COMMUNITY HOSPITALS STRATEGY REFRESH

FOREWORD BY THE CABINET SECRETARY FOR HEALTH WELLBEING AND CITIES STRATEGY

Community hospitals in Scotland occupy a unique niche in the Scottish health and social care landscape. Furthermore they have a rich cultural heritage, with many of the services and facilities pre-dating the creation of the NHS. Since their formation, community hospitals have continually evolved and today they are more important than ever in providing both health and social care services for local communities.

The Scottish Government's vision for the future provision of health services in Scotland centres upon the *Quality Strategy* (2010) and the six Quality Ambitions: *Person Centred*; *Safe*; *Effective*; *Efficient*; *Equitable*; and *Timely*. At the heart of delivering these quality ambitions are the plans to integrate health and social care. A key part of integration is continuing to drive forward the work in shifting the balance of care from large institutions into community settings. As such, it is envisaged that community hospitals will play a vital role in delivering a significant change in the provision of both health and social care in Scotland.

This strategy refresh develops the work started by the *Developing Community Hospitals: A Strategy for Scotland* (2006) by providing a new direction and fresh focus for these valuable resources. The strategy delivers a bright vision for the future development of community hospitals through:

- ensuring that people who utilise community hospitals are the centre of care pathways;
- providing provision for the development of the workforce in community hospitals; and
- identifying how community hospitals can de developed to better provide for local communities.

The Scottish Government will be promoting the development of community hospitals and community hospital staff through the creation of an Improvement Network and a short life working group. The Improvement Network will be developed in collaboration with community hospitals and hosted by NHS National Education Scotland. It will provide a portal for development opportunities for community hospital staff. The working group will provide support for the development of the clinical side of community hospitals.

In addition to the working group and the Improvement Network, a set of actions has been drawn together in this strategy that will be taken forward by NHS Boards. The outcomes of these actions will provide the blueprints for NHS Boards and Community Health Partnerships to not only develop modern, locally sustainable community hospital services that are responsive to local community needs, but to also enable community hospitals to fulfil a valuable role in a modern Scottish health and social care service.

Community hospitals will remain a key resource for the people of Scotland which must be refocused to meet the changing needs of the population. This strategy refresh outlines how community hospitals, NHS Boards and the Scottish Government can best achieve the redevelopment of our valuable community hospitals in order to deliver a person centred, safe, effective, efficient, equitable and timely service to the community.

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Contents

Executive Summary

Section 1:
Building a better picture of care provision
- What Are Community Hospitals?
- What Do Community Hospitals Do?
    - (a) Rehabilitation in a community hospital
    - (b) Community services, diagnostics and outpatient services
- How can Community Hospitals Develop to Improve Patient Outcomes?

Section 2:
Delivering better outcomes for patients
- Putting Quality at the Heart of What We Do
- Demographic Change
- Integration of Health and Social Care
- Community Based Services
- Managing Patient Pathways in the Community
- Working with Secondary Care
- Rehabilitation, Enablement and Intermediate Care
- Specialising
- Assessing the Best Use of Resources
- Broadening the Services Available
- Working With Communities
- Developing the Workforce

Section 3:
Delivering the changes
The Scottish Government
- NHS Board Actions
- Additional Support and Programmes of Work
- The Scottish Association of Community Hospitals

Section 4:
Reference List
- Key Strategies
- Academic References
- Web References
- Data Sources

Annex 1: List of Community Hospitals in Scotland
Annex 2: Specialities in Community Hospitals in Scotland

Executive Summary

1. Since 'Developing Community Hospitals: A Strategy for Scotland'[1] was published in December 2006 there have been significant changes in the policy landscape and the challenges that face NHS Scotland and its partners. The pressures of demographic change and technological advances have expanded the range of options that may be provided in a community setting. There is a greater opportunity than ever before to provide more integrated community services that anticipate and address the needs of those most at risk, and community hospitals will sit at the heart of this for many areas.

2. A common feature across the community hospital estate is variability. They differ in size, age, function, staffing, accessibility, condition and links with their local community. This presents opportunities to utilise the variability to develop community hospitals to match the needs of the local populations and support the broader challenges faced by NHS Scotland and its partners. The 'Healthcare Quality Strategy for NHS Scotland'[2] provides the framework for the ongoing development of community hospitals in Scotland as part of an integrated health and social care system.

3. This document builds on the 'Developing Community Hospitals: A Strategy for Scotland' and reflects on how current strategic priorities should influence the vision for community hospitals. Planning services should reflect key policy drivers and deliver high quality, accessible and sustainable care as locally as possible to where the person, their family and/or their carers live. It is the tenets within the broader policy agendas noted below that will provide direction for community hospital development and ensure that they play their full part in improving outcomes for patients across Scotland. This document connects to:

- Healthcare Quality Strategy for NHS Scotland;
- Reshaping Care for Older People;
- Integration of Health and Social Care;
- Delivering for Remote and Rural Healthcare;
- Intermediate Care Framework;
- Living and Dying Well: A national action plan for palliative care and end of life care in Scotland;
- Scotland's National Dementia Strategy;
- NHS Scotland Efficiency and Productivity Framework for SR10;
- Shifting the Balance of Care;
- AHP Delivery Plan[3].

4. This document seeks to demonstrate, through examples of good practice, how community hospitals can become more effective in the delivery of improved pathways of care, especially with regard to supporting the older population. It is primarily aimed at NHS practitioners from primary, community and secondary care,

[1] Developing Community Hospitals: A strategy for Scotland; Scottish Government; Dec 2006
[2] The Healthcare Quality Strategy for NHS Scotland; Scottish Government; May 2010
[3] AHP Delivery Plan Consultation http://www.scotland.gov.uk/Publications/2012/02/8445

social work teams and managers who work in and with community hospitals but will be of interest to wider stakeholders, such as the public and third sector partners.

5. Community hospitals are well placed to support patients on their journeys of care through the health and care system. They should provide a hub for community services, telehealth and anticipatory care, make most effective use of inpatient and ambulatory services offered locally, including rehabilitation, reablement and specialist dementia and palliative care services. Through the provision of these services, community teams can help to prevent emergency admissions to acute hospitals and will play a significant role in supporting the reduction of hospital delayed discharges from the current maximum wait of six weeks to 14 days by April 2015.

6. Not all community hospitals will be able to provide all of these functions. It is therefore essential that community hospitals are included within local service plans, care pathways and workforce development so that staff and the public are clear about the role of community hospitals and that they are well linked to other appropriate health and social care services.

7. The Scottish Government's commitment to integrating adult health and social care, and the planned 'Intermediate Care Framework'[4], will have significant impact on the care provided by community hospitals, especially their links with care home and home care support. These agendas will require local teams to 'knit' community hospitals into the fabric of local care and support services, ensuring improved outcomes for patients.

8. This re-setting of community hospital priorities may see some facilities expand the clinical services they offer, others specialise in a small number of clinical areas and some reduce their inpatient capacity to support more appropriate community based services. These changes to service provision will require careful planning and the involvement and support of local communities and clinicians is essential to ensure that the right services are developed to match the needs and expectations of the communities they serve.

9. To improve outcomes this document outlines a number of actions that will be taken forward over the next two years. These include:

- The Scottish Government will support NHS National Education Scotland to develop, in consultation with community hospital staff, a national network to facilitate education, sharing of good practice, exchange of knowledge and clinical skills and to provide an improvement forum;

- The Scottish Government will convene a short life working group for community hospitals with a remit to look at the challenges of delivering medical cover, in and out-of-hours within community hospitals;

- NHS Boards will ensure that each community hospital has a clear service plan that identifies its role and maximises its contribution to managing demand and

[4] Intermediate Care Framework, due to be published in 2012, The Scottish Government

delivering outcomes within specified care pathways. These will be agreed with clinical teams from primary and secondary care;

- NHS Boards will review and address the learning needs and improvement capability and capacity of their community hospital workforce, particularly around the care of older people, those with dementia and delirium and the need for rehabilitation, reablement, palliative and end of life care;

- NHS Boards will ensure that Geriatrician, Psycho-geriatrician, Community Paediatricians, Palliative Care, rehabilitation and pharmacy support is embedded within the community to support GP led and shared care inpatient services for older people;

- NHS Boards will ensure that all staff involved in the transfer of patients from acute sites to local community hospitals are fully aware of the differing admissions criteria in place in each facility;

- NHS Boards will ensure that community hospital staff engage with the local community health and care services that might be utilised to support their patients onward care journey;

- NHS Boards and ISD will work together to ensure coding of community hospital facilities reflects their current function, while ensuring that any changes made do not have a negative continuity impact on the data that underpins our HEAT targets and other priorities, or if it does impact that we are well prepared to revise data to keep robustly in-line with the targets;

- NHS Boards will ensure that their ehealth strategies enable IT and telehealth capability at appropriate community hospital sites;

- NHS Boards will ensure that the actions contained within their Property and Asset Management Strategies and infrastructure plans support the delivery of the service plans establishment for their community hospitals;

- NHS Boards should continue to make use of results of the inpatient patient experience survey to support local improvement work including work in community hospitals.

