Item 5

Health and Wellbeing Scrutiny Committee

Future of Community Hospitals Task Group

September 2012

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CS/12/23
6th September 2012
Health and Wellbeing scrutiny committee

1. Recommendations

The task group ask the Health and Wellbeing Scrutiny Committee, Cabinet and NHS Devon to endorse the report and recommendations below. The task group also recommends that the Health and Wellbeing scrutiny committee receives a report on progress against recommendations no later than 12 months after this report is published.

Aim	Measure – how can this be achieved?	lead
1. To gain greater clarity and consistency over the role of community hospital provision	1.1. Develop a strategy and plan that offers a clear approach regarding future commissioning of services in community hospitals 1.2. Differentiate between the designation of 'hospitals' 1.3. Encourage providers to review signage directing people to hospitals. 1.4. Review MIU opening hours so that there is greater clarity and consistency of opening hours 1.5. Communications programme so that the community is aware of what services are provided in which hospital at what times.	NHS Devon
2. Reduce the average stay in community hospitals	2.1 Exend the positive policy to consult families before discharge 2.2 Review links between local residential care homes and community hospitals 2.3 Increase awareness/support in accessing benefits to help ensure that people are using their entitlements to support living independently 2.4 Develop the right provision supporting people living at home and being treated at home	NHS Devon/ Devon CC
3. Ensure that patients are at the heart of service change	3.1 Before any changes are made there needs to be real, meaningful and early engagement over the future of services. So that local people are shaping the future direction of local healthcare.	NHS Devon/ Devon CC
4. Extend support across providers	4.1. Co-ordinate services around patients so that their support follows them, for example physiotherapy, between the acute hospital and the community hospital to support patient improvement when discharged home. 4.2. To support people to return home develop a model to ensure a focus on rehabilitation support as early as possible and for this to be an on going process throughout their care	All agencies

2. Introduction

2.1. The scrutiny task group met for the first time on the 29th February 2012 and agreed the following terms of reference:

To understand the pressures on community hospitals and the contribution they make to patient care whilst contributing to the future direction of the service.

2.2. The subsequent aim of the task group has been twofold, to listen and understand the current service but also to gather evidence, acknowledging the challenges of the financial climate to look at how community hospitals and their services can continue to be provided and develop for the future.

2.3. Since February the task group have met eight times, including visiting the following eight community hospitals:

- Okehampton hospital
- Honiton Hospital
- Tiverton Hospital
- Bovey Tracey Hospital
- Newton Abbot Hospital
- Exeter Community Hospital (Whipton)
- Bideford Community Hospital
- Torrington Community Hospital

The hospitals that the task group visited were chosen to represent a cross section of localities, urban and rural and size and facilities. The task group also conducted a round table Minor Injury Unit discussion. In total the task group have spoken and gathered qualitative evidence from thirty two experts.

2.4. Community hospitals provide much valued local resources and the task group recognise the importance of the services they currently provide. However in the current tsunami of change and financial austerity current provision needs to stretch further and treat more people than ever before. Additional pressures and developments (section 8 of the report) mean that decisions need to be taken in order to provide the best and most cost-effective model of care for patients. At the heart of the service is the need to engage in effective dialogue with patients about how patients' current needs are met while not being unduly constrained by what is effectively a historical model of care.

3. What is a community Hospital?

3.1. Surprisingly the task group have found that there is not one nationally accepted common definition of what a community hospital is. This is significant because in order to evaluate the effectiveness of community hospitals it would be helpful to have clarity over the services provided and the role that they undertake. It became apparent early in the investigation that there is significant variation throughout Devon and that this mirrors the national development of community hospitals. This lack of commonality is due to the gradual evolution of local hospitals since the Victorian era.

3.2. The term 'community hospital' was first used in the 1970s, when Dr Rue and Dr Bennett developed a model of a community hospital in Oxford Regional Health Authority. This took the original concept of a cottage hospital and widened its role. The model of a community hospital was complementary to acute hospitals and had a strong focus on rehabilitation. Ideally, community hospitals would have health

centres or GP practices integrated as part of the overall facility. One of the first examples was Wallingford Community Hospital.[1]

3.3. As clearly explained in the Annual Public Health Report for Devon 2011/12: *'A celebration of 60 years of Public Health in Devon 1952-2012'*[2] , the current provision of community hospitals throughout Devon is a historical legacy. Many hospitals predate the NHS and were locally donated or developed and have organically grown into the services provided today. This has led to significant differences in provision.

3.4. The box below shows some definitions of what a community hospital is; the first five are from a literature review carried out by Heaney et al 2006[3]. The last definition is from Sir Lewis Ritchie quoted in the Scottish Community Hospital Strategy Refresh[4]

Definitions of Community Hospitals

1. *'A general practitioner community hospital can be defined as a hospital where the admission, care and discharge of patients is under the direct control of a general practitioner who is paid for this service through a bed fund, or its equivalent.'*
2. *'A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources. These will include inpatient and may include outpatient, diagnostic, day care, primary care and outreach services for patients provided by multidisciplinary teams.*
3. *Medical care is normally led by general practitioners in liaison with consultants, nursing and allied health professional colleagues, as necessary, Consultant long stay beds, primary care nurse-led and midwife services may also be incorporated'*
4. *'Community hospitals are local hospitals, units or centres whose role is to provide accessible health care and associated services to meet the needs of a clinically defined and local population As an extension of primary care they enable GPs and primary health care teams to support people within their own communities. Community hospitals play a major role in rehabilitation and also offer palliative care, health promotion, diagnostic, emergency, acute and therapeutic services.'*
5. *'The general practitioner community hospital is one dominated by a primary care orientation in which patient selection, admission and management are all under the direct supervision of the general practitioner. These hospitals serve a confined geographical locality ....'*
6. *'A local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources. Medical care is normally led by GPs, in liaison with consultant nursing and allied health professional colleagues as necessary and may also incorporate consultant long stay beds, primary care nurse-led and midwife services.'*

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[1] Information provided by the commuity hospital association

[2] NHS Devon**,** *A celebration of 60 years of Public Health in Devon 1952-2012'* http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/05/Annual_Public_Health_Report_2011_12.pdf

[3] Referenced in Heaney et al, 'Community hospitals – the place of local service provision in a modernising NHS: an integrative thematic literature review' http://aura.abdn.ac.uk/bitstream/2164/146/1/Heaney%20et%20al%20Sys%20Review%20Com%20hosp.pdf accessed on 03.08.12

[4] http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/community-hospitals/Strategyrefresh accessed on 06.08.12

3.5. As might be expected in the above definitions there are consistent themes. Instead of choosing one definition over another, all of the definitions have been mapped on the word cloud below. The more frequently a word occurs in the text, the larger it shows on the diagram. The pictorial representation of these definitions highlights several key words, such as local, practitioner, community, patients, health and care.

