Best Buy Hospital

These considerations underlay the Best Buy Hospital, which was introduced on the basis of an acute inpatient provision of two beds per 1,000. It was assumed that patients would stay a minimum of time necessary in hospital and that there would be full supporting services in the community.

Almost independent of the community services, the South East Thames Regional Health Authority has introduced an acute bed norm based on 2·4 beds per 1,000 population for the region as a whole. Within this breakdown, however, an age specific norm had been calculated for each specialty which takes into account the national discharge rate for each age group and also their mean duration of stay. It was also assumed that there would be a mean turnover interval of 2·2 days apart from those specialties in which the national turnover interval is already less than that—that is, gynaecology and dentistry, where the figure of 1·8 was used.

For mental handicap the Cmnd. paper[6] recommended specific provision for both hospital inpatients and local authority places. The South East Thames Region[7] has proposed that the run down in the hospital inpatient provision from 15·3 beds for children and 93·7 beds for adults per 100,000 population to 13 and 55 places, respectively, will coincide with the proposed build-up of the local authority services—from 5·6 places for children and 14·5 places for adults to 12 and 75 places respectively in the community per 100,000 population.

One could also argue that in the geriatric service and the services for the mentally ill and psychogeriatric cases, similar account should be taken of the community day and residential service in calculating the number of inpatient beds required. Unlike the position with acute beds there has been very little change in the last few years in the discharge rate and duration of stay in geriatric accommodation. Only a very small proportion of the elderly population are in inpatient accommodation at any one time, and perhaps resources would be better used not to increase the inpatient provision but rather the day patient and community services.

In providing maternity beds there are even greater difficulties. Ideally these should be based on the fertility rate (the number of births per 1,000 women between the ages of 15 and 44). Nevertheless, like the crude birth rate, even this is changing dramatically, while there have been considerable changes in the pattern of stay in maternity cases. Even allowing for every woman to be confined in hospital and considerable seasonal fluctuations, there is still much spare capacity in the country.

One aspect of the more efficient use of hospital beds that is often discussed is the development of day hospitals and day surgery facilities. But it must be remembered that a secondary effect of the development of these services is to increase the level of dependence of those patients that require admission. Every inpatient will then be at the level of either medium or high dependency and therefore many more nurses will be needed for any given bed than when there were also some low-dependency patients in the wards. Hence it will become more difficult to run efficiently the same number of beds.

Will this continual trend in the reduction of beds affect the quality of care for patients? Probably not—certainly as regards acute beds. A study in Finland[8] has shown that regardless of the number of beds that are available urgent cases are still admitted to hospital at the same rate. Since available hospital beds will always be used, a ceiling must be set if the other aspects of health care are to develop properly. Too often admitting a patient to hospital has been used because the services are deficient elsewhere.

[1] National Health Service, *A Hospital Plan for England and Wales*, Cmnd. 1604. London, H.M.S.O., 1962.
[2] Department of Health and Social Secutiry, *Digest of Health and Social Services Statistics for England and Wales. 2972* London, H.M.S.O., 1972.
[3] White, Kerr, L., *New England Journal of Medicine*, 1967, 277, 516.
[4] Peterson, O., *et al.*, *Lancet*, 1967, 1, 771.
[5] Forsythe, M., *Report on the Gynaecological Services to the Wessex Regional Hospital Board*, in press.
[6] Department of Health and Social Security, *Better Services for the Mentally Handicapped*, Cmnd. 4683. London, H.M.S.O., 1971.
[7] Lampin, J. D., and Parsons, R. A., *South East Thames Regional Health Authority Reports on Bed Planning Norms for Geriatric, Acute, and Mentally Handicapped Services.*
[8] Vaananen, I., in *Information Processing of Medical Records*, ed. J. Anderson, and M. Forsythe. North Holland Publishing Co.

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What Could the G.P. Treat at Home—with Proper Support?

