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NHS Trust

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Councillor Ruth Wright
Civic Offices
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Dear Councillor Wright

Thank you for your letter of 5 February 2018.

We fully appreciate the importance of the role of the Newcastle-under-Lyme Health and Wellbeing Scrutiny Committee and respect the position of your members. We are, therefore, sorry that your members were disappointed that we did not send a representative to the meeting on 10 January 2018. However, the request to us was that we send a representative or, if not possible, a report. Given the severity of the pressures that the entire NHS was experiencing in January I am sure you can appreciate that we were focusing all of our efforts into resolving the very operational issues that your members were asking about. This is why we sent a report on this particular occasion. I do think organisations would find it helpful if the Committee could be clear if their attendance is required as this will prevent such misunderstandings occurring which are frustrating for both parties.

In normal circumstances we would be very pleased to send a representative to the Committee and, in terms of specific meetings, we will send the most appropriate colleague to discuss the chosen topic. For more general contact, my colleague Naomi Duggan, Director of Communications, would be very happy to meet with you to discuss how we can best work with your Committee in the future. Naomi can be contacted on 01782 676620.

I can appreciate that the report that was sent to you was too literal in answering the specific questions asked, rather than giving members the broader context around delays, although again the Committee may wish to note that the requirement was not particularly clear. I attach a fuller, more up to date, report which should provide more helpful context. You may still find it worthwhile to share this with your members for information as timely discharges need to be viewed as a whole system year-round responsibility, and to a lesser extent so do cancelled operations.

I am sure that we can work together more productively in the future and look forward to doing so.

Thank you again for taking the trouble to write to me.

Yours sincerely

PAULA CLARK
CHIEF EXECUTIVE

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cc Naomi Duggan, Director of Communications

Report for Newcastle Borough Health and Wellbeing Scrutiny Committee in response to questions raised by Members

Is the Royal Stoke achieving timely discharges for residents of Newcastle under Lyme?

Achieving timely discharges for the residents of Newcastle under Lyme is dependent on a wide variety of factors, and is the responsibility of the whole health and care economy.

Effecting discharges to the community or to people's homes from Royal Stoke has been a significant challenge for a number of months. The bed capacity in the system wide winter plan was based on assumptions about demand (numbers of people needing care) which were exceeded during the autumn and the type of illness more acute than expected. Disappointingly a number of out of hospital schemes, that should have come on stream by autumn 2017 have not operated to the levels expected by commissioners and this left University Hospital North Midlands with more medically fit patients in our beds than we should have to enable efficient flow and timely discharges.

There are regularly 150-200 people who are medically fit for discharge (MFFD) occupying beds at Royal Stoke. This means that they no longer need acute care, but they may need on-going support at home or within a community setting such as a nursing home. A more acceptable figure for a hospital would be 100. As these patients are still occupying beds this contributes to long waiting times in A&E.

Complex discharges, where patients need more intensive support, remain the biggest problem as these are not occurring in sufficient numbers, leaving medically fit for discharge patients stranded in acute beds.

Many independent commentators, including NHS Improvement and the Care Quality Commission have commented on the compassionate care we provide to patients despite our pressures, so once people are admitted they can expect to receive high quality care. Indeed our latest Care Quality Commission report rated us as outstanding for caring.

However it is well documented that acute hospitals are not the best place for many people, especially the frail elderly, to receive care once they no longer need medical intervention. Extended lengths of stay in hospital can lead to de-conditioning with patients losing muscle mass and becoming confused. This then reduces their chances of remaining independent and in control once they do leave hospital. Extended lengths of stay are also unnecessarily expensive, as acute hospitals are the most costly part of the health system.

If there are delays what is the cause?

There are a number of historic and current issues that have contributed to the lack of timely discharges:

Demand

The demand for services this winter throughout the NHS has been higher and more acute than anticipated leading patients to occupy beds for longer than usual. Committee members will not doubt have seen the national media coverage in relation to this.

Lack of Acute Beds

Royal Stoke University Hospital is too small to fully meet the evolving needs of both the local population and those from a wider catchment. This is why despite our challenges we have invested £2m to create 45 new beds on the site. At the moment we have a net gain of 41 beds, with more to follow in the coming weeks.

