TALKING POINT

Medical staffing of hospital geriatric units

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Services for the care of the elderly in Britain have developed haphazardly. From time to time, however, the British Geriatrics Society has attempted to lay down guidelines¹ about the number of medical and nursing staff necessary to provide a reasonable standard of care in the hospital setting. NHS reorganisation in 1974 should have brought the hospital service closer to the primary care and community health services. Indeed, community links have been developed by hospital geriatric departments for many years but no consideration of these developments is taken when medical establishments for the geriatric services are determined. So it is time that the number of medical staff necessary to provide an integrated geriatric service to a "standard" community of 200 000 with a population over 65 of 28 000 was reviewed. This would guide regional and area health authorities in creating establishments for district and area services in these categories of staff.

Hospital geriatric medical service

The number of staff necessary for the district general hospital geriatric unit will vary with the job of the DGH and the community it serves. For instance, a hospital which undertakes undergraduate teaching will need more staff than one which undertakes only postgraduate medical, student, and pupil nurse teaching. A hospital serving a community with an above-average population of elderly—that is over 65, particularly with a large proportion over 75—will need extra facilities and staff. Similarly, a high turnover of patients, difficult traffic conditions, long distances to travel between community hospitals will mean more staff. Another important factor is the proportion of the elderly medical (as opposed to surgical) sick needing hospital admission who are admitted directly to the geriatric department. The recent development of psychogeriatric services calls for close liaison between psychiatrists and physicians in geriatric medicine and additional medical time must be allocated for this. Furthermore, the development of special liaisons with other disciplines—for example, orthopaedics, or the creation of special services such as stroke units—may require special staffing considerations.

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In a letter to regional hospital boards² the DHSS gave guidance on the siting of hospitals for geriatric services, and on geriatric day hospitals. This guidance related to the siting of inpatient, outpatient, and day hospital services. Beds for inpatients were required for:

A Diagnoses, assessment, and immediate treatment.

B (1) Intensive rehabilitation.

(2) Somewhat less intensive rehabilitation.

C Longer-term treatment.

D Short-term care—(i) terminal; (ii) temporary relief.

The DHSS suggested that category A, B(1), and part of B(2) beds should be in DGHs, including those doing undergraduate teaching, and that these represented about five beds per 1000 elderly. Categories C, D, and the remaining part of B(2)—another five beds per 1000 elderly—the DHSS suggested might be in a community hospital. Outpatient clinics could be held either in a general outpatient clinic or in a geriatric day hospital. Day hospital places should be provided at a rate of two places per 1000 elderly.

This policy has since been confirmed in the "priorities" document³ and the work relating to the care of our "standard" population of 28 000 elderly can be summarised as follows:

BASIC HOSPITAL COMMITMENTS

The supervision, organisation, and management of 140 beds for category A, B(1), or B(2) (part) patients in a DGH; 140 beds for category B(2) (part), C, and D patients in community hospitals; 56 day places, probably in two day hospitals.

Outpatient clinics for new and old patients.

Consultations with other specialties.

COMMUNITY COMMITMENTS

Domiciliary consultations and home assessment visiting; clinics in health centres or general practitioner group practices (partial educational role) or both; health care planning team for the elderly; administration (including letters and communications with GPs and others); liaison with local authority and voluntary services associated with the elderly; and maintaining close relationships with residential services for the elderly, particularly old people's homes and sheltered housing.

GENERAL COMMITMENTS

Teaching, which may include undergraduates, postgraduate doctors, nurses, remedial therapists, health visitors, social

workers, local authority health care assistants, and voluntary workers; pre- and post-retirement courses; research—clinical or community; self-education; travelling; and committee meetings.

Medical staffing

By taking all these factors into consideration it is possible to work out a formula for the number of sessions needed for medical staff and this can then be translated into people and grades. This formula, based on the British Geriatrics Society's memorandum on medical staff,¹ has been agreed by the Wessex Regional Board Working Party; and the BMA's Working Party for the Care of the Elderly.⁵

FORMULA FOR MEDICAL STAFF

A basic allowance of three and a half sessions a week/100 admissions a year, applied at the rate of four patients per bed per year.

Twenty-two sessions per 50 day-hospital places.

Eleven to 15 sessions psychogeriatric liaison.

Seven to 11 sessions liaison and consultation with other specialties.

Nil to 44 sessions (average 22) to cover other factors—for example, outpatients, geographical scatter, a high proportion of patients over 75, teaching, etc.

