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The NHS needs joined-up thinking: its new plan must reflect patients' care journeys and overcome the 'silo thinking' that hinders this

An open letter to Wes Streeting MP, Secretary of State for Health and Social Care

from

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IN A NUTSHELL

- Some NHS leaders have realised the importance of 'joined-up thinking'.[1] The latest guidance on discharging patients from hospital, for example, highlights the entire **care journey** that patients take through the hospital system, from admission to treatment and on to recovery, rehabilitation and reablement. ***This joined-up approach should be a starting point for drawing up the new 10-year plan for the NHS.***
- But such an approach risks being derailed by the investigation into the current state of the NHS that Professor Lord Darzi has been asked to lead.[2] He is a distinguished surgeon but his views show signs of **'silo thinking'**. He sees his task as being to 're-establish quality of care as the organising principle of the NHS'. But while the quality of the care provided to patients by a surgeon or team in an operating theatre can be assessed against just a few criteria, that is not the case for large organizations like NHS trusts and the NHS itself. To achieve the best possible quality of care is certainly a laudable aim, but ***'quality of care' is simply not usable as an organizing principle for the NHS.***
- Acute hospital trusts are not required to collect data on patients' care journeys. ***Their leaders have no incentive to ask what can be learned from patients' experiences.*** But we know that the entire care journey that a patient needs to take to regain their well-being extends beyond their being 'medically fit for discharge'. A further 'step-down' stage beyond the acute hospital is required. ***That step-down stage can be provided by community hospitals.***
- Amanda Pritchard, NHS Chief Executive, has promised to 'work closely with the government, independent experts and NHS staff' to look at the challenges and make plans to address them. ***She must work closely with patients too.***

Learning from patients' experiences of their care journey

A brief anecdote illustrates how a patient can deteriorate in the course of a stay in hospital.

Stuck in a hospital bed, unhappy and distressed

Ann, age unknown

This patient story 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.[3] On the first visit the patient, whom I am calling 'Ann', 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.'

Ann's story contrasts with a pioneering study of a patient's care journey that was carried out at Warwick Hospital by the South Warwickshire NHS Foundation Trust.[4] 'A complaint from a patient called Gerry prompted the Trust to invite him to come in and talk to them about his experience. Gerry spent eight days with them in total. He explained that, whilst his experience of the clinicians was excellent, there was no coordinated approach to his care and communication between specialties was poor.

The Trust mapped Gerry's journey through the hospital and discovered that, during his eight-day stay, there were only 34 hours' of value-added time. The rest of the time was spent waiting ... for decisions to be taken, for tests to be carried out, for results to come through, for lists of To Take Out Medications to be compiled. By improving their procedures, the Trust achieved significant reductions in mortality and numbers of medical outliers, and a rise in staff satisfaction levels.

The Warwick study illustrates the kind of learning that an institution can gain by examining individual care journeys, and the value of applying joined-up thinking and studying the care journey as a whole: an examination of individual stages would have been far less revealing. But it had nothing direct to say about Gerry's well-being.

The need to study patients' well-being

There is now a patient flow policy in place at the Royal Cornwall Hospital that explicitly emphasizes 'the need to understand why patients who do not meet the criteria to reside have not been discharged'.[5] But the hospital trust does not collect information about how those 'overstaying' patients such as Ann fare, or inform the public what – if anything – the hospital does to help them escape from the hospital, or to further their recovery, rehabilitation and reablement.

To gain such understanding a purposeful stage-by-stage study of the care journeys of individual patients is called for: such studies, properly carried out, will go far beyond the data on the dashboards currently presented to Trust Board meetings.

Hospital-acquired deconditioning

We are well aware today that patients in hospital for treatment, especially older people living with frailty, experience what is termed hospital-acquired deconditioning (HAD). The physical manifestations of HAD are well-known: loss of muscle strength, balance and mobility, for example.[6]

Less well-known are the psychological manifestations of HAD, although these are very apparent in patients' stories: confusion, fear, despair, a sense of being trapped, anxiety about what the future holds. These are borne partly of conditions in the wards of acute hospitals, notably lack of autonomy, unfamiliar surroundings, being confined to bed in the company of strangers similarly confined and having your ability to move around severely restricted, being forced to live according to a timetable set by others, being assaulted by surrounding noise from other patients and from the day-to-day providing of ward services.

Silo thinking keeps patients in hospital

When specialist clinicians and managers are in positions of power in acute hospitals there may be no-one given the task of keeping patients mentally positive and equipped to find a home elsewhere. Once a patient has been declared 'medically fit for discharge', clinicians such as Lord Darzi will have no interest in

them, while it appears that managers too do not regard it as their responsibility to maintain patients' physical and mental fitness and keep them equipped them to pursue a life elsewhere. Ironically, patients who are desperate to escape may find themselves treated as 'freeloaders', not deserving of an acute hospital's care.

The role of keeping recovering patients in touch with the outside world is one that in the early days of the NHS was performed mainly by hospital almoners. Aneurin Bevan grasped this, back in 1948:

> The work of the doctor must be reinforced by the work of the Almoner, for it is now recognized that it is not possible for even the most skilled medical service to have its best beneficial effects upon the patient if he is harassed by domestic anxieties and by fears of the future that intelligent activity can remove. Therefore the Almoner has become a very important part indeed of the modern healing work.[7]

There is a lesson here for Lord Darzi's investigation.

Joined-up thinking highlights a role for community hospitals

The NHS needs joined-up thinking to ensure that clinicians and managers are aware of the world beyond their silos, aware of the fact that patients' care journeys should move them on to the best of well-being possible for them.

Senior clinicians and the managers of acute hospitals are desperately anxious today to rid their hospitals of patients who are medically fit for discharge: they may not be aware that those patients are no less desperately anxious to escape.

If patients are to achieve the best state of well-being feasible for them, **their care journeys must include a 'step-down' stage beyond the acute hospital. That step-down stage can be provided by community hospitals.**

Community hospitals can also provide a local focus for general practice. Where they exist now, GPs already rely on them for various services. Building on this would go far towards creating a genuinely integrated National Health Service.

To conclude, while 'quality of care' is not capable of serving as an organizing principle for the NHS, joined-up thinking with a clear view of the whole of patients' care journeys could fulfil precisely that function. Lord Darzi please note!

Peter Levin