NHS Overview and Scrutiny Committee Briefing Note

Community hospitals (West Kent)

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General background

There are currently 332 community hospitals in England. They are often popularly known as "cottage hospitals" and many are located in smaller towns and rural areas – although there are also many in urban and suburban areas.

Community hospitals mostly pre-date the National Health Service, owing their origins to endowments from wealthy benefactors and public subscriptions; many were set up as war memorials. When the NHS was established in 1948, the community hospitals then existing were effectively gifted to the new service.

As a legacy of their charitable origins, many community hospitals often have strong voluntary Leagues of Friends that support them by raising funds and lobbying on their behalf.

NHS Primary Care Trusts are usually responsible for running community hospitals.

In recent years, the reconfiguration of NHS acute hospital services has been gathering pace, with the increasing centralisation of specialist services (including elements of emergency services), such that they serve catchment populations of around 500,000. As this occurs, some former district general hospitals (serving populations of around 250,000) are being downgraded, effectively becoming community hospitals. Such former acute hospitals tend still to be run by the NHS hospital Trusts that previously operated them as acute hospitals.

There is significant variety in the size of community hospitals and the scope of the services that they provide. The range of services provided in community hospitals can include all of the following (this is not an exhaustive list):

- diagnostic tests;
- preventative healthcare (including screening, advice and health promotion);
- day-case operations;
- outpatient clinics;
- intermediate care (to prevent unnecessary admission to an acute hospital bed, support timely discharge, reduce avoidable use of long-term care and maximise independent living);
- palliative/end-of-life care (helping patients with incurable conditions, including terminal illness);
- support for long-term conditions;
- rehabilitation services (supporting recovery from illness);
- urgent/unscheduled care (dealing with minor injuries and minor illnesses).

The services that community hospitals provide are often of particular importance for older people.

Community hospitals are greatly valued by their local communities for their convenience, accessibility, continuity and familiar, friendly atmosphere – as well as the sense of local ownership.

They tend to work closely with local GP practices and can provide a convenient base for Out of Hours primary-care services and community health professionals, such as health visitors, district nurses and midwives. They can also be a focus for the integration of health services with social-care provision.

As providers of intermediate care, community hospitals play an important role in freeing up both inpatient and outpatient resources in acute hospitals. “Step-down” beds allow patients to be discharged from acute hospitals even though they are not yet well enough to return home. “Step-up” beds allow patients to be admitted to hospital without taking up an acute-hospital bed. Community hospitals also save patients from having to travel in order to access hospital services.

Government policy

The importance of community hospitals in delivering healthcare locally was recognised in the *NHS Plan*, published in 2000.

In 2003, the Department of Health published a discussion document entitled *Keeping the NHS local – a new direction of travel*. This indicated that the government saw a continued important role for community hospitals as one of a number of ways of delivering “ambulatory care plus”.

At the 2005 general election, the Labour Party manifesto included the following promise:

> *To help create an even greater range of provision and further improve convenience, we will over the next five years develop a new generation of modern NHS community hospitals. These state-of-the-art centres will provide diagnostics, day surgery and outpatients facilities closer to where people live and work.*

In October 2005, the Secretary of State for Health, Patricia Hewitt, gave an undertaking that:

> *Through an initial £100m investment, we will build, rebuild or refurbish 50 new community hospitals in the next Parliament. Because community hospitals will be smaller, they can be sited closer to where people live and work. They will also reflect the latest standards of design and layout.*

The White Paper *Our health, our care, our say: a new direction for community services*, published in January 2006, clearly indicated that community hospitals would play an important part in the major shift of health services into primary care to which the government was committing itself. And it committed the government to fulfilling the manifesto promise regarding the creation of a new generation of community hospitals:

> *These will be places where a wide range of health and social care services can work together to provide integrated services to the local community.*

> *They will complement more specialist hospitals, serving catchment areas of roughly 100,000 people, but taking on more complex procedures, for example complex surgery requiring general anaesthetic or providing fully-fledged accident and emergency facilities.*

The White Paper stipulated that:

> *PCTs taking current decisions about the future of community hospitals will be required to demonstrate to their SHA [Strategic Health Authority] that they have consulted locally and have considered options such as developing new pathways, new partnerships and new ownership possibilities. SHAs will then test PCT community hospital proposals against the principles of this White Paper.*

The White Paper promised to make capital funding available for a "new generation of community hospitals and smaller facilities offering local, integrated health and social care services".

