APPENDIX 1

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NHS
Grampian

NHS GRAMPIAN STRATEGY FOR COMMUNITY HOSPITALS

2004 – 2009

The Grampian Community Hospitals Network's contribution to the Change and Innovation Plan

DRAFT

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EXECUTIVE SUMMARY

There are presently 19 community hospitals located within NHS Grampian. This is the highest concentration of such facilities of any Health Board area in Scotland. Community hospital provision is recognised as an integral resource for the delivery of health care services to the localities within which they are based and the wider NHS Grampian system. This Strategy sets out the potential future role and action plan for Grampian's community hospitals in response to the changing local and national context.

The Strategy has a set of core aims:

- To improve services to patients delivered through community hospitals;
- To link the Grampian community hospitals network(s) to the Change and Innovation Plan;
- To inform the NHS Grampian system with regard to the current role of community hospitals;
- To identify capacity and aspiration to develop the NHS Grampian agenda in community hospitals;
- To encourage both community hospital and NHS Grampian leaders to direct the development of the future role(s) of community hospitals in Grampian.

The document describes the key functions and activity of the community hospitals in Grampian today, including outpatient, casualty and diagnostic services, and the range of clinical and professional input. This takes cognisance of the differences across community hospital provision and capacity within Aberdeenshire, Moray and Aberdeen City Shadow Community Health Partnerships (CHPs), and is supported by a supplementary document detailing each individual hospital's provision.

The strategy presents the links between community hospitals and each of the major change projects within the NHS Grampian Change and Innovation Plan. Key changes and developments include: GP Out of Hours arrangements and unscheduled care provision, workforce and pay modernisation, Diagnostic and Treatment Services/Centres and the intermediate care agenda.

It sets out recommendations in key areas of action (see page 26) and identifies the responsibilities of the community hospitals, CHPs, lead clinicians and NHS Grampian as a whole, in order to realise the strategic direction and vision for community hospitals within NHS Grampian over the next 5 years and ensure the most effective utilisation of this resource.

1. INTRODUCTION

1.1 AIMS

The key aims of this strategy are:

- To improve services to patients delivered through community hospitals
- To link the Grampian community hospitals network(s) to the Change and Innovation Plan
- To inform the NHS Grampian system with regard to the current role of community hospitals
- To identify capacity and aspiration to develop the NHS Grampian agenda in community hospitals
- To encourage both community hospital and NHS Grampian leaders to direct the development of the future role(s) of community hospitals in Grampian.

1.2 WHAT IS A COMMUNITY HOSPITAL?

NHS Grampian is in a very fortunate position with regard to community hospital provision; there are currently 19 such establishments across the region (see Appendix 1 for map of locations within Grampian). However, they all differ in terms of the services they offer to their local communities and to the NHS system in Grampian.

Community hospitals are hospitals where most patients are admitted, and cared for, by their own GPs. Their functions are usually considered to be:

- Acute medical care where patients cannot be cared for at home, but where the expertise and/or the specialist diagnostic facilities of a major specialist hospital are not required
- Post acute care including rehabilitation
- Casualty services
- Palliative Care.

In addition they may host a variety of functions for the locality including:

- Diagnostic facilities (e.g. x-ray, ultrasound, sigmoidoscopy, cardiac assessment, telemedicine)
- Therapeutic facilities (e.g. Physiotherapy, Occupational Therapy, Minor Surgery, Day Hospital)
- Facilities for joint teams (community nursing teams and social work/care management teams)
- Specialist outpatient clinics
- Intermediate Care Clinics
- Renal dialysis.

Hospitals have often shared expertise and equipment, and offered cross border services to patients not nominally in their areas.

The traditional roles for the provision of long stay care for older people and psycho-geriatric care in community hospitals are changing dramatically as a result of policy and strategic direction. Many continuing care beds/units have closed over the past ten years; this trend is continuing along with the more flexible use of these resources and an emphasis on rehabilitation/step down care.

All community hospitals are different; this is not an homogeneous resource, but a range of service provision developed within each locality over time.

1.3 WHY DEVELOP A COMMUNITY HOSPITALS STRATEGY?

1.3.1 Context for the development of the strategic direction for community hospitals in Grampian

There is a range of key forces and drivers converging both within the NHS in Scotland and across Grampian which influence the development of, and need for, a strategy for community hospitals. These are outlined in the following table.

Table 1: National, Local and Other Policy Drivers and Impact on Community Hospitals

POLICY DRIVERS	IMPACT
NATIONAL DRIVERS	
Partnership for Care, 2003[1]	• changing the organisation of care towards whole system NHS • more care to be delivered locally • more Managed Clinical Network (MCN) development, pathways of care • partnership working with Local Authorities and the creation of Community Health Partnerships (CHPs)
Pay modernisation, 2004: New Consultant Contract; New GMS Contract; Agenda for Change	• opportunities to redesign services and link changes to professionals' contracts • out of hours redesign • workload management, all staff groups • opportunities for innovative approaches to care provision
A Joint Future, 2002[2]	• movement towards closer integration of health and social care across community care groups • sharing/aligning resources (including community hospitals)
LOCAL DRIVERS	
HealthFit principles, 2002[3]	1. *Re-modelling traditional forms of care to increase system capacity.* 2. *Involving the public to improve understanding and gain wider ownership to enable the HealthFit changes to happen.* 3. *Developing local care and service centres to provide a wide range of services that improve fair access for all Grampian people. This might entail the compression of community hospitals overall with fewer providing a wider range of services, and maximising use of other facilities across the health and social care system.* 4. *Re-shaping the configuration and activity of the acute and tertiary centres to get the most out of specialist skills within the health system.* 5. *Developing partnerships to engage with the private and voluntary sectors.* 6. *Developing appropriate new technologies to assist reconfiguration, e.g. telemedicine, mobile diagnostic facilities, ECCI.* 7. *Strengthening managed clinical networks at three levels – across Grampian, regionally and nationally.* 8. *Balancing the needs of communities with the requirement to provide safe and sustainable specialist services.* 9. *Building on existing partnership working and collaboration within the NHS and between health and social care providers.* 10. *Focusing on long-term workforce development and integrated workforce planning.*

[1] Scottish Executive Health Department (2003) *Partnership for Care – Scotland's Health White Paper*
[2] *A Joint Future – Report of the Joint Future Group* (2000)
[3] As cited in NHS Grampian/Office for Public Management (2002) *HealthFit: Creating the Vision for Grampian's Health*

POLICY DRIVERS	IMPACT
LOCAL DRIVERS continued	
Primary Care Strategy 2003 – 2006[4]	• outlines strategic direction for primary care in Grampian, setting out clinical priorities based on agreed principles • development (in partnership) of intermediate care services, NHS Grampian redesign and modernisation of primary care • where appropriate ensuring clinical services are provided as close to patients as possible
Changing demographics	• increasing population of older people with significant needs • increasing Aberdeenshire population whilst City population declines
Financial constraints	• NHS Grampian budget continues to put pressure on the system to reduce activity; affects capital and revenue spending • need to demonstrate value for money with regard to all community hospitals
Workforce constraints	• difficulty recruiting to some professional groups • shortages of key skills
Single system redesign	• community hospitals as part of the whole NHS Grampian system • development of Community Health Partnerships (CHPs) • review of organisation of community hospitals required • Managed Clinical Network links
Older peoples' strategy[5]	• continues the move to community based models of care • expresses need to reduce number of community hospitals
Psychogeriatric Care	• need to review provision and need across NHS Grampian; rationalisation
Unscheduled Care	• increasing pressure on acute sector from unscheduled medical care • role of community hospitals in future managed network for unscheduled care
OTHER DRIVERS	
Impact of technology	• single patient record; community hospitals more accessible clinically • telemedicine developments, PACS • links with the A&E IM&T system • mobile diagnostic facilities
Quality Improvement Scotland	• community hospital standards have to be met • need to further enhance clinical audit in community hospitals

RECOMMENDATION:

1) In response to our new environment, an agreed network arrangement for community hospitals in Grampian should be developed, reflecting the CHPs and 'single system' organisation.

[4] NHS Grampian (2003) *Strategy for Primary Care April 2003 – March 2006*
[5] *Ageing with Confidence – A Joint Strategy for Older People in Grampian 2001-06*

2. COMMUNITY HOSPITALS IN GRAMPIAN TODAY

2.1 NUMBERS AND LOCATION

There are currently 19 community hospitals managed by primary care in Grampian. Campbell and Spynie hospitals are not included within the context of this report, taking cognisance of the existing agreed plans for the future closure of these establishments (at the time of writing). Other hospitals (Maud and Ugie) are currently subject to locality reviews and linked to the Psychogeriatric Services redesign.

From section 2.2 an overview of the services and activity in all of Grampian's community hospitals is provided. The following sub-sections outline the context and arrangements within each Community Health Partnership (CHP) area.[6]

2.1.1 Aberdeenshire

There are a total of 13 community hospitals within Aberdeenshire (Shadow) CHP, situated within the following Local CHP (LCHP) groupings:

North Aberdeenshire LCHP

- Campbell Hospital, Portsoy
- Chalmers Hospital, Banff
- Fraserburgh Hospital
- Maud Hospital
- Peterhead Community Hospital
- Turriff Hospital
- Ugie Hospital, Peterhead

Central Aberdeenshire LCHP

- Insch Hospital
- Inverurie Hospital
- Jubilee Hospital, Huntly

South Aberdeenshire LCHP

- Aboyne Hospital
- Glen O'Dee Hospital, Banchory
- Kincardine Community Hospital, Stonehaven

The proposal for an Aberdeenshire Community Hospitals Network has been developed, based on the LCHP groupings. The functions of this network will be:

- to promote mutual support, for example, attaining QIS accreditation, representation on MCNs, joint training, clinical support (e.g. via telemedicine);
- to promote the development and sharing of diagnostic and therapeutic facilities in a networked way across localities;
- to work with specialist services to establish more integrated and seamless care for patients and establish a balance between acute and post acute care.

[6] GP acute activity within nursing homes (for example, the Auchtercrag Care Home in Ellon) can also be considered within the wider context of this area of service provision.

2.1.2 Moray

The following 6 community hospitals are located within Moray CHP:

- Fleming Hospital, Aberlour
- Leanchoil Hospital, Forres
- Seafield Hospital, Buckie
- Spynie Hospital, Elgin [7]
- Stephen Community Hospital, Dufftown
- Turner Memorial Hospital, Keith

Moray is designing a single system approach to health and social care. A key element of this is the 'Virtual Medical Ward'. This is a concept that brings together the complete bed capacity within Moray (Dr Gray's District General Hospital, community hospitals, nursing homes and patients' homes) and concentrates efforts to place the patient in the most appropriate care setting that also meets their health and social care needs.

2.1.3 Aberdeen City

This strategy also encompasses the Links Unit within the City Hospital in Aberdeen. This is a 45-bedded unit with 24 continuing care/interim care beds, 5 GP beds and 16 rehabilitation beds (these are however used flexibly). Strategic thinking and planning around hospital based provision across Aberdeen City as a whole is currently taking place. The outcomes of this review will inform and further develop the role of urban community hospital provision within this strategy.

2.2 SUMMARY OF CURRENT SERVICES AND ACTIVITY

2.2.1 Overview

This section outlines the current activity within NHS Grampian's community hospital beds in some detail. In summary, the 301 GP Acute beds see around 5500 admissions each year. The 202 beds designated as Long Stay are used flexibly (including for example, slow stream rehabilitation and GP Acute activity). The hospitals' outpatient clinics have more than 24,000 patient appointments seen by outreach consultants each year, and many more locally operated. The 14 casualty units have recorded more than 48,000 attendances annually. Furthermore there are many examples of good practice across all of the hospitals.

2.2.2 Background to Information

The development of this document has taken cognisance of the existing range of data and information regularly collated in relation to community hospitals (for example TIP reports and SMR data). For the purposes of this Strategy a separate information-gathering exercise was also undertaken via interviews with the Community Hospital Medical Directors, Management Teams and other hospital/locality staff where appropriate. This was followed up by further consultation and discussion at a Grampian Community Hospitals Network Away Day (Raemoir House Hotel, 24 March 2004). This allowed the views and opinions of key professionals to be fed directly in to the evolution of the Strategy and helped to build a broader picture of current activity, resources and key

[7] Spynie Hospital was closed as of October 2004.

issues, as well as future plans and aspirations, across all of Grampian's community hospitals today.

The information gathered is summarised in the following sections on a pan-Grampian basis. The supplementary document to this Strategy – 'Community Hospital Information Tables' - details some of the key services, staffing and activity within each individual community hospital.

2.2.3 Beds

Based on ISD designations, there are a total of 301 GP Acute beds, 147 Psycho-geriatric beds and 202 Long Stay beds provided by the community hospitals included within this report (including the City Hospital Links Unit). Maternity beds are provided in addition in some hospitals. The breakdown of these figures across all of the community hospitals is provided in table 2 (see following page).

These figures should nevertheless be considered cautiously. In Grampian the need for locally appropriate re-designation/determination of bed usage within Grampian's community hospitals has previously been identified[8], particularly in the context of the older people's strategy and the reconfiguration of continuing care beds.

Table 2 does however highlight that Grampian currently still has a significant number of ISD designated long stay and psycho-geriatric beds across the community hospitals. This is in addition to the 307 Geriatric beds in Woodend Hospital (104 Long Stay and 203 Geriatric Assessment Unit beds), and 65 Long Stay General Psychiatry beds and 147 Old Age Psycho-geriatric beds within Royal Cornhill Hospital. It is anticipated that the implementation of the older people's strategy and the current review of Old Age Psychiatry will impact significantly on these numbers.

The individual community hospital information tables provide detail as to the actual usage of beds within each community hospital (see supplementary document). Broadly categorised, this encompasses:

- Acute medical care/admissions
- Assessment
- Post-acute care
- Long Stay/Rehabilitation (including Slow Stream Rehabilitation)
- Palliative/terminal care (a small number of hospitals have dedicated palliative care suites).

RECOMMENDATION:

2) Agree, by locality, the use of the bed stock outwith the current limiting ISD classification and ensure the *actual* use is known throughout NHS Grampian. Community hospital teams/localities should also examine future use.

