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1. Background

1. The Care Services Improvement Partnership London Regional Change Agent & Lead for community hospitals, Claire Goodchild, commissioned a piece of work to produce a good practice guide for use by local authorities and PCTs who were contemplating reviews of their community hospital and intermediate care provision. This was at the request of a number of local authority and PCT leads who having identified that there was no single model or template to undertake this work, felt it would be helpful to have a guide based on good practice and approaches taken in a number of PCTs.

2. The brief for this work commissioned by CSIP, focused on identifying a methodology to be used to determine the appropriate number of community hospital (and/or intermediate care beds) in a given locality/PCT. It became evident from an initial survey of work undertaken by PCTs and local authorities in this area of work, that as community hospitals varied greatly in their role and function with a very broad range of different services provided, it was difficult to produce any standard methodology that looked at an optimum bed complement that could apply across different health and social care economies. Also, given the different approaches to reviews undertaken to date, in terms of whether it was a single community hospital review, a review of community hospital provision and other intermediate step-up/step-down and transitional care beds (the definition of which varies) and the inter-relationship with home based rehabilitation and support, or a wider review of community based services, meant that to be meaningful and of use to leads undertaking this work, the brief for this work needed to be broadened.

3. The Health & Social Care Change Agent Team & Community Hospital Association collaborated with University of Warwick in collating evidence (research, reviews, publications and articles) that relate to community hospitals. The March 2005 publication outlines that of the 147 references, 10 relate to ‘costing and planning’. Unfortunately, this is an under researched area and out of the 10 areas noted, only 5 were post 2000 (all in 2001) and 3 were research/audit projects.

This is significant, as there is limited previous work on the evaluation of the effectiveness, including cost effectiveness, of community hospitals that can be drawn upon for this work.

4. Therefore, this guide identifies a number of examples where PCTs have undertaken reviews and have been selected because they appear to be based on a sound methodology and a clear process.
These case studies are included in 2 appendices included in this paper.
Appendix 1, presents the approach taken by local authorities & PCTs in establishing the scope of their review and provides some detail of the process undertaken. This also includes the process of engagement of key stakeholders and the involvement of service users and approaches to formal consultation.

A range of approaches have been selected, ranging from:

- A PBC led review relating to a single community hospital (Gloucestershire - Study A)
- A single PCT wide review of all community hospitals (Somerset - Study B)
- A community hospital review across 2 PCTs (Herefordshire & Worcestershire - Study C)
- A strategic review of all community services across a PCT (Leicestershire & Rutland - Study D)
- A sub-regional review of health and social care services (Northamptonshire PCT - Milton Keynes and South Midlands sub-region Study E)

Appendix 2, presents, the type of information collected, how it was analysed and how conclusions were drawn from this analysis for a number of PCTs. (Gloucestershire - Study A); (Leicestershire & Rutland - Study B); (West Kent PCT Study C); (Herefordshire & Worcestershire - Study D).

This in effect is the methodology used. While there were some elements that were different in the methodologies used, there was also some commonality in terms of a core set of data collated and analysed.
2. Context

1. A number of recent policy developments have given impetus to PCTs and local authorities in their commissioning roles and indeed providers who manage community services, to review their current provision of community based beds and related community services. The introduction of Payment by Results, Practice Based Commissioning and the separation of PCT provider services from their commissioning function, have all been key drivers in this respect.

2. A clear direction in policy underpinned by Our Health, our care, our say, and the DH Commissioning Frameworks, to provide care in community rather than hospital settings and provision of care closer to home, have provided the policy framework for the development of strategies to achieve this objective. PCTs commissioning community services using Practice Based Commissioning and Payment by Results to best effect, in particular the flexibility to unbundle the tariff for diagnostics and post-acute care, have also undertaken community hospital reviews.

3. The commitment in Our Health, our care, our say to develop a new generation of modern NHS community hospitals over a 5 year programme, was followed up by Our Health, Our Care, Our Community: Investing in the future of community hospitals and services inviting PCTs via their SHAs to bid for capital funding in the autumn of 2006 totalling £750 million over a 5 year period. In bidding for this funding, PCTs had to ensure there was a strategic fit with their longer term plans for developing community and primary care services, anticipating future needs and developing integrated solutions based on redesigned care pathways.

4. In addition, the re-configuration of PCTs in October 2006 following Commissioning a patient-led NHS, meant many PCTs had to take stock of their inherited community services provision, which in some cases represented a larger and more diverse range and models of service than had been the case before reconfiguration. In many cases where PCTs were now coterminous with their local authority, it gave both partners an opportunity to review existing provision to achieve a more integrated service model.

5. A further key driver for this work in many PCTs was the financial turbulence PCTs experienced at the time of reconfiguration, which left a number of PCTs facing significant deficits, in some cases inherited from predecessor organisations, with the requirement to achieve financial balance. The reviews undertaken in this context, were often a key component of formal financial recovery plans. In some cases, reconfiguring PCTs inherited proposed and ongoing capital developments under LIFT and the community hospital programme and PFI, with business cases at various stages, again inherited from their predecessor PCTs, which they had to re-evaluate in the context of their
new population. In order to re-appraise proposed schemes, many PCTs found they had to undertake a wider evaluation of their existing provision of community services including beds, to ensure they were consistent with the future needs of their population.

6. In some instances an Independent Sector Treatment Centre had been commissioned or a Foundation Trust had developed a new service, within a PCT’s health economy which impacted upon utilisation of care and existing community hospital provision. There were also instances where the community hospital / intermediate care review was being undertaken as component of a review of urgent care or out of hours care.

7. In addition, even for those PCTs that did not reconfigure, the separation of community provider services and the requirement to establish provider units meant PCTs had to take stock of existing provision including community hospitals and intermediate care, in order to determine the operating costs of those services in order to begin to produce business plans. In some cases reviews were led by commissioners but in others it was provider service leads that had instigated the review.
3. Information Sources

1. Information was gathered from a number of PCTs who had either undertaken a review of their community hospital and/or intermediate care provision or were in the process of undertaking a review, in both cases as a stand alone review or as an element of a wider community services strategic review.

2. Information was collated from 16 PCTs in total (Appendix 3 lists those PCTs) provided by lead managers contacted and through Board reports. In some instances, PCTs had commissioned external consultancies to undertake reviews and information has been drawn from their reports.
4. Community Hospitals - Role and Function

1. Our health, our care, our say set out a model of community hospitals providing diagnostics, day surgery and outpatient facilities, closer to where people live and work (par 6.38). Our NHS, our future, the NHS Next Stage Review Interim Report produced by Lord Darzi in October 2007, set out the government’s vision of promoting community health centres, ideally co-located with other community based services such as diagnostic, therapy, pharmacy and social care services (Ch.5)

2. This model, based on a multi-purpose clinic, can also be defined as a community hospital whereas many existing and traditional community hospitals, which can also take the form of reconfigured District General Hospitals, incorporate inpatient beds for the provision of rehabilitation, outpatient services and in some cases minor injuries services. Other existing models provide integrated health and social care, or an intermediate care service but also extend to many other generalist services.

