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REINVENTING THE COMMUNITY HOSPITAL

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A recent investigation by Healthwatch England into the 'Discharge to Assess' scheme found that 82% of patients discharged from hospital did not receive a follow-up visit or assessment. This paper suggests that to meet an evident need some community hospitals should be repurposed as 'recovery centres' to assess and assist the recovery of discharged patients who have returned home, and accommodate for brief transitional stays others who are not quite ready to take that step. The former Edward Hain Hospital in St Ives, Cornwall, would make an excellent trailblazer.

Captain Edward Hain was the only son of Sir Edward and Lady Hain, of St Ives in Cornwall. By all accounts a gifted and popular young man, he lost his life in the Great War, at Gallipoli, on November 11th, 1915, at the age of 28. A memorial fund was set up in his name. After the end of the War it was widely felt that St Ives needed a hospital: a suitable building came on the market, and it was bought with money from the memorial fund and a donation from Lady Hain. The Edward Hain Memorial Hospital, often referred to locally as 'the convalescent hospital', was opened in 1920 and has been a treasured feature of the town ever since. But in 2016 the inpatient beds were closed and four years later, in 2020 NHS Kernow, Cornwall's clinical commissioning group, finally decided to close the hospital.[1]

Executive summary

- The middle of the Covid-19 pandemic may not seem like an opportune moment to be worrying about the closure of a community hospital. But the issues are connected by the question of how to free up beds in acute hospitals. In the past, patients who no longer needed to be in an acute hospital could 'step down' to a community hospital, which served as a 'staging post' for them on their journey home. Those hospitals too are now under pressure, but our healthcare system needs those staging posts more than ever.

- During the Covid-19 pandemic, the UK Department of Health & Social Care published a 'rulebook'[2] in which it directed all hospital trusts in England to implement what it calls the 'Discharge to Assess' model. This model is unsatisfactory on four counts:

  (1) It instructs hospitals to discharge very promptly patients who are judged 'medically fit for discharge', but this judgment is to be based only on a 'snapshot' view of their current physiological condition, not on indications of how they are progressing;

  (2) It fails to distinguish between assessment of a patient's need for community support and assessment of their need for continuing medical treatment;

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(3) It fails to take account of the likely impact of speedy discharge on the risk that a patient will need to be readmitted as an emergency.

(4) It is inherently based on the assumption that there is an identifiable point in a patient's recovery after treatment when responsibility for care can, without doing harm, be abruptly switched from the hospital to a completely different system, one which involves the patient either being returned home and supported with a 'package of care' and visits from their general practitioner, or being placed in a care home or nursing home.

- This paper makes the case that staging posts are indeed still needed but, if Discharge to Assess is to become standard practice, they should take a different form from the community hospitals that we are accustomed to. There needs to be a transitional stage in a patient's recovery, to take place in a setting where (a) their recovery can continue to be monitored, and (b) they can – with assistance – take their own steps towards resuming an active life. A 'recovery centre' could provide such a setting, and an Edward Hain Memorial Recovery Centre in St Ives (in West Cornwall) could serve as a prototype. There are other community hospitals in Cornwall that could be similarly repurposed. This paper proposes eight principles for the design of such a centre. These are shown in the table below.

Eight principles for designing a recovery centre
Principle 1: The process of recovering after illness or surgery requires the active involvement of the patient. It is more than merely receiving care.
Principle 2: Aiding recovery is a multi-disciplinary specialism. It requires people with a range of qualifications to work in teams in a suitably equipped environment.
Principle 3: Medical and nursing professionals can and should be part of the recovery team, but it should be run as a co-operative, not a hierarchy.
Principle 4: The recovery model needs its own language: it should avoid the language of the medical and nursing professions.
Principle 5: Recovery should be thought of as the concluding stage of a patient's journey through the health care system, not as an afterthought to treatment. It should be joined up to the stages that precede it.
Principle 6: A recovery centre would be the appropriate setting for carrying out assessments of patients discharged from an acute hospital and should be made use of for this purpose.
Principle 7: Recovery is likely to be more effective and beneficial when carried out in a social context rather than on individual visits to people in their own homes.
Principle 8: A recovery centre should have its own premises and include some beds for overnight stays. It should work with hospitals, and could play an extremely valuable part in operating the Discharge to Assess scheme, but *it should not be a hospital or care home*.

