic and Diagnostic descriptors

Organic mental illness

Dementia - patients who need day care but won't accept it – ideally treatment resource for patients with dementia

Functional and organic mental health needs

Organic illness with challenging behavior (sessional)

Individuals who suffer from organic/functional illness

Early stage dementia into middle stage

Potential for link with memory clinic if in Day Hospital

Patients with diagnosis of dementia (memory clinic)

Organic mental illness

Over age 65 with mental health needs or early onset dementia who need MD specialist assessment, treatment and care planning

Predominately 65 yrs and over

Early onset dementia

Early onset dementia (including younger onset)

Specific service (day hospital) for pre-senile dementias

Contribute to identification of early onset memory patients

Benefits of being able to provide something other than drugs for early memory problems/early onset dementia

Early onset dementia sufferers and under 65's dementia sufferers (diagnostic phase)

Early onset dementia

Over age 65 with mental health needs or early onset dementia who need MD specialist assessment, treatment and care planning

Functional

Depression and anxiety disorders

Dementia – patients with depression or dementia

Functional and organic mental health needs

Individuals who suffer from organic/functional illness

Functional

Functionally ill patients

Functional disorders

Patients with functional illness

Functional illnesses

Functional mental health illness

Functional

:patients with functional disorders

Younger patients with dementia

Early onset dementia
patients with onset of dementia under the age of 65

Ethnicity

Trans-cultural mental health issues awareness
Ethnic minority flagging up

1. Patients with severe mental illness

Patients with unpredictable and severe mental health problems needing access to specialist mental health team.

Patients with limited insight into their mental illness

High scorers GDS – no suicidal ideation

Patients with suicidal ideas (mild-moderate)

Patients with morbid ideation

Severe and enduring mental health

Severe end of spectrum

Severely depressed and suicidal

Patients with unpredictable and severe mental health problems needing access to specialist mental health team.

Clients would mainly be depressed and/or complex and/or severe and/or high risk and/or difficult family dynamics and/or poor social skills and/or relationship problems and/or resistant to first line treatments (sometimes second line treatments)

To deal with more severe service mental health problems but do not require admission

Can target chronically ill and more severely ill but whose risks are less acute than those on wards

Severe enduring mental illness that may be stigmatized

Those most in need

Patients with unstable mental illness

Patients with severe mental illness

Patients that are described as suffering from severe levels of mental illness. They include patients who have suicidal ideation, unstable and lacking insight, tending to require more intense services than can be provided by CMHTs.

2. Challenging/disinhibited behavior

Unexplained/un-modifiable behavior change in previously assessed patients

Day centre needed for patients with dementia and challenging behavior

Assessing and planning treatment of a person with challenging behaviors

Challenging behavior

Behavioral assessment away from home environment (“the funny do’s”)

Behaviorally disturbed patients with functional or early organic problems because i) can keep in own environment while giving carer a break ii) can work on assessing the behavioral problem in naturalistic setting as have mental health expertise

Functional illness with increased elements of risk/challenging behavior

Organic illness with challenging behavior (sessional)

Patients with disturbed, complex and recurrent behaviors that may cause exclusion from other services

Management of behavioral/psychological syndromes

Functional illness with increased elements of risk/challenging behavior
Behaviorally disturbed patients with functional or early organic problems because i) can keep in own environment while giving carer a break ii) can work on assessing the behavioral problem in naturalistic setting as have mental health expertise
Challenging/disinhibited behavior
Community patients with challenging, disinhibitive, high risk or antisocial behaviors that cannot be tolerated in local authority of voluntary day care centers. Those that require assessment and management of such behaviors.

