Community hospitals under threat: Are decisions being taken on scrappy information and limited understanding?

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Work on the Sustainability and Transformation Plan (STP) for health and social care in Cornwall and the Isles of Scilly, now rebranded as Shaping Our Future (SOF), has reached a critical stage. We risk being gulled into earnest round-table discussions under the guise of 'engagement' while an organizational bulldozer lightly camouflaged with poor quality information lumbers towards us. Community hospitals are under threat and it appears that decisions may be being taken on scrappy information and limited understanding.

This report examines recent developments and draws some pessimistic conclusions, but goes on to suggest a more positive way forward.

Recent development (1): Local area workshops have been held.

In July 2017 half-a-dozen 'local area workshops' were held across Cornwall. They brought together people from three groups: people who work in the health and social care services, people who work for voluntary bodies (the 'third sector') in delivering those services, and people who have recently received support from these services, or their full-time carers.

The stated aim of these three-hour events was 'to ensure that any changes to the health and social care system achieve our aims of improving the health and wellbeing of our local population by improving the quality of local health and care services in ways that are financially sustainable', and the idea was that the three groups of participants would work together, setting aside organizational roles, 'to help produce detailed options for what local people can do themselves, for local community support, and for local services'. The term 'co-production' is sometimes used as shorthand for working-together endeavours of this kind.

So patients and carers have sat round a table with service providers and members of voluntary organizations, and (as I have witnessed) some worthwhile exchanges have taken place. At the time of writing this, we wait to see what written records emerge from these exchanges and how frankly they reflect them. And, importantly, what can be built on them.

Recent development (2): Information packs of very poor quality have been handed out.

At each local area workshop, an information pack was handed out. It included a section on 'The case for change', and here we find four snippets of quantitative data on hospital services (p.5):

(1) 'Around 60 people each day are staying in acute hospital beds in Cornwall and they don't need to be there.'

> Comment This statement could be extremely misleading, because it does not necessarily follow that people who no longer need acute treatment are fit to go home, although this seems to be the conclusion we are intended to draw. It may be that many of these people are awaiting transfer to a community hospital. Evidently the Royal Cornwall Hospitals Trust does not collect data on the fitness of patients for a particular destination. It exists within its own 'silo', not looking beyond its own boundaries, so we are given this number out of context. Also we aren't told what date or period the figure of 60 people refers to: it is a snapshot taken at an unspecified time.

(2) '35% of community hospital bed days are being used by people who are fit to leave.'

> Comment Similarly, we are not told what destinations the people in community hospital beds who are judged 'fit to leave' are fit to go to, or on what date or over which period this percentage figure was gathered.

(3) '83% of admissions to community hospitals are from acute services compared to 42% nationally.'

>Comment While this statement does recognise the connection between acute and community hospitals, and it does provide a national comparison (though we aren't told whether 'national' denotes England, Great Britain or the UK), we could draw quite different inferences from it.

>We could infer that community hospitals are coming under greater pressure in Cornwall than elsewhere to take patients who have been discharged following acute treatment, and conclude from this that Cornwall needs more community hospital beds or more provision in care homes and/or people's own homes.

>Or we could infer that among the 'national' population there is a need for care that is different from 'step-down' (rehabilitation) from acute treatment, and that in other parts of the country this need is being met by community hospitals, whereas in Cornwall the community hospitals are close to being monopolized by patients moving out of the acute hospital at Treliske. Maybe part of the pressure that we know is experienced by the Emergency Department at Treliske comes from patients who, elsewhere, would be admitted directly into a community hospital. Again, we could conclude that Cornwall needs more community hospital beds.

(4) '62% of hospital bed days are occupied by people over 65 years old.

>Comment It is impossible to draw any sensible conclusion at all from this piece of information. We are given nothing to compare it with. We aren't told whether this figure applies to Cornwall and the Isles of Scilly only or to a larger area, and when, or whether the proportion has increased over recent years. 65 years was formerly the state pension age in the UK for men. For women the state pension age was formerly 60. At present those ages are in the process of being both raised and equalized, so the very benchmark of 65 years seems entirely arbitrary.

