important aim of management within the NHS is to enable the right sort of care to be given in the most efficient and effective way. If efficiency and effectiveness can be improved by extension of the nurses' role in particular ways and if the necessary provisos can be met the merits of such extension should be seriously considered, so long as the ability of the nurses to continue to meet the full nursing needs of the patient is safeguarded.¹⁰ This, however, raises a problem in relation to attached nurses because the employing authority is given the task of recognising satisfactory training¹¹ and it is difficult if not impossible for an area health authority, working by consensus management through a system of committees, to authorise (or forbid) continually changing sets of procedures in differing general practices to be carried out by a changing population of individual nurses. Not surprisingly therefore a contraction of nursing activities has been reported by Ashworth,¹² who sees a solution in general practitioners employing their own nurses directly. Presumably the employment trend reported by Reedy *et al* and referred to earlier⁸ reflects Ashworth's views nationally, and certainly the study practice developed its pattern of treatment-room work over the years using directly employed staff so that the partners took the responsibility and decisions as the employing authority. Some of the additional advantages of such an arrangement included:

(1) Greater opportunity for finding compatible colleagues because making an appointment is a personal matter between the doctors and the nurses.

(2) More professional independence and therefore job satisfaction for the nurse.

(3) Greater continuity of staff within the team.

(4) Hours of work are a matter for local negotiation and can be flexible part time; thus there is the opportunity to employ experienced nurses who are unavailable to area health authorities owing to family commitments and who would, in other circumstances, be unemployed.

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Hospital Topics

“Asset stripping” the declining mental hospital

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Summary and conclusions

A psychogeriatric day hospital was developed from a long-stay back ward of a large mental hospital whose population of patients had decreased by half. Women in the 70-80 age group with varying degrees of dementia benefited most from such facilities. In view of the current cut-back in Government spending one of the greatest assets in providing a comprehensive service for the elderly mentally infirm may well be found in the declining mental hospital.

Introduction

Psychogeriatric day hospitals are an integral part of a comprehensive service for elderly mentally infirm people maintained

in the community. Such a unit has been developed in a long-stay back ward of a large mental hospital, whose population had decreased by half in 10 years. We discuss the functioning of the unit over two years (1976-8), and the desirability of developing such units in view of the expected increase in the number of elderly mentally infirm patients and the cut-back in Government spending.

Development of the day hospital

The day hospital was developed in a long-stay back ward of Tooting Bec Hospital in south-west London. The ward chosen was on the ground floor, on the edge of the grounds surrounded by a large green area, and easily accessible to ambulances. The architecture of the ward lent itself admirably to adaptation: the dining area continued as such, the dormitory became a large occupational therapy area, and an annexe functioned as an “aids to daily living” assessment area. Offices and small adjoining rooms functioned as offices for medical and para-medical personnel.

The number of patients on this ward was run down, and the ward was closed for upgrading and decorating, which cost only £29 000 as little structural alteration was necessary. There were few revenue implications and staffing was provided from within the hospital pool. Agreement and co-operation between medical and nursing staff was most important and accelerated development. Administration was

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concerned only after this agreement had been achieved, the ward had been selected, and the number of patients had been reduced.

Operational policy

The unit provided a service for the St Thomas's health district and for patients aged 65 and over in the Roehampton district—a total catchment area of about 45 000 aged 65 or older. Requests for admissions were made by medical and paramedical personnel: general practitioners 38 (23%); psychiatrists of parent hospital 112 (69%); geriatricians 6 (4%); social workers 4 (2%); and psychiatric community nurses 3 (2%). The unit was run on a multidisciplinary basis, and all disciplines met at a weekly meeting.

About 90% of patients needed transport, and this was provided by the unit's own ambulance and by the London Ambulance Service. Most arrived between 10 and 10 30 am and left between 3 30 and 4 pm. Morning coffee, lunch, and afternoon tea were provided.

Occupational therapy was predominantly diversional or recreational, and "aids to living" assessment was also carried out. Patients had access to all hospital facilities such as physiotherapy and chiropody.

Patients

During the first two years 163 patients (72% women) were admitted. Ages ranged from 65 to 85 or older, with most in the 70-75 group (table I). The diagnostic range was broad, and the commonest diagnosis was dementia (table II). Patients included those with previous psychiatric treatment in hospital 77 (47%); previous geriatric treatment in hospital 6 (4%); in poor physical health 25 (15%); chairbound 5 (3%); and doubly incontinent 7 (4%). Incontinent patients were not excluded as access to a medibath and a washing machine in the unit enabled us to extend the service to this group.

