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The role and function of community hospitals

HELEN TUCKER

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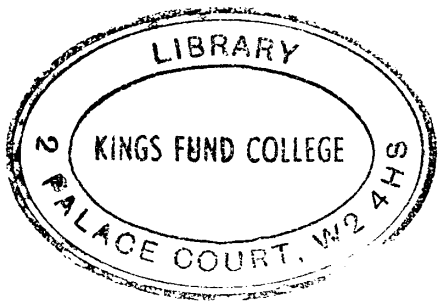
by Helen Tucker



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Foreword

When I was appointed administrator to a community hospital, I set out to research the specific role of the community hospital to fill in gaps in my own knowledge. It was my impression that the community hospital could, if utilised effectively by consultants and general practitioners, ease the pressure on district general hospitals. A preliminary survey[29] on comparative outpatient waiting times demonstrated this. My previous health service experience lay in the acute sector, including involvement in the management of surgical beds. My own lack of awareness of the specific role of the community hospital, not uncommon in those working in the acute sector, concerned me. This contrasted strongly with the clear objectives and enthusiasm of those working in the community hospital.

I was impressed by the service given by the hospital, its integration with the community services, its preconvalescent care relieving bed blocking in the general hospital, and the approach to patient care demonstrated by its GPs. I was also impressed with the respite care offered to patients and to the elderly and the physically or mentally handicapped living in the community – which concurred with the aims of the 'care in the community' initiative. I wanted to find out whether other community hospitals functioned in this way, whether they were being developed as an integral part of strategic plans, or whether small hospitals were affected by the current financial constraints and being closed.

I would like to thank Graham Cannon, then Director of the King's Fund Centre, for responding swiftly and enthusiastically to the research idea, and the Centre Committee for financial support. My thanks to my Unit General Manager, David Scoggins, who has given every cooperation to the project. I would particularly like to thank Dr June Clark who, although heavily committed, kindly agreed to supervise the project.

I was overwhelmed by the high level of response to my postal questionnaire and the speed with which the majority were returned with positive comments and requests for copies of the final report. I am indebted to regional health authority staff who provided the information for the database, and also to local community hospital staff who spent time answering the questionnaire. I am grateful to Dr Mitchelmore of Wallingford Community Hospital for sharing some of his views on community hospitals and confirming some of the assumptions I had made. It was a very worthwhile visit to the hospital where the concept really began.

I placed many demands on the local postgraduate medical library staff who always provided me with the information I needed. I am aware of the time-consuming nature of chasing references, and would like to record my thanks to Enid Forsyth, William Lawrence and the many staff from the libraries involved in the literature search.

Particular thanks to Anita, Sally and Gerry for taking on the mammoth task of typing the report.

Simon, my husband, made it possible for me to do the project, giving me moral and practical support. Without his positive approach to the task and to the many repercussions on family life, I may not have considered pursuing the idea at all.

Helen Tucker
1987

Summary

The project was undertaken with the intention of clarifying and updating the original concept of the community hospital. In defining what community hospitals are, emphasis has been placed on their philosophy and on ensuring that their role is clearly understood.

In reviewing the current provision, comparison was made with the original DHSS circular HSC(IS)75, *Community hospitals: their role and development in the NHS.*[9] The community hospital may answer a new health need – to support locally patients who may be discharged into the community following 'care in the community' and 'early discharge' initiatives – and this is considered.

Those working in community hospitals tend to be defensive and supportive because some hospitals may be under threat of closure. The potential of many community hospitals may not have been fulfilled, mainly because their role has not always been fully understood and, therefore, they have not been used appropriately. But, it is hoped, this study will clarify the contribution they make to health services.

Criticisms of community hospitals tend to stem from the view that they provide a second-class, low-tech service, and accusations such as 'geriatric dumping ground' and 'outdated anachronism' need to be answered for individual hospitals and generally. Drawbacks to this form of provision are discussed. Community hospitals tend not to be given a high profile, high status image. Contrary to the advice given in HSC(IS)75, appropriate hospitals are not always officially designated as 'community hospitals' and, as already stated, their use is not always fully understood. The limitations tend to be documented in written admission and discharge policies, and part of the drive to publicise the benefits of this type of care would be to clarify its limitations.

A national count was carried out using information given by the

regional health authorities. A broad definition, based on the original definition (by Dr R Rue) and HSC(IS)75, was sent to each region. Each region was asked to identify all officially designated community hospitals and those equivalent in role and function. Two hundred and forty-nine community hospitals were identified, with a total of 9050 inpatient beds. Most were in the south of the country. A stratified sample of small community hospitals (under 50 beds) and large (over 50 beds) totalling 92 hospitals was sent a questionnaire requesting information on the services provided. The response rate of 87 per cent was equivalent to 80 hospitals – nearly one-third of all community hospitals. Information from the questionnaire complemented information gained from a literature search and informal interviews.

Survey results were compared with HSC(IS)75. The main findings were that community hospitals are smaller than originally envisaged. The number of GP community beds (that is, not designated to any specialty) remains constant at between 20–28 beds, regardless of the overall size of the hospital. A feature of inpatient provision is respite care or holiday relief. Outpatient clinics, minor casualty and operating theatres are also featured. Less than half the hospitals have day patient facilities, and very few benefit from a health centre on site. The level of integration with the community is high; community hospitals attract full medical support from GPs and consultants involved. Conclusions reached are that the original concept has remained intact, that the problem is that of clearly defining the role and function and ensuring that management arrangements allow for the establishment of a clear direction for community hospitals.

A hospital may be designated a community hospital if it considers itself to be an extension of primary health care. Its objectives should be to meet the local community's non-specialist health needs, to take a holistic approach to patient care (that is, to consider the medical *and* social needs of the patient), and to work towards maintaining patients in the community wherever possible. If a hospital provides a broad range of services to enable a district general hospital to concentrate its resources on those patients who require specialist facilities, then it is a positive contributor to cost-effective health care in a district.

The community hospital concept: past and present

Discussion and debates at medical study weekends held in Oxford led to the development of the concept of community hospitals in 1969. The first pilot study was carried out in a 15-bed ward – Norman White Ward, Peppard Hospital. The first purpose-built community hospital was Wallingford Community Hospital, the first phase of which was opened in 1973.

A King's Fund Centre conference in 1974, 'Community hospitals – progress in development and evaluation'[1], was addressed by A E Bennett, Director of the Community Hospital Research Programme, Dr R Rue, Senior Administrative Medical Officer, J H Rickard, Research Officer, and a general practitioner, consultant and nurse. The conference resulted in a publication in which Professor Doll complimented the Oxford Regional Hospital Board on tempering its enthusiasm for its new project with sufficient scepticism to enable it to seek convincing evidence of its value. The document has proved to be an invaluable contribution to the debate on the future of the community hospital.

DEFINITION

Alison Hyde[17] reported on the Association of General Practitioners Hospitals' view that the community hospital's strength was its diversity, a fact which was considered to be smothered by HSC(IS)75. The circular was not well received by GPs who considered it to be too prescriptive. This was seen to be rectified to a certain extent in the later publication, *The way forward*, which advocated a more flexible approach, and stated that previous guidance in HSC(IS)75 should not stand in the way of flexible and practical solutions agreed locally. A later definition in HC(78)12, suggested for use in strategic planning, was as follows:

1 The community hospital is intended to provide services for patients living locally who do not need the full specialist facilities of a district general hospital.

2 The community hospital does not form part of a district general hospital complex.

3 The commuity hospital provides services for patients under the care of GPs as well as patients under the care of hospital consultants.

4 The community hospital is not confined to one specialty.

5 Where appropriate and practical, the community hospital provides among other services rehabilitation and continuing care of elderly patients including the elderly severely mentally infirm.

This very broad definition leads to an important consideration, vital to the accurate definition of the community hospital, that lies at the root of the problems of identifying community hospitals, historically and currently. Loudon[19] saw the omission of the Oxford Regional Hospital Board to confront the question of whether existing GP hospitals in the 1970s could be considered as community hospitals as a major flaw to the community hospital programme; he argued that the evasion of this question had compounded confusion. Although it was appreciated that the concept of the community hospital was completely new, to totally ignore the 350 GP hospitals in England and Wales and their contribution was unwise.[3] It was clear that some of these GP hospitals provided a service as described in the concept and included some of the key features. Loudon suggested that this evasion was designed to avoid criticism and to avoid seeming to give a new name and appearance to existing cottage hospitals in order to perpetuate their existence. However, it was accepted that the concept was new and had positive features.

According to Rue, a conceptual breakthrough was made with the recognition that community hospital facilities were an extension of primary care rather than, as previously suggested, a peripheralisation of secondary services. Rue also referred to the difference in approach to the patient by a GP and a consultant. This approach has been termed the holistic approach, as the GP

concerns himself with the total medical and social needs of the patients, treating the whole person. The generalist approach of the GP as compared to the specialist approach of the consultant makes the designation of GP beds to particular specialties unrealistic. Community hospital care, therefore, comes to be understood as a style of care, an approach to patient management.

The lack of a clear definition and lack of understanding of the basis of the concept may have hindered the development of community hospitals.

> In view of the size of their contribution to the NHS the ignorance about the work and function of GP hospitals (at all levels except among people who have direct experience of them) is remarkable. One reason is their uneven distribution ... another is that frequently the links with local Consultant hospitals are slight, and the privacy of the GP hospital is often jealously guarded.[28]

One problem hindering the development of the community hospital programme is the slow progress in developing district general hospitals because of the reduction in capital programmes. This results in small district general hospitals continuing in use which might otherwise have been adapted.[20] Other problems relate to disputes over the range of services and the arrangements for medical staffing, including financial arrangements.

THE PATIENT

In considering the advantages of the community hospital, the first consideration must be the patient. A series of articles by Davidson[5,6,7,8] and Hyde[17,18] suggested that these hospitals were valued by patients. Davidson[5] quotes Dr James as saying:

> Patients are very happy to come here. They are often terrified of going into a bigger hospital. We know the person and we know the home. We can see them as whole people, rather than isolated cases.

According to North, Hall and Kearns[21]

> ... the community hospital focuses on the patient in the environment, an approach which ties in with the emerging philosophy of holistic care.

These authors emphasised the benefits of continuity of medical care and the regular respite care which could be given to help relieve carers. Other benefits accrue to elderly patients attending a day hospital within the community hospital. Staff are able to recognise deterioration in the patients and admit them promptly if necessary.[18]

Weston Smith and others[30] noted that

> ... the waiting time for admissions to a community hospital was usually a few weeks or days, whereas for a District General Hospital may be a matter of months or years.

A further benefit lay in the 'more informed and timely judgement on the right moment for discharge back to the community'.

> For many older patients the community hospital is seen to present the only acceptable solution when hospitalisation becomes essential.[1]
>
> This apparent elderly and terminal role [may however] appear uninviting to the young patients.

The importance of ease of access to the community hospital for patients, relatives and friends has been emphasised.[13]

Bosanquet[2] expressed his reservation about a geriatric service being built up in community hospitals while the district general hospital's geriatric service is still far from satisfactory. He states:

> The setting up of community hospitals may lead to a further diffusion of desperately limited resources in specialised geriatric care.

In the written comments made by staff of community hospitals in this survey, the role of these hospitals in caring for the elderly was referred to more than any other aspect of its provision. They may even help in the earlier discharge of patients from acute geriatric beds in the district general hospital and be seen therefore to be contributing to the care of the elderly in the district.

NURSING STAFF

The community hospital may attract local professional staff, full or part-time, who would not otherwise choose to work. Staff who

are enthusiastic about these hospitals usually refer to the personalised service and to the fact that local residents are often already known by staff in the hospital when they are admitted.

The greater number of highly dependent patients may offset this recruiting advantage. There is a well-publicised fear of the community hospital becoming a 'geriatric dumping ground', with 'elderly patients admitted for social reasons, with comparatively few acute or convalescent cases'.[10] This may deter professional staff.

