JUNE 2018 REPORT TO HEALTH IN DACORUM COMMITTEE

1. NASCOT LAWN

1.1 The HCC Health Scrutiny Committee passed unanimously a resolution proposed by S Quilty and seconded by J Birnie which, inter alia, expressed Members' concerns;

- about the availability of future respite provision and equity of location;
- as to the impact on the wider health and social care system, the disruption and/or reduction in the level of respite service currently available;
- about transition planning, staff costs and retention.

The resoltion also stated that "Members considered that the new service should be in place before Nascot Lawn is decommissioned."

1.2 Sadly, the transition arrangements promised by HVCCG, admittedly a reduction in service in themselves, have not run satisfactorily even at the reduced level of service and the committee members continue to receive complaints from parents about massively reduced access to any kind of respite care, staff shortages at Nascot Lawn and blatant disregard by the CCG of the last point in the resolution quoted above.

2 PATIENT FLOW

2.1 A topic group was established by the HCC Health Scrutiny Cpmmittee to examine the arrangements at WHHT and the Lister Hospital. Similar systems exist at both trusts, but this report concentrates on WHHT with comparative comments on the Lister where relevant.

2.2 The basic care principle in speeding patient flow is that patients recover better both clinically and mentally at home rather than in hospital. Generally speaking also, care outside of hospital is cheaper.

2.3 The target for transfer of care once clinical needs have been met is largely determined by spare bed availability in the hospital and in WHHT this equates to 3.5% of the total or 22 patients. The actual delayed transfer of care ((DTOC's) since 2016 has averaged 6% (41 patients) per day. This has improved since the end of April 2018 to 27 patients per day, but usually increases dramatically in winter, especially over the festive period because of A&E pressures.

2.4 Main causes of DTOC

a. Social care requiring public funding problems
b. Problem placibg patient in care home
c. Delayed completion of assessment for care package needs
d. Further non acute NHS care needed
e. Non availability of intermediate care beds, especially for stroke patients and those with mental conditions.
f. Failure to dispense take home drugs on time

2.5 Amelioration measures

2.5.1 The most obvious way to avoid DTOC is not to admit the patient in the first place and this is most obviously achieved by

a. The 111 service redirecting many callers to more appropriate care options than A&E
b. The Emergency Care Practitioner's Car in Three Valleys (Early Intervention Vehicle in E&N Herts) folowing a 999 call to direct the patient appropriately
c. GP's embedded in the hospital admissions area
d. Ambulatory Care departments led by a consultant and fully equipped to deal with such "walking wounded" cases as diabetic trauma, dialysis, minor

injuries. This has been so successful, that GP practices have begun to refer patients directly to the department. The drawback is that the department is next to A&E and in winter crises, given the limitations of the WHHT decrepit estate, Ambulatory Care is often used as an overflow space for acute cases.

e. Frailty Units where specialists can complete a geriatric profile and assess quickly where admission is unecessary (leading at WHHT to an increase in discharge rate on the day from 23% to 60%)

2.5.2 Since most causes of DTOC are social care, as opposed to medical problems, HCC has funded and embedded social care specialists in an Integrated Discharge Team at WHHT. Some of the initiatives developed by this team are;

a. To start planning the patient's care package as soon after admission as possible. One of the problems here is that, unlike Lister, no social care member of the team is present at the triage stage, where clinicians plan the care stream for the patient's time in hospital. Although this may change as treatment progresses, notification of expected discharge date is often not received by the social care members for up to 8 days from admission. Efforts continue to bring this down to 48 hours.
b. Social care specialists are included in a weekly ward round with clinicians to privide input as part of the NHS England "Fresh Eyes" project.
c. Any patient remaining in hospital in excess of 14 days is reviewed weekly with clinicians and managers.
d. A weekly conference call with members of the Integrated Discharge Team, the CCG and both voluntary care organisations and care homes covers all DTOC patients. This is sometimes compromised by inadequate telecommunications.
e. Close liaison with care homes, whose bed availability is constantly monitored, as well as the care profiles of individual residents.
f. "Discharge home to assess" packages involving WHHT nurses and therapists and social services visitors. Unfortunately, this service has only been rolled out in Watford to date.

2.5.3 Even though the main cause of DTOC remains social care problems, one positive result of the above measures is an average DTOC reduction of 20.5 patients per week since November 2016 when average timely discharges into social care was 71 per week and is now 91.5 patients.

2.5.4 WHHT has also established an early discharge room with nurses in attendance where patients can be comfortably accommodated while awaiting take-home drug packs or transport. The main aim of this facility is to fulfill the aim of discharging at least 33% of patients who have reached the end of their clinical treatment stream before midday. Unfortunately, delays are often caused at the pharmacy because junior doctors fail to write up complex prescriptions at the end of their ward rounds and the IT limitations at WHHT do not make e-prescribing "on the hoof" possible. (There is currently a discussion about embedding trained pharmacists in the ward round to solve this problem at the Lister.)

3 Proposed WHHT/Royal Free tie up

3.1 RFH is regarded as an exemplar of good practice, having progressed from a CQC rating of "Requires Improvement" in 2008/9 to "Good" today. It had 13% higher costs than the national average then to 3% lower costs than the national average now. It now also has 7% lower costs than the average acute (non specialised) London hospital trust. (Every percentage point reduction in London = circa £100m p.a. saving).

3.2 RF has a number of other hospitals as members of a core provider system for integrated care where members share clinical practice infrastructure and corporate support services. There are also “Clinical Partners” who share these benefits in exchange for a fee but retain their separate identity and statutory governance.

3.3 WHHT proposes to join the latter group, leading to;

a. adoption of common leadership practices
b. reduction of unwarranted variation
c. consolidation of clinical and non clinical activity
d. digital improvements

3.4 Unfortunately, the main driver of this proposal is the CEO at WHHT who is about to leave, so it remains to be seen whether the proposal will survive her departure.

Cllr J R Birnie
19th June 2018