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Cornwall's new Integrated Care System: what we are hoping for

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The go-ahead has been given for setting up an 'integrated care system' for Cornwall. This will absorb NHS Kernow, Cornwall's Clinical Commissioning Group, which currently commissions health services from hospital trusts and other organizations. We wait to see whether Cornwall Council, which currently has statutory responsibility for social care and which commissions (in effect, rents) places in privately-owned care homes and nursing homes, for elderly people in particular, will lose this duty to the new system. We also wait to see whether the two hospital trusts in the county will be combined or stay separate, and whether GP surgeries will be drawn more into the NHS mainstream. In particular, we wait to see how well equipped the new system will be to identify and respond to the needs of the people who live here.

While we are waiting, we have been reviewing the present situation.[1] This exercise has helped us to clarify what we are hoping for.

1. NHS Kernow has closed down the two community hospitals in Penwith, depriving the area of the 22 NHS-provided 'step-down' beds that they previously offered. For many patients discharged from Cornwall's main acute hospital at Treliske who were not yet able to return home, this has resulted in their being sent, without being consulted, to community hospitals and private care homes at the eastern end of the county, up to 70 miles from where they lived. After the onset of Covid-19, NHS Kernow's governing body was told, patient choice had been 'set aside'. In February 2021 a Cornwall GP reported encountering patients who had been discharged to a care home as a short-term measure but were still there 10 to 12 months later.[2]
NHS Kernow and Cornwall Council appear not to collect data in any systematic way on patients who are discharged to care homes, so it is unable to formulate a policy to help them. This is a failing that the new integrated care system must remedy. It must work to return patients to their home community as early as possible.

2. The G7 summit at Carbis Bay made matters worse for Cornwall's hospitals, but the problems were concealed. It has been reported that in preparation for the summit, 78 beds had to be freed up at Treliske. This was achieved by putting even more pressure on care homes to take patients from the acute hospital. NHS Kernow said all patients discharged by this route were 'medically fit for discharge'.[3] But, but, but ... (1) Why

hadn't those patients already been discharged? (2) Weren't some of those discharged being kept in for a good reason, e.g. for observation, and was nothing lost by discharging them without continuing to observe them? (3) What arrangements were there to monitor the readmission of patients who have been discharged? Instead of addressing such issues frankly and honestly, NHS Kernow made policy on the hoof and were not open with the public about it.

The new integrated care system must be open about the pressures on it and discuss in meetings open to the public how to respond to those pressures.

3. NHS Kernow and Cornwall Council have been naïve in accepting assurances from private sector providers. In December 2020 NHS Kernow's governing body took a decision to finally close the Edward Hain community hospital in St Ives. One factor in this decision was an assurance from Cornwallis Care Ltd that 28 'reablement beds' at a new care home in Penzance would become available in mid-January 2021.**[4]** By mid-June 2021, no new beds had materialized, and completion of the new care home appeared to be still some way off.

But NHS Kernow has done nothing to review the decision or even hasten the process, saying only that this was a matter for Cornwall Council, the body commissioning the beds. The Council is certainly demonstrating no urgency: it is simply waiting to be notified that the beds are ready. And neither it nor NHS Kernow has documented any stipulation that the beds should be in a setting that has reablement facilities (see Point 4 below).

The new integrated care system must adopt a business-like approach to ensuring that assurances it is given by providers are actually fulfilled and that timetables are kept to.

4. NHS Kernow has been so keen to replace beds in NHS community hospitals with beds in private care homes that it has failed to notice that reablement facilities are lost by closing those hospitals. All it has taken is for a private provider to label promised beds as 'reablement beds' for NHS Kernow to be satisfied. But the term is a misnomer: a bed does not provide reablement: it provides only a place to sleep. It is the setting that is important. Community hospitals such as those in Devon provide a setting with not only inpatient beds and specialist outpatient clinics, but also on-site staff such as physiotherapists and occupational therapists and rehabilitation facilities such as a gymnasium.**[5]** We know of no private care home in Cornwall that does this (although there is a move in this direction: see Point 6 below).

NHS Kernow's single-minded focus on beds has resulted in a narrow and unimaginative approach to step-down care.

