Community hospitals: new wine in old bottles?

Community hospitals occupy an uneasy middle ground between primary and secondary care sectors: they have at times been threatened, promoted, and occasionally overlooked. The ebb and flow of the fortunes of community hospitals has been well described by a number of authors in a series of reports,[1-9] all of which take a carefully critical, but ultimately supportive, view of their place in the spectrum of health care provision. Irrespective of the views of policy makers and academics about the merits of community hospitals, they enjoy substantial support from the localities they serve and from the general practitioners and other health professionals who work in them.

The changing ethos of the National Health Service emphasizes the importance of primary and community care with a focus on high-quality health services that are more readily accessible to patients.[10,11] There is a balance to be struck between increasingly specialized and high-technology secondary care facilities and the expanding agenda and growing expectations of primary care. Community hospitals sit at the interface, representing a significant and valued health care resource. It is important that they are focused, developed and appraised appropriately in order to maximize patient benefits.[12]

Value of community hospitals

A number of descriptive studies from throughout the United Kingdom (UK) have indicated that community hospitals have a distinct and important role for health care delivery,[13-18] but definitive evidence of the place and worth of community hospitals is still lacking despite earlier calls for more rigorous studies.[8,19] The view that community hospitals may be unsafe (because inappropriate levels of care are being provided by insufficiently skilled staff and poor facilities) is not supported by any available published evidence. The opposite and widely held view (that patients in community hospitals are appropriately selected and enjoy high standards of care) requires further elucidation. With few exceptions,[20] clarity is hindered by the lack or inaccessibility of routine data on community hospital activities;[20] this is compounded by the absence of robustly designed investigations, such as randomized studies comparing the clinical and financial effectiveness of treatment in different settings.[21-23] A particular concern that the ready availability of community hospital beds encourages unnecessary admissions has not been substantiated,[24] and there is consistent evidence that the availability of such facilities offsets medical admissions to specialist units.[25-31] Calculations of the costs and benefits of community hospitals must take account of social benefits to patients and carers as well as voluntary support — these benefits may be significant, elusive, and difficult to measure, but they must not be overlooked in the final equation.

Scope of community hospital services — old and new models

There is great diversity in the use of community hospital facilities throughout the UK, which have evolved from a mix of historical provision, resource availability, professional expertise and enthusiasm, geographical factors, and the health needs and aspirations of local communities. Although community hospitals are commonly thought of as appropriate for rural or provincial care settings, they should also be considered for urban locations.[32,33]

They account for approximately three per cent of acute beds in the NHS, amounting to 10 000 beds in some 350 hospitals.[34] Overall, the majority of admissions are for acute medical care and include rehabilitation and convalescence, respite care, palliative care,[17] observation and assessment, and long-stay care.[2,13,14,19] Some community hospitals also include maternity care, surgical services (primarily for day-case activities), day care,[16] outpatient clinics, minor casualty,[15] paramedical functions, and imaging and diagnostic equipment.[2,12-14,33]

The view of a community hospital as a variation on a bed theme is limited — the concept of a 'community care centre' may be one alternative. New developments could take into account primary care and community services in addition to inpatient care. As such, community care centres could become integrated sites for 'one stop' health care provision. This might include general practitioner consulting, pharmacy, physiotherapy, dentistry, chiropody, occupational therapy, community nursing (including psychiatric nursing), health visiting, community care management, and voluntary services, as well as traditional inpatient, outpatient, and day-patient activities. The concept of one multifunctional base for all primary care team members, with a shared vision for locality care, is central to this model. The Lambeth Community Care Centre, which opened in 1985, contains many of these elements.[35,36] A number of other models of intermediate care facilities,[37] including primary care resource centres,[38] nurse-led inpatient care units,[37] polyclinics, and hospital-at-home schemes,[39] have been described and continue to evolve. Successful innovations will pivot on the formation of creative partnerships and alliances between general practitioners and other health professionals, health authorities and boards, NHS trusts, social services, the private sector, and voluntary agencies — with the active support of patients.

Community hospitals: promoting progress

There are a number of barriers impeding progress. These are not confined to structural issues and may include absent development plans, ineffective information systems, insufficient exploitation of new technologies (including telemedicine),[40] management limitations, inadequate operational policies and protocols, underdeveloped quality assurance mechanisms,[41] insufficient nursing staff flexibility, and inappropriate patient expectations.[12] None of these are insuperable and they can be addressed successfully.[2,41-48] Lack of incentives for general practitioner involvement remains largely unresolved: realistic levels of remuneration must be determined for additional clinical and managerial responsibilities. Although general practitioners who are currently working in community hospital services are almost uniformly enthusiastic, there appears to be some reluctance among those who are not yet involved directly. This is not just the result of inadequate financial recompense; there is likely to be a mixture of factors, including personal preference and ambitions,[3] practice selection, extent of current commitments, and lack of previous community hospital experience. The situation should be remedied by greater future use of community hospitals for undergraduate teaching[49] and vocational training, allowing increased exposure to this type of care environment for multidisciplinary learning.[12]

Community hospitals continue to make significant contributions to patient care throughout the UK. Enthusiasm for them has waxed and waned, and although the current outlook appears more optimistic some units remain vulnerable to closure. Their rational development will depend on creativity, enterprise, and experiment allied to robust evaluation. Much of the service and educational potential remains untapped and there is considerable scope for the assessment of new integrated and intermediate care models. The biblical metaphor of 'new wine in old bottles'[50] in effect cautions

against over-ambitious plans without adequate additional resources. In the current climate of resource constraints, the best way forward is for community hospitals to establish their place as part of a range of quality patient services. We must now provide the systematic evidence and commitment to make that happen.

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Shifting the work

THIRTY years ago the mad were confined in hospital while women in labour were confined at home. Today the situation is reversed and it is the mad that are looked after in the community while childbirth has become a hospital specialty. Equally startling shifts in the balance of work between primary and secondary care have occurred elsewhere: a significant portion of secondary care nursing has been transferred into the community as the length of stay after elective surgery has halved and the throughput doubled, and as large numbers of National Health Service respite beds have been shut. Changes in clinical treatments mean that, today, patients suffering acute myocardial infarction or miscarriage are almost always sent to hospital, while antenatal patients and those with peptic ulcer disease are largely looked after in primary care. Some work has