3. High risk

Patients likely to relapse

Patients who are vulnerable to relapse
Frequent relapse of functional illness
Early monitoring and those requiring frequent adjustment of medication
High-risk relapse patients
Frequent relapse of functional illness

Patients that are of risk of neglect, harm to self or others

Patients who are at risk to themselves or others
Organic – S.U. who in risky situations where attendance can negate risk
High risk
Most at risk (functional or organic)
Patients who are considered to be at high risk and community team were not sufficient
Can target chronically ill and more severely ill but whose risks are less acute than those on wards
Dementia (risks at home) assessments
Organic – S.U. who in risky situations where attendance can negate risk
Most at risk (functional or organic)

4. Complex needs

Patients presenting with complex and difficult diagnostic problems
Atypical presentations
Patients whose diagnosis is unclear
Where unclear diagnosis exists we can provide more in-depth assessment
New diagnosis of mental health problem
Individuals in need of assessment and treatment
New assessments with probable/possible complex need
Complexity
Patients newly diagnosed with illness and commencing on medication/other treatment
The “uncertains” – those who nobody knows quite what’s wrong
Complex needs
Patients in which there are diagnostic/assessment difficulties that may require more intensive investigations and access to the MDT.
Patients with complex psycho-social and physical management problems
Functional illness – older patients with depression – treatment resistant – associate high risk – complex needs

Acute complex/enduring needs (enhanced CPA?)
Acute complex/enduring needs (enhanced CPA?)
Patients with complex needs e.g. social, mental, medical, psychological etc – increased risk factors
Complex range of needs
Long-term management of patients with complex problems
Patients with disturbed, complex and recurrent behaviors that may cause exclusion from other services
Those with complex needs
We manage complex co-morbid and social conditions
Clients would mainly be depressed and/or complex and/or severe and/or high risk and/or difficult family dynamics and/or poor social skills and/or relationship problems and/or resistant to first line treatments (sometimes second line treatments)
Functional illness – older patients with depression – treatment resistant – associate high risk – complex needs
Over age 65 with mental health needs or early onset dementia who need MD specialist assessment, treatment and care planning
Functional illness – older patients with depression – treatment resistant – associate high risk – complex needs
Patients with high levels of co-morbidity
Patients with dementia may be better supported in Multi-disciplinary diagnosis clinic and outreach compared to day centres and day hospitals
Patients with complex needs e.g. social, mental, medical, psychological etc – increased risk factors
Complex needs
Patients in which there are diagnostic/assessment difficulties that may require more intensive investigations and access to the MDT.
Patients with complicated psycho-social and physical needs that require intensive or long terms multidisciplinary engagement. These include patients with treatment resistant conditions, co morbidity, psycho-social complications and adversity that require on-going intensive community management.
Patients requiring specialist services
Deliver specialist support to resource centre
Specialist mental health needs
Enduring mental health needs that need specialist support
Those needing medical supervision
Specialist
Patients requiring access to other specialists (hospital or community based) or regular medical (psychiatric) monitoring

5. Patients with mental illness in crisis or at risk of admission

Patients in crisis

Psychosis – as for depression – acute
Those who may only need 'short sharp' treatment
Patients acutely distressed needing daily medication treatment from medical staff/registered nurse

Individuals in crisis

Patients in crisis

Those in need of assessment in crisis situation

Crisis intervention to prevent hospitalization to a person with a functional illness

S.U. who would benefit from crisis intervention and prevent admission or readmission to hospital

Those in crisis

Patients starting to experience onset of acute symptoms which impact on daily life – and hence avoid/delay/prevent hospital admission

Acute episode of enduring mental illness

Patients with mental illness in crisis

Patients that are defined as in crisis, requiring assessment, suffering from acute symptoms, distressed and requiring immediate assessment/intervention.

Patients at risk of admission

Functionally mentally ill in the acute stage if possible because avoiding institutionalization will prevent additional problems accumulating but has mental health expertise to look at proper mental health needs

Patients at risk of admission to psychiatric wards

Crisis intervention to prevent hospitalization to a person with a functional illness

Those needing treatment (to prevent re-admission and early discharge)

Those needing on going monitoring (to prevent re-admission and early discharge)

Those needing assessment (regular) (to prevent re-admission and early discharge)

Patients who require intensive care and support and treatment from MDT to avoid admission

Patients starting to experience onset of acute symptoms which impact on daily life – and hence avoid/delay/prevent hospital admission

Those in need of urgent assessment to prevent hospital admission

Patients who have refused admission to hospital but are considered to require intense intervention

