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Do we really have enough hospital beds in Cornwall?

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Introduction

The question of how many hospital beds we need in England has been a divisive one for some time, especially during the Covid-19 pandemic.

In Cornwall, which has recently had the highest incidence of the disease in England and acute hospital facilities under huge strain, we saw the county's clinical commissioning group, NHS Kernow, going into the latest wave saying there is evidence of an over reliance on hospital beds. But the Royal Cornwall Hospitals Trust (RCHT), which runs Cornwall's main acute hospital at Treliske and its two satellites, says more beds are needed.

They can't both be right. But might they both be wrong? This paper examines the two claims and finds both wanting.

An over reliance on hospital beds?

'We have evidence already that we have an over reliance on hospital beds and many people remain in hospital beds which is not achieving the best outcome for them. If hospital beds are used appropriately there is no system evidence that we require more hospital beds. … There is no evidence to suggest that we need an increase in hospital beds.'

NHS Kernow Clinical Commissioning Group, *Community based care/Edward Hain Community Hospital: engagement and service review*, 27 May 2021

Or too few?

'Whilst hospital, ambulance, GP and social care services across Cornwall continue to face sustained operational pressures, we are having to make changes to some of our services to ensure we can continue to care safely for everyone who urgently needs admission to our acute hospitals. … [The] level of demand means we need more inpatient beds in order to care for medical patients.'

Royal Cornwall Hospitals NHS Trust, *Briefing Note: Temporary changes to support emergency care*, 13 August 2021

The Royal Cornwall Hospitals Trust sees its world in terms of 'inpatient beds'. In effect it is taking it for granted that the purpose of hospital beds is simply to accommodate patients who are being given surgical or medical treatment. Its language shows no concern with what happens to them after their treatment.

NHS Kernow is not specifying any particular type of hospital bed. It has made it its mission to close 'hospital beds', and it has been concentrating on closing beds in community hospitals. In the past a proportion of the patients discharged from Treliske have gone to these en route to their homes or to a care home. Now Cornwall has lost the only two community hospitals in Penwith, the westernmost area of the county: two more (in Fowey and Saltash) are on the way. That's 40 beds gone. Some Penwith residents Now there is no community hospital in Penwith. In recent years a number of Penwith residents who would previously have been discharged to Edward Hain hospital for rehabilitation and recovery have instead been sent to community hospitals and care homes as far as the other end of the county, up to 70 miles away from their home community.

Guidance from above: The 'Discharge to Assess' model

Under the impetus of the Covid-19 pandemic, the Department of Health & Social Care (DHSC), having noted that a number of patients who were staying in hospital after treatment were waiting first for an assessment of their fitness to go to accommodation elsewhere and then to be actually moved there, concluded that beds would be freed if those assessments were carried out after rather than before they vacated their hospital bed.

In March 2020 the Department published guidance which directed all hospital trusts in England to implement what it calls the 'Discharge to Assess' (D2A) model. This instructed hospitals to assess patients twice a day and judge whether they were 'medically fit for discharge'. If they were so judged 'they must be transferred from the ward to a ... discharge area or lounge as soon as possible, to leave hospital the same day'.

How to judge whether a patient is'Medically fit for discharge'

The DHSC's guidance said that the judgment as to whether a patient is 'medically fit for discharge' needed to be based on only a snapshot, a here-and-now view of their current physiological condition: for example, whether they required intravenous fluids or had undergone lower limb surgery within the past 48 hours.

The clinician's judgment did not have to be based on how the patient was progressing, or whether in normal circumstances they would be kept in for observation, or what their prospects were for successful post-treatment recovery and rehabilitation if they were discharged immediately. It did not have to be based on consideration of the patient's overall situation – e.g. if their condition was complex, or they were living with frailty, or approaching their end of life.

What the 'medically fit for discharge' criterion did was to invite the clinician to ask a simple question: 'Can I do anything more for this patient by way of treatment?' If the answer was 'No' the next step was obvious: schedule them for immediate removal. No further thought was required: the patient's treatment episode was now finished and he or she was now someone else's problem.

