COMMUNITY HOSPITALS – THE NEXT 50 YEARS MATTER!
Dr Alastair Noble – A Personal Reflection

Scotland is a visionary country

If we really want to give the highest quality of care, we need to deliver the right structures and organisations. All patients must have access to the full range of options.

This means a Community Hospital bed in all localities.

Why? Because it allows the complex team working to allocate the patient to the correct level of care for them at all times. It provides the level playing field that allows both Generalist and Specialist to fulfil their best roles and target optimum care.

Last but not least we must look at educating a suitably trained work force in all professions for the future. Most care will be in a community setting. We must make sure most education is in that community setting. The Generalists in all professions must do the bulk of training and this is where the Community Hospital with the extended Community Teams comes into its own. Specialists have undermined the quality of Generalist training and we must put it back at the top of the agenda.

I hope this strategic paper will give the necessary impetus to restore the Generalist role to its essential core building block in both Education and service delivery. It also allows the Specialist in all Professions to concentrate and deliver their care where it is appropriate, but above all to allow them to stop doing what is not in our Patients best interest-over treating, over diagnosing and above all delivering no continuity of care. Patients and their relatives value continuity of care. The cradle to death aspect of General Practice immersed in its own rich locality is fundamental to that trust and human relationships which makes General Practice so fulfilling as a profession.

We have the right model available and now is the best opportunity ever to deliver the highest quality Health and Social Care for Scotland. This must also be linked to the correct Education and Training for all Professions.

In summary, I believe that General Practice provides real Professional satisfaction for Generalists, like myself, and if we get it right it allows people with Specialist minds to deliver their skill and input. Above all we need a balanced system and that means for next few years we concentrate on General Practice and train our next workforce to be both Generalists for the majority and fewer Specialist where we need them.

Well done to the Community Hospitals Association for reaching 50.

It would be a nice present if we can deliver a Community Hospital for all our patients.

infocommunityhospitals@gmail.com

Why General Practice Teams including Community Hospitals are an essential part of Patient Care in the future.

This paper is written to celebrate the 50th anniversary of the Community Hospital Association in England. I have been asked to write the Scottish View. I have chosen not to do a historical review and would recommend Sir Lewis Ritchie's Community Hospitals in Scotland paper from 1996 (1) along with the output from the SACH Alumni last conference in 2016 (2) as essential reading.

We have inherited an ageing model of care which is no longer fit for purpose. We must deliver an integrated, locality-based health and care service to meet the real needs of our population going forward in all localities in Scotland

We have over-concentrated on Specialist Big Hospital Medicine and almost totally disregarded the essential role of Generalist Community Care. We have increased Consultant numbers in Highland for example from 160 in 2005 to 242 in 2016 whilst the GP count went from 300 to 305.The ratio being 0.7 Consultant per GP in Highland. Tayside historically is 1.6 Consultant and Glasgow 1.9 Consultant per GP.

A recent BMJ paper (3) shows the same pattern in prescribing in England, the total rising from £13 bn in 2010-11 to £17.4 in 2016-17. The GP prescribing rising slightly from £8.8 bn to £9.1 bn while hospital spend went up from £4.2 to nearly double at £8.3 bn.

The health and social care models have delivered massive benefits since their inception. We have the fittest, healthiest population ever. Yet all we hear are complaints! People are still dying. It must be stopped - everybody must live forever. Well my outcomes are the same as every other Doctor, 100% of my patients have been born and 100% of my patients will die.

The Covid-19 saga has been highly informative. Big hospitals with ventilators and renal dialysis have not cured frailty. How much has been wasted on kit/toys for boys for no return? The patients in nursing homes are frail and do not overcome terminal illness. It awaits us all.

We have been seduced by research. It is a massive growth industry. The answer is always more research and we waste billions on repeating the same sort of investigation to learn nothing new. Why do we not use research properly as an essential component of development?

Why do we not deliver the best systems to ensure maximum gains for our population and that they are as cost effective as they can be. High quality community care is the essential building block for all care systems. If it is performing to its optimum, we can deliver the highest quality secondary care where appropriate. The evaluations of the Total Purchasing sites (4) showed clearly that those GPs with extended Community teams delivered the best community care outcomes. They were also the best commissioners of secondary care as they knew what their teams can do and what they cannot. The best commissioning is when the GP and Consultants agree what needs to be done in Consultant Care and as importantly what does not and when to transfer the patient back to the integrated locality-based Community Team. This clinical decision-making treats both Consultant Care and General Practice Care as equals.

The clear outcome of the Multi Agency Inspection Team's work (5) is that high quality Community Care can and should deliver over 99% of the occupied bed days for our over 75 population (our biggest spend). Put simply most elderly people are in their own homes living independently and enjoying life.

Background DATA Scotland

Data (6) Total occupied bed days (OBD)

- 6.4 million OBD
- 0.8 m scheduled/planned
- 5.6 m unscheduled/unplanned
- 600,000 DELAYED DISCHARGES = 50-55 wards full of delayed discharges=2 DGHs full
- Nearly 4m OBD are occupied by patients over 65
- 2% of patients occupy 79% of OBD
- 2.5 % of total population =50% of spend on hospitals and prescribing

It is understood that of the frail elderly patients who were unscheduled admission who are in hospital today it is estimated that one third up to will be dead within 1 year and 1 in 10 will die in this hospital admission.

Can we save the Titanic? Do we even want to?

Francis/Mid Staffordshire Report (7) showed how dangerous it can be in an acute hospital if you do not need to be there and 20% were discharged straight to a Nursing Home. The coronavirus death rates again show how dangerous institutional care can be. Both hospitals and nursing homes clearly show this. Can we improve on this?

