

Five kinds of nonsense keeping a community hospital closed

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Nonsenses revealed

The much-loved Edward Hain community hospital in St Ives, Cornwall, was closed 'temporarily' in April 2016, to great local concern. It is still closed 'temporarily'. Recent reports to Cornwall Council's Health and Adult Social Care Overview and Scrutiny Committee on the matter have revealed five kinds of nonsense that face both the hard-working people trying to bring together health and social care services in Cornwall and the members of the public who are trying to make head or tail of a complicated situation. The reports [1,2,3], which were presented by the Chief Executive of the Cornwall Partnership NHS Foundation Trust (CPFT), demonstrate:

- ◆ The nonsense of 'silo thinking': one organization taking a decision while ignoring the potentially damaging implications of that decision for others
- ◆ The nonsense of an organization presenting partial information in order to justify its case
- ◆ The nonsense of 'we won't decide until you've decided' as the model for a decision-making process
- ◆ The nonsense of calling the closure 'temporary' when no reopening date has been set, so in fact the closure is 'indeterminate'
- ◆ The nonsense of labelling the bed-based model of hospital care as 'expensive'.

This report asks what lies behind these various nonsenses. Is there a hidden - or not so hidden - agenda?

The backstory

The Edward Hain Memorial Hospital, founded in 1920, is a community hospital that until February 2016 ago provided 12 beds for in-patients needing rehabilitation, alcohol detoxification or end-of-life care. Admissions included orthopaedic patients who may have had hip replacements, patients with leg ulcers, oedema, stroke, amputees, spinal problems, chronic or acute breathing problems and cardiac patients. Some of these patients were bed-bound and able to be moved only with the assistance of a hoist, but others were mobile, with assistance if necessary. It was the only hospital serving the Penwith peninsula that provided a specialist rehabilitation/reablement service.

Since April 2013 the building has been owned by NHS Property Services (NHSPS), a limited company wholly owned by the Department of Health. At that time the hospital was run by Peninsula Community Health (PCH). In February 2016 PCH closed the 12 inpatient beds, following a fire safety review which found there was no provision for moving beds out in case of fire. PCH had previously been relying on using 'evacuation mats', on which immobile patients could be placed and dragged out of the building. Evidently the leaders of PCH had changed their minds about the acceptability of that manoeuvre.

To give effect to the closure, patients were initially transferred to a ward at Camborne and Redruth Hospital. For approximately 6 months local GPs supported patient treatment and discharge on that ward. However, this medical cover could not be sustained and it was discontinued. [1]

In April 2016, Cornwall Partnership NHS Foundation Trust (CPFT) took over the running of the hospital from PCH. They continued to keep the 12 inpatient beds closed. The Trust's leaders understood that NHS Property Services were working on a programme of remedial work to allow the hospital to reopen those beds.

In June 2016 NHS Property Services produced a report recommending certain remedial works, to start the following September. When CPFT staff looked at the plans they realised that after the works there would still be no provision for moving beds out if there were a fire. We read: 'The Trust believes (sic) the use of a mat is an extreme approach to evacuation which is likely to cause injury to both patients and staff. Relying on this approach as the sole means of evacuation does not sit comfortably with the Trust's obligation to maintain a safe environment.' [1]

In July 2016 CPFT undertook an evacuation exercise in Edward Hain with a live subject, using the drag mats. It was concluded that the time, physical demands of the procedure and the need for staff to return again and again into what would become a very dangerous environment was unacceptable as the main evacuation procedure. (This process was filmed: the film can be viewed [here](#).)

CPFT asked NHS Property Services to go back to the drawing board and produce a design conducive to bed evacuation. Four alternative designs were produced for a meeting in August 2016, and one was chosen. It involves widening of doors and corridors and would cost around £900K. 'The Trust understands that the League of Friends have offered NHSPS £600K towards this work, leaving a potential shortfall of £200-300K. It is the decision of NHSPS whether or not to accept the generous offer from the League of Friends. ... The Trust is due to meet with NHSPS Executive Team by October 2017 to discuss the potential options for the re-opening of the facility.' [1]

The CPFT chief executive also told the Overview and Scrutiny Committee: 'We need to consider any work at Edward Hain alongside our Shaping Our Future plans (Cornwall's Sustainability and Transformation Plan, STP). These plans are being developed alongside health and care partners across Cornwall and the Isles of Scilly. We have completed a round of six locality-based engagement events with around 300 clinicians, volunteers, councillors, patients and staff sharing their insight, experiences and views to co-design proposals to transform the way health and social care is delivered. All the information captured during these workshops along with the feedback that has been received will be collated and will help to tailor a series of two further workshops taking place throughout September and November. This co-design process will enable us to then develop a "service specification" for out of hospital services for the locality within which St Ives sits. Until this work is complete which may well then require formal public consultation we will not be clear on the long term use of Edward Hain as a facility.'