Grouping patients who were an 'embarrassment' to the district general hospital could result in a 'hospital which would not be viable because it could not be staffed to anyone's satisfaction'.[16] However, staff, particularly nursing staff, may be attracted to posts because of the added responsibilities engendered by the lack of resident medical cover. This would, of course, add interest to the job. The feeling in community hospitals is very much one of being in the forefront of developing nursing care and of achieving centres of excellence of nursing.[15] Nursing staff at Lynton Cottage Hospital in Devon[7] believe that they have a more satisfying job and refer to the fact that patients are not a case or a number or a symptom. 'We can treat them as individuals, as whole people.'

MEDICAL ARRANGEMENTS

The Gillie report[11] stressed the importance of GPs having admitting rights to inpatient beds. Concern was expressed that GPs would regard the community hospital as unglamorous; they may consider the hospitals to be inferior, low level, second-class geriatric units. The Oxford Regional Hospital Board believed that the three aims in bringing GPs into hospital work should be to improve patient care, to make the best use of medical manpower, and to unify medical effort. Hewett[14] stated that community hospitals would be complex organisations, and that 'their medical staffing must be carefully thought out'.

One of the difficulties is that the number of GPs represented in the management of the hospital create problems in setting clear directions and defined standards. An average of 10 different GPs may be admitting patients to a community hospital, all of whom

may be looking after them within each ward of the hospital. While a ward in a district general hospital allocated to a particular consultant may operate under precise guidelines set by the consultant and, therefore, have a clear medical identity, a community ward may have a different medical practitioner for each patient and nursing staff may need to use more initiative in developing styles of care.

Financial arrangements for the payment of GPs present further problems. Each GP may be paid a certain sum for each patient on his list who occupies a bed (currently 68p per bed per day). This sum is calculated from a pool bed fund which is divided between all admitting GPs. The sums involved are so small that GPs are tempted to claim no remuneration, putting the sum involved into endowment funds for equipment for the hospital or towards much needed cost improvement programmes. This trend has alarmed the Association of General Practitioner Hospitals.

One of the recommendations in the document *General practitioner hospitals*[22], states that 'GPs in GP hospitals should be recognised and remunerated adequately'. The need for GP hospitals to be supported is stressed, on the basis of their large and important contribution to medical care. A further recommendation is for the recognition that GPs have special educational needs. This point has been raised by other authors, who plead for special refresher courses for GPs working in community hospitals.[30] Hewett,[14] who discusses hospital practitioner contracts, also notes the need for specialist training and a continuing clinical commitment; Shaw[27] discusses the postgraduate clinical training needs, which would be a combination of programmes geared for the acute and the primary sector. Therefore, in order to assist GPs to realise the potential of community hospital provision, attention needs to be given to training needs and adequate remuneration.

Cochrane[4] was optimistic about the role of the GP. 'The GP of the future ... should have a wonderful chance to organise the complete care of the community.' The enthusiasm expressed by GPs for the provision has proved vital in retaining the community hospital. There should be close links between medical staff at the district general hospital and visiting consultants, and joint premises for GP surgeries and consultant clinics would help this.

Case conferences between primary and secondary medical staff are also seen as beneficial to the health care of the patient, and the community hospital provides the setting for this.

Discussion has taken place on the increased workload of the GP, bearing in mind present policies of early discharge for patients from district general hospital acute wards, the 'care in the community' programme, as well as caring for inpatients in GP hospitals. A study was carried out on GPs in south west England[23] which concluded that having the facility of admitting inpatients did not affect the mean consultation rate in surgery, follow up and home visiting ratios. It is therefore acknowledged that the community hospital will create an additional workload, but will also increase the range of facilities to the doctor and service to the patient.

COSTS

When comparing the cost of nursing patients in the hi-tech, specialist district general hospital with the low-tech community hospital, it would appear an efficient use of resources to use the facilities of the community hospital where appropriate. Rickard studied the cost effectiveness of the community hospital programme[24] and concluded that community hospital units were not cost effective compared with the district general hospital costs. However, Rickard based his study on two wards at Peppard Hospital and Wallingford Hospital, of 17 and 15 beds, and concluded that future community hospitals should be built with 35 beds, as this was the optimum cost level. His results were surprising as the low-tech beds, staffed by poorly remunerated GPs would normally be assumed to be considerably cheaper than hi-tech district general hospital beds. His optimum size was also surprising, and detailed reference to his tables demonstrated that total costs for 75 and 80 beds were not dissimilar to the cost of 35-bed units. Rickard related the high cost of community hospital beds to the high numbers of nursing staff. His assumptions were based on two pilot studies primarily, and it is evident that an updated study on comparative costs must be carried out. Some of the later studies on the cost of community hospital inpatient beds, however, may encourage the use of GP beds.[12]

COMMUNITY SUPPORT

The advocates of community hospitals stress the excellence of the service given to a defined local community. The issue is an emotive one, and often the hospital serves as a focus for the community. The hospital may have been built, for instance, by public subscription – a memorial to the war years. Even where community hospitals are purpose-built, without the historic connections, local feeling in support of the hospital is often very strong.

The cottage hospital has been viewed as the direct ancestor of the community hospital. It was a focus for the community, making it the recipient of voluntary help and financial aid. Its successor has been seen to be of great value in reducing inefficiency, in treating patients who might otherwise be admitted to a district general hospital. Cochrane, an advocate of random clinical trials, stated that only those patients should be admitted for whom hard evidence existed that there was little risk of medical detriment in treating them in the community hospital as opposed to the district general hospital.[4]

The support given to these hospitals by the local community is referred to constantly, and voluntary organisations such as Leagues of Friends and WRVS, who have given financial support and volunteer aid, are often referred to.

CONCLUSION

Benefits to patients include ease of access, familiarity and the reassurance that their doctor is fully aware of their individual needs. When patients are referred to specialist beds there are 'attendant risks of discontinuity of information and treatment methods'.[1]

Benefits to the elderly, particularly when considering rehabilitation needs, are well publicised, as are the sensitive discharge arrangements which may be made, including home visits, home assessments, attendance at a day hospital, and respite care. The development of community hospitals throughout the country would ensure that the aims of the NHS reorganisation – to provide a 'local' health service – would be achieved. Also, the community

hospital would enable policies and initiatives such as 'care in the community' to be achieved by offering respite care to patients being maintained in the community and providing the wherewithal to GPs to provide a back-up service to recently discharged patients.

> If anyone ever doubted the intrinsic value of the community hospital health centre, simply being an observer ... would dispel all misgivings. It is in environments such as this that health care begins.[25]

I can only echo the sentiments. A period of time spent in Wallingford Community Hospital was invaluable. The common waiting area for patients awaiting either GP attention or consultant appointments allowed me to view primary and secondary health services working closely together, and gave the individual patient visual assurance of continuity of care.

Community hospitals, however, are under pressure to establish their worth in other ways.

> The general recipe for progress in GP hospitals is to define their functions and incorporate these into district planning. GP hospitals must not only be effective and economical, but also politically adept at proving it.[27]

Some of the issues raised, such as medical training and pay and costs, need to be addressed. This project concentrates primarily on reviewing the services and facilities offered by community hospitals and the development of the community hospital nationally.

The overall objective of the project was to assess the role and function of the community hospital by:

1 Defining and clarifying the concept of the community hospital.

2 Comparing the pattern of current provision with the original DHSS guidance.

3 Assessing whether the community hospital has a new role to play, to help achieve 'care in the community'.

NATIONAL DATABASE

The first stage of this project, namely setting up the database on community hospitals nationally, not only gave the sample frame for the study but was a basis for analysis itself. A questionnaire was sent to regions requesting a list of community hospitals, number of beds, and person to be contacted at each hospital. The following definition was given to regional health authorities as a guide:

An ideal community hospital has the following:

1 Between 50–150 general practitioner beds.
2 Consultant outpatient clinics.
3 Ex-local authority clinics.
4 Day treatment facilities.
5 Certain diagnostic services.
6 Health centre accommodation for general practitioners.

Two hundred and forty-nine community hospitals were identified, with a total of 9050 inpatient beds. Of the 249, 135 were in the south – South Western, Wessex, South West Thames and South East Thames Regions. South Western Region has the largest number of community hospitals overall, and it is acknowledged that this region also has the largest number of total hospitals. The bar chart (page 22) gives a crude comparison of regional provision related to the total number of hospitals per region. The variety in provision may be accounted for by the geography of the region, local medical opinion, the proportion of elderly within the population, the existence of suitable hospitals for conversion and adaption to the new concept, and finance.

In all these results, however, account must be taken of the difficulties in defining and identifying the community hospital, and how loosely or specifically the term is applied.

Regional health authorities were invited to make general comments on their community hospital provision. A sample of their comments is given below:

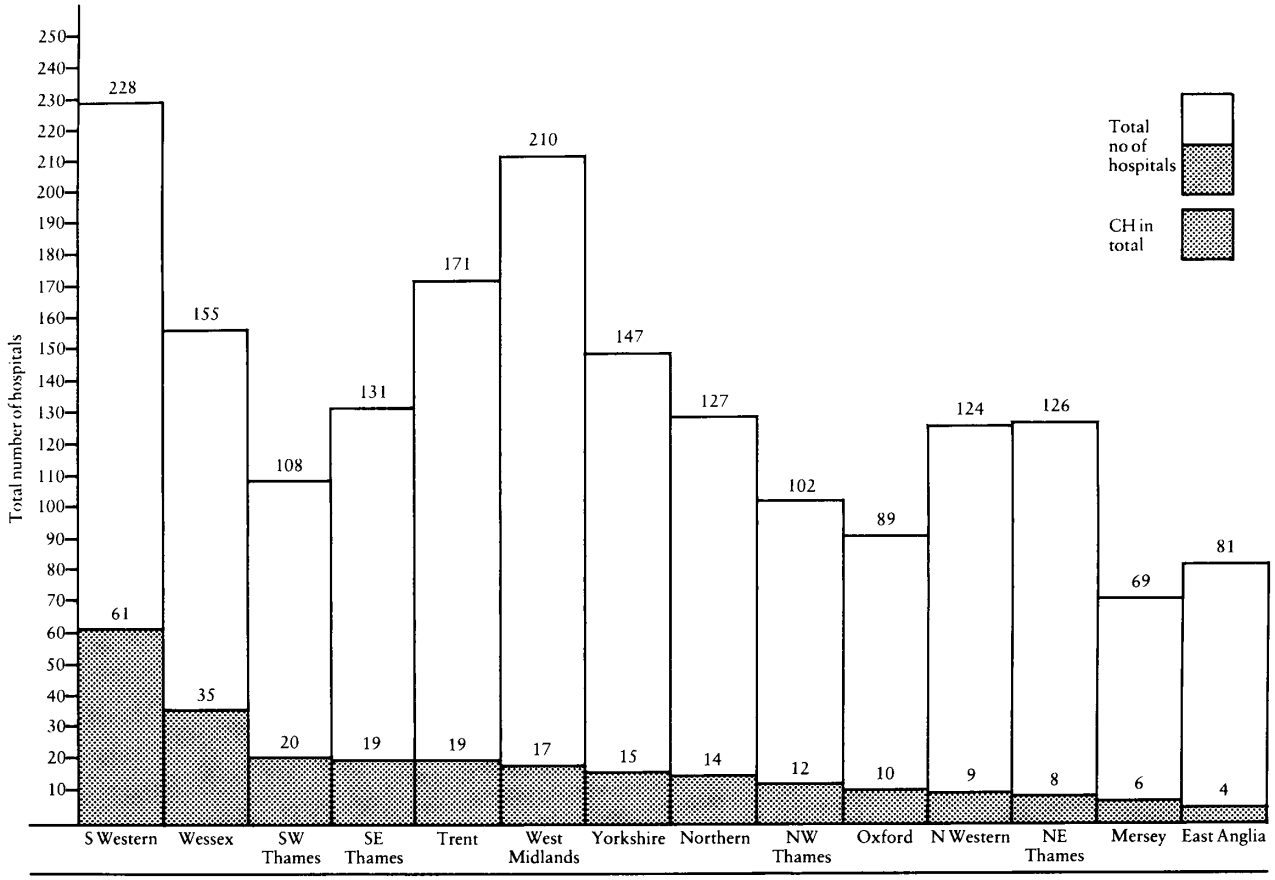
> We are keen to improve the way in which this major resource is used to improve people's access to health services in a predominantly rural region, and to see that this is spelt out in plans. One would expect this to be a key aspect of the review of acute services, which is to be our key strategic planning task in 1985/86.