3. The different models of what constitutes a community hospital was acknowledged in the guidance Our Health, Our Care, Our Community: Investing in the future of community hospitals and services which confirmed the capital funding available could be deployed for other models of provision in addition to a traditional hospital build.

4. Many communities have a vision of their community hospitals as integrated health and social care resource centres, where co-location can be offered to staff, particularly those working in rural settings, with inpatient beds that are more locally accessible to their community. This is why reviews of existing community hospital provision have become controversial and politically sensitive in many areas, making the process of engagement of local communities and service users and consultation with key stakeholders, a crucial element of the review process.

5. What is clear, is that community hospitals appear to be a significant component of the new architecture for the NHS, and will provide an opportunity for primary care to incorporate a range of community hospital services and facilities that integrate with social care.
6. Nevertheless, there is a wide range of models, functions, and services provided which presents PCTs and local authority partners with real challenges in undertaking such reviews and in particular comparative analysis of cost, quality, efficiency, and outputs. In one PCT alone, the following services were provided from its range of existing community hospitals:

- Day Centre
- Outpatients
- Minor Injuries Unit
- X-Ray
- Day Hospital
- Speech & Language Therapy
- Dietetics
- Podiatry
- General Rehabilitation
- Young Disabled rehabilitation
- COPD Service
- Rehabilitation Therapy Centre
- Neuro Gym
- Audiology
- Hydrotherapy Pool
- Diagnostics
- Community Dentistry
- Women and Children's Centre
- In-patient physio
- Out-patient physio
- On-call care
- Evening & Night nurse service
- Rapid Response Nurse Team
- Radiology
- Occupational Therapy
- Specialist Dental Services
- Speech & Language Therapy
- Community Rehab Team
- Neuro. rehab. specialist beds
- Out of Hours
- Inpatient rehabilitative care beds

7. In undertaking reviews of current provision therefore, it is important to be able to separate out different functions and types of service provision and in the following case studies, this has been the approach undertaken by PCTs, albeit with slightly different descriptions or groupings.
5. Good Practice Guide

Notwithstanding the above complexities, there are some general conclusions that can be drawn from the information gathered from PCTs and their leads, which point to good practice and provide a checklist of how these reviews should be approached and undertaken and methodologies for analysing current and future provision. The case studies in the appendices provide more detail of both.

Approach and Scope of Reviews

1. Given the interdependence of services provided in community hospitals and intermediate care (both beds and home based services), with wider community based services, it would seem important to ensure any review of community hospital beds is undertaken as part of a wider review of community services.

2. In order to implement a community services strategy in a PCT and local authority with significant community hospital provision, a community hospitals review needs to be part of that strategy. This can become the start of a medium to longer term development plan for community services, developing the plans in conjunction with stakeholders as proposals are refined and implemented.

3. It is important to ensure there are governance arrangements with clear accountability and reporting processes in place that ensue the involvement of the providers but accountability to commissioners.

4. Whether the review is commissioner or provider led, it is important further process can then follow to take forward the proposals and produce locality based plans. This is particularly important in PCTs covering a large geographical area and where there are a number of locality based PBC consortia. This ensures local needs and variations can be taken into account when producing final proposals.

5. Clearly a community services strategy must look beyond the immediate 1-2 financial years and take account of the medium and longer term health needs of the population, the models of care required in the future, commissioning trends, referral patterns and priorities set by commissioners. Therefore the methodology must include future projections of need over a longer term period.
6. The component of the wider review that analyses community hospital provision should be designed to assist local stakeholders to reach a clear and shared understanding of the overall strategic direction for community services. Specifically, the future pathways and models of care to be delivered in community hospitals should be based on the emerging findings from the community hospital review.

7. A clear statement of the underlying drivers and objectives of the review needs to be articulated at the outset. e.g. an agreement to reduce the number of acute sector beds over several financial years or reducing a deficit as part of a PCT recovery or financial plan over a specified period.

8. There needs to be a setting out of the strategic context e.g. that services will need to be radically different in the future when compared with current models and will need to respond to new commissioning arrangements or and/ or will help to restore financial balance.

9. There needs to be consideration of not only the immediate opportunities and constraints but also the longer-term position in terms of the viability and sustainability of the community hospitals and services they provide, specifically within the context of the models of care they will provide and the amount of activity they will need to deliver.

10. In recognising that community hospitals and services have very strong local links and support from the communities they serve - for individuals, local populations and their representatives, a clear engagement and consultation strategy needs to be developed and in place at the first stage of the process.

Methodology

1. The number, function and location of community hospital beds required by any local health and social care community are dependent on a whole range of interdependent factors and as such there is no simple methodology for calculating this requirement.

2. Also the number and type of beds needed in each locality in a PCT will be dependent upon a range of factors including the commissioning intentions of local GPs and the balance of care being commissioned for delivery either in patient’s homes, in an acute care setting, or in community settings.
3. Furthermore, the functions and services provided by community hospitals vary significantly in many PCTs as referred to in Section 4 above and even where there are similar functions and services, the model of care is not consistent. Also hospital facilities and infrastructure were variable.

4. There are however a number of key elements that comprise a methodology in this context. In Appendix 2, a number of case studies are presented of PCTs that have used such a process to draw conclusions as to what the bed configuration should be in the future and what action is required to achieve this, given current provision.

5. The approaches adopted by PCTs differ in some respects, but there are a number of common elements and steps that need to be taken which are summarised below.

**Population Needs and Demographic Projections**

1. An analysis needs to be undertaken of population needs on a locality basis allied with demographic changes for the total populations in those localities.

2. The information to assess population needs will vary in quality across PCTs but in order to ensure the analysis undertaken and future configurations reflect local needs and requirements, this information needs to feed in to the methodology.

3. Changes in population from the base year being used, also needs to be factored in to the methodology. Population projections based on Office of National Statistics (ONS) projections and the age, gender, and residential ward of the current inpatients (where that information is available) should be used in the calculation of future bed requirements for each community hospital, PBC locality and whole PCT population.

**Activity**

Data needs to be segmented according to category of service provided eg.

Inpatient beds
Day hospital activity
Minor injuries appointments
Outpatient appointments
Radiology examinations
a) Inpatients
An analysis of the current length of stay (LOS) and occupancy rates of each the community hospitals by:

Case Mix
Utilisation
LOS
Occupancy Levels

Average Length of Stay (ALOS)
Analysis of the PCT reviews selected for this paper found that the average length of stay was variable for in-patients. It would be expected that the in-patient rehabilitation areas would have a longer length of stay but often there was no apparent or clear reason for the difference between the community hospitals.

Utilisation of beds within the community hospitals could also be categorised into:

Palliative Care Beds
Beds for medical admissions including those from GPs, and beds for rehabilitation.

