

How to get better value for money from Cornwall's NHS hospitals: eight challenges that the NHS leadership must rise to

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Before health and social care services can be successfully integrated the NHS needs to get its own house in order. This report sets out eight challenges revealed by the Embrace Care project in Cornwall and suggests how the leadership should respond to them to provide better value for the money that we spend on the NHS: a better service for patients and a better working environment for staff.

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Background: The Embrace Care project

This report draws mainly on findings from the Embrace Care project, which was set up in May 2019 'to focus on improving the health outcomes for older people' across Cornwall and the Isles of Scilly. The following month, 'the diagnostic part of the project started to build an evidence base around what opportunities there are to achieve this'.^[1]

This work was entrusted to Newton Europe Ltd, a firm of consultants.^[2] In early August 2019 they presented their findings in the form of a 'diagnostic review' to two audiences of Kernow Clinical Commissioning Group (KCCG) and Cornwall Council (CC) staff and health and social care professionals. A printout of their slideshow has been more widely circulated, under the title *Detailed Findings from the Embrace Care Diagnostic Review*.

At the time of writing, the *Detailed Findings* document has not been published. In our judgement, as a document funded by public money, it ought to be, and so it is being made available here.^[3] We refer to it as 'the Diagnostic Review'. A summary of it was presented to the Shaping our Future Transformation Board in August 2019: this is available on the web.^[4]

West Cornwall HealthWatch[5] sent committee members' comments on the *Diagnostic Review* to KCCG, and met with KCCG and Newton Europe (NE) staff and others on January 27th, 2020 to discuss it.[6] This report draws mainly on information contained in the *Diagnostic Review*. We feel that the NE team could have done more to draw attention to the challenges that they identified and to steps that could be taken to meet those challenges, so we are offering suggestions of our own in this report.

Challenge No 1: To find out how the hospital system works

Those in charge of the Embrace Care project tell us that their proposals are 'evidence-based' and 'data-driven'. But evidence and data on their own rarely tell us much about how things actually work. They tend to portray only what can be seen on the surface of a system and are straightforward to measure. And as students of government know very well, quantitative data – especially in the hands of economists – can all too easily trump qualitative.

To improve a system we need first of all to understand how it's working at the moment. And that means digging below the surface to identify the processes, the mechanisms, at work.

Here's an example. The Diagnostic Review tells us, on the basis of workshops with 131 practitioners, that 7% of cases where someone was not getting an ideal outcome[7] from the hospital system 'were due to the patient, family or carer's choice to take an alternative pathway'. [8] And we read: 'family choice [was] a significant driver for non-ideal outcomes at every stage ...'[9] The implication is that family members were acting in their own interests and against the best interest of the patient, an argument which would justify overriding family choice.

But if we look at a close-up study of delayed transfers of care carried out by Healthwatch Cornwall during July 2019[10], and ask what was actually going on, we learn that families may be well aware – correctly – that community hospitals are under a great deal of pressure and that unless they hold out for a place near home patients may be placed far away. Families may also have noticed that the condition of their elderly relative is getting worse, probably mentally as well as physically, and worry that they won't be able to cope if the decline continues.

Here the process at work – i.e. the reasoning of family members – appears perfectly rational and understandable. It follows that proposals for a change in policy should address the concerns that families have rather than seek to override them.

Uncovering processes within complex organizations requires expertise in a number of social science disciplines, notably operational research, social psychology and organizational analysis. [11] Since management is taught in the UK largely as a craft rather than the application of careful observation, cross-checking and other elements of scientific method, people who attain management positions in health and social care are unlikely to possess relevant analytical skills unless they have acquired them intuitively or have worked alongside someone who already possesses them. In recent years we have seen the Department of Health implicitly recognising this by urging clinical commissioning groups to employ management consultants to draw up Sustainability and Transformation Plans. The fact that many of these plans have since been abandoned testifies to the inadequacy of this arrangement.

SUGGESTION

As a collective, the health and social care leadership in Cornwall, as personified in the membership of the Shaping our Future Transformation Board, does not possess analytical skills or a questioning, analytical mindset. It would be sensible for the leadership to inaugurate and develop an in-house multi-disciplinary team that does possess these attributes, charged with inquiring into how systems work within health and social care, and with using their findings to formulate and evaluate policies and plans.

