HTA Ltd

Helen Tucker Associates Ltd
Registered Company Number: 5393200
VAT: 871 7754 86
Helen.tucker@tiscali.co.uk

Report

To

"Keep Watch"

"Keep Watch Over Our Community Hospital Beds"

Dumfries and Galloway

Review of the Role and Potential of Thornhill and Moffat Community Hospitals

Design a Community "Watching Brief" on Local Pathfinder Initiatives and service provision

Helen Tucker

August 2012

Contents

Executive Summary

The "Keep Watch Over Our Community Hospital Beds" group (now known as Keep Watch) was formed out of concern for the future of Moffat and Thornhill community hospitals which were under threat of loss of beds or closure of the hospital.

Local people had seen services at the hospitals had been reduced over time and believed that there was not a visible commitment within the NHS to invest in developing local health and social care services appropriate to the needs of the population. Keep Watch has the support of community groups and community councils in their remit to promote their community hospitals, encourage the development of the services and facilities, and to monitor the impact of the service over time.

This study has involved a critical appraisal of documents, meeting and interviewing local people and stakeholders, listening to views in public meetings, visiting the hospitals, and discussing the issues with Keep Watch and staff in NHS Dumfries and Galloway. The study has also taken into account the Scottish policy context and evidence in relevant research. In order to illustrate how other community hospitals have developed and how communities have influenced their development, case study examples have been provided. These case studies features aspects such as integration, community ownership, networking, locality planning, and illustrate the potential for a diversity and range of community hospital services and facilities. A review of the literature has also been undertaken to illustrate the evidence for developing community hospital services and benefits of community engagement.

This study concludes with recommendations to Keep Watch with regard to continuing to raise the profile of community hospitals and extend their networking across the community so that they can demonstrate a mandate for progressing their work. Recommendations also include the need to identify resources to engage with a locality planning exercise, so that they are co-producers of the Service Plan that is now required by the Scottish Government for each community hospital. The report also identifies the tasks that Health Boards are required to undertake to fulfil their responsibilities, and how local people can engage with this process. It is understood that Keep Watch will be consulting with their communities on how best to take their role forward.

1. Introduction

The communities living in and around Moffat and Thornhill have come together to fundraise for this study on the future of their community hospitals. This collective effort has demonstrated the strength of feeling. Local people clearly value their community hospital services and believe that they need to be proactive in order to safeguard existing services and hopefully develop these services further. The communities formed an organisation called "Keep Watch," signalling their role in monitoring local health services and acting accordingly. Members of the group have given considerable amounts of their time and resources to establishing the group. Tasks have included researching and visiting other community hospitals, meeting the Health Board, studying documents and networking within their localities. Alis Ballance, Chair of Keep Watch, decided to commission this study, to help guide and inform their work.

Keep Watch wanted to work with someone who had experience of working with community hospitals within the UK, and understood the policy and research evidence base for these services. I am Vice Chair of the Community Hospitals Association for England and Wales, and have been a member of the Scottish Association of Community Hospitals. I am a researcher in integrated care and community hospitals at Warwick University. I have been an independent consultant for over 25 years, and have visited and/or worked in over 150 community hospitals (Appendix F). However each situation, each community and each community hospital is different and in undertaking this study I wanted to, listen to the views of local people, familiarise myself with the service and consider the overall context for the service.

2. Objective of the Study

Keep Watch and HTA agreed the brief to be as follows:

A. Review the Role and Potential of two community hospitals

B. Design a Community "Watching Brief" on Local Pathfinder Initiatives and service provision.

This is in keeping with the aims and objectives of "Keep Watch Over Our Community Hospital Beds" (Keep Watch). The following are extracted from the Keep Watch constitution:

- To establish a method of monitoring Dumfries and Galloway Health Board meetings, minutes and public statements
- To ensure public awareness of moves to reduce or close community hospitals
- To create a community-led vision of what services community hospitals could provide
- To undertake or commission studies on models and possible developments of community hospital services and facilities
- As a group to engage with Scottish Government and other organisations to reduce the risk of community hospital closures.

Therefore this study is in alignment with the aims and objectives of Keep Watch.

3. Method

Helen Tucker submitted a proposal to the Keep Watch committee for a study of eight days. This included preparation and research, a visit to each hospital, interviews with key individuals and organisations, two meetings with Keep Watch, public meetings at Moffat and Thornhill, further analysis of data and documents, and the preparation of this report. Keep Watch provided information and discussed progress throughout the period. Keep Watch recorded the views of local people at the public meeting.

Officers from Dumfries and Galloway Health Board were contacted, and were fully appraised of the study. Officers were asked to provide data on service activity over the last 5 years for the two hospitals, in order to establish a baseline. This was required this to be an official formal Freedom of Information request and data was supplied in a period of six weeks (Appendix D). Permission was granted for visits to each of the hospitals, with the exception of patient areas. Fortunately patients were aware of the study and a number came forward and volunteered to contribute their views and share their experiences.

The Keep Watch group have raised awareness and provided a channel for local people to express their views of their local health and social care services. The high attendance at the public meetings was a testimony to the strength of feeling locally.

The visits to the hospitals and the public meetings took place in January 2012. This was followed by research and analysis of documents and requests for information. Following some discussion on key people to consult with, Keep Watch invited Dr Alastair Noble from Nairn to come and speak to the group and to local GPs. Dr Noble is on the Scottish Association for Community Hospitals, and is a medical and policy advisor to the Scottish Government. Helen Tucker and Dr Noble have worked together through their respective roles on national community hospital associations, and also on the redevelopment of Nairn hospital and welcomed the opportunity to work together again. Dr Noble continues to assist Keep Watch, and a further visit is planned.

It was also noted that two policy documents were pending, and these were known to be helpful to this study. It was therefore decided by Keep Watch to defer the preparation of the report until the documents, The Community Hospital Strategy Refresh, and the Consultation on the Integration of Adult Health and Social Care were issued. Therefore, the time period between the visit and the writing of the report has been extensive. However, the policy direction, and in particular the support for community hospital services, has served to strengthen the case for community engagement and developing community hospital services.

4. Moffat Community Hospital

I have prepared a summary profile for Moffat community hospital services and facilities following my visit to the hospital.

Moffat community hospital serves a population which includes Moffat and surrounding areas. The population is estimated at 5,317 and was described in terms of distance from the hospital (12 miles south, 12 miles west, 15 miles east and 23 miles north). The hospital is used predominantly by local people. Moffat Community Hospital has a long tradition of providing local and accessible care for residents living in Moffat and surrounding areas. The hospital has a ward of 12 beds, a day hospital, a minor injuries unit and space for clinics, therapies and meetings. As of this year the hospital also serves as a base for community nursing staff. The hospital offers a range of services including:

- A ward of 12 beds for patients who need support from our GP, nursing, social work and therapist team who offer rehabilitation, acute care and end of life care. The beds are for patients admitted by their GPs directly from home, or transferred from Consultant care from the DGRI.
- A Day hospital for older people which offers support, monitoring and rehabilitation
- Clinics for out-patients including specialist Consultant clinics, pre-operative assessment, social work sessions and health promotion clinics. 16 types of clinics are held.
- A rehabilitation service for patients at home, in clinics or on the ward from physiotherapy and occupational therapy staff
- A podiatry service
- A minor injuries service for urgent and emergency care
- A minor surgery service including cryotherapy
- A base for health and social work staff working within the hospital and the community including health visitors and district nurses.
- Facilities for staff and community training and meetings
- An on-site kitchen cooking freshly prepared meals
- A supportive League of Hospital Friends which has generously donated funds for equipment and funded improvements to the hospital building.
- Productive partnership working with staff and agencies such as Marie Curie and Macmillan

The hospital had a mortuary that served the hospital and the town, and subsequent to my visit this was closed by the Health Board.

Plans for the Future

There are some suggestions within the hospital for extending or enhancing services to further meet the needs of the community.

- Increase Day Hospital use by offering a Day for older people with Alzheimers.
- Increase the number of Consultant clinics, such as a Consultant Physician for Older People.
- Be able to offer Intravenous therapies, with appropriate staff training and support
- Explore the possibility of increasing the number of single rooms (currently 3) which would be appropriate for people who are at the end of their life, and those with infectious diseases.

