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Hospitals in the NHS

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Based on working papers of the Royal Commission on the NHS

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1

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CONTENTS

EDITORS' INTRODUCTION

The Royal Commission on the National Health Service considered at some length patient attitudes to hospital services, government policies on hospital provision, the relationship of hospitals to community health services, the problems of teaching hospitals and hospital management. Their deliberations and recommendations are outlined in chapters nine, seventeen and twenty of the Royal Commission's report.[1] The papers reproduced here were written as background to the Royal Commission discussions on these far-ranging subjects. They include a descriptive paper on hospitals in the NHS prepared by the Secretariat of the Royal Commission which has been updated since the publication of the Royal Commission's report, and papers from members of the Commission describing the problems of the relationship between hospital and community services from their various professional viewpoints. These papers are but a few pieces made available to the Royal Commission on this subject. They received a wide variety of information and views through evidence submissions, discussions with experts, hospital visits, and commissioned research. The latter included a major survey of patient attitudes to hospital services conducted by the Office of Population Censuses and Surveys.[2] The views expressed here do not necessarily reflect the views of the Royal Commission or of the King's Fund.

This is the fifteenth in a series of project papers based on the background papers of the Royal Commission on the NHS. We are grateful to King Edward's Hospital Fund for London for giving us a grant to enable this series to be produced, and to the Polytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

1 GREAT BRITAIN, PARLIAMENT. Report of the Royal Commission on the NHS (Chairman: Sir Alec Merrison) London, HMSO, 1979 Cmnd 7615.

2 GREGORY, JANET, Patients' Attitudes to the Hospital Service, Royal Commission on the National Health Service, Research Paper Number 5, London, HMSO, 1978.

HOSPITALS IN THE NHS: A BACKGROUND PAPER
by the Secretariat of the Royal Commission on the NHS

INTRODUCTION

In 1948 the NHS took over 2 800 local authority and voluntary hospitals with a total of just over 500 000 beds. In Great Britain in 1977 there were 2 655 hospitals with a total of 463 000 allocated beds.[1] (Northern Ireland had 98 hospitals with 18 038 beds in 1975). Nearly half of these hospitals had been built before 1891. The stated aim of the hospital service since 1948 has been 'to achieve a more rational system in addition to correcting the worst local deficiences and adjusting to changes in medical knowledge and practice, plus development of supporting skills'.[2]

Policy evolved since then has been to build a network of district general hospitals providing for the whole population of its district the full range of specialised treatment for acute specialities and the necessary diagnostic and supporting facilities. More recently this policy has expanded to include the provision of community hospitals for long or short stay patients who do not need specialised facilities, but require care that cannot be given at home. [In May 1980 two years after this paper was written the Department of Health and Social Security published a consultation paper (Hospital Services, the Future Pattern of Hospital Provision in England) recommending that in future hospitals should place 'less emphasis on very large hospitals and allow for the retention of a wider range of local facilities ...'. In summary what is proposed is:

1 to retain the basic concept of the district general hospital but with less emphasis on concentration of services on large hospitals;

2 to accept the provision of district general hospital services on more than one site as a valid long-term policy, thus retaining many medium-sized hospitals in urban areas and enabling the main hospitals to be normally of no more than 600 beds, with exceptions to meet special requirements;

3 to retain small and medium-sized hospitals wherever sensible and practicable, particularly in rural areas where the population is widely spread and existing hospitals serve an identifiable local population.]

HOSPITAL TYPES AND NUMBERS

Two types of hospital are defined in the Priorities Document [3] and DHSS Circular DS 85/75. They are district general hospitals and community hospitals.

District General Hospitals

The policy on district general hospitals (DGHs) is that they should provide for the whole population of its district a full range of specialised treatment, including a maternity unit, a psychiatric unit, a geriatric unit containing at least half the geriatric beds, and a children's department as well as specialised surgical and medical facilities. Some, but not all, DGH's would have accident and emergency units, and some would have in-patient units for ear, nose and throat and ophthalmology. Some would also provide regional specialties such as neurosurgery.

Precise statistics are not available on the number of DGH's in existence. The only available information so far is contained in the DHSS circular DS 85/75, Annex 2 which states that:-

'The objective is to create about 250 district general hospitals in England, with associated community hospitals where appropriate. It has hitherto been assumed that a DHG should be on a single site, and either completely new building or extensive alteration, upgrading and/or extension of existing buildings is needed. The national picture of progress and intentions in December 1973 (before the reductions in the capital programme) was:

A	DGH expected to be substantially complete by 31.3.76.		
	On new sites	34	
	On existing sites	30	64
B	To be started but not substantially completed by 31.3.76		125
C	To start after 31.3.76		62
		Total	251

It was expected that the programme would have made very substantial progress towards completion by the year 2000 but this picture will be substantially affected by the reductions in the capital programme starting in 1973/74. Future progress will depend on capital available in subsequent years, and priorities for its use'.

Since 1975, the cuts in capital expenditure have led to a substantial slowing down of the development of these plans. Health authorities were encouraged to examine the possibilities of achieving a comprehensive service by better integration and co-operation of geographically separate units even where the most effective and economic solution in the longer term may be redevelopment on a single site. Linked to this policy is the concept of the nucleus hospital which aims to provide an economic basic hospital design for around 300 beds which can be used when complete but can also form the first phase of a district general hospital.

Community Hospitals

Community Hospitals are defined by the DHSS in the Priorities Documents and Circular HSC(IS)75 as: Hospitals 'for those patients not requiring the full specialist facilities of a DGH, and often nearer their own homes. While arrangements will vary according to local conditions (including population density), up to a quarter of all in-patient beds and many day places might eventually be in community hospitals.

It is intended that up to two-thirds of community hospital beds should be for geriatric patients and for elderly patients with severe dementia. The remainder would be medical or post-operative surgical patients including pre-convalescent cases transferred from the DGH.[3]

In *The Way Forward* (paras 2.15 to 2.17) this definition was repeated but a more flexible approach to the development of community hospitals was advocated: 'Detailed aspects of the previous guidance on community hospitals (HSC(IS)75) should not stand in the way of flexible and practical solutions agreed locally'.[4]

Further clarification of this definition was issued in DHSS Circular HC(78)12. Paragraph 2.9 of this Circular says: 'RHAs have been advised that, for the purpose of constructing revised strategic plans, a community hospital should be regarded as a local hospital which:

- it is intended to retain to provide services for patients living locally who do not need the full specialist facilities of a DGH;
- does not form part of a DGH complex;
- provides services for patients under the care of general practitioners as well as patients under the care of hospital consultants (precise arrangements for the management of medical care are for local discussions);
- is not confined to one speciality;
- where appropriate and practicable, provides among other services, rehabilitation and continuing care of elderly patients, including the elderly severely mentally infirm'.

The original policy for the development of community hospitals never really got off the ground partly because progress in DGH development has been slowed down due to the reduction in the capital programme (small general hospitals have been continued in use that might otherwise have been developed as community hospitals), and partly because of unresolved differences about the range of services and medical staffing of community hospitals. The present position appears to be that the DHSS expects the new flexibility to encourage the designation of more small hospitals as community hospitals and that strategic plans will provide details. The 'new flexibility' seems to mean that some specialist

facilities (eg minor and intermediate type surgery, radiology and other diagnostic services) can be provided in community hospitals.

The concept of community hospitals seems to have had a mixed reception amongst the medical profession. Some of the problems were spelled out in an article in the BMA News Review in 1976 and centre around the possibility of finance being diverted from the acute sector and the roles of consultants and GPs in these hospitals. The article admits that 'there is some element of GP-Consultant rivalry in the community hospital controversy'.[5] Reading between the lines it seems that the BMA's real concern is with money. Two crucial issues seem to be (a) how will doctors working in community hospitals be paid, and (b) if resources are used to build up local community hospitals, will specialist facilities in DGHs suffer.

The Oxford Experience

Several articles and papers have been produced which describe the concept and working of the Oxford experimental community hospital unit set up in Wallingford in 1973. This hospital/health centre provides accommodation for five general practitioners, specialist out-patient clinics, 17 in-patient beds and a 20-place day ward. A second phase will add a further 38 beds, mainly for the longer-term care of the elderly. Reports of its success come from the Health Service Evaluation Unit but some critics have said that this was an experiment with enthusiasts and therefore not a fair test.

Evidence to the Royal Commission on NHS Hospitals

In the evidence submitted to the Royal Commission on the NHS, concern was expressed about the concentration of hospital services in a smaller number of large hospitals. In particular, there was a clear consensus from evidence given in rural areas that hospital services should be decentralised by the development of community hospitals. For example Powys Area Health Authority outlined five principles on which community hospitals in rural areas should be based:

1 They must be accessible to the population they serve.
2 In-patient facilities must be flexible in order to accommodate seasonal and other variable factors.
3 Out-patient facilities for consultant clinics should be provided.
4 Diagnostic services should be capable of supporting the out-patient and in-patient needs.
5 Day treatment facilities should be expanded to all such hospitals in order to meet the ever-growing needs of an ageing population.

These views were supported by the Association of Metropolitan Authorities which recommended a significant move towards the development of community hospitals providing medical, not necessarily specialist care and by the Royal College of General Practitioners who wished to see the reduction of unnecessary use of specialist hospital resources by the development of community hospitals where general practitioners working in cooperation with local specialists could look after patients who could not be nursed at home but who would remain near relatives and friends.

Sheffield City Council were critical of the development of DGHs where the present trend towards specialisation in the fashionable fields of medicine had dominated and overshadowed community health services. The British Medical Association submitted a future framework for hospital services which reflected the main view in the evidence to the Commission: the DGH should be linked to one or more local hospitals thus improving access of both patients and their relatives to the hospital system.