The route from acute

The original D2A model specified four 'pathways' for patients being discharged:

- 'Pathway 0: 50% of people simple discharge, no input from health / social care'
- 'Pathway 1: 45% of people: support to recover at home; able to return home with support from health and/or social care'
- 'Pathway 2: 4% of people: rehabilitation in a bedded setting'
- 'Pathway 3: 1% of people: there has been a life-changing event. Home is not an option at point of discharge from acute'

A new version of the guidance was published in July 2021. It divides patients into the same four categories as the original but introduces the concept of 'likelihood'. It says it is 'likely' that 50% of patients will be able to simply go home (those on 'Pathway 0'). It is 'likely' that another 45% will be able to return home and recover with support from health and/or social care (these are on 'Pathway 1').

On Pathway 2 there is 'likely to be [a] maximum of 4% of people discharged [for] recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home'.

And finally on Pathway 3 there is 'likely to be a maximum of 1% of people discharged' who will require bed-based 24-hour care and will need to be discharged to a care home for the first time.

The significance of 'likelihood' is that it allows for adjustment of the percentage figures to take account of the age structure of the local population. This will be necessary in Cornwall because there are half as many people again in the over-65 age bracket as in the population of England. Evidently it is now seen that there was previously a risk that clinical commissioning groups and providers would take the percentage figure for each pathway as a target.

Unfortunately, in its calculation of Cornwall's need for hospital beds, NHS Kernow has done exactly that. So it will have significantly under-estimated the number of people likely to need rehabilitation and recovery in a bed-based setting.

Rehabilitation and recovery

The latest guidance says that a small proportion of the people placed on Pathway 2 'will need and benefit from short-term care in a 24-hour bedded facility for the purposes of rehabilitation or recovery where time is given to the assessment and consideration of options for longer term care. This could be in a rehabilitation facility, care home or hospice care'. Local health and care systems must ensure adequate rehabilitation is provided in relevant 24-hour bedded facilities.

In Cornwall we can add something to this latest guidance. 'Bedded facilities for the purpose of rehabilitation or recovery' already exist here. They are called community hospitals. But because the beds in them are, not unsurprisingly, labelled 'hospital beds' these are precisely the facilities that for the past seven years NHS Kernow has been set on closing down. 40 beds that used to be available have been lost.

The community hospitals in Cornwall have historically provided a rehab/recovery 'step-down' function for patients discharged from Cornwall's main acute hospital at Treliske and its satellites. The lack of those 40 beds is a significant contribution to the problems that the Royal Cornwall Hospitals Trust is now facing in its struggle to dispatch patients who have been judged medically fit for discharge.

Closing community hospitals has created major problems for the local population, of course. In Penwith, the far western area of Cornwall, two community hospitals have been lost: just recently Edward Hain Community Hospital in St Ives and before that Poltair Hospital in Penzance. Now there is no community hospital in Penwith. In recent years a number of Penwith residents who would previously

have been discharged to Edward Hain hospital for rehabilitation and recovery have instead been sent to community hospitals and care homes as far as the other end of the county, up to 70 miles away from their home community.

How NHS Kernow made use of the 'Medically fit for discharge' criterion

We can see that NHS Kernow, besides basing its calculations on misinterpreted targets, is resting its argument that there is an over-reliance on hospital beds in Cornwall on two propositions:

- A clinician's judgment that a patient is medically fit for discharge can be taken at face value: that patient is ready to leave hospital and there is no need to ask how that judgment was arrived at.
- Beds should be occupied only by patients not yet judged medically fit for discharge.

RCHT is adopting the same two propositions. What both organizations are failing to do is to look at hospitals' roles in the context of the paths that patients need to follow to regain their health.

For once central Government is leading the way in responding to patients' needs, and indeed identifying those paths with some sensitivity. The latest guidance says some inpatients (especially in acute hospitals) will need to move on to a '24-hour bedded facility' for rehabilitation or recovery before they can go home.

RCHT is manifestly working on the principle that it is not its job to provide rehab/recovery facilities, although it has done so in the past. Such facilities do exist elsewhere in Cornwall but they are in community hospitals (which are run by a different Trust), so the beds are labelled 'hospital beds', precisely the ones which NHS Kernow has made it its mission to close.