Section 1 – Building a better picture of care provision

What Are Community Hospitals?

10. Community hospitals in Scotland have a rich history. Many of the services and facilities started before the creation of the NHS, funded by local benefactors and often built as fever hospitals or war memorials. They are spread across 11 NHS Boards, providing over 2,900 inpatient beds and over 750,000 outpatient, allied health professional and nurse led appointments[5]. They remain the heart of health services in many rural and remote communities allowing access to more specialised services and inpatient facilities closer to home.

11. There is no official definition for a community hospital in Scotland though the most commonly used is Sir Lewis Ritchie's:

> *'A community hospital is a local hospital, unit or centre providing an appropriate range and format of accessible health care facilities and resources. Medical care is normally led by GPs, in liaison with consultant, nursing and allied health professional colleagues as necessary and may also incorporate consultant long stay beds, primary care nurse-led and midwife services.'*[6]

More recently, many community hospitals have co-located social care practitioners and other staff to facilitate more joined up care for patients and service users. This has included an expansion in co-location with minor injury units and the Scottish Ambulance Service. Co-location has significantly helped to improve joint working across the professions.

12. There is also no definitive list of community hospitals in Scotland though two are widely used and accepted. The first, the official data return gathered by NHS Information Services Division (ISD), lists 58 community hospitals across Scotland. The second, collected by the Scottish Association of Community Hospitals includes a further 34 hospitals (Annex 1). This difference highlights the changing nature of care offered by facilities within the community and the difficulty in categorising community hospitals.

13. Analysis on both lists show similar patterns of variation across the size, the specialties offered, the cost per bed day, length of stay and a range of performance measures used to assess performance of acute facilities. The data analysis exercise also highlighted that there is little or no correlation between these factors on either dataset. One must conclude, that there are significant challenges at looking at comparative data across these variable facilities at a national level[7].

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[5] Information Services Division, SMR00 & SMR01

[6] Richie LD; Community hospitals in Scotland; promoting progress; Aberdeen: Department of General Practice and Primary Care, University of Aberdeen, 1996

[7] Community Hospital Data Paper; Scottish Government. Available on request

14. A study carried out in the UK by Small *et al*[8] compared the philosophies of care between six community hospitals (of varying size, location and age) with four district generals hospitals. The study concluded that:

> *'…there were stated similarities between general hospital and community hospital services but that community hospitals aimed to provide a more homelike style of care (Figure 1). These aspirations were realised to the extent that they were both recognised and appreciated in patient and caregiver interviews. This homelike style of care is an attribute of recognisable importance to patients and one they linked with the promotion of recovery and independence.'*

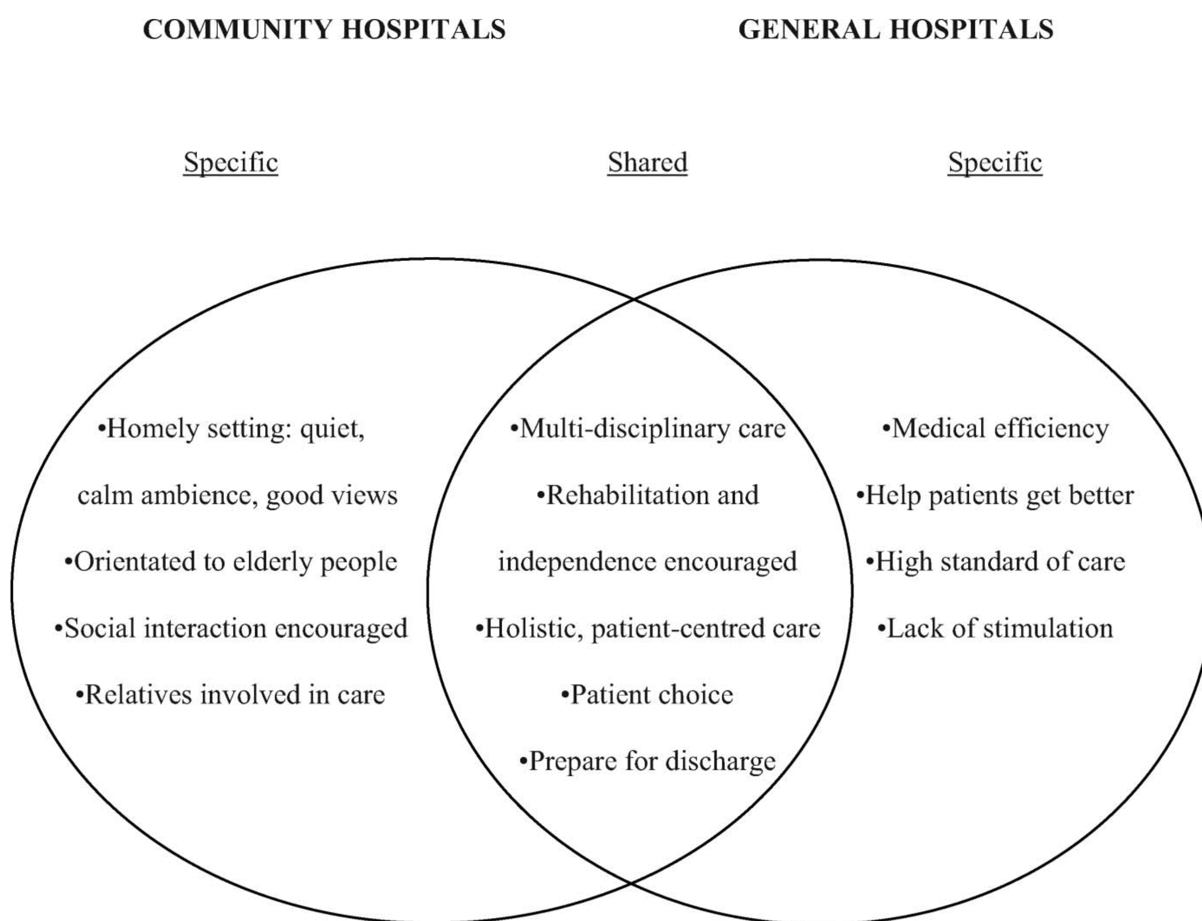

Figure 1 from Small *et al* (2009): Similarities and differences between the philosophies of care of community hospitals and general hospitals. These points were generated from semi-structured interviews with 42 staff from six community hospitals and four district general hospitals.

15. Community hospitals are hard to define, compare and categorise and they have a different philosophy of care when compared to larger hospitals. Each hospital provides a different range of specialist services (see Annex 2), however, it is this flexibility and person centred approach to care that makes community hospitals so

[8] Small *et al* (2009) Post-acute rehabilitation care for older people in community hospitals – Philosophies of care and patients' and caregivers' reported experiences: A qualitative study. *Disability and Rehabilitation*. **31:** 1862-1872.

valuable. In developing the services they provide to improve the health of the local population, we must not lose sight of these factors.

16. They are usually led by local GP practices who provide the clinical leadership and the focus of the services that the community hospital offers. The medical teams' work is underpinned by Nursing, Allied Health Professionals and social work teams who deliver the majority of the care and support to patients. Ensuring that these professionals are supported in these roles and have time to work together will ensure the continuity of care and support that community hospitals need to deliver.

What Do Community Hospitals Do?

17. In simple terms community hospitals have three main functions. First, they support the rehabilitation and recovery of patients after a stay in an acute hospital; second, they provide the specialist end of community services, whether this be co-ordinating care around high risk patients, providing/co-locating services that patients have traditionally had to travel to bigger sites for and beds for clinical specialties (such as palliative care and mental health); third, they provide some diagnostic and out patient services. The majority of community hospitals and the clinical services they provide will see patients in most of these categories.

a. Rehabilitation in a community hospital

18. Patients who have undergone treatment at a major acute site, but are stable and no longer need to receive specialist acute care, can be transferred to a community hospital to continue their rehabilitation before being discharged. This ensures that patients are treated in the most appropriate setting, with the right level of care, are often closer to home for friends and families to visit and is often a more relaxed atmosphere than a major acute site. Transfer to a community hospital frees up specialist beds in acute hospitals ensuring their more efficient use.