Comment

There is still considerable confusion about the term community hospitals and how they differ from cottage hospitals and GP units. It seems reasonably clear that the concept of and policy on community hospitals developed in the late 1960s/ early 1970s, partly in response to public outcry against the closure of local hospitals and the development of large remote DGHs, and partly through financial cutbacks which inhibited the planned development of hospital services. The policy guidance issued by DHSS (outlined above) seems to indicate that community hospitals should

be small, offer a limited range of services and be staffed by local doctors. In this respect it is not clear how they do differ from the old cottage or local hospitals.

The most important issue however which does not seem to have received much attention is related to geriatric provision. Paragraph 3(11) of DS85/75 Annex 2[6] (which discussed present policies for hospital services) talks of a community hospital serving up to half the geriatric beds for a population of 30 100 to 100 000. Enquiries about how this figure was reached revealed that it derived from an earlier circular, issued in 1971, on the siting of geriatric beds.[7] This advised that beds required for diagnosis, assessment, immediate treatment, intensive and medium stream rehabilitation (amounting to 50 percent of geriatric bed-need) should be sited in the DGH. The remaining beds for slow-stream rehabilitation, continuing care and holiday relief need not be in DGHs and could be sited elsewhere. When the community hospital concept was developed, this was seen to be the appropriate site for the non-DGH beds - a long-term aim. It seems likely that not more than 30 percent of geriatric beds on the DGH site in all districs will be achieved for some time to come.

The norm for geriatric beds (mentioned in para 5 Annex 2 DS85/75) is 10 beds per 1 000 population aged 65 and over. This ratio was arrived at in **1957** following a review of services for the chronic sick and elderly, as sufficient to give a reasonable hospital service in an area with a fully effective geriatric service and adequate domiciliary and welfare services. It is generally accepted now that this figure needs revision in view of the greater increase in the population aged 75 and over, and in the context of modern practice and policies in geriatric medicine.

If however geriatric bed norms are increased before DGHs are able to meet their planned 50 percent, it seems clear that community hospitals will have to take increased numbers of geriatric patients. This will have implications for the staffing and organisation of community hospitals. If, in addition, the policy of decanting old people from mental hospitals into the community is pursued, community hospitals are likely to be under pressure to take a higher than envisaged proportion of senile dementia cases.

The Oxford Community Hospital recognised the risk of their experimental unit being filled with elderly long-stay patients and sought to avoid this and other problems by drawing up a code. The code says that the admitting GP should prepare notes for direct admission in which the predicted duration of stay should be stated and that no patient should have a predicted duration of stay longer than 13 weeks; GPs of patients with predicted or actual stays of longer than this are asked to seek specialist advice. In this way the unit sought to avoid patients becoming long-stay inadvertantly without a specialist assessment. The risk of long-stay elderly patients being transferred from district hospitals was also recognised, by the unit. In an article 'Community Hospitals and General Practice', AE Bennett, Director of the Health Services Evaluation Group at the University of Oxford commented 'One other check in the system relates to the transfer of patients. Here the intention is to provide the unit with some degree of safeguard as it seeks to maintain a reasonably balanced case mix. It recognises the problem of requests for transfer of long term recovery cases from general medical firms of the district hospital. When these refer to elderly patients it is recommended that they are channelled through the geriatrician so that his assessment and advice are available'.[8]

It seems clear from the Oxford experience that a committed team of professionals and administrators working in a fairly prosperous region can overcome the problems facing the development of community hospitals. Success however can lead to further problems. Where experiments like this are successful in offering a better or different service, local expectations change and demand increases. In areas where commitment to the concept of community hospitals may be strong but resources limited, frustration may increase. If the development of community hospitals takes place more slowly than other policies, transferring the mentally ill from large mental hospitals to the community, for example, a serious mismatch of physical and manpower resources will occur.

In summary, there seem to be four major issues involved in consideration of community hospitals in addition to the usual problem of limited finance. They are:

(a) lack of clarity about what a community hospital is and does;

(b) the risk of their turning into long-stay hospitals for the elderly and therefore being 'unattractive' to professionals;

(c) inter-professional disputes, for example between the general practitioner and the consultant, about bed and patient responsibility. This is linked to methods of remuneration for doctors working in community hospitals;

(d) since community hospitals are seen as a long-term development there is a risk that other related policies will be implemented in advance which will pre-determine the service they must offer.

Teaching Hospitals:

There are twelve post-graduate teaching hospitals, all of them in London. There are 33 medical schools in the UK; 26 in England, five in Scotland, one in Wales and one in Northern Ireland. The General Medical Council publishes a list of all hospitals recognised for teaching purposes. The current publication (1976) lists 511 such hospitals in the UK; 407 in England; 65 in Scotland; 22 in Wales and 17 in Northern Ireland.

There appears to be no statutory definition of teaching hospitals although they are generally regarded as those associated with a university undergraduate medical school and in the case of postgraduate hospitals, with an institute.

Certain hospitals have been generally treated as teaching hospitals, but in addition much teaching is carried out at associated 'non teaching' hospitals. Indeed some such hospitals have, to make the situation more complex, been termed by academic authorities 'University Hospitals'. The White Paper on NHS Reorganisation described the organisation of area health authorities which provide substantial facilities in support of medical and dental teaching as Area Health Authority (Teaching) (AHA(T)s).[9]

Whereas an AHA has only one member nominated by the University the AHA(T) has two and at least two additional members with teaching hospital experience. On the whole the deployment of clinical services in support of teaching, as for the service provided to patients by those hospitals, is a matter for the local regional health authorities and AHA(T)s in consultation with University Liaison Committees and the appropriate medical schools.

The Resource Allocation Working Party (RAWP) report recognised the additional service costs to health authorities of the presence of medical and dental undergraduate students and in Chapter 4 set out methods for determining an allowance, SIFT, deemed to cover the additional service costs incurred by the NHS in providing clinical teaching facilities to ensure that it is taken into account in the revenue distribution process to RHAs, AHAs and districts. In addition the DHSS gave an assurance that the allocations to teaching districts would be monitored, and this has been a regular commitment of the regional divisions.

There is no statutory definition of a teaching hospital in Scotland, nor has there been since the inception of the NHS, but the definition could perhaps be said to be a hospital where undergraduate medical students receive their clinical training and junior doctors their higher specialist training. In the main the teaching hospitals are situated in the same area as the medical schools ie Edinburgh, Glasgow, Aberdeen and Dundee. However, there is currently a trend to spread clinical teaching of undergraduates from the traditional centres and the extension of teaching facilities at Inverness by Aberdeen University has in fact taken place.

The training of senior registrars takes place also in the four teaching areas in the main, but a handful of senior registrars are seconded from Edinburgh and Glasgow to Fife and Dumfries and Galloway areas respectively. These arrangements evolved during the period when the hospitals involved were administered under the same regions prior to the reorganisation under the NHS (Scotland) Act 1972.

On medical staffing, a higher ratio of consultants is allowed for teaching hospitals than for non-teaching hospitals in Scotland. When the Committee on Medical Staffing Structure in Scottish Hospitals reported in 1964 (Wright Report) they pointed out that the teaching hospitals in Scotland formed a higher proportion of the total hospital service than was the case in England and Wales. In setting manpower levels they provided for a higher ratio of staffing for teaching units in the recognition not only that there was a teaching and research commitment but that the nature of the work itself was often more complicated and the investigations more elaborate. In practical terms they determined a formula which allowed that teaching hospitals as compared to non-teaching hospitals had a hundred percent more consultants in their professorial units and fifty percent more consultants in their other teaching units. There are no recognised ratios of consultants to population for any of the specialties in teaching areas but the Advisory Committee on Hospital Medical Establishments - a joint committee with representatives from the profession and from the department advising the Secretary of State on medical manpower levels in hospitals - considers the teaching commitments and the provision of supra-area speciality services when recommending the size of the consultant establishments in specialities in teaching hospitals. Funds are not allocated specifically to teaching hospitals but teaching areas have a higher financial allocation than non-teaching hospitals based to some degree on historical costs reflecting the extra commitments. The establishments in the junior grades are, of course, higher in the teaching hospitals where most of the postgraduate training takes place.

With regard to other staff, the Aberdeen formula for assessing nurse-staffing needs takes into account the distinction between hospitals which have clinical places for students and pupil nurses and those which do not. Because teaching hospitals are also generally the hospitals that carry out the more complex and sophisticated treatments, they are probably more fully staffed with professional and teaching support than non-teaching hospitals and probably have more administrative and clerical staff. But that is basically a consequence of the types of service they provide, not of the fact that they train medical students, and the staffing required will be assessed by the health board in the same way as for other hospitals.

During the SHARE discussions, mention was made of the need for more information on the hospitals which offer specialist courses for nurses so that some account could be taken of the financial implications of these courses.

Hospitals with teaching responsibilities are financed in exactly the same way in principle as all other hospitals. Teaching responsibility is one of the elements which enters into the functional classification of hospitals; this classification was produced some years ago by a committee of the senior administrative medical officers of the former regional hospital boards. The main use to which this classification is put in financial management as far as the SHHD is concerned is in the distribution of revenue monies to health boards. This is now being done under the recommendations of the SHARE Report when it is used to establish the total size of the teaching commitment and supra-area services in Scotland. [10]

Specialist Hospitals

The specialist hospitals were a development of the middle of the nineteenth century. They developed for a number of reasons, including the slowness of the voluntary teaching hospitals to accept the emergency of new clinical disciplines, and in some cases the desire on the part of some doctors for professional advancement. A good account will be found in the Third Report of the Select Committee of the House of Lords (1892), and more recently in Appendix 14 to the Todd Report (1968).[11]

Outside London, specialist hospitals were few in number and often came to be grouped with the teaching hospital as a specialist part of the teaching group. In London they maintained far more independence and after the 1939-45 war the development of institutes associated with the British Postgraduate Medical Federation strengthened them in an academic sense.

The 12 postgraduate teaching hospitals were not affected by the main provisions of the 1974 and 1977 Health Service Acts. They are adminsitered by 12 separate boards of governors which are preserved by Order till 1979.

