The changing face of geriatric medicine in North Staffordshire

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As the number of elderly patients requiring hospital care increases and as expectations for care demand a better service, major changes have occurred in the practice of geriatric medicine. Poor departments with the oldest hospital wards, junior medical staff, inadequate in both number and quality, together with a large number of beds under one consultant, have made geriatric medicine the poor relative of general medical specialties. In 1977 it was proposed that integration of acute medical and geriatric services could be the solution to many of these problems [1]. In February 1983 this approach was implemented in North Staffordshire.

Background

North Staffordshire has a total population of 453,000 with 68,100 over the age of 65 of which 22,400 are over 75 (1984 figures). The projected figures until 1996 are shown in Table 1. The geriatric unit already had 84 beds on the District General Hospital site, these being adjacent to the medical admissions unit at the City General Hospital. A further 144 beds used for acute assessment and rehabilitation are situated at Bucknall Hospital some five miles from the DGH. Six long-stay hospitals within the District hold 443 continuing care beds. Two 25-place day hospitals are situated at the City General and Bucknall Hospitals (Table 2).

Prior to integration the geriatric unit functioned as an independent unit. The majority of patients admitted into geriatric beds had been seen on domiciliary visits and their names placed on the waiting list for admission. Hospital referrals were also placed on a waiting list before transfer.

Priority was given to patients requiring admission from home and this led to a lengthening list of hospital patients awaiting transfer, particularly to long-stay geriatric wards. Junior medical posts consisted of four registrars, three being shared with the Infectious Diseases Unit at Bucknall Hospital and four senior house officers, one being shared; none of these posts was recognised for general professional training. There was also a senior registrar post in geriatric medicine. In addition, there were 13 clinical assistant sessions, these being used to cover the long-stay hospitals at night. Daytime cover of several long-stay hospitals was provided by junior medical staff travelling from the hospital centre.

Reasons for integration

The waiting list for admission and transfer, particularly from acute medical beds, meant that a considerable delay occurred before patients received the intensive rehabilitation that was available on the geriatric unit. Whether this delay led to more patients requiring long-term hospital care is uncertain but, obviously, early rehabilitation following admission to hospital would seem to offer the best prospect for returning the patients to independent living within the community or at least making them fit for residential care within Part III homes. A general lack of acute medical beds in North Staffordshire was aggra

Table 1. The population of North Staffordshire (in thousands) in 1986 with projections for 1991 and 1996.

| Year | Total population | Over 65 years | Over 75 years | Over 80 years |
|------|------------------|---------------|---------------|---------------|
| 1986 | 462.1            | 70.1          | 26.8          | 11.7          |
| 1991 | 459.3            | 74.7          | 28.7          | 13.5          |
| 1996 | 454.2            | 74.0          | 29.4          | 14.1          |
| Change over decade (%) | -2 | +5 | +10 | +21 |

Table 2. ‘Geriatric’ beds in North Staffordshire.

| Acute/assessment/rehabilitation: |
|----------------------------------|
| Bucknall Hospital | 144 |
| District GH | 84 |
| Continuing care (long-stay hospitals) | 443 |

| Day hospital places: |
|----------------------|
| City General | 25 |
| Bucknall | 25 |

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vated by ‘geriatric’ patients occupying these beds while awaiting transfer.

Junior medical posts within the geriatric unit were not recognised by the Royal College of Physicians for general professional training and, therefore, career prospects for doctors in these posts were poor. With integration it was proposed that rotational senior house officer and registrar posts in general medicine would include periods on the geriatric unit. In addition, senior house officer posts from the general practice vocational training scheme would rotate through the geriatric unit, providing experience in care of the elderly to these trainees.

As acute care of the elderly was to take place on the geriatric wards it was thought that both medical and nursing staff would gain better experience from this change. Finally, it was hoped that working relationships between geriatricians and other physicians would im-

prove as a result of integration. To ensure full implementation of the proposed change it was agreed that it would commence with the appointment of or change of contract to a physician with an interest in geriatric medicine followed by integration of the junior posts.

Results of integration

Elderly patients who are acutely ill can now be admitted to the District General Hospital and have immediate access to all investigational and treatment facilities. These patients may be admitted under the care of the physician with an interest in geriatric medicine when he is on ‘acute medical take,’ or transferred to his care on the day following admission if it is thought that the patient requires the facilities and expertise found in the geriatric unit. Because of this arrangement, fewer patients are awaiting transfer from acute wards to long-stay geriatric beds. Junior medical staff rotate and gain experience in caring for the elderly and their posts are either recognised for general professional training or are part of the vocational training scheme for general practice. In addition, two house physician posts have been created on the acute geriatric wards. There is no longer an artificial age barrier which previously had determined the type of care and access to facilities which patients had received. The changes in work load for the geriatricians are shown in Table 3 and Figure 1.