Innovations

The NHS is constantly striving to improve the service and make it appropriate for the needs of local people. Examples of innovations include:

- Integrating community nursing staff, so that nurses can work within the hospital and within the community, offering a continuity of care for patients and flexibility according to changing needs
- Implementing efficiency systems which have been shown to “Releasing Time to Care”, so that nurses can spend as much time with patients as possible
- Recognition of good practice, as staff have won awards for “Excellence in Care”
- Promoting healthy living, such as working in schools and inviting school children into the hospital
- Exploring the potential for new technology, such as the use of “e pens” for staff

More detailed notes from my visit are contained in Appendix A, and activity statistics in Appendix D.

5. Thornhill Community Hospital

I have prepared a summary profile for Thornhill community hospital services and facilities following my visit to the hospital.

Thornhill community hospital serves a population of 10,000 people which includes Thornhill and surrounding areas of Upper and Mid Nithsdale. Thornhill community hospital has a long tradition of providing local and accessible care for residents living in Thornhill and surrounding areas and is described in terms of distance from the hospital as7miles South,11 miles west,13 miles east and 15 miles north. Thornhill hospital opened in 1903, and has been serving the local population for over 100 years. It is understood that there have been plans to redevelop the site in the past. The site of Thornhill hospital incorporates five unconnected buildings. These are the inpatient ward, the day hospital, administration, the health centre and the mortuary/store. The hospital provides inpatient care as well as accommodation for therapies and community meetings in a rehabilitation day unit. The GP health centre is on the hospital site and provides primary care and clinics. Services include:

- Inpatient Beds – 13 for patients admitted directly from the community or transferred from Dumfries & Galloway Royal Infirmary (DGRI).
- Day Unit/Rehabilitation 8 different types of clinics such as ante-natal, parent craft. Also speech and language therapy, eye clinics, and a continence service.
- Community group meetings such as Alcoholics Anonymous.
- Space for training and meetings
- Therapy Physiotherapy and OT
- Clinics held in Health Centre include psychiatry, psychology, urology, smoking cessation and child health.
- A mortuary with viewing area.
- An on-site kitchen with freshly cooked breakfasts and lunches
- Partnership and support from Macmillan nurses
- Support from nurse specialists (such as stoma nurse, heart failure nurse etc) as well as link nurses (such as for tissue viability).
- The League of Friends have generously funded equipment and building developments

Plans for the Future

Some suggestions from within the hospital for service developments or enhancements include:

- Increase number of clinics, such as leg ulcer clinic

- Offer day care and rehabilitation
- Consider IV therapies and blood transfusions
- Integrate the services and buildings more fully

Innovations

- Community nursing and community hospital staff are implementing a programme to improve quality and efficiency, and enable nursing staff to optimise their time with patients called “Releasing Time to Care.”
- Practitioners meet weekly to discuss and plan care for patients in the hospital and the community.
- Staff in Thornhill hospital have been nominated for awards from the Health Board for quality care

More detailed notes from my visit are contained in Appendix B and activity statistics in Appendix D.

6. Local Context

Communities in Moffat and Thornhill have seen a gradual erosion of services over the years., and are concerned that the level of service at the hospital currently reduces its viability. It is understood that this has prompted the creation of the Keep Watch group, which is undertaking a role for supporting community hospitals, promoting the current and potential role of their local hospitals and seeking more community engagement with their health and social care services.

In Moffat, it is understood that beds were previously reduced from 15 to 12. There is a concern that the number of beds is on the edge of viability. There is a reported previous announcement by NHS Dumfries and Galloway that if the beds went down to 10 the beds would not be viable and would have to close. It is understood that there has been a reduction in the number of days that the day hospital is held at Moffat, and the Thornhill day hospital is closed. Fewer patients now attend the minor injuries unit in Moffat, following a reduction in opening hours, and the application of a tighter criteria. There is also a concern that outpatient clinics have reduced. The mortuary was closed by the Health Board this year. This served the hospital and the town, and there has been a strong public reaction to the removal of this facility, not only to the loss of the service but also to the way that the decision was made, and the speed of the change.

For Moffat hospital the statistics show that an average of 9 out of the 12 beds are usually occupied (75%), and that the length of stay has increased from an average of 21 days in 2006/2007 to 26 days in 2010/2011 (See Appendix D). The charge nurse at Moffat reported that in January to December 2011 it was down to 67%.

An average of 4-5 people attend the minor injuries unit a week, totalling 240 attendances in 2010/2011. The day hospital is open for two days a week, and an average of 5 people attend per session. The number of outpatients attending consultant clinics has increased from 180 per year in 2006/2007 to 410 in 2010/2011.

For Thornhill Hospital the beds were previously reduced from 15 to 12 to comply with new legislation regarding bed spacings. Statistics show that an average of 9 out of the 13 beds are usually occupied (67%). There is a higher occupancy demand for female beds than male beds. The length of stay has decreased from an average of 46 days in 2006/2007 to 28 days in 2010/2011

As a benchmark, the Scottish Association carried out a survey a few years ago which showed an average length of stay of 15 days and a 75% occupancy (Liddell 1994). An assessment of appropriateness and good practice would need to be undertaken with a more detailed knowledge of what the beds are being used for, with regard to case mix and dependency. For instance, many community hospitals have admission criteria which includes patients with very complex and high care needs, and these patients may require a longer period in hospital. An assessment of the clinical activity in the hospital may well be undertaken by the GPs and NHS D&G in order to monitor and review the service and act accordingly.

As assessment of the services provided within each locality will have been undertaken by NHS D&G in relation to the health needs of the local population. An analysis of health prevalence, based on data collected in GP practices, shows that people living in Dumfries and Galloway have a higher incidence in many of the main conditions that the rest of Scotland. These include diabetes, hypertension, asthma, chronic obstructive airways disease, cancer and dementia (Appendix C). These factors would need to be taken into account when designing services for the future, and creating an increase in capacity of local community services to cater for these needs, which would include community beds. Local people have also expressed their views on what they would value locally, and services include an increase in outpatient clinics, and the provision of expanded welfare and health services as part of a prevention strategy that would enhance people's health and wellbeing .

Initiatives to increase community services are clearly welcome, although there are some concerns about whether some services are being introduced at the expense of community hospital services. For instance, the pilot for integrating nursing teams is designed to enable nurses to work within the community by offering experience and training. The pilot does not support the potential for community nurses to work within the community hospital however. This "one way" flow of nurses feeds people's anxiety that the focus will be on home care as an alternative to community hospital beds.

The lack of trust and communication between local people and the authorities within the NHS does not help. For instance, it is understood that The NHS "Drop in Session" to be held in Wallace Hall Academy, Thornhill was abandoned due to the high level of local attendance (reported to be approximately 400) and the promised re-scheduling of a public meeting never took place. This further contributed to the feelings of mistrust. There appears to be few systems in place for genuine dialogue and engagement at a local level. Therefore, local communities feel disempowered and yet they have a lot to offer.

GPs have said that they want to retain local services for their patients and appreciate the difficulties in access and travel for patients and families, but are not as engaged as they would like to be in the planning and decision making process. Dr Noble has suggested that local contracting and future integrated budgets may help to provide a mechanism for GPs to use their clinical decision-making to influence the use of resources and availability of services.

It is noted that where there is confidence in the strategy, operation and management of a service, engagement and sharing of information on local services, matched with an investment in staff and services within localities, communities do not feel the need to create campaign groups. This should be a last resort. There is clearly some work to do to ensure that the communities can use the channels of engagement that are open to them, respond positively to NHS D&G local planning processes when they are in place in Moffat and Thornhill, such as through the Putting You First (PYF) Programme, which they have started to access. However the PYF meetings which were scheduled for Moffat and Thornhill for March 2012 were postponed by the Health Board and have not yet been re-scheduled. The community wants to ensure that they are in a strong position and are well informed to play their part in designing services for the future.

7. Initial Findings

As an independent consultant and researcher, I have approached this study objectively with an open mind.

My observations of my visits to the hospitals was that there did not appear to be anyone advocating for community hospital services, either from within the hospitals or from within the regional Health Board. There appeared to be a poverty of aspiration for local services. Local people had expressed the view that they believed that community hospital services were "dwindling" and gradually being withdrawn to an unviable level, and were concerned that this would lead to a closure of their community hospital.

It would appear that in both hospitals the number of beds had reduced and the hours of opening of minor injuries units at Moffat had reduced with more rigorous criteria applied. At Thornhill the once active day hospital which provided a range of services, including speech therapy, physiotherapy, and podiatry has closed. The day hospital at Moffat hospital has reduced to 2 days a week. This picture does not suggest a thriving local facility that fits with the vision of accessible integrated services that enables people to avoid going to the DGRI unless absolutely necessary.

