One day in the life of old age psychiatrists in the United Kingdom

Susan Mary Benbow[1] and David Jolley[2]

[1] Visiting Professor of Mental Health and Ageing, Centre for Ageing and Mental Health, Staffordshire University, and Director, Older Mind Matters Ltd.

[2] Consultant Psychiatrist and Honorary Reader Manchester University.

* Address for correspondence: Prof Susan M Benbow, Centre for Ageing and Mental Health, Faculty of Health and Sciences, Staffordshire University, Blackheath Lane, Stafford ST18 0AD.
Email: drsmbenbow@gmail.com
Phone: 07789 485435
Office Phone: 01785 353742

Running title: One day in the life of UK old age psychiatrists

Abstract

Background

The provision of mental health care for older people will become increasingly important with rising demand related to global demographic changes. This project aimed to identify changes in work patterns of UK consultant old age psychiatrists between 1993 and 2012.

Method

A link to an online questionnaire was circulated to consultant old age psychiatrists through the Faculty of Old Age Psychiatry, Royal College of Psychiatrists.

Results

210 usable responses were received. On the survey day 71% of old age psychiatrists arrived at work before 9am, and 40% left work after 6pm. Over one third (35%) worked for another hour or more at home. The range of activities was broader than previously reported. Administrative activity was undertaken by over 60% and acute ward work by only 26%. Few consultants reported time in long-stay care or day hospitals. Outpatient activity included Memory Clinics and Health Centre Clinics.

The main stressors reported by consultants were lack of resources and pressures from management-imposed, financially driven service changes. Relationships with people at work (including patients and their families) and outside work were the main identified support.

Conclusions

Consultants' working hours have changed little since1997, but the range and emphases of activities have changed. Changes in service organisation are stressful and consultants are supported by relationships with colleagues and patients. Work patterns are changing in response to demands and constraints on the specialty. Research is needed into service design and work patterns, which can provide humane care in the current economic climate.

Keywords

Service design; stress; supports; work patterns; workload

Population ageing is a global challenge and will be associated with increasing mental health demands on health and social care systems worldwide. The big questions are how to meet these needs and how to finance the services required to meet them (Draper *et al.*, 2010; Horgan *et al.*, 2009; Suh and Han, 2008). In 2010 the total number of people with dementia across the world was estimated at 35.6 million and a doubling every 20 years has been projected, giving an anticipated total of 115.4 million in 2050 (World Health Organisation, 2012). Similarly the global cost of dementia was estimated at US$ 604 billion in 2010 (World Health Organisation, 2012): this total will rise as population demography changes. Alongside this the profile of the workforce is changing too, as there are fewer younger people to support a rising number of elders (de Mendonça Lima *et al.*, 2012). Thus dementia, and the associated health and social care needs of those living with the condition, is an issue of political concern for policy-makers across the world and, coupled with this, there is increasing focus on implications for the dementia workforce.

In the United Kingdom (UK) old age psychiatry became a specialty in 1989 and numbers of consultants and other professionals specializing in the subject grew as services expanded in the late 20th century (Hilton *et al.*, 2010; Macdonald *et al.*, 2007; Pitt *et al.*, 2006). The 21st century finds the specialty under pressure, and services in the UK have been paradoxically criticized as ageist (Royal College of Psychiatrists, 2009; Royal College of Psychiatrists, 2011; Royal College of Psychiatrists, 2013) in providing specialist mental health care for older adults. If the global challenge of dementia is to be addressed we need to attend to service design and workforce issues.

Workforce models employed currently in high income countries (which are not applicable in low and middle income countries) will need to evolve and change.

It is therefore important that we understand the work patterns of staff working in old age psychiatry, what supports them in their work and what they find stressful, in order to plan to meet the future needs of the increasing older adult population. We describe here a preliminary investigation of how work patterns have changed in consultant old age psychiatrists in one country (the UK) over the last twenty years, together with an analysis of their views on stressors and supports in their practice.

The aims of this exploratory project were: to obtain information regarding the current work patterns of consultant old age psychiatrists; to compare these with work patterns in the past; and to obtain initial indications of what factors old age psychiatrists identify as supportive and as stressful in their working lives.

