Community Hospitals Preferred Option - Rationale and Vision (final version – 26 May 2016)

Executive summary

This paper sets out our proposals for the future of community hospitals in West, North & East (WNE) Cumbria as part of the wider WNE Cumbria Success Regime programme.

These proposals need to be seen in the context of the changing needs of the population and the wider clinical strategy which aims to reduce demand for hospital care through the implementation of Integrated Care Communities. We recognise that the role of community hospitals need to change in this context and also recognise that we can expect these changes will evolve over time. Therefore these proposals set out our view of the next step in what will undoubtedly be a continuing journey of change.

These proposals have been developed through a series of workshops and engagement events during 2016 in which the WNE Cumbria Success Regime developed a long list of options for the 9 community hospitals in North Cumbria that ranged from no change through consolidation onto fewer sites, to closure of all beds.

This document sets out our *preferred* option for the inpatient bed provision within community hospitals alongside our vision for community hospitals.

Vision for community hospitals

Once people no longer need hospital care, it is best to get home or to another community setting as quickly as possible because:

- Nobody wants to stay in hospital any longer than is necessary;
- Being at home or in a community setting (such as a care home) is the best place to continue recovery once an illness requiring hospital care is over;
- Once people are aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting;
- Severely ill patients may be unable to access services, if hospital beds are occupied with patients who no longer need them.

Following a hospital admission, most people are able to return home. Sometimes this can be with a care package of services, aids or adaptations made to their home. However, some people are unable to return home. They need the added support which is only available in a care home. Other people need a further period of rehabilitation and recuperation, with extra support for a period of days weeks, or sometimes months until they regain full health or reach their maximum potential. Community hospital facilities - both outpatient and in-patient services - currently play a key role in providing this support.

Our strategy of developing Integrated Care Communities (ICCs) aims to reduce demand on hospital services and speed up discharge into a more appropriate setting.

Whilst we have focussed a lot on the beds most community hospitals have a wide range of functions such as out-patient care, minor injuries, day care, hosting community teams and sometimes integrated with primary care.

We have developed these proposals while acutely aware of:

- The strong public support for these units
- The intense financial pressures in the health economy and the need to radically rethink the way in which we deliver healthcare in WNE Cumbria
- The need to ensure adequate staffing, quality and sustainability in the longer term
- The current severe bed pressures on North Cumbria Hospitals NHS Trust
- Often polar opposite views from different parts of the health economy as to the future of these units.
- The huge challenge of delivering care to our rapidly ageing population (oldest in the North West) across one of the less densely populated areas of England.
- National evidence and best practise supporting out of hospital models.

Our proposal:

- **Provides** a consolidated bed base in multiples of 8 allowing more efficient and sustainable staffing models

- **Re-focuses** the purpose of the units towards more admission avoidance and planned transfers from the acute setting following research based clinical pathways, and for the 3 sites without beds reinvests some of the savings back into building stronger community admission avoidance approaches looking after people in their own homes.

- **It recognises** that there should equitable access to community hospital in-patient beds across North Cumbria for those patients who are not able to be discharged to or cared for in their normal place of residence.

- **In part it seeks to address** the immediate short to medium term issues which need addressed in relation to quality of the environment, staffing/recruitment difficulties and efficiency.

The evolving role of community hospitals

Community Hospitals cannot be viewed in isolation and should be considered in the context of emerging Integrated Care Communities whose primary aim is to radically change the way services are provided and to primarily care for people in their own homes**.**

The community hospitals should have **2 clear functions** which support the model of Integrated Care Communities to maximise an individual's wellbeing through integrated population based care:

- as an **integral part of the whole elderly care bed base** with medical cover usually from a team of GPs from local practices and elderly care physicians. They should be used for step down (after a short stay in the acute) and step up care.

- as **enhanced admission avoidance hubs**, acting as 'Frailty units' - one stop assessment centres for the frail elderly (replacing outpatient clinics), focussing on comprehensive geriatric assessment, reablement and rehab, prevention (co-opting third sector and community resource) and admission avoidance such as falls assessments. Working closely with Integrated Care Communities

- The **community hospital and Step up Step down unit (Copeland Unit) beds should be closely linked to the elderly care beds in the acute trusts** to form a mainly community bed base for older people.

- GPs/Community medics and elderly care physicians should work as one team looking after these beds.

- The norm for the **acute trust should be very short stays (i.e. <48 hours) for older people** with rapid transfer out to home ('home first') or one of the community facilities for further assessment and treatment.

- There should be **day case/ambulatory units** within each locality where transfusions and other IV therapies can be *reliably* delivered. The portfolio of these ambulatory treatment centres should be developed in partnership with our acute trust.

- Community Hospitals will be natural hubs **to support Integrated Care Communities**, providing staff bases and health and social outpatients and day services to enhance health and well-being.