Elderly patients with sub-acute and chronic problems are still referred by general practitioners, and either domiciliary consultation visits are made or, if appropriate, appointments are sent for an outpatient clinic (Table 4). The number of patients seen as outpatients has increased, as has the number attending the day hospitals.

Table 3. Changes in workload with integration (all ages).

|                        | 1982 (Year prior to integration) | 1984 (Year after integration) |
|------------------------|----------------------------------|-------------------------------|
| No. of patients:       |                                  |                               |
| Admissions             | 1194                             | 2201                          |
| To City General        | 597                              | 1389                          |
| Average length of stay (days): |                      |                               |
| District General Hospital | 38.5                           | 14.6                          |
| Non DGH Site           | 64.4                             | 49                            |
| No. of patients:       |                                  |                               |
| Admissions             | 1983                             | 1986                          |
| To City General        | 2526                             | 2199                          |
| Average length of stay (days): |                      |                               |
| District General Hospital | 1464                           | 1230                          |
| Non DGH Site (Bucknall)| 36                               | 37.16                         |

Fig. 1. Admissions to the City General Hospital under the care of a 'Geriatrician' 1982-1984.
Patients who are seen at home and require inpatient assessment and rehabilitation are admitted to Bucknall Hospital. As a result of integration, all investigational

Table 4. Geriatric outpatients and those attending day hospitals.

| District General | New | Total |
|------------------|-----|-------|
| 1982             | 403 | 676   |
| 1983             | 782 | 1414  |
| 1984             | 933 | 1785  |
| 1985             | —   | 1895  |
| 1986             | —   | 2060  |

| Day hospital patients | Bucknall | City General |
|-----------------------|----------|--------------|
| 1982                  | 2122     | 2389         |
| 1983                  | 2246     | 2387         |
| 1984                  | 2498     | 2562         |

and treatment facilities of a District General Hospital are also easily available to these elderly patients although an ambulance journey has to be made to the main hospital centre for investigations such as barium X-rays, ultrasound scans and computerised tomography. Day hospital facilities at both hospital sites are used for both in- and outpatient treatment. Physiotherapy, occupational therapy and nursing procedures available in these departments are geared to rehabilitation as part of the

Table 5. Average length of stay for geriatric patients.

|                   | 1982 | 1983 | 1984 |
|-------------------|------|------|------|
| City General      | 38.5 | 37.2 | 27.0 |
| Bucknall          | 64.4 | 49.6 | 35.8 |
| Long-stay Hospitals| 398.8| 382.9| 465.4|

Fig. 2. Admissions to Bucknall Hospital 1982-1984.

Fig. 3. Discharges and Deaths, Bucknall Hospital 1982-1984.
multidisciplinary team work. Their aim is to return patients to functional independence within the community.

Integration has not only changed the practice in the District General Hospital (City General Hospital) but also has affected care at Bucknall Hospital, there being an increase in the number of patients treated with the average length of stay falling each year since integration took place (Fig. 2, Table 5). Discharges home have risen in proportion to admissions (Fig. 3). These improvements have resulted mainly because of better access to investigational facilities and treatment, and the quick admission of patients who previously had to wait for a bed to become available. A more rapid turnover of patients means that beds are more often available for new admissions. The effects of integration on long-stay hospital care are difficult to quantify, but if early rehabilitation can prevent patients from requiring long-term hospital care, then this would reduce the pressure on long-stay beds. Less acutely ill patients can then be admitted there and more staff time devoted to improving the quality of life of patients who will spend their remaining life in hospital.

Conclusion
Integration of acute geriatric medicine and general medicine took place in North Staffordshire in 1983. This fundamental change in the approach to acute medical care for the elderly has led to a marked increase in the workload of the geriatric unit but this has been countered by a more rapid turnover of patients, perhaps due to the fact that the elderly are seen and treated sooner by the geriatric unit with its multidisciplinary team which not only includes physiotherapists and social workers but also junior medical staff of the division of medicine who are attached to the department as part of general professional training.

Following successful integration, the most recent statistics (Tables 3 and 4), show that the workload has continued. Further improvement of hospital care for the elderly in North Staffordshire will result from the appointment of a fourth consultant physician with an interest in geriatric medicine in 1987.

Improved liaison and relationship with other departments have been achieved because of integration and this has enabled the geriatric department to practice prompt and effective care of the elderly. Hence, this change in approach to acute care has benefited the elderly people of North Staffordshire and, hopefully, should continue to do so in the future.

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Reference
1. Royal College of Physicians (1977) Working Party Report on medical care of the elderly, *Lancet*, i, 1092.