In 1978 the DHSS issued a consultative documents on the future management of London's specialist post-graduate hospitals. Three main options emerged concerning the future management arrangements for these hospitals. These are: direct management by AHA(T)s, with no additional statutory authority; Special Health Authorities (SHAs) accountable to specified RHA s; and a single SHA accountable to specified RHAs; and a single SHA accountable to the Secretary of State.

The Todd Report and Specialist Hospitals

In 1968 the Royal Commission on Medical Education (Chairman Lord Todd) commented as follows on London's specialist postgraduate teaching hospitals.

> London has long occupied a leading position in medical education and practice and its medical schools are known throughout the world. Medical education in London developed, however, as an adjunct of the great voluntary hospitals and, at the postgraduate level, of the numerous special hospitals which sprang up in the London area during and since the latter part of the nineteenth century. The growth of the twelve London undergraduate medical schools has been rather haphazard; the schools vary widely in size and are semi-autonomous bodies whose relation to the central university authorities is less close than that of medical schools elsewhere. In our view the maintenance of twelve medical schools, each with its independent teaching hospital group and without direct contact with a single multi-faculty college of the University of London, is not compatible with a continuation of the highest standards of medical education in London in the long-term future. The central university authorities, and the staff of the medical schools and their associated hospitals, have by great skill and determination been able to make the present arrangements work effectively for many years; they deserve a more appropriate and modern setting. [11]

Their report recommended a series of mergers which would reduce the number of London medical schools to six and that the specialist teaching hospitals be brought into physical proximity with general teaching hospitals and their associated postgraduate institutes be integrated with the appropriate undergraduate medical schools. They regarded the separation of postgraduate training and research from the main stream of medical education and medical care as indefensible as well as uneconomic.

By June 1978 little progress had been made on Todd's recommendations that postgraduate hospitals should be associated and in some cases rebuilt with undergraduate teaching hospitals.

In Scotland, a separate Scottish Council for Postgraduate Medical Education was set up with regional postgraduate committees after publication of the Todd Report. The Todd Report had recommended a central council with a Scottish committee but the professional bodies in Scotland preferred a separate council. Close liaison takes place among the chairmen of the postgraduate councils.

[In February 1980, eight months after the publication of the report of the Royal Commission on the NHS the Flowers Report on medical education in London concluded that:

> ..... clinical facilities needed in central London for health services purposes are less than those required by the medical schools for undergraduate medical teaching. The concentration of hospital facilities in London is far in excess of local needs and the number of acute beds in London is expected by the London Health Planning Consortium to be reduced over the next ten years by 6 200 of which 2 300 are in teaching health districts .... [12]

They too recommended that the present medical institutions be grouped into six schools of medicine and dentistry in London in place of the thirty-four separate establishments that exist at present.]

Evidence to the Royal Commission on the NHS on the subject of teaching hospitals came mainly from the hospitals themselves and organisations/ individuals connected with them. The majority concluded that reorganisation and RAWP had threatened their services and would lead to a diminution of their functions.

Some of the main issues for consideration can be identified as:-

(a) the financing of teaching hospitals
(b) the problems of integration and distribution of the postgraduate teaching hospitals
(c) the siting of medical and dental schools

SPECIFIC ASPECTS OF HOSPITAL SERVICES:

Centres of Excellence

The best available discussion of 'centres of excellence' is to be found in a piece of evidence submitted to the Royal Commission by MF Drummond, an economist at York University. He pointed out that 'excellence' in the NHS is hard to classify. It may be used to refer to 'technological hardware and medical talent of the kind found in Londong teaching hospitals'; to the 'range and difficulty of treatments undertaken'; to the immediate or future impact on patients' health, and to the value to the community of the work carried out in teaching hospitals. He defined the first of these as **inputs**; the second as **processes** and the third and fourth as **outcomes**. The term 'excellence' may be used to refer to one or all of these factors. Drummond went on to say that it is possible to find evidence of the 'excellence' of inputs and processes in the London teaching hospitals, but evidence of 'excellent' outcomes from these hospitals is harder to find.

It is this difficulty in measuring medical outcomes which made the RAWP's task of assessing additional NHS service costs arising from teaching medical and dental students so hard. It is worth quoting from their report in full:

'Teaching hospitals are on average more costly to run than hospitals in which no teaching takes place. But, as we pointed out in Chapter I, the incidence of these higher costs bears no relationship either to the size or needs of the populations served by these hospitals. Thus means must be found of identifying the additional cost necessarily incurred as a direct result of the NHS's commitment to provide clinical facilities, protecting the finance involved from the effect of allocation processes based upon population and service need criteria, as recommended in Chapters II and III, and arranging for its allocation an an equitable and proportionate basis to the institutions discharging the commitment.

The higher cost of teaching hospitals is not wholly and directly attributable to the teaching function and the presence of students. Factors also contributing to higher costs levels include:

Regional specialties tend to be located in teaching hospitals.
Research work tends also to be similarly concentrated.
Over the years teaching hospitals in various degrees have developed as 'centres of excellence'.

In our Interim Report and as an interim measure for 1976/77 only, we recommended a 'Teaching and Research Allowance'. The use of this title led to some misunderstanding and questions were raised as to the degree of protection it afforded to the factors mentioned above. We must make it clear at the outset that the sole purpose of the 'allowance' which we later propose is to cover the additional service costs incurred by the NHS in providing facilities for the clinical teaching of medical and dental students. Its purpose is to provide an increment to service costs. We believe this will be better understood if it were referred to as a 'Service Increment for Teaching' (SIFT) and we have adopted this terminology in this Report.

The question has been posed how are the additional costs of teaching hospitals referred to above to be financed if not through SIFT? Clearly these factors have strong associations with the teaching function but by no means exclusively. Many Regional specialties and much research work

are to be found in non-teaching hospitals, many of which have developed as 'centres of excellence' in their own right. Whilst it may be found convenient and, in many cases, highly beneficial to regard teaching hospitals as natural centres in which to conduct research and provide higher standards of care, this ought in our view to continue to be a question of choice to be exercised by Health Authorities in consultation with the other interests concerned.

It has to be recognised too that, since the resources available to the NHS are finite, a balance has to be struck between the desirability and need to pursue excellence on the one hand and the need to provide generally better standards of provision and care. There is no escaping the fact that one centre's 'excellence' may be bought at the price of another's 'deprivation'. We stress that this is not an argument against excellence, which we support, but for a conscious balance to be struck in the way limited resources are deployed. It is our view that such deployment should be judged in relation to the needs of the populations served and therefore that the factors to which we have referred fail to be considered and dealt with within the main service allocation to RHAs, AHAs and Districts. The interaction of these factors (paragraph above) on the higher costs of teaching hospitals is, we have found, difficult to interpret and quantify from data currently available.

It is also possible that part of the disparities between RHAs is explicable in these terms. Research into the interrelationship between 'centres of excellence', centres for clinical teaching and centres where other educational and research facilities are concentrated to establish their effect upon the level of service provision and their impact upon costs should, in our view, be undertaken. We recommend accordingly.'[13]

The RAWP proposals mean that all the health services are in competition for resources at the local level. There was a considerable amount of complaint about this, some of which is recorded in evidence to the Commission. In his evidence, Mr Drummond discussed whether the movement of funds away from London teaching hospitals, due to the RAWP proposals, presented special problems. He concluded by saying:

'The redistribution of resources away from teaching hospitals, particularly those in London, means that there may be a shift away from the treatment of the more complex cases. (The extent of this will depend on (a) the extent to which London teaching hospitals are able to win extra resources within their own Areas (b) the extent to which those regions 'gaining' from RAWP use any extra funds to treat these cases at their own 'centres of excellence). Two possible implications should be noted. First, if the treatment of more complex cases provides more opportunities for medical research and development work then these opportunities **may** be fewer in the future. Therefore if the community wishes to maintain the same level (and type) of medical research, a revision of funding arrangements for research may be required. (In general it would be desirable to devise a more coherent policy for the funding of medical research). Second, if provincial regional authorities do decide to promote excellence, there is the possibility that this excellence may be obtained at a higher cost than the retention of that which **may** already be existing in London; ie one **may** be faced with a trade-off between geographical equality and efficiency.'[14]

CONCLUSION

Any attempt to resolve or even discuss the question of 'centres of excellence' will be hampered by lack of an adequate definition, the absence of information on the numbers, types and location of such 'centres' and difficulties of comparing the results of their work with other NHS institutions. The major issues however might be identified as (a) should 'centres of excellence' remain (b) should they be encouraged by separate finance and management; (c) will the present system of financing lead to their disappearance.

Waiting Lists

The length of time patients have to wait for hospital treatment is an aspect of the NHS which engenders considerable thought and anxiety. In particular it is used as a reason for doing away with private practice. This paper looks at the position in England.

Background

The problem of waiting lists has been with the NHS for many years. In 1975 DHSS issued a circular (HSC(IS)181) recommending a review of the methods of managing waiting lists. This circular set out the following targets for waiting times:

> All patients who do not require immediate or near immediate admission and are placed on an in-patient waiting list and described as 'urgent' should be admitted within one month. At some hospitals with long waiting lists nearly 40 percent of non-urgent patients wait more than a year for admission, and it should be an initial objective to admit all such patients within a year at the absolute longest. This achievement would have a considerable effect on present waiting times - if the longest wait is a year, most patients will be admitted in considerably less time. When the initial objective had been reached the maximum waiting time should be progressively reduced and a more acceptable target adopted. (para 2, Appendix 2, Circular).

Health authorities were asked to review the position in their respective areas and to report to DHSS during 1976. The most recent available statistics on waiting lists in England are shown below.