We have developed a proposal for additional beds in the Trent Building but this would be a longer term initiative and is dependent on funding from NHS Improvement.

Closure of Community Beds

The Stoke-on-Trent and North Staffordshire Clinical Commissioning Group has closed significant numbers of beds at Bradwell, Cheadle, Longton and Leek Community Hospitals in recent years.

Whilst UHNM supports the principle of providing care as close to home as possible, we believe that some of these closures occurred prematurely as they were based on assumptions of demand that were too low, and predicated on out of hospital initiatives which did not come on line as quickly as expected. Bradwell Hospital temporarily re-opened in December 2017 to help absorb some of the winter pressures and is being used to care for patients who are medically for discharge from RSUH.

Other additional community capacity has recently been put in place at Haywood Hospital, Brighton House and Milford House.

The CCG are carrying out a consultation on the long term future use of the community hospitals.

Care Home Provision

The community care home sector is very congested and whilst there is some private nursing home provision there have been some quality issues and providers closing for financial or other reasons. These homes will often not take patients with complex needs, so whilst on paper there may be beds available, in practice these often do not correlate to the needs of patients waiting to be discharged leaving the patients in an acute bed.

Another issue we are facing is that homes are sending frail older people into hospital even though they could be better cared for in situ or by primary care. The Clinical Commissioning Group have been very clear that patients should not sent to hospital without a GP referral, and we are working with the West Midlands Ambulance Service to ensure that patients are not brought to Royal Stoke unless they have such a referral.

Domiciliary Care

In recent months there has been an increase in the number of care packages within people's homes, but the local domiciliary care offer still isn't strong enough to sustain a healthy flow throughout our hospitals.

Discharge to Assess

This is nationally recognised best practice which provides patients with an assessment in the community or their home and gives them up to six weeks of enablement support once they leave hospital. This is seen by the CCGs as the solution to issues with hospital flow. However Discharge to Assess can only work if there is capacity in the community.

Over Cautious Approach to Discharges by Clinicians

Whilst accepting all the challenges relating to a lack of sufficient appropriate community capacity, the national view is that UHNM has unnecessarily long lengths of stay for some patients and that we could do more ourselves to achieve discharges. In recent weeks John Oxtoby, our Medical Director, has written to our consultant body asking them to review their threshold for discharge in relation to every patient, so that we achieve more timely discharges. We are not asking anyone to compromise their integrity, but we are asking everyone to ensure their decision making is appropriate in the circumstances we currently face.

Multi Agency Discharge Event

We recently held a week long Multi Agency Discharge Event (MADE) involving all health and care system partners which focused on working together to reduce the queues and waiting times in our hospitals, and identifying and removing the barriers to discharges. All stranded patients (those with long stays as outlined above) have been reviewed as part of this exercise. We will be using the learning from this week to improve processes throughout the whole health economy so that more patients can get back home or to the most appropriate care setting as quickly as possible. Discharging patients in a timely way will help free up beds, reduce waiting times and improve patient experience.

As part of this event we have had the support of nationally respected experts including Dr Ian Sturgess and Liz Sergeant OBE, and are committed to taking advice and best practice on board.

Do the residents of Newcastle under Lyme experience any delays in relation to operation waiting times?

Much of the Trust's income is reliant upon the income received for performing operations, so it is in our interest as well as that of our patients that we do everything we can to prevent cancellation of operations.

There are many reasons for delays in operation waiting times some of which are associated with system pressures, or in-hospital issues such as staff sickness. However some do not take place because of patient cancellations or failure to attend appointments.

Cancer and urgent operations are our priority, and even when we are pressurised we do everything we can to minimise any cancellations. Our biggest challenge has been a lack of critical care capacity, as we cannot perform major operations without having the appropriate skilled aftercare in place. Flu has had an effect on this capacity throughout January as have the number of other acutely unwell patients coming through our doors.

Some elective surgery was cancelled in the autumn, and we have moved more routine surgery down to County Hospital to help prevent such cancellations in future. We paused non-urgent elective surgery during January 2018 in line with the national directive to do so in order to deal with winter pressures but are aiming to get back on track this month.

UHNM February 2018