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For the record: an assessment of policy-making by NHS Kernow, Cornwall's clinical commissioning group

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This paper presents an assessment of the policy-making behaviour of NHS Kernow, Cornwall's clinical commissioning group. It was originally formulated as a complaint to the Parliamentary and Health Service Ombudsman, but in that format it became redundant when it was announced that clinical commissioning groups in England were to be abolished and their functions taken over by integrated care systems. The assessment is presented here in the belief that there should be a record of the making of policies which led in some cases to patients being harmed, especially patients whose homes were in Penwith in the far West of Cornwall.

The policy-making which this paper examines was undertaken by the Governing Body and senior staff of NHS Kernow between January 2019 and June 2021. It resulted in the final removal of all 'step-down' community hospital beds in Penwith.

Those step-down beds in community hospitals – better described as beds in step-down settings – had previously been available locally for Penwith residents discharged from Cornwall's main acute hospital at Treliske, near Truro. Since inpatient beds at the last remaining community hospital in Penwith (the Edward Hain Memorial Hospital in St Ives) were closed in 2016, a number of those residents have been sent to community hospitals and to privately-owned and run care homes up to 70 miles from home, with some being held there for long periods.

Much of the evidence on which this assessment is based is contained in a report entitled Community Hospital Engagement[1] presented to a meeting of NHS Kernow's Governing Body on 1 December 2020 and a variety of documents referenced in it. That presentation was the final stage in a sequence of workshops and associated activities. (Minutes and slides are available.)[2]

The assessment identified the following defects in the policy-making process:

1. The harmful impact of the policy of NHS Kernow and NHS Trusts on local people, especially people discharged from acute care and sent far away from home, was not identified and addressed. During the Covid-19 pandemic, a senior NHS Kernow executive informed the Governing Body that patient choice had been 'set aside'.

Thanks to a request for information submitted to NHS Kernow by West Cornwall HealthWatch, we now know that after Edward Hain hospital lost its 12 in-patient beds in 2016, the need for such beds rose significantly: the number of Penwith residents aged 65 or over who were discharged from Treliske and needed to go to a bed in a 'step-down setting', because although considered medically fit to leave they weren't yet able to manage at home, increased: it rose from 195 in 2015-16 (the last year that the Edward Hain beds were in use) to 232 in 2019-20, a rise of almost 20%.[3]

We also now know that in 2019-20 no fewer than 75 Penwith residents aged 65+ were discharged from Treliske and found themselves in community hospitals far from home: in Falmouth (17 patients, an average distance of 24 miles from home); Newquay (20 patients, 34 miles); St Austell (12 patients, 40 miles); Bodmin (11 patients, 47 miles); and Liskeard (15 patients, 63 miles). These are all places that had previously taken very few Penwith residents: only 8 between them in 2015-16, the last year in which Edward Hain was offering inpatient beds.

This situation is continuing. At the February 2021 meeting of the NHS Governing Body, a GP member said that she knew of elderly patients from West Cornwall who had been discharged from Treliske and sent to care homes in the East of Cornwall near the Devon border, far from their home area. She said she had also encountered some patients who had been discharged to care homes as a short term measure but were still there 10 to 12 months later. At the meeting she was told by a senior NHS executive that under the pressure of the Covid-19 pandemic options around choice had been set aside as part of the response to the pandemic.[4] [5]

It is evident that closing Edward Hain hospital resulted in the dispersal of a number of Penwith residents aged 65 or over to community hospitals and care homes far from their home territory and beyond the catchment area of their GP surgeries. NHS Kernow staff did not present this crucial information to the workshops, nor to their Governing Body, nor to Cornwall Council's Health and Adult Social Care Overview and Scrutiny Committee.

The person who chaired the workshops that were held (the 'clinical lead') admitted, at the last of them (a virtual meeting on 22 October 2020): '[Until] we understand the true need for beds, instead of current use, we will not know what beds we need.'[6] Leaving aside the question of whether there can be such a thing as 'true' need, it is clear that the decision to finally close Edward Hain Community Hospital was taken with no attempt to gauge the need for beds generated by the population of Penwith.

2. The scope of the decision-making process was considerably narrowed, without publicizing the fact, from a review of options for the possible future shape of

community services in the locality to only a consideration of the future of the Edward Hain Community Hospital building in St Ives, thereby preventing public discussion of the Penwith 'model of care'.

In April 2019 NHS Kernow invited a number of people to participate in a 'review of community services in Penwith, including those [services] that were provided from Edward Hain community hospital' [in St Ives].[7] The purpose of this 'workshop' was 'to help identify a list of options for the possible future shape of community services in the locality, which will determine the future of Edward Hain Community Hospital'.

