

Use of general practitioner beds in Leicestershire community hospitals

J TOMLINSON

N T RAYMOND

D FIELD

J L BOTHA

SUMMARY

Background. The shift in care from secondary to primary services is likely to place greater demands on community hospitals. Before changes in the provision of community hospitals can occur, baseline data are needed, outlining their current use.

Aim. A study was undertaken to obtain baseline data describing the use of general practitioner beds in Leicestershire community hospitals.

Method. A three-month prospective, observational study was carried out between February and May 1992 using data from a questionnaire completed by nurses and general practitioners and from patient hospital records. Study patients comprised all patients admitted to general practitioner beds in all eight Leicestershire community hospitals.

Results. A 100% questionnaire response rate was obtained giving data on 685 hospital admissions. Around 70% of admissions were of patients aged 75 years and over. Of admissions, 35% were for acute care, 31% for respite care, 22% for rehabilitation, 7% for terminal/palliative care and 5% for other reasons. Fifteen per cent of patients had been transferred from a consultant bed. Of those not transferred, 91% were admitted by their usual general practitioner or practice partner and for 96% of these patients this was the general practitioner's first choice for care. There was significant variation in both the age mix and care category mix of patients between individual hospitals. Medical deterioration in an underlying condition and family pressure on the general practitioner or carers' inability to cope each contributed to around half of all admissions. Of all admissions, 38% lived alone, and 18% of carers were disabled. Incontinence was reported for 35% of patients, and 26% of all patients were of a high nursing dependency. There was low utilization of community services before admission and 33% received none. There was variation between individual hospitals in use of local and district general hospital investigations, specialist referral and types of therapy. Of 685 admissions 11% died during their stay. Of those discharged, 76% went to their own or a relative's home, 10% to a residential or nursing home and 9% were transferred to an acute bed. Nine per cent of discharges were postponed and 10% were brought forward. On discharge to non-residential care, 26% of patients received no community services.

J Tomlinson, MRCP, registrar, Department of Public Health, Leicestershire Health, Leicester. N T Raymond, BA, research associate; D Field, PhD, senior lecturer in medical sociology; and J L Botha, MFPHM, senior lecturer in epidemiology, Department of Epidemiology and Public Health, University of Leicester Medical School.

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Conclusion. Shifting resources from secondary to primary care is a priority for purchasers. Both the introduction of the National Health Service and community care act 1990, and acute units having increasing incentives for earlier discharge, are likely to place greater demands on community hospital beds. Not all general practitioners have the option of community hospital beds. Before access to general practitioner beds can be broadened, existing beds should be used appropriately and shown to be cost-effective. Purchasers therefore require criteria for the appropriateness of admissions to general practitioner beds, and the results of a general practitioner bed cost-benefit analysis.

Keywords: community hospitals; bed and patient statistics; hospital utilization; bed occupancy.

Introduction

THE future of community hospitals within the National Health Service is uncertain.^{1,2} The present philosophy behind community hospitals has become one of meeting local community non-specialist health care needs, which involves a holistic approach to both social and medical needs, while maintaining the patient in the community whenever possible.³ To determine the future role of community hospitals, information is required on their activity within the context of the health district, including whether existing beds are being used appropriately, reasons for admission, levels of unmet need for beds, and hence whether the number of beds in each locality is adequate. Previous studies have looked at the number of community hospitals, cost-benefit analyses, the type of patient admitted and whether admission had any effect on general practitioner consultation rate, follow up, home visit ratios or the need for acute hospital beds.⁴⁻¹²

A study was undertaken to obtain baseline data describing the pattern and type of admission to general practitioner beds in Leicestershire community hospitals. Leicestershire community hospitals were defined as hospitals: not forming part of a district general hospital complex; providing services for patients living locally but not needing specialist district general hospital services; not confined to one specialty; providing services under general practitioner as well as hospital consultant care; and providing rehabilitation services.¹² The aims of the study were to investigate: care groups admitted, whether the admission was the general practitioner's first choice, social factors related to admission, the level of nursing dependency of patients on admission and discharge, provision of community services, use of facilities within each hospital, bed occupancy and median length of stay.

Method

The study was a prospective, observational study which included all admissions to general practitioner beds in all eight community hospitals in Leicestershire during the period 17 February to 17 May 1992. This period was chosen to provide well-timed information to inform health authority purchasing decisions and to avoid fluctuations of service provision around Christmas and the summer break. The organization of the Leicestershire community hospitals was within a single management structure. At the start of the study period, 8% of Leicestershire general practices were fundholding practices, this proportion increasing to 17% during the next financial year.

