RESPONSE TO THE WELSH GOVERNMENT WHITE PAPER – WG41756 ENTITLED "REBALANCING CARE AND SUPPORT"

1. This response to the Welsh Government White Paper – WG41756 entitled "Rebalancing care and support" is submitted by Tom Brooks, Associate Committee Member for Wales for the COMMUNITY HOSPITALS ASSOCIATION (CHA). Because of the Covid-19 pandemic, it has not been possible to formally consult community hospital sources in Wales. This response is submitted based on opinions and anecdotal evidence from various CHA members in Wales and consultation with the CHA committee members in the three other home countries. As such Tom Brooks takes responsibility for the contents of this response.
2. This response is in two parts. Part One provides succinct answers to the questions posed by the White Paper and continues with a selection of evidence to support this response. This response expresses the opinion that the White Paper proposals, if implemented, would be detrimental to those in our population who need care and support. It is recommended that the proposals in the White Paper are not proceeded with.
3. Part Two of this response describes some alternative approaches to rebalancing, resetting the health and care services that have demonstrated merit in other countries. These are commended to the Minister for serious consideration.

PART ONE - WHITE PAPER CONTEXT AND SUCCINCT ANSWERS

4. The context described in the White Paper is not evidenced based. The assertions made are not justified by the supporting evidence offered. In many parts of Wales the assertions made are alien to the public's experience. Hence unsurprisingly, the questions you ask receive generally a very negative response.
5. The Summary of Answers to your Questions are below:

YOUR QUESTIONS	**OUR ANSWERS**
Question 1: Do you agree that complexity in the social care sector inhibits service improvement?	**NO**
Question 2: Do you agree that *existing* commissioning practices are disproportionately focussed on procurement?	**NO** – There are many examples of sensitive commissioning by local authorities
Question 3: Do you agree that the ability of RPBs to deliver on their responsibilities is limited by their design and structure?	**NO –** They are undertaking a supplementary role to accountable local authorities
Question 4: Do you agree a national framework that includes fee methodologies and standardised commissioning practices will reduce complexity and enable a greater focus on service quality?	**NO** – A solution that fits Cardiff is unlikely to be appropriate for Criccieth, or one that works well in Pontypridd to fit suitably in Presteigne.
Question 5: Do you agree that all commissioned services provided or arranged through a care and support plan, or support	**NO –** They should be based upon individual's needs

plan for carers, should be based on the national framework?	
Question 6: Do you agree that the activities of some existing national groups should be consolidated through a national office?	**Yes**
Question 6a- If so, which ones?	Welsh Government Chief Social Care and Social Work Officer, Social Care Wales and appropriate ***advisory*** elements of the WLGA National Commissioning Board
Question 7: Do you agree that establishing RPBs as corporate legal entities capable of directly employing staff and holding budgets would strengthen their ability to fulfil their responsibilities?	**NO –** There is evidence that a regional board is the wrong level at which to hold health and social care budgets
Question 8: Do you agree that real-time population, outcome measures and market information should be used more frequently to analyse needs and service provision?	**Yes** – But note that they are already used appropriately by the more proficient local authorities
Question 9: Do you consider that further change is needed to address the challenges highlighted in the case for change?	**Yes –** In line with 'keeping care local – the Welsh Government's policy, by enhancing domiciliary care further and closer working with the primary and community health care practitioners
Question 9a- what should these be?	Social care delivered in a person's home according to assessed needs should be free of charge! This would solve many frustrations experienced by people needing care and reduce the burden on the residential sector and the NHS.
Question 10: What do you consider are the costs, and cost savings, of the proposals to introduce a national office and establish RPBs as corporate entities?	**There will be NO cost savings,** but the budgeted spend of other Quangos in Wales suggests that extra bureaucratic costs of some £20M a year can be expected**.**
Question 10a- Are there any particular or additional costs associated with the proposals you wish to raise?	The financial disaster exemplified by the creation of Betsi Cadwaladr Health Board is clear evidence of the inappropriateness of a body created to cover a large regional area where there is little or no synergy in economy, rural/urban or first language.

Welsh language	
Question 11*:* We would like to know your views on the effects that a national framework for commissioning social care with regionally organised services, delivered locally would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English.	**It is difficult enough** in current circumstances for older native Welsh people to be able to speak their own language in some care homes even in Welsh speaking heartlands. I draw your attention as evidence to the Care Inspectorate Report - Inspection Report on Meddyg Care Dementia Home, Criccieth published in March 2020, just before the Covid-19 lockdown. The problem of the failure to provide Welsh speaking staff is understood have been addressed by Gwynedd Social Services because they can ensure there is a local implementation of a Welsh language policy in care homes. As has been proven to be case in schools, bilingual language policy is best organised by local government, close to the affected person and not by a more distant regional body.