5. Unlike a private care home or nursing home, where there is an incentive to maximize profit from the space available, an NHS-owned community hospital would be able to justify providing a 'social space' for treatment. The value of such a space has been impressively demonstrated locally by an initiative in West Cornwall, where community nurses employed by the Cornwall Partnership Foundation Trust set up the Centipede Club, a community hub for older people with leg ulcers.[6]

How does this work? After an initial assessment, patients referred to the leg ulcer service are invited to attend weekly group meetings in a relaxed café-style setting in a community location. No appointments are required. Patients are treated while they sit together, with a separate room for those wishing to be seen privately. People continue to be seen even when their legs are healed. Tissue viability specialist nurses attend the group, updating the knowledge and skills of all the staff involved and the therapy services on offer. Patients have testified to the relaxed and friendly nature of the group meetings, compared with more formal clinical encounters. Staff say they love working at the group and are more confident in the work they do.

The Club clearly makes a highly effective use of staff time, not least by eliminating the time taken for nurses to drive between appointments at the homes of individual patients. It operates as an unofficial professional development organization too.
Importantly, the Centipede Club provides three valuable lessons: (1) that reablement can usefully be thought of as a social process, not just an individual one; (2) that valuable innovations can come from allowing experienced people who work directly with patients to produce ideas and act on them ; and (3) that such a social facility enables patients to span the transition from hospital to home: whoever conceived it was demonstrating joined-up thinking: precisely what integrated care calls for.

6. The Embrace Care project in Cornwall has also demonstrated joined-up thinking by placing hospital trust employees in care homes. Places in three care homes have been commissioned for people who are ready to be discharged from a hospital but need support to get back home.[7] To enable patients to make those hospital-to-home transitions, therapists from Cornwall Partnership NHS Foundation Trust have begun practising in those care homes, a rare example of integrating NHS hospital care with a private care home environment. The therapists' role is to work closely with hospital colleagues to get people back to independence quickly after a stay in hospital.
We wait to see whether this innovation will be extended. Three care homes are a start, but there are altogether around 220 care homes in Cornwall. One extension of the scheme could be for acute hospitals (Treliske and its satellites) to be allocated places in care homes for patients who, although they are technically medically fit for

discharge, would ideally be kept under observation. That would be a further and practical step towards implementing the principle of integration. Unifying Cornwall's two hospital trusts should make this easier to do (see Point 12 below).

7. NHS Kernow has failed to pay attention to the impact on end-of-life care of closing community hospitals. We know from bitter experience that when local hospices are full, in the absence of a nurse-led community hospital a private nursing home will be pressed into providing end-of-life care. Because it is run for profit, to save money such a nursing home is liable to be understaffed at night and not provided with all the equipment needed to make a dying patient comfortable. NHS Kernow appears to have no way of knowing about this state of affairs.

The new integrated care system must keep a close eye on people nearing their end of life and ensure that if they are placed in a care home their treatment is not inferior to that received by patients in hospices and community hospitals.

8. Earwax: an urgent issue for the NHS or one to be kicked into the long grass? In the past people in Cornwall whose ears have become blocked with earwax have always been able to go to their GP surgery for the necessary treatment, known as 'syringing' (a procedure superseded in recent years by 'irrigation, which is safer). They are now discovering that this service has been withdrawn. Understandably the earwax issue, which was first raised about two years ago, has not been uppermost for doctors during the Covid-19 pandemic, but more recently GP surgeries refusing the service have been saying that earwax treatment had 'never been in the GP contract'. Some patients have had to travel across the county and pay privately for treatment; some have been going without. Very few GP surgeries now offer this procedure, so an intervention that is essential to accurate diagnosis of ear conditions, or prior to primary treatment or fitting NHS hearing aids, is no longer universally available.**[8]**

Losing your hearing is highly distressing and seriously inhibits your ability to participate in society. (The former chairman of NHS Kernow claimed that an aim underlying all its policies is to provide reablement, but doing nothing about people's hearing loss is a policy that amounts to *dis*abling them.) What we might reasonably expect is that NHS Kernow and its successor take the trouble to assess the need for earwax treatment, to count the number of people in need of it. The latest news we have is that they will be reviewing services to identify unmet need, and will report back in six months' time, meanwhile stressing that to make services more widely available would impose heavy demands on a limited workforce and a finite budget: language that suggests that measuring the need for this service is regarded as more trouble than it's worth.

The new integrated care system must be alert to the needs that people express by simply asking for them at doctors' surgeries. It must measure these needs and be prepared to respond to them.

9. NHS Kernow has demonstrated an inability to think critically, analytically and imaginatively. It has cherry-picked evidence that supports what it is already committed to doing and ignored data that is inconvenient;[9] it has made fundamental errors in analysing data that it has obtained;[10] it persists in justifying its decisions by citing endorsements rather than evidence;[11][12] and it consistently fails to read between the lines of policy documents from central government and examine their implications. One consequence of this is that account is not being taken of Cornwall's very high proportion of residents aged over 65 or the significant proportion of older people living with frailty.[13] These failings rather suggest that NHS Kernow's impending demise is to be welcomed.

