

# Ledbury Community Health and Care Centre



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## Key Partners

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## Brief Description

Ledbury's Community Health and Care Centre opened in March 2002. It was developed and is operated through an innovative Public Private Partnership which provides a range of health and care services/facilities to the people of Ledbury and the surrounding district. This case study describes the development of the Centre and identifies some lessons to be drawn from experience to date.

## Ledbury Community Health and Care Centre

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# **Ledbury Community Health and Care Centre**

## **INTRODUCTION**

Ledbury is a market town in south east Herefordshire, near to the Malvern Hills. The town and surrounding district has a population of about 18,000.

Ledbury's Community Health and Care Centre opened in March 2002. In 2006, it won a Community Hospitals Association award for its improved model of care.

The Centre was developed and is operated through an innovative Public Private Partnership which provides a range of health and care services/facilities to the people of Ledbury and the surrounding district. On a single town centre site, these include community hospital services, a nursing home for older people, a GP surgery, an NHS dental access centre, and an office base for the local social work team. It also has an acquired brain injury unit with a much wider, regional catchment.

The Public Private Partnership agreement between Herefordshire Primary Care Trust, Shaw Healthcare Ledbury Ltd and the Shaw Healthcare Group Ltd was/is unusual in that it covers less than half – by area, by capital cost, by service value – of the total development. The financial risk of both development and ongoing operation rested and continues to rest with Shaw rather than the PCT or any of the other organisations involved. Shaw developed the Centre, primarily with funding obtained from the market plus a small element of local donation, and the largest part of the services provided there are independently funded.

Arrangements around services provision at the Centre vary. Shaw provide some services directly with their own staff team. Other services are provided by public sector agencies in accommodation leased or rented from Shaw. In all cases, Shaw provides the facilities management.

## **THE DEVELOPMENT OF THE CENTRE**

By the late 1990s, it was clear that, although it had a place in Herefordshire's agreed *hub and spoke* configuration for hospital services, Ledbury's 13 bed nineteenth century cottage hospital was in no way fit for purpose. It was too small, had inadequate facilities and the estimated cost of upgrading was prohibitive.

The Health Authority (HA) explored the possibility of re-providing through a PFI scheme and went as far as tendering for a partner. The process was, however, constrained by a lack of resources – the HA had no capital to contribute and nothing to add to its existing level of revenue funding. The test of affordability

then was that a new hospital would have no capital implication for the HA and would cost no more to operate than the old cottage hospital. It was perhaps not surprising that, although there was considerable interest from the private sector, none of the bids received were affordable.

Following this abortive attempt at direct reprovision, the HA got into discussions with one of the bidders, Shaw Healthcare – at that time a not for profit health and social care organisation – about alternative approaches to re-provision. Out of this came what was, especially for the time, a far more radical whole systems proposal.

There were two other local factors apart from the need to replace the inadequate hospital beds that were of critical importance in putting together a viable and locally appropriate package. Firstly, one of the town's two GP practices was coming to the end of the lease on its 18<sup>th</sup> Century listed premises. Although it would probably have been possible to renew the lease, the existing building required considerable investment and, even with this, would not really meet modern primary care requirements. Secondly, although there was some care home provision, there were no nursing home beds for older people locally.

These factors made it possible to develop a proposal for a multi-purpose scheme centred around a 60 bed care home with 13 (later increased to 14) beds dedicated to NHS use and providing a range of cottage hospital services/facilities. The scheme would also accommodate the GP practice and a number of complementary facilities/services.

Two features made this a really attractive and viable option. Firstly, the range of services and activities to be provided from the centre meant that the development, infra-structure, managerial, supervisory and support costs would be widely spread thus reducing the individual service unit cost. Secondly, the model involved the cottage hospital nursing staff transferring to Shaw's employ on their existing employment terms including, crucially, their retention of NHS pension scheme membership. (As an exempt charity, Shaw was able to employ former NHS staff on their existing terms and conditions.) It was anticipated that, by integrating the cottage hospital staff into its own staff team, the resulting single team working across both the nursing home and the hospital unit would produce considerable cost efficiencies. Twenty four hour nurse cover on a 13 (or 14) bed hospital unit is not an efficient use of costly and scarce nurse resources.

One of the challenges in developing the proposal was identifying and bringing together a range of services and facilities for which there was a real local market and which would produce sufficient efficiencies and economies of scale to create overall viability. The 10 place Acquired Brain Injury Unit, for instance, was not part of the original plan, which assumed a 46 bed nursing care home, but was built in when the original model failed to stack up financially. In this case, there were no similar provisions within a considerable distance of Ledbury and so it

was possible to be reasonably confident about the likely market. Indeed the Unit has proven to draw from a regional – and more than regional – catchment.

These factors enabled Shaw to put together a viable business plan and meant that the proposed scheme was affordable for the Health Authority. It solved the problem of finding a new home for the GP practice, with the added advantage that the premises were new, modern, specially designed and in the closest possible proximity to cottage/community hospital facilities. It also addressed the lack of nursing home beds in the locality – a serious commissioning concern.