EVIDENCE TO SUPPORT THE ABOVE ANSWERS

REBUTTAL OF ASSERTIONS MADE ABOUT THE CARE SECTOR IN WALES

The assertion that "More management and consolidation of the market is needed" is a Falsehood in much of Wales

6. The Covid-19 pandemic proved that this assertion was a myth.

7. According to CSSIW[1], as at early 2015, there were 22,413 older people's beds across Wales in 661 care homes. The was also 443 care homes classed as "Younger adult care homes with 3439 beds, a total of 1104 care homes with 25852 beds . This was about double the number of beds available in the NHS in Wales. Ownership of the care homes was distributed between local authorities, larger group providers (4 or more care homes for older people), smaller group providers (2 or 3 care homes for older people) and single home providers (1 care home for older people). The single home providers provided half of the beds. Bed occupancy in the care home sector was stated as around 89%.

8. By early 2019 CSSIW[2] declared that there were 1080 care homes in Wales with 26,035 beds. No further breakdown was provided, but no indication was given of any issues existing regarding capacity.

9. By contrast, between 2015 and 2019, fears of a shortage of care home beds in England materialised under its more formalised commissioning system. Between 2015 and 2019, care home beds in England reduced[3] by 6% and nursing home beds by 2%.

[1] CCISW Annual report 2014-15
[2] Care Inspectorate's Chief Inspector Report 2018-19
[3] Care Home bed availability – Nuffield Trust July 2020

10. The proposals in the White Paper to seek to artificially modify this successful nature of the Welsh care home market is particularly flawed. The White Paper says:

> "Within these new arrangements, small providers will be encouraged to work together to respond to local commissions. This could be achieved by the development of a collective approach to enabling shared activities, such as marketing, procurement, HR and IT support. This approach will contribute to the rebalancing of the care and support market to fewer individual providers competing for contracts, reducing time-consuming activity and complexity".

11. Why does the Minister want fewer individual providers? Over the past five years, while care places provision has grown satisfactorily, there has been no increase in Wales in the percentage of care homes added by large group providers. It was the providers with few homes who enabled Wales to have the necessary care home flexibility and places to ride out the pandemic.

12. The growth of provision in Wales was almost entirely due to the "small providers". The "Big Five" care home operators made a negligible contribution to the provision of care home sufficiency.

13. In the summer of 2020, only three of the "Big Five" care home providers operated in Wales. Two of "the Big Five", Four Seasons Healthcare and CareUK, did not operate in Wales. HC-One, (13 in South Wales including Daffodils which publicised at the time that they were used by the NHS through Ysbyty Cwm Cynon), Barchester (8 in Wales one in the North - Bradshaw in Rhyl) , and Bupa (Swansea plus 11 in Powys– One combined with the 'community hospital' in Builth Wells) provided just 3% of the care homes in Wales.

14. What has kept the care home provision at a sufficiency level in Wales has been the relationships that many local authorities have developed with the smaller care homes providers. Local relationships, local provision, local government delivering!

15. This model has been a success because variety in care home provision delivers a relatively wide range of choice, thereby providing an ability to match different styles of provision with people's needs. Manipulating the market could remove this ability to match services with individuals' needs.

16. For some time, the media has been reporting on historic cases of care home mismanagement in Wales that are up to 10 years old. There is evidence that some care homes in these historic cases[4] failed to provide the standards of patient dignity in care homes that the various Older People's Charters demand. These are historic events and better inspection and scrutiny in recent years has materially improved the situation. : The statement[5] of Care Inspectorate Wales (CIW) is that:

> "We are starting to see the benefits of the Regulation and Inspection of Social Care (Wales) Act 2016 come to fruition, with providers of regulated social care services having a greater focus on outcomes for people."

17. The current regulatory system is working and is not in need of any fundamental overhaul. Nevertheless, although care homes are now much responsive to individual's needs,

[4] Puretruce Health Care Ltd is a recent example

[5] Care Inspectorate Wales Chief Inspector's Annual Report2019—20

many older people would much prefer a good provision of domiciliary care rather than a place in a care home.

The suggestion that placing older people in care homes is in some way synonymous with "Producing Better Outcomes for People" is simply inaccurate

18. The Wanless Report[6] which covered the United Kingdom, predicted "The health service in 2022". The foresight of his team and himself was remarkable.