As we see, the information presented in the information pack to justify reorganizing our hospitals – a mere four statistics – is of extremely poor quality. It is scanty and arbitrary. It is silo-dominated, and indeed it could be taken to imply that managers do not care where discharged patients go so long as they vacate their beds. The fact that acute hospitals count numbers of patients while community hospitals count percentages (another silo effect) makes it very difficult to compare the stress that they are under.

Moreover, the information presented is in the form of snapshots. These represent situations at particular points in time or over particular periods. We are not told at what particular points in time, or over what particular periods, the data were collected. This is not good professional practice. And such truncated information ignores dynamics, how situations change over time, and – importantly – it largely ignores processes that link organizations together, such as the movements of patients through the health and social care system. Failing to state the sources of data or the relevant dates or periods it applies to is an unprofessional way of managing and presenting information.

To sum up: As a basis for taking decisions, information of this calibre is not fit for purpose and is likely to pull wool over the eyes of people who don't have specialized knowledge.
It is not the demonstrated outcome of careful research, and no serious reasoning from it is presented. So we may conclude that it is offered to support a case, to sell a message, the message seemingly being that Cornwall is over-supplied with community hospital beds and consequently some community hospitals should be closed.

Recent development (3): The Transformation Board say they support the co-production approach, but they are not taking responsibility for ensuring it is put into practice.

At the head of the Shaping Our Future (SOF) operation is the Transformation Board, which has 20-plus members, mainly appointed as representatives of various organizations. The key members are Kate Kennally (Chief Executive, Cornwall Council), who is in the chair; Kathy Byrne (Chief Executive, Royal Cornwall Hospitals NHS Trust); Phil Confue (Chief Executive, Cornwall Partnership Foundation NHS Trust); and Jackie Pendleton (Interim Chief Officer, Kernow Clinical Commissioning Group).

Until recently the Transformation Board met every month, but as from May 2017 it will meet only every two months. The papers that are presented to the Board are not published, and nor are the minutes of its meetings until they have been approved by the following meeting, so it can be the best part of four months before the public gets to know what was on the agenda and what was agreed. (The latest minutes currently available are those of the May 2017 meeting.) It appears, then, that the four leading members will have considerable autonomy.

At the May 2017 meeting of the Transformation Board it was reported, under the heading of 'Communications and engagement strategy: co-production plan', that 'senior communication and engagement support had been secured … with a view to them taking over the strategic lead for this work'. This refers to the secondment to SOF of the current NHS Regional Head of Stakeholder Engagement and the Regional Head of Communications and Engagement Specialist Projects. The minutes also record that '[there] was full support from Transformation Board members for the co-production approach'. And Jackie Pendleton of KCCG is recorded as saying: 'It is important to be able to give answers to questions raised in the first phase of events to show the public that we have listened and we will continue to listen.'

While we might take encouragement from this, other items recorded in the minutes of the May meeting are worrying. We learn that the leading Board members want to be a 'first wave Accountable Care System' and have put in an application to NHS England to that effect. And we learn that it was proposed to establish two 'delivery groups' ('Model of Care' and 'System Reform'), and that the 'Programme Board' was to be renamed the 'Portfolio Board', 'to reflect the scale and scope of work'. No mention is made of publishing the minutes of these bodies. In a nutshell, *this is all about fashioning the organizational bulldozer.*

What recent developments tell us

1. Experience of the *local area workshops* tells us that it is possible to bring together round a table people who work in the health and social care services, people who work in the voluntary sector and people on the receiving end of services. Particularly noticeable is the part played by *stories* – accounts of personal experiences – in their conversations.

2. The quality of the *information packs* on the subject of how the system works is so abysmally poor, although lavishly illustrated, that it could be taken to indicate either incompetence, i.e. a lack of appreciation of what data are significant and why, or, more sinisterly, an attempt to coerce the reader into conceding without quibble that a case has been made for change. A third possible explanation for these poor quality scraps of information on hospital services presented to the public in the information pack may simply be that they were deemed good enough for us. If that was so, it indicates an attitude of condescension, if not contempt, towards the public. This can only breed suspicion and contempt in return: not a healthy state of affairs for our society and no basis for genuine co-production.