- **Technology will be maximised** ,such as video consultations, creating live links for urgent care and maximising the links to third sector groups in the town to enhance and support patient care

- **Attract and retain staff** by offering high quality training placements including the potential for training hubs for community, primary care and integrated care teams.

Summary of our proposals

The table below summarises our proposed changes to the inpatient bed provision for community hospitals in WNE Cumbria. These proposals will be subject to full public consultation.

Success Regime Preferred option for inpatient bed provision for community hospitals in WNE Cumbria				
	Community Hospital	**Existing beds**	**Proposed future Number of beds**	**Rationale (discussed in detail later in document)**
Allerdale	**Workington**	14	16	Serves large deprived population of 30,000+, modern building 12 years old
	Maryport	13	0	Currently serves circa 14,000 deprived population, sits between Workington and Cockermouth, Hospital building is likely to require significant investment/replacement and would need to be re-provided over the next few years.
	Cockermouth	11	16	New purpose built integrated care facility, serves approx. 18,000, potential for diagnostic facilities including docking for mobile scanners Significant unused space
	Wigton	19	0	Currently serves a scattered population of approx. 30,000 across the Solway plain. Ward environment acceptable but overall hospital infrastructure is likely to require significant investment/replacement.
Copeland	**Copeland unit**	15	16	Community Step up step down ward on West Cumberland hospital site. Part of future older peoples integrated bed base.
Carlisle and	**Brampton**	15	16	Currently serves East Carlisle and Brampton area. Estate in

district				good condition.
	Keswick	12	16	Serves Keswick population Estate in good condition.
Eden	**Penrith**	28	24	Serves Eden Valley population circa 60,000.
	Alston	6	0	Serves 2,400 population but most isolated town in England – see proposal for future sustainability of health and care in Alston below.
		Total current beds: 133 (of which 10 – 19 closed over last 2 years	**Proposed future beds: 104**	This provides 32 beds for Allerdale, 16 for Copeland (but Copeland also has West Cumberland Hospital), 24 for Eden and 32 serving Carlisle. It brings the Cumbria bed closer to the national intermediate care audit average. It results in 3 fewer units with beds.

Individual community hospital recommendations

There are strongly held views both in favour and against the continuation of provision of inpatient beds within these hospitals. Our future strategy for care is based on the principle that care is provided wherever possible in the patient's home or as close to home as possible. Indeed the primary purpose of our Integrated Care Communities is to deliver far more care in the home setting (avoiding both hospital admission and residential and nursing home admission whenever possible). Our proposed consolidation of beds in community hospitals is aligned to this overall strategy and to county council plans to provide more extra care housing, more personalised care choices and a strong focus on rehabilitation and reablement.

This proposal makes clear recommendations for each community hospital facility which are set out below. Recognising the huge public support for these facilities we have looked where possible to describe a positive future for them, with or without beds. These proposals will be the subject of full public consultation.

COPELAND

- **Copeland unit to increase from 15 beds to 16.**
  In addition we should consider the Copeland Unit beds within a fully integrated older people's bed base at West Cumberland Hospital. This could include a 'Frailty Unit' providing ambulatory assessments aimed at admission avoidance.

  The Copeland unit together with the elderly care acute beds in WCH provide the older peoples bed base for Copeland.

CARLISLE AND DISTRICT

- **Keswick Hospital to increase from 12 beds to 16**
  Keswick has predominantly served the local town. It is run and strongly supported by the local GP practice. Keswick has one of the lowest rates of acute non elective admissions for older people in Cumbria. As the hub of the integrated care community it should increase its admission avoidance functions e.g. more ambulatory assessment of the Frail elderly

- **Brampton to increase from 15 beds to 16**
  Brampton has historically served Carlisle as well as the 14,000 in Brampton and district itself. As the hub of the integrated care community (which includes Longtown) it should increase its admission avoidance functions e.g. more ambulatory assessment of the Frail elderly.

EDEN

- **Alston Beds to reduce from 6 to 0**
  Alston is the most isolated town in England with a community that cares passionately about their community hospital. The GP practice and hospital serve a population of just 2,400. Sustaining health and care in Alston is very challenging and this includes general practice, residential care and home carers. The community hospital is expensive to run per bed day and it is becoming increasingly difficult to staff on a sustainable basis. Many parts of the existing model are interdependent so simply closing the community hospital beds would create instability and threaten the general practice. We propose therefore to reinvest part of any money saved to build a more robust innovative and **fully integrated health and care service in Alston** which would jointly redesign the Cumbria Care led residential home, extra care housing and hospital to fully support caring for people in their own beds by developing a significantly enhanced community nurse and therapy team. Alston Hospital would remain the hub of healthcare, hosting the general practice and enhanced community health and care teams. It would provide ambulatory frailty assessments.

  Penrith Hospital would reduce from 28 beds to 24 beds.
  This would allow a more efficient staffing model (i.e. multiples of 8 beds). Penrith Hospital would remain a major health hub within the integrated care community.