Method

As a first step we sought to replicate our 1993 survey (Benbow *et al.*, 1993) by obtaining a profile of work undertaken on a defined Wednesday. A link to an online questionnaire (designed using Qualtrics) was circulated to all consultant old age psychiatrists on the list of the Faculty of Old Age Psychiatry with a request for those who agreed to be included in the survey to

complete the questionnaire with details of their work pattern on their last working Wednesday. The questionnaire incorporated information and consent procedures and the project was scrutinised by, and approved by, Staffordshire University under their fast-track ethical approval procedure.

The following basic demographic information was requested: age; gender; years in current post; whether the consultant was in their first consultant post; information about their work on a specified working Wednesday; the three things which they were finding most stressful in their current job; the three things that they were finding most supportive in their current job.

Responses were stored electronically. The researchers did not at any stage have access to the identities of the people mailed or of those who responded since the mailing went out through the Royal College of Psychiatrists. A second reminder email was sent through the College approximately 6 weeks after the first.

Free text answers were analysed thematically using NVIVO (Bazeley, 2007; QSR International, 2011): one author coded the text thematically by reading and re-reading the source material in order to identify themes. Themes and text segments coded to themes were reviewed, discussed, modified and developed by both authors.

Results

Quantitative data

In total there were 210 usable responses, which contributed to analysis. Not all respondents completed every question. 203 respondents specified their gender: just under 50% were women. Of 205 respondents who gave their age, most were under the age of 50 (Table 1); in the UK consultant psychiatrists appointed before March 6th 1995 had mental health officer status which entitled them to retire early, about the age of 55 years (NHS Business Authority, 2009) and the General Medical Council (GMC) has suggested that numbers of older doctors left practice after the introduction of licensing in 2009 (GMC, 2012). The Workforce Review Team found that just over one third of psychiatrists were aged over 50 in 2007 (NHS Workforce Review Team, 2008). 153 of 204 (75%) reported that they were in their first consultant post. Most (75%) were working full-time; 3% (6) worked fewer than 5 sessions and 23% 5 or more sessions.

Figure 1 compares the hours at work of respondents in 2012 with those reported by the 1993 cohort (Benbow *et al.*, 1993). In 1993 50% of old age psychiatrists reported arriving at work before 9am: in 2012 this had increased to 71%. In 1993 50% of old age psychiatrists remained at work beyond 6pm: in 2012 the corresponding figure was 40% and in 1993 33% reported going on to work for another hour or more at home, 35% doing that in 2012.

Table 2 lists individual activities contributing to the working day in rank order for 2012 and 1993. The range of activities reported in 2012 is broader than that reported in 1993. Both administration and acute ward work were

undertaken by over 60% of consultants on the Wednesday in 1993; only administration rated so highly in 2012, and acute ward work had fallen to 26%. Other hospital-based clinical activity was also less prominent: time in long-stay care fell from 27% to 3%, and day hospitals from 36% to 3%. Outpatient activity, however, remained steady in the high teens and was supplemented in 2012 by Memory Clinics (16%) and Health Centre Clinics (8%). Planned visits to patients at home increased from 23% in 1993 to 30% in 2012. More time was given to teaching and to supervision of junior staff, but personal study and research by consultants received even less time allocation in 2012 than in 1997 (Jolley and Benbow, 1997).

Qualitative data

The qualitative data consisted of respondents' free text answers to two questions: what are the three things that are stressing you most in your job, and what are the three things that support you most in your job? Figure 2 sets out a model showing the stresses and supports identified in the analysis. Although we include below reference to the numbers of text segments coded under major themes, these numbers depend on coding practice: they should be regarded only as indicative, in general terms, of the overall pattern of coding and one text segment might be coded to more than one theme.

Stresses

The two main themes identified were: lack of resources (242 coded text segments (CTS)) and management (201 CTS). Three minor themes were:

constant change and uncertainty (61 CTS); personal and morale issues (46 CTS); and clinical factors (31 CTS).

1. Lack of resources: Increasing demand was an issue here:

> '*increasing clinical workload and expectations with no more time'*
>
> '*too much of it (work); impossible to cope with demands in contracted hours'*

as was lack of time. One respondent simply wrote:

> *'My hours are too long.'*

and another noted that:

> '*General workload is excessive for hours employed'*.