Typically when visiting community hospitals there is often a pride in the service and some excitement about service improvements, developments or initiatives. Although there was clearly attention to providing an efficient quality service at the hospital, the image was not of an expanding service that was meeting a populations needs.

Another observation was the disconnection between the community and the community hospital. One of the strong features of local community hospitals is often the high level of involvement and participation by local people. I am often shown around by the hospital manager/matron, GP and member of the League of Friends, illustrating the close working between primary care, community hospital services and the local community. It is not uncommon for management structures to incorporate local involvement. This was not the case in Moffat and Thornhill. There was even a suggestion that League of Friends meetings were discouraged from being held in the hospitals, and involvement has been reduced over time.

Information on the hospital services was not readily accessible, which raised the question of how the services and facilities could be optimised if information on what is available is not shared or promoted within the community. The profiles I have compiled in the previous sections were created following interviews and requests for information, and were not readily available to patients in the hospital or on the website.

There is concern within the community that there will be a shift of funding and staffing to enhanced community teams at the expense of the community hospital, and this may also lead to further reductions. It is understood that the arrangement for community hospital staff to work within the community for experience is not matched by community staff working in the community hospital.

Knowledge of this “one way” skills and experience training supports the concern that future investment will be in care in people’s homes and not in community hospitals. In many places, the increase in community capacity to accommodate the shift of services to local areas has required community hospitals and community teams working together, rather than one model being at the expense of the other.

Overall there is a lack of trust and confidence in the local NHS by local people that was expressed strongly in individual and group interviews, as well as in public meetings. The history of the cancelled consultation on the previous Clinical Services Strategy has contributed to this. Therefore there is work to do to rebuild confidence, share information, manage expectations and develop a more collaborative approach. Essentially the goal of the Health Board and local people is the same – to ensure that there is an appropriate, safe, high quality, effective local service for promoting the health and well being of local communities.

The Health Board has made a public commitment not to close any (cottage) community hospitals during the period 2011-2016. It is noted that the Health Board has designated local hospitals as cottage hospitals, although this is not the term used nationally. This difference is not explained or defined on their website, and has been taken as a further sign by local people that the services are diminished.

8. Strategy of NHS Dumfries and Galloway

NHS Dumfries and Galloway (NHS D&G) is developing a strategy for person-centred community-based services, and has made a commitment on their website *"we will not close any cottage hospitals*" in the period 2011-2016 in their vision "Putting you first" [1]. This Commitment is also stated clearly on the front page of their website: **"***The NHS Board have no plans to close its cottage hospitals."* There has, however, been no commitment to keeping open the beds. NHS D&G is exploring service developments that will enhance community services and has announced that it is developing initial "pathfinder" sites in Annandale & Eskdale and Dumfries & Upper Nithsdale. It is understood that these pathfinders will be pilots of service initiatives include the development of community teams, to enable more support to be offered to people within their own homes. The community has reported difficulties in accessing information on pathfinders. The community has even submitted Freedom of Information requests, but has not yet received pertinent information.

The local community have a vested interest in their local community health services, including their Community hospitals, and wish to create a system to enable them to have a watching brief on these developments, so that they can contribute to the debate about the impact overall on any potential service redesign. Following the previous consultation paper that was released by NHS D&G for 2009/2010 which proposed the closure of some of the smaller community hospitals, there is some concern that these valued services and facilities, and in particular the beds, may still be at risk. Therefore, members of the local community wish to take an active role in assessing the potential of the community hospitals, and to contribute in a constructive way to the vital discussions about the future services in these remote and rural areas.

In the minutes of the Dumfries and Galloway Older People's Consultative Group March 2012, a record was made of questions and responses regarding the future of community hospitals in relation to the plans for the redevelopment of the DGRI. The Health Board response was to confirm that community hospitals had an important role to play, that investment had been made in Moffat community hospital which should be taken as a sign of commitment, and that a survey was being undertaken of all community hospitals to identify the best use for each one according to local needs. It is not clear whether local people will be involved in this survey, and how the outcome will be shared. It is also unclear about the commitment to retaining community beds.

In the "Putting You First" paper in March 2011 the feedback from local people was recorded and the first item was that people supported their community hospitals, and in response to this the Health Board formally confirmed that "we will not close cottage hospitals and will support staff in maximising their contribution to the service." This is contrary to their earlier proposals to close or reduce services in community hospitals in 7-10 years' time. People also wanted local and accessible health care, care closer to home, more community teams, more "working together." In response to the consultation (albeit suspended), the Health Board

[1] http://www.nhsdg.scot.nhs.uk/dumfries/3745.html

made a number of commitments for the time period of the Putting You First Strategy (2011-2016)

- We will not close existing cottage hospitals;
- We will not build any new hospitals;
- We will take forward improved care pathways;
- We will test models of working together.

NHS Dumfries and Galloway has now established a programme entitled "Putting You First" and has started a series of meetings in other selected communities. This is very welcome. At the start of this study, it was not known when the communities of Moffat and Thornhill would be invited to workshops to start the process of reviewing and redesigning their local services. In March dates were announced but these workshops were cancelled and they have yet to be rescheduled.

In the meantime, concern continues to be expressed by the community about their local hospitals. Since this study has been taking place, the facility of the mortuary has been closed in Moffat Hospital. Local people protested about the loss of the service, the lack of consultation and lack of notice. There is concern that this does not indicate a willingness to work with the community. The rationale for the closure, provided in writing from the Board, contained factual inaccuracies and did little to help increase trust.

Although the clinical services strategy that was proposing the closure of community hospitals has been suspended, local people still have concerns about the future of their local hospitals. Their perception is that services have been reducing over time, and that further reductions could render the hospitals with their inpatient facilities unviable. In the public meetings, in interviews and in correspondence, local people expressed their concerns about being "excluded" from the vitally important decision making on **their** local hospital and local health and social care services.

9. National Context

The Scottish Government has made a firm commitment to community hospitals in their Strategy "Refresh" for Community Hospitals, describing them as *"more important than ever."*

The strategy describes a vision of community hospitals and wants to ensure that patients are at the centre of care pathways, that staff have appropriate training and development, and that the hospital services are developed to provide for the needs of local communities. The Scottish Government is establishing an Improvement Network, which will provide support, advise, information and resources. The strategy requires a Service Plan to be developed for each hospital by Health Boards, local communities, GPs and other stakeholders.

The model that the strategy sets out is one which sees the role for community hospitals to include health promotion, rehabilitation/reablement, intermediate care, dementia care, integrated health and social care, diagnostics services, and palliative care. Services may be provided in outpatient clinics, day services or on an inpatient basis. The service is for the whole community, with older people being the major users of the service. There are 92 community hospitals in Scotland with many being in remote and rural settings. The strategy sets out examples of good practice in providing locally accessible services with the support of technology and telehealth.

The strategy refresh does not commit to retaining community hospital beds in all community hospitals. It acknowledges that its "commitment to integrating adult health and social care...will have significant impact on the care provided by community hospitals...this re-setting of community hospital priorities may see some...reduce their inpatient capacity to support more appropriate community-based services." Keep Watch therefore wants to be active to help ensure that Moffat and Thornhill community hospitals retain their beds, and that there is no further reduction in the local inpatient capacity.

It is clear in the strategy that service plans and any changes or developments in community hospitals must be undertaken with the local community. This draws on the findings of the Christie Commission which reported that there needed to be improvements in the way that public services engaged with their communities. The "co-production" approach is described, whereby the NHS develops services with local communities rather than for them. The response to the Christie report confirmed a national commitment to involve communities in redesigning and reshaping their services.

The strategy envisages community hospitals as being part of a whole system and being embedded within their communities. Community hospitals traditionally provide integrated health and social care services, and have been described as community "hubs" as the hospitals typically accommodate a range of services from multiple providers. This may include third sector services, acute hospital clinics, mental health services, primary care services and community teams. It is vital to coordinate these services so that the patient experiences an integrated service. There is evidence of benefits of the co-location of staff and services in community hospitals.

The Scottish Government has described a key role for community hospitals in preventing avoidable admissions to acute hospitals, and enabling early discharge from acute hospital beds to community hospitals. This shift in the balance of care from acute to community will require an increase in community capacity, and "*community hospitals will play a vital role in delivering a significant change in the provision of both health and social care"* in supporting this policy (Nicola Sturgeon, Cabinet Secretary for Health, Wellbeing and Cities Strategy). This policy to shift services into communities supports the aims of Keep Watch to retain inpatient services.