> Many of the hospitals which now provide a service as part of a total district service as opposed to a community one will become community hospitals either within or shortly beyond the current strategic planning period.

> The critical factors (in community hospitals) are the presence of GP beds and at least one other specialty on site. No particular designation of these hospitals now, or in the future, as 'full' community hospitals is implied. The regional health authority has had investment plans for the development of community hospitals.

> In general, however, it remains the ultimate aim to achieve a

Total numbers of hospitals by region and total numbers of community hospitals by region



balanced pattern of provision between the district general hospital and the community hospital.

The comment regarding the designation of 'full' community hospitals has proved to be particularly interesting in view of the findings from the questionnaire sent to individual hospitals.

A stratified sample of small community hospitals (under 50 beds) and large (over 50 beds) totalling 92 hospitals was sent a questionnaire requesting information on the services provided. Eighty replies were received, the respondent being the operational manager of the hospital, usually the administrator or nurse. From the replies it was clear that only two of the hospitals contained all the key elements of the concept, which indicates that while community hospitals are certainly developing, the total 'package' as originally envisaged within the Oxford Region is not being universally adopted. The questionnaire aimed to bring out and clarify the elements of the concept considered relevant and appropriate to the 1980s.

Results of the survey

QUESTIONNAIRE

The questionnaire to individual community hospitals covered the following areas:

1 Title
2 Access
3 Inpatients
4 Day patients
5 Outpatients
6 General practitioners
7 Operating theatre
8 Casualty
9 Other clinics
10 Diagnostic and paramedical services
11 Community support
12 Future plans
13 Views of medical staff

The results of the postal questionnaire are split into two groups – 'large community hospitals' and 'small community hospitals' and an overall total is given. The term 'large community hospitals' is used for survey I, hospitals with 50–150 beds, and represents 27 hospitals. The term 'small community hospitals' is used for survey II, hospitals with less than 50 beds, and represents 53 hospitals. A total of 80 hospitals is covered in the survey, which is an 87 per

cent response rate to the questionnaire, and gives a sample of 32 per cent of the total given figure of 249 community hospitals in the country. As 201 of these hospitals are under 50 beds, survey II had a larger sample group than survey I.

SUMMARY OF QUESTIONNAIRE RESULTS

Description of a typical community hospital with less than 50 beds

The hospital is known locally as the GP hospital and is situated 13 miles from the nearest district general hospital. The total number of inpatient beds in the hospital is 30, with an average occupancy of 66 per cent, and a total of 495 discharges and deaths per annum. The inpatient beds are primarily general practitioner community beds, although some beds may be allocated to specialties such as geriatric, general surgery or maternity. The hospital offers respite or holiday relief, to enable patients being cared for in the community to be admitted for a short stay. The hospital has outpatient clinics served by eight visiting consultants, holding 26 outpatient sessions per month for an average of 294 patients. Fifteen GPs have admitting rights to the hospital and their respective health centres and surgeries are located off the hospital site. An operating theatre, for procedures other than would be carried out in a GP's surgery, is in use and a casualty service is provided. The hospital has its own physiotherapy and radiology departments and holds certain non-consultant clinics such as a dietetic clinic. The hospital has strong community links, with a League of Friends specific to the hospital, for instance, and a generally good response to fund-raising ventures. School children or students may visit the hospital. Future plans do not include proposals to reduce either inpatient beds or outpatient clinics. In fact, proposals may include an increase in outpatient clinics and day places may be planned for. Most of the local GPs and consultants are known to be very favourable towards the hospital provision.

Description of a typical community hospital with 50–150 beds

The hospital is known as the local community hospital and is 13 miles from the nearest district general hospital. There are 73

inpatient beds in the hospital, with an average occupancy of 65 per cent and a total of 1160 discharges and deaths per annum. The beds are mainly GP community beds with a quarter of the beds allocated to the geriatrics specialty and a proportion allocated to other specialties such as general surgery and maternity. The hospital offers short-stay care for holiday or respite relief for those patients being cared for in the community. This enables the 'carers' to have a break. The hospital has an outpatient department, served by 13 visiting consultants holding 44 sessions per month for 424 patients. A total of 20 GPs have admitting rights to the hospital, and none of the GPs has a surgery or health centre on site. An operating theatre is in use at the hospital and a casualty service is provided. Various clinics are held, such as chiropody, speech therapy, antenatal, postnatal and dietetic. The hospital has physiotherapy, occupational therapy and x-ray departments.

The hospital has strong community links, a League of Friends specific to the hospital, a generous level of endowment funds, a generally good response to fund-raising ventures and a high level of volunteers coming into the hospital. The hospital also benefits from visits from school children and students. Future plans for inpatient beds and outpatient clinics do not include proposals for reductions or closures of facilities. Although the community hospital may not have a day hospital, plans for the future are likely to contain this provision, which is seen to assist in discharge arrangements. Encouragement is given to the community-based nurses to carry out hospital visits; this is also seen as easing discharge arrangements. Most GPs are very favourable towards the community hospital provision and most consultants are quite favourable. None of the medical staff is known to be unfavourable towards the community hospital.

1 TITLE

The first question referred to the title of the hospital. All hospitals in the survey had been identified by their regional health authority as being community hospitals and were considered to be carrying out that function. However, not all were called community hospitals.

Table 1 Description of hospital

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Community hospital	13	(48)	17	(32)	30	(38)
GP hospital	10	(37)	22	(41)	22	(40)
Cottage hospital	1	(4)	11	(21)	12	(15)
Other	3	(11)	3	(6)	6	(7)
Total	27	(100)	53	(100)	80	(100)

Table 1 shows that the use of the term GP hospital is marginally more popular overall. The large hospitals are more likely to be officially designated community hospitals because they fulfil the criteria set out in HSC(IS)75. The 'other' category included terms such as 'local hospital', 'small general hospital', 'geriatric hospital' and 'mainly long-stay hospital'. The use of the term 'cottage hospital' is still retained for some of the smaller hospitals.

The difficulties encountered in identifying community hospitals suggest that clear designation and development of the concept has not always occurred. From the sample, only 38 per cent of the hospitals were known locally as community hospitals, although 48 per cent of the larger ones were known as such. Official recognition of the role may well help, not only at region and district levels, but also locally and with the general public. HSC(IS)75 emphasised the importance of explaining the functions and relationships of the community hospital to other health services, to the local social services, and to the local population. One step forward would be to name community hospitals as such, and not continue to refer to them as GP hospitals or cottage hospitals, which should have quite different connotations.

Acceptance of the title, and the concept, may bring its own benefits, as one respondent's comment suggests:

Since designation to community hospital, the liaison between hospital based staff and community staff has greatly improved.

2 ACCESS

The community hospital concept is based on providing a defined community with a local hospital, with a broad range of services including inpatient beds, outpatient clinics and day patient facilities. It is considered that such a local provision would, to some extent, take pressure off the centralised district general hospital and would save a number of patients from travelling there for treatment. For large and small community hospitals, the average distance to the nearest district general hospital is 13 miles. A full range of distances for both sizes of hospital may be observed (see Table 2).

The siting of the community hospital is not seen as critical, as the development of the community hospital ward in a district general hospital in Oxford and the recent development of community hospitals in inner city areas have demonstrated.[26] Therefore, the varying distance from the nearest district general hospital, averaging 13 miles, is not seen as an essential part of the concept. It is seen, however, as an essential benefit to the patient who, in the

Table 2 Distance in miles of the community hospital from the district general hospital

Distance in miles	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–4	4	(15)	6	(11)	10	(12.5)
5–9	5	(18)	13	(25)	18	(22.5)
10–14	8	(30)	14	(26)	22	(27.5)
15–19	6	(22)	8	(15)	14	(17.5)
20+	4	(15)	12	(23)	16	(20)
Total	27	(100)	53	(100)	80	(100)

absence of the provision of a community hospital, would have to travel that distance for health care. This particularly applies to the elderly, who may not have their own transport.

Staff have commented:

> The local GPs and patients would wish to retain facilities in the community rather than travel to the district general hospital – 12 miles away.

> It is an added bonus to be able to admit patients and care for them in their own environment. The small unit is much appreciated by the elderly for example who are not sent miles away to the large county hospitals, where visiting by their relatives can prove on occasion quite impossible.

Therefore, staff and patients recognise the great benefit of local provision. Ease of access is particularly helpful to the elderly, who may have to rely on public transport or have restricted mobility; it also means friends and relatives can visit more easily. A study carried out, *Community hospitals and rural accessibility*[13], assessed some of the benefits to the rural community of dispersed hospital services, and explored the feasibility of implementing the DHSS community hospital policy in a rural health district.

One respondent's comment summarises the perceived benefits of local provision.

> The unit is situated in a very rural area. Local transport services are poor, and a visit to the general hospital can take a whole day. Many of the patients admitted are elderly, and have lived in the town all their lives. Relatives and friends can continue to assist with their care in hospital. The hospital is very much a part of the local community, and is supported as such by the local inhabitants.

3 INPATIENTS

a Bed numbers

Five hospitals were found to be outside their original sample group, due to recent changes in bed numbers (see Table 3). It was

Table 3 Number of available beds

Beds available	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–25	–	(–)	22	(41)	22	(27.5)
25–50	2	(7)	28	(53)	30	(37.5)
51–75	16	(59)	1	(2)	17	(21.25)
76–100	5	(19)	1	(2)	6	(7.5)
101–125	4	(15)	1	(2)	5	(6.25)
126–150	–	(–)	–	(–)	–	(–)
151+	–	(–)	–	(–)	–	(–)
Total	27	(100)	53	(100)	80	(100)

decided to keep these hospitals within the original sample frame. Therefore, survey I (large community hospitals) shows the equivalent of two hospitals with less than 50 beds, and survey II (small community hospitals) shows the equivalent of three hospitals with more than 50 beds.

The average number of beds overall is 44, with a 95 per cent confidence of a range of 43 to 46 beds. For the large community hospitals the average is 74 beds, with a 95 per cent confidence of a range of 65 to 80 beds. The small community hospitals have an average of 30 beds and a 95 per cent confidence of a range of 24 to 35 beds.

The number of available beds, per community hospital, was available from the original regional database, and it is interesting to note that 81 per cent of the community hospitals identified had less than 50 beds. Referring to HSC(IS)75 which stated, 'Local circumstances may occasionally suggest a community hospital with under 50 beds, but this is rarely likely to be justified', presumably this recommendation was made on the basis of economies of scale. The recommended size for a community hospital was 50–150 beds for 30,000 to 100,000 population. In the sample,

there were no hospitals with over 126 beds and 86 per cent had less than 75 beds. It has already been noted that out of the total of 249 community hospitals identified, 201 had less than 50 beds. This could suggest that a smaller hospital is what is needed locally, that it can be sustained by local GPs, and is favoured by the planners.

If districts are utilising existing hospitals as community hospitals the size could be restricted by the buildings which already exist. The fact that so many smaller community hospitals are developing, or have been developed, may result in some elements of the concept, such as the breadth of services, not being provided. It is recognised that a reduced number of inpatient beds need not necessarily indicate a small hospital site. If it is the case that developing small community hospitals are catering primarily for the elderly then the criticism that they are simply geriatric hospitals is understandable.

