TALKING POINT

Psychiatric facilities in an "over-resourced" NHS region*

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The Resource Allocation Working Party proposed that NHS resources should be redistributed between regions.¹ Redistribution is also proposed within regions, with peripheral areas benefiting at the expense of central ones.² Consultant psychiatrists in South-east Thames RHA thought that psychiatric services in their region were seriously inadequate. We decided, therefore, with the consent of the regional psychiatric specialty subcommittee, to ask consultant colleagues in the region for information about their work load and clinical duties. The regional psychiatric specialty subcommittee includes one consultant from each district and he was asked to provide information about the psychiatric facilities in his district.

Consultant work load

The 58 consultants in adult psychiatry with four or more notional sessions (paid or honorary) with the region were sent a questionnaire asking 15 questions about clinical duties and for a specimen weekly timetable. Forty-five consultants returned forms containing useful data. Seven completed the form anonymously; of the others, 16 were from consultants in the AHA(T) (including three full-time honorary (academic) consultants) and seven from the Greenwich and Bexley AHA. (These 23 consultants were from the two areas from which resources are apparently to be diverted to less endowed areas.) The remaining 22 named replies were from consultants east of Bexley.

Three academic consultants had no district responsibility; twenty-five regional consultants reported that they provided general adult and psychogeriatric services for the same population, which was on average 75 600. Seven other respondents were from areas where separate psychogeriatric services had been developed, but we calculated that each consultant was responsible for the equivalent of 74 400 people for both general psychiatric and psychogeriatric care. The average respondent was responsible for 31.4 acute beds (in general and/or psychiatric hospitals) and for 74.7 chronic (including psychogeriatric) beds. If AHA(T) and anonymous responses are excluded, the average number of acute beds remains much the same (32.5), but the figure for chronic and geriatric beds rises to 93. Thus AHA(T) consultants had fewer chronic beds. Acute psychiatric beds in general hospitals are mainly confined to parts of the AHA(T), Greenwich, Dartford, Farnborough, and East Sussex. Fifteen respondents (including two academic) had care of beds on one site, six consultants had beds on three sites, and the remainder on two sites. Almost

one-third of the respondents had no day-patient facilities. The mean number of day places was 28.3 per consultant who had any, or 18.4 for all consultants. Each consultant was on average responsible for three weekly outpatient clinics and saw a weekly average of four inpatients in non-psychiatric beds in 2.3 hospitals. He did 3.3 domiciliary visits weekly. On average, each consultant visited penal institutions 1.7 times monthly, submitted 2.2 court reports a month, and attended court 3.6 times a year.

Taking all respondents together, the average number of junior staff sessions (11ths) attached per consultant was 23.8. If the AHA(T) is excluded, the figure is 22.4. Trainees formed the bulk of this assistance.

Several consultants emphasised that they were always on call for their own patients; consultants participating in duty rotas reported between 15 and 36 weekly duty hours.

ADMINISTRATIVE AND OTHER ACTIVITIES

Estimated weekly hours spent in Cogwheel divisions of psychiatry, medical committees, and other Cogwheel and regional meetings were added together. For 40 consultants whose responses could be analysed, the average weekly figure for these meetings was 4.8 hours. This included eight consultants who spent two hours or less per week in meetings and who indicated that they had deliberately stopped attending such activities.

The mean number of hours spent in undergraduate and postgraduate psychiatric education taken together was 3.7 hours. When teaching to other than doctors was added the figure rose to 5.1 hours. AHA(T) consultants gave an average of 4.3 weekly hours each to

undergraduate education, and seven other consultants were also concerned with this for an average of two hours weekly each. (Undergraduate psychiatric education in the South-east Thames Region is at King's, St Thomas's, and Guy's medical schools. The meagre establishment of academic psychiatrists at all three schools means that undergraduate psychiatry teaching depends heavily on NHS personnel.)

Physical facilities

Each of the consultants who represented a health district on the regional psychiatric specialty subcommittee was sent a questionnaire asking for information about the provision of various kinds of facility in his district. Fourteen of 16 colleagues replied within two weeks; data for the remaining two districts were obtained by further personal inquiry (see table).

