London Road Community Hospital Wards 4/5/6 – Update and Next Steps

Derby City Adult & Health Scrutiny Board

June 2021

Purpose of the Meeting

- Overview of London Road Community Hospital - wards 4, 5 & 6
- National Discharge to Assess Definitions
- Covid impact
- Alternative Provision and Overview of Transformation
- To inform the City Adult and Health Scrutiny Board of our intentions to start fine-tuning the process of a more permanent solution
- To ask the Board for their views on how we should engage with people on the transformation of London Rd Community Hospital wards 4,5 and 6?
- Any Questions

London Road Community Hospital Wards 4/5/6

Overview

- Wards 4/5 & 6 provided short term, rehabilitation nursing beds
- In 2019/20:
  - 79% of bed days were occupied by people registered with a Derby/Derbyshire GP
  - 21% of bed days were occupied by people registered with GP's outside of Derby and Derbyshire i.e. Staffordshire, Leicestershire etc).

60 beds out of 76 were occupied by DDCCG patients

LRCH Capacity

Ward 4	30 beds	**Ward 5**	23 beds (flex 28)	**Ward 6**	18 beds

Independent Reviews of people's needs

Independent Review in 18/19
In the South of the county the proportion of provision of P3/2/1 was not in line with national or locally agreed optimal complex care provision.

Not enough people were being discharged home – too many people were remaining in a hospital bed

Clinical Audits in 2019/20
Conclusions proposed that streamlining or relocating assessment and discharge planning to more appropriate settings that better matched the intended discharge destination could reduce unnecessary days within a bed and could reduce any unintended harm caused by extending patients stay in hospital.

Audit proposed that 79% of patients (48 of 56) did not need to be in a P2b bed

National Discharge To Assess Definitions

Covid-19 Pandemic Impact

Changes to services – Wards 4/5/6 (temporary closure)

- **During March 2020, following the outbreak of Covid19, NHSE/I published the document "COVID-19 Hospital Discharge Service Requirements".**
- This included agreement for Continuing Healthcare (CHC) funding processes to be simplified and fully funded by NHSE/I**.**
- **RDH focussed on discharging patients from Wards 4, 5 and 6 in order to enable these wards to be repurposed for supporting the Covid19 response – for instance to be used for palliative care or sub-acute Covid19 capacity.**
- As a result, Wards 4 and 6 discharged all patients on 30th March and the majority of patients were discharged from Ward 5 which then remained open to support a small number of patients until 6th April.
- **Across the 3 wards a total of 52 patients were discharged**.

- **Most common condition - frail elderly people with delirium or dementia**

- **National discharge principles changed – Clear evidence that discharging people home delivered the best outcome for patients**

Service developments / Alternative to LRCH

Derby City Enhanced P1 service (Delirium Pathway)

The Service

- Urgent 2 hour Home First response
- Planned response to non-urgent to prevent escalation
- Full team will take up to 12 customers over 14 days
- Up to 7 calls per 24 hour period – 6 hours contact time
- Incorporated into D2A Pathway 1
- Access with D2A referral to IDH/H2H Team

Soft launch from 15/03/21

- New staff team recruited
- Enhanced induction & training
- Adapted MDT's to include mental health support
- Escalation Planning with GP's
- Operational processes established

Criteria

- Clinical diagnosis of acute delirium
- Enhanced care needs manageable at home
- Preventing admission or facilitating discharge
- Derby City adult residents

Exit & Outcomes

- Longer period of care in P1 if needed
- P2 bed if needed
- Referral to specialist services
- Supporting carers to recognise & prevent future crisis
- Measuring outcomes short, medium & longer term
- Capturing customer & staff experience

Service developments/Alternative to LRCH

Dementia Palliative Care Team (AKA Dementia pilot)

Aim: Improving the Pathway for People with Dementia & Delirium

Previously people with Dementia/Delirium often default to a nursing bed (P2b), which is often an inappropriate placement
Their length of stay in P2b is 20+days and discharge can be challenging
Purpose is to close gap in the pathway for people with dementia and complex, high level needs

