SOCIAL POLICY RESEARCH FOR CORNWALL

27 August 2022 https://spr4cornwall.net

How NHS England, top doctors and acute hospitals MANUFACTURE need for social care, and why we need to rediscover convalescence

Dr Peter Levin (PhD)

EXECUTIVE SUMMARY

- A blame game is being played out before our eyes. Ambulances are waiting for hours outside emergency departments to discharge people in need of urgent care, amid claims by NHS England and acute hospital trusts that thousands of acute hospital beds are unavailable for emergency patients because they are occupied by patients who can't be discharged because they are waiting for social care.
- But if we look into these claims and ask what actually goes on in acute hospitals, we find that NHS England, the Academy of Medical Royal Colleges (AMRC) and clinicians bear a heavy responsibility for creating this situation.
- Focused as they are on providing 'treatment episodes', the hospitals do little to maintain inpatients' well-being: to recognize, monitor and ameliorate processes of physical deconditioning and psychological deterioration. In a nutshell, they fail to recognize that care is needed as well as cure, and that providing care has to be a process, not an episode.
- Acute hospitals create need for further care by discharging patients when they can, at very short notice, on the basis of 'criteria to reside' drawn up by the AMRC. These criteria are exclusively clinical and take no account of the patient's level of well-being and whether they are fit to go elsewhere.
- NHS England's attempts to improve matters by issuing directives and setting targets will continue to fail until they recognize that while highly-qualified doctors and surgeons may excel at diagnosing ailments and providing episodes of treatment, on the evidence they are simply not interested in how being in hospital affects patients.

- Not only do trainee doctors learn from consultants that their role is to provide episodes of treatment rather than think in terms of process, they go through the NHS Leadership Academy which sees its role as equipping them 'to be a leader of people at the start of their career'. So we have brand-new doctors coming in to hospitals having already been taught to think of themselves as leaders, then finding themselves among nurses and allied health professionals who have far more experience than they do, and bringing with them no awareness of the processes of damage to their well-being that patients undergo.
- Before the NHS was born, the UK learned from two world wars that convalescent homes were crucial to the recovery and reablement of members of the armed forces suffering from war wounds. It is time to relearn those lessons. Every acute hospital should have a group of convalescence establishments around it, or at least a designated convalescence unit within one or two local community hospitals. They should be led by therapists, not doctors or nurses. Their role would be to immediately whisk away from the acute hospital every patient who no longer meets the criteria to reside, and go on provide any further medical care that they need, while also nurturing their well-being and provide them with the therapies, the life skills and the social environment they need to regain their place in their communities. That move would be a tangible step for them on their road back to 'normal' life, as well as freeing up much-needed beds in acute hospitals.

Introduction

All over the UK, we are being told that large numbers of patients occupying beds in acute hospitals don't need to be there: they are medically fit for discharge, and the reason why they are still there is that they have been unable to move on from medical care to out-of-hospital social care. For example, the Royal Cornwall Hospitals Trust (RCHT) recently reported

> Acute hospital and ambulance services in Cornwall are being directly and severely impacted by the current significant shortfall in social care capacity in the Duchy … . Over the last two years the number of acute hospital beds

> occupied by patients who are waiting for social care or other community support [before they can be discharged has] almost doubled ... and this has resulted in over 100 of RCHT acute hospital beds now [being] unavailable for our emergency patients.

NHS England, 'top doctors' – in the form of the Academy of Medical Royal Colleges (AMRC) – and acute hospital trusts seem to have unanimously identified the crucial issue as one of length of stay: patients are staying too long in a hospital bed. There has been a stream of initiatives from the centre directed towards discharging patients from hospital sooner.

Without exception, these initiatives have ignored the experiences that patients have, alongside their medical treatment, during their stay. But there is evidence that for many, and for 'over-stayers' in particular, those experiences harm their well-being and leave them in need of care to help them recover it.

The emphasis that NHS England is currently placing on maximizing the flow of patients through hospitals while ignoring the experiences that they have has resulted in *manufacturing* need for what we know in the UK as 'social care'. The decisions of NHS leaders, aided and abetted by the AMRC and hospital clinicians, have had the effect, when acted on, of creating more such need than there would otherwise be. The newly-established integrated care systems seem unlikely to change this.

