MEDICAL PRACTICE

*Contemporary Themes***Changing trends in gynaecological surgical workload**

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Abstract

A reduction has been recorded in National Health Service gynaecological bed occupancy in Winchester and Wessex. At least part of this change may be explained by an increase in private hospital practice.

NHS managers should plan for similar changes elsewhere in the United Kingdom.

Introduction

The gynaecological case load in the Winchester Health District has changed noticeably over the past few years. This led me to examine the possible causes of change in Winchester and to question National Health service resource planning.

Features of Winchester Health District

NHS gynaecological practice in the Winchester Health District is unusual. Throughout the period I studied (1975-82 inclusive, these dates being dictated by the availability of regional data) there were three consultant gynaecologists and they usually saw referred patients without delay. Every three months general practitioners were circulated with a list of outpatient waiting times, the idea being that general practitioners should differentially refer to the consultant with the shortest waiting time. During the period under review there were times of industrial dispute and other occasions when one or more of the consultants had an extended waiting time for non-urgent consultations, but there was always one consultant whose waiting time was less than three weeks. In his outpatient clinic each consultant kept an operation book diary (a system preceding but similar to that described by Harris¹), and the patient was given a

date at the time of her consultation—usually within eight weeks. Effectively therefore there was (and is) no outpatient waiting time or inpatient waiting list. It is important to make this point for reasons which will become clear later.

Cross boundary flows—During seven of the years studied there was a positive flow and in one (1975) a negative flow. The variations, however, were slight, and the average net inflow was only 1.5%, meaning that in terms of numbers the cross boundary flow was not important. The case mix, however, must also be taken into account. Therapeutic abortion has traditionally had a low priority in Winchester with the result that these cases have for a long time been referred away from the Winchester Health District. This has been counterbalanced by a reciprocal flow of other patients, many of whom have needed major surgery. In recent years Winchester has operated on more of its own abortion cases, with fewer patients being referred elsewhere. Numerically this has been roughly balanced by a reduced cross boundary flow of patients needing major surgery. Thus, although numbers of cases have changed little, demand in terms of occupied bed days has been significantly reduced.

Clinical practice—Laparoscopy, colposcopy, and conservative surgery for cervical intraepithelial neoplasia, prostaglandins and antiprostaglandins, and many other innovations have reduced the need for major surgery. At the same time the number of requests by women for hysterectomy because of inconveniently heavy periods has tended to increase. Whether the balance of these changes is to increase or decrease the numbers of major operations is difficult to assess, but whatever the direction of change, it should be similar regionally and nationally.

Duration of stay after major surgery—Improved surgical techniques, prophylactic antibiotics, better cooperative care, improved liaison with medical and nursing community services, and fashion have all worked towards shortening duration of stay, but in these respects Winchester practice is again not likely to differ from the practice of other health districts.

New private hospitals—Before 1975 there were some 20 acute beds in private hospitals in the Winchester Health District. From 1977 there were 50 but these were also available to consultants working outside the district. Generally speaking, the standard of

amenity has noticeably improved and now betters that found in most pay beds available in NHS hospitals. It would be surprising if these changes had not affected NHS workload.

Changes in the NHS workload

Before the period of survey and up to 1976 Winchester appeared to be exposed to a progressive and increasing workload. The actual and projected population growth of the district suggested that this would continue, and the district management team agreed to increase the number of NHS gynaecological beds from 31 to 41. Meanwhile, the work was accommodated by decanting some patients to postoperative "convalescent" beds elsewhere in the district. It should be noted that our provision of 31 beds for a district population of 200 000 is below the regional and national average and that Winchester does not have a separate day unit.

It later became evident, however, that bed occupancy had peaked and begun to fall. The SH3 returns showed that case numbers (deaths and discharges) had peaked in 1979 but that the number of occupied bed days had peaked in 1976 (table I). From that time (1976) fewer patients had to be discharged very early or transferred elsewhere when convalescent. The reason appeared to be a fall in the number of major operations, which peaked in 1976 (table II). These patterns of change in workload were also seen in Wessex, for which data show that numbers of cases peaked in 1980 and numbers of occupied bed days in 1977 (table III).

The fall in numbers of occupied beds has tended to obscure an actual rise in the number of patients treated. This has been the case especially in Wessex as compared with Winchester, because day unit work is not included in these figures. Furthermore, both 1975 and 1982 were blighted by industrial action and were "trough"

TABLE I—Numbers of patients and occupied bed days for gynaecology in Winchester Health District*

Year	No of patients dying or discharged	No of occupied bed days	Average duration of stay (days)
1975	2212	11 096	5.0
1976	2799	11 205	4.0
1977	2856	10 804	3.8
1978	2767	10 147	3.7
1979	2957	10 293	3.5
1980	2913	9 662	3.3
1981	2917	9 334	3.2
1982	2642	9 161	3.5

*Source: SH3 monthly returns.