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The context: the National Health Service under pressure

This paper is being written ten months into the 2020 Covid-19 pandemic, at a time when sheer numbers of patients are putting the people who work in the NHS under pressure as never before. Doctors, nurses, other health professionals and support staff are chronically stressed. Equipment has been in short supply and much-needed funding held back, while the Government has been criticized for the extent to which it has entrusted some crucial services to the private sector. Waiting lists for elective treatment that is not immediately urgent have grown considerably.

At national level, responsibility for handling this situation falls primarily to the Department of Health and Social Care (DHSC) and NHS England (NHSE), an executive non-departmental public body sponsored by DHSC, which has administrative oversight of the trusts that provide hospital and other health services (such as mental health care) at local level and of the local clinical commissioning group governed by general practitioners which commissions those services from the providers. Social care services, however, are provided by the upper tier of elected local authorities, of which Cornwall Council is one.

The NHS is good at responding to emergencies, when there is a single, well-defined goal to focus on, such as getting the 'Nightingale' hospitals built in the early stage of the Covid-19 pandemic. Planning may not be the system's strongest feature, as witness the remarkably brief life of Sustainability and Transformation Plans. Urged by the centre on the localities, it soon transpired that neither understood what such planning entailed and how to do it. After a mere 15 months, in 2015-2017, those plans were quietly abandoned.[3]

Joined-up thinking may present particular problems, to judge by the way in which 'protecting the NHS' was taken to justify the indefinite postponing of hospital treatments that weren't immediately urgent and the exporting to care homes of elderly patients without providing them or other care home residents or staff with equipment to protect them against catching Covid-19. Failing to appreciate that the Discharge to Assess model would have an impact on emergency readmissions to hospital is another example. The episodic nature of hospital care, discussed below, is yet another.

At the centre, DHSC and NHSE have long wanted to reduce the numbers of patients who were thought to be taking up hospital beds when they were suitable for transfer elsewhere, such as from an acute hospital to a community hospital or from either to a care home. In 2019 Government Mandates to NHS England instructed it to reduce 'NHS-related delayed transfers of care' from hospitals. The 2019 NHS Long Term Plan duly set as a goal 'to achieve and maintain an average Delayed Transfer of Care (DTOC) figure of 4,000 or fewer delays'. NHSE provided hospital trusts with 'guidance' for preparing their DTOC figures. This attempted to shoehorn together two very different approaches, one of which did not even offer a procedure to follow.[4]

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In practice, it transpired that every trust was free to decide for itself how to measure its DTOC figures, as examples from Cornwall and elsewhere showed. So their figures could not meaningfully be added together. This clearly did not provide a sound basis for planning.

That situation was known about at local level for several years, and concerns were relayed upwards, but nothing was done about it. NHSE said its latest guidance would remove ambiguity, but it did not. It was supposed to emphasize local collaboration, but it removed an injunction to that effect in the previous version. It was claimed that it would offer 'good practice examples' from around the country, but it presented none at all. NHSE then forced a 'comply or explain' regime on to trusts, but this merely distracted them into playing a game of 'satisfy the statisticians'.[5] The Covid-19 pandemic has at least had the beneficial consequence that the collection of DTOC data has been suspended.

The defects of Discharge to Assess

The Department of Health & Social Care, having noted that patients are often kept in hospital while waiting for assessments of their fitness to leave and be accommodated elsewhere, has concluded that beds would be freed if those assessments were carried out after rather than before they leave. In the Covid-19 rulebook[6] it directs all hospital trusts in England to implement what it calls the 'Discharge to Assess' model. This instructs hospitals to promptly discharge patients who are judged 'medically fit for discharge'. Patients are to be assessed twice daily. If they are assessed as medically fit for discharge 'they must be transferred from the ward to a … discharge area or lounge as soon as possible, to leave hospital the same day'.