19. In 2003 he was retained to advise on a review of health and social care in Wales. In his preface to the Welsh Assembly Government's Team Report, Derek Wanless said "Long hospital waiting lists and assessments without subsequent social service provision are the unacceptable consequences and are symptoms of the deep underlying problems needing to be faced."

20. Derek Wanless said "evidence-based recommendations should be followed through" and then regretted that the project team "worked often with limited information". Because of the paucity of evidence in Wales an ethos built up that placing people in care homes was less effort for those managing social care than assessments leading to quality packages of domiciliary care.

21. As the ethos developed in Wales, some social care services encouraged early relocation of elderly people from their own homes into care homes. The 'Care Home' residential market was cultivated, including by transferring care homes from the public sector into the private sector. The weak element in the care system was and remains domiciliary care.

22. A significant factor has been the Welsh Government's charging structure for domiciliary care.

23. There is little evidence that this relocation of elderly people into care homes as a strategy has been beneficial to the elderly. There are no studies published of the resultant patient outcomes by comparing domiciliary care and residential care in terms of (say) extended quality of life or the development of co-morbidities

24. In 2011, the Welsh Assembly Government declared an intent to develop increased dependence on the private social care residential sector and to encourage a focus on "commissioning" that was financially based. It said[7]:

> "The financial outlook is difficult. We cannot buy a way forward. This Paper is based on the assumption that efficiencies gained from initiatives such as pooling back office functions and ***smarter procurement*** are the bread and butter of day-to-day delivery" *my highlight*

25. Fortunately for Wales the "Priorities For Action" chapter of the "Sustainable Social Services for Wales: A Framework for Action" 2011 guidance, was only partially implemented by local government who generally acted to protect citizens welfare.

[6] Derek Wanless to the Chancellor of the Exchequer 2002,

[7] Sustainable Social Services for Wales: A Framework for Action WAG10-11086 1.10

26. The public's predominant view is that enabling people to live ***independently*** for as long as possible is the desired approach. The domiciliary care sector has made a significant contribution to such independent living. So too have those sectors providing supported or sheltered housing. Wales has not always found it easy to obtain the capital for such schemes but some have been highly successful. For example the Cynefin Group[8] continues to deliver successive supported housing schemes in North West Wales

27. Overall, it can be demonstrated that the social care sector in Wales has coped well.

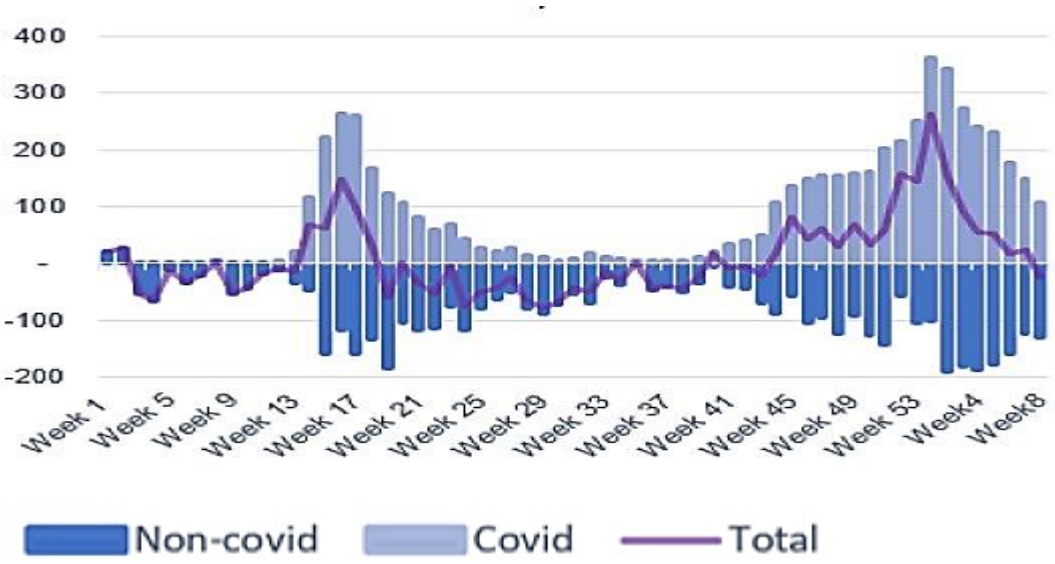
Until Covid-19 arrived it was often postulated that "Care Homes were a Safe Destination to House Elderly People" – This proved to be a falsehood.