The nonsense of 'silo thinking': one organization taking a decision while ignoring the potentially damaging implications of that decision for others

The 'Comprehensive Impact Assessment' presented to the Overview and Scrutiny Committee said the aims of the assessment were (1) To establish the impact of the temporary closure on patients, carers and staff; (2) To determine if the temporary mitigations are delivering safe care; and (3) To present findings to support the consideration of the longer term future as part of STP. [1] As we see, there was no aim to establish the impact of the closure on the running of Treliske hospital.

A second report presented to the Committee, as a supplementary 'impact assessment', included a brief section on financial impact (capital, revenue, risks, sustainability).[2] Here we read:

Implications for NHS organisations: No impact.

Implications for the wider Health Community: No impact as community beds are available in Cornwall.

So neither of the impact assessments covers Edward Hain hospital's role of taking patients from the Royal Cornwall Hospital at Treliske after they have had surgery, so-called 'transfers of care'. (Treliske is run by the Royal Cornwall Hospitals Trust, RCHT.) Edward Hain took patients through rehabilitation/'reablement' procedures, equipping them to return to normal life. In May 2015 Edward Hain was already running at 92.7% of capacity, with 316 of its 341 available bed-nights occupied in that month. Figures show that all the other community hospitals in Cornwall were also running at more than 90% of capacity (including a staggering 99% at Camborne-Redruth). [4] Which makes a nonsense of the statement that 'community beds are available in Cornwall'.

Where would patients who had undergone surgery go when Edward Hain was closed? It would not be surprising to find that the closure of Edward Hain had resulted in a high count of 'delayed transfers of care' (DTOCs) out of Treliske, and indeed reports to the RCHT Board show that in August 2016 patients awaiting transfer took up an average of 7.1% of beds at Treliske, more than twice the national expected maximum of 3.5% and equating to an average of 55 patients per day: the 'worst performance for at least five years'. In August 2017 the equivalent figures were 9.3% and 54 patients, i.e. maintaining that 'worst performance'. The top causes of delay were the need for further non-acute NHS care (i.e. precisely the kind of care that Edward Hain formerly provided), followed by the need for domiciliary packages and completion of assessment.[5] Evidently, then, there was a major impact on Treliske and this went completely unmentioned in the CPFT reports to the Overview and Scrutiny Committee.

The nonsense of an organization presenting partial information in order to justify its case

While the 'Comprehensive Impact Assessment' listed the categories of patient who had been cared for in Edward Hain, it gave no figures. So we have no idea what proportion of patients were there for rehabilitation, alcohol detoxification or end-of-life care, or were bed-bound and/or needed a hoist to be moved. Conceivably it would have been possible to restrict admissions to patients who were not bed-bound, but lacking the information that figures provide we are unable to exercise our own judgment, or check the judgment of those who took the decision to close the hospital to inpatients.

And note the language used: 'The Trust believes the use of a mat is an extreme approach to evacuation which is likely to cause injury to both patients and staff. Relying on this approach as the sole means of evacuation does not sit comfortably with the Trust's obligation to maintain a safe environment.' Reliance on belief and the emotive term 'sitting comfortably' is not the same as using hard evidence to justify a significant public policy change.

Note too that the filmed experiment with evacuation mats used a well-built, middle-aged man as their model. It clearly required a considerable effort to drag him along the floor, much more than would be required to move a frail, elderly woman. Once again, we have a select piece of information used to justify a decision.

The nonsense of 'we won't decide until you've decided' as the model for a decision-making process

One of the reports presented to the Overview and Scrutiny Committee on September 27th (contained in a supplementary information paper circulated to Committee members only two days before) was entitled *Fire Position Statement - The Management of Fire Safety*. Buried in it (on Page 27 of 30) is this information:

NHS Property Services [has] developed alternative proposals including improved layout that will enable horizontal bed evacuation and bed holding areas. To deal with the external fire control issues a sprinkler system would be introduced that will restrict fire growth quickly and in the majority of cases prevent the need to remove patients from the building.

This revised proposal is accepted by [CPFT] as it would create an environment where we could reasonably keep staff patients and visitors safe in the event of a fire incident. The plan is to reopen inpatient services on this site when this work has been undertaken.[3]

If this proposal has been accepted, why isn't work proceeding? It transpired at the Committee meeting that CPFT is waiting until the building has been made safe. But NHS Property Services has decided to wait to see whether Edward Hain has a long-term future. Kernow Clinical Commissioning Group is waiting to see the outcome of the Sustainability and Transformation Plan process, and will not give any guarantee about Edward Hain's future until it does. And, of course, we may expect there to be a further wait until the powers that be (NHS England or the Secretary of State for Health) have decided what to do about the STP. (These are further examples of silo thinking, of course.)