19. It is critical that community hospitals understand their contribution to the 'whole system' in terms of patient flow and that they need to be looking to 'pull' those patients who are ready for and will gain from the services which they provide without delay. This is in order to prevent any delay in providing the treatment in the community while ensuring that beds are available in a timely manner for those patients requiring treatment in an acute setting.

20. The move to a community hospital will put the patient back under the care of a local GP/GP practice extended team and discharge for patients can then be better integrated with local community and social care services, especially where these have been co-located into community hospital facilities.

21. There is a growing academic evidence base comparing the clinical outcomes for patients who have a period of rehabilitation within a community hospital as opposed to a general hospital[9,10,11]. The studies demonstrate that patients have

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[9] Garåsen *et al* (2007) Intermediate care at a community hospital as an alternative to prolonged general hospital care for elderly patients: a randomised controlled trail. *BMC Public Health*. **7:** 68-76.

[10] Young *et al* (2007) Postacute Care for Older People in Community Hospitals: A Multicenter Randomized, Controlled Trial. *JAGS*. **55:** 1995-2002.

greater independence once they return home where their rehabilitation has been conducted within a community hospital as opposed to a general hospital. The use of an intermediate care team supports this process.

b. Community services, diagnostics and outpatient services

22. Community hospitals provide patients with more intensive clinical input than can be provided in their own homes without the need for admission to a district general hospital or a major acute site. This ensures that patients are seen closer to home by local primary care and social work teams, providing good continuity of care and better transitional arrangements for the patient. Telehealth solutions can be utilised to provide some of these services and are often cost effective in remote and rural areas.

23. A number of community hospitals provide specialist services that have been traditionally offered at large acute care facilities. This includes specialist inpatient services such as dementia care, diagnostic tests and procedures, minor injury services or general clinical services. This ensures that services are delivered as close to patients as possible and in remote and rural areas of Scotland this can result in patients savings hours of costly transport to and from major centres and the stress and other opportunity costs associated with travel.

How Can Community Hospitals Develop to Improve Outcomes?

24. The evidence is clear that community hospitals provide clinically effective services that improve the outcomes for patients and support the delivery of services closer to home. In the 2011 hospital inpatient experience survey results[12], from the 44 community hospitals that responded with sufficient data, the scores for the majority of questions were either on a par with the national average or significantly higher. NHS Boards should continue to make use of results of the inpatient patient experience survey to support local improvement work including work in community hospitals.

25. The main challenge for NHS Scotland has been to ensure that community hospitals are fully aligned and linked to the wider delivery of services within NHS Board areas. In order to make full use of these valuable resources, it is vital that community hospitals are as effective as possible at delivering pathways of care and have clear links with the broad range of services provided by the NHS and it's Partners and in particular, acute hospitals, care homes and social care services. The results from the inpatient surveys indicate that on going care after hospital treatment is of concern to a number of patients that have attended community hospitals and as such, the links with on going care such as social services and care homes should be strengthened.

26. NHS Boards need to ensure that strong relationships are built up with other areas in the system, whether this be with secondary care services and clinicians or

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[11] O'Reilly *et al* (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:** 513-520.
[12] http://www.bettertogetherscotland.com/bettertogetherscotland/24.html

community based teams and facilities such as care homes. Community hospitals that work in isolation lessen the impact that they have improving patient outcomes. The inpatient experience data is seen as an important indicator of performance. In the future community hospitals should look to actively work with the Better Together Scotland team to improve the dataset for community hospitals and patients should be encouraged to submit feedback through this forum. Furthermore, each hospital should be seen to be trying to improve on this years score.

Section 2 – Delivering better outcomes for patients

Putting Quality at the Heart of What we do

27. The overarching context for the ongoing development of community hospitals in Scotland is the Healthcare Quality Strategy (Scottish Government, 2010). The Quality Strategy identifies three Quality Ambitions which act as the focus for priority action for all services. The three Quality Ambitions are:

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making;

- There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times;

- The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.

28. Six healthcare Quality Outcomes will provide a more comprehensive description of the priority areas for improvement in support of the Quality Ambitions and provide a context for partnership discussions about local and national priority areas for action.

29. For community hospitals this means identifying and supporting patients on their journey of care through the health and care system. The hospital should ensure that: appropriate patients are being seen at the right time; patients have clear clinical care plans and are involved in their own healthcare decisions; and patients are discharged safely when they can be better cared for in another setting. A recent joint study carried out by NHS Education for Scotland (NES) and the Scottish Association of Community Hospitals[13] highlighted concerns made by staff working in community hospitals that some patients had been referred to them inappropriately. This should be a particular focus for community hospitals. The work progressed on anticipatory care planning, and intermediate care teams will be essential to driving forward improvements.

30. It means supporting the clinical and professional teams that work in community hospitals to improve skills to deliver the necessary specialist services that are required locally. Improving joint working with secondary care, community teams, local care homes and social care to draw on their skills to ensure that patients receive effective care within the hospital and a smooth transition onwards on their care pathway. Ensuring secondary care expertise is available in the community and the work undertaken in partnership with COSLA, Scottish Care, the care home regulator and other key stakeholders to enhance the quality of care being provided,

[13] Identifying the Learning Needs of Community Hospitals in Scotland

and the services offered, by care homes through the National Care Home Contract is key to this.

31. In some cases it may be about making the decision to redirect resources from community hospital inpatient beds to community services that can better provide the support and care that patients require. NHS Boards working with health and social care professionals need to be able to clearly demonstrate how these facilities function within the wider health and social care system for the benefit of the patients that they serve and make the necessary changes to facilities to ensure they are delivering care that is safe, effective and person-centred. The development of clear locality based pathways of care by NHS Boards will be essential to ensuring that community hospitals can play their full part in delivering better outcomes for patients.

Demographic Change

32. The 'Reshaping Care for Older People' ten year programme of work[14] sets out the strategic direction for service development to support the aging population. At its heart is the shift of services and resources to support people within their own homes and through community facilities. This focus puts the person at the centre of the decision making process, provides them with the support they need to keep healthy and safe and reduces the incidences of unplanned admissions to hospitals that can be so disruptive to people's lives.

33. The majority of patients that community hospitals support are older people and with growing demographic pressure it is likely that the role of community hospitals in providing care for this group will increase. NHS Boards will need to consider the implications of this for community hospitals and community based services to effectively manage this expanding group of patients, many of whom will have multiple long term conditions, including in many cases dementia.

34. A notable consequence of demographic change is the increasing age of patients cared for within community hospitals. This influences the care needs of patients but also the ability of staff to adapt the environment of care to meet the needs of different care groups. For example adults with acquired brain injury may share the same facilities with much older people with dementia. An environment designed for older people with dementia may not be appropriate for younger people with physical disability or alcohol related brain injury. NHS Boards must ensure that patients are cared for in appropriate and enabling environments.

Integration of Health and Social Care

35. Scottish Ministers have announced proposals to further integrate health and social care services [15]. The proposed reforms will focus on:

- Nationally agreed outcomes that will apply across health and social care, focusing in the first instance on older people's services;

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[14] Reshaping Care for Older people: A programme for Change 2011-2021; The Scottish Government, COSLA, NHS Scotland
[15] http://www.scotland.gov.uk/Topics/Health/care/IntegrationAdultHealthSocialCare

- Joint accountability to Ministers, NHS Board chairs, Council Leaders and the public for delivery of those outcomes;

- A single integrated budget that will include, as a minimum, expenditure on older people's community health and adult social care services, and, importantly, expenditure on the use of some acute hospital services; and

- Strong clinical and professional leadership, and engagement of the third sector, in commissioning and planning of services.

36. The integration of health and social care will have a significant impact on the way that community hospitals are managed and developed. The proposed reforms will include plans to integrate budgets for some acute care, community care and adult social work; thus enabling local teams to ensure that resources match patient needs. This will include the budgets currently set aside for community hospitals.

37. It will be essential for community hospitals to proactively engage with this agenda to ensure that their considerable resources are utilised in the best way possible and they should be looking to develop their service provision accordingly. For example, where appropriate developing a hospital as a community hub for health and social care[16], or providing a specialist service to the community such as palliative care or dementia services.

