TALKING POINT

Medical staffing in community hospitals

D J HEWETT

Are community hospitals a distant mirage? Some doctors may think so but quite a lot of detailed planning is going on at local level.[1] Most of the discussions have been concerned with questions such as the size, location, and clinical content of proposed developments rather than the details of medical staffing.

The DHSS has encouraged planning to start in its 1974 circular HSC(IS)75.[2] Though it dealt with clinical content in some depth, the circular assumed that the existing medical staffing and financial arrangements for peripheral hospitals would be adequate. These arrangements consist of a combination of GP clinical assistant sessions in appropriate specialties, coupled with direct payments through local bed funds where patients are admitted to hospital under the care of a GP. But planners are now discovering several factors which cast doubt on the adequacy of the present arrangements.

Firstly, HSC(IS)75 was originally restrictive in its conception of clinical content. It attracted a great deal of criticism for adopting this stance, especially from the Association of General Practitioner Hospitals.[3] This criticism appears to have been well taken for, in *The Way Forward*,[4] a more permissive line has been proposed. Local experience has shown that when public consultation occurs[5] there may be strong pressures to add other services beyond the outline envisaged by the original circular. In particular, demands are likely to be made for minor surgery, a "walking wounded" accident service, and GP maternity. Consequently the range of work to be undertaken and the number of departments included in the community hospital have grown.

Secondly, much of the original research work leading to the circular was done in the Oxford Region during the late 'sixties and early 'seventies.[6] The size of the pilot hospitals studied, however, was quite small (16 beds at Wallingford), whereas those envisaged by the circular are larger (50 to 150 beds) and serve a wider population (30 000 to 100 000 people). Inevitably, a hospital operating at the upper end of this scale would serve a catchment area containing 30 or even 40 local general practitioners, who could be expected to have an active interest in and access to it. Managing a clinical unit with this number of medical staff has its problems.

Thirdly, community hospitals have an important component of day places for the elderly, the elderly mentally infirm, and the mentally ill. To function effectively these facilities must integrate with existing community services, thereby providing a local centre where the hospital and domiciliary services come together. Unfortunately, the implications of such a development for the work load of individual general practitioners have never been evaluated. Planners seem to assume that if buildings are provided then the services will automatically work. For the day hospitals to function, the enthusiasm and time of committed and experienced doctors will be essential. Clearly this requires more than the odd clinical assistant session.

Community hospitals will be complex organisations and their medical staffing must be carefully thought out. Furthermore, they may permit rather different patterns of care to develop, particularly the domiciliary aspects, for which present employment practices are inadequate.

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Possible community hospital

Table I shows the possible facilities for a typical hospital serving a relatively isolated market town and surrounding rural parishes with a population of about 60 000 people. A fairly liberal interpretation has been placed on the original DHSS circular to show the consequences that might follow if the public are consulted and their views taken into account. About 24 general practitioners would have an interest in the hospital, though inevitably those whose practices were closest to it would be most affected. Unfortunately, there are no reliable criteria with which to calculate the hospital's work load in terms of the number of doctor sessions required. The estimates in table II represent what might happen if certain assumptions were made about the way various units operated.

TABLE I—*Possible community hospital*

General practitioner beds	20 beds
Elderly	48 beds
Psychogeriatrics	22 beds
Preconvalescent/minor surgery	7 beds
Maternity	6 beds
Elderly day places	10 places
Psychogeriatric day places	15–20 places
Psychiatric day hospital	20 places
Accident service ("walking wounded")	10 000 attendances
Outpatient clinics	16 000 total attendances
Physiotherapy department	
X-ray room	

TABLE II—*Possible need for sessional appointments*

GP beds	No sessional allocation
Elderly + day hospital	5 sessions + 2 DGH sessions
Psychogeriatrics + day hospital + MI day hospital	5 sessions + 2 DGH sessions
Minor surgery	2 sessions
Anaesthetics	4 sessions
Accident department cover	10 sessions

For the elderly, the assumption has been made that the beds are controlled by the district geriatric service and that they provide long-stay and rehabilitative facilities. As well as supervising the beds, doctors would also be needed in the day hospital and perhaps for some domiciliary work. Though the unit would be supervised by a consultant geriatrician the local practitioner would have to provide day-to-day specialist care, especially if the service offered was to be more than just long-term custodial care. In such circumstances the sessional commitment could not be shared easily by several people. The doctor would also have to take part regularly in the work of the district team to maintain professional standards and enthusiasm.

Similar considerations apply in psychogeriatrics and acute mental illness. Though consultant supervision would have to be

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readily available by telephone day-to-day specialist care would be required. The doctor would also keep in regular contact with other members of the psychiatric team, a clinical function that could not easily be divided between doctors.

