16 March 2020 www.spr4cornwall.net

Does Cornwall really need two NHS hospital trusts?

Dr Peter Levin, for West Cornwall HealthWatch

This report examines the consequences of having Cornwall's acute hospitals and community hospitals under different managements: the Royal Cornwall Hospitals NHS Trust and the Cornwall Partnership NHS Foundation Trust. The problems already experienced by patients will inevitably worsen when the coronavirus epidemic reaches Cornwall.

Under the present arrangement:

- A patient's medical condition, mental health and overall physical state aren't able to be treated together.
- Care isn't integrated along a patient's path through the hospital system, so when they are ready to leave the acute hospital but still need NHS care there is no 'step-down' place reserved for them in a community hospital near their home.
- Services for people living with frailty are not integrated: they are divided between the two trusts.

These consequences can only worsen under the pressure of the coronavirus epidemic.

Such a situation cannot be allowed to continue. The two trusts must be integrated, brought under a single management. To spell out the potential benefits:

- Integration would enable a patient's medical condition, mental health and overall physical state to be treated together.
- Integration would enable care to be integrated along a patient's path through the system, so when they are ready to leave the acute hospital there is a 'step-down' place reserved for them in a community hospital near their home.
- Integration would enable services for people living with frailty to be brought together within a 'frailty powerhouse' in Cornwall.

The situation today

At present Cornwall has two NHS hospital trusts: the Royal Cornwall Hospitals NHS Trust (RCHT) and the Cornwall Partnership NHS Foundation Trust (CPFT).

RCHT is the principal provider of acute care services, including urgent and emergency care, medicine, surgery, maternity services, sexual health, and end-of-life care. Its main hospital is at Treliske, near Truro. CPFT provides mental health, learning disability and community health services. These services include community hospitals, community mental health services for adults, older people and young people, and a range of mental health inpatient services.[1,2]

The need for integrated services

And herein lies a problem. While services are split between physical health conditions on one hand and mental health conditions on the other, the ailments of human beings do not fall neatly into one or other of these categories.

Here are some relevant facts (courtesy of Dr Sean Cross, of Maudsley Learning):

- Nearly half of people with mental illness also have at least one long-term physical health condition.
- 30% of people with long-term physical health conditions also have a mental illness.
- Life expectancy is 15-20 years shorter for someone with a severe mental illness or learning disability than for someone without.

And there are two further complications.

One is that, as we know, even patients who arrive in an acute or community hospital without any mental illness may become depressed and demoralized. There is documented evidence that their mental health is liable to suffer catastrophically.[3]

In particular, a fall is likely to lead to a patient being abruptly plucked from familiar surroundings. Confined to a hospital bed, they are suddenly deprived of stimulus, of control over their own daily pattern of life, and often of the ability to discover from those in positions of power how soon they might be able to leave. These deprivations cannot possibly help them to maintain a good level of mental health. Irrespective of their physical health, they are in a situation which inherently disables them by reducing them to a state of despair.

The other complication is this: not only is the patient's mental health likely to deteriorate but also their overall physical state, a process called 'hospital-acquired functional decline':[4]

> For people over 80, 10 days in a hospital bed leads to the equivalent of 10 years of ageing in the muscles, and building this muscle strength back up takes twice as long as it does to deteriorate. One week of bedrest equates to 10% loss of strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between independence and dependence.[5]

It follows that someone admitted to Treliske's Emergency Department with a fracture or illness needs

- surgical/medical treatment for the immediate cause of their admission
- to have mental health and learning disability services available to care for them, and
- to have their overall physical state, especially their musculoskeletal system, cared for, especially if they are living with frailty.

Treating 'the whole patient' requires bringing all three of these together.

But in Cornwall, that is not what we find. Instead, surgical/medical treatment is the responsibility of RCHT while mental health services and physical reablement are the responsibility of CPFT. So there are institutional barriers to treating the whole patient. Integrating the trusts would remove these barriers.

Delayed Transfers Of Care

A delayed transfer of care (DTOC) from NHS-funded acute or non-acute care is defined as occurring when an adult (18+ years) patient is ready for discharge from acute or non-acute care but is still occupying a bed.[6]

NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is considered safe to discharge/transfer.

As soon as a patient meets all three of these conditions but remains in a bed, the 'clock' starts: from that moment on they fall into the 'delayed transfer of care' category.

