NHS
South West
Clinical Senate

## Clinical Senate Council Meeting

Thursday 19th September 2019
South West Clinical Senate Council: Community settings of care

**Question**

***What is the future role of community hospitals in the South West and how should they be configured to meet population health needs, taking into consideration location, size, beds, services and staffing?***

**Overview**

This topic was first brought to the South West Clinical Senate by Somerset Sustainability and Transformation Partnership (STP) who are looking to make transformational changes to community services and settings of care in their area as part of their wider Fit for My Future Programme. Many of the other STPs and ICS' in the South West are also considering how they make best use of community facilities and were keen for the Clinical Senate to revisit this topic. Previously in 2014 and 2016 the Clinical Senate shared recommendations around community services transformation as well as previously conducting some formal clinical reviews of large-scale change in this area. However, the topic remains a contentious one with much variation in how the 70+ community hospitals in the South West are utilised, as well as there being significant public resistance to changes to services delivered from these facilities.

Somerset specifically has 13 community hospitals (of which 2 are temporarily closed due to staffing levels) with 190 community hospital beds currently open but maintaining staffing levels within small locally based sites has been one of its main challenges. For example, its registered nurse workforce currently has vacancy rates of 40% and staffing levels across current MIU provision are challenging with temporary daily closures taking place.

Another key challenge for Somerset, which is not dissimilar to other areas in the South West, is the estate itself with 5 hospitals in Somerset built pre-1948, of which 2 are rated as Band C under the NHS Estate Code. This means they are operational but require major repair or replacement to bring them up to Band B (sound and operationally safe with only minor deterioration). Therefore, the clinical advice from Council members hopes to establish how best to use these (and all community hospitals across the South West) and to explore ways that these buildings can become enablers for the provision of population-based healthcare rather than the driver of what is provided within a community. In order to inform these recommendations, the South West Clinical Senate Council brought together NHS Benchmarking, NHS Devon Clinical Commissioning Group (CCG), NHS Kernow CCG, Sirona, the Royal Devon and Exeter NHS Foundation Trust and the Citizens' Jury from Gloucestershire STP to explore innovative ways in which intermediate care is being delivered across the South West, and the contribution made by community hospitals.

**Evidence**

In 2014, the Clinical Senate explored possible criteria to be used to determine suitability for discharge from acute units to community settings (including normal place of residence) and in 2016, the Clinical Senate

went on to develop a set of generic principles for community transformation as a resource for Clinical Commissioning Groups (CCG). It was found that there is broad support for well thought through models of community reconfiguration moving towards an increase in place-based care. This is in line with the policy direction set out by Five Year Forward View.

Research has highlighted, however, that there is a lack of evidence around community hospitals specifically in terms of their role, function and value leading to the National Institute for Health Research concluding 'neither investment in nor closure of community hospitals has been informed by authoritative guidance'[1]. Therefore, the Clinical Senate relied upon evidence from NHS Benchmarking's National Audit of Intermediate Care (NAIC) (2018) and case studies from across the region and nationally to inform its response to the question posed.

The Clinical Senate heard from Devon CCG who, as part of their "Enhanced" Intermediate Care model, closed the wards in 5 of 9 community hospitals and opened 9 Health and Wellbeing Hubs in their place. The 4 remaining community hospitals were rationalised as all having the same offer with specialist OP clinics, inpatient beds, a rehabilitation gym and regular visits from GPs and daily multi-disciplinary team (MDT) meetings being held on-site involving the voluntary sector. The Health and Wellbeing Hubs are supported by a health and wellbeing team, the voluntary sector, wellbeing coordinators and community clinics.

As a result of these changes, Devon reported a reduction in the length of stay in its community hospitals from 14 days in 2015 to 11 days in 2018 and despite shutting half of its inpatient beds, only reduced admissions by 500 from 3,500 to 3,000. Its admissions per bed per year went from an average of 18.6 admissions per bed in 2015 to 31.5 admissions per bed in 2018 and they saw a significant reduction in the number of patients transferred back to community hospitals 3 months after discharge.