All general practitioners with access to Leicestershire community hospital beds were notified of the study by letter. All community hospitals were visited, both to discuss the study and to give verbal and written guidance to nurses and general practitioners on the method of completion of a questionnaire. Patients admitted during the study period were followed through to their discharge or death.

The study used information from the patient hospital records and the questionnaire; patients or their carers were asked about community services received. The questionnaire collected the patient's identifying data and demography (age, sex, domestic circumstances and services received before admission), details of admission (source and precipitating factors), data relating to hospital stay (care category, diagnosis, level of dependency, and investigations/specialist referral/therapy received) and discharge (length of stay, discharge address and services on discharge). Nurses were the main source of information; general practitioners referring patients to community hospitals needed to complete items detailing factors influencing admission and first choice for managing patient care.

On admission, patients were assigned to one of five care categories, based on working definitions. The categories were: acute care — care for a patient with an acute episode of illness not requiring high-level medical intervention; respite care — a patient being admitted in order to give a carer a break; rehabilitation — a patient being admitted directly rather than from another hospital for rehabilitation and nursing care, or a patient being transferred from an acute unit for rehabilitation to prepare for discharge; terminal/palliative care — care for a dying patient; and all other admissions to general practitioner beds. The *International classification of diseases* ninth revision (ICD-9) coding system was used to categorize patient diagnoses on admission.

Two scoring systems were used routinely on all admissions to Leicestershire hospitals in early 1992.^{13,14} The 'monitor patient dependency score'¹⁴ provides details of a patient's nursing dependency level. It has four categories which describe patients' general mobility, ability to dress and feed themselves, and frequency of necessary nursing observation. Dependency categories one and two indicate lower levels of dependency and categories three and four indicate higher levels of dependency. The 'Norton score' calculator¹³ has a subcategory which was used to provide details of the patient's continence status. Information using both scoring systems was collected in this study.

The questionnaire was piloted for a two-week period in January 1992 at two of the community hospitals. During the main study, questionnaires were collected weekly by the ward sister, checked for completion, and forwarded for central collation. Any subsequent missing data prompted a telephone call to either the appropriate hospital or general practitioner. All general practitioners and hospitals involved in the study received a written report of the final results. Five out of eight hospitals had a feedback presentation to facilitate local debate.

Data were analysed using the SAS statistical software package¹⁵ to calculate chi square tests of independence, Fisher's exact tests and non-parametric Kruskal-Wallis tests, where appropriate.

Results

There were 685 general practitioner bed admissions during the three-month study and a questionnaire was completed for each admission. Of 191 general practitioners, five (2.6%) from different practices and localities refused to complete their items in the questionnaire. As a result these items were missing from 17 admissions (2.5%).

Age and sex of patients

Of the 685 admissions, 56.6% were female patients and 43.4% were male patients. Of all admissions 69.6% were patients aged 75 years and over. There was significant variation in the age group mix for each hospital, with those hospitals furthest geographically from Leicester city centre having a higher proportion of younger patients ($\chi^2 = 55.04$, 21 degrees of freedom (df), $P < 0.001$).

Care category

A total of 238 admissions were for acute care (34.7%), 215 were for respite care (31.4%), 149 were for rehabilitation (21.8%), 50 were for terminal/palliative care (7.3%) and 33 were admissions for other reasons (4.8%). There was significant variation in the utilization of beds by care category between hospitals (Kruskal-Wallis test $\chi^2 = 105.18$, 7 df, $P < 0.001$; Table 1).

Diagnoses

Diseases of the circulatory system accounted for 175 admissions (25.5%), including 90 admissions for cerebrovascular disease (ICD-9 rubrics 430–438), 46 for congestive heart failure and 16 for coronary heart disease (ICD-9 rubrics 410–414). Neoplasms accounted for 71 admissions (10.4%) of which 41 were admissions for terminal care and 18 for respite care. There were 67 admissions for diseases of the respiratory system (9.8%) of which 23 were for chronic airways obstruction and 21 for chest infection. There were 55 admissions in the injury and poisoning category (mainly falls) (8.0%). Fifty three admissions were coded as diseases of the nervous system and senses (7.7%), of which 19 were for parkinsons disease and 17 were for multiple sclerosis. The other main category was admissions for complications of the musculoskeletal system and connective tissue, accounting for 50 admissions (7.3%).

Transfers

In total, 105 admissions (15.3%) were transfers from a consultant bed. Of these, 90 were from a district general hospital and 15 were from another community hospital. Of the 105 transfers, 67 were admissions for rehabilitation (63.8%).