In February 2006, a letter to SHA Chief Executives from the Department of Health set out core expectations of local consultations (in accordance with Section 11 of the Health and Social Care Act 2001 – now Section 242 of the National Health Service Act 2006) regarding community hospitals. The letter indicated that the following questions should be posed in respect of any proposals for community hospitals:

> *Do the proposals fit with our commitment to invest an increasing proportion of NHS resources in providing care in community settings?*
>
> *Do the proposals support the White Paper principles of providing modern health and social care in more local and community settings?*
>
> *Do the proposals fit with the White Paper vision of a new generation of community hospitals, for example, giving scope for the provision of specialist care more locally such as diagnostics, day-case surgery and outpatients?*
>
> *Are the proposals consistent with the White Paper goal of reducing unnecessary bed occupancies, eg for providing step-down rehabilitation beds in community hospitals?*

The White Paper was followed in July 2006 by *Our health, our care, our community: investing in the future of community hospitals and services*. This outlined how the government planned to invest the promised capital funding – £150 million in each year over five years, amounting to £750 million in all. This scheme is known as "Central Capital Funding for Community Hospitals and Services".

The document recognised that community hospitals were in many cases operating in old buildings that were not adequate for delivering modern healthcare and that some brand-new community hospitals would have to be built. Also, new diagnostic equipment and other technology would have to be bought – possibly including equipment to allow services to be delivered to patients in their own homes.

It was stated that the new capital funding would be made available to PCT-sponsored schemes "to support proposals involving the public and in some cases the independent sectors as part of a mixed programme of investment". There would be no requirement to apply for this funding – it was intended to be an optional additional resource.

Investment proposals would have to demonstrate that they had met a set of principles set out in the document. These principles included goals set out in the White Paper:

- better prevention of, and earlier intervention in, disease;
- more choice and a louder voice for patients;
- tackling health inequalities and improving access to services;
- more support for people with long-term needs.

They also included the various strands of "system reform" that are bringing market-type mechanisms and outsourcing of service-provision into the NHS:

- Practice-based Commissioning;
- Patient Choice;
- a greater diversity of providers – including the for-profit and voluntary sectors;
- Payment by Results.

Regarding service-design, it was stipulated that plans must:

- be locally led;
- provide high quality services;
- re-design patient pathways;
- anticipate future needs as the population changes;
- adopt new technologies;
- plan across primary and secondary care;
- be affordable for the whole health economy;
- promote integrated service solutions;
- engage and harness the potential of staff;
- enable the transition of staff.

It was emphasised that PCTs must:

> *reconsider current proposals to close or reduce the scope of community hospitals if their only purpose is to make short-term financial savings. They cannot be supported on that basis and this has been made clear.*

Three investment models were set out for PCTs to choose from:

> *a. Public capital – using NHS capital directly.*
>
> *b. Local Improvement Finance Trust (LIFT) – an existing approach for bringing together public capital and independent sector expertise.*
>
> *c. Community Ventures – a new approach for capital investment not only in buildings or property but in services. This allows for the establishment of a joint*

venture between a PCT and a partner (which could be a third sector or private organisation). This joint venture company would be given capital. The Department of Health would retain a stake in the joint venture company's equity.

It is clear that the shift to primary care envisaged by the government entails a whole range of different models of service provision alongside traditional community hospitals/"cottage hospitals". These include GPs with Special Interests, walk-in centres, health-centres, polyclinics and domiciliary services. These could potentially all be run by a diversity of providers, including for-profit companies and the voluntary sector, in the context of a competitive NHS "market" in which patients are increasingly free to choose their provider.

There is plainly no set model for what services (if any) community hospitals will provide, how they will provide them or what catchment population they should serve. These are matters that PCTs are having to address, as the strategic commissioning bodies within the NHS. They are having to do so in the light of local circumstances (including financial issues) and taking account of the potentially powerful forces that are being unleashed by NHS "system reform".

Against this background, the definition of the term "community hospital", as it is now used by the Department of Health, has become very broad and flexible. The Health and Social Care Change Agent Team (which provides advice and support to health and social care communities on issues affecting the care of older people) states that "a community hospital is a 'service' not a building".

The Health and Social Care Change Agent Team's publication *Developing Community Hospitals: Models of Ownership – Options for Community Hospitals*, published in February 2006, describes a range of possible options for the ownership of community hospitals providing NHS services. These include ownership by:

- an NHS Trust (Hospital Trust, Foundation Trust or Health and Social Care Trust);
- a Primary Care Trust;
- clinicians working under a Specialist Provider Medical Services contract (an extension of the Personal Medical Services scheme for GPs, although this option does not actually require GP involvement);
- a non-profit independent provider (charity; voluntary organisation; "social enterprise");
- a for-profit independent provider (private company limited by shares; private company limited by guarantee; private unlimited company; public limited company, including community interest public limited companies);
- an independent provider working under an Alternative Provider Medical Services contract.

Despite the stipulation by the Department of Health that community hospitals must not be closed in order to make short-term financial savings, there remains widespread concern that this is exactly what is happening.