An important policy drive is for the integration of health and social care, and there is a document out for consultation which seeks to set in legislation a new structure to enable health and social care to be integrated. It is recommending the creation of Health and Social Care Partnerships which will be required to integrate budgets for joint strategic commissioning and direct more resources into local communities. Central to this will be a locality planning process which the document suggests will be led by clinicians and care professionals but will require engagement with communities, third sector and other stakeholders. The Health and Social Care Partnerships will replace the Community Health Partnerships (CHPs) which are currently the key mechanism through which all primary and community based services are planned and delivered. They have a remit to support the shifting of the balance of care to more local settings, reducing health inequalities and seeking an improvement in the health of local people. An example where this has worked well is where scanning services have been brought to community hospitals (Stevenson 2010).

It is clear from this selection of documents that there will be locality planning that will be undertaken by communities, health and social care professionals as well as other stakeholders in order to design services that are appropriate to local need. Community hospitals are described as central to the policy shift that will create more capacity within communities, and developments of community hospital buildings and services are anticipated. Community hospitals provide an important focus for integrated health and social care, and are highly valued and trusted by local people.

This policy direction matches the vision expressed by local people in Moffat and Thornhill, and local people have expressed a strong desire to play a constructive and proactive part in safeguarding valued services, building on good practice and planning service developments.

10. Views of Local People

Helen Tucker interviewed local people, listened to views in the public meeting, spoke to patients in the hospitals and was provided with copies of letters that had been sent to the Health Board. The following are a selection of quotations which serve to illustrate the themes of access, a local service, continuity, quality, and trust.

Some of the letters were very strongly worded. For instance, one person said that *"it was with shock, horror and disbelief"* that they heard about proposals to close their local community hospital. Another said *"Leave our hospitals alone. They're important; we need them!" "Please, please let us keep our hospital – everyone is so kind to all patients in their care."*

The main message in the responses was that: "*The role of the community hospital is vital in our rural communities."* Many spoke of the need to extend, develop and modernise community hospitals, making the point that *"they should be kept and ideally expanded to meet the needs of the increasing elderly population."*

One responded said that we need *"local services for local people"* and pointed out that local people have consistently supported and valued their local community hospitals.

Many of the letters referred to rural transport issues and concern about travel if local hospitals were to close. This would mean that local people would have to travel to the DGRI for their care, or community teams would support patients in their own homes. Many spoke of the difficulty of access, especially during the winter months. *"The recent spell of bad weather is a good example of how the proposed home care service would be extremely badly affected to the point of being rendered totally ineffectual."* Other factors to be considered were fuel prices, environmental issues and the reliance on a public transport system.

Concerns were raised about the proposed enhanced community teams, which could be at the expense of community hospital services rather than complement them. Practical considerations such as staff time, staff working in isolated remote and rural areas, travel difficulties for staff and the ability to provide an adequate cover for vulnerable people living at home were raised by local residents, demonstrating a lack of trust in the feasibility of such arrangements.

The quality of care was described by many respondents. *"The level of anxiety is far less within a small hospital where patients are near family and friends, and are more likely to know members of staff and fellow patients, and such inclusiveness must be an important factor in a patient's recovery or comfort."* One respondent said that her involvement in the hospital over many years as a member of the League of Friends meant that she had witnessed "*the quiet, calm effect within and the special caring of the nursing staff helps with the recovery process."* Others mention the high standards of hygiene and cleanliness in the community hospitals and low levels of hospital acquired infections.

Patients spoke of their appreciation of the service, with comments such as: *" I am getting very good care"* and *"The staff are wonderful. If I need a nurse I can ring the bell, even at night, and they come straight away."* A gentleman who had been transferred from the DGRI said *"I feel like a new man after a couple of days in the community hospital. I had been in the DGRI for 3 weeks, and they sent me home too quickly. So after 4 days my wife was very worried and called the doctor. The doctor wanted to readmit me to the DGRI, and I said I did not want to go. He offered me a bed in the community hospital. I am well cared for and feel so much better. It saves my wife worrying about the responsibility, and she can visit easily. I can now walk across the room – I could not do that before. Good luck with the meeting. I read about it in the paper."*

Many spoke of the model of care in community hospitals, with recognition of the value of rehabilitation, palliative care and intermediate care in particular. Local people have stressed the importance of having an inpatient facility for patients who are discharged from the DGRI, but are not yet well enough to go home. *"The current arrangements are a blessing to the elderly – it enables them to reacclimatise themselves and be close to friends and family." "The NHS should, remember that they are employed to treat patients sensibly – not to inconvenience them or disturb them unduly especially when they are under stress,"* and this point was made again with regard to the implications of closing local community hospitals and the prospect of older people having to travel by public transport to the DGRI. Practical considerations such as parking and local hospitals within walking distance were pointed out.

The need for genuine community engagement was stressed in the correspondence: *"We, like most people, are dismayed by the lack of consultation or forethought."* Other comments: *"As the Independent Scrutiny panel says NHS Dumfries and Galloway needs to take change forward* ***with*** *their community rather than* ***for*** *their community."* Several letters make this point: *"The Kerr report argues that options should be developed* ***with*** *people, not* ***for*** *them, starting from the patient experience and engaging the public early on to develop solutions, rather than have them respond to pre-determined plans by the professionals."* Another said "*Local people need to have a voice and need to be heard"* which echoed the sentiment of many other respondents.

Local people have made suggestions for improvements and developments in their correspondence and in public meetings. *"There is potential for innovative links between doctor's surgeries and local hospitals."* and suggestions such as: *"Opportunities should be taken to increase outpatient clinics."*

In summary, many people alluded to the role plays within the community that goes beyond health and social care and is at the heart of the wellbeing of the population. *"Local hospitals keep the community spirit which benefits all in the community."*

11. Community Hospital Case Studies

The following selection of case studies shows some aspects of community hospital developments of buildings, facilities and services. Some of these examples were presented in the public meetings and are described here so that Keep Watch can assess their relevance to their situation. Keep Watch has already been in contact with some of the communities concerned, and visited community hospitals. The case studies feature examples of locality planning, community ownership, ambition in vision, diversity in provision, health promotion, improving the estate, partnership with care home, consolidation and co-location, networks and integration.

- **Locality Planning**

Dr Alastair Noble, GP colleagues and community in Nairn in the Highlands were concerned about the future of their community hospital. Local people initiated a locality planning exercise to determine their vision for their local health and social care services. Their vision was for accessible integrated primary, community and social care services, with teams co-located in a newly developed hospital building which would also accommodate the GP practice. The determination of local people and their GPs has meant that their hospital is now rebuilt to a modern high standard, and includes 19 beds, a minor injuries unit, intermediate care, mental health services and a day hospital.

- **Community Ownership**

Proposals for closing Rye hospital in East Sussex were countered by local people who commissioned a feasibility study to develop the service. The local community formed a charity and have taken on the ownership and management of the community hospital. This has been operating successfully for over ten years, and is continually developing and improving. The hospital site now accommodates the GP practice, very sheltered housing, day services, inpatient beds, clinics and social care services. The community charity takes a responsibility for coordinating and integrating the services, and works in partnership with the NHS, Local Authority, and the voluntary sector.

- **Ambition in Vision**

The League of Friends of Edgware hospital were concerned that the plans for the redevelopment of their hospital as a true community hospital lacked ambition. Local people campaigned to have the plans withdrawn, and then took an active part in working with the NHS to reconsider the proposals and consider opportunities for the future. Their influence meant that the hospital now has the widest range of services of any community hospital. Edgware is an urban community hospital.

- **Diversity in Provision**

Wells hospital in North Norfolk is remote, rural and coastal, and was considered unviable by the NHS. Local people now own and manage the hospital, and have extended its remit to include more health promotion, education and training, dentist, social care, and intermediate care. The hospital now offers a kidney dialysis service.

- **Health Promotion**

Victoria Hospital in Northwich has won awards for being a "health promoting hospital." It offers health education and health promotion for all ages. Programmes have been developed for patients, families and staff. This includes programmes for caring for carers, a Falls group, cardiac rehabilitation, breast care hydrotherapy, and a healthy wards programme.