General practitioner data

Of 580 patients not transferred from another hospital 402 were admitted by their usual general practitioner (69.3%), 128 by a practice partner (22.1%), 34 by a general practitioner trainee (5.9%), six by a locum (1.0%) and three by a covering practice (0.5%); data was missing for two cases. Five admissions were of

Table 1. Reasons for admission to the general practitioner beds in the eight Leicestershire community hospitals.

Hospital	% of admissions to hospital for				
	Acute care	Respite care	Rehabilitation	Terminal care	Other
S (n = 79)	68.4	15.2	7.6	3.8	5.1
T (n = 110)	4.5	60.0	28.2	3.6	3.6
U (n = 92)	52.2	25.0	18.5	3.3	1.1
V (n = 92)	55.4	9.8	21.7	10.9	2.2
W (n = 93)	16.1	49.5	17.2	14.0	3.2
X (n = 55)	41.8	20.0	25.5	3.6	9.1
Y (n = 103)	18.4	34.0	25.2	11.7	10.7
Z (n = 61)	37.7	21.3	31.1	4.9	4.9

n = number of admissions to community hospital.

temporary residents (0.9%). In 540 of 564 admissions where general practitioner data were available, the general practitioners stated that admission to the general practitioner bed had been their first choice (95.7%). In a further 21 cases the general practitioners stated it had not been their first choice (3.7%) and in three cases the general practitioner was not sure (0.5%).

On a patient's admission, the general practitioner was asked to indicate whether a selection of medical and social factors had contributed towards the patient requiring admission. Medical deterioration in an underlying condition was considered a contributing factor to hospital admission in 328 cases (47.9%). Family or carer pressure on the general practitioner/carer inability to cope was considered a factor in 304 cases (44.4%). In all care category groups, these two factors (medical deterioration and family or carer pressure/inability to cope) each contributed to approximately half of all admissions. A supervening medical problem was considered to be a contributory factor in 17.7% of cases, a patient's request for admission in 14.3% of cases, a formal service (for example district nursing) having difficulty caring for a patient at home in 14.2% of cases, and breakdown of other social support in 8.2% of cases. In 12.7% of cases, another reason was a contributory factor for admission.

Patients' domestic circumstances and main carer

Patients' domestic circumstances and main carer on admission are shown in Table 2. In 38.0% of cases, patients lived alone before admission, and 25.9% looked after themselves. In 216 cases, the carer was the spouse (31.6%). In a further 215 cases, patients were cared for by another relative or friend (31.4%) and of these, 108 lived in the same house. In 17 cases, patients lived in a residential home and 12 lived in other unspecified accommodation. Seventy seven of the carers who were spouses or relatives/friends were disabled (17.9%).

Patient dependency

Nursing dependency data were missing for one patient. Therefore of 684 admissions, 40 (5.8%) were classified on the 'monitor patient dependency score' as category one (lowest level of dependency), 464 as category two (67.8%), 134 as category three (19.6%) and 46 as category four (6.7%). No relationship was found between patients' age and their nursing dependency category. A relationship was found between nursing dependency category and care category with a higher percentage of terminal care patients being more dependent ($\chi^2 = 53.08, 12 \text{ df}, P < 0.001$; Table 3).

Table 2. Patients' domestic circumstances and main carer on admission to the community hospital.

Domestic circumstances ^a	No. (%) of admissions in circumstance				
	Main carer				Total
	Self	Spouse	Relative/ friend	Other ^b	
Lives alone	111 (42.7)	1 (0.4)	96 (36.9)	52 (20.0)	260 (38.0)
Lives with spouse	36 (13.7)	215 (82.1)	10 (3.8)	1 (0.4)	262 (38.3)
Lives with relative/carer	21 (15.8)	0 (0)	108 (81.2)	4 (3.0)	133 (19.4)
Residential home/other	9 (31.0)	0 (0)	1 (3.4)	19 (65.5)	29 (4.2)
Total	177 (25.9)	216 (31.6)	215 (31.4)	76 (11.1)	684 (100)

^aDomestic circumstances unknown for one patient. ^bIncludes voluntary visitor, home help, district nurse and other unspecified.

Table 3. Nursing dependency category of patients on admission, by category of care.