December 1976	-	606 968
March 1977	-	595 490
June 1977 (provisional)	-	594 000

The present (1978) position is that DHSS have asked health authorities to take specific action designed to reduce waiting times, for example regional plans were to indicate allocation of resources for this purpose and this has shown that during 1977/78 £9½m is being specifically

designated for appropriate projects. In addition the DHSS has asked the Office of Population Censuses and Surveys (OPCS) to consider the mounting of a major research project into hospital waiting lists. Waiting lists, both in- and out-patient, feature in the OPCS report to the Royal Commission on *Patients' Attitudes to Hospital Services*.[15]

A consideration of waiting lists should not be restricted to in-patient waiting in isolation from out-patient waiting times. It was proposed that during 1977 information would be collected centrally about out-patient waiting times but there was considerable resistance from health authorities to the introduction of any new returns to enable this to be carried out.

Evidence to the Royal Commission on the NHS

A great deal of evidence was submitted to the Commission on the 'problem' of waiting lists. The following extracts provide examples of the conflicting views expressed to the Commission.

'Hospital waiting lists are another source of friction because non-urgent cases are left. It is possible to reduce these lists provided that the lists are managed by medical staff who are aware of the relative duration of stay of each case, and provided patients are given sufficient notice to enable them to make suitable domestic arrangements. Not all urgent cases require immediate admission. In many cases admission is sought for domestic or social reasons rather than for medical reasons. A much better service exists when admission arrangements are made between doctors provided that a general practitioner may speak to a more senior members of the hospital medical staff when beds are in short supply.

Many patients on waiting lists are given inadequate notice of admission, so that they are unable to make adequate arrangements and either resent admission or fail to arrive.
Waiting lists should be run in collaboration with the GPs who are most able to assess the frequency and severity of their patients' symptoms and can indicate the length of notice required before admission'.
(Dr Ann F Tuxford)

'The problem of long waiting lists in these districts is a reflection of the inadequate provision of staff, buildings and resources.' (Chairman and Vice-chairman of the Medical Advisory Committee, Southern and Central Derbyshire Health Districts).

'It is becoming the normal practice to have consultants only at specialist hospitals where they can have all the back-up facilities. The inevitable result for remote areas is that the patient has to bow to the whim of the consultant, distance ensures infrequent visits for consultation, an addition to already long waiting lists in urban centres creates even longer backlogs for service. The need for specialist services at major hospitals is conceded but small community hospitals should be the bases of care.' (Argyll and Bute LHC)

'Whilst accepting that hospital waiting lists are to some extent artificial, they do show trends. At present these trends, certainly locally, are very disturbing. Waiting times are increasing and the more militant attitude of medical staff is having its effect. There may well be some measure of truth in the suggestion that waiting lists are being 'created' in order to support the doctors' stance on remuneration.
Private practice is not a major problem facing the NHS, but it is one which does affect far more people than is generally recognised, as it affects waiting times for all those on the waiting lists when a private consultation leads to queue-jumping.' (B Maunder)

'My uneasy feeling about the provision of beds for geriatric patients leads me to question the significance of hospital waiting lists. It is difficult to understand the reasoning behind the present proposals to reduce the provision of acute beds in the face of the large waiting lists even if it is true to say that the lists are inflated.
It might well be that the 'norms' on which the latest proposals are based would be adequate if the patients over 65 years of age, that is to say - the geriatric patients according to the strict definition, were excluded.
It would, of course, be unthinkable to exclude a sick person from an acute bed on grounds of age as the primary aim of all hospital work is to discharge the patient back into the community.

It is not possible to make any definite proposal about this matter without much information of a kind which is not easily available to members of area authorities but it is to be hoped that the Royal Commission will satisfy itself that the current plans are soundly based.' (Sir Desmond Bonham-Carter)

'Excessively long waiting lists for out-patient and in-patient services, particularly in those specialties most in demand by the elderly, appears to justify the belief that the NHS does not provide a common standard of service in different areas of the country.
It is a corollary of the long waiting lists for out-patient appointments that, where financially able, the general public seek their first appointment with the consultants on a private practice basis, in order to avoid delay in being put on the waiting list for any subsequent treatment. This provides two separate standards of availability of health services.' (Blackpool Community Health Council)

'The Council would place high priority on the significance of hospital waiting lists. The level of concern continually expressed on waiting lists is such that the highest priority should be given to an examination of their significance.
Although these may be of importance and are used by administrators to gauge needs they often give a very false impression of a need. For example it can easily be shown that many surgical waiting lists (for example for hernia and haemorrhoid operations) are excessively long, whereas medical waiting lists may not be as long. Administrators are very apt to use this argument for cutting medical beds. In fact, medical waiting lists are to some extent self deleting in that patients either get better or get so much worse quickly that they are admitted as an emergency or die! Thus, the significance of hospital waiting lists must be examined in relation to their medical content.' (Dr Hugh Jones)

'In my opinion the significance of waiting lists is slight. By definition they are those of the longest wait and so therefore if you see 90% of your patients within a week but tend to wait some time before seeing those who are not acute (or may well cure themselves in time) then your waiting list is set down as two or three months. On the occasions when

patients requiring more urgent treatment have not received it, it has always been an instance of mal-administration rather than lengthy waiting lists.' (Dr S J Surtees)

'A reduction in the present length of waiting lists could only be achieved by an increased availability of resources. Unless a greater proportion of the GNP were devoted to the NHS there is little hope of early improvement in the present situation. One of the results of separating private practice from the NHS would be to lengthen waiting lists.' (Dorset AHA, Medical Advisory Committee).

Reconstructive surgery today concerns the problems of children and the elderly in particular, though all age groups are involved. As reconstructive surgical techniques advance, and they are doing so rapidly, the already diverse field of operations to reduce crippling presents ever increasing demands. The development of joint replacements and surgery for rheumatoid arthritis are only two of the better known examples. Much surgery of disabled people is preventive or prophylactic in that it avoids future crippling, particularly in children. In old people independence is often retained only by surgery, for instance hip joint replacement. The immense waiting lists for this type of operation are an indicator of the size of the problem.

Most orthopaedic units are arranged so that the acutely injured and those needing reconstructive orthopaedic surgery share the same wards and operating facilities. The absolute necessity of dealing with the former group, and the increasing frequency of injuries over the years has gradually diminished the capacity of orthopaedic surgeons to cope adequately with the increasing demands of the second group. Many of these patients are unable to work or are threatened with loss of their independence and yet they have to wait for the surgery which would cure or improve them.

Much of the work of elective orthopaedics consists of out-patient consultations for the diagnosis and treatment of the innumerable minor ailments of the locomotor system. Such out-patient referrals are

proving an insuperable problem, and this aspect of the hospital service is at present in a state of failure. In about half the centres of this country a patient must wait three months or more for a routine non-urgent consultation. In 55 instances the waiting time is more than six months and in 26 it is more than one year!

There follow some comments on the results of the second part of our questionnaire, which made enquiry into the status of elective orthopaedic work throughout the country:

> The 409 surgeons who replied had combined waiting lists for elective operative surgery amounting to 64 806 people.

'Orthopaedic surgeons are clearly failing to cope with the demand for the surgery of arthritis and they are particularly concerned with their long waiting lists which, due to lack of facilities, they are powerless to reduce. In half the hospitals the patient must wait a year or more for total hip replacement. Since nearly all these patients are elderly and in pain, their continued independence is at risk for lack of the operation, this position can only be regarded as disgraceful.' (British Orthopaedic Association).

'There should be experimentation in one areas of open access of GPs to hospital equipment and facilities to see if these would lead to a reduction of out-patient waiting lists.' (Gwent Health Authority)

'The Significance of Hospital Waiting Lists

It is our view that hospital waiting lists are significant only to local management and then only if the following conditions are fulfilled:

(a) A system of monitoring the waiting list is implemented so that the list is an accurate measure of the number of people who are believed by the medical staff to require in-patient or out-patient care.

(b) Information is available as to how the waiting list has changed in the recent past for the various types of patient - those requiring attention urgently, those requiring attention as soon as possible, and non-urgent cases. This classification of patients is, of course, based on subjective judgements, and clearly more research is required to attempt to make it more objective for each speciality.

(c) The causes of the length of the waiting list are known - lack of beds, lack of theatre time, lack of outpatient sessions, etc.

(d) It is known or can be estimated by how much the size of the waiting list, for each type of patient, will reduce in the short term if particular extra facilities are provided.

If these conditions are fulfilled and the information indicated is collected on a routing basis, then the size of the waiting list is a significant aid to monitoring the current distribution of resources in a hospital. Otherwise the size of the waiting list is largely a meaningless concept.' (Operational Research (Health and Social Services) Unit, Reading University)

Longer Waiting Lists

Factors affecting hospital waiting lists are:-

- availability and staffing of beds and their geographical distribution.
- availability of operating theatres, diagnostic facilities and other equipment.
- patterns of referrals to consultants.
- blocking of acute beds by long-term patients.
- industrial action by various groups of hospital workers.
- administrative bottle-necks.

'It is not to be expected that there should be a direct correlation between waiting lists and pay beds.' (Quoted from *Private Practice in NHS Hospitals* 1973 Cmnd 5270 p6 para 21).

'Phasing out pay beds from NHS hospitals can only mean that waiting lists will lengthen as patients who would previously have waited for a private bed join the waiting list for an NHS bed. More important, part-time NHS doctors who now do all their NHS and private work in NHS hospitals will have to tend their private patients in private hospitals. This may well involve extensive wasted time in travelling with consequent additional risks for both their NHS and private patients.' (Private Patients Plan)

'The shortage or inadequacy of operating theatres is widespread and leads to delays in treatment and lengthening waiting lists. It is to be hoped that the moratorium on major capital works will not extend to the desperately-needed upgrading or new provision of operating theatres and their essential ancillary facilities.' (Royal College of Surgeons of England)

Day Care and Treatment in Hospitals

The current moves to tackle the waiting list problem envisage an expansion of day care and treatment at hospital. This paper comments on two aspects, namely:

(a) Pre-admission clinics;
(b) Out-patient surgery and investigation.

