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Comhairle na n-Ospidēal

Regional Hospital Boards.

Discussion Document on the Role of the Smaller Hospitals

→ General Hospital Scheme — Staff

→ Community Hospital — G.P. Consultants advice

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Comhairle na n-Ospidēal

DISCUSSION DOCUMENT ON THE ROLE OF THE SMALLER HOSPITALS

1. INTRODUCTION

1.1. The functions of Comhairle na n-Ospidéal as laid down in Section 41 (1) of the Health Act, 1970 include the following:

"(b) (iii) to advise the Minister or any body established under this Act on matters relating to the organisation and operation of hospital services,

(iv) to prepare and publish reports relating to hospital services".

1.2. In pursuance of these functions, the Comhairle, in October 1973 issued "Guidelines on Consultant Medical Staffing and Related Population Catchment for General Hospitals", which were accepted by the Minister for Health as a reasonable basis for planning the development of the general hospital services, particularly in the rural areas. In addition, the Comhairle has published reports on the future development of general hospital services in the Dublin City Area (November 1973) and in the Cork City Area (May 1974). Government decisions on the Dublin Report have been announced, and the Cork Report is currently under consideration by the interests concerned. Following completion of an extensive consultation process, decisions by the Government are awaited on hospital development outside of the Dublin area.

1.3. The basic principles of future hospital development, reflected in the documents mentioned above, as also in the Report of the Consultative Council on the General Hospital Services (Fitzgerald Report) published in 1968, are part of a world-wide move towards the organisation of general hospital services on a broader medical and technological base within the hospital and an enlarged population catchment related to the increased capability of the larger hospital. The need for re-organisation on these lines has arisen mainly because of changes in the practice of hospital medicine including increasing emphasis on the contribution of scientific investigation (e.g. laboratory and x-ray), a beneficial tendency towards a greater degree of specialisation by consultants and the involvement of consultant "teams" in difficult problems of complex disease and injury.

1.4. In the future situation, where acute medical and surgical services will be concentrated into fewer and larger hospital centres with a full range of supporting facilities, it is essential that the maximum utilisation of such expensive resources should be achieved. It is most important that patients should be accommodated in these centres only for such period as they require the extensive facilities available there. Coupled with this

consideration is the desirability of reducing as much as possible the inconvenience, to both patients and relatives, inherent in the provision of fewer centres. In meeting these requirements, the Comhairle considers that the smaller hospitals have an important positive role in a re-organised hospital system. The purpose of this discussion document is to elaborate in some detail on the range of activities which would be appropriate for a smaller hospital. It is hoped that the ideas expressed will be of assistance to the Minister for Health, the Health Boards and other bodies charged with responsibility for decision-making in this area.

1.5. The Comhairle wishes to emphasise that this document is not intended to influence the question of which particular hospitals should be developed on the lines set out. It is the function of hospital authorities and the Minister for Health to decide on the future role of particular hospitals. The intention behind this document is to explore the potential role of the smaller hospitals in order to stimulate discussion and, hopefully, to assist those who are faced with making decisions about them.

2. GENERAL

2.1. For the purposes of this study, the smaller hospitals concerned are divided into two categories:–

(i) former County Hospitals which would not continue as acute medical and surgical centres. Because of their large size in relation to other district hospitals, one or two district hospitals might be included in this category;

(ii) district hospitals which, generally speaking, are too small to accommodate extensive diagnostic facilities.

There is also a further group of district hospitals which should be replaced by welfare homes. These institutions are not included in this study, as it is considered that they should not function as hospitals.

2.2. In addition to the health board hospitals, there is a small number of voluntary hospitals which would also fit into the categories mentioned above.

2.3. The Fitzgerald Report (paragraphs 3.30–3.40) deals, in a general way, with the role of smaller hospitals and calls them "Community Health Centres". This term led to some misunderstanding and, consequently, the Comhairle suggests that the term *Community Hospital* might be more appropriate in conveying the role and functions of these hospitals in the future.

3. SERVICES AND FACILITIES APPROPRIATE TO COMMUNITY HOSPITALS

3.1. The services and facilities suggested in this document as appropriate for community hospitals, are intended as a general model for those smaller hospitals (categories i and ii) which might be thought of as possible community hospitals. The extent to which the general model might be applicable to particular hospitals can only be determined by the authorities concerned after careful examination of the local circumstances. In the following paragraphs, a broad range of services is looked at with a view to identifying the positive role which the community hospital might play in the delivery of such services to local populations.