## **OBTAINING A SITE**

Finding an appropriately sized site in a market town such as Ledbury was not an easy task, especially as there was a strong preference among the general population, commissioners and Shaw for a town centre location. Two sites on the outskirts of Ledbury were investigated but in both cases there were planning problems and, in the end, the only possible site was the town's long established livestock market. This was well located in the town centre and had come to be very little used, its business mostly having moved to other market towns. Indeed, by around 2000, its main function was as a car park.

The market was owned by a company made up of some 200 local shareholders. These were mainly farmers but there were also some people holding shares *for the good of the town*. However, although the site was little used, it took considerable time and effort to persuade both the shareholders and the wider population that the market should close and the site be used for the new hospital and GP surgery.

There seem to have been two major factors driving local resistance. One was the actual loss of the market although, as it was so little used by that time, this probably had more to do with the symbolism than with the reality of the proposal. There is no doubt that its closure marked (or forced recognition of) a major and undesired shift in the nature of the local economy and culture. Secondly, the proposed community health and care centre was seen by many as a replacement of the cottage hospital by a private facility – and this fuelled strong opposition. However, there was also a body of support for the proposal.

The directors of the Market company eventually agreed to sell the site through the mechanism of Shaw purchasing the company itself. Even once terms had been agreed with the directors of the company, it took nearly a year of discussions, public meetings and debate in the local press before purchase of the necessary minimum 90% of the shares could be effected and the PPP agreement set in place. The two processes needed to be synchronous. It was reportedly a difficult and tenuous process and on two occasions it nearly foundered – the first time because of continued resistance to the proposal from

shareholders at a critical stage of the process and the second time because of difficulties in finalising the detail of the partnership agreement.

Once the site had been acquired and the partnership agreement was in place, it took a further 18 months to build the centre. It finally opened in March 2002.

## **THE DESIGN AND BUILD PROCESS**

The design and delivery of the Centre had its challenges. Shaw needed to deliver a large building on a tight site within a small scale conservation area. This had to be done within a short time scale and with cost certainty; and the resulting building had to meet the functional requirements of the different tenants/services. The design process also needed to be facilitated by responsiveness to local sensitivities and the requirements of planners.

Shaw determined that the best way to meet these varying drivers was to control the design process themselves only identifying (through limited competition) a developer once planning approval had been obtained. This design and build approach also offered a cost certainty and reduction of risk that was attractive to the financial backers who reportedly found the combination and type of revenue funding streams quite challenging.

The brief was very diverse in that the different stakeholders/future tenants had very specific requirements in relation to space, location, sound insulation, and functional suitability. For instance, the GP practice considered it essential that all its accommodation was ground floor, with high street access, and designed for security. The Care Home needed to maximise the number of rooms and have good garden access. Physical therapists needed appropriate wall space and strength for certain equipment. It was also important that the areas of the building/service funded through the *Friends* were clearly identifiable.

A ground floor location was important to a high proportion of the future tenants and the sloping nature of the site – which would not always be seen as advantageous - actually helped delivery of everyone's aspirations.

The selected construction management company was Castleoak - a company specialising in the development, design and construction of care homes and other supported accommodation for older people. Although overall design had been agreed prior to their appointment, Castleoak worked closely with Shaw (and the architect) in teasing out the detail, making necessary amendments, and in the continuing dialogue with the various stakeholders.

The building is timber framed. This was relatively unusual at the time but it was felt that this offered the quickest build period, the best price and the greatest cost certainty for both Shaw and Castleoak. Although sustainability did not have its

present day profile, this was reportedly also a consideration and Shaw believe that timber framed buildings *have a warmer feel to them*.

The project was delivered on budget - and at a budget that all partners consider very good value - and, with a small extension to accommodate some of the inevitable design adjustments, on time. The relationship with the construction management company was a tendered contractual process described as being more heavily regulated and less flexible than the partnering approach that would be expected today. However, both parties speak very positively of the experience and they have worked together, on a partnering basis, on subsequent projects.

Both partners consider that in terms of design, quality and functional suitability, and indeed overall value for money, the building has worked well and is standing up well to use. It was highly innovatory for its time and is probably still unusual in the range of diverse functions and requirements that it accommodates and in the range of stakeholders involved.

## **THE COMMUNITY HEALTH AND CARE CENTRE**

The Centre provides a home for the following services and facilities:-

### **Community Hospital services**

#### ***Inpatient Intermediate Care***

The 14 beds in this unit are contracted to the PCT, providing a direct replacement for the 13 bed cottage hospital ward, and are available to adults needing hospital care, post-operative and palliative care. Patients are referred there either by their GP or by the acute hospital in Hereford. It is registered with CSCI as a *Care Home only (physical disability; physical disability over 65 years of age)* providing Intermediate Care but, as far as service users are concerned, it operates as a National Health Service facility - free at the point of delivery.