ALLERDALE

- **Workington – to increase from 14 beds to 16**
  This small change would improve the efficiency of the ward. This is a PFI in a centre of significant population (30,000 with high levels of deprivation). As part of the integrated care community development there are plans to use the hospital site further as the hub of healthcare in Workington, co-locating more general practice services and considering more ambulatory assessment such as for Frailty as the clinical model develops.

- **Cockermouth – to increase from 11 beds to 16**

This facility is a 3 years old LIFT building designed for integrated care with a purpose built community ward. General practice is on site as are all the community teams. It has space (unused) for diagnostics including docking facilities for mobile scanners. There is a significant amount of unused (but paid for) space including a large vacant dental clinic and unused minor surgery suites.

- **Wigton – to reduce from 19 beds to 0**
  Much loved Wigton Hospital was built in 1840 as a workhouse. It serves a dispersed population of approximately 30,000 across the Solway plain but historically has had a significant proportion of step down patients from Cumberland Infirmary Carlisle and until a few years ago was a consultant led unit outreaching from the acute hospital. It is 11 miles from Cumberland Infirmary. The ward environment is acceptable but overall the hospital infrastructure is likely to require significant investment/replacement. and on a hill on the outskirts of town. New GP premises, new extra care housing and established residential care home are all in a cluster near the centre of town. We propose the reinvestment of a proportion of the cost of the ward on an enhanced community based nursing and therapy team and enhanced primary care providing more care to older people in their own beds at home focussing on admission avoidance.

- **Maryport – to reduce from 13 beds to 0**
  Maryport Hospital serves a deprived population of approximately 14,000 and is passionately supported by the local population who feel strongly that they frequently lose out to the more affluent parts of Cumbria. It is 6 miles from Workington and 8 miles from Cockermouth both of which have modern facilities with beds. The hospital in Maryport is likely to require a rebuild or substantial refurbishment in the near future. The general practice next door is similar and ideally needs a new build. There are clear opportunities here to reinvest a proportion of the savings from the beds to enhance community nursing and therapy but also to build and sustain extended primary care with the innovative local general practice. With sustained investment in the practice and community there are great opportunities to address the many public health issues facing Maryport, thus keeping a significant part of the resource in the town.

It is important to note that in Alston , Maryport and Wigton we propose that 50% of the savings generated by the closure of community hospital beds should be reinvested into community services in these areas that would enhance patient care. The exact nature of these changes may vary between areas and need jointly developed by the Integrated Care Communities informed by active public and patient engagement.

The proposals particularly where in-patient bed bases are being lost need to be considered within the context of Cumbria County Council strategies: *Commissioning Strategy for Care and Support delivered by Adult Social Care 2015-2020* and *Extra*

Care Housing and Supported Living Strategy 2015-2025. With a trend for limited Nursing and Residential placements, increased support for people to stay in their own homes and developments in extra care housing it is essential that opportunities to work together are explored and solutions found for the care needs of the local populations that offer home based care as well as access to bed based care as required.

Within this proposal there are associated capital costs to bring the estate up to modern day standards and expand wards to deliver bed bases at no less than 16 beds. Indicative capital costs to bring the units up to modern day standard have been calculated in the region of 7.5 million, however this figure should be treated with some caution as detailed estates planning and design would need to be considered and costed for each unit, that said although approximate if the indicative figure is broadly correct savings in revenue over within 3 years would cover the capital works in full.

Proposed timeline

The proposed changes reduce the overall number of beds by 29 although due to staff recruitment issues between 10 and 19 beds have been closed for the last 2 years so the actual net reduction is 10-19 beds. The anticipated impact of ICCs will be to reduce overall bed utilisation by 20% over time.

Over recent months there have been significant patient flow issues reducing bed capacity in the system. This is largely due to a health and social care inability to help people move home or to their new long term setting. Service capacity issues in the system are around: domiciliary care, reablement, where services are bottle necked because of the inability to pass people into long term domiciliary care, specialist dementia and long term nursing care with beds in nursing homes closed due to quality concerns and a lack of capacity in community services such as CRS and District Nursing. There are also hold ups in the system due to shortfalls in Social Work Capacity to assess and CHC assessment processes and the fact that we don't have a dedicated Fast Track service. The movement towards Integrated Care Communities is intended to address and find joined up solutions to these live issues.