The basic allocation is that suggested by the council of the BGS. A turnover rate of four patients per bed per annum may seem low, yet many units do not achieve this figure, though some have a rate of more than six patients per bed. The day hospital sessions are calculated on a basis of a 30-place day hospital handling 250 to 300 admissions per year, experience having shown that 13½ sessions of medical time are required for this volume of work. The psychogeriatric liaison sessions are for medical time only (as opposed to psychiatric time) and assume a closely collaborative geriatric/psychogeriatric service with joint and cross consultation and perhaps a joint care unit.⁶ These sessions would be concerned in both medical liaison and planning of admission and long-stay beds needed in a service.⁷ The number of sessions allocated for liaison and consultation with other specialties assumes that close collaboration exists between the physician in geriatric medicine and all his medical and surgical hospital colleagues. The need for special units such as that described in Hastings by Devas⁸ will increase the number of sessions to a maximum. Finally, the number of sessions necessary for other factors will depend on local policies and conditions. Morbidity increases after 75 and an increasing proportion of geriatric beds are occupied by patients in this age group. Consequently in areas which have large numbers over 75 additional staff weighting will be necessary, particularly if local policy determines that all those over 75 are the responsibility of the geriatric medical team.

For an average unit, serving a population of 28 000 elderly people, this would give a total of 107 sessions: basic—39 sessions; day hospital—24 sessions; psychogeriatric—13 sessions; other specialties—nine sessions; and other factors—22 sessions.

If these sessions were divided by grade in the following percentages: consultant (35%); junior medical staff, including preregistration house physicians (50%); and clinical assistants

(15%) the following numbers of staff would be appropriate:

Three consultants	= 33 sessions
Five junior medical staff	= 55 sessions
clinical assistants	= 19 sessions
	—
	107
	—

This is equivalent to 0.11 consultants per 1000 elderly and 0.35 doctors per 1000 elderly. To see how such a theory measured against actual staffing levels of geriatric units 22 geriatric units were asked four questions—the population over 65 in the catchment area; the total population in the catchment area, and the number and grading of staff. Eighteen units replied (table).

Discussion

The staffing level reaches the proposed theoretical target of about 10 full-time staff to serve a population of 28 000 in only a few instances. The four exceptions—units 3, 4, 8, and 15—are all units linked to teaching hospitals. One of these, unit 8, was closely linked to the general medical establishment and all its staff were undertaking general medical duties as well as geriatric so that the number of sessions devoted specifically to the care of the elderly was probably less than it appears. The other three units were operating high turnover services and accepting emergency admissions (conditions which applied to many other units in the survey). All these units, however, thought that they were understaffed for the work load they were undertaking. Unit 13 has a staffing level much lower than the rest. This unit caters for an area with a large retired population, so increasing the number of elderly in the catchment area. The local medical policy is for close integration of general with geriatric medicine so that both physicians in geriatric medicine have some general medical sessions, while the general physicians and other specialists do some short- and medium-term geriatric medicine. In spite of this both consultants in geriatric medicine have a heavy work load. The staffing level of this unit emphasises the point that all medical disciplines except paediatrics and obstetrics have elderly patients.

General medicine takes its share. Usually this relates to the treatment of acute, short-term illness in elderly patients, 60% of these being under 75.⁹ We have assumed such a medical policy with geriatric medicine accepting the remainder of the elderly needing hospital medicine—that is, acute illness in the elderly with social problems or chronic disability or great age, short-term rehabilitation for disabled elderly, intermittent admission to maintain function and give family relief, longer-term rehabilitation, and long-term care. Obviously, if general medicine takes an appreciably larger or smaller share then staffing levels will have to be adjusted. As general medicine becomes more specialised it will take only those acutely ill elderly whose illness coincides with the specialty interest and the work load of geriatric medicine will increase. Indeed an age-related specialty already exists in some places and such development would make assessment of work load and staffing policy much easier. In those units which are able to perform this service the elderly benefit considerably with no waiting list for those over 65 needing admission, and there is no longer initial misplacement, with consequent benefit to patients, resulting in a much smaller number of continuing care beds being needed.^{10 11} Many factors will influence the numbers of staff needed. This paper has considered only one variable—the size of the elderly population. The resources available to units and the areas in which they work are so variable that no other parameter is comparable. The units were selected on a personal rather than a geographical basis but all the units had the reputation of running average or better than average services. Admittedly, there is a southern and London bias and only one unit was in Scotland and one in the North of England as opposed to six in London, five in the South, three in the Midlands, one in Wales, and one in East Anglia. The table shows that the 18 units together related to a population of 730 750. Given the suggested staffing ratios 2792 sessions of medical time are needed to provide an average service and these would be divided as 861 consultant, 1435 junior medical staff, and 496 clinical assistant sessions. This means that altogether these departments have a deficiency of 251 senior staff, 130 junior staff, and 301