The rulebook offers four 'pathways' for patients judged fit for discharge. They are based on the expectation that 50% of patients will be able to simply go home, with no formal input needed from health or social care: this is 'Pathway 0', and it is expected that those patients will be out of the hospital within two hours of leaving the ward. It is expected that another 45% will be able to return home and recover with support from health and/or social care (Pathway 1). It is also expected that 4% of people will need rehabilitation or short-term care in a 24-hour bed-based setting (Pathway 2). Finally it is expected that 1% of people will require ongoing 24-hour nursing care, 'often in a bedded setting' (Pathway 3). They are seen as likely to require long-term care.'

Discharge to Assess (D2A) has four major defects:

(1) It fails to take account of the likely impact of speedy discharge on emergency readmission of patients. We know that many patients are discharged from hospital only to be admitted again as an emergency. The Nuffield Trust found that between 2010/11 and 2016/17 the total number of 30-day emergency readmissions to hospital in England rose from nearly 1,158,000 to nearly 1,380,000. The percentage of admissions followed by an emergency readmission within 30 days rose from 7.5% in 2010/11 to 8.0% in 2016/17.[7] While some of those emergency readmissions may have entirely new causes, it is clearly *not* safe to assume that all patients can be discharged without harm.

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Healthwatch England reported in October 2020, on the basis of a survey of patients' experiences of leaving hospital (sample size more than 500):

> approximately one in five people (19%) felt they were not prepared to leave hospital. For those that were discharged at night, 27% felt they were not prepared. People who told us they had a significantly worse experience of leaving hospital than they had had previously, generally felt that it was too soon for them to be discharged.[8]

The Covid-19 rulebook provides no advice on steps to be taken to guard against an increase in 30-day emergency readmissions. And in relation to discharges at night, we should note that 'out of hours' is when inexperienced clinicians are likely to be on duty. Consultants will be on call, but their juniors may well be reluctant to disturb them.

(2) Discharge to Assess also fails to distinguish between assessment of a patient's need after treatment for social care – to help them manage at home, for example – and assessment of their post-treatment need for continuing medical care, e.g. for rehabilitation or reablement. Again, it appears that the prime concern is to get patients off hospital premises as quickly as possible.

(3) The expected percentages of patients likely to use each pathway might well become informal targets, as the Healthwatch England report says.[9] This seems more likely than not. In Cornwall the proportions might well be affected by demography: the proportion of people aged 65 and over in the population is half as much again as the national percentage for England, and in some parts of the county household incomes are among the lowest 10% in the country. But the formula does not allow for such variations to be taken into account in responding to local needs, and hospital staff will know that they may have to justify any departures from the norm.

(4) The judgment as to whether a patient is 'medically fit for discharge' is required to be based on only a 'snapshot' here-and-now view of their current physiological condition (e.g. whether they require intravenous fluids or have undergone lower limb surgery within 48 hours), not on their progress. None of the criteria are dynamic, to do with how well the patient is progressing or drawing on the consultant's experience-based judgment of how they might progress.

So the Discharge to Assess system rests on an underlying but unspoken assumption that there is an identifiable point in a patient's recovery after treatment when responsibility for care can, without doing harm, be abruptly switched from the hospital doctor or surgeon to a completely different system, involving the patient being returned home and supported with a 'package of care' and visits from their general practitioner, or being placed in a care home. The acute hospital treatment is but one episode in the patient's pathway through the healthcare system.

The episodic nature of hospital work

That lack of continuity of care is consistent with the way that NHSE sees the work of doctors, as a series of episodes. (The unit of work done in the NHS is the 'finished consultant episode'.) When one set of doctors in a hospital finish their shift and hand over to another, they hand over responsibility for the continuing care of their patients to the set taking over: consequently the

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system discourages doctors from seeing as a single process an ill or injured patient's journey all the way through the healthcare system, from initial condition to their resumption of normal life. It discourages continuity of care; it discourages doctors from looking ahead to that stage in a patient's pathway through the healthcare system when they have been discharged from hospital but still need healthcare and/or social care to complete their recovery.