[8] Grampian Association of Community Hospital Medical Directors *'Policy on the Future of the Care of Frail Elderly Patients in Community Hospitals and Community Localities'* (Saplinbrae House Hotel, 27 June 2002)

Table 2: Grampian Community Hospital Bed Numbers by ISD Designation and Actual Usage

COMMUNITY HOSPITAL	ISD BED CATEGORY				NOTES ON ACTUAL USAGE
	GP ACUTE	PSYCHO-GERIATRIC	LONG STAY	MATERNITY	
Chalmers	34	12	0	6	Future plans to reduce maternity beds to 2 and use of 6 GP beds for slow stream rehab; redevelopment will result in 24 GP acute and 6 slow stream rehab
Fraserburgh	25	0	30	6	Long stay ward officially designated as 30 beds but used as 12-bedded rehab ward from beg. 2003 (10 slow stream rehab; 2 long stay – geriatrician)
Maud	6	25	19	0	Use of long stay beds currently changing to slow stream rehab facilities
Peterhead	29	0	0	6	All 29 beds managed as GP Acute
Turriff	13	0	6	0	All 19 beds now used as GP acute 1 used as day hospital bed as required
Ugie	0	30	14	0	14 long stay frail elderly beds – slow stream rehab trying to be developed; 7 beds now used as slow stream rehab
Insch	13	0	0	0	1 palliative care suite
Inverurie	20	26	23	0	1 palliative care suite 23 beds slow stream rehab, 5 of which long stay (18 currently in use) Psycho-geriatric – 10 assessment, 16 long stay (14 presently in use)
Jubilee	28	12	5	4	General Ward (15 beds) and Rothieden (13) used as long stay and GP Acute 4 maternity beds temporarily closed
Aboyne	12	0	7	4	3 palliative care suites
Glen O'Dee	14	30	7	0	16 GP Acute 3 Long Stay; 2 beds held empty
Kincardine	19	12	18	0	2 palliative care suites Psycho-geriatric – 2 assessment Long stay – 2 slow stream rehab
Fleming	9	0	6	0	In practice all are GP acute beds
Leanchoil	23	0	0	0	Also used as overnight observation beds and 24 hour treatment beds as required
Seafield	22	0	14	0	20 acute; 2 continuing care; 2 rehab; 1 23-hour; 7 nurse-led
Stephen	10	0	10	0	All managed as GP acute beds
Turner	19	0	3	0	All beds GP acute in actual use
Links Unit, City Hospital	5	0	40	0	Long stay - 24 continuing care/interim care beds, plus 16 rehab. GP and Rehab beds used flexibly according to need.
TOTAL (by ISD category)	**301**	**147**	**202**	**26**	

2.2.4 Current GP Acute Bed Management

The total number of inpatient episodes (elective, emergency and transfers) across the GP Acute bed stock in 2001-02 and 2002-03 was 5711 and 5497 respectively (Source: SMR01). This is detailed per community hospital in the following table. Full year data are not included for Aboyne (which was closed for redevelopment and re-opened in May 2003).

Table 3: Hospital Discharges for 2001/2002 and 2002/2003(p) (GP Other than Obstetrics or GP Acute E12) [9]

CHP/LCHP		Community Hospital	2001/02 In-Patients				2002/03 (p) In-Patients			
			Elec	Emer	Tran	Total	Elec	Emer	Tran	Total
Aberdeenshire	North LCHP	Campbell	7	38	24	69	1	31	14	46
		Chalmers	172	392	101	665	208	443	20	671
		Fraserburgh	56	506	125	687	70	517	104	691
		Maud	5	49	37	91	2	33	14	49
		Peterhead	45	481	115	641	20	513	126	659
		Turriff	14	259	55	328	23	227	53	303
	Central LCHP	Insch	34	84	45	163	26	72	44	142
		Inverurie	29	63	124	216	30	100	132	262
		Jubilee	74	564	102	740	51	529	95	675
	South LCHP	Aboyne	39	37	13	89	-	-	-	-
		Torphins	69	16	39	124	59	20	35	114
		Glen O'Dee	30	82	31	143	53	78	41	172
		Kincardine	24	140	162	326	7	105	164	276
Moray		Fleming	26	63	28	117	20	54	45	119
		Leanchoil	30	125	86	241	23	97	81	201
		Seafield	33	115	41	189	49	190	70	309
		Spynie	63	134	78	275	47	130	103	280
		Stephen	18	82	63	163	19	72	63	154
		Turner	22	267	71	360	10	236	53	299
City		Links Unit	0	80	4	84	0	70	5	75
		TOTAL	**790**	**3577**	**1344**	**5711**	**718**	**3517**	**1262**	**5497**

Source: SMR01

These figures exclude day case numbers. The growing day case activity within community hospitals should be noted.

Table 4 details the frequency of admission and bed turnover (similarly as above data are not included for Aboyne which was closed for redevelopment).

[9] Information covers 19 community hospitals, including Torphins (closed in May 2003), Spynie and Campbell hospitals. Data for 2002-03 is provisional and may therefore be incomplete.

Table 4: Throughput, Turnover and Average Length of Stay per Community Hospital for Year Ending 31 March 2003 (GP Other than Obstetrics or GP Acute E12)[10]

CHP/LCHP		Community Hospital	Throughput	Turnover (Days)	Average Length of Stay (Days)
Aberdeenshire	North LCHP	Campbell	10.8	5.1	28.8
		Chalmers	17.1	8.8	12.6
		Fraserburgh	24	5.2	10
		Peterhead	22.7	3.1	12.9
		Maud	9.4	2.7	36.2
		Turriff	22.5	1.8	14.5
	Central LCHP	Insch	10.9	5.1	28.4
		Inverurie	13.1	9.6	18.3
		Jubilee	27.1	3.7	9.7
	South LCHP	Aboyne	-	-	-
		Torphins	15.3	5.4	18.6
		Glen O'Dee	12.2	7.3	22.5
		Kincardine Community	14.5	3.4	21.7
Moray		Fleming	13.5	4.1	22.9
		Leanchoil	8.7	1.8	40.2
		Seafield	11.1	-	32.8
		Spynie	9.3	5.5	33.9
		Stephen	12.1	0.1	30.1
		Turner	16.3	5	17.4
City		Links Unit	13.1	0.2	27.8

Source: Community Hospitals TIP Reports

Table 5 provides the total number of births over 2001-02 and 2002-03 (NB: following the closure of Torphins Hospital in May 2003 all activity within Deeside is now transferred to Aboyne).

Table 5: Total Deliveries in Community Hospitals (Live and Still Births)[11]

Community Hospital	Number of Maternity Beds	Number of Deliveries	
		2001-02	2002-03 (p)
Chalmers	6	37	48
Fraserburgh	6	68	68
Peterhead	6	101	108
Insch[12]	2	15	-
Jubilee	4	22	27
Torphins	5	35	27
Total	**29**	**278**	**278**

Source: SMR02

[10] Throughput per bed is the average number of inpatients discharged per bed within a specialty over the period of time. Turnover interval is the average length of time in days that elapses between the discharge of one inpatient and the admission of the next inpatient to the same bed at specialty level over a period of time.

[11] Year based on date of discharge. Data for 2002-03 is provisional and may therefore be incomplete.

[12] Insch's 2 maternity beds have since been redeveloped in to a palliative care suite.

2.2.5 Staffing

- **Medical**

The medical input to the community hospitals can be broadly summarised as follows:

- Admitting rights for local GPs (payments by admission) for GP Acute activity; with responsibility for day to day medical care/management as appropriate to each (Para 94 payments for long stay and psychogeriatric care)
- Medical Director/Superintendent (sessional basis/payment)
- Consultant input on sessional basis for wards/inpatients (e.g. Geriatricians, Psychogeriatricians) in addition to consultant-led outpatient clinics
- In addition in some hospitals/localities GPs with Special Interests provide intermediate care services/clinics (e.g. Dermatology, Minor Surgery).

- **Nursing**

Details of the nursing complement for each Community Hospital by Whole Time Equivalent (and grade where possible) are provided in each individual hospital table contained in the supplementary document (recognising that the total Establishment resource for a hospital may not reflect the actual numbers in post).

Nurse staffing covers hospital wards and casualty units (including nurse-led minor injury units), supporting inpatient care and outpatient clinics (nurse-led clinics also run in some hospitals).

- **Allied Health Professions (AHPs)**

In terms of dedicated input commonly identified forms of AHP support in the community hospitals include Occupational Therapy and Physiotherapy, encompassing both inpatient care, outpatient clinics and community care (information by WTE available for some community hospitals in the supplementary document to this strategy).

Input from and access to Dietetics, Speech and Language Therapy and Podiatry are also generally available, including outpatient clinics run from some hospitals.

- **Other Staffing Input**

Administrative and facilities staff clearly form a key component of the core community hospital workforce.

There are also specific posts associated with local service developments within individual community hospitals and/or their localities including, for example:

- Banff and Buchan GP Dermatology post (comprised of 3 GPs providing a sessional service across the locality)
- Emergency Nurse Practitioner (Peterhead)
- Community Pharmacist (based in Huntly but providing a service across the Central Aberdeenshire locality)
- LCHP Community Geriatrician (Moray and Central Aberdeenshire).

2.2.6 Outpatient Clinics

A very approximate initial analysis of the information on outpatient activity received from the community hospitals finds there to be around 150 clinics presently running on-site across 17 of the hospitals (this may include clinics which run from within adjoining health centre accommodation). This includes both outreach/secondary care clinics and locally run clinics. This does not include the actual number of sessions or frequency of each clinic, which range from being run on a regular, dedicated basis to ad hoc or as required. They are supported/led by consultants or local GPs on a sessional basis and nursing staff. From the information gathered from the community hospitals some of the more common outpatient clinics currently running can be identified including:

- General Surgery and Medical clinics
- Psychiatry
- ENT
- Orthopaedics
- Audiology
- Diabetes
- AHP clinics such as Dietetics

Gynaecology and/or Obstetrics, Ophthalmology and Dermatology are also provided in a smaller number of hospitals. The frequency and range of clinics across all of the community hospitals is however varying and complex (further detail provided in each individual community hospital table, see supplementary document).

This nevertheless represents a very significant element of the services hosted and provided by community hospitals for their localities. Looking at outreach secondary care clinics alone, the total number of patients seen (both new and return) was 24,337 in 2001-02 and 21,016 in 2002-03 (Source: SMR00)[13]. Where recorded, DNA rates average at less than 10%. This percentage figure is reduced to zero in some cases where specific local initiatives have been put in place, such as pre-appointment telephone reminders.

In addition these services are clearly supported by a range of resource held within community hospitals, including accommodation and equipment. In addition to clinic rooms, for example, some hospitals may house theatre suites, audiology booths/kit, renal dialysis bays, and minor surgery equipment, amongst other facilities. The available skills resource of community hospital staff should also be recognised. Other examples of outpatient or day case activity in some hospitals includes minor surgery, blood transfusions, and IV therapies.

2.2.7 Casualty Services

14 of Grampian's community hospitals have casualty departments (including nurse-led minor injury units). In the majority of cases this service is provided on a 24-hour basis. Staffing is provided from within the hospital nursing staff (including minor injuries trained nurses) and local GPs (medical cover arranged as appropriate to the local system). The casualty services are supported by access to other on-site facilities such as telemedicine and diagnostic provision including X-ray.

From data on A&E activity within Grampian's community hospitals there were a total of 48,115 patient attendances (both new and return) in 2002-03 and 48,185 in 2003-04 (Source: Community Hospitals TIP Reports). The number of attendances per hospital is detailed in the following table.

[13] Information recorded for 13 hospitals, including Spynie. Data for 2002-03 is provisional and may therefore be incomplete.

Table 6: A&E Activity in Community Hospitals[14]

CHP/LCHP		Community Hospital	2002/03			2003/04		
			New	Return	Total	New	Return	Total
Aberdeenshire	North LCHP	Chalmers	4464	2188	6652	4486	2031	6517
		Fraserburgh	10247	4268	14515	7959	4837	12796
		Peterhead	6905	1726	8631	7149	1898	9047
		Turriff	2273	1086	3359	2414	988	3402
	Central LCHP	Insch	590	182	772	725	292	1017
		Inverurie	935	4	939	1136	9	1145
		Jubilee	2272	1643	3915	2237	1659	3896
	South LCHP	Aboyne	575	62	637	923	95	1018
		Kincardine			1730	0	0	1870
Moray		Fleming	562	122	684	514	104	618
		Leanchoil	906	30	936	859	50	909
		Seafield	1357	213	1570	1792	124	1916
		Stephen	499	219	718	615	260	875
		Turner	1946	1111	3057	2042	1117	3159
		Totals			**48115**			**48185**

Source: Community Hospitals TIP Reports

2.2.8 Diagnostic Provision

Over and above the routine diagnostic facilities provided by community hospitals (for the purposes of this strategy defined in terms of examples such as ECGs and resuscitation) 10 community hospitals provide X-ray facilities (supported by sessional radiography input). Ultrasound facilities are provided on-site in 6 community hospitals.

Although less commonly identified other types of diagnostic provision include sigmoidoscopy, endoscopy, cardiac assessment/echocardiography, exercise ECG testing and Holter/event monitoring.

RECOMMENDATION:

3) In light of existing and developing services, basic requirements for diagnostic equipment should be defined by each community hospital/locality.

2.2.9 Telemedicine

Telemedicine facilities are available in 14 community hospitals, in particular providing acute services support to the casualty units via links to Aberdeen Royal Infirmary and Dr Gray's Hospital, Elgin.

Telemedicine fulfils a number of other functions within the community hospitals including virtual outpatient clinics for example orthopaedics, dermatology, eating disorder consultations, fracture clinics, and teleconferencing.

[14] 2002-03 data is full year; 2003-04 based on February 2004 report with full year effect.

2.2.10 Other On-Site Services

It is important to recognise the range of services co-located on community hospital sites and the linkages between these. In several cases the community hospitals have adjoining health centres. In addition GDOCs and the Scottish Ambulance Service are co-located on some sites (for example both are situated at Inverurie and Kincardine hospitals). Other examples of services utilising on-site office and/or hot desking accommodation include community nursing teams, social work staff, and community dementia teams.