Patients who refuse admission but agree help

Alternative to admission

S.U. who would benefit from crisis intervention and prevent admission or readmission to hospital

Patients at risk of admission to psychiatric wards

The ones we need to keep out (of in patient care)

Those that would otherwise been admitted

Working with patients that are of a high risk of admission

6. In patients

Early/staged discharge from I.P. care

Patients who find it more difficult to access community services unless they have support and transitional period Patients who had just been discharged from hospital would benefit from Day Hospital

Can manage transition from ward to community

Progressive discharge

In-reach

Intensive 'step down' follow-up of inpatients

Group requiring rehabilitation after hospital admission

Patients recovering from acute episode of mental health problem severe enough to have been hospitalized

In patients

7. Patients requiring psychological therapies

Patients requiring long term supportive role

Patients with mental illness living alone

isolated

Vulnerable

Can offer long-term support to those with long-term/chronic conditions – meet a wider audience than CMHT

Those who experience difficulties in social interaction

Isolated users without any other support/live alone

Long term really old patients – i) Day Hospitals have the understanding and mental health expertise to maintain them to keep as well as possible ii) + the regular contact

Patients with mental illness living alone

The isolated

Those with no outside support

Offer individual time with patients that would be difficult in a ward setting

Those with no outside support

Longer term – (in the absence of specialist day centre) if AMH have no resource

Patients requiring psychological therapies

Patients who benefit from social/non specific supportive aspects of the day hospital, including patients with difficulty socializing the lonely, the vulnerable and those with little support.

Patients requiring specific interventions

Patients with personality disorders

Patients with neuroses

Patients who could benefit from several time limited interviews carried out by MDT for specialist needs, i.e. anxiety management, goal setting

Persons requiring sessional treatments

Patients require health promotion

Need/ability to enable patients to be able to make use of therapies available

Patients with identified psychotherapeutic needs

Patients with specific therapeutic objectives

Patients that would benefit from an intensive therapeutic environment

Needing: psychological assessment

Management of behavioral/psychological syndromes

Patients with relationship problems where group therapy can be most useful

Patients needing specific therapies

Functional illness – for patients who can benefit/learn/improve

Patients requiring psychological therapies

Patients who benefit from social/non specific supportive aspects of the day hospital, including patients with difficulty socializing the lonely, the vulnerable and those with little support.

Patients that have been identified as warranting formal psychotherapeutic interventions, including CBT, anxiety management, behavioral therapies, psychological assessment, psychoeducation etc.

Patients benefiting from group work

Patients for group therapy

Patients who want to come for groups/sessions can do so

In the treatment of functionally ill- i) patients can be grouped together so more efficient

ii) group work can be very effective iii) in the course of a day individual and group work

iv) multi-disciplinary setting allows for reflective views

Those needing specific groups e.g. CBT, memory group

Patients who will benefit from group interventions

Patients requiring psychological therapies

Patients who benefit from social/non specific supportive aspects of the day hospital, including patients with difficulty socializing the lonely, the vulnerable and those with little support.

Patients that have been identified as warranting formal psychotherapeutic interventions, including CBT, anxiety management, behavioral therapies, psychological assessment, psycho education etc Patients that may benefit from group therapies, family therapies etc.

8. Patients with long standing mental health problems

Those that need intensive drug monitoring;

Prescription of and assessment of response to medication over longer period of time (than allowed by community setting)

Enduring mental health – monitoring – motivation

Patients that need frequent treatment monitoring/adjustment

Non-compliant with medication

Persons needing: medication (polypharmacology), prescription of new medication, titration, specialized monitoring

Early monitoring and those requiring frequent adjustment of medication

Patients with unstable mental illness

Patients that need frequent treatment monitoring/adjustment

Persons needing: medication (polypharmacology), prescription of new medication, titration, specialized monitoring

Those with only partially – responsive functional illness (not tolerated in “ordinary” day care)

Patients with enduring mental health problems

Enduring functionally ill patients

Severe and enduring Schizophrenia and Bipolar

Enduring mental illness

Severe enduring mental illness that may be stigmatized

Enduring mental illness

Patients with enduring mental illness based in the community
Enduring mental health
Severe and enduring mental health
Patients with long standing mental health problems

