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Health Overview and Scrutiny Committee
Tuesday, 15 July 2014, County Hall - 1.30 pm

Minutes

Present:

Mrs J Marriott (Chairman), Mr W P Gretton, Mrs P A Hill, Mr M Johnson, Mr A P Miller, Mrs F M Oborski, Mrs M A Rayner, Mrs F S Smith, Mr G J Vickery and Mrs P Witherspoon

Also attended:

South Worcestershire Clinical Commissioning Group
Mari Gay, Director of Quality and Patient Safety
Ruth Davoll, Urgent Care Strategy Lead
Carl Ellson, Chief Clinical Officer
Simon Trickett, Chief Operating Officer

Redditch and Bromsgrove Clinical Commissioning Group
Marion Radcliffe, Urgent Care Lead
Paul Sheldon, Chief Financial Officer

Future of Acute Hospital Services in Worcestershire
Simon Angelides, Programme Director
Claire Austin, Communications Lead

Worcestershire Acute Hospitals NHS Trust
Chris Hetherington, Consultant in Emergency Medicine

Care UK
Rebecca Chislett, General Manager
Zahida Adam

Healthwatch Worcestershire
Peter Pinfield, Chairman

Officer Support
Suzanne O'Leary, Overview and Scrutiny Manager
Jo Weston, Overview and Scrutiny Officer

Available papers

A. Agenda papers (previously circulated);

B. Presentation handouts

C. Minutes of the previous meeting (previously circulated).

A copy of documents A and B will be attached to the signed Minutes.

Date of Issue: 4 August 2014

688	**Apologies and Welcome**	Apologies had been received from Mr A Roberts (Chairman), Mr P Grove and Prof J Raine. Mrs J Marriott (Vice Chairman) would take the Chair. Mr M Johnson was welcomed to the Health Overview and Scrutiny Committee as the new Worcester City representative.
689	**Declarations of Interest and of any Party Whip**	None.
690	**Public Participation**	Mr N Stote, Chair of the Save the Alex Campaign, addressed the Committee to raise concerns in relation to the recommendation that the consultant led Delivery Unit at the Alexandra Hospital close. He believed there was a reluctance by Worcestershire Acute Hospitals NHS Trust to work with other providers and understood that additional capacity to be provided through Birmingham Women's Hospital would not be visible for 2 to 3 years, resulting in pregnant women being forced to travel to Worcester. He asked what information had been shared with the Committee and whether Members shared his concerns.
691	**Confirmation of the Minutes of the Previous Meeting**	The minutes of the meeting held on 17 June 2014 were confirmed as a correct record and signed by the Chairman.
692	**Winter Pressures**	Attending for this item and representing the 3 Worcestershire Clinical Commissioning Groups were: <u>South Worcestershire Clinical Commissioning Group</u> Mari Gay, Director of Quality and Patient Safety, Executive Nurse Ruth Davoll, Urgent Care Strategy Lead **Background** The Health Overview and Scrutiny Committee (HOSC) was reminded of the increasingly integrated approach to health services and winter pressures was a good example of this with various partners working together to plan accordingly. In addition, the HOSC had discussed the work undertaken on the county wide urgent care strategy earlier in the year. An evaluation of the winter schemes in 2013/14 was carried out by the Emergency Care Intensive Support

Team (ECIST), concluding that:

- data suggested that the 2013/14 winter schemes did not lead to a significant reduction in emergency admissions or A&E attendance
- the reduction in type 1 A&E attendances seemed to be part of a longer term trend and nationally attendances were also lower than in the previous winter
- the A&E conversion rate had been steadily increasing, partly driven by the fall in A&E attendances
- there was little evidence overall to suggest the schemes collectively reduced admissions or A&E attendances and some schemes were relatively small scale and therefore unlikely to have a measurable impact
- several of the hospital based schemes were late starting and relied on recruitment.