Although this is unsatisfactory as a definition, not least because it fails to provide us with a clear picture of the decision-making process, we can see that:

1. To Judge a patient's fitness to leave solely on clinical grounds is to ignore their mental health and their overall physical state, and that once a patient is judged medically fit for discharge, they are no longer the primary concern of the acute hospital.

2. NHS England's definition does not specify whether the multi-disciplinary team entrusted with judging whether the patient is safe to discharge or transfer should include people from potential receiving organizations as well as members of the hospital's staff.

3. There is inevitably an interval between the clinical decision that a patient is ready for transfer and the multi-disciplinary team's decision(s) that he or she is both ready and safe to transfer. So there is a 'window', which in Cornwall may be two or three days,[7] within which a patient is considered medically fit for discharge but not yet counted as a delayed transfer of care.

The main reason identified by RCHT for delayed transfers of care from Treliske is that the patients involved are waiting for further non-acute NHS care, which would need to be provided in a community hospital.[8] Why is this so?

The Embrace Care project reported in August 2019 that in the acute hospitals 15% of beds were occupied by patients in the 2-day window and a further 5% by patients categorized as DTOC. In the community hospitals, 33% of beds were occupied by patients in the 2-day window and 28% by patients categorized as DTOC. These figures are based 'on a review of 943 beds across acute and community hospitals, asking what the next step is for the patient'.[9]

So we see that in the acute hospitals 20% of beds (15% + 5%) were taken up by patients medically fit for discharge, while in the community hospitals no fewer than 61% of beds (33% + 28%) were taken up by such patients. It is particularly concerning that while in the acute hospitals the 15% in the 2-day window fell by two-thirds to 5% in the DTOC category, in the community hospitals the

33% in the 2-day window fell only to 28% DTOC, indicating a much more sluggish discharge rate in the latter.

At the beginning of 2020 RCHT was under considerable pressure. It was reduced to making provisional bookings in local hotels to enable 'social discharges', the discharge of patients with] low social needs.[10] While 'extra escalation beds' were made available at three community hospitals, given that 61% of community hospital beds were being taken up by patients who were medically fit for discharge or already in the DTOC category – this equates to roughly 150 beds – we must ask: Is CPFT, which runs those hospitals, playing its proper role as part of the hospital system? There is no indication that CPFT was following the example of RCHT in energetically seeking and taking innovative measures.

Statistics published by NHS England for the period October-December 2019 show that of 253 available beds in community hospitals in Cornwall, no fewer than 229 were occupied overnight on average, an occupancy rate of 90.5%,[11] well above the England standard of 85%. To put it another way, the 'margin' – the leeway for responding to an emergency at Treliske or a build-up of demand in the system, or providing a place in the hospital nearest to a patient's home – is only 9.5% as opposed to the recommended standard of 15%.

CPFT is known locally for shutting down community hospitals. Currently three of the 12 in Cornwall are closed to inpatients. One of them, Edward Hain Memorial Hospital in St Ives, has been closed to inpatients for four years. It sits on very valuable land: if it is sold, the money it realises will go to the Treasury.

Whitehall departments and NHS England may feel that this is to be applauded. But it suggests that CPFT has its own agenda, and that this does not extend to assisting patient flow through the acute hospital at Treliske. Bringing CPFT and RCHT together into a single organization would be a step towards remedying this. It would enable care to be integrated along a patient's path through the system, so when they are ready to leave the acute hospital there is a 'step-down' place reserved for them in a community hospital near their home.

To sum up: The Cornwall Partnership Foundation Trust is failing to provide in community hospitals the beds that are needed to free up beds in RCHT's acute hospital at Treliske because:

1. As many as 61% of its beds in community hospitals have been taken up by patients who were medically fit for discharge, and its discharge rate is notably sluggish.

2. In early 2020, when RCHT was under great pressure and energetically seeking and taking innovative measures to secure more beds, CPFT showed no inclination to follow that example.

3. Despite running its community hospitals at an occupancy rate significantly above the England standard, with a correspondingly low margin for responding to an emergency or build-up of local need, CPFT has made no move to replace the beds in community hospitals that it has closed to inpatients, notably Edward Hain hospital in St Ives, shut to inpatients more than four years ago.

Combining the two trusts in Cornwall would provide an opportunity to remedy these failings.