Care category	No. (%) of admissions				
	Dependency category ^a				
	1	2	3	4	Total
Acute	17 (7.2)	152 (64.1)	45 (19.0)	23 (9.7)	237 (34.6)
Respite	10 (4.7)	147 (68.4)	53 (24.7)	5 (2.3)	215 (31.4)
Rehabilitation	9 (6.0)	115 (77.2)	20 (13.4)	5 (3.4)	149 (21.8)
Terminal/ palliative	1 (2.0)	24 (48.0)	13 (26.0)	12 (24.0)	50 (7.3)
Other	3 (9.1)	26 (78.8)	3 (9.1)	1 (3.0)	33 (4.8)
Total	40 (5.8)	464 (67.8)	134 (19.6)	46 (6.7)	684 (100)

^aDependency category unknown for one patient.

On admission 239 patients (34.9%) had some form of incontinence: 130 patients had occasional urinary incontinence (19.0%), 71 had urinary incontinence (10.4%) and 38 had both urinary and faecal incontinence (5.6%).

Community services before admission

Patients or carers were asked about community services they were receiving before admission (Table 4). District nurse, home help and meals on wheels were the services most commonly received. Of the 239 patients with incontinence, 13 received a laundry service at home (5.4%). In 33.1% of cases, patients received no services before admission. Associations were found between whether or not a patient received community services and age group ($\chi^2 = 48.04, 3 \text{ df}, P < 0.001$), care category ($\chi^2 = 52.08, 4 \text{ df}, P < 0.001$) and patient nursing dependency score ($\chi^2 = 11.81, 3 \text{ df}, P < 0.01$). Community services had been received by fewer than expected patients who were in age groups 0-44 years and 45-64 years who were admitted for acute care or who were in low nursing dependency categories (categories one and two).

Investigations, specialist referral and therapy received

During their hospital stay, 41.6% of all 685 admissions (range 23% to 62% at individual hospitals) had a blood test at the com-

Table 4. Community services received by patients before admission.

Service	% of 685 admissions
District nurse	38.5
Home help	32.6
Meals on wheels	15.9
Chiropodist	9.3
Previous respite care	8.9
Home aids/adaptations	7.9
Private home help	5.8
Day centre	4.8
Laundry	4.7
Physiotherapy/occupational therapy	3.1
Hospital day unit care	2.9
Social worker	2.5
Member of voluntary agency	1.9
Mobile library	1.5
Counselling	0.7
Speech therapy	0.7
Community psychiatric nurse	0.7
Private nurse	0.3
Health visitor	0.1
None	33.1

munity hospitals, 80.1% (range 57% to 95%) had urine analysis and 21.8% (range 8% to 36%) had an x-ray. Thirty eight patients overall (5.5%, range 2% to 13% at individual hospitals) had an investigation at the district general hospital (usually x-ray or ultrasound) and 99 patients overall (14.5%, range 8% to 26%) had a specialist referral (mainly orthopaedic, geriatric or surgical referral). A total of 114 patients overall (16.6%, range 10% to 27%) had an investigation at the district general hospital and/or specialist referral. Overall, 45.1% of patients received physiotherapy (range 10% to 90%), 26.7% received occupational therapy (range 0% to 92%) and 1.0% received speech therapy (range 0% to 3%). Of the 149 rehabilitation patients 61.1% received physiotherapy.

Hospital discharge

The bed occupancy for all hospitals was 70% (range 55% to 86% at individual hospitals). The median length of stay for patients at all hospitals was 14 days. There was some variation in lengths of stay between hospitals, mostly reflecting the differences in distributions of age and care category groups. Hospitals having a greater number of younger, acutely ill patients tended to have shorter median lengths of stay and those with a greater number of older, rehabilitation patients had longer median lengths of stay.

Of the 685 cases, 608 (88.8%) were discharged; and 77 (11.2%) died during their stay (25 of whom had been admitted for acute care). Of the 608 cases discharged, 67.8% were discharged to their own home, 8.2% to a relative's home, 2.5% to sheltered accommodation and 9.5% to a residential or nursing home. Fifty six cases (9.2%) were transferred to an acute bed in a district general hospital (35 of whom had been admitted to the community hospital for acute care) and 2.8% were discharged elsewhere. Of the 462 cases discharged to non-residential care, 34.2% had received no services before hospital admission, compared with 26.4% who received no services on discharge.

Of the 608 discharges, the date of discharge was brought forward in 9.7% of cases and postponed on 8.7% of cases. Approximately half of the discharges brought forward were at the patient's or family's request (28, 47.5%). Reasons for the discharge being postponed were: problems identified on home assessment (10 cases), non-availability of residential accommodation (10), deterioration in the patient's health (seven), social services support not being in place on time (seven), the carer being unwell (five) and other reasons (13); reason not known for one case.

