The developing role of community hospitals: an essential part of a quality service

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Current changes to the organisation of the NHS and the introduction of "market forces" into health care have resulted in a re-evaluation of district hospital services as the most appropriate centres for the delivery of patient care. The present emphasis on primary health care has further heightened the debate about centralised services versus locally based services. Both the Community Care Act[1] and the Tomlinson report[2] emphasise the importance of locally based services meeting the needs of local populations. As a result of both of these initiatives, community hospitals find themselves, yet again, in the political "batting alley." However, on this occasion the emphasis seems to have changed; the argument is not whether community hospitals should continue to exist but instead the focus is on the direction for development of the present hospitals and the creation of more local centres, in order to create the service shifts that are recommended for the future of the health services.

In this era of technological development the need for community hospitals is greater than ever. Pietroni argues the need for holistic medical care in health care provision.[3] His argument centres around the assertion that in today's health culture, technology has resulted in the patient's journey through "the health care tube" becoming more rapid. Procedures that in the past entailed a lengthy stay in hospital are now often done as day case procedures. In the world of efficiency and effectiveness this is an appropriate development, but usually the recovery period which patients experience is greater than one day – a period which they often have to endure on their own without consistent or continuous support. Pietroni's argument for holistic medicine is not centred on some "alternative" concept, but on a belief that it is inappropriate to treat the illness alone without addressing the individual as a whole. His assertions lead one to ask the question "*Are we prepared to resource a health service that treats people or one that treats illness?*" If we pursue this question, then the need for the community hospital as a valuable health care resource becomes more obvious.

This paper highlights some important considerations about the interface between primary and secondary care and explores the future of community hospitals in providing locally based health care. It emphasises the need for securing a community care infrastructure, which includes community hospitals, before service shifts can occur between secondary and primary care. The popular image of the community hospital as a place where elderly people can spend time "convalescing" is rejected as unrepresentative of the reality of this important service today. The experience of service development in Oxfordshire will be considered where appropriate.

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Community hospitals: past and present

It is said that history repeats itself, and in the case of the community hospital, this is certainly true. A review of the history of community hospitals[4] illustrates their chequered history and a tension of consumer demands in direct conflict with the reluctant providers of the service.

Originating in cottage hospitals, community hospitals have grown in number to today's figure of 350 in England and Wales, containing about 10 000 hospital beds, 3% of the acute beds of the NHS; in Scotland 72 community hospitals contain over 2000 beds. At present about 15% of general practitioners in the United Kingdom have access to community hospitals.[5] In Oxfordshire alone, there are 11 such hospitals, providing a total of 357 beds to local populations, with about 5398 admissions a year.

But what is a community hospital? In general, the concept of a community hospital seems to vary from area to area, according to historical origins and the needs of the local population. However, while the size, location, and organisation of particular hospitals may differ, some common characteristics are evident (box).

Potential of community hospitals

The most important demographic change to affect the United Kingdom is now recognised as the dramatic rise in the numbers of people over the age of 85. It is those over 75 and, especially, those over 85 who place the greatest demands on the health and social services.[6] With this increasing demand being exerted on all branches of service provision, there is a need to have available a number of services to meet the needs of older people. In 1991, after a review of services for mentally ill people and elderly people in Oxfordshire Health District,[7] the Health Advisory Service recognised this need and recommended the community hospitals as ideal centres to promote multidisciplinary working, to develop a distinct "outreach" philosophy, and to strengthen links between primary and secondary care.

Some common characteristics of community hospitals

1 The hospitals are located within a specifically defined geographical area and serve a particular population
2 Medical support is provided by general practitioners, with specialist medical support offered on request from appropriate clinical specialists
3 Patients suitable for admission may be broadly defined as:
Those who, though requiring hospital care as they cannot be managed at home, do not require the facilities of the district general hospital nor the continuous services of a specialist team
Those who would derive benefit from an extended period of care which could not be reasonably provided in their own homes, in an acute hospital, or in a specialist unit
Those who because of their age or psycho/social circumstances, require an extended period of rehabilitation provided by a multidisciplinary team to recover from an acute episode of illness or treatment
4 The hospitals are "nursing led," the dominant treatment required being nursing in partnership with other disciplines
5 Other services commonly provided include:
Visiting consultant outpatient services
Day hospital provision
Minor casualty services
Direct access services including physiotherapy, occupational therapy, and radiography
Minor surgery