Challenge No 2: To explain why there are inappropriate admissions to hospital

The Diagnostic Review tells us that a case review workshop of 54 people from across Cornwall admitted to hospital found that in 22 cases (41%) the reviewers answered ‘no’ to the question ‘Should the patient have been admitted?’ In effect, they were said to have been admitted inappropriately.^[12] In six cases, the reason attributed was ‘Risk aversion’; in four cases ‘Lack of time to make correct decision’; and in three cases ‘Lack of a multi-disciplinary team approach’.

Unfortunately we are not told what the risks were to which decision-makers were averse, but if the risk was that the patient would come to harm if not admitted, it can be questioned whether the decision to admit was indeed inappropriate. ‘Lack of time to make correct decision’, presumably denoting pressure of time – pressure to make a snap decision, perhaps – does not tell us what could have been done differently if more time had been available. Like ‘Lack of a multi-disciplinary team approach’, this looks like a judgement made with the benefit of hindsight.

It was also found that level of frailty was a significant factor.^[13] At the highest levels of frailty, more than half of the people admitted were judged to have been admitted inappropriately, whereas at the lowest levels none were.

Some comments from workshop attendees^[14] shed light on these findings:

Inexperienced clinicians at the front door at out-of-hours times, of course decision making is going to be affected! – *Geriatric consultant*

It’s much harder to discharge someone from the Emergency Department into community services later in the day ... admitting them is the easiest option. – *Discharge coordinator*

SUGGESTIONS

- (1) There is a case for entrusting out-of-hours admissions to an experienced clinician. At the very least, specific training in making decisions on admission should be given to those new to the task.
- (2) There is clearly an issue around people with a level of frailty. Consideration should be given to designing a separate pathway for them. Such a pathway could perhaps involve a one-night stay, allowing observation free of time pressure, followed by moving out to a community hospital if necessary.

Value for money These measures would allow the Emergency Department to work in a calmer, more orderly way and should be achievable with little extra expense.

Challenge No 3: To uncover the causes of delayed transfers of care

The Diagnostic Review found that of the acute hospital beds available at Treliske (as the main RCHT hospital is locally known) and Derriford (Plymouth, used by many residents of East Cornwall), some 22% were occupied by patients who were recorded as having no medical need to remain: Medically Fit for Discharge 15%, Delayed Transfer of Care 5% or Could be treated elsewhere 2%. Of the available beds in community hospitals in Cornwall, an extraordinary 67% were occupied by patients in these categories.[15]

In the period January-March 2019 bed occupancy at Treliske at midnight averaged 91%, significantly above the England standard of 85%.[16] In January 2020 RCHT was under considerable pressure. It was reduced to making provisional bookings in local hotels 'to facilitate social discharges or [the discharge of patients with] low social needs'.[17]

While 'extra escalation beds' were made available at three community hospitals, the fact that around 67% of community hospital beds were occupied by patients who had no medical need to be there – this equates to between 160 and 180 beds – leads us to ask: Is the Cornwall Partnership Foundation Trust (CPFT), which runs those hospitals, playing its proper role as part of the hospital system? There is no indication that CPFT was following the example of RCHT in energetically seeking and taking innovative measures.

The latest integrated performance report from RCHT tells us: 'The top reason for delayed transfers of care remains waits for further non-acute NHS care These will be patients waiting for onward care, *largely those awaiting a community hospitals bed.*' (my italics)[18]

The Diagnostic Review does not say anything about how beds are currently utilized in the community hospitals, but for May 2015 there are figures showing that the community hospitals in Cornwall then in use were running at an average overnight bed occupancy rate of 90% or more, with several registering more than 95% and in one case a staggering 99.4%.[19] Three of those hospitals have since been closed. Statistics published by NHS England for the period July-September 2019 show that of 235 available beds in community hospitals in Cornwall, no fewer than 214 were occupied overnight on average, an occupancy rate of 91%,[20] well above the England standard of 85%. To put it another way, the 'margin' – the leeway for responding to emergencies or a build-up of demand in the system – is only 9% as opposed to the recommended standard of 15%.

So the scepticism of patients' families that they can rely on their relative being moved out of Treliske to a community hospital near their home can certainly be understood.

SUGGESTIONS

(1) There needs to be an investigation, covering both admission and discharge procedures, into why there are currently a massive 67% of patients in community hospitals who on medical grounds do not need to be there.