3. At *Transformation Board* level there is no shortage of expressions of goodwill towards public engagement and co-production. But it may be that in some quarters this is seen as a useful manipulative tool, a means of 'selling the message' and 'nobbling' influential lay people so they

won't be obstructive when proposals are published. Tellingly, among the proposals for reorganizing the SOF enterprise *there is no mention of a co-production delivery group*. And the two engagement specialists who have been brought in from regional level have been given the absolute bare minimum of support staff. Judged on these criteria, within the SOF set-up engagement and co-production have a very low priority indeed.

The way forward

1. The *local area workshops* have shown that when people talk about their experiences of health and social care services they are invariably telling a story. One of the great values of stories, along with their authenticity (the fact that they represent genuine experiences as recounted by the people who experienced them) is that they are *dynamic*. Unlike the information presented as snapshots in the information pack, they tell us what took place over a period of time and how the different parts of the system interacted with one another. It follows that those in charge of 'engagement' have the task of finding a way of taking these stories and using them, drawing lessons that can be fed into the planning process.

There is an unfortunate tendency among academically-schooled planners, in all disciplines, to disparage the worth of individual stories. If they are acknowledged at all, they are placed in a category labelled 'anecdotal evidence', a rank some levels below statistical evidence. (Some will recognise this as a variant of Gresham's law: 'Quantitative evidence drives out qualitative.')

This was vividly illustrated in the information pack, where the reader was presented with a jumbled mass of data, collated and summarized in the form of figures and charts, and presumably expected to draw conclusions from it, or to accept the conclusions that other people have drawn.

There is no obvious, meaningful way in which individuals' stories about their experiences can be integrated into the kind of 'framework' presented in the information pack.

Here is a little true story that illustrates that point. A 95-year-old Penzance woman living in her own home fell and broke her hip (fractured neck of femur). An ambulance took her to Treliske, where they mended her hip very efficiently, but she was left with some damage to the skin of her leg, so she was not fit to go home. She needed to go to a community hospital for rehabilitation. A bed became available for her in Edward Hain community hospital, but only after several days, during which she was kept in the noisy and disorientating Trauma Ward, where she visibly deteriorated. After a week in Edward Hain, however, which provided the necessary therapy in a calm atmosphere, she was able to return home and continue her recovery in the care of her daughter, district nurses and carers.

What this story does, like many others, is to draw our attention not only to this one 'statistic' but also to patients' 'trajectories' through the hospital and social care system. These trajectories reveal with perfect clarity the interactions that linked the parts of the system: acute hospital, community hospital and home in this case.

Here, then, is a role for the public, to contribute the stories that transcend organizational boundaries and give an insight into the interactions at work (or that fail to work) and the obstacles that hinder effective interactions.

And the corresponding role for those in charge of 'engagement' must be to find ways of searching out these stories, of acknowledging their validity, and – in feeding them into the planning process – of drawing out and responding to the lessons to be gained from them. This is the role that future local area workshops should play. And the people in charge of this stage must be given the human resources that they need to enable them to perform this role.

2. The *information pack*, as we have seen, provided numerical information about hospital services that was scanty, arbitrarily selected, silo-dominated, and in the form of snapshots, and its presentation did not meet professional standards. If this is all that is available to the planners, they will be forced to work on the basis of 'design principles', 'models' and other such general abstractions, and any attempts on their part to foster public engagement will be – and will be seen to be – a waste of time and effort. If this very poor presentation denotes an attitude of condescension towards the public, again, attempts to foster public engagement will come to nothing.

In either case, the planners need to be challenged to demonstrate their professional competence by researching and presenting a much sounder – properly investigated and more complete – information base, one that both takes a view of the system as a whole and covers patients' encounters with and trajectories through the health and social care system. They need to know *why*, for example, 83% of admissions to community hospitals are from acute services compared to 42% nationally. This information needs to be set alongside, checked against and integrated with information from patients' stories.