3.6. One word that is no surprise to see in large font is ‘hospital’. But given the variation in provision, as discussed further on in the report, should we apply the same term to all health care settings that have evolved to be called community hospitals? The task group would like to see differentiation between the terminologies used to reflect the significant differences in provision offered.

Recommendation 1.2 Differentiate between the designation of ‘hospitals’

3.7. Community Hospitals play a crucial role in taking pressure off acute hospitals both by treating patients locally so they don’t have to go into an acute setting and by transfer out of an acute hospital as part of the rehabilitation process. They are also playing an increasing role in providing outpatient clinics and diagnostics and in some settings there is more scope to extend this. Rehabilitation is a key role of the community hospital and the patient profile tends to be older than the average in an acute setting.

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4. Legislation and National Context

4.1. Recognising the vital role that community hospitals play in locally provided healthcare there is an inherent tension in providing cost effective services in every locality. This part of the report will explore central government direction and relevant studies to situate community hospitals in a wider context.

4.2. Questions over the sustainability of community hospital provision have been asked for many years. The box below is taken from the Annual Public Health Report for Devon 2011/12[5] and demonstrates the anticipated developments when District General Hospitals were built.

Plans to reduce the number of community hospital beds 40 years ago

The Minster of Health's ten-year plan for health services, as revised in 1966, indicates that he expects many of the smaller hospitals to be closed when the new district [general] hospitals are built. Considerable opposition has been expressed to this probable loss of general practitioner hospital beds and also because communications within the area are difficult in the height of summer by reason of tourist traffic, and during very severe winters because of snow on moorland roads.'

4.3. Thinking had moved on significantly and exactly forty years later 'Integrating Care in Community Hospitals'.[6], was published in the Journal of Integrated Care. The extract below is taken from the abstract but gives a clear insight into the recognised importance of community hospitals.

The importance of community hospitals 6 years ago

The national strategy for health in England now gives community hospitals a central role in providing integrated health and social care, in a policy referred to as 'care closer to home'. The evidence emerging from international and national studies is demonstrating the benefit of the community hospital model of care. Public support for community hospitals over their 100-year history has been strong, with value being placed on accessibility, quality and continuity. There is, however, a tension between the national policy and the current financial pressures to close or reduce services in one in three community hospitals in England.

4.4. The current coalition government has put great store in localism and decentralisation. These concepts have manifested themselves in the Localism Act and the intention of Open Pubic Services Reform. The Health and Social Care Act

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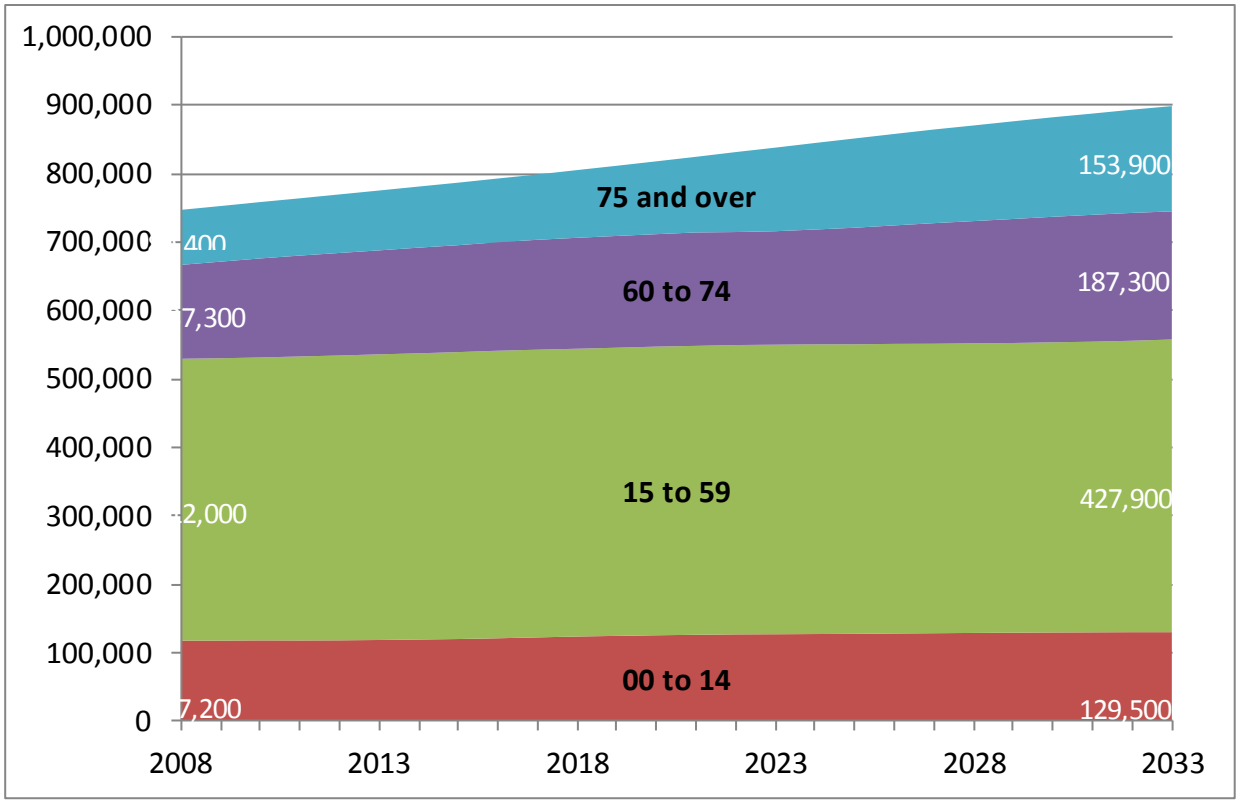
[5] NHS Devon, *A celebration of 60 years of Public Health in Devon 1952-2012'* http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/05/Annual_Public_Health_Report_2011_12.pdf

[6] Helen Tucker, (2006) "Integrating Care in Community Hospitals", Journal of Integrated Care, Vol. 14 Iss: 6, pp.3 - 10 14 Iss: 6, pp.3 - 10

2012 makes significant changes to the way services will be commissioned in future and the oversight of wellbeing[7]. These developments challenge the NHS further at a time when there is a continuing increase in demand and complexity of care as well as a national climate of financial austerity:

'… We are reforming the NHS. The number of people aged over 85 in this country will double in the next 20 years. And the cost of medicines is rising at a rate of £600 million a year. This means that, despite protecting the NHS budget, costs are rising at an unaffordable rate. To protect the NHS for future generations, we must be more efficient.'[8]

4.5. The projected population increase in Devon is shown on the chart below using data prepared for the Joint Strategic Needs Assessment. The growth is clearly in the older segments of society. [9]