Only one-fifth of the hospitals identified were of the recommended size. It would seem, therefore, that size has not proved to be a critical element of the concept. An alternative to this assumption is to consider the possibility that the small hospitals are a 'corruption' of the original definition and that the only true community hospitals are those with at least 50 beds. Analysis of further findings should assist in discovering whether small community hospitals have retained key elements of the concept.

b Occupancy

In order to understand the current role and functions of the community hospital it was necessary to ascertain how well the inpatient beds were being used (see Table 4). The average bed occupancy for all hospitals in the sample is 65 per cent. The samples illustrated a 95 per cent confidence range of 61 to 71 per cent and 58 to 71 per cent. Twenty-four per cent of the hospitals had over 80 per cent occupancy and 20 per cent less than 49 per cent occupancy, so there is considerable variation in bed usage. It is noted that for those hospitals with specialties other than GP community (maternity, for instance) the overall percentage occupancy may well be reduced. The percentage occupancy of maternity

Table 4 Percentage bed occupancy (inpatients 1984)

Bed occupancy	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
%		%		%		%
0–39	4	(15)	10	(19)	14	(17.5)
40–49	1	(4)	1	(2)	2	(2.5)
50–59	1	(4)	3	(6)	4	(5)
60–69	12	(44)	12	(23)	24	(30)
70–79	4	(15)	13	(24)	17	(21.25)
80–89	3	(11)	14	(26)	17	(21.25)
90+	2	(7)	–	(–)	2	(2.5)
Total	27	(100)	53	(100)	80	(100)

beds is variable because admission needs to be as and when the patient requires it. Therefore, because of fluctuation in demand, the overall occupancy of a maternity unit may be acceptable at a level of just over 50 per cent. Some respondents to the questionnaire clearly defined the variations in average occupancy by specialty where appropriate, and this illustrated that GP community beds tended to have a higher percentage occupancy than beds reserved for specialties such as maternity and general surgery (for those with an operating theatre). Surgical beds may be unoccupied on certain days of the week, according to operating schedules. Another factor to be considered is the distortion of percentage occupancy by small hospitals. For hospitals with less than 20 beds, the percentage occupancy can appear to fluctuate considerably.

Considering the range of provision – not only of 'booked' holiday and respite care beds, beds reserved for rehabilitation patients on weekend leave, general surgery beds, acute beds taking emergencies, and maternity beds (all of which necessarily show well under 80 per cent occupancy), and long-stay beds (which can consistently be well over 80 per cent occupancy), the average

occupancy of 65 per cent may be considered to be reasonabl Obviously, there are variations according to local circumstances.

Staff have commented:

> At present all space is used as fully as possible. The bed occupancy fluctuates because of the use of the operating theatre.

c Deaths and discharges

The questionnaire included a question on the number of discharges and deaths per annum. The overall figure gives an indication of throughput of patients (see Table 5).

For all community hospitals, the average number of discharges and deaths per annum is 720, with a 95 per cent confidence of a range between 596 and 843. This figure represents an average throughput of 16 patients per bed per year, with an average length of stay of 23 days. The proportion of discharges and deaths to the number of beds for large or small hospitals is equivalent – that is, 15.89 patients per bed for large hospitals and 16.5 patients per bed for smaller hospitals. The average number of discharges

Table 5 Number of discharges and deaths per annum (1984)

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–299	3	(11)	16	(30)	19	(23.75)
300–599	2	(7.5)	23	(43)	25	(31.25)
600–899	5	(18.5)	10	(19)	15	(18.75)
900–1199	4	(15)	1	(2)	5	(6.25)
1200–1499	3	(11)	1	(2)	4	(5)
1500–1799	5	(18.5)	1	(2)	6	(7.5)
1800+	5	(18.5)	1	(2)	6	(7.5)
Total	27	(100)	53	(100)	80	(100)

and deaths for large hospitals is 1160; for small hospitals it is 495.

The throughput of patients, averaging at 16 patients per bed, totals 720 discharges and deaths per annum. Again, considering the mix of long-stay and acute usually found in a community hospital, this may be considered not an unreasonable turnover. Taking the number of beds provided in community hospitals, and the average throughput of patients, an estimated 144,800 patients may be treated in one year.

d Designation of beds

Having determined occupancy and throughput, the next question attempted to define the number of designated beds in community

Table 6 Designation of community hospital beds

Specialty	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
	Beds	*%*	*Beds*	*%*	*Beds*	*%*
GP (general)	711	(38)	1714	(75)	1825	(54)
General surgery	154	(8)	87	(6)	241	(7)
General medical	139	(7)	3	(0)	142	(4)
Mental handicap	20	(1)	–	(0)	20	(1)
Obstetrics	124	(7)	51	(3)	175	(5)
Gynaecology	42	(2)	37	(2)	79	(2)
Dental	4	(0)	–	(0)	4	(0.5)
Paediatric	29	(2)	1	(0)	30	(1)
Young disabled	37	(2)	9	(0)	46	(1)
Geriatric	456	(24)	88	(6)	544	(16)
Terminal/continuing care	–	(0)	16	(1)	16	(0.5)
ESMI	56	(3)	20	(1)	76	(2)
Other	105	(6)	90	(6)	195	(6)
Total	1877	(100)	1516	(100)	3393	(100)

NB: 0% denotes nil, or less than 1%.

hospitals (see Table 6). Accepting that GP community beds are used flexibly, an attempt was made to try to identify other specialties catered for.

The actual designation of beds is usually considered inappropriate to the GP style of patient care. However, in order to sustain over 50 beds for a defined community, specialties other than GP community may be provided. One region stated that the provision of at least one other specialty on site served to differentiate the cottage/GP hospital from the community hospital.

Results demonstrated that 75 per cent of the beds in small hospitals are GP community beds. Therefore, 22 out of an average of 30 beds in a small hospital are GP community beds and not designated to any specialty. Similarly, 38 per cent of the beds in a large hospital are GP community beds – that is, 28 out of a total average of 74. Therefore, the provision of actual community beds does not greatly differ according to the size of the hospital, leading to the assumption that this is the level of provision seen as viable for a community population and capable of being supported by local GPs. Regardless of the total bed numbers in a community hospital, the number of GP beds can be expected to remain constant at between 20 and 28.

The questionnaire gave a list of 11 other specialties and an 'other' category, all of which were shown to be present in certain community hospitals, the most popular being geriatric, general surgery, general medicine and maternity/obstetrics. The 'other' category included orthopaedic, ENT, and psychiatric beds, demonstrating an extensive range of inpatient provision overall. The circular HSC(IS)75 does not refer to all specialties mentioned but makes the following points.

General medical patients may be admitted if satisfying admission criteria, as may preconvalescent patients. General surgery beds may not be considered appropriate, as only the procedures GPs would expect to carry out in their own practice premises would be considered appropriate to a community hospital and, by their very nature, would not result in inpatient care. However, a total of 241 general surgical beds are currently provided in the community hospitals in the sample, indicating that contrary to original guidance, general surgery is carried out in some of them.

The circular also recommends the provision of inpatient dental beds for pain relief and other urgent symptoms. Only four beds are designated 'dental' out of the total 3393 beds within the sample.

Also recommended was the provision of half a district's requirement of geriatric beds in community hospitals. The total designated geriatric beds identified were 544 in the 80 community hospitals, making up approximately 16 per cent of the total bed allocation. It is understood that in certain regions, the total GP community bed allocation is also counted towards either acute bed provision or geriatric bed provision. For instance, in the Oxford Region previously 75 per cent of all community beds were informally considered to contribute to the provision of geriatric beds. This is now recommended to be 100 per cent. Therefore there is a distinction between official designation, unofficial assumptions about use of beds, and regional variations on how this information is presented in either the 'acute' statistics or the 'geriatric' statistics. Therefore, the total contribution of community hospitals towards geriatric inpatient care is difficult to assess.

Staff completing the questionnaire recognised the particular role played by the community hospital in caring for the elderly.

The circular recommended the use of the community hospital for elderly severely mentally infirm patients requiring separate accommodation, and only 76 beds from the sample of 3393 catered for this specialty. A hundred and seventy-five maternity beds are provided, in spite of the statement that provision separate from the district general hospital would rarely be justified, and that new delivery facilities should only exceptionally be placed in community hospitals. This is equivalent to 5 per cent of beds in the sample. Designated paediatric beds are also relatively uncommon as are mental handicap units and young disabled units, although the circular allows for this provision where the balance of advantage lies in being cared for in a local environment. No mental illness beds, with the exception of ESMI beds were declared, and this concurs with the circular.

The reasons for the official and unofficial use of beds in community hospitals are varied, depending on which services are provided elsewhere in the district, and on what GPs locally are

prepared to take responsibility for. Comments from survey respondents confirm this:

> This is a traditional, originally locally-funded cottage hospital which the local GPs began to use for certain categories of patients when the surgical services withdrew some years ago. The type of patient admitted includes: terminal care; holiday nursing relief; acute, hopefully short-stay, geriatric patients; and categories of post-operative patients.

> The current role of this particular community GP hospital is to admit acute patients from the community by GP referral, to admit convalescent patients from acute beds at a district general hospital, to offer holiday relief for members of the community caring for invalid relatives, and to care for patients during a terminal illness.

The flexible nature of GP beds is clearly defined by the above comments. GPs may utilise their inpatient beds as required: pre-convalesence, continuing care, respite care, care of the elderly, and so on.

e Respite care

HSC(IS)75 states that community hospitals will also be able to provide short-term hospital care for patients normally cared for at home in order to give temporary relief to families. It is known as respite care, holiday relief or shared care and enhances people's chances of a normal life in the community. Most of the hospitals – 69 out of 80 (86 per cent) – offer this type of care (see Table 7).

This service, often used in an emergency, gives the necessary support to carers to enable them to continue caring for patients at home. Considering that this is a key element in the role of the community hospital, it is reassuring that 89 per cent of large and 85 per cent of small community hospitals offer respite care. Hospital staff confirm the value of this provision and understand that future health care policies, in particular 'care in the community', will result in a variety of patients living in the community but needing occasional inpatient admission.

Table 7 Respite care

Is respite care provided?	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Yes	24	(89)	45	(85)	69	(86)
No	3	(11)	8	(15)	11	(14)
Total	27	(100)	53	(100)	80	(100)

The community hospital will have to be prepared to meet the needs of the new style community it serves which may contain patients transferred from mental illness institutions and mental handicap hospitals (which may have closed), as well as a number who, under previous treatment regimes, would have been admitted to hospital for their condition. Bed occupancy rates would, of course, be reduced if beds were reserved for an emergency respite care service.

4 DAY PATIENTS

Another factor in helping to maintain patients in the community is the provision of a day hospital or day unit. Survey results indicated that day hospitals are being provided for a full range of patients, including the mentally handicapped, the elderly, the mentally ill, the physically handicapped, psychogeriatric and GP patients. Day hospitals may be used for specific therapeutic aims, and may include physiotherapy, rehabilitation and occupational therapy, as well as providing the patient with comforts such as a hot meal and a bath.

Surprisingly, however, most do not have day hospital facilities, although the provision is marginally more likely in the large than the small community hospitals. Day treatment facilities were considered an important element in the concept of community hospital care, and yet only one-third offer this facility (see Table 8).

Table 8 Day hospital facilities

Are day hospital facilities provided?	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Yes	10	(37)	16	(30)	26	(32.5)
No	17	(63)	37	(70)	54	(67.5)
Total	27	(100)	53	(100)	80	(100)

Where geriatric day hospitals are provided, discharge care plans can be drawn up; these enable full monitoring of a patient for the period immediately following discharge and give him or her the reassurance of keeping in touch. The circular HSC(IS)75 stated that rehabilitation facilities for elderly patients living in the community should be provided. Such patients could then attend as day patients for treatment to improve or maintain their physical independence.

The reasons for the lack of progress in day care provision are difficult to understand as the benefit of the service may be proved in economic terms alone. The capital and revenue needed to start it up may not have been available, nor the space to provide the facility. Those involved in planning the development and direction of a community hospital, whether district officers, local medical, nursing or administrative staff, may not have favoured this provision, nor felt it to be an essential part of the concept. However, it is encouraging to see further on in the study that 30 hospitals intend to provide day places in the future or expand the existing provision.

5 OUTPATIENTS

Outpatient clinics were also seen as important to the role and function of community hospitals, and the questionnaire included a series of questions on their provision and use. Only two in the

Table 9 Outpatient clinics

Are outpatient clinics held?	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Yes	26	(96)	52	(98)	78	(97.5)
No	1	(4)	1	(2)	2	(2.5)
Total	27	(100)	53	(100)	80	(100)

Table 10 Number of visiting consultants

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–4	2	(7)	17	(33)	19	(24)
5–9	7	(26)	16	(31)	23	(30)
10–14	8	(30)	11	(22)	19	(24)
15–19	5	(18.5)	6	(12)	11	(14)
20+	5	(18.5)	1	(2)	6	(8)
Total	27	(100)	51	(100)	78	(100)

sample did not hold outpatient sessions (see Table 9), although one commented that small informal clinics were occasionally held in the casualty department.