38. The Scottish Government will expect significant progress in drawing together health and social care into a coherent, jointly delivered service, whilst the proposals for integration progress through the Scottish Parliament. It is important that, whatever local service model exists, that the hospital service is fully integrated across the spectrum of care.

Community Based Services

39. A large proportion of community hospitals provide care, through GP practices, directly to the communities that they serve. This traditional model provides greater clinical options for community teams rather than admission to a major acute site and provides a hospital setting closer to peoples' homes. Admissions are usually controlled and coordinated by patients' GPs.

40. This is key to providing a 'community-hub' for health and social care and in many of the new facilities they play this dual role. It can provide a base for telecare services and manage patients on a 'virtual ward' basis, bringing those patients in who require a short stay of more intensive medical support whilst actively managing other high risk patients within their own homes. With integrated arrangements between health and social care services, patients' conditions are better managed, reducing the need for unplanned admissions to hospital and improving early and preventative intervention.

41. Community hospitals provide the specialist end of community healthcare provision and can be used as a 'hub' to co-ordinate care for their local population.

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[16] Remote and Rural Steering Group, 2007, The Scottish Government

They allow community teams an extra clinical option for specialist outpatient and inpatient treatment. The interaction with secondary care colleagues, especially Geriatricians, Psycho-geriatricians, Community Paediatricians and palliative care, helps to develop this role and expand the services that can be offered. Clinical teams are better equipped to judge which patients will benefit most from managed inpatient stays within the community hospital. Targeting the right patients and providing them with the right type of care will reduce the incidence of unplanned admissions to major acute sites and allow teams to manage patients within a community setting.

Managing Patient Pathways in the Community

42. The key to successfully managing patients within the community and knowing when and whom it is appropriate to admit is vital to a good understanding of the clinical needs of the local community and identifying those most at risk of a clinical episode. Traditionally this has relied almost solely on GP interaction with their patients but there are an increasing number of tools that can support this process and engage the rest of the community team in the decision making process.

43. Risk Prediction tools such as SPARRA[17], anticipatory care planning, case/care management and Virtual Ward are some of the techniques that community teams use to identify patients who are at risk of an unplanned admission and proactively manage their care. Joint working with social work is essential as often those at high risk require adaptations and specialised equipment within their homes alongside support services. Interaction with care homes is often required as teams provide medical support directly within the care home to allow residents to stay there rather than come into the community hospital.

44. The basis of both anticipatory care and Virtual Ward involves risk modelling to identify people who are likely to have a clinical incident now, or in the near future. The provision of health and care services to support the identified cohort of patients reduces the risk that they will have an unplanned admission. The inclusion of secondary care colleagues within the management group strengthens the ability of the team to make the best decisions for patients. These initiatives strengthen community response and ensure that specialist acute services are used by those who require them most.

On Going Case Study - Virtual Ward (NHS Tayside)

What is a Virtual Ward?
In a Virtual Ward there is no physical building to which patients are admitted. They are cared for in their own communities, usually at home, using an admission method based on a computer based, risk stratification tool (RST). This method identifies patients at an early stage of their illness and aims to reduce preventable hospital admissions by helping better manage their conditions at home.

Tayside case study

[17] SPARRA (Scottish Patients At Risk of Readmission and Admission). For further information see: http://www.scotland.gov.uk/Resource/Doc/309288/0097425.pdf

There are currently tests taking place across the three CHP's in NHS Tayside with 13 GP practices and multidisciplinary teams, supported through a development LES until May 2012. A RST is being used to identify patients suitable for assessment and who may benefit from a virtual ward admission. The RST identifies people aged 40 and above using the GP practice based data from Vision, generates a risk score reflecting risk of admission in the coming year. The tool has only been fully operational with these teams since April 2011 and the identified people are many and varied but the disease areas are based on QOF.

The learning relating to the documentation and sharing of information has led to the development of Virtual Ward in MiDIS which will allow sharing of information across services with appropriate data governance. There is a consensus though, that the virtual ward concept is supporting a move towards better MDT working, anticipatory care planning and support for self management.

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Anticipatory Care (NHS Highland)

Issue

In the UK, the over 65 year old population is increasing rapidly. Multi-morbidity places more demands on all health services including end of life and palliative care. This population are at high risk of hospital admissions, some of which are potentially avoidable.

Solution

A single GP practice was used to trial Anticipatory Care Planning. Anticipatory Care Planning has been described as "*a process of discussion between patient and a professional carer, which sometimes includes family and friends*". High risk patients were identified and then offered an Anticipatory Care Plan (ACP). ACPs aim to provide a patient centred, cost effective approach to patients with multiple morbidities and illness trajectories that will deteriorate.

Outcome

80 survivors from the ACP cohort and 81 survivors from a control cohort were used in the study. The following results were reported:

- The survivors from the ACP cohort had 510 fewer days (52% reduction; p=0.020) in hospital than in the previous twelve months, compared to a 12.7% reduction in the control cohort (p=0.188). There were 37 fewer admissions by the survivors from the ACP cohort post intervention (42.5% reduction; p=0.002) compared to 23.8% reduction in the admission rate in the control cohort (p=0.087).
- The cost of unplanned hospitalisation for the survivors from the ACP cohort fell by £161,944 (48.6% reduction; p=0.029) compared to the cost for the survivors from the control cohort which fell by £50,163 (12% reduction; p=0.221).
- There was a significant difference (p=0.007) in the proportion of deceased patients that died in hospital, with three deceased ACP patients dying in

hospital compared to 11 deceased patients from the control cohort. Therefore, it is anticipated that ACP will help to deliver an outcome (death at home) that the NHS is historically poor on delivering.

Further work
Following the successful trial, ACP has now been rolled out across the whole of NHS Highland and approximately 4,000 patients are now in receipt of this plan.

Information supplied by Adrian Baker (adrian.baker@nhs.net)

45. The use of these systems in areas where there is community hospital provision ensures that the right patients are admitted, when they require intensive clinical support. A better understanding of the local population and their needs will ensure that the right balance of resources is invested in the hospital and community services.

Working with Secondary Care

46. In the vast majority of community hospitals, work is undertaken by primary care multidisciplinary teams with support from secondary care consultant colleagues to provide significant benefits for patients. Joint working and shared care provides primary care colleagues with a greater understanding of clinical specialism and for secondary care colleagues a better understanding of the care and support delivered within primary care.

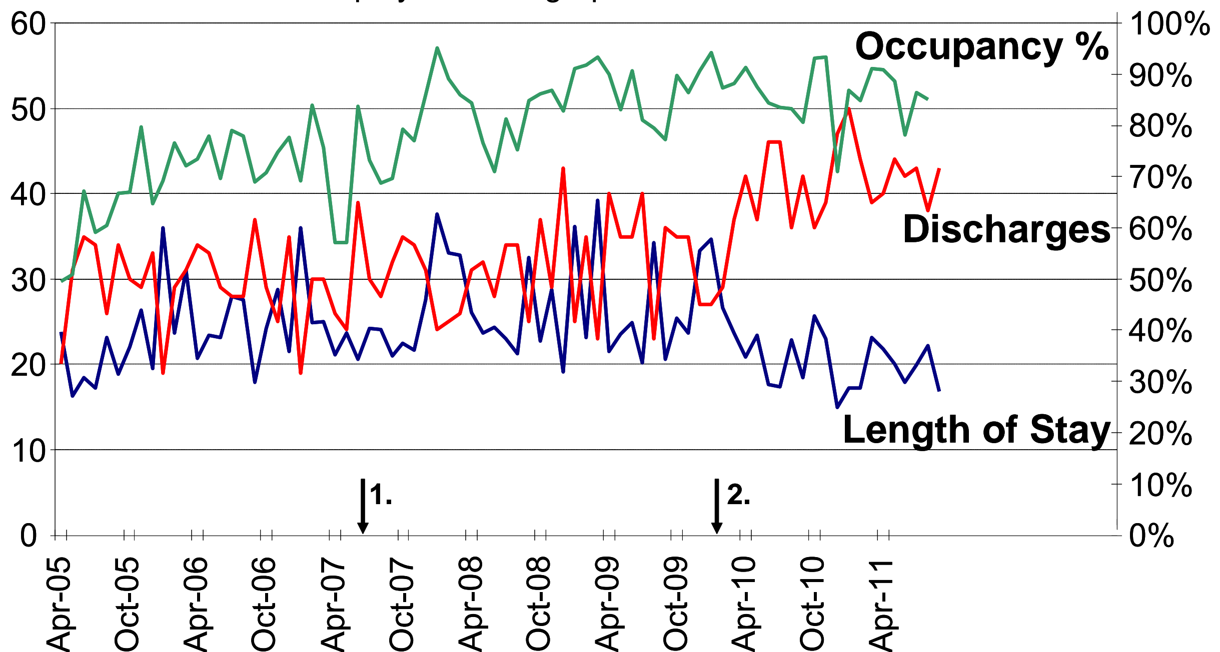
47. The support of geriatricians and psycho-geriatricians are particularly key given the demographic of patients that community hospitals largely serve. Better joint working between clinical colleagues allows patients to be supported within the community for longer and often results in a shorter length of stay at acute facilities as community hospital teams become more confident in looking after people with more complex support needs. NHS Boards should seek to promote closer collaboration between the GP leads that provide medical cover in community hospitals and appropriate secondary care colleagues.