A new recovery model

I conclude that a new post-treatment recovery model is needed, one that will both allow patients to be followed while they are continuing their recovery and, where appropriate, allow hospital clinicians to work with recovery specialists in contributing to that process. No one model will fit all circumstances, but acting on the eight fundamental principles set out here should help.

Principle 1: The process of recovering after illness or surgery requires the active involvement of the patient. It is more than merely receiving care.

Recovering is the process by which a person who has had to spend time in a bed in an acute hospital after treatment gets back the skills and confidence, the physical health and the mental health, that they need for resuming normal life. To achieve a successful recovery, the individual must play an active part in the process. He or she must actively *want* to recover, and should be supported to envisage both that goal and the path by which it can be reached.

Principle 2: Aiding recovery is a multi-disciplinary specialism. It requires people with a range of qualifications to work in teams in a suitably equipped environment.

Aiding recovery is the province of people with different skills, knowledge and qualifications: specialists in rehabilitation medicine,[10] physiotherapists, occupational therapists, expert strength and fitness coaches, dieticians, podiatrists, speech and language therapists, geriatricians, and mental health practitioners such as psychotherapists. These specialists require appropriately equipped places in which to work.

Importantly, they need to work together in teams, where the team is defined by the particular set of needs of the individual person being helped, not by managers or administrators allocating staff to boxes on organization charts. Teamwork also implies getting away from the style of working commonly experienced in NHS hospitals where, although staff talk about teams and often have regular team discussions about patients, they tend to work in 'silos', especially when coping with busy work schedules:

> The physio does their job, the speech therapist does theirs, the occupational therapist does theirs, the nurse encourages and supports … but rarely do they work with the same patient simultaneously. [Former NHS Trust Medical Director, now retired]

A multi-disciplinary team approach in a recovery centre also avoids wasted time between therapy visits, time in which the patient, if he or she is not able to self-motivate, will inevitably regress.

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Importantly, such an approach will get practitioners away from thinking that their role is to 'deliver packages of care'. That way of thinking is not only episodic: it casts people who are in the process of recovering as mere recipients of a service rather than as active participants in a process, which needs to be the case if recovery is to succeed.

Principle 3: Medical and nursing professionals can and should be part of the recovery team, but it should be run as a co-operative, not a hierarchy.

Doctors are trained from medical school onwards to think of themselves as leaders in any healthcare context: 'clinical leadership' is a term we frequently encounter. (Interestingly, few if any medical school syllabuses incorporate any specific training in clinical leadership, let alone in being led.) Among nurses, we see this trait in 'territorial domination' behaviour, where the territory – the domain – is the hospital ward. Unless it is made clear that the role of doctors and nurses is to *work with* their partners in the recovery team, dominating behaviours of these kinds will often hinder team working.

The assiduous application of the 'medically fit for discharge' test in hospitals further underlines the message that doctors and nurses should not automatically be in charge of a recovery centre. The pressures on hospital doctors distract them from patients once they are on the road to recovery: not only is there nothing more that they, the doctors, can do for them at that point but patients needing immediate treatment necessarily have a greater claim to priority. And as mentioned earlier, while nurses are in the business of providing care, they may – as some nurses have been found to do[11] – take it for granted that patients will be going to a care home when they leave. A multi-disciplinary recovery centre of the kind suggested here should be run not as a hierarchy but as a co-operative, with respect accorded to the representatives of every discipline.

A centre that is not monopolized by a single profession could and should be flexible, so clients can move gradually from bed-based to on-your-feet provision; from residential provision for someone nervous about spending their first night or two out of hospital alone, to sleeping in their own bed; and from close medical supervision to none at all. The Covid-19 rulebook draws a hard-and-fast distinction between bed-based and home-based care, but recovery requires something altogether more flexible.

Principle 4: The recovery model needs its own language: it should avoid the language of the medical and nursing professions.