In an attempt to measure the consultant input to outpatient care, the 78 hospitals holding outpatient clinics were asked how many visiting consultants held clinics (see Table 10). The average number of visiting consultants is ten.

It is interesting to note the efforts being made in one community hospital to attract consultants to the community hospital.

> The unit management group is actively encouraging consultants and other paramedical services to provide services in the smaller hospitals in the way of extra outpatient clinics and where possible operating sessions that do not require specialised facilities or equipment. This is a long-term process as many of the existing consultants like to base their 'empire' on the district general hospital site.

In another, consultants already favour the provision and wish to retain the facility.

> When sessions are threatened, the consultants usually fight vigorously to have them maintained at the peripheral hospital.

The benefit to the patient is clear, and voiced by one of the respondents.

> Consultants' outpatient clinics are much appreciated by patients.

In order to assess this subjective comment, it is necessary to measure the number of clinics held, and the use made of them. The average number of outpatient sessions a month for the combined samples is 32, with a 95 per cent confidence of a range of 27 to 38 sessions (see Table 11). As may be expected, the mean is higher for

Table 11 Number of outpatient sessions a month

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–19	7	(26)	25	(50)	32	(41)
20–39	9	(33)	12	(24)	21	(27)
40–59	3	(11)	10	(20)	13	(17)
60–79	3	(11)	3	(6)	6	(8)
80–99	2	(8)	–	(–)	2	(3)
100+	3	(11)	–	(–)	3	(4)
Total	27	(100)	50	(100)	77	(100)

the large community hospitals (44 sessions) than the small (26 sessions). The large community hospitals display a broader range than the small; there is a 95 per cent confidence of a range of 32 to 57 sessions. The range for small community hospitals is 21 to 31 sessions.

Given that at least one consulting room is set aside for outpatient clinics, a total of 40 sessions a month could be achieved if sessions were held mornings and afternoons on each weekday. The number of sessions held may depend on the willingness of consultants to hold peripheral clinics, on the availability of space and on the provision of the necessary medical equipment and facilities.

The number of patients seen each month averages 424 for the larger community hospitals and 294 for the smaller ones, making an average of ten patients per outpatient clinic. The total may be considered to be a conservative estimate, as the highest range offered in the questionnaire was 500+ and 38 per cent of respondents ticked this category (see Table 12). This may have undervalued the final figure for both groups of hospital.

The range of outpatient clinics in community hospitals was not explored, and it may be assumed that circumstances such as local need and consultants' willingness to utilise them would all be factors contributing to the final range.

Table 12 Number of outpatients seen a month

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–99	3	(11)	8	(16)	11	(14)
100–199	–	(0)	13	(26)	13	(17)
200–299	3	(11)	9	(18)	12	(16)
300–399	4	(15)	3	(6)	7	(9)
400–499	2	(7)	3	(6)	5	(6)
500+	15	(56)	14	(28)	29	(38)
Total	27	(100)	50	(100)	77	(100)

A final comment from one of the respondents indicates the value placed on the provision of outpatient clinics at the community hospital, and refers to the comparative waiting times at the district general hospital. This comment is supported by previous research.[29]

> The very active clinics provide an excellent service with senior consultants visiting the hospital. The atmosphere remaining on a personal level, with the patient a personality not a notes number. This is quite a valuable asset in this day and age. The clinics are naturally much smaller than the ones at the county hospitals, waiting times much shorter. Another valuable asset.

6 GENERAL PRACTITIONERS

A further factor in the concept of a community hospital is the integration of primary care with inpatient provision, and it is recommended in the original concept that a health centre be provided on the site of the community hospital.

The circular envisaged health centres and other group practice premises being closely associated with community hospitals but acknowledged that it would not always be possible to provide them on the same site. This has certainly proved to be the case, with less than 20 per cent of GPs having premises on site (see Table 13).

Table 13 Health centre on site

Is there a health centre on site?	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Yes	4	(15)	11	(20)	15	(19)
No	23	(85)	42	(80)	65	(81)
Total	27	(100)	53	(100)	80	(100)

Although seen as an element in the original concept, the advantages of having health centres on site, when most are local to the hospital, must seem fairly minimal. The questionnaire yielded comments indicating that GP premises were opposite or next to the community hospital, which may be viewed as local enough to gain the benefits of integration. A visit to Wallingford Community Hospital gave the clear impression of integration in practice, with GP surgeries and consultant clinics being held side by side, allowing for medical staff to meet informally. Patients gain reassurance from witnessing primary and secondary care working closely together under the same roof. This element of community hospital provision is particularly important for the elderly; referral to a specialist clinic is not then the daunting prospect it might otherwise be for them. Although the survey did not specify purpose-built and adapted hospitals it would appear that some of the new purpose-built community hospitals are being designed to include GP premises on site, and this is to be welcomed. Therefore, the provision of GP premises on the site of the community hospital may not, in practice, have been retained as a key element in the concept, but would enhance the integration of primary and secondary health care. GPs remain, however, independent contractors who may prefer to retain a separate identity for their surgeries.

Table 14 Number of GPs with admitting rights to community hospitals

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
0–9	2	(7)	18	(35)	20	(26)
10–19	16	(59)	23	(44)	39	(49)
20–29	5	(19)	5	(9)	10	(13)
30–39	1	(4)	4	(8)	5	(6)
40+	3	(11)	2	(4)	5	(6)
Total	27	(100)	52	(100)	79	(100)

An evaluation was made of the number of GPs who enjoyed admitting rights to community hospitals (see Table 14). The overall mean is 16 GPs per community hospital. As may be expected, the larger hospitals attract a higher number of GPs who have the use of the inpatient provision. In assessing the number of GPs who have admission rights, estimates based on survey findings indicate a total of 3975 GPs, 3015 of whom admit to the smaller community hospitals. The average number of GPs admitting to a community hospital is 15, and considering the average number of actual community beds, ranging from 20 to 28 beds per hospital, this would appear reasonable. Surveys carried out have highlighted the fact that a significant proportion of GPs would welcome admitting rights to a hospital, and a planned programme to extend this facility beyond the estimated 4000 GPs who currently enjoy it would presumably be welcomed.

The comments below indicate the arguments, benefits and difficulties faced by GPs.

> If it was not for the committed input by our GPs who work tremendously hard, I don't think the place would run at all.

> The existence of a community hospital encourages the recruitment of the top class GPs to the town with the resultant high level of care throughout the community. GPs feel that without this facility, patients whom they care for in GP beds would often block acute beds at district general hospitals.

> We have a medical staff committee which is made up of GP representatives. All agree that it is essential for GPs to have free access to the hospital facilities.

7 OPERATING THEATRE

One debatable issue regarding the concept of the community hospital is the provision of an operating theatre. Most community hospitals have operating theatres, but they are more likely to be found in the larger hospitals (see Table 15).

The circular HSC(IS)75 was quite explicit on the provision of

Table 15 Operating theatre provision

Is an operating theatre provided?	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Yes	17	(63)	28	(53)	45	(56)
No	10	(37)	25	(47)	35	(44)
Total	27	(100)	53	(100)	80	(100)

operating theatres in community hospitals, suggesting that treatment rooms be provided for GPs to carry out procedures they would normally carry out in their own practice premises, 'but no facilities beyond this should be provided for surgery, which is not considered appropriate to a community hospital'. This clause has proved to be fairly contentious, and the contribution the community hospital can make to easing the pressure on waiting lists at the district general hospital may be seen as significant.

Just over half the community hospitals have an operating theatre sufficient for undertaking procedures not normally undertaken in GPs' surgeries. The arguments against the provision cite the duplication of equipment, and question the standards of medical care, including the lack of resident medical staff. However, in practice, carrying out minor operations in a community hospital setting is proving to be an acceptable part of the service provision and may be seen as freeing beds at the district general hospital for more major operations requiring 'hi-tech' support. An earlier study found that:

> ... over 70,000 operations a year are being performed safely in GP hospitals (including community hospitals) which represents 12% of the present England and Wales waiting list. This might be interpreted as a reason for increasing surgical facilities rather than otherwise.[3]

8 CASUALTY

Eighty per cent of all community hospitals, both large and small, offer a casualty service (see Table 16). Considering that the average distance to the nearest district general hospital has been found to be 13 miles, the provision of a minor casualty service may be considered an important local provision for the community. This

Table 16 Provision of a casualty service

Does the hospital have a casualty service?	*Large community hospitals (50+ beds)*		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Yes	22	(81)	42	(79)	64	(80)
No	5	(19)	11	(21)	16	(20)
Total	27	(100)	53	(100)	80	(100)

Table 17 Non-consultant clinics

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Chiropody	13	(48)	20	(38)	33	(41)
Speech therapy	14	(52)	14	(26)	28	(35)
Antenatal and postnatal	14	(52)	15	(28)	29	(36)
Family planning	8	(30)	11	(21)	19	(24)
Dietetic	18	(67)	27	(51)	45	(56)
Others	11	(41)	15	(28)	26	(33)
Total	78		102		180	

facility also enables casualties to be treated away from the central accident and emergency departments which are usually under tremendous pressure of work.

9 OTHER CLINICS

In order to assess the range of provision of services, a question regarding the number of non-consultant clinics held at the hospital was raised. Chiropody, speech therapy, antenatal and postnatal, family planning and dietetic clinics were identified, and respondents given the opportunity to include any other clinics held (see Table 17).

The results demonstrated the broad range of clinics held, as the 'other' category included references to 18 other clinics. These were surgical appliances, community dental, orthoptics, audiometry, cytology, diabetic, wart, prothombin, medical photography, fracture, verucca, parentcraft, psychology, clinical pathology, varicose veins, psychiatry, anti-coagulant and immunisation clinics. The most commonly mentioned were surgical appliances, orthoptics and audiometry. Some of the above clinics may not strictly qualify as non-consultant clinics, but the information is useful in gauging the range of clinics held.

From the results, it may be seen that less than half of all community hospitals hold these clinics and that the only clinic likely to be found in both large and small community hospitals is the dietetic clinic. From close examination of received questionnaires, it appeared that only eight community hospitals, that is ten per cent of the total survey, held no clinics of this nature. Therefore, most community hospitals have one or two of the above clinics but are unlikely to have the full range.

Although omitted from HSC(IS)75 in any direct form, the provision of clinics other than consultant outpatient clinics required investigation. Certainly when considering one of the objectives of the community hospital, to help maintain patients within the community, the provision of clinics such as chiropody would be seen as vital to that objective.

It must be concluded that the clinics provided are filling gaps or answering a particular community's need, but without an in-depth

study of other facilities provided by health authorities, privately, by local authorities, or family practioner committees, it is difficult to make any judgments on this. Family planning clinics are held in 24 per cent of community hospitals but many GPs prefer to provide this service in their own surgeries.

10 DIAGNOSTIC AND PARAMEDICAL SERVICES

Reference is made in the circular to the importance of rehabilitation as a community hospital function; so the provision of diagnostic and paramedical departments must be viewed as critical.

Almost all community hospitals have a physiotherapy department, 75 per cent have an x-ray department, but only 50 per cent have an occupational therapy department (see Table 18). In keeping with the recommendations of the circular, few have their own pathology or pharmacy departments. The figures show that the larger community hospitals are more likely to provide physiotherapy, x-ray and occupational therapy, perhaps because of their greater range of patients. The circular states, however, that 'physiotherapy and occupational therapy will be essential for all types of patients in community hospitals, especially patients under the care of the geriatric service'.

Table 18 Diagnostic/paramedical departments

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Physiotherapy	26	(96)	48	(91)	74	(93)
Occupational therapy	16	(59)	24	(45)	40	(50)
Radiology	24	(89)	36	(68)	60	(75)
Pathology	7	(26)	3	(6)	10	(13)
Pharmacy	5	(19)	–	(–)	5	(6)
Other	3	(11)	6	(11)	9	(11)
Total	81		117		198	

11 COMMUNITY SUPPORT

One of the key elements in the community hospital concept is the support given by the community. Staff from Wallingford Community Hospital encapsulate this in the phrase:

> The community hospital serves the community, and is served by the community.

