TALKING POINTS

Comparing hospital resources

L T REES

Reasonably accurate information is now available on patient throughput, bed numbers, and medical staffing in NHS hospitals. The data clearly show that resources within regions are not always distributed as effectively as they might be. It is not easy, however, to digest the relevant facts in the form in which they are published because comparisons among areas and specialties need continuous cross-reference from one set of figures to another. Perhaps for this reason disparities among areas or within them (unlike inter-regional differences) have received scant analysis and any pronouncements have often been more emotional than factual.

In this paper I describe a technique of presenting the most important data visually. This makes comparisons easier. The seven health areas of Wales are used to illustrate a method in which patient turnover, bed availability, and consultant staffing levels in each area are equated to local population, and then expressed diagrammatically as percentages of the appropriate Welsh averages. The information is then incorporated into diagrams which are concerned either with a single specialty throughout the region or with several specialties in one area. The diagrams may therefore be regarded as, respectively, specialty and area profiles in which patient throughput is correlated with two of the major factors affecting it.

These profiles make it easy to recognise obvious anomalies in the distribution of resources and to identify possible connections between poor patient throughput and low bed numbers or levels of medical staff. Other factors also affect productivity and must be examined before firm conclusions are reached and action is taken. These include the extent of back-up facilities, cross-boundary flow of patients, and variations in geography, in disease pattern, and in population distribution. The initial profiles, therefore, do no more than show useful avenues of further study. Hasty conclusions—for example, on medical productivity—must be avoided.

Method

The examples concern the seven main health areas of Wales for 1976, though the individual areas are not identified. In each diagram separate symbols represent consultant staff levels, inpatient discharges, numbers of outpatients seen, and numbers of beds in the specialty, expressed in relation to specified

numbers of population (see fig 1). In most specialties the figures are for 100 000 of the local population, but in paediatrics, gynaecology, and geriatrics they relate to appropriate numbers of the age or sex groups concerned. Each measurement is then expressed as a percentage of the previously determined Welsh average. Figure 1 gives the relevant information for otorhinolaryngology in each area. Area A, for example, has a consultant staff level 25% below the Welsh average and 4% more beds than the mean, and achieves inpatient and outpatient throughput close to the average; whereas area D has a level of consultant staffing 45% above the Welsh average, a bed complement which is only

52% of the mean, and inpatient and outpatient throughputs that are respectively 80% and 70% of the Welsh average.

I am more concerned with the method of presentation than the analysis of data but a comparison of areas D and A shows that the former has the highest ratio of consultants and yet the lowest number of beds, while in area A almost the reverse applies. Area F is the teaching area of the region and seems at first sight to be generously blessed with both beds and staff. Further study, however, has shown that 20% of the patients treated in the area in this specialty come from outside the area boundaries and there is virtually no compensatory outflow. When this cross-boundary

FIG 1—Profile of otorhinolaryngology in Wales in 1976.

FIG 2—Profile of geriatrics in Wales in 1976.

FIG 3—Profile of health area E in figures 1 and 2 for the specialties listed (1976).

traffic and the burdens of undergraduate and postgraduate teaching are taken into account, the staffing levels in the area have to be accepted as being surprisingly modest. This shows how wrong conclusions may be drawn in the absence of more detailed examination.

Figure 2 treats geriatrics in the same way, though a smaller scale has had to be used to accommodate the greater variations encountered. (All figures relate to population per 10 000 people aged 65 and over.) The high clinical throughput of area F, despite its

modest bed numbers, seems to suggest a radically different system of clinical management in the area, which at least deserves debate among other geriatricians in the region.

Figure 3 is a partial profile of one single area in which similar data are presented for several specialties. The profile, taken in conjunction with waiting lists in different specialties, is a logical starting point from which the AHA might modestly reappraise its present bed allocations and plan for effective expansion in the future.

Conclusions

This method of presenting specialty and area profiles may help to identify apparent resource anomalies that need further study. Geographically appropriate diagrams of this sort might therefore be of use to regional manpower committees, medical staff committees, and health authority members. The complexity of the problems and difficulties of interpretation, however, mean that informed medical commentary should be available during any debate that takes place.

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Secretary of State sells land to GPs

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A group of six doctors, three in Leatherhead and three in Ashted, have recently exchanged contracts for the purchase of a plot of land to build new premises for the Ashted half of the practice. The sale was unusual because the county council had originally bought the site six years ago to build a health centre. Now the Secretary of State was reselling it to the GPs. What had happened and why did it take so long?

Ten years ago the expanding Ashted practice had taken on a third partner and the premises became even more overcrowded—a ground floor flat of two consulting rooms, a waiting room, tiny office, and cloakroom; a total of 59 square metres, compared with the 249 recommended for a three-GP practice unit. The two receptionists worked in conditions forbidden by the Shops, Offices, and Railway Premises Act. After fruitless years on the books of local estate agents hoping for the larger rented accommodation recommended by their accountant, the doctors realised that the ideal site for a health centre was the large Georgian house and garden in the centre of the practice, next to the clinic. They asked

the owner to give them first refusal if he ever wished to sell. When he did—by coincidence almost immediately—they told the county council. Two other practices in Ashted were also interested in moving to a health centre, and a year later the site was purchased.

Then the trouble started. The first scheme, which took another year to come off the drawing board, was for a "temporary" wooden extension housing four consulting rooms to be put up at the back of the house; the ground floor of the house was to be used for a waiting room, records and reception area, treatment room, and a fifth consulting room. It was not a large capital cost so could be funded immediately out of current account. All the doctors and the area health authority team of officers agreed the drawings. But "No," said the district management team, "we accommodate five nurses in the building; there is nowhere else for them to live, and we have greater priorities for the money." "No," said the community health council, and its chairman was specific. "I know what a desperate need there is for the very limited funds available in so many departments of health care in the district." "No," said three lay members of the AHA after a visit, "a bad buy, and the method of funding would create a precedent." So the scheme, costing £40 000, was turned down in October 1975.

In November 1975 the doctors wrote to

the AHA chairman asking if they could buy the garden to build their own practice premises. He agreed to investigate, promising to reply "as soon as I can." Six months passed before the next meeting—between AHA officers and GPs in May 1976. The minutes record that "it was agreed to investigate the possibility of releasing part of the site for sale to the GPs." The next meeting was five months later, chaired by the area administrator. "Watch out," whispered the LMC secretary, "they've brought on the big guns." The AHA wanted priority for a health centre in Leatherhead, where the clinic was bad, not in Ashted, where the clinic was good. But the authority wished to retain the possibility of building a health centre in Ashted in the future. The practice, however, had good premises in Leatherhead and did not wish to move to a health centre there. The meeting was not a success.

Nearly a year after asking to buy the garden site, the Ashted GPs were offered, at some distant date, the possibility of a permanent building attached to the clinic but sited in the library car park with the windows looking at the library windows on one side and a brick wall 4 m away on the other. The beautiful garden site was to be a new car park. This layout would constitute a health centre. A new building in the garden 50 metres from the clinic would not, for it would not be attached to the clinic. Anyway, the AHA was sure that planning permission could not be obtained for the garden site. A wretched site, the advent of Barbara Castle, and the increasing expense of health centres decided the doctors. "Sell us the garden," they wrote to the AHA chairman yet again, "or we will build elsewhere." In February 1977 the AHA

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