The ICU is staffed by nurses and care workers employed by Shaw Healthcare. Other clinical services such as physiotherapy or other therapist services are provided through the Primary Care Trust. Medical care is provided by the local GPs who are happy to care for patients originating from areas outside Ledbury as well as local residents.

As indicated above, the primary purpose of the service is to offer restorative care to enable people to return to the community. This might be because they have rehabilitation and recuperation needs following an acute illness and hospital stay. Alternatively, they might have nursing or *reablement* needs which cannot be provided at home. A stay on the unit is normally for up to 6-8 weeks but can extend to 10 weeks.

However, although not a major issue for any of the organisations involved, there is something of a tension between the Unit's registration and both the way in which it actually functions and the understanding of the local population. A recent CSCI inspection observed that the ICU was providing a broader range of services than it was registered to provide because some people were too unwell to receive care aimed at rehabilitation and in some cases were in need of end of life care. It also noted that many professionals and members of the public think of the service as *a cottage hospital* - perhaps not surprising given the background to its development.

### ***Outpatient Clinics***

Visiting consultants and specialists from the PCT and Hereford Hospital Trust run clinics, mainly weekly or fortnightly, in the following specialisms using two consulting rooms located in the PCT tenanted area:-

- |                           |                      |
|---------------------------|----------------------|
| ~ anti-coagulant          | ~ ophthalmology      |
| ~ child health            | ~ orthoptist         |
| ~ chiropody               | ~ paediatrics        |
| ~ continence              | ~ palliative care –  |
| ~ DASH                    | lymphoedema clinic   |
| ~ dermatology             | ~ Parkinson's clinic |
| ~ diabetic Eye Screen     | ~ podiatry           |
| ~ gynaecology             | ~ urology            |
| ~ older people's services | ~ midwife clinics    |

### ***Minor Operations Theatre***

This unit is used by Ledbury GPs and visiting consultants for some surgical procedures that do not require general anaesthetics. Utilisation is not high.

### ***X-ray Unit***

Initially, this was equipped with a mobile X-ray machine recycled from elsewhere but after a while this reached the end of its life span. For a time - while the pros, cons and costs of different types of replacement were considered - there was no X-ray facility but it a new digital system linking directly to the consultants in Hereford is being installed by the PCT.

### ***Physiotherapy Suite***

Staffed by the PCT, this unit provides a service to both the community and the ITU. The physiotherapists had a strong input to the design and layout of this light, attractive, small scale suite.

### **Minor Injury Unit**

Specialist nurses employed by Shaw provide a 24/7 emergency minor injuries service. This is nurse led unit operating under the medical supervision of the local GPs.

### **The Ledbury Home**

The 36 bed Ledbury Home is registered as a *care home with nursing (old age, not falling within any other category; physical disability over 65 years of age)*. It is described as specializing in the provision of high dependency and palliative care services for older people.

The Home occupies one wing of the Centre and is on two floors although the sloping contours of the site mean that it is actually on three different levels. There are 19 single bedrooms plus two communal sitting and dining rooms on the second floor. There is similarly set out accommodation for 17 people on the first floor, but with the slope, some of these rooms look out at ground floor level. All bedrooms are en suite and have nurse call, telephone and television points (There are also televisions in the lounges). There is a lounge and dining area where people have their meals (unless they chose to have them in their bedrooms) for every 10 bedrooms

The main access to the home is at the first floor level and there is a lift providing access to both floors for people with mobility problems.

In addition to conventional care and nursing care, the Home provides/facilitates:-

- ~ physical therapies
- ~ memory strategies
- ~ complementary therapies
- ~ hairdressing and beauty treatments
- ~ gardening, painting and other communal activities
- ~ chiropody and optical services.

### **Acquired Brain Injury Unit**

This is a specialist unit providing a transitional living service with professional nursing care and therapeutic support for people with brain injury resulting from direct or organic trauma. The providers say that the facility provides *an opportunity to attain realistic goals along developed pathways of care whilst (being) supported with a holistic approach to personal choice, nursing and therapeutic needs*. Regular assessments are carried out and care programmes developed in partnership with other health and medical professionals. The unit has its own neurological OT and is staffed by RMNs as well as RGNs.

Individual programmes can include:-

- ~ full assessment service
- ~ professional nursing care
- ~ one-to-one support
- ~ short/long term planning
- ~ physiotherapy
- ~ hydrotherapy
- ~ complementary therapies
- ~ speech and language therapy
- ~ coaching and support in activities of daily living
- ~ coaching and support in personal hygiene
- ~ anger/problem behaviour management
- ~ mobility training
- ~ cognitive rehabilitation
- ~ memory strategies
- ~ relationship support
- ~ counselling
- ~ community health access
- ~ travel training
- ~ facilitation of access to/attendance at accredited college courses
- ~ coaching and support in social skills
- ~ access to the Snoezlem – a sensory room

The Unit is registered as a 10 place *care home with nursing (physical disability, sensory impairment)*. It occupies the first floor of one of the wings and provides individual en suite accommodation for its 10 residents. As with the nursing home, every bedroom has nurse call, telephone and television points.