HSC(IS)75 states that 'care in the community loses much of its purpose if the local community does not help in the provision of community services', and it is interesting to note that the community hospital is quoted as being part of and important to the 'care in the community' initiative. Measuring integration with the community, and community support, is necessarily subjective, but a general impression may be gained from the questions raised.

All but one of the large community hospitals in the sample had a League of Friends specific to the hospital; in fact, 95 per cent of all the hospitals had this benefit (see Table 19). This is a measure of active community support; a League of Friends can raise funds for the hospital by organising fetes and so on, attracting legacies and deeds of covenant, and can also be a useful link between hospital staff and members of the community. The smaller hospitals enjoy marginally more response to fund-raising ventures, possibly because they are a focus for a well defined community more likely to be steeped in historic traditions. Some of the smaller community hospitals were built by public subscription, while some of the larger ones are purpose-built or adapted. However, the differences are not great, and a high response to fund raising is recorded for both groups.

The high level of volunteer input hovers around 50 per cent for both groups, with the larger community hospitals attracting slightly more volunteers. Circular HSC(IS)75 expressed the hope that the new community hospitals would attract more voluntary help than existing small hospitals (not necessarily smaller community hospitals), possibly because of the greater range of duties. Although just less than half the community hospitals in the sample considered that they received a high level of voluntary input, most would agree that what help they get is very valuable.

Table 19 Community support

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Totals*	
		%		%		%
League of Friends specific to hospital	26	(96)	50	(94)	76	(95)
Generous level of endowment funds	17	(63)	23	(43)	40	(50)
Trips or visits for patients initiated by the community	5	(19)	7	(13)	12	(15)
Regular trips or visits by patients into the community arranged by the hospital	11	(41)	3	(6)	14	(18)
Visits by college students/school children	18	(67)	30	(57)	48	(60)
Generally good response to fund-raising ventures	21	(78)	46	(87)	67	(84)
High level of volunteers involved in hospital	15	(56)	24	(45)	39	(49)
Others	1	(4)	4	(8)	5	(6)
Total	114		187		301	

The 'generous' level of endowments enjoyed by most of the larger community hospitals was shared by only 50 per cent of the smaller, possibly because the lower number of patients treated reduces the likelihood of donations.

Only 6 per cent of small hospitals compared with 41 per cent of

the larger recorded regular trips by patients into the community being arranged by the hospital. The majority does not arrange trips for patients. The hospitals that have a voluntary services coordinator or medical social worker may have a person who is prepared to take long-stay patients out, and where this is done it is valued by the patients.

Most community hospitals enjoy visits by school children and students into the hospital. This is seen to be mutually beneficial – for the education and experience it offers to the scholar, and the company and stimulation it offers to the patient. The trend for schools and colleges to encourage students to carry out voluntary work or to visit patients, particularly the elderly, may develop an understanding of health care provision in the younger generation and encourage more community input in the future. Under the 'others' category, local community support included significant gifts from schools and local businesses, and support from such organisations as the WRVS.

A sample of 'general comments' given in the questionnaire is included to indicate the importance local staff place on the high level of community support.

> The community hospital is very effective in the district as support to the district general hospital. It is popular as a focal point for the community (affluent League of Friends and trust funds). It is a very important provision for an ageing population, as visiting and clinic appointments are easier for patients, and being admitted to familiar surroundings enhances well being and minimises concern.

> Historically, this hospital has responded to changing circumstances, always endeavouring to meet the requirements of the community it serves. This policy has met with the approval of most people concerned, and has contributed to the continued support and loyalty of the community, GPs, visiting consultants and staff.

12 FUTURE PLANS

In assessing the current role and function of the community hospital, it was considered that an indication of the perceived role

Table 20 Future plans for inpatient, outpatient and day patient services

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Inpatient beds						
expand	6	(22)	13	(26)	19	(24)
maintain	13	(48)	27	(51)	40	(50)
reduce	7	(26)	11	(21)	18	(23)
not applicable/ nil response	1	(4)	2	(4)	3	(4)
Outpatient clinics						
expand	9	(33)	23	(43)	32	(40)
maintain	14	(52)	23	(43)	37	(46)
reduce	2	(7)	1	(2)	3	(4)
not applicable/ nil response	2	(7)	6	(11)	8	(10)
Day places						
expand	10	(37)	20	(38)	30	(38)
maintain	8	(30)	7	(13)	15	(19)
reduce	–	(–)	–	(–)	–	(–)
not applicable/ nil response	9	(33)	26	(49)	35	(44)
Total	81	(100)	159	(100)	240	(100)

may be contained in future plans for each hospital. Respondents were asked if strategic plans for the hospital allowed for expansion, reduction or maintenance of three categories: inpatient, outpatient and day patient services (see Table 20). New services would be covered in the 'expand' category.

There is a clear commitment to expand or maintain day places, and no plans to reduce this provision. However, only 32.5 per cent of all community hospitals currently offer day places. Thirty-four per cent of all respondents ticked the box marked 'not applicable',

indicating that no day places were currently provided and none was planned. A nil response was received from eight questionnaires, representing 10 per cent of the total, and the assumption is made that there may be no known plans for developing day places in these particular hospitals. Forty-five out of the 80 hospitals are, however, committed to maintenance or expansion.

As in one hospital:

> The old maternity wing of the hospital has recently been converted for inpatient use. The main body of the hospital is currently being upgraded and will become the new day unit.

Similarly, outpatient clinics are planned to be reduced in only four per cent of community hospitals. Five hospitals did not respond to this section and three marked 'not applicable'. Therefore, 69 hospitals (86 per cent) intend to expand or maintain outpatient clinics.

The following sample of comments supports this trend.

> District plans include proposals for a new OPD, 80 additional geriatric beds and day facilities, a pharmacy on site and possibly accommodation for younger physically disabled.

> Local views on the hospital are extremely strong in terms of keeping the hospital open. Management view is therefore to expand the number of facilities at the hospital to make it more efficient – increase outpatient usage, school health, family planning, breast screening, antenatal classes etc.

> The hospital is due for replacement in the next ten years. A unit of over 200 beds is planned, with beds allocated to GP community patients, psychogeriatrics, geriatrics, and a small number of beds for young disabled patients and GP maternity. Minor injuries and outpatient clinics will continue as at present, and the facilities will take into account the closure of a nearby local hospital.

Clearly, then, outpatient and inpatient services will be maintained. In both sizes of community hospital, a quarter will reduce inpatient bed numbers, a quarter will expand them and a half will maintain existing numbers.

The following comment tells of plans to increase bed numbers for patients in priority services:

> Plans include use of the hospital as a base for community services for elderly etc – and development of community based services and hospital services for younger chronic sick. There are plans to expand the number of beds for the care of patients in priority services with joint responsibility of GPs and specialists.

Plans for improvements include the following:

> A purpose-built community hospital will be opened in 1987, to replace the present beds and facilities. The community hospital will have GP medical beds, long-stay geriatric and ESMI beds, and geriatric and ESMI day facilities, and ultimately some post-natal GP maternity beds. Improved diagnostic and paramedical services are also envisaged. In general, the present cramped hospital facilities will be replaced by a much better service to the community.

> There are plans to replace GP beds with a new unit within the next ten years. Money from the sale of a local hospital is to be used to develop the community hospital site, but to improve existing facilities rather than increase services.

The emphasis on care for the elderly has been stressed by respondents to the questionnaire.

> The strategic plan proposals include the replacement of the hospital in the 1990s with the larger hospital providing longer-stay geriatric care. The authority's policy is to locate long-stay patients as near to their homes as possible. The plan depends critically on the willingness of local GPs to provide on-call cover for any consultant beds. The geriatricians are aware that many of the patients of this hospital are aged 75+ and would be a demand on their services if not admitted by the GPs.

> There are proposals in hand for building a geriatric ward and geriatric day hospital on the site – this provision being transferred from an existing geriatric hospital, which will be closed.

> The hospital has recently undergone a major upgrading programme ... including an extension to the physiotherapy and occupational therapy services. Redesignation of beds is due to take place in April 1986 when the consultant geriatrician takes over responsibility for some beds.
>
> GPs would like to expand rather than contract facilities, but the local health authority strategic plan envisages developments in geriatric care rather than acute medicine.

There were, however, a number of expressions of uncertainty about the role of the community hospital and its future within the district.

> The present hospital has been extensively upgraded. However, the future remains uncertain.
>
> The future of the community hospital is uncertain. This is to be investigated by an outside consultancy firm as to its viability. Local concern as to the possible closure of beds causes great anxiety.
>
> The hospital's long-term future hangs in the balance.

Fears of this kind were not uncommon. One respondent stated quite clearly that the community hospital was to change in use, and referred to the strength of feeling of the local population to proposed changes.

> We are in the consultation period relating to the strategic plan. The town is unwilling to accept that this unit must play its part in the provision of total health services, and cannot remain an expensive isolated anachronism.

The politics of this local health service provision cannot be ignored, and the strength and influence of the local community can be considerable.

> We have had to fight to retain our maternity department – even carrying our case, when all else failed, to the Minister, who over-rode the decision of both district and regional health

> authorities for at least five years. We are also still battling to try to maintain operating under general anaesthesia.

The local population is the main benefactor of the provision of a community hospital and GPs are in a position of influence locally. Certain voluntary organisations and self-help groups are highly organised, and those that are praised for their support of the local hospital are also those that are feared when proposals are forwarded for a change in use or closure of a hospital. The Association of General Practitioner Hospitals provides information packs to those wishing to defend the closure of a local GP hospital, and will give advice. This great involvement in a local hospital makes any proposals for changes within the district difficult to carry out. The image of a district health authority is not enhanced if the closure of a valued local hospital is carried out at great inconvenience to the local people who are not impressed by arguments of economics, centralisation, or specialisation. The strength of the local population's view is suggested in the following comment:

> The development of this community hospital approach is desirable and supported by the local community. It does not, however, accord with our region's strategy. Some adjustment supporting the community view is likely.

Not all communities are successful in affecting health care policies.

> The function and role of our particular hospital will cease when it is connected to a unit for the mentally handicapped. This change of role has been unsuccessfully opposed by the members of the community, the GPs, the McMillan team and the League of Friends.
>
> The district health authority believes the hospital facilities can appropriately be converted to a mental handicap resource centre, the need for which has long been felt in this locality. The present GP hospital service is very much a local service and its transfer to the district general hospital is resisted by the local population.
>
> The hospital is due to close within the next ten years, all the services being transferred to the new community hospital. The

local people resent the proposed move as it is felt that the facilities presently offered are of great value to the local community.

The future of a community hospital is brighter if it has support from voluntary organisations.

The bed usage of the maternity unit is to be increased by more local births instead of admission to the district general hospital. There is a planned increase in theatre use. A 50 bedded geriatric hospital on another site is to be replaced on the GP hospital site, and will include day hospital and ESMI places within six years. An upgrading of the maternity unit is being funded by the League of Friends.

One of the perceived strengths of the community hospital is the fact that, because patients are nursed close to home, discharge arrangements may be easier. In an attempt to analyse this assumption into sections, a question was included on discharge arrangements, citing four aspects of provision which could contribute to

Table 21 Plans for care after discharge

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Respite care facilities	5	(19)	19	(36)	24	(26)
Day hospital	15	(56)	21	(40)	36	(45)
Home visits by hospital-based nurses	2	(7)	8	(15)	10	(13)
Hospital visits by home-based nurses	13	(48)	23	(43)	36	(44)
Other	1	(4)	7	(13)	8	(10)
Total	36	(100)	78	(100)	114	(100)

effective discharge (see Table 21). The first aspect was respite care facilities, assuming that this provision would reassure patients that phased discharge, and occasional readmission, would be possible. (This may be particularly reassuring to the elderly, either living alone or with relatives.) The second was the provision of a day hospital, which allows the patient to become as independent as possible at home and to have regular assessment and therapy at the hospital. This also provides a very gradual discharge arrangement. The third and fourth related to the nursing staff – namely, the visits made by community nurses while the patient is in hospital and the home visits made by hospital-based nurses. The continuity gained by this may help to ensure that the patients' needs are catered for in both environments and allow for a clear professional link between the hospital and care in the community.