The evaluation made some recommendations, mainly:

- patient flow through the Acute Trust needed to be improved
- new processes, including ambulatory emergency care, assertive management of frailty pathways and a relentless focus on eliminating internal delays, needed to be developed to improve flow
- the local reliance on community hospitals as a preferred discharge destination needed to be questioned
- discharge to assess must replace assess then discharge
- processes to lessen the number of frail older people being admitted to hospital needed to be developed at scale with the ambition of reducing admissions by at least 25%
- the length of stay in community hospitals should be halved
- the need for whole system action and collaboration and the avoidance of the temptation to blame others for system failures.

Resilience and Capacity Planning 2014/15

New national guidance on resilience and capacity planning had been jointly produced by NHS England, the NHS Trust Development Authority, Monitor and the Association of Directors of Adult Social Services (ADASS). Published on 13 June 2014, each Clinical Commissioning Group (CCG) received a one-time funding allocation to support delivery during 2014/15. In Worcestershire, the allocation was just over £3million

across the three CCGs and, to promote maximum benefit, it had been agreed locally to pool this resource. This was in addition to a proportion of the Better Care Fund already devolved to the CCGs. Furthermore, additional funding was expected from NHS England to contribute to the delivery of Referral to Treatment waiting time targets.

The guidance made it clear that urgent care working groups needed to evolve into system resilience groups, covering both urgent care and elective activity. Locally, the Group would need to develop a local operational resilience and capacity plan. Members learned that all health economy partners were working together to submit a plan to NHS England by 30 July 2014.

Key Priorities
The operational working group responsible for the implementation of the urgent care strategy, including winter planning had met and agreed a number of key priorities.
Frailty Unit – aimed to provide a multidisciplinary acute frailty and elderly assessment unit at Worcestershire Royal Hospital with a length of stay up to 72 hours
Discharge home to assess – Pathway 1 – patients to be discharged home once stable with assessment for on-going health and social care and rehabilitation completed at home
Discharge to assess – Pathway 2 for patients who require assessment of their long term care needs – entailed the block provision of nursing home beds to enable a speedy discharge of patients who required assessment of their long term care needs in a more appropriate community setting
Discharge to assess – Pathway 3 for patients with severe dementia, who require assessment of their long term care needs – entailed the block provision of care home beds to enable the speedy discharge of patients with moderate to higher level dementia/delirium
Patient Flow centre – aimed to provide a link between the organisations, developing an integrated patient flow centre to reduce the complexity of achieving the right care in the right place at the right time
Enhanced access to Primary Care – aimed to include seven day access to primary care and comprehensive flu planning

In the ensuing discussion, the following main points were made:

- Committee Members agreed that patients had better outcomes if rehabilitation occurred at home,

however, commented on the poor choice of wording for the Frailty Unit. Thought had already been given to this and the unit would be referred to as the Silver Unit

- Although the Worcestershire Royal Hospital had the most challenge, the planning was applicable to the whole of the County
- Members queried the recommendation to halve length of stay in community hospitals. This was based on a "point prevalence study" which, on one day, had shown that 50% of community hospital patients did not need to be there. Changes were being made to improve patient flow, such as nurse-led discharge
- It was clarified that the ECIST was an external body, which did not fully understand the local processes in place, yet had published a report which was concerning to read in part. There was recognition that the recommendations were valid but Members were reassured that they would be developed in a Worcestershire way
- Members were assured that GPs and ambulance services were working well together
- Members asked about the increased conversion rate from A&E attendance to admission; was this due to a reduction in the threshold for admission? It was explained that patient acuity had increased and work was ongoing to have a GP at A&E to prevent admissions.
- If utilised properly, the proposed schemes would increase capacity by approximately 50 beds
- In response to a concern that data would not be collected to assess impact, Members were reassured that a system wide dashboard would be in place
- In relation to future planning, the urgent care strategy was a five year plan with providers mindful of additional housing planned in Worcestershire
- It was recognised that acute hospital wards were not fully equipped to treat patients with dementia and treatment at home was more valuable. It was confirmed that a geriatrician and a multi-disciplinary team would assess patients with severe dementia
- There was some discussion about whether discharge to assess in effect meant shunting costs from the Acute Trust to Social Care. It was noted that budgets and care were integrated
- Outbreaks of the winter vomiting virus, Norovirus,

had been limited over the winter period and benchmarking had suggested Worcestershire had fared well.