3.2. The main focal point to which patients in each Health Board area will be referred for consultant advice and treatment will be the general hospital. A proportion of the in-patient facilities for the population of the area, together with some day hospital treatment, could, however, be provided in community hospitals which could provide a service complementary to the general hospital and to the community care services. However, it must be clearly understood that the level of in-patient activity in the community hospitals should be that which can appropriately be supervised by a general practitioner. Seen in this role the community hospitals could play a most important part as a bridge between the general hospital services and the general practitioner services.

3.3. The basic principles on which acute medical and surgical services should be provided in line with modern hospital practice have already been referred to in the introduction to this document (in particular, paragraphs 1.3. and 1.4). In accordance with these principles, surgery as a specialty is not suitable for community hospitals, apart from pre-convalescent care. Modern surgical procedures involve an increasing reliance on sophisticated equipment and specialised support staff. It is extremely difficult to safely separate surgery into different categories – a minor operation may have serious consequences whereas a major operation may go very smoothly. The safety of the patient demands that the performance of surgery should be conducted in an environment appropriate to a general hospital staffed by consultants and other highly trained personnel with full facilities including extensive laboratory, radiology and other supporting services. This would not preclude a general practitioner from carrying out procedures which he might normally expect to do in the course of his practice in well-equipped premises.

3.4. It is suggested that the available beds in a community hospital might be divided into short-stay (no longer than three weeks) and long-stay for chronic patients (see below, paragraph 3.8). Some patients could be admitted direct to the community hospital for general medical treatment, and pre-convalescent cases

could be transferred from medical or surgical wards in the general hospital.

3.5. A wide range of consultant clinics should, depending on the need, be held at community hospitals (Category (i)) and suitable facilities should be provided to cater for such clinics. These clinics should be conducted by consultants from the general hospital. Consultant advice should also be available for in-patients of community hospitals. Patients transferred from the general hospital (e.g. post-operative cases) should continue to be the responsibility of the consultant concerned. Facilities for clinical conferences should be made available.

3.6. All seriously injured patients requiring hospital treatment should be taken direct to accident and emergency units at general hospitals which should be staffed and equipped to deal with major injuries and other emergency cases at any hour of the day or night. Facilities should be available at the community hospital to provide resuscitation for emergency cases who may find their way direct to the community hospital and who require to be transferred for treatment to the general hospital. It would however, be unreasonable to require a patient with an injury requiring no more than minor treatment to travel a long distance when it might easily be carried out in a treatment room at a community hospital nearer home. It will be necessary to ensure that the community hospital's limited role is clearly known in the locality so that it is not asked to undertake work which ought to be referred to an accident and emergency department. It is essential that an ambulance service should be maintained on the basis of providing speedy and effective response to emergency calls.

3.7. If communiy hospitals undertake the assessment or treatment of patients with minor injuries, there should be an on-call rota of general medical practitioners who would accept responsibility. In certain circumstances, nurses who have been suitably trained may help in such assessments, but the responsibility must remain with the doctor concerned.

3.8. While the community hospital should be thought of as essentially providing acute medical care, nevertheless, a proportion of beds for the elderly chronic sick might be provided in such hospitals. Patients who might appropriately be transferred to a community hospital after assessment in the general hospital include:

(a) those needing treatment and rehabilitation as in-patients but who no longer require direct access to the full diagnostic and treatment facilities of a general hospital;

(b) those who have not responded or are unable to respond to efforts at rehabilitation and who need continuing medical treatment or nursing care

beyond that which the family, helped by the community care services, or a welfare home can normally be expected to provide;

(c) patients normally cared for at home who require short-term hospital care in order to give temporary relief to their families.

3.9. Day-patient facilities should also be provided wherever possible for elderly patients who are able to live in the community but still require to receive treatment or to continue a course of rehabilitation for the improvement or maintenance of their physical independence. They might join in-patients to use these facilities during the day.

3.10. Out-patient clinics might also be held by consultant geriatric physicians at community hospitals.

ANAESTHESIA

3.11. The services of an Anaesthetist should not normally be required at a community hospital.

OBSTETRICS

3.12. The Comhairle considers that the provision of obstetrical services in institutions requires special consideration and is outside the scope of this discussion document. This problem is the subject of a separate study which it is hoped to complete in the near future. However, as a matter of urgent priority, ante-natal clinics should, depending on workload and geographical factors, be conducted at community hospitals. These clinics should be conducted by Obstetrician/Gynaecologists from the general hospitals.

CHILDREN

3.13. A few children in need of short-term medical or nursing care might be admitted to the community hospital. Arrangements for their care and management should be planned and co-ordinated in close co-operation with the paediatric department of the general hospital. Children with serious illness should always be treated at the general hospital.