4.6. The difficulty of this when applied to community hospitals or any local services becomes apparent. As recently discussed in the House of Commons this tension has resulted in a reduction to some local services in favour of centrally provided ones:

'The centralisation process is well under way at Guisborough hospital, in my constituency, and that is just one example of what is happening across the north-east. The hospital has already been forced to operate a reduced service owing to staffing pressures, opening only from 9 am to 5 pm on weekdays and 8 am to 8 pm at weekends instead of the usual round-the-clock service. The Chaloner ward there is an eight-bed bed unit providing palliative, post-operative and respite care,

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8 HM Government, Open Public Services 2012
http://files.openpublicservices.cabinetoffice.gov.uk/HMG_OpenPublicServices_web.pdf

9 Sub-National Population Projections 2008-based, Office for National Statistics, 2010.

with dedicated nursing care for a variety of medical conditions. There is also an out-patient suite and a minor injuries unit.[10]'

4.7. The current government has enshrined in legislation a series of measures intended to achieve a substantial and lasting shift in power away from central government and towards local people. Of relevance to local heath services this will include: new rights and powers for communities and individuals including Community Right to Challenge and Community Right to Bid for Assets of Community Value. Open Public Services Reform, whilst not legislation in its own right, articulates many of the legislative strands of community empowerment in the Localism Act and the whole philosophy of Open Public Service Reform is to decentralise services to the lowest appropriate level, placing them in the hands of local people.[11]

4.8. These developments will not come to fruition until April 2014 as health related services are excluded from the Community Right to challenge until this time. In order to 'to enable the NHS commissioners (the NHS Commissioning Board and local clinical commissioning groups) established by the Health and Social Care Act 2012, to have sufficient time to become fully operational, consider the contractual arrangements'[12]

4.9. There are already examples (below) quoted by the government itself in policy of locally commissioned solutions to some of these challenges.[13]

National Innovation

- The Dartford, Gravesham and Swanley Clinical Commissioning Group's focus on preventing hospital admissions saw a 33 per cent reduction in hospital attendances and admissions among care home patients over a six-month period.
- In Nottingham, the clinical commissioning group has reduced emergency admissions by working with all GP practices in the area to provide as much information as possible to patients about the new 111 service.
- A clinical commissioning group in Barnet has set up a community gynaecologist, helping over 400 women a month get this treatment closer to home, not in a hospital.
- A clinical commissioning group in Bedfordshire has set up a team to deal exclusively with care home emergency calls and arranged for vulnerable older people to be treated in their home, and made nearly a 40 per cent reduction in hospital visits.
- A clinical commissioning group in Wigan has redesigned stroke services and reduced the average hospital stay for patients from 56 days to 12 days, reducing A&E waits and saving £700,000 per year.

[10] www.simonburnsmp.com/index.php?option=com_content&view=article&id=404:community-hospitals-north-east-house-of-commons-20-june-2012&catid=35:latest-speeches&Itemid=55
[11] Localism Act http://www.communities.gov.uk/documents/localgovernment/pdf/1896534.pdf
[12] HM Government, Localism Act, section 2.8
http://www.communities.gov.uk/documents/localgovernment/pdf/1896534.pdf
[13] [13] HM Government, Open Public Services 2012
http://files.openpublicservices.cabinetoffice.gov.uk/HMG_OpenPublicServices_web.pdf

4.10. Although these examples relate to national innovation, there has been tremendous local innovation in Devon. Services in local community Hospitals have won national awards, for example the Newton Abbot stroke service, and new models have been introduced such as 'hospital at home'. The task group has witnessed first hand the dedication and quality provided in community hospitals during the visits to 8 hospitals and in speaking to he many witnesses in Devon.

Local Innovation

- Use of predictive modelling to support the proactive case management of patients at high risk of emergency hospital admission, this has seen a 9.63% drop in admission rates for this high risk group in its first year
- Initial small scale test working collaboratively with the local British Red Cross providing post-discharge support to aid people with low level need has seen a saving in its first 6 months of over 100 beds days in an acute hospital and 20 bed days in community hospitals.
- Specialist support to provide hospital based and assertive community outreach services to alcohol mis-users has seen significant reductions in risk being achieved.
- Installation of equipment into patient's homes to monitor and share on a daily basis with healthcare professionals key health indicators is enabling patients with Chronic Obstructive Pulmonary Disease to be in more control of their health and managing decisions with confidence.

4.11. Other regions in the UK are also looking at challenges and opportunities presented by community hospitals: In Scotland the 'Community Hospitals Strategy Refresh' sets out some similar actions to those suggested in this report including improving specific working relationships across agencies and using patient survey information to improve services.[14] The task group have not found evidence of other scrutiny reviews of community hospitals. Not all parts of the Country have community hospitals, in Salisbury in Wiltshire for example. In these areas more use is made of residential and nursing homes.

5. Current Devon Provision

5.1 In 2008 in a survey of all community hospitals[15] the South West had more than a quarter of all community hospitals. Today in the area covered by Devon County Council there are 26 community hospitals, 9 presently provided by Torbay and Southern Devon Health and Care Trust (this trust also provides 2 community hospitals in Torbay Council area) and 17 by Northern Devon Healthcare Trust. The hospital locations are detailed on the map on page 10.

*This is data from 18 community hospitals and is not representative of all sites
**This is data from 26 community hospitals and is not representative of all sites
[15] Community Hospital Association, Report to Department of Health and Community health Partnerships, Profiling community hospitals in England 1998-2008