Expected Outcomes

- Reduce system impact – LoS, inappropriate P referrals & bed days, readmission rates, challenging discharges
- Improve Dementia pathway – clinical quality and equity
- Support Care Home staff with dementia complex cases & Covid 19
- Improve training and education – (dementia, delirium, Covid 19, end of life, symptom management, palliative care)
- Implement National Guidance & Evidence based practice in end of life and dementia care

80 Referrals September 2020 – February 2021 from the Derby City Alliance Group

- Rate of referral higher than pilot anticipated
- New EMAS pathway going live, will increase referrals
- Referrals for discharge support increasing
- Increasing links with PCNs
- Increasing links with Care Home support networks
- Increasing number of referrals for people with learning disabilities

Proposed Service developments

Additional P2a / P2b Capacity

- Developed a P2b specification for 10 beds in the City to be provided by an independent nursing home

- We have explored the market and there are good nursing homes that have expressed an interest

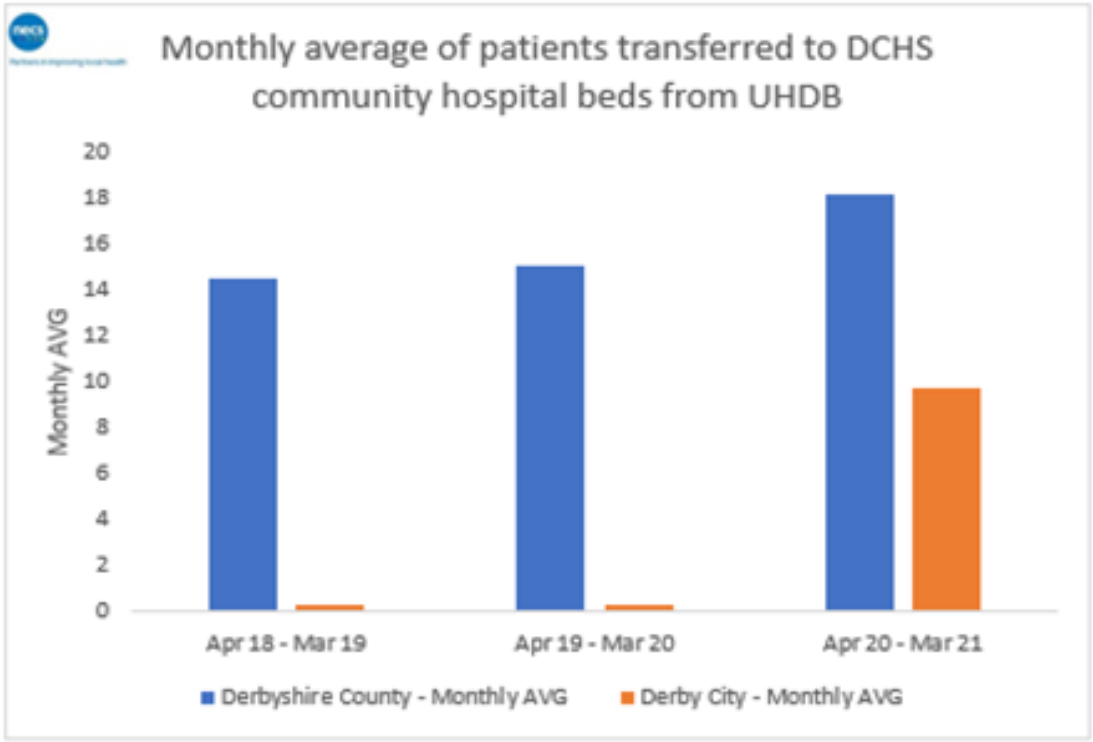
- **But at the moment the system feels we have enough provision because:**

    - Well established Home First service
    - Integrated delivery model (DCHS, DCC, UHDB)
    - Can easily flex up and down within the P1 – P2 provision – flexible staffing and flexible estate (across the County)
    - Well connected primary care network
    - New dementia and delirium models
    - P2b provision is available elsewhere

However if we feel we need more bedded provision we could easily commission more provision.