Length of Stay
There should be a model used for the optimum LOS eg. patients should have a length of stay of no more than 5 days for a sub acute medical admission which could be all or part of the patient pathway, for specialist stroke rehabilitation stays should be 28 days, and intensive rehabilitation should be no longer than 21 days.

b) Minor Injuries Unit - data presented for:
Number of attendances/Assessment minutes & minutes per week /opening time projected attendances by site with projected growth

c) Outpatients - data presented for:
Current activity - clinic sessions by site Predicted shift from Trust activity & non-trust activity Capacity gap (Modeling should assume improved DNA rates, new to follow up rates and lower cancellation rates & shift from activity @ Trust to a community setting)

d) Day care
Lengths of stay (lengths of stay of patients for Day Care in many of the studies were found to be variable)

e) Radiology - data presented for:
Type of scan/number of scans/equipment @ site
5.2.3 Benchmarking and Cost Comparison

1. Having produced activity data, the next step needs to include a review of comparative unit costs.

2. This comprises of:
   The current forecast out turn full-year revenue costs for each community hospital provided by:

   Inpatient / Outpatient / Day case / MIU / Daycare

This can be presented by segmenting data in the following categories:

- Wards - Cost per patient week
- Medical - Cost per patient day
- Day Hospital - Cost per patient day
- MIU - Cost per patient day
- X-ray - Cost per scan
- Hotel Costs - Cost per meal inpatient - Cost per meal day care

3. Benchmarking Costs and Activity

In order to assess the financial performance of the hospitals, the national community hospitals reference cost index was used by a number of PCTs.

3.1 Reference cost data demonstrates whether units are cost effective in the services they provide in relation to the national averages.

The reference cost index, is a national tool by which the financial performance of all NHS organisations, (cost divided by activity), is assessed against all other NHS organisations. Consequently, a position of 100 represents the national ‘average’ cost of providing the respective services.

However, concern has been expressed about the robustness of this data. This is important data (if the budget allocation is correct) as it will inform further work on analysis of income for community hospitals and the potential to split the national tariff costs when patients are transferred to community hospitals from acute care settings.

3.2 In some instances under the PbR regime, PCTs measured activity and costs by spells. Data in this format, whilst available, is potentially misleading as the national data set is skewed towards acute hospital activity and costs and as such does not provide a robust measurement of community hospital activity. Therefore the most common approach for community hospital activity was to measure in terms of occupied bed days.
3.3 PCTs in a few cases used the weighted average occupied bed day (OBD) reference costs as a more accurate measure of community hospital beds.

3.4 A further element of the methodology is to set out the income that would be generated at each hospital site if national tariff prices were applied to all activity. For inpatient activity, as there is no directly applicable national tariff for community hospitals, as it is measured in occupied bed days, a weighted average reference cost can be used instead.

3.5 An analysis is then undertaken to position each community hospital against national tariff, producing for each, a national community hospital Reference Cost comparison.

3.6 The costs for each hospital as a percentage of weighted average national reference costs can then be produced.

4. Cost Comparisons

It is important to acknowledge when comparing budgets of community hospitals, there was often not a ‘like for like’ comparison for a number of reasons:

The budgets allocated to each community hospital can include other services that provide a service to a wider population than those registered with local GPs e.g. Rehabilitation in-patient beds being provide across a PCT

The activity and expenditure may be directly associated with the hospital e.g. Outpatients, compared to other units where only a facilities charge is paid.

Some budgets did not include all the corporate costs associated with running the hospitals e.g. Facilities/capital, cleaning & catering

It was therefore often difficult to draw any conclusions from this data, and in some cases was included by PCTs for information, noting that further work was required to gain clarity to enable comparisons to be made.

5. Unit Costs

There were wide variations of unit costs between community hospitals within PCTs. This was sometimes due to a variation in skill mix, with some hospitals having a high level of qualified nurses and a low level of band 2 and 3 nurses. There were also apparent differences in the cost of hotel services, in particular catering costs.
A relatively high unit cost in itself did not necessarily indicate inefficiency since it might be associated with a more appropriate standard of care or may simply reflect differences in volume. However variations did merit further investigations by PCTs and reviews of budgets often revealed that with improved efficiency and reduced ALOS, inpatient capacity could be increased from the current level to full capacity with a modest investment. There were indications in some PCTs that this investment could be met through increased efficiency, such as better bed management.

6. Assessment of the hospital environment for each community hospital and intermediate care units using Patient Environment Assessment Team (PEAT) self assessment annual scores can also be factored in cost assessments. Not surprisingly, where this information was used by PCTs, some of the older facilities did not fair as well against PEAT scores.

7. Increasing productive working time in all aspects of provider services operations is a key priority in terms of achieving cost improvement and financial viability. Analysis of the reviews undertaken indicates that there are differences in skill mix and staffing levels within community hospitals, which significantly impact on costs per occupied bed days. Further analysis and benchmarking assists in identifying that the most cost and clinically effective staffing levels are adopted to maximise the skills and efficiency of the available workforce. It is only after this exercise has been undertaken, does it become clear whether there is a need for increased staff numbers to deliver increased activity.

8. Workforce Costs

As nurses provide a 24 hour service to in-patient beds, it is acknowledged to be difficult to compare nursing costs across community hospitals, as the nurses will often provide other services as part of their work, which are not costed separately e.g. nurses covering a minor injury unit and theatre sessions. The nursing skill mix was often different across hospitals, depending on the services provided. An analysis therefore of the detailed grades of nurses and costs, comparing the average salary for each band of nursing staff can identify the average nursing cost per in-patient Finished Consultant Episode (FCE).

9. Assessment of Income

It is important to assess how community hospitals/intermediate care units will gain income in the new financial framework of ‘Payment by Results’. Unfortunately much of the work relating to community hospitals has not been completed nationally and many services do not have a national tariff price.

However, it is possible to estimate potential income under PbR for each community hospital based upon some assumptions.
10. Performance Indicators

There was not a great deal of evidence of outcome measures featuring in methodologies rather than input measures such as activity cost etc. Where they were included, they covered data on:

- Delayed discharges
- Infection rates
- Complaints
- Incidents
- Serious Untoward Incidents

More work needs to done by PCTs and local authorities to develop outcome measures for community services particularly in relation to quality outcomes and focusing on user and stakeholder satisfaction.

Use of data analysis

1. Using the type of methodology and the various elements outlined above, enabled a number of PCTs to reach conclusions about the future community hospital and intermediate care provision required, both in terms of beds and level and types of services provided, to deliver key strategic objectives. The analysis of current community hospital resources also informed action plans to reconfigure existing provision to meet future needs.

2. The benchmarking analysis pointed to where community hospitals or particular elements of service provided could become more effective or productive ie. bed utilisation.

3. Cost comparison led in many cases to further investigations about costs, budget allocations and efficiency. The calculation of investments required in some instances to increase efficiency or local access enabled PCTs to make decisions about the future of particular hospitals and services provided there.