Two and a half months later, and without consultation, that approach was abandoned in favour of treating the issue much more narrowly: the review was no longer about community services but only about what to do with the building that housed the Edward Hain hospital.[8] As a result, no debate took place on how to replace the service that the hospital had provided, in particular beds in a step-down setting for patients who were discharged from Cornwall's main acute hospital at Treliske, near Truro, but not yet fit enough to return home.

Nor was the possibility ever considered of using the Edward Hain building in any other way than as a conventional community hospital – as a wellbeing centre, for example. This enabled NHS Kernow to rule out retaining it on the grounds that it provided only 12 beds, given that the South West Clinical Senate had recommended 'that the minimum number of beds in any single location should be 16 for safe, reliable and efficient staffing'. In fact the Senate's report also cited the conclusion of a study carried out for the National Institute for Health Research that 'neither investment in nor closure of community hospitals has been informed by authoritative guidance'. [9]

As we see, NHS Kernow staff made no attempt to explore the potential of a 12-bed unit for particular categories of patient, or for patients making the transition out of *or in to the* acute hospital (such a unit could be used to get patients ready who are awaiting elective surgery), or of using it as an adjunct to West Cornwall Hospital in Penzance for patients who are able to walk. For good measure they informed the Governing Body (without citing a source) that 'it would need 29 new nurses to support 12 beds',[10] but that of course would not apply if the building were used in a way that was different from a traditional community hospital.

3. NHS Kernow staff shifted the format of the workshops they held from 'bottom-up' round-table discussions to 'top-down' presentations followed by questions and answers, so attendees had no opportunity to discuss those presentations among themselves.

The first workshop had a 'bottom-up' format – small-group round-table discussions, enabling attendees to exchange views and learn from each other – and adopted a methodology that can be summarized as 'planning by Post-It Note', based on collecting snippets of information and opinion about health and social care services: these were recorded as 'key points' and as jottings on Post-It Notes. Not all of the minutes have been published (despite being promised the missing ones have not appeared), but even so 111 key points and 77 Post-It jottings are presented.[11]

This methodology was abandoned for subsequent workshops – perhaps those in charge were defeated by the challenge of how to fit these fragments together – and a new 'top down' format took its place, of presentations followed by question-and-answer sessions (still styled as 'workshops'). This format changed the pattern of communication to one centred on the speaker and deprived attendees of an opportunity to discuss the presentations among themselves.

4. NHS Kernow staff formulated a scoring scheme for evaluating options that was inherently unsound. It gave weight to subjective opinions and speculation rather than to empirical evidence, and it took the quantity of so-called evidence, rather than any measures of costs and benefits, as the measure of each criterion used. Challenges to this defective approach, which generated a 'score' of only 13 out of a possible 84 for the single option evaluated, have gone unacknowledged.

The attendees at the third workshop were presented with eight options. They agreed that just one of them should go forward to full evaluation:

> Re-provision of 12 inpatient reablement beds [at Edward Hain hospital] and continuation of existing ... community clinics in a fire safety compliant and refurbished environment.[12]

(The minutes of this workshop show that the attendees had different motives. Three representatives of the Edward Hain Hospital League of Friends favoured implementing that option, but some others present supported proceeding to full evaluation because they expected the evaluation to demonstrate that it was not feasible.)

The full evaluation was undertaken by 13 evaluators: five were senior executives of the Cornwall Partnership Foundation NHS Trust, three were senior executives of NHS Kernow, one was a senior executive of the Royal Cornwall Hospitals NHS Trust; and two were senior officers of Cornwall Council. Of the other two, one was a local Cornwall Councillor and the other a committee member of West Cornwall HealthWatch, a voluntary watchdog and campaigning group set up in 1997. They used 21 criteria 'pre-determined' by 'subject matter experts' drawn from all over Cornwall. The scores on four criteria were not agreed by the evaluators, and these were escalated to a 'super

moderation' stage, carried out by four senior NHS Kernow executives. They decided that the evaluated option was not viable.

The scoring system gave weight to subjective opinions and speculation rather than to empirical evidence. It bears no resemblance to a cost-benefit analysis. NHS Kernow staff published an evaluation document that took the form of a compilation of 82 very brief statements.[13] All are expressed as opinions, and many as speculation: the words 'may', 'could', 'if', 'but', 'likely' and 'unlikely' appear in total more than 30 times. For example, we find 'It is unlikely that GP and other services could be provided 24 hours' and 'It may be a "false choice" as local people may still need to have inpatient care elsewhere'.

Subjective and speculative statements of this kind do not constitute evidence from which extrapolations into the future may reliably be made. Empirical evidence is notably absent from the scoring system used in this case.