The Clinical Senate also heard from Sirona about its Integrated Care Approach which won the Primary Care Innovation Award at the 2017 Healthcare Transformation Awards for its focus (similarly to Devon) on practice-based multi-disciplinary team (MDT) working and coordinating health and care services to support patients at risk of hospital admission. The model featured Primary Care Networks (PCNs), Locality Hubs, Integrated Locality Teams (ILTs), Acute and Reactive Care and specialist advice and support. Also highlighted as an integral part of their teams was dedicated administrative support in the form of ward clerks who can ensure processes are followed.

As a result of this integrated approach, Sirona reported that it was extremely effective at preventing the type of crises that can lead to emergency hospital admissions as there was no increase in the number of South Gloucestershire residents attending a hospital Emergency Department between April 2016 and January 2017, compared to the previous year. This is despite an increase of around 5% nationally during this period.

Sirona also explained the implementation of treatment chairs in its 3 remaining community hospitals in Bristol, North Somerset and South Gloucestershire (BNSSG). Run by GPs with a Special Interest (GPSIs), the treatment chairs aim to source packages of care for patients to support them in their own homes and are available to GPs, the South West Ambulance Service Trust (SWAST) and emergency care practitioners. This type of ambulatory care provision enables same day assessment referral and near point testing.

[1] *Deborah Davidson, Angela Ellis Paine, Jon Glasby, Iestyn Williams, Helen Tucker, Tessa Crilly, John Crilly, Nick Le Mesurier, John Mohan, Daiga Kamerade, David Seamark and Jan : Analysis of the profile, characteristics, patient experience and community value of community hospitals: a multimethod study HEALTH SERVICES AND DELIVERY RESEARCH VOLUME 7 ISSUE 1 January 2019*

In terms of bed numbers, as part of the South West Clinical Senate's clinical review of Devon's Reconfiguration of Community Services in 2016, it was recommended that '16 beds are the minimum in a community hospital, staffed by 2 registered nurses' (and increasing in multiples of 8)[2] while NHS Benchmarking's National Audit of Intermediate Care (NAIC) (2018) recommends 23 beds should be commissioned per 100,000 people.

The Clinical Senate heard evidence that hospital beds may not always be the best place for a patient to receive care. Devon found in their 2012 Scrutiny Review that 40% of those in community hospitals were fit for discharge. This was further highlighted by the NAIC who explained that new models of community care should aim to expand and enhance Intermediate Care services with the aims of managing more complex patients in the community and providing more home-based care and short-term care placements.
The importance of engagement with the local community when considering the future of community hospitals was highlighted as crucial during the meeting. Devon CCG went on to describe the value of using trusted people in the community to deliver a clear message and that nurses and GPs should, along with the rest of the workforce affected, be briefed on a strong, single message to provide to the public. An innovative example of public engagement was provided by the Gloucestershire STP and their Citizens' Jury, recruiting people in the Forest of Dean to help them decide on a preferred location for their community hospital.

The Clinical Senate's most recent literature review and ongoing consideration of evidence around community settings of care suggests that key themes when addressing community service transformations include concerns about workforce, the importance of considering an ageing population in the South West, reducing costs and maintaining skills and safe provision of care. As highlighted in the King's Fund, Reimagining Community Services publication, the Clinical Senate understands that community service transformation needs to focus on a system-wide approach that links primary and secondary care with community services thus 'reducing fragmentation in service delivery.' Given that there is no single model of community provision, in the 3 example models presented to the Clinical Senate during this meeting all demonstrated a flexible needs-based approach which relied on multi-disciplinary teams who included primary, secondary, social and voluntary care meeting regularly in a community setting and had the ability to evolve. This links to evidence provided during the meeting emphasising the importance of services striving to make independent providers part of the locality, establishing clear links with Primary Care Networks (PCNs) and emerging Integrated Care Systems (ICS's).

**Recommendations**

The South West Clinical Senate Council recognises that community hospitals are not the defining feature of good quality community care and STPs/ICS' should instead be focusing on establishing clearly defined pathways of care that are responsive to the needs of the patients in their area. Community hospitals may or may not have a role as an enabler to deliver these clinical pathways.

The Clinical Senate Council recommends that innovative use of hospital buildings, whether in an urban or rural setting, can create a unique opportunity to co-locate services and support the delivery of seamless integrated care.