Four of 16 districts have no acute adult psychiatric beds available in the district. Only in the four districts of the teaching area and in three others does the overall acute bed provision approach DHSS norms. Eleven of 16 districts have no psychogeriatric assessment beds within the district and ten have apparently none anywhere. The overall number of beds for elderly demented patients appears adequate but many are inappropriately located outside the districts in the large psychiatric hospitals. In addition, provision is insufficient in south coast districts with particularly large geriatric populations. Six districts have no day-patient places with associated beds, and 13 districts lack day places without associated beds. Nine have no psychogeriatric day-patient places. There is

Psychiatric facilities in the South-east Thames Region

Facility	Total regional provision*	DHSS norms†	% Difference‡
BEDS			
Acute Illness			
Health district	822		
Outside district	459		
Total	1281	1731	-26
Psychogeriatric assessment	155	273	-43
Dementia			
Health district	1036		
Outside district	660		
Total	1969	1775	-4
DAY PLACES			
Acute Illness			
Associated with beds	519	2200	-76
Without associated beds	131	1046	-87
Psychogeriatric	230	1723	-86
Day care (local authority places)	261	1646	-84
Residential care group	157	?	?
Special new long-stay provision	25	533	-95
Intensive aftercare places	122	253	-52
Long-stay places (staffed)	24	93	-74
Long-stay places (unstaffed)	6	277	-98

*An earlier version of this paper was presented at a seminar on psychiatric services arranged by the South-east Thames Regional Health Authority on 15 April 1977.

*Figures here are for 14-16 health districts, as for some variables districts did not provide usable information. Naturally the "norms" were applied to the same districts as had provided useful data.

†Norms derived from *Better Services for the Mentally Ill*.³

‡Figures for regional provision divided by DHSS norm multiplied by 100.

clearly a gross deficiency in day care, residential care, and hostel places of all kinds.

Discussion

These data indicate gross deficiencies in both NHS and local authority provision for psychiatric services in the South-east Thames Region. The problem is most serious for psychogeriatric patients whose numbers will undoubtedly increase substantially in the near and foreseeable future.

This assessment of facilities in one region has been made by comparing consultants' reports of what is available with what should be available if DHSS norms were met. The norms are themselves not over-generous so that the deficits noted here are indeed substantial. No conceivable unreliability in the data can obscure this finding.

The data on consultant work load provide an interesting comparison with figures by Russell,² who computed a theoretical timetable for a consultant psychiatrist responsible, with a trainee colleague, for the psychiatric service for 60 000 adults. In arriving at this theoretical consultant's timetable Russell assumed that one hour should be given to each new outpatient; 15 minutes to each follow-up outpatient; 30 minutes weekly to each new inpatient; 30 minutes weekly to each review inpatient; and the equivalent of five minutes weekly to each long-stay inpatient. Using readily available statistics, Russell then calculated that the clinical work generated by a population of 60 000 would occupy a consultant (helped by one junior psychiatrist) for 10 sessions weekly.

Our average regional consultant spent three weekly sessions in outpatients, the equivalent of one session seeing general wards, case and two sessions in meetings. (For argument's sake, we may allow "meetings" to include "education" and allow domiciliary visits to be done "out of hours," as they are paid extra.) This leaves four sessions for acute beds, day patients, and chronic beds (or five sessions if we accept the existence of Saturday mornings). How is he to deploy these four or five sessions? If he is responsible for day places the consultant must surely spend a minimum of one weekly session looking after his day patients. This leaves three or four sessions in which to look after 30 acute and 100 other beds. Russell suggested two sessions for the acute inpatients from a population of 60 000; it seems possible that two sessions might suffice for the inpatients from 75 000, so long as the patients do not speak to the consultant more than once a week, or at length (for more than 30 minutes at admission, or 10 minutes during second and subsequent weeks). This leaves one or two sessions for the 100 other beds, which include the psychogeriatric beds. These calculations overestimate the time actually available to the consultant for clinical work. For example, travelling time alone can readily occupy five or even 12 hours a week in different parts of the region.