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Despite the Government's good intentions the proportion of money spent on general practice has gradually fallen over the years, while hospitals have taken an increasing share of N.H.S. funds. Since general practitioners and their teams cope economically with 90% of an illness in the community it is difficult to see what large savings they could effect. Nevertheless, many practices give some of their time each week to non-practice matters—such as clinical assistantships, industrial appointments, etc. Some of these jobs are essential to the community, but they should always be allowed for when assessing the total practice work load and not be undertaken to the detriment of patients under care. Practice audits will guide doctors in the best way to apportion their time. Since the reorganization of general practice there have been several assessments of work loads by general practitioners confining their scope to primary care. These have shown the possibility of larger work loads than were formerly considered consistent with good practice. If this pattern continues it would seem wiser to give general practitioners more support to treat cases at home than to increase list sizes.

Without any major changes the general practitioner could at present cope with most of the follow-up of patients discharged from hospital. He should be the doctor of first contact in almost all casualties. Now that the principle of item-of-service payments is becoming more acceptable much minor surgery and other procedures could be done on this basis. Doctors must be encouraged and expected to complete medical assessments of most patients themselves with the good access to diagnostic facilities now enjoyed by most practitioners. When asking for specialist advice or admission to hospital they should be more critical of what they can expect. Such changes in attitudes and skills are expected from vocationally trained general practitioners if their training is to mean anything. Badly trained, they will increase rather than decrease demand on the hospital services.

What is needed is careful community studies of projected forms of treatment before expensive facilities are provided. We have seen this done in Cleveland during the last few years, in myocardial infarction, surgery of hernias, the care of stomata, and family planning. Local management teams should insist on such evidence and ensure they get value for money. For example, our community survey on myocardial infarction in Cleveland showed that many cases could be kept safely at home.[1] It was then possible to plan what was necessary and practicable in terms of community care.

The general practitioner's team is gradually being increased in size, and, used wisely, is adding to the quality of primary care. A serious omission is the lack of provision for nursing or "guardian care" for patients who need more than a few minutes attention each day. Many hospital admissions could be averted if the general practitioner had more substantial support and could call on members of his team to give this care.

More facilities for general practice mean proportionately less for hospitals no matter how the sums are done. This makes sense only if priorities are evaluated on a community basis.

[1] To be published.

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Can the Community Cope with Patients Discharged Early from Hospital?

M. Bott

As a consultant psychiatrist my brief must be the consideration of early discharge of *psychiatric* patients. I would like to beg the question at the outset by asking "Do we need to admit patients to hospital?"

My recent experience has shown that many patients who would previously have been admitted to hospital can, in fact, be treated at home with great success.

It is vital to think of mental illnesses rather than mental illness, since the needs of patients suffering from different types of psychiatric illness are widely different. For example, a patient with a phobic anxiety state—whose problem is that she cannot enter shops, travel by bus, and so forth—will clearly benefit from a type of treatment which can be given to her in her own home, whereas a wife with a puerperal psychosis may need admission to hospital to remove her from the stressful environment which will interfere with her rapid recovery. So we can consider the subject of early discharge from the standpoint of the patient, relatives, general practitioner, and nursing services.

The patients' expectations on admission to hospital affect the use that they make of the hospital admission, and their expectation that their stay will be brief will not lead to their feeling rejected or undertreated. Relatives, equally, often feel that there is some relationship between the time a patient spends in hospital and what can be achieved. Carefully planned active treatment with the elimination of unnecessary delays in organization and investigations can lead to very rapid treatment and early discharge.

General practitioners often regard patients who have been referred to psychiatrists (and particularly patients who have been admitted to hospital for treatment) as no longer their concern, and here too the reasons behind an early discharge policy will have to be explained to family doctors.

Liaison among all the services involved in the management of the patients is vital. Active transfer of information about the patient's state, treatment, and follow-up must be available to the general practitioner before the patient is discharged. In view of the delays which frequently occur in the postal service, a telephone call may be more appropriate. Active support systems—for example, community psychiatric nurses, psychiatric social workers, and health visitors—will need to be primed and involved in the therapeutic regimen. Access to early readmission if treatment is not progressing satisfactorily will encourage both doctors and nurses to accept patient's discharge from hospital before treatment has been completed. Education of the general practitioners to expect patients to return to their care before treatment has been completed is also important, as is the continuity of therapy.

Investment in Support Services

It is important that the money which would have been spent on hospital beds is invested in support services, both nursing and medical, while employers may have to be more flexible in accepting that patients will return to work on a part-time basis.