9. Carer support/respice

Patients who have need of 'health respice'
Those resistant to day care who are likely to benefit from it (short term only)
Ability to offer education and support to carers
Support home situation
Social, Voluntary, Residential, General for education
Require social and health
Every need that can't be met in the community
Based in community not 24 hour care
Families of patients with functional illness and enduring mental health
Carers who require support and education re: group work, one to one discussion
Patients with stressing carers
Carer support/respice
Summary: Provision of respice and peer support for carers in patients for whom day services are inappropriate, providing carers with education, support.
Carers
Needs led users

Standards and Criteria (referenced)

Appendix 4

Source references for standards and related criteria

- a. National Standards, Local Action. Health and Social Care Standards and Planning Framework 2005/06-2007/08, Standards for Better Health . Department of Health 2005.
- b. Everybody's Business. Integrated mental health services for older adults: a service development guide
DH November 2005 (www.everybodiesbusiness.org.uk)
- c. National Service Framework for Older People Department of Health
March 2001
- d. Finch J, Orrell M. Health Advisory Service Standards for Mental health Services for Older people ISBN 1 900600 110 Pavilion Publishing (Brighton) Ltd 2000
- e. Audit Commission Forget-me-not; Mental Health services for older people.
2000 ISBN 1 86240 203 5 printed by Holbrooks Printers Ltd, Portsmouth
- f. Quality Assurance in Mental health Care: Check lists and Glossaries volume 2
Division of Mental health and prevention of substance abuse (1997) World Health organisation (WHO/MSA/MNH/97.2)
- g. Wimo A, Ineichen B, Mattson B et al (1993) Assessments of productivity of psychogeriatric day care. Int Journal of Geriatric Psychiatry 8, 675-679

Standard A

Each day hospital unit should have an agreed, written philosophy/mission statement and demonstrate the role of users and carers in planning and designing service delivery^{f,d}.

Criteria

The philosophy mission statement should include the following^f

1. Two mandatory functions:

- i. Multidisciplinary assessment
- ii. Provision of education/support for carers and families

The inclusion of other functions will be determined by consultation and planning processes.

2. A description of the patient groups targeted by the day hospital, including an agreement concerning the percentage of patients in attendance for greater than a year.

3. An agreed percentage of patients attending for more than one year

4. Information on the degree of expected patient, family and carer involvement. This includes evidence of pre-planned regular meetings with user groups in reviewing service delivery and process, patient involvement in planning and development of services^f.

5. There is an established on-going audit programme relating to the functions and associated standards of the unit.

Standard B.

There should be evidence of collaborative planning and working between day care services provided by the Local Authority or Voluntary Agencies and the day hospital provided by the NHS^{b,d,e,f}

Criteria

1. The Philosophy/mission statement and functioning of the unit has been agreed and planned with other stake holders. Stake holders may include; inpatient units, community mental health teams, day care units, patient groups^e

2. Evidence is required that specified and agreed (with referring and accepting agencies) referral and access procedures are in place^d

An agreed procedure by which patients are referred including agencies that can refer them.

An agreed time-frame by which patients will undergo preliminary assessment and acceptance.

Agreed procedures (with stake holders) for refusal of referred patients.

3. Evidence that there is agreement with agencies (primary care, day care, community mental health teams, etc. regarding discharge protocols.^d

4. There should be written agreements with day care services, enabling a seamless delivery of services^b.

5. Regular, documented contact is maintained with other community services and inpatient facilities^f.

6. Individual and groups are seen in other venues including outpatients services, GP clinics, social care facilities etc. ^d

Standard C

The day hospital should provide separate services for functional and/or organic patients. ^{c,d,e}

Criteria

1. Patients with established functional or organic syndromes are not routinely expected to mix in terms of assessment and management.
2. Transport provision is separate for patients with functional and organic syndromes.
3. Day hospital assessment and management reflect the specific needs individuals and groups attending at any specific time. Examples of this include memory clinics, orientation groups, depression education and psychotherapy groups, bereavement management.
4. Services should be flexible, enabling infrequent or sessional attendance ^d

Standard D

The day hospital should be readily accessible to the population that it serves ^{d,e,f}
(transport and geographical location)

Criteria: transport

1. Transport arrangements should be flexible, utilising ambulances, NHS minibuses, taxis, private vehicles, public transport, enabling individualised transport arrangements ^{d,e}.
2. Cost of transport should not be a disincentive for patients to attend the facility ^d.
3. Each patient is not expected to travel for more than an hour between home and the day hospital.
4. There is flexibility in pick up and drop off times of patients.