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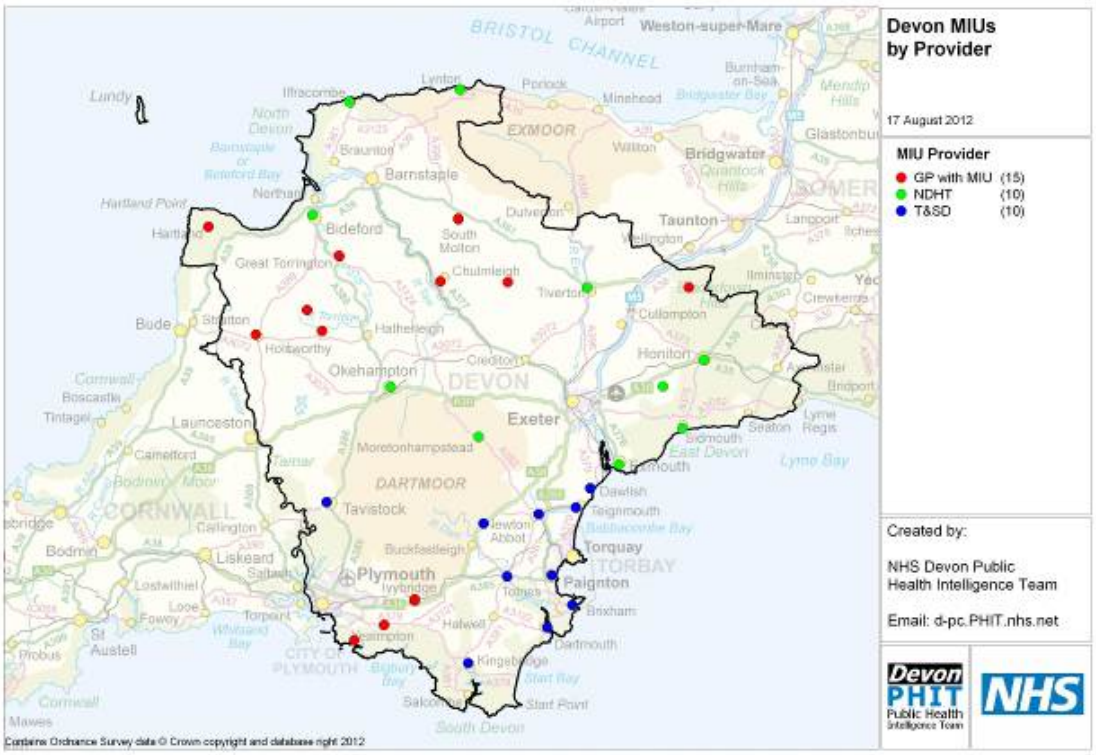
5.2 In the reporting year 2011/12 there were more than 53,000 outpatient visits to a community hospital* in Devon, this breaks down as 18,000 first attendances and 35,000 follow ups. The number of inpatients over the course of the same year came to 9805 **

5.3 Nineteen of those community hospitals have Minor Injury Units situated on site. The hospitals provide a range of services and have varying numbers of beds. An inventory of the services provided is in Appendix 1.

Community Hospital	Provider
Ashburton	Torbay and Southern Devon Health and Care Trust
Bovey Tracey	
Dartmouth	
Dawlish (PFI Hospital)	
Kingsbridge	
Newton Abbot (PFI Hospital)	
Tavistock	
Teignmouth	
Totnes	
Axminster	Northern Devon Healthcare Trust*
Bideford	
Budleigh Salterton	
Crediton	
Exeter (Whipton)	
Exmouth	
Holsworthy	
Honiton	
Illfracombe	
Moretonhampstead	
Okehampton	
Ottery St Mary	
Seaton	
Sidmouth	
South Molton	
Tiverton (PFI Hospital)	
Torrington	

*Note: NDDT also provides Lynton



5.4 Patients can be admitted to a community hospital either directly from a GP or transferred from an acute hospital. When used as part of the rehabilitation pathway the task group has heard that community hospitals have significant psychological benefits as patients can view them as the next stage in treatment, and the community hospital often bridges the gap between moving from an acute setting to home. However it will not be appropriate for every patient to be discharged to a community hospital, and there should not be an assumption that this will be the best pathway.

5.5 The chart below demonstrates the percentage of patients for each hospital directly admitted (dark blue) compared to those who are transferred from an acute hospital (light pink). The hospitals at the top of the chart have very low direct admissions, Paignton has less than 5% and Whipton less than 10%, compared to the hospitals at the bottom of the chart where the majority of their patients are directly admitted, Axminster has more than 90% of its patients this way.[16]

5.6 The task group believes that the variance in admission (direct admission or transfer) may be at least partly attributable to the attitudes of medical staff and variation in the normal route of referral.

[16] Devon Public Health Intelligence Team, 2012

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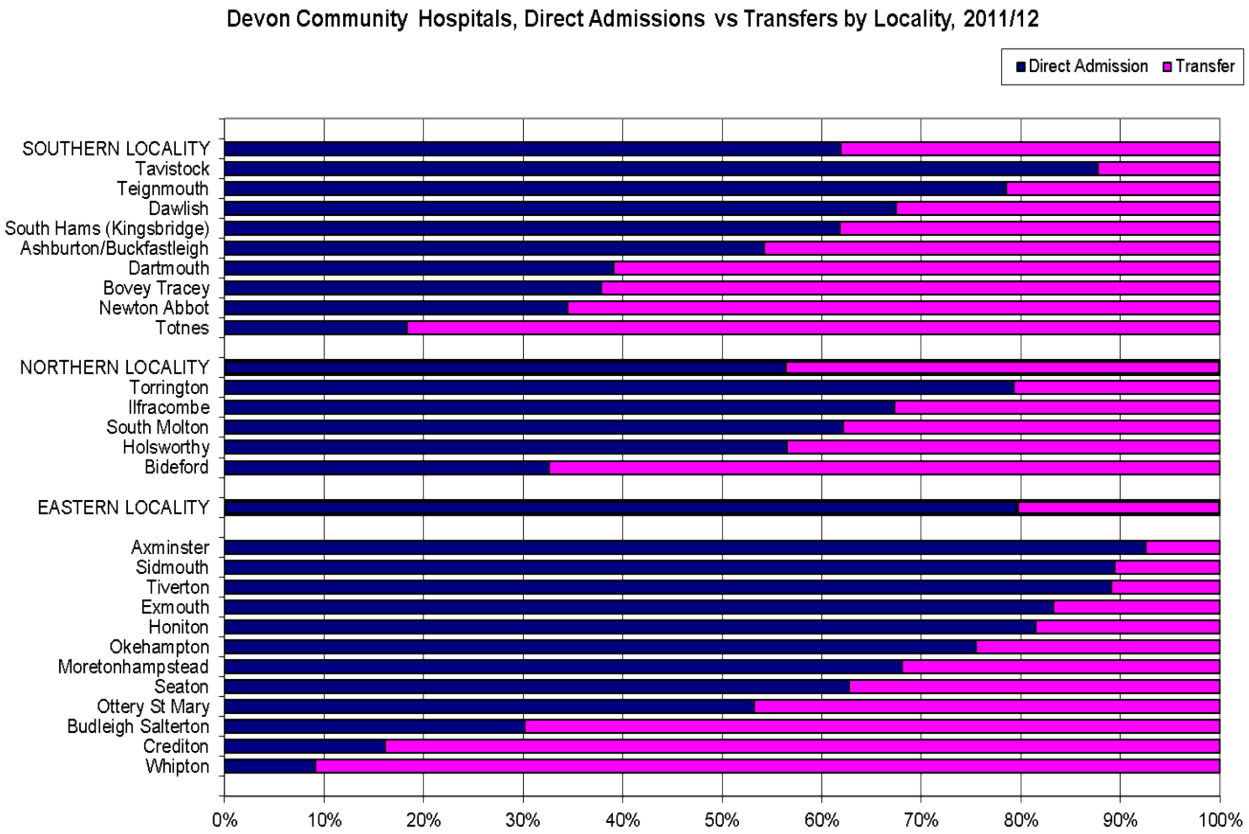

5.7 Community hospital services are provided in a range of ways. All are supported by medical staff, although some services within hospitals are run by nurse practitioners. The task group has heard about difficulties that have been encountered with recruitment in some smaller hospitals. Once recruited, maintaining expertise and skill can also be an issue, particularly in those with minor injury units where there are low patients numbers. In some cases ward nurses are used to provide cover for minor injury units, however they will not have less opportunity to use and therefore maintain their skills as dedicated MIU nurses.