So CPFT is waiting for NHSPS, which is waiting for KCCG, which is waiting for the STP, which will wait for higher approval.

The role of NHS Property Services here is crucial. The property company, which has not responded to the 'generous offer' made by Edward Hain's League of Friends, has taken it upon itself to keep this community hospital out of use for reasons that are entirely its own and have nothing to do with health care. As its website shows, it prides itself on realising large sums from the sales of 'surplus' property.[6] So its decisions have taken no account of the burdens that are falling - and will continue to fall - on Treliske hospital and on patients.

We can think of planning as a process of colonizing the future. KCCG's attitude appears to be that while planning is taking place the present needs to be frozen. To bring Edward Hain hospital up to scratch would be to create a bridgehead into the future, so a certain amount of 'thawing' would be required. It should not be beyond the wit of KCCG's managers to envisage alternative scenarios in which a safe Edward Hain building could be seen as offering opportunities for being usefully employed. Planning in the field of public policy always takes place in a dynamic situation. The world does not stop. The planners have to deal with that, to adapt, to look for ways of incorporating those dynamics into their plans. If they make no attempt to do so, we must question their competence.

As things stand, the planners have given NHS Property Services, which has an interest in seeing land and buildings declared surplus to requirements, a veto over the use of Edward Hain in the immediate future. (Meanwhile the expenses of rates, security and basic maintenance will still be incurred, of course.)

The nonsense of calling the closure 'temporary' when no reopening date has been set, so in fact the closure is 'indeterminate'

It would be legitimate to describe the closure of Edward Hain hospital as temporary if the reopening were contingent on some tangible process with a completion date, like the actual carrying out of works under a contract. But when the chief executive of CPFT chooses to call an indeterminate closure 'temporary' should he be surprised when local people feel they are being taken for fools?

The nonsense of labelling the bed-based model of hospital care as 'expensive'

The Outline Business Case for the STP published in October 2016 put forward a case for change that incorporated several references to 'expensive bed-based care'.^[7] Bed-based care is also described as 'outdated' (on page 43). Interestingly, hardly anything else in this substantial document is described as 'expensive'. In normal usage the adjective 'expensive' is a relative one: X is expensive compared with Y. But here we are given nothing to compare bed-based care with.

We are also told, among a number of 'facts that support the need for change', that 'Around 60 people each day are staying in an acute hospital bed in Cornwall and they don't need to be there'^[8] – which looks to be at least in part a consequence of the closure of Edward Hain, of course. Further, we are told 'Older people can lose 5% of their muscle strength per day of treatment in a hospital bed': we aren't told, however, what percentage of muscle strength per day you would lose staying unwell at home in your own bed, being visited for limited periods by a physiotherapist who spends a good deal of her or his professional time driving from one patient's home to the next. It would appear that these so-called facts are being trotted out to support the argument that bed-based care is 'expensive'.

Is there a hidden - or not so hidden - agenda?

This question is essentially about the interests that motivate the people who commission and provide health and social care services in Cornwall.

The officers of Kernow CCG are manifestly under pressure from their masters in NHS England, to whom they account for their spending, which in 2016 showed they were heading for a budget deficit of £264 million by 2020/21. NHS England have also been pursuing a national policy of saving money by cutting the number of hospital beds, and a number of clinical commissioning groups have produced STPs which show large reductions. We cannot expect KCCG to be immune from this pressure, which would explain the labelling of bed-based care as 'expensive' and their 'scraping the barrel' efforts to find other justifications for closing beds.

Recently-published research by the King's Fund^[9] and the Nuffield Trust^[10] has high-lighted the harmful consequences of this policy, and it may be that KCCG officers are in two minds as to whether it is in their interest to continue with it or not. That would be consistent with their 'kicking the can down the road' policy of deferring any decision until they see the STP – although it is of course within their power to determine what actually goes into the STP!

The front-line player in the Edward Hain saga is the Cornwall Partnership Foundation Trust (CPFT). CPFT describes itself as a 'mental health provider'^[11] and on his LinkedIn profile its chief executive describes as his achievements that CPFT was one of only a small number of mental health providers assessed as Good by the Care Quality Commission, that he successfully managed local PFI companies regularising the arrangements and securing compensation in excess of a four million pounds, and that he 'successfully delivered two transactions, children's services for £12 million in 2011 and adult community services for £78

million in 2016', as well as growing the organisation from £70 million to £160 million in six years.