In many ways the language of doctors and nurses today reflects a Victorian way of thinking: it is language that Florence Nightingale would have recognised. Essentially, it assigns a dispensing rather than enabling role to staff and a submissive, receptive role to users of the service. _Hospitals_ are institutions that are defined by the number of _beds_ in them. A care home my be designated as offering a certain number of 'reablement beds'. The beds contain _patients_ and are grouped into _wards_. _Doctors_ are in charge, and they decide what's good for you. The wards are staffed by _nurses_ whose role is to _provide care_ for patients.

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In the 21st century, we need _recovery centres_ with _places_ for _clients._ Work should be done in _rooms_ – including seminar rooms, a gym and a kitchen – in a centre staffed by _recovery specialists_, _therapists_ and _trainers_ whose role it is to _re-enable_ and _re-skill_ clients and help them get physically and emotionally fit and confident so they can resume life at home and in their local community. The ethos of such a centre would be one of movement and dynamics, of development rather than of being – literally – patient. Getting the language right would be an important step towards instilling that ethos.

Principle 5: Recovery should be thought of as the concluding stage of a patient's journey through the health care system, not as an afterthought to treatment. It should be joined up to the stages that precede it.

As noted earlier, all the criteria set out in the Covid-19 rulebook for judging whether a patient is medically fit for discharge involve taking a 'snapshot' view of their physiological condition: none of the criteria are dynamic, to do with how well the patient is progressing or drawing on the consultant's experience of how they might progress.

Although some hospital doctors, for example those who work with stroke patients, fully appreciate the importance of treating the patient's journey to recovery as a whole, the 'medically fit for discharge'/'Discharge to Assess' scheme is inherently, albeit possibly unconsciously, based on the assumption that the patient's journey need not be viewed in this way, that there is an identifiable point in a patient's recovery after treatment when care can, without doing harm, be abruptly switched away from the hospital doctor or surgeon to a completely different system. But we know that in England as many as one patient in seven is discharged from hospital only to be readmitted as an emergency within 30 days. So it is simply *not* safe to assume that all patients can be discharged without harm.

To be clear: the implicit assumption in the Covid-19 rulebook that no harm will be done by cutting care off and abruptly transferring the patient elsewhere is not well-founded. There needs to be a transitional stage in a patient's recovery, to take place in a setting where (a) they can continue to be visited by the hospital clinician who has been treating them, and (b) they can – with assistance – take their own steps towards resuming an active life. A recovery centre could provide such a setting: an Edward Hain Recovery Centre in St Ives could serve as a prototype.

Importantly, the availability of such a setting would make implementation of Discharge to Assess much more straightforward to deliver while reducing the number of emergency readmissions to acute hospitals, and thereby also reducing the pressure on emergency departments and beds.

Principle 6: A recovery centre would be the appropriate setting for carrying out assessments of patients discharged from an acute hospital and should be made use of for this purpose.

The Healthwatch England investigation into hospital discharge during the Covid-19 pandemic found that a remarkable 82% of discharged patients 'did not receive a follow-up visit or assessment'. It appears that acute hospitals are – understandably – giving priority to the actual

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treatment of patients, with little thought about what happens to them afterwards. This finding echoes that of another investigation made in 2019 of delayed discharges in 14 systems covering more than 10,000 discharges. This found that up to 54% of those who were delayed were discharged to a setting where the levels of care were not well-matched to their needs. Of these, in 92% of cases the setting was providing a more intense level of care than would have maximized the individual's independence.[12]

Ideally a patient's destination on discharge would be borne in mind from the day that they entered hospital but, as the Covid-19 rulebook demonstrates, mainstream thinking in the NHS is that hospital doctors need not concern themselves with what happens to a patient once discharged from their immediate care.

The consequences of the lack of care given to patients on discharge have been uncovered by earlier investigations:

> Discharge planning to maximise independence would save money and improve outcomes. For nearly a quarter of people (24%) who were discharged from hospital with a care package, a preferable pathway was identifiable that could have delivered better outcomes at lower cost. Given that a significant subset of these pathways results in costly long-term residential placements this is of particular significance. Practitioners … estimated that 59% of long-term residential placements resulting from an acute hospital admission could be delayed or avoided.[13]

There is clearly a need for assessment to be put on a systematic and rigorous basis. A purpose-designed recovery centre would be the obvious and natural place for it. Patients who have been discharged home would be referred to it for assessment, while those who feel unable to leave hospital safely could be transferred to it for a short stay. The arrangements for assessment specified under Discharge to Assess would work as they were intended to, and smoothly.