This theme also covered lack of resources in specific areas:

(i) administrative/ secretarial support - as illustrated in two comments below:

> *'appalling secretarial support - 5 to 6 weeks to get a letter out',*
>
> *'extremely limited secretarial support so that outpatient letters take at least 4 weeks to be typed'.*

(ii) medical support included both quantity and quality of medical staff:

> '*being the sole dedicated medic for my sector, no dedicated junior support for long stay ward (both of which came about when staff grade post was CIPed*[1] *when the incumbent moved elsewhere)*'
>
> '*low quality of core trainees that can not work independently and can not pass any exams'.*

(iii) management involvement and availablity were identified stressors:

[1] CIP means Cost Improvement Programme and is a term used as a synonym for cuts.

'*increasing demand for involvement in meetings/committees at the expense of clinical work';*

'*medical staffing - the medical staffing department has been shut so noone is responsible for organising the rota, therefore when I've been on call recently, every time the junior doctor has failed to appear for their shift'.*

(iv) other staff shortages were another source of stress:

'*no replacement of staff following retiral or on long term sick (numbers very depleted) but increased pressures on me to run an effective and bulletproof service'*;

'*cuts to service provisions, including frontline clinical staff*'.

(v) Facilities were also highlighted here, largely lack of beds with resulting pressure to find a bed when someone needed admission, plus a lack of office space.

2. Management: This included bureaucracy, form filling, computer systems or, in the words of one respondent:

'*Increasing amount of paperwork and form-filling which adds little or nothing to patient care*.'

One person gave their three stresses simply as:

'*NHS red tape; NHS red tape; NHS red tape'*,

and a number of people commented on how computer systems had slowed things down and hindered access to information. Similarly targets figured here:

'*A "target driven" culture. I feel I am constantly failing to meet unrealistic targets. Success in this organisation is calculated by dashboards rather than what is delivered at the coal face. While I accept there may be some benefit from this approach the pendulum has swing too far towards achieving targets*.'

'Achieving any target is minimalised and the next round of what you are failing to meet hits the agenda and off we go again.'

and financially driven cuts:

'*the iterative annual erosion of services (from CRES[2] savings)*'.

Some people commented on their lack of control or influence, as illustrated here:

'*feeling helpless to influence things in my team'* and

'*other people making decisions about my working practice without even consulting me'*.

3. constant change and uncertainty (minor theme) included concern about the NHS generally and the future of old age psychiatry in particular:

'*changes (unnecessary I might add) to local service provision (replacing "old age psychiatry" with organic/functional split)*' and

'*rapid changes in service provision without adequate consideration of impact on patients and staff - all to do with efficiency, but not actually efficient*.'

[2] CRES is the acronym for Cost Releasing Efficiency Saving, another synonym for cuts.

4. Personal and morale issues (minor theme) included working with unhappy demoralised or difficult colleagues, travelling and parking, worry, isolation and tiredness, and a few more personal comments such as:

> *'having to constantly apologise for the absence of things - from Social Services support to admission beds and most other things you can mention'*.

5. Clinical factors (minor theme) included complaints, challenging patients and families, but also inappropriate referrals and a feeling of personal responsibility for lack of continuity of care and poor standards of care.

Supports

The two major themes here were work supports (449 CTS) and other people (86 CTS), but work supports often captured relationships with people the old age psychiatrist worked with.

1. Work supports

(i) Adminstrative support was a major subtheme here, usually a good, excellent, supportive, or efficient secretary or personal assistant (PA) (101 CTS).

(ii) Colleagues was a word which featured repeatedly (99 CTS) (often prefaced by an adjective such as good, great, excellent, supportive or empathic) but, when qualified, it referred to a wide range of professions operating in various different settings. It was closely followed by:

(iii) team (81 CTS), often the community mental health team, but also various other teams, and again adjectives were applied by some; including excellent, good, experienced, supportive, conscientious, strong and cohesive.

(iv) Medical support (72 CTS) was also a large subcategory, usually consultant colleagues, but also trainees and specialty doctors/ staff grades.

(v) Trust managers of various types were less prominent (42 CTS) but included:

> '*a sensible Chief Executive who I've meaningful dialogue with*'.

(vi) Some people commented on aspects of their work pattern as being supportive eg time to think; or a particular activity (research or teaching) as sustaining them, but each of these was a minor sub-theme.