Community Geriatrics Example of Best Practice (NHS Highland)
A Consultant Geriatrician based at Raigmore District General Hospital started working at County Community Hospital Invergordon in June 2007 on a part time basis. Invergordon is a 32 bedded unit in a modern building. Prior to June 2007, the 32 beds were split into two 16 bed wards: one run by GPs, the other run by a Consultant. Three changes were implemented in June 2007:

- The two wards were combined and co-run by the GPs and the Consultant;
- A weekly, joint GP/Consultant ward round of all patients in the hospital was started (arrow 1 in the graph indicates when this initiative was started);
- And a weekly, joint multidisciplinary team meeting was started. This was initially between the Consultant and GPs, but now social workers, home care organisers, local community nurses and allied health professionals attend as standard.

In February 2010, the multidisciplinary team meeting was extended to discuss patients active to the community teams, but who were not currently receiving treatment at Invergordon. A small budget of £30K was set up to allow the community teams to directly spot purchase home care. The aim of this was to allow patients to be discharged quicker and also to avoid admission in the first place (arrow 2 on the graph indicates when this initiative was started).

The results of the changes made in Invergordon were recorded by looking at the turnover and occupancy of the over 75s at County Community Hospital Invergordon over time. These are displayed in the graph below:



Over time, the occupancy levels in the community hospital (green line) has risen. The discharge rate (red line) and length of stay (blue line) indicate that the increase in occupancy is not due to patients increasing their stay at the hospital. Furthermore, the figures for the number of beds in Raigmore District General Hospital occupied by patients over 75 show an overall decrease since 2005-06 (data not shown).

The data demonstrates that the initiatives and joint-working that has been put in place at Invergordon is having a real impact on the outcomes of patients. The community hospital is better utilised, patients are treated in their community and discharged quicker to home and fewer patients need to travel and be admitted to Raigmore Hospital, freeing up space for other patients and cutting the expense and inconvenience of travelling to Inverness.

The team have noted that over time their confidence has built as the have learnt from each other. They are able to treat more patients with more complex conditions than previously and have confidence that the necessary support will be in place in the community. This initiative has linked health and care services from Raigmore, through Invergordon, to people's homes improving patient outcomes in their local community.

Information from Martin Wilson (Consultant Physician martinwilson2@nhs.net)
Additional contact Jim Hutton (Invergordon Clinical Lead justjim@talk21.com)

Rehabilitation, Enablement and Intermediate Care

48. Much of the work progressed under 'Reshaping Care for Older People' will support the reduction of unplanned and unnecessary admissions to major acute facilities but there will always be a number of patients who require specialist treatment in such a facility. Many of these patients will need rehabilitation and reablement after an operation or stay in hospital through local community services. The 'Intermediate Care Framework' will set out how acute and community teams can be developed to provide a range of enabling and intermediate care functions within a variety of settings, including community hospitals. To ensure a person has the opportunity to recover fully it may be appropriate for a period of intermediate care to be provided within a community hospital. This can provide an individual with a period of rehabilitation and enablement which can often avoid the need for an admission to long term care.

49. For this to work effectively and to achieve the best outcomes for the patient, co-ordinated admissions and discharge planning between the acute sites and the community hospital wards must be in place. By providing a range of different skills mix, facilities and clinical capacity, community hospitals are well placed to provide intermediate care, which could avoid the need for an acute admission, or facilitate a timely discharge from that setting. When developing intermediate care services and teams, NHS Boards should consider how community hospitals can best support these initiatives.

50. Acute centres also need to be aware of the different types of intermediate care that may be available within community hospitals to ensure patients are able to access it when needed. Community hospitals may also benefit from reviewing their models of health and care provision. Moving from traditional models which focus on patient's problems and needs, to those which focus on patient outcomes and build upon assets and abilities, can help to promote self management and independence.

51. Any intermediate care provided should be time limited and based on a clear set of outcomes agreed with the patient and their family, or carers. There is evidence to suggest that access to a Comprehensive Geriatric Assessment (CGA), for those who would benefit the most is highly desirable. Randomised control trials of CGA also show that care organised in a Medicine for the Elderly ward increases the proportion of older people who return home from hospital, reduces length of stay and admission to care homes.

52. Early involvement of social care teams in this planning is essential to ensure that when patients are clinically fit to leave hospital the appropriate support packages are in place so they can be discharged and returned home. Co-location of health and social care teams on a single site can significantly support this joint working and planning for the needs of individual patients.

Specialising

53. A number of community hospitals or wards within them specialise in providing palliative care or services for people with dementia. The requirement for such facilities may well grow as demographic pressures increase over the next two decades. These centres are specialist by nature and therefore require significant specialised training for all staff and greater interaction with colleagues in secondary care. The national Palliative[18] and Dementia[19] care strategies provide the framework in which these services should develop and highlight the importance of strong links to community based services and interaction with family and carers. When designing new or refurbishing existing community hospitals, good practice design principles should be applied.

54. The flow of patients into these facilities requires cognisance and co-ordination with the pathways that have led patients to be admitted. If they have come through the acute sector then good working relationships need to exist and clear admissions and discharge processes need to be in place. NHS Boards should encourage staff to experience working within these settings to ensure that the most appropriate patients are transferred to them. NHS Boards need to ensure that there is significant joint working relationships with secondary care specialists in place to support these units.

55. Patients may also be admitted from community teams who can no longer provide the support to keep the person within their own home. Community teams should be proactively managing the most high risk patients within the community and communicating with these specialist facilities. Through joint working between the teams, the admissions process can be as smooth as possible for the patient without undue distress or the need for an unplanned admission to a larger acute facility.

56. Palliative care units will play a role in supporting patients who wish to die at home or in a homely setting. Links with families, carers, community teams, local care homes and hospices are essential to make this a reality for people and careful planning has to be undertaken between all partners to make sure this happens in a joined up and dignified way.

Palliative care (NHS Tayside)

Issue

Some patients with palliative care needs would prefer to die at home rather than in a hospital. For those with conditions where this is not possible, the view of many is that the next best thing for them and their families is to be able to die close to home in a community based site such as a care home or community hospital.

Solution

The introduction of a Palliative Performance Scale (PPS) as part of an Advanced or Anticipatory Care Plan (ACP) has been carried out. The PPS is used to assess patients conditions and the level of care that they need to receive. This is carried out for all patients admitted to wards and they are reassessed weekly. These

[18] Living and Dying Well: A national action plan for palliative and end of life care in Scotland; September 2008; The Scottish Government

[19] Scotland's National Dementia Strategy; June 2010; The Scottish Government

assessments help in the decision of being able to move patients onto another care facility/home.

Example of use
An ACP was in place for a gentleman who wanted to die at home with support from his wife, social services and district nurses. The PPS assessed that he would be able to receive suitable levels of care at home; however, documented in his ACP was his wish to return to a local community hospital if things became too difficult for his family or him to cope with rather than a larger acute site.

Within a week a phone call was received at the community hospital from Out Of Hours Services (OOH) to readmit the patient. The OOH medical team voiced that they were very impressed with a clear plan of care being in place for a patient they were unfamiliar with and without the documentation the patient would have been admitted to the acute site.

Further work
All patients/family moving to nursing home care now have the option of having an ACP in place. This has been well received by the patient/family as well as nursing home managers and GPs. Furthermore, it has reduced the amount of calls to OOH, therefore assisting with continuity of care.

Information supplied by Duncan Dorothy (dorothyduncan@nhs.net)

Assessing the Best Use of Resources

57. The development of community teams and information systems to track at risk patients and the involvement of secondary care colleagues in a primary care setting is important. NHS Boards, multidisciplinary teams and local authorities must look at the current use of resources to ensure that they represent best value and are providing the support required by the local community.

