

Don't close community hospitals: use them as re-ablement centres

Dr Peter Levin

formerly of the Department of Social Policy, London School of Economics and Political Science
Committee member, West Cornwall HealthWatch

This report shows how limited and poor-quality information is being used to justify a policy of 'freeing up' hospital beds, in effect allowing wards and hospitals to be closed. In Cornwall three community hospitals are currently facing closure. Unfortunately, policy makers seem not to understand that patients stay in hospital not only to recover clinically after their treatment but to go through a process of 're-ablement' so they can regain the skills of daily living and a place in their community. Re-ablement is difficult to achieve in acute hospitals, where patients are more likely to become institutionalized: it calls for specialized re-ablement centres. Local community hospitals should be utilized for this purpose. Staffed by teams of physiotherapists, counsellors and social workers, and providing a base for occupational therapists working in the community, re-ablement centres would take patients who have gone through their treatment and would thereby free up beds in acute hospitals.

'Freeing up hospital beds': a policy based on inadequate information

NHS England has become very careful lately to avoid suggesting that it is seeking closures of hospital beds and, by implication, hospitals. But we currently see numerous references to 'freeing up' hospital beds, as in the recently published NHS Long Term Plan.^[1]

In Cornwall we keep being told: 'Older people can lose 5% of their muscle strength per day of treatment in a hospital bed.'^[2] Interestingly, we are never told how much exercise, if any, those 'older people' were given. Nor are we told how much muscle strength people lose if confined to bed in their own home. Without this information, that figure of 5% is utterly worthless as a basis for policy making. And the cost of having physiotherapists spending time driving around (with limited equipment) instead of treating patients throughout the day is another factor that policy makers show no sign of taking into account.

We are also told that 'Around 60 people each day are staying in an acute hospital bed in Cornwall and don't need to be there', and that '35% of community hospital bed days are being used by people who are fit to leave'. We aren't told, though, who is making these judgments and what they are taking for granted about a patient's ability to cope after leaving.

It seems all too likely that these judgments are being made by hospital consultants who consider that there is nothing more that they can do for the patient and are not taking any account of the patient's housing opportunities or indeed of their need for 're-ablement'.

At the present time occupational therapists working in the community are noticing that people are being discharged from hospital despite being very unwell. Evidently, under the pressure to free up beds, too little attention is being paid to the capabilities of patients who are in line for discharge.

The pressures

In NHS hospitals today there is a chronic shortage of funding and of staff. Many staff are overworked, they go home exhausted, and their morale is understandably low. Most of them know what patients need and are frustrated because they don't have time to provide it. Medical procedures, administering medication and changing dressings have to take priority over encouraging and supporting patients. And pressure of time limits the attention that can be given to the particular needs of an individual.

In some wards, especially geriatric wards, patients who struggle to feed themselves become undernourished because ward staff don't have time to feed them. Patients who need to be helped to drink become dehydrated. Patients who need but don't get help with toileting, either using a bedpan or going to the bathroom, may soil themselves and be left in that state for some time.

Imprisoned in hospital

Hospital in-patients, just like the inmates of prisons, are confined. Indeed, they may be confined more tightly, if they are in a bed from which they can't escape. The lives of both patients and prisoners are governed by a discipline, decisions and a daily timetable over which they have no control. If there are disruptive fellow-inmates in close proximity, patients suffer from a lack of privacy and access to their possessions, and very probably from sleep deprivation too.

Subjected to these conditions, many elderly patients become resigned to their fate, especially if they have been living on their own and have had an accident, been taken to hospital, and then not only found themselves confined in a hospital bed but faced with the fact that they will never see their home again. Many give up. Their mental health, like their physical health, gets worse and worse. They are conditioned to become dependent. They become, in a word, institutionalized.

Reducing reliance on bed-based care

We are currently being told in Cornwall that 'reducing reliance on bed-based care' and instead having people 'supported at home and kept as independent as possible, whenever possible ... provides a better experience of care for individuals'. The subtext here is of course that with less reliance on (hospital) bed-based care there will be less need for hospital beds.

What this argument leaves out is any comprehension of the last of the four processes that constitute a patient's 'trajectory' through a hospital: (1) admission and observation; (2) treatment; (3) recovery (in the clinical sense) after treatment; and (4) re-ablement.

Processes 1-3 need no explanation. But note that preparing patients to leave hospital requires more than just recovery after treatment. They have to be equipped to regain their autonomy (the ability to take decisions for themselves), their self-confidence and the physical and mental skills they need for daily living, so they move from a passive state to an active one. This fourth process is known as 're-ablement'.^[3]

Shockingly, we are told that 'older people admitted to hospital spend a significant amount of time not being physically active (83-95%)'. What this tells us is that far too little is being done to prepare patients for leaving hospital. Far too little attention is being paid by hospital managers to re-ablement, and consequently far too little by way of resources is being devoted to it.