2. Other people (86 CTS) was a theme capturing people other than working colleagues, namely friends, family, patients and patients' relatives. It appears that patients and their families are more often regarded as supports than stressors. One person described:

> '*pleasures and privilege of clinical encounters with both patients and carers*'.

3. Personal supports (minor theme) (41 CTS) captured a range of enjoyment, interest and job satisfaction and also personal characteristics (including one person with a '*sense of black humour*').

4. Rewards was a minor theme (23 CTS) including pay, respect, early retirement.

5. Similarly things/ objects was a minor theme (only 13 CTS) including laptops, phones, offices.

If the people within the working environment who were seen as supportive were combined with people outside work, then relationships were overwhelmingly the major support of responding old age psychiatrists.

Discussion

In the 20 years since our original work, the National Health Service and mental health services have undergone serial reorganisations in the UK, and these have changed the shape and probably the dynamics of Old Age Psychiatry. 'New Ways of Working' was an initiative, which was intended to reduce the workload and stress perceived by consultant general psychiatrists (CSIP/NIMHE, 2007; Department of Health, 2005). It was subsequently generalised across mental health services and, in association with reduced finances and remodelled facilities, resulted in unanticipated service changes including the introduction of a split between functional and organic services, loss of continuity of care and changes to consultant responsibility (St John-Smith *et al.*, 2009). 'New Ways of Working' has attracted considerable controversy as enthusiasts have been countered by outrage from traditional clinicians who feel cheated of their role and the satisfaction of delivering continuity of care which is valued by patients and families (Dale and Milner,

2009; Rathod *et al.*, 2011; Royal College of Psychiatrists, 2011; Singhal *et al.*, 2010).

Services for older people and services specifically for people with dementia in the UK have experienced different pressures. Anti-dementia drugs have entered mainstream old age psychiatry practice (National Institute for Health and Clinical Excellence, 2011). An ambitious National Dementia Strategy in England (Department of Health, 2009) has been followed by similar initiatives in Scotland, Wales and Northern Ireland (Department of Health Social Services and Public Safety Northern Ireland, 2011; The Scottish Government, 2010; Welsh Assemby Government, 2011) in keeping with a world movement to respond to the dementia epidemic (World Health Organisation, 2012). Indeed, many countries have national dementia plans at various stages of development (see the Alzheimer Europe website http://www.alzheimer-europe.org/EN/Policy-in-Practice2/National-Dementia-Plans and Alzheimer's Disease International http://www.alz.co.uk/alzheimer-plans).

The UK dementia lobby has become powerful and effective and has required, via the National Dementia Strategy, that every locality provides a memory clinic, a phenomenon imported from the USA and adopted in many other countries as a way of reaching people earlier in their difficulties, with good quality assessments and minimal stigma (Jolley *et al.*, 2006). There is additional pressure to identify and respond to the special needs of people with dementia when they enter a general hospital (Alzheimer's Society UK, 2009) and to improve care and continuity within Care Homes and the community

(Alzheimer's Society UK, 2007; Banerjee, 2009). But what about the larger number of older people who experience problems of mood or other short or long term disorders other than dementia? There is continuing controversy, as blinkered interpretations of the need for age equality (Royal College of Psychiatrists, 2009) and age integration of services (Hill, 2008), threaten to dismiss the gains of specialized services for older people in the UK, while no-one questions the desirability of designated services for children and adolescents (Department of Health, 2004). Thus the needs of people with dementia are receiving attention in the UK, but there is concern that this is occurring at the expense of older people with other mental disorders (Age Concern, 2007) and the marked variation in how services function identified by Challis and colleagues has probably become more not less marked over recent years (Challis *et al.*, 2002).