This paper examines guidance for hospital discharge issued in August 2020 and March 2022 and subsequently. It shows that such guidance continues to be concentrated on terminating treatment episodes as early as possible, and pays little or no attention to maintaining and restoring patients' well-being. It suggests that such episodes need to be seen as part of a process, which should conclude with convalescence.

March 2020 and March 2022: Two versions of hospital discharge guidance

The first version of the hospital discharge guidance after the onset of the Covid-19 pandemic was published in March 2020: a 'fully updated' version of it appeared in August 2020, with the title Hospital Discharge Service: Policy and Operating Model. A subsequent – and significantly different – version appeared in March 2022, entitled Hospital Discharge and Community Support Guidance. Salient differences between the two versions are highlighted in Table 1 below:

Table 1: Salient differences between the two versions of hospital discharge guidance

	August 2020 version	March 2022 version
Title	Hospital Discharge Service: Policy and Operating Model	Hospital Discharge and Community Support Guidance
Author/publisher (as on cover)	HM Government & NHS	Dept of Health and Social Care
Others who contributed	Academy of Medical Royal Colleges (their logo is on the 'criteria to reside' page), together with the Local Government Association and the Association of Directors of Adult Social Services	British Geriatrics Society, CarersUK, Homecare Association, The Patients Association, Principal Social Workers Network, The Royal College of Occupational Therapists and 15 others
References to multi-disciplinary teams	Two	Thirteen
References to collaboration	None	Seven
Attention paid to process	Minimal, apart from references to patient 'pathways'. A patient can be removed at very short notice (see Table 2).	Some. Guidance is structured around the individual's 'care journey' and 'discharge journey'. 'Planning for discharge from hospital should begin on admission.' No reference to patients' care once classified as over-stayers.
Application of 'criteria to reside'	Inflexible.	Under review.

The list of 'Criteria to Reside' is shown in Table 2. Every single one is to do with the patient's clinical condition. None is to do with their physical or psychological well-being, feelings of anxiety that they might have, or whether they will be safe at whatever might be their destination. Nor is there scope for a clinician to judge the likelihood of a patient needing to be readmitted for further treatment, for example, or the advisability of keeping them in for observation.

Table 2: 'Criteria to Reside'

'Acute hospitals must discharge all persons who no longer meet these criteria as soon as they are clinically safe to do so.'
'Requiring ITU or HDU care? | Requiring oxygen therapy/NIV? | Requiring intravenous fluids? | NEWS2 > 3? (clinical judgement required in persons with AF and/or chronic respiratory disease) | Diminished level of consciousness where recovery realistic? | Acute functional impairment in excess of home/community care provision? | Last hours of life? | Requiring intravenous medication > b.d. (including analgesia)? | Undergone lower limb surgery within 48 hours? | Undergone thorax-abdominal/pelvic surgery with 72 hours? | Within 24 hours of an invasive procedure? (with attendant risk of acute life- threatening deterioration)'

The differences between the two versions of the hospital discharge guidance as highlighted in Table 1 are striking. The earlier version, on which NHS England (presumably) took the lead along with the Academy of Medical Royal Colleges, is cast in the authoritarian 'we know best' mould: 'The discharge to assess model will be fully implemented across England.' The role assigned to anyone outside the treatment team is minimal: the concepts of the multi-disciplinary team and collaboration appear to be foreign to its authors. It appears to be perfectly acceptable that decisions that will take almost instantaneous effect, are not open to challenge and will affect the whole future of patients' lives, should be based on the 'rule-book'.

The later version of the guidance could hardly be more different. Decisions are not to be handed down from on high but arrived at collaboratively; it is accepted that people from a range of disciplines often have a useful contribution to make, and multi-disciplinary teams are an appropriate means of working through issues and finding solutions that command wide support.

But the concept of collaboration here is limited to partners working with each other simultaneously. No thought seems to have been given to collaboration with staff who will be working with patients 'down the line', further along in their 'care journey'. So there is no awareness of benefits to be gained by – for example – working with patients during their stay to prepare them for leaving.