(2) On the face of it, there is a case for amalgamating the two hospital trusts, RCHT and CPFT, to unify their management and thereby facilitate the freeing-up of Treliske to concentrate on acute and emergency treatment. The feasibility of doing this should be investigated urgently.

Value for money Amalgamating the two hospital trusts will save money by eliminating the duplication of organizational structures, and having a unified management must facilitate the transfer of patients from the acute hospital to community hospitals.

Challenge No 4: To explain variations in the effectiveness of community hospitals

As part of the Diagnostic Review, daily 'delay conference calls' were examined for two community hospitals 'using our improvement cycle analysis framework ... Staff attitudes, and actions and accountability from those meetings dramatically differ... Effective meeting and review enables Community Hospital 1 to have a much higher visibility of delays during discussion, allowing for more effective planning and problem solving.'^[21]

It was also observed that while reasons for delayed discharge of 'fit-to-discharge' patients were recorded for 62% of patients in Community Hospital 1, they were recorded for only 38% of those in Community Hospital 2.

The Diagnostic Review also contains a flow chart contrasting discharge procedures in the two community hospitals. In Community Hospital 1 they appeared to work smoothly while in Community Hospital 2 it was noted that there were 'dysfunctional relationships between social services and nursing teams, [and] debates over to whom delays should be attributed'. In the latter case, the Progress Coordinator, when asked to explain the objective of the morning patient flow conference call, gave a one-word reply: 'Blame'.^[22]

We do not know for how long the disparity between the two community hospitals has existed, but it points to a failure of management at Trust level that it has not been addressed.

SUGGESTION

The existence of a number of community hospitals within a single Trust and with much the same brief offers an opportunity, as the Diagnostic Review demonstrates, for the Trust management to discover where there is best practice and for the weaker hospital managements to learn from this. Full advantage should be taken of this opportunity.

Value for money There can be no dispute that bringing the management of weaker hospitals up to the standard of the best would improve their performance at little if any extra cost.

Challenge No 5: To discover why elderly people decline quickly in hospitals

An acute hospital shouldn't be seen as a place of safety ... protracted length of stay can do significant harm to a patient. – *Consultant Geriatrician*[23]

There is a considerable amount of anecdotal evidence of how elderly patients decline in acute hospitals. The report on a study carried out in July 2019 by Healthwatch Cornwall contains a distressing account of two visits to a patient at Treliske.[24] On the first visit the patient – let's call her A – is engaging and engaged:

[A 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 A 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.

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Another example of decline, this time in a community setting, is provided by the Embrace Care project:[25]

Day 0: J, 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 J 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, J 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: J starts to require full support to wash herself.

Day 74: A support package has been found to allow J 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 J again expresses her desire to return home.

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

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

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There are several lessons to be learned from these two stories.

First, in both there is a very evident decline in the patient's mental health. Mental health gets only a single mention in the Healthwatch Cornwall study and no mention at all in the Diagnostic Review. But it is clear that both A and J had been abruptly plucked from familiar surroundings and were now being deprived of stimulus, of control over their own daily pattern of life, and of any opportunity to discover from those in positions of power what the future might hold for them. These deprivations cannot possibly have helped them to maintain a good level of mental health. What we see in action here is inherently a process that, irrespective of their physical health, disables people by inducing in them a state of despair.

Second, physical decline can be very rapid, from the outset. As we see, J's two days in bed severely reduced her ability to look after herself unaided.

Third, what we seem to be witnessing in J's case is an instance of a patient being 'parked'. She was held in a 'temporary' bed for more than three months, a period that ended only when she died. We have to ask: Did 'out of sight' mean 'out of mind'? No doubt parking her in this way allowed staff to turn their attention to the pressing needs of other patients.

The mental and physical decline that patients suffer may go some way to explaining why some family members shy away from taking their elderly relatives home. Witnessing it must inevitably lead them to ask 'Where is this heading?' and whether they will be able to cope.

SUGGESTIONS

(1) There is a need for mental health nurses and therapists, as well as physiotherapists, to be involved in a patient's care, and from the moment a patient enters a community hospital.

(2) It would be worth investigating how the discharge process works in practice. The existence of the discharge co-ordinator role shows that this process is taken seriously, but some simple questions should be asked about how the system works. Are discharge co-ordinators involved early enough in a patient's stay? Exactly what do they co-ordinate? Who do they talk to? Is it perhaps the case that they talk to everyone except patients?

