The future of the small(er) district general hospital

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Introduction

With the inexorable advance of technology, the UK's larger hospitals, which are frequently tertiary or quaternary centres, appear to grow bigger, consuming increasing proportions of the available national resources and attracting first-rate medical graduates who aspire to develop or contribute to delivering cutting-edge clinical services, education and research. Striving for the new and the excellent, embracing intellectual initiatives and promoting scientific advancement are all essential if we are to enjoy a health system capable of delivering high-quality care that improves continually with advances in knowledge. However, this picture of achievement is counterbalanced by serious and growing threats to equality in the system.

First, cutting-edge therapeutic interventions should be accessible to all, regardless of geographical variations in proximity to a centre of excellence. Moreover, what might be termed the 'bread and butter' or day-to-day care that serves most of the population deserves to be allocated an appropriate and equitable proportion of the resources available. Second, the public desire and deserve health care delivered as close to their homes as is feasible and safe; familiarity with the environment, not having to travel significant distances to access care and having immediate support from friends and family are hugely important factors in aiding recovery from illness.

There is a challenge, however, in achieving the necessary compromise between delivering effectively those services that can (and should) be provided locally ('core services') and accessing those that cannot, for reasons of economy of scale and safety of delivery. Indeed, the UK report on emergency services published at the end of last year recognises this.[1] Furthermore, smaller district general hospitals (DGHs) and community hospitals are struggling both to achieve financial balance and to attract high quality clinical staff, both nursing and medical, as they find themselves in competition with larger centres. Longer-term and better-informed planning is therefore essential if the future of the safe, efficient and clinically balanced smaller DGH is to be assured.

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Defining core services

'One size, pattern or combination of clinical services does not fit all' is a mantra more frequently articulated than followed in practice. It is not intended to exclude potentially valuable lessons learnt from examples of good practice but, rather, to emphasise that the engagement or transference of these ideas should be led by an adaptive rather than a slavishly adoptive approach. Intuitively, the structure of a health service should reflect the nuances of local needs and preferences. The prevailing patterns of demography, social factors, transport and geography are all factors that should determine the shape and size of a local secondary health care system optimised to meet the needs of the community it serves. However, underpinning this deductive approach are core or essential clinical components and a multi-specialty emergency service is one such example. It is within these core elements that the scope of specialty care provision will vary between local hospital providers.

A deductive approach to service design requires each small DGH to define 'ceilings of care' within its core services and to analyse local factors to inform its decisions. Safe delivery of specialised services, for example applied to stroke or heart attack victims, demands a minimum case-load and thereby the ability to maintain appropriate skill levels. Inevitably, this means that 'best care' for some clinical conditions will mandate referral to a specialist centre and this will demand responsive transfer arrangements that include not only speedy ambulance transport by road or air, but also highly effective lines of communication between DGH and tertiary centre. The optimal timing of a patient's transfer is better served by a conversation that is styled, 'I have a patient for you' rather than 'Do you have a bed for this patient?' The incorporation of the DGH into a healthcare system of this type is a fundamental principle of the Future Hospital Commission.[2]

Regardless of local decisions on levels of 'ceilings of care' in smaller DGHs, access to precise, speedy diagnosis and resuscitation of seriously ill patients must be preserved, and this mandates the presence of skilled personnel. Many clinical services require the support of others in order to provide safe and efficient patient care. Acute medical patients cannot be adequately managed nor elective surgery delivered in the absence of either skilled intensive care or comprehensive diagnostic services.

If these premises are accepted, fundamental themes begin to emerge. First, defining core services in a smaller DGH requires the local establishment of consensus-informed definitions of

appropriate ceilings of care and of the skill mix of personnel required to achieve these. Second, transport arrangements and systems facilitating the movement of patients and information between hospitals (embracing the concept of pulling patients into tertiary care rather than pushing them) are vital. Finally, it must be recognised that recruiting and retaining highly trained staff is a priority for any secondary care facility, regardless of its size or the extent to which its service is comprehensive. Moreover, removing one core service may threaten the integrity of others and is a clear testament to the need to avoid 'pruning' smaller DGHs by removing departments that provide essential diagnostic or clinical support.