5.8 To overcome this, some hospitals are trying to create a rotational learning environment to train and develop staff, however it is not possible in all areas.

5.9 The task group visited hospitals where the complex care teams, including health staff such as occupational therapists and social workers, are based onsite. This has many benefits including improving communication between agencies and subsequently leading to faster treatment for the patient.

5.10 In some areas there are a number of different providers which can lead to complexity over who provides which service in a community hospital. For example, Tiverton Community Hospital has a complex provider model: the Northern Devon Healthcare NHS trust run the wards and theatre, the Royal Devon & Exeter NHS Foundation Trust run maternity services, the Devon Partnership NHS Trust run mental health services and Devon Doctors as well as GPs also provided services.

5.11 Different providers enable a wider range of services to be available and can offer quality through competition, but this does require an integrated delivery model and clear oversight.

Recommendation 4.1 Co-ordinate services around patients so that support follows them, for example physiotherapy, between the acute hospital and the community hospital to support patient improvement when discharged home.

5.12 Staff in community hospitals work with many different agencies including Age Concern and the Red Cross to support individuals in the best way possible particularly in the discharge process. Social Care re-enablement helps patients who may have lost confidence to regain their independence.

5.13 The network of community hospitals provides a good service across all of Devon. This is demonstrated on the map below. Only in the most remote parts of Dartmoor is the travel time to a community hospital longer than 30 minutes. At the moment the signage for community hospitals may suggest acute hospital services to those who are unfamiliar with community hospitals. The task group believe this could particularly be a problem for tourists.

Recommendation: 1.3 **Encourage providers to review signage directing people to hospitals.**

5.14 As the future role of hospitals is planned it is important services available and times are shared at a local level. Although information is already on provider websites, as part of the engagement in the future there would also be benefits in greater awareness raising of services and where and how they can be accessed.

Recommendation 1.5 Communications programme so that the community is aware of what services are provided in which hospital at what times

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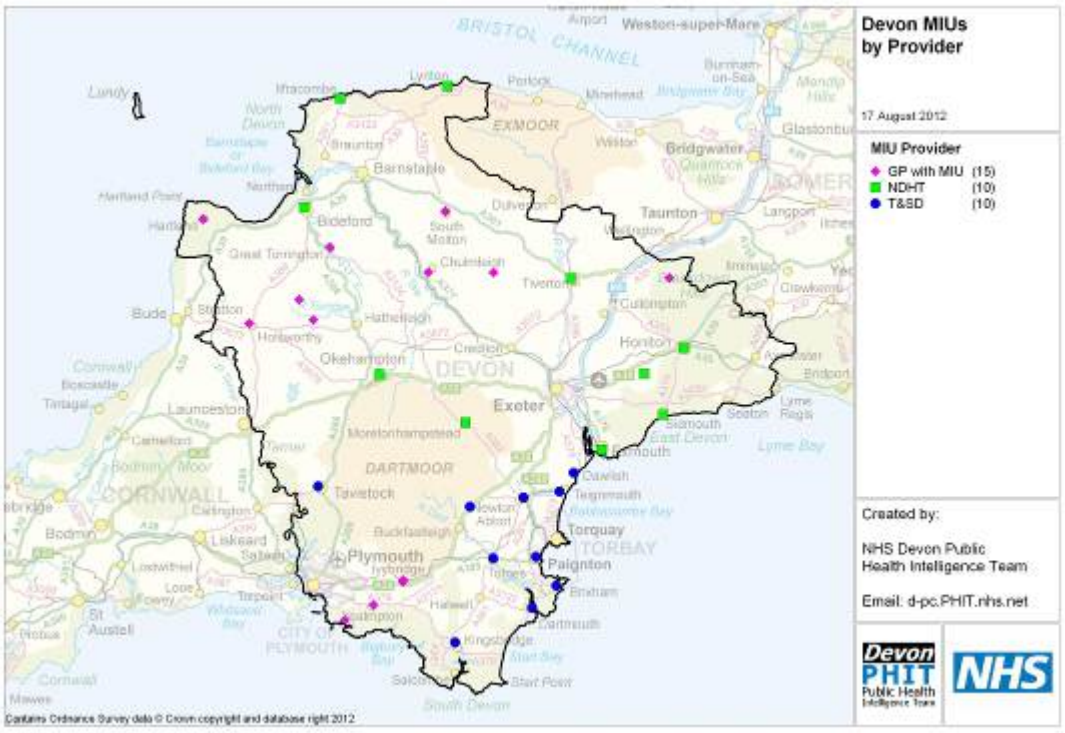
6. Minor Injury Units

6.1. The task group took a different approach in looking at minor injury units or MIUs. The group had viewed several MIUs as part of the programme of hospital visits and their use and need had come up as part of many discussions. However to specifically focus on the service the task group held a round table discussion with professionals from across provision in Devon. This two hour intensive session was designed to look at need and what might be required in the community. This included reviewing how services are currently provided and culminated in an open discussion about the future.



6.2. Several themes emerged as challenges, including opening hours, transport and access, training and maintaining skills, repeat admissions and how patients were admitted.

6.3. Of particular interest was the issue of overnight opening hours. The chart below shows aggregated patient numbers across the majority of MIUs in Devon. It charts attendance over two years, from April 2010 – April 2012 and demonstrates the spikes in attendance over the summer months. The higher bars 'In hours', refers to the daytime between 8:00 and 17:59 hours. The lower bars plot the number of patients treated in out of hours between 18:00 and 8:00. In this time almost all out of hours patients are seen between 18:00 and 23:00.