4. Having measured the current activity and compared it against future activity required based on population forecasts, PCTs were able to identify any capacity gap (or surplus) and how existing community hospitals and individual services could be reconfigured to meet that gap or reduce the surplus.
5. Where work had been undertaken to develop a new model of care for these community hospitals and services provided, factoring in the analysis of existing and future capacity needs to the new model, enabled PCTs to develop clear plans about what services would look like in the future and what steps and action would be required to achieve these plans.

6. This in turn enabled PCTs to clearly articulate changes required and communicate this to communities affected by the proposal and other stakeholders.

7. The outcomes of these reviews ranged from proposed closure of some community hospitals, re-designation, redesign and new investment through to a planned programme of bed re-opening in some PCTs.

8. In summary, using the key elements outlined in this section, PCTs and local authority partners have a methodology which will deliver clear outcomes from any reviews undertaken.
6. Acknowledgements

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Sue Balcombe, Associate Director for Adult Provider Services, Somerset PCT
sue.balcombe@somersetpct.nhs.uk

Rachel Cox/Anne Mawson, Community Hospitals Development Project Managers
Dominic Cox, Associate Director of Primary Care, Leicestershire County and Rutland PCT
lisa.brelsford@lcrpct.nhs.uk

Donna Hakes, Special Projects Manager, Northamptonshire PCT
donna.hakes@northants.nhs.uk

Trish Jay, Director of Clinical Development, Lead Executive Nurse, Herefordshire PCT
trish.jay@herefordpct.nhs.uk

Sharon Jones, Director of Community Services, West Kent PCT
sharon.jones@westkentpct.nhs.uk

Jenny McNeill, Assistant Director of Strategic Development, Devon PCT
jenny.mcneill@middevon-pct.nhs.uk

Liam Williams, Head of Commissioning, Gloucestershire PCT
liam.williams@glos.nhs.uk
6.2 Finally, as the author of this paper, my contact details for further information are below.

**Ged Taylor, Independent Consultant**
Director
jgt solutions ltd
Milenda, South Drive, West Derby, Liverpool, L12 2AE

Email: ged@jgtsolutions.co.uk
Mobile: 07810 881 295
Office: 0151 220 8278
Appendix 1 - Case Studies - Approach and Scope of Reviews

In this appendix, a number of case studies are presented which highlight how PCTs have approached undertaking these reviews, what had been the drivers and the scope of the review. A mix of approaches are highlighted, some wholesale across a PCT while some focused on specific locations or hospitals.

A. Gloucestershire PCT

1. Context

A practice-based commissioning (PBC) cluster representing nine out of 13 local practices was already active in the Forest of Dean in 2006 when West Gloucestershire PCT considered closing Dilke Memorial Hospital, built in 1923, to make financial savings and promote a new model of care closer to home.

This sparked strong local protest. Some members of the community formed a group to build on this strength of feeling, carrying out independent assessments of the state of the hospital estate, and successfully put a bid into the Department of Health to become one of the social enterprise trust pathfinder sites.

Meanwhile, the PBC cluster developed an alternative commissioning plan to demonstrate how the hospital could be used more cost effectively while meeting local healthcare needs.

The main focus of the plan was making better use of community hospital beds, particularly for intermediate care and rehabilitation. In addition, the GPs looked at developing elective care provision by switching follow-up from secondary to primary care for certain conditions and taking a more robust approach to referrals.

The commissioning plan also proposed expanding the diabetes, dermatology and orthopedic services already offered by the PBC cluster.

2. Nature of development

GPs reviewed non-elective inpatient activity at local acute hospitals over the previous year, and concluded that Dilke Community Hospital could viably offer the care required by reducing the existing 36-bed unit, with mixed primary and secondary care ownership, to a 26-bed unit wholly owned by primary care.

This activity review, plus financial modeling using the PbR tariff, indicated that the hospital should switch from mainly treating older people requiring rehabilitation or waiting to be discharged to social or residential care, to providing care to a case mix of 70% patients requiring sub-acute care, admitted directly from primary care, and 30% transfers from the local district general hospital.
GPs agreed to give up their admission rights and associated income for managing the hospital beds, and put the contract for inpatient medical care out to national tender. It was awarded to a local practice, based on a service specification drawn up with input from therapy, nursing and social care colleagues.

Non-elective demand is proactively managed using other services, and case management is a priority for both primary and community clinicians. Blood transfusion and intravenous (IV) drug infusion services have been set up, including a community-based urgent care IV antibiotics service. A local COPD management plan has been developed and implemented by all practices and intermediate care provision has been increased.

In elective care, follow-ups are no longer carried out in secondary care if GPs feel the condition can be actively managed by the community hospital, and more peer reviews have been introduced to reduce inappropriate referrals.

### 3. Outcome of Development

The newly formed Gloucestershire PCT board’s acceptance of the PBC cluster’s alternative commissioning plan in September 2006 effectively ensured the immediate future of Dilke Memorial Hospital.

However, the GP commissioning cluster is engaged in discussions to determine how high quality services will be delivered locally in modern facilities and the changes that will be required to achieve this. For local GPs, the key difference is that any changes will be developed in partnership and will not be rushed.

The GPs’s input into service redesign has helped the hospital provide financially viable services in line with local priorities. Services available include diagnostics and cellulitis, dermatology, diabetes, minor surgery and COPD clinics. Plans for an integrated intermediate care unit and other services are underway.

The PBC cluster is looking at cost effective ways to increase capacity, such as GP trainee placements, and is keen to identify how a referral management centre could work in the current policy framework.

Although some targets may need to be revisited, such as the proportion of sub-acute patient occupancy, significant cost savings have been achieved. The methodology worked up to assess potential community hospital inpatient activity has been used elsewhere in the PCT.
Other positive outcomes include:

- Improved access
- Reduced average length of inpatient stay from 17.4 to 13.3 days
- More consistent care and referrals
- Better communication between service providers

There were some obstacles, for instance it took longer than expected for practitioners to gain the clinical confidence to admit patients directly from the community. Also, the impact that changing the bed configuration could have on the total rehabilitation tariff spend was not fully understood initially but overall this approach to the review produced positive outcomes.

### B. Somerset PCT

#### 1. Somerset PCT provides inpatient and outpatient services from 13 community hospitals. The condition of the community hospital estate varies across the county and the PCT had to ensure that community hospitals were fit for purpose and met national environmental standards.

Somerset PCT inherited one approved Full Business Case for the reprovision of a Community Hospital, with a building programme due for completion in 2008, and a further three Outline Business Cases for reprovision of community hospitals in other localities.

In recognising that community hospitals were integral to the provision of locally based health services and that there was a high level of stakeholder interest across Somerset in the development of proposals, the PCT prioritised the early consideration of the proposed redevelopments when it was established.