28. It is an illusion to consider, as the White Paper[9] suggests, that less competition leads to better value for money. Innumerable public sector investigation reports have proven the contrary. Moreover, the pandemic has illustrated that the standard of care of, and especially the safety of, care home residents is best protected in the smaller care homes.

29. Living in a care home still proves to present an increased risk to residents of being Covid-19 infected. Even after twelve months experience of managing Covid-19, in the month of February 2021, 253 of the 1048 care homes in Wales reported[10] being infected with the SARS-CoV-2 virus and after 10 months of experience had been unable to implement measures to stop infection.

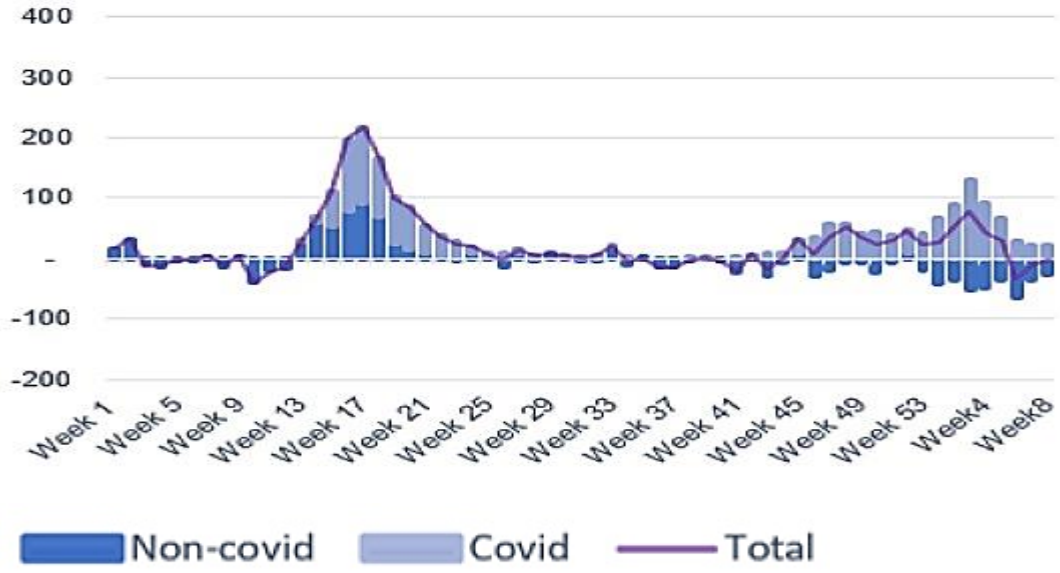
30. There have been a total of 1,627 Covid-19 deaths in care homes up to 26 February, making up 21.6% of all coronavirus deaths in Wales. The Welsh Technical Advisory Group has recently published an informative paper[11]. It illustrates the death location patterns between the first and second major Covid-19 waves. Both waves produced peaks of care homes deaths. Two diagrams from the paper are reproduced below.

31. HOSPITAL DEATHS



[8] http://www.grwpcynefin.org/en/chwilio-am-gartref/extra-care-housing/
[9] White Paper Page 18
[10] Notifications to Care Inspectorate Wales related to COVID-19 in adult care homes
[11] Examining Deaths in Wales associated with COVID-19 24 March 2021 – Technical Advisory Group

32. CARE HOME DEATHS



33. Commenting on these graphs, the Technical Advisory Group paper observes:

> "For deaths in care homes we see a more pronounced first spike around week 17. The weekly number of excess deaths observed in the second period is currently lower than the first. This may be as a result of better protocols in place to reduce the virus from entering care homes in the first place, and/or that care home residents could have been transferred and subsequently passed away in different settings particularly in hospitals."

34. Being resident in a care home significantly increased the risk of early mortality. But did all care homes present the same risk to their residents? A study conducted by Public Health Scotland has concluded that all care homes did NOT present equal risk to residents

35. Public Health Scotland (PHS) reviewed hospital discharges to care homes[12] between 1 March and 31 May 2020 because of the significant number of Covid-19 cases and deaths in care homes. PHS found that hospital discharge was associated with an increased risk of an outbreak of Covid-19 when considered in isolation. However**, the risk of an outbreak was much more strongly associated with the size of care homes.** Of the care homes with more than 90 places, 90 per cent had an outbreak, compared to less than four per cent of care homes with fewer than 20 places.