- **Improving the Estate**

The community hospital in Invergordon, Easter Ross was housed in short-life buildings which were no longer adequate for purpose. The GPs pressed for a new community hospital in which they could also locate their practice. After an extensive planning period, the new County community hospital opened in 2005. The services now include 44 inpatient beds for intermediate care and dementia care, day hospital, minor injuries unit, X ray, Ultrasound, social care services and out of hours service.

- **Partnership with Care Home**

A small community hospital building in Ledbury, Herefordshire was no longer fit for purpose. Proposals for redevelopment incorporated a care home, a GP practice with the community hospital services. The development also includes a market cafe and now forms a health and social care focus for the community. The development represents a partnership between local people, a private company, the NHS and the Local Authority.

- **Consolidation and Co-Location**

Whitehills Health and Community Care Centre, Forfar, is a new development that replaced two existing hospitals. Services include inpatient beds and clinics, mental health services, community nursing teams, school health teams, community pharmacist, a hospice, X ray, day facilities for people with physical disabilities, rehabilitation therapies, podiatry and continence services. This development was driven by GPs, who worked with the Health Board to improve and extend the local provision.

- **Networks and Integration**

The Leagues of Friends for the nine community hospitals in Cumbria joined together to promote community hospitals and counter proposals for closure. Their collective effort brought people together. The Leagues jointly commissioned a study, which was used to help make the case for retaining and further developing community hospitals (Tucker & Morgan 2010). The GPs were very actively involved, and Dr John Howarth provided clinical evidence to support the case. Dr Howarth now leads the programme for developing community hospitals as integrated health and social care facilities, and two more community hospital facilities have now opened.

Other examples of good practice in Scotland may also assist Keep Watch in their deliberations about the future vision. http://www.scotland.gov.uk/Topics/Health/NHS-Scotland/community-hospitals/examplesofpractice

12. Research on Community Hospitals

I have carried out a review of the literature to community hospitals and community engagement to help provide some evidence from international studies. A strong theme in the literature is one of community engagement, showing that local people should be considered as legitimate stakeholders of *"their hospital."* The benefit of early involvement and partnership with service users has been demonstrated (Leutz 1999).

The World Health Organisation declared that *"people have a right and a duty to participate, individually and collectively, in the planning and implementation of their health care"* (WHO Alma Ata 1978).

Studies have consistently shown that there is a benefit to having service users and communities setting service values. People who use the service are able to determine and agree the values and principles to guide service review, planning and development. Examples of values include accessibility, person-centred care, local care, and continuity of care. Local people are then able to work with authorities to ensure that these principles are applied. This was carried out successfully in a study in Sweden (Ahgren 2003), in the EPICS programme in Buckinghamshire (Foote & Stanners 2002) and in Norfolk (Tucker 2010).

Researchers have explored the rural context and environment for community hospitals and concluded that there is a social and psychological benefit to patients with regard to the accessibility and smallness of local hospitals (Haynes and Bentham 1979). There are many accounts extolling the virtue and value of community hospitals from the perspective of the community, such as: *"If anyone ever doubted the intrinsic value of the community hospital/health centre, simply being an observer …would dispel all misgivings. It is in environments such as these that health care begins"* (Rose 1975). The confidence and trust that local people put into their community hospitals has come from their direct experience and from the tradition of care. This supports a concept of "*healing places*" which Gesler suggests should be seriously considered in terms of the health and wellbeing of the population that associates health with this service and facility (Gesler 2003:2).

When local people are asked about their community hospitals, the accessibility to services is typically a prime consideration. A review of 64 community hospitals in Scotland recorded an average distance of 30 miles for the nearest District General Hospital (DGH), and concluded that the contribution that these hospitals made to the health of local communities should not be under-estimated (Grant 1984).

A number of studies have considered the role of community hospitals in alleviating pressure and workload from specialist acute hospitals. One such study highlighted the extent of primary care involvement, the multidisciplinary rehabilitation services for patients discharged from acute hospitals, and the availability of diagnostic services which place community hospitals in a strong position to contribute to intermediate care (Seamark et al 2001).

A reduction in the utilisation of acute hospitals was recorded in a review of the use of community hospitals in Norway over a five year period and demonstrated better access to quality health care for people in rural areas at a lower cost than alternative options (Aaraas 1998). A randomised controlled trial in Norway concluded that intermediate care at a community hospital significantly reduced the number of readmissions for the same disease to a general hospital and also increased

the level of independence of patients supported in community hospitals as opposed to those cared for in general hospitals (Garasen et al 2007). This finding concurs with a randomised controlled trial in Bradford (Green et al 2005). AWHO study also concluded that *"United Kingdom studies confirm that GP hospitals save costs by reducing referrals and admissions to higher-cost general hospitals staffed by specialists"* (Atun 2004).

Community hospitals have been described as moderating the flow of patients between primary care and the DGH, enabling better access to care for patients at an overall lower cost (Aaraas 1998). A randomized controlled trial (RCT) in England concluded that care in a community hospital was associated with greater independence for older people than care in a DGH (Green et al 2005). Post acute care was deemed to be cost-effective in a community hospital (O'Reilly et al 2008), and there were benefits in patient outcomes (Young et al 2003; Young and Stephenson 2006; Young et al 2007). An evaluation of a GP hospital in the Netherlands concluded that it is a valuable alternative to care at home, nursing home or general hospital, particularly for older people with poor health-related quality of life conditions requiring short term care (Charante et al 2004). Nearly twenty years ago, Scottish GR Dr Liddell wrote *"if care in the community is to work well, and if the expected increase in the number of extremely elderly patients is to be coped with by primary care, then the presence of community hospitals as a safety net when acute illness intervenes is going to be even more important than it is now"* (Liddell 1994). This is proving to be the case. Community hospitals enable acute hospitals to concentrate on appropriate specialist services, and there are benefits in terms of quality and costs in maintaining and developing community hospital services. There are also benefits in patient satisfaction and patient outcomes.

Community hospitals provide a wide range of services, including palliative care rehabilitation, mental health services, day surgery, maternity, diagnostic services, and minor injuries services. Health promotion, welfare and social care services can also be based in community hospitals. Services can be provided in an inpatient, day patient or outpatient basis, and can be supported through telemedicine links. A community hospital profiling study for the department of Health in England detailed the hospitals, services, models of ownership and developments in community hospitals over a ten year period (Tucker et al 2008).

It has been argued that, because small hospitals have been vulnerable to closure for so many years, they have become adept at innovation. According to Higgins, a small hospital, with little bureaucracy and short chains of command, changes in professional practice can be implemented in days instead of the months or years which it can take in large hospitals (Higgins 1993:65). The findings of a literature review carried out in Scotland concluded that the strengths of community hospitals may be linking primary and secondary care and providing a location for the delivery of complex packages of health and social care and public health, and that this role could be further developed (Heaney et al 2006).

Studies show that patient satisfaction and outcomes of care in community hospitals compare favourably with other models of care (Green at al 2005). A study on patient satisfaction of community hospital services demonstrated a positive outcome, although found that there was scope to improve collaborative care and patient participation (Small et al 2007).

One of the policy directives is for integrated care, and researchers have demonstrated that community hospitals have traditionally operated in this way (Ritchie 1996, Tucker 2006, Young et al 2001). Arguably, community hospitals can provide a focus or "hub" for a wide range of coordinated and integrated services and facilities associated with the health and wellbeing of its population.

The Community Hospital Strategy Refresh cites some of these research studies, to provide an evidence base for its decision to support and promote the further development of community

hospitals in Scotland. However the strategy does envisage a model of community hospital without beds, as well as options for reducing bed numbers. Many of the initiatives have extended their inpatient facilities in order to help manage the avoidance of acute hospital admissions, and facilitate early discharge from acute hospitals.

13. Recommendations

This study draws on a review of the literature on community hospitals, a consideration of case studies of community hospitals that I have been involved with, an appraisal of the national and local context, an assessment of the current hospital services and consideration of the views of local people. This overview of the current situation has led to a number of recommendations.

This report has addressed two objectives. The first is to review of the role and potential of Thornhill and Moffat Hospitals. The second was to design a watching brief for local health and social care services. These recommendations are framed to help Keep Watch to achieve these objectives.

Recommendations for Keep Watch

1. Continue to establish Keep Watch as an organisation that networks with the community and coordinates local views and has a mandate to represent the community. Continue to maintain the high profile of the issue of the future of local community hospitals through public meetings, presentations to local groups, local media cover, newsletters etc.