Pre-admission clinics

It is the health departments' policy that patients who are to be admitted to hospital should reach hospital only after all investigations and treatment which can reasonably be carried out on an out-patient basis have been completed. It would also be expected that surgeons should seek to have their in-patients admitted for a final routine check the day before their operations. This policy is designed to ensure that patients do not spend unnecessary time in expensive hospital accommodation away from their home environment.

A development in this field is pre-anaesthetic clinics where all the pre-operative investigations and clinical assessment of the patient, including the anaesthetic check-up, are carried out on an out-patient basis prior to the patient's admission for surgery. This means that patients need not be admitted until the day of the intended operation.

The need for these clinics is not universally accepted. For example DHSS(NI) have found that those that have used the system consider that it does help to reduce the length of patients' stay in hospital, but others are of the opinion that with modern anaesthesia such clinics are not necessary; another view is that at a time when anaesthesia is a shortage speciality and hence that consultants in it are very much in demand, it would not be appropriate to advocate a system which has not yet been proven.

Out-patient Surgery and Investigation

The British Hospital Doctors Federation, in its evidence to the Royal Commission, commented that:-

'A wide range of procedures (investigations and operations) now done by admitting the patient to an expensive acute hospital bed, could equally well be done quite safely as out-patients. If this were the common practice, not only would money be saved but the in-patient waiting list would be reduced.'

There is nothing new about the suggestion that a wide range of procedures, both medical investigations and operations, for which patients are often admitted to hospital can be and increasingly are carried out in out-patient departments on a day basis. This method of clinical management has been commented upon favourably in medical literature for some twenty years and has been actively promoted by the health departments since the latter half of the 1960s. For example, in July 1973 a DHSS memorandum was issued on *The Arrangements for the Care of Persons Attending Hospital for Surgical Procedures as Day Patients* (HM(73)32). A survey conducted in 1969 suggested that up to

one-third of all in-patients were then being admitted for the treatment of conditions which could be treated on a day or out-patient basis. Since then, although ways of clinical management change slowly, there has been a considerable increase in the number of day patients and day surgical cases. It is expected that the numbers will increase even further as facilities are expanded.

The principal advantages of day surgery are seen as:

(a) the greater throughput which is possible enables waiting times for the treatment of certain common conditions to be reduced:
(b) at a time when the recruitment of nursing staff is difficult, it eases employment problems; since the day surgery department is closed at night and at weekends, it is possible to offer working hours to staff who prefer to work as such times;
(c) the patients are not exposed to the risks of cross-infection to the same extent as they would be in an in-patient ward;
(d) treatment can be offered without the stress of hospital admission which is an important consideration, particularly with the elderly and with children;
(e) the cost per case is less than for equivalent surgery carried out on an in-patient basis.

The principal advantages of day or short-stay programmed investigation units are seen as:

(a) admissions can more easily be arranged to suit the patient's convenience;
(b) the workloads for the diagnostic departments can be organised, since the patient's requirements are notified and scheduled in advance of admission;
(c) investigations are carried out more quickly and reliably because staff develop an expertise on this kind of work;
(d) stay is shorter than in a more traditional ward and the cost per case is less.

There is not necessarily a saving in money from the greater use of day and out-patient facilities. Savings would only arise if there were no increase in the number of patients treated, and thus it was possible to close beds. Since the service provided, particularly on day surgery, tends to cater for additional patients and those whose treatment is of a lower priority than that required by emergency cases and those for whom in-patient admission is essential, and provided that the numbers of operating theatres and the staff to maintain both in- and out-patient services at full capacity are adequate, extended day and out-patient treatment does reduce waiting times for the more common and important non-urgent conditions; the total numbers on waiting lists may remain unchanged as general practitioners may then lower their threshholds for referral and more surgeons more readily add patients to their waiting lists.

Clinical opinions vary on what investigations and operations can be carried out on a day basis; it would be acting contrary to the accepted principle that the manner in which any particular patient is treated is a matter for the individual clinician to decide, to seek to produce a definitive list. Further, although it may be feasible and indeed even desirable for some patients, for example, to have their varicose veins treated and their hernias repaired on a day basis, it almost certainly will not be equally feasible or desirable for others. The home circumstances of the patient, the capacity of the community services to cooperate, the personality of the patient and other factors, as well as the views of surgeons and physicians on what can and should be done as out-patient treatment, necessarily influence decisions on which patients to treat as out-patient and which to admit to hospital.

However the following operations and medical investigations and treatments are increasingly carried out on a day basis:

(a) General Surgery and Urology

Amputation of digits
Excision of breast tumours
Hernia repairs
Ligation of haemorrhoids
Rectal sphincter stretching
Ligation and injection of varicose veins
Urethral dilatations
Cystoscopy
Lymph-node excisions
Vasectomies
Circumcisions
Excision of cysts and lumps
Removal of in-growing toe-nails.

(b) Orthopaedics

Manipulation of joints under anaesthesia
Tendons divisions and splitting
Palmar fasciectomy
Anthodesis of interphalangial joints
Carpal tunnel decompression
Nails and nail-bed procedures
Excision of bursae and ganglia.

(c) Ear, Nose and Throat Surgery

Antral puncture and wash-out
Removal of nasal polyps
Cauterisation
Myringotomy

(d) Gynaecology

Dilations of cervix and curettage
Urethral caruncle cauterisation
Vaginal dilatation
Tubal insufflation
Removal of small cysts and papillomata

(e) Radiology

Arteriography
Retrograde Pyelography
Hysterosalpingograms

(f) Dental

Extensive clearance of teeth
Wisdom teeth extraction

(g) Medical

Endoscopic examinations
Paracenteses of abdomen or thorax
Minor haematology procedures and blood transfusions
Certain time-consuming investigations

It would be possible using data from the *Hospital In-patient Inquiry* and from what is known of the nature of conditions on current waiting lists, to make rough estimates of the nature and extent of the workload involved in treating certain conditions for which patients are normally admitted on a day basis. However, an accurate estimate would require a special survey but it would be impossible and indeed self-defeating to undertake detailed surveys at national and even at regional and area levels in the absence of general agreement within the medical professions on what conditions could and should be treated on a day basis. Even were there such agreement - which could only cover a smaller number of conditions than are in fact so treated variously over the country as a whole - the magnitude of the task of a special country-wide survey would still be considerable.

In Scotland SHHD encourage health boards to include in major capital developments short-stay wards which should include single rooms, four-bedded rooms, trolley cubicles and day-space places. At the present time there are purpose-built short-stay wards in use in seven hospitals and in the plans of all district - general or teaching hospitals under construction. In addition, a number of hospitals have adapted existing premises for this purpose.

The principal inhibition to more work being undertaken than at present on an out-patient basis is staff time, since a large proportion of medical and nursing staff time is taken up with the treatment of emergencies and more urgent major cases than the largely cold, non-emergency, non-urgent, non-major cases which lend themselves to outpatient treatment. Other limitations are theatre time, since the first demand on operating departments is for emergency and urgent in-patient surgery, and finance, since the extension of out-patient facilities will generally increase the overall number of patients treated. The capital expenditure on the extensions will almost certainly not reduce subsequent revenue expenditure, but it will increase it. It is pointed out that increased revenue costs will fall on the community services whose involvement is inevitably increased as more out-patient treatment and more rapid discharges from hospital shift the burden for post-treatment care onto them from the hospitals.

Accident and Emergency Services

Concern with the inadequate provision of accident and emergency services was first expressed in 1960 in a report published by the Nuffield Provincial Hospitals Trust - *Casualty Services and Their Setting.* This report was closely followed by the *Platt Committee Report* (1962) which recommended a change of emphasis from 'casualty' to 'accident and emergency' and the rationalisation of small departments within larger units to be adequately staffed at all times. The *Platt Report* marked the beginning of a trend to fewer, larger accident and emergency departments and the creation of a 'new' specialty in medicine. By 1973 the number of accident and emergency units had been reduced to 680 from 2 600 in 1962. The increase in the number of consultant accident and emergency appointments took longer to achieve, but by 1976 100 full-time appointments had been made and a training programme for senior registrars had been approved.

There are two main problems now facing accident and emergency departments. They are:

(a) an increasing proportion of attendances are self-referrals for **non-urgent** complaints. Recent surveys have shown that about half the patients passing through accident and emergency departments are self-referred and that over a third of these are not minor or trivial complaints. The definition of accident and emergency departments as providing hospital treatment for **urgent** cases may therefore be too restrictive;

(b) the staffing of these departments or units needs to be more carefully planned. Not only are they under-staffed, but there is a need for accident and emergency consultants who are not surgeons (eg physicians). Also because of the variety of cases which present themselves to these units, some kind of skilled 'sorting' needs to be done as they arrive. This raises the issue of whether initial diagnosis should be done by substitute doctors; ie emergency technicians (as is the practice in the USA) or trained nurse practitioners.

Accident and emergency departments are at the interface of community and hospital services and it has been suggested that if they are to fulfil their role properly full consideration needs to be given to these and other problems. Since it is evident that patients are choosing to take themselves to these departments, for whatever reasons (and these need to be identified separately), the role and function of accident and emergency departments needs to be reconsidered.

Evidence: The weight of the evidence deals with two aspects of accident and emergency departments, (a) their abuse by patients with trivial complaints and (b) the inconvenient location of many units. Evidence from the Association of Casualty Surgeons and a report from Dr K Little emphasise the 'urgent and emergency' definition of accident and emergency services. In an article in *Conflicts in the NHS*, A Gunawardena and K Lee [16] argue that this definition is inappropriate, given the way in which consumers are reacting to the current (inadequate) provision of primary care services by using accident and emergency departments as an alternative or substitute service. They claim that there are economic advantages in using these high technology departments to provide low cost medical care alongside the emergency services. These and other issues need to be fully considered.