It seems likely that all these changes have influenced the work patterns of old age psychiatrists. We first gathered information about work patterns in Old Age Psychiatry in the UK in the early 1990s starting with a simple audit of activities on one day amongst colleagues attending a Section (now a Faculty) meeting (Benbow et al 1993). This suggested that old age psychiatrists had long working days leaving little opportunity for family life, recreation, personal study or research. This pattern was confirmed by more detailed studies using questionnaires covering every day of the week and including measures of stress and burn out (Benbow and Jolley, 1997; Benbow and Jolley, 1999; 2002). People were at work on average nearly 9 hours per day during the working week (except on Fridays); in addition more than 40% did work at

home on every weekday except Friday and more than 30% worked at home on Saturdays and Sundays (Jolley and Benbow, 1997). Many identified symptoms of stress and burnout which they related to work overload and organisational structure and climate (Benbow and Jolley, 1997; Benbow and Jolley, 2002). Our new study shows that, despite attention to consultant psychiatrists' workload and despite changes in how services are provided, the working hours of consultant old age psychiatrists in 2012 are very similar to those in 1993 and 1997. Many start work early and finish late, and spend at least as long on administration as they did in the 1990s.

What has changed is the activity profile of UK old age psychiatrists. Work in long stay care has decreased considerably, but perhaps care home liaison should be regarded as a replacement for it, since care homes provide the vast majority of long term care. Memory clinics have been given a boost since the introduction of the National Dementia Strategy, and there is growing interest in primary care memory clinic models (Greaves and Greaves, 2011; Jolley *et al.*, 2010). Day hospitals have become unfashionable: the Royal College of Psychiatrists survey of day hospitals described day hospitals as 'becoming "silted-up" with patients who would be better provided for by social care' (Day Hospital Network (Faculty of Old Age Psychiatry), 2008; Holmes *et al.*, 2010) and acute bed numbers have fallen (Keown *et al.,* 2011). Overall there has been a shift away from time devoted to the clinical care and treatment of patients on the in-patient wards, towards work with patients and families via clinics at the hospital, in Health Centres, in their own homes and/or in other care settings, such as general hospitals and care homes. More time is given

to support and teaching of doctors and others in training, but the benefit of personal study and involvement in research to consultants (as identified in previous work) is neglected. Greater outreach activity has to be a good thing, but loss of specialist inpatient and day hospital facilities may have adverse effects, especially for patients with the most severe symptoms. This loss may result in personal suffering and additional pressures in other care-settings. Loss of continuity of care is certainly felt by patients and families. The apparent disregard of the need for consultants to have time for personal study and involvement in research or audit is worrying, for these activities can refresh them and provide the opportunity for valuable reflection to measure where services are achieving good or floundering. Such feedback from the clinical interface would give ownership to clinicians and ensure honest responsiveness and best use of resources.

The move to reorganize into so-called functional teams in UK psychiatry was not investigated directly here. Where applied to services, it has divided psychiatrists into community and hospital-based consultants (a change imported from general psychiatry) (Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists, 2011; Goldberg, 2008), and this change (perhaps alongside a decrease in bed numbers (Keown *et al.*, 2011)) may partly explain why fewer respondents in 2012 report time on acute wards. Similarly the introduction of consultants in liaison old age psychiatry (Holmes *et al.*, 2010; Royal College of Psychiatrists, 2005) may explain why general hospital liaison has failed to become a more prominent activity amongst old age psychiatrists as a group, despite growing acknowledgment of its

importance. Another driver for change has been misinformed interpretations of the need for age equality (Royal College of Psychiatrists, 2009) and age integration of services (Hill, 2008). The Royal College of Psychiatrists' position statement on age discrimination points out that:

> 'comprehensive specialist mental health services for older people are essential to meet need across the life cycle. This is consistent with the principle of recognising people's different needs, addressing those needs in an equal way and not treating all people the same when their needs are different.' (Royal College of Psychiatrists, 2009)

Banerjee's work on anti-psychotic drug prescribing emphasises the need for specialist services (Banerjee, 2009), as does the Dementia Guideline (NICE/ SCIE, 2007) which refers to Everybody's Business (Department of Health/ Care Services Improvement Partnership, 2005) and:

> 'specialist mental health services, including community mental health teams, memory assessment services, psychological therapies and inpatient care.' (NICE/ SCIE, 2007) page 20.