The Perth & Kinross Perfect equation work shows the realistic alternative, and sets standards which improve both quality of care, but also quality of life. Which bed did you sleep in last night? A great question for the over 75s!

- 95% OBD - they are getting on with enjoying life with only GP & General medical services input
- 3% OBD - they are at home with complex care health and social care package-under regular review
- 0.8% OBD - they are in nursing homes with average length of stay 1 year
- 0.5% OBD - they are in Community Hospital (including Hospice care) average length of stay2-3 weeks
- 0.7% OBD - they should be in Consultant bed and average stay should be about 1 week

This is being delivered in the best areas in Scotland where we still have extended Community Teams with GP-led Community Hospitals. This would give Scotland a quite different pattern of care.

5.6 m OBD would be reduced by 600,000 OBD of delayed discharges being eliminated. The variations would reduce another 2m OBD to reach our perfect equation standard of quality care. Again, the evidence is overwhelming. The proximity of a big hospital drives admissions and worried well/social class use more OBD in hospital and Nursing Homes. This is not clinically appropriate

A realistic outcome total of 3.8 m OBD in all Scottish hospitals. There is also a 3-4 times variation in Nursing Home rates and in >10.5 hours of home care. The patterns are clearly historical rather than clinical. It is aye been that way!

Our Elderly and Infirm deserve a 'Gold Standard' of care

I firmly believe that having 60% of all OBD in hospital being in GP-Led Community Hospital Beds, as in Aberdeenshire, is the gold standard of care for our frail elderly/near to death patients. Aberdeenshire also has the lowest hospital OBD rate and again I believe this is because the GPs, their community teams and above all their local communities and individuals all know this is the optimum quality of care.

Patients, relatives and communities all value continuity of care. There is no alternative to the GP and the community teams in delivering that quality of care. The Covid-19 experience has again shown the fundamental weakness of the disease specific specialist model. Most people have more than one condition and most need health and social care.

The role of the disease-specific specialist is to help the patient get optimum treatment for that specific condition. All my discussions with the best of Consultants and General practitioners have agreed on this fundamental point. This is why we pay the Consultants and General Practitioners to take responsibility and accountability for the clinical care.

Scotland's 2020 vision

I have some thoughts on the benefits of bringing back of Kerr (8) and reflecting on the lack of progress to the "2020 Vision." There are some difficult questions with some obvious answers.

** Why have we bought the Specialist model?*

Common conditions are Common. The commonest is old age/frailty and closeness to death. None of these is a Specialist condition. It just needs honesty, integrity, and good generalist clinical skills to help our patient and their relatives/friends /carers see what they already know.

Every report I have read says we need more Generalists/more community care/more integrated health and social care-yet we keep not doing this.

** Why are GP s not being valued?*

Some of this is our own failing. "Everybody "can do what the GP can do? Absolute rubbish-the most difficult skill in medicine is getting the diagnosis right. This is especially true when diagnosing nothing wrong with the patient and being right! The next most difficult is in diagnosing where therapeutic (curative) treatment is no longer in the patient's interest and supporting palliative care.

We must cherish and support the excellent GPs we have now and promote them as the model for teaching our young Doctors to be Proud to be a GP.

** Why Independent Contractor Status?*

Simple answer to the GPs who do not want to be partners. Would you prefer to be managed by a fellow GP (who knows what it is like) or by a non-medical low to middle grade manager? I always think of Bob Liddell (9) explaining to me why the individual clinician is always responsible for their own clinical decision-making and how as a manager he could not and would not take that responsibility away from them (polite version).

** Why localities must take 24/7 accountability and responsibility?*

We take 100 bright young doctors. 50 become Consultants and continue to do nights and weekends, 40 become GPs and will never do another night or weekend and 10 will do all the GP. Out of hours work. I cannot think of a dafter contact decision. It must be changed. It can be changed.

Nairn still has our own Nurses triaging our Out of Hours (O-O-H) calls and our own GPs on call. It is a great source of local knowledge and again a massive benefit to our patients. It allows for example remarkably close co-operation and liaison between our mental health Team and the O-O-H care which benefits some of our most vulnerable patients with mental health conditions. It reinforces our continuity of care with shared access to our medical records. Again, particularly essential in end of life care where we consistently see over 75% of our deaths taking place in our own community.

** Why Localities and Integrated Care*

All the team working evidence is around stable settled teams who are confident and trust each other. This must be locality based and involve all health and social care. This also gives maximum confidence to the Consultant Team.

** Why has the situation not improved for GPs and Community Integrated Care?*

The clinical decision has and always will be the purchasing decision. We have always ducked the value for money debate and discussion. There will always be a top line budget. My recent experiences in Tayside and Highland have just confirmed that without clinical change overspends and write off from debts will just roll on.

Therefore, the Integrated Resource Framework (IRF) Fair Share Integrated Locality based Budget (10) is essential and the GP leadership in each Locality becomes accountable and responsible for staying within that agreed Fair Share budget.

However, and this is vital the clinical decision-making and therefore accountability and responsibility is shared with and accepted by Consultants and GPs together. This equally applies to all the teams-community/social and hospital. Probably and this is most important the individuals in each locality share/understand and can contribute to improving their health and social care outcomes. It also allows us to target the variation we accept in Fair Share allocation and see if the extra allocation is working or not.

The future?

General Practice Teams, including Community Hospitals, are an essential part of Patient Care in the future.

Dr Alastair L Noble MBE

Community Hospitals Association Committee and Lead for Scotland
Chair of Scottish Association of Community Hospitals Alumni

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