Importantly, by taking advantage of such a centre the number of emergency readmissions to acute hospitals would be reduced, as would the pressure on emergency departments and acute beds. It would also reduce the need for expedients such as placing patients in care homes intended primarily for long-term residents and, in seaside areas like Cornwall, in a hotel room. These environments are neither designed for nor suited to a recovery programme.

A recovery centre would be the setting for the penultimate stage in a patient's journey back from hospital to their home and normality. Its staff would constitute a group to whom hospital doctors and surgeons could refer patients on discharge and would provide a service that general practitioners in the local area could take advantage of (a 'step-up' function). There would be the possibility, to put it no higher, of developing team-like relationships between members of the medical and nursing professions and the recovery specialists.

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Principle 7: Recovery is likely to be more effective and beneficial when carried out in a social context rather than on individual visits to people in their own homes.

The value of this principle has been impressively demonstrated by an initiative in West Cornwall, where community nurses employed by the Cornwall Partnership Foundation Trust set up the Centipede Club, a community hub for older people with leg ulcers.[14] After an initial assessment, patients referred to the leg ulcer service are invited to attend weekly group meetings in a relaxed café-style setting in a community location. No appointments are required.

Patients are treated while they sit together, with a separate room for those wishing to be seen privately. People continue to be seen even when their legs are healed. Tissue viability specialist nurses attend the group, updating the knowledge and skills of all the staff involved and the therapy services on offer. Patients have testified to the relaxed and friendly nature of the group meetings, compared with more formal clinical encounters. Staff say they love working at the group and are more confident in the work they do.

The Club clearly makes a highly effective use of staff time, not least by eliminating the time taken for nurses to drive between appointments at the homes of individual patients. It operates as an unofficial professional development organization too. Importantly, it demonstrates that recovery can usefully be envisaged as a social process, not just an individual one.

At the present time there is a great deal of emphasis within the NHS on getting people back to their own homes. In West Cornwall, Penzance STEPS (Short Term Enablement and Planning Service), part of Cormac Solutions Ltd, provides personal care to people in their own homes. The aim of the service is to re-enable people to maximise and regain their independence, within their own home, after a period of illness and/or hospital stay. It helps people for up to six weeks with daily activities such as washing, dressing, showering, getting up and going to bed; toileting; preparing meals; doing exercises and mobility practice; and identifying local community services to support them in the long term.[15] [16] It implies no criticism of the service to point out that there is no collective, social, out-of-the-house component to it, such as there is with the Centipede Club. Mutual support, shared enthusiasm and learning from one another are not available in one's own home.

Principle 8: A recovery centre should have its own premises and include some beds for overnight stays: it should work with hospitals, and could play an extremely valuable part in operating the Discharge to Assess scheme, but *it should not be a hospital or care home.*

A recovery centre that has its own premises in a settled location can provide a much wider range of services than a 'flying visits' service. Ideally it will have a dedicated gymnasium with installed equipment for developing strength and fitness, and a kitchen in which to demonstrate and teach cookery skills and dietary knowledge. It should have rooms for discussion and teaching, a room suitable for clubs like the Centipede Club, and one or more rooms with basic equipment and store cupboards that regular clinics can use. It would be advantageous for it to have a small

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number of 'sleepover' rooms for people who are literally half-way home: who have just been discharged from hospital and are understandably nervous about spending the night on their own.

The recovery centre would of course provide a base for the specialists who practise there. So it should have office accommodation, together with a staff room and seminar rooms, as well as consultation rooms. Doctors and nurses have institutional and physical bases in hospitals, clinics and GP surgeries. Specialists in recovery need exactly the same if they are to be effective. And if the recovery service extended to supporting people in their own homes, staff who travel around the area would have a base to work out of and return to.