December 2021: Management by target-setting

Between the two versions of discharge guidance, the Chief Executives of the NHS and NHS Improvement became concerned with preparing the NHS for the potential impact of the Omicron variant and other winter pressures. They resorted to setting targets for NHS bodies. On 13 December 2021, they circulated a letter to NHS trusts and other bodies:

> [You] are asked now to work together with local authorities, and partners across your local system including hospices and care homes to release the maximum number of beds (and a minimum of at least half of current delayed discharges) … An immediate focus [is] to support people to be home for Christmas. Throughout the [holiday] period ... ensure there is support in place to discharge medically fit patients across all seven days of the week.

The concept of 'medically fit for discharge' was evidently in use at this time, although the (earlier) version of the discharge guidance in force at the time firmly instructed clinicians not to use the term 'medically fit'.

July 2022: Management by challenge

On 1 July 2022, NHS England's Chief Operating Officer wrote to the chief executives of the Integrated Care Boards, which had become established as statutory bodies that same day, and to the chief officers of acute trusts and community trusts, challenging them to 'improve flow and … discharge' within 100 days. Among other measures, he suggested 'identify patients needing complex discharge support early', 'ensure multidisciplinary engagement in early discharge plan' and 'set expected date of discharge, and discharge within 48 hours of admission'.

While acknowledging the learning that had been gained from pilot schemes, he went on

> The taskforce has found there is still significant variation between hospitals and systems as a result of the processes employed by individual trusts and their partners. As a result, there is a need to codify and systematically implement change across England to ensure consistency and drive improvement …

As we can see, the approach here is what we might call 'top-down managerialism', demonstrated by the emphasis on reducing variation, codifying, ensuring consistency and 'driving' improvement, while use of the term 'flow' suggests the view that patients can be treated like inanimate objects on a factory production line, although the flow is actually of episodes of treatment. Again, we get no sense of the benefit of allowing clinicians to use their judgement, or of working with patients during their stay to help them maintain their well-being, so they can look forward with confidence to leaving hospital.

August 2022: A new approach to working together?

On 12 August 2022, the (newly appointed) NHS chief executive sent the chief executives and chairs of Integrated Care Boards (ICBs) and hospital trusts a letter outlining practical measures to reduce bed occupancy. These would include 'increasing capacity by the equivalent of at least 7,000 general and acute beds,

through a mix of new physical beds, virtual wards, and improvements elsewhere in the pathway', and ensuring timely discharge by working with social care partners ...'. The letter continued:

> ICBs have been clear with us that much of the pressure on urgent and emergency care is driven by the current, significant, growing strain in social care. Too many patients are spending longer in hospital than they need to, creating pressure along the entire pathway.

Here, as we see, the emphasis is still on minimizing the duration of hospital stays rather than maintaining patients' well-being. We should note, by the way, that ICBs are no more than messengers: they themselves depend on hospital executives for information.

The clinician's mindset

In the NHS today hospital trusts receive payment for the work they do calculated per patient on the basis of the length of time – the 'spell' – they have spent within the hospital, a spell comprising one or more episodes under the care of a consultant, whose contribution is counted as a 'finished consultant episode'.

This is significant. It denotes a particular mindset – a way of viewing the world – in which it is taken for granted that health care is something provided in *episodes*, as in medical or surgical treatment directed towards relieving a condition of some kind. In contrast, elsewhere among the medical profession we find a mindset where the focus is on process: patients are *restored* to health over a period of time. Today we can see episode-focused and process-focused mindsets coexisting uneasily in general practice, which some doctors, such as those who prefer working as sessional GPs or locums, view primarily as providing individual episodes of care, while for those who see themselves as family doctors, it is continuity of care, an ongoing process, that is crucial.

In the provision of care in acute hospitals, it is the episode-focused mindset that dominates. And now we can see that the 'criteria to reside' perform a vital function: at the point on a patient's journey when those criteria are no longer met, clinicians and managers are able to say without fear of contradiction, 'this consultant episode finishes here'. We can see, too, that for all the talk of improving 'patient flow' in acute hospitals, it is improving the flow of consultant

episodes that has become key to maximizing efficiency. Having the clearly visible 'cut-off' that the criteria to reside provide will assist in achieving this.