Research and service development in caring for older people living with frailty

Both RCHT and CPFT are devoting resources to caring for older people living with frailty. At Treliske, a frailty assessment service is provided in the Emergency Department and Medical Admissions Unit. It also cares for patients with a fractured neck of femur on the Trauma Unit. Consultants and multidisciplinary teams provide specialist frailty care on wards at all the Trust's main acute hospitals and at community hospitals. There is a special acute older people's ward at Royal Cornwall Hospital where the most frail acute patients are seen.[12]

At CPFT too there is a frailty team, and a frailty study is under way to help older people live healthier lives.[13]

There is a strong case for bringing the frailty specialists together under one roof in a frailty centre. This would facilitate rotation of staff into and out of the acute hospital at Treliske, giving them all a wider experience of conditions across Cornwall. Having a larger group of specialists would offer scope for initiatives and experiment to find better ways of helping people living with frailty. It would provide the flexibility that allows staff to act proactively and in a measured way rather than merely reacting to daily pressures and demands. It would provide a better learning environment and a richer environment for research, especially valuable at Treliske since it is a teaching hospital. And it would serve as a 'mother ship' for the frailty specialists who work with general practitioners as members of primary care networks.

Building a reputation for innovation in frailty care would attract good people, and help to create the critical mass necessary to make a strong claim for resources. Care for people living with frailty is going to become ever more important given the increasing number of elderly and 'super-elderly' in Cornwall:[14] this is an opportunity to create a 'frailty powerhouse'. Instead of the currently fragmented effort, placing the management with a single Hospital Trust would remove an obstacle to achieving this.

Conclusions

The answer to the question posed in the title of this report – Does Cornwall really need two NHS hospital trusts? – is a clear 'No'. The present division of responsibility for hospital and hospital-based services between two Trusts is plainly dysfunctional.

Uniting the Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust into a single hospital trust would:

- Allow a patient's medical/surgical care, mental health and overall physical condition to be treated together;
- Enable care to be integrated along a patient's path through the system, so when they are ready to leave the acute hospital there is a 'step-down' place reserved for them in a community hospital near their home;

- By integrating services for people living with frailty, enable the creation of a 'frailty powerhouse' in Cornwall.

Notes and references (websites last checked 14 March 2020)

1. For Royal Cornwall Hospitals NHS Trust, see https://www.nhs.uk/Services/Trusts/HospitalsAndClinics/DefaultView.aspx?id=568
2. For Cornwall Partnership NHS Foundation Trust, see https://www.nhs.uk/Services/Trusts/HospitalsAndClinics/DefaultView.aspx?id=RJ8
3. Healthwatch Cornwall, *Delayed Transfers of Care: What it's like for patients and families*, 2019 http://bit.ly/HwC-DTOC
4. James Illman, 'Exclusive: Hidden epidemic 'dwarfing harm by hospital superbugs' (Interview with Dr Ian Sturgess), *Health Service Journal*, 8 January 2019. http://bit.ly/hsj08Jan2019
5. Jane Cummings, 'We should all support #EndPJparalysis', 23 February 2017 https://www.england.nhs.uk/blog/jane-cummings-32/
6. NHS England, *Monthly Delayed Transfers of Care Situation Report*, November 2018 http://bit.ly/NHSEstatsNov2018
7. Three days is said to be taken currently as the length of the window at Treliske.
8. RCHT *Integrated Performance Report*, January 2020, p. 41 http://bit.ly/RCHT-IPR-Jan2020
9. *Detailed Findings from the Embrace Care Diagnostic Review*, July 2019 http://bit.ly/EmbCare01
10. Richard Whitehouse, *Royal Cornwall Hospital put patients in hotels during 'black alert' crisis*, 16 January 2020 https://www.cornwalllive.com/news/cornwall-news/royal-cornwall-hospital-put-patients-3746083
11. NHS England, *Bed Availability and Occupancy Data – Overnight* Data at http://bit.ly/NHSEbeds01
12. RCHT, *Older People's Services* https://www.royalcornwall.nhs.uk/services/older-peoples-services/
13. CPFT, *Frailty study underway to help older people live healthier lives*, 28 May 2019 http://bit.ly/CPFT28-May-2019
14. The 'super-elderly' are defined as people aged 85 or over.

Note: Shortened links are used here to avoid splitting a URL between lines.