The new integrated care system must incorporate a team of social researchers, policy analysts and out-of-the-box thinkers who are able to identify up-and-coming issues and brief decision-makers on their implications and ways of tackling them.

10. Cornwall Council's Health and Adult Social Care Overview and Scrutiny Committee does not have the means to exercise its functions effectively. The Committee's terms of reference spell out what it is supposed to do:

> The Committee's main function is to provide effective critical friend challenge and policy development as part of the decision making process to improve outcomes for the residents of Cornwall.[14]

The problem is that the Committee has no access to the Council's decision-making processes, to the mechanisms of policy development. It receives updates and other reports – often very lengthy – that emerge at the end of these processes, but there is no role for members in the processes themselves. Identifying issues, exploring and evaluating alternatives, weighing pros and cons: these activities are kept to officers only.

Policy-making processes within the new integrated care system must conform to the principle of transparency. From start to finish they must at least be open to viewing by councillors and – ideally – by the public and patient groups, who should have opportunities to put questions and make suggestions.

11. Cornwall Council is supposed to have a care homes strategy. Where is it? A year and a half ago, in January 2020, Cornwall Council, along with NHS Kernow, drafted a document entitled *Care Homes Market Development Strategy: Joint Strategic Commissioning Intentions*.[15] This identified three types of bed provided in private care homes in Cornwall: Residential, Residential Dementia, and Nursing. It said nothing about

the settings – the accommodation, equipment and staffing – needed for the different categories. The document has appeared on the Council's website only within the past month, it has not been scrutinized by councillors, and it has not been updated to include the category of Reablement provision. Given that it identified four priority localities within the county (one of which is West Penwith), and that the Covid-19 pandemic has given the matter much greater urgency, its inspection and overhaul are long overdue. ***The new integrated care system must lose no time in addressing this gap in policy-making. The matter is urgent: addressing it would make a valuable contribution to addressing Points 1, 3, 4, and 6 above.***

12. Why does Cornwall Partnership Foundation Trust appear to be digging in its heels against integrated care? For more than a year the leaders of the Cornwall Partnership Foundation Trust (CPFT), which runs Cornwall's community hospitals, were discussing with the leaders of the Royal Cornwall Hospitals Trust (RCHT), which runs the acute hospitals in the county, how the two organizations might be amalgamated. That would make a lot of sense.[16]

But in May this year the Chief Executive of CPFT resigned, following an investigation into allegations of governance and financial failings at the Trust, and the post he vacated was advertised on May 28th. The job description acknowledges that the Trust had experienced 'several governance and Board leadership failures recently so we are keen to meet candidates who will provide open, honest and straightforward leadership'.[17] Surprisingly, the job description made no mention whatever of the integrated care system of which Cornwall's community hospitals and mental health services would be a part, nor of the fact of the negotiations with RCHT. And it described the post as 'permanent', from which we can only conclude that someone, somewhere has decided that CPFT should continue to exist as a separate entity, not integrated with RCHT. ***The new integrated care system must address urgently the question of how to integrate what are currently two hospital systems. This is particularly crucial for the many patients who make a transition from one to the other, whether stepping down from acute to community hospital or stepping up in the reverse direction.***

13. Are health services in Cornwall actually governable? In contemplating the future of health and social care in Cornwall, residents might justifiably worry about the existence of some professionals within the system who seem to be a law unto themselves. The Care Quality Commission (CQC) reported in February 2021 on an investigation it had carried out into what could be learned from seven 'never events' (literally, events that should never have occurred) that took place within the Royal Cornwall Hospital group during 2020.[18] Following its investigation, the CQC took regulatory enforcement action 'as a

result of our findings in surgical care services' and issued a formal Warning Notice that required the Trust to make significant improvements in the quality of the healthcare it provides.

While the people of Cornwall have every reason to be especially grateful at the present time to everyone who works in the county's hospitals, and to the CQC for carrying out its supervisory task, it is clear that the new integrated care system must incorporate structures and mechanisms that will ensure that clinicians do not lose sight of their accountability to the public they serve.

14. Designing a new model of care. An early task for the new integrated care system will be to design a model of care – a set of arrangements for providing health and social care for the people of Cornwall – that meets the needs of today's population. Some work has already been done towards this end, as set out in the document *Penwith model of care position statement*.**[19]** This implicitly views a model of care as a collection of services.