2. Meet Julie White the Interim Chief Operating Officer, who is now the designated lead officer for Community Hospitals for Dumfries and Galloway, at the earliest opportunity. This is a newly created post, as part of the implementation of the national Community Hospitals Strategy Refresh. The community would be able to present their case and demonstrate the community commitment, skills and knowledge that can contribute to designing an appropriate model of health and social care for the communities in and around Thornhill and Moffat.

3. Create a resource pack of information with local GPs and the NHS/LA that is regularly updated that can be freely available to individuals and groups which provides information on the hospital services and facilities, how they may be fully used, sets out options with service models and invites suggestions for proposals for the future.

4. Utilise the national network being developed for community hospitals by NHS Education for Scotland which aims to facilitate education, share good practice, exchange knowledge and clinical skills and provide an improvement forum.

5. Continue to link with, and be advised by, the Scottish Association of Community Hospitals as well as the Community Hospitals Association for England and Wales.

6. Offer to carry out surveys of local people to help to provide a mandate for change and improve the way that local voices influence local services.

7. Undertake a Locality Planning exercise to develop a Service Plan for the community hospital with GPs, the Health Board and a range of local stakeholders. Identify resources for working

collaboratively on service planning and development as well as evaluation, asking for the locality planning workshops cancelled back in March to be re-scheduled.

8. Explore the many options for the community hospital by networking with other communities and researching alternatives so that possibilities can be presented when developments are considered.

9. Develop a vision for an integrated health and social care service for the two communities of Thornhill and Moffat which reflects the views, experiences and outcomes of patients, families, carers and the community and is based on key values and principles

10. Monitor local health and social care services using an agreed evaluation tool that will enable changes to be identified, and the impact on patients and the community to be measured.

The NHS & Local Authority are required by the Scottish Government to progress the following:

1. **I**mprove information available to general public on the services and facilities in community hospitals such as a leaflet and details on the website.

2. Celebrate good practice and share achievements through local press and events.

3. Establish a closer engagement with the community such as through League of Friends and community groups by establishing a formal planning and communication structure.

4. Establish a locality planning group with communities to initiate a Service Plan for each community, to involve local service users, carers, community groups and third sector as well as community hospital staff, community staff, GPs and other stakeholders.

5. Work with the community to establish values and principles to guide the process.

6. With the community, carry out a detailed service mapping exercise, to match current services across the whole health and social care system with the current and projected needs of the local population.

7. Refine and develop a Service Plan on the basis of the views of those using the service and working in the service, building on existing good practice, drawing on evidence from research internationally, and working within latest policy guidance and requirements of the Scottish Government.

8. Explore the implications of developing community services and shifting service activity from acute to community and carry out an impact assessment which includes governance, quality, risk and finance.

9. Further develop care pathways for conditions that are particularly appropriate for community hospital care, showing their role and contribution. These would include

rehabilitation/reablement, palliative care, dementia care, health promotion, intermediate care, health and social care and the care of people with complex care needs and long term conditions.

10. Work closely with GPs on fair share contracts and referral patterns.
11. Prepare for the proposed integration of Adult health and social care, including devolved financial integration and options for the co-location of staff and services, shared systems such as IT and telehealth.
12. Incorporate community benefit clauses into any contracts to illustrate how the community benefits overall
13. Create a vision for local community health and social care services, with the community hospital having a key role. And which increases community capacity with services provided locally which are of high quality, safe, effective and person-centred.
14. Assess the appropriateness of the existing hospital buildings, and review the estate according to the proposed function and initiate development plans.
15. Create a development plan for the services and facilities with explicit tasks and timescales.
16. Co-produce an evaluation tool with the community that incorporates regular reporting on service availability and usage, performance and outcome measures, and patient satisfaction.

14. Conclusions and Next Steps

Local people are to be commended for taking a proactive and constructive approach to safeguarding and improving their health and social care services in their area. This is a strong testimony to the contribution that the community hospitals make to each community, and how highly they are valued. This study has focused on describing a locality planning process that would bring together those people that use the services and those that work in the service to co-produce a service plan for each community hospital. It has been shown that the vision for community hospital services can be greatly enriched with the contribution of local people who understand the local context and needs of the population. It is hoped that NHS D&G will welcome this approach, which is felt to be in keeping with the spirit and the aims of the latest policy guidance from the Scottish Government.

The community hospitals are clearly providing a valuable service currently and the quality of care is greatly appreciated within the community. Keep Watch has an objective of reviewing the role and potential of the community hospital with all stakeholders, and then undertaking a monitoring role so that the impact of any changes can be measured. It is hoped that through their efforts that local people can have a say in their health services, and that a more collaborative way of working is developed for the future.

It is understood that Keep watch intend to consult with the community regarding the contents of this report and its recommendations. In particular, Keep Watch is considering asking the community about the level of engagement that they would consider.

Discussions are being held within the community about how the options may be framed with regard to the level of community engagement and responsibility. The following represents the discussion on the wording to date, and this wording is expected to be further refined.

Draft Options

a) Do nothing and place confidence in the new strategy and policy to deliver an appropriate service

b) Respond to requests to contribute to the health board as it sets the agenda and creates local community hospital service plans

c) Take the initiative and through active participation in the locality planning structure, set the agenda and co-produce local community hospital service plans.

Acknowledgements

Thank you to those that gave their time and provided information to this study. In particular Dr Alastair Noble GP (retired) in Nairn and advisor to the Scottish Government, Frances Smith Scottish Association of Community Hospitals and Barbara Moore Community Hospitals Association England and Wales.

References

Aaraas, I. (1998) “General Practitioner Hospitals: Use and Usefulness.” Norway: Institute of Community Medicine, University of Tromso, Norway.

Ahgren, B. (2003) "Chain of care development in Sweden: results of a national study." Int J Integr Care Vol. 3 October 7th 2003

Atun, R. (2004) "What are the Advantages & Disadvantages of Restructuring a Health Care System to be more focused on Primary Care Services." Health Evidence Network, World Health Organisation.

Charante E.M., Hartman, E., Yzermans,J., Voogt, E., Klazinga, N., Bindels, P. (2004) “The first general practitioner hospital in the Netherlands: towards a new form of integrated care?” Scandinavian Journal of Primary Health Care 22(1) March 2004:38-43

Foote, C. and Stanners, C. (2002) “Integrating Care for Older People: New Care for Old - A Systems Approach” London & Philadelphia: Jessica Kingsley Publishers.

Garasen, H., Windspoll, R. and Johnsen, R. (2007) "Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: a randomised controlled trial." BMC Public Health 7:68.

Gesler, W. (2003) “Healing Places.” Oxford: Rowman & Littlefield Publishers.

Grant, J.A. (1984) "Contribution of General Practitioner Hospitals in Scotland." British Medical Journal (Clin Res Ed) 288(6427):1366-1368.

Green, J., Young, J., Forster, A., Mallinder, K., Bogle, S., Lowson, K. and Small, N. (2005) "Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial." Br Med J 331(7512):317-322.

Haynes, R.M. and Bentham, C.G. (1979) “Community Hospitals & Rural Accessibility.” Farnborough : Saxon House.

Heaney, D., Black, C., O'Donnell, C. A., Stark, C. and van Teijlingen, E. (2006) "Community hospitals--the place of local service provision in a modernising NHS: an integrative thematic literature review." BMC Public Health 6:309.

Higgins, J. (1993) "The Future of Small Hospitals in Britain." Institute for Health Policy Studies, Occasional Paper, University of Southampton.

Leutz, W. (1999) "Five Laws for Integrating Medical and Social Services: Lessons from the United States and the United Kingdom." The Millbank Quarterly (771):77-110.

NHS Dumfries & Galloway March 2011 “Change Programme “Putting You First”
Liddell, R. W. (1994) "Community hospitals in the new NHS." Br Med J 309(6946):56-57.

O'Reilly, J., Lowson, K., Green, J., Young, J. B. and Forster, A. (2008) "Post-acute care for older people in community hospitals--a cost-effectiveness analysis within a multi-centre randomised controlled trial." Age and Ageing 37(5):513-520.

Ritchie, L. (1996) "Community Hospitals in Scotland - Promoting Progress." Aberdeen: University of Aberdeen.

Rose, V. (1975) "The Cottage Hospital." Nursing Mirror July 10th 1975 :65-67.

Seamark, D., Moore, B., Tucker, H., Church, J. and Seamark, C. (2001) "Community hospitals for the new millennium." Br J Gen Pract 51(463):125-127.