The question was phrased taking into account plans for care after discharge, and yielded a low result on all counts. Nearly half the hospitals had, or planned for, day hospitals and nearly half had community nurses visiting patients in hospital. The latter idea stemmed from a concept of having community and hospital nurses as almost interchangeable, a concept which has proved difficult to put into practice although the benefits are clear. It is acknowledged that the question posed did not clearly differentiate between currently provided and planned discharge arrangements, and the results may need to be interpreted in the light of this.

Eighty-six per cent of the hospitals in the survey currently provide respite care, and it appears that planning to build up respite care to help and support patients on discharge is recognised as important by 26 per cent. Day hospitals and hospital visits by community-based nurses are the most likely services being planned, although by less than 50 per cent of the total. One hospital referred to working as a team under one senior nurse, and the benefits will be appreciated as will the practical difficulties of such an arrangement.

13 VIEWS OF THE MEDICAL PROFESSION

The views of the medical profession were sought. A scale from 'very favourable' to 'very unfavourable' was used, including 'mixed

Table 22 Views of general practitioners with admitting rights to community hospitals

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Very favourable	19	(70)	42	(79)	61	(76)
Quite favourable	6	(22)	5	(9)	11	(14)
Neither favourable nor unfavourable	–	(–)	–	(–)	–	(–)
Not very favourable	–	(–)	–	(–)	–	(–)
Very unfavourable	–	(–)	–	(–)	–	(–)
Mixed reactions	–	(–)	2	(4)	2	(2.5)
Not known	2	(8)	4	(8)	6	(7.5)
Total	27	(100)	53	(100)	80	(100)

reactions' and 'not known'. The first group were GPs with admitting rights to community hospitals (see Table 22).

A total of 90 per cent of all GPs are either quite favourable or very favourable towards community hospital provision. None of the GPs is known to be opposed, although four per cent of those for the small community hospitals are thought to have mixed reactions.

The smaller hospitals attract slightly more support and enthusiasm, presumably because local GPs have more control over the smaller hospitals, whereas larger hospitals have more specialties overseen by consultants.

Some general comments include:

> There is a firm commitment by the GP practices for the continuing and expanding use of the hospital facilities to meet the

Table 23 Views of consultants utilising community hospitals

	Large community hospitals (50+ beds)		*Small community hospitals (–50 beds)*		*Total*	
		%		%		%
Very favourable	8	(30)	24	(45)	32	(40)
Quite favourable	14	(52)	12	(23)	26	(33)
Neither favourable nor unfavourable	1	(4)	2	(4)	3	(4)
Not very favourable	–	(–)	1	(2)	1	(1)
Very unfavourable	–	(–)	–	(–)	–	(–)
Mixed reactions	2	(7)	8	(15)	10	(12)
Not known	2	(7)	6	(11)	8	(10)
Total	27	(100)	53	(100)	80	(100)

growing population. There is a commitment to increase the support for consultant clinics within the hospital.

The GPs would welcome an expansion of the existing facilities of the provision of community hospitals in each market town central to the authority's strategy.

Most consultants utilising community hospitals are known to be either very favourable or quite favourable (73 per cent), with 40 per cent very favourable (see Table 23). None of the consultants is very unfavourable, although there are some mixed reactions.

It is encouraging to find that most medical staff are in favour of the provision and this gives encouragement for planning for the future.

Local comments are as follows:

The view of local consultants, dependent on resources, is the more points of call, the more hours of input required.

The surgeons regard it as a useful safety valve for postoperative transfer from the district general hospital.

Consultants appear to be quite favourable towards use and enhancement of outpatient facilities, but have only limited involvement with inpatient facilities.

Conclusion

The project remit was as follows:

1 Definition and clarification of the concept of the community hospital.

2 Comparison of current provision with the original DHSS guidance HSC(IS)75.

3 Assessment of whether the community hospital has a new role to play to help achieve 'care in the community'.

1 DEFINITION AND CLARIFICATION OF THE CONCEPT OF THE COMMUNITY HOSPITAL

CONCEPT

Original concept (Rue, 1972)	*Current provision (1985)*
50–150 GP beds	Majority less than 50 in-patient beds, including at least one other specialty
Consultant outpatient clinics	Consultant outpatient clinics
Local health authority clinics	Some local health authority clinics
Day treatment facilities	Few day hospitals established
Health centre accommodation for GPs	Health centre accommodation only exceptionally available on site
Certain diagnostic services	Certain diagnostic services

The key elements of the original concept appear to have been eroded, although the philosophy of the community hospital persists. Emphasis continues to be laid on the provision of inpatient GP beds, outpatient clinics, various diagnostic services and other clinics, providing a breadth of services appropriate to local need. The current community hospital is smaller than was envisaged. Its beds are used as anticipated – for terminal care, respite care, rehabilitation and preconvalescence. The elderly have proved to be the major users of the facility. Inpatient beds have provided a bridge between secondary and primary health care, and certain patients have benefited from being transferred from an acute bed in a district general hospital to a community bed in a community hospital. The community hospital also provides respite care or holiday relief to support carers in the community.

The development of day hospital facilities is disappointingly slow, but there are plans for some of the community hospitals identified to develop this facility. Rickard[24] studied the cost effectiveness of this provision, and demonstrated that patients who attend day hospitals might not have to be admitted long term and, therefore, not only is it cost effective it also conforms to the government initiative to maintain as many patients as possible in the community. Few community hospitals have a health centre on site, but many have GP practices which are very local to the hospital. The provision of operating theatres was not seen as part of the original concept, although more than half the community hospitals have them. The importance of this provision has been fiercely defended by GPs.

Only two hospitals in the sample met all the criteria of the original concept and met most of the guidelines. Permission was sought to identify these hospitals, as the relevance of this information is clear. The two hospitals, both within the Oxford Region, are Wallingford Community Hospital and Townlands Community Hospital. Townlands houses the Norman White Ward, now known as Peppard Ward, which was moved when Peppard Hospital closed. The original pilot study took place on this ward; Wallingford was the first community hospital. Ten years on from the original concept it can be seen that the key features have been retained. It is interesting to note, however, that the total

concept has not been adopted by other hospitals. It may be necessary to accept that these two hospitals are models of what community hospitals should be. However, it was acknowledged earlier on in the study that the role and function of the community hospital is necessarily broad and variable. Hospitals may still retain the concept without having all of the key features as identified.

In assessing why hospitals have not adopted the total 'package' of the community hospital concept, local circumstances such as funding, attitudes of medical staff, nearness of the district general hospital, services provided by other agencies, overall district provision, population profiles, regional and district strategies, and many other considerations, need to be taken into account.

At what point a hospital becomes a community hospital is extremely difficult to identify, and perhaps it is more relevant to study the philosophy of the hospital and its role within the district rather than the specific definition of essential elements crucial to the concept. Therefore, a small local hospital should be considered a community hospital if it includes the following: a broad range of services, including inpatient beds managed by GPs; integration between the hospital and the community to enable patients to be maintained and supported in the community; the conscious objectives of meeting local health needs, relieving the acute sector and building up the primary health care team.

Without compounding earlier problems of defining the community hospital too closely, I attempt below to describe in general terms what a community hospital is:

> A community hospital serves a defined local community, has a broad range of health services based on primary services, and can be viewed as a low-tech 'buffer' to the hi-tech district general hospital. The key features of the community hospital are the size, usually less than 80 beds, and the continuity of care provided by GPs. The range of services include inpatient beds (community beds and at least one other specialty), outpatient clinics and certain non-consultant clinics. A day hospital, where provided, is seen to be a valuable contributor to the overall provision of health care. Certain diagnostic and paramedical

services are available which enable rehabilitation to be offered, particularly to the elderly; this is another key feature. Respite care facilities should also be a crucially important part of a community hospital, now and in the future, to help to maintain patients in the community by offering back-up support when required. A community hospital may have a casualty department and an operating theatre – both of which contribute to a comprehensive service for the local population. There should be close links with primary health care teams, with acute and specialist services, and close integration with the community and voluntary organisations. A community hospital should, as a result, be a vital focal point for the health care of the community.

2 COMPARISON OF CURRENT PROVISION WITH THE ORIGINAL DHSS GUIDANCE HSC(IS)75

	TEN YEARS ON
1975	*1985*
Designated community hospitals	Official designation not often made
50–150 beds	Up to 50 beds
Mainly GP community beds with beds for the elderly. Beds only exceptionally provided for other specialties	Between 20 and 28 GP community beds, with provision for other specialties
Respite care	Respite care
Day hospital	Few have day hospitals
Consultant outpatient clinics	Consultant outpatient clinics
Minor casualty	Minor casualty
No operating theatre	Most have full operating theatre
Diagnostic services	Diagnostic services
Health centre on site, or associated	Few health centres on site

Circular HSC(IS)75 acknowledged that community hospitals would vary in content and function, although the actual trend could not be anticipated. The GPs, as the major stakeholders, have held on strongly to the operating theatre facility in many cases. This could not be achieved without the close cooperation of medical colleagues in district general hospitals. The current drive to reduce waiting lists for operations may result in community hospital theatres being used even more extensively for routine minor surgery. Reservations have been expressed about standards, medical techniques, quality of care, duplication of medical equipment, lack of hi-tech back-up support, and lack of resident medical staff for inpatients. Cavenagh[3] argued against these points, and cited the number of operations carried out *safely* in community hospitals. Certainly with careful monitoring of patients and regular staff training, some of the reservations may be answered.

The circular, which drew from the work carried out by Rue and the Oxford Regional Board, recommended the provision of day hospitals and health centres on site. Few community hospitals have followed this direction.

The major disappointment is the lack of official designation of hospitals as community hospitals – declared to be crucial in the original circular. If there were such official designation, that, together with the philosophy and role of community hospitals, could then be communicated to all concerned.

3 NEW ROLE FOR COMMUNITY HOSPITALS

The philosophy of the community hospital is to extend primary health care, focusing on the community hospital, to enable local GPs to organise the complete health care of a community.[4] The particular role of the hospital is seen to be to maintain patients in the community by providing back-up support such as short-stay relief or attendance at the hospital's day unit. The fact that patients may be nursed 'close to home' encourages sensitive discharge arrangements which involve community and hospital staff overseen by the family doctor.

Townlands Hospital offers respite care to mentally and physically handicapped children, the elderly, and physically handicapped

adults. Such care is offered not only on a planned basis but also as an emergency service. This has proved to be an enormous benefit to carers who find that they are more able to cope with their relatives or children with the reassurance that help is on hand should they need it. Staff at the hospital find that their role is extended into a counselling role, and patients may be admitted for monitoring, to re-establish sleep patterns, and to regulate their drug regime. With the increase in the number of patients being maintained in the community, and the consequent closure of other hospitals and facilities, continued growth in this role is anticipated.

> If the development of community hospitals takes place more slowly than other policies, transferring patients from large institutions to the community, for example, a serious mismatch of physical and manpower resources will occur.[20]

With the progress being made in the 'care in the community' initiative the community will inevitably contain larger numbers of people who have been discharged from hospital; some hospitals will have closed. The community hospital may find that the 'back-up role' falls automatically on it as the local low-tech hospital offering many of the services necessary to rehabilitate the patients concerned. This may be seen as the real role of the community hospital.

It is noted that few community hospitals have designated mental handicap or mental illness beds, although if such patients are admitted from the community they may well be informally admitted to 'undesignated' GP community beds. It remains to be seen how well prepared or equipped the community hospital and its staff will be to provide care for patients transferred into the community from institutions. It is hoped that all patients living in the community requiring outpatient, inpatient and day patient care will benefit from a local community hospital. The drive towards 'care in the community', together with initiatives such as early discharge policies from acute hospitals, is increasing the workload and burden of responsibility of the general practitioner. Access to community hospital beds should help the GP to provide the health care required.

It is to be accepted that the role of the community hospital will evolve and develop and that the local health needs of its population will be constantly changing as a result of many factors. The development of respite care and day hospital facilities, along with rehabilitation and diagnostic services, should ensure that the community hospital is well equipped to meet these needs.

General comments

Respondents to the questionnaire were invited to make general comments, and 54 out of the 80 questionnaires included a response to an open question. An assessment has been made of the points most often raised, and five main themes are listed in order of frequency with a sample quote:

1 BENEFIT TO THE ELDERLY

Many of the patients who are admitted are elderly, who have lived in the town all their lives. Relatives and friends can continue to assist with their care in the hospital.