We might infer from this that his main priorities are mental health provision and financial success, in which fields success can be attributed to him and his organization alone. His interest in providing 'intermediate care' and working with other health care providers would come correspondingly low down in his priorities. We might say that in keeping more than 90% of the beds in his community hospitals occupied he is using them efficiently, but the consequence for Cornwall's provider of acute hospital services, RCHT, is that the managers there have no idea from day to day whether they will be able to move out a patient who is recovering from surgery. The CPFT chief executive's interests appear not to extend to providing an integrated service.

The CPFT chief executive continues to affirm that CPFT's plan is to reopen inpatient services at Edward Hain hospital when the fire safety work has been undertaken.[3] Is that genuinely his intention? He shows no sign of trying to find a way forward that would encourage NHS Property Services to carry out those works, while NHSPS know that if they can promote the idea that the building and land are surplus to requirements they can highlight their achievement in raising a large sum from selling it. It does appear that the CPFT chief executive's agenda is not one in which the reopening of Edward Hain hospital will feature.

What can we say about the interests of RCHT? Management and staff appear to have a common interest in getting on with the job, and are frustrated by the continuing difficulty of moving out patients who have undergone surgery and are fit to leave. Unfortunately, because their interests are evidently narrowly focused on moving patients out, when collecting data they focus only on patients' fitness to leave: they do not collect data on where those patients are fit to move to. If they were to distinguish between fitness to go home, given an appropriate home-care package, and fitness to move to an intermediate care hospital such as Edward Hain, which would provide rehabilitation/re-ablement care, they would be able to add their voice and inside information to the case for keeping Edward Hain open.

Cornwall Council, the local authority with responsibility for social care, does keep a record of the number of delayed transfers of care that are attributable to adult social care from acute hospital per 100,000 population.

Officers have told HASCOSC that the Council has been working closely with health partners to improve delayed transfers of care. In March 2017 the Government announced a national adult social care grant for local authorities. Cornwall's share is approximately £12m. In July the Department of Health (DoH) attached targets to this funding. For Cornwall this amounts to achieving a performance of 6.3 DTOCs per 100,000 18+ population by September. Later data are not available, but such an achievement would have been a remarkable feat, given that the figure for June was 16.4. Council officers say they are addressing 'issues with delays for assessments, market stabilization, patient flow and prevention'.^[12] It is evidently in the interest of Council officers to attain the DoH target, but they are encountering obstacles.

Council officers are also working on Integration of health and social care through the Shaping our Future Programme, as work on the STP has been rebranded. The focus here is on 'recommissioning Integrated Community Teams and Community Hubs (including community hospitals and bed provision)'. As of mid-June 2017, they have reported, 'despite some progress, the status of the programme is now Red (i.e. out of tolerance with no current approved plan to bring the situation back under control) because: (1) There is insufficient capacity within the central team for Integrated Community Care to deliver at the pace required given the

acknowledged complexity of the programme; (2) [Resulting from] the complexity of the organic and locally based nature of integrated practice across primary care and community health and social care, the central team have not yet identified a way to fully understand this, increase the visibility of positive operational change and construct this into a coherent framework for Cornwall; and (3) Based on learning from North Devon, we are not currently collecting the acuity data needed to show the impact of Integrated Community Care on hospital bed demand.[12]

Reading between the lines, it seems evident that what we have here are council officers with a keen awareness of the position of community hospitals and bed provision who have found the 'central team' very limited (to put it politely) in its capability to address the issue. Yet it is this self-same central team that has been entrusted with producing the STP on which the future of Edward Hain hospital depends.

The STP team is ostensibly working under the supervision of a four-person collective, comprising the chief officers of Cornwall Council, the Royal Cornwall Hospitals Trust, Cornwall Partnership Foundation Trust and Kernow Clinical Commissioning Group. They reported to HASCOSC in July that they have three programmes of work running in parallel under Shaping our Future: (1) Development of business case for new integrated model of care; (2) Moving to an Accountable Care System; (3) Developing a strategic case for Devolution.[13]

This is all 'high-level stuff': it reveals the overwhelming interest of those involved in gathering powers and creating a power structure, rather than in sorting out the complex situation on the ground identified by the less senior council officers. It is hard to see the future of Edward Hain hospital featuring high on their agenda.

And with that being the case, it is not hard to envisage the other members of the 'gang of four' leaving it to the chief executive of CPFT to do whatever he wants, despite the five kinds of nonsense identified in this report, and ride out any little local difficulty that might ensue.