The unit has its own lounge and a small garden area accessed via a flight of stairs. Part of the learning about the Centre is that this Unit would have been better located at ground level.

Take up of places is good now although it took time to get established and there was initially a higher than anticipated vacancy rate. It was found that the demand was for a facility with nursing care rather than for a simple care home and the service and registration changed to reflect this. There is a residence restriction of 5 years maximum stay – described as a CSCI requirement. The experience to date has been that residents move on to other transitional facilities or to mainstream nursing home care, including in some cases EMI units. (The provider has developed a step-down transitional service for ABI service users in Evesham, some 25 miles away. This comprises six independent living apartments and has reportedly proved a successful option for those who can manage more independently.)

## **Health Partnerships and Community Services**

### ***St Katherine's GP Surgery***

This purpose built base for the largest of Ledbury's GP practices comprises an attractive and specious reception with an area dedicated to children, six consulting rooms and two treatment rooms as well as administrative offices, a large meeting room/library and a kitchen/staff room. One of the consulting rooms (the practice has 5 partners) is used by

a number of visiting clinicians including a visiting psychiatrist and counselors dealing with a range of mental health and psychological issues, a speech therapist and a dietician.

The surgery also houses both children's and older people's health visitors and support assistants and provides the base for the practice's district nurses. The district nurse/midwife/Red Cross Out-of-Hours service for the area also operates from the building.

### ***NHS Dental Access Centre***

This emergency dental centre was developed to provide unregistered patients pain relief and, if indicated, a course of routine care. It is staffed and equipped by the PCT who rent the accommodation from Shaw.

### ***PCT Office***

The PCT have an office in the Centre which provides a local Ledbury base for the Locality Manager (whose main base is in Ross on Wye).

### ***Drug Advice and Needle Exchange***

The Drug Advisory Service has a weekly clinic at the Centre (using the consulting rooms mentioned earlier) and there is a twice weekly needle exchange service located in the Reception area.

### ***Social Services Community Team***

Herefordshire Social Services' locality team for older people and people with disabilities is also based in the Centre, providing assessment and care management services for the Ledbury and Ross on Wye areas.

### ***Snoezlem Room***

This multi sensory facility is available to all services based in the Centre and to the wider community. This facility has been developed since the Centre opened. The area it occupies originally provided a mortuary but it was decided that this was not really a justified use of space. An alternative arrangement was set up with a local undertaker and the space released was refitted to provide the Snoezlem. This facility is used on a regular basis by the ABI Unit. In the Centre's early days, it was also used regularly by the local community but this use has now declined.

### ***Conference Facilities***

There is a Conference Room on the top floor available for use by Centre services or more widely by other organisations on a commercial basis.

## **Other Facilities**

The Centre has no on-site pharmacy although space was originally designated for this within the GP practice area. There was interest in using this area from a local pharmacist, who made two applications for registration. However, these were unsuccessful apparently for reasons associated with Ledbury's population size. The area intended for a pharmacy is now used by the GP practice. This means that drugs have to be brought from Hereford.

Two facilities/services intended to extend the range of support to the community and to encourage community involvement with the Centre did not remain there for long. These were:-

- ~ a *Tots to Teens Group* which aimed to provide wraparound child care seven days a week to staff and users of the Centre and parents in the local community; it eventually moved elsewhere to larger premises
- ~ a privately operated café which proved unviable commercially - the location away from, albeit close to, the main high street did not attract *sufficient footfall*.

A large studio facility previously used by the Tots to Teens Group is now leased to Social Services and the potential for the remaining areas to be taken up by another clinical service is currently being explored. It is hoped that this will be commissioned later in 2008.

## **THE BUILDING**

The Centre is on four floors on a sloping site. Loosely E shaped on the two main floors, there is a lower ground floor, accessed at street level on the lower part of the site, accommodating the GP surgery.

The main Reception is on the ground floor along with the ICU, Outpatients, Minor Injuries and Physiotherapy suites, and one floor of the Ledbury Home. The second floor accommodates the Home's second floor, the Acquired Brain Injury unit, the Social Services locality team, and the laundry rooms. Above the central arm of the E is a small second floor accommodating the dental access service and the Centre's conference facilities. The *Tots to Teens* group was also located on this floor – part of that space now having been taken up by Social Services.

## **CONTRACTUAL STRUCTURE**

The building was developed and is owned by Shaw Healthcare Ledbury Limited. This is a company which was set up by the Shaw Healthcare Group to develop, own and operate the Ledbury Community Health and Care Centre – a

mechanism for protecting other parts of the Shaw organisation from risk. It is 100% owned by the Shaw Healthcare Group.