58. For some community hospitals this may require a change in the number of beds or functions to allow resources to be used by alternative community based teams. If Boards are planning to make changes in the use of community hospitals, then these plans and the associated investment/disposal plans should be incorporated within their Property and Asset Management Strategies. NHS Boards must engage proportionately with local stakeholders, including the public, in undertaking these changes; with a clear plan of how resources will shift, what the implications are for local provision of services and how this will support the community over the coming years.

59. Central to proposals of this type will be evidencing change and the Integrated Resource Framework (IRF) will support Partnerships to do this. The IRF enables partners in NHS Scotland and Local Authorities to be clearer about the cost and quality implications of local decision-making about health and social care. It enables better local understanding of costs, activity and variation across service planning and provision for different population groups.

60. Work to evidence the flow and distribution of resources across community support is particularly important where NHS Boards have a number of community hospitals in one Community Health Partnership area. Using the data, consulting with stakeholders and planning for demographic change should give NHS Boards the strategic direction to make sure that the community hospitals are fully integrated into the wider system of healthcare and providing services that benefit patients from the whole community, not those that are necessarily attached to a single GP practice that provides medical cover. This includes community hospitals contribution in NHS Boards' efficiency and productivity plans which will help improve quality, reduce waste and achieve best value for patients and communities.

Broadening the Services Available

61. In a number of areas across Scotland, community hospitals are expanding the number of outpatient, inpatient and diagnostic appointments and procedures they can undertake. This allows patients and clinicians better local access to specialist services and reduces the footfall of patients through major acute sites. It allows community hospitals to play a greater part in delivering HEAT targets, as well as other priorities, by taking activity directly from acute sites and delivering it close to peoples' homes.

62. The development of these services is particularly valuable where there are concentrations of community hospitals or if they are in remote and rural sites. This will ensure that hospitals are fully utilised and improve access for patients. What is essential is that services are built on a sustainable basis and that resources are shifted in a planned way from the acute hospital to support the services within community hospitals. Without the move of resources from secondary to primary care the changes cannot be sustained as NHS Boards will be effectively providing the service twice. These shifts in care provision can put pressure on NHS Board resources. However, integrated resourcing as part of the Integration of Health and Social Care agenda will provide greater flexibility in resource allocation.

63. The provision of diagnostic and outpatient services within a community hospital can be challenging as NHS Boards have to balance the requirement to have appropriately qualified staff and relevant equipment to support local need, geography, clinical enthusiasm, specialist availability, effective use of resources and sustainability. Business cases for starting or stopping these services must be detailed and have at their heart the impact on patients and value for money. The use of tele-health solutions can often provide a cost effective mechanism to deliver care locally.

Telehealth Example of Best Practice (NHS Grampian)

Issue

Fraserburgh Hospital opened a six bedded stroke rehabilitation unit in 2009. The clinical lead for the beds within the unit is a consultant AHP whose additional duties mean being based in Aberdeen. The journey to Fraserburgh takes approximately 1.5 hours by car, which means that both the monetary and time expenditure in getting the Consultant to Fraserburgh more than once per week was prohibitive. Furthermore, the frequency of patient goal setting meetings that the AHP consultant could attend was relatively few.

Solution
Telehealth equipment has been installed, with access to video consultation. This has enabled remote attendance of the specialist at patient goal setting meetings.

Outcome
The service was evaluated in March 2011 - the patient satisfaction survey and evaluation of the economic impact indicate that the use of video conferencing to deliver patient goal setting by the consultant lead for the unit is a satisfactory method of service delivery.

The AHP consultant feels that they have been able to see patients more frequently at Fraserburgh, which has supported an effective rate of rehabilitation. The telehealth facilities are used routinely, with up to three goal setting sessions being handled this way. Face to face sessions are still an important part of rehabilitation, with the specialist visiting the unit once a week.

In addition to the medical benefits, the scheme has also had a positive economic impact, saving an estimated £6440 per year in travel and time costs.

Further work
Following the success of this project, the AHP Consultant is working with the Western Isles to support them in the introduction of goal setting for their patients, which will be done via telehealth technology. Furthermore, access to other rehabilitation support via video consultation is now being explored and the potential for home assessments, therapy consultations, interventions and advice is also planned.

Information supplied by Thérèse Jackson (therese.jackson@nhs.net)

64. In times of financial constraint there is an urge to centralise services back to major acute sites to utilise economies of scale and reduce the unit price of undertaking a procedure or a test. Whilst this is an understandable response to scarce resources it can often lead to an increase in the overall numbers being referred or later detection of clinical conditions. GPs are well placed to manage risks within individual patients and the availability of local secondary care services to diagnose or treat problems aids their ability to do so.

65. Where NHS Boards are making decisions to centralise a service from a community hospital they must account for the impact locally and ensure that primary care teams and the public are fully involved in the decision making process. Plans must be carefully considered and demonstrate best quality, sustainability and value.

Working with Communities

66. The Christie Commission[20] report highlights the need for public services to better engage with, and identify the needs of, local communities. The Scottish

[20] Commission on the Future Delivery of Public Services; APS Group Scotland; June 2011

Government response[21] to this report confirmed a national commitment for public services to work harder to involve people everywhere in the redesign and reshaping of their activities. Within NHS Scotland, all NHS Boards have had a duty of public involvement for a number of years[22] and the involvement of people and communities is recognised as an important aspect to its efforts to improve the quality of services provided. Good progress has been made and there is evidence that informing, engaging and consulting people and communities is having an impact and influencing NHS service planning and delivery. Areas for improvement have been identified and partnership and close collaboration with other public service providers will be an important aspect to achieving those.

67. Community hospitals are highly valued by the local community, many of which raise significant funds for their development. This can be seen as a challenge where the views of the community may not reflect those of NHS clinicians or managers, often when care services are being redesigned resulting in the investment in non-institutional based care and change in the numbers or use of beds or a particular service. However, community involvement and interest in a particular facility should be seen as positive and working in partnership with communities to develop better pathways of care supported by community hospitals will bring significant benefits and support co-ownership of outcomes.

68. The Christie Commission report highlights a number of good practice examples from around Scotland of positively engaging and supporting communities. In particular the Marr Community Planning Group which draws together representatives of the community with Community Planning Partners to identify the needs of local people. It ensures that all public services develop in line with the needs of the local community and are better integrated together. Thought should be given to how community hospital facilities can be utilised better to provided space for community health and social care activities and services. Where there is potential to do this it will support community engagement and ensure that facilities are better utilised.

69. Co-production is an approach being increasingly adopted through the NHS across the UK that develops services with local communities rather than for them. It sees patients, their families and their carers not as passive recipients of care but active participants in the process; assets not burdens on the system. This is an entirely different way of managing, engaging and consulting with local communities and will take time and energy from NHS staff to make it work, but evidence suggests the approach can have significant benefits[23]. The use of Community Benefit Clauses[24] in contracting services within a community hospital should also be considered.

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[21] Renewing Scotland's Public Services; Priorities for reform in response to the Christie commission; Sept 2011

[22] Section 2B of the National Health Service (Scotland) Act 1978, as inserted by the National Health Service Reform (Scotland) Act 2004

[23] A wide variety of resources and information on co-production and community capacity building can be found on the Joint Improvement Team website: see references for link;

[24] Further advice on Community Benefit Clauses can be found at this link: http://www.scotland.gov.uk/Topics/Government/Procurement/policy/procurecombenefits

Developing the Workforce

70. The clinical, non-clinical and support workforce within community hospitals are central to their success. The variability in services offered by the different sites require NHS Boards to look in detail at how best to support the development of skills in individual hospitals. This will ensure that safe and clinically effective care continues to be delivered now, and that plans for the future build upon staff acquiring the skills and knowledge to deliver new services. It is especially important that all staff are trained to use a reablement and assets based approach, enabling patients to regain their independence and confidence as quickly as possible to facilitate discharge back to their own homes.

71. Community Hospitals can offer unique training opportunities to medical students. It supports the development of generalist skills in trainee medics and will ensure that there is greater numbers of qualified GPs who have experience of working within a community hospital setting.

Workforce Development (NHS Fife)
The University of St. Andrews has been working with the community hospitals within Glenrothes and North East Fife community health partnership. A scheme has been set up which introduces second year medical students to community hospitals and to patients with a broad range of illnesses. Groups of students visit the community hospitals once a week over a 20 week period. They are introduced to the types of work carried out in a community setting by GPs and nurses and get to practice their skills in history taking and in the examination of patients. The scheme has been receiving positive feedback from all those involved: students, community hospital staff and patients.