36. Living in a larger size care home proved catastrophic for too many care home residents.

[12] 'NHS in Scotland 2020' – Report of Audit Scotland February 2021

37. In 2011, the Welsh Assembly Government revealed that its philosophy for increased dependence on the private social care sector and a focus on commissioning was a financially based philosophy. It said[13]:

> "The financial outlook is difficult. We cannot buy a way forward. This Paper is based on the assumption that efficiencies gained from initiatives such as pooling back office functions and ***smarter procurement*** are the bread and butter of day-to-day delivery*" my highlight*

38. The White Paper[14] "rebalancing care and support" also focusses more on the "funding challenge" than the needs of the populace, with an apparent focus on a desire to commit less financial resource rather than to providing necessary care. It is highly dubious as to whether any strategy that places dependence on "procurement practice changes" will, on past evidence, deliver the outcomes that the Welsh Government desires.

[13] Sustainable Social Services for Wales: A Framework for Action WAG10-11086 1.10

[14] The Funding Challenge Pages 15 and 16

PART TWO -POST THE MAIN PHASES OF THE COVID-19 PANDEMIC,

RESETTING, REBALANCING AND RE-ESTABLISHING HEALTH AND SOCIAL CARE WILL BE HEAVILY DEPENDENT ON SERVICES IN LOCAL COMMUNITIES, IN WHICH DOMICILIARY SERVICES, AND UTILISING AND SUCCESSFULLY TRANSFORMING LOCAL COMMUNITY HOSPITALS, WILL NEED TO PLAY A CRITICAL ROLE.

'CARE IN ONE'S OWN HOME IS MUCH TO BE PREFERRED TO CARE IN A CARE HOME'.

Helping People to Remain in their Own Homes Longer is our Recommended Philosophy

39. The vast majority of older people express the wish to remain in their own homes for as long as possible and for as long as they can receive appropriate care and support.

40. The impediments to the domiciliary care service in Wales are the assessment process and the patient charging structure that the Welsh Government imposes. Domiciliary care services are not free services, as healthcare usually is, but are services to which, on a means tested basis, the State will make a contribution.

41. To qualify for subsidized domiciliary care patients have to undergo an assessment. People complain that the current assessment rules for care to keep people in their own homes produce mean, barely sufficient care packages: The Welsh Government could, as the 2019 Labour Party election manifesto suggested, offer more generously assessed packages of domiciliary care to help people remain in their own homes longer.

42. Second, very many people, although they have very modest means, fail to qualify for "free" domiciliary care. They find that they have to pay up to £100 a week (the Welsh upper limit) for domiciliary care which would be free if they lived in Northern Ireland. As a first step, it has been argued that the £100 a week cap on care charges should be reduced to £50.

43. The assessment process not infrequently awards the recipient such a limited care assessment that the patient feels obliged to purchase additional care outside the £100 capped package.

44. A particular older person's complaint is that some carer visits are too short, some as short as 15 minutes. A significant number of 'carer' calls are not long enough to provide the personal care, the medication oversight and the assistance with getting a meal that the patient needs. Short scheduled calls lead to the carer being rushed and the patient (who often cannot rush) left flustered and upset, with the additional risk that something important is missed.

45. All of these constraints add to the pressure on the older person to consider moving into residential care.

Delivering the Older Person's Vision is Affordable – Utilising Quality Domiciliary Care

46. It is said that the cost to the Government of providing a place for an older person in a care home is five times as great as that of providing for their domiciliary care in their own home. If this is true, the scope for transforming the quality of domiciliary care is great.

47. The Welsh Government's 2021-22 budget book expresses budgeted expenditure as "budget allocation per head of population". The 'per head' annual budget for healthcare is £2190 and that for domiciliary care is just £90. It is impractical, given the backlog of NHS work, to expect any transfer of funds from the healthcare budget to the domiciliary care budget. Any suggestion to the contrary would seriously impede the NHS in its Post Covid-19 recovery.

48. However, even a modest budget allocation from other non health and care sector budget expenditure headings could permit the Government to address both the assessment constraints and the charges imposed on service users. A quality domiciliary care service in Wales is a vision that we can aspire to attain.

49. Unfortunately, the recently published report[15] "Alternative models of domiciliary care" focusses on achieving cost savings rather than on the cost of uplifting the standard of domiciliary care, which could help deliver the NHS recovery plan which is so badly needed.

50. The WLGA[16] says "Local councils are at the centre of delivering this vision. No other sector is better placed to deliver Wales' social care or public health services. We believe councils must be given the freedom to shape their care services based on the needs of their own locality and expand their areas of responsibility".