This arrangement means that the finances of the Centre are completely ring fenced and transparent. This, obviously, removes direct risk from the parent organisation but it also means that the funders – the bank and private donors – and the local community can see a clear link between their funding and the facilities and services being provided. It also provides a way for the people of Ledbury to have ownership and control over their own facility by having local directors of the Company.

The contractual arrangements and relationships whereby different services and units occupy and use the Centre vary as are shown in the following table:-

	<b>Services/Units</b>	<b>Management, Nursing, Care, Professionals provided by</b>	<b>Facilities Management Services provided by</b>	<b>Form and Term of contracts with Shaw Healthcare Ledbury Ltd</b>
NHS Services provided jointly by Shaw Healthcare and the NHS under the Public Private Partnership Agreement	ITU Inpatient Beds	Nursing services and management provided by Shaw Healthcare Medical care provided by GPs Therapists and other occasional clinicians provided by PCT	Shaw Healthcare	25 Year Service Contract with PCT
	24/7 Minor Injury Service	Shaw Healthcare	Shaw Healthcare	25 Year Service Contract with PCT
	Outpatient Clinics	Herefordshire PCT	Shaw Healthcare	25 Year Lease with PCT
	Physiotherapy Services	Herefordshire PCT	Shaw Healthcare	25 Year Lease with PCT
	GP Services	St Katherine's Surgery	Shaw Healthcare	25 Year Lease with GPs

	<b>Services/Units</b>	<b>Management, Nursing, Care, Professionals provided by</b>	<b>Facilities Management Services provided by</b>	<b>Form and Term of contracts with Shaw Healthcare Ledbury Ltd</b>
Services provided jointly by other partners under various commercial agreements	NHS Dental Access Service	Herefordshire PCT	Shaw Healthcare	Business tenancy
	Social Services Office	Herefordshire Social Services	Shaw Healthcare	Business tenancy
	Pharmacy	Now let as an extension to GP surgery	Shaw Healthcare	Business tenancy
	Tots and Teens Group	Independent Charity Discontinued	Shaw Healthcare	Annual tenancy
Care and nursing services provided directly by Shaw Healthcare independently of NHS or other parties	The Ledbury Home (care home with nursing)	Shaw Healthcare	Shaw Healthcare	Individual agreements made with each resident or their funding agency
	Acquired Brain Injury Unit	Shaw Healthcare	Shaw Healthcare	

## **MANAGEMENT AND STRUCTURES**

Management arrangements for the Centre have changed over the six years of its operation. During the development phase, Shaw appointed a Project Manager and a General Manager to oversee the building and fitting out process and the initial establishment of the services. There have been two general managers since that time but, when the last of these moved on in March 2007, the structure was changed with the Area Manager taking a more direct management role with three Centre unit managers reporting to him. These posts previously reported to the General Manager. There have also been some adjustments in the Facilities Manager's responsibilities so that he now deals purely with facilities management and associated contractual relationships – previously he also managed domestic and support staff. Shaw considers the new arrangement to be working well.

## RELATIONSHIPS BETWEEN SERVICES AND PARTNERS

### Primary Care Trust

The Centre itself and the relationship between the Centre/Shaw and the PCT are generally described in positive terms. As in any landlord/tenant or commissioner/provider arrangement, there have been matters and relationships that need to be sorted out - *contracts never cover all the detail* – and this will have been complicated by the fact that Shaw is both landlord and provider, the PCT both tenant and commissioner. However, it is clear that both organisations have been prepared to work steadily and non-confrontationally together to clarify and resolve issues - many of which have essentially been concerned with *who is responsible for doing what* or *who is responsible for paying what*.

With hindsight, the PCT commissioners would frame the contracts rather differently and would look to make them rather more robust - although this comment was drawn more from experience elsewhere and not meant to indicate that there had been major problems with the Ledbury scheme. Certainly, the world has moved on in the last six years and commissioning/contractual processes are now better understood and capable of greater sophistication. The context for such initiatives has also changed with the greater focus on communities and real joint commissioning between health and local authorities.

National policy changes and directives have also at times raised issues about relative responsibilities and it was suggested that it might be wise, for those contemplating similar arrangements, for contracts to include specific clauses about dealing with change.

In the last year or so, both the PCT and Shaw have had a complete change of structure and personnel and a lot of corporate knowledge has been lost – the new teams are finding that they need to work through many of the *softer* and *unstated* elements of the arrangements again.

One of the lessons or areas of advice for others contemplating similar arrangements is around the essential importance of having good relations and understanding and of being prepared to work at these. The importance of trust and of balancing the big picture of maintaining an effective and productive relationship against the small picture of an immediate win – and of understanding what the impact of a particular decision might be for the other organisation - was emphasised. Understanding and being realistic about each other's timescales and pressures was also identified as an essential component of an effective relationship. Similarly, regular formal and informal discussions and the importance of recognising that this is a routine business and contractual process – *without it being personal* – were seen as key. The involvement of both the PCT and the GP practice in the appointment of the new ITC manager was quoted as an example of real partnership working geared to promoting a sense of common purpose within the Centre.