clinical assistant sessions. Thus, another 23 consultants and 12 junior doctors or roughly one senior and one junior doctor per unit in WTE are needed. Moreover, many of the units were staffed by doctors who though of a high calibre were doing a limited number of sessions. This lessens a unit's efficiency and the numbers of doctors working half time or less must be limited. To correct such a consultant deficiency poses recruitment and training problems. The official training period if the recruits are to fulfil a full and adequate training is four years. So it would take five years to bring the consultant staff up to full strength and to do this would absorb all the senior registrars being trained in these units. These represent about one-third of the total number of senior registrars in geriatric medicine. Therefore, expansion of consultant posts throughout the country is likely to be slow unless more senior registrar training posts are created. The amount of teaching will vary depending on whether the DGHs undertake undergraduate teaching. Nevertheless, the educational opportunities in geriatric medicine are great¹² and the teaching can be divided into four needs: undergraduate; postgraduate; education of medical ancillaries—for example, nurses, social workers, health visitors, physiotherapists, occupational and speech therapists; and education of the public—for example pre- and post-retirement courses, school sixth forms, voluntary organisations. So the allowance for other factors may need to be increased to the full 44 sessions in the case of DGHs undertaking undergraduate teaching and to 33 sessions in other hospitals with large teaching commitments. The staffing scale in the formula represents an increase on the present one. Appropriate training posts at senior registrar level must be included in the establishment of selected DGHs, and these must be sufficient to allow for expanding the service as well as for consultant wastage. To achieve this the DHSS, the royal colleges, and others concerned will need to initiate an appropriate national policy. Senior registrars, however, are in training posts and should not have to perform more than six sessions per week of service work. All senior house officer appointments in (concluded on page 976)

Population served by 18 geriatric units and staff employed

Unit No	Population over 65	Consultant (sessions in brackets)	Medical assistants or SHMOs	Senior registrars	Registrars	SHOs	Pre-reg house physicians	GP sessions	Consultants in WTE per 1000 pop over 65 served	Total medical establishment in WTE per 1000 pop over 65 served
1 (T)	79 000	4 (44)	2	2	3	4		22	0.05	0.22
2 (T)	54 500	3+ (34)	1	2½	1	4		22	0.055	0.27
3 (T)	14 000	1 (11)		1		3	1½		0.07	0.375
4 (T)	32 000	4 (44)		2	5	11	3	20	0.08	0.52
5	36 000	2 (22)			2	3		3	0.55	0.20
6*	21 000	3+ (25)		2 sessions	3 sessions	7 sessions	6 sessions		0.11	0.19
7	48 000	2 (22)	1	1	2	2		14	0.04	0.19
8* (T)	16 250	1 (11)		2		2	3	4	0.06	0.51
9	21 000	2 (22)		1	1	3			0.09	0.33
10	69 000	3 (33)		1	1	5		16	0.03	0.17
11	35 000	1 (11)		1	1	1	1		0.04	0.14
12	56 000	2 (22)	1	2	1	4		28	0.02	0.22
13*	64 000	1+ (13)		1	1	1	1	9	0.07	0.08
14 (T)	27 500	2 (22)		1		3½		2	0.06	0.27
15 (T)	17 000	1 (11)		2		4		2	0.07	0.42
16 (T)	55 000	4 (44)		3	1	6	2	25	0.12	0.33
17	25 000	3 (33)		1	1			15+	0.05	0.26
18	40 500	2 (20)	1	1	1	1	2	14		0.23
	730 750	444 sessions = 40.36 consultants	66 sessions = 6	292 sessions = 26½	232 sessions = 21	640 sessions = 58+	141 sessions = 11+	194+ sessions	0.055	0.25

*Geriatrics linked to general medicine.

New charter for ophthalmic medical practitioners

The Ophthalmic Group Committee is discussing with the DHSS a proposed new charter for ophthalmic medical practitioners. Reporting this to the General Medical Services Committee last week, the OGC's chairman, Mr M J Gilkes, said that the charter was intended to fill the ophthalmological "gap" in the NHS's primary care service. It also aimed to improve the morale and status of OMPs.

Recruitment of OMPs had been erratic in recent years: figures showed that in 1974 the level fell to 918 compared with 980 for the previous year, and though recruitment had increased since it had failed to reach the levels of the early 1970s. That was due, Mr Gilkes

responsible for any complications from his treatment or would GPs be expected to treat these?

Dr David Williams forecast a compromise between two alternatives: a system in which patients went straight to the OMP, as happens with the dentists, or GPs would have to learn more about eye conditions. Dr W P Lambie, however, saw the arguments about responsibility as a red herring. Every medical practitioner took responsibility for his actions; he saw nothing but good coming from the proposals.