2 BREADTH OF SERVICES PROVIDED

The hospital fulfils a local need, providing facilities for inpatient GP care, holiday and terminal care for the elderly and day surgery facilities. The physiotherapy, radiology and ECG services are in constant demand.

3 VITAL ROLE THE COMMUNITY HOSPITAL PLAYS IN THE COMMUNITY

The community hospital fulfils a vital role in the care and treatment of patients locally.

4 COMMITMENT OF GENERAL PRACTITIONERS

There is a firm commitment by the GP practices for the continuing and expanding use of the hospital facilities to meet the needs of the growing population.

5 EASE OF ACCESS

> Elderly people are able to receive local care, where previously they had to go more than 20 miles away to an isolated geriatric hospital, difficult to reach by public transport by relatives.

Considering the sample group, which concerned only those staff already involved in community hospitals, one might expect a bias towards positive comments. Two cautionary comments need to be included:

> Difficulties exist in areas of standards of service provided in small hospitals (and large!) and in maintaining staff awareness and training.

> There are feelings that the community hospitals proposed are merely scaled down versions of long-stay institutions and not community hospitals in the true sense because of limited facilities.

These comments signify the image the community hospital may have, of being in reality a long-stay geriatric hospital, with staff striving to present their hospital as something more dynamic. The enthusiasm expressed by staff and the community has been received with some distrust, and the emotive tone taken on the subject may have created more sceptics than supporters. The main limitations to this type of service are the lack of resident medical cover, the low-tech service, and the friendly informal atmosphere which may not project a professional image. The efforts to ensure that the hospital is appropriately utilised, and standards maintained, are constant and the need to clarify the limitations of the service is vital.

A final comment provides a useful conclusion:

> The support of relatives, especially in a rural area, is very important. Patients, particularly the elderly, appear to make better progress in a smaller hospital, and it is possible in the local community to retain the link with home, neighbours, and family, which enhances the success of returning the patients to their own home.

Recommendations

PHILOSOPHY AND MANAGEMENT ARRANGEMENTS

The key to the community hospital may lie in its defined philosophy, which needs to be clearly understood by all who use the hospital. Setting a clear direction for a community hospital has many practical difficulties, not least of which is the number of medical staff utilising the hospital. GPs, who are independent practitioners contracted to the family practitioner committee, are responsible for their own patients in the hospital. GPs may also be paid on a sessional basis to take responsibility for certain specialties under the overall control of a designated consultant. There are an average of 15 GPs with admitting rights to a community hospital and 10 visiting consultants holding outpatient clinics. It benefits the hospital if the medical staff work as a cohesive group, preferably with a community hospital medical committee. However, those hospitals which have a GP with clear management responsibilities, who represents his medical colleagues, may have a clearer direction than those which do not have this management arrangement.

The management arrangement set up at Wallingford Community Hospital originally involved the division of management responsibility between a nominated GP, a senior nurse and an administrator. Future management arrangements in other community hospitals are known to include the clinician in the management structure, as encouraged by Griffiths, and this is to be welcomed. Certainly, those responsible can be charged with the task of publicising the specific role and function of the community hospital, of clearly defining its philosophy, and jointly planning and setting its direction. With this positive, dynamic approach, charges of 'geriatric dumping ground' and 'institutional backwater' may be avoided. Giving the hospital a high profile and high status within the

district, should ensure that the hospital is appropriately used to maximum benefit.

Recommendation

Careful consideration should be given to unit management structures, and to the need to appoint staff who are able to set a positive philosophy and direction for the community hospital.

ADMISSIONS POLICY

Certain practical points have arisen during the study, one of which is the need to adhere to a written admission and discharge policy which should incorporate the three criteria stated in HSC(IS)75.

1 Patients who need medical and nursing care that cannot reasonably be provided in their own homes.

2 Patients who are not expected to require highly specialised care.

3 Patients who will derive benefit from care nearer their own homes.

Recommendation

A written admission and discharge policy should be drawn up by GPs and made available throughout the district to encourage appropriate use of the facility.

STATISTICS

A practical difficulty is encountered over the use of statistical forms and the accurate measurement of activity in community hospitals. The activity carried out very often does not fit neatly into standard SH3 forms, with inpatient activity being recorded under 'GP other' or under miscellaneous headings. The assessment of the contribution made by community hospitals to the overall health care of a district would be simplified if forms could be

tailored to the hospitals' needs. Also, GPs need to be encouraged to accurately record activity by completing HAA discharge forms with the appropriate details. Specific performance indicators, utilising a combination of the components of acute and community Körner minimum data sets, would facilitate the accurate measurement and use made of the provision.

The main barrier to achievement of this objective stems from the 'whole patient' or 'holistic' approach to care, which distinguishes the community hospital from the district general hospital and the GP from the consultant. The GP, who is a generalist rather than a specialist, will admit a patient without needing to categorise the patient under any particular heading. Therefore an elderly person with respiratory difficulties, who requires an acute admission because of social reasons, may be categorised primarily as a 'geriatric', 'medical' or 'social' admission. However, whereas the patient may occupy either a medical or geriatric bed in a district general hospital, the patient will occupy a GP community bed in a community hospital.

In order to enhance the specific role of the community hospital, and the professional image, it is vital that accurate measurement of activity is produced, and performance and standards of care regularly monitored. Related to the need to measure performance is the need for medical audit (a direction welcomed by some GPs as the only way to answer criticisms of this type of care) using objective data and scientific measurement.

Recommendation

Performance indicators should be developed specifically for GPs and community hospitals. A minimum Körner data set would be required, quite separate from acute hospital data sets.

COSTINGS

Reference has been made to the financial viability of small local hospitals, and previous work (Rickard[24]) has not always been encouraging. However, one would expect that low-tech hospitals, with low cost medical cover, would, over a certain size, be

economically very attractive, and local costings have demonstrated that such hospitals are very low cost overall. If it can be demonstrated that costs can be kept down and that the cost per inpatient day compares favourably with the acute hospitals, the community hospital may be an even more attractive proposition.

Recommendation

There should be a comparative costing exercise of acute district general hospital beds and community hospital beds.

FUTURE ROLE

In view of the changing health needs of a given population, changing government initiatives, changes in medical treatment and so on, it is likely that the role of the community hospital will continue to evolve and adapt to current need.

Recommendation

A further evaluation of the role and function of the community hospital should be carried out in five to ten years' time.

APPENDIX A

Number of beds in community hospitals nationally

Region	*Number of community hospitals*	*Small community hospitals (–50 beds)*	*Large community hospitals (+50 beds)*	*Total number of beds*
South Western	61	1445	376	1821
Wessex	35	804	418	1222
South West Thames	20	477	159	636
South East Thames	19	411	550	961
Trent	19	394	374	768
West Midlands	17	343	180	523
Yorkshire	15	381	122	503
Northern	14	255	251	506
North West Thames	12	291	106	397
Oxford	10	152	302	454
North Western	9	128	422	550
North East Thames	8	170	224	394
Mersey	6	162	–	162
East Anglia	4	69	84	153
Total	249*	5482 Average bed size 27	3568 Average bed size 74	9050

*201 community hospitals have less than 50 beds; 48 community hospitals have over 50 beds.

APPENDIX B

Some advantages and disadvantages of community hospitals

ADVANTAGES	DISADVANTAGES
To patient	
1 Convenience of access;	1 The young may find the number of elderly and terminally ill off-putting – not a balance of patients usually;
2 continuity of care;	2 low technology may reduce confidence;
3 familiar surroundings;	3 lack of resident medical staff may reduce confidence.
4 personalised service;	
5 shorter waiting times;	
6 closer to home and family, facilitating discharge;	
7 patients, particularly elderly, tend to make good progress.	
To staff	
1 Local and convenient;	1 Low technology may be unattractive to professionals;
2 may be familiar with patients within the community;	2 if hospital tends to have high dependency, long-stay patients, this may lead to some demoralisation of staff;
3 nursing staff have opportunities for extended roles and additional responsibilities;	3 May have problems recruiting trained staff.
4 informal and friendly atmosphere.	

To medical staff

1. Attracts high calibre GPs;
2. adds dimension to primary care;
3. reduces feeling of isolation of GPs from consultants and other colleagues;
4. GP can provide more 'total' care for patients and monitor progress;
5. opportunity to be involved in HA as well as FPC, including management opportunities.

1. May be lack of training;
2. poor remuneration generally;
3. may have lack of direction as medical group;
4. regularly on call for inpatients;
5. inter-professional disputes between consultants and GPs;
6. additional workload.

To health authority

1. Eases pressure on DGH;
2. assists in maintaining patients in the community;
3. a cheaper option, possibly, per inpatient day;
4. may reduce outpatient and operating waiting lists;
5. saves high ambulance costs to take patients to DGH.

1. Scatters resources into peripheral units;
2. may duplicate DGH services;
3. lack of clarity of role;
4. lack of control over staff, especially GPs;
5. often poor record keeping of hospital activity – difficulties of measurement.

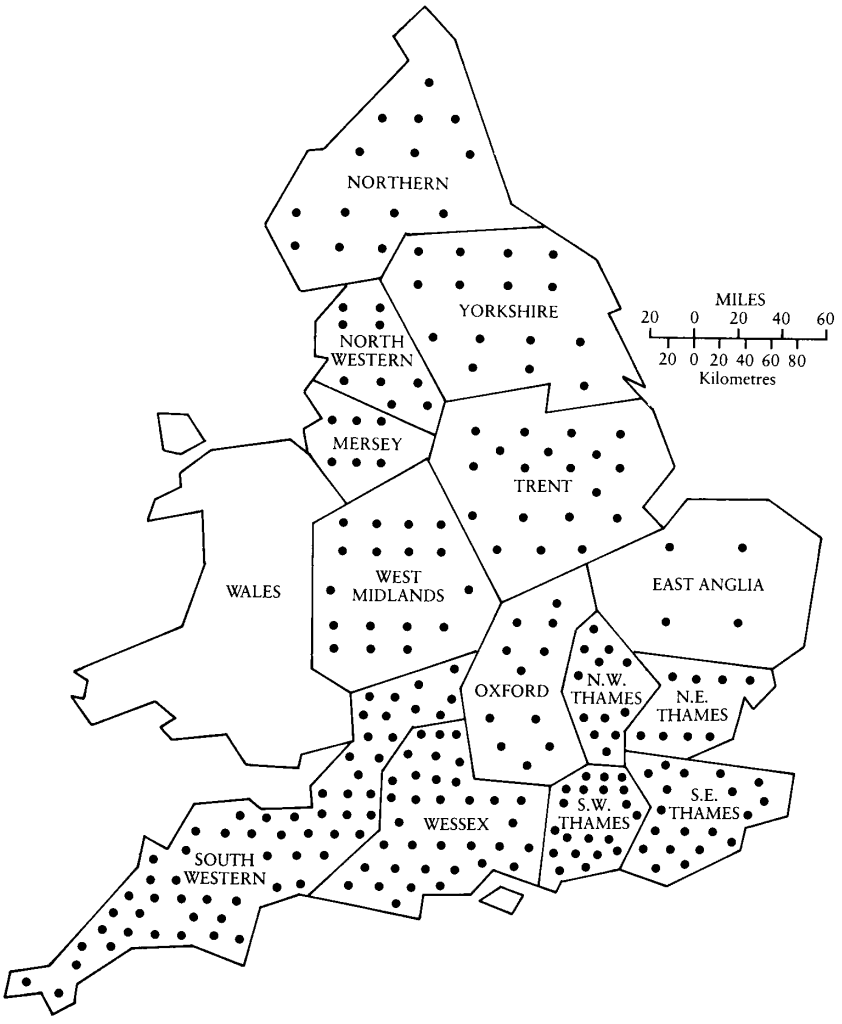
To community

1. Focus for community;
2. attracts volunteers and funding;
3. tends to benefit from close integration with community;
4. may benefit from pressure groups for resources or against closure.

1. May have high expectations;
2. need awareness of limitations of service and to understand role.

APPENDIX C

Distribution of community hospitals in England by region (NHS regional health authority boundaries, England)



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A full bibliography is available from the author.

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