2.2.11 Analysis

The preceding sections have demonstrated the variety of activity across Grampian's community hospitals. In the national context, in addition to measuring our performance against NHS Quality Improvement Standards and CASPE, there are crucial linkages to the development of the national framework of contractual arrangements for GPs working in community hospitals which will focus on identifiable activity measures and quality and outcomes standards.

A detailed analysis and comparative study is required for future action planning. Based on an agreed set of performance indicators which are meaningful and realistic to community hospitals, this would enable robust decision-making to ensure the most efficient and effective utilisation of our community hospital provision in the future. Related to individual community hospital resource, including bed availability and staffing capacity, such analysis could include, for example: the proportion of community and 'step down' admissions; length of bed occupancy; and appropriateness of case mix and the type of patients being admitted.

RECOMMENDATION:

4) A Grampian system of community hospital performance indicators and regular performance review (complementary to national guidance/frameworks) should be agreed.

2.3 EXAMPLES OF GOOD PRACTICE AND INNOVATION

Within this broad summary of current service provision there are a number of areas of good practice and innovative/pilot activity across the community hospitals in Grampian. These include, for example:

- Geriatric Assessment (Aboyne)
- Community Geriatrician (Moray and Inverurie)
- Virtual medical ward (Moray)
- Discharge Planning Co-ordinator (ARI)
- Diagnostic and Treatment Service pathfinder projects (ENT; Stonehaven)
- A&E IM&T system (Stonehaven)
- Intermediate care (Moray CHP/North Aberdeenshire LCHP)
  - Minor surgery
  - Dermatology
  - Cardiac assessment
  - Palliative care
  - Audiology
  - Sigmoidoscopy
- Rapid Response Teams/Community rehabilitation (Deeside)
- Telemedicine eating disorders clinic (Aberdeenshire)
- Emergency Nurse Practitioner (Peterhead)

RECOMMENDATION:

5) Mechanisms to extend/transfer good practice across community hospitals (building this in to local plans) should be developed. This should be aligned with both local needs and the overall single system service requirements/direction.

2.4 CARE OF FRAIL ELDERLY IN COMMUNITY HOSPITALS

At a NHS Grampian event organised by the Grampian Association of Community Hospital Medical Directors (GACHMD), work was undertaken around care for older people within a community hospital setting. This focused on the need to adhere to a consistent policy across NHS Grampian[15]. The recommendations were as follows:

1. *All community hospital continuing care beds should be considered "slow stream", "intermediate stay" or "rehabilitation" beds.*
2. *The appropriate mixture of acute and intermediate stay beds should be determined within localities.*
3. *Research should be commissioned which would assist localities in determining the number of intermediate stay beds needed.*
4. *Primary Care Teams should be strengthened and extra GP time secured to support increased continuing care in community settings.*
5. *The role of community Geriatrician should be developed in order to support local teams. Geriatric opinions should be obtained through a referral process with General Practitioners retaining responsibility for continuing care. A similar approach within Old Age Psychiatry should be explored.*
6. *Joint health and social work locality teams should be further developed. The community hospital Medical Director should be part of this team. The team should be responsible for the best use of locality resources.*
7. *The role of community hospital liaison manager should be developed and extended to Woodend. All post acute discharges should be managed through her.*
8. *Care management should be available to Aberdeenshire/Moray patients in Aberdeen Hospitals.*

All areas have demonstrated some progress. This should be supported.

RECOMMENDATION:

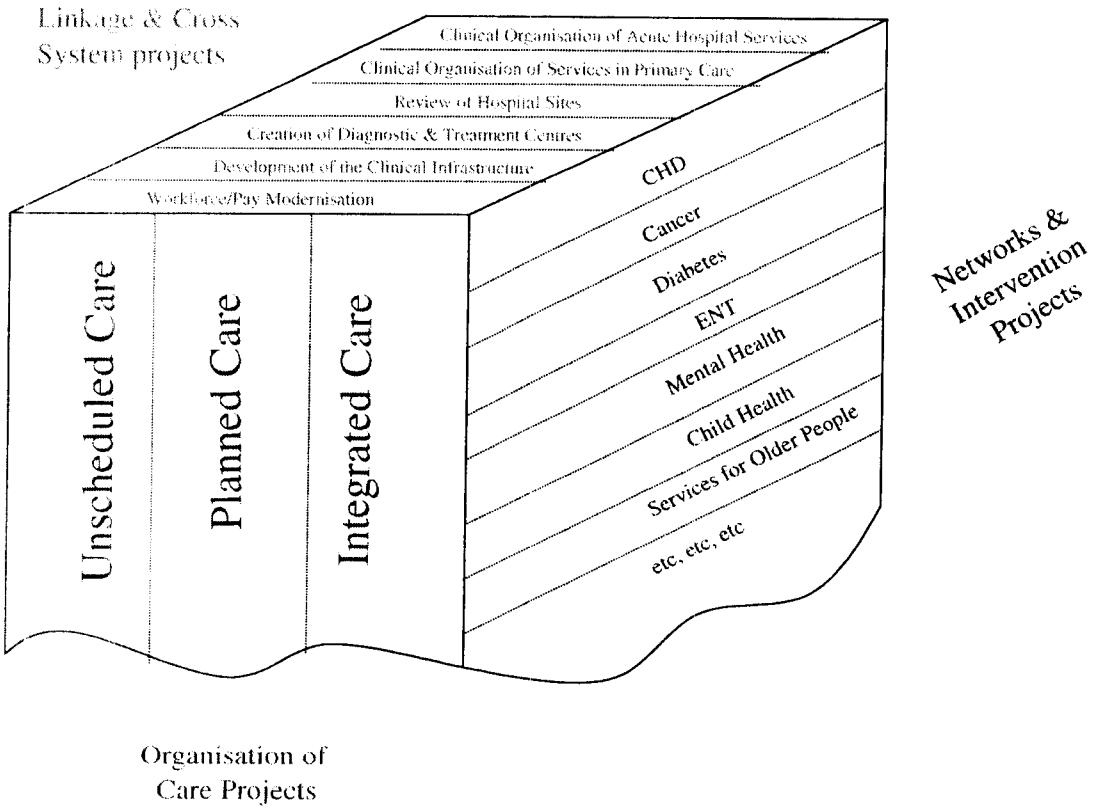
6) Specific models of care for frail elderly should be devised to support implementation of the NHS Grampian/GACHMD recommendations from the *'Policy on the Future of the Care of Frail Elderly Patients in Community Hospitals and Community Localities'*.

[15] Grampian Association of Community Hospital Medical Directors *'Policy on the Future of the Care of Frail Elderly Patients in Community Hospitals and Community Localities'*, Saplinbrae House Hotel, 27 June 2002

3. THE FUTURE - NHS GRAMPIAN CHANGE AND INNOVATION PLAN

3.1 COMMUNITY HOSPITAL SUPPORT/ROLE IN THE CHANGE AND INNOVATION PLAN

NHS Grampian has developed the Change and Innovation Plan to assist the new single system organisation to integrate and link all of the current major change initiatives across the clinical system. The model shown demonstrates the interaction between organisation of care, cross-system projects and Networks and Intervention Projects[16].



The Clinical Organisation of Services in Primary Care project has a key responsibility to deliver upon the position of community hospitals within this new environment. The following sections outline how the community hospitals and their networks can support this process. Appendix 2 maps out the various linkages between each project in relation to primary care and community hospitals.

[16] NHS Grampian, *Change and Innovation Plan 2004-05* (draft as at March 2004)

3.2 PLANNED CARE

3.2.1 Flexible use of resources

The information-gathering exercise undertaken as part of the development of this Strategy sought to identify any existing capacity within the community hospitals to take on additional activity. This covered, for example, accommodation, equipment, and clinic space/utilisation. At the subsequent Grampian Community Hospitals Network Away Day (24 March 2004) it was agreed that community hospitals should review their existing capacity on the principle of stopping some activity in order to take on other areas of work.

There are various influences impacting upon such decision making, including: the Primary Care Strategy[17]; Diagnostic and Treatment Services prioritisation for NHS Grampian (via the Change and Innovation Plan projects); fortuitous external funding; willingness across the service areas to redesign; and locally identified need.

Most of the Medical Directors and senior managers expressed a clear desire to develop the intermediate care facilities provided within their community hospital. Such developments are, however, checked by several factors, namely, physical space, IT, skills and training, time to deliver care and resource to support the delivery of care. In partnership with the acute sector most of these barriers could be overcome. To make this successful then there must be a more systematic and agreed approach to:

- Identifying which services/techniques are delivered in an intermediate care environment
- Introducing the agreed techniques
- Determining where best (amongst all of the community hospitals) to deliver the new services.

The Planned Care Steering Group, as part of the Change and Innovation Plan, is looking to redesign services using intermediate care-based solutions known as 'tier 2'.

RECOMMENDATIONS:

7) In partnership across the system, ensure Community Hospital Medical Director and Senior Management input to developing a prioritised list of developments for planned care leading to tier 2 (intermediate care) services.

8) Expand use of technology to support care.

9) All community hospitals to discuss at both locality level and CHP level the preparedness to stop existing services to create capacity to take on new areas of care should their priority be more significant to the locality and/or NHS Grampian.

The Planned Care discussion group at the Community Hospitals Network event on 24 March 2004 identified a core set of principles to facilitate the prioritising of services in relation to redesign. These were:

- Identification of a service under pressure (for example waiting times).
- Willingness from the acute service to redesign.
- Willingness from primary care and community services to redesign.
- Whole system approach.
- Identification of pump priming resource to redesign.
- Identification of GPs with a special interest in the area (strategically/geographically spread).

[17] NHS Grampian (2003) *Strategy for Primary Care April 2003 – March 2006*

- Community Hospital Network commitment to support redesign (even if this means reducing a clinic currently held in order to free up capacity to support the development).
- Agree venues for clinics/intermediate care (tier 2) services according to local networks.

By applying these principles key priority areas for action in the short-term as identified by the planned care discussion group on 24 March 2004 were:

- **Dermatology** - This is a specialty under pressure. GPs with a special interest are already working within the specialty, and others are currently in training. The specialty has demonstrated a willingness to redesign. There is also the possibility to look at lateral integration across dermatology, plastics and minor surgery.

- **ENT** - This is already identified as a Diagnostic and Treatment Service pathfinder project. A plan is in place which should be implemented. The plan reduces the number of peripheral clinics. This can now be viewed positively in terms of releasing capacity in some community hospitals for developing other prioritised intermediate care services.

- **Orthopaedics** – This service is under pressure with long waiting times. A willingness to redesign is apparent. Involvement with GPs with special interests and physiotherapists has demonstrated effectiveness in pilot areas.

RECOMMENDATION:

10) The Community Hospital Network should engage with the appropriate secondary care specialists to move forward with the redesign and implementation of dermatology, ENT and orthopaedics.

3.2.2 Transport infrastructure

A key difficulty for the delivery of services at community hospitals is patient transport. Individuals from all of the sites reported difficulties in transporting patients between different locations and their community hospitals. Anecdotally, all transport appears to be designed to go from any location to Aberdeen (or back) but journeys between other places appear impossible.

Clearly, if we aim to develop intermediate care services at various community hospital sites it will be imperative for the patient transport to be effective and timely. In order for this to be both affordable and achievable, appropriate links with voluntary organisations and Local Authorities must be made.

RECOMMENDATION:

11) A "HealthFit" type event for Grampian transport should be arranged. Part of this event should focus on transport between peripheral sites.

3.3 UNSCHEDULED CARE

3.3.1 Out of Hours

In light of the New GMS Contract, discussions held with Medical Directors as part of the Strategy's information-gathering exercise included consideration of the future Out of Hours Care for community hospital patients. All of the respondents indicated that the new Out of Hours model would be "in line" with evolved arrangements (supporting medical provision to community hospitals). However, there was some concern raised about the amount of proposed medical cover.

The Grampian Community Hospitals Network Away Day (24 March 2004) also included a specific focus on exploring these issues and potential options. The crucial importance of recognising community hospital cover particularly in relation to the wider consequences for unscheduled care was highlighted. A number of other key issues have been raised around this topic, including:

- Significant concern around weekend cover, for example, the management of acute conditions, and the potential for "changed admission behaviour" amongst local GPs at weekends if the medical cover is low (and the impact on the wider system i.e. ARI, AMAU).
- The value of local GPs/practices' knowledge of their community hospital, its patients, capacity and so on.
- The key role of and implications for nursing staff including, for example, the opportunities to 'up skill', but also the need to consider where medical support will continue to be required.
- Recognition that 'one solution will not fit all', that is to say, a weekend ward round may continue to be seen as necessary to some hospitals, but not to others.

RECOMMENDATION:

12) As the GP Out of Hours models for NHS Grampian are consulted upon, Medical Directors/lead clinicians and senior managers with responsibility for community hospitals should influence the process to ensure key issues and concerns in this area are fed in.

3.3.2 Virtual Medical Ward

In Moray a plan for a 'virtual medical ward' between their community hospitals and Dr Grays has been developed. At the Grampian Community Hospitals Network event (24 March 2004) one group discussed the development of a similar model for the Aberdeenshire-based community hospitals.

On an Aberdeenshire basis a virtual medical ward will maximise the ability of specialist clinicians, normally based at an acute facility, to utilise the beds in community hospitals. However, this must be balanced with the ability for local GPs to admit to the GP Acute beds directly from the community. Specialist input would be combined with the enhanced expertise of local teams ensuring that more people can be cared for closer to home. This shift in care (which is already well underway with step-down care) will also contribute to the HealthFit aim of ensuring all ARI activity is either specialist or emergency.

This advance in the control of admissions to community hospital beds would need to be tempered with ensuring some local control is maintained. For example, there is little benefit in enabling a transfer as described above if it then results in another person, who requires a GP acute bed 40 miles from Aberdeen, then having to be admitted to AMAU. A further advantage of developing a virtual medical ward will be the potential ability to utilise GP expertise within AMAU. This closer association between GPs and the AMAU will ensure that more beneficial connections can be made between traditionally segmented parts of the care pathway.

The discussion group at the Grampian Community Hospitals Network Away Day suggested the following action.