#### 2. The PCT established a Community Hospital Review Panel in November 2006 to reconsider the Business Cases developed by the former Somerset Primary Care Trusts and develop recommendations with regard to prioritisation and way forward for the proposed developments within the wider Somerset context.

The Community Hospital Review Panel, presented recommendations for the further development of community hospitals in Somerset for the period 2007/08 to 2011/12.
3. The review set out a new model for community hospitals:

Community hospitals in the future will work in different ways to those that exist now, and will provide a different balance of services. Some of the most significant changes are set out below:

- The new generation of community hospitals will have fewer beds. The combined effect of changed working practices, staff ratios and modern facilities enable inpatient beds to be used more effectively. Patients do not stay in hospital for as long as they did previously, and this means they are generally more able to retain their mobility and independence when they return home.

- New community hospitals will offer a greater range of diagnostic tests, including telemedicine facilities, to support inpatient services, outpatient services and general practitioner referrals.

- More tests and treatments previously undertaken in a main acute hospital will be carried out in community hospitals, for example, day surgery, blood transfusions and interface services.

- This wider range of services, combined with shorter lengths of stay, will result in significantly higher levels of activity and throughput compared to existing levels.

- There will be more ‘one-stop shops’, where patients can have a diagnostic test, treatment if appropriate, advice and information, all as part of one clinic appointment.

- Community hospitals will play a much stronger role in encouraging self care, providing information for patients and actively promoting links with resources in the local community.

4. Public and Stakeholder Engagement

The PCT undertook extensive public consultation in preparation for the proposed community hospital developments and there was considerable and continued support shown by local people. Consultation mechanisms across the county included the following:

- Publication of consultation documents which were made available within libraries, Local Authority Offices and on the Primary Care Trust websites.

- Copies of the consultation documents sent to key stakeholders requesting written comments on the proposals.

- Public meetings within the relevant localities.
5. In Somerset the consultation processes for community hospital developments also included a focus on clinical engagement with general practitioners, practice teams, Primary Care Trust community hospital staff and community based teams. Engagement of clinical staff took place through a range of mechanisms including:

- Primary Care Trust Professional Executive Committee meetings
- Primary Care Trust Board meetings
- Discussion at Local Medical Council meetings
- Meetings with key local practices
- Practice Based Commissioning GP cluster groups
- Heads of department meetings
- Workshops

The input and support of local clinicians was critical in securing the planning of new community hospital developments, the development of new models of working and the redesign of services to reflect local need.

C. Leicestershire County & Rutland PCT

1. Leicestershire County & Rutland PCT initiated Implementing a Community Services Strategy in 2006. A community hospitals study, which was part of that strategy, was the start of a medium to longer term development plan for community services and the PCT was committed to developing the plans in conjunction with stakeholders as the proposals were refined and implemented.

2. A further process followed to take forward the proposals and produce locality based plans. These aimed to develop explicit recommendations for community hospitals consistent with the strategic direction of the wider review. This process ensured proposals for the development of community hospitals had
been exposed to rigorous testing with key stakeholders in the locality, had been subject to detailed planning, based on robust data and were capable of delivering the intended benefits.

3. The process adopted consisted of:
   • Identifying the current position within community hospitals and the future model of care to be developed
   • Detailing emerging findings and proposals for the future development of the community hospital infrastructure across the PCT
   • Summarising the implications for community hospital infrastructure by site, in terms of the opportunities, benefits constraints, risks, and costs, of the strategic direction proposed
   • Linking to emerging findings of this phase with an Out of Hours Review being undertaken, where relevant to do so

4. The review was based on certain assumptions:
   • An agreement to re-provide in community settings a large amount of activity (day cases, outpatients and diagnostic tests) that had traditionally been provided at the local Acute Trust. This was being planned to achieve the desired shift of activity into more locally accessible and convenient settings for patients - where clinically appropriate to do so. Much of the activity identified for this planned shift in the 2 subsequent years was already being earmarked for delivery in community hospitals. The PCT was undertaking a modelling exercise to quantify this activity, identify exactly where it would take place to support patient flows, as well as decide what action the PCT would need to take to accommodate the extra activity within the various community hospitals.
   • An agreement to reduce the number of acute sector beds over several financial years
   • An agreement to unbundle the tariff

5. The new PCT inherited a financial plan deficit for 2006/7 from the 4 former organisations initially totalling £45m, with further deterioration in year. The PCT had consolidated a forward turnaround plan accordingly. The PCT had to deliver some of this target by changing the model and balance of care delivered within the health economy in favour of:
   • Improved utilisation of community based assets and infrastructure to support the development of service models promoting care outside of acute hospital setting
   • Confirming and challenging the costs of the existing infrastructure, the cost benefit analysis of any planned infrastructure developments and by driving a more cost effective utilisation of all available assets in the future
The community hospitals study supported a critical component of the financial plan so this had been an important influence on the review in order to reduce the use of acute sector hospitals and to improve the efficiency of community services and their infrastructure.

D. Northamptonshire PCT (Milton Keynes and South Midlands sub-region)

1. Northamptonshire PCT was part of a 6-month project to work with local agencies in the Milton Keynes and South Midlands sub-region, to develop a strategic framework for health and social care. It was commissioned by the Health and Social Care Sub-Group of the Milton Keynes & South Midlands Growth Area (MKSM) and carried out by a consultancy consortium led by HEDRA.

2. The objectives of this work were to:
   - Provide a high level planning analysis of the likely impact of population growth, demographic and demand forecasts
   - In the light of future projections enable the local health and social care agencies to develop their local plans in ways that are congruent with anticipated population growth to 2031 in MKSM

3. This Strategic Framework was supported by and drew upon detailed work to help local people to plan more effectively and in a way that was congruent with the challenges faced to 2031. The detailed work comprised of:
   - Baseline modelling of demography, demand and capacity
   - The development of human capital
   - Analysis of health and social care workforce data
   - Models of Care

3.1 Demand & Capacity

The aim was to provide a recognised and accepted baseline for demand and capacity planning to 2031. The approach was to gather and analyse existing aggregate data on the use of services in the sub-region so as to inform estimates of future demand for services, and the capacity to meet these from existing resources.

This work investigated the challenges of developing a workforce with the capacity and capabilities to provide the health and social care services required by the rapidly growing population of MKSM. The aim here was to ensure that workforce considerations become integral to health & social care planning.
3.2 Workforce

The task was to:

- Collate and analyse existing workforce data for the statutory social care service, independent and voluntary sectors, and the NHS in the sub-region
- Undertake real time working to gather information and start to build a network of those responsible for workforce issues in the sub-region
- Undertake desk research to analyse local and national issues in developing human capital and workforce planning

3.3 Models of Care

The aim was to support the re-thinking that could lead to new and ambitious models of care in the long term and to build on cutting-edge practice within the growth area and beyond. Using desk research and analysis, a functional description of health & social care services was produced and provided a means of thinking about these functions in such a way as to avoid getting trapped by traditional professional boundaries and historical patterns of provision. This allowed a radical re-thinking of where these functions would be provided in the future, and by whom. It helped planners to generate new ideas for service design and to evaluate them rigorously.

