TALKING POINT

Juniors' accommodation: a costly mess

C A C CLYNE

It has never failed to surprise me that those who "administer" to our needs, and many of our senior colleagues who work at the interface with those administrators, frequently see fit to press on the resident junior staff living and sleeping conditions that they themselves would not tolerate. Why should those who cannot leave the hospital in the evening not be provided with basic facilities similar to facilities available to those who can? After all, the junior and senior house officers who remain behind at work are in general terms those most stressed during the off peak hours, and do we not owe them a pleasant sitting room, bar facilities, adequate (if not separate) dining facilities, and a moderate sized bedroom with at least an en suite wash-basin? It is possible that I am missing some basic point in personnel administration, but in several years' experience in the mess facilities area no one has yet pointed it out. I firmly believe that you get the best out of your colleagues if they are led to believe that some interest is being shown in them beyond the immediate production of the latest haemoglobin on the 8.30 am ward round. The provision of good supporting facilities (long recognised as being essential for morale by the armed forces) does actually extend its benefits way beyond the confines of day to day comfort, and there must be little doubt that not a tiny fragment of the success of institutions such as the Hammersmith Hospital lies in the exchange of information both clinical and social in the bar at 5 pm.

When I arrived in Southampton I went to a meeting of the committee formed to reallocate the doctors' mess when the Old General Hospital was to be demolished. This scenario was first envisaged in 1977, and I joined the deliberations in 1979. We met every three or four months and made no real progress as the whole project was without funds and neither the region nor the district accepted it as their responsibility. Eventually, I wrote to Dr Gerard Vaughan, then Minister of Health, in May 1980. His prompt reply in September 1980 to our local member of parliament clearly showed some understanding of the problem and mentioned that revision of building guidance would mean consultation with the Joint Consultants Committee and junior staff representatives; a start was being made.

By April 1982 the government seemed to have got inflation under control so I thought that it would be fair to ask what progress had been made on mess facilities since my original letter. The response this time was honest—there was no reply. Instead I heard from a senior medical officer at the Department of Health and Social Security, who had been handed the file. He pleasantly explained that he shared my concern, which was at least encouraging, and said that he thought that the Joint Consultants Committee was having a joint meeting with the DHSS shortly in an attempt to rethink some of the hospital building notes. He thought that the junior staff representative might well be one of the doctors concerned in a "mess facilities report" from Wessex but declined to give me his name. I rang the BMA and realised that the joint liaison committee for hospital building was about to have a meeting with the DHSS and I, of course, had been the junior staff representative for several years although this was its first meeting. The meeting, which took place on 30 November 1982, must certainly have

made some impact on the DHSS representatives, for one hour of the three hour meeting centred on the lack of facilities for resident junior staff and the problems that that creates.

Wessex working party

We had not, however, been idle ourselves in 1979. A working party on junior doctors' messing, accommodation, and catering in the Wessex Regional Health Authority had been formed consisting of senior medical staff, junior medical staff, the assistant regional architect, and the regional catering officer. Our remit was to review the present status of messing, catering, and accommodation throughout Wessex and to advise the health authority through the regional medical advisory committee on future policy for Wessex with particular reference to new hospital building. Our first task was to peruse the literature and determine any mandatory or minimum requirements for doctors' living conditions. There are none. The actual level of accommodation, messing, and catering provided is apparently decided by individual health authorities and districts after a variable degree of consultation with the users. There are about six relevant publications, of which *Hospital Building Note No 24*¹ seems the most substantial document—it is, however, only a recommendation but well worthy of close scrutiny and would certainly represent a strong basis on which to start negotiations. Quite rightly, flexibility of building design is the key—"It is therefore important that the accommodation should be designed so that changes in occupancy can be simply achieved." Residential staff have been given six grades (A-F) and accommodation is built appropriate to rank. Suffice it to say that "scale B . . . suitable for house officers . . . each should have a separate bedsitting room with a lavatory basin." None of the bedsitting rooms are projected as being less than 120 sq feet. Progressing to scale D for registrars—"each should be provided with a small self contained flat consisting of bedroom, living room, bathroom, WC, and kitchen." There is much more detail than described that would clearly be difficult to achieve in full in today's economic climate, but "adequate provision of heating, lighting, and laundry facilities should be made."² "Car parks may be provided on the basis of one to every self contained flat. . . . Where site conditions permit, some outside play space should be provided for the children."

There is no provision made specifically for mess facilities for medical staff, but "common room provision may be provided in a number of ways . . . a larger central room for group activities and dancing. There should be provision of sitting rooms for small groups of people but possibly of more use and importance. . . ." This note assumes the provision of central common rooms on the scale of 10 to 20 sq feet per person, "indeed . . . when there are a number of residents there should be a separate common room of adequate size and suitable furnishings." Perhaps the spirit of any provision of facilities is expressed in "the committee (of the medical Whitley Council) wish to emphasise that in their view the provision of satisfactory accommodation is of the greatest importance to the spirit and efficiency of the hospital service."³ How true!

Sadly, years after these guidelines came off the press no firm policies exist. Here in Southampton it has cost us dearly. If a move had been made to provide a proper mess in 1977 the

Faculty of Medicine, The University of Southampton, Southampton General Hospital, Southampton SO1 6HU

C A C CLYNE, MB, FRCS, lecturer in surgery

General Medical Services Committee

Dr John Ball re-elected chairman

At its first meeting of the 1983-4 session on 21 July the General Medical Services Committee had a long debate on the action taken by the Treasury to cut the budget of cash limited services by £100m because of an anticipated "overspend" on family practitioner services (p 371). Dr John Ball was re-elected chairman unopposed. Some of the matters discussed at the meeting are reported here.

