APPENDIX L

HOSPITAL SERVICES

THE FUTURE PATTERN OF HOSPITAL PROVISION IN ENGLAND

A Consultation Paper from the
Department of Health and Social Security

May 1980

FOREWORD

Hospitals in England are getting larger. In 1969 less than a quarter of our non-psychiatric beds were in hospitals of more than 500 beds. By 1978 the proportion had risen to one-third. Looking ahead, Health Authorities are planning more large hospitals as money becomes available. Some of those planned are very large indeed - 1,000 beds or more. Because there is a limit to the money available for running hospitals, the plans imply the closure of many smaller hospitals.

There are sound medical reasons - and some financial ones - for concentrating some services in district general hospitals. Among other advantages, such hospitals can provide a much greater range of services and up-to-date expensive facilities, thus improving patient care. Yet there is a real risk of concentrating services more heavily than the advantages strictly justify, to the detriment of other considerations such as the accessibility of hospitals to patients and visitors, and the sense of identity which many local communities have with their local hospital. There are also a number of arguments against building very large hospitals: their remoteness, complexity and impersonality, and the effect these have on the morale of staff.

Practical problems reinforce the doubts which I have about present policies and plans. It takes many years to finance and build a major new hospital. Few parts of the country are ideally served at present, sometimes because the available money has gone to major developments elsewhere and sometimes because only the early phases of a new hospital have been

completed, leaving an unsatisfactory interim pattern. This state of affairs will continue, if we go on pinning our hopes on too many major building projects which may be decades away. It would generally be better to concentrate on making the best of what exists.

For these reasons - getting the balance right between medical and other considerations, and taking a realistic view of what we can achieve in the foreseeable future - I believe that the time is ripe to take a fresh look at our policies. We should modify them where experience and economic expectations show modification to be sensible. This consultative document suggests what changes might be made.

Although this paper suggests mainly changes in hospital services, I believe that their adoption and implementation would also considerably benefit the provision of primary care and other health services - health service planning should be comprehensive.

In the past Government has tended to prescribe a single basic pattern for the whole country. This is both unrealistic and undesirable. Different circumstances demand different solutions. So I have no intention of producing a blueprint to be applied everywhere. We do not need a national development plan, but we do need some ground rules. Our aim is to establish a set of broad policies, acceptable to the professional and other interests concerned, and then to give Health Authorities the greatest possible discretion within those policies and within their financial allocations to arrange their services in the way best suited to their local circumstances.

I should like to have the views of the general public, as well as of Health Authorities and the health professions on what the broad policies should be. This consultation paper is therefore being given a wide circulation. I hope that those who receive it will take the opportunity to let the Department have their views.*

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Minister for Health

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THE FUTURE PATTERN OF HOSPITAL PROVISION IN ENGLAND

INTRODUCTION

1. The Department of Health and Social Security is issuing this consultation paper on changes in policies for planning hospital services in order to obtain comments from professional and other interested bodies, and from NHS authorities. The changes proposed could significantly affect the future pattern of hospitals, their size, their range of provision, and their accessibility and relations with the communities they serve. All hospital services are covered except those for mental handicap.

2. Hospital policy for the 1960s and 1970s was to concentrate hospital services in major hospitals with only a limited range of services remaining in small local ("community") hospitals. It is proposed that this policy be changed to place less emphasis on the centralisation of services in very large hospitals and to allow for the retention of a wider range of local facilities. The new policy will have varied local implications - and is intended to allow for local flexibility.

POLICY OF THE LAST 20 YEARS

3. For the last 20 years the policy has been to develop a comprehensive network of district general hospital services, normally on a single site - but occasionally on a split-site or with 2 or 3 hospitals working together. Other local hospitals would be retained for geriatric or elderly severely mentally infirm patients and some limited general work. This has meant the planned elimination of a good many hospitals, including both small and medium sized ones,

which could not fit into these roles; and the provision of district general hospitals of up to 900 beds, on a single site, with some of them planned to exceed this figure.

4. The "district general hospital services" concept, embodied in the 1962 Hospital Plan, was aimed to secure important clinical and professional objectives:

- to provide acutely ill patients and those with complex conditions with all the specialised (and often expensive) staff and facilities their treatment requires together in one place;

- to enable expertise to be developed in less common as well as routine work; to group specialties together in units of the most economical size, particularly as regards staffing;

- to provide the more sophisticated support services efficiently and economically;

- to provide clinical facilities suitable for under-graduate and post-graduate medical education and training.