The Chairman thanked those present for a detailed discussion.

693 Future of Acute Hospital Services in Worcestershire

Attending for this item were:

South Worcestershire Clinical Commissioning Group
Carl Ellson, Chief Clinical Officer
Simon Trickett, Chief Operating Officer

Redditch and Bromsgrove Clinical Commissioning Group
Paul Sheldon, Chief Financial Officer

Future of Acute Hospital Services in Worcestershire
Simon Angelides, Programme Director
Claire Austin, Communications Lead

The Committee was reminded that the last update was on 22 January 2014, at which point, the outcome of the Independent Clinical Review was known and the 'case for change' was developing.

In the subsequent months, NHS England had completed strategic checks and its Assurance Panel was due to meet on 6 August 2014 to decide whether to authorise a consultation process for the Future of Acute Hospital Services in Worcestershire (FoAHSW).

Members were reminded that the Independent Clinical Review Panel had recommended a modified Option 1 (delivering care across all three sites in Worcester, Redditch and Kidderminster, to refine and update the proposals) and this had received a warm response from both the public and politicians.

In summary, the Independent Clinical Review Panel found:

- move inpatient services for sick children to Worcestershire Royal Hospital (WRH) and establish a new paediatric assessment unit at the Alexandra Hospital (AH)
- move consultant led maternity services to WRH
- enhance local access and birthing choice and consider a midwifery led unit in North Worcestershire
- led by consultants, network hospital based emergency services across the County. Introduce

an Emergency Centre at the AH, which would be co-located with a GP led integrated urgent care centre. At WRH a major emergency centre would be developed
- there was a need for clear communication with the public about the proposed changes
- issues such as transport and ambulance requirements would need to be addressed.

An engagement timetable had been drafted in anticipation of consultation being agreed to start in September. The three Clinical Commissioning Groups were committed to a widespread and inclusive 12 week consultation and considered it vital to encourage all residents to have a say. There would be roadshows and public meetings and it was hoped that every household would be delivered a postcard for feedback. There were also ideas for a Community Bus to travel the County and work to engage with hard to reach groups was developing. Officers were also committed to utilising existing networks and encouraged all Councillors to spread the word. NHS colleagues also welcomed requests to attend any stakeholder group if practicable.

In the ensuing discussion the following main points were made:

- HOSC Members were encouraged with the wide reaching proposals in relation to consultation and engagement, however, expressed caution with a postcard drop, which could get confused with general junk mail by the householder
- When concern was raised about the timing of the consultation, especially the end being near to Christmas, it was noted that there would be ongoing independent analysis of the consultation responses, allowing continuous feedback throughout the 12 week period
- It was noted that the General Election in May 2015 constrained the consultation timescales
- Discussions were ongoing in relation to the need for a Joint HOSC with local authorities affected by the proposed changes. It was still unclear whether neighbouring CCGs felt the changes proposed were substantial and this determined whether a Joint Committee was required
- There would be concern if neighbouring CCGs raised objections from this point as the level of engagement with them so far had been very high
- It was noted that Worcestershire Acute Hospitals NHS Trust (WAHT) was doing an admirable job to ensure services were sustainable during these

unsettling times and although the implementation timescales were unknown, it was the responsibility of WAHT to ensure that services were provided efficiently through the transition phase