Criteria: Geographic location

5. Facilities are available during the evening, night and weekends ^d.
6. The location of the facility is planned (relating to access and access to other services) in relationship to the rest of the services and target population ^d.
 - a. Is the facility easily accessible (public transport, well signposted, easy for physical disabilities or dependent patients) (one point score)
 - b. Is the facility co-located with or readily accessible by other health service providers? E.g., can other specialists readily access the facility (e.g. Geriatric medicine)

Standard E.

Day hospitals should provide intensive multi-disciplinary assessment and intervention. A multidisciplinary team should include medical staff, nursing staff, physiotherapists, occupational therapists social workers and psychologists. Additional staff may include speech therapists, art and music therapists and other practicing therapists^{b,c,d,f}.

Criteria

1. Documented evidence of multiprofessional staff working at or with specific responsibility for the day hospital

This should include a minimum of

- Qualified mental health nursing staff
- Qualified psychiatric medical staff
- Occupational Therapist
- Psychologist
- Other(s)

2. There is evidence of multidisciplinary health care assessment (including risk assessment) and management recorded in documentation and care plans^d
3. There is access to specialist input^d.

Specialist input is defined as

Specialists other than mental health specialists at the day hospital (e.g geriatric medicine, physical health assessment and treatment, other acute hospital specialists)

Access is defined as

Speed of access that would not be available to the patient if they were not attending the day hospital.

Standard F

Admission procedures should be expeditious, patient and carer friendly and consist of full psycho-social and physical assessment identifying patient and carer specific needs that inform a care plan^{b,c,d,f}.

Criteria

1. Recorded evidence that patients are introduced^f. This includes
 - f. Orientation around the unit
 - g. Introduction to key staff
 - h. Introduction to other patients
 - i. Explanation regarding process and procedures
 - j. Provision of written material supporting the induction process.
2. Recorded evidence that assessments are multidisciplinary^d (more than one profession), including psychiatric, social and physical
3. Assessments are initiated within 24 hours of attendance^f
4. Assessment process involved a needs and risk assessment which inform care planning (documented evidence)

Standard G

Discharge procedures should be formalised early in the patient's care. They should be planned, include elements of education concerning relapse, recurrence and subsequent management of the condition, orientation, building independence, appropriate referral and working with carers and families^{d,f}.

Criteria

1. Discharge plans are discussed by all staff, patient and carers^f
2. Documented evidence that patients and carers are provided with literature and appropriate advice regarding^f
 - i. The nature of the experienced problems
 - ii. The possibility of relapse
 - iii. Drug management
 - iii. Arrangements for transfer, follow-up or discharge from service
 - iv. Offer of copies of discharge correspondence given to the patient^f
3. Evidence that correspondence relating to transfer to other services^f (including discharge letters to primary care) are delivered within 5 working days.

Standard H

The majority of day hospital assessments and treatments should be time-limited, goal, orientated and focused^{b,e}.

Criteria:

Maintaining throughput, turnover and avoiding institutionalisation.

1. The turn-over index^g is less or the same as that agreed in the philosophy/mission statement

The turn-over index is calculated by:

Number of patients discharged at end of audit period (1 year) X 100%

Number of patients at beginning of audit period

2. There is recorded evidence of pre-planned review dates relating to finished periods of assessment or intervention^d.
3. There is recorded evidence that an explanation regarding purpose and proposed length of stay at the day hospital is given to patients and carers within or at the end of the initial assessment period.
4. There are contingency plans in place to facilitate the discharge of institutionalised or reluctant patients/patients from the day hospital. (e.g. leavers groups, graded discharge procedures, introduction to alternative community resources)

Managing crisis

5. There is evidence that the day hospital has crisis intervention and management as a defined function within the philosophy/mission statement.
6. If the day hospital is prioritizing this role then appropriate staffing levels and grades have been provided and funded.