The Community Hospitals Association (CHA) claims that as many as a quarter of community hospitals are facing possible cuts in services or outright closure. A national campaign group called Community Hospitals Acting Nationally Together (CHANT) was formed in 2005 to draw together around 30 local groups that have been formed to oppose

what they see as cuts in community hospitals. CHA and CHANT have identified the following as factors in attempts by PCTs to cut community hospitals:

- the need to save money, in order to address deficits;
- the drive to provide more care in patients' homes (the feasibility of doing which on a large scale is disputed);
- the imperative to commission services from non-NHS providers (the for-profit and voluntary sectors).

The introduction of Payment by Results has caused financial problems for some community hospitals, due to the issue of "tariff unbundling". Under PbR, each "spell" of acute care is paid for by the commissioning PCT according to the relevant national tariff, set centrally by the Department of Health (based on average costs across the NHS, adjusted to allow for unavoidable regional variations in cost). Where a patient is discharged from an acute hospital into "step-down" care in a community hospital, the tariff has to be split ("unbundled"), so that the PCT can retain a portion of it to pay for that part of the patient's pathway being provided by the community hospital. The DoH has only recently begun to formulate national benchmarks for post-acute rehabilitation costs, in order to facilitate unbundling.

Any reductions in the availability of beds at community hospitals obviously raise concerns for acute hospital Trusts regarding "bed blocking" – and for local authorities with Social Care responsibilities as regards "cost-shunting".

Some campaigners in support of community hospitals see opportunities in NHS system-reform that might allow threatened hospitals to be kept in existence. It is argued that charities or companies might be formed to take over community hospitals (as indicated by the Health and Social Care Change Agent Team, there is a range of possible ownership options). These would then be able to secure income under the operation of Patient Choice, Practice-based Commissioning and Payment by Results.

As part of its "Productive Community Hospital" project, the NHS Institute for Innovation and Improvement commissioned a profiling project in respect of community hospitals throughout England, the results of which were published in March 2007. This found that, although the study had been carried out "during a time of radical change for Primary Care Trusts", there was "evidence of innovation and a clear commitment to service improvement" in community hospitals.

Community hospitals in West Kent
The following community hospitals are currently operated by West Kent PCT:

- Edenbridge and District War Memorial Hospital (17 beds);
- Gravesham Community Hospital, Gravesend (22 beds);
- Hawkhurst Hospital (23 beds);
- Livingstone Hospital, Dartford (38 beds);
- Sevenoaks Hospital (47 beds);
- Tonbridge Cottage Hospital (30 beds).

In early 2006, the Maidstone Weald and South West Kent PCTs (two of the predecessors of the present West Kent PCT) proposed that the four community hospitals in the south of

West Kent should refocus their provision of services towards:

- accepting predominantly direct referrals from the community;
- providing continuing care and respite care (according to strict protocols);
- providing planned rehabilitation care (subject to contract negotiation to support timely discharge from hospital);
- providing intermediate care, including management of long-term conditions (according to agreed protocols).

These plans were explained to members of the NHS Overview and Scrutiny Committee at a briefing meeting held on 9 February 2006.

It was reported that, since July 2005, of the 117 beds in the four community hospitals in the south of West Kent, nine (eight at Sevenoaks and one at Edenbridge) had been temporarily closed as part of a package of cost-cutting measures.

It was planned to achieve the following temporary bed closures in February 2006:

- 15 beds at Tonbridge;
- seven beds at Edenbridge;
- 27 beds at Sevenoaks;
- six beds at Hawkhurst.

It was argued that these short-term, temporary measures had to be taken in the interests of the future viability of the community hospitals – as they would contribute to restoring the PCTs' financial stability. If the PCTs failed to address their financial problems, then more drastic measures, such as the permanent closure of one of the community hospitals, would have to be taken.

Faced with continued financial problems in the 2006–7 financial year, the Maidstone Weald and South West Kent PCTs formulated a Turnaround Plan in July 2006. At the same time, it was announced that a review of community hospitals would take place, separate from the Turnaround Plan, to consider the long term future of the community hospitals in the light of the January 2006 White Paper.

The consultancy firm Tribal was engaged to undertake this review. During the review, the PCTs worked with the Leagues of Friends at all four community hospitals concerned and held stakeholder meetings at each of the hospitals. The review was carried out in the autumn of 2006 and the stated intention was to bring forward proposals on which formal consultation would begin in early 2007.

The then Chief Executive of the PCTs, David Meikle, indicated that the future of Sevenoaks Hospital was secure. He said it was intended to make a bid for a share of the DoH's Central Capital Funding for Community Hospitals and Services in order to expand services at Sevenoaks. There was a widespread perception that services were to be concentrated at Sevenoaks and that the other three community hospitals were under threat of closure.

In February 2007, the Secretary of State for Health stated in a Parliamentary Answer that the review was likely to be completed in spring 2007. She said that the bed-closures in the

community hospitals in the South of West Kent that had been made for financial reasons in 2006 would stay in operation pending the outcome of the review.