51. Many people will concur with that viewpoint.

Welsh Language Services are easier to provide in the patient's own home than in a care home

52. Several CIW reports on care homes assert that residents are still not receiving the dignity of care they deserve, especially in regard to receiving care in their first language. For example, a recent Care Inspectorate Report[17] published in March 2020, just before the Covid-19 lockdown said

> "People whose first language is Welsh do not always have their individual identities and cultures recognised. They were requested by the staff member to speak English as they could not speak Welsh, The rota was not always planned to ensure a Welsh member of staff was on each shift".

53. The number of Welsh speakers in a domiciliary team is invariably much greater than in care homes, because significant numbers of domiciliary care workers are drawn from those living in the local community, whereas there is a dependency in the residential care sector on the use of care staff imported from overseas.

[15] Welsh Centre for Public Policy – December 2020
[16] Cllr Huw David, WLGA Spokesperson for Health and Social Care
[17] Inspection Report on Meddyg Care Dementia Home, Criccieth

COMMUNITY HOSPITALS HAVE BEEN AND ARE THE "FLEXIBLE FRIEND" DURING THE PANDEMIC

The Welsh Government is urged to recognise the importance of community hospitals as the local base from which to deliver services

54. Delivering a strategy of "care in the home", where practical, depends on providing an infrastructure to deliver "care near to the home", when required.

55. During the first two phases of the Covid-19 pandemic, access to acute hospitals to receive healthcare in Wales was severely restricted. There was a vastly increased dependence on care provided by teams in the community. These multi-disciplinary teams were much assisted by the flexibility provided by Welsh community hospitals.

56. From April 23rd 2020, details and statistics were released which demonstrated:

    - the high utilisation of beds attained in Welsh community hospitals,
    - the opening of many additional beds and wards,
    - the diversion of less serious unscheduled care needs from A&E departments to "Minor Injury Units", and
    - the redirection of various investigated tests from acute hospital sites to community hospital sites etc.

57. From all over the UK the Computer Hospitals Association has received accounts of how the local community hospitals during the pandemic became, as the Secretary for Health in England put it during a TV interview, – "flexible".

58. 'Flexibility' of community hospitals was not a new discovery. Prof Emma Pitchforth in her paper[18] "Community Hospitals and their services in the NHS" stated, "The Community Hospital presents a 'fluid' concept, with the greatest advantage perhaps being its flexibility to respond to local needs."

59. Utilizing flexible assets is a key criteria in any service transformation. The management consultants, McKinsey & Company, in their classic 2015 survey report[19] found that "just 26 percent of respondents say their transformations were very successful". Innumerable other reports demonstrated that the transformations that disappointed were top down, corporate reorganisation style transformations.

60. Many reports argued for bottom-up agile transformation strategies, especially for service organisations where the beneficiaries of a transformation should be the recipients of the service. McKinsey and Company themselves in "How to beat the transformation odds", said "Focus on people, not the project. Transformations are about the people in the organization as much as they're about the initiatives". In a follow up report[20] McKinsey and Company said, ""Becoming armed with the right level of understanding for how to drive an agile transformation, and respecting the complexity of such a transformation, is a first step toward a successful journey".

[18] Pitchforth E, et al, Community Hospitals and their services in the NHS: Identifying transferable learning from international developments, Health Services and Delivery Research Vol 5; Issue 19, June 2017.
[19] "How to beat the transformation odds" McKinsey & Company 2015
[20] How to mess up your agile transformation in seven easy (mis)steps McKinsey & Company 2015 April 2018

61. The community hospital provides a flexible tool to effect an agile transformation addressing the bottom up needs as well as the top down governance.

62. Regrettably, the "Rebalancing care and support" Welsh Government White Paper, while claiming to be aimed at "strengthening partnership working to better support people's well-being, makes no mention of the critical role of local community service delivery and the importance of community hospitals as the local base from which to deliver services.

There is evidence of Scotland, Cornwall, Lincolnshire and Northern Ireland formalising a more rebalanced and rebuilt NHS than appears to be in the plan for Wales.

63. The Scottish Government is committed to rebuilding[21] the NHS differently. The Scottish Government published its "Re-mobilise, Recover, Re-design Framework" in May 2020. Two central features are "providing more care closer to home, minimising unnecessary travel", and "commitment to review and develop the role of the Covid-19 community assessment hubs and virtual appointments", both with the aim of providing more care closer to home effected through more intensive and flexible use of community hospitals.

64. Prior to the pandemic, most local community hospitals in Scotland, were usually viewed as being available for patients discharged from an acute hospital. Only in some locations were they at the disposal of local primary care teams to help ensure that the patient did not occupy an acute hospital bed.