Recommendation 1.4 Review MIU opening hours so that there is greater clarity and consistency of opening hours

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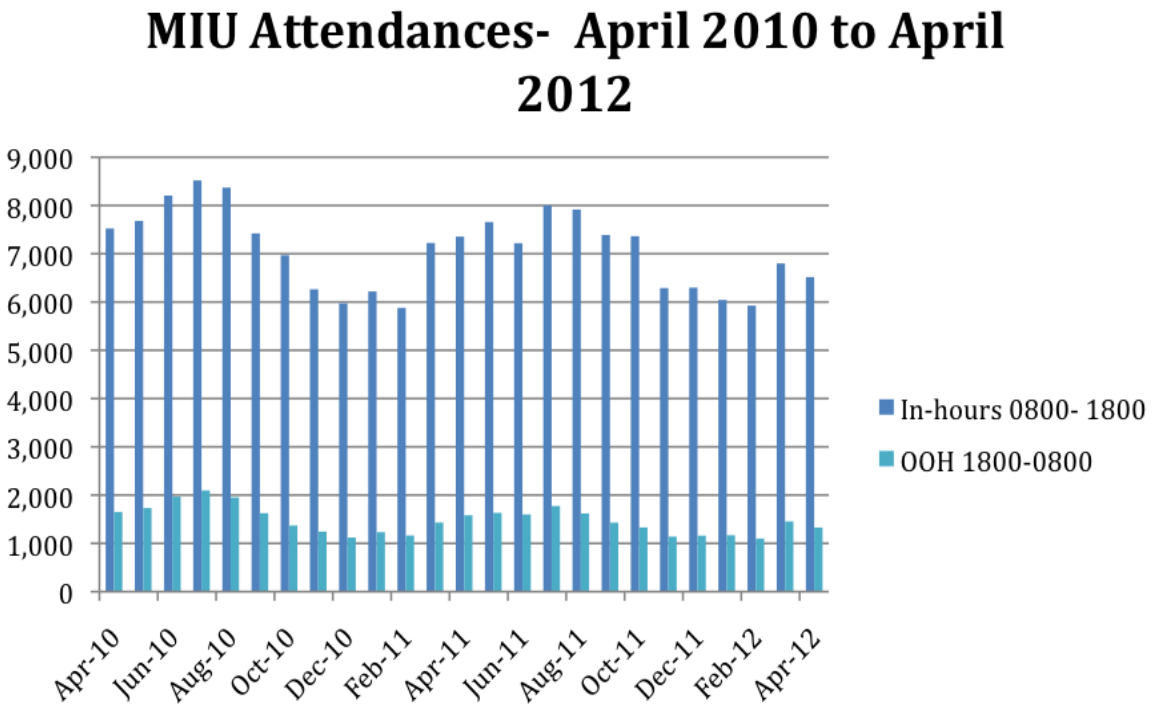

6.4. Whilst this session alone was never going to resolve some of the challenges of providing minor injury units, there was a consensus around the table about the principles that should be adhered to as difficult decisions are made in the future:

- Importance of localism and having high quality locally accessible provision wherever possible to treat patients quickly.
- The need to balance access with essential quality standards recognising that some decisions on how to achieve this do need to be made sooner rather than later.
- Taking a whole system approach to services and designing based on need, not necessarily according to location of existing buildings. This includes considering the locations and numbers of MIUs.
- Clarity about the range of services provided within each MIU and clear communication with local communities with appropriate sign posting to emergency services
- Patients and communities must be at the heart of any changes to local provision and actively involved in a mature discussion before decisions are made.
- To facilitate all this there has to be a clear commitment from all agencies to work collaboratively across the whole patient pathway.

7. What do patients want?

Recommendation 3.1 Before any changes are made there needs to be real, meaningful and early engagement over the future of services. So that local people are shaping the future direction of local healthcare.

7.1. At the heart of this investigation has been the question; what is the best possible treatment and outcomes for patients? To truly understand patient opinion has been difficult as already stated the task group has not been focussing on individual

community hospitals. So to understand what the public would like the task group have asked the Devon Local Involvement Network (LINk) and spoken to some community and voluntary groups. The task group have aimed to have a strategic overview of the issues and from this perspective have not consulted more specifically on patient views in localities. However the task group would expect patient consultation to form the corner stone of any service development or change. The general themes are summarised below:

- Huge amount of good feeling towards and ownership of local community hospital
- People like quality services closer to home and it is believed this can result in fewer missed appointments
- Local provision may increase the ability for professionals to get to know patients and their carers and provide a more holistic service. Including carers health and wellbeing checks.

7.2. The task group have also spoken to GPs from Tiverton and heard about the innovative work that is underway. The task group commend Tiverton's efforts to genuinely listen to patients and then plan services accordingly[17]:

Case Study: Tiverton Community Hospital Patient Centred Care Project

Philosophy: the public should have a voice in the way services are planned and delivered and accountability should lie with the local population. Different options in governance were also being explored, including the use of governors and different financial models.

The Project designed a questionnaire and a staff survey. The League of Friends set up a sub-committee and collected approximately 700-800 questionnaires so far which were analysed in cooperation with a PhD brief at the University of Exeter. ***The aim was to establish what the local population want and then match the evidence with funding and facilities.***

7.3. It should not be assumed that all patients prioritise local treatment above everything else. The Devon Local Involvement Network (LINk) recently carried out a patient survey in North Devon District Hospital, one of the questions asked respondents:

'If you had been offered your appointment at a community setting closer to home (such as GP or community hospital) would you have preferred this?'

Out of those who answered the question slightly less than half would prefer to be treated locally. Although this is surprising figure, and the task group might expect it to be much higher.

[17] Tiverton Patient Centred Project http://www.devonpct.nhs.uk/Be_involved/Tiverton_Patient-Centred_Care_Project.aspx

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8. Why is there a need to make changes?

8.1 The task group has seen that community hospitals are well regarded by the communities they serve; they are run by dedicated professional staff and support acute, as well as providing a resource for primary care. So the obvious question is: why is change needed? This section of the report will outline why taking no action is not an option. Briefly summarised the task group has identified the following, these are explored in more detail below:

- Patients in Community Hospitals might not have a medical need to be there
- Increase in complexity of cases for example dementia as well as an ageing population (see 4.5)
- Advances in technology and models of care allow more flexibility to treat people in different settings
- Financial Climate – services can no longer be provided in the way that they have been, there is the need to do more with less

Patients in Community Hospitals might not need to be there

8.2 The task group has seen the figures from the annual Acuity Audit carried out by the Director of Public Health. This audit reviews all patients across Devon on a single day. According to the figures almost 40% of patients staying in Community Hospitals were fit to leave the care setting but were unable to do so. In the Acute setting this figure was less that 30%.

8.3 Staying in hospital over weeks or months is not necessarily a good option and may decrease the chance of successful rehabilitation. Patients might need to stay in hospital if they do not have adequate support at home or the appropriate community services are not in place. In some areas in Devon hospitals have made good progress with rehabilitating patients quickly. All hospitals in the South have recently introduced a positive policy where they routinely consult with families and carers before discharge. The task group would like to see this applied across Devon.