*2 South West Clinical Senate, Stage Two Clinical Review Report: Clinical Review of South Devon and Torbay CCG Community Services Transformation*

Community hospitals are not a service in themselves but should be enablers for the delivery of responsive integrated intermediate care services. As a consequence, the functional value of a community hospital will be dependent on the model of intermediate care that is being developed in each locality.

Key recommendations are as follows:

1. Community hospital buildings that are appropriately designed and maintained can be an invaluable asset supporting the co-location of services and creating health and wellbeing 'hubs' providing health and social care that is responsive to the needs of the populations in which they are located.

2. It is unhelpful to attempt to prescribe the services that could or should be delivered from a community hospital. Their contribution to local health and social services will be responsive to the needs of the population they serve and the local models of intermediate care.

3. The services delivered from community hospitals will change over time as health and social care services develop and needs of local populations change. As a consequence, any new community facilities should be designed around flexible spaces that can be repurposed if necessary and capable of being used by different services at different times or days of the week. They should be seen as a 7 day, actively used local facility.

4. Transport links to vibrant, busy community hospitals are key and should be prioritised in travel plans

5. Vibrant, busy community facilities are great places to work and develop and should make recruitment and retention easier and the services more sustainable. Space and environments for teaching and training should be considered in any design.

6. There should be acknowledged that some current community hospitals are too small, in a poor state of repair, in inappropriate locations, or unattractive workplaces due to the scope of services delivered or the physical environment. In these circumstances there should be public debate to determine how best to deliver intermediate care in these locations, recognising that not all models require a community hospital.

7. Community hospitals do not always need to contain inpatient beds but where they exist they need to be able to safely, reliably and efficiently staffed. The minimum number of beds in any single location is 16.[2]

8. Local communities often invest considerable symbolic and cultural value in their community hospital Public engagement is crucial when proposing any changes to community hospitals to allow the public to understand how access to services will be maintained or improved. STP / ICSs may wish to consider using a Citizens' Jury model or something similar once clearly defined options are available.

9. The emergence of Integrated Care Systems provides an opportunity for community facilities to be seen as an asset for the whole of the system, including the emerging Primary Care Networks with their focus on multidisciplinary working.

10. The utility of community facilities can be greatly enhanced through the use of technology including, imaging, near patient testing, shared information systems and networked technology with specialist centres. This should be positively designed in to any new facilities or refurbishments.

**Next steps**

These recommendations will be used as a reference tool to inform Somerset STP's planning as part of their Fit for my Future programme. They will also be shared with Intermediate Care providers, CCGs, STPs, ICSs and NHS England in the South West as well as with other Senates nationally so they can be considered in future planning arrangements for community hospitals in the region.

**Pre Reading**

1. Community hospitals and their services in the NHS: identifying transferable learning from international developments –scoping review, systematic review, country reports and case studies, NIHR, June 2017 https://njl-admin.nihr.ac.uk/document/download/2010674

2. South West Clinical Senate Council, principles for community reconfiguration, 2016 http://www.swsenate.org.uk/wp/wp-content/uploads/2014/01/Advice-10.11.16-final-1.pdf

3. South West Clinical Senate Council, Discharge from Acute Units, 2014 http://www.swsenate.org.uk/wp/wp-content/uploads/2014/12/recommendations-Discharge-from-Acute-Units.pdf

4. South West Clinical Senate Council, UTCs, 2014

http://www.swsenate.org.uk/wp/wp-content/uploads/2019/03/2018-11-29-Senate-Recommendations-UTCs-FINAL.pdf

5. 2018 Adult Inpatient Survey, CQC, June 2019 https://www.patientlibrary.net/tempgen/196798.pdf

6. King's Fund, 2018, Reimagining Community Services – https://www.kingsfund.org.uk/publications/community-services-assets

NAIC Benchmarking report 2018 **https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2018/2.%20NAIC%202018findings%20FINAL.pdf**

**Shared as Attachments**

NHS Right Care frailty toolkit, 2019
Making the most of Community Services in Somerset, SWCSU, 2014
South West Hospital Spells Map, South West Clinical Senate, 2014
Discharge to Assess Case Study, RCP, 2017
Stage 2 Clinical Review Report South Devon and Torbay CCG Community Hospitals Transformation, South West Clinical Senate, 2016