5. These are still important objectives. Safer and more effective medicine and a more comprehensive service result from a concentration of resources, which can also make it unnecessary to duplicate expensive facilities. The 1962 Hospital Plan, involving district general hospitals with 300-800 beds or more, reflects the view that such considerations far outweighed the disadvantages of longer travel for some patients and their visitors.

Subsequent reports, in particular the Bonham-Carter Report of 1969, implied even greater concentration and made no reference to the convenience of patients.

6. But many factors have changed since the policy was formulated and we have learnt by experience some of its adverse effects on patients and staff alike. It is right that it should now be reviewed.

THE REGIONAL PATTERN

7. Regions inherited different patterns of hospital provision and in the period 1960-1980 have planned, and made some progress with, a new pattern, based generally on the dgh concept but suited to their particular geographical and social needs. In some places this has involved starting from a very low baseline or planning to replace a large number of unsatisfactory units, sometimes by planning to build a few very large new hospitals and to concentrate the new and more expensive facilities in them. In others the overall pattern was reasonably satisfactory, with a good relationship of main hospitals to centres of population, and the main task has been to modernise major hospitals to bring them up to district general hospital standard - without involving a great expansion of their size nor numerous closures of medium-sized units.

8. Whatever their inheritance most Regions have a considerable way to go to reach their final goal and the current shortage of money means that some building plans are farther from attainment than was once expected. Few plans with such a long time-scale are immutable and it is therefore sound to review them in order to ensure that they

are sensible in the short and medium-term as well as in the long. It is also necessary to make sure that services to patients are provided in the most effective way in what may previously have been considered only an interim period.

9. The direction of policy for the next 20 years must also recognise that regional and local differences still exist and should be allowed to continue to do so.

THE CASE FOR REVIEWING POLICY ON THE SIZE OF HOSPITALS

Large Hospitals

10. Experience has shown that a large degree of concentration on a single site may in itself have serious disadvantages. Communications of all kinds within the hospital become more complex and difficult, as does management. Patients and relatives, as well as staff, find the hospital too impersonal. It often suffers from physical disadvantages, such as distance between different departments and the need to provide air-conditioning to internal areas, with high energy requirements. It is sometimes supposed that one building is cheaper to build and run than two, of equivalent functional content, but this may not always be the case.

11. Steep rises in motoring costs mean that travel to hospital is more expensive for patients, staff and visitors. Ambulances and other forms of hospital transport all cost more to run. Public transport costs more. And in rural districts it is not as comprehensive, nor as frequent, as it used to be - an important factor for many elderly patients and mothers with young children.

Small Hospitals

12. Relationships with the local community, and with primary care services, are easier where people can identify with the hospital which serves their own community. Local pride in an institution prevents it from becoming isolated and encourages support in many practical forms.

13. Recruitment of some categories of staff is easier when the hospital is "local". This is only partly attributable to easier travel; commitment of a community to its hospital also influences the enthusiasm of people to work in it. And this seems to be all the more true of volunteers.

14. Technical developments within medicine, and changes such as teamwork involving different specialties and disciplines, while not necessarily requiring an increase in numbers of beds, do cause mounting pressure on sites where the majority of acute specialties are grouped. The NHS cannot afford to lose physical assets which are suitable for those patients not needing the full panoply of investigation and treatment.

15. All these factors suggest a need to reconsider the balance between concentration of services and convenience for patients and staff.

RANGE OF HOSPITAL SIZES

16. In England out of a total of some 2,000 hospitals over half have less than 100 beds and a further 600 hospitals have between 100 and 400 beds. The Government has already made clear its wish to retain small hospitals wherever sensible and practicable, though recognising

that some closures of old, inefficient or badly situated units are necessary. Constraints on building new hospitals, social and geographical factors all suggest that many larger hospitals should also be retained. In urban areas they could form an economical and effective part of comprehensive district general hospital services provided on several sites. In rural areas and smaller towns they could provide a range of hospital services, but not merely long stay services, for the local community. Providing locally in small and medium-sized hospitals for patients not requiring the full range of dgh facilities, and particularly for those who require relatively long stays or frequent visits, admirably meets the community need for "our local hospital"- even though the range of services provided might differ considerably from hospital to hospital, according to local circumstances. Appendix I sets out in more detail some of the options available.