Clinical staffing

In the smaller hospital, accurate diagnosis, efficient resuscitation, deciding if transfer is required and stabilising patients sufficiently to facilitate safe movement are fundamental (but sophisticated) clinical skills. Smaller hospitals struggle to recruit and retain clinical staff, particularly within acute care, and strategies are required to ensure that they can compete with larger institutions in recruitment of staff within the acute medical specialties, emergency medicine and general surgery. To achieve this will require flexibility of thought and application. There is confusion (and conflict) between those medical roles that are seen as generalist and those that are devolved to specialists. An individual consultant physician commonly divides their professional (clinical) commitment between specialty roles and supporting the acute intake. This applies particularly in the smaller DGH, where acute general medical duties may be perceived as an unwelcome intrusion into specialty practice. Further, consultants who are exclusively engaged in delivering acute general care may consider their role more onerous than that of their specialist colleagues. At worst, a perceived consultant hierarchy in favour of specialists may emerge to the detriment of professional cohesion. Engendering the recognition of equality of opportunity, working conditions and professional status regardless of specialty should be a priority for all hospitals, which increasingly need access to a cadre of physicians who are highly skilled in resuscitation, broad-based diagnosis and correction of abnormal physiology. Second, the concept of the 'general physician with an interest' is outmoded. Technological advance demands increasing specialist knowledge and skills from its proponents and training programmes cannot be expected to provide these skills as well as including sufficient exposure to general medicine. Similarly, short-term exposure of acute medicine and emergency medicine trainees to multiple specialties will only create general physicians with imperfect knowledge and skills.

There is a large body of evidence to support the contention that patients with a defined single pathology have improved outcomes if managed by an appropriate specialist. Consequently, immediate triage to relevant specialist opinions (independent of or via generalists through the use of appropriate management protocols) should help to avoid the unnecessary duplication of emergency patient assessment.[3]

Both acute and general medicine are specialties in their own right and should be promoted as such. Adopting the term 'internal' to replace 'general' promotes the recognition of the discrete sub-specialties (acute medicine, chronic disease management and elderly care) of which it is comprised. Developing appropriately structured training programs to reflect exposure to these sub-specialities, including experience gained at varying levels of clinical dependency up to and including intensive care, should feature significantly for those trainees choosing to specialise in acute medicine. By contrast, those seeking appointments orientated towards chronic disease management (and there is huge potential for expanding this aspect of consultant-led care) should train with a different emphasis to include leadership of multi-professional teams, holistic management of patients with multiple clinical problems and development of care strategies that span community, primary and secondary care environments.[4]

Competition between secondary and tertiary hospitals for recruitment of top-class graduates is a difficult problem but a potential solution could be offered by promoting joint working contracts, through which a substantial number of physicians appointed to tertiary hospitals would be contracted to work sessions at one or more linked smaller DGHs. Not only would this ameliorate the recruitment and retention problems currently experienced by smaller hospitals, but it would also provide the variety of day-to-day specialist advice and assessment that smaller hospitals so desperately need. By virtue of being linked appointments, communication between secondary and tertiary care centres would be facilitated and a 'health care system' suited to the needs of a geographically defined population would emerge.

Integration of services: the healthcare system

There are interesting examples of successfully integrated health services nationally[5] and internationally[6] and there must be opportunities to adapt these in order to develop integrated care that is patient-centred and dismantles the barriers that separate the various elements of community services, primary and secondary care, mental health services and social support. Improved dialogue between primary and secondary care with mandatory communication at various stages of a patient's hospital stay would assist the processes whereby care is transferred from the hospital to community settings. Avoiding hospital admission (or even attendance) has to be a future priority and initiatives such as the 'virtual hospital ward', where care is supervised by a consultant but delivered vicariously through a team of professionals visiting the patient's home, have exciting potential for reducing repeated hospital attendances for those with long-term disabling conditions. The concept of extending consultant-led care across traditional boundaries – out of an exclusive hospital environment and into the community – will be a future priority, and smaller hospitals are ideally placed to contribute to these advances in the integration of care. Training and appointing internal physicians with a special interest in chronic disease management is an initiative that should enable such an integrated approach, but there is also a role for specialists who regularly manage patients with long-term conditions, such as diabetologists, rheumatologists, dermatologists and chest physicians.

Conclusion

Defining the core services delivered by smaller hospitals is fundamental to ensuring their survival, a process that should be initiated and owned by the populations they serve. Equally vital

is the need to improve staffing shortages in such institutions. By integrating them into larger health care systems, staff can be shared and rotate between physical locations.

Future clinical redesign initiatives should be assessed as scientifically as possible. We should be wary of heavily edited review articles (particularly of evidence of good practice from elsewhere) that can reach biased conclusions and we need to be astute when choosing outcome criteria to assess the success of a service intervention, distinguishing carefully between efficiency and quality markers; there is a significant difference between 'targets' and 'outcomes'. ■

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