Our view of an integrated care system is a more dynamic one. As we see it, for care to be integrated into a system these arrangements must not merely be a collection of services that seem to fit together for organizational purposes: they must be integrated along the pathway or 'trajectory' that patients follow through the system. There are many such pathways. Perhaps the best-known is that taken by a patient who is admitted to an acute hospital as an emergency case, then after treatment is discharged to a community hospital to continue their recovery (step-down), and then discharged to their home. Less well-known is the pathway mentioned under Point 4 above for patients who have undergone treatment for a fracture and subsequently require attention to a leg ulcer: this pathway runs from the acute hospital to the Centipede Club (which does not merit a mention in the position statement).

In Penwith, where there is no longer a community hospital, the current *de facto* model of care is that some beds in the sub-acute West Cornwall Hospital (WCH, run by the RCH Trust) in Penzance are being used as step-down beds. '[Inpatients at Treliske] who cannot be discharged home and/or who need further assessment and intervention ... will be "pulled" from [Treliske] so they can be seen and treated closer to their home.'**[20]** But the position statement shows that the emphasis at the present time is on developing WCH as a 'Centre of Excellence for Healthcare for the West of Cornwall':

> WCH has the facilities and staff to provide rehabilitation and reablement as part of its 'core offer' to inpatients. It has on site Occupational Therapy and Physiotherapy staff with in-reach input from Dietetics and Speech and Language Therapy as

required. The team work across 5 days at the moment, with an ambition to move to 7 day working.**[21]**

The staff limitations, and absence of any reference to specific facilities such as a gymnasium, demonstrate that providing reablement for step-down patients is taking second place to installing facilities that befit an acute 'centre of excellence'.
We want to see the new integrated care system designed to be integrated along the pathway or 'trajectory' that patients follow through the system, with the rehabilitation and reablement stages equipped to the same standards of excellence as the stages of acute treatment that precede them.

15. Involving patient participation groups. Any new model of care should incorporate the patient participation group (PPG) that every GP surgery should have. Since April 2016, it has been a contractual requirement for all English practices to form a patient participation group (PPG) and to make 'reasonable efforts' for this to be representative of the practice population.**[22]**
A PPG can serve as a channel of communication from patients to the commissioners and providers of the integrated care system. The PPGs in a locality should be provided with facilities for getting together to discuss matters of common interest and putting forward a common view, where one exists, with a guarantee that it will be listened to, considered and responded to. At a societal level, it is to be hoped that such arrangements would help to move the current model of the doctor-patient relationship towards something more like an alliance between doctors and patients, in which we face up together to threats such as coronaviruses and the social impositions forced upon us, and work together towards the common goal of better health for everyone.

Notes and references (Websites last accessed 24 June 2021)

[1] Peter Levin, *For the record: an assessment of policy-making by NHS Kernow, Cornwall's clinical commissioning group*, 22 June 2021
https://spr4cornwall.net/for-the-record-an-assessment-of-policy-making-by-nhs-kernow-cornwalls-clinical-commissioning-group/

[2] Richard Whitehouse, 'Elderly people discharged from hospital and sent to residential care miles from home', *Cornwall Reports*, 3 February 2021
https://cornwallreports.co.uk/eldery-people-discharged-from-hospital-and-sent-to-residential-care-miles-from-home/

[3] Steven Morris, 'Cornwall hospital discharging patients to free space for G7, claim Lib Dems', *The Guardian*, 8 June 2021
https://www.theguardian.com/world/2021/jun/08/cornwall-hospital-discharging-sick-patients-to-free-space-for-g7-claim-lib-dems

[4] NHS Kernow, *Community hospital engagement*, Report GB2021/071 to meeting of Governing Body, 1 December 2020
https://doclibrary-kccg.cornwall.nhs.uk/DocumentsLibrary/KernowCCG/OurOrganisation/GoverningBodyMeetings/2021/202012/GB2021071CommunityHospitalEngagementReport.pdf

[5] South West Clinical Senate, *Clinical Review of South Devon and Torbay CCG Community Services Transformation*, 14 October 2016. 'For effective rehabilitation therapists will need access to a gym with parallel bars and miscellaneous equipment.'
https://swsenate.nhs.uk/wp-content/uploads/2016/11/Clinical-Review-Report-SDT-Final-October-2016.pdf

[6] NHS England, *The Centipede Club, a community hub for older people with leg ulcers*, 20 November 2018
https://www.england.nhs.uk/atlas_case_study/the-centipede-club-a-community-hub-for-older-people-with-leg-ulcers/

[7] CIoS Health and Care Partnership, *Discharge to Assess (D2A) pathway 2 team focus*, 6 April 2021
https://cioshealthandcare.nhs.uk/discharge-to-assess-d2a-pathway-2-team-focus/

[8] West Cornwall HealthWatch, *Wax in your ears?* 5 June 2021
http://westcornwallhealthwatch.com/wax-your-ears-0
West Cornwall HealthWatch, founded in 1997, is an independent voluntary body which aims to monitor developments in healthcare and campaigns to safeguard and improve existing services provided in West Cornwall by the National Health Service.