17. It will not be enough simply to retain these hospitals as they are now. Consideration will need to be given, in the light of the needs of the district as a whole, to the range of functions they perform. For many some change of use will be required.

18. The success of a policy which involves the retention of smaller hospitals will depend on sound planning and efficient communications between the various locations. It will depend also on careful selection of the specialties and support services to be provided in each hospital, on the combination of in-patient and out-patient facilities, and on the consultants' handling of their admission policies to ensure that, as far as possible, patients are admitted to hospitals

offering staffing levels and the range of facilities appropriate to the treatment they require. Where both major and satellite facilities are used in the same specialties it would be important for consultants to organise their work and time to ensure proper selection of cases and to avoid detriment to the image and quality of the service at local hospitals.

19. Whatever the pattern of services there will be a need for a main hospital containing the major accident services and the range of specialised facilities needed to deal with the more difficult and complex case. Appendix I suggests an appropriate size range but bed numbers are at best a very crude measure and there is no suggestion that there should be a fixed limit on the numbers to be provided on any one site. Local circumstances, such as site availability, would in any case make such a limit impracticable. However most existing plans envisage hospitals much largr than is implied by these bed ranges suggested and have significant consequences in terms of closures and concentration of services. Many of these plans could be modified in the direction suggested in this paper. The main decisions needed to achieve this would be:

- to provide in other hospitals (possibly involving some change of use) for part of the bed requirements for the acute specialties;
- to provide up to 70% of the geriatric beds elsewhere;
- to limit the size of the psychiatric unit.

Such modifications would have important implications for specialty policies. Appendix II sets out an initial consideration of the main points.

20. Important features of hospital policy have been the increasing association of "non-acute" specialties treating the mentally ill and chronically sick (including geriatric medicine) with "acute" specialties such as general medicine and surgery, and the reduction in the number of single specialty institutions. These will continue to be aims of the new policy. The proposals in this paper will still allow for assessment and some short stay beds in these "non-acute" specialties on the main dgh site. At levels of provision currently being planned a dgh of the sort of size indicated in Appendix I would leave a sufficient range of beds to be provided elsewhere to permit an acceptable mix of services in the other hospitals.

CLOSURES AND CHANGE OF USE

21. The proposed policy would mean fewer closures than are now planned, particularly in rural areas and small towns. However some closures will be necessary and appropriate under any policy - and indeed the majority of closures are accepted locally. Rationalisation does not always mean unacceptable centralisation of services. Some hospitals are structually or functionally obsolescent and are not susceptible to adaptation. Some are inconveniently sited or cannot be satisfactorily staffed. There will be others where plans for closure have advanced to a point where it wouldnow be prohibitively expensive to retain them, even if it were desirable to do so.

22. As indicated in paragraph 17, some changes of use will also be required, both to produce a sensible pattern of general services and to provide satisfactorily for groups such as the elderly, the handicapped, the elderly severely mentally infirm and the mentally ill. For instance it will often not be possible to close large and unsuitable long-stay hospitals, particularly in mental illness, unless some or all of the services can be reprovided elsewhere.

FINANCIAL IMPLICATIONS

23. Prima facie, running two or more units is more expensive than running one of comparable standard, since overheads will be higher and there will usually be duplication of some services. Staff costs - mainly medical - will be higher where they have to travel between two sites and there will be less time spent with patients. Such a policy could therefore result in a lower overall quantity of clinical service for a given level of revenue than would be possible with a more concentrated service. The problem will be most apparent in shortage specialties (eg anaesthetics) where even increased expenditure could not make good the lower quantity of clinical service. There could also be delay to other improvements in - and redistribution of - services.

24. It will therefore be essential to ensure not only that individual hospitals are planned to run as economically as possible, but also that a proper balance is struck between clinical, social and economic factors and that the financial premium (if any) to be paid for smaller hospitals on more sites is properly assessed in advance. (The concept of "appraisal" of capital projects has recently been developed, in the Review of

Health Capital, published to health authorities.) It follows that the Department does not regard these proposals as a means to secure reductions in planned capital expenditure.

STAFFING

25. Some staffing problems eg local recruitment should be eased by the proposed changes. But there will be problems too. In particular where a hospital needs to employ junior medical and dental staff in training posts ways will need to be found of ensuring to the satisfaction of the Royal Colleges that their experience is relevant to their training needs, and properly supervised. Further, the problem of arranging cross-cover and achieving the target of shorter working hours for junior staff is more difficult in smaller hospitals.

