TALKING POINT

Community hospitals—what is their role?

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The Department of Health and Social Security's document on community hospitals indicates the latter's function in the overall health services of a health district.¹ The DHSS suggests that surgical services should not extend beyond those which a general practitioner would expect to perform in his own practice or health centre. Facilities for general anaesthesia should be provided only for minor surgical procedures and for dentistry.

Investigation at a 40-bed peripheral hospital (planned for development as a community hospital) showed that 19% of orthopaedic, 11% of gynaecology, and 10% of general surgery for the district was carried by this hospital. If the Department's guidance on surgical services was accepted in this district it could adversely affect the existing resources of the district general hospital. The resulting problem could be overcome only by increasing financial capital investment, which is contrary to the DHSS's present philosophy of maximising the use of existing resources.

Present situation

The hospital is part of the acute resources of a health district with a population of 188 500.² It is 14 miles (22 km) from a district general hospital of 360 acute beds and a consultant maternity unit. The DGH has four main theatres for all surgical work including accident and emergency cover. The present theatre schedule indicates that the surgical sessions undertaken at the peripheral hospital could not be accommodated without additional recruitment of theatre staff and facilities. (A suggested norm of provision has been one surgical theatre for 40 surgical beds.) The DGH has fewer acute beds than the suggested norm of provision and the transfer of any additional work load would require additional facilities (see table).

The peripheral hospital serves a new town of 26 000 people, and a total catchment area of 45 000, approximately 25% of the health district's population. There are 40 beds, 10 general practitioner maternity beds, and two unclassified beds.

Using the 1972 hospital activity analysis data I investigated the type of operation performed at the hospital. Most operations were in the minor/intermediate classification based on classification in *The Law Relating to Hospital and Kindred Institutions*.³ The following list shows the range of operations which includes: in surgery—herniorrhaphy, dilatation of urethra, haemorrhoidectomy, ligation of vas, circumcision, and stripping and ligation of varicose veins; in orthopaedics—external manipulation under GA, tendon operations, cartilage removal, nerve decompression, and joint manipulations; and in gynaecology—dilation and curettage of uterus, and sterilisation. Consultants decide the cases for admission and they or their registrars do the operating. There are no resident medical officers; the local GPs providing on-call medical cover. Some practitioners have clinical assistantship sessions at the hospital.

EFFECTS OF WITHDRAWAL OF SERVICES

The additional work load could not be undertaken unless further capital and revenue was provided for additional theatre facilities and staff, and an

increase in inpatient resources. The revenue consequences would not be offset by not operating at the peripheral hospital. The waiting lists and waiting times for operation would increase for the health district as a whole and patients from the periphery would have to travel further for operations.

The ambulance service would become more expensive as more patients would be carried to and from the periphery. The present estimated cost is 55p per mile (34p per km).

The DHSS circular suggests that up to 20% of acute beds of a health district should be located in community hospitals (predominantly convalescent), and that 50% of geriatric and the majority of psychogeriatric beds should also be in community hospitals. This would produce a predominantly long-stay hospital. The presence of acute services and the involvement of consultants in peripheral hospitals is known to have considerable morale raising effect on nursing staff.⁴ Any reduction in the range of work and hence consultant involvement could materially affect the present morale and recruitment, and staff would be unlikely to travel 14 miles to the DGH.

Patients could no longer be treated locally, whereas the philosophy of community hospitals was to try and prevent the use of expensive DGH resources where they were not necessary. It seems illogical to take patients 14 miles to a DGH for surgery when this is currently being accomplished locally. The peripheral unit provides the same quality and standard of care since consultant staff do the anaesthetics and operations.

Liaison between the community nursing staff in the periphery and the surgical unit at the DGH could present difficulties whereas at present the local nursing services are well integrated. More seriously, however, the community as a whole would suffer a decline in the present standard of service, facing either an expensive journey for themselves by their own or public transport or the authority ambulance service. Very little attention is ever paid to the economic effect of alterations in patterns of health care on the community.

Conclusion

Health authorities are continually asked to make better use of existing resources,⁵ and it is illogical to close peripheral hospitals only to face additional capital and revenue consequences. Not all peripheral hospitals have the facilities of the one investigated and clearly those would not be affected. I have tried to highlight the problems that could be caused if the present advice from the DHSS is followed rigorously and to ask again, "What is the role of the community hospital?"

¹ *Community Hospitals*, DHSS Circular HSC(IS)75.

² *Census 1971 County Report Hampshire Part 1*, Office of Population Census and Survey. London, HMSO, 1972.

³ Speller, S R, *The Law Relating to Hospitals and Kindred Institutions*. London, Lewis, 1966.

⁴ *Health and Social Service Journal*, 1973, 83, 1302.

⁵ *Review of Health Services and Resources Planning Task 1975-6*, DHSS Circular DS 85/75.

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Analysis of work load by specialty at the district general hospital and the peripheral hospital*

Hospital	Specialty	Average No of beds available per day	Required by norm per 1000 pop	Average No of beds occupied per day	Discharges and deaths per available bed†	Average length of stay†	Discharges and deaths per year‡
District general hospital	General medicine	63.4	97	58.3	29.8 (22.9)	11.3 (13.9)	1890
	General surgery	73.3	86	63.8	38.7 (31.9)	8.2 (9.0)	2838
	Orthopaedics	42.0	69	39	23.4 (19.5)	14.7 (15.2)	979
	Gynaecology	28.2	35	25	55.3 (45.4)	5.8 (6.1)	1560
Peripheral hospital	General medicine	3	0	2.3	18.7 (22.9)	14.9 (13.9)	56
	General surgery	6	0	4.4	33.8 (31.9)	7.9 (9.0)	203
	Orthopaedics	4	0	2.4	36.7 (19.5)	6.0 (15.2)	147
	Gynaecology	4	0	1.7	54 (45.4)	2.9 (6.1)	216
	GP medical	11	0	7.6	23.6	10.4	267

*Information from Wessex Regional Hospital Board, 1972.

†National figures given in brackets.

‡Excludes day surgical cases.