SERVICES FOR THE PHYSICALLY HANDICAPPED

3.14. Community hospitals might usefully admit disabled patients where the balance of advantage lies in being cared for in a local environment rather than in a more distant specialised unit, and also disabled people normally living at home who need short-term nursing care in hospital to relieve their families.

RADIOLOGY

3.15. Radiology facilities, appropriate to the work-load, should be provided in many community hospitals.

PATHOLOGY

3.16. Small laboratories should be maintained at community hospitals in Category (i) i.e., former County Hospitals. These laboratories should be operated under the direction of the main laboratory for the area and should be part of the regional laboratory services. Because of the likely low volume of demand for tests, it will not be appropriate for community hospitals in Category (ii) i.e., former district hospitals, to have laboratories. Laboratory services should be readily available (e.g., a collection service for specimens) to the community hospitals in Category (ii) and to the general practitioners in the area.

REHABILITATION

3.17. Physiotherapy, occupational therapy and chiropody will be essential for many types of in-patients and day-patients in community hospitals, especially geriatric patients. This service should be provided under the general supervision of the appropriate consultants and senior remedial staff at the general hospital. These services should be available in all community hospitals providing services for the chronic sick.

VOLUNTARY HELP

3.18. Every opportunity should be sought to involve local voluntary organisations and individuals willing to assist in the activities of the community hospital. For example, it is highly desirable that a library service for patients should be available in co-operation with the local County Library service. Voluntary organisations should be encouraged to assist in this respect.

4. RELATIONSHIP BETWEEN GENERAL HOSPITALS, COMMUNITY HOSPITALS & COMMUNITY CARE SERVICES

TYPES OF PATIENTS SUITABLE FOR ADMISSION TO A COMMUNITY HOSPITAL

4.1. The types or patient who could suitably receive treatment in a community hospital are as follows:–

(a) those who need medical or nursing care (including terminal care) of a kind which cannot reasonably be provided in their homes even with the support of the community care services;

(b) those who, during their period of stay in the community hospital, do not require facilities for special investigation or highly specialised care. Many patients will be transferred to community hospitals (Category (i)) after a period in a general hospital. If such patients, or others admitted direct to the community hospital, later require more specialised care, transfer to the general hospital will be necessary. Certain patients of the community hospital might be able to go to the general hospitals for some forms of investigation as out-patients;

(c) those who could derive particular benefit from hospital care being delivered as near as possible to their homes. This will allow more frequent visits by friends and relatives and the maintenance of other links with their local community. This is particularly important for patients who need to stay in hospital for a considerable time, and for pre-convalescent and other in-patients who may benefit from regular or occasional visits outside the hospital.

ADMISSIONS POLICY

4.2. A policy to co-ordinate admissions and discharges for the general hospital and the community hospital should be introduced. The admissions policy should be determined by a joint committee which would include representatives of the consultants, the general practitioners, the Matron and the hospital management. At present, the Matron is the admitting authority in the case of many smaller hospitals. She should continue to act in this capacity within the framework of the admissions policy.

WORKING RELATIONSHIPS

4.3. Close working relationships between the general practitioners staffing the community hospitals, visiting consultants and community care teams will be particularly important if the community hospitals are to make their maximum contribution.

OVER-ALL USE OF BEDS

4.4. When planning future general hospitals, it is essential that full account should be taken of the important role to be played by the community hospitals in the total hospital service for an area. Particular attention should be given to the necessity for using, community hospitals for patients in the intermediate care and pre-convalescent stage. The Comhairle feels that this would result in better use of general hospital beds. Other advantages would include a reduction in the demand for high-level nurse staffing and the opportunity to introduce an element of self-help with consequent psychological advantages for patients.

5. STAFFING OF COMMUNITY HOSPITALS

MEDICAL

5.1. The medical staff responsible for day-to-day care of patients should be general practitioners working in co-operation with the area consultants in accordance with an agreed policy (see paragraphs 4.2. and 4.3). Appropriate arrangements for the medical administration of the hospital will be required.

5.2. All general medical practitioners in the locality should be encouraged to be involved in the community hospital, provided they have had appropriate post-graduate training. Attendance periodically at post-graduate refresher courses should be a condition of participation in the community hospital.

5.3. General practice training schemes might include a period of training with a general practitioner who works in a community hospital.

5.4. While it is not expected that community hospitals will need to have resident medical staff, it is essential that, one way or another, there should be continuous on-call cover.

5.5. Some members of the medical and nursing staff of the community hospitals should be specifically trained in resuscitation techniques and should also attend, on a regular basis, refresher courses in the application of these techniques.