Small, Neil., Green, J., Spink, J., Forster, A., Lowson, K. and Young, J.(2007) "The patient experience of community hospital - the process of care as a determinant of satisfaction." Journal of Evaluation in Clinical Practice: 95-101.

Stevenson, B. 2010 "Study Of Community Health Partnerships" Scottish Government Social Research

The Christie Commission Report June 2011 "Commission on the future delivery of public services"

The Scottish Government (2012) "Integration of Adult Health and Social Care in Scotland – Consultation on Proposals"

The Scottish Government (2012) "Community Hospitals Strategy Refresh"

Tucker, H. (2006) "Integrating Care in Community Hospitals." Journal of Integrated Care 14(6) December 2006 :3-10.

Tucker, H. (2010) "Integrating Care in Norfolk - Progress of a National Pilot" Journal of Integrated Care 18 (1)

Tucker, H. (2008) "Profiling Community Hospitals in England 1998- 2008." Community Hospitals Association: Department of Health and Community Health Partnership. http://www.communityhealthpartnerships.co.uk/index.php?ob=1&id=321

Tucker, H., Morgan , P. (2006) *Developing a future locally* A Resource Document - A Report on behalf of the Joint League of Friends of the Community Hospitals of North Cumbria

WHO (1978) "The Alma-Ata conference on primary health care." WHO Chron 32(11):409-430.
Young, J., Forster, A. and Green J. (2003) "An Estimate of Post-Acute Intermediate are Need in an Elderly Care Department for Older People." Health & Social Care in the Community 11(3):229-231.

Young, J., Green. J., Forster, A., Small, N., Lowson, K., Bogle, S., George, J., Heseltine, D. and Jayasuriya, T. (2007) "Postacute care for older people in community hospitals: A Multicenter Randomised Controlled Trial." JAGS 55(12) December 2007: 1995-2002

Young, J and Stevenson, J. (2006) "Intermediate Care in England: where next?" Age and Ageing 35:339-341.

Young, J. and Donaldson, K. (2001) "Community Hospitals and Older People." Age and Ageing . 2001 Aug; 30 Suppl 3:7-10.

Appendix A Notes from a Visit to Moffat Hospital

Address: Moffat Hospital, Holmend, Moffat, DG10 9JY Tel: 01683 220031

Senior Charge Nurse - Elizabeth Shannon - liz.shannon@nhs.net

Services

Inpatient Beds – 12

- 7 GP beds and 5 Consultant beds – although beds used flexibly according to need
- Admission for adults aged 16 years and over
- Have 3 single rooms, the rest shared accommodation
- Average 70% to 75% occupancy (typically 8-10 patients out of 12).
- %. In the year 2010-2011 it was recorded as 75% [2] For January to December 2011 the average occupancy was 67% [3]
- The hospital used to have 15 beds – reduced numbers because of occupancy levels
- Admissions direct from the community or transferred from hospital
- Reason for admission includes rehabilitation (slow stream), end of life care, postoperative care, blood transfusions, acute care etc
- Patients in hospital and in the community discussed at a fortnightly Multi Disciplinary Team (MDT) meeting – (formerly Primary Assessment Team (PAT)) involving GPs, social workers, nurses and Allied Health Professionals (AHPs). There is also a weekly meeting with Occupational Therapist.

Day Hospital

- Attendances on two days a week.
- Offer assessment, stimulation (art work), exercise (Wii and chair exercises) and social support

[2] Source: Dumfries and Galloway Health Board Bed Modelling Presentation

[3] Source: Charge Nurse Moffat Hospital

- There is interest in holding a day service for people with Alzheimers

Minor Injuries Unit

- The service is open out-of-hours (evenings, nights and weekends), with patients attending their GP surgery during week days. It is understood that some patients attend during the day in the week.
- Attendance criteria is that patients are 12 years and over
- Patients are encouraged to call NHS24 initially, and the majority of patients do this.
- Nurse-led service, with GPs attending if required.
- Rates of attendance average 7 a month, and for Jan-Dec 2011 totalled 84[4].
- The MIU is staffed by the community hospital nurses working on the ward, and it is understood that they will attend to patients presenting and requiring attention, and will refer patients on as appropriate.

Physiotherapy

- Available 4 days a week for in patients and community patients
- Self-referral

OT

- Visiting OT who is part of the rehabilitation team
- Carries out home visits

Podiatry

- 4 days a week – podiatrist and trained nursing auxiliary as assistant podiatrist

Clinics

- Consultant medical
- Consultant surgical

[4] Source: Charge Nurse Moffat Hospital

- Alcohol counselling
- Diabetic retinopathy
- Optometry
- Audiology
- Ante-natal and post-natal
- Pre-operative assessment
- CAMHS Child and Adult Mental Health Services
- Minor surgery – dermatology cryotherapy liquid nitrogen treatments
- Social work – child protection
- Drug treatments (IVF etc)
- Phlebotomy
- Dressings
- Health Visitor – baby massage and breast feeding
- "Hale and Hearty" cardiac rehab, and the "Huffin Puffin Club" patient group

Facilities

- Community Staff Base – Health Visitors, District Nurse, Marie Curie service
- Catering – freshly cooked breakfasts and lunches, and cook chill suppers

Innovations

- Integrated nursing teams (pilot)

Integrated nursing teams, whereby community nurses and community hospital nurses are managed together. Hospital staff can be seconded into the community, and acquire the skills and experience to be able to work not only in the hospital but also in the community. It is hoped that in future, community staff may experience working in the hospital. The aim is to develop a nursing resource that can work flexibly to support people in their own homes as well as in the community hospital.

- Integrated Diabetic Day

The GPs initiate a diabetic day, whereby those practitioners supporting people with diabetes can work together. This includes the GPs, consultant staff, nutritionist, and podiatrist.

- Releasing Time to Care

The staff are working through the “Productive Community Hospital” programme to improve quality and efficiency, and enable nursing staff to optimise their time with patients. The community nursing staff are also working on this in the “Productive Community Services” programme.

- Rapid Treatment Programme

The staff are about to implement a trial for an early warning system for patients who are at risk of deterioration.

- Health Promotion

Nurses have given talks in schools on health promotion. Annually, pre-school children are invited into the hospital for a tour and an opportunity to become familiar with the service.

- E-pen

The district nurses are trialling an “e-pen” which will enable them to write in the patient’s notes in the home, then plug the pen into their PC to transfer data. Patient information would therefore be timely.

- Multi-Disciplinary Team (PAT. Primary Assessment Team)

Practitioners meet weekly to discuss and plan care for patients in the hospital and the community. Attendance may include GPs, community hospital nurses, community nurses, social workers, physio, OT and home care staff.

- Excellence in Care Awards

Staff in Moffat hospital has won awards from the Health Board for quality care

- End of Life Care

Have support from Macmillan nurses

- League of Friends

Generous donations of equipment etc.

Issues

- Night cover – 2 nurses on duty at night for the inpatients and also MIU. The nurse in charge will increase the staffing to 3 if the needs and dependency of the patients require this level of support. Have CCTV and red phone. However there is no porter onsite and police are not local. So concern that staff may be at risk, particularly for attenders at MIU.

- Emergency and Urgent service – the local ambulance station closed and there is local concern about the time taken to attend emergencies. Support for exploring options such as First Response Service.

- Not a pathfinder hospital (unlike Annan) but may become one
- Would like to be able to do IV – but an issue with training and keeping skills up

Development

- Potential to increase the days that the Day Unit is open
- Would like more single beds – for flexibility and to offer single rooms for end of life care and for barrier nursing for patients with infections.
- Would like the community geriatrician to hold clinics

Acknowledgment

This profile has been compiled by Helen Tucker, following a visit to Moffat Hospital and an interview with Liz Shannon the Senior Charge Nurse. Thank you to the staff for accommodating the visit.

Appendix B Notes from a Visit to Thornhill Hospital

Address: Thornhill Hospital, Townhead Street, Thornhill, DG3 5AA Tel: 01848 330205

Senior Charge Nurse: Jacqui Swan who is the site manager and who manages community hospital nurses and community nurses

Services

Inpatient Beds – 13

Beds are used flexibly - admissions direct from the community or transferred from hospital

Admission for adults aged 16 years and over

Have 1 single room, 1 x 6 bed male ward and 1 x 6 bed female ward

Average 60% occupancy

Reason for admission includes rehabilitation, end of life care, post-operative care, people with complex care needs etc.