What is missing and what to do about it (1): Joined-up thinking

What we can see is missing from the calculations of both NHS Kernow and the Royal Cornwall Hospitals Trust is the joined-up thinking that would identify and remove obstacles to the flow of patients needing rehab/recovery facilities from the acute hospital to those facilities elsewhere – in community hospitals, for example. To close down community hospitals and thereby create a blockage in the acute hospitals is not sensible.

NHS Kernow and its successor body should be aware that some urgently needed bedded facilities for the purpose of 'rehabilitation or recovery' already exist, and the need for such facilities is recognized by the DHSC. Just because those facilities are called 'community hospitals' and the beds in them are consequently known as 'hospital beds', that is no reason to close them down. Community hospitals perform a 'step-down' function that is crucial to the smooth running of acute hospitals, and should be cherished.

Joined-up thinking is also lacking when clinicians are making 'medically fit for discharge' decisions solely on the basis of whether there is more treatment that they themselves could provide for a patient.

Joined-up thinking requires the paths followed by patients through the hospital system to be considered as a whole. Treatments should be considered from beginning to end. It makes no sense to increase the provision for people to go through surgical or medical treatment and not do the same thing with the provision for their subsequent rehabilitation and recovery. There must exist an appropriate ratio between acute beds and rehab/recovery beds and a fact-finding study should be carried out to provide the basis for judging what this should be. Our hospitals badly need joined-up thinking, sadly not greatly in evidence to date, and patients deserve no less.

If a clinician categorizes someone as medically fit for discharge without considering their overall condition or contributing to an assessment of what they still need in terms of rehabilitation or recovery, that is also an example of the failure of joined-up thinking. Indeed, they are abdicating their responsibility towards the patient. It should be their duty to make constructive contributions to patients' future wellbeing.

What is missing and what to do about it (2): Geographical fairness

Geographical fairness is conspicuously absent from the current distribution of community hospitals in Cornwall. Penwith, shaped like an isosceles triangle with Land's End at its peak and sea on its two long sides, is the most remote part of Cornwall: it is the last place that should be deprived of its own community hospital. But the recent closure of Edward Hain Community Hospital in St Ives has left it with none.

NHS England's guidance on planning, assuring and delivering service change for patients reminds commissioners of their duty to reduce health inequalities. Since the closure of inpatient beds at Edward Hain there has been inequality of community hospital provision as between Penwith and other areas in Cornwall. For example, the Camborne-Redruth area has its own community hospital, and the Cornwall Partnership Foundation Trust's website specifically says: 'Camborne Redruth Community Hospital provides physical and mental health care ... services for people in the local area.' Penwith has nothing like this.

Penwith is its own local area and deserves at least the same community hospital service as other parts of Cornwall. To reduce health inequalities, the replacement of Edward Hain Community Hospital with a modern rehab/recovery facility, with a full complement of physiotherapists and occupational therapists, must be a priority. Given its likely contribution to the smooth functioning of the acute hospitals, it must be a cost-effective measure.

In conclusion

To return to our question: Do we really have enough hospital beds in Cornwall?

We can see now that this question is unanswerable as it stands, because it does not distinguish between acute hospital inpatient beds and rehab/recovery beds. What we can say with confidence is that there must exist an appropriate balance between the two. If the Covid pandemic has shown us anything it is that such a balance does not exist at the moment, and that NHS Kernow's ill-advised attack on community hospitals has contributed to this.

As for the total number of beds needed, there is no straightforward answer. A new pandemic against which there is as yet no vaccine could invalidate all previous calculations, and different people will make different judgments about how many beds it would be appropriate to allow for unexpected developments.

Under the Health and Care Bill currently before Parliament, the bodies that will make up the new Integrated Care System are specifically expected to work 'in the best interest of their immediate service users [and to] have strong engagement with their communities'. Acting to promote joined-up thinking and geographical fairness would show the people of Cornwall that those running the new Integrated Care System do have their best interests at heart.