3.4 Planning

The aim was to:

- Engage local planners from agencies across the sub-region
- Start to build a sense of identity and develop a shared agenda
- Devise a framework for thinking strategically about the complex system of both health and social care
- Support local planners to explore the local implications of the strategic framework

A Planning Collaborative was formed to bring together key people from the local health & social care economies and start to build capacity for system-wide long-term planning.

3.5 System Impact

Most of the planning for health and social care in the growth area was to be carried out using existing planning mechanisms. However, if this was to add up to appropriate planning across the growth area, all health & social care plans needed to be reviewed to ensure that they address potential knock-on effects between neighbours.
Strategic plans were reviewed against using a System Impact Tool. This assessed plans by:

The Issue / Question to be asked / Examples of how to know that a strategic plan has been reviewed against this issue

4. Conclusions and recommendations were drawn from this work recognising the planning task was complex as change would occur simultaneously in demography, demand, capacity, models of care, workforce, the range of service providers and the impact of public health interventions. As the rates of change and the interactions amongst them were unpredictable, it was recognised, the data and analysis provided was one snap shot in time. If the activities of the organisations and planning authorities were to add up to coherent behavior across the whole system in the future, this would mean health and social care needing to:

- Assess the extent to which public health interventions and the effective management of long-term conditions would impact on patterns of health
- Assess the extent to which primary care changes were likely to impact on service delivery
- Monitor the extent to which the assumptions on length of stay and proportion of day case activity that underlie the National Beds Inquiry were being achieved
- Make a judgement on what could realistically be achieved, year on year, in moving care from acute to community settings
- Develop a sub-regional approach to staff recruitment and retention to prevent unnecessary competition
- Agree mechanisms for developing new, flexible and cross agency staff roles
- Address the issue of future workforce training needs

5. Next Steps
Arising from this work, Northamptonshire PCT has undertaken a review of its community hospital and intermediate care services which has involved undertaking a baseline review in the context of 2 LIFT developments. Work is also being undertaken to develop a new model of care and one outcome is a proposal being considered to have integrated and co-located intermediate health and social care teams.
E. Herefordshire & Worcestershire PCTs

1. A Community Hospitals Project commenced in April 2006, and was designed to collect evaluation data across the community hospitals and intermediate care units in Herefordshire & Worcestershire. Terms of Reference and a Project Plan for the work were agreed by the participating four PCTs, with information on the work being provided to the two public/private partnership units in Herefordshire and the two County Councils.

2. Phase 1 comprised of a data collection review which identified the current scope and range of services that were provided across the identified hospitals and units, including data on efficiency indicators. Data gathering proformas were designed, consulted upon and completed by the participating organisations, and checked by the individual units and organisational leads.

   After an initial Steering Group meeting, further data was requested on Bank and Agency expenditure, medical staffing expenditure, consultant out patient clinics activity and other activities taking place in the hospitals/units.

3. Phase 2 comprised of a comparison of data. The data collected was available for each Community Hospital/Intermediate care unit within the health system; however comparison across all 14 hospitals units would have made the report too detailed for each health community. It was decided therefore, to split the data into two parts, one for Herefordshire and a separate one for Worcestershire. This was reflected in the report arising from the review, which reported on Worcestershire data, but compared it to the range of information (highest and lowest indicators) for Herefordshire.

4. Phase 3 comprised recommendations, with conclusions drawn from the data comparisons and suggested areas of work and development for future consideration.

5. The review structure commenced with a demographic overview, followed by a service context and then results broken down by individual community hospitals.

6. The results were categorised by:
   - Population served by each hospital/unit
   - Financial overview
   - Assessment of the hospital environment
   - Ownership of premises & clinical leadership
Appendix 2 - Case Studies - Methodologies

In this appendix, a number of methodologies are presented which highlight how PCTs have undertaken an analysis of community hospitals, primarily of activity and cost.

A. Gloucestershire PCT

Methodology undertaken for determining potential community bed provision for a locality.

The steps undertaken focused on two main themes - Activity modelling and financial impact.

1. Activity modelling

Review non elective admission data - review all 2006/07 non elective inpatient data relating to Gloucester City GP practices including key information component of diagnosis coding (HRG & ICD10) and associated cost - Typical charge being:

There were 12,460 non elective admissions from the Gloucester City practices in 2006/07

Review potential to admit patients directly into a community bed based upon work undertaken with GPs from the Forest of Dean when assisting them with their cluster savings proposals for 2006/07 - this work was produced to support a reduction in non elective admissions and reduce length of stay within GRH and promote direct admissions/early transfer into the Dilke Memorial Hospital - 1,181 could have been directly admitted into a community hospital bed had one been available in Gloucester City.
Review additional patients whose pathway includes rehabilitation as per the payment by results (PbR) guidance for 2007/08 these are:

- Stroke
- Fracture neck of femur
- Hip and knee replacement

In addition locally they included multiple sclerosis.

This element of the service model would see patients continue to flow into GRH for the ‘acute’ phase of their care but then transfer earlier to a specific ‘rehabilitation’ facility.

This cohort of patients totalled 270.

The same methodology was applied to the out of county (OOC) ‘acquired brain injury’ (ABI) patients - 9 patients currently OOC.

Once the number and type of patients had been identified it was then possible to calculate the number of beds that this cohort of patients would utilise if no bed constraints existed using ‘best practice’ targeted length of stay - this would equate to 52 beds.

Given a 25 bed constraint the capacity and number of patients per annum was calculated:

- 10 beds for direct admissions
- 13 beds for stroke, fracture neck of femur, hip and knee replacement and MS
- 2 beds for ABI patients

This service model would target 576 patients per annum.

2. Financial impact

Cost of current care pathways known from charges by GRH i.e. PbR and rehabilitation therefore the value of the idirect admissions! savings was calculated ñ Potential savings - £530k per annum.

The 2007/08 PbR guidance recommends the ‘unbundling’ of certain national tariffs particularly those associated with rehabilitation - essentially this means that the PbR charge for some procedures is reduced where the rehabilitation element of the pathway is provided in an alternative setting i.e. not within an acute hospital environment - these areas are:

- Stroke
- Fracture neck of femur
- Hip and knee replacement

In addition locally they included Multiple Sclerosis.
Using the ‘unbundled tariffs’ it is possible to calculate the savings that would be generated for these conditions including the associated savings within rehabilitation - Potential savings of £403k per annum for ‘unbundling’, £1.5m for rehab and £325k for ABI.

The costs of re-providing the service was calculated - Cost of £1.3m.

These costs then deducted from the combined commissioner savings to arrive at a net saving to the PCT - Net savings of £1.5m per annum.