26. If full 24-hour staff cover cannot be provided at a hospital, its role becomes severely limited. Ways of increasing the contribution of gps may need to be sought. The recently negotiated improved terms of remuneration for gps working in hospitals may help.

27. Similarly, smaller hospitals do not have the same scope for deploying nursing staff as larger ones. Where nurse training facilities do not exist the problem may be exacerbated; such units have to rely on an unacceptably high proportion of unqualified nursing staff. The effect of any major change in hospital policy on plans for nurse training will require early consideration in the light of local circumstances.

CONCLUSION

28. This paper has discussed reasons why from now on plans for hospital provision should incorporate major district general hospitals that are generally smaller than those envisaged in the 1960-1980 period; and retain, in a variety of useful supporting patterns, more of the other hospitals than had previously been expected. Such a shift of direction provides plenty of scope for local variation. Some of the implications of the proposed changes, including the financial implications, will in many cases depend substantially on the local circumstances. There will inevitably be some costs to set against the benefits. Any financial costs - which, broadly speaking, are likely to be a sacrifice of potential revenue savings rather than an actual increase in expenditure, offset by some reduction of pressure on the capital programme - will have to be met within the financial allocations to the NHS. Some adjustment to priorities is thus implied, though not necessarily everywhere.

29. In summary, what is proposed is:

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

ii. to accept the provision of district general hospital services on more than one site as a valid long-term, policy, and 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;

iii. 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.

30. Regional Health Authorities have already been asked to review their plans in the light of the suggested policy in order to identify any schemes currently at an advanced stage of planning which appear to be incompatible with the above proposals. These will be considered urgently in order to decide whether there are nevertheless good reasons for allowing them to proceed.

APPENDIX I

NEW PATTERN OF HOSPITAL SERVICES

Urban Areas

1. In urban areas which do not divide naturally into separate catchment areas, and where communications are good, a number of options may be available. The solution adopted will depend on such local factors as the present pattern of services, the state and adaptability of the stock, the availability of sites and the economics of different solutions, including the implications for provision of specialised support services.

2. In conurbations, economic and staffing considerations will nearly always rule out a pattern of services which simply replicates a semi-comprehensive service on a number of separate sites - a series of "mini-district-general hospitals". The aim might rather be a combination of units, operating together to provide a comprehensive hospital service, with the dgh element either on a single site or on more than one site, depending on local circumstances. Other hospitals of the sort described in paragraph 3 might be retained where they are some distance from the dgh complex.

Rural areas and smaller towns

3. In rural areas, or small country towns, the situation is different. The desirability of retaining local units is greater, but so are the problems of doing so on a satisfactory and economical basis. To the extent that medium-sized hospitals are retained to provide services in smaller towns or otherwise at some distance

from main district general hospital services, they may appropriately provide - or be adapted for - a wider range of service than has previously been envisaged for the small local community hospitals. The range of services - which would not all necessarily be found in every such hospital - might be:

- some casualty service preferably staffed by general practitioners (but not the major accident service, which should remain a dgh facility);
- clinics for out-patients, including an ante-natal clinic;
- selected surgical and medical specialist services, with day surgery and day abortion facilities, and related rehabilitation;
- geriatric services, with day centre and rehabilitation;
- provision for elderly severely mentally infirm people;
- some mental illness services.

The smaller hospitals would also provide a selection of these services, depending on the facilities available and their staffing arrangements. The significant clinical advantages, from the point of view of safety of mother and baby, of obstetric provision on a main site associated with paediatrics and key support services, and with full medical staff cover, are widely recognised. It would only be appropriate to consider retaining dispersed provision in the most scattered communities, and even there the

importance of good staff cover and available support from the main centre must be taken fully into account.

The Major Hospital

4. Plans for major hospitals being developed to provide comprehensive district general services typically include, in accordance with past guidance by the Department, a major Accident and Emergency department, a psychiatric unit, most of the District's acute beds, all obstetric beds, and up to 50% of geriatric beds required for the assigned catchment area, together with supporting diagnostic and rehabilitation services. Some, particularly teaching hospitals, also contain regional or supra-regional specialties. It is proposed that this range of service should be retained in the main hospital which may itself be part of a dgh complex. But on what scale need they be provided? Recent calculations in the Department have suggested that a balanced hospital containing the major A and E unit, associated surgical and medical services, the majority of maternity beds, the childrens' unit, a smaller psychiatric unit and a modified target of 30% of geriatric beds would require a minimum of 450 beds. For a catchment population of 200,000 this would leave about 500-600 in these specialties to be provided elsewhere. Sometimes - where the catchment population is larger or for other reasons - it might be appropriate to provide up to 600 or so beds in the main hospital. These figures do not cover the inclusion of sub-regional (eg ENT), regional (eg neurology) and supra-regional services, and there may also be a case (in addition to such special services) for greater concentration of services in teaching hospitals; some 200 or so additional beds may be needed for these purposes.

