

End of an experiment: report from an inner city community hospital

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SUMMARY. *Community hospitals are associated with the provision of health care in rural rather than urban areas. However, the urban community hospital can reduce the pressure on acute hospitals and decrease the isolation of community health workers. In 1982 a community hospital was established in an inner London health district. This paper examines the role and function of this hospital over a one-year period in 1986–87 and makes comparisons with the hospital's first two years of operation. The problems identified in the initial evaluation, such as low bed occupancy and the limited participation by general practitioners in the area, were still present. It was found that there had been a decrease in the number of patients treated for musculoskeletal, nervous system and respiratory problems but an increase in circulatory disorders and injuries or poisoning. There was also a marked decrease in the percentage of acute admissions but an increase in admissions for convalescence, rehabilitation and carer relief. Following a severe financial crisis in the health district the hospital was closed temporarily in November 1987.*

Introduction

THE concept of the community hospital may be traced back to nineteenth century cottage hospitals, which provided medical care for those whose condition did not necessitate admission to an acute hospital. The first cottage hospital, with six beds and a nurse in attendance, was established in Cranleigh, Surrey, in 1859.¹ The concept proved popular and by 1895 more than 600 such hospitals were in existence. With the formation of the National Health Service in 1946 these small cottage hospitals were incorporated into a tripartite structure consisting of the local authority medical service, the hospital sector and the general practitioner service.

In 1962 the hospital plan for England and Wales proposed the closure of small cottage hospitals and the centralization of facilities in district general hospitals.² The subsequent return to popularity of community hospitals was a response to three factors. First, in rural areas the centralization of hospital facilities brought problems of access and travel. Thus, locally based community hospitals were developed initially in rural areas³ as an extension of primary care whereas the cottage hospital had been more closely allied to secondary care. A second impetus was the view that some hospital beds should remain under the control of general practitioners^{4,5} in order to raise the standard of general practice and promote more liaison between hospital and community medical staff. Thirdly, community hospitals were seen as a response to research which suggested that up to 70% of patients in a district general hospital did not need the full range of facilities provided.⁶⁻⁸

Community hospitals are now an integrated part of the health

service. Tucker reports that there are currently 249 community hospitals in England providing 9050 beds.⁹ However, community hospitals remain closely associated with rural areas and are comparatively rare in inner cities. Within the health service many of the general hospitals serving inner city areas have national and regional responsibilities in addition to their local functions.¹⁰ Additionally, there are problems in providing nursing and support services in inner city areas and the problems of multiple deprivation make caring for patients in their own homes problematic. The urban community hospital was seen as a means of reducing the pressure on acute hospitals by catering for patients who did not require specialist beds and whose conditions could be managed by their general practitioner. Furthermore, the urban community hospital was seen as a way of reducing the isolation of community health workers.

The first inner city community hospital was opened in January 1982 by Paddington and North Kensington health authority following the proposed closure of one of the general hospitals in the district. This inner London district is one of the most deprived areas in the country,¹¹ and so such a unit was felt to be particularly appropriate. The first two years of operation have been evaluated¹²⁻¹⁴ and the admissions over a one-year period, June 1986 to May 1987, are described here. At the time of this study the hospital provided 24 beds and admitted five main categories of patient: acute medical, observation, convalescence, rehabilitation and carer relief. Children aged under 16 years, obstetric and psychiatric patients, and patients with an anticipated length of stay of more than 28 days were not eligible for admission. General practitioners were responsible for admission and for their patients in the hospital and provided 24-hour medical cover. Twenty-four hour nursing cover was provided by nine trained nurses and 12 auxiliaries. No outpatient or diagnostic facilities were provided and there were no consultants.

Method

Routine data and admission requests to the hospital were examined and a survey of all general practitioners holding admission contracts was also undertaken. The doctors were sent a questionnaire, based on those used in the original evaluation,¹²⁻¹⁴ asking for their views on the role and operation of the community hospital, together with a covering letter outlining the aims of the study and a stamped addressed envelope for their reply. All potential respondents were ensured of the confidentiality of the study. Reminder letters and a further questionnaire were sent to all those who had not replied within one month of the initial mailing.