7. If the day hospital is prioritizing this role then flexible out-reach arrangements have been made so that staff can support patients in community settings if required.
8. If the day hospital is prioritizing this role then there are recorded operating procedures including documented arrangements of referral, case management and support of community mental health teams
9. If the day hospital is prioritizing this role then there are and appropriate recorded and auditable supervision of staff working in community settings
10. In some situations the day hospital may have control over access to inpatient beds. If this is the case then there needs to be agreed written operational policies relating to this.

Standard I

The day hospital should undertake rehabilitation of inpatients^{b,c,d,,f}.

Rehabilitation is based on the following principles (Royal College of Psychiatrists)

- Enhancing the strengths and resilience of patients and their families.
- Maintaining optimism for individual growth and recovery.
- Treating disability with respect and acceptance.
- Improving the holistic quality of life for those with the most severe disabilities.
- Reducing stigma and promoting social inclusion.
- Therapeutic risk-taking to promote personal responsibility.

Criteria

Inpatient liaison

1. There is an agreed (inpatient and day hospital) policy relating to the joint management of inpatients attending the day hospital.
2. Inpatient and day hospital staff attend joint case reviews of inpatients using day hospital facilities.
3. specific sessions/interventions are in place for patients who are either at risk of institutionalisation or are institutionalised.

Outreach services

1. There are agreed, documented protocols relating to duration of engagement, purpose and review of interventions undertaken by the outreach team.
2. Care plans clearly specify care co-ordinator and supervision responsibilities particularly in relationship to interfaces with CMHTs

Standard J

Long term care (greater than one year) should be provided to patients that would otherwise require admission into institutions and for which other community based facilities are either inappropriate or not provided^{c,e}.

Criteria

1. There is specific identification and active management of long term patients (LTSU).

2. Each LTSU should have an individual needs assessment and regular 3 monthly (at least) reviews ^d with view to exploring potential for developing independence and recovery and promoting discharge to alternative community facilities ^b.
3. Each LTSU should have a care plan ^d which specifies the therapeutic need to attend for greater than one year. This includes:
 - i. Evidence of lack of alternative services/facilities
 - ii. Social dysfunction/isolation, lack of support, preventing the patient from being rehabilitated
 - iii. Medical or psychiatric instability and unacceptable risk if discharged
4. Each LTSU should have an individualised care plan that identifies therapeutic and goal orientated treatment, activities and management, driven by needs assessment^d.

Additional quantitative evidence supporting rehabilitative process ^g of LTSU patients can be developed:

Across an audit period (usually of one year):

Proportions of LTSU patients:

Discharged from the day hospital back into main stream mental health services

Discharged into day care or voluntary/ social services organisations

Discharged from mental health services.

Re-admissions to the day hospital

Standard K

Day hospitals enable patients to benefit from group and individual psychotherapy^{b,d}.

Criteria;

1. Staff have demonstrable skills/experience in undertaking the relevant psychotherapeutic intervention (formal training for formal psychotherapy and informal training for informal psychotherapy)
2. Documented evidence demonstrating that both formal and informal psychotherapeutic work is pre-planned and reviewed through supervision.
3. Formal and informal psychotherapeutic involvement of individual patients is needs driven and included within care plans.
4. Evidence that there is feedback from patients and staff recorded on a regular basis in care notes

Standard L

The day hospital should promote close working relationships with families and carers of attendees through support and education ^{b,f}.

Criteria

1. Evidence of patients, family members and carers having access to staff for discussion regarding the patient's care (where appropriate) ^f
2. Documented evidence that family and carers are encouraged to participate in the patients' management (where appropriate) ^f
3. Each carer has a carer assessment and appropriate support ^f

4. The day hospital carries out home visits so as to improve care and coping skills of families and carers^f
5. Evidence that patients, carers and families are included in developing improving the day hospital services^f.