But from the patient's point of view, the consultant episode – or the treatment episode, as they experience it – is only part of what happens to them. They are confined to a hospital bed; they suffer physical deconditioning and psychological deterioration. These are processes. And recovery from their effects and from the medical treatment they have received is also a process. They need attention from practitioners who understand process and see the world from that perspective.

Process: four case studies in hospital disablement

There appears to have been no systematic study of what happens to patients who can't make a quick getaway from hospital after their treatment. But here are four short case-studies of the experiences of older patients. They all date from before the Covid-19 pandemic. The first two are from a report by the consultant firm Newton.

Mike, aged 89

Mike was enjoying an early evening at home when he tripped over the edge of a rug and hit his head on the side of a cupboard. He remained conscious and was able to get to the phone to call 999. He was seen swiftly in A&E and was found to have no serious injuries, just some bruising.

The medical team decided to admit Mike overnight for observation, as a precaution, simply to be sure he was safe to go home. A day or two passed, during which time some tests were carried out. They all confirmed that there had been no serious or lasting damage and no underlying cause for the fall. He had simply tripped.

10 days later, Mike was still in his hospital bed. By this time he had lost a good deal of mobility, so an assessment by the physiotherapy team was arranged. The physiotherapists felt that Mike really needed assessment by the occupational therapists, and also by the social work team. All of these assessments took further time to arrange, and the days turned into weeks.

Based on the assessments, a recommendation was made for 24-hour residential care and that is where Mike was placed.

The occupational therapist (OT) who conducted Mike's assessment felt very strongly that had the physiotherapists, the OTs and the social care team all worked together as a single unit from the outset, this scenario might have been avoided. They could have worked in parallel rather than in series, thereby dramatically reducing the time it all took.

[The] opinion of the OT and the other teams involved was that, had they worked more effectively together, Mike could have gone home, with reablement support for his mobility issues.

We can draw four lessons from Mike's case. First, a reminder that confinement to bed results in physical deconditioning; second, that delay can be caused by internal hospital procedures alone, with no involvement at all of local authority or other social care services; third, had 'criteria to reside' been in force at the time Mike would have been discharged very much sooner; and fourth, that the people who were most acutely aware of Mike's plight were not clinical or nursing staff but physiotherapists and occupational therapists.

Jane, aged 85

Whilst cleaning her kitchen, Jane, who has had insulin-dependent diabetes for 59 years, slipped on the wet floor and fell. Jane was enjoying living independently with the support of a care package to help monitor and control her diabetes. She was seen in A&E and admitted for observation and monitoring of her diabetic control.

10 days later, Jane was declared medically fit. She was keen to go home.

There was then a series of delays with discharge, as a result of some internal communication processes not working as well as they should. Three weeks [after] her fall, Jane developed a severe hospital-acquired infection. Two months after admission to hospital, Jane was discharged – to a residential home.

Had Jane's discharge been managed more effectively and rapidly, she would have been less likely to suffer a hospital-acquired infection and far more likely to have been discharged to her own home and independent life – as she had wanted.

Two lessons from Jane's experience are, as Newton pointed out, that inefficient internal hospital communication procedures can of themselves – as in Mike's case – result in delays, and that staying in hospital exposes one to the risk of hospital acquired infection. We should also note that 10 days after being admitted Jane was still keen to go home, so she was clearly a woman of some determination: the hospital failed to capitalize on this.

The third case study, a chronology of a patient's experience in a community hospital setting, is provided by the Embrace Care project in Cornwall.

Jean, aged 90

Day 0: Jean, an elderly woman with a history of falls, has a fall at home. After a very short stay in the acute hospital, she is discharged to a community hospital.

Day 1: At this point Jean is able to use the commode, is washing herself (with some support to reach her feet), cleaning her teeth, brushing her hair, and is moving around. She says she wants to return home when she is discharged from hospital. A search begins for support at home to enable her to do this.

Day 60: After many attempts to source a support package in the community have failed, Jean is told she will have to be moved into an intermediate care setting while a long term support package is found. She spends the following two days in bed.

Day 62: Jean starts to require full support to wash herself.

Day 74: A support package has been found to allow Jean to return home. However, her needs have increased and her physiotherapist suggests that the support package is now not sufficient, and it is refused.