The re-ablement model and the role of the physiotherapist

Who is best placed to help patients and guide them through the re-ablement process? Ideally it will be someone who can form an 'alliance' with the patient. Historically this has never formed part of a nurse's role. Nurses care *for* patients during their recovery, and good ones have excellent 'people skills', but they are not taught and trained to work *with* patients, to form an alliance with them.

However, there is one professional group who *are* taught that it is their responsibility to work with patients in the re-ablement process: they are the hospital's physiotherapists, members of an 'allied health profession'. It is their responsibility to 'mobilize' patients and restore their fitness.

It is time to rethink the role of physiotherapists. Although they are conventionally viewed as playing an ancillary role in acute hospitals, they don't just do exercises with people. They take a 3-year training course, during which they learn anatomy (nearly to the same level as doctors), as well as physiology and pathology. They are vital members of teams which carry out transplants, and they work in intensive care and medical wards.

Physiotherapists are equipped to play a key role in the re-ablement process. It is they more than any other professionals who can assist patients to regain their autonomy, self-confidence and physical and mental skills, and leave hospital to resume their place in their community.

The skills of physiotherapists put them in an excellent position to add 'personal trainer' to their portfolio of skills. They know very well that working with patients involves treating them as allies. They appreciate the importance of helping patients to set goals and providing feedback on their progress. With continuing professional development they would, as the recently-published NHS Long-Term Plan says, also be well placed to help patients suffering from anxiety and depression.^[4]

A re-ablement service needs to be properly staffed and financed. If it is not, patients will be competing for resources: inevitably younger patients, with jobs and family responsibilities, will be given priority. Older people will be at the back of the queue: they won't get enough exercise, they will continue to lose muscle strength that they will never regain, and they will stay in hospital longer than necessary. But if enough resources are devoted to re-ablement, the number of people staying in a hospital bed in Cornwall who 'don't need to be there' will certainly be reduced.

Re-ablement centres: a use for community hospitals

Hospitals are commonly known by the services they provide. For example, Cornwall's main hospital at Treliske, near Truro, is described as the provider of acute care services for the county. Cornwall also has a number of so-called 'community hospitals', three of which are currently closed to in-patients and at risk of being closed completely and the buildings and land sold off.

Taking a 'process view' of hospital provision in Cornwall, one thing stands out. To date, consultants and managers have not shown much if any interest in the re-ablement process. Consultants appear to be no longer interested in patients once recovery after treatment is under way, while managers seem most sensitive to beds being 'blocked' ('delayed transfers of care'). It would suit both groups to have patients moved out of the acute care hospitals after they have received treatment, and if re-ablement centres can be established at the community hospitals, these are the obvious places to move patients to. They would also be closer to home.

Recommendations

Cornwall's Clinical Commissioning Group should commission 'physiotherapy-plus' re-ablement centres for patients, to be based in community hospitals that might otherwise be sold off. Providers would be paid not to supply 'warehouse space' to accommodate patients while they regain their autonomy after their incarceration in the acute hospital but to employ teams of physiotherapists, counsellors and social workers in properly-adapted accommodation to create a stimulating mental and physical environment for them.

These centres should also serve as bases for occupational therapists who provide a service to people in their own homes, so there can be continuity of care for former in-patients. And the NHS should affirm the status of therapists as being central, not peripheral, to the process of helping patients to leave care fit and well and raring to go. Finally, policy makers should be reminded that if more resources are provided for re-ablement, this will undoubtedly reduce the number of people staying in an acute hospital bed in Cornwall who 'don't need to be there'.

Notes and references (Websites last visited on 23 January 2019)

1. *The NHS Long Term Plan*, January 2019, pp.7, 14, 18, 21
www.longtermplan.nhs.uk
2. These figures have been supplied in the course of a consultation currently taking place in West Cornwall. See also Peter Levin, 'Community hospitals under threat: Are decisions being taken on scrappy information and limited understanding?', 7 August 2017
<http://spr4cornwall.net/wp-content/uploads/Community-hospitals-under-threat.pdf>
3. 'Re-ablement: The active process of regaining skills, confidence and independence after a traumatic or ischaemic injury.'
<https://medical-dictionary.thefreedictionary.com/re-ablement>
See also Karen Johnson, 'Recognizing and treating depression in hospital patients', 24 Oct. 2017
<https://blog.medstarwashington.org/2017/10/24/recognizing-and-treating-depression-in-hospital-patients/>
4. As Note 1, p.11

Further reading

Peter Levin, 'Five kinds of nonsense keeping a community hospital closed', 4 October 2017
<http://spr4cornwall.net/wp-content/uploads/Five-kinds-of-nonsense-keeping-a-community-hospital-closed.pdf>