RECOMMENDATION:

13) Clinical leads of the CHPs, community hospitals and acute hospitals should meet and agree the 'rules of engagement' for a virtual medical ward for Aberdeenshire. Such discussions will ensure that this virtual medical ward is workable and that issues such as clinical responsibility for patients following transfer are clear.

3.3.3 Managed Clinical Network Concept for Unscheduled Care

Unscheduled care is more than medical cover, out of hours cover and making good use of inpatient facilities. Expanding the concept to connect all aspects of unscheduled care in the future lends itself to the development of a managed network for unscheduled care. This would be multi-disciplinary, multi-agency and cross the whole system of health care. The potential of the Managed Clinical Network approach to this complex area of care is worthy of exploration.

RECOMMENDATION:

14) The potential offered through the MCN approach as applied to unscheduled care should be examined by NHS Grampian with its partners.

3.4 INTEGRATED CARE

3.4.1 Frail elderly

The Grampian-wide Integrated Care Project has taken responsibility for the business of two former groups, namely the Winter Planning Group and the Older People's Strategy Group. The CHPs and their Local Authority partners will have key responsibility in the implementation of the integrated care work.

The role of the community hospitals in this work is also very important. The older people's strategy is very clear about the continued reduction in long stay beds and the continued development of community-based services to ensure that the need for institutional care (NHS, Local Authority and independent) is minimised. The development of community based services and intermediate care is central to ensuring that this vision can be fulfilled; community hospitals have much to contribute to this agenda.

3.4.2 Old Age Psychiatry

In a similar vain to the frail elderly, there is a continued drive to reduce the number of Long Stay Old Age Psychiatry beds within the community hospitals, ensuring people are cared for in more appropriate environments. However, the reduction of these bed numbers must be preceded by the development of alternative services within the community.

Often there is a perception that the Old Age Psychiatry beds can be reduced to zero within the community setting. However, there is a need for some Old Age Psychiatry beds to allow assessment and the care of individuals during particular phases of certain diseases. For example, individuals' behaviour can often be very difficult and require NHS care during certain stages of dementia disease.

RECOMMENDATION:

15) The exact number and location of Old Age Psychiatry beds required will be determined on a locality basis (Moray, North, Central and South Local CHPs) in partnership with the Department of Old Age Psychiatry, under the umbrella of the Integrated Care Group.

3.5 WORKFORCE/PAY MODERNISATION

3.5.1 GP Remuneration

The Scottish Executive have recently updated their position in relation to future contractual arrangements for community hospitals in Scotland. Although the issues are not finalised in their letter, following a meeting with the SGPC and the Scottish Association of Community Hospitals, their conclusions were:

- *A national framework for contractual arrangements for GPs working in CHs* [Community Hospitals] *should be developed. This would need to contain sufficient flexibility to recognise the different circumstances in different areas and CHs across Scotland, but would focus on key principles on the use of CHs, readily identifiable activity measures, and quality and outcomes standards*
- *The framework would seek to recognise the important contribution of all members of the clinical team, and to reinforce the integration of care across the different health (and social care) sectors*
- *The draft quality standards already produced by NHSQIS would be an important element in any arrangements*
- *Work should be undertaken to look at a possible model of GP remuneration which reflected both the essential requirements of delivering day time patient care and minor injury services (both of these relating in some way to the scale of the CH and population served) and reward for attaining specific activity and quality markers (detail to be determined). Any such national model would have to be capable of adaptation and implementation at local level.*
- *There should be local flexibility in agreeing the nature of any contractual arrangements – e.g. with individual GPs (either contracted or employed), practices, or groups of practices*
- *Any arrangements agreed in the short term should accord with the emerging findings of the strategic review of CHs in Scotland, and should be capable of being refined and developed in the future*
- *It was important to ensure that better information is gathered on the use of CHs (a key element in the strategic review work to date) to inform future developments*
- *The aim should be to produce an initial national framework by April 2005.*[18]

Although the consultation with Grampian's Community Hospital Medical Directors was concluded prior to the above agreement, the suggested flexibility would certainly allow for the currently favoured model (front loaded payment to promote fast turn around) to be explored. Such a payment model is financially acceptable whilst also delivering specific activity. It would be anticipated that further quality markers would have to be built in.

RECOMMENDATION:

16) In view of pay modernisation changes in terms and conditions of employment for medical staff, the medical input (and remuneration) to community hospitals should be reviewed in light of the evolving national policy.

[18] Quoted verbatim from letter of 10 August 2004, 'Community Hospitals' from Dr H. Wilson and M. Palmer, Scottish Executive Health Department.

3.5.2 Clinical Leadership

Currently the clinical leadership for community hospitals is provided by the Hospital Medical Director and in many instances supported by the local nurse manager. Although this system provides a good model for the hospital services, it does not always provide a high level of integration between the hospital and other community services. As this paper has indicated, such integration is essential for the delivery of the older people's strategy, the development of intermediate care and the utilisation of managed clinical networks.

On this basis two possible alternative models are immediately obvious; firstly the hospital Medical Directors could take clinical lead responsibility for a whole locality, including the hospital. Secondly, hospital Medical Directors could undertake additional responsibilities, for example, supporting specific Managed Clinical Networks area-wide. Either of these models would enhance the integration and ensure that all of the community hospitals can be at the centre of developments, where appropriate.

3.6 DEVELOPING THE CLINICAL INFRASTRUCTURE

Community hospitals can be enabled to respond more efficiently and creatively to the Change and Innovation Plan projects by being appropriately 'connected' electronically. This should take the form of enhancing the network capacity, developing EPR/EHR (Electronic Patient Records/Electronic Health Records) across Grampian, participating actively in the roll out of PACS (Picture Archive and Communication System), A&E systems and connecting the GP IM&T systems to the local community hospitals.

Currently, ECCI (Electronic Clinical Communications Implementation) initiatives enhance the ability of primary and community hospital services to link cross system and this will develop further. Cognisance should also be paid to the joint health and social care e-records through the Modernising Government Fund projects.

3.7 CREATION OF DIAGNOSTIC AND TREATMENT SERVICES

Each of the three operational units (i.e. CHPs) will develop implementation plans for Diagnostic and Treatment Services/Centres upon agreement/clarification of the NHS Grampian position.

RECOMMENDATION:

17) Community hospital representation must be fed in to the NHS Grampian planning process and CHP implementation process around Diagnostic and Treatment Services/Centres.

3.8 RATIONALISATION OF HOSPITAL SITES

Not all community hospitals provide the same range of services, but all have developed over time to meet the needs of their localities. 'Rationalisation' of community hospital sites can therefore only be achieved by locality-based needs assessments in partnership with the wider NHS system requirements.

RECOMMENDATION:

18) All areas to review current need for existing community hospital provision, balancing local need with NHS Grampian priorities.

4. COMMUNITY HOSPITALS IN 2009?

The future should incorporate a balance of provision of services locally in response to local needs assessment with the development of services traditionally provided within District General or major acute hospitals as part of a whole system redesign. Community hospital accommodation will be fit for modern medicine, flexible (i.e. able to change usage as demand/need changes) and supported by the latest information technology. It is important for the community hospitals of the future to be networked electronically with their 'feeder' GP practices and with the acute service sites. Technology should be harnessed to ensure high quality, responsive services are available locally, particularly (but not exclusively) in rural settings.

The development of community hospitals to become diagnostic facilities will indeed serve to provide diagnosis locally and to reduce pressure on the Foresterhill site. Advances in technology and the associated reduction in price will enable community hospitals to deliver, for example, MRI scans locally. Other developments in "kit" will offer two outcomes following the diagnostic investigation; the machine will be supported by its own computer which can interpret the "test"; or alternatively, the PACS system will be functioning so effectively that the results will be interpreted remotely (possibly in another area or even a foreign country). These advances in diagnosis will ensure that individuals do not have to wait for long periods to initiate treatment. Other tests, currently run through the laboratory, will be available on a near patient testing basis, again reducing waiting times significantly.

Clinical service provision will continue to support palliative care, acute medicine for older people, rehabilitation, and post acute care. The large scale development of intermediate care, in line with the Primary Care Strategy, will ensure that many treatments can also be delivered locally by the primary care team. Visits to Foresterhill will genuinely only be for specialist or emergency care.

Changing roles of other specialists, for example community geriatrics, will ensure that we maintain people more effectively in their own homes supported by new technologies and improved community provision. This will then "free up" some community hospital beds enabling fast access when individuals' health declines.

The development of a "not for profit" capital investment model will enable the development of the facilities to ensure that they are maximised to deliver a central part of the package of care through the 21st century.

5. RECOMMENDATIONS FOR ACTION

All actions will be taken forward within the context of NHS Grampian's strategic priorities.

	RECOMMENDATION	RESPONSIBILITY
1)	In response to our new environment, an agreed network arrangement for community hospitals in Grampian should be developed, reflecting the CHPs and 'single system' organisation.	CHPs/Local CHPs; co-ordination by GCHN
2)	Agree, by locality, the use of the bed stock outwith the current limiting ISD classification and ensure the *actual* use is known throughout NHS Grampian. Community hospital teams/localities should also examine future use.	CHPs/Local CHPs
3)	In light of existing and developing services, basic requirements for diagnostic equipment should be defined by each community hospital/locality.	CHPs/Local CHPs; GCHN
4)	A Grampian system of community hospital performance indicators and regular performance review (complementary to national guidance/frameworks) should be agreed.	GCHN
5)	Mechanisms to extend/transfer good practice across community hospitals (building this in to local plans) should be developed. This should be aligned with both local needs and the overall single system service requirements/direction.	CHPs/Local CHPs; GCHN
6)	Specific models of care for frail elderly should be devised to support implementation of the NHS Grampian/GACHMD recommendations from the *'Policy on the Future of the Care of Frail Elderly Patients in Community Hospitals and Community Localities'*.	CHPs/Local CHPs; GCHN; in addition to the *Change & Innovation Plan* Integrated Care Group
7)	In partnership across the system, ensure Community Hospital Medical Director and Senior Management input to developing a prioritised list of developments for planned care leading to tier 2 (intermediate care) services.	NHS Grampian system and GCHN reps
8)	Expand use of technology to support care.	CHPs/Local CHPs; GCHN
9)	All community hospitals to discuss at both locality level and CHP level the preparedness to stop existing services to create capacity to take on new areas of care should their priority be more significant to the locality and/or NHS Grampian.	CHPs/Local CHPs; GCHN
10)	The Community Hospital Network should engage with the appropriate secondary care specialists to move forward with the redesign and implementation of dermatology, ENT and orthopaedics.	GCHN; CHPs/Local CHPs

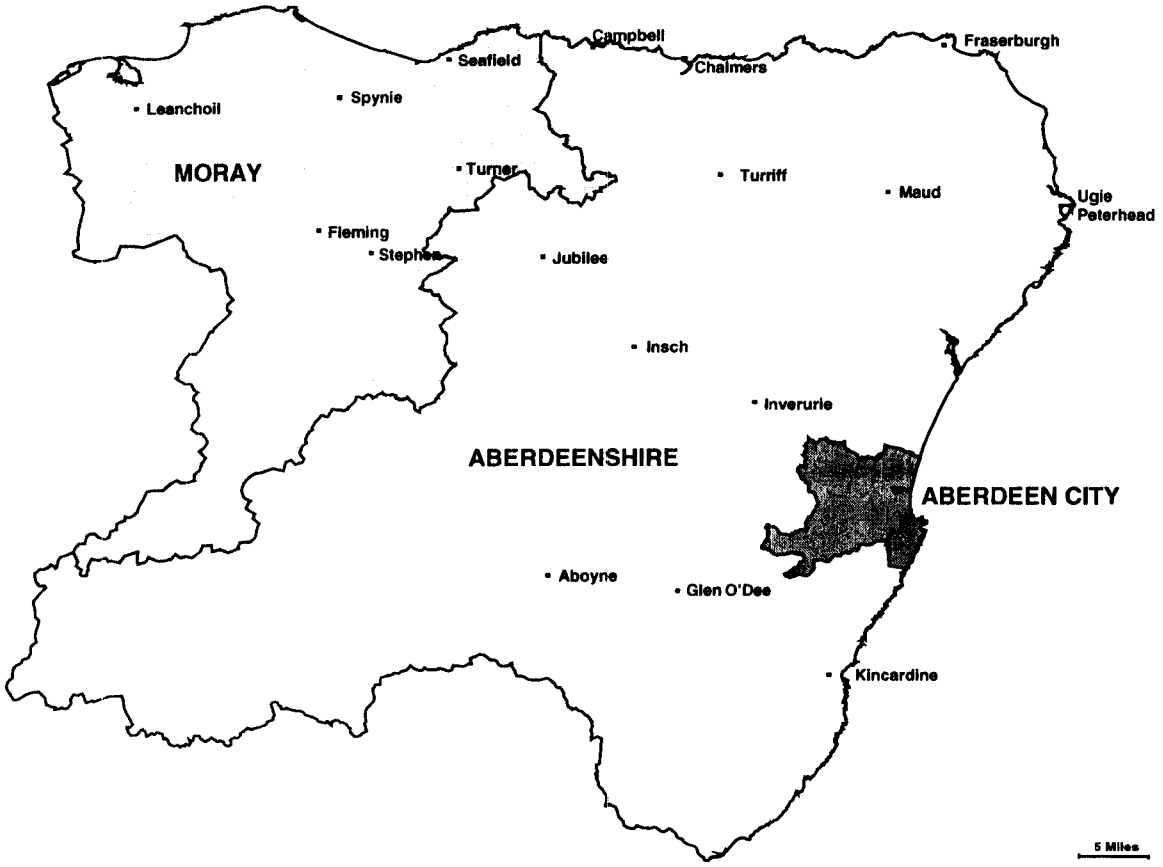
RECOMMENDATION	RESPONSIBILITY
11) A "HealthFit" type event for Grampian transport should be arranged. Part of this event should focus on transport between peripheral sites.	NHS Grampian system
12) As the GP Out of Hours models for NHS Grampian are consulted upon, Medical Directors/lead clinicians and senior managers with responsibility for community hospitals should influence the process to ensure key issues and concerns in this area are fed in.	Medical Directors, Lead Clinicians, General Managers; *Change & Innovation Plan* Unscheduled Care Group
13) Clinical leads of the CHPs, community hospitals and acute hospitals should meet and agree the 'rules of engagement' for a virtual medical ward for Aberdeenshire. Such discussions will ensure that this virtual medical ward is workable and that issues such as clinical responsibility for patients following transfer are clear.	NHS Grampian system and GCHN reps (Aberdeenshire CHP); in addition to the *Change & Innovation Plan* Unscheduled Care Group
14) The potential offered through the MCN approach as applied to unscheduled care should be examined by NHS Grampian with its partners.	*Change & Innovation Plan* Unscheduled Care lead
15) The exact number and location of Old Age Psychiatry beds required will be determined on a locality basis (Moray, North, Central and South Local CHPs) in partnership with the Department of Old Age Psychiatry, under the umbrella of the Integrated Care Group.	CHPs/Local CHPs; Old Age Psychiatry; *Change & Innovation Plan* Integrated Care Group
16) In view of pay modernisation changes in terms and conditions of employment for medical staff, the medical input (and remuneration) to community hospitals should be reviewed in light of the evolving national policy.	GCHN
17) Community hospital representation must be fed in to the NHS Grampian planning process and CHP implementation process around Diagnostic and Treatment Services/Centres.	CHPs/Local CHPs; GCHN
18) All areas to review current need for existing community hospital provision, balancing local need with NHS Grampian priorities.	CHPs/Local CHPs
19) Each CHP community hospital network and the Grampian Community Hospitals Network should develop action plans to implement these recommendations; the Grampian Community Hospitals Network should be used to co-ordinate and monitor progress on behalf of the Grampian Primary Care Group.	CHPs/Local CHPs; GCHN

6. CONCLUSION

The Grampian Community Hospitals Network and its constituent members have demonstrated a positive and proactive approach to the development of services and the contribution the community hospitals in Grampian can make to assist the system in moving forward the NHS Grampian Change and Innovation Plan.