Value for money Supporting the mental health of patients will clearly enable them to leave hospital sooner, and will thus offset much if not all of the cost entailed. But, no less important, it is a humanitarian service, and should be part of what the NHS provides, just as physical health care is. A patient's physical and mental health are as indivisible as body and mind: they cannot be successfully treated in isolation from one another.

Challenge No 6: To re-imagine the role of community hospitals

It is very easy to fall into thinking of community hospitals as nothing more than places to which patients can be moved after they have been treated at the acute hospital. Conceiving of their provision in terms of 'beds' does nothing to dispel this way of thinking. It is all too easy to slip into regarding them as parking places for patients for whom no other place can be found. This essentially 'static' view inevitably leads to decline, not improvement, in a patient's condition.

Alternative views are possible. We can take a 'dynamic' view, seeing patients as being on a pathway, or 'trajectory', with one or more intermediate stops between acute hospital and home.

For example, we could re-imagine community hospitals as ‘half-way homes’. Instead of being consigned to a bed in a ward, where they are effectively trapped for much of the day as well as at night, people staying there overnight could, during the day, be actively being reskilled, re-enabled to function, physically and socially, in their homes and communities. Indeed, they could progress to spending some nights at home. They would be literally half-way to home. It follows that staff, and those who employ them, would have to think of their roles as much wider than the traditional one of seeing to patients’ bodily needs.

Half-way homes could also be made use of as ‘activity centres’ along the lines of the Edward Hain Centre, run by Age UK Cornwall during 2019 in the Edward Hain hospital building as a ‘hub’ attended during the day by local people for rehabilitation and therapy, and greatly appreciated by its users.

This service has got me out of the house and to meet folk, many in similar situations to me. – *User of the Edward Hain Activity Centre.*[26]

Another alternative to the community hospital, suitable for patients who require daily treatment but are able to return home or to a safe place at night, is the ‘day hospital’. This is an outpatient facility that can provide not only professional health care services but social care as well, adding up to both physical and mental support.

It has become an article of faith on the part of the health and social care leadership in Cornwall that as many patients as possible should be cared for at home. There is danger in treating this as dogma: it encourages hospitals to resist admitting a patient and to send patients home before they are ready. Moreover, patients confined to their home find themselves spending their days waiting for a carer to call, for what may turn out to be a disappointingly brief visit. They become isolated; they lose social confidence. Their mental health suffers. So this dogma needs to be challenged.

The manager of West Cornwall Hospital, part of the RCHT group, recently told West Cornwall HealthWatch of his observation that patients whose homes are in the local area are able to leave sooner than those who live some distance away. It could be that local patients are visited more regularly by relatives and friends, maintaining their sense of membership of the local community: maybe they simply don’t have a sense of having been torn away from familiar surroundings. Whatever the cause or causes, this is a significant observation by an authoritative source.

On January 23rd, 2020, it was announced that investment would be made available to Cornwall and the Isles of Scilly (one of seven areas across the country) to enable community teams to respond quickly to peoples’ needs and prevent unnecessary hospital admissions. ‘[It is intended that] the additional investment will see urgent requests responded to within two hours. In addition, support to help people regain their ability to perform their usual activities like cooking meals, washing and getting about will be provided within two days. The quicker response times should help people to remain well, in their own homes and independent 365 days a year.’[27]

While the additional resources can only be welcomed, it is to be hoped that the effort going into making a success of this bright and shiny new initiative will not distract attention from the pressing problems existing now in community hospitals.

SUGGESTIONS

(1) The role of community hospitals needs to be completely rethought. Currently, they are being treated as mere providers of ‘beds’, as ‘parking places’ for people who aren’t fit to be discharged home or to a safe place. They should be reassessed for their suitability as ‘half-way homes’ or ‘day hospitals’, and fresh thought should be given to the role and skills of the staff needed and to the facilities provided.

(2) Given that local patients get home sooner, thought should urgently be given to the geographical distribution of facilities. It is striking that since the closure of Poltair (Penzance) and Edward Hain (St Ives) community hospitals, there is no community hospital west of Helston, more than an hour away by bus from both Penzance and St Ives. The far south-west of Cornwall, Penwith, has a strong claim to a half-way home, providing in-patient beds as well as re-ablement facilities for an increasingly elderly population: already one in four are over the age of 65.^[27]

Value for money Again, the underlying argument here is for the provision of a humanitarian service, treating mental health as well as physical and what we might call social health. And again, there will be a payoff in terms of enabling patients to leave bed-based hospital provision and thereby release scarce resources sooner.