Results

Wherever possible the results obtained in this study have been compared with those of the previous evaluation.¹²⁻¹⁴

Analysis of administrative data

Since the inception of the hospital, the number of admissions has remained static at approximately 300 per annum (Table 1). There are monthly fluctuations in the number of admissions and although the precise pattern varies yearly, there are two peaks, in April and July, with a sharp decline in admissions in August.

In 1986 the mean length of stay in the hospital was 15.6 days

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(Table 1). The length of stay decreased immediately after the hospital opened and then increased since 1983. The mean number of beds occupied daily has increased from 11.5 in 1982 to 14.5 in 1986 while the percentage of beds occupied has also increased from 48% in 1982 to 63% in 1986 (Table 1).

Of the 25 practices with admission rights to the community hospital at the time of the study, 12 had three or more partners, five were two handed and eight single handed. The majority of admissions to the hospital originated from a small number of doctors — over the period 1 June 1986 to 31 May 1987 one practice was responsible for 25% of admissions and a further six practices accounted for another 60% of admissions. Group practices accounted for the vast majority of admissions (92%). Eight practices, including three two-handed and four single-handed practices, did not admit any patients over this period. This represents a continuation of the trend observed in the initial study, for the facility to be actively used by a minority of general practitioners concentrated in group practices.

Table 1. Admissions to the community hospital, 1982–1986.

	Year				
	1982	1983	1984	1985	1986
Total no. of admissions	264	413	326	322	336
Mean length of stay (days)	15.6	13.0	13.9	13.0	15.6
% of beds occupied	48	59	52	51	63

Analysis of admission request forms

When a general practitioner requests admission, a form is completed providing basic demographic information about the patient. Information is also collected about the diagnosis and reason for admission as well as estimated length of stay and urgency of admission. Admission requests for the 12-month period 1 June 1986 to 31 May 1987 were analysed.

Of the 312 patients admitted to the community hospital over this period, 62% were female; this is the same sex distribution as reported in the initial study. Twelve per cent of the patients admitted were aged under 60 years and 29% were over 85 years, compared with 18% and 21%, respectively, in the earlier period. In the initial study the mean age of patients was 72 years and the median age 76 years, compared with 76 and 79 years, respectively, in this study.

Of the 218 admissions with a stated diagnosis on the form, the major medical conditions were chest infections (9%), cancer (9%), heart disease (9%), fractures (9%), ulcers (8%), falls (8%) and mobility problems (7%). The diagnoses were categorized using the *International classification of diseases* (9th revision) and compared with admissions during the earlier period, 1 January 1982 to 31 December 1983 (Table 2). Since 1984 there has been a decrease in the numbers of patients treated for musculoskeletal, nervous system and respiratory problems but an increase in the numbers treated for circulatory disorders and injuries or poisoning.

Of the 312 admissions 17% were from other hospitals within the district and 77% from the patient's home. Compared with the earlier period there has been a 5% increase in the proportion of patients admitted from acute hospitals within the health authority area. The majority of patients (85%) were expected to be discharged back home. However, long stay or residential care was thought to be required by a minority of patients (13%). This proportion was the same for both periods of study.

The reasons for admission to the community hospital are

Table 2. Admissions to the community hospital over the periods 1 June 1986 to 31 May 1987 and 1 January 1982 to 31 December 1983 categorized by diagnosis.

Diagnostic group	Number (%) of admissions	
	June 1986– May 1987	January 1982– December 1983
Circulatory system	52 (24)	93 (18)
Injury or poisoning	35 (16)	31 (6)
Respiratory system	24 (11)	67 (13)
Symptoms and ill-defined conditions	24 (11)	51 (10)
Neoplasms	20 (9)	31 (6)
Musculoskeletal	15 (7)	67 (13)
Specials ^a	13 (6)	21 (4)
Nervous system	4 (2)	42 (8)
Other	31 (14)	114 (22)
Total	218 (100)	517 (100)

^a Holiday/relief admissions, immobility, frailty, bereavement, and so on.

shown in Table 3. Rehabilitation and carer relief were the reasons cited for almost half (47%) of all admissions. There has been a marked decrease in the percentage of acute admissions and an increase in admissions for convalescence, rehabilitation and carer relief compared with the first two years of operation.