(a)

(b)

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THE RELATIONSHIP BETWEEN HOSPITAL AND COMMUNITY SERVICES

A SOCIAL WORK VIEW

from Kay Richards

INTRODUCTION

The main objective of the reorgainisation of the health services in 1974 was to establish an integrated service. This was both laudable and essential yet regretfully evidence to the Commission and our own discussions and visits appear to indicate that with few exceptions integration has not been achieved either in terms of more effective planning and development of services, or in the crucially important area of integration of service delivery to the patient.

As a Commission we started out with the bold statement 'the interests ..... of the patients and of those who work in the NHS may sometimes conflict. Although we hope that such conflicts will be rare, we take it as axiomatic that if they arise the needs of patients must be paramount[1]. (The Task of the Commission,)'. Perhaps we had in mind here issues concerning individual patients, or issues concerning certain groups of staff, or an issue such as industrial action which has already been the focus of lively discussion amongst us and some of those giving evidence to us. Increasingly, however, I feel we are being faced with the implications of this statement in terms of the non-manageability of certain parts of the health service and the difficulties this is creating in achieving the goal of integration, and in achieving the best use of resources. The difficulties are present most acutely in the management of the medical contribution, though they are also visible at times within other professional groups. The freedom of general practitioners to practise without tight geographical limits, the lack of ability to ensure their attendance at case conferences or medical audit debriefings, the ability of consultants in hospital to practise what is quite often high

cost medicine/surgery without consideration of the wider needs of the community health services, the inability of an area or district medical officer to implement his part of an agreed management team decision because of his lack of 'control' over his medical colleagues, the failure to develop the health centre concept positively, and the continuing boundary disputes between some members of the nursing/health visiting / midwifery profession are examples of the issues we are faced with.

If as a Commission we really do wish to put the patient first we must also take account of the problems which patients encounter in gaining access to the different parts of our so called integrated health services and our own examination of our task with its initial split between hospital and community services has in some ways 'blinkered' us against seeing the full impact of the problems. In examining therefore what is to me a very crucial aspect of effective health service provision, namely the relationship between hospital and community services, I want to put up for discussion an alternative model for provision which aims to cut out or reduce many of the problems identified in paragraph two above. It may create others and no doubt colleagues will let me know, for I have not had time to explore this approach as fully as I would have liked.

AN INTEGRATED SERVICE - A LONG TERM VIEW

My approach, simply, is to suggest that we view all the personnel working in the health services as part of a large resource pool, differentiated in relation to knowledge and skills relevant to the tasks and role we ask them to undertake and with contracts which clearly specify their place of work within a hospital, or a health centre, or clinic, or (and this I see as crucial) increasingly identifying a role within the health service which will require them to contribute within the community and within the hospital. Working to commonly agreed and stated objectives, identified through an appropriately participative and democratic process, and sharing a common ethical approach to the patients in their care, and with a sense of professional and inter-professional responsibility commonly shared and acknowledged, the development of an integrated service might indeed become a reality.

Such an approach would have considerable implications for manpower planning since the numbers of say present day 'consultants' who by and large carry responsibilities clearly within the boundaries of the hospital or its associated outpatient clinics, with the odd domiciliary visit, would have to increase if they had added to their area of responsibility the provision of clinic and diagnostic facilities within health centres, or schools, or old people's homes, depending on the specialty concerned. Similarly the possibility of general practitioners carrying certain responsibilities within local community hospitals or health service nursing homes, would have implications for the number of GPs required, since lists would have to fall, and for the skills they need to acquire in post-qualification training. Within this framework too there would be opportunities to further develop the concept of 'hospital at home' where teams normally based in the hospital are available to move into the community to nurse an acutely ill old person without the disruption for her of removal into hospital with all its attendant implications of increased dependence and institutionalisation.

Certain staff would be permanently employed within a hospital to ensure continuity and stability, and because some tasks would only exist in the hospital. The opportunities though for transfer to a permanent post in the clinic or health centre should increase and indeed be part of the staff development programme for many individuals.

Implicit within such an approach is the expectation that within each management unit, be it area or district but not both, would be a policy forum for the agreement of area objectives which took account of national objectives and developed more local objectives and priorities in consultation with public, consumer, professional and politician. Each management unit would also have its own senior officer team of professionals who would be responsible for policy implementation and for the deployment of personnel and for ensuring the monitoring of professional practice. Individual professionals would be expected to operate within the mores, policies and priorities of their area, while their accountability for the standard and quality of their professional competence would be via regular audit carried out in conjunction with

their responsible professional organisation. Guidelines on the implementation of such a dual accountability would have to be worked out and agreed nationally by the appropriate bodies and be accepted by the individual staff members and his/her employing management unit at the time of appointment.

If such an approach were adopted it could break through many of the problems encountered through years of real or felt medical domination since each professional group would be seen to be employed and contributing to the health service within the same common framework, though naturally undertaking often very specific and different roles. Equally it could lead to a greater willingness to broaden out roles and to examine carefully the contribution of different professionals, since there might be a greater acceptance of the 'greatest good' and less wanting to hold on to an established position and task for its own sake. It could also enhance the position and contribution of semi-professional and non-professional staff within the health service, whose contribution is often vital and whose conduct of practice may, and often already does, equate favourably with professionals when it comes to attitudes to the patient and to matters of confidentiality, etc. The common ethical approach mentioned in paragraph four is vital here.

Movement to such an integrated service would take time and arguably stands a greater chance of being more effective than today's pattern if it can be accepted by those concerned rather than imposed. To me however the salutary implication of suggesting such an approach is the reality that much of what I am seeking to achieve could be achieved within our existing structures if the attitude of those who work within those structures was changed and if there could be real agreement to work together to achieve stated aims and objectives. Experience, however, I believe demonstrates that attitudes will not change sufficiently without the impetus of a more radical approach. Existing structures too are counter-productive to the achievement of an integrated structure and while we may be able to make some suggestions as to how this is improved in the short or medium term, I am convinced that something more is needed for the long term. This paper should also be read

in conjunction with my paper on the boundaries between the NHS and the social services.[2] A truly integrated health service would be in a much stronger position to liaise and plan effectively with those other departments with whom it shares patients and objectives, namely social services, education, housing, planning, even if as today those departments remain the administrative responsibility of a different authority, ie local government. In the long term an integrated health service as one department of regional local authorities who carry responsibilities also for departments of education, social services and housing offers the possibility of really developing services which can reach the patient/client in an integrated way and lessen for him problems of access and transfer. The development of a truly integrated health service is a major challenge for the health service and I hope the Commission will accord it proper priority.

INTEGRATION - SHORT TERM

I have not spelled out here the implications for future practice in any detail. I strongly support the points made by Chris Wells in his paper (pp 57–67). Ways of improving relationships between hospital and community services within the existing framework do, as he says, depend so much on understanding, communication and attitudes. More multidisciplinary assessment before decisions are made to place people in hospital or social services accommodation can be helpful, plus formal agreements being reached between the services concerned that if after assessment in an assessment unit whichever service is required, it will be provided, otherwise assessment beds get blocked. The need for full consultation and discussion prior to discharge is often crucial and greater direct liaison between community based nurses and the patient ready for discharge and her hospital based care staff can be important. Too often today it gets held up by bureaucratic attitudes and an unwillingness to blur boundaries. The contribution to be made by voluntary services at the point of discharge is important and brought out well in the British Red Cross Society publication *Home from Hospital,* published some four or so years ago. Access to services, bringing the services to the patient wherever possible, reducing waiting time in outpatient departments and considering the patient in hospital within the context of his

home, family and work situation are all very important aspects of the relationship between hospital and community services. Greater value and therefore more money needs to be placed on the community health service by the health services generally and positive steps taken to remove the barriers between them.

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A NURSING VIEW
from Jean McFarlane

THE DISTRIBUTION OF CARE BETWEEN HOSPITAL AND COMMUNITY

Recent policy statements have placed great emphasis on the virtues of care in the community for all groups of patients wherever this is possible. The advantages put forward are physical (eg minimising the risk of cross infection), psychological (eg the home is more 'restful'), and economic (eg community care is 'cheaper' than institutionalised care). All these statements could be challenged and future generations may wish to reconsider the distribution of resources between hospital and community and recommend that more careful assessment of the needs of the individual patient and his family is made with a view to long term effectiveness.

Greater care in promulgating policies is desirable since, with increasing specialisation, the deployment of professional staff between hospital and community is not highly flexible and there is an inevitable time lag between policy making, retaining and reallocation of resources.

This relative inflexibility is a function of the specialised nature of health needs in hospital and the community and the motivation of people to work in institutional or less structured environment.

DECISIONS ABOUT THE LOCUS OF CARE

Institutionalised care is required when:

(a) highly specialised and expensive diagnostic services are needed;

(b) high technology medicine is required;

(c) there is a high nursing dependency as in some geriatric or surgical cases;

(d) supporting social services are not available or too costly.

Community care can only be supported when:

(e) medical and nursing services are only required on an intermittent basis; OR

(f) when more continuous care of a nursing nature can be supplied by an auxiliary or the mobilisation of family and friends AND

(g) there are adequate supportive social services.

Many problems arise because transition from home to hospital and back again is based on a narrow view of medical needs of the patient and the efficient use of beds in mind. A total plan of care taking in nursing and social work demands is often lacking.

FRAGMENTATION OF CARE

The specialised nature of the services and their separate organisation makes for fragmentation of care.

There is very adequate documentation of the fragmentation and inadequacies of care (Skeet 1970). Hockey (1968); Harrison (1977). There have been some attempts to find organisational and administrative answers to the problems, but the objective of the re-organised service - to achieve a smooth transfer of the patient - has not been achieved appreciably.