B. Leicestershire & Rutland PCT

1. A complete analysis of the costs, condition, utilisation and productivity of the community hospitals estate, facilities and equipment to support current and future provision was undertaken.

2. The study considered each of the ten community hospital sites individually, performing a thorough site-by-site analysis, which examined:

   • Current service provision and the current position with respect to the capital infrastructure at each site (buildings/estate) including the cost, condition, utilisation, efficiency and productivity of the community hospitals services, estate and equipment

   • The model of care to be provided in the future - in particular for inpatient services (beds), outpatient services, diagnostic and day surgery pathways

   • Barriers to improved utilisation of community hospital infrastructure and services

   • Locality health needs, access and population flows affecting patient usage and referral patterns

   • Commissioning intentions (of GPs under practice based commissioning and those of the PCT as a whole)

   • The levels of activity to be delivered in community hospitals in the future

   • Referencing capacity planning data, and other planning information available at the time of the study (e.g. the LDP, financial recovery plans, unscheduled care strategy and long term conditions strategies)

   • The ability of community hospital services to adapt and support new models of care and care pathways
The ability of community hospital estate and equipment to adapt to and deliver new models of working within the short to medium term.

Where change of use or expansion of existing assets should be targeted to support development of new models of care

The ability of local community hospitals to adapt to support new service developments

The ability to develop a cohesive sub acute model where community based beds support admission avoidance from the acute sector, provide step down care etc

The ability to adapt to support new community based care pathways for stroke, pneumonia, hip/knee replacements, and diagnostics

The ability to change the case mix of procedures, diagnostic tests or outpatient care to be delivered in community hospitals in the future

3. Inpatients

There was then an analysis of the current length of stay (LOS) and occupancy rates of each the community hospitals by:

- Case Mix
- Utilisation
- LOS
- Occupancy Levels

Utilisation of beds within the community hospitals were categorised into: palliative care beds, beds for medical admissions including those from GPs, and beds for rehabilitation.

3.1 Length of Stay

The model used was:
Patients should have a length of stay of no more than 5 days for a sub acute medical admission which could be all or part of the patient pathway, for specialist stroke rehabilitation stays should be 28 days, and intensive rehabilitation should be no longer than 21 days.
Reviews of Community Hospital/Intermediate Care Provision

The PCT was aiming to use community hospital beds to support admission avoidance in the acute sector and completed an analysis of the opportunities to develop this model of care.

3.2 Future Model of Care

The PCT’s future model of care identified 4 broad categories of clinical care to be provided in a number of locally available beds. They also identified good practice in terms of length of stay for each category where appropriate (in brackets).

3.3 Category of Care

- Care Pathways
- Sub Acute Care (5)
- Urinary Tract Infection
- Chest Infection
- Falls
- Deep Vein Thrombosis
- Pneumonia
- Exacerbation of Long Term Conditions
- Intensive Rehabilitation (21)
- Intensive programmed rehabilitation i.e. elective hip and knees, fractured neck of femurs
- Specialist Rehabilitation (28) i.e. post acute stroke
- Palliative Care(n/a)
- End of life care, supporting patient choice

To deliver the level of productivity and efficiency required, each community hospital site aimed to operate at 93% occupancy.

4. Outpatients & Day Surgery (Planned Care):

A detailed capacity planning analysis was undertaken by the PCT for the two subsequent years covering diagnostics, day case surgery and outpatient services. This identified all the activity delivered including elements to be delivered in community hospitals.

The community hospitals study examined existing capacity within community hospitals (in terms of theatre space, treatment rooms and outpatient facilities) to support the shift of planned activity from the acute sector.
Modelling work had already been completed by site for day surgery, including assumptions about those procedures that could be performed in treatment/procedure rooms and those that require full theatre facilities. Site by site outpatient room planners were analysed demonstrating where outpatient facilities were currently underutilised.

5. Unscheduled Care and Out of Hours Services
Proposals for unscheduled care, underpinned by a programme of work already in progress, supported the strategic direction for community services, promoted care closer to home, admissions avoidance, choice and access, and the PCTs local delivery plan/financial plan.

The proposals for unscheduled care formed part of the development plan for each locality, taking account of emerging findings of the OOH Study, and fed into the work of the Unscheduled Care Board operating across the local health economy.

6. Long term Conditions
A baseline assessment covering the implementation of the business model for long term conditions (LTC), performance towards LTC targets and an examination of key care pathways was completed by PCT.

7. Community Hospital Estate Analysis
A full estates report was prepared and a summarised condition appraisal given with cost estimates showing the immediate investment requirements over the next 1-5 years.

8. Financial Analysis
The current forecast out turn full-year revenue costs for each of the PCT’s ten community hospitals was provided by:

- Inpatient
- Outpatient
- Day case
- MIU
- Daycare
8.1 Benchmarking Costs and Activity
In order to assess the financial performance of the hospitals, two principal benchmarks were used.

The first of these was the national community hospitals reference cost index. The second of the benchmarks relates to activity based on inpatient spells (acknowledging that the national data set is skewed towards acute hospital activity and costs and as such does not provide a robust measurement of community hospital activity).

The weighted average occupied bed day (OBD) reference costs were therefore also used as a more accurate measure of community hospital beds.

8.2 Analysing Income
Having considered costs and their benchmarks, the methodology then set out the income that would be generated at each hospital site if national tariff prices were applied to all activity. For inpatient activity, as there is no directly applicable national tariff for community hospitals, as it is measured in occupied bed days, a weighted average reference cost was used instead.

An analysis was undertaken to position each community hospital against national tariff producing for each a national community hospital Reference Cost comparison.

The costs for each hospital as a percentage of weighted average national reference costs was then produced.

C. West Kent PCT
In undertaking a Community Hospital Strategic Review, West Kent PCT commissioned Tribal Consultancy to undertake this review and used the following methodology.

1. Capacity Requirements
Capacity modelling and planning work was carried out as part of the review. Activity was modelled in the following areas (where relevant) for each of the six community hospitals in West Kent:

- Inpatient beds
- Day hospital activity
- Minor injuries appointments
- Outpatient appointments
- Radiology examinations
1.1 Inpatient Beds
The results for each of those areas presented current (or baseline) activity and two forecasts:
one with demographic growth and one with demographic growth and (where relevant) the expected shift in activity from the NHS Trust as a result of a PFI development.

The data for the Baseline year presented:
• FCEs
• ALOS
• Occupancy level
• Beds Requirement at 85% occupancy

The assumption for modelling the future requirement was a performance improvement to a lower 18 days ALOS. This highlighted whether population changes could be managed within the current bed-base.

In relation to Future Bed Requirements for Current Activity, the PCT was expecting a level of activity shifting from the Acute Trust, categorised as admissions avoidance, rehabilitation and elderly acute.