There is no doubt that meeting the challenge of increasing numbers of people older people living with dementia and other mental disorders is an issue that clinicians, managers, governments and societies across the world need to address at a time when there are financial constraints and concern that demographic changes will limit the available workforce (Draper and Anderson,

2010; de Mendonça Lima *et al.*, 2012; Jeon, 2012). Old age psychiatry will need to respond to this challenge by evolving ways of working which make specialist expertise available to those who need it, whilst supporting other professionals in continuing to care for people with dementia and their families, in both primary and secondary care. This pilot project suggests that work patterns in old age psychiatry are indeed changing in response to these demands, within the constraints placed upon the specialty. In other countries old age psychiatry has achieved specialty status (eg Canada (Andrew and Shea, 2010)) or aspires to develop its specialty/ subspecialty knowledge, training and practice across the whole range of mental disorders in later life (Colenda *et al.*, 2005; Ribeiro *et al.*, 2010; Stek *et al.*, 2008) and across different professions involved (Pachana *et al.* (2010) write about the same issue in relation to psychology).

The method employed in the study involved the Faculty of Old Age Psychiatry in sending out a link to an electronic questionnaire to their members so that they could respond anonymously. A majority of old age psychiatrists in the UK will belong to the Faculty of Old Age Psychiatry, but the Faculty circulation list includes many members who are not old age psychiatrists but who choose to be on the list because of an interest in older adults. In addition at any time there will be numbers of email addresses listed, which are no longer functioning. Thus it is not possible to know how many Faculty members were asked to take part in the survey. The Workforce Review Team quote a figure of 510 consultant old age psychiatrists in 2007 (NHS Workforce Review Team, 2008): it would be reasonable to estimate that about 40% of old age

psychiatrists have responded to the survey. Those consultants who are most stressed and over-worked may be less likely to respond so the details of hours worked and stresses perceived may represent underestimates. The results are a snapshot of work patterns, stresses and supports in one country and do not necessarily generalise to other areas of the world. They do, however, offer a description of what is happening in the UK, and a base which people in other countries can use for comparisons.

It will be important to explore these changes further in the UK through a survey of a representative whole week and its work. In addition we should attempt to monitor the impact of these work-patterns and hours on the health, well-being and morale of consultants and on the appropriateness and effectiveness of services. It will, perhaps, be even more important to look at different service models around the world and how specialist expertise is made available to those who need it in different economic and social contexts. Our concern is that financial pressure has become the main factor re-shaping services, often in response to short term considerations. Whilst economic considerations are undoubtedly very important, they must not obscure the need for care and humanity.

Conflict of interest declaration

Neither author receives any fees or grants from, employment by, consultancy for, shared ownership in, or close relationship with, any organisation or individual whose interests, financial or otherwise may be affected by publication of this paper.

Description of authors' roles

Both authors were involved in all stages of the study.

Acknowledgements

The authors wish to thank all those consultant old age psychiatrists who responded to the survey and the Faculty of Old Age Psychiatry for circulating the invitations to take part.

Table 1: Respondents' gender profile, age profile and breakdown of time in years in current post

Characteristic	Number of respondents	% of respondents	Comparison with previous surveys
Gender			**Gender in 1997:**
Women	97	48	45%
Men	106	52	55%
Age profile			
30-39	34	17	Not recorded in 1993. In !997 median age 42, age range 33-65.
40-49	90	44	
50-59	77	38	
60-69	4	2	
Years in post			
<5yrs	61	30	No comparative figures
5-9	66	32	
10-14	40	20%	
15-19	27	13%	
20-24	9	4%	
25+	1	0%	

Table 2: Proportions of respondents spending time in particular activities on one Wednesday in 1993 and in 2012, listed in rank order

Rank order	1993	%	2012	%
1	Acute ward	64	Administration	68
2	Administration	63	Home visits	30
3	Day Hospital work	36	Acute wards	26
4	Travel	33	CMHT	26
5	Long stay care	27	Travel	24
6	Home visits	23	Other	20
7	Out patients	19	Out patients	16
8	Local committee	18	Memory Clinic	16
9	General hospital liaison	10	Supervision	14
10	Teaching	9	Local committee	14
11	Supervision	7	Teaching	14
12	Relatives	5	General hospital liaison	11
13	Study	5	Care home liaison	11
14	Research	5	Relatives	9
15	Professional visits	3	Professional visits	9
16	National Committee	2	Health Centre	8
17	Eating	0	Research	5
18			Study	3
19			Long stay care	3
20			Day Hospital work	3
21			National Committee	1
22			Eating	0

Figure 1: Consultant old age psychiatrists' hours at work in 1993 compared with 2012