[9] Newton, Detailed findings from the Embrace Care Diagnostic Review, 16 August 2019
https://spr4cornwall.net/wp-content/uploads/Embrace-Care-Diagnostic-Detailed-Findings-abridged-final.pdf
This document (1) advocated discharging patients on the basis of their being 'medically fit for discharge', a criterion later adopted for the 'Discharge to Assess' scheme during the Covid-19 pandemic that is based only on a 'snapshot' here-and-now view of a patient's current physiological condition and ignores a consultant's judgment of the desirability of keeping them in for observation or of the likelihood that they will need to be readmitted; (2) identified as a specific category elderly patients living with frailty but made no recommendation whatever for addressing their needs; (3) identified disturbing variations in the care provided by community hospitals but made no recommendations for bringing the poorer ones up to the standard of the others.

[10] See Note 1

[11] Peter Levin, *Closing a community hospital: how consultation went wrong*, 14 November 2020
https://spr4cornwall.net/closing-a-community-hospital-how-consultation-went-wrong-2/

[12] Peter Levin, *Taking sound decisions requires evidence, not endorsements, as shown by the debate over closing Edward Hain Community Hospital*, 2 January 2021
https://spr4cornwall.net/wp-content/uploads/Taking-sound-decisions-requires-evidence-not-endorsements.pdf

[13] Neil Walden, *Community based care: providing care where people need it*, 27 May 2021
https://spr4cornwall.net/wp-content/uploads/Community-based-care-PICF-270521.pdf
This policy document aims to 'implement a discharge to assess model that meets the expectations of the Hospital Discharge Policy for over 65's' (p.8). Under this model, 4% of people would require rehabilitation or short-term care in a 24-hour bed-based setting, and 1% of people would require ongoing 24-hour nursing care, often in a bedded setting. What we see here is an expectation that is being treated as a target. Unfortunately this is a model that is based on national population figures. In Cornwall the proportion of residents aged 65 and over in the population is half as much again as the national percentage for England. So while those percentages might perhaps be reasonable for England as a whole, for Cornwall they are likely to be considerable underestimates. Moreover the Embrace Care project (see Note 9) identified a significant proportion of elderly people who were living with frailty: the national Hospital Discharge Policy makes no mention of this group.

[14] Cornwall Council, Health and Adult Social Care Overview and Scrutiny Committee
https://democracy.cornwall.gov.uk/mgCommitteeDetails.aspx?ID=1153

[15] Cornwall Council, *Care Homes Market Development Strategy: Joint Strategic Commissioning Intentions*, 17 January 2020
https://www.cornwall.gov.uk/media/5bpntvjr/market-development-strategy-vfinal.pdf

[16] Peter Levin, *Does Cornwall really need two nhs hospital trusts?*, 15 March 2020
https://spr4cornwall.net/does-cornwall-really-need-two-nhs-hospital-trusts/

[17] Vacancy for the Chief Executive Officer role of Cornwall Partnership NHS Foundation Trust, 28 May 2021
https://www.hsjjobs.com/job/2607926/chief-executive-officer/?TrackID=56518&utm_source=emailfriend&utm_medium=email&utm_campaign=0

[18] CQC tells Royal Cornwall Hospitals NHS Trust to make improvements to its surgical care services, 19 February 2021
https://www.cqc.org.uk/news/releases/cqc-tells-royal-cornwall-hospitals-nhs-trust-make-improvements-its-surgical-care

[19] NHS Kernow, *Cornwall and Isles of Scilly integrated community services and community hospital reviews and engagement, Penwith model of care position statement, November 2020,* p.12
https://spr4cornwall.net/wp-content/uploads/Penwith-Model-of-Care-Nov-2020-final-3.pdf

[20] As Note 18, p.35

[21] As Note 19

[22] Roger Henderson, *Patient Participation Groups*, 7 February 2017
https://patient.info/doctor/patient-groups