Patients encouraged to sit in the day area during the day

Patients in hospital and in the community discussed at a weekly MDT meeting – Primary Assessment Team (PAT) involving GPs, social workers, nurses and therapists.

Medical cover primarily by Dr Khumar from Thornhill Health Centre

Prior to the introduction of "Out of Hours" services GP's in Mid and Upper Nithsdale (3 Practices) provided 24 hour and weekend On Call services, on a rotational basis, and were based at Thornhill Hospital

Day Unit/Rehabilitation

No longer used for day attendances

There is tender out for a social care day service with 10 places for one day a week

Building used for therapies, clinics and community meetings such as:

- Ante-Natal and Post-Natal
- Parent craft
- Eye clinic for children

- Cardiac Rehabilitation
- Speech and Language Therapists outpatients
- Smoking Matters meetings
- Alcoholics Anonymous
- Continence Service
- Training – community hospital and community staff
- District nurses meetings

Physiotherapy

2 days a week for in patients and community patients

OT

Visiting OT for 2 days a week and carries out home visits

Clinics held in Health Centre

- Psychiatry
- Psychology
- Urology
- Smoking Matters
- Child Health and Well Baby clinics

Facilities

Mortuary – 2 fridges and chapel/viewing area. A facility for the hospital and the town.

Catering – freshly cooked breakfasts and lunches, and cook chill suppers

Innovations

- Releasing Time to Care

The staff are working through the “Productive Community Hospital” programme to improve quality and efficiency, and enable nursing staff to optimise their time with patients. The community nursing staff are also working on this in the “Productive Community Services” programme.

- Primary Assessment Team

Practitioners meet weekly to discuss and plan care for patients in the hospital and the community. Attendance may include GPs, community hospital nurses, community nurses, social workers, physio, OT and home care staff.

- Excellence in Care Awards

Staff in Thornhill hospital have been nominated for awards from the Health Board for quality care

- End of Life Care

Have support from Macmillan nurses

- Specialist Support

Have support from nurse specialists (such as stoma nurse, heart failure nurse etc) as well as link nurses (such as for tissue viability).

- League of Friends

Funded equipment, and built single room

Issues

- Space constraints within the ward – all areas and lack of storage
- Accommodation does not meet current disability access standards, and access to the ward day room is through male ward
- Need more private space for patients and relatives
- Under use of the Day Unit/Rehabilitation
- A recognition of the wide geographical area served – remote and rural. Including Auldgirth, Penpont, Keir, Tynron, Moniaive, Dunscore, Carronbridge, Durisdeer, Mennock, Sanquhar, Kirconnel and Kelloholm.
- It is very difficult to provide home care when people go home, as it is so rural. Some carers refuse to go to very remote houses. Some patients have their care provided by two agencies as they do not have enough carers on their books.
- Plans for developing the site as an integrated facility were produced in 1984 by Cameron Medical Services

- Would like to be able to do IV – but an issue with training and keeping skills up
- Used to have 15 beds, but number of beds reduced
- NHS now purchases intermediate and rehabilitation beds in a private facility (Allanbank) which is adjacent to Dumfries & Galloway Royal Infirmary. (29 miles from Kirkconnel in Upper Nithsdale)

Development

- Potential to utilise Day Unit building more fully
- Would like to explore the case for a day hospital for one day a week
- Might be a case for clinics such as a leg ulcer clinic (have a doplar on the ward)
- Would like to be able to offer IV therapy and blood transfusions
- Might be scope for extending the ward area – perhaps fill in the patio area
- Potential to join buildings and integrate services and staff more fully
- Space also needed in Health Centre
- It is understood that within the grounds is a Scottish Ambulance station and a detached cottage, and that there is additional land owned by NHS D&G which could allow for further development

Acknowledgment

This profile has been compiled by Helen Tucker, following a visit to Thornhill Hospital and an interview with Jacqui Swann the Senior Charge Nurse. Thank you to the staff for accommodating the visit.

Appendix C Health Prevalence in Dumfries and Galloway

The QOF indicators show that in almost every condition, D&G has a higher prevalence than Scotland overall. The table below shows the high levels of hypertension, obesity, heart disease and diabetes in particular. There is also a high incidence of depression. Long term conditions such as chronic obstructive pulmonary disease and stroke are also higher than the national average.

The role of the community hospitals in health promotion and early intervention and monitoring may be explored, as well as their role in diagnosis and treatment, and in the support of patients, carers and families.

Conditions	QOF register	Dumfries & Galloway per 100 patients	Scotland per 100 patients
Hypertension	24,009	15.5	13.5
Depression 2 (of 2): new diagnosis of depression	13,900	8.9	9.0
Obesity	12,813	8.2	7.7
Asthma	9,508	6.1	5.9
CHD (Coronary Heart Disease)	8,222	5.3	4.4
Diabetes	7,638	4.9	4.3
Hypothyroidism	5,672	3.7	3.6
CKD (Chronic Kidney Disease)	4,826	3.1	3.3
Stroke & Transient Ischaemic Attack (TIA)	3,756	2.4	2.1
COPD (Chronic Obstructive Pulmonary Disease)	3,834	2.5	2.0
Cancer	3,208	2.1	1.7
Atrial Fibrillation	2,746	1.8	1.4
Dementia	1,430	0.9	0.7
Heart Failure	1,418	0.9	0.8
Mental Health	1,294	0.8	0.8
Epilepsy	1,126	0.7	0.7
LVD (Left Ventricular Dysfunction)	781	0.5	0.6

http://www.scotland.gov.uk/Resource/0038/00386110.xls

Appendix D Moffat and Thornhill Hospital Activity Statistics

This information was supplied by the Health Board under Freedom of Information Request.

Moffat Hospital

Inpatients	**2010 to 2011**	**2009 to 2010**	**2008 to 2009**	**2007 to 2008**	**2006 to 2007**
Number of beds	12	12	12	12	12
Available bed days	4380	4380	4380	4380	4380
Occupied bed days	3288	3394	3265	2780	3065
Bed occupancy %	75.1%	77.5%	74.5%	63.5%	70.0%
Length of Stay	26.3	25.7	23.8	23.0	21.7
Number of admissions	125	132	137	121	141

Minor Injuries	**2010 to 2011**	**2009 to 2010**	**2008 to 2009**	**2007 to 2008**
Attendances	240	329	159	75 (10 months)

Day Hospital	**2010 to 2011**	**2009 to 2010**	**2008 to 2009**	**2007 to 2008**	**2006 to 2007**
Available places	1000	980	1020	1000	980
Attendances	552	593	563	538	698

Out-Patient Clinic	**2010 to 2011**	**2009 to 2010**	**2008 to 2009**	**2007 to 2008**	**2006 to 2007**
New patients	215	141	144	80	67
Follow up patients	195	258	117	109	114
Total Attendances	410	399	261	189	181

Thornhill Hospital

In-Patients	**2010 to 2011**	**2009 to 2010**	**2008 to 2009**	**2007 to 2008**	**2006 to 2007**
Number of beds	13	13	13	13	13
Available bed days	4745	4745	4745	4745	4745
Occupied bed days	3196	3580	2708	2978	3493
Bed occupancy %	67.4%	75.4%	57.1%	62.8%	73.6%
Length of Stay	28.0	38.1	36.1	41.4	46.6
Number of admissions	114	94	75	72	75

Appendix E Consultant

Helen Tucker is a researcher and consultant, having worked in health care, social care and housing for nearly 30 years. Helen is based in the medical school of the University of Warwick, and is completing her PhD in health sciences. Her thesis is on integrated care and focuses on case studies that include community hospitals and community teams. She is currently working within a Department of Health programme to develop integrated care, and is supporting an Integrated Care Organisation (ICO) in Norfolk over a two year period as they promote integration between primary care, community health services and social care services. Helen has been commissioned to work in Scotland in the past, including service and hospital development in Nairn and reviewing community hospital services in Grampian. Helen has worked with Leagues of Friends for community hospitals, campaign groups and GPs. A commission in Rye, East Sussex challenged a closure proposal for the community hospital and resulted in the hospital being owned and developed by local people. She has also been supporting communities in North Norfolk, who have also formed a charity for their hospital. Helen worked with Leagues of Friends and GPs in Cumbria to assist with developing a strategy for community hospitals that helped to demonstrate their value and potential. Helen works predominantly in primary and community care services. She is Vice President of the Community Hospitals Association for England and Wales.

Helen Tucker Helen.tucker@tiscali.co.uk

Mobile: 07831485210 Landline: 00441379898548