Appendix 5

Standards rating instrument

Name of day hospital

Name of contact person

Good Practice Point number

**Questions relating to Standards for Better Health
Safety**

1. Does this good practice point promote a day hospital building and transport service that encourages safety

Very strongly strongly moderately poorly very poorly

2. Does this good practice point: enhance patient safety, preventing or reducing the risk of harm to patients.

Very strongly strongly moderately poorly very poorly

Clinical and cost effectiveness

3. Do you think that this good practice point is likely to effect the direct or indirect care of patients attending the day hospital?

Very strongly strongly moderately poorly very poorly

4. Is the good practice point likely to promote effective clinical outcomes?

Very strongly strongly moderately poorly very poorly

5. Will the good practice point help promote appropriate (as opposed to inappropriate) care

Very strongly strongly moderately poorly very poorly

6. Does this good practice point have strong support in terms of clinical judgement or research evidence with which you are familiar?

Very strongly strongly moderately poorly very poorly

7. Can you identify improvements in health outcomes that might be linked to the good practice point?

Very strongly strongly moderately poorly very poorly

Governance

8. Does this good practice point promote probity (openness and clarity?)

Very strongly strongly moderately poorly very poorly

9. Does this good practice point promote quality assurance?

Very strongly strongly moderately poorly very poorly

10. Does this good practice point promote quality improvement?

Very strongly strongly moderately poorly very poorly

Patient focus

11. Does this good practice point promote partnerships with patients, their carers and relatives?

Very strongly strongly moderately poorly very poorly

12. Does this good practice point promote respect for the needs, preferences and choices of patients, carers and relatives?

Very strongly strongly moderately poorly very poorly

13. Does this good practice point promote working with other organisations (especially social care organisations) likely to impact on patient care well being

Very strongly strongly moderately poorly very poorly

Accessible and responsive care

14. Does this good practice point encourage patients to receive services as promptly as possible, and not experience unnecessary delay at any stage of service delivery or of the care pathway?

Very strongly strongly moderately poorly very poorly

Care environment and amenities

15. Does this good practice point promote a day hospital building and transport services that enhance effective delivery of care

Very strongly strongly moderately poorly very poorly

16. Does this good practice point promote a day hospital building and transport services that enhance privacy and respect

Very strongly strongly moderately poorly very poorly

17. Does this good practice point promote a day hospital building and transport services that enhance cleanliness and an appropriate environment.

Very strongly strongly moderately poorly very poorly

Public Health

18. This good practice point will contribute to enhancing the health of the community.

Very strongly strongly moderately poorly very poorly

19. This good practice point will help prevent further illness in the community

Very strongly strongly moderately poorly very poorly

Questions relating to the Implementation of the Good Practice point

20. The good practice point is accompanied by clear instructions for its use in reviewing care

Very strongly strongly moderately poorly very poorly

21. Does the good practice point include clear definitions of variables to be measured?

Very strongly strongly moderately poorly very poorly

22. Is the Good Practice point unambiguous?

Very strongly strongly moderately poorly very poorly

23. Is the implementation of this good practice point practical?

Very strongly strongly moderately poorly very poorly

24. Do you think that the collection of information for a review/audit of this good practice point would be acceptable to the staff whose care is being reviewed?

Very strongly strongly moderately poorly very poorly

25. Do you think that the collection of information for a review/audit of this good practice point would be acceptable to the patient whose care is being reviewed?

Very strongly strongly moderately poorly very poorly

26. Do you think that the collection of information for a review/audit of this good practice point would be minimise demands on the patients

Very strongly strongly moderately poorly very poorly

27. Do you think that the collection of information for a review/audit of this good practice point would minimize demands on the staff

Very strongly strongly moderately poorly very poorly

Overview

28. Taking everything into consideration do you think that this good practice point should be included as a good practice point for day hospitals for older people with mental health problems?

Very strongly agree that it should be

Strongly agree that it should be

Indifferent

Feel strongly that it should not

Feel very strongly that it should not

29. Do you have any comments concerning this good practice point in terms of it being clarified, improved, or changed in any way?

