From the Editor

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The future of the acute hospital

Among the myriad of medical abbreviations, the DGH (district general hospital) is perhaps one of the most readily understood, held in high esteem and fiercely protected. Established in the era of general medicine and general surgery it continues to provide accident and emergency (A&E) services, acute medicine, surgery, obstetrics, gynaecology and paediatrics. This model of care has been under threat for many years, principally because of increased specialisation and the difficulties in providing round the clock cover in each specialty as working hours are reduced.

In the past as one of the regional advisers for the Royal College of Physicians, we made visits with the regional adviser in paediatrics. We were alerted then to the challenges ahead. At that time if special care baby units were to survive they needed three tiers of medical staff (junior, middle grade and consultant cover), 24 hours a day, 7 days a week. These specialist units could simply not be sustained in every DGH, but their loss in turn threatened the viability of the obstetrics unit. The relocation of neonatal paediatricians also threatened the paediatric service and the loss of this resource adversely impacted on the A&E services. It was easy to appreciate the ongoing domino effect.

The general surgeon with their wide ranging technical skills needed to sustain the DGH has, because of major technical developments, all but disappeared and led to the emergence of surgical specialists to deal with specific problems. Each acute surgical specialty (upper gastrointestinal, colorectal, urology and vascular) has to provide round the clock cover and this cover (in addition to maintaining a reasonable workload) can only be sustained in large centres.[1]

Medicine has faced its own challenges in recent years with the huge and continuing increase in acute medical admissions. The subspecialty groups face challenges of their own in maintaining and developing their specialty skills when they have often been overwhelmed by demands within acute medicine. This has led to the emergence of acute medicine as a specialty in its own right.[2]

All these changes tend to point to larger hospitals, more remote from the communities they serve. This contrasts with the recent White Paper, *Our health, our care, our say*, which focused on providing care closer to the patient and moving some outpatient consultations and diagnostics from acute hospitals into the local community.[3] If one adds to this heady mix, the introduction of Payment by Results and practise-based commissioning, the pressures of the European Working Time Directive, more rigorous approaches to patient safety and the changes in postgraduate medical training, the dilemma between providing local and centralised care seems impossible to resolve.

Help, however, is at hand with the publication of *Strengthening local services: the future of the acute hospital.*[4] If one key element could be extracted from the report then I would identify the term ‘network’. This approach has already been used extensively in Scotland and identifies within each specialty which service component can be delivered at each level of care. This concept has been embodied in an updated report for Scotland entitled *Building a healthy health service fit for the future*,[5] and has also been incorporated in reports concerned with access to healthcare in Wales.[6]

Certain areas of planned care, for example uncomplicated elective surgery, outpatient consultation and diagnostics, would see competition between local hospitals and other providers with different incentives emerging between each institution. As a consequence some clinical staff may spend more time working across institutional boundaries and as part of the structured clinical networks. Centrally the local acute hospital would serve as one key component of the local urgent care networks closely integrated

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with primary care, ambulance services, hospital, social care and mental health services.

The other key recommendation is that some of the traditional DGH services, such as trauma, emergency surgery, specialist surgery, paediatrics, obstetrics and gynaecology, would be managed across well-defined and accountable networks. In plain English, not all services can be provided locally. Alongside these changes, ambulance services would play an expanding role in providing immediate care and making key decisions on appropriate routing of patients requiring further treatment. Where A&E departments are provided they would need to be supported by a minimum set of acute care services to ensure patient safety. This approach helps to square the circle, but it is easier, of course, to write a report than to implement its findings. Quality of care, patient safety, evaluation of outcome and the economic implications of change must remain central in any proposed implementation.

References

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6. NHS Wales. *Access and excellence: acute health services in Wales*. Cardiff: NafW, 2000.

And finally ...

Warm congratulations to Alan and Marcia Emery whose book, *Surgical and Medical Treatment in Art* has won the BMA Illustrated Book Award and received a commendation in the Basis of Medicine category. Published by the Royal Society of Medicine and the Royal College of Physicians, this is the second volume of a series based on articles published in this journal (see page 620 for further details).

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