65. Covid-19 hubs and assessment centres have been established[22] in Scotland usually in community hospitals. These hubs assess patients presenting with Covid-19 symptoms in the community, relieving pressure on GP surgeries. Between March 2020 and January 2021, over 250,000 consultations for advice or assessment were conducted through these hubs and centres.

66. Wales has encouraged patients to use a minor injuries unit where possible instead of attending at an A& E during the pandemic. Lincolnshire is formalising such a practice. The MIU at the community hospital in Spalding has been re-designated as an "Urgent Treatment Centre" with the capability to provide a more extensive range of injury and ailment treatments.

67. Cornwall has created[23] Community Assessment and Treatment Unit (CATUs) in community hospitals to support Elderly and Frail Patients across the county. They provide local access to point of care testing such as bloods and X-rays.

68. The ethos of the CATUs is about multi-agency working to achieve optimum patient outcomes. Whilst centring on Multi Disciplinary Team working, the team supporting patients includes a variety of professionals, included and not limited to; GPs, Nurses, Geriatricians, Paramedics, Dieticians, Health Care Assistants, Housekeepers, Speech and Language Therapy, Pharmacists, Physiotherapists, Occupational Therapists, Voluntary Sector, Junior Doctors and F2 Doctors. The benefits are a confirmed reduction of mortality per 100,000 inhabitants compared with other areas by providing appropriate clinical care for those affected by COVID 19

[21] NHS in Scotland 2020' – Report of Audit Scotland February 2021
[22] 'NHS in Scotland 2020' – Report of Audit Scotland February 2021
[23] https://www.cornwallft.nhs.uk/catu

69. There has been a trend in Wales to orientate community hospitals towards being Covid-19 + (and caring for Covid patients) and Covid-19 -, (aimed at being Covid free).

70. In Northern Ireland this cohort labelling has been formalised. Minor injury spaces in Covid-19+ community hospitals have been reorganised to create space for respiratory diseases. A few community hospitals built on single bed unit models have been identified and cleared of patients for use as moderate Covid-19 patient care.

71. When community hospitals are orientated to Covid-19 patient care, such an orientation often leads to a significant reduction in local clinics particularly for therapies such a physio, speech and language, audio etc. A backlog of patients needing help is building up and some patients may have permanent problems because of the unavailability of a full therapy service. Reduces services for stroke patients has been especially mentioned as risk area.

72. With Covid-19 now viewed as a highly contagious illness that will be inflicting us for some years, the cohort separation protocols that are adopted will be critical and as part of an NHS recovery plan, community hospitals can be expected to play a major role in reducing nosocomial infection in forthcoming years.

Rebalancing Care – Rebuilding Care Differently – the Critical Role of Community Hospitals - The Community Hospitals Association View

73. Globally, the greatest increase in serious health-related suffering is projected for people aged 70 years and over. Living into advanced age is often accompanied by multimorbidity[24], frailty and an uncertain illness trajectory of gradual decline over many years into end of life. This trajectory is punctuated by points of marked decline from an often seemingly minor event, like an infection and risk of poor outcomes including hospitalisation and death. Unplanned hospitalisations are common, even in many elderly people but unplanned hospitalisation numbers rise with nearness of end of life. This trajectory is well described, but less understood are the priorities for high-quality care for people to live as well as possible with advancing age and chronic conditions.

74. Care homes, with or without auxiliary nursing support, are rarely the best place for delivering the care needed to support this large cohort of “over 70 year old, multimorbidity patients”. Most of them have better outcomes through receiving domiciliary care at home, supported as necessary by local multimorbidity care episodes in a local community hospital.

75. Compared with healthcare models overseas, the UK is often labelled as “having overcooked the specialist role and downplayed the generalist medical role and the social care role. Care in the community needs to be expanded by deploying community hospitals more imaginatively, thereby relieving more specialist establishments and staff of interventions that generalists are well capable of performing.

76. Much of the care needs of the over 75 year old population can be provided in their own community – usually at home with a domiciliary care package, or if necessary in a

[24] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet (London, England). 2012; 380(9836):37–43.

nursing home. A fully staffed community hospital is ideal as an integrated site/base for all the community care teams of different disciplines providing a whole community service.

77. The small number of the over 75 year olds who needs Consultant hospital care then gets the full benefit of easier admission to more complex investigations and treatments through a referral from a community hospital generalist. When a modern community hospital is available, once the specialist episode is done, the patient can be transferred back to the community team for ongoing care.