ORGANISATIONAL AND ADMINISTRATIVE SCHEMES FOR CONTINUITY

Liaison Officers: these may be health visitors or district nurses. Health visitors are employed where adequate after care is seen as an aspect of prevention and where the major needs of a group of patients is health education or social advice and referral, eg paediatric and geriatric after care, after care of the diabetic patient etc. The district nurse is employed as a liaison officer where continuity of clinical nursing care is required. Liaison officers assess the patient's needs before transfer home and assess the home circumstances so that smooth transfer can be achieved. There are however problems about one liaison officer working with one surgeon for example and then relating to many nurses in primary care teams over a wide geographical area. She may become skilled and knowledgeable about patient needs in a special field of nursing, but she may often be yet another level of communication between the hospital nursing staff and the district nurse or health visitor.

The organisation of nursing divisions: a considerable amount of variation exists in the organisation of nursing divisions. In some districts, primary care nursing is seen as so specialised as to demand a community division often organised and having its headquarters quite separately from the hospital divisions. In other instances an attempt has been made to integrate hospital and community nurses into the same divisions by fields of nursing so that the psychiatric nursing division will have community nurses attached and the midwifery division, domicilliary midwives. In some places the geriatric and community nursing services form one division, but the nursing care of other categories of patients in the community must all be organised from the geriatric division. Any attempt to allocate community nurses to each hospital division results in a break up of the primary care team, ie a number of different district nurses would have to relate to one general practice. There is therefore a very real discontinuity caused by an attempt to relate to specialised medical care in the hospital and general medical care in the community. See Hockey (1970).

Consultancy schemes: in some highly specialised aspects of nursing (renal dialysis, stoma therapy, etc.) the hospital based nurse may advise in the community. It is however unrealistic for many nurses to move between hospital and community because of the need to maintain adequate establishments in both sectors (there tends to be a heavier work load in both hospital and community at the same time, eg winter) and the comparative inflexibility of roles.

INTERCHANGEABILITY OF NURSING ROLES

Recent changes in nursing education have introduced a broader based training which gives an introduction to most fields of nursing. Every student now passes through a module of community experience as they do a module of psychiatric nursing experience. The objective of the module however is not to produce a skilled practitioner in that field, but to give an appreciation or insight. Just as the hospital nurse needs post basic preparation for specialised fields, so the district nurse and health visitor need post basic education for their specialised role. This is a function not so much of professionalisation but arises out of an analysis of the different skills and knowledge required. The Panel of Assessors for District Nurse Training reported on the education and training of district nurses in 1976. Having analysed the key tasks of the district nurse's role they recommended a six months' programme of integrated theory and practice followed by three months' supervised practice. It is widely held that this training should be mandatory. The health visitors training is one year in length and a statutory requirement before employment. The training reflects the specialised knowledge and skills required.

Without such training it would be virtually impossible for a hospital nurse to transfer to the community unless it were into less skilled posts in clinic nursing. Similarly it would be virtually impossible for a district nurse to transfer to intensive care nursing or geriatric nursing without further training. There is virtually no mileage therefore in exploring a greater

flexibility in nurse manpower deployment between hospital and community. The days have gone when a nurse is a nurse is a nurse! Any re-allocation of nurse manpower resources implies retraining programmes.

One has also to bear in mind the motivation of nurses to work in either a hospital setting or in a community setting where they have greater authority.

POSITIVE SUGGESTIONS

Manpower and training: given these restraints the nurse manpower policy and training programme has to be carefully developed with the needs of both sectors given due weight.

Liaison and consultancy schemes: although these have their limitations they should not be abandoned.

Communications: smooth transfer of patients demands communication between hospital and community nurses as much as between consultant and GP. There are problems because the ward sister's assessment of the patient needing district nursing care is very often bounded by the needs for stitches to come out or physical care only. Skeet (1970) shows how inadequate is the referral system and the need for the community nurse to make an assessment of home nursing needs. Roberts (1975) attempted a scheme of assessment before transfer home. We have found the problem orientated record a useful means of communicating with the district nurse. A 'transfer home' summary of the extant nursing problems and the relevant nursing care being used is a valuable basis for assessment in the home. Similarly we have found the district nurse's account of the patient problems and care being given a useful basis for maintaining that programme of care in admission to hospital so preserving a continuity of approach.

The communication needs to achieve continuity of care are far wider than between nurse and nurse. They call into question the nature of relationships in the hospital team and the primary care team, coordination of

their functioning and methods of referral between members of the team besides the nature of the community nursing team. These will be dealt with elsewhere. Parnell and Naylor (1973) describe a scheme 'Home for the weekend, back on Monday', which was highly successful in the rehabilitation of elderly patients. It called for skillful use of the primary care team in a coordinated way at weekends.

Communication networks of the complexity of those involved in the health care system demand very adequate record systems and facilities for written and verbal communications such as supporting clerical staff, telephones, and interviewing rooms.

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A GENERAL PRACTITIONER'S VIEW
from C J Wells

Each year some 10 percent of the population find their way into and out of a hospital bed. The statistics for England - they differ from the rest of the UK only in size - are:

Population 46.5m
Hospital discharges and deaths 4.9m
Attendances at accident and emergency departments 12.8m
New out-patients 6.9m
All out-patient attendences 30.9m
NHS ambulance services carried 17.5m per persons
NHS ambulance services travelled 100.3m miles
GP consultations 152.6m
GP pathology requests 7.1m
GP radiology requests 22.1m
Home nurses attended 2.4m patients
(H & PSS statistics for England 1976 - DHSS)

Most patients who attend hospital are referred by their general practitioner (GP). The referral system has grown out of the historical split between physicians and apothecaries which persists as the different modes of practice of consultants and general practitioners. It is recognised, however, in the profession's ethical code that, while a patient may be referred to a consultant for his opinion and perhaps specialist treatment, he remains in the continuing charge of the GP. As long as this system continues it behoves everyone involved to ensure that it works to the patient's advantage.

An essential requirement for the easy passage of a patient between the two arms of the service is good communication between all those involved in his case. The size of the NHS, its complex structure, the need

for a close working relationship with PSS and the huge and continuous volume of work do not make for easy communication. There is evidence that the system sometimes fails.

Communication between professions and within a profession can be bad. I think we have improved on 'Dear Mr A, Please see Mrs B and advise. Sincerely C'; 'Dear C, Have seen Mrs B and advised. K. Regards, A' Though content has improved delays are frequent. Consultants often blame lack of secretarial staff. GPs still write by hand in urgent cases and if staff is not available. Though the GP's letter starts the process of referral the consultant's reply begins the dialogue of continuing treatment and care.

There is considerable ignorance of conditions and patients' problems on the other side of the interface. Many professionals working in hospital have never treated or even seen a patient in the community since their early training - and *vice versa.* This is particularly true of academic staff. We have received evidence that in both hospital and community there are deficiences in human and material resources. These deficiences are aggravated by incorrect deployment and inappropriate job allotment, and by undue demand for the use of limited resources by the patient or his agents and by staff.

Failures of the system since reorganisation of the NHS are also blamed. A personal view is that community services have gained something by improved functional integration, though the transfer of nurses, midwives and health visitors from local authorities to the NHS has isolated the personal social services. Staff in hospital are not so convinced.

Success or failure in providing continuing care varies between patient groups. It may be useful to consider some groups.

Maternity There are still too many agencies involved in ante-natal care. The need for health authority ante-natal clinics in addition to those provided by hospitals and GPs is doubtful. Communication on discharge is good because of the crucial role of the midwife in post-natal care. In some GP units the district midwife attends confinements with the GP.

Paediatric Again many agencies are involved and lack coordination - 'With all their shortcomings the present services do provide the foundations on which to build a new service. We have in general practice a strong tradition of family-based care, whose practitioners are increasingly trained to see their patients in the context of their home and social environment. We have inherited from the former local health and education authorities a tradition of preventive medicine, committed to ensuring that services reach those in need, even when they do not seek them, and clinical staff who are skilled in developmental and educational medicine. Within the hospital service we have the specialist disciplines of paediatrics and paediatric nursing with their recognition of the need for special skills and training for those working with children. Alongside them are child psychiatrists, paediatric surgeons, and adult specialists involved in the care of children. All are necessary for an effective service for all children. Yet expertise, and understanding of the problems of children and their families acquired in each part of the service have been confined to that branch, so that each has but a partial understanding of the whole. And so many sick and disabled children do not receive the full benefit of all that has been learnt about the way to treat their illness, prevent their disability and promote their health. Often those at greatest risk have little contact with services at all. It is against this background that we have endeavoured to set new objectives for the future'. (*Report of the Committee on Child Health Services,* Cmnd 6684, para 4.48)

Surgical Perhaps the least good at liaison. Pressures on acute surgical wards are considerable and sometimes necessitate early and unplanned discharge. On most occasions this does not cause problems but it does in the case of the immobile, the heavily dependent and the solitary elderly patient.

Medical The pace is slower - so is communication. Many patients attend out-patient clinics for very long periods. Practice is variable. Recall is for a number of reasons: eg maintenance and observation of therapy, research and investigation, laissez-faire, distrust of GPs' capacity or willingness to maintain continuing care. The longer recall continues, the worse becomes communication.

Geriatric Here the need for good communication is paramount. The elderly patient is often unwelcome in the wards and in the home. To the outsider there appears to be a need for more interdepartmental liaison in hospital. In the community, pressure from patients, relatives, neighbours and professionals tends to make criteria for requesting admission subjective rather than objective. The majority of elderly patients are now admitted for diagnosis, treatment, rehabilitation and return to the community. Consultation before discharge is essential.

Psychiatric Personal observation suggests that there is no agreed model for post-discharge care though the patient is formally discharged back to the care of his GP. It is necessary to establish the roles of GP, social work and psychiatric services in order to provide continuing care. There is, and always has been, difficulty in obtaining admission of patients - zoning has not helped. The elderly get a particularly raw deal.

Mentally and Physically Handicapped There appears to be a lack of necessary specialist knowledge in the community for the care of these patients.