The scoring system drawn up by NHS Kernow staff and employed for evaluation confused quantity of 'evidence' with actual performance criteria, and this has not been rectified. The scoring system ran from 0 to 4 as follows: 0 = No evidence; 1 = Limited evidence; 2 = Adequate evidence; 3 = Good evidence; 4 = Exceptional evidence. While these could be used as criteria for gauging the *confidence* that we might have in assigning a particular score, they are not substantive scores, e.g. scores on criteria to do with the quality of actual healthcare services, as might be found in a cost-benefit analysis.

In the case of the proposal to keep the Edward Hain hospital, as the slides for the August 2020 workshop show,[14] of the 21 so-called criteria, on eight the score was 0 and on thirteen the score was 1. On none of the criteria was the score 3 or 4. Thus, for eight of the 'criteria' we are told there was 'No evidence' and for the other thirteen there was only 'Limited evidence' There is no other word than 'bizarre' to describe this misconceived scoring system.

It is extremely disturbing that NHS Kernow staff based their decision on what they themselves described as 'No evidence' and 'Limited evidence', and that this was not queried by the majority of the evaluators.

5. NHS Kernow staff misinterpreted statistical data and drew erroneous conclusions from them.

The figures provided by NHS Kernow in response to the request for information from West Cornwall HealthWatch allow us to check a calculation presented in the recent *Edward Hain Community Hospital engagement report*.[15] This says:

> We have looked at data to understand if Penwith residents need to travel further to access a hospital bed. Recent data shows that in the recent 12 months

> compared with the 12 months when the Edward Hain Community Hospital beds were open, Penwith residents were admitted to hospitals on average 5.36 miles further away than residents outside Penwith who were discharged from [Treliske].

This figure of 5.36 miles is as low as it is purely because of the method of calculation. Averaging the distances travelled by Penwith residents means offsetting the long distances travelled by some (e.g. 63 miles to Liskeard) against the short distances travelled by others (e.g. 3 miles to West Cornwall Hospital). Those two figures give an average distance of 33 miles, but that figure is meaningless to a prospective patient. **Averages obtained in this way have no meaning for patients in the real world.** At the very least the calculation should have been carried out using 'out of local area' journeys only.

Taking that average figure hides the fact that in 2019-20 no fewer than 75 Penwith residents aged 65+ were transferred to a community hospital 24, 34, 40, 47 or 63 miles from their home. They were removed from their local community at an extremely vulnerable point in their lives. There is no indication that large numbers of elderly residents of any other area of Cornwall have experienced being sent so far from home.

6. NHS Kernow staff began to describe attendees at so-called workshops as 'the community stakeholder group': this 'group' had no constitution and no officers, and members of local voluntary organizations were in the minority at every workshop, but the the authors of the report to the Governing Body frequently justified their reasoning by saying that 'the community stakeholder group' was involved throughout the process.[16] That 'group' was an invention on their part.

The attendees at all the workshops, other than NHS Kernow staff, included members of the Edward Hain Hospital League of Friends, West Cornwall HealthWatch, and patient participation groups from various surgeries, as well as a small number of Cornwall councillors and town councillors and members of various voluntary organizations, but in every workshop they were outnumbered by the paid staff of hospital trusts, Cornwall Council etc. So the 'community stakeholder group' cannot be regarded as representative of the Penwith community.

But this form of words enabled the staff, in papers that they prepared for the Governing Body and Cornwall Council, to ascribe a single monolithic view to this 'group' – mostly in a way that supported their position – and thereby conceal differences of opinion among attendees.

We see a similar sleight of hand in the report to the Governing Body if we look for references to the Penwith Primary Care Network (PCN) and the Penwith Integrated Care Forum (PICF). There are more than a dozen references such as this one:

> Penwith PCN continues to involve the community with the model of care development through the existing Penwith Integrated Care Forum.

As a member of PICF for at least four years, I can say with confidence that although we have occasionally received verbal updates from Penwith PCN the most substantial document we have received (in April 2018) contained no research: just generalities, endorsements, general aspirations, like this:

> We expect delivery of the new model to be built on strong relationships between local multidisciplinary teams and local communities. The foundation for this will be the unique relationship GPs have with their registered practice population ...

and a child-like picture entitled 'Penwith – our house of bricks'![17]

7. The Governing Body of NHS Kernow took the decision to close the Edward Hain hospital partly on the basis of an assurance it was given by Cornwall Council that 28 new care home beds designated as Discharge to Assess would become available in January 2021. That assurance was not honoured, but the decision was never reviewed. Those beds remained unavailable to Penwith residents during the winter months of early 2021 and were still unavailable as of mid-June 2021.