One third of the 312 admissions (33%) were classed as planned, a further 32% as semi-urgent and 24% as urgent. In the earlier period 36% of admissions were urgent. Thus, between the two study periods there has been a 12% decrease in the proportion of admissions described as urgent.

Table 3. Reasons for admission to the community hospital over the periods 1 June 1986 to 31 May 1987 and 1 January 1982 to 31 December 1983.

Reason for admission	Number (%) of admissions	
	June 1986– May 1987	January 1982– December 1983
Rehabilitation	85 (27)	185 (24)
Carer relief	63 (20)	124 (16)
Acute illness	45 (14)	232 (30)
Convalescence	43 (14)	54 (7)
Observation	37 (12)	100 (13)
Other	32 (10)	77 (10)
Not stated	7 (2)	— (—)
Total	312 (100)	772 (100)

Survey of general practitioners

At the time of this study 65 general practitioners held admission contracts with the hospital compared with 48 in the earlier study. Despite being sent a reminder 26 doctors failed to return their questionnaire, two refused to participate in the survey because of their infrequent use of the community hospital and one had retired from active practice. Completed questionnaires were returned by only 36 doctors (response rate 55%) so the results should be interpreted with caution. To investigate the direction of non-response bias the number of patients admitted by responders and non-responders was considered. Of the 40 general practitioners who had admitted patients in the previous year, 32 replied to the survey. Thus only four responders had not used the hospital in the previous year. Of the 36 responding doctors 35 felt that it was important or very important to have a community hospital in the area, thus confirming that the response was biased.

The general practitioners were asked to describe, in their own words, why they felt it was important to have a community hospital in an inner city area. This produced 58 different responses which were grouped into seven categories (Table 4). The prime reason given was the ability of the community hospital to provide appropriate care to groups who would not be well served by admission to the district general hospital, such as those with chronic long term health problems. The control exercised by general practitioners over admission and treatment as well as the ability of the community hospital to offer social/holiday/care relief admissions were also seen to be important as was the reduction in pressure on acute beds within the district.

Table 4. Reasons given by the 36 general practitioners for the importance of the community hospital.

	No. of responses
Provides appropriate care	17
Reduces pressure on district general hospital beds	10
Admission/treatment controlled by GPs	6
Popular with patients	6
Extends the role of GP	5
Takes social/holiday/care relief admissions	5
Other reasons	9
Total	58

Respondents were also asked to describe the main drawbacks of the community hospital. Ten doctors felt that there were no disadvantages while the remaining 26 identified 46 disadvantages which were grouped into six categories (Table 5). The main drawbacks were seen to be the increase in workload, time and travel difficulties and problems of attracting and retaining qualified nursing staff.

Table 5. Main disadvantages of the community hospital given by 26 general practitioners.

	No. of responses
Difficulty in attracting/retaining trained nursing staff	10
Distance from practice/time constraints	10
Increased GP workload	8
Lack of investigation facilities	5
Administration	4
Other	9
Total	46

Discussion

Defining what constitutes a community hospital is problematic. Following government circular HSC(IS) 75, Rue indicated that a community hospital should ideally consist of five elements: a health centre with the full complement of facilities, diagnostic services, day treatment facilities, consultant clinics and inpatient accommodation.¹⁵ This definition was rejected by general practitioners as too prescriptive and inflexible in the face of local needs and a wider definition was proposed in government circular HSC(IS) 78. The inner city hospital described in this study meets this specification, except that patients are not cared for by consultants. However, the range of facilities offered is much more limited than in the majority of community hospitals. Tucker⁹ reports that 80% of such hospitals provide casualty facilities, 56% have operating facilities, 33% provide day care and 98% have outpatient services, reflecting their concentration in rural areas. On average, community hospitals are 13 miles

from a district general hospital⁹ but the Paddington community hospital is within two miles of two general hospitals, one of which is a major teaching hospital.

The annual number of admissions to the Paddington community hospital has remained approximately 300 since it was founded and there is no evidence to suggest that the number of admissions has increased as the unit has become better known. As yet there has been no marked change in the number of admission requests following the closure of acute beds in the district.¹⁶ In England the average annual number of admissions to all community hospitals is 720 — 1160 for units with over 50 beds and 495 for units with less than 50 beds.⁹ Thus, the average number of admissions to the Paddington community hospital is well below the national average.