- One Member asked why there seemed to be reluctance for the Acute Trust to work in collaboration with neighbouring Trusts, to be informed that was not the experience of Officers to date. It was suggested that the pace of change perhaps resulted in some information being outdated fairly quickly
- It was suggested that the proposed changes to maternity services were not fair and women in North Worcestershire deserved better. Reference was made to a letter from the Birmingham Women's NHS Foundation Trust sent earlier this year which noted there was not enough capacity there to deal with extra births from Worcestershire. It was confirmed that if births did not take place at the Alexandra Hospital, about 1000 would go to Worcestershire Royal Hospital, 300-500 to the Midwife Led Unit and 300-400 to South Warwickshire, due to the location of the mothers. It was clear that patient choice was vital; however a certain number of babies had to be delivered in a unit to make services clinically safe and sustainable. It was stressed that a midwife led unit in Redditch would not be accessible to mothers from Wyre Forest
- In relation to transport, concerns were raised as Members recalled the discussions when the route between Kidderminster Treatment Centre and Worcestershire Royal Hospital was proposed and implemented. The route had now closed. It was noted that transport plans were being developed in consultation with County Council colleagues and would form part of the consultation process.

The Chairman of Healthwatch was invited to comment on the discussion and reported to the HOSC that he was content with the inclusive process to date and was pleased to hear the proposed consultation ideas for public engagement.

The Chairman thanked all those present for the useful update and looked forward to the next chapter in the elongated hospital review process.

694 Pilot Project Introducing a

Attending for this item were:

<u>Redditch and Bromsgrove Clinical Commissioning Group</u>

System of Clinical Navigation at the Alexandra Hospital

Marion Radcliffe, Urgent Care Lead
Paul Sheldon, Chief Financial Officer

Worcestershire Acute Hospitals NHS Trust
Chris Hetherington, Consultant in Emergency Medicine

Care UK
Rebecca Chislett, General Manager
Zahida Adam

Dr Marion Radcliffe, Urgent Care Lead for Redditch and Bromsgrove Clinical Commissioning Group outlined the proposal for a 'clinical navigation' pilot at the Alexandra Hospital in Redditch, as part of the strategic priority to improve and enhance current systems within the Emergency Department.

In summary, the project would allow a patient to present at the entrance to the Emergency Department and be triaged by a multi-disciplinary team to be navigated to the most appropriate healthcare, whether primary care, social care, general practice, home or the emergency department. A GP service at the Hospital would be available up to midnight every day of the week, re-opening in the early hours. It was hoped that in future this provision could be 24 hours a day.

Dr Radcliffe explained that the pilot dovetailed with national initiatives in developing new types of emergency care (type 2 emergency centres) and would provide vital experience to the ongoing reorganisation of hospitals in Worcestershire.

The overarching benefits included:

- Patients being seen by the right clinician at the right time
- Enhanced patient experience would be achieved with a key focus on self-care and patient education
- Significant reductions in unnecessary acute admissions and attendances
- Improvements in the national 4 hour A&E performance target.

In the ensuing discussion, the following main points were made:

- The Pilot would be for a period of one year, introduced from September 2014
- As Care UK provided the out of hours service at the Alexandra Hospital, the transition would not be anticipated to be great and the organisation had

		experience of clinical navigation elsewhere • Members were encouraged to hear that small changes to the local environment would take place to show patients clear signage • If patients were navigated towards making an appointment with their own GP, this could be done immediately through a booking system. Members felt this was a useful tool as staff would be equipped to undertake this task • Dr Hetherington suggested that the project would enable patients to be re-directed to primary care more efficiently and would more clearly support patients to navigate the healthcare system. He also added that data gathered would be extremely useful to the Clinical Commissioning Groups. There was a risk of creating an increase in demand for the out of hours GP service, but the aim was to redirect appropriate patients to primary care in order to increase capacity in the emergency department to look after sicker patients • The Committee supported the Pilot and looked forward to receiving an evaluation report at a future meeting.
695	**Health Overview and Scrutiny Round-up**	This item was deferred until the next meeting.

The meeting ended at 3.55 pm

Chairman …….