7. APPENDICES

APPENDIX 1 LOCATION OF GRAMPIAN'S COMMUNITY HOSPITALS



APPENDIX 2

CHANGE AND INNOVATION PLAN 2004-05

PROJECT LINKAGES TO PRIMARY CARE AND COMMUNITY HOSPITALS

Project and Strategic Intent	PRIMARY CARE	COMMUNITY HOSPITALS
FIRST DIMENSION		
Unscheduled Care Development and implementation of an integrated and progressive approach to the arrangements for emergency care to achieve effective alternative provision of out of hours services.	• Redesign of services • Developing primary care capacity (GMS Contract) • Out of Hours • Integrate A&E service (minor injury units)	Hosting Out of Hours services? Links with minor injury units Minor injury units Minor illness work? Telemedicine units A&E IT system
Planned Care The matching of demand for planned healthcare with the capacity to deliver services, to be achieved through radical redesign of outpatient, diagnostic, treatment and inpatient/day case services.	• Redesign of services • DTSs • Patient pathways • MCNs development and links • GPs with special interests • Capacity vs GMS2	Bed management model (acute medicine) ? Moray Intermediate care Assessment centres Locus for intermediate care?
Integrated Care Through provision of appropriate community services, maintain people at home (or other provision), reducing the requirements for hospital admission and hospital care. Provide diagnosis, treatment and care for people in the most appropriate location. Provision of rehabilitation and community services to enable discharge from hospital as quickly as possible.	• Prevent readmission • Rapid discharge • Rehab • Care homes • Winter planning/delayed discharge • Bed management: single network	All relevant to community hospitals Manage admissions/ discharges
SECOND DIMENSION		
Clinical Organisation of Acute Hospital Services To ensure that only those who require specialist services located in the Specialist Acute Care Sector are admitted there and that the services provided are effective, efficient, accessible, well located and deliver a high quality training experience and working environment.	• Dedication to complex care in acute sites • Protocols, patient pathways, MCNs • Enhanced services • Intermediate care	Better use of community hospital beds; increased throughput/step-down Shared care protocols

Project and Strategic Intent	PRIMARY CARE	COMMUNITY HOSPITALS
Clinical Organisation of Services in Primary Care		
To work across the NHS Grampian system in order to reconfigure services in Primary Care in line with Healthfit, the Grampian Primary Care Strategy and the new GMS contract, ensuring they are co-ordinated across localities and responsive to national and local priorities.	• GMS2 and Change and Innovation Plan • Primary Care Strategy implementation • Primary care – MCNs link • Community hospitals and strategic fit	Community hospital strategy
Cross-System Projects		
Workforce/Pay Modernisation Re-shaping the workforce in Grampian to support the strategic agenda/move towards the HealthFit vision.	• Full impact of New Consultant Contract, New GMS Contract and Agenda for Change to be determined	New ways of working Payment/model of community hospital medical care
Clinical Support Systems Development of a Grampian Strategy for clinical support systems that is consistent with the strategic agenda of progressing the Healthfit vision. To ensure that risk management and development are effectively managed.	• System-wide services	(Clinical infrastructure - IM&T, telemedicine, medical equipment) Integrated IT; SCI; EPR
Diagnostic and Treatment Centres Develop proposals for the function, number and location of Diagnostic and Treatment Centres (DTCs) in Grampian.	• Must be engaged in process • Major impact	Community hospital development or compression
Rationalisation of Hospital Sites *Acute Hospital Sites* *Community Hospitals:* Development of a strategy for re-shaping community hospital provision taking account of the development of unscheduled care and planned care initiatives, DTCs, and the implementation of the older people's strategy.	• Major impact	
THIRD DIMENSION		
Major Clinical Areas/Managed Clinical Networks • CHD • Diabetes • Cancer • ..... etc	• All patient pathways begin and end; some also have significant input throughout from primary care • Ensure appropriate level of primary care engagement	Service delivery Intermediate care GPs with special interests

Fiona Francey, Project Lead – Clinical Organisation of Services in Primary Care, March 2004

SUPPLEMENTARY DOCUMENT

COMMUNITY HOSPITAL
INFORMATION TABLES

NHS
Grampian

NHS GRAMPIAN STRATEGY FOR COMMUNITY HOSPITALS

2004 – 2009

The Grampian Community Hospitals Network's contribution to the Change and Innovation Plan

DRAFT

Draft Version 2.1
October 2004

CONTENTS

DRAFT

INTRODUCTION

This Supplementary Document to the NHS Grampian Strategy for Community Hospitals provides basic information on the services, staffing and facilities available and/or in use across the community hospital sites within NHS Grampian.

The information was collected via questionnaire and interviews with local clinical leaders and locality staff, covering 17 community hospitals (excluding Campbell and Spynie Hospitals) and the Links Unit within the City Hospital.

1. CHALMERS HOSPITAL, BANFF

MEDICAL DIRECTOR Dr Iain Brooker

Number of beds (by ISD designation)	GP Acute	34	Psycho-geriatric	12	Long stay	0

Actual current bed usage

6 maternity beds. Chalmers Hospital redevelopment - future plans will see the maternity beds reducing to 2. Plan to use 6 GP beds for slowstream rehab, in support of Portsoy closure. Redevelopment will see 24 GP acute and 6 slowstream.

Type/numbers of staff and input to hospital

Medical	• Medical director = 1 session • 5 medical practices (15 GPs) have admitting rights • Para 94 post (Portsoy GP) • Palliative Care GP • Consultant psychiatrist (Responsibility for psychogeriatric beds, 1 ward) • GP Dermatology post • GP Slow Stream Rehab post
Nursing	• WTE Grades (in post): 2 G+ grade; 11.15 G grade; 3.75 F grade; 10.3 E grade; 14.35 D grade, 21.11 A grade • 0.5 WTE E grade and 3 WTE D grade Renal Dialysis Nurses
AHPs	• Physio - 3.32 WTE • OT – 1.36 WTE • Speech and Language Therapy – 0.2 WTE
Other	• Admin 4.89 WTE

Outpatient clinics

Outreach/ Local	**Type**	**Frequency**	**Average patients per clinic**
Cons	Chest clinic	2nd & 4th Tuesdays	25 – 30 patients
Cons	ENT	2nd, 4th, 5th Mondays	16 new. 16 review
Cons	Eye clinic	Wednesdays	10 new 18 review
Cons	General Medical	4th Friday	10 – 15 as and when
Cons	Gynae	1st Tues. 4th Monday	10 – 15 as and when 15 –20 as ansd when
Cons	Orthoptic	1st Thursday	30 as and when
Cons	Surgical (diagnostic)	1st and 2nd Mondays	24 new 16 review
Cons	Urology	2nd Friday	9 new 11 review
Joint	Dermatology(PMS)	1st Thursday	15 - 20
Local	Renal Dialysis		
Local	Level 3 Surgery (PMS)		
Local	GP Minor surgery		
Visiting	Paediatrician	Dr J Crum As and when Dr Dufty 4 times per year	
Visiting	Obstetrics	Twice monthly	
Local	Physiotherapy	Daily	
Local	Nurse led Wart clinic	Weekly (Evenings)	
Cons	Psychiatry	2nd and 4th Thursdays	

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Local	Podiatry S&LT Dietitian	As and when	

Any other day case provision, facilities and/or intermediate care activity

- 2 x Renal Dialysis stations (4 in new development) used 5 days per week
- Theatre used for minor surgery outpatients, podiatry nail surgery
- Evening clinics used by voluntary organisations, Turning Point, Needle exchange, Midwives
- Clinics used for retinal screening, benefits doctor, and health visitors (hearing tests for babies) as and when room available
- Ophthalmology equipment – Visual Field analysis
- Full Audiology equipment proposed for new development
- Minor surgery equipment, including sigmoidoscopy
- Venesection
- Blood transfusions
- IV therapies e.g. steroids, antibiotics

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- Staffed 24 hours with dedicated hospital establishment. 24-hour minor injury service – only downtime when trained staff unavailable due to sickness.
- Walk In casualty. Medical cover available via GDOCS doctor on duty.
- Radiography. Telemedicine link with Aberdeen and Elgin (Potential for link with GDOCS)
- Minor injury protocols
- TOX base/Internet
- Casualty nurses trained in Emergency Contraception

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- Radiographer. Visiting Sonography.
- X Ray: Monday – Friday 8.30am to 5.00pm
- ECG
- Sigmoidoscopy: Used by O/P department

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

- A&E work: Fractures acute & review; Trauma
- Eating disorder consultations (Potential for link with MHS)
- Teleconferencing
- *Teledermatology: Completely different system, but similar service*

Any other on-site provision/services

- Dedicated office for Community Support Team (Learning Disability)
- Health centre used for a number of "Hot Desking" requirements: Adult Mental Health; Podiatry; Child development team
- No general Social Work base as yet

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2. FRASERBURGH HOSPITAL

MEDICAL DIRECTOR Dr William Steele

Number of beds (by ISD designation)	GP Acute	25	Psycho-geriatric	0	Long stay	30

Actual current bed usage

Officially there is a 30-bedded Long Stay ward but from the beginning of the year it has been used as a 12-bedded rehab ward (10 Slow Stream Rehab; Geriatrician has 2 Long Stay patients). Over the next year it is planned to use the freed up resources to support the community rehab teams and the Older People's Strategy.

In addition the integrated midwifery team support 6 maternity beds.

Type/numbers of staff and input to hospital

Medical	GPs look after own patients		
Nursing		**Grade**	**WTE**
	Kinnaird Ward (12 bed slow stream rehab)	G	1.00
		E	2.00
		D	5.21
		A	7.31
	Philorth Ward (25 bed GP acute)	G	1.00
		E	2.00
		D	6.53
		A	10.43
	Maternity (6 bed ward)	G	1.00
		F	8.39
		A	5.17
	Casualty/OPD	G	1.00
		E	5.64
		D	3.59
		A	1.22
AHPs	Physiotherapy	Senior I	1.5
		Senior II	1.72
		Assistant	0.53
	Occupational Therapy	Senior I	1.00
		Senior II	0.83
		TI II	0.91
		Head III	0.16
	Speech and Language Therapy	Adult	0.2
		Paediatric (0.27 ED. Funded)	1.27
		Schools Paediatric	0.2
		Paediatric	0.8
	Podiatry	Senior I	0.6
		Senior II	0.5

Other	

Outpatient clinics

- Urology monthly (1 session)
- Dermatology twice a month (2 sessions)
- General Surgery monthly (1 session)
- Metabolic disease twice a month (3 sessions)
- ENT monthly (3 consultants equating to 3 sessions)
- Audiology 3 times per month (6 sessions)
- Ophthalmology weekly (4-5 sessions)
- Orthoptist monthly (2 sessions)
- Gynaecology monthly (2 consultants equating to 2 sessions)
- Antenatal monthly (2 consultants equating to 2 sessions)
- Diabetic Paediatric tri-monthly (1 session)
- Child audiology monthly (4 sessions)
- Radiotherapy bi-monthly (1 session)
- Geriatric assessment monthly (1 session)
- Orthopaedics monthly (2 consultants equating to 4 sessions)

Any other day case provision, facilities and/or intermediate care activity

Additional equipment available for clinics:

- Visual Fields Analyser (used by Orthoptic/Ophthalmology Clinic)
- Ear, Nose and Throat Microscope (used by ENT consultant)
- Obstetric Ultrasound Scanner (Maternity Department)
- DCA2000 machines for measuring Hba1C (used at Diabetic and Paediatric Clinics)

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24 hour casualty, minor injuries nurse led unit
- Dedicated Nursing Staff
- Medical Support when needed – GDOCs for Out of Hours

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- X-ray – Radiographer (1.5 wte + 1.00 wte ATO)
- GP Referral from Maud Surgery/Hospital and Mintlaw/Central Buchan/Crimmond Practices

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

- Mainly casualty use – appointment basis – X-rays – A & E – identification
- Eating Disorders Clinic
- Potential further development with OP

Any other on-site provision/services

- GDOCs
- Mental Health Team
- Speech and Language Therapy
- Child Development
- Podiatry/Physio/OT
- Diabetes Team
- Rapid Response
- Macmillan Nurse
- Old Age Psychiatry
- Holter Monitoring
- Palliative Care

3. MAUD HOSPITAL

MEDICAL DIRECTOR Dr Andrew Robertson

Number of beds (by ISD designation)	GP Acute	6	Psycho-geriatric	25	Long stay	19

Actual current bed usage

Psychogeriatric ward - patients admitted from home or from Cornhill. Patients admitted into the 19 long stay beds from either Woodend Hospital or for assessment from home under the care of the geriatrician. Use of long stay beds is currently changing to slow stream rehab facilities. Patients are admitted to the 6 GP Acute beds either from home or from ARI/Woodend.