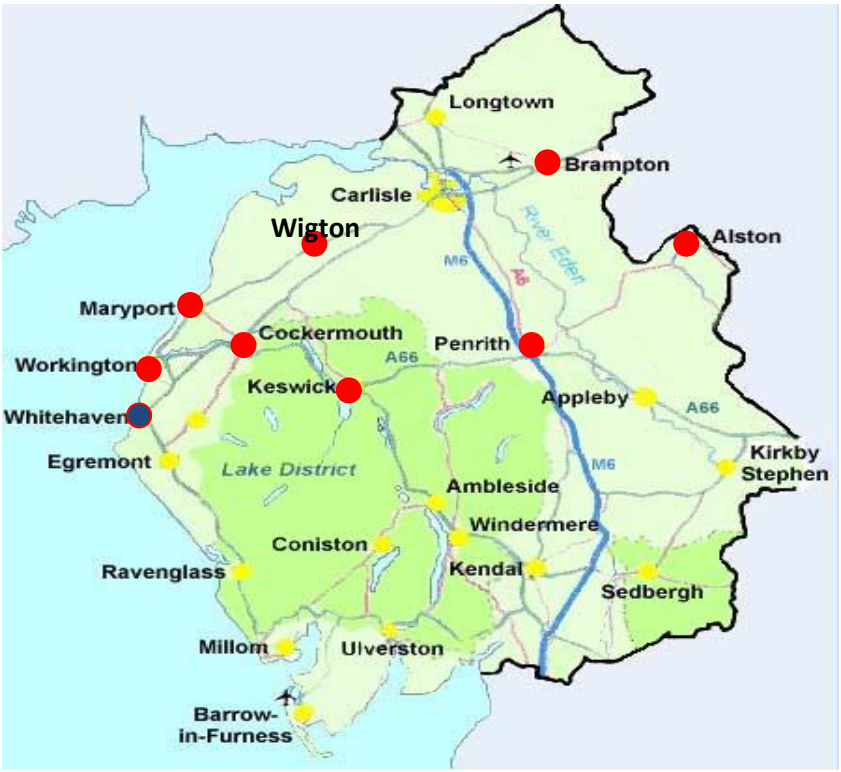
We would have to plan any changes to community hospitals carefully and phase the changes in over several months and plan the enhanced community model. The increase of bed numbers in other community sites will in some cases need capital investment with remodelling of wards. The overall consolidation could begin shortly after the public consultation ends in the autumn (if the proposal is agreed). It is likely to take 6-9 months to complete. We do not anticipate making any staff redundant and would look to redeploy them in the community team or other community hospitals which have significant vacancies.

The background analysis leading to this preferred option is set out in in Appendix One.

Appendix One

1. Current state

Cumbria CCG currently commissions 9 community hospitals with a combined 133 beds in North Cumbria. There are 8 traditional community hospitals (Alston, Brampton, Cockermouth, Keswick, Maryport, Penrith, Wigton and Workington) and 1 step up step down (SUSD) unit (the Copeland Unit in West Cumberland Hospital, Whitehaven) that was created in 2010.



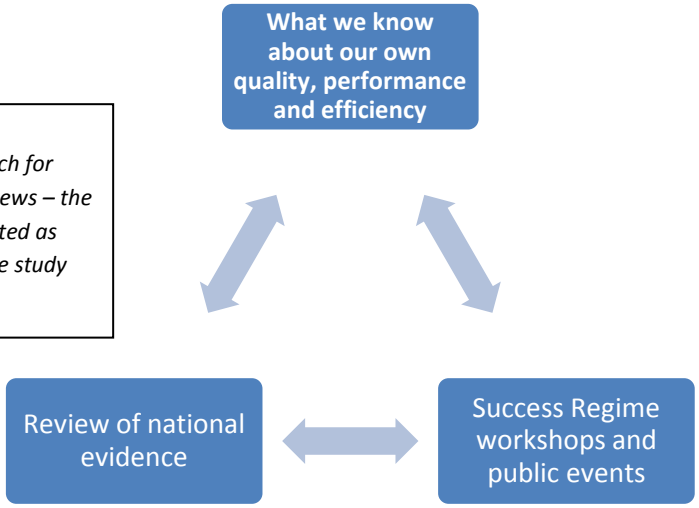
= SUSD Unit
= Community Hospital

***Only WNE Cumbria community hospitals are shown on this map**

2. Methodology

The method we used **triangulated** analysis of our own quality, staffing, performance and financial data, a review of national evidence and a number of workshops and events run by the Success regime.

We developed this triangulation approach for previous services reviews – the method was highlighted as best practice in a case study by NICE in 2013



We reviewed **national evidence** including the recent intermediate care review, the RCP Future Hospital report and reviewed evidence of good practice from the last 5 national conferences of the community hospitals association. We also looked at reviews of community hospitals done in other parts of the UK e.g. Scotland.