The Edward Hain Recovery Centre: A prototype in West Cornwall

For a recovery centre to serve its purpose, it would be vital that it complement and work closely with the hospitals in its vicinity, and not compete with them. How would this work? We can consider two distinct cases: the centre vis-à-vis West Cornwall Hospital (sub-acute) in Penzance, and second, the centre vis-à-vis the Royal Cornwall Hospital (acute) at Treliske.

Consider the case of West Cornwall Hospital. Presumably because today the priority of NHS Kernow and the Royal Cornwall Hospitals NHS Trust is to develop West Cornwall Hospital as a centre of healthcare excellence, recovery in that hospital seems to be inevitably taking second place to surgical and medical treatment. There is no re-enablement gym, the physiotherapy and occupational therapy services are ward-based, and therapy staff are so stretched at the moment that there is no cover at weekends: evidently recovery services are accorded low priority when it comes to funding. A patient may see a physiotherapist just once or twice a week for only 15 to 20 minutes, and be expected to do their exercises in bed on their own. Nurses may be expected to 'walk' them, but in practice not have time to do so.

However, a specialist recovery centre in nearby St Ives, especially if it were equipped with a small number of beds for clients staying overnight, could work closely with West Cornwall Hospital and could provide the recovery services that the latter cannot or will not provide. For example, when patients are being discharged from the acute hospital at Treliske, those in need of continuing medical or nursing care could go to West Cornwall Hospital, while those ready to start on a recovery programme could go to the Edward Hain Memorial Recovery Centre. So there is a complementary role for a recovery centre in St Ives.

As an acute hospital, the Royal Cornwall Hospital at Treliske is under pressure to operate the Discharge to Assess scheme. The Governing Body of NHS Kernow was told at its meeting on December 1st, 2020:

> [We] have received confirmation that a purpose built new care home will be open to receive its first residents in Penzance in January 2021. This is the first time a new care home has been built in Cornwall for over a decade. This will provide 28 beds and these have been commissioned as discharge to assess beds which by their nature have a focus on reablement. The intended length of stay for individuals will be up to 6 weeks ... Some

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> beds will be for people with dementia and complex care needs. This will increase bedded reablement capacity in the west of Cornwall ...[17]

A subsequent Freedom of Information request elicited the information in mid-January 2021 that the 'new care home' would not be 'purpose built' but a conversion of a former nursery school, that planning permission had not yet been granted, and that the beds would not be available until March 2021 at the earliest. There appears to be nothing to prevent a CCG's officers from relaying hopelessly optimistic 'assurances' to its Governing Body.

More importantly, it is difficult to comprehend the thinking here. If 'Discharge to Assess' is to be taken at face value, assessing should take a matter of days, certainly much less than six weeks. The notion that 'discharge to assess beds ... by their nature have a focus on reablement' is very much open to question. No explanation is provided of how the care home is to provide simultaneously for two very different classes of resident: those in transit undergoing 'reablement' and residents in for the long term 'with dementia and complex care needs'.

The point needs to be made forcefully that a care home of the kind widely found in the UK is very different from a centre for recovery. As the above quotation itself demonstrates, it is defined in terms of beds; some of those beds will be used for people who are not capable of being re-enabled; and as for six-week stays, once you have been in a care home for that length of time, that is where you are likely to end your days, as various case studies illustrate.[18] Far from being a place of recovery, a care home will *disable* those who find themselves there.

The closing of Edward Hain Community Hospital offers an opportunity to rethink in its entirety the journey of a sick or injured patient through the healthcare system. The resources freed should be used to create a recovery centre that completes the path from hospital bed to bed at home. The Discharge to Assess scheme as it stands seems destined to end in the abandonment of discharged patients on a large scale, a mushrooming of care homes, and a mish-mash of care packages delivered in flying visits to people's homes. A recovery centre would provide the final link in a patient's journey that has hitherto been missing.

Doctors and nurses have institutional and physical bases in hospitals, clinics and GP surgeries. Specialists in recovery need exactly the same if they are to be effective. The NHS and Cornwall Council should do some joined-up thinking and provide buildings and organizational structures for them. It would be good to see the Edward Hain Recovery Centre lead the way in this.

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