Data / Evidence

Changes to patient flows out of Royal Derby Hospital



Period	Apr 18 - Mar 19	Apr 19 - Mar 2	Apr 20 - Mar 21
Derbyshire County - Monthly AVG	15	15	18
Derby City - Monthly AVG	0.3	0.3	10

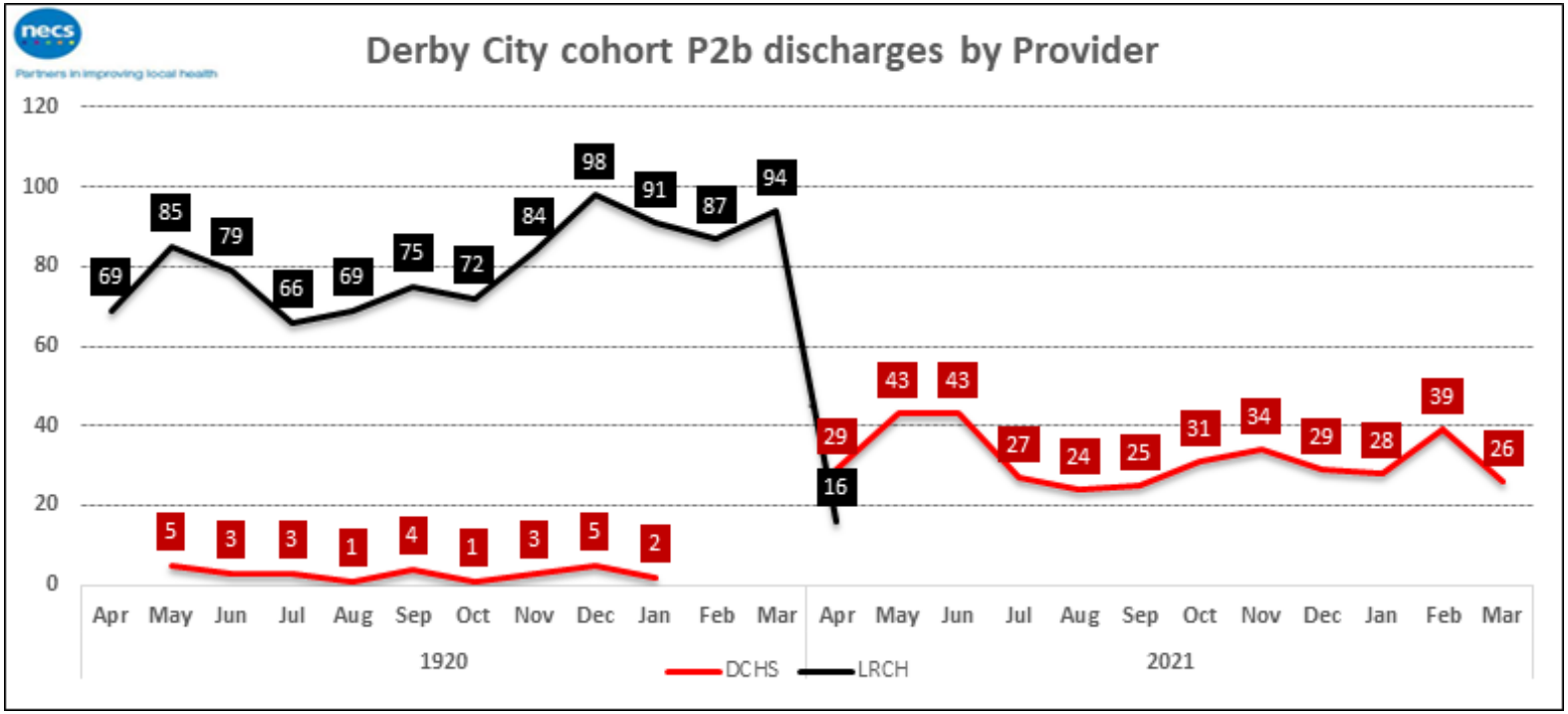
The LoS at DCHS has reduced from 22 days in 19/20 to 15 days 20/21 & this has released capacity and increased throughput.

DCHS increased ward capacity to admit covid+ patients.