We undertook an **analysis** of:

- Demographical challenges
- Hospital admission rates and patient flows
- Productivity
- Quality and patient experience
- Finances
- Estates

3. Findings

3.1 What does the national evidence tell us?

In **2012 NHS benchmarking** undertook a project around community hospitals. The project included 29 organisations with 124 community hospitals around the country. It found:

- Average LOS across 124 community hospitals of 27 days
- Overall nationally 70% of admissions to community hospitals in the audit were step down and 30% step up (similar mix to Cumbria)
- Wide range of community hospital beds commissioned per 100,000 population in the study group (and of course many more areas with none)
- Only slight decrease in acute non elective bed days as community hospital beds increased

The National Audit of Intermediate Care 2013 looked at both bed and non-bed based intermediate care. It classified intermediate care into 4 main areas:

1. **Crisis response** – services providing short-term care (up to 48 hours only)

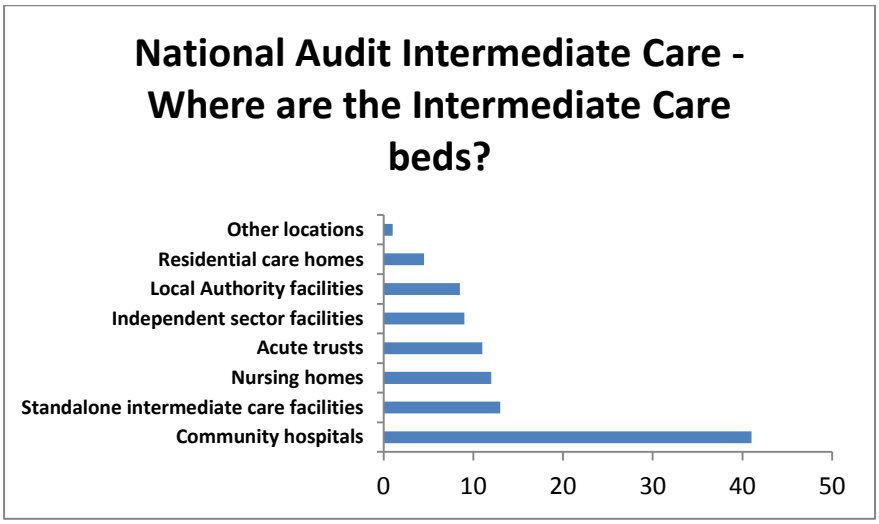
2. **Home based intermediate care** – services provided to people in their own homes by a team with different specialties, but mainly health professionals, such as a nurses and therapists.

3. **Bed based intermediate care** – services delivered away from home, for example, in a community hospital.

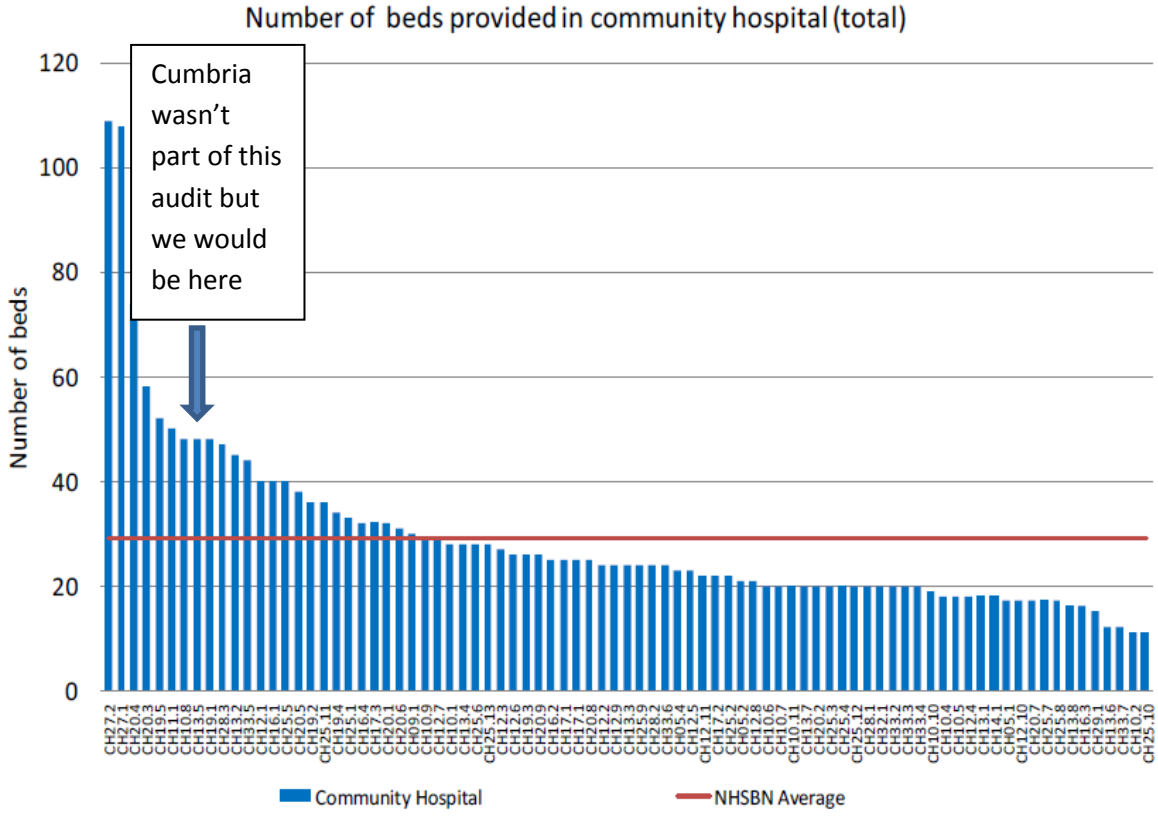
4. **Re-ablement** – services to help people live independently again provided in the person's own home by a team of mainly social care professionals.