To date, the regular contract monitoring discussions between the PCT and Shaw have actually been conducted on the PCT side by the Directorate Manager of Adults and Older People's Services – a provider rather than a commissioner. This reflected the historic unity of provider and commissioner within PCTs but, although it was not reported as having been an issue in practice, it is recognised that this is no longer appropriate. This practice will change as the PCT moves with Social Services commissioners into a new public services trust separating commissioning out from its internal providers, It is intended that the latter will reform as a social enterprise model. This may raise questions about the nature of their relationship with Shaw – will they be partners or business competitors?

In addition to the contract monitoring and liaison meetings mentioned above, there are also regular liaison meetings involving Centre management, the PCT and the GP practice. These are more concerned with day to day operations and relationships and are reported as effective and productive. These stopped in early 2007 when the last General Manager moved on but are currently being reinstated. The ICU manager routinely attends the PCT modern matrons meeting in Hereford. This is at the PCT's invitation and recognises that she experiences the same issues as her peers within the Health Service. It is also a testament to the reality of the partnership between Shaw/the Centre and the PCT.

The PCT is pleased with the scheme and feels that it has a responsive private partner who listens and does respond to issues. Overall, outcomes for the PCT were described as good, specific points being that the arrangement/facility has:-

- ~ met the PCT's main commissioning objectives - reproviding the cottage hospital beds and services, expanding the care market, reproviding the GP premises. It was suggested, though with hindsight, that a much larger scheme might have been desirable
- ~ worked well
- ~ provided new and modern services
- ~ proved reasonably cost effective
- ~ provided a model of integration that fits with best value drivers
- ~ demonstrated good public/private partnering
- ~ created partnerships where they would not otherwise have existed
- ~ created opportunities that would not have occurred without the existence of the Centre
- ~ helped the development of lateral thinking across care pathways
- ~ proved to be a well used facility that is popular with the local community
- ~ attracts few complaints.

## COMMISSION FOR SOCIAL CARE INSPECTION

The three residential units were separately registered. The relationship with CSCI was described in positive terms – *we can bounce ideas and concerns off them*. Not surprisingly, with such a new model, it had presented some challenges in regulatory terms, specifically in relation to the ICU and the ABI Unit.

Examination of the most recent inspection reports indicates a reasonable level of satisfaction currently with the ABI Unit receiving a particularly positive assessment. However, it is clear that the ICU does not fit comfortably within the CSCI regime:-

*This service is unlike most registered care homes.... This is an issue that makes working within its registration conditions and meeting some of the National Minimum Standards a challenge for the service. The Commission will be contacting the service provider to have discussions about the status of the service for regulatory purposes...*

*...Ledbury ICU is currently providing a broader range of services than the service was registered to provide. This is because some people are too unwell to receive care aimed at rehabilitation and in some cases are in need of end of life care..... it is clear that many professionals and members of the public think of the service as being a 'cottage hospital'..... This view is perhaps partly created by the layout and furnishings which do create an impression of a hospital rather than a care home. The admission policy that the service operates under is the Herefordshire Primary Care Trust operational policy for admissions to community hospital bed.*

The same issue was identified from the other perspective expressed in terms of the registration requirement's ability to restrict the range of care in terms both of length of stay and type of care/medical condition that the ICU can provide, resulting in admissions to the acute hospital in Hereford or to a hospice of people who could be adequately and more happily cared for near their home and family at the Centre.

The message from this is to take time to explore and understand at the outset any potential restrictions that registration may bring. This involves clarity at a level of some detail about exactly what services it is intended to provide.

## RELATIONSHIP WITH THE COMMUNITY

As indicated earlier, initial relationships with the community of Ledbury and the surrounding area were difficult with considerable public opposition to the plan to develop the Centre (in part) as a replacement for the well established cottage hospital. At the same time, again as noted earlier, there were also enthusiastic and influential advocates for the development, such as the long standing Ledbury

Hospital Action Group, the Town Council and the GP Practice's (then) senior partner.

Disquiet about the scheme was reportedly driven by a range of factors as initial opposition to the principle gave way to concern about the detail:-

- ~ the perception that it involved a highly valued NHS provision being replaced by a private facility and that that meant that *the taxpayer (was) funding the private sector* – this had not been anticipated given Shaw's non-profit making status.
- ~ the attachment that many people felt for the cottage hospital building – which had been donated to the town and had a lot of meaning for residents
- ~ the loss of the cattle market – while, as observed earlier, this probably had more to do with the symbolism than the reality, it was a significant and emotional issue for local people
- ~ concern about what would happen to existing NHS staff and also that it would prove impossible to attract the necessary staff to work in this location – which would turn the scheme into a white elephant
- ~ objections to the design.