If the League of Friends of Edward Hain Hospital want to save it, the last community hospital remaining in Penwith, they must not only challenge the hidden agenda of CPFT and NHS Property Services to close it: they must also raise it up the agenda of those who might otherwise close their minds to the issue. And if they make a great noise in doing so, can anyone say they are being unreasonable? It is currently anticipated that there will be a round of public consultation on community hospital closures in February 2018. [2] This story is not over yet.

Notes

[1] [Comprehensive Impact Assessment](https://democracy.cornwall.gov.uk/documents/s103287/Appendix%201%20-%20Edward%20Hain%20-%20Impact%20Assessment.pdf), Version 7, February 2017
<https://democracy.cornwall.gov.uk/documents/s103287/Appendix%201%20-%20Edward%20Hain%20-%20Impact%20Assessment.pdf>

[2] [Proposed Service Change or Development: Substantial Variation Impact Assessment](https://democracy.cornwall.gov.uk/documents/s103485/Appendix%202%20Edward%20Hain%20Substantial%20Variation%20Impact%20Assessment.pdf), submitted to HASCOSC 22 September 2017
<https://democracy.cornwall.gov.uk/documents/s103485/Appendix%202%20Edward%20Hain%20Substantial%20Variation%20Impact%20Assessment.pdf>

[3] [Fire Position Statement](https://democracy.cornwall.gov.uk/documents/b24077/Supplementary%20Information%20Provided%20for%20Edward%20Hain%20Hospital%2027th-Sep-2017%2010.00%20Health%20and%20Adult%20S.pdf?T=9) (incorporated in supplementary information paper for HASCOSC)
<https://democracy.cornwall.gov.uk/documents/b24077/Supplementary%20Information%20Provided%20for%20Edward%20Hain%20Hospital%2027th-Sep-2017%2010.00%20Health%20and%20Adult%20S.pdf?T=9>

- [4] See [Community Hospitals Under Threat](http://spr4cornwall.net/community-hospitals-under-threat-are-decisions-being-taken-on-scrappy-information-and-limited-understanding/) <http://spr4cornwall.net/community-hospitals-under-threat-are-decisions-being-taken-on-scrappy-information-and-limited-understanding/>
- [5] [Integrated Performance Report](https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/TrustBoard/Minutes/1718/201709/App05IntegratedPerformanceReport.pdf) to RCHT Board, 28 September 2017
<https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/TrustBoard/Minutes/1718/201709/App05IntegratedPerformanceReport.pdf>
- [6] <http://www.property.nhs.uk/>
- [7] [Cornwall and the Isles of Scilly: Sustainability and Transformation Plan: Draft Outline Business Case](https://www.cornwall.gov.uk/media/22984634/cornwall-ios-stp-draft-outline-business-case.pdf), 21 October 2016
<https://www.cornwall.gov.uk/media/22984634/cornwall-ios-stp-draft-outline-business-case.pdf>
- [8] In [Taking Control, Shaping our Future](https://www.cornwall.gov.uk/media/22983857/taking-control-shaping-our-future.pdf) (A summary of the Draft Outline Business Case), p.15
<https://www.cornwall.gov.uk/media/22983857/taking-control-shaping-our-future.pdf>
- [9] Ewbank *et al*, [NHS hospital bed numbers: past, present, future](https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers), The King's Fund, 29 September 2017 <https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers>
- [10] N.Edwards, [What's behind delayed transfers of care?](https://www.nuffieldtrust.org.uk/resource/what-s-behind-delayed-transfers-of-care), Nuffield Trust, 8 February 2017
<https://www.nuffieldtrust.org.uk/resource/what-s-behind-delayed-transfers-of-care>
- [11] NHS Benchmarking Network, [Current Members](https://www.nhsbenchmarking.nhs.uk/current-members)
<https://www.nhsbenchmarking.nhs.uk/current-members>
- [12] Cornwall Council, Health and Adult Social Care Overview and Scrutiny Committee - [Performance Dashboard, Quarter 1 2017/18](https://democracy.cornwall.gov.uk/documents/s103141/Appendix%202%20Work%20Plan%20Performance%20Dashboard%20Q1.pdf)
<https://democracy.cornwall.gov.uk/documents/s103141/Appendix%202%20Work%20Plan%20Performance%20Dashboard%20Q1.pdf>
- [13] K. Byrne, [Shaping Our Future](https://democracy.cornwall.gov.uk/documents/s103143/Shaping%20our%20Future%20Report.pdf), report to HASCOSC 27 September 2017
<https://democracy.cornwall.gov.uk/documents/s103143/Shaping%20our%20Future%20Report.pdf>