What is important to emphasis is the fundamental difference in approach of a community hospital from that of an acute general hospital. The focus of care in the community hospital is not the specialty to which the patient's diagnosis belongs. That is of secondary consideration. The identification of care needs is driven by the individuality of the patient. Therefore the patient will not be classified as a "surgical case" or a "medical case" but as an individual requiring a particular level of medical, nursing, and associated care in order to resolve a complex collection of physical, social, and psychological problems. These problems cannot easily be dealt with in the patient's own home or in the inappropriate environment of an acute general hospital. Community hospitals are ideally placed to liaise and integrate with an array of services and organisations in a particular locality and thereby establish close multidisciplinary working relationships. This situation is one that is familiar to most community hospitals. However, it does need to be recognised that the service is sometimes viewed with scepticism by some health authorities and the closure of a local community hospital is often seen as the immediate answer to a health authority's financial problems.

Provision of intermediate care

A recent report highlighted the need for local based health care to be developed which is not essentially medically orientated.[8] Shorter lengths of stay mean that people are often recovering at home, with variable levels of support. Some districts have developed creative systems to allow earlier discharge of patients from acute hospitals with the knowledge that follow up support will be available. Such schemes as Hospital at Home and 24 hour district nursing services are such examples of good practice. However, we should not assume that these services are what the user or consumer of the service actually wants. Research into respite care needs highlights the demand for carer support which is provided outside the home environment.[9] Equally, not all patients want to remain at home while receiving their treatment or care. Instead they value the security of the hospital environment. Community hospitals can provide the best of both worlds – that is, treatment in a local environment with the security of a hospital.

With the emphasis on increased technological advancements, there is a growing awareness of the need for provision of intermediate care to bridge the gap between secondary and primary care. Community hospitals go some way toward bridging this gap and are well positioned as resource centres to provide a comprehensive range of services aimed at maintaining patients in their own homes or helping them to find a suitable alternative. It is an inappropriate use of resources and an inappropriate experience for the particular patient to have people with such non-acute care needs occupying acute beds. Research by Anderson *et al* highlighted that for only 38% of bed days were patients considered to have medical, nursing, or life support reasons for requiring a bed in a provincial teaching hospital.[10] Indeed, the requirements for a bed in the hospital decreased with the patient's age and length of stay in hospital. The arrangement and coordination of complex packages of care, involving multiple agencies is a central remit of the community hospital. The value of this service to acute units is one that is predominantly underestimated and undervalued. The problems associated with discharging patients from acute beds have been recognised in the creation of the Community Care Act.[1] Without the services of the community hospitals this situation would be exacerbated, not just for the acute services but also for primary health care teams. In Oxfordshire common guidelines and standards for discharging patients have now been agreed between both social and health care providers, and this has resulted in greater cooperation between acute services and community hospitals.

What needs to be understood in these debates is the interface between health and social care – that is, what is the responsibility of social services and what is the responsibility of the health authority. Although a large number of admissions to community hospitals are a result of deteriorating or failing social circumstances, this does not detract from the

fact that the person admitted has associated health care needs and that by dealing with one need the other becomes easier to manage. Critics of community hospitals, failing to understand the inextricable link between health and social circumstances, will say that some patients are admitted to community hospitals for social reasons. This demonstrates a failure to perceive the complexity of health care issues, as illustrated by the following example (box).

Margaret is an 87 year old woman with a longstanding history of chronic arthritis. Though her mobility is greatly compromised and her ability to attend to her daily activities is limited, she manages to maintain her independence at home with help and support from her daughter. However, Margaret is a "hoarder," to the extent that the actual space she has available in her house is decreasing all the time. Boxes are piled high, and the corridors are dangerously narrowed by the space they occupy. Margaret falls and sustains a Colles' fracture. After the application of a plaster cast and immediate care and rehabilitation she is discharged home. After a short period the district nurse contacts the community hospital because "Margaret is not coping". Margaret is admitted to the hospital, and on assessment it becomes clear that the primary aim in her care is to make her home safe so that she may return to it, as she wishes. She also requires further rehabilitation to regain her confidence in attending to her daily activities of living. Through close collaboration with the social and voluntary services a package of care is organised which supports both her and her family. Margaret's nurse, acting as her advocate, ensures that while the house is made safe, Margaret's privacy, individuality, and autonomy are maintained, by constantly ensuring that the decisions made by the various care agencies represent Margaret's wishes. Margaret eventually is discharged home with the support of a full health and social care package.