Community Services GP follow-up of discharged patients is often inadequate. A need for nursing care alerts the nursing service. The 'weekend' is a favourite time for hospital discharges - a time when community care is at its thinnest. This applies to nurses, health visitors, social workers, chemists, dentists and doctors alike. Ambulance services are often erratic. Decisions to collect or not are made without reference to clinicians responsible for care of patients.

The patient The patient is the most important link in the chain of communication. If doctors and other staff fail to give necessary information to patients they create difficulties for the patients and for themselves. Most patients wish to have some responsibility for their own care and also wish to be helpful and not unduly demanding. Failure to give information causes needless worry and work.

Remedies, like the problems, are complex and might be considered as follows:

Philosophy The concept of continuing care, patchy as it is, is worth preserving, fostering and improving. If so it seems that the GP is the one to organise it if not to carry it out in all cases. I presume that a 'List' system of patient registration will continue whether it be with an individual doctor, group or premises where they work. If this is accepted then I believe the referral system should continue.

Attitudes Professionals and their managers must be more flexible in their approach to movement of staff between hospital and community.

Education Here is the opportunity to alter attitudes early in professional training. Multidisciplinary training, training in personnel relationships, management techniques and in the organisation and functioning of the NHS are required. At least some part of every doctor's training should be spent in the community.

Structure Of itself is not crucial but I think the district or a similar management unit should continue. At this level hospital and community workers can get together. Family practitioner services should be involved at this level. The district community physician has a major role here.

Organisation

(a) There should be more movement of doctors between hospital and community. Consultant domiciliary visits; consultant clinics in health centres, group practice premises and cottage

(community) hospitals, eg ante-natal, paediatric, psychiatric and geriatric - considerable transport problems; GPs should work in district general hospitals and community (cottage) hospitals;

(b) there should be uniform access to diagnostic facilities:

(c) the FPC (or its successor) should be more involved at district level. Planning begins here and must involve all staff. The district community physician must be a prime mover.

(d) GP records must be improved and integrated and possibly computerised.

APPENDIX EXTRACTS FROM THE EVIDENCE TO THE ROYAL COMMISSION ON THE QUESTION OF THE RELATIONSHIP BETWEEN HOSPITAL AND COMMUNITY SERVICES

'Consideration should be given to providing a *GP Liaison Office* in each major hospital. Enquiries from GPs could be routed through this office which would also have details of the practices of its area enabling it to help hospital staff establish contact in the opposite direction'. (A General Practitioner)

'**Community Care and the Hospital Service** - The link between primary care and hospital care must be maintained by contact at many more levels than has previously been possible by general practitioners. Occasional sessions by GPs at hospital have not been productive of the necessary type of contact.

Open access for assessment services at hospitals, such as X rays pathology etc, with suitable reporting, should be the right of all family doctors. The duplication at health centres of expensive equipment and highly paid personnel should be avoided. Organisation of transport between health centres and hospitals may be needed. When practicable, freedom of choice by doctors and patients as to which hospital referrals should be made, is desirable. Whilst recognising some difficulty in planning if this is permitted too extensively, we still feel that rigid rules are contrary to the freedom we hope to maintain.

Hospital staff should be encouraged to come into the community. For example, such services as geriatric assessment, paediatrics, physiotherapy, chiropody and others could be either based in health centres or be extended from hospitals to health centres and include, when beneficial, home visits. The present separation of staff between hospital and community would thus be discouraged, and freedom of movement with opportunities to work in either sphere would become accepted. Hospital staff could of course serve more than one health centre. Many branches of nursing could be interchangeable, affording greater interest for the nursing profession, and more understanding of the patients in

their homes. In-service training, when necessary, should be offered.

The community physician should occupy the key role of monitoring both the performance of the hospitals and the health of the community. Unfortunately, it seems that many are so bogged down with committee work that they are not able to do either. The district community physician should have a statutory duty, as did the medical officer of health, to report on the community annually. Additionally, the district community physician should also report on the hospital and its performance (eg waiting lists) and ensure adequate representation for the needs of the community services *vis-a-vis* the hospital.' (The Socialist Medical Association)

'It is imperative that foolproof procedures be introduced to ensure that no patient in need is discharged from hospital without the local GP and the social services department being notified in advance, and given proper opportunity to make any necessary arrangements in the home. The joint consultative committees are not yet achieving that level of effectiveness, and it has been suggested to us that part of the problem is poor liaison within the medical profession, for instance between GPs and the consultants.' (Bromley Community Health Council).

Balance between in-patient and community care

'It is interesting also to note that for many years the pattern of hospital bed provision in this region, currently 6.66 per thousand of the population as against the national provision of 8.34 beds, has been low and the number of patients treated in each bed per year has been high. We do not consider that throughput is a measure of quality but where well developed primary health care is available the minimal use of expensive hospital resources in this way has been an important feature in freeing funds for further development. We accept that it is important to watch the balance with care.' (Oxford Regional Health Authority).

'Communication

With delay in transfer of information, primary care becomes increasingly difficult. A worsening postal service is only partly responsible. The transfer of personal medical records takes longer and longer while the documents used are a serious hindrance. There is a great need to review the storage and retrieval of medical information so that it would be immediately available in an integrated fashion to both hospital and primary care services.' (The Royal College of Physicians of Edinburgh).

'Responsibilities of general practitioners to patients

It is submitted that patients committed to the care of hospital consultants by their general practitioners too often find the general practitioner either unable, or reluctant, to give them medical advice or general support in the event of the patient becoming dissatisfied or apprehensive about the quality or appropriateness of the treatment given at the hospital. Such patients increasingly turn to the Community Health Council for advice and support which only a doctor, familiar with the medical history and/or home circumstances could properly give. The Commission is asked to consider ways in which closer liaison between general practitioners and hospitals can be encouraged and the establishment of the right and duty of general practitioners to pursue the best interests of their patients, in the role of personal physician; notwithstanding the involvement of any other physicians or surgeons in their care at any time.' (Bristol CHC)

'Economy

General practice provides a domiciliary service for both the acute and chronic sick which helps to keep patients out of hospital. When specialists and practitioners have worked closely together home visiting by general practitioners and nurses has facilitated earlier discharge, reduced the number of admissions, and impressively reduced out-patient follow up.' (Royal College of General Practitioners).

'Primary health care teams have now been operating long enough for their role to be clearly understood within the community, and for the individual members to be clear on their role in the team. However, the time may now be appropriate to review the whole concept and role of the health centre and perhaps strengthen its intergration with the community. The hospitals provide support to the primary health care team by open access to X-ray, laboratories, and in some cases, physiotherapy and other services. This enables far more people to be treated entirely by their general practitioner and his colleagues.

Where the system seems to break down is the referral from hospital to general practitioner. Once a patient has been seen in a hospital clinic or been an in-patient, the hospital seems reluctant to discharge them back to the primary health care team.

Follow-up out-patient sessions are booked, patients drag up to hospitals for dressings, for stitches to be removed etc. Unless the hospitals are to be directed, the only way to cut down this unnecessary work is by a massive publicity scheme in hospitals.

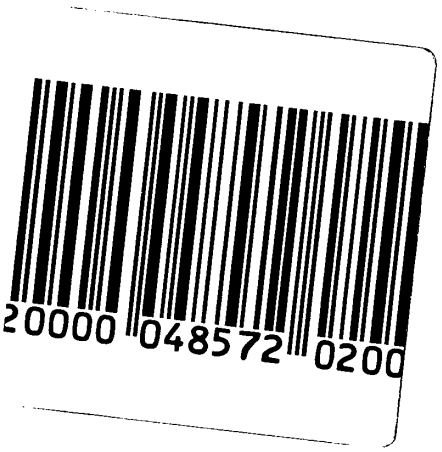
We are obliged financially to take as ideal the situation whereby in-patients time is kept to a minimum and as much care as possible is provided at home by the primary health care team, together with out-patient facilities in hospitals and health centres. It is important to try and determine the optimum time needed in hospital for various illnesses. Obviously individuals react in different ways to the same procedure, but broad principles can and are being established.

The general practitioner and the primary health care team are the key to the National Health Service; its success or failure. The general practitioner is the person most able to reduce demand for expensive National Health Service facilities, for all referrals for treatment are by him or through him. Without the total cooperation of the general practitioners changes in the National Health Services will not be obtained, primary care will not be improved, and demand on institutional services will not be reduced.' (Community Physicians in the Oxford Region)

'Community and other services

There is still too little support for the patient (and relatives) in this area. There are very many complaints surrounding discharge from hospital. Relatives and patients often suffer unnecessary worry because they are given insufficient information as to after-care. They may be directed to consult the GP who may receive no report from the hospital for several weeks. There can be real confusion for elderly people when they have to cope, with numbers of different tablets and they often have to administer to themselves difficult and dangerous medication which they find frightening.

Of widespread concern is the fact that people may be discharged when they live alone and there are no relatives nearby. This is particularly the case with elderly people. Neighbours may give a little help perhaps with shopping and it is then too readily assumed by doctors and social workers that they are then prepared or capable of taking full responsibility. With most younger women at work neighbours are often themselves elderly.' (National Board of Catholic Women)



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LIST OF TITLES IN THIS SERIES

Paper No.	
RC1	Conflict and Consensus: An analysis of the evidence submitted to the Royal Commission on the NHS
RC2	Essays on Nursing
RC3	The Expanded Role of the Nurse
RC4	Ideology, Class and the NHS
RC5	Consumers, Community Health Councils and the NHS
RC6	NHS Finance and Resource Management
RC7	Deputising Services, Prescribing in General Practice and Dispensing in the Community
RC8	Health Education and Self Help
RC9	International Comparisons of Health Needs and Services
RC10	Health Service Objectives
RC11	The NHS and Social Services
RC12	Multi-disciplinary Clinical Teams
RC13	Aspects of Dentistry
RC14	The Nation's Health and the NHS
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