The defusing of local concern involved considerable effort by local managers who were eventually successful in shifting the focus of public debate to issues around patients and good care. Another significant factor was the creation of an Advisory Group, still in existence, made up of key community representatives who monitored and supported the development process and subsequently the operation and management of the Centre. People moved from opposition and uncertainty to acceptance and support – although it was noted that people do still think nostalgically of the old cottage hospital.

The Centre management has worked hard to build a positive relationship with the community, focussing on getting the service right, on establishing a reputation for good care, and on ensuring that the Centre participates in local events and initiatives and supports the local economy by using local suppliers and trades people. Today, the Centre is reportedly a valued part of Ledbury life with the local community fund raising for specific projects to enhance facilities and volunteers working within the hospital. The care home in particular is actively supported by Ledbury Mother's Union who visit and spend time with people living there.

The general view is that the way in which the partners involved and consulted with the community would be very different today. With hindsight, it is suggested that insufficient time was taken to find out what the local concerns were and to addressing these directly. Combating the initial perceptions of Shaw as a private provider threatening the NHS and the resentment about the proposed site required a huge amount of energy throughout the development period and into

the early days of operation. There is a lesson here for others contemplating similar changes.

Another factor that apparently had a major impact in terms of gaining community acceptance/support was the fact that because the ICU had to be registered with CSCI it could not be called a *hospital*. So people thought that their local hospital was being removed by a sleight of hand:-

*This had a major impact for local residents....it nearly undermined the whole thing*

This eventually resolved itself as far as the local community are concerned – they continue to call it *the hospital*. However, as noted elsewhere, the community's solution is something of an issue for CSCI.

## **ADDITIONAL COMMUNITY BENEFITS**

A further and associated benefit to the Ledbury community has come with the recently started redevelopment of the old Cottage Hospital site. This is the first NHS site to be developed in the West Midlands under English Partnerships' Hospital Sites Programme and is another example of public-private sector partnership involving, as with the Community Health and Care Centre, complex partnership working between a range of organisations:-

- ~ the Ledbury and Area Development Trust - an independent non-profit making organisation established by the Market Towns Initiative Programme and concerned to promote and support regeneration in and around Ledbury
- ~ English Partnerships
- ~ Advantage West Midlands
- ~ a registered social landlord - Two Rivers Housing
- ~ the local Council.

This £1 million development will convert the site into six affordable, shared equity apartments and 160 square metres of commercial *start-up* workspace (to be managed by the Development Trust) targeted at local, young entrepreneurs working in the creative industries. The work/live opportunities can be taken up separately or together. The property will be owned by Two Rivers Housing who are carrying out the development and will manage the housing element (obviously selling on a share of the equity in the flats). Local businesses are being asked to support the initiative by, for instance, subsidising the first year's rent on a workspace or becoming the *named sponsor* of an office or workspace.

There is a shortage of both work space for small businesses and affordable housing in Ledbury and the surrounding area. It is anticipated that this development will partly address these issues, contributing to both economic and social regeneration – and using the site to benefit the local community as

intended by its original Nineteenth Century benefactor. Like the Community Health and Care Centre, this development demonstrates what can be achieved in partnership and thinking outside the box - for instance, through the contribution RSLs can make to community regeneration over and above the straight forward provision of social housing.

## **OTHER LESSONS – POSITIVES AND NEGATIVES**

### **Location of Services**

We were told that, with hindsight and experience, some services might have been better located within the building but this was not identified as a major issue overall. The biggest issue has been with Minor Injuries which, contrary to PCT preference and the original plans, ended up at some distance from ICU.

For people developing similar schemes, the advice would be to look at existing schemes and talk to their staff, managers and service commissioners. (This was not much of an option for Shaw as there was little around in the way of existing models at the time the Centre was planned and developed.)

### **Staff Issues**

There has perhaps been less in the way of integrated teams than was originally envisaged. It is felt that in practice the crossover of skills and expertise between the different units is not sufficient to make an integrated team appropriate. So, staff are contracted to specific units. For a time managers reportedly felt that their particular units needed such specialist skills that it was more appropriate to look to agencies rather than other Centre staff to cover staff shortages. In recent years, this has changed and a *Bank* for the Centre now works quite effectively. This is advantageous both to staff who are often appreciative of the opportunity to boost income and to the finances of the Centre.

The transfer of cottage hospital staff to Shaw did not quite result in the long term stability and seamless transition that had been anticipated although it was undoubtedly of assistance in facilitating the initial establishment of the scheme. In practice, most of the original nursing staff left over the first year or so. Interviewees were clear that the ethos and culture of working within Shaw is different from the NHS and it may well be that this was influential in decisions to move on. Impressionistically, this is not an unusual event following transfers of this sort. Shaw certainly appear to have kept to the spirit of accepting existing terms and conditions – implementing the Agenda for Change uplifts even though not obliged to do so.

## **Clinical policies**

Early and close working was needed in relation to clinical policies as it was important that Shaw worked in a way that was integrated with the rest of the health economy – for example, over medicines management or discharge protocols. There was considerable scope here for lack of clarity and confusion and it needed close management and cooperation. It would be easy to underestimate this and the message to others would be to be prepared for the time and effort needed by this and to be clear that it is needed at the earliest stage.