Minor surgery would normally be carried out by consultants helped by GP anaesthetists. There could, however, be a place for appropriately qualified GPs or others to operate. Accident services are the biggest problem. Communities make strong demands for a local service, especially when they are a long way from district hospitals and travelling is difficult. Usually this means the establishment of a "walking wounded" service run mainly by nurses, with readily available medical supervision. GPs are understandably reluctant to take part in this unless the service is properly organised and adequately paid.

Posts

The staffing needs described mean that GPs would require some specialist training, a continuing clinical commitment, and some participation in the main hospital services. The clinical assistant contract was not designed for this purpose and is not financially attractive. The hospital practitioner grade has many advantages: it provides for security of tenure and requires an assessment of specialist skill before appointment. In the smaller hospitals—as well as perhaps for surgery and accident work in bigger hospitals—the grade should offer a satisfactory way of providing doctor sessions.

Some alternative employment model will be needed to fill posts dealing with the elderly and mentally ill if these are to be attractive and filled by candidates of good quality. The extent of the commitment is likely to be more than can be expected of a GP with a full list. Group practices will also have the problems of providing child health, maternity, and family planning services. The negotiation of a mark II hospital practitioner contract for doctors who are not principals in general practice but who nevertheless wish to work on a part-time or sessional basis is particularly relevant here. These doctors are likely to increase in numbers as the numbers of women doctors rise over the next decade. Inevitably, many women will wish to combine professional activity with raising a family and training programmes will have to accommodate their different needs. At the same time, the need for the services provided by community hospitals will be rising dramatically. A potential solution may lie in making the terms of service and the content of posts in community hospitals attractive. Even so, there is a real danger of this solution becoming a second-class option, especially if the hospitals are seen purely as long-stay annexes. Only if the community hospitals are accepted as having a definite local contribution, if they adopt a variety of active functions, and if the doctors who work in them are given satisfying jobs will we avoid the real danger of creating institutional backwaters. Those who are formulating the mark II hospital practitioner contract should take these points into account.

References

1 Wessex Regional Health Authority, *Regional Plan 1978-9*, paper R 447.
2 DHSS, *Community Hospitals: Their Role and Development in the NHS*. HSC(IS)75. London, HMSO, 1974.
3 Association of General Practitioner Hospitals, *Community Hospitals: Their Role and Development in the NHS*, October 1974.
4 DHSS, *The Way Forward*. London, HMSO, 1977.
5 Hampshire Area Health Authority (Teaching), *Planning of Health Services in Alton*, paper H 194, 1977.
6 Bennett, A E, ed, *Community Hospitals: Progress in Development and Evaluation*, Oxford RHB, 1974.

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GMSC calls on Mr Ennals to "fulfil his obligations"

The GMS Committee spent most of its meeting on 15 February debating the report of the New Charter Working Group (24 February, p 568). There was also a short debate on the effects of industrial action; the committee was particularly concerned about decisions on the transport of patients being taken by strike committees. The chairman was asked to contact the Secretary of State about these difficulties and the committee unanimously approved the following resolution: "That the GMSC is gravely concerned about the severe problems faced by patients as a result of the present industrial dispute affecting the NHS, and calls upon the Secretary of State for Social Services to take immediate steps to fulfil his obligations to ensure that adequate health care facilities are available to all patients."

Dr R A Keable-Elliott reported that an informal and amicable meeting had been held among representatives of the GMSC, the Association of Community Health Councils, the Society of Family Practitioner Committees, and the DHSS to discuss CHCs. During a useful exchange of views the Association of CHCs had been sympathetic to the problem of confidentiality of service committee proceedings and had said that it would do its best to ensure that confidentiality was maintained. It had not been possible to reach agreement with the CHC representatives on the question of CHC secretaries acting on behalf of complainants at service committee hearings. The GMSC believes that it is inappropriate for secretaries to act in this way, though it accepts that they should be able to advise patients if necessary. It was proposed that further meetings should be held with CHC representatives and the representatives agreed to encourage local co-operation between LMCs and CHCs.

Representatives of the GMSC and of the JCC had met to discuss revision of the circular on the hospital practitioner grade. Dr Keable-Elliott reported that a revised circular would be issued shortly and he hoped that the JCC would advise consultants to agree to appointments to the grade being made in areas where these have been held up.

In brief . . .

Drugs: emergency arrangements ended

The agreement which was made between the DHSS, the General Medical Services Committee, and the Pharmaceutical Services Negotiating Committee for arrangements to deal with shortages of drugs because of industrial disputes (3 February, p 360) was ended on 28 February.

IRO in south and south-west

Mr Tony Coley, who has been on the secretariat of the Hospital Junior Staff Committee for five years, is to be the full-time industrial relations officer for the Oxford, South-western, and Wessex NHS regions, and the Channel Islands. He will take up his post on 1 April and will be available to help BMA POWARs (place-of-work accredited representatives) and individual members of all disciplines with employment problems.

COMAR

Friday, 30 March is the closing date for nominations to the Conference of Medical Academic Representatives (COMAR) to be held on Monday, 4 June.

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