It found:

- "The current provision of intermediate care is around half of that required to avoid inappropriate admissions and provide adequate post-acute care for older people". Prof John Young National Clinical Director for integration and Frail Elderly.
- "Clear evidence of weak local strategic planning processes".
- "Long waits to access services – delays are counterproductive to older people who rapidly deteriorate when held in a queue".
- Nationally average 78% step down 21% step up in bed based units



Community hospitals are the commonest form of 'bed based' provision of intermediate care nationally. Nationally the mean number of intermediate care beds commissioned per 100,000 weighted population is 26.3. In Cumbria the number is approx. 47 per 100,000 – we have significantly more community beds than most (but not all) health economies in this audit.



This audit also looked at costs in different bed based settings:

Bed based setting	Mean cost per occupied bed day £
Acute trust setting	169
Community hospital	196
Independent sector facilities	149
Local Authority facilities	202
Nursing homes	162
Residential care homes	203
Standalone intermediate care facilities	196

It is not clear however that the method used for calculating costs was the same as the one we have used and some values are based on small numbers (e.g. only 4 independent sector facilities). It does however give ball park daily costs in each setting.

Prof John Young concludes "Strategically planned adequate intermediate care capacity should be an essential step for local health and care commissioners if the whole system is to function optimally".

There was a clear recommendation to build a stronger intermediate care level of services. We need to consider how community hospitals fit into the Intermediate care

structure in Cumbria including the home based services, how they fit with the acute care bed base and how they fit with a primary care service that needs to develop to manage more and more care for the elderly outside hospital.

3.2 Demographics

Cumbria has the oldest population in the North West and we are ageing at a faster rate.

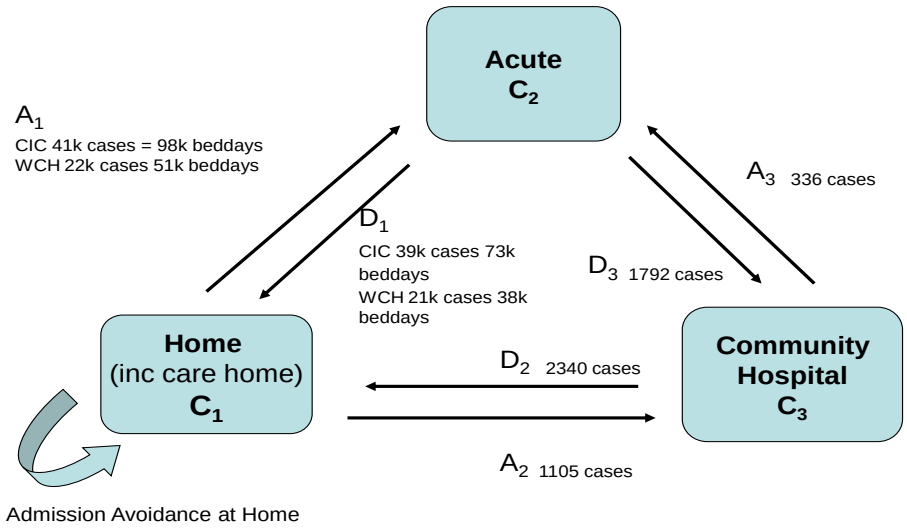
Older people with multiple and complex conditions make up the bulk of the community hospital caseload. The number of people with dementia for example is rising at 4% per year (equivalent to an additional patient with dementia *every 2 weeks* for the next 20 years in a town the size of Penrith).The preferred pathway for patients with dementia following an acute episode would be to return directly home to reduce further confusion as prolonged hospital stays exacerbate problems and decrease functionality. The number of people with frailty syndrome likely to need intermediate care will significantly increase.

3.3 Hospital patient flows

During 2013 we undertook an analysis of patient flow in the North Cumbria system:

In the diagram below A1 A2 and A3 all relate to admission flows, D1 D2 D3 all relate to discharges.

Flow between Home, North Cumbria Acute and Community Hospitals in 2012/13 (annualised from first 9 months data 2012/13)



Whilst this is 2013 it shows clearly that the majority of people (60,000) leaving North Cumbria acute trust go home with just 1792 stepping down to community hospitals and 1105 stepping up to community hospitals.