My own discharge policy takes account of the fact that the community and the patients can tolerate a particular level of symptoms before requiring admission to hospital. Equally I think that the patient can be discharged from hospital before total recovery has taken place, provided that his symptoms have been adequately reduced. The community can cope with early discharge provided adequate support is mobilized, provided there is adequate transfer of information from hospital to general practitioner, and provided that support in the patient's home is available. The success of an early discharge policy depends on a rapid feed-back of information about the patient's state and also on setting up an early warning system to prevent the possibility of relapse.

Early discharge from hospital may not necessarily be to the patient's home. Group homes and halfway houses, where they exist, sometimes provide a suitable stepping stone between hospital and home. Day hospitals, which provide an effective mixture of social support and active psychiatric treatment, again provide an interim stage between inpatient treatment and full discharge. Though the formal organizations may not be able to provide adequate befriending, in addition to their suicide prevention work, the Samaritans also accept referrals to provide support to lonely isolated people. Nevertheless, the relatives must not be over-stressed and other voluntary organizations—for example, the National Schizophrenia Fellowship—should be brought in to help them cope with the burden of patients with chronic mental illness.

Early discharge of patients suffering from affective illness or from phobic disorders is unlikely to result in the patient wandering away from home or hostel. Nevertheless, patients suffering from schizophrenia frequently wander away from home or from treatment, and present legislation makes it difficult to enforce outpatient care. Thus, if a pattern of care for schizophrenia swings away from inpatient care —and indeed there are many arguments in favour of this—I believe that it will be necessary to introduce legislation to enforce attendance at an outpatient clinic, just as present legislation enforces admission to hospital for treatment.

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Do Doctors Need to See Everybody?

R. H. Hardy

The answer to this question is an emphatic "No." One feature that general practice and the hospital accident service have in common is the increase in demand for medical services. It is difficult to measure this in the former, but some of my own figures for a regional hospital illustrate it well for the latter. Between 1965 and 1973 first attendances in the Hereford Accident Department rose from 6,900 to 16,600 annually, an overall increase of 250%. In the same period the population concerned rose from 138,250 to 140,700—an increase of about 1·8%. Analysis of these figures has shown no identifiable cause for the rise—such as an increase in industrial or road traffic accidents, or increased summer holiday invasion—and they must represent a true increase in demand. My own experience in general practice also supports this conclusion. These figures are from an area where there is a tradition of responsible general practice of a high quality and our relations with the family doctors are good. To some extent, therefore, our accident department can largely select and control its own work load, which is essential for effective running with limited staff and premises. Nevertheless, there is always a residuum of patients who have to be seen by the accident service, who are left largely unaided by the reorganized general practitioner service and increasingly busy practitioners of sophisticated hospital medicine.

Those working in accident departments recognize that there is a steady influx of ludicrously trivial injuries—tiny scratches, bruises, and disabilities which need nothing but to be ignored or at most treated with the simplest domestic remedies. Add to these the attention-seeking, the litigious, and the manipulators who want their spoilt child brought to heel or their spouse punished, and the department is faced with a sizeable overload which distracts medical care from where it is needed. The result is an erosion of the quality and extent of medical care; a fall in the quality of the doctor-patient relationship; the erection of doctor/patient barriers (with all the apparatus of appointments and receptionists so sadly familiar in general practice); and a decay of medical responsibility.

As a profession doctors have some responsibility for this state of affairs, with its former emphasis on "see your doctor early," "come to the hospital at the time of injury," and so forth. But the trend has gone too far, and must be reversed—but how? Propaganda has spent its force. Expansion of medical services to meet an unlimited expansion of demand is neither economically acceptable, nor socially beneficial. Regulations and penalties can be enforced only in an authoritarian society. Probably the only practical remedy lies in a fee-for-item-of-service system to rebuild a sense of social and personal responsibility. Having rejoiced in the provision of a free National Health Service, I find this a deplorable but inescapable conclusion. Alternatively, could medical care be extracted from the political muddle which besets it and handed over to some independent corporation which can allow commonsense to direct its distribution? Certainly the problem has somehow to be solved if a general deterioration is not to become the rule.

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