The maximum length of stay in the hospital is 28 days and the mean length of stay increased from 13 days in 1983 to 16 days in 1986 compared with an average of 23 days for all community hospitals in England.⁹ The trend for length of stay to increase is contrary to that in the acute hospital sector where the duration of inpatient stay has decreased. This presumably reflects the different types of patients being cared for in these two settings.

Government circular HSC(IS) 75 described the ideal community hospital as having 50–150 beds and in England the average size of a community hospital is 44 beds,⁹ considerably more than this inner city hospital with 24 beds. However, of the 249 community hospitals identified by Tucker, 201 had less than 50 beds.⁹ Thus, the development of a smaller scale version of the community hospital is not unique and may be more suited to the circumstances of inner city districts.

The original evaluation observed low bed occupancy¹² and this problem was again noted in the re-evaluation. Bed occupancy had increased only slightly and the mean number of beds occupied daily was only 15 out of a possible 24 suggesting that the number of beds is too high, given the number of doctors using the service. The mean bed occupancy for community hospitals in England is 65% and shows little variation with the size of unit.⁹ Thus, the Paddington hospital is performing as well as the majority of other community hospitals in England. However, it is worth noting that 34% of large community hospitals (over 50 beds) and 50% of small hospitals have a bed occupancy of over 70%.

The initial study recommended an increase in the number of doctors actively using the community hospital and the number with admission contracts increased from 48 in 1982 to 65 in 1986. However, a few general practitioners still made the vast majority of admissions. This could be because doctors received only a nominal payment for their services. Further deterrents were the practical difficulties of travel within inner London and the possible impact upon workload. Thus, there is still scope for increasing the number of actively participating doctors, or withdrawing the contracts of those who do not admit patients and reducing the size of the hospital. Only 6% of community hospitals nationally have more than 40 doctors with admission rights,⁹ making the Paddington hospital exceptional in trying to involve such a large number of general practitioners.

Between 1982 and 1986 there has been an increase in the proportion of patients admitted from acute hospitals. This probably reflects a more widespread knowledge of the community hospital within the acute sector together with increased pressure on acute beds and reductions in the length of inpatient stays within the acute sector. However, there has also been a decrease in the proportion of patients admitted for acute episodes of illness and an increase in the carer relief, rehabilitation and convalescence functions of the community hospital. The provision of respite care, on both a planned and emergency basis, gives vital sup-

port to many carers and probably enables them to continue caring for elderly, disabled or handicapped relatives. The switch towards care in the community for these groups will increase demand for respite care services.

The major drawbacks of the community hospital mentioned by the responders revolved around the amount of time they felt was involved in caring for a patient in the hospital and problems with nursing staff. They felt that the high turnover of staff made it impossible to establish any continuity of care and they were also worried by the difficulty in attracting qualified staff. These worries have some justification as the Paddington hospital, like other parts of the hospital service in inner London, experienced considerable difficulty in attracting trained staff.

These data provide only an overview of the operation of a community hospital within an inner city area and it is not possible to evaluate the effectiveness of treatment or to make comparisons with alternative forms of care. There has been no clear policy for the development of the role of the community hospital and its clinical contribution is difficult to enumerate. However, as Jones¹⁷ notes, these data are not available for the district general hospital, rather its central role in the provision of care is an implicit assumption.

The cost of caring for patients in the community hospital was perceived by managers to be high, presumably because of the hospital's low occupancy rates compared with acute facilities elsewhere in the district. Detailed data about the cost of caring for patients in community hospitals remain sparse because of the difficulties involved in calculating costs. However, a study of the cost effectiveness of the Oxford community hospitals suggested that a unit with 35 beds was the most cost effective.¹⁸

Following a severe financial crisis the Paddington hospital was closed temporarily in November 1987. This is not a reaction unique to Paddington and North Kensington health authority; between 1984 and 1986 at least 50 general practitioner hospitals were threatened with closure or loss of beds.¹⁷ Until detailed data are available about the effectiveness and efficiency of community hospitals they will remain vulnerable to closure.

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