Table III shows that 42% of the patients had no form of community support before admission, while the commonest form of supervision was by the local social services. Only 8% were discharged home, and 21% needed psychiatric treatment in hospital.

TABLE I—Ages of 163 patients who attended the day hospital. (Percentages in parentheses)

Age	<65	65–	70–	75–	80–	≥85
No (%) of patients	8 (5)	24 (15)	49 (30)	37 (23)	35 (21)	10 (6)

TABLE II—Diagnoses of 163 patients who attended the day hospital. (Percentages in parentheses)

Schizophrenia	12 (7)	Dementia	72 (44)
Depression:		Neuroses	9 (6)
Endogenous	45 (28)	Alcoholism	6 (4)
Reactive	15 (9)	Others	4 (2)

TABLE III—Community support, and number of re-referrals

Community support:		
Meals on wheels	16	(10%)
Social worker supervision	51	(31%)
Home helps	11	(7%)
District nurse attendance	13	(8%)
Psychiatric community nurse supervision	4	(2%)
None	68	(42%)
No of re-referrals (discharges)		
Total re-referred	57	(35%)
Home	13	(8%)
Psychiatric treatment in hospital	35	(21%)
Old people's home	4	(2%)
Died	5	(3%)

Discussion

One of the exciting aspects of this day hospital was the relative ease and low cost of the conversion. The spacious new occupational therapy areas became the envy of other OT

departments. The buildings are structurally sound and indeed with age have gained a certain grace by contrast with modern, purpose-built units; and upkeep is also much less. A purpose-built unit with similar facilities would cost from £250-£500 000 or more.

Indeed, the experience with this unit suggests that there is considerable potential in the declining mental hospital for providing various low-cost services for the elderly. In general, staff in these hospitals do not wish to leave, and their skills should not be lost if the decline of the hospital makes them redundant. Wards could perhaps be converted into day centres, hostels, and half-way houses, not only for the elderly mentally infirm but also for long-stay patients for whom at present there is no suitable alternative accommodation. One of the greatest assets in providing a comprehensive service for the elderly mentally infirm—paradoxically, in the light of its history of neglect and institutionalisation—may well be found in the declining mental hospital. The prevailing adverse economic climate may offer little alternative. Hospitals close to their catchment areas have distinct advantages in developing such a service as about 90% of patients who attended needed transport.

Women in the 70-80 age group with varying degrees of dementia, and with some supporting relative, appeared to benefit most from attending the unit—or perhaps rather their caring relatives did. The only contraindication to attendance was severe physical frailty or persistent refusal to co-operate with transport. That over 40% had no community support (apart possibly from support of relatives for some) before admission suggested that a large percentage of elderly people who are physically or mentally infirm (or both) in the community are unknown to those who organise community support and facilities. Of those in contact with support of some type, the greatest number were known to the local social services. They were not, however, an important source of direct referrals to the day hospital.

There is a continuing need to publicise locally the availability of day hospital facilities. Although there were places for only 30 patients daily, by varying the number of attendances weekly an average of over 50 patients could be kept on the books. The number of attendances could not easily be reduced as dependence develops quickly. For many the question of discharge never arose, as their survival in the community depended on their coming to the day hospital. Two types of day hospitals are needed, one with less medical emphasis for the more independent patient with features of social isolation (a club) and one with medical and nursing emphasis for the patient who has deteriorated more and is likely to need continuing supervision. Both types should be feasible within the declining mental hospitals, especially those near large conurbations.

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It has recently been claimed that drinking tea without milk is a cause of oesophageal carcinoma. Is the evidence convincing?

The theory that tea without milk might predispose to oesophageal cancer is based on two forms of evidence. Firstly, cancers of throat and oesophagus have a higher incidence in some populations whose consumption of certain tannins is high.¹ These tannins are contained in acacia, betel-nut, millet, and calvados, but there is no epidemiological evidence of an association between human cancer and tea consumption. Secondly, extracts of tea (and other tannin-containing herbs) have produced cancers in experimental animals when painted on the skin,² or injected subcutaneously.³ The link between human oesophageal cancer and the consumption of tea without milk is therefore merely speculative.

¹ Morton, J F, *Quarterly Journal of Crude Drug Research*, 1972, **12**, 1829.

² Kaiser, H E, *Year Book of Cancer*, ed R C Clark, and R W Cumley, p 436. Chicago, 1969.

³ Kapadia, G J, et al, *Journal of the National Cancer Institute*, 1978, **60**, 683.