Following on from this work, there are further proposals to extend the exposure medical students have of working in a community setting. The Glenrothes and North East Fife community health partnership is proposing offering fifth year medical students seven week placements based around a community hospital. This type of scheme will benefit community hospitals and services in the long run as more recently qualified clinicians will have had experience within a community setting and of generalist skills and so will have a better understanding of what is entailed in providing care in the community.

Information supplied by Dr Ed Wallace (ed.wallace2@nhs.net)

72. NHS Boards face challenges in providing training opportunities for staff at community hospitals. In many cases the complement of nurses is small and so opportunities to release staff for non-essential training are limited. Community hospitals can be customised to facilitate multidisciplinary meetings, education and training. Technological solutions for managing patients such as telehealthcare, videoconferencing and teleconferencing can also be used for the purpose of education, training and research.

73. The way that GP and medical staff are contracted to deliver in-hours services in community hospitals differs between NHS Boards. This can have an impact on the quality of care that patients receive, the overall management and smooth running of

a community hospital and the support that other members of staff receive. Additionally, arrangements for out-of-hours medical cover can be improved.

74. The Scottish Association for Community Hospitals (SACH) and NES have recently conducted a learning needs analysis of community hospitals[25] and are in the process of drawing up their findings and recommendations for future work. Early indications are that the learning needs analysis has indentified the need for a shared learning and development function for the workforce in a community hospital setting.

75. In response to the learning needs analysis conducted by NHS Education Scotland and the SACH, the Scottish Government will support NHS National Education Scotland to develop a national network to facilitate education, sharing of good practice, exchange of knowledge and clinical skills and to provide an improvement forum. This will be carried out in partnership with the SACH and in consultation with community hospital staff.

76. The challenges in delivering medical cover to community hospitals also requires a national response. The Scottish Government will convene a short life working group for community hospitals with a remit to look at the challenges of delivering medical cover, in and out-of-hours within community hospitals. The working group will include representatives from the geographical and special NHS Boards.

[25] http://www.scotcommhosp.org.uk/downloads/SACH_LNA_Report_772011.pdf

Section 3 – Delivering the changes

77. The primary responsibility for developing Community Hospitals rests with their NHS Boards but given their variable nature it is appropriate for the Scottish Government to provide national support. The actions noted within the document are laid out below.

The Scottish Government

- The Scottish Government will support NHS National Education Scotland to develop, in consultation with community hospital staff, a national network to facilitate education, sharing of good practice, exchange of knowledge and clinical skills and to provide an improvement forum;

- The Scottish Government will convene a short life working group for community hospitals to address the challenges of delivering medical cover, in and out-of-hours within community hospitals.

NHS Board Actions:

- NHS Boards will ensure that each community hospital has a clear service plan that identifies its role and maximises its contribution to managing demand and delivering outcomes within specified care pathways. These will be agreed with clinical teams from primary and secondary care;

- NHS Boards will review and address the learning needs and improvement capability and capacity of their community hospital workforce, particularly around the care of older people, those with dementia and delirium and the need for rehabilitation, reablement, palliative and end of life care;

- NHS Boards will ensure that Geriatrician, Psycho-geriatrician, Community Paediatricians, Palliative Care, rehabilitation and pharmacy support is embedded within the community to support GP led and shared care inpatient services for older people;

- NHS Boards will ensure that all staff involved in the transfer of patients from acute sites to local community hospitals are fully aware of the differing admissions criteria in place in each facility;

- NHS Boards will ensure that community hospital staff engage with the local community health and care services that might be utilised to support their patients onward care journey;

- NHS Boards and ISD will work together to ensure coding of community hospital facilities reflects their current function while ensuring that any changes made do not have a negative continuity impact on the data that underpins our HEAT targets and other priorities, or if it does impact that we are well prepared to revise data to keep robustly in-line with the targets;

- NHS Boards will ensure that their ehealth strategies enable IT and telehealth capability at appropriate community hospital sites;

- NHS Boards will ensure that the actions contained within their Property and Asset Management Strategies and infrastructure plans support the delivery of the service plans establishment for their community hospitals;

- NHS Boards should continue to make use of results of the inpatient patient experience survey to support local improvement work including work in community hospitals.

Additional Support and Programmes of Work

78. In addition to the specific actions noted above there are a number of programmes of work being undertaken that may support NHS Boards and community hospital teams to redesign and improve services. The Quality Efficiency and Support Team (QuEST) and the Joint Improvement Team (JIT) run, or commission programmes, provide bespoke support and promote best practice tools and techniques. Of particular interest for community hospitals are the following pieces of work:

Quality Efficiency and Support Team –

Releasing Time to Care in Community Hospitals;
Releasing Time to Care in Community Services;
Productive General Practice – Releasing Time;
Efficiency and Productivity Work Streams: Primary Care, Community and Outpatients, Acute Flow, Improving Population Health, Workforce, Service Transformation – Cancer and Mental Health.

For further details contact – jason.cormack@scotland.gsi.gov.uk

Joint Improvement Team –

Supporting the development and implementation of Change Plans and Improvement Network;
Joint Commissioning;
Support for Delivering on Delayed Discharge;
Intermediate Care;
Community Capacity Building;
Supporting Delivery of Health and Social Care Integration;
Talking Points – Personal Outcomes Approach;
Telecare.

For further details contact – Brian.Spence@Scotland.gsi.gov.uk

Section 4 – Reference List

Strategies that are of key import to this one:

1. Developing Community Hospitals: A Strategy for Scotland; The Scottish Government (2006)

2. The Healthcare Quality Strategy; The Scottish Government (2010)

3. Living and Dying Well: A national action plan for palliative care and end of life care in Scotland; The Scottish Government (2008)

4. Reshaping Care for Older People: A Programme for Change 2011-2021 (2011) The Scottish Government, COSLA and NHS Scotland.

5. Scotland's National Dementia Strategy; The Scottish Government (2010)

6. Intermediate Care Framework; The Scottish Government (due in 2012)

Academic References:

1. Garåsen *et al* (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:** 68-76.

2. O'Reilly *et al* (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:** 513-520.

3. Ritchie, L.D (1996) *Community hospitals in Scotland: promoting progress*; Aberdeen: Department of General Practice and Primary Care, University of Aberdeen.

4. Ritchie, L.D and Robinson, K (1998) Community hospitals: new wine in old bottles? *British Journal of General Practice*. **48:** 1039-40.

5. Small *et al* (2009) Post-acute rehabilitation care for older people in community hospitals – Philosophies of care and patients' and caregivers' reported experiences: A qualitative study. *Disability and Rehabilitation*. **31:** 1862-1872.

6. Young *et al* (2007) Postacute Care for Older people in Community Hospitals: A Multicenter Randomized, Controlled Trial. *JAGS*. **55:** 1995-2002.

Web references:

1. Better Together Scotland
2. Community Benefit Clauses
3. Integration Website
4. The Joint Improvement Team
5. SPARRA (Scottish Patients at Risk of Readmission and Admission)

Data sources:

1. Information Services Division Scotland

Other References:

1. Report on the Parliamentary debate on integration (2011)
2. Remote and Rural Steering Group; The Scottish Government (2007)
3. Identifying the Learning Needs of Community Hospitals in Scotland; SACH (2011)

Annexe 1: List of Community Hospitals in Scotland.