This was presented as:
Bed Requirements for Activity Shifting from the Acute Sector for 2006/07, 2010/11 and 2016/17 by:
• Current activity
• Activity shift:
  • Admissions avoidance
  • Rehabilitation
  • Elderly Acute

This gave the figure for:
Total shift with a Grand Total, leading to a calculation of the Capacity Gap

1.2 Day Hospitals
Data presented for:
Attendances/Average per week/places per week
Projected attendances based on demographic changes

1.3 Minor Injuries Unit Appointments
Data presented for:
Number of attendances/Assessment minutes & minutes per week /opening time projected attendances by site with projected growth
1.4 Outpatients

Data presented for:
Current activity & clinic sessions by site
Shift from Trust activity & non-trust activity
Capacity gap (Modeling assumed improved DNA rates, new to follow up rates and lower cancellation rates & shift from activity @ Trust to a community setting)

1.5 Radiology Examinations

Data presented for:
Type of scan/no. of scans/equipment @ site
Projected equipment required by site based on forecast growth in population

2. Service Review

2.1 The findings from the review on how the services currently provided supported the Model of Care at the Community hospitals was based on a Criteria for service provision

2.2 The PCT agreed that services to be provided at each site would be specified based on the following non-financial criteria:
- Strategic Fit - against the Strategic Context and Consistency with Commissioning
- Intentions
- Supporting the delivery of the Model of Care - delivering Health gain
- Offering an accessible service for patients
- Fulfilling a sustained demand identified by the Capacity Plan
- Delivering the service in an efficient way
- Meeting clinical governance requirements

2.3 In relation to Fit with Strategic Context and Commissioning Intentions the assumption was to:
reduce LOS to 18 days;
by end of 2007/08, reduce A&E conversion rate to PCT targets through delivery of the agreed model of care;
Deliver sufficient capacity to contribute to the success of the PFI development opening in 2010;
to align the Community Hospitals to deliver the strategic vision, which was likely to result in an increase of community hosted clinics (some of which may be Community Hospital based);
to ensure financially sustainable services over the planning period.
2.4 In relation to Health Gain the assumption was to: Minimise LOS in any hospital bed and maximize care at home; services address a clearly defined rehabilitative health need and deliver a positive health outcome.

2.5 In relation to Accessibility for Patients the assumption was: patients are not prevented from accessing services that they require due to location.

2.6 In relation to Meets Current and Projected Demand the assumption was: capacity planning demonstrates a need for this service both in the short and longer term (10 yrs).

2.7 In relation to Efficient Form of Provision the assumption was: provision within the Community Hospitals was the most efficient location for this service.

2.8 In relation to Meets Clinical Governance Requirements the assumption was: critical mass of patients seen to ensure clinicians keep up skill base and deliver safe & effective to patients.

The review highlighted areas of current service provision at the Community hospitals which required further action and/or further investigation.

3. Finance

3.1 The finance work for the review focused on two areas: Identifying areas of costs where there was considerable variation between the hospitals not explained by differences in services, activity levels and estate. Carrying out a high level assessment of the effect of opening beds at each of the hospitals to meet the expected demand.
3.2 Cost comparison

A review of comparative unit costs was undertaken by:

- Wards - Cost per patient week
- Medical - Cost per patient day
- Day Hospital - Cost per patient day
- MIU - Cost per patient day
- X-ray - Cost per scan
- Hotel Costs - Cost per meal inpatient - Cost per meal day care

3.3 From this methodology, conclusions were drawn in terms of:

- Meeting the expected demand for extra beds (through a planned programme of bed re-opening)
- Model of Care - adopting the new Model of Care across all six community hospitals for wards, day centres and MIUs.
- Respite beds - Managing the use of respite beds

D. Hereford & Worcestershire PCTs

1. The methodology adopted by Hereford & Worcester PCTs started with a Demographic Review and an analysis of:

   Population Served by CHs by weighted GP Practice populations that are served by the local units. The decision on the allocation of specific practices to individual units was made by the lead Directors from each PCT

2. There was a Financial Overview comparing the budgets.

3. There was an Assessment of the hospital environment for each community hospital & and intermediate care against the Patient Environment Assessment Team (PEAT) self assessment annual scores.

4. There was also an analysis against each category of service provided at each of the community hospitals.
4.1 In-patient beds

Type of beds:
A categorisation of beds, was undertaken reflecting the type of medical support ie.

- GP beds
- Consultant led or Intermediate care (classification by the CSCI for registration)
- Consultant led rehabilitation beds
- GP medical beds

In-patient activity was recorded as FCEs, reliant upon a number of factors, including bed availability, the number of FCEs per bed during 2005/06 and the average occupancy levels.

4.2 Nursing Staffing

Nurses provide a 24 hour service to the in-patient beds, and while it was acknowledged to be difficult to compare nursing costs across community hospitals, as the nurses often provided other services as part of their work, which are not costed separately.

Therefore, information was provided on the detailed grades of nurses and costs demonstrating the average nursing cost per in-patient Finished Consultant Episode (FCE)

4.3 Bank & Agency Use

The percentage bank and agency nursing spend as a proportion of the total budget was analysed

4.4 Reference Costs

There Reference Cost for the category of GP bed was calculated

4.5 Discharge Destination

Discharge destination was categorised for this piece of work into four categories:

- Discharge to original home setting (i.e. if the patient was admitted from a care home)
- Transfer back to acute setting
- Discharge to a care home
- Other discharge destination
4.6 Minor Injury Units
This was calculated in attendances per year for each community hospital.

4.7 Staffing
Some hospitals were staffed by a separate team of nurses, where in others were staffed by the ward nurses.

4.8 Medical Staffing
The medical staffing for the MIUs was provided through specific contractual arrangements with local GPs Specialist A&E consultant advice was also purchased from the local Acute Trust.

4.9 Activity
By people attending each hospital by the population served.

4.9 Reference costs
Each unitís cost compared to the national MIU reference cost for each attendance.

4.10 Diagnostic Services
Within the Community Hospitals/Units there were a range of diagnostic services available. Activity was measured as follows:
- X ray - Days per week
- Ultra Sound Scans - Sessions per week
- Echo cardiograms - Sessions per week
- Endoscopy - Sessions per week
- Breast Screening - Sessions per week

4.11 Other services provided
A range of other services were provided by the community hospitals

Rehabilitation and assessment day services
Therapy services - Physiotherapy and Occupational Therapy were provided at all of the units for in-patients, out-patients, and some group sessions and out-reach to community patients.
4.12 Quality Indicators

Three specific areas of quality indicators were chosen:

- Infection control - infection rates for both MRSA (colonised rates) and Clostridium Difficile per bed.
- Complaints
- Incidents
- Serious Untoward Incidents
Appendix 3 - PCTs Used for Information Source

- Bristol
- Cambridgeshire
- Devon
- Great Yarmouth & Waveney
- Hereford
- Leicestershire & Rutland
- Northamptonshire
- Norfolk
- Oxfordshire
- Portsmouth
- Shropshire
- Somerset
- Suffolk
- West Kent
- Wiltshire
- Worcestershire