SOCIAL POLICY RESEARCH FOR CORNWALL

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It's extraordinary! A plan to shift NHS healthcare 'from hospital to the community' that doesn't mention community hospitals! It should have: there is much to be learned from them.

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Fit for the Future, the 10-Year Health Plan for England[1], which was published with no indication as to how it is to be implemented, proposes 'three shifts', one of which is a shift 'from hospital to the community'. Since there are around 360 community hospitals in England today, we might have expected to find some reference to them in *Fit for the Future* and in Lord Darzi's report *Independent Investigation of the National Health Service in England*[2] that preceded it, but we find no mention of them there either. I suggest that ignoring them is a mistake, because they offer useful lessons for planning the future of England's NHS.

Community Hospitals: some facts

Although there is currently no official category bearing that name, hospitals known today as a 'Community Hospital' or 'Cottage Hospital' have existed for more than 150 years in the UK. Of the 360 or so in England today, many are located in small towns, some of which have become suburban while others are still country towns. As publicly funded hospitals since the setting up of the NHS in1948, today most are administered through Foundation Trusts or NHS Trusts.

The Community Hospitals Association describes them as follows:

> Originally established as converted cottages offering inpatient beds, they have developed into hubs of services that have developed to meet changing needs. These services range from health promotion, diagnostics, treatments, [to] rehabilitation and end of life care. The community hospital plays a particular role in intermediate care, and is a focus for integration for many staff and services in both health and social care.
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> Community hospitals vary considerably, as they have adapted to the needs of their local populations. They are typically highly valued by local people, and this support is shown through actions such as volunteering, fundraising, promoting and campaigning.[3]

A wide-ranging and insightful study *Analysis of the profile, characteristics, patient experience and community value of community hospitals* by Deborah Davidson, Angela Ellis Paine, Jon Glasby, Iestyn Williams, Helen Tucker, Tessa Crilly, John Crilly, Nick Le Mesurier, John Mohan, Daiga Kamerade, David Seamark and Jan Marriott, published in 2019[4] but not referenced by Lord Darzi or in *Fit for the Future*, found that among the considerable range of community hospitals, the provision of intermediate care, helping patients to 'step down' from acute care and rejoin their local community, is indeed a common feature.

Community hospitals provide four important lessons for planners of the new NHS.

1. Their development has taken place without central direction. Community hospitals have many different setups. Each has its own particular history. They provide different ranges of services, and they have different relationships with voluntary organizations and with NHS bodies and local GPs. These relationships reflect differences in local circumstances and in the ways that local people have responded to those circumstances. The development of this sector of the NHS has come about with no central direction by the Department of Health or its predecessors or NHS England. It reveals the ability of people in local communities to mobilize their energy and resources, without any direction or exhortation from local or central government, or any invitation from these bodies to 'have your say'.

The lesson here is that to be effective, a plan for the NHS must say how it will unlock energy and resources at local level: among patient groups, voluntary and community organizations and especially GPs, whether in individual surgeries or primary care networks.

2. As providers of intermediate care, the staff of community hospitals have to think in terms of 'process'. They understand very well that each patient with whom they are working is on a 'journey', undergoing a process, made up of rehabilitation, reablement and recovery.[5] So they know they always have to be thinking about what comes next for the patient. Staff know that having a patient in their care is not just a matter of keeping them safe until they are handed over to the next shift. They share with their patients the therapeutic goal of seeing them complete their journey back to wellness, health and ability to function in society.

In an acute hospital, by contrast, care is seen as something that staff 'deliver', as various references in the 10-year plan make clear. Patients receive care in the form of self-contained 'acute episodes of care', as Lord Darzi puts it (p.54). When these episodes are brief and fragmented, not properly joined up, patients may die.[6]

Delivery of care is often interrupted by long delays for patients, when they are held in queues for the next episode of their treatment. And they may find themselves kept in hospital unable to leave because ward staff are not persuaded that they are ready to be discharged.[7] The atmosphere in a ward where patients are 'stuck' can be disheartening and demoralizing, very damaging psychologically: very different from that in a community hospital ward, where efforts are constantly under way to get patients looking forward and ready to leave.

The lesson here is that whatever 'shifts' a plan for the NHS involves, that plan must incorporate a complete overhaul of the ethos, organization and working practices of acute hospitals, to ensure that patients' journeys and needs are understood and respected.