This case raises several important issues about the complexity of the health care needs of older people. Callahan argues that the future goal of medical practice should be to improve the quality of the lives of older people, not to lengthen them.[11] A central tenet of this argument is the philosophy that it is not just the physical alteration that accompanies the aging process that presents the threat of loss but that it is indeed the inevitable alienation from a body that is regarded as an imprisoning object.[12] In Margaret's case, her approach to recovering the alienation that she experienced was the gathering of security through hoarding of possessions. As a result, however, her health status was adversely affected. But how can one separate the social and health aspects of this case? Clearly, in pragmatic terms there are established role boundaries which demand inter-agency cooperation and designation of tasks. However, while this may be a practical approach to the division of labour, it is the recognition by health care practitioners of the patient's combined needs that ultimately achieves a satisfactory outcome for the patient. It represents an opportunity to cultivate a deliberate integrity between the individual and their health and social care context.

The close relation between health and social care is central to the case. It is not always appropriate or helpful to separate the two, if the aim is to deliver a quality care package. Though the ideal would be to manage such cases with the patient remaining in his or her home, the reality is that this is not always possible. Therefore community hospitals are the appropriate alternative. The recognition of these centres as valuable resources to the support of community care needs to be made explicit, particularly as reports such as *The Health of the Nation*[13] do not expressly address the needs of older people. While the debate about separatist versus integrated services for older people prevails, the needs of older people (such as Margaret) who do not require the services of specialist or acute centres needs to be carefully considered and the place of community hospitals addressed.

Margaret's needs demonstrate the ability of community hospitals to provide an active rehabilitation programme. The continuing usage of such language as "convalescence" detracts from the nature of the rehabilitation service provided. Convalescence, with its emphasis on the passive recovery of health after illness, does not represent the reality of community hospital practice. Community hospitals are ideally placed to provide and further develop a rehabilitation service that is actively pursuing the most suitable "home" environment for the individual within their locality. The local knowledge held by patients and practitioners is often underestimated as a valuable resource when seeking the best outcome for the patient.

Provision of acute care

It would be inappropriate to provide a single view of community hospitals as centres for coordinating discharge planning. In Oxfordshire plans for developing health care for the needs of people in the early twenty first century, known as *The Headington Strategy*, recognises the value of the eleven community hospitals to the health services of the region. This recognition, however, does mean that the community hospitals must demonstrate their ability to provide a service appropriate to the needs of the population and one that meets the needs of the acute sector. If the community hospital is to develop into a community resource centre, then service shifts from acute units to community hospitals need to be given careful consideration and require careful planning. Such local hospitals are capable of expanding their roles in order to deal with more "acute" cases. It is inappropriate for patients to be admitted to acute hospitals for procedures and care needs that can be equally well dealt with in a local centre. As well as those already discussed, care

needs such as those listed below could all be met in a community hospital.

- Simple rehydration programmes and intravenous administration of certain drugs – for example, antibiotics in the acute onset of confirmed respiratory disease – and blood transfusion to patients with a confirmed diagnosis
- Support of patients in the community with longstanding health status that requires regular professional support – for example, perenteral and enteral nutrition, treatment via "Hickman lines," and continuous ambulatory peritoneal dialysis
- Acute episodes of confirmed illness that do not require major investigative procedures – for example, chest infections, dehydration, and anorexia
- Extension of services to accommodate early discharge from acute beds with subsequent earlier commencement of rehabilitation
- Terminal and palliative care.