1	**J26**	**Aberdeen City Hospital**	Grampian	49	**J26**	**Islay Hospital**	Highland
2	**J26**	**Aberfeldy Cottage Hospital**	Tayside	50	**J26**	**Kello Hospital**	Lanarkshire
3	**J26**	**Aboyne Hospital**	Grampian	51	**J26**	**Kelso Hospital**	Borders
4	**J26**	**Adamson Hospital**	Fife	52	**J26**	**Kincardine Community Hospital**	Grampian
5	**B7**	**Annan Hospital**	D&G	53	**J26**	**Kirkcudbright Cottage Hospital**	D&G
6	**A3**	**Arbroath Infirmary**	Tayside	54	**B7**	**Kirklandside Hospital**	A&A
7	**A3**	**Arran War Memorial Hospital**	A&A	55	**J26**	**The Knoll Hospital**	Borders
8	**B9**	**Bannockburn Hospital**	Forth Valley	56	**J26**	**Lady Home Cottage Hospital**	Lanarkshire
9	**A3**	**Belford Hospital**	Highland	57	**J26**	**Lady Margaret Hospital**	A&A
10	**J26**	**Belhaven Hospital**	Lothian	58	**B7**	**Lawson Memorial Hospital**	Highland
11	**J26**	**Blairgowrie & Rattray Cottage Hospital**	Tayside	59	**J26**	**Leanchoil Hospital**	Grampian
12	**B9**	**Bo'ness Hospital**	Forth Valley	60	**B7**	**Little Cairnie Hospital**	Tayside
13	**B9**	**Bonnybridge Hospital**	Forth Valley	61	**B7**	**Loanhead Hospital** (see note 6)	Lothian
14	**J26**	**Brechin Infirmary**	Tayside	62	**B9**	**Lochmaben Hospital**	D&G
15	**A3**	**Caithness General Hospital**	Highland	63	**J26**	**Lockhart Hospital**	Lanarkshire
16	**J26**	**Campbell Hospital**	Grampian	64	**A3**	**Mackinnon Memorial Hospital** (note 5)	Highland
17	**J26**	**Campbeltown Hospital**	Highland	65	**J26**	**Maud Hospital** (note 1)	Grampian
18	**J26**	**Castle Douglas Community Hospital**	D&G	66	**J26**	**Mid Argyll Hospital**	Highland
19	**J26**	**Chalmers Hospital**	Grampian	67	**B9**	**Midlothian Community Hospital**	Lothian
20	**B9**	**Clackmannan Hospital**	Forth Valley	68	**B9**	**Migdale Hospital**	Highland
21	**B7**	**Corstorphine Hospital**	Lothian	69	**J26**	**Moffat Community Hospital**	D&G
22	**J26**	**Cowal Community Hospital** (note 3)	Highland	70	**J26**	**Montrose Royal Infirmary**	Tayside
23	**J26**	**Crieff Community Hospital**	Tayside	71	**J26**	**Nairn Town and County Hospital**	Highland
24	**J26**	**Davidson Cottage Hospital** (note 4)	A&A	72	**J26**	**Netherlea Hospital**	Fife
25	**G21**	**Dunaros**	Highland	73	**J26**	**Newton Stewart Hospital**	D&G
26	**J26**	**Dunbar Hospital**	Highland	74	**J26**	**Peterhead Community Hospital**	Grampian
27	**J26**	**Dunoon and District General** (note 3)	Highland	75	**J26**	**Portree Hospital**	Highland
28	**J26**	**East Ayrshire Community Hospital**	A&A	76	**J26**	**RNI Community Hospital**	Highland
29	**B9**	**Edenhall Hospital**	Lothian	77	**J26**	**Ross Memorial Hospital**	Highland
30	**J26**	**Edington Cottage Hospital**	Lothian	78	**B7**	**Rothesay Victoria Hospital Annexe**	Highland
31	**B9**	**Ellen's Glen House**	Lothian	79	**J26**	**Rothesay Victoria Hospital**	Highland
32	**B9**	**Ferryfield House**	Lothian	80	**J26**	**Seafield Hospital**	Grampian
33	**B9**	**Findlay House**	Lothian	81	**J26**	**St Andrews Community Hospital**	Fife
34	**J26**	**Fleming Cottage Hospital**	Grampian	82	**J26**	**St Brendans Cot Hospital**	W. Isles
35	**J26**	**Fraserburgh Hospital**	Grampian	83	**J26**	**St Margaret's Hospital**	Tayside
36	**A3**	**Galloway Community Hospital**	D&G	84	**B7**	**St Michael's Hospital**	Lothian
37	**J26**	**Girvan Community Hospital** (note 4)	A&A	85	**B9**	**St Vincent's Hospital**	Highland
38	**B7**	**Glencoe Hospital** (note 2)	Highland	86	**J26**	**Stephen Cottage Hospital**	Grampian
39	**J26**	**Glen O'Dee Hospital**	Grampian	87	**B7**	**Thomas Hope Hospital**	D&G
40	**J26**	**Glenrothes Hospital**	Fife	88	**B7**	**Thornhill Hospital**	D&G
41	**J26**	**Hawick Community Hospital**	Borders	89	**B9**	**Tippethill Hospital**	Lothian
42	**J26**	**Hay Lodge Hospital**	Borders	90	**B9**	**Town and County Hospital**	Highland
43	**J26**	**Jubilee Hospital**	Grampian	91	**J26**	**Turner Memorial Hospital**	Grampian
44	**J26**	**Ian Charles Cottage Hospital**	Highland	92	**J26**	**Turriff Cottage Hospital**	Grampian
45	**J26**	**Insch & District War Memorial Hosp.**	Grampian	93	**J26**	**Ugie Hospital**	Grampian
46	**B9**	**County Community Hospital Invergordon**	Highland	94	**G21**	**Uist & Barra Hospital**	W. Isles
47	**J26**	**Inverurie Hospital**	Grampian	95	**J26**	**Victoria Memorial Cottage Hospital**	Lanarkshire
48	**J26**	**Irvine Memorial, Pitlochry**	Tayside	96	**B7**	**Whitehills Hospital**	Tayside

Notes: 1) Maud Hospital closed October 2008; 2) Glencoe Hospital closed March 2009; 3) Dunoon and District Hospital renamed Cowal Community Hospital in 2010; 4) Davidson Cottage Hospital closed April 2010 and reopened as Girvan Community Hospital 30th April 2010; 5) Mackinnon Memorial is also know as Broadford Hospital; 6) Loanhead hospital closed 2010.

Annex 2: Specialities in Community Hospitals in Scotland

Specialities provided in community hospitals and the number of hospitals providing the service (2010 data from ISD). This list is a starter list which represents information provided by NHS Boards, CHPs and Community Hospitals with a view to developing a more complete list of specialities in the future.

Speciality	Hospitals	Inpatient	Day Case	Outpatient	AHP	Nurse Led	Speciality	Hospitals	Inpatient	Day Case	Outpatient	AHP	Nurse Led
Accident & Emergency	52		X			X	Hearing aids	10				X	
Adolescent Psychiatry	10			X		X	Learning Disability	6			X		X
Anaesthetics	6	X	X	X		X	Medical Oncology	2					X
Audiometry	7				X		Medical Paediatrics	30			X		X
Cardiology	23			X		X	Midwifery	1	X				
Child & Adolescent Psychiatry	2					X	Nephrology	11			X		X
Child Psychiatry	12			X		X	Neurology	15			X		X
Chiropodists/podiatrists	44				X		Obstetrics	5	X	X	X		X
Clinical Genetics	1			X		X	Obstetrics Ante-Natal	26			X		X
Clinical Oncology	6			X		X	Obstetrics Post-Natal	2			X		
Clinical Psychologists	24				X		Occupational therapists	67				X	
Community Dental Practice	2	X	X				Ophthalmology	28		X	X		X
Community Midwifery	1					X	Optometrists	6				X	
Dermatology	20			X		X	Oral Surgery	4	X	X	X		X
Diabetes	6			X		X	Orthodontics	5			X		X
Diagnostic Radiology	37				X		Orthopaedics	35	X	X	X		X
Dieticians	52				X		Orthoptists	17				X	
Ear, Nose & Throat (ENT)	22	X	X	X		X	Others	2				X	
Electrocardiography	12				X		Palliative Medicine	10	X	X	X		X
Endocrine	1			X			Physiological Measurement Tech.	4				X	
Endocrinology & Diabetes	14			X	X	X	Physiotherapists	82				X	
Family Planning Service	1					X	Plastic Surgery	3			X		
Forensic Psychiatry	1			X			Prosthetists/orthotists	21				X	
Gastroenterology	8		X	X			Psychiatry of Old Age	51	X	X	X		X
General Medicine	37	X	X	X		X	Rehabilitation Medicine	26	X	X			X
General Psychiatry	39			X		X	Respiratory Medicine	18			X		X
General Surgery	17	X	X	X		X	Rheumatology	11	X	X	X		X
General Surgery (excl Vascular)	29	X	X	X		X	Speech and language therapists	36				X	
Genito-Urinary Medicine	4			X		X	Surgical Paediatrics	2			X		
Geriatric Medicine	63	X	X	X		X	Ultrasonics	12				X	
GP Obstetrics	13	X	X	X			Unspecified	3					
GP Other than Obstetrics	72	X	X	X		X	Urology	18		X	X		X
Gynaecology	35	X	X	X		X	Vascular Surgery	4			X		X
Haematology	2			X		X							

COMMUNITY HOSPITALS STRATEGY REFRESH

This document is also available on the Scottish Government website:

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