Type/numbers of staff and input to hospital

Medical	• Para 94 amongst 4 GPs • Practice input for immediate care • GP Acute beds – under care of GP from Central Buchan Medical Practice • 25 psychogeriatric beds – under care of psychogeriatrician (regularly attends hospital) • Geriatrician - long stay beds		
Nursing		**Grade**	**WTE**
	Ward One	G	1.00
		E	4.50
		D	3.00
		A	11.68
	Ward Two	G	1.00
		E	4.06
		D	3.15
		A	11.80
AHPs	1 x Physio, 1 OT, 1 x OT Helper		
Other			

Outpatient clinics

- None

Any other day case provision, facilities and/or intermediate care activity

- None
- Implementation of the older people's strategy could mean that services and beds within the Maud area may be delivered differently in the future

Casualty unit/department (including nurse-led minor injury)	Yes		No	✓
Diagnostic facilities	Yes		No	✓

Staffing and activity/type of diagnostic provision

No, over and above routine diagnostic equipment (e.g. ECGs).

Telemedicine provision	Yes		No	✓

Any other on-site provision/services

- GDOCs room
- Community Nursing
- Health Visiting
- Old Age Psychiatry – CPN
- Holter Monitoring

4. PETERHEAD COMMUNITY HOSPITAL

MEDICAL DIRECTOR Dr Graham Strachan

Number of beds (by ISD designation)	GP Acute	29	Psycho-geriatric	0	Long stay	0

Actual current bed usage

All 29 beds managed as GP Acute (palliative care, rehab, convalescence etc). In addition there is a midwifery-led obstetric unit with 6 beds.

Type/numbers of staff and input to hospital

Medical	4 practices admit (approximately 25 GPs)
Nursing	• Summers Ward – WTE 1.0 G grade; 3.0 E grade; 9.2 D grade • A&E – WTE 1.0 G grade; 1.0 F grade; 3.39 E grade; 2.72 D grade • Maternity – WTE 1.0 G grade; 6.15 F grade • Cover two wards and A&E/Treatment Room/Outpatient Department
AHPs	Physio, OT, Dietetics, Speech and Language Therapy and Podiatry
Other	• Facilities staff (domestics, catering etc); Admin • Home care supervisors; Social Work Managers; MacMillan; Housing

Outpatient clinics

- Audiology – 2nd and 4th Mon (am); plus 3rd Mon, 2nd and last Tues, Fri (various times)
- Child Development – 1st Mon all day
- Dietician – 4th Thurs (am), 3rd Wed (pm)
- ENT – 2nd Mon, 2nd Tues, last Fri, last Tues (all pm)
- Epilepsy – 3rd Tues
- Eye – 1st and 3rd Fri (all day); plus additional consultant session every Fri am except 2nd Fri
- General Medical – 2nd and 4th Wed (am/pm)
- Geriatric assessment – 2nd Thurs (am/pm)
- Gynaecology – 3rd Wed and 1st Thurs (am)
- Minor surgery – 3rd Thurs (am)
- Occupational Health – 1st Wed (am/pm)
- Orthopaedics – 3rd Tues (am/pm) and 1st Tues (pm)
- Orthoptist – 4th Mon, 4th Thurs, 5th Thurs (am/pm)
- CPN – 2nd last Thurs
- Psychiatry – every Thurs (am/pm)
- Radiotherapy – 2nd Fri (am)
- Sigmoidoscopy – 1st Thurs and 3rd Wed (pm)
- Skin – 2 x consultants on both 2nd and 4th Tues (am)
- Surgical – 1st Tues (am) and 1st Mon (pm)
- Urology – 3rd Mon (am)
- Family planning – 2nd and 4th Wed (evening)
- Psychologist – every Wed (am/pm)
- Nebuliser – 1st Mon (am)
- Alcohol advisory service
- Smoking cessation
- Antenatal
- Breast feeding – every Thurs (evening)
- Mums 4 Mums – every Mon (am)

Any other day case provision, facilities and/or intermediate care activity

- Maternity – Midwifery led unit – ante natal and post natal care; around 110 births per year
- Dialysis – currently 3 dialysis bays within GP Acute Ward (looking to expand to 7 in purpose-built accommodation although this is at an early stage of development)
- 3 consulting rooms (including 1 used for minor surgery) and waiting area
- Patient transport – ad hoc service; all routes run to ARI/Woodend but no flexibility within current contract for more locally delivered service
- Expansion of ENT surgical service and establishment of Audiology sound proof chamber within outpatient services planned during 2004/05

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24 hour/7 days per week.
- Minor injury service and Casualty – dedicated staff.

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- X-ray – 2 radiographers – Casualty, outpatient support and GP referrals
- Ultrasound – general and obstetric

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

High usage – supports A&E for first attenders; also used for reviews for variety of services and for teleconferencing

Any other on-site provision/services

- MacMillan nursing
- Out of Hours Social Work service
- Adult Mental Health CPN service
- Hospital League of Friends shop

5. TURRIFF HOSPITAL

MEDICAL DIRECTOR Dr Robert Liddell

Number of beds (by ISD designation)	GP Acute	13	Psycho-geriatric	0	Long stay	6

Actual current bed usage

All 19 beds now used as GP Acute. (6 long stay formerly used by geriatrician.)

1 bed can be used as Day Hospital bed (used mainly for falls assessment as required).

Type/numbers of staff and input to hospital

Medical	• Medical director = 1 Session • Admitting rights from: Turriff; Cuminestown; Fyvie (14 GPs) • Trust employs Turriff practice to manage casualty • Para 94 post for care of elderly, converted to Care of Elderly in Community under PMS contract • Palliative Care GP • Dermatology GP post
Nursing	• Trust establishment: 1 G grade; 5.15 E grade; 6.25 D grade; 6.60 A Grade
AHPs	• 1 WTE OT + 18 hrs OT Helper (Hospital and Community) • Part time Physio 28 Hours (shared with Banff) + 18 hrs. Helper (Inpatient and Community) • Part time Physio 28 hours (Out Patient work) • Speech & Language 1 WTE – attends as required • Podiatrst 1 WTE – attends as required
Other	• Administrative staff 1.8 WTE

Outpatient clinics

- Audiology - Turriff facility used by secondary care to provide for wide area, not only Banff and Buchan (Hearing aid service and 2nd tier screening) 1 day per fortnight, increasing shortly to weekly
- Cardiology - Service jointly run with secondary care, Visiting Echo Cardiographer, 1 day per fortnight. Exercise ECG and Holter monitoring run by GPs and nurses.
- Dietetics - fortnightly
- Psychiatry and Clinical Psychology - fortnightly
- CPN - As required
- Eating Disorders - Telemedicine service as and when required
- GP minor surgery - 4 Afternoons per week (includes rigid Sigmoidoscopy)
- Level 3 Minor Surgery - 1 session per month (GP from Mintlaw covers Fraserburgh and Turriff)
- Smoking cessation, Alcohol advisory service; Health Promotions
- Drug misuse service – weekly
- Speech and Language Therapy - Based in hospital
- Podiatrist; Plus Diabetic specialist (level 3 Surgery) - as required
- Health visitor – Based in hospital
- Midwives - Visit from Banff, shared rooms with H/V
- Voluntary Counsellor - Attends as required
- HIV one day per week

Any other day case provision, facilities and/or intermediate care activity

- Full range of audiology equipment, minor surgery equipment (including sigmoidoscopy), steriliser

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- Staffed 24 hours from hospital establishment. E Grade dedicated to support casualty. All E Grades are minor injury trained and an E Grade is on duty 24 hours.
- Duty doctors (In hours from Turriff and OOHs by rota) cover casualty 24 hours
- Minor injury service
- Virtual fracture clinic, 2 Nurses trained to plaster and follow up service for patients who initially attended Aberdeen
- Telemedicine facility well used

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- Visiting radiographer and Echo cardiographer
- X Ray: Monday – Friday 9.00am – 12.00pm
- Ultrasound: GPs carry out general scan, Midwives perform detailed pregnancy scan

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

- X Rays assessment – supporting fracture clinic and casualty service
- Lesser use Out of Hours

Any other on-site provision/services

- Social Work Care Manager, Home Care Co-ordinator, Social Work OT and District Nurse - based in Hospital
- Paediatric OT and Physio, New Primary Health Care Mental Health Worker, and Local Authority Mental Health worker – Hot desk

6. UGIE HOSPITAL, PETERHEAD

MEDICAL DIRECTOR No dedicated Medical Director input - Peterhead Medical Director has overview of both hospitals

Number of beds (by ISD designation)	GP Acute	0	Psycho-geriatric	30	Long stay	14

Actual current bed usage

30 long stay psycho-geriatric. 14 long stay frail elderly beds – in terms of the usage of long stay beds true slow stream rehab is trying to be developed in conjunction with medical colleagues; 7 now used as slow stream rehab.

Type/numbers of staff and input to hospital

Medical	3 GPs paid Para 94 sessions – each with responsibility for specific area of either 30 Psychogeriatric beds, 14 Long Stay beds or 12 place psychiatric day hospital – each of these also supported by consultant teams
Nursing	• Buchanhaven (30 Psycho-geriatric) – WTE 1.0 H grade; 0.8 G grade; 3.91 E grade; 4.0 D grade; 0.64 C grade • Ravenscraig (14 Frail Elderly) – WTE 1.0 G grade; 1.64 E grade; 4.14 D grade • Collieburn (Day Hospital) – WTE 1.0 F grade; 2.0 D grade
AHPs	• OT and Physio • Podiatry and Dietetics on occasion
Other	• Social Work Care Managers • Old Age Psychiatry Team • Facilities/Admin

Outpatient clinics

- N/A

Any other day case provision, facilities and/or intermediate care activity

- 12 place Day Hospital for Psychiatric assessment and treatment (runs 5 days per week, Monday – Friday)
- Aspirations to reconfigure Ugie to provide more therapeutic activity (AHPs, rehab etc)

Casualty unit/department (including nurse-led minor injury)	Yes		No	✓
Diagnostic facilities	Yes		No	✓
Telemedicine provision	Yes		No	✓

Any other on-site provision/services

- Community Care Co-ordinator
- Podiatry (Outpatients)
- Volunteers
- Out of Hours

7. INSCH WAR AND DISTRICT MEMORIAL HOSPITAL

MEDICAL DIRECTOR Dr Mike Kay

Number of beds (by ISD designation)	GP Acute	13	Psycho-geriatric	0	Long stay	0

Actual current bed usage

GP/Medical acute admissions; rehab/convalescence/post-acute care and terminally ill/palliative care. Bed numbers include one new palliative care suite (established from 2 beds vacated by maternity closure).

Type/numbers of staff and input to hospital

Medical	2 full-time and 2 half-time partners in Insch practice all look after the patients they admit. Admissions also from Alford and Rhynie, occasionally other practices.
Nursing	0.50 WTE G grade; 5.31 E grades; 2.93 D grades; 0.51 C grades; 5.48 A grades.
AHPs	• OT - 3 days per week • Physio – 3 sessions per week; 9 hours per week on Ward and 1 hour per day for day unit. Physio in adjoining health centre can also be accessed when needed • Podiatrist based in health centre – reasonably good access • Dietetics and Speech and Language Therapy accessed as and when required
Other	Community geriatrician (via LHCC pilot) - Patient reviews once a month and also ad hoc advisory support

Outpatient clinics

Local clinics in diabetes, hypertension and psychiatry provided by adjoining practice - no clinics provided from hospital itself/for hospital patients.

Any other day case provision, facilities and/or intermediate care activity

- Day case activity e.g. venesection, IV antibiotics
- Treatment room and equipment for minor injuries, minor illness etc.
- Day care provided Monday to Thursday (funded by GPCT, Social Work and Friends of Insch Hospital), normally involving 5-6 day care patients, staffed by enrolled nurse and GPs sometimes have input. Nurse undertakes over 70s assessment, blood tests, catheterisation etc.

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24-hour service, including nurse-led minor injury, staffed from within hospital ward staffing; medical cover from local GPs during the day and GDOCs out of hours.
- Mainly minor injury.

Diagnostic facilities	Yes		No	✓

- No, over and above routine diagnostic equipment (e.g. ECGs).
- Huntly accessed for X-Ray facilities

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

Access advice from Aberdeen e.g. examinations, cardiography, skin specialists etc. Potential for greater use. Able to interpret basic cardiography on-site.

Any other on-site provision/services

- Health Visitors, District Nurse, community nursing team
- Health centre adjoining the hospital
- Midwives based on-site (pre-natal clinics etc)
- Community Pharmacist (based at Jubilee Hospital, Huntly) covers whole locality

8. INVERURIE HOSPITAL

MEDICAL DIRECTOR Dr Jim Black

Number of beds (by ISD designation)	GP Acute	20	Psycho-geriatric	26	Long stay	23

Actual current bed usage

- Allan Ward – 20 GP Acute beds including 1 palliative care suite.
- Donbank – 23 beds used as slow stream rehab, 5 of which long stay; 18 currently in use due to staffing shortages.
- Ashcroft – 26 psycho-geriatric beds; 10 of which assessment, 16 long stay (14 presently in use). Looking to re-classify more of long stay to assessment beds (e.g. 50:50 split). Allan/GP Acute generally used as 'fast stream' and Donbank as slow stream.