3.4 Productivity

During the period 2007 – 2010 there was an intense focus on improving productivity and quality in community hospitals. During this period:

- Overall admission numbers to community hospitals doubled
- Length of stay (LOS) reduced in every hospital (average of 9 days less)
- Overall there was an 80% increase in the 'throughput per bed'

Between 2010 and 2013:

- Admission numbers stayed more or less steady
- There was been a small further reduction in LOS of 1.3 days
- Throughput per bed increased by a further 5%

Between 2013- 2016 (particularly over recent months)

- There has been a significant increase in length of stay to 21 days in community hospitals with significant numbers of delayed transfers of care .
- Increased proportion of step down patients 75-80% over the last 12 months reflecting significant bed pressures in the acute trust and on community based services (home care, reablement and community health provision).

A Points prevalence survey of 105 in-patients in April 2016 identified the following reasons why a patient was admitted to or transferred to a community hospital.

Reason for Admission	**Percentage**
Infection	10%
Palliative Care/End of life	9%
EMI	1%
Social admission	10%
Rehabilitation	60%
*Other -	10%
Total now delayed transfers of care	**38%**

**Other includes (Transfusion, awaiting surgery, Post op care, awaiting Outpatient review, to wait for a nursing home bed, Pain review, Assessment, Discharge planning, Complex wound care, exacerbation of COPD)*

3.5 Quality overview

Patient experience:

Generally patient experience in community hospitals and SUSD units in Cumbria is excellent.

In 2013 we undertook a very detailed review of our community hospitals led by Dr Keith Hurst a national expert in this field. It analysed 11,035 nurse interventions and found:

Dependency:

Wards	***Dep. 1***	***Dep. 2***	***Dep. 3***	***Dep. 4***
All 145 benchmarked best practice elderly care wards	8%	26%	50%	16%
Cumbria average	3%	39%	46%	12%

Overall the dependency mix of Cumbria community hospital wards was slightly less than the UK elderly care ward average.

Nursing quality:

Nursing quality overall score	The 145 best elderly care wards	Cumbria Community hospitals and SUSD units
Overall score	76%	83%

Overall Cumbria community hospitals scored significantly higher on nursing quality when benchmarked against the 145 best elderly care wards.

Recent CQC inspections however have rated our in-patient services as 'requiring improvement'. In particular there are very significant challenges around sustaining safe staffing levels.

The position in May 2016 is an RGN staffing gap of 17%. This equates to 618 hours or 16.48wte. There is also a 6% HCA gap, which equates to 247.5 hours or 6.6 wte in vacancies and 127.5 hours. The ward manager gap is at 33% which is 3 wte or 112.5hrs. Historically Sickness levels are approximately 1% higher than other

community services; averaging 5.87% over the last 12 months, more recently this has improved to 4.7%.

These issues have had an impact upon the small units, beds have been closed in an ad hoc manner to ensure safe staffing levels of 1:8 nursing are achieved; this has proved challenging and its impact is felt across the wider healthcare system.

Some of our units are very small and often only have 1 registered nurse on duty, recruitment and sickness issues in small units can lead to crisis situations where no registered staff are available to work which results is unplanned bed closures putting pressure on the whole system. This can lead to existing staff working long hours, double shifts and for prolonged periods of time without rest periods which could result in clinical errors, staff stress, increased sickness and staff leaving. The CQC report in autumn 2015 highlighted that staff often felt isolated and vulnerable. CPFT have invested £1.8 million above our contract value to achieve safer staffing levels but have found it extremely difficult to recruit as there is a national shortage of trained staff.

Consolidation of inpatient community services to larger units could deliver more sustainable and resilient models of staffing. Where the evidence base suggests that 24 is the optimum number of beds for total efficiency – modelling in ratios of 8 but no less than 16 also deliver efficient models of working and consolidation needs considered within what is possible within the current estate.

Medical cover across 13 geographically separate sites is challenging. In hours cover is provided by local GP practices in the historic community hospitals and by directly employed GP or staff grade doctors in the SUSD unit. Out of hours cover is provided by the GP out of hour's provider CHOC.

Specialist geriatrician input to wards varies from weekly ward rounds to support on request remotely by telephone.

The increase in the number of delayed transfers of care is also of concern – a proportion of our patients are spending too long in hospital. The majority of patients want to be at home or their normal place of residence but patients are spending time in hospital because we do not have the services in the community to care for them .Apart from the inconvenience and distress this can cause emotionally, there are significant physical effects for the elderly on unnecessary and prolonged hospital stay such as loss of functionality, susceptibility to infection, muscle wastage and skin problems.

3.6 Financial analysis

What do the wards cost to run?