The Chief Executive of the Hospice in the Weald, John Ashelford, stated in February 2007 that the continued closure of beds at the Edenbridge and Tonbridge community hospitals had led to "bed-blocking" at the hospice, meaning that it was not always able to admit terminally-ill patients.

In spring 2007 it became clear that the PCT had decided to re-run the review, with a different focus. In March 2007, it was announced that a new review of community hospitals was being conducted (again by Tribal), this time also covering the two in the north of West Kent (at Gravesend and Dartford).

It was stated that an "enormous information gathering exercise" was being undertaken. This was looking at "geographic and transport considerations, the current hospital premises, the services offered in each of the hospitals and elsewhere in the community and the place of community care within the wider health service context". The emphasis on treating patients "closer to home" was noted as a key aspect of the "Fit for the Future" review of health services across Kent and Medway.

According to the PCT, there was to be "a change of emphasis from 'step down', where patients are transferred from the acute sector to community hospitals, to 'step up', whereby patients are referred to community hospitals by their GP or from acute hospital A&E departments".

It was noted that Livingstone Hospital in Dartford had been cited by the national older-persons "Czar", Prof Ian Phelp, as an example of best practice (in *A Recipe for Care – Not a Single Ingredient*, published in January 2007).

The Chief Executive of the PCT, Steve Phoenix, also stated in March 2007 that the 27 beds closed at Sevenoaks Hospital (in Holmesdale ward) were to be reopened, on an interim basis for six months in the first instance.

The outcome of the review was presented to the PCT Board on 24 May 2007. Its conclusions were as follows:

- Best practice must be generalised across the six community hospitals in West Kent.
- Eighteen beds (out of the 62 currently closed) must be reopened in the short term, to meet demand.
- Over the next three to five years, all the currently closed beds must be reopened.
- Community hospitals must be a key part of the PCT's strategy for providing more care closer to home.
- All the community hospitals in the south of West Kent must remain in place and continue to provide most of the services they already do (modernised in some cases); and investment must be made accordingly.
- The Livingstone Hospital buildings are out-of-date; but the hospital provides a model service and needs to continue doing so. The most likely solution is to "reprovision", *i.e.* to provide the service at an alternative location (rather than refurbishing the Livingstone Hospital, or building a new hospital on the same site). This will need to be looked at further; any proposed changes will be subject to

formal consultation.

- The Minor Injuries Unit at Edenbridge Hospital is not clinically viable and needs to close. This proposal will be subject to formal consultation.

The PCT decided immediately to rename the Edenbridge Minor Injuries Unit a "Treatment Centre", on the basis that it was not actually functioning as an MIU. This decision proved controversial locally, being opposed by the hospital's League of Friends, who regarded it as pre-empting the outcome of the consultation on the future of the unit.

The PCT also agreed that there was an opportunity for the renal dialysis service, provided by Guy's and St Thomas' NHS Trust, to be relocated from Pembury Hospital to Tonbridge Cottage Hospital – with an increase in provision from 14 units to 20. This too proved controversial, since it entailed the 15 temporarily-closed beds at the Cottage Hospital being taken over by the renal unit and, thereby, ceasing to be available for the provision of services specifically for local people.

Guy's and St Thomas' Trust has now decided that Tonbridge Cottage Hospital is not an appropriate location for the renal dialysis service and the PCT is considering alternative uses for the part of the hospital in which it was to have been housed. The PCT takes the view, in line with the review's findings, that the 15 temporarily-closed beds at Tonbridge are effectively surplus to requirements – so some other use for the space concerned will have to be found. The new proposals should be considered and agreed by the PCT Board in July and put out to full public consultation later in the year. The 15 temporarily-closed beds will remain closed pending the outcome of the consultation.

In recent months, concerns have been expressed about the withdrawal from Gravesham Community Hospital of some outpatient services that have hitherto been provided there by Dartford and Gravesham acute Trust. The perception locally is that these services have been withdrawn from the Community Hospital and relocated at Darent Valley Hospital, the acute hospital that the Trust runs in Dartford. It has also been claimed that the motivation behind this has been primarily financial, resulting from the inflated costs that the local health economy has to bear in consequence of GCH and DVH having both been built under the Private Finance Initiative.

The NHS Overview and Scrutiny Committee dealt with this issue at its meeting on 9 March 2007. Representatives of the PCT and the Trust stated that the services in question were not being removed from Gravesham but would in future be commissioned by the PCT from local GP practices. This was stated to be in accordance with the principles set out in *Our Health, Our Care, Our Say*; it was denied that there was any financial motivation for the changes. Any gap in the local availability of services in Gravesham (causing patients to travel to Dartford) was only temporary, while new services were being established in the area.