Aim: 2 Reduce the average stay in community hospitals (this includes all the recommendations under the aim)

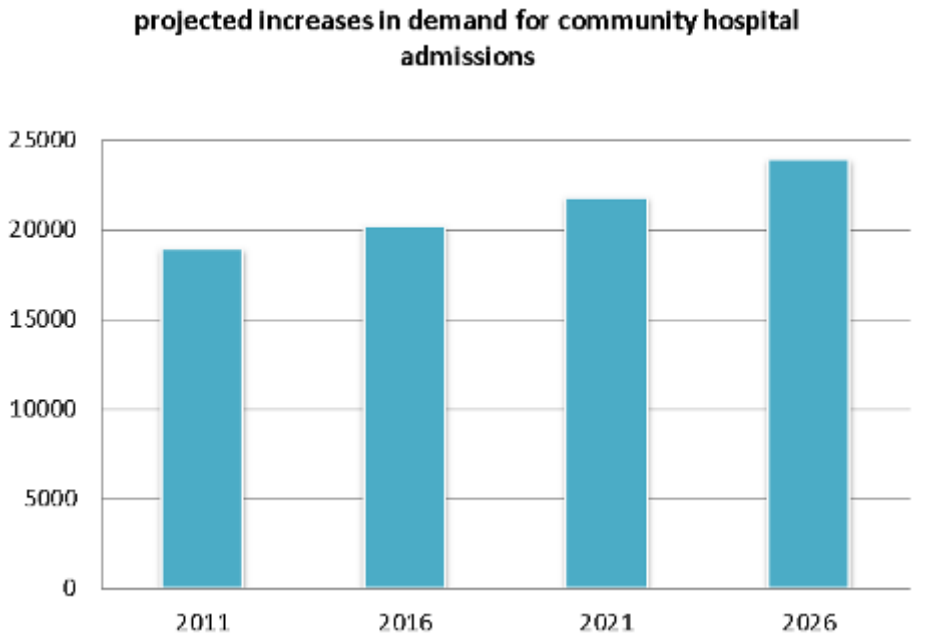
Recommendation 4.2 To support people to return home develop a model to ensure a focus on rehabilitation support as early as possible and for this to be an on going process throughout their care

Financial climate

8.4 If there are no changes to the current model, patient numbers are predicted to increase. The chart below models the future admissions to community hospitals based on current hospital admissions, taking into account age-specific admission rates and projects these forward according to demographic change in the local

population. Based on these figures if age-specific demand remains unchanged there will be a 26% increase in admissions between 2011 to 2026.'[18]

8.5 If there are no changes, demand will increase and put more pressure on already stretched budgets. The chart below models the future admissions to community hospitals based on current hospital admissions, taking into account age-specific admission rates and projects these forward according to demographic change in the local population. Based on these figures if age-specific demand remains unchanged there will be a 26% increase in admissions between 2011 to 2026.



[19]

8.6 Although this indicates higher numbers, this also needs to be balanced with the reductions in length of stay, and the development of new approaches and community delivery models over the coming years. This demand chart is therefore indicative but does highlight the importance of effective modelling to achieve the right future mix of services. The fact there is a need to look wider than bed based models and to consider community alternatives has already been described in this paper.

Increase in complexity of cases and dementia

8.7 There is a nationally documented increase in patients with dementia, in community hospitals approximately 40% of patients suffer with dementia and the figure is rising. The Health and Wellbeing scrutiny committee has carried out work in this area and is currently documenting progress. Many patients with dementia are transferred into a community hospital from an acute setting. Patients with dementia or other mental health conditions can be disruptive and work is underway in developing community hospital settings to support the rising numbers of people with dementia who have medical care needs as effectively as possible.

The direct admissions graph in section 5.6 of this report shows that in some hospitals patients are mainly transferred from acute settings. This brings benefits of caring for people closer to their families where they require a further period of

[18] Nuffield Trust, http://www.nuffieldtrust.org.uk/blog/what-budget-means-nhs-bit-less-now-lot-less-later

[19] Devon County Council Population Projections by Devon Town, 2010, except Torbay (ONS Sub-National Population Projections 2008-based, 2010)

hospital treatment due to the complexity of their health condition or requirement for rehabilitation. However the variation in types of admission, combined with the outcomes of the acuity audit, would suggest this needs further exploration regarding the opportunity of more people transferring directly home. ***Advances in technology allow more flexibility to treat people in different settings***

8.8 As technology advances more people can be supported in their own homes. The pioneering work on the virtual ward in Devon is helping to deliver better access to health care in rural areas. The virtual ward uses a special formula which combines GP, hospital and social services data to rank patients for their risk of admission and pro-actively support them to provide alternative care in their own home. Telehealth and telecare also have a real part to play and these areas are being progressed in Devon.

8.9 As well as technology models of care are changing. The role of complex care teams, the virtual ward, hospital at home schemes and targeted support for people with long term conditions at risk of admission, can all contribute to less time in hospital and more time at home.

Potential for development

8.10 All of these elements indicate that tough decisions need to be taken in the near future, and redirection of resources increasingly towards community services but there are also other drivers for change and opportunities for development.

8.11 Some services are working well in locations they have been trialled in, such as weekend radiographer services in Tiverton stepping- up the care available. There may be scope to offer similar services in other large community hospital settings. Some hospitals have facilities and training to enable fractures to be diagnosed and treated, others would like to develop this facility.

8.12 Whilst visiting many of the community hospitals the task group did see parts of hospitals out of commission. There were specific instances of closed wards with good reason, the task group would like to see the potential realised for further and imaginative development within existing facilities

Recommendation 1.1: Develop a strategy and plan that offers a clear approach regarding future commissioning of services in community hospitals

9. Conclusion:

9.1. The role of the task group has been to understand Devon-wide provision and treatment in community hospitals with a view to future development. The task group has looked at case studies of specific hospitals but not made judgements about how future services should be provided locally.

9.2. The task group has clearly seen the enduring need for local provision, although this may be different from before. The complicated evolution of provision over decades has led to a patchwork of different services evolving in locality settings. The task group does not believe that there needs to be uniformity in service across every hospital however patients do need to know what they can expect and receive quality treatment. So clarity in service provision and the potential to develop specialism and the potential for hospitals to outreach into the community need to be explored.

9.3. The challenge is to move the debate from the tangible ‘bricks and mortar’ of community hospitals to a discussion about the best possible treatment for patients in their community.

9.4. The agenda needs to be set about how to achieve quality patient outcomes for the whole community, not just providing bed space to a small number of individuals. The task group anticipates seeing the development of community hospitals into centres offering a range of health and social care services, and welcomes a change in focus from just those who are unwell. Preventative services and developing capacity in the community are very important.

9.5. Finally whatever decisions are taken in the future, local people must be at the centre of shaping their services.

10. Membership

The task group was made up of the following Members:

Chairman Councillor Richard Westlake

Councillor Andy Boyd, Councillor Anne Fry, Councillor Roger Giles

11. Contact

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12. Sources of evidence:

Expert Witnesses

The task group heard testimony from a number of sources and would like to express sincere thanks to them for their involvement and the information that they have shared as well as to express a desire of continuation of joint work towards the fulfilment of the recommendations in this document.