Day 78: A checklist is completed and Jean again expresses her desire to return home.

Day 89: Jean is moved into a temporary bed in a care home.

Day 185: Still in the temporary bed in the care home, Jean dies.

Jean was evidently, like Jane, a woman of some determination. 78 days after admission she still wanted to return home. But just two days of being confined to bed reduced her condition to the point that she needed full support to wash herself. The lesson here is that being confined to bed is like being warehoused.

The fourth case study is an anonymized account of two visits a week apart in July 2019 to an elderly woman patient in the Royal Cornwall Hospital at Treliske, near Truro. The visitor was from Healthwatch Cornwall.

Ann, age unknown

On the first of the two visits the patient was engaging and engaged:

Ann says: 'I have good and bad days. It feels like I've been in hospital a long time – too long. ... I have no idea when I'm leaving. The doctors haven't spoken to me about leaving here yet. I'm worried about money. It's not always possible to get what you want. I'm from a large family and wish I could be with them now. But I'm quite happy here on the ward. The food is good and I'm well looked after.'

The visitor says: 'We visited Ann again seven days later. It was like visiting a different patient. Last week she was engaging and although [she] clearly had a level of cognitive impairment, she had a degree of understanding and seemed happy and talkative. Today she seemed unhappy and distressed and kept repeating that she wanted to go home.'

While Ann's story is incomplete, it is evident that her spirit had been broken in those seven days at Treliske and the days before, when no-one had spoken to her about leaving. Her story is another demonstration of how damaging staying in an acute hospital can be. Treliske was clearly not an appropriate place for her to be, and seemingly there was no other that could serve as a stepping stone on her route home. In earlier times a 'step-down' bed might well have been found for her in one of Cornwall's community hospitals, but over the past eight years NHS Kernow, Cornwall's clinical commissioning group, has been doing its best to reduce the number of hospital beds in the Duchy, despite their occupancy rate in community hospitals being well above 90%.

How appropriate are discharge destinations?

These four case studies raise the question: What discharge destinations are available to people in the situations of Mike, Jane, Jean and Ann, and how are they chosen? In Penwith in the far West of Cornwall, the last community hospital lost its inpatient beds in 2016: in 2019-20 no fewer than 75 Penwith residents aged 65+ discharged from Treliske and needing a 'step-down' bed found themselves in a community hospital far from their home community: one-third of them were 50 or 60 miles from home.

A study carried out by Newton in 2018-19 of 10,400 individuals' care pathways found that of the people who experienced a delayed discharge, between 32% and 54% were eventually discharged to a setting where the levels of care were not suitable for their needs. No fewer than 92% of them were receiving a higher level of care than they needed. Newton found that none of the health care systems were measuring the outcome of their discharge decisions.

Seven ways in which NHS England, top doctors and acute hospitals harm patients' well-being and create need for further care

1. Focused as they are on providing 'treatment episodes', they create need for further care by doing little to maintain patients' well-being while they are in an acute hospital: to recognize, monitor and ameliorate processes of physical deconditioning and psychological deterioration. In a nutshell, they fail to recognize that care is needed as well as cure, and that providing care has to be a process, not an episode. Their only response to pressure on beds appears to be

to contend that patients' stays should be shorter, and that this is the responsibility of others, namely providers of social care.

2. They create need for further care by failing to recognise the contribution that physiotherapy (PT) and occupational therapy (OT) services can make to in-patients' wellbeing. While engaging patients in physical exercise therapists can and do talk with them and gain their confidence, enabling them to voice anxieties which they cannot express to clinicians and busy nurses. Moreover when patients are clustered together in a hospital ward PT and OT services can be provided efficiently: therapists do not have to visit patients at home and waste valuable time driving around from one patient's home to the next. (The expense of that would not have to be borne by hospital funds, of course.)

3. They create need for further care by discharging patients when they can on the basis of 'criteria to reside' that are exclusively clinical and take no account of whether the patient is fit to go elsewhere. Decisions to discharge are taken as the province of clinicians only, whereas prior to the Covid-19 pandemic they were to be taken by multi-disciplinary teams.

