**Open letter to Simon Stevens**
**From The Community Hospitals Association**

30th June 2015

Dear Simon

We were so grateful to you for taking time to speak to the annual conference of the Community Hospitals Association immediately after the NHS Confederation Conference earlier this month. Your input was much appreciated. Your messages about the role of community hospitals as social assets, offering humanity and compassion and fitting with the new NHS were very well received. The aim for triple integration resonated and evidence of integrated care was presented throughout the conference, particularly in our Innovations and Best Practice programme.

Thank you again for your invitation to submit this communication to you. I do hope that we can continue a dialogue. Please let us know if we can provide any supporting information.

With best wishes,

**Dr Phil Moore, Chair**

## We need a national strategy for community hospitals and related local services

*'What applies to acute does not apply to community hospitals.'*

We committed to letting you know things that we would like from you to help the development of community hospitals and related local services, drawn from the things our members said at the conference. **The essential message is that we need a national strategy**.

We believe this is needed to reflect that community hospitals have distinct and varied roles that cannot simply be wrapped up in other strategies around integration, community or primary care services. The over-riding message from over 50 contributions was that the current systems and measures do not always fit with what community hospitals do.

Some of those distinctives that need to be picked up by a strategy are enumerated below, illustrated by actual comments from delegates.

## 1. We are part of our communities

*'Community hospitals are social assets – how can we get this more widely recognised?'*

*'Can we have some advice on how to make sure that communities are engaged at an early stage when changes/developments/closures are being planned? The communities have a lot to offer.'*

*'What do you advise us to do if our community hospital is under threat?'*

*'We view community hospitals as levers for social mobilisation. We are designing our services from the community upwards. Would you agree this is the right approach?'*

Community hospitals are characterised by the high level of support shown by their communities, for example, through volunteering, fundraising and promoting 'their' community hospitals. The CHA is able to provide some inspiring examples of community support and we are also cooperating in research that is expected to quantify the financial and volunteer support given.

## 2. We have a wider strategic function that needs to be recognised

*'Can we have a 'signal' from the centre on the value and importance of community hospitals?'*

*'Community hospitals provide a wide range of services and their services are part of many national work streams. Is there scope for a specific focus on community hospitals or a specific strategy such as in Scotland?'*

Community hospitals provide locally accessible services supported by community-based staff. Services typically include in-patient care (rehabilitation, end of life care,

acute care, maternity etc.), urgent care in minor injuries units, community clinics, specialist clinics, diagnostics, day services, ambulatory care, renal dialysis and many more. So although the local hospitals are typically small, they provide a wide range of care and support in partnership with many providers. There is scope for a specific strategy showing how community hospitals fit within the architecture of the NHS and can be embedded into local systems and health and care services.

## 3. Our ownership and management is diverse

Ownership and management lies with a wide variety of NHS Acute Trusts, Mental Health Trusts and Community Trusts as well as community interest and private organisations. Not only are the ownership and management arrangements very varied, but community hospitals are multi-provider sites, with many provider organisations working in partnership. Whilst this diversity increases the range of services for local people, it does create complex contractual arrangements which may be viewed as disproportionate to the size of the hospital and service. We suggest that this needs to be reflected in the local capacity for coordination, integration and management. We make this point as a number of small hospitals have had onsite management reduced.

## 4. Our leadership models are varied and flexible

*'Move focus from medical model leadership to one which balances with nurse and AHP leadership. The doctor does not always know best.'*

*'AHPs to have more of a lead responsibility for managing services'*

*'More nurse-led leadership for community wards – not a medical model'*

Community hospitals may be clinically led by doctors, nurses or AHPs, reflecting the integrated care model for 'out of hospital' care. There is a consistent need for medical input but community hospitals are ideally placed for nurse and AHP leadership. The CHA would be pleased to provide examples of integrated care, team working and diverse clinical leadership arrangements.

## 5. Our staffing is diverse and team based

*'Review safer staffing levels across the board for community hospitals.'*
*'Devise a safer staffing level for AHPs'*
*'Consider factors such as old buildings.'*

When assessing safer staffing levels, it is important to consider the whole team with its members from a wide range of professions and agencies across health and social care. The CHA has supported NHS Benchmarking to collect data on staffing and team working from 158 community hospitals, and is repeating the survey this year.

## 6. Payment systems are not aligned to the work we do

*'We could be so much more productive and generate work for my theatre in my community hospital if money followed the patients.'*
*'Is it possible to split the tariff as this is a serious disincentive to using community hospitals currently?'*
*'We need support to demonstrate cost-efficiency.'*
*'Less emphasis on measuring our patient flow please and more emphasis on safe discharges.'*
*'Can we influence the design of the data collection systems so these do more justice to the services we provide?'*
*'There is more to rehabilitation that discharge planning and assessments.'*
*'The Early Warning System (EWS) should not be used in community wards as it is an acute tool – please adapt.'*
*'Focus spotlight on delayed transfers of care (DTOC) and on the organisation causing them.'*

The current payments for intermediate care, rehabilitation and episodes in community hospitals are problematic and do not recognise the very different work we do. So, there is concern about activity measures such as number of admissions

and lengths of stay as these need to be understood in the context of acuity, frailty, and complex care packages.

## 7. We are a training and learning environment

*'Medical students…more of them'*

*'Nurses should leave school with all the skills to function in the facility (IV insertion, Foleys catheter, blood work, etc.)'*

*'Develop link nurse roles to include training in speciality onsite clinics.'*

Community hospitals offer generalist and extended community services, and already provide education and training and could do more. The CHA knows of training, education and professional development offered to all disciplines in community hospitals and can offer training and education to practitioners, services users, carers and the community.

## 8. Commissioners are often not fully informed about our contributions

*'Put the clinical back in clinical commissioning'*

*'Stop hero worshipping GPs and medical colleagues. Nurses and AHPs are feeling undervalued and their voice is not being heard.'*

*'Be realistic that every £1 that you remove from local authority budgets affects health care, and that the sums don't add up!'*

*'Need to get money out of acute.'*

We are often hidden in the much larger organisation-wide contracts that manage us, so commissioners are commonly unaware of the work we do and therefore are less likely to commission our services proactively. This is particularly the case as community hospitals are multi-provider sites working across a whole system with partnerships across the NHS, social care, third sector and their community.

The opposite is also true. Some commissioners are targeting the services for change. Even though they are not always fully informed of what community hospitals currently do or their potential, and that this could help them deliver their strategy

for “increasing community capacity.” We are asking for informed decision-making from commissioners? The CHA can help in this regard of with research evidence and good practice.

## 9. We provide test beds for Innovation

*‘Is there a way we can be allowed to be more creative? Many of the systems such as HR and risk management systems stop or limit innovation and creativity.’*

*‘Facilitate innovation.’*

*‘Please invest in start-up.’*

Community hospitals are described as a microcosm of the NHS, and can test change and innovations on a small scale. It would be helpful if this was recognised and encouraged. At the prompting of the Department of Health a number of years ago we commenced an Innovations and Best Practice Programme where we have given over 100 awards in 15 years. We can therefore offer expertise on nurturing and fostering innovation.