At the Governing Body meeting on 1 December 2020, members received a report assuring them that new care home beds would soon become available in Penzance:

> This is the first time a new care home has been built in Cornwall for over a decade. This will provide an additional 28 reablement beds and these have been commissioned as discharge to assess beds. The intended length of stay for individuals will be up to 6 weeks. ... Some beds will also be for people with dementia and complex care needs. This will increase bedded reablement capacity in the west of Cornwall ... The beds are due to open mid-January 2021.[18]

In fact the care home is not a new building but a conversion of a building previously used as a nursery school; planning permission was yet to be granted; and by mid-June 2021 the new beds had still not materialized. But the report to the Governing Body has never been updated and the Governing Body has had no opportunity to review its decision to close the Edward Hain hospital. Meanwhile some Penwith residents discharged from Treliske are still being sent far from home.

In a recent (27 May 2021) verbal update for the Penwith Integrated Care Forum, a Cornwall Council officer said that the new facility would be 'a nursing home to reduce

impact on community nursing teams'. Eventually the home would have 32 beds, the first 12 were to open the following week. They did not.

8. NHS Kernow staff have taken it for granted that 'reablement beds in private care homes' is the answer to the question 'Where should patients go who are discharged from the acute hospital but not yet able to return home?' While beds so labelled are key to planning healthcare for Cornwall, especially during the Covid-19 pandemic, staff have not said what they mean by a 'reablement bed' nor investigated the facilities in care homes but passed the buck to Cornwall Council, who appear equally uninterested.

NHS Kernow's response to Freedom of Information requests demonstrates how it has passed the buck to Cornwall Council, as the following questions and answers illustrate: [19]

Q: What steps has NHS Kernow taken to ensure that its officers are familiar with the NICE guideline 'Intermediate care including reablement'?

A: The new care home is the responsibility of Cornwall Council; please contact them for more information.

Q: Has NHS Kernow decided that 'the new care home' should accommodate long-term residents? If so, please provide documents that demonstrate that thought has been given to how to accommodate short-term and long-term residents in the same establishment.

A: The care homes purpose will be determined by its owners, please contact Cornwall Council for more information.

The concept of 'reablement bed', taken literally, is a contradiction in terms: reablement cannot take place in a bed. A 'reablement bed' must be short for 'bed in a reablement *setting*'. Unfortunately neither NHS Kernow nor Cornwall Council has spelled out in documentary form what a reablement setting entails by way of accommodation, equipment and staffing.

In January 2020 Cornwall Council produced, jointly with NHS Kernow and Cornwall Partnership NHS Foundation Trust, a draft document entitled *Care Homes Market Development Strategy: Joint Strategic Commissioning Intentions*.[20] This drew a distinction between three types of bed provided in care homes in the market sector in Cornwall: Residential, Residential Dementia, and Nursing. It says nothing about the accommodation and equipment needs for the different categories, and at the present time, the document has not been updated to include the category of Reablement beds nor ratified as policy.

The market development strategy predicted a significant increase in the number of people with dementia and in the level of complexity of their condition, with a forecast increase in numbers of approximately 40% between 2020 and 2030. In 2020 there were approximately 0.35 beds per person with dementia aged 65 or over. If that ratio were to continue into the future, Cornwall would require a total of 4,906 'dementia beds' in 2030, an increase of 37% over the number in 2020. However, given that it was already difficult to place people with complex and challenging behaviour, whose number was likely to increase in future, the number of dementia beds required would rise even further than this.

NHS Kernow's reallocation of the beds in the anticipated care home in Penzance from dementia to reablement appears to take no account of the current or future need for 'dementia beds' in Cornwall, nor is it based on any assessment of the different accommodation, equipment and staffing needs for reablement and dementia care. We can only conclude that it is a matter of labelling carried out for the purpose of heading off the demand to retain beds in a step-down setting in Penwith. This is not how policy should be made.

It has never been explained to Governing Body members – nor do NHS Kernow staff themselves appear to have asked – how a single establishment can adequately provide short-term accommodation for patients needing reablement alongside long-term residential accommodation for patients with dementia and exhibiting complex and challenging behaviour. Nor indeed do they appear to have asked in what way 'Discharge to Assess beds' and 'reablement beds' are 'by nature' the same.

An important lesson of the Covid-19 pandemic is provided by people who have experienced 'Long Covid'. It no longer makes sense, if it ever really did, to think of ill-health as a sequence of episodes, where an episode of treatment is followed by an episode of recovery. A study of nearly 48,000 individuals who had a hospital episode with a primary diagnosis of Covid-19 in the first eight months of 2020 found that almost 30% were readmitted within 140 days of discharge (a rate of readmission 3½ times that for those in a control group).[21] It seems clear that for many patients, after rapid spur-of-the-moment discharge in line with the Government's current Discharge to Assess instructions, a 'step-down' stage before returning home could help to prevent readmission.

Notes and references (All websites last accessed 17 June 2021)

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