SOCIAL POLICY RESEARCH FOR CORNWALL

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'Overstaying' patients in Cornwall's main acute hospital: a problem that calls for careful monitoring and ongoing collaboration

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IN A NUTSHELL

The chief executive of the Royal Cornwall Hospitals Trust continues to blame the social care sector for bed space in his wards at Treliske being taken up by people who 'don't need to be in hospital'. He is ignoring his own hospital's contribution to this state of affairs.

This paper asks three questions about his management:

1. What information does the hospital collect when monitoring the wellbeing and the individual histories – the 'patient journeys' – of each of the 'overstaying' patients before and after admitting them?

2. What policies does the hospital have about looking after patients once they are categorized as 'overstayers', and what information does it collect about their condition and well-being?

3. Is the Chief Executive open to his staff collaborating on Treliske premises with people who are based in community hospitals, residential homes and at-home services, working alongside them in preparing patients to leave hospital as soon as possible after treatment, so as few of them as possible become 'overstayers'?

It would be good to receive answers to these questions and to be able to take encouragement from them.

In a recent interview (February 2nd) with James Churchfield on BBC Radio Cornwall, Steve Williamson, Chief Executive of the Royal Cornwall Hospitals Trust, was questioned about the length of time people are waiting to be seen in the Emergency Department at Treliske (Cornwall's main acute hospital) and the delays experienced by ambulances waiting to off-load patients. In response, he said he had '130 patient who have finished their hospital stay, and are waiting to go home with social or community care, or to a nursing, residential or dementia care home. That ... equates to 4 wards' worth of people.'

Mr Williamson said nothing at all about what his own hospital could do to ease this 'blockage'.

Of course, if these 130 patients are still occupying hospital beds they evidently have ***not*** finished their hospital stay, so already there seems to be some muddle in Mr Williamson's mind. What does he actually know about how his hospital is managed? Here are three questions it would be good to have him answer:

1. What information does the hospital collect when monitoring the wellbeing and the individual histories – the 'patient journeys' – of each of the 'overstaying' patients before and after admitting them

This information is important because proper provision cannot be made for patients, and providers of social care or accommodation cannot be expected to do their share, unless it is known which among them are special cases: for example, they are elderly and frail, and/or have multiple medical problems (co-morbidities), or have not responded as anticipated to treatment (e.g. they have developed an infection), or have been discharged and then readmitted.

Some may have completed their treatment but the clinician in charge may feel that in the interest of safety their clinical condition and well-being should be monitored for a short time before they are discharged. Treliske's current policy for managing 'patient flow' treats patients as if they are standard 'products', and this will inevitably be inappropriate for all those who are or who become special cases.

2. What policies does the hospital have about looking after patients once they are categorized as 'overstayers', and what information does it collect about their condition and well-being?

It is clearly important that patients who are regarded as 'not needing to be in hospital' are not treated as second-class citizens but are well looked after, so they don't deteriorate mentally or physically, but their morale is sustained and they are helped to stay in a ready-to-leave condition.

This needs to be emphasized because it would not be surprising if nursing and therapy-providing staff gave priority to patients whom they had just met as they were coming to the end of their clinical treatment, with the result that those regarded as 'overstayers' took second place, parked in an 'outlying' bed in a ward where there happened to be space, with consequent deterioration in their condition and morale. If Treliske turns out to be under-provided with these nursing and ancillary staff, that should not be acceptable.

3. Is the Chief Executive open to his staff collaborating on Treliske premises with people who are based in community hospitals, residential homes and at-home services, working alongside them in preparing patients to leave hospital as soon as possible after treatment, so as few of them as possible become 'overstayers'?

This is important because we see you asking other people and organizations to share in shouldering the burden of 'overstayers', essentially 'doing their own thing' or having patients handed over to them, but you say nothing about ***working with them***. You appear not to have considered collaborating with other organizations in a sharing way, ***along the patient's journey***.

In this context, it is surprising that when James Churchfield suggested to you that it would be helpful to have a separate facility, an intermediate tier, charged specifically with getting people through the system and home, all you could say was: 'These patients don't need to be in a hospital.' Perhaps you were expressing what is evidently the view of some clinicians at Treliske that it is not their job to provide post-treatment care.

Of course, this 'step-down' role is exactly what community hospitals used to perform and to some extent still do, although – as the Embrace Care project found – some are much more efficient at this than others. It is surprising that your passing mention of those hospitals did not mention their role. Close collaboration with community hospitals could be effective in getting 'overstayers' out of Treliske. Indeed, a pre-discharge ward at Treliske, in which community hospital staff worked together with on-site Treliske staff to prepare patients for leaving, would be one possibility. Please give it your consideration.

One would hope that, given its name, the Integrated Care Board for Cornwall and the Isles of Scilly would see fit to contribute towards any financing required to enable a collaborative process of this kind to take place.

<u>Further reading</u>

Peter Levin, How NHS England, top doctors and acute hospitals MANUFACTURE need for social care, and why we need to rediscover convalescence, 27 August 2022

Peter Levin, Patient flow in an acute hospital: learning from system failures, 5 September 2023