Representation on the General Medical Council

At its meeting in May the committee had approved the setting up of a working party to see how many doctors who were exclusively engaged in general practice in the National Health Service could be elected to the General Medical Council in the 1984 election (7 May, p 1526). Last week the committee discussed the working group's recommendations, and it has urged local medical committees to nominate and support suitable general practitioners who are BMA members in the forthcoming BMA sponsorship primary elections. It has been suggested that where appropriate local medical committees might wish to consult BMA divisions and faculties of the Royal College of General Practitioners.

Continuous ambulatory peritoneal dialysis

Concern had been expressed on several occasions about reports that the West Midlands Regional Health Authority proposed to transfer responsibility for prescribing fluids used in continuous ambulatory peritoneal dialysis to general practitioners (7 May, p 1526). The Department of Health and Social Security has assured the committee that "prescribing implies responsibility for the treatment of a patient . . . and this applies both to general practitioners and to hospital doctors." The DHSS has been advised that provided local medical committees were satisfied that any transfer of prescribing responsibility was not being undertaken in an attempt to reduce the expenditure of the health authority and the general practitioner was prepared to accept the clinical responsibility that went with the act of prescribing, the committee would not wish to hinder such arrangements.

Catchment areas for hospital services

The committee was concerned to learn of a health authority's introduction of catchment areas for outpatients and accident and emergency patients (p 372). It was agreed to make an approach to the Joint Parliamentary Under Secretary of State requesting that representations should be made to the district health authority to revoke the decision and to ask him to ensure that health authorities were made aware of the Department's policy not to restrict the right of any general practitioner to seek help wherever he wished on his patients' behalf.

Community psychiatric nursing services

The committee's commitment to community psychiatric nurses, and indeed to any specialist nurses working in the community, being

accountable to general practitioners was reaffirmed and it was agreed that eventually they should be attached to primary health care teams. Meanwhile, it was suggested that the problems that may be caused by these nurses working in the community but being accountable to the hospital services could be lessened by liaison between community services and psychiatric services units of management. The committee hopes that local medical committees will encourage such liaison in the future.

Selection of trainers

A regional general practice education sub-committee had resolved normally to exclude all general practitioners, including existing trainers, from further appointments as trainers unless they possessed the membership of the Royal College of General Practitioners by examination. The committee deplored the resolution and reaffirmed its policy that the membership should not be an exclusive requirement for trainers. It was the committee's view that if a doctor's application to become a trainer was turned down solely on the grounds that he did not possess the membership he should appeal.

Revised revenue cash limits for England 1983-4

Revenue cash limits

Regional health authority	Revenue cash limits* (£m)	Service addition reduction† (£m)	Percentage addition/reduction (%)
Northern	546 212	1129	0.21
Yorkshire	611 661	3629	0.61
Trent	739 128	9811	1.40
East Anglian	308 983	5664	1.90
North west Thames	653 611	-4250	-0.68
North east Thames	823 977	-5334	-0.68
South east Thames	718 583	-4430	-0.64
South west Thames	549 307	-3460	-0.64
Wessex	437 882	4699	1.10
Oxford	348 566	1529	0.45
South Western	533 038	3378	0.65
West Midlands	845 714	2579	0.31
Mersey	451 575	495	0.11
North Western	755 216	1860	0.25
Total	8 323 453	17 299	0.21

* Excluding joint finance; this column also excludes cash limit adjustments in respect of the 1983 review body award, the reduction in National Insurance surcharge and London weighting; these adjustments will be notified to regional health authorities shortly.

† These figures comprise the extra money generated by "efficiency" savings that are to be distributed regionally according to the RAWP formula.

The BMA's economic department has worked out the new position for England as follows:

	£m
(1) Cash limits for 1983-4	£8404
(2) Less "cuts"	£81
(3) Revised cash limit	£8323
(4) Less pay and price inflation (at 4.5%)	£7965
(5) Plus "efficiency" savings (at 1.5%)	£8005
(6) Cash limit in 1982-3	£7984
(7) "Real" growth	0.3%

Nationally, the BMA states, the level of resources provided last year will only be maintained if the "efficiency" savings at (5) above are made. Given that at least 0.6% real growth is required to make up for alterations in the demography of the country, a standstill in real terms is a cut in health service terms. If regions cannot make the required efficiency savings then a cut in real terms will take place—which will be exacerbated if inflation forecasts do not hold.

Talking Point—continued from page 373

whole project could probably have been carried out for £30 000. Just before Christmas I learnt that the district had agreed to pay out £70 000 to supplement the £50 000 provided by the region for what is really an alteration to the ground floor of one of our tower blocks, and even that has been estimated by private building consultants to be £40 000 short of what may be required. The rest of you may not be so lucky—in September the DHSS essentially put a stop to capital schemes with revenue consequences, so individual negotiations are now going to be even more difficult. Let us hope that the expensive lessons learnt here in Wessex encourage us to formalise the requirements

of medical residents and include them in new hospital buildings. It would save much time, money, and frustration in the end—and lead to more contented medical staff.

References

- 1 Department of Health and Social Security. *Hospital building note No 24*. London: DHSS, 1964.
- 2 Department of Health and Social Security. *Attack on inflation: building and engineering contracts, supplies and services contracts*. HC(PC)(79)4. London: DHSS, 1979.
- 3 Ministry of Health. *Residential accommodation for hospital staff*. HM(58)68. London: Ministry of Health, 1958.

(Accepted 22 June 1983)