Design of Hospitals

5. There has been some confusion about the role of Nucleus hospitals within overall hospital policy. The first phase of a major hospital built on Nucleus lines can be expanded according to need as and when finance becomes available from an initial 300 bed plus A and E and support services. It is thus possible to meet the wide range of requirements appropriate in different localities. The Nucleus solution can also be used for providing extensions to existing hospitals.

POSSIBLE IMPLICATIONS FOR PARTICULAR PATIENT GROUPS

1. This appendix considers, in general terms, changes which might follow for certain groups if the hospital policies outlined in the main paper are adopted. Some modifications are in any case being considered in the light of resource constraints, the delays in implementing existing policy and the difficulty of securing a substantial increase in the contribution of small hospitals to the care of the elderly. However more substantial changes would be necessary.

2. The elderly. Current policy is that 50% of geriatric beds should be in the dgh with an interim target of 30%. As with acute services there would be fewer beds in the main dgh but this would be off-set by the benefit of greater association with acute services in other, particularly medium-sized, hospitals. Further consideration would need to be given on how long-stay patients who need care rather than treatment can best be accommodated. Consideration is being given to a new type of facility - a NHS nursing home - which could offer a service close to the patient's home, but this is still at an early stage of developmental planning. A number of practical problems, including staffing problems, have to be worked out, and the intention is to sponsor a few carefully planned experimental schemes to enable this to be done.

3. For the ESMI there might also be benefits from association with acute provision in local hospitals, but the scale of the problem will probably also demand continuing reliance on large mental illness hospitals or on change of use in smaller hospitals.

4. The Mentally Ill. In recent years policy has been for a comprehensive service for the mentally ill to be provided within each district by means of integrated health and local authority services including, for example, day hospitals and a range of local authority residential and day services. It has been envisaged that the health component of this service would be based on the dgh with about half the in-patient provision, ie that for long-stay patients and the elderly severely mentally infirm, in other hospitals in the district. Existing large mental illness hospitals would (apart, perhaps, from certain specialised units within them) close.

It is now clear that in the 70 or so districts which have a well sited mental illness hospital this will usually have to continue to provide all hospital in-patient care and be the focus for the service in its own district often for many years to come. Only in this way can proper attention be paid to districts at present served by a distant or otherwise unsuitable mental hospital.

In the remaining districts, various possibilities may need to be considered to provide a comprehensive district service with the smaller dgh base now proposed, and to enable the other large mental illness hospitals - perhaps 30 - to be closed as soon as possible. Such possibilities may include:

a. In scattered districts it may be helpful, despite some disadvantages, to split the service geographically so that the dgh - with its smaller base - serves part of the district and the rest is served from a second base created in an existing hospital (perhaps by change of use).

b. It may be possible to meet the psychiatric needs of a comprehensive service with a dgh base with fewer psychiatric beds than the present guideline of 0.5 per 1,000 (which is being reviewed because some districts with the new pattern of services have found it excessive). Such a smaller base would make it essential to plan carefully eg to ensure that there was no delay in moving elderly patients who have been assessed in the dgh as needing continuing care on to more appropriate accommodation.

c. Some districts will have a small or medium-sized hospital which is near enough to the main dgh site to secure most of the benefits of association discussed in paragraph 20 of the main paper; such a hospital could be allocated entirely for psychiatric services.

There should, however, be no question of moving mental illness provision which has been already made in the dgh.

5. Children. Current policy is to treat all children except the long-stay mentally handicapped in a comprehensive children's department in the dgh with a minimum size of unit of 40 beds. It should be possible to provide units of this size on the main dgh site though there may be a greater need for children's units in other hospitals than under present policy.

6. Maternity. Somewhat different considerations apply in relation to maternity since greater progress has been made toward the goal of total provision in new dgh units. Where geographical and other factors prevent centralisation there will inevitably be difficulties in duplicating facilities and 24 hour specialised staff cover in obstetrics, anaesthesia and paediatrics.