3. Community hospital staff work in multi-disciplinary teams which form around the needs of patients. The staff of community hospitals learn early in their careers the necessity of working alongside staff from other disciplines, as part of a multi-disciplinary team. Especially in intermediate care, physiotherapists and occupational therapists together with nursing staff and allied health professionals join together in helping patients to progress, as may a patient's own GP, although there is known to be a current insufficiency of psychological support.

In an acute hospital, on the other hand, we may find that the protocol for a morning ward round positively requires the attendance of clinicians but the attendance of therapy professionals is not essential, merely preferable.[8] In acute hospitals, we find inter-professional rivalries: those between obstetricians and midwives, trained in their professional silos, may have life-changing or fatal outcomes for newborns and mothers (see Dr Bill Kirkup[9] and Lord Darzi (p.4)).

Significantly, teams in community hospitals tend to form around the needs of particular patients, whereas the use of fixed (settled) teams seems to be routine in acute hospitals.

There are lessons here for the training of clinicians. They are taught 'leadership' skills, but not – it seems – to appreciate the skills possessed by other staff, such as midwives, nurses and allied health professionals, many of whom have decades of experience. This is a defect that needs to be put right. So long as specialist training continues to take place in silos, the ability to appreciate these skills will be crucial, as will the skills of working alongside other people in teams that are patient-centred, as happens in multi-disciplinary teams in community hospitals.

4. Many community hospitals usefully serve as ancillaries to distant acute hospitals, but this makes them vulnerable to financial pressures. In rural, coastal and semi-urbanized areas of England, such as parts of Cornwall, Kent and Lincolnshire, many community hospitals in small and medium-sized towns act as ancillaries to acute hospitals by providing services away from the main hospital, such as outpatient clinics, urgent treatment centres, surgical hubs and diagnostic services, e.g. computerized imaging facilities. Some also offer a minor injury (or minor injury and illness) unit, which may be run by the community hospital itself.

But when budgets are under pressure, acute trusts are tempted to cut funding for services provided away from their own centre, even though this will defy the Government's intention to shift services 'from hospital to community'. For example, the Royal Cornwall Hospitals (acute) Trust (RCHT) has recently been planning to 'repatriate' to its main hospital at Treliske outpatient clinics that had previously been provided at its 'satellite' West Cornwall Hospital in Penzance, claiming that providing these outpatient clinics 'in-house' would be more efficient than running a decentralized system. It would of course be cheaper for the Trust, (and favoured by surgeons who don't want to travel to Penzance) but would impose costs on patients who have to make longer and doubtless more expensive journeys to get their treatment. Many community hospitals would be vulnerable to cuts on 'repatriation' grounds. (The Trust's behaviour does of course directly contravene the intended shift of services 'from hospital to community'.)

How is this relevant to our present concerns? Soon after the 10-Year Health Plan was published, neighbourhood health teams were launched in South-East London: they are to be 'hosted', we are told, by acute hospital trusts.[10] But Cornwall's experience suggests that the administration of neighbourhood health teams should be kept well away from any acute hospital trust, because those trusts will have very strong incentives to channel funding away from those teams and use it for their own purposes.

In Cornwall we also know that our acute NHS Trust is poor at understanding and responding to the interests and needs of patients. Its appointment booking system for outpatient clinics demonstrates this clearly. The staff who man it make no attempt to offer appointments at clinics nearest to patients' homes, although they know where patients live. Nor are patients informed, when offered an appointment, that they have the legal right to choose where they are seen.

So here is one more lesson. Under no circumstances should the administration of neighbourhood health teams be entrusted to acute hospital trusts.

Summary: The lessons for 10-year NHS planning

1. A worthwhile plan for the NHS must say how it will unlock energy and resources at local level: among patient groups, voluntary and community organizations and especially GPs, whether in individual surgeries or primary care networks.

2. Whatever 'shifts' a plan for the NHS involves, it must incorporate a complete overhaul of the ethos, organization and working practices of acute hospitals, to ensure that patients' journeys and needs are understood and respected.

3. The training of clinicians needs attention. They are taught 'leadership' skills, but not – it seems – to appreciate the skills possessed by other staff, such as midwives, therapists, nurses and allied health professionals, many of whom have decades of experience. This is a defect that needs to be remedied. So long as specialist training continues to take place in silos, the ability to appreciate other people's skills will be crucial, as will the skills of working alongside other people in teams that are patient-centred, as happens in multi-disciplinary teams in community hospitals.

4. Under no circumstances should the administration of neighbourhood health teams be entrusted to acute hospital trusts.

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