Challenge No 7: To make best use of therapists’ time

The Diagnostic Review team asked whether services are being used effectively. It was found that only 29% of ‘therapist time [was] spent directly in contact with people, carers or families, for example on individual assessments or reviews’. 20% of therapist time was spent on travelling between visits and meetings.^[28]

The Diagnostic Review team also reviewed 106 therapy visits with senior therapists (Bands 6 and 7) to understand how patient-facing time was being spent. They found that 23% of the visits were not using therapist time effectively. ‘Most of these unnecessary visits were covering for patients with mental health needs, not therapy needs. This takes up 370 visits each month.’^[29]

Further, the Diagnostic Review also reveals that ‘community therapy teams are struggling to meet patient needs due to job dissatisfaction and limited resources ... leading to staff shortages and delays in patient care. One Band 6 occupational therapist has to spend 40% of her time conducting personal care visits, which are usually done by Band 3 support workers.’^[30]

‘Older people in need of rehabilitation don’t only have to contend with [long] wait times for short-term therapy. The care that they receive once their treatment begins varies significantly between teams. In one area, patients receive one visit every 10 days and take twice as long to rehabilitate as those in another area, where patients are visited every five days.’^[31] (The difference is typically nine weeks as opposed to four and a half.)

SUGGESTIONS

(1) Wide local differences in team behaviour and job satisfaction clearly point to a problem for and within management. Those in charge at the Cornwall Partnership Foundation Trust, which provides these services, and in individual hospitals, should be held accountable by the Kernow Clinical Commissioning Group.

(2) As already noted, it has become something of an article of faith on the part of the health and social care leadership in Cornwall that as many patients as possible should be cared for at home. It does seem that the impact of this on the time that therapists spend travelling has not been fully thought through, as it needs to be. Given Cornwall's notoriously poor road network, which becomes heavily congested from May to September, and the proportion of unproductive visits found by the Diagnostic Review team, it is nonsensical, wasteful and frustrating for therapists to have to spend so much time driving themselves around. An alternative way of delivering their services needs to be found.

Setting up local hubs for rehabilitation, for therapy work, along the lines of the temporary activity centre run by Age UK Cornwall during 2019 in the Edward Hain hospital building, or the half-way homes or day hospitals suggested above as replacements for community hospitals, should be seriously considered.

Value for money Levels of job satisfaction for therapists in some parts of Cornwall are outstandingly poor. Reorganizing their work to address this can only increase the benefit that the therapy services provide to patients and make it easier to recruit more and more highly-motivated staff.

Challenge No 8: To establish and encourage teamwork in hospitals and community services

There are some references in the Diagnostic Review to failures of teamwork, notably to 'dysfunctional relationships between social services and nursing teams, [and] debates over to whom delays should be attributed' and to 'community therapy teams ... struggling to meet patient needs due to job dissatisfaction and limited resources ... leading to staff shortages and delays in patient care'.^[22,29] At Treliske, a lack of teamwork has been identified as a contributory cause of the death in 2017 of a six-year-old child with autism.^[32]

Fostering of teamwork expertise in the NHS is long overdue. Tellingly, while the NHS has a Leadership Academy this organization has paid little attention to teamwork, and where it has done so its approach has been to view teams as if they were competing on a sports field, with an inherently competitive ethos of 'us against them' and defining boundaries rather than being open and permeable to questions and ideas from any source. Real life issues like those that have arisen in Cornwall – in getting social services and nursing teams to work together, for example, and establishing constructive working relationships between young doctors and experienced nurses – are not being addressed.

SUGGESTIONS

The Embrace Care Project has identified a damaging absence of teamwork within health providers on the ground in Cornwall. At the same time, the leaders of the health and social care system in Cornwall and the Isles of Scilly have committed themselves to ‘culture change’, albeit without specifying what form this should take.^[33] Given that our health and social care system requires members of different professions and with different levels of experience to work together, and will increasingly do so, the leadership should commit to developing a culture that prioritizes teamwork behaviours, skills and ways of thinking in their staff across the system.

Value for money Embedding an ethos of teamwork within the health and social care system in Cornwall will provide the staff with a structure of supportive relationships within which to work, confidence to ask if they don’t know the answer to a question, and job satisfaction. We are not talking massive expenditure here, simply growing a culture that works purposefully and with good humour towards attaining brilliant results.