NURSING

5.6. Community hospitals will need a twenty-four hour nursing service under the direction of a Matron. They will also certainly need to attract qualified married nurses living in the locality who are prepared to rejoin or continue in the nursing service, either full-time or part-time. Staffing arrangements will have to be flexible and might vary according to local circumstances. Nurses working in community hospitals should be an integral part of the nursing service for the area, with the same educational and career opportunities as their colleagues in the general hospital.

5.7. It would be desirable for public health nurses to work in close liaison with, and have access to, the community hospital, in order to provide continuity of nursing care.

REMEDIAL STAFF

5.8. As mentioned in paragraph 3.17, physiotherapy, occupational therapy and chiropody will be essential. There might be difficulty in recruiting trained staff, but some trained staff who would otherwise not be available to the health service might be attracted to working at community hospitals near their homes, full-time or part-time. Remedial staff should work under the general direction of the appropriate department at the general hospital, and some staff might be seconded from rehabilitation departments to the community hospital.

6. THE TRANSITIONAL PERIOD

Category (i)– COUNTY HOSPITALS

6.1. The problems arising from the change of function to a community hospital for certain County Hospitals relate to patients and patient care, the hospital staff and the local environment. If the change is to be a success, patient care will have to improve, and be seen to improve during the change-over period. Patients and their relatives cannot be expected to accept change and some dislocation, unless they can be satisfied that it is to their benefit.

6.2. Local opinion sees the local hospital sometimes as a status symbol for the community and always as a source of employment and business for the town. Publicity must stress that a change in the role of a hospital will not effect either of these factors to any significant extent. There is also genuine anxiety regarding casualty arrangements and prompt hospitalisation and this anxiety will have to be allayed by adequately publicising any new arrangements and explaining their advantages.

6.3. Sensible publicity and an obviously improved service (both locally and at the main hospital centre) are likely to achieve public acceptance of the change of functions in a County Hospital. In addition, it is very important that the existing staff of a County Hospital whose role is changed should be treated fairly in the changeover arrangements. The Comhairle recommends that the following steps should be taken in the change-over period:

(a) every County Hospital which is likely to undergo a change in function to a community hospital should be associated or amalgamated with the general hospital which is likely to drain its area;
(b) consultant staff in the existing County Hospital should have the option to do some of their work at the main centre. Relief and some of the County Hospital workload should be undertaken by consultants from the main centres; clinical responsibility in each centre should be clearly defined;
(c) nurses and para-medical staff at the County Hospital should have transfer and promotional opportunities;
(d) decisions as to when the full change in function is likely to be achieved should be made as quickly as possible;
(e) new or replacement appointments at consultant level should be made jointly to both hospitals;
(f) the services provided at the County Hospital should be reviewed regularly with the aim of

achieving a possible increase in specialist out-patient clinics conducted by consultants from the general hospital;

(g) there should be a gradual increase in the number of general practitioner beds and pre-convalescent beds.

Category (ii)—District Hospitals

6.4. It is clear that a number of District Hospitals have, in reality, become institutions catering mainly for the aged, though this role has not been formally assigned to them. The problem in such circumstances is that the local community expect such hospitals to be able to provide an acute service, particularly in emergencies. A further problem is that some District Hospitals are accommodating sick elderly patients though they are not equipped for this role.

6.5. The Comhairle recommends that all existing District Hospitals should be either re-classified as community hospitals or replaced by welfare homes (as defined in the Report on the Care of the Aged). This re-classification should be undertaken by the health board concerned in each case.

7. CONCLUDING REMARKS

7.1. There has been much controversy in various parts of the country regarding the future of particular hospitals. In the course of it, there has been too much emphasis on the negative aspects of the proposed re-organisation of the general hospital system and very little discussion on the important positive, though changed, role of the smaller hospitals in the future. There is a great need for information to be conveyed to the public on the improvement in the quality of hospital services which will accrue to them as a result of changes. The need for change has its roots in the beneficial developments which have occurred, and continue to occur, in the practice of hospital medicine. The present system of general hospitals evolved in a different era and is not designed to cope with the advances in modern medicine without radical re-organisation. The smaller general hospitals cannot provide the type of modern hospital services which only a hospital complex of reasonable scale can embrace. They could, however, be of great service to local communities in alleviating the disadvantages inherent in the development of acute hospitals on a basis adequate to cater for the variety of services they must provide for those who are acutely ill. By assuming a more positive role, appropriate to its facilities, the smaller hospital could significantly reduce inconvenience to patients and relatives, provide a more personal service locally, and at the same time, ease the pressure which would otherwise fall on the general hospital. This positive role must involve distinct improvements in existing services and facilities at the smaller hospitals. The best use of highly expensive hospital resources could be achieved by general hospitals and community hospitals functioning in a complementary manner in close liaison with the community care services.