We don't know who the planners are. Are they KCCG staff? People hired on short-term contracts to work on SOF? Or are they employees of the American firm of consultants, GE Healthcare Finnamore who are also working on SOF? The information pack contains no information about who wrote it, who supplied the information in it, who supervised it, or who authorized it for publication. It would be reassuring if these people were prepared to be publicly accountable for what they do. It is to be hoped that they will respond to this challenge, whoever they are, because it is seriously against the public interest for far-reaching plans, policies and public expenditure to be based on the pathetically flimsy foundation that we have seen so far.

3. Within the *Transformation Board*, some transformation needs to take place. Halving the number of meetings, holding meetings in private, not publishing the agenda in advance and the minutes for several months after the meeting: these are characteristics of a body that is uncomfortable with transparency and shuns the light. It and the people working for it seem to be more concerned with securing power, autonomy and status than with doing a good job for the public they ostensibly serve. For starters, let us have more transparency and let us have a co-production delivery group.

Peter Levin

Appendix: Bed occupancy in community hospitals

Here is a table drawn from data supplied two years ago by Peninsula Community Health (PCH), which formerly administered community hospitals in Cornwall: it shows that in May 2015 all of the community hospitals in Cornwall were running at an average bed occupancy rate of 90% or more, with several registering more than 95% and in one case a staggering 99.4%.

The position was clearly very tight in 2015, and presumably it still is. On average, in only five of the 17 community hospitals in Cornwall itself was it likely that a bed could be found on a randomly-picked night for an emergency case (see Column G). Strikingly, in 2017 there was no information whatever in the information pack on bed usage and availability in community hospitals. Is that information no longer collected? Or is it collected but someone consciously choose not to include it in the presentation? Certainly, the bed occupancy figures in the table provide a prima facie case for more community hospital beds in Cornwall, not fewer.

The information presented in this table is informative but it is not a sufficient basis for understanding how the system works, because it is silo-dominated. No doubt PCH managers could pride themselves on making extremely efficient use of their resources two years ago, but what were the consequences for the managers at Treliske? They can have had no day-to-day control whatever over resources on which they crucially depended. The two sets of managers were working in separate compartments – silos – from one another.

Occupancy of Community Hospital Beds in Cornwall, May 2015

A	B	C	D*	E	F	G
Hospital ward	May 2015 average occupancy (%)	Beds (as at June 22nd)	Bed nights available in May [C x 31]	Bed nights taken up in May [B x D]	Bed nights not taken up in May [D - E]	On average, one or more beds available every night
Bodmin Anchor	94.1	12	372	350	22	No
Bodmin Harbour	92.8	23	713	662	51	Yes
Bodmin Woodfield (stroke)	98.2	9	279	274	5	No
CRCH Lamorna (Camborne-Redruth)	99.0	23	713	706	7	No
CRCH Lanyon (stroke) (Camborne-Redruth)	99.4	21	651	647	4	No
Edward Hain (St Ives)	92.7	11	341	316	25	No
Falmouth	97.3	24	744	724	20	No
Fowey	90.6	10	310	281	29	No
Helston	98.0	24	744	729	15	No
Launceston	93.3	19	589	550	39	Yes
Liskeard Oak	94.2	25	775	730	45	Yes
Liskeard Willow	94.5	19	589	557	32	Yes
Newquay	95.8	19	589	564	25	No
SACH Harold White (St Austell)	95.6	22	682	652	30	No
SACH Heligan (St Austell)	95.7	22	682	653	29	No
Stratton	90.6	13	403	365	38	Yes
St Barnabas (Saltash)	90.3	9	279	252	27	No
St Mary's, IoS	23.5	10	310	73	237	Yes

*For Column D it is assumed that the June 2015 figure for the number of beds was applicable throughout May.

Note 1 The above table contains no information on turned-away patients. It appears that figures on these were not kept.

Note 2 In May 2015 the number of community hospital beds in Cornwall (excluding the Isles of Scilly) was 305. Of these, only 11, at Edward Hain Hospital, were located in Penwith. There is clearly some geographical imbalance here, especially as Edward Hain is not now in use. These are supposed to be *community* hospitals.