TABLE II—Number of gynaecological operations done in National Health Service beds in Winchester*

Year	No of major operations	No of minor operations	Total	Notional No of bed days
1975	710	1277	1987	6390 (710 × 9) + 1277 = 7667
1976	973	1388	2361	8757 (973 × 9) + 1388 = 10 145
1977	813	1457	2270	7317 (813 × 9) + 1457 = 8774
1978	738	1537	2275	6642 (738 × 9) + 1537 = 8179
1979	687	1664	2351	6183 (687 × 9) + 1664 = 7847
1980	670	1752	2422	6030 (670 × 9) + 1752 = 7782
1981	610	1732	2342	5490 (610 × 9) + 1732 = 7222
1982	582	1532	2114	5238 (582 × 9) + 1532 = 6770

*Source: Royal Hampshire County Hospital annual reports.

TABLE III—Numbers of patients and occupied bed days for gynaecology in Wessex*

Year	Patients dying or discharged	Occupied bed days
1975	27 146	124 064
1976	30 425	133 554
1977	32 422	137 425
1978	33 380	135 488
1979	33 823	133 554
1980	35 644	133 444
1981	34 677	123 553
1982	33 183	120 085

*Source: SH3 monthly returns.

years. There was a compensatory surge in 1976. If numbers of occupied beds are averaged for 1975 and 1976 and these figures compared with those for 1981 an increase of 16% can be seen in number of cases treated in Winchester and of 21% in Wessex.

Impact of private hospitals

As stated above, three consultant gynaecologists work in Winchester. During the early part of this study only one operated in private hospitals, but from 1980 two, and from 1981 all three, were doing so. Table IV shows the increase in case load in private hospitals where the operating surgeon was appointed to the Winchester NHS health district. The reasons for this growth are well

TABLE IV—Number of gynaecological operations done in private hospital beds in Winchester Health District*

Year	No of major operations	No of minor operations	Total	Notional No of bed days
1975	22	21	43	198 (22 × 9) + 21 = 219
1976	36	47	83	324 (36 × 9) + 47 = 371
1977	35	68	103	315 (35 × 9) + 68 = 383
1978	52	129	181	468 (52 × 9) + 129 = 597
1979	49	116	165	441 (49 × 9) + 116 = 557
1980	66	123	189	594 (66 × 9) + 123 = 717
1981	74	142	216	666 (74 × 9) + 142 = 808
1982	87	165	252	783 (87 × 9) + 165 = 968

*Source: ADN.

understood and include political actions taken against pay bed private patients, the willingness of surgeons to operate outside their home district general hospital, the increasing number of insured patients, and the improvement of the private hospitals themselves. So far as Winchester is concerned, this growth has owed nothing to an NHS waiting list.

I have already explained that bed occupancy is much dependent on case mix between major and minor surgical cases. Reference to tables II and IV shows that relatively more major cases are being treated in private hospitals. For the purposes of comparison with NHS beds the concept of notional bed occupancy is used, where a minor case (for example laparoscopy or diagnostic curettage) is counted as one day and a major case as nine. For private hospitals these statistics have been taken from the hospitals' operation books and for NHS hospitals from the annual reports of the department of obstetrics and gynaecology. These figures differ from the SH3 returns, which include all hospitals in a district and all admissions, including those patients who do not undergo an operation. The data from tables II and IV are used for comparative purposes and for figure 1, which shows the notional bed occupancy in private hospitals expressed as a proportion of total (NHS and private) notional bed occupancy.

How should these changes be interpreted?

Taking the Winchester NHS and private hospital work together, there was a fall of 2778 notional occupied bed days from the peak year of 1976 to 1982 (table V). Changes in cross boundary flow case

FIG 1—Notional bed occupancy by private patients expressed as a proportion of total district notional bed occupancy (Winchester Health District).

TABLE V—Notional bed occupancy in Winchester*

Year	Private practice	NHS	Total
1975	219	+ 7667	= 7886
1976	371	+ 10 145	= 10 516
1977	383	+ 8774	= 9157
1978	597	+ 8179	= 8776
1979	557	+ 7847	= 8404
1980	717	+ 7782	= 8499
1981	808	+ 7222	= 8030
1982	968	+ 6770	= 7738

*Source: ADN.

