# Norfolk proposes reviving cottage hospitals to ease pressure on NHS beds



As healthcare systems across the UK experience increasing pressures, the situation at Norfolk and Norwich University Hospital has brought to light urgent concerns regarding patient discharge and capacity. Reports indicate that as many as 140 patients have been ready for discharge in recent weeks, yet their transition home remains stalled due to insufficient support services. This predicament highlights not only the challenges faced by hospitals but also the potential for existing, underutilised resources to alleviate some of these burdens.

Steve Morphew, the leader of the Labour group at Norfolk County Council, has proposed a compelling solution that centres around repurposing closed care homes into modern-day cottage hospitals. Recently shuttered facilities such as Springdale Care Home in Brundall and Burman House in Terrington St John are seen as prime candidates for this initiative. Norse Care, the care branch of the county council's Norse Group, stated the homes were no longer suitable for residents' needs, but Morphew argues that they could serve a critical function as "step-down" facilities for patients transitioning from acute care to recovery.

Echoing this sentiment, he emphasised the importance of collaboration between the county council and the NHS. "We could see the return of much-missed cottage hospital type services that would free up beds for those needing treatment, cut waiting lists, and may work out cheaper in the long run," he asserted. The argument is that these step-down services demand fewer resources and less specialised infrastructure compared to long-term care, yet remain crucial for patient recovery and minimising hospital stays.

In response to Morphew’s proposals, council leader Kay Mason Billig acknowledged ongoing partnerships with the Integrated Care Board regarding intermediate care services. According to her, the focus is currently on community-based support, including initiatives such as Norfolk First Support, which offers up to six weeks of assistance in patients' homes post-discharge. However, the pressing need for additional intermediate care options remains clear, particularly as hospital demand continues to rise.

The historical context of cottage hospitals—small facilities set up in rural areas during the 19th century to provide accessible care—underscores the relevance of Morphew's proposal. Many towns in Norfolk, like North Walsham and Cromer, formerly had such establishments. However, the broader shift towards larger hospitals within the NHS framework led to the decline of these facilities. Now, in an era marked by increasing healthcare demands and a growing ageing population, rekindling the cottage hospital concept could present a feasible strategy to manage patient care more effectively.

Beyond the potential for repurposing existing facilities, Norfolk and Norwich University Hospitals has already taken steps to enhance discharge processes. The hospital employs a multidisciplinary approach, involving ward nursing staff, specialised nurses, and social services to ensure safe, timely transitions from hospital to home. Initiatives such as welfare calls and the Home First Unit, a dedicated 30-bed facility for patients awaiting community support, prioritise patient independence and well-being post-discharge. These strategies aim to reduce readmissions and free up hospital beds for those requiring urgent care, but they also underline the complexity of managing patient pathways effectively.

The rising number of closures and an ongoing reassessment of care needs further complicate the picture. For instance, after the closure of Burman House, Norfolk County Council plans to explore potential uses for the site, signalling a recognition of the need to assess community care requirements more thoroughly. Yet, clear plans for how these facilities might be operationalised remain to be articulated.

In conclusion, while the challenges surrounding hospital discharges highlight immediate systemic issues, they also beckon an opportunity to rethink the provision of healthcare in Norfolk. Reimagining under-utilised care homes into practical healthcare extensions could play a crucial role in improving patient outcomes, enhancing service efficiency, and ultimately ensuring a more responsive and sustainable healthcare system for the future.

### Reference Map

1. Paragraph 1: 1
2. Paragraph 2: 1
3. Paragraph 3: 1
4. Paragraph 4: 2, 4
5. Paragraph 5: 3
6. Paragraph 6: 1
7. Paragraph 7: 1, 2, 3
8. Paragraph 8: 1, 3, 6

Source: [Noah Wire Services](https://www.noahwire.com)

## Bibliography

1. <https://www.edp24.co.uk/news/25153101.call-make-unused-care-homes-modern-day-cottage-hospitals/?ref=rss> - Please view link - unable to able to access data
2. <https://www.nnuh.nhs.uk/departments/discharge/> - The Norfolk and Norwich University Hospitals NHS Foundation Trust provides comprehensive discharge services to ensure patients transition safely from hospital to home or alternative accommodations. Their discharge process involves a multidisciplinary team, including ward nursing staff, specialist nurses, social services, therapists, and community-based services, all working collaboratively to plan and execute discharge arrangements tailored to each patient's specific needs. This holistic approach aims to facilitate a smooth transition and promote the patient's independence and well-being post-discharge.
3. <https://www.lynnnews.co.uk/news/council-will-look-into-options-of-how-to-use-care-home-bui-9390399/> - Following the closure of Burman House Residential Home in Terrington St John, Norfolk County Council, which owns the building, plans to explore future uses for the site. The council's spokesperson confirmed that Norse Care, the operator, will return the property once their lease ends. The council intends to assess potential options for repurposing the building, considering community needs and the facility's suitability for various services, though specific plans have yet to be detailed.
4. <https://www.nnuh.nhs.uk/departments/discharge/complex-discharge-team/> - The Complex Discharge Team at Norfolk and Norwich University Hospitals NHS Foundation Trust focuses on facilitating the timely and efficient discharge of patients with complex needs. Collaborating with ward staff, the team monitors and advances discharge plans, offering practical assistance, discussing arrangements with patients and their families, providing specialist advice, and liaising with internal and external organizations. Their goal is to ensure patients transition safely to their chosen environment, prioritizing safety and preventing unnecessary delays in care.
5. <https://www.nnuh.nhs.uk/news/supporting-discharge-with-welfare-calls/> - Norfolk and Norwich University Hospitals NHS Foundation Trust has implemented a welfare call service to support patients post-discharge. Volunteers contact patients 24 hours after leaving the hospital to assess their well-being, inquire about daily activities, and identify any concerns. This initiative aims to prevent readmissions by addressing issues early and connecting patients with necessary support services, thereby enhancing the overall discharge experience and promoting patient safety and independence.
6. <https://www.nnuh.nhs.uk/news/spotlight-on-steph-ward-home-first-unit/> - The Home First Unit at Norfolk and Norwich University Hospitals NHS Foundation Trust is a 30-bed facility designed to support patients who are medically ready for discharge but awaiting community support or care packages. The unit focuses on re-enablement, encouraging patients to regain independence in daily activities through exercise programs and therapy. By improving patients' physical and cognitive abilities before discharge, the unit aims to reduce readmissions and free up acute hospital beds for those in need of urgent medical care.
7. <https://www.nnuh.nhs.uk/departments/discharge/complex-discharge-team/> - The Complex Discharge Team at Norfolk and Norwich University Hospitals NHS Foundation Trust focuses on facilitating the timely and efficient discharge of patients with complex needs. Collaborating with ward staff, the team monitors and advances discharge plans, offering practical assistance, discussing arrangements with patients and their families, providing specialist advice, and liaising with internal and external organizations. Their goal is to ensure patients transition safely to their chosen environment, prioritizing safety and preventing unnecessary delays in care.