Discussion

The aim of this study was to provide a description of the use of general practitioner beds in Leicestershire community hospitals in order to inform service provision. The timing of the study meant that some seasonal fluctuation in the use of general practitioner beds was quite likely, and thus the period studied may not reflect the overall annual distribution of admissions. However, a number of findings are worth highlighting as they bear on the appropriate use of community hospitals in the recently restructured NHS.

First, there is some debate about whether general practitioners are using community hospital beds appropriately.² Locally preconceived ideas that many admissions were occurring through the deputizing service or covering practice, and that general practitioners were only admitting patients to community hospitals owing to a lack of alternatives, are not supported by the findings of this study. Most patients were admitted by their usual general practitioner or practice partner, as the first choice for patient management. Acutely ill patients comprised 35% of all admis-

sions. Although it might seem that these admissions would be more appropriately managed in a district general hospital, only 15% of these patients were later transferred to an acute bed in a district general hospital. A further 11% of acute patients died, but the majority (75%) were managed in the community unit and discharged following treatment. Their care in community hospitals appeared to be appropriate and effective.

Variation between community hospitals in the use of beds by age of patients and care category group was not totally reflected by the size of the local elderly population or distance from the nearest district general hospital. It is therefore likely that this is also related to variation in practice between individual general practitioners. This study was not designed to investigate the admitting practices of general practitioners, but this is crucial for the appropriate use of community hospitals.

Secondly, evidence suggests that for chronically and terminally ill patients cared for in their own homes, problems focus around management of symptoms and long-term pressures on carers.^{16,17} For patients who are terminally ill the two main reasons for hospital admission are for symptom control and carers' inability to cope.^{18,19} Family pressure on the general practitioner and carer inability to cope were important contributory factors to admissions in this study.

A number of community services which would help carers cope with their daily burden appear in this study to have been underutilized before admission. These include health visitors, community psychiatric nurses, counsellors, day centres, day hospital units and speech therapy. For example only one patient had been seen by a health visitor before admission, and yet caring for and targeting elderly people is an important component of health visitor training. Similarly, few patients seem to have received support from a voluntary agency, and laundry services were poorly utilized by patients with incontinence. It is not clear what accounts for this underutilization of services but lack of awareness, perceived poor service quality, underprovision, or refusal of services by the patient or carer could all be related factors. Patients receiving no services before admission were from the younger age groups and less dependent care groups and the lack of provision may have been quite appropriate for these patients. A more detailed investigation of community services may shed light on levels of need and provision.

Thirdly, coordination of services in the community, including the community hospital, is important. In response to the NHS and community care act 1990 and the increasing incentive for acute providers to discharge patients early, it is likely that general practitioners will need to make more use of community hospitals. Most community hospitals are in small towns and rural areas, so inner city general practitioners do not have this option. In the future, general practitioner beds may be made available by acute providers and by private or voluntary sector nursing homes which may partly address this issue.²

No attempt was made to analyse data by fundholding status because of the relatively small number of fundholders at the start of the study. General practitioner fundholders now hold the budget for community services, and will increasingly wish to scrutinize the services they are purchasing, both in quality and quantity. This may considerably alter work patterns of community staff in the future. Community hospitals can provide an important intermediary role, but their effectiveness will depend on the appropriate matching of services to need. For example, this study found that use of physiotherapy varied between hospitals. It is difficult to estimate the most appropriate level of provision of this service for all admissions, but all professionals involved with this study agreed that provision of physiotherapy for all rehabilitation patients would have been appropriate. Approximately 60% of rehabilitation patients received physiotherapy.

A commonly-held perception by health professionals is that patient discharges from community hospitals are delayed as a result of poor coordination with social services. In this study, 53 cases had their discharge delayed, but only seven of these were because social services were not in place in time. These results do not support this perception, and more discharges were brought forward than were postponed. The community unit had a policy of admitting patients to a general practitioner bed with a view to discharge after 14 days; the study found a median length of stay of 14 days.

The question remains: should purchasers be supportive of increasing the number of and access to general practitioner beds to include all general practitioners in all localities? Although shifting resources from secondary to primary care is a priority, such a recommendation cannot be wholly supported until there is evidence that existing beds are used appropriately and are a cost-effective option. In the future an increasing demand for general practitioner beds is likely. To allow informed purchasing to take place, purchasers need to facilitate the development of criteria for appropriateness of admission to general practitioner beds and commission a cost-benefit analysis.

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Address for correspondence

Dr J Tomlinson, Department of Public Health, Leicestershire Health, Gwendolen Road, Leicester LE5 4QF.

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for Travellers Abroad
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