A GOOD SERVICE

What clinical load could we ask of a consultant psychiatrist who was able to provide a good service as opposed to the minimum one with which Russell was concerned? To begin with, we should state unambiguously that in a good psychiatric service someone

must have the time to talk to the patients (and their relatives). Also, we may assume that the consultant should do some of this talking. One hour (of someone's time) per new outpatient seems reasonable, and we suggest three outpatient sessions as a practical possibility. One general hospital referral session should suffice and two sessions could be appropriately spent in administrative and educational activities. This leaves four sessions for inpatients and day patients. This is, in fact, the pattern of work for our South-east Thames regional consultants. Hence it is possible that while the breakdown of time which our average regional consultant reports is reasonable, the problem is that too much work is squeezed into each period. The point is made by thinking of the difference from the present state of affairs which would obtain if each person saw two new patients per clinic, six old patients per outpatient clinic, two patients per ward conference, and two patients per general hospital referral session. Staffing has been at an equivalent level in medicine and surgery in quite a few places.

It is arguable that a consultant's clinical load has only to increase a very little beyond 10 beds plus two new patients per clinic for immediate consultant treatment to be impossible, and that thereafter it is possible to add to the clinical responsibility almost indefinitely. There is little difference between a catchment area of 75 000 and one of 100 000 or 200 000—all are impossible. The magic norm of 60 000 is perhaps especially difficult, for it is impossible for the consultant with average resources to practise good psychiatry, yet everyone expects him to. South-east Thames regional consultants at least have the advantage of being so overburdened that their task can be readily seen to be impossible, or so we think. But the Resource Allocation Working Party did not see it that way.

WHAT IS TO BE DONE?

Clearly there is not going to be a sufficient number of consultant psychiatrists in this region as is the case elsewhere. Clearly, there are not going to be more "bricks and mortar" facilities on anything like the scale required to

meet present deficiencies, let alone to allow any development. What is to be done?

It would be useful to ensure that people know what levels of psychiatric service are available to them. It is easy to mislead people by using the word "comprehensive" about psychiatric services—the description has even been applied to services in developing countries with one psychiatrist per million population. Personal assessment by senior experienced psychiatrists is available to some persons in our region. Personal treatment by such psychiatrists is not available to most people. Should the authorities or perhaps the profession publicise a list of psychiatric disorders and problems for which no treatment is available in our region? Unhappily the list is a long one.

One solution might be to develop methods of working which would enable psychiatric services to be effective without substantial expenditure on "bricks and mortar." This would mean expenditure on people who could join community-based multiprofessional teams which would aim to serve districts by applying their skills in patients' homes rather than in institutional units. Such methods of working must be encouraged if they are better as well as cheaper than more traditional approaches. We are actively exploring such developments.

We are grateful to Mrs T Jenkins of the South-east Thames RHA for distributing questionnaires and to the colleagues who completed them.

References

- ¹ DHSS, *Sharing resources for health in England*, Report of the Resource Allocation Working Party. London, HMSO, 1976.
- ² South-east Thames RHA, *Regional Resource Allocation Working Party, First Report*. London, HMSO 1976.
- ³ Russell, G F M, in *Policy for Action*, ed R Cawley and G McLachlan. London, Nuffield Provincial Hospitals Trust and Oxford University Press, 1973.
- ⁴ DHSS, *Better Services for the Mentally Ill*, Cmnd 6233. London, HMSO, 1975.

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CCHMS elections

At its first meeting of the 1977-8 session the Central Committee for Hospital Medical Services re-elected Mr A H Grabham, a consultant surgeon from Kettering, as chairman. This will be his third year of office. CCHMS members also re-elected Mr David Bolt, a consultant surgeon at the West Middlesex Hospital, as chairman of the Negotiating Subcommittee, and Dr Brian Lewis, an anaesthetist from Kent, as chairman of the General Purposes Subcommittee. A report on the meeting will be published in a forthcoming issue.