4. The Newton study of 2018-19 found that hospitals create need for further care by requiring discharge destinations to provide an unnecessarily high level of care in nursing and care homes. While ward-based staff such as nurses will spend more time with the patients in their care than doctors on their ward rounds, a study published by the Local Government Association found that nurses, although they lacked knowledge of the full range of alternatives that were available to support patients at home, tended to feel that patients should move on to a short or longterm residential placement rather than return home. (Nurses are not therapists: it is not generally regarded as part of their brief to help patients retain or regain the skills they need for living at home, whether on their own or with others.)

5. NHS bodies – notably clinical commissioning groups, now absorbed into integrated care systems – have created need for further care by closing hospital beds, especially 'step-down' beds in community hospitals, as in Cornwall, in pursuit of arbitrary targets and without an understanding of the likely consequences. The result has been that the care sector has had to bear the brunt when need has increased.

6. NHS leaders have allowed need for further care to grow by failing to investigate and hence to understand how some patients in acute hospitals experience loss of well-being, how some become 'overstayers', how these are treated (as second-class citizens?) while they are overstaying, and how they eventually get to leave.

7. NHS leaders have also helped to create need for further care by by failing to comprehend the role of the convalescence process in helping patients to regain their previous normal life, and hence the value that convalescent homes and hospitals formerly brought to the system. Convalescent homes provided a social experience too. Those who provide convalescence support should be regarded as specialists, not generalists, but unfortunately there is no Royal College of Convalescence Practitioners.

Conclusions and recommendations

The situation in our acute hospitals today is dire. Executives and NHS leaders find it easy to blame the situation on social care providers. Their failure to gather information on what happens to patients who do not manage to leave the moment they no longer meet all the criteria to reside, and who are told in no uncertain terms 'you don't need to be here', is shocking.

Acute hospitals are manifestly unwilling and unfit to provide for patients who no longer meet any of the criteria to reside. We might fairly conclude that while highly-qualified doctors and surgeons may excel at diagnosing ailments and providing episodes of treatment, they are simply not interested in how being in hospital affects patients or in how patients can be helped to recover their well-being and stay out of hospital in future. NHS England's attempts to improve matters by issuing directives and setting targets will continue to fail.

It is a matter of great concern that health care provision in our hospitals is so heavily dominated by episode-focused thinking. In 2018 the NHS Leadership Academy published a set of guidelines designed to help education providers to maximize leadership learning in the pre-registration healthcare curricula. The guidelines were to enable newly qualified healthcare professionals to graduate and enter the healthcare workforce with 'the skills, knowledge, mindset, behaviours and tools to be a leader of people at the start of their careers'. (Unfortunately that was the solitary reference to 'mindset' in the guidelines!)

So we have brand-new doctors coming in to hospitals having been taught to think of themselves as 'leaders of people', finding themselves among nurses and allied health professionals who have far more experience than they do, and bringing with them an inappropriately episode-focused mindset and no awareness of the processes of damage to their well-being that patients are undergoing.

To make matters worse, at least some of the new integrated care boards, as in Cornwall and the Isles of Scilly, are looking to clinicians to fill managerial posts. It is to be hoped that a cadre of managers will emerge who can think in terms of processes as well as episodes (and who receive some training in working in teams as well as leading them). The Messenger review, Leadership for a collaborative and inclusive future, published in June 2022, 'encouraged the medical profession to examine honestly their role in setting cultures, given their unique influence in the workplace dynamic'. One would hope that such an examination does take place, and that exploring mindsets plays a part in it.

Before the NHS was born, the UK learned from two world wars that convalescent homes were crucial to the recovery and reablement of members of the armed forces suffering from war wounds. It is time to relearn those lessons. Today every acute hospital should not only care for the wellbeing of its inpatients but also have a group of convalescence establishments around it, or at least a designated convalescence unit within one or two local community hospitals. They should be led by therapists, not doctors or nurses. Their function would be a 'step-down' one: their role would be to immediately whisk away from the acute hospital every single patient who no longer meets the criteria to reside, and go on to provide any further clinical care that they need but also to nurture their well-being and provide them with the therapies, the life skills and the social environment they need to regain their place in their communities. That move would be a tangible step for them on their road back to 'normal' life – besides, of course, freeing up much-needed beds in acute hospitals. NHS England, please note!