Changes in National Discharge Guidance has allowed patients to flow directly into a nursing home for CHC assessment

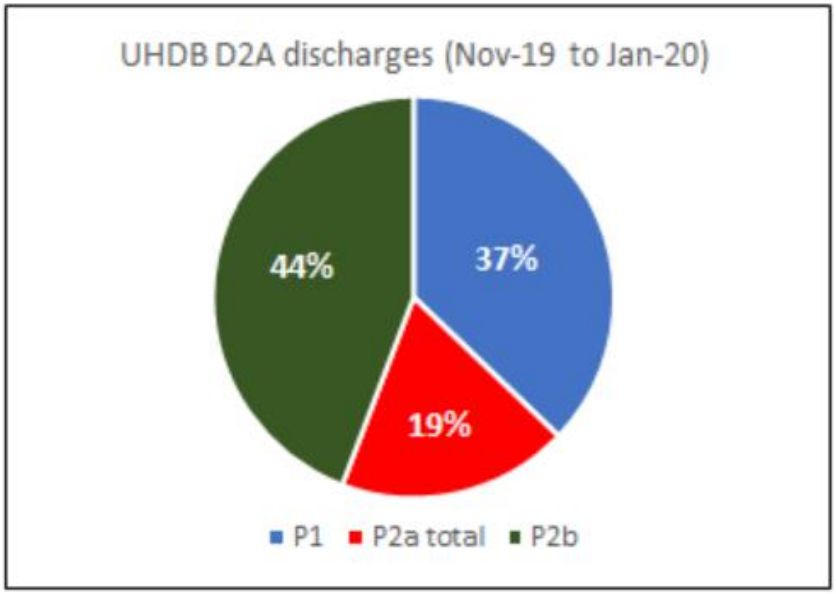
Derby City Alliance patient access to Pathway 2b

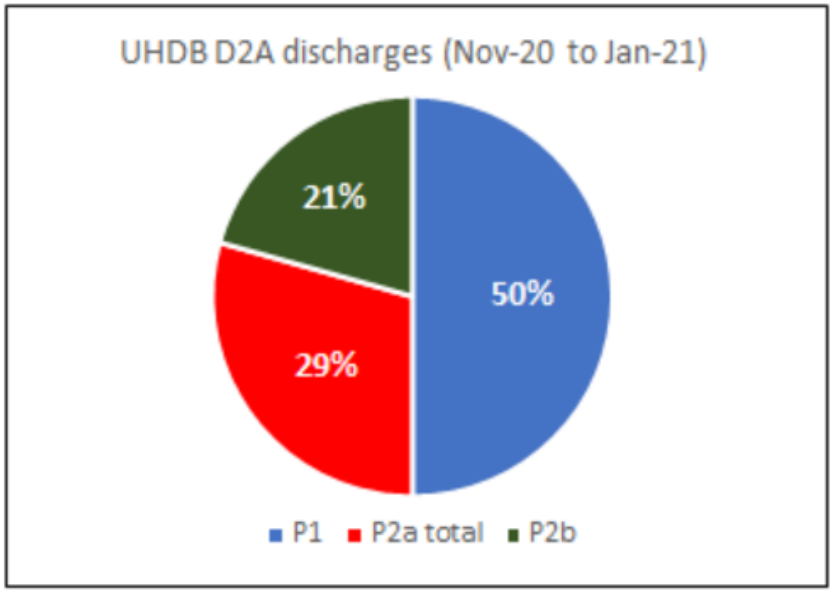
- Since May an average of 32 discharges per month from DCHS community hospitals are for Derby City patients



Discharge pathways : more patients going home

- **13% (126) more people went home**
- **P2a discharges increased by 13%**
- **P2b discharges Halved**





Next Steps

Develop the case for change:

Further refine the Case

- Have we got enough evidence to support the continued/permanent closure of LRCH? What would help, what is missing?
- What does the data tell us about the demand for D2A Pathways and therefore capacity required? Have we got that right?
- What are the risks associated with the proposed change /impact on others and how do we mitigate them?
- How should we engage and communicate with stakeholders?
- What is the Roadmap for making a final decision?

Engagement and communication

- Develop the plan to engage with stakeholders:
  - Staff LRCH
  - Adult and Health Scrutiny Board
  - City Place Alliance
  - PCNs & Primary Care
  - Staff (NHS & LA)
  - Public
  - Carers
  - Partners NHS & LA
  - Independent Sector – voluntary and private

Any Questions

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