## **FURTHER DEVELOPMENT**

Both the PCT and Shaw consider the Centre a success story and have indicated an ongoing interest in any possibilities for further development linked to the Centre. (A new mixed tenure 52 unit Extra Care facility opened by Shaw in Ledbury, which is in effect a replacement for a Social Services care home, is managed as a separate service and has no link to the Centre.) However, apart from the possible use of the space vacated by the café being taken up by another clinical service, this is not something that is likely to happen in the immediate future.

## APPENDIX

# BUILDING LAYOUT

In terms of physical space, the centre overall is 4000 square metres.  
This divides up as follows:-

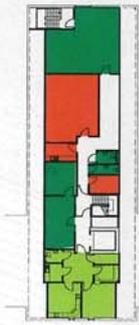
Residential beds/units	2000 square metres
ITU	
The Ledbury Home	
Acquired Brain Injury Unit	
GP Practice	450 square metres
Outpatients Facility	650 square metres
Physiotherapy suite	
Minor Operations	
Treatment rooms	
Consulting and examination rooms	
Radiology unit	
Chiropody rooms	
Occupational therapy suite	
Other leased areas	300 square metres
Dental Access service	
Social Services offices	
Originally designated pharmacy area	
Circulation and support facilities	600 square metres
Kitchen	
Corridors	
Lifts	
Reception areas	
Staff rooms	
Conference room	
Laundry	

The layout can be seen in the following floor plans.

# Location of Services and Floor Plans

## Layout of Services

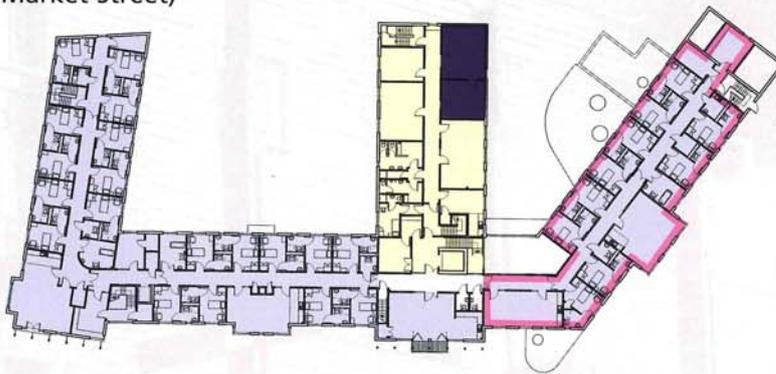
**Second Floor**  
(above Market Street)



## Colour Code

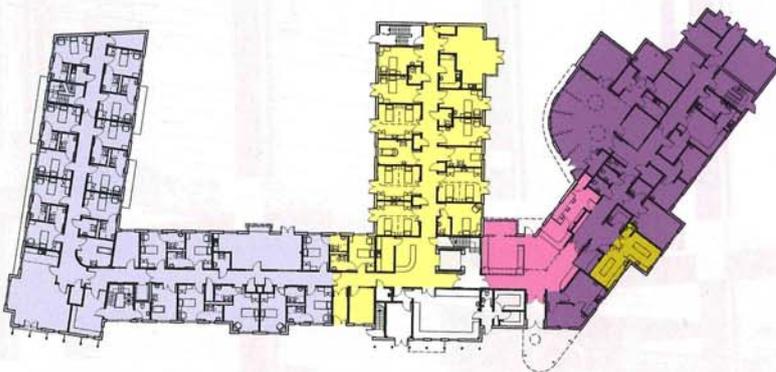
- NHS Dental Access Service ■
- Tots to Teens ■
- Conference Facilities ■

**First Floor**  
(above Market Street)



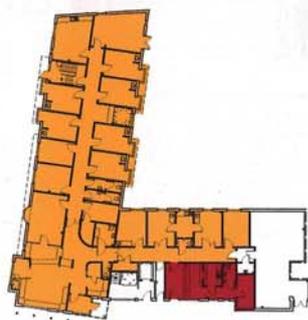
- Nursing Home ■
- Acquired Brain Injury ■
- Social Services Locality Team ■
- Laundry Rooms ■

**Ground Floor**  
(Market Street)



- Reception ■
- Outpatients & Physiotherapy ■
- NHS Intermediate Care Unit ■
- Nursing Home ■
- Minor Injury Service ■

**Lower Ground Floor**  
(Bye Street)



- GP Surgery ■
- Pharmacy ■

Other Housing LIN publications available in this format:

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Case Study no.5: **Village People: A Mixed Tenure Retirement Community (Bristol)**  
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Case Study no.34: **Mini-Cost Model of Housing with Care Project**

The Housing LIN welcomes contributions on a range of issues pertinent to Extra Care housing. If there is a subject that you feel should be addressed, please contact us.

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