Type/numbers of staff and input to hospital

Medical	• Allan – 14 GPs from Inverurie practice can admit – 1 visits on a daily basis. Admissions also received from Fyvie/Oldmeldrum and Kemnay and other areas (e.g. Dyce, Ellon, Alford); payments by admission • Donbank – under care of consultant geriatrician with day to day medical management from sessional GP (3 sessions per week) • Ashcroft – 1 consultant session (1.5 hours) per week plus support/advice as and when required, with day to day medical care provided on sessional basis by Inverurie GP (3 sessions per week)
Nursing	• Allan – 1 WTE G grade; 0.87 F grade; 4 E grade; 3.32 D grades; 7.84 A grade • Donbank – 1 WTE G grade; 2.92 E grade; 4.26 D grade including 1.00 vacancy; 10.7 A grade including 0.53 vacancy • Ashcroft – 1 WTE G grade; 3.80 E grade; 6.07 D grade; 14.77 A grade including 0.96 vacancy
AHPs	• Physio – 25 hours per week. Clinics on Monday and Wednesday evenings and Saturday mornings; Community – 67.5 hours per week for all areas except Huntly • OT unit • Access to Speech and Language Therapy if needed • Podiatry –ward visits once a month
Other	Access to Community Hospital Liaison Nurse (ARI)

Outpatient clinics

- Audiology clinic once a month
- Chronic lymphodaema clinic – once a fortnight
- Diabetic clinic – once a week (specialist nurse)
- Retinal screening clinic on monthly basis
- Cardiological assessment unit (within Physio Unit) run by GP 0.5 day/week

Any other day case provision, facilities and/or intermediate care activity

- Blood transfusions, complicated dressings, catheter removal trials, etc.

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- Casualty service (including nurse-led minor injury) provided Out of Hours (Monday to Thursday 6.00pm – 8.30am) and weekends (Friday 6.00pm to Monday 8.30am)
- No dedicated casualty staff; normally 1 registered nurse from Allan Ward covers late shift; medical cover from GDOCs

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- Cardiological assessment unit (within Physio building) run by Inverurie GP 0.5 day/week
- Ultrasound - mainly used for echoes
- ECGs and pre-hospital thrombolysis facilities

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

Available within casualty unit. Possibly potential for greater use. Also used for reviews/follow-ups on patients.

Any other on-site provision/services

- GDOCs cell
- Scottish Ambulance Service
- Health and Community Care Team have office
- Dementia team– support dementia patients
- Night settling service based at hospital providing community out of hours care for Inverurie, Insch, Huntly, Alford, Rhynie/Strathdon, Kemnay, Oldmeldrum/Fyvie, Westhill, and Ellon practices
- Community Pharmacist (based at Jubilee Hospital, Huntly) provides cover for whole locality

9. JUBILEE HOSPITAL, HUNTLY

MEDICAL DIRECTOR Dr David Easton

Number of beds (by ISD designation)	GP Acute	28	Psycho-geriatric	12	Long stay	5

Actual current bed usage

In addition 4 maternity beds (temporarily closed). General Ward (15 beds) and Rothieden (13 beds) used as both long stay and GP Acute. Gordon Villa – psycho-geriatric ward. Casualty staff now also borrow beds when needed.

Type/numbers of staff and input to hospital

Medical	• 6 GPs (from Huntly Health Centre) have admitting rights. Provide care on behalf of other practices who admit (e.g. Rhynie, Alford, Aberchirder). 2 GPs undertake ward visits/provide on-call cover over approx. 2-3 week rota basis • 1 Psycho-geriatrician – weekly meetings and ward rounds with Community Dementia Team • 1 Geriatrician – input via patient visits etc; GPs providing day to day care
Nursing	• General Ward – 8.20 WTE trained; 6.49 untrained • Rothieden – 8.27 WTE trained; 8.89 untrained • 1 x G grade covers both General and Rothieden Wards • Casualty – 0.8 WTE G Grade; 6.52 E grade; 0.53 A grade plus 0.2 D grade (bank nurse)
AHPs	• Physio – 14 hours per week for Ward; 18 hours for Day Unit; 15 hours physio assistant. Community – 9 hours per week. 2 evening clinics. • OT on-site • Speech and Language Therapy – as and when required, based on referral • Dietetics, Podiatry – input if needed
Other	Community pharmacist based on-site and provides input/advisory support

Outpatient clinics

- General surgeon (from Elgin) – 2 clinics per month; 2 short day surgery lists
- Obs and Gynae – 2 sessions per month
- ENT – 1 clinic per month (usually 2 doctors attending)
- Eye clinic once a month
- Dermatology – 1 clinic per month
- Orthopaedics – 1 clinic per month
- Oncology – less than once a month, depends on demand
- Medical – less than once a month
- Nurse-led leg ulcer clinic
- Dietetics
- Audiology
- Orthoptic
- Deaf Society – open drop-in session
- Psychiatry – on-site outpatient clinic
- Drug and alcohol advisory service (from health centre)

Any other day case provision, facilities and/or intermediate care activity

- Full theatre suite; Minor surgery equipment (level 3 minor surgery provided); slit lamp; microscope – ear suction kit etc
- Blood transfusions; venesection; catheter removal trials; steroids for MS patients etc
- Day unit run for two 4-hour sessions per week for up to 12 people (joint funded with Social Work)

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24 hour service, including nurse-led minor injury, staffed by dedicated casualty nursing team (minor injury trained nurses); medical cover from local GPs
- Total throughput of approximately 18k between April 2002 and March 2003 – covering A&E patients, road traffic accidents, GP Acute/Surgery/Theatre and Clinic patients (not casualty activity alone)

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- X-Ray
- ECGs; routine diagnostic testing by GPs/nurses etc
- Fully functional Ultrasound only at present used for ante-natal ultrasound

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

- Telemed to Aberdeen or Elgin, e.g. fracture clinic, follow-up X-Ray
- Telemetry also used e.g. possible MIs

Any other on-site provision/services

- Community nurses, health visitors – adjoining health centre
- Podiatry – as and when required
- Community Dementia Team – based in Gordon Villa
- Community pharmacist on-site – provides cover to whole locality

10. ABOYNE HOSPITAL

MEDICAL DIRECTOR Dr Jack Taylor and Dr John Glass

Number of beds (by ISD designation)	GP Acute	12	Psycho-geriatric	0	Long stay	7

Actual current bed usage

3 palliative care suites. GP Acute borrow Long Stay beds (3 Long Stay patients). Additional 4 maternity beds.

Type/numbers of staff and input to hospital

Medical	• 1 Para 94 session (Aboyne GPs) • 8 GPs paid per admission to GP Acute bed (bed fund)
Nursing	• 1 WTE G grade; 0.8 F grade; 5.24 E grade; 4.17 D grade; 8.35 A grade (includes 0.32 A grade – cautery clinics; 0.83 E grade – casualty; 20 hours per week (0.54) cover to practice) • Maternity 7.01 WTE G grade – manage maternity beds and all Deeside community midwifery
AHPs	• Physio (plus assistants) and OT (plus assistants) - regular hours/input to hospital • Podiatry and Speech and Language Therapy – as and when required
Other	Facilities, admin

Outpatient clinics

Hosted by hospital
- Antenatal clinics
- Parent craft classes
- Sigmoidoscopy 1 day per week
- Audiology 2 days per week (from 01/04/04)
- Adult Mental Health – twice a month
- Eating Disorder – 0.5 day per week
- CPNs – ad hoc

Any other day case provision, facilities and/or intermediate care activity

- Resus trolley; telemed/moby med; endoscopy washer and fully stocked minor injuries unit
- Audiology booth

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24 hour minor injuries unit staffed by 0.83 E grade
- Minor injuries protocols
- All E grades and above have had training
- GDOCs on-site, links to A&E in Aberdeen

Diagnostic facilities	Yes		No	✓
No, over and above routine diagnostic equipment (e.g. ECGs, resus etc).				
Telemedicine provision	Yes	✓	No	
Nature and frequency of use of telemedicine provision For minor injuries, acute emergencies and GP patient consultations				
Any other on-site provision/services • GDOCs cell • Hot desks				

11. GLEN O'DEE HOSPITAL, BANCHORY

MEDICAL DIRECTOR Dr Katrina Morton

Number of beds (by ISD designation)	GP Acute	14	Psycho-geriatric	30	Long stay	7

Actual current bed usage

3 long stay patients; 2 beds held empty; 16 acute

Type/numbers of staff and input to hospital

Medical	• Medical Director – 1 session • Psycho-Geriatric – sessional/Long Stay Para 94 • Bed fund – GP Acute admissions
Nursing	• Scolty Ward – Psychogeriatric - G x 1 WTE; E x 4.5; D x 3.95; A x 14.44 (Total 23.89) • Morven Ward – GP Acute/Frail Elderly - G x 1 WTE; E x 4.5; D x 4.35; A x 8.44 (Total 18.29)
AHPs	• OT – approximately 20 hours (hospital and community) • Physio – approximately 20 hours (hospital and community) including evening outpatient clinic
Other	Admin and facilities

Outpatient clinics
- Evening Physio clinic
- Counselling

Any other day case provision, facilities and/or intermediate care activity
- Psycho-geriatric day hospital
- One clinic room available
- Blood transfusion for haemotology patients in development

Casualty unit/department (including nurse-led minor injury)	Yes		No	✓
Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

Ultrasound and sonographer – based at Banchory Surgery (PMS pilot)

Telemedicine provision	Yes		No	✓

Any other on-site provision/services
- LHCC admin/management offices
- CPNs office
- Physio and OT office

12. KINCARDINE COMMUNITY HOSPITAL, STONEHAVEN

MEDICAL DIRECTOR Dr Alistair Morgan

Number of beds (by ISD designation)	GP Acute	19	Psycho-geriatric	12	Long stay	18

Actual current bed usage

19 GP Acute; 12 EMI; 16 Long Stay; 2 Slow Stream Rehab

Type/numbers of staff and input to hospital

Medical	• GPs – 22 • Consultants – 15 • Radiologist – 1 • Consultant Psychiatrist (Old Age) – 1 • Psychiatrist (Eating Disorders Clinic) – 2 • Medical Time – 2 Sessions for Mearns Unit/1 Session for Ardoe Unit – Para. 94 Payments • Hospital Medical Director 2 Sessions – Consultant Payments • Arduthie (GP Acute) – attendance by each patient's individual GP as and when admitted – Admissions Payments
Nursing	• A Grade – 25.23 WTE; D Grade – 11.63 WTE; E Grade – 9.18 WTE; G Grade – 3.06 WTE (includes DSN). F Grade – 1 WTE (ENT redesign post) • Provide care to inpatients and support outpatient clinics. • CPNs – 2
AHPs	• Physiotherapy – 2.20 WTE • Dietetics – 0.40 WTE • Podiatry – 0.60 WTE • Occupational Therapy – 2.00 WTE • Speech and Language Therapy – 1.00 WTE • Input to inpatients, out patient clinics, community care. • Child Development Team

Other	• Admin/Clerical Staff:
	  • A & C D Grade – 1.2 WTE
	  • A & C 2/3 Grade – 1.6 WTE
	• Part-time Admission and Discharge Planning Co-ordinator (G grade 0.5 WTE)
	• Session G Grade available for chronic lymphodaema service

Outpatient clinics

- Antenatal - Every Friday morning, 1st and 3rd Friday's by consultant; 2nd and 4th by midwives.
- Audiology - 1st Tuesday of the month morning only and Thursdays am & pm
- Dermatology - Saturday mornings
- Diabetology - 3rd Wednesday of the month – full day by Consultant. Last Monday of the month (school term only) – full day by Consultant. The Diabetic Support Team supports both clinics. Weekly clinics run by Diabetic Specialist Nurse and dietician – Thursday all day. Diabetic podiatry is also undertaken on a weekly basis within the Podiatry department.

- Eating Disorder Videotherapy - Monday afternoons
- Endoscopy - One Saturday per month depends on demand - Dr I Gillanders
- ENT - 1st and 3rd Friday mornings and 1st Tuesday of the month all day – commences 02/04/04
- Gynaecology - 2nd and 4th Friday mornings (occasional 5th Friday); one Tuesday/month (all day)
- Ophthalmology - 3 sessions per month. Nurse led clinic (Cyst Clinic) – one session per month depending on demand.
- Orthoptic - Non-Consultant. Last Wednesday of the month – all day. Child Orthoptic clinic on last Friday of the month – afternoon.
- Orthopaedics - Last Wednesday of the month – all day.
- Pain Management Clinic - OT and Nurse led clinic – Monday mornings each week
- Retinal Screening - as and when required
- Sigmoidoscopy - Consultant 2 –3 sessions per month – Monday afternoon (clinic booked through ARI)
- Ultra-sound - Tuesday mornings – antenatal detailed scans, afternoons – general scans. Friday morning – ante-natal clinics/Gynaecology
- Urology - 1St Wednesday of every month – all day.
- Vasectomy - Saturday mornings. Normally twice per month depending on demand
- X-Ray - Monday afternoon and Thursday morning each week.

Information provided on attendances and DNAs

Any other day case provision, facilities and/or intermediate care activity

- Vasectomies, Cystoscopies, Gynaecological and Dermatological Biopsies etc
- Four clinic rooms, all with computer linked up to trust system. Also chiropody and podiatry
- Ongoing development within GP Acute ward – IV therapies, blood transfusions, ambulatory chemotherapy etc
- Equipment including:
  - Video equipment for Endoscopy - plus gastric scopes, cleaning cabinet
  - Cystoscopies and light source
  - X-ray machine - plus film processor
  - Ultrasound machine x2
  - Slit lamp

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24 hours 7 days per week; Medical care provided by local GPs. Trained nurse practitioners
- Staffed by minor injuries trained nurse (based within GP acute ward) where possible so can diagnose and treat without medical staff involvement. Though if backup is required or no minor injuries trained nurse is available, medical support is via Stonehaven Medical Practice during surgery hours or obtained via the OOH service G-DOCs or Telemed link to ARI A&E dept.
- Protocols are drafted and finalised via the Minor injuries group.

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Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- X-Ray – support to out patient clinics/inpatients. 2 sessions per week.
- Ultrasound – service to GPs, out patient clinics/inpatient support. Upper abdominal and obstetric ultrasound available. 3 sessions per week.
- Endoscopy
- Cystoscopy
- Audiology
- Orthoptics
- Cardiac Assessment – planned service
- All sessions provided by 1 x radiographer.
- Consultants do clinics.

Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

- Used if an initial/ further assessment/advice is required or medical staff in ARI have set up reviews. Not used regularly, as staff feel supported and competent in using protocols. But at times when used time delays in getting an attending doctor to review (busy in main dept) or some just have a fear of the new technology (training has been provided to try and reduce this worry)
- Meeting Room for Eating Disorder Clinic (Wednesdays)
- Teleconferencing

Any other on-site provision/services

- G-Docs
- Community Paediatrics
- Rapid Response Service (in partnership with Social Work Department)
- Community Rehabilitation
- Community Night Nursing Service
- Scottish Ambulance Service

13. FLEMING COMMUNITY HOSPITAL, ABERLOUR

MEDICAL DIRECTOR Dr Duncan MacDowal

Number of beds (by ISD designation)	GP Acute	9	Psycho-geriatric	0	Long stay	6

Actual current bed usage

Palliative care; GP acute admissions; Assessment; Rehabilitation. (In practice over the last 5 years they have all been GP acute beds.)

Type/numbers of staff and input to hospital

Medical	5 local GPs have admission rights to the hospital
Nursing	• Grades G to A • WTE 15.16 • Inpatient care, out patient clinic, casualty
AHPs	• Inpatient care – Physio has 2 hours per week, OT has 3 sessions in Speyside • Access to podiatry and other AHP support
Other	Hospital staff have access to the cross boundary nurse at Dr Grays

Outpatient clinics

- Surgical clinic – outreach (12 clinics provided each year)
- Acute psychiatry clinic (every 2 weeks)
- Consultant led medical sessions- for inpatient and out patient clients - weekly

Any other day case provision, facilities and/or intermediate care activity

•

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24 hour casualty staffed from ward staff. Supported by local GPs
- Minor Injury protocols
- Telemedicine support

Diagnostic facilities	Yes		No	✓
Telemedicine provision	Yes	✓	No	

Nature and frequency of use of telemedicine provision

- Teleconferencing
- Links to Dr Grays casualty and ARI
- Links to other community hospitals

Any other on-site provision/services

- The Hospital is linked to Aberlour Health Centre, where the community nursing team is also based.
- Onsite bungalow provides accommodation for various groups through mental health services. Also provides accommodation for the Food and Health project group.

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14. LEANCHOIL HOSPITAL, FORRES

MEDICAL DIRECTOR Dr David Stevenson

Number of beds (by ISD designation) GP Acute	23	Psycho-geriatric	0	Long stay	0	

Actual current bed usage

As above, plus overnight observation beds and 24 hour treatment beds

Type/numbers of staff and input to hospital

Medical	• Two practices – 13 GPs • Contact – ward rounds, telephone
Nursing	• Presently 27.34 WTE • 30 members of staff Grades A-G
AHPs	• OT – 18 hours 0.48 WTE • Physio Outpatient Department – 129 hours 2.60 WTE • Physio – 80 Inpatient Clinics, inpatient – community visits
Other	

Outpatient clinics

- Surgical
- ENT
- Ophthalmology
- Dermatology
- Gynaecology
- Reproductive Endocrine
- Orthopaedic
- Midwifery
- Audiology
- Psychology
- Psychiatry
- Diabetic
- Dietetics/Dietician
- Speech Therapy
- Medical (consultant-led)
- Falls prevention clinic

1000 clinics per year. Attendance figures kept for surgical, ENT, Ophthalmology, Dermatology, Gynaecology, Reproductive Endocrine, and Orthopaedic clinics. Approximately 2500 attendances, 200 DNAs.

Any other day case provision, facilities and/or intermediate care activity

- Sound proof booth for hearing tests
- Minor surgery (level 2)

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24-hour casualty/minor injury service. Staffed by hospital nursing staff and local GPs.
- Activity low, patients attend Health Centre treatment room. Protocols available in department and Health Centre.

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- X-Ray only
- Trained nurses – ready to continue developing/training to provide new services

Telemedicine provision	Yes	✓	No	
Nature and frequency of use of telemedicine provision				
Training ongoing – linking to Dr Grays/ARI daily as and when required				
Any other on-site provision/services				
• Offices – District Nurses work from hospital • Care Manager – Social Services work from hospital • Care Organisers – Social Services work from hospital • Out Reach – accommodation on-site • Locality Nurse Facilitator, Forres – accommodation on-site				

15. SEAFIELD HOSPITAL, BUCKIE

MEDICAL DIRECTOR Dr B Welsh

Number of beds (by ISD designation)	GP Acute	22	Psycho-geriatric	0	Long stay	14

Actual current bed usage

- 20 acute
- 2 continuing care
- 2 rehabilitation
- 1 23-hour
- 7 nurse-led beds

Type/numbers of staff and input to hospital

Medical	• 12 GPs • 1 session of Consultant Physician time
Nursing	36.77 WTE 1 Full-time G+ grade; 7.71 E grades; 11.03 D grades; 1 C grade; 16.29 A grades
AHPs	• 1 Occupational Therapist 18 hours - hospital and community • 1 Physiotherapist 18 hours – hospital and community • 1 generic therapy assistant 15 hours – hospital and community (rapid response funding)
Other	Community nurses set up care packages and help deliver care to patients in the nurse-led beds

Outpatient clinics

- Gynaecology
- Orthopaedics
- Medical
- Surgical
- ENT
- Antenatal
- Diabetic
- Ophthalmology
- Hearing
- Attendance 2581 DNA's 243
- Falls prevention clinic - run by physiotherapists

Any other day case provision, facilities and/or intermediate care activity

- Sound proof booth for hearing test
- Ear suction equipment
- Minor surgery equipment – level 3 minor surgery provided

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- Casualty open 24 hours, 7 days per week with no down time. Serviced 80% of the time with minor injuries trained nurses.
- Emergency care, casualty, supported by local GPs, GDOCs and paramedics

Diagnostic facilities	Yes	✓	No	

Staffing and activity/type of diagnostic provision

- X-Ray
- Part-time radiographer

Telemedicine provision	Yes	✓	No	
Nature and frequency of use of telemedicine provision Casualty for supporting patient care and for virtual out patient clinic (predominantly orthopaedics)				
Any other on-site provision/services • Co-location of paramedics within Casualty Department				

16. STEPHEN COMMUNITY HOSPITAL, DUFFTOWN

MEDICAL DIRECTOR Dr T Heneghan

Number of beds (by ISD designation)	GP Acute	10	Psycho-geriatric	0	Long stay	10

Actual current bed usage

(Over the last 5 years, all 20 beds have been managed as GP acute beds.)

- GP acute admissions
- Palliative Care
- Assessment
- Orthopaedic Rehab
- Rehabilitation

Type/numbers of staff and input to hospital

Medical	Two
Nursing	• Grades G to A • WTE 20.11 • Inpatient care, outpatient, casualty, day centre

AHPs	• Inpatient care/outpatient:
	  • Physio – 20 hours per week
	  • OT had 3 sessions
	• Access to podiatry and other AHP support

Other	• Hospital staff have access to the cross boundary nurse at Dr Gray's • Therapy assistant for inpatient/outpatient • B grade nursing assistants support

Outpatient clinics

- General surgical clinic – monthly
- Consultant led medical sessions – for inpatient and weekly outpatient clinic
- Dressing clinic – daily
- Acute psychiatry clinic- every 3 weeks
- Dietetic clinic-monthly

Any other day case provision, facilities and/or intermediate care activity

- Falls prevention clinic at clinic and in community
- Nurse Manager training to develop outreach
- Breathless clinic linked to The Oaks in Elgin
- Oral chemotherapy pilot within hospital

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24-hour service staffed from ward staff
- Minor injury protocols
- Supported by local GPs
- Telemedicine support

Diagnostic facilities	Yes	✓	No	
Staffing and activity/type of diagnostic provision • X-Ray facilities • Radiographer – one session per week				

Telemedicine provision	Yes	✓	No	
Nature and frequency of use of telemedicine provision • Teleconferencing • Links to Dr Gray's casualty and ARI • Links to other community hospitals • Dermatology • Recently trialling stethoscope				

Any other on-site provision/services

- Day centre within hospital
- Hot desk for Social Work staff and OT
- Attached to Health Centre

17. TURNER MEMORIAL HOSPITAL, KEITH

MEDICAL DIRECTOR Dr J. H. Harrington

Number of beds (by ISD designation)	GP Acute	19	Psycho-geriatric	0	Long stay	3

Actual current bed usage

- All 22 beds now GP Acute in actual use
- GP acute, palliative care, convalescence/rehab and symptom control

Type/numbers of staff and input to hospital

Medical	5 full-time GPs and 1 part-time GP (Keith practice)
Nursing	• H grade 1:00 WTE Nurse co-ordinator for hospital and community, some clinical input + TNCC • F grade 1:00 WTE Ward Sister, general nursing duties in ward and casualty, minor injuries trained • E grade 4:82 WTE; 7 part time S/N - general nursing duties in ward and casualty (6 minor injury trained, seventh on training just now) • D grade 4:86 WTE 1 F/T and 1P/T S/N and 5 P/T E/N - general nursing duties in ward and casualty • B grade 1:00 WTE 1 F/T Therapy assistant, continues programmes of care initiated by Community Physiotherapist (funded from the nursing budget) • A grade 7:77 WTE 2 F/T and 9 P/T nursing auxiliaries - general nursing duties
AHPs	• Community Physio 2 days per week • OT input – provision is 10 hours per week but actual input is as and when required • Dietician, Speech and Language Therapy and Podiatry as and when required
Other	

Outpatient clinics

(All outreach)

- General surgery
- General Medicine
- Orthopaedics
- Ophthalmology
- ENT
- Obs and Gynae
- Psychiatry
- Podiatry
- Dietetics
- Orthoptist
- 96 clinics per annum; 1112 attendees; 63 DNAs

Any other day case provision, facilities and/or intermediate care activity

- Slit lamp in ophthalmology room

Casualty unit/department (including nurse-led minor injury)	Yes	✓	No	

Staffing and nature/activity of casualty service

- 24-hour service, staffed by GPs, 7 minor injury trained nurses and rest of the trained nursing staff (minor injury trained nurse always on duty Out of Hours)
- At present GP-led casualty session daily
- Minor injury protocols used by relevant trained staff (locally agreed protocols also in place)

Diagnostic facilities	Yes	✓	No	
Staffing and activity/type of diagnostic provision • X-Ray 2 sessions per week • Radiographer for 2 sessions per week				
Telemedicine provision	Yes	✓	No	
Nature and frequency of use of telemedicine provision In the past it has not been used often because of technical problems, however it is now being used more for nurse/nurse consultations and has also been used by Consultants and GPs				
Any other on-site provision/services •				

18. LINKS UNIT, CITY HOSPITAL

MEDICAL DIRECTOR Dr George Crooks

Number of beds (by ISD designation)	GP Acute	5	Psycho-geriatric	0	Long stay	40

Actual current bed usage

24 continuing care/interim care beds (lower floor), plus 16 rehab and 5 GP Acute (upper floor). GP and Rehab beds used flexibly according to need.

Type/numbers of staff with input to the unit and activity

Medical	• GP Acute Beds –This is a nurse led unit. Patients remain under the care of their own GP but are supported by GP from Links Medical Practice on-site (daily visits). [Out of hours cover from GDOCs.] Admissions can be received from all City GPs, community nursing teams, rapid response teams and care managers. • Rehab Beds – Ongoing medical responsibility of Consultant Geriatrician and day to day cover from GP. [Out of hours cover from on-call doctors at Woodend.] • Total cover/input of 4 fixed GP sessions
Nursing	Nursing complement for entire Unit: H Grade - 1 WTE; F Grade - 1WTE; E Grades - 5.86 WTE; D Grades - 8.2 WTE; A Grades - 20.85 WTE
AHPs	• Dedicated Physio input to upper floor (Rehab/GP Acute beds) comprising: 0.5 WTE Staff Grade; 0.5 WTE Senior 1; 0.25 WTE Technical 3 Instructor • Dedicated OT input primarily to upper floor but cover provided for lower floor if required, comprising: 1 WTE Senior 2; 9 hours Technical 3 Instructor (plus Senior 1 supervisory support as and when) • Speech and Language Therapy, Dietetics and Podiatry input – accessed on an 'as required' basis • Weekly multi-disciplinary meetings held
Other	

Outpatient clinics
- None

Any other day case provision, facilities and/or intermediate care activity
- Therapy area – resource and equipment used for both inpatients and community-based patients (e.g. physio).

Casualty unit/department (including nurse-led minor injury)	Yes		No	✓
Diagnostic facilities	Yes		No	✓

Staffing and activity/type of diagnostic provision

No, over and above routine diagnostic facilities (ECGs etc).

Telemedicine provision	Yes		No	✓

Any other on-site provision/services

- Rapid Response Team
- Domiciliary Physiotherapy and Outpatient Physiotherapy
- Learning Disabilities team
- Library/Unit Information/In-Service Education area
- Links Medical Practice and pharmacist on-site

NHS GRAMPIAN STRATEGY FOR COMMUNITY HOSPITALS 2004-2009
CONSULTATION QUESTIONNAIRE

NAME .....

ROLE TITLE .....

ORGANISATION/SERVICE .....

Please state if you are providing a response on behalf of a particular group/organisation

CONTACT DETAILS *(optional)* .....

1. SECTION 1 – INTRODUCTION Are the aims of the Community Hospitals Strategy clear? Are they appropriate?
2. SECTION 2 – COMMUNITY HOSPITALS IN GRAMPIAN TODAY Is the information contained on current services and activity useful? Is there any key information not included?
3. SECTION 3 – THE FUTURE – NHS GRAMPIAN CHANGE AND INNOVATION PLAN Does the strategy make clear the role and contribution of community hospitals in relation to the various elements of the Change and Innovation Plan?

4. SECTION 4 – COMMUNITY HOSPITALS IN 2009?

Are there any other key issues of concern to community hospitals in the future which you think should be included?

5. SECTION 5 – RECOMMENDATIONS FOR ACTION

Are the recommendations appropriate? Are they realistic?

6. ADDITIONAL COMMENTS

If there are any further relevant issues you would wish to highlight please do so in the following space provided.

Thank you for taking the time to provide feedback on this document. Please return your comments by **FRIDAY 10 DECEMBER 2004** to Angela Logie, NHS Grampian, Summerfield House, 2 Eday Road, Aberdeen AB15 6RE or via email: angela.logie@gpct.grampian.scot.nhs.uk