Final thoughts

The eight challenges revealed by the Embrace Care project vary widely. The suggestions put forward here are similarly varied. To go down the paths suggested will call for an open mindedness and flexibility of thinking that health and social care leaders have yet to show. Some observers will find it laughable that NHS leaders can call for integration of health with social care and at the same time overlook the lack of integration within the NHS itself.

If the suggestions put forward in this report are implemented, will we be getting better value for money from Cornwall’s NHS hospitals? They add up not only to a claim for more resources, but also to be allowed to make better use of those that are available. If the NHS in Cornwall can show that it makes good use of the resources that it already has, that it understands the needs of its population and can respond sensitively to them, that it appreciates those who work for it and will support and encourage them to develop their skills and work as teams, it will be able to make a strong case for more resources when they become available.

Notes and references (Web sources last checked 9 February 2020)

1. *Embrace Care: A Summary of the Diagnostic Findings*, July 2019, p.4 <http://bit.ly/EmbCare02>
The Shaping our Future Transformation Board is made up of all the leaders of the major health and care organisations in Cornwall, including Healthwatch Cornwall.
2. <https://www.newtoneurope.com>
3. *Detailed Findings from the Embrace Care Diagnostic Review*, July 2019 <http://bit.ly/EmbCare01>
To respect the privacy of individuals who were the subject of short case studies, pages 8 and 9 have been removed from the original.
4. As Note 1.
5. West Cornwall HealthWatch is a voluntary, independent campaigning health watchdog that has been serving West Cornwall since 1997. It monitors developments and campaigns to safeguard and improve services provided in West Cornwall by the National Health Service.
6. The meeting was originally arranged for November 2019. It was delayed by two months on account of the state of ‘purdah’ leading up to the December 2019 general election.

7. 'Ideal outcome' is used in the Diagnostic Review to denote the ideal path to be followed by the patient, not successful treatment of the patient's condition.
8. As Note 3, p.11.
9. As Note 3, p.42
10. Healthwatch Cornwall is one of 152 local Healthwatch bodies set up under the Health and Social Care Act 2012. They work with the national body, Healthwatch England. 'Our sole purpose is to understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf. See <https://www.healthwatch.co.uk/our-history-and-functions>
11. The seminal study here is that of Tom Burns and G.M. Stalker, described in their book *The Management of Innovation* (Tavistock 1961).
12. As Note 3, p.23. 'There were 36 workshop attendees from acute Emergency Departments, inpatient wards and health onward care team, adult social care, therapy, home-based reablement and GPs.'
13. As Note 3, p.25
14. As Note 3, p.25
15. As Note 3, pp.34-36
16. As Note 3, p.16
17. Richard Whitehouse, *Royal Cornwall Hospital put patients in hotels during 'black alert' crisis*, 16 January 2020
<https://www.cornwalllive.com/news/cornwall-news/royal-cornwall-hospital-put-patients-3746083>
18. Royal Cornwall Hospitals Trust, *Summary Integrated Performance Report*, December 2019, p.41
<http://bit.ly/RCHTBoard01>
19. Peter Levin, *Community hospitals under threat: Are decisions being taken on scrappy information and limited understanding?* <http://bit.ly/spr4co1>
20. NHS England, *Bed Availability and Occupancy Data – Overnight, 2019-20* <http://bit.ly/NHSEbedso1>
21. As Note 3, p.38
22. As Note 3, p.38
23. As Note 3, p.5
24. On Healthwatch Cornwall, see Note 10, p.3
25. As Note 1, p.7
26. Age UK Cornwall & Edward Hain, *Learning Report 2019*, Age UK Cornwall, 2019
27. Cornwall and Isles of Scilly to fast track plans to help older people stay well and avoid hospital admissions, 23 January 2020 <http://bit.ly/CloSPresso2>
28. As Note 3, pp.57-59. No distinction is made between therapist specialisms, e.g. between physiotherapists and occupational therapists.
29. As Note 3, pp.60-61
30. As Note 3, p.60
31. As Note 3, p.62
32. Peter Levin, *How a lack of teamwork at the Royal Cornwall Hospital contributed to the death of a child with autism*, December 2019 <https://bit.ly/TeamworkRCHT>
33. As Note 1, p.12