References:

- Ashworth M, Nafisa MA, Corkery M: Respite care in an intermediate care centre: the views of patients and carers. Health & Social Care in the Community 1996, 4:234-245. Referenced in Heaney et al, 'Community hospitals – the place of local service provision in a modernising NHS: an integrative thematic literature review' http://aura.abdn.ac.uk/bitstream/2164/146/1/Heaney%20et%20al%20Sys%20Review%20Com%20hosp.pdf accessed on 03.08.12
- Community Hospital Association, Report to Department of Health and Community health Partnerships, Profiling community hospitals in England 1998-2008
- Community Hospitals (North-East) - House of Commons - 20 June 2012http://www.simonburnsmp.com/index.php?option=com_content&view=article&id=404:community-hospitals-north-east-house-of-commons-20-june-2012&catid=35:latest-speeches&Itemid=55
- Devon County Council Population Projections by Devon Town, 2010, except Torbay (ONS Sub-National Population Projections 2008-based, 2010)

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- HM Government, Localism Act, section 2.8 http://www.communities.gov.uk/documents/localgovernment/pdf/1896534.pdf
- HM Government, Open Public Services 2012 http://files.openpublicservices.cabinetoffice.gov.uk/HMG_OpenPublicServices_web.pdf
- HM Government, Open Public Services 2012 http://files.openpublicservices.cabinetoffice.gov.uk/HMG_OpenPublicServices_web.pdf
- Localism Act http://www.communities.gov.uk/documents/localgovernment/pdf/1896534.pdf
- McCormack B: Community hospital-issues for older people. *Elderly Care* 1998, 10:42-43. Referenced in Heaney et al, 'Community hospitals – the place of local service provision in a modernising NHS: an integrative thematic literature review' http://aura.abdn.ac.uk/bitstream/2164/146/1/Heaney%20et%20al%20Sys%20Review%20Com%20hosp.pdf accessed on 03.08.12
- NHS Devon**,** *A celebration of 60 years of Public Health in Devon 1952-2012'* http://www.devonhealthandwellbeing.org.uk/wp-content/uploads/2012/05/Annual_Public_Health_Report_2011_12.pdf
- Plain English Guide to the Localism Act http://www.communities.gov.uk/documents/localgovernment/pdf/1896534.pdf
- Practitioners RCG: Community hospitals: preparing for the future. London, Royal College of General Practitioners; 1990. Referenced in Heaney et al, 'Community hospitals – the place of local service provision in a modernising NHS: an integrative thematic literature review' http://aura.abdn.ac.uk/bitstream/2164/146/1/Heaney%20et%20al%20Sys%20Review%20Com%20hosp.pdf accessed on 03.08.12
- Ritchie LD, Robinson K: Community hospitals: new wine in old bottles? British Journal of General Practice 1998, 48:1039-1040. Referenced in Heaney et al, 'Community hospitals – the place of local service provision in a modernising NHS: an integrative thematic literature review' http://aura.abdn.ac.uk/bitstream/2164/146/1/Heaney%20et%20al%20Sys%20Review%20Com%20hosp.pdf accessed on 03.08.12
- www.simonburnsmp.com/index.php?option=com_content&view=article&id=404:community-hospitals-north-east-house-of-commons-20-june-2012&catid=35:latest-speeches&Itemid=55
- Tiverton Patient Centred Project http://www.devonpct.nhs.uk/Be_involved/Tiverton_Patient-Centred_Care_Project.aspx

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Appendix 1. Inventory of the services provided across community hospitals in Devon

Community Hospitals	General Inpatient unit(s)	Additional inpatient/ day specialty	MIU	DDoc centre	Imaging	Consultant or therapy outpatients	CCT on site
Ashburton	10		10am-6pm 7 days			Yes	
Bovey Tracey	10		None			Yes	CCT on site
Dartmouth	16	Minor ops	8am-10pm 7 days		X-Ray Part time	Yes	
Dawlish (PFI Hospital)	18		10am-4pm 7days			Yes	
Kingsbridge	12	Minor ops	9am-5pm 7 days		X-Ray Full time	Yes	
Newton Abbot (PFI Hospital)	20	Stroke Unit Midwifery Unit Minor ops	8am – 10pm 7 days	DDoc OOH	X-Ray Full time	Yes	CCT on site
Tavistock	15	Surgery	8am – 10pm 7 days	DDoc OOH	X-Ray Full time	Yes	
Teignmouth	12	Surgery	8am – 10pm 7 days	DDoc OOH	X-Ray Part time	Yes	CCT on site
Totnes	18		*24 hours* *7 days**	DDoc OOH	X-Ray Part time	Yes	
Axminster	18	Surgery	GP MIU		X-Ray Full time	Yes	CCT on site
Bideford	36	Stroke Unit	7.30am 8.30pm 7days	DDoc OOH	X-Ray Part time	Yes	
Budleigh Salterton	4medical beds 8 stroke beds	Stroke Unit				Yes	
Crediton	5 medical beds 7 stroke beds	Stroke Unit				Yes	CCT on site
Exeter (Whipton)	See next column	Elderly care 39 beds				Yes	
Exmouth	30	Surgery Unit	24 hours 7 days		X-Ray Full time	Yes	CCT moving on site next month
Holsworthy	28			DDoc OOH		Yes	

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Honiton	18	Dialysis Unit Midwifery Unit	*24 hours* *7days**	DDoc OOH	X-Ray Part time	Yes	CCT on site
Illfracombe	10	None	8am-7.30pm 7 days		X-Ray Part time	Yes	

Community Hospitals	**General Inpatient unit(s)**	**Additional inpatient/ day service**	**MIU**	**DDoc centre**	**Imaging**	**Consultant or therapy outpatients**	**CCT on site**
Moretonhampstead	9		*10am -4pm* *7 days**			Yes	
Okehampton	16	Midwifery Unit	8am- 10pm 7 days	DDoc OOH	X-Ray Part time	Yes	
Ottery St Mary	18		8am-4pm 7 days		X-Ray part time	Yes	
Seaton	18					Yes	CCT on site
Sidmouth	18	Surgery Unit Reablement	10am-6pm 7 days		X-Ray Part time	Yes	CCT being relocated on site next couple of months
South Molton	28	Dialysis Unit				Yes	
Tiverton (PFI Hospital)	36	Surgery Unit Endoscopy Midwifery Unit	24 hours 7 days	DDoc OOH	X-Ray Full time plus W/E	Yes	CCT on site
Torrington	12					Yes	

Notes:
* = *MIU's temporarily working to reduced hours*
NDDT also provides Lynton Resource Centre which has MIU and clinic services
Surgery is day surgery that is considered suitable for community settings
Outpatients are wide ranging depending on site including consultant outpatients, therapy services, day treatment services