FIG 2—Number of acute beds available in private hospitals in Wessex.

mix might account for some part of this fall, but the Wessex regional SH3 returns also show a fall in occupied gynaecological beds, this despite the Wessex population being on the increase.

No doubt the aforementioned changes in NHS gynaecological practice and organisation account for some reduction in occupied bed days both in Winchester and Wessex, but this is not easy to measure. I therefore return to the suggestion that work in private hospitals is an important factor. Although I do not know the numbers of private patients treated in Wessex as a whole, I do know that activity in this sector has increased.² Indeed, one private hospital, opened in 1977 in the Winchester Health District, actually treats

TABLE VI—Number of available acute beds in private hospitals in Wessex (excluding day units)

Year	No of beds	Year	No of beds
1975	126	1979	184
1976	146	1980	208
1977	176	1981	240
1978	176	1982	271

What practical self help treatment do you recommend for a person with a chronic stammer?

There is no known cure for stammering in adulthood. This does not imply, however, that the person who stammers cannot be helped to gain control over speech and to diminish the stammering behaviours and feelings considerably. Even with face to face speech therapy, this may be difficult. Although it is fairly easy to learn techniques that facilitate fluency, the person who stammers usually finds it difficult to apply these techniques in all speaking circumstances. Quite understandably, anyone would find it difficult to perfect motor control when feelings of anxiety and fear dominate one's consciousness.

For someone undertaking his own treatment, however, I can recommend: (1) Read about the problem and its treatment. There are three books which are specifically directed at self help and provide a thorough overview of techniques currently in use.¹⁻³ (2) If possible obtain a portable cassette recorder. This will be invaluable for analysing the features of speech that require changing in the first instance, and will help to monitor the changes in speech that occur at a later stage. (3) In most speech therapy settings adults who stammer are treated in groups. This approach seems to be productive in

more patients resident in Southampton and Portsmouth and has an operating surgeon based in those districts. This Wessex private hospital work was in addition to that occurring in the newly opened beds in other districts. Figure 2 and table VI show the expansion in numbers of private hospital beds in Wessex. This expansion has been continuing since 1982, with major increases in 1983 and 1984 and more planned for 1985 (now building).

Discussion

This study shows a fall in the number of occupied NHS gynaecological beds in Winchester and Wessex. During the period studied gynaecological work in private hospital beds increased. Winchester appeared to have had a generally better provision of private hospital beds than Wessex as a whole and to have anticipated work shifts now occurring more generally.

Although we can measure these shifts between NHS and private hospital practice, the impact of other changes in working practice is harder to assess. Whatever their relative importance, however, they appear to be working together to reduce NHS bed occupancy. So far as Winchester is concerned an earlier decision to increase the number of NHS gynaecological beds from 31 to 41 has now been reversed, and these newly built "beds" will now be allocated for orthopaedic or geriatric use. This is a real and measurable improvement in NHS resources.

Winchester could be argued to be unusual because of its generous provision of private hospital beds and its absence of NHS gynaecological waiting lists. This makes it more rather than less interesting to study. Other districts, other regions, and other specialties are likely to experience similar changes. Planners should take note and revise their expectations of the beds that their hospitals will need.

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References

- 1 Harris N. Hospital waiting lists. *Br Med J* 1971;iii:554.
- 2 Williams BT, Nicholl JP, Thomas KJ, Knowelden J. Analysis of the work of independent acute hospitals in England and Wales, 1981. *Br Med J* 1984;289:446-8.

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terms of providing mutual support and understanding as well as helping to keep each other task oriented. If it is at all possible to form a self help group by advertising for members this is highly recommended. (4) In Britain Association for Stammerers (c/o Finsbury Health Centre, Pine Street, London EC1) has leaflets on running a self help group, as well as a demonstration tape of one of the more popular speech therapy techniques. The speech therapy advisers of the association are willing to correspond with members and to offer advice where possible. Membership is £5 a year and includes receipt of a quarterly magazine called *Speaking Out*.

The development of fluency is usually viewed as a long term undertaking. Although stammerers improve rapidly at first, the road to eventual fluency is fraught with ups and downs. Many clients take up to a year to acquire the necessary speech skills, while psychologically the changes in self perception may take longer. Despite being a challenging task, it is well worth doing.—CELIA LEVY, speech therapist, London.

- 1 Byrne R. *Let's talk about stammering*. London: George Allen and Unwin, 1983.
- 2 Irwin A. *Stammering: practical help for all ages*. Middlesex: Penguin Books, 1980.
- 3 Fraser M, ed. *Self therapy for the stutterer*. Memphis, Tennessee: Speech Foundation of America, 1984.