78. In 2014, The Welsh Government commissioned a study[25] from Prof Marcus Longley of the Welsh Institute of Health and Social Care. He particularly compared the community hospital contribution to healthcare in rural parts of Scotland with some hospitals in Mid-Wales. The principle hospitals reviewed were Broadford Hospital[26] on Skye, Nairn Town and County Hospital and Cowall Community Hospital Dunoon. Data was presented to compare the service availability at these hospitals with the services available at Dolgellau, Tregaron and Cardigan. The services available in the Scottish community hospitals were significantly more extensive.

79. The Mid Wales Healthcare Study demonstrated that there is much scope for community hospitals in Wales to expand their contribution to their community. Had Prof Longley been able in his study to examine hospitals in community localities in other countries, much more evidence that the community hospitals in Wales are under-utilised and under-deployed would have emerged.

80. Professor Longley in his report supports the premise that the multi-disciplinary community team should be a locality entity fully accepting responsibility for all its patients. He says this in the context that[27]:

> "It seems clear that community hospitals will continue to be an important facility that straddles both primary and secondary healthcare and health and social care settings as financial and service pressures drive public bodies towards greater collaborative approaches to extract the most from (locally accessible) resources".

81. The Community Hospitals Association agrees with Prof Longley. A community hospital provides a place for interaction between a person with needs, and a practitioner with a responsibility to help assess those needs, and then to find the right combination of advice, support, care and treatment that is likely to best address the needs. The services cannot simply be for direct care and treatment, but must also provide advice and assessment of individual need.

82. A community hospital includes services for people who have additional short-term needs. Where a "need" has arisen that would usually lead to a hospital admission (at some physical distance) a community hospital can often circumvent that acute hospital admission by providing additional short-term support.

83. A community hospital is also a centre that supports those who wish to obtain access "virtually" to specialist advice and support, which would otherwise only be obtainable by the individual or the specialist travelling some distance in an "inefficient" manner. Whilst

[25] MID WALES HEALTHCARE STUDY Report for Welsh Government, Marcus Longley, Mark Llewellyn, Tony Beddow and Rhys Evans

[26] http://www.nhshighland.scot.nhs.uk/Services/Pages/DrMacKinnonMemorialHospitalBroadfordHospital.aspx

[27] MID WALES HEALTHCARE STUDY Report for Welsh Government Page 108

some people may be able to access such virtual support digitally direct from their own home, the benefits of being able to obtain practical support in a local community hospital include potentially linking to local practitioners / volunteers who can be with the person during such a digital “appointment” and provide additional support before and after.

84. A community hospital provides a physical “base” for community health staff to coordinate with social care and third sector staff to provide a holistic service to the patient. It may also provide convenient accommodation for social care and some third sector staff.

85. The models of care that support delivery of what is best for the patient in “care in the community models”, display the features of

- Possessing a significantly devolved locality budget
- A single reporting chain of command – not separate organisations seeking to find ground to co-operate
- 24/7 responsibility
- Control over locality estate
- Patient assessment responsibility
- Step-up interventions
- Step-down care for patients being discharged from acute services
- Planned care pathways including inpatient, elements and domiciliary support
- Delivery of re-ablement services to the community
- A wide range of investigative test support systems
- Remote base for consultant consultations increasingly via technology
- Less serious injury and ailment treatment
- Advice and information centre

Research Into the Deployment of Community Hospitals Post the Pandemic

86. The White Paper makes reference to the research activities of the Health Foundation. Amongst the Health Foundation’s many research initiatives underway are two that should be of interest to the Welsh Government.

87. The Community Hospitals Association is engaged to examine “Community Hospitals: Embedding Covid-19 positive impact changes through shared learning”.

88. Public Health Wales is leading a Q study into the use of the third sector and others in a sustainability study “learning lessons from the community response to COVID-19 in Wales".

89. The Covid-19 pandemic has accelerated significantly the deployment in the UK of digital infrastructures and has boosted the use of two technologies that add significant value to the roles of community hospitals – “remote consultations via digital imaging” and “remote investigations via the use of Artificial Intelligence” (AI).

90. It is recommended that the Welsh Government embarks on further research into the contribution that should be expected from hospitals in local communities serving their localities to obtain a much better assessment of how it should reset, rebalance and re-establish quality health and social care in Wales post the worse of the Covid-19 pandemic.

SUBMITTED BY

Tom Brooks
Glaneifion
Borth-y-Gest
Porthmadog
Ll49 9TP

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