	Operating Costs £'000 Direct and indirect ward costs (includes medical cover)
Workington	978
Maryport	913
Wigton	1,175
Cockermouth	758
Copeland Unit (not Loweswater)	1,335
Brampton	960
Keswick	1,180
Alston	662
Penrith	1,682
TOTAL	**£9,643**

Current operating costs for all community hospitals and SUSD unit in North Cumbria is £9,643,000

3.7 Estates overview

The buildings are of different ages and condition, generally the in-patient facilities have limitations due to their age and design and most are smaller than ideal.

The estates position is summarised in the table below:

	Who owns the estate?	Condition summary
Workington (Allerdale)	PFI	12 year old PFI Hosts 2 general practices and many other offices and clinics. Ward expansion possible but may be costly
Maryport (Allerdale)	CPFT	Hospital likely to require significant investment re-provision over the next few years. General practice next door in similar position
Wigton	CPFT	Ward environment acceptable but overall hospital infrastructure likely to require significant investment /replacement and is on a hill on the outskirts of town. New GP premises, new extra care housing and residential care home are all in a cluster near the centre of town.
Keswick	CPFT	Recent £1.3m investment to upgrade facilities including ward and minor injuries/minor ops suite
Cockermouth	Lift company	£11m new build fully integrated facility opened 27.1.14 with general practice out patients community hospital High spec, 11 single rooms
Copeland Unit	NCUHT	Ward within WCH – will need to

		re-provide in next phase WCH rebuild
Brampton	CPFT	1914 War memorial building but in relatively good state.
Alston	CPFT	Old building in reasonable condition, with co-located general practice
Penrith	CPFT	Old facility in need of some refurbishment. Whole site owned by CPFT and adjacent fire station site recently acquired

A risk rating of all our in-patient units shows the current position and highlights the concerns re estates.

	Unit	Alston	Brampton	Penrith	Keswick	Wigton	Maryport	Cockermouth	Workington	Copeland WCH
Age of Building		1900	1900	1960	1900	1820	1900	2013	2005	1960
Owner		CPFT	CPFT	CPFT	CPFT	CPFT	CPFT	eLIFT	PFI	NCUH
Beds (Capacity)	**Beds**	6	15	28	12	19	13	11	14	15
Condition of building		Good	Good	Satisfactory	Good	Satisfactory	Satisfactory	Excellent	Good	Satisfactory
Quality (access, space etc)		Good	Satisfactory	Satisfactory	Excellent	Satisfactory	Satisfactory	Excellent	Good	Satisfactory
Suitability (for current use)		Satisfactory	Sig Imps	Sig Imps	Good	Sig Imps	Sig Imps	Good	Good	Sig Imps
Engineering Services		Good	Sig Imps	Sig Imps	Good	Sig Imps	Sig Imps	Excellent	Good	Sig Imps

What do the buildings cost to run? **(Note the community hospitals have multiple functions including minor injuries, outpatient clinics, team offices etc.).**		
	Rent, rates and utilities £'000	**Capital – depreciation and Public Dividend Charge £'000**
Workington	829	228
Maryport	60	102
Wigton	98	149
Cockermouth	647	Not CPFT owned
Copeland Unit	113	24
Brampton	49	62
Keswick	80	124
Alston	43	51
Penrith	70	427
Total	**1,989**	**1,167**

In addition there are annual maintenance costs which vary greatly between hospitals, collectively over the last 5 years £5 million pounds have been spent on essential improvements to the estate.

4. Conclusion

Community hospitals have a long history in Cumbria and are strongly supported by their local communities and active League of Friends that contribute significant funds.

Overall they deliver a high standard of nursing care and excellent patient experience. However medical cover across 13 units presents a challenge and nurse recruitment is becoming a critical issue. These units have grown organically and have not been part of a designed system so are not distributed evenly around Cumbria. They are closely connected to primary care which is a strength but the connection to specialist elderly care is variable and they do not form a coherent bed base for step down care with the elderly care wards. There is also a view that many people who use the hospitals could go directly home had the appropriate community care been available with many professionals expressing concern that patients decompensate whilst in hospital and this may mean that ultimately their ongoing care costs more emotionally physically and financially.

These are exceptional times with the health and care economy in Cumbria facing extreme financial pressures. The direction of travel nationally is to deliver far more care outside acute hospitals. There is general agreement that we have to build a stronger intermediate care tier that sits between primary care and secondary care. This should mainly be delivered to people in a bed in their own home. We have a relatively high number of beds in the intermediate tier in Cumbria.

Taking all these issues into consideration we propose a consolidation of community hospital beds onto fewer sites with overall a reduction of 29 beds (noting that 10-19 have been closed for the last two years due to recruitment difficulties). For all hospitals we propose a strengthening of their use as admission avoidance hubs within the emerging integrated care communities. For the three hospitals without in-patient beds, Alston, Wigton and Maryport we propose the reinvestment of 50 % of the savings to greatly strengthen local primary and community nurse and therapy teams aimed at supporting more people to stay in their own homes.