The chairman commented that he would be very hesitant to advise the committee to agree to a system where patients had direct access to another doctor without reference to a GP. Mr Gilkes reminded the committee that even

before the abolition of the eye test form, OSC 1, patients had direct access to OMPs and to specialists. Most of the public's visual needs related to refraction, and while it was desirable that people should go to their GPs for advice on refraction, that was not happening. The committee accepted that if a patient felt that he wanted spectacles, he should be permitted to go to an OMP to obtain them. It also accepted that if a patient had some medical condition that required urgent treatment, the OMP should be permitted to give that urgent treatment, provided he informed the patient's GP immediately. The proposals for a new contract will be considered by the Joint Consultants Committee and by other BMA committees. Meanwhile discussions on it will continue with the DHSS.

Mr M J Gilkes, chairman, Ophthalmic Group Committee

maintained, to inadequate remuneration and poor job satisfaction. Fewer OMPs, for example, were doing school eye clinics, and it was becoming harder to obtain a consultant domiciliary visit for refraction because no extra money was paid for that service.

The OGC wanted a contract like the pre-NHS one. This would allow an OMP—a change of name to primary health care ophthalmologist was suggested—to undertake a limited form of treatment using this specialist knowledge, as well as to continue with refraction work. Three ways were envisaged in which patients would be treated by the PHCO: (a) via a consultant, (b) via a general practitioner, and (c) via the "walk-in" service. The PHCO would also play a particular role in domiciliary consultations where there was a higher risk of undetected abnormalities. He would be an independent contractor as was the OMP at present. Mr Gilkes said that he should be paid on an item-of-service basis, with one standard fee.

Job satisfaction

The charter was seen as offering a great opportunity for ophthalmologists to achieve more job satisfaction and to enhance their role in the field of primary care, thereby preserving that important part of their work. But speakers in the debate had reservations about the proposals. In particular, they were worried that GPs might be bypassed. Furthermore, would a subconsultant grade develop and how would opticians react? Would the OMP be

From the CCHMS—continued

had been extensive discussions with the DHSS and the Health and Safety Executive about the implications for the Health Service; and Dr Lewis emphasised that the BMA was as concerned as any other union for the safety of staff and, though the authorities (as Crown agents) would not be obliged to act on the recommendations of safety committees, it was important that the professions should co-operate.

Medical assistants

The new chairman of the Medical Assistants Subcommittee, Dr J G Maden, paid tribute to his predecessor, Dr D C S McAlister, for the work he had done on behalf of medical assistants. His subcommittee, Dr Maden reported, had decided to ask for increased

representation on the CCHMS and its subcommittees, and for a seat on the Council. The Negotiating Subcommittee would be asked to take under its wing the few medical assistants who worked in special hospitals. Earlier in the meeting Mr Bolt had reported that good progress had been made at the meetings of the Joint Working Party with the Department, which is negotiating a new contract for medical assistants. The negotiators are aiming for a contract which is as close as possible to the one for consultants, bearing in mind the differences in the two grades but recognising that medical assistants were permanent members of the senior hospital staff. The Office of Manpower Economics had undertaken a survey on behalf of the Review Body on certain aspects of the activities of a sample of medical assistants. A questionnaire had been issued in July with a closing date of 11 August.

Talking Point—continued

geriatric medicine should be rotational, as should all senior registrar posts. In this way more potential consultants would have training in geriatric medicine, in addition to general medicine, making the appointment of physicians with a genuine special interest in geriatric medicine, as the Royal College of Physicians has envisaged,¹³ more feasible.

We would like to thank our colleagues who were kind enough to reply to the questionnaire referred to in the text.

References

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- ² DHSS, *Hospital Geriatric Services*, DS 329/71, December 1971.
- ³ DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.
- ⁴ Wessex RHA, *Working Party on the Care of the Elderly*, 1972, 3, 58.

⁵ BMA, *Care of the Elderly*, Report of the Working Party on Services for the Elderly. London, 1976.

⁶ Godber, C, in *Recent Advances in Geriatric Medicine*, p 131, ed Bernard Isaacs. Edinburgh, Churchill Livingstone, 1978.

⁷ Andrews, J, et al, *Gerontologia Clinica*, 1972, 14, 100.

⁸ Devas, M B, *Modern Geriatrics*, 1970, 1, 45.

⁹ DHSS, *Hospital Inpatient Inquiry*, 1973.

¹⁰ O'Brien, T D, Joshi, D M, and Warren, E W, *British Medical Journal*, 1973, 4, 277.

¹¹ Bagnell, W, et al, *British Medical Journal*, 1977, 2, 75.

¹² Brocklehurst, J C, *Age and Ageing*, 1974, 3, 1.

¹³ Royal College of Physicians of London, *Report of the Working Party on the Care of the Elderly*, 1976.

Correction

The Medical Act 1978

We regret that a printer's error occurred in the Talking Point article by Lord Hunt of Fawley (16 September, p 842). On p 844, column 2, the wording of line 6 is incorrect and should have read "when the Bill had been debated there). It".