These services in particular highlight changes in health policy and need, and with the growing numbers of patients with such chronic conditions as AIDS, the requirement for such services in local communities in partnership with primary health care teams is growing. However, should this service shift occur, then clear and unambiguous organisational arrangements will be necessary among all professions, with good cooperation and collegiality between specialist and generalist health professionals.[8] Fundamentally, this change cannot occur without cooperation from general practitioners and their acceptance of the ensuing medical responsibility.

Potential barriers to development of community hospitals

Already some community hospitals are expanding their roles to accommodate service shifts, according to local need. However, for these shifts to occur a sustained commitment to this change is needed, both financially and professionally. The Tomlinson report highlights the need for services such as those of community hospitals and primary health care to be securely established financially and professionally before this change is initiated.[2] Without this commitment the service can only limp forward without being able to demonstrate its real potential.

PROFESSIONAL BOUNDARIES

Interprofessional barriers need to be challenged and in some cases redefined. Do all patients necessarily require the services of medical specialists or, indeed, can general practitioners provide an expanded range of services to patients with acute needs? Can a clinical assistant in collaboration with general practitioners provide a suitable model to manage acute care needs? Alternatively, can the role of nurses in such settings be expanded to take on a more specialist rehabilitation and acute care function? We need to recognise that the patient's concern is to receive the best possible outcome from his or her hospital stay. Therefore, does it really matter who assesses and prescribes particular aspects of care and treatment, as long as that practitioner has the necessary knowledge and skill to do so?

We must also recognise that often these patients' greatest need is for nursing. Community hospitals are ideally placed to develop "nursing beds." In Oxfordshire such an experiment was carried out, and, although the research demonstrated many positive results, the unit was closed. Such innovations pose great challenges to the establishment; as Pembrey and Punton asserted, it is a paradox of innovation that, although the service may have been needed, its threat to the established order resulted in its suppression.[14] The problems surrounding the nursing beds issue seem to relate to interprofessional conflict and protection of professional boundaries rather than an objective view of what is best for the patient. The issue is not that we need nursing beds to demonstrate the "power" of nursing or indeed to challenge the practice of medicine, it is about giving the most appropriate therapy to patients and recognising that in some instances that will be nursing.[15] The increasingly aging population represents one such group where nursing can make a difference to health status.[16]

Vaughan asserted that the dimensions of nursing cannot be static, they need to be flexible and responsive to changing needs and, nurses need to be clear thinking about the way they respond in an ever changing arena (B Vaughan, paper presented at clinical nursing conference, Burford, Oxfordshire, 1993). Already, many nurses are practising in this creative, interdependent way. However, this work needs to be made more explicit. Indeed, it could be argued that for many the introduction of nursing beds formalises work which many people have striven to do for years (B Vaughan, paper presented at clinical nursing conference, Burford, Oxfordshire, 1993), and certainly this is the case in community hospitals. Nursing in a community hospital takes a different focus with its allegiance being closer to the "therapies" than that of medicine. This focus is appropriate for the development of interdisciplinary working. It is worth re-emphasising that an approach to patient care utilising a nursing beds concept is not one of nurses exerting inappropriate power, but is indeed another important, if not essential, consideration when creating service shifts from acute services. If the shift to community based local care is to occur then a range of services need to be considered so that patient choice can be exercised while maximising the use of resources.

FINANCIAL CONSTRAINTS

The financial constraints of the "new" NHS may prove to be the Achilles' heel for the development of community hospitals. It is not enough to espouse the value of community care without the financial support. However, rationalisation of community services needs to be considered in order to make the best use of

resources and reduce overlap and replication of services in the community.

There is little evidence to suggest that local hospital services are an ineffective use of resources. Indeed, a House of Commons health committee doubted whether the use of community hospitals was necessarily more expensive than centralised services.[5] As the Royal College of General Practitioners suggested: "... any calculations about the cost effectiveness of small hospitals should take account of the value of voluntary giving and the social costs and benefits to patients as well as the more conventional and more easily measurable capital and revenue costs." While Higgins shows how health planners may be critical of this approach to cost appraisal in the current NHS, she does suggest that "the social and economic costs to patients of not providing local services is very high" because of the isolation and loss of social ties experienced with family and friends.[17]

Creating the environment for change

The development of a quality service cannot happen without sustained financial and professional commitment. Creating such an environment in community hospitals requires systematic development of information and communication systems, practitioners' knowledge and skill, and interprofessional or interagency collaboration. Just as there is a need for continuous professional development in nursing, so there is an equal need in general practice and the professions allied to medicine.

In Oxfordshire this commitment is being demonstrated by nurses, through a programme of development activity centred on the vision of developing clinical practice in the community hospitals and a desire to invest in creating a corporate strategy for streamlining standards and the development of "new initiatives." The Community Hospitals' Nursing Development Unit, which incorporates all 11 community hospitals, is undertaking a three year development programme, with baseline information and standards being established, against which innovations can be measured. It is anticipated that this work will eventually involve general practitioners and the other professions. However, for this innovation to be successful other considerations are needed, as follows.

(1) There is a need for re-evaluation and exploration of the criteria that represent acute care. In some cases acute care represents high technological investigative procedures and invasive treatment, in others it may just mean an acute exacerbation of a chronic condition. It is in the last category that the controversy is greatest in terms of where treatment and care should be provided. When options of location of care are being considered the community hospital needs to be looked at objectively as one such option for particular clients.

(2) The effects of shorter lengths of stay and advanced technology need to be considered in purchasing strategies. Purchasers need to consider carefully whether the service provided focuses more on the illness than the person. While shorter lengths of stay and increased throughput are admirable objectives, their effects on patients' recovery does need consideration. It would be an equal waste of resources if readmission rates were increased as a result of ineffective patient recovery. Community hospitals are well placed to provide a comprehensive, multidisciplinary rehabilitation programme for patients discharged from acute hospitals early.

(3) There needs to be a range of services available to meet the needs of an aging population in a society that is undergoing major politico-economic and cultural change. There is no doubt that attitudes towards caring for older people have changed in an increasingly economically stretched society. There cannot be one right way to cater for the needs of older people. Instead a range of options needs to be considered. Community hospitals, by virtue of their local orientation are in a position to develop the close working relationships with multiple agencies required to coordinate complex packages of care most suitable for older people.

(4) There is a need for community hospitals to be developed as resource centres for locally based health care. Service provision in local centres needs to be considered to ensure a comprehensive range of services to meet the demands of people with continuing health care needs, whose present reliance on acute services is an inappropriate use of resources. Community hospitals are able, and should be able, to offer a suitable and cheaper alternative, and where they exist it does not make economic sense to neglect their development. The Tomlinson report clearly recommends this shift in focus but cautions against it without firstly developing the infrastructure of the local centres.

(5) The need for creative interprofessional collaboration centred on patient need is imperative to achieving truly patient centred health care practices. Professional barriers do need to be challenged. We need to be able to trust and value each others' contribution to the care of patients. Should this not be achieved, then community hospitals will continue to limp forward instead of becoming even more creative locally based resource centres.

(6) If a truly integrated approach to health care is desired, then there needs to be a commitment to development programmes that recognise the complexities of professional practice. Educational development in primary and community care settings should be treated with equal importance to that in acute care. Ongoing training programmes, coordinated jointly between the acute services and primary care, would ensure that practitioners use an up to date knowledge base and skills in order to meet the demands of the service.

Conclusions

A community hospital, with a commitment to developing and improving quality, that is sensitive to the needs of its local community

and the acute sector, can present a strong case for contributing to the overall pattern of health care, with costs forming just part of that debate.[5] If the shift to community based care is to be realised a range of services needs to be considered so that patient choice can be exercised while maximising the use of resources. Community hospitals are in a strong position to compete as providers of a range of services and are an important resource within the new NHS. Many patients in acute beds in district general hospitals do not require the high technology, investigative facilities of these units, and community hospitals are ideally placed to provide the level of care they need. However, much more systematic research and evaluation of the services of community hospitals needs to be performed, together with inclusion of community hospitals in strategic planning.

Community hospitals offer a suitable environment for developing models of health care that extend the remit of the acute unit. They provide the opportunity for acute services to demonstrate their commitment to patients' progress